

**Sustaining Minority Elders in Their Communities
Vietnamese Elders in the Twin Cities:
A Community Needs Assessment
2006**

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For further information about Vietnamese elder services

Contact Gaoly Yang at MAAA by phone 651-917-4603 or email Gaoly@tcaging.org for further information on these Vietnamese-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)'s *Sustaining Minority Elders in Their Communities project*, Vietnamese Social Services (VSS) staff worked with the MAAA and Malone Consulting to conduct a needs assessment of the Vietnamese elder community related to long-term care services. VSS received funding from the MAAA to assess the Vietnamese community's needs to serve frail elders through focus groups with elders and key informant interviews. The MAAA staff conducted focus groups with care coordinators to assess their views about services among the Vietnamese elder population. The MAAA also provided data from the 2000 Census and state Medical Assistance (MA) beneficiary records for Vietnamese 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 Vietnamese elders for home- and community-based, culturally specific services
2. Examines the likelihood that Vietnamese elders will use non-family care
3. Identifies potential opportunities to enhance support of Vietnamese elders within the Vietnamese community.

Methodology

The initial data collection design included five key informant interviews and elder interviews at the monthly birthday celebration. However, upon attending the celebration and attempting to interview elders, this approach was found to be ineffective for a number of reasons:

- Some families already receive money from the county for providing services, resulting in concern by elders about losing this support.
- Elder were confused about the purpose of interviewing for service gaps.
- Elders were not comfortable saying their families could not help.
- Elders had to have both a level of comfort with the interviewer and the surroundings to respond to the questions. This level of comfort could not be achieved.
- There was not enough time on the agenda for the extensive interviews.
- Even though the questions had been tested, more time than expected was required to clarify their meaning during the interviews.

The re-design of the process included three VSS staff assigned to do personal telephone interviews with elders, modifications to the questions, and additional training with the interviewers. In the data collection process **45 elders** and five **(5) key informants** were interviewed. The five key informants were three VSS staff or volunteers who work in elder programming areas and two Vietnamese service providers to the elder community. It should be noted these results reflect a small sampling of approximately 1.7 percent of the Vietnamese elder population in Minnesota and are not the result of an extensive community needs assessment.

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 (CAD) 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 Vietnamese Medical Assistance (MA) beneficiaries. There are significant limitations to the Census data that result in an undercounting of the Vietnamese elder population. The data is limited because it identifies elders by country-of-origin or language rather than by ethnicity. However, the data is provided in order to give an overall indication of the potential need for long-term care services by the Vietnamese elder population, as well as current and potential future service utilization.

Population Characteristics

The following section highlights demographic information related to the overall elderly Vietnamese population in Minnesota. 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 needing 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 thought of as the minimum likely number of individuals in any given table. The remaining 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 smaller population groups.

Additional information is presented from the MN Department of Human Services' (DHS) records of Medical Assistance (MA) beneficiaries in March 2005. The information is provided for those Vietnamese 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 Vietnamese elders.

Demographics

Age group and county. According to the Census, Hennepin County has the largest number of Vietnamese elderly (1449), with over twice as many as Ramsey County, at 707. Dakota County has the third-largest population of older people, at 241, with Anoka County fourth at 150 individuals. The Vietnamese elder population is relatively young with over 70 percent of its population between the ages of 50 and 64. There are 726 elders age 65 or older.

Table 1: Elderly Vietnamese 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	2672	1946	514	173	39
Anoka	150	166	20	13	1
Dakota	241	177	45	17	2
Hennepin	1449	1065	275	92	17
Ramsey	707	497	152	40	18

Source: Census 2000, SF2 files.

Poverty status (Census). The table below highlights the number and percentage of Vietnamese elders in different age groups who live in households at or below poverty level. Approximately seven percent of Vietnamese age 50-64 lives in households at or below poverty level. Of those Vietnamese ages 65 and older, 13.5 percent live in households at or below poverty level. Income information in the Census is based on the income of the total household, not the individual's income. Thus, the actual number of Vietnamese 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 and percentage of elderly Vietnamese aged 50+ by age and poverty status, 7-County Metro Area

Age Category	Above Poverty	Below Poverty	Total
Age 50-64	1858 (93.0 %)	140 (7.0 %)	1998 (100 %)
Age 65+	606 (86.5 %)	95 (13.5 %)	701(100 %)
Total Age 50+	2464 (91.3 %)	235 (8.7 %)	2699 (100%)

Source: Census 2000, PUMS data.

Poverty status of those living with other versus living alone. As illustrated in Table 3 below, a total of 197 (seven percent) of Vietnamese age 50+ live alone, half of whom live below poverty level. However, the vast majority of Vietnamese elders live with others. Approximately five percent of this population lives below poverty level.

Table 3: Vietnamese 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	67	23	1791	117
Age 65-74	0	59	446	18
Age 75-84	30	18	120	0
Age 85+	0	0	40	0

Source: Census 2000, PUMS data.

MA beneficiaries. As of March 2005, there were 940 Vietnamese MA beneficiaries. A total of 686 (73 percent) of the beneficiaries were age 65 or older.

Table 4: Vietnamese MA beneficiaries by age group, for total 7-County Metro Area and selected counties

Age Categories	7-County Metro Total	Hennepin	Ramsey	Anoka	Dakota
50-64	254	13	95	20	14
65-74	431	247	114	23	30
75-84	205	100	63	17	16
85+	50	25	11	5	4
Total	940	485	283	65	64

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.

Table 5: Total Vietnamese CADI or Elderly Waiver Beneficiaries as of March 2005 and those with 12 or more months of eligibility during the study period (January 2004 – March 2005), 7-County Metro Area

Waiver-Eligible MA Beneficiaries as of March 2005	92
Number of Waiver- eligible MA Beneficiaries with at least 12 months of eligibility during the study period	92

Source: DHS Data Warehouse

Differences in Data: Census and Medical Assistance. It is important to note the significant differences in the data from the Census and Medical Assistance records regarding the Vietnamese elder population living below poverty. The Census identifies a total of 235 Vietnamese elders living below poverty level. However, the MA records identify a total of 940 Vietnamese elders living below poverty level and receiving long-term care services. These differences also 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. In addition, the overall undercounting of smaller population groups by the Census likely adds to the discrepancy.

Elder Interview Demographics. Forty-five (45) elders were interviewed. Eleven of the elders (25 percent) lived alone and 34 lived with family.

Health and Functional Characteristics

The following section provides information regarding the health and functional status of Vietnamese 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 Vietnamese elders for whom MA services may be beneficial today.

Number of individuals reporting disabilities. According to the Census, 30 percent of the Vietnamese population age 50 and older reported having any disability. 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 four percent (4%) of the population 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 ADL (Activities of Daily Living) and IADL (Instrumental Activities of Daily Living) categories of need for human assistance described in more depth below.

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

Age Category	Any Disability Reported?		Total
	Yes	No	
Age 50-64	500	1498	1998
Age 65+	311	390	701
Total, age 50+	811	1888	2699

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

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

Age Category	Self-Care Disability Reported?		Total
	Yes	No	
Age 50-64	59	1939	1998
Age 65+	58	643	701
Total, age 50+	117	2582	2699

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.

Percentages of MA waiver-eligible Vietnamese age 50+ with selected IADL/ADL needs are shown in Table 8. About 60 percent of the Vietnamese waiver population needs highly intensive assistance with three or more ADL/IADLs. The most common need is for medication management followed by dressing.

Table 8: Percentage of Vietnamese Waiver clients needing ADL/IADL Assistance*

Total Number of Waiver beneficiaries	92
<i>ADL/IADL need</i>	<i>% (# of people)</i>
Medication Management	77 % (71 people)
Dressing	59 % (54 people)
Toileting	42 % (39 people)
Waiver recipients with Zero of selected** ADL/IADL needs	11 % (10 people)
Waiver recipients with 1 or 2 of selected** ADL/IADL needs	30 % (28 people)
Waiver recipients with 3 or more of selected** ADL/IADL needs	59 % (54 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.

Chronic conditions. Table 9 highlights the prevalence of chronic conditions typically linked to the need for long-term care services. Diabetes and depression are the most prevalent chronic diseases in the Vietnamese MA beneficiary population. The percentage of Vietnamese elders with Alzheimer’s Disease/dementia and CVD (stroke) is significantly higher in the waiver population as compared to the overall MA population. The percentage of Vietnamese elderly with COPD (breathing complications), diabetes and depression is slightly higher in the waiver population. Because waiver beneficiaries need a higher level of care than those in the general MA population and chronic conditions are progressive, it is likely only those individuals in the later stages of these conditions are eligible for waiver services.

The prevalence of these chronic conditions provides an indication of need for regular monitoring by a registered nurse as well as other support provided through the waiver program. For example, insulin-dependent elders may require registered nurse supervision for injections, and, therefore, need the services of a licensed home health agency, one of the services on the Elderly Waiver menu.

Table 9: Percentage of Vietnamese MA Beneficiaries with selected diagnoses within the total community population and for the subgroup of Waiver-eligible individuals, 7-county Metro Area

Disease	All Community MA Beneficiaries	MA Waiver Population
Alzheimer’s/ dementia	4.7 %	13 %
CVD (cardio-vascular disease)	7.0 %	17.4 %
COPD (chronic obstructive pulmonary disease)	11.5 %	18.5 %
Diabetes	28.7 %	35.9 %
Depression	18.7 %	27.2 %

Source: DHS Data Warehouse

Differences in Data: Census and Medical Assistance.

According to the Census, 117 Vietnamese elders reported a self-care disability. This level of disability would very likely require the level of assistance available through the MA Elderly Waiver (EW) program. However, only 92 Vietnamese elders were receiving MA waiver services in March 2005. The difference in these numbers may point to additional individuals for whom waiver services would be beneficial.

Current Service Utilization

Table 10 shows the most frequently utilized services by Vietnamese waiver beneficiaries are personal care assistance and medical supplies and equipment. These are followed closely by home delivered meals and skilled nurse visit. Two services which have notably low levels of use are home health aide and assisted living plus.

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

Waiver Services	All age 50+, CADI + EW	Age 50-64 (CADI)	Age 65+ (EW)
Total Eligible	92	2	90
Personal Care Assistance (PCA)	33	1	32
Home Delivered Meals	27	1	26
Skilled Nurse Visit	20	2	18
Home Health Aide Visit	0	0	0
Assisted Living Plus and other residential (e.g., foster care)	1	0	1
Med Supp/Equipment	30	2	28
Adult Day Center Services	1	0	1
Homemaker Service	16	1	15

Source: DHS Data Warehouse

Findings from Interviews and Focus Groups

Case manager focus group participants noted Vietnamese elders have basic health needs along with the need for assistance in daily activities, primarily with IADLs. The presenting issues are often mental health related such as depression, diagnosed and undiagnosed, and post-traumatic stress syndrome. They noted hypertension and diabetes are prevalent in the Vietnamese elder population. Many ethnic-minority elders have not had access to Western healthcare in their countries-of-origin, so addressing basic health issues (such as vision and hearing) from a western health care point-of-view are not a part of their experience.

Of the **45 elders** interviewed for this study, 31 (almost 70%) reported currently receiving services from outside their family. Two-thirds of these elders received assistance with transportation and the same proportion received interpretation services. In both cases, Vietnamese Social Services (VSS) was the main service provider. Case manager focus group participants identified one Vietnamese personal care assistance (PCA) agency. They noted Vietnamese elders utilize family members as PCAs.

Service Gaps

By the elders, the top two areas identified as potential future needs interviewed were transportation and assistance in accessing healthcare services. Chore services, such as laundry and shopping, and interpretation services were also identified as future needs.

The key informants also identified transportation as the number one unmet need of the elders. They also focused on social and mental health issues (something not identified by the elders).

Case manager focus group participants identified the need for interpretation and paperwork assistance related to accessing and maintaining health care and public benefits, transportation, culturally-specific services and health education methods, and socialization opportunities to mitigate depression.

Cultural Considerations

The most important consideration identified in the interviews is services be provided in Vietnamese. This was reflected in both the elder and key informant data. The idea of moving to a nursing home is not considered a possibility within the Vietnamese culture. In addition, this generation of elders is uniquely the first generation of Vietnamese elders in the United States. Future generations may be more “Americanized” and have differing service needs. Future generations may also be more open to non-Vietnamese service providers.

The interview process with the Vietnamese elders highlighted cultural considerations important to note. The current Vietnamese elder population is reluctant to accept help from someone other than a family member. Vietnamese elders felt their needs should be met by their family members and were reluctant to identify unmet needs to an outsider. In addition, the Vietnamese elders interviewed had difficulty applying Western definitions of ADL and IADL to the concept of “need.”

Conclusion

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

Insights from Medical Assistance and the Census

The majority of Vietnamese elders are relatively young, with 70% between ages 50-64. The Medical Assistance data is a much more reliable indicator than Census data of the number of potential low-income elders who would be financially eligible for waiver services. The MA records identified a total 947 elders as of March 2005, and the 2000 Census only identified 235 elders living below poverty. Of those 947, only 92 were receiving long-term care benefits through the Elderly Waiver or CADI program. Chronic disease prevalence among the total MA population shows a potential group of elders

may have functional needs for long-term care assistance through the waiver program. For instance, the 29 percent of MA clients with a diagnosis of diabetes converts to 274 elders, compared to the 33 with diabetes receiving waiver benefits as of March 2005

There may also be more Vietnamese elders receiving MA benefits than were identified by the DHS Data warehouse. A major limitation of the MA data relates to country-of-origin and language spoken – the only way to identify specific cultures within the race categories. Country-of-origin is frequently not identified on enrollment forms. And, financial workers do not consistently identify the language spoken by the elder unless they need assistance from an interpreter. As of March 2005, there were 1,075 MA clients in the “Asian unknown” category. There may be elders from any number of Asian countries found in this broad category, including Vietnamese elders.

Insights from Interviews

A total of 45 elders were interviewed by telephone. Notable characteristics of the elders interviewed are they were:

- Not receiving personal care assistance because they were able-bodied,
- Aware of needing transportation, interpretation, personal care and chore assistance in the future , and
- Aware and accepting of their need for long-term care in the future

Additional insights were gleaned from VSS staff, volunteers and service providers in the community. These insights largely corroborated the data from the elders. In addition, care managers identified socialization opportunities to mitigate depression, training for personal care assistants, and assistance with paperwork to maintain eligibility and culturally-specific services.

Service Development

The data provided in this study provides direction for service development that would better support Vietnamese elders in the community now and in the future. Current service development recommendations include:

- Services that fall into the IADL category such as: help with medication management, assistance to ensure the elder’s house is safe and clean, adequate nutrition, improved ability to manage basic health care needs. These are especially needed for the smaller subset of elders living alone.
- Innovative services that address mental health are needed to mitigate the physical health impacts of depression. The overall mental health of elders and quality of social/psychological/spiritual life needs to be addressed.
- Improving the supply and quality of healthcare interpretation
- Improve transportation services of elders whose family cannot get them to medical appointments.
- Independent Living Services (ILS) which assist elders fill out paperwork, maintain public assistance status including immigration, and monitor financial issues.