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Authors

Song, Nina Huynh

Sim, Shao-Chee

Borja, Gemma

et al.

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Resource Paper

Exploring Different Methods to Obtain Patient Experience Feedback in a Community Health Center for Quality Improvement and Quality Assurance Purposes

Nina Huynh Song, Shao-Chee Sim,
Gemma Borja, and Perry Pong

Abstract

This paper will provide the policy context for the important role of capturing patient experience at federally qualified health centers (FQHCs), especially with the implementation of the patient-centered medical home model. We discuss various quantitative and qualitative methods that were utilized to capture patient experience at the Charles B. Wang Community Health Center in New York City. Specifically, we describe our experience in adapting, pilot testing, and refining the Consumer Assessment of Healthcare Providers and Systems survey to address the unique cultural and linguistic needs of our health center's patient population. We also explore the benefits and limitations of these methods, and discuss factors that FQHCs should consider when capturing patient feedback.

Introduction

Various health care models to improve quality of services and increase patient-centeredness, such as patient-centered medical homes (PCMH), have been implemented across the United States as a means to increase patient satisfaction, decrease costs, and improve health outcomes. As part of this health care landscape shift toward patient-centeredness, capturing patient satisfaction and

obtaining feedback from patients about their experiences has become increasingly important.

Federally Qualified Health Centers

As recipients of federal funds, federally qualified health centers (FQHCs) are required by the Health Resources and Services Administration (HRSA) to have in place an ongoing quality improvement/quality assessment (QI/QA) program. The QI/QA program focuses on clinical services and management, in addition to assessing the quality and appropriateness of services that are provided at the health center. The board of directors of an FQHC is encouraged to assess patient experience data as part of their oversight of their health center's operations (HRSA, 2014).

Patient-Centered Medical Home

The National Committee for Quality Assurance (NCQA) is a leader in improving the quality of health care in the United States. For FQHCs, obtaining NCQA recognition as a PCMH has many benefits for the health center, as well as for the patients. Health centers that are recognized as a PCMH may be rewarded with additional per member, per month (PMPM) payments, generating more revenue.¹ Patients who utilize PCMHs for their health care services can rest assured that they are receiving high-quality, comprehensive, patient-centered care that meet or exceed national standards.

The Charles B. Wang Community Health Center

The Charles B. Wang Community Health Center (CBWCHC) located in New York City is a FQHC that is recognized as a level-three PCMH. In 2013, more than forty-seven thousand patients were served by CBWCHC. Approximately forty-five thousand are Asian American and more than forty-two thousand are best served in a language other than English. The majority of patients at CBWCHC are under the federal poverty level (CBWCHC, 2014).

As a recipient of Section 330 funds, CBWCHC administers patient satisfaction surveys biannually as an integral part of the practice. In addition to meeting HRSA requirements to gather feedback from patients, patient satisfaction surveys are also a part of maintaining NCQA PCMH recognition at CBWCHC. Results from patient satisfaction surveys guide various QI/QA initiatives at CBWCHC to ensure that services provided are accessible to patients and that the quality of care is up to national standards. Survey re-

sults are shared with clinical chiefs in order to provide individual feedback to providers regarding their performance on an ongoing basis. Clinical chiefs use survey findings to inform providers to areas of improvement or notify them of areas that they excel at, which help determine individual provider bonuses at CBWCHC. Moreover, the board of CBWCHC requires timely information about services at the health center to assess patient satisfaction.

For several years, CBWCHC has utilized surveys to gather patient feedback. FQHCs are not required to use a specific tool to obtain feedback from patients, although HRSA does provide suggestions for surveys. CBWCHC, which serves primarily Chinese-speaking patients, developed a two-page survey (one page, double-sided) with thirty-one items in English and Chinese using HRSA's survey suggestions (HRSA, n.d.) Each item in the survey is measured using a five-point scale; ranging from "poor" (1) to "great" (5).² A sample of CBWCHC's survey can be found in Appendix A.

As part of a push to standardize how FQHCs capture patient experience, NCQA began to encourage FQHCs to utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey with PCMH items to capture patients' experiences in January 2012. FQHCs that utilize the CAHPS survey are able to score more points on their PCMH application, which may impact the health center's level of recognition by NCQA. Although reimbursement rates to FQHCs are not currently determined by CAHPS survey scores, this may be the case in the future, as other health care organizations such as hospitals and health care plans are incorporating CAHPS survey scores into their reimbursement models.

CAHPS Survey

The CAHPS survey is developed by the Agency for Healthcare Research and Quality (AHRQ) and consists of several types of surveys. These include health plan; clinician and group; surgical care; American Indian; dental plan; experience of care and health outcomes; home health care; hospital; in-center hemodialysis; nursing home; and multiple supplemental item sets (AHRQ, 2012).

Many health care organizations utilize the CAHPS survey as a way to capture patient experience; however, it is not always feasible to do so due to the length of the survey and the availability of appropriate languages. The AHRQ currently has developed the

CAHPS surveys in English and Spanish. Other organizations, such as the Rand Corporation with funding support from the California HealthCare Foundation, have translated the Health Plan 2.0 CAHPS surveys (2001) into several other languages which include Chinese, Khmer, Korean, and Vietnamese (Rand Corp., 2002). Because the CAHPS Health Plan survey would not be applicable to FQHCs, health centers that serve populations other than English or Spanish speakers may have difficulty in finding language-appropriate CAHPS surveys.

FQHCs may use the CAHPS Clinician and Group (CG-CAHPS) survey with PCMH items for their patients. The CG-CAHPS survey is a seven-page survey and includes fifty-two items (AHRQ, 2013). Survey items are measured using a four-point scale which ranges from “never” (1) to “always” (4).³

Although it is possible to adapt the translated materials from the CAHPS Health Plan survey into one that aligns closely to the CG-CAHPS surveys with PCMH items, the translated materials are somewhat dated. The Rand Corporation translated the Health Plan CAHPS 2.0 survey into various Asian languages in 2002. The current version of the Health Plan CAHPS survey is 5.0.

Adaptation of CAHPS Survey at CBWCHC

Due to a possible policy shift toward the standardization of utilization of the CAHPS survey in various health care organizations and the language limitation of the existing CG-CAHPS survey, CBWCHC decided to adapt certain items from the CG-CAHPS with PCMH items survey into CBWCHC’s existing patient experience survey in April 2012.

Identifying CAHPS Survey Items

A thorough review of the CG-CAHPS survey was conducted by the research and evaluation department at CBWCHC. Each CG-CAHPS survey item was compared with CBWCHC’s survey item and matched according to what the item is measuring. Based on existing survey measures, CG-CAHPS survey items that captured similar domains were incorporated into CBWCHC’s existing survey. CBWCHC also replaced its existing five-point scale with the CAHPS four-point scale. Samples of CBWCHC’s previous patient survey and current CAHPS adapted survey are available in the appendices.

Ad Hoc Survey Adaptation Committee

After incorporating CG-CAHPS survey items into CBW-CHC's existing survey, a survey adaptation committee collected feedback from health center providers and staff under the leadership of the Chief Medical Officer and Chief Strategy Officer. The committee consisted of representatives from different departments including internal medicine, women's health, dental, pediatrics, health education, social work, and research and evaluation.

An English draft of the CG-CAHPS adapted survey was presented to the survey committee for review and changes were made based on staff feedback. A final version was developed and translated into Chinese by bilingual and bicultural health educators at CBWCHC. Although back-translation was not performed, the translation process was an iterative process that included various levels of review. First, the health education department conducted the first translation, which was then sent to bilingual staff in different clinical departments at different sites for review. Translated surveys were then pilot tested with patients from various departments. Revisions were made to reflect comments and feedback from staff and patients.

Due to the length of the entire CG-CAHPS survey, committee members decided to focus on adapting ten to fourteen survey items to increase the response rate and ensure survey completion. The survey committee also realized that some survey items needed to be tailored specifically for each clinical department. For instance, some survey items for pediatric patients are different for those targeting women's health patients.

Pilot Testing of Surveys

Over a period of three days, the newly adapted surveys were pilot tested with five to ten patients across various clinical departments at the health center. After patients completed the survey, staff interviewed the survey respondent to obtain their feedback regarding the new survey. Some questions that were asked included whether the survey was easy to understand, if questions made sense, and if the font size was large enough to read. Research staff reviewed feedback and adjusted the survey accordingly. If patients had any comments about the translation, this feedback was provided to the health education department to make adjustments to the survey.

CG-CAHPS Adapted Survey

In July 2012, CBWCHC began administering the CG-CAHPS adapted survey to patients after pilot testing the survey in Chinese and English to patients at CBWCHC. This survey continues to be utilized to obtain patient experience feedback biannually at the health center. A sample of the CAHPS adapted survey is in Appendix B (English version) and Appendix C (Chinese version).

CBWCHC In-Clinic Survey Administration

In-clinic survey administration at CBWCHC is a coordinated effort that includes managers and receptionists in each department working with clinical administration staff.

Surveys are administered biannually at CBWCHC, in January and August of each year. Quota sampling is used to ensure that each department and provider obtains the necessary number of survey responses from patients. The minimum number of surveys required for each department is based on the total number of patients in each department. A sample size calculator from HRSA's website is used to determine the minimum number of surveys required for each department for a precision level of ± 10 percent, at a 95 percent confidence interval (HRSA, n.d.). Each department is given one month to collect the surveys and to enter the data into a database for analysis by clinical administration staff. Data entry instructions are provided to each department to ensure consistency across departments and to help minimize errors. Surveys are randomly selected and are reviewed by a survey coordinator who is responsible for performing data analyses. If discrepancies are found between the actual survey and the entered data, the survey coordinator will correct the errors. Upon completion of data analyses, findings from the surveys are compared to prior years. If results vary greatly, the survey coordinator will double-check all surveys and correctly enter in the data if issues are present.

During the survey period, receptionists provide patients with the survey upon check-in and patients are instructed to complete the survey after their visit with their provider. After completion, patients drop the survey off in a collection box. Administering the survey to patients during the check-in process minimizes the impact that survey administration has on the clinical flow at the health center.

Although in-clinic survey administration minimally impacts the clinical flow at the health center, the results of the surveys may be biased because of perceived response bias (or “socially desirability bias”) from our patients because the surveys are given out by our health center staff. For instance, patients may feel pressured to provide very positive feedback on the survey. After administering the in-clinic surveys for a number of years, CBWCHC decided to pilot mailed surveys to patients at the health center in 2012 and early 2013 to explore other ways to capture patient experience data and to assess the reliability of in-clinic survey findings.

Mailed Surveys

For the mailed surveys, one health center staff coordinated the logistics of mailing out the surveys to patients and worked with departmental managers to obtain a list of five hundred patients in each department who had visited CBWCHC in the past three months. Each list was then randomized and the first two hundred patients on the list were mailed surveys in English and Chinese with a stamped return envelope, and a cover letter explaining the purpose of the survey with instructions to return the survey within two weeks. All materials were in English and Chinese. The information technology department at CBWCHC was able to personalize each cover letter with the patient’s information, such as their name, date of visit, and the name of their provider, automatically. In the summer of 2012, CBWCHC mailed out the first round of surveys to patients at the Flushing site in the internal medicine, women’s health, and pediatrics departments. After two weeks, a total of thirty-one (15.5 percent) completed surveys were returned to CBWCHC.

The second round of mailed surveys was also administered for the Flushing site for the same departments in January 2013. The same processes were used in the second round as the first round, but in addition a reminder letter and survey were sent to patients approximately two weeks after the initial survey was sent. The total time period that patients had to return surveys was approximately one month. The total response rate for round two was 31.5 percent ($n = 63$).

The third round of mailed surveys was administered to patients in the pediatrics department at the Chinatown site in July 2013. Similarly to round two, reminder letters and surveys were

also sent approximately two weeks after the initial survey was sent out. Coincidentally, the total number of complete surveys returned about one month was also sixty-three (31.5 percent).

Comparison of Survey Findings

Although we expected mailed survey results to score lower than the in-clinic administered surveys, the differences in findings were not statistically significant.⁴ However, the written comments and suggestions section of the mailed surveys tended to include more information than those that were administered in-clinic. For example, the majority of in-clinic surveys, comments that were provided were very brief, such as “improve wait time” or “all good.” Comments provided in the mailed surveys were longer and provided specific information about their opinions. An example of a comment from the mailed survey includes, “I hope that the appointment wait time can be improved a bit. Don’t want to wait too long.” This seems to suggest that patients would have more time to reflect on receiving care at our health center and also could provide more detailed information about their experiences when they were asked to complete the survey at home.

Patient Focus Groups at CBWCHC

As part of CBWCHC’s quality improvement efforts and as a way to bolster CBWCHC’s NCQA PCMH reapplication, three patient focus groups were conducted in the first half of 2013.⁵ Patients were recruited from various departments at CBWCHC.

Focus group participants were identified by department managers. Each manager identified a list of approximately fifteen individuals who have had at least one visit to the health center in the past twelve months who might share their opinions and experiences at the health center. Bilingual health education staff contacted patients to invite them to take part in the focus group discussion and made reminder phone calls one day prior.

A focus group discussion guide was developed by research staff to explore similar domains as the surveys. This included accessibility to care, wait time, facilities, and their satisfaction with front desk staff and providers. Each focus group was comprised of eight to twelve participants from all departments of the health center. Focus group sessions lasted approximately an hour and a half, and lunch was provided for participants. Each focus group

was moderated by one bilingual research staff and audio recorded. Focus groups were conducted in either Cantonese or Mandarin. Summaries of focus group discussions were developed and shared with CBWCHC's clinical leadership team.

Focus group discussions allowed participants to talk in depth about their experiences at the health center and to share their thoughts on how the health center could better meet their needs. For example, parents who participated in the pediatrics department focus group all mentioned that they would be interested in attending a support group for parents of children with special needs. As a result, CBWCHC pediatrics department has initiated the development of this support group.

Other Methods to Assess Patient Experiences

Although surveys are usually the most commonly used method to capture patient experience, there are several other methods that can be used by FQHCs to assess the patient experience. In the California HealthCare Foundation's 2011 report, *Feedback Loop: Testing a Patient Experience Survey in the Safety Net*, different qualitative methods were outlined, including focus groups, walk-throughs, shadowing, complaint/compliment letters, and comment cards.

Discussion

Summary of Findings

Administering surveys in-clinic biannually has become routine at CBWCHC. All providers and staff members are aware and familiar with the processes that are required to complete the administration, data entry, and analyses. Although it minimally impacts the workflow of staff, it requires coordination and multiple staff members' time for administration, data entry, and analyses. Because each departmental manager assigns an individual to enter the data, there may be errors, despite having data entry instructions available. A survey coordinator is responsible for collecting and spot-checking all surveys. If findings vary drastically from previous years, the coordinator will double-check all survey data.

Mailed surveys differ from in-clinic survey administration because all surveys are sent, received, and recorded by one coordinator. The coordinator is also responsible for conducting the analyses. Because there are fewer people involved with the survey

administration and analyses, we presume that errors are minimal. Based on our prior experience with survey administration, the more people that are involved with survey administration, data entry, and analyses, the more errors were found.

Due to the fact that mailed surveys were completed at the patients' homes, we anticipated lower satisfaction results than the in-clinic administered surveys. However, analysis has revealed that there are not significant differences between the results of the in-clinic administered surveys and the mailed surveys. Mailed surveys did, however, contain more written and in-depth comments than the in-clinic surveys.

Although focus groups provide rich information about patients' experiences and satisfaction at CBWCHC, it is not feasible to regularly conduct focus groups due to time and resource constraints. Focus group findings were very helpful to provide specific details about the patients' experiences at the health center and allowed patients to make various comments and suggestions. Many comments in the surveys were related to wait time, whereas the focus group comments consisted of other topics, such as facilities and new services that patients would be interested in at the health center. CBWCHC realizes the importance of obtaining qualitative feedback from patients and collects patient comments regularly using patient suggestion and comment boxes located throughout the health center, and through CBWCHC's Patient Relations Committee, which allows staff to collect information about services and patient care experience every three months at the Flushing and Chinatown site. Patient feedback and comments are regularly shared with the clinical team.

Adapting CG-CAHPS survey items into the existing survey and scale at CBWCHC has been beneficial to the health center in several ways. The CAHPS program has developed a database that contains data from organizations that utilize the CAHPS survey. By adapting some of the CAHPS items into the existing survey, CBWCHC will be able to compare results to a national benchmark and to other organizations that utilize similar measures. Comparing results with other health centers and to a national benchmark will help to inform CBWCHC's continuous quality improvement projects as well as help to prepare for operational site visits of FQHCs that are conducted by HRSA every five years. Surveys are also used to measure provider performance, which determines

provider bonuses at CBWCHC, and results are regularly reported to the board of directors.

Factors for FQHCs to Consider

Capturing patient experience is important for FQHCs and patient feedback is required to meet HRSA's and NCQA's PCMH requirements. Currently, there are no specific methods that are required by either organization, although NCQA encourages the utilization of the CG-CAHPS survey for FQHCs.

Costs, type of data needed, and time are all important factors for FQHCs to consider when determining the type of method to utilize to obtain patient feedback. As with any organization, resources are often limited. Table 1 highlights some additional factors that FQHCs should consider when determining the best method to capture patient experience at their health center.

Table 1: Factors to Consider When Determining Which Data Collection Method to Utilize in Your FQHC

	In-Clinic Survey Administration	Mailed Surveys	Focus Groups
Comparative costs	High	Low	Low
Coordination between departments and staff	High	Low	Low
Impact on clinical flow	Low	Low	Low
Data collection time	May vary	May vary	Short
Sample size	Large	Large	Small
Additional facilities needed ¹	No	No	Yes

¹ Additional facilities include meeting rooms or space that would be required to carry out the proposed data collection methods.

Costs are often the most important factor to consider in any FQHC. Costs are high for in-clinic survey administrations because various staff are involved with the coordination between departments and the survey administration. Mailed surveys and focus groups are relatively low in cost because they can be carried out in their entirety with one or two people.

Depending on the type of data that is needed and the topics, FQHCs will need to determine whether surveys or other qualitative methods, such as focus groups, are most appropriate. Table 2 provides

an overview of the types of skills that are required for each type of data and when an organization may use one method over the other.

Table 2: Factors to Consider for Surveys and Focus Groups

	Surveys	Focus Groups
Administrator training required	No	Yes
Permit follow-up questions	No	Yes
Standardization of responses	Yes	No
Ability to compare results	Yes	Yes
Allows statistical analyses	Yes	No
Quantitative data analysis skills	Yes	No
Qualitative data analysis skills	No	Yes
Sensitive topics	Yes	No
In-depth responses	No	Yes
Can ensure confidentiality	Yes	No

Conclusion

Feedback on patients’ satisfaction and experiences with health care services as well as clinical outcomes is becoming increasingly important in the current health care environment. More organizations are requiring that community health centers and other health service providers obtain feedback from their patients. Although the CAHPS survey is currently not required through the NCQA PCMH application, and patient satisfaction scores are not tied to reimbursement, this may be the case in the future.⁶

Therefore, this paper outlines how one FQHC tested and implemented such a survey. We used the CAHPS survey, a validated, standardized survey. Using a validated, standardized survey would have been helpful but not feasible due to the limited availability of languages and the length of the survey, so adapting the CAHPS survey in its entirety or parts of the survey may be an attractive option because it will help FQHCs score more points on their PCMH application, which may impact the health center’s level of recognition by NCQA. Using a standardized survey also allows health centers to ask the same core questions that are used in other health care settings and makes it easier to compare findings.

For community health centers serving the Asian American and Pacific Islander population, linguistic and cultural factors need to be taken into account when developing various approaches to capture patient feedback. As discussed, CBWCHC spent time and resources in the adaptation and pilot testing of the CAHPS survey to ensure that the survey is practical for the organization and is linguistically and culturally appropriate for the patients who will be completing them.⁷ To ensure that the surveys are appropriate for the patients, bilingual and bicultural health education staff at CBWCHC translated surveys and solicited feedback from other bilingual and bicultural staff in various departments. Revisions were made and the survey was pilot tested with patients. Patient feedback and comments were incorporated as health education staff revised the surveys. Although the health center has finalized the survey, surveys are continuously modified as needed based on feedback from patients.

Various methods exist to collect patient experience data, with surveys being the most common. Although using an external, third-party vendor to administer and analyze the survey and results is ideal because it would minimize response bias from respondents, without funds it would not be feasible for many FQHCs to hire an external vendor such as those that are used by large hospital systems. FQHCs should continue to explore various methods to capture patient experience within their means, because capturing patient experience is becoming more imbedded in the health care landscape. More importantly, obtaining feedback from patients about their experience provides useful information to health center staff and leadership so that they can provide better quality care to serve their patients.

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Notes

1. In New York State, PMPM provides prospective, monthly payments to the health center based on the number of Medicaid patients that are enrolled at the health center. Rates vary in each state and with

the level of PCMH recognition. PMPM payments are in addition to revenue obtained for services provided.

2. HRSA five-point survey scale: 1 = poor; 2 = fair; 3 = okay; 4 = good; 5 = great.
3. CAHPS four-point survey scale: 1 = never; 2 = sometimes; 3 = usually; 4 = always.
4. A two samples t-test was conducted to assess the statistical significance for all survey items.
5. Health centers that obtain qualitative feedback from patients score higher points on their NCQA PCMH application.
6. Health plans and hospitals reimbursement rates are tied to their CAHPS scores.
7. Ad hoc committee met three times over a period of three months to translate, modify, and pilot the survey.

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NINA HUYNH SONG, MPH, CPH is a Research and Evaluation Associate at the Charles B. Wang Community Health Center in New York City. She performs research and evaluation activities for various programs and services at the health center. Prior to working at Charles B. Wang Community Health Center, Nina was an intern with B Free CEED at New York University's Center for the Study of Asian American Health. She was also a Research Assistant at the Mailman School of Public Health where her work focused on Chinese immigrant populations, schizophrenia, and stigma. She is a graduate of the University of Minnesota, Twin Cities and received her Masters in Public Health degree from the Mailman School of Public Health at Columbia University.

SHAO-CHEE SIM, PhD, MPA is the Chief Strategy Officer of the Charles B. Wang Community Health Center in New York City. In addition to assisting with grants management, patient experience survey, quality improvement and strategic planning efforts, he leads research and evaluation activities of Charles B. Wang Community Health Center's disease prevention, intervention and health service projects. He worked as Research and Evaluation Officer at the Wallace Foundation where he guided the foundation's research and evaluation strategies and projects. Prior to that, Dr. Sim was Director of Research at the Asian American Federation where he was the lead principal investigator for an economic impact assessment of September 11th on New York City's Chinatown and a mental health needs assessment of September 11th victim families of Asian descents. Dr. Sim holds a PhD in public policy from the Lyndon Baines Johnson School of Public Affairs at the University of Texas at Austin and a Master in Public Administration from the John F. Kennedy School of Government at Harvard University.

GEMMA BORJA, PT, MS, MBA is currently the Clinical Director at the Charles B. Wang Community Health Center where she oversees quality improvement activities at all clinical sites in collaboration with clinical chiefs and clinical leadership as well as lead the health center's transformation to meet National Committee for Quality Assurance Patient Centered Medical Home standards. Prior to working at Charles B. Wang Community Health Center, Gemma worked at Lutheran Medical Center, New York Presbyterian Hospital-Cornell and Weill Cornell Medical College in both clinical and administrative areas. Gemma received her BS in Health Science and MS in Physical Therapy from Boston University. She also received her MBA in Healthcare Administration from Baruch College – Zicklin School of Business.

PERRY PONG, MD is the Chief Medical Officer at the Charles B. Wang Community Health Center. Born in San Francisco, he early on saw the need for good medical care to the Asian community. His interests include the care of underserved and culturally diverse patients, medical education and quality improvement for patient safety. He is a graduate of Harvard University and the University of California, San Diego School of Medicine.