

HEALTHCARE REVIEW

ASIAN AND PACIFIC ISLAND HEALTHCARE

Tessa Novick and Allison Werner-Lin, Ph.D.*

Psychosocial needs of the Asian and Pacific Islander (API) population in New York City inhibit their access to primary healthcare. This study analyzes the disparities in API healthcare, and makes suggestions for reaching this underserved population. Six qualitative interviews were conducted with staff in the pediatric department of an urban, public hospital that sees underserved API immigrants with low socioeconomic status from the larger New York City area. Interviews examined care provider awareness of and ability to accommodate for API patients' psychosocial needs and barriers to care. Literature and interviews confirm that basic needs such as food and housing are often prioritized over health needs, determining health behavior and greatly inhibiting access to care. Health professionals do not have information on community resources or time to confront psychosocial issues. Community-based, culturally competent infrastructure providing information to connect patients, caregivers and services should be integrated into healthcare settings to improve overall health of API individuals.

Population studied. From 2000 to 2005, the number of individuals in the United States who identified as Asian increased by over 2 million people, concentrating in certain urban areas like New York City.¹ In New York City, where 44% of all residents are foreign born,² immigration issues, including overall health and wellness, access to health care, and cost burdens, present major concerns. Immigrants from Asia and the Pacific Islands (API) have been identified as the second fastest growing minority group, increasing in New York City by 63.1% from 1999-2000.³ API immigrants have a poverty rate of 10.2%—compared with the 7.8% of non-Hispanic whites.⁴ They tend to live in concentrated and isolated areas with low-income work and overcrowded housing.⁴ Residents of these neighborhoods generally have low educational attainment, limited work skills, language deficits, low earnings, lack of substantial employment, healthcare or affordable housing.⁴ High school education completion is significantly lower than the national average, contradicting their reputation as highly educated “model citizens.” They normally hold jobs in the restaurant and garment industries, resulting in neighborhoods with significantly lower than regional average wages⁴. Many live below or close to the poverty line, and are less likely to have health insurance; impoverished living conditions directly afflict the health of families, increasing barriers to social services and medical care.⁵⁻⁷

These characteristics of API immigrant communities are seen in New York City's Lower East Side, where 35% of the population identifies as Asian.⁸ A policy initiative developed in 2004, Take Care New York assesses community health by measuring the presence of 10 key variables that substantially increase morbidity and mortality, all preventable with primary medical care. Take Care New York's most recent Community

Health Report on the Lower East Side revealed that API immigrants are not accessing the primary care and social services necessary for basic health. In a community where one in four individuals lives below the poverty level, the Lower East Side ranked below average on half of these variables, including: (1) determining HIV status, (2) getting checked for cancer, and (3) making homes safe and healthy.⁸ Further, one in four adults reported they did not have a regular doctor (which was average), and over one in four said they were uninsured or had been so within the past year.⁸

These statistics contribute to looming public health concerns that disparities in care for minority groups are mounting across the nation.⁹ The API population's underutilization of basic health care is a national crisis because of their rapid growth. Previous speculation about this population looked toward traditional health beliefs and practices in cultural traditions as barriers to utilization of Western health services, but recent studies are proving this is not the case; a study examining API underutilization of health services in San Francisco reported that poverty status was one of the most consistent predictors of healthcare access.¹⁰ Yet for this immigrant population, immigration history, language barriers, and cultural norms compound socioeconomic challenges, making the population especially difficult to reach.¹¹ Families prioritize basic physical environment needs like housing and food over health maintenance, preventing API immigrants from having a medical home with primary care. The aims of this study are to examine healthcare professionals' perceptions of the psychosocial issues that contribute to API immigrant patients' underutilization of primary health care. The information will serve as a needs assessment, investigating gaps in the API population-healthcare system interaction. From this, strategies for reaching API families can be explored.

Understanding the needs of API populations. The Charles B. Wang Community Health Center (CBWCHC), a local clinic in Chinatown, is spearheading the efforts of several

*** Author Contact Information:**

New York University, Silver School of Social Work, Class of 2008.
Address correspondence to tessanovick@gmail.com.

community organizations to research the exact health status of API populations, aiming to build a comprehensive understanding of their needs and how to connect them with medical care. For example, to address the significant presence of Hepatitis B seen in API neighborhoods across the United States, CBWCHC's Asian American Hepatitis B Program provides free screening and services at several local sites.¹² A 2006 report stated that during six months observed in 2005, 56.6% people screened said it was their first time being tested. Of this group, 14.8% had chronic HBV infection.¹³ In other health areas, more research from the CBWCHC found that when practitioners began using the PHQ-9 to routinely screen this population for depression, 4.1% had clinically depressive symptoms that were never before addressed.¹⁴ More alarming was the CBWCHC's report on API children with asthma. When school-based asthma allergy questionnaires (translated into Chinese) were sent home with 476 second grade students from four public schools in lower Manhattan, 48.1% of the children tested positively with no previous asthma diagnosis.¹⁵

It is important to recognize the significance of the tactics used by the CBWCHC to increase screening and reach more API individuals. The CBWCHC made Hepatitis B screening free, highlighting that cost of care and lack of insurance are major roadblocks. To identify and combat depression, clinicians used the PHQ-9 as part of every routine visit instead of just when the patient expressed concerns about their mental health. Asians traditionally do not respond to western interpretations of mental health, viewing such problems as indicators of hereditary weaknesses, imbalance between yin and yang, supernatural intervention, or just emotional exhaustion, and they may somatize psychosocial concerns, underutilizing mental healthcare.¹⁶ Asthma questionnaires enhanced screening efforts by sending home translated fliers, eliminating language barriers and the reliance on patients to actively seek services. Putting the information in their language seemed to have the most success in reaching API families.

These studies confirm the findings of Take Care New York's Lower East Side Healthcare Report: this population has chronic disease and health issues that are manageable and preventable, but they are not receiving the diagnostic or treatment attention that comes with having a primary care doctor or access to preventative care. This can aggravate symptoms until conditions reach detrimental states, and API individuals arrive in emergency rooms or urgent care sites. Yet even after emergency room and clinic visits, it is unclear whether API families will receive further check ups or education about managing chronic health conditions. Further, API immigrants are often unaccustomed to or confused by western medications and terms, and it is common for them to add their own traditional remedies.¹⁷ This

challenges hospital staffs to gauge how these families interpret their conditions, let alone know how they are treating conditions at home.^{18,19}

API families are falling victim to the visible racial and socioeconomic disparities in access to and provision of healthcare.²⁰ There appears to be insensitivity in the system to the psychosocial and unique health factors faced by all minority populations, and specifically API immigrants.¹² Floating to the surface above these statistics is the continually debated question that follows all minority and vulnerable populations: what barriers are keeping them from accessing the care available? Are there simply not enough services? One theory suggests health care regulation efforts contribute to the neglect of needs and public attention towards API immigrants. Davies, Washington, and Bindman measured trends in public health reporting and explained that the way statistics are collected, analyzed and presented further marginalizes the experiences of vulnerable populations within the healthcare and social service system.²¹ If a population does not have access to healthcare facilities they are not included when statistics are measured. This misleading absence from records diverts public attention instead of highlighting a need for supportive services.²¹

A different theory addressing ethno-cultural barriers suggests it is not a deficiency in services but a deficiency in the services' ability to accommodate for unique API needs. A recent study examined the Bridges Project, a community based organization that specifically targets the API population living with HIV/AIDS in New York City.²² According to the report, the success of HIV/AIDS treatment was a result of the methods used by the Bridges Project to connect patients with available community services. Those clients who were undocumented and/or spoke an Asian primary language had a significantly lower receipt rate of services than English speaking documented participants.²² When asked six months into the program about significant barriers that previously kept them from using services with which they were currently connected, the top three were that (1) the staff did not speak their language, (2) they were not sure where to go, and (3) the costs were prohibitive. Participants also reported confidentiality concerns: they feared what providers would say and that their HIV status, and possibly their immigration status, would be exposed.

The Bridges Project analysis revealed that low service utilization could indicate a lack of familiarity with where services are located, or that systems of care lacking in linguistic and cultural resources resulted in poor system recognition and failure to provide adequate medical treatment.²² In other words—no cultural component means low service utilization. The staff spoke the appropriate languages, which enabled them to connect their patients with legal aid organizations, housing placement

services, ambulatory care services, and immigrant advocacy agencies. They also incorporated the use of traditional eastern medicinal treatments by developing an acupuncture clinic, an Asian food and nutrition program, and social events to address support needs. API families are often hesitant to seek help for fear that their medical conditions will somehow be revealed to their community; confronting the social stigmas of certain health conditions, which previously prevented some API families from seeking available treatment, reinforced confidentiality.²² This could keep them from reaching critical services or even addressing health concerns altogether. Conclusions from this report further confirmed the indications of the CBWCHC clinical studies—that cost, language, knowledge of social service location and unique cultural stigmas must be addressed to successfully provide API immigrants care, and to help them find the services they need.

Research methodology. Many children in immigrant families are born in the United States and are United States citizens, eligible for federal health insurance and other public benefits like food stamps, WIC, and public assistance. Immigrant families are therefore more likely to visit healthcare settings for their children's issues, if at all. Children are seen in community or hospital clinics for general care, and sent to hospital specialty clinics for specific issues like asthma and developmental disorders. In New York City, urban public hospitals also act as a modern Ellis Island for the city's influx of immigrants, and are often one of the first stops for newly arrived individuals and families. However, because of tremendous demand, healthcare staff is generally not large enough and often lacks necessary funding to accommodate the patient population. Specialty clinics in public hospitals often receive API referrals from various community organizations and social service agencies in Chinatown and around the metropolitan New York area. Thus, to further explore the disparities seen in API access to and utilization of care, interviews were conducted with various providers who work with the API population treating children on a regular basis.

A semi-structured interview guide was created to elicit information about staff interactions with and perceptions of API patient needs, inquiring about the experience of communicating with and accommodating to the needs of API families. Six members of the pediatric health and allied health team of a large, Northeastern urban hospital that sees API children from around the metropolitan area were identified and approached to participate in this study. These individuals included social work and child life specialists, physicians from the pediatric developmental and asthma clinics, a department director, and a bilingual pediatrician working with API families. Each person approached consented to participate, and interviews lasted approximately 45 minutes. A set of core questions guided each interview, and in-

cluded four main questions:

1. Can you describe the populations you work with (major health issues/presenting problems, etc.)?
2. What services do your patients typically use most?
3. What specific subgroups within this patient population are your department's services having trouble reaching? What has been challenging?
4. Is there a need you wish you could address, but have to push aside due to lack of time/funding/resources? What would be helpful?

Results. A basic content analysis of interview guide responses revealed characteristics and problems in the relationship between healthcare systems and API immigrants in NYC. These are presented below, categorized by the interview guide question. After the initial analysis, responses were compared with the TCNY and literature findings about the API population.

Interviewees described patients, mainly immigrants, many of whom are illegal with very low incomes. Major health issues for the entire population noted by all respondents included ADHD, developmental and language delays, obesity, asthma and diabetes. Physicians specifically noted the disorganized nature of patient homes, making it difficult to ensure that parents bring in their children for regular visits and correctly distribute medication. Parent depression and isolation is common, and many patients ask for help with housing, education, employment, legal status, and finding food.

Overall, patients ask health professionals for advice and advocacy regarding documentation and complicated legal issues. Families need help finding appropriate schools and special education programs. The physicians agreed that families sought referrals for schools and childcare, and many needed to know how to find after-school programs and other resources in their area. Families uniformly need help understanding and navigating insurance and public benefits. On top of chronic health conditions, patients come to their doctors for help with the daily tasks that prevent them from functioning in a novel environment.^{23, 16} However, patient expectations for advice are not always satisfied; all interviewees reported they rarely know where to send families who ask for help with resources. Even if they could make suggestions for outside referrals, they do not have time to follow up with the families on these issues to ensure that social service connections were made.

Further, API patients are generally not receptive to support groups or educational services offered in the hospital. This may be a function of low self-efficacy regarding the health of their children, or alternatively, of low service utilization due to the absence of the ethno-cultural sensitivity. It is questionable whether these services are equipped to handle the language and cultural needs of this population, which is a fear that prevents

many API families and individuals from using social services.²² One physician reported that API parents specifically underutilize the developmental, language delay, and behavioral services offered by the developmental clinic, and found that a significant cultural stigma regarding such issues prevents them from addressing disorders these clinics seek to treat.

Collectively, interviews indicated a need to provide information on where to find help with housing, immigration, health insurance, and other psychosocial issues. The short duration of a clinic visit gives insufficient time to address both medical and psychosocial concerns completely. Provider education about psychosocial and concrete services in the community is needed to enable discussions with families about the environmental and social needs that are inhibiting patient health, and multiple interviewees independently expressed the need for a consolidated resource of available social services in the city. They need a functional way to connect low-income immigrant families with services in their communities, and to efficiently follow up to ensure that referrals successfully address concerns.

Responses from the staff were consistent. Expression of psychosocial concerns was a dramatic trend in nearly every question, indicating that these families spend so much time trying to satisfy basic needs that health concerns are attended to secondarily. Providers are aware of the direct impact this has on health outcomes and on the unique cultural needs that keep families from seeking healthcare, and educational guidelines for healthcare professionals have recently been revised to incorporate the assessment of psychosocial issues. The Institute of Medicine's Proposal on Medical School Curriculum Reform states, "Identifying personal, familial, social, and environmental factors that may affect a patient's health enables physicians to provide better, more patient-centered care."²⁴ To this the American Academy of Pediatrics responded, "(t)he purpose of this statement is to reaffirm the commitment of the AAP to prevention, early detection, and management of behavioral, developmental, and social problems as a focus in pediatric practice."²⁵ In isolation, this genuine effort is substantial, but it counts on the ability of patients to actually access care; being trained and committed to the "early detection" and "management" of the psychosocial issues is not necessarily bringing these families into medical offices.

Discussion and conclusions. This study measured providers' perceptions of the psychosocial issues that prevent low-income, API immigrants from pursuing primary care and other health services. Findings from this investigation, which concur with the TCNY findings, reveal three main issues surrounding the interaction between healthcare and the API population that providers should address to reach these individuals. First, API immigrants experience tremendous barriers when trying to sat-

isfy basic needs. Language difficulties prevent them from working through red tape of the city's many benefit programs, policies, and regulations. Located throughout the city are numerous immigrant advocacy groups and organizations that help with and provide legal services, public benefits, childcare, housing, and job training—the "outside system," but they continue to go underutilized.

Second, the extensive web of social and medical services in the city is complicated and scattered. Healthcare professionals do not have a knowledge of local, targeted resources to help patients.²⁷ Even if providers could make a suitable referral, it is difficult for healthcare staff to follow up, and to ensure the problems are adequately addressed.

The third substantial finding from this investigation reveals that API immigrant families use their children's pediatrician as an advisor on health issues and psychosocial issues. This suggests medical settings are ideal for addressing the needs of API immigrant populations. A study conducted by Johns Hopkins School of Medicine and the University of Connecticut School of Medicine surveyed parents in an urban hospital clinic for low-income children to determine whether they felt comfortable seeking advice from their child's doctor about psychosocial issues.²⁸ Of 100 parents questioned, 67% felt comfortable asking the pediatrician for help with needs like housing, childcare and job training, and of those, 70% expected doctors to actually provide referrals and advice. Families view their child's doctor as a part of "the system" who is able to listen to and advocate for them. Thus, an approach addressing the social problems of low-income families (especially immigrants) needs to be integrated into the medical setting where they receive healthcare.²⁸

The challenges faced by API immigrants and providers can be addressed with a shift in the traditional medical care model to include infrastructure to connect and serve all constituents—care providers, social service agencies to help with afflicting basic needs, and providers. One approach to this is seen in the presence of Project HEALTH Family Help Desks in multiple hospitals nationwide. The Project HEALTH Family Help Desk serves as an interactive database that brings access to services into hospital waiting rooms. Families can walk up to the desk while they wait and meet a volunteer who will perform a quick analysis of their needs, screen them for public benefit eligibility, and help them find programs in their community. When a family indicates to their healthcare provider a need for resources, they are referred to the Family Help Desk where a well trained volunteer will provide the follow up, guidance and advocacy they cannot. The volunteers fill the gap in services that the present healthcare system does not support.

Yet, while the integration of information and referral services into healthcare settings is substantial, it may not com-

pletely address the needs of API families unless an ethno-cultural component is also included. If community based information and referral programs are placed in healthcare settings, several suggestions can be made to better reach API populations. Routine psychosocial surveys translated into Asian languages could be issued at the beginning of every doctor's visit as a part of regular paperwork, serving as publicity and providing the connection to attract API families in need to the service. Furthermore, the staff needs education about the various cultural traditions and languages that might determine API families' interpretation of services. Incorporating background knowledge of the unique psychosocial or health issues API populations experience into a separate screening test not recommended for the general population may also be helpful.²⁹

To better serve Asian and Pacific Island populations, this study calls for culturally competent information and referral services to be placed in healthcare settings. This may ameliorate the API disparities in healthcare by addressing basic needs that act as barriers to adequate care. Further, such services may enable health professionals to discuss basic needs with API patients, providing complete and comprehensive care. More research is required to determine the services API populations specifically need, and what is difficult to find in their communities.

References

1. U.S. Census Bureau. American Community Survey: 2005. Washington DC: US Census Bureau, 2005. Available at http://factfinder.census.gov/servlet/DTTable?_bm=y&-geo_id=01000US&-ds_name=ACS_2005_EST_G00_&-redoLog=false&-mt_name=ACS_2005_EST_G2000_B02001.
2. Kim M, Van Wye G, Kerker B, et al. The health of immigrants in New York City. New York Department of Health and Mental Hygiene, 2006.
3. New York City Department of City Planning: Population Division. The newest New Yorkers 2000: immigrant New York in the new millennium. (Pub. no. [NYC DCP] 04-09.) New York City: Department of City Planning, Oct 2004.
4. Handler JF, Hasenfeld Y. The State of Poverty. In: Blame Welfare, Ignore Poverty and Inequality. Cambridge: Cambridge University Press, 2006.
5. Schneiderman N. Psychosocial, behavioral, and biological aspects of chronic diseases. *Current Directions in Psychological Science*. 2004 Dec;13(6):247-51.
6. Elstad JI. The psychosocial perspective on social inequalities in health. *Sociology of Health & Illness*. 1998;20(5):598-618.
7. Masi C. Community and Health. In: Gehlert G, Browne TA, eds. *Handbook of Health Social Work*. Hoboken, New Jersey: John Wiley & Sons, Inc, 2006.
8. Olson EC, Van Wye G, Kerker B, et al. Take Care Lower East Side. NYC Community Health Profiles, Second Edition; 2006;27(42):1-16.
9. McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Affairs*. 2002 March/April;21(2):78-93.
10. Jenkins CN, Le T, McPhee SJ, Stewart S, et al. Health care access and preventative care among Vietnamese immigrants: do traditional beliefs and practices pose barriers? *Soc Sci Med*. 1996 Oct;43(7):1049-56.
11. Ahmed MH, Lemkau JP, Nealeigh N, et al. Barriers to healthcare ac-

- cess in a non-elderly urban poor American population. *Health and Social Care in the Community*. 2001 Oct 15;9(6):445-53.
12. Ma GX, Shive SE, Fang CY, et al. Knowledge, attitudes, and behaviors of hepatitis B screening and vaccination and liver cancer risks among Vietnamese Americans. *J Health Care Poor Underserved*. 2007 Feb;18(1):62-73.
13. Pollack H, Wan K, Ramos R, et al. Screening for chronic hepatitis B among Asian/Pacific islander populations—New York City, 2005. *Morbidity and Mortality Weekly Report*. 2006 May 12;55(18):505-10.
14. Chen TM, Huang FY, Chang C, et al. Using the PHQ-9 for depression screening and treatment monitoring for Chinese Americans in primary care. *Psychiatr Serv*. 2006 Jul;57(7):976-81.
15. Lin DH, Au L, Lee W, et al. Evaluating the Use of School-based Asthma and Allergy Screening Questionnaires in Lower Manhattan Public Primary Schools. Presented at: American College of Allergy, Asthma and Immunology Annual Scientific Meeting, Philadelphia (PA), Nov 9-15 2006.
16. Lee E. Asian American families: an overview. In: McGoldrick M, Giordano J, Pearce JK, eds. *Ethnicity and Family Therapy*. New York: The Guilford Press, 1996.
17. Lee E. Chinese Families. In: McGoldrick M, Giordano J, Pearce JK, eds. *Ethnicity and Family Therapy*. New York: The Guilford Press, 1996.
18. Rolland JS, Werner-Lin A. Families, health, and illness. In: Gehlert G, Browne TA, eds. *Handbook of Health Social Work*. Hoboken: John Wiley & Sons, Inc., 2006.
19. Block P. Alternative, complementary, and integrative medicine in a conventional setting. In: Gehlert G, Browne, TA, eds. *Handbook of Health Social Work*. Hoboken: John Wiley & Sons, Inc., 2006.
20. Griffith DM, Moy E, Reischl TM, et al. National data for monitoring and evaluating racial and ethnic health inequities: where do we go from here? *Health Educ Behav*. 2006 Aug;33(4):470-87.
21. Davies HT, Washington AE, Bindman AB. Health care report cards: implications for vulnerable patient groups and the organizations providing them care. *J Health Polit Policy Law*. 2002 Jun;27(3):379-99.
22. Chin JJ, Kang E, Kim JH, et al. Serving Asians and Pacific Islanders with HIV/AIDS: challenges and lessons learned. *J Health Care Poor Underserved*. 2006 Nov;17(4):910-27.
23. Gehlert S. Communication in healthcare. In: Gehlert G, Browne TA, eds. *Handbook of Health Social Work*. Hoboken: John Wiley & Sons, Inc., 2006.
24. Institute of Medicine. IOM report: Improving Medical Education—Enhancing the behavioral and social science content of medical school curricula. *Acad Emerg Med*. 2006 Feb; 13(2):230-1. Epub 2006 Jan 25.
25. Committee on Psychosocial Aspects of Child and Family Health. American Academy of Pediatrics. The new morbidity revisited: a renewed commitment to the psychosocial aspects of pediatric care. *Pediatrics*. 2001 Nov;108(5):1227-30.
26. Garg A, Butz AM, Dworkin P, et al. Pediatric residents' attitudes and behaviors regarding family psychosocial screening at well-child care visits. Presented at: Pediatric Academic Societies' Annual Meeting, Toronto (Canada), May 2007.
27. Gunasekera H, Buckmaster A. Training in general pediatrics: Is it time for change? *J Paediatr Child Health*. 2004 Sept-Oct;40(9-10):510-6.
28. Garg A, Butz AM, Dworkin, P, et al. Low-Income Parents' Attitudes and Willingness to Seek Assistance for Social Needs from Their Child's Medical Home. Presented at: Pediatric Academic Societies' Annual Meeting, Toronto (Canada), May 2007.
29. Nelson KR, Bui H, Samet JH. Screening in special populations: a "case study" of recent Vietnamese immigrants. *Am J Med*. 1997 May;102(5):435-40.