The Health of Asian Americans, Native Hawaiians, and Pacific Islanders Served at Health Centers: An Analysis of the 2021 Uniform Data System

December 2023
About AAPCHO

The Association of Asian Pacific Community Health Organizations (AAPCHO) is a national association of community health organizations dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of Asian Americans (AAs) and Native Hawaiians/Pacific Islanders (NH/PIs) within the United States, its territories, and freely associated states.

AAPCHO supports all health centers, which provide high quality health services to medically underserved communities, regardless of insurance status or ability to pay. By operating under governing boards primarily composed of patients and community members, health centers deliver culturally sensitive care that reflect the needs of the populations they serve. To learn more about the Health Center program, visit https://bphc.hrsa.gov/about/index.html.1
Abbreviations and Readability

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AA</td>
<td>Asian American</td>
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<tr>
<td>“AANHPI” or “AA and NH/PI” or “AA&amp;NHPI”</td>
<td>Asian American, Native Hawaiian, and Pacific Islander</td>
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<td>BPHC</td>
<td>Bureau of Primary Health Care</td>
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<td>CHC</td>
<td>Community Health Center</td>
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<td>COFA</td>
<td>Compacts of Free Association</td>
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<td>EHR</td>
<td>Electronic Health Record</td>
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<td>ES</td>
<td>Enabling Services</td>
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<td>HRSA</td>
<td>Health Resources and Services Administration</td>
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<tr>
<td>LEP</td>
<td>Limited English Proficiency</td>
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<tr>
<td>NH</td>
<td>Native Hawaiian</td>
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<tr>
<td>NH/PI</td>
<td>Native Hawaiian and Pacific Islander</td>
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<tr>
<td>PI</td>
<td>Pacific Islander</td>
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<tr>
<td>PRAPARE</td>
<td>Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences</td>
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<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
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<tr>
<td>SDOH</td>
<td>Social Drivers of Health or Social Determinants of Health</td>
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<td>UDS</td>
<td>Uniform Data System</td>
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<tr>
<td>USAPI</td>
<td>U.S. Affiliated Pacific Islands</td>
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For easier readability, AA- and NH/PI-serving health centers will be addressed as AA&NHPI-serving health centers, whereas NH/PI-serving health centers will be addressed as NHPI-serving health centers. In this report, AAs and NH/PIs will be referenced as racial and ethnic groups, and specific AA (e.g., Cambodian, Hmong, Indian) and NH/PI communities (e.g., Marshallese, Native Hawaiian, Samoan) will be referenced as racial and ethnic subgroups.
Chronic Disease and Infectious Disease Disparities
Chronic Disease and Infectious Disease Disparities

Highlights

• Compared to the national health center average of 11.15%, AA&NHPI- and NHPI-serving health centers had lower rates of diabetes mellitus (10.56% and 9.34%, respectively).

• When disaggregating UDS data on uncontrolled diabetes among Asian American (AA), Native Hawaiian, and Pacific Islander (NH/PI) populations, AAs had the lowest rates of uncontrolled diabetes at 21%. NH/PIs had the highest rates of uncontrolled diabetes at 39% for NHs and 40% for PIs.

• When disaggregating UDS data on uncontrolled hypertension among AA and NH/PI populations, AAs had the lowest rates of uncontrolled hypertension at 39%. NH/PI rates were among the highest racial/ethnic subgroups with uncontrolled hypertension at 44% percent for both NHs and PIs.

• AA&NHPI-serving health centers, NHPI-serving health centers, and health centers nationally had higher active tuberculosis incidence (30 cases per 100,000 persons) than the national incidence rates reported by the CDC (2.4 cases per 100,000).

• AA&NHPI-serving and NHPI-serving health centers had higher rates of rates of chronic hepatitis B virus infection (HBV) than health centers nationally; 0.17% of patients nationally had chronic HBV while 0.36% of patients at AA&NH/PI-serving and 0.24% at NHPI-serving health centers had chronic HBV.
• AA&NHPI-serving and NHPI-serving health centers administered COVID-19 vaccines to a greater percentage of their patients compared to the national average (17.9%). At AA&NHPI-serving health centers, 20% of patients received the COVID-19 vaccine while 21% of patients at NHPI-serving health centers received the COVID-19 vaccine.

• Aggregating data on AA and NH/PIs masks chronic and infectious disease disparities within the broader racial and ethnic group and subgroups.
Introduction

Some chronic and infectious diseases disproportionately impact Asian American (AA), Native Hawaiian, and Pacific Islander (NH/PI) communities. Such disparities, which are often the consequence of historical and contemporary systemic racism, pose major barriers in the quest to advance health equity. This section discusses the chronic and infectious diseases measured by the UDS and their impact on the AA and NH/PI population.

Diabetes and Hypertension

According to CDC’s Diabetes Report Card, about 37.3 million people in the U.S. had diabetes in 2019. In 2021, 11.1% of all health center patients had diabetes. While AA&NHPI- and NHPI-serving health centers experienced lower rates of diabetes compared to health centers nationally (10.56%, 9.34%, and 11.15% respectively), disaggregated racial data on diabetes is important for revealing the unique health needs of AA and NH/PI subgroups.

Many studies on diabetes disparities exclude NH/PIs and list only Asians who, in aggregated datasets, shown to have the second lowest diabetes prevalence. Studies using disaggregated racial and ethnic data show disparate diabetes rates among AA and NH/PI subgroups. Such studies have found that NH/PIs are more likely to be diagnosed than AAs and when AAs are disaggregated Filipinos and South Asians are statistically diagnosed more often than other AA subgroups.

Similarly, AA&NHPI- and NHPI-serving health centers experienced lower rates of hypertension compared to health centers nationally (18%, 19%, and 20% respectively). However, when disaggregated by racial subgroups, UDS data show that NHs and PIs were among the highest subgroups with uncontrolled hypertension at 44% percent for both NHs and PIs. Moreover, while AAs in the UDS dataset are among the lowest with uncontrolled hypertension at 39%, other more granular studies have found South Asians to have up to 43% prevalence of uncontrolled hypertension.
When aggregated, AAs have one the lowest rates of uncontrolled diabetes and uncontrolled hypertension. However, the lower rate of uncontrolled diabetes among AA patients may be attributed to potentially high rates of missed diagnoses since AAs are at risk for type 2 diabetes at a lower BMI of 23 compared to the standard screening guidelines of BMI of 25. These findings support initiatives that encourage AA patients with a BMI of 23 to be tested for diabetes.

Increasing capacity for health centers to develop chronic disease management programs that are culturally and linguistically tailored to each racial and ethnic group is an opportunity to improve the program efficacy. While there are limited management programs that do this, culturally and linguistically responsive prevention programs are successful. For example, the Pacific Islander Diabetes Prevention Program (PI-DPP) serves as a preventive program model to build the infrastructure of local organizations to deliver PI-tailored and CDC-recognized lifestyle change programs to PI communities.
In 2021, 7,882 cases of active tuberculosis (TB) were reported across the continental U.S., Hawai’i, five U.S. territories, and the Compacts of Free Association (COFA) nations. AA and NH/PI populations continue to be impacted by TB at a greater rate compared to other racial and ethnic groups. According to the CDC’s 2021 edition of Reported Tuberculosis in the United States, 37% percent of individuals with TB identified as “Asian” or “Native Hawaiian or Other Pacific Islander.” 71% of cases occurred among non-U.S.-born individuals, the Philippines, India, Vietnam, and China were the top four countries of origin.

In contrast to the national TB incidence rate of 2.4 cases per 100,000 reported by the CDC, NH/PI populations had the highest TB incidence rate of 18.4 cases per 100,000 persons while U.S.-born and non-U.S.-born Asian populations have the second highest TB incidence rate of 14.4 cases per 100,000 persons. When further disaggregated, incidence rates for Marshallese are the highest among non-U.S.-born persons, with an incidence rate of 169.6 cases per 100,000 persons. While the UDS does not disaggregate TB by race, data show that AA&NHPI-serving health centers, NHPI-serving health centers, and health centers nationally have higher TB rates (30 cases per 100,000 persons). This provides an opportunity for health centers to advance TB elimination by collecting standardized data on TB that is disaggregated by racial and ethnic groups. Because treatment of latent TB often prevents development of active TB infection, identifying racial and ethnic subgroups with high rates of TB would promote programs to increase screening for latent TB in high-incidence populations, as well as the development of strategies to increase treatment of latent TB.
Hepatitis B virus (HBV) also disproportionately affects AA and NH/PI populations. While AAs and NH/PIs represent less than 7% of the total U.S. population, they make up more than half of the cases of chronic HBV in the U.S. UDS data show that AA&NHPI-serving and NHPI-serving health centers serve a higher proportion of patients with chronic HBV. For all health center patients, 0.17% of patients had chronic HBV while 0.36% and 0.24% of patients at AA&NH/PI-serving and NHPI-serving health centers had HBV. Chronic HBV rates have been reported to be particularly high among individuals from China and Vietnam. The continued high incidence of active TB and high prevalence of chronic HBV among AA and NH/PI populations demonstrates the need for culturally and linguistically appropriate health education resources for patients and providers.
COVID-19

At the one-year anniversary of the World Health Organization declaration of COVID-19 as a global pandemic, COVID-19 precautions began to ease in many regions across the world. While rapid border closures in the Pacific Islands kept them largely isolated from severe cases of COVID-19 in the first year of the pandemic, vaccine deliveries early in 2021 and re-opening borders caused a surge in cases from late 2021 to early 2022. Similarly, lifted restrictions across the continental U.S. and Hawai‘i in mid-2021 preceded increased rates of COVID related to the highly contagious Delta Variant of the virus.

There was minimal difference in average COVID-19 infection rates for AA&NHPI-serving (3.38%), NHPI-serving health centers (3.14%), and health centers nationally (3.61%). However, AA&NHPI-serving and NHPI-serving health centers administered COVID-19 vaccines to a greater percentage of their patients compared to the national average. Compared to the national health center average of 17.9%, 20% of patients at AA&NHPI-serving and 21% of patients at NHPI-serving health centers received the COVID-19 vaccine. Disaggregated data on vaccination rates would allow improved understanding of barriers to vaccine uptake.

While the UDS does not capture COVID-19 infection rates by race, other studies have observed the outsized impact of the disease on NH/PI populations. In a study of COVID-19 cases in Hawai‘i between March 2020 and February 2021, disaggregated data show that PIs represented 22% percent of cases while only making up 5% of the population in Hawai‘i. The Marshallese population in Hawai‘i was particularly impacted with an incidence rate of 10,580 per 100,000 (%).48

It is evident that diseases such as diabetes, tuberculosis, and chronic hepatitis B are prevalent in AA and NHPI populations, but it is likely that the rates vary widely among different racial and ethnic subgroups. Disaggregated data will help further capture the impact of chronic and infectious disease amongst AA and NH/PI subgroups so that health centers can appropriately diagnose, support, and treat patients in an equitable way.
References


18. 42 U.S. Code § 11701.


23. Increase the proportion of high school graduates in college the October after graduating — SDOH-06. Healthy People 2030. [https://health.gov/healthypeople/objectives-and-data/browse-objectives/education-access-and-quality/increase-proportion-high-school-graduates-college-october-after-graduating-sdoh-06]


Disclaimer

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