

**Sustaining Minority Elders in Their Communities**

**Hmong Elders in the Twin Cities:  
A Community Needs Assessment  
2006**

**Prepared by**  
**Metropolitan Area Agency on Aging**  
2365 N. McKnight Road, Suite 3  
North St. Paul, MN 55109-2264  
Main Phone: 651-641-8612  
Fax: 651-641-8618

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## **For further information about Hmong elder services**

Contact Gaoly Yang at MAAA by phone 651-917-4603 or email [Gaoly@tcaging.org](mailto:Gaoly@tcaging.org) for further information on these Hmong-specific elder services:

- Home health services including Personal Care Attendants (PCAs)
- Adult day programs
- Assisted living programs
- Adult foster care
- Meals on wheels

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## Introduction

As part of the Metropolitan Area Agency on Aging (MAAA) *Sustaining Minority Elders in Their Communities* project, Hmong American Partnership (HAP) staff worked with the MAAA and Malone Consulting to conduct a needs assessment of the Hmong elder community related to long-term care services. HAP received funding from the MAAA to assess the Hmong community's needs to serve frail elders through focus groups with elders and key informant interviews. MAAA staff conducted focus groups with care coordinators to assess their views about services among the Hmong elder population. The MAAA also provided data from the 2000 Census and state Medical Assistance (MA) beneficiary records for Hmong elder program participants. Malone Consulting analyzed this data to provide a general indication of the potential need for long-term care services.

The goal of the "Sustaining Minority Elders in Their Communities" project is to develop new high quality services for elders that respect and honor different cultures and the family role in caring for elders.

This assessment:

1. Addresses the current and future needs of Hmong elders for home- and community-based, culturally specific services
2. Examines the likelihood that Hmong elders will use non-family care
3. Identifies potential opportunities to enhance support of Hmong elders within the Hmong community.

## Methodology

This report includes comments from a total of 56 individuals in the Hmong community: **43 elderly**, nine **(9) caregivers/adult children**, and four **(4) professionals** with expertise in elderly care.

HAP lead staff worked with CHIA Consulting, Inc. and MAAA staff to develop the key informant interview and focus group questions. Individual interviews were conducted with four key informants. Interviewees were selected based on their extensive knowledge of the Hmong community and their professional experience with elderly Hmong community members. Two interviews were conducted face-to-face and two by telephone.

Two focus groups were conducted with elderly Hmong individuals. One was held with HAP's elderly program participants at the McDonough community center and the other at the St. Paul Hmong Alliance church.

In addition, a caregiver/adult children focus group was held at HAP's offices. Invitations were sent electronically to Hmong who care for their elderly parents and/or have elderly parents or grandparents.

The MAAA staff conducted focus groups with **29 case managers** from the following agencies: 14 - Ramsey County; 4 - Hennepin County; and, 11 MSHO case managers groups divided in two groups. (MSHO is Minnesota Senior Health Options a managed care product provided by several health plans.) Staff asked the case managers to

identify the long-term care needs of the elders, current services available, and any gaps in service.

The case managers of the MSHO product work closely with elders who receive publicly-funded services under the *Elderly Waive (EW)* program. Waiver programs provide Medical Assistance (MA) funded home and community-based services to elders at risk for nursing home level of care. Counties are responsible for purchasing services for elders under the age of 64 eligible for the Community Assistance for Disability Individuals (CADI) programs as well as for elders 65+ for the Elderly Waiver (EW) and Alternate Care (AC) programs. MNSHO healthplans case managers are responsible for purchasing services for elders eligible for the EW program.

The information gleaned from the interviews and focus groups was augmented by Malone Consulting with an analysis of data from the 2000 Census and MN Department of Human Services' (DHS) data about Hmong Medical Assistance (MA) beneficiaries. There are significant limitations to the Census data that result in an undercounting of the Hmong elder population. The data is limited because it identifies elders by country-of-origin or language rather than by ethnicity. A Hmong elder may be from Laos but consider herself Hmong first. However, the data is provided in order to give an overall indication of the potential need for long-term care services by the Hmong elder population, as well as current and potential future service utilization.

CHIA Consulting, Inc. analyzed the elder and key informant interviews and case manager focus groups as well as some of the data pieces. The MAAA staff incorporated the remaining data pieces and additional focus group input to create this final report. A conclusion section was added to highlight the major findings from all of the sources regarding the current and future need for long-term care services of the Hmong elder population.

### **Population Characteristics**

The following section highlights demographic information related to the overall elderly Hmong American population in Twin Cities metropolitan area. This information is provided to give an indication of the potential need for publicly funded long-term care services. The data should be used to identify general proportions of the elderly population that may be at risk for long-term care services.

The primary source of this information is the 2000 Census. The majority of the data was pulled from the Census Public Use SF2 Files. The SF2 information is only available for Census tracts in which there are at least 100 persons of the specified subcategories, e.g., racial/ethnic group. As a result, these numbers should be considered the minimum likely number of individuals in any given table. The remaining Census tables display data from the Census Public Use Micro Sample (PUMS) data files. These numbers are based on population areas that have at least 100,000 residents. These numbers may not exactly match the SF2 numbers because they are based on a selection of five percent of all household forms returned to the Census and also often under-represent in smaller population groups.

Additional information is presented from the DHS records of Medical Assistance (MA) beneficiaries in March 2005. The information is provided for those Hmong elders who were receiving MA services in March 2005. This data source provides a more accurate picture of the overall demographic characteristics of this group of Hmong elders.

But, ethnicity is not a requested data field on Medical Assistance forms. Therefore, the Medical Assistance data is limited by the *uneven* identification of minority elders' specific ethnicity through listing either language spoken or country-of-origin.

## Demographics

According to the 2000 Census, there are 2,957 Hmong individuals 50 years of age and older living in the Minneapolis-St. Paul seven-county metro area. This constitutes approximately seven percent of the Minnesota Hmong population. The population is concentrated in Hennepin, Ramsey, and Dakota counties. Ramsey County has the largest number of Hmong elderly (2,036) with just under two and one-half times as many as Hennepin County, which has 880. Dakota County has the third largest population of older people, at 41.

Table 1: Elderly Hmong by age group, 7-County Metro Area and selected counties

| Geographic Area            | Total Population Age 50+ | Age 50-64 | Age 65-74 | Age 75-84 | Age 85+ |
|----------------------------|--------------------------|-----------|-----------|-----------|---------|
| Total 7-County Metro Area* | 2957                     | 1891      | 584       | 365       | 117     |
| Dakota                     | 41                       | 32        | 6         | 2         | 1       |
| Hennepin                   | 880                      | 589       | 157       | 105       | 29      |
| Ramsey                     | 2036                     | 1270      | 421       | 258       | 87      |

Source: Census 2000, SF2 files.

**Poverty status (Census).** The percentage of Hmong elders living in households at or below poverty level was 35.7 percent in the Hmong population age 50-64 and 36.5 percent for those age 65 and older. Income information in the Census is based on the income of the total household, not the individual's income. Thus, the actual number of Hmong elders who are living below poverty based on their own individual income is likely much higher than the numbers shown in this table.

Table 2: Number & percentage of 50+ Hmong elders by age & poverty status, 7-County Metro Area

| Age Category | Above Poverty | Below Poverty | Row Total   |
|--------------|---------------|---------------|-------------|
| Age 50-64    | 1392 (64.3%)  | 774 (35.7%)   | 2166 (100%) |
| Age 65+      | 507 (63.5%)   | 291 (36.5%)   | 798 (100%)  |
| Total Age50+ | 1899 (64.1%)  | 1065 (35.9%)  | 2964 (100%) |

Source: Census 2000, PUMS data.

### **Poverty status of those living with others versus those living alone (Census).**

About 95 percent of Hmong elders live with family members or with spouses, three percent live alone and two percent live with non-family members. Those living alone and in poverty are the most likely to need assistance from government-funded programs in order to be able to continue living in the community.

Table 3: Hmong 50+ population living in households by age & by poverty status, 7-County Metro Area

|           | Elders Living Alone |               | Elders Living with Others |               |
|-----------|---------------------|---------------|---------------------------|---------------|
|           | Above Poverty       | Below Poverty | Above Poverty             | Below Poverty |
| Age 50-64 | 36                  | 22            | 1356                      | 752           |
| Age 65+   | 0                   | 22            | 507                       | 269           |

Source: Census 2000, PUMS data.

**MA beneficiaries.** According to the MA database, there were 3,191 Hmong MA beneficiaries aged 50+ in March 2005 in the metro area. The table below shows the number of MA beneficiaries in the total seven-county metro area for this point in time plus the four counties with the highest number of MA beneficiaries.

Table 4: Hmong MA beneficiaries by age group, by county area

| Age Categories | 7-County Metro Total | Ramsey | Hennepin | Anoka | Washington |
|----------------|----------------------|--------|----------|-------|------------|
| 50-64          | 1684                 | 1082   | 486      | 48    | 48         |
| 65-74          | 821                  | 502    | 233      | 39    | 31         |
| 75-84          | 486                  | 294    | 137      | 27    | 23         |
| 85+            | 200                  | 119    | 51       | 11    | 14         |
| Total          | 3191                 | 1997   | 907      | 125   | 116        |

Source: DHS Data Warehouse

Table 5 compares the total number of waiver beneficiaries in March 2005 with those who had 12 or more months of continuous eligibility during the study period. One can assume that the Hmong waiver population is quite stable given that the numbers are the same.

Table 5: Total Hmong CADI or Elderly Waiver beneficiaries as of March 2005 & those with 12 or more months of eligibility, January 2004-March 2005, 7-County Metro Area

| Waiver-Eligible MA Beneficiaries as of March 2005   |     |
|---|-----|
| Number of Waiver-eligible MA Beneficiaries with at least 12 months of eligibility during the study period | 320 |

Source: DHS Data Warehouse

**Differences in data: Census and Medical Assistance.** It is important to note the significant differences between the Census and Medical Assistance data reporting the number of Hmong elders living below poverty. The Census identifies a total of 1,065 Hmong elders living below poverty. However, the MA records identify a total of 3,191 Hmong elders living below poverty who are receiving MA benefits. In fact, the total number of Hmong MA beneficiaries is larger than the total Hmong elder population identified by the Census. These differences support the assumption that the household income data collected by the Census under-counts the actual number of elders who are living below poverty and, as such, may be eligible for Medical Assistance. Other potential reasons for these significant differences include:

- The arrival of 119 Hmong refugees age 65+ from outside the U.S. between 2001 and 2004;
- Additional numbers of Hmong elders moving to Minnesota from other states; and

- Undercounting by the Census, as explained above (the State Demographer estimates that the total Hmong population was under-counted by 30 percent).

### Health and Functional Characteristics

The following section provides information regarding the health and functional status of Hmong elders age 50 and older. As with the data in the previous section, the Census Bureau information is likely undercounting those individuals who have a disability of some type since it is based on a five percent (5%) selection of the forms actually returned to the Census Bureau in 2000. Additional information is presented from DHS records of MA beneficiaries in March 2005. As stated previously, the data is limited because it identifies elders by country-of-origin or language rather than by ethnicity. However, it can provide an indication of the potential need for additional services in the future for this population, especially for those in the 50-64 age group. In addition, a comparison of the two data sources might identify a group of Hmong elders for whom MA services may be beneficial today.

**Number of individuals reporting disabilities.** According to the Census, 1,386 Hmong elders age 50 and older (close to half of all Hmong elders) reported having a disability in 2000. Individuals reporting “any disability” may be currently using long-term care services or are likely to be at a higher risk of needing these services than the general population. Approximately fifteen percent (15%) of all Hmong elders (449) reported having a self-care disability. Those reporting a “self-care disability” are highly likely to require long-term care services. The definition for self-care disability is similar to the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) categories of need for human assistance which are described in more depth below.

Table 6: Hmong elderly reporting any disability, by age 50-64 and 65+

| Age Category   | Yes  | No   | Total |
|----------------|------|------|-------|
| Age 50-64      | 959  | 1207 | 2166  |
| Age 65+        | 427  | 371  | 798   |
| Total, age 50+ | 1386 | 1578 | 2964  |

Source: Census 2000, PUMS data. Population: those for whom disability questions were answered.

Table 7: Hmong elderly reporting self-care disability, by age 50-64 and 65+

| Age Category   | Yes | No   | Total |
|----------------|-----|------|-------|
| Age 50-64      | 206 | 1960 | 2166  |
| Age 65+        | 243 | 555  | 798   |
| Total, age 50+ | 449 | 2515 | 2964  |

Source: Census 2000, PUMS data. Population: those for whom disability questions were answered.

**Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).** ADLs and IADLs are commonly used to describe activities for which an individual needs help from another person on a daily basis whether they continue living in the community or reside in a nursing home or assisted living facility. ADLs include bathing, dressing, eating and using the toilet. IADLs include such things as using the telephone, buying groceries, cooking for oneself, and managing one’s own medications correctly.

It is informative to compare the types of disabilities reported by Hmong with those reported by the U.S. population as a whole. According to the Hmong National Development report, Hmong were less likely to report having one disability. They were somewhat more likely to report having two or more types of disabilities.

Percentages of MA waiver-eligible Hmong age 50+ with selected ADL/IADL needs are shown in Table 8. Over 65 percent of waiver beneficiaries have highly intensive needs (3 or more ADL/IADL needs). The most common need identified in the table is medication management with the vast majority of waiver beneficiaries needing this type of assistance.

Table 8: Percentage of Hmong waiver clients needing ADL/IADL Assistance\*

| <b>Total Number of Hmong 50+ Waiver Beneficiaries</b>         | <b>320</b>             |
|---|------------------------|
| <i>ADL/IADL need</i>  | <i>% (# of people)</i> |
| Medication management   | 82.8 % (265 people)    |
| Dressing  | 75.0 % ( 240 people)   |
| Toileting   | 56.0 % ( 179 people)   |
| Waiver recipients with zero of selected** ADL/IADL needs      | 5.6 % (18 people)      |
| Waiver recipients with 1 or 2 of selected** ADL/IADL needs    | 28.7 % (92 people)     |
| Waiver recipients with 3 or more of selected** ADL/IADL needs | 65.6 % (210 people)    |

Source: DHS Data Warehouse

\*for MA Clients having 12 months of Eligibility in 15-Month Time Period, 1-1-04 to 3-30-05

\*\* Selected ADL/IADL needs include Medication Management, Dressing, Eating, Transferring from Bed to Chair or getting in and out of chair; Toileting, Walking 50 or more feet indoors.

Table 9 highlights the prevalence of chronic conditions which are typically linked to the need for long-term care services. The percentage of Hmong elders with Alzheimer's disease/dementia, Cardiovascular Disease (CVD) which can lead to heart attacks and strokes, Chronic Obstructive Pulmonary Disease (COPD) which cause breathing complications, and Diabetes is higher in the waiver population as compared to the overall MA population. Since these conditions are progressive, it is likely that only those individuals in the later stages of these conditions are eligible for waiver services since waiver beneficiaries must need a higher level of care than those in the overall MA population. In contrast, the prevalence of depression in the waiver population is only slightly higher than in the overall MA population. This may point to an increasing prevalence of this condition in the Hmong elder population.

The prevalence of these chronic conditions can provide an indication of need for regular monitoring by a registered nurse as well as other supports that could be provided through the waivers. For example, those with diabetes are more likely to need assistance with the set-up or administration of insulin shots. This increases the likelihood that they would require registered nurse supervision and therefore require the involvement of a licensed home health agency.

Table 9: Percentage of Hmong MA beneficiaries with selected diagnoses within the total community population and for the subgroup of waiver-eligible individuals, Metro Area

| Disease                                      | All Community MA Beneficiaries | MA Waiver Population |
|--|--------------------------------|----------------------|
| Alzheimer's/Dementia                         | 3.9%                           | 8.6 %                |
| CVD (cardio-vascular disease)                | 8.3 %                          | 15.0 %               |
| COPD (chronic obstructive pulmonary disease) | 11.2 %                         | 20.4 %               |
| Diabetes                                     | 25.6 %                         | 36.1 %               |
| Depression                                   | 30.3 %                         | 37.4 %               |

Source: DHS Data Warehouse

**Differences in data: Census and Medical Assistance.** According to the Census, a total of 449 Hmong elders reported having a self-care disability. Those reporting a “self-care disability” are highly likely to require long-term care services. In contrast, the MA records identified 320 Hmong elders who are receiving long-term care services through the MA waiver program. Those in the waiver program generally require more intensive assistance with personal care as compared to the overall MA population. The difference in these numbers may point to an additional group of Hmong elders who may need MA waiver services.

### Findings from Interviews and Focus Groups

**Health problems among Hmong elders.** Focus group participants agreed elderly Hmong people have difficulties taking care of themselves because they have language and cultural barriers they are not able to overcome in this country. This makes it hard for many elderly Hmong to address health concerns that may be self-managed by people living in their own culture. Health problems among Hmong elders identified by focus group participants and interviewees include the following: depression; stress; chronic diseases, such as hepatitis B, high blood pressure and blood sugar, heart problems, stroke, diabetes and cancer; physical limitations, such as the inability to walk; mental illness; gout; arthritis/pain, gall bladder problems; kidney failure/kidney stones; isolation, lack of family members to care for them; back pain; migraine headaches; poor vision; neck pain; shoulder pain; and, “mob laug” which is chronic pain associated with aging.

Case manager focus group participants highlighted hypertension, diabetes, depression and dementia as the most prevalent conditions in the elderly Hmong population. The case managers have noticed an increasing number of strokes related to hypertension, an increasing prevalence of end-stage renal disease related to diabetes, and an increasing prevalence of dementia. However, case manager focus group participants identified IADL needs as the most prevalent need for assistance by Hmong elders at this time.

**Emotional conditions among Hmong elders.** All 43 elderly focus group participants indicated that they have days when they are lonely or sad. Their loneliness is affected by the presence or absence of their children and the weather. One woman indicated every time the weather changes, her mood changes. Many others agreed. Another woman said she prefers to live alone. She said, “It’s so hectic to live with other people. I want to be alone because that is peaceful to me. My children want me to babysit my grandchildren, but I tell them no. I already raised them. I am tired and I don’t want to raise my grandchildren. So, they take the grandchildren to child care providers.”

About half of the group members said they were sometimes sad or lonely. Some explained they are not sad often because they have caring children and grandchildren to help them. They mainly worry about their health, but there is always someone to take care of them. Those who said they were sometimes sad or lonely explained they did not always have family members around and/or because they feel isolated. Some of their comments include:

“I sometimes think about what it would be like if I became more ill. Now, I can still take care of myself most of the time, so it’s okay my children are busy and do their own things. But, what I’m afraid of is when I become more disabled. I don’t think any of them will have time to take care of me. *‘Nwg rua zoo thaum yug tseem noj qaab nyob zoo xwb.’* (It’s only fine when I’m still healthy.)” (*Elderly focus group participant*).

“Everybody has worries and it’s impossible to avoid them, especially when you live in a country that you do not speak the language. It’s like you’re stuck because you have to depend on everyone else. So, it’s no wonder many of us elderly people are lonely and sad.” (*Elderly focus group participant*).

“Sometimes people understand us and sometimes they don’t understand why we are sad. I think some people think we shouldn’t be sad because we live in America where we have everything. We actually don’t have everything. We have no country. We have lost everything. I was a soldier for many years and it’s hard to think now I am just an old man who is not able to do things for myself.” (*Elderly focus group participant*).

### **Current Service Utilization**

The data included in this section illustrate the characteristics of those Hmong elders who are receiving long-term care services MA and MA waiver programs. The table below identifies the types of services received by Hmong waiver clients. The services most frequently used by all beneficiaries are personal care assistance (215), adult day center services (107), and skilled nurse visit (93). The table also shows the vast majority of Hmong waiver clients are age 65 or older. The services were used to the same degree in both age groups. Two services which have notably low levels of use include assisted living plus (and other residential) as well as home health aide visit. This may be related to a high reliance on personal care assistants and a possible reluctance to living in non-family group settings by Hmong elders.

Table 10: Number of Hmong EW and CADI Waiver clients receiving at least one unit of service in each of selected waiver-covered service categories, January 2004-March 2005, 7-County Metro Area

| Waiver Services  | All age 50+, CADI + EW | Age 50-64 (CADI) | Age 65+ (EW) |
|--|------------------------|------------------|--------------|
| Total Eligible   | 313                    | 26               | 287          |
| Personal care assistance (PCA)                                 | 215                    | 16               | 199          |
| Home delivered meals   | 26                     | 2                | 24           |
| Skilled nurse visit  | 93                     | 4                | 89           |
| Home health aide visit   | 2                      | 0                | 2            |
| Homemaker service  | 11                     | 1                | 10           |
| Assisted Living Plus and other residential (e.g., foster care) | 2                      | 0                | 2            |
| Medical supplies and equipment                                 | 43                     | 11               | 32           |
| Adult day center services                                      | 107                    | 20               | 87           |

Source: DHS Data Warehouse

### Findings from Interviews and Focus Groups

**Existing Services.** Of the nine individuals interviewed who currently receive PCA services, all stated they were mostly satisfied with the services. All caregivers for these individuals are family members employed by PCA agencies. However, current services for elderly and disabled Hmong who do not have access to family care are varied. While there are many home health agencies providing PCA and skilled nurse visits to the elderly, there are few other Hmong-specific elderly services in the community. Based on interviews with key informants, the following are current services available to Hmong elderly.

Table 11: Services available to Hmong elderly. These are representative examples.

|                    | Ramsey County  | Hennepin County  |
|--------------------|--|--|
| Adult Day Services | Tsev Laus Kaj Siab, 80 enrolled: 28-30 daily; Pebmoob Senior Center, Hmong Elderly Social Center, Tsev Laus Tshwj Xeeb | Hmong Day Elders, Metro Senior Center, Kashia Adult Day Service,                 |
| Social Services    | HAP, approximately 45 participants; Wilder Foundation; SE Asian Ministry; Neighborhood House                           | Hmong Elders Connection (VOA,) 120 enrolled                                      |
| Assisted Living    | High rise at Mt. Airy homes; and new program started by local business owners, e.g. Sunlight Assisted Living           | One corporate adult home in Asian American Assisted Living, Brooklyn Park/Center |

Case manager focus group participants also identified Galtier Plaza as a nursing home with a relatively significant number of Hmong residents.

When asked about the satisfaction of the elderly with the existing services, key informants and caregiver/adult children focus participants said many seemed to be

happy with the services they receive. If they are not, it is not common for clients to complain. As one key informant explained:

“About their satisfaction with the current services they receive, I’m not sure. Even though we are licensed to serve 38, we don’t have 38 people coming here regularly. There are many barriers for people to come even if we provide transportation, culturally appropriate meals, and recreational activities. I think it’s hard to find out about how satisfied elderly people are with the care they receive because sometimes Hmong people do not like to say bad things about their family members or other Hmong who are providing services to them. They don’t want them to lose face.”  
*(Key informant).*

Hennepin County case manager focus group participants explained one of the adult day care centers for Hmong elders goes over and above the services provided in the day center by assisting with medications, medical appointments, and financial issues. The existence of a Southeast Asian Meals on Wheels program has also been beneficial to Hmong elders. In Ramsey County several adult day care centers are available to Hmong elders, which the case manager interviewees feel are helpful to elders.

One Ramsey County case manager explained:

“When you can convince clients to go to Adult Day – many needs are met. Two Hmong elders were weak, fearful, depressed, and since going to Wingspan have moved out of the home into their own apartment, and are feeling more confident and happy – [one is] able to be on her own out of the stress and isolation she felt with family.”

### **Service Gaps**

Elders identified the following as service gaps that affect them the most:

Most would like to have places to congregate and meet with friends, but want to make sure they do not replace the personal care they receive from their family members. They also wanted assistance with interpretation, paperwork, learning English and socialization/companionship opportunities.

Case managers identified the following services for clients, caregivers, and families most frequently

Family caregiver support, interpretation services, assistance with paperwork related to public benefits, socialization/companionship opportunities, and culturally specific health and social services.

Caregivers and adult children identified information, education, and support as priorities.

### **Cultural Considerations**

#### **Caring for the Elderly in Hmong Culture**

**Family responsibility in caring for the elderly.** Caregiver/adult children and elderly focus group participants as well as key informants generally agreed in Hmong culture, it is the responsibility of children to care for their parents and grandparents when they are no longer

able to care for themselves. Children feel obligated to take care of their elders because it is expected of them. Those who do not take on this responsibility are perceived as disrespectful. As explained by one caregiver/adult children focus group participant:

“We Hmong people are very prideful. If an outsider comes in to take care of our elderly family members, others may think our family is dysfunctional. They might think we don’t care about our parents or grandparents. It can be shameful.” Participants indicated elderly Hmong are more valued when they have family members living with them. (*Caregiver/adult child*)

Some representative quotes regarding children’s role in caring for parents include:

“In Hmong culture, it’s the young people who take care of those who are old.” (*Elderly focus group participant*).

“It’s our young children who have to take care of us because we took care of them when they were young.” (*Elderly focus group participant*).

“Children are parents’ security. There is the expectation the young will care for the elderly. It’s been part of our traditions for generations.” (*Caregiver/Adult children focus group participant*).

**Care delivered by other than children.** While participants emphasized the importance of having children to care for their parents, many also indicated it is also appropriate for other relatives and non-relatives to take care of the elderly, especially in American culture. To these elders, it is more important to have an individual who understands and values Hmong culture and who speaks kindly to them. Some of their comments are:

“Sometimes it’s your children, sometimes it is other relatives.”

“We old people become like small children. We’re often hard to please, angry and depressed. Those who take care of us need to understand how old people are.”

“When we get older, we just want someone to talk to. Having kind words said to you is sometimes enough.”

In the event no children are available or willing to care for a frail parent or grandparent, it is common that other extended family members, such as nephews and nieces, play that role. There were mixed feelings about which living situations would be preferred. Participants all agreed sometimes it depends on whether there are other extended family members who are willing to help. If there are other members, they are the preferred choice. If not, then many Hmong elders will live by themselves.

**Perceptions about nursing homes.** If elderly Hmong are dependent and not mobile on their own, then focus group participants and key informants generally agreed they should be placed in nursing homes-like facilities. However, it is clear from many responses nursing homes are not desirable except in extreme cases. Some participant comments are:

“I would rather die than be placed in a nursing.” (*Elderly focus group participant*).

“Nursing homes are terrible. I know some people who are not even that sick, but because they don’t have anyone to take care of them, they are in nursing homes. What I don’t like is that even if you’re not that sick, you have to live amongst those who may be very ill. It’s so depressing.” (*Elderly focus group participant*).

“I don’t like how all kinds of patients with all kinds of illnesses live next to each other. It’s sad to see how old people are treated in this country.” (*Elderly focus group participant*).

“If someone at the nursing home helps then it is good, but if you are still capable of working at home then stay home.” (*Elderly focus group participant*).

## **Cultural Factors**

From the interviews and focus groups, clearly cultural expectations, such as children caring for aging parents and grandparents, play a key role in determining how elderly Hmong access services outside the family. As described by a key informant:

“Hmong culture is built on strong family ties where the young people are responsible for taking care of the old. In Laos, we didn’t have any programs to help the elderly. The reason the children have to take care of them is because of traditions, and because when people get old, they no longer have the energy to go work in the fields to support themselves. So, because parents have children with the expectation that their children will care for them in old age, it is difficult for our people to change this way of thinking. This is why they often do not want to ask for help from people who are not their family members.”

Other cultural factors which prevent Hmong from seeking non-family services include:

- Elderly people are valued more when they have family members present;
- Building trust with someone who is outside of the family can be difficult;
- Lack of transportation;
- Lack of English language skills;
- Parents are very dependent on their children;
- Elderly are extremely shy, and thus do not want strangers to care for them;
- Elders are not willing to leave their families because of fear of the unknown, they don’t see benefits because they have never experienced life outside of the family system;
- Some elders prefer to stay home because “it’s the norm;”
- Many elders want social services which may not qualify for reimbursement;
- Family caregivers would lose PCA income if elder care received by non-family member; and.
- Parents are committed to their children

A few representative comments are:

“Non-family personal care is very hard because many of our elderly are so shy. For example, I learned from one of our clients his wife doesn’t feel comfortable coming to our program because she is extremely uncomfortable. She doesn’t

even join clan gatherings, which are members of her extended family.” (*Key informant*).

“Their mentality has not changed because they have little opportunities to be exposed to activities outside of their families. It is the responsibilities of the adult children to help expose them to other things.” (*Key informant*)

“Need to get to adult children. They are the main barrier to elders receiving care outside of the family.” (*Key informant*).

### **Willingness to Use Non-Family Care**

While most elder focus group participants indicated receiving care from a relative would be the best-case scenario, most also agreed it is important to have someone who cares about their well-being. That person, they indicated, could be someone other than a family member. As one key informant explained, “The important thing is to make sure the person providing the service is understanding and sensitive to elderly Hmong peoples’ needs.” However, the willingness to receive help from a non-family member seems directly related to the availability of family help. For instance, one focus group participant stated no outside help is needed because “I get help from my children.” Help participants would be willing to have non-family members provide include:

- Trips to store or to visit family (Transportation)
- Cooking and food preparation (Nutrition)
- Household chores (Chore service)
- Someone to talk with because children are very busy (Socialization)

The nine people who currently have a PCA said they would not seek services outside of their family because they do not want their children to lose the income for taking care of them. If there were funding sources in addition to the home care services, they would be willing to participate. Some responded favorably to have an agency like HAP develop programs to help elderly Hmong community members, others said they would probably seek help first from their family members. In the event no one is available or willing to help out, they may consider non-family care.

While three individuals said they would welcome opportunities to live with others, the rest indicated their preference would be to stay with their children. Only if the children do not want them would they consider such living arrangements. One elderly focus group participant was quite passionate about attempts to bring elderly people together. She said, “The other elderly programs can’t even find enough people to come. If they have a place far from the city where many other Hmong live, most elderly people do not want to go live in these places. They would rather stay where they are closer to their family and other services.”

### **Concerns Regarding Non-Family Care**

Key informants and caregiver/adult children offered some observations and concerns regarding the current services elderly Hmong receive. The quality of care is frequently mentioned. Little oversight makes it difficult to assess the quality of services. One

frustrated individual expressed she needs help with daily living activities, but when the county nurse came to assess her conditions, the nurse did not recommend any personal care support. In addition, isolation of elderly in the next ten years is expected to be a significant challenge. Concerns include:

- Fear of health consequences for those who do not receive adequate care from family members;
- Lack of an adequate number of clients to generate enough revenue to effectively operate care agencies
- Care agencies often fail because their owners lack knowledge and expertise regarding public pay programs, and
- Liability issues

Some representative comments are:

“There are cases where the elderly parents’ or grandparents’ health conditions are very bad and the young people in the family do not know how or are not willing to take care of them.” (*Key informant*)

“Many children say they take of their elderly, but here at [our HMO] we are concerned the services are not being provided adequately. We started to do home visits and I found out our elderly are suffering so much. In a few cases, the elderly person has not received any personal hygiene care, but the caregiver is being paid to care for this elderly person for eight hours a day. Since we started to do home visits, many Hmong families switched their health plan to others. This is troubling to me. The elderly are so important and they need to be cared for properly.” (*Key informant*).

“Some take PCA money, but do not provide the care to the elderly person. I know this is happening, but to do anything about it is to somewhat ‘betray’ my own people.” (*Key informant*).

Hennepin and Ramsey County case manager focus group participants echoed some similar concerns with current services for the elderly and disabled. Themes which emerged include:

- Lack of bilingual staff and culturally specific services – from homemakers to nurses;
- Lack of culturally sensitive food and assisted living arrangements;
- Language barriers;
- Lack of flexible and intensive case management;
- Limited oversight of the quality of care, especially with personal care attendants;
- Poor performance of personal care agencies and the possibility of fraud;
- Strong mistrust of western health care system; and
- Inadequate information regarding personal care services.

A couple of representative quotes include:

“It is hard to get a true picture of what the elder’s true needs are – several examples of situations where case manager could not “get straight answers” to

the elders health needs were, how the family was providing care and why they needed the amount of PCA hours they were requesting.” (County staff).

“Many elders are suspicious of the western health care system. Communication with elders and families at clinics is very poor – so mistrust is strong.” (County staff).

## **Conclusion**

The data gathered for this report provides insight into service needs, service utilization, and cultural considerations for serving Hmong elders in any future service development. The following summary highlights these insights while noting the limitations of the data for making firm estimates of demand/need for any specific service.

### **Insights from Medical Assistance and Census data**

It is important to note the limitations of these data sources when estimating current and future demand for services. The most significant difference between these two sources involves the number of individuals identified as living below poverty level. The Census identifies a total of 1,065 Hmong elders living below poverty. However, the MA records identify a total of 3,191 Hmong elders living below poverty level and receiving long-term care services. In fact, the total number of Hmong MA beneficiaries is larger than the total Hmong elder population identified by the Census. These differences support the assumption the household income data collected by the Census undercounts the actual number of elders who are living below poverty and, as such, may be eligible for Medical Assistance. Other potential reasons for these significant differences include:

- The arrival of 119 Hmong refugees age 65+ from outside the U.S. between 2001 and 2004;
- Additional numbers of Hmong elders moving to Minnesota from other states; and
- Undercounting of the overall Hmong population by the Census (the Minnesota State Demographer estimates the total Hmong population was undercounted by 30 percent).

Despite these limitations, initial conclusions can be made regarding the current service needs and utilization of the Hmong elder population in the metro area.

- The current Hmong elder population is relatively young, with more than half between the ages of 50 and 64.
- The vast majority of Hmong elders live with family members.
- Based on MA data, most Hmong elders live below poverty.
- Significant rates of depression exist among Hmong elders (25% among all MA beneficiaries, 36% among Waiver clients)
- Personal care assistance is utilized by a large number of Hmong waiver beneficiaries, as are skilled nurse visits and adult day center services.

### **Insights from Interviews and Focus Groups**

Focus groups with elders and stakeholder interviews completed by the Hmong American Partnership (HAP) provided the following.

- The Hmong elders receiving (family) personal assistance wanted to ensure any additional services they receive will not jeopardize the receipt of this assistance.

- All stakeholder groups noted that additional training and support is needed for personal care assistants.
- For those who do not have access to family care, the availability of culturally appropriate services varies. Several adult day centers provide culturally appropriate services to Hmong elders as well as a Southeast Asian Meals on Wheels Program, social service programs, assisted living and a corporate adult foster home.
- Even when available and accessible, these services may not be utilized by Hmong elders because they are reluctant to seek non-family assistance.
- The elders themselves as well as their family members and professionals interviewed identified a significant number of basic and chronic health problems.
- Case manager focus group participants noted similar conditions for the overall Hmong population.
- Language and cultural barriers make it difficult for Hmong elders to take care of themselves and manage chronic conditions.
- Case managers reported a high incidence of mental health issues among Hmong waiver recipients. Some of this may be attributable to the language and cultural barriers Hmong elders face on a daily basis.

### **Service Development**

These findings provide the following directions for service development:

- Address the significant rates and risks for depression among this population with both in-home and group services which reduce the physical and cultural isolation elders experience.
- Focus on services which support busy families to care for their elderly family members: education about chronic diseases management (medications and other self-care issues), support to build a sense of competency with health issues, and strategies for working through the health and social services systems.
- Develop health education/disease management programs and materials in visual/audio formats (due to non-literacy among many elders) to bridge western with traditional Hmong perspectives on health and engage bilingual bicultural Hmong health educators to work with elders.
- Invest in more services to help elders with paperwork/eligibility, and effective, accurate interpretation/translation to maintain public benefits and understand health care instructions.
- Given elders' reluctance to seek non-family care, and case managers' assessment that most elders need help with non-personal care IADLs, build experience and comfort with services like companion, grocery shopping, transportation, benefits/paperwork and socialization services which address isolation and depression.
- For the smaller group of at-risk elders with little or no family support, work with Hmong community advisors and elders to develop alternate housing with service projects Hmong elders will accept.