

PROCEEDINGS OF THE
HEALTH BRAIN TRUST
on Data & Research

**Improving the Health & Well-Being of
ASIAN AMERICANS
NATIVE HAWAIIANS
& PACIFIC ISLANDERS**

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HEALTH BRAIN TRUST ON DATA & RESEARCH
***Improving the Health & Well-Being of Asian Americans,
Native Hawaiians & Pacific Islanders***

A publication of the ***Asian & Pacific Islander American Health Forum***

APIAHF's mission is to enable Asian Americans and Pacific Islanders to attain the highest possible level of health and well being. The Health Forum does so by pursuing its five main policy goals to:

- *Increase access to healthcare*
- *Improve quality of healthcare through cultural and linguistic competence*
- *Ensure a diverse and culturally competent healthcare workforce*
- *Increase research and improve data collection*
- *Increase investment in community-based healthcare*

The Asian & Pacific Islander American Health Forum's policy team advances legislation, and state and federal government policies that benefit the health and well-being of Asian Americans, Native Hawaiians and Pacific Islanders. We do this through policy development, research, organizing and advocacy. We also provide technical assistance and help build the capacity of local Asian American, Native Hawaiian and Pacific Islander organizations to inform and engage in policy advocacy.

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EXECUTIVE SUMMARY

On April 30 – May 1, 2007, a diverse group of researchers, advocates, health professionals, public health officials, community members, and other leaders gathered in Washington, D.C., for the first *Health Brain Trust on Data & Research* (“Health Brain Trust”). The Asian and Pacific Islander American Health Forum (APIAHF) Health Brain Trust is an annual meeting of selected individuals, organized around a particular topic of interest to Asian American, Native Hawaiian and Pacific Islander (AA & NHOPI) stakeholders. The purpose of this meeting was to deepen the understanding of AA & NHOPI health data and research issues; develop new frames for AA & NHOPI health data and research and the concept of health disparity; explore different levers for change; and build recommendations around an agenda for change.

The four main areas of speaker presentations and discussion were:

- **Framing and overview of Asian American & Native Hawaiian and Other Pacific Islander (AA & NHOPI) health issues.**

Accurate, timely, disaggregated data on Asian Americans, Native Hawaiians, and Pacific Islanders (AA & NHOPI) are vital to developing and monitoring programs and policies aimed at improving health and well-being. Although there have been key policy changes since 1986 to improve data collection for AA & NHOPI, there is still a lack of data due to data not being available, data being collected, but not analyzed or data not reported due to the small sample size.

- **Models of national and state research.**

Some promising national and state models were developed that have resulted in successful collection, analysis and reporting of data for AA & NHOPI subgroups. While improvements can certainly be made with respect to these specific models, they illustrate the challenges and promise of focusing on subgroup populations for data collection and research.

- **Opportunities for AA & NHOPI data collection, analysis and reporting.**

AA & NHOPI data are usually not available for most national health surveys due to sample size. Oversampling may provide a solution, but the costs may be prohibitive. Other methods could be explored that are more cost-effective. Since sample size will always be an issue for national data sets, improving data collection and analysis of AA & NHOPI subgroups on a state level is an important strategy to pursue.

- **Collecting and reporting data from health systems.**

Health plans, hospitals and other providers can play a role in increasing our knowledge of AA & NHOPI health status including a better understanding of disparities and development of interventions to improve health care quality and health outcomes. However, there are some barriers that need to be addressed to encourage health systems to collect this data.

Summary of Recommendations

After each set of presentations, APIAHF led discussions in which participants shared their questions, observations and recommendations. The recommendations fall into several broad categories.

Given the lack of national data, two general approaches to increasing data are:

I. Conduct further analysis and dissemination of existing sources of data

APIAHF's analysis of the 22 leading health indicators in Healthy People 2010 shows that one-third (7 of 22) are denoted "DNA" meaning that data was collected but not analyzed for the Asian/Pacific Islander population in aggregate. There are many other datasets yet to be mined as listed in the text box "Existing data sets with AA & NHOPI populations" (Page 17). The reasons for this lack of analysis are many, including lack of funding and/or staff, confidentiality issues, and insufficient samples.

Given the amount of data, conducting new analyses will require planning, prioritization and collaboration among agencies, researchers and community members, along with sufficient resources.

II. Conduct more research—nationally and locally—and address sampling and design issues

This means improving ongoing surveys (i.e. National Health Interview Survey, California Health Interview Survey) and data collection systems (i.e. Medicare, hospitals, health plans, vital statistics, cancer registries), as well as initiating new research (i.e. for defined geographic areas or specific subpopulations).

In any case, in order to yield sample sizes large enough for meaningful analysis, the effort to collect more data must address persistent sampling and design issues. As demonstrated by the presentations regarding models of national and state research, it is possible to focus on specific populations, overcome methodological issues, and produce data that takes causal and contextual factors into account. It is also necessary to prioritize research questions with involvement and leadership from AA & NHOPI communities, and to allocate funding towards data collection of small populations.

To increase attention and resources dedicated to AA & NHOPI health, strong advocacy and communication are essential. In order to move forward on the above recommendations, it is necessary to gain political leverage. The Health Brain Trust participants recommend strategic advocacy and communications activities, and additional policy assessment and analysis in the following areas:

III. Strategic advocacy and communication activities

- Identify and nominate individuals to serve on federal advisory committees, peer review boards and other committees that influence data collection, survey (re)design and publication.
- Advocate for AA & NHOPi data needs in other (beyond health care) professional communities and associations.
- Advocate for increased funding for the CDC National Center for Health Statistics.
- Develop web-based communications and networking space for AA & NHOPi data stakeholders.

IV. Policy Assessment and Analysis

- Call for an HHS-funded report, to revisit sample sizes being collected by subgroup.
- Monitor quality of data reporting from federal agencies and other institutions.
- Assess the compliance/adoption of the 1997 OMB Guidance relative to the NHOPi category within HHS data sets.
- Disseminate studies on AA & NHOPi populations.
- Develop and disseminate guidance for translation and interpretation of surveys.

A detailed list of recommendations following the above outline is included in the full proceedings.

Conclusion

The collective experience and wisdom of the first APIAHF Health Brain Trust participants resulted in highly informative presentations, insightful discussions, and actionable recommendations, a few of which are already in motion. In spite of the setback brought on by the 1985 Report on Black and Minority Health, progress has been made in gathering the data needed to recognize and address AA & NHOPi health needs. But persistent issues of data content and survey design continue to leave AA & NHOPi populations out of official national and state reports on health. This is still not acceptable. Moreover, all of the communities that comprise AA & NHOPi are growing and diversifying. Therefore, we must continue to make progress.

APIAHF, in its role as a convener and a policy advocate, will work with volunteers from among the participants to prioritize the recommendations, develop short- and long-term action plans for selected recommendations, and identify partners to take the lead on other recommendations. Additionally, during the meeting, participants suggested subjects for further inquiry and analysis which may become the basis for the next Health Brain Trust on Research and Data (scheduled for Spring 2008). APIAHF is extremely thankful to the participants, presenters and sponsors for their insight, guidance and commitment.

HEALTH BRAIN TRUST ON DATA & RESEARCH

Improving the Health & Well-Being of Asian Americans, Native Hawaiians & Pacific Islanders

On April 30 – May 1, 2007, APIAHF convened a diverse group of researchers, advocates, health professionals, public health officials, community members, and other leaders gathered in Washington, D.C. for the first *Health Brain Trust on Data & Research*. The Asian and Pacific Islander American Health Forum (APIAHF) *Health Brain Trust* is a meeting of selected individuals, organized around a particular topic of interest to Asian American, Native Hawaiian and Pacific Islander (AA & NHOPI) stakeholders. The *purpose* of this meeting was to deepen our understanding of AA & NHOPI health data and research issues; explore different levers for change; and build recommendations for a policy agenda for increasing national and state health data on AA & NHOPI. [See Appendix A for the full agenda]

The Health Brain Trust consisted of 53 participants, from 9 states (California, Illinois, Maryland, Massachusetts, Michigan, New York, Pennsylvania, Texas, and Washington) and Washington D.C., and a myriad of academic institutions, federal agencies, think tanks, and community organizations. [See Appendix B for a complete list of participants]

The four main areas of speaker presentation and discussion were:

- Framing and overview of Asian American & Native Hawaiian and Other Pacific Islander (AA & NHOPI) health issues
- Models of national and state research
- Opportunities for AA & NHOPI data collection, analysis and reporting
- Collecting and reporting data from health systems

FRAMING AND OVERVIEW

Accurate, timely, and disaggregated data on Asian Americans, Native Hawaiians, and Pacific Islanders (AA & NHOPI) are vital to developing and monitoring programs and policies aimed at improving health and well-being.

Dr. Marguerite Ro, MPH, DrPH Deputy Director of APIAHF and Dr. Marjorie-Kagawa Singer, PhD, MA, MN, RN, Board Member of APIAHF, began the meeting with a background and overview of AA & NHOPI data and research issues.

Background

In 1985, the Report on Black and Minority Health was produced by the US Department of Health and Human Services (HHS). The findings from the report showed disparities

between Black and White communities, but not for AA & NHOPI communities.

The report was the catalyst for creating the HHS Office of Minority Health (OMH) to address these disparities. But it also closed the doors on AA & NHOPI issues by

claiming "...the Asian Pacific Islander minority in aggregate is healthier than all racial/ethnic groups in the US including whites." This statement perpetuated the model minority myth that Asian Americans are healthy, wealthy and wise. As a consequence, the federal government (and the newly created OMH) would not always recognize Asian Americans and Pacific Islanders as underserved minorities; AA & NHOPI needs would not be identified, much less addressed, and AA & NHOPI community-based organizations and researchers would not be eligible for grants.

Asian American health professionals and advocates responded to this report by organizing a national convening in 1986 with the help of the newly created OMH at which the Asian American Health Forum (now APIAHF) was created. Since 1986, the APIAHF has regularly sponsored national health conferences (1986, 1988, 1990, 1992, 1994, 1997, 2001, 2004, 2006), focusing on the health needs and disparities of the AA & NHOPI population. At the most recent APIAHF conference in 2006, over 400 community members came together to discuss AA & NHOPI health issues. One of the most prevalent topics was data and research.

Why data collection is important

Data collection (including subsequent analysis and dissemination) is an essential component in identifying, monitoring and eliminating health disparities for the growing and diverse AA & NHOPI communities. Data collection allows us to identify needs, develop effective programs, inform policy, and identify when discrimination is occurring in the health care system, and thus helps to ensure that discrimination does not continue. Thus we advocate for data collection not for its own sake, but to

achieve measurable improvements in health and healthcare.

Since 1986, there have been key policy changes to facilitate increased and improved data collection including the 1997 *Office of Management and Budget (OMB)* "Revisions to the standards for the classifications of federal data on race and ethnicity." This revision created a new racial category of Native Hawaiian and Other Pacific Islander, separate from Asian in federal data sets to be implemented by 2003. Executive Order 13125 (1999) "Improving the quality of life of Asian Americans and Pacific Islanders" included an assessment of AA & NHOPI data in federal data sets, and Executive Order 13166 (2000) "Improving access to services for persons with limited English proficiency" led to federal agency guidance that encourages collection of data on primary language. The AA & NHOPI community must continue to partner with other communities of color, and federal and state governments in order to develop policies conducive to AA & NHOPI data collection.

Data needs of Asian American, Native Hawaiian, and Other Pacific Islanders

The OMB policy changes mentioned above were made in 1997 and agencies were given until 2003 to change their data collection systems. Therefore, these changes are relatively recent, and coupled

'TIALOD'

"There Is a Lack of
DATA"

with the normal lag from collection to reporting, this means that data are still not available, most often for NHOPI populations separate from Asian. This is most evident in Healthy People 2010, which is a set of health objectives for the Nation to achieve over the first decade of the new century. Thus when framing the objectives for AA & NHOPI, many objectives were immeasurable because:

- “DNC”: data has not been collected at all
- “DNA”: data has been collected, but has not yet been analyzed
- “DSU”: data has been analyzed, but is not reported due to small sample size
- “- - -”: data not available

Results of individual research studies and state data also often lack NHOPI and Asian data. In a review of published literature in Medline from 1966-2000, Ghosh (2003) found only .01% of articles related to Asian American and Pacific Islander (AAPI). His review of government grants from 1986-2000 found only .2% for AAPI health

projects or research. (AJPH 2003:2093-2098).

These deficiencies result in limited capacity to characterize the health status of Asian Americans and NHOPIs. But as we endeavor to correct this, we must also improve our ability to characterize the health of specific ethnic groups (e.g. Hmong, Samoans, Pakistanis) by age, sex, immigration or native born status, date of entry into US, income, education, acculturation, geography, socioeconomic, cultural context, and language. We must look not just in terms of incidence and prevalence of disease, but also in terms of determinants of health such as immigration patterns and status, behavior patterns (e.g. nutrition, sex); healthcare access and utilization; and other socioeconomic indicators.

MODELS OF NATIONAL AND STATE RESEARCH

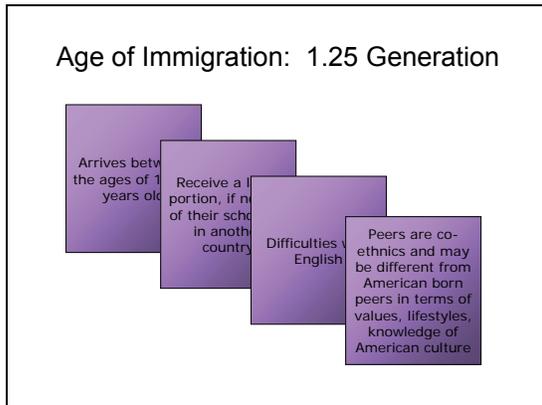
There have been several groundbreaking studies that successfully collected, analyzed and reported data for AA & NHOPI subgroups. Three were highlighted: the National Latino and Asian American Study (NLAAS), the California Health Interview Survey (CHIS), and the US Census efforts specific to NHOPI populations.

David Takeuchi, PhD, from The University of Washington, School of Social Work shared “One step back, two steps forward: Challenges and opportunities in doing a national study of Asian Americans.”

The National Latino and Asian American Study (NLAAS) study was an opportunity to explore heterogeneity among Asian Americans, compare prevalence of mental health disorders of Latino and Asian American ethnic groups and to compare results to other national studies. Dr. Takeuchi reviewed the “construct of

developmental context (4 categories)” which hypothesized that age of an individual at immigration into the US would result in different rates of mental health problems. For example, people who immigrated as teenagers, between the ages of 13 and 17 are characterized as the 1.25 generation. They receive a large portion, if not all, of

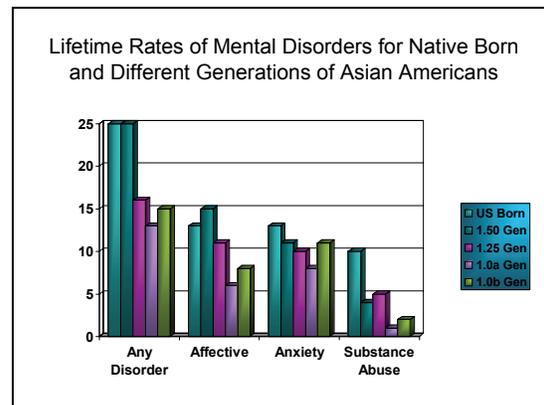
their schooling in another country, have difficulties with English, and their peers are often from different countries/cultures (co-ethnics) and may be different from American born peers in terms of values, lifestyles, knowledge of American culture. This generation is cast as the generation caught between two cultures.



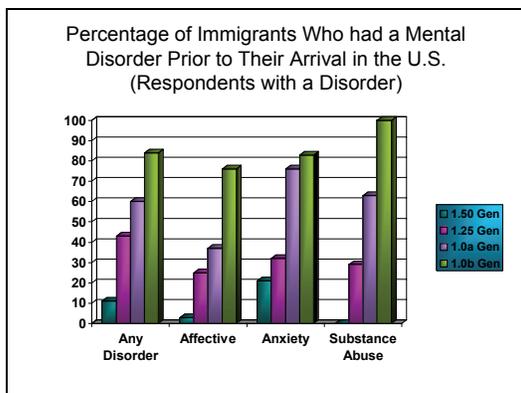
Dr. Takeuchi reviewed the lifetime rates of mental disorders for native born versus the different generations of Asian Americans (1.0b, 1.0a, 1.25, and 1.50 generations).

- **1.50 generation:**
 - Arrives at 0-12 years old. School as principal socialization agent outside the family. Able to quickly grasp American culture and values.
 - Receives most of their schooling in the U.S.
 - Greater capacity to speak English.
 - More like native born than other immigrant categories.
 - Will have similar opportunities as native born to engage in risky behaviors.
- **1.25 generation:**
 - Arrives between the ages of 13-17 years old.
 - Receives a large portion, if not all, of their schooling in another country.
 - Difficulties with English.
 - Peers are co-ethnics and may be different from American born peers in terms of values, lifestyles, knowledge of American culture.

- **1.0a generation:**
 - Arrives between 18-39 years old.
 - Access college and work environments.
 - Receives all of their schooling (except for college) in another country.
 - Limited English but may not be critical if networks use another language to communicate.
 - May have constrained mobility because of their education and may not have similar social and educational rewards as American born peers.
- **1.0b generation:**
 - Arrives at 40+ years of age.
 - Schooling likely completed.
 - Receives all of their schooling in another country and unlikely to accrue the same rewards.
 - May have difficulties finding jobs that match their educational levels.



Those who are born in the US and those who immigrate between the ages of 0-12 years of age (1.50 generation) have higher rates of mental disorders. However broken down by the type of mental disorder, such as anxiety, those who are older (40+) when they immigrate to the US are just as likely as those who were 0-12 years old during immigration to have anxiety. Those who immigrate later in life (1.0b and 1.0a generations) have lower rates of substance abuse disorders, but by percentages of disorders prior to arrival in US, older immigrants have a high risk of a



mental disorder prior to their arrival, as illustrated by the chart above.

Dr. Takeuchi also reviewed lessons learned from NLAAS, including the “Model of cumulative advantage and disadvantage.” Instead of looking at the big effects, review the small effects and how they cumulate, adding up to advantages and disadvantages and increased disparities. The big effects are not ignored, but a model of cumulative advantage and disadvantage will lead to a greater payoff in understanding health and health disparities over time.

Jennifer Tsui, MPH, UCLA Center for Health Policy Research, presented on the “California Health Interview Survey: Successes and challenges of AAPI data collection.”

California is able to report statewide health data for specific ethnic groups because of the California Health Interview Survey (CHIS). CHIS is conducted through a statewide random digit dialing (RDD) telephone survey of 48,000 households in 44 geographic strata, and is conducted every two years. CHIS covers a wide range of topics such as health status, conditions and behaviors, health insurance coverage, health access, and use of health care services. CHIS incorporates Korean and Vietnamese household oversamples and interviews in Chinese (Mandarin, Cantonese), Korean and Vietnamese language.

The challenge for CHIS sample design was to balance the need for local-level estimates for counties (many of which are rural and sparsely populated), and statewide estimates for overall population, including major racial/ethnic groups and their subgroup samples. CHIS design also includes linguistically isolated communities, through English simplification, cultural adaptation and linguistic translation of its materials. The interview process takes

approximately 30 minutes in English and 1 hour or more in other languages. The findings show significant differences within an ethnic group based on the interview language. For example, Chinese Californians interviewed in Chinese (either Cantonese or Mandarin) were more likely than Chinese interviewed in English to have a high school diploma or less (59.3% vs. 15.4%), and less likely to be insured (76.1% vs. 92.7%), thus reinforcing the need for translated surveys.

Because of its inclusiveness, CHIS is able to produce population-based subgroup data for Asian and Latino populations, including linguistically isolated communities, for publications and public use files that are, in turn, used for state and local policy, and program implementation efforts.

Sample Design

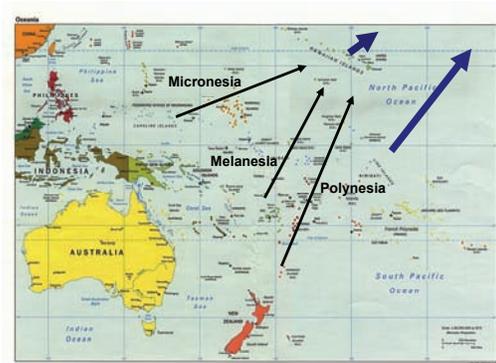
- ▶ CHIS sample designed to meet two goals:
 - ▶ Local-level estimates for counties
 - ▶ Statewide estimates for overall population, including its major racial/ethnic groups
 - ▶ Oversampling of subgroups with geographic targeting and supplemental surname list.

	CHIS 2001	CHIS 2003	CHIS 2005
Koreans	326	Koreans 112	Koreans 123
Vietnamese	540	Vietnamese 114	Vietnamese 127
American Indians	351		
Japanese	330		
South Asians	443		
Cambodians	126		

Sela Panapasa, PhD, University of Michigan, Institute for Social Research, and Member, NHOPI Racial/Ethnic Advisory Committee, US Census Bureau, "Pacific Islanders in the United States: Census 2000."

Census 2000 was able to produce, for the first time, data on Native Hawaiians and Other Pacific Islanders disaggregated from Asians in the 50 states and Washington, DC, due to the 1997 Office of Management and Budget (OMB) "Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity," which replaced OMB Directive 15. Census 2000 revealed Native Hawaiians and Other Pacific Islanders (NHOPI) comprise .3% of the total US population (largest concentrations of Pacific Islanders on the US continent are in California, Washington State, Texas, New York and Utah). Those who do move to the US continent do so because of job availability in certain industries, and many travel to the US continent to access health care services unavailable in the Pacific Islands (i.e. x-rays, surgery procedures, cancer treatment).

Dr. Panapasa reviewed Census data on NHOPI age, average household size, language, education, occupation, income, and poverty. The federal NHOPI category encompasses 20 different Pacific Islander nationalities (primarily of Polynesian, Micronesian and Melanesian heritage). However, many national health surveys do not capture data on this population even in the aggregate, resulting in data cells filled with "/" or "*" meaning the sample size was not large enough to analyze or the data was not available.



Arrows pointing towards Hawaii, and the US continent.

Dr. Panapasa's recommendations include:

- Concerted effort to analyze administrative data on NHOPI in order to establish baseline information on the health status and needs of this subpopulation and its subgroups.
- Establish a NHOPI survey with sufficient sample size to provide robust information and to improve understanding of the health and health care status of this subpopulation and subgroups.
- Ongoing support for NHOPI workforce development, infra-structure and community-based research to help reduce/eliminate disparities in health and healthcare.

OPPORTUNITIES FOR AA & NHOPI DATA COLLECTION, ANALYSIS AND REPORTING

As established by previous speakers, most national health surveys do not have large enough samples of AA or NHOPI populations to produce useful data. Next, we discussed the opportunities and challenges for expanding the samples of AA & NHOPI in national surveys.

Leighton Ku, PhD, MPH, Senior Fellow in Health Policy at the Center on Budget and Policy Priorities. "Improving national health survey data about Asians & Pacific Islanders."

Dr. Ku reviewed a few large federal surveys:

- Current Population Survey (CPS):**
 Conducted for over 50 years, CPS is a monthly survey of approximately 50,000 households conducted jointly by the Bureaus of the Census and Labor Statistics. Includes questions on employment, gender, age, marital status, and race. Supplemental questions providing estimates on a variety of topics may include school enrollment, health, employee benefits, national origin, immigration status, and language proficiency. CPS data are used as indicators of the nation's economic situation and to then plan/evaluate government programs.

	CPS	NHIS	MEPS	CHIS
National origin	x	x		x
Immig. status	x	partial	partial	x
Language proficiency	x	partial	partial	x
Oversample APIs		x	?	x
Interview in Asian languages				x

- National Health Interview Survey (NHIS):** Begun in 1957, NHIS is a cross-sectional interview survey of approximately 43,000 households conducted throughout the year to monitor the health of the US population.

NHIS is composed of three modules: basic module (socio-demographic characteristics, household composition, basic indicators of health status and utilization of health care services), periodic module (more detailed information from sample persons), and the topical module (used to respond to new public health data needs as they arise). The NHIS sample is drawn from each State, but the sample is too small to provide precise State level data. NHIS may include questions on national origin and also has partial information on immigration status and language proficiency. NHIS has pooled data over a period of time in order to identify the dental needs of Pacific Islander populations. NHIS oversamples African Americans, Hispanics and Asians. Oversamples of Asians began in 2006, which should be in place for 10 years, but budget constraints reduced the overall sample size by approximately 25%, bringing the total of Asian households down to 7,500 from 10,000.

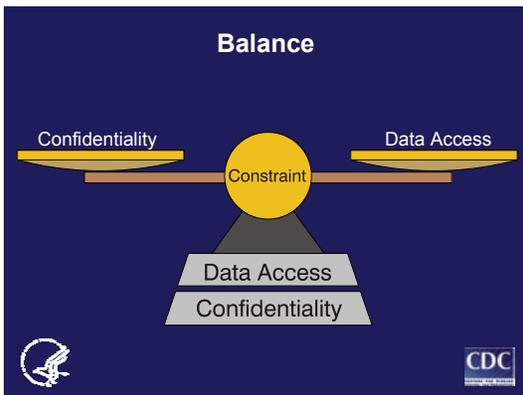
- Medical Expenditure Survey (MEPS):**
 Begun in 1996, MEPS is a large-scale survey of families, individuals and their medical providers (doctors, hospitals, pharmacies, etc). MEPS collects data on specific health services that Americans use, how frequently they are used, costs

of such services, how services are paid for, and health insurance costs and availability of US workers. Drawn from NHIS sample, it includes partial information on immigration status and language proficiency. MEPS may start to oversample AAPIs in the future.

Dr. Ku described the pros of focusing on these national surveys (data are widely used; possible to compare AAPIs to other groups) and cons (cost, usually based on self-reported interviews, may be hard to change ongoing surveys, hard to get details on issues of importance to subpopulations). Dr. Ku identified two key areas of improvement--data content and survey design. Data content is determined by the ability to collect (and hence differentiate findings by) national origin, ancestry or

country of birth, immigration status (1st, 2nd, 3rd generation, acculturation or years in the US), foreign-born, US-born, naturalized citizen, refugee, temporary legal, undocumented, education (in US or abroad, level), language/English proficiency (spoken, written). Dr. Ku noted that including such data content has to balance the resources necessary to do so with the information it will provide. Survey design addresses the issue of oversampling and conducting interviews in Asian languages. Oversampling can increase screening and total survey costs, though screening data could be shared across surveys to reduce costs. Targeting high geographic concentrations of Asians and Pacific Islanders could also reduce costs, though Dr. Ku posited it could also create biases.

Virginia Cain, PhD, Director of Extramural Research, National Center for Health Statistics, Centers for Disease Control and Prevention, Department of Health and Human Services, "NCHS data systems: Current and future possibilities for AA and NHOPI data."



Dr. Cain reviewed the major National Center for Health Statistics (NCHS) data systems and gave examples of Asian and NHOPI data that are available from these systems, particularly in vital statistics. She also showed that by pooling data over several years, the National Health Interview Survey found that 13.9% of NHOPI had unmet dental care needs due to cost. She

highlighted states that collect detailed data and areas of local and national collaboration. For example, California, Hawaii, Illinois, New Jersey, New York, Texas, and Washington provide detailed race/ethnicity mortality data. The National Health and Nutrition Examination Survey (NHANES) oversamples African Americans and Hispanics, but does not oversample Asians. However, the Community HANES (CHANES) project collects data similar to NHANES at community level. NCHS helped develop CHANES in New York City, Brownsville-Matamoros, TX, California, Seat Pleasant, MD and Wisconsin. NCHS can provide technical assistance, but cannot pay for CHANES. Finally, she offered the Research Data Centers around the country as a way for researchers to access national data not usually released to the public, because of nondisclosure or confidentiality.

Rob Santos, MA, Senior Institute Methodologist at the Urban Institute, “Oversampling AAPI populations in federal health surveys.”

Mr. Santos provided a historical perspective of oversampling and reviewed several ideas for AA & NHOPI data collection (oversampling, disproportionate sampling, dual frame sampling, innovative screening methods, and integrated design methods). He made recommendations for three low-cost ideas:

- Cumulation (exploit continuous surveys, promote small health modules for non-health surveys, promote government/private sector research partnerships).
- Add-ons in specific cities with high rates of AA & NHOPI populations.
- Spread the costs through “add and stretch” (superimpose AA & NHOPI national sample on continuous surveys in replicates over time, i.e. 5 years).

Mr. Santos also recommended where and how the community should be participating in the federal process by participating in re-design of surveys (for example, NHIS re-designs every 10 years). Communities can

participate in statistical advocacy via participation in federal statistical agency community advisory groups. He noted that because participation in phone surveys is decreasing, alternative methods need to be developed and may be more costly.

AAPI Oversampling: ideas

Three relatively low-cost ideas

– Cumulation

- Exploit the *continuous* surveys
- Promote small health modules for non-health surveys
- Gov./private sector research partnerships emerging

– Add-ons in *specific cities with high rates AAPI*

- Highest risk: AAPI in poverty AND in high density areas

– Spread the costs through ‘Add & Stretch’

- Superimpose AAPI national sample on continuous survey
- Implement in replicates over time (say 5 years)

OPPORTUNITIES FOR AA & NHOPI DATA COLLECTION, ANALYSIS AND REPORTING (PART II)

Beyond data collection, attention and effort must be paid towards analysis and data dissemination and reporting. Two models were presented: the National Health Disparities Report and Kaiser Family Foundation Key Facts series.

Ernest Moy, MD, MPH, AHRQ Center for Quality Improvement and Patient Safety, “AA & NHOPI in the National Healthcare Disparities Reports.”

The National Healthcare Disparities Report (NHDR) is a congressionally mandated report designed to provide simple, uniform, and descriptive national snapshots of priority populations including racial and ethnic

minorities using the 1997 OMB guidance. It is produced annually so trends from year to year are also noted. The report uses data that already exist; there is no additional primary data collection. Therefore, the

NHDR is a reflection of the Department of Health and Human Services (HHS) and the data collected by its agencies. Asians are represented in about two-thirds of the measures in the report. However, in the 2006 NHDR, estimates for NHOPIs could be made for only three of the 42 core report measures of quality (one measure from the National Health Interview Survey and two measures from the CMS Home Health Care Outcome and Assessment Information Set). Only three of the eight core report measures of access are available for NHOPIs. These include persons with health insurance and persons with a source of ongoing care from

the National Health Interview Survey and persons with a primary care provider from the Medical Expenditure Panel Survey. Since the NHOPi racial category is relatively new to the federal data collection systems (which had until 2003 to be compliant with the 1997 OMB standards) as more data become available, this information will be included in future reports. AHRQ is also working on providing state snapshots as well; however it may not be possible to disaggregate Asian data by state. Dr. Moy recommended that we work with individual states to improve their data collection and reporting.

Cara James, PhD, Senior Policy Analyst, The Henry J. Kaiser Family Foundation, "Measuring and reporting health disparities from Asian and Native Hawaiians and Other Pacific Islanders."

The Key Facts: Race, Ethnicity, and Medical Care, 2007 Update documents racial and ethnic disparities as they change over time and is distributed for use by legislators, think tanks, state and local officials, and academicians. "Asian only" and "Asian and Pacific Islander" categories are both referred to in the report based on available data. Like the NHDR, The Henry J. Kaiser Family Foundation (KFF) relies on existing government data including the Current Population Survey. Therefore, AA & NHOPIs are often not reported in charts because of insufficient sample sizes. The Key Facts Report may miss some underlying problems due to its reliance on national databases. For example, in the fifth

section of Key Facts entitled "Specialty Care," except for information on hospitalizations for uncontrolled diabetes and asthma and new cases and deaths from HIV, KFF had difficulty finding information on specialty care for Asians and Native Hawaiians or other Pacific Islanders. Therefore, more data collection on larger sample sizes is needed for subgroup analyses. KFF is working on specific fact sheets regarding each ethnic group and gender; however, they may not be able to create a separate fact sheet for Asian women and Asian men because of a lack of data disaggregated by gender.

COLLECTING AND REPORTING DATA FROM HEALTH SYSTEMS

Health plans, hospitals and other providers can play a role in increasing our knowledge of AA & NHOPI health status. Two representatives of the healthcare system reinforce that collecting data from patients can lead to better understanding of disparities and, more importantly, lead to interventions to improve health care quality and health outcomes.

Romana Hasnain-Wynia, PhD, Vice President, Research, Health Research and Educational Trust/AHA, "Collecting race, ethnicity, and language data from patients."

Primary data collection (including granular race/ethnicity data) from patients is a tool to provide patient-centered care to diverse populations and to ultimately improve quality of care to these populations. This data collection model is a quality of care framework, which providers are familiar with (i.e. for monitoring and looking at a baseline), so patient demographic information can be incorporated into the equation to ferret out where the care process breaks down for these populations and where interventions should be targeted.

The data collected at the local and hospital level have huge implications in an era of pay for performance. The need to stratify measures by race, ethnicity, language and other demographic variables is critical if we want to move from documentation to action. Dr. Hasnain-Wynia reviewed HRET/AHAs research to understand the common barriers to collecting data, and internal and external reasons why hospitals should be collecting race/ethnicity/language data. Responding to the HRET/AHA 2000 survey of hospitals and health systems, there are 15 languages that 20% or more of hospitals encounter frequently (Spanish, Chinese, Vietnamese, Japanese, Korean, Russian, German, French, Arabic, Italian, Laotian, Hindi, Polish, Tagalog, and Thai).

Recommendations For Standardization

- Who provides the information
- When to collect
- Which racial and ethnic categories to use
- Where and how data are stored
- Address Patients' Concerns
- Provide Staff training



Tell People Why You are Asking

Now I would like you to tell me your Race and Ethnic Background. We use this to review the treatment patients receive and make sure everyone gets the highest quality of care.



As a result of the research, HRET/AHA developed a tool kit for hospitals to implement data collection policies and procedures, including recommendations for standardization. HRET's toolkit is available for public use at <http://www.hretdisparities.org/index.php>. Additionally, there are system-wide efforts to analyze the data to measure quality, address policy issues and even determine reimbursement levels. One effort is an AHRQ-funded network with 18 hospitals and

Toolkit For Collecting Race, Ethnicity, and Language Data
www.hretdisparities.org

- **Toolkit Links**
- [How to Use the Toolkit](#)
- [Who Should Use the Toolkit](#)
 - Chief Executive Officer
 - Legal Affairs Department
 - Quality Improvement
 - Clinicians
 - Patients/Consumers
 - Registration/Admission
 - Information Technology Department
 - Interpreter Services
- [Why Collect Race, Ethnicity, and Primary Language?](#)
- [Why Collect Data Using a Uniform Framework?](#)
- [Collecting the Data - The Nuts and Bolts](#)
- [How to Ask the Questions](#)
- [How to Use the Data](#)
- [Staff Training](#)
- [Inform and Engage the Community](#)
- [Deaf and Hard of Hearing](#)
- [Tools and Resources](#)
- [Frequently Asked Questions](#)
- [References](#)



health care systems, 12 health plans, and 43 researchers across the country, with the goal of using provider level data to answer policy questions, especially focusing on issues serving diverse populations and addressing disparities.

Rita Carreón, Senior Manager, Clinical Strategies, America's Health Insurance Plans, "Collection and use of race and ethnicity data for quality improvement: 2006 AHIP-RWJF Survey of Health Insurance Plans."

In 2003 and 2006, AHIP collaborated with the Robert Wood Johnson Foundation (RWJF) to survey health insurance plans about the extent to which they collect and use data on race, ethnicity, and primary language. Some health plans have increased data collection on race, ethnicity and primary language, but many still have reservations. Ms. Carreon discussed the reasons health plans collect such data as well as some of the barriers to collection (i.e. provide language and culturally appropriate communications to enrollees versus state laws that inhibit collection of this data). Six states do not allow health plans to collect this information on enrollment forms: California, Maryland, New Hampshire, New

Jersey, New York, and Pennsylvania. Health plans generally are able to collect such data through self-identification post-enrollment, federal and state agency information, geocoding software, surname analysis, and satisfaction surveys. Nevertheless, because of commitment to the elimination of health disparities, AHIP does encourage such data collection and developed a toolkit to assist health plans on the collection of data, entitled "Data as building blocks for change," available at <http://www.ahip.org/content/default.aspx?docid=10761>.

Plans Use Data to Close Gaps in Care and Improve Health Care Quality 

Top Three Reasons Health Insurance Plans* Collect Race and Ethnicity Data

- Support language and culturally appropriate communications to enrollee
- Identify racial/ethnic disparities in health care or health
- Implement or strengthen quality improvement efforts

* Asked of all Medicare, Medicaid, and a segment of Commercial plans n = 72

Tools to Address Disparities in Health: Data as Building Blocks for Change 

- A data collection toolkit for health insurance plans and other health care organizations
- Why Collect Data?
- Legal Perspective
- National Activities & Programs
- How to Collect, Analyze & Use Data
- Health Plan Examples
- Resources and Tools



RECOMMENDATIONS

After each set of presentations, APIAHF led discussions in which participants shared their questions, observations and recommendations. The recommendations fall into several broad categories.

Given the lack of national data, two general approaches to increasing data are to:

- I. Look to existing sources of data for further analysis and dissemination
- II. Conduct more research—nationally and locally—and address sampling and design issues.

In order to move forward on the above recommendations, it continues to be necessary to gain political leverage via:

- III. Strategic advocacy and communication activities
- IV. Policy assessment and analysis

What follows is a detailed list of recommendations following the above outline.

I. Look to existing sources of data for further analysis and dissemination

APIAHF's analysis of the 22 leading health indicators in Healthy People 2010 shows that one-third (7 of 22) are denoted "DNA" meaning that data was collected but not analyzed for the Asian/Pacific Islander population in aggregate. There are many other datasets yet to be mined as listed in

the text box "Existing data sets with AA & NHOPI populations." The reasons for this lack of analysis are many, including lack of funding and/or staff, confidentiality issues, and insufficient samples.

Existing data sets with AA & NHOPI populations *[Compiled by Dr. Gilbert Gee]*

- Asian Tobacco Education, Cancer Awareness & Research Survey (n=1174) [PI-Dr. Grace Ma]
- California Health Interview Survey (n=4264 in 2001; n=3977 in 2003) [PI-Dr. Rick Brown]
- Chinese American Psychiatric Epidemiologic Study (n=1700) [PI-Dr. David Takeuchi]
- Filipino American Community Epidemiological Study (n=2200) [PI- Dr. David Takeuchi]
- Korean American Community Health Survey, 1997 (n=1090) [PI-Dr. Barbara Wismer]
- National Latino and Asian American Study (n=2095) [PI-Dr. David Takeuchi]
- National Longitudinal Survey of Freshmen (n=959) [PI-Dr. Douglas S. Massey & Dr. Camille Z. Charles]
- Pilot National Asian American Political Survey, 2000-2001 (n=1218) [PI- Pei-te Lien]
- South Asian Health Initiative [PI- Sapna Pandya]
- Survey on Disparities in Quality of Health Care, 2001 (n=669) [PI- Mary McIntosh]
- 2004 assessment in Palau (100% household participation) [PI- Dr. Stevenson Kuartei]

Given the amount of data, conducting new analyses will require planning, prioritization and collaboration among agencies, researchers and community members. Resources will have to be allocated. The Health Brain Trust offered several recommendations:

- A. Establish a national academic consortium of AA & NHOPI researchers whose purpose would be to analyze selected data and research, and disseminate the findings. Funding can be allocated based on existing relationships with NIH and other government agencies
- B. Address sample size deficiencies in existing surveys by pooling several years worth of data and bridging data from different surveys. This can boost sample size and enable disaggregation across subgroups (provided subgroup data was collected in the first place).
 - NCI, NCHS, and other partners should provide guidance and conduct workshops for investigators to learn how to pool data and link existing databases.
 - Similarly, government agencies and research institutions can develop guidance for bridging datasets and databases. For example, a collaboration of NCI, NCHS and University of Michigan researchers are exploring combining information from BRFSS and NHIS to obtain

small area estimates. Combining estimation procedures from various surveys helps to address non-coverage and non-response issues and to estimate prevalence rates of other factors. This collaboration plans to have a public website available at the end of the 2007 calendar year. In another example, RAND, with funding from the Office of Minority Health is investigating bridging methodologies in order to obtain greater precision in estimating AA & NHOPI groups within the National Health Interview Survey (NHIS).

- C. The Census Bureau should continually allow agencies and other researchers to correlate its data with Census surname and first name lists.
- D. HHS should ensure that it is consistently implementing OMB guidance on the 1997 Standards for Federal Data on Race and Ethnicity. HHS and OMB should develop additional guidance on presenting data to ensure that publications that show findings by race explicitly state the reason for data not being represented for any one of the minimum five race categories. Similar to the standard used by Healthy People 2010 (e.g. DNA, DNC, DSU) this helps readers identify gaps in data and plan for future research needs.

II. Conduct more research—nationally and locally—and address sampling and design issues

This means improving ongoing surveys and data collection systems, as well as initiating new research. Ongoing surveys include national and state population surveys such as the National Health Interview Survey or California Health Interview Survey. Data collection systems refer to Medicare, hospitals, health plans and other entities that process enrollment and claims data. Data collection systems also include vital statistics, cancer registries and other epidemiological surveillance tools and activities that are dependent on federal and state cooperation. New research includes special surveys for defined geographic areas (e.g. Pacific territories) or a specific subpopulation such as Native Hawaiians.

In any case, in order to yield sample sizes large enough for meaningful analysis, the effort to collect more data must address persistent sampling and design issues. As demonstrated by the NLAAS and CHIS, it is possible to focus on specific populations, overcome methodological issues, and produce data that takes causal and contextual factors into account. But, like the previous group of recommendations, it will be necessary to prioritize research questions with involvement and leadership from AA & NHOPi communities, and to allocate funding towards data collection of small populations. The Health Brain Trust offered several recommendations:

A. Select specific national and state surveys to advocate for oversampling of Asian and Native Hawaiian and Other Pacific Islander populations. Recommend specific sampling methods and other design changes that will maximize the AA & NHOPi

samples in that survey. Develop an advocacy plan incorporating Congressional action, participation in federal advisory committees, and other avenues for influencing the design of the survey.

- B. Prioritize state and local research. Collect and analyze data by smaller geographic units such as counties or metropolitan statistical areas. Use geocoding for sample design and data analysis.
- C. Establish a NHOPi health survey with sufficient sample size to provide robust information and to improve understanding of the health and health care status of this subpopulation and subgroups.

In tandem or to build support for this survey, the National Committee on Vital Health Statistics (NCVHS) Subcommittee on Populations should have a hearing to update its December 1999 report, *Health Data Needs of the Pacific Insular Areas, Puerto Rico, and the U.S. Virgin Islands.*

- D. Provide resources to states to analyze Medicare claims data by race and ethnicity. Doing so will provide state estimates, which will provide a more disaggregated picture for state and federal legislators and advocates at the state level to prove their case.
- E. Work with selected states and municipalities to encourage adoption of the 1997 OMB Standards for Maintaining, Collecting and Presenting

Federal Data on Race and Ethnicity. States with large AA & NHOPI populations should be encouraged to collect more than the minimum five race categories, and collect data on AANHPI subgroups. Community-based organizations in partnership with national organizations should advocate for this change.

F. Work with selected health plans and hospitals to implement race, ethnicity and primary language data collection, and then to analyze the data for quality assurance purposes.

G. The Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA) should collaborate to improve its Medicare data.

- The Social Security Administration and the Centers for Medicare and Medicaid Services should develop a

program to collect data on race, ethnicity, and socioeconomic status at the time of enrollment in Medicare and for current enrollees.

- SSA should collect information on race and ethnicity on Form SS-5 and through the Enumeration at Birth process using the 1997 OMB Standards.

- CMS should evaluate the findings of recent studies of the effectiveness of using lists of surnames to identify the race and ethnicity of enrollees.

- Medicare Advantage plans should be required to collect and report to CMS the race and ethnicity of all enrolled Medicare members.

H. Investigate ways to incorporate new technology in screening, data collection and analysis to yield granular data.

III. Strategic advocacy and communication activities

A. Identify individuals to serve on specific federal advisory committees, peer review boards and other committees that influence data collection, survey (re)design and publication. For example, the Committee on National Statistics of the National Academies (CNSTAT) works to improve the statistical methods and information on which public policy decisions are based.

B. Advocate for AA & NHOPI data needs in other professional communities and associations.

- The Association of State and Territorial Health Officers (ASTHO), National Association of City and

County Health Officials (NACCHO) and Council of State and Territorial Epidemiologists (CSTE) may be helpful partners in developing state policy campaigns.

- Present at the annual meetings of the American Statistical Association, American Medical Association, American Nurses Association, National Governor's Association, and National Conference of State Legislators.

C. Advocate for increased funding for the National Center for Health Statistics (NCHS). Provide specific recommendations to NCHS about what surveys and survey modules to save in an environment of flat funding.

- D. Develop a web-based communications and networking space for AA & NHOPI data stakeholders to collaborate on research activities, share published and unpublished research and datasets, and provide mentoring opportunities for researchers.

IV. Policy assessment and analysis

- A. In 2000, the HHS Assistant Secretary for Planning and Evaluation (ASPE) produced a report with analytic sample size by subgroup. But, due to reduced funding, many national surveys have since reduced sample sizes. Call for a follow-up ASPE funded report, to revisit the sample sizes being collected by subgroup, either through HHS or through Congressional action.
- B. Monitor quality of data reporting from federal agencies and other institutions. Develop an award to present at the bi-annual APIAHF Voices conference for an agency/branch that does this well. Develop a report card of agencies.
- C. Assess the compliance/adoption of the 1997 OMB Guidance relative to the Native Hawaiian and Other Pacific Islander category within HHS data sets.
- D. Widely disseminate studies to researchers and policy makers that document bias created when limited English proficient populations take surveys in English.
- E. Develop and disseminate guidance for translation and interpretation of surveys.

CONCLUSION

The collective experience and wisdom of the first APIAHF Health Brain Trust resulted in highly informative presentations, insightful discussions, and actionable recommendations, a few of which are already in motion. In spite of the initial setback brought on by 1985 Report on Black and Minority Health, progress has been made in gathering the data needed to recognize and address AA & NHOPI health needs. But persistent issues of data content and survey design continue to leave AA & NHOPI populations out of official national and state reports on health. This is still not acceptable. Moreover, all of the communities that comprise AA & NHOPI are growing and diversifying. Therefore, we must continue to make progress.

APIAHF, in its role as convener and policy advocate, will work with volunteers from among the participants to prioritize the recommendations, develop short- and long-term action plans for selected recommendations, and identify partners to take the lead on other recommendations. Additionally, during the meeting, participants suggested subjects for further inquiry and analysis which may become the basis for the next Health Brain Trust on Research and Data. APIAHF is extremely thankful to the participants, presenters and sponsors for their insight, guidance and commitment.

APPENDICES

A. Health Brain Trust Meeting Agenda

B. Health Brain Trust Attendee List



Health Brain Trust on Data & Research¹

Agenda

Dates: Monday, April 30, 2007, 3:00-7:30pm
Tuesday, May 1, 2007, 8:00am-4:00pm

Location: Beacon Hotel, Ballroom, 1615 Rhode Island Avenue, N.W., Washington, D.C. 20036

Health Brain Trust Objectives:

- To examine the status of data collection and research related to Asian American & Native Hawaiian and Other Pacific Islander (AA & NHOPI) communities.
- To broaden participation in the national AA & NHOPI health agenda from researchers, community members, advocates, health professionals, public health officials, academic institutions, think tanks, and other leaders.
- To share experiences, and gain knowledge that enable participants to develop recommendations for future action
- To identify policy and system levers for change related to AA & NHOPI data collection and research.
- To develop and recommend policy strategies for increasing national and state health data related to AA & NHOPIs.

Monday, April 30th:

2:30-3:00 Registration

3:00-3:15 Welcome
Marguerite Ro, DrPH
Deputy Director, APIAHF

3:15-4:15 Framing and Overview
Accurate, timely, and disaggregated data on Asian Americans, Native Hawaiians, and Pacific Islanders (AA & NHOPI) are vital to developing and monitoring programs and policies aimed at improving health and well-being. We will begin the meeting with an overview of AA & NHOPI data and research issues.

- Marguerite Ro, DrPH
Deputy Director, APIAHF
- Marjorie Kagawa-Singer, PhD, MA, MN, RN
UCLA School of Public Health/Asian American Studies Professor
Board Member, APIAHF

4:15-5:15 Models of national and state research

There have been several groundbreaking studies that successfully collected, analyzed and reported data for AA & NHOPI subgroups. We will hear about two of them: the National Latino and Asian American Study (NLAAS) and the California Health Interview Survey (CHIS). We will also hear information about the U.S. Census as it relates to data on NHOPI populations.

- David Takeuchi, PhD
University of Washington, School of Social Work
- Jennifer Tsui, MPH
UCLA Center for Health Policy Research
- Sela Panapasa, PhD
University of Michigan, Institute for Social Research

5:15-5:45 Discussion and Wrap-up
Marguerite Ro, DrPH
Deputy Director, APIAHF

5:45-7:00 Dinner, Beacon Room

Tuesday, May 1st:

8:00-8:45 Continental Breakfast

8:45-9:00 Welcome back and review
Deeana Jang, JD
Policy Director, APIAHF

9:00-10:15 Opportunities for AA & NHOPI data collection, analysis and reporting (Part I)
We will discuss the opportunities and challenges for expanding the samples of AA & NHOPI in national surveys such as (but not limited to) the National Health and Nutrition Examination Survey (NHANES) or the Current Population Survey (CPS).

- Leighton Ku, PhD, MPH
Senior Fellow in Health Policy, Center on Budget and Policy Priorities
- Virginia Cain, PhD
Director of Extramural Research, National Center for Health Statistics,
Centers for Disease Control and Prevention, Department of Health and
Human Services
- Rob Santos, MA
Senior Institute Methodologist, Urban Institute

10:15-10:30 Break

10:30-11:15 Opportunities for AA & NHOPI data collection, analysis and reporting (Part II)

It is important to not only collect data, but to also analyze and report the results. Two models will be presented: the National Health Disparities Report and Kaiser Family Foundation Key Facts series and other publications.

- Ernest Moy, MD, MPH
AHRQ Center for Quality Improvement and Patient Safety
- Cara James, PhD
Senior Policy Analyst, The Henry J. Kaiser Family Foundation

11:15-12:15 Discussion and Policy Recommendations

12:15-1:15 Lunch

1:15-2:15 Collecting and reporting data from health systems

Health plans, hospitals and other providers can play a role in increasing our knowledge of AAPI health status. Collecting data from their patients can lead to better understanding of disparities and, more importantly, lead to interventions to improve health outcomes. What efforts are underway to collect patient data? What have been the challenges and successes? How has this data collection led to improved care or health outcomes?

- Romana Hasnain-Wynia, PhD
Vice President, Research, Health Research and Educational Trust/AHA
- Rita Carreón
Senior Manager, Clinical Strategies, America's Health Insurance Plans

2:15-2:30 Break

2:30-3:30 Priorities – A facilitated dialogue

Deeana Jang, JD
Policy Director, APIAHF

3:30-4:00 Summary/Thank you

Marguerite Ro, DrPH
Deputy Director, APIAHF

**Funded by the Centers for Disease Control and Prevention and the W.K. Kellogg Foundation*

**Proceedings will be recorded*

¹ The APIAHF Health Brain Trust is a meeting of selected individuals, organized around a particular topic of interest to Asian Americans, Native Hawaiian and Pacific Islander Health. The purpose of the meeting is to deepen our understanding of AA & NHOPI health issues; develop new frames for AA & NHOPI health and the concept of health disparity; explore different levers for change; and build consensus around an agenda for change. The Brain Trust will be comprised of community members, advocates, researchers, health professionals, public health officials, and other leaders chosen for their experience and expertise depending on the topic.

**Asian & Pacific Islander American Health Forum (APIAHF)
Health Brain Trust on Data & Research
Attendee List
April 30-May 1, 2007**

Rajni Banthia, PhD Program Associate PolicyLink	Mona Bormet, MPH, CHES HAAPI Policy Fellow Asian & Pacific Islander American Health Forum
Marie Briones-Jones, MHSA Deputy Program Director Center for the Advancement of Health	Virginia Cain, PhD Director, Extramural Research Department of Health and Human Services Centers for Disease Control and Prevention National Center for Health Statistics
Rita Carreón Senior Manager, Clinical Strategies America's Health Insurance Plans	Olivia Carter-Pokras, PhD Associate Professor University of Maryland College of Health & Human Performance Department of Epidemiology & Biostatistics
Moon Chen, PhD, MPH Professor Associate Director for Population Research and Cancer Disparities University of California-Davis	John Chin, PhD Senior Research Associate NY Academy of Medicine Center for Urban Epidemiologic Studies
Marshall Chin, MD, MPH Associate Professor of Medicine University of Chicago Section of Internal Medicine	Chic Dabby, MA API Institute on Domestic Violence Director Asian & Pacific Islander American Health Forum
Gem Daus, MA Senior Policy Associate Asian & Pacific Islander American Health Forum	Brent Ewig, MHS Senior Program Associate Grantmakers in Health
Gil Gee, PhD Assistant Professor University of Michigan School of Public Health	Romana Hasnain-Wynia, PhD Vice President, Research Health Research & Educational Trust American Hospital Association
Chiehwen Ed Hsu, PhD, MPH Assistant Professor, Public Health Informatics University of Maryland-College Park/ Department of Public and Community Health	Marjorie Innocent, PhD Associate Director of Research Congressional Black Caucus Foundation, Inc.
Amelia Irmer Executive Assistant to the Deputy Director APIAHF	Deeana Jang, JD Policy Director Asian & Pacific Islander American Health Forum
Cara James, PhD Senior Policy Analyst The Henry J. Kaiser Family Foundation	Howard Koh, MD, MPH Associate Dean for Public Health Practice Harvey V. Fineberg Professor of the Practice of Public Health Harvard University School of Public Health Division of Public Health Practice
Marjorie Kagawa-Singer, PhD, MA, MN, RN Professor UCLA School of Public Health/Department of Community Health Sciences/Department of Asian American Studies * APIAHF Board Member	Barbara Krimgold Director, Kellogg Fellows and Scholars Center for the Advancement of Health

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Leighton Ku, PhD, MPH Senior Fellow Center for Budget and Policy Priorities	Sunmin Lee, ScD Assistant Professor University of Maryland Department of Epidemiology & Biostatistics
Betty Lee Hawks, MA Special Assistant to the Director Department of Health and Human Services Office of Minority Health	ManChui Leung HIV Program Director Asian & Pacific Islander American Health Forum
Marsha Lillie-Blanton, DrPH Vice President in Health Policy The Henry J. Kaiser Family Foundation	Jacqueline Lucas, MPH Health Statistician Department of Health and Human Services Centers for Disease Control and Prevention National Center for Health Statistics Division of Health Interview Statistics
Grace Ma, PhD Professor of Public Health Director of Center for Asian Health Temple University Department of Public Health College of Health Professions	Barry Miller, DrPH Epidemiologist Department of Health and Human Services National Cancer Institute
Ernest Moy, MD, MPH Medical Officer Department of Health and Human Services Agency for Healthcare Research and Quality Center for Quality Improvement and Patient Safety	April Oh, MPH, PhD Candidate Kellogg Fellow University of Illinois-Chicago School of Public Health
Sela Panapasa, PhD Research Investigator University of Michigan, Institute for Social Research	Rea Pañares, MHS Director, Minority Health Initiatives Families USA * APIAHF Board Member
Canta Pian, MA Director, Division of Economic Support for Families Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE)	Beverly Quan Gor, EdD Director, Community Relations University of Texas M.D. Anderson Cancer Center Health Disparities Research Center for Research on Minority Health
Anita Raj, PhD Associate Professor Boston University SPH Department of Social and Behavioral Sciences	Marguerite Ro, DrPH Deputy Director Asian & Pacific Islander American Health Forum
Rob Santos, MA Senior Institute Methodologist The Urban Institute Statistical Methods Group	Salma Shariff-Marco, PhD, MPH Cancer Prevention Fellow Department of Health and Human Services National Cancer Institute Applied Research Program Division of Cancer Control and Population Sciences

**Asian & Pacific Islander American Health Forum (APIAHF)
Health Brain Trust on Data & Research
Attendee List
April 30-May 1, 2007**

Shobha Srinivasan Health Disparities Research Coordinator Department of Health and Human Services National Cancer Institute Division of Cancer Control and Population Sciences	Alek Sripipatana, MPH, PhD Candidate Policy Coordinator Kellogg Fellow California State University, Fullerton/Department of Health Sciences
Francisco Sy, MD, DrPH Chief, Office of Community-Based Participatory Research & Outreach Program, Director NCMHD Loan Repayment Program Acting Program Director, Research Endowment Program Department of Health and Human Services National Institutes of Health National Center on Minority Health and Health Disparities	Phitsamay Sychitkokhong Uy, M.ED, PhD Candidate Research Associate Education Development Center, Inc./Harvard Graduate School of Education
David Takeuchi, PhD Social Welfare Doctoral Faculty University of Washington School of Social Work	Sora Park Tanjasiri, DrPH, MPH Associate Professor California State University, Fullerton Department of Health Sciences
Laurent Tao, MD, MPH Consultant McKinsey & Company	Chau Trinh Severin, DrPH Director Center for the Study of Asian American Health New York University
Jennifer Tsui, MPH Senior Research Associate University of California-Los Angeles Center for Health Policy Research, California Health Interview Survey	Khatharya Um, PhD Professor University of California-Berkeley Department of Comparative Ethnic Studies
Frank Wong, PhD Associate Professor Georgetown University Department of International Health	Albert Yee, MD, MPH Program Director W.K. Kellogg Foundation
Mieko Yoshihama, PhD, MSW Associate Professor University of Michigan School of Social Work	

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지역 사회

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지견

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