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October 26, 2016

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1800 G St
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Submitted at: www.regulations.gov

RE: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Docket No. OMB 2016-23672

Dear Ms. Wallman,

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to offer comments related to maintaining, collecting, and presenting federal data on race and ethnicity. The AAMC is a not-for-profit association representing all 145 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC represents nearly 160,000 faculty members, 83,000 medical students, 115,000 resident physicians, and thousands of graduate students and postdoctoral trainees in the biomedical sciences.

The AAMC recognizes that health and health care disparities arise from conditions in which people are born, live, work and age. These disparities are persistent in certain populations such as racial/ethnic subgroups, the elderly, veterans, individuals from lower socioeconomic status backgrounds, and lesbian, gay, bisexual, and transgender (LGBT) and rural populations. Ensuring that federal efforts to collect and present race and ethnicity data allow for the valid identification of inequities between racial/ethnic subgroups is crucial to developing interventions aimed at closing health and health care gaps. The AAMC applauds the Office of Management and Budget's (OMB) current efforts to partially revise its data collection standards to ensure the validity and utility of the demographic information captured.

The AAMC appreciates OMB's guiding principles for race/ethnicity data collection used to frame the initial 1977 standard and subsequent 1997 revision, particularly those related to issues of administrative burden and support for on-going trend analyses. Any revision to the current standard should not only avoid overburdening federal agencies charged with gathering relevant data, but also avoid overburdening other entities —such as institutions of higher learning and healthcare facilities—that often align their own demographic data collection efforts with the OMB standard. Similarly, in service of moving our nation toward health and health care equity, it is imperative that any revision to the current standard permits analyses of time trends as a means to assess changes in racial/ethnic health and health care gaps prospectively.

With those guiding principles in mind, the AAMC is pleased to offer the following comments:

The AAMC supports the current proposal to utilize one combined race/ethnicity question instead of two separate questions. The 2010 Census Race and Hispanic Origin Alternative Questionnaire Experiment and qualitative follow-up revealed that a combined question facilitated self-identification for Hispanic/Latino respondents. Specifically, utilization of one race/ethnicity question resulted in significant decreases in the proportion of respondents choosing "Other" or "White race alone," changes attributed to Hispanic respondents' finding their identity in the combined question. The AAMC saw similar decreases in "White race alone" reporting when it switched to a combined race/ethnicity question format for its surveys and administrative data collections in 2013. Any revision to the current standard that allows respondents to more readily and accurately self-identify their race/ethnicity should be pursued. Additionally, **we urge OMB to provide guidance related to the presentation and interpretation of trend analyses given that changes in "Other" and "White" reporting will be an artifact of the survey methodology and not necessarily a result of demographic shifts**.

Data the AAMC collects on medical school aspirants indicate approximately 2.2% of medical school applicants in 2014 and 2015 selected "Other" for their race and wrote in a country of origin indicative of Middle Eastern / North African (MENA) self-identity, representing a significant proportion. **The AAMC therefore supports the creation of a separate subcategory for MENA respondents**, a group currently aggregated into the "White" race category. Recent literature identifies significant health and health care inequities for Americans of Middle Eastern and North African descent.[1] However, the evidence base documenting these inequities is relatively sparse,[2] in part due to a lack of robust data collection efforts. In order to accelerate the documentation of disparities germane to this population with the aim of successfully intervening, it is imperative individuals from the Middle East and North Africa be able to "find themselves" in the OMB standard and to select a racial/ethnic category that most adequately reflects their self-identity. Given the aforementioned principle of supporting trend analyses, the AAMC understands that MENA populations will still be aggregated into the White race category for certain analyses. In support of transparency, **we urge OMB to make it clear to MENA respondents, via appropriate survey response category design, that such aggregation will occur for some analyses.**

Relatedly, **AAMC supports OMB's efforts to clarify that the minimum set of racial and ethnic categories for use when collecting or presenting such data does not limit agencies from gathering more granular race/ethnicity data,** provided those additional subgroups can

[1] Padela, A. I., Raza, Afrah. (2014). American Muslim Health Disparities: The State of the Medline Literature. *Journal of Health Disparities Research and Practice, 8*(1), 1-9.

[2] Killawi, A., Heisler, M., Hamid, H., & Padela, A. I. (2015). Using CBPR for Health Research in American Muslim Mosque Communities. [Article]. *Progress in Community Health Partnerships-Research Education and Action, 9*(1), 65-74.

be aggregated into the minimum set when required. Race/ethnicity categories such as "Asian American" are composites of many smaller subgroups (e.g. Chinese Americans, Korean Americans, etc.) between which there might also be significant differences in health outcomes, education, etc. Such differences will be missed if agencies only adopt the minimum set of categories.

Finally, **the AAMC supports the abandonment of the "principal minority race" category** currently in use and reserved for "Black or African Americans." The continued use of the category permits in certain circumstances the presentation of the "White" category, the "Black / African American" category, and an "All other races" category. Significant differences might, however, exist between groups aggregated into the "All other races" category (i.e. Asian Americans, Native Americans, Hispanics/Latinos, etc.), thereby impeding our ability to identify salient inequities. In service of detecting subgroup differences with the aim of developing needed interventions, use of "All other races" as a reporting category should be discontinued in instances where the sample sizes of racial/ethnic subgroups permit more detailed reporting. Should OMB choose to maintain use of the "principal minority race" designation, revision of the designee might be in order: current United States Census estimates show that while roughly 13% of Americans identify as "Black or African American alone", 17% self-identify as "Hispanic or Latino."

As OMB contemplates these revisions, the AAMC encourages the office to develop standards around other demographic data collection for groups not represented in the current standard, such as LGBT populations. Standardizing federal data collection efforts of sexual orientation and gender identity data would accelerate our nation's ability to address health and health care inequities for LGBT groups.

The AAMC appreciates the opportunity to comment to the OMB on this issue, and would be happy to provide any further information that would be of use. Please contact me or my colleague, Philip M. Alberti, Ph.D. (palberti@aamc.org), with any questions about these comments.

Sincerely,

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Chief Scientific Officer