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

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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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<tr>
<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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<tr>
<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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<tr>
<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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<tr>
<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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</table>

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.
Recommendations

AAPCHO recommends the following priority areas to build a health center’s capacity to serve all patients and equitably improve the AA and NH/PI patient experience:

1. **Increase Collection of Social Risk Data and Disaggregated Race and Ethnicity Data**

   - **Screening for and Collecting Data on Social Risk Factors**

     The 2021 UDS findings indicate that 62.4% of health centers collect data on social risk factors. AAPCHO recommends that 100% of health centers move towards the adoption of social risk factor screening and implementation of appropriate social interventions. Integration and equitable access to electronic health record (EHR) systems capable of incorporating these screenings is further recommended. Without this critical data, AA and NH/PI patients’ unique health and social needs that impact their ability to access healthcare and improve health outcomes will continue to be hidden and overlooked.

     Social risk screening processes and procedures along with documentation of health centers’ most commonly offered Enabling Services both measure effectiveness social interventions. Demonstrating the value of Enabling Services staff and services will prepare health centers for value-based healthcare transformation.

     Finally, health centers should collect standardized data on patients’ social risk factors to proactively address systemic barriers that otherwise inhibit access to care for AAs and NH/PIs.
Disaggregate Race and Ethnicity Data

AAs and NH/PIs represent over 50 racial/ethnic groups and more than 100 languages spoken. Each subgroup is diverse in culture, health beliefs, language, and socioeconomic background. It is recommended for health centers to receive expanded training and technical assistance on the collection of detailed racial/ethnic data to identify unique health characteristics of subgroups within broader racial/ethnic categories. For example, research shows that PI subgroups, like Micronesians, experience disproportionate health disparities related to prenatal care. Health centers can leverage disaggregated data to cultivate new and/or expand existing programs and services that are culturally and linguistically tailored for AAs and NH/PIs.

2. Tailor Health and Social Services to Reflect the Needs of AA and NH/PI Patients

Invest In Programs and Care Delivery Models Geared Specifically Towards AA and NH/PI Patients

AA and NH/PI patients have a diverse array of health and social needs, which necessitate culturally and linguistically appropriate healthcare services. Investment in programs and care delivery models tailored for specific AA and NH/PI communities can improve patient-centered care and address disproportionate rates of disease (e.g., diabetes, hepatitis B, tuberculosis). Below are a few examples of culturally responsive programs and care delivery models that address specific chronic and infectious diseases that disproportionately impact AA and NH/PI patients:
Community Health Worker Workforce Collaborative: https://chwworkforcecollaborative.org/
Hep B United: https://www.hepbunited.org/
The Pacific Islander Diabetes Prevention Program: https://pacificislanderdpp.org/
The Pacific Islander Center of Primary Care Excellence: https://pi-copce.org/
The Tuberculosis Elimination Alliance: https://tbeliminationalliance.org/

° **Hire, Train, and Sustain AA and NH/PI Healthcare Workforce:**

AA&NHPI-serving and NHPI-serving health centers have historically invested in non-clinical staffing (Enabling Services) to ensure availability of in-language, culturally relevant support and critical navigation services that have been shown to increase health center visits and patient satisfaction.  
Critical services including eligibility assistance to ensure patients keep and retain health coverage are necessary to support continuity of care.

Health insurance coverage increases access to preventative care services to diagnose, prevent, and/or manage chronic and infectious diseases among AA and NH/PI patients. Health insurance coverage and retention are impacted by upstream, policy-level as well as downstream, provider-level decisions. Enabling Services staff play a key role for patients to navigate the complex insurance system and must be factored into value-based care contracts and payment reform efforts to ensure long-term sustainability of the health center workforce.
Behavioral and mental health professionals who understand the unique social and cultural needs of AA and NH/PI communities can dismantle stigmas of mental illness and help-seeking that stem from cultural beliefs, attitudes, and generational trauma. Additional barriers that AA and NH/PI face in behavioral and mental health treatment include limited access to services, minimal in-language resources, insufficient insurance coverage, and financial instability. Health centers should provide culturally tailored educational resources on behavioral and mental health and support the hiring and training of staff who understand the cultural differences that contribute to patients’ mental well-being and ability to seek help.

The COVID-19 pandemic amplified the importance of community health workers and the crucial role they have in connecting members of their community to health services. With their linguistic, cultural, and social knowledge, community health workers build trust and promote the long-term health and wellbeing of the communities they serve. With $9.5 million in funding from HRSA, the Community Health Worker Workforce Collaborative supported health centers in developing community-based initiatives to boost COVID-19 vaccine confidence and expand outreach and education efforts. With the sunsetting of COVID-19 funding, community health workers will remain indispensable in addressing ongoing healthcare needs and ensuring equitable access to health services.

AAPCHO recommends that health centers offer skills-based training on the principles and concepts of cultural humility to help staff and providers navigate multicultural communities more effectively. Health centers must re-examine and reorient to nationally recognized frameworks such as the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care which have served as foundational guidelines to improve health equity and decrease health disparities.
3. Cultivate and Sustain Community and National Partnerships

° **Promote Cross-Sector Community Partnerships**

Health centers may not be able to provide comprehensive in house services that address all social needs among AA and NH/PI populations. It is recommended that health centers cultivate existing and/or explore new community partnerships with local social service agencies, faith-based organizations, and/or community-based organizations to address social needs that are unique to AA and NH/PI populations. Cross-sector community partnerships allow health centers to be better equipped with resources to support and improve health outcomes for AA and NH/PI patients.

° **Leverage State and National Networks, Resources, and Expertise**

HRSA funds a diverse array of state and national organizations that directly support the health center program. It is recommended that all health centers access and partner with their state and/or regional Primary Care Associations (PCAs), Health Center Controlled Networks (HCCNs), and National Health Center Training & Technical Assistance Partners (NTTAPs) that focus on addressing AA and NH/PI health disparities.

Through these cross-sector and multi-level partnerships, health centers can strengthen existing programs and policies that may result in increased funding and resources to address health disparities for AA and NH/PI patients living throughout the United States and USAPI jurisdictions. For PCAs and HCCNs, AAPCHO serves as an NTTAP to support new initiatives and special projects focused on ES Data Collection and SDOH screening training for health centers.
Methodology

For the purposes of this report, AAPCHO formulated a specific methodology to create a profile of the Asian American, Native Hawaiian, and Pacific Islander-serving health centers, as well as Native Hawaiian and Pacific Islander-serving health centers, and their impactful work across underserved and marginalized communities.

Defining “AA&NHPI-Serving Health Center”

The AA&NHPI-serving health center definition was revised to simplify a complicated formula that included both a threshold number and percentage cutoff of AA and NH/PI patients served at a health center. Through AA and NH/PI community feedback, AAPCHO formulated a simpler AA&NHPI-serving health center definition to offer a clearer translation of the analyzed UDS data.

For the NHPI-serving health center definition, 1,000 patients were determined as the threshold number for the health centers serving NH/PIs. Through community feedback, AAPCHO learned that health centers often increase their workforce capacity when patient population counts of new racial and ethnic subgroups and their language needs exceed 1,000. AAPCHO intentionally did not use 1,000 patients as the threshold number for the AA&NHPI-serving health center definition. If that definition were to be applied, then the number of health centers that serve AA and NH/PIs would expand from 139 to 253 health centers. This would represent 16.8% of health centers nationally. The larger overlap with the health centers nationally would mask some unique characteristics of AA and NH/PI populations, preventing the opportunity to identify population-specific health trends.

Lastly, AAPCHO did not identify a separate group of AA-serving health centers because this health center group would have a large overlap with the AA&NHPI-serving health centers, thus making the report findings repetitive. AAPCHO acknowledges that the current AA&NHPI-serving health center and NHPI-serving health center definitions have limitations and may update its methodology in future iterations of this report based on community feedback and research best practices (e.g., natural cutoff points based on means and standard deviations).
Limitations

Firstly, the current definitions may unintentionally exclude smaller health centers that serve a large proportion of AA and NH/PI patients or NH/PI patients from the analysis. Since the total number of patients are lower at smaller health centers, these health centers would not be included based on the aforementioned definitions.

Secondly, the currently structured tabular data in the UDS make it difficult to assess health trends and disparities directly and accurately by racial and ethnic groups (i.e., the inability to cross-tabulate data by racial/ethnic groups), which leads to individual interpretation to disaggregate and analyze racial and ethnic data from its aggregate form.

Although the UDS data has its limitations, AAPCHO formulated a methodology to highlight minoritized AA and NH/PI populations. AAPCHO continues to utilize this specific methodology to create a profile of the AA&NHPI-serving and the NHPI-serving health centers and their impactful work across underserved and marginalized communities. With improvements in the UDS data structure, and better understanding of the AA&NHPI-serving and NHPI-serving health centers and the populations they serve, AAPCHO is committed to refining its definitions to equitably represent AAs and NH/PIs in future reports.
References


18. 42 U.S. Code § 11701.


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