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HOUSE COMMITTEE ON ENERGY AND COMMERCE

**HEARING ON H.R. 3014,
“THE HEALTH EQUITY AND ACCOUNTABILITY
ACT OF 2007”**

**STATEMENT OF DEEANA JANG, JD,
POLICY DIRECTOR
ASIAN & PACIFIC ISLANDER AMERICAN
HEALTH FORUM (APIAHF)**

**TESTIMONY BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
HOUSE COMMITTEE ON ENERGY AND COMMERCE**

JUNE 24, 2008

**Summary of Testimony of Deeana Jang, J.D., Policy Director,
Asian & Pacific Islander American Health Forum
Before the Subcommittee on Health of the House Committee on Energy and Commerce
June 24, 2008**

- The Asian & Pacific Islander American Health Forum (“Health Forum”) is a national advocacy organization dedicated to improving the health and well-being of Asian American and Pacific Islander (AA and PI) communities through policy, programs and research.
- AAs and PIs experience disparities in health coverage, access to care, quality of care and health outcomes and disease prevalence. AAs and PIs are not heterogeneous and disparities are greater for specific ethnic subpopulations. For example, 17% of AAs and 24% of PIs are uninsured compared to 12% of nonHispanic Whites, but the rates of uninsurance for some subgroups are even higher (Koreans, 31%; Vietnamese, 21%) Factors such as language, cultural barriers and citizenship requirements prevent many AAs and PIs from accessing quality care.
- H.R. 3014, the “Health Equity and Accountability Act of 2007,” contains many provisions that will improve access to health coverage, access to health care services, improve the quality of care and increase investments in community-based approaches to achieve health equity.
- Accurate, timely, disaggregated data by race, ethnicity, and primary language on AAs and PIs are vital to developing and monitoring programs and policies aimed at improving health equity. Data on race and ethnicity need to be standardized, collected and reported by all HHS programs using, at minimum the 1997 Office of Management and Budget Revised Standards, and when possible, for smaller population groups.
- Language barriers can reduce access to health care, jeopardize the quality of care, lower patient satisfaction and adherence, increase the risk of medical errors and lead to adverse outcomes. More than a third of AAs and 12 percent of PIs speak English less than very well. There is a need for more research on the provision of culturally and linguistically appropriate health care. More funding for language assistance, technical assistance for providers and more enforcement of civil rights laws are necessary components to ensuring that limited-English proficient persons can access quality health care.
- Barriers to participation in Federal health care programs must be removed for immigrants and other noncitizens including Pacific Islanders.
- A diverse and culturally competent healthcare workforce is critical to improving access to quality care.
- Community-driven strategies such as the Racial and Ethnic Approaches to Community Health (REACH) 2010 program and the Minority AIDS Initiative and support for community health workers must be expanded.
- The Office of Minority Health, the Office for Civil Rights and the National Center for Minority Health Disparities must be strengthened and given more authority to coordinate and hold accountable HHS agencies to the Nation’s goal to eliminate health disparities as articulated by Healthy People 2010.

Thank you, Chairman Pallone, Ranking Member Deal, and members of the House Energy and Commerce Subcommittee on Health, for inviting me to testify on disparities in health and health care. I also want to thank Congresswoman Solis for your leadership, along with members of the Congressional Asian Pacific American Caucus, Congressional Hispanic Caucus and Congressional Black Caucus, in taking a comprehensive approach to achieving health equity through your introduction of H.R. 3014, the “Health Equity and Accountability Act of 2007.”

The Asian and Pacific Islander American Health Forum (“Health Forum”) is a national advocacy organization dedicated to improving the health and well-being of Asian American and Pacific Islander (AA and PI) communities through policy, programs, and research. We advocate on health issues that impact AA and PI communities, provide community-based technical assistance and training to address chronic diseases, HIV/AIDS, and domestic violence in AA and PI communities, and convene regional and national conferences on AA and PI health. To achieve optimal health and well-being of AAs and PIs, the Health Forum promotes policies that:

- Increase access to health care coverage and services;
- Improves the quality of health services including culturally and linguistically competent services;
- Improves data and research on AA and PI health;
- Promotes a diverse health care workforce; and
- Increases investment in community-driven health programs.

H.R. 3014 includes provisions that address all five of these policy priorities. My testimony today will highlight some of the major provisions and how they would impact AA and PI communities. First, I want to provide an overview of disparities in health care and health status experienced by AAs and PIs.

Disparities in Health Coverage among AAs and PIs

As a group, Asian Americans and Pacific Islanders are more likely to be uninsured than non-Hispanic whites. Specific AA and PI groups face extremely high rates of uninsurance: from 2004-2006, 24 percent of

Native Hawaiians and Pacific Islanders and 31 percent of Korean Americans were uninsured.¹

The high rate of uninsurance in several Asian American communities is related to their employment in small businesses that do not offer health insurance benefits. For example, more than half of Korean Americans work in businesses with less than 25 employees. Yet, only half of employees in such firms are provided coverage through their employer. As a result, Korean Americans have one of the lowest rates of employer-sponsored health coverage among AAs and PIs, 49 percent, compared to South Asians who have the highest rate at 75 percent.²

Public programs such as Medicaid and SCHIP also play an important role in reducing uninsurance in AA and PI communities. Gains in coverage by these programs, between 1997 and 2004-2006, helped protect AAs and PIs from declines in job-based coverage. This helped decrease the number of uninsured AAs and PIs from 21 percent to 19 percent over that same period.³ An expansion of public programs is critical for individuals who do not have access to affordable coverage through an employer or the private market.

Disparities in Access to Care

Health insurance coverage is an important predictor of access to health care in AA and PI communities. From 2004 to 2006, uninsured Asian Americans were more than 4 times as likely as insured Asian Americans to lack a usual source of care.⁴

However, disparities in access to care remain regardless of health coverage. Nonelderly AAs and PIs were more likely to lack a usual source of care than non-Hispanic Whites (18 percent vs. 14 percent).⁵ Similarly, 52 percent of nonelderly uninsured AAs and PIs lacked a usual source of care, compared to 46 percent of non-Hispanic uninsured Whites. Factors such as language and cultural barriers prevent many AAs and PIs from accessing quality care.

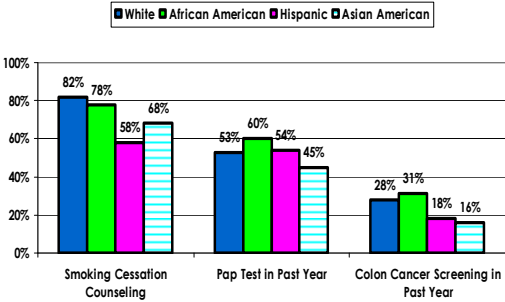
Disparities in Quality of Care

Findings from the Commonwealth Fund's 2001 Health Care Quality Survey concluded that Asian

Americans experience poor access to quality care on a range of measures.”⁶ Asian Americans reported greater communication difficulties and lower levels of satisfaction during their health care visits.⁷ They were also “the least likely to feel that their doctor understands their background and values, to have confidence in their doctor, and to be as involved in decision-making as they would like to be.”⁸

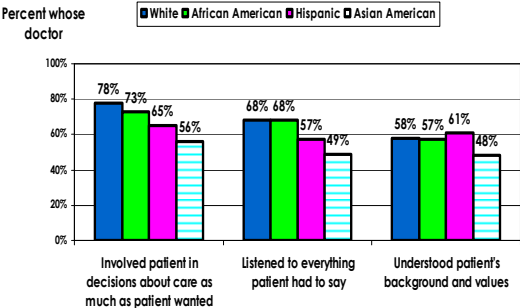
Despite having higher rates of certain health conditions, many AAs and PIs do not receive the recommended levels of prevention, counseling, or care they need. The 2001 and 2006 Health Care Quality Surveys revealed that Asian Americans were significantly less likely to receive preventive services such as cancer screenings or cholesterol checks, or counseling about smoking cessation, diet, weight, exercise, and mental health.⁹ Less than half of Asian Americans with chronic conditions received the care they needed to manage their conditions.¹⁰

Figure 1: Preventive Care and Physician Counseling



SOURCE: The Commonwealth Fund 2001 Health Care Quality Survey

Figure 2: Asian Americans Experience Communication Problems with their Doctors



SOURCE: The Commonwealth Fund 2001 Health Care Quality Survey

Disparities in Health Outcomes and Disease Prevalence

The lack of health coverage, limited access to health care, and the lack of culturally and linguistically competent services can manifest in harmful, and even fatal ways:

- Cancer deaths are increasing at a faster rate among AAs and PIs than any other racial and ethnic population. For example, the risk of death for Asian American women with breast cancer is 1.5 to 1.7 times higher than that for white women.¹¹ This is due in part to the relatively low screening rates and late stage diagnoses that occur among AA and PI women.

- Although statistics on the overall prevalence of diabetes in AA and PI communities are unavailable, it is the fifth leading cause of death among AAs and PIs. In Hawaii, AAs and PIs aged 20 and over are more than 2 times as likely to have diagnosed diabetes as whites after adjusting for population age differences. In California, Asian Americans are 1.5 times as likely to have diagnosed diabetes as non-Hispanic whites. Despite the importance of managing diabetes, nearly half of AA and PI adults with diabetes in California had not received a foot exam in the past year, compared with less than 30 percent of Whites and African Americans.¹²
- Asian American women aged 15-24 and over 65 have the highest suicide rates across all racial and ethnic groups.¹³ Furthermore, Asian American girls have the highest rates of depression across both race/ethnicity and gender.¹⁴

Strategies to address disparities in coverage, access and quality

There are six important strategies included in H.R. 3014 that address disparities in coverage, access and quality:

1. Standardizing the collection, analysis and reporting of data on race, ethnicity and primary language in an accurate and appropriate manner.
2. Ensuring that effective communication takes place between provider and patient through the provision of competent language assistance.
3. Removing barriers to enrollment in public health programs based on citizenship status.
4. Promoting a diverse and culturally competent health care workforce.
5. Increasing investment in community-based health promotion programs.
6. Improving accountability and evaluation.

Importance of collection of data on race, ethnicity and primary language

Accurate, timely, disaggregated data by race, ethnicity, and primary language on Asian Americans and Pacific Islanders are vital to developing and monitoring programs and policies aimed at improving health equity.

In 1999, Congress requested that the Institute of Medicine (IOM) assess the extent of health disparities; explore factors that may contribute to inequities in care; and recommend policies and practices to eliminate them.

Its report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," found significant disparities in the quality of health services received by minorities — even when insurance status, income, age, and severity of condition were comparable. The IOM study further revealed that minorities are less likely to be given appropriate cardiac medications, undergo bypass surgery, and receive kidney dialysis or transplants. Sadly, they are also more likely to receive last-resort procedures, such as lower limb amputations for diabetes. Subsequent research suggests that these disparities continue to this day for both minorities and women. For example, a recent study released by the Robert Wood Johnson Foundation found that the rate of leg amputation is four times greater in African American Medicare beneficiaries than in whites.¹⁵ Another recent study published in *Health Affairs* found that, although there were some variations related to geography and socioeconomic status, overall, Asian Medicare beneficiaries were less likely than whites to receive mammography and colorectal cancer screening services and all three diabetic services.¹⁶ The National Healthcare Disparities Report in 2006 found that Asians receive lower quality of care compared with whites for one-third of the core measures tracked in the report, and for 75 percent of those measures, the gaps in quality were not improving over time.¹⁷

To help close the disparity gap, the IOM recommended that the Federal government: (1) collect and report data on health care access and utilization by patients' race, ethnicity, and socioeconomic status; (2) include measures of disparities in performance measures; and, (3) monitor progress toward the elimination of health care disparities. In 2001, the Commonwealth Fund went a step further by recommending that quality measurement and reporting tools, such as the Health Plan Employer Data and Information Set collect and report health data by race, ethnicity, and primary language. However, no comprehensive action has been taken on these recommendations; it is long overdue. There are a number of policies and practices that have created barriers to the collection and reporting of race, ethnicity and primary language data.

OMB Revised Standard on the Collection of Race and Ethnicity Data

In 1997, the Office of Management and Budget (OMB) revised the standards for collection of race and ethnicity data by the Federal government. This policy was of great significance to AA and PI communities,

because a major change included the Federal government requiring the collection of data on Asian Americans separate from Native Hawaiians and Other Pacific Islanders. Following the revision, the U.S. Department of Health and Human Services adopted a “Policy Statement on Inclusion of Race and Ethnicity in DHHS Data Collection Activities.”¹⁸ That policy clarified that the OMB standards do not require that race and ethnicity be included in data collection and reporting, but that HHS’s policy is that “data on race and ethnicity will be included in all data collection and reporting activities.” Unfortunately, this policy has never been fully implemented, and most HHS recipients, including states and private industry, are not required by HHS funding agencies to collect or report this data. The policy also does not require HHS programs to collect data on primary languages spoken by the beneficiaries of HHS services and programs. ***We support the provisions in Title III of H.R. 3014 to promote data collection, analysis, and reporting by race, ethnicity, and primary language among federally supported programs. Specifically, we support the required collection of data using at minimum the OMB standards, but also collecting data for additional ethnic subgroups.*** We further support the collection and reporting of race, ethnicity and primary language by region and state. AA and PI populations are concentrated in several regions of the United States including the West Coast and the Pacific, Mid-West and major cities on the East Coast. Therefore, more granular data on specific subgroups may be more readily available on regional or state levels.

Health Insurance Portability and Accountability Act

As part of the 1996 Health Insurance Portability and Accountability Act (HIPAA), Congress included provisions for the development of standards for electronic data interchange. Under the HIPAA rule implementing this provision, HHS could adopt a standard set by a standard setting organization accredited by the American National Standards Institute (ANSI) or adopt another standard if it will reduce costs for health plans and providers or if no standard has been adopted by an ANSI accredited organization, HHS may act on the recommendation of the National Committee on Vital and Health Statistics. With respect to standards for the collection of data on race, ethnicity and primary language, ANSI did not adopt a standard requiring that race and ethnicity data be collected,

but designated it as a “situational” standard in its claims data set. ***We support the provisions in H.R. 3014 that require the establishment of a new data code set for primary language and the designation of racial, ethnic and primary language code sets as “required” for claims and enrollment datasets.***

Medicare Data

Medicare data has provided a rich source of information about racial, ethnic, and socioeconomic disparities in health and health care among Medicare beneficiaries. And while there have been some improvements in the quality of data collected on race and ethnicity, there remain much more that needs to be done to improve the quality and accuracy of data. For example, an analysis of 2002 Medicare administrative data show that only 52 percent of Asian beneficiaries and 33 percent of both Hispanic and American Indian/Alaska Native beneficiaries were identified correctly.¹⁹ Medicare’s data on race and ethnicity come from Social Security’s administrative records and are collected on a consistent basis when an individual applies for a Social Security number. The way the data is collected was not (and has not been) updated when the Office of Management and Budget revised the standards for collection of race and ethnicity data in 1997. In addition, since the late 1980’s, most applications for Social Security numbers are made through the Enumeration at Birth process, and questions regarding race and ethnicity are not included. Finally, 12 percent of Medicare beneficiaries are enrolled by Medicare health plans that are not required to collect or report data on race, ethnicity or primary language.²⁰

APIAHF is part of the Out of Many, One (OMO) Data Task Force, a coalition of advocates working to eliminate racial and ethnic health disparities. At the request of OMO, the Congressional Tri-Caucus has sent a letter to the Social Security Administration requesting information on the status of its efforts to improve data collection on race, ethnicity and primary language. ***We support the provision in H.R. 3014, the Health Equity and Accountability Act of 2007, that requires the Social Security Administration to collect data on the race, ethnicity, and primary language of all applicants for social security numbers or benefits.***

OMO and APIAHF are also supporting language in pending Medicare legislation in the Senate to grant authority to the Secretary of Health and Human Services to require Medicare plans and providers to report race,

ethnicity, and gender-specific data as part of the quality measures they are currently required to collect and report. We support the provisions included in Subtitle D of H.R. 3162, the Children's Health and Medicare Protection Act of 2007 (CHAMP Act) that would require collection of data on race, ethnicity, and primary language of each applicant for and recipient of Medicare benefits in conformity with the 1997 revised OMB standards and further disaggregation, where practicable, for additional population groups. Such provisions would help identify and eliminate disparities in the quality of health services that minorities and women enrolled in the program receive.

In addition to enacting these critical provisions of H.R. 3014, more needs to be done to improve data collection on smaller populations including Asian American and Pacific Islander subgroups. Important health and surveillance data on AAs and PIs continues to be collected and reported at the federal and state level as "Other/Unknown," or the data is not collected, reported, or analyzed. This lack of data is made even more acute by the growth and diversification of AA and PI communities over the last 20 years. It is still difficult to know the health status of specific AA and PI ethnic groups such as Hmong, Laotians, Asian Indians or Micronesians. It is also difficult to disaggregate socioeconomic groups such as new immigrants or the poor. We support policies that improve the collection, analysis and reporting of data on AAs and PIs including translation of survey instruments and use of bilingual interviewers, oversampling of smaller populations, bridging of datasets, pooling data over a number of years, increasing funding for community-based participatory research and providing resources for more data collection at regional, state and community levels.

Ensuring that effective communication takes place between provider and patient through the provision of competent language assistance.

Language barriers can reduce access to health care, jeopardize the quality of care, lower patient satisfaction and adherence, increase the risk of medical errors and lead to other adverse outcomes. More than a third of Asian Americans and 12 percent of Pacific Islanders speak English less than very well. The rate of limited English proficiency is even higher for specific groups: more than half of Vietnamese, Hmong, Cambodian, Laotian, Bangladeshi, and Taiwanese are limited English proficient. Research indicates that the use of trained interpreters

and especially the use of language concordant health providers can improve access to and quality of care for persons with limited English proficiency.²¹ Research also shows that Medicare beneficiaries who are limited English proficient in English are less likely than those who are proficient in English to have access to a consistent source of care and less likely to receive important preventive care, including cancer screening tests.²² However, more research is needed to determine the impact of language services on the health and health care of limited English proficient populations. ***We support the provisions in H.R. 3014 to:***

- Require the Agency for Healthcare Research and Quality to expand research related to the barriers to health care and mental and behavioral health services faced by LEP individuals, the impact of cultural and language services on the quality of health care and the health status of LEP individuals, the attitudes and knowledge of health care providers and administrators regarding these barriers, and what are the most effective means of providing language assistance;
- Require the Secretary of HHS to contract with the Institute of Medicine to publish a report on Federal efforts to ensure that all individuals have meaningful access to culturally and linguistically appropriate health care services; and
- Establish a grant program to promote innovations in culturally competent and linguistically accessible health care programs.

Medicare programs should ensure that meaningful access to enrollment and health care services is provided for persons with limited English proficiency.

Under Title VI of the Civil Rights Act of 1964, all recipients of Federal financial assistance are required to provide meaningful access to its programs, services and activities, including those that are not directly Federally funded, to persons with limited English proficiency. Not all Medicare programs are considered Federal financial assistance. While Medicare Part A providers are considered recipients of Federal financial assistance, providers (e.g. individual physicians, who only receive Medicare Part B and no other form of Federal financial assistance, e.g. Medicaid) are not obligated to comply with federal civil rights law.²³ This has caused some confusion as new

Medicare programs have been initiated with a mixture of Part A and Part B funds, e.g. Part C, and other sources so that determining whether participants in some Medicare programs are required to comply has become more complex. **We support the provision included in Title I of H.R. 3014 requiring Medicare Part B providers to comply with Federal civil rights laws.** We also support the provision in H.R. 3162 to require the HHS Inspector General to prepare and publish a report on the extent to which Medicare providers and plans are complying with Title VI and are providing culturally and linguistically appropriate services as described in the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care.

Furthermore, Executive Order 13166 requires that all Federal agencies develop plans to ensure that programs conducted by the Federal government are accessible to persons with limited English proficiency.²⁴ Therefore, outreach and enrollment in the Medicare program conducted by the Centers for Medicare and Medicaid Services (CMS) should be accessible for persons with limited English proficiency. We are concerned that while CMS translated much of the outreach materials for enrollment in the Medicare Part D program, there remain issues of inaccessibility to telephone assistance and enrollment materials. We are also concerned that Medicare informational materials, applications and beneficiary notices are not available in languages other than English and Spanish. **We support the provisions of H.R. 3014 that require all Federal agencies that conduct health care-related activities to prepare a plan to improve access to federally conducted health care-related activities by LEP persons.**

The Federal government should provide reimbursement for the cost of language assistance and provide technical assistance to providers to ensure that high quality and effective language assistance is available in a timely manner.

Health care providers from across the country have reported inadequate funding of language services to be a major barrier to LEP individuals' access to health care and a serious threat to the quality of the care they receive.

- 63% of hospitals encounter patients with LEP daily or weekly; an additional 17% encounter LEP patients at least monthly.

- 65% of internal medicine physicians have active patients who are LEP.

Almost every major health organization (including the AMA, AHA, ANA, AAP, AAFP, ACP, ANA, APHA, APA, NACHC, NAPH, NASW, NMA and NHMA), **supports government payments for language services as necessary to ensuring quality healthcare.** Over 75 organizations have endorsed the Language Services in Healthcare Statement of Principles which supports funding mechanisms to ensure language services are available where and when they are needed.

- The American College of Physicians recommends that Medicare should pay for the added expense of language services and the additional time in providing clinical care.
- The American Hospital Association stated that resources should be targeted to improving language services for all patients with LEP.
- According to a recent article in *Pediatrics*, discussing results from a survey of pediatricians supported by the American Association of Pediatrics, reimbursement for language services is associated with greater use of professional interpreters.

Medicaid and State Children's Health Insurance Program Reimbursement

Although CMS has clarified that states can get federal matching funds for the provision of language services in its Medicaid and State Children's Health Insurance Programs, according to the National Health Law Program, only about a dozen states have taken advantage of this option. ***H.R. 3014 provides for 100 percent Federal funding for language assistance services in the Medicaid and SCHIP programs -- a much greater incentive for states to take action to pay for interpreters and translators.***

Medicare

Although the regulations for Medicare Advantage require managed care plans to "ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds,"²⁵ it is unclear whether and how Medicare Advantage

plans are paying for language services and if they need or should have additional payments. Most managed care plans pass on the requirement to their contracted providers without specific funding or incentives. So while the managed care plans may have contractually agreed to provide language assistance, their payment policies may in fact create a disincentive for providers to participate and use language services.

We recognize that determining the best methodology and structure to provide reimbursement in the Medicare program is complex given the payment structure of the various providers, including in- and out-patient hospital care, physician care and managed care. ***Therefore, we support H.R. 3014's provisions to establish demonstration projects in different settings, a report to include recommendations on how to extend language services to all Medicare providers, and evaluation of the projects to assess the impact of the projects on access, utilization, efficiency, cost-effectiveness, patient satisfaction and impact on some health outcomes.***

Technical assistance for health providers

While obtaining more Federal support to pay for the cost of language services is essential, many providers remain in need of technical assistance to develop their language access plans and policies and to implement them. Federally assisted health providers are obligated to provide language assistance services to everyone who wishes to access their services regardless of whether they are covered by Medicaid, SCHIP or Medicare. ***The establishment of the Robert T. Matsui Center for Cultural and Linguistic Competence in Health Care, as provided in H.R. 3014, will provide this needed support and assistance.***

Barriers to participation in Federal health care programs must be removed for immigrants and other noncitizens

In order to ensure coverage and access to health care for all, federal programs including Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) must remove barriers to eligibility for immigrants and other noncitizens such as some Pacific Islanders.

Coverage of AAs and PIs in public programs grew in part due to federal and state efforts over the last decade to reduce barriers faced by minority and immigrant communities. Many AAs and PIs qualify for public programs but remain uninsured because of language and cultural barriers in the enrollment process, misinformation about eligibility, and other family hardships such as food and housing insecurity. There are others who do not qualify even if they are low-income and legal immigrants. Since 1996, legal immigrants in low-income families have been barred from receiving Medicaid or SCHIP during their first five years in this country, even if they meet all other requirements for the programs. Citizens of the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), and the Republic of Palau are ineligible for public programs as well, even though they are allowed to work and travel in the US. Many of these Pacific Islanders have health issues for which they are unable to access care. For example, approximately 6000-8000 Marshallese live in Northwest Arkansas. As a group, they have higher propensity for diabetes, high blood pressure, cancer and related complications because they delay seeking care, yet they are ineligible for most federally funded programs.²⁶

To address these disparities in coverage, many states developed strategies to help enroll individuals with limited English proficiency in Medicaid and SCHIP.²⁷ States also took additional steps to simplify enrollment and renewal procedures for children.²⁸ And, nearly half of states have continued to provide coverage for legal immigrants during their first five years in the country through state-funded programs.²⁹

We support the provisions in H.R. 3014 to allow states to cover lawfully residing immigrant children and pregnant women in SCHIP and Medicaid. We urge the Committee to include ALL lawfully residing immigrant children and pregnant women including permanent residents who are ineligible because of the five year bar. H.R. 3014 also provides eligibility for Medicaid and SCHIP for citizens of RMI, FSM and the Republic of Palau. In addition, other barriers such as excessive citizenship documentation in the Medicaid program must be repealed.

Ensuring a diverse and culturally competent healthcare workforce

A diverse healthcare workforce is critical to improving access to quality care, access to culturally and linguistically appropriate care, and patient choice and satisfaction for minority, AA, and PI communities.

Although statistics suggest that Asian Americans as a whole are well-represented among physicians, a comprehensive look at the healthcare workforce reveals that many groups are poorly represented.³⁰ For example, findings from a survey conducted by the California Medical Board indicate that there are shortages of many AA and PI subgroups in California's physician workforce. Less than 0.05 percent of California's physicians, or an estimated 90 of the 61,861 physicians in the state, were Cambodian, Laotian, Hmong, or Samoan.³¹ In 2005, the Association of American Medical Colleges reported 3,111 Asian American medical school graduates nationally compared to 45 Native Hawaiian or Pacific Islander medical school graduates.³²

Even less progress has been made in reporting data on the diversity of AAs and PIs in other health professions, such as nursing, dentistry, and allied health, which include many frontline healthcare workers, such as community health workers, health educators, and outreach workers. This limited data suggests that AAs and PIs are underrepresented as nurses, psychologists, and health services researchers.³³

Fortunately, academic institutions and state medical associations are taking steps to address the lack of data on AA and PI subgroups in health professions. The California Medical Association sponsored legislation, which was enacted in 2001, requiring the California Medical Board to survey physicians when they renew their licenses. Every two years, physicians are asked to identify their ethnicity from a list of 28 ethnicities, and to indicate if they speak any of 34 languages listed.³⁴ In 2007, the University of California became the first public higher education institution to collect and report data on AA and PI subgroups through its undergraduate application.³⁵ ***By requiring health and allied health profession schools to collect and report data on the race, ethnicity, and language proficiency of students, H.R. 3014 would improve the data we need to diversify the health care workforce.***

The shortage of AAs and PIs in the health professions is a serious concern because many AA and PI communities continue to be medically underserved, with little or no access to culturally and linguistically appropriate primary and mental health care, and because the needs of AAs and PIs are often not considered in broader health research agendas. The U.S. Surgeon General noted in 2001 that nearly half of AAs and PIs have

problems accessing mental health services because of the lack of providers with appropriate language skills.³⁶

From 1986 to 2000, only 0.01 percent of Medline articles mentioned Asian Americans and Pacific Islanders.³⁷

Efforts to increase the diversity of AAs and PIs in the healthcare workforce are also limited by the lack of a standard definition and process for determining underrepresentation in the various health professions.³⁸ Because public and private agencies and academic institutions use different definitions and this determination serves as the basis for allocating funds from numerous programs, AA and PI communities are often excluded from programs that seek to increase diversity in the health professions. For example, the Health Resources and Services Administration (HRSA), within HHS, utilizes a definition of underrepresented minorities that includes Native Hawaiians and Pacific Islanders but excludes “Chinese, Filipino, Japanese, Korean, Asian Indian, Thai, and Vietnamese/Southeast Asians.” We urge HHS to adopt a standard definition of “underrepresented minorities” that considers the inclusion of specific AA and PI subgroups that are underrepresented in specific health professions.

The shortage of AAs and PIs in health careers is also closely linked to the inequalities in educational opportunities that face many AA and PI communities. Ten AA and PI groups have lower than average rates of high school completion, and three groups have the lowest rates among racial and ethnic groups.³⁹ ***The Health Forum supports the provisions in H.R. 3014 that reauthorize and increase funding for financial resources, such as scholarships and loan repayment, and pipeline programs for minorities who are underrepresented in the healthcare workforce.*** Specifically, these provisions would:

- Authorize \$100 million in grants for educational institutions committed to health workforce diversity.
- Provide career development support to promote diversity among health professionals.
- Establish Regional Minority Centers for Excellence Programs in underserved regions.
- Reauthorize the Health Careers Opportunity Program at \$50 million in FY2008.
- Reauthorize the Program of Excellence in Health Professions Education for Underrepresented Minorities for \$50 million for FY2008.
- Authorize \$50 million for the Health Professions Student Loan Funds.

- Reauthorize the National Health Service Corps' scholarship and loan repayment programs and authorize training grants for community health centers.
- Reauthorize the loan repayment program for CDC employees.

I would also like to highlight the importance of frontline healthcare workers, interpreters, and bilingual and bicultural providers in our efforts to diversify the healthcare workforce. ***We urge the Committee to consider workforce development and training strategies that would increase the availability and competency of health care interpreters and bilingual and bicultural health professionals.*** Strategies could include the recruitment and training of bilingual and bicultural members from underrepresented communities, the provision of ESL and job training, as well as changes in health professions programs that include cross-cultural education and training on how to work with interpreters.

Increasing investment in community-based health promotion programs

H.R. 3014 increases investment in community-driven strategies and solutions, provisions that the Health Forum strongly supports. When addressing health disparities in minority communities, it is important to engage and partner with communities. While improvements in health systems are important, multiple strategies are needed to address the root causes of disparities, including social, economic, and cultural factors that may impact health and health disparities.

H.R. 3014 would codify the Racial and Ethnic Approaches to Community Health (REACH) 2010 program, within the CDC, which funds 40 grantees to develop and evaluate strategies that reduce health and health care disparities. Currently, only 6 of the 40 grantees address disparities faced by AA and PI communities. With additional support, the REACH program could build on its successful base of programs, expand technical assistance and training, disseminate lessons learned, and award grants to additional communities.

In Santa Clara County, California, a coalition funded by the REACH 2010 program is working to increase awareness and use of breast and cervical cancer screening among Vietnamese women, who face a rate of cervical cancer that is 5 times the rate of cervical cancer in white women. Despite the importance of regular Pap

tests in detecting cervical cancer, more than 25 percent of Vietnamese women have never had a Pap test. With assistance from a lay health worker, 48 percent of women received their first test Pap test, 52 percent of women received a second pap test within 18 months, and 4,187 women enrolled in a reminder system.

The evaluation of this program, as well as many others, demonstrates the impact that community health workers can have on health promotion and prevention in AA and PI communities. As community members who work in community settings, community health workers are uniquely effective in bridging the gap between communities and health systems. Community health workers offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening. ***The Health Forum supports the provision in H.R. 3014 that would establish grants to promote positive health behaviors in women and children through the use of community health workers.*** We hope the subcommittee will also consider other policies and funding streams that would support the growing field of community health workers.

The Health Forum also supports other provisions in H.R. 3014 that direct resources toward evidence-based health programming and the elimination of health disparities in communities, such as increased funding for the Minority AIDS Initiative, and the development of cancer prevention and treatment demonstrations for racial and ethnic minorities.

Improving Accountability and Evaluation

Finally, H.R. 3014 improves accountability and evaluation within HHS by expanding the role of key agencies within the department. The Institute of Medicine concluded that civil rights enforcement is an important component of a comprehensive strategy to address health care disparities, but too often this work is relegated to a low priority. ***We support the IOM's recommendation of providing greater resources to the Office for Civil Rights to enforce civil rights laws within health care and human services settings.***

As the lead office within HHS for addressing minority health needs, the Office of Minority Health (OMH) supports health promotion and disease prevention programs in communities of color, and cultural and linguistic competence in health care systems. We support an increase in funding for OMH programs as well as an elevated role in overseeing and evaluating minority health and health disparity efforts across HHS.

H.R. 3014 would strengthen the National Center on Minority Health and Health Disparities (NCMHD) within the National Institutes of Health. We also support recommendations from the IOM report, “*Examining the Health Disparities Research Plan of the National Institutes of Health: Unfinished Business,*” to improve planning and coordination of health disparities research across NIH.

Conclusion

We look forward to working with you and other members of Congress to move forward on this historic piece of legislation to achieve health equity in America.

¹ Kaiser Family Foundation and Asian & Pacific Islander American Health Forum, “Health Status, Coverage, and Access to Care for Asian and Native Hawaiian and Pacific Islander Americans” (Washington, DC: April 2008).

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ K. Collins, D. Hughes, M. Doty, B. Ives, J. Edwards, and K. Tenney, “Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans: Findings from the Commonwealth Fund 2001 Health Care Quality Survey,” (New York: The Commonwealth Fund, March 2002).

⁷ Ibid.

⁸ Ibid.

⁹ Collins et al, “Diverse Communities, Common Concerns,” 2002. A. Beal, M. Doty, S. Hernandez, K. Shea, and K. Davis, “Closing the Divide: How Medical Homes Promote Equity in Health Care,” (New York: The Commonwealth Fund, June 2007).

¹⁰ Beal et al, “Closing the Divide,” 2007.

¹¹ C. Chappell, “Health Care Needs of Asian American Women,” *Issues, Concerns, and Responsive Human and Civil Rights Advocacy: Asian American Women, Second Edition*, Chapter 5, pages 101-120, 2007.

¹² Centers for Disease Control and Prevention, National Diabetes Fact Sheet, United States, 2005.

¹³Centers for Disease Control and Prevention, “Deaths: Leading Causes for 2001,” *National Vital Statistics Reports*, 52(9), 1-86, 2003.

¹⁴ National Center for Health Statistics, “Health, United States, 2003,” (Hyattsville, MD: US Public Health Service, 2003).

¹⁵ E. Fisher, D. Goodman, and A. Chandra, “Disparities in Health and Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project,” The Robert Wood Johnson Foundation, June 2008.

¹⁶ E. Moy, L. Greenberg, and A. Borsky, “Community Variation: Disparities in Health Care Quality Between Asian and White Medicare Beneficiaries,” *Health Affairs*, Vol. 27, No. 2, March/April 2008.

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- ¹⁷ Agency for Healthcare Research and Quality, *2006 National Healthcare Disparities Report*, December 2006.
- ¹⁸ U.S. Department of Health and Human Services, Office of Information Resources Management, "HHS Policy for Improving Race and Ethnicity Data," October 24, 1997.
- ¹⁹ A. McBean, "Improving Medicare's Data on Race and Ethnicity," Medicare Brief, No. 15, National Academy of Social Insurance, October 2006.
- ²⁰ Ibid.
- ²¹ Green, A., et al. "Interpreter services, language concordance, and health care quality. Experiences of Asian Americans with limited English proficiency." *J Gen Intern Med.* 20(11):1050-6, Nov. 2005. Flores, G. "The impact of medical interpreter services on the quality of health care: a systematic review." *Med Care Res Rev.* 62(3):255-99, June 2005. Ngo-Metzger, Q. "Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use." *J Gen Intern Med.* 22 (Suppl 2):324-30. Nov. 2007.
- ²² N. Ponce, L. Ku, W. Cunningham, and E. Brown, "Language Barriers to Health Care Access Among Medicare Beneficiaries," *Inquiry*, Spring 2006.
- ²³ U.S. Department of Health and Human Services, Office for Civil Rights, "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," 68 Fed. Reg. 47311, August 8, 2003.
- ²⁴ *Improving Access to Services for Persons with Limited English Proficiency*, 65 Fed. Reg. 50121, August 16, 2000.
- ²⁵ 42 C.F.R. 422.112(a)(8).
- ²⁶ J. Lyon, "Marshallese in Arkansas unhealthy, ineligible for health care programs," *The Morning News*, December 10, 2007.
- ²⁷ M. Youdelman, J. Perkins and J. Brooks, "Providing Language Services in State and Local Health-Related Benefits Offices: Examples from the Field," (New York: The Commonwealth Fund, January 2007).
- ²⁸ Kaiser Family Foundation, "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and SCHIP in 2008," (Washington, DC: January 2008).
- ²⁹ L. Ku, "Reducing Disparities in Health Coverage for Legal Immigrant Children and Pregnant Women," (Washington, DC: Center on Budget and Policy Priorities, April 2007).
- ³⁰ M. Ro, "Workforce"
- ³¹ Center for California Health Workforce Studies, University of California, San Francisco, "Physician Diversity in California, New Findings from the California Medical Board Survey," March 2008.
- ³² Association of American Medical Colleges, "Matriculants by Race and Ethnicity within Sex, 2002 – 2004," 11/16/2004.
- ³³ M. Ro, "Workforce"
- ³⁴ Center for California Health Workforce Studies, "Physician Diversity in California," 2008.
- ³⁵ M. Ro, "Workforce"
- ³⁶ U.S. Surgeon General. 2001. "Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General." Washington, DC: U.S. Department of Health and Human Services.
- ³⁷ C. Ghosh, "Healthy People 2010 and Asian Americans/Pacific Islanders: Defining a Baseline of Information," *Am J Public Health* 93:2093-2098, 2003.
- ³⁸ M. Ro, "Workforce"
- ³⁹ Asian American Justice Center and Asian Pacific American Legal Center, *A Community of Contrasts: Asian Americans and Pacific Islanders in the United States*, 2006.