The Health of Asian Americans, Native Hawaiians, and Pacific Islanders Served at Health Centers: An Analysis of the 2021 Uniform Data System
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.†
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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<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.
Social Drivers of Health and the Complex Needs of AA & NH/PI Patients
Social Drivers of Health and the Complex Needs of AA and NH/PI Patients

Highlights

• In 2021, 40.9% of AA&NHPI-serving and 64.1% of NHPI-serving health centers collected data on patients’ social risk factors compared to 62.4% of all health centers nationally.

• Of the health centers that collected data on social risk factors, the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) social risk screening tool was used by 42.3% of AA&NHPI-serving health centers and 35.9% of NHPI-serving health centers compared to 39.8% of all health centers nationally.

• AA&NHPI-serving and NHPI-serving health center patients have lower rates of housing insecurity, financial strain, and lack of transportation compared to the health centers nationally.

• AA&NHPI- and NHPI-serving health centers have higher proportions of patients with Limited English Proficiency (LEP), 34% and 28% respectively, compared to the national average (24%).

• 92% of patients at both AA&NHPI- and NHPI-serving health centers lived at or below 200% the Federal Poverty Guideline compared to 90% percent of patients at health centers nationally.

• Both AA&NHPI- and NHPI-serving health centers served many patients (55% and 52% respectively), who received public insurance benefits.
Introduction

Social drivers of health (SDOH) are conditions where people live, learn, work, and play that affect a wide range of health and quality-of-life-risks and outcomes. According to Healthy People 2030, there are five domains of SDOHs: 1) economic stability; 2) education and access; 3) health care access and quality; 4) neighborhood and built environment; and 5) social and community context. Within these domains, SDOH factors would include income, food security, social norms, segregation, language and literacy, and much more. SDOH have a major impact on the quality of life of an individual and directly correlate with broader, structural, and institutional health disparities and inequities. For example, one study demonstrates that individuals with lower income are two to four times more likely to develop type 2 diabetes, even after adjusting for other factors such as body mass index (BMI) or physical activity.

There are various tools available that support screening for SDOH. According to the UDS 2021, health centers that collected social needs data nationally used the following screening tools: PRAPARE (64%), Recommended Social and Behavioral Domains for EHRs (10%); Accountable Health Communities Screening Tools (8%); WE CARE (8%); and another tool (35%). For the health centers that do not implement a standardized social needs screening tool, they may ask their patients about their social risk factors through other means (e.g., intake and registration forms).

**Social Drivers of Health (SDOH):** Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes.
Social Needs at AA&NHPI- and NHPI-serving Health Centers

Asian Americans (AAs), Native Hawaiians, and Pacific Islanders (NH/PIs) have unique social needs that serve as barriers to accessing quality healthcare. Assessing SDOH needs of individuals through standardized data collection can inform and support patient and population health needs through tailored social interventions. The 2021 UDS findings indicate that 62.4% of health centers collected data on social needs. Of the 137 AA&NHPI-serving and 39 NHPI-serving health centers, 56 (40.88%) and 25 (64.10%) collected data on patients’ social risk factors, respectively.

The 2021 UDS Dataset includes the number of patients who screened positive for SDOH measures such as food insecurity, housing insecurity, transportation, and financial strain. The UDS data show that AA&NHPI-serving and NHPI-serving health center patients have lower rates of housing insecurity, financial strain, and lack of transportation compared to their national counterparts.

The table below shows the percentage of patients who screened positive for social risk factors at health centers. It should be noted that the UDS report was updated for the 2020 reporting year to include measures of social risk factors. As initial reporting of social risk data continues to be optional, many health centers are only beginning to incorporate social risk screening and data into their electronic health records. Thus, the data should be interpreted with caution.
Social Risks Measured in the UDS*  
(Percentage out of total number of patients from health centers that screen positive for social risk factors)

While the UDS does not measure educational attainment, lack of education poses significant barriers to future health and health access. Studies that disaggregate AA and NH/PI groups have found disparities in educational attainment among NHs and PIs. AAs have one of the highest rates of educational attainment with 59% of AAs ages 25 and older having at least a bachelor’s degree.34

In 2019, 23.8% of NH/PIs had obtained a bachelor’s degree or higher. NH/PIs are also more likely to drop out of school. According to a report by APIA Scholars, Samoans (58.1%), Tongans (54.2%), Native Hawaiians (50.0%), and Guamanians or Chamorros (47.0%) who attended college, left without earning a college degree.35 As education often leads to better job outcomes and higher incomes, less education is linked to lower socioeconomic status and, in turn, poorer health.36 This demonstrates the need for improved education access and services to support NH/PI students as well as disaggregated data that unmasks disparities in education among AA and NH/PI subgroups.
The table below shows additional factors that can affect patients’ health. Compared to the health centers nationally (24%), both AA&NHPI-serving and NHPI-serving health centers report a higher proportion of patients with limited English proficiency (34% and 28%, respectively) as well as incomes below 200% the federal poverty level (92% and 93%, respectively) compared to 90% of patients at health centers nationally. Additionally, a greater percentage of patients at AA&NHPI-serving and NHPI-serving health centers receive Medicaid benefits (55% and 59%, respectively) and public insurance benefits (64% and 67%, respectively) compared to health centers nationally (48% and 50%).

However, AA&NHPI-serving and NHPI-serving health centers both reported a lower rate of uninsured patients (18% and 19%, respectively) compared to the national average of 20%. This may be attributed to the higher rates of Enabling Services FTEs (e.g., eligibility assistance workers, community health workers, case managers) at AA&NHPI-serving and NHPI-serving health centers who assist patients in securing access to social service and assistance programs such as Medicaid, Medicare, and the Children’s Health Insurance Program (CHIP).
COVID-19 and the Exacerbation of Social Risk Factors

Social risk factors, like access to nutritious food, transportation, and health care in preferred language, were worsened by COVID-19 for many AA and NH/PI patients. Food distribution events that responded to lack of food access became multi-faceted opportunities for health centers to reconnect with patients, provide a much-needed temporary intervention, and deliver COVID-19 vaccine education and care. The pandemic and public health policies further disrupted transportation for patients. AA and NH/PI elders experienced interruption to their health care and experienced increased isolation due to social distancing policies, lack of mobility, and fear from violence and infection of COVID-19.37

Moreover, the pervasive challenge of lack of access to in-language COVID-19 care and education worsened across AA&NHPI-serving health centers. The pace of evolving information created general gaps in communication. Translated public health materials were not widely available, which worsened the spread of misinformation about COVID-19 vaccines, social distancing guidelines, and Personal Protective Equipment (PPE) usage. While the COVID-19 pandemic exposed inequities across every sector, health and healthcare related social risk factors were among the most impacted for AA and NH/PI patients.

It is important to note the challenges of gathering data on social risk factors. The UDS data may not fully capture the scope and count of patients who are experiencing food insecurity, housing insecurity, financial strain, and lack of transportation among other social risk factors. In health centers without an established, trusting relationship, patients may refuse to answer any or all of the questions on a social risk screening tool. Health center staff should receive training on person-centered and empathetic listening before administering social risk screening to ensure that patients are not retraumatized when reporting on sensitive topics. Furthermore, health centers must invest in establishing trust and relationship building to ensure that the screening is not transactional and the data collected is reflective of the true lived experiences of patients. However, this should not diminish the importance of gathering social risk data and building robust networks of enabling and supportive services to address SDOHs.


18. 42 U.S. Code § 11701.


Disclaimer

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Data Analysis:
• Rosy Chang Weir, PhD, Director of Research, AAPCHO
• Julia Liu, MPH, Research Assistant, AAPCHO
• Vivian Li, MS, Consultant, AAPCHO

Writers:
• Gabrielle Peñaranda, MA, Program Manager, Training and Technical Assistance, AAPCHO

Community Reviewers:
• Nia Aitaoto, PhD, Technical Lead, Pacific Islander Center of Primary Care Excellence (PI-CoPCE)
• Chia Wang, MD, Infectious Disease Consultant – International Community Health Services (ICHS)

Report Design:
• Dionne Nguyen, Communications and Member Services Coordinator, AAPCHO
• Kristine Cecile Alarcon, MPH, Communications and Storytelling Manager, AAPCHO