A Toolkit for Outreach and Education
For Asian American and Pacific Islander Medicare Beneficiaries
About the National Asian Pacific Center on Aging
Our mission is to preserve and promote the dignity, well-being, and quality of life of Asian Americans and Pacific Islanders as they age.

Sponsors
This project was supported in part by grant number 90SM00013 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

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Introduction and Purpose

The National Asian Pacific Center on Aging

The National Asian Pacific Center on Aging (NAPCA) is a non-profit organization committed to preserving and promoting the well-being of Asian Americans and Pacific Islanders (AAPI) as they age. NAPCA develops and administers programs to enhance the dignity and quality of life of its constituents.

While AAPI older adults share characteristics that are prevalent among the general aging population, such as declining physical strength, limited mobility, fixed incomes, and expanded leisure time, there are unique challenges that AAPI older adults face, including a history of racially discriminative legislation as exhibited in anti-miscegenation statutes, and restrictive deportation and citizenship policies. Cultural, racial and language barriers have also prevented full participation in health and social services, which has hampered the economic, social and psychological well-being of AAPI older adults. Ultimately, the lack of access to, and underutilization of, health and social services by AAPI older adults result in the deprivation of opportunities accorded to others. Through advocacy, employment programs, engagement with community based organizations, and capacity building of support systems, NAPCA strives to improve the status of all AAPI older adults across the nation.

To accomplish the mission, NAPCA:

- Administers culturally and linguistically appropriate employment assistance programs, health education and awareness, and senior benefits counseling to limited and non-English speaking AAPI older adults.
- Compiles, assesses and publishes relevant data to showcase the needs of AAPI older adults.
- Informs and educates stakeholders on a local, regional and national level to positively impact services to, and systems for, AAPI older adults.
- Provides technical assistance to local AAPI communities and the aging network to enhance their capability in serving AAPI older adults across the country.

About this Toolkit

The purpose of this toolkit is to provide, in a convenient and easy-to-use method, a comprehensive approach to better reach and engage AAPI older adults. Readers should use this toolkit as a guide to maximize their agency's interactions with AAPI older adults and their caregivers, with the goal of improving their agency's capability in serving this
unique and diverse community. Periodically, we will expand this toolkit to ensure its accuracy and relevancy; please visit [___] for the most updated version.

**About the Hard to Reach Beneficiary Project**

The Administration for Community Living (ACL) awarded NAPCA a grant to provide training and technical assistance to help Senior Medicare Patrol (SMP) programs and State Health Insurance Assistance Programs (SHIP) to better reach and serve limited English proficient (LEP) AAPI Medicare beneficiaries. The overall objective is to increase the number of LEP AAPI Medicare beneficiaries who are aware of and utilize their Medicare benefits, and who can identify and prevent Medicare fraud, error and abuse.

Specifically for this project, NAPCA developed a three-part cultural competency webinar series to educate SMP and SHIP programs on AAPI cultures, and published this comprehensive toolkit as a means of documenting best practices and providing SMP and SHIP grantees with strategies on how to better reach and engage LEP AAPI older adults. In partnership with the Pacific Gateway Center and the Southeast Asian Resource Action Center, we developed three linguistically appropriate outreach and education materials in 10 different AAPI languages: Cambodian, Chinese, Hmong, Ilocano, Korean, Laotian, Samoan, Tagalog, Tongan and Vietnamese. All the materials and resources developed through the project can be found in the SMP Resource Library ([http://www.smpresource.org](http://www.smpresource.org)), SHIP Technical Assistance Center ([http://www.shiptacenter.org](http://www.shiptacenter.org)), as well as through NAPCA’s National Resource Center on AAPI Aging ([http://napca.org/technical-assistance/](http://napca.org/technical-assistance/)).

**Senior Medicare Patrol Overview**

SMPs empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. Funded by the ACL, U.S. Department of Health and Human Services, SMPs focus on three main areas:

1. **Conduct Outreach and Education.** SMPs give presentations to groups, exhibit at events, and work one-on-one with Medicare beneficiaries. In 2013, more than 1 million people were served nationally by the SMP program’s outreach and education efforts.

2. **Engage Volunteers.** Protecting older persons’ health, finances, and medical identity while saving precious Medicare dollars is a cause that attracts civic-minded Americans. The SMP program engages over 5,000 volunteers nationally who collectively contribute approximately 150,000 hours each year.

3. **Receive Beneficiary Complaints.** When Medicare beneficiaries, caregivers, and family members bring their complaints to the SMP, the SMP decides whether
fraud, errors, or abuse is suspected. When fraud or abuse is suspected, they make referrals to the appropriate state and federal agencies for further investigation.

SMPs are in each of the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. SMP grantees are supported by an ACL-funded national resource center. The national SMP Resource Center manages a website and provides direct technical assistance.

State Health Insurance Assistance Program Overview

SHIPs provide free, unbiased, in depth, one-on-one insurance counseling and assistance to Medicare beneficiaries, their families, friends, and caregivers. Also funded by ACL, SHIPs help Medicare beneficiaries and their caregivers by:

- Providing one-on-one assistance with reviewing a Medicare beneficiary’s health or prescription drug plan options.
- Educating individuals about assistance programs that one might be eligible for (i.e. low income subsidy, Medicare Savings Program, Medicaid, etc.).
- Helping individuals understand Medicare guidelines and eligibility criteria.
- Educating individuals on what is covered and can assist in reading individuals Medicare summary notices.
- Explaining how Medicare works with supplemental policies, retiree coverage, Medicaid, and other insurers.

SHIPs are in each of the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. SHIP grantees are supported by a national resource center; the SHIP Technical Assistance Center manages a website and provides direct technical assistance.
Asian Americans and Pacific Islanders

The demographics of our country are rapidly changing. The U.S. Census estimates that “by 2030, one in five Americans will be 65 and over; by 2044, more than half of all Americans are projected to belong to a minority group, and by 2060, nearly one in five of the nation’s total population is projected to be foreign born” (Colby and Ortman, 2015). Between 2014 and 2060, the AAPI population is projected to see a 129% increase.

The term AAPI, as defined by the U.S. Census (2016), is a person with origins in any of the peoples of the Far East, Southeast Asia, Indian Subcontinent or Pacific Islands. The term does not include persons from all countries in Asia, such as the countries in the Middle East, Northern and Western Asia. This diverse group is the fastest growing minority group in the country, and consists of over 30 countries with diverse ethnicities that speak over 100 different languages. Per the U.S. Census, the AAPI population accounts for 9.7% of the increase for the total U.S. population. As described in Table 1, the Asian population saw an increase of 53% between 1990 to 2010, an increase of 7.76 million individuals, and the Native Hawaiian and Pacific Islander population saw a 32% increase, or about 175,000 individuals (US Census Bureau, 1990, 2000, 2010).

| Table 1: Population Growth Trends of AAPI and AAPI Ethnic Sub-Groups (1990-2010) |
|---------------------------------|----------|----------|----------|------------------|
|                                | 1990     | 2000     | 2010     | % Change from 1990 |
| United States                  | 248,709,873 | 281,421,906 | 308,745,538 | 19%               |
| White                          | 188,128,296 | 194,552,774 | 223,553,265 | 16%               |
| Black or African American      | 29,986,060  | 34,658,190  | 38,929,590  | 23%               |
| Hispanic or Latino             | 22,354,059  | 33,081,736  | 50,477,594  | 25%               |
| Asian                          | 6,908,638   | 10,242,998  | 14,674,252  | 53%               |
| American Indian/Alaska Native  | 1,959,234   | 2,475,956   | 2,932,248   | 33%               |
| Native Hawaiian/Pacific Islander| 365,024    | 398,835     | 540,013     | 32%               |
| Asian Indian                   | 815,447     | 1,678,765   | 2,843,391   | 71%               |
| Bangladeshi                    | 11,838      | 41,280      | 128,792     | 91%               |
| Cambodian                      | 147,411     | 171,937     | 231,616     | 36%               |
| Chinese, except Taiwanese      | 1,573,883   | 2,314,537   | 3,137,061   | 50%               |
| Filipino                       | 1,406,770   | 1,850,314   | 2,555,923   | 45%               |
| Hmong                          | 90,082      | 169,428     | 247,595     | 64%               |
| Indonesian                     | 29,252      | 39,757      | 63,383      | 54%               |
| Japanese                       | 847,562     | 796,700     | 763,325     | -11%              |
| Korean                         | 798,849     | 1,076,872   | 1,423,784   | 44%               |
| Laotian                        | 149,014     | 168,707     | 191,200     | 22%               |
| Malaysian                      | 12,243      | 10,690      | 16,138      | 24%               |
Pakistani | 81,371 | 153,533 | 363,699 | 78%
Taiwanese | 71,589 | 118,048 | 196,691 | 64%
Thai | 91,275 | 112,989 | 166,620 | 45%
Vietnamese | 614,547 | 1,122,528 | 1,548,449 | 60%
Fijian | 7,036 | 9,796 | 24,629 | 71%
Guamanian or Chamorro | 49,345 | 58,240 | 88,310 | 44%
Native Hawaiian | 211,014 | 140,652 | 156,146 | -35%
Samoan | 62,964 | 91,029 | 109,637 | 43%
Tongan | 17,606 | 27,713 | 41,219 | 57%

US Census Bureau, 1990, 2000, 2010

Figure 1 is a map illustrating the AAPI population percentage by state, for those AAPI who identified with one race alone. The state with the highest percent of AAPIs is Hawaii, where 48% of their total population is AAPI. California has the second highest percent of AAPIs with 13.9%, followed by New Jersey, Nevada, Washington, New York, Alaska, Virginia, Maryland, and Massachusetts (US Census Bureau, 2014). The state with the highest number of AAPI individuals is California, where there are 5.3 million AAPIs. New York is second with having 1.5 million AAPI individuals, followed by Texas, New Jersey, Hawaii, Illinois, Washington, Florida, Virginia, and Massachusetts (US Census Bureau, 2014).

Figure 1: AAPI Population Percent and Number of Persons

US Census Bureau, 2014

AAPI Older Adults - Demographic Profile

AAPIs represent 4.6% of the total older adult population, and about 10.2% of the total AAPI population. Approximately 2.2 million AAPIs were aged 65 and older in 2015. As
seen in Figure 2, over the next 45 years, the number of AAPIs aged 65 years and above is expected to grow by 232% to 7.3 million, representing approximately 21% of the total AAPI population by 2060 (National Asian Pacific Center on Aging, 2013a).

As seen in Figure 3, California, New York, Hawaii and Texas have the largest AAPI older adult populations in the United States, and account for approximately 54% of the AAPI population aged 65 years and above (US Census Bureau, 2014). The ethnic sub-groups that represent the largest percentage of AAPI older adults are Chinese (26%), Filipino (20%) and Japanese (13%). However, approximately 1 in 4 Japanese Americans are aged 65 years and above, or nearly 25% (National Asian Pacific Center on Aging, 2013a).
**Population Growth**

AAPIs are one of the fastest growing populations of older adults in the United States. In comparison to other races, the AAPI older adult population 60 years and above increased significantly. Asian American elders increased by 76% and Native Hawaiian and Pacific Islander elders increased by 60%, while African American elders increased by 30%, Hispanic elders increased by 65%, and White elders increased by 19%, respectively. Between 2010 and 2030, the AAPI older adult population is projected to increase by 145% (US Census Bureau, 2014).

Figure 4 illustrates the population growth trends of AAPI older adults in states across the country. States with the highest percentage rates of AAPI older adult population growth are North Dakota, Montana, South Dakota, Vermont, North Carolina, Tennessee, Georgia, Florida, Wyoming, Indiana and Texas. These increases are due to several factors that will continue to have an impact on an aging America: (1) immigrants who entered the U.S. in their early age are now aging, and (2) older immigrants entering the U.S. with the support from their adult children or relatives (National Asian Pacific Center on Aging, 2013b).

**Figure 4: AAPI Population Percentage 2006 and 2013**

![Map showing AAPI population percentage growth from 2006 to 2013](image)

*Administration for Community Living, 2016*

**Socioeconomic and Health Disparities**

Despite the fact that AAPIs are the fastest growing groups of ethnic elderly in the country, they remain largely invisible. AAPI needs are not well researched, concerns often go unaddressed by public policies, and relatively few programs and services are designed for their unique needs. Not only are the needs of AAPIs different from other ethnically diverse older adults across the country, each AAPI ethnic sub-population face their own unique challenges. Although many AAPI older adult sub-populations enjoy higher levels of educational attainment than the general population, they also experience higher levels of poverty, health disparities, and economic, housing and transportation insecurity.
Disaggregated data reveals the extent of vulnerability among AAPI older adults, as numerous AAPI subgroups rank among the poorest in the U.S.

**Poverty and Economic Status**

In aggregate, AAPI older adults face lower levels of poverty as compared to other minority counterparts. However, within certain AAPI sub-populations, poverty rates are extremely high (see Figure 5). For example, more than one-fourth of all Micronesian older adults, one-fifth of Bangladeshi, Burmese, Cambodian, Korean and Nepalese older adults, and 15% or more of Chinese, Hmong, Laotian, and Vietnamese older adults live in poverty.

*Figure 5: Poverty Rates for Older Adults 65 Years and Above*

<table>
<thead>
<tr>
<th>Total Population</th>
<th>9.50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>7.30%</td>
</tr>
<tr>
<td>African American</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>17.80%</td>
</tr>
<tr>
<td>American Indian</td>
<td>18.40%</td>
</tr>
<tr>
<td>Asian American</td>
<td>13.30%</td>
</tr>
<tr>
<td>NHPI</td>
<td>14.60%</td>
</tr>
<tr>
<td>Asian Indian</td>
<td>6.70%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td></td>
</tr>
<tr>
<td>Burmese</td>
<td>20.10%</td>
</tr>
<tr>
<td>Cambodian</td>
<td>23.90%</td>
</tr>
<tr>
<td>Chinese</td>
<td>18.70%</td>
</tr>
<tr>
<td>Filipino</td>
<td>13.20%</td>
</tr>
<tr>
<td>Guamanian</td>
<td>18.00%</td>
</tr>
<tr>
<td>Hmong</td>
<td></td>
</tr>
<tr>
<td>Indonesian</td>
<td>4.70%</td>
</tr>
<tr>
<td>Japnese</td>
<td>6.70%</td>
</tr>
<tr>
<td>Korean</td>
<td>20.30%</td>
</tr>
<tr>
<td>Laotian</td>
<td>16.20%</td>
</tr>
<tr>
<td>Micronesian</td>
<td>26.60%</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>9.80%</td>
</tr>
<tr>
<td>Nepalese</td>
<td>23.50%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>14.90%</td>
</tr>
<tr>
<td>Samoan</td>
<td>12.50%</td>
</tr>
<tr>
<td>Taiwanese</td>
<td>11.10%</td>
</tr>
<tr>
<td>Thai</td>
<td>12.10%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>19.30%</td>
</tr>
</tbody>
</table>

*U.S. Census Bureau, 2016*
AAPI older adults are more likely to receive Supplemental Security Income (SSI), a federal program that pays benefits to low-income seniors 65 years of age and above. Roughly 14% of AAPIs receive SSI, as compared to the national average of 3.2% (National Asian Pacific Center on Aging Data Brief, Volume 1 Number 4). In addition, AAPI older adults are more likely to use supplemental nutrition assistance programs, have little to no retirement savings, owe debt on a housing mortgage, or pay rent on housing (American Community Survey, 2012).

Health Disparities and Status
While certain AAPI sub-populations such as Japanese and Filipino Americans have higher life expectancies than the rest of the U.S., AAPI older adults experience worse access to care than White Americans by 17%, and worse care by about 30% (US-DHHS, 2012). Overall, AAPI elders face a number of critical health disparities, including disproportionately high prevalence of hepatitis B, tuberculosis, and dementia. Over half of the 1.25 million Americans with chronic hepatitis B infection are AAPI older adults. AAPI older adults also show a greater prevalence of dementia than the total older population.

Furthermore, studies have shown that AAPI older adults experience higher rates of certain chronic conditions, as compared to their White counterparts. Asian women experience higher cervical cancer incidence and mortality, a greater risk of diagnosis at the later stages of breast cancer, and a greater risk of dying from breast cancer when compared with White women, their rates of attaining Papanicolaou testing (Pap tests), clinical breast exams, and mammography testing. Similarly, lung and bronchial cancer are the leading causes of death for Asian American men, and AAPIs who are overweight are at an increased risk of diabetes. Filipino and Japanese Americans are twice as likely, while Native Hawaiians are four times as likely, to be diagnosed with diabetes, and three times more likely for women than men. There are also a number of mental health concerns for the AAPI population. Southeast Asian refugees are at an elevated risk for post-traumatic stress disorder associated with trauma experienced before and after immigration to the U.S. Finally, older AAPI women have the highest suicide rate of all women aged 65 years and older.

AAPI older adults are more likely to be uninsured or to rely on public insurance, as compared to the total U.S. population. Only 33% of Asian American older adults have private insurance, compared to 52% of all American older adults. One in every seven Tongan (15%), Pakistani (15%), and Bangladeshi (23%) older adults are uninsured. Moreover, AAPIs who are covered by Medicare are at a significantly lower rate than non-Hispanic whites, 65 years and above.
**Immigration and Citizenship**

Immigration and foreign-born rates are significantly higher for AAPI older adults compared to the national average and to minority counterparts. Disaggregated data shows that many AAPI sub-populations have significantly higher rates of older adults who are foreign born. Figure 6 shows that 50% or more of Asian Indian, Bangladeshi, Burmese, Cambodian, Chinese, Filipino, Indonesian, Korean, Laotian, Nepalese, Pakistani, Taiwanese, Thai and Vietnamese older adults are foreign born.

**Figure 6: Foreign Born Rates – Percent of Foreign Born AAPI Older Adults**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Foreign Born Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>13.3%</td>
</tr>
<tr>
<td>WHITE</td>
<td>3.9%</td>
</tr>
<tr>
<td>AFRICAN</td>
<td>9.1%</td>
</tr>
<tr>
<td>HISPANIC</td>
<td>6.1%</td>
</tr>
<tr>
<td>AMERICAN INDIAN</td>
<td>20.8%</td>
</tr>
<tr>
<td>NHPI</td>
<td>66.5%</td>
</tr>
<tr>
<td>ASIAN INDIAN</td>
<td>70.9%</td>
</tr>
<tr>
<td>BANGLADESHI</td>
<td>73.8%</td>
</tr>
<tr>
<td>BURMESE</td>
<td>86.7%</td>
</tr>
<tr>
<td>CAMBODIAN</td>
<td>58.4%</td>
</tr>
<tr>
<td>CHINESE</td>
<td>69.6%</td>
</tr>
<tr>
<td>FILIPINO</td>
<td>65.6%</td>
</tr>
<tr>
<td>GUAMANIAN</td>
<td>3.1%</td>
</tr>
<tr>
<td>HMONG</td>
<td>6.9%</td>
</tr>
<tr>
<td>INDONESIAN</td>
<td>38.9%</td>
</tr>
<tr>
<td>JAPANESE</td>
<td>41.3%</td>
</tr>
<tr>
<td>KOREAN</td>
<td>33.1%</td>
</tr>
<tr>
<td>LAOTIAN</td>
<td>31.1%</td>
</tr>
<tr>
<td>MICRONESIAN</td>
<td>31.1%</td>
</tr>
<tr>
<td>NATIVE HAWAIIAN</td>
<td>67.2%</td>
</tr>
<tr>
<td>NEPALESE</td>
<td>69.4%</td>
</tr>
<tr>
<td>PAKISTANI</td>
<td>75.9%</td>
</tr>
<tr>
<td>SAMOAN</td>
<td>10.8%</td>
</tr>
<tr>
<td>TAIWANESE</td>
<td>87.5%</td>
</tr>
<tr>
<td>THAI</td>
<td>67.9%</td>
</tr>
<tr>
<td>VIETNAMESE</td>
<td>67.9%</td>
</tr>
</tbody>
</table>

*U.S Census Bureau, 2016*

**Limited English Proficiency**

The rate of foreign-born AAPI older adults is significantly higher than the national average, therefore it would seem likely that the rate of LEP would be significantly higher than the national average as well. In aggregate, 60% of Asian Americans and 25% Pacific Islanders speak English less than "Very Well" (see Figure 7). However, disaggregated data shows that there are extraordinary differences between ethnic groups. An astonishing 100% of all Bhutanese older adults are LEP, in comparison to Native Hawaiians at 3%, and all but two AAPI older adult sub-populations have LEP rates of 25% or higher.

In addition, 27% of AAPI older adults reside in linguistically isolated households, meaning that no one in the household over the age of 14 speaks English "Very Well" (National Asian Pacific Center on Aging, 2013a). Approximately one-third of all Cambodian,
Laotian, and Chinese American older adults, 45% of Korean American older adults, and 46% of Vietnamese American older adults are linguistically isolated.

LEP has a negative effect and severely impairs access to health care and health status, in comparison to their English proficient or fluent counterparts (Ninez, 2006). LEP has also been associated with restricted employment opportunities and racial discrimination, and older adults with LEP are more likely to have a poorer quality of life (Ninez, 2006).

**Figure 7: Limited English Proficiency Rates in AAPI Older Adults**

<table>
<thead>
<tr>
<th>AAPI Sub-population</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>8.07%</td>
</tr>
<tr>
<td>WHITE</td>
<td>2.45%</td>
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<tr>
<td>AFRICAN AMERICAN</td>
<td>2.94%</td>
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<tr>
<td>HISPANIC</td>
<td>15.44%</td>
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<td>ASIAN INDIAN</td>
<td>24.46%</td>
</tr>
<tr>
<td>NHPI</td>
<td>47%</td>
</tr>
<tr>
<td>ASIAN INDIAN BANGLADESI</td>
<td>78%</td>
</tr>
<tr>
<td>BHUTANSESE</td>
<td>91%</td>
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<tr>
<td>BURMESE</td>
<td>75%</td>
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<tr>
<td>CHINESE</td>
<td>74%</td>
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<tr>
<td>FILIPINO</td>
<td>90%</td>
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<td>GUAMANIAN</td>
<td>61%</td>
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<tr>
<td>HAMONG</td>
<td>27%</td>
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<td>INDOONESIAN</td>
<td>47%</td>
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<td>JAPANESE</td>
<td>78%</td>
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<td>100%</td>
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<td>LAOTIAN</td>
<td>47%</td>
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<td>MALAYSIAN</td>
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<td>75%</td>
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<td>MONGOLIAN</td>
<td>61%</td>
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<td>NATIVE HAWAIIAN</td>
<td>40%</td>
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<td>TAIWANESE</td>
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<td>83%</td>
</tr>
<tr>
<td>VIETNAMESE</td>
<td>8%</td>
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</table>

U.S. Census Bureau, 2016

**Cultural Implications**

This section will contain cultural-based generalizations as a means of raising awareness of the cultural differences that may exist between Western cultures and cultures within the AAPI sub-populations. This section should not be used to profile or stereotype AAPIs; an individual may, and more likely will, deviate from these cultural norms. Each AAPI sub-population differs in socio-cultural traits and in a variety of other ways. The degree to which a person adopts U.S. cultural values varies, and there are a number of factors as to why a person may not assimilate as fast, or at all.

Cultural awareness is the first and foundational element of cultural competence. Cultural awareness is defined as being cognizant, observant, and conscious of similarities and differences among cultural groups, and understanding that one's culture may influence values, beliefs, judgments and decisions (National Center for Cultural Competence, 2016).
Poorly understood differences lead to adverse outcomes that result in (1) lower participation rates, (2) delayed action during a crisis, (3) inaccurate history or documentation of an incident, (4) non-compliance with recommendations that an agency provides, and (5) decreased satisfaction of the program or agency (Yale Journal of Medicine and Law, 2006).

Historically, AAPI cultures are highly group-oriented and place a strong emphasis on the family as the sole source of identity. The traditional household is comprised of multiple generations; it is normal to find three to four generations living under one roof (Ogawa, 1978). AAPIs often value the family unit over oneself. For example, Picture Brides – similar to "arranged marriages" - is a term that refers to a practice during the early 1900's where immigrant Asian workers in Hawaii, the West Coast and Canada married women based on the exchange of photos and a matchmaker. It was considered acceptable because of the obligation to one's family, especially if money or resources were needed (Ogawa, 1978). Another example is the Native Hawaiian term "hanai," which has a loose meaning of adoption or to take into one's family. But in its simplest meaning, hanai is a person that is considered as a family member (Okamura, 2008). Loyalty to one's family is highly regarded, and independent behavior that may disrupt the harmony of the family is discouraged.

AAPIs pride themselves on their status and retaining the family name in the eyes of others. When a family member brings shame to the family, the family must work as a unit to mend the wrong. In addition, the concept of filial piety, meaning the primary duty of respect, obedience and care for elderly parents or relatives, is very important in the AAPI culture (Ogawa, 1978). AARP reinforced this value by reporting that AAPIs are significantly more likely to take charge of caregiving duties, as compared to other ethnic groups (AARP, 2014).

Cultural Identity
Cultural identity is multifaceted and the process in achieving one’s cultural identify is not the same for everyone. Experts believe that identity may be inherent, or ever-changing and constantly being revised through one’s social setting or historical events (Lee and Kye, 2016). For example, some Japanese Americans during or after WWII found a resurgence, or pride, in being Japanese, and spawned the creation of a group identity, like "Asian American," where a new or blended culture is born (Lee and Kye, 2016).

The ability to assimilate also plays a factor in a person's cultural identity. Assimilation is a process by which a person absorbs the cultural norms, values, beliefs and behavior patterns of the "host" society. Table 2 explains the different factors as to why assimilation may occur faster for some ethnic groups. These factors, and its effects, vary from ethnic
group to ethnic group, or person-to-person; they help shape an AAPI person's cultural identity, and shows that varying needs and vulnerabilities exists for each AAPI sub-population.

<table>
<thead>
<tr>
<th>Assimilation Factors</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racial Differences</td>
<td>White immigrants faced prejudice and discrimination, but were able to integrate more quickly than non-white immigrants and minorities.</td>
</tr>
<tr>
<td>Economy Structure at Time of Immigration</td>
<td>During economic difficulties, there isn't as much to go around which can lead to more competition and hostility.</td>
</tr>
<tr>
<td>Racism and Discrimination</td>
<td>How a person reacts or responds to racism and/or discrimination.</td>
</tr>
<tr>
<td>Socioeconomic Factors</td>
<td>Different AAPI sub-populations have varying levels of educational attainment, job skills, English proficiency, etc.</td>
</tr>
</tbody>
</table>

*Chae, 2002*
Organizational Best Practices

An organization’s commitment to cultural awareness leads to an individual, community, program, or organization to becoming culturally competent. Not all AAPI older adults are the same, so it is important for agencies to adopt and apply the philosophy of person-centeredness when working with the AAPI communities. Person-centeredness involves perceiving and evaluating interventions from an individual’s perspective, adapting those interventions to meet the needs and expectations of that person. Similarly, prioritizing AAPI cultural and linguistic competency will increase an agency’s ability and confidence in providing direct services to AAPI older adults and their caregivers, as well as increase client satisfaction.

Cultural Competency

Cultural competence is an evolutionary process towards cultural humility (Southeastern Health Equity Council, 2014). The goal of cultural humility is defined as a "lifelong commitment to self-evaluation and self-critique, to redress the power imbalances in [provider-consumer] dynamic, and to develop mutually beneficial and advocacy partnerships." A best practice for an organization to be culturally and linguistically responsive to AAPI older adults in their geographic service area is as follows (see Figure 8):
Being culturally competent involves an ongoing commitment to learning about the AAPI cultures within your community, and looking at a person's culture through their individual lens (Southeastern Health Equity Council, 2014). Organizations should keep this framework in mind when planning and implementing local programs.

**Organizational Self-Assessment**

The primary goal of an organizational self-assessment is to reduce racial inequities and increase the opportunities for AAPI inclusion within an agency. AAPI older adults are one of the fastest growing and most diverse populations in the country. Numerous differences between AAPI and mainstream American culture cause barriers that restrict AAPIs from fully accessing long-term services and supports. NAPCA adapted and published the *Asian American and Pacific Islander Inclusion: A Self-Assessment for Organizations* fact sheet (Appendix A). This tool helps organizations raise awareness, evaluate areas for improvement to increase AAPI inclusion, and track organizational change.

**Language Access Self-Assessment for LEP AAPI Older Adults**

The primary goal a language access self-assessment is to effectively communicate with LEP AAPI older adults and their caregivers. AAPI older adults have high rates of LEP,
and therefore, assessing how and the extent to which LEP AAPI older adults and caregivers interact with an agency or program is the first step to providing culturally competent and linguistically appropriate services.

For example, it is critical to measure the relationship between LEP participants and an agency’s hotline/I&R calls, outreach and education programs, access to agency websites, written materials, agency brochures, etc. Agencies should consider assessing the number or proportion of LEP older adults from each AAPI language in the geographic service area to determine appropriate language assistance services and programming decisions for service delivery. NAPCA developed two fact sheets to assist organizations in using the U.S. census data as follows: (1) Identifying Languages within Your Community: AAPI Older Adult Data, and (2) Identifying Population Counts within Your Community: AAPI Older Adult Data (Appendix B, C). This analysis must also include evaluating the number of LEP AAPI persons with whom the agency encounters while carrying out program functions. Agencies can do this by reviewing and analyzing the available data in your service area, and use the data to drive program development by developing language access procedures (i.e. how to access AAPI language interpreters), linguistically appropriate outreach materials, and train staff on how to access language assistance services. As a reference, NAPCA developed a fact sheet, Four Strategies to Identify an Interpreter: For an AAPI Older Adult (Appendix D).

Collecting and Analyzing Data on AAPI Older Adults

It is important to collect and analyze data to better understand the population being served, and to ensure that programming is meeting the needs of the community. Disaggregated data collection is vital in meeting the needs of AAPI older adults. There are significant ethnic distinctions, cultural norms, traditions, social and economic health needs among and between AAPI subpopulations. Often, AAPI older adults are aggregated into one ethnic category that obscures meaningful differences between AAPI subpopulations and leads to "one-size-fits-all" programs and policies.

Needs Assessment

Conducting a comprehensive needs assessment is a necessary step to understand the specific needs and challenges that AAPI older adults face within a geographic service area. Currently, disaggregated AAPI data is limited, and therefore, collecting one's own data is a viable alternative. While comprehensive needs assessments take time and resources, it provides the best information to adopt a culturally and linguistically appropriate approach to assess the needs of AAPI older adults, set priorities, allocate resources or time, and ensure equitable access to services (see Figure 9). As a reference, NAPCA developed a fact sheet, Seven Best Practices when Conducting a Community Needs Assessment with AAPI Older Adults (Appendix E). This publication is a useful guide for organizations to conduct a culturally sensitive needs assessment.
Partner with AAPI Community Leaders/Organizations
If an organization has limited resources but ample staff time, a best practice is to partner and work directly with AAPI community leaders or local AAPI service community-based organizations. Building trust and engaging local AAPI community leaders will allow agencies to better understand the AAPI population within their service area. AAPI community leaders and community-based organizations provide direct services to the AAPI community, and experience the needs and challenges that the AAPI community face. These organizations are also the trusted source that AAPI older adults and their caregivers go to. If resources are limited, building relationships and conducting key informant interviews and/or focus groups with AAPI community leaders and staff are a reasonable alternative.

Re-Design Program Evaluation
If time and resources are limited, re-designing program evaluation to collect disaggregated data is a simple method to understand the unique needs of AAPI older adults and their caregivers, especially if data collection, or program evaluation, is already occurring. Most organizations collect simple demographic data such as age, gender, and ethnicity. Expanding the list of options that an AAPI individual is able to choose as their ethnicity(s) is a simple first step. Organizations could also collect data on primary language. This allows the organization the ability to analyze the disaggregated number of AAPI consumers and the number of LEP AAPI consumers they are serving.

Data and Resources for AAPI Older Adults
The following are available datasets for agencies to utilize to determine the LEP AAPI populations:
• The U.S. Census Bureau – American Community Survey
  (http://www.factfinder.census.gov)
• The U.S. Census Bureau – Language Use Section
  (https://www.census.gov/topics/population/language-use.html)
• The Federal Interagency Working Group on Limited English Proficiency
  (https://www.lep.gov/demog_data.html)
• State and local government offices (i.e. social service agencies, office of language
  access, etc.)
• Higher education institutions (i.e. universities, community colleges, etc.)

Other published reports and references guides to assist in determining the LEP AAPI
population composition include the following:

• AAPI Data – (http://www.aapidata.com)
• Department of Health and Human Services – Civil Rights: Revised HHS LEP
  Guidance (http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-
  english-proficiency/index.html?language=es)
• National Asian Pacific Center on Aging – National Resource Center on AAPI
  Aging: Fact Sheets (Appendix A-E)
Medicare Education and Information Needs

As mentioned in the previous section, it is important to understand the unique needs and challenges faced by AAPI older adults from one's own service area. NAPCA and its partners conducted a series of focus groups with ten LEP AAPI Medicare beneficiary sub-populations (Appendix F). This section will discuss on a general level the needs of LEP AAPI Medicare beneficiaries.

Overall, there is a general lack of education and understanding of the Medicare program, the available benefits and how to best utilize the benefits (NAPCA, 2016). This may lead to negative consequences such as a high risk of AAPI older adults being victims of Medicare fraud, increased risk of chronic conditions (i.e. cancer), and decreased overall quality of life. LEP AAPI Medicare beneficiaries need basic in-language Medicare information, such as (1) Medicare benefits and coverage, (2) differences between Part A, B, C and D, (3) Medicare terminology and definitions, (4) Medicare and alternative medicine, and (5) differences between Medicare and Medicaid.

The lack of education and understanding is due to the fact that information and materials are not translated into languages that many AAPI older adults comprehend (NAPCA, 2016). Focus group participants expressed the need for the annual Medicare guide, "Medicare & You," be translated into a language that they can understand. The only copy they receive is in English, a language that they cannot read. In addition, several focus group participants mentioned that they "throw away the Medicare Summary Notice" because they don’t know what it is and its importance. If these documents cannot be translated into multiple AAPI languages, then it would be greatly beneficial to LEP AAPI Medicare beneficiaries to receive in-language trainings and educational presentations.

Medicare Fraud

LEP AAPI Medicare beneficiaries are vulnerable to Medicare fraud because information and vital documents are in English. There are two key steps to preventing Medicare fraud: (1) detecting and (2) reporting. Detecting Medicare fraud is directly related to LEP AAPI Medicare beneficiaries' ability to understand (1) the Medicare program, (2) the Medicare Summary Notice, and (3) the various services they receive from physicians/providers. LEP AAPI Medicare beneficiaries need an in-language training series that will provide the basic competency to detect Medicare fraud.

The second step to prevent Medicare fraud is to understand the process and overcome barriers to report fraud. Focus group participants described various reasons that prevent LEP AAPI Medicare beneficiaries from reporting Medicare fraud, including language
barriers, not knowing the reporting process, embarrassment or shame, and fear of retaliation. In addition, many focus group participants expressed that, to identify fraud, they rely on their family or adult children to assist in reading or translating vital documents. LEP AAPI Medicare beneficiaries who live alone, or have no family or informal supports, are at a higher risk of being victims of Medicare fraud.
Outreach and Education Strategies and Best Practices

By developing an outreach and education campaign, an organization is committing to extending its services beyond their current or usual limits. In order to facilitate a successful campaign, organizations should ensure they have adopted and applied the best practices mentioned in the previous section Organizational Best Practices, which is the foundation for delivering quality services to AAPI older adults and their families. In addition to the following strategies in this section, having the proper policies, procedures, staff training and competencies to serve AAPI older adults will increase the likelihood of a successful outreach campaign.

AAPI Community Based Organizations

A key strategy for engaging AAPI populations is to partner with AAPI serving community-based organizations. It's important to build trust and develop partnerships with community-based organizations that have a long history of serving AAPI older adults. These partnerships help to cultivate an awareness of assets within the AAPI community and to gain trust as you work closer with AAPI older adults.

These community-based organizations tend to:

- Be staffed by people who reflect the AAPI populations (including languages spoken) of your community;
- Respond to shared needs of the community they originate from;
- Mobilize members of their community as volunteers;
- Be visible and trusted within community neighborhoods;
- Build relationships with the community in addition to delivering needed education and services.

Begin with relationship building, recognizing that partnerships with AAPI-serving community-based organizations may need to focus on capacity building over time. In your initial conversations, explore the shared benefits of partnership. Many of these community-based organizations operate with very limited resources, and therefore consider using dispersed site management strategies to address the needs of rural organizations; this could include resources like AmeriCorps VISTA, whereby a host agency is granted a VISTA member who is then assigned to a community-based organization. Another strategy is to partner on a grant where implementation of the
project would be through the community-based organization whereby a portion of the funds would be utilized to hire staff within their organization. Another strategy is to collaborate on public awareness meetings and community events.

**AAPI Churches and Community Leaders**

Partnering with AAPI places of worship, like churches and temples, and collaborating with AAPI community leaders are often effective strategies to gain trust and to develop closer relationships with AAPI communities. As mentioned previously, NAPCA and its partners conducted a series of focus groups with ten LEP AAPI Medicare beneficiary sub-populations. The results showed that LEP AAPI Medicare beneficiaries prefer receiving their information from churches or places where they can receive information in their own language. For example, the Laotian focus group participants said they don't speak English and don't know how to communicate with people outside of the Lao community.

An example of an effective partnership with AAPI-community based organizations is highlighted from the work of the University of Hawaii’s National Technical Assistance Center. The Center developed a strategy to increase job opportunities and community awareness of AAPI persons with disabilities through local AAPI church communities. In an effort to build relationships with church leaders, the Center invited the faith-based communities to co-host an event featuring a well-known AAPI figure with a disability, and at the event, the AAPI figure shared his personal success story. The event was a tremendous success, including an attendance of more than 400 guests and 100 volunteers, the commitment of 15 AAPI employers to hire qualified workers with disabilities, and statewide media coverage that increased awareness of disability issues within the AAPI community and the need for increased job opportunities.

**Communication Strategies**

The communication style of AAPIs tends to be very different from Western culture. AAPIs tend to be highly keen on non-verbal cues, such as hand gestures, body language, eye contact, voice pitch and intonation, and word stress; even the use of silence is just as important as the words used. Table 3 summarizes the communication style differences between Western and AAPI cultures.
Table 3: Differences Between Western and AAPI Communication Styles

<table>
<thead>
<tr>
<th>Western Culture</th>
<th>AAPI Cultures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfortable with direct questions and answers</td>
<td>Often view direct questions and answers as abrupt or rude</td>
</tr>
<tr>
<td>Smiling indicates pleasure and humor</td>
<td>Smiling may also indicate confusion or embarrassment</td>
</tr>
<tr>
<td>Less likely to be tuned in to moods of others during conversation</td>
<td>More likely to be tuned to moods of others, and expect others to be</td>
</tr>
<tr>
<td>Comfortable with expressing and accepting concerns and confusion in a direct manner</td>
<td>Expect those to sort out their concerns, confusion and hesitance through polite conversation</td>
</tr>
</tbody>
</table>

Asian Pacific Health Care Venture, Inc., 2016

There are cultural factors that may impact effective communication and engagement with AAPI older adults. AAPI cultures value harmony and balance, and therefore, AAPI older adults may be reluctant to complain or to ask for clarification. AAPI older adults also value group or family consensus, and therefore, speaking only to the individual may not be an effective way to communicate or seek action/results. In addition, there are often varying degrees of acculturation that influences each family member's perspective, varying from very traditional to very "Americanized." Lastly, professionals should be aware of the effects of historical trauma, particularly if programs are housed in government agencies; some AAPI cultures may have trust issues with government bodies.
Volunteer Engagement Strategies and Best Practices

In many AAPI subcultures, formal volunteering is not historically relevant; yet there are strong cultural traditions of informal volunteering (for example, helping neighbors, caregiving, village concept). There is emerging evidence, however, that volunteering as a more formal activity through organizations or groups is growing in significance for older people from culturally and linguistically diverse cultures, and particularly Asian cultures (Warburton and Winterton, 2010). Finding relevant volunteer roles for AAPI older adults is important for maintaining and promoting cultural knowledge and values within a broader western society, contributing to generativity, or, imparting a legacy for future generations to explore the human need to pass on societal traditions and ways of life.

AAPI Community Based Organizations

Collaborating with trusted AAPI-serving community based organizations to outreach, recruit and train volunteers is a key strategy for mainstream aging organizations. As mentioned previously, volunteering may be a new and unfamiliar process for some AAPI older adults. Some AAPI languages or cultures may not have a term or translation for "volunteering." And therefore, by working with AAPI-serving community based organizations that know culturally appropriate ways to engage the community members in volunteerism is an efficient and effective way to engage and mobilize AAPI individuals.

Foundational Elements to Enhance the AAPI Volunteer Experience

Before conducting an AAPI volunteer outreach and recruitment campaign, organizations can take preliminary steps in programming to enhance the AAPI volunteer experience. Work with the AAPI community based organization to identify barriers and solutions to volunteering with your organization. NAPCA's focus groups with AAPI Medicare beneficiaries indicated that many of the participants from multiple AAPI ethnicities currently volunteer. They reported volunteering with their local church, temple, or AAPI community based organizations. Focus group participants said that they best way to recruit is through the locations where they currently volunteer. However, participants also reported that because they do not speak English very well, agencies should:

1. Refine their training program to be inclusive of LEP AAPI older adults who want to volunteer.
2. Eliminate or reduce the effects of language barriers by developing partnerships with AAPI churches, temples and community based organizations to be the AAPI volunteer station, point of contact or hub.

3. Broaden various roles and job descriptions to follow a strengths perspective strategy, thereby offering flexibility and maximizing the skills of AAPI volunteers.

It is also good practice to adopt a person-centered approach when engaging AAPIs in volunteer activities. An example of taking a person-centered approach to engage the AAPI community is from the Asian Pacific American Legal Resource Center (APALRC), where the organization empowered and assisted the residents of the Wah Luck House to organize into their first Tenant’s Association. The Wah Luck House is a low-income senior housing complex, in the middle of Chinatown, in Washington D.C. The association, which is made up of residents and volunteers of Chinese descent, is now actively engaged in advocacy on issues impacting them within their community. Issues such as affordable housing, language access, health and social services, and access to ethnic grocery stores are the biggest challenges faced by the residents of the Wah Luck House. They are also concerned about the impact that gentrification is having on their ability to remain living in Chinatown. Currently, a little more than 300 Chinese immigrants remain in Chinatown (a trend that is not unique to DC’s Chinatown). The APALRC took a person-centered approach by listening and empowering the AAPI residents to get involved and self-advocate for themselves, and their community members.

Finally, consider incentives that may attract AAPI older adults to volunteer, such as:

- Educational programs; there is a strong desire for learning and having new experiences.
- Personal requests from trusted professionals.
- Stipends (e.g. Senior Corps programming or SCSEP) or free meals.
- Volunteer recognition.

Organizations should integrate volunteer motivational factors in needs assessments, which should be conducted on a regular basis to examine the differences so that strategies or programs can be designed, and revised, according to any changes that may occur over time.
References:

   http://www.agid.acl.gov/StateProfiles/Profile/Pre/?id=41&topic=1&years=2006
   http://www.agid.acl.gov/StateProfiles/Profile/Pre/?id=41&topic=1&years=2013
   http://www.pewsocialtrends.org/2012/06/19/the-rise-of-asian-americans/
   https://docs.google.com/viewer?a=v&pid=sites&srcid=bnBhLXJ[9ZWMub3JnHfHlZ2tvbiR8Z3g6MJyfYW13NmY2NmNhM TBkYw
Appendix

A. Asian American and Pacific Islander Inclusion: A Self-Assessment for Organizations
B. Identifying Languages within Your Community: Asian American and Pacific Islander Older Adult Data
C. Identifying Population Counts with Your Community: Asian American and Pacific Islander Older Adult Data
D. Four Strategies to Identify an Interpreter: For an Asian American and Pacific Islander Older Adults
E. Seven Best Practices when Conducting a Community Needs Assessment with Asian American and Pacific Islander Older Adults
F. Hard to Reach Medicare Beneficiary Project – Focus Group Reports
G. Translated Outreach and Education Materials - http://napca.org/technical-assistance/
Asian American And Pacific Islander Inclusion:

A Self-Assessment for Organizations

Adapted, with permission, from the Annie E. Casey Foundation’s Race Matters Toolkit and Organizational Self-Assessment (http://www.aecf.org/)

National Asian Pacific Center on Aging
National Resource Center on AAPI Aging

1511 Third Avenue | Suite 914 | Seattle, Washington 98101 | www.napca.org
A Self-Assessment for Organizations

Why should an organization use this tool?
Asian Americans and Pacific Islanders (AAPIs) are a diverse group originating from over 30 countries with a multitude of ethnicities that speak over 100 different languages - and also have the fastest growing aging population. Numerous differences between AAPI and mainstream American culture cause barriers that restrict AAPIs from fully accessing long-term services and supports. Prioritizing cultural and linguistic competencies are critical to eliciting racially equitable results for AAPI older adults throughout our communities.

How to use this tool:
1. For each question, circle the response that most closely reflects your current organizational environment.
2. Add up the numbers associated with each answer to get your organization’s AAPI Inclusion Score.
3. Use the chart at the end of the tool to determine what your organization’s AAPI Inclusion Score means and next steps to consider.

AAPI Inclusion
What will the tool accomplish?
This tool will help organizations raise their awareness, evaluate areas for improvement to increase inclusion, and track organizational change as they strengthen their work with AAPI older adults within their communities.

Staff Competencies

1. Staff have a basic knowledge about AAPI populations, including population demographics, disparities faced, and the specific barriers experienced by AAPI older adults when accessing long-term services and supports.
   0=None 1=Some 2=Almost All 3=All

2. Staff have a deep level of understanding about AAPI populations living in the service area, including population demographics, disparities faced, and the specific barriers experienced by AAPI older adults when accessing long-term services and supports.
   0=None 1=Some 2=Almost All 3=All

3. Staff are comfortable and competent in discussing AAPI populations living in the service area, including population demographics, disparities faced, and the specific barriers experienced by AAPI older adults when accessing long-term services and supports.
   0=None 1=Some 2=Almost All 3=All

4. Staff know how to access interpreters for AAPIs.
   0=None 1=Some 2=Almost All 3=All

5. Staff utilize interpreters for AAPI older adults.
   0=None 1=Some 2=Almost All 3=All

6. Staff exhibit cultural and linguistic competence in their interactions with AAPI older adults.
   0=None 1=Some 2=Almost All 3=All

7. Staff disaggregate AAPI data by race in all analyses.
   0=None 1=Some 2=Almost All 3=All

8. Written materials produced by staff reflect a deep level of knowledge and understanding of AAPI populations living in the service area.
   0=None 1=Some 2=Almost All 3=All

9. Staff can articulate the costs of failing to include AAPI older adults into policy and practice discussions within the organization.
   0=None 1=Some 2=Almost All 3=All
1. Equitable access to culturally and linguistically appropriate long-term services and supports for AAPI populations in the service area is an explicit goal of the organization.
   0=No  1= Moving in that Direction  2= Yes

2. There is an internal team that guides the work of the organization to elicit racially equitable results for diverse populations, including AAPI older adults.
   0=No  1= Moving in that Direction  2= Yes

3. The organization conducts regular assessments to evaluate the operations’ impacts on eliciting racially equitable results for diverse populations, including AAPI older adults.
   0=No  1= Moving in that Direction  2= Yes

4. The organization conducts regular community needs assessments to evaluate the needs and barriers faced by AAPI older adults in the service area, with inclusion of AAPI older adults throughout that process.
   0=No  1= Moving in that Direction  2= Yes

5. The organization’s goals of enabling equitable access to culturally and linguistically appropriate long-term services and supports for AAPI older adult populations are reflected in resource allocations.
   0=No  1= Moving in that Direction  2= Yes

6. The results of the organization’s investments show a reduction of barriers to access culturally and linguistically appropriate long-term services and support for AAPIs.
   0=No  1= Moving in that Direction  2= Yes

7. There is a mechanism for AAPI older adults to address complaints about barriers to accessing long-term services and supports through the organization.
   0=No  1= Moving in that Direction  2= Yes

8. The organization partners with the AAPI community (AAPI serving community-based organizations and community leaders) to promote equitable access to culturally and linguistically appropriate long-term services and supports.
   0=No  1= Moving in that Direction  2= Yes

9. The organization has a deliberate plan to recruit, develop, and promote diverse staff who reflect the AAPI communities they serve.
   0=No  1= Moving in that Direction  2= Yes

10. The organization promotes and enables access to training for staff on AAPIs within the service area.
    0=No  1= Moving in that Direction  2= Yes

11. The environment of the organization (e.g., food, art, celebrations, etc.) is multicultural, with opportunities to celebrate the diversity of AAPIs.
    0=No  1= Moving in that Direction  2= Yes

<table>
<thead>
<tr>
<th>AAPI Inclusion Score</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>Prioritize AAPI Older Adults</td>
</tr>
<tr>
<td></td>
<td>Make a deliberate change within the organization to commit to eliciting equitable results for AAPI older adults within a community; begin by demonstrating that commitment through mission/vision statements. Apply the competencies and utilize the additional resources available through the National Resource Center on AAPI Aging to develop stronger organizational goals.</td>
</tr>
<tr>
<td>20 - 29</td>
<td>Build Capacity</td>
</tr>
<tr>
<td></td>
<td>Staff competencies are weak; identify opportunities to increase staff understanding of AAPI populations, including the specific barriers experienced when accessing long-term services and supports. The organization’s competency is lacking; identify operational changes that can be implemented to reduce barriers faced by AAPI older adults in the community.</td>
</tr>
<tr>
<td>30 - 39</td>
<td>Modify to Strengthen</td>
</tr>
<tr>
<td></td>
<td>Identify the items that scored the lowest and develop a plan to strengthen those competencies.</td>
</tr>
<tr>
<td>40 - 49</td>
<td>Share Best Practices!</td>
</tr>
<tr>
<td></td>
<td>The success of one organization can promote change within another. Share these best practices with the National Asian Pacific Center on Aging to strengthen the aging network in their work with AAPI older adults nationwide.</td>
</tr>
</tbody>
</table>

Looking for helpful resources? Contact the National Resource Center on AAPI Aging admin@napca.org
IDENTIFYING LANGUAGES WITHIN YOUR COMMUNITY
Asian American and Pacific Islander (AAPI) Older Adult Data

Go to www.factfinder.census.gov and click on ADVANCED SEARCH

1. Click TOPICS
   - Click PEOPLE
     - Click LANGUAGE
     - Click LANGUAGES SPOKEN AT HOME

2. Click RACE AND ETHNIC GROUPS
   - Type CODE -04 "ALL AVAILABLE DETAILED ASIAN RACES" [click add]
   - Type CODE -05 "ALL AVAILABLE DETAILED NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER RACES" [click add]

3. Click GEOGRAPHIES
   - Click NAME
     - Type in your GEOGRAPHY NAME (e.g. state, county, etc.)
Select table “AGE BY LANGUAGE SPOKEN AT HOME BY ABILITY TO SPEAK ENGLISH FOR THE POPULATION 5 YEARS AND OVER” and click view.

View and analyze the disaggregated data on AAPI languages for the geographic region you specified.

**CAUTION!** There are limitations to these data sets.

- These data sets do not provide disaggregated information on older adults who identify with more than one AAPI race.
- These data sets do not account for all AAPI races. It only includes the AAPI races that are available in the area you specified.

Use this data to enable your organization to be more culturally and linguistically responsive to your community’s AAPI older adults.

For examples of specific strategies, access resources available through the National Resource Center on AAPI Aging.
IDENTIFYING POPULATION COUNTS WITHIN YOUR COMMUNITY
Asian American and Pacific Islander (AAPI) Older Adult Data

Go to www.factfinder.census.gov/ and click on ADVANCED SEARCH

Click TOPICS

Click PEOPLE

Click AGE GROUP

Click OLDER POPULATION

Click RACE AND ETHNIC GROUPS

Type CODE -04 "ALL AVAILABLE DETAILED ASIAN RACES" [click add]

Type CODE -05 "ALL AVAILABLE DETAILED NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER RACES" [click add]

Click GEOGRAPHIES

Click NAME

Type in your GEOGRAPHY NAME (e.g. state, county, etc.)
1. Select your geography [add]

2. Select table “SELECTED POPULATION PROFILE IN THE UNITED STATES” and click view

2. Analyze Data on AAPI Languages Ages 65+

- View and analyze the data on AAPI population counts for the geographic region you specified.

- CAUTION! There are limitations to these data sets.

- These data sets do not provide disaggregated races, and also do not include older adults who identify with more than one AAPI race.

- These data sets do not account for all AAPI races. It only includes the AAPI races that are available in the area you specified.

3. Data Drives Program Development

- Use this data to enable your organization to be more culturally and linguistically responsive to your community’s AAPI older adults.

- For examples of specific strategies, access resources available through the National Resource Center on AAPI Aging.

The National Asian Pacific Center on Aging
1511 Third Avenue | Suite 914 | Seattle, Washington 98101
www.napca.org

For questions, please contact us at admin@napca.org
4 STRATEGIES TO IDENTIFY AN INTERPRETER
For an Asian American and Pacific Islander (AAPI) Older Adult

1. ONLINE DIRECTORY
Access the website www.atanet.org/onlinedirectories and search for your location(s).

2. COMMUNITY-BASED ORGANIZATIONS (CBO)
With the help of technology, such as Video Conferencing and/or Calling platforms, arrangements can be made with local AAPI serving CBOs to assist with in-language interpretation.

3. STATE GOVERNMENT
Call your local Translation and Interpreting Bureau or Agency to access your state’s pool of interpreters.

4. UNIVERSITIES AND COLLEGES
First, consider what terminology is important for the interpreter to understand (e.g. medical, legal, etc.). Then, contact departments within local universities where students understand the necessary terminologies, and request students that speak that language.
Seven Best Practices When Conducting a Community Needs Assessment with Asian American and Pacific Islander (AAPI) Older Adults

**Purpose:** To adopt a culturally and linguistically appropriate approach to assess the needs of AAPI older adults, so an organization can take action, set priorities, allocate resources, and ensure equitable access to appropriate services.

---

**BEST PRACTICE 1: Form an AAPI Advisory Committee**
- Initiate a voluntary AAPI Advisory Committee*
- OR
- Contract with AAPI experts to establish a AAPI Advisory Committee*

**BEST PRACTICE 2: Conduct a Review of Existing Data on AAPI Older Adults and Develop a Plan**
- Review existing records (e.g., service utilization, needs assessments) and government databases (e.g., U.S. Census, local health department) to understand the current landscape and to assess gaps in AAPI data
- AND
  - Engage AAPI Advisory Committee in plan development (i.e., timeline, budget, responsibilities, goals, objectives)

**BEST PRACTICE 3: Modify Survey Instrument to be Culturally and Linguistically Appropriate**
- Integrate AAPI specific measures into survey instrument*
- AND
- Translate into AAPI language(s)
- AND
- Pretest survey instrument; make survey modifications based on findings
BEST PRACTICE 4: Tailor Survey Methods to the Targeted AAPI Community

Identify AAPI population counts and subgroups in your community

AND

Tailor outreach and recruitment methods to the specific AAPI community that is being surveyed (*Consult with AAPI Advisory Committee (AAPI-serving community based organizations, AAPI community leaders, churches, etc.))

BEST PRACTICE 5: Conduct Interviews In-Language

Recruit bi-lingual volunteer interviewers (*)

OR

Hire bi-lingual interviewers (*)

AND

Provide training to bi-lingual interviewers

BEST PRACTICE 6: Translate and Transcribe Data

Translate the findings into English and transcribe the data

AND

Consult with the interviewer to confirm that the data was translated correctly; make necessary edits

BEST PRACTICE 7: Publish and Disseminate Results Broadly

Self-publish the results broadly to increase available data on AAPI older adults

AND

Integrate the findings and recommendations into strategic plans and to target resources

What else to Consider?

- Implementation will require additional resources (i.e., time and money).
- Maximize available resources, such as: local universities/colleges (e.g., Urban and Regional Planning department, student interns, academic researchers); donated resources (e.g., venue space); multilingual staff; local foundation funding; and technical assistance through NAPCA’s National Resource Center on AAPI Aging.
- These best practices often overlap throughout the needs assessment

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### Appendix F: Hard to Reach Medicare Beneficiary Project - Focus Group Report

**Q16. Barriers to Reporting**

- **Language barriers**: Language should not be academic. Use font size bigger, spelling has to be corrected, picture smaller, and font bigger.
- **Accessibility**: Information is clear and easy to understand. Language is native and relevant. Visual messaging is good. Content and message are good. All information is important and should be for people. Translation is good and easy to read. It’s better to have pictures. Make print bigger. Colors are off, too many blank spaces. Make font darker.
- **Knowledge and awareness**: Medicare recipients. Knowing that Medicare was, so throw it away. Yes, everything is new. Information was good, not sure if it was language or phonetic. Words were clear. Everything is new. No, it’s a new information. Yes, it’s a new information.
- **Sacrifice**: Information about Medicare fraud. Know to protect your DDS, identity theft for Medicare. Knowing that Medicare might come after them. They might come after them. They are afraid someone else will get the information. It’s better to have pictures. More photos of a pacific islander. Background is dark. Nothing.
- **Transportation**: Problem making for volunteers. Translation: "Original documents and translation" should be in Tagalog. There was some confusion on the differences. Language barriers, it becomes more complex. There was some confusion on the differences. Different types of benefits of Medicare. Difference between Medicare and Medicaid. In my language and my culture, it’s important. If they didn’t know, they know more now. It’s helpful to know where to call to report. Photographs are nice.
- **Time**: The number to call to report Medicare fraud. Defining what Medicare fraud is, lack of education of what fraud actually is. Participants just throw it away. Yes, everything is new. Dermatologists.
- **Health**: Health care. Transportation. Taking time to translate information for an elderly man in an apartment building. Teach chinese, tai chi, tutor, translate information for an elderly man in an apartment building.
- **Education**: Yes, several examples of medicare fraud. See an number to call. If you don’t know the name of the scammer and phone number, how can/do you report it, but now they know there is a number to call. They want to help people.
- **Scheduling**: Volunteer at the temple and churches, or help with interpretting at the community center. They will respond to this. They will respond to this. They want to help people. They are ready to help people.
- **Other**: Volunteers. Taking time for an elderly man in an apartment building.

**Q8. Factors would make Volunteer**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>Simple work, easy, flexible, not requesting much time.</td>
</tr>
<tr>
<td>Language</td>
<td>Everything is new. Like that the brochures are in Korean. Information is clear and easy to understand. Language is native and relevant. Visual messaging is good. Content and message are good. All information is important and should be for people. Translation is good and easy to read. It’s better to have pictures. Make print bigger. Colors are off, too many blank spaces. Make font darker.</td>
</tr>
<tr>
<td>Knowledge and awareness</td>
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</tr>
<tr>
<td>Other</td>
<td>Volunteers. Taking time for an elderly man in an apartment building.</td>
</tr>
</tbody>
</table>

**Q7. Factors to Volunteer**

- **Volunteer**: Best to go through the churches to recruit volunteers. To help people. They want to help people. Volunteer at their church and many other non-profit organizations to help them understand the difference between Medicare and Medicaid. Community outreach materials, and also to promote it at the community center. Help people. They are ready to help people.
- **Community**: Community outreach materials, and also to promote it at the community center. Help people. They are ready to help people.
- **Other**: Volunteers. Taking time for an elderly man in an apartment building.

**Q5. Suggestions**

- **Volunteer service or programs, lack or**
  - **Time**
  - **Language**
  - **Scheduling**
  - **Knowledge and awareness**
  - **Other**

- **Accessibility**: Information is clear and easy to understand. Language is native and relevant. Visual messaging is good. Content and message are good. All information is important and should be for people. Translation is good and easy to read. It’s better to have pictures. Make print bigger. Colors are off, too many blank spaces. Make font darker.
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- **Other**: Volunteers. Taking time for an elderly man in an apartment building.

**Q4. Dislike**

- **Location**: Have not experienced or seen these types of benefits of Medicare.
- **Knowledge and awareness**: Having enough time, lack of motivation. Reliable transportation, language barrier, not knowing themselves. Medicare 101, the difference between Medicare and Medicaid. In my language and my culture, it’s important. If they didn’t know, they know more now. It’s helpful to know where to call to report. Photographs are nice.
- **Other**: Volunteers. Taking time for an elderly man in an apartment building.

**Q3. Like**

- **Volunteer service or programs, lack or**
  - **Time**
  - **Language**
  - **Scheduling**
  - **Knowledge and awareness**
  - **Other**

- **Accessibility**: Information is clear and easy to understand. Language is native and relevant. Visual messaging is good. Content and message are good. All information is important and should be for people. Translation is good and easy to read. It’s better to have pictures. Make print bigger. Colors are off, too many blank spaces. Make font darker.
- **Knowledge and awareness**: Medicare recipients. Knowing that Medicare was, so throw it away. Yes, everything is new. Information was good, not sure if it was language or phonetic. Words were clear. Everything is new. No, it’s a new information. Yes, it’s a new information.
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