



VIA ELECTRONIC SUBMISSION
April 30, 2017

Office of the U.S. Chief Statistician
Office of Information and Regulatory Affairs
Office of Management and Budget
1800 G Street, 9th Floor
Washington, D.C. 20503

To the Office of the U.S. Chief Statistician:

The Association of Asian Pacific Community Health Organizations (AAPCHO) appreciates the opportunity to submit additional comments on potential changes to the Office of Management and Budget's (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. AAPCHO is a national not-for-profit association of 35 community-based health care organizations, 30 of which are Federally Qualified Health Centers (FQHCs). AAPCHO members are dedicated to promoting advocacy, collaboration, and leadership to improve the health status and access of medically underserved AA&NHPIs in the U.S., its territories, and its freely associated states.

We are the Association of Asian Pacific Community Health Organizations (AAPCHO), a national association of 35 community-based health organizations, including 30 Federally Qualified Health Centers. AAPCHO members are dedicated to promoting advocacy, collaboration, and leadership to improve the health status and access of medically underserved AA&NHPIs in the U.S., its territories, and its freely associated states. We rely on the race and ethnicity data collected by federal departments and agencies in much of our work, as well as the work of our partners, to address key health issues that impact our members' patient populations.

Our comments focus on the third issue for which OMB is seeking comments, regarding requiring additional minimum race and ethnicity classifications. We comment on the proposals to combine the race and ethnicity questions, to create a distinct Middle Eastern and North African classification, and to update some of the terminology used for race and ethnicity classifications.

Additional Minimum Race and Ethnicity Reporting Categories

We strongly urge OMB to require ALL federal departments and agencies to collect, analyze, use, report, and disseminate disaggregated data for Asian and for Native Hawaiian and Pacific Islander populations. Specifically, we urge OMB to require agencies to follow the question format used in the U.S. Census's National Content Test (NCT) Final Report that resulted in optimal response rates (Figure 26, page 88). This includes check boxes for Chinese, Filipino, Asian Indian, Vietnamese, Korean, and Japanese under Asian, with "Pakistani, Cambodian, Hmong, Sri Lankan, etc." listed as "for example" write-in groups, and check boxes for Native Hawaiian,



Samoan, Chamorro, Tongan, Fijian, and Marshallese, with “Palauan, Tahitian, Chuukese, etc.” listed as “for example” write-in groups.¹

It is critically important that disaggregated data for Asian and Native Hawaiian and Pacific Islander populations are thoroughly collected and made more readily available. Greater disaggregation is essential for federal departments and agencies to understand and effectively serve our diverse Asian and Native Hawaiian and Pacific Islander communities. Disaggregated data also help state agencies, community-based organizations, and researchers better identify the needs facing different populations. The 2015 National Content Test demonstrates that using the six most populous classifications, plus listing the next three most populous populations as “for example” write-in options, resulted in the greatest number of responses from these disaggregated groups.¹ Therefore, all federal departments and agencies should be required to collect, analyze, use, report, and disseminate data at these more granular levels.

We also recommend that these categories should not be static. We have seen both extensive population growth in Asian & NHPI communities, as well as shifts in which communities are growing the fastest and in which regions. The new standards should account for future predictions. The Asian population is projected to grow 137% between 2015 and 2060, while the NHPI population is projected to grow 97%.² These are rates faster than any other race group. We urge OMB to require that these standards be regularly updated so that when Asian & NHPI groups change in relative size over time, new check boxes are added to reflect new populations. To ensure consistent data over time, the six groups in the NCT format should remain, but influxes of new groups due to global factors may mean additional check boxes may be necessary.

We encourage OMB to issue guidelines that make it clear these are minimum standards and encourage programs or surveys collecting state or other regional data to add additional check boxes and examples of groups that may have larger representation in those states or regions, but are not represented in the NCT standards. For example, states like Hawaii and Oregon have large groups of people residing under the Compact of Free Association (COFA) who come from the Marshall Islands, Federated States of Micronesia and Palau. While Marshallese are included in the standards, other populations from COFA jurisdictions, such as those from the islands of Chuuk and Pohnpei of the Federated States of Micronesia are not. Surveys and programs collecting information specifically from regions with high COFA populations should add those options under Native Hawaiian and Pacific Islander as such data can assist federal agencies in tailoring their programs to the target audiences served.

We wish to note the important responsibility the federal government plays in the lives of people originating from COFA jurisdictions. Under COFA, the United States has exclusive military access to the regions under the compact jurisdictions, which are of great strategic importance. In exchange, residents of those countries, may freely reside and work in the United States without a visa. The federal government has a particular responsibility to ensure the well-being of these communities, whom are often not counted in most federal surveys. By adding the detailed check boxes and write-in examples,

¹ U.S. Census Bureau. 2015 National Content Test Race and Ethnicity Analysis Report. (2017), <https://www.census.gov/programs->

² U.S. Census Bureau. Population Projections. (2015), <http://www.census.gov/population/projections/data/national/2014/summarytables.html>

community groups and government agencies serving these populations will be able to better understand and address their needs.

OMB should issue guidelines emphasizing that these standards are the minimum categories and federal agencies can and should continue to go beyond them in their data collection where practicable. There are times when making a larger number of race and ethnicity options available both provides important data and would not be burdensome. For example, including a greater number of race and ethnicity categories available as selections or checkboxes in online surveys or digital program intake forms would result in lower level burden than on paper surveys. Agencies collecting data online should be expected, therefore, to collect data beyond the minimum standards we are recommending, where practicable.

Examples demonstrate the importance of collecting disaggregated data

Research has shown that disaggregated data on Asian and on Native Hawaiian and Pacific Islander populations have an important and meaningful impact on how programs and services are made available to specific Asian and Native Hawaiian and Pacific Islander groups and in dispelling the “model minority” myth that all Asians are well-educated, wealthy, and healthy.³ This harmful stereotype masks the social and medical consequences faced by Asians and Native Hawaiian and Pacific Islanders experiencing disparities.⁴ For example:

- An analysis of U.S. Census and other available disaggregated data by the Asian American Center for Advancing Justice (now Asian Americans Advancing Justice) demonstrated differences in poverty, education, health insurance, and home ownership among Asian and Native Hawaiian and Pacific Islander groups.⁵
- A National Institutes of Health study found that, while overall cancer mortality for Asian and Native Hawaiian and Pacific Islander men was lower than non-Hispanic White men, cancer mortality rates were higher for Samoan (293.9 per 100,000 persons) and Native Hawaiian men (263.7 per 100,000 persons) than for non-Hispanic White men (241.3 per 100,000 persons) and for all other Asian groups.⁶
- Breast cancer rates vary widely among women by disaggregated Asian group and immigration status. While Asians as an aggregated group have some of the lowest rates in the United States; one study found breast cancer rates are higher among foreign-born Chinese women and Filipina women than White women.⁷

³ Linshi, J. The real problem when it comes to diversity and Asian-Americans. Time. Oct 14, 2014, <http://time.com/3475962/asian-american-diversity/>

⁴ Yi, SS, Kwon SC, Sacks R, Trinh-Shevrin C. Persistence and health-related consequences of the model minority stereotype for Asian Americans. *Ethn Dis*, 2016;26(1):133-138

⁵ Asian Pacific Center for Advancing Justice. A Community of Contrasts Asian Americans in the United States, (2011), http://www.advancingjustice.org/pdf/Community_of_Contrast.pdf

⁶ Miller BA, Chu KC, Hankey BF, Ries LA. Cancer incidence and mortality patterns among specific Asian and Pacific Islander populations in the U.S. *Cancer Causes Control*. 2008;19(3):227–256

⁷ Gomez, SL, Quach T, Horn-Ross PL, Pham JT, Cockburn M, Chang ET, Keegan THM, Glasser SL, Clarke CA. Hidden breast cancer disparities in Asian women: Disaggregating incidence rates by ethnicity and migrant status. *Am J Pub Health*. 2010;100(S1): S125-S131

- The University of Michigan Institute for Social Research found that Samoans and Tongans had higher rates of hypertension than Californians at large, smoked at about four times the rate of Californians, were less likely to have health insurance, and used available health care services at lower rates, relying heavily on emergency room care.⁸

These examples demonstrate the need for disaggregated data to identify and meet the needs of our diverse Asian and Native Hawaiian and Pacific Islander communities. Moreover, state agencies, as well as community-based organizations, also need disaggregated data to develop focused interventions and allocate resources appropriately to address the varying needs of Asian and Native Hawaiian and Pacific Islander groups. For example:

- A Federally Qualified Health Center that is an AAPCHO member, Asian Americans for Community Involvement in San Jose (AACI), learned through disaggregated data that Vietnamese women were at the greatest risk for cervical cancer, but had the lowest cervical cancer screening rates among Asian groups. AACI was then able to secure grant funding and collaborate with the University of California San Francisco to implement a culturally competent cervical cancer education program that increased cervical cancer screening among Vietnamese women.
- When New York City conducted an anti-smoking campaign, overall smoking rates dropped but rates among Asian Americans did not. A study using data from the REACH US Risk Factor Survey was able to identify differences among trends in different Asian groups, including gender trends. For example, Korean men had smoking rates twice that of Chinese men and three times that of Asian Indian men.⁹ Asian American advocacy groups and providers were able to use these data to work with the city Department of Health to better target their anti-smoking efforts.

When OMB last updated these standards in 1997, it required that federal departments and agencies collect and report separate data on Asians from Native Hawaiians and Pacific Islanders, rather than as a combined group. In doing so, and in examining other questions about race, OMB made numerous references to changing demographics and the need for data on smaller groups, such as Native Hawaiians, that were facing different experiences than the aggregated Asian and Pacific Islander classification revealed.ⁱⁱ For example, OMB noted differences in educational outcomes, income, and poverty between the two groups, not unlike the research cited above. It also considered the statistical methodology challenges with collecting data on smaller groups, but decided that disaggregation was both feasible and justified. It is for these same reasons that the standards should now be to require additional disaggregation of Asian and Native Hawaiian and Pacific Islander data.

The collection, analyses, use, reporting, and dissemination of disaggregated race and ethnicity data has increased at the federal level.

OMB's 2012 Statistical Policy Working Paper found that it was common for federal departments and agencies to collect, analyze, use, report, and disseminate disaggregated Asian and Native Hawaiian and Pacific Islander data in meaningful ways:

⁸ Panapasa, S. Health Disparities in Two Pacific Islander Populations in California (2016), <http://www.ns.umich.edu/new/releases/24748-survey-finds-health-disparities-in-two-pacific-islander-populations>

⁹ Li, Shijan et al. Smoking Among Asian Americans: Acculturation and Gender in the Context of Tobacco Control Policies In New York City. *Health Promot Pract.* 2013; 14: 18S.

- Data from the Census 2010 Summary File 2 identify 47 Asian and 43 Native Hawaiian and Pacific Islander groups; the 2010 decennial census included disaggregated classifications for 6 Asian groups and 4 Native Hawaiian and Pacific Islander groups.
- The American Community Survey utilizes multi-year estimates to provide more detailed information about race and ethnic groups.
- The Department of Labor uses the Current Population Survey to collect and releases annual information on labor trends for specific Asian groups including Asian Indians, Chinese, Filipinos, Japanese, Koreans, and Vietnamese. They survey uses multi-year estimates to provide more detailed information.
- The National Health Interview Survey asks specifically about 6 Asian groups and 3 Native Hawaiian and Pacific Islander groups. The survey utilizes oversampling and multi-year pooling techniques to report on smaller groups
- The Department of Health and Human Services (HHS) has recommended using 6 Asian and 3 Native Hawaiian and Pacific Islander groups in federal health surveys; HHS’ implementation guidance states that “While data alone will not reduce disparities, it can be foundational to our efforts to understand the causes, design effective responses, and evaluate our progress.”¹⁰
- The HHS Office of the National Coordinator for Health Information Technology 2015 certification requirements for health information technology requires that electronic health records have the capability to use the Centers for Disease Control and Prevention (CDC) Race and Ethnicity Code Set, which contains 921 detailed races and ethnicities.¹¹

The federal government has prioritized the use of disaggregated data.

The federal government has consistently recognized that racial and ethnic disparities, such as in health care, are some of the greatest public policy problems facing our country, creating both a human and economic toll. Many agencies have identified the lack of consistent, accurate data as a major barrier to addressing expensive disparities. By adopting the Census NCT optimal question format and requiring that agencies use it as a threshold for data collection, OMB would ensure the level of data consistency that currently does not exist within the federal government, but is necessary to achieving equity in public policies and government services.

For example, the CMS Equity Plan for Improving Quality in Medicare, the Centers for Medicare & Medicaid Services Office of Minority Health states that the “comprehensive patient data, including race, ethnicity, language... are required to plan for quality improvements, and to address changes

¹⁰ U.S. Department of Health and Human Services, Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status (2011), accessed at <https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status>

¹¹ Office of National Coordinator for Health Information Technology, 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule, 80 Fed. Reg. 62602-62759, October 16, 2015, <https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25597.pdf>

among the target populations over time.”¹² The CMS National Quality Strategy, for goals 1 and 6, includes the collection of quality race and ethnicity data in its foundational principles.¹³ The 2018 Medicare Final Call Letter notes that, “CMS also expects MAOs to analyze enrollee data to identify disparities among their enrollees and undertake quality improvement and outreach activities to increase enrollee engagement so that appropriate care, including preventive services, can be provided to enrollees who have been identified as having worse health outcomes.”¹⁴

The Department of Education has provided grants to state education agencies to collect and analyze disaggregated data on English learner Asian and Native Hawaiian and Pacific Islander groups.ⁱⁱⁱ In response to a Request for Information on the use of disaggregated Asian and Native Hawaiian and Pacific Islander student data in school planning and programming, the Department of Education received over 700 comments, overwhelmingly in support of data desegregation.^{iv}

The collection, analyses, use, reporting, and dissemination of disaggregated race and ethnicity data is also increasingly common at the state level.

Strong standards that include disaggregated racial classifications also are emerging at the state level. Oregon requires data collection and intake forms to include 9 Asian and 3 Native Hawaiian and Pacific Islander groups. In addition, all covered programs must report biannually on progress, challenges and plans for addressing challenges in implementing the standards.¹⁵ California recently passed a law strengthening its data disaggregation requirements for its Department of Public Health, Department of Fair Employment and Housing, and Department of Industrial Relations, adding 8 Asian and 2 Pacific Islander groups.¹⁶ New York City passed a resolution in 2016 requiring agencies collect data on the city’s top 30 ethnicities and language speakers.¹⁷ The Hawaii Department of Education reports on students and teachers using 7 Asian and 7 Native Hawaiian and Pacific Islander groups.¹⁸ This year, the state of Washington’s Healthy Youth Survey started collecting disaggregated data on Asian students, to reflect its diverse and growing population.¹⁹

¹² Centers for Medicare & Medicaid Services Office of Minority Health. The CMS Equity Plan for Improving Quality in Medicare. (2015), https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf

¹³ Centers for Medicare and Medicaid Services. CMS Quality Strategy. (2016), <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf>

¹⁴ Centers for Medicare and Medicaid Services. Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information. (2017), <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf>

¹⁵ Oregon Health Authority Office Of Equity And Inclusion, Race, Ethnicity, Language, And Disability Demographic Data Collection Standards, <http://www.oregon.gov/oha/oei/policyprocedures/Race%20Ethnicity%20Language%20Disability%20Data%20Collection%20Standards.pdf>

¹⁶ California Assembly Bill 1726 (2016), http://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1726

¹⁷ Intro 251-A. New York City Council, <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=1709693&GUID=DF6A0998-A600-43B1-96FD-8C3F91F3A7B5>

¹⁸ Hawaii State Department of Education, 2015 Superintendent's 26th Annual Report Data Tables (2015), http://arch.k12.hi.us/PDFs/state/superintendent_report/2015/2015AppendixCDataTbl.pdf

¹⁹ Washington State Commission on Asian Pacific American Affairs, 2016 Healthy Youth Survey to begin collecting disaggregated data on Asian American youth, October 14, 2016, <http://capaa.wa.gov/2016-healthy-youth-survey-to-begin-collecting-disaggregated-data-on-asian-american-youth/>



New York City’s legislative findings included in the 2016 resolution state “...Existing data often do not provide City government and others with full information about the demographics of the individuals served by City agencies. Detailed information about the ancestral/ethnic and linguistic makeup of an agency’s client population can help agencies and community organizations to make ongoing adjustments to their outreach and service delivery models. This legislation will help the City and its partners to better understand and serve residents of all backgrounds and identities.”²⁰

If OMB adopts standards that require the collection of disaggregated data, state and local governments that already require this collection will see reductions in complexity of implementation, both as they benefit from being able to follow the best practices laid out by OMB and because their data systems will match the federal government’s.

We also wish to note that national data provides insights that state and local data do not, and that state efforts cannot substitute for federal disaggregation standards. It is important to understand trends of specific populations throughout the entire country so that targeted efforts can be undertaken to assist them. For example, Kevin Nadal, professor of psychology at the City University of New York and President of the Asian American Psychological Association, testifying in favor of New York City’s data standards bill, stated that the “disaggregated data that does exist tends to focus on Asian Americans on the West Coast, which are often not generalizable to Asian Americans on the East Coast.”²¹

The lack of disaggregated data has hampered efforts to further the public good

We have consistently heard from our partners working directly to reduce health disparities and improve public health how the lack of disaggregated data from surveys and programs has hampered their efforts. Following, are some examples of how their experiences have played out.

Currently, there is no health data available for Vietnamese community in the Gulf Coast nor they are being collected at the local health department and Federal Qualified Health Centers. When BPSOS, a community based organization working in Mississippi and Alabama, applied for funding to address the health issues and needs in our community, they were forced to rely on anecdotal and self-reported information as evidence. In many cases, their proposals got rejected because they could not provide statistics and data to substantiate the issues and problems. Their most recent proposal to Aetna addressing cardiovascular diseases (education, prevention and treatment) was rejected because they did not have any relevant data for Vietnamese American in Mobile County. Furthermore, because of lack of critical health data, they are often hesitant to apply for any funding opportunities even if we know the issues are rampant.

HOPE Clinic in Houston, TX, another AAPCHO member, wants to better understand cancer data on Asian groups in order to better serve their clients and improve health care outcomes. Yet

²⁰ Intro 251-A. New York City Council, <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=1709693&GUID=DF6A0998-A600-43B1-96FD-8C3F91F3A7B5>

²¹ Kevin Nadal. Testimony before the New York City Council - Joint Hearing of the Governmental Operations and General Welfare Committees. May 11, 2015, <http://legistar.council.nyc.gov/View.ashx?M=F&ID=3754113&GUID=2543CD89-617C-4695-87B1-B7CEC8D73225>



because the data they have found usually does not disaggregate Asian groups, they have had trouble identifying the specialized issues faced by specific groups, particularly around specific types of cancer. They have started to sample their own client intake data, but because it is limited to their service area, it is limited. While they would be able to have broader conclusions from broader data, they have been able to bring more resources to their community by highlighting trends in their own data.

It is difficult for groups and agencies working to provide services to or conduct research on specific Asian & NHPI populations to receive funding without sufficient data that can be used to justify the need for that work. In the experience of our partners and our own experience, access to both private and public resources are constrained for groups because the data often does not exist. For example, APIAHF analysis of CDC funding profiles found that only 24 of the agency's 8,679 available grants were awarded to organizations focusing on Asian and NHPI communities.²²

Minimizing cost and burden and factors in feasibility

The notice requests comments on the costs and benefits of requiring federal agencies to collect disaggregated data. The important benefits to government programs, communities, researchers, and advocates, described above, outweigh costs and burdens to implementing agencies. Indeed, we echo the comments of Asian Americans Advancing Justice | AAJC that NOT collecting disaggregated data would result in a burden to communities, researchers, advocates and policy makers.

Technical assistance can support implementation of changes.

We also trust that OMB can work with agencies to provide assistance to support implementation of any changes to these standards. It took several years to adopt the 1997 changes to the standards and we expect a similar incremental adoption of these proposed changes. Adding additional disaggregated categories also should not be viewed in isolation. If the other working group recommendations to combine the race and ethnicity question and create a new MENA category are adopted, then many federal departments and agencies would already be making changes to their data collection and reporting systems. Adding disaggregated data checkboxes would not present as a substantial incremental cost or burden when all these changes are made together.

We recommend, in terms of prioritization and minimization of burden and cost, the government apply the new Census National Content Test optimal question format to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys when they are next updated. At least four of the most common surveys, the health plan commercial, health plan Medicaid, clinician and group, and hospital CAHPS surveys use the current OMB standards but do not ask for disaggregated Asian or NHPI groups. Such knowledge is important both for individual providers, to ensure their services are available to all groups, as well as for researchers, government agencies and advocates wishing to understand whether the diverse needs of Asian and NHPI subgroups are being met by providers. Since these CAHPS surveys are on a regular cycle for updates, the additional disaggregated categories should be added in the next updates.

²² Centers for Disease Control and Prevention. Grant Funding Profiles. 2017. <https://wwwn.cdc.gov/FundingProfilesApp/>

We also would prioritize collection and reporting of the Census National Content Test optimal question format for the following surveys and data collection instruments, which, from our experience and that of researchers working on Asian & NHPI issues, would be important for identifying trends in specific groups:

- All Census administered surveys, such as the American Community Survey and the Current Population Survey.
- The National Health Interview Survey, which currently already collects data on six Asian groups but only three NHPI groups.
- The Integrated Postsecondary Education Data System
- The Youth Risk Behavior Surveillance System
- The National Notifiable Disease Surveillance System
- The Pregnancy Risk Assessment Monitoring System
- The National Crime Victimization Survey

Current burdens fall on community groups

Currently, because of the lack of disaggregated data for the populations they serve, many community groups undertake time consuming and expensive data collections of their own. Because these groups typically lack the expertise on statistical services, they must put greater relative resources into data collection efforts than government agencies that are already engaging in data collection. The expense and time put towards these custom efforts are certainly a less good use of resources than the services they might be providing. OMB should consider the reduction in the burden on community based organizations when considering any new responsibilities for government agencies.

In Illinois, the Asian Health Coalition, an AAPCHO member, found the lack of disaggregated data masks the diversity of health outcomes, disease burdens, and health disparities within and across the Asian American and Pacific Islander (AAPI) population. In their words, “Having information on the health status and needs of specific subgroups would allow policymakers, health planners, and community-based organizations (CBOs) to develop more effective and targeted health programs and policies, thereby improving health outcomes and reducing disparities within each distinct AAPI community.” In response, they conducted a comprehensive assessment of the health needs, determinants of morbidity and mortality, and health care access patterns of three AAPI communities in Chicago. The survey found public health programs were not tailored to meet the cultural and linguistic needs of many AAPI communities.²³ The survey consumed around \$100,000 in resources and the equivalent of two dedicated full time employees.

Community groups that provide health services, such as clinics, will also benefit from the enhanced standards. Many health centers that provide services to diverse populations already track detailed origin, race, and ethnicity data during their client intake process. For example, when Asian Health Services in Oakland, CA started tracking their clients’ health outcomes by detailed race, because information was not otherwise available on local health trends at that level, they found higher smoking rates for Korean and Vietnamese immigrant men, higher hepatitis B rates for Chinese and Vietnamese

²³ Asian Health Coalition of Illinois. Chicago Asian Community Surveys: A Comprehensive Report. (2010), . https://www.dropbox.com/s/4fpr9ym7i6wh8c9/AHC_CACS_2010.pdf?dl=0

patients, and high levels of diabetes among their overall Chinese population. However, health centers do not have a standardized set of detailed checkboxes or guidelines for guidance and therefore different health centers may not collect race and ethnicity data the same way. While the OMB standards do not apply to the type of data that federally qualified health centers report, they will, along with guidance, provide a resource for these centers.

Reduction in burden on survey tabulation and analysis

We acknowledge that adding additional check boxes may lead to some initial upfront costs in system upgrades and new paper in non-digital data collection. Yet, there is reason to believe the federal government will save money in the long term by avoiding the costs already associated with the current standards and lack of detailed data collection.

Some surveys have fill-in-the-blanks options for race and ethnicity. Adding check boxes not only encourages more self-identification, as found in the Census National Contest Test, but it reduces the costs in determining the intent and correct categorization of potentially unclear or illegible write in responses. More check boxes that increase the likelihood that respondents will see categories that they identify with, such as the top six Asian and NHPI populations that we recommend OMB adopt, reduce the likelihood that they will use write-in answers. For example, Ninez Ponce, PhD, MPP, Principal Investigator, California Health Interview Survey (CHIS), University of California Los Angeles Center for Health Policy Research, told APIAHF the following, “for a diverse state as California, expanding racial/ethnic categories in surveys acknowledges a greater range of cultural identities, increases the quality of representation in surveys, AND facilitates data processing savings. For CHIS, it actually costs more to code open-ended ‘Other specify’ responses than to create pre-specified response categories for race and ethnicity.”

Furthermore, standardizing the collection of detailed race and ethnicity data will provide consistency across federal data collection, reducing costs and complexities in comparing responses across programs and surveys. Currently, there is no standard format for which detailed checkboxes agencies should utilize, adding complications to researchers using multiple datasets in studies. Requiring a minimum six checkboxes, along with a write-in with consistent examples, will increase reliability of federal race and ethnicity data. For national standardization and consistency, we also encourage OMB to issue guidance to state and local agencies that are not subject to federal government standards (such as state agencies administering vital records) recommending they follow the new standards.

Federal agencies and OMB have the potential to consider methods of tabulating survey and other data collections in ways that further reduce any burdens. For example, New York City is implementing its standards by using one standardized race and ethnicity data collection form, both for written and digital data collections. This form is processed by the mayor’s office as a way to centralize reporting processes and reduce the implementation costs for agencies required to collect detailed data. Because there is one form with one method of processing data, costs are less. The city plans to have its standards fully implemented within a year. While this method may be difficult to replicate for the entire federal government, it demonstrates that there are creative processes OMB can consider when evaluating any burdens of requiring collection of disaggregated data.



Data collection supports compliance with federal civil rights laws.

In addition, we echo the comments of the Leadership Conference on Civil and Human rights that our nation must have the most effective and updated tools to investigate and enforce civil rights laws. Discrimination takes an uncountable toll on human lives in everything from housing to voting rights to health care. By collecting detailed data, federal agencies will be better equipped to protect the civil rights of our increasing diverse country.

In summary, OMB should require ALL federal departments and agencies, when collecting, analyzing, using, reporting, and disseminating data on race or ethnicity, to collect, analyze, use, report, and disseminate disaggregated data for Asian and Native Hawaiian and Pacific Islander groups using the U.S. Census Bureau 2015 National Content Testing disaggregated classifications.

Combined Question to Collect Race and Ethnicity Data

The Census Bureau's 2015 National Content Test provides evidence for maximizing the response rates to race and ethnicity questions through changes in phrasing. Asians and Native Hawaiians and Pacific Islanders self-identified more often when they were posed a question that presented combined race and ethnicity.^v Based on the results of the 2015 National Content Test, we support the combined race and ethnicity question because it increases the rates of Asian and Native Hawaiian and Pacific Islander participation and self-identification. We also support the combined question because it appears to, broadly, better align with people's preferences and concepts of identity.

However, we urge OMB to also issue complementary guidance on the wording and instructions accompanying the race and ethnicity question. Respondents should clearly understand they may check as many boxes as they feel they personally identify with. OMB should also consider advising agencies that different people may interpret the words "race" and "ethnicity" differently and that question wording should be as inclusive as possible.

A Distinct Middle Eastern and North African Classification

We echo the comments of the National Network for Arab American Communities in favor of establishing a new Middle Eastern and North African (MENA) group and reporting category. Currently, people from this population must select one of the current five race categories, regardless of their how they self-identify. The MENA population has a distinguishable community and background that warrants identification in federal surveys. As the 2015 Census National Content Test showed, many people who are of MENA origins select the category when given the option, suggesting a significant population that has not been able to identify itself. Current standards do not allow federal agencies to identify the unique issues faced by this population and adequately serve them. Creating this category would allow agencies, as well as community-based organizations, to identify instances of discrimination, better address hate crimes, and prioritize health and social services programs. **Therefore, we urge OMB to establish the new MENA category in revising the standards.**



Updates to Terminology Used for Race and Ethnicity Classifications

We strongly urge OMB to change the terminology for Native Hawaiian and Pacific Islander populations. We strongly urge changing the terminology in the standards to “Native Hawaiian and Pacific Islanders” rather than the current “Native Hawaiian and Other Pacific Islander.” We developed this position with the Native Hawaiian & Pacific Islander Alliance.²⁴ This terminology reflects the common wording used by the NHPI community. We also support ending the use of the term “Guamanian” and using “Chamorro”.

We support the removal of the term “Far East” from the standards. This term is not in common use, many consider it offensive and it should not be used in any federal data collection.

We support the proposal to end the use of a “principal minority race” as a designation in the standards. As the diversity of the U.S. population continues to increase, agencies must adopt standards of reporting out at least all the OMB minimum categories, unless unable to for statistical significance or privacy and confidentiality reasons, in which case agencies should clearly and publically justify such exclusions. When combined, Asians and Native Hawaiians and Pacific Islanders are the “majority” populations in the state of Hawaii. Communities of color are the majority populations in the state of California. Demographics have significantly changed over the past twenty years. Asians are the fastest growing race group in the United States, with 43% growth between the 2000 and 2010 Censuses.²⁵ The difference in changes over time among Asian groups illustrates both the need for disaggregated data and the need for reconsideration of terminology. For example, between the two Censuses, the Bhutanese population experienced a nearly 1000% increase while the Japanese population decreased. The Native Hawaiian and Pacific Islander population also grew rapidly between 2000 and 2010 at 35%, more than three times faster than the U.S. population as a whole.²⁶

Best Practices in Collecting Race and Ethnicity Data

In addition to collecting higher quality data, we urge OMB and all agencies involved in data collection to continue to follow best practices in stakeholder engagement and confidentiality and privacy. When collecting this data, agencies would be best served to partner with community groups with connections to diverse populations in order to ensure respondents understand the purpose of the data collection. Community groups are able to explain the importance of race and ethnicity data. In addition, data collections should have clear information on the purpose and uses for which the data will be used, as well as descriptions of the steps agencies take to protect respondent privacy and confidentiality.

We have been waiting for the opportunity to provide comment on this rule for a long time, as it would have a great impact on the communities that we serve. Asian Americans and Pacific Islanders, according to our classifications, hail from 32 Asian countries and around 23 Pacific Islands, and there

²⁴ Native Hawaiian & Pacific Islander Alliance and the Asian & Pacific Islander American Health Forum, Guidance on the Classification of Native Hawaiian and Pacific Islanders (2008),

http://www.apiahf.org/sites/default/files/NHPI_Healthbrief0131_2008.pdf

²⁵ U.S. Census Bureau, 2010 Census Briefs, The Asian Population: 2010 (2012),

<https://www.census.gov/prod/cen2010/briefs/c2010br-11.pdf>

²⁶ U.S. Census Bureau, 2010 Census Briefs, The Native Hawaiian and Other Pacific Islander Population: 2010 (2012),

<http://www.census.gov/prod/cen2010/briefs/c2010br-12.pdf>



are more than 20 Middle Eastern and North African countries. Helping to accurately assess how persons from different backgrounds and cultures are represented in health, labor, education, etc. will help us to gain a better picture of how best to allocate resources to address barriers that populations are facing, or reallocate funds, if some populations are doing better than others, to help those who really need essential services and dedicated programs.

Thank you again for the opportunity to provide comments on the proposed changes to the standards. Please direct any questions about our comments to Isha Weerasinghe, AAPCHO's Director of Policy and Advocacy, at isha@aapcho.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Isha Weerasinghe", is written over a light yellow rectangular background.

Isha Weerasinghe
Director of Policy and Advocacy
Association of Asian Pacific Community Health Organizations (AAPCHO)

ⁱ (U.S. Census Bureau, 2015 National Content Test Race and Ethnicity Analysis Report, Table 14 and Table H39
ⁱⁱ Office of Management and Budget. Recommendations from the Interagency Committee for the Review of the Racial and Ethnic Standards to the Office of Management and Budget Concerning Changes to the Standards for the Classification of Federal Data on Race and Ethnicity. 62 Fed. Reg. 36874-36946, July 7, 1997, accessed at: <https://www.gpo.gov/fdsys/pkg/FR-1997-07-09/pdf/97-17664.pdf>
ⁱⁱⁱ U.S. Department of Education, Asian American and Pacific Islander Data Disaggregation Initiative Frequently Asked Questions, accessed at: <http://www2.ed.gov/programs/d2/faq.html>
^{iv} U.S. Department of Education, Request for Information To Gather Technical Expertise Pertaining to the Disaggregation of Asian and Native Hawaiian and Other Pacific Islander Student Data and the Use of Those Data in Planning and Programmatic Endeavors. 77 Fed. Reg. 26531-26534, May 2, 2012, accessed at: <https://www.gpo.gov/fdsys/pkg/FR-2012-05-04/pdf/2012-10835.pdf>
^v U.S. Census Bureau, 2015 National Content Test Preliminary Results on Race and Ethnicity, 2016, accessed at: <http://www2.census.gov/cac/nac/meetings/2016-10/2016-nac-jones.pdf>