



2010 Asian & Pacific Islander Health: Community Needs Assessment OVERVIEW

Vision

Healthy people, stronger families, vibrant communities.

Mission

ICHS provides culturally and linguistically appropriate health services to improve the health of Asian Pacific Islanders and the broader community.

ACKNOWLEDGEMENTS

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Introduction

International Community Health Services (ICHS) was founded in 1973 as a small storefront clinic by a group of volunteers who wanted to reduce the health disparities and barriers to accessing care faced by low-income, elderly, and limited English-proficient (LEP) Asian residents of Seattle's Chinatown and Beacon Hill neighborhoods.

37 years later, ICHS now runs two full-service primary care clinics in the International District and Holly Park neighborhoods of Seattle that have the capacity to see over 17,000 patients annually. In addition, ICHS' staff has grown from a handful of volunteers to over 200 full-time employees. While ICHS has expanded in response to the broader needs of Seattle's Asian, Native Hawaiian, and Other Pacific Islander (A/NHOPI) communities, the enduring mission has remained to provide culturally and linguistically appropriate and affordable health care for A/NHOPIs and other communities in King County as well as neighboring counties within Washington State.

ICHS' model of care focuses on prevention, education, and early intervention, with an emphasis on health maintenance, chronic disease self-management, risk-behavior reduction, life cycle needs, and lifestyle changes. In addition to primary medical and dental care, both clinics offer behavioral health services, laboratory and pharmacy services, women's health screenings, well-child check-ups, health education, WIC (Women, Infants, and Children) enrollment and assistance, enabling services such as screening and enrollment into health insurance programs, and other supplemental services. The ID clinic also offers traditional Chinese medicine including acupuncture.

The first community needs assessment was conducted in 1995; in response to its findings, ICHS expanded services, which included the construction of a new clinic and the addition of dental services. Another community needs assessment was performed in 2006, and pointed to the need for more health education for patients regarding health issues and the western health care system and showed that the clinic's target communities are spreading out from the city center. In response, ICHS created health educator positions that are integrated into the clinic operations and began planning for a third clinic outside of Seattle. With the uncertainty of how the health care environment will change in the face of impending health care reform and a weak economy, ICHS is seeking to understand the needs of the patients and how to best meet these needs in the coming years with this third community needs assessment. Its primary purpose is as follows:

- Objective 1: Develop an understanding of the current constituent base and its service utilization.
- Objective 2: Identify unmet health needs of ICHS patients and potential patients.
- Objective 3: Conduct a competitor analysis of services and identify ICHS' competitive advantage.

In the years since the 2006 Community Needs Assessment, the health care and economic landscape in the US has shifted considerably. In 2008, the subprime mortgage crisis caused several major U.S. financial institutions to collapse and the effect on the economy as a whole triggered a recession and rapidly rising rates of unemployment. The Obama administration developed a stimulus program which community health centers such as ICHS have benefited from through a series of grants. In 2010, a health care reform bill was passed that will overhaul the current health care system while providing additional funds for community health centers. All U.S. citizens and most legal residents will be required to purchase health insurance, in the hopes of decreasing the number of uninsured and thus lowering the costs of health care for everyone.

Washington State has also been impacted by the weak economy facing a \$2.6 billion shortfall in 2010. The state slashed funding to health care programs such as Basic Health Plan, the insurance plan for low-income Washington residents in 2009, drastically decreasing the number of slots available while doubling premiums for current enrollees.

Methodology

ICHS employed the following sources to create this report:

- Internal patient data, including medical and dental
- External reports and data from local, state, and national sources
- Information from focus groups conducted by the Nonprofit Assistance Center on behalf of ICHS
- Internet searches
- Telephone research
- ICHS provider surveys

ICHS uses a method of triangulation to verify data. It gathers data from a variety of sources in order to ensure that anecdotal data from focus groups and provider surveys is supported by objective data sources. All of the data is backward-looking and does not indicate what will happen in the future. However, trends can be used to identify changes and predict future trends.

Validity: diagnosis data from 2005 and 2009 are not comparable due to changes in ICHS' electronic medical and dental records systems. In some places we have noted percentage changes; however, it is difficult to know if this is due to an actual increase in diagnosis or better data collection.

Reliability: data reliability ranges from very reliable (census data and external reports) to anecdotal (focus groups and provider surveys). Despite this variation, the various data sources support each other and show that issues identified in research are also concerns of ICHS patients.

Caveats: Census data used in this report comes from 2008 estimates based on the 2000 Census data. While reliable, it does not show any new population trends that may have emerged in the last ten years.

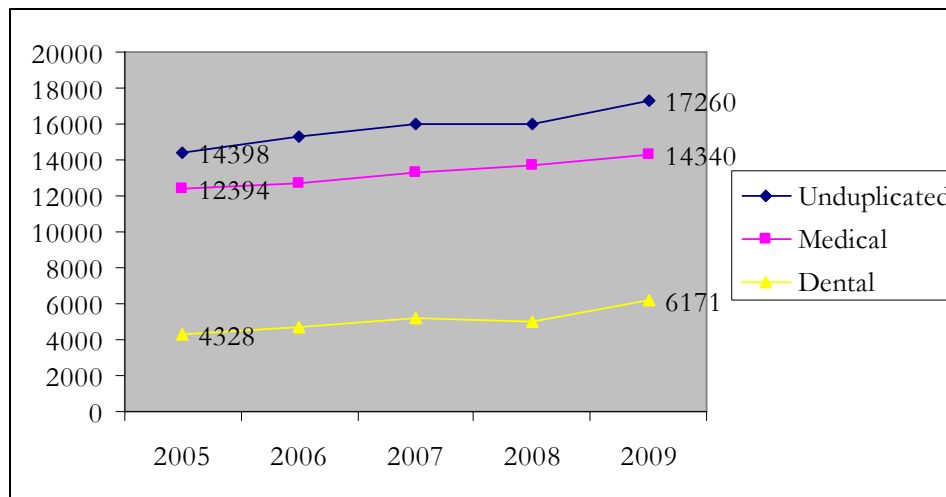
Due to resource constraints, ICHS data has not undergone any statistical analysis and is only reported in terms of number of occurrence or change since the last reporting period.

ICHS Patient Population and Social Determinants of Health

Over the past 15 years, the number of ICHS patients increased by 450%, from 3,133 in 1994 to 17,260 in 2009. This growth has also brought an increased diversity of patients and service needs. To meet these needs, the Holly Park Clinic moved into a new building with expanded capacity in 2005 and added additional space in 2008 for services such as WIC (Women, Infants, and Children), behavioral health, health education, and community advocacy. In 2009, ICHS used a vacancy in the ID Clinic building to expand services and consolidate administration and pharmacy into the same building as the clinic.

ICHS has seen steady growth in terms of number of patients and number of encounters in both medical and dental. From 2005 to 2009, the total number of unduplicated patients increased by 20% (2,862 patients), medical patients increased by 16% (1,946 patients) and dental patients had the largest percentage increase at 43% (1,843 patients). Increase in the number of patients can be partially attributable to the physical expansion of both clinics, resulting in increased capacity to see patients.

Figure 1: ICHS Unduplicated, Medical and Dental Patients, 2005-2009



Ethnically, ICHS patients have remained very diverse. In 2009, the largest ethnic groups in unduplicated patients were Chinese (41%), Vietnamese (26%), and Filipino (6%), which was consistent with the largest groups in 2005. The smaller ethnic groups have experienced more changes with the number of Black/African Americans increasing while the number of some of the smaller Asian groups remaining constant or declining. The number of Korean dental patients increased dramatically due to an addition of a Korean dentist while the number of Korean medical patients declined. The number of Filipino dental patients remained very low in comparison to the number of Filipino patients seen in the medical clinic, warranting further research into the reasons behind this trend.

Table 1: ICHS Patient Ethnicity

	Total Unduplicated Patients 2009	% Change 2005-2009	Total Medical Patients 2009	% Change 2005-2009	Total Dental Patients 2009	% Change 2005-2009
Chinese	7,122	9.9%	6,307	12.9%	2,652	59.4%
Vietnamese	4,553	52.0%	4,079	46.5%	1,316	54.8%
Filipino	1,055	22.8%	941	16.2%	192	25.5%
Black/African American	941	44.1%	618	27.4%	435	32.2%
Korean	890	12.4%	682	-1.2%	379	37.8%
White	496	-1.4%	301	6.0%	221	-10.2%
Unlisted	450	-	194	-	274	-
Unreported/Refused	331	-66.6%	154	-82.5%	185	-57.1%
Cambodian/Khmer	237	30.2%	201	35.8%	64	-7.2%
Laotian	233	10.4%	198	17.2%	67	36.7%
Asian (Other) ¹	209	65.9%	152	105.4%	73	21.7%
American Indian/Alaskan Native	208	116.7%	83	93.0%	124	90.8%
Mien	187	0.0%	165	25.0%	55	25.0%
Native Hawaiian and Other Pacific Islanders	167	57.5%	145	15.1%	49	2.1%
Hispanic Or Latino	165	-22.5%	108	-41.3%	78	73.3%
More than one race	16	-	12	-	7	-
Total	17,260	19.9%	14,340	15.7%	6,171	42.6%

Compared to other King County community health centers (CHCs), ICHS has a greater percentage of patients that are 60 or older at 23% compared to the county average of 9%.² In addition, the largest increase in unduplicated patients was in patients 80-84 years old, suggesting that services for older adults will continue to be in great demand, especially since elderly patients require more care and as the baby boomer generation ages. Younger patients in the 22-44 age group comprised 27% of medical patients and saw almost no growth due to negative growth in 20-24 year olds, 25-29 year olds, and 30-34 year olds. Patients in these age groups tend to be healthier and are more likely to be uninsured. Children also made up a significant proportion of patients with the largest five-year age group being children aged 0-4 years, at 7% (1,266 patients). However, this group also experienced the greatest percent decrease, falling 7% during the past five years.

One of the conclusions from the 2006 Community Needs Assessment was that ICHS needed to target dental patients in the 5-9 year old age group. In 2009, this was the largest group for both males and females at 10%

¹ Asian (Other) includes Japanese, Thai, Indonesian, Burmese and other Asian groups seen in small numbers at ICHS' clinics.

² Comparative data provided by Public Health of Seattle/King County and only reflects data from CHCs receiving funding from the Community Health Services grant in 2009. See Appendix A for more information.

of all patients seen in 2009, indicating that effective outreach has taken place. It may be successful to target outreach toward adults, especially males as they are currently underserved in both medical and dental services.

Females comprise the majority of all patients at 59% (10,219), while the number of males and females both increased significantly since 2005. Usage by male patients decreased drastically among male patients in their late teens while the number of female patients declined slightly among women in their early teens and then increased among women in their childbearing years (15-44 years old). This gap between male and female patients closed when patients reached their 70s.

The percent of patients under 100% of the federal poverty level (FPL) has decreased by almost 20% and the percent of patients whose income is unknown has increased by over 10%. Given the tough economy, this trend is contrary to what was expected. However, with the increase of patients whose income is unknown, it is possible that some patients are not taking advantage of the sliding fee scale and could be eligible if their income data was known.

Insurance products have undergone many changes in the past few years. ICHS has been so effective at keeping patients enrolled in insurance plans that the number of uninsured has decreased over the past five years. However, Basic Health Plan, which ICHS relies heavily on, has reduced its number of enrollment slots and may cut more in the future. Washington State's Apple Health for Kids program was established in 2008 and combined existing children's insurance resources under an umbrella plan, expanding eligibility to 300% FPL. ICHS has maintained diversity in terms of its payer mix, with 31% of medical and 55% of dental patients having Medicaid coverage and 18% of medical and 10% of dental having private insurance. The weak economy and health care reform could potentially have a huge impact on coverage, and its effect is difficult to predict.

Based on 2009 data, ICHS patients speak over 50 different languages and dialects, which consistently challenges the staff charged with providing interpretation between physicians and patients. Staff interpreters called "Health Assistants," provided interpretation in more than 10 different languages and dialects in the clinic.³ Bilingual staff members, who speak a total of more than 20 languages and dialects, as well as external interpreters, are used to fill gaps. The AT&T Language Line is used for languages that could not be covered by staff resources and/or walk-in patients who do not have an interpreter scheduled.

For unduplicated patients who need interpretation, the largest demand has been for Cantonese, Vietnamese, and Mandarin. English-speaking patients are the third largest group. ICHS staff has reported an increasing need for Somali interpreters. However, though they are increasing quickly, Somali-speaking patients still make up less than 2% of clinic patients (268 patients).

³ Cantonese, Mandarin, Vietnamese, Korean, Mien/Laos, Shanghainese, Taiwanese, Toisanese, Chaozhownese, Cambodian

Table 2: Languages preferred by ICHS patients

Preferred Language	2009					
	Unduplicated		Medical		Dental	
	Patients	%	Patients	%	Patients	%
Cantonese	5,470	31.7%	4,897	34.1%	2,062	33.4%
Vietnamese	4,242	24.6%	3,808	26.6%	1,237	20.0%
English	3,634	21.1%	2,491	17.4%	1,468	23.8%
Mandarin	1,025	5.9%	866	6.0%	387	6.3%
Korean	806	4.7%	618	4.3%	341	5.5%
Tagalog	440	2.5%	408	2.8%	70	1.1%
Other Languages	435	2.5%	300	2.1%	171	2.8%
Somali	268	1.6%	132	0.9%	169	2.7%
Toisanese	254	1.5%	240	1.7%	66	1.1%
Cambodian/Khmer	178	1.0%	148	1.0%	50	0.8%
Laotian	151	0.9%	127	0.9%	48	0.8%
Mien	135	0.8%	117	0.8%	45	0.7%
Ilokano	130	0.8%	125	0.9%	18	0.3%
Spanish	92	0.5%	63	0.4%	39	0.6%
Total Users	17,260	100.0%	14,340	100.0%	6,171	100.0%

The physical location of ICHS patients largely remained the same with the greatest proportion (46%) of patients coming from the neighborhoods surrounding the ICHS clinics while many others were spread over King and other neighboring counties.

A/NHOPI Population Determinants of Health

Many factors play into A/NHOPI health such as socioeconomic status, physical environment, and an individual's characteristics and behavior. Disparities in these determinants of health can be detrimental to a population's overall wellbeing. Using data from the 2008 U.S. Census American Community Survey, ICHS assessed the status of determinants of health in the A/NHOPI population in King, Pierce, and Snohomish County.

Between 1990 and 2009, the population of King, Pierce, and Snohomish County grew by 38%, from 2.6 million to 3.4 million residents.⁴ Population projections for 2030 by OFM project that A/NHOPI and Hispanic populations are expected to be the largest and fastest-growing. In Washington, the number of Asians, Native Hawaiians, and Other Pacific Islanders is projected to increase by 132%, for a statewide population of 825,000 by the year 2030.

Low educational levels are linked with poor health, more stress and lower self-confidence. Lower education levels also directly correspond with lower median household incomes which affect the ability to spend money on healthy foods and health care needs. Research has also shown links between parental education levels and child outcomes for educational experience and academic achievement. Children with highly educated mothers were more likely than other children to participate in early children education programs and home

⁴ Table 1. Annual Estimates of the Resident Population for Counties of Washington: April 1, 2000 to July 1, 2009 (CO-EST2009-01-53). U.S. Census Bureau, Population Division. March 2010.
< <http://www.census.gov/popest/counties/tables/CO-EST2009-01-53.xls>>

literacy activities.⁵ Although the stereotype that Asians consistently strive for higher education persists, Asians have a higher percentage that has less than a high school education as compared with the total population. NHOPIs have overall received much less education which in turn affects their earning ability, health and education of their children over the course of their lives.

Given that higher income and social status are linked to better health and a higher likelihood of being insured, and the greater the gap between the richest and poorest people, the greater the differences in health. It is important to note that although Asians had a higher median income in King and Snohomish counties, they had a significantly lower median income in Pierce and a higher percentage live in poverty in all three counties. NHOPIs have a lower median income and a higher percentage live in poverty in all three counties, and therefore, are more likely to experience poorer health. Data from the 2000 Census show that variability exists within the A/NHOPI subgroups and within the three counties. Asian Indians earn consistently higher than median income levels in all three counties. Koreans have a high percentage of population earning less than \$10,000 in all three counties. Overall, A/NHOPIs have less variability in income in Pierce and Snohomish counties.

Housing can also significantly affect health. Indoor air quality, dampness, housing design, allergens and dust mites, accident and fire hazards can all adversely affect health. In addition, individuals and families with less than the median household income are more likely to live in areas where they are exposed to possible environmental pollutants released by manufacturing facilities.

General Health Status of A/NHOPI Population and ICHS Patients

The A/NHOPI population faces many culturally-specific factors that inhibit healthy and preventative habits and may lead to infrequent primary care visits. Some of these include lack of health insurance or inadequate health insurance coverage, linguistic/cultural barriers and the fear of deportation. In addition, they are disproportionately affected by certain conditions and risk factors.

The leading diagnoses amongst ICHS medical patients have remained the same for several years which demonstrates the continued need for resources to be directed in these areas of focus. Hypertension continues to be an area of focus and concern for patients, and represents the most frequent diagnosis among all patient medical encounters. The three main chronic diseases that are monitored at ICHS--heart disease, cancer and stroke--represent the top three leading causes of death for the A/NHOPI community.

Behavioral Health

Culturally-specific values within A/NHOPI populations often prevent individuals from seeking assistance for behavioral health problems. Many hold self-reliance, reservation, and not bringing shame to the family in high regard; not surprisingly, A/NHOPIs have extremely low utilization of mental health services relative to other racial and ethnic groups in the U.S.⁶

A national study was conducted by the National Institute of Mental Health in 2003 to measure the rates of mental illness and treatment use among a sampling of three major Asian American groups. The study found that overall, Asian Americans have lower rates of mental illnesses than Whites but would seek treatment less often. Those who used mental health services were more severely ill than other groups, suggesting that they delayed seeking treatment because of the stigmas associated with it. Children with immigrant parents were put under high stress because of expectations to be obedient and to perform well in school and were more likely to develop symptoms of social anxiety, social phobias, and trauma-related disorders. Older Asian Americans showed higher rates of dementia than the general population. The rate of illicit drug use among

⁵ U.S. Department of Education 2006, indicator 2; U.S. Department of Education 2003, indicator 37).

⁶ Young KNJ. *Help Seeking for Emotional/Psychological Problems Among Chinese Americans in the Los Angeles Area: An Examination of the Effects of Acculturation* [dissertation]. Los Angeles, Calif: University of California at Los Angeles; 1998.

Pacific Islanders is 9% higher than any other ethnic group and treatment admissions for stimulant abuse among A/NHOPIs is nearly four times higher than total admissions for substance abuse. In addition, Asian Americans showed disproportionately high rates of gambling, suicide, and eating disorders.

Since 2005, the number of mental health diagnoses at ICHS has increased greatly, except for alcohol-related disorders and other mental disorders. Most notably, other substance-related disorders have increased by 19 patients (475%), depression has increased by 225 patients (292%) and attention deficit increased by 27 patients (270%). The number of users and encounters for six indicators--alcohol-related disorders, other substance-related disorders, depression, anxiety, attention deficit, and other mental disorders--has also increased overall by 231 patients (36%) since 2005.⁷ This could be explained by an increased awareness and acceptance among patients for the use of behavioral health providers, as well as improved coordination among clinic staff in referring patients to ICHS behavioral health providers. Since 2005, two social workers and a maternal child behavioral health coordinator increased the behavioral health department's total FTE by 2.75. The increased staff capacity from these grant-funded positions has allowed ICHS to serve more patients.

Cancer

Although A/NHOPIs generally have lower cancer rates than the non-Hispanic White population, cancer is the leading cause of death among A/NHOPIs, with lung cancer being the most common cancer among A/NHOPIs.⁸ Smoking among NHOPIs is significantly higher than the King County general population. Breast cancer rates are also higher for Chinese American and Japanese American women than women of their same age in China and Japan. Fear of cancer, perceived cost of care, and lack of a physician referral are common barriers to cancer screening and other preventive services for A/NHOPIs.

Diabetes

Despite a lower average body weight, Asian Americans are more at risk than White Americans to have diabetes. It currently affects about 7% of Asian Americans, but a rising trend in cases suggests it could very likely become higher. Ninety to nine-five percent of Asians with diabetes have type 2 diabetes because of a combination of genetic and environmental factors.⁹ Diabetes rates among Asians in the U.S. are much higher than Asians living in Asia.

There are several risk factors related to diabetes, including obesity, hypertension, high cholesterol, and cigarette smoking. A western diet that is high in saturated fat and calories, lack of physical activity, and genetic makeup are also believed to be contributing factors to the rising rates of diabetes among A/NHOPIs.

Those who live in poverty are also disproportionately affected by diabetes. Treating diabetes has become increasingly costly, leading to higher rates of ER visits and death due to diabetes or diabetes related conditions. Among adults aged 45 and older in King County, 18% of those living below 200% of the poverty level had diabetes, compared to 8% of those living above 200% of the poverty level.¹⁰

Diabetes continues to be a serious issue for ICHS patients as a higher percentage of ICHS patients are diagnosed with this disease compared to the King County average. Pacific Islanders have the highest diabetes prevalence of any racial or ethnic group in King County. In addition, the incidence of chronic kidney diseases among ICHS patients has risen faster than the overall patient population has grown.

⁷ As selected by UDS

⁸ Except for Asian Indian women

⁹ National Diabetes Education Program. Retrieved from <http://ndep.nih.gov/diabetes-facts/index.aspx#race>

¹⁰ Public Health – Seattle & King County. Public Health Data Watch. April 2007. Volume 9, No. 1. "Diabetes in King County"

HIV/AIDS and Sexually-Transmitted Diseases

Although A/NHOPIs have lower AIDS incidence and mortality rates than non-Hispanic Whites do, the number of reported AIDS cases has been increasing for Asian Americans. Those diagnosed with HIV/AIDS were 78% men, 21% women, and 1% children. A/NHOPIs are more likely to face barriers to HIV/AIDS prevention such as substance abuse, low testing rates, high risk sexual behavior among A/NHOPI men who have sex with men, sheer cultural and socioeconomic diversity, and limited use of services.

The number of A/NHOPIs living with HIV/AIDS in King County is small, with 192 Asians (3% of the total population with HIV/AIDS in King County) and 13 NHOPIs (0.2%) living with HIV/AIDS. ICHS also has a low number of HIV-positive patients (3 patients in 2009). In addition, 17 ICHS patients were diagnosed with STDs in 2009.

Hypertension/Hyperlipidemia/Cardiovascular Disease

Overall Asian American adults are less likely than White adults to have heart disease and have lower rates of risk factors that put individuals at higher risk of developing heart disease. However, native Hawaiians and other Pacific Islanders are 30% more likely to be diagnosed with high blood pressure and are 30% more likely to be obese compared to non-Hispanic Whites.

The number of ICHS patients diagnosed with hypertension increased by 375 patients (20%), representing 8% of all medical encounters in 2009. Those diagnosed with hyperlipidemia also increased significantly since 2005 from 829 patients in 2005 to 2,867 in 2009, an increase of 262%. Such a large increase, however, could be attributable to education about screening and more cholesterol tests being performed. Diagnosis of cardiovascular disease also rose, 226 patients were diagnosed in 2009, an increase of 27% since 2005.

Communicable Diseases and Immunizations

In King County, rates of immunization for Haemophilus influenzae type b (Hib), hepatitis B, measles, mumps, and rubella (MMR), polio, and chicken pox in A/NHOPI children aged 19-35 months have greatly improved and have reached the Healthy People 2010 goal of 90% immunized.

The number of children who have received required vaccines by their second birthday at ICHS increased from 99 patients (43%) in 2008 to 203 (65%) in 2009.¹¹ ICHS is moving closer to the national target of 90% immunization for adults aged 65 years and older. The rate of vaccination for influenza at ICHS has risen significantly from 591 patients in 2005 to 9,371 in 2009, representing a 65% influenza vaccination rate in 2009. By comparison, the vaccination rate in 2005 was 29%. The large increase in vaccinations since 2005 can be attributed to the increased media attention, changes in guidelines for flu vaccination, clinic resources and education placed on flu season and the H1N1 virus.

A/NHOPIs had more than 24 times the rate of new tuberculosis (TB) cases compared to non-Hispanic whites in 2007.¹² Although TB cases decreased nationally from 2006 to 2007, TB cases in King County increased by 11%. King County's rate of tuberculosis is 8.6 cases for every 100,000 individuals, almost double the national rate of 4.4. per 100,000.¹³ In 2007, 122 cases (76% of all King County TB cases) were found in patients born outside of the U.S. The five most common countries of origin for TB cases were Vietnam, Somalia, Ethiopia, India and the Marshall Islands. A/NHOPIs make up 46% of TB cases by race in King County. The number of TB cases at ICHS has declined sharply since 2005, decreasing from 20 patients in 2005 to 4 in 2009, a decrease of 80%.

¹¹ 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV, 4 Pneumococcal conjugate

¹² U.S. Department of Health and Human Services. The Office of Minority Health. Immunizations and Data/Statistics. <http://raceandhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=60>

¹³ Public Health – Seattle & King County. Intersecting Infections of Public Health Significance: The epidemiology of HIV, Hepatitis, STDs and Tuberculosis in King County, 2008.

A/NHOPIs have the highest rates of chronic hepatitis B virus (HBV) among all racial/ethnic groups in the U.S. making up half of the 1 million persons with HBV. The rate of chronic hepatitis B is also on the rise in King County with 839 cases reported in 2007, an increase of 111% since 2000.¹⁴ At ICHS, there were 388 patients with hepatitis B in 2009, an increase of 64% (152 patients) since 2005. This increase also corresponds with the increase seen in the number of patients with chronic liver disease.

The rate of chronic hepatitis C in King County is about 95 per 100,000 (0.09%) and has remained stable in recent years.¹⁵ At ICHS, the incidence of hepatitis C has decreased by 50% since 2005, from 202 patients in 2005 to 101 patients in 2009.

Maternal and Child Health

Although A/NHOPIs had the highest percentage of prenatal care of all racial groups in the U.S. in 2006, Native Hawaiian mothers were more than twice as likely as non-Hispanic White mothers to begin prenatal care in the third trimester, or not receive prenatal care at all.¹⁶ ICHS patients showed very low rates of low birth weight, late or no prenatal care, gestational diabetes, and adolescent birth.

Obesity and Overweight

Being overweight or obese increases an individual's risk for a number of diseases including heart disease, type 2 diabetes, high blood pressure, stroke, breathing problems, arthritis, gall bladder disease, sleep apnea, osteoarthritis, and some cancers.¹⁷ Because Census data on Pacific Islanders was classified with Asians until 2000, accurate mortality and morbidity statistics for this population are limited. Native Hawaiians and Samoans have high rates of obesity, as well as related problems such as diabetes, hypertension, cardiovascular disease and stroke. Dietary and lifestyle changes, combined with a likely genetic predisposition to store fat are possible causes for these high rates.¹⁸

ICHS began collecting all patients' body mass index (BMI) data as of April 2010 and will have BMI data for future reports. Only 88 ICHS patients (0.6%) were reportedly overweight or obese in 2009, which is much lower than the national average where 40% of A/NHOPIs were overweight and 11% were obese.

Oral Health

Oral health is related to an individual's overall well-being and quality of life. Poor oral health adversely affects diet, nutrition, sleep, psychological status, social interactions, and school. According to the Surgeon General's report *Oral Health in America*, tooth decay (dental caries) is the single most common chronic disease of childhood and affects nearly 60% of children in the United States.¹⁹ Left untreated, tooth decay can lead to significant consequences such as pain, chewing difficulties and lack of sleep which can impact children's learning and growth.

¹⁴ Public Health – Seattle & King County. *Intersecting Infections of Public Health Significance: The epidemiology of HIV, Hepatitis, STDs and Tuberculosis in King County*, 2008.

¹⁵ Public Health – Seattle & King County. *Intersecting Infections of Public Health Significance: The epidemiology of HIV, Hepatitis, STDs and Tuberculosis in King County*, 2008.

¹⁶ Centers for Disease Control and Prevention. *Health, United States, 2009*. Table 140

¹⁷ U.S. Department of Health and Human Services.

<http://www.womenshealth.gov/minority/asianamerican/obesity.cfm>

¹⁸ Misra, Ranjita; James, Delores C. S.. "Pacific Islander Americans, Diet of." *Nutrition and Well-Being A to Z*. 2004. *Encyclopedia.com*. 4 Mar. 2010

¹⁹ U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

In a national survey of the number of dental visits in 2007, Asian adults between 18 to 64 years of age had the highest number of dental visits while Asians who were 65 years and over ranked second behind Whites.²⁰ While this seems promising, research still indicates that vulnerable populations such as minorities, low-income persons, and non-English-speaking children are at particular risk for poor oral health.

Although some Asian subpopulations seem to have better-than-average statistics with regard to oral health, other segments of the population still experience a number of oral health disparities. Moreover, there is a particular lack of national data on the oral health of Asian ethnic subgroups, Native Hawaiians, and other Pacific Islander groups, which indicates that there may be oral health disparities that are not being reported.

At ICHS, dental services have experienced double-digit growth between 2005 and 2009 for all users and encounters with the exception of emergency services. These increases range from a 10% increase in oral surgery patients (107 users) to a 135% increase in patients with sealants (267 users). The focus on preventative dental care has led to significant increases in oral exams, sealants, and prophylaxis, as well as an increase of 3,940 (31%) in users and 7,499 (41%) in number of encounters in the top eight selected dental services. A large part of this growth can be attributed to the 43% increase in dental patients since 2005.

Osteoporosis

Asian American women have a higher risk for osteoporosis because of their lower bone mass and density and smaller body frames. Contributing to this is their lower intake of calcium compared to other groups of women. The average calcium (essential nutrient for bone health) intake among Asian women has been observed to be half that of Western population groups. As many as 90 percent of Asian Americans are lactose intolerant or cannot easily digest dairy products.²¹

Stroke

In general, A/NHOPI adults have lower mortality rates due to stroke and have lower rates of risk factors linked to strokes such as being overweight or obese, lower rates of hypertension, and lower rates of smoking. Despite these factors, stroke remains the third leading causes of death for A/NHOPIs in King County. Heart disease risk and death rates are higher among Native Hawaiians and Asian Indians partly because of higher rates of obesity, diabetes and high blood pressure. High cholesterol rates are highest in Japanese women. ICHS, however, has a low incidence rate for stroke and virtually no change between 2005 and 2009.

Patient and Community Perceptions of Services and Needs

ICHS commissioned a consultant from 2008 to 2009 to conduct focus groups with patients and potential patients from three Asian ethnicities – Chinese, Filipinos, and Koreans – in order to ascertain their perceptions of ICHS, their access to health care services, preliminary need for and interest in a north King County ICHS facility, and perceptions of middle-income participants in order to diversify payer mix.

With the skyrocketing costs of medical care in the U.S. and the flagging economy, finding the appropriate health care is growing increasingly stressful and confusing for many people. Not surprisingly, many focus group participants cited the cost of health care as an important factor for where and when they choose to receive services. ICHS was perceived as a safety net for community members who seek low-cost alternatives to expensive health care schemes. Even among middle-income populations, the availability of low-cost, state-funded insurance is an attractive benefit for either themselves or someone they know.

²⁰ National Center for Health Statistics. Health, United States, 2009: With Special Feature on Medical Technology. Hyattsville, Maryland. 2010.

²¹ President's Advisory Commission on Asian Americans and Pacific Islanders, *Asian Americans and Pacific Islanders Addressing Health Disparities: Opportunities for Building a Healthier America*, 2003.

In addition to the affordability of health care services, focus group participants consistently placed high value on the need for quality health care services, good customer service, bilingual and bicultural health care teams, and the availability of a comprehensive range of services, including preventive care and care for the elderly. Location and the availability of parking were also highly valued.

Regarding the quality of care, more than one ICHS patient felt that their provider had allowed their illness to drag on unnecessarily. Others felt that, because they did not have an assigned provider, they often spent a long time explaining their symptoms or their health status to a new provider. It may be that patients did not fully understand their condition or treatment. Likewise, providers may also be able to improve how they talk to and explain things to patients.

Customer service was another frequent theme among focus group participants: how patients were treated by staff (such as mispronouncing someone's name or making patients feel looked-down-upon), the time between making an appointment and the appointment itself, wait times in the waiting room, the availability of after-hours care for patients who work all day and on weekends, and the availability of multiple services under one roof were some of the customer service issues cited. Participants preferred providers who could make referrals to specialists when needed.

The availability of bilingual and bicultural staff was an important factor for participants when choosing a provider. Thus, the fact that the majority of ICHS staff members are bilingual/bicultural was generally well-received by participants. Participants said that improvements could be made in the availability of translators that speak Mandarin, Ilokano, Visayan and Korean. Adding Korean staff may also improve perceptions in the Korean community that ICHS is primarily for Chinese patients. Participants did not trust translators to adequately explain symptoms or conditions.

Participants all agreed that location matters. If ICHS were to open a new clinic that was accessible by bus, has ample parking, is near participants' work or home, or is close to shopping, participants said they would welcome the opening of an ICHS clinic in North King County. At least one participant also wanted a health care facility to be located in a safe and clean environment.

Negative stereotypes regarding community-based clinics, such as perceived lower quality of service and/or poor customer service, persisted among focus group participants. This was due either to personal experience or general perceptions in the community. However, many focus group participants also had positive experiences with ICHS services. In particular, participants appreciated the low cost of services as well as the ethnic-specific and linguistically appropriate approach used by ICHS. Generally speaking, focus group participants from the Filipino community had more positive perceptions and experiences with ICHS than Chinese and Korean community members.

ICHS Provider Survey Results

The providers' responses to the survey clearly expressed that language continues to be a challenge at ICHS clinics. Providers felt that there was not enough in-house interpreters, not enough "good quality" interpreters, not having interpreters for needed languages such as Somali and Amharic, and that the patient should have the same interpreter at each visit to help the provider "understand the patient better as a person." Cuts made to support staff in 2009 due to the economy are still felt in the clinic. Another theme was a concern about issues broader than basic medical or dental care, such as access to insurance, specialists, behavioral health, health education, and the need for navigation through the health care system.

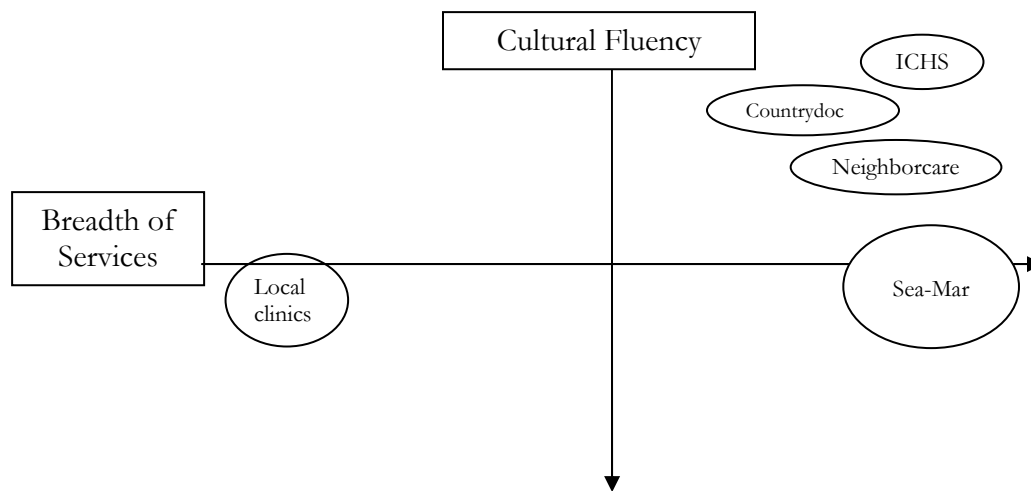
ICHS can support providers' efforts by improving systems and internal communication to help with tracking and recalling patients and with problem-solving. One provider specifically requested that there be a clearer delineation of duties in the health care team.

Despite the many variations in the provider ratings of the most serious health issues affecting patients, four issues were highlighted as particularly serious: preventive dental services, depression and other mood disorders, diabetes and chronic hepatitis.

Service Environment

Many factors must be considered in the possibility of a third ICBS clinic and whether it will be feasible and viable in a particular location. ICBS conducted an analysis of comparable clinics that share the same characteristics as ICBS such as catering to the A/NHOPI population, offering a range of health services, and focusing on those who are low-income or uninsured in the International District and New Holly neighborhoods.

Providers that were comparable to ICBS in regards to primary medical care are other community health clinics and smaller independent clinics. Most CHCs are able to offer similar services to ICBS in terms of interpretation services, health care coverage, and sliding fee scale, but smaller independent clinics generally offered neither formal interpretation services nor sliding fee scale. Patients looking for dental services have less selection to choose from. ICBS and Neighborcare are the only community health centers with dental clinics that offer flexible options for low-income, uninsured individuals who have limited English proficiency. This is particularly true for adults since most programs and grants target children. Other services such as behavioral health, WIC, traditional Chinese medicine, women’s health, adolescent services, and a pharmacy were offered by various clinics. However, ICBS was the only organization to offer them collectively.



ICBS’ strengths lie in its strong position throughout its history of providing comprehensive quality care while also making it accessible to patients with LEP. It has made a significant effort to understand its patients and to consistently tailor services to better suit them. In addition, ICBS has unfailingly worked to improve facilities, funding, and quality to expand upon these services for its patients.

Implications of Findings

Based on data collected, the foremost health issues facing ICBS’ patients are cancer, poor oral health, diabetes, heart disease, high blood cholesterol, and hypertension. Most of these conditions can lead to further health complications if left untreated. In order to address these areas, ICBS has focused their efforts on dental care, diabetes, and hypertension and has begun to track them on the agency’s Performance Scorecard to improve patient outcomes. In addition, heart disease and high blood cholesterol are routinely treated and managed as part of primary care services. ICBS also now routinely screens patients for cancer,

particularly breast, cervical, and colorectal cancer. If a patient is diagnosed with cancer, ICHS providers will refer them to specialists for treatment.

ICHS is doing a very thorough job in serving the Chinese and Vietnamese communities but Filipinos are the most underserved out of the target ethnic groups served by ICHS. The Korean patient population has grown in the past five years and continues to be an opportunity for expansion. The addition of a Korean dental provider has attributed to the increased number of Korean dental patients so further addition of Korean staff will likely increase Korean patients.

Provided the appropriate resources are available, ICHS has several opportunities for growth. After the expansion of the ID clinic, it still has excess physical capacity, particularly in the medical program, while both clinics have the option of adding additional hours. In addition, the feasibility and need for a third ICHS clinic has been supported by focus groups and market analysis data. Provider surveys also expressed strong support for expanding behavioral health services, health education and dental services.

Focus group participants identified ICHS as a provider of a unique set of services to an underserved community. They recognized ICHS as a location where they could find affordability/insurance coverage, quality of care, interpretation, all at a convenient location.

Since the first assessment in 1996, ICHS has seen a tremendous amount of patient growth. Without a more detailed study, a number of external and internal variables could be factors behind it. With as many as 43 distinct ethnic groups under the A/NHOPI umbrella, it is important that current research is now collecting and reporting more disaggregated data to reflect disparities among A/NHOPIs. However, disaggregated data is especially needed in areas where A/NHOPIs have not traditionally used services such as behavioral health or areas where previously they have been seen to do very well (i.e.: weight management). Furthermore, educational attainment for Asians presents itself as a bimodal distribution with large numbers of the community without high school education as well as large numbers with a bachelor's degree or higher, warranting further disaggregated data to specifically identify which subgroups are within each distribution.

Even with a large increase in the number of patients, ICHS still has opportunities to expand its services, in particular to underserved target ethnic groups such as Filipinos and Koreans. ICHS was identified by those who were surveyed in being a unique provider of services that would be welcomed in an additional third site. Further disaggregated data would be useful in determining additional needs of the A/NHOPI community; however, it appears that ICHS is doing a good job in addressing chronic conditions in its patients, which remains the foremost health issue facing ICHS' patients.

Recommendations

One of the primary purposes of the 2010 Community Needs Assessment is to evaluate what further actions should be taken by ICCHS in order to further improve services for patients. Generally, more outreach will be needed to certain populations to ensure that patients are accessing all the services that were available to them.

Outreach should be targeted toward adults, especially males, as they are currently underserved in both medical and dental services. A particular effort should be made to educate ICCHS medical patients on the importance of oral health on their overall health. Thirty-six percent of female medical patients are in their childbearing years and need to be informed of the impact that poor oral health can have on their child if they are pregnant. In addition, further research into why Filipino patients are seen in such low numbers in dental is recommended and a pilot program to refer Filipino medical patients to the dental program should be developed. Maintaining and expanding programs for older adults are also important given the large percentage of ICCHS patients over 65.

Insurance products have undergone many changes in the past few years. Staff should continue to monitor insurance status to anticipate possible financial impacts. Additionally, it is important to be certain that patients know about all the waiver and payment options available so that they are not foregoing needed care because they are unable to afford it. ICCHS should review the income verification process to ensure that the maximum number of patients have current income data and are able to access the sliding scale or enroll in public insurance programs.

With 66% of patients reporting a language barrier and with patients speaking over 50 unique languages and dialects, translation and interpretation continues to be a challenge. Aside from medical and dental, other programs should monitor patients' language needs when deciding which languages to translate materials into and which languages staff need to speak.

Nearly half of ICCHS' patients come from the areas around the clinic locations and the rest travel great distances from King, Pierce, Snohomish and other counties. This means that ICCHS' services are unique and highly valued in regards to the amount of interpretation and translation services it provides which should be used for marketing to other patient and planning for future satellite clinics.

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