

# INVENTORY OF RESOURCES FOR STANDARDIZED DEMOGRAPHIC AND LANGUAGE DATA COLLECTION

**Collecting standardized patient demographic and language data across health care systems is an important first step toward improving population health.** Comprehensive patient data on race, ethnicity, language, and disability status are key to identifying disparities in quality of care and targeting quality improvement interventions to achieve equity. Here you will find an overview of:

- Minimum standards for data collection as outlined by the U.S. Department of Health and Human Services;
- Best practices and guidelines for health care organizations in implementing standardized data collection, including information to address key challenges in collecting these data;
- Training tools and webinars to help health care organizations educate their staff on the importance of standardized data collection and best practices for data collection; and
- Sentinel articles and books that provide in-depth discussion of issues, challenges, recommendations, and best practices in standardized data collection.

The resources in this document are grouped by REaL and Disability categories as well as by the type of resource it is. Please click on the desired topic area or type of resource on the table of contents below.

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# RACE, ETHNICITY, AND LANGUAGE DATA COLLECTION RESOURCES

A robust body of guidance and tools has been developed for the collection of Race, Ethnicity, and Language (REaL) data in health care settings. Organizations are increasingly collecting these data to meet regulatory requirements and build a foundation for monitoring racial and ethnic disparities, as well as disparities in quality of care due to language barriers. Variation in the methods used to collect REaL data, and the accuracy and reliability of the data collected, calls for increased awareness and implementation of best practices and guidelines for standardized collection of REaL data. The following resources and tools offer guidance to hospitals, health plans, and other health-related organizations interested in implementing or improving REaL data collection.

## MINIMUM STANDARDS FOR REaL DATA COLLECTION

In 1997, the [Office of Management and Budget \(OMB\)](#) developed standardized questions on race and ethnicity required for reporting by federal agencies and recipients of federal funds.<sup>1,2</sup> To ensure data quality, OMB advises collecting race and ethnicity data using two questions, with ethnicity being collected first.

### The OMB categories for ethnicity are:

- Hispanic or Latino
- Not Hispanic or Latino

### The OMB racial categories are:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Respondents may select from one or more racial categories. These categories represent the minimum standard, and OMB encourages the collection of more granular data using categories that can be aggregated back to the minimum categories.<sup>2,3</sup>

Additionally, [Section 4302](#) of the [Affordable Care Act](#) requires any data standards published by the U.S. Department of Health and Human Services (HHS) to comply with the OMB standards. HHS developed [data standards](#) that provide additional granularity within the OMB standard categories of Asian and Native Hawaiian or Other Pacific Islander, as well as for respondents who are of Hispanic, Latino/a, or Spanish origin.

In addition to race and ethnicity, the data collection standards include a question for capturing English language proficiency and optional questions for language spoken at home:

### Data Standard for Primary Language:

- How well do you speak English?
  - Very well
  - Well
  - Not well
  - Not at all

### Language Spoken Standard (optional):

- Do you speak a language other than English at home?
  - Yes
  - No
- For persons speaking a language other than English (answering yes to the question above):  
What is this language?
  - Spanish
  - Other language (Identify)

To accompany the standards, HHS has developed an explanation of the data standards, as well as [guidance for implementation](#).

While the collection of more precise REaL data may be needed to identify disparities in care for specific groups, data collection efforts should, at a minimum, conform to the standards outlined by the OMB and required by Section 4302 of the Affordable Care Act.

## REFERENCES

1. Office of Management and Budget. DIRECTIVE NO. 15 - Race and Ethnic Standards for Federal Statistics and Administrative Reporting. 1977; [https://transition.fcc.gov/Bureaus/OSEC/library/legislative\\_histories/1195.pdf](https://transition.fcc.gov/Bureaus/OSEC/library/legislative_histories/1195.pdf). Accessed March 28, 2022.
2. Office of Management and Budget. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. 1997; [https://obamawhitehouse.archives.gov/omb/fedreg\\_1997standards](https://obamawhitehouse.archives.gov/omb/fedreg_1997standards). Accessed March 28, 2022.
3. Weissman JS, et al. *Commissioned Paper: Healthcare Disparities*. Disparities Solutions Center; 2012.

## **2023 COMPENDIUM OF DISABILITY DATA COLLECTION METHODS**

Mathematica Policy Research

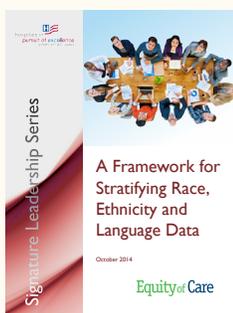


Entities involved in quantitative and qualitative data collection—such as federal agencies, university survey centers, and private polling firms—should (and sometimes by law must) consider the extent to which their methods create barriers to participation for people with disabilities. Yet few resources are available to address this problem. To fill this knowledge gap, we created the Compendium of Disability Data Collection Methods, an easily accessible source of research on the methodological issues associated with collecting data from or about people with disabilities. The 2023 version of the compendium, an indexed reference list, contains 615 references on the following subjects:

disability/impairment type (for example, developmental, cognitive and intellectual impairments, physical disabilities), data collection modes and adaptive technologies, proxies, questionnaire design and measurement issues, inclusive strategies and participatory research, special populations such as youth with disabilities and veterans’ populations.

## **A FRAMEWORK FOR STRATIFYING RACE, ETHNICITY AND LANGUAGE DATA**

American Hospital Association, Equity of Care



Collecting and stratifying patient REaL data are crucial for hospitals and health systems to understand the populations they serve and to implement the appropriate interventions for improving quality of care. While each health care system will stratify data in different ways to meet its own institutional needs, using the five-step framework recommended by this report will help systems to stratify REaL data to more effectively identify health care disparities. This report summarizes the framework and provides dashboard templates.

## **RACE, ETHNICITY, AND LANGUAGE DATA: STANDARDIZATION FOR HEALTH CARE QUALITY IMPROVEMENT**

Institute of Medicine



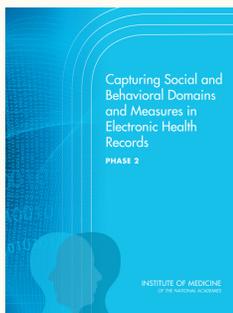
In this report, the Institute of Medicine goes beyond standard OMB categories and provides guidance and examples of granular categories for REaL data collection. Key recommendations include:

- Expanding the six OMB race categories to include a “some other race” option.
- Including granular ethnicity categories that reflect the population of interest.
- At minimum, collecting data on a patient’s spoken English language proficiency.

## REPORTS (CONTINUED)

### CAPTURING SOCIAL AND BEHAVIORAL DOMAINS AND MEASURES IN ELECTRONIC HEALTH RECORDS: PHASE 2

Institute of Medicine



This report explores and provides rationale for including social determinants in the electronic health record and shares examples of how physicians can utilize this technology to improve the health of their patients. The domains outlined in the report include sociodemographic domains, psychological domains, behavioral domains, individual-level social relationships and living conditions, and neighborhoods/community domains. The report also outlines various organizational challenges to including these measures in electronic health records.

### MULTIRACIAL IN AMERICA: CHAPTER 1: RACE AND MULTIRACIAL AMERICANS IN THE U.S. CENSUS

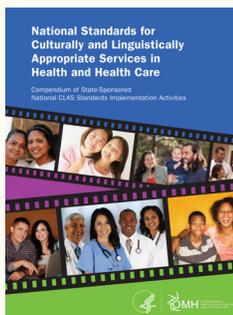
Pew Research Center



Collecting and stratifying patient REaL data are crucial for hospitals and health systems to understand the populations they serve and implement the appropriate interventions to improve quality of care. This report recommends a five-step framework that will help systems to stratify REaL data to more effectively identify health care disparities. This report summarizes the framework and provides dashboard templates.

### COMPENDIUM OF STATE-SPONSORED NATIONAL CLAS STANDARDS IMPLEMENTATION ACTIVITIES AND TRACKING CLAS TOOL

U.S. Department of Health and Human Services, Office of Minority Health



The U.S. Department of Health and Human Services recently released the first compendium of activities undertaken by states to implement the National Culturally and Linguistically Appropriate Services (CLAS) Standards, which includes the collection of patient race, ethnicity, and language data. The report includes an overview of the National CLAS Standards, recommendations for improving state-sponsored implementation, and detailed findings from each state's activities.

The [Tracking CLAS Tool](#), is an interactive map that identifies state efforts to implement CLAS standards, including legislation related to cultural competency training for health professionals and state-sponsored implementation activities as of 2015.

## REPORTS (CONTINUED)

### IMPROVED RACE AND ETHNICITY MEASURES REVEAL U.S. POPULATION IS MUCH MORE MULTIRACIAL

United States Census Bureau



This webpage provides updated information on racial and ethnic composition of the country as a result of improvements in the design of the race and ethnicity questions, processing, and coding.

### COUNTING A DIVERSE NATION: DISAGGREGATING DATA ON RACE AND ETHNICITY TO ADVANCE A CULTURE OF HEALTH

PolicyLink



A report outlining how the research community and governmental policy can take on reforms to better collect data that is more extensive and specific to the multidimensional diversity across America.

## GUIDES

### BUILDING AN ORGANIZATIONAL RESPONSE TO HEALTH DISPARITIES

Centers for Medicare and Medicaid Services, Office of Minority Health

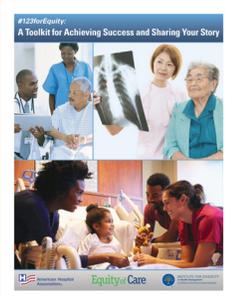


Disparities in the quality of care that minority populations receive even when they have the same insurance, socioeconomic status, and comorbidities as their non-minority counterparts are well documented. Evidence-based interventions are an effective tool for reducing health disparities and lowering cost. Therefore, focused quality-improvement efforts should be targeted to populations at risk for disparities. This document includes resources and concepts key to addressing disparities and improving health care quality.

## GUIDES (CONTINUED)

### **#123FOREQUITY: A TOOLKIT FOR ACHIEVING SUCCESS AND SHARING YOUR STORY**

American Hospital Association, Equity of Care



A user-friendly “how-to” guide to help accelerate the elimination of health care disparities. This guide contains resources to assist all hospitals in their work to achieve the Equity of Care goals.

### **HRET HIIN HEALTH EQUITY ORGANIZATIONAL ASSESSMENT**

Health Research and Educational Trust

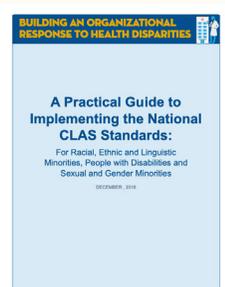


A guide to classifying the extent to which hospitals are reducing disparities through 7 categories: data collection, data collection training, data validation, data stratification, communication of findings, addressing and resolving gaps in care, and organizational infrastructure and culture. This a general tool for understanding how hospitals can reduce disparities seems less relevant to data collection and more relevant to disparities solutions in general.

## TOOLKITS

### **A PRACTICAL GUIDE TO IMPLEMENTING THE NATIONAL CLAS STANDARDS: FOR RACIAL, ETHNIC AND LINGUISTIC MINORITIES, PEOPLE WITH DISABILITIES AND SEXUAL AND GENDER MINORITIES**

Centers for Medicare and Medicaid Services, Office of Minority Health



The purpose of this toolkit is to enable organizations to implement the National CLAS Standards and improve health equity. It is organized according to the enhanced National CLAS Standards and provides practical tools and examples of CLAS, in addition to efforts to implement the National CLAS Standards that can be adapted for use by health care organizations. It is intended for organizations that have already decided to pursue CLAS to improve equity and eliminate health care disparities.

# TOOLKITS (CONTINUED)

## DISABILITY DATA ADVOCACY TOOLKIT

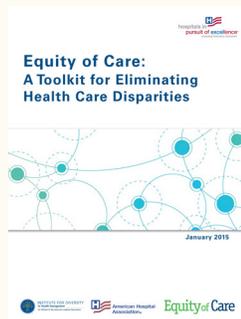
Washington Group



This toolkit was created in response to increasing interest and requests from persons with disabilities and their representative organizations from all over the world. The aim of this toolkit is to contribute to the growing global dialogue on the importance of data on persons with disabilities, specifically to provide some basic knowledge on data collection, analysis, and use of data for evidenced based advocacy to influence policy and decision makers. The toolkit discusses the use of the WG questions as best practices to be employed in data collections and disaggregating data by disability.

## EQUITY OF CARE: A TOOLKIT FOR ELIMINATING HEALTH CARE DISPARITIES

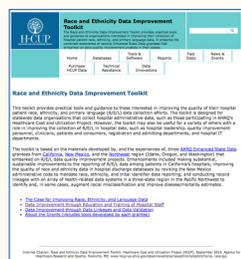
American Hospital Association, Equity of Care



The American Hospital Association toolkit provides best practices for improving the quality of REaL data, stratifying REaL data, and identifying disparities within health care organizations. This resource is appropriate for organizations at all stages of the REaL data collection process. In addition to data collection, the toolkit includes resources for cultural competency training and increasing diversity in governance and leadership.

## RACE AND ETHNICITY DATA IMPROVEMENT TOOLKIT

Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services



This toolkit provides guidance for organizations aiming to improve the collection of REaL data from patients. The toolkit incorporates experience from Enhanced State data grantees that have made significant efforts in improving data collection within their states. The toolkit provides resources for ensuring adequate IT infrastructure, collecting REaL data from patients, and measuring the effectiveness of education and training efforts.

# TRAINING TOOLS & WEBINARS

## IDENTIFYING AND MEETING THE LANGUAGE PREFERENCES OF HEALTH PLAN MEMBERS

### Resources for Integrated Care



A webinar discussing the strategies that health plans can use to meet and assess diverse language preferences. The webinar has multiple speakers who talk about strategies for collecting language data and then using this data to inform operations.

# BOOKS & SENTINEL ARTICLES

## DATA ON RACE, ETHNICITY, AND LANGUAGE LARGELY INCOMPLETE FOR MANAGED CARE PLAN MEMBERS



**Citation:** Ng JH, Ye F, Ward LM, Haffer, SC. Health Aff. (2017).

This article presents findings from assessing REaL data availability in commercial, Medicaid, and Medicare managed care plans using the Healthcare Effectiveness Data and Information Set (HEDIS). The authors looked at 2012–2015 HEDIS data and found that in 2015 the largest gaps in race data occurred in commercial and Medicaid plans, while all plan types reported incomplete data on ethnicity and language. Between 2012 and 2015, completeness of data generally did not improve. The authors conclude that the ability to identify

disparities through improved documentation of race, ethnicity, and language is necessary in order to reduce disparities.

## IMPROVING THE COLLECTION OF RACE, ETHNICITY, AND LANGUAGE DATA TO REDUCE HEALTHCARE DISPARITIES: A CASE STUDY FROM AN ACADEMIC MEDICAL CENTER



**Citation:** Lee WC, Veeranki SP, Serag H, Eschbach K, Smith KD. Perspect Health Inf Manag. (2016).

Well-designed electronic health records (EHRs) must integrate a variety of accurate information to support efforts to improve quality of care, particularly equity-in-care initiatives. This case study provides insight into the challenges those initiatives may face in collecting accurate REaL information in the EHR. The authors present the experience of an academic medical center strengthening its EHR for better collection of REaL data with funding from the EHR Incentive

Programs for meaningful use of health information technology and the Texas Medicaid 1115 Waiver program. They also present a plan to address some of the challenges that arose during the course of the project. These experiences at an academic medical center can provide guidance about the likely challenges similar institutions may expect when they implement new initiatives to collect REaL data, particularly challenges regarding scope, personnel, and other resource needs.

# BOOKS & SENTINEL ARTICLES (CONTINUED)

## A ROADMAP AND BEST PRACTICES FOR ORGANIZATIONS TO REDUCE RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE



**Citation:** Chin MH, et al. J Gen Intern Med. (2012).

This article summarizes the key findings of the literature reviews and funded research projects conducted through Finding Answers, a Robert Wood Johnson Foundation initiative. The authors use these findings to provide a roadmap for health care organizations to address disparities within diverse populations.

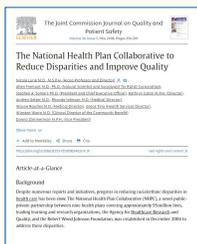
## A PLAN FOR ACTION: KEY PERSPECTIVES FROM THE RACIAL/ETHNIC DISPARITIES STRATEGY FORUM



**Citation:** King RK, et al. Milbank Q. (2008).

This paper summarizes six key recommendations for organizations to address disparities in care, including standardized collection of race and ethnicity data. The recommendations are: collect race and ethnicity data on patients or enrollees in a routine and standardized fashion; implement tools to measure and monitor for disparities in care; develop quality improvement strategies to address disparities; secure the support of leadership; use incentives to address disparities; and create a message and communication strategy for these efforts.

## THE NATIONAL HEALTH PLAN COLLABORATIVE TO REDUCE DISPARITIES AND IMPROVE QUALITY



**Citation:** Lurie N, et al. Jt Comm J Qual Patient Saf. (2008).

The National Health Plan Collaborative represents a model of shared learning and innovation through which health plans are addressing racial/ethnic disparities. This paper describes the challenges and lessons learned by health plans in obtaining information on race/ethnicity of their enrollees and examining their diabetes performance measure to assess disparities in care.

## OBTAINING DATA ON PATIENT RACE, ETHNICITY, AND PRIMARY LANGUAGE IN HEALTH CARE ORGANIZATIONS: CURRENT CHALLENGES AND PROPOSED SOLUTIONS



**Citation:** Hasnain-Wynia R & Baker DW. Health Serv Res. (2006).

This paper provides an overview of why health care organizations should collect race, ethnicity, and language data, reviews current practices, discusses the rationale for collecting this information directly from patients, and describes barriers and solutions.

## BOOKS & SENTINEL ARTICLES (CONTINUED)

### STRATEGIES TO RECORD AND USE ETHNICITY INFORMATION IN ROUTINE HEALTH DATA



**Citation:** Routen, A., Akbari, A., Banerjee, A. et al. Strategies to record and use ethnicity information in routine health data. *Nat Med* 28, 1338-1342 (2022). <https://doi.org/10.1038/s41591-022-01842-y>

Ethnicity information is often missing from health data, impeding action on inequalities. Recording and using ethnicity data will require training, efforts at standardization, and policy changes, while engaging with patients and the public.

### A PATIENT AND FAMILY DATA DOMAIN COLLECTION FRAMEWORK FOR IDENTIFYING DISPARITIES IN PEDIATRICS: RESULTS FROM THE PEDIATRIC HEALTH EQUITY COLLABORATIVE



**Citation:** Tan-McGrory A, Bennett-AbuAyyash C, Gee S, Dabney K, Cowden JD, Williams L, et al. A patient and family data domain collection framework for identifying disparities in pediatrics: results from the pediatric health equity collaborative. *BMC Pediatrics*. 2018;18(1):18.

By 2020, the child population is projected to have more racial and ethnic minorities make up the majority of the populations and health care organizations will need to have a system in place that collects accurate and reliable demographic data in order to monitor disparities. The goals of this group were to establish sample

practices, approaches and lessons learned with regard to race, ethnicity, language, and other demographic data collection in pediatric care setting. A panel of 16 research and clinical professional experts working in 10 pediatric care delivery systems in the US and Canada convened twice in person for 3-day consensus development meetings and met multiple times via conference calls over a two year period. Current evidence on adult demographic data collection was systematically reviewed and unique aspects of data collection in the pediatric setting were outlined. Human centered design methods were utilized to facilitate theme development, facilitate constructive and innovative discussion, and generate consensus. Group consensus determined six final data collection domains: 1) caregivers, 2) race and ethnicity, 3) language, 4) sexual orientation and gender identity, 5) disability, and 6) social determinants of health. For each domain, the group defined the domain, established a rationale for collection, identified the unique challenges for data collection in a pediatric setting, and developed sample practices which are based on the experience of the members as a starting point to allow for customization unique to each health care organization. Several unique challenges in the pediatric setting across all domains include: data collection on caregivers, determining an age at which it is appropriate to collect data from the patient, collecting and updating data at multiple points across the lifespan, the limits of the electronic health record, and determining the purpose of the data collection before implementation. There is no single approach that will work for all organizations when collecting race, ethnicity, language and other social determinants of health data. Each organization will need to tailor their data collection based on the population they serve, the financial resources available, and the capacity of the electronic health record.

# BOOKS & SENTINEL ARTICLES (CONTINUED)

## CHALLENGES WITH QUALITY OF RACE AND ETHNICITY DATA IN OBSERVATIONAL DATABASES



**Citation:** Polubriaginof FCG, Ryan P, Salmasian H, et al. Challenges with quality of race and ethnicity data in observational databases. *J Am Med Informatics Assoc.* 2019. doi:10.1093/jamia/ocz113

This study assesses the quality of race and ethnicity information in observational health databases, including electronic health records (EHRs). The authors assessed completeness of race and ethnicity information in large observational health databases in the United States (Healthcare Cost and Utilization Project and Optum Labs), and at a single healthcare system in New York City serving a racially and ethnically diverse population. They compared race and ethnicity data collected via administrative processes with data recorded directly by respondents via paper surveys (National Health and Nutrition Examination Survey and Hospital Consumer Assessment of Healthcare Providers and Systems). The article discusses findings on the quality of race and ethnicity data and proposes opportunities for improvement, including patient self-recording

## THE CRITICAL ROLE OF RACIAL/ETHNIC DATA DISAGGREGATION FOR HEALTH EQUITY



**Citation:** Kauh, T. J., Read, J. N. G., & Scheitler, A. J. (2021). The critical role of racial/ethnic data disaggregation for health equity. *Population research and policy review*, 40, 1-7.

Population-level health outcomes and measures of well-being are often described relative to broad racial/ethnic categories such as White or Caucasian; Black or African American; Latino or Hispanic; Asian American; Native Hawaiian and Pacific Islander; or Alaska Native. However, the aggregation of data into these groups masks critical within-group differences and disparities, limiting the health and social services fields' abilities to target their resources where most needed. While researchers and policymakers have recognized the importance of disaggregating racial/ethnic data - and many organizations have advocated for it over the years - progress has been slow and disparate. The ongoing lack of racial/ethnic data disaggregation perpetuates existing inequities in access to much-needed resources that can ensure health and well-being. In its efforts to help build a Culture of Health and promote health equity, the Robert Wood Johnson Foundation has supported activities aimed to advance the meaningful disaggregation of racial/ethnic data - at the collection, analysis, and reporting phases. This special issue presents further evidence for the importance of disaggregation, the technical and policy challenges to creating change in practice, and the implications of improving the use of race and ethnicity data to identify and address gaps in health.

# BOOKS & SENTINEL ARTICLES (CONTINUED)

## COLLECTION OF RACE, ETHNICITY, LANGUAGE (REL) DATA ON MEDICAID APPLICATIONS



**Citation:** Collection of Race, Ethnicity, Language (REL) Data on Medicaid Applications. State Health Access Data Assistance Center (SHADAC); 2022

This issue brief documents how race, ethnicity, and language data are collected for the Medicaid programs in the 50 U.S. states, the District of Columbia, and five U.S. territories: American Samoa, Guam, the Commonwealth of Northern Mariana Islands (CNMI), Puerto Rico, and the U.S. Virgin Islands. This serves as an update to State Health Access Data Assistance Center's (SHADAC) previous brief, providing up-to-date information on Medicaid REL data collection among the states and extending the analysis to include the District of Columbia and the five territories.

## ETHNICITY AND PALLIATIVE CARE: WE NEED BETTER DATA - FIVE KEY CONSIDERATIONS



**Citation:** Clarke G, Hussain JA, Allsop MJ, et al. Ethnicity and palliative care: we need better data - five key considerations. *BMJ Supportive & Palliative Care*. Published Online First: 19 May 2022. doi: 10.1136/bmjspcare-2022-003565

Complete and valid ethnicity are essential for monitoring racial and ethnic disparities but consideration needs to be given to collecting data well and using it responsibly. Palliative care could provide leadership in this field.

## CAUTIONS WHEN USING RACE AND ETHNICITY IN ADMINISTRATIVE CLAIMS DATA SETS



**Citation:** Nead KT, Hinkston CL, Wehner MR. Cautions When Using Race and Ethnicity in Administrative Claims Data Sets. *JAMA Health Forum*. 2022;3(7):e221812. doi:10.1001/jamahealthforum.2022.1812

Race and ethnicity variables are commonly used in research using administrative claims data sets. Recently updated guidelines on the use of race and ethnicity in medical journals specify that the methods section of articles “should include an explanation of who identified participant race and ethnicity and the source of the classification used.” Administrative claims data sets, consisting of insurance claims and/or electronic health record data, are a frequent and increasingly used source for medical research. A MEDLINE search of titles and abstracts from cohort and case-control studies using large, national-level administrative claims data sets shown in the Table returns more than 10,000 articles in the past 5 years. Analyses in administrative claims data sets frequently include race and ethnicity, when available, in analytic models as covariables (eg, confounders) or as part of the primary research question (eg, comparing outcomes by race). However, the articles reporting such analyses do not always include an explanation of how and by whom participant race and ethnicity were determined or include a discussion of the implications of not having race and ethnicity variables. Neither do the articles always state whether methods to determine race and ethnicity have been validated or discuss how the quality of race and ethnicity variables may influence the study interpretation.

## BOOKS & SENTINEL ARTICLES (CONTINUED)

### CONCEPTUALIZATION, OPERATIONALIZATION, AND UTILIZATION OF RACE AND ETHNICITY IN MAJOR EPIDEMIOLOGY JOURNALS, 1995-2018: A SYSTEMATIC REVIEW



**Citation:** Rae Anne M Martinez, Nafeesa Andrabi, Andrea N Goodwin, Rachel E Wilbur, Natalie R Smith, Paul N Zivich, Conceptualization, Operationalization, and Utilization of Race and Ethnicity in Major Epidemiology Journals, 1995-2018: A Systematic Review, *American Journal of Epidemiology*, Volume 192, Issue 3, March 2023, Pages 483-496, <https://doi.org/10.1093/aje/kwac146>

Despite repeated calls by scholars to critically engage with the concepts of race and ethnicity in US epidemiologic research, the incorporation of these social constructs in scholarship may be suboptimal. This study characterizes the conceptualization, operationalization, and utilization of race and ethnicity in US research published in leading journals whose publications shape discourse and norms around race, ethnicity, and health within the field of epidemiology. We systematically reviewed randomly selected articles from prominent epidemiology journals across 5 periods: 1995-1999, 2000-2004, 2005-2009, 2010-2014, and 2015-2018. All original human-subjects research conducted in the United States was eligible for review. Information on definitions, measurement, coding, and use in analysis was extracted. We reviewed 1,050 articles, including 414 (39%) in our analyses. Four studies explicitly defined race and/or ethnicity. Authors rarely made clear delineations between race and ethnicity, often adopting an ethnoracial construct. In the majority of studies across time periods, authors did not state how race and/or ethnicity was measured. Top coding schemes included “Black, White” (race), “Hispanic, non-Hispanic” (ethnicity), and “Black, White, Hispanic” (ethnoracial). Most often, race and ethnicity were deemed “not of interest” in analyses (e.g., control variables). Broadly, disciplinary practices have remained largely the same between 1995 and 2018 and are in need of improvement.

### DEFINING AN INFANT'S RACE AND ETHNICITY: A SYSTEMATIC REVIEW



**Citation:** Weikel, Blair W., et al. “Defining an infant’s race and ethnicity: a systematic review.” *Pediatrics* 151.1 (2023): e2022058756

Infant race and ethnicity are used ubiquitously in research and reporting, though inconsistent approaches to data collection and definitions yield variable results. The consistency of these data has an impact on reported findings and outcomes. The authors systematically reviewed and examined concordance among differing race and ethnicity data collection techniques presented in perinatal health care literature. Their initial search identified 4329 unique citations. Forty articles passed title/abstract review and were reviewed in full text. Nineteen were considered relevant and assessed for quality and bias, from which 12 studies were ultimately included. Discordance in infant race and ethnicity data were common among multiple data collection methods, including those frequently used in perinatal health outcomes research. Infants of color and those born to racially and/or ethnically discordant parents were the most likely to be misclassified across data sources.

# BOOKS & SENTINEL ARTICLES (CONTINUED)

## A QUALITY FRAMEWORK TO ADDRESS RACIAL AND ETHNIC DISPARITIES IN EMERGENCY DEPARTMENT CARE



**Citation:** Khidir, Hazar, et al. “A quality framework to address racial and ethnic disparities in emergency department care.” *Annals of emergency medicine* 81.1 (2023): 47-56.

The emergency department serves as a vital source of health care for residents in the United States, including as a safety net. However, patients from minoritized racial and ethnic groups have historically experienced disproportionate barriers to accessing health care services and lower quality of services than White patients. Quality measures and their application to quality improvement initiatives represent a critical opportunity to incentivize health care systems to advance health equity and reduce health disparities. Currently, there are no nationally recognized quality measures that track the quality of emergency care delivery by race and ethnicity and no published frameworks to guide the development and prioritization of quality measures to reduce health disparities in emergency care. To address these gaps, the American College of Emergency Physicians (ACEP) convened a working group of experts in quality measurement, health disparities, and health equity to develop guidance on establishing quality measures to address racial and ethnic disparities in the provision of emergency care. Based on iterative discussion over 3 working group meetings, we present a summary of existing emergency medicine quality measures that should be adapted to track racial and ethnic disparities, as well as a framework for developing new measures that focus on disparities in access to emergency care, care delivery, and transitions of care.

# DISABILITY DATA COLLECTION RESOURCES

Disability covers a wide range of impairments that may be physical, sensory, or cognitive. The degree to which impairments and environmental factors impact individual functioning may vary. The reasons for collecting disability status data are also varied. Health care organizations may collect disability data in order to ensure compliance with the Americans with Disabilities Act and improve the accessibility of facilities, equipment, and services; to inform clinical practice and individual care plans for patients with functional limitations associated with physical, cognitive or other mental impairments; or to monitor for disparities in quality of care for subpopulations. While all of these are valid and important reasons for collecting data on disability status, how organizations plan to use the data will determine what questions to ask. The following resources offer recommendations and frameworks from several leading national and international organizations related to disability and disability data collection.

## MINIMUM STANDARDS

The [six-item set of questions](#) developed for the [American Community Survey](#), U.S. Census Bureau, represent the minimum data standard for disability data collection within federal agencies. The questions cover six types of disability: hearing, vision, cognitive, ambulatory, self-care, and independent living. Respondents who report difficulties in one or more of these categories are considered to have a disability. This six-item set cannot be altered and must be used as a set to assure a meaningful measure of disability.

The U.S. Department of Health and Human Services [Implementation Guidance](#) on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status was developed to promote standardized data collection in HHS-conducted or -sponsored surveys.

The U.S. Census Bureau's [Guidance for Disability Data Users site](#) describes how disability information is collected in a number of existing federal surveys.

# REPORTS & ARTICLES

## THE FUTURE OF DISABILITY IN AMERICA

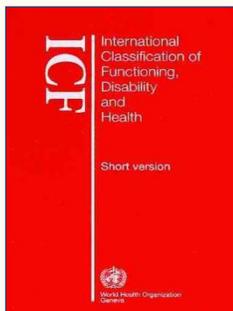
Institute of Medicine



Disability affects between 40 million and 50 million people in the United States and will continue to affect a large number of Americans as the population ages. The report offers recommendations in the areas of disability monitoring, disability research, access to health care and other support services, and public and professional education.

## INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH

World Health Organization



The World Health Organization uses the International Classification of Functioning, Disability, and Health (ICF) to classify different types of functioning and disabilities. The ICF provides classifications for body function, including mental and physiological functions; activities and participations, including learning, daily tasks, and relationships; and environmental factors, including the physical and social environment.

## PERSONS WITH DISABILITIES AS AN UNRECOGNIZED HEALTH DISPARITY POPULATION



**Citation:** Krahn GL, Walker DK, Correa-de-Araujo R. Am J Public Health. (2015).

This paper recommends that observed population-level differences in health outcomes among persons with disability supports classification as a health disparity population.

## THE DISABILITY DATA REPORT, 2021



**Citation:** Mitra, S. and Yap, J. (2021). The Disability Data Report. Disability Data Initiative. Fordham Research Consortium on Disability: New York

This report provides a systematic analysis of the availability and quality of questions on disability between 2009 and 2018 in national censuses and surveys. This report also presents disaggregation results for 41 countries with censuses or national surveys with functional difficulty questions in at least four domains (seeing, hearing, walking, cognition). For some countries, data is also available for the self-care and/or communication domains and the Washington Group Short Set of questions. This report has not been peer reviewed.

## REPORTS & ARTICLES (CONTINUED)

### HEALTH CARE EQUITY REQUIRES STANDARDIZED DISABILITY DATA IN THE EHR



**Citation:** Morris, M. A., Yee, S., Breslin, M. L., Savage, M., & Swenor, B. K. (2022). Health Care Equity Requires Standardized Disability Data In The EHR. *Health Affairs Forefront*

The electronic health record (EHR) is an essential tool for linking demographic and clinical data within and across health care systems, as well as to public health databases. Data collected within the EHR are crucial for understanding and addressing inequities that negatively impact health and health care outcomes of marginalized communities, including persons with disabilities. Unfortunately, the lack of standardized collection of patients' disability status within EHRs has limited progress toward addressing inequities for people with disabilities. In recent estimates, 27 percent of US adults have a disability. Persons with disabilities experience significant inequities in access to high-quality care services due to factors such as clinician biases and inaccessible medical environments. Currently, the vast majority of health care systems do not systematically collect patients' disability status, impeding efforts to identify and address these factors. The lack of data collection also impedes organizations' efforts in providing mandated disability accommodations and modifications that ensure equitable care as required by the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990 and Section 1557 of the 2010 Patient Protection and Affordable Care Act (ACA).

### HARMONIZING DISABILITY DATA TO IMPROVE DISABILITY RESEARCH AND POLICY

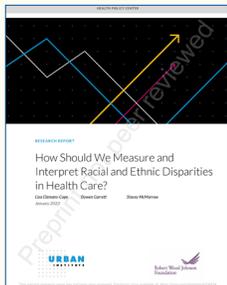


**Citation:** Mont, D., Madans, J., Weeks, J. D., & Ullman, H. (2022). Harmonizing Disability Data To Improve Disability Research and Policy. *Health Affairs*, 41(10), 1442-1448. <https://doi.org/10.1377/hlthaff.2022.00479>

Disability is complex and multifaceted, complicating governments' efforts to collect the high-quality, comprehensive data necessary for developing, implementing, and monitoring policies. Yet data are needed to obtain information on functioning in the population, to identify the population with disabilities, and to disaggregate indicators of well-being by disability to determine whether people with disabilities are participating in society to the same extent as those without disabilities. In this article, we discuss the need for data harmonization to improve disability research and policy. We describe standard question sets on disability developed for inclusion in surveys and administrative systems, as well as the need for coordination of both statistical and administrative data systems. Until disability data become more harmonized, it will not be possible to support the development of comprehensive, evidence-based policies and programs to address the needs of the population with disabilities.

## REPORTS & ARTICLES (CONTINUED)

### HOW SHOULD WE MEASURE AND INTERPRET RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE?



**Citation:** Clemans-Cope, Lisa, A. Bowen Garrett, and Stacey McMorrow. “How Should We Measure and Interpret Racial and Ethnic Disparities in Health Care?” Available at SSRN 4376574 (2023).

Efforts to eliminate racial disparities in health and health care are a critical national priority, and quantifying and interpreting measures of these disparities are important but challenging parts of that effort. This paper offers five recommendations for producing and interpreting estimates of racial and ethnic disparities in health care. To illustrate these recommendations, we provide several empirical examples to demonstrate some of the ways in which disparity estimates and interpretation can vary with different definitions and estimation methods, affirming the importance of motivating methodological choices with an explicit definition, research question, and comprehensive conceptual framework.

## VIDEOS

### WASHINGTON GROUP 2015 VIDEO SERIES



This video series, presented by Mitchell Loeb from the National Center for Health Statistics, provides background on the six-item short set of questions designed by the Washington group. The series presents the short set of questions and provides recommendations for data collection and analysis of disability data.

- [Video 1 - Introduction to the Washington Group](#)
- [Video 2 - The Approach Developed by the Washington Group](#)
- [Video 3 - Short Set of Questions: Tool Presentation](#)
- [Video 4 - Short Set of Questions: Data Collection](#)
- [Video 5 - Short Set of Questions: Data Analysis](#)
- [Video 6 - Presentation of the Methodology to Implement WG Tools](#)

## VIDEOS (CONTINUED)

### **WASHINGTON GROUP TRAINING FOR NON - GOVERNMENTAL ORGANIZATIONS, MARCH 16, 2017**



The Washington Group presented a 1 day training event on Disability Measurement using the Washington Group methodology specifically for an NGO audience.

- [Video 1 - Introduction to the Washington Group and Disability Measurement](#)
- [Video 2 - Collecting Disability Data](#)
- [Video 3 - The Importance & Feasibility of Disaggregation by Disability Status](#)
- [Video 4 - The WG/UNICEF Module on Child Functioning](#)