



November 18, 2010

Nicole Patterson,  
Office of Shortage Designation  
Bureau of Health Professions  
Health Resources and Services Administration  
Room 9A-18  
Parklawn Building  
5600 Fishers Lane  
Rockville, Maryland 20857

Dear Ms. Patterson:

The National Asian Pacific American Women's Forum (NAPAWF) is the only national, multi-issue Asian/Pacific Islander (API) women's organization in the country. Our mission is to build a movement to advance social justice and human rights for API women and girls. Successfully reforming health care requires putting patients first and improving how their care is delivered. This is particularly important for low health literacy, immigrant, and limited English proficient populations such as API women.

We applaud and strongly support your initiative to create a comprehensive methodology and criteria for the Designation of Medically Underserved Populations and Primary Care Health Professional Shortage Areas, using a Negotiated Rulemaking (NR) process. We welcome the opportunity to share our perspective with the Negotiated Rulemaking Committee through the submission of written comments.

NAPAWF believes that it is critically important that the methodology that is used to identify a community as being a medically underserved population consider the disproportionate barriers that some communities experience. For the API community, immigration status, cultural and linguistic barriers, and lack of health insurance have severely impacted API health outcomes and led to significant health disparities of preventable diseases. Thus, when the Negotiated Rulemaking Committee considers the methodology and criteria for Designation of Medically Underserved Populations and Primary Care Health Professional Shortage areas, we ask that the Committee consider the following:

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1. **Include limited English-proficiency (LEP) and immigration status variables** in the development of the next iteration of the Index of Medical Underservice. Immigrant status and Limited-English Proficiency (LEP) factors are highly correlated with higher rates of poverty, lack of insurance, and unmet health needs.

More than one-third of API women struggle with English, which can cause significant communication difficulties in health care settings. These difficulties result in patients who are unable to fully communicate the extent of their health issues and must rely on family members and friends who must often interpret confidential and private health information on behalf of an LEP patient. It also results in unnecessary follow up visits due to misunderstanding a health provider's original instructions, and medical errors that sometimes lead to fatalities.

2. **Include an uninsured status variable** in the Index as well. Other variables, such as low-income status and employment, are valid indicators of need but are not accurate proxies for insurance status because a large proportion of the uninsured are employed. Furthermore, many low-income people have insurance coverage through Medicaid.

Many API women work in small business and industries where health insurance is unaffordable but they are not able to participate in the Medicaid program. The Korean American community has the highest rate of uninsured individuals of any racial or ethnic group. This lack of health insurance creates barriers to access to services that would otherwise allow API women to obtain necessary medical care. For example, API women experience disproportionately high rates of Hepatitis B virus, yet many are unaware of their health status or increased risk for the virus. Lack of health insurance is one factor for this negative outcome.

3. **Support the aggregation of the racial categories into one “non-white” variable.** It is NAPAWF's understanding that an increased score for racial categories would boost this variable's visibility on the Index of Medical Underservice. For this reason alone, we ask that APIs be grouped with other racial groups in order to raise the percentage of this variable, and therefore the need score on the Index of Medical Underservice. We also support the use of the variable, “% Hispanic” in order to address U.S. Census Bureau data limitations.

However, we want to draw attention to the fact that the lack of disaggregated scientific data on API subgroups continues to result in adverse health outcomes for our communities. For example, although cervical cancer rates have fallen for all major racial groups, rates for API women continue to rise, with Vietnamese American women seeing cervical cancer rates that are five times higher than that of White women.<sup>1</sup> Elsewhere within the implementation of PPACA, we are advocating that data collection practices must disaggregate by ethnicity and include appropriate standardized measures, indicators, and methods for collecting and reporting data to learn more about health care access,

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<sup>1</sup> National Asian Women's Health Organization (NAWHO), *Learning from Communities: A Guide to Addressing the Reproductive Health Needs of Vietnamese American Women* (1998).

quality and outcomes by patient demographic factors, including race and ethnicity, age, gender, primary language, socio-economic position, geographic location, and health literacy.

4. **Include a wider range of health status variables** in order to address disparities in health status and other preventable health conditions.

APIs are significantly less likely than non-Hispanic whites to receive recommended levels of screening, counseling, or care and face additional barriers that reduce accessibility of important health programs and services. As a result, APIs are at increased risk for diseases that are preventable. Studies have found that diabetes is the fourth leading cause of death for API females.<sup>2</sup> While many factors contribute to the high rates of preventable diseases among API individuals, including lack of culturally and linguistically appropriate services, the lack of health insurance and knowledge about preventive care within API communities push available services out of reach.

5. **Support the development of an additional, separate process to designate Medically Underserved Populations** for communities that are clearly underserved but are disadvantaged by data availability and data quality issues when calculating a needs score.

There is an unacceptably low amount of research and data available on API communities and their health needs. The little research that does exist demonstrate unacceptably high health disparities that are often the result of the failure of medical communities to provide linguistically and culturally competent services, recognize the need to test and treat for certain preventable diseases, or otherwise make their services affordable and accessible for low-income and LEP API individuals. Thus, we urge for the better collection of disaggregated research and data for API populations in order to monitor, prevent, treat and support the recovery and wellness of these groups in terms of substance abuse and mental health issues.

At the same time, we want to ensure that the collection of disaggregated data does not result in race/ethnicity variables lowering the impact of this variable on the Index of Medical Underservice.

6. **Support the substitution of state and local data for national data** in order to more accurately reflect local community conditions and needs.

Thank you for your consideration of these comments.

Sincerely,

Miriam W. Yeung, MPA

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<sup>2</sup> National Center for Health Statistics, 1999

Executive Director  
National Asian Pacific American Women's Forum