

February 17, 2011

Secretary Kathleen Sebelius  
United States Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

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**Headquarters:**  
450 Sutter Street  
Suite 600  
San Francisco CA 94108  
Main 415-954-9988  
Fax 415-954-9999  
www.apiahf.org

**Washington D.C. Office:**  
1828 L Street N.W.  
Suite 802  
Washington, D.C. 20036  
Main 202-466-7772  
Fax 202-466-6444

National Advocates for  
Asian American,  
Native Hawaiian &  
Pacific Islander Health

Re: *Comments on the HHS Agency Plan for the White House Initiative on Asian Americans and Pacific Islanders (WHIAAPI)*

Dear Secretary Sebelius:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Department of Health and Human Services (HHS) and the White House Initiative on Asian Americans and Pacific Islanders (WHIAAPI) for the opportunity to comment on the draft HHS Agency Plan for the WHIAAPI. We strongly support the efforts of HHS and WHIAAPI in seeking to ensure Asian Americans, Native Hawaiians and Pacific Islanders (AA and NHPI) are meaningfully included in federal agency priorities and directives.

For 25 years, APIAHF has dedicated itself to improving the health and well-being of Asian American, Native Hawaiian, and Pacific Islander communities (AA and NHPI). While HHS has made tremendous strides in developing policies, providing investments and promoting research to reduce health disparities, people of color and other vulnerable populations continue to experience differences in health and health care outcomes when compared to their white counterparts. AAs and NHPIs in particular suffer disproportionately high rates of cervical cancer, stomach cancer, hepatitis B, mental health issues, and many other serious health impairments. In addition, high rates of uninsurance, affecting over one in six Asian Americans and one in four Native Hawaiian and Pacific Islanders, and limited English proficiency compound the obstacles these communities face in preventing illness and achieving good health.

For these reasons, we strongly support the development of the HHS Agency Plan for the WHIAAPI. In addition, we urge HHS to consider the following modifications and additions to the plan:

## **Hepatitis B**

***Goal 1: Decrease health disparities of AANHPI populations who are unaware that they have chronic Hepatitis B virus (HBV) infection by increasing early identification.***

- **Include Liver Cancer in a National Educational Campaign:** HHS should incorporate liver cancer within a national education campaign and in community based outreach as we know that many families are familiar with liver cancer deaths, but are unaware of the connection of liver cancer to hepatitis B infection.

- Expand the Number of Languages PSAs will be Translated into: PSAs should also be translated into other AA and NHPI languages, such as Tagalog, Samoan and Tongan.
- Partner with Local and Community Based Organizations and Universities to Develop the National Educational Campaign: HHS should partner and work with existing city/state, community based organization and university campaigns as they provide existing models for the national hepatitis B educational campaign. For example, the San Francisco Hep B Free Campaign and Asian Liver Center in Stanford offer existing models.
- Revise Goal 2 to “Establish targets for the next 10 years about the percentage of AA & NHPI who have been tested and appropriately vaccinated to prevent hepatitis B infection”: We recommend that vaccination be more strongly integrated into the plan as vaccination can safely and effectively narrow the disparity gap in hepatitis B infection in AA and NHPI individuals.
- Add other Health Conditions that Disproportionately Impact AA and NHPI Communities: HHS should add some of CDC’s other winnable battles, in addition to hepatitis B, such as obesity, nutrition and food safety and tobacco prevention. National organizations such as APIAHF and APPEAL can provide assistance on goals and strategies to address these winnable battles.

*Goal 3: Increase Capacity of community based organizations that advocate for programs for early detection and prevention of HBV infection in medically underserved AANHPI communities.*

- Specifically Incorporate Hepatitis Vaccination: We urge HHS to specifically incorporate the use of the hepatitis B vaccine as a strategy to preventing HBV infection in medically underserved AA and NHPI communities.

*Goal 4: Decrease the disease burden of HBV infection among AANHPI and improve HBV screening.*

- Specifically Incorporate Hepatitis Vaccination: We urge HHS to improve access to HBV vaccine as a method of decreasing the disease burden of HBV infection in AA and NHPI communities. Train health care providers to screen AA and NHPI patients living in HBV endemic regions with HBsAg (hepatitis B surface antigen) and vaccinate those susceptible to prevent transmission.
- Incorporate Liver Cancer: We urge HHS to add a benchmark to increase the percentage of HBV positive AA and NHPIs who are in care (being monitored every 6 months for viral load and liver cancer).

*Goal 5: Eliminate Perinatal HBV in the United States.*

- Develop a National Campaign to Eliminate Perinatal HBV in the United States: An estimated 1,000 babies are infected each year in the U.S. with perinatal HBV. CDC and HRSA should collaborate to expand case

management to include screening and vaccination of all household contacts and referral to care for both mother and household contacts (this is the ring vaccination strategy which helped to eliminate smallpox).

- CMS Should Implement Perinatal Hepatitis B Screening: CMS should implement perinatal hepatitis B screening in its Medicaid quality measures, as endorsed by the National Quality Forum.

## **Data Collection**

*Goal 1: Increase the capacity to conduct more reliable health data and research throughout the U.S. and U.S. affiliated jurisdictions for AANHPI populations to better describe and understand the need of the AANHPI growing population as part of the PPACA Provision: Understanding Health Disparities: Data Collection and Analysis (Sec. 4302).*

- Implement the IOM's Recommendations on the Standardization of Race and Ethnicity Data: We urge HHS to adopt all of the recommendations from the 2009 Institute of Medicine (IOM) Report<sup>i</sup> on race, ethnicity and language data (*Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*), which was commissioned by AHRQ to develop standards for the collection of race, ethnicity and language data. The report highlighted the need for granular ethnicity data, and recommended that HHS develop and make available nationally standardized lists for granular ethnicity categories, and proposed strategies for aggregating granular ethnicity categories to the broader OMB race and Hispanic ethnicity categories. Specifically, the IOM Report proposed the following order of questioning in the collection of race and ethnicity data: Hispanic ethnicity first, followed by OMB race categories, and then granular ethnicity. The granular ethnicity categories should be locally relevant response categories selected from a national standard list with appropriate coding, such as the Centers for Disease Control and Prevention (CDC)/Health Level 7 (HL7) Race and Ethnicity Code Set 1.0. In addition, an open-ended option of "Other, please specify: \_\_" should be provided for persons whose granular ethnicity is not listed as a response option.
- Implement the IOM's Recommendations on the Standardization of Spoken Language Needed: We urge the Secretary to follow the recommendations from the 2009 IOM Report<sup>ii</sup> regarding language need. Although Section 4302 requires the collection of "primary language" data, it is silent on the meaning and application of primary language. We hope HHS can adopt the recommendation of the IOM report which prioritizes spoken language for individuals with limited English proficiency (LEP), defined as able to speak English as "less than very well." Specifically, the report proposes two questions to assess spoken language need: one assessing the respondent's ability to speak English, and the second to determine the spoken language preferred in a health care setting using a list of locally relevant response categories from a national standard list, which should include sign language. In addition, an open-ended option of "Other, please specific: \_\_" should be provided to capture spoken languages not listed as a response option. Where

possible, surveys should also collect information on the language spoken at home by the respondent.

- Encourage the Collection of Written Language Need: While there is evidence that supports a high correlation between English-language proficiency in speaking, reading, and writing ability, differences in education level and health literacy can have an impact on an individual's reading comprehension. As such, HHS should support the recommendations of the 2009 IOM Report and encourage the collection and reporting of written language preference including Braille.
- Ensure Community Stakeholder Involvement: APIAHF supports the inclusion of AA and NHPI organization involvement in implementing HHS 4302 Workgroup recommendations. In addition, we ask that HHS continue to ensure that community stakeholders are included in the decision-making process and testing of the Secretary's data collection, reporting and analysis protocol under Section 4302. The inclusion of community stakeholders will help address privacy concerns and the unique cultural, linguistic, and social barriers that prevent our populations from participating in surveys. Moreover, the inclusion of community representation will help to build partnerships with local community organizations and trusted groups within these hard-to-count communities and develop data collection protocols that are culturally respectful, and ensure confidentiality for the survey participants.

***Goal 2:** Data Management within US DHHS to reflect the revised OMB 15 requirements for data collection, analysis, and reporting to meet the official OMB categorization for "Asians" and "Native Hawaiian and Other Pacific Islanders" and take into account the 2009 IOM recommendations on standardized data collection of race, ethnicity and language.*

- Adopt and Implement the 2009 IOM Recommendations on Data Collection: We support and strongly recommend implementing the variables for standardized collection of race, ethnicity, and language need developed in the 2009 IOM Report. The report highlighted the need for granular ethnicity data, and recommended that HHS develop and make available nationally standardized lists for granular ethnicity categories, and proposed strategies for aggregating granular ethnicity categories to the broader OMB race and Hispanic ethnicity categories.
- Avoid Prioritization Schemes or other Preference Categories for Multiracial Respondents: Develop more accurate data collection of multiracial respondents by following the recommendations of the IOM Report regarding multiracial respondents which states that "where possible, information on specific combinations of races and ethnicities should be preserved so the data can be aggregated over enough reporting units or periods to provide more informative analyses and the basis for targeted interventions." In addition, HHS should not use a single category labeled "multiracial" or "more than one race" because it masks detailed information that could be used in analysis.

- Apply Multiple Sampling Strategies to Improve the Collection and Reporting of Smaller Populations: We support the use of oversampling of Asian Americans in NCHS’s National Health Interview Survey and in the 2011-2014 National Health and Nutrition Examination Survey. In addition, we recommend that the Secretary direct all other HHS-federally conducted and supported health programs to utilize sampling strategies appropriate to the target populations in the collection, reporting and analysis of race and ethnicity data.
- Add CDC to the List of Lead Agencies: HHS should add CDC to the list of lead agencies in Goal 2, as CDC is primarily responsible for funding disease surveillance at the state level.
- Revise Strategy 4 to “Continue to oversample Asian Americans in 2011-2014 NHANES”: Since NHANES is already oversampling Asian Americans, the language in Strategy 4 should be changed to “continue to oversample.”

## **Workforce**

*Goal 3: Develop a workforce recruitment and retention strategy specific to Native Hawaiians and Pacific Islanders.*

- Work with Native Hawaiian and Pacific Islander Communities to Improve the Health Professional Pipeline: Native Hawaiian and Pacific Island communities have different needs and capacity differences, especially between the more rural and urban areas. HHS should develop a workforce recruitment and retention strategy specific to Native Hawaiians and Pacific Islanders.

## **Native Hawaiians and Pacific Islanders**

*Goal 2: Provide enhanced technical assistance to National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funded state and programs in the Pacific to increase outreach to underserved Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities and populations.*

- Edit Strategy 2 to include Native Hawaiian Women: Strategy 2 should be edited to read “As part of NBCCEDP, provide support for underinsured and uninsured AA and NHPI women to complete annual clinical breast and mammography exams per established clinical guideline to improve the early detection of breast cancer in Native Hawaiian and other AA and PI women.”
- Add Better Communication and Documentation Across Goal 2: All strategies in Goal 2 should be amended to include providing better communication and documentation.

**Goal 3:** *Enhance surveillance and epidemiological response capacity for communicable diseases in U.S. territories and in the Pacific Island Jurisdictions.*

- Develop a Comprehensive Regional Approach to Communicable Disease Management: The health care infrastructure in the U.S. territories and Freely Associated States vary by jurisdiction, which causes public health interventions to be uncoordinated. We recommend HHS develop a comprehensive regional approach to ensure communicable disease management, taking into account barriers to care faced by these populations and the unique status of citizens of the Freely Associated States. This strategy should include diverse public health interventions, including education, immunization and technical assistance to enhance existing health infrastructure. In addition, HHS should develop benchmarks addressing tuberculosis and pandemic flu, in addition to mumps.

**Goal 9:** *Improve coordination of obesity prevention efforts of the Hawaii Department of Health targeting Native Hawaiian population through inter-sectoral approach.*

- Expand Goal 9 to Include Pacific Island Jurisdictions and the Freely Associated States: HHS should expand Goal 9 to improve coordination of obesity prevention efforts across Pacific Island populations and the Freely Associated States, in addition to Native Hawaiians. HHS should ensure these jurisdictions are able to access funding, by taking into consideration the limitations of some jurisdictions' ability to access grants.

**Goal 11:** *Expand the Supplemental Nutritional Assistance Program (SNAP) and school lunch program to better serve Hawaii's eligible AANHPI population to increase access to healthy foods and prevent childhood obesity.*

- Expand Goal 11 to Include Guam, the Commonwealth of the Northern Mariana Islands and American Samoa: Guam, the Commonwealth of the Northern Mariana Islands and American Samoa receive SNAP and school lunch program funds. HHS should expand Goal 11 to ensure eligible persons in these jurisdictions have access to these programs and consider developing partnerships with small farm operations as community based approaches in childhood obesity prevention.

**Goal 13:** *Work with the Public Health Agencies of Guam, the Commonwealth of the Northern Mariana Islands and American Samoa to understand the challenges faced in Medicaid funding as a result of the Affordable Care Act.*

- HHS should Provide Technical Assistance (TA) to the U.S. Territories and Pacific Island Jurisdictions: The PPACA's changes to Medicaid funding differ for the U.S. territories and Pacific Island jurisdictions as compared to the states. HHS should provide TA to the U.S. territories and Pacific Island jurisdictions to ensure access to increased funding and changes in eligibility under the PPACA to maximize benefits for these populations.

In addition to the above recommendations, APIAHF urges HHS to make the addition of the following topics and corresponding goals:

### **Health Care Reform**

The Patient Protection and Affordable Care Act (PPACA) is the single most sweeping reform of our health care system since the creation of Medicare and Medicaid in 1965. The health reform law also represents a historic civil rights victory, making significant investments in programs and services that seek to reduce health and health care disparities in communities of color, such as no-cost preventive services and increased affordability and funding for new community health centers.

Given the significance of the health reform law, we request that HHS convene an advisory committee for PPACA implementation as part of the agency's work plan. This advisory committee should be composed of a diverse stakeholder group to advise HHS and the WHIAAPI on health reform implementation, and outreach to Asian American, Native Hawaiian and Pacific Islander communities.

### **Limited English Proficient (LEP) Persons**

- **Review Title VI Language Access Policy Guidance and LEP Plans and Report:** HHS should review Title VI language access policy guidance and LEP plans to ensure all HHS-federally funded programs are given clear, specific guidelines on how to ensure meaningful access. We suggest the following benchmarks/measurable outcomes: 1) Within 180 days, issue a status report to the WHIAAPI showing how HHS and each operating division has disseminated/will disseminate the guidelines internally to program staff and externally to HHS grantees, and 2) Require HHS TANF grantees and job training partners to be trained in working with interpreters, and ensure interpreters are available at all eligibility interviews and meetings with recipients. Work related activities, including work search, job training, and job experience should be language accessible.
- **Ensure Proper Allocation of Resources for Written Translation and Spoken Interpretation Assistance:** National surveys should increase language access by hiring bilingual interviewers and translators, and translate and administer surveys in multiple languages. For example, the Census Bureau hires bilingual enumerators to ensure meaningful participation, and the California Health Interview Survey reaches linguistically isolated communities through English implication and linguistic translation (into Chinese, Korea and Vietnamese) of its materials. Providing language assistance helps address privacy and confidentiality concerns of respondent's and also ensures HHS' compliance with Title VI of the Civil Rights Act of 1964, which prohibits any federally-funded program or activity from race or national origin discrimination. Section 1557 of the Affordable Care Act reinforces this prohibition against discrimination by forbidding any federally conducted program or entity that receives funding or assistance from discrimination on the grounds of race, color, national origin, gender and disability.

- Conduct Trainings and Technical Assistance (TA): HHS should conduct trainings and provide TA for actors within the agency and operating divisions on language access issues and projects.
- Standardize Translations of Common Applications and Notices: HHS should standardize translations of common applications and notices used in HHS-federally funded programs using the DOJ threshold of the primary language spoken by the lesser of five percent or 1,000 persons “eligible to be served or likely to be affected or encountered,” with the 1,000 person threshold used at the national aggregate level. We suggest the following benchmark/measurable outcome: HHS should translate all notices and forms for welfare applicants and recipients, including TANF.

## **HIV/AIDS**

Consistent with the National HIV/AIDS Strategy (NHAS) for the United States and Federal Implementation Plan, APIAHF recommends the following additions and modifications:

***Goal 1:** Develop national-level reports for measuring baseline and progress benchmarks on the goals of the National HIV/AIDS Strategy, as related to AA and NHPIs.*

- Develop a National Surveillance Report: NHAS provides that “Federal and State agencies should consider efforts to support surveillance activities to better characterize HIV among smaller populations such as Asian American and Pacific Islanders (AAPI), American Indians and Alaska Natives (AI/AN).” CDC should develop a national surveillance report addressing the impact of the HIV/AIDS epidemic on AA and NHPI populations. This report should build upon a potential action step identified in CDC’s National Consultation on HIV/AIDS in AA and NHPI Communities on April 29-30, 2010. CDC should develop and disseminate this national surveillance report within one year.
- Develop a National Report Assessing Care: HRSA should develop a national report assessing AA and NHPI access to and utilization of HIV care and treatment services. HRSA should develop and disseminate this report within one year.
- Provide State Health Departments with Recommendations on Effective HIV Surveillance Activities: Building upon the Federal Implementation Plan for NHAS, CDC should provide State health departments with greater concentrations of AA and PI or AI/AN populations with recommendations on effective HIV surveillance activities for these populations. CDC should develop and disseminate these recommendations within one year.

***Goal 2: Address HIV-related stigma and homophobia, particularly for AA and NHPI gay and bisexual men and Transgender individuals, as 70% of these groups are living with HIV/AIDS.***

HIV-related stigma is a significant barrier faced by AA and NHPIs and other communities of color. AA and NHPI MSM populations face strong cultural barriers, including homophobia and presumed heterosexuality. Taboos over questions of sexual orientation and gender identity place unique burdens on transgendered AAs and NHPIs. HIV-related stigma and cultural taboos directly affect the health of AA and NHPI MSM and transgendered persons by preventing them from seeking HIV testing, accessing care and developing family support systems.

- Engage Communities in Anti-Stigma Work: Building upon the Federal Implementation Plan for NHAS, HHS OS should, in partnership with DOJ and DOL, engage communities, including AA and NHPI, to affirm support for people living with HIV. Faith communities, businesses, schools, health care providers, community based organizations, social gathering sites, and all types of media outlets should take responsibility for affirming nonjudgmental support for people living with HIV and high risk communities.
- Develop Recommendations for Including People Living with HIV on Planning Bodies: Building upon the Federal Implementation Plan for NHAS, HHS (HRSA, CDC, and HHS OS) should develop recommendations for strengthening the parity, inclusion, and meaningful representation of people living with HIV on planning and priority-setting bodies, including AA and NHPIs living with HIV/AIDS.

***Goal 3: Increase access to resources and capacity building to strengthen infrastructure and capacity of AA and NHPI-serving community based organizations and health centers to integrate HIV services and to support stronger health outcomes.***

- Convene an HHS Consultation on HIV/AIDS in AA and NHPI Communities: CDC currently estimates that nearly 30% of AA and NHPIs living with HIV/AIDS are unaware of their status. This is the highest proportion across all racial/ethnic groups. To address this disparate impact, HHS OS should convene an intra-agency HHS consultation on HIV/AIDS prevention, care, and research in AA and NHPI communities.
- Develop a Plan of Action Steps to Reduce the Proportion of HIV-positive Individuals with Undiagnosed HIV Infection: HHS (CDC, HRSA, SAMHSA, OMH and HHS OS) should develop and implement a plan of action steps to reduce the proportion of HIV-positive AA and NHPI individuals with undiagnosed HIV infection. HHS should develop and implement this action plan within one year.
- Convene Consultations to Address HIV Prevention among Gay and Bisexual Men and Transgenders: HHS OS should convene consultations to address HIV prevention among gay and bisexual men and transgenders and ensure

representation from AA and NHPI communities across the U.S. and the six U.S.-affiliated Pacific Island jurisdictions. HHS OS should convene the first consultation by mid-2011.

- Evaluate Adaptations of Interventions for Gay and Bisexual Men and Transgender Populations: HHS (CDC and NIH) should expand current efforts to evaluate adaptations of evidence-based interventions for gay and bisexual men and transgender populations, including AA and NHPIs. By mid 2012, CDC should issue a report that documents previous and current adaptation and evaluation efforts of interventions targeted to AA and NHPI populations.
- Evaluate the Sociocontextual Factors that Drive HIV Risk Among AA and NHPI Women: HHS (CDC and NIH) should conduct research on the sociocontextual factors that drive HIV risk among AA and NHPI women, and develop recommendations for essential prevention activities based on this research.
- Support Community Based Organizations Engaged in Prevention: HHS (HHS OS, CDC, SAMHSA and OMH) should provide support for AA and NHPI community based organizations to develop targeted outreach programs designed to reach specific populations at risk for HIV through culturally sensitive and linguistically appropriate evidence based interventions.

*Goal 4: Increase access to resources and capacity building to strengthen the infrastructure and capacity of health departments/ministries and community based organizations in the 6 U.S.-affiliated Pacific Island jurisdictions to provide HIV prevention and care services.*

- Convene an Inter-Agency Consultation on HIV/AIDS in the 6 U.S.-affiliated Pacific Island Jurisdictions: HHS OS should convene an intra-agency HHS consultation on HIV/AIDS prevention, care, and research in the 6 U.S. - affiliated Pacific Island jurisdictions.

## **Domestic Violence**

Healthy People 2020 recommends a reduction in violence caused by current and former partners through reduction in physical, psychological and sexual violence. 41-61% of Asian American women report experiencing intimate partner violence during their lifetime.<sup>iii</sup> Nationally, the costs of domestic violence, including rape, physical assault and stalking, exceed \$5.8 billion.<sup>iv</sup> Domestic violence causes not only immediate health consequences for women and their families, but is linked to chronic health conditions, including neurological and gynecological problems and increased risk of HIV/AIDS.

Consistent with Healthy People 2020, APIAHF recommends the following additions:

*Goal 1: Address domestic violence within AA and NHPI communities.*

- Provide Support for AA and NHPI Community Based Organizations: Provide support for AA and NHPI community based organizations to develop targeted outreach programs designed to reach specific populations at risk for domestic violence through culturally-sensitive and linguistically appropriate evidence based interventions.
- Develop and Disseminate Education Materials in a Variety of AA and NHPI Languages: HHS, in consultation with WHIAAPI and AA and NHPI stakeholders, should develop and disseminate domestic violence education materials in a variety of AA and NHPI languages.
- Incorporate Domestic Violence Prevention in a more Comprehensive Manner: The Patient Protection and Affordable Care Act (PPACA) and Healthy People 2020 provide numerous entry points to address domestic violence prevention. HHS should incorporate domestic violence prevention in a more comprehensive and integrated manner throughout its programs.

***Goal 2:** Understand the degree to which language access remains a barrier for AA and NHPI survivors of domestic and sexual violence.*

- Require HHS Recipients of Federal Funding to Track the Need for Language Services: HHS recipients of federal funding should track the need for language services in the population served. Recipients of federal funds should use standardized categories for collecting data about language assistance needs as recommended by the Institute of Medicine<sup>v</sup> (at a minimum, collecting data on English language proficiency and preferred spoken language needed for effective communication with a service provider) in all data collection activities conducted directly or indirectly by the federally funded grantee. Recipients of federal funds should use the IOM recommended standardized national list of languages.

In conclusion, APIAHF appreciates the opportunity to comment on the draft HHS Agency Plan and the WHIAAPI's commitment to meaningfully include AA and NHPs within the federal government. Please contact Priscilla Huang, Associate Policy Director for the Asian & Pacific Islander American Health Forum at [phuang@apiahf.org](mailto:phuang@apiahf.org) with any questions or additional information. We welcome future opportunities to work together on behalf of our communities.

Respectfully,

Kathy Lim Ko  
 President & CEO  
 Asian & Pacific Islander American Health Forum

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<sup>i</sup> Institute of Medicine, Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement (2009), available at <http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx>

<sup>ii</sup> Id.

<sup>iii</sup> This range is based on studies of women's experiences of domestic violence conducted among different Asian ethnic groups in the U.S. The low end of the range is from a study by A. Raj and J. Silverman, "Intimate partner violence against South-Asian women in Greater Boston," *Journal of the American Medical Women's Association*. 2002; 57(2): 111-114. The high end of the range is from a study by M. Yoshihama, "Domestic violence against women of Japanese descent in Los Angeles: Two methods of estimating prevalence," *Violence Against Women*. 1999; 5(8):869-897.

<sup>iv</sup> "Costs of Intimate Partner Violence Against Women in the United States." Atlanta, GA: Centers for Disease Control and Prevention and National Center for Injury Prevention and Control, (March 2003).

<sup>v</sup> Institute of Medicine, Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement.