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Spotlight: The Health of Asian Americans, Native Hawaiians and Other Pacific Islanders Served at Federally Qualified Health Centers

A Report Developed by the Association of Asian Pacific Community Health Organizations

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ABOUT AAPCHO

Established in 1987, the Association of Asian Pacific Community Health Organizations (AAPCHO) is a national association of 35 community health organizations dedicated to promoting advocacy, collaboration and leadership that improves the health status and access of Asian Americans, Native Hawaiians and other Pacific Islanders (AA&NHOPIs) in the United States and its territories.

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EXECUTIVE SUMMARY

The nation's network of Community, Migrant, Homeless and Public Housing Health Centers provide high quality, cost-effective, primary and preventive care to the medically underserved, regardless of insurance status or ability to pay. Over 1200 federally qualified health centers (FQHCs) serve over 9,000 urban and rural communities in every U.S. state and communities. Many FQHC patients are Asian American & Native Hawaiian, and other Pacific Islanders (AA&NHOPI). AA&NHOPIs are among the fastest growing racial/ethnic groups, currently representing 6% (18 million) of the U.S. population and is expected to almost triple in numbers by 2050 to 43 million or 9%[1]. At the same time, the number of AA&NHOPIs served at FQHCs has also been growing, increasing by 118% between 2005 and 2014. An examination of the health of AA&NHOPI populations served at FQHCs is necessary to better understand quality of care and health outcomes for this growing population at Health Resources and Services Administration (HRSA)-supported FQHCs.

This report examines current patient demographics and utilization of health services at FQHCs serving AA&NHOPIs, and highlights the differences between these centers and the national average of all FQHCs in the United States. The data will help advance a better understanding of the AA&NHOPI communities served by FQHCs, and help identify priorities and opportunities to improve AA&NHOPI health.

Based on our analysis of the Bureau of Primary Health Care (BPHC)) Uniform Data System (UDS) data, our findings indicate that AA&NHOPIs accessing services at FQHCs face multiple social determinants of health (SDH) risk factors that impact their health. The World Health Organization defines SDH as "the conditions in which people are born, grow, work, live and age and the wider set of forces and systems shaping the conditions of daily life." Some examples of SDH include income, language, education and employment. The majority of AA&NHOPI patients at FQHCs are low-income, with 93% under the 200% Federal Poverty Level (FPL) and 1/3 of patients are Limited English Proficient (LEP) compared to 23% at FQHCs nationwide. These factors are well-known characteristics of vulnerability associated with access to care[2]. Furthermore, when compared against the average FQHC patient, AA&NHOPI patients are also more likely to be diagnosed with the following conditions: TB, asthma, hepatitis B, hepatitis C, abnormal breast and cervical findings.

To meet the multiple needs of their patients, AA&NHOPI-serving FQHCs also provide statistically significant greater number of enabling services (ES) and employ almost double the number of ES staff in full-time employees (FTEs) compared to FQHCs nationally. ES is defined as "non-clinical services that aim to increase access to healthcare and improve health outcomes;" some examples include health education, interpretation and case management. FQHCs are also providing high quality care that lead to improved health outcomes. When compared against the national FQHCs, patients at AA&NHOPI-serving FQHCs are more likely to have controlled hypertension and less likely to have HbA1c > 9, indicating patients' diabetes are under control. These better health outcomes at AA&NHOPI-serving FQHCs may be due to the higher of number ES and the resulting quality outcomes when compared to national FQHCs.

Based on these findings, AAPCHO recommends disaggregated data collection for AA&NHOPIs to better understand health needs and disparities within and among the population. AA&NHOPIs are highly diverse in their culture, language and health needs, representing more than 50 ethnic groups and 100 languages. Data that presents AA&NHOPI as one racial/ethnic group masks the multiple health needs and disparities of this diverse and growing population. Disaggregated data will allow FQHCs to better understand and direct their services to the needs of the specific patient populations. AAPCHO member FQHCs collects and strongly recommends collection of disaggregated racial/ethnic and language data. Additionally, due to the high disease burden from hepatitis B, hepatitis C, TB, asthma and other conditions, funding and payment to cover recommended preventative services and care are critical to meeting the needs of the AA&NHOPI population at these FQHCs. Finally, as evidenced by the high volume of ES and the resulting high quality care delivered by FQHCs, AAPCHO recommends that ES be recognized and adequately reimbursed by all payers as part of the medical care that patients receive at FQHCs. Central to these efforts include enhanced data collection on ES that includes intensity and duration as well as SDH data to better understand and assess their impact on quality of care and health outcomes.

AA&NHOPIs in the United States

Asian Americans, Native Hawaiians and other Pacific Islanders (AA&NHOPIs) are among the fastest growing racial/ethnic groups and currently account for 6% of the total U.S. population[3]. While the total U.S. population is projected to increase by 48% between 2005 and 2050, Asian Americans are projected to triple in size.[4] AA&NHOPIs are highly diverse in their culture, language and health needs, representing more than 50 ethnic groups and over 100 languages. Coming from different backgrounds and origins, this population faces unique and significant social, emotional and physical health burdens due to deficits in many of the social determinants of health (SDH) (e.g., poverty, limited English proficiency, education, health insurance status). AA&NHOPIs are more likely to live below 100% of Federal Poverty Level (FPL) than non-Hispanic Whites, with almost three-quarters of AA&NHOPIs living below 200% of FPL. Low-income AA&NHOPIs are more likely to be uninsured (35%) than their non-Hispanic White counterparts (26%). In addition, 35% of AA&NHOPIs, in aggregate, live in linguistically isolated households. About two-thirds of AA&NHOPIs are foreign born compared to 10% of the U.S. population[5]. In general, AA&NHOPIs are less likely to utilize health care and to participate in health programs for which they are eligible compared to other racial groups leading to significant health disparities[6, 7, 8]. These include less access to care, less satisfaction with care, fewer screening and preventive services, poorer quality care, and higher disease incidence of liver cancer, tuberculosis, certain cancers and heart disease, compared with non-Hispanic whites.

Due to the cultural and linguistic barriers and disease burden this population faces, AA&NHOPIs have increasingly relied on federally qualified health centers (FQHCs) to access primary health care and preventative services. FQHCs are open to all individuals and have a particular focus on making care available and accessible to those who are uninsured or publicly insured, low income or otherwise medically vulnerable. FQHCs are among the largest safety net providers; about 93% of FQHC patients live at or below 200% of the FPL, 35% are uninsured and 42% are covered under Medicaid[9]. In 2013, 1202 FQHCs across the country served 21.7 million patients in 9,208 different delivery sites[10]. FQHCs provide culturally appropriate, comprehensive care, fitting their patients' individual language and cultural needs. Literature on FQHCs link their services to improved patient health[11] which leads to reduced low birth weight[12, 13], effective management of chronic illness[14], high patient satisfaction[15] and reduced emergency room utilization[16]. As a result of improved health outcomes, FQHCs have lowered overall costs related emergency room utilization and caring for patients with chronic illnesses.

As leaders in providing quality and culturally and linguistically appropriate care to the nation's medically underserved populations, FQHCs are well positioned to address health disparities facing AA&NHOPIs. However, little is known about the patient demographics and utilization of health services at FQHCs that serve AA&NHOPIs. While all FQHCs serve vulnerable and medically underserved populations, those serving AA&NHOPIs encounter unique challenges amounted with population characteristics. The task of providing culturally and linguistically appropriate care to meet the needs of patients, who are often Limited English Proficient (LEP), is increasingly complicated when serving such a diverse and fast growing population.

The purpose of this report is to provide an examination of patient demographics and utilization of health services at Health Resources and Services Administration (HRSA)-supported FQHCs serving AA&NHOPIs, and to highlight the differences between these FQHCs and the national average of all FQHCs in the United States. This data will help advance a better understanding of AA&NHOPI-serving FQHCS, and help identify priorities and opportunities to improve AA&NHOPI health.

METHODOLOGY

Dataset

For this report, we examined data from the Uniform Data System (UDS) maintained by the Bureau of Primary Health Care (BPHC) within the Health Resources Service Administration (HRSA) provided to us on September 2, 2014. Each year, all HRSA-supported federally qualified health centers (FQHCs) are required to report on their performance to UDS. UDS contains a core set of information on the operation and performance of FQHCs. The total number of FQHCs reporting to UDS for 2013 is 1,202.

Defining AA&NHOPI-Serving Federally Qualified Health Centers

From this dataset of 1202 FQHCs, we determined a total of 112 as AA&NHOPI-serving FQHCs. AA&NHOPI-serving FQHCs are those that serve at least 5% or more Asian American, Native Hawaiian and other Pacific Islanders totaling at least 1,000 AA&NHOPIs. The 5% threshold was selected because it is the total proportion of Asian Americans (4.8%, 3.6%) plus Native Hawaiians and other Pacific Islanders (0.2%, 1.3%) according to the Census 2010 U.S. population and UDS 2013 data, respectively. Also in practice, serving a subpopulation larger than 1,000 will have an impact on the FQHC's resource allocation for culturally competent services. To ensure we included smaller FQHCs, we also included those that served at least 25% of AA&NHOPIs but that do not reach the threshold of 1,000. There were a total of four such FQHCs, serving between 583-923 AA&NHOPIs.

Data Analysis

National averages and AA&NHOPI-serving FQHC averages are calculated using raw UDS data. National averages serve as references to compare with AA&NHOPI- serving FQHC average data. To determine if there are significant differences between the two datasets, two-sample t-tests were conducted. Results were considered statistically significant at the level of $p \leq 0.05$.

Limitations

UDS data provides summary level data, not individual patient data, thereby preventing us to conduct cross tabulations of data, for example Asian ethnicity by insurance status. Additionally, the sample sizes were very different: national FQHC total (1,202) is much larger than the total number of AA&NHOPI-serving FQHCs (112). Finally, for comparison purposes, certain scores and data represent the average center for each group and groups may not be directly comparable due to large differences amongst FQHCs (i.e., FQHC size, patient demographics).

Demographics

This section includes demographic and descriptive information on the population served by the 112 AA&NHOPI-serving federally qualified health centers (FQHCs). These FQHCs are located across the country in 27 U.S. states, 3 U.S. territories, and 3 other territories (Federated States of Micronesia, Marshall Islands and the Republic of Palau). The top five states with the most number of AA&NHOPIs served by AA&NHOPI-serving FQHC patients are California, Hawaii, New York, Massachusetts and Washington (figure 1).

Top AA&NHOPI Serving FQHCs by State

Total AA&NHOPIs served	State/Territory	Total FQHCs
162,219	CA	30
89,390	HI	14
63,566	NY	7
58,322	MA	10
46,658	WA	7

Figure 1: Top AA&NHOPI-serving FQHCs by State

Total patients served at these FQHCs were about 2.8 million, and among these patients, around 600,000 are AA&NHOPIs. The number of AA&NHOPIs served per FQHC ranged from 583 to 55,023 (median = 2369 AA&NHOPIs and mean = 5,299). The majority of patients, about 60%, served at these AA&NHOPI-serving FQHCs are working-age adults between 18-64 years old while children and people age 65 and older comprise a smaller percentage of the total patient population (fig.2). Additionally, a little more than half of the patients served at AA&NHOPI-serving FQHCs are female and about 70% are publicly insured (figures 3 & 4). Taken together, these percentages indicate that low-income working age adults and children are especially reliant on these FQHCs for care. The average number of visits per patient was 4.2, figure 6 shows patient visits by type.

Patients of AA&NHOPI Serving FQHCs by Age

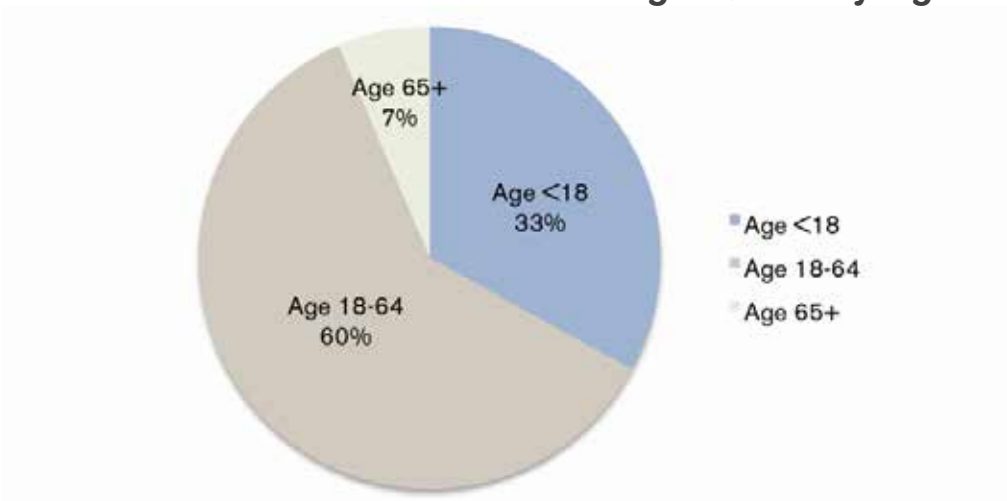

Figure 2: Patients of AA&NHOPI-serving FQHCs by Age

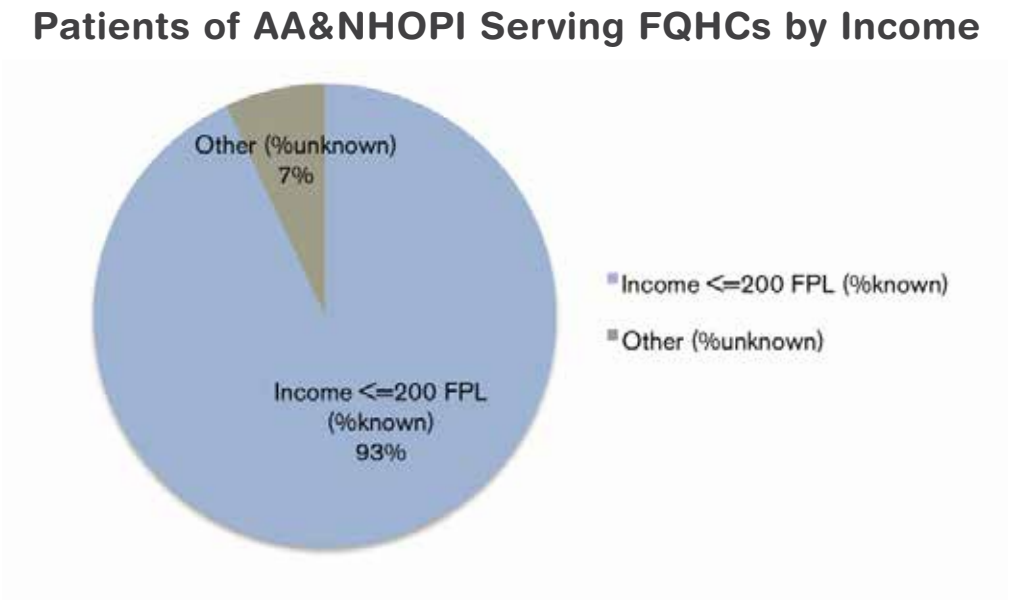

Figure 3: Patients of AA&NHOPI-serving FQHCs by Income

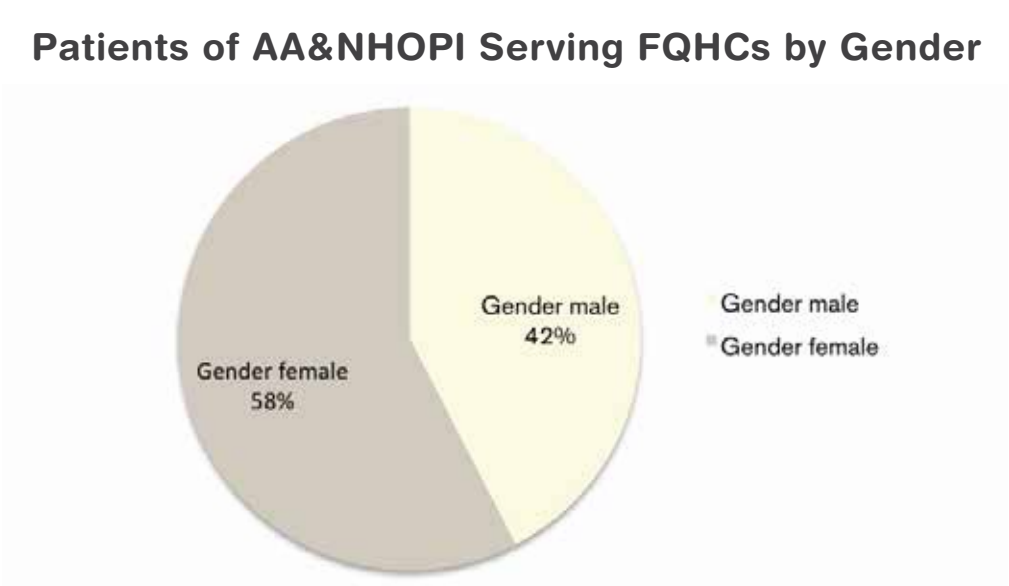

Figure 4: Patients of AA&NHOPI-serving FQHCs by Gender

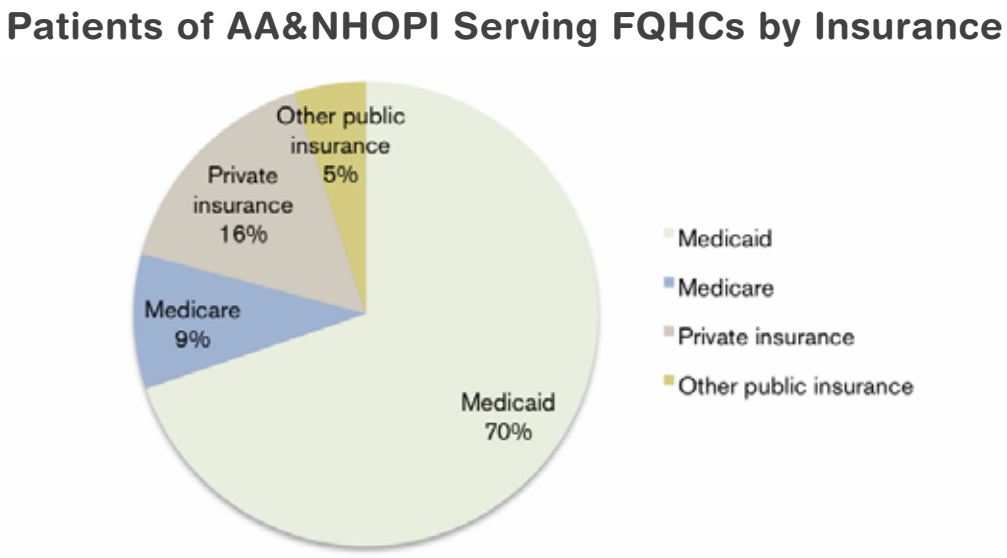

Figure 5: Patients of AA&NHOPI-serving FQHCs by Insurance

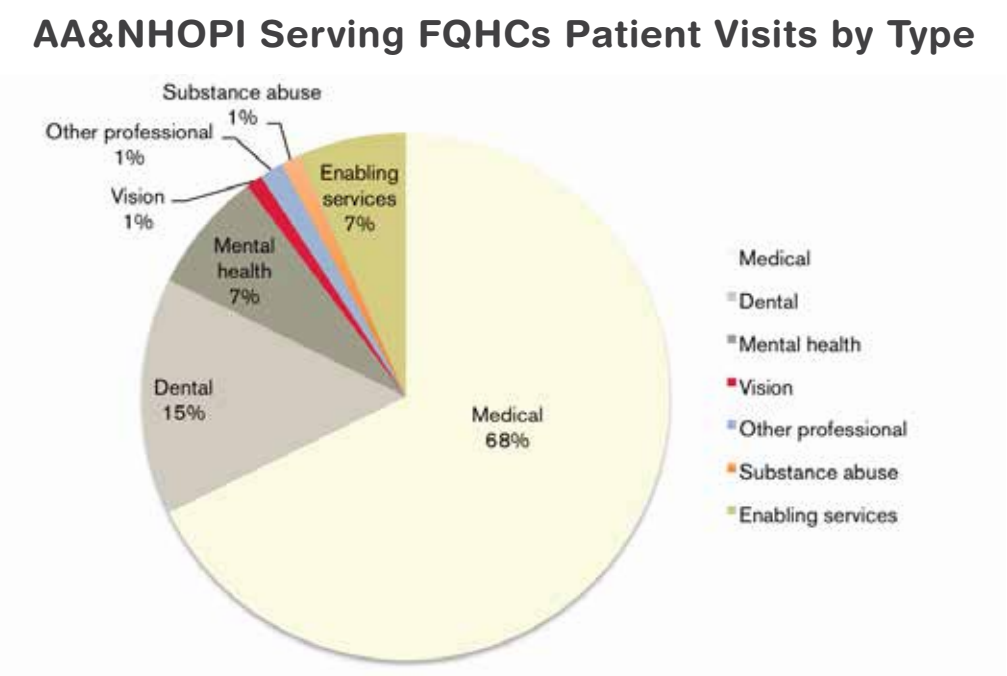

Figure 6: AA&NHOPI-serving FQHCs Patient Visits by Type

How AA&NHOPI-serving FQHCs Compare Nationally

More Complex Patients

Compared to the national average, AA&NHOPI-serving FQHCs serve a statistically significant higher proportion of low-income, Medicaid, Limited English Proficient (LEP), prenatal, and AA&NHOPI patients. Most of these factors are well-known characteristics of vulnerability associated with access to care[17]. The average number of patients seen at AA&NHOPI-serving FQHCs based on our definition (24,324 patients per FQHCs) is 34% more than the average number of patients seen at FQHCs nationally (18,106). On average, AA&NHOPIs comprise about 22% of the total patient population at AA&NHOPI-serving FQHCs versus the national average of 4%. This high percentage of AA&NHOPI per FQHC is consistent with previous studies that indicate AA&NHOPIs living in poverty are more likely to be concentrated in a limited number of metropolitan areas[18]. Nationally, a majority of patients seen at FQHCs are low-income, however, the average percentage of patients at or below 200% Federal Poverty Level (FPL) is higher at AA&NHOPI-serving FQHCs, 93.0% versus a national average of 92.7%. The percentage of Medicaid patients seen at AA&NHOPI-serving FQHCs is also higher at 46.29% versus the national average of 40.63%. AA&NHOPI-serving FQHCs also see a higher percentage of prenatal patients than the national average (2.5% vs. 2.3%). Most notably, the proportion of LEP patients seen at AA&NHOPI-serving FQHCs is significantly higher than the national average (33% versus 23%).

In addition to experiencing multiple social determinants of health (SDH) barriers, AA&NHOPI patients seen at AA&NHOPI-serving FQHCs are also more likely to have TB, hepatitis B, hepatitis C, asthma, and abnormal breast and cervical findings. Hepatitis B and hepatitis C are among the leading causes of preventable deaths worldwide[19]. The greatest disparity is seen for hepatitis B, where the percentage of patients with hepatitis B is four times greater in AA&NHOPI-serving FQHCs.

Patient Characteristics Differences

	AA&NHOPI-serving FQHCs (average or %)	National FQHCs (average or %)
Average total patients/FQHC	24,323	18,106
Average total AA&NHOPIs	5,299	750
% AA&NHOPI	22%	4%
% patients best served in a language other than English	33%	23%
% <=200% poverty	93.01%	92.78%
% Medicaid	46%	41%
% Uninsured	34%	35%
% Prenatal patients	2.5%	2.3%
% Hepatitis B	0.54%	0.13%
% TB	0.08%	0.05%
% Hepatitis C	0.90%	0.78%
% Asthma	6.30%	5.88%
% Abnormal breast findings	0.61%	0.52%
% Abnormal cervical findings	0.98%	0.91%

Figure 7: Patient characteristics differences.
All results indicate that AA&NHOPI-serving FQHCs averages & percentages are significantly different (P<0.05) from national percentages.

The percentage for the selected diagnoses are calculated by taking the number of patients with the diagnosis out of the number of patients with medical conditions, instead of the total number of patients. We conducted the analysis this way to be consistent with the UDS clinical data presented on HRSA's website (http://bphc.hrsa.gov/uds/datacenter.aspx?year=2014#), in which medical conditions are depicted as % of patients with medical conditions. These are the percentages that were used in our test for significance. We do not know if the percentages will still be significantly different if we are taking the percentages of total patients.

Greater Number of Enabling Services

Patients at AA&NHOPI-serving FQHCs utilized statistically significant more services than those at the national average FQHCs. Average number of total encounters for AA&NHOPI-serving FQHCs is 45% higher than the national average, 103,112 versus 71,309 encounters. The most notable differences between AA&NHOPI-serving FQHCs and the national average FQHCs can be seen in patients' utilization and the FQHCs' provision of enabling services (ES). A greater percentage of patients utilized ES (10.7% vs. 9.6%) resulting in a higher number of ES encounters for AA&NHOPI serving FQHCs when compared to the national average, 7679 versus 4953, representing a 55% difference. The total number of full-time ES employees at AA&NHOPI serving FQHCs is almost double the national average, 21.68 versus 12.30 FTEs respectively. Consequently, the total cost for ES for AA&NHOPI-serving FQHCs ($1.8 million) is also almost double the total costs of $958,052 for the national average. This striking difference in ES may be attributable to the high needs and high risk profile of the AA&NHOPI patient population. For example, to address the high number of LEP patients, total full-time equivalent employees (FTEs) for interpretation staff at AA&NHOPI-serving FQHCs are significantly higher than the national average, 3.10 FTEs versus 1.04 FTEs. The higher number of case manager, patient/community education specialists, and eligibility assistance FTEs allow AA&NHOPI-serving FQHCs to better address their medically underserved patient populations who often have limited healthcare experience and low literacy.

Encounters and Costs

	AA&NHOPI-serving FQHCs (N=112)	National FQHCs (N=1202)
Average total encounters	103,112	71,309
Average total ES	7,679	4,953
Average total ES costs	1,823,109	958,052

Figure 8: Encounters and costs
All results indicate that AA&NHOPI-serving FQHCs averages & percentages are significantly different (P<0.05) from national percentages.

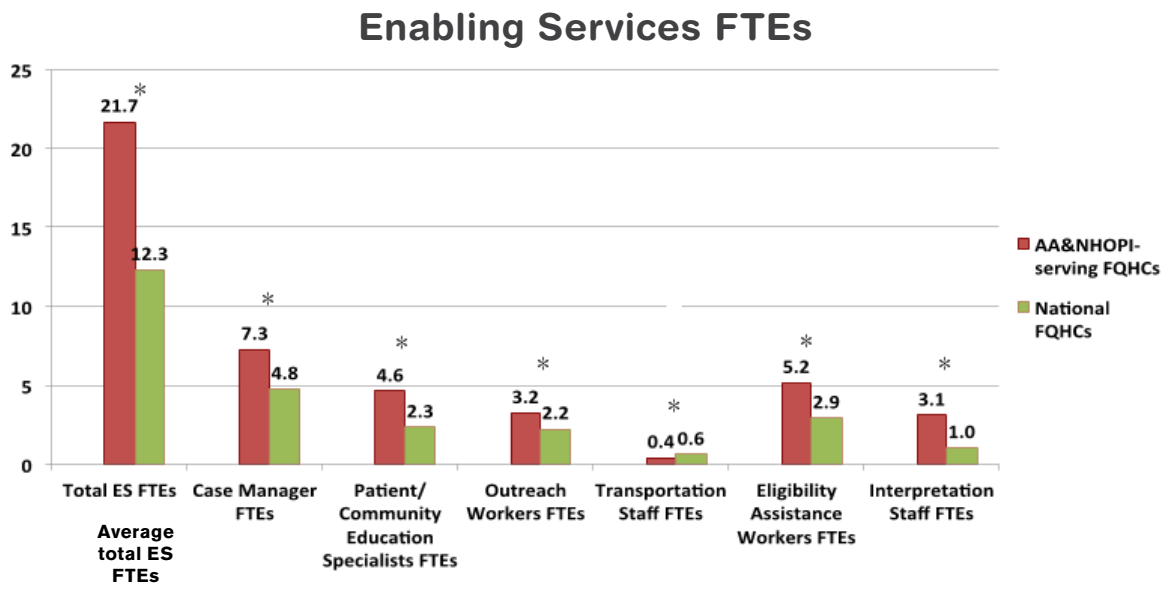

Figure 9: Enabling services FTEs in averages.
All results indicate that AA&NHOPI-serving FQHCs averages & percentages are significantly different (P<0.05) from national percentages.

High Quality Care

Despite the high disease burden of its patient population, AA&NHOPI-serving FQHCs have statistically significant better health outcomes for hepatitis B, pap smears, hypertension and diabetes. AA&NHOPI-serving FQHCs have a higher proportion of patients with controlled hypertension and lower proportion of diabetic patients with HbA1c greater than 9, indicating that diabetic patients have their disease under control. Screening rates at AA&NHOPI-serving FQHCs are also better when compared to the national average. The percent of patients with a hepatitis B test and percent of female patients aged 24-64 with one pap test are higher among AA&NHOPI-serving FQHCs. These outcomes may be attributable to the substantially higher number of ES and the resulting quality outcomes. AAPCHO's membership network of 24 AA&NHOPI-serving FQHCs has also seen similar results for ES and quality health outcomes. When compared against the national average FQHC, AAPCHO member FQHCs also provide a higher number of ES and employ twice as many ES FTEs. The percentage of female patients aged 24-64 who had at least one Pap test performed in the last two years was also significantly higher in AAPCHO member FQHCs than in national FQHCs. Additionally, AAPCHO member FQHCs had a significantly smaller percentage of diabetic and hypertensive patients, higher proportion of patients with controlled blood pressure and lower proportion of diabetic patients with HbA1c>9.

Quality of Care Measures and Health Outcomes

	AA&NHOPI-serving FQHCs (N=112)	National FQHCs (N=1202)
Cervical cancer screening[1]	457,077 (62.3%)	3,400,431 (57.8%)
Patients with controlled hypertension	205,946 (63.9%)	1,887,838 (63.6%)
Diabetic patients with HbA1c >9	52,699 (29.7%)	477,698 (31.1%)

[1] Female patients who received at least one pap test

Figure 10: Quality of Care Measures and Health Outcomes
All results indicate that AA&NHOPI-serving FQHCs percentages are significantly different (P<0.05) from national percentages.

RECOMMENDATIONS

Based on the results and differences with national averages, AAPCHO recommends federally qualified health centers (FQHCs), community based organizations, funders and payers serving AA&NHOPIs to focus on language access, social determinants of health (SDH) and enabling services (ES), and to pay attention to several health conditions including hepatitis B, hepatitis C and TB. More specifically, we developed the following recommendations as priority areas to improve AA&NHOPI health:

1) Implement Culturally and Linguistically Appropriate Services

To help address the cultural and linguistic barriers of AA&NHOPIs, we must stress the need for Cultural Competence and Language Access. One recommendation is that all initiatives and efforts related to the provision of health care services include the integration of the national Culturally and Linguistically Appropriate Services (CLAS) standards for health care providers. The 15 standards, which comprise of Culturally Competent Care, Language Access Services, and Organizational Supports for Cultural Competence, should be integrated throughout health care provider organizations and undertaken in partnership with the community being served. By implementing the CLAS standards, we can help ensure that all health care providers are transforming their practices to better meet the needs of their patients.

2) Collect Disaggregated Data on AA&NHOPIs to Better Identify Needs and Priorities

AA&NHOPIs are highly diverse in culture, language and health needs, representing more than 50 ethnic groups and 100 languages. AA&NHOPI data are often reported nationally as one racial/ethnic group, which masks the health disparities of the racial/ethnic groups within this diverse population. Data that presents AA&NHOPI as one racial/ethnic group masks the multiple health needs and disparities of this diverse and growing population. At a minimum, the standard for disaggregated data collection should come from the American Community Survey and U.S. Census Bureau 2010 form that have been developed through rigorous research to allow for more accurate counts. Disaggregated data will allow FQHCs to better understand and direct their services to the needs of the specific patient populations; ultimately, supporting FQHCs in their efforts to attain meaningful use. AAPCHO member FQHCs collect and strongly recommend collection of disaggregated racial/ethnic and language data.

3) Adopt Nationally Recognized Standards on Enabling Services and Social Determinants of Health to Prioritize Interventions and Justify Reimbursement

Based on the significant amount of ES provided by AA&NHOPI-serving FQHCs, AAPCHO recommends a standardized and systematic collection of ES data, above and beyond the current UDS ES data. Systematic ES data will enable us to assess and further examine the importance and impact on quality of care. AAPCHO also recommends for the collection and inclusion of standardized SDH (e.g., education, homelessness) to better understand the impact of SDH on the receipt of appropriate ES and help prioritize ES interventions. Both datasets can provide further evidence to support the argument of greater patient complexity for AA&NHOPI-serving FQHCs and conduct risk adjustment analyses to level the playing field for all providers, particularly for those who see higher risk patients.

4) Ensure Adequate and Sustainable Payment for Enabling Services

ES are critical to addressing AA&NHOPI multiple barriers to care. These ES allow FQHCs to target systemic SDH factors that contribute to poor health outcomes and perpetuate disparities in health and health care. Despite their impact, these services are often jeopardized due to budgetary limits. We recommend that widely used risk-adjustment models impacting the provision of ES be revaluated and improved to make more accurate predictions that capture all factors affecting expected costs in order to sustain this work. Within our membership FQHCs, we have found that due to the complexity of our patient mix and the high volume of ES provided, these FQHCs are

routinely underpaid without accurate risk adjusters. We know this financial situation is likely replicated at other AA&NHOPI-serving FQHCs. As evidenced by the higher cost of care reported, additional risk adjusters would more accurately match the actual cost of providing healthcare to AA&NHOPI patients. Variables to consider include: high proportions of limited English proficient patients, patients with multiple chronic conditions, and a high number of patients with intense or acute conditions.

5) Dedicate Funding and Payment for Recommended Preventative Services for Hepatitis B, Hepatitis C and TB to Improve Health Outcomes

Hepatitis B, hepatitis C and TB are significant medical problems for AA&NHOPIs. Funding dedicated to prevention and care is critical to meeting the growing health needs of the AA&NHOPI population. In addition, greater coordination and cross training for medical providers and other allied health staff would greatly enhance the provision of management and prevention services for these health issues at FQHCs.

6) Dedicate Funding to Support and Sustain Research Infrastructure and Submission of Data to a Centralized Data Warehouse

This effort would allow FQHCs and other AA&NHOPI-serving organizations to collaborate, conduct patient-centered outcome research, and identify effective interventions to improve patient care.

CONCLUSION

This report aimed to examine current patient demographics and utilization of health services at federally qualified health centers (FQHCs)-serving AA&NHOPIs, and to highlight the differences between these FQHCs and the national average of all FQHCs in the United States. Data analysis from this report highlight the multiple needs and barriers experienced by AA&NHOPIs seen in AA&NHOPI-serving FQHCs. AA&NHOPI-serving FQHCs serve a statistically significant higher proportion of low-income, Medicaid, limited English proficient, prenatal, and AA&NHOPI patients. These patients are also more likely to have TB, hepatitis B, hepatitis C, asthma, and abnormal breast and cervical findings. To address these social and medical needs, AA&NHOPI-serving FQHCs are providing comprehensive primary medical and culturally and linguistically appropriate enabling services (ES) to improve quality and patient health outcomes. AA&NHOPI-serving FQHCs have better health outcomes for hepatitis B screening, pap tests, hypertension and diabetes. These better health outcomes may be due to the significantly higher number of ES. Despite their impact, ES are non-reimbursable and are funded through disjointed and term-limited funding. Sustainable payment for ES is critical as well as increased data collection and funding for language access, social determinants of health and the prevention and management of several health conditions including hepatitis B, hepatitis C and TB.

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