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Limited English Proficiency as a Critical Component of the Department of Health and Human Services Proposed Rule for Medically Underserved Areas

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Summary

Medically underserved Asian Americans, Native Hawaiians, and Other Pacific Islanders (AA&NHOPIs) and other racial/ethnic minorities are often left out of the health center system (OMB, 1997; Papa Ola Lokahi, 2007). The Department of Human and Health Services is updating its Proposed Rule, which determines key population health indicators for medically underserved areas (MUA) and health professional shortage designations. This is important as revisions could increase Community Health Center (CHC) health care access for underserved AA&NHOPIs. We recommend that Limited English Proficiency be used as one of the measures in determining MUAs, as it is a scientifically valid and available measure that can identify where underserved AA&NHOPIs and other minorities who face an added language barrier can access needed health services.

Introduction

Since 1976, the U.S. Department of Health and Human Services (DHHS) has used an index of "need indicators" to identify medically underserved areas (MUAs), or areas of the country where residents are without adequate access to health care services. The MUA indicators include the percent of the catchment area population in poverty, population age sixty-five and over, infant mortality, and primary care physicians to 1,000 population ratio

(DHHS, 1995). DHHS identifies MUAs to determine where health care needs exist and allocates funding for community health centers (CHCs) based on that need. As required by the Patient Protection and Affordable Care Act, DHHS announced it would update the Proposed Rule in 2010, which allows for revisions in how DHHS identifies MUAs. In 2010, a special national committee of stakeholders, or the Negotiated Rulemaking Committee (NRM) consisting of CHC stakeholders, was created and tasked with issuing recommendations to help DHHS update its MUA index. This effort to identify new MUA standards that would better represent diverse medically underserved populations is critical given its potential impact on the current and future CHCs serving these growing populations.

The health issues of Asian American & Native Hawaiian and Other Pacific Islanders (AA&NHOPIs) and other communities of color are a growing national concern.[1] AA&NHOPIs are among the fastest-growing racial groups and will grow from 5.3 percent (or 16.5 million people) and 0.4 percent (1.2 million people) of the total U.S. population in 2010 to 9.2 percent (40.6 million people) and 0.6 percent (2.6 million people) of the total U.S. population in 2050, respectively (Bureau of Census [BOC], 2008). They represent over forty-nine ethnic groups with more than one hundred languages and are socioeconomically and linguistically disadvantaged compared to non-Hispanic whites with 14 percent versus 8 percent poverty, 18 percent versus 11 percent uninsured, and 50 percent versus 2 percent Limited English Proficiency (LEP) rates nationally (Barnes and Bennett, 2002; Grieco, 2001; Islam et al., 2010). AA&NHOPIs experience multiple health disparities, including higher prevalence rates of tuberculosis, hepatitis B, and stomach and liver cancer than other racial/ethnic groups and are unable to access care due, in part, to a lack of adequate funding for health centers in their area, including resources for staffing in-house bilingual providers (Asian Liver Center, 2009; Centers for Disease Control, 2004; DHHS, 2009; Miller et al., 1996; Pamuk et al., 1998).

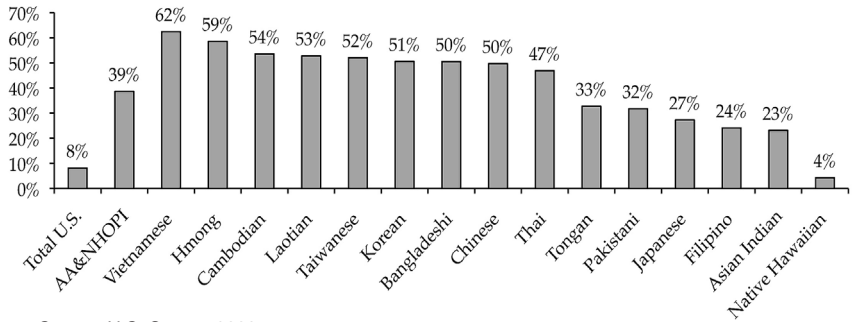
CHCs provide high-quality, cost-effective, and culturally appropriate primary and preventive health care to an increasing number of underserved patients, including more than six hundred fifty thousand AA&NHOPIs, regardless of insurance status or ability to pay (DHHS, 2009). However, the CHC system has also excluded many AA&NHOPIs because of its current Index of Medical

Underservice for determining MUAs (Weir et al., 2009). Increasing the range of comprehensive services and number of existing health centers is required to provide culturally appropriate health care to the growing AA&NHOPI population (BOC, 2008).

The current DHHS MUA methodology does not account for the unique health and social factors that affect AA&NHOPI and other ethnic and indigenous populations. LEP is a fundamental measure that should be included in the final updated methodology to identify MUAs. The number of LEP individuals in the United States is growing. For the purpose of this paper, LEP individuals are defined as those whose primary language is not English and are unable to speak, read, write, or understand English at a level that allows effective interaction with health care providers. More than fifty-five million people speak a language other than English at home (19.7% of the population and an increase of 8 million since 2000) (BOC, 2000a, 2008). More than twenty-five million (9% of the population and an increase of 3 million from 2000) speak English less than "very well" and are considered LEP. Eighty-four percent of federally qualified health centers provide clinical services daily to LEP patients, 45 percent of CHCs see more than ten LEP patients a day, and 39 percent see from one to ten LEP patients a day (BOC, 2000c; NACHC, 2008; Weir, 2005). The national survey did not report results by center size, as smaller centers may lack language capacity. Patients best served in a language other than English at the Association of Asian Pacific Community Health Organizations' (AAPCHO's) twenty-one member CHCs, which serve primarily AA&NHOPIs, average 51.2 percent with a range of from 0.16 percent to as high as 99.8 percent. The AAPCHD average LEP rate is even higher at 68 percent when eight health centers in the state of Hawaii are excluded (DHHS, 2009). Thirty-five percent of AA&NHOPIs and more than 28 percent of Spanish speakers live in linguistically isolated households and some ethnic groups, such as the Vietnamese, have LEP rates as high as 62 percent (see Figure 1).

Numerous studies indicate that health disparities are often magnified for patients who are LEP (Fox and Stein, 1991; Ghandi et al., 2000; Jacobs et al., 2003; Pitkin and Baker, 2000). Non-English speaking patients are less likely to use primary and preventive care services and more likely to use emergency departments (Bernstein et al., 2002; Flores et al., 2003). They are less likely to be given follow-up appointments than English-speaking patients, use

Figure 1. Limited English Proficiency Rates Among AA&NHOPI Subgroups



Source: U.S. Census 2000.

fewer preventative services such as mammograms and cervical screening, and often are unaware of the need for these services. In addition, they are less likely to participate in health care programs in which they are eligible (Andrulis, Goodman, and Pryor, 2002). These barriers associated with patients who are LEP demonstrate the need for inclusion of the criteria of LEP in the Proposed Rule so that CHCs can better serve LEP AA&NHOPIs who are typically excluded due to outdated MUA designations. New recommendations are currently being considered, and the evidence presented in this brief supports inclusion of an LEP measure.

Methodology/Analysis

The purpose of this article is to demonstrate that the LEP indicator can feasibly be utilized in DHHS's proposed definition of MUA by providing evidence that (1) the data are scientifically reliable and (2) the data have proven useful in identifying areas with medically underserved AA&NHOPIs.

The NRM has been hesitant to include LEP data in the Proposed Rule due to purported methodological issues. However, LEP data recently became available through the U.S. Census American Community Survey (ACS) and is estimated using a five-year average from 2005 to 2009 providing the most detailed and scientifically reliable data since the 2000 Census. The ACS is updated with current estimates annually. The definition of LEP uses the U.S. Census categories of ability to speak, read, and write English less

than "very well." The data is available by census-tract geographic level through the five-year ACS data sets that will be updated annually starting from 2005 to 2009 (BOC, 2009a, 2009b, 2009c).

Our efforts to develop an index of MUAs for AA&NHOPIs using LEP data clearly demonstrate that LEP is a feasible indicator in representing underserved areas nationally and distinguishing AA&NHOPI priority need areas. The Bureau of Primary Health Care (BPHC) uses a MUA index to determine federally qualified health centers' budgetary allocations. BPHC's MUA index utilizes poverty, population age sixty-five years and over, infant mortality, and primary care physician to 1,000 population ratio in its formula (DHHS, 1995). In contrast, the AAPCHO alternative methodology to identify medically underserved AA&NHOPI counties (MUACs) includes a standardized, weighted index, which is based on the BPHC's index and utilizes U.S. Census and BPHC data sets. AAPCHO's MUAC index uses AA&NHOPI poverty, primary care physician to 1,000 population ratio, AA&NHOPI population, and AA&NHOPI LEP. The most significant difference between the two indexes is that BPHC MUA applies to the general population and does not include LEP. (Please see Table 1 for a comparison of the indexes.)

Table 1: Comparison of Association of Asian Pacific Community Health Organizations (AAPCHO) Medically Underserved Asian American & Native Hawaiian and Other Pacific Islander (AA&NHOPI) County (MUAC) and Bureau of Primary Health Care (BPHC) Medically Underserved Area (MUA) Indices

Measure	AAPCHO MUAC	BPHC MUA
Population	Rate for *AA&NHOPIs*	Rate for *all populations age sixty-five years and older*
Poverty	Rate for *AA&NHOPIs*	Rate for *all populations*
Physician Supply	Primary care physician full-time equivalents (FTE) per 1,000 population ratio	Primary care physician full-time equivalents (FTE) per 1,000 population ratio
Additional Measure	*Limited English proficiency*	*Infant mortality*

Original Source: Weir, Rosy Chang, Tseng, Winston, Yen, Irene H., and Jeffrey Caballero. 2009. "Primary Health-Care Delivery Gaps Among Medically Underserved Asian American and Pacific Islander Populations." *Public Health Reports* 124(6): 831-40.

Table 2. AAPCHO MUACs with AA&NHOPI populations >10,000 that were excluded from the Bureau of Primary Health Care's Medically Underserved Area County-Level[a]

County	AA&NHOPI[b] N (%)	Limited English Proficiency[b] N (%)	Below poverty level[b] N (%)	Physician FTE/1,000 population[b] ratio (proportion)	AAPCHO MUAC score
Philadelphia, PA	68,383 (5)	31,002 (50)	18,738 (30)	0.07 (1:14,329)	28.4
Suffolk, MA	48,728 (7)	24,030 (52)	13,874 (30)	1.10 (1:910)	31
Merced, CA	14,717 (7)	6,477 (48)	5,604 (38)	0.38 (1:2,655)	32.1
Fresno, CA	65,362 (8)	28,637 (48)	24,626 (39)	0.48 (1:2,068)	32.5
San Francisco, CA[c]	243,409 (31)	120,459 (52)	26,429 (11)	0.06 (1:16,595)	33.1
Kings, NY[c]	187,283 (8)	105,215 (60)	48,464 (26)	0.19 (1:5,189)	33.7
Baltimore, MD	10,207 (2)	3,541 (36)	2,865 (30)	0.18 (1:5,495)	36.3
Ramsey, MN	45,159 (9)	20,628 (53)	11,994 (27)	0.88 (1:1,135)	36.7
San Joaquin, CA	66,238 (12)	27,772 (45)	18,530 (28)	0.47 (1:2,122)	38.7
Yolo, CA	17,121 (10)	4,385 (28)	6,130 (41)	0.50 (1:2,015)	39.8
Oklahoma, OK	19,085 (3)	8,527 (49)	3,665 (20) 0.11	(1:8,986)	40.5
Orleans, LA	11,081 (2)	4,637 (47)	3,051 (30)	1.22 (1:820)	40.8
Alameda, CA[c]	304,360 (21)	111,945 (40)	33,487 (11)	0.05 (1:19,775)	41.3

Stanislaus, CA	20,377 (5)	7,613 (40)	5,108 (25)	0.43 (1:2,326)	41.9
New York, NY[c]	145,607 (10)	67,988 (49)	32,742 (24)	0.21 (1:4,696)	42.1
Providence, RI	18,442 (3)	7,665 (44)	4,498 (26)	0.80 (1:1,247)	43.1
Ingham, MI	10,416 (4)	3,949 (41)	2,578 (28)	1.47 (1:681)	43.4
Sacramento, CA	142,163 (12)	54,739 (42)	28,878 (21)	0.57 (1:1,764)	44.8
Queens, NY[c]	392,831 (18)	183,346 (50)	62,460 (16)	0.26 (1:3,788)	44.9
Dane, WI	14,868 (4)	5,201 (39)	3,577 (26)	0.80 (1:1,249)	45.3

Notes: MUAC = medically underserved AA&NHOPI county, FTE = full time equivalent

AAPCHO MUAC index score calculated using measures of AA&NHOPI population, AA&NHOPI limited English proficiency (LEP), AA&NHOPI poverty, and primary care physician full-time equivalents (FTE) per 1,000 population ratio. BPHC MUA index score was calculated using general population measures of poverty, population aged 65 and older, infant mortality rate and primary care physician full-time equivalents (FTE) per 1,000 population ratio. Differences between the indices' are italicized. Please see Weir, Tseng, and Yen (2009) for further description of the indices and their rationale for selection.

[a]Data are from the Census Bureau 2000 (US) and the Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions (US). Summary File 3 for the poverty and LEP data, U.S. Census 2000 Summary File 1 for the population data, and the Bureau of Primary Health Care (BPHC) 2004 dataset for the primary care physician FTE per 1,000 population ratio data.

[b]We calculated the AAPCHO MUAC index score using AA&NHOPI population, AA&NHOPI LEP population, AA&NHOPI poverty, and primary care physician FTE per 1,000 population ratio.

[c]Counties representing the top five MUACs with the greatest AA&NHOPI population

Original Source: Weir, Rosy Chang, Tseng, Winston, Yen, Irene H., and Jeffrey Caballero. 2009. "Primary Health-Care Delivery Gaps Among Medically Underserved Asian American and Pacific Islander Populations." *Public Health Reports* 124(6): 831-40.

AAPCHO's MUAC analysis identified the top counties with both the lowest AAPCHO MUAC scores and the largest AA&NHOPI populations, together indicating areas in which health services need expansion in order to more adequately serve AA&NHOPIs. We also compared the AAPCHO MUAC index with the National Association of Community Health Centers' (NACHC) existing national MUA data and identified a number of "unserved counties" (those with more than 35.3% of residents living below 200% of federal poverty level and lacking a CHC) (Weir et al., 2009).

Findings

When we compared the AAPCHO MUAC index with other national MUA indexes at the county-level, we found that 138 (51.9%) of the 266 AAPCHO MUACs were not designated as federal MUA counties. Of these unidentified 138 AAPCHO MUACs in the federal MUA index, twenty counties (14.8.%) had an AA&NHOPI population of ten thousand or more, and twenty-nine counties (21.0%) had an AA&NHOPI population of five thousand or more. The AA&NHOPI poverty and LEP rates for these counties on average were 28.5% and 44.6%, respectively (see Table 2). We also compared the unidentified 138 AAPCHO MUACs in the federal MUA index with the NACHC's designations of "unserved counties" and found that only 23 percent, or 32 of the 138 AAPCHO MUACs, overlapped. Overall, these findings illustrate the value of using the LEP indicator to identify and compare national MUAs in addition to how the LEP indicator may be feasibly used in the Proposed Rule.

Recommendations

This article has demonstrated that: (1) LEP patients who encounter barriers to accessing health services are significant and increasing in number due to rapidly growing diverse ethnic populations, and that being LEP is a major barrier to health and health care delivery; (2) LEP data are scientifically reliable given its five-year pooled data set measurement and are readily available from the ACS; and (3) LEP data can be feasibly used in national indexes and can distinguish gaps in services for underserved populations, as evidenced in AAPCHO's aforementioned study. Based on these findings, we recommend that DHHS's Proposed Rule use LEP as an indicator.

Identifying more appropriate index indicators for DHHS's Proposed Rule is more critical than ever, given the impending threat to health care reform and associated funding cuts that limit CHCs in their ability to serve existing patients and growing medically underserved AA&NHOPI populations nationally. The diversity of languages, relative population size, and other socioeconomic characteristics of AA&NHOPIs and other communities of color may lead many to understate the importance of LEP for inclusion in the Proposed Rule. However, without consideration of LEP, the Proposed Rule would neglect the unique health and social factors that affect medically underserved AA&NHOPI and other populations served by CHCs. As the number of underserved citizens continues to rise, the CHC program is more vital than ever to this country's safety net. By including LEP in the new MUA index, we would be one step closer to assuring that underserved AA&NHOPI and other growing ethnic populations, such as Latinos, with sizable LEP populations could access health care services. Overall, we need to support adequate and sustainable CHC funding in order to improve health care access for AA&NHOPIs and others who are uninsured or publicly insured, low income, and otherwise medically vulnerable, and thus reduce health disparities for all.

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Notes

1. The term *Asian American and Native Hawaiian and Other Pacific Islander* is used in this article in order to adhere to the Office of Management and Budget standards for the classification of federal data on race and ethnicity.

References

Andrulis, Dennis P., Goodman, Nanette, and Carol Pryor. 2002. "What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency." Pp. 1-14. Boston: The Access Project (Center for Community Health Research and Action,

Heller School of Social Policy and Management, Brandeis University. http://www.accessproject.org/downloads/c_LEPreportENG.pdf.

Asian Liver Center at Stanford University School of Medicine. 2009. "FAQ about Hepatitis B." http://liver.stanford.edu/Education/faq.html (accessed June 21, 2009).

Barnes, Jessica S., and Claudette E. Bennett. 2002. *The Asian Population: 2000. Census 2000 Brief.* U.S. Bureau of the Census. http://www.census.gov/prod/2002pubs/c2kbr01-16.pdf (accessed April 15, 2011).

Bernstein, Judith, et al. 2002. "Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up." *Journal of Immigrant and Minority Health* 4(4): 171–6.

Centers for Disease Control and Prevention. 2004. "Fact Sheet: Racial/Ethnic Health Disparities." http://www.cdc.gov/media/pressrel/fs040402.htm (accessed April 15, 2011).

Flores, Glenn, Laws, M. B., Sandra J. Mayo et al. 2003. "Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters." *Pediatrics* 111(1): 6–14.

Fox, Sarah A., and Judith A. Stein. 1991. "The Effect of Physician-Patient Communication on Mammography Utilization by Different Ethnic Groups." *Medical Care* 29(11): 1065–82.

Ghandi, T. K., Burstin, H. R., E. F. Cook et al. 2000. "Drug Complications in Outpatients." *Journal of General Internal Medicine* 15: 149–54.

Grieco, Elizabeth M. 2001. *The Native Hawaiian and Other Pacific Islander Population: 2000. Census 2000 Brief.* U.S. Bureau of the Census. http://www.census.gov/prod/2001pubs/c2kbr01-14.pdf (accessed April 15, 2011).

Islam, N. S., Khan, Suhaila, Kwon, Simona, Jang, Deeana, Ro, M., and Chau Trinh-Shevrin. 2010. "Methodological Issues in the Collection, Analysis, and Reporting of Granular Data in Asian American Populations: Historical Challenges and Potential Solutions." *Journal of Health Care for the Poor and Underserved* 21(4): 1354–81.

Jacobs, E. A., et al. 2003. "Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature." *The California Endowment*. http://www.hablamosjuntos.org/pdf_files/Cal.Endow.Bibliography.pdf (accessed March 29, 2011).

Miller, B. A., Kolonel, L. N., Bernstein, Leslie, Young, J. L. G., Swanson, M. D., W. West et al., eds. 1996. "Racial/Ethnic Patterns of Cancer in the United States, 1988–1992." Bethesda: National Institutes of Health, National Cancer Institute. Publication No. 96-4104.

National Association of Community Health Centers. 2008. "Serving Patients with Limited English Proficiency: Results of a Community Health Center Survey." http://www.nachc.com/client/documents/LEP_report.pdf (accessed April 2, 2011).

Office of Management and Budget. 1997. *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, Federal Register*

Notice. Washington, DC: The White House. http://www.whitehouse.gov/omb/fedreg_1997standards#main-content (accessed July 8, 2011).

Pamuk, E., Makuc, D., Heck, K., Reuben, C., and K. Lochner. 1998. "Health, United States, 1998, with Socioeconomic Status and Health Chartbook." National Center for Health Statistics. http://www.cdc.gov/nchs/data/hus/hus98.pdf (accessed April 30, 2005).

Papa Ola Lokahi. 2007. "Threads in the Human Tapestry. The Disaggregation of the API Identifier and the Importance of Having the NHOPI (Native Hawaiian and Other Pacific Islander) Category in Data Collection, Analysis, and Reporting." http://www.papaolalokahi.org/coconut/news/pdf/Disaggregation_API_AAPI.pdf (accessed July 5, 2011).

Pitkin, Kathryn Derose, and David W. Baker. 2000. "Limited English Proficiency and Latinos' Use of Physician Services." *Medical Care Research and Review* 57(1): 76–91.

U.S. Bureau of the Census. 2009a. *ACS Design and Methodology Report: Data Collection and Capture for Housing Units.* Washington, DC: U.S. Government Printing Office. http://www.census.gov/acs/www/Downloads/survey_methodology/acs_design_methodology_ch07.pdf (accessed April 2, 2011).

—. 2009b. *ACS Design and Methodology Report: Frame Development.* Washington, DC: U.S. Government Printing Office. http://www.census.gov/acs/www/Downloads/survey_methodology/acs_design_methodology_ch03.pdf (accessed April 2, 2011).

—. 2009c. *ACS Design and Methodology Report: Sample Design and Selection.* Washington, D.C.: U.S. Government Printing Office. http://www.census.gov/acs/www/Downloads/survey_methodology/Chapter_4_RevisedDec2010.pdf (accessed April 2, 2011).

—. 2008. *U.S. Population Projections: 2008 National Population Projections.* http://www.census.gov/population/www/projections/2008projections.html (accessed April 15, 2011).

—. 2000a. *DP-2. Profile of Selected Social Characteristics: 2000.* http://factfinder.census.gov (accessed March 26, 2011).

—. 2000b. *Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin: 1999 to 2100.* http://www.census.gov/population/projections/nation/detail/d2041_50.pdf (accessed April 15, 2011).

—. 2000c. *QT-P17 Ability to Speak English: 2000*. http://factfinder.census.gov (accessed March 26, 2011).

U.S. Department of Health and Human Services. 2009. Health Resources and Services Administration. *Uniform Data System (UDS) 2009*. Rockville, MD: Bureau of Primary Health Care.

—. 1995. *Guidelines for MUA and MUP Designation*. http://bhpr.hrsa.gov/shortage/muaguide.htm (accessed March 14, 2007).

Weir, Rosy Chang. 2005. *AAPI Limited English Proficiency (LEP).* Association of Asian Pacific Community Health Organizations. http://www.

aapcho.org/altruesite/files/aapcho/Publications_FactSheets/AAPI LEP Fact Sheet. final.pdf (accessed April 15, 2011).

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