June 9, 2010

Health Resources and Services Administration
Department of Health and Human Services
Attention: HRSA Regulations Officer
Parklawn Building Rm. 14A-11
5600 Fishers Lane
Rockville, MD 20857

RE: Solicitation of Comments on Notice of Intent to Form Negotiated Rulemaking Committee, 75 Fed. Reg. 26167, et.seq. (May 11, 2010)

To Whom It May Concern:

On behalf of the Association of Asian Pacific Community Health Organizations (AAPCHO), the Asian & Pacific Islander American Health Forum (APIAHF), and Out of Many One (OMO), we are pleased to respond to the above-cited notice from the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (DHHS) soliciting comments on HRSA's intent to establish a Negotiated Rulemaking Committee under a Federal Advisory Committee Act (FACA) in order to establish a comprehensive methodology and criteria for the designation of Designation of Medically Underserved Populations (MUPs) and Primary Care Health Professions Shortage Areas (HPSAs).

AAPCHO is a national organization representing 27 community health organizations that primarily serve Asian Americans, Native Hawaiians, and other Pacific Islanders (AA&NHOPIs), particularly the medically underserved including a majority living under poverty level and who are limited English Proficient (LEP). AAPCHO members, predominantly community health centers, serve over 350,000 patients annually, providing health care for underserved AA&NHOPIs across the nation, its territories and freely associated states. ***APIAHF*** influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of AA&NHOPIs. APIAHF is recognized as a leading voice for health policy on behalf of Asian Americans(AAs) and in support of Native Hawaiians and Pacific Islanders (NHOPIs) in the U.S. and its jurisdictions. ***OMO*** is a national multicultural advocacy coalition committed to achieve health parity for people of color. OMO's membership is comprised of organizations representing the five OMB categories for the major racial and ethnic health groups that experience health disparities in the United States.

We appreciate HRSA's efforts in developing a more coordinated MUP and HPSA designation methodology and procedure. Further, we strongly support utilizing the NRM process to develop the designation methodology and procedure. However, we have some concerns regarding the procedure outlined in the Notice. We believe there is room for modification to ensure that the unique needs of many underserved minority populations served by CHCs are considered and make the following recommendations:

In response to B.2.a "What provider availability measures should be used" we urge you to consider measures that better reflect special populations. Research has shown that LEP is an essential measure highly associated with access to care. LEP patients are less likely to be given follow-up appointments, to take prescribed medication, to appear for follow-up appointments, and to participate in health care programs in which they are eligible. A survey of over 2,000 internists conducted by the American College of Physicians in 2007, *Language Services for Patients with Limited English Proficiency: Results of a National Survey of Internal Medicine Physicians*, found that about half the physicians devote an additional 5 to 15 minutes to persons who are LEP, compared to non-LEP patients. Another 26% reported that the average additional time is 16-30 minutes. Thus it's critical to include measures that take into consideration a providers ability to communicate and understand the patient and the culture. The measures should consider increased time to conduct a health encounter with someone who is LEP.

In response to B.2.c "What health status indicators should be included" and B.2.e. "What demographic indicators should be included, if any?" we urge you to consider factors that better reflect special populations. Minority, LEP and disenfranchised populations experience vast health disparities relative to the Non-Hispanic White population. Thus, the revised MUP and HPSA designation methodology should be more appropriate for these populations and consider the unique health factors that greatly impact individual communities (e.g., hepatitis B, diabetes, disease comorbidities). The measures should also address the social vulnerabilities across all medically underserved populations. One particular measure that deserves serious consideration is Limited English proficiency (LEP). Approximately 39% of AA&NHOPIs are LEP. Disaggregating this data reveals more significant numbers: 62% of Vietnamese, 59% of Hmong, 54% of Cambodian, 53% of Laotian, 51% of Korean, and 50% of Chinese, and 33% of Tongans are LEP.

Based on experiences of AAPCHO member centers, we know that patients will travel far distances to receive care from a culturally competent provider. For example, South Cove Community Health Center (SCCHC) in Boston, MA, reports that 98% of their patients are Asian and their staff is 98% Asian. SCCHC lists about 175 zip codes in their UDS report. SCCHC serves Asians who have traveled by buses and trains, and have passed many other CHCs to obtain the culturally competent services offered by SCCHC. To give access to 24,000 Asian patients in MA, SCCHC is the port that registers these patients, that not only allows them access to their services, but also access to the hospital system, referrals, WIC and food stamps. Similarly, North East Medical Services (NEMS) in San Francisco, CA saw 43,641 patients in 2009, of which 39,774 patients (91%) were better served in a language other than English. Their patients come from within and beyond the San Francisco Bay Area, sometimes as far as 100 miles away from Turlock, CA, to San Francisco. Prior to opening their San Jose clinic in 2008, several hundred Chinese-speaking patients would often make the 100-mile roundtrip trek from the South Bay to San Francisco in order to seek health care. Rather than a CHC serving a

demographic community by area, SCCHC and NEMS are essentially demographic communities by culture and language.

The increased time to conduct a health encounter with someone who is LEP (as shared in response to B.2.a), combined with the significant growth in LEP population over the last 10 years, strongly suggests that any equation seeking to identify medically underserved areas or populations will be largely inaccurate if it does not account for the impact of LEP patients.

In response to B.1. "Are the objectives of the MUP designations and the HPSA designations clearly different?" we urge you to separate HPSA/MUA and MUP designations. HPSA/MUA is a national data source driven approach based on an index of national indicators while the MUP is a local driven approach to demonstrating need. Guidelines should also be appropriate for disenfranchised populations, such as small and hard to reach AA&NHOPI communities, missed by the current safety net. These populations, such as rural Hmong populations to inner city low income Chinese, exist in small communities of 5,000-10,000 that may be located within an already designated non-MUA county and therefore fall under the radar screen of current MUA designation. For example, there is a great deficiency of MUA/MUP in the county of San Mateo, CA where the average household income sits above poverty level, yet within which an "invisible" population of working poor exists and face barriers in accessing adequate, linguistically competent health care in their county. It is currently not possible to designate an MUA/MUP in the area with current data and designation formula however there are at least 500 people who are uninsured and willing to cross county lines to get care at NEMS in San Francisco, CA.

Similarly, in response to B.3. "What methodology should be used to incorporate/combine the impact of these various underserved indicators on access", we suggest that different types of methodologies are developed for identifying and assessing the HPSA/MUA (national) versus MUP (local) designations.

In response to 7. "What types of Population Groups should be considered for designation" we urge you to consider disenfranchised populations, such as small and hard to reach AA&NHOPI communities, missed by the current safety net. The AA&NHOPI population consisting of 49 ethnic groups speaking over 100 languages and dialects. Although traditionally grouped together or not included in any data category, there are many subgroups within Asian American, Native Hawaiian and Pacific Islander communities, each with unique cultures and histories. For racial/ethnic groups with a relatively small number of members, such as Asian Americans, Native Hawaiians and other Pacific Islanders, and American Indians/Alaskan Natives, there is often inadequate data to identify salient health issues and appropriate interventions and solutions to those issues. Such data is often not collected, collected but not analyzed, or not reported due to inadequate sampling. Disaggregating data shows great disparities in health status and access to health care. For example, Native Hawaiians and other Pacific Islanders (NHOPI) are often overlooked due in part to the size of the population and the historic practice of aggregating these groups with Asian Americans for statistical purposes. However, aggregating AA&NHOPI data masks the true socio-economic status and disparities with the Pacific Islander population. According to the latest U.S. Bureau of the Census statistics, there are approximately 1 million NHOPI nationwide and this population is beginning to grow significantly in various parts of the U.S. Between 2005-2006, Utah experienced a 26% increase in its NHOPI population, with 18,958 living in the state. Other states have seen their NHOPI

populations rise as well. According to a report issued by the Arkansas Department of Health, the number of Marshallese immigrating to Springdale, Arkansas increased dramatically since 2000. Currently, an estimated 6,000-10,000 Marshallese live in and around Springdale. Beginning in 2003, the Washington County Health Unit identified increases in both tuberculosis and syphilis cases among the Marshallese living in Springdale. Compared to Americans as a whole, NHOPIs experience poorer health, with greater risk of developing and dying from cancer, heart disease, diabetes and other diseases. This new and increasing population requires a disproportionate amount of time and resources. The increased time to conduct a health encounter combined with the significant growth in populations such as NHOPIs strongly suggests that any equation seeking to identify medically underserved areas or populations will be largely inaccurate if it does not account for the impact of disenfranchised populations.

In response to III. "Affected interests and potential participants", we strongly urge you to include representatives from AA&NHOPI serving organizations and other organizations of color. We nominate Sherry Hirota to the Negotiated Rulemaking Committee. Including Ms. Hirota on the Negotiated Rule Making Committee will ensure that the needs of underserved minority populations served by CHCs are considered. We believe Ms. Hirota's specific experience in the provision of primary health care services to medically underserved LEP populations at Asian Health Services, gives her rare insight into the unique issues facing these populations. Her experience in leading rulemaking bodies that determine medically underserved designations and language access standards and criteria for medically underserved designations, gives her valuable experience and expertise that can be utilized on the Negotiated Rulemaking Committee. Her unwavering commitment and focus on minority, LEP and disenfranchised populations, will ensure that these growing populations have a staunch advocate and voice in any national rulemaking process. Please see attached nomination letter as well as Ms. Hirota's resume and written commitment.

Thank you for the opportunity to respond to the above-referenced Notice. If you have any questions, please feel free to contact Jeff Caballero at (510) 272-9536 x.105 or at jeffc@aapcho.org.

Sincerely,



Jeffrey B. Caballero, MPH	Kathy Lim Ko, MPH	Ruth Perot, MAT on behalf of the
AAPCHO Executive Director	APIAHF President & CEO	OMO Executive Committee

Enclosures (3)

cc: White House Initiative on Asian Americans and Pacific Islanders

June 7, 2010

Health Resources and Services Administration,
Department of Health and Human Services
Attention: HRSA Regulations Officer
Parklawn Building Rm. 14A-11
5600 Fishers Lane
Rockville, MD 20857

To Whom It May Concern:

On behalf of Association of Asian Pacific Community Health Organizations (AAPCHO), the Asian & Pacific Islander American Health Forum (APIAHF), and Out of Many One (OMO), we are writing this letter to nominate Sherry Hirota to the Negotiated Rulemaking Committee that will help HRSA establish a methodology and criteria for Designation of Medically Underserved Populations (MUPs) and Primary Care Health Professions Shortage Areas (HPSAs).

We are nominating Sherry Hirota to serve on this committee because of her 30-plus years of experience as a chief administrator and CEO of Asian Health Services in Oakland, CA; as a founding member of national and local health advocacy organizations; as a member of national, state, local health policymaking bodies and committees determining criteria for indigent care, population-based medically underserved designations, strategies for urban health policy, language access standards; and as a grassroots champion for improved access and quality health care for medically underserved Asian Americans, Native Hawaiians and other Pacific Islanders (AA&NHOPIs). Ms. Hirota will offer the committee insight that will help HRSA develop a methodology and criteria that meet the needs of minority, Limited English Proficient (LEP), and disenfranchised populations, and the community health centers that serve them.

The negotiation participants in the notice under Section III do not adequately represent minority, LEP and disenfranchised populations. These populations experience vast health disparities relative to the Non-Hispanic White population. Thus, the revised MUP and HPSA designation methodology should be more appropriate for these populations and consider the unique health factors that greatly impact individual communities (e.g., hepatitis B, diabetes, disease comorbidities). The measures should also address the social vulnerabilities across all medically underserved populations. One particular measure that deserves serious consideration is Limited English proficiency (LEP). Approximately 39% of AA&NHOPIs are LEP. Disaggregating this data reveals more significant numbers: 62% of Vietnamese, 59% of Hmong, 54% of Cambodian, 53% of Laotian, 51% of Korean, and 50% of Chinese, and 33% of Tongans are LEP.

Research has shown that LEP is an essential measure highly associated with access to care. LEP patients are less likely to be given follow-up appointments, to take prescribed medication, to appear for follow-up appointments, and to participate in health care programs in which they are eligible. A survey of over 2,000 internists conducted by the American College of Physicians in 2007, *Language Services for Patients with Limited English Proficiency: Results of a National Survey of Internal Medicine Physicians*, found that about half the physicians devote between an additional 5 to 15 minutes to persons who are LEP, compared to non-LEP patients. Another 26% reported that the average additional time is 16-30 minutes. This increased time to conduct a health encounter with someone who is LEP, combined with the significant growth in the LEP population over the last 10 years, strongly suggests that any equation seeking to identify medically underserved areas or populations will be largely inaccurate if it does not account for the impact of LEP patients.

The revised MUP and HPSA designation methodology should also be more appropriate for disenfranchised populations. These populations, such as small rural Hmong populations to inner city low income Chinese, exist in small communities of 5,000-10,000 that may be located within an already designated non-MUA county and therefore fall under the radar screen of current MUA designation.

Including Ms. Hirota on the Negotiated Rule Making Committee will ensure that the needs of underserved minority populations served by CHCs are considered. We believe Ms. Hirota's specific experience in the provision of primary health care services to medically underserved LEP populations at Asian Health Services, gives her rare insight into the unique issues facing these populations. Her experience in leading rulemaking bodies that determine medically underserved designations and language access standards and criteria for medically underserved designations, gives her valuable experience and expertise that can be utilized on the Negotiated Rulemaking Committee. Her unwavering commitment and focus on minority, LEP and disenfranchised populations, will ensure that these growing populations have a staunch advocate and voice in any national rulemaking process. Attached please find her resume and written commitment.

The undersigned recommend Ms. Hirota to the Negotiated Rulemaking Committee in the highest of terms. We hope you will strongly consider this nomination. If you have any questions, please feel free to contact me at (510) 272-9536 x.105 or at jeffc@aapcho.org.

Sincerely,

Jeffrey B. Caballero, MPH	Kathy Lim Ko, MPH	Ruth Perot, MAT on behalf of
AAPCHO Executive Director	APIAHF President and CEO	OMO Executive Committee

Enclosures (2)

cc: White House Initiative on Asian Americans and Pacific Islanders