2012-2018

HEALTH ATLAS

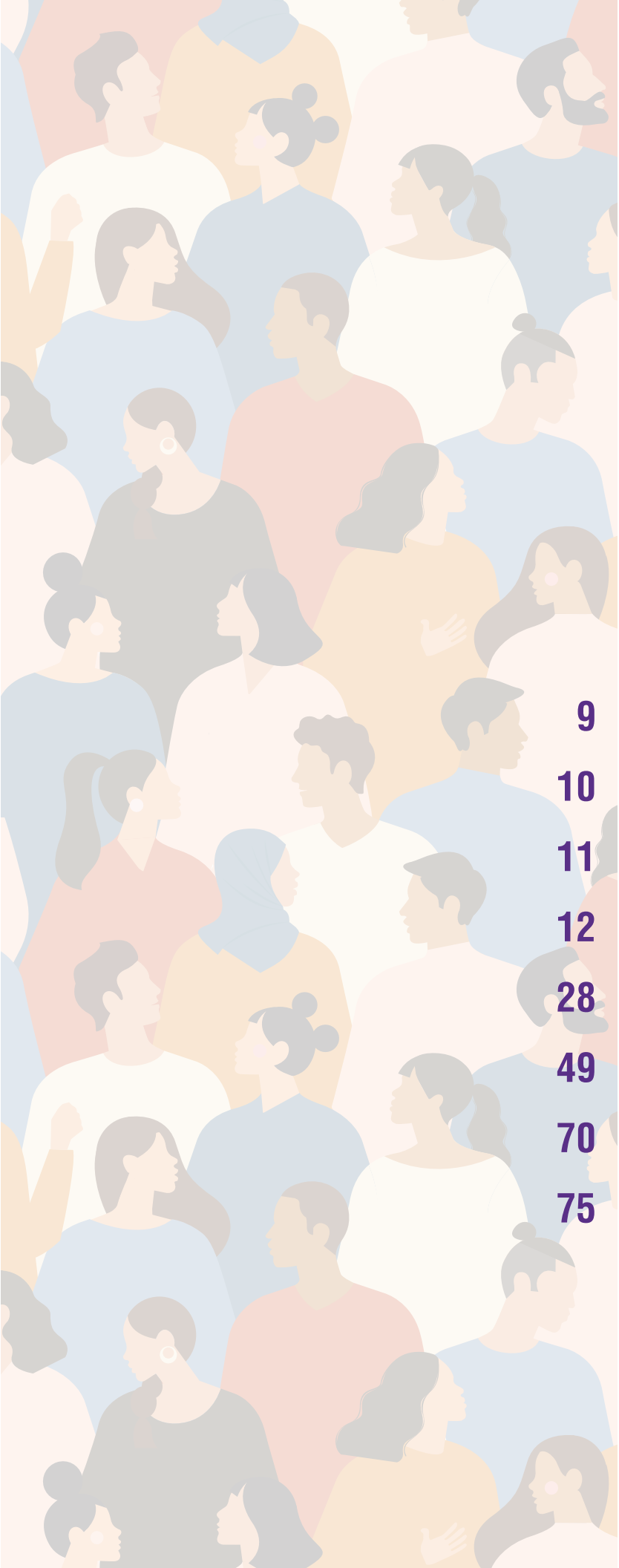
for Asian Americans, Native Hawaiians, and Pacific Islanders

A comprehensive look at AA and NH&PI health in the U.S.

NYU Langone Health

NYU CENTER FOR THE STUDY OF ASIAN AMERICAN HEALTH

DC 4/8/2021 TEMP



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[a]Health Behaviors include: routine check-up, regular health provider, dentist visit, mammogram, Pap test, colonoscopy, flu shot, HIV test

[b]Risk Factors include: diabetes, hypertension, high cholesterol, BMI (≥23, ≥25, ≥27.5, ≥30), asthma, fair/poor self-reported health, food insecurity

[c]Lifestyle Behaviors include: current smoking (overall and by gender), e-cigarettes (ever and current), current drinks alcohol, binge drinking, recommended weekly physical activity, fruits and vegetable intake, daily soda intake

EXECUTIVE SUMMARY

The NYU Center for the Study of Asian American Health (CSAAH) aims to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders (AAs and NH&PIs). There is a substantial body of evidence that demonstrates that AAs and NH&PIs are disproportionately impacted by disease and experience various disparities, with meaningful variation in risk and prevalence across subgroups. Building from a series of community-engaged, community-participatory health resources and needs assessment work, in 2017, CSAAH initiated development of a Health Atlas, a tool to compare AA and NH&PI health disparities in regional communities using local and national datasets. The Health Atlas aims to visually document health disparities in risk factors, disease prevalence, and key health topics across the geographic spectrum of the United States (U.S.), disaggregated by AA and NH&PI subgroups.

CSAAH worked with partners throughout the U.S. to assess and analyze available local and national datasets to create the Health Atlas; the datasets are disaggregated by AA and NH&PI population subgroups whenever possible. Firstly, CSAAH identified U.S. regions with the largest AA and NH&PI populations, which included areas where disaggregated data on AAs and NH&PIs are most readily available, including California, Hawaii, and New York. Secondly, CSAAH identified and included data from regional areas with growing AA or NH&PI populations, including Arizona, Chicago, Texas, and Utah. Arizona, Texas, and Utah are regions represented in CSAAH's National Advisory Committee (NAC) on Research, which is comprised of local and national AA or NH&PI community-based partner organizations and health centers.

The Health Atlas presents a visual comparison of AA and NH&PI population health across local and national datasets. We present the prevalence of health behaviors, risk factors, and lifestyle factors for overall AAs and NH&PIs, as well as for each disaggregated AA or NH&PI subgroup, stratified by dataset, to highlight differences by AA and NH&PI subgroup and geographic location. Aggregated datasets were used in order to increase smaller cell sizes. Detailed information on the datasets and methods are included at the end of this report.

Key findings highlight vast differences in AA and NH&PI health and risk factors, compared to the overall U.S. population, across AA and NH&PI subgroups, and by geographic location. We present critical research methodology and survey administration recommendations in this report in order to strengthen community partnerships and engagement in research to address health disparities in existing and emerging AA and NH&PI populations.

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- Chicago Department of Public Health, who disclaims responsibility for any analysis, interpretations, or conclusions.

The content is solely the responsibility of the authors and does not necessarily represent the official views of the state and local health departments.

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We would also like to thank the CSAAH community and scientific advisory groups for their continued guidance and support of our health disparities research efforts.

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We appreciate our longstanding partnership with the Asian & Pacific Islander American Health Forum (APIAHF), with whom we co-lead our National Advisory Committee and Scientific Committee.

APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

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HEALTH ATLAS: BACKGROUND

The Asian American (AA) population is growing faster than any other racial and ethnic group in the U.S. Between 2000 and 2015, the AA population grew by 72% (from 11.9 million to 20.4 million), and by 2055, it is projected that AAs will become the largest immigrant group in the U.S., surpassing Hispanics in proportion of immigrants.[1] AAs can trace their roots to more than 20 countries in East, Southeast and South Asia, with more than 50 different ethnic subgroups speaking hundreds of languages.[2] Six subgroups accounted for 85% of all AAs in the U.S. in 2015, including Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese.[3] The aggregation of AAs into one group masks the heterogeneity of these culturally and linguistically different AA subgroups and often makes the 15% of AAs making up less than 2% of the population invisible.

Native Hawaiians and Pacific Islanders (NH&PIs) are a distinctly different racial category and diverse group. NH&PIs include individuals of Hawaiian, Samoan, Guamanian or Chamorro, Fijian, Tongan, or Marshallese origins, as well as people from the U.S. jurisdictions of Melanesia, Micronesia, and Polynesia.[4] The 2010 U.S. NH&PI population (alone or in combination) was estimated at 1.2 million, with a growth of 40.1% between 2000 and 2010.[5] The NH&PI group is also the largest to report multiple races (NH&PI and another race) on the Census (56%).[5] Historically, AAs and NH&PIs have been grouped together into one category or combined with other racial/ethnic category, often by government classifications, despite the large diversity seen among these different groups, further masking differences between these very diverse ethnic subgroups. Disaggregating data on AAs and NH&PIs is a necessary step in order to fully understand the needs of AA and NH&PI populations.

While AAs have primarily been concentrated in large urban areas, including San Diego and San Francisco in California and the New York metropolitan area, there are growing populations in other U.S. cities. Between 2000 and 2010, the AA population showed substantial growth within counties in Florida, Texas, Georgia, Arizona, Texas, Illinois, and Nevada.[6] The largest populations of NH&PI groups live in Hawaii and California, followed by Washington, Texas, Florida, Utah, New York, Nevada, Oregon, and Arizona; there are growing NH&PI populations in the Southern U.S.[5]

HEALTH ATLAS DEVELOPMENT

Between 2013 and 2016, NYU Center for the Study of Asian American Health (CSAAH) conducted Community Health Resources and Needs Assessments (CHRNA), large-scale community health surveys serving to examine specific health challenges in diverse, low-income, underserved Asian American (AA) communities in the metropolitan New York City (NYC) area, using a community-engaged, community venue-based survey collection approach. Data from this initial work highlighted significant social, demographic, and economic differences across AA subgroup communities in NYC.

Building off this work, CSAAH initiated development of its Health Atlas in 2017, a tool to compare AA and Native Hawaiian, and Pacific Islander (NH&PI) health disparities in regional communities using local and national datasets. The Health Atlas tool visually documents health disparities in risk factors, disease prevalence, and key health topics across a wide selected geographic spectrum of the United States (U.S), disaggregated by AA and NH&PI subgroups.

To create the Health Atlas, CSAAH worked with partners throughout the U.S. to examine available race and ethnicity data, presenting data disaggregated by AA and NH&PI subgroups whenever possible. Firstly, CSAAH identified U.S. regions with the largest AA and NH&PI populations, which also happen to be areas where disaggregated data on AAs and NH&PIs is also readily available: NYC, California, and Hawaii. Secondly, CSAAH identified and included data from regional areas with growing AA or NH&PI populations, such as Arizona, Chicago, Utah, and Texas. Arizona, Utah, and Texas are regions represented in CSAAH's National Advisory Committee (NAC) on Research, which is comprised of local and national AA or NH&PI community-based partner organizations and health centers. The Health Atlas presents a visual comparison across local and national datasets of AA and NH&PI populations.

To highlight differences by AA and NH&PI subgroup and geographic location, the Health Atlas presents the prevalence of health behaviors, risk factors, and lifestyle factors for overall AAs and NH&PIs, as well as for each disaggregated AA or NH&PI subgroup, stratified by dataset. We present data separately by AA and NH&PI race and compare the prevalence to the national average and overall AA and NH&PI racial group, respectively. The national average was calculated using the 2012-17 National Health Interview Survey (NHIS) or the most recent Behavioral Risk Factor Surveillance System (BRFSS). Aggregated data were used to increase cell sizes. Detailed information and methodologies on the datasets are included at the end of this report.

Data from the following surveys were included: 2012-2017 NHIS, the 2014 NH&PI NHIS, 2013-2017 New York City Community Health Survey (NYC CHS), 2013-2016 NYC CHRNA, 2013-2018 California Health Interview Survey (CHIS), 2015 & 2018 Los Angeles County Health Survey (LACHS), 2015-2017 Health Chicago Survey (HCS), and 2013-2017 Arizona, Texas, and Utah Behavioral Risk Factor Surveillance Survey (BRFSS), 2013-2018 Hawaii BRFSS. All datasets included adults ages 18 and older. Table 1 provides detailed information about each survey, survey years, survey administration languages, methods, AA and NH&PI subgroups included and data availability.

TABLE 1: SOURCES OF DATA FOR THE HEALTH ATLAS

Survey	Years	Languages	Methods	AA and NH&PI subgroups included	Availability
National Health Interview Survey (NHIS)	2012-2017	English, Spanish	Cross-sectional, yearly interviewing, conducted in-person by trained interviewers, non-institutionalized adult population aged 18 and older	Chinese, Asian Indian, Filipino, NH&PI	Data available online for Chinese, Asian Indian, and Filipino subgroups (all years) and NH&PI (2014); Additional AA subgroups require special access.
New York City Community Health Survey (NYC CHS)	2013-2017	English, Spanish, Chinese, Russian	Cross-sectional, yearly interviewing, conducted over landline and cellular phones, non-institutionalized adult population aged 18 and older	Chinese, South Asian, Filipino, Korean, Japanese, Vietnamese	Limited data available online; Asian subgroups and combined weights available through Data Use Agreement
New York City Community Health Resources and Needs Assessments (NYC CHRNA)	2013-2016	English, Mandarin, Korean, Japanese, Vietnamese	Cross-sectional, one survey administration, conducted in-person, community sampling strategies with venue-based approaches, adults, aged 18-85	Chinese, Asian Indian, Filipino, Korean, Japanese, Vietnamese	Data available through Data Use Agreement with NYU CSAAH
California Health Interview Survey (CHIS)	2013-2018	English, Spanish, Mandarin, Cantonese, Korean, Tagalog, Vietnamese	Cross-sectional, conducted over landline and cellular phones, interviewing on a continuous basis, non-institutionalized residential population of adults aged 18 and older	Chinese, South Asian, Filipino, Korean, Japanese, Vietnamese	Data available online for Chinese, Filipino, Korean, Vietnamese, and Japanese subgroups; South Asian and NH&PI subgroups available on 2-year datasets with a Data Use Agreement.
Los Angeles County Health Survey (LACHS)	2015 & 2018	English, Spanish, Mandarin, Cantonese, Korean, Vietnamese	Cross-sectional, conducted over landline and cellular phones, two years of data collection, population-based sample of adults aged 18 and older	Chinese, South Asian, Filipino, Korean, Japanese, Vietnamese	Statistician ran data and filled out tables by request
Healthy Chicago Survey (HCS)	2015-2017	English, Spanish	Cross-sectional, yearly interviewing, conducted over landline and cellular phones, non-institutionalized adult population aged 18 and older	Chinese, Asian Indian	Available through Data Use Agreement with the Chicago Department of Public Health
Behavioral Risk Factor Surveillance System (BRFSS) - Arizona	2013-2017	English, Spanish	Cross-sectional, yearly interviewing, conducted over landline and cellular phones, non-institutionalized adult population aged 18 and older	Chinese, Asian Indian, Filipino, NH&PI	Limited data available online; Asian subgroups available through a Data Use Agreement.
Behavioral Risk Factor Surveillance System (BRFSS) – Hawaii	2013-2018	English, Spanish	Cross-sectional, yearly interviewing, conducted over landline and cellular phones, non-institutionalized adult population aged 18 and older	Chinese, Asian Indian, Filipino, Korean, Japanese, Vietnamese, Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander	Data was queried using the Hawaii-indicator based information system online tool.
Behavioral Risk Factor Surveillance System (BRFSS) – Texas	2013-2017	English, Spanish	Cross-sectional, yearly interviewing, conducted over landline and cellular phones, non-institutionalized adult population aged 18 and older	Chinese, Asian Indian, NH&PI	Data available online; Asian subgroups available through a Data Use Agreement.
Behavioral Risk Factor Surveillance System (BRFSS) – Utah	2013-2017	English, Spanish	Cross-sectional, yearly interviewing, conducted over landline and cellular phones, non-institutionalized adult population aged 18 and older	Chinese, Asian Indian, Japanese, NH&PI	Data available at cost through a Data Use Agreement.

MAIN FINDINGS

Below are some of the main findings our team gathered after analyzing, comparing, and presenting data from the aforementioned datasets.

Among AA subgroups compared to U.S. adults:

- A low prevalence of a dentist visit was seen among Asian Indian adults in NYC, and among South Asian adults in LA County;
- Chinese, Asian Indian/South Asian, Filipino, Korean, and Vietnamese adults had a low prevalence of an up-to-date Pap test, while Japanese adults had a higher prevalence;
  Chinese adults in NYC, LA County, and Chicago; and Vietnamese adults in NYC and LA County.
- Overall AA had low prevalence of an up-to-date colonoscopy; however much of the AA subgroup data was suppressed;
- Nearly all groups had a high prevalence of a flu shot in the past year, with the highest prevalence seen among Filipino and South Asian/Asian Indian adults;
- A high prevalence of diabetes was seen among Filipino, Asian Indian/South Asian, and Korean adults, and hypertension and cholesterol prevalence was high among Filipinos;
- Overall AA had low BMI, but highest prevalence was seen among Filipino and South Asian/Asian Indian adults;
- Fair/poor self-reported health was high among Chinese in NYC and California as well as Vietnamese and Korean adults;
- Korean and Vietnamese men had high current smoking prevalence;
- Overall AA women had low current smoking, but a high prevalence was seen among Filipino women in NYC;
- Filipino, Korean, and Japanese adults had high current e-cigarette usage;
- Filipino, Korean, and Chinese adults had low fruit and vegetable intake; and
- Japanese adults in NYC and California had a high prevalence of current alcohol use.

Among NH&PI subgroups compared to U.S. adults:

- Regionally, NH&PI overall had a low prevalence of a check-up in the past year;
- All NH&PI subgroups had high diabetes and high cholesterol prevalence;
- Among all overall NH&PI groups except in California, hypertension prevalence was high as well as among Native Hawaiian, Samoan, and Other Pacific Islander adults in Hawaii;
- High BMI prevalence was seen among most NH&PI subgroups except for overall NH&PI in Texas
- Asthma was high in all NH&PI groups except in Utah and California (CHIS);
- Fair/poor self-reported health was high in all overall NH&PI subgroups except in Arizona, and the highest prevalence was seen among Samoan adults in Hawaii;
- Current smoking prevalence was high among all NH&PI groups (overall and men) except in Utah;
- Current smoking prevalence among women was high among all NH&PI subgroups in Hawaii;
- Current e-cigarette usage was high among all NH&PI groups; and
- Binge drinking was high in all NH&PI groups, except in Utah.

Our analyses highlight important differences by AA and NH&PI subgroup related to health behaviors, risk factors, and lifestyle factors. Moreover, our findings provide key insight on what data is absent, thereby providing guidance for future data collection efforts looking to assess population-level data.

ACTION STEPS & IMPLICATIONS

We believe the disaggregation of health-related data on AA and NH&PI subgroups will shed light on disparities that exist among these populations as well as on differences by geographic location. Disaggregated data on AAs and NH&PIs is lacking, as can be seen from the small numbers available or absence of data in some of the regional datasets, despite combining multiple years of survey data. We recommend the following steps for health survey research, methodology, survey administration, and data collection at local, state, and national levels.

1. Consider data collection strategies (such as oversampling) when conducting research in underrepresented populations, particularly in new, emerging, or growing AA and NH&PIs subgroups.
   • Model: The Asian & Pacific Islander American Health Forum (APIAHF) – a longtime partner of CSAAH – has been working towards the collection of disaggregated racial/ethnic data in a Robert Wood Johnson Foundation-funded project.[7]

2. Collect health survey responses in-language, specifically in languages other than English and Spanish, in order to include and better represent the changing and diverse AA and NH&PI subgroup landscape of the U.S.
   • Tip: Reach out and provide resources for local, community-based organizations to conduct survey tool translations are a productive way to both recruit participants and build local partnerships.

3. Ensure survey question wording and survey administration methods are culturally and linguistically tailored to AA and NH&PI subgroups' unique sociodemographic, cultural, and health needs.
   • Tip: Consider the health literacy and linguistic ability of the target population to determine ideal methods to collect the highest quality data.

4. Correct the omission, aggregation, or extrapolation in the reporting of AA and NH&PI data. Excluding data perpetuates stereotypes about AA and NH&PI subgroups that contributes to research biases, encourages false assumptions about AAs and NH&PIs, and contributes to the invisibility of AAs and NH&PIs in data.
   • Tip: If sample sizes for AA and NH&PI subgroups are too small to make reliable estimates, acknowledge this in the results and interpretation of findings. If AA or NH&PI data are not present or unavailable, explain this in the methods and conclusions do not exclude them in the results. If AA and NH&PI data are reported together, explain why the data did not allow for reporting on AAs and NH&PIs separately.

The COVID-19 pandemic has had a significant impact on racial and ethnic minority populations disproportionately burdened with chronic conditions, many of whom are particularly vulnerable to the effects of the pandemic due to structural inequities affecting their access to health care, risk of occupational exposure to infection, experiences of racism and discrimination, and economic stability.

The pandemic has demonstrated the urgency and importance of the collection and reporting of disaggregated data – to understand what populations have been hardest hit, to illuminate existing health gaps that have been exacerbated by COVID-19, and to ensure that already vulnerable populations, including AAs and NH&PIs, are not further ignored in the emergency response. Timely, accessible, and disaggregated race and ethnicity data is necessary to ensure there is an effective plan for the equitable distribution of testing, vaccinations, and resources to respond to the COVID-19 pandemic.

RELATED PRODUCTS

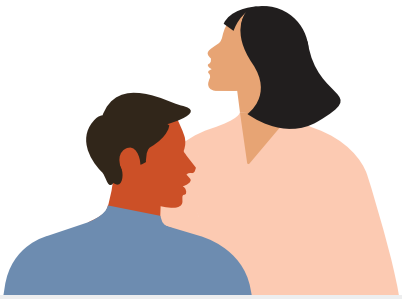
In addition to this Health Atlas, NYU CSAAH is developing complimentary products for use including:

- Addition of AA, NH&PI, and Latinx subgroups to the City Health Dashboard[2]
- Health Atlas: Maps Book – a tool that displays geographic distributions of AA and NH&PI subgroups across various cities in the U.S. and highlights rapid growth areas/regions

HOW TO USE THE HEALTH ATLAS

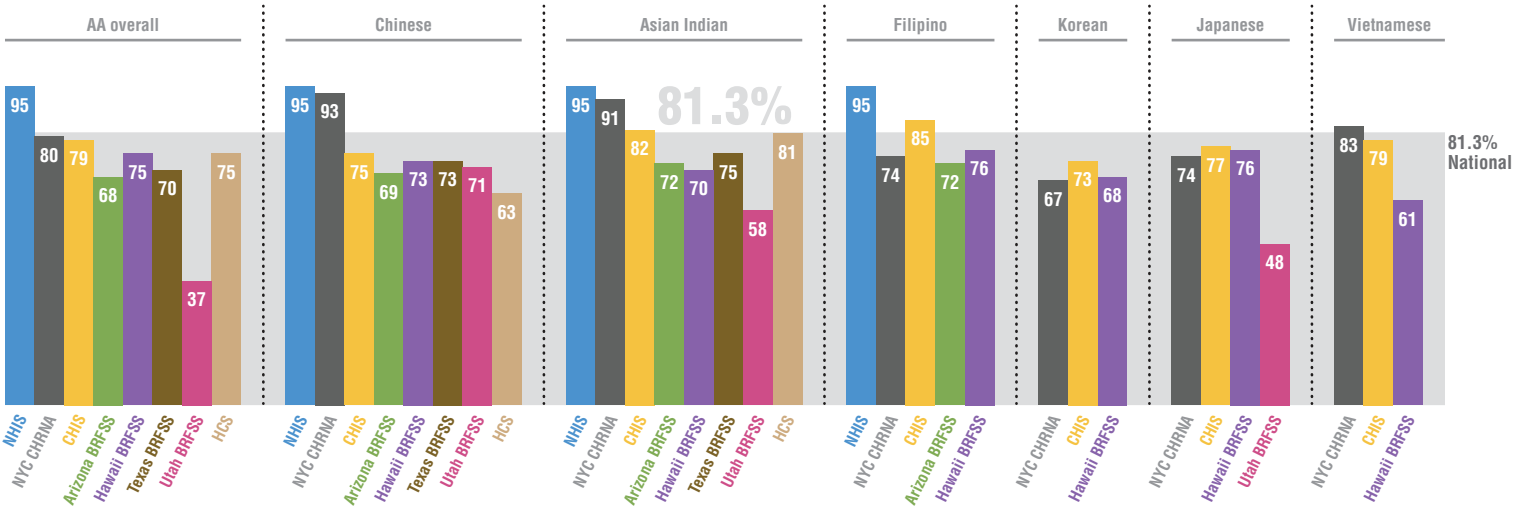
Here is a brief summary of how to use and digest the information presented in the Health Atlas tool.

- On each page, you will see a bar chart presenting prevalence for a specified health issue/concern.
- Each shaded bar on the chart represents a different dataset. Bars are grouped into aggregated and disaggregated AA and NH&PI subgroups
- Aggregated subgroup data appears toward the left part of the page, followed by individual AA or NH&PI subgroups.
- National prevalence is shown in a contrasting shaded grey wall behind the bars for easy comparison to datasets and subgroups.
- A box below the chart includes technical notes and a key defining each of the abbreviated datasets on each page.
- Bolded text summarizes selected key findings and interpretations of the data at the bottom of each page.
- A more detailed explanation of each dataset, AA and NH&PI subgroup definitions, and further technical notes can be found at the end of the Health Atlas tool.



1. HEALTH BEHAVIORS

Had a routine check-up in past year by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-2018); CHIS, California Health Interview Survey 2013-18; HCS, Healthy Chicago Survey 2015-17; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16

[1]AA and NH&PI in place of AA – HCS; [2]South Asian in place of Asian Indian - CHIS

[3]Crude prevalence - NYC CHRNA and Hawaii BRFSS

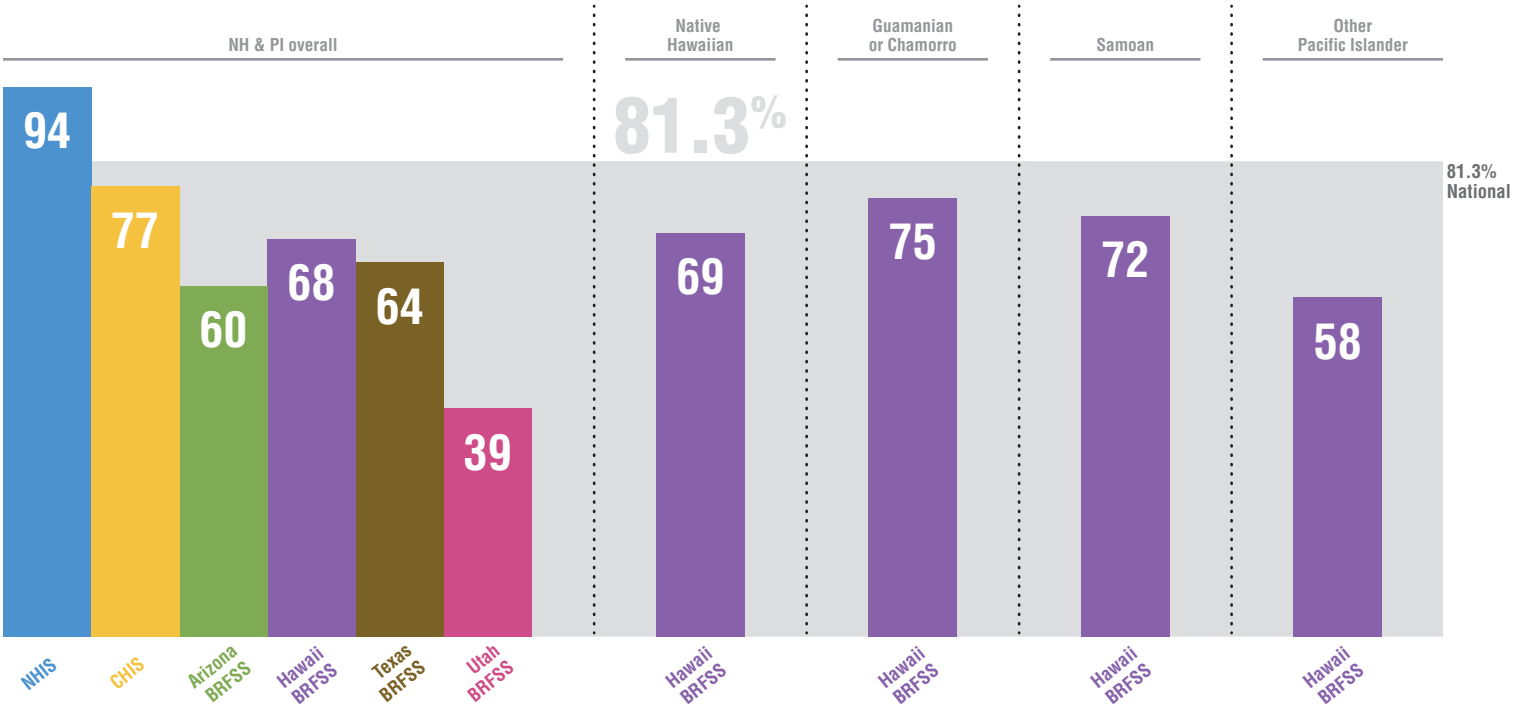
[4]Question not asked on NYC CHS or LACHS

- The overall national prevalence of a routine check-up in the past year was 81.3%, from the 2012-2017 NHIS.
- Nationally, prevalence of a routine check-up in the past year was 95% among AA overall, 95% among Chinese, 95% among Asian Indian, and 95% among Filipino.
- Regionally, prevalence of routine check-up in the past year among AA overall was 80%[1,3] in NYC (NYC CHRNA), 79% in California, 68% in Arizona, 75%[3] in Hawaii, 70% in Texas, 37% in Utah, and 75%[1] in Chicago.

WHILE THE PREVALENCE OF A ROUTINE CHECK-UP IN THE PAST YEAR WAS 81.3% NATIONWIDE:

- In NYC, prevalence of a routine check-up in the past year was 93%[3] among Chinese, 91%[3] among Asian Indian, 74%[3] among Filipino, 67%[3] among Korean, and 74%[3] among Japanese.
- In California, prevalence of a routine check-up in the past year was 75% among Chinese, 82%[2] among South Asian, 85% among Filipino, 73% among Korean, 77% among Japanese, and 79% among Vietnamese.
- In Arizona, prevalence of a routine check-up in the past year was 69% among Chinese, 72% among Asian Indian, and 72% among Filipino.
- In Hawaii, prevalence of a routine check-up in the past year was 73%[3] among Chinese, 70%[3] among Asian Indian, 76%[3] among Filipino, 68%[3] among Korean, 76%[3] among Japanese, and 61%[3] among Vietnamese.
- In Texas, prevalence of a routine check-up in the past year was 73% among Chinese and 75% among Asian Indian.
- In Utah, prevalence of a routine check-up in the past year was 71% among Chinese, 58% among Asian Indian, and 48% among Japanese.
- In Chicago, prevalence of a routine check-up in the past year was 63% among Chinese and 81% among Asian Indian.

Had a routine check-up in past year by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-17; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

[1]Crude prevalence - Hawaii BRFSS

[2]Question not asked on LACHS

- The overall national prevalence of a routine check-up in the past year was 81.3%, from the 2012-2017 NHIS.
- Nationally, prevalence of a routine check-up in the past year among NH&PI overall was 94%.
- Regionally, prevalence of a routine check-up in the past year among NH&PI overall was 77% in California, 60% in Arizona, 68%[1] in Hawaii, 64% in Texas, and 39% in Utah.

WHILE THE PREVALENCE OF A ROUTINE CHECK-UP IN THE PAST YEAR WAS 81.3% NATIONWIDE:

- In Hawaii, prevalence of a routine check-up in the past year was 69%[1] among Native Hawaiian, 75%[1] among Guamanian or Chamorro, 72%[1] among Samoan, and 58%[1] among Other Pacific Islander.

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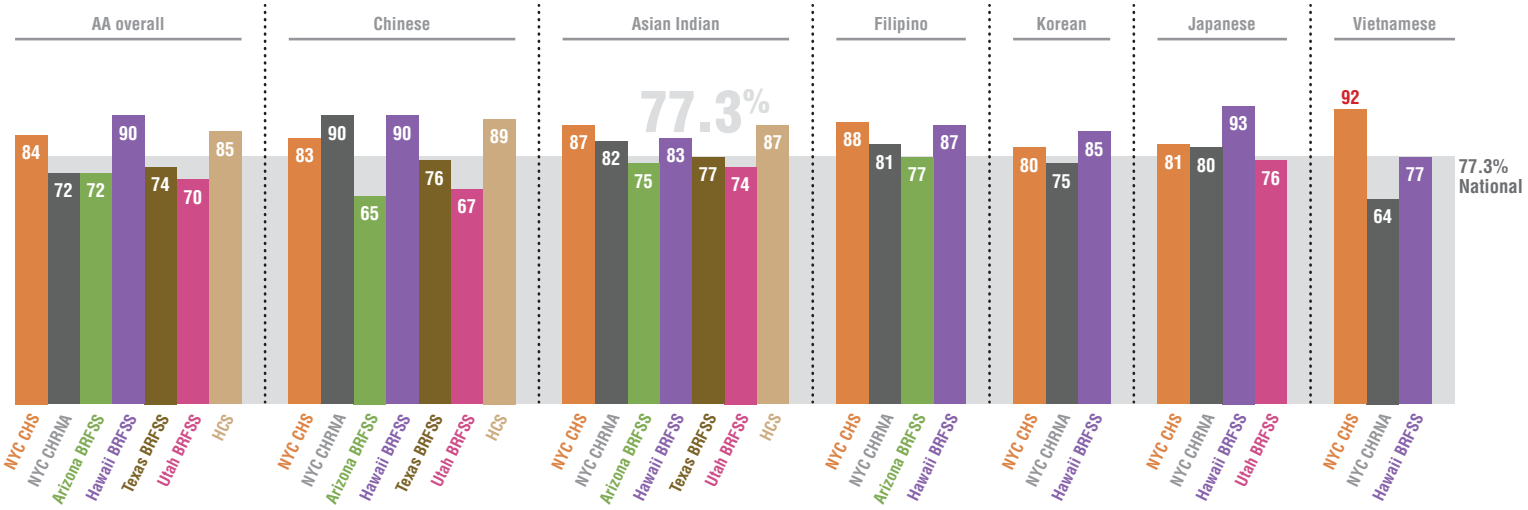
Has a regular health provider by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); HCS, Healthy Chicago Survey 2015-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Vietnamese

[2]AA and NH&PI in place of AA – NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS

[4]Crude prevalence - NYC CHRNA, Hawaii BRFSS and 2018 National BRFSS (national prevalence)

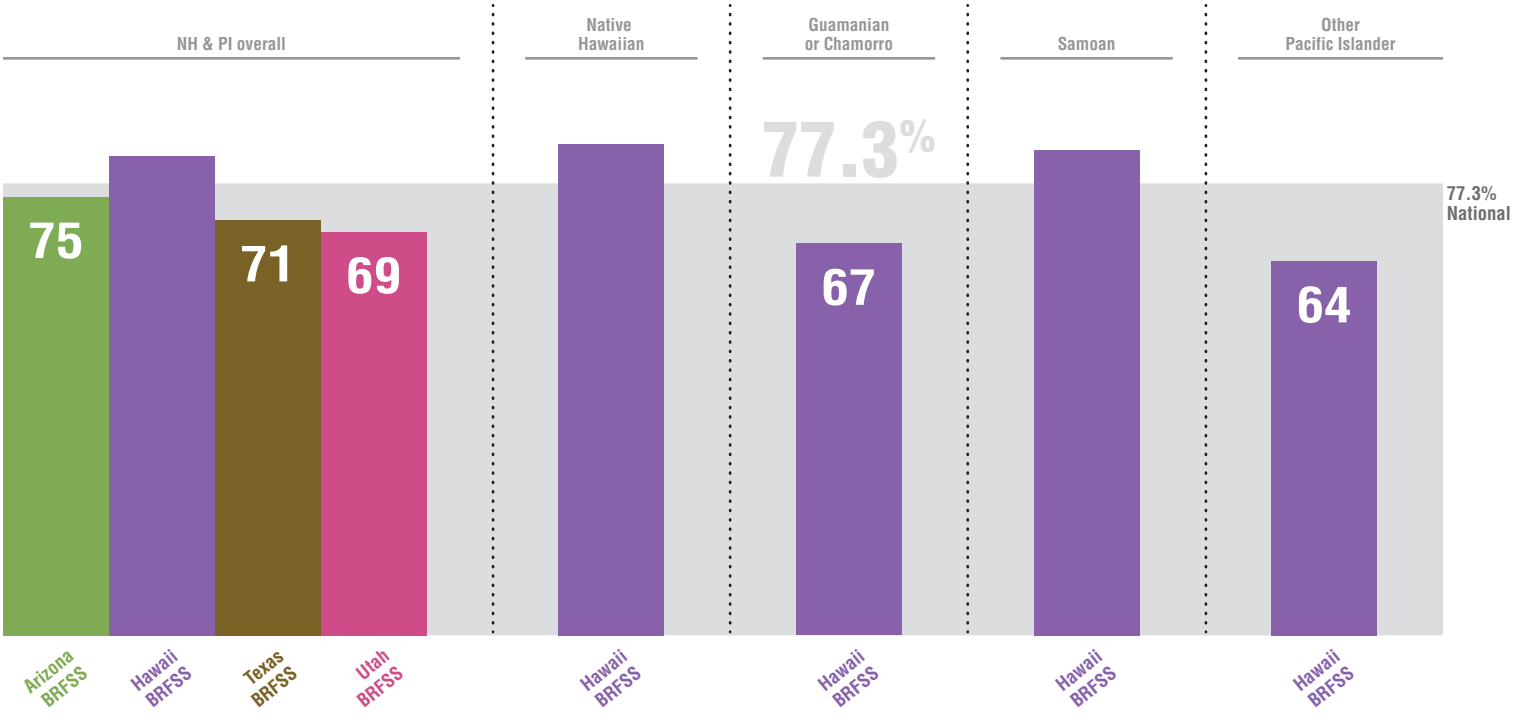
[5]Question not asked on NHIS, CHIS or LACHS

- **The overall national prevalence of having a regular health provider was 77.3%[4], from the 2018 BRFSS.**
- **Regionally, prevalence of having a regular health provider among AA overall was 84%[2] in NYC (NYC CHS), 72%[4] in NYC (NYC CHRNA), 72% in Arizona, 90%[4] in Hawaii, 74% in Texas, 70% in Utah, and 85%[2] in Chicago.**

WHILE THE PREVALENCE OF HAVING A REGULAR HEALTH PROVIDER WAS 77.3% NATIONWIDE:

- **In NYC (NYC CHS), prevalence of having a regular health provider was 83% among Chinese, 87%[3] among South Asian, 88% among Filipino, 80% among Korean, 81% among Japanese, and 92%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of having a regular health provider was 90%[4] among Chinese, 82%[4] among Asian Indian, 81%[4] among Filipino, 75%[4] among Korean, 80%[4] among Japanese, and 64%[4] among Vietnamese.**
- **In Arizona, prevalence of having a regular health provider was 65% among Chinese, 75% among Asian Indian, and 77% among Filipino.**
- **In Hawaii, prevalence of having a regular health provider was 90%[4] among Chinese, 83%[4] among Asian Indian, 87%[4] among Filipino, 85%[4] among Korean, 93%[4] among Japanese, and 77%[4] among Vietnamese.**
- **In Texas, prevalence of having a regular health provider was 76% among Chinese and 77% among Asian.**
- **In Utah, prevalence of having a regular health provider was 67% among Chinese, 74% among Asian Indian, and 76% among Japanese (76%).**
- **In Chicago, prevalence of having a regular health provider was 89% among Chinese and 87% among Asian Indian.**

Has a regular health provider by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); NH&PI, Native Hawaiian & Pacific Islander

[1]Crude prevalence – Hawaii BRFSS and 2018 National BRFSS (national prevalence)

[2]Question not asked on NHIS, CHIS or LACHS

- The overall national prevalence of having a regular health provider was 77.3%[1], from the 2018 BRFSS.
- Regionally, prevalence of having a regular health provider among NH&PI overall was 75% in Arizona, 82%[1] in Hawaii, 71% in Texas, and 69% in Utah.

WHILE THE PREVALENCE OF HAVING A REGULAR HEALTH PROVIDER WAS 77.3% NATIONWIDE:

- In Hawaii, prevalence of having a regular health provider was 84%[1] among Native Hawaiian, 67%[1] among Guamanian or Chamorro, 83%[1] among Samoan, and 64%[1] among other Pacific Islander.

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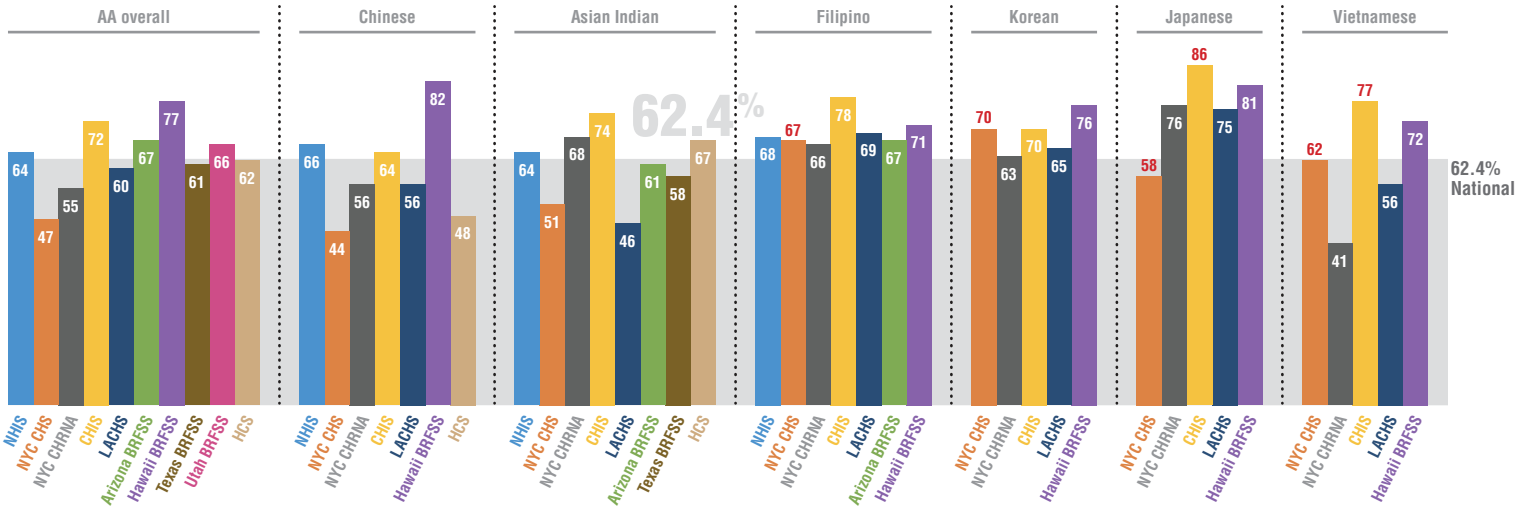
Dentist visit in past year by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2014, 2016 & 2018; CHIS, California Health Interview Survey 2013-14, 2017-18; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-14

[1]Interpret with caution: NYC CHS Filipino, Korean, Japanese, and Vietnamese; CHIS Japanese and Vietnamese

[2]AA and NH&PI in place of AA – NYC CHS and HCS; [3]South Asian in place of Asian Indian – NYC CHS, CHIS and LACHS.

[4]Crude prevalence - NYC CHRNA and LACHS: [5]Estimates were suppressed for Arizona BRFSS Chinese; Texas BRFSS Chinese; Utah BRFSS Chinese, Asian Indian and Japanese

- The overall national prevalence of a dentist visit in the past year was 62.4%, from the 2012-2017 NHIS.
- Nationally, prevalence of dentist visit in the past year was 66% among Chinese, 64% among Asian Indian, and 68% among Filipino.
- Regionally, prevalence of a dentist visit in the past year among AA overall was 47%[2] in NYC (NYC CHS), 55%[4] in NYC (NYC CHRNA), 72% in CHIS, 60%[4] in LA County, 67% in Arizona, 77% in Hawaii, 61% in Texas, 66% in Utah, and 62%[2] in Chicago.

WHILE THE PREVALENCE OF A DENTIST VISIT IN THE PAST YEAR WAS 62.4% NATIONWIDE:

- In NYC (NYC CHS), prevalence of a dentist visit in the past year was 44% among Chinese, 51%[3] among South Asian, 67%[1] among Filipino, 70%[1] among Korean, 58%[1] among Japanese, and 62%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of a dentist visit in the past year was 56%[4] among Chinese, 68%[4] among Asian Indian, 66%[4] among Filipino, 63%[4] among Korean, 76%[4] among Japanese, and 41%[4] among Vietnamese.
- In California, prevalence of a dentist visit in the past year was 64% among Chinese, 74%[3] among South Asian, 78% among Filipino, 70% among Korean, 86%[1] among Japanese, and 77%[1] among Vietnamese; in LA County, prevalence of a dentist visit in the past year was 56%[4] among Chinese, 46%[3,4] among South Asian, 69%[4] among Filipino, 65%[4] among Korean, 75%[4] among Japanese, and 56%[4] among Vietnamese.
- In Arizona, prevalence of a dentist visit in the past year was 61% among Asian Indian and 67% among Filipino
- In Hawaii, prevalence of a dentist visit in the past year was 82% among Native Hawaiian, 71% among Filipino, 76% among Korean, 81% among Japanese, and 72% among Vietnamese.
- In Texas, prevalence of a dentist visit in the past year was 58% among Asian Indian.
- In Chicago, prevalence of a dentist visit in the past year was 48% among Chinese and 67% among Asian Indian.

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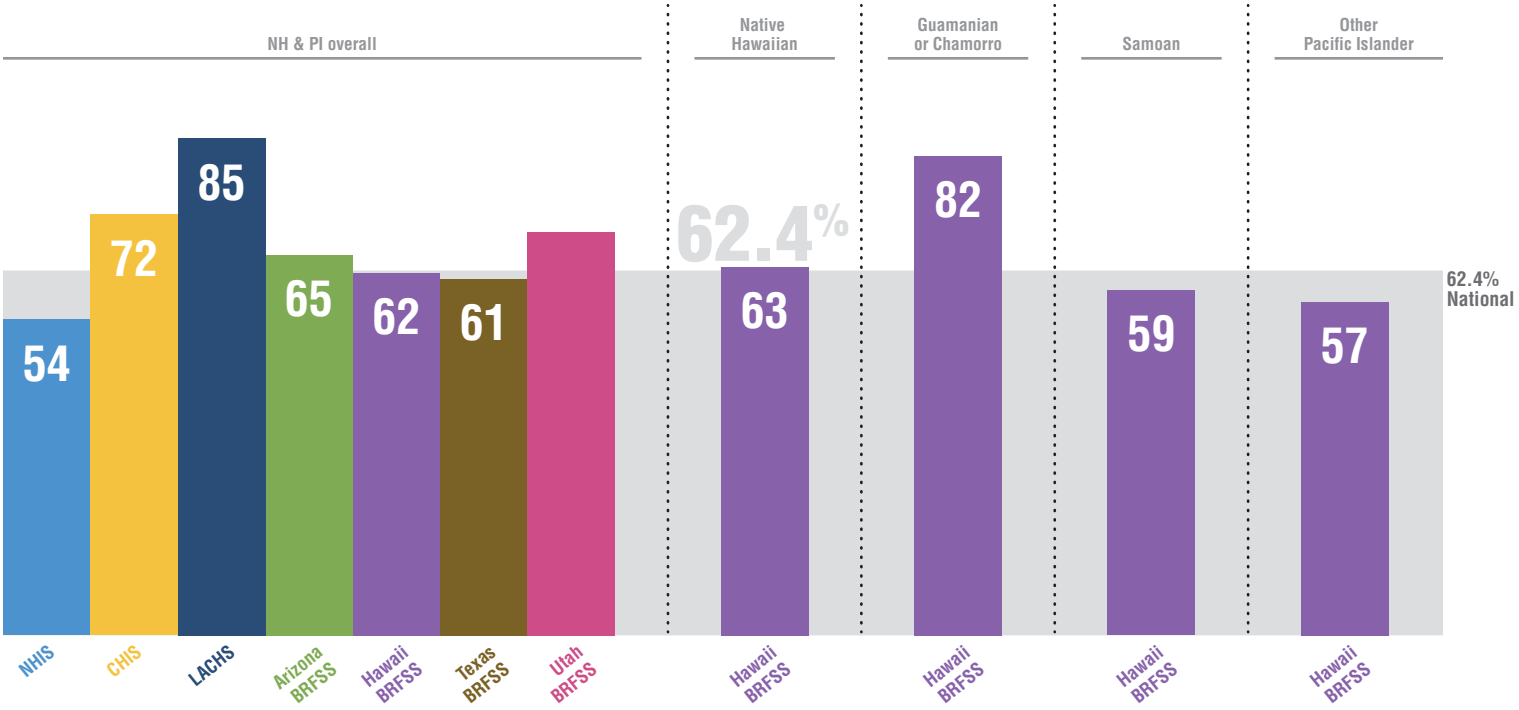
Dentist visit in past year by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2014, 2016 & 2018; CHIS, California Health Interview Survey 2013-14 and 2017-18; LACHS, Los Angeles County Health Survey 2015; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

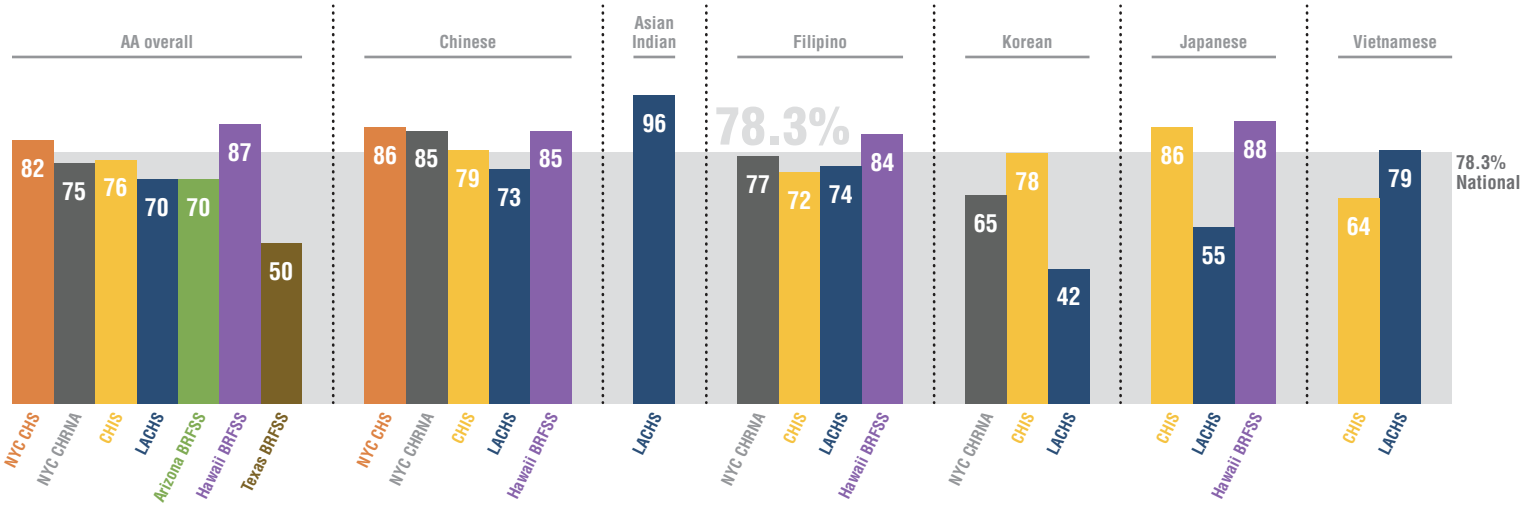
[1]Crude prevalence - LACHS

- The overall national prevalence of a dentist visit in the past year was 62.4%, from the 2012-2017 NHIS.
- Nationally, prevalence of a dentist visit in the past year was 54% among NH&PI overall.
- Regionally prevalence of a dentist visit in the past year among NH&PI overall was 72% in California, 85%[1] in LA County, 65% in Arizona, 62% in Hawaii, 61% in Texas, and 69% in Utah.

WHILE THE PREVALENCE OF A DENTIST VISIT IN THE PAST YEAR WAS 62.4% NATIONWIDE:

- In Hawaii, prevalence of a dentist visit in the past year was 63% among Native Hawaiian, 82% among Guamanian or Chamorro, 59% among Samoan, and 57% among other Pacific Islander.

Mammogram in the past 2 years among women age 50-74 by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2014, 2016 & 2018 (Hawaii 2013-18); CHIS, California Health Interview Survey 2015-16; LACHS, Los Angeles County Health Survey 2015 & 2018; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2014

[1]AA and NH&PI in place of AA and age 50 and up – NYC CHS; [2]South Asian in place of Asian Indian - LACHS

[3]All datasets include crude prevalence, including the 2018 National BRFSS (national prevalence)

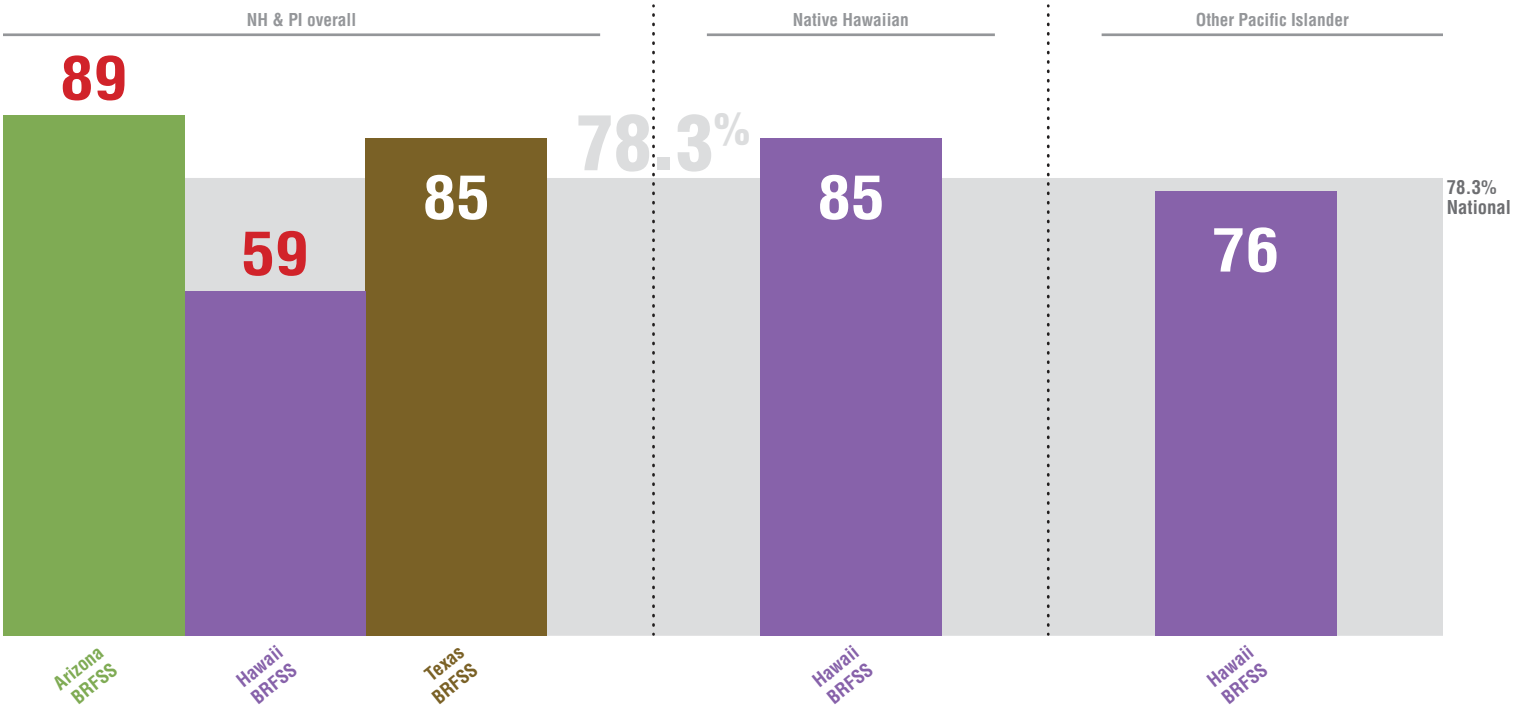
[4]Question not asked on NHIS; estimates were suppressed for NYC CHS South Asian, Filipino, Korean, Japanese, and Vietnamese; NYC CHRNA Asian Indian, Japanese, and Vietnamese; Arizona BRFSS Chinese, Asian Indian and Filipino; Texas BRFSS Chinese and Asian Indian; Utah BRFSS Chinese, Asian Indian and Japanese; HCS Asian overall, Chinese and Asian Indian

- The overall national prevalence of a mammogram in the past 2 years was 78.3%[3], from the 2018 BRFSS.
- Regionally, prevalence of a mammogram in the past 2 years among AA overall was 82%[1] in NYC (NYC CHS), 75% in NYC (NYC CHRNA), 76% in California, 70% in LA County, 70% in Arizona, 87% in Hawaii, and 50% in Texas.

WHILE THE PREVALENCE OF A MAMMOGRAM IN THE PAST 2 YEARS WAS 73.8% NATIONWIDE:

- In NYC (NYC CHS), prevalence of a mammogram in the past 2 years was 79%[2] among Chinese; in NYC (NYC CHRNA), prevalence of a mammogram in the past 2 years was 85% among Chinese, 77% among Filipino, and 65% among Korean.
- In California, prevalence of a mammogram in the past 2 years was 79% among Chinese, 72% among Filipino, 78% among Korean, 86% among Japanese, and 64% among Vietnamese; in LA County, prevalence of mammogram in the past 2 years was 73% among Chinese, 96%[2] among South Asian, 74% among Filipino, 42% among Korean, 55% among Japanese, and 79% among Vietnamese.
- In Hawaii, prevalence of a mammogram in the past 2 years was 85% among Chinese, 84% among Filipino, and 89% among Japanese.

Mammogram in the past 2 years among women age 50-74 by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System Hawaii 2013-18; CHIS, California Health Interview Survey 2015-16; LACHS, Los Angeles County Health Survey 2015 & 2018; NH&PI, Native Hawaiian & Pacific Islander;

[1]Interpret with caution: CHIS NH&PI; LACHS NH&PI

[2]All datasets include crude prevalence, including the 2018 National BRFSS (national prevalence)

[3]Question not asked on the NHIS; estimates were suppressed for Arizona BRFSS NH&PI; Texas BRFSS NH&PI; Utah BRFSS NH&PI

- **The overall national prevalence of a mammogram in the past 2 years was 78.3%[2], from the 2018 BRFSS.**
- **Regionally, prevalence of a mammogram in the past 2 years among NH&PI overall was 89%[1] in California, 59%[1] in LA County, and 85% in Hawaii.**

WHILE THE PREVALENCE OF A MAMMOGRAM IN THE PAST 2 YEARS WAS 73.8% NATIONWIDE:

- **In Hawaii, prevalence of a mammogram in the past 2 years was 85% among Native Hawaiian and 76% among Other Pacific Islander.**

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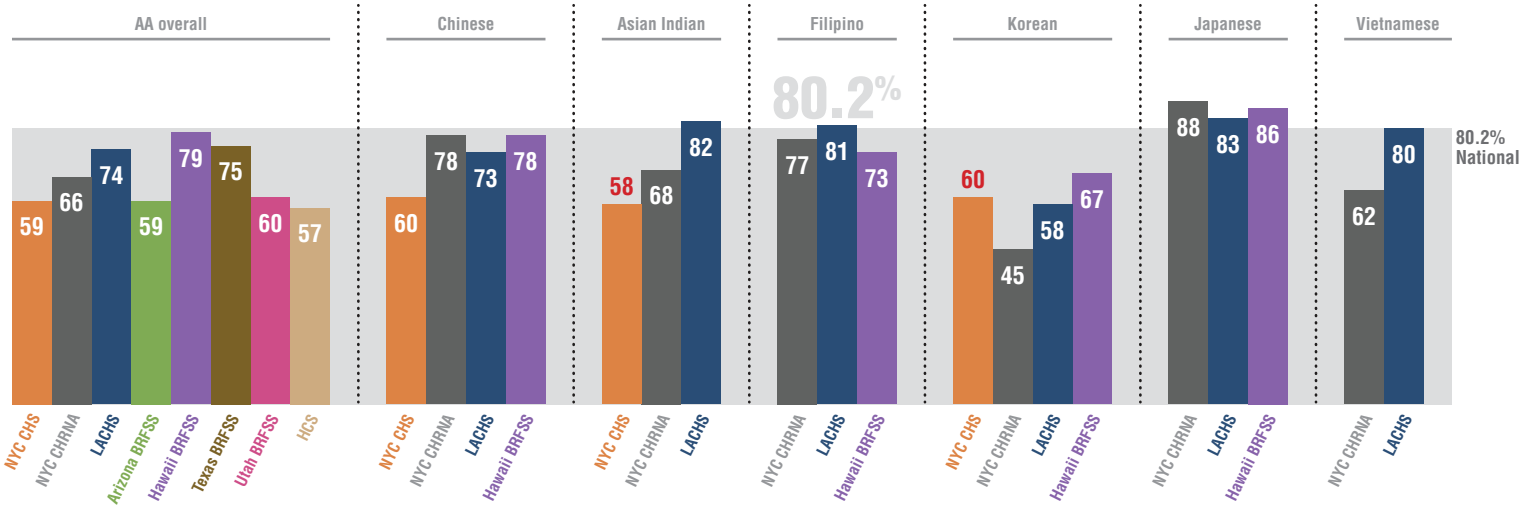
Pap test in the past 3 years among women age 21-65 by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System (Arizona and Utah 2014 & 2016, Hawaii 2013-16 & 2018, Texas 2014-16); HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2017

[1]Interpret with caution: NYC CHS South Asian and Korean

[2]AA and NH&PI in place of AA – NYC CHS and HCS; [3]South Asian in place of Asian Indian – NYC CHS and LACHS

[4]All datasets include crude prevalence, including 2018 National BRFSS (national prevalence)

[5]NYC CHS includes 21-64

[6]Question not asked on NHIS or CHIS; estimates were suppressed for NYC CHS Filipino, Japanese, and Vietnamese; Arizona BRFSS Chinese, Asian Indian and Filipino; Texas BRFSS Chinese and Asian Indian; Utah BRFSS Chinese, Asian Indian and Japanese; HCS Chinse and Asian Indian

- **The overall national prevalence of a Pap test in the past 3 years was 80.2%[4], from the 2018 BRFSS.**
- **Regionally, prevalence of a Pap test in the past 3 years among AA overall was 59%[2,5] in NYC (NYC CHS), 66% in NYC (NYC CHRNA), 74% in LA County, 59% in Arizona, 79% in Hawaii, 75% in Texas, 60% in Utah, and 57%[2] in Chicago.**

WHILE THE PREVALENCE OF A PAP TEST IN THE PAST 3 YEARS WAS 80.2% NATIONWIDE:

- **In NYC (NYC CHS), prevalence of a Pap test in the past 3 years was 60%[5] among Chinese, 58%[1,3,5] among South Asian, and 60%[1,5] among Korean; in NYC (NYC CHRNA), prevalence of a Pap test in the past 3 years was 78% among Chinese, 68% among Asian Indian, 77% among Filipino, 45% among Korean, 88% among Japanese, and 62% among Vietnamese.**
- **In LA County, prevalence of a Pap test in the past 3 years was 73% among Chinese, 82%[3] among South Asian, 81% among Filipino, 58% among Korean, 83% among Japanese, and 80% among Vietnamese.**
- **In Hawaii, prevalence of a Pap test in the past 3 years was 78% among Chinese, 73% among Filipino, 67% among Korean, and 86% among Japanese.**

Pap test in the past 3 years among women age 21-65 by NH&PI subgroup and dataset, 2012-18

Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System (Hawaii 2013-16 & 2018); LACHS, Los Angeles County Health Survey 2015 & 2018; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: LACHS NH&PI

[2]All datasets include crude prevalence, including 2018 National BRFSS (national prevalence)

[3]Question not asked on NHIS or CHIS; estimates were suppressed for Arizona BRFSS NH&PI; Texas BRFSS NH&PI; Utah BRFSS NH&PI

- **The overall national prevalence of a mammogram in the past 2 years was 78.3%[2], from the 2018 BRFSS.**
- **Regionally, prevalence of a mammogram in the past 2 years among NH&PI overall was 89%[1] in California, 59%[1] in LA County, and 85% in Hawaii.**

WHILE THE PREVALENCE OF A MAMMOGRAM IN THE PAST 2 YEARS WAS 73.8% NATIONWIDE:

- **In Hawaii, prevalence of a mammogram in the past 2 years was 85% among Native Hawaiian and 76% among Other Pacific Islander.**

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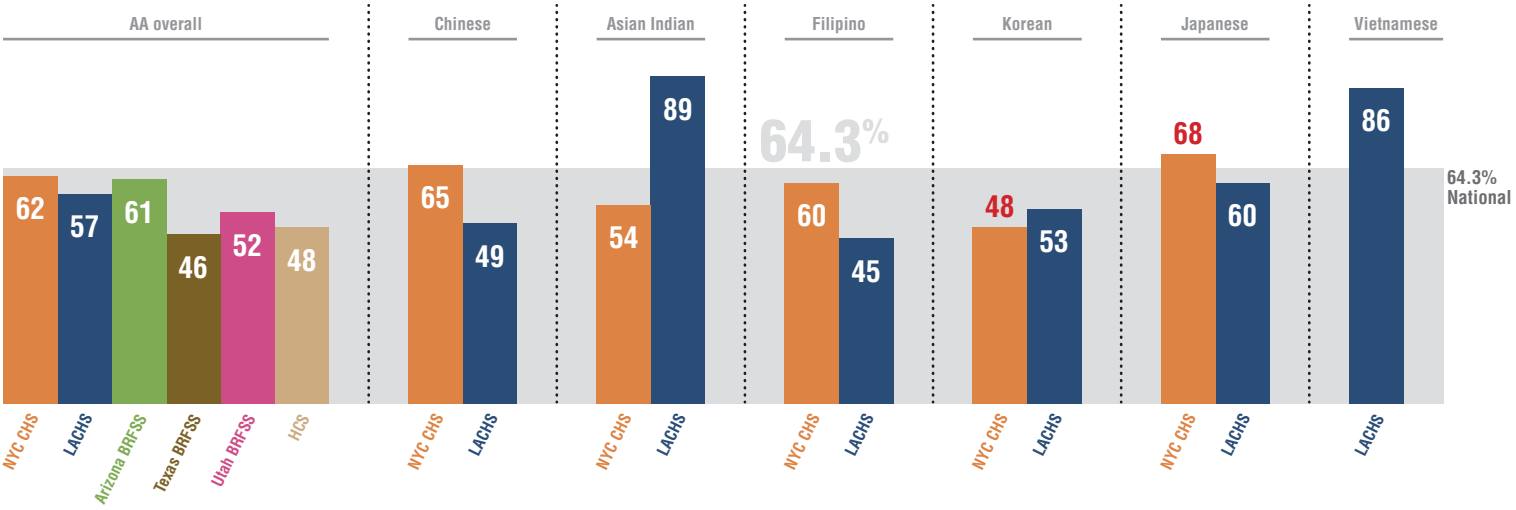
Colonoscopy in the past 10 years among age 50-75 by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2014 & 2016; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2018; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Korean and Japanese

[2]AA and NH&PI in place of AA – NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS and LACHS

[4]Among age 50 and over – NYC CHS

[5]All datasets include crude prevalence, including 2018 National BRFSS (national prevalence)

[6]Question not asked on NHIS, NYC CHRNA, CHIS, or Hawaii BRFSS; estimates were suppressed for NYC CHS Vietnamese; Arizona BRFSS Chinese, Asian Indian and Filipino; Texas BRFSS Chinese and Asian Indian; Utah BRFSS Chinese, Asian Indian and Japanese; HCS Chinese and Asian Indian

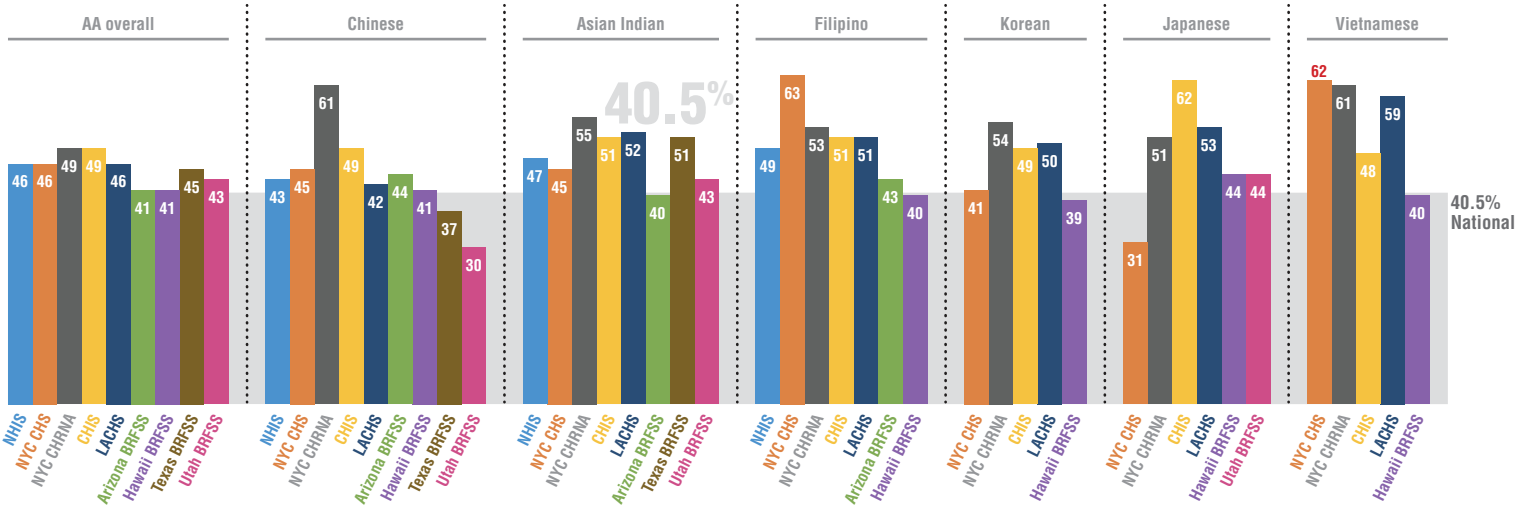
- The overall national prevalence of a colonoscopy in the past 10 years was 64.3%[5], from the 2018 BRFSS.
- Regionally, prevalence of a colonoscopy in the past 10 years among AA overall was 62%[2,4] in NYC (NYC CHS), 57% in LA County, 61% in Arizona, 46% in Texas, 52% in Utah, and 48% in Chicago.

WHILE THE PREVALENCE OF A COLONOSCOPY IN THE PAST 10 YEARS WAS 64.3% NATIONWIDE:

- In NYC (NYC CHS), prevalence of a colonoscopy in the past 10 years was 66%[4] among Chinese, 59%[3,4] among South Asian, 60%[4] among Filipino, 48%[1,4] among Korean, and 68%[1,4] among Japanese.
- In LA County, prevalence of a colonoscopy in the past 10 years was 49% among Chinese, 89%[3] among South Asian, 45% among Filipino, 53% among Korean, and 60% among Japanese (60%).

DC 4/8/2021 TEMP

Flu shot in past year by AA subgroup and dataset, 2012-2018



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2015-16; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Vietnamese; [2]AA & NH&PI in place of AA – NYC CHS

[3]South Asian in place of Asian Indian – NYC CHS, CHIS and LACHS; [4]Hawaii BRFSS is among age 18-64

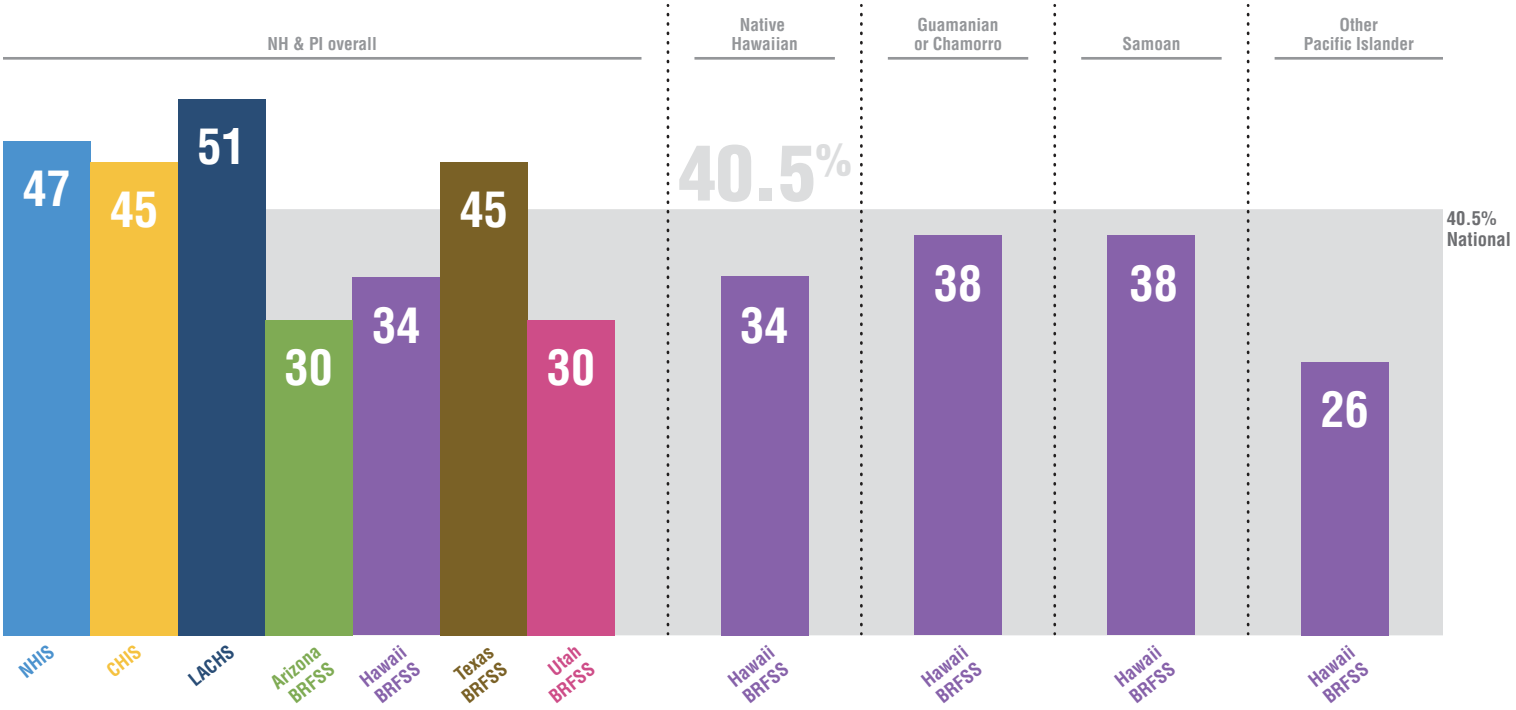
[5]Crude prevalence - NYC CHRNA, LACHS and Hawaii BRFSS; [6]Question not asked on HCS

- The overall national prevalence of a flu shot in the past year was 40.5%, from 2012-2017 NHIS.
- Nationally, prevalence of a flu shot in the past year was 46% among AA overall, 43% among Chinese, 47% among Asian Indian, and 49% among Filipino.
- Regionally, prevalence of a flu shot in the past year among AA overall was 46%[2] in NYC (NYC CHS), 49%[5] in NYC (NYC CHRNA), 49% in California, 46%[5] in LA County, 41% in Arizona, 41%[5] in Hawaii, 45% in Texas, and 43% in Utah.

WHILE THE PREVALENCE OF A FLU SHOT IN THE PAST YEAR WAS 40.5% NATIONWIDE:

- In NYC (NYC CHS), prevalence of a flu shot in the past year was 45% among Chinese, 45%[3] among South Asian, 63% among Filipino, 41% among Korean, 31% among Japanese, and 62%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of a flu shot in the past year was 61%[5] among Chinese, 55%[5] among Asian Indian, 53%[5] among Filipino, 54%[5] among Korean, 51%[5] among Japanese, and 61%[5] among Vietnamese.
- In California, prevalence of a flu shot in the past year was 49% among Chinese, 51%[3] among South Asian, 51% among Filipino, 49% among Korean, 62% among Japanese, and 48% among Vietnamese; in LA County, prevalence of a flu shot in the past year was 42%[5] among Chinese, 52%[3,5] among South Asian, 51%[5] among Filipino, 50%[5] among Korean, 53%[5] among Japanese, and 59%[5] among Vietnamese.
- In Arizona, prevalence of a flu shot in the past year was 44% among Chinese, 40% among Asian Indian, and 43% among Filipino.
- In Hawaii, prevalence of a flu shot in the past year was 41%[4,5] among Chinese, 40%[4,5] among Filipino, 39%[4,5] among Korean, 44%[4,5] among Japanese, and 40%[4,5] among Vietnamese.
- In Texas, prevalence of a flu shot in the past year was 37% among Chinese and 51% among Asian Indian.
- In Utah, prevalence of a flu shot in the past year was 30% among Chinese, 43% among Asian Indian, and 44% among Japanese.

Flu shot in past year by NH&PI subgroup and dataset, 2012-18



Abbreviations: CHIS, California Health Interview Survey 2015-16; LACHS, Los Angeles County Health Survey 2015 & 2018; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

[1]Crude prevalence – LACHS and Hawaii BRFSS

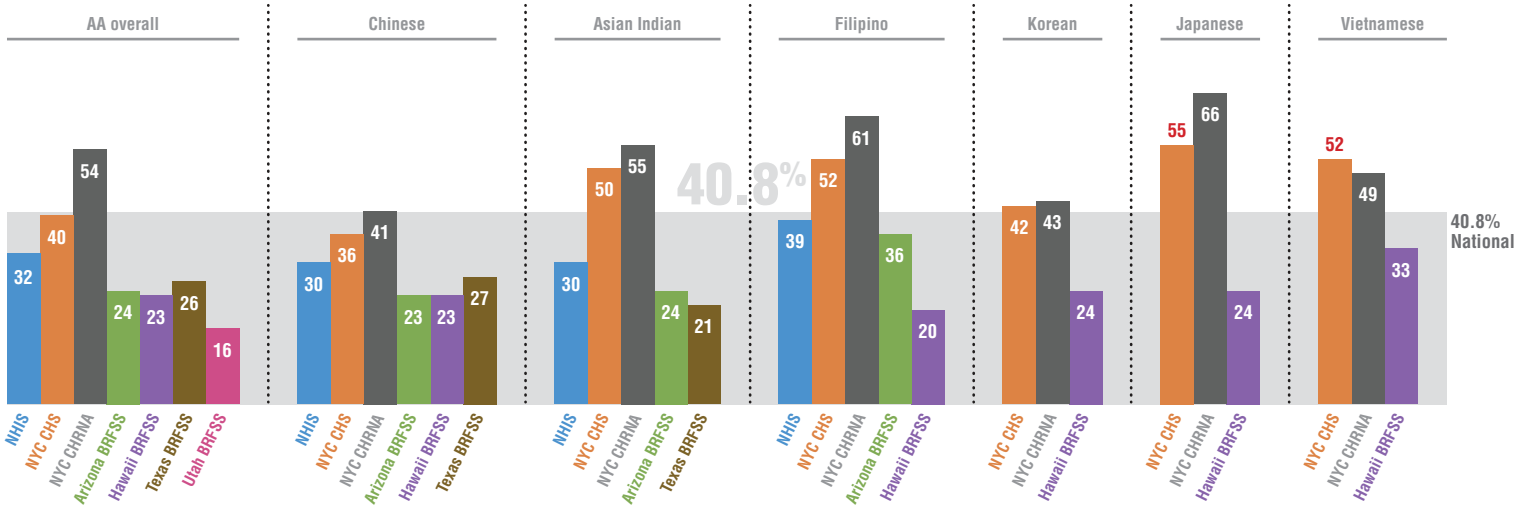
[2]Hawaii BRFSS is among age 18-64

- The overall national prevalence of a flu shot in the past year was 40.5%, from 2012-2017.
- Nationally, prevalence of a flu shot in the past year among NH&PI overall was 47%.
- Regionally, prevalence of a flu shot in the past year among NH&PI overall was 45% in California, 51%[1] in LA County, 30% in Arizona, 34%[1,2] in Hawaii, 45% in Texas, and 30% in Utah.

WHILE THE PREVALENCE OF A FLU SHOT IN THE PAST YEAR WAS 40.5% NATIONWIDE:

- In Hawaii, prevalence of a flu shot in the past year was 34%[1,2] among Native Hawaiian, 8%[1,2] among Guamanian or Chamorro, 38%[1,2] among Samoan, and 26%[1,2] among Other Pacific Islander.

Ever had HIV test by AA subgroup and dataset, 2012-2018



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Japanese and Vietnamese

[2]AA and NH&PI in place of AA – NYC CHS; [3]South Asian in place of Asian Indian – NYC CHS

[4]Hawaii BRFSS is among age 18-64

[5]Crude prevalence - NYC CHRNA and Hawaii BRFSS

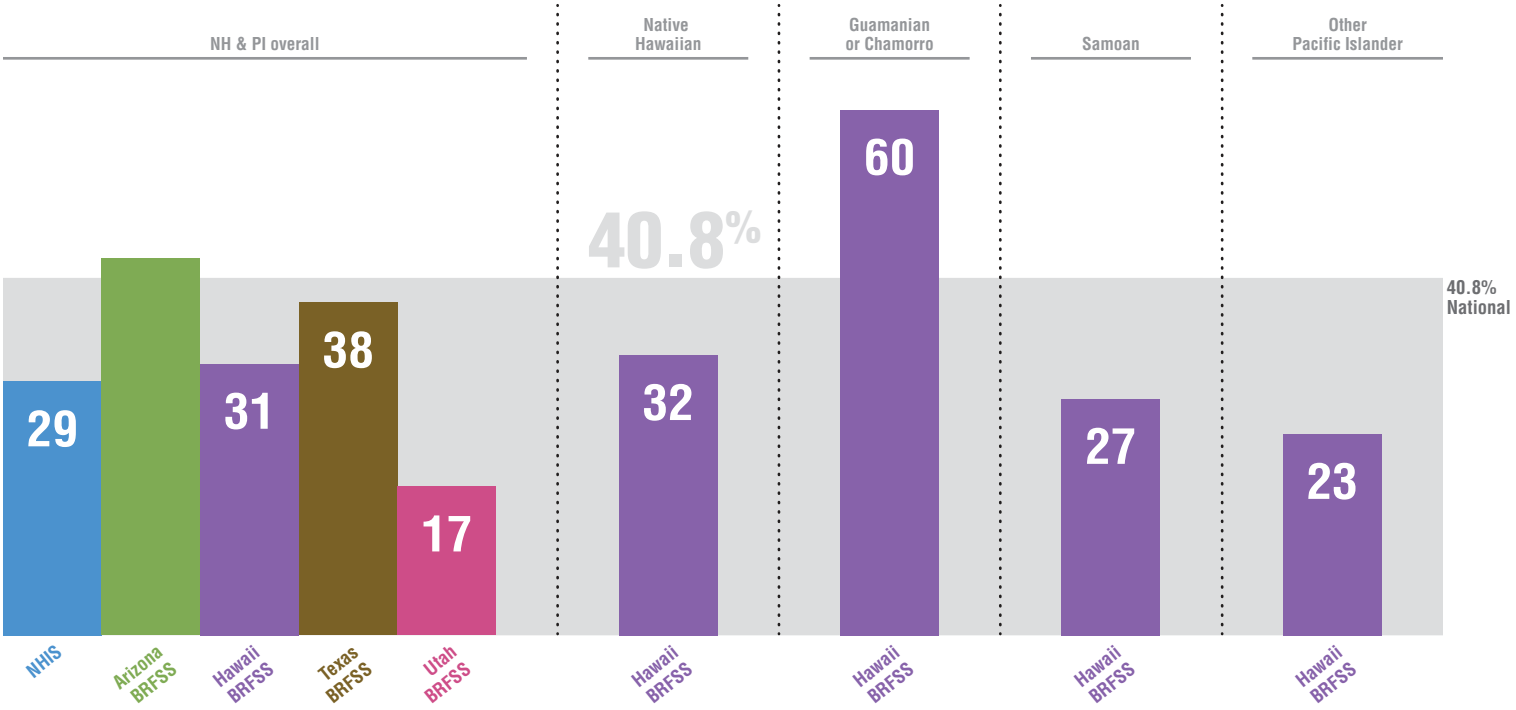
[6]Question not asked on CHIS, LACHS, or HCS; estimates were suppressed for Utah BRFSS Chinese, Asian Indian and Japanese

- The overall national prevalence of an HIV test was 40.8%, from 2012-2017 NHIS.
- Nationally, prevalence of an HIV test was 32% among AA overall, 30% among Chinese, 30% among Asian Indian, and 39% among Filipino.
- Regionally, prevalence of an HIV test among AA overall was 40%[2] in NYC (NYC CHS), 54%[5] in NYC (NYC CHRNA), 24% in Arizona, 23%[4,5] in Hawaii, 26% in Texas, and 16% in Utah.

WHILE THE PREVALENCE OF AN HIV TEST WAS 40.8% NATIONWIDE:

- In NYC (NYC CHS), prevalence of an HIV test was 36% among Chinese, 50%[3] among South Asian, 52% among Filipino, 42% among Korean, 55%[1] among Japanese, and 52%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of an HIV test was 41%[5] among Chinese, 55%[5] among Asian Indian, 61%[5] among Filipino, 43%[5] among Korean, 66%[5] among Japanese, and 49%[5] among Vietnamese.
- In Arizona, prevalence of an HIV test was 23% among Chinese, 24% among Asian Indian, and 36% among Filipino.
- In Hawaii, prevalence of an HIV test was 23%[4,5] among Chinese, 20%[4,5] among Filipino, 24%[4,5] among Korean, 24%[4,5] among Japanese, and 33%[4,5] among Japanese.
- In Texas, prevalence of an HIV test was 27% among Chinese and 21% among Asian Indian.

Ever had HIV test by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); NH&PI, Native Hawaiian & Pacific Islander; NHIS, National Health Interview Survey 2014

[1]Hawaii is among age 18-64, crude prevalence

[2]Question not asked on LACHS or CHIS

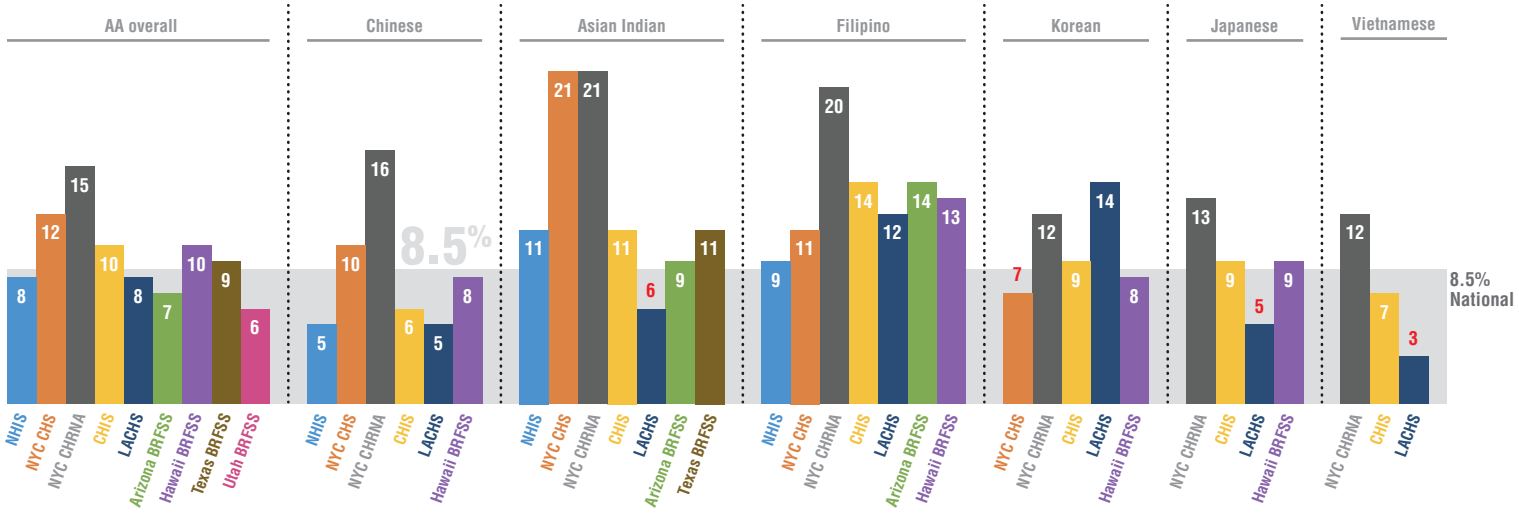
- The overall national prevalence of an HIV test was 40.8%, from 2012-2017 NHIS.
- Nationally, prevalence of an HIV test among NH&PI overall was 29%.
- Regionally, prevalence of an HIV test among NH&PI overall was 43% in Arizona, 31%[1] in Hawaii, 38% in Texas, and 17% in Utah.

WHILE THE PREVALENCE OF AN HIV TEST WAS 40.8% NATIONWIDE:

- In Hawaii, prevalence of an HIV test was 32%[1] among Native Hawaiian, 60%[1] among Guamanian or Chamorro, 27%[1] among Samoan, and 23%[1] among Other Pacific Islander.

2. RISK FACTORS

Diabetes Prevalence by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Korean; LACHS South Asian, Japanese, and Vietnamese

[2]AA and NH&PI in place of AA - NYC CHS; [3]South Asian in place of Asian Indian – NYC CHS, CHIS and LACHS

[4]Crude prevalence - NYC CHRNA and LACHS

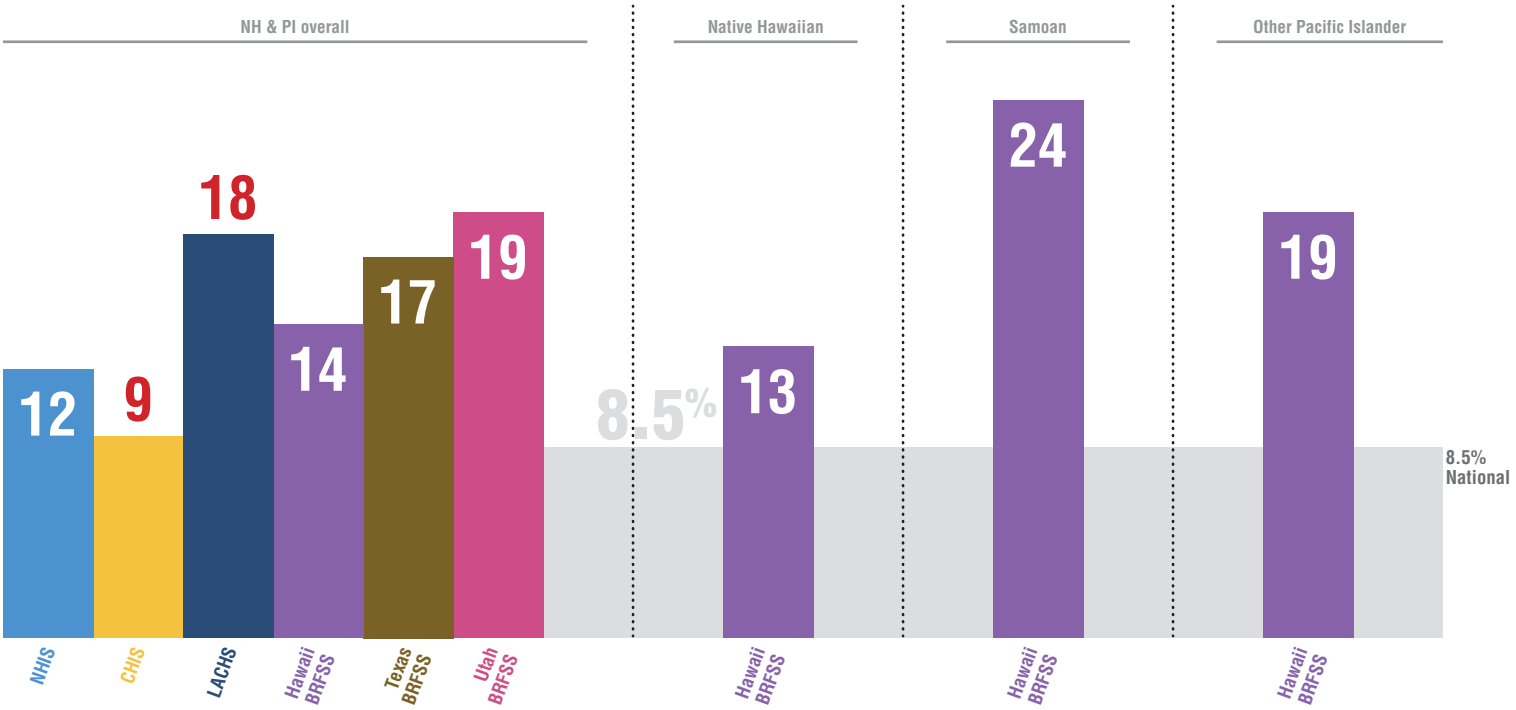
[5]Estimates were suppressed for NYC CHS Japanese and Vietnamese; Arizona BRFSS Chinese; Texas BRFSS Chinese; Utah BRFSS Chinese, Asian Indian and Japanese; HCS AA overall, Chinese and Asian Indian

- The overall national prevalence of diabetes was 8.5%, from the 2012-2017 NHIS.
- Nationally, prevalence of diabetes was 8% among AA overall, 5% among Chinese, 11% among Asian Indian, and 9% among Filipino.
- Regionally, prevalence of diabetes among AA overall was 12%[2] in NYC (NYC CHS), 15%[4] in NYC (NYC CHRNA), 10% in California, 8%[4] in LA County, 7% in Arizona, 10% in Hawaii, 9% in Texas, and 6% in Utah.

WHILE THE PREVALENCE OF DIABETES WAS 8.5% NATIONWIDE:

- In NYC (NYC CHS), prevalence of diabetes was 10% among Chinese, 21%[3] among South Asian, 11% among Filipino, and 7%[1] among Korean; in NYC (NYC CHRNA), prevalence of diabetes was 16%[4] among Chinese, 21%[4] among Asian Indian, 20%[4] among Filipino, 12%[4] among Korean, 13%[4] among Japanese, and 12%[4] among Vietnamese.
- In California, prevalence of diabetes was 6% among Chinese, 11%[3] among South Asian, 14% among Filipino, 9% among Korean, 9% among Japanese, and 7% among Vietnamese; in LA County, prevalence of diabetes was 5%[4] among Chinese, 6%[4] among South Asian, 12%[1,3,4] among Filipino, 14%[4] among Korean, 5%[1,4] among Japanese, and 3%[1,4] among Vietnamese.
- In Arizona, prevalence of diabetes was 9% among Asian Indian and 14% among Filipino.
- In Hawaii, prevalence of diabetes was 8% among Chinese, 13% among Filipino, 8% among Korean, and 9% among Japanese.
- In Texas, prevalence of diabetes was 11% among Asian Indian.

Diabetes prevalence by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI; LACHS NH&PI

[2]Crude prevalence - LACHS

[3]Estimates were suppressed for Arizona BRFSS NH&PI

- The overall national prevalence of diabetes was 8.5%, from the 2012-2017 NHIS.
- Nationally, prevalence of diabetes among NH&PI overall was 12%.
- Regionally, prevalence of diabetes among NH&PI overall was 9%[1] in California, 18%[1,2] in LA County, 14% in Hawaii, 17% in Texas, and 19% in Utah.

WHILE THE PREVALENCE OF DIABETES WAS 8.5% NATIONWIDE:

- In Hawaii, prevalence of diabetes was 13% among Native Hawaiian, 24% among Samoan, and 13% among Other Pacific Islander.

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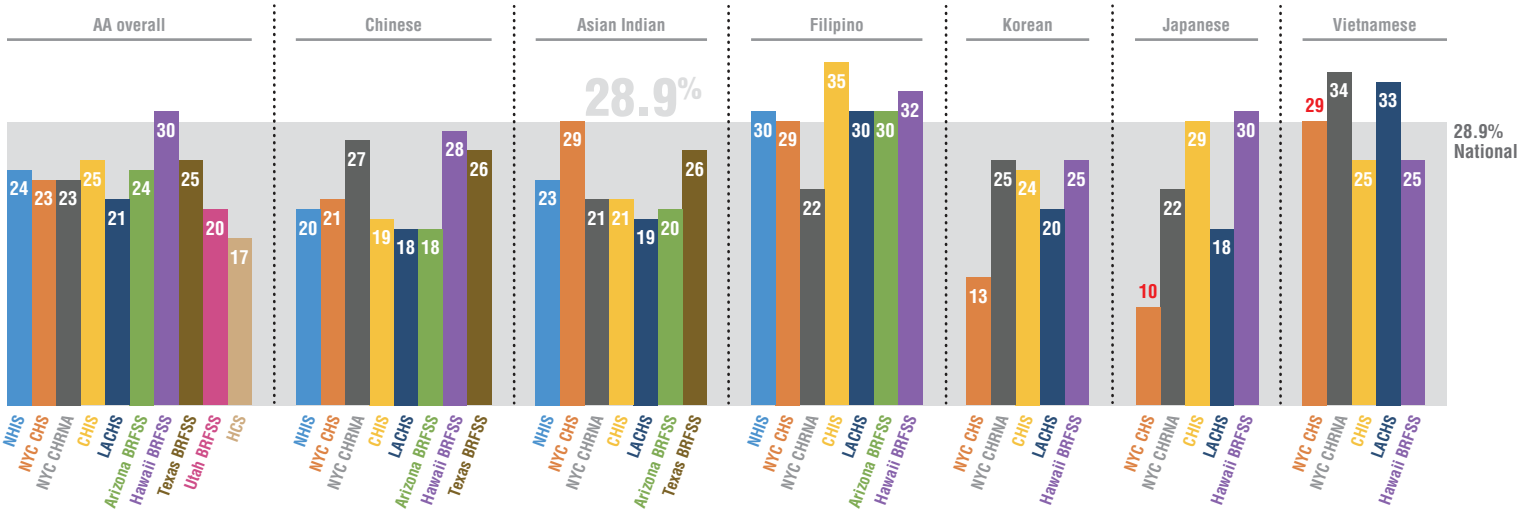
Hypertension prevalence by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System (Texas 2013 & 2015-17; Arizona, Hawaii, and Utah 2013, 2015 & 2017); CHIS, California Health Interview Survey (2013-18); HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment (2013-16); NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Japanese and Vietnamese

[2]AA and NH&PI in place of AA - NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[4]Crude prevalence - NYC CHRNA and LACHS

[5]Estimates were suppressed for Utah BRFSS Chinese, Asian Indian and Japanese; HCS Chinese and Asian Indian

- The overall national prevalence of hypertension was 28.9%, from the 2012-2017 NHIS.
- Nationally, the prevalence of hypertension was 24% among AA overall, 20% among Chinese, 23% among Asian Indian, and 30% among Filipino.
- Regionally, the prevalence of hypertension among AA overall was 23%[2] in NYC (NYC CHS), 23%[4] in NYC (NYC CHRNA), 25% in California, 21%[4] in LA County, 24% in Arizona, 30% in Hawaii, 25% in Texas, 20% in Utah, and 17%[2] in Chicago.

WHILE THE PREVALENCE OF HYPERTENSION WAS 28.9% NATIONWIDE:

- In NYC (NYC CHS), prevalence of hypertension was 21% among Chinese, 29%[3] among South Asian, 29% among Filipino, 13% among Korean, 10%[1] among Japanese, and 29%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of hypertension was 27%[4] among Chinese, 21%[4] among Asian Indian, 22%[4] among Filipino, 25%[4] among Korean, 22%[4] among Japanese, and 34%[4] among Vietnamese.
- In California, prevalence of hypertension was 19% among Chinese, 21%[3] among South Asian, 35% among Filipino, 24% among Korean, 29% among Japanese, and 25% among Vietnamese; in LA County, prevalence of hypertension was 18%[4] among Chinese, 19%[3,4] among South Asian, 30%[4] among Filipino, 20%[4] among Korean, 18%[4] among Japanese, and 33%[4] among Vietnamese.
- In Arizona, prevalence of hypertension was 18% among Chinese, 20% among Asian Indian, and 30% among Filipino (30%).
- In Hawaii, prevalence of hypertension was 28% among Chinese, 32% among Filipino, 25% among Korean, 30% among Japanese and 25% among Vietnamese.
- In Texas, prevalence of hypertension was 26% among Chinese and 26% among Asian Indian (26%).

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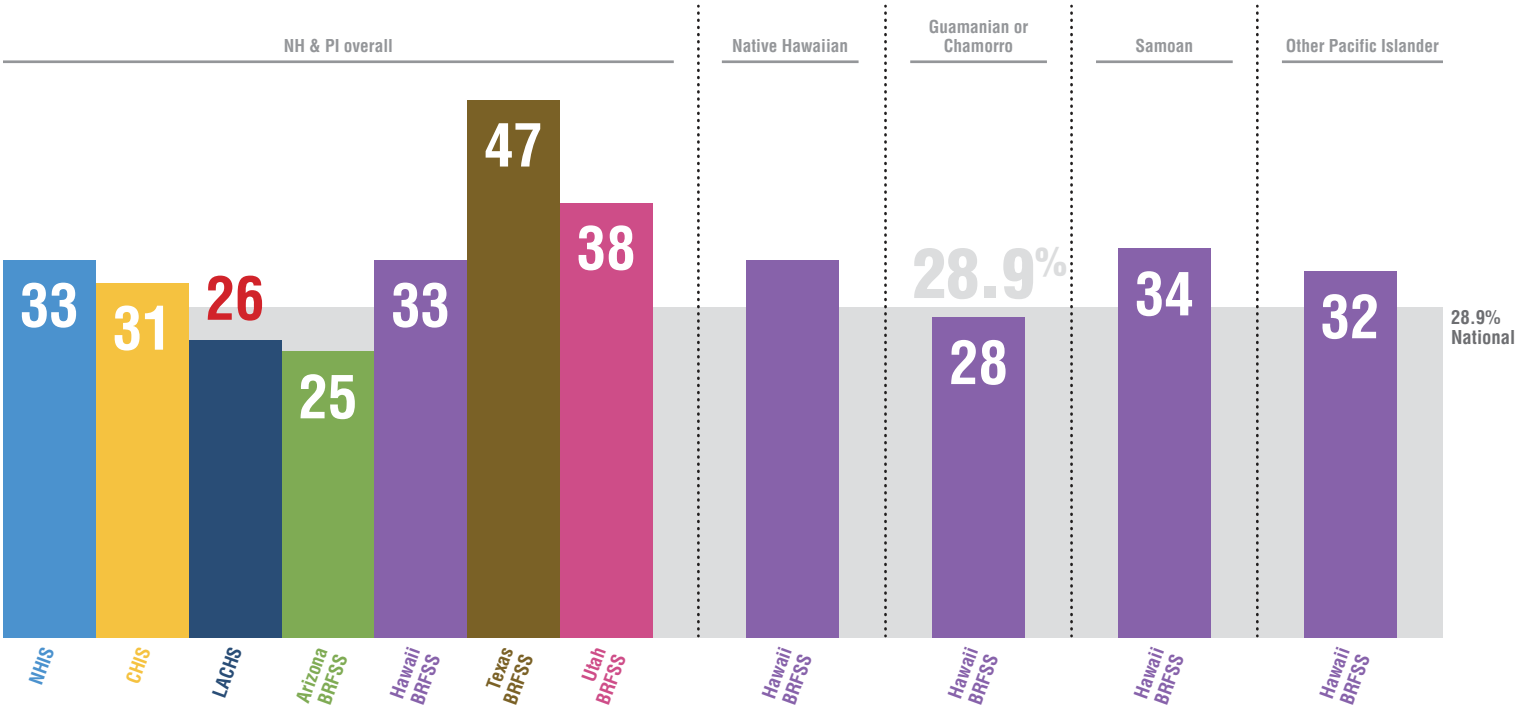
Hypertension prevalence by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System (Texas 2013 & 2015-17; Arizona, Hawaii, and Utah 2013, 2015 & 2017); CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: LACHS NH&PI

[2]Crude prevalence - LACHS

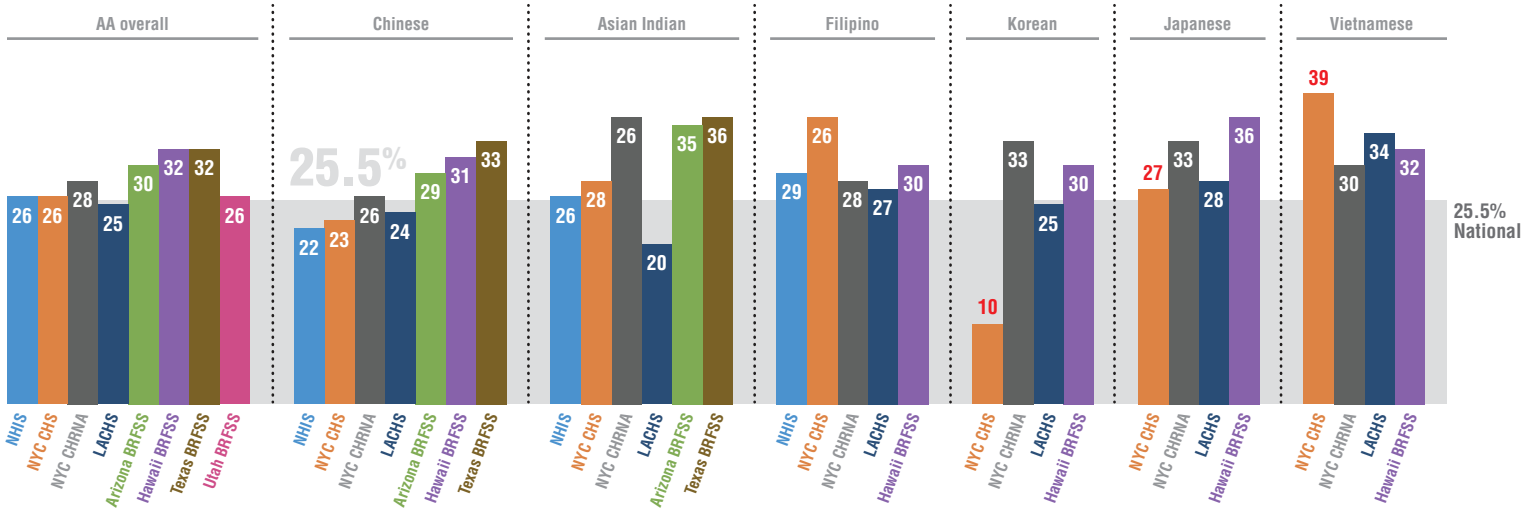
- The overall national prevalence of hypertension was 28.9%, from the 2012-2017 NHIS.
- Nationally, prevalence of hypertension among NH&PI overall 33%.
- Regionally, prevalence of hypertension among NH&PI overall was 31% in California, 26%[1,2] in LA County, 25% in Arizona, 33% in Hawaii, 47% in Texas, and 38% in Hawaii.

WHILE THE PREVALENCE OF HYPERTENSION WAS 28.9% NATIONWIDE:

- In Hawaii, prevalence of hypertension was 33% among Native Hawaiian, 34% among Samoan, 28% among Guamanian or Chamorro, and 32% among Other Pacific Islander.

DC 4/8/2021 TEMP

High cholesterol diagnosis by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013, 2015 & 2017); LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012 & 2014-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-14

[1]Interpret with caution: NYC CHS Korean, Japanese, and Vietnamese

[2]AA and NH&PI in place of AA - NYC CHS; [3]South Asian in place of Asian Indian – NYC CHS and LACHS

[4]Crude prevalence - NYC CHRNA and LACHS

[5]Arizona, Hawaii, Texas, and Utah BRFSS include the prevalence among the total screened for high cholesterol

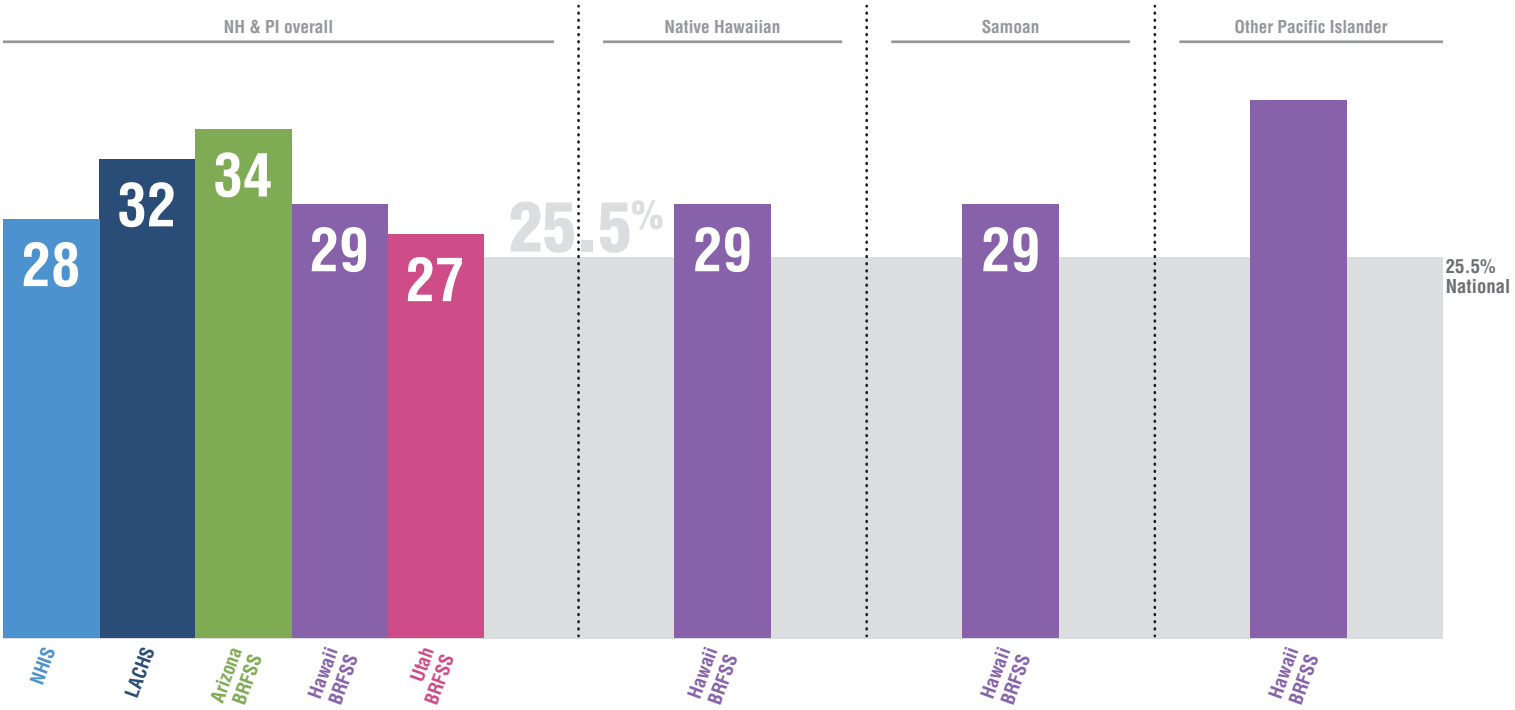
[6]Question not asked on CHIS or HCS; estimates were suppressed for Arizona BRFSS Filipino; Utah BRFSS Chinese, Asian Indian and Japanese

- The overall national prevalence of high cholesterol was 25.5%, from the 2012 & 2014-2017 NHIS.
- Nationally, prevalence of high cholesterol was 26% among AA overall, 22% among Chinese, 26% among Asian Indian, and 29% among Filipino.
- Regionally, prevalence of high cholesterol among AA overall was 26%[2] in NYC (NYC CHS), 28%[4] in NYC (NYC CHRNA), 25%[4] in LA County, 30%[5] in Arizona, 32%[5] in Hawaii, 32%[5] in Texas, and 26%[5] in Utah.

WHILE THE PREVALENCE OF HIGH CHOLESTEROL WAS 25.5% NATIONWIDE:

- In NYC CHS, prevalence of high cholesterol was 23% among Chinese, 28%[3] among South Asian, 36% among Filipino, 10%[1] among Korean, 27%[1] among Japanese, and 39%[1] among Vietnamese; in NYC CHRNA, prevalence of high cholesterol was 26%[4] among Chinese, 36%[4] among Asian Indian, 28%[4] among Filipino, 33%[4] among Korean, 33%[4] among Japanese, and 30%[4] among Vietnamese.
- In LA County, prevalence of high cholesterol was 24%[4] among Chinese, 20%[3,4] among South Asian, 27%[4] among Filipino, 25%[4] among Korean, 28%[4] among Japanese, and 34%[4] among Vietnamese.
- In Arizona, prevalence of high cholesterol among those screened was 29%[5] among Chinese and 35%[5] among Asian Indian.
- In Hawaii, prevalence of high cholesterol among those screened was 31%[5] among Chinese, 30%[5] among Filipino, 30%[5] among Korean, 36%[5] among Japanese, and 32%[5] among Vietnamese.
- In Texas, prevalence of high cholesterol among those screened was 33%[5] among Chinese and 36%[5] among Asian Indian.

High cholesterol diagnosis by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013, 2015 & 2017); LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

[1]Crude prevalence - LACHS

[2]Arizona, Hawaii, and Utah BRFSS include the prevalence among the total screened for high cholesterol

[3]Question not asked on CHIS; estimates were suppressed for Texas BRFSS NH&PI

- The overall national prevalence of high cholesterol was 25.5%, from the 2012 & 2014-2017 NHIS.
- Nationally, the prevalence of high cholesterol among NH&PI overall was 28%.
- Regionally, the prevalence of high cholesterol among NH&PI overall was 32%[1] in LA County, 34%[2] in Arizona, 29%[2] in Hawaii, and 27%[2] in Utah.

WHILE THE PREVALENCE OF HIGH CHOLESTEROL WAS 25.5% NATIONWIDE:

- In Hawaii, prevalence of high cholesterol was 29%[2] among Native Hawaiian, 29%[2] among Samoan, and 36%[2] among Other Pacific Islander.

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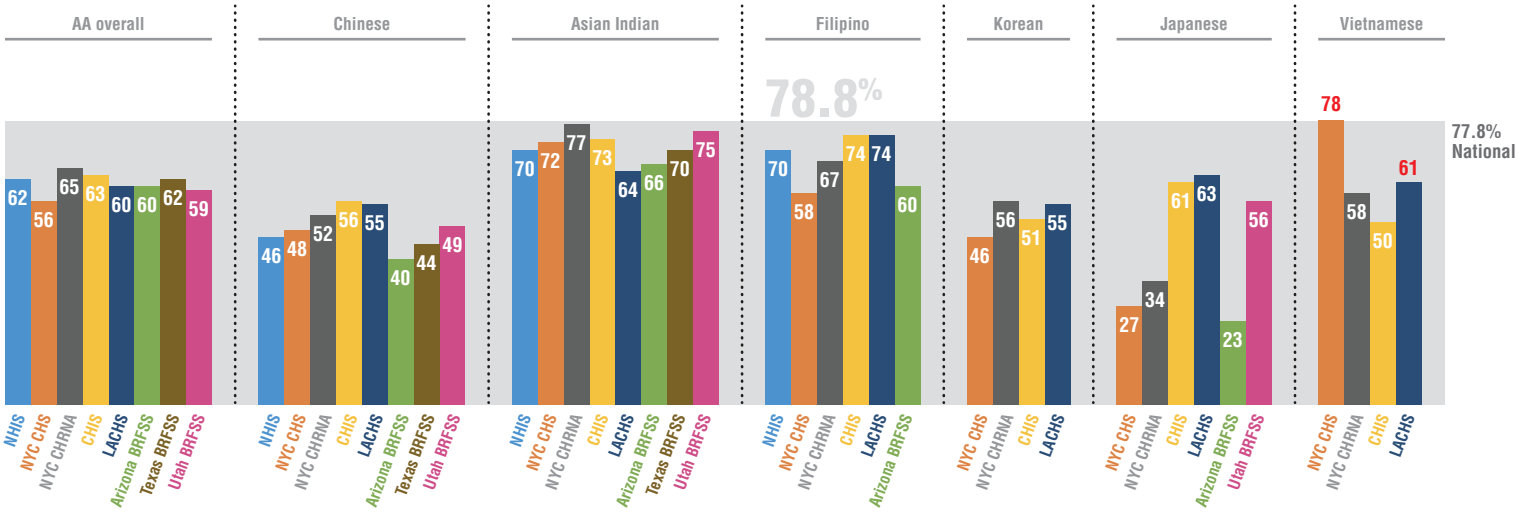
BMI ≥ 23 by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BMI, body mass index; BRFSS, Behavioral Risk Factor Surveillance System 2013-17; CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Vietnamese; LACHS Vietnamese

[2]AA and NH&PI in place of AA - NYC CHS; [3]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[4]Crude prevalence - NYC CHRNA and LACHS

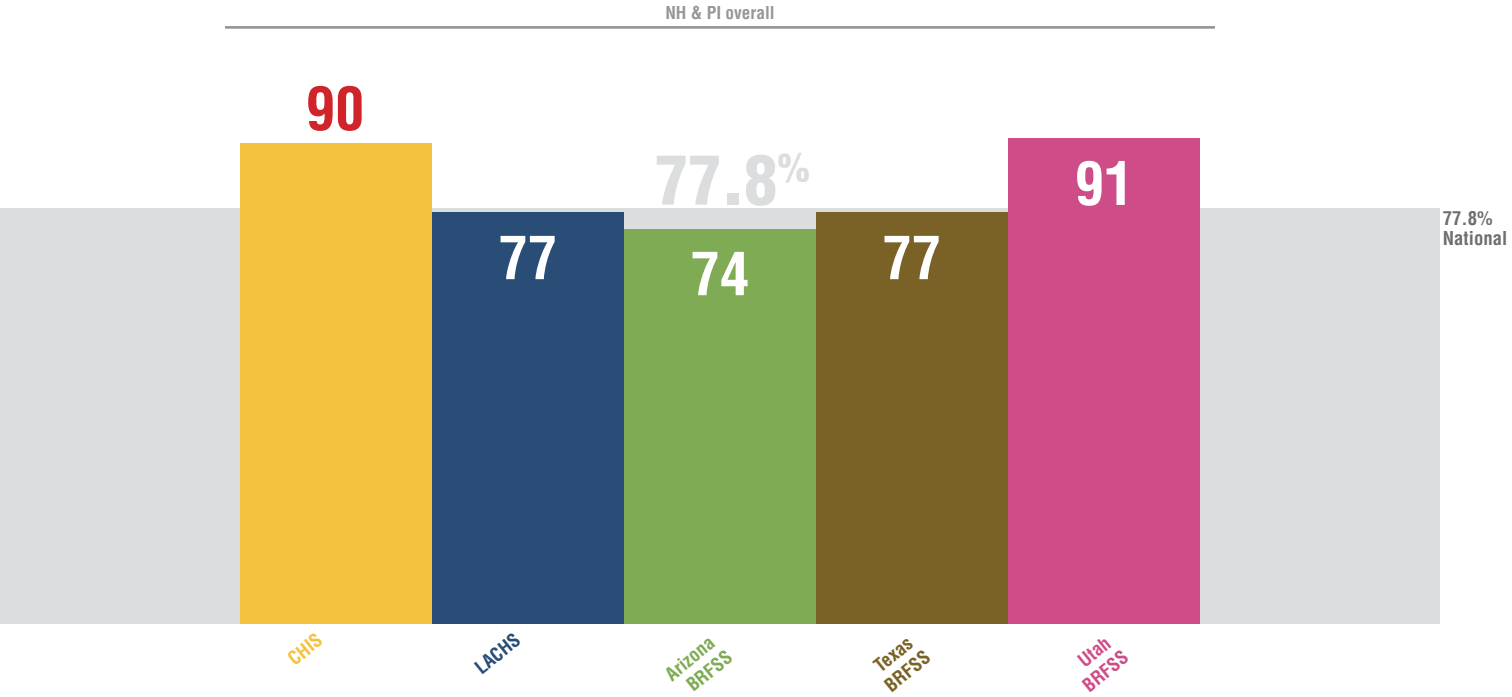
[5]This BMI grouping was not available for HCS or Hawaii BRFSS; estimates were suppressed for NYC CHS Korean and Japanese

- The overall national prevalence of BMI ≥23 was 77.8%, from the 2012-2017 NHIS.
- Nationally, prevalence of BMI ≥23 was 62% among AA overall, 46% among Chinese, 70% among Asian Indian, and 70% among Filipino.
- Regionally, prevalence of BMI ≥23 among AA overall was 56%[2] in NYC (NYC CHS), 65%[4] in NYC (NYC CHRNA), 63% in California, 60%[4] in LA County, 60% in Arizona, 62% in Texas, and 59% in Utah.

WHILE THE PREVALENCE OF BMI ≥23 WAS 77.8% NATIONWIDE:

- In NYC (NYC CHS), prevalence of BMI ≥23 was 48% among Chinese, 72%[3] among South Asian, 58% among Filipino, 46% among Korean, 27% among Japanese, and 78%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of BMI ≥23 was 52%[4] among Chinese, 77%[4] among Asian Indian, 67%[4] among Filipino, 56%[4] among Korean, 34%[4] among Japanese, and 58%[4] among Vietnamese.
- In California, prevalence of BMI ≥23 was 56% among Chinese, 73%[3] among South Asian, 74% among Filipino, 51% among Korean, 61% among Japanese, and 50% among Vietnamese; in LA County, prevalence of BMI ≥23 was 55%[4] among Chinese, 64%[3,4] among South Asian, 74%[4] among Filipino, 55%[4] among Korean, 63%[4] among Japanese, and 61%[1,4] among Vietnamese.
- In Arizona, prevalence of BMI ≥23 was 40% among Chinese, 66% among Asian Indian, 60% among Filipino, and 23% among Japanese.
- In Texas, prevalence of BMI ≥23 was 44% among Chinese and 70% among Asian Indian.
- In Utah, prevalence of BMI ≥23 was 49% among Chinese, 75% among Asian Indian, and 56% among Japanese.

BMI ≥ 23 in NH&PIs by dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17; BMI, body mass index; LACHS, Los Angeles County Health Survey; CHIS, California Health Interview Survey 2013-18; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI

[2]Crude prevalence: LACHS

[3]BMI not available for NHIS; BMI grouping not available for Hawaii BRFSS

- **The overall national prevalence of BMI ≥23 was 77.8%, from the 2012-2017 NHIS.**
- **Regionally, prevalence of BMI ≥23 among NH&PI overall was 90%[1] in California, 77%[2] in LA County, 74% in Arizona, 77% in Texas, and 91% in Utah.**

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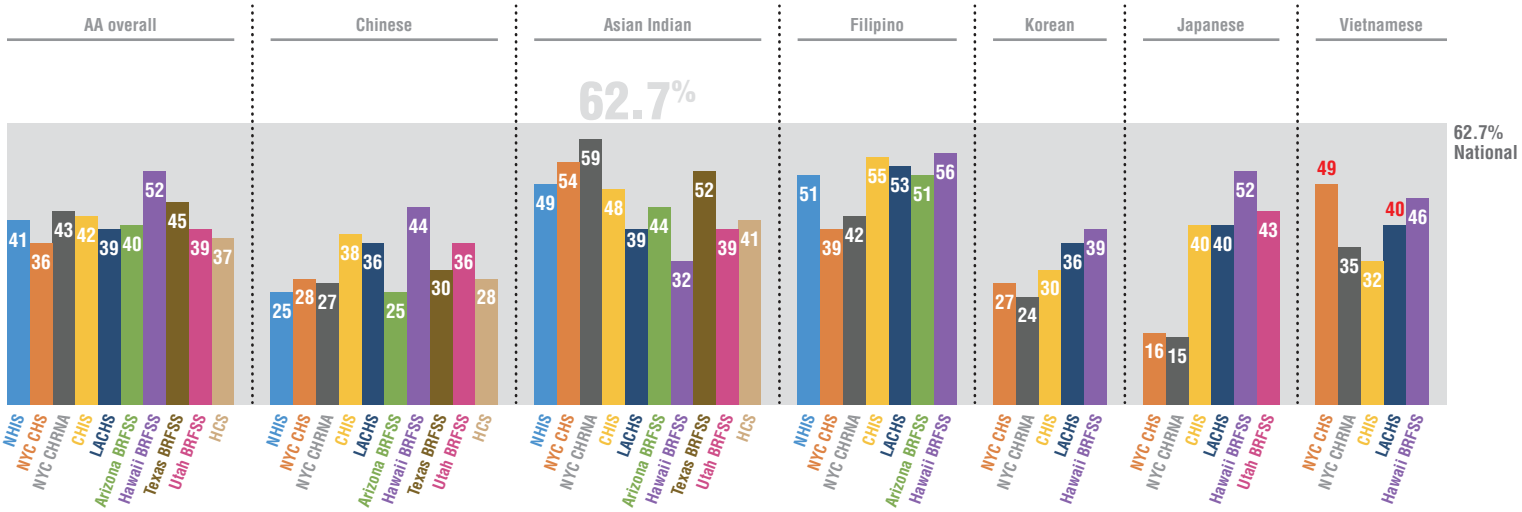
BMI ≥ 25 by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); BMI, body mass index; CHIS, California Health Interview Survey 2013-18; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Vietnamese; LACHS Vietnamese

[2]AA and NH&PI in place of AA – NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[4]Crude prevalence - NYC CHRNA and LACHS

- The overall national prevalence of BMI ≥25 was 62.7%, from the 2012-2017 NHIS.
- Nationally, prevalence of BMI ≥25 was 41% among AA overall, 25% among Chinese, 49% among Asian Indian, and 51% among Filipino.
- Regionally, prevalence of BMI ≥25 among AA overall was 36%[2] in NYC (NYC CHS), 43%[4] in NYC (NYC CHRNA), 42% in California, 39%[4] in LA County, 40% in Arizona, 52% in Hawaii, 45% in Texas, 39% in Utah, and 37%[2] in Chicago.

WHILE THE PREVALENCE OF BMI ≥25 WAS 62.7% NATIONWIDE:

- In NYC (NYC CHS), prevalence of BMI ≥25 was 28% among Chinese, 54%[3] among South Asian, 39% among Filipino, 27% among Korean, 16% among Japanese, and 49%[1] in Vietnamese; in NYC (NYC CHRNA), the prevalence of BMI ≥25 was 27%[4] among Chinese, 59%[4] among Asian Indian, 42%[4] among Filipino, 24%[4] among Korean, 15%[4] among Japanese, and 35%[4] among Vietnamese.
- In California, prevalence of BMI ≥25 was 38% among Chinese, 48%[3] among South Asian, 55% among Filipino, 30% among Filipino, 40% among Japanese, and 32% among Vietnamese; in LA County, the prevalence of BMI ≥25 was 36%[4] among Chinese, 39%[4] among South Asian, 53%[3,4] among Filipino, 36%[4] among Korean, 40%[4] among Japanese, and 40%[1,4] among Vietnamese.
- In Arizona, prevalence of BMI ≥25 was 25% among Chinese, 44% among Asian Indian, and 51% among Filipino.
- In Hawaii, prevalence of BMI ≥25 was 44% among Chinese, 32% among Asian Indian, 56% among Filipino, 39% among Korean, 52% among Japanese, and 46% among Vietnamese.
- In Texas, prevalence of BMI ≥25 was 30% among Chinese and 52% among Asian Indian.
- In Utah, prevalence of BMI ≥25 was 36% among Chinese, 39% among Asian Indian, and 43% among Japanese.
- In Chicago, prevalence of BMI ≥25 was 28% among Chinese and 39% among Asian Indian.

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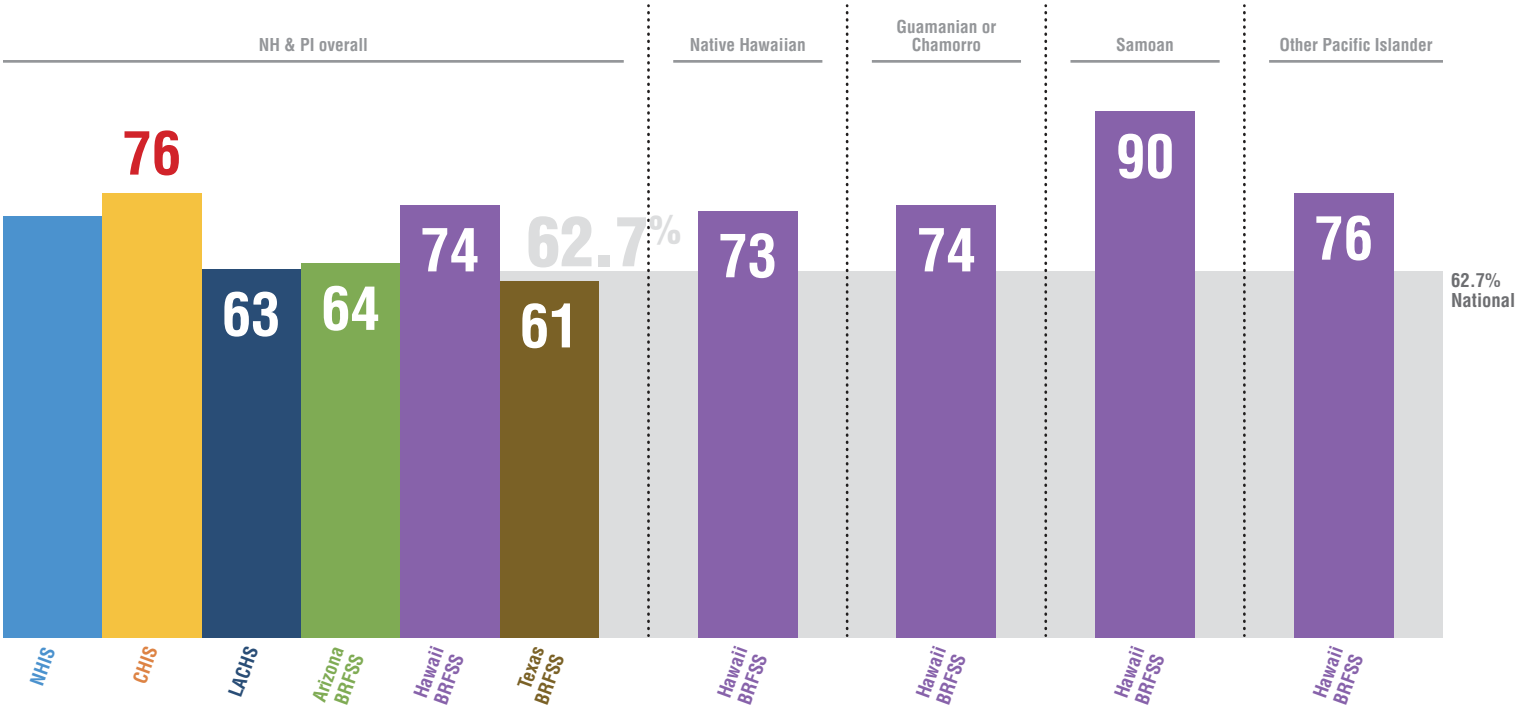
BMI ≥ 25 by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); BMI, body mass index CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey 2015 and 2018; ; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI

[2]Crude prevalence - LACHS

- The overall national prevalence of BMI ≥25 was 62.7%, from the 2012-2017 NHIS.
- Nationally, prevalence of BMI ≥25 among NH&PI overall was 72%.
- Regionally, prevalence of BMI ≥25 among NH&PI overall was 76%[1] in California, 63%[2] in LA County, 64% in Arizona, 74% in Hawaii, and 61% in Texas.

WHILE THE PREVALENCE OF BMI ≥25 WAS 62.7% NATIONWIDE:

- In Hawaii, prevalence of BMI ≥25 was 73% among Native Hawaiian, 90% among Samoan, 74% among Guamanian or Chamorro, and 76% among Other Pacific Islander.

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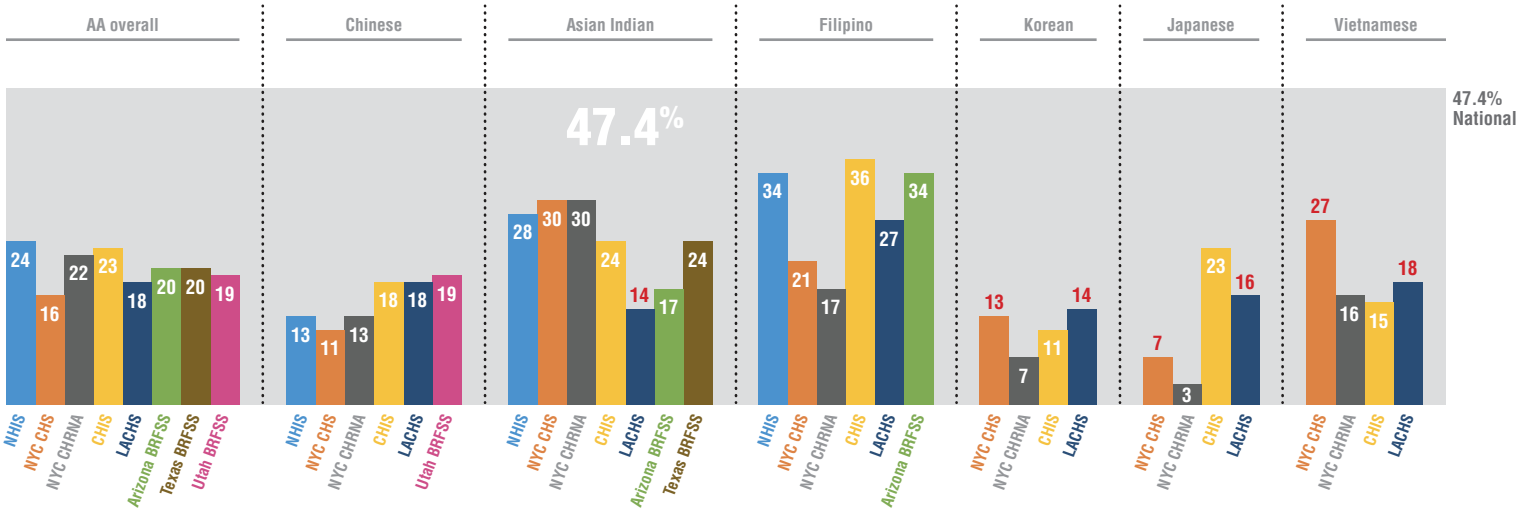
BMI ≥ 27.5 by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17; BMI, body mass index; CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Korean, Japanese, and Vietnamese; LACHS South Asian, Korean, Japanese, and Vietnamese

[2]AA & NH&PI in place of AA - NYC CHS; [3]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[4]Crude prevalence - NYC CHRNA and LACHS

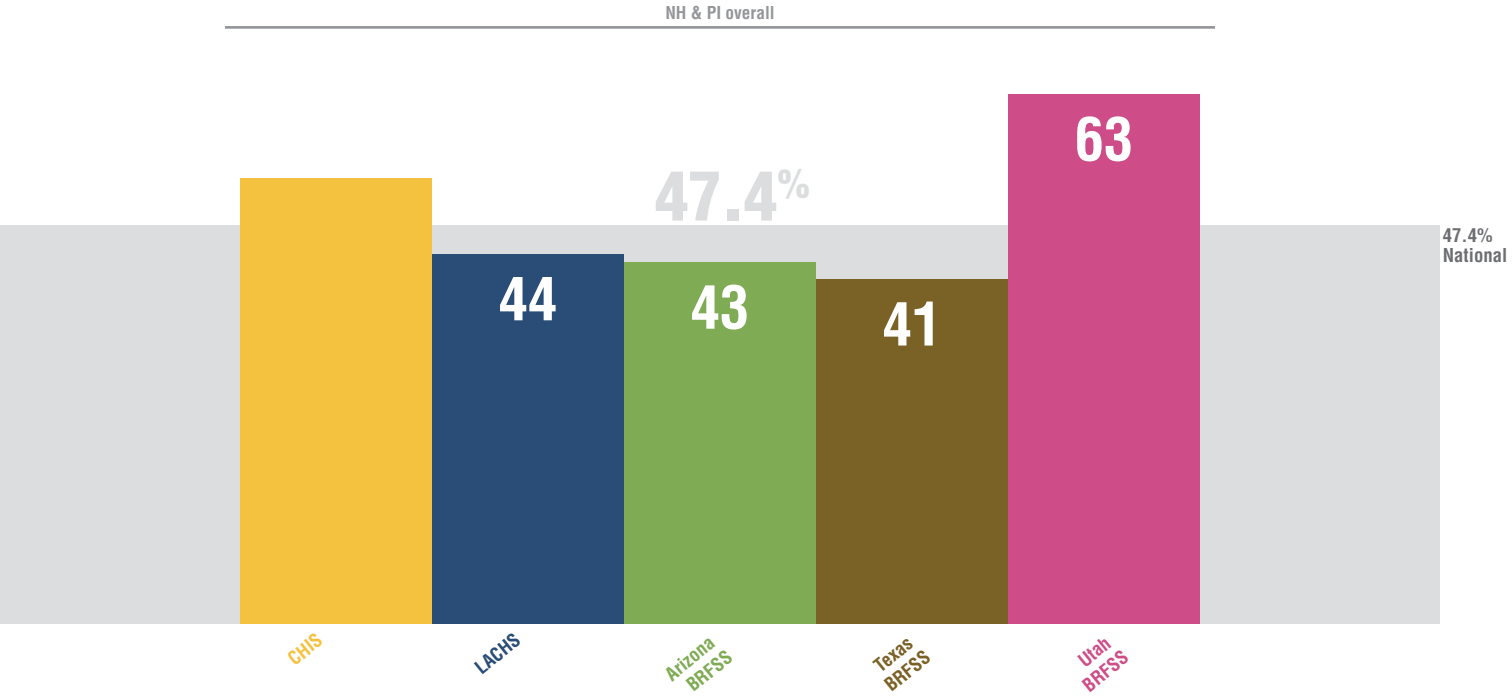
[5]BMI grouping not available for HCS or Hawaii BRFSS; estimates were suppressed for Arizona BRFSS Chinese; Texas BRFSS Chinese; Utah BRFSS Asian Indian and Japanese

- The overall national prevalence of BMI ≥27.5 was 47.4%, from the 2012-2017 NHIS.
- Nationally, prevalence of BMI ≥27.5 was 24% among AA overall, 13% among Chinese, 28% among Asian Indian, and 34% among Filipino.
- Regionally, prevalence of BMI ≥27.5 among AA overall was 16%[2] in NYC (NYC CHS), 22%[4] in NYC (NYC CHRNA), 23% in California, 18%[4] in LA County, 20% in Arizona, 20% in Texas, and 19% in Utah.

WHILE THE PREVALENCE OF BMI ≥27.5 WAS 47.4% NATIONWIDE:

- In NYC (NYC CHS), prevalence of BMI ≥27.5 was 11% among Chinese, 30%[3] among South Asian, 21% among Filipino, 13%[1] among Korean, 7%[1] among Japanese, and 27%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of BMI ≥27.5 was 13%[4] among Chinese, 30%[4] among Asian Indian, 17%[4] among Filipino, 7%[4] among Korean, 3%[4] among Japanese, and 16%[4] among Vietnamese.
- In California, prevalence of BMI ≥27.5 was 18% among Chinese, 24%[3] among South Asian, 36% among Filipino, 11% among Korean, 23% among Japanese, and 15% among Vietnamese; in LA County, prevalence of BMI ≥27.5 was 18%[4] among Chinese, 14%[3,4] among South Asian, 27%[1,4] among Filipino, 14%[4] among Korean, 16%[1,4] among Japanese, and 18%[1,4] among Vietnamese.
- In Arizona, prevalence of BMI ≥27.5 was 17% among Asian Indian and 34% among Filipino.
- In Texas, prevalence of BMI ≥27.5 was 24% among Asian Indian.
- In Utah, prevalence of BMI ≥27.5 was 19% among Chinese.

BMI ≥ 27 in NH&PIs by dataset, 2012-18



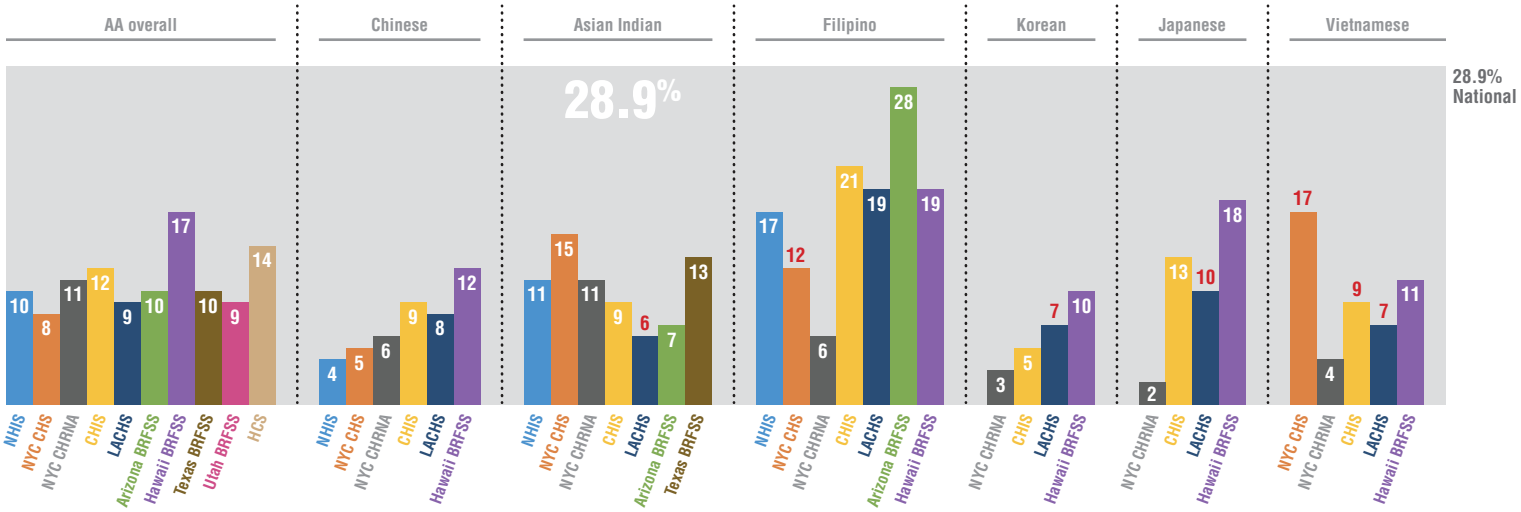
Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17; BMI, body mass index; CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey; NH&PI, Native Hawaiian & Pacific Islander

[1]Crude prevalence - LACHS

[2]BMI not available for NHIS; BMI grouping not available for Hawaii BRFSS

- **The overall national prevalence of BMI ≥27.5 was 47.4%, from the 2012-2017 NHIS.**
- **Regionally, prevalence of BMI ≥27.5 among NH&PI overall was 53% in California, 44%[1] in LA County, 43% in Arizona, 41% in Texas, and 63% in Utah.**

BMI ≥ 30 by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); BMI, body mass index; CHIS, California Health Interview Survey 2013-18; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Filipino and Vietnamese; CHIS Vietnamese; LACHS South Asian, Korean, Japanese, and Vietnamese

[2]AA and NH&PI in place of AA - NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[4]Crude prevalence - NYC CHRNA and LACHS

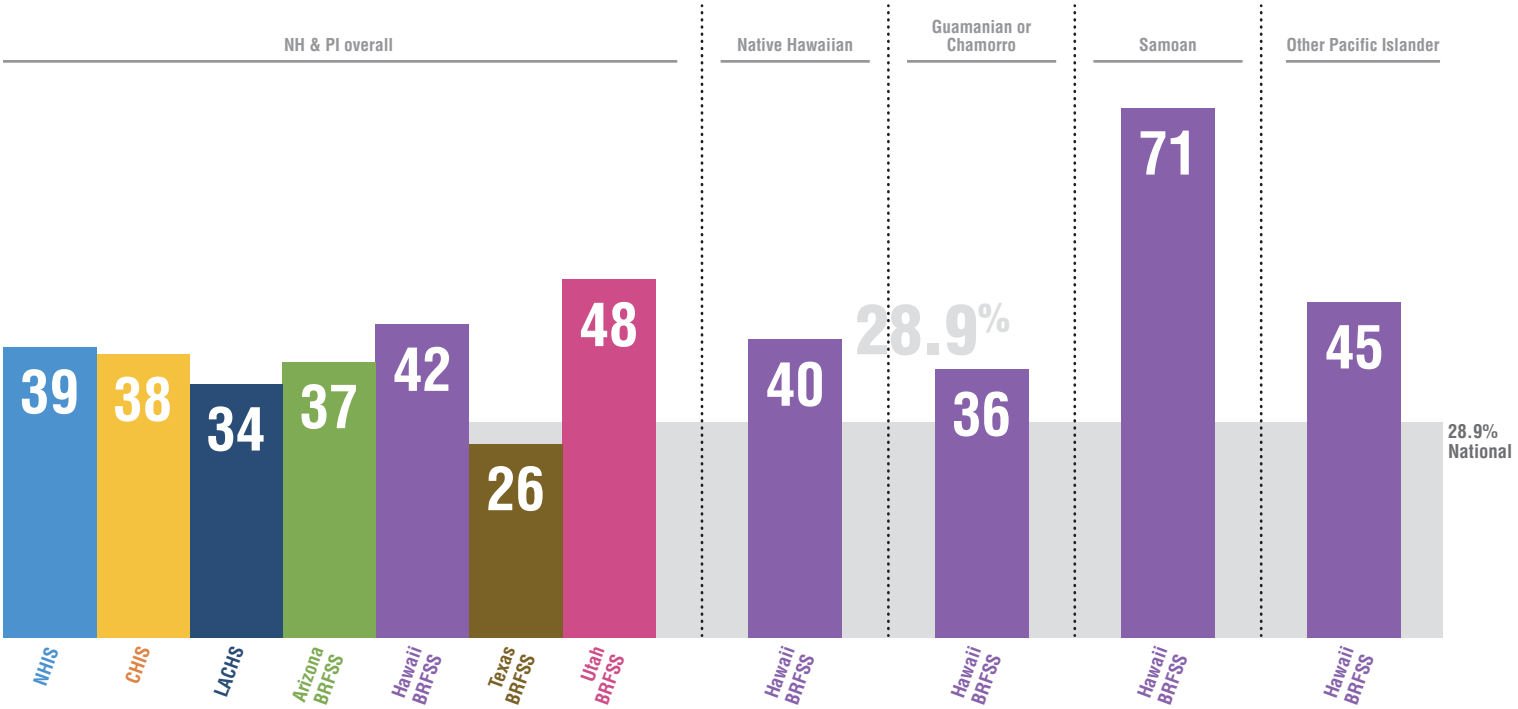
[5]Estimates were suppressed for NYC CHS Korean and Japanese; Arizona BRFSS Chinese; Texas BRFSS Chinese; Utah BRFSS Chinese, Asian Indian and Japanese; HCS Chinese and Asian Indian

- The overall national prevalence of BMI ≥30 was 28.9%, from the 2012-2017 NHIS.
- Nationally, prevalence of BMI ≥30 was 10% among AA overall, 4% among Chinese, 11% among Asian Indian, and 17% among Filipino.
- Regionally, prevalence of BMI ≥30 among AA overall was 8%[2] in NYC (NYC CHS), 11%[4] in NYC (NYC CHRNA), 12% in California, 9%[4] in LA County, 10% in Arizona, 17% in Hawaii, 10% in Texas, 9% in Utah, and 14% in Chicago.

WHILE THE PREVALENCE OF BMI ≥30 WAS 28.9% NATIONWIDE:

- In NYC (NYC CHS), prevalence of BMI ≥30 was 5% among Chinese, 15% among South Asian, 12%[1] among Filipino, and 17%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of BMI ≥30 was 6%[4] among Chinese, 11%[4] among Asian Indian, 6%[4] among Filipino, 3%[4] among Korean, 2%[4] among Japanese, and 4%[4] among Vietnamese.
- In California, prevalence of BMI ≥30 was 9% among Chinese, 9%[3] among South Asian, 21% among Filipino, 5% among Korean, 13% among Japanese, and 9%[1] among Vietnamese; in LA County, prevalence of BMI ≥30 was 8%[4] among Chinese, 6%[1,3,4] among South Asian, 19%[4] among Filipino, 7%[1,4] among Korean, 10%[1,4] among Japanese, and 7%[1,4] among Vietnamese.
- In Arizona, prevalence of BMI ≥30 was 7% among Asian Indian and 28% among Filipino.
- In Hawaii, prevalence of BMI ≥30 was 12% among Chinese, 19% among Filipino, 10% among Korean, 18% among Japanese, and 11% among Vietnamese.
- In Texas, prevalence of BMI ≥30 was 13% among Asian Indian.

BMI ≥ 30 by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); BMI, body mass index; CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

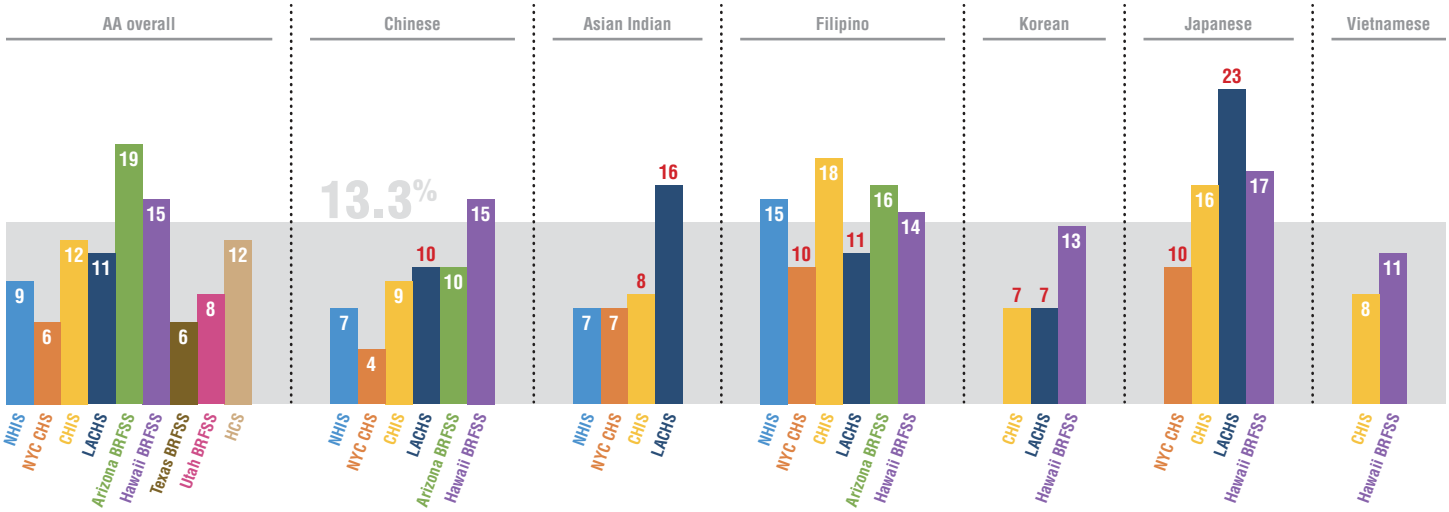
[1]Crude prevalence - LACHS

- The overall national prevalence of BMI ≥30 was 28.9%, from the 2012-2017 NHIS.
- The national prevalence of BMI ≥30 among NH&PI overall was 39%
- Regionally, prevalence of BMI ≥30 among NH&PI overall was 38% in California, 34%[1] in LA County, 37% in Arizona, 42% in Hawaii, 26% in Texas, and 48% in Utah.

WHILE THE PREVALENCE OF BMI ≥30 WAS 28.9% NATIONWIDE:

- In Hawaii, prevalence of BMI ≥30 was 40% among Native Hawaiian, 71% among Samoan, 36% among Guamanian or Chamorro, and 45% among Other Pacific Islander.

Asthma (ever) by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-18; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-14;

[1]Interpret with caution: NYC CHS Filipino and Japanese; CHIS South Asian and Korean; LACHS Chinese, South Asian, Filipino, Korean, and Japanese

[2]AA and NH&PI in place of AA - NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[4]Crude prevalence - LACHS

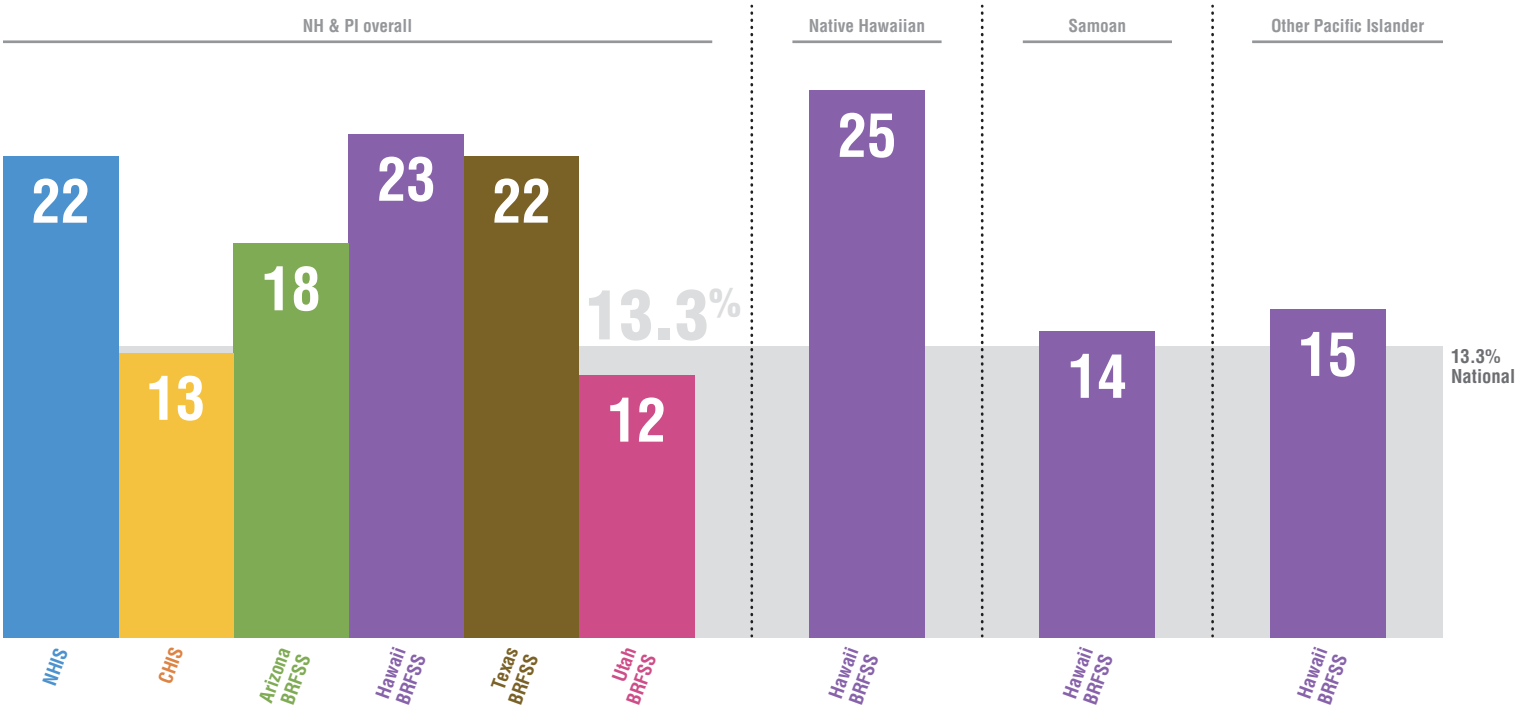
[5]Estimates were suppressed for NYC CHS Korean and Vietnamese; BRFSS Arizona Asian Indian; BRFSS Texas Chinese and Asian Indian; Utah BRFSS Chinese, Asian Indian and Japanese; LACHS Vietnamese; HCS Chinese and Asian Indian

- The overall national prevalence of asthma (ever) was 13.3%, from the 2012-2017 NHIS.
- Nationally, prevalence of asthma (ever) was 9% among AA overall, 7% among Chinese, 7% among Asian Indian, and 15% among Filipino.
- Regionally, prevalence of asthma (ever) among AA overall was 6%[2] in NYC (NYC CHS), 12% in California, 11%[4] in LA County, 19% in Arizona, 15% in Hawaii, 6% in Texas, 8% in Utah, and 12%[2] in Chicago.

WHILE THE PREVALENCE OF ASTHMA (EVER) WAS 13.3% NATIONWIDE:

- In NYC (NYC CHS), prevalence of asthma (ever) was 4% among Chinese, 7%[3] among South Asian, 10%[1] among Filipino, and 10%[1] among Japanese.
- In California, prevalence of asthma (ever) was 9% among Chinese, 8%[1,3] among South Asian, 18% among Filipino, 7%[1] among Korean, 16% among Japanese, and 8% among Vietnamese; in LA County, prevalence of asthma (ever) was 10%[1,4] among Chinese, 16%[1,3,4] among South Asian, 11%[1,4] among Filipino, 7%[1,4] among Korean, and 23%[1,4] among Japanese.
- In Arizona, prevalence of asthma (ever) was 10% among Chinese and 16% among Filipino.
- In Hawaii, prevalence of asthma (ever) was 15% among Chinese, 14% among Filipino, 13% among Korean, 17% among Japanese, and 11% among Vietnamese.

Asthma (ever) by NH&PI subgroup and dataset, 2012-18



Abbreviations: CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey; NH&PI, Native Hawaiian & Pacific Islander; NHIS, National Health Interview Survey 2014; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18)

[1]Estimate was suppressed for LACHS NH&PI

- The overall national prevalence of asthma (ever) was 13.3%, from the 2012-2017 NHIS.
- Nationally, prevalence of asthma (ever) among NH&PI overall was 22%.
- Regionally, prevalence of asthma (ever) among NH&PI overall was 13% in California, 18% in Arizona, 23% in Hawaii, 22% in Texas, and 12% in Utah.

WHILE THE PREVALENCE OF ASTHMA (EVER) WAS 13.3% NATIONWIDE:

- In Hawaii, prevalence of asthma (ever) was 25% among Native Hawaiian, 14% among Samoan, and 15% among Other Pacific Islander.

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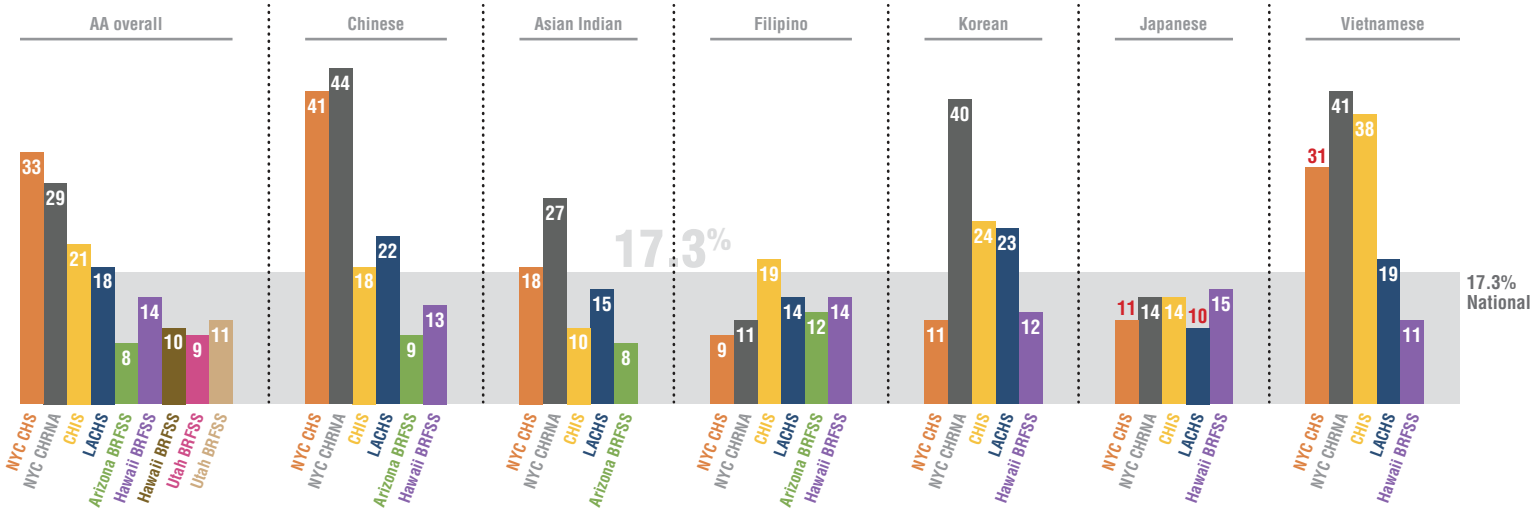
Fair/Poor self-reported health by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-18; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Japanese and Vietnamese; LACHS Japanese

[2]AA and NH&PI in place of AA - NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[4]Crude prevalence - NYC CHRNA, LACHS, Hawaii BRFSS, and 2018 National BRFSS (national prevalence) are crude prevalence

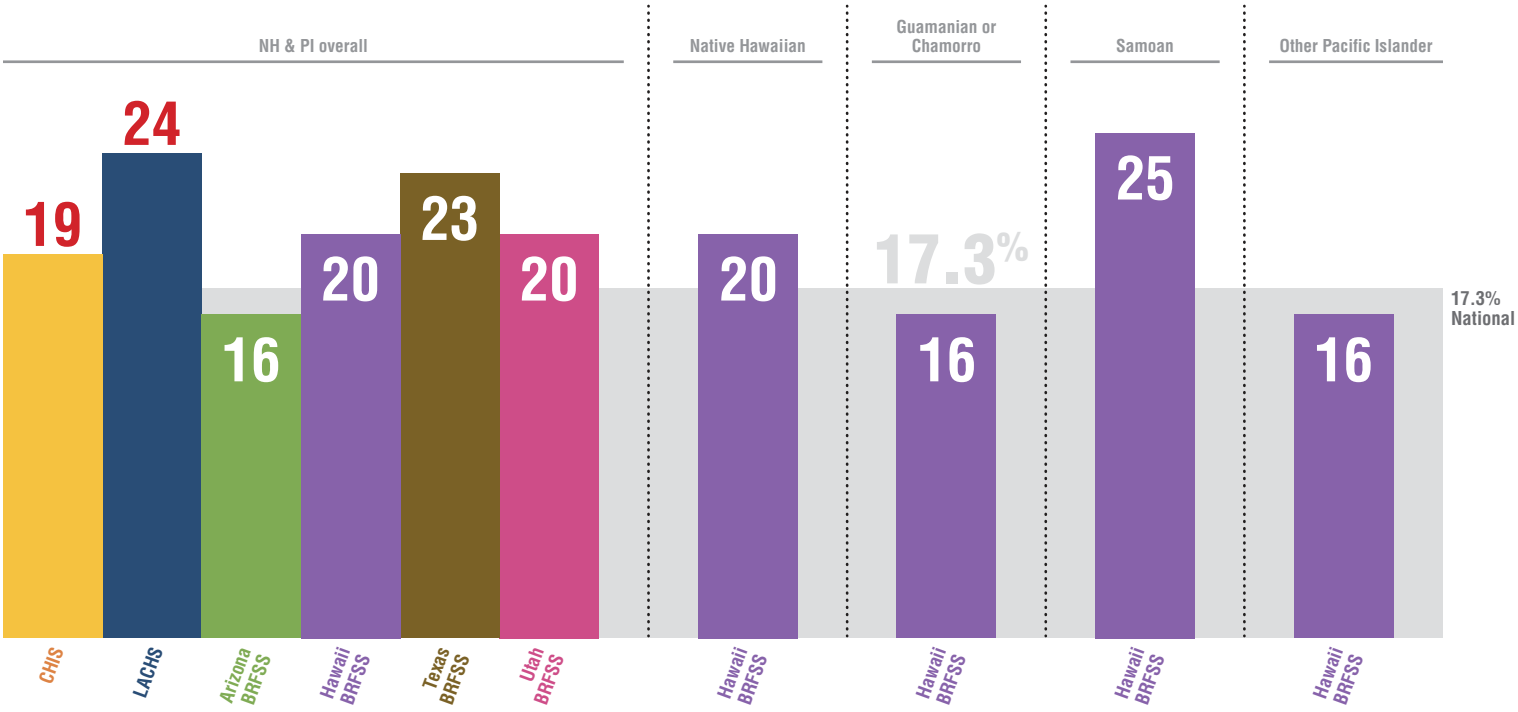
[5]Estimates were suppressed for Texas BRFSS Chinese and Asian Indian; Utah BRFSS Chinese, Asian Indian and Japanese; HCS Chinese and Asian Indian

- The overall national prevalence of fair/poor self-reported health was 17.3%[4], from the 2018 BRFSS.
- Regionally, prevalence of fair/poor self-reported health among AA overall was 33%[2] in NYC (NYC CHS), 29%[4] in NYC (NYC CHRNA), 21% in California, 18%[4] in LA County, 8% in Arizona, 14%[4] in Hawaii, 10% in Texas, 9% in Utah, and 11%[2] in Chicago.

WHILE THE PREVALENCE OF FAIR/POOR SELF-REPORTED HEALTH WAS 17.3% NATIONWIDE:

- In NYC (NYC CHS), prevalence of fair/poor self-reported health was 41% among Chinese, 18%[3] among South Asian, 9% among Filipino, 11% among Korean, 11%[1] among Japanese, and 31%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of fair/poor self-reported health was 44%[4] among Chinese, 27%[4] among Asian Indian, 11%[4] among Filipino, 40%[4] among Korean, 14%[4] among Japanese, and 41%[4] among Vietnamese.
- In California, prevalence of fair/poor self-reported health was 18% among Chinese, 10%[3] among South Asian, 19% among Filipino, 24% among Korean, 14% among Japanese, and 38% among Vietnamese; in LA County, prevalence of fair/poor self-reported health was 22%[4] among Chinese, 15%[3,4] among South Asian, 14%[4] among Filipino, 23%[4] among Korean, 10%[1,4] among Japanese, and 19%[4] among Vietnamese.
- In Arizona, prevalence of fair/poor self-reported health was 9% among Chinese, 8% among Asian Indian, and 12% among Filipino.
- In Hawaii prevalence of fair/poor self-reported health was 13%[4] among Chinese, 14%[4] among Filipino, 12%[4] among Korean, 15%[4] among Japanese, and 11%[4] among Vietnamese.

Fair/Poor self-reported health by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System; CHIS, California Health Interview Survey; LACHS, Los Angeles County Health Survey; NHIS, National Health Interview Survey; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI; LACHS NH&PI

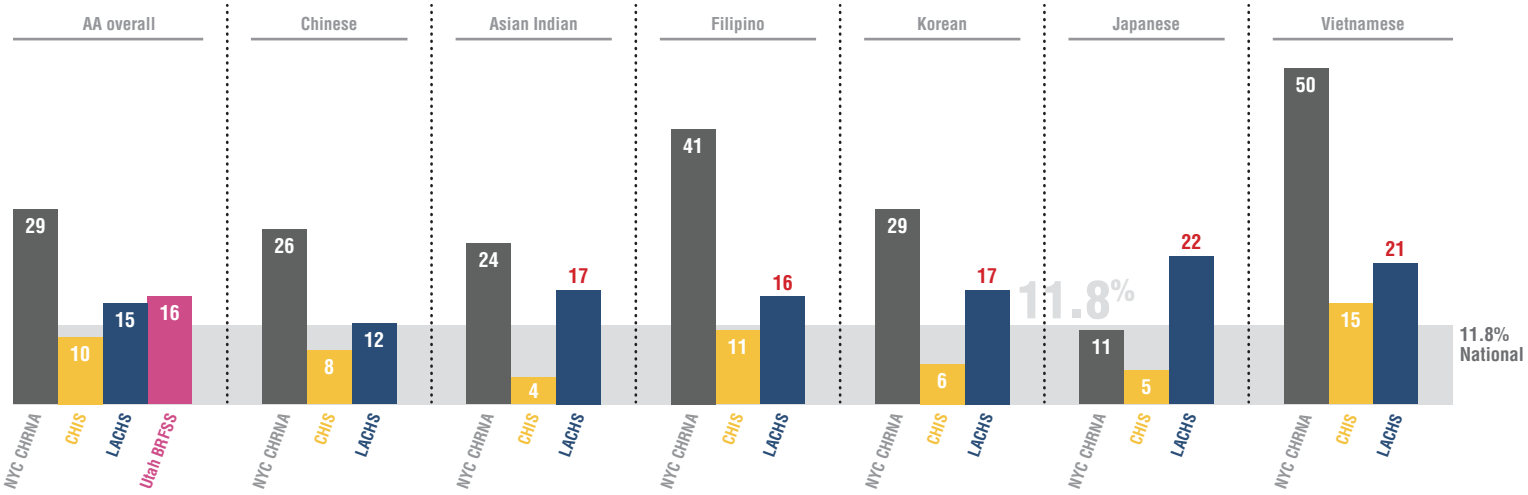
[2]Crude prevalence – LACHS, Hawaii BRFSS, and 2018 national BRFSS

- The overall national prevalence of fair/poor self-reported health was 17.3%[2], from the 2018 BRFSS.
- Regionally, prevalence of fair/poor self-reported health among NH&PI overall was 19%[1] in California, 24%[1,2] in LA County, 16% in Arizona, 20%[2] in Hawaii, 23% in Texas, and 20% in Utah.

WHILE THE PREVALENCE OF FAIR/POOR SELF-REPORTED HEALTH WAS 17.3% NATIONWIDE:

- In Hawaii, prevalence of fair/poor self-reported health was 20% among Native Hawaiian, 16% among Guamanian or Chamorro, 25% among Samoan, and 16% among Other Pacific Islander.

Food Insecurity by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System (Utah 2017); CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey 2015 & 2018; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16

[1]Interpret with caution: LACHS South Asian, Filipino, Korean, Japanese, and Vietnamese

[2]South Asian in place of Asian Indian - CHIS and LACHS

[3]Crude prevalence: LACHS and NYC CHRNA

[4]NYC CHRNA: Food insecurity is based on one question: "How often in the past 12 months would you say you were worried or stressed about having enough money to buy nutritious meals? Sometimes, usually, or always

[5]CHIS: Food insecurity is a scaled question based on a series of five questions. Data presented are for households with incomes <200% FPL. Household income ≥200% are considered food secure.

[6]LACHS: Food insecurity is a scale variable based on a series of five questions. Data presented are for households with incomes <300% FPL [Ref: Ref: SJ Blumberg, K Bialostosky, WL Hamilton, and RR Briefel. The effectiveness of a short form of the Household Food Security Scale. Am J Public Health; 1999(89): 1231-1234]

[7]Utah BRFSS: Food insecurity is based on two questions. Data presented are for all households. [Ref: Hager et al. Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics; 2010]

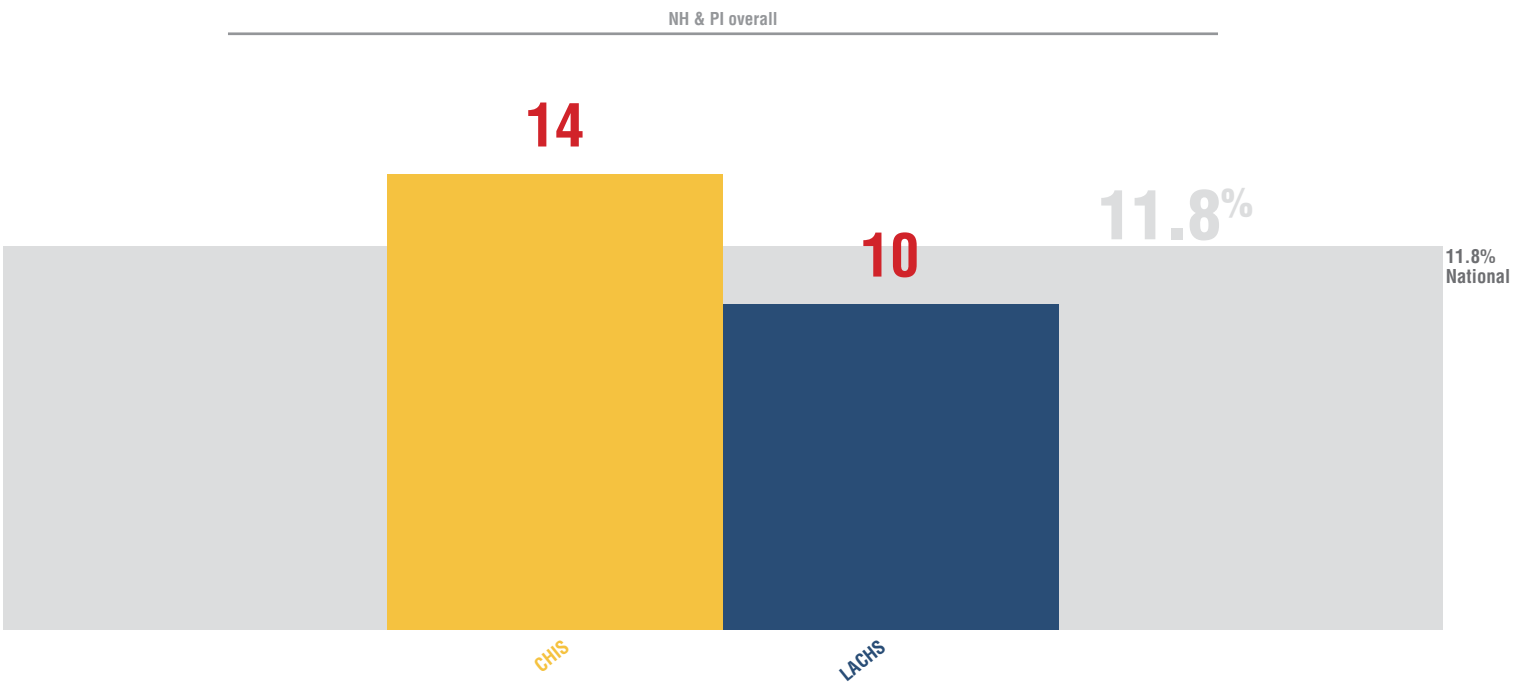
[8]Food insecurity was not asked on NHIS, NYC CHS, Arizona, Hawaii or Texas BRFSS, or HCS; estimates were suppressed for Utah BRFSS Chinese, Asian Indian and Japanese

- Questions to determine food insecurity differed by dataset.
- The overall national prevalence of food insecurity was 11.8%, from the 2017 U.S. Census Bureau Food Security Supplements Survey.
- Regionally, prevalence of food insecurity among AA overall was 29%[3,4] in NYC (NYC CHRNA), 10%[5] in California, 15%[3,6] in LA County, and 16%[7] in Utah.

WHILE THE PREVALENCE OF FOOD INSECURITY WAS 11.8% NATIONWIDE:

- In NYC (NYC CHRNA), prevalence of food insecurity was 8%[3,4] among Chinese, 4%[3,4] among Asian Indian, 41%[3,4] among Filipino, 29%[3,4] among Korean, 11%[3,4] among Japanese, and 50%[3,4] among Vietnamese.
- In California, prevalence of food insecurity among individuals with household income <200% FPL was 8%[5] among Chinese, 4%[2,5] among South Asian, 11%[5] among Filipino, 6%[5] among Korean, 5%[5] among Japanese, and 15%[5] among Vietnamese; in LA County prevalence of food insecurity among individuals with household income <300% FPL was 12%[3,6] among Chinese, 17%[2,3,6] among South Asian, 16%[3,6] among Filipino, 17%[3,6] among Korean, 22%[3,6] among Japanese, and 21%[3,6] among Vietnamese.

Food Insecurity in NH&PIs by dataset, 2012-18



Abbreviations: CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey 2015 & 2018; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI; LACHS NH&PI

[2]Crude prevalence: LACHS

[3]CHIS: Food insecurity is a scaled question based on a series of five questions. Data presented are for households with incomes <200% FPL. Those with household income ≥200% are considered food secure.

[4]LACHS, crude prevalence: Food insecurity is a scale variable based on a series of five questions. Data presented are for households with incomes <300% FPL [Ref: Ref: SJ Blumberg, K Bialostosky, WL Hamilton, and RR Briefel. The effectiveness of a short form of the Household Food Security Scale. Am J Public Health; 1999(89): 1231-1234]

[5]Food insecurity was not asked on NHIS, Arizona, Hawaii, or Texas BRFSS; estimates were suppressed for Utah BRFSS NH&PI

- **The overall national prevalence of food insecurity was 11.8%, from the 2017 U.S. Census Bureau Food Security Supplements Survey.**
- **Regionally, prevalence of food insecurity among NH&PI overall was 14%[3] in California and 10%[2,4] in LA County.**

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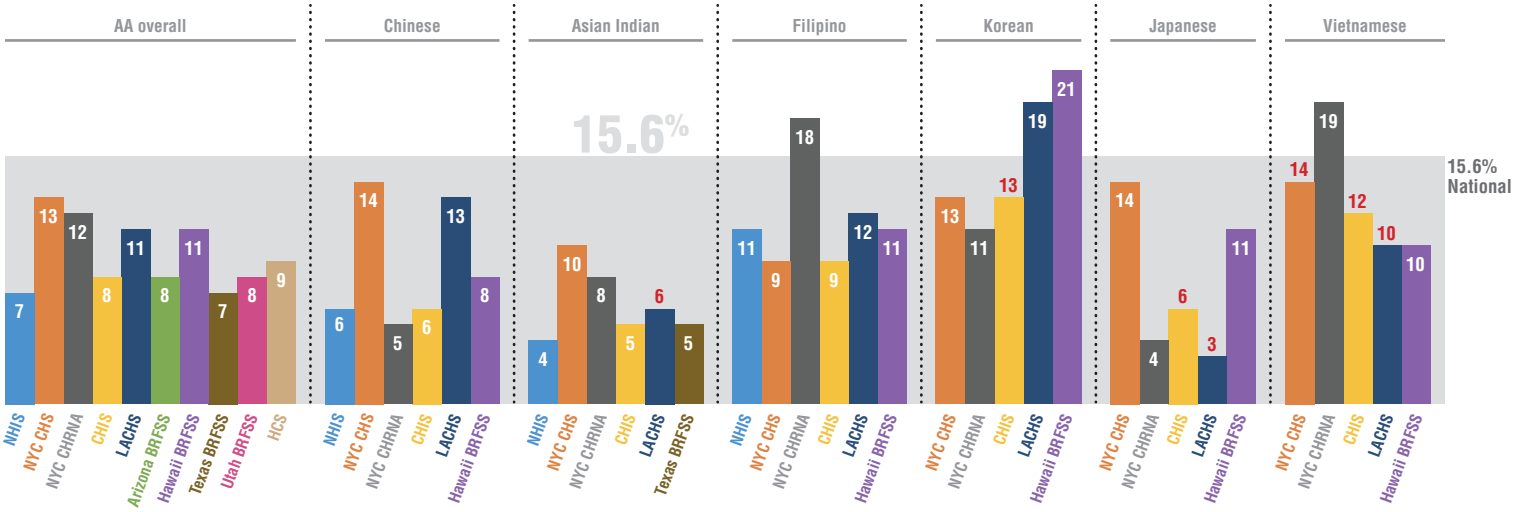
3. LIFESTYLE BEHAVIORS

Current smoker by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-18; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17;

[1]Interpret with caution: NYC CHS Vietnamese; CHIS Korean, Japanese, and Vietnamese; LACHS South Asian, Japanese, and Vietnamese

[2]AA and NH&PI in place of AA - NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[4]Crude prevalence - NYC CHRNA and LACHS

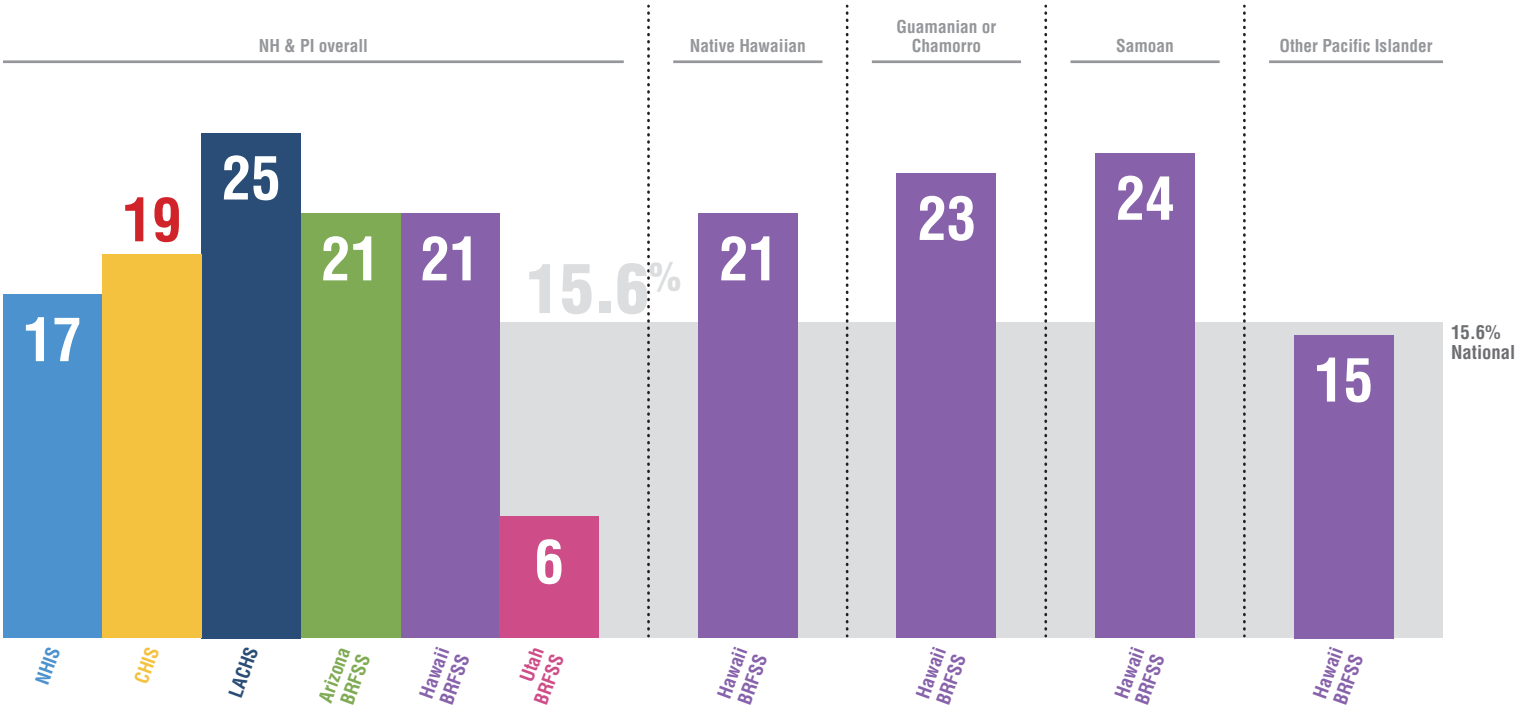
[5]Estimates were suppressed on Arizona BRFSS Chinese, Asian Indian and Filipino; Texas BRFSS Chinese; Utah BRFSS Chinese, Asian Indian and Japanese; HCS Chinese and Asian Indian

- The overall national prevalence of current smoking was 15.6%, from the 2012-2017 NHIS.
- Nationally, prevalence of current smoking was 7% among AA overall, 6% among Chinese, 4% among Asian Indian, and 11% among Filipino.
- Regionally, prevalence of current smoking among AA overall was 13%[2] in NYC (NYC CHS), 12%[4] in NYC (NYC CHRNA), 8% in California, 11%[4] in LA County, 8% in Arizona, 11% in Hawaii, 7% in Texas, 8% in Utah, and 9%[2] in Chicago.

WHILE THE PREVALENCE OF CURRENT SMOKING WAS 15.6% NATIONWIDE:

- In NYC (NYC CHS), prevalence of current smoking was 14% among Chinese, 10%[3] among South Asian, 9% among Filipino, 13% among Korean, 14% among Japanese, and 14%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of current smoking was 5%[4] among Chinese, 8%[4] among Asian Indian, 18%[4] among Filipino, 11%[4] among Korean, 4%[4] among Japanese, and 19%[4] among Vietnamese.
- In California, prevalence of current smoking was 6% among Chinese, 5%[3] among South Asian, 9% among Filipino, 13%[1] among Korean, 6%[1] among Japanese, and 12%[1] among Vietnamese; in LA County, prevalence of current smoking was 13% among Chinese, 6%[1,3,4] among South Asian, 12%[4] among Filipino, 19% among Korean, 3%[1,4] among Japanese, and 10%[1,4] among Vietnamese.
- In Hawaii, prevalence of current smoking was 8% among Chinese, 11% among Filipino, 21% among Korean, 11% among Japanese, and 10% among Vietnamese.
- In Texas, prevalence of current smoking was 5% among Asian Indian.

Current smoker by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI

[2]Crude prevalence: LACHS

[3]Estimates were suppressed for Texas BRFSS

- The overall national prevalence of current smoking was 15.6%, from the 2012-2017 NHIS.
- Nationally, prevalence of current smoking among NH&PI overall was 17%.
- Regionally, prevalence of current smoking among NH&PI overall was 19%[1] in California, 25%[2] in LA County, 21% in Arizona, 21% in Hawaii, and 6% in Utah.

WHILE THE PREVALENCE OF CURRENT SMOKING WAS 15.6% NATIONWIDE:

- In Hawaii, prevalence of current smoking was 21% among Native Hawaiian, 23% among Guamanian or Chamorro, 24% among Samoan, and 15% among Other Pacific Islander.

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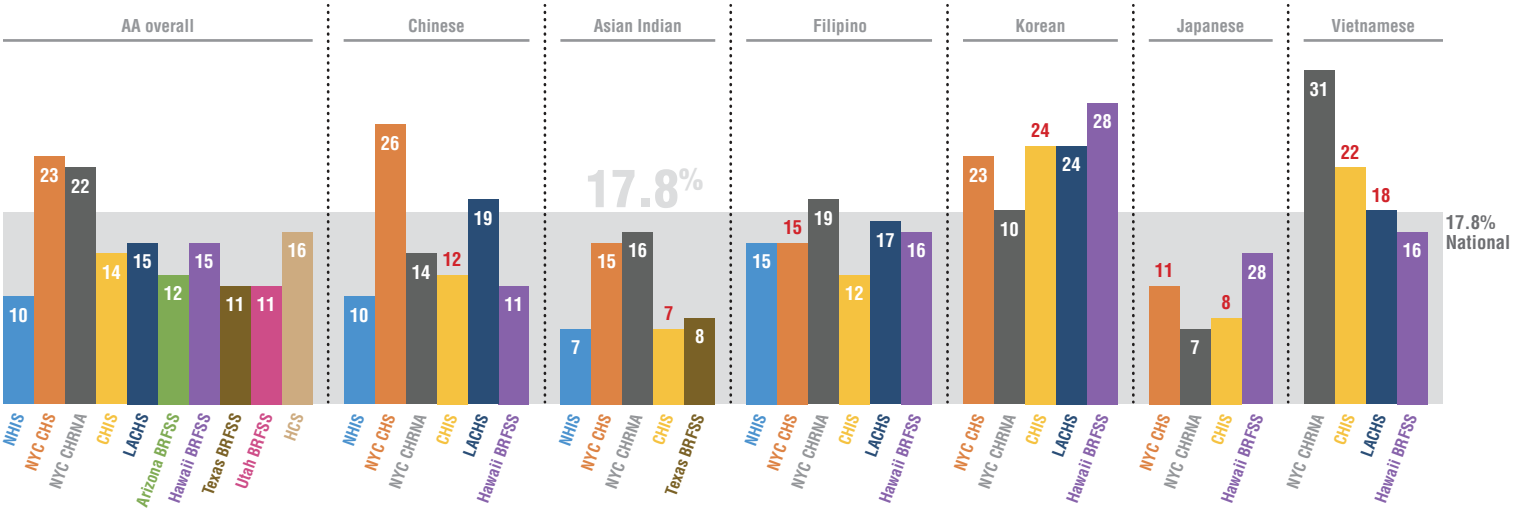
Current smokers among men, by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-18; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Filipino and Japanese; CHIS Chinese, South Asian, Korean, Japanese, and Vietnamese; LACHS Vietnamese

[2]AA and NH&PI in place of Asian – NYC CHS and HCS; [3]South Asian in place of Asian Indian – NYC CHS and CHIS;

[4]Crude prevalence - NYC CHRNA and LACHS

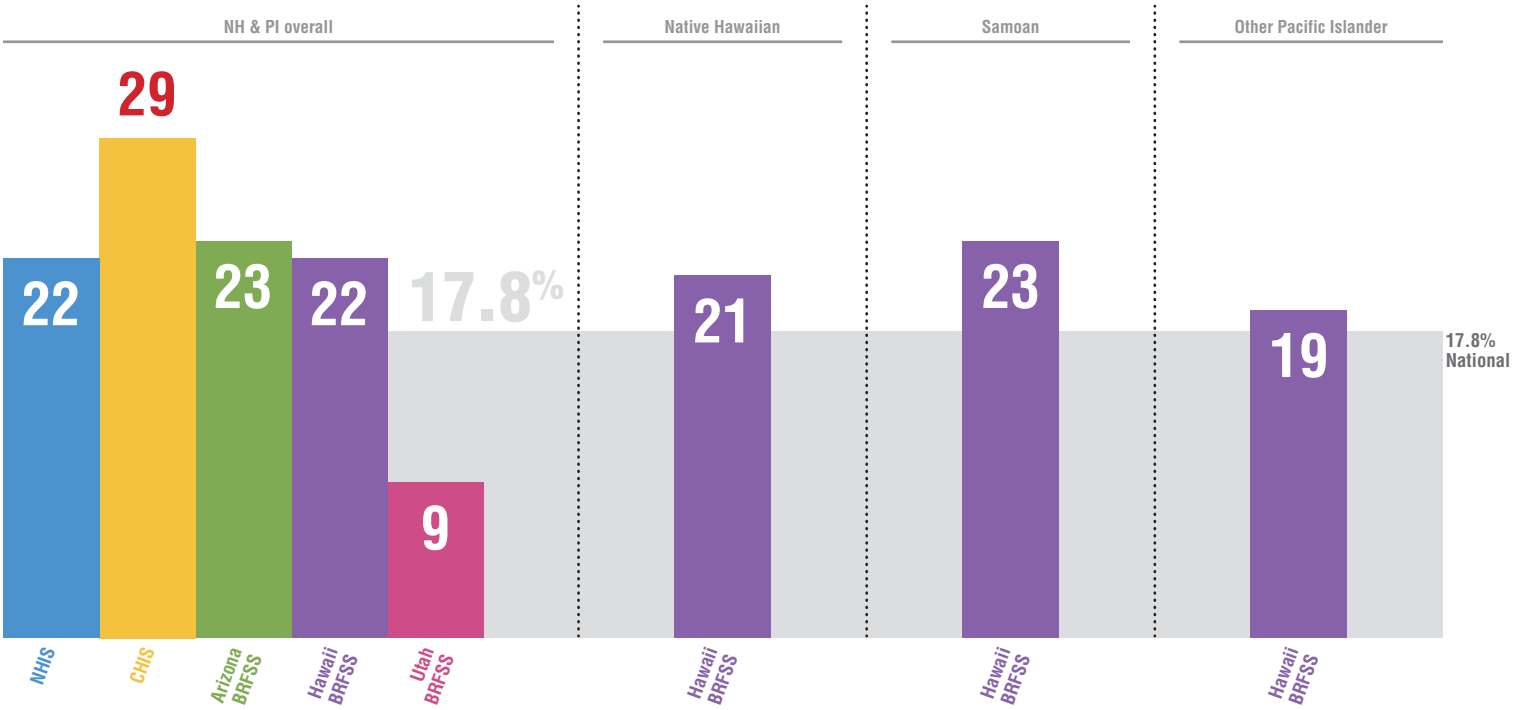
[5]Estimates were suppressed for NYC CHS Vietnamese; Arizona BRFSS Chinese, Asian Indian and Filipino; Texas BRFSS Chinese; Utah BRFSS Chinese, Asian Indian and Japanese; LACHS South Asian and Japanese; HCS Chinese and Asian Indian

- The overall national prevalence of current smoking among men was 17.8%, from the 2012-2017 NHIS.
- Nationally, prevalence of current smoking among men was 10% among AA overall, 10% among Chinese, 7% among Asian Indian, and 15% among Filipino.
- Regionally, prevalence of current smoking among men among AA overall was 23%[2] in NYC (NYC CHS), 22%[4] in NYC (NYC CHRNA), 14% in California, 15%[4] in LA County, 12% in Arizona, 15% in Hawaii, 11% in Texas, 11% in Utah, and 16%[2] in Chicago.

WHILE THE PREVALENCE OF CURRENT SMOKING AMONG MEN WAS 17.8% NATIONWIDE:

- In NYC (NYC CHS), prevalence of current smoking among men was 26% among Chinese, 15%[3] among South Asian, 15%[1] among Filipino, 23% among Korean, and 11%[1] among Japanese; in NYC (NYC CHRNA), prevalence of current smoking among men was 14%[4] among Chinese, 16%[4] among Asian Indian, 19%[4] among Filipino, 18%[4] among Korean, 7%[4] among Japanese, and 31%[4] among Vietnamese.
- In California, prevalence of current smoking among men was 12%[1] among Chinese, 7%[1,3] among South Asian, 12% among Filipino, 24%[1] among Korean, 8%[1] among Japanese, and 22%[1] among Vietnamese; in LA County, prevalence of current smoking among men was 19%[4] among Chinese, 17%[4] among Filipino, 24%[4] among Korean, and 18%[1,4] among Vietnamese.
- In Hawaii, prevalence of current smoking among men was 11% among Chinese, 16% among Filipino, 28% among Korean, 14% among Japanese, and 16% among Vietnamese.
- In Texas, prevalence of current smoking among men was 8% among Asian Indian.

Current smokers among men, by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-18; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI

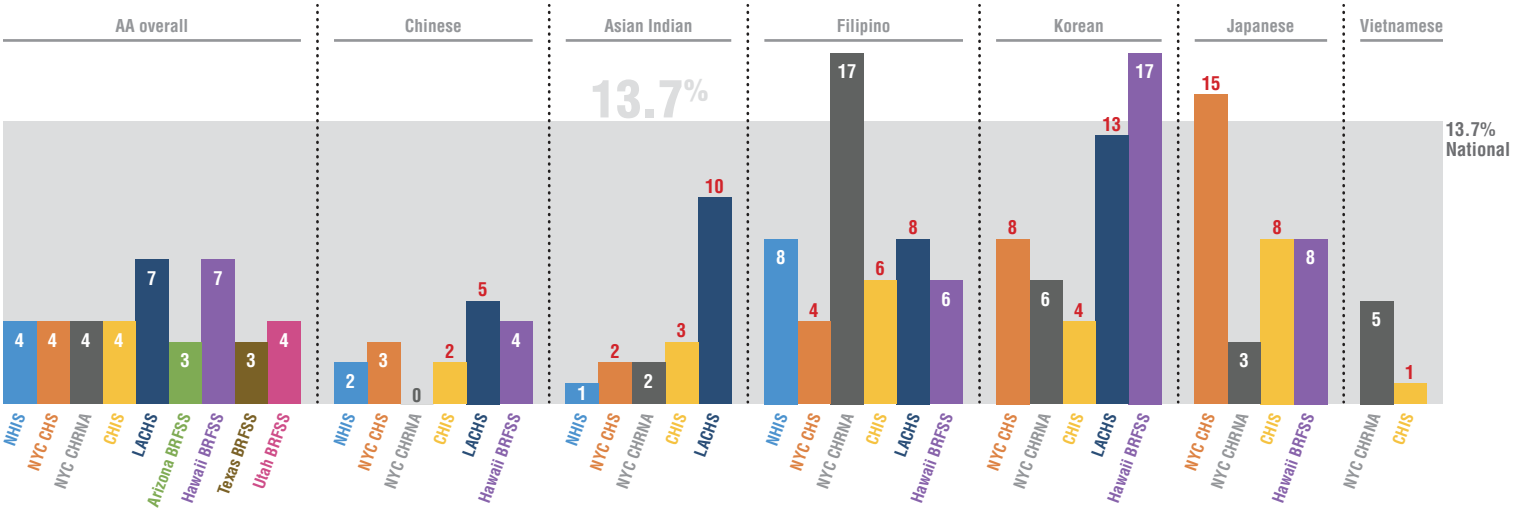
[2]Estimates were suppressed for Texas BRFSS NH&PI and LACHS NH&PI

- The overall national prevalence of current smoking among men was 17.8%, from the 2012-2017 NHIS.
- Nationally, prevalence of current smoking among men was 22% among NH&PI overall.
- Regionally, prevalence of current smoking among men among NH&PI overall was 29%[1] in California, 23% in Arizona, 22% in Hawaii, and 9% in Utah.

WHILE THE PREVALENCE OF CURRENT SMOKING AMONG MEN WAS 17.8% NATIONWIDE:

- In Hawaii, prevalence of current smoking among men was 21% among Native Hawaiian, 23% among Samoan, and 19% among Other Pacific Islander.

Current smokers among women, by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-18; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS South Asian, Filipino, Korean and Japanese; CHIS Chinese, South Asian, Filipino, Korean, Japanese, and Vietnamese; LACHS Chinese, South Asian, Filipino, and Korean

[2]AA and NH&PI in place of AA - NYC CHS; [3]South Asian in place of Asian Indian - NYC CHS and CHIS

[4]Crude prevalence - NYC CHRNA and LACHS

[5]Estimates were suppressed for NYC CHS Vietnamese; Arizona BRFSS Chinese, Asian Indian and Filipino; Texas BRFSS Chinese and Asian Indian; Utah BRFSS Chinese, Asian Indian and Japanese; LACHS Japanese and Vietnamese; HCS AA overall, Chinese and Asian Indian

- The overall national prevalence of current smoking among women was 13.7%, from the 2012-2017 NHIS.
- Nationally, the prevalence of current smoking among women was 4% among AA overall, 2% among Chinese, 1% among Asian Indian, and 8% among Filipino.
- Regionally, the prevalence of current smoking among women among AA overall was 4%[2] in NYC (NYC CHS), 4%[4] in NYC (NYC CHRNA), 4% in California, 7%[4] in LA County, 3% in Arizona, 7% in Hawaii, 3% in Texas, and 4% in Utah.

WHILE THE PREVALENCE OF CURRENT SMOKING AMONG WOMEN WAS 13.7% NATIONWIDE:

- In NYC (NYC CHS), the prevalence of current smoking among women was 3% among Chinese, 2%[1,3] among South Asian, 4%[1] among Filipino, 8%[1] among Korean, and 15%[1] among Japanese; in NYC (NYC CHRNA), the prevalence of current smoking among women was 0%[4] among Chinese, 2%[4] among Asian Indian, 17%[4] among Filipino, 6%[4] among Korean, 3%[4] among Japanese, and 5%[4] among Vietnamese.
- In California, the prevalence of current smoking among women was 2%[1] among Chinese, 3%[1,3] among South Asian, 6%[1] among Filipino, 4%[1] among Korean, 8%[1] among Japanese, and 1%[1] among Vietnamese; in LA County, the prevalence of current smoking among women was 5%[1,4] among Chinese, 10%[1,3,4] among South Asian, 8%[1,4] among Filipino, and 13%[1,4] among Korean.
- In Hawaii, the prevalence of current smoking among women was 4% among Chinese, 6% among Filipino, 17% among Korean, and 8% among Japanese.

Current smokers among women, by NH&PI subgroup and dataset, 2012-18

Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-18; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

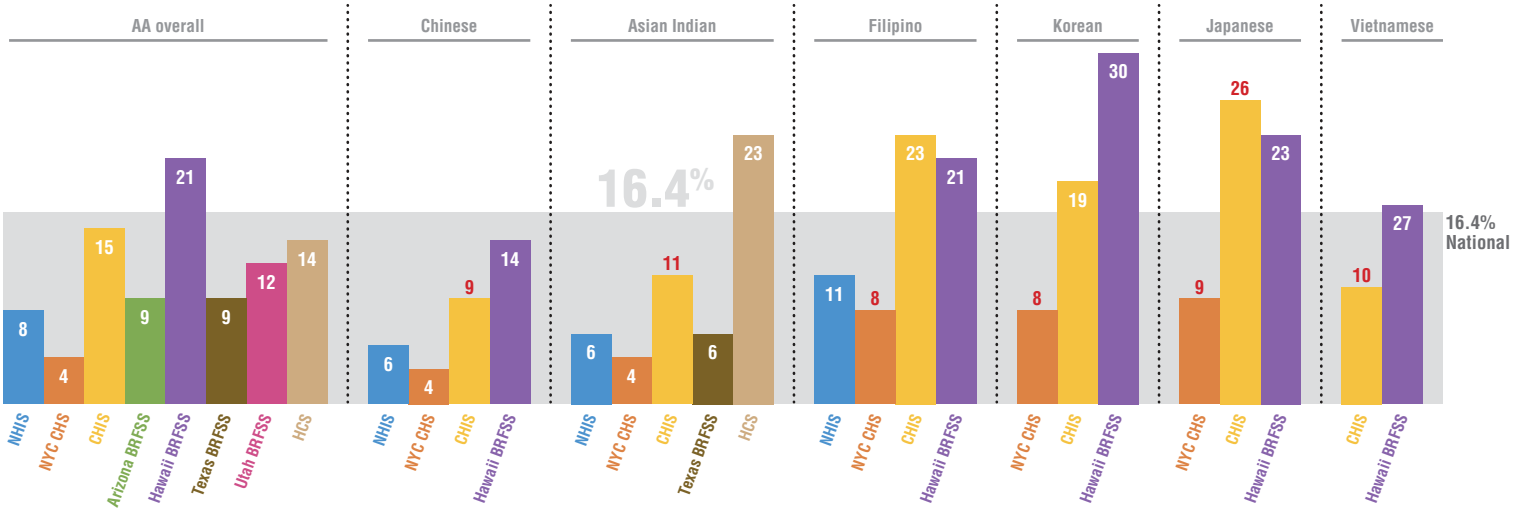
[1]Estimates were suppressed for Arizona BRFSS NH&PI; Texas BRFSS NH&PI; LACHS NH&PI

- The overall national prevalence of current smoking among women was 13.7%, from the 2012-2017 NHIS.
- Nationally, prevalence of current smoking among women among NH&PI overall was 11%.
- Regionally, prevalence of current smoking among women among NH&PI overall was 11% in California, 20% in Hawaii, and 3% in Utah.

WHILE THE PREVALENCE OF CURRENT SMOKING AMONG WOMEN WAS 13.7% NATIONWIDE:

- In Hawaii, prevalence of current smoking among women was 20% among Native Hawaiian, 24% among Samoan, and 11% among Other Pacific Islander.

Ever used e-cigarette by AA subgroup and dataset, 2014-2018



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System (Arizona 2016-17, Hawaii 2014 & 2016-18, Texas 2015-18, Utah 2016-18); CHIS, California Health Interview Survey 2015-18; HCS, Healthy Chicago Survey; NHIS, National Health Interview Survey 2016-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHS, NYC Community Health Survey 2016-17

[1]Interpret with caution: NYC CHS Filipino, Korean, and Japanese; CHIS Chinese, Korean, Japanese, and Vietnamese

[2]AA and NH&PI in place of AA – NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS and CHIS;

[4]NYC CHS includes e-cigarette use in past year

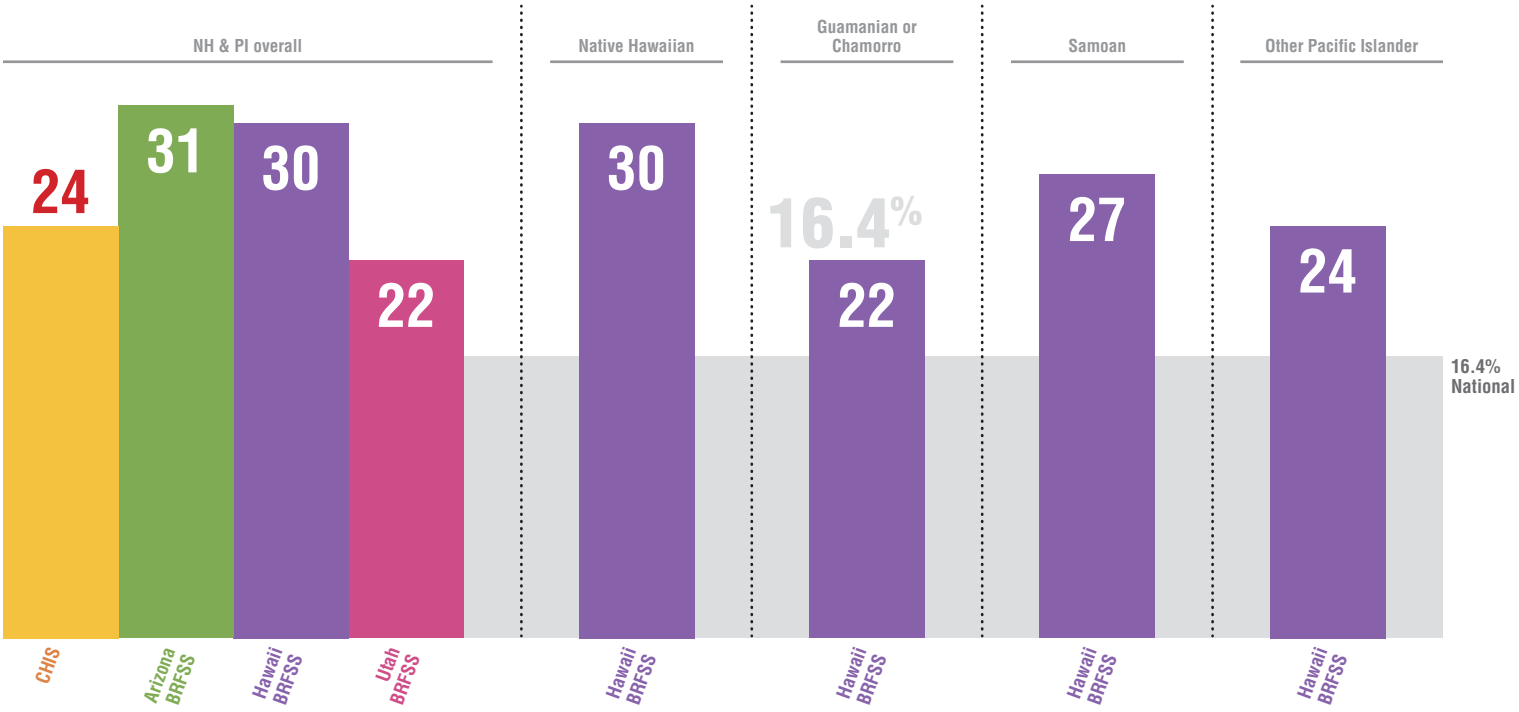
[5]Question not asked on NYC CHRNA or LACHS; estimates were suppressed for NYC CHS Vietnamese; Arizona BRFSS Chinese, Asian Indian and Filipino; Texas BRFSS Chinese; Utah BRFSS Chinese, Asian Indian and Japanese; HCS Chinese

- The overall national prevalence of ever using an e-cigarette was 16.4%, from the 2016-2017 NHIS.
- Nationally, prevalence of ever using an e-cigarette was 8% among AA overall, 5% among Chinese, 6% among Asian Indian, and 11% among Filipino.
- Regionally, prevalence of ever using an e-cigarette among AA overall was 4%[2] in NYC (NYC CHS), 15% in California, 9% in Arizona, 21% in Hawaii, 9% in Texas, 12% in Utah, and 14%[2] in Chicago.

WHILE THE PREVALENCE OF EVER USING AN E-CIGARETTE WAS 16.4% NATIONWIDE:

- In NYC (NYC CHS), prevalence of using an e-cigarette in the past year was 3%[4] among Chinese, 4%[1,3,4] among South Asian, 8%[1,4] among Filipino, 8%[1,4] among Korean, and 9%[1,4] among Japanese.
- In California, prevalence of ever using an e-cigarette was 9%[1] among Chinese, 11%[3] among South Asian, 23% among Filipino, 19%[1] among Korean, 26%[1] among Japanese, and 10%[1] among Vietnamese.
- In Hawaii prevalence of ever using an e-cigarette was 14% among Chinese, 21% among Filipino, 30% among Korean, 23% among Japanese, and 17% among Vietnamese.
- In Texas, prevalence of ever using an e-cigarette was 6% among Asian Indian.

Ever used e-cigarette by NH&PI subgroup and dataset, 2014-2018



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System (Arizona 2016-17, Hawaii 2014 & 2016-18, Utah 2016-18); CHIS, California Health Interview Survey 2015-18; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI

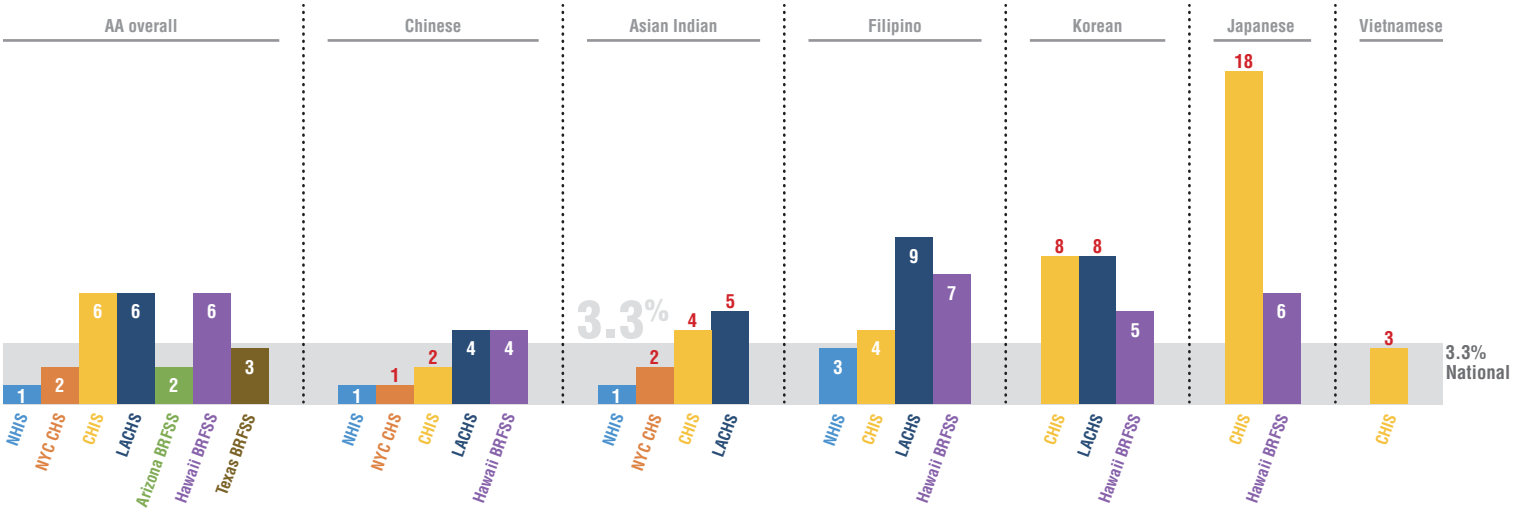
[2]Question was not included on NHIS NH&PI sample or LACHS; estimate was suppressed for Texas BRFSS NH&PI

- The overall national prevalence of ever using an e-cigarette was 16.4%, from the 2016-2017 NHIS.
- Regionally, the prevalence of ever using an e-cigarette among NH&PI overall was 24%[1] in California, 31% in Arizona, 30% in Hawaii, and 22% in Utah.

WHILE THE PREVALENCE OF EVER USING AN E-CIGARETTE WAS 16.4% NATIONWIDE:

- In Hawaii, the prevalence of ever using an e-cigarette was 30% among Native Hawaiian, 22% among Guamanian or Chamorro, 27% among Samoan, and 24% among Other Pacific Islander.

Current e-cigarette use by AA subgroup and dataset, 2014-2018



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System (Arizona 2016-17, Hawaii 2014 & 2016-18, Texas 2015-17); CHIS, California Health Interview Survey 2015-18; LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2016-17; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHS, NYC Community Health Survey 2016-17

[1]Interpret with caution: NYC CHS Chinese and South Asian; CHIS Chinese, South Asian, Korean, Japanese, and Vietnamese; LACHS South Asian and Korean

[2]AA and NH&PI in place of AA – NYC CHS; [3]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[4]Crude prevalence - LACHS

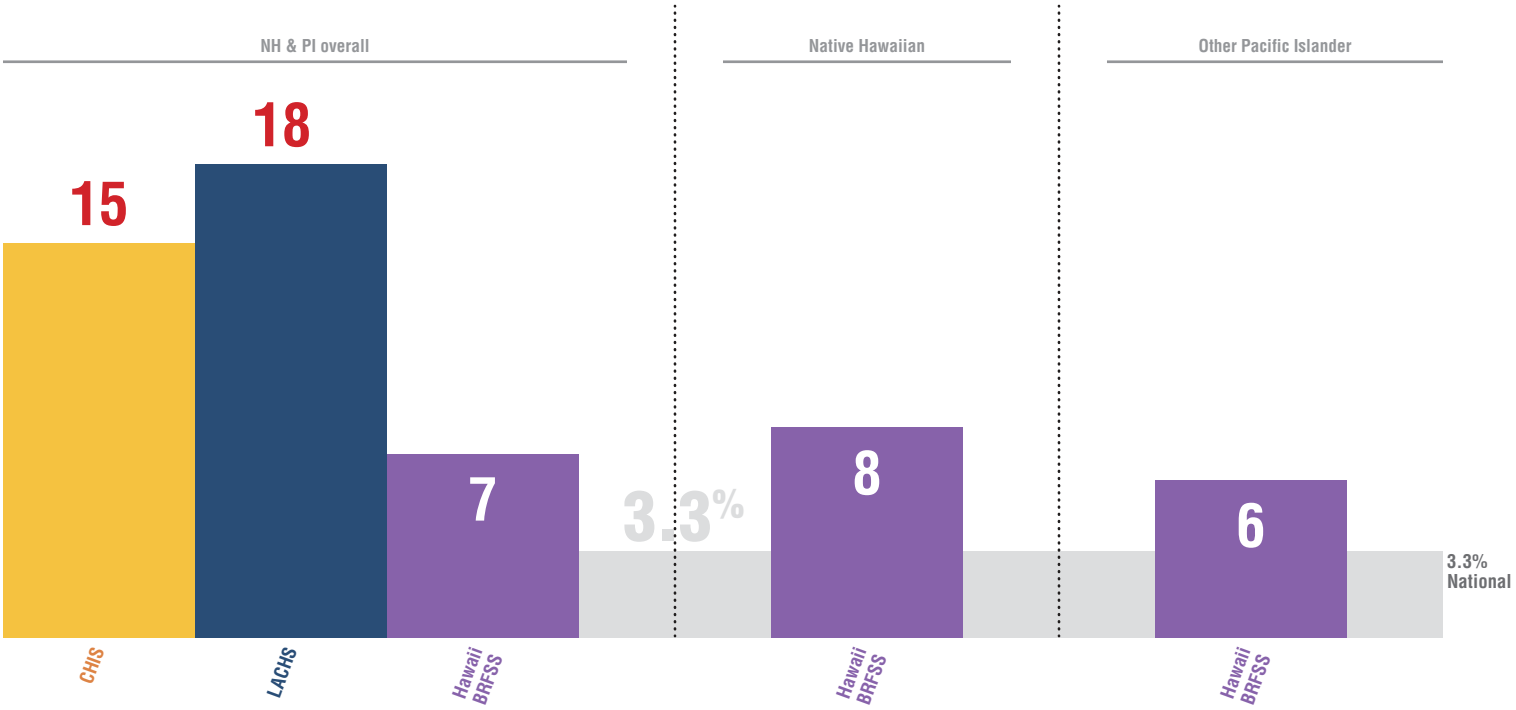
[5]Question not asked on NYC CHRNA; estimates were suppressed for NYC CHS Filipino, Korean, Japanese, and Vietnamese; LACHS Japanese and Vietnamese; Arizona BRFSS Chinese, Asian Indian and Filipino; Texas BRFSS Chinese and Asian Indian; Utah BRFSS AA overall, Chinese, Asian Indian and Japanese; HCS AA overall, Chinese and Asian Indian

- The overall national prevalence of current e-cigarette use was 3.3%, from the 2016-2017 NHIS.
- Nationally, prevalence of current e-cigarette use was 1% among AA overall, 1% among Chinese, 1% among Asian Indian, and 3% among Filipino.
- Regionally, prevalence of current e-cigarette use among AA overall was 2%[2] in NYC (NYC CHS), 6% in California, 6%[4] in LA County, 2% in Arizona, 6% in Hawaii, and 3% in Texas.

WHILE THE PREVALENCE OF CURRENT E-CIGARETTE USE WAS 3.3% NATIONWIDE:

- In NYC (NYC CHS), prevalence of current e-cigarette use was 1%[1] among Chinese and 2%[1] among South Asian.
- In California, prevalence of current e-cigarette use was 2%[1] among Chinese, 4%[1] among South Asian, 4% among Filipino, 8%[1] among Korean, 18%[1] among Japanese, and 3%[1] among Vietnamese; In LA County, prevalence of current e-cigarette use was 4%[4] among Chinese, 5%[1,3,4] among South Asian, 9%[4] among Filipino, and 8%[1,4] among Korean.
- In Hawaii, prevalence of current e-cigarette use was 4% among Chinese, 7% among Filipino, 5% among Korean, and 6% among Japanese.

Current e-cigarette use by NH&PI subgroup and dataset, 2014-2018



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System (Hawaii 2014 & 2016-18); CHIS, California Health Interview Survey 2015-18; LACHS, Los Angeles County Health Survey; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI; LACHS NH&PI

[2]Crude prevalence - LACHS

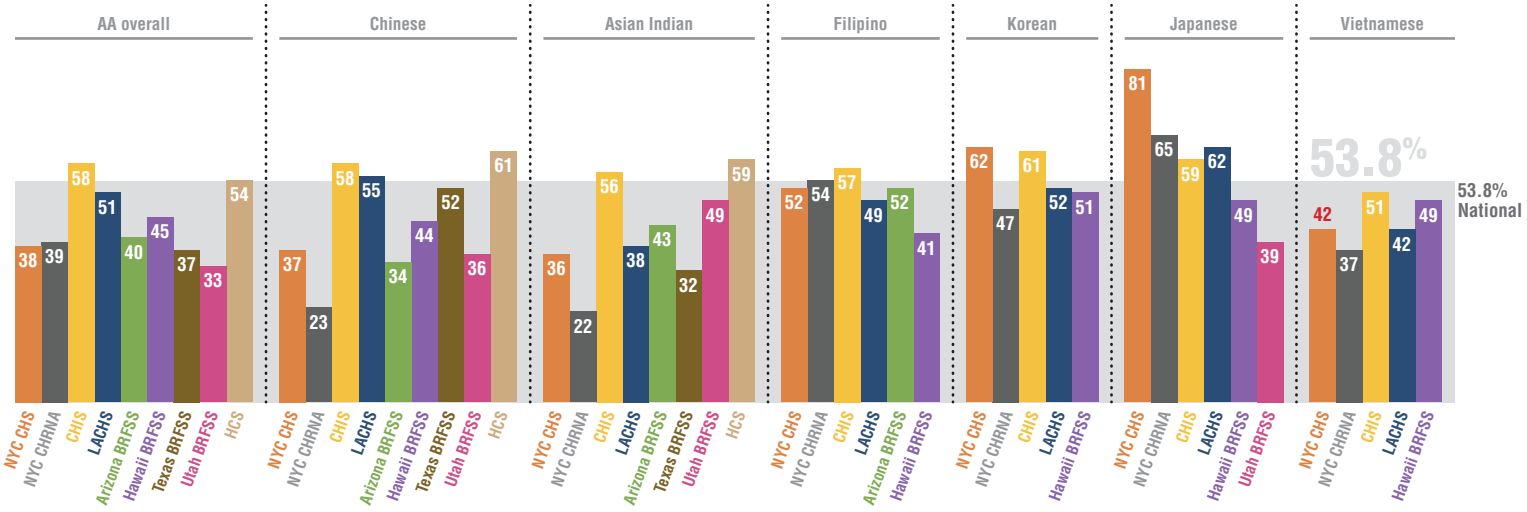
[3]Question was not included on NHIS NH&PI sample; estimates were suppressed for Arizona BRFSS NH&PI; Texas BRFSS NH&PI; Utah BRFSS NH&PI

- The overall national prevalence of current e-cigarette use was 3.3%, from the 2016-2017 NHIS.
- Regionally, prevalence of current e-cigarette use among NH&PI overall was 15%[1] in California, 18%[1,2] in LA County, and 7% in Hawaii.

WHILE THE PREVALENCE OF CURRENT E-CIGARETTE USE WAS 3.3% NATIONWIDE:

- In Hawaii, prevalence of current e-cigarette use was 8% among Native Hawaiian and 6% among Other Pacific Islander.

Currently drinks alcohol (past month) by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-14; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Vietnamese

[2]AA and NH&PI in place of AA - NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[4]CHIS includes at least one drink in past year

[5]Crude prevalence - NYC CHRNA, LACHS, and 2018 National BRFSS (national prevalence)

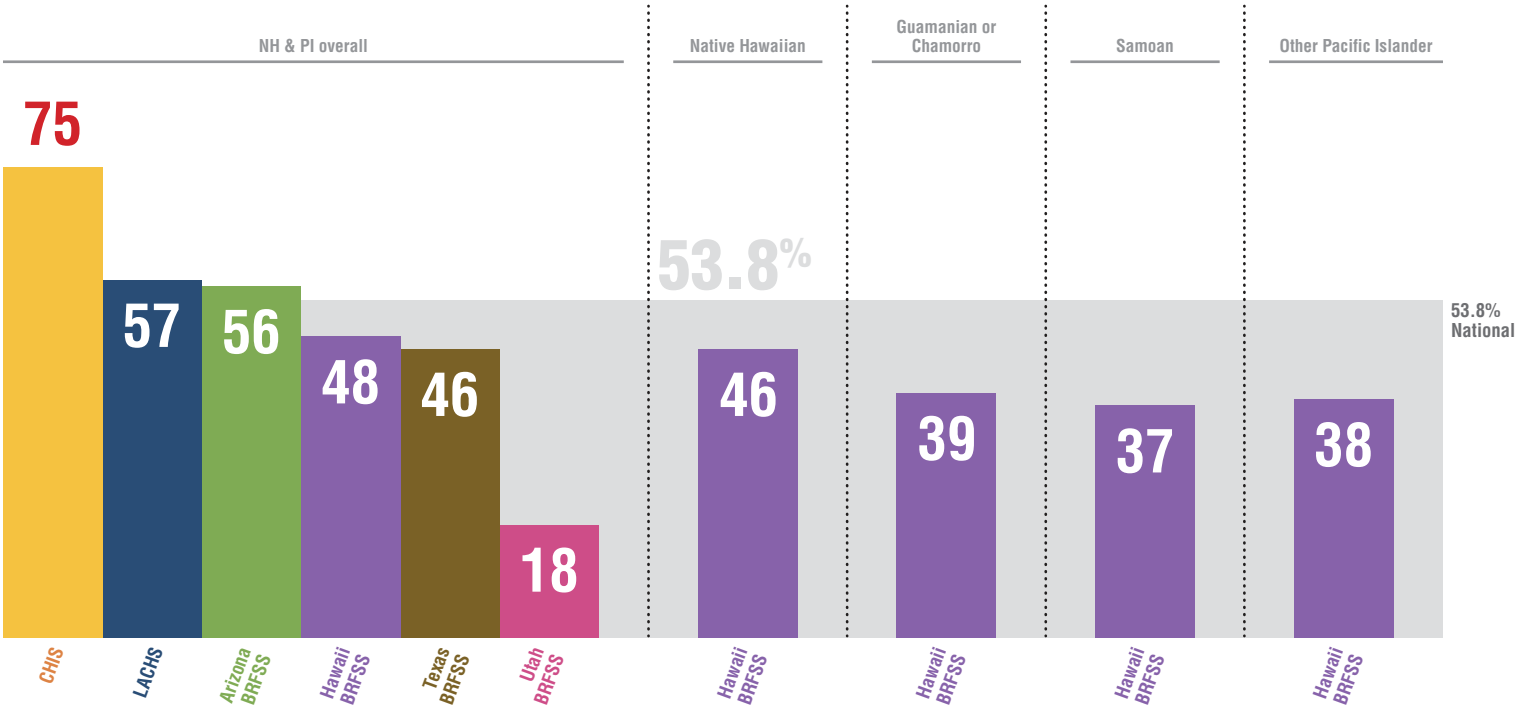
[6]Question not asked on NHIS

- The overall national prevalence of alcohol in the past month was 53.8%[5], from the 2018 BRFSS.
- Regionally, prevalence of alcohol in the past month among AA overall was 38%[2] in NYC (NYC CHS), 39%[5] in NYC (NYC CHRNA), 58%[4] in California, 51%[5] in LA County, 40% in Arizona, 45% in Hawaii, 37% in Texas, 33% in Utah, and 54%[2] in Chicago.

WHILE THE PREVALENCE OF ALCOHOL IN THE PAST MONTH WAS 53.8% NATIONWIDE:

- In NYC (NYC CHS), prevalence of alcohol in the past month was 37% among Chinese, 36%[3] among South Asian, 52% among Filipino, 62% among Korean, 81% among Japanese, and 42%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of alcohol in the past month was 23%[5] among Chinese, 22%[5] among Asian Indian, 54%[5] among Filipino, 47%[5] among Korean, 65%[5] among Japanese, and 37%[5] among Vietnamese.
- In California, prevalence of alcohol in the past year was 58%[4] among Chinese, 56%[3,4] among South Asian, 57%[4] among Filipino, 61%[4] among Korean, 59%[4] among Japanese, and 51%[4] among Vietnamese; in LA County, prevalence of alcohol in the past month was 55%[5] among Chinese, 38%[3,5] among South Asian, 49% among Filipino, 52%[5] among Korean, 62%[5] among Japanese, and 42%[5] among Vietnamese.
- In Hawaii, prevalence of alcohol in the past month was 44% among Chinese, 41% among Filipino, 51% among Korean, 49% among Japanese, and 49% among Vietnamese.
- In Texas, prevalence of alcohol in the past month was 52% among Chinese and 32% among Asian Indian.
- In Utah, prevalence of alcohol in the past month was 36% among Chinese, 49% among Asian Indian, and 39% among Japanese.
- In Chicago, prevalence of alcohol in the past month was 61% among Chinese and 59% among Asian Indian.

Currently drinks alcohol in the past month by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-14; LACHS, Los Angeles County Health Survey 2015 & 2018; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI

[2]CHIS includes at least one drink in past year

[3]Crude prevalence – LACHS and 2018 National BRFSS (national prevalence)

[4]Question not asked on NH&PI NHIS

- The overall national prevalence of alcohol in the past month was 53.8%[3], from the 2018 BRFSS.
- Regionally, prevalence of alcohol in the past month among NH&PI overall was 75%[1,2] in California, 57%[3] in LA County, 56% in Arizona, 48% in Hawaii, 46% in Texas, and 18% in Utah.

WHILE THE PREVALENCE OF ALCOHOL IN THE PAST MONTH WAS 53.8% NATIONWIDE:

- In Hawaii, prevalence of alcohol in the past month was 46% among Native Hawaiian, 39% among Guamanian or Chamorro, 37% among Samoan, and 38% among Other Pacific Islander.

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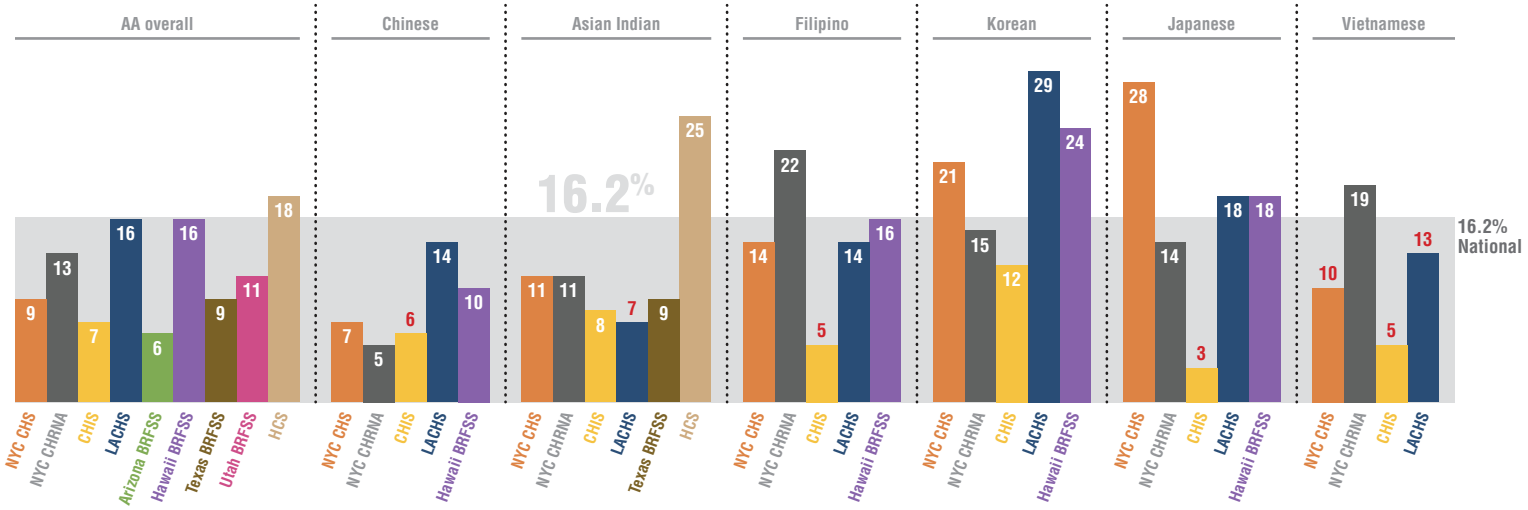
Binge drinking by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); NH&PI, Native Hawaiian & Pacific Islander; CHIS, California Health Interview Survey 2013-14; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NYC, New York City; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Vietnamese; CHIS Chinese, Filipino, Japanese, and Vietnamese; LACHS South Asian and Vietnamese

[2]Binge drinking is defined as ≥4 drinks at a time for women, and ≥5 drinks at a time for men; NYC CHRNA includes ≥5 drinks for men and women

[3]AA and NH&PI in place of AA - NYC CHS and HCS; [4]South Asian in place of Asian Indian - NYC CHS, CHIS and LACHS

[5]Crude prevalence - NYC CHRNA, LACHS, and 2018 National BRFSS (national prevalence)

[6]Question not asked on NHIS; estimates were suppressed for Arizona BRFSS Chinese, Asian Indian and Filipino; Texas BRFSS Chinese; Utah BRFSS Chinese, Asian Indian and Japanese; HCS Chinese

- The overall national prevalence of binge drinking was 16.2%[5], from the 2018 BRFSS.
- Regionally, prevalence of binge drinking among AA overall was 9%[3] in NYC (NYC CHS), 13%[5] in NYC (NYC CHRNA), 7% in California, 16%[5] in LA County, 6% in Arizona, 16% in Hawaii, 9% in Texas, 11% in Utah, and 18%[3] in Chicago.

WHILE THE PREVALENCE OF BINGE DRINKING WAS 16.2% NATIONWIDE:

- In NYC (NYC CHS), prevalence of binge drinking was 7% among Chinese, 11%[4] among South Asian, 14% among Filipino, 21% among Korean, 28% among Japanese, and 10%[1] among Vietnamese; in NYC (NYC CHRNA), prevalence of binge drinking was 5%[2,5] among Chinese, 11%[2,5] among Asian Indian, 22%[2,5] among Filipino, 15%[2,5] among Korean, 14%[2,5] among Japanese, and 19%[2,5] among Vietnamese.
- In California, prevalence of binge drinking was 6%[1] among Chinese, 8%[4] among South Asian, 5%[1] among Filipino, 12% among Korean, 3%[1] among Japanese, and 5%[1] among Vietnamese; in LA County, prevalence of binge drinking was 14%[5] among Chinese, 7%[1,4,5] among South Asian, 14%[5] among Filipino, 29%[5] among Korean, 18%[5] among Japanese, and 13%[1,5] among Vietnamese.
- In Hawaii, prevalence of binge drinking was 10% among Chinese, 16% among Filipino, 24% among Korean, and 18% among Japanese.
- In Texas, prevalence of binge drinking was 9% among Asian Indian.
- In Chicago, prevalence of binge drinking was 25% among Asian Indian.

Binge drinking by NH&PI subgroup and dataset, 2012-18

Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013-17 (Hawaii 2013-18); CHIS, California Health Interview Survey 2013-14; LACHS, Los Angeles County Health Survey 2015 & 2018; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: LACHS NH&PI

[2]Binge drinking is defined as ≥4 drinks at a time for women, and ≥5 drinks at a time for men

[3]Crude prevalence - LACHS and 2018 National BRFSS (national prevalence)

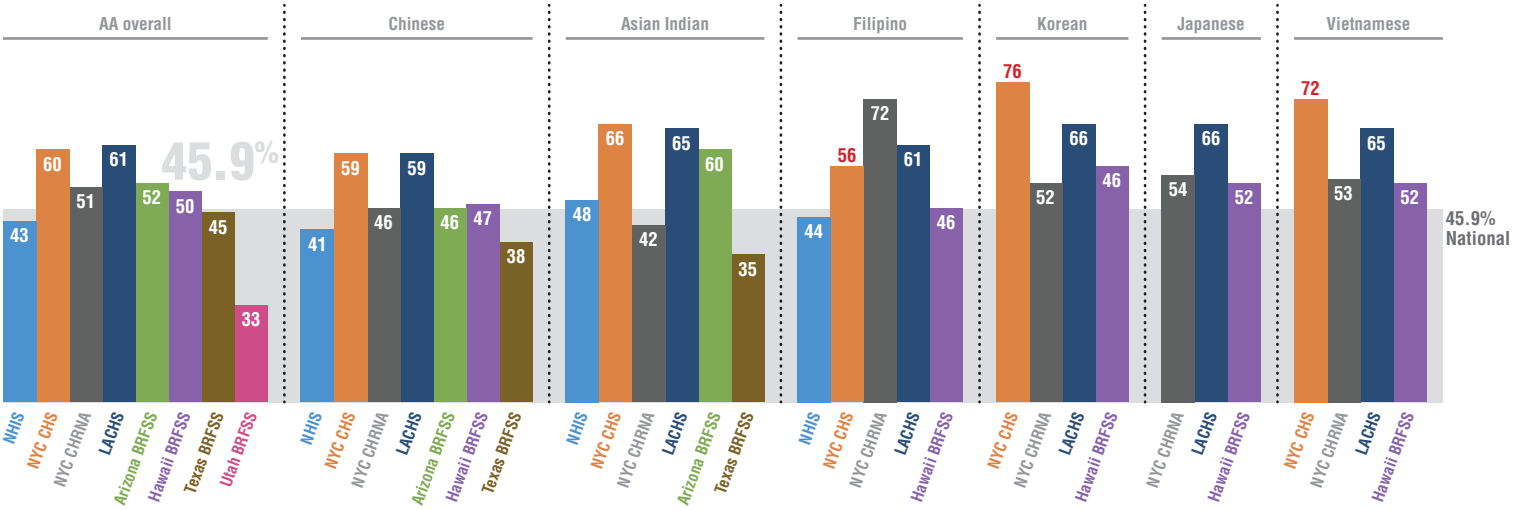
[4]Question not asked on NHIS; estimate was suppressed for Texas BRFSS NH&PI

- The overall national prevalence of binge drinking was 16.2%[3], from the 2018 BRFSS.
- Regionally, prevalence of binge drinking among NH&PI overall was 35% in California, 20%[1,3] in LA County, 18% in Arizona, 25% in Hawaii, and 10% in Utah.

WHILE THE PREVALENCE OF BINGE DRINKING WAS 16.2% NATIONWIDE:

- In Hawaii, prevalence of binge drinking was 25% among Native Hawaiian, 24% among Samoan, 22% among Guamanian or Chamorro, and 20% among Other Pacific Islander.

Recommended weekly physical activity by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System 2013, 2015 & 2017; LACHS, Los Angeles County Health Survey 2015 & 2018; National Health Interview Survey 2012-17; NH&PI, Native Hawaiian & Pacific Islander NHIS; NYC CHRNA, NYC Community Health Resources & Needs Assessment 2013-16; NYC CHS, NYC Community Health Survey 2013-14

[1]Interpret with caution: NYC CHS Filipino, Korean, and Vietnamese

[2]Recommended weekly physical activity is calculated as ≥75 minutes of vigorous activity, ≥150 minutes of moderate activity, or a combination to include vigorous and moderate

[3]AA and NH&PI in place of AA - NYC CHS; [4]South Asian in place of Asian Indian - NYC CHS and LACHS

[5]Crude prevalence - NYC CHRNA and LACHS

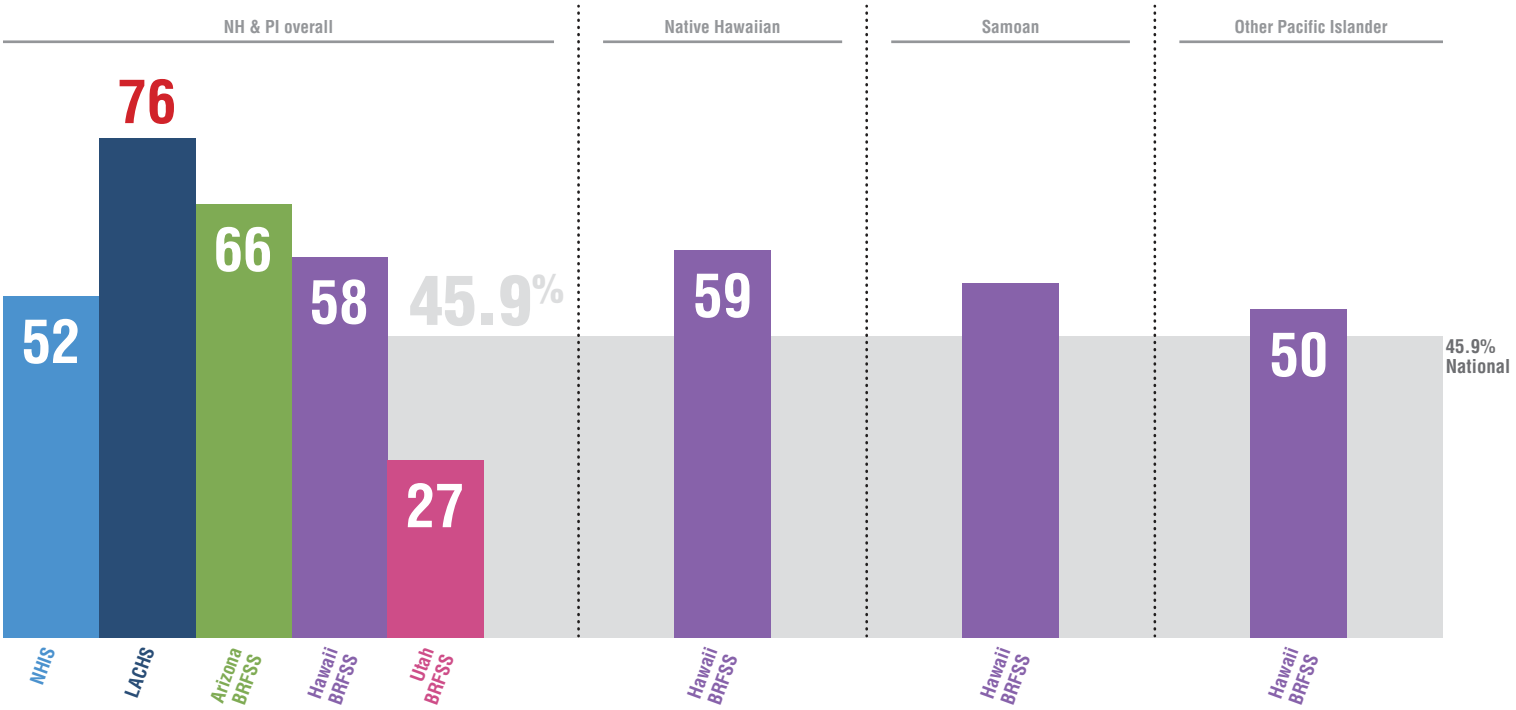
[6]Question not asked on CHIS or HCS; estimates were suppressed for NYC CHS Japanese; Arizona BRFSS Filipino; Texas BRFSS Chinese, Asian Indian and Japanese

- The overall national prevalence of recommended weekly physical activity was 45.9%, from the 2012-2017 NHIS.
- Nationally, prevalence of recommended weekly physical activity was 43% among AA overall, 41% among Chinese, 48% among Asian Indian, and 44% among Filipino.
- Regionally, prevalence of recommended weekly physical activity among AA overall was 60%[3] in NYC (NYC CHS), 51%[5] in NYC (NYC CHRNA), 61%[5] in LA County, 52% in Arizona, 50% in Hawaii, 45% in Texas, and 23% in Utah.

WHILE THE PREVALENCE OF RECOMMENDED WEEKLY PHYSICAL WAS 45.9% NATIONWIDE:

- In NYC CHS, prevalence of recommended weekly physical was 59% among Chinese, 66%[4] among South Asian, 56%[1] among Filipino, 76%[1] among Korean, and 72%[1] among Vietnamese; in NYC CHRNA, prevalence of recommended weekly physical was 46%[5] among Chinese, 42%[5] among Asian Indian, 72%[5] among Filipino, 52%[5] among Korean, 54%[5] among Japanese, and 53%[5] among Vietnamese.
- In LA County, prevalence of recommended weekly physical was 59%[5] among Chinese, 65%[1,4,5] among South Asian, 61%[5] among Filipino, 66%[5] among Korean, 66%[5] among Japanese, and 65%[5] among Vietnamese.
- In Arizona, prevalence of recommended weekly physical was 46% among Chinese and 60% among Asian Indian.
- In Hawaii, prevalence of recommended weekly physical was 47% among Chinese, 46% among Filipino, 56% among Korean, 52% among Japanese, and 52% among Vietnamese.
- In Texas, prevalence of recommended weekly physical was 38% among Chinese and 35% among Asian Indian.

Recommended weekly physical activity by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System 2013, 2015 & 2017 (Hawaii 2013-18); LACHS, Los Angeles County Health Survey 2015 & 2018; NHIS, National Health Interview Survey 2014; NH&PI, Native Hawaiian & Pacific Islander

[1]Recommended weekly physical activity is calculated as ≥75 minutes of vigorous activity, ≥150 minutes of moderate activity, or a combination to include vigorous and moderate

[2]Crude prevalence - LACHS

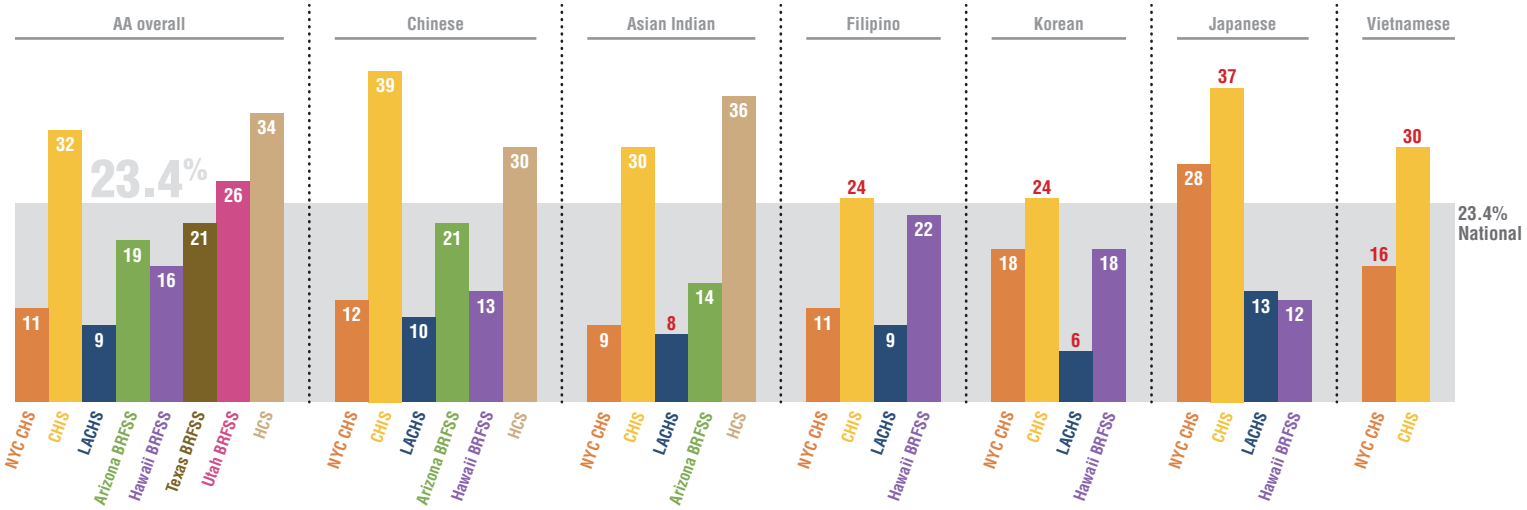
[3]Question not asked on CHIS; estimate was suppressed for Texas BRFSS NH&PI

- The overall national prevalence of recommended weekly physical activity was 45.9%, from the 2012-2017 NHIS.
- Regionally, prevalence of recommended weekly physical activity among NH&PI overall was 52% in California, 76%[2] in LA County, 66% in Arizona, 58% in Hawaii, and 27% in Utah.

WHILE THE PREVALENCE OF RECOMMENDED WEEKLY PHYSICAL WAS 45.9% NATIONWIDE:

- In Hawaii, prevalence of recommended weekly physical was 59% among Native Hawaiian, 54% among Samoan, and 50% among Other Pacific Islander.

Five or more servings of fruits and vegetables per day by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System (Hawaii 2013 & 2015; Arizona, Texas and Utah 2013, 2015 & 2017); CHIS, California Health Interview Survey 2017-18; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NH&PI, Native Hawaiian & Pacific Islander; NYC, New York City; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Vietnamese; CHIS Filipino, Korean, Japanese, and Vietnamese; LACHS South Asian and Korean

[2]AA and NH&PI in place of AA - NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS and CHIS

[4]Crude prevalence – LACHS, Hawaii BRFSS, and 2009 National BRFSS (national prevalence)

[5]Question not asked on NHIS or NYC CHRNA; estimates were suppressed for Arizona BRFSS Filipino; Texas BRFSS Chinese and Asian Indian; Utah BRFSS Chinese, Asian Indian and Japanese

- The overall national prevalence of five or more servings of fruits and vegetables per day was 23.4%[4], from the 2009 BRFSS.
- Regionally, prevalence of five or more servings of fruits and vegetables per day among AA overall was 11%[2] in NYC (NYC CHS), 32% in California, 9%[4] in LA County, 19% in Arizona, 16%[4] in Hawaii, 21% in Texas, 26% in Utah, and 34%[2] in Chicago.

WHILE THE PREVALENCE OF FIVE OR MORE SERVINGS OF FRUITS AND VEGETABLES PER DAY WAS 23.4% NATIONWIDE:

- In NYC (NYC CHS), prevalence of five or more servings of fruits and vegetables per day was 12% among Chinese, 9%[3] among South Asian, 11% among Filipino, 18% among Korean, 28% among Japanese, and 16%[1] among Vietnamese.
- In California, prevalence of five or more servings of fruits and vegetables per day was 39% among Chinese, 30% among South Asian, 24%[1] among Filipino, 24%[1] among Korean, 37%[1] among Japanese, and 30%[1] among Vietnamese; in LA County, prevalence of five or more servings of fruits and vegetables per day was 10%[4] among Chinese, 8%[1,3,4] among South Asian, 9%[4] among Filipino, 6%[1,4] among Korean, and 13%[4] among Japanese.
- In Arizona, prevalence of five or more servings of fruits and vegetables per day was 21% among Chinese and 14% among Asian Indian.
- In Hawaii, prevalence of five or more servings of fruits and vegetables per day was 13%[4] among Chinese, 22%[4] among Filipino, 18%[4] among Korean, and 12%[4] among Japanese.
- In Chicago, prevalence of five or more servings of fruits and vegetables per day was 30% among Chinese and 36% among Asian Indian.

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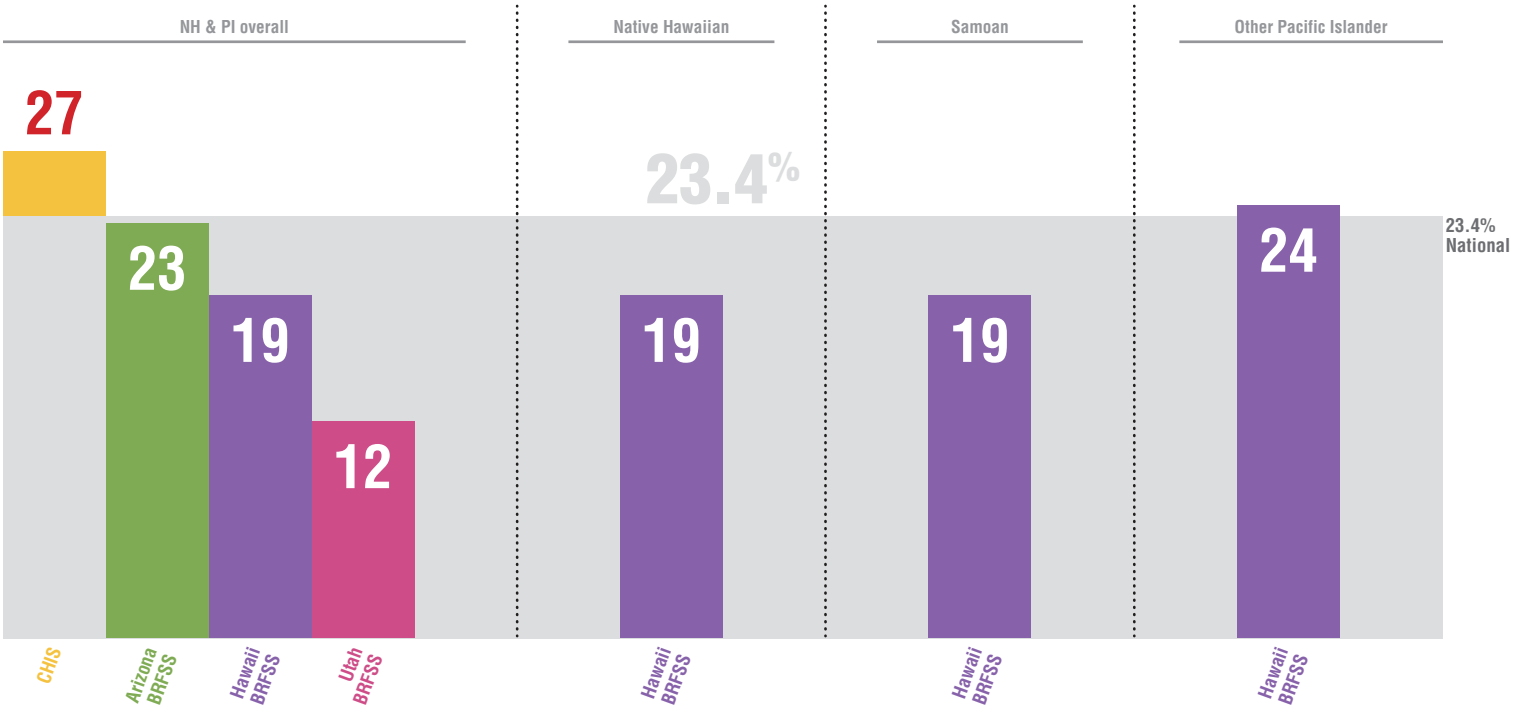
Five or more servings of fruits and vegetables per day by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System (Hawaii 2013 & 2015, Arizona and Utah 2013, 2015 & 2017); CHIS, California Health Interview Survey 2017-18; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI

[2]Crude prevalence - Hawaii BRFSS and 2009 National BRFSS (national prevalence)

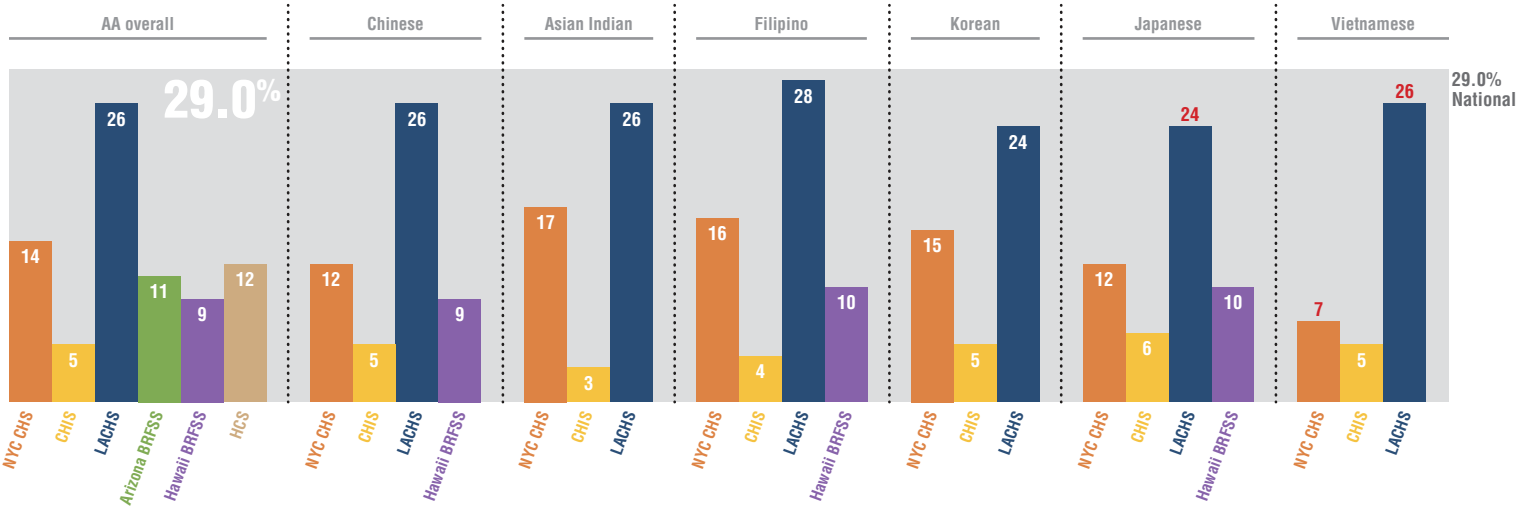
[3]Question not asked on NHIS; estimates were suppressed for Texas BRFSS NH&PI and LACHS NH&PI

- The overall national prevalence of five or more servings of fruits and vegetables per day was 23.4%[2], from the 2009 BRFSS.
- Regionally, prevalence of five or more servings of fruits and vegetables per day among NH&PI overall was 27%[1] in California, 23% in Arizona, 19%[2] in Hawaii, and 12% in Utah.

WHILE THE PREVALENCE OF FIVE OR MORE SERVINGS OF FRUITS AND VEGETABLES PER DAY WAS 23.4% NATIONWIDE:

- In Hawaii, prevalence of five or more servings of fruits and vegetables per day was 19%[2] among Native Hawaiian, 19%[2] among Samoan, and 24%[2] among Other Pacific Islander.

Daily soda intake by AA subgroup and dataset, 2012-18



Abbreviations: AA, Asian American; BRFSS, Behavioral Risk Factor Surveillance System (Arizona 2013 & 2017; Hawaii 2017); CHIS, California Health Interview Survey 2013-18; HCS, Healthy Chicago Survey 2015-17; LACHS, Los Angeles County Health Survey 2015 & 2018; NYC, New York City; NYC CHS, NYC Community Health Survey 2013-17

[1]Interpret with caution: NYC CHS Vietnamese; LACHS Japanese and Vietnamese

[2]AA and NH&PI in place of AA - NYC CHS and HCS; [3]South Asian in place of Asian Indian - NYC CHS and CHIS

[4]HCS and LACHS measure daily sugar sweetened soda or drinks

[5]Crude prevalence - LACHS and Hawaii BRFSS

[6]National prevalence comes from 2016 BRFSS, 23 states and the District of Columbia

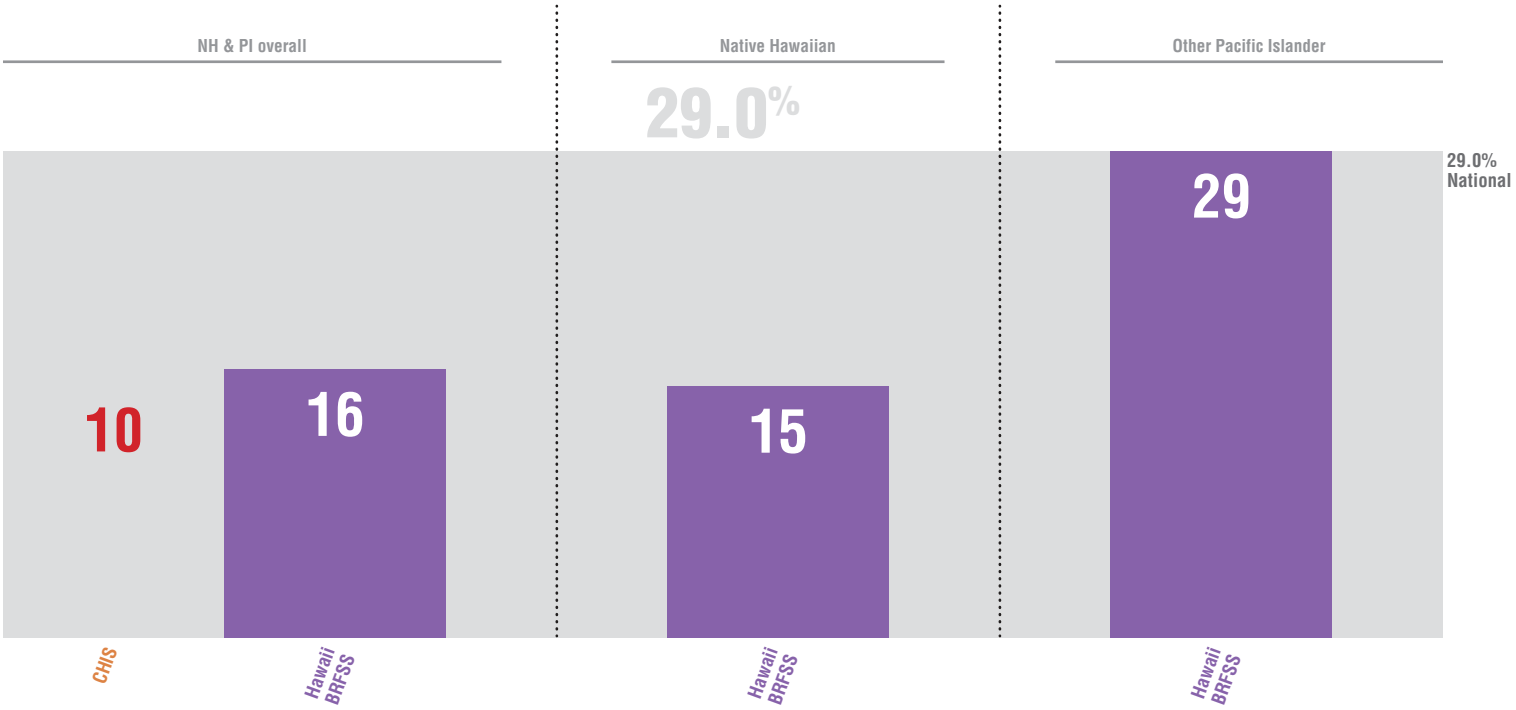
[7]Question not asked on NHIS, NYC CHRNA, Texas or Utah BRFSS; estimates were suppressed for Arizona BRFSS Chinese, Asian Indian and Filipino; HCS Chinese and Asian Indian

- The overall national prevalence of daily soda intake was 29.0%[7], from the 2016 BRFSS.
- Regionally, prevalence of daily soda intake among AA overall was 14%[2] in NYC (NYC CHS), 5% in California, 26%[4,5] in LA County, 11% in Arizona, 9%[5] in Hawaii, and 12%[2,4] in Chicago.

WHILE THE PREVALENCE OF DAILY SODA INTAKE WAS 29.0% NATIONWIDE:

- In NYC (NYC CHS), prevalence of daily soda intake was 12% in Chinese, 17% among South Asian, 16% among Filipino, 15% among Korean, 12% among Japanese, and 7%[1] among Vietnamese.
- In CHIS, prevalence of daily soda intake was 5% among Chinese, 3%[3] among South Asian, 4% among Filipino, 5% among Korean, 6% among Japanese, and 5% among Vietnamese; in LA County, prevalence of daily soda intake was 26%[4,5] among Chinese, 26%[3,4,5] among South Asian, 28%[4,5] among Filipino, 24%[4,5] among Korean, 24%[1,4,5] among Japanese, and 26%[1,4,5] among Vietnamese.
- In Hawaii, prevalence of daily soda intake was 9%[5] among Chinese, 10%[5] among Filipino, and 10%[5] among Japanese.

Daily soda intake by NH&PI subgroup and dataset, 2012-18



Abbreviations: BRFSS, Behavioral Risk Factor Surveillance System (Hawaii 2017); CHIS, California Health Interview Survey 2013-18; NH&PI, Native Hawaiian & Pacific Islander

[1]Interpret with caution: CHIS NH&PI

[2]Crude prevalence – Hawaii BRFSS

[3]National prevalence comes from 2016 BRFSS, 23 states and the District of Columbia

[4]Question not asked on NHIS, Texas or Utah BRFSS; estimates were suppressed for Arizona BRFSS NH&PI and LACHS NH&PI

- The overall national prevalence of daily soda intake was 29.0%[3], from the 2016 BRFSS.
- Regionally, prevalence of daily soda intake was among NH&PI overall was 10%[1] in California and 16%[2] in Hawaii.

WHILE THE PREVALENCE OF DAILY SODA INTAKE WAS 29.0% NATIONWIDE:

- In Hawaii, prevalence of daily soda intake was 15%[2] among Native Hawaiian and 29%[2] among Other Pacific Islander.

TECHNICAL NOTES

AA and NH&PI subgroup definitions

Asian American (AA) refers to individuals reporting Asian alone (no other racial or ethnic group). Any AA individuals reporting two or more AA subgroups were excluded from the detailed AA subgroup analyses.

Native Hawaiian & Pacific Islander (NH&PI) refers to individuals reporting NH&PI alone (no other racial or ethnic group). Any NH&PI individuals reporting two or more NH&PI subgroups were excluded from the detailed NH&PI subgroup analyses.

Data sources

National Health Interview Survey (NHIS) 2012-2017. The NHIS monitors the health of the U.S. civilian noninstitutionalized adult population through confidential interviews conducted in households. It provides data for analyzing health trends and reaching national health objectives. The survey is cross-sectional with yearly sampling and interviewing. To our knowledge, the survey is conducted in English and Spanish. This report includes aggregated years 2012-2017. NHIS data is publicly available, and includes n=10,998 AAs. AA subgroups include Asian Indian (n=2,295), Chinese (n=2,401), and Filipino (n=2,431). In 2014, the Native Hawaiian and Pacific Islander (NH&PI) NHIS was conducted, collecting information about NH&PIs in all 50 states (n=1,247). AA subgroups were determined using MRACRPI2 and ORIGIN_I. For survey methodology and details, visit www.cdc.gov/nchs/nhis.

New York City Community Health Survey (NYC CHS) 2013-2017. The NYC CHS is conducted annually by the NYC Department of Health and Mental Hygiene (DOHMH), and surveys about 9,000 non-institutionalized adults annually over landline phones and cellphones. All records have a weight applied, which includes an adjustment for the probability of selection, a post-stratification weight, and the distribution of the adult population comprising three telephone usage categories (landline only, landline and cell, cell only). The survey is conducted in English, Spanish, Chinese, and Russian. This report includes aggregated years 2013-2017, unless otherwise noted. NYC CHS data is publicly available, although a data use agreement was required for Asian ethnicity variables. Total AA and NH&PI includes n=5,648, and Asian subgroups include Chinese (n=3,520), Asian Indian (n=966), South Asian (n=1,023), Filipino (n=202), Korean (n=191), Japanese (n=103), and Vietnamese (n=41). The NYC DOHMH includes two different variables: one for Asian subgroup and one for Asian ancestry. We used Asian subgroup for all groups except Asian Indian; we chose to use South Asian ancestry rather than Asian Indian subgroup due to a wide range of countries of birth reported among Asian Indians. Suggested guidelines for CHS data reliability was followed, incorporating relative standard error (RSE), confident interval width, and sample size: https://www1.nyc.gov/assets/doh/downloads/pdf/episrv/bes-data-reliability.pdf. Suppressed estimates are not presented, and estimates to be interpreted with caution are mentioned in table footnotes. For example, any estimate with a denominator <50 is flagged, as well as estimates with 30% ≤ RSE ≤ 50%. RSEs and CI half-widths are checked for other estimates. For survey details, visit www.nyc.gov/health/survey.

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NYC Community Health Resource and Needs Assessments (NYC CHNRA) 2013-2016. The NYC CHRNA was a large-scale health needs assessment conducted in diverse, low-income AA communities in NYC by the NYU Center for the Study of Asian American Health (CSAAH). The project used a community-engaged and community venue-based approach to assess health issues, available resources, and best approaches to meet community needs. Data was collected between 2013 and 2016, but differs by subgroup; the majority of data collection was performed between 2014 and 2015. The survey was conducted in English, Mandarin, Japanese, Vietnamese, and Korean. AA subgroups include Chinese, Asian Indian, Bangladeshi, Pakistani, Himalayan (Nepali and Tibetan), Korean, Filipino, Vietnamese, Cambodian, Sri Lankan, Japanese, Indo-Caribbean, Indonesian, Burmese, Thai, and Arab American (not all groups were included in the Health Atlas). For consistency with the other datasets, we include Chinese (n=213), Asian Indian (n=111), Filipino (n=107), Korean (n=161), Japanese (n=103), and Vietnamese (n=103), for a total AA group of n=1,684. For additional details and community reports, visit https://med.nyu.edu/departments-institutes/population-health/divisions-sections-centers/health-behavior/section-health-equity/dissemination/community-health-reports-research-briefs.

California Health Interview Survey (CHIS) 2013-2018. The CHIS is a web and telephone survey that asks questions on health topics of California's residential, non-institutionalized population. The survey is conducted on a continuous basis, in order to generate timely one-year estimates. Representative data is provided on all 58 counties in California, and the methodology ensures that the CHIS is representative of California's diverse population. The survey was conducted in English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese. The reports aggregates years 2013-2018. CHIS data is publicly available; however, our analysis includes aggregated 2-year datasets in order to include South Asian and NH&PI subgroups. Total AA includes n=10,935 and total NH&PI includes n=288; AA subgroups in the public datasets include Chinese (n=3,595), Filipino (n=1,252), Korean (n=1,248), Japanese (n=1,217), South Asian (1,105), and Vietnamese (n=1,503). Prevalence estimates with RSEs ≥ 30% are flagged as interpret with caution. For additional details, visit http://healthpolicy.ucla.edu/chis/about/Pages/what-is-chis.aspx

Los Angeles County Health Survey (LACHS) 2015 & 2018. The LACHS is a population-based telephone survey that provides information on the health of LA County residents. The data are used for assessment of health-related needs of the population, program planning and development, and program evaluation. The survey was conducted in English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese. This report includes pooled data from two years, 2015 & 2018. We did not have direct access to the datasets, and data was run by the analyst at the LA County Department of Public Health, Population Health Assessment Unit. Total AA includes n=1,254, and AA subgroups include Chinese (n=420), South Asian (n=135), Filipino (n=264), Korean (n=157), Japanese (n=117), and Vietnamese (n=74). Overall NH&PI includes n=42. Prevalence estimates with RSEs ≥ 30% are flagged as interpret with caution, and cell sizes less than 5 are suppressed. For additional details, visit http://www.publichealth.lacounty.gov/ha/hasurveyintro.htm.

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Healthy Chicago Survey (HCS) 2015-2017. The HCS is an annual telephone survey that was launched in 2014 by the Chicago Department of Public Health in order to better understand the health of Chicagoans. The surveyed population is non-institutionalized adults living in the city of Chicago that have phone service, with a phone number associated with a common Chicago area code, and English or Spanish language ability for survey completion. A final survey weight ensures that the sample is representative of Chicago's adult population. The survey was conducted in English and Spanish. This report includes aggregated data from 3 years, 2015-2017. Total AA and NH&PI includes n=287, and AA subgroups include Chinese (n=76) and Asian Indian (n=81). Prevalence estimates with RSEs ≥ 50% are suppressed and prevalence estimates with 0.3 < RSE ≤ 0.5 are flagged as interpret with caution; estimates with denominator ≥50 are included. HCS data is not publicly available, and we obtained access to the datasets with a data use agreement.

Behavioral Risk Factor Surveillance Survey (BRFSS) 2013-2017 (Arizona, Texas, Utah) or 2013-2018 (Hawaii).[9] The BRFSS is a telephone survey that collects state data on U.S. residents regarding their health-related risk behaviors, chronic health conditions, and preventive service use. It is the largest continuously conducted health survey system in the world. Data is weighted, taking into account age, categories of ethnicity, sex, geographic regions within states, marital status, education, home ownership, and type of phone ownership. The survey was conducted in English and Spanish. Public data is available by state but does not include AA subgroups. Data from Arizona, Texas, and Utah were obtained with data use agreements for combined years 2013-2017. The year 2018 was included for select indicators that were only asked during even years for Arizona and Texas. Prevalence estimates with RSEs ≥ 30% are suppressed per BRFSS guidelines.

Arizona data includes n=787 AAs, and AA subgroups include Chinese (n=116), Filipino (n=109), and Asian Indian (n=251). Overall NH&PI includes n=156.

Texas data includes n=1,329 AAs, and AA subgroups include Chinese (n=127) and Asian Indian (n=398). Overall NH&PI includes n=99.

Utah data[10] includes n=643 AAs, and AA subgroups include Chinese (n=79), Asian Indian (n=76), and Japanese (n=64). Total NH&PI includes n=238. At the state-level, Utah was the first U.S. state to develop a methodology and conduct BRFSS oversampling among Utah's NH&PI group; additionally, following a community based participatory approach, the Utah Pacific Islanders report was the first statewide survey conducted in English, Samoan, and Tongan - https://health.utah.gov/disparities/data/ohd/PacificIslanderReport2011.pdf.

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Data estimates from Hawaii were produced using Hawaii's Indicator Based Information System (IBIS) using years 2013-2018 as available (http://ibis.hhdw.org/ibisph-view/); prevalence estimates were calculated using 2011+ race/ethnicity categories and non-Hispanic ethnicity. Estimates were produced for overall AA, overall NH&PI, Chinese, Korean, Filipino, Japanese, Vietnamese, Native Hawaiian, Samoan, Guamanian or Chamorro, and Other Pacific Islander. Total unweighted numbers were not provided in the query system. For additional details on the BRFSS, visit https://www.cdc.gov/brfss/data_documentation/index.htm

Data Analyses

All estimates are age-adjusted to the 2000 U.S. population, except for the NYC CHRNA, LACHS, and other datasets if noted. SAS-callable SUDAAN or STATA were used, depending on dataset and data analyst. Unless noted otherwise, all estimates are compared to the national estimate from NHIS. No statistical tests were performed to assess differences between groups.

Population Characteristics

Demographic tables provide socio-demographic details by AA and NH&PI subgroup.

Overall AA. AAs in the Hawaii BRFSS were older and younger than AAs in the Arizona, Utah BRFSS and Healthy Chicago. Lower health insurance rates and education were seen in NYC CHS and CHRNA, and a greater percentage of college graduates were seen in CHIS, LACHS, Arizona and Texas BRFSS, and Healthy Chicago. There was a greater percentage of U.S.-born individuals in CHIS and LACHS when compared to NYC CHS and CHRNA. There was higher income seen in Arizona and Texas BRFSS, while there were high poverty rates and low income in NYC CHS and NYC CHRNA.

Overall NH&PI. Subgroup data for NH&PIs was available in NHIS (2014), CHIS, LACHS, and Arizona, Hawaii, Texas, and Utah BRFSS. Both nationally and in Hawaii BRFSS, lower income was seen compared to the other geographies.

Chinese. The Chinese subgroup was the only subgroup found in every dataset. Chinese in NYC CHRNA and Hawaii were older, while Chinese in Arizona and Texas BRFSS and HCS were younger. There was a greater percentage of U.S.-born Chinese in CHIS and LACHS when compared to NYC CHS and CHRNA. Lower education was seen in NYC CHS and CHRNA, while higher education was seen in Arizona, Hawaii, Texas, and Utah BRFSS. Higher poverty was seen in NYC, while lower poverty was seen in CHIS, LACHS, and HCS.

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Filipino. Subgroup data for Filipinos was available for NHIS, NYC CHS, NYC CHRNA, CHIS, LACHS, Healthy Chicago, and Arizona and Hawaii BRFSS. Nationally, Filipinos were older than in specific geographic areas. There was a greater percentage of U.S.-born Filipinos in CHIS and LACHS when compared to NYC CHS and CHRNA. Filipinos had lower education in Hawaii and Arizona BRFSS, and bimodal income/poverty was seen across all datasets.

Asian Indian/South Asian. Subgroup data for Asian Indians or South Asians was available for NHIS, NYC CHS, NYC CHRNA, CHIS, LACHS, Healthy Chicago, and BRFSS in Arizona, Hawaii, Texas, and Utah. In Hawaii, most measures were not available due to small sample sizes. There were higher percentages of men in NYC CHS, LACHS, Healthy Chicago, and Arizona, Texas, and Utah BRFSS, and all groups were primarily younger vs. older. Low insurance was seen among Asian Indians/South Asians in NYC CHS, NYC CHRNA, and Utah BRFSS, and high education was seen in all groups except NYC CHRNA. Low income/high poverty was seen in NYC CHS and CHRNA, and high income/low poverty was seen in Healthy Chicago, LACHS, and Arizona, Texas, and Utah BRFSS.

Korean. Subgroup data for Koreans was available for NYC CHS, NYC CHRNA, CHIS, LACHS, and Hawaii BRFSS. Low insurance, older age, and higher foreign-born were characteristics seen among Koreans in NYC CHRNA.

Japanese. Subgroup data for Japanese was available for NYC CHS, NYC CHRNA, CHIS, LACHS, and Hawaii and Utah BRFSS. A greater percentage of Japanese women in NYC CHS and CHRNA. Older age was seen among Japanese in Hawaii, NYC CHRNA, and CHIS, and younger age was seen among Japanese in NYC CHS and LACHS. Overall, high insurance and education rates were seen, while there was overall high income/low poverty.

Vietnamese. Subgroup data for Vietnamese was available for NYC CHS, NYC CHRNA, CHIS, LACHS, and Hawaii BRFSS. Vietnamese in NYC CHRNA had low insurance, education, and income, while Vietnamese in LACHS had higher poverty than CHIS.

NH&PI subgroups. Subgroups included Native Hawaiian, Samoan, Guamanian or Chamorro, or Other Pacific Islander. Subgroup data for specific NH&PI subgroups was only available for the Hawaii BRFSS.

About the NYU Center for the Study of Asian American Health (CSAAH)

The NYU Center for the Study of Asian American Health (CSAAH) is a National Institutes of Health (NIH) National Institute on Minority Health and Health Disparities (NIMHD) funded Specialized Center of Excellence based in the Section for Health Equity within NYU Grossman School of Medicine's Department of Population Health at NYU Langone Health.

Established in 2003 through an NIH NIMHD Project EXPORT (Excellence in Partnership, Outreach, Research, and Training) Center grant, CSAAH is the only center of its kind in the country that is dedicated to research and evaluation on Asian American health and health disparities. CSAAH's work is guided by a population health equity framework. In close collaboration with over 75 local and national community partners, we have evolved our mission and goals to advance health disparities research within a health equity framework.

CSAAH's guiding principles are as follows:

- We believe in systemic change through multi-pronged strategies and working with diverse stakeholders;
- We believe in equitable collaboration and partnerships;
- We believe in action-oriented research;
- We believe in strengthening the research capacity of both community and academic partners to fully engage in the research process;
- We believe in multi-cultural evaluation.

For more information, please visit us at: https://med.nyu.edu/asian-health.

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