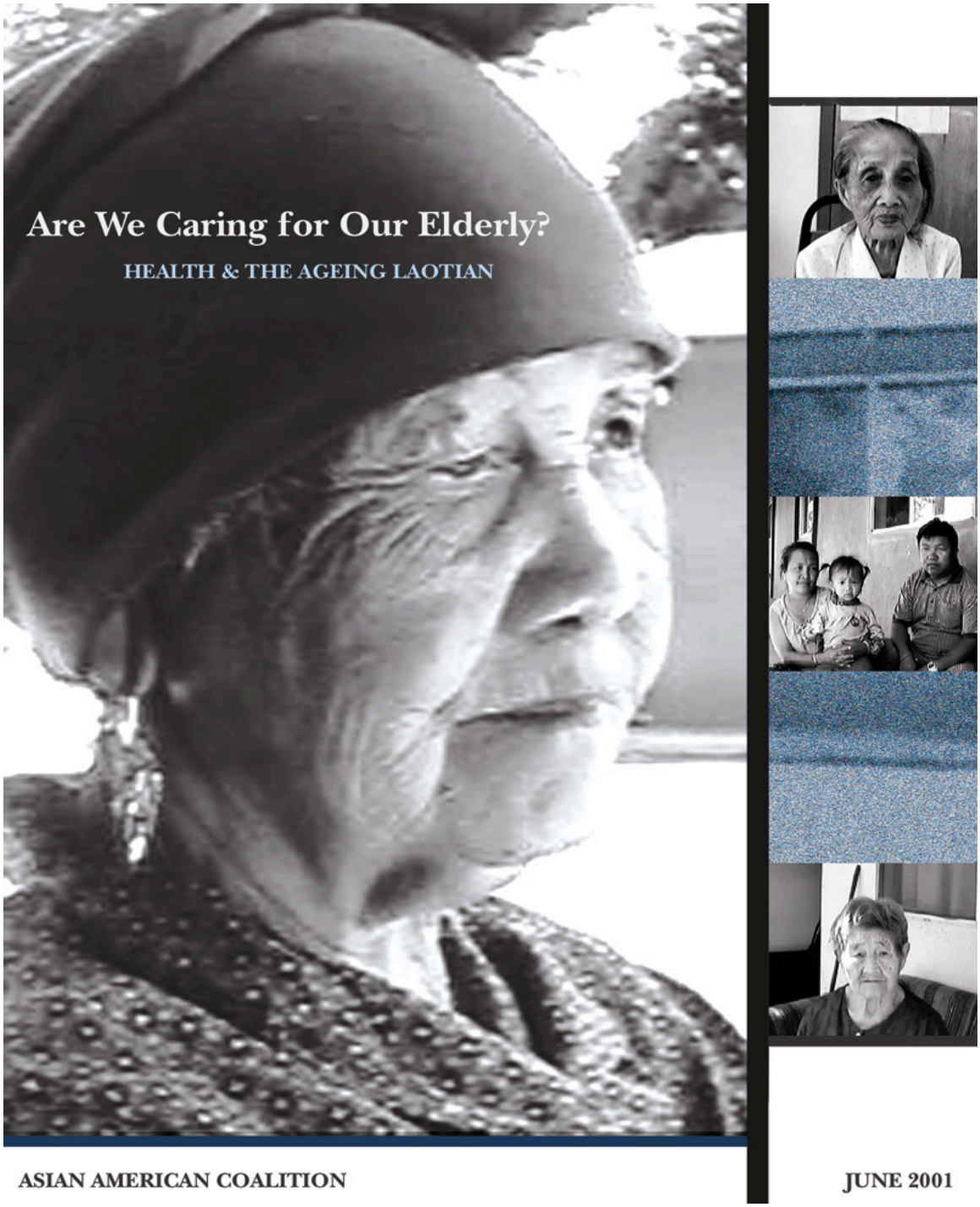

ASIAN AMERICAN COALITION

JUNE 2001

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Preface

The Asian American Coalition, is a 501 (c) 3 organization, established in 1993. The main purpose of the Asian American Coalition (AAC) is to:

Increase and broaden life's options, opportunities, and wellness, through education and/or economic development, and to assist and preserve the various Southeast Asian American cultures and traditional values.

The Asian American population in the United States is growing at an astonishing rate. Between 1980 and 1990, the Asian American population increased by 108%. Although Asian Americans make up the fastest growing racial group of elderly in the United States, there has been relatively little research conducted on this population. It is difficult to access accurate data about the various Laotian ethnic sub-groups they are often counted together under the generic categories "Laotian," "Asian," or even "Asian and Pacific Islander." Aggregate data for the Asian and Pacific Islander (API) population have presented an overly-optimistic picture – portraying Asian Americans as the "model minority" whose health and wealth are better than other minority groups. However, when API data are disaggregated into sub-ethnic groups such as Laotian, Hmong, Korean, or Chinese, a very different picture emerges. There are actually wide disparities in the socio-demographic and health conditions among the more than 26 census-defined API sub-ethnic groups.

Refugee health care emerged as a special area of interest in the United States following the influx of almost a million Southeast Asians since 1975. However, few studies have investigated the influence of the refugee experience on elderly health and utilization of health care. Southeast Asian immigrant populations were damaged physically and psychologically from exposure to war, torture, economic hardship, the disintegration of traditional society, and forced relocation. Additionally, the stresses of migration, linguistic isolation, acculturation, inter-generational conflicts, and continued poverty have negatively impacted the health of this population. Southeast Asian immigrant groups also have great strengths that need to be considered when assessing their health and creating programs. For example, their strong sense of community, dedicated involvement in religious activity, use of traditional medicines, and the strong influence of local leaders can facilitate effective programmatic interventions.

Elderly Hmong, Lahu, Lao and Mien seniors participated in focus group interviews and described their episodes of illness, health beliefs, behaviors, and health care decisions. Such qualitative research is important because the increasing cultural diversity in the United States, and particularly in California, necessitates that health care professionals understand the importance of cultural factors for access to and the use of health care by all patients including refugee and other immigrant groups.

The purpose of this study is to investigate the needs and utilization experiences of elderly Laotians in Tuare County. This study was conducted according to the assumption that equity in health care access is both desirable and attainable. Many policy initiatives (DiversityRx, 2001) have called for eliminating disparities in health care access among minority groups. It is the AAC's hope that the results of this study will serve as a guideline in creating policy and programmatic interventions targeting and serving elderly Laotians in Tulare County in order to facilitate equitable access to health services in the county wide.

As the Acting Executive Director of the Asian American Coalition, Inc., I urge all Laotian immigrants to make good use of this study. It is also my hope to inspire many of you to write, to do research, and to publish your works to further our understanding of health in the Laotian Community. Thank you.

Paul Chao
Acting Executive Director

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Family Services of Tulare County
Gambro Healthcare – Tricounties
Good News Center
Hospice of Tulare County
Kaweah Delta Health Care District (KDHCD)
Kaweah Delta Private Home Care
Kaweah Manor
Kings and Tulare County Agency of Ageing
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Mission Medical Enterprises, Inc.
Mobile Life Support Ambulance
Sequoia Family Medical Center
Senior Independence
Sierra Valley Rehabilitation Center
Soleas Health Care Services
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1. Definitions, Purpose, Objectives, and Overview of Methods Used

A. Defining Laotian

Sixty-eight officially recognized ethnic groups live in the country of Laos. Rural village living allowed these ethnic groups to evolve and maintain unique cultures and languages. It is important to consider that the term "Laotian" is often used in America to refer to all of the refugee and immigrant groups who fled Laos after the takeover by the communist Pathet Lao in 1975. In fact, these groups remain distinct, and continue to retain important cultural and linguistic differences here in the Central Valley of California. The Laotian community in Visalia is made up of four ethnic groups: Lao, Hmong, Mien, and Lahu.

For the remainder of this report, the word "Laotian" will be used to refer to the Hmong, Lahu, Lao, and Mien. The word "Southeast Asian" will be used to refer to the "Cambodian, Laotian, Thai, and Vietnamese." The word "Asian" will be used to refer Asian or Asian Pacific Islanders." In other parts of the report, the ethnic groups will be referred to individually.

B. Defining health

This study utilizes the following definition of health as put forward by the World Health Organization in 1948: health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1948).

C. Purpose: To determine the needs and barriers to care for elderly Laotians in Visalia in order to suggest policy and programmatic interventions to best deliver services to this community.

D. Objectives

1. To determine the approximate number of Laotian adults with functional impairments and elderly Laotian adults in Visalia.
2. To identify and investigate the availability, accessibility, and accountability of senior health care facilities and service providers
3. To determine gaps in services and/or barriers to care in elderly community

E. Methodology

The Asian American Coalition conducted this study with the assumption of the value of multiple inputs and data sources. Thus, our methodology utilized both primary and secondary data collection as well as descriptive, quantitative, and qualitative data analysis. We understand the importance of quantitative data for the provision of funds and other policy decisions; it is the hope of the AAC that the qualitative data will provide a human face to the numbers. This report draws from the medical literature, existing local and state data sets, a Community Resource Survey which was conducted in Visalia from February to May of 2001, and from focus group data collected in Visalia with the Hmong, Lahu, Lao, and Mien. Specific methodologies used will be discussed further in the appropriate sections.

F. Advisory Committee

In order to gain support from the Laotian community and to have a reciprocal role with community members, the Asian American Coalition decided that a community-based advisory committee would be an important addition to the project. The Coalition identified and selected a number of people with an interest in the Southeast Asian Community. Several sectors were represented within the advisory committee including health, education, religion, law enforcement, and business. The identified community stakeholders generally hold positions of leadership within the Southeast Asian community and were asked to serve, in that capacity, as advisors on the project. We would like to thank these community leaders and hope that the committee will continue to act in an advisory capacity to the AAC on projects in the future.

2. Demographic Profile of Southeast Asians in Tulare County

A. A brief history

Laos is a small, agrarian country situated in the center of Southeast Asia. Although the population of Laos is only 5.8 million, there are more than 68 officially recognized ethnic groups (each with unique languages, religions, and customs) residing within her borders. In speech, the Lao often make a more functional distinction between ethnic groups, dividing themselves into four rough categories – Lao Loum ("low Lao"), Lao Thai, Lao Theung ("upland Lao"), and Lao Seung ("high Lao") – according to the altitude at which they reside.

During the 1950s and 1960s, American foreign policy vigorously opposed Communism lest the "domino" theory become manifest causing country after country to fall to Marxist ideology. From 1964 to 1973 in Laos, the CIA sponsored an "Armee Clandestine" in a war against the communist Pathet Lao and the North Vietnamese Army who frequently pushed into Northeastern Laos along the infamous Ho Chi Minh Trail (Robbins, 1987). Hill tribes (particularly the Hmong and Mien) were recruited by the CIA to fight the communists. This U.S. sponsored conflict is often referred to as "The Secret War" because few Americans were aware that the CIA was involved in an ongoing top-secret military operation in Laos.

The Secret War severely disrupted the lives of the hill tribes who fought with the CIA; the conflict decimated people, their lifestyles, and the land. Laos earned the distinction of being the most heavily bombed nation on a per-capita basis in the history of warfare. To give some idea of the level of economic, social, environmental, and personal devastation experienced in Laos during this period, consider the following (Robbins, 1987):

- One and a half times more sorties were flown over Laos than were flown over Vietnam during the entire Vietnam War
- The secret airforce dropped an average of one planeload of bombs on Laos every 8 minutes, 24 hours a day, for 9 years
- By the end of the war, the bombing amounted to 1.9 million metric tons – or 10 tons per square kilometer of Laos

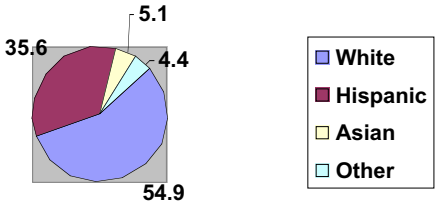
When the communist Pathet Lao gained control of the government in 1975 and the US withdrew support, many hill tribes and some lowland Lao feared repercussions for their anti-Communist activities. In May of 1975, when the Lao Peoples Revolutionary Party (the Pathet Lao) was declared the ruling party of the newly named Lao Peoples Democratic Republic, countless numbers of the fearful slipped over the border and blended into Lao-speaking Northeastern Thailand to escape the recrimination they knew would follow (Robbins, 1987). During the first two years of Pathet Lao rule, harsh political and economic reprisals caused tens of thousands of refugees to flee Laos for refugee camps in Thailand.

Many refugees who made their way to camps in Thailand waited months or years before being resettled in the US or other Western nations. In 1980, the United States government made asylum widely available to Laotian refugees; by December of 1989, over 204,800 Laotian refugees had settled in the United States. Initial resettlement in selected communities across the United States was followed by a second migration to the western United States in order to flee from discrimination, find jobs, and reunite families.

B. Demographic Profile

The 2000 Census found 12,018 Asians living in Tulare County. Of that number, 4,683 live in Visalia, comprising 5.1% of the total population (Redistricting Data, US Census 2000). US Census findings from 1990 indicated that a larger number of Asians (4,869) lived in the city of Visalia a decade ago and made up a greater proportion of the population (6.4%) (1990 Census of Population and Housing, U.S. Census Bureau, 1990). Most of the net loss of 186 Asians in the past decade can be explained by the out-migration of several clans for employment opportunities in other cities and states (Andy Phetsada, Interview, 2001)

Figure 1: Percent Race in the City of Visalia



In Visalia, the Laotian community is comprised of four main ethnic groups: the Hmong, Lahu, Lao, and Mien. The Lao are from the low-lying river valleys of Laos, while the Hmong, Mien, and Lahu are from the hills and mountains. The Lowland Lao (Lao Loum) are ethnic Lao who have traditionally lived a sedentary subsistence lifestyle based on the cultivation of wet rice. The Lao are Theravada Buddhists who concurrently maintain remnants of ancient animist belief systems. The Hmong, Mien, and Lahu lived in the mountainous regions of Laos and are known as Lao Sung or "mountain-top Lao." These groups lived by practicing slash and burn agriculture; their plant-based diet was typically supplemented with domesticated animals and wild game. The traditional religion of the highland tribes incorporates aspects of ancestor worship, Chinese Taoism, and animism. Some hill-tribe refugees converted to Christianity after fleeing Laos, while others have maintained their traditional beliefs.

Southeast Asians have the highest levels of poverty among all Asian and Pacific Islanders (APIs) in the United States. In California, 63% of Southeast Asians were 300% below the poverty level in 1996/7 (Levan, Kagawa-Singer, Wyn, 2000). The Laotians who reside in Visalia reflect these alarming statistics, and are generally segregated residentially in poor neighborhoods with small substandard housing. On average, households are larger than those of white families, and are generally comprised of two to three generations (US Census, 2000).

Laotians make up the highest proportion of foreign-born Asian and Pacific Islanders in the United States, with more that 80% having been born overseas (US Census, 1993). Due to poor education systems in Laos and the turmoil of war, education levels amongst Southeast Asian-American subgroups are very low: 49 - 59% of Laotian have had less than a 5th grade education.

Most often Laotians speak their native tongue in the home. Of those Tulare County residents speaking an Asian language in the home, 69% of them indicated that they do not speak English "very well." Comparatively, in Spanish-speaking households, 49% felt they did not speak English "very well" (US Census, 1990 Census of Population and Housing, 1990). The Hmong have the highest levels of Limited English Proficiency (LEP) rates in California at 76%. Laotians (including Lao, Lahu, and Mien) have the second highest LEP rates at 68% (US Census, 1990). These statistics imply that potentially high numbers of Laotian household experience linguistic isolation, which can negatively impact employment opportunities and access to healthcare.

3. Focus Groups

Laotian Voices from the Community

This report presents the results of five focus group discussions concentrating on issues of elderly health and medical care in the Southeast Asian community. All focus groups were conducted at the Ferguson Street Fire Station in Visalia and were conducted between February and May of 2001. The groups were selected according to convenience methods, in which moderators and assistant moderators recruited participants from Southeast Asian neighborhoods and/or through friends and family members. Although in a small sub-community (such as the various Laotian ethnic groups in Visalia) it is difficult (if not impossible) to find participants who do not know one another, we avoided recruiting participants who were kin or members of the same household in order to reduce external normative influences.

Each focus group was made up of one ethnicity (Hmong, Lahu, Lao, or Mien) and was held in the participants' native language. The groups consisted of between six and nine participants who ranged in age from 33 to 87 years with a mean of 63 years. Focus groups were made up of only one sex as experts have reported better results with homogeneous participants (Krueger, 1994). Three groups were with female participants (Hmong, Lao, and Mien), and two were with male participants (Hmong and Lahu).

Presentation of Results

This report consolidates the information shared at the focus groups. It is structured into five sections: (A) Perceived Health, (B) Methods of Coping with Illness, (C) Knowledge of Available Services, (D) Barriers to Care and Problems Experienced when Seeking Care, and (E) Facilitating Access to Healthcare Services.

A. Perceived Health

The initial discussion was intended to get the participants to think about some of the health problems they had experienced or witnessed among the elderly in their communities. Group members viewed their lifestyle and the physical environment as integral parts of their health and well being. For example, some members discussed gardening and walking as an important part of maintaining physical and mental health; others discussed housing and sufficient income as a necessity to be healthy. For many participants, violence and gang activity is a primary concern regarding their own personal health, and the health of their families and neighborhoods. Family problems in immigrant communities are often amplified due to the demands of assimilation and cultural conflicts that exist within their families and particularly between generations.

There were many physical health problems identified by elders of the Hmong, Lahu, Lao, and Mien focus group participants as well. Members of the focus groups appeared to personally suffer primarily from hypertension and heart disease. Diabetes, functional disabilities, stroke, and asthma were also identified as problems commonly being faced by seniors. The Lahu and Mien mentioned ulcers and chronic pain. The Hmong identified chronic pain, headaches, and dizziness, as well as gastro-intestinal and vision problems. The Lao focus group mentioned tuberculosis as a health problem for the elderly.

Although the Hmong , Lahu, and Mien all discussed chronic pain as a problem among the elderly, the members of the Hmong group presented numerically and qualitatively more problems with chronic pain than any of the other groups. This finding is consistent with the history of the Hmong, and may

be a function of higher levels of exposure to traumatic war events, injuries, and genocide. A comment from a member of the Hmong focus group illustrates the physical and psychological relationship of the health issues some seniors are facing:

> *Our country was not a free country so I worked hard with the CIA in order to protect our families and friends. I got hurt from a bomb and a gun. One of my arms broke during the war. When I came to the United States, my arm started to hurt again. When my arm hurt, it made the all the nerves on my back and neck hurt. Because of these problems, I became very sad. (Hmong man)*

The following are typical expressions of chronic pain among Hmong, Lahu, and Mien participants:

> *I have too many problems, so I don't know where to start. No matter how many times I go see the doctor, nothing seems to help. My whole back hurts from the bottom to the top. My head hurts…I have to be careful when I go places or I can faint at any time from the headache. (Hmong woman)*

> *I have too many body aches. I can not do anything. I stay home every day. (Lahu man)*

> *I had surgery two months ago. I cannot move. I know at least five other people that tell me that their wrists and knee joints always bother them. (Mien woman)*

Explanations of the causes of their illnesses ranged from war trauma, to health problems early in life, to behaviors associated with an American lifestyle, to the germ theory of disease.

> *I have had problems for a long time. I think my problems began at the age of 14. I used to deliver ammunition (in Laos), and I was shot in the side with a bullet. My body is still in pain from the incident. (Hmong woman)*

> *Food in America is good for them [non-Lao], but for us, we aren't used to eating food that has chemicals spread on it. If we eat food like they eat, we will have more problems than they do. Because we eat their food and our blood or bodies aren't used to it, we get sick easily. (Hmong woman)*

> *In the Lahu community, there are many problems with high blood pressure, strokes, and diabetes because the elderly don't do enough exercise. Back in Laos, we didn't have problems with these diseases because we did farm work everyday. (Lahu man)*

Hmong women were particularly fatalistic in their discussion of sick elders in the community. They seem to hold the belief that individual destiny is one of the primary reasons for ill health.

> *It's up to our luck to stay alive. (Hmong woman)*

> *If we can't get a doctor to help, then the only thing left to do is watch our loved ones slip slowly away. (Hmong woman)*

While no group members mentioned specific mental health problems, issues of sadness came up in the focus groups. Research has shown that distressed refugees from Southeast Asia express symptoms that are more consistent with Asian classification of mental disorders than with Western clinical categories

(Chung and Kagawa-Singer, 1995). These symptoms often resemble the construct for neurasthenia, which includes both physical and psychological manifestations of distress. Major symptoms of neurasthenia include a feeling of weakness or fatigue, which may be accompanied by chest pain, rapid irregular heartbeat, dizziness, and physical discomfort.

B. Methods of Coping with Illness

Members of the Laotian community agreed that the most common response to illness in the elderly is to call "911" or to take the elderly to the hospital emergency room. Most participants were aware that "911" should only be used in case of an emergency.

> *We can't do anything except to take them to the hospital emergency room. (Lao woman)*
>
> *When we get sick, we call emergency and the paramedics answer the call. (Lahu man)*
>
> *I have called emergency (911) three times. They take us to the emergency room and help us very well. (Hmong man)*
>
> *The only way to get a doctor is through an emergency call, and the ambulance can take me to a doctor. When it's not important, I can find a ride to the nearest clinic. (Hmong woman)*

The other common response to elderly sickness is to use local clinics. The Visalia Health Care Center and the Mental Health Clinic on North Dinuba Boulevard seem to be best at meeting the needs of Laotian elders by providing translators and assistance with transportation.

> *We can't do anything when we experience a health problem. The only thing we can do is go to see the doctor. (Lahu man)*
>
> *I know that the doctor will help us. I only go to the North Visalia Health Clinic because they have someone that speaks my language and can pick me up for the appointment. (Mien woman)*
>
> *I think the best clinic would be the Mental Health Clinic. That is the clinic I always go to, I have to find someone to take me there. The Mental Health clinic has a translator, but you have to wait for a long time. (Hmong man)*

The elderly Hmong, Lao, and Mien focus group participants acknowledged that many members of their communities use traditional healing practices. It did not appear that a preference for traditional medicine was acting as a cultural barrier to seeking allopathic services. According to some participants, Western medical treatments were sought first. It was only after the patients were sent home, or if the treatment failed that they used traditional medicine. In most cases, traditional treatments and western biomedicine are used concurrently to treat the ill.

> *If we can't get a doctor, we will return to our traditional Hmong ways of having a shaman give a ceremony. (Hmong woman)*

We ask the doctors first, but if the doctor can't help we will use traditional medicine (Lao woman)

I went to see this doctor for my stomach problems…although I took medicine, it didn't help. So, I used some Hmong medicine for about 30 minutes…In the morning, my daughter took me back to see the doctor. (Hmong man)

I think the doctor's medicine is really helping. But sometimes I use an herbal bath to sooth my aching joints. (Mien woman)

The Lahu in Visalia are mostly Christian and are active members in one of the two Lahu churches in Visalia. Adoption of Christianity has led to significant differences in Lahu social support systems, beliefs, and practices concerning health. Unlike the other Laotian groups, the Lahu said that they do not typically use traditional medicine. Rather they look to Western medical care, religion, and the church for treatment and support.

For our daily needs we praise God, and God provides for us. (Lahu man)

In the Lahu community, we have the Visalia Lahu Baptist Church, which provides support to the community through prayer. (Lahu man)

We are no longer using traditional medicine when we get sick. We only go to see the doctor. But remember this: we are Christian. So, besides going to your doctors, we also ask the Lord for help. (Lahu man)

Self-medication is another traditional form of coping with illness in the Laotian community. It is a common practice in many Southeast Asian communities to self-prescribe imported medicines from Thailand, China, or Vietnam (Gilman, Justice, Saepharn, and Charles, 1992). For example, some focus group participants took Thai medication to treat chronic pain, and others self-prescribed penicillin for stomachaches. Some participants implied that they were sharing prescription medication with other members of their households and with friends in the greater community.

If I am not too sick then I can just take medicine. (Lao woman)

I go ask for medicine from the Thai doctor. I take medicines from Thailand to help me get better. Thai medicines help me more than the medicines here. (Hmong man)

I brought an old bottle of medicine that had helped my pain previously with me to the doctor…. I knew that the medicine I brought to show him was the one that would help me…The doctor said, "This is not your name [on the bottle], why did you bring this?" The doctor was yelling, "Why are you bringing other people's medicine?" (Hmong woman)

Participants discussed taking medication to combat chronic pain. However, many participants expressed the inadequacy of their medication to effectively treat pain. Pain management has emerged in recent years as a specialization in medicine, but has not yet reached Tulare County except through Hospice. The poor do not commonly have access to doctors who specialize in this area.

Everyday I have to take my medication. I'm tired. Taking my daily medication is like eating a complete meal. (Mien woman)

> *I also have backaches. Sometimes it hurts so much I can't even move. I went to see the doctor and he gave me medicine, but it didn't help. Although it didn't help, he didn't send me to another doctor. (Hmong woman)*
>
> *The old medicine could help ease the pain, but the medicine I am taking now doesn't work at all. The pain is still there even after taking many pills. (Hmong man)*

Group members expressed the cultural inappropriateness of nursing homes and other institutionalized care. Laotians have strong normative expectations that children should provide material and non-material assistance to their elderly parents. While the responsibility of caring for chronically ill or functionally disabled elderly parents can cause financial and emotion strain in families, a lack of support for the elderly is interpreted as abandonment in the Hmong, Lahu, Lao, and Mien cultures.

> *I think if we were to take my mother to a nursing home, she would probably cry for home every night. (Lao woman)*
>
> *Nursing homes are difficult. It would be better to take care of my mother myself. (Lao woman)*
>
> *I have been to the nursing homes…I saw lots of ways that they were treating the patients were incomplete or not good enough. (Hmong woman)*
>
> *In nursing homes…when the patients want to have their diapers changed, the nurses say, "I'll be back in 5 minutes." But they take about 45 minutes…The patient is so sad that this could make him die. (Hmong woman)*

A few participants had received home-health care in the past. In-home care is an appropriate method to cope with health problems in the Laotian community, as it does not undermine cultural norms of family responsibility to provide care to their elders. Access to non-medical health care appears to be less problematic in the Laotian community. In specific questioning regarding access to dental care, Lahu respondents said they all utilize the same dentist. Lahu respondents also indicated no problems with obtaining basic dental and vision care, although several medical eye problems were reported. Participants of several focus groups had used chiropractic care in the recent past.

C. Knowledge in the Community

The participants as a whole were aware of the main county health and mental health clinics and Kaweah Delta Health Care District Hospital. Several respondents said they had used and were satisfied with the County's Preventive Health Care for the Ageing program. They were not aware of additional services (such as hospice, Healthy Families, congregate meals, home health care, etc…) that exist for the elderly. Focus group members felt that limited English proficiency affected their ability to access information about available services. Some participants expressed anxiety about their lack of knowledge, about their inability to care for the elderly, and about their own futures.

> *I don't now anything about them. Only people like yourself who work in the community would know. According to what I know, there is no other medical care available; what we have now is it. (Hmong woman)*
>
> *As for me, I don't know of many other clinics. I think the clinic that helps us is the mental health clinic. (Hmong man)*

We don't know English, so we don't know about available services. (Lao woman)

Elderly Laotian participants stated that the current method of information dissemination in the Laotian community was through "word of mouth." For example, the Lahu participants said that they get information about available services and health information through members of the community who are employed by the county and through the Lahu church. Word of mouth is a powerful means of disseminating information in many immigrant communities that do not have access to other media for information.

We would tell out relatives and people in our community. (Lao woman)

We know about programs because Lahu people are working in these places, and they tell us. (Lahu man).

D. Barriers to Care and Gaps in Services

Limited English proficiency was the most often mentioned barrier to accessing services. Limited English proficiency may result in linguistic isolation in medical settings, improper diagnoses, low patient satisfaction, and poor compliance with treatment regimens.

I walked many times to the clinic because I couldn't find anyone to take me. When I get there, I don't know how to tell them why I am there. That makes me so sad and tired. This is the worst thing I have experienced in the United States. Lack of English is the worst thing in our lives living in this country. (Hmong woman)

If we don't understand English, who are we going to call for help? (Lao woman)

I don't know how to talk to doctors and my family is not available to help me translate. (Mien woman)

We are old and we don't know how to speak English. It is like being a blind person who can not see anywhere. (Hmong man)

Sometimes we are so sick that we almost die, but there is no one to translate for us or to take care of us. We would rather stay home and die then go to the hospital because when we get there, we don't know how to tell them why we came. We don't know how to explain what parts of our bodies are hurt. (Hmong woman)

Transportation also emerged as a serious barrier to care for many Laotian elders in the community. Seniors who can not drive must rely on family members or public transportation, which can delay care for the elderly. Additionally, relying on family members to provide transportation may cause truancy from work or school. If members of the Laotian community can not access transportation, they will call 911 to obtain it. Some felt they were abusing the system by calling in non-emergencies, but believed they did not have any other options.

I think that I would like to go see a doctor but no one will take me. My children all work and I can't ask anybody else. Nobody has time to take me to the doctor. (Hmong man)

Helping me translate and getting me to my doctor is very difficult right now. (Mien woman)

> *The mental health clinic already has people pick us up. What I want is for other clinics to have the same service. There are times when I can get a ride, but there are times when I can't find a ride at all. (Hmong man)*

> *I feel that the only way to get to a doctor when I can't find a ride is to call 911. The bad thing about this is that the policemen follow you to the hospital and they charge the hospital for the inconvenience. Sometimes, we can't afford to pay for these charges, and I feel that this is not right. All I want is to be able to get direct contact with the doctors; not through the emergency room. (Hmong man)*

Inability to access health care services was affected by the economic conditions of the participants. Several participants expressed limitations of Medi-Cal and cash payments.

> *When I wanted to see a doctor I had no money. I have to pay for medical care so I stay at home rather than go to see a doctor. (Hmong woman)*

> *The reason I can't use services is that the providers don't take government Medi-cal. If you don't have cash, they don't take you. I really want them to love us and give us some help too. If they don't help us, those who have money will get the help and those of us who don't have money will die. (Hmong woman)*

The Laotian elders emphasized that while they believed that elderly health care services were available to the public, they were not aware of what services would accept Medi-Cal. Many participants expressed confusion at the recent changes in Medi-Cal which require them to sign up with a specific HMO health care plan and seem to reduce their benefits, especially prescriptions. Countless local Medi-Cal beneficiaries, regardless of primary language or ethnicity, share this confusion and frustration regarding the changes in Medi-Cal.

> *When I go buy my medicine, it costs only five or 6 dollars. So, Why does Medi-cal not cover it? If I have the money, it will be okay. But if I don't have the money, what should I do? We want to know the law of our Medi-cal. (Hmong woman)*

> *My main concern is not the help of the doctor or the chiropractor, but it is the problems with the Medi-cal system. I know that the Medi-cal system has changed and I don't understand the coverage of the new system…Personally, I would like to talk to the head of the Medi-cal system and get them to fix the problems. (Hmong woman)*

> *I don't know any services that would serve the elderly better because they have changed our Medi-Cal to Blue Cross and Health Net. I don't know what services will take that, or how they are going to serve us. They want us to choose a doctor…A few years ago, when Medi-Cal hadn't changed, we could go to any clinic. But now we can't because of the changes in Medi-Cal. This year it is very hard for us to go to any clinics, so we just stay home and bare the pain. (Hmong man)*

Nearly all participants in the focus groups mentioned waiting times at the clinics; the elderly members of our focus groups stated that they regularly wait anywhere from two to four hours in local clinics. Members of several groups felt that they were being discriminated against in the clinics because of their race, while others felt they were being discriminated against due to being a Medi-cal recipient. One participant emphasized that waiting times were a ubiquitous problem in the clinics regardless of

race. Laotian clients may experience longer waiting times and delays in treatment due to a lack of available translators.

> *I have to wait too long to see my doctor at the clinic. I am an old lady. Sitting for two hours on a rough seat is painful for my lower back. (Mien woman)*
>
> *The doctor made an appointment for me at 11 o'clock in the morning, but I had to wait until 1:30 or 2 o'clock to see the doctor. I was very sick, almost dying, but I still had to wait for a long time. If I am that sick, when I wait for the doctor, I think I may die before they call me in. (Hmong man)*
>
> *For us Lao, we will be the last ones waiting. They call the Mexican people first. (Lao woman)*
>
> *When you go see the doctors in the morning they make you wait and they let their own kind, the white-skinned people, go in front of you. (Hmong woman)*
>
> *I would like the doctors to call me when it is my appointment time. I believe that it is not only us that have that problem because I see many Mexicans waiting there also. (Hmong man)*

Many Laotian participants showed extreme skepticism about the health-care system. In particular, there are great trust barriers to be overcome in the Hmong community. Hmong women feel disrespected and misunderstood by the clinic employees. They regard the health care establishment as being driven by profits, lacking in cultural understanding, and disregarding the health of their patients. Some women even believe that they are being used in medical experiments against their will.

> *No matter how sick we are, the doctors will tell us that there is nothing wrong and that we are just lying. This is what makes me mad…I know that I am really sick, but the doctors will tell me that I'm not. (Hmong woman)*
>
> *They lie to you and make all kinds of promises in order to get you to sign all the paperwork. Then they do nothing that was stated in the papers to help you at all. (Hmong woman)*
>
> *It's as if they have no respect for people like us who can't speak English well. It hurts to be disrespected. Even if you are a citizen, they still don't have any respect for you…This is how I see it: The doctors know that we are people with no county to go back to and that we only migrate to countries that can offer us shelter and food. They have no idea how hard it was for us to get here, and that's why they have no respect for us. They don't know where we came from, and they think we are just complaining. As for the older generation like myself, we came right out of war camps, and that is why we are in so much pain. It's not just complaints; it's real pain…So I see that the doctors think that when we go stay in the hospitals we just want free health care. The doctors think that we just want to use their tax money, but they don't know is the hardships that we have gone through. It may seem like we are dogs following our masters to a better place, and this is the reason why we don't receive any respect from doctors. The only thing is that they don't know the truth. (Hmong woman)*

> *I think they just want to give a little food to the [institutionalized] patients so they will only have to take care of them for a short time. They probably think the patients are dying anyway. (Hmong woman)*

> *I know that these doctors are just trying to do experiments on us. I feel that if they are, they should go do it on animals and not on human beings. (Hmong woman)*

Members of the Laotian community do not trust that the care they receive will be of a high quality, particularly if they are Medi-cal recipients. Participants were very sensitive to the "second-class" nature of Medi-cal.

> *The best providers are the ones that don't take Medi-cal. (Hmong woman)*

> *When Medi-cal doesn't cover everything, then the doctors don't want to treat us well. (Hmong woman)*

Participants expressed a desire for more consistent personalized care. Some studies have found that having a personal physician can improve care and increase access.

> *There are so many doctors, and one doctor checks you differently from another…I don't know which doctors know best about health. (Hmong man)*

> *I don't understand why that clinic is always switching doctors…I would get a new doctor every two to three months. Why is this so? All I really want is just one doctor who really knows who I am and what kind of illness I have. (Hmong woman)*

> *When I actually get a doctor who knows exactly what is going on with me and can help me…I want that doctor to stay. Also, if you continue to have the same doctor, I feel that this doctor will be nice to you and will pay attention to you. (Lao woman)*

Participants expressed interest in learning about and utilizing available health-care services; particularly clinics and in-home care support services.

> *We want help for elderly people with problems. If the elders knew how to ask for help, they would ask. (Lao woman)*

> *We really want to know how many clinics or hospitals are in Visalia so that maybe in the future we can use them. (Hmong man)*

> *We want the community to help us. Although we know that there are clinics that can help us, we still need someone to show us where they are and who they are for. Although we are told that there are clinics, we still don't know how to make contact. (Hmong man)*

The participants explained that they have a need for home health care that exceeds the current levels received.

> *I would like someone to come help my mother because she is suffering…Some days she is in terrible pain four or five times a day. I don't know what to do. It is very difficult…We have to change her diapers every day…She can't put on her own clothing, she can't shower; she can't eat by herself. (Lao woman)*

> *Once my mom was discharged from the hospital following a surgery. My mother was supposed to dress the wound everyday but no one in my family know how. The home-health nurse did not come and the wound became badly infected. My mom had to go back to the hospital and had to be cut open again. (Lahu man)*
>
> *I heard someone saying that a home-health aid came to her home. I need to have that too. (Mien woman)*

There was confusion about who qualifies for in-home care and what services are provided by in-home care among participants.

> *Sometimes, after the patient is discharged from the hospital, the home health nurse comes to monitor their health. But sometimes they do not. I think it depends on whether or not the members of the household speak English. (Lahu man)*
>
> *I don't use home health care services because they say I'm not sick enough. They say that for a person to qualify, they must have had a stroke, be paralyzed, or be unable to take care of themselves anymore…I think when we can't walk or do anything; they probably will come and help us. Now we don't know. (Hmong man)*
>
> *Now the doctor said [my mother] is better, so one of the nurses stopped coming. Now the other one just comes to give her the medication and leaves. I want them to stay there, but they just give her medicine and leave. I want them to come every day, but they don't come. How am I going to tell them what I need? (Lao woman)*

Most focus group participants did not know how to gain access to home health care. While some focus group members were aware of the need for a doctor referral to access care, they were not able to advocate for themselves and their elders when decisions about care were being made. Respect for authority is an important part of Laotian cultures. Southeast Asians may not express their desires to, argue with, or even ask questions of authority figures. Health care providers must provide Laotian elders and their families with all available options for care.

There was concern specifically in the Lahu group that elderly persons who should qualify for in-home supportive services (IHSS) were routinely denied benefits by the county. IHSS pays for a non-professional caregiver, who may be a family member, to assist with personal care in the home. There was confusion about why there was a barrier to Southeast Asians receiving these services. County bureaucracies need to assess their intake procedures to make sure that members of multigenerational living groups are not denied benefits because of the Western definition of a household and its income.

E. Facilitating Access to Services

Translators were felt to be the most effective tool to enable utilization by all participants in the focus groups.

> *What we need is someone who can translate for us. (Lao woman)*
>
> *We need a clinic with translators so the doctors know what we want and we know how the doctor is going to treat us. This would make us happier. (Hmong man)*

> *The overall need for our elderly is to have translators. We really need someone who can help us. If we have the doctors already, but we don't know how to speak English, it still cannot help us. We have many questions but we can not get them out of our mouths to the doctors. (Hmong woman)*

Recruiting people from the Laotian community for nursing, social work, and other medical related education programs would function to increase both linguistic access and culturally competent care for the Laotian community.

> *Our people should work with them so they can help us. The people who work in the clinics would understand us and understand the doctors. This would be the best for our people at this point. It they have Asian people working in the clinics it would be easy for us to talk. (Hmong woman)*

> *We are not all uneducated. They need to hire some of us who are educated that can help the rest of us. I know that there is someone out there who is educated enough to go in and work for them. (Hmong woman)*

In addition, participants expressed the need for transportation to health services, preferably by someone who speaks their native language.

> *We need someone to pick us up and translate for us when we see the doctor (Mien woman)*

> *I need a person to help me with transportation and making appointments. I also want someone to take me to the doctor and take me home. This is all I want. I see the doctor once a month, but it is very hard for me to go. (Hmong woman)*

The Laotian elders felt that the education of the community would be crucial to enable the use of available services. The current fragmentation and confusion surrounding Medi-Cal reform is a barrier to care that could be reduced with increased knowledge, advocacy, and improved referral processes. Informal information dissemination (i.e. word of mouth) was also initially raised as a possible way to increase knowledge of available services in the community. However, participants recognized the limitations of this method of both disseminating and acquiring information due to its informal nature.

> *If someone asked me, I would tell him or her about the clinics. However, if they don't ask me, I don't tell. (Hmong man)*

> *Whom can we tell about the services? We don't know the other groups (i.e. the Hmong, Lahu, and Mien). (Lao woman)*

The main point that arose was the need for information about available services in the language of the community, disseminated by a community leader or by translators at the county public health clinics. Fears of having to approach community leaders due to differential social status were expressed. This indicates a need for a formal means of dissemination of information to the community.

> *We can tell someone to tell the community about the services. If we don't go to someone, nobody will know about the services. If no one is informed, no one will know. (Lao woman)*

> *They have to tell the community where they [the services] are, what they are called, and what they are for. (Lao woman)*

> *We wouldn't dare ask important or respected people about the services that exist because they are busy. (Lao woman)*

Other traditional means of outreach (e.g. flyers, newspaper advertisements, and other printed media) have a limited ability to penetrate the Laotian community due to low literacy skills. Radio and television have more potential; however, there are currently no local stations or programs that target the Laotian community. Approaches to disseminating health information must be linguistically and culturally appropriate.

Having access to a senior center for Laotian elders emerged as a way for elders to access services and improve their quality of life. Respondents want to have a centralized locale where they can access information through education, preventative care, and socialize.

> *I would like a gathering place where a doctor can visit us or we will have things to do that keep us healthy and safe. (Mien woman)*

> *In order to help the elderly, the Lahu would like a place to meet where we can come for training and workshops about health care services. (Lahu man)*

> *We want a place where they [health aids] can come once or twice a month to see us. (Mien woman)*

Participants were appreciative of the opportunity of giving input and discussing problems in the community. Having additional forums or community meetings and actively attempting to recruit Laotian participants as community representatives might help empower them to participate in providing solutions to some of the health problems in their communities.

> *I think that talking like today, we can help each other. (Mien woman)*

> *I feel that in order for us to get help, or to get anything through to the important people, it will be through people like you…I want people like you to spread the word so that others can know what we're going through…I want them to open their eyes and look at us, so we can have a better life. (Hmong woman)*

4. Secondary Data Analysis in Tulare County

The Asian American Coalition utilized multiple inputs and existing data sources when investigating the needs of elderly Laotians in Visalia. Our secondary data sources were as follows: County Vital Statistics, Medi-Cal, Social Security Administration, the Kings/Tulare County Agency on Ageing, Tulare County Health and Human Services Mental Health, a Parent Needs Assessment conducted by Green Acres Middle School and Redwood High School, and Kaweah Delta Health Care District.

A. Tulare County Vital Statistics: Leading Cause of Death

In 1999, nearly three out of five deaths in Tulare County were from diseases of the heart, malignant neoplasms, or cerebro-vascular disease. Chronic lower respiratory diseases, accidents, and influenza/pneumonia were also important causes of death among the total population of Tulare County. Heart disease is the leading cause of death in the elderly population (Center for Statistics and Death Records, California Department of Health Services, 2000). The leading causes of death for Laotians are similar to the leading causes of death for the general population. Of the Laotian deaths recorded in the year 2000, seven were due to heart disease, three were due to cerebro-vascular disease, and three were due to respiratory diseases. The remaining deaths were due to sepsis, renal failure, and drowning (Tulare County Vital Statistics, 2001).

According to the State of California Death Records (Center for Health Statistics and Death Records, Department of Health Services, 2000), three Laotians died in Tulare County in 1999 out of 2,545 deaths. Death record data received directly from the Tulare County Office of Vital Statistics indicates that, in the year 2000, there were 18 Laotian deaths. There were six deaths in the Lahu community, two deaths in the Mien community, six deaths in the Lao community, and four deaths in the Hmong community. While California's vital statistics offer the most accessible information on cause of death by ethnic subgroups, it seems that county level data may not reach the state data accurately. According to the Office of Minority Health, mortality data is often inaccurate due to misclassifications of deaths and death rates for subgroups (Ross, May 2000).

B. Medi-Cal Eligibility

Southeast Asians have been dramatically affected by Medi-Cal reform. To be eligible for Medi-Cal, adults must be disabled, elderly, or in a family below the poverty line with dependent children. In 1994/5, Medi-Cal insured 51% of Southeast Asians in California, however, by 1996/7 the percentage of Southeast Asians covered by Medi-Cal dropped to 34%. During this time period, employment coverage and privately purchased medical insurance remained static. It was the rate of those without insurance that increased; for Southeast Asians the uninsured rate more than doubled from 11% to 23% (Levan, Kagawa-Singer, and Wyn, 1999).

In Tulare County in 1999, there were 94,945 residents eligible for Medi-Cal. Of those, approximately 4,000 of the total Asian and Pacific Islander population (33%) are eligible for Medi-Cal in Tulare County (Advance Report – County Data California's Medical Assistance Program Calendar Year 1999, 2000, DHS, 2000). Tulare County has an average eligibility rate of 26.8 percent; the second highest percent of Medi-Cal eligibles by county in the state of California (Advance Report – County Data California's Medical Assistance Program Calendar Year 1999,2000, DHS, 2000). As Southeast Asians have a higher than average eligibility rate (33%) in Tulare County, they have either higher levels of disability or poverty than other ethnic groups.

The following chart, based on a California Department of Health Services report, shows that Medi-Cal recognized 13,238 blind and disabled persons in Tulare County in March of 2001, or 3.6% of the total population. (See Chart 3) As there is no racially disaggregated data regarding disability

presented by the Department of Health Services, we can only estimate the numbers of disabled Laotians in Tulare County. As there are 4,000 Asian and Pacific Islander Medi-Cal recipients in Tulare County, we would estimate that 7% (280) are elderly, 0.4% (16) are blind, and 14.4% (576) are disabled.

CHART 2: PERSONS CERTIFIED ELIGIBLE FOR MEDI-CAL IN MARCH 2001

Category	N	Percent
Aged	6,261	7.0%
Blind	385	0.4%
Disabled	12,853	14.4%
Poor Families with Dependent Children	69,698	78.1%
Total	89,197	100%

C. Supplemental Security Income Eligibility

The AAC received data from Tulare County Social Security Administration in order to compare their data to the Medi-Cal estimates of aged, blind, disabled, and poor. Social Security of Tulare County has 540 Laotian Supplemental Security recipients of whom 422 are disabled, six are blind, and 93 are aged. These numbers can be compared to the expected number of Laotian disabled (See Chart 3).

CHART 3: EXPECTED AND OBSERVED NUMBERS OF LAOTIAN DISABLED, BLIND, AND AGED IN TULARE COUNTY, 2001

	Expected Number of Asian and Pacific Islander Disabled, Blind, and Aged (Medi-Cal Advanced Report, 2001)	Expected Number of Laotian Disabled, Blind, and Aged (38% of the total API population in Tulare County)	Observed Number of Laotian Disabled, Blind, and Aged (Tulare County Social Security Administration, Internal Report, 2001)
Disabled	576	219	422
Blind	16	6	6
Aged	280	106	93
Total	872	331	521

The observed number of disabled Laotians is nearly twice as high (422) as would be expected if the burden of disability was evenly distributed amongst ethnic groups (219). The number of blind Laotians is as expected, and the number of elderly SSI recipients is lower than expectations. The number of disabled and elderly are believed to be conservative by several leaders in the Laotian community, probably due to the numbers of Laotian immigrants that were exposed to war trauma in Laos (Somkhith Souryasack and Paul Chao, 2001).

D. Kings and Tulare County Agency on Ageing: Contact Profiles

The Kings and Tulare County Agency on Ageing serves some 60,000 adults aged 60 years and older who live in Kings and Tulare Counties (Profile of General Demographic Characteristics: 2000, US Census Bureau, Census 2000). The Agency provided the AAC with a contact profile for the numbers of Asian and Pacific Islanders (API) served by the agency from July of 1999 to May of 2001 and for the numbers of Whites and Hispanics served from January of 1999 to May of 2001.

The Agency served 153 API clients during the 22-month period assessed for an average of 7.0 clients a month. The majority of API clients served (86 hours or 56%) were assisted on tax rebates and other financial issues. The second highest number of API clients (53 hours or 35%) were assisted on nutritional issues such as congregate meals and home-delivered meals. The remaining 10% of API clients received assistance on other issues, primarily Medicare and Medi-Cal.

The Agency on Ageing served 5,544 white clients during a 28-month period for an average of 198 clients a month. The 1568 Hispanic clients served over a 28-month period averaged 56 clients per month. When comparing the average monthly utilization rates to the proportion of the population that APIs, Hispanic, and Whites make up in Tulare and Kings County, it appears that there may be accessibility problems for minority groups, and particularly Hispanics. Asian and Pacific Islanders appear to slightly under-utilize services at the Tulare and Kings County Agency on Ageing. The average monthly breakdown of Agency on Ageing service utilization by ethnicity (Asian, Hispanic, and White) as provided by the Agencies contact profiles are presented in Chart 4.

CHART 4: PROPORTIONAL AVERAGE MONTHLY UTILIZATION OF KINGS AND TULARE COUNTY AGENCY ON AGEING SERVICES AND PROPORTION OF THE POPULATION IN KINGS AND TULARE COUNTY BY ETHNICITY

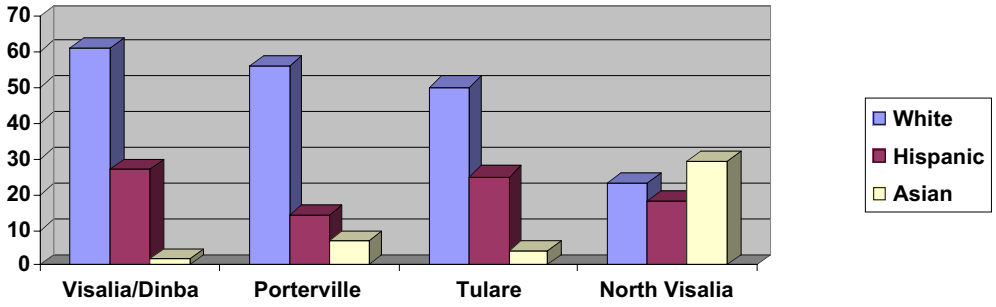
Ethnicity	Proportional Average Monthly Utilization of Agency on Ageing Services	Proportion of the Population in Kings and Tulare Counties
API	2.7%	3.3%
Hispanic	21.5%	48.9%
White	75.8%	41.0%
Other	unknown	6.8%

E. Tulare County Health and Human Services, Mental Health Branch

The Mental Health Branch of Tulare County's Health and Human Services Agency (HHSA) completed a Cultural Competency Plan in June of 1998. This plan looked at utilization patterns of County Mental Health Services by ethnicity, and analyzed the cultural competence of HHSA's service delivery. According to the HSSA report, there were five staff members representing all the local Laotian groups (Hmong, Lahu, Lao, and Mien) (Tulare County HHSA, Mental Health Branch, Cultural Competency Plan, 1998).

Utilization of Medi-Cal Specialty Mental Health Services including the Adult System of Care and Outpatient Services were presented in the report. Use of the services varied greatly by race and clinic location (See Chart 5). Adult Asian clients rarely utilize clinics other than the North Visalia Mental Health Clinic.

CHART 5: UTILIZATION OF MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES IN TULARE COUNTY, DECEMBER 1997



There was no information on primary diagnosis by ethnicity. According to one HHSA case-worker who has worked extensively with Laotian clients, most diagnoses were Post Traumatic Stress Disorder (PTSD) and Major Depression (Andy Phetsada, interview, 2001).

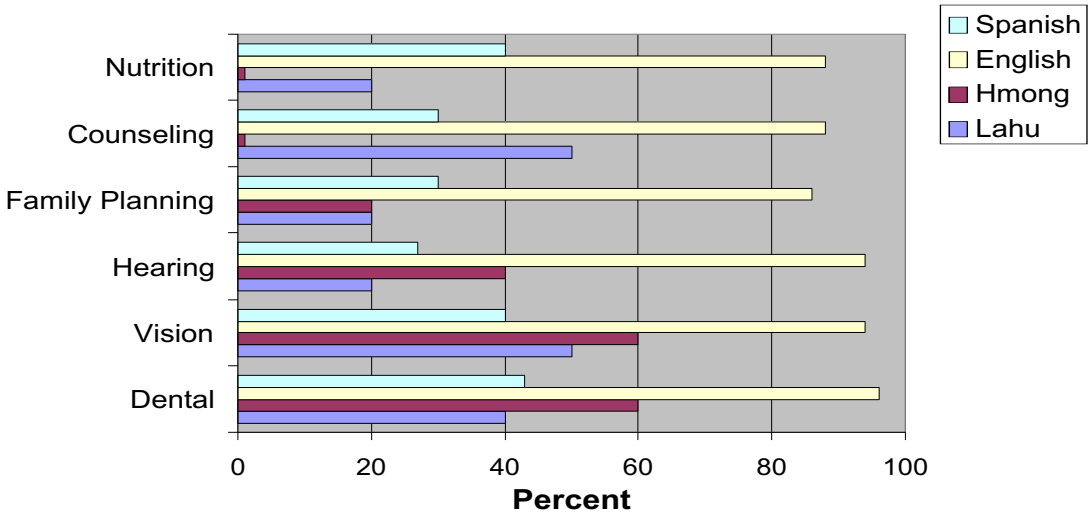
F. Green Acres Middle School – Redwood High School, Healthy Start Parent Needs Assessment, Fall 1997

A survey of Green Acres Middle School and Redwood High School parents was conduced in the fall of 1997. Out of the 397 surveys that were received, 100 were randomly drawn using the following method: 50 were taken from the English-speaking Group, 30 were taken from the Spanish-speaking group, 10 were Lahu, and 10 were Hmong.

The Southeast Asian groups were more likely to be Medi-Cal recipients than the English-speaking group. Of the Lahu group, 100% of the sample reported Medi-Cal as their only payment method for health care. The Hmong reported three payer sources: Medi-Cal (80%), Private Insurance (20%), and Cash Payments (20%). In response to the question, "What do you do when someone in your family is sick or doesn't feel well?" the Hmong group responded that they would see a medical doctor in his or her office (100%), use folk remedies and other traditional ways of healing (80%), go to the county health clinic (70%), and use the emergency room (60%). The Lahu also stated that they would see a doctor (80%), use the county health clinic (90%), and use the emergency room (70%). However, the Lahu had much lower levels of traditional medicine use, with only 10% reporting using folk remedies and other traditional ways of healing.

While 80 percent of the Hmong sample agreed with the statement, "people in our family are usually healthy," only 30% of the Lahu sample agreed with this statement. The Parent Needs Assessment Survey also contained measures of service accessibility in the community. English-speaking participants consistently reported higher levels of access to health services that the Hmong, Lahu, and Spanish-speaking participants (See Graph 6). Zero percent of the Hmong sample reported having access to nutritional and counseling services, while 88% of the English-speaking sample reported access. Only 20% of the Hmong and Lahu samples reported having access to family planning services. The Hmong reported slightly better levels of access to vision, hearing, and dental services than the Lahu sample.

Graph 6: Percent of Primary Language Group Samples Reporting Access to Services



G. Kaweah Delta Health Care District (KDHCD)

Kaweah Delta Health Care provides the most comprehensive private health care services to residents of Visalia. Hospital and other service discharge data contain information about utilization, diagnoses, and payor method. As with most data concerning Laotians, these data are collected for generic "Asian" categories and thus, have limited applicability to the specific sub-groups of the Laotian community.

The secondary data received by KDHCD allowed for analysis of specific sub-services utilization of Kaweah Delta Health Care including emergency, medical, occupational, outpatient, and surgery (Chart 7). Asians used an average of 2.2% of KDDHC services, while comprising 5.1% of the population in Visalia. Hispanics and whites utilized 22.7% and 75.4% of KDHCD services respectively, while Hispanics comprise 35.6% and whites comprise 54.9% of the population.

CHART 7: NUMBER AND PROPORTION OF PATIENTS UTILIZING KDHCD SERVICES BY RACE, 2000

Service	Asian		Hispanic		White		Total	
	Total N	% of service use	Total N	% of service use	Total N	% of service use	N	%
Emergency	348	3.2%	3,324	30.8%	7,138	66.0%	10,810	100%
Medical	247	1.7%	3,066	21.1%	11,194	77.2%	14,507	100%
Occupational	5	1.1%	172	36.7%	292	62.3%	469	100%
Outpatient	1,051	1.8%	12,678	21.6%	44,963	76.6%	58.692	100%
Surgery	39	1.2%	688	20.5%	2,637	78.4%	3,364	100%
Total	1,690	2.2%	19,928	22.7%	66,224	75.4%	87,842	100%

The AAC looked at the payor source for utilization of any of the services provided by Kaweah Delta Health Care District including emergency, medical, occupational, outpatient, and surgical care. Unfortunately, for each ethnic group (Asian, Hispanic, and white), between 50 and 56% of the payor source data were missing. Although there were missing data from all groups, the data that is left can provide some clarification about the relationships between payor source and race.

Fewer Asians and Hispanics were covered by Medi-care than whites; 4.2% of Asians were covered and 3.4% of Hispanics were covered vs. 11.5% for whites. These differences in Medi-Care coverage are probably due to the relative youth of Asian and Hispanic populations in comparison to whites. Conversely, Medi-Cal payor source was higher for Hispanics (7.3%) and Asians (19.4%) than for whites (2.6%). Increased levels of Medi-Cal coverage are probably associated with higher levels of poverty and disability among Asian residents of Tulare County.

5. Community Resource Survey

A. Methods

This exploratory study utilized survey methodology to assess the health care resources available to Laotian elders in the city of Visalia. The primary purpose of this survey was to gather data on the availability, accessibility, and accountability of local service providers. Secondly, this study will be used to create or strengthen relationships between service providers and the Laotian community.

Respondent agencies served as the unit of analysis. The AAC attempted to compile a complete list of human health service providers and senior programs located in the City of Visalia. The following categories of providers and programs were included: county health programs, public and private clinics and hospitals, home-health care providers, convalescent hospitals, and non-profit agencies. We did not include retirement homes in our survey. In all, 45 programs and agencies were identified at the time of the survey. Senior service providers were identified through the following means: the Yellow Pages, and the Tulare County Community Resource Directory (Tulare County Health and Human Services and United Way of Tulare County, 1999). Each of the 45 agencies identified was mailed a questionnaire in April of 2001. Follow-up contacts were made one month later to improve the response rate.

B. Measures

The survey instrument included twenty questions regarding availability (type of service provision, utilization by Laotians in the community), accessibility (eligibility requirements, payment sources, method to gain access, provision of interpreters, staffing characteristics, outreach methods, languages of written materials and signs, and services provided to enable access), and accountability (measures of client satisfaction, staff evaluations). A penultimate question inquired about the organization's interest in future cooperation with the Asian American Coalition and other local agencies in the areas of client outreach, translation services, and interagency referrals. The final question was open-ended and allowed respondent agencies to discuss issues that may have not been addressed in the survey.

Thirty-one programs (69%) participated in the study by returning the survey questionnaire.

C. Results

The participating agencies represented a range of services provided to the elderly from socialization/support services, to preventive care, to hospitalization (See Chart 8).

CHART 8: SERVICES PROVIDED TO ELDERLY RESIDENTS OF VISALIA BY RESPONDENT AGENCIES

Services Provided	N	Percent
Medical Outpatient Care	9	29%
Inpatient Care	10	32%
Emergency/Urgent Care	6	19%
In-home Care	7	23%
Psychiatric Care	5	16%
Long-term Care	6	19%
Patient Information Services	11	36%
Community Education	10	32%
Information and Referral Services	14	45%
Case management	9	29%
Skilled Nursing	7	23%
Rehabilitation	9	29%
End-of-Life Care	9	29%

Among the 31 respondent organizations that provided medical or other services to the elderly community in Visalia, 71% had served members of the Laotian community in the past year, 9% had not served members of the Laotian community, and 19% did not know whether or not they had served members of the Laotian community.

The survey included multiple measures of accessibility including structural and cultural items. Structural items included eligibility requirements, method to gain access, payment sources, and services provided to enable access. Cultural competency measures included provision of interpreters, languages of written materials and signs, staffing characteristics, and outreach methods.

Structural measures of support indicated that in the case of most services (84%), all elderly adult residents would be eligible to receive their services. Approximately 14% of the respondent agencies had other eligibility requirements including low-income status or being a dependent elder or disabled. The most common methods used to access services were making an appointment (58%), walk-in (61%), and referral (65%).

Agencies often accept multiple methods of payment. The following chart indicates the methods of payment accepted by local respondent agencies (See Chart 9)

CHART 9: PAYMENT SOURCES FOR RESPONDENT AGENCIES

Payment Type	N	Percent
Medicare/Medi-Cal	19	61%
Private Insurance	20	65%
HMO Insurance	15	52%
Healthy Families	9	29%
Sliding-Scale Fee	7	23%
Free services (limited)	11	36%
Private Payment	5	16%

Enabling services are provided to facilitate utilization by members of the community that may have special needs. Many organizations provided at least some enabling services to their clients (See Chart 10).

CHART 10: PERCENT OF ORGANIZATIONS PROVIDING THE FOLLOWING SERVICES TO ENABLE ACCESS

Enabling Services	N	Percent
Transportation	10	32%
Home Visits	14	45%
Information and Referral	17	55%
Counseling	13	42%
Culturally and linguistically sensitive outreach	7	23%
Childcare	1	3%
Community education	13	42%
Case Management	7	23%
Reminder system	5	16%

Staffing characteristics of the agencies did not indicate high levels of cultural competence for serving elderly Laotian clients, with only 26% of agencies having bilingual staff interpreters. An

additional 35% of agencies surveyed reported having access to translators external to their organization. Four of the agencies surveyed responded in an open-ended format that access to translators in their organization exists in theory but not in practice, and that the level of access to translators is inadequate to meet the needs of their Laotian clients. In all, sixty-one percent of the 31 agencies surveyed reported having access to interpreters on staff or externally to their agency (See Figure 11).

Figure 11: Organization Access to Laotian Interpreters

Signboards and written materials were provided in languages other than English in 81% of the organizations surveyed. Of those agencies providing materials in languages other than English, 100% had Spanish language signs and/or written materials. However, only 25% had any language signs and/or written materials in locally spoken Laotian languages.

The AAC was pleased to learn that some local organizations (61%) have adopted strategies to recruit and/or train diverse and culturally competent staff. Moreover, more than half of these organizations (58%) also evaluate their staff for cultural competence.

All organizations surveyed had some mechanisms in place to measure client satisfaction. Organizations commonly use informal complaints, interviews, and surveys in order to measure client satisfaction, and most organizations (58%) utilize more than one measure of satisfaction. However, very few organizations collected these measures in languages other than English. Fifty-five percent of local agencies collected client satisfaction measures in Spanish, but only 23% collected measures in *any* of the locally spoken Southeast Asian languages (see Chart 12).

CHART 12: LANGUAGES IN WHICH CLIENT SATISFACTION MEASURES ARE COLLECTED

Language	N	Percent
English	31	100%
Spanish	17	55%
Hmong	6	19%
Lahu	4	13%
Lao	6	23%
Mien	4	13%

The agencies surveyed used a variety of outreach techniques in their efforts to inform and market their services to elders in Visalia. The outreach technique used most frequently was client word of mouth. Outreach methods utilized by organizations surveyed can be seen in Chart 13. Additional methods of outreach mentioned were community education, traditional media, marketing, and the internet.

CHART 13: PERCENT OF ORGANIZATIONS USING THE FOLLOWING OUTREACH TECHNIQUES

Outreach Techniques	N	Percent
Word of Mouth	25	81%
Referrals	22	71%
Flyers	12	39%
Television	4	13%
Ethnic Radio/Media	7	23%
Other	10	32%

We included one open-ended question in which we asked the respondents to discuss important issues or questions that should be addressed. This question was included in order to allow the agencies to tell us what concerns they have when serving the Laotian community. Cultural training and staffing needs emerged as the two primary issues that concern local agencies. Typical responses were as follows:

> *Previous Southeast Asian Cultural Awareness training by Somkhith Souryasack was extremely helpful.*
>
> *We would be interested in having names of agencies or individuals that could be potential speakers at in-services for staff regarding cultural awareness.*
>
> *We need RN nurses from the Hmong, Lahu, Lao, and Mien community and/or translators who are willing to assist.*
>
> *Assistance is needed in locating and recruiting culturally diverse individuals/professionals… could be helpful to our (or any) organization.*

Other responses included requests for report results. Some examples were as follows:

> *We would like information on the outcome of this report.*
>
> *Will the results of this report be disseminated through education/in-services to local health care providers?*

The AAC was encouraged to note that seventy-one percent of the organizations surveyed were interested in cooperation with other local agencies in the areas of client outreach, translation services, and inter-agency referrals. This type of cooperation can lead to increased acceptability and accessibility of local services amongst elders in the Laotian community. With future collaboration between agencies, we hope to improve access of Laotian elders to available services in the City of Visalia.

6. Discussion

A. Needs: Health of Elderly and Disabled Laotians in Tulare County

Elderly Asian Americans tend to have poorer health status and have disproportionate risk of preventable chronic diseases and disabilities than the elderly population in general (Takamura, May 2000). As no studies currently exist specifically regarding disabled Asian and Pacific Islanders in California, it is difficult to generalize about the state of disabled Laotians in Tulare County. However, the disproportionate risk of disabilities for Laotians was confirmed through secondary analysis of Social Security data for Tulare County. These data showed that there are nearly twice the numbers of functionally disabled Laotian adults than would have been expected according estimates based on Medi-Cal data.

Information received from the Office of Vital Statistics indicates that, much like white populations, elderly Laotians leading causes of mortality are heart disease, cerebro-vascular disease, and respiratory diseases. Focus group data supported this information; according to focus group respondents, the primary causes of morbidity are hypertension and heart disease. Diabetes, asthma, and chronic pain were also causes of morbidity in the Laotian community according to focus group participants. Additionally, chronic pain management emerged as an important health need for the hill-tribe Laotians, and particularly for the Hmong.

The mental health needs of Laotians in Visalia are unknown, as there has been no local community-based research conducted on the mental health status of Laotians. Much research has concluded that sub-groups of immigrants and refugees may be at particularly high risk of mental disorders(Chung and Kagawa-Singer, 1995). Major risk factors include: pre-migratory trauma and stress, separation from family or community, isolation from people of similar ethnic background, inability to speak the language of the host country, unemployment or underemployment, and negative public attitudes and rejection. Many of these risk factors are present in the lives of Laotian immigrants in Visalia. According to County Mental Health, the most common diagnoses are Post-traumatic Stress Disorder (PTSD) and major depression.

B. Utilization

Southeast Asians in general, and Laotians in particular, have been shown to be at risk for physical and mental health problems in the United States. Part of this risk may come from the under-utilization of health services. The API population has been found to be less likely to visit a physician, have a regular source of health care, have routine preventive health checkups, and are more likely to use the emergency room as the first line of treatment (The Health Status of Asian and Pacific Islander Americans in California, 1997). Secondary data from Kaweah Delta District Health Care demonstrates that while Asians tend to use emergency services at levels slightly below what would be expected in Visalia, they are much less likely to use outpatient, medical, occupational, and surgical services. Asians used only 1.1% to 1.8% of KDDHC services, while making up 5.1% of the population. Likewise, Hispanics were found to have low utilization levels of KDDHC services. Asians and Hispanics also have low levels of service utilization for the Kings and Tulare County Agency on Ageing.

Elderly Asian and Pacific Islanders are under-represented in nursing homes (US Census Data 1990) and tend to use informal support to care for the elderly at home. Studies have not confirmed whether this under-utilization is due to cultural norms, economic inaccessibility, or for other reasons (Morrison, 1983). More than seven million Americans are informal caregivers, with the highest rates among Asian Americans (31.7%) (Oxendine, 2000). Laotian culture and tradition values care of the elderly by family members, a value that is facilitated by multiple generation households.

Focus group data demonstrates that older Laotians in Tulare County strongly prefer home-care to institutional care. Unfortunately, health policies tend to reinforce a model of institutional care and undermine options for home and/or community based care. The burdens of providing home care for the elderly with no economic, skills, or social support can be massive. There are few non-institutional long-term care benefits accessible to families interested in home care. Furthermore, the need for home-health care services was found to exceed the amount received in focus group data. Few focus group participants were aware of the availability and variety of home and community-based health services in the City of Visalia. Community or home-based long-term care are more culturally acceptable to Laotians than institutional care. As physicians often act as "gate-keepers" for home-health care services, they should be aware of the cultural preferences of Laotian clients. Issues such as low English proficiency, limited knowledge, and cultural tendencies not to ask questions among Laotian clients amplify the importance of the physician's role as a disseminator of knowledge, an advocate, and a "gate-keeper."

Knowledge in the community is crucial to facilitate appropriate utilization of health care services. Focus group members were not aware of many of the available services in the community. Very few members were aware of home-health, and in-home support services. No participants knew about Hospice, Meals on Wheels, or even the Healthy Families program. Linguistically isolated elders are risk for not learning about the services available to them. Community education and outreach is important to increase the knowledge of available resources in the community. Outreach attempts should consider the unique multi-generational composition of Laotian households and the responsibility of the younger generations to act as caretakers. Involving all generations in outreach and education is important as adult children and even teenagers assist older relatives in making health care decisions.

Researchers have presented two main hypotheses to explain the under-utilization of preventive and other routine services by Southeast Asians. The first hypothesis is that acculturation can affect utilization patterns and act as a barrier to seeking health care. It is generally believed that immigrants who have adopted the practices and values of American society will be more likely to utilize services. Low levels of English proficiency, traditional health beliefs, and traditional practices are hypothesized to explain low levels of service utilization by immigrant groups (Jenkins, Le, McPhee, Stewart, Ha, 1996). For example, concepts such as "soul loss" may cause Laotian patients to fear medical procedures such as surgery or even blood tests, limited English proficiency may hinder seeking care, and traditional medicine may act as the first line of defense for Laotian immigrants (Chang, Interview 2001). The second hypothesis is that structural barriers such as poverty, lacking health insurance, and not having a regular physician are the strongest predictors of low utilization. Data show that access to health care (particularly preventive and chronic-illness care) is influenced by having a regular source of care and health insurance. In fact, these two hypotheses most likely exist in some combination for most Laotian immigrants in Tulare County. It is recognizing the complex interplay of class and cultures as they effect health care that is a challenge to local health care providers and policy makers.

C. Barriers in Accessing Quality Care

i. Language and Cultural Barriers: Limited English Proficiency/Linguistic Isolation

On August 11, 2000, President Clinton issued Executive Order 13166, requiring federally funded programs to improve access to health and social services for Limited English Proficient persons. This order is based on Title VI of the Civil Rights Act of 1964, which prohibits discrimination because of race, color, or national origin. In order to avoid discrimination against LEP persons on grounds of national origin, health and social service providers must take adequate steps to ensure that LEP clients receive the language assistance necessary to give them meaningful access to their services, free of charge (Federal Register, August 30, 2000).

In Tulare County, 69% of residents speaking an Asian language in the home indicated that they do not speak English "very well" (U.S. Bureau of the Census, 1990 Census of Population and Housing). The Hmong and Lao have the highest levels of Limited English Proficiency (LEP) rates of any API groups in California at 76% and 68% respectively (US Bureau of the Census, 1990). A lack of English proficiency can lead to social, cultural, and linguistic isolation for Laotian and other immigrants in the United States. In turn, this isolation can lead to ignorance about available medical and social services, client-provider miscommunication, and non-compliance with medical treatments. Medical services that are denied, delayed, or provided under adverse circumstances may have serious, even life-threatening consequences for Limited English Proficiency ("LEP") individuals and often constitute discrimination on the basis of national origin (Federal Register, August 30, 2000).

There are five in-patient hospitals, 47 long-term care facilities and 236 physicians or physician groups which received Medi-Cal program payments in Tulare County in 1999 (Advance Report – County Data California's Medical Assistance Program Calendar Year 1999, Medical Care Statistics Section, Department of Health Services, 2000). According to Title VI of the Civil Rights Act, these organizations must provide interpreters to Limited English Proficient patients. According to service provider reports, 61% of local organizations that provide health related services to the elderly have access to translators. Although this is a positive step in facilitating access to services for LEP clients, focus group data and survey respondents indicate that a gap exists between organizations having theoretical access to translators and using those translators in practice. By far, the most often identified barrier to care by members of the Laotian community was limited English proficiency. Translation services were identified as being inadequate to serve the needs of the local Laotian community by both service providers and Laotian focus group members. Even delays in service utilization due to an insufficient number of translators can be considered a violation of the Civil Rights Act.

Medical interpreters must be appropriately trained to provide interpretation services in order to benefit the client to the fullest. People who serve as medical interpreters should be skilled in cultural sensitivity, medical terminology, the ethics of translation, and the practice of translation. For members of the Laotian community, the practice of using family members as informal translators has multiple repercussions as identified in focus groups and in interviews with key informants:

- The burden of providing the translator falls upon the patient
- The quality of translation is not insured
- Traditional family hierarchies and cultural norms are disrupted when children translate for parents, men translate for women, and women translate for men
- Patient privacy is compromised
- Emotional involvement of the family member acting as the interpreter may hinder translation
- Translation of sensitive issues (e.g. domestic violence, sexual abuse, or birth control) may be seriously compromised
- Family translators may be forced into school or work absenteeism

While health-care providers may shy away from medical interpretation due to costs and inconvenience, the provision of medical translators can actually be an economically feasible option. For by "ensuring client histories, better understanding of exit and discharge instructions, and better assurances of informed consent, providers will better protect themselves against tort liability, malpractice lawsuits, and charges of negligence" (Federal Register, August 30, 2000). Additionally, health-care providers may reduce the use of expensive emergency and urgent-care services, reduce hospitalizations and return visits due to complications and non-compliance, and ensure greater satisfaction among their clients.

ii. Language and Cultural Barriers: Traditional Beliefs, Attitudes, and Practices

Traditional health practices are commonly used by Laotian immigrants, although there are substantial differences in the prevalence of these practices among sub-ethnic groups. The reasons for these differences remain unclear, but are probably related to religious beliefs, acculturation levels, knowledge of Western medical practices, and social support networks. The Lahu community reported low levels of traditional medical practices in focus groups and the Parent Needs Assessment Survey conducted by Green Acres Elementary School and Redwood High School. The Hmong, Mien, and Lao all reported the use of traditional practices, often in conjunction with Western medical practices. Previous studies have found that traditional medicine is often used prior to seeking Western medical treatment by Southeast Asian immigrants. It is only after traditional medicine fails, that Western medical services are typically sought (Uba, 1997). This was not supported by focus group data, which found that Laotian immigrants typically seek Western medical services before or concurrently with traditional practices.

Traditional health care practices include treatments such as herbal remedies, over-the-counter drugs from Thailand, coining and pinching the skin, sacrifices, prayer, and magic. Laotian health practices may be beneficial through actual and placebo effects, or may harm the patient through a delay of Western medical care and the use of inappropriate medication. Health care providers should encourage the use of neutral or beneficial treatments used by Southeast Asians, as traditional practices can allow Laotians some level of control over their illness. Providers should maintain a non-judgmental attitude, allow Laotians to treat all aspects (physical and spiritual) of the disease according to traditional beliefs, and assist in decreasing cultural conflicts for clients who embody multiple belief systems. Local health-care providers should be aware that self-medication is an important aspect of self-care in the Laotian communities and that there may be contraindications for physician-prescribed medications and/or side effects from self-administered medication. This calls for particularly diligent patient interviews to determine which medicines are being used by Laotian clients and possibly the recommendation that clients take all medication in to appointments for review.

The Laotian community has a high proportion of foreign-born members who retain many traditional attitudes and values. Low levels of education, low literacy levels, religion, and an emphasis on kin networks may increase the likelihood of maintaining these values. Focus group participants explicitly stated that they felt providers "don't understand" their culture, which emphasizes "saving face" (i.e. avoidance of shame), politeness, and respect for authority (Uba, 1992). Many Laotians, in order to maintain these cultural norms, will not ask questions of health care providers, disagree with providers, or indicate that they do not understand conversations with providers. Health care providers should communicate in a culturally competent fashion, check for understanding, and open conversations to a question and answer period to facilitate communication with Laotian clients.

Issues of trust emerged in focus groups as a potentially important barrier to care for Laotian (and particularly Hmong) clients. Like other low socioeconomic status populations, Laotians perceive the world in fatalistic and chaotic terms. The Hmong women in focus groups appear to believe that suffering is an inevitable part of life and that individual destiny is one of the primary reasons for ill health. The Hmong believe that the length of a person's life is predetermined and, therefore, that life-saving healthcare may be useless (Brainard and Zaharlick, 1989). This fatalistic belief system may be rooted in Hmong culture, or in socioeconomic conditions associated with poverty (Hoppe and Heller, 1975). Researchers have suggested that a fatalistic attitude toward illness may cause patients to delay seeking care (Jenkins, Le, McPhee, Stewart, and Ha, 1996).

Hmong women also expressed the most blatant distrust of the medical community citing issues ranging from disrespect, to discrimination, to unethical experimentation on Southeast Asian subjects. This frank mistrust of the medical setting may influence Laotian immigrants to delay seeking treatment, and may cause the medical treatment received to be "too little, too late." Improving cultural competence, showing respect for immigrant clients, and focusing on meaningful provider-client communication will increase an organizations ability to build trust in the Laotian community.

iii. Structural and System Barriers: Poverty and Health Insurance

Poverty is a problem for many Laotian elders in the community. Poverty can affect many aspects of life that impact health such as housing, nutrition, and access to healthcare. In a review of studies concerning the poor, Hoppe and Heller concluded that lower-class populations have a number of similar characteristics including a distrust of the world outside family and friends, a perception of the world as chaotic and catastrophic, heavy involvement in family and peer relationships, and a lack of participation in the community (1975). In another study, it was class position, and not ethnicity, that determined utilization of health-care services (Briones, Heller, Chalfant, Roberts, Aguirre-Hauchbaum, and Farr, 1990). Previous studies have shown that lacking health insurance is associated with important clinical consequences including experiencing barriers to preventative services, having poor health status, and delaying or forgoing care (Liu and Yu, 1985).

Compared to the general population, Laotians are more likely to be uninsured or Medi-Cal recipients. This is related to high poverty levels, low-education levels, and employment in low-skill jobs that do not provide insurance benefits. Often low-skill jobs that don't offer benefits place the employee in a double bind: they are not eligible for Medi-Cal because they earn too much money, and yet they earn too little to afford private health insurance premiums. Medi-Cal provides an important service by providing health coverage to people who can not afford private insurance. However, Medi-Cal and Medi-Cal providers are often viewed by the public as a parallel "second-class" system of care. In focus groups, Laotians did not trust that they received care of a quality comparable to care received by persons with private insurance. Frustration with the constantly changing doctors in County Clinics, and excessively long waiting times exacerbate this belief. All focus group participants requested timely, personalized care from physicians who know them and their health needs. Hiring a Laotian community health advocate could increase access to services through assistance with information, appropriate education, and paperwork.

iv. Structural and System Barriers: Transportation

Transportation emerged as a significant barrier to accessing health care services for elderly Laotian immigrants. Many elderly Laotians can not drive and are dependent on family members for transportation. No senior focus group members were aware of Dial-a-Ride services and public transportation is currently limited and is often inappropriate for transportation needed for medical reasons. Nearly all focus group members had called 911 for non-emergency medical transportation.

Transportation was offered as a service to facilitate access by 32% of organizations in the Community Resource Survey (nearly all of which were county programs). An expansion of transportation services offered by the City of Visalia, Tulare County, or a private organization could facilitate access to services for all elderly. Considerable cost-savings can be expected if seniors are provided with a viable alternative to "911" when seeking medical-related transportation.

v. Structural and System Barriers: Cultural Competence

In a thorough discussion of cultural competence, Dr. Jean Chin outlines the need for a skill-focused model for healthcare providers which acknowledges and incorporates "the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to culturally unique needs" (Chin, 2000). The California Department of Health Services conducted a survey in spring of 1999, which assessed strengths, weaknesses, and attitudes toward cultural competency among DHS branches and programs throughout the state (Ross, Sep/Oct 2000). Most programs indicated a paucity of useful information on the cultural beliefs and attitudes of ethnic groups residing in California (Ross, Sep/Oct 2000). Many health problems can be avoided or modified through

medical and life-style interventions. As factors such as beliefs, attitudes, and practices can influence the effects of these interventions, they become issues of cultural competence.

Indicators of accessibility and accountability in the Community Resource Survey showed that efforts are being made to provide culturally competent care, but that there is still much room for improvement. Results demonstrate that many organizations both recruit and evaluate staff based on cultural competency. Kaweah Delta Health Care District expressed that a barrier to designating bilingual Southeast Asian language positions was a lack of a reliable local means of testing the bilingual capabilities of potential Southeast Asians they might want to hire for bilingual positions. While approximately 60% of organizations have access to bilingual interpreters on staff or externally, there were indications that access to interpreters was not sufficient to provide timely, quality care for Laotian clients. Recruiting people from the Laotian community for nursing, social work, and other medical related education programs would increase linguistic access and culturally competent care for the Laotian community. The collection of patient satisfaction measures needs the most improvement, as very few local organizations collect measures in any languages but English and Spanish.

The Office of Minority Health of the US Department of Health and Human Services has developed standards for culturally and linguistically appropriate health care services (See box below) (DiversityRx, 2001). The Asian American Coalition strongly endorses these standards and supports their adoption by local health care organizations.

Recommended Standards for Culturally and Linguistically Appropriate Health Services

Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training, and as appropriate, treatment planning.
4. Develop and implement a strategy to recruit, retain, and promote qualified, diverse, and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.
5. Require and arrange for ongoing education and training for administrative, clinical and support staff in culturally and linguistically competent service delivery.
6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.
7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.
8. Translate and make available signage and commonly used written patient educational material and other materials for members of the predominant language groups in services areas.
9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowable in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.

10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.
11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.
12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for [culturally and linguistically appropriate services (CLAS)] into other organizational internal audits and performance improvement programs.
13. Develop structures and procedures to address cross-cultural ethical and legal conflict in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive, or discriminatory treatment, or difficulty in accessing services, or denial of services.
14. Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources.

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vi. Structural and System Barriers: Insufficient Research on Laotian Populations

According to the Office of Minority Health, one of the biggest barriers facing states is a lack of minority health data (Ross, Sept/Oct 2000). Limited health data on ethnic groups and sub-groups can make it difficult for agencies to identify disparities on health, to make appropriate policy and programmatic decisions, and to evaluate the effects of those decisions on minority health. On June 7, 1999, President Clinton signed Executive Order 13125, calling on all Federal Departments to mobilize their resources to address the unmet needs of Asian Americans and Pacific Islanders. The first step to mobilizing local resources to meet the needs of Laotian elders is by gaining an understanding of those needs through research. A thorough community-based assessment of the physical and mental health status, socio-demographic variables, utilization patterns, traditional medicine use, and other factors should be conducted to further elucidate the health of the Laotian community.

D. Enabling Dynamics for Future Programs

There are dynamics specific to the Laotian community that can be utilized to facilitate programmatic interventions to improve the health of the Hmong, Lahu, Lao, and Mien sub-groups. These dynamics include the traditional emphasis on family and clan social networks, local Laotian organizations such as the Asian American Coalition, religious organizations (Hmong, Lahu, and Mien churches and Buddhist temples), Laotian businesses, and existing traditional healers. For example, in Merced, a cultural-exchange program is being implemented in which traditional Hmong healers exchange information and beliefs about health with physicians at a local hospital in order to provide care for Hmong patients that is both culturally and medically appropriate. Additionally, local leaders in the various Laotian communities can facilitate outreach, provide cultural training, and help arrange for translators. Paradigms for intervention and advocacy exist throughout the state and nation in Southeast Asian communities, and can provide an example for the development of new programs in the City of Visalia.

7. Recommendations

Accessible and appropriate health care for Laotian elders is imperative to reach our goals for a healthy community. Unfortunately, language, cultural, and system barriers have limited Laotian elders ability to access healthcare services. To facilitate Laotian access to mainstream health and social services, the cultural competence of local organizations must be maximized. The following policy and service recommendations offer a framework for Visalians/Tularians to improve knowledge, understanding, communication, access to care, and quality of care in and for the Laotian community.

Policy Recommendations:

1. Support of a state-wide system of universal health-care coverage

2. Support of governmental and organizational level policies that improve availability of and access to culturally and linguistically sensitive care for local minority groups and limited English proficiency refugees and immigrant clients

3. Support of policies at all levels for flexible home and/or community-based care that is acceptable and accessible to Laotians, rather than traditional institution-based care for the functionally disabled elderly

Service Recommendations:

4. Create organizational committees to investigate the results and implement the recommendations of this study

5. Provide and promote regular workshops and in-services for healthcare providers on Laotian culture, health beliefs, and health practices

6. Provide access to free translation services for Laotians (including the Hmong, Lahu, Lao, and Mien) with limited English proficiency (LEP)
    - provide trained medical interpreters
    - provide training for service providers to work effectively with translators
    - provide oral and written notification of a patient's right to a translator in their native language
    - keep records of client's primary language and translation needs
    - provide practical, timely access to translators
    - provide linguistically appropriate signage and health education materials

7. Adopt and implement the Office of Minority Health "Standards for Culturally and Linguistically Appropriate Services"

8. Provide services in a timely manner through reasonable and efficient scheduling practices

9. Provide the Laotian community with appropriate education regarding available transportation services, and create or expand existing transportation services to enable access to healthcare services

10. Improve access to personalized, consistent care through the promotion of personal physicians and family doctors

11. Promote physician assessment of the functional disability levels of elderly Laotian patients, make appropriate referrals, and provide counseling to them about available community-based services
12. Support and provide Laotian-specific community health education campaigns to increase knowledge of health, disease prevention, and available preventive and primary care programs

Other Recommendations:

13. Promote further research in the Laotian community, including community-based surveys of the physical and mental health needs, functional disability levels, and utilization patterns of the Laotian elderly

14. Improve local data collection and health surveillance systems by disaggregating data to include Laotian sub-groups

15. Support the hiring of Laotian community health advocates and educators to facilitate access to healthcare services for Laotian elders, and to provide health education

16. Create local scholarship funds and actively recruit Laotian students into healthcare and social service professions

17. Support inter-sectoral collaboration between service providers, county agencies, local businesses, religious organizations, law enforcement, school districts, and the Laotian community

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