2008 Ohio Community Conversations on Minority Health

June 27 – 28, 2008

Submitted to

The Ohio Asian American Health Coalition

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- Event Assistant: **Karen Jiobu** (Regional Coordinator, Health Through Action)
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1. Morning Group Recorders: **Hannah Seoh** (Community member); **Rita Zusman** (School of Psychology, Wright State University); **Barbara Snyder** (Director of Programs, Asian Services In Action, Inc.); **Karen Jiobu** (Regional Coordinator, Health Through Action); **Kevin Pan** (Northeast Ohio Universities College of Medicine, Asian Pacific American Medical Student Association).

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EXECUTIVE SUMMARY

In the fall of 2002, ASIA's founding director, May Chen, convened a group of Asian American leaders from Akron, Cleveland, Columbus, and Dayton. The purpose of their meeting was to discuss how to learn more about the use of tobacco products by Ohio's Asian American youth and young adults. As a result of a series of ongoing discussions, the Asians for Tobacco Free Ohio Youth Survey was developed and administered. **That was the first comprehensive statewide survey of AAPI (Asian American and Pacific Islander) youth to ever be conducted in the Midwest area of the United States**. The survey was revised as needed and additional data collected throughout the state over a four-year period.

The most important point to be taken from this information is that it was not until 2002 that the Asian American populations residing within Ohio were able to see disaggregated data specific to their communities' use of tobacco. Prior to this survey, over 20 highly individualized Asian American ethnic populations were viewed by mainstream researchers as all being one and the same – Asian.

According to the 2000 U. S. Census, there were 159,776 "Asians" living in Ohio. This number included only 16 specific Asian populations – Asian Indian, Bangladeshi, Cambodian, Chinese (not including Taiwanese), Filipino, Hmong, Indonesian, Japanese, Korean, Laotian, Malaysian, Pakistani, Taiwanese, Thai, and Vietnamese. Also included were 5,000+ individuals labeled as "Other Asians."

There continues to exist a great need for Asian American health-specific disaggregated data. It is this type of data that will be invaluable to those individuals who develop and test new health promotion and disease prevention programming for underserved and often forgotten populations. Disaggregated data which demonstrates the differences in the health care needs and concerns of Ohio's Asian American populations and mainstream populations could

provide guidance and direction to researchers, health educators, prevention providers, and numerous others involved in various areas of the health professions and social services. Disaggregated data holds the potential to help individuals, service providers, and funders to better recognize and understand people's differences as well as their similarities. Through the use of such data, perhaps we could grow and move past the traditional "one-size-fits-all" menu of program services. If recognition and understanding foster acceptance and respect, then state-of-the-art, evidence-based programming could eventually be designed and implemented to meet the specific needs of *each* of Ohio's diverse communities.

In recognition of health disparities among Ohio's numerous Asian American populations, an Ohio Asian American Health Conference was convened in 2002 and, again, in 2005. At the conclusion of the second conference, representatives of various Asian American community organizations, health care professionals, students, and community leaders joined to form the Ohio Asian American Health Coalition. While acknowledging that there are many Asian American health care needs, the group focused upon three that were considered to be among the most urgent: (1) hepatitis B and associated liver cancer, (2) mental health issues, including domestic violence, and (3) prevention and control of tobacco use. There was a general consensus that education was needed to (a) inform health care providers of the health needs among Asian American populations and (b) inform members of these populations of existing health care programs and services.

From this beginning, the coalition has continued to grow in number and stature. The organization has been granted its 501c3 status as an Ohio nonprofit organization, which has allowed Coalition members to begin seeking funding for coalition growth and activities. Through this process, the coalition has been awarded funding from the W. K. Kellogg Foundation, the Health Through Action Program, and the State of Ohio Commission on Minority Health. Through these funds, the coalition has been able to participate in the statewide Community Conversations on Minority Health.

On June 27 and 28, 2008, the Ohio Asian American Health Coalition held a two-day event which was the first of its kind in Ohio. The event brought together 82 individuals who represented 15 different ethnic communities. Through a casual but highly structured group process, the attendees were able to begin identifying the health needs of Ohio's Asian American populations.

It is anticipated that this event will serve as the stepping stone for the coalition to begin an in-depth process of collecting disaggregated data on the health needs and issues of the state's many Asian communities. The information presented in this report reflects some of the first steps taken by the coalition as it strives to empower Asian American organizations, communities, and individuals to learn the skills necessary to address their own health concerns.

SUMMARY OF FINDINGS

Community Conversations Morning Discussion Groups

On Saturday morning, June 28, 2008, 63 individuals participated in the Asian American Community Conversations on Minority Health event. The 63 participants comprised of 35 females and 26 males (not including two blank responses) who represented twelve specific ethnic populations.

The participants were divided into four groups, with each group being assigned its own discussion topic. Although the topics were different, the discussion process was identical across groups. As a result of the morning Community Conversations, the following information has been gathered:

- The four morning groups mentioned 14 different diseases and health conditions during their Community Conversations discussions. Of those listed, ten had been mentioned by only one of the four groups. The remaining four conditions had each been mentioned by two of the four groups and included the following diseases/conditions:
  - Diabetes
  - Stroke
  - Mental Health Disorders
  - Prenatal Care
- Were any problems encountered by participants when they had gone to a mainstream doctor for help?
  - Among the four morning groups, 12 problem areas were listed.
  - Only one problem was mentioned by all four groups --"I would prefer going to a doctor who comes from the same culture I do – to understand my beliefs, my customs, my language, etc."
  - Two problems were mentioned by three of the groups. These two problems were "I had no interpreter and had problems understanding everything that was said to me,"

and "I had no interpreter and had problems telling the doctor what was wrong – my English is not good."

- Twelve ethnic groups were represented in the morning sessions.
    - One ethnic group (Mon) was represented by males only.
    - Four ethnic groups were represented by females only (African American, Cambodian, Caucasian/Mainstream, and Filipino).
    - The remaining seven groups were a blend of both genders.
- Morning participants represented both an ethnic group and one of five community groups.
    - The community group with the largest number of participants was Ethnic Organizations and Community Representatives, which had 22 participants (34.92% of the total morning participants).
    - Medical Schools was the category with the smallest number of participants with five participants (7.94% of the total morning participants).
- Fifty-four percent of the morning participants listed their addresses as being in one of four cities
    - Columbus (13)
    - Cincinnati (9)
    - Akron (6)
    - Cleveland (5)
- Morning groups were asked to identify health service needs within their communities.
    - The four groups combined identified 53 community needs.
    - Only two of the 53 needs were identified by all four groups.
        1) the need for transportation support
        2) AAPIs need to know about available services.
    - Five needs were identified by three of the four groups.
    - Seven needs were identified by two of the four groups.
    - Thirty-nine needs were identified by one group only.

- Once needs were identified, each group was instructed to prioritize its list of needs. First priority needs identified by each group were as follows:
    - Group 1: research data on AAPI populations
    - Group 2: research data on AAPI populations; need for funding; and comprehensive needs assessment with disaggregated data (3-way tie for first)
    - Group 3: health education services
    - Group 4: comprehensive needs assessment with disaggregated data
    - Two needs were listed as number one priorities by two of the four groups: (1) lack of research data, and (2) comprehensive needs assessment.
    - The remaining two needs -- “need funding" and "need health education services" -- were each prioritized one time by one group.
- Each group was then instructed to develop a list of strategies to address its prioritized needs.
    - When all group lists were combined, the four groups had itemized 42 different strategies.
- Of the 42 strategies, only one had been listed by three of the four groups –
    - A comprehensive needs assessment
    - No strategy had been listed by all four groups
- It should be noted that even though each of the four groups was assigned a different discussion topic, and each of the four groups was diverse in gender, ethnicity and background, the groups still arrived at many of the same responses regarding needs, priorities, and strategies.

Health Through Action Afternoon Focus Groups

On Saturday afternoon, June 28, 2008, there were 42 individuals who participated in the Health Through Action Focus Groups sponsored by the W. K. Kellogg Foundation and the Health Through Action Program. Participants were divided into three groups, with each group being assigned its own facilitator, recorder, and meeting room.

The 42 individuals who participated in the afternoon session represented ten different ethnic populations. The ethnic group with the greatest representation was the Chinese (N=16), which comprised 38.10% of the total afternoon participants. Three self-identified ethnic groups with the least representation were the Caucasian/Mainstream, Pakistani, and Vietnamese.

Of the 42 participants, 18 were male (42.86%), 22 were female (52.38%); and 2 participants (4.76%) chose to leave this question blank. Three of the ethnic groups were represented by males only (the Korean, Mon and Vietnamese) and two of the ethnic groups were represented by females only (Caucasian/Mainstream and Filipino). The remaining five groups were a blend of both genders.

Each facilitator was given an identical list of questions which had been furnished by the W. K. Kellogg Foundation. The facilitators were to lead their groups through a discussion of the following, with responses noted by each group's recorder:

1) What are some of the biggest problems facing you and your community?
2) Do you worry about your health? How do you define being “healthy”? What are your biggest health concerns?
3) Do you know where to go to get your health needs met?
4) Do you know your rights for accessing health care? (e.g., Medicare coverage, insurance coverage, etc.)? Where do you go to get this information? How comfortable do you feel advocating/pushing for your rights to health care? (e.g., your right to an interpreter, Medicare rights, etc.)
5) Does any agency help you get health services? How have they helped you?
6) Do you go to any specific organization or doctor for your health needs? (e.g.,

community clinic, local hospital, doctor, etc.)

a) Do they understand your health needs?
b) Do they help you?
c) Do they understand your cultural traditions when it comes to health?
d) Do you understand and agree with the treatment the doctor prescribes for you?
e) Does the treatment the doctor prescribes for you take into consideration any traditional healing practices you are using?

7) What are your biggest challenges in getting your health needs met? What additional resources could you use?

As a result of the Health Through Action Focus Groups, the following information has been gathered:

1) What are some of the biggest problems facing you and your community?

The three groups came up with a combined list of 22 problems. Four of the items they listed were mentioned by two of the three groups. These four problems included the following:

1) diabetes
2) cardiovascular disease
3) hypertension
4) dental hygiene/oral health

The remaining 18 problems listed were each mentioned by only one of the three groups.

2) Do you worry about your health? How do you define being "healthy"? What are your biggest health concerns?

In response to these questions, the three groups listed a total of nine health concerns. Of the nine concerns, only one was mentioned by more than one group. That one was a "biggest health concern" based on "My insurance rates

were increased because of having chronic illnesses." Other than this one concern, all remaining eight concerns were by individual groups.

3) Do you know where to go to get your health needs met?

The responses to Question 3 so closely paralleled participants' responses to Question 6 that these answers have been listed with responses for Question 6 found below.

4) Do you know your rights for accessing health care? Where do you go to get this information? How comfortable do you feel advocating/pushing for your rights?

It has been observed that when more than one question is asked at one time, as is the case with Question 4, the groups' responses usually do several things – 1) participants do not answer all of the questions asked, and 2) their answers often do not clearly respond to any one of the questions asked.

In response to the three questions asked in Question 4, the following answers were given by two of the three groups:

Group 1:

- Right to have interpreting services
- Right to refuse treatment

Group 2:

- No responses given

Group 3:

- Often need to have someone else to speak up for us
- The system needs universal paperwork requirements (such as all insurance forms use same format, all intakes and histories use same format, etc.)
- Health care providers need training regarding immigrant/refugee rights

5) Does any agency help you get health services? How have they helped you?

For some reason, participants struggled with these two questions. They seemed unclear of what the questions were specifically asking, since all the participants have resided in the United States long enough to know where they have to go for their health services.

As a result of the confusion, two groups had no responses to these questions and the third group provided the following responses:

- Refugee programs, e.g., refugees can get Medicaid for 8 months.
- The Akron International Institute [Resettlement Program] helps refugees during their first six months in the U.S.
- In Summit County & Cuyahoga County, Asian Services In Action, Inc., helps both immigrants & refugees, with no time limits on services.

> [It should be noted that neither the International Institute nor ASIA, Inc., provides health services. Both offer interpreting services, health education services, and can help navigate individuals through the system, but neither has a medical facility or provides medical services.]

6) Do you go to any specific organization or doctor for your health needs?

The following six responses were listed by Group 1:

- Urgent care center
- Emergency room
- Primary care physician
- Mini-clinics located in pharmacies or supermarkets
- Consult with our community leader
- Go to a family member

Group 2 listed only one response: Urgent care center

Group 3 also listed only one response: Primary care physician

a) Do they understand your health needs?

Group 1 had only one response:

- They have problems interpreting information about medicine.

Group 2 had seven responses:

- Usually have to wait too long – I once had to wait 5 hours.
- I am starting to think that the only way to get good service is to complain – if you don't complain, they act like you're fine.
- Mainstream doctors do not seem to realize that most AAPIs often need lower dosages of medication.
- I have found that most doctors miss the diagnosis until it's "too late."
- Even with insurance, care can be much too expensive.
- Cost of insurance keeps going up every year – it is getting too expensive.
- I believe Asian medicine is better than mainstream, so I try not to go to mainstream doctors.

Group 3 had no responses for this question.

6-b) Do you believe your provider helps you?

None of the three groups discussed this question.

6-c/d) Does your provider understand your cultural traditions, especially in regard to health? Do you understand and agree with the treatment the doctor prescribes for you?

Group 1 had five responses:

U.S. doctors should give more details when explaining what is wrong and what's needed for treatment.

- Too many times my questions are not answered.
- Would like to see diabetes treatment menu that includes rice in the diet.
- U.S. doctors often talk down to us.

- U.S. doctors often act condescending.

Group 2 did not discuss these questions.

Group 3 had four responses:

- U.S. doctors need to be more accepting and knowledgeable about homeopathic treatment.
- Adjustment disorder in immigrants and refugees is often misdiagnosed as depression.
- All the required paperwork is often a barrier to seeking services for many LEP (Limited English Proficient).
- Funding is needed to hire and train bilingual caseworkers.

6-e) Does your provider use any alternative healing practices?

Group 1 had six responses for this question:

- Culturally competent doctors will ask about supplements.
- Doctors need both cultural sensitivity and cultural competency trainings.
- No one discusses with the AAPIs the possible negative effects of mixing two medications, mixing medication with alcohol, mixing medication with herbal products, etc.
- There is a lack of research that compares the effectiveness of traditional and alternative treatments.
- There is a lack of research done on outcomes of combining traditional and alternative treatments
  - What combinations work?
  - What combinations produce harmful effects?
- Some colleges and medical schools are now developing departments of Complementary Medicine. More schools should be doing this.

Group 2 had two responses:

- Chinese medicines and AAPI treatments are not covered under mainstream health insurance policies.

- Everything I have heard and seen and experienced tells me that traditional Asian medicines are better than Western medicines.

Group 3 had no responses to this question.

7) What are your biggest challenges in getting your health needs met? What additional resources could you use?

Group 1 had the following responses:

- Availability of interpreters
- Poorly trained interpreters or interpreters who have had no training
- Problems of having to use male interpreters with female patients
- Problems with issues of privacy when interpreters and patients know each other
- Need for affordable health care
- Issues around using ER instead of having a primary care doctor
- Patient's expressed feelings get lost in interpretation, so often feelings are ignored or not made known.
- Most of us would prefer an ethnic doctor of our same culture.
- Need increased accessibility to health care services
- All providers should have translated medical dictionaries available.
- Ethnic community members and leaders need to be trained about the U.S. medical system.
- Needs for more free clinics – especially in or near larger ethnic communities
- Need more culturally competent doctors
- Need dedicated community leaders to advocate setting up free clinics in their communities
- Need universal healthcare that will include immigrant and refugee populations in the U.S.

Group 2 gave the following responses:

- Availability of interpreters

- Need for affordable health care
- Most of us would prefer an ethnic doctor of our same culture
- Need more culturally competent doctors
- Need universal healthcare that will include immigrant and refugee populations in the U.S.

Group 3 participants gave the following responses:

- Availability of interpreters
- Need for affordable health care
- Most of us would prefer an ethnic doctor of our same culture
- Ethnic community members and leaders need to be trained about the U.S. medical system
- Need more culturally competent doctors

UNASKED QUESTIONS FOR WHICH PLANNERS SOUGHT ANSWERS

During the course of planning the morning Community Conversations, there were several questions which came up that the planners hoped to have answered by the participants. There was discussion about adding several questions of their own to the format expected by the program's funder. Because of time constraints, it was decided to not ask facilitators to include the additional questions.

Instead, these questions would be addressed as part of the final reporting/evaluation process. A thorough review of all group minutes would be done to determine if participants had addressed any or all of these questions during their conversations on needs, strategies, and priorities.

The responses listed below may, at first glance, look very similar to needs, priorities, and strategies already listed in other parts of this report. However, what is listed below was taken

from participants' conversations that were included in the minutes. These responses are included below because they expand upon items that were simply "listed" elsewhere.
It is in these "expanded responses" that the evaluator believes the answers to the three additional questions can be found. Table 1 addresses Question 1; Table 2 addresses both Questions 2 and 3. As the reader reviews these two lists, however, it may be noticed that many of the responses overlap in content and could apply to more than one of the three questions.

Unasked Questions That Planners Wanted Answered

> **Question 1: Are there certain diseases or health conditions which are of particular interest or concern to the AAPI communities?**
>
> **Question 2: What are some of the problems you have had when going to a mainstream doctor to get help for health care problems (help for either you or for someone else)?**
>
> **Question 3: What are some of the insurance problems that you or others have had?**

Question 1: Are there certain diseases or health conditions which are of particular interest or concern to the AAPI communities?

Health Conditions Mentioned: Morning and Afternoon groups were not requested to discuss specific diseases or health conditions. Review of the minutes, however, showed that in several groups these were mentioned during the course of the discussion.

Below is a complete listing of all diseases and health conditions mentioned by participants of the four morning groups and three afternoon groups. The table following this listing matches the diseases and conditions to the groups in which they were mentioned.

<u>List of All Diseases and Health Conditions Mentioned By Morning and Afternoon Group Participants</u>

1. Diabetes
2. Hepatitis B
3. TB
4. Asthma
5. STDs/STIs
6. Stroke
7. High cholesterol
8. Osteoporosis
9. Glaucoma
10. Mental health disorders
11. Gambling addiction
12. Tobacco addiction
13. Alcohol addiction
14. Prenatal care
15. Dental hygiene
16. Cardiovascular diseases
17. Hypertension
18. Metabolic Syndrome
19. Alzheimer's
20. Allergies
21. Parkinson's

Table 1 lists 21 diseases and health conditions mentioned by the morning participants in the Service Group, Resource Group, Capacity Building Group, and Infrastructure Group and the afternoon participants of the Health through Action focus groups.

Table 1: Diseases and Health Conditions Mentioned by Morning & Afternoon Group Participants

	Diseases and Health Conditions Mentioned by Morning and Afternoon Group Participants	A.M. Service Group	A.M. Resource Group	A.M. Capacity Building Group	A.M. Infra-structure Group	P.M. Group 1	P.M. Group 2	P.M. Group 3	*Total Number of Groups Naming Condition*
1	Diabetes	X		X		X	X		*4*
2	Hepatitis B	X					X		*2*
3	TB	X					X		*2*
4	Asthma	X							*1*
5	STDs/STIs	X							*1*
6	Stroke		X	X					*2*
7	High cholesterol			X			X		*2*
8	Osteoporosis			X			X		*2*
9	Glaucoma			X					*1*
10	Mental health disorders	X		X		X		X	*4*
11	Gambling addiction	X							*1*
12	Tobacco addiction	X							*1*
13	Alcohol addiction	X							*1*
14	Prenatal care	X		X					*2*
15	Dental Hygiene						X		*1*
16	Cardiovas-cular Diseases					X	X		*2*

17	Hypertension						X		*1*
18	Metabolic Syndrome						X		*1*
19	Alzheimer's					X			*1*
20	Allergies					X			*1*
21	Parkinson's					X			*1*
	Totals	*10*	*1*	*7*	*0*	*6*	*9*	*1*	

Question 2: What are some of the problems you have had when going to a mainstream doctor to get help for health care problems (help for either you or for someone else)?

Question 3: What are some of the insurance problems that you or others have had?

<u>Morning Groups' Discussion Responses for the Unasked Questions</u>

Table 2 shows the responses of the Services Group, Resources Group, Capacity Building Group, and Infrastructure Group to Questions 2 and 3 listed above.

Table 2: Morning Group Discussion Responses That Fit Questions 2 and 3

Morning Group Responses For Questions 2 & 3	Services Group	Resources Group	Capacity Building Group	Infrastruc-ture Group	Total
1. Finding transportation	X				1
2. Had no interpreter and had problems understanding every-thing that was said to me.	X	X	X		3

3. Had no interpreter and had problems telling the doctor what was wrong – my English is not good.	X	X	X		3
4. At least 90% of my community's elders need an interpreter at the doctor's office – they speak only their home language.			X		1
5. I was told I would have to pay for an interpreter with my own money, so I didn't get one.	X				1
6. There are lots of issues with using ER all the time instead of a primary care doctor.	X				1
7. Interpreters have told me they often have a very hard time trying to put patients' feelings into English words.	X				1
8. There's a stigma about certain illnesses, so AAPIs typically will not see doctors for these problems – i.e., mental health problems such as depression.	X				1
9. Because of the stigma attached to mental health disorders, when doctors ask AAPI patients questions about emotions/ feelings, we often don't give honest answers.	X				1
10. I would prefer going to a doctor who comes from the same culture as me – to understand my beliefs, my customs, my language, etc.	X	X	X	X	4

11. There is very little AAPI-specific health data, and what does exist is spread throughout the city, county, state, and federal levels – it all needs to be compiled and made easily retrievable for all interested AAPIs and all health providers.				X	1
12. One participant told of asking another woman to go to a Health Fair with her. The other's response was "What for? I'll just get an unfavorable result and I cannot afford to go to the doctor, so I would rather not know what is wrong." [Note: This was a very common response because free health screenings almost never provide any follow-up. (*B. Snyder*)]				X	1
Total	9	3	4	3	19

Afternoon Groups' Discussion Responses for the Unasked Questions

Table 3 shows 30 responses for Questions 2 and 3 from the three afternoon groups.

Table 3: Afternoon Groups' Discussion Responses for the Unasked Questions

Afternoon Group Responses For Questions 2 and 3	After-noon Group 1	After-noon Group 2	After-noon Group 3	Total
1. Availability of interpreters	X	X	X	3
2. Poorly trained interpreters or interpreters who have had no training	X			1
3. Problems of having to use male interpreters with female patients	X			1

4. Problems with issues of privacy when interpreters and patients know each other	X			1
5. Need for affordable health care	X	X	X	3
6. Oral hygiene in AAPI populations may be an important funding issue; for example, the Karens always chewed beetlenuts, which stained their teeth. This practice is considered to be a risk factor for oral cancers.		X		1
7. Patient's expressed feelings get lost in interpretation, so often feelings are ignored or not made known.		X		1
8. I try to never go to the doctor because I have no health insurance.		X		1
9. I don't expect health insurance to be free, but it should at least be affordable.		X		1
10. AAPI women should be encouraged to go through interpreter training – often they won't because of cultural norms to remain "shy" and "quiet."		X		1
11. Because of many cultural issues, many AAPI women do not feel comfortable addressing their healthcare needs with a male OB/GYN.		X		1
12. In one area hospital, AAPI refugee patients were told to "turn and talk to the wall" if they knew their interpreter and were worried about privacy issues.		X		1
13. Often I do not understand what the doctor is telling me about how to take the medicine he prescribed.		X		1
14. We need more communication and education between immigration lawyers and family lawyers about the rights of immigrants – esp. around issues such as domestic violence and abuse.			X	1
15. I will not tell a doctor that I do not have money to buy the medicine he says I should take – I am a proud person and he does not need to know how much money I have.	X			1

16. Senior abuse is seldom reported to the doctor – the language barrier keeps the elders from trusting the doctors, and you have to trust someone before telling them something so shameful.	X			1
17. Most of us would prefer an ethnic doctor of our same culture.	X	X	X	3
18. Limited English AAPIs or new arrivals often are easily lost in the system once a service has been provided for them, i.e., receiving emergency care at ER and then having no follow-up.			X	1
19. We need more people to advocate appropriately for others' health needs, esp. for the elderly, the children, and the English-limited.			X	1
20. Elderly AAPIs need to be educated on safe use of mainstream medications.			X	1
21. AAPIs need to be taught the dangers of "sharing" their medications.			X	1
22. AAPIs need to be taught the dangers of trying to save money by skipping days of taking their meds, or by cutting dose levels in half.			X	1
23. Limited English AAPIs and new arrivals often do not know that the law requires doctors to provide them with interpreters, if needed, at the doctors' or health facilities' expense.			X	1
24. Some questioned how honest to be with insurance companies; one woman has paid for health insurance for 13 years, but when they learned she had diabetes & heart disease, they raised her rates, which she could not afford, so she dropped her insurance and now has none.	X			1
25. Many believe mainstream doctors do not know the right dose levels of medication needed by AAPIs; AAPIs typically believe they need less than is customarily ordered for Caucasians.	X			1

26. One group member asked if any of the others knew of any studies that had been done to determine the number of Asians who have had a problem with medication dosages. No one knew of any. All decided that such research would be very beneficial to AAPIs and also to main-stream medical providers.	X			1
27. It was noted that most Asians living in the U.S. do not complain a lot. Therefore, as patients, they are often not diagnosed because doctors assume they are OK if they are not complaining.	X			1
28. Even with health insurance, the costs of health care and medications are still overwhelming.	X			1
29. We need to "create a marriage" between the older and younger generations in order to develop future leadership – combine the elders' experience and knowledge with the younger ones' energy and desire for professional development. The older generation can teach the people skills to the younger generation, and the younger generation can teach the technological skills to the older generation.			X	1
30. One participant summed up the above statement (29) by stating "we **all** need to understand that the different generations are also different cultures."			X	1
Total	13	11	12	36

ADDITIONAL RECOMMENDATIONS FOR FUTURE DIRECTION

The Coalition's goal is to "empower Asian American organizations, communities, and individuals to address their own health concerns." This is done primarily through the combined efforts of the Coalition's statewide leadership and membership. The roles assumed

by the Coalition are to provide ideas, direction, and advocacy efforts designed to support and empower AAPI individuals who are in various stages of developing the skills needed to "address their own health concerns." To accomplish this, the Coalition must also provide ideas, direction, and support for the professionals – both AAPI and mainstream -- who provide services for the AAPI populations.

Morning group participants presented many of the recommendations listed in Dr. Yung's report as strategies. The majority of these strategies represents direct services and would be appropriate for both AAPI and mainstream agencies to adopt, develop, and put into action. Not all of Dr. Yung's recommendations, however, would be practical for the Coalition to adopt and implement. As Ms. Bounthanh Phommasathit told her fellow Coalition members at one of their earlier meetings, "Coalitions focus on policy structure, not on providing direct services."

The complete list of Dr. Yung's recommendations is available from the Ohio Commission on Minority Health. However, based on the information presented within this report, there are several additional recommendations. They are listed below.

Recommendation #1:
The Coalition may be in an ideal position to convene its full membership and use Dr. Yung's list of recommendations to begin a serious discussion of the Coalition's future direction. Such a discussion could parallel the process used in the Community Conversations groups.

Using the list of strategies/recommendations, the membership could review the list and then prioritize the items to determine which would be critical to advancing the Coalition's goal. The group would then identify strategies appropriate for addressing the highest-ranked priority items.

A series of meetings would then be convened, with one meeting held in each of the Coalition's five primary targeted cities – Akron, Cincinnati, Cleveland, Columbus, and Dayton. Members

from each of the five cities would be responsible for working with the Coalition in extending invitations to their meetings. Included in the invitation lists should be area mainstream and AAPI healthcare service providers, local foundations and other potential funders, AAPI community leaders and members, faith-based leaders, and any other interested parties.

The same group process used for the Community Conversations could be used at the city meetings – introduction of the process, discussion of the needs (the list of recommendations selected by the Coalition members), prioritizing the recommendations, then developing detailed implementation strategies. Each city would then have the responsibility for working with and supporting others in implementing their selected recommendations.

One of the criticisms that appeared frequently in Community Conversation discussions was the need for follow-up health services. One example mentioned by several was free health screenings offered at ethnic events, with no follow-up given. Often the AAPIs who received the free screenings became “lost in the cracks” of the healthcare system.

To prevent this same action from occurring with each city’s attendees, quarterly meetings should be held in all participating cities. This would provide participants the opportunity to share their successes and find answers for the problems they’ve encountered in developing and implementing their chosen strategies. This would also serve as an excellent reporting system for keeping the Coalition informed.

Recommendation #2:
All groups mentioned the need for more interpreters, trained interpreters, and appropriate matching of interpreters with individuals needing their services. Few groups, however, mentioned translation services, and even that was done in very generic terms: need more written translated materials, more graphic translated materials, and translated emergency preparedness materials.

Keeping in line with the Coalition's goal to empower AAPI organizations, communities, and individuals to address their own health concerns, the Coalition may want to emphasize the need for translated signage in all healthcare facilities, both mainstream and AAPI. Translated paperwork would be another appropriate recommendation. Items such as intake forms, patient histories, payment requirements, appointment cards, and HIPPA regulations could all be translated into bilingual formats.

Recommendation #3:
When working on needs and strategies, the groups mentioned several ways of using the media. Two basic uses would be to promote the Coalition's efforts as well as use the press to inform and educate the mainstream public about the AAPI communities within their readership area.

The leadership of the Coalition has been very conscious of the power of the media, and has taken advantage of numerous opportunities to develop press releases for use by newspapers across the state. Recommendation #3 is to continue developing the press releases, with one minor change.

At the end of each article include one or two sentences that tell the readers something very specific they can do if they wish to help or be part of the Coalition's efforts to create positive change. Even a statement as simple as "For information on what you can do to help _____________ [fill-in the blank – immigrants, refugees, new arrivals, AAPIs, Limited English Proficient school children, etc., etc.], please call ________________ or check our website at __________ ."

Recommendation #4:
Preparing this report provided an excellent opportunity to closely examine what participants had to say. It also provided several opportunities to reflect upon what sometimes appeared to be conflicting statements.

For example, the needs identified by the four morning groups resulted in a final list of 53 needs. Of these 53 needs, only two had been listed by all four of the groups. These two were (1) need for transportation, and (2) need for AAPIs to know about available services.

The fact that these two needs were listed by all four groups appears to indicate the level of their importance in the group members' eyes. However, when the groups were instructed to prioritize the needs they had listed, **no group** included "Need for transportation" as a priority. And, as for the second need that all four groups had included as a need, "need for AAPIs to know about available services" received mixed ratings as an identified priority: It was tied for 2nd, also tied for 3rd, ranked 5th by one group, and not even included in the priority list by another group.

The needs that were prioritized as being most important were the following: "Comprehensive needs assessments need to be conducted," which was ranked as the first priority of two groups, and "There is a lack of research data on AAPIs," which also was ranked as the first priority by the remaining two groups. During the morning group discussions, both of these needs had been identified as critical to advancing positive growth for AAPI agencies and providers. Data would be extremely useful in advocacy efforts, funding applications, recruiting services from mainstream providers, etc.

When examining what first appear to be conflicting statements, the following statements can be made, along with the assumption drawn from those statements:

1) Only two needs were listed by all four groups, and these two needs were specific to the needs of the AAPI communities.
2) Only two needs were prioritized as being number 1 in importance, and these two needs were specific to the needs of the AAPI service providers.
3) It may be that agencies are recognizing they can only take care of others if they first take care of themselves. Strengthening the position of the AAPI agencies and service providers is critical in order for them to develop and implement new or expanded services.

When the Coalition reviews the lists of needs and priorities, it will be important to keep in mind which needs and priorities are meant to directly impact the agencies and which are meant to directly impact the AAPI immigrants and refugees.

Recommendation #5:

Funding was one of the predominant themes mentioned throughout all morning and afternoon group sessions. With the current state of the economy, however, it seems very likely that funders will be giving less while at the same time more people will be requesting larger amounts from the smaller pot of funds.

Therefore, it is critical that when seeking funding, all proposals reflect the most current data available, including best practices and program models. To strengthen any funding applications developed and submitted by the Coalition, it is recommended that the Coalition begin to create a database that it will make available to all AAPI Coalition members and their agencies.

One example of what should be included in this database would be recent research articles applicable to any of the health conditions mentioned within this report. No article older than the past five years should be included, unless it is a recognized seminal piece that provides still-current information.

It is also critical to include program models and theories that can be applied to the development of health-specific grant applications. Inclusion of theory-based program models demonstrate to the funders a knowledge base that fosters a comprehensive understanding of the problem presented – something that is often not found in most proposal applications. The use of such theories and models will also be invaluable in guiding the direction of the proposal's evaluation component.

To simplify the development of such a database, Coalition members and/or Health Through Action staff from each of the program's five sister counties could volunteer their time and services. There were 21 health conditions and diseases mentioned during the Community Conversations group sessions. Each county could assume responsibility for materials specific to one of the 21 illnesses or disorders. The Coalition could provide the format they would like to see used in the database, and all materials gathered by each county would need to fit those requirements.

To have such a database available to Coalition members would be an invaluable resource that could reap rewards for both the members' agencies as well as for the Coalition itself.

METHODOLOGY

On June 27 and 28, 2008, the Ohio Asian American Health Coalition (OAAHC) participated in Ohio's Regional Community Conversations on Minority Health. The Coalition was one of 19 groups throughout the state that planned and conducted a local Community Conversations event. Through grant funding provided by the State of Ohio Commission on Minority Health and the Asian Pacific Islander Health Forum/W. K. Kellogg Foundation Health Through Action, OAAHC was able to conduct the two-day event, free of charge, for 83 attendees.

Friday Evening, June 27, 2008

The evening session on June 27 was held at the Sunflower Restaurant in Columbus, Ohio, and began with featured keynote speaker Cheryl Boyce, Executive Director, State of Ohio Commission on Minority Health. Ms. Boyce's presentation was followed with dinner and extensive professional networking.

A. Morning Community Conversations Discussion Groups
June 28, 2008, 8:15 a.m. – 12 noon

Procedure

The daylong session on Saturday, June 28, was held at the Holiday Inn in Worthington, Ohio. The event began with a community meeting which featured a PowerPoint presentation on *The Purpose and Process of the Local Conversations in Ohio.* The presentation was given by Dr. Betty Yung from the Research Evaluation and Enhancement Program (REEP) at Wright State University in Dayton, Ohio. Dr. Yung was also responsible for reporting the findings of all 19 Community Conversation events across the state.

Following Dr. Yung's presentation, participants were randomly assigned to one of four groups – (1) Capacity Building, (2) Infrastructure, (3) Resources, or (4) Services. Each group was provided with a trained facilitator, a group recorder, and a private meeting room. Facilitators and recorders

were provided with written instructions detailing their specific roles and responsibilities. These instructions were provided by Dr. Yung and were identical to the instructions used by the facilitators and recorders at the other 18 Community Conversations events being conducted in Ohio.

When the groups convened and introductions were completed, each group's facilitator briefly went over the ground rules, introduced the group to its assigned topic, reviewed the group's task and purpose, and proceeded to lead the group through the discussion process.

Sample

The convenience sample was comprised entirely of individuals who either registered to attend or who were working as staff or volunteers with the Community Conversations event. During the two-day period of the event, a total of 83 people attended Friday evening, Saturday, or both.

Of the 83 attendees, 63 individuals participated in the Saturday morning group sessions. Within the morning groups, twelve specific ethnic populations were self-identified by participants when they completed registration forms and sign-in sheets. The identified ethnic groups included African American, Asian Indian, Cambodian, Caucasian/Mainstream, Chinese, Filipino, Japanese, Karen, Korean, Mon, Pakistani, and Vietnamese. The morning groups – including participants, facilitators and recorders -- were composed of 35 females and 26 males (two responses were left blank).

Group Process

Each morning group was assigned one of four specific discussion topics: (1) Capacity Building, (2) Infrastructure, (3) Resources, and (4) Services. All four groups were led through a similar opening exercise: introduction of all participants, explanation of the group process, and a brief review of basic ground rules.

Group members were then asked to discuss what they believe are "the most pressing needs" in their communities. Participants were requested to identify needs specific to their group's assigned topic. It was recognized, however, that discussions might overlap several different topic areas.

Some needs were presented as straightforward one-sentence statements. Other needs were presented anecdotally, typically through personal experience stories that spoke of a service system that is hard to access, difficult to navigate, too expensive, and typically mainstream in method and mindset, with limited cultural awareness or competency.

Each group's facilitator recorded all responses on flip chart paper and each completed page was taped to the walls of the group's room. Participants were then given five "dots" (stickers) and asked to place them on the flip chart pages to indicate what they considered to be the highest priority needs.

When completed, the facilitator tallied the number of dots placed with each need. The group was then given the remainder of the time to suggest which strategies could be used to address the top five needs selected by the participants. Both the group recorder and the group facilitator recorded their group's suggestions.

Data Collection with the Morning Groups

In each of the four groups, participants introduced themselves; their names were noted in minutes prepared by the group recorders. In addition, sign-in sheets were distributed to each group at the beginning of the morning sessions. At the conclusion of the morning sessions, all sign-in sheets were collected by the Event Coordinator, Lek Smitananda.

Group recorders were also responsible for taking accurate and detailed minutes of the groups' discussions of their assigned topic. Recorders were also responsible for preparing the minutes of their respective group sessions.

The Community Conversations results, along with the findings of 18 other Conversations being held throughout Ohio, have been included in a report by Dr. Yung. The final Community Conversations report was then submitted to the State of Ohio Commission on Minority Health, which then submitted it as Ohio's contribution to the development of the *National Blueprint for Action*. Dr. Yung also agreed to provide the Asian American Health Coalition with a separate report specific to the morning sessions conducted during the Coalition's Community Conversations event.

The report Dr. Yung submitted to the Coalition covered only the portion of the Community Conversations (morning group sessions) which was funded through the State of Ohio Commission on Minority Health. Afternoon sessions were conducted as part of the Coalition's Health Through Action grant requirements, which were funded through the Asian Pacific Islander Health Forum/W. K. Kellogg Foundation (Grant #6 STTMP051025-03-01, U.S. Department of Health and Human Services). The afternoon sessions' findings were not included in Dr. Yung's final report.

A second report was written by Barbara Snyder, Director of Programs with Asian Services In Action, Inc. This report covers in detail both the morning and afternoon sessions and includes additional materials of interest to the Coalition. Ms. Snyder's report will be submitted for the approval of the Coalition's Chair and Executive Committee.

When approved, courtesy copies will be sent to the State of Ohio Commission on Minority Health and to Dr. Yung. Copies of both reports will also be submitted to the Asian Pacific Islander Health Forum and the W. K. Kellogg Foundation. In addition, both reports will be posted on the Coalition's website in order to provide easy accessibility to all Coalition members, group participants, potential funders, and other interested parties.

Analysis of the Morning Groups' Data

Upon review of each recorder's notes, a great deal of overlap was found amongst the groups' responses. Therefore, data management for this report was simplified by using several techniques.

1) All responses were compiled into one primary list.
2) The primary list was thoroughly reviewed and duplicate responses were combined and treated as one response.
3) The list was then reviewed again, with the intent of matching and combining "nearly identical" items.
4) The final list of items was closely reviewed and each item was "assigned" to one of eleven categories. The categories used were based on the content of the specific discussion questions used in the morning groups and included the following:
    - Resource Information
    - Transportation
    - Language Assistance
    - Health Services
    - Health Providers
    - Health Insurance
    - Research Data
    - Cohesive AAPI Community
    - Funding
    - Mainstream Involvement
    - Other Needs
5) All category responses were then coded and entered into the SPSS statistical software program. Frequencies and percentages were run, and cross tabulations were completed for selected variables.

6) Response findings are reported by group responses (vs. individual responses) due to the wide variations in the group members' levels of verbal participation.
7) Individual participants' demographic data (gender, ethnicity, representation, etc.) are based on individual responses gathered from registration forms, registration sign-in, etc.
8) Each group's demographic data (gender, ethnicity, representation, etc.) was determined by taking members' names as listed in their respective group minutes and cross-referencing those names with the demographic data collected for each participant (see 7 above).

B. Afternoon Health Through Action Focus Groups
June 28, 2008, 1 p.m. – 3:30 p.m.

Procedure

Afternoon sessions were held on the second day of the event, with the time used to conduct focus groups for the Health Through Action Community Members. Participants were assigned to one of three groups, and all groups were given the same set of questions to discuss. The questions used were provided by the W. K. Kellogg Foundation Health Through Action evaluation staff.

As with the morning session, each group was provided with a trained facilitator, a group recorder, and a private meeting room. Facilitators and recorders were provided with written instructions detailing their specific roles and responsibilities.

When the groups convened and introductions were completed, facilitators briefly went over the ground rules and explained the format that would be used during the group session. Facilitators then proceeded to lead their groups through the discussion process, using the questions listed below:

1) What are some of the biggest problems facing you and your community?
2) Do you worry about your health? How do you define being "healthy"? What are your biggest health concerns?
3) Do you know where to go to get your health needs met?
4) Do you know your rights for accessing health care? (e.g., Medicare coverage, insurance coverage, etc.)? Where do you go to get this information? How comfortable do you feel advocating/pushing for your rights to health care? (e.g., your right to an interpreter, Medicare rights, etc.)
5) Does any agency help you get health services? How have they helped you?
6) Do you go to any specific organization or doctor for your health needs? (e.g., community clinic, local hospital, doctor, etc.)
    a) Do they understand your health needs?
    b) Do they help you?
    c) Do they understand your cultural traditions when it comes to health?
    d) Do you understand and agree with the treatment the doctor prescribes for you?
    e) Does the treatment the doctor prescribe for you take into consideration any traditional healing practices you are using?
7) What are your biggest challenges in getting your health needs met? What additional resources could you use?

Participants responded as they did in the morning sessions – some responses were short one-sentence statements while other responses were anecdotal. Group facilitators recorded all responses which were then included in the group minutes.

Afternoon focus group sessions lasted approximately two hours. When participants completed their assignment, they reconvened into one large group, completed evaluations, and participated in a raffle.

Sample

As with the morning groups, the afternoon focus groups comprised a convenience sample of participants who either registered to attend or who were working with the Community Conversations event. Based on each focus group's minutes and sign-in sheets, Saturday afternoon groups had a total of 42 participants representing the following ten ethnic populations: Asian Indian, Caucasian/Mainstream, Chinese, Filipino, Japanese, Karen, Korean, Mon, Pakistani, and Vietnamese. The afternoon focus groups were composed of 18 males and 22 females (two gender responses were left blank).

Group Process

Each afternoon group was assigned an identical set of seven questions that had been provided by the W. K. Kellogg Foundation Health Through Action. The three Focus Groups were led through a similar opening exercise: introduction of all participants, explanation of the group process, and a brief review of basic ground rules.

Group members were then asked to respond to the Foundation's questions. As facilitators asked each question, response styles mirrored the morning groups – some responses were presented as straightforward one-sentence statements, while other responses were anecdotal and very personal. Due to the high interest level and the personal nature of many responses, not all groups were able to complete the seven questions within their allotted time. Group facilitators recorded all responses that were given and these were included in the minutes they would prepare and submit.

Data Collection with the Afternoon Focus Groups

In each group, participants introduced themselves; their names were noted in minutes prepared by the group recorders. In addition, sign-in sheets were distributed in each group at the beginning of the afternoon session. At the conclusion of the sessions, all sign-in sheets were collected by the Event Coordinator, Lek Smitananda.

Group recorders were also responsible for taking accurate and detailed minutes of the groups' responses to the Foundation's questions. Completed minutes were submitted to the Event Coordinator, Lek Smitananda. Afternoon sessions were conducted as part of the Coalition's Health Through Action grant requirements, which were funded through the Asian Pacific Islander Health Forum/W. K. Kellogg Foundation (Grant #6 STTMP051025-03-01, U.S. Department of Health and Human Services). For this reason, results of the afternoon Focus Groups were not included in Dr. Yung's reports for the Coalition or for the State of Ohio Commission on Minority Health. However, the second report, prepared by Barbara Snyder, includes the results for the afternoon session as well as the morning session.

Analysis of the Afternoon Focus Groups' Data

Upon review of each recorder's notes, a great deal of overlap was found amongst the groups' responses. Therefore, data management for this report was simplified by using the same techniques used in analyzing the morning session data:

1) All responses were compiled into one primary list.
2) The primary list was thoroughly reviewed and duplicate responses were combined and treated as one response.
3) The list was then reviewed again, with the intent of matching and combining "nearly identical" responses.
4) The final list of responses was closely reviewed and each response was "assigned" to one of eight categories. The categories used were based on the content of the questions and responses and included the following:
    a) Problems Faced
    b) Participants' Worries and Concerns
    c) Participants' Problems Encountered in Seeking Care
    d) List of Agencies Participants Know Will Help with Health Needs
    e) Where Participants Get Their Own Health Needs Met
    f) Wanted Resources
    g) Specific Health Conditions/Diseases Mentioned

5) All category responses were then coded and entered into the SPSS statistical software program. Frequencies and percentages were run, and cross tabulations were completed for selected variables.
6) Response findings are reported by group responses (vs. individual responses), due to the wide variations in group members' levels of verbal participation.
7) Individual participants' demographic data (gender, ethnicity, representation, etc.) are based on individual responses gathered from registration forms, registration sign-in, etc.
8. Each group's demographic data (gender, ethnicity, representation, etc.) was determined by taking members' names as listed in their respective group minutes and cross-referencing those names with the demographic data collected for each participant (see 7 above).

MORNING COMMUNITY CONVERSATION GROUPS

Demographic Profile of Morning Participants

Morning participants with valid responses (N = 63) presented the following dominant profile:

<u>Ethnic Representation</u>

Twelve specific ethnic populations were self-identified by the morning participants (N = 63). Populations included the following:

1. African American
2. Asian Indian
3. Cambodian
4. Caucasian/Mainstream
5. Chinese
6. Filipino
7. Japanese
8. Karen
9. Korean
10. Mon
11. Pakistani
12. Vietnamese

- The ethnic group with the greatest representation was the Chinese (n = 23), which comprised 36.51% of the total morning participants.

- The two ethnic groups with one attendee each comprised a total of 3.17% of the 63 morning participants. They represented the following populations: African American and Cambodian.
- Supportive data for the above findings can be viewed in Table 4-a.m. below.

Gender

Sixty-three morning participants represented 12 ethnic populations. Of these 63 participants, 27 were male (42.86%), 33 were female (52.38%), and 3 individuals (4.76%) left this question blank.

- One ethnic group (8.33% of the 12 ethnic populations) was represented by males only -- the Mon (m = 2, f = 0).
- Three ethnic groups (25%) represented by both males and females but predominantly male were Japanese (m = 2, f = 1), Karen (m = 5, f = 1), and Korean (m = 3, f = 1).
- Four ethnic groups (33.33%) represented by females only included African American (m = 0, f = 1), Cambodian (m = 0, f = 1), Caucasian/Mainstream (m = 0, f = 3), and Filipino (m = 0, f = 4).
- The two ethnic groups (16.67%) represented by both males and females but predominantly female were Asian Indian (m = 4, f = 5) and Chinese (m = 9, f = 14). One Chinese participant left the gender question blank.
- Of the twelve ethnic groups, two groups (16.67%) had equal representation from both males and females – Vietnamese (m = 1, f = 1) and Pakistani (m = 1, f = 1). One Pakistani participant left the gender question blank.
- Supportive data for the above findings can be viewed in Table 4-a.m.

Table 4-a.m.: Morning Participants by Gender and Ethnicity

Ethnicity	Male	Female	No Response	Total Number of Group Participants
African American	0	1	0	1
Asian Indian	4	5	0	9
Cambodian	0	1	0	1
Caucasian/ Mainstream	0	3	0	3
Chinese	9	14	1	24
Filipino	0	4	0	4
Japanese	2	1	0	3
Karen	5	1	0	6
Korean	3	1	0	4
Mon	2	0	0	2
Pakistani	1	1	1	3
Vietnamese	1	1	1	3
Total by Gender	27	33	3	63

Community Representation

Morning participants attended not only as representatives of their respective ethnic communities but also represented one of five community categories. These five categories included the following: (1) Ethnic Organizations or Community Representatives, (2) Health-Related Organizations, (3) Professional Organizations, (4) Medical Schools, and (5) Universities. There were also ten morning participants (15.87%) who did not specify their affiliation when they registered.

The category with the largest number of participants was Ethnic Organizations and Community Representatives, which had 22 participants (34.92% of the total morning participants). The category with the smallest number of participants was Medical Schools, with five participants (7.94% of the total a.m. participants).

Ethnic Organizations or Community Representatives

During the registration process, 21 (33.33%) of the 63 morning participants self-identified as representing ten of the eleven different ethnic organizations and community groups. These ten groups are shown in Table 5 below.

Table 5: Morning Demographics for Ethnic Organization/Community Representative Participants

Organization/ Community Represented	# of Morning Participants*	% of all Organization/ Community Morning Group Participants N = 21	# of Males	% of all Organization/ Community Morning Participants Males N = 10	# of Females	% of all Organization Community Morning Participants Females N = 10	Left Blank N = 1
Akron Mon Community	1	4.76%	1	10%	0	0%	
Asian American Council of Dayton	3	14.29%	1	10%	2	20%	
Asian Community Service Council	1	4.76%	0	0%	1	10%	
Federation of India Community Association	3	14.29%	2	20%	1	10%	
Japanese American Citizens League	1	4.76%	0	0%	1	10%	

Community of Akron	6	28.57%	5	50%	1	10%	
Lucky Seniors of Akron	1	4.76%	1	10%	0	0%	
North East Ohio Telugu Association	1	4.76%	0	0%	1	10%	
Vietnamese Mutual Assistance Association	1	4.76%	0	0%	0	0%	1
Community Members	3	14.29%	0	0%	3	30%	
Philippine Chamber of Commerce, Inc.	0	0%	0	0%	0	0%	
Total	21 100%		10 47.62%		10 47.62%		1 4.76%

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**

<u>Health-Related Organizations</u>

During the registration process, 7 (11.11%) of the 63 morning participants self-identified as representing all six of the different health-related organizations. Demographic information is shown in Table 6.

Table 6: Morning Demographics for Health-Related Organization Participants

Health-Related Organizations Represented	# of Morning Participants*	% of all Health-Related Organization Morning Group Participants N = 7	# of Males	% of all Health-Related Organizations Morning Participants Males N = 1	# of Females	% of all Health-Related Organizations Morning Participants Females N = 6	Gender Left Blank
Cincinnati Health Department	2	28.57%	0	0%	2	33.33%	
Cuyahoga County Board of Health	1	14.29%	0	0%	1	16.67%	
Hospital	1	14.29%	1	100%	0	0%	
New Realm Acupuncture Center	1	14.29%	0	0%	1	16.67%	
Private Practice	1	14.29%	0	0%	1	16.67%	
Public Health Dept. of Dayton and Montgomery Counties	1	14.29%	0	0%	1	16.67%	
Total	7 100%		1 14.29%		6 85.71%		0

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**
(Due to rounding error, percentage figures do not add up to 100%).

Professional Organizations

During the registration process, 16 (25.40%) of the 63 morning participants self-identified as representing nine of the twelve different professional

organizations. The demographics for these nine organizations are listed in Table 7 below.

Table 7: Morning Demographics for Professional Organization Representatives

Professional Organizations Represented	# of Morning Participants*	% of all Prof. Orgs. Morning Group Participants N = 16	# of Males	% of all Prof. Orgs. Morning Participants Males N = 4	# of Females	% of all Prof. Orgs. Morning Participants Females N = 10	Gender Left Blank N = 2
Asian American Community Services	4	25%	0	0%	4	40%	
Asian Festival, Inc.	3	18.75%	1	25%	1	10%	1
Asian Services In Action, Inc.	3	18.75%	0	0%	3	30%	
Catholic Diocese of Columbus, Office of Social Concerns	1	6.25%	0	0%	1	10%	
LifeCare Alliance	1	6.25%	1	25%	0	0%	
Multiethnic Advocate for Cultural Competence, Inc.	1	6.25%	1	25%	0	0%	
State of Ohio Commission on Minority Health	1	6.25%	1	25%	0	0%	
Sycamore Community School	1	6.25%	0	0%	0	0%	1
Xavier Women's Center	1	6.25%	0	0%	1	10%	

Chinese Center of Toledo	0	0%	0	0%	0	0%	
United Way of Greater Dayton	0	0%	0	0%	0	0%	
Has own business	0	0%	0	0%	0	0%	
Total	16 100%		4 25.0 %		10 62.5%		2 12.50 %

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**

Medical Schools

During the registration process, 5 (7.94%) of the 63 morning participants self-identified as members of all four different medical schools. These four schools are listed in Table 8.

Table 8: Morning Demographics for Medical School Participants

Medical Schools Represented	# of Morning Participants*	% of all Med. Schools Morning Group Participants N = 5	# of Males	% of all Med. Schools Morning Participants Males N = 3	# of Females	% of all Med. Schools Morning Participants Females N = 2	Gender Left Blank
Northeastern Ohio Universities College of Medicine, Asian Pacific American Medical Student Association	1	20%	0	0%	1	50%	

University of Toledo, School of Medicine, Asian Pacific American Medical Student Association	2	40%	2	66.67%	0	0%	
Ohio State University Medical Center	1	20%	1	33.33%	0	0%	
University of Toledo, College of Pharmacy	1	20%	0	0%	1	50%	
Total	5 100%		3 60%		2 40%		0

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**

Universities

During the registration process, 6 (9.52%) of the 63 morning participants self-identified as being associated with four different universities. Demographic information for University participants can be found in Table 9.

Table 9: Morning Demographics for University Participants

Universities Represented	# of Morning Participants*	% of all University Morning Group Participants N = 6	# of Males	% of all University Morning Participants Males N = 3	# of Females	% of all University Morning Participants Females N = 2	Gender Left Blank N = 1
Capital University	1	16.67%	0	0%	1	50%	
University of Cincinnati	2	33.33%	2	66.67%	0	0%	
University of Dayton	1	16.67%	1	33.33%	0	0%	
Wright State							1

University	2	33.33%	0	0%	1	50%	
Total	6 100%		3 50%		2 33.33%		1 16.67%

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**

Participant City/Zip Code

There were 63 attendees who participated in the morning group discussions. Of these 63 participants, 6 (9.52%) did not include city or zip code or both city and zip code on their registration. Sixty-one morning participants listed a city on their registration.

Of these 61 participants, 54.10% were from four cities: Columbus (N=13), Cincinnati (N=9), Akron (N=6) and Cleveland (N=5). Table 10 shows the city and zip code information of participants from the morning group discussion.

Table 10: Demographics for Morning Group City & Zip Code

City	Number of Morning Participants* N = 63	Zip Codes 43*** 44*** 45***	Number of Morning Participants
43***	30		
1. Columbus	13	43085	1
		43204	3
		43214	2
		43215	2
		43225	1
		43229	1
		43235	1
		missing	2
2. Delaware	2	43015	2
3. Dublin	2	43018	1
		43017	1
4. East Liverpool	1	43920	1
5. Hilliard	1	43026	1
6. Perrysburg	1	43551	1

7. Toledo	2	43609	1
		43614	1
8. Upper Arlington	1	43221	1
9. Westerville	3	43081	3
10. West Jefferson	1	43162	1
11. Worthington	3	43085	3
44***	17		
12. Akron	6	44310	3
		44311	1
		44333	1
		missing	1
13. Cleveland	5	44102	1
		44111	1
		44114	3
14. Cleveland Heights	1	44118	1
15. Hudson	1	44236	1
16. Parma	1	44130	1
17. Solon	1	44139	1
18. Strongsville	1	44149	1
19. Wadsworth	1	44281	1
45***	14		
20. Beaverbrook	1	45431	1
21. Cincinnati	9	45207	1
		45221	1
		45227	1
		45229	1
		45242	2
		45249	2
		missing	1
22. Dayton	3	45431	3
23. Springfield	1	45502	1
24. Missing Data	2	missing	2

*__Total number of participants determined solely on the group's sign-in sheet and recorded minutes.__

Brief Overview of Group Format

Participants were randomly assigned to one of four groups – (1) Capacity Building, (2) Infrastructure, (3) Resources, or (4) Services. Prior to the participants joining their assigned groups, each group was provided with a trained facilitator, a group recorder, and a private meeting

room. Facilitators and recorders were provided with written instructions as to their specific roles and responsibilities.

When the groups convened and introductions were completed, each group's facilitator briefly went over the ground rules, introduced the group to its assigned topic, reviewed the group's task and purpose, and proceeded to lead the group through the discussion process. The list of group facilitators and their assigned topics are shown in Table 11.

Table 11: Facilitators, Topics & Definitions for Morning Groups

Group	Assigned Topic	Topic Definition	Group Facilitator
1	Capacity Building	What is needed to build the capacity of organizations or groups in order to provide effective health services?	Ron Katsuyama Professor of Psychology University of Dayton
2	Infrastructure	What physical, human resources, administrative and financial capacity are needed in our communities in order to provide health services?	Betty Yung The Research Evaluation & Enhancement Program Wright State University
3	Resources	Who are the people and what are the material things needed to address minority health needs in our community?	Manju Sankarappa Chairperson Asian Festival, Inc.
4	Service	What programs/agencies are there that provide health education, health promotion, or healthcare to the minority communities?	Cora Munoz Professor of Nursing Capital University

Even though each group had a different discussion topic, all four groups were required to follow the same process format. The standardized process involved moving each group through four critical components:

(1) identification of local health needs specific to Asian American immigrants, refugees and residents;
(2) prioritization of the identified needs;
(3) the development of potential strategies for addressing the prioritized needs; and, if time allows,
(4) prioritization of the identified strategies.

Individual group specifics, including demographics and critical component responses, are discussed below.

Group 1: Capacity Building Group

Topic to be discussed

What is needed to build the capacity of organizations or groups in order to provide effective health services?

Ethnicity

The ethnicity of the participants of the Capacity Building Group is shown in Table 12.

Table 12: Group 1 Membership Ethnicity

Capacity Building Group Self-reported Ethnicity N = 5	Reporting Number of Participants N = 14*	Percentage of Capacity Building Group's Participants
Asian Indian	2	14.29%
Caucasian/Mainstream	1	7.14%
Chinese	7	50.00%
Japanese	2	14.29%
Korean	2	14.29%

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**
(Due to rounding error, percentage figures do not add up to 100%).

Needs

When asked to identify specific needs within their respective communities, the 14 participants in the Capacity Building Group identified 10 of the 53 needs named by all four groups combined. In other words, the Capacity Building Group identified 18.87% of the total needs listed in the morning session. Included in the Capacity Building Group's identified needs were the following:

1. New arrivals need information on health care systems.
2. Need more interpreters
3. Need transportation support
4. Need leadership training for AAPIs
5. Inform AAPIs of what is happening in our communities
6. Need affordable health care
7. Need affordable medications
8. AAPIs need health care provider education.
9. Need health education services for AAPIs
10. Need to know about available services

Needs prioritized

Each group was instructed to prioritize its list of identified needs. The 14 participants in the Capacity Building Group had identified 10 needs. Table 13 shows the four highest ranking needs.

Table 13: Capacity Building Group List of Prioritized Needs

Priority Ranking	Identified Need
1st	Health education services for AAPIs
2nd	AAPIs need to know about available services
3rd	Affordable healthcare
4th	Affordable medications

Strategies identified

Upon completing their needs and priorities lists, groups were instructed to compile a third list. This new list would consist of all strategies group members could think of which could be used to address their prioritized needs. When they had completed their strategies list, and if time allowed, they would then work on prioritizing their identified strategies. The Capacity Building Group had the following on its list of strategies:

1. Disseminate information
    a. Develop new or utilize existing Asian Newsletters written in different languages.
    b. Visit senior groups and area churches to provide health information (including medication procedures) in their native languages.
    c. Develop bilingual booklets that identify ethnic doctors, their location(s) and contact information, etc., and then provide these to clients, senior groups, ethnic churches, and patients at hospitals, clinics and physician offices.
    d. Distribute information in the ethnic communities.
2. Provide professional training/education for all physicians – especially since there may be no area physicians from many of the ethnic groups.
3. AAPI volunteers can be used to drive buses to transport AAPI community members.
4. Provide multi-language medication procedures.
5. Create a database of area AAPI physicians and bilingual physicians. Obtain help from the various medical associations, e.g., the Asian Indian Physicians Association, etc.

Strategies Prioritized

The Capacity Building Group did not have time to prioritize its list of strategies.

Health Conditions Mentioned

Morning Community Conversation groups were not requested to discuss specific diseases or health conditions. However, several groups mentioned specific disorders in the course of their group's

discussion. The Capacity Building Group participants mentioned seven diseases and health conditions. They are listed below.

1. Diabetes
2. Stroke
3. Mental health disorders
4. Prenatal care
5. High cholesterol
6. Osteoporosis
7. Glaucoma

Group 2: Infrastructure Group

Topic to be Discussed

What physical, human resources, administrative and financial capacity are needed in our communities in order to provide health services?

Ethnicity

Table 14 shows the self-reported ethnicity of the members of the Infrastructure Group.

Table 14: Group 2 Membership Ethnicity

Infrastructure Group Self-reported Ethnicity N = 5	Reporting Number of Participants N = 14*	Percentage of Infrastructure Group's Participants
Asian Indian	5	35.71%
Caucasian/Mainstream	2	14.29%
Chinese	5	35.71%
Filipino	1	7.14%
Pakistani	1	7.14%

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**
(Due to rounding error, percentage figures do not add up to 100%).

Needs

When asked to identify specific needs within their respective communities, the 14 participants in the Infrastructure Group identified 14 of the 53 needs named by all four groups combined. In other words, the Infrastructure Group identified 26.42% of the total needs listed in the morning session. Included in the Infrastructure Group's identified needs were the following:

1. There is a lack of research data on AAPIs (Asian American/Pacific Islander).
2. Need more written translated materials
3. Need transportation support
4. Need health insurance
5. Physicians who use alternative medicine are needed.
6, Need AAPI involvement in policy-making and advocacy
7. AAPIs need to support other organizations (both AAPI and mainstream).
8. AAPIs need a community center open to and used by all AAPI ethnicities.
9. AAPIs need to become involved and to volunteer in mainstream organizations & boards.
10. AAPIs need health care provider education.
11. Need one-stop shops for obtaining resource information
12. Comprehensive needs assessments need to be conducted.
13. Need free clinics
14. Need to know about available services

Needs prioritized

Each group was instructed to prioritize its list of identified needs. The 14 participants in the Infrastructure Group had identified 14 needs. Table 15 shows the five highest ranking needs.

Table 15: Infrastructure Group List of Prioritized Needs

Priority Ranking	Identified Need
1st	Comprehensive Needs Assessment (with disaggregated data)
2nd tied	* Increased cultural sensitivity of service providers * One-stop shop for all AAPIs for culturally and linguistically appropriate resource information
3rd	AAPIs need to be involved in mainstream organizations & boards
4th	Need an AAPI community center to be used by all AAPI ethnic groups
5th	Need more physicians to use alternative medicines

Strategies identified

When the Infrastructure Group had completed its needs list, the members proceeded to work on identifying strategies for addressing those needs. The following is their list of strategies:

1. Develop and share community center resources.
   a. Create a regional shared facility.
   b. Share services of center with all AAPI groups/populations.
2. Conduct Extensive Needs Assessment -- develop a health database (include information regarding health insurance).
3. Pipeline development (include number of AAPI health providers). Provide professional training/education for all physicians -- especially since there may be no area physicians from many of the ethnic groups.
4. Market Ohio in a way that will recruit Asians to move here and stay here.
   To do this, must also work on making/improving Ohio's marketability.
5. Develop a resource inventory for services/programs -- consolidate resource sharing for all subgroups.

6. Develop a statewide coalition across cities/expand existing OAAHC.
7. Demand that the State establish an Asian Advisory Council to the Governor.
8. Vote!! (Make your voices be heard) -- encourage AAPI communities to vote.
9. Create local advisory committees.

<u>Strategies prioritized</u>

The Infrastructure Group prioritized their strategies in the same way they had prioritized their identified needs. This time group members were given one "dot" (sticker) and told to place it beside the strategy they ranked as most critical. Table 16 shows this group's prioritized list of strategies.

Table 16: Infrastructure Group Strategies Prioritized

Identified Strategy	Number of dots received	Priority Ranking
Develop and share community center resources	0	
Conduct extensive Needs Assessment	9	1st Tied
Pipeline development	4	3rd Tied
Market Ohio in a way that will recruit Asians to move here and stay here	2	4th Tied
Develop a resource inventory for services/programs	4	3rd Tied
Develop a statewide coalition across cities	8	2nd
Demand that the State establish the Asian Advisory Council to the Governor	9	1st Tied
Vote!! (Make your voices be heard)	0	
Create local advisory committees	2	4th Tied

<u>Health conditions mentioned</u>

Morning Community Conversation groups were not requested to discuss specific diseases or health conditions. However, several groups mentioned specific disorders and these were noted in their

group's minutes. The Infrastructure Group is the only group that did not mention any specific diseases or conditions in the course of their discussion.

Group 3: Resources Group

Topic to be Discussed

Who are the people and what are the material things needed to address minority health needs in our community?

Ethnicity

Table 17 shows the ethnicity of the members of the Resources Group.

Table 17: Group 3 Membership Ethnicity

Resources Group Self-reported Ethnicity N = 5	Reporting Number of Participants* N = 12	Percentage of Resources Group's Participants
Asian Indian	2	16.67%
Caucasian/Mainstream	1	8.33%
Chinese	5	41.67%
Korean	2	16.67%
Vietnamese	2	16.67%

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**
(Due to rounding error, percentage figures do not add up to 100%).

Needs

When asked to identify specific needs within their respective communities, the 12 participants in the Resources Group identified 15 of the 53 needs named by all four groups combined. In other words, the Resources Group identified 28.30% of the total needs listed in the morning session. Included in the Resources Group's identified needs were the following:

1. Need more interpreters

2. There is a lack of research data on AAPIs (Asian American/Pacific Islander).
3. New arrivals need information on health care systems.
4. Need transportation support
5. Need health insurance
6. Need to link new arrivals with those who have been here a while
7. AAPIs are not a cohesive community (tend to stay within own ethnic group).
8. No database of resources exists.
9. AAPIs need to promote nonprofit organizations' services.
10. AAPIs need to support other organizations (both API and mainstream).
11. AAPIs need a community center open to and used by all AAPI ethnicities
12. Need more health service providers who will serve uninsured
13. AAPIs need to become involved and to volunteer in mainstream organizations & boards.
14. Need funding
15. AAPIs need health care provider education.

Needs prioritized

Table 18 shows the ranking of the needs identified by the Resources Group.

Table 18: Resources Group List of Prioritized Needs

Priority Ranking	Identified Need
1st tied	** There is a lack of research data on AAPI populations. ** A real need for funding ** Comprehensive Needs Assessment (with disaggregated data)
2nd tied	** AAPIs need to be involved in mainstream organizations and boards. ** AAPIs need to actively support one another's organizations.
3rd	AAPIs are not a cohesive community.
4th tied	** Need to increase cultural sensitivity of service providers ** More education/training of health care providers is needed.
5th tied	** AAPIs need to know about available services. ** New arrivals need information on the health care system. ** Need to have an AAPI community center that is used by all AAPI populations.

Strategies identified

When the Resources Group had completed its needs list, the members proceeded to work on identifying strategies for addressing their needs. The format they chose to use was to list their strategies by "categories." The following replicates the Resources Group's list of strategies:

Funding Strategies

1. Identify specific basic needs.
2. Research – find out the number of AAPIs in need.
3. We need to find out who's offering funding, along with their contact information.
4 Compile findings and disseminate them.

5. Private organizations should be contacted, educated, and asked for funding possibilities.
6. Hospitals have funds available but they don't advertise them.
7. Big local corporations such as General Electric (GE), Proctor & Gamble (P & G), etc., may provide community reinvestment funds.

Delivery of Services

1. Recruit mainstream media as a resource to help bring about mainstream awareness – public service announcements (PSAs).
2 Work with community organizations.
3 Most of the Cincinnati Korean community utilizes ethnic church/ethnic restaurant/grocery stores, etc., as locations for providing services.
4. Outreach to universities – especially to student organizations and groups on those campuses
5. Local corporations need to acclimate their Asian employees.
6. Schools should provide orientation to parents in their native language.

Promote Asians to be Part of Bigger Community

1. Need to get parents to volunteer in ethnic schools and churches first so they can become comfortable with the idea of eventually volunteering their time to mainstream organizations and groups, as well as the organizations of other AAPI cultures.
2. AAPIs shouldn't just expect a 'seat at the table' to be offered to them – we need to create that place for ourselves. Show your value first, then maybe you will become a board member. Volunteering is key.
3. Encourage volunteers – many 1st generation immigrants are more concerned with getting established so they don't want to get involved. The 2nd generation seems to be more comfortable.

Cultural Sensitivity

1. Disseminate information – if AAPIs volunteer more they will have more visibility and others will know more about our cultures.

2. Ohio's Asian Festival is a good example of AAPI communities sharing their culture with the general public.
3. An easy, non-confrontational and non-threatening way to "teach" others about your culture is to bring in ethnic food to your workplace.
4. Existing providers need cultural sensitivity, but it shouldn't be "forced" on them.
5. Need cultural sensitivity training/education of professionals in medical schools, all healthcare professions, and all social service providers. Follow-up should include ongoing continuing education/reminders for them to practice.

Education/Wellness

1. Community center
2. Use existing resources – find out how many Asians are using these resources, and if they aren't, find out the barriers so that they can be addressed.
3. Increase communication of available resources to ethnic communities.

Strategies prioritized

The Resources Group did not have time to prioritize their list of strategies.

Health conditions mentioned

Morning Community Conversation groups were not requested to discuss specific diseases or health conditions. However, several groups mentioned specific health conditions in the course of their group discussions. The Resources Group participants mentioned only one health condition, stroke.

Group 4: Services Group

Topic to be discussed

What programs and agencies are there that provide health education, health promotion, or healthcare to the minority communities?

Ethnicity

Table 19 shows the ethnicity of the participants belonging to the Services Group.

Table 19: Group 4 Membership Ethnicity

Services Group Self-reported Ethnicity N = 5	Number of Participants* N = 17	Percentage of Services Group's Participants
Chinese	6	35.30%
Filipino	2	11.80%
Karen	6	35.30%
Mon	2	11.80%
Vietnamese	1	5.88%

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**
(Due to rounding error, percentage figures do not add up to 100%).

Needs

When asked to identify specific needs within their respective communities, the 17 participants in the Services Group identified 33 of the 53 needs named by all four groups combined. In other words, the Services Group identified 62.26% of the total needs listed in the morning session. Included in the Services Group's identified needs were the following:

1. Need more interpreters
2. Need more trained interpreters
3. Need more training programs for interpreters
4. Need more written translated materials
5. Need more graphic translated materials
6. Need more audio forms of materials
7. There is a lack of research data on AAPIs (Asian American/Pacific Islander)
8. New arrivals need information on health care systems
9. Need Mental Health programs for AAPIs
10. Need gambling treatment programs for AAPIs
11. Need tobacco cessation programs for AAPIs

12. Need diabetes prevention programs for AAPIs
13. Need alcohol treatment for AAPIs
14. Need alcohol prevention programs for AAPIs
15. Need Hepatitis B programs for AAPIs
16. Need TB prevention & treatment for AAPIs
17. Need asthma treatment & prevention programs for AAPIs
18. Need education on second-hand smoke programs for AAPIs
19. AAPI women's health issues need to be addressed
20. Problems with human trafficking
21. Need transportation support
22. Need health insurance
23. Nutritional needs of the elderly are not met
24. Health services for the elderly
25. Need more community health screening events
26. Need affordable housing
27. Financial support for higher education
28. Physicians who use alternative medicine are needed
29. Free health screenings
30. Need help with the language barriers
31. Need translated emergency preparedness materials
32. AAPIs need health education services.
33. Need to know about available services

<u>Needs prioritized</u>

The Services Group identified 33 needs, as prioritized in Table 20.

Table 20: Services Group List of Prioritized Needs

Priority Ranking	Identified Need
1st	** There is a lack of research data on AAPI populations.
2nd tied	** Need more interpreters ** Need more *trained* interpreters ** Need more training programs for interpreters
3rd tied	** AAPIs need to know about available services. ** Need diabetes prevention programs for AAPIs
4th tied	** Need more written translated health materials ** Need more graphic translated health materials ** Need linguistically appropriate audio health materials ** Need for health insurance ** Need for financial support for AAPI higher education costs
5th tied	** Need culturally and linguistically appropriate tobacco cessation programs for AAPIs ** Need more community health screening events
6th	** Need health services for the elderly AAPIs

Strategies identified

When the Services Group had completed its needs list, the members proceeded to work on identifying strategies for addressing their needs. The following is their list of strategies:

1. Community involvement
    a. Ethnic communities must become proactive and advocate for language assistance and language-appropriate access information, as is their right.
    b. Increase community involvement
    c. Become involved in advocacy
    d. Community support of agricultural efforts

2. Need to link our strategies and needs with mainstream events – e.g., 2012 Anniversary.
3. Conduct extensive needs assessment.
4. Create intentional ethnic communities – e.g., establish communities for the Karen in rural, farming environments.
5. Languages and Transition
    a. Identify existing translated health materials overseas.
    b. Develop ESL home-based programs for the elderly and for youth.
    c. Develop computer-based ESL classes for small groups.
    d. Provide native language classes for youth.
    e. Create language partner programs.
6. Provide Education and Information
    a. Provide culturally appropriate written materials.
    b. Develop a multi-language Info Line.
    c. Create and use language-appropriate DVDs to disseminate health information.
    d. Offer community and leadership trainings for AAPI youth.
    e. Provide information about affordable health insurance or other options.
    f. Include elderly programs as places providing information and education.
    g Ethnic agencies, organizations and/or events should link with providers and offer free health screenings.
    h. Conduct an Assets Inventory.
7. Partnerships
    a. Partner with religious organizations.
    b. Develop academic/ethnic community partnerships.

8. Funding
    a. Seek funding to support services.
    b. Provide grant-writing training for AAPI organizations and community groups.

Strategies prioritized

The Services Group did not have time to prioritize their list of strategies.

Health Conditions Mentioned

Morning Community Conversation groups were not requested to discuss specific diseases or health conditions. However, several groups mentioned specific disorders in the course of their group's discussion. The Services Group participants mentioned ten diseases and health conditions. They are listed below.

1. Diabetes
2. Hepatitis B
3. TB
4. Asthma
5. STDs/STIs
6. Prenatal care
7. Mental health conditions
8. Gambling addiction
9. Tobacco addiction
10. Alcohol addiction

MORNING COMMUNITY CONVERSATIONS: EXPANDED DATA

Sixty-three professionals, community members, and interested individuals participated in the Saturday morning Community Conversations on Asian Minority Health Needs. All

participants were divided into four groups, each with its own specific assignment. The four groups included (1) Capacity Building, (2) Infrastructure, (3) Resources, and (4) Services.

Each group was to identify needs specific to the group's assigned topic. Below is a complete listing of the needs identified by the four morning groups. In addition, following this list is a table that shows the needs identified by each group.

List of All Needs Identified By Morning Group Participants

1. Need more interpreters
2. Need more trained interpreters
3. Need more training programs for interpreters
4. Need more written translated materials
5. Need more graphic translated materials
6. Need more audio forms of materials
7. There is a lack of research data on AAPIs (Asian American/Pacific Islander).
8. Need to know about available services
9. New arrivals need information on health care systems
10. Need Mental Health programs for AAPIs
11. Need gambling treatment programs for AAPIs
12. Need tobacco cessation programs for AAPIs
13. Need diabetes prevention programs for AAPIs
14. Need alcohol treatment for AAPIs
15. Need alcohol prevention programs for AAPIs
16. Need Hepatitis B programs for AAPIs
17. Need TB prevention & treatment for AAPIs
18. Need asthma treatment & prevention programs for AAPIs
19. Need education on second-hand smoke programs for AAPIs
20. AAPI women's health issues need to be addressed.
21. Problems with human trafficking

22. Need transportation support
23. Need health insurance
24. Health services for the elderly
25. Nutritional needs of the elderly are not met.
26. Need more community health screening events
27. Need affordable housing
28. Financial support for higher education
29. Physicians who use alternative medicine are needed.
30. Free health screenings
31. Need help with the language barriers
32. Need to link new arrivals with those who have been here a while
33. AAPIs are not a cohesive community (tend to stay within own ethnic group).
34. Need to inform AAPIs of what is happening in our communities
35. No database of resources exists
36. AAPIs need to promote the services of nonprofit organizations.
37. Need more health service providers who will serve the uninsured
38. AAPIs need to become involved/volunteer in mainstream organizations and boards.
39. AAPIs need to support other organizations (both AAPI and mainstream).
40. AAPIs need a community center open to and used by all AAPI ethnicities.
41. Need funding
42. More providers need to be culturally sensitive
43. Need affordable health care
44. Need affordable medications
45. AAPIs need health care provider education.
46. Need one-stop shops for obtaining resource information
47. Comprehensive needs assessments need to be conducted.
48. Need free clinics
49. AAPIs need health education services.
50. Need more AAPI physicians

51. Need leadership training for AAPIs
52. Need AAPI involvement in policy-making and advocacy
53. Need translated emergency preparedness materials

The needs, as identified by members of the morning group--Services Group, Resources Group, Capacity Building Group, and Infrastructure Group--are shown in Table 21.

Table 21: Needs Identified by the Morning Groups

	Identified Need	Services Group	Resources Group	Capacity Building Group	Infra-structure Group	*Original Total Number of Groups Identifying Need*
1	Need more interpreters	X	X	X		*3*
2	Need more trained interpreters	X				*1*
3	Need more training programs for interpreters	X				*1*
4	Need more written translated materials	X			X	*2*
5	Need more graphic translated materials	X				*1*
6	Need more audio forms of materials	X				*1*
7	There is a lack of research data on AAPIs (Asian American/ Pacific Islander)	X	X		X	*3*
8	New arrivals need information on health care systems	X	X	X		*3*
9	Need Mental Health programs for AAPIs	X				*1*
10	Need gambling treatment programs for AAPIs	X				*1*
11	Need tobacco cessation programs for AAPIs	X				*1*

12	Need diabetes prevention programs for AAPIs	X				*1*
13	Need alcohol treatment for AAPIs	X				*1*
14	Need alcohol prevention programs for AAPIs	X				*1*
15	Need Hepatitis B programs for AAPIs	X				*1*
16	Need TB prevention & treatment for AAPIs	X				*1*
17	Need asthma treatment & prevention programs for AAPIs	X				*1*
18	Need education on second-hand smoke programs for AAPIs	X				*1*
19	AAPI women's health issues need to be addressed	X				*1*
20	Problems with human trafficking	X				*1*
21	Need transportation support	X	X	X	X	*4*
22	Need health insurance	X	X		X	*3*
23	Health services for the elderly	X				*1*
24	Nutritional needs of the elderly are not met	X				*1*
25	Need more community health screening events	X				*1*
26	Need affordable housing	X				*1*
27	Need leadership training for AAPIs			X		*1*
28	Financial support for higher education	X				*1*
29	Physicians who use alternative medicine are needed	X			X	*2*
30	Free health screenings	X				*1*
31	Need help with the language barriers	X				*1*
32	Need to link new arrivals with those who have been here a while		X			*1*

33	Need translated emergency preparedness materials	X				*1*
34	Need AAPI involvement in policy-making and advocacy				X	*1*
35	AAPIs are not a cohesive community (tend to stay within own ethnic group)		X			*1*
36	Need to inform AAPIs of what is happening in our communities			X		*1*
37	No database of resources exists		X			*1*
38	AAPIs need to promote the services of nonprofit organizations		X			*1*
39	AAPIs need to support other organizations (both AAPI and mainstream)		X		X	*2*
40	AAPIs need a community center open to and used by all AAPI ethnicities		X		X	*2*
41	Need more health service provider who will serve the uninsured		X			*1*
42	AAPIs need to become involved and to volunteer in mainstream organizations & boards		X		X	*2*
43	Need affordable health care			X		*1*
44	Need affordable medications			X		*1*
45	Need funding		X			*1*
46	AAPIs need health care provider education		X	X	X	*3*
47	Need one-stop shops for obtaining resource information				X	*1*
48	Comprehensive needs assessments need to be conducted		X		X	*2*
49	Need free clinics				X	*1*
50	AAPIs need health education services	X		X		*2*

51	Need more AAPI physicians		X			*1*
52	More providers need to be culturally sensitive		X			*1*
53	AAPIs need to know about available services	X	X	X	X	*4*
	Total needs listed by **each** group	33	19	10	14	--
	*Total needs listed by **all** four groups*					*76*

List of All Needs Prioritized

When the Services Group, the Resources Group, Capacity Building Group, and the Infrastructure Group had completed their lists of identified needs, group members were instructed in the process to be used to prioritize the items on their list. Table 22 shows this combined listing of prioritized needs.

Table 22: Combined Listing of Prioritized Needs

	Identified Need	Services Group Ranking	Resources Group Ranking	Capacity Building Group Ranking	Infra-structure Group Ranking	*Total Rankings of Identified Need*
1	Need more interpreters	2nd tied				*3*
2	Need more trained interpreters	2nd tied				*1*
3	Need more training programs for interpreters	2nd tied				*1*
4	Need more written translated materials	4th tied				*2*
5	Need more graphic translated materials	4th tied				*1*

6	Need more audio forms of materials	4th tied				*1*
7	There is a lack of research data on AAPI (Asian American/Pacific Islander)	1st	1st tied			*3*
8	New arrivals need information on health care systems		5th tied			*3*
9	Need Mental Health programs for AAPIs					*1*
10	Need gambling treatment programs for AAPIs					*1*
11	Need tobacco cessation programs for AAPIs	5th tied				*1*
12	Need diabetes prevention programs for AAPIs	3rd tied				*1*
13	Need alcohol treatment for AAPIs					*1*
14	Need alcohol prevention programs for AAPIs					*1*
15	Need Hepatitis B programs for AAPIs					*1*
16	Need TB prevention & treatment for AAPIs					*1*
17	Need asthma treatment & prevention programs for AAPIs					*1*
18	Need education on second-hand smoke programs for AAPIs					*1*
19	AAPI women's health issues need to be addressed					*1*
20	Problems with human trafficking					*1*
21	Need transportation support					*4*

22	Need health insurance	4th tied				*3*
23	Health services for the elderly	6th				*1*
24	Nutritional needs of the elderly are not met					*1*
25	Need more community health screening events					*1*
26	Need affordable housing					*1*
27	Need leadership training for AAPI	5th tied				*1*
28	Financial support for higher education	4th tied				*1*
29	Physicians who use alternative medicine are needed				5th	*2*
30	Free health screenings					*1*
31	Need help with the language barriers					*1*
32	Need to link new arrivals with those who have been here a while					*1*
33	Need translated emergency preparedness materials					*1*
34	Need AAPI involvement in policy-making and advocacy					*1*
35	AAPIs are not a cohesive community (tend to stay within own ethnic group)		3rd			*1*
36	Need to inform AAPIs of what is happening in our communities					*1*
37	No database of resources exists					*1*
38	AAPIs need to promote nonprofit organizations' services					*1*

39	AAPIs need to support other organizations (both AAPI and mainstream)		2nd tied			*2*
40	AAPIs need a community center open to and used by all AAPI ethnicities		5th tied		4th	*2*
41	Need more health service providers who will serve uninsured					*1*
42	AAPIs need to become involved or to volunteer in mainstream organizations & boards		2nd tied		3rd	*2*
43	Need affordable health care			3rd		*1*
44	Need affordable medications			4th		*1*
45	Need funding		1st tied			*1*
46	AAPIs need health care provider education		4th tied			*3*
47	Need one-stop shops for obtaining resource information				2nd tied	*1*
48	Comprehensive needs assessments need to be conducted		1st tied		1st	*2*
49	Need free clinics					*1*
50	AAPIs need health education services			1st		*2*
51	Need more AAPI physicians					*1*
52	More providers need to be culturally sensitive		4th tied		2nd tied	*1*

53	Need to know about available services	3rd tied	5th tied	2nd		*4*

List of All Strategies Identified by Morning Group Participants

Upon completing their needs and priorities lists, groups were instructed to compile a third list. This would consist of all strategies their group members could think of which could be used to address their prioritized needs. Table 23 identifies all of the strategies listed by each of the four groups.

Table 23: Strategies Listed by Morning Group Participants

	Strategies for Addressing Identified Needs	Services Group N = 27	Resources Group N = 14	Capacity Building Group N = 5	Infra-structure Group N = 8	*Total Number of Groups Listing the Strategy*
1	Needs assessment	X	X		X	*3*
2	APPI community must be proactive	X	X			*2*
3	APPI community must advocate for rights	X				*1*
4	More involvement with mainstream professional groups	X	X			*2*
5	Support agricultural efforts	X				*1*
6	Link strategies with mainstream events	X				*1*
7	Increase community involvement	X	X			*2*
8	Create intentional communities	X				*1*
9	Identify existing translated material	X				*1*
10	Identify existing translated material overseas	X				*1*
11	Home-based ESL for elderly	X				*1*

12	Home-based ESL for youth	X				*1*
13	Computer-based ESL for small groups	X				*1*
14	Native language programs for youth	X				*1*
15	Language partner programs	X				*1*
16	Provide culturally appropriate materials	X				*1*
17	Develop a multi-language Info Line	X				*1*
18	Develop & use multi-lingual DVDs to disseminate health information	X				*1*
19	Prepare APPI youth for leadership (provide trainings)	X	X			*2*
20	Information on affordable health insurance	X				*1*
21	Develop elderly programs	X				*1*
22	Provide free health screenings	X				*1*
23	Conduct Assets Inventory	X			X	*2*
24	Partner with religious organizations	X	X			*2*
25	Partner with academic communities	X	X			*2*
26	Provide grant-writing trainings	X				*1*
27	Partner in seeking funding for services	X				*1*
28	Identify funding sources & contacts		X			*1*
29	Recruit mainstream media		X			*1*
30	Work with Asian employees hired into mainstream businesses		X			*1*
31	Disseminate information		X	X		*2*

32	Provide professional trainings for all levels of service providers		X	X		*2*
33	Create a community center for AAPI		X			*1*
34	Increase communication to AAPI about resources		X			*1*
35	Use AAPI volunteers to drive buses to transport			X		*1*
36	Provide multi-language medication procedures			X		*1*
37	Create database of AAPI physicians			X	X	*2*
38	Market Ohio to recruit AAPI physicians and health services providers				X	*1*
39	Build an AAPI coalition across cities throughout the state				X	*1*
40	Establish an Asian Advisory Council to the Governor				X	*1*
41	Vote and encourage other AAPIs to vote				X	*1*
42	Create local AAPI advisory committees				X	*1*
	Totals	27	14	5	8	*54*

AFTERNOON HEALTH THROUGH ACTION FOCUS GROUPS

Demographic Profile of Afternoon Participants

Afternoon Focus Group participants with valid responses (N = 42) presented the following dominant profile:

<u>Ethnic Representation</u>

Ten specific ethnic populations were self-identified by the afternoon participants (N = 42). Populations included the following:

1. Asian Indian
2. Caucasian/Mainstream
3. Chinese
4. Filipino
5. Japanese
6. Karen
7. Korean
8. Mon
9. Pakistani
10. Vietnamese

- The ethnic group with the greatest representation was the Chinese (N=16), comprising 38.10% of the total afternoon participants (N = 42).
- Three self-identified ethnic groups with the least representation each comprised 2.38% of the total number of participants. Combined, these three ethnic groups comprised 7.14% of the 42 afternoon participants and represented the following populations: Caucasian/Mainstream, Pakistani and Vietnamese.
- Supportive data for the above findings can be viewed in Table 25-p.m. below.

Gender

Forty-two afternoon participants represented 10 ethnic populations. Of these 42 participants, 18 were male (42.86%), 22 were female (52.38%), and 2 participants (4.76%) chose to leave this question blank.

Comparing morning (N = 63) to afternoon (N = 42) group participation, there were 21 fewer participants (-33.34%) attending the afternoon session. With attendance decreased a full third, there was a noticeable change in the gender/ethnicity of the afternoon groups.

- Three ethnic groups (30% of the 10 ethnic populations) were represented by males only -- the Korean (N = 2), Mon (N = 2), and Vietnamese (N = 1).
- Only one ethnic group (10%) was represented by both males and females but was predominantly male -- the Karen (m = 5, f = 1).
- Three ethnic groups (30%) represented by females only included the Filipino (N = 5), Caucasian/Mainstream (N = 1), and the Pakistani (N = 1).
- Only one group (10%) was represented by both males and females but was

predominantly female -- the Chinese (m = 5, f = 11).

Supportive data for the above findings can be viewed in Table 24 p.m. below.

Table 24-p.m.: Afternoon Participants by Gender and Ethnicity

Ethnicity	Male	Female	No Response	Total Number of Group Participants*
Asian Indian	2	2	1	5
Caucasian/ Mainstream	0	1	0	1
Chinese	5	11	1	17
Filipino	0	5	0	5
Japanese	1	1	0	2
Karen	5	1	0	6
Korean	2	0	0	2
Mon	2	0	0	2
Pakistani	0	1	0	1
Vietnamese	1	0	0	1
Total by Gender	18	22	2	42

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**

Community Representation

Afternoon participants attended not only as representatives of their respective ethnic communities, but each person also represented one of five community categories. These five included (1) Ethnic Organizations or Community Representatives, (2) Health-Related Organizations, (3) Professional

Organizations, (4) Medical Schools, and (5) Universities. There were also eight afternoon participants (19.05%) who did not specify their affiliation when they registered.

The afternoon category with the largest number of representatives was Ethnic Organizations and Community Representatives, which had 14 participants (33.33% of the total afternoon participants). The category with the smallest number of representatives was Universities, with 2 participants (4.76% of the total afternoon participants).

Ethnic Organizations or Community Representatives

During the registration process, 14 (33.33%) of the 42 afternoon participants self-identified as representing 6 (54.55%) of the eleven different ethnic organizations and community groups. These six groups are shown in Table 25 below.

Table 25: Demographics for Ethnic Organization/Community Representative Participants

Afternoon Focus Groups Organization/ Community Represented	# of Afternoon Participants*	% of all Organization Community Afternoon Group Participants N = 14	# of Males	% of all Org./Com. Afternoon Participant Males N = 8	# of Females	% of all Org./Com. Afternoon Participant Females N =6	Blank
Akron Mon Community	1	7.14%	1	12.50%	0	0%	
Asian American Council of Dayton	0	0%	0	0%	0	0%	
Asian Community Service Council	0	0%	0	0%	0	0%	
Federation of India Community Association	3	21.43%	2	25%	1	16.67%	
Japanese American Citizens League	1	7.14%	0	0%	1	16.67%	

Karen Community of Akron	6	42.86%	5	62.5%	1	16.67%	
Lucky Seniors of Akron	0	0%	0	0%	0	0%	
North East Ohio Telugu Association	1	7.14%	0	0%	1	16.67%	
Philippine Chamber of Commerce, Inc.	0	0%	0	0%	0	0%	
Vietnamese Mutual Assistance Association	0	0%	0	0%	0	0%	
Community Members	2	14.29%	0	0%	2	33.33%	
Total	14 100%		8 57.14%		6 42.86%		0

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**
(Due to rounding error, percentage figures do not add up to 100%).

Health-Related Organizations

During the registration process, 4 (9.52%) of the 42 afternoon participants self-identified as representing three of the six different health-related organizations. Table 26 shows the demographic information for the participants of the Health-Related Organizations.

Table 26: Afternoon Demographics for Health-Related Organization Participants

Health-Related Organizations Represented	# of Afternoon Participants*	% of all Health Related Orgs. Afternoon Group Participants N = 4	# of Males	% of all Health Related Orgs. Afternoon Participant Males N = 1	# of Females	% of all Health Related Orgs. Afternoon Participant Females N = 3	Left Blank N = 0
Cincinnati Health Department	2	50%	0	0%	2	66.67%	
Cuyahoga County Board of Health	1	25%	0	0%	1	33.33%	

Hospital	1	25%	1	100%	0	0%	
New Realm Acupuncture Center	0	0%	0	0%	0	0%	
Private Practice	0	0%	0	0%	0	0%	
Public Health Department of Dayton and Montgomery Counties	0	0%	0	0%	0	0%	
Total	4 100%		1 25%		3 75%		0

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**

Professional Organizations

During the registration process, 12 (28.57%) of the 42 afternoon participants self-identified as representing 8 of the 12 different professional organizations. Table 27 shows the number of participants from each of the 12 different professional organizations.

Table 27: Afternoon Demographics for Professional Organization Representatives

Professional Organizations Represented	# of Afternoon Participants*	% of all Prof. Orgs. Afternoon Group Participants N = 12	# of Males	% of all Prof. Orgs. Afternoon Participants Males N = 4	# of Females	% of all Prof. Orgs. Afternoon Participants Females N = 7	Left Blank N = 1
Asian American Community Services	1	8.33%	0	0%	1	14.29%	
Asian Festival, Inc.	2	16.67%	1	25.	0	0%	1
Asian Services In Action, Inc	4	33.33%	0	0%	4	57.14%	

Catholic Diocese of Columbus, Office of Social Concerns	1	8.33%	0	0%	1	14.29%	
LifeCare Alliance	1	8.33%	1	25%	0	0%	
Multi-ethnic Advocate for Cultural Competence, Inc.	1	8.33%	1	25%	0	0%	
State of Ohio Commission on Minority Health	0	0%	0	0%	0	0%	
Sycamore Community School	0	0%	0	0%	0	0%	
Xavier Women's Center	1	8.33%	0	0%	1	14.29%	
Chinese Center of Toledo	1	8.33%	1	25%	0	0%	
United Way of Greater Dayton	0	0%	0	0%	0	0%	
Has own business	0	0%	0	0%	0	0%	
Total	12		4 33.33 %		7 58.33 %		1 8.33 %

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**
(Due to rounding error, percentage figures do not add up to 100%).

<u>Medical Schools</u>

During the registration process, only 2 (4.76%) of the 42 afternoon participants self-identified as members of two of the four medical schools. Table 28 lists the demographic information of the participants from these medical schools.

Table 28: Afternoon Demographics for Medical School Participants

Medical Schools Represented	# of Afternoon Participants*	% of all Med. Schools Afternoon Group Participants N = 2	# of Males	% of all Med. Schools Afternoon Participants Males N = 1	# of Females	% of all Med. Schools Afternoon Participants Females N = 1	Left Blank N = 0
Northeastern Ohio Universities College of Medicine, Asian Pacific American Medical Student Association	0	0%	0	0%	0	0%	
University of Toledo, School of Medicine, Asian Pacific American Medical Student Association	0	0%	0	0%	0	0%	
Ohio State University Medical Center	1	50%	1	100%	0	0%	
University of Toledo College of Pharmacy	1	50%	0	0%	1	100%	
Total	2 100%		1 50%		1 50%		0

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**

Universities

During the registration process, only 2 (4.76%) of the 42 afternoon participants self-identified as associated with two of the four universities. These two schools are listed in Table 29.

Table 29: Afternoon Demographics for University Participants

Universities Represented	# of Afternoon Participants*	% of all University Afternoon Group Participants N = 2	# of Males	% of all University Afternoon Participants Males N = 1	# of Females	% of all University Afternoon Participants Females N = 1	Gender Left Blank N = 0
Capital University	1	50%	0	0%	1	100%	
University of Cincinnati	1	50%	1	100%	0	0%	
University of Dayton	0	0%	0	0%	0	0%	
Wright State University	0	0%	0	0%	0	0%	
Total	2 100%		1 50%		1 50%		0

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**

Participant City/Zip Code

As shown in Table 30, there were 42 attendees who participated in the afternoon Focus Groups. Of these 42 participants, 5 (11.9%) did not include both city and/or zip code on their registration. Thirty-seven afternoon participants listed both city and zip code on their registration. Of these 37 participants, 51.35% had listed zip codes from four specific cities: Columbus (N= 5), Cincinnati (N=4), Akron (N=5) and Cleveland (N=5).

Table 30: Afternoon Participants' Reported City & Zip Code

City	Number of Afternoon Participants* N = 42	Zip Codes 43*** 44*** 45***	Number of Afternoon Participants
43***	17		
1. Columbus	5		
	0	43085	
	1	43204	1
	1	43214	1
	1	43015	1
	1	43225	1
	0	43229	
	1	43235	1
2. Delaware	1	43015	1
3. Dublin	0	43018	
	0	43017	
4. East Liverpool	0	43920	
5. Hilliard	1	43026	1
6. Perrysburg	1	43551	1
7. Toledo	1	43609	1
	0	43614	
8. Upper Arlington	1	43221	1
9. Westerville	3	43081	3
10. West Jefferson	1	43162	1
11. Worthington	3	43085	3
44***	16		
12. Akron	5	44310	3
		44311	1
		44333	1
13. Cleveland	5	44102	1
		44111	1
		44114	3
14. Cleveland Heights	1	44118	1

15. Hudson	1	44236	1
16. Parma	1	44130	1
17. Solon	1	44139	1
18. Strongsville	1	44149	1
19. Wadsworth	1	44281	1
45***	4		
20. Beaverbrook	0	45431	
21. Cincinnati	4	45207	1
		45221	1
	0	45227	
		45229	1
	0	45242	
		45249	1
24. Missing Data	5	missing	5

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**

Brief Overview of Group Format

Health Through Action Focus Groups were conducted during the second day of the event and lasted approximately two hours. Including the three facilitators and three recorders, there was a total of 42 people who participated in the three Focus Groups.

As with the morning session, each afternoon group was provided with a trained facilitator, a group recorder, and a private meeting room. All facilitators were given a written list of the seven discussion questions that had been provided by the W. K. Kellogg Foundation Health Through Action evaluation staff.

The same process format was used in all three groups. Participants introduced themselves to their fellow group members. When completed, the facilitators explained the format that would be used during the group session and clarified how the afternoon session differed from the morning group sessions. Facilitators then led their groups through the discussion

process, using the required questions. Table 31 shows the list of facilitators for the afternoon focus group.

Table 31: Afternoon Focus Group Facilitators

Group	Number of Participants* N = 42	Group Facilitator
1	12	May Chen Executive Director Asian Services In Action, Inc.
2	17	Ron Katsuyama Professor of Psychology University of Dayton
3	13	Cora Munoz Professor of Nursing Capital University

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**

Individual group specifics, including demographics and critical component responses, are shown below.

Group 1: Ethnicity and Gender

Table 32: Group I Membership Ethnicity and Gender

Self-reported Ethnicity N = 5	Number of Participants* N = 12	Percentage of Group 3 Participants	Female	Male	Left Gender Blank
Asian Indian	3	25.00%	1	2	-
Caucasian/Mainstream	1	8.33%	1	-	-
Chinese	4	33.33%	2	2	-
Filipino	2	16.67%	2	-	-
Pakistani	1	8.33%	1	-	-
Blank	1	8.33%	-	-	1
Totals			7 58.33%	4 33.33%	1 8.33%

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**
(Due to rounding error, percentage figures do not add up to 100%).

Group 2: Ethnicity and Gender

Table 33: Group 2 Membership Ethnicity and Gender

Self-reported Ethnicity N = 5	Number of Participants* N = 17	Percentage of Group 1 Participants	Female	Male	Left Gender Blank
Chinese	5	29.41%	4	1	-
Filipino	3	17.65%	3	--	-
Karen	6	35.29%	1	5	-
Mon	2	11.76%	-	2	-
Vietnamese	1	5.88%	-	1	-
Blank					0
			8 47.06%	9 52.94%	0

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**
(Due to rounding error, percentage figures do not add up to 100%).

Group 3: Ethnicity and Gender

Table 34: Group 3 Membership Ethnicity and Gender

Self-reported Ethnicity N = 4	Number of Participants* N = 13	Percentage of Group 2 Participants	Female	Male	Left Gender Blank
Asian Indian	1	7.69%	1	--	
Chinese	7	53.85%	5	2	
Japanese	2	15.38%	1	1	
Korean	2	15.38%	--	2	
Blank	1	7.69%	--	--	1
			7 53.85%	5 38.46%	1 7.69%

***Total number of participants determined solely on the group's sign-in sheet and recorded minutes.**
(Due to rounding error, percentage figures do not add up to 100%).

Responses to Health Through Action Question 1

1) What are some of the biggest problems facing you and your community?

Group Responses to Question 1	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
1. Diabetes	X	X		2
2. High cholesterol	X			1
3. Cardiovascular disease	X	X		2
4. Hypertension	X	X		2
5. Dental hygiene	X	X		2
6. Osteoporosis	X			1
7. Metabolic syndrome	X			1
8. Tuberculosis	X			1
9. Emotional stress		X		1
10. Injuries from falls		X		1
11. Allergies		X		1
12. Poor dissemination of health information			X	1
13. Transportation needs			X	1
14. Poor interpreting services			X	1
15. Lack of translated health materials			X	1
16. No follow-ups provided after free health screenings			X	1

17. Lack of bilingual mental health providers			X	1
18. Stigma about going to free clinics (“only used by poor people”)			X	1
19. Need more community advocates			X	1
20. Elders should be mentoring young leaders			X	1
21. Insurance does not cover alternative medicines and treatments			X	1
22. Need to address the nutrition needs of the elderly			X	1
Total	8 30.77%	7 26.92%	11 42.31%	26 100%

2) Do you worry about your health? What are your biggest health concerns?

Group Responses to Question 2	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
1. Clash of western medicine and traditional beliefs	X			1
2. AAPIs’ cultural beliefs may delay people from seeing a doctor	X			1
3. Negative effects of stress		X		1
4. Mental health concerns caused by outside circumstances		X		1

5. How to maintain my current good health coverage		X		1
6. Affordable health coverage		X		1
7. It's very hard to find a good doctor		X		1
8. Insurance rates were increased because of having chronic illnesses		X	X	2
9. Concerned because family history of diseases is often a predictor			X	1
Total	2 20%	6 60%	2 20%	10 100%

2a) How do you define being "healthy"?

Group Responses to Question 2-a	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
1a. Sleeping and eating well.	X			1
1b. Not having to go see a doctor because of illness.	X			1
2a. Good food, exercise and community activity are important to be healthy.		X		1
2b. We all need human contact to be healthy.		X		1
2c. The quality of a person's life is more important than how long the person lives.		X		1

3. Definition of health/healthy was not discussed.			X	1
Total	2 33.33%	3 50%	1 16.67%	6 100%

3) Do you know where to go to get your health needs met?

When asked this question, participants of all three groups responded with answers about where they do go for their health needs – which is Question 6 on the list. Therefore, the answers that were given will be listed under Question 6.

4) Do you know your rights for accessing health care? (e.g., Medicare coverage, insurance coverage, etc.)? Where do you go to get this information? How comfortable do you feel advocating/pushing for your rights to health care? (e.g., your right to an interpreter, Medicare rights, etc.)

Group Responses to Question 4	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
1. Right to have interpreting services.	X			
2. Right to refuse treatment.	X			
3. Often need to have someone else to speak up for us.			X	
4. The system needs universal paperwork requirements (as all insurance forms should use same format, all intakes and histories use same format, etc.).			X	
5. Health care providers need training regarding immigrant/ refugee rights.			X	

6. Question was not discussed.		X		
Total	2 33.33%	1 16.67%	3 50%	6 100%

5) Does any agency help you get health services? How have they helped you?

Group Responses to Question 5	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
1. Refugee programs, e.g., refugees can get Medicaid for 8 months.	X			1
2. At the Akron International Institute [Resettlement Program] they help refugees for their first 6 months in the U.S.	X			1
3. In Summit County & Cuyahoga County, Asian Services In Action, Inc., helps both immigrants & refugees, with no time limits on services.	X			1
4. Question was not discussed.		X	X	2
Total	3 60%	1 20%	1 20%	5 100%

6) Do you go to any specific organization or doctor for your health needs? (e.g., community clinic, local hospital, doctor, etc.)

Group Responses to Question 6	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
1. Urgent care center	X	X		2
2. Emergency room	X			1
3. Primary care physician	X		X	2
4. Mini-clinics located in pharmacies or supermarkets	X			1
5. Consult with our community leader	X			1
6. Go to a family member	X			1
	6 75%	1 12.5%	1 12.5%	8 100%

6-a) Do you believe your health care provider understands your health needs?

Group Responses to Question 6-a	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
1. They have problems interpreting information about medicine.	X			1
2. Usually have to wait too long – I once had to wait 5 hours		X		1

3. I am starting to think the only way to get good service is to complain – if you don't complain, they act like you're fine.		X		1
4. Mainstream doctors do not seem to realize that most AAPIs often need lower dosages of medication.		X		1
5. I have found that most doctors miss the diagnosis until it's "too late."		X		1
6. Even with insurance, care can be much too expensive.		X		1
7. Cost of insurance keeps going up every year – it is getting too expensive to pay for.		X		1
8. I believe Asian medicine is better than mainstream, so I try not to go to mainstream doctors.		X		1
9. Question was not discussed.			X	1
Total	1 11.11%	7 77.78%	1 11.11%	9 100%

6-b) Do you believe your provider helps you?

None of the three groups discussed this question.

Group Responses to Question 6-b	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
1. This question was not discussed.	X	X	X	3

6-c) Does your provider understand your cultural traditions, especially in regard to health?

6-d) Do you understand and agree with the treatment the doctor prescribes for you?

Group Responses to Questions 6-c and 6-d	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
1. U.S. doctors should give more details when explaining what's wrong, what's needed for treatment, etc.	X			1
2. U.S. doctors should take the time to provide patients with more assurance	X			1
3. Too many times my questions are not answered.	X			1
4. Would like to see diabetes treatment menu that includes rice in the diet.	X			1
5. U.S. doctors often talk down to us.	X			1
6. U.S. doctors often act condescending.	X			1
7. U.S. doctors need to be more accepting and knowledgeable about homeopathic treatment			X	1
8. Adjustment disorder in immigrants and refugees is often misdiagnosed as depression			X	1

9. All the required paperwork is often a barrier to seeking services for many LEPs (Limited English Proficient)			X	1
10. Funding is needed to hire and train bilingual case workers			X	1
11. These two questions were not discussed.		X		1
Total	6 54.55%	1 9.09%	4 36.36%	11 100%

6-e) Does your provider use any alternative healing practices?

Group Responses to Questions 6-e	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
1. Culturally competent doctors will ask about supplements.	X			1
2. Doctors need both cultural sensitivity and cultural competency trainings.	X			1
3. No one discusses with AAPIs the possible negative effects of mixing two medications, mixing medication with alcohol, mixing medication with herbal products, etc.	X			1
4. There is a lack of research that compares effectiveness of traditional and alternative treatments.	X			1

5. There is a lack of research done on outcomes of combining traditional and alternative treatments – what combinations work? What combinations produce harmful effects?	X			1
6. Some colleges and medical schools are now developing Departments of Complementary Medicine. More schools should be doing this.	X			1
7. Chinese medicines and AAPI treatments are not covered under mainstream health insurance coverage.		X		1
8. Everything I have heard and seen and experienced tells me that traditional Asian medicines are better than Western medicines.		X		1
9. This question was not discussed.			X	1
Total	6 66.67%	2 22.22%	1 11.11%	9 100%

7) What are your biggest challenges in getting your health needs met? What additional resources could you use?

Group Responses to Question 7	Afternoon Group 1	Afternoon Group 2	Afternoon Group 3	Total
Challenges				
1. Availability of interpreters	X	X	X	3

2. Poorly trained interpreters or interpreters who have had no training.	X			1
3. Problems of having to use male interpreters with female patients	X			1
4. Problems with issues of privacy when interpreters and patients know each other	X			1
5. Need for affordable health care	X	X	X	3
6 Issues around using ER instead of having a primary care doctor	X			1
7 Patient's expressed feelings get lost in interpretation, so often feelings are ignored or not known.	X			1
8 Most of us would prefer an ethnic doctor of our same culture.	X	X	X	3
Total for Challenges	8	3	3	14
Needed Resources				
1. Need increased accessibility to health care services	X			1
2. All providers should have translated medical dictionaries available.	X			1
3. Ethnic community members and leaders need to be trained about the U. S. medical system.	X		X	2

4. Need to have more free clinics – especially in or near larger ethnic communities.	X			1
5. Need more culturally competent doctors	X	X	X	3
6. Need dedicated community leaders to advocate setting up free clinics in their communities	X			1
7. Need universal healthcare that will include immigrant and refugee populations in the U. S.	X	X		2
Total for Needed Resources	7 63.64%	2 18.18%	2 18.18%	11 100%