

August 15, 2011

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

Re: Healthy Communities Study: How Communities Shape Children's Health
(HCS) (2011-15021)

Dear Director Lauer:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Department of Health and Human Services (HHS) and the National Institutes of Health (NIH) for the opportunity to comment on the Healthy Communities Study (HCS). We strongly support NIH's efforts in developing and conducting the HCS to evaluate community-level interventions designed to prevent and address childhood obesity. Moreover, we offer recommendations intended to help generate credible and valid data, especially as they concern Asian American (AA), Native Hawaiian, and Pacific Islander (NHPI) children.

General Comments

A large number of community health programs, policy, and other interventions have been implemented in recent years. As such, the HCS, designed to evaluate the effectiveness of such programs in the context of the communities where they were implemented, is timely. Health researchers and community advocates have long noted that community conditions may influence individual-level health behaviors and health outcomes. The multi-pronged approach taken in the HCS to investigate the modifying or mediating effects of community, family, and child factors is of great utility. Moreover, given the documented limitations of quantitative methods in investigating the outcomes of community-level interventions, the mixed methods incorporating qualitative methods (presumably intended to evaluate the processes and outcomes of community-level outcomes) will be very useful in addressing these shortcomings.

HCS findings will improve our understanding of childhood obesity and guide future interventions by shedding light on the various factors that address or exacerbate obesity, and the circumstances under which interventions are effective. As such, the HCS is consistent with the goals of Healthy People 2020 in understanding and promoting healthy behaviors and environments, as well as the goals of the National Prevention Strategy, which seeks to move our nation from one of disease treatment to prevention. For these reasons, APIAHF strongly supports the collection of community and individual-level data in the HCS.

Specific Data Collection Strategies and Methodologies

As recognized by the Affordable Care Act (ACA), consistent, accurate and standardized data collection and reporting is an essential aspect of identifying racial and ethnic health and health care disparities. The following recommendations align with implementation of the Section 4302 data collection requirements of the ACA, Title VI of the Civil Rights Act of 1964 and Section 1557 of the ACA, which reinforces the prohibition against discrimination by any federally conducted program or entity, that receives funding or assistance on the grounds of race, color, national origin, gender and disability.

For these reasons, we strongly recommend NIH consider the following data collection strategies and methodologies in regards to the prospective data collection aspect of the HCS.

Adopt the Proposed HHS Section 4302 Data Collection Standards for Collection of Race and Ethnicity

On June 29, 2011, HHS released proposed data collection standards (“draft standards”) implementing Section 4302 of the ACA. The standards address the need for granular race and ethnicity data and align more closely with the recommendations of the 2009 Institute of Medicine (IOM) Report on Race, Ethnicity and Language Data (IOM Report). Importantly for AA and NHPI communities, the standards propose the use of more granular Asian, Native Hawaiian and Pacific Islander ethnicity categories, aggregating to the broader OMB race categories.¹ Given the ethnic, linguistic, and socioeconomic diversity among AA and NHPI subpopulations and varying degree of health related disparities, granular level data is essential to accurately accessing these factors. Therefore, we commend HHS for addressing the need for granular race and ethnicity data in the proposed standards and strongly encourage NIH to adopt the same standards in the HCS. In addition, we recommend NIH expand the number of Asian ethnic subgroups provided as response options, to better identify disparities in smaller populations.

Oversample AAs and NHPIs

We urge NIH to oversample AAs and NHPIs in the HCS data collection. Because AAs and NHPIs make up a small proportion of the overall U.S. population, nationally representative samples tend to include small numbers of AAs and NHPIs, in particular, making it difficult to generate stable health estimates.

AA and NHPI ethnic subgroups are incredibly diverse, differ in access to health care coverage, are affected by different community conditions and reside in geographically diverse areas. For example, although obesity rates are known to be low among AAs generally, recent research indicates obesity rates are higher among U.S.-born AA adolescents, especially in some ethnic groups, such as Filipinos. Moreover, according to the Centers for Disease Control and Prevention (CDC) 2009 Youth Risk Behavior Surveillance data, prevalence of obesity among NHPI

¹ The Section 4302 Draft Standards go beyond the 1997 Office of Management and Budget (OMB) standards for the classification of federal data on race and ethnicity categories that separated the “Asian or Pacific Islander” category into two categories, “Asian” and “Native Hawaiian or Other Pacific Islander.”

adolescents (20.4%) is higher than any other racial group; which also corresponds to high rates of obesity, diabetes and heart disease among NHPI adults. Given this diversity, it is critical to understand if and how community or policy interventions influence AA and NHPI subgroups differently.

The HCS, which appears to include cluster sampling, may offer the opportunity for oversampling groups such as as NHPIs. Because NHPIs tend to cluster in pockets scattered mostly in Western states, the HCS may be a useful tool for evaluating the effectiveness of community or policy interventions, to the extent that such interventions took place in communities where large numbers of NHPIs reside. Collecting data in a sufficiently large sample of NHPIs would be the first step in helping to understand the health and health care access disparities this underserved population experiences and will, in turn, guide future policy and other intervention efforts.

In addition, oversampling of AAs is critical in that it may allow for more fine-grained analysis that can help improve our understanding of the potentially differential effects interventions have on various AA adolescent subgroups. Oversampling of AAs is consistent with other CDC efforts, such as data collection by the National Center for Health Statistics (NCHS), which has been oversampling Asians in National Health Interview Survey data since 2006 and, more recently, in the 2011-2014 National Health and Nutrition Examination Survey (NHANES). Therefore, we urge NIH to follow the important precedent set by NCHS in designing and conducting the HCS.

Primary Language

We urge NIH to include questions assessing primary language in the HCS data collection. According to the 2007-2009 American Community Survey, 70.5% of Asian Americans speak a language other than English at home. In addition, of the 8 million people in the United States that speak Asian and Pacific languages at home, more than 4 million are considered “limited English proficient,” meaning they speak English less than “very well” or not at all.²

Language barriers are widely known to reduce rates in enrollment and lower the quality and effectiveness of prevention, treatment and patient education programs. Members of these communities are often linguistically isolated and continue to encounter significant health and health care disparities. Section 4302 of the ACA requires that any federally conducted or supported health care or public health program, activity or survey collects and reports data on a number of demographic factors, including primary language. HHS’ release of its draft Section 4302 data standards take the important step of including a set of questions assessing the respondent’s ability to speak English.

While the recent draft standards address primary language, they place an emphasis on collecting information about a respondent’s English fluency, and to a lesser extent, information about Spanish speakers. We urge NIH to expand on these efforts and fully implement the 2009 IOM recommendations regarding language need.

² “Language Use in the United States: 2007,” U.S. Census Bureau, American Community Survey Reports, April 2010. Available at <http://www.census.gov/prod/2010pubs/acs-12.pdf>.

Consistent with the IOM recommendations, we recommend NIH use 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.

Additionally, 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, NIH should support the recommendations of the 2009 IOM Report and collect and report written language preference, including Braille.

Moreover, to ensure limited English proficient (LEP) persons are able to meaningfully participate in the HCS, we strongly recommend the HCS be administered in-language for LEP participants. Population-based surveys conducted only in English capture a fraction of the eligible individuals from Asian ethnic groups. Recent research has found that those who respond to surveys in English are significantly different from those who do so in ethnic Asian languages, with the latter being of lower socioeconomic status and experiencing potentially greater barriers in accessing health care and information, including that disseminated by community interventions.³ Findings from an English-only survey may thus lead to a vastly skewed sample of Asian Americans and gross underestimation of the health disparities affecting those with limited English proficiency.

In summary, we appreciate the opportunity to comment on the proposed Healthy Communities Survey. We welcome future opportunities to work together to improve the health and well-being of our communities.

Respectfully,



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

³ "Importance of native language in a population-based health survey among ethnic Chinese in Australia," Kam Cheong Wong and Zhiqiang Wang. 2008. Australian and New Zealand Journal of Public Health 32(4):322-324.