

Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities:

A Blueprint for Action

Consensus Statements and Recommendations

January 2012

**U.S. Department of Health and Human Services
Office of Minority Health**

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This publication is based on research conducted by the National Asian American Pacific Islander Mental Health Association and proceedings from the 2011 national consensus meeting titled: Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities: A Blueprint for Action.

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Suggested citation:

Ida, DJ, SooHoo, J and Chapa, T. **Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities: A Blueprint for Action: Consensus Statement and Recommendations.** Rockville, MD: U.S. Department of Health and Human Services, Office of Minority Health, Jan. 2012. 43p.

ACKNOWLEDGEMENTS

We would like to thank everyone who assisted in the research, planning, and execution of the expert consensus meeting, as well as with the writing and editing of this document.

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EXECUTIVE SUMMARY

On April 8, 2011 the U.S. Department of Health and Human Services (US DHHS) issued an action plan to reduce racial and ethnic health disparities. As part of its ongoing commitment to enhance health equity and eliminate disparities in behavioral health for racial and ethnic minority populations, the US DHHS Office of Minority Health (OMH) partnered with the National Asian American Pacific Islander Mental Health Association (NAAPIMH) to convene an historic summit titled *Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities: A Blueprint for Action*. The August 15-16, 2011 meeting in San Francisco, California brought together more than 40 key stakeholders— all committed to improving the quality of life for Asian American, Native Hawaiian, Pacific Islander (AANHPI) communities. For the first time, providers, consumers, policy makers, evaluators and administrators from the areas of primary healthcare, integrated care, mental health, substance use and disabilities came together to develop a national agenda to examine the benefits of integrated care for AANHPIs. Participants identified core components most relevant to AANHPI overall health and healthcare. Recommendations were designed to inform both governmental and non-governmental partners on best approaches and models of care that take into account the unique cultural and language needs of this diverse AANHPI population.

The four break-out sessions were designed to work as think tanks and were selected based on best evidence and practices available; and resulted in the following: 1) develop strategies to implement integrated care; 2) workforce training and development; 3) use of health information technology; and 4) community based participatory research and evaluation. Although each group made independent recommendations, they collectively agreed to the following:

- Disparities exist in quality of care for AANHPIs that is a detriment to the overall health and mental health of AANHPI communities.
- Integrated care must take a public health approach, be holistic, work across the life span, include prevention and early intervention, and be person-centered, strength-based and recovery-focused.
- AANHPI leadership must be represented at OMH, SAMHSA along with other federal partners to provide oversight to implementing the recommendations outlined in this *Blueprint for Action*.
- There is a need to expand the current workforce; focusing on who and how we train providers to work in integrated care. Workforce must include consumers and para-professionals in addition traditional health and behavioral health practitioners.
- Research and data collection must include AANHPIs; including granular data to reflect the diversity within and between various AANHPI populations.
- All services and research must reflect the culture and language of AANHPI communities.

Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities:

A Blueprint for Action

INTRODUCTION:

The need to improve the healthcare system has been a topic of discussion in the United States for over a century. The passage of the Patient Protection and Affordable Care Act of 2010 and the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 sparked much debate on how to improve the quality of care for individuals living in this country. This debate is particularly significant for vulnerable populations including Asian Americans, Native Hawaiians and Pacific Islanders (AANHPIs) who often receive inadequate health and behavioral health care due to an array of factors including the critical lack of providers who have the language and cultural skills needed to meet their unique health needs.

AANHPI populations are one of the fastest growing ethnic minority communities in the US. Approximately 16.6 million AAPIs reside in the USA and represent over 30 countries of origin and more than 100 languages. Nearly two-thirds of AAPIs were foreign born, while 38 percent of Asian Americans do not speak English fluently. Most AAPIs live and reside in metropolitan areas of California, New York, Hawaii, Texas and New Jersey.

High rates of limited English proficiency compound the obstacles AANHPIs face in achieving meaningful access to good health and behavioral healthcare, as many cannot communicate effectively with healthcare providers. AANHPIs along with Hispanic/Latino populations, report the highest level of dissatisfaction with the quality of health care they receive, expressing frustration that providers do not respect or understand them (Commonwealth Fund, 2001). Failure to receive culturally and linguistically appropriate services results in the increased likelihood AANHPIs will not seek care, engage with care providers, or follow through with recommended treatments, resulting in poor adherence and premature termination of treatment. There also exists the increased risk for misdiagnosis and/or ineffective treatment plans, including unnecessary duplication of services—all potentially costly both personally and financially. Ultimately, the overall health of AANHPIs may be greatly compromised, leading to negative consequences not only for individuals, but also for families and entire communities.

Integrated care has become central to the discussion on how to improve health and behavioral healthcare quality. Because the medical sector is the primary point of entry for AANHPI's seeking health or behavioral health care, it is important to create a system of care that includes both medical and behavioral health care providers (Chung, 2002, Lu, 2002, Chapa, 2004, Chen, 2008, Ida 2009). Additionally, primary care settings often serve in identifying individuals with

undiagnosed or untreated mental disorders. By removing barriers to treatment AANHPIs are provided a venue different from specialty mental health services. Furthermore, there is a growing recognition in healthcare that the mind-body split is a false dichotomy, something AANHPIs have known all along. Finally, integrated care practices must also respect the cultures and languages of the people they serve with a bilingual and culturally competent staff and approaches, while also incorporating indigenous healing practices for success and effectiveness of care within AANHPI communities.

Reasons to incorporate integrated care models as a vehicle for improving overall health outcomes for AANHPIs include:

- 1) AANHPIs utilize primary care as a source for all health care, including behavioral health care.
- 2) A holistic approach to care is culturally congruent and consistent with AANHPI traditions that do not separate the mind, body and spirit.
- 3) Studies support integrated care approaches as effective strategies for improving health outcomes for AANHPI and for potentially reducing health disparities.
- 4) Integrated care can cut spiraling costs by reducing duplication of services encountered when there is a lack of coordination between service providers.
- 5) An integrated care approach that focuses on both primary health and behavioral health will help reduce the stigma of seeking services focusing solely on behavioral health and is more comprehensive than primary health alone.

OMH INTEGRATED CARE SUMMIT FOR AANHPI COMMUNITIES

The 2011 HHS Action Plan to Reduce Racial and Ethnic Health Disparities highlights goals and actions that HHS will take to reduce health disparities among racial and ethnic minorities, and the Office of Minority Health is leading the charge to put the action plan into practice. One particular approach is the integration of mental health and substance abuse with primary care. OMH recognizes that primary care is often the first point of contact for minority populations, especially for AANHPIs seeking behavioral and physical health interventions and that this portal to service is perceived as less stigmatizing than specialty behavioral health settings. Not all primary health settings, however, are adequately equipped to handle those with serious behavioral health problems. It is therefore important that coordinating services and finding the right recipe for integrated care is essential in creating an equal partnership between the primary care provider and the behavioral health professional.

OMH and its partner, the National Asian American Pacific Islander Mental Health Association (NAAPIMHA), convened a 2-day Summit in San Francisco, California on August 15 & 16, 2011 titled: *Integrated Care for AANHPI Communities: a Blueprint for Action*. The Summit brought

together key stakeholders and leading experts from the Asian American, Native Hawaiian and Pacific Islander (AANHPI) health, mental health, substance use and disability sectors and was the first ever national meeting that coalesced the different health and behavioral health related fields to discuss the state of whole health of AANHPIs with integrated care as a central theme and model approach to quality of care.

The invitation-only group was comprised of over 40 individuals who crossed disciplines and included peer specialists, consumers, physicians, pharmacists, social workers, psychologists, psychiatrists, nurses, policy makers, advocates, administrators, and educators (see Appendix A for a List of Participants). Participants were selected based on knowledge and experience with AANHPI communities, subject matter expertise, ongoing advocacy efforts and overall commitment to improving the quality of life for AANHPIs. Each was expected to add value to the national dialog on integrated care for AANHPI communities. Key outcomes from the summit include the consensus statements and recommendations presented in this report.

This consensus statement and recommendation paper is the third in a series of OMH sponsored activities that address specific areas of need within underserved targeted communities, beginning with *Movilizandonos por Nuestro Futuro: Strategic Development of a Mental Health Workforce for Latinos (2010)* and *Pathways to Integrated Health Care: Strategies for African American Communities and Organizations (2011)*.

In preparing for the Summit, the organizers conducted a thorough literature review, examined current integrated care programs and models for AANHPI populations, and identified key areas of concern for discussion. It would not be feasible to address all pertinent issues in a two-day summit nor try to summarize all the issues in one document. Staying too narrow in focus would also not provide the depth required to develop a meaningful Blueprint for Action, therefore the Summit focused on key integrated care areas including: 1) workforce development and training; 2) research and data collection; 3) use of health information technology; and 4) developing strategies to eliminate disparities through integrated care. Each sub group can stand alone but collectively build on each other for a stronger action plan.

The Summit opened with greetings from Teresa Chapa, PhD, MPA, Senior Policy Advisor for Mental Health at OMH and DJ Ida, PhD, Executive Director of NAAPIMHA. This was followed by three plenary sessions designed to lay the foundation for the summit discussions:

- 1) Developing Effective Integration Strategies for AANHPI Communities: examined different community-based integrated care programs and provided a consumer advocate testimony that drove home the need for integrated care from a patient/consumer perspective; 2) Working in a Changing Landscape: focused on the impact of the Patient Protection and Affordable Care Act has on health and behavioral health for AANHPIs, and the Massachusetts model of health care

reform as an example of a state-level system change, and 3) Health Information Technology: explored the expanding role of technology in the health and behavioral health fields.

The panel presentations were followed in the afternoon and the morning of the second day by four break-out groups:

- 1) Strategies to Eliminate Disparities through Integrated Care
- 2) Integrated Care Workforce Development and Training
- 3) Community-Based Participatory Research and Evaluation of Integrated Care
- 4) Health Information Technology

Participants were asked in advance to self-select from one of the identified think-tank groups. Those who did not select were assigned a group to balance the number assigned to each issue. (See Appendix B for Break-out Group Rosters.) Each workgroup was assigned a facilitator and scribe and participants were charged with developing recommendations reflecting their specific content area.

The consensus statements and recommendations outlined in this document are intended to inform a broad audience including but not limited to community leaders, consumers and families, providers working with AANHPI communities, federal partners, local, state and national health and behavioral health policy makers, appointed and elected officials, and others who are interested in examining integrated care approaches for eliminating health and behavioral health disparities, designed for AANHPI communities.

The Summit participants want this *Blueprint for Action* to be used to educate stakeholders, providers and decision makers on the importance of developing, supporting and implementing models of integrated healthcare. Furthermore, if these models are to be effective, they must reflect the unique health and behavioral needs and diverse cultures and experiences of AANHPIs throughout the country.

CONSENSUS STATEMENTS

The following consensus statements were derived from the expert participants:

- Disparities in care for AANHPIs exist to the detriment of the overall health of AANHPI populations and communities.
- Improve research and collect granular data to better assess the health and behavioral health status of each of the diverse subpopulations for AANHPIs.
- AANHPIs are in critical need for improved access and receipt of health and behavioral healthcare from a culturally and linguistically competent health and behavioral health workforce.
- Integrated care must take a public health approach! It must be holistic, work across the life span, include prevention and early intervention, be person-centered, strength-based and recovery-focused. Approaches must be capable of addressing social determinants of health such as access to food, shelter, employment and education.
- AANHPIs must have strong representation within various federal agencies with the purpose of representing the health and behavioral needs of the AANHPI communities.
- Establish a National AANHPI Integrated Care Steering Committee to work closely with OMH, SAMHSA and other federal partners to provide guidance in implementing the recommendations outlined in this *Blueprint for Action*.

The Steering Committee should be comprised of representatives from the national health and behavioral health focused organizations (i.e. Asian Pacific Islander American Health Forum, Association of Asian Pacific Community Health Organizations, the National Asian American Pacific Islander Mental Health Association, the National Asian Pacific American Families Against Substance Abuse and the National Council of Asian Pacific Islander Physicians) and must also include peers, family members and other key stakeholders.

- Maintain ongoing communication between OMH and the AANHPI community to monitor the progress of implementing this *Blueprint for Action* and its recommendations.

AANHPI HEALTH AND BEHAVIORAL HEALTH

Asian American, Native Hawaiian and Pacific Islanders experience health and behavioral health disparities on multiple levels, including high rates of morbidity, comorbidities, and mortality compounded by obstacles in achieving meaningful access to good health and healthcare.

Ten Leading causes of death for AANHPIs:

- 1. Cancer**
- 2. Heart disease**
- 3. Stroke**
- 4. Unintentional injuries**
- 5. Diabetes**
- 6. Chronic lower respiratory disease**
- 7. Influenza and pneumonia**
- 8. Kidney disease**
- 9. Suicide**
- 10. Alzheimer's disease**

(CDC, 2010)

AANHPIs health and behavioral health needs have historically been overlooked due to the myth of the 'model minority': of being passive, compliant, and without problems or needs. Some of the effects of this myth have been the failure to take seriously the very real concerns of these heterogeneous populations.

AANHPIs are at increased risk for cancer, heart disease, stroke, unintentional injuries and diabetes. They also have a high prevalence and risk factors for chronic obstructive pulmonary disease, hepatitis B, HIV/AIDS, and liver disease. Of the 1.25 million individuals in the U.S. suffering from Chronic Hepatitis B (HepB), half are Asian Americans. HepB is a highly contagious virus that can lead to chronic liver disease and death. AANHPIs also have higher rates of smoking and alcohol use, while Pacific Islanders and Native Hawaiians also have high rates of obesity.

Asian American women were the least likely to have had a Pap test (66%) as compared to other women, and Vietnamese women are five times more likely than other ethnic groups to be diagnosed with cervical cancer due primarily to lack of early testing (NCHS, 2010).

Approximately 10% of Asian Americans have diabetes, the fifth leading cause of death for this population, with a rate that is almost two times greater than the general US population (5.9%). The rate of diabetes increased from 8.8% to 9.4% for Asian American men from 2004-2008 (CDC, 2011). Despite having a lower Body Mass Index (BMI), AANHPIs are more likely to have Type 2 diabetes compared to non-Hispanic whites (Hsu et al., 2006). Even a small amount of weight gain above Western standards greatly increases the risk of developing diabetes; cogent for providers using the accepted standard for BMI as benchmark for people of Asian descent to measure risk for developing the disease.

Asian American, Native Hawaiian, and Pacific Islander (AANHPI) patients should be encouraged to talk their health care providers about diabetes and routine screening. Diabetes is a serious health concern, with Native Hawaiian and Pacific Islander populations especially at risk. There is a startling 47% diabetes prevalence in American Samoans, 20% diabetes prevalence in Native Hawaiians, and 10% among Asian Americans, compared with 8% of the US general population (NCAPIP, 2010).

AANHPI populations also experience serious mental health problems including high rates of depression, posttraumatic stress disorder and suicide ideology. Suicide is the ninth leading cause of death for all ages for AANHPIs (compared to eleventh for the overall US population). Although Native Hawaiian youth have significantly higher rates of suicide attempts when compared to other adolescents in Hawaii, Chinese women over the age of 65 have the highest reported rate of suicide within their gender and age group (CDC, 2011).

War trauma has greatly affected the Southeast Asian populations resulting in high rates of posttraumatic stress disorder (PTSD) and affecting close to 70% of the refugee populations (Kinzie, 1997). Fifty-four percent of Cambodian, 11% of Vietnamese, and 92% of Hmong outpatient clients met the criteria for PTSD (Marshall, 2005). Additionally, 40% of the SE Asian refugee groups suffer from depression while 35% report anxiety disorders (NIMH 2005). The Cambodian refugee community overall suffers from high rates of PTSD (62%) and major depression (51%), while almost 100 % reported near-death experiences due to starvation and 54% were tortured, while 90% had a family member or friend murdered (Marshall, 2005).

AANHPI populations often experience barriers to good health, including infrequent medical visits, fears of immigration and deportation, limited English proficiency (LEP), stigma and shame, and lack of health insurance. They are the least likely of any ethnic group to report easily understanding the information provided by their doctors, including instructions for prescription medicines and materials from the doctor's office. Only 16% of foreign born Asian American/Pacific Islanders said they were able to understand the information presented in the doctor's offices. Not only were there serious communication problems with health providers, but Asian Americans received fewer preventive services and less chronic disease care. Additionally, almost half of the respondents (46%) said their doctor's advice was too difficult to follow and almost one-third (32%) said they did not follow the doctor's advice because it went against their personal beliefs (Commonwealth Fund, 2001).

According to a survey conducted by the California Endowment (2003) more than 90% of Vietnamese, 80% of Hmong, and 60% of Cambodians interviewed about their health concerns reported that healthcare was very important to them. Additionally, nearly 30% Hmong and Vietnamese and 23% Cambodian reported experiencing difficulties getting medical care when needed. AANHPIs, along with Hispanic respondents were the most likely to report dissatisfaction with the quality of care they received and felt the doctors did not understand them (Institute of Medicine, 2003). Much of the dissatisfaction can be attributed to the language barriers that make effective communication difficult. The perceived disrespect and disinterest on behalf of practitioner can be attributed to a lack of cultural competency on the part of the provider. For example, twenty-seven percent of Asian Americans reported that their doctor 'did not listen to everything they said', 'did not fully understand their doctor', or 'felt comfortable asking questions during their visit with the doctor'. This compares with only 16% of the white population. The myth of the model minority must be put to rest and can no longer be used as an excuse for inaction.

BUILDING A CASE FOR INTEGRATED CARE FOR AANHPI POPULATIONS

A Strong Correlation between Physical Health and Behavioral Health

Substantial evidence shows a direct correlation between physical health and behavioral health (Unutzer, 2002; Koyanagi, 2004; Oxman, 2005; Rollman, 2006). Further studies reveal that individuals with diabetes and depression or heart disease and depression demonstrate poor health behaviors-- like adherence to self-care regimens (diet, exercise, smoking and taking medications as prescribed) (Lin, 2004), resulting in higher medical costs (Simon, 2005) and increased risk of medical complications and mortality (Fraser-Smith, 1993; Ngo-Metzger, 2004). Individuals with a comorbid history of diabetes and depression are more likely to develop diabetic complications when compared to those without depression (NIH, 1999), while individuals with depression alone are also at greater risk for developing heart disease (Musselman, 1998).

Rates of smoking are 2-4 times higher among people with psychiatric disorders and substance use disorders with 60% of current smokers reporting a past or current history of a mental health

There is a direct relationship between cardiovascular disease, diabetes, and depression.

Cigarette smoking is 2-4 times higher for those with psychiatric and substance use disorders.

People with serious mental health problems die 25 years earlier than the general population.

Sixty percent of these deaths are due to medical conditions that could have been treated with health care interventions.

diagnosis (Heiligenstein, 2006; Kalman, 2005). Chronic alcohol and drug abuse is associated with major depression, schizophrenia, bipolar disorder, attention deficit hyperactivity disorder (ADHD), generalized anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, panic disorder, and antisocial personality disorder (DOJ National Drug Intelligence Center, 2004).

One of the most sobering health statistics is that individuals with serious mental health conditions die 25 years earlier than the general population. While suicide and injury account for approximately 30-40% of premature deaths, 60% of deaths are due to comorbid medical conditions such as cardiovascular, pulmonary and infectious diseases which could have been prevented or treated, had they received proper healthcare services (NASHMPD, 2006).

AANHPIs and those with limited English proficiency (LEP), in particular, are more likely to receive mental health care in

primary care settings as it is perceived as less stigmatizing than specialty mental health care settings. Therefore, a seamless integrated health and behavioral health care is essential in reaching and serving AANHPIs

For persons with mental illnesses, there is also an increased risk for kidney failure and respiratory disease, including pneumonia and influenza as well as higher rates of smoking and alcohol use. Mortality rates among this group are several times higher than the general population. Unfortunately, exact numbers among AANHPIs are not completely known due to lack of population data collection. However, it is known that AANHPIs are less likely to seek or receive appropriate behavioral and physical healthcare because of a number of factors, including associated stigma and shame. They are also less likely to find providers with needed language skills, cultural competency and experience working in integrated care settings--- an approach that could potentially prevent premature death.

Individuals who experience both behavioral and physical health conditions also utilize a disproportionate level of emergency and other medical care services resulting in higher health costs. As much as 70% of primary care visits are due to mental health needs. Unfortunately, most primary care providers are ill prepared or lack the appropriate infrastructure to address the array of complex issues associated with behavioral health problems—overt or hidden (Kathol, 2006).

For AANHPI communities, an integrated preventative care approach is critical. Although trauma can be directly linked to comorbid health, mental health, and substance use problems, little attention is paid to early trauma and the potential for developing future health risks. In 1994 the Center for Disease Control (CDC) and Kaiser Permanente initiated the Adverse Childhood Experiences (ACE) study to assess the relationship between adult health risks and traumatic events in childhood. This study aimed to analyze the relationship between multiple categories of childhood trauma and the potential for health and behavioral health outcomes in later life. Although the findings were relevant for all populations, they were particularly salient for victims of torture and warfare, such as experienced by Southeast Asian refugees and the secondary trauma experienced by the following generations; the colonization of Native Hawaiians and the subsequent poverty experienced by other Pacific Islanders.

The ACE study concluded that childhood traumatic events include the physical and emotional abuse by a parent, sexual abuse by anyone, growing up with an alcohol and/or drug abuser in the household, the incarceration of a household member, living with a family member with mental

Prevention matters!

Early childhood trauma can increase the risk of a person experiencing heart, lung or liver disease and multiple types of cancer in adulthood.

illness, domestic violence, loss of a parent, emotional neglect and physical neglect. While this is a co-relational study, the results have strong implications for looking at the causal relationship between early trauma and negative health and behavioral health outcomes throughout the lifespan. In addition to suicide, elevated ACE Scores were also associated with increased risk for physical disease like heart, lung, and liver disease as well as multiple types of cancers. All better reasons for early identification and intervention, care coordination and, integrated care.

Cost of poor healthcare

The need to improve health outcomes is increasingly important to our overall public health, in addition to addressing the major burden on the country's economy due in part to out-of-control health costs (Insel, 2008). Health care costs are projected to account for as much as 20% of the nation's gross domestic product by 2016 (Poisal, 2007).

The lack of coordination in care is particularly difficult for AANHPIs with limited English proficiency who must navigate multiple systems. The lack of collaboration between disciplines results in lack of coordination in care, development of inappropriate and ineffective treatment plans, and duplication of services and overall poorer health outcomes and lack of patient/consumer follow through—all costly. The situation is exacerbated when there is a lack of transportation, increasing the likelihood that they will not continue to seek services until there is a crisis.

The American Psychiatric Association reviewed research on the effectiveness of integrated care, and in 37 randomized trials, it was shown to significantly improve the treatment of depression in medical outpatient settings. Individuals diagnosed with depression in a collaborative care setting showed improved mental health outcomes as well as the likelihood of saving medical costs over a two-year period. In a series of studies, individuals with depression and diabetes who were treated in an integrated setting had 2 months fewer days of depression per year with a projected \$2.9 million/year lower total health costs; those with panic disorders also had 2 months fewer days of anxiety/year for a projected \$1.7 million lower total health costs; those with unexplained physical complaints had up to 53% decrease in costs associated with healthcare utilization.

The Institute of Medicine's report *Improving the Quality of Health Care for Mental and Substance Use Conditions* showed that the lack of proper mental health treatment has adverse consequences that are felt in the workplace, in our education system, in the welfare and justice systems and impacts the nation's economy as a whole. It is estimated that mental illness accounts for 59% of the economic loss from illness or injury-related productivity each year and is the leading cause of disability in the United States. Research conducted by the National Comorbidity Survey collected data from nearly 5,000 individuals and found that serious mental illness is associated with an annual loss of earnings totaling \$193.2 billion (Kessler, 2008).

Cultural and Linguistic Competence

Integrated care focuses on a seamless approach for mental health, substance use and physical care for individuals and families. Models require collaboration across systems of care, interdisciplinary communication, delivering services in a coordinated manner, and the shared goal of whole health for all. Integrated care is more than the physical location or co-location of primary care, behavioral health and other specialty services. For a successful care approach for AANHPI communities, integrated care models must be designed with the individual and family at the center, along with the language and culture of the target population.

Working with AANHPIs would also require that the team recognize cultural definitions of health and pathology, and incorporate traditional healing practices. Common characteristics to consider essential for AANHPI integrated care include: a) a team approach; b) culturally and linguistically competent clinical and management leadership; c) a strong philosophy and practice of knowledge exchange; and d) effective use of mid-level practitioners, para-professionals, peer specialists, cultural navigators, community health workers and trained interpreters.

It is possible to have two separate agencies provide culturally appropriate integrated care while maintaining separate locations and staffing patterns. This is accomplished by working collaboratively to develop a true coordinated treatment plan. They must have clarity on who provides what services, how information will be shared and identify new resources that may be needed and collectively address issues of culture and language.

While there is no single definition for integrated care, there was clear agreement among Summit participants regarding core elements for culturally and linguistically competent integrated systems of care. Integrated care for AANHPIs must:

- Include language and culture at each level of development, implementation, and evaluation of services, including the use of traditional healing practices.
- Be person-centered, strength-based, and recovery-focused.
- Work across the lifespan.
- Include prevention and early intervention.
- Incorporate a public health approach that not only includes primary health and behavioral health but also looks at the impact of employment, housing, education, poverty, immigration, neighborhood safety and other social determinants of health.

Health Homes

Health homes have been authorized under the Patient Protection and Affordable Care Act (ACA) under section 2703 & 1945(e) to allow States to build person-centered systems of care for individuals with at least two chronic conditions; or only one, if the condition is a serious mental illness. Health homes are not a physical location or integrated care model specifically, but a strategy to provide coordinated care and supports to individuals and families. However, integrated care models for AANHPIs should be considered when including the health home model. Facilitating access to care under one roof would greatly benefit AANHPIs, particularly those with limited English proficiency; reducing the complexity of navigating multiple systems. Individuals, families and communities can become fully engaged in the development of intervention strategies that incorporate language and culture at every step of health and behavioral healthcare. Interventions should also acknowledge and include traditional healing practices for higher levels of treatment engagement and adherence.

Deciding that integrated care is an important road to take is the easy part.

The challenge is figuring out how to get there!

In order for health homes to become culturally relevant, a variety of access points or “front doors” must be available to accommodate the diverse needs of AANHPI individuals and communities. “Front doors” may include community health clinics, but must also include community-based organizations, homeless shelters, substance abuse treatment centers, etc. In general, “front doors” should be patient/consumer defined and friendly. Integrated care sites must be located where patients/consumers are likely to reside and seek care, within the respective communities. Likewise, integrated care sites must also incorporate traditional and spiritual healing methods and must include these practitioners as potential entry points into care.

ACA provisions allow Medicaid to reimburse providers for the time spent coordinating interdisciplinary care. This becomes a key incentive for agencies that struggle to provide services which have not been traditionally reimbursable. Seventy-percent of individuals who have significant mental health and/or substance use disorders also have at least one chronic physical health condition, 45% have two, and almost 30% have three or more, making them excellent candidates for receiving this type of service. A health home with an integrated care approach could promote the collaboration between health centers, community based specialty mental health or substance use centers, traditional healers and other supports needed to secure better health for AANHPIs.

RECOMMENDATIONS FROM THE SUMMIT

Strategies to Eliminate Disparities through Integrated Care

The Affordable Care Act provides an opportunity for improving overall health and behavioral health quality for AANHPI communities by employing affordable integrated care models that are culturally and linguistically relevant. Summit participants highlighted elements of integrated care by outlining priorities and recommendations for: 1) eliminating disparities, 2) building capacity through workforce development and training, 3) health information technology, and 4) Community-Based Participatory Research.

1. Strategies to Eliminate Disparities Subcommittee

Priorities and Recommendations for integrated care models:

- Need a uniform definition of integrated care.
- Integrated care must be guided by equal standing between primary care, mental health and substance use.
- Avoid medical model and include attention to critical social determinants of health, i.e. immigration, trauma, lack health insurance, poverty, language/cultural barriers, etc.
- Incorporate the following business practices into integrated care model:
 - Training of staff
 - Delivery of services
 - Billing
 - Record keeping
 - HIPPA
- Ensure quality services through building a diverse workforce, including peer specialist and para- professionals.
- Incorporate core competencies across disciplines and professions.
- Implement safeguards for patient/client confidentiality when working across systems.
- Develop a research and evaluation agenda on best integrated care practices for AANHPI populations.
- Demand effective communications and coordination of care when working across geographical distances.

Priorities and Recommendations to U.S. Department of Health and Human Services

- HHS AANHPI Action Plan must include behavioral health and integrated care.
- Ensure for AANHPI representation on advisory groups, including for groups that focus on health care reform and integrated care.

- Adopt full Institute of Medicine (IOM) recommendations for granular AANHPI ethnicity data and commission IOM study on language access. Support analysis and reporting of granular ethnicity and language data and over sampling of AANHPI populations.
- Commission an IOM study on patient-centeredness and equity.
- Apply standards for data collection on race, ethnicity, sex, primary language and disability status, as required by Section 4302 of the Affordable Care Act, to health and behavioral health care services and electronic health records.
- Require that CLAS Standards be embedded in all HHS funding and ensure that cultural competency always includes AANHPIs.
- Develop and fund a national AANHPI Accountable Care Organization (ACO), using the Veteran’s Administration system model to operate under the “Underserved Populations” rules of the Affordable Care Act. The national AANHPI ACO could function similar to a Health Maintenance Organization (HMO) with a national network of culturally and linguistically competent service providers.
- Proactively review state Medicaid health home applications to include AANHPIs.
- Ensure that the six Pacific jurisdictions are supported in creating Medicaid health homes.
- Fund bilingual/bicultural models of integrated care for AANHPIs and ensure all other grant initiatives have at least one Asian American and one Native Hawaiian/Pacific Islander grantee. Disseminate lessons from integrated care projects focused on AANHPIs.
- Designate a senior staff employee for AANHPI issues to the OS Office of Minority Health and to the Substance Abuse and Mental Health Services Administration (SAMHSA) and create infrastructure with responsible staff to address needs of AANHPI communities.
- Review the National Registry of Evidence-Based Practices for AANHPIs and develop process for recognizing practice-based projects for AANHPIs.
- Provide funding for the Medicare/Medicaid/Children’s Health Insurance Program (CHIP) for language services in integrated care.
- Include language services as essential benefits in state health insurance exchanges.
- Support integrated care in Compact of Free Association jurisdictions through Medicaid and Medicare.
- Fund both payer-specific and multi-payer models of integrated care to reach all populations, including underserved populations.
- Enforce parity in billing for behavioral health providers in Federally Qualified Health Centers (FQHCs).

A culturally and linguistically competent workforce is essential to eliminating disparities, while enhancing meaningful access to quality health and behavioral health care.

Priorities and Recommendations to State Governments:

- Encourage states to apply for Medicaid health home demonstrations that include AANHPIs.
- Collect/analyze/report granular data on AANHPI ethnicities and language needs.
- Ensure AANHPIs represented on community and expert advisory entities for health reform implementation.
- Create infrastructure and assign staff to address AANHPI community needs.
- Meet with state, local and national AANHPI organizations as community resources for advocacy support, information on community needs and guidance.

Workforce Development and Training for Integrated Care

Revamping the current workforce to establish culturally and linguistically appropriate integrated models are central to improving the quality of services for AANHPIs. True integrated care approaches reduce the stigma associated with behavioral health concerns for AANHPIs. While they often seek services from primary care providers, these services have not always provided the level of care hoped for, as AANHPIs are often dissatisfied with the quality of care they

Invest in building community health workers, health navigators and peer specialists into the integrated care team!

receive. At 44%, AANHPIs were the least likely of any ethnic group to report that it was easy to understand the information provided by their doctors, including instructions for prescription medicines and materials from the doctor's office. They were the least likely to have a great deal of trust in their doctor (55% vs. 71% for white patients). Nearly half of Asian Americans (46%) said their doctor's advice was too difficult to follow and almost one-third (32%) said they did not follow the doctor's advice because it went against their personal beliefs. It is therefore imperative that both primary and behavioral health providers refocus their efforts to effectively address the total health and behavioral health concerns of AANHPIs.

Increasing meaningful access is frequently cited as a central component to eliminating healthcare disparities. However, without a properly trained workforce, there are few options for receiving care for AANHPIs, especially those with LEP. Providers may include physicians, social workers, nurses, pharmacists, dentists, psychiatrists, certified chemical dependency counselors, psychologists, therapists, acupuncturists, naturopaths, etc. Providers must also include patient navigators, community health workers, peer specialists and spiritual leaders.

One of the strengths in training peer specialists and other para-professionals is the ability to increase the current workforce in a timely manner with individuals who have the language and cultural skills needed to effectively engage with those in need of services. Peer specialists also

offer the additional benefit of ‘lived experience’ while providing their unique perspective on the whole-health situation and challenges facing the individual in need of services. The intent is not to replace professionals but rather augment the current workforce in a timely and cost effective manner. Traditional healers, acupuncturists, ayurvedic medical practitioners, naturopaths, meditation guides, in collaboration with Western treatment providers must also be incorporated for the utmost success with AANHPIs communities.

The workforce must also be recovery-focused and patient/consumer centered, addressing the whole person from an emotional, physical and spiritual perspective. It must take a public health approach which looks at individual, family, communities and systems, as well as at environmental factors impacting an individual, including immigration, housing, employment, education, poverty, and safety.

2. Workforce Development and Training Subcommittee

Priorities and Recommendations for building a workforce

- Increase the number of AANHPIs entering graduate programs in various health-related fields including primary care medicine, nursing, pharmacy, public health, psychology, social work, counseling and psychiatry.
- Develop a National AANHPI Training Center that includes on-going supervision support to trainees. The Center can be a virtual center using technology to access expertise from around the country to train and provide supervision and consultation.
- Provide career ladders, continuing educations and credentialing for community health workers, health navigators, peer specialists, care coordinators and interpreters.
- Fund the development of training models across disciplines at AANHPI integrated care facilities. (e.g. Center for Integrated Health Solutions) and incorporate use of traditional healers. Involve peers in developing curriculum as was done with NAAPIMHA’s “Growing Our Own” curriculum.

Priorities and Recommendations of Core Components of Training

- The concept of self among AANHPIs must be re-defined. The concept of self among AANHPIs needs to be re-defined. For AANHPI communities, self is embedded in family, community, and the land. All prevention and treatment efforts must be competent at addressing care at all of these levels.
- Understanding the meaning of language (verbal and non-verbal) as expressions of worldview, socio-cultural, historical and political contexts of each group. The depth and breadth of context and differences of each group needs to be understood across disciplines and across generations.
- Incorporate knowledge from different philosophies of life and foci of care.
- Understanding confidentiality and enhanced knowledge of law and ethics in integrated care models.
- The construct of ‘self care’ must comprise cultural significance and include family and community.

- Improved training for the identification of and culturally competent models of intervention for trauma for the diverse AANHPI communities. Include war, torture, cultural trauma, trans-generational trauma and conflict, areas unique to the AANHPI experience.

Priorities and Recommendations for Screening, Recruitment and Retention

- When developing and implementing recruitment and screening strategies, use community leaders as linguistic and cultural experts and advisors.
- Create job descriptions for linguistic and cultural care providers, community health providers, care coordinators; and create job ladders for these workers. Include mentoring and support with professional development opportunities.
- Provide minority fellowships that focus on integrated care within AANHPI communities.
- Create a K-12+ educational-career pipeline.
- Train for health promotion and wellness careers in the community to decrease stigma and provide incentivizing stipends for students entering these fields.
- For federal health professions loan reimbursement programs, allow students to work in both urban and rural settings.
- Reimburse linguistic and culturally appropriate services at higher rates given the need for special skills required for coordination of care and direct services.
- Create reimbursement schedules for all levels of care including, community health workers, traditional healers, shamans, care coordinators, language and cultural specialists.
- Develop an annotated guide for AANHPI integrative services in existing credentialing programs (e.g., JACHO standards).

The development of HIT must include AANHPIs to capture the unique cultural and language experiences of the community.

Health Information Technology for Integrated Care

Many AANHPI communities are isolated due to language, cultural and/or geographical barriers. The use of technology can be an effective tool not only to address these barriers, but also for establishing new and creative ways of providing services. For those AANHPI communities where linguistic and cultural isolation impedes access to care, technologies such as tele-health are being used to address the service challenge, and this technology enables culturally and linguistically competent clinicians the ability to extend their reach into isolated communities.

The AANHPI community must also be engaged in software development for electronic health records. For example, practitioners must be able to use health records to document the use of traditional medicines and herbs, and use of traditional practices such as acupuncture and acupressure across the diverse cultures.

Moore's Law tells us that every three-years the functionality of technology doubles while the price of that technology drops in half. With the current rate of innovation and the recent investment of government funds into advancing Health Information Technology (HIT), opportunities to ensure the cultural and linguistic relevance of emerging tools, electronic health records software and HIT policies are great.

3. Health Information Technology (HIT) Subcommittee

Priorities and Recommendations for HIT in Integrated Care

- Create incentives for HIT research and development in cultural and linguistic competency for integrated care.
- Involve AANHPI communities in developing and testing on the front end of product development of all health information technologies and software to address cultural and linguistic relevance and cost effectiveness.
- Provide ongoing technical assistance to AANHPI providers to assist in the adoption and implementation of HIT.
- Electronic health record systems must be able to aggregate and disaggregate data, including demographics.
- Ensure that data systems collect and use disaggregated and granular data for informing, reporting and determining language and communication needs of the AANHPI populations.
- Data systems should be capable of evaluating treatment approaches and tracking longitudinal outcomes, epidemiology and morbidities.
- Mandate “bluetooth” concept of connectivity among electronic health records systems, whereby individual software vendors can preserve their innovation, but still allow different systems to talk to each other.
- Advocate for standards and certification requirements that will maintain connectivity across systems. The goal is to connect electronic health record systems to ensure ease of secure health information exchange, with appropriate privacy and confidentiality protections.

Priorities and Recommendations for HIT for Promoting Patient/Consumer/Community Access

- Bridge the “digital divide” within AANHPI communities by funding language-specific consumer education for AANHPI communities so that limited-English proficient consumers understand how to use new health technologies and how to access information regarding their health care rights, care protections, medical records and how to navigate the system.
- Ensure broadband access and connectivity in all communities, especially low income communities of color. As systems become more dependent upon internet access, whether for tele-health communications or health data access, low income communities must not be left out due to slow internet connections or lack of access to the internet.

- Access Universal Service Fund (USF) from the 96 Telecom Act to expand broadband access to communities that need it.
- Use mobile health technologies such as text messaging in addition to internet-based technologies; change mobile phone service plans to allow health-related text messages to be received and sent for free, as all U.S. carriers have agreed to with the Text4Baby program.

Community-Based Participatory Research for Integrated Care

AANHPI communities deserve the best knowledge and receipt of health, prevention and care that will lead to their optimal health. Research that is developed and focused specifically on AANHPI populations is sparse and yet desperately needed in order to inform health, behavioral health and public health fields of useful science, culturally relevant approaches and evidence-based interventions. Too often decisions about what should be studied excludes the specific needs, concerns, inputs, expertise and leadership of the communities targeted, particularly for AANHPI and other racial and ethnic minorities, leading to inaccurate or ineffective collection of data, misunderstanding and misrepresentation of the issues, and failure to provide critical resources to improve the quality of care based on the needs of the community. For health and behavioral health interventions, the lack of community participation can lead to patient/consumer and provider distrust; resulting in poor health outcomes.

Community-Based Participatory Research (CBPR) is a research methodology that involves all partners, including community stakeholders in the research process, and begins with topics valuable to the communities themselves. The aim is to recognize the importance of social, political and economic systems to health and behavioral health outcomes with a goal towards enhancing health equity and eliminating disparities for AANHPI communities.

A literature review and survey is needed in order to further inform the AANHPI CBPR agenda. See the HHS Agency for Healthcare Research and Quality National Agenda for Research in Collaborative Care at: <http://www.ahrq.gov/research/collaborativecare/collabcare.pdf>

4. Community-Based Participatory Research Subcommittee

Priorities and Recommendations for CBPR to Innovate Models of Integrated Care

- Develop an inventory of effective integrated care practices in the AANHPI community as well as an approach to community-defined evidence. Use the National Network to Eliminate Behavioral Health Disparities’ “Community-Defined Evidence Models in Latino Communities” see: http://nned.net/index-nned.php/NNED_content/standard_article/cdep
- Establish a Center of Excellence on CBPR for AANHPI communities.
- Invest in building capacity by developing researchers from within AANHPI communities.

- Develop a national AANHPI CBPR network for integrated care building from the American Academy of Family Physicians' Collaborative Care Research Network. See: www.aafp.org/nrn/ccrn
- Develop common definitions/usage of language between researchers, practitioners, policy makers, community leaders and users, including a lexicon and glossary of terms that is also culturally and linguistically relevant.

Priorities and Recommendations for CBPR to Improve Data Collection

- Supplement the 2011 CDC National Health Survey with a survey report on AANHPI Health and Wellness. This report should include:
 - A literature review and environmental scan of AANHPI health and behavioral health needs.
 - A survey of models of integrated care in AANHPI communities.
- Incorporate the need for better data collection, with particular focus on the diverse AANHPI populations

Priorities and Recommendations for CBPR Research and Evaluation Questions:

The following research questions should be considered when examining integrated care models developed for or utilized with AANHPI populations:

- What models of integration have been used and how effective are they with AANHPI communities? Is one model more effective than another?
- Does one integrated care setting produce better outcomes than another (i.e. medical clinic versus community-based organization)?
- What are the identified barriers to successful integration and sustainability?
- How is culture addressed and what impact does this have?
- What are the core competencies that cut across disciplines, including peer specialists and para-professionals?
- What are the core elements of an effective integrated care model when working with AANHPIs? Which elements of integration are vital toward producing desired goals?
- To what extent does the impact of integrated care vary for different populations? Who is most likely to benefit from this type of care? Is there variation in outcomes produced across ethnicities? Will this approach work with children and adolescents and elders? Is integrated care a viable approach for substance abuse as it is with mental illness? Will this model work in rural settings?
- Who would most likely benefit from integrated care? Are there particular diagnoses like depression that are more effectively addressed through an integrated care approach?
- Does it make a difference whether a bilingual provider is used as opposed to using an interpreter?

- How can the use of technology support integrated care? How effective is HIT for mental health consultations?
- Does the use of health information technology (HIT) improve outcomes in integrated care?
- Can HIT be used effectively when working with LEP populations?

CONCLUSION

The US DHHS, Office of Minority Health along with its partner, the National Asian American Pacific Islander Mental Health Association convened a national consensus meeting of experts to review, discuss and highlight promising and best practices in integrated care for Asian American, Native Hawaiian and Pacific Islander populations and communities.

Summit participants considered the Affordable Care Act and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 as important components in building a framework for examining opportunities for improving overall health and behavioral health quality for AANHPIs by creating affordable integrated care models that are culturally and linguistically relevant.

The consensus statements and recommendations presented in this document describe key strategies for establishing models for an integrated care **blueprint** to be used when working with AANHPI communities. The **blueprint** is for improving meaningful access to health care and improving health quality for AANHPIs, while the priorities and recommendations provide ample suggestions for creating an integrated care framework. Summit participants highlighted elements of integrated care by outlining priorities and recommendations in the following topics: 1) eliminating disparities, 2) building capacity through workforce development and training, 3) health information technology, and 4) Community-Based Participatory Research.

This **blueprint** is intended to provide guidance to a broad audience including but not limited to community leaders, persons and families, providers working with AANHPI communities, federal partners, local, state and national health and behavioral health policy makers, appointed and elected officials, and others who are interested in examining integrated care approaches for eliminating health and behavioral health disparities, designed for AANHPI populations and communities.

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APPENDICES

Appendix A: List of Participants

Appendix B: Break-Out Group Rosters

Appendix C: Summit Agenda

Appendix A: LIST OF PARTICIPANTS

Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities: A Blueprint for Action

Listing of Summit Participants

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Event Scribes

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Graduate Student
San Francisco University

Yumi Iwai

Graduate Student
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Margie Lam

Graduate Student
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James Millan

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San Francisco University

APPENDIX B: BREAK OUT ROSTERS

Workforce Development and Training

Facilitator: Ann Yabusaki, PhD

Kavoos Bassiri, LMFT, CGP	Ben Lui, MD, MPH
Tom Buckley, MPH, RPh	Jeff Mori
Terry Gock, PhD	Lily Stearns, PhD
Keawe Kaholokula, PhD	Kinike Thompson
Francis Lu, MD	

Community-Based Participatory Research and Evaluation

Facilitator: Ed Wang, Psy.D

Alvin Alvarez, PhD	Theanvy Kuoch, MA, LPC
Rocco Cheng, PhD	Poka Laenui, JD
Jaesu Han, MD	Ben Miller, Psy.D
Ramey Ko, JD	Ho Tran, MD

Health Information Technology

Facilitator: Sharon Black, JD

Jean Lau Chin, Ed.D, ABPP	Mary Scully, APRN, CS
Daphne Kwok	Lance Toma, LCSW
Dexter Louie, MD	Chris Wanifuchi, MA
Myron Quon, Esq	Jorge Wong, PhD

Strategies to Eliminate Disparities through Integrated Care

Facilitator: Ignatius Bau, JD

Jeff Caballero	Ford Kuramoto, DSW
Teddy Chen, PhD	Jean Lin
Yoon Joo Han, Med, MSW	Charmaine Manansala, MPH
Sherry Hirota	Diem Nguyen, Pharm.D

APPENDIX C: SUMMIT AGENDA

Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities: A Blueprint for Action

Sunday, August 14, 2011

Sunday August 14, 2011

6:30 PM – 8:00 PM: Meet and Greet Reception

Monday, August 15, 2011

7:00 AM – 8:15 AM: Breakfast

8:00 AM – 8:30 AM: Registration

8:30 AM – 9:00 AM: Welcome and Introductions

D.J. Ida

Executive Director

National Asian American Pacific Islander Mental Health
Association

Teresa Chapa

Senior Policy Advisor, Mental Health

United States Department of Health and Human Services
Office of Minority Health

9:00 AM – 9:10 AM: Overview of Meeting Agenda and Goals

D.J. Ida

NAAPIMHA

Janet SooHoo

Independent Consultant

9:10 AM – 9:15 AM: White House Initiative on Asian Americans Pacific Islanders

Daphne Kwok

Chair

President's Advisory Commission on Asian Americans and
Pacific Islanders

9:20 AM – 10:35AM: Developing Effective Integration Strategies for Asian American,
Native Hawaiian, Pacific Islander (AANHPI) Communities

Jae Han

Residency Training Director, Family Medicine/Psychiatry
Department of Family and Community Medicine
University of California, Davis

Keaweaimoku Kaholokula

Chair and Associate Professor
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John A. Burns School of Medicine
University of Hawai'i, Manoa

Theanvy Kuoch

Executive Director
Khmer Health Advocates, Inc.

Mary Scully

Clinical Director
Khmer Health Advocates, Inc.

Thomas Buckley

University of Connecticut
School of Pharmacy

Teddy Chen

Program Director
Bridge Program, Charles B. Wang Health Center

Kinike Bermudez Thompson

Consumer Advocate

10:35 AM – 10:45 AM: Break

10:45 AM – 11:30 AM: Working in a Changing Landscape

Charmaine Manansala

Vice President for Strategic Engagement
Asian Pacific Islander Health Forum

Ed Wang

Director
Office of Multicultural Affairs
Department of Mental Health, Commonwealth of Massachusetts

11:30 AM – 12:15 PM: Health Information Technology

Sharon Black

Adjunct Professor
University of Colorado
Interdisciplinary Telecommunications Department

Ignatius Bau
Health Policy Consultant

Mary Scully
Clinical Director
Khmer Health Advocates, Inc.

- 12:15 PM – 1:15 PM: Lunch provided on-site
- 1:15 PM – 1:30 PM: Review of Break-Out Group Assignments and Expected Outcomes
Janet SooHoo
- 1:30 PM – 3:00 PM: Breakout Groups
- A) Workforce Development and Training
 - B) Community-Based Participatory Research and Evaluation
 - C) Health Information Technology
 - D) Strategies to Eliminate Disparities through Integrated Care
- 3:00 PM – 3:15 PM: Break
- 3:15 PM – 4:15 PM: Break-out Groups Continued
- 4:30 PM – 5:00 PM: Reconvene: Review of day's meeting and prepare for Day Two
Janet SooHoo
- 5:00 PM: Adjourn - Dinner on your own

Tuesday, August 16, 2011

- 7:00 AM – 8:30 AM: Breakfast
- 8:30 AM – 9:00 AM: Overview of Day 1 and Review of Tuesday's Schedule
Janet SooHoo
- 9:00 AM – 10:30 AM: Breakout Groups Continued
- Goal: Develop Action Plans and Final Recommendations*
- A) Workforce Development and Training

B) Community-Based Participatory Research and Evaluation

C) Health Information Technology

D) Strategies to Eliminate Disparities through Integrated Care

10:30 AM – 12:00 PM: Facilitators prepare Power Point Presentations for Afternoon Session

Break for Participants

12:00 PM – 1:00 PM: Lunch provided on site

1:00 PM – 1:15 PM: Special Greeting

Congresswoman Judy Chu

Chair

Congressional Asian Pacific American Caucus

1:15 PM – 2:15 PM: Presentation of Breakout Group Recommendations

Workforce Development and Training

Ann Yabusaki

Community-Based Participatory Research & Evaluation

Ed Wang

Health Information Technology

Sharon Black

Strategies to Eliminate Disparities through Integrated Care

Ignatius Bau

2:15 PM – 2:30 PM: Break

2:30 PM – 3:30 PM: Feedback on Recommendations

3:30 PM – 3:45 PM: Purpose of Consensus Statements and Position Paper

Teresa Chapa

3:30 PM – 4:00 PM: Next Steps and Adjourn

D.J. Ida