AAPCHO

FACT SHEET 2018

The Health of Asian Americans, Native Hawaiians, and Pacific Islanders Served at Health Centers: UDS 2017

Health centers provide high quality, cost-effective, primary and preventive care to a growing medically underserved community, regardless of insurance status or ability to pay. This fact sheet examines current patient demographics and utilization of health services at health centers serving Asian Americans, Native Hawaiians, and Pacific Islanders (AA&NHPIs), and highlights the differences between these centers and the national average of all health centers in the United States. AA&NHPIs are among the fastest growing racial/ethnic groups projected to triple in size between 2005 and 2050.[1] AA&NHPIs are diverse in their culture, language and health needs, representing more than 50 ethnic groups and over 100 languages. As a rapidly growing and highly diverse population, AA&NHPIs face unique and significant social, emotional, and physical health burdens due to many social determinants of health (SDoH) factors (e.g. poverty, limited English proficiency, health insurance status). Despite all the SDoH barriers, AA&NHPI-serving health centers perform relatively well on quality of care and health outcome measures, due to the significantly higher volume and provision of enabling services.[2] The data presented throughout this fact sheet are intended to improve understanding of the 870,730 AA&NHPI patients served by a select 137 AA&NHPI-serving health centers nationwide.

In 2017, Health Center grantees under section 330 of the Public Health Service Act served more than 27 million patients across the U.S. and its territories. Approximately 4.7% (over 1.2 million) with known ethnicity are AA&NHPI patients.[3] The top five states with the highest number of AA&NHPIs served by AA&NHPI-serving health centers remained the same as 2016: California, New York, Hawaii, Washington, and Massachusetts. States that experienced new growth in the number of AA&NHPI health center patients served in 2017 when compared to 2016 include: Arizona, Colorado, Connecticut, Florida, Nevada, and Texas.[4]

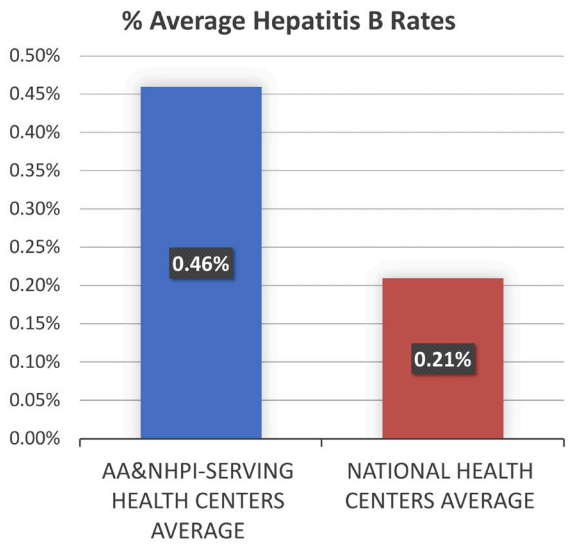
- AA&NHPI-Serving Health Center: AA&NHPI-serving health centers are defined as the top 10% of health centers in terms of the number of AA&NHPI patients served at the health center in 2017. A total of 137 health centers were identified as AA&NHPI-serving health centers, of which 61% (83 out of 137) were the same as the previous year.
- Dataset & Data Analysis: This fact sheet uses the Uniform Data System (UDS) 2017 data. The total number of health centers reporting to UDS in 2017 was 1,373. National averages serve as references to compare with AA&NHPI serving health center averages. Results were considered statistically significant when $p<0.05$.

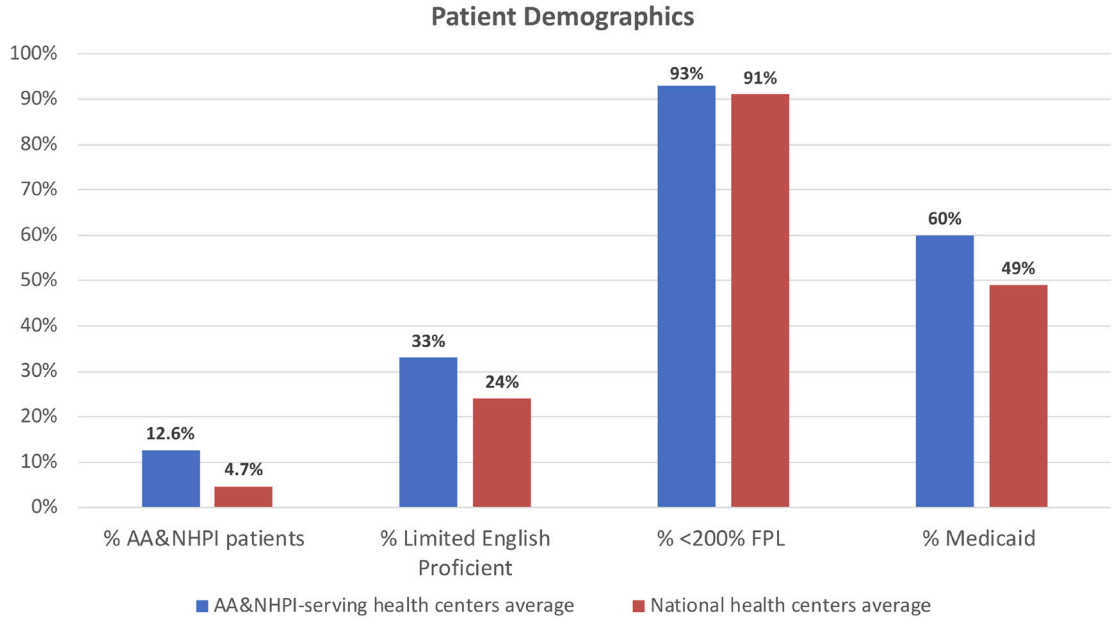
[1] Pew Research Center, U.S. Population Projections: 2005-2050. Available at: http://www.pewhispanic.org/2008/02/11/us-population-projections-2005-2050/
[2] Centers for Medicare and Medicaid Services (2003). Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities (Baltimore, MD, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services).
[3] The 4.7 percent is calculated using number of AA&NHPI patients with known race (1,227,133) out of the total patients with known ethnicity (26,291, 661). Available at: https://bphc.hrsa.gov/uds/datacenter.aspx?q=t3b&year=2017&state=
[4] 2017 Uniform Data System. Bureau of Primary Health Care. HRSA, DHHS. Available at: https://bphc.hrsa.gov/uds/datacenter.aspx

How AA&NHPI-Serving Health Centers Compare Nationally

Higher Concentration of AA&NHPI Patients with Complex Health Needs

In 2017, the 1,373 health centers served 27,174,372 patients, among which 1,227,133 were AA&NHPIs. The 137 AA&NHPI-serving health centers served 7,191,535 patients, among which 870,730 (12.6%) were AA&NHPIs. Thus, the AA&NHPI-serving health centers served 71% of all AA&NHPIs health center patients nationwide. Compared to the national average, AA&NHPI-serving health centers serve a statistically significant higher proportion of Medicaid (60%), Limited English Proficient (33%), and AA&NHPI patients (12.6%). Most notably, the proportion of uninsured patients seen at AA&NHPI-serving health centers is lower than the national average, which may be attributable to Medicaid expansion and insurance marketplace enrollment efforts under the 2010 Affordable Care Act.[5] In addition to experiencing multiple SDoH barriers, patients at AA&NHPI-serving health centers are likely to have more than double the rates of hepatitis B (0.46% vs. 0.21%). Beyond chronic hepatitis B, other AA&NHPI health issues include chronic liver disease, excess prevalence of diabetes, heart disease and cerebro-vascular health issues, lung cancer amongst Native Hawaiians, and lower screening rates.[6]



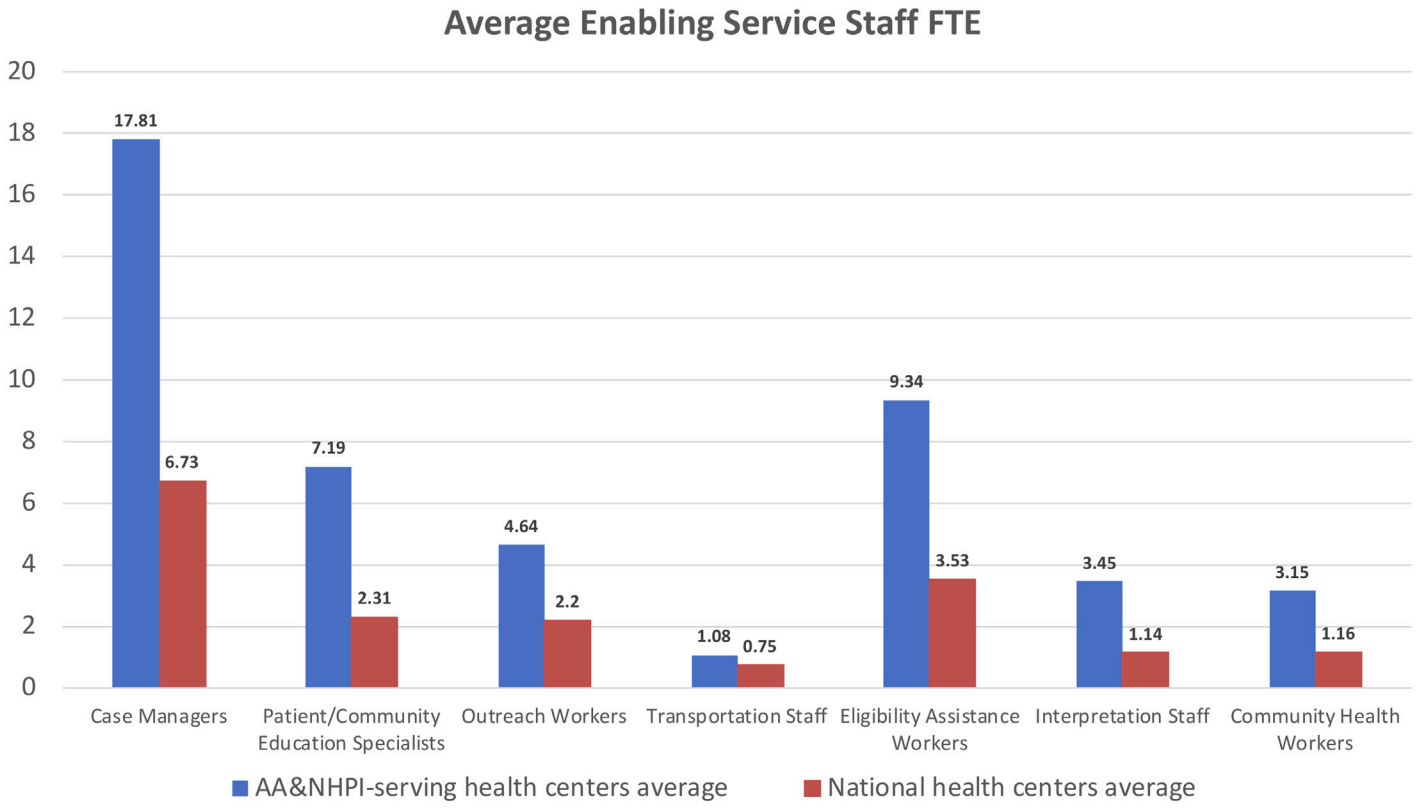


[5] Park JJ, Humble S, Sommers BD, Colditz GA, Epstein AM, Koh HK. Health Insurance for Asian Americans, Native Hawaiians, and Pacific Islanders Under the Affordable Care Act. JAMA Intern Med. 2018;178(8):1128–1129. doi:10.1001/jamainternmed.2018.1476

[6] Pérez-Stable, M.D, Eliseo J. "NIMHD and the Model Minority: Dismantling Stereotypes." 9th Biennial Asian American, Native Hawaiian, and Pacific Islander Health Conference, 24 September 2018, Farkas Auditorium at NYU Langone Health, New York, NY. Afternoon Keynote Address.

Greater Number of Enabling Services Staff

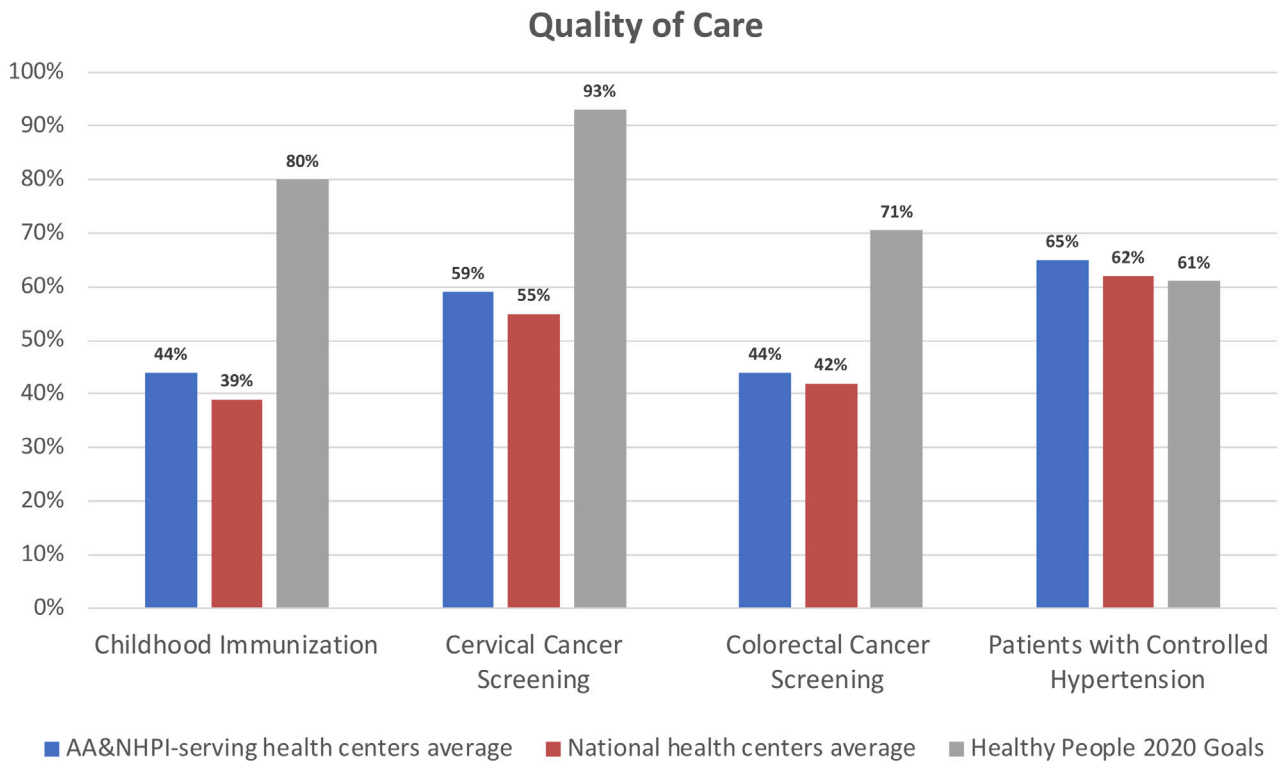
The most notable differences between AA&NHPI-serving health centers and the national average health centers can be seen in the health centers' provision of enabling services (i.e. non-clinical services) that support access to health care and improve health outcomes (i.e. case management, outreach, eligibility assistance, interpretation, etc.). The greatest differences are seen in enabling services provided by "case managers," "patient/community education specialists", "eligibility assistance workers", "intepretation staff", and "community health workers", where the full-time equivalent (FTE) rates are nearly double or triple that of the national average. The number of enabling service staff FTE would be higher if this type of staffing data was captured for enabling services provided in a language other than English. Also, AA&NHPI-serving health centers employ multilingual staff and may serve as high as 99% LEP patients with some health centers providing services in over 15 languages. Moreover, these differences are even more pronounced when we compare national health centers to health centers serving a much higher proportion (68%) of AA&NHPIs.[7]



[7] Association of Asian Pacific Community Health Organizations (AAPCHO). An Analysis of AAPCHO Health Centers: UDS 2016. Available at: http://www.aapcho.org/resources_db/aapcho-members-uds-fact-sheet/

High Quality Care

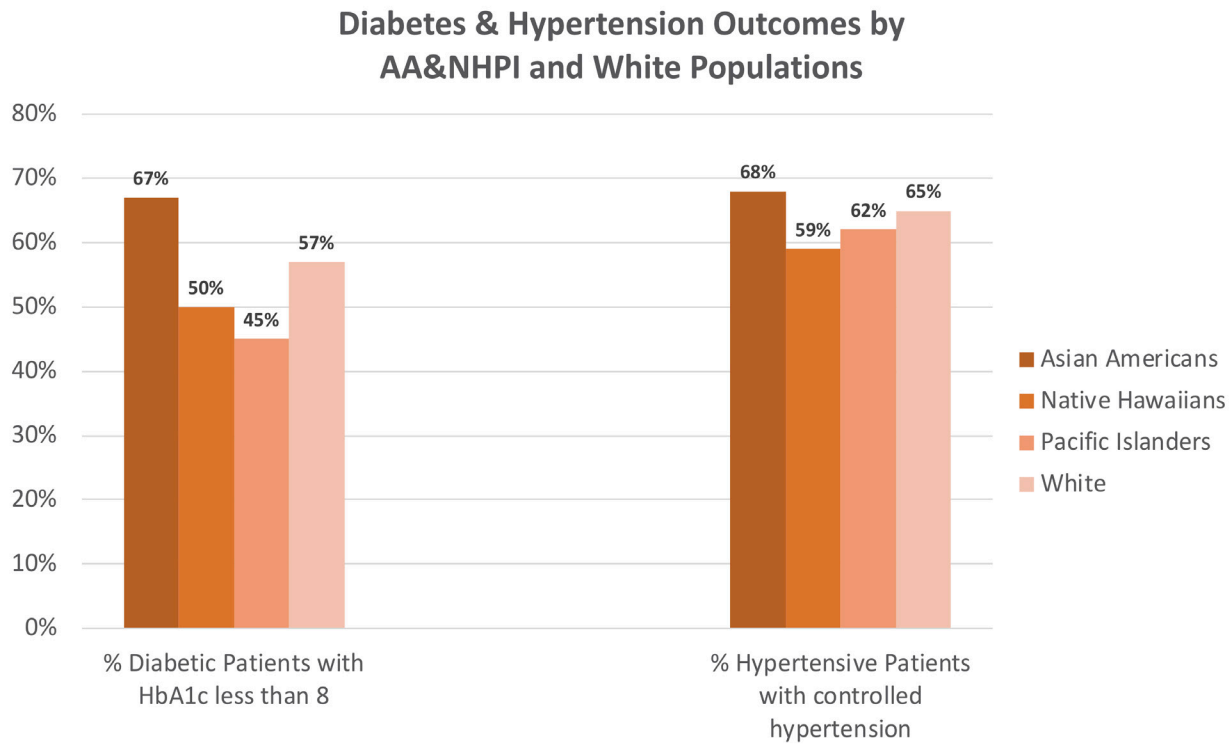
Despite the high SDoH barriers and disease burden of their patient population, AA&NHPI-serving health centers have statistically significant better screening rates and health outcomes for childhood immunization, cervical cancer screening, colorectal cancer screening, and controlled hypertension when compared to the national average. These relatively better health outcomes may be partially attributable to the substantially higher number of enabling services provided to support quality outcomes. With the exception of controlled hypertension, neither the AA&NHPI-serving nor national health centers meet the Healthy People 2020 benchmark goals for childhood immunization, cervical cancer screening, and colorectal cancer screening; which warrants a shared and collective effort to increase the nation's quality of care for these preventative measures.[8]



[8] Healthy People 2020. Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx

Health Disparities Are Masked When AA&NHPI Subpopulations Are Combined

When comparing diabetes and hypertension outcomes of Asian Americans, Native Hawaiians, and Pacific Islanders separately with Whites, differences within the AA&NHPI populations that were masked when combined together appeared. Compared to Whites, Asian Americans had higher rates of HbA1c less than 8 and controlled hypertension, whereas Native Hawaiians and Pacific Islanders had lower rates in both outcomes. There was not much difference between the AA&NHPI-serving health centers and the national health centers in terms of the outcomes for these two chronic diseases, except that Native Hawaiians and Pacific Islanders had overall lower rates of both controlled hypertensive patients and diabetic patients with HbA1c less than 8 compared to Whites and Asian Americans (AA) groups. Health disparities may be masked in the Asian American group because AA subgroups are often aggregated. When data is disaggregated, health disparities are more apparent.[9] [10]



[9] National Council of Asian Pacific Islander Physicians. The Impact of the Affordable Care Act on Asian Indian, Chinese, Filipino, Korean, Pakistani, & Vietnamese Americans, 2015 Full Report, 2016, available at ncapip.org, accessed November 2016.

[10] Islam NS, PhD, Khan S, Kwon S, Jang D, Ro M, Trinh-Shevrin C. Methodological Issues in the Collection, Analysis, and Reporting of Granular Data in Asian American Populations: Historical Challenges and Potential Solutions. J Health Care Poor Underserved. 2010 November; 21(4): 1354–1381. Islam, N. 2010

Summary

Analysis of 2017 UDS data indicate that in comparison with the national average health centers, AA&NHPI-serving health centers provide access to care to a statistically significant higher proportion of Medicaid, limited English proficient, and AA&NHPI patients. AA&NHPIs have higher prevalence of hepatitis B. Social determinants of health factors including poverty, education level, and limited English proficiency additionally impact the ability of AA&NHPI population's ability to access care. All of these findings are even more pronounced when we compare national health centers to health centers serving a much higher proportion of AA&NHPIs. AA&NHPI-serving health centers provide comprehensive primary medical and culturally and linguistically appropriate non-clinical enabling services, to improve quality and patient health outcomes. The quality health outcomes may be attributed to the significantly higher number of enabling services that assist in the prevention and management of health conditions, including hepatitis B.

Recommendations

Importance of Disaggregated Data: AA&NHPIs are highly diverse in their culture, language, and health needs, representing more than 50 ethnic groups and over 100 languages. As a rapidly growing and diverse population, AA&NHPIs face unique and significant social, emotional, and physical health burdens due to SDoH barriers. Such SDoH barriers may include poverty level, limited English proficiency (LEP), education, and health insurance status that are largely uncaptured due to the aggregation of AA&NHPI race data that masks their health disparities. According to the Census 2010, 31% of Asian Americans are LEP, ranging from 35% to 48% depending on the Asian subgroup, compared to 8.5% of the total US population. Studies that analyze Asian American disaggregated groups have found higher rates of SDoH barriers such as education level compared to other racial groups. For example, six of the top 10 highest groups with less than a high school educated groups are Asian American (Cambodian 34%, Hmong 30.2%, Laotian 30.1%, Vietnamese 26.7%, Bangladeshi 17.8%, Chinese 17.3%, Black 16.2%, Hispanic 35.3%, American Indian/Alaskan Native 17.3%, Other 39.8%). Disaggregated Asian ethnicity data show the greatest inequalities among Asian racial groups compared to other non-Asian racial groups. Overall, this underscores the limitations of aggregating data within the UDS and emphasizes the importance of analyzing race/ethnicity on a disaggregated level in order to illustrate and effectively respond to health disparities of AA&NHPIs.

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WWW.AAPCHO.ORG

California Office
101 Callan Avenue, Suite 400
San Leandro, CA 94577

Washington, D.C. Office
718 7th Street NW, Second Floor
Washington, D.C. 20001