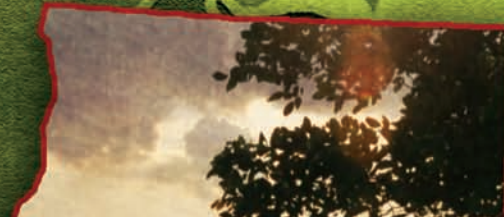


ETHNIC HEALTH ASSESSMENT FOR ASIAN AMERICANS, NATIVE HAWAIIANS AND PACIFIC ISLANDERS IN CALIFORNIA



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PREFACE

In California, approximately 56 per cent of our state's 38.2 million people are Latinos, African Americans, Asian-Pacific Islanders, and Native Americans. These ethnic groups comprise the four largest communities of color in our state. These groups also contribute extensively to California's economic and social vitality. Therefore, it is in our state's best interest to insure the health and well being of these populations.

The Ethnic Health Assessment Project seeks to clearly frame the health needs of these four population groups and makes recommendations for meeting those needs. The four companion reports generated from the Project are the result of close collaboration between academic researchers, lead ethnic organizations, and ethnic stakeholders.

The Project's leading ethnic organizations and researchers include:

- Latino Coalition for a Healthy California (LCHC) and Michael A. Rodríguez MD, MPH, David Geffen School of Medicine, University of California, Los Angeles
- California Black Health Network and Lonnie Snowden PhD, School of Public Health, University of California, Berkeley
- Asian Pacific Islander American Health Forum and Winston Tseng PhD, School of Public Health, University of California, Berkeley
- California Rural Indian Health Board. (CRIHB) and Carol Korenbrot PhD, CRIHB Research Director

The unique feature of the Project was the inclusion of "stakeholders," or representatives from advocate organizations, provider networks, and consumer and community-based organizations.

The stakeholders brought their real-life experience to the discussion table, and helped frame the content and mold policy recommendations found in each of the four reports. A separate stakeholder list is presented in the beginning of each report.

The four final reports will be distributed to California's decision makers, as well as to decision makers in other states with a significant minority presence, and to national level officials who have an interest in California's racial-ethnic health care issues.

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EXECUTIVE SUMMARY

The State of California alone accounts for one-third of the total Asian American, Native Hawaiian, and Pacific Islander population in the nation, collectively, numbering almost 5 million and representing one in seven Californians. The largest population concentrations are in the San Francisco Bay Area and in the greater Los Angeles area.

Asian Americans represent over 13% of the total California population and include: Chinese; Filipino; Southeast Asian (Vietnamese, Cambodian, Laotian, Hmong); South Asian (Asian Indian, Pakistani); Indonesian; Japanese; Korean; Taiwanese; Thai; Other Asian.

Native Hawaiians and Pacific Islanders represent 0.6% of the total California population and include: Native Hawaiian; Guamanian or Chamorro; Samoan; Tongan; Other Pacific Islander.

AAs and NHPIs are often portrayed as model minorities who are self-sufficient and hardworking groups that have overcome barriers to social mobility and wellness. However, this cultural stereotype masks the documented health disparities and social and economic differences across AA and NHPI subgroups.

Health Disparities

Asian Americans (AAs) and Native Hawaiians and Pacific Islanders (NHPIs) are the only major racial group for whom the leading cause of death is cancer. Language and cultural barriers pose a particular health care problem for many AA and NHPI subgroups because they are incredibly diverse, representing over 50 racial/ethnic backgrounds and speaking over 100 different languages.

Significant AA and NHPI health and health care problems include:

- **Hepatitis B and Tuberculosis:** AAs and NHPIs account for the largest proportion of all chronic Hepatitis B and tuberculosis cases in California, with the majority of cases in their immigrant populations.
- **Cancer and STD Screenings:** AA women have nearly double the rate of non-compliance with cervical cancer screening guidelines compared to the California average. AAs also have high rates of non-compliance with breast cancer and colorectal cancer screening guidelines compared to the overall state average. AAs report much lower rates of sexual transmitted disease (STD) and HIV screening than the state average.
- **Obesity and Diabetes:** More Samoan children have a body mass index (BMI) not within the Healthy Fitness Zone compared to other children in California. Also, NHPI and Filipino adults have some of the highest rates of diabetes in the state.
- **Mental Health:** Korean elders and NHPI adults reported among the highest rates of serious psychological distress in the state.
- **Health Insurance:** Tongans and Koreans reported the highest rates of currently uninsured in the state, more than double the state average.
- **Usual Source of Health Care:** Tongans, Hmong, and Koreans reported the highest rates of not having usual source of care in the state.

Social and Economic Factors

Social factors contribute to the health disparities experienced by AAs and NHPs in California.

- **Discrimination:** More AAs and NHPs reported being treated badly due to race or ethnicity “sometimes,” “often,” or “all of the time” compared to the state average.
- **Poverty and Unemployment:** Hmong, Cambodian, and Laotian populations have at least two times lower per capita income rates, higher poverty rates, and higher unemployment rates compared to the California average.
- **Lack of Language Capacity by Providers:** Few physicians speak the languages of the limited English proficient AA populations, particularly for the Hmong, Cambodian, and Laotian populations.

Recommendations to Reduce Health Disparities

To improve the health of California’s Asian Americans, Native Hawaiians, and Pacific Islanders, we make the following recommendations by policy issue areas:

Neighborhood Health and Food Consumption

1. Support local leaders and programs that promote neighborhood safety and social interaction in AA and NHPI neighborhoods, like Neighborhood Watch, community policing programs, and National Night Out, an annual neighborhood crime prevention event. Use “built environment” strategies, such as lighting, stop signs, and signage, to increase safety.
2. Pressure local elected and appointed officials to implement policies that promote the availability healthy choices in underserved AA and NHPI neighborhoods.
3. Support the First Lady’s *Let’s Move* initiative to help end the childhood obesity epidemic within a generation. *Let’s Move* uses a multi-pronged approach, encouraging healthy choices, healthier schools, physical activity and access to healthy, affordable food.
4. Support existing neighborhood models and foster peer-support models for physical activity among NHPI and Filipino adults and children.

Health Status and Specific Disease Areas

1. Reduce Hepatitis B rates in the AA and NHPI population by increased screening and vaccination among adolescents and adults. Since July 1, 1999, all California students entering the 7th grade are required to be immunized against Hepatitis B. Outreach, screening, and vaccination to AAs and NHPs must continue to protect California’s population against this infectious disease.
2. Reduce tuberculosis (TB) rates among AA immigrant groups, particularly among immigrants from the Philippines and Vietnam, by supporting county efforts in health education, surveillance, and prevention and control programs.
3. Continue to support counties, community and provider organizations that undertake education and awareness campaigns that reduce the stigma of Hepatitis B, TB, cancer, and sexually transmitting diseases, including HIV, and that promote culturally-competent prevention and control efforts.

4. Create legislation that supports the health care system in the prevention and control of diabetes, targeting NHPI and Filipino adults who have diabetes rates that are markedly higher than the state average.
5. Create policies promoting diversification of the mental health workforce to respond to the unique mental health needs and mental health access issues of AAs and NHPIs, with special attention to AA and NHPI adults who report high rates of frequent and severe mental distress.

Access to Care

1. Support culturally and linguistically appropriate patient education programs emphasizing the importance of having a regular source of care, getting an annual physical exam, and getting screened for certain cancers, Hepatitis B, and TB.
2. Continue to monitor and hold health plans accountable for implementing SB 853, the Health Care Language Access Act, which requires health plans to provide language services (translated documents and interpreters) at all points of care.
3. Support a pilot project to test a hybrid delivery system for language services, as proposed by the Medi-Cal Language Access Services Taskforce. This system would test both a broker and direct provider billing system for language service delivery.
4. Remove the five-year waiting period for newly arriving legal immigrants, which will help address health disparities and increase access to care for AAs and NHPIs.
5. Remove prohibitions against undocumented immigrants that prevent purchasing health insurance through Exchanges and create a system of coverage that serves and includes everyone.

Health Care Workforce

1. Encourage health care providers, particularly in the 14 medically underserved AA and NHPI counties, to apply for grants established by recent health care reform legislation that would fund training for culturally appropriate care and services.
2. Support workforce development and training programs that increase the availability and competency of bilingual and bicultural health professionals.
3. Encourage public health departments, clinics, and hospitals to apply for grants established by recent health care legislation that promote the use of community health workers in medically underserved areas.
4. Support the development of a statewide master plan on increasing diversity in the health care workforce.

Women's Health and Partner Violence

1. Reauthorize and fully fund the Family Violence Prevention and Services Act to allow communities to continue to provide life-saving services to victims of domestic violence and their children; funding is necessary for emergency shelters, crisis lines, counseling and advocacy. Violence prevention is necessary to meet the needs of underserved communities and break the cycle of violence.
2. Assure adequate funding for California's network of domestic violence shelters.

3. Continue to support counties, community, and provider organizations that undertake education and awareness campaigns to reduce the stigma of reporting partner violence, and promote culturally-competent prevention and treatment efforts.

Data and Research Development

1. Expand collection of subgroup data for AA and NHPI populations; require all California agencies and commissions to match current U.S. Census data categories.
2. Increase awareness among national surveillance and epidemiological study teams of the need to collect disaggregated AA and NHPI racial/ethnic data.
3. Encourage health and policy research institutions, such as the National Institutes of Health and the Centers for Disease Control and Prevention, to prioritize research and data collection on AA and NHPI subgroups.

If put into action, these recommendations would make important strides to improve health outcomes found among California's AA and NHPI populations.

INTRODUCTION

Asian Americans (AAs) and Native Hawaiians and Pacific Islanders (NHPIs) are often portrayed as model minorities who are self-sufficient and hardworking groups that experience few if any barriers to social mobility and wellness. However, this cultural stereotype masks what are often severe health disparities and social and economic disadvantages across AA and NHPI subgroups.

In this report, we evaluate the health disparities facing AAs and NHPs. We also seek to uncover the full range of cultural, linguistic, and socioeconomic adversities that contribute to the health issues faced by these populations.

This report builds on our 2009 study entitled: “The State of Asian American, Native Hawaiian and Pacific Islander Health in California Report.” The 2009 report was the first comprehensive study showing the health profile of Chinese, Filipino, Japanese, Korean, South Asian, Vietnamese, and Native Hawaiian/Pacific Islander racial/ethnic groups living in California. The 2009 report detailed the health and health care gaps and emphasized the critical need for disaggregated or individualized data for each of the AA and NHPI subgroups to fully measure health disparities.

In this 2010 health assessment report, we incorporate key issues from the 2009 report. We also provide a more comprehensive assessment of social and health system factors contributing to health disparities, and additional data by AA and NHPI subgroups. Disaggregated data for NHPI Californians by social factors using the U.S. Census data are presented for the very first time. Key health system factors such as health care coverage, usual source of care, and emergency room use are disaggregated by 17 AA subgroups and 5 NHPI subgroups in California. In addition, new data by AA and NHPI subgroups on food insecurity, sexual orientation, and sexual transmitted disease screening are reported.

A reframing of how to conceptualize and address health disparities for all is taking place. This paradigm shift is changing the cultural norms and practices for carrying out community health interventions and research to reduce and eliminate health disparities. The traditional “one size fits all” approach is not appropriate or effective in addressing the full range of cultural, linguistic, and socioeconomic adversities faced by populations of color, particularly underserved AAs and NHPIs.

We hope this report provides useful information that can be used by elected and appointed officials, community advocates, and residents to develop appropriate and effective legislation, programs, and partnerships to reduce and eliminate health disparities among AAs and NHPIs.

I. A SOCIAL HISTORY AND DEMOGRAPHIC PROFILE: WHO ARE CALIFORNIA'S ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS

A Social History

California is the home of one-third of the nation's Asian American (AA) and Native Hawaiian and Pacific Islander (NHPI) populations.¹ AA and NHPI Californians have deep roots in California. As early as 1587, Filipino sailors who were part of Spanish exploration expeditions arrived in Morro Bay. Later, AAs and NHPIs came to California seeking economic opportunities, starting with the Chinese arrivals during the Gold Rush era.² Emigrants from Japan, the Philippines, Korea and India soon followed, taking on agricultural, manufacturing, and service jobs.³ During the 1950s and 1960s, the U.S. military and Christian missionaries lured a host of NHPIs to California, promising a better quality of life than on the islands.⁴ The end of the Vietnam War in 1975 brought waves of refugees from Southeast Asia to the United States, many of whom settled in California.⁵

Today, family reunification represents the primary source of AA and NHPI immigration to California in addition to the continuing cheap labor and brain drain immigrant flows and refugee flows from regions of U.S. military engagement. At the same time, increased birth rates contribute to the fast population growth for California's AAs and NHPIs. As this report will show, AAs and NHPIs are transforming California's politics, culture, and identity.

History of Asian Americans in California

The first major wave of Asian immigrants occurred in 1852, when Chinese contract laborers arrived in San Francisco on their way to work in the Sierra Nevada gold mines. Chinese merchants also arrived to provide these miners with foods, clothing, and other materials from China.⁶ ⁷ In 1865, many Chinese miners provided cheap labor for the construction of the first transcontinental railroad. In the 19th century, Chinese immigrants branched into farming, manufacturing, and service businesses. However, the Chinese Exclusion Act of 1882 closed the door on Chinese labor immigration.

Japanese workers first came to California from 1902 to 1906 to work in the railroad industry, farming, and lumber mills, but the Gentlemen's Agreement of 1907 slowed Japanese immigration by limiting entry of Japanese laborers. In 1910, Filipino immigrants arrived in California, a dozen years after the U.S. annexed the Philippines. In the 1920s, Filipinos became California's largest group of Asian farm workers. Small numbers of Koreans and Asian Indians also entered the farming, manufacturing, and service industries during this same period. However, immigration laws such as the 1917 Asiatic Barred Zone Act and the Quota immigration laws of 1921 and 1924 further limited Asian immigration. It was not until the Immigration Act of 1965 that Asian immigration restrictions and exclusions were lifted entirely.

In the post-1965 period, open immigration policies facilitated the largest Asian immigrant waves in California's history. At the same time, the U.S. military engagement in the Vietnam War led to the

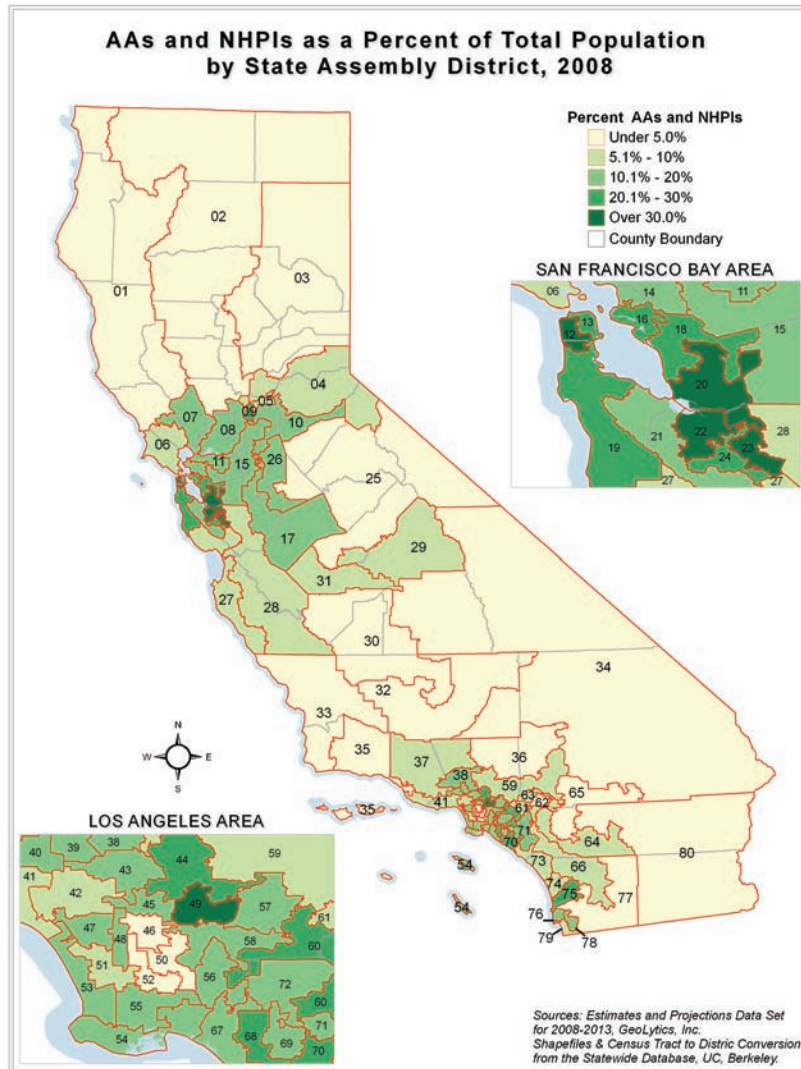
largest refugee resettlement program in American history, with major refugee waves arriving in California from Vietnam, Cambodia, and Laos. In 1960, AAs represented 2% of Californians with Japanese, Chinese, and Filipino Americans accounting for almost all of California's AA population.⁸ Today, AAs represent more than 13% of Californians with Filipinos, Chinese, Vietnamese, Asian Indians, and Koreans accounting for the largest AA subgroups.

History of Native Hawaiians and Pacific Islanders in California

Native Hawaiians and Pacific Islanders (NHPIs) arrived in California in the 1950s after World War II.⁹ ¹⁰ Post World War II military service brought Pacific Islanders from the U.S. territories of American Samoa and Guam to California. Native Hawaiians and Tongans came to California seeking economic opportunities, with many Tongans migrating to California via American Samoa. Mormon church activities also brought Tongan students and other NHPI immigrants to California. Many NHPIs initially settled in Southern California cities like Los Angeles, Long Beach, Oceanside, and San Diego, while others settled in San Francisco. Today, NHPIs represent more than 0.6% of Californians with Native Hawaiians and Samoans accounting for the largest NHPI subgroups. Most NHPI Californians today reside in the greater Sacramento, San Francisco, and Los Angeles areas.

Total AA and NHPI Populations by California State Legislative Districts

Map 1.



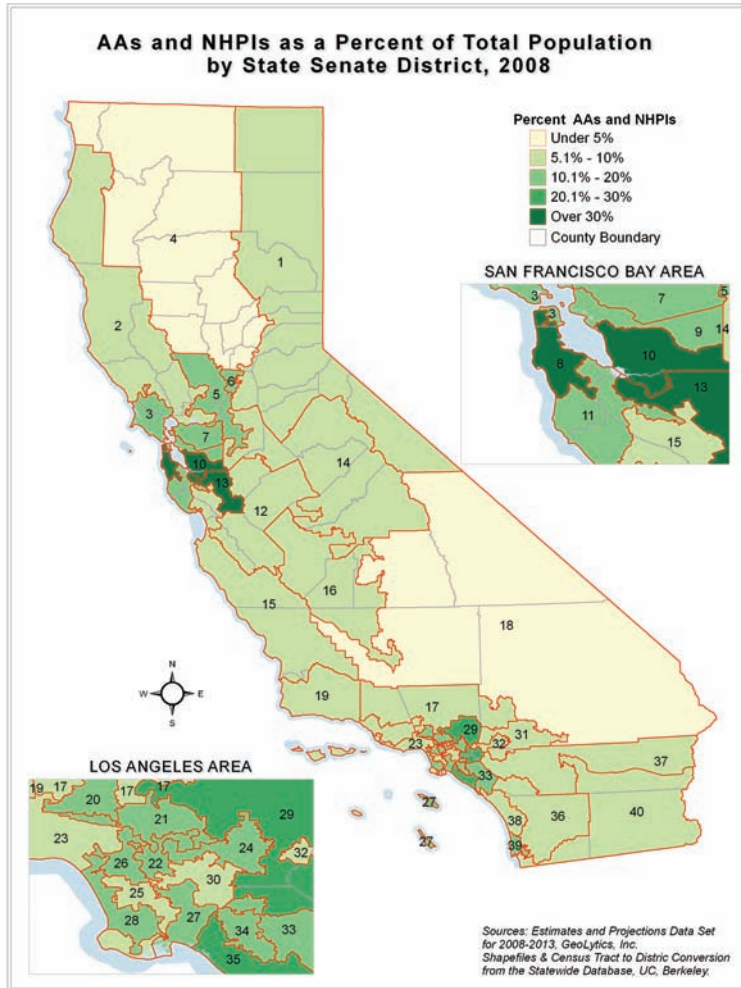
Map by Silvia Jimenez & Paul Ong

Concentrations of AAs and NHPIs by Political Districts

Asian American, Native Hawaiian and Pacific Islander (AA and NHPI) Californians are among the State's fastest growing racial/ethnic groups in California. From 1960 to 2006, AA and NHPIs grew from 2% to 14% of the total California population.¹¹ AAs and NHPIs represent one in seven Californians, are a key voting block across California's legislative districts, and are transforming the state's political landscape. The State Assembly Districts with the highest AA and NHPI concentrations in California are located in the San Francisco Bay Area and the Greater Los Angeles Area (see Map 1). Assembly Districts 12 (San Francisco/San Mateo, 46%), 20 (Alameda/Santa Clara, 43%), 22 and 23 (Santa Clara, 40% and 31% respectively), 49 (Los Angeles, 41%), 68 (Orange, 30%), and 60 (Los Angeles/ Orange/San Bernardino, 29%) have the highest proportion of AAs and NHPIs.

Assembly Districts in or surrounding San Diego County have the next highest proportion of AAs and NHPs, ranging from 10% to 21%. Generally, the further the district is from San Francisco and Los Angeles, the lower the proportion of AAs and NHPs, ranging from 2% to 21%. In districts that are farthest north and east, and in some Assembly Districts, between the Bay Area and Los Angeles, AAs and NHPs account for less than 5% of the total population. Assembly Districts 1 (2%), 52 (2%), 50 (3%), and 80 (3%) have the smallest proportion of AAs and NHPs.

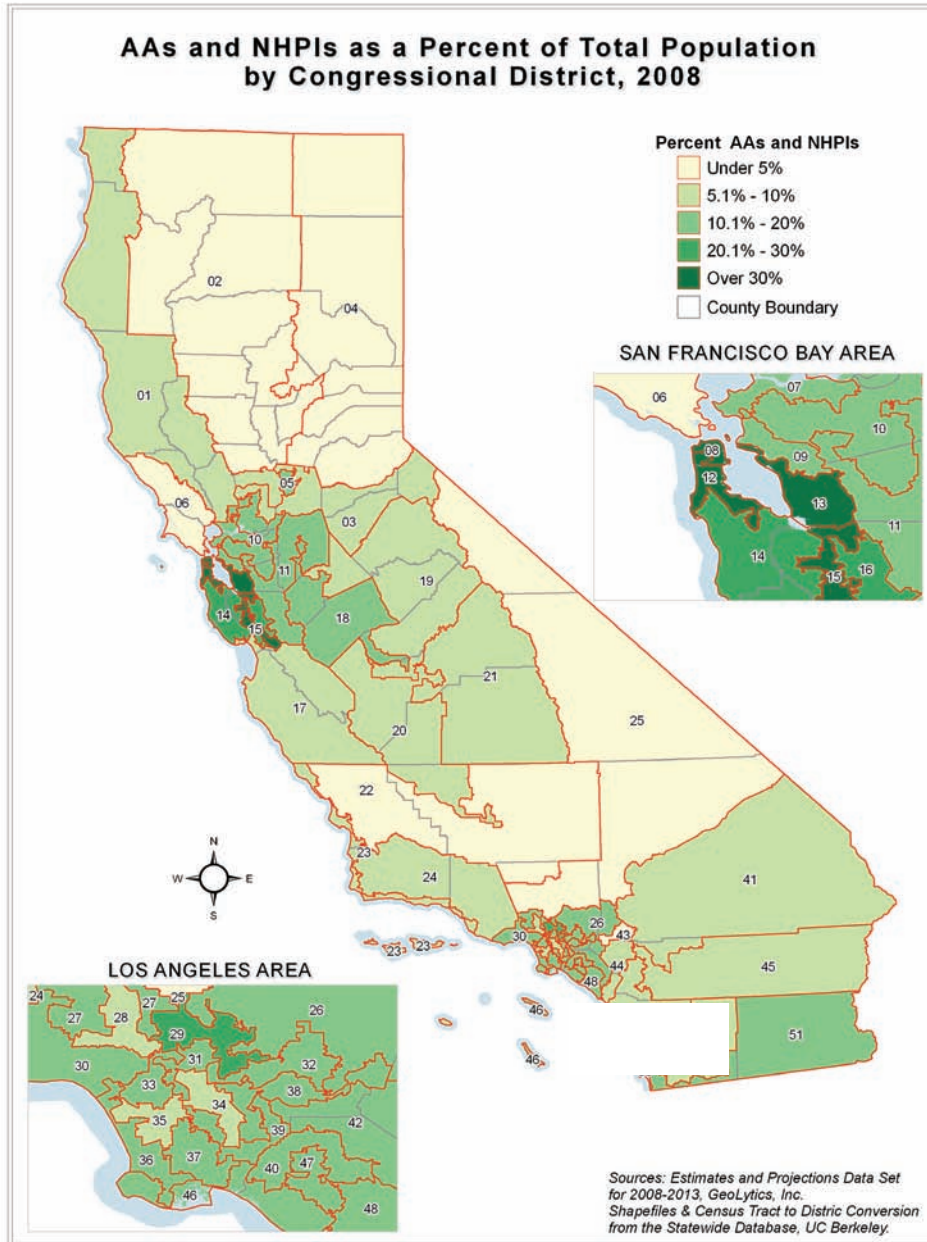
Map 2.



Map by Silvia Jimenez & Paul Ong

Similarly, as shown in Map 2, the California State Senate Districts with the largest AA and NHP concentrations are located in the San Francisco Bay and the Greater Los Angeles areas: Senate Districts 8 (San Francisco/San Mateo, 36%), 10 (Alameda/Santa Clara, 36%), 13 (Santa Clara, 32%), 9 (Alameda/Contra Costa, 19%), 29 (Los Angeles/Orange/San Bernardino, 23%), 35 (Orange, 20%), 24 (Los Angeles, 19%), and 34 (Orange, 19%) have the highest proportion of AAs and NHPs across California. A number of adjacent districts also have sizable AA and NHP populations, ranging from 6% to 18%. The remaining Senate Districts have AA and NHP populations ranging from 4% to 8%, with the smallest in Senate Districts 18 (4%), 4 (5%) and 32 (5%).

Map 3.



Map by Linda Hui, Silvia Jimenez & Paul Ong

Similar to the State Assembly and Senate Districts, the U.S. Congressional Districts with the highest proportion of AAs and NHPIs in California are located in the San Francisco Bay and the Greater Los Angeles areas. Districts 15 (Santa Clara, 36%), 12 (San Francisco/San Mateo, 34%), 13 (Alameda, 34%), 8 (San Francisco, 31%), 16 (Santa Clara, 28%), and 29 (Los Angeles, 27%) have the highest proportion of AAs and NHPIs across California (see Map 3). A number of adjacent districts also have sizable AA and NHPI populations, ranging from 5% to 20%. AA and NHPI populations in the remaining congressional districts range from 4% to 15%. The smallest proportions are in districts 4 (4%), 22 (4%), and 43 (4%).

Ethnic Breakdown

Table 1. Ethnic Composition in California

ACS 2006-2008	Alone Population	Inclusive Population
CA Total	36,418,499	--
Asian Total	4,471,394	4,915,229
Asian Indian	462,475	498,704
Cambodian	79,769	92,769
Chinese (except Taiwanese)	1,119,810	1,263,902
Filipino	1,125,864	1,324,861
Hmong	71,810	78,347
Indonesian	26,047	36,854
Japanese	274,920	405,703
Korean	427,105	471,180
Laotian	57,477	67,249
Pakistani	28,991	33,621
Taiwanese	36,560	40,594
Thai	44,824	57,180
Vietnamese	535,901	589,790
Native Hawaiian/Pacific Islander Total	132,437	206,388
Guamanian/Chamorro	24,720	35,435
Native Hawaiian	24,350	65,285
Samoan	31,949	46,770
Tongan	--	20,542
Non-Hispanic White	15,497,272	16,138,444
Black or African American	2,250,630	2,549,314
American Indian/Alaska Native	285,162	610,997
Hispanic or Latino (of any race)	--	13,160,978

The Asian American (AA) and Native Hawaiian and Pacific Islander (NHPI) population is very diverse, representing more than 50 racial/ethnic groups and 100 languages.¹² The social profile of AAs and NHPs by subgroups also differs **dramatically** by culture, language, religion, immigrant status, and socioeconomic status.^{13 14} AAs and NHPs represent over 13% and 0.6% of the total California population respectively. Filipinos represent the largest Asian subgroup (27%), followed by Chinese (26%), Vietnamese (12%), Asian Indians (10%) and Koreans (10%). Among AAs, Japanese report the highest proportion of mixed-race background. Native Hawaiians represent the largest NHPI subgroup (32%), followed by Samoans (23%) and Guamanians/Chamorros (17%). The NHPI population is comprised of many mixed race individuals. Native Hawaiians, in particular, have the highest proportion of mixed-race background.

Age, Gender, and Household Size

Age

By median age, Asian Americans (AAs) (35.7 years) are similar to the California average (34.7 years) and older than all other racial/ethnic groups except for Whites (42.0 years), while Native Hawaiians and Pacific Islanders (NHPs) (27.6 years) are younger than the California average and all racial/ethnic groups except for Latinos (26.8 years) (see Table 2). Among people younger than age 18, AAs have a lower proportion of youth (24%) than all other racial/ethnic groups except for Whites (20%).

However, a sizable proportion of people younger than age 18 are found among the Hmong (45%), Pakistanis (34%) and Laotians (31%). NHPs have a higher proportion of people younger than age 18 (33%) than all other racial/ethnic groups except for Latinos (35%), with Samoans (41%)

representing the largest NHPI subgroup with people younger than age 18, followed by Tongans (39%), Guamanians/Chamorros (32%) and Native Hawaiians (30%).

Among people age 65 or older, AAs have a higher proportion (11%) than all other racial/ethnic groups except for Whites (16%), with Japanese (16%) and Chinese (12%) having the largest proportion. NHPIs have the lowest proportion of people age 65 or older (6%) across all racial/ethnic groups except for Latinos (5%), with Tongans (8%) and Native Hawaiians (7%) having the largest proportions.

Table 2. Age, Gender and Household Size in California

ACS 2006-2008	Age			Gender	Household
	Median	% < 18	% ≥ 65	% Women	Size Average
CA Total	34.7	25.7%	11.0%	50.0%	2.92
Asian Inclusive	35.7	23.8%	10.6%	51.7%	3.15
Asian Indian	32.3	25.6%	6.7%	47.0%	3.16
Cambodian	26.3	30.6%	6.5%	52.2%	4.18
Chinese except Taiwanese	38.2	21.7%	12.4%	52.1%	2.99
Filipino	35.4	25.2%	10.4%	52.9%	3.50
Hmong	19.9	45.3%	4.1%	50.5%	5.39
Indonesian	34.0	23.9%	7.4%	53.3%	3.01
Japanese	39.1	22.9%	15.6%	54.1%	2.36
Korean	36.1	22.8%	10.7%	52.8%	2.75
Laotian	27.8	30.9%	6.4%	48.0%	4.44
Pakistani	28.9	33.8%	3.7%	44.3%	3.50
Taiwanese	36.2	17.3%	9.5%	52.2%	2.80
Thai	35.2	20.6%	5.3%	55.7%	2.93
Vietnamese	35.5	24.4%	9.0%	50.8%	3.57
Native Hawaiian/Pacific Islander Inclusive	27.6	32.8%	5.9%	50.1%	3.47
Guamanian/Chamorro	28.1	31.9%	5.5%	49.9%	3.24
Native Hawaiian	29.5	30.3%	6.7%	49.0%	2.82
Samoan	22.9	40.8%	4.0%	51.3%	4.72
Tongan	22.7	39.4%	7.6%	52.7%	4.49
Non-Hispanic White	42.0	19.6%	16.0%	50.4%	2.43
Black or African American	30.7	30.0%	8.4%	50.7%	2.63
Indian/Alaska Native	32.3	27.9%	7.9%	49.9%	2.86
Hispanic or Latino (of any race)	26.8	34.8%	5.1%	48.7%	3.89

Gender

By gender, AAs and NHPIs have similar proportions of women compared to the state average. The greatest proportion of AA women is found among Thais (56%) and Japanese (54%), while the smallest proportion of AA women is found among Pakistanis (44%) and Asian Indians (47%). Among NHPI subgroups, Samoans have the highest proportion of women (51%), while Native Hawaiians have the lowest (49%).

Household Size

The average household size for AAs (3.15 persons) and NHPIs (3.47 persons) is larger than the state average

(2.92 persons) and larger than that of all other racial/ethnic groups except for Latinos (3.89 persons). Among AA subgroups, however, Hmong (5.39 persons) and Laotians (4.44 persons) have the largest average household size and Japanese (2.36 persons) and Koreans (2.75 persons) have the smallest. Among NHPI subgroups, Samoans (4.72 persons) and Tongans (4.49 persons) have the largest average household size and Native Hawaiians (2.82 persons) have the smallest.

Immigration, Naturalization, and Language

Immigration

Many more Asian Americans (AAs) (60%) were born outside the U.S. than Californians as a whole (27%). (See Table 3.) Taiwanese (71%) have the most foreign-born, followed by Asian Indian (69%), Korean (68%), and Indonesian (67%). Japanese (30%) have the fewest foreign-born. A substantial proportion of Native Hawaiians and Pacific Islanders (NHPIs) (20%) were born outside the U.S. compared to other groups except for AAs and Latinos (41%). Tongans (46%) have the largest NHPI foreign-born population.

Table 3. Foreign Born, Naturalization & English Proficiency

ACS 2006-2008	Foreign Born	Naturalization Rate of Foreign Born	Limited English Proficiency
CA Total	27.1%	43.8%	19.9%
Asian Inclusive	60.2%	61.9%	35.2%
Asian Indian	69.3%	47.2%	23.7%
Cambodian	55.9%	59.9%	46.1%
Chinese except Taiwanese	62.3%	67.5%	43.7%
Filipino	56.8%	65.2%	20.0%
Hmong	43.9%	52.9%	49.2%
Indonesian	66.5%	40.7%	32.2%
Japanese	29.5%	36.2%	20.0%
Korean	67.8%	53.1%	49.3%
Laotian	57.6%	57.2%	43.1%
Pakistani	63.3%	65.7%	25.2%
Taiwanese	70.7%	74.8%	45.4%
Thai	64.4%	53.4%	42.4%
Vietnamese	66.4%	76.9%	52.6%
Native Hawaiian/Pacific Islander Inclusive	19.9%	51.5%	10.4%
Guamanian/Chamorro	6.1%	64.3%	6.5%
Native Hawaiian	2.3%	75.7%	2.1%
Samoan	11.1%	49.5%	11.9%
Tongan	46.3%	32.8%	21.8%
Non-Hispanic White	8.6%	62.4%	3.2%
Black or African American	5.9%	49.8%	2.2%
American Indian/Alaska Native	8.2%	36.5%	8.0%
Hispanic or Latino (of any race)	40.6%	28.9%	38.8%

Naturalization

The naturalization rate of foreign-born AAs is much higher (62%) than the California average (27%) and higher than most racial/ethnic groups, and is equivalent to that of foreign-born Whites (62%). By AA subgroups, foreign-born Vietnamese (77%) have the highest naturalization rates, followed by Chinese (68%) and Pakistani (66%). Foreign-born NHPIs have a substantially higher naturalization rate (52%) than most racial/ethnic groups except for AAs and Whites, with the highest among Native Hawaiians (76%) and Guamanians/Chamorros (64%).

Language

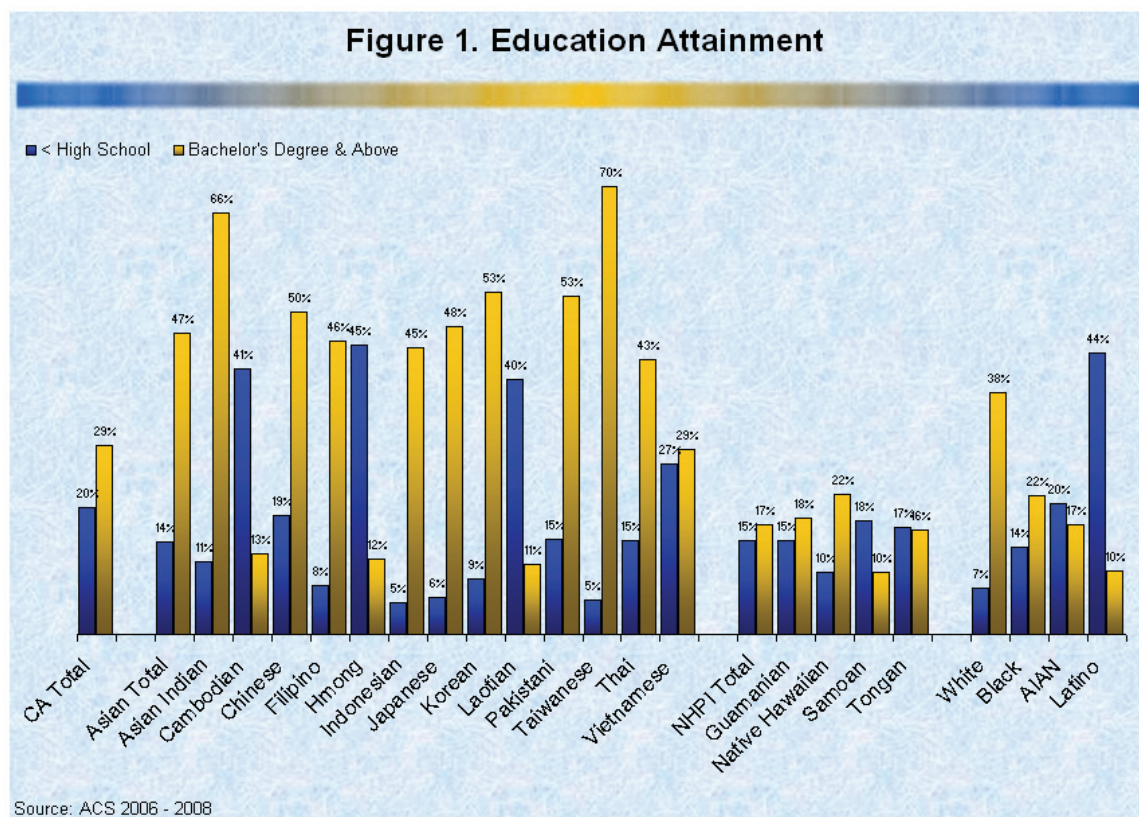
More AAs (35%) have limited English proficiency (LEP) than the state average (20%) and most other racial/ethnic groups except for Latinos (39%). Vietnamese (53%) have the highest proportion of LEP, followed by Korean (49%), Hmong (49%) and

Chinese (46%). NHPIs also have high proportion of LEP (10%) compared to other racial/ethnic groups except for AAs and Latinos. Among NHPI subgroups, Tongans (22%) have the highest proportion of LEP.

Education, Occupation, and Other Economic Indicators

Education

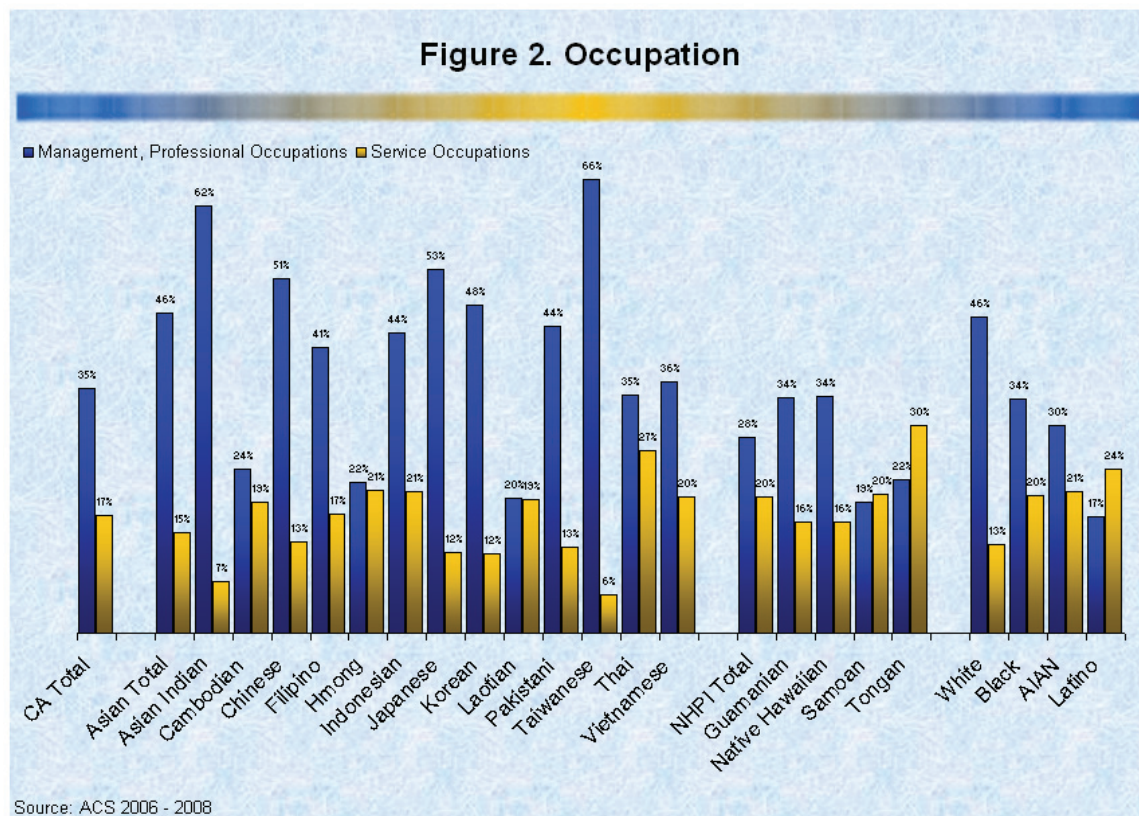
At first glance, the educational attainment of Asian Americans (AAs) appears to be higher than the California average, while that of Native Hawaiians and Pacific Islanders (NHPs) appears to be lower (see Figure 1). More AAs (47%) have earned at least a bachelor's degree compared to the state average (29%), and fewer AAs (14%) have not completed high school compared to the California average (20%). However, although more AAs have completed college than Whites (38%), there are more AAs without a high school diploma than Whites (7%).



There are severe disparities in educational attainment for specific AA subgroups. Taiwanese (70%) have the highest college graduation rate, followed by Asian Indians (66%), Koreans (53%), Pakistanis (53%), and Chinese (50%). However, Laotians (11%) have the lowest college graduation rates, followed by Hmong (12%) and Cambodians (13%). The Hmong have the highest high school incompleteness rate (45%), followed by Cambodians (41%), Laotians (40%), and Vietnamese (27%). The AA subgroups with the lowest high school incompleteness rates are Indonesians (5%), followed by Taiwanese (5%), Japanese (6%), and Filipinos (8%).

Fewer NHPs (17%) earned at least a bachelor's degree compared to the state average and Whites, and more NHPs (15%) have not completed high school compared to the California average and Whites. Although the NHP high school attainment rate is similar to that of AAs, fewer NHPs hold at least a bachelor's degree. By NHP subgroups, Native Hawaiians have the highest rate of college graduates (22%) and the lowest rate of individuals not completing high school (10%). Samoans have the lowest proportion of college graduates (10%) and the largest proportion of those who have not completed high school (18%).

Occupation



The types of occupation in Figure 2 show that AAs (46%) exceed the state average (35%) of Californians who hold managerial and professional occupations, while NHPIs (28%) are below the state average. Fewer AAs (15%) are in service occupations than the average Californian (17%), while more NHPIs (20%) are in service occupations than the state average. Asian Americans' rates are comparable to the proportion of White Californians in management (46%) and in service jobs (13%), while NHPIs' rates are comparable to American Indian/Alaska Native Californians in management (30%) and in service jobs (21%).

There are large disparities by occupation for specific AA and NHPI subgroups. Taiwanese (66%) have the highest proportion in management and professional occupations, followed by Asian Indians (62%), Japanese (53%), and Chinese (51%). Laotians (20%) have the lowest proportion in management positions, followed by Hmong (22%) and Cambodians (24%). The largest AA subgroups in service professions are Thai (27%), Hmong (21%), and Indonesians (21%). Taiwanese (6%) and Asian Indians (7%) have the lowest proportion in service professions.

Among NHPI subgroups in management and service jobs, Native Hawaiians (34%) and Guamanians/Chamorros (34%) have the highest percentage holding management jobs, while Samoans (19%) and Tongans (22%) have the lowest percentage in management jobs. Tongans (30%) have the highest percentage in service jobs, while Native Hawaiians and Guamanians /Chamorros have the lowest percentage in service jobs (both 16%). Samoans hold similar types of occupations (19% in managerial, 20% in service) as some Southeast Asian groups, particularly Laotians, Hmong, and Cambodians.

Other Economic Factors

Table 4. Other Economic Indicators

ACS 2006-2008	Per Capita Income	Below Poverty	Labor Force Participation	Unemployed
CA Total	\$29,405	12.9%	64.8%	4.4%
Asian Inclusive	\$29,984	9.7%	64.1%	3.7%
Asian Indian	\$40,566	5.9%	68.4%	3.6%
Cambodian	\$14,325	24.7%	57.3%	6.3%
Chinese except Taiwanese	\$32,690	10.4%	62.4%	3.2%
Filipino	\$27,155	5.5%	68.9%	4.1%
Hmong	\$10,186	29.4%	58.3%	7.1%
Indonesian	\$26,626	8.4%	66.7%	3.8%
Japanese	\$35,780	8.3%	61.1%	2.9%
Korean	\$29,028	11.9%	59.5%	3.5%
Laotian	\$14,909	14.5%	60.5%	6.6%
Pakistani	\$25,434	14.5%	65.3%	6.1%
Taiwanese	\$41,170	8.5%	62.6%	2.8%
Thai	\$24,103	13.5%	65.4%	3.4%
Vietnamese	\$23,815	13.6%	62.1%	3.8%
Native Hawaiian/Pacific Islander Inclusive	\$21,281	11.4%	67.6%	5.6%
Guamanian/Chamorro	\$23,393	11.8%	69.4%	4.4%
Native Hawaiian	\$26,066	8.7%	70.0%	5.3%
Samoan	\$15,882	11.8%	64.6%	6.2%
Tongan	\$11,686	21.3%	58.0%	8.5%
Non-Hispanic White	\$40,891	8.1%	63.6%	3.6%
Black or African American	\$21,673	19.7%	61.3%	7.3%
American Indian/Alaska Native	\$22,520	16.0%	62.0%	6.6%
Hispanic or Latino (of any race)	\$15,992	18.7%	67.6%	5.4%

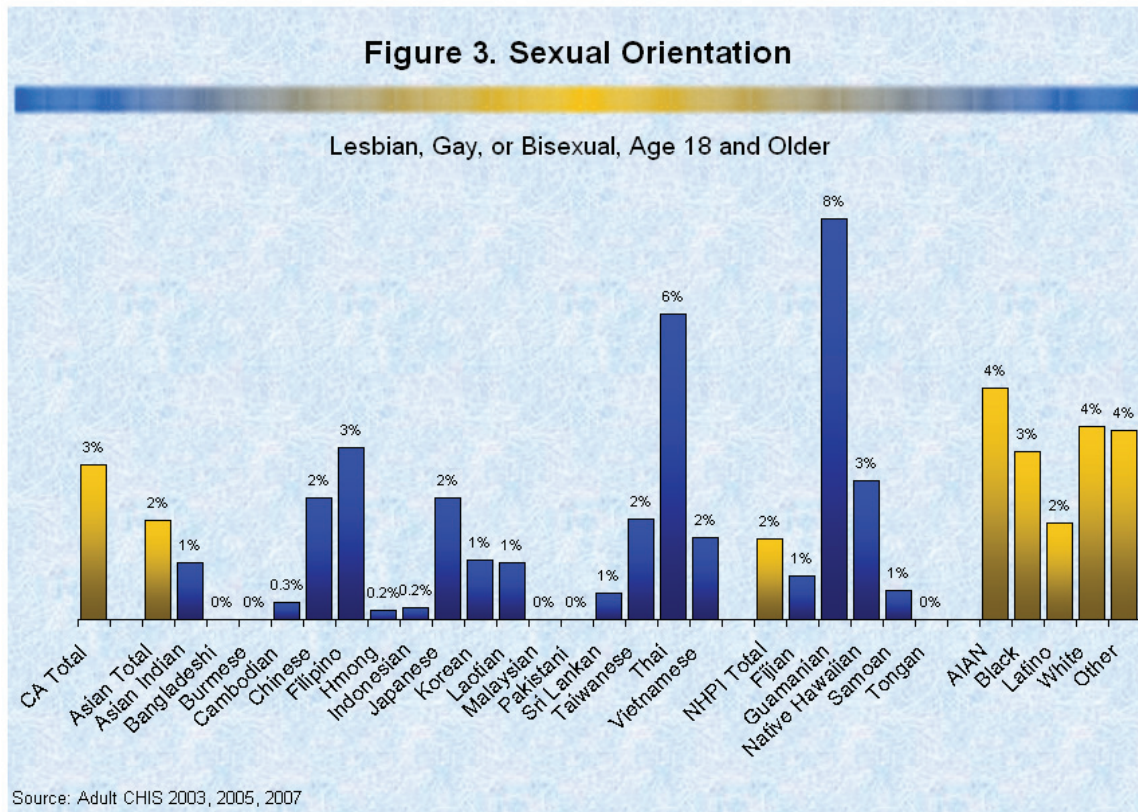
Overall measures of socioeconomic status in Table 4 show that the per capita income and unemployment rates of AAs (\$29,984 and 4%) are similar to the California averages (\$29,405 and 4%), and the poverty rate is slightly lower than the state average (10% vs. 13%). NHPIs have lower per capita income (\$21,281), lower poverty rates (11%) and higher unemployment rates (6%) than the state average. AAs have lower per capita income, higher poverty, and similar unemployment rates as Whites (\$40,891; 8%; 4%), while NHPIs have much lower per capita income, higher poverty, and higher unemployment rates. By subgroup, there are severe economic

disparities. Taiwanese (\$41,170) and Asian Indians (\$40,566) have the highest per capita income – similar to Whites. The Hmong, Cambodians, and Laotians, however, have the lowest per capita income and the highest poverty and unemployment rates: Hmong (\$10,186; 29%; 7%), Cambodians (\$14,325; 25%; 6%), Laotians (\$14,909; 15%; 7%). The Hmong, Cambodians, and Laotians have similar economic profiles to Blacks, American Indians/Alaska Natives, and Hispanic/Latinos. The lowest poverty rates are found among Filipinos (6%), Asian Indians (6%), and Japanese (8%), and the lowest unemployment rates among Taiwanese (3%), Japanese (3%), and Chinese (3%). Filipinos interestingly have the highest labor force participation rate and lowest poverty rate, but only moderate per capita income compared to other AA subgroups.

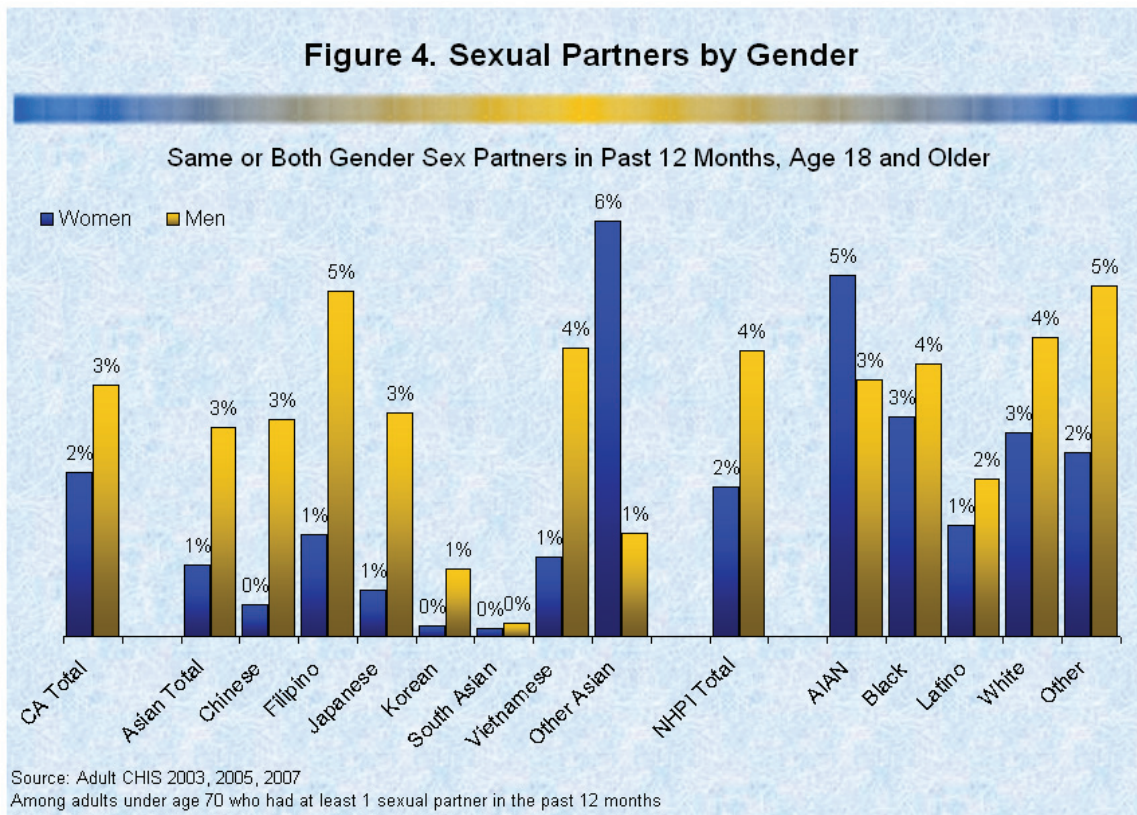
Among NHPI subgroups, Native Hawaiians and Guamanians/Chamorros have the highest per capita income and lowest poverty and unemployment rates: Native Hawaiians (\$26,066; 9%; 5%) and Guamanians/Chamorros (\$23,393; 12%; 4%). However, very low per capital income levels as well as high poverty and unemployment rates are found among both Tongans (\$11,686; 21%; 9%) and Samoans (\$15,882; 12%; 6%), similar to many of the Southeast Asian subgroups.

Sexual Orientation and Same Sex Partners

Little is known about sexual orientation and same sex couples among Asian Americans (AAs) and Native Hawaiians and Pacific Islanders (NHPIs) in California, although patterns of partner selection have substantially shifted across California over the past few decades. Sexual orientation and same sex partners have important implications for health care access and utilization, and for health status in general. By sexual orientation (see Figure 3), AA (2%) and NHPI (2%) adults in California appear to have slightly lower rates of lesbian, gay or bisexual orientation than the California average (3%) and Whites (4%). However, by AA and NHPI subgroups, Guamanians (8%), Thais (6%), and Filipinos (3%) report the highest proportion of lesbian, gay, or bisexual populations.



The percentages of AAs and NHPIs who had same sex partners over the past 12 months were similar to the California average and slightly lower than the percentages for Whites (see Figure 4). By gender, more AA and NHPI men (3% and 4%) have same sex partners than women (1% and 2%), which is similar to all racial/ethnic groups except for American Indians/Alaska Natives. Among Other Asians, substantially more women than men (6% vs. 1%) had same sex partners in the past 12 months than all other racial/ethnic groups.



For same sex households, no California data are currently available. The little existing national data on AA same sex couples indicate that the average age for individuals in Asian same sex couple households was mid-40s with two Asian partners, and younger where one of the partners was non-Asian (see Table 5).¹⁵

Table 5. Asian Same Sex Households in the U.S.

ACS 2005-2007	Age	Gender	Education	English-speaking Ability	English		Foreign Born	Hourly Wage
	Average	% Men	Average # of Years	Not well	Well or Very Well	English Only	%	Average
Asian-Asian Household								
Head of Household	47.7	53%	14.1	21%	67%	12%	84%	\$26.85
Partner	45.8	52%	13.7	25%	64%	12%	88%	\$18.98
Asian-Non-Asian Household								
Head of Household	39.6	55%	15.9	2%	35%	63%	53%	\$36.50
Partner	41.6	65%	14.3	2%	52%	46%	81%	\$23.35

When one individual was non-Asian, there was higher educational attainment, English proficiency, and higher wages for the household head and sometimes for partners compared to same sex couple households with two Asian partners (household head and partner). The average education attainment level was higher for heads of household (15.9 years) and partners (14.3 years) when at least one individual was non-Asian, compared to households with two Asian partners. English language capacity was higher in same sex couple households where one individual was non-Asian. The highest average hourly wage was reported by heads of households (\$36.50) where one individual was non-Asian. The heads of same sex couple households where both partners were

Asian (\$26.85) reported earnings similar to the partners in same sex couple households where one partner was non-Asian (\$23.35).

The smallest proportion of foreign-born individuals were heads of households (53%) where one of the individuals was non-Asian. The proportions of immigrants were larger in same sex couple households where both the heads of household (84%) and partners (88%) were Asian, and for the partners (81%) where one partner was non-Asian.

II. ENVIRONMENTAL CONTEXTS OF HEALTH: ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER COMMUNITIES AND HEALTH CARE INFRASTRUCTURE

Medically Underserved Counties

Map 4.



The national Medically Underserved Area (MUA) index has been used to determine resource allocations across the federal system of community health centers, but has not been updated since the 1970s and therefore does not adequately capture the diverse underserved people of color. The MUA index took into account the area's poverty rate, infant mortality rate, percentage of population aged 65 years and older, and P-to-1,000P ratio. However, the MUA index neglected to include the key indicators that most directly relate to AAs and NHPIs' unique barriers in accessing health care. The Medically Underserved Asian American, Native Hawaiian, and Pacific Islander Counties (MUAC)

Index¹⁶ was recently developed to highlight the flaws of the MUA index as well as identify medically underserved AA and NHPI areas. The indicators of the MUAC index incorporated relevant indicators for AA and NHPIs with data available across counties nationally and also included percentage of the area's population that is AA and NHPI, AA and NHPI poverty rate, AA and NHPI limited English

proficiency (LEP) rate, and the number of primary care physicians per 1,000 population (P-to-1,000P). Fourteen Medically Underserved Asian American, Native Hawaiian, and Pacific Islander Counties (MUACs) were identified in California (see Map 4), with Glenn, Merced, Butte, Fresno, and Yuba Counties in the top five. Most MUACs were located in the rural regions of Northern and Central California where concentrations of underserved Asian Americans (AAs) reside, particularly Southeast Asians. Thirteen of these 14 counties were not captured by the HRSA Bureau of Primary Health Care’s (BPHC) MUA designation. Glenn County was the only one that also fulfilled BPHC’s MUA criteria. The MUAC index can be used to identify the areas in California and the U.S. where underserved AAs and Native Hawaiians and Pacific Islanders (NHPIs) lack access to primary health care and support the health care reform efforts to expand the reach of the safety net health centers. Future work to identify primary care delivery gaps among AAs and NHPIs will need to further examine geographic and racial/ethnic differences by disaggregated AA and NHPI populations in addition to considering AA and NHPI community health relevant indicators.

Health Care Workforce

Table 6. AA and NHPI Languages Spoken by Licensed Physicians and Primary Languages Spoken at Home ^{17 18}

AA and NHPI Languages Spoken by Physicians	CA Total	AA and NHPI Primary Languages Spoken at Home	CA Total
Hindi	7,998	Chinese	926,918
Mandarin	7,829	Tagalog	706,785
Tagalog	4,654	Vietnamese	460,203
Vietnamese	3,933	Korean	347,778
Cantonese	3,781	Japanese	143,291
Korean	3,087	Hindi	123,797
Punjabi	2,892	Mon-Khmer, Cambodian	68,455
Other Chinese	2,692	Hmong	67,522
Japanese	1,137	Thai	41,448
Thai	819	Gujarati	39,733
Ilocano (Philippines)	593	Urdu	36,151
Hmong	194	Laotian	35,153
Samoan	162	Other Asian languages	114,726
Cambodian	146	Other Pacific Island languages	115,226
Lao	142	Other Indic languages	150,356
Mien (Laos, Vietnam, Thailand, China)	61	Total	33,748,857

A linguistically and culturally proficient healthcare workforce is vital to serve diverse Asian American (AA) and Native Hawaiian and Pacific Islander (NHPI) Californians. Among California’s physicians, the top five AA and NHPI languages spoken by California’s licensed physicians are Hindi (7,998), Mandarin (7,829), Tagalog (4,654), and

Vietnamese (3,933) (see Table 6). The five AA and NHPI languages that physicians speak least are Mien (61), Lao (142), Cambodian (146), Samoan (162), and Hmong (194).

By primary languages spoken at home in California by AA and NHPI subgroups, Chinese (926,918) including Cantonese, Mandarin and other Chinese languages is the largest language group followed by Tagalog (706,785), Vietnamese (460,203), and Korean (347,778). By primary languages spoken at home, some of the major AA language groups without any or with an inadequate number of physicians who can speak their primary languages include Cambodian, Hmong, Thai, Gujarati, Urdu, and Laotian. In addition, few California physicians speak the languages of such limited English proficient Southeast Asian populations as the Hmong (49%), Cambodians (46%), and Laotians (43%), and the few physicians who do speak these languages may serve a region different from the AA and NHPI communities that need language access to healthcare.

Ethnic concordance also plays a vital role to healthcare access and providing culturally relevant patient-centered care. Among physicians and registered nurses, it appears ethnic concordant AA physicians (4.4 per 1,000 population) and registered nurses (11 per 1,000 population) are well represented in the healthcare workforce compared to the state average (2.3 physicians per 1,000; 5.9 nurses per 1,000) and Whites (2.6 physicians per 1,000; 6.1 nurses per 1,000).¹⁹

The increasing presence of AAs and NHPs across a variety of disciplines in California’s healthcare system is fulfilling market needs for health care workers and is a major asset to California’s health care system. AAs and NHPs are by far the fastest growing and among the largest health professional groups by race (see Table 7).²⁰ From 2003 to 2007, AAs and NHPs together accounted for almost two-thirds of all pharmacy school graduates (63%), the largest across all racial/ethnic groups. From 2003 to 2007, AAs and NHPs represented over one-third of the California’s dental school graduates (36%), more than any other racial/ethnic group except for Whites (41%). In 2008, AA and NHP physicians active in practice was estimated to represent over one-quarter (26%) of this physician workforce, more than all other racial/ethnic groups except for Whites (62%). From 2001 to 2008, AAs accounted for 25% of California’s new U.S. Citizen public health students, more than all other racial groups except for Whites (47%). From 2000 to 2008, Asians accounted for 28% of new nursing school enrollees, more than any other racial/ethnic groups except for Whites (44%).

However, for NHPs and specific AA subgroups, ethnic concordance between health providers and patients is very low. NHPs physicians (0.7 per 1,000) and nurses (4.2 per 1,000) were far below the state average for health providers per 1,000 population. Laotians (0 physicians per 1,000; 1.4 nurses per 1,000), Cambodians (0.4 physicians per 1,000; 1.2 nurses per 1,000), and Hmong (0.5 physicians per 1,000; 0.4 nurses per 1,000) have the lowest ratio of physicians and nurses per 1,000 population compared to all other racial/ethnic groups. California physicians and nurses are severely underrepresented from Southeast Asian and NHP subgroups.

Table 7. Healthcare Professionals in California

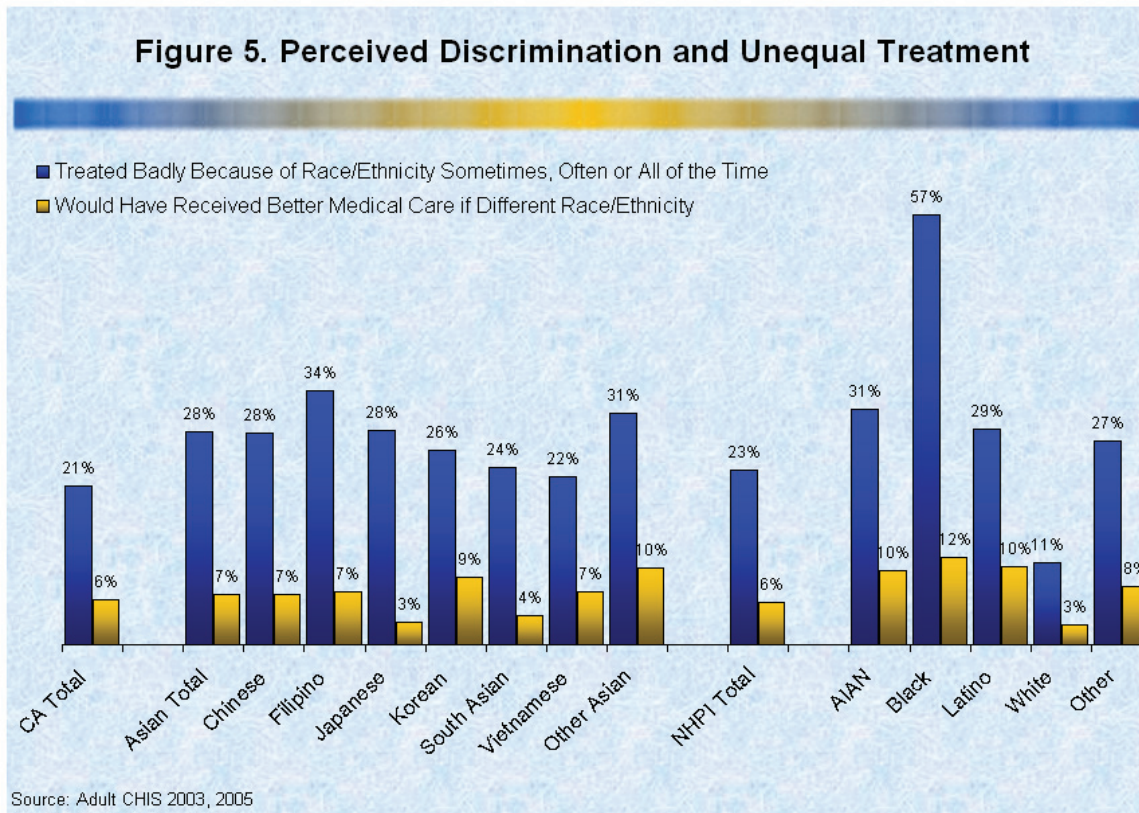
	Physicians Grumbach et al. 2008 ²¹	Dental School Graduates 2003-2007 CPEC 2009	New Registered Nursing Students 2000-2008 BRN 2009	Pharmacy School Graduates 2003-2007 CPEC 2009	U.S. Citizen Public Health School Entrants 2001-2008 ASPH 2009
AA and NHP	26.4%	35.6%	-	63.1%	-
Asian	-	-	27.9%	-	24.8%
Filipino	-	0.8%	13.7%	1.6%	-
White	61.7%	41.2%	43.5%	24.0%	47.2%
Black or African American	3.2%	1.3%	7.7%	1.7%	7.6%
American Indian/Alaska Native	0.6%	0.2%	0.8%	0.2%	0.8%
Hispanic or Latino	5.2%	4.0%	19.5%	4.6%	10.2%

NOTE: ASPH = Association of Schools of Public Health; BRN = Bureau of Registered Nursing; CPEC = California Postsecondary Education Commission;

Perceived Discrimination by Race/Ethnicity

Racial discrimination is a key environmental risk factor that has major impacts on health-related quality of life²² and health care access²³ for Asian Americans (AAs) and Native Hawaiians and Pacific Islanders (NHPs) in California. Those who experience discrimination may face more stress, leading

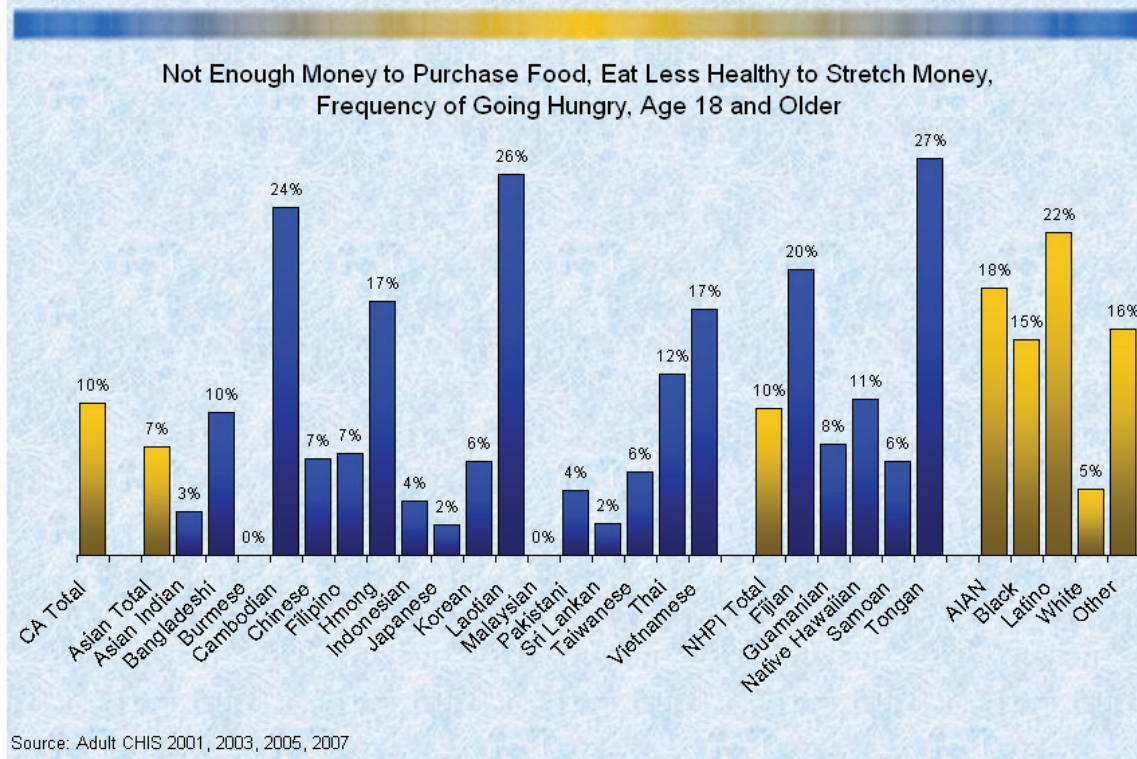
to diminished well-being. AAs (28%) and NHPs (23%) reported being treated badly because of race or ethnicity at least “sometimes”, “often”, or “all of the time”, more often than the California average (21%) and substantially more often than Whites (11%) (see Figure 5). Among AA subgroups, Filipinos (34%) reported the highest rates of perceived discrimination, followed by Japanese (28%) and Chinese (28%). These rates are similar to that of AIANs (31%) and Latinos (29%). In the medical care setting, AAs (7%) and NHPs (6%) believed that they would have received better medical care if they were a different race or ethnicity, at rates that were similar to the California average (6%) and substantially higher than Whites (3%). Among AA subgroups, Other Asians (10%) and Koreans (9%) reported the highest levels of perceived unequal treatment, almost as high as Blacks (12%), American Indians/Alaska Natives (10%), and Latinos (10%).



Food Consumption

Food consumption patterns affect the health and well-being of all Californians every day. Food insecurity, in particular, is a major social health challenge among underserved Californians. Food insecurity was measured using a scale based on questions about not having enough money to purchase food, eating less healthy or smaller meals to stretch limited money, and frequency of going hungry. Asian Americans (AAs) (7%) were below the California average (10%) and higher than Whites (5%) for food insecurity, while Native Hawaiians and Pacific Islanders (NHPs) (10%) were similar to the state average and double the rate of Whites (see Figure 6). Among AA subgroups, Laotians (26%) and Cambodians (24%) reported the highest rates of food insecurity. Among NHP subgroups, Tongans had the highest rate (27%) – higher than any other racial/ethnic group. Burmese and Malaysians did not report any food insecurity.

Figure 6. Food Insecurity



Among older adults, AAs (2.2 times) and NHPIs (1.3 times) aged 65 years and older reported higher rates of food insecurity than the statewide average, and AAs aged 65 years and older were the only racial/ethnic group for whom more reported food insecurity than those who were younger (13% vs. 7%) (see Figure 7). Further, Vietnamese (4.5 times) and Koreans (3.2 times) aged 65 years and older reported the highest rates of food insecurity across all racial/ethnic groups. The results indicate that some AA and NHPI elders face serious food security issues with not enough money to purchase food, eating less healthy to stretch their money, and going hungry.

Negative food consumption and associated dietary behaviors such as fruit and vegetable consumption have been linked to obesity and chronic conditions.^{24 25} By fruit consumption per week, AAs (8 times) and NHPIs (9 times) reported similar rates as the California average (8 times) and other major racial/ethnic groups (7 to 8 times) (see Figure 8). However, all groups fall below the federal recommended guidelines of two servings of fruit of day (i.e., 14 servings per week). By AA subgroups, Indonesian (5 times) and Hmong (5 times) reported the lowest rates of fruit consumption among all racial/ethnic groups, while Malaysians (12 times) and Taiwanese (9 times) reported the highest rates of fruit consumption. By NHPI subgroups, Fijians (14 times) reported the highest average fruit consumption per week followed by Samoans (10 times).

Fast food consumption also impacts the everyday health of AA and NHPI communities. AA adults (1.2 times) consumed less fast food weekly than the California average (1.5 times) and were similar to Whites (1.2 times), while NHPI adults (1.5 times) consumed fast food at similar rates as the California average (see Figure 9). Among AA subgroups, Other Asians (1.7 times) and Filipinos (1.5 times) reported the highest rates of fast food consumption while Chinese (1.0 time) and Koreans (1.0 time) reported the lowest rates. Comparing adults with adolescents, most adolescents (age 12 to 17 years old) across racial/ethnic groups consumed more fast food than adults. AA adolescents

(1.6 times) consumed slightly less than the California average (1.8 times) and were similar to Whites (1.6 times), while NHPI adolescents (2.4 times) consumed the most fast food compared to the state average and all racial/ethnic groups, and were similar to the American Indian/Alaska Native rates (2.4 times). Among AA subgroups, Filipino (1.9 times) and Korean (1.8 times) adolescents reported the highest fast food consumption rates while Vietnamese (1.2 times) and South Asian (1.3 times) adolescents reported the lowest rates.

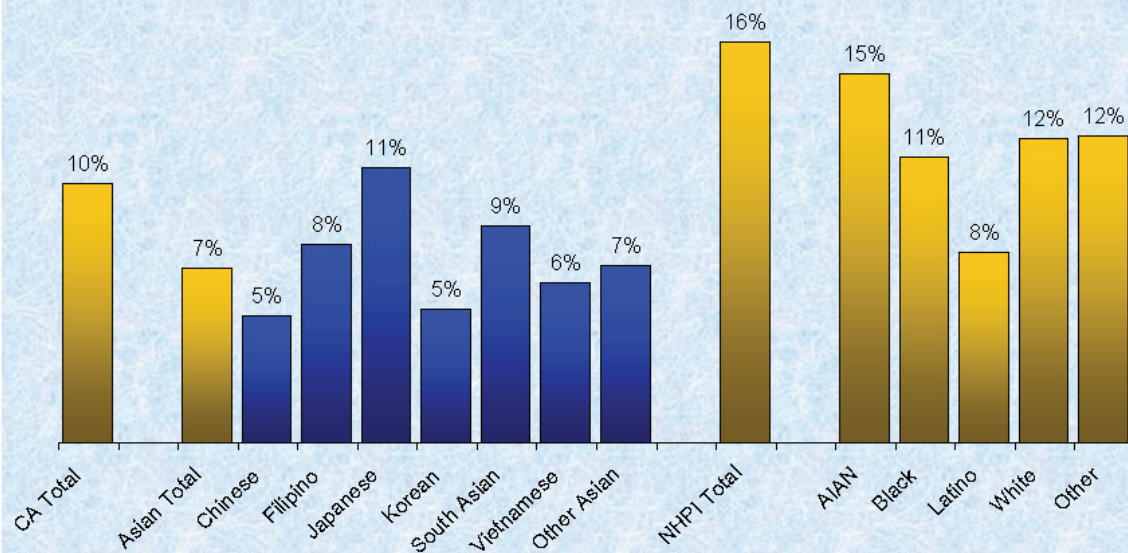
Neighborhood Health

In addition to the food environment, neighborhood cohesion, stability, and safety are vital to cultivating healthy communities. Looking at familiarity among neighbors, fewer Asian Americans (AAs) (7%) reported that they strongly agree that people in their neighborhood know each other than the California average (10%) and all other racial/ethnic groups, while Native Hawaiians and Pacific Islanders (NHPIs) (16%) reported the highest rates of familiarity with neighbors than the state average and all other racial/ethnic groups (see Figure 10). By AA subgroups, Chinese (5%), Koreans (5%), and Vietnamese (6%) had the lowest rates of strongly agreeing that people in their neighborhood know each other, indicating lower neighborhood social interaction, while Japanese (11%) and South Asians (9%) had the highest reported rates of neighbor familiarity.

By average length of residence, AAs (98 months or 8.2 years) and NHPIs (97 months or 8.1 years) resided in their current residence for fewer months on average in comparison to the California average (115 months or 9.6 years) and Whites (135 months or 11.3 years) (see Figure 11). Overall, AAs and NHPIs experienced similar residential instability as Latinos, and more instability than White, Black, and American Indian/Alaska Native groups. By AA subgroups, the Hmong (33 months or 2.8 years) experienced the most residential instability, while Japanese (183 months or 15.3 years) experienced the least. By NHPI subgroups, Samoans (68 months or 5.7 years) experienced the most residential instability while Guamanians/Chamorros (99 months or 8.3 years) experienced the least.

Figure 10. Knowing Neighbor

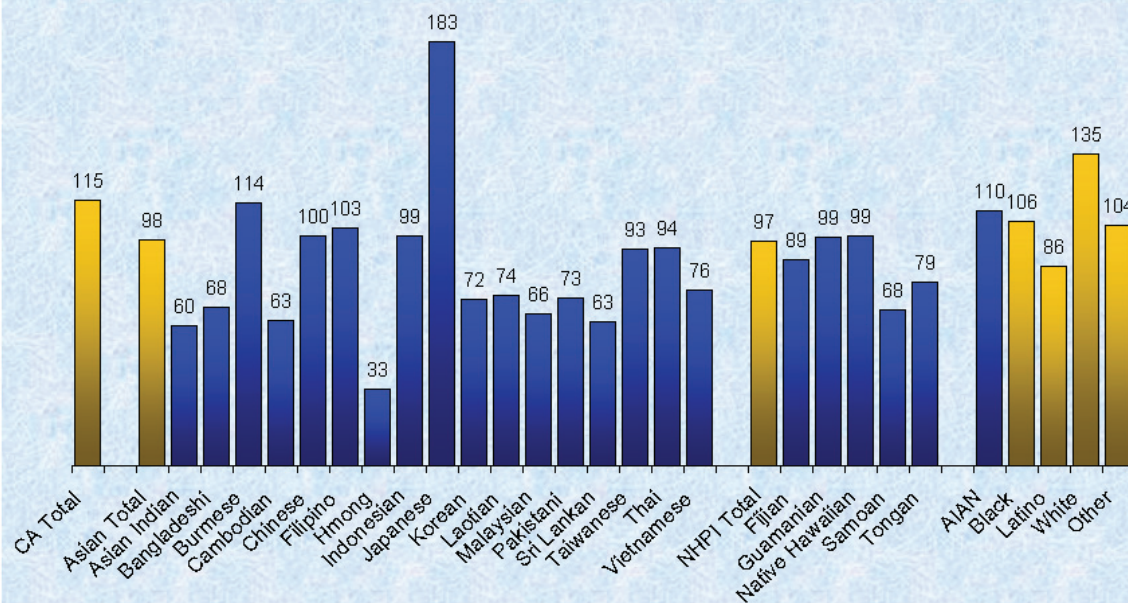
Strongly Agree that People in Neighborhood Know Each Other, Age 18 and Older



Source: Adult CHIS 2003

Figure 11. Length of Time in Neighborhood

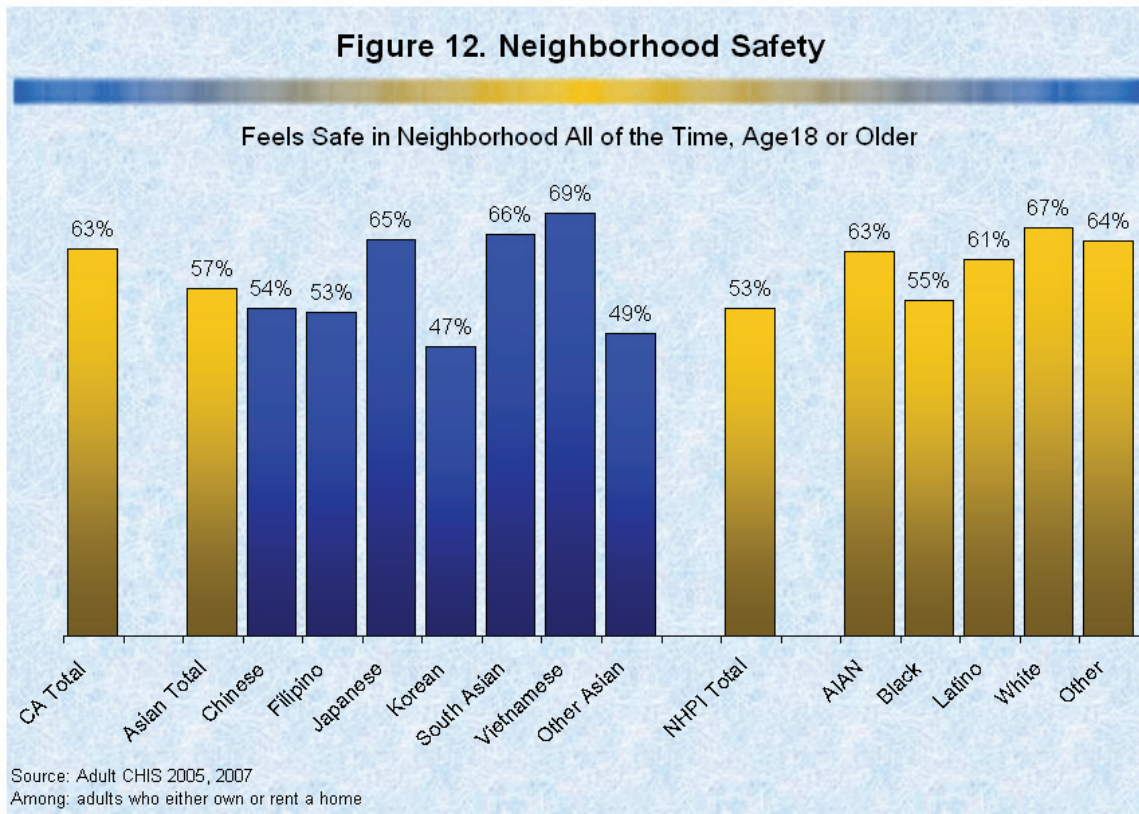
Number of Months Lived at Current Address (mean), Age 18 and Older



Source: Adult CHIS 2003, 2005, 2007

Safety is also an important indicator of neighborhood health and stability. Fewer AAs (57%) and NHPIs (53%) reported feeling safe in the neighborhood all of the time than the California average (63%) and most other racial/ethnic groups except for Blacks (55%) (see Figure 12). By AA

subgroups, Koreans (47%) reported the lowest rates of neighborhood safety across all racial/ethnic groups while Vietnamese (69%) reported the highest rates.



III. KEY POPULATION HEALTH CONCERNS FACING CALIFORNIA'S ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS

Major Disease Indicators

Cancer and Cancer Screening

California's Asian Americans (AAs) are the only major racial group for whom the leading cause of death is cancer. Cancer is the second leading cause of death for all Californians.^{26 27} When looking at California's cancer deaths, AAs (27.7%) and Native Hawaiians and Pacific Islanders (NHPIs) (25.4%) have higher rates than Whites (23.3%), Blacks (22.4%), Latinos (20.4%), and American Indians/Alaska Natives (20.3%). By AA subgroups, Koreans (31%), Chinese (31%), and Vietnamese (30.1%) have the highest proportion of cancer deaths by race/ethnicity.

Cancer screenings for cervical, breast, and colorectal cancers have been shown to reduce mortality rates. However, AAs often report screening rates far below other racial/ethnic groups.²⁸ For cervical cancer screening, AAs (29%) have nearly double the rate of non-compliance with Pap test recommendations as the state average (16%), with Koreans (35%), Other Asians (35%), and Vietnamese (30%) having the highest rates of non-compliance across all racial/ethnic groups. For breast cancer screening, AAs (26%) have higher rates of non-compliance with mammogram recommendations than the state average (23%), with Koreans (41%) and Other Asians (37%) having the highest rates of non-compliance across all racial/ethnic groups. For colorectal cancer screening, NHPIs (57%) and AAs (53%) reported higher rates of non-compliance with colorectal cancer screening recommendations than the state average (46%), with Koreans (70%), Filipinos (59%), and South Asians (59%) having the highest rates of non-compliance across all racial/ethnic groups.

Chronic Hepatitis B and Liver Cancer

Chronic Hepatitis B and liver cancer account for the greatest health disparity between AAs and other racial/ethnic groups in the U.S.^{29 30} The estimated prevalence of chronic Hepatitis B among AA adults (10%) is 20 times higher than the total U.S. adult prevalence rate (0.5%). In particular, AAs account for the largest proportion of chronic Hepatitis B cases in California with chronic Hepatitis B accounting for the majority of liver cancer incidence and mortality.

Among AA subgroups from 1997 to 2001, Vietnamese (33.3 per 100,000), Korean (20.2 per 100,000), and Chinese (14.1 per 100,000) Californians reported the highest liver cancer incidence rates.³¹ At the same time, Vietnamese (20.8 per 100,000), Korean (15.6 per 100,000), and Chinese (12.4 per 100,000) Californians reported the highest liver cancer mortality rates. In addition, excluding Japanese, AA men have substantially higher liver cancer incidence and mortality rates than AA women (2.4 times to 3.4 times; 2 times to 3.7 times respectively).

Obesity and Diabetes

Among children, California schools use Healthy Fitness Zones (HFZ) to evaluate whether a student meets the HFZ goal of physical activity and body composition. NHPIs reported the highest proportion of 5th graders whose Body Mass Index (BMI) are not in the HFZ, with Samoans (53.9%) and Other Pacific Islanders (41.5%) having the highest rates across all racial/ethnic groups.

Guamanian (34.7%), Native Hawaiian (34.6%), and Tahitian (34.4%) Californians also reported higher rates of 5th graders whose BMI are not in the HFZ compared to the state average (32%).

Among AA subgroups, Filipino (29.6%) and Laotian (28.7%) 5th graders reported the highest rates of not being within the HFZ.

Among adults, NHPIs (38% overweight; 32% obese) reported the highest rates of obese adults as well as combined overweight and obese adults across all racial/ethnic groups. Among AA subgroups, Filipinos (35% overweight; 11% obese) reported the highest proportion of overweight adults as well as combined overweight and obese adults.

Compared to other racial/ethnic groups, NHPIs (10.8%) have some of the highest rates of diabetes. Among AA subgroups, Filipinos (8.8%), Japanese (7.7%), and Vietnamese (7%) reported diabetes rates higher than the California average (6.8%) and Whites (4.9%).

Tuberculosis

AAs and NHPIs account for the largest proportion of all tuberculosis cases in California.^{32 33 34}

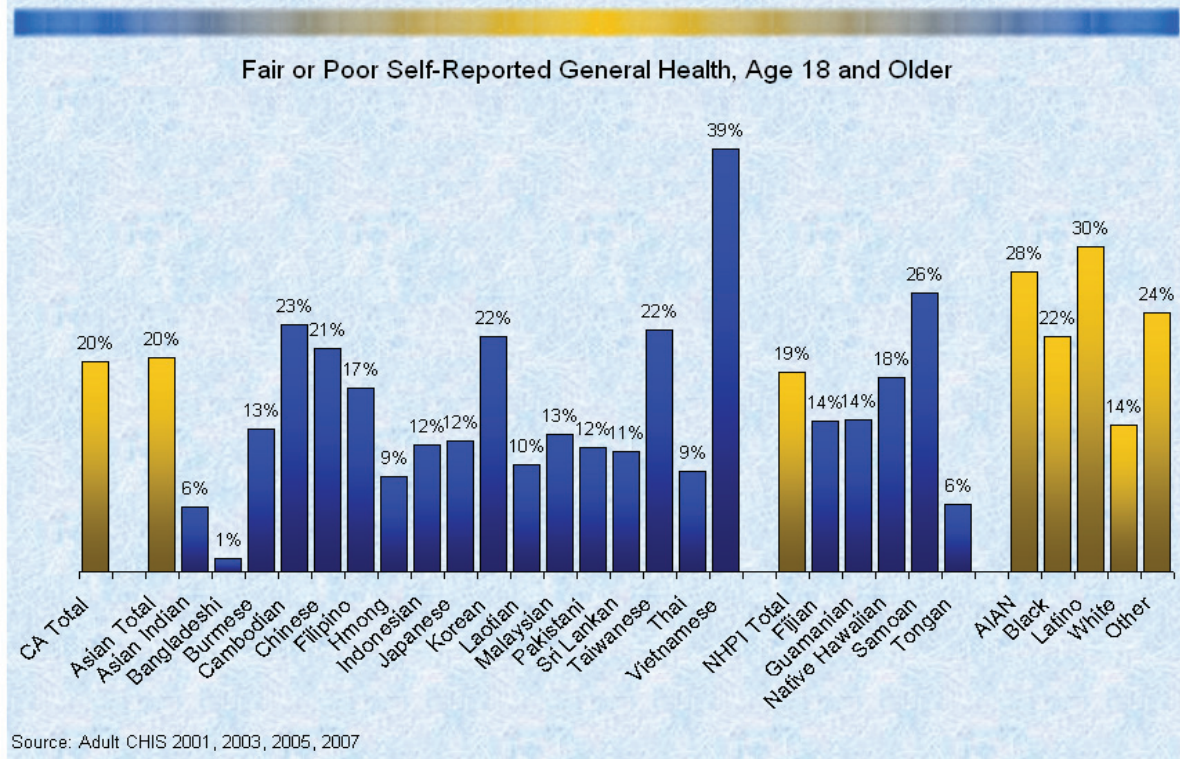
Tuberculosis case rates for AAs and NHPIs combined (25.5 per 100,000) are 3.5 and 18.2 times higher than the tuberculosis case rates for the California average (7.2 per 100,000) and Whites (1.4 per 100,000) in 2007. In addition, AAs and NHPIs combined accounted for 42% of all tuberculosis cases in California from 1998 to 2007. Even though tuberculosis cases declined for all racial/ethnic groups, AAs and NHPIs reported the smallest declines, with the AA and NHPI tuberculosis burden actually increasing during this period. The proportion of tuberculosis cases by AA and NHPI Californians increased from 39.6% of the total cases in 1998 to 46.3% of the total cases in 2007. Foreign-born Californians accounted for 77.5% of the tuberculosis cases in 2007 with the largest proportion of AA foreign-born tuberculosis cases reported by Filipino (22.6%), Vietnamese (12.2%), Chinese (6.2%), and Asian Indian (4.8%) Californians.

General Health Status

Key Population Health Status

Self-reported general health condition is one of the most common measures to assess health condition and reflects physical, behavioral, and social aspects of health and well-being. One in five Asian American (AA) (20%) and Native Hawaiian and Pacific Islander (NHPI) (19%) adults reported their general health condition as fair or poor, similar to the California average (20%) and much higher than Whites (14%) (see Figure 13). Among AA subgroups, Vietnamese (39%) reported the highest rates of fair or poor health, the highest across all racial/ethnic groups, followed by Cambodians (23%), Koreans (22%), and Taiwanese (22%), while Bangladeshis (1%) reported the lowest rates of fair or poor health, followed by Asian Indian (6%), Tongans (6%), and Hmong (9%). Among NHPI subgroups, Samoans (26%) reported the highest rates of fair or poor health, while Tongans (6%) reported the lowest rates of fair or poor health.

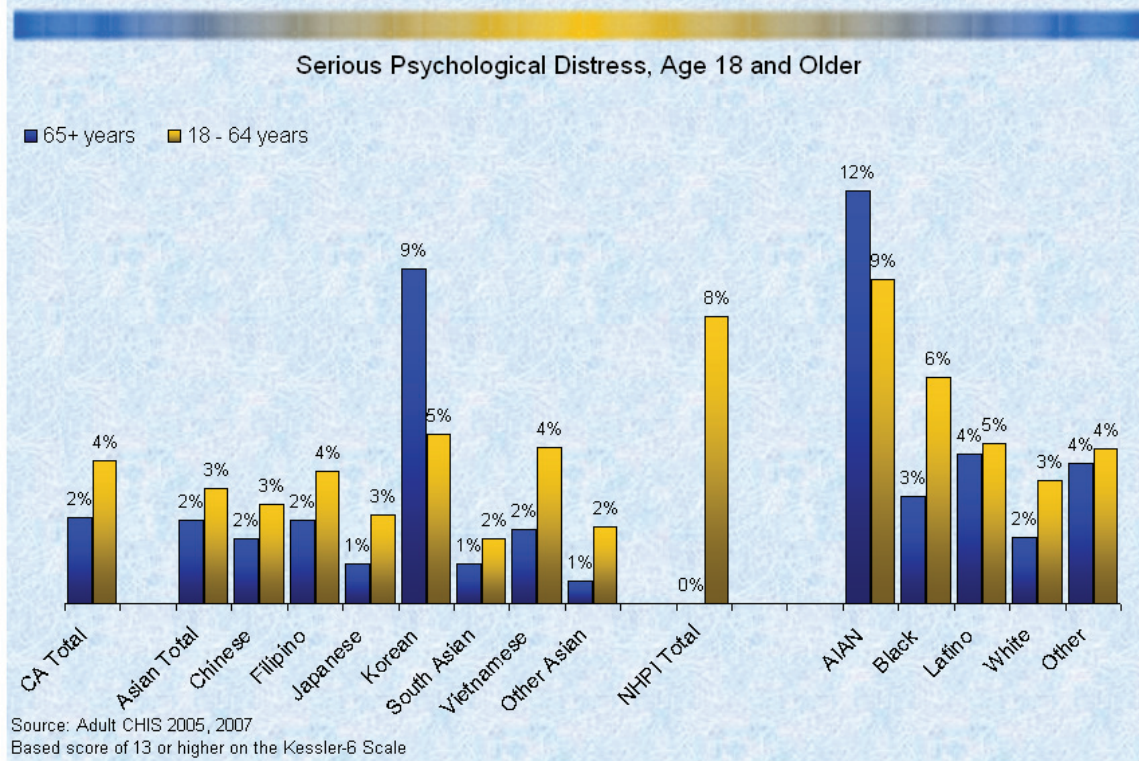
Figure 13. General Health Status



Key Population Mental Health

Mental health among AAs and NHPs has been difficult to assess due to the combination of the model minority myth, the underrepresentation of AAs and NHPs in epidemiological studies, the lack of disaggregated data, the conceptualization of physical and mental health as one, the immigrant and refugee transitions, and the role of racial discrimination.^{35 36} The Kessler-6 Scale for serious psychological distress assesses individuals who feel depressed, feel worthless, feel everything is an effort, feel nervous, feel restless, and feel hopeless in the past 30 days. According to this scale, AA adults aged 18 to 64 (3%) reported similar rates of serious psychological distress as California as a whole (4%) and White adults (3%). NHPI adults (8%) reported substantially higher rates of serious psychological distress than the state total (2 times) and White adults, and were similar to American Indians/Alaska Natives (9%) (see Figure 14). Among AA subgroups, Korean adults (5%) reported the highest rates of serious psychological distress among AA adults, similar to Black (6%) and Latino (5%) adults, while South Asian (2%) and Japanese (3%) adults reported the lowest rates. In addition, Korean elders (9%) reported substantially higher rates of serious psychological distress than the state average (4.5 times) and all other racial/ethnic groups except for American Indian/Alaska Native elders. These findings suggest some serious mental health concerns among AAs and NHPs, particularly among Korean elders and NHPI adults.

Figure 14. Mental Health by Age



Los Angeles County Department of Mental Health – API Full Service Partnerships

The Los Angeles County Department of Mental Health formed Full Service Partnerships with two Asian Pacific Islander (API) mental health treatment collaboratives. Both collaboratives provide cultural and linguistic concordance between the health provider and the client. As a result, API individuals who suffer from psychological distress utilize and remain in mental health treatment at significantly higher rates in these settings than in non-API treatment settings. When the mental health system supports API treatment settings, APIs get treated for mental health problems. APIs feel comfortable in the cultural environment of these agencies and feel they can be understood, therefore helped. For more information, visit: <http://dmh.lacounty.gov/>.

Key Population Physical Activity

Physical activity is a key determinant for maintaining and enhancing physical, behavioral, and social health.³⁷ Physical activity increases muscle and bone strength, lowers risks for chronic diseases, decreases body fat, enhances psychological well-being, and reduces depression and anxiety. For adults, federal guidelines recommend 150 minutes a week of moderate physical activity or an equivalent combination of moderate and vigorous physical activity. Moderate physical activity is defined as activities that make one breathe somewhat harder than normal and include carrying light loads, bicycling at regular pace, or doubles tennis.³⁸ Fewer AAs (61%) engaged in activities that take moderate physical effort in the past 7 days than the California average (66%) and Whites (71%), while more NHPIs (76%) engaged in moderate physical activity than the state average and all other

major racial/ethnic groups (see Figure 15). When examined by AA subgroups, Cambodians (56%) and Chinese (56%) reported the lowest rates of engaging in moderate physical activity across all racial/ethnic groups, while Sri Lankans (81%) reported the highest rates of engaging in moderate physical activity across all racial/ethnic groups. For NHPI subgroups, Guamanians (72%) reported the lowest rates of among NHPIs, while Tongans (79%) reported the highest rates of moderate physical activity.

Vigorous physical activity is a key health measure and for adults. Federal guidelines recommend 75 minutes a week of vigorous physical activity or an equivalent combination of moderate and vigorous physical activity.³⁹ Vigorous physical activity is defined as activities that make one breathe much harder than normal and may include heavy lifting, digging, aerobics, or fast bicycling.⁴⁰ Fewer AAs (32%) engaged in activities that take vigorous physical effort in the past 7 days than the California average (37%) and Whites (40%), while more NHPIs (39%) engaged in vigorous physical activity than the state average and were similar to Whites (see Figure 16). Among AA subgroups, Burmese (12%), Taiwanese (26%), and Chinese (28%) reported the lowest rates of engaging in vigorous physical activity across all racial/ethnic groups, while Vietnamese (88%), Malaysians (66%), and Indonesians (49%) reported the highest rates of vigorous physical activity across all racial/ethnic groups. Among NHPI subgroups, Tongans (29%) reported the lowest rates of vigorous physical activity, while Native Hawaiians (46%) and Fijians (46%) reported the highest rates of vigorous physical activity among NHPIs.

Healthcare Access

Key Population Insurance Coverage

Health care coverage is a critical indicator of healthcare access and will be positively impacted by health care reform. Asian Americans (AAs) (14%) and Native Hawaiians and Pacific Islanders (NHPIs) (15%) reported slightly lower rates of being currently uninsured compared to the California average (16%), and much higher uninsured rates than Whites (9%) (see Figure 17). By AA subgroups, Koreans (33%) reported the highest currently uninsured rates, followed by Hmong (24%), Cambodians (22%), and Indonesians (22%), all substantially higher than the state average, while Burmese (2%) and Japanese (7%) reported the lowest rates of uninsured, the lowest rates across all racial/ethnic groups. By NHPI subgroups, Tongans (39%) reported the highest currently uninsured rates, the highest across all racial/ethnic groups, followed by Fijians (26%), while Guamanians (12%) reported the lowest currently uninsured rates among NHPIs.

Key Population Usual Source of Care

In addition to healthcare coverage, having a usual source of care is vital to accessing healthcare. AAs (16%) reported similar rates of not having usual place to go when sick or needing health advice as the California average (16%) but higher than Whites (11%). NHPIs (18%) reported higher rates of not having usual source of care than the state average and Whites (see Figure 18). **By AA subgroups, the Hmong (38%) had the highest rates of not having usual place to go when sick or needing health advice, the highest across all racial/ethnic groups,** followed by Koreans (27%) and Vietnamese (20%); Bangladeshis (5%) reported the lowest rates of not having usual source of care followed by Malaysians (10%), and Filipinos (11%). By NHPI subgroups, Tongans (37%) reported

the highest rates of not having a usual source of care, while Guamanians (15%) reported the lowest rates of not having a usual source of care among NHPs.

Key Population Emergency Room Visits

Emergency room (ER) visits are also a key measure of healthcare access, particularly for underserved and at risk populations. Emergency room visits provide a way to measure multiple health issues – lack of preventative care and screening, delay of care, and at times, lack of health care coverage. Far fewer AAs (12%) reported visiting the emergency room for their own health in the past 12 months than the California average (18%) and Whites (19%), while substantially more NHPs (30%) reported visiting the ER compared to the state average and all racial/ethnic groups (see Figure 19). By AA subgroups, more Burmese (29%) and Malaysians (22%) and fewer Cambodians (4%) and Bangladeshis (6%) visited the ER. By NHP subgroups, Tongans (45%) reported the highest ER rates, followed by Samoans (28%), while Guamanians (17%) reported the lowest ER rates.

Gender and Health

Gender and Health Status

California women reported higher rates of fair or poor health compared to men for all racial/ethnic groups. Asian American (AA) women (1.2 times) reported slightly higher rates of fair or poor health than AA men and higher rates compared to the California average and White women and men (see Figure 20). Native Hawaiian and Pacific Islander (NHP) women (1.1 times) reported slightly lower rates of fair or poor health than NHP men and higher rates than Whites, but lower rates compared to the state average. For AA subgroups, more than twice as many Vietnamese women (44%) reported fair or poor health compared to the state average (21%), which was the highest rate across all racial/ethnic groups by gender. Korean (1.5 times) and Vietnamese (1.2 times) women more often reported fair or poor health than men, which was similar to the differences between Black women (1.3 times) and men.

California Healthy Nail Salon Collaborative

The California Healthy Nail Salon Collaborative was created in 2005 out of growing concern for the health and safety of nail salon and other cosmetology workers, owners, and consumers, many of whom are Vietnamese women. “The Collaborative” uses policy advocacy, research, industry advocacy outreach, and education strategies to address health and safety concerns facing these communities. The Collaborative’s members include nail salon workers and owners, as well as non profit and community organizations. The issues addressed include environmental and reproductive health/justice, labor issues, and Asian American community health. The collaborative also works with educational institutions and government agency allies. The mission of the Collaborative is to advance a preventative environmental health agenda for the nail salon sector in California. For more information, visit: <http://cahealthynailsalons.org/>.

Gender and Fertility Rate

There is wide variation among AA and NHP women in terms of fertility. Hmong women (11.0) reported the highest fertility rates across all racial/ethnic groups (see Figure 21). Further, Asian Indian (7.0) and Cambodian (7.0) women reported substantially higher rates than the state average

and were similar to Latinas (7.2). Tongan women (3.9) reported the lowest fertility rates across all racial/ethnic groups followed by Chinese (4.1) and Japanese (4.2) women.

Gender and Food Insecurity

Food insecurity is a major environmental health issue among underserved Californians, but there are additional issues related to gender. California women (1.3 times) are more affected by food insecurity than men of the same race/ethnicity, when assessed using a scale based on questions about not having enough money to purchase food, eating less healthy or smaller meals to stretch limited money, and frequency of going hungry (see Figure 22). At first glance, food insecurity appears to affect AA and NHPI women and men almost equally, in contrast to the state average and other racial/ethnic groups. However, by AA and NHPI subgroups, there were more Korean (1.6 times) and Vietnamese (1.5 times) women facing food insecurity than men compared to the state average (1.3 times) and across all racial/ethnic groups. In addition, Japanese and NHPIs were the only racial/ethnic groups where more men reported food insecurity than women. These results indicate food insecurity affects women of color, with Vietnamese women (21%) most affected among AAs and NHPIs, at rates similar to American Indian/Alaska Native women (21%).

Gender and Mental Health

AA women reported more serious psychological distress, 2 times more than AA men. White women and women in the California average categories reported 1.3 times more psychological distress than men in the same group (see Figure 23). In addition, among AA subgroups, Japanese (3 times), South Asian (3 times), and Korean women (2.3 times) reported the highest serious psychological distress compared to men. Korean (7%) and Vietnamese (5%) women reported distress rates that were higher than the state average for women overall (4%) and White women (4%). In contrast, NHPI men (3.7 times) reported much higher serious psychological distress compared to NHPI women. Further, NHPIs were the only racial/ethnic group with more men reporting serious psychological distress than women. NHPI men (11%) reported among the highest rates of serious psychological distress across all racial/ethnic groups, and were similar to American Indian/Alaska Native women (12%).

Gender and Violence

Almost one in four California women and over one in ten California men reported having experienced physical or sexual violence as an adult (see Figure 24). California women are 2.1 times more likely to experience physical or sexual violence as an adult than California men. AAs reported lower rates of experiencing physical or sexual violence than the state average and Whites, while NHPIs reported higher rates than the state average and Whites. In contrast, NHPI women (27%) and NHPI men (16%) reported the highest rates of experiencing physical or sexual violence among AAs and NHPIs, while Japanese, Chinese, and South Asian men reported the lowest rates across all racial/ethnic groups.

Among AA subgroups, however, Japanese women reported much more often than Japanese men (7 times) that they experienced physical or sexual violence compared to all racial/ethnic groups. Though on average, men in California tended to report physical or sexual violence as adults less often than women; however, this was not the case for Korean and Vietnamese men who report experiencing more violence than women.

Among Californians who have experienced physical violence in their lifetime, 1.9 times more California men reported recent intimate partner physical violence in the past year than women (see Figure 25). Filipino men (52%), Vietnamese women (44%), and Chinese men (44%) reported the highest rates of recent intimate partner physical violence among AA and NHPI subgroups. Chinese (4 times) and Filipino men (3.3 times) reported that they experienced recent intimate partner violence more often than women of the same ethnicity. However,

Japanese, NHPI, Vietnamese, and Korean women more often reported recent intimate partner physical violence than men of the same ethnic background. These racial/ethnic and gender variations point to the need to highlight intimate partner physical violence for men (especially Filipino and Chinese), and women (especially Vietnamese, Japanese, NHPI, and Korean).

Gender and STD Screening

California women reported that they were 1.7 times more likely than California men to be tested for sexual transmitted diseases (STDs) in the past 12 months (see Figure 26). NHPI women (42%) reported the highest rates of testing for STDs and Korean (4%) and Japanese (7%) men reporting the lowest rates of testing for STDs across all racial/ethnic groups. There is a clear need for targeted STD screening information and awareness about STD transmission for specific AA and NHPI subgroups by gender, especially Korean and Japanese men.

California women reported slightly more often than California men that they had ever been tested for HIV (see Figure 27). AAs reported substantially lower rates of HIV testing than the state average and Whites. NHPI women (56%), Filipina women (47%), NHPI men (47%), and Filipino men (44%) reported the highest rates of HIV testing among AAs and NHPIs subgroups. Korean men (24%), Chinese men (25%), Korean women (27%), and Chinese women (29%) reported the lowest rates of HIV testing across all racial/ethnic groups by gender. There is a clear need for targeted HIV testing information and awareness about HIV transmission for specific AA subgroups by gender, especially Korean and Chinese men and women.

IV. 2010 HEALTH CARE REFORM

The enactment of health care reform will advance access to affordable, quality care for Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities. The projected doubling of the safety net population from 20 to 40 million will benefit safety net health centers that serve medically underserved AAs and NHPIs. The increased support to the National Physician Service Corps will facilitate the training of bilingual and bicultural physicians, including physicians representing select AA and NHPI subgroups.

Federally-funded health programs will collect data on race, ethnicity, and primary language, and where necessary, oversample sub-populations to ensure sufficient data collection, furthering our understanding of health disparities and prevention strategies. The elevation of the National Center on Minority Health and Health Disparities to the National Institute on Minority Health signals a stronger commitment from the federal government to address minority health issues. Health care reform also codifies the Office of Minority Health within the Department of Health and Human Services (DHHS) and a network of minority health offices within DHHS to monitor minority health and the quality of care minority patients receive. This further solidifies the federal government's intent to mitigate health disparities.

These advancements lay the groundwork for improved health, but future improvements are needed to ensure true, effective reform. Additional improvements include:

- Elimination of the five-year waiting period for legal immigrants to access Medicaid.
- Allowing undocumented immigrants to purchase coverage in the Exchanges at full price with their own money.
- Requiring that all qualified health plans participating in the Exchanges reimburse for language services.

V. POLICY ISSUES AND RECOMMENDATIONS

Issue 1: Neighborhood Health and Food Consumption

Summary:

Policy changes are needed to support AA and NHPI neighborhoods. AA and NHPIs are less likely than most other racial/ethnic groups to know their neighbors or feel safe in their neighborhoods. Neighborhood cohesion, one's sense of residential safety, is vital to cultivating healthy communities. Policy changes are also needed to help assure food security and healthy food choices in AA and NHPI communities. One in 10 NHPIs experience food insecurity; furthermore, fast food consumption by AA and NHPI adolescents outpaces the fast food consumption by adults.

Recommendations:

1. Support local leaders and programs that promote neighborhood safety and social interaction in AA and NHPI neighborhoods, like Neighborhood Watch, community policing programs, and National Night Out, an annual neighborhood crime prevention event. Use “built environment” strategies, such as lighting, stop signs, and signage, to increase safety.
2. Pressure local elected and appointed officials to implement policies that promote the availability healthy choices in underserved AA and NHPI neighborhoods.
3. Support the First Lady's *Let's Move* initiative to help end the childhood obesity epidemic within a generation. *Let's Move* uses a multi-pronged approach, encouraging healthy choices, healthier schools, physical activity and access to healthy, affordable food.
4. Support existing neighborhood models and foster peer-support models for physical activity among NHPI and Filipino adults and children.

Issue 2: Health Status and Specific Disease Areas

Summary:

Very little is known about AA and NHPI health status, due to lack of data. The little health data available about AAs and NHPIs appear to indicate AAs and NHPIs are doing better than the state average. However, upon a closer look, AAs and NHPIs experience a wide range of health status and health care needs. Stark differences appear across racial/ethnic groups, with certain AA and NHPI subgroups encountering major health and disease disparities.

Recommendations:

1. Reduce Hepatitis B rates in the AA and NHPI population by increased screening and vaccination among adolescents and adults. Since July 1, 1999, all California students entering the 7th grade are required to be immunized against Hepatitis B. Outreach, screening, and vaccination to AAs and NHPIs must continue to protect California's population against this infectious disease.

2. Reduce tuberculosis (TB) rates among AA immigrant groups, particularly among immigrants from the Philippines and Vietnam, by supporting county efforts in health education, surveillance, and prevention and control programs.
3. Continue to support counties, community and provider organizations that undertake education and awareness campaigns that reduce the stigma of Hepatitis B, TB, cancer, and sexually transmitting diseases, including HIV, and that promote culturally-competent prevention and control efforts.
4. Create legislation that supports the health care system in the prevention and control of diabetes targeting NHPI and Filipino adults, who have diabetes rates that are markedly higher than the state average.
5. Create policies promoting diversification of the mental health workforce to respond to the unique mental health needs and mental health access issues of AAs and NHPs, with special attention to AA and NHPI adults who report high rates of frequent and severe mental distress.

Issue 3: Access to Care

Summary:

Given that more than one in three AAs and one in ten NHPs are limited English proficient, California must assure that this LEP population has meaningful language and cultural access to health care. The recently-passed health care reform law advances quality care for many Americans; however, AA and NHPI communities will still face language, cultural, and health system barriers in accessing quality care. In addition, more than three in five of Asian Americans are foreign born. Thus, the current five-year waiting period imposed on tax-paying, legal immigrants who are seeking Medicaid coverage has a considerable impact on access to care. Furthermore, denying undocumented immigrants the opportunity to purchase health insurance through the newly created Exchanges only serves to make health care more expensive for everyone.

Recommendations:

1. Support culturally and linguistically appropriate patient education programs emphasizing the importance of having a regular source of care, getting an annual physical exam, and getting screened for certain cancers, Hepatitis B, and TB.
2. Continue to monitor and hold health plans accountable for implementing SB 853, the Health Care Language Access Act, which requires health plans to provide language services (translated documents and interpreters) at all points of care.
3. Support a pilot project to test a hybrid delivery system for language services, as proposed by the Medi-Cal Language Access Services Taskforce. This system would test both a broker and direct provider billing system for language service delivery.
4. Remove the five-year waiting period for newly arriving legal immigrants to help address health disparities and increase access to care for AAs and NHPs.
5. Remove prohibitions against undocumented immigrants that prevent purchasing health insurance through Exchanges and create a system of coverage that serves and includes everyone.

Issue 4: Health Care Workforce

Summary:

Currently, the supply of racial/ethnic minority health providers in the state does not reflect the diversity of the patient population. This is particularly true for groups such as Southeast Asians and Native Hawaiians and Pacific Islanders (NHPIs). Recent health care reform legislation promotes diversifying the nation's health workforce and provides a tremendous opportunity for California to increase the diversity of its health workforce.

Recommendations:

1. Encourage health care providers, particularly in the 14 medically underserved AA and NHPI counties, to apply for grants established by recent health care reform legislation that would fund training for culturally appropriate care and services.
2. Support workforce development and training programs that increase the availability and competency of bilingual and bicultural health professionals.
3. Encourage public health departments, clinics, and hospitals to apply for grants established by recent health care legislation that promote the use of community health workers in medically underserved areas.
4. Support the development of a statewide master plan on increasing diversity in the health care workforce.

Issue 5: Women's Health and Partner Violence

Summary:

While AA women are less likely than their counterparts in other racial/ethnic groups to have experienced physical or sexual violence, some AA women report recent intimate partner violence at more than double the rate of other racial/ethnic groups. AA and NHPI men are also reporting victimization, especially for particular racial/ethnic subgroups.

Recommendations:

1. Reauthorize and fully fund the Family Violence Prevention and Services Act to allow communities to continue to provide life-saving services to victims of domestic violence and their children; funding is necessary for emergency shelters, crisis lines, counseling and advocacy. Violence prevention is necessary to meet the needs of underserved communities and break the cycle of violence.
2. Assure adequate funding for California's network of domestic violence shelters.
3. Continue to support counties, community, and provider organizations that undertake education and awareness campaigns to reduce the stigma of reporting partner violence, and promote culturally-competent prevention and treatment efforts.

Issue 6: Data and Research Development

Summary:

In California and across the nation, data available for AAs and NHPs lag far behind other racial/ethnic groups... Existing state and national secondary data sets often restrict access to disaggregated, or individualized, AA and NHPI data. In addition, aggregated, or combined, AA and NHPI data fails to capture the diversity and stark differences across AA and NHPI subgroups. Policies are needed to facilitate open access to subgroup data from existing large data sets. Support for new primary data collection and longitudinal studies are needed to fully capture the diverse social and health assets and needs faced by the AA and NHPI communities.

Recommendations:

1. Expand collection of subgroup data for AA and NHPI populations; require all California agencies and commissions match current U.S. Census data categories.
2. Increase awareness among national surveillance and epidemiological study teams of the need to collect disaggregated AA and NHPI racial/ethnic data.
3. Encourage health and policy research institutions, such as the National Institutes of Health and the Centers for Disease Control and Prevention, to prioritize research and data collection on AA and NHPI subgroups.

APPENDIX A: METHODOLOGY AND DATA SOURCES

This report is a product of secondary data analyses of several sources, as well as a compilation of information from published administrative reports and peer-reviewed articles. The specific data source is noted directly in each figure or table along with any subsample restrictions (e.g., age, gender, or if those who answered the question had to have specific responses to previous questions).

The most frequently used data sources included the U.S. Census Bureau's American Community Survey (ACS, available at <http://www.census.gov/>) and the California Health Interview Survey (CHIS, available at <http://www.chis.ucla.edu/>). The ACS is a new national household survey that collects population and housing information annually instead of every 10 years. The primary ACS data that the report utilized included the 3-year ACS estimates from 2006 to 2008 as well as the 1-year estimates from ACS 2008.

The CHIS is the nation's largest state health survey. It takes place every two years through a random-dial telephone survey conducted by the University of California, Los Angeles (UCLA) Center for Health Policy Research (<http://www.healthpolicy.ucla.edu/>) in collaboration with the California Department of Public Health (<http://www.cdph.ca.gov/>), the Department of Health Care Services (<http://www.dhcs.ca.gov/>), and the Public Health Institute (<http://www.phi.org/>). To capture the rich diversity of the California population, interviews for CHIS are conducted in five languages: English, Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese, and Korean.

All available CHIS data were used for this report – from each of the four years that the survey has been conducted (2001, 2003, 2005, and 2007) as well as from the adolescent (12-17 years of age) and adult (18 years and older) survey populations. Total sample sizes are as follows:

CHIS Survey Sample Sizes by Year and Population

Population	2001	2003	2005	2007
Teen	5,858	4,010	4,029	3,638
Adult	56,270	42,044	43,020	51,048

Because it is not feasible to survey every household in California, and because CHIS is not a simple random sample, CHIS uses a probability sampling method in an attempt to accurately represent the population of adults, adolescents, and children living within households in California. Population weights were also applied to produce accurate population estimates and totals. The weight variables were constructed through a complex and iterative process by Westat (<http://www.westat.com/>) using population totals obtained from the California Department of Finance (www.dof.ca.gov/) and the American Community Survey (www.census.gov/acs/).

SPSS 16.0 (Chicago, IL) was used for all CHIS analyses.

APPENDIX B: ABOUT THE AUTHORS

Wendy Ho, MPA, is the State Policy Analyst for the Asian & Pacific Islander American Health Forum (APIAHF). Prior to working at APIAHF, Ms. Ho served as a legislative fellow for Congressman Mike Honda (CA-15) where she managed the Congressman's Homeland Security, language access, and Asian American and Pacific Islander issue portfolio. She also served as an Assistant Language Teacher on the Japan Exchange and Teaching (JET) Program in southwestern Japan. Ms. Ho holds a Master of Public Affairs (MPA) from Indiana University and a double Bachelor of Arts in Political Science - International Relations and Japanese Studies from UC San Diego.

Christina Lee, BA, is Research Assistant for Health Research for Action (HRA) Center at UC Berkeley School of Public Health. She received her Bachelor's in Public Health with a minor in Public Policy. Ms. Lee was formerly a member of the Cal Undergraduate Public Health Coalition and has also interned for the California Medical Association (CMA) Foundation, where she worked on a cervical cancer and human papillomavirus (HPV) project.

Diana D. McDonnell, PhD, is Research Epidemiologist for the Center for Family and Community Health - a Centers for Disease Control and Prevention (CDC) Prevention Research Center (PRC) at the University of California, Berkeley that has focused for more than 15 years on the health of Korean Americans. Dr. McDonnell has expertise in study development, questionnaire design, and data analysis and has worked extensively with all four years of the California Health Interview Survey (CHIS) on analyses of Asian American health, women's health, smoking, LGBT health, and community needs assessments. Dr. McDonnell serves as an advisor to the CDC PRC policy committee. She earned her undergraduate degree at UC Santa Cruz and PhD at Johns Hopkins University.

Lois M. Takahashi, PhD, is Professor in the Departments of Urban Planning and Asian American Studies at UCLA, and Director of the UC Asian American and Pacific Islander Policy Multicampus Research Program (UC AAPI Policy MRP), a partnership of over 70 faculty members across the UC campuses to develop policy relevant research. She has over 50 publications on her research interests, which include access to social services and overcoming the NIMBY (Not In My Back Yard) syndrome in the US, and community participation and environmental governance in Bangkok, Thailand and Ho Chi Minh City, Vietnam.

Winston Tseng, PhD, is Research Sociologist in the Division of Community Health and Human Development at the University of California, Berkeley School of Public Health. He serves as Co-Chair of the Health Working Group of the UC AAPI Policy MRP (and was co-author of the UC AAPI Policy MRP's 2009 health report) and Advisor on the Community-Based Participatory Research (CBPR) Subcommittee of the National Center on Minority Health and Health Disparities. He conducts research on health and health care disparities, community health, and human development utilizing mixed methods, participatory, and organizational approaches. He has over 15 years of experience collaborating with community-based organizations in California and beyond.

Stephanie Wong, BA, is Research Assistant for the Asian & Pacific Islander American Health Forum (APIAHF). Ms. Wong has contributed to a variety of APIAHF's publications as a co-author, designer, and researcher, including a national AA and NHPI demographic data sheet, the first of its kind in being a single source for disaggregated AA and NHPI data. She received her Bachelor's degree in Public Health from the University of California, Berkeley.

APPENDIX C: POLITICAL HISTORY IN CALIFORNIA

Since the 1960s, 20 Asian Americans have served in the California State Legislature, beginning with Korean American Alfred Song. A number of notable Asian Americans followed, including Congressman Mike Honda (CA-15), Floyd Mori, current National Executive Director of the Japanese American Citizen League, and Wilma Chan, Vice President of Policy for Children Now.⁴¹ At present, the 11-member Asian Pacific Islander Joint Legislative Caucus is the largest it has been since its formation in 2001.⁴²

Asian Pacific Islander Joint Legislative Caucus

Formed in 2001 by Assemblymembers George Nakano (D-Torrance), Wilma Chan (D-Oakland) and Carol Liu (D-La Canada Flintridge), the Asian Pacific Islander Joint Legislative Caucus of the California State Legislature represents and advocates for the interests of the diverse Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities throughout California. The Caucus strives to increase AA and NHPI participation in all levels of government. Since its establishment, its members have authored and supported a wide array of legislation benefiting the AA and NHPI community in the areas of civil rights, health disparities, and consumer protection. Caucus members serve in key leadership positions in the Legislature which allows them to have maximum influence on the State's policymaking process and its subsequent impact on AA and NHPI communities.⁴³ It is the second largest ethnic Caucus in the Legislature.

Tri-Caucus Work

In 2008, the Asian Pacific Islander Legislative Caucus, the Black Legislative Caucus and the Latino Legislative Caucus began working with a coalition of 10 large California foundations to strengthen support for minority and low-income communities. The foundations pledged to work together to make grants “that provide capacity-building support and technical assistance targeted to minority-led and grassroots, community-based organizations that primarily serve minority and low-income communities” in California. In addition, the foundations will support leadership development activities that “bolster and train executives, staff, and board members for the nonprofit and philanthropic sectors.”⁴⁴

Commission on Asian and Pacific Islander American Affairs

The Commission on Asian and Pacific Islander Affairs was established in 2002 by AB 116 (Nakano) to “elevate the political, economic and social issues of Asians and Pacific Islanders by contributing to and strengthening how state government addresses the needs, issues and concerns”⁴⁵ of AA and NHPI communities. It is charged with advising the Governor, the Legislature, state agencies, departments and commissions on issues relating to the social and economic development, rights, and interests of AA and NHPI communities.

Notable Policies

Dymally-Alatorre Bilingual Services Act

The Dymally-Alatorre Bilingual Services Act (1973) requires state and local agencies serving a “substantial amount of non-English speaking people” to employ a “sufficient number of qualified bilingual staff in public contact positions” and to translate documents explaining available services into their clients' languages.⁴⁶

AB 540 (Firebaugh)

AB 540 (2001) allows qualifying students, including undocumented immigrant students, to pay in-state tuition fees at California's public college and universities. To qualify for in-state tuition under AB 540, students must meet all of the following requirements: attend a California high school for three years or more, graduate from a California high school or receive the equivalent of a high school diploma, be registered or currently enrolled in a state institution of higher learning, and, if undocumented, file an affidavit with the college or university or stating that they will file an application to adjust their immigration status as soon as they are eligible.⁴⁷ Prior to AB 540, undocumented students were charged out-of-state tuition fees to attend one of California's public higher education institutions.

AB 309 (Chu)

AB 309 (2003) extends consumer protections already available for Spanish speakers to speakers of the top five primary non-English languages spoken by Californians in their homes (Cantonese, Mandarin, Tagalog, Vietnamese and Korean). AB 309 requires businesses that choose to negotiate a narrow set of essential contractual agreements in these languages – such as buying a car, getting a basic unsecured consumer loan, or entering into a legal fee agreement –to translate their contracts into the language used for the negotiations.⁴⁸

SB 853 (Escutia)

SB 853 (2003) requires health plans to provide language access and charges the California Department of Managed Health Care to develop standards for interpreter services, translation of materials, and the collection of data on race, ethnicity and language. All vital documents must be translated into threshold languages and interpretation services made available to enrollees.⁴⁹

AB 800 (Yee)

AB 800 (2006) requires hospitals and clinics to include a patient's principal language spoken in his or her medical records.⁵⁰

AB 2283 (Oropeza) Medical Board of California Physician License Renewal Survey

AB 2283 (2006) amended the California Business and Professions Code and authorized the Medical Board of California to collect information on physicians' race/ethnicity and foreign language proficiency at the time of license renewal. It also stipulated annual aggregation of the data to determine statewide totals and the zip codes of the physicians' primary practice location.⁵¹

AB 295 (Lieu)

This 2007 bill would have required state departments concerned with health and human services, employment, and civil rights to collect data on additional AA and NHPI ethnic subgroups to reflect the diversity of information reported by the U.S. Census. (The groups included Hmong, Tongan, Thai, Pakistani, Bangladeshi, Sri Lankan, Malaysian, Indonesian, Taiwanese, and Fijian.⁵²) The bill passed both houses of the State Legislature, but was ultimately vetoed. In his veto message, Governor Schwarzenegger stated that the bill was “unnecessary and imposes additional costs on state agencies at a time the state cannot afford them,” given that “state agencies have the flexibility to collect to expand upon current demographic categories if necessary.”⁵³

AB 269 (Eng)

To address the growing disparities in access to dental care for underserved communities. AB 269 (2007) allows the California Dental Board and the Committee on Dental Auxiliaries to collect data on their licensees’ ethnic background and language proficiency based on the zip code of primary practice. The bill stipulated annual reporting of data for use by policymakers, researchers, health officials and the general public.⁵⁴

AB 614 (Eng)

AB 614 (2007) would have strengthened the Secretary of State's ability to monitor the compliance of elections officials with various voting rights laws to ensure the provision of language assistance at polling sites, and meet other requirements to facilitate the ability of limited English-proficient and first-time voters to participate in California's voting process.⁵⁵ Governor Schwarzenegger vetoed the bill, stating that current law already requires the provision of language assistance to voters and that such monitoring would “place an unnecessary strain on the state's limited resources.”⁵⁶

Mental Health Services Act (Proposition 63)

California voters passed Proposition 63 in 2004. The Mental Health Services Act (MHSA) significantly expands mental health care services and dedicates a portion of funds for preventative and early intervention (PEI) and innovative programs. MHSA is funded through a 1% tax on personal income exceeding \$1 million, and is estimated to generate over \$2 billion in funding between 2008 and 2011. Funds are being used to increase clients’ and families’ participation and involvement in all aspects of the public mental health system, reach out and expand services to underserved client populations to eliminate ethnic disparities in accessibility and cultural competency, and integrate services so that clients and families can address their needs without dealing with multiple agencies in multiple locations.⁵⁷

UC Disaggregation of AA and NHPI Subgroups

Thanks to the hard work of students involved in UCLA’s Asian Pacific Coalition’s “Count Me In” campaign in 2006 and 2007, undergraduate admission applications at the University of California will include 23 AA and NHPI subgroups starting in 2010, including: Chinese, Taiwanese, Asian Indian, Pakistani, Japanese, Korean, Filipino, Vietnamese, Hmong, Thai, Cambodian, Laotian, Bangladeshi, Indonesian, Malaysian, Sri Lankan and Other Asian, Native Hawaiian, Guamanian/Chamorro, Samoan, Tongan, Fijian and Other Pacific Islander. Previously, the University of California had categories for eight AA and NHPI subgroups.⁵⁸

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