



Health Centers' Role in Reducing Health Disparities Among Asian Americans, Native Hawaiians, and other Pacific Islanders

HEALTH CENTERS' MISSION

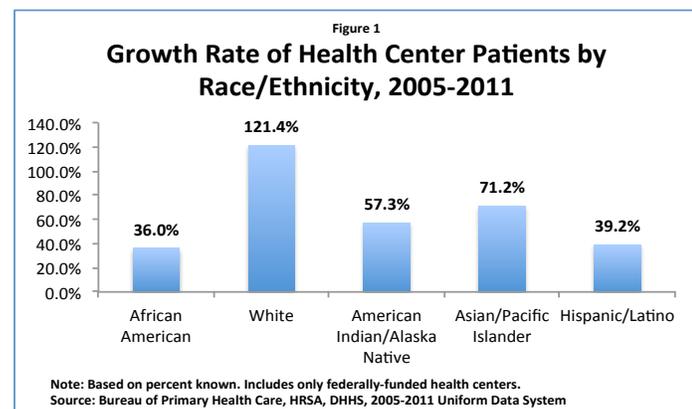
The nation's network of Community, Migrant, Homeless, and Public Housing Health Centers provides high quality, cost-effective, primary and preventive health care to the medically underserved, regardless of insurance status or ability to pay. Over 1,200 health centers serve over 9,000 urban and rural communities in every state and territory. Many health center patients are Asian American, Native Hawaiian, and other Pacific Islanders (AA&NHOP).¹

Health centers play a major role in addressing racial and ethnic health disparities. They are successful where other providers are not because they provide a multi-disciplinary approach to care that combines biomedical, psychological, and social approaches to care for patients, families, and entire communities. While other physicians may feel that they lack the skills or resources necessary to address patients' social needs, health centers are equipped, experienced and determined to overcome the challenges plaguing communities while simultaneously working to decrease health disparities.¹

HEALTH CENTERS AS PROVIDERS FOR AA&NHOPIS

Currently, health centers are the health and medical home for 20 million people, including over **760,000 AA&NHOPIS**.² As Figure 1 displays, **the number of AA&NHOPIS served at federally-funded health centers grew 71% between 2005 and 2011**, the second fastest growing race/ethnicity group. In addition, health centers are rapidly expanding under the Affordable Care Act.

Health centers are open to all individuals and have a particular focus on making care available and accessible



DISPARITIES AMONG AA&NHOPIS

Although AA&NHOPIS represent 6% (18 million) of the US population and by 2050, will comprise over 9% (43 million) of the total US population,^{5,6} there is a lack of data on AA&NHOPIS health status. In addition, AA&NHOPIS health data are often aggregated into one category, masking meaningful differences among the numerous AA&NHOPIS subgroups, especially those who are recent immigrants. In total, AA&NHOPIS represent over 43 ethnic groups and 77 dialects and **are extremely diverse in health and socioeconomic status. They are among the fastest growing minority populations in the US**, increasing 45% between 2000 and 2010.^{6,7} While very little health services research focuses on AA&NHOPIS as a study population, available data point to **substantial disparities among and within the US AA&NHOPIS population:**

- **Lack of access to regular care.** Asians are less likely to report having a personal doctor compared to whites.⁸ Twenty-five percent of Asian adults compared to 16.7% of whites report being without a usual source of health care.⁹ In California, approximately 12% of Asian Americans and 10% of NHOPIS did not see a doctor because of costs, rates higher than whites.¹⁰ Among Asians in California, Koreans were more than three times as likely as

¹ AAPCHO's membership represents 33 community based health organizations, mostly AA&NHOPIS-serving FQHCs. AAPCHO is dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of all AA&NHOPIS.

to those who are uninsured or publicly insured, low income, and otherwise medically vulnerable. Nationally, 36% of health center patients are uninsured, 39% have Medicaid or CHIP, and 93% are low income. The Association of Asian Pacific Community Health Organizations' (AAPCHO)' member health centers (whose patient population is on average 66% AA&NHOPIS) have similar rates of uninsurance, Medicaid/CHIP coverage, and poverty.² The proportion of AA&NHOPIS in poverty continues to grow nationally, increasing 46.3% from 2007 to 2011.³ For AAPCHO centers, the proportion of patients in poverty has increased 16.7%.⁴ Federally-funded health centers whose patient populations are over 60% AA&NHOPIS have patients with higher rates of hepatitis B and tuberculosis than all health centers nationally.²

Health centers provide culturally appropriate, comprehensive care, fitting their patients' individual language and cultural needs. Approximately half of AAPCHO patients are best served in a language other than English, with individual AAPCHO centers serving as high as 99% limited-English-proficient patients.²

whites to be uninsured all year in 2009.¹¹ Among Asian American groups, more Korean (27%), Thai (22%), and Cambodian Americans (21%) lack health insurance. One quarter of Tongan Americans live without health insurance, the highest of the NHOPI groups.¹⁰

- **Less satisfaction with care.** AA&NHOPIs are less likely than African Americans, non-Hispanic whites, and Hispanics to rate their health care quality highly.¹²
- **Fewer preventive services.** Asian women are less likely to have a mammogram than white and black women and a smaller percentage of NHOPI adults receive cholesterol screening compared to whites.¹¹ In addition, Koreans, Filipinos, and South Asians had a lower likelihood than non-Hispanic whites to undergo colorectal cancer screening.¹³ Koreans also consistently showed the lowest rates of breast and cervical cancer screenings.¹⁴
- **Poorer quality care.** NHOPIs have the lowest rate of early prenatal care in the first trimester among all race and ethnic groups and have higher infant mortality than whites.^{15, 16} Compared to whites, Asians also reported lack of timely care for illness, injury, or conditions.¹¹
- **Higher disease incidence.** AA&NHOPIs are nearly three times more likely to develop liver cancer than non-Hispanic whites, having the highest rate of liver cancer among all ethnic groups.¹⁷ The rate of tuberculosis per 100,000 is nearly 23 times greater among AA&NHOPIs than among whites.¹⁸ AA&NHOPIs are the only racial/ethnic group whose incidence of breast cancer increased from 2000 to 2010.¹⁹ NHOPIs are also three times more likely to be diagnosed with coronary heart disease and diabetes compared to non-Hispanic whites.²⁰

HOW HEALTH CENTERS ADDRESS DISPARITIES

Health centers are uniquely poised to address disparities facing AA&NHOPI subgroups. These providers meet five unique federal requirements that are central to their success in reducing disparities. Health centers must:

1. Be located in *high-need areas* that are identified by the federal government as “medically underserved.” They eliminate disparities by improving access for people who traditionally confront geographic barriers to health care.
2. Be able to provide *comprehensive* health care and “enabling” services. They tailor their services to fit the special needs and priorities of their communities, and provide services in a *linguistically and culturally appropriate* setting. They also connect patients to other social services, such as WIC and Medicaid/SCHIP enrollment.
3. Provide services *to all* residents, regardless of income, with sliding scale fee charges for out-of-pocket payments based on an individual’s or family’s income and ability to pay.
4. Be governed by *patient/user boards*, of which the majority must consist of their patients to assure responsiveness to local needs.
5. *Follow rigorous performance and accountability requirements* regarding their administrative, clinical, and financial operations. While this reporting requirement does not directly remove barriers to care for patients, it establishes a means of health center accountability and ensures quality of care.

HEALTH CENTER SUCCESS IN REDUCING DISPARITIES

Despite a lack of disaggregated data on the diverse AA&NHOPI populations, it is clear that health centers remove barriers to care for AA&NHOPIs and reduce racial and ethnic disparities. Thus, the disparities in health access among health center patients are lower compared to the US population.²¹ Literature on health centers link their community-based, culturally appropriate, and comprehensive primary health care services to improved patient health²² which leads to:

- **Reduced Low Birth Weight.** AA&NHOPI women who receive prenatal care at health centers have lower rates of low birth weight compared to AA&NHOPI women nationally – 6.9% vs. 8.5% in 2010.^{23, 24}
- **Improved Access to Primary and Preventive Care and Reduced Emergency Room Utilization.** Studies continuously show that health centers improve access to timely screening and preventive services for high-risk patients – including AA&NHOPIs – who would not otherwise access services such as immunizations, health education, mammograms, pap smears, and other screenings.^{25, 26, 27} Low income, uninsured health center patients are more likely to have a usual source of care than the uninsured nationally.²⁰ Health center patients also have less emergency room utilization²⁸ than patients not seen at health centers.
- **Effectively Managing Chronic Illness.** The Institute of Medicine and the General Accountability Office have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV. Health centers’ efforts have led to *improved health outcomes* for their AA&NHOPI patients,⁴ as well as *lowered the cost of treating patients* with chronic illness.²⁹
- **High Patient Satisfaction.** Health center patients were more likely to be satisfied with the care they receive than U.S. low-income patients and the overall U.S. patient population.²¹

REFERENCES

- ¹ National Association of Community Health Centers: Powering Healthier Communities: Community Health Centers Address the Social Determinants of Health. Issue Brief August 2012.
- ² U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. 2011 Uniform Data System
- ³ U.S. Census Bureau American Community Survey. Census poverty reports 2011 (1973K) and 2007 (1349K).
- ⁴ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. 2007-2011 Uniform Data System
- ⁵ U.S. Census Bureau Newsroom Release (2008). An Older and More Diverse Nation by Midcentury. August 2008.
- ⁶ U.S. Census Bureau Census Briefs (2010). The Asian and Native Hawaiian and Other Pacific Islander Population: 2010
- ⁷ U.S. Census Bureau (2006-2008). Detailed Language Spoken at Home and Ability to Speak English for the Population 5 Years and Older by States: 2006-2008 (ACS).
- ⁸ The Henry J. Kaiser Family Foundation. State Health Facts tables. No Personal Doctor/Health Care Provider for Men and Women, by State and Race/Ethnicity, 2006 – 2008.
- ⁹ Agency for Healthcare Research and Quality (2010). Table 1: Usual Source of Health Care and Selected Population Characteristics, United States, 2010. Medical Expenditure Panel Survey Household Component Data.
- ¹⁰ A Community of Contrasts: Asian Americans, Native Hawaiians and Pacific Islanders in California, 2013. Asian American Center for Advancing Justice.
- ¹¹ National Healthcare Quality & Disparities Reports 2011 and 2012. Agency for Healthcare Research and Quality, Rockville, MD. March 2013.
- ¹² Sorkin DH, Ngo-Metzger Q, Alba ID. Racial/Ethnic Discrimination in Health Care: Impact on Perceived Quality of Care. *J Gen Intern Med.* 2010 May; 25(5): 390–396.
- ¹³ Lee YL. Colorectal Cancer Screening Disparities in Asian Americans and Pacific Islanders: Which Groups Are Most Vulnerable? *Ethn Health.* 2011 Dec; 16 (6): 501-18.
- ¹⁴ Lee HY, Ju E, Vang PD, Lundquist M. Breast and cervical cancer screening among Asian American women: does race/ethnicity matter? *J Women Health.* 2010 Oct; 19 (10): 1877-84.
- ¹⁵ U.S Department of Health and Human Service, Office of Minority Health (2012). Infant Mortality and Native Hawaiians/Pacific Islanders.
- ¹⁶ U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA 2012. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.
- ¹⁷ Office of Minority Health. Cancer and Asians/Pacific Islanders. Accessible at <http://minorityhealth.hhs.gov/templates/content.aspx?ID=3055>. Accessed 5/15/13
- ¹⁸ American Lung Association. State of Lung Disease in Diverse Communities 2010.
- ¹⁹ U.S. Department of Health and Human Service, National Institutes of Health, National Cancer Institute. Age-Adjusted SEER Incidence Rates By Race/Ethnicity Female Breast, All Ages, Female 2000-2010 (SEER 18)
- ²⁰ U.S Department of Health and Human Service, Office of Minority Health (2012). Native Hawaiians and Pacific Islanders Profile.
- ²¹ Shi L, Lebrun-Harris LA, Daly CA, et al. Reducing Disparities in Access to Primary Care and Patient Satisfaction with Care: The Role of Health Centers. *Journal of Health Care for the Poor and Underserved.* 2013; 24(1):56-66.
- ²² Based on review of lit and conclusions in Politzer RM, et al. “The Future Role of Health Centers in Improving National Health.” 2003 *Journal of Public Health Policy* 24(3/4):296-306.
- ²³ Martin JA, Hamilton BE, Ventura SJ, et al. Births: Final data for 2010. National vital statistics reports; vol 61 no 1. Hyattsville, MD: National Center for Health Statistics. 2012.
- ²⁴ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. 2010 Uniform Data System
- ²⁵ Shi, L., Lebrun, L.A., Hung, L., Zhu, J., & Tsai, J. (2012). US primary care delivery after the Health Center Growth Initiative. *J Ambulatory Care Manage*, 35(1):60-74.
- ²⁶ Shi L, Tsai J, Higgins PC, Lebrun La. Racial/ethnic and socioeconomic disparities in access to care and quality of care for US health center patients compared with non-health center patients. *J Ambul Care Manage* 2009 Oct-Dec; 32(4): 342 – 50.
- ²⁷ Dor, A, et al. “Uninsured and Medicaid Patients’ Access to Preventive Care: Comparison of Health Centers and Other Primary Care Providers.” RHCN Community Health Foundation. August 2008; Research Brief #4.
- ²⁸ California Primary Care Association. Value of Community Health Centers Study. January 2013. Accessible at <http://www.cPCA.org/cPCA/assets/File/Data-Reports/2013-03-18ValueofCHCStudy.pdf>. Accessed 5/15/13.
- ²⁹ Chin MH. Quality improvement implementation and disparities: the case of the health disparities collaboratives. *Med Care.* 2010 Aug;48(8):668-75.