



COMMENT ON HSU ET AL.

BMI Cut Points to Identify At-Risk Asian Americans for Type 2 Diabetes Screening.

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Hsu et al. (1) provided a comprehensive and informative overview of the existing literature pertaining to BMI, body composition differences, and type 2 diabetes prevalence and incidence in Asian American adults. We commend the authors' excellent policy recommendation based on the data available and further applaud the American Diabetes Association for its subsequent change of the BMI cutoff for diabetes screening in Asian Americans. Throughout the article, the authors highlighted the need for prospective data in Asian American populations, and we would like to offer further expansion and support for this perspective.

A common stereotype that has been applied to Asian Americans is that they are the model minority—this stereotype posits that Asian Americans are educated, law-abiding, and hardworking and have high incomes, low crime rates, and close family ties (2,3). From a broad perspective, it implies that Asian Americans are not an underprivileged racial/ethnic minority when compared with other racial/ethnic groups (4).

Because of the model minority stereotype, Asian Americans are commonly believed not to experience health disparities compared with whites or other racial/ethnic minorities. Therefore, less priority and resource allocation are placed on understanding the health needs among and within Asian American populations. For example,

many national and local health databases and surveys often lack adequate sample sizes of Asian Americans, thereby inhibiting the ability to fully assess the disease burden for these populations. Even when available, Asian Americans are not routinely reported nor often considered in the discussion around racial/ethnic health disparities.

As Hsu et al. suggested (1), there is a severe lack of longitudinal cohort studies that include Asian Americans, that report on the Asian American results disaggregated from the larger cohort, or that are comprised exclusively of Asian American participants. In this particular case of BMI and diabetes, the authors, together with stakeholders in other sectors, came together to change screening recommendations that are relevant and appropriate for Asian Americans. These types of collaborations are unusual and commendable. These singular efforts, however, need to be supported by a firm commitment at the federal and state level to capture prospective data on a range of health conditions that reflect the full breadth and diversity of the Asian American population. Further, efforts to more effectively capture clinical data indicators for Asian Americans through collection and reporting of racial/ethnic subgroup data in registries and electronic health record data are needed in order to ensure the meaningful assessments of health status, the understanding of the magnitude and

nature of health disparities, and the advancement of evidence-based practice for Asian Americans. We close with a quote from Lee et al. (5): "Can an evidence-based protocol with efficacy in a predominantly racial/ethnic minority sample (ie, Black or Korean) be considered [evidence-based practice] for the White population?"

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