

February 15, 2010

Garth Graham. M.D., M.P.H.
Deputy Assistant Secretary for Minority Health
United States Department of Health and Human Services
The Office of Minority Health

Re: Comment on *Changing Outcomes – Achieving Health Equity, The National Plan for Action*

Dear Deputy Assistant Secretary Graham:

The Asian & Pacific Islander American Health Forum (APIAHF) and the undersigned organizations thank the Office of Minority Health (OMH) for its efforts to address the health of minority populations in the United States. In particular, we commend OMH's over two-year effort to bring about *Changing Outcomes – Achieving Health Equity, The National Plan for Action* (NPA). The NPA lays out a strong, systemic approach to combating health disparities in this nation through its five key objectives (to improve awareness, leadership, health and health system experience, cultural and linguistic competency, and research and evaluation) and 20 strategies for achieving those objectives. In particular, the NPA's focus on workforce diversity, cultural and linguistic competency within the health care system, data collection, and community-based participatory research will benefit the Asian American, Native Hawaiian and Pacific Islander (AA and NHPI) communities significantly. These communities suffer disproportionately high rates of cervical cancer, stomach cancer, hepatitis B, mental health issues, and many other serious health impairments. Additionally, high rates of uninsurance (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 achieving good health. For these reasons, we strongly support the strategies outlined in the NPA.

In addition, we urge OMH to consider the following changes to the NPA to ensure that the report most accurately represents the AA and NHPI populations and their specific needs.

STATISTICS

With the use of statistical information, the NPA draws critically-needed attention to the alarming disparities affecting this nation's minority communities. Such statistics, however, must be carefully presented. We hope that the NPA's final version will incorporate the following suggestions in presenting greater data on the AA and NHPI communities.

- **DISAGGREGATED DATA:** The AA and NHPI communities have long borne the model minority myth which mischaracterizes these communities as having few health or other social issues. Studies that lack data or that present data that aggregates these communities help to perpetuate this dangerous myth. The Office of Management and Budget recognized the importance of categorizing Asians and Pacific Islanders separately for data collection purposes when it revised OMB Directive 15 in 1997. Grouping data for these two populations together generates results that significantly misrepresent these communities. Moreover, the Institute of Medicine's *Race, Ethnicity,*

and Language Data: Standardization for Health Care Quality Improvement report discussed the importance of collecting data at the granular level, moving beyond OMB's 1997 standards. The NPA should promote these significant advancements by the consistent adoption of these standards and recommendations. We highlight the following in the NPA:

- NPA features graphs and charts on low birthrate/preterm birth and adult mortality (pg. 40-43 and pg. 48) which group Asians and Pacific Islanders together. Statistics included below highlight the significant health trends concealed within this chart's figures.
- The discussion of diversity within the health care workforce (pg. 91-92) states that the aggregate group of Asian Americans and Pacific Islanders are "overrepresented" in public health schools and medical school faculties. Disaggregated data would reveal that Pacific Islanders and some Asian ethnic subgroups are under-represented in the health care workforce. This under-representation by the disaggregated groups has been recognized by NIH, HRSA, and other federal agencies.
- **STATISTICAL COMPARISONS:** We were disappointed to see comparisons of other minorities against the AA and NHPI populations. Comparisons between minority populations are inappropriate for the discussion of disparities and should be made against the general U.S. population. Such comparisons are also problematic because they mask the problems that exist within the latter comparison group. The NPA, however, includes such comparisons:
 - In its discussion of educational attainment (pg. 19), the NPA includes the statement: "However, African Americans and Hispanics have lower academic achievement compared to Whites and Asians."
 - In its discussion of injury deaths (pg. 51): the NPA includes the statement: "American Indians and Alaska Natives have the highest death rate from accidents of those populations shown in Exhibit 2-15. Their rates were more than three times that of Asian/Pacific Islanders and 1.75 times that of Hispanics."
 - In its discussion of suicide and self harm (pg. 52), the NPA includes the statement: "Whites (15.7 per 100,000) and American Indians/Alaska Natives (14.7 per 100,000) have the highest rates of suicide or intentional self-harm. Exhibit 2-15 shows that their rates are more than twice that of Hispanics, Asian/Pacific Islanders, and Blacks." This comparison is of particular concern for the AA and NHPI communities as it connotes insignificance with regard to mental health issues in these communities. Studies have shown, however, that serious mental health conditions disparities afflict Asian American youth and the elderly.¹
 - In its discussion of mortality due to assaults and homicides, the NPA includes the statement: "Deaths from assaults or homicide (Exhibit 2-15) are nearly eight times higher for Blacks compared to Asian/Pacific Islanders and nearly six times higher compared to Whites."
- **DETERMINANTS OF CARE:** The NPA's discussion of social determinants of health would be greatly enhanced with a discussion about race and ethnicity as social constructs and as proxy measures for social and environmental circumstances. For instance, the NPA (pg. 75) describes data collected on exercise level by race and ethnicity, stating, "Exhibit 2-35 indicates that race, ethnicity, low education levels, and low income are related to low

participation in physical exercise.” This statement implies that race and ethnicity have an influence over levels of physical exercise, whereas, more likely, factors that disproportionately affect these groups such as low income and safe open space may be contributing factors.

- **HEALTH INSURANCE COVERAGE:** The NPA’s discussion of health coverage (pg. 11) as a significant contributing factor to health disparities should not omit the Asian American, Native Hawaiian, and Pacific Islander communities. Over one in six Asian Americans and one in four Native Hawaiian and Pacific Islander communities lack insurance. Disaggregated data shows 55% of Korean Americans and 37% of Vietnamese without health coverage.ⁱⁱ
- **ADULT MORTALITY:** The grouping of Asians and Pacific Islanders together severely masks the alarming mortality rates within several of the communities included within this broad category. For example:
 - Exhibit 2-9 (pg. 43) states that A/PI malignant neoplasm mortality rates for the breast are 12.8 per 100,000. Studies have shown that rates among Samoans are 36.2 per 100,000 and among Filipina are 17.2 per 100,000.ⁱⁱⁱ
 - Exhibit 2-9 (pg 43) states that A/PI malignant neoplasm mortality rates for the prostate are 9.6 per 100,000. Studies have shown that rates among Samoans are 36.2 per 100,000, among Vietnamese are 17.8 per 100,000, and among Japanese are 15.2 per 100,000.^{iv}
- **DIABETES:** The NPA’s discussion of diabetes should highlight the disparities that exist within the Asian American population. The risk of type 2 diabetes for Asian Americans occurs at a lower body-mass index than for non-Asian Americans.^v Local studies have also shown alarming rates of increase in gestational diabetes among Asian American women.^{vi}

OBJECTIVES AND STRATEGIES

The implementation of the NPA’s strategies for achieving its five key objectives lays the foundation for essential improvements in the quality of health care AA and NHPI communities receive. We commend the NPA’s strong framework for achieving the mitigation of health disparities. We hope, however, that the NPA’s final version will incorporate the following recommendations for additional improvements upon these strategies.

- **GREATER INCORPORATION OF LINGUISTICALLY AND CULTURALLY APPROPRIATE ACTIONS:** To ensure the effectiveness of the NPA’s strategies for communities like ours, where over one-third of Asian Americans have limited English proficiency and over 60% are foreign born, we hope to see linguistically and culturally appropriate actions diffused throughout the strategies for the NPA’s various objectives in addition to being its own standalone objective.
 - **OBJECTIVE 1: AWARENESS, STRATEGY 4: COMMUNICATION (pg. 115):** With respect to action items discussing outreach efforts to racial and ethnic communities through innovative media such as blogs, podcasts, and other interactive means, action items should specifically state that such efforts will be conducted in a culturally and linguistically appropriate manner.

- OBJECTIVE 3: HEALTH AND HEALTH SYSTEM EXPERIENCE, STRATEGY 10: PROMOTE SCHOOL READINESS (pg. 121): This strategy seeks to enforce the connection between greater educational attainment and long-term health benefits and to provide children with health and physical education. We hope to add as an action item, the creation of health education materials geared towards use in English Language Learner classes.
- OBJECTIVE 3: HEALTH AND HEALTH SYSTEM EXPERIENCE, STRATEGY 11: CHILDREN, ACTION 4 (pg. 122): This action promotes communication of health information to at-risk children and their parents. Such communications should be delivered in a linguistically appropriate manner.
- **WORKFORCE DIVERSITY:** As recognized in the NPA, workforce diversity is critical to providing quality care to minority populations where many lack English proficiency and come from diverse cultural backgrounds. Unfortunately, Asian Americans are often inaccurately considered “overrepresented” in the healthcare workforce. Disaggregated data has shown that many Southeast Asian groups and Pacific Islanders are severely underrepresented.^{vii}
 - OBJECTIVE 4: CULTURAL AND LINGUISTIC COMPETENCY, STRATEGY 14: DIVERSITY (pg. 125): We hope the NPA will include an action item that promotes ethnic and not just racial diversity within health professions schools.

ACTIONS

As stated, “NPA promotes systematic and systemic change.” We believe that in order to achieve this change, it is important that leaders at all levels seek to identify system changes that are supported by policy and program improvements. We recommend the following:

- **OBJECTIVE 2, STRATEGY 5, ACTION 1:** Add the following step “Identify specific systems and policy improvements” that are critical to building an equitable health care system and healthier communities. (p. 116)

IMPLEMENTATION

The NPA provides critical frameworks and models for change to occur. Having a federal team with representatives from a broad range of agencies reflects the understanding that health disparities are driven by social, economic, and environmental factors. What is less clear, however, is the participation from national ethnic organizations such as ours and our many other sister organizations in the implementation process and whether we would have a role on boards of advisors or as intermediaries. National ethnic organizations, such as ourselves, have a long history of trusted relationships with our ethnic communities and often serve as a “liaison” to federal agencies and other national stakeholders. More clarity in a final version as to how national ethnic organizations can be engaged in the NPA process would be helpful.

- **BOARD OF ADVISORS:** (second paragraph, second sentence) This section discusses the change that is being sought through the NPA. To be consistent with the effort to achieve systematic and systemic change, it is important not to imply that the success of the NPA

will rely on change at the individual level. We suggest the following phrasing “Change is desired at all levels, and it is particularly important that individuals at the community level are engaged in change processes.”

EVALUATION

We agree that evaluation of the NPA and the Blueprints is useful. Importantly, we suggest that OMH seek input from national foundations and other such entities who have conducted national evaluations and consider “lessons learned” from past evaluation efforts. Past experience suggests that there are considerable differences among evaluation firms and that for a major investment and effort such as the NPA, it may be useful to consider how to have more than one evaluation firm/entity in the process. Importantly, from a community perspective is having an evaluation that engages the community in the interpretation of the evaluation findings. In addition, having timely feedback allows for critical mid-course adjustments.

TECHNICAL CORRECTIONS

- The NPA’s chart on “Economic Burdens of Health Inequities in the United States” (pg. 8) misspells “medical” as “medial.”
- The NPA makes reference to “disabled individuals” (pg. 10), which should be changed to “individuals with disabilities.”

We thank you and the OMH staff for leading this monumental effort to combat health disparities and look forward to seeing the final version of the NPA. Please feel free to have your staff contact Marguerite Ro, Deputy Director, at mro@apiahf.org or Alice Dong, Senior Policy Analyst, at adong@apiahf.org for any further information.

Respectfully,

Asian American Justice Center (AAJC)
Asian & Pacific Islander American Health Forum (APIAHF)
Association of Asian Pacific Community Health Organizations (AAPCHO)
National Asian Pacific American Women's Forum (NAPAWF)
OCA
Southeast Asia Resource Action Center (SEARAC)
South Asian Americans Leading Together (SAALT)

ⁱ ASIAN AMERICAN COMMUNITIES AND HEALTH: CONTEXT, RESEARCH, POLICY AND ACTION 118, 141 (Chau Trinh-Shevrin, Nadia Shilpi Islam, and Mariano Jose Rey eds., 2009).

ⁱⁱ FAMILIES USA, HEALTH COVERAGE IN ASIAN AMERICAN AND PACIFIC ISLANDER COMMUNITIES: WHAT'S THE PROBLEM AND WHAT CAN YOU DO ABOUT IT? (2002), <http://www.familiesusa.org/assets/pdfs/AsAm1044.pdf>.

ⁱⁱⁱ Barry A. Miller, Kenneth C. Chu, Benjamin F. Hankey, and Lynn A. G. Ries, *2007 Cancer Incidence and Mortality Patterns among Specific Asian and Pacific Islander Populations in the U.S.*, *Cancer Causes and Control* (Apr. 2008), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2268721/>.

^{iv} *Id.*

^v National Diabetes Education Program, Your Game Plan to Prevent Type 2 Diabetes, <http://ndep.nih.gov/publications/OnlineVersion.aspx?NdepId=NDEP-60&redirect=true> (last visited Feb. 9, 2009).

^{vi} ASIAN AMERICAN COMMUNITIES AND HEALTH: CONTEXT, RESEARCH, POLICY AND ACTION, *supra* note 1 at 139.

^{vii} ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM, 2008-2012 POLICY AGENDA 9 (2008).