

Acculturation Measures in HHS Data Collections

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Acculturation

- Described as the constant interaction between two distinct and independent cultures that results in individuals and groups modifying behaviors native to their country of origin (Berry et al, 2005)
- Acculturation is a differential process of change in knowledge, attitudes, values and practices that does not take place at the same rate or to the same extent for all individuals and populations (Wallace, 2010)
- Associations between race, ethnicity, and acculturation status and health
- Acculturation also as consideration for the development of culturally tailored health programs and services



Acculturation Measures in HHS Surveys (Proxies)

- Language
 - English proficiency
 - Language of interview
- Country of origin
- U.S. born/non-U.S. born
- Generational status (e.g., 1st, 2nd, and 3rd generation)
- Length of time in US
- No acculturation scales
- May not be collected consistently



EXAMPLES OF HHS DATA SYSTEMS



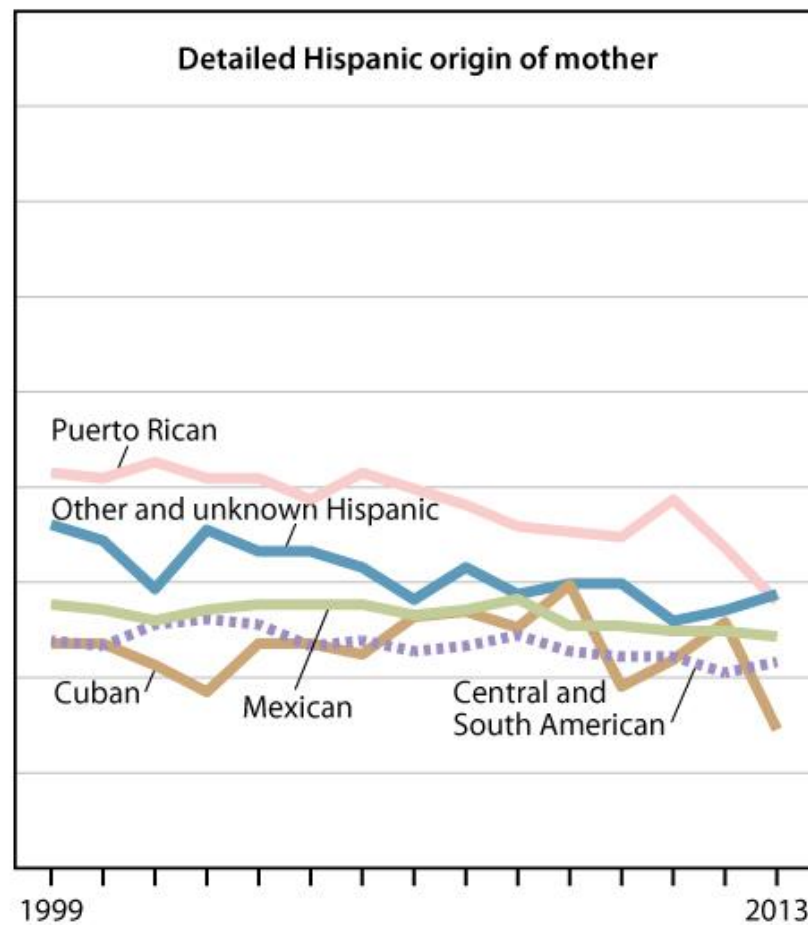
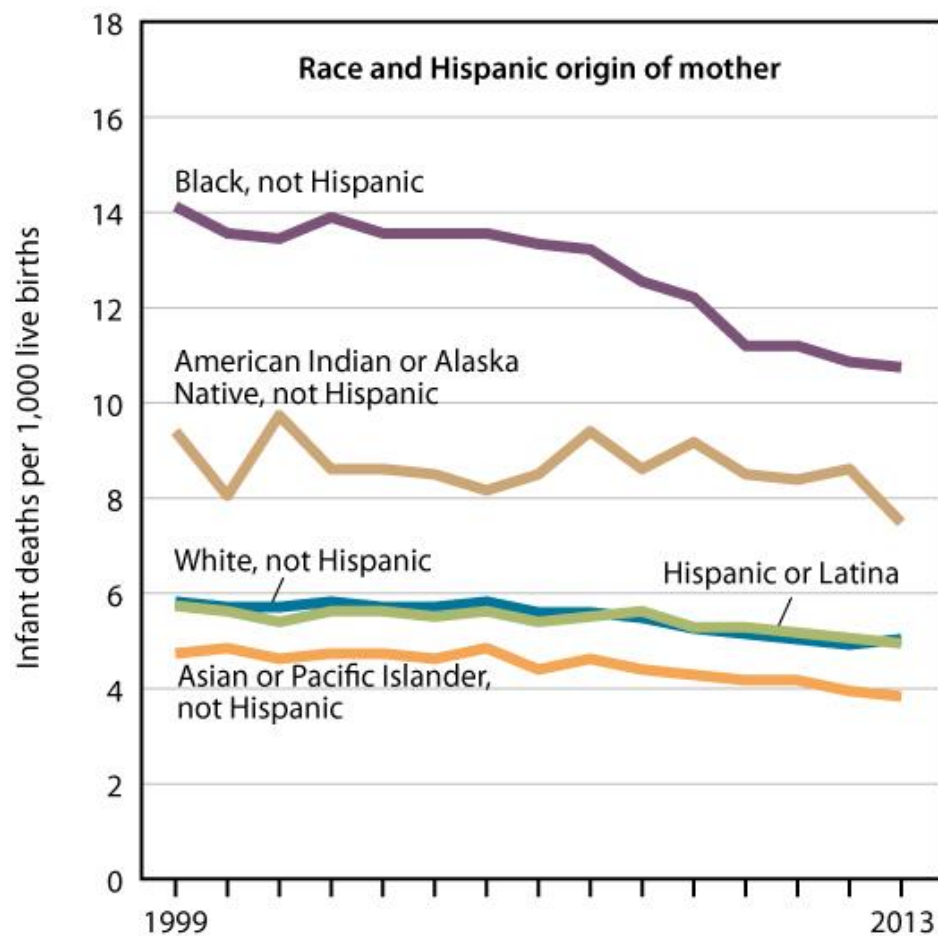
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Acculturation Data in HHS Data Systems

- National Vital Statistics System (NVSS)
 - Sponsored by: National Center for Health Statistics, Centers for Disease Control and Prevention (CDC)
 - Acculturation/immigration status measures: Decedent's nativity/immigrant status; maternal nativity status derived from place-of-birth variable
 - Advantage: Large number of vital records; race/ethnicity detail; geographic detail; long-term time trend; various health, mortality, and birth outcome measures



Infant Mortality



Source: National Vital Statistics System (NVSS)



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Acculturation Data in HHS Data Systems -continued

- National Linked Birth and Infant Death Files
 - Sponsor: National Center for Health Statistics, Centers for Disease Control and Prevention (CDC)
 - Acculturation/immigration measures: Mother's nativity/immigrant status
 - Advantages: Large population size; ethnic detail; extensive infant mortality analysis by age, cause of death, and medical risks

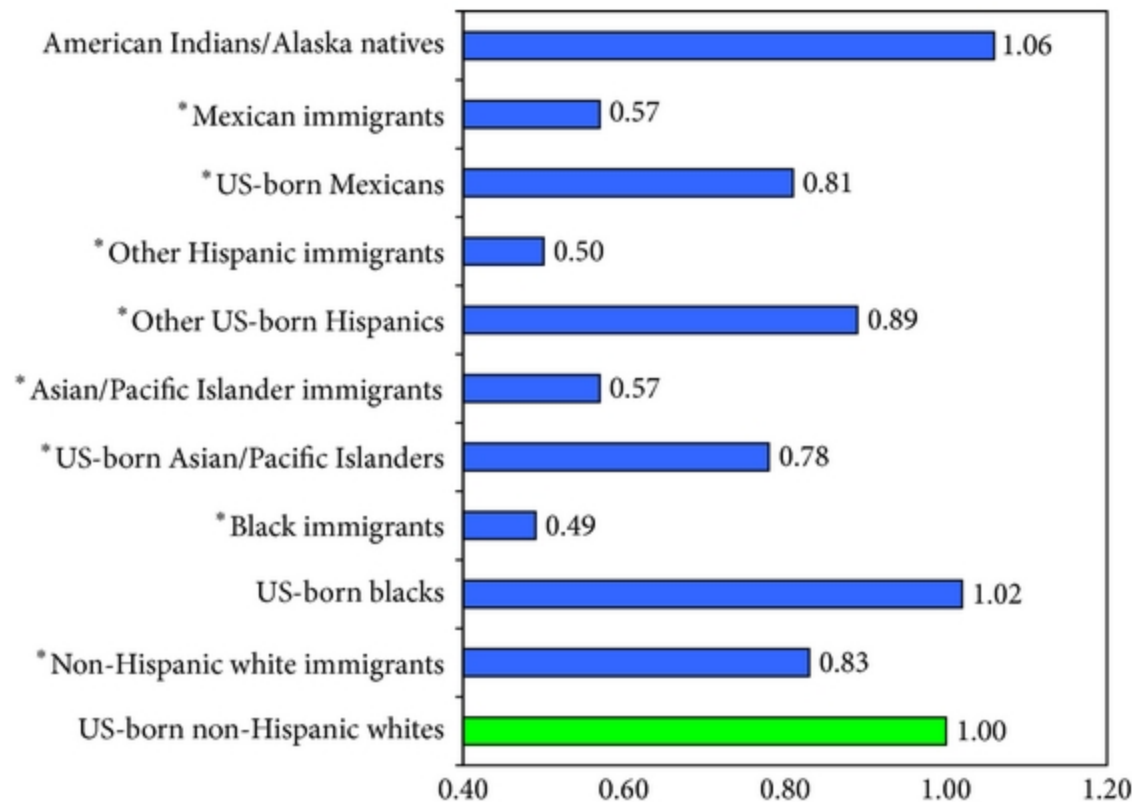


Acculturation Data in HHS Data Systems -continued

- National Longitudinal Mortality Study (NLMS)
 - Sponsor: National Institutes of Health, US Census Bureau and National Center for Health Statistics, CDC
 - Acculturation/immigration measures: Nativity/Immigrant status; country/region of birth
 - Advantages: Large sample size; self-reported race/ethnic detail; longitudinal; mortality by cause of death



Ethnic-immigrant differentials in US all-cause mortality



Source: The US National Longitudinal Mortality Study, 1980–1998 (N=304,594). Adjusted by Cox regression for age, sex, marital status, household size, education, family income, employment status, and rural/urban residence. . US-born non-Hispanic whites were the reference group. (Singh et al. 2013)



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Acculturation Data in HHS Data Systems -continued

- National Notifiable Disease Surveillance System (NNDSS)
 - Sponsor: Office of Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC)
 - Acculturation/immigration measures: It varies by specific disease or surveillance subsystem. For example, the Tuberculosis Surveillance System collects country of birth, year of arrival to the US, and country of birth for primary guardian(s), among others. For other notifiable diseases, no immigration variables are collected
 - Advantages: National system; race/ethnicity detail; geographic detail; long-term time trend; various health outcome measures



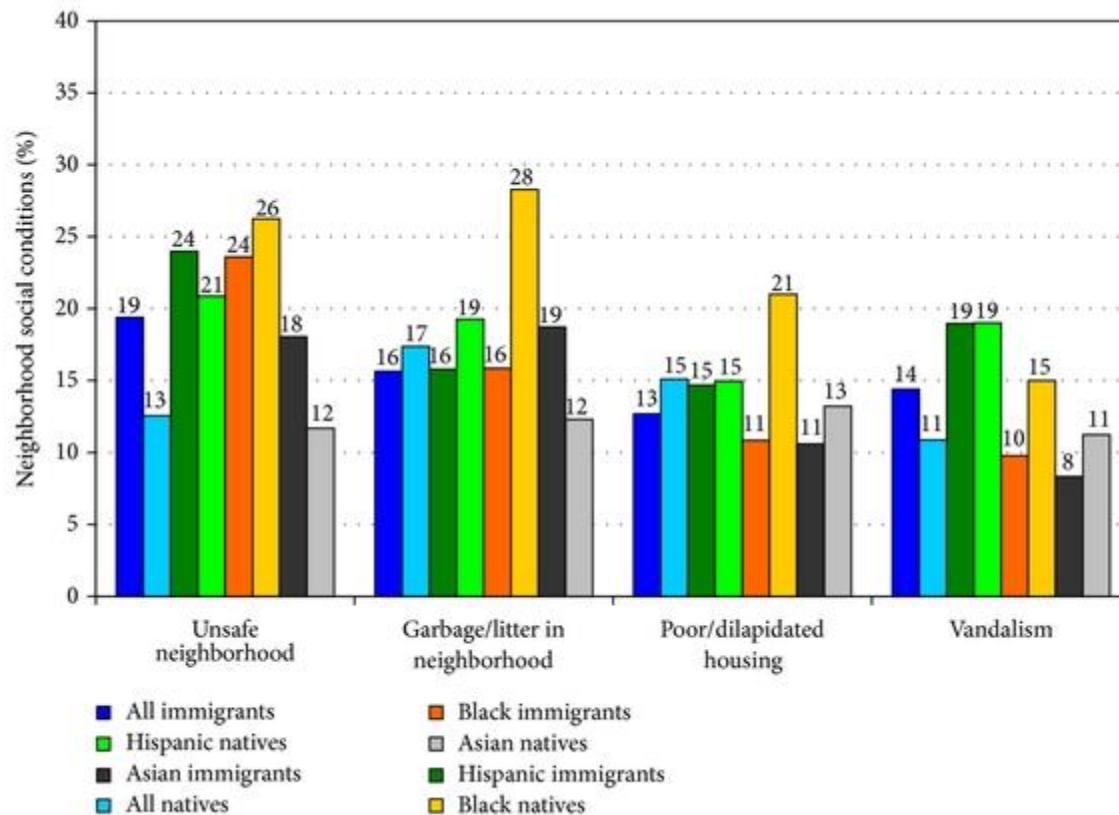
Acculturation Data in HHS Data Systems -continued

- National Survey of Children's Health (NSCH)
 - Sponsor: Health Resources and Services Administration (HRSA) and National Center for Health Statistics, CDC
 - Acculturation/immigration measures: Parents' and children's nativity/immigrant status; duration of residence in the US; English language proficiency
 - Advantages: Large sample size; state-specific analyses; large number of health and behavioral indicators



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Neighborhood environments for immigrant and native-born children, United States, 2007.



Source: The 2007 National Survey of Children's Health (N=91,642). Immigrant children: children of immigrant parents; native-born children: children of US-born parents. (Singh et al. 2013)



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Acculturation Data in HHS Data Systems -continued

- National Health Interview Survey (NHIS)
 - Sponsor: National Center for Health Statistics, Centers for Disease Control and Prevention (CDC)
 - Acculturation/immigration measures: Children's and adults' nativity/immigrant status; duration of residence in the US; naturalization status; English language proficiency
 - Advantages: Large sample size; race/ethnicity detail; long-term time trend; extensive socio-demographic, behavioral, health, and morbidity indicators





Demographic Characteristics and Health Behaviors among a Diverse Group of Adult Hispanic/Latino Males (Ages 18 to 64 years) in the United States

Data Brief No. 2

May 2015

Shondelle M. Wilson-Frederick, Ph.D.; Gloria González, Ph.D., M.A.; Chazeman S. Jackson, Ph.D., M.A.; Lacreisha N. Ejike-King, Ph.D., M.S. and Rashida R. Dorsey, Ph.D., M.P.H.

Background

Previous studies have shown sex differences in cardiovascular risk factors, such as hypertension prevalence and smoking rates among Hispanics/Latinos [1, 2]. However limited evidence exists on the varying health outcomes among diverse groups of adult Hispanic/Latino males. Hispanics/Latinos are a heterogeneous population; however analyses using national data sources are often limited by small sample sizes or only include few Hispanic/Latino groups. The growing proportion of the Hispanic/Latino population in the United States supports the importance of collecting and reporting detailed data for population groups.

With the implementation of Section 4302 of the Affordable Care Act, HHS adopted new data collection standards for race, ethnicity, sex, primary language and disability status that include additional granularity for race and Hispanic/Latino ethnicity [3]. More granular or detailed information on demographic data strengthen data collections by providing information on differential health needs and access to care that

Highlights

Among non-elderly Hispanic/Latino males, 78% of Puerto Ricans, 72% of Mexican Americans, 71% of Dominicans, 69% of Cuban Americans, and 68% of Central American and Caribbean Americans were

Less than half of the sample (40%), Puerto Rican (40%), Mexican American (35%), Dominican American (30%), Cuban American (30%), and Central American and Caribbean American males had a usual source of care.

Nearly four out of five (80%) of the sample, Dominican male, Mexican American, and Puerto Rican males were classified as never



Características Demográficas y Coportamiento en Materia de Salud de un Grupo Diverso de Varones Adultos (de 18 a 64 Años) Hispanos o Latinos en Estados Unidos

Resumen de Datos n.º 2

Mayo 2015

Shondelle M. Wilson-Frederick, Ph.D.; Gloria González, Ph.D., M.A.; Chazeman S. Jackson, Ph.D., M.A.; Lacreisha N. Ejike-King, Ph.D., M.S. y Rashida R. Dorsey, Ph.D., M.P.H.

Antecedentes

Estudios anteriores habían demostrado diferencias entre los sexos en relación con factores de riesgo cardiovascular, como la prevalencia de hipertensión y los índices de tabaquismo en los hispanos o latinos [1, 2]. Sin embargo, son limitadas las pruebas sobre los variados resultados de salud en grupos diversos de varones adultos hispanos o latinos. La población hispana o latina es muy heterogénea; sin embargo, los estudios que usan fuentes de datos nacionales suelen estar limitados por el tamaño pequeño de las muestras o porque incluyen pocos grupos hispanos o latinos. La creciente proporción de la población hispana o latina en Estados Unidos pone de relieve la importancia de recoger y divulgar datos detallados sobre los grupos de población.

En la aplicación del Artículo 4302 de la Ley de Cuidado de Salud a Bajo Precio, el HHS adoptó nuevas normas de recolección de datos sobre raza, etnia, sexo, idioma principal y situación de discapacidad que incluye mayores detalles sobre la raza y la etnia hispana o latina [3]. Una información demográfica más detallada fortalece la recolección de datos al

Datos destacados

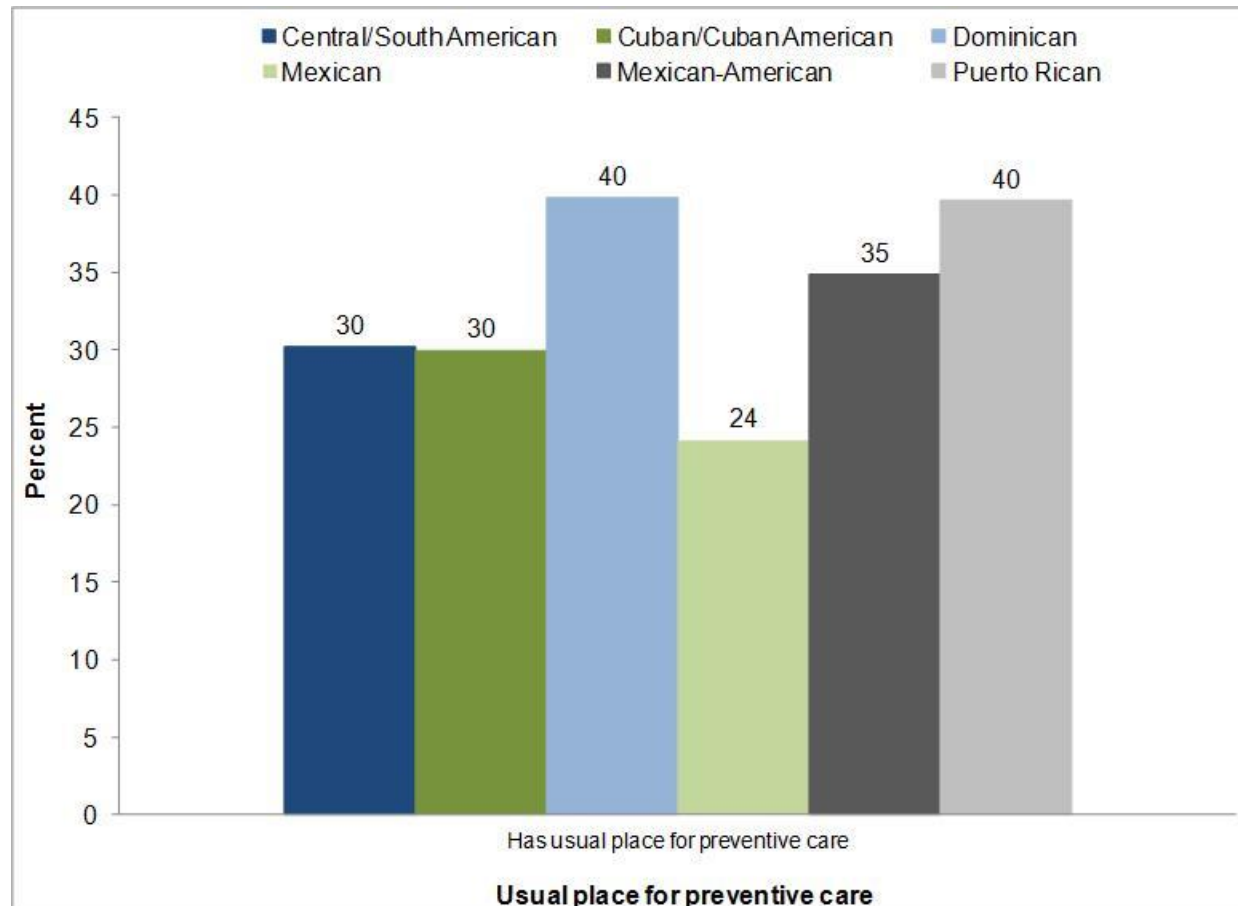
Entre los hombres hispanos o latinos no ancianos, se clasificaron como asegurados el 78% de los puertorriqueños, el 72% de los mexicanoamericanos, el 71% de los dominicanos, el 69% de los cubanos y cubanoamericanos y el 53% de los centroamericanos y sudamericanos.

Menos de la mitad de los hombres no ancianos dominicanos (40%), puertorriqueños (40%), mexicanoamericanos (35%), centroamericanos y sudamericanos (30%), cubanos y cubanoamericanos (30%) y mexicanos (24%) tenían un centro de atención preventiva habitual.

Casi cuatro de cada cinco hombres dominicanos no ancianos nunca fumaron (la proporción más alta de los seis grupos de hombres hispanos o latinos).

Source:
<https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=8#db>

Proportion of adult Hispanic/Latino males who have a usual place for preventive care (NHIS 2002-2012)



NOTE: Data are based on household interviews of a sample of the civilian non-institutionalized population. All prevalence estimates were age-adjusted to the 2000 U.S. population standard. Individuals who reported not obtaining preventive care anywhere or going to the emergency room for preventive care were classified as not having a usual place for preventive care.

Significant difference in having a usual place for preventive care among a diverse group of Hispanic/Latino males, $p < 0.001$

(Source: Wilson-Frederick SM et al. 2015)



Demographic and Health Characteristics among a Diverse Group of Adult Black Males in the United States: 2002-2012

Data Brief No. 5

November 2015

Shondelle M. Wilson-Frederick, Ph.D.; Juanita J. Chinn, Ph.D.;
Lacreisha N. Ejike-King, Ph.D., M.S. and Rashida R. Dorsey, Ph.D., M.P.H.

Background

Despite considerable efforts in recent years to reduce health disparities in the United States, non-Hispanic Black males (hereafter referred to as Black males) tend to experience greater adverse health outcomes relative to their racial and ethnic counterparts [1, 2]. Black males experience the lowest life expectancy at birth and are disproportionately impacted by chronic health conditions relative to other racial and ethnic or sex groups [3]. However, analyses often do not examine the impact of nativity on these observed health outcomes. To better understand the underlying factors that contribute to the disparate health outcomes in Black males in the United States, it is important to examine both U.S. born and foreign-born Black males.

Blacks in the United States are a diverse population that includes Caribbean, African, South and Central American immigrants as well as U.S.-born Blacks [4]. However, analyses typically report on measures of health and well-being among Blacks without

Highlights

Among Black males, 78% of foreign-born Black males in the United States had health insurance coverage.

Nearly all Black males in the United States had a usual place for preventive care.

Across all categories of nativity and years in the United States, a majority of Black males had never smoked.



Demographic and Health Characteristics among a Diverse Group of Adult Black Females in the United States: 2002-2012

Data Brief No. 4

November 2015

Shondelle M. Wilson-Frederick, Ph.D.; Juanita J. Chinn, Ph.D.;
Lacreisha N. Ejike-King, Ph.D., M.S. and Rashida R. Dorsey, Ph.D., M.P.H.

Background

Non-Hispanic Black females (hereafter referred to as Black females) in the United States experience vastly different morbidity and mortality profiles relative to other racial and ethnic U.S. populations [1]. Indeed, Black females experience the highest rates of hypertension and obesity compared to other racial or sex groups [2]. However, analyses often do not examine the impact of nativity on these observed health outcomes. To better understand the underlying factors that contribute to the disparate health outcomes in Black females in the United States, it is important to examine both U.S. born and foreign-born Black females.

Blacks in the United States are a diverse population that includes Caribbean, African, South and Central American immigrants as well as U.S.-born Blacks [3]. However, analyses typically report on measures of health and well-being among Blacks without examining nativity or length of time in the United States.

Highlights

Among Black females, 80% of U.S. born, 78% of foreign-born who lived in the United States for 10 years or more, and 63% of foreign-born who lived in the United States for less than 10 years had health insurance coverage.

Nearly two out of five foreign-born females who lived in the United States for less than 10 years had a usual place for preventive care.

Across all categories of nativity and years in the United States, a majority of Black females had never smoked.

Source:
<https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=8#db>

Demographic and Health Characteristics among U.S.-born and Foreign-born Blacks (Age 18-64 years) in the United States: National Health Interview Survey 2002-2012

	U.S.-Born	Foreign-born < 10 years in the United States	Foreign-born ≥ 10 years in the United States
Age (SD ± Mean)	39.0 ± 14.5	32.6 ± 10.6	41.7 ± 12.4
Some college or greater	49.8	49.7	61.0
Married	42.1	53.1	53.9
Ratio of income to poverty			
Less than 1.00	22.6	52.3	25.1
1.00 to 3.99	52.3	53.8	16.3
4.00 or greater	25.1	52.5	34.4
No health insurance coverage	22.0	38.6	21.7
Usual place for preventive care	50.3	30.1	48.4



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Demographic and Health Characteristics among U.S.-born and Foreign-born Blacks (Age 18-64 years) in the United States: National Health Interview Survey 2002-2012 --continued

	U.S.-born	Foreign-born < 10 years in the United States	Foreign-born ≥ 10 years in the United States
Current smoker	23.7	6.6	9.5
Weight Status (BMI, kg/m ²)			
Healthy weight (18.5 kg/m ² to 24.9 kg/m ²)	26.3	37.3	33.0
Overweight (25.0 kg/m ² to 29.9 kg/m ²)	32.2	34.1	41.8
Obese (30.0 kg/m ² or more)	41.5	28.6	25.5
Diagnosed hypertension	37.3	24.4	29.0

Note: Estimates are presented from the 2002-2012 National Health Interview Surveys (NHIS). Sampling weights were used to produce national estimates that were representative of the civilian non-institutionalized U.S. population. The analysis was restricted to non-Hispanic Black/African American adults between the ages 18 to 64 years who specified their nativity or length of time in the United States. This yielded a final sample of 38,061 non-elderly Black adults. The chi-square test was used to test for statistically significant differences across categories of nativity and years in the United States. (Source: Dorsey et al., forthcoming)



CULTURE AND HEALTH



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What Is Cultural Competency?

- Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.
- 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.
- 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).



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Culture and Health Care

- Culture defines:
 - how health care information is received;
 - how rights and protections are exercised;
 - what is considered to be a health problem;
 - how symptoms and concerns about the problem are expressed;
 - who should provide treatment for the problem; and
 - what type of treatment should be given.



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What are Culturally and Linguistically Appropriate Services?

Services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization (regardless of size) at every point of contact.



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Why are the National CLAS Standards significant?

The National CLAS Standards are intended to **advance health equity, improve quality, and help eliminate health care disparities** by establishing a blueprint for health and health care organizations to implement and provide culturally and linguistically appropriate services.

- First published by the HHS Office of Minority Health in 2000
- Provided a framework for health care organizations to best serve the nation's diverse communities
- Enhanced CLAS Standards released in April 2013

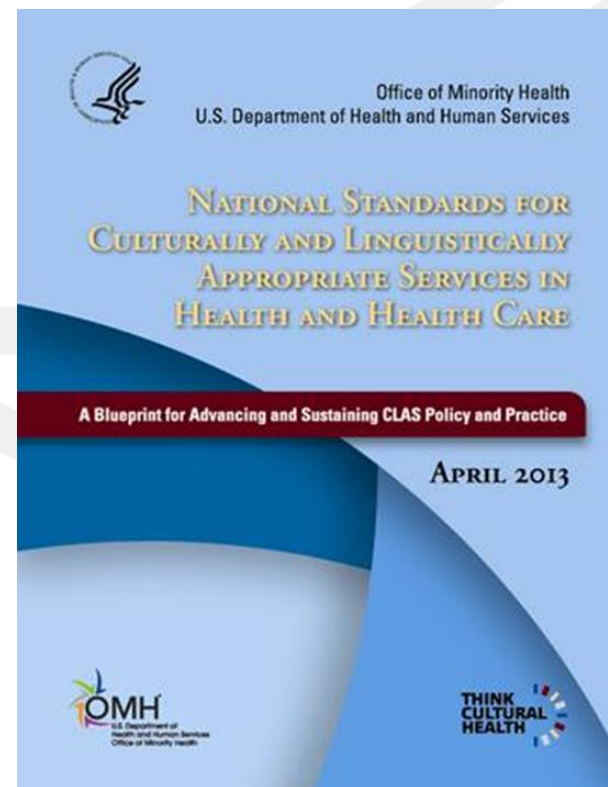


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A Blueprint for Advancing and Sustaining CLAS Policy and Practice

Accessible at:

www.thinkculturalhealth.hhs.gov



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Summary

- Acculturation measures (proxies) collected in HHS data collections
- Acculturation data provides an important source of data to describe the health status of population groups in the U.S.
- Acculturation data provides information to identify disparities and develop approaches to achieve health equity



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Questions?

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