



## Connecticut Race, Ethnicity and Language (REL) Standards Implementation Guide

### Race, Ethnicity, and Language (REL) Mandate

Enacted in 2021, the goal of Public Act (PA) 21-35 (Appendix 1) is “to attain at least a seventy per cent reduction in the racial disparities set forth in subdivisions (1) to (4), inclusive, of this subsection from the percentage of disparities determined by the commission on or before January 1, 2022.”<sup>1</sup>

In pursuit of this goal, PA 21-35 Section 11, mandates that the Office of Health Strategy (OHS) develop race, ethnicity, and language (REL) data collection standards in alignment with the OHS Community and Clinical Integration Program (CCIP) recommendations, US Office of Management and Budget (OMB)<sup>2</sup> race and ethnicity standards, and International Organization for Standardization (ISO)<sup>3,4</sup> language standards, to enable the aggregation and disaggregation of REL data.

The legislation mandates uniform collection of REL data to support *The Commission on Racial Equity in Public Health’s* mission to create a comprehensive strategic plan to eliminate health disparities and inequities across sectors. Availability of REL data will also support development of targeted interventions to reduce racial disparities, and augment health care providers’ continuous efforts to provide high quality, effective, timely, patient-centered, equitable care to all patients.

Consistent with PA 21-35 section 11 subsection (c), OHS engaged and consulted stakeholders to create a technical standards document and a guide for implementing the standards for health care providers with electronic health records, and health services and public health state agencies, their boards or commissions and organizations that contract with state agencies and collect REL data. The PA 21-35 REL Data Collection Standards is the result of these engagements.

### Race, Ethnicity, and Language Defined

**Race:** A social construct linked to perceived biological differences demarcated by characteristics, such as skin color, hair type, eye shape. OMB requires five minimum categories: American Indian or Alaska Native, Asian, Black, or African American, Native Hawaiian or Other Pacific Islander, and White. Both the OMB and CCIP standards emphasize self-identification and the ability to select multiple races. The CCIP standard also expands the race subcategories and includes the options to write in a race(s), "Other" and "Decline to Identify," and hierarchical mapping of race aligned with the OMB minimum standard.

**Ethnicity:** Shared beliefs, culture, ancestry, and language closely and uniquely relevant to an individual, group or population. OMB requires two minimum categories: Hispanic or Latino and non-Hispanic or not-Latino. Both the OMB and CCIP standards emphasize self-identification and

<sup>1</sup> <https://www.cga.ct.gov/2021/ACT/PA/pdf/2021PA-00035-R00SB-00001-PA.pdf>

<sup>2</sup> [Office of Management and Budget. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity](#)

<sup>3</sup> [International Organization for Standardization: ISO 639 Language Codes](#)

<sup>4</sup> [Library of Congress International Organization for Standardization 639 /Joint Advisory Committee \(ISO 639/JAC\)](#)



the ability to select multiple races. The CCIP standard expands the ethnicity subcategories, includes the options to write in ethnicity(ies), "Other" and "Decline to Identify," and hierarchical mapping of ethnicity aligned with the OMB minimum standard.

**Race/Ethnicity:** While OMB requires and explicitly prefers mutually exclusive formats for collecting race and Hispanic ethnicity with two separate questions, OMB provides the ability to combine the two in a single question, but ethnicity must be asked first. In recognition of this and that some current REL data collection may be to information systems that collect race/ethnicity in a single field, the REL data collection standards document provides the crosswalk to facilitate that collection in alignment with the CCIP standard.

**Language:** A system of conventional spoken, manual (signed), or written symbols by means of which members of a social group and participants in its culture, express themselves.

The rationale for collecting primary language is for English proficiency measurement, as health disparities have been associated with limited English language proficiency. Collection of data on English proficiency and the specific language spoken is appropriate for the point of health care delivery. For the purposes of REL data collection, language information to collect is the primary comprehensive language for the individual. Comprehensive language is the appropriate standard used 'in the context of health care or for the provision or receipt of health care services or for any public health purpose.' Many individuals may not have a spoken language, for example, individuals with speaking disabilities or using an alternative communications device. In such cases, sign language or alternative communication devices may be written in on the data collection form or media.

The ISO has designated the Library of Congress ISO 639 Joint Advisory Committee (ISO 639/JAC) to maintain the alpha-3 language code standard. The REL data collection standards document utilizes the ISO 639-2/639-5, the most current coding version. The standard uses ISO country codes to identify the likely nationality and languages spoken by populations of "foreign-born" Connecticut residents identified through the [US Census Bureau 2013 American Community Survey, as speaking English "less than well."](#)

### **What Must be Collected**

The REL standards document enumerates how to uniformly collect and code self-reported race, ethnicity and language by clients/patients. The information is self-reported by the client/patient. Clients/patients are not required to provide REL data to receive care or services, however entities mandated to collect REL data must do so in alignment with the OHS REL Data Collection Standards where applicable.

Only in cases or situations when an individual is unable to self-identify race(s), ethnicity(ies), or primary language may an individual authorized to make medical decisions on said person's behalf, make the selection. If that option is unavailable, "unable to collect" may be written in for



the individual. If an individual selects more than one race and/or ethnicity, that selection should not be coded under “Other.”

Collection systems must enable documenting self-identification of multiple races and/or ethnicities.

### Mapping to Other Data Collection Standards

The REL Data Collection Standards provide the detailed subcategories of race and ethnicity, and hierarchical mapping to the OMB national standards. This facilitates continued reporting in alignment with federal standards and provides crosswalks to support existing collection systems for health care providers, state health services agencies and their contractors.

### Who is Mandated to Adhere to the REL Collection Standards?

Entities covered under this mandate include “any state agency, board or commission that directly, or by contract with another entity, collects demographic data concerning the ancestry or ethnic origin, ethnicity, race or primary language of residents of the state in the context of health care or for the provision or receipt of health care services or for any public health purpose.” The entities include but are not limited to agencies and contractors that provide clinical services, behavioral health services, community health services and support, and public health services and surveillance. These include:

- Department of Social Services
- Office of Health Strategy
- Office of the Medical Examiner
- Department of Children and Families
- Department of Mental Health and Addiction Services
- Department of Developmental Services
- Department of Public Health
- Department of Veteran Affairs
- Department of Corrections

Additionally, health care providers that have electronic health record (EHR) systems required to connect to and participate in the State-wide Health Information Exchange (Connie), must collect in their EHR system patient self-reported REL data in alignment with the OHS REL Data Collection Standards.

### How and When to Collect REL Data

The point of collection of REL data varies statewide, and each collection entity’s operations context is different. Consequently, each context requires the use of different methods and modes of collection, which makes setting a universal implementation standard inappropriate. This guidance provides flexibility in how and when to collect REL data in accordance with existent workflows. OHS supports the Connecticut Health Foundation’s [“A Roadmap for Race, Ethnicity, and Language Data Collection and Use in Connecticut”](#) which maps out how to collect, store and utilize REL data for health care for providers.



OHS also recommends that organizations proceed with collection from clients/patients in alignment with the Culturally and Linguistically Appropriate Standards outlined by the US Health and Human Services [Think Cultural Health](#) program.

#### [REL Data Aggregation and Disaggregation](#)

PA 21-35, section 11 requires collection of detailed races, ethnicities, and primary languages for analyses to track, monitor, and support development of targeted interventions to minimize racial disparities. The REL standards document provides examples of aggregations and notes that federal, state or agency cell suppression requirements or guidelines, influence public reporting of data. The standards also note need for other considerations in publicly reporting REL data aggregations.

#### [REL Data Collection Standards and Implementation Guide Feedback](#)

Establishment of the REL data collection standards and implementation guide is an iterative process. PA 21-35 requires review and evaluation of the REL data collection standards and guide from time to time. OHS' is committed to robust and inclusive stakeholder engagement and feedback. Accordingly, OHS appreciates comments and insights from all interested parties. Please send any communications to OHS at [ohs@ct.gov](mailto:ohs@ct.gov)



## Appendix 1

### Public Act 21-35

Section 11 of Public Act 21-35 states that:

Sec. 11. (NEW) (Effective from passage) (a) On and after January 1, 2022, any state agency, board or commission that directly, or by contract with another entity, collects demographic data concerning the ancestry or ethnic origin, ethnicity, race or primary language of residents of the state in the context of health care or for the provision or receipt of health care services or for any public health purpose shall:

- (1) Collect such data in a manner that allows for aggregation and disaggregation of data.
- (2) Expand race and ethnicity categories to include subgroup identities as specified by the Community and Clinical Integration Program of the Office of Health Strategy and follow the hierarchical mapping to align with United States Office of Management and Budget standards;
- (3) Provide the option to individuals of selecting one or more ethnic or racial designations and include an "other" designation with the ability to write in identities not represented by other codes;
- (4) Provide the option to individuals to refuse to identify with any ethnic or racial designations;
- (5) Collect primary language data employing language codes set by the International Organization for Standardization; and
- "(6) Ensure, in cases where data concerning an individual's ethnic origin, ethnicity or race is reported to any other state agency, board or commission, that such data is neither tabulated nor reported without all of the following information:
  - (A) The number or percentage of individuals who identify with each ethnic or racial designation as their sole ethnic or racial designation and not in combination with any other ethnic or racial designation;
  - (B) the number or percentage of individuals who identify with each ethnic or racial designation, whether as their sole ethnic or racial designation or in combination with other ethnic or racial designations;
  - (C) the number or percentage of individuals who identify with multiple ethnic or racial designations; and
  - (D) the number or percentage of individuals who do not identify or refuse to identify with any ethnic or racial designations."



(b) Each health care provider with an electronic health record system capable of connecting to and participating in the State-wide Health Information Exchange as specified in section 17b-59e of the general statutes shall, collect and include in its electronic health record system self-reported patient demographic data including, but not limited to, race, ethnicity, primary language, insurance status and disability status based upon the implementation plan developed under subsection (c) of this section. Race and ethnicity data shall adhere to standard categories as determined in subsection (a) of this section.

(c) Not later than August 1, 2021, the Office of Health Strategy shall consult with consumer advocates, health equity experts, state agencies and health care providers, to create an implementation plan for the changes required by this section.

(d) The Office of Health Strategy shall (1) review (A) demographic changes in race and ethnicity, as determined by the U.S. Census Bureau, and (B) health data collected by the state, and (2) reevaluate the standard race and ethnicity categories from time to time, in consultation with health care providers, consumers and the joint standing committee of the General Assembly having cognizance of matters relating to public health.