

Training Providers to Improve Service Delivery to Asians and Pacific Islanders

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Introduction

Inadequate access and inconsistent utilization of care among Asians and Pacific Islanders (A&PIs) living with HIV-related illness have been focal concerns in New York City, where this population constitutes the fastest growing racial group. As of September 1999 there were 761 cumulative adult A&PI AIDS cases in NYC, accounting for approximately 95 percent of cumulative A&PI AIDS cases in the state and 13 percent of cumulative A&PI AIDS cases in the U.S. We estimate conservatively that at least 1,600 A&PIs are living with AIDS or HIV infection in New York City. Recent studies indicate that reported AIDS diagnoses may not accurately reflect the escalating HIV/AIDS problem within this community. Despite their growing presence and emerging HIV problem, Asians and Pacific Islanders have difficulty accessing HIV-related services.

Cultural values, beliefs, and experiences coupled with a fragmented and daunting service delivery system make it difficult to access culturally competent and language-appropriate services. Moreover, for those who encounter linguistic barriers, navigating through systems of care

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constitutes a significant stressor. The result is that Asians and Pacific Islanders with AIDS show the highest rate of delayed care of all race groups in New York City.

To address these concerns, the Bridges Project was developed to improve access to care by:

- integrating a range of HIV medical and social services through a system of formal linkages with comprehensive service sites and a Referral Services Network made up of 80 individual bilingual providers;
- increasing levels of cultural competency and HIV sensitivity among providers through training;
- bridging linguistic barriers through language interpretation by bilingual peer advocates (BPAs) and comprehensive case management by case managers.

The distinctiveness of this navigation model centers on its capacity to expand the range of HIV care to A&PIs living with HIV/AIDS without creating new ethnic-specific service sites. During its operation, the Bridges Project has been confronted by expected and unexpected problems in working to achieve its three primary goals, and its staff has learned valuable lessons in overcoming them.

Project Setting

The Bridges Project at APICHA specifically targets A&PIs living with HIV/AIDS in the New York City metropolitan area, particularly those with limited or no English language capacity and who have difficulty accessing HIV-related services.

Unlike San Francisco and Honolulu, where Asians and Pacific Islanders make up 30 percent or more of the total population, they represent a relatively small segment of the citizenry in New York City currently between 7-11 percent. This, combined with the popular myth that Asians and Pacific Islanders do not experience social problems, tends to make them marginalized, even invisible, in the arena of medical and social services, despite the fact that in absolute terms, they constitute a large and growing community in New York City (687,547 strong in 1997).

Immigrants, migrants, and refugees make up 77 percent of NYC's expanding A&PI population. According to the 1990 U.S. Census, of that population, 47 percent are

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- **29 Distinct Asian Groups**
- **20 Pacific Islander Groups**
- **100 Languages & Dialects**

information or to meet the needs of this community. These shortcomings are compounded by the fact that A & PIs constitute a very diverse group.

Chinese, 17 percent Indian, 14 percent Korean, 9 percent Filipino, 3 percent Japanese, and 2 percent Vietnamese. An additional 8 percent included Pakistani, Bangladeshi, Thai, Cambodian, Indonesian, Guamanian, and other rapidly growing communities. Forty-one percent of census-recorded Asian and Pacific Islander households in New York City are considered linguistically isolated, speaking little or no English. Fifteen percent live below the poverty level.

A&PIs with HIV/AIDS in NYC have a particularly difficult time accessing linguistically appropriate, culturally competent services because most hospitals and health clinics as well as mainstream HIV-related service providers do not allocate resources to provide information to and meet the needs of this community. These shortcomings are compounded by the fact that Asians and Pacific Islanders constitute a very diverse group, with 29 distinct Asian groups and 20 Pacific Islander groups speaking more than 100 languages and dialects.

According to New York City Department of Health statistics from September 1999, 58.5 percent of cumulative A&PI AIDS cases in NYC are known to be among immigrants or refugees, who generally have the most difficulty accessing mainstream services because of language and cultural barriers. This is certainly an underestimate, since for fully 22 percent of cases country of birth is unknown (19.5 percent are U.S.-born). The Health Department admits they haven't been good about collecting this information. The countries most heavily represented are the People's Republic of China (12 percent of all A&PI AIDS cases in NYC), the Philippines (11 percent), India (9 percent), Japan (6 percent), Guyana (4 percent), Hong Kong (2 percent), Taiwan (2 percent), South Korea (2 percent), Thailand (2 percent), Pakistan (2 percent), and Trinidad (2 percent) (Asians and Pacific Islanders from Guyana and Trinidad are probably south Asians).

Of those Asians and Pacific Islanders in New York City who have been diagnosed with AIDS, 53 percent of are gay, bisexual, and other men who have sex with men (MSM), 11 percent are women, and 12 percent are injection drug users. Unfortunately, many Asian and Pacific Islander-focused health and social service providers are blatantly homophobic and AIDS-phobic, woefully misinformed about HIV, and thus ill-prepared to work with clients who may come to them for information and treatment services. Even when health and social service agencies offer piecemeal HIV services, Asians and Pacific Islanders living with HIV/AIDS are wary of providers and unconvinced that confidentiality will be guaranteed.

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They are afraid they will see people they know when seeking services, both among staff and other clients.

Thus, while representing an expanding population with increasing needs for HIV-related services, Asians and Pacific Islanders are effectively prevented from accessing adequate services because of a number of barriers, including: lack of culturally competent, linguistically accessible, and HIV-sensitive providers; lack of coordinated primary care and case management services; lack of health insurance; distrust of institutions; and stigma within their communities surrounding sex, substance use, homosexuality, illness and death.

Program Intervention

The overall goal of Bridges is to improve access to care by minimizing the impact of factors associated with service under utilization. Components of the intervention such as language interpretation and client advocacy, for example, address factors such as limited English proficiency, immigration status, and familial and peer support that can impede service use.

APICHA has linkages and referral agreements with a number of agencies and hospitals, many of which are Ryan White CARE Act grantees. Potential clients are referred to the Bridges Project by providers at service sites that are unable to provide the needed service primarily because of language and cultural barriers. When a client is referred to APICHA, he or she is assigned a bilingual case manager and, if necessary, a bilingual peer advocate (BPA) who escorts clients to service sites and provides language interpretation and advocacy. In addition to helping service providers understand their clients' cultures, BPAs are able to explain the health care and social service systems to clients. They are paid, but work only part-time as needed. As a result APICHA is able to maintain a corps of 15 to 20 advocates speaking up to 12 Asian and Pacific Islander languages and dialects. In addition to being able to access services through linkage relationships, APICHA clients can also receive a number of in-house services, including full body acupuncture, free legal services, an Asian food pantry and a range of culturally appropriate support groups.

APICHA's Education Department facilitated 371 workshops/rap sessions to 5,588 attendees and made more than 52,000 face-to-face contacts with Asians and Pacific Islanders in the past year. This extraordinary effort was implemented by 53 bilingual peer educators who were thoroughly trained and supported by professional staff. The department continues ongoing efforts to broaden the offering of HIV sensitivity trainings to non-linkage providers.

APICHA's technical assistance and staff training services have been provided free to all of the smaller community-based organizations in the Asian and Pacific Islander communities of New York. APICHA has provided workshops in harm reduction, health and sexuality issues, fund raising, presentation and facilitation skills, workshop development, immigration issues, media outreach, and leadership development. In APICHA's women's project domestic violence issues, self-defense and safer sex

Extraordinary effort

In the past year APICHA's 53 bilingual peer educators:

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-

negotiation have been the leading subjects of workshops. APICHA has reached out as well to gay activists and HIV/AIDS organizations in Burma, Korea, India and Thailand.

What APICHA Has Learned

Ideally, any Asian and Pacific Islander immigrant living with HIV/AIDS in New York City would be able to access any needed HIV-related service in the language that he or she speaks. In this ideal situation, the service would also be provided in a way that recognizes the cultural practices and attitudes of the client or patient. Given a tight funding environment, a lack of prioritization and the numerous languages, national, and cultural groups within the Asian and Pacific Islander communities, such an ideal is difficult to achieve.

The BPA program—which trains and maintains a corps of paid, part-time, bilingual workers to act as language interpreters, cultural guides, and client advocates for clients as they navigate the medical and social service systems—has demonstrated innovation in overcoming these barriers. It has also proven to be a cost-effective method for meeting the unique service needs of the community. Preliminary data indicate that the program has a positive impact on the service system and on client satisfaction.

One of the most striking facts to emerge from focus groups conducted on these issues is that neither case managers nor advocates have ever received a complaint from an outside service provider about their performance. An explanation for this, beyond the high quality of work of BPAs, is the great need of service providers to have a bridge to their clients. Service providers feel quite paralyzed and frustrated when they are confronted with clients with whom they are unable to communicate. The great need that service providers have for bilingual peer advocate services is a testament to the great difficulty immigrants have in accessing HIV-related services. As one advocate said, “Yeah, [outside service providers] appreciate [BPAs] because they have a difficulty communicating with the clients. So, they need us. They definitely need us.”

Some real life situations illustrate this need. Another BPA reported, “...just as soon as I got to the hospital . . . the receptionist and the other nurse called me ‘Come on, come on! Your client’s in the waiting room!’ ...Sometimes I couldn’t believe [how] they just call me, ‘hurry up,’ ...without any checking out [who I am].” She continued with another example: “Several times when I was waiting with a client . . . for too long for the doctor’s appointment, I go to the nurse station to talk to them. ‘I don’t have time to wait here, I gotta go. Otherwise you have to find an interpreter for the patient.’ Then the nurse will put the client [at the top of the list]. So it means that they really need us

to give them the help. Otherwise they have a big problem. They have to . . . find another interpreter.”

Aside from the confirmation that the Bridges Project is needed in the community, APICHA has learned some valuable things about how to best carry out their work. Three of the key lessons learned relate to (1) the prospects and pitfalls involved in establishing and maintaining formal linkages with comprehensive health-care service sites and developing a referral service network of medical and social service providers; (2) when and how to offer and carry out cultural competency training, and; (3) how to combine case management services and a bilingual peer advocacy program.

Lesson #1: A successful service network requires consistent efforts.

APICHA’s Department of Client Services conducts regular client outreach to hospitals, clinics, and social service agencies. BPAs conduct the client recruitment/outreach work under the supervision of a linkage coordinator. The linkage coordinator visits at least two service sites each month to meet with staff and discuss APICHA’s services. A large portion of the trainings is devoted to apprising linkage staff of the services provided through the Bridges Project. In addition to ongoing outreach, the trainings for linkage site staff serve as dissemination activities, during which a client services brochure printed in five languages is distributed to both service providers and potential clients.

Two activities seem to help most with ensuring that linkage relationships move from paper to reality. One is regular training provided by APICHA’s diversity trainer. The trainer provides staff at linkage sites with information on APICHA’s services and specifically on the nature of the linkage agreement. She also provides training on how to work with A&PIs living with HIV/AIDS and with the BPAs as language interpreters. The other activity that helps with maintaining a vibrant linkage relationship is cultivating working relationships among frontline service staff in both agencies. Frontline service staff members cross-refer and consult with each other more frequently if they are aware of the available services at the other agency, and then only if they feel comfortable with each other and confident in the services the other agency provides.

Lesson #2: Streamline trainings to make them more effective and useful.

Getting providers at other institutions to prioritize diversity training for their staff has been a challenge. Therefore, in addition to covering the components of the linkage arrangement with APICHA and the range of APICHA’s services, HIV sensitivity training specific to the Asian and Pacific Islander experience is incorporated into the linkage site training sessions. The training sessions cover topics such as cultural competence, homophobia, cultural beliefs and practices and how they create barriers to accessing health care, how to develop culturally competent communication, and epidemiology and demographics.

Another difficulty is that providers seem to prefer a cookbook style training in which they receive hard-and-fast rules for dealing with Asians and Pacific Islanders from different language/ethnic groups. This approach is counterproductive since even within each language/ethnic group, there is vast diversity. To remedy this problem, training sessions are scheduled in smaller one to one-and-a-half-hour segments that follow in succession. The curriculum was modified to incorporate more of a didactic style

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interspersed with experiential exercises. Participants are walked through a chart listing common cultural characteristics of Asians and Pacific Islanders and how these characteristics play out in the area of HIV. The goal is to honor providers' need for concrete, useful information that can be applied in day-to-day work without oversimplifying the issue.

Lesson #3: Clear roles, specialized training and open communication help the program run smoothly.

Of APICHA's current 96 HIV-positive clients receiving comprehensive case management, 31 clients are being served by bilingual peer advocates; some clients need none because of their English fluency and some are awaiting recruitment of an advocate with

suitable language skills. Each month, BPAs spend 8-12 hours working directly with clients, 3-5 hours conducting client outreach, 10 hours in travel, and two hours in training. They are provided clinical supervision by three full-time case managers and are paid because they commit more time to work and training than volunteers. BPAs start with a three-day, intensive training and then receive a two-to-three-hour, monthly follow-up training. They are expected to be available on a regular basis; some are on-call and carry beepers. BPAs work only part-time in order to retain a level of flexibility that full-time staff do not typically have. More importantly, part-time status allows APICHA to hire a broader range of individuals representing more cultures and languages. Currently APICHA maintains a corps of 18 bilingual peer advocates. Among them, they speak 10 major languages in addition to English: Cantonese, Mandarin, Toishanese, Japanese, Korean, Tagalog, Hindi, Bengali, Gujarati and Urdu.

Because of the unique staffing structure introduced by the program, however, a number of difficulties in program implementation have arisen in the areas of role definition and supervision, training, and communication.

Problems of role definition

Peer advocates receive an hourly rate of pay and have no office space at the agency. They are considered neither part-time staff, nor volunteers, nor independent contractors or consultants. Given their unique status, it is not always immediately clear how to work with them and what to expect.

Some case managers express frustration over BPAs' lack of professionalism and their tendency to see themselves as volunteers. The advocates in turn, view their volunteer

spirit as a positive quality that should be nurtured. Another point at issue is their role as translator. Case managers feel that advocates sometimes confuse their role by speaking for clients instead of allowing clients to speak for themselves. BPAs stress how difficult it is to do strict translation given the emotional context of HIV disease and clients' hesitancy to disclose personal information. They understand from their training that the ideal interpreter conveys the exact meaning, but they find this ideal hard to meet in the field.

Supervision, training and communication problems

Ambivalence about the role of bilingual peer advocates also gets expressed in discussion about whether a client is assigned a single advocate on a permanent basis or is served by many depending on availability. The system varies from case manager to case manager. Some case managers permanently pair a client with one person, while others rotate advocates among clients. BPAs agree that the ideal is a permanent one-on-one assignment.

Both case managers and BPAs expressed distress at the lack of preparation case managers receive to supervise a small team of BPAs. Case managers with more supervisory experience seem to have smoother working relationships with the BPAs. In addition, the training peer advocates receive needs to be tailored to their role. The most effective peer advocates seem to be those who understand the procedures of the agency, communicate regularly with the case manager, but also feel confident in using their own judgment. Those who work toward this type of stance feel very satisfied when the case manager supports them. Most feel that greater job satisfaction comes from developing a deep one-on-one relationship with clients, something that can occur only if they are not rotated among clients. Although they express frustration with case managers' seeming rigidity in enforcing boundaries, they understand the need for boundaries.

Despite the difficulties of working in this fairly unique staffing structure, those involved in implementing the program do not see the difficulties as outweighing the benefits. The effectiveness of the program is also corroborated by the high level of client and provider satisfaction. Still, the bilingual peer advocate program requires improvements, including:

- more support and training for case managers who supervise BPAs;
- permanent pairings between peer advocates and clients whenever possible;
- additional training to BPAs on boundary issues, advocacy and language interpretation;
- regular case conferences between case managers and BPA teams;
- clarification of roles and responsibilities; and
- cultivation of trust and communication through team-building and staff development programs.

While the ideal situation would be to have all needed services provided by those who speak the client's language and understand his or her culture, this is not always

possible, particularly in tight funding environments and where racism, intolerance, or simple lack of awareness make such an ideal goal a very low priority. The bilingual peer advocate program provides a cost-effective option that ensures minority access to lifesaving and life-enhancing services.

It is the hope that information presented here will be useful to those who might be interested in starting similar programs to serve the needs of language, cultural, racial or ethnic minorities. The lessons learned from the implementation of the bilingual peer advocates program may be adapted to a wide range of service contexts in which a language/cultural/racial minority experiences barriers to accessing services, especially when this minority is heterogeneous and small relative to the larger population.

Summary

Current findings show that APICHA has been successful in reaching the immigrant A&PI population, as only 10 percent of clients were born in the U.S. Breaking the data down by citizenship status show that noncitizens/nonpermanent-residents have more barriers to accessing services than citizens/permanent residents. Thirty-one percent of noncitizen/nonresident clients report English fluency, but only 10 percent say they are comfortable negotiating their service provision in English. Seventy-two percent of citizen/resident clients report English-language fluency. Only 18 percent of noncitizen/nonresident clients report having a full-time job, while 36 percent of citizen/resident clients are employed full-time. Seventy-six percent of noncitizen/nonresident clients have a primary care physician, compared to 97 percent of citizen/residents.

Data also show that clients are accessing APICHA's services fairly soon after receiving an HIV-positive test result (although this does not necessarily mean that they are accessing care early, since they may not be tested early in relation to their date of infection). Nearly 38 percent came to APICHA within a month of testing HIV positive and 52 percent showed up within three months of a positive test. Concerns about early access are especially important in light of recent New York City Department of Health AIDS surveillance statistics showing that Asians and Pacific Islanders and Native Americans have the highest rate of opportunistic infections at the time of AIDS diagnosis in comparison to other racial groups followed. Only 23.4 percent of those who sought APICHA's services within three months of their HIV-positive test result were asymptomatic at the time of the intake interview.

The Bridges Project Chronology

April-May 1996

- Model designed to create a comprehensive, integrated system of care for A&PIs living with HIV/AIDS. The model includes three main components: linkages with key providers, training of providers, and comprehensive case management utilizing full-time case managers and part-time bilingual peer advocates.

October 1996

- APICHA is awarded a SPNS grant.
- Begin recruiting staff for the Bridges Project.

December 1996

- APICHA's founding executive director resigns.
- Linkage coordinator hired.

February 1997

- New director of client services and Queens site coordinator hired.

March 1997

- Diversity trainer and research analyst hired.
- Linkage coordinator develops protocols for hiring, training, and supervising bilingual peer advocates. She also develops recruitment materials.

April 1997

- Two case managers hired.
- APICHA and the Bridges Project receive publicity through the local media, including articles in *World Journal* (Chinese-language), *New York Newsday*, and *The New York Times*, as well as a spot on Chinese-language cable TV.

May 1997

- Begin negotiating new linkage agreements with original six linkage sites established for the Bridges Project, in order to include a provision for the linkage sites to provide APICHA with data. Two linkage sites are reluctant to sign new agreement and insist on making the data requirement voluntary.
- Sixteen BPAs are hired. They include eight men and eight women, speaking Bengali, Urdu, Hindi, Punjabi, Sindhi, Telugu, Gujarati, Tagalog, Cantonese, Mandarin, Taiwanese, Korean, Japanese and English.
- First version of the Bridges Project baseline-intake form is completed (goes through three more revisions to include core elements and other modifications before final version is settled on in late 1998.)

May-June 1997

- Pilot BPA training curriculum is completed and first three-day training takes place.

June 1997

- APICHA holds a public celebration at Queens Borough Hall to mark the opening of its new site, the APICHA Queens Community Center.

March-July 1997

- Research on potential sites for Queens office. Conduct meetings with community board and borough president to introduce APICHA. Lease for Queens site signed in July after long negotiation process.

October 1997

- Monthly follow-up trainings for BPAs begin.
- First linkage coordinator resigns. She is replaced in January 1998.
- Third case manager is hired.

- Training of staff at five of six original linkage sites is completed. The sixth linkage site does not respond to requests to train staff. Trainings end up being shorter than desired as linkage sites agree to only two- to three-hour trainings.

November 1997-February 1998

- Second three-day BPA training is completed for six new BPAs.
- Total pool of BPAs is 17.

December 1997

- First client satisfaction survey conducted.

March 1998

- First research analyst resigns. She is replaced in July 1998.
- APICHA receives a Ryan White Title I award — hire fourth case manager.

April 1998

- APICHA receives federal certificate of confidentiality.

May 1998

- APICHA receives IRB approval, allowing collection of data that is not purely service-related.
- Focus groups conducted with bilingual peer advocates and case managers on program implementation issues.

June 1998 - present

- APICHA is required to implement the Uniform Reporting System (URS) by New York State and Title I funders. The database heavily overlaps with the Bridges Project database in development without meeting data collection needs. Ongoing work takes place to integrate the two databases and to allow data entry from both our Queens and Manhattan offices.

July 1998

- Director of client services resigns. Case manager is promoted into the position in October 1998, leaving a case management vacancy.
- Two new linkage sites added to the original six.
- Findings from focus groups with BPAs and case managers are presented in poster at the 12th World AIDS Conference in Geneva. Poster is then revised for submission to *American Journal of Community Psychology*. Summary of poster is published in *International Journal of Sexual Health*, special issue on peer-based interventions.

July-August 1998

- Third three-day BPA training is completed.

September-October 1998

- Refresher trainings conducted for three of original six linkages sites.

October 1998

- Team case conferences between BPAs and case managers begin every other month in response to feedback from focus groups.

November 1998

- One case manager resigns.

December 1998

- A senior case manager is hired through Ryan White Title II funds.

January 1999

- Two new case managers are hired to fill vacancies from one resignation and one promotion.
- Diversity trainer resigns.
- APICHA receives reapproval from IRB.
- Lead evaluation consultant relocates from Boston to New York City. New York-based data management consultant is hired to replace Boston-based consultant. Thus the evaluation team is completely based in New York City for the first time.

February-April 1999

- SPNS evaluation databases installed at APICHA for data entry.

March 1999

- BPA appreciation party takes place. BPAs are given certificates.

May 1999

- New diversity trainer hired after almost four months of searching.
- Evaluation team generates first data output, mostly baseline data.
- Redesigned program management structure to allow us to engage in better program planning and provide more consistent supervision.
- Evaluator left. New evaluator hired.
- New half-time research assistant hired to help with data collection and data entry.

July-August 1999

- Three-day training conducted for nine new BPAs.

September 1999

- APICHA hosts second East Coast Conference on AIDS in Asian Communities. Offered two provider trainings on providing case management services for A&PIs with HIV.
- Discontinue relationship with one linkage agency because it has not been open to receiving training from APICHA.

October-December 1999

- Finalize linkages with three new sites, all of which serve A&PIs with HIV.

- Cultural competency trainings held at two hospitals.
- Referral Services Network database completed. Provider information entered on more than 80 providers.
- Design new service utilization form for BPAs, whose work is not tracked adequately by the existing form.

Further Information and Technical Assistance

If you are interested in obtaining further information about the Bridges Project and the service delivery model APICHA has developed, please contact the project director:

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