

Road Map to the New Horizon: Linking Asians to Improved Health & Wellness

An assessment of the Chinese, Korean and Vietnamese communities in Multnomah and Washington Counties in Oregon.

Conducted by the Asian Health and Service Center

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CONTENTS:

- I.** Background
- II.** Purpose/Objectives
- III.** Methods
- IV.** Results
- V.** Discussion/Recommendations
- VI.** Conclusion
- VII.** References
- VIII.** Summary of Findings Forums
- IX.** Attachment 1 = Power Point presentation used during Findings Forums
- X.** Attachment 2 = English Version of Survey Instrument

I. BACKGROUND

Asians in Oregon

The Asian Pacific Islander population includes people who originate in the Far East, Southeast Asia or Indian subcontinent or nations in the Pacific Ocean. The Asian population in Oregon is very diverse; consisting of more than 25 ethnicities, speaking over 100 languages and dialects, and holding various traditions and socio-cultural histories.

Both nationwide and in Oregon, the Asian Pacific Islander (API) population is growing. The estimated distribution of the Asian population in the US, Oregon and the Portland tri-county area (Clackamas, Multnomah and Washington Counties) is provided in Table 1. According to data from the 2005 American Community Survey, almost four percent of the population of Oregon is made up of members of the Asian and Pacific Islander (API) communities. Table 2 provides the distribution of all Asian ethnic groups in the tri-county area.

The API population is the second largest minority group in Oregon and consists of both refugees and immigrants. The majority of Asian refugees in the Portland tri-county area arrived after 1975 from Vietnam, Laos, Cambodia and other regions of Southeast Asia. Asian immigrants in Oregon include persons from China, Korea, Japan, India, the Philippines and Thailand.^{1,2,3,4}

Table 1: Estimated Distribution of Asian Population (Total Asian and Chinese, Korean and Vietnamese alone (not mixed race)) in United States (U.S.), Oregon, Multnomah, Washington and Clackamas Counties, 2005

Location	All Groups	Asian	Chinese	Korean	Vietnamese
U.S.	288,378,137	12,471,815	2,889,280	1,246,240	1,418,334
Oregon	3,560,109	125049 3.5% of state population	28,913 23% of total Asian in state	17,647 14% of total Asian in state	25,684 21% of total Asian in state
Multnomah County	656146	41498 6% of county population	9356 23% of Asian in county	2930 7% of Asian in county	13062 32% of Asian in county
Washington County	495597	39805 8% of county population	9352 24% of Asian in county	7536 19% of Asian in county	4475 11% of Asian in county
Clackamas County	365,723	12,615 3.4% of county population	3,336 26% of Asian in county	1,172 9% of Asian in county	3,347 27% of Asian in county

Data from the U.S. Census Bureau, 2005 American Community Survey

Table 2: Estimated Distribution of Asian Ethnic Groups in Clackamas, Multnomah and Washington Counties in Oregon, 2005

	Clackamas County, Oregon Estimate	Multnomah County, Oregon Estimate	Washington County, Oregon Estimate
Total:	12,615	41,498	39,805
Asian Indian	1,100	1,977	6,784
Chinese	3,336	9,356	9,352
Filipino	1,491	2,799	2,943
Japanese	1,772	3,102	3,285
Korean	1,172	2,930	7,536
Vietnamese	3,347	13,062	4,475
Other Asian	397	8,272	5,430

Source: U.S. Census Bureau, 2005 American Community Survey

Total includes people who reported Asian only, regardless of whether they reported one or more detailed Asian group.

Other Asian includes people who reported one detailed Asian group not shown separately and people who reported two or more specified Asian groups (and no other race). The Other Asian, not specified includes people who checked the "Other Asian" only response category on the census questionnaire or wrote in generic terms such as "Asian," "Oriental," "Asiatic," and so forth.

Asian Health

Asian American women have the longest life expectancy of any racial/gender group.^{2,3} In Multnomah County, Oregon, at birth, an Asian can expect to live, on average, 6 years longer than a non-Hispanic White person.⁴

Asian Americans have similar health issues as other racial groups. However, Asian Americans suffer disproportionately from certain diseases such as:

- Liver Cancer
- Lung Cancer
- Cervical Cancer (especially Vietnamese women)
- Tuberculosis
- Hepatitis B

Several factors may contribute to poor health outcomes for Asian Americans including language and cultural barriers, cultural stigma associated with certain health conditions, and lack of health insurance.^{2,3}

In Multnomah County (Oregon) from 2000-2004, three areas of health disparities were reported to exist for Asian Americans: homicide, lack of early pre-natal care, and Chlamydia. Data showed the homicide rate for Asians to be almost twice (1.9) the rate of non-Hispanic Whites. Asian women were 1.4 times more likely than non-Hispanic White women to NOT have early prenatal care, and the Chlamydia infection rate was slightly higher than the rate for non-Hispanic Whites.⁴

Although the exact percentage of Asians without health insurance in the Portland Metropolitan area is unknown, nearly 60% of the 500 attendees of the Asian Health and Service Center 2006 Asian Community Fair reported not having health insurance. A 2002 study of several Asian communities in the Portland tri-county area found that four percent of their study population did not have health insurance.⁵

II. PURPOSE OF STUDY

In the U.S. and Oregon, the Asian and Pacific Islander (API) population is growing rapidly. Little is known about the health status of the API population. Even less is known about the health of different Asian ethnic communities, such as Chinese, Korean and Vietnamese groups. To date, few studies have investigated the diverse factors that impact health-related practices and preferences for members of different Asian communities. However, In order to improve health outcomes and prevent disease among these communities, we need to develop and implement culturally-tailored health programs and delivery of health services.

The Roadmap to the New Horizon: Linking Asians to Improved Health and Wellness study was conducted by the Asian Health and Service Center (AHSC) to understand the health concerns and barriers to primary care services and health promotion programs for members of the Chinese, Korean and Vietnamese communities living in Washington and Multnomah Counties in Oregon. The study also aimed to identify the current health practices and preferences of these communities and how they may differ from one another. Data collected in this study will inform the development of culturally-tailored health programs and will be used to improve delivery of health services for members of these communities.

The study intended to obtain completed surveys from 200 members from each of the Chinese, Korean and Vietnamese communities (600 total). These communities were chosen because each is a target community served by the Asian Health and Service Center, a local non-profit organization whose mission is to “bridge the gap between the Asian and American culture in an effort to build a better community” through improving access to quality health promotion and health care services for all Asians. Moreover, the Chinese, Korean and Vietnamese communities comprise the majority of the Asian-Pacific Islander population in Multnomah and Washington counties. Finally, these communities provide a diverse array of cultural beliefs and practices, social positions and levels of acculturation, all characteristics associated with health status and access to health services.

III. METHODS

Research Team

The *Roadmap to the New Horizon: Linking Asians to Improved Health and Wellness* project was conceived and administered by the Asian Health and Service Center (AHSC). AHSC is a local non-profit organization, which was established in 1983 as the Chinese Social Service Center. The mission of the Center is “to bridge the gap between the Asian and American culture in an effort to build a better community.” At both its Beaverton and SE Portland locations, the AHSC provides a comprehensive array of services including behavioral health, health education, disease prevention and chronic disease management. Services are provided in a culturally and linguistically-specific manner by trained, bilingual providers. The Center creates collaborative working relationships with other health and social service providers in the community. Finally, all services, such as case management and information resources, are provided in a wrap-around manner to further assist Asians experiencing unmet needs.

Members of the *Roadmap to the New Horizon: Linking Asians to Improved Health and Wellness* project team include:

- Holden Leung, MSW, Executive Director, Asian Health and Service Center (AHSC)
- Christine Lau, MA, Program Director, AHSC
- Gemma Kim, RN, MSW, LCSW, Public Health Program Manager, AHSC
- Staff members of AHSC
- Community Volunteers
- Siobhan Maty, PhD, MPH, Assistant Professor, Portland State University (PSU), School of Community Health
- Jennifer Berning and Nicole Smith, students in the PSU School of Community Health
- Members of the Chinese, Korean and Vietnamese communities in the Portland Metropolitan area

The study protocol and data collection instruments were reviewed and approved by the Human Subjects Research Review Committee at Portland State University. Research team members were trained in protocol for protecting Human Subjects in research studies. Staff members from AHSC were trained to conduct focus groups with each ethnic community in order to pilot test the surveys. AHSC staff members also were trained to administer surveys within community settings.

Study Population

Three communities were surveyed: Chinese, Korean and Vietnamese, with a purpose of collecting completed surveys from 200 persons from each ethnic group (600 total). These communities were chosen because each is a target community served by the Asian Health and Service Center, a local non-profit organization whose mission is to “bridge the gap between the Asian and American culture in an effort to build a better community” through improving access to quality health promotion and health care services for all Asians. Moreover, the Chinese,

Korean and Vietnamese communities comprise the majority of the Asian-Pacific Islander population in Multnomah and Washington counties. Finally, these communities provide a diverse array of cultural beliefs and practices, social positions and levels of acculturation, all characteristics associated with health status and access to health services.

Participants were recruited at the Asian Health and Service Center locations in SE Portland and Beaverton; local Chinese, Korean and Vietnamese businesses; during different New Year celebrations (Chinese, Korean); and at several local churches, schools (e.g., Lac Hong Vietnamese School) and housing complexes. A total of 792 surveys were collected. Prior to analysis, we excluded several surveys for the following reasons:

- Excluded 8 surveys because could not verify that participants were at least 18 years of age;
- Excluded 1 survey because participant did not live in United States;
- Excluded 3 surveys because had significant missing data (more than 80% of survey missing);
- Excluded 8 participants because they did not complete the question about ethnicity; and
- Excluded 52 because they did not report being a member of the Chinese, Korean or Vietnamese community exclusively.

The final sample consisted of 720 participants with sufficient data for analysis: 305 Chinese, 226 Korean, and 189 Vietnamese participants. All participants were at least 18 years of age. All research participants gave their permission (completed an informed consent statement) to be part of the research study.

Data Collection

Survey

Data was collected by questionnaires that were either self-administered or completed with the help of a member of the research team. Approximately 21% of the respondents wanted a member of the research team to read the survey to them. Surveys were collected between January and May 2007.

The survey was drafted by Mr. Leung, Ms. Lau, Ms. Kim and Dr. Maty and translated into Chinese, Korean and Vietnamese. The draft survey was pilot-tested during focus groups with members of each ethnic community in order to determine the readability, cultural appropriateness, and interpretation of the questions. Focus group participants provided feedback on and recommended changes to the survey, which were incorporated into the original survey draft. The survey included questions about the following topics:

- General health status
- Health beliefs
- Health behaviors
- Barriers to health services
- Preference for health services
- Sociodemographic information about study participants

Survey questions were intended to collect information that will be used to improve existing health-related services and to identify gaps in current service delivery that may be filled by the creation of new programs. Questions were drawn from several validated sources including the Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention (CDC),⁶ the Survey on Disparities in Quality of Health Care,⁷ the World Health Survey⁸ and one scale measuring preferences for alternative medicine.^{9, 10}

Findings Forum

A “Findings Forum” was conducted with each of the communities that participated in this project. At each forum, attendees reviewed a presentation of initial survey findings.

At several points during the presentation (after the findings were presented, after the recommendations were shared and during the evaluation of the project), audience members were asked to respond to several questions. These questions were intended to get feedback on how the results had been presented and interpreted thus far, to accept and/or modify the proposed recommendations, and to evaluate the project overall. The questions are provided below:

Discussion Questions about Results:

- What do YOU think about these finding
- Do you agree with the results?
- Are the results similar to what you would say?
- Were there any findings that you did not expect?
- If so, which ones?

Discussion Questions about Recommendations:

- What do YOU think about the recommendations?
- What is missing?
- What should change?

Evaluation of Project

At the end of each findings forum we asked participants several questions about the *Roadmap to the New Horizon: Linking Asians to Improved Health and Wellness* study (see below). The feedback provided from participants regarding the conduct of the study will help us improve our methods for relevant projects in the future.

Evaluation Questions:

- What did you like about the *Roadmap to the New Horizon: Linking Asians to Improved Health and Wellness* project?
- What did you think about having to read and sign a “informed consent statement” before filling out the survey?
- What could we do to get more members of different Asian communities to participate in projects like this one?
- What other improvements can you recommend for this project?

Dissemination of Findings

Results and recommendations from the *Roadmap to the New Horizon: Linking Asians to Improved Health and Wellness* project will be shared with a wide audience in order to make the larger community aware of the diverse health-related needs, beliefs, behaviors and preferences of members of the Chinese, Korean, and Vietnamese communities. Results will be shared with study participants, other members of the Chinese, Korean and Vietnamese communities, clinical and non-clinical organizations that serve these communities, city and county officials, and health care providers. Moreover, academic research papers will be written to share the results with communities beyond Oregon.

IV. RESULTS

The findings from the *Roadmap to the New Horizon: Linking Asians to Improved Health and Wellness* study are presented below using the following categories: participant characteristics, health status, health beliefs, health behaviors, barriers to health services, and preferences for health services. The final sample used in the analyses consisted of 720 individuals: 305 Chinese, 226 Korean, and 189 Vietnamese participants.

Participant Characteristics

Table 3 provides the mean value of select characteristics of the study population for the total study sample and by ethnic group. On average, the study populations were similar. The Chinese, Korean and Vietnamese groups have resided in the United States for a similar length of time, are similarly educated (~12 years), have a similar number of people in the household and who speak English, and are of comparable ages, although the Vietnamese group was a bit younger.

Table 3: Means of Select Participant Characteristics for Total Group and by Ethnicity

Group	Age in Years	Years in US	Years of Education	Years of Education in U.S.	Number of People in Household - including respondent	Number of People in Household who speak English - including respondent
Total	53.4	17.5	12.5	3.6	3.3	2.8
Chinese	55.3	15.9	12.0	2.8	3.3	2.7
Korean	55.1	16.7	13.3	2.7	3.0	2.6
Vietnamese	48.9	17.7	12.0	4.7	3.8	3.1

Table 4 provides the number and proportion (percentage) of the study population that reported a particular characteristic. Data are provided for the total study sample and each ethnic group. Like the characteristics presented in Table 3, the study populations were similar, on average, for most characteristics in Table 4, although a few differences exist. For example, close to half (43%) of all Vietnamese participants were between the ages of 18-44 years, whereas the Chinese and Korean participants tended to be older.

More Vietnamese participants reported being employed (doing work), full-time or part-time, compared to the Chinese and Korean participants. This may reflect their younger age distribution or market forces/opportunities that draw particular groups to Oregon (e.g., technology). In contrast, more than a third of the Chinese samples were retired and Korean participants were more than four times as likely to not work as the other two groups.

Most of the Chinese participants live in Multnomah County whereas Korean participants were more likely to live in Washington County. The Vietnamese participants were evenly distributed between the two counties. More than half of all study participants own their homes.

The study population was made up of more women than men, regardless of ethnic group. The study participants reported a significant amount of care-giving. For example, 47% of the total population reported taking care of children and 24% of participants reported taking care of their elders.

More Vietnamese are U.S. citizens compared to the other two groups, which may reflect their socio-political history and unique relationship with the U.S. government. Chinese participants were more likely to receive subsidized services (Oregon Health Plan, Oregon Trail Card, Prescription Assistance) compared to Korean or Vietnamese study participants.

Table 4: Proportion (%) of Study Population reporting Select Characteristics: by Total Group and Ethnicity

Variable (Total number that answered the question)	Category	Total Population N (%)	Chinese N (%)	Korean N (%)	Vietnamese N (%)
Population		720	305	226	189
Gender (N=669)	Women	456 (68.2)	193 (68.2)	152 (73.1)	111 (62.4)
Age (N=622)	Age 18-44	206 (33)	74 (28.6)	58 (30.2)	74 (43.3)
	Age 45-64	243 (39)	101 (39)	75 (39.1)	67 (39.2)
	Age 65 or older	173 (28)	84 (32.4)	59 (30.7)	30 (17.5)

Residency Status (N=661)	US Citizen	463 (70)	184 (65.5)	129 (62.9)	150 (85.7)
	Permanent Residents	165 (25)	88 (31.3)	52 (25.4)	25 (14.3)
County of Residence (N=605)	Multnomah County, OR	274 (45.3)	160 (63.5)	39 (21.1)	75 (44.6)
	Washington County, OR	263 (43.5)	58 (23)	122 (66)	83 (49.4)
	Clackamas County, OR	49 (8)	23 (9.1)	18 (9.7)	8 (4.8)
	Clark County, WA	12 (2)	8 (3.2)	4 (2.1)	0
	Other County	7 (1.2)	3 (1.2)	2 (1.1)	2 (1.2)
Home Ownership (N=645)	Own	371 (57.5)	161 (58.3)	103 (51.2)	107 (63.7)
	Rent	206 (31.9)	95 (34.4)	76 (37.8)	35 (20.8)
	Share	68 (10.5)	20 (7.3)	22 (11)	26 (15.5)
Take Care of Own Kids (N=661)	YES	310 (46.9)	109 (40.1)	102 (46)	99 (59.3)
	NO, kids grown	219 (33.1)	92 (33.8)	84 (37.8)	43 (25.7)
	NO kids	132 (20)	71 (26.1)	36 (16.2)	25 (15)
Take Care of Elders (N=654)	YES	155 (23.7)	71 (26.5)	38 (17.4)	46 (27.4)
	NO	499 (76.3)	197 (73.5)	180 (82.6)	122 (72.6)
Employment Status (N=635)	Any Work (FT or PT)	311 (49)	116 (43.5)	85 (41.3)	110 (67.9)
	Retired Only	125 (19.7)	89 (33.3)	17 (8.3)	19 (11.7)
	Not-Working Only	128 (20.2)	19 (7.1)	90 (43.7)	19 (11.7)

	Home Care Only	41 (6.5)	28 (10.5)	5 (2.4)	8 (4.9)
	Student Only	25 (3.1)	11 (4.1)	9 (4.4)	5 (3.1)
Receive OHP	YES	115 (22.9)	58 (28.6)	30 (17.4)	27 (21.1)
(N=503)	NO	388 (77.1)	145 (71.4)	142 (82.6)	101 (78.9)
Oregon Trail Card (N=503)	YES	82 (16.3)	49 (24.1)	9 (5.2)	24 (18.7)
	NO	421 (83.7)	154 (75.9)	163 (94.8)	104 (81.3)
Prescription Assistance	YES	44 (8.8)	25 (12.3)	16 (9.3)	3 (2.3)
(N=503)	NO	459 (91.3)	178 (87.7)	156 (90.7)	125 (97.7)

Table 5 provides an overview language use for the study population. Approximately 43% of the study population reported speaking English “poorly” or not at all. More than a third of the participants do not read English or do so poorly. Twenty percent of the total study population speaks English and at least one other Asian language at home.

Table 5: Number and Proportion (%) of Study Population reporting Language-Related Characteristics: by Total and Each Ethnic Group

Variable (Total number that answered the question)	Category	Total Population N (%)	Chinese N (%)	Korean N (%)	Vietnamese N (%)
How Well Speak English (N=715)	Do NOT Speak English	133 (18.6)	77 (25.3)	32 (14.4)	24 (12.8)
	Speak English Poorly	171 (23.9)	59 (19.4)	81 (36.3)	31 (16.5)
How Well Read English (N=715)	Do NOT Read English	135 (19)	84 (27.8)	27 (12)	24 (12.8)
	Read English Poorly	129 (18)	47 (15.6)	53 (23.6)	29 (15.4)
	CHINESE (Cantonese or	216 (30.2)	211 (70)	0	5 (2.7)

	Mandarin) Only				
Language Spoken Most Often at Home (N=716)	KOREAN Only	169 (22.6)	1 (0.33)	168 (74.3)	0
	VIETNAMESE Only	126 (17.6)	0	0	126 (67)
	ENGLISH and Another Language	144 (20)	64 (21.2)	37 (16.4)	43 (22.9)
	ENGLISH Only	45 (6.3)	14 (4.6)	21 (9.3)	10 (5.3)

Health Status

Participant general health status was assessed with the question, “In general, would you say your health is ... poor, fair, good or very good?” On average, most people replied either “fair” or “good” across all ethnic groups. Participants also were asked to describe how well they take care of their health. The answer choices were “poorly, fair, well, very well or I don’t want to answer.” Most participants replied either “fair” or “well” in the total population and across all ethnic groups.

Study participants were asked if they currently have any disease or illness. Of the total study population, 26% reported they did have a disease or illness (25% of Chinese, 31% of Korean, 22% of Vietnamese reported an illness) and almost 13% (N=87) reported they do not know if they currently have a disease or illness (11% of men, 14% of women; older versus younger participants; 11% of Chinese, 11% of Korean, 16% of Vietnamese).

Among the 184 study participants who reported having a current illness or disease, the most common illnesses reported were:

- High Blood Pressure (6.4%) – most participants reporting High Blood Pressure are Chinese
- Pain, Musculoskeletal (3.6%)
- High Cholesterol (2.9%) – most participants reporting High Cholesterol are Vietnamese
- Diabetes (1.9%)
- Gastrointestinal problems (1.3%)

It is possible that the proportion of participants who reported having an illness or disease may be underestimated. During the findings forums, study participants remarked that other persons may not have wanted to answer this question as asked (“Do you currently have any disease or illness?”) and may have been more likely to provide responses to questions if asked as “Do you have diabetes? or similar.” Others remarked that Asians don’t like to reveal their illnesses.

Participants were asked to indicate which health-related exams/tests they had within the last 12 months. The most common reported exams/tests were:

- Blood Pressure Test (72% of study population reported having a blood pressure test)
- Cholesterol Test (60%)
- Dental Exam (59%)
- Eye Exam (55%)
- Blood Glucose Test (53%)

Respondents also were asked to identify where they had received health-related care in the last year from a list of health-related facilities. The most common places participants received health-related care in last year include:

- Private Western doctor's office (55% of respondents received care at this location)
- Hospital outpatient department (22%)
- Oriental medicine provider (18%)
- 8.3% reported getting care at emergency room

During the findings forums, participants stated that many members of their communities use Western health services when they first become ill and, if those services are not perceived to work, they proceed to Oriental forms of health services.

Study participants were asked what type of health insurance coverage they have at this time. Almost half (48%) of the total study population has private insurance, 21% have the Oregon Health Plan, 15% have Medicare, and 20% do NOT have any type of health insurance. Almost one-fifth (18%) of Chinese participants, one-third (29%) of Korean participants and 10% of Vietnamese participants do not have health insurance. For persons without health insurance, the average time spent without health insurance was 5.7 years (3.4 for Chinese, 6.8 for Korean, and 2.2 years for Vietnamese participants).

Finally, study participants were asked to identify the three items they spend the most money on each month. Of the total study population, 18-19% said one of the three items they spend the most money on monthly was health care treatment, medications or health insurance premiums.

Health Beliefs

The belief about the causes of disease and what one should do to cure illness is specific to each individual and often culturally determined. In this survey, participants were asked to identify, from a list of options, factors that cause someone to become ill or, once ill, to get sicker. Below are listed the most commonly chosen factors thought to make people sick/get sicker. Although each group reported some typical causes of illness, such as not exercising, smoking or drinking too much, there are differences between the groups. For example, both Chinese and Vietnamese participants commonly believe a lack of sleep as a factor leading to illness. Korean and Vietnamese participants identified work-related factors as contributors to disease.

Among Chinese participants, the most common factors that make people sick/get sicker are:

- Eating unhealthy food (78% of all Chinese participants chose this causal factor)
- Not sleeping enough (69%)
- Not exercising (66%)
- Smoking (66%)

Significantly more Chinese respondents (78%) chose 'eating unhealthy food' as factor that makes people sick compared to Korean (56%) or Vietnamese (38%) respondents

Among Korean participants, the most common factors that make people sick/get sicker are:

- Work stress (73%)

- Not exercising (72%)
- Not taking care of oneself (62%)
- Being overweight (59%)

More Korean respondents (12%) chose ‘fate or destiny’ as factor that makes people sick compared to Chinese (9%) or Vietnamese (7%) study participants. Interestingly, 28% of Korean respondents chose ‘not having health insurance’ as a factor that makes people sick or get sicker (Chinese 23%, Vietnamese 19%).

Among Vietnamese participants, the most common factors that make people sick/get sicker are:

- Working too much (58%)
- Not sleeping enough (57%)
- Age (47%)
- Drinking too much (43%)

Vietnamese participants were much less likely to choose certain factors that make people sick. For example, only 29% of Vietnamese respondents chose ‘overweight’ as factor that makes people sick compared to 57% of Chinese or Korean respondents. Similarly, only 38% of Vietnamese participants chose ‘eating unhealthy food’ as factor that makes people sick compared to Chinese (78%) or Korean (56%) study participants.

On the survey, a set of statements about Western and Oriental medicine were provided. Participants were asked to identify which statements they agreed with and which they did not. Table 6 provides the percent of each study population that agreed with each statement. The response patterns differ by ethnic group. For example, only 19% of Korean participants believe Western medicines/treatments have bad side effects, whereas almost half of the Chinese and Vietnamese participants agree.

Table 6: Proportion (%) of Study Population that Reported Agreement with Statements about the Use of Western and Oriental Medicine

STATEMENTS	TOTAL	Chinese	Korean	Vietnamese
Western medicine is effective for my particular health problem	67	83	80	63
Western medicine doctors understand my culture	39	45	38	32
Western medicine doctors understand my health problems	66	73	52	72
Using both Western and Oriental medicine together is better for them than using only one type	53	61	60	33

Oriental medicine will be more effective for my health problems than Western medicine	26	34	24	16
Western medicines/treatments have bad side effects	38	48	19	47

Health Behaviors

On the survey, participants were asked to identify, from a list of options, the activities they engage in to stay healthy. The three most common activities participants reported doing to stay healthy are: Don't smoke, eat fruits and vegetables, and don't drink too much alcohol. These behaviors are commonly recommended by health providers in order for people to stay healthy. Yet, only 47% of the total study population reported doing exercise to stay healthy (53% of Chinese, 31% of Korean, and 56% of Vietnamese participants). Although these numbers are lower than the proportion of the U.S. population (62 %) that report not engaging in any vigorous leisure-time physical activity,¹¹ the proportions are still too high and suggest the need for increased physical activity, given its health benefits.

At least 60% of the study population reported visiting a health provider at least one time per year. However, only 45% reported taking their medication regularly. Between 10-14% of the study population sought acupuncture, took herbs or visited a Chinese medical doctor. Chinese participants were approximately twice as likely to report using herbs, traditional medicines or a Chinese medical doctor as Korean or Vietnamese participants. Acupuncture was reported similarly for all three groups (10% of population, on average).

Interestingly, Korean study participants were twice as likely to report going to church or temple or doing spiritual activities as way to stay healthy compared to Chinese or Vietnamese participants. Although more than half the study population reported spending time with family or friends as a way to stay healthy, Vietnamese study members were much less likely to report this activity compared to the Chinese or Korean participants.

Approximately 40% of the total study population have family or friends who tell them to use Oriental medicine. However, differences exist between the study groups, whereas 52% of Chinese, 34% of Korean and 25% of Vietnamese participants have friends or family who encourage them to use Oriental medicine. Similarly, 37% of study population use Oriental medicine between their Western medicine medical appointments or treatments. Vietnamese participants (52%) were more than twice as likely as Korean participants (21%) to report this behavior.

Finally, we asked study participants to choose from a list of options the actions they take when they first get sick. Almost two-thirds (73%) of the study sample reported that they visit a Western medicine doctor when they first get ill compared to the 14% who visit an Oriental Health provider. A quarter of the respondents report taking over-the-counter medicine, while 10% of participants take a home remedy when they first get sick. Chinese participants are less

likely (17%) to take an over-the-counter medicine compared to Korean (28%) or Vietnamese (31%) participants. Some participants reported doing nothing when they get sick. Approximately two percent of total respondents report they do nothing because they do not want to know why they are sick. The majority of these respondents were Vietnamese. Another 15% reported they do nothing when they first get sick; rather they wait to get better. Korean participants were twice as likely as Chinese or Vietnamese respondents to report this action. This action may not be by choice as a large proportion of Korean study participants (29%) do not have any health insurance. Finally, 14% of the study population reported visiting an emergency room at a hospital when they first get sick. Although we do not have data to answer this question, it would be interesting to know why these individuals use the emergency room. For example, is the emergency room used only for emergency needs or for general health care? Many anecdotal comments are made about the impact of unnecessary uses of emergency rooms on rising health care costs.

During the Findings Forums, many participants, especially Vietnamese, remarked that older members of their communities are not aware of activities they can do to prevent disease.

Barriers to Health Services

We were interested in identifying significant barriers to the use of health services for members of our study population. Study participants were asked the following question: “In the last 12 months, was there a time where you needed medical care but did not get any?” Approximately 21% of the total study sample (62 Chinese (22%), 41 Korean (19%), and 43 Vietnamese (24%) participants). reported they did need medical care but did not get any in the last year.

Table 7 provides a distribution of the reported barriers for those participants who reported needing medical care but not getting any. The most common reasons cited for why participants did not seek care when they needed it were: Did not have health insurance (30% of total study sample); could not get an appointment right away (30% of total sample); and did not know where to get medical care (26% of sample).

Barriers due to language and culture were significant. One-third (32%) of Korean respondents and 26% of Vietnamese respondents did not seek care because they could not speak English well. Alarmingly, a third (33%) of Chinese respondents did not seek care because people at the clinic treat them rudely or unfairly. However, having health providers that don’t understand their language or culture were not significant barriers to care seeking for this group of respondents.

Table 7: Barriers to Medical Care for Proportion (%) of Study Population that Reported Not Getting Medical Care when Needed: Total Sample and by Ethnicity

BARRIERS	TOTAL	Chinese	Korean	Vietnamese
Don’t want medical care	12	3.6	14.7	22.9
Home remedies will cure me	8.9	9.1	2.9	14.3

Don't want to find out if I am sick	7.3	9.1	2.9	8.6
Don't know where to get medical care	26	29.6	35.3	11.4
Don't know how to make an appointment	16	18.2	20.6	8.6
Could not get an appointment right away	30	26	35.3	31.4
Wait for the doctor in the lobby was too long	14.5	16.4	8.8	17.1
Don't have transportation	12	12.7	8.8	14.3
In too much pain to move	6.5	5.5	8.8	5.7
Didn't have health insurance	34.7	38.2	44.1	20
Health insurance co-payment is too high	17.7	21.8	20.6	8.6
Don't understand how to use my health insurance	8.1	7.3	11.8	5.7
Health insurance would not pay for visit or treatment	6.5	7.3	5.9	5.7
Don't trust Western medicine	9.7	18.2	5.9	0
Western health care providers cannot help me	8.1	10.9	9.1	2.9
Health care providers don't understand my language	6.5	5.5	8.8	5.7
Health care providers don't understand my culture	4.9	3.7	6.1	5.7
People at clinic treat me rudely or unfairly	16.9	32.7	0	8.6
People look down on me if I practice my customs	4	7.3	2.9	0
Feel uncomfortable when others expect me to know American ways of doing things	11.4	14.6	15	2.9

I cannot speak English well	17.7	3.6	32.4	25.7
Hard to understand others speaking English	11.3	3.6	20.6	14.3
Feel uncomfortable around people who only speak English	5.7	5.5	11.8	0

Preferences for Health Services

Our final section provides results for a series of questions that inquired about the study participants' preferences for health providers, health education and health service delivery. According to study participants, the five characteristics of health care providers considered most important are:

- A health care provider who tells me what to do to get healthy
- A health care provider who gives me specific instructions on how to take my medicine
- A health care provider who asks me specific questions about my health or health symptoms
- A health care provider who listens carefully to what I have to say
- A health care provider who answers all my questions in a way I can understand

In terms of health topics, the top six topics study participants would like more information about include high blood pressure, high cholesterol, exercise/physical activity, nutrition/healthy cooking, allergies and osteoporosis. Korean respondents also indicated stress relief and cancer as other key topics of interest and Vietnamese participants also want more information on mental health issues.

Study participants also were asked how they prefer to receive health-related information or education. Overall, the top four methods of delivering health information/education include: Newspapers or magazines in their own language; books; pamphlets or brochures; and the television. The internet is the preferred method of delivery for younger study participants (less than 44 years of age).

Compared to other study participants, Korean participants are more likely to prefer presentations at their religious organizations or in group classes. In contrast, Vietnamese participants were much less likely to prefer health seminars in the community compared to Korean or Chinese participants. Most important, at least 70% of study population want health-related information or education provided in their native language.

V. DISCUSSION/RECOMMENDATIONS

The *Roadmap to the New Horizon: Linking Asians to Improved Health and Wellness* study was done to identify the current health practices and preferences of members of the Chinese, Korean

and Vietnamese communities in the Portland Metropolitan area. This study highlights the diversity of these three communities in relation to health issues. Consequently, individuals and organizations who serve members of the Chinese, Korean and Vietnamese communities in the local area need to resist clumping all Asian ethnic groups into one category, thereby incorrectly assuming that the multitude of cultures represented in this population express similar beliefs and behaviors.

Recommendations

After analyzing the data, and interpreting the findings with the help of study participants, several recommendations were revealed that, if acted upon, may lead to improved delivery of health services or health education/health promotion programs for members of the local Chinese, Korean and Vietnamese communities. The recommendations are listed below:

Overall

Acknowledge the similarities and differences between members of the Chinese, Korean and Vietnamese communities in the Portland Metropolitan area

Health Education/ Health Promotion

Provide health information/education in native languages - only 30% of the study population wants information in English

Provide health information/education in printed format (Asian newspapers, books, brochures/pamphlets) or through community health seminars; internet is first choice for younger participants (age 44 years and younger)

Develop health information/education programs on healthy living, such as nutrition, cooking healthy meals, and physical activity

Screen community members who currently do not know their health status so can help prevent disease or disease complications

Promote importance of disease prevention and provide examples of how to prevent illness, especially among older community members

Removing Barriers to Health Services

Help community members obtain health insurance

Reduce waiting time for appointments with health care providers

Create resource lists (or some other tool) to help members of the Chinese, Korean and Vietnamese communities find health services

Provide on-site, gender-specific, culturally-sensitive interpreters. Study participants reported a lack of confidence in and discomfort with telephone interpretation services.

Provide cultural-sensitivity training for health care providers and staff, and ensure that patients are treated with respect.

Delivery of Health Services

Create resource lists to help Asian community members find safe and reputable Oriental Medicine providers

Create resource guide to help community members understand what Oriental medicines are, how to use them, and whether or not they are safe for everyone to use

Inform providers that many members of these communities (~55% of study population), especially the Chinese and Korean communities, may believe using both Western and Oriental medicine is better than using one type alone

Inform providers that many members of these communities (~37% of study population), especially the Chinese and Korean communities, may use Oriental or other non-traditional medicine between visits to a Western health care provider

Train more bi/tri-lingual and bi/tri-cultural (Chinese, Korean and Vietnamese) Western medical doctors and other health providers

Train health care providers to:

- Directly tell patients what they need to do to get healthy;
- Give patients specific instructions on how to take their medicines or perform relevant health-related tasks;
- Ask patients specific questions about their health or health symptoms (rather than waiting for patients to tell the provider);
- Listen carefully to what patients have to say; and
- Answer patient questions in ways that the patient can understand easily.

Limitations of Study

This study has several limitations. First, the sample was small in number, although we did exceed our expected sample size (N=600). However, given the number of people in each ethnic group (305 Chinese, 226 Korean, and 189 Vietnamese participants), we are limited in the types of associations we can measure, especially when stratified by gender or age group. Second, the study sample is not representative of all members of the Chinese, Korean and Vietnamese communities in Multnomah and Washington Counties in Oregon. The study population was more likely to be made up of women, people of higher socioeconomic means, and more acculturated persons than may be found in the general Chinese, Korean and Vietnamese populations in the Portland Metropolitan area. If so, then the findings presented may be underestimates of true health patterns in the populations under study.

Strengths of Study

This study has many strengths:

- The study builds upon findings from the only other study of local Asian/Pacific Islander communities.⁵
- This study is the first to assess the health needs, practices and preferences of members of the local Korean community;
- This study used a community-based participatory research approach. Study participants were the first persons to see the results of the survey and played an integral part in the interpretation of results and creation of recommendations. Study participants especially liked being part of the study and feeling that their knowledge and information was needed and important to the study.
- This study provides an overview of the health-related preferences of members of the local Chinese, Korean and Vietnamese communities;
- The information gathered in this study can be used to identify gaps in services, to improve health care service delivery and to inform the development of culturally-relevant health education and health promotion materials and programs; and
- Finally, this study identified a list of recommendations, drawn from the study participants, which will be useful for service providers in order to create or modify current services to better serve the needs of members of the local Chinese, Korean and Vietnamese communities.

Lessons Learned

This study was reviewed and approved by the Human Subjects Research Review Committee at Portland State University. All study participants were required to read (or have read to them) and sign an informed consent statement that granted their permission to take part in the study. Study participants stated that they were not comfortable with signing their name, regardless of statements ensuring their confidentiality. These participants recommended using a verbal consent instead.

Participants stated that one of the only reasons they were willing to take part in the study is because they were approached by someone or an organization (Asian Health and Service Center) that they trusted. Future research and programs need to build trusting relationships with community members and organizations in order to enhance participation in community-related activities.

During the Korean Findings Forum, several participants remarked that Korean community members are only likely to provide 70% “true” information on surveys. If this is true, other forms of data collection may be more valid with members of the Korean community.

Although the survey instrument was modified and shortened during pilot testing, study participants still complained of its length. Shorter surveys, and possibly web-based surveys, may lead to better participation rates, especially among male participants. In addition, be rigorous with ensuring cultural appropriateness and question validity of survey instruments, especially after translation.

VI. CONCLUSIONS

As the Asian population continues to grow in Oregon, it is important that members of the health community, whether creators, evaluators, administrators or providers of services, acknowledge the diversity of this population and work with its multicultural splendor to promote health and eliminate disease.

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VIII. SUMMARY FROM FINDINGS FORUMS

A “Findings Forum” was conducted with each of the communities that participated in this project. At each forum, attendees reviewed a presentation of the initial findings from the survey. The results were presented in English by Dr. Maty. The presentation was simultaneously translated during the Chinese and Korean forums. Approximately 30 people attended the Chinese forum, 27 attended the Korean forum and 19 people attended the Vietnamese forum.

Results were presented for several categories: participant characteristics, health status, health behaviors, health beliefs, barriers to health services and preferences for health services. A copy of the presentation is available as an attachment (see Attachment 1). Results were presented for the study participants as a whole, with specific information about each ethnic community.

At several points during the presentation (after the findings were presented, after the recommendations were shared and during the evaluation of the project), audience members were asked to respond to several questions. These questions were intended to get feedback on how the results had been presented and interpreted thus far, to accept and/or modify the proposed recommendations, and to evaluate the project overall. The questions and their answers are provided below for each ethnic group and as a whole.

► Discussion of Findings

- 1. What do YOU think about these findings?**
- 2. Do you agree with the results?**
- 3. Are the results similar to what you would say?**
- 4. Were there any findings that you did not expect?**
- 5. If so, which ones?**

Chinese:

When you make an appointment to see the doctor it takes a long time

It is safer to see a Western doctor

Go to a Western doctor when have an emergency

For care over the long-term, see an Oriental health care provider

The type of doctor depends upon the disease, may need both

For chronic disease, Western medicine is better

What can you do to get treatments when don't have health insurance

New immigrants don't always have health insurance

If don't have money, don't go to the doctor

If go to the doctor, don't get medicine because don't have money (medicine costs a lot)

Some providers cancel appointments when they find out you don't have health insurance
If you have an illness, you should not delay but some clinics don't want to help

Why every time I go to the doctor they always take blood?
Why do I feel like an experiment?
All the tests are done to make money – each test costs money that is why they keep doing them
Why don't they do tests once and then look at the results

Medical interpretation needed because don't speak English
Telephone interpretation can be disruptive
Often don't find someone with knowledge of medical terms
Confusing, not clear

Some insurance programs/clinics don't allow patient to choose interpreter
Want freedom to choose own interpreter
If a female patient want a female interpreter

Want doctors who speak our language

Need help to set up appointments because of language issues
Many people use Asian Health and Service Center to help set up appointments.

Korean:

It's shocking to know that 30% of Koreans have no health insurance

Interesting to know there are people without insurance among Korean community

Need education about Medicare, Medicaid and private insurance

What is the age of people without insurance? Is it mostly families with children? OHP still covers kids.

Results likely underestimate what is really going on with Korean participants, who usually fill out 70% of survey with "true" information

People with small business did not quite participate in survey
If they were to participate, maybe the number of participants with no insurance would increase

Asians tend not to reveal their illnesses even in a survey

Information that Koreans view being overweight as a factor to make people sick was unexpected result

Why do certain groups have more illness than others?

How do rates of uninsured among Koreans in this survey compare to other surveys?

Hard to find interpreters for Korean patients

Many hospitals, general providers have interpreters but specialists do not
Patients told to bring their own interpreters to specialist appointment

Need transportation to health appointments

Telephone interpretation is limited and not good quality

Telephone interpreters tell patients to answer “Yes” or “No” to doctors’ questions even when patients want to say more

Face-to-face interpretation needed, especially for seniors

In Korea, people report similar information about major health problems and type of health-related information wanted

Vietnamese:

I thought more people would list diabetes as a health problem or a topic that people would want more information about

Recommend looking at data by age and by county as Vietnamese in Washington County are likely to be younger, with higher income and higher education and with health insurance. Vietnamese in Multnomah County are likely to be different and working in small businesses.

Medical interpreters give emotional support
Telephone interpreters do not give support
Providers, patients and interpreters feel more comfortable with in-person interpreters

Vietnamese seem most Westernized, maybe due to their political situation.

Vietnamese feel more American, view themselves as American first.

Vietnamese don’t report doing as much prevention as the Chinese and Korean participants
Maybe because the people who filled out the survey are healthier
Older Vietnamese persons are not as aware of what they can do to prevent illness so they wait until they get sick and then go to a Western health provider

Vietnamese have questions about mental health maybe because they are more Westernized

Not all Vietnamese use Oriental health providers

If Western medicine does not “work” for them, then they use Oriental health providers
Some Chinese medicine is good for some people but not all
Want to know what medicines or Oriental health providers are safe/good and which are not

Older persons like to have health education/information in their own language and written by health professionals

The results may be skewed because about half of the Vietnamese sample is young, professional and associated with the _____ school

Maybe did not answer the questions (about illness) because of how it was read – maybe say “what are your five top health concerns”

► Discussion of Recommendations

1. What do YOU think about the recommendations?
2. What is missing?
3. What should change?

Chinese:

<The recommendations are> very good
Explain why doing tests (laboratory, other)
Share results of tests with patients

Korean:

Patients need to let clinic/provider know they need an interpreter

Clinics/providers should provide interpreters, but not at the cost of the patient

Better to have an interpreter system in place at clinics/hospitals

Need to recruit more Korean interpreters and educate interpreters

Provide face-to-face interpretation, especially for seniors

Provide transportation to health appointments or tell patients how to find help to travel to appointments

In Korea, many institutions collaborate to create TV programs about health
Here we produce a TV series or program on diseases or illnesses, such as hypertension or cholesterol

Use media for education

Produce video tapes of programs in different languages

Provide information about low-cost vaccinations, such as pneumonia and tetanus, especially for seniors.

Provide education about Medicare, Medicaid and private insurance, especially for seniors

Look forward to see benefit and changes that result from project

Vietnamese:

Internet would be a good way to disseminate information, especially for younger people

Health care providers should be invited to visit nursing homes and hospitals to spend time with elders to see what happens as people get older and when they do not take care of their health

Older persons like to have health education/information in their own language and written by health professionals

Create a rating system for all Oriental health providers and their backgrounds so we can find them and know who is good and who is not.

Create a rating for all Oriental medicines so that we can know what the medicine is and whether it is safe or not

Need to understand importance of prevention, especially the elderly

Older persons should have printed health education materials, younger persons give information on the internet

Have organizations sponsor quarterly meetings on health topics

We need Vietnamese doctors

Need to know how to get cheap health insurance

Need to know where to get health care

► **Evaluation of *Roadmap to the New Horizon: Linking Asians to Improved Health and Wellness* Project**

1. What did you like about the “*Roadmap to the New Horizon: Linking Asians to Improved Health and Wellness*” project?

Chinese:

Liked project

Good to listen to what we have to stay

Korean:

Liked having the opportunity to give feedback

Liked process of participation

Liked feeling of belonging, being part of the study

2. What did you think about having to read and sign an “informed consent statement” before filling out the survey?

Chinese:

Respecting our privacy shows respect for us

Participants willing to fill out informed consent statement because received them from someone at the Asian Health and Service Center

Korean:

Korean people don't trust signing
People are reluctant to sign – avoid signing part

Participants willing to fill out informed consent statement because received them from someone they know or from a community organization (e.g., Asian Health and Service Center, churches, etc.)

This is a trust issue. Need to go through known organizations otherwise they won't sign consent.

Vietnamese:

People get paranoid about putting their names (on consent or survey)

3. What could we do to get more members of different Asian communities to participate in projects like this one?

Chinese:

Respecting our privacy shows respect for us

In order to have community members participate, find participants through trusted community members or organizations

If a stranger were to ask someone to participate, would not do it

Tell/ask friends to participate

Go to work settings so people who work can have chance to participate

Korean:

Need a longer time to advertise the project

Collaborate with local businesses

Work with organizations that community members trust to increase participation.

Invite neighbors

Vietnamese:

Make survey shorter – women are more patient so more likely to fill out a longer survey – men like short surveys

Administer survey in person (interview-like) people may be more likely to complete the survey

Use an electronic version of the survey so can send to friends or use a web-based survey

Send surveys to Vietnamese churches, temples, and different organizations

Use incentives – for gift card or to be in a raffle drawing

4. What other improvements can you recommend for this project?

Chinese:

Need more money and resources

Community members are hesitant to sign forms, so using a verbal consent may be a better approach.

Korean:

Make survey shorter (too many questions)

Print final report in different languages

Tailor future surveys to particular groups (e.g., families with children, retired elders, etc.)

Distribute findings to people who can make a difference

Distribute findings to health care providers and city officials

Post report on Oregon Medical Association website

Post report on city and county websites

Post findings in Korean business newsletters

Share with news media

Print summary of findings in newspapers such as the Asian Reporter, the Scribe (medical association) and others

Distribute information through churches, businesses and community organizations

Share results with the City of Portland – Tom Potter – Asian Focus Group

Vietnamese:

Survey is too long, make shorter

Vietnamese version was a bit confusing – due to “word-for-word” translation