Community Health Resources and Needs Assessment of New York City Asian Americans

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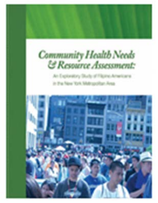
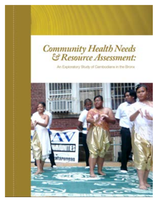
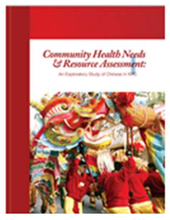
Background

- Data in the literature suggest significant and wide variation of health disparities among different Asian American (AA) ethnic subgroups.
- Lack of disaggregated data on AA subgroups in the East Coast, and specifically in NYC.
- AAs were the fastest growing group in NYC -- a 30% increase from 2000, currently comprising 14% of the population.
- AAs were only group to experience a growth in all 5 of NYC's boroughs.







In 2004-2006, the Center for the Study of Asian American Health (CSAAH) developed and implemented the Community Health Resources and Needs Assessment (CHRNA) project- a large-scale health needs assessment in diverse AA communities in NYC using a venue-based sampling and community-engaged approach to:
1) determine existing health issues; 2) resources available; and 3) best approaches to meet community needs. Communities surveyed included:

- Bangladeshi (157)
- Cambodian (97)
- Chinese (207)
- Indian (127)
- Japanese (112)
- Korean (102)
- Pakistani (89)
- Thai (189)
- Vietnamese (100)

In 2013-2015, CSAAH is implementing a second round of the CHRNA to assess the increasing AA diversity in NYC, including new emerging subgroups, and changes in health priorities in the last decade.

Methods

- Developed through the adaptation of existing surveys, such as the National Health and Nutrition Examination Survey, with community input.
- 'Master survey' was designed with 14 topic modules:

1. Demographics
2. Health Status
3. Health care access
4. CAMS
5. Tobacco
6. Mental health
7. Sleep
8. Food access
9. Environment
10. Communication
11. Discrimination
12. Alcohol
13. Income

- Modules were included or omitted based on relevancy per Asian subgroup (i.e. smokeless tobacco module included for South Asian and Himalayan communities; Alcohol module omitted for Bangladeshi community).
- Surveys were translated into multiple languages including Chinese, Korean, Tibetan, Bangla, and Vietnamese.
- In partnership with community groups, surveys are administered in-language at community venues during cultural events, community meetings and faith-based gatherings. This method ensures that underserved and hard-to-reach immigrant populations are surveyed.

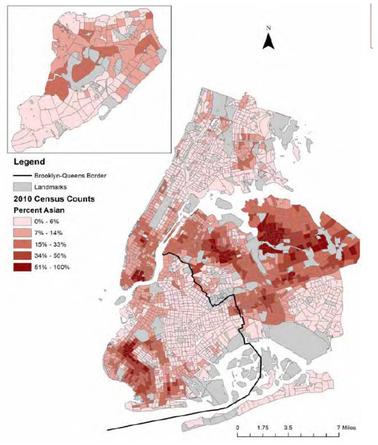
Results

To-date, 1,036 surveys have been collected from the following communities:

- Arab (28)
- Bangladeshi (151)
- Cambodian (64)
- Chinese (194)
- Filipino (43)
- Himalayan (157)
- Indian (69)
- Indo Caribbean (19)
- Korean (155)
- Pakistani (98)
- Thai (1)
- Vietnamese (57)

Preliminary data analysis demonstrates that AA communities in NYC report low levels of English language proficiency and high levels of low income.

Figure 1. AA population in New York City in 2010 by Census Tract



Conclusions

- In 2015, the following communities will be surveyed: Sri Lankan, Burmese, Bhutanese, Indonesian, Malaysian, Thai, and Japanese.
- CHRNA findings will be used to identify community health priority areas which will help guide CSAAH's research, strategies, and interventions to advance the health of AAs in NYC.
- Findings will be disseminated back to the community and community partners and will provide much needed local contextual data on the AA community for policy makers and public health agencies to ensure informed public health practice decision-making.

Table 1. Selected variables and AA subgroups from round 1 and 2 CHRNA

Variable		NYC Overall	CHRNA 2004-2006				CHRNA 2013-present				
		NYC Overall	Chinese	Korean	Bangladeshi	Pakistani	Chinese	Korean	Bangladeshi	Pakistani	Himalayan
English language proficiency	% who speak English < "very well"	9%*	79%	91%	87%	75%	81%	96%	78.5%	55.1%	87%
Income	% whose income is <$55,000 (<$50,000 for NYC overall)	47% *	75%	79%	87%	63%	49%	47%	66%	53%	63%
	Don't Know/ Decline to State	1%*	25%	22%	13%	37%	37%	31%	34%	19%	26%
Smoking	% who currently smoke	16%**	7%	33%	6%	23%	5%	12%	11%	8%	11%
Flu Vaccine	% who have received a flu vaccine in the past 12 months	50%**	N/A	N/A	N/A	N/A	60%	54%	57%	47%	33%

*American Community Survey 2013, Year 1 Estimates
** New York City Department of Health and Mental Hygiene EpiQuery, 2012 Estimates

Figure 2. Community-engaged process for CHRNA survey development, administration, and dissemination

Step 1: Refine and Tailor → Step 2: Implementation → Step 3: Dissemination

E.g., for cultural and linguistic relevancy, including translation

E.g., identifying venues and events for surveying

E.g. identifying how and where to share back findings to the community

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