

2023 Uniform Data System Insights: Health Outcomes of Community Health Center Patients



April 2025

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Executive Summary

Community Health Centers (CHCs) play a crucial role in delivering essential healthcare services to underserved populations. The Uniform Data System (UDS) provides a comprehensive view of patient demographics, service utilization, and health outcomes, serving as a critical tool for monitoring and improving healthcare delivery. This publication analyzes the health outcomes among Asian Americans (AAs), Native Hawaiians, and Pacific Islanders (NH/PIs) using data from the 2023 UDS.

Key findings from the analysis indicate notable differences in health outcomes among AAs and NH/PIs. NHs exhibited the highest prevalence of chronic conditions such as diabetes and hypertension, while PIs demonstrated lower rates of preventive service utilization, including vaccinations and routine screenings. In contrast, AAs generally reported better health outcomes and higher engagement in preventive care. However, subgroup data for AAs reveal significant health outcomes and unique needs among specific subgroups, allowing for more tailored and effective interventions.

The publication highlights the importance of patient-centered care, community engagement, and tailored health education programs to address the unique health challenges faced by AAs and NH/PIs. It emphasizes the need for CHCs to implement actionable strategies to enhance access to care and improve health outcomes.

Recommendations

1. Implementation of patient-centered care practices
2. Community engagement and outreach
3. Targeted health education programs
4. Improved access to preventive services
5. Improved data collection methods and monitoring



This report underscores the urgency of addressing and improving health outcomes among AAs and NH/PIs and provides a collaborative approach to create a more effective healthcare system. By leveraging insights from the UDS, stakeholders can implement targeted interventions that contribute to better health outcomes in healthcare.

Reference for Definitions

The UDS Manual¹ serves as an essential reference for definitions in this publication and is utilized for the comprehensive review of data. Please refer to the UDS Manual for definitions and guidance in this publication.

Introduction

Health outcomes among AAs and NH/PIs have gained increasing attention in public health discourse, yet these populations remain underrepresented in healthcare studies. This publication aims to analyze the health outcomes of these groups as reported in the 2023 UDS, emphasizing the role of CHCs in providing care. In 2023, based on UDS data submissions, over 1,300 CHCs provided care to more than 31 million patients.²

CHCs in the U.S. play a critical role in providing accessible and affordable healthcare services to underserved populations, including AA and NH/PIs. CHCs are community-based organizations that deliver primary care services regardless of a patient's ability to pay.³ These centers focus on holistic care, addressing not only medical needs but also non-medical factors through preventive services, health education, and outreach programs.

In 2023, the UDS data revealed critical trends and outcomes among AAs and NH/PIs. Key findings included higher rates of chronic conditions, such as diabetes and hypertension, particularly among NHs, as well as lower utilization rates of preventive services among PI subgroups. AAs and NH/PIs experience a range of unique health challenges influenced by traditional, socioeconomic, and geographic factors. This data underscores the importance of patient-centered interventions and targeted health programs to address the unique healthcare needs of these communities. The 2023 UDS introduced additional racial/ethnic categories including Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, NH, Other Pacific Islander, Guamanian or Chamorro, and Samoan; CHCs were able to report data that reflects the heterogeneity within AA and NH/PI populations. This publication will present a comprehensive analysis of UDS data, highlight health outcomes, and provide recommendations for CHCs to enhance service delivery to the AA and NH/PI communities.²

1. [Uniform Data System Manual](#) (2023). Health Resources & Services Administration. U.S. Department of Health and Human Services.

2. [National Health Center Program Uniform Data System \(UDS\) Awardee Data](#). Health Resources & Services Administration. U.S. Department of Health and Human Services.

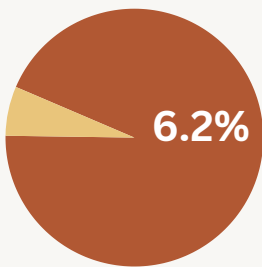
3. [What is a Health Center?](#) Bureau of Primary Health Care. U.S. Department of Health and Human Services.

AA&NHPI-Serving Health Centers and NHPI-Serving Health Centers

AAs and NH/PIs are generally grouped together and encompass over 50 different groups in the U.S. with over 100 different languages spoken.⁴ In this publication, AA&NHPI-serving and NHPI-serving CHCs are presented as two distinct categories. Data for AA&NHPI-serving CHCs include all NHPI-serving CHCs. NHPI-serving CHCs' data is broken down into subgroups to highlight trends that emerge when the NH/PI population is separated from the AA population.



The Asian population will grow to 41 million in 2050, nearly tripling in size. The AA and NH/PI population grew much faster than the total U.S. population from 2010 to 2020 according to the Census.



20.6 million people identified as AA and NH/PI, making up 6.2% of the population. This included 19.9 million people who identified as Asian alone, 4.1 million who identified as Asian in combination with another race, 690,000 who identified as NH/PI alone, and almost 900,000 who identified as NH/PI in combination with another race.



According to the 2020 Census, the NH/PI population grew by approximately 29.1% from 2010 to 2020, with the "Native Hawaiian alone or in any combination" group experiencing the largest growth within the NH/PI category.

4. Abby Budiman, Neil G. Ruiz. [Asian Americans are the Fastest-Growing Racial or Ethnic Group in the U.S.](#) Pew Research Center.

Definitions of AA&NHPI-Serving and NHPI-Serving Health Centers

How are AA&NHPI-Serving CHCs defined in this analysis?

- The top 10% of all CHCs serving AAs and NH/PIs reported in the UDS are considered to be AA&NHPI-Serving CHCs.

How are NHPI-Serving CHCs defined in this analysis?

- CHCs that served greater or equal to 1,000 NH/PI patients combined in 2023 are considered AA&NHPI-Serving CHCs.



For clarity and readability, AA- and NH/PI-serving health centers will be referred to as AA&NHPI-serving health centers, while NH/PI-serving health centers will be referred to as NHPI-serving health centers. In this report, AAs and NH/PIs will be referred to as subgroups, while specific AA (e.g., Cambodian, Hmong, Indian) and NH/PI communities (e.g., Marshallese, NH, Samoan) will be referred to as specific subgroups.

Frequently Asked Questions about the UDS and UDS data

What is the UDS?

The UDS is a standardized reporting system administered by the Health Resources and Services Administration (HRSA) and the Bureau of Primary Health Care (BPHC) for all health centers that receive federal award funds (“awardees”) under the Health Center Program.

When was the 2022 UDS data collected?

Health centers reported on their HRSA-related activities for the 2023 calendar year from January 1, 2024 through February 15, 2024.

How is UDS data used?

HRSA uses UDS data to assess the impact and performance of the Health Center Program and to promote data-driven quality improvement.

Key Characteristics of AA&NHPI-Serving Health Centers and NHPI-Serving Health Centers

AA&NHPI-Serving Health Centers

AAPCHO did not identify a separate group for AA-serving CHCs because this group would have a large overlap with the AA&NHPI-serving CHCs and lead to repetitive findings.



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AA&NHPI-serving CHCs

8,392,635

Total Patients Served at AA&NHPI-Serving Health Centers



936,887

Total AA and NH/PI Patients

69.2%

of all AA and NH/PI Patients Were Served Nationally at AA and NH/PI-Serving CHCs



NHPI-Serving Health Centers

Health centers often increase their workforce capacity when patient population counts of new subgroups and their language needs exceed 1,000.



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NHPI-serving CHCs

2,537,868

Total Patients Served at NH/PI-serving Health Centers



163,810

Total NH/PI Patients

60.1%

of all NH/PI Patients Were Served Nationally at NH/PI-Serving CHCs



Table: Hepatitis B, Hypertension, and Tuberculosis Rates at AA&NHPI-serving and NH/PI-serving CHCs vs. National CHC Averages (2019-2023):

Statistic	2019	2020	2021	2022	2023
Health Center Hepatitis B Rates					
AA&NHPI-Serving Health Center	0.41%	0.34%	0.36%	0.38%	0.38%
NHPI-Serving Health Center	0.24%	0.21%	0.24%	0.23%	0.28%
National Health Center Average	0.19%	0.17%	0.17%	0.17%	0.18%
Health Center Hypertension Rates					
AA&NHPI-Serving Health Center	16%	17%	18%	16.8%	17.64%
NHPI-Serving Health Center	15%	16%	19%	16.40%	16.94%
National Health Center Average	19%	21%	21%	19.8%	21.36%
Health Center Tuberculosis Rates					
AA&NHPI-Serving Health Center	0.029%	0.03%	0.03%	0.04%	0.31%
NHPI-Serving Health Center	0.027%	0.05%	0.03%	0.04%	0.25%
National Health Center Average	0.03%	0.03%	0.03%	0.03%	0.17%

AAPCHO intentionally does not use the same method for defining AA&NHPI-serving health centers as it does for NHPI-serving health centers. If the threshold for NHPI-serving CHCs were applied to AA&NHPI-serving CHCs, then the number of the latter would greatly expand and mask the unique characteristics of AA and NH/PI populations and impede efforts to identify population-specific health trends. The larger overlap with the health centers nationally would mask some unique characteristics of AA and NH/PI populations and impede efforts to identify population-specific health trends.

Chronic and Infectious Disease Data

Diseases such as hepatitis B and tuberculosis disproportionately impact AA and NH/PI communities. Current UDS datasets lack subgroup rates for these conditions. Further breakdown of the AA and NH/PI subgroups would allow CHCs to better tailor their services to address these outcomes.

NHPI-serving CHCs have higher rates of hepatitis B and tuberculosis at almost twice the national CHC average. AA&NHPI-serving CHCs' rates of hepatitis B and tuberculosis are more than twice the national CHC averages. AANHPI-serving CHCs and NHPI-serving CHCs have lower rates of hypertension as compared to the national CHC average.

In 2023, the national CHC rate of tuberculosis increased by more than 5 times the average in 2022. This increase was more than 6 times the average for NHPI-serving CHCs and more than 7 times the average for AA&NHPI-serving CHCs.

Health Outcomes and Access to Care

AAs and NH/PIs often experience higher rates of health conditions such as diabetes, hypertension, and certain cancers compared to their White counterparts.⁵ NH/PIs have particularly high rates of obesity and related chronic diseases, exacerbated by limited access to healthcare services.⁶ These findings emphasize the importance of understanding the specific health profiles of these populations to develop targeted interventions. CHCs provide essential services and patient-centered care that enhances trust and engagement within AA and NH/PI communities.

Importance of Non-Medical Factors of Health Data Collection

Non-medical factors are the “conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”⁷ These factors shape health outcomes and significantly influence overall wellbeing and access to necessary medical care.

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5. R.J. Lee, R.A. Madan, J. Kim, E.M. Posadas, E.Y. Yu. [Disparities in cancer care and the Asian American population](#). *Oncologist*, 26, no. 6 (2021): 453-460.
 6. [Obesity and Native Hawaiians/Pacific Islanders](#). U.S. Department of Health and Human Services. Office of Minority Health.
 7. [Healthy People 2030](#). U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion.

Quick Facts on Patient Demographics (2019-2023)

	2019	2020	2021	2022	2023
Limited English Proficiency (LEP) Patients					
AA&NHPI-Serving Health Center	34%	33%	34%	35.2%	36.3%
NHPI-Serving Health Center	30%	30%	28%	29.3%	28.5%
National Health Center Average	25%	24%	24%	25.8%	26.8%
<200% Federal Poverty Level (FPL) Patients					
AA&NHPI-Serving Health Center	93%	92%	92%	92.1%	92.4%
NHPI-Serving Health Center	94%	93%	92%	92.7%	90.5%
National Health Center Average	91%	91%	90%	89.7%	89.9%
Medicaid Patients					
AA&NHPI-Serving Health Center	58%	55%	57%	59.5%	59.7%
NHPI-Serving Health Center	62%	59%	58%	59.5%	58.6%
National Health Center Average	48%	46%	48%	49.9%	50.1%
Uninsured Patients					
AA&NHPI-Serving Health Center	20%	20%	18%	16.8%	16.1%
NHPI-Serving Health Center	17%	18%	19%	17.3%	14.9%
National Health Center Average	23%	22%	20%	18.6%	17.9%

Enabling Services Staff and Quality of Care at AA&NHPI-Serving and NHPI-Serving Health Centers

Enabling services (ES) play a vital role in improving health outcomes. UDS data provides insight into the availability and utilization of these services. Integration of ES staff improves CHC ability to address complex factors impacting health.

In 2023, CHCs employed more than 29,000 full-time equivalents (FTEs) for ES personnel.⁸ ES staff FTE at AA&NHPI-serving and NHPI-serving CHCs exceeded the national average, specifically with case managers, and eligibility assistance workers, reflecting a growing recognition of the importance of addressing non-medical factors.

AA&NHPI-serving and NHPI-serving CHCs employ significantly more ES staff than the national CHC average, with staffing levels for most categories at least twice as high—and sometimes nearly three times as high—as the national rate.

Table: Average CHC FTEs for ES Staff Categories

	AA&NHPI-Serving Health Centers	NHPI-Serving Health Centers	National Average
Case Managers	26.80	28.37	10.53
Patient and Community Education Specialists	6.99	7.05	2.34
Outreach Workers	5.17	6.29	2.41
Transportation Staff	2.00	2.17	1.07
Eligibility Assistance Workers	12.03	11.15	3.96
Interpretation Staff	3.37	1.74	1.30
Community Health Workers	6.30	5.47	2.60

8. [Table 5: Staffing and Utilization](#). UDS National Data. Health Resources & Services Administration.

Quality of Care

Quality of care is defined by the Institute of Medicine as “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”⁹

Services that improve quality of care are focused on preventive measures as benchmarks to improve health outcomes. Per the 2023 UDS, AA&NHPI-serving CHCs exceeded national averages for most preventive screenings, except for depression screening. NHPI-serving CHCs were slightly below national averages overall, except for childhood immunizations where they surpassed both national and AA&NHPI-serving CHC averages.

AA&NHPI-serving CHCs generally provided preventive screenings at rates equal to or higher than the national CHC average. In contrast, NHPI-serving CHCs typically provided preventive screenings at rates lower than the national average.

Table: Average Health Center Quality of Care Categories By AA&NHPI-Serving x NHPI-Serving Health Centers x National Average

	AA&NHPI-Serving Health Centers	NHPI-Serving Health Centers	National Average
Breast Cancer Screening	56.0%	50.9%	52.4%
Cervical Cancer Screening	59.7%	54.3%	55%
Childhood Immunization	34.8%	36.9%	30.2%
Colorectal Cancer Screening	42.8%	37.7%	41.1%
Depression Screening	69.9%	59.5%	71.7%
Tobacco Cessation	85.6%	80.8%	84.9%

9. Understanding Quality Measurement. Agency for Healthcare Research and Quality. Department of Health and Human Services.

Differences in Health Outcomes Using Subgroup Data

Methodology

The 2022 UDS data did not capture detailed patient-level data, which meant that some measures of chronic and infectious diseases did not fully reflect their impact on AA and NH/PI subgroups. However, for the 2023 UDS, CHCs were able to voluntarily submit de-identified patient-level data for the following tables:

- Patients by ZIP Code Table
- Table 3A: Patients by Age and Sex Assigned at Birth
- Table 3B: Demographic Characteristics
- Table 4: Selected Patient Characteristics
- Table 6A: Selected Diagnoses and Services Rendered
- Table 6B: Quality of Care Measures
- Table 7: Health Outcomes

The addition of subgroup data is a significant step forward in better understanding the needs of and patient-centered care for populations served by CHCs.

This section outlines the study design, data sources, and analytical methods used to examine the health outcomes of AAs and NH/PIs as reported in the 2023 UDS. The dataset marks a major advancement in the effort to identify and address health outcomes, particularly with the inclusion of newly expanded subgroup categories.

For the first time, CHCs are able to report data separately for subgroups such as Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiian, Other Pacific Islander, Guamanian or Chamorro, and Samoan.

This expansion enables a more granular analysis of health outcomes across specific subgroups, revealing nuanced differences in healthcare access, quality, and outcomes that were previously masked by broader categories.

This report analyzes the 2023 UDS health outcomes, focusing on how expanded categories highlight key issues like diabetes management, high blood pressure control, and maternal health outcomes such as low birth weight.

AA and NH/PI Data Analysis

Descriptive statistics were used to summarize demographic characteristics, health outcomes, and service utilization rates among AA and NH/PI populations, allowing for comparisons between and within these groups.

Subgroup differences in health outcomes were analyzed using data from the UDS Health Outcomes Table to inform targeted interventions.



Data Counts at Health Centers

This table shows subgroup demographic data for AA and NH/PIs across CHC patients, with Other Asian patients representing 68.44% of all Asians, NHs listed separately, and "Other Pacific Islander" patients making up 85.43% of all PI patients served. The high rates of "Other Asian" and "Other Pacific Islander" highlight the need for further disaggregation to better represent the health transformations within these groups.

Patients by Subgroups Across All Health Centers		
Asian Categories		
Subgroups	Total Patients	Percentage of Asian Total
Asian Indian	66,339	6.13%
Chinese	174,746	16.16%
Filipino	40,717	3.77%
Japanese	5,265	0.49%
Korean	14,407	1.33%
Vietnamese	39,836	3.68%
Other Asian	740,049	68.44%
All Asian	1,081,359	100%
Native Hawaiian Category		
All Native Hawaiian	58,482	100%
Pacific Islander Categories		
Other Pacific Islander	182,713	85.43%
Guamanian or Chamorro	7,688	3.59%
Samoan	23,485	10.98%
All Pacific Islander	213,886	100%

Findings: Health Outcomes

Analysis of subgroup differences in health outcomes focused on indicators such as low birth weight, high blood pressure control, and uncontrolled diabetes across demographics (e.g., Koreans, Vietnamese, and Samoans).⁹



Deliveries and Low Birth Weight Patterns Across AAs and NH/PIs

Low Birth Weight Patterns Across AAs and NH/PIs:

- Japanese and Asian Indian groups show highest rates of low and very low birth weight babies
- Korean and Samoan populations have the lowest rates of low birth weight babies

Section A (Table 7) - Health Outcomes		
	Prenatal Care Patients Who Delivered During the Year (1a)	% Low and Very Low Birth Weight
Not Hispanic, Latino/a, or Spanish Origin		
Deliveries and Low Birth Weight		
Asian Indian	685	13.43%
Chinese	676	6.64%
Filipino	435	11.34%
Japanese	27	18.52%
Korean	26	4.17%
Vietnamese	189	7.51%
Other Asian	6,188	8.41%
Native Hawaiian	568	6.86%
Other Pacific Islander	2,549	7.91%
Guamanian or Chamorro	254	9.8%
Samoan	450	5.3%
Total Not Hispanic, Latino/a, or Spanish Origin	12,047	9.08%

Controlling High Blood Pressure

- Groups with lower blood pressure control rates than the national CHC average face significant challenges in managing hypertension: Guamanian/Chamorro, Korean, Other Pacific Islander, Samoan
- Groups with higher blood pressure control rates than the national CHC average highlight better hypertension management: Chinese, Other Asian, and Vietnamese
- Groups with moderate blood pressure control rates have room for improvement: Filipino, Japanese, Native Hawaiian



Section B (Table 7) - Health Outcomes			
	Total Patients 18-85 Years of Age with Hypertension (2a)	Patients with Hypertension Controlled (2c)	Estimated % Patients with Controlled Blood Pressure
Not Hispanic, Latino/a, or Spanish Origin			
Controlling High Blood Pressure			
Asian Indian	8,811	5,983	68.19%
Chinese	33,834	23,165	68.47%
Filipino	9,667	6,363	66.65%
Japanese	834	542	65.16%
Korean	3,839	1,810	47.17%
Vietnamese	8,642	6,235	72.19%
Other Asian	118,520	81,742	69.06%
Native Hawaiian	7,564	4,520	59.79%
Other Pacific Islander	16,231	8,867	57.64%
Guamanian or Chamorro	703	211	48.71%
Samoan	1,699	866	51.08%
Total Not Hispanic, Latino/a, or Spanish Origin	210,344	208,784	61.28%

Diabetes: Hemoglobin A1c Poor Control

Hemoglobin A1c (HbA1c) Poor Control provides insight into the management of diabetes across different demographic groups. High percentages indicate poor control.

- High Rates of Poor Diabetes Control in PI Groups:
 - Samoan and Other Pacific Islander populations have the highest rates of poor HbA1c control, indicating diabetes management challenges
 - Guamanian/Chamorro and NH groups also have high levels of poor control, although slightly lower than that of other PIs and their PI counterparts, respectively.
- Moderate Rates of Poor Control in Other Asian Groups:
 - The Other Asian category shows moderate levels of poor diabetes control, though it is unclear which specific subgroups are contributing.
- Lower Rates in Korean, Vietnamese, and Chinese Populations:
 - Korean, Vietnamese, and Chinese populations show better diabetes control compared to other groups.



Section C (Table 7) - Health Outcomes			
	Total Patients 18-75 Years of Age with Diabetes (3a)	Patients with HbA1c>9.0% or No Test During Year (3f)	Estimated % Patients with HbA1c>9.0%
Not Hispanic, Latino/a, or Spanish Origin			
Diabetes: Hemoglobin A1c Poor Control			
Asian Indian	6,529	1,463	22.44%
Chinese	15,681	1,694	10.93%
Filipino	5,409	1,035	19.61%
Japanese	470	102	21.78%
Korean	2,191	394	17.99%
Vietnamese	4,498	582	12.95%
Other Asian	73,452	15,243	20.78%
Native Hawaiian	5,256	1,850	35.20%
Other Pacific Islander	13,781	5,276	41.91%
Guamanian or Chamorro	634	127	35.67%
Samoan	1,769	875	49.46%
Total Not Hispanic, Latino/a, or Spanish Origin	129,670	28,641	26.25%

The expansion of subgroup categories in the UDS 2023 dataset marks a significant step forward in the ongoing effort to improve health outcomes for underserved populations. By collecting subgroup data, CHCs are moving toward a better understanding of unique challenges faced by specific subgroups, enabling more targeted interventions, patient-centered care, and increased access to healthcare resources.

Limitations of the Analysis

While the expansion of the demographic categories for AA and NH/PI populations in the 2023 UDS dataset provided valuable insights into these health outcomes across different populations, several limitations must be considered when interpreting the findings:



- This is the first year that this granular data has been collected, and challenges remain in ensuring accuracy, representation, and consistency across categories.
 - CHCs and reporting agencies are still adjusting to these changes, which may lead to inconsistencies or gaps in the data collection process.
- A major challenge with collecting detailed data is the risk of small sample sizes for certain smaller subgroups (e.g., Guamanian, Chamorro, or Samoan), making it difficult to draw statistically significant conclusions.
- The Other Asian and Other Pacific Islander categories also pose challenges, as they group together distinct groups with unique health challenges, languages, and practices. “Othering” can obscure important differences and impact access to responsive care.

While the 2023 UDS data provides a useful baseline, it will take several years of consistent, standardized data collection to identify clear trends and fully understand the impact of detailed data analysis on healthcare delivery.

Programmatic Recommendations for Community Health Centers

Based on these findings, AAPCHO proposes the following recommendations to enhance health center effectiveness to serve AAs and NH/PIs. These recommendations aim to improve health outcomes, and advance health care transformation efforts.

1. Patient-Centered Care

Health centers should prioritize patient-centered care by training providers in humility and integrating it into staff education. Language support services, including interpreters and translated materials, are essential for effective communication, building trust, and fostering a sense of belonging for patients.

Staff Training: Implement mandatory humility training programs for all staff, focusing on the traditional beliefs and practices of AAs and NH/PIs.



- Activity: Organize regular, ongoing workshops and training opportunities led by experts in humility to provide and support real-life scenarios and role-playing exercises.

Language Services: Establish a robust language access system.



- Activity: Hire multilingual staff and contract with medical interpreter service providers who are trained in patient-centered care.
- Activity: Create patient materials in multiple languages including those commonly spoken in the community and create accessible audio and visual formats for people with low literacy or whose languages are an oral tradition. Incorporate staff (from different departments) and community feedback to increase engagement.

2. Community Engagement and Outreach

Health centers should prioritize engaging with community leaders and organizations to understand the unique needs of AAs and NH/PIs, build partnerships, and create tailored, patient-centered health education initiatives.

Partnership Development: Build relationships with local community organizations and leaders.



- Activity: Host regular meetings with community representatives to discuss health needs and plan joint initiatives.

Health Fairs: Organize community health fairs to raise awareness about preventive services and encourage participation in health programs.



- Activity: Collaborate with local businesses and organizations to sponsor events, offering activities such as health screenings, nutrition workshops, and fitness demonstrations.
 - Build partnerships with community leaders, including the Chiefs in the Pacific Island communities, to support patient-centered programming.
 - Nutrition workshops can highlight traditional foods and dishes, cooking tips, and food access.
 - Fitness demonstration examples include gardening activities or traditional dances such as the hula.
- Activity: Offer free screenings and educational workshops to community members who may otherwise not have access to the CHC.

3. Targeted Health Education Programs

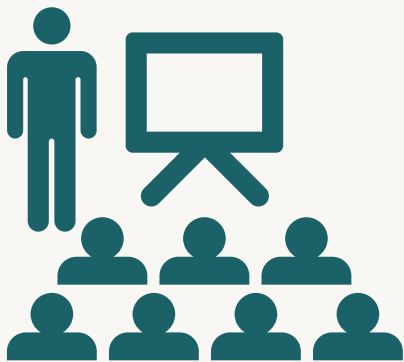
Health education programs should address specific health outcomes among AAs and NH/PIs. CHCs should utilize community-relevant materials and delivery methods, such as peer educators or community health workers (CHWs) from within AA and NH/PI communities, to build trust and enhance program effectiveness and engagement.

Program Design: Develop patient-centered health education programs specifically addressing prevalent health issues (e.g., diabetes management, nutrition).



- Activity: Create educational materials that incorporate resonant images and messaging and use testimonials from community members to enhance relatability.

Peer Educator Training: Train CHWs and peer educators to deliver health education.



- Activity: Establish a CHW and/or peer educator program where community members are trained to share health information in relevant ways.
- Activity: Engage AA and NH/PI communities in the design and implementation of health programs to ensure that strategies are tailored to their unique needs.

4. Improved Access to Preventive Services

Health centers should increase access to preventive services to improve utilization rates, enhance health outcomes, reduce healthcare costs, and promote an environment of prevention, supporting communities to take control of their health.

Extended Hours: Adjust clinic hours to accommodate patients' schedules, including evenings and weekends.



- Activity: Incorporate various tools for engagement when conducting surveys to determine preferred hours of operation among the target population. Ensure surveys are conducted periodically to account for changing patient demographics.

Transportation Assistance: Implement transportation programs to support rides to and from appointments for patients.



- Activity: Partner with local transportation services including local public transit authorities or consider hiring drivers to assist patients with transportation to health services.
- Activity: Start mobile clinics to take services to patients.
- Activity: Utilize and expand telehealth services as appropriate to reduce unnecessary travel for patients.
 - Support for implementation of new technology through tools, services, and education for staff and patients.

5. Data Collection and Monitoring

Health centers should improve data collection methods to better monitor health outcomes for AAs and NH/PIs using the Office of Management and Budget's (OMB) revised subgroup categories as a minimum standard. This data is key to identifying health outcomes and CHCs should receive support from the HRSA in transitioning to the Uniform Data Set Modernization Initiative (UDS+). UDS+ collects de-identified, patient-level data to better understand factors that influence care-seeking behavior, care received, and health outcomes.

Enhanced Data Practices: Improve collection and analysis of demographic data specific to AAs and NH/PIs (e.g., offering additional subgroup categories).



- Activity: Train staff on the importance of data collections and ensuring accurate data entry. Include the necessity of demographic data collection and disaggregation of data to capture the health needs of AA and NH/PI subpopulations.
 - Support CHWs and other frontline staff to collect this data through training and education.
 - Ensure training and ongoing conversation with staff to relay importance of data collection and the benefits of a standardized process.
- Activity: Evaluate and update processes for collecting data and utilizing this data to make informed decisions about clinic operations and services to better serve the communities' needs.

Regular Evaluations: Conduct ongoing evaluations of health programs to assess effectiveness.



- Activity: Use Plan Do Study Act (PDSA) models to deliver workforce and patient surveys for continuous quality improvement.
- Activity: Conduct focus groups to gather qualitative data from patients about their experiences and health outcomes.

Conclusions

AAs and NH/PIs face significant challenges that require immediate and sustained attention from healthcare providers and policymakers. This analysis highlights critical issues including elevated rates of chronic diseases, underutilization of preventive services, and barriers to accessible, patient-centered care.

By implementing targeted programmatic recommendations and collecting detailed data, CHCs can enhance their capacity to provide effective care tailored to the unique needs of AAs and NH/PIs. This will improve access to preventive services and enhanced data collection practices to guide CHCs to monitor and address challenges. By collaborating with community organizations and engaging in public health education, CHCs can contribute to systemic changes that address the non-medical factors of health affecting AAs and NH/PIs.

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Acknowledgements

- **Data Analysis:**
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- **Data Strategy:**
 - Rosy Chang Weir, PhD, Director of Research, AAPCHO
- **Writing:**
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 - Dr. Jake B.M. Edilyong, Yap (Wa’ab) Community Health Center
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