

# Community Counts



Assessing Social Drivers of Health among  
Asian Americans, Native Hawaiians, and Pacific Islanders

Prepared by the Center for Social Impact at  
the Chinese American Service League

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# Who We Are

Change InSight® is a nationwide partnership with community-based organizations (CBOs) that provide social services to Asian American, Native Hawaiian and Pacific Islanders (AANHPIs) and other underrepresented communities.

**Change InSight® collects data on social drivers of health (SDOH)** among AANHPI communities, then disaggregates that data by origin group to provide a clearer picture of each community's needs. **In 2022, 2,244 individuals from six CBOs** in the Chicagoland area participated. **In 2023, 5,932 individuals from 19 CBOs** (Figure 1) in five states participated.

Change InSight® is the first known group of community-based social service organizations to administer the PRAPARE® (Protocol for Responding to and Assessing Patients Assets, Risks, and Experiences) tool to understand SDOH. This tool is typically used in a primary healthcare setting where social needs referrals are outsourced. **Change InSight® uses this assessment within the local community to understand the different risks that populations are facing.**



## Change InSight® Partner Organizations by Type (2023)

Figure 1





# Social Drivers of Health (SDOH) and Disaggregating AANHPI Data

Good health and life satisfaction are often the result of nurturing environments and opportunities. Unfortunately, these factors are not available for everyone.

Populations that experience racism and discrimination, fewer educational or employment opportunities, or limited health care access often experience health disparities. As a result, these communities have higher rates of severe illness and mortality. **It is important to remember, however, that health disparities are preventable and solvable.**

The conditions in which we live, work, play, or worship are known as social drivers<sup>1</sup> of health, and they can significant-

ly impact health outcomes. Medical care—the services you might receive at a hospital or clinic—is mistakenly regarded as the main contributor of health outcomes. In fact, it only accounts for 20% of one’s health. Social drivers have a much larger role: up to **80% of health outcomes result from socioeconomic factors, physical environments, and health behaviors** (Figure 2).<sup>2</sup>



80% of health outcomes are driven by **socioeconomic factors, physical environment** and **health behaviors**

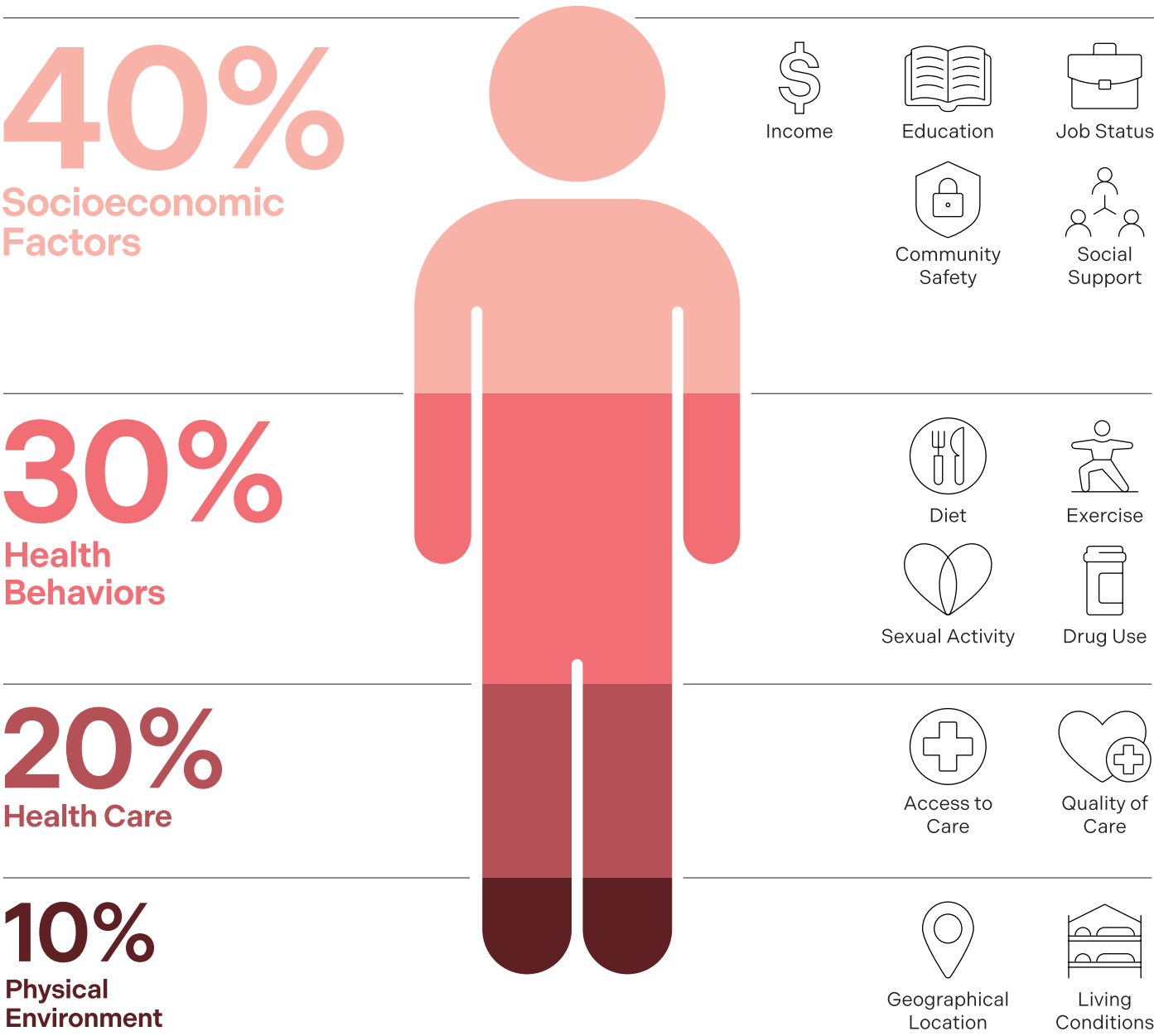


Figure 2: Social Drivers of Health  
Adapted from the Institute for Clinical Systems improvement;  
*Going Beyond Clinical Walls: Solving Complex Problems*, 2014.



AANHPIs are many different ethnicities



East Asians | 8.6 mil

Chinese, Korean, Japanese, Taiwanese, Mongolian, Hong Kong, Macanese, Tibetan



Southeast Asians | 7.6 mil

Filipino, Vietnamese, Cambodian, Thai, Hmong, Laotian, Burmese, Indonesian, Malaysian, Singaporean



South Asians | 5.3 mil

Indian, Pakistani, Bangladeshi, Nepalese, Sri Lankan, Bhutanese, Maldivians



Pacific Islanders | 1.5 mil

Native Hawaiians, Tongans, Samoans, Fijians, Marshallese, Chamorros



Other Asians | 700k

Within AANHPI communities, many disparities go unnoticed due to **false narratives like the “Model Minority Myth,” which assumes that all Asians are successful and have few needs.** This myth reinforces institutionalized stereotypes that create division among minority populations, ultimately hurting the entire community. Additionally, Asian Americans (AAs) and Native Hawaiian and Pacific Islanders (NHPIs) have commonly been grouped together as “the same,” despite being **comprised of 50+ ethnicities, 100+ languages and dialects**, and having origins all throughout Asia and the Pacific Islands (Figure 3).<sup>3,4</sup> Figure 4 shows some *aggregated* (whole) and *disaggregated* (separated) health-related outcomes about the AANHPIs in the U.S., based on available data.<sup>5,6,7,8,9</sup>

**When data is lumped together, the risks, needs, and solutions become invisible.** AANHPI communities were originally labeled as a homogeneous group to standardize government classification systems and to strengthen socio-political representation for AANHPI communities as a whole. But, it has become apparent that aggregation can harm instead of empower, making it more difficult for policy-makers to appropriately and effectively address community-specific barriers. **Currently, only five states have enacted policies for disaggregated data collection.<sup>10</sup> This means that 90% of the U.S. does not formally recognize the 50+ unique ethnicities.** Thus, the purpose of the Change InSight® movement is to capture how AANHPI communities are negatively impacted by aggregation, highlighting the diversity and distinctiveness of these communities.

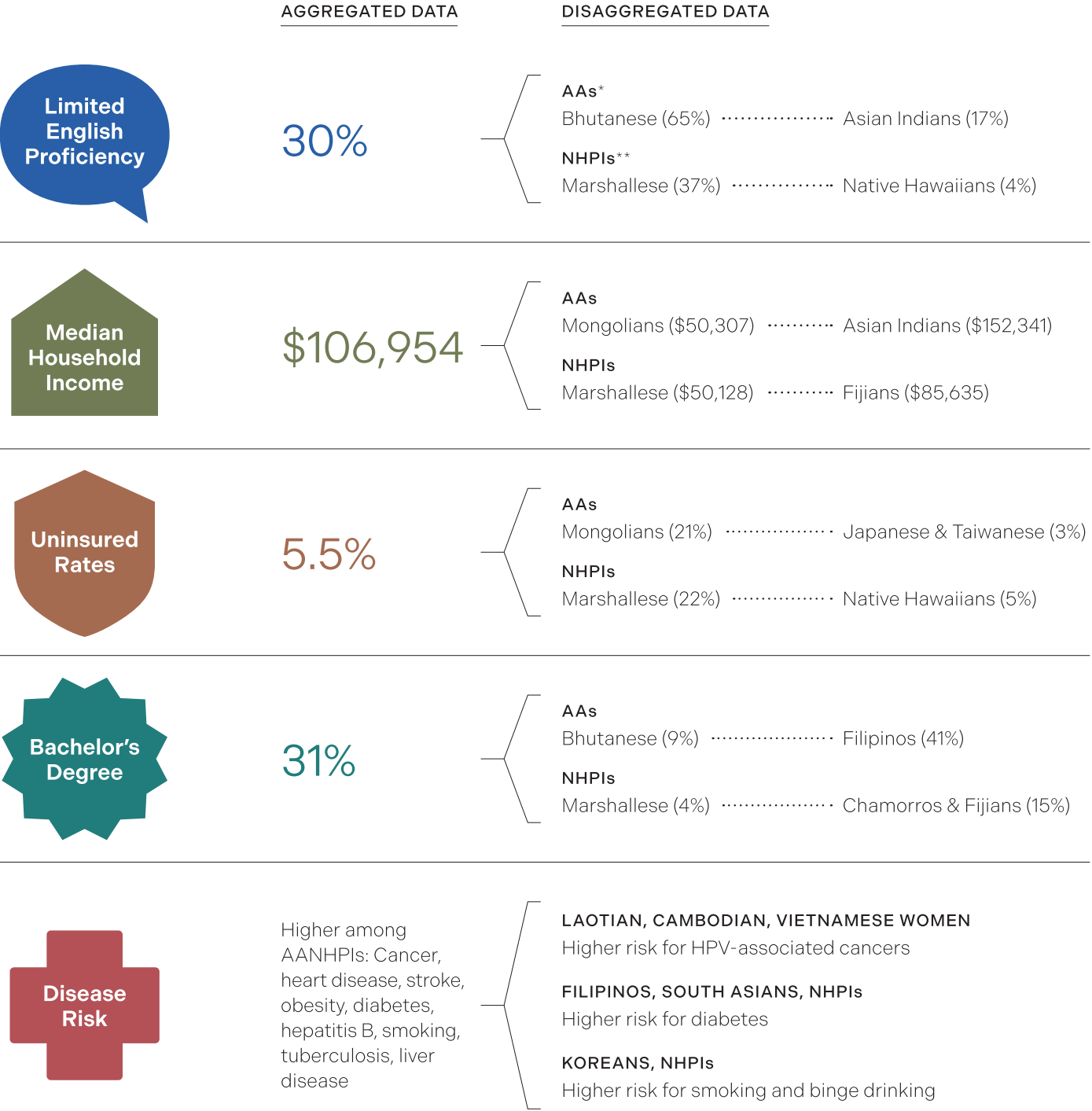
“*Aggregation is a form of erasure of diversity, perspective, and also health needs.*”

— DR. SARA WATERS  
Associate Professor of Human Development  
Washington State University

**Figure 3**  
AANHPIs are comprised of 50+ ethnicities, and have origins all throughout Asia and the Pacific Islands. Only some ethnicities are listed here. Source: Jin, Connie H. 2021. “Asian Americans As Model Minority: Dismantling The Myth.” NPR.

Aggregated and disaggregated health outcomes of AANHPIs

Figure 4



The percentages in the disaggregated data represent the lowest and highest rates.  
\*AAs: Asian Americans | \*\*NHPIs: Native Hawaiians and Pacific Islanders

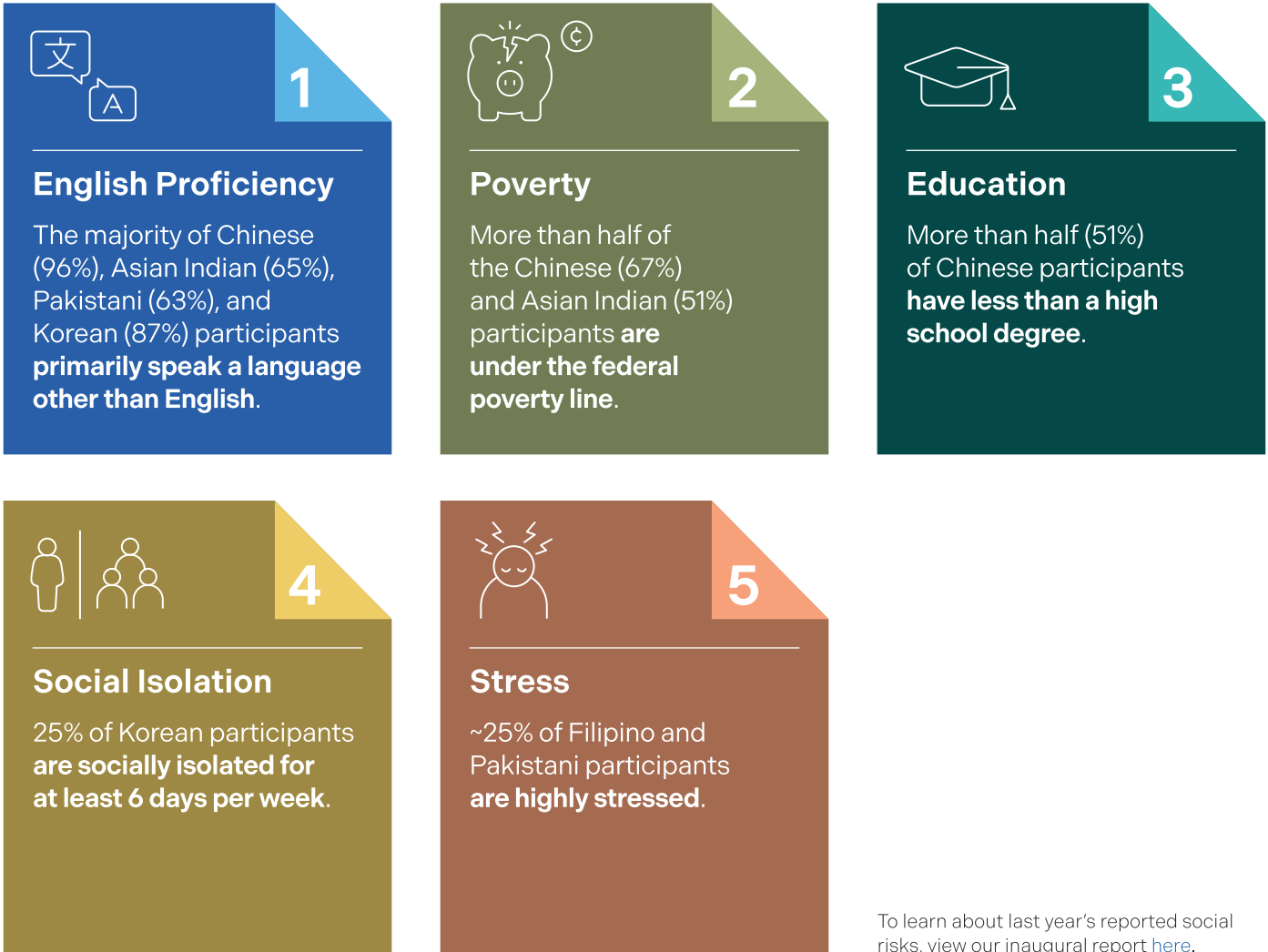


# What We Found

The top 5 AANHPI origin groups<sup>11</sup> represented in the Change InSight® 2023 sample<sup>12</sup> are **Chinese, Indians, Filipinos, Pakistanis, and Koreans**. The top five common risk factors among these communities are **1—English not being a primary language** (low English proficiency), **2—poverty**, **3—education** (less than a high school degree), **4—social isolation**, and **5—stress**. Additionally, among all participants, the largest age group were those 65+ years old.

## Summary of main findings

Figure 5



## 1—Limited English Proficiency

Individuals who do not primarily speak English, or who do not speak English “very well,”<sup>13</sup> are considered to have “limited English proficiency (LEP).” AANHPIs have varying degrees of English proficiency. Among Asian Americans (AAs), it ranges from 17% of Asian Indians to 65% of Bhutanese, while among Native Hawaiians and Pacific Islanders (NHPIs), it ranges from 4% of Native Hawaiians and Chamorros to 37% of Marshallese.<sup>14</sup> **Compared to other races/ethnicities, AANHPIs do not have the highest LEP rates, but they do speak a wider variety of languages.** Although federally funded institutions are regulated to provide meaningful and discrimination-free access to essential services for those with limited English, these populations still struggle to find appropriate and timely healthcare or other essential services.<sup>15, 16</sup> **Only five states and the District of Columbia have enacted policies to improve AANHPI language access, indicating that AANHPIs in the rest of the country are struggling to access health and social services.**<sup>17</sup>

### Why is limited English proficiency a risk?

AANHPI languages are not regarded as common in America, and data shows that individuals speaking AANHPI languages experience greater psychological distress.<sup>18</sup> Middle-aged AANHPIs with LEP have a higher risk of social isolation, which is the fourth most common risk factor in our Change InSight® sample.<sup>19</sup> English that is “imperfect” or spoken with an accent contributes to the stereotype of being a “perpetual foreigner,” leading to stigma and discrimination. Out of all the racial/ethnic groups, AA adults are the most likely to be living in a household where all members speak limited English, and this socially isolates the whole family.<sup>20</sup> Language barriers and insufficient community outreach prevent AANHPIs from applying for citizenship and social support services.<sup>21</sup> Consequently, **AANHPI adults with LEP are more likely to be non-citizens, economically disadvan-**

**tagged, uninsured or on Medicaid, and have only up to a high school/GED education.**<sup>22</sup>

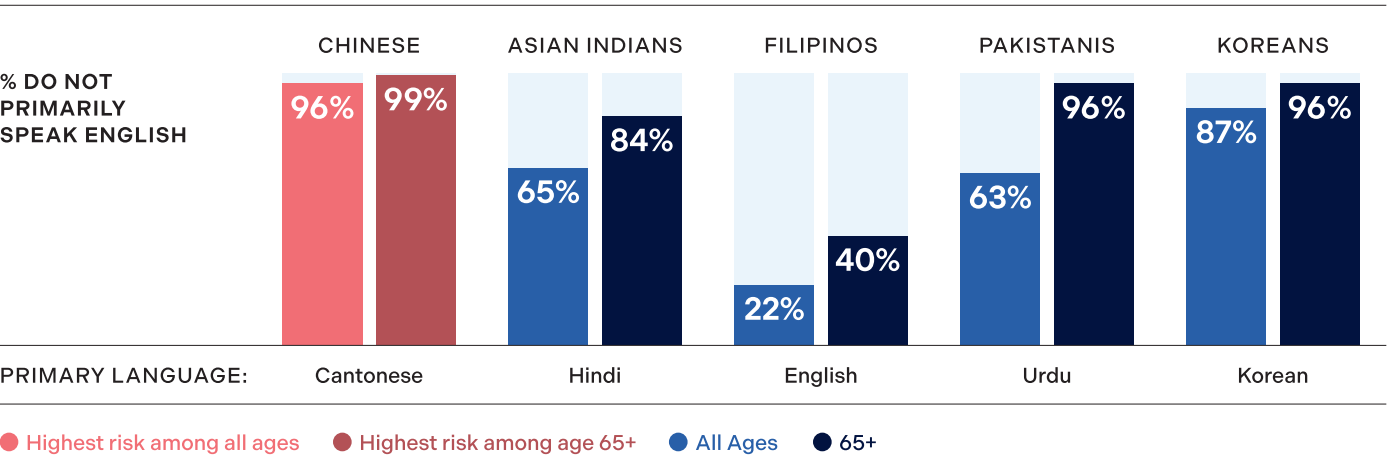
**LEP makes it difficult to not only find appropriate and timely healthcare, but also to understand a doctor's instructions.** Healthcare resources are usually not translated (or are poorly translated) into AANHPI languages. AANHPIs with limited English are nearly twice as likely to have an inconsistent place for care, attend regular check-ups, and experience unmet medical needs.<sup>23</sup> Language services are also expensive; only a few states offer reimbursement for language services through Medicaid and SCHIP, and there is no reimbursement through Medicare or for uninsured individuals. Considering that there are 100+ AANHPI languages and dialects, healthcare and social service information needs to be translated into languages that the community is comfortable with.

### What were our findings?

The majority of Chinese, Asian Indian, Pakistani, and Korean participants speak languages other than English, while the majority of the Filipino participants are comfortable speaking English. Furthermore, the **Chinese community has the highest rate of LEP for both all age groups and for those age 65+.** Chart 1 (below) shows the percentage of participants who do not primarily speak English, as well as their most commonly reported primary language.

It is interesting to note that although most Filipinos in our sample are comfortable speaking English, they ranked LEP as their second top risk factor. This may be because 19% of Filipino respondents are aged 65+, and Filipino seniors make up 40% of the non-English-speaking respondents. Similarly, the **large majority of seniors from the other origin groups speak non-English languages.**

Chart 1: Non-English language use among the top 5 origin groups, for all age groups and for seniors (age 65+)





Recommendations include **providing linguistically and culturally appropriate resources that are more accessible and easier to navigate**. This can be accomplished by offering practical and age-appropriate English classes, increasing employment of bilingual and multilingual workers, and training healthcare professionals to provide linguistically and culturally sensitive services.

In this current sample, the top five AANHPI languages are **Cantonese, Mandarin, Hindi, Korean, and Urdu**. While the language needs of every community are different, commonly spoken languages should be identified and incorporated into linguistically accessible resources.

## 2—Poverty

The federal poverty level (FPL) is a guideline that is commonly used to determine eligibility for public services. It is calculated with the number of people living in a household and the total annual income for that household. The 2023 poverty guidelines start at \$14,580 for one person per household and \$19,720 for two people, increasing by \$5,140 for each additional person.<sup>24</sup>

**AANHPIs have the largest income gap, compared to other racial/ethnic groups.** National poverty rates among AAs range from 6% of Asian Indians to 23% of Mongolians, while NHPI poverty rates range from 10% of Fijians to 29% of Marshallese.<sup>25, 26</sup> Furthermore, **the AANHPI elderly population, usually unseen in aggregate data, has many more financial struggles than the general elderly population.**<sup>27</sup> One of the largest concerns for older AANHPIs is finding affordable senior housing, as residing in subpar living conditions can lead to economic instability, social isolation, and health issues.<sup>28</sup> When looking at the national breakdown of expenses for households making less than \$29,999, 41% of their income goes towards housing.<sup>29</sup> This only leaves 59% of their income for other necessities, such as food, transportation, utilities, and education. The rising cost of housing and associated fees increases the risk for low-income individuals to be unhoused.

### Why is poverty a risk?

Poverty can be caused by societal factors (e.g., systematic racism and discrimination), which can persist for generations. Children growing up in poverty may not have access to quality education or be in a healthy environment, which reduces their chances of having a well-paying job and a healthy lifestyle. Consequently, their own children will often experience the same outcomes. **This cycle is known as the poverty trap, which keeps low-income individuals in**

**poverty.**<sup>30</sup> Being in poverty is associated with shorter life expectancies, higher mortality rates, and chronic health conditions, which significantly reduces quality of life.

Poverty due to unemployment reduces one's ability to pay for nutritious foods, rent or mortgage, and other bills. **During the COVID-19 pandemic, the unemployment rate for AANHPIs reached 24%.**<sup>31</sup> Being unemployed is a health issue because employer-provided health care allows for greater access to higher quality healthcare services. However, low-income workers are also at risk; 33% do not receive health benefits.<sup>32</sup> Without insurance, people may avoid medical care, leading to double or triple the risk of preventable emergency room visits—which are much more costly and detrimental to one's health.<sup>33</sup>

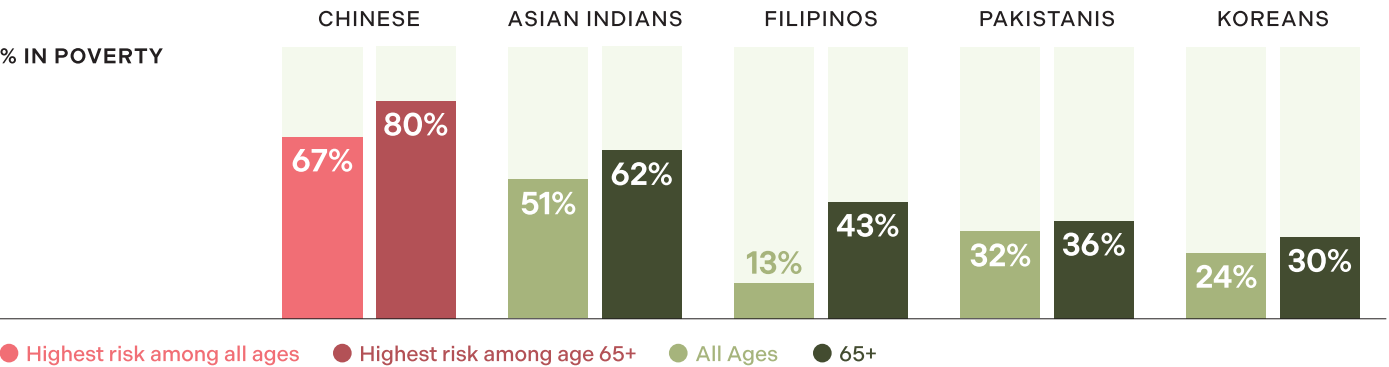
### What were our findings?

**In our sample, 67% of Chinese participants live below the FPL.** In contrast, the smallest percentage of Filipino respondents are under the FPL. These findings are similar on a national scale. When comparing poverty rates among participants aged 65+, **Chinese seniors reported the highest levels of poverty**, while Korean seniors reported the lowest levels.

Most households in our sample had one or two people, so this indicates that the majority of our participants were making less than \$14,580 or \$19,720 per year. Poverty was the second most commonly reported risk among Chinese, Asian Indian, and Pakistani participants, while it was the fourth for Filipinos and Koreans.



Chart 2: Poverty rates among the top 5 origin groups, for all age groups and for seniors (age 65+)



POVERTY  
WHAT CAN WE DO ABOUT IT?

₹ \$

Our findings indicate **the need to increase the accessibility and availability of social services**, such as cash assistance, assisted living and caregiving assistance, food stamps and home-delivered meals, health insurance counseling and enrollment, housing assistance, employment assistance, and utility bill assistance. As prices of essentials continue to rise, public benefits enrollment—especially those who do not speak English—must become a top priority.

Despite the critical role that philanthropy plays in the social services sector, **AANHPI communities receive**

**only 0.2% of philanthropic funding; this translates into \$0.20 out of every \$100.**<sup>34</sup> **This inequity has remained the same since 1992**, even though philanthropic giving overall has increased and the AANHPI population has more than doubled.<sup>35</sup> Low philanthropic investment makes it extremely difficult to provide comprehensive social services for communities in need, so it is particularly important for policymakers to support increased funding for AANHPIs.



3—Education

Education helps people learn daily life skills, social norms, and moral values. This ultimately improves life trajectories by lifting people out of poverty and reducing socioeconomic inequalities.<sup>36, 37</sup> Education facilitates effective communication and critical thinking, and it also promotes gender equality, female empowerment, higher income, and higher child survival rates.<sup>38</sup>

Despite the right to a free, high quality education without discrimination,<sup>39</sup> there are wide gaps in educational attainment among AANHPI students. **South Asian and NHPI children are less likely to complete high school or beyond (and thus less likely to obtain high-paying jobs) than other AA children.** Dropout rates in 2016 for AAs aged 16-24 ranged from 0.7% for Koreans to 56% for Bhutanese.<sup>40, 41</sup> Monthly school absences in 2017 for 8th graders were more common among NHPIs (62%) than AAs (38%).<sup>42</sup> High school completion among AANHPIs varies, ranging from 52% of Burmese to 97% of Taiwanese and Japanese.<sup>43, 44</sup> The rates for college degrees follow a similar trend.<sup>45, 46</sup>

Why is low educational attainment a risk factor?

Learning environments influence health outcomes. Having high quality education during childhood reduces negative health consequences later in life, such as engaging in risky behaviors (e.g., binge-drinking and smoking), obesity, high blood pressure, diabetes, and high cholesterol.<sup>47, 48</sup> High school graduates have greater financial and health-related achievement, earning 24% more than those who did not finish high school.<sup>49</sup> Furthermore, **college graduates have significantly higher chances of maintaining a higher-paying job**, which could improve one's quality of life. During the COVID-19 pandemic, many workers were displaced, but

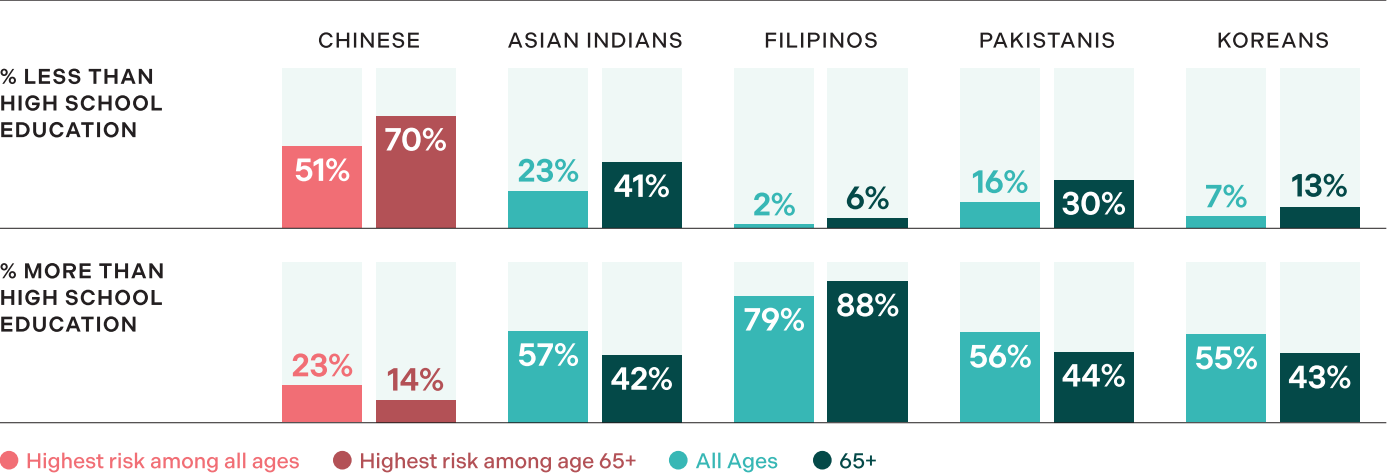
employees with higher education were more likely to keep their jobs and were able to work from home.<sup>50</sup>

Adverse childhood experiences and being in a socio-economically disadvantaged household are notable factors to low educational attainment. Trauma, stress, and financial limitations have been shown to cause learning and behavioral problems.<sup>51</sup> Additionally, **children who grow up in households with limited English proficiency are at an academic disadvantage, compared to their English-fluent counterparts.** Another factor to low educational attainment is bullying. Youth who identify as South Asian, are Muslim, Sikh, Micronesian, LGBTQ+, immigrants, refugees, or have limited English proficiency are the most common targets of bullying.<sup>52</sup> Bullying may stem from a variety of factors such as systemic racism, misogyny, homophobia, inadequate resources or cultural barriers to name a few.<sup>53</sup> This can be an isolating experience for AANHPI youth, resulting in self-hate and suicidal ideations.

What were our findings?

Chinese participants reported the lowest overall educational attainment, with most having less than a high school degree. Filipino participants have the highest level of educational attainment (more than a high school degree), followed by Asian Indian, Pakistani, and Korean participants. These trends are similar when comparing those aged 65+. **Our findings support the association between higher English proficiency and educational success;** 78% of Filipino participants are comfortable speaking English and 79% completed more than high school, while only 4% of Chinese participants feel comfortable with English and 23% completed a high degree.

Chart 3: Educational attainment among the top 5 origin groups, for all age groups and for seniors (age 65+)



EDUCATION  
WHAT CAN WE DO ABOUT IT?



**Low educational attainment can be impacted by many factors and stressors, so the needs of socio-economically disadvantaged households should be at the forefront of social policies.** It is important to link families to social service agencies in order to ensure that they are financially supported through nutrition (SNAP benefits, food pantries), cash assistance, and counseling.

The school environment could also be improved. For example, the Center for American Progress emphasizes a racial equity lens towards policymaking education: recruiting and retaining AANHPI educators and school leaders; supporting AANHPI immigrants, refugees, and English language learners; increasing college readiness and ending disproportionate discipline towards NHPIs; promoting the mental health of AANHPIs; and pre-

serving NHPI languages.<sup>54</sup> Additionally, in 2017, Rhode Island became the third state in the U.S. to pass the “All Students Count Act” to mandate the disaggregation of AANHPI data in K-12 schools.<sup>55</sup> This helps advocate for data disaggregation as the norm, not the exception.

**To reduce bullying and to enhance understanding of AANHPI cultures and histories, more schools can adopt and enforce policies that expand ethnic studies.** Teaching AANHPI histories in public schools have been mandated in 21 states through 26 policies, including the Teaching Equitable Asian American Community History (TEAACH) Act and the Teaching Asian Pacific American History Act.<sup>56, 57</sup> These acts incorporate anti-racist curriculums to enhance understanding and eliminate stereotypes.

“*Too often, the teaching of AANHPI history has been limited to passing references or minor footnotes that barely scratch the surfaces of our diverse and resilient communities.*”

—SENATOR MAZIE HIRONO





4—Social Isolation

Social isolation is when someone has few or no meaningful social interactions with people whom they feel close (such as family and friends). **Studies have shown that when adults have high-quality social interactions, they are healthier, live longer, and have better coping mechanisms for stress, anxiety, and depression.**<sup>58</sup> People may also develop health-promoting attitudes and behaviors if they are more socially connected. For example, Chinese and Filipinos have a higher rate using professional support services if they have a positive social network.<sup>59</sup>

Why is social isolation a risk factor?

Being isolated can result in loneliness, higher levels of stress, mental and physical illness, and death.<sup>60</sup> Severe health concerns include increased risks for dementia (50%), stroke (32%), and heart disease (29%).<sup>61</sup> Some studies show that loneliness increases the risk of mortality by 50%, which is higher than mortality due to air pollution, obesity, or alcohol overuse.<sup>62</sup>

Recent statistics show that **one in ten AANHPI adults have no relatives, friends, or neighbors to rely on for social support.**<sup>63</sup> Additionally, older adults are more at risk for social isolation and loneliness. During the COVID-19 pandemic,

25% of older adults were socially isolated, 43% felt lonely.<sup>64</sup> Although connecting online was an option, many did not have access to or felt comfortable using the internet.<sup>65</sup> Many seniors may also be immunocompromised, and they often have little contact with people they do not live with.<sup>66</sup>

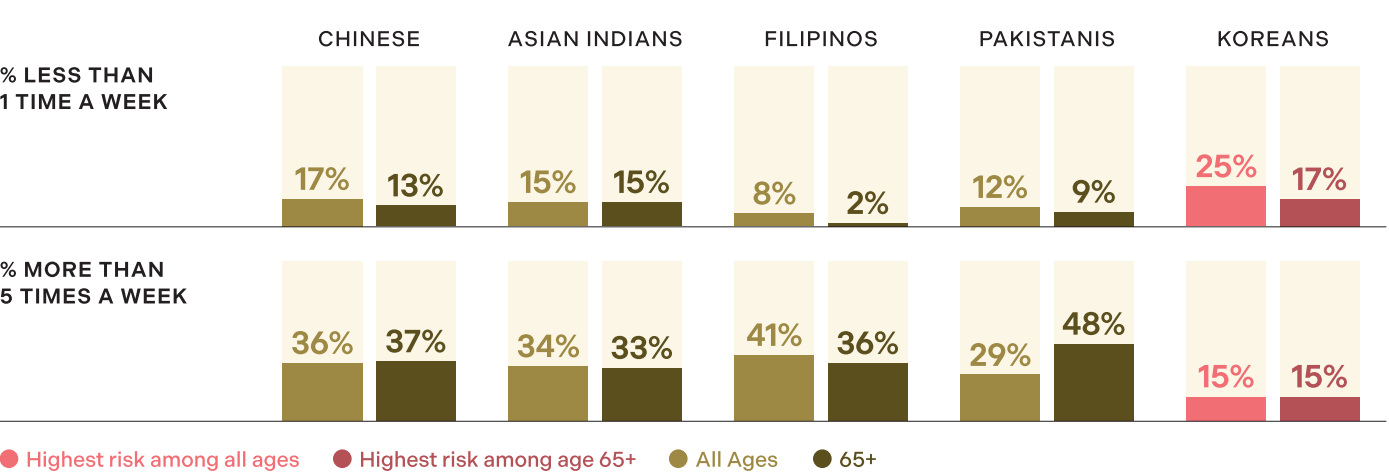
What were our findings?

Generally, across the top five origin groups, most participants had frequent social connections per week. The majority of Chinese, Asian Indians, and Filipino participants typically have more than five meaningful interactions per week. However, **Korean participants have the greatest risk for social isolation; 25% of Korean participants have less than one social interaction per week.**

When looking at age, the majority of Chinese, Asian Indian, Filipino, and Pakistani seniors socially connect more than five times a week. In contrast, most Korean seniors connect three to five times a week. This may be due to the fact that 53% of Koreans are seniors, and that 96% of Korean seniors do not speak English as a primary language. These risks can impact their social interactions within the community.



Chart 4: Frequency of social connections among the top 5 origin groups, for all age groups and for seniors (age 65+)



SOCIAL ISOLATION  
WHAT CAN WE DO ABOUT IT?



**Building a sense of unity, developing wider social networks, and promoting outreach efforts to AANHPIs and vulnerable populations is crucial** in reducing social isolation. Because opportunities for social interaction differ between origin groups and age groups, solutions should be tailored accordingly. For our participants, more attention is needed for the Korean community. Additionally, for seniors in particular, there is a lot of potential to foster social integration. There are over 11,000 senior centers across the U.S., so there should be more active promotion and encouragement to use these spaces.<sup>67</sup>

Our Change InSight® partners provide a variety of social programs that are hosted in culturally-relevant social spaces. Activities include fitness groups, recreational gatherings, crafts, or specific festivities and meals. Age-appropriate programming could be applied to fitness and exercise events, arts and crafts, resource navigation, and leadership opportunities. **To promote these shared spaces, messaging should be easily accessible through more traditional forms of communication (e.g., mail, flyers, and word of mouth). This can help address the varying levels of technological literacy among older adults.**



5—Stress

Stress is a feeling of worry or mental tension that comes from many different factors, including racism, stigma and discrimination, low socioeconomic status, low educational attainment, generational trauma, and adverse childhood experiences (ACEs). A significant risk factor for mental illness is childhood adversity, which includes traumas such as bullying, parental loss, and sexual, emotional, or physical abuse.<sup>68</sup> **Racism and discrimination are commonly neglected considerations when assessing for stress, and these forces have devastating mental, emotional, and physical impacts on racial/ethnic minorities.**

Why is stress a risk factor?

Stress can help in certain situations (for example, when one is in danger), but it becomes a concern when it is long-term (chronic) or very intense.<sup>69,70</sup> **When there are insufficient resources or coping mechanisms for managing stress, it can lead to the development of mental health disorders** (such as depression and anxiety), **metabolic syndrome** (a group of health conditions that result from the dysregulation of body systems, such as the metabolic, inflammatory, and cardiovascular), **or poor lifestyle choices** (including reduced quality of sleep, nutrition, and physical activity).<sup>71</sup>

AANHPIs are largely impacted by stressors such as intergenerational trauma, stereotypes, and microaggressions, which increases the risk for severe health complications. Concerningly, **AANHPI adults report using mental health services the least out of any racial/ethnic population.** In 2021, 77% of an estimated 2.6 million AANHPI individuals in the U.S. did not receive care for a mental health problem.<sup>72</sup> **Compared to White individuals, AAs are 60% less likely and NHPIs are 300% less likely to receive mental health services.**<sup>73</sup>



Limited access to culturally or linguistically appropriate healthcare services, as well as the cultural stigma towards mental illness, contribute to the low rate of seeking mental health support.<sup>74</sup> Additionally, cultural factors can be barriers to resource-seeking: many AANHPIs consider mental health as something that can be independently controlled.<sup>75</sup>

What were our findings?

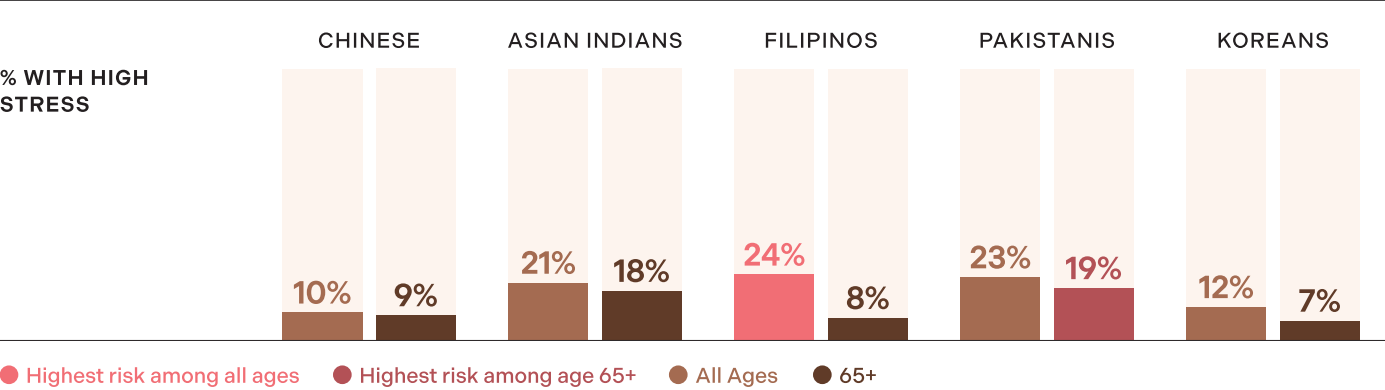
Participants who reported being stressed “quite a bit” or “very much” are considered as “highly stressed.” Among all age groups, **Filipino participants have the highest stress levels, and are closely followed by Pakistani participants.** On the other hand, Chinese participants reported the lowest stress levels. When looking at older age, our results indicate that older adults feel less stressed than their younger counterparts. Pakistani seniors reported the highest stress, and are closely followed by Asian Indian seniors. Korean and Filipino seniors reported the two lowest stress levels.

**While determining one’s stress level is subjective, our findings suggest that Filipino and Pakistani participants experience more stressors, or have less effective coping mechanisms.** Conversely, it is also possible that Chinese and Korean participants may have underreported their stress levels.

Although social connection is a coping mechanism, our findings do not support an association between more social connections and lower stress levels. Filipino and Pakistani respondents have more frequent social interactions than Koreans, but they also have higher stress levels. This suggests that these communities experience stressors that are not resolved through social connection.



Chart 5: High stress levels among the top 5 origin groups, for all age groups and for seniors (age 65+)



STRESS  
WHAT CAN WE DO ABOUT IT?



**Stress management techniques and social support systems can prevent stress from becoming toxic to the body.**<sup>76</sup> Eating healthy, exercising regularly, getting sufficient sleep, journaling, and meditating are all forms of positive self-care. Building a strong support system with friends, family, counselors, or other trusted individuals can also help manage stress. To prevent the develop-

ment of ACEs, resources and support systems should be accessible and available starting at an early age. **Further investigation should be conducted to identify the types of stressors that each community faces.** This can help develop coping mechanisms and solutions that are culturally sensitive and appropriate.



# Next Steps

As we continue to gather SDOH insights, AANHPI-serving CBOs now have a way to address common barriers to health risks through tailored approaches while simultaneously advocating for much-needed resources. Limited English proficiency, poverty, low educational attainment, social isolation, and stress are all risk factors that contribute to poor health outcomes and quality of life.

It can be difficult to know exactly how to address SDOH. Since our sample only includes individuals served by 19 CBOs, these insights are not representative of ethnic communities as a whole. However, using what we know, we can:

- 1
- Evaluate the health and social services we offer
- 2
- Determine gaps in the service delivery models
- 3
- Find or develop interventions to comprehensively address the health and social needs of our communities

## How we move forward

### Language justice for those with limited English proficiency

The majority of Chinese, Pakistani, Korean, and Asian Indian participants reported being more comfortable speaking languages other than English. Additionally, the majority of seniors from these four origin groups had even higher rates of limited English proficiency. The next steps of promoting language access include offering age-appropriate English classes, hiring bi- and multi-lingual workers, and training providers to provide linguistically and culturally sensitive services in languages such as Bengali, Cantonese, Hindi, Korean, Mandarin, Tagalog, Urdu, and Vietnamese.

**POLICY RECOMMENDATION**  
*Implement a statewide language access plan to reduce linguistic barriers by increasing access to programs/services in all state and local agencies for LEP populations. Additionally, support continuous funding for English as a Second Language (ESL) programs that employ culturally competent teachers.*

### Economic assistance for those living below the federal poverty level

Out of our top five communities, Chinese participants reported the highest levels of poverty. An even higher percentage of Chinese seniors live in poverty. We need to empower social service agencies to not only ensure the accessibility of public benefits and caregiving services, but also to advocate for more philanthropic funding to effectively serve our communities.

**POLICY RECOMMENDATION**  
*Strengthen federal poverty reduction efforts with a focus on AANHPI communities, and invest in eradicating root causes of poverty (such as structural barriers). Empower the community by providing low-income families with essential resources and social services, such as SNAP benefits or free meals, tutoring and educational support, and job skills.*



### Educational opportunities for those who need support in the school setting

Filipino participants in our sample had the highest level of educational attainment, whereas the majority of Chinese participants had less than a high school diploma. This trend is also true for Chinese seniors. We can improve educational attainment by supporting students by hiring more AANHPI educators, sharing anti-bullying resources, and teaching AANHPI history as part of everyday curricula.

**POLICY RECOMMENDATION**  
*Support AANHPI communities with resources that promote education, remove barriers to educational attainment, and increase college readiness to ensure that AANHPI students have full access to all educational opportunities. Additionally, invest in scholarships for AANHPI or at-risk youth.*

### Social spaces for those who are socially isolated

Korean participants reported being the least socially connected, while Filipino and Chinese participants had the most frequent social contact. This disparity is exacerbated when considering age: Korean and Asian Indian seniors have higher rates of social isolation than Filipino and Pakistani seniors. Building unity is a process, and requires intentional effort from everybody. Community building activities can include group fitness classes, shared recreation spaces, and cultural demonstrations and performances.

**POLICY RECOMMENDATION**  
*Tailor programs to address social isolation across different age groups, such as providing age-appropriate networking and community-building activities. Increase access to culturally sensitive social support resources among AANHPI communities.*

### Mental health resources for those who are stressed

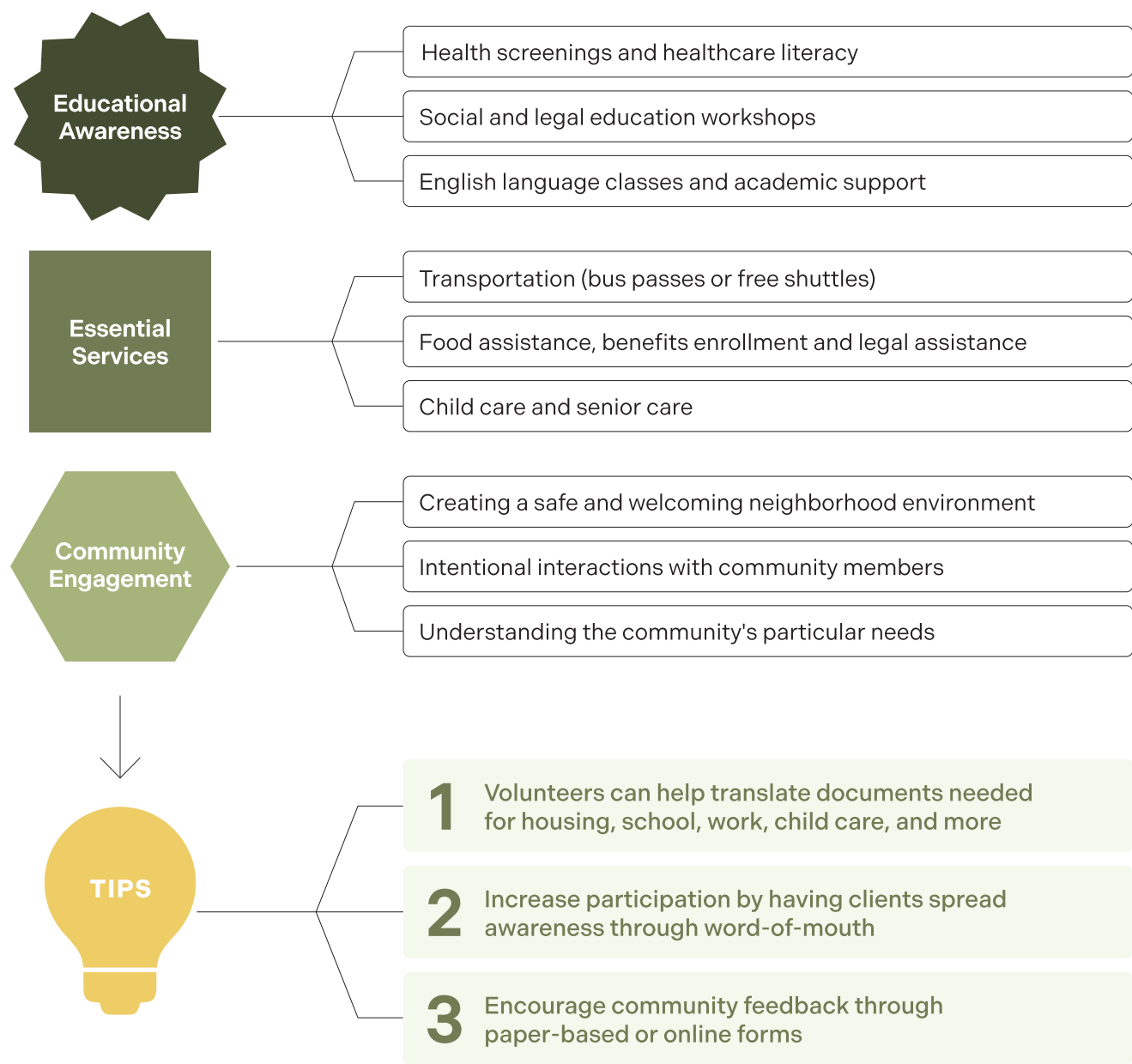
From our sample, Filipino participants reported experiencing stress more often than other communities. Participants under age 65 generally reported being more stressed than the senior participants. Social support and mental health resources can offer security, and can be coupled with community education about self-care and mental wellness to address the stigma of seeking support, promote self-advocacy and self-care, and break the generational cycle of trauma.

**POLICY RECOMMENDATION**  
*Reduce stigma that is associated with accessing mental health support by emphasizing the importance of mental well-being and reducing barriers of access (such as cost and transportation). Increase behavioral health services that are culturally and linguistically sensitive, and that offer personalized clinical treatment for all AANHPI age groups.*



General support to address SDOH and risk factors

The negative impacts of risk factors are well documented, but tailored solutions require **cultural humility**—a willingness to be self-critical and to learn from others. We must recognize that disparities need to be disrupted. Some ways to address the many risk factors, including the ones not highlighted in this report, include:



# A Final Word

**Health disparities are *preventable* and *solvable*.** Change InSight® is addressing the disparities that affect AANHPI communities by using the power of SDOH data. As a whole, it may seem like AANHPIs are better off than other ethnic communities, but that is a myth. When we look at each community separately, we learn that they each have a unique circumstance that creates significant barriers or facilitators to good health.

**Addressing health disparities is not a one-size-fits-all solution;** we must take into account the environment, the community's skills and assets, and the appropriate responses. To address the risk factors that affect our participants, we can develop interventions such as hiring more AANHPI providers to represent the neighborhoods they serve; translating more resources to match the linguistic needs within communities; and teaching the importance of mental wellbeing at an early age.

**Change InSight® is changing the way CBOs approach culturally competent data collection and solutions.** By disaggregating data and developing appropriate solutions for unique health concerns, Change InSight® shines a light on the diverse strengths and needs of the many AANHPI communities.



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