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**Re: Proposed data collection for National Health Interview Survey 2010-2012
(OMB No. 0920-0214) – Revision – National Center for Health Statistics,
Centers for Disease Control and Prevention**

To Whom It May Concern

The Asian & Pacific Islander American Health Forum (APIAHF) is a national health policy advocacy organization dedicated to promoting policy, program, and research efforts for the improvement of health of Asian Americans, Native Hawaiians and Pacific Islanders (AA and NHPI).

APIAHF is a national Census Information Center and was established to serve organizations by providing better access to census data, offering technical support, and providing products that meet census data needs. Thus, APIAHF meets the census data needs of organizations interested in identifying, defining, targeting, and serving AAs and NHPIs throughout the United States. APIAHF also tries to collaborate and partner with other government data collection agencies to provide timely and accurate data to address the health disparities of AA and NHPI communities.

APIAHF highly commends the efforts of the Centers for Disease Control and Prevention (CDC) for soliciting comments and recommendations on the proposed data collection for National Health Interview Survey (NHIS) for years 2010-2012 (OMB No. 0920-0214) – Revision – National Center for Health Statistics (NCHS).

We support the basic principles of the document (plan) and have several recommendations for you to consider regarding this endeavor.

Recommendations

Issue: Whether proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility.

Recommendation: NHIS should continue to collect such information. As NHIS is a major source of general statistics on the health of the population of the United States

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(US). The information from NHIS has long been used by university and private researchers as well as community based organizations and national ethnic organizations who serve underserved communities of color.

Issue: Ways to enhance the quality, utility, and clarity of the information to be collected.

Recommendation: It is highly recommended that there is standardization of the indicator race-ethnicity across the different surveys the CDC supports (e.g. NHIS, NHANES, MEPS, etc.). This will lead to higher quality, utility and clarity of the collected data. The NHIS framework is very important as it is used in other federal data collections efforts (e.g. Medical Expenditure Panel Survey). For small populations such as the AA and NHPI community, data pooling by combining different years of data and different types of data sets is done on a regular basis by advocates and researchers who work with these communities. However, the definitions of race and ethnicity vary from data set to data set and makes pooling of different data sets very difficult.

CDC needs to explicitly include cultural and linguistic competency in its data collection efforts to promote higher quality of data from underrepresented groups such as AAs and NIPIs who have high rates of Limited English Proficiency. As such, questionnaires need to be translated/transcribed into AA and NIPI languages. Interviewers also need to be trained to be culturally and linguistically competent.

Issue: Ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

Recommendation: Collecting data in a culturally and linguistically competent manner will greatly minimize the burden of data collection on respondents, especially for underrepresented groups such as AAs and NIPIs who have high rates of Limited English Proficiency. As such, questionnaires need to be translated/transcribed into AA and NIPI languages. Interviewers also need to be trained to be culturally and linguistically competent.

Issue: For 2010, supplement information will be collected on cancer, occupational injury, epilepsy, and child mental health.

Recommendation: In addition to the suggested health issues, data also needs to be collected on obesity. There is anecdotal evidence that in some AA and NIPI communities obesity rates are > 60%; obesity leads to higher rates of cardiovascular diseases, diabetes, and cancers.

Issue: Lack of disaggregate data, lack of reporting of data, and lack of appropriate sampling methodology to address small populations continue to hamper AA and NHPI health.

Recommendation: CDC should ensure that the 1997 OMB classifications are adopted and implemented in healthcare settings at national/state/local levels and in all government data collection efforts. Or at least ensure adoption and implementation of CLAS standards in all CDC supported data collection efforts.

CDC should adopt the OMB standards for the Classification to include information about AA and NHPI sub-populations (disaggregated data) as part of a national agenda.

CDC should adopt their existing databases as necessary in order to capture

critical race/ethnicity information, and to seek out other sources of data to supplement it.

It is imperative that, regardless of whether disparity is calculated using local data or national data, heterogeneity of the “Asian American, Native Hawaiian and Pacific Islander” group be taken into account. The AA and NHPI category encompasses more than a hundred different languages and dialects, diverse cultural backgrounds, and unique immigration experiences. Many of these groups suffer from high rates of poverty and low rates of education, yet are not considered “under-represented minorities”. Failure to view AAs and NHPIs as separate and distinct communities has resulted in an inaccurate reflection of whether the provider needs of these communities are being met. If such provider needs cannot be met then healthy healthcare setting goals cannot be achieved. Data is an extremely important tool to identify and address these needs.

APIAHF recommends oversampling of small populations where necessary to address the instability of data, especially since NHIS is a nationally representative household-based survey. Oversampling is also important to AA and NHPI communities as it took 5 years of data to produce the report last year on Asian Americans. Eight years of data have to be pooled to produce the report on NHPIs, which has issues in itself of waiting 8 years to collect and report on such data and how factors change over 8 years.

APIAHF would like to commend the CDC-NCHS for its commitment to an open process and consideration of these and other public comments. We would also like to offer any assistance we can provide to support CDC-NCHS’s efforts in collecting, tracking or analyzing data about various racial and ethnic populations, or in providing technical assistance to medical institutions.

If you would like to discuss any of our comments or opportunities for collaboration, please do not hesitate to call us.

Sincerely,



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August 7, 2009

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Dear Dr. Khan,

We appreciate your effort to provide comments and recommendations related to the proposed data collection for the National Health Interview Survey (NHIS) 2010-2012 (OMB No. 0920-0214). Here are our responses to your recommendations.

NHIS should continue to collect such information.

Conducted by the National Center for Health Statistics, the NHIS has monitored the health of the nation since 1957. For over 50 years, the U.S. Census Bureau has been the data collection agent for the NHIS. There is an ongoing effort to make improvements to the survey to make it more useful to policymakers, academics and other researchers, government and non-government organizations, and the public. For example, for the 2004 NHIS a major reengineering was implemented, resulting in the release of data within six months after the completion of the annual survey. Such efforts should help build support for the continued operation of the survey.

It is highly recommended that there is standardization of the indicator race-ethnicity across the different surveys the CDC supports (e.g. NHIS, NHANES, MEPS, etc.).

Pursuant to the Paperwork Reduction Act of 1995, the Office of Information and Regulatory Affairs of the Office of Management and Budget reviews the content and design of all federally sponsored surveys. This ensures that surveys collect key demographic information, such as race and ethnicity, on a comparable basis.

CDC needs to explicitly include cultural and linguistic competency in its data collection efforts to promote higher quality of data from underrepresented groups such as AAs and NHPIs who have high rates of limited English proficiency. As such, questionnaires need to be translated/transcribed into AA and NHPI languages. Interviewers also need to be trained to be culturally and linguistically competent.

Currently the questionnaire is available in English and Spanish. Each Census Regional Office maintains a list of interpreters to assist interviewers in completing cases in which the respondent speaks another language. If the gender or cultural background of the interviewer becomes an issue, another would be sent to conduct the interview. This approach helps minimize the number of interviews lost because of language difficulties. In 2008, of 54,999 assigned cases, only 58 (about 0.1%) were not conducted because of language difficulties.

In addition to the suggested health issues, data also needs to be collected on obesity.

As part of the core component of the NHIS, respondents are asked for their height and weight. Self-reported height and weight are used to calculate a Body Mass Index that can be used as an indicator of whether a person is overweight or obese. In addition the core survey asks a series of questions about leisure-time physical activities.

CDC should ensure that the 1997 OMB classifications are adopted and implemented in healthcare settings at national/state/local levels and in all government data collection efforts.

We are not involved in overseeing data collection efforts beyond our own survey. As mentioned previously, the Office of Management and Budget reviews the content and design of all federally sponsored surveys to ensure that key demographic information is collected on a comparable basis.

APIAHF recommends oversampling of small populations where necessary to address the instability of data, especially since NHIS is a nationally representative household-based survey.

A major feature of the current NHIS sample design is to increase the reliability of estimates on the minority domains of black, Hispanic, and Asian persons by oversampling these groups. One example of benefits from such oversampling is a report (Advance Data No. 368, April 20, 2006: Access to Health Care Among Hispanic or Latino Women: United States, 2000-2002) that analyzes access to health care among subgroups of Hispanic or Latino women: Mexican, Puerto Rican, Cuban, Central or South American, and Other Hispanic.

Oversampling additional population subgroups would be feasible only with an increase in budget support. Budget shortfalls in recent years have resulted in reductions in sample size, which limit information on all subgroups. Obtaining more reliable data on small population subgroups could be improved by a larger sample size or by more oversampling. Both strategies would require larger, not smaller budgets.

Once again we appreciate your comments. Additional information about the NHIS may be found at our website: <http://www.cdc.gov/nchs/nhis.htm>

Sincerely,



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