



AAPCHO

Association Of Asian Pacific Community Health Organizations

February 18, 2011

Health Resources and Services Administration
U.S. Department of Health and Human Services
Attention: Ms. Andy Jordan
8C-26 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Re: Testimony to the Negotiated Rulemaking Committee on the Designation of MUA/Ps and HPSAs

Dear Members of the Negotiated Rulemaking Committee:

On behalf of the Association of Asian Pacific Community Health Organizations (AAPCHO) and the more than 350,000 patients who our members serve, I come to express support for the Negotiated Rulemaking Committee's efforts to create a new national system to identify and designate Medically Underserved Areas/Populations and Health Professional Shortage Areas (MUA/Ps and HPSAs).

AAPCHO is a not-for-profit national association representing 27 community health organizations that serve low-income Asian Americans, Native Hawaiians, and Pacific Islanders (AAPIs) across the nation, its territories and freely associated states. AAPCHO members, which are predominantly community health centers, provide comprehensive primary health care, and are at the forefront in providing responsive, affordable, and culturally and linguistically appropriate primary health care services.

Recognition of racial, cultural, and linguistic barriers to access in health care are reflected in a long history of federal policies and guidelines. Most significant is Title VI of the Civil Rights Act of 1964, which prohibits discrimination in federal programs on the basis of race, color, or national origin.

It has been more than 10 years since the U.S. Dept. of Health and Human Services (DHHS) first established national standards to clarify the relationship of federal health programs to the Civil Rights Act of 1964. Formally referred to as the national standards on Cultural and Linguistic Appropriate Services (CLAS) in health care, DHHS' standards are now in wide use by large national accrediting agencies such as the Joint Commission and NCQA.

There are 14 CLAS standards, most of which address linguistic barriers. The effect of linguistic barriers on health care access and outcomes is well documented in the literature; language as an indicator is available in national data sets (e.g. decennial Census, annual American Community

Survey). Interventions to reduce linguistic barriers are also clearly defined, e.g. bilingual staffing, trained health care interpreters. Cultural barriers to health care access are less easily measured but are generally understood to be tied to social stigma and discrimination; indicators are race, ethnicity, and national origin.

We call on the Committee's moral obligation to ensure that the most historically underserved and stigmatized groups are recognized by the negotiated rulemaking process. We urge the Committee to:

1. **Include direct measures that represent populations facing *socio-economic, cultural, and linguistic barriers to health care access*.** Cultural and linguistic barriers to health care access are well-documented in the literature and can be measured by a number of indicators that are easily understandable by the public: poverty level, race, ethnicity, immigration status and linguistic isolation;
2. **Ensure that any proposed designation method is *transparent, easily understandable, and uses easily available data*.** We need to lower the burden on truly medically underserved communities to prove that they are underserved; the method must have a scientific basis, yet should not force low-income communities to rely heavily on expensive consultants and “experts” to construct complex analyses to demonstrate underserved status; as the Affordable Care Act states, we must “take into account the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data”;
3. **Recognize local and population-specific health conditions as a part of any proposed designation method.** In order to effectively target resources to communities, there needs to be *flexibility* to choose from a menu of health status indicators that are based on national priorities, such as those outlined in Healthy People 2020.

I can testify to you that the issues that I raise with you today are not abstract but are in fact very real. At International Community Health Services in Seattle where I work, we serve a largely immigrant population. Immigrants in this country are, as you know, critical for our country's workforce needs. Yet similar to many other stigmatized groups, they are treated as a “throw away” population. Well, these are the people who my health center serves. These are low-income people who would delay or not get health care at all if it were not for our efforts to provide culturally and linguistically accessible services.

Speaking to just the issue of language access—this is a critical aspect of access that we deal with every day. Our patients speak over 54 languages and dialects. Among our Medicaid patients, 41% are limited English-Proficient, totaling 7,475 visits in one year. To reduce the language barriers, we provide interpretation for the 10 most common languages and dialects. Outside interpreters are used whenever the language demand exceeds in-house capability for languages we serve or the language is not covered internally. These extra steps cost us more than \$800,000 annually and are critical to addressing barriers to access. We are doing this work every day, and yet ironically the burden on us to demonstrate that our communities are underserved is great, and often unrealistic.

We know that each Committee member faces a heavy responsibility, for the creation of a new designation system for MUA/Ps and HPSAs involves a complex process of comparing methods and data indicators that can most accurately identify medically underserved populations and areas of the U.S. We thank you for your time and perseverance in this process. Thank you for hearing my testimony.

Sincerely,

A handwritten signature in blue ink, appearing to read "T. Batayola", with a long, sweeping horizontal line extending to the right.

Teresita Batayola
Chair, Board of Directors
Association of Asian Pacific Community Health Organizations