OHS CONNECTICUT Office of Health Strategy

Connecticut's Master Implementation Toolkit for Race, Ethnicity, and Language (REL) Data Collection

Version 3.0

Prepared by the Office of Health Strategy

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Purpose of REL Master Toolkit

Connecticut's *Master Implementation Toolkit for Race, Ethnicity, and Language (REL) Data Collection* (REL Master Toolkit) has been developed and is maintained by the Office of Health Strategy (OHS). The purpose of the REL Master Toolkit is to support the implementation of REL data collection by health care provider organizations using electronic health record systems (EHRs) and by state agencies, boards, commissions, and contractors, as set forth in Public Act (PA) 21-35 and later codified in C.G.S. §19a-754d.

In accordance with PA 21-35 §11(6)(b),*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 also, 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*. The guidance and information contained within the REL Master Toolkit, specifically the implementation plan, may be utilized by health care providers for the collection of insurance and disability status data.

The REL Master Toolkit resources include an updated REL Implementation Plan (Version 3.0) and an updated REL Data Collection Standards Document (Version 3.0), and several other informational resources intended to be a comprehensive framework for the collection of REL data. Each section of the REL Master Toolkit is a stand-alone resource document in the OHS REL Online Resource Library; all resources are maintained on the OHS website as a collection of informational materials on REL data collection in pursuit of health equity and the elimination of racial and ethnic health disparities.

REL Data Collection Standards Document History

The chart below outlines changes made to the standards since their original publication in early 2022.

Version	Worksheet Name	Update
REL Data Collection Standards Document Version 3.0 **December 2023**	PA 21-35 § 11	Updated statutory reference
	Race Standards	Deleted "for database use only" and clarified category purpose
	Ethnicity Standards	Defined Spaniard
		Deleted "for database use only" and clarified category purpose
		Added "Latine" to the Latin American ethnicity category and combined race/ethnicity standards to comply with newly enabled PA 23-133 §1, i.e. "Hispanic/Latino/Latina/**Latine/**Spanish"
		Corrected spelling of ethnicity code E703 from "Columbian" to "Colombian"
	Race/Ethnicity Standards	Deleted "for database use only" and clarified category purpose
	CT Languages ISO_639	Deleted redundant row labeled as "Portugese"
		Added "Unknown" category with code "und"
		Added "English" to list of languages with code "eng"
		Added "Spanish" to list of languages with code "spa"

Background

Identifying and Eliminating Racial and Ethnic Health Disparities

In 1985, a report was issued by the U.S. Department of Health and Human Services with evidence of disparities in the health status and inequities in health care services to Blacks, Hispanics, Native Americans, and those of Asian/Pacific Islander heritage in the United States. The Report of the Secretary's Task Force on Black and Minority Health, known as The Heckler Report, was issued by the Secretary of the U.S. Department of Health and Human Services (DHHS), Margaret Heckler, who established the Task Force and called for a comprehensive report on race and ethnicity-based health disparities. The Heckler Report identified significant disparities for Black and minority populations with specific health conditions, and the Secretary's Task Force made nine recommendations to begin to address the stark disparities identified in the report's data. One recommendation (#7) focused on improving the collection and use of data to gain better understanding of racial health disparities, calling for DHHS to undertake activities such as enhancing vital records data in states and "incorporating specific racial/ethnic identifiers in databases".

At the time The Heckler Report was released, most medical records were paper documents filed in chart folders. While many health researchers readily adopted the practice of collecting racial and ethnic identifiers, it took over thirty years for the majority of physician practices to have the technical capability to collect the discreet data elements in an electronic health record system (EHR) necessary for a more comprehensive view of health disparities across populations. By 2021, every hospital and most medical practices in the state had adopted EHR technology, and Connecticut's state-designated health information exchange (HIE) had been established, paving the way for more informed research on all types of health conditions and social factors impacting the state's Black and minority populations.

Collection of Race, Ethnicity, and Language Data

Public Act 21-35, signed into law in 2021, established the Commission on Racial Equity in Public Health and mandated the collection of race, ethnicity, and language demographic data by state agencies, boards, and commissions and by all health care providers in Connecticut with an EHR system capable of connecting to Connie, the state-designated HIE. The statute requires OHS to engage stakeholders and develop standard codes and fields for the demographic data categories of race, ethnicity, and language (REL standards). In passing this new law, Connecticut's General Assembly (CGA) is advancing the ability for health researchers to identify health disparities related to race and ethnicity more quickly and with more granularity, allowing systemic causes for disparities to also be identified, so targeted interventions can be developed, applied, and studied.

An example of the usefulness of REL data in identifying racial disparities in health outcomes was illustrated in research done by Kaiser Health Foundation with hospital data compiled by the Centers for Disease Control (CDC). In this study, Black, Hispanic, and Alaskan Native populations were shown to have higher incidences of COVID infections, hospitalizations, and mortality than those of White and Asian descent.

The guidance in this document is intentional in its flexibility for describing how and when to collect REL data in accordance with existing workflows. In addition to this document, OHS suggests that organizations review the Connecticut Health Foundation's resource, "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 providers, and examine other sources made available by the U.S. Health and Human Services Think Cultural Health program.

Roles and Responsibilities Specified in PA 21-35

Commission on Racial Equity in Public Health

Connecticut's Commission on Racial Equity in Public Health (the Commission) was established with the **purpose of eliminating health disparities and inequities in health outcomes for all sectors**. The Commission is required to address the incorporation of health and equity into a comprehensive strategic plan with focused considerations for addressing racial disparities across nine public policy domains.

Public Policy Domains for Consideration by the Commission on Racial Equity in Public Heath

The Commission's strategies are to address policies, programs, and government decision-making processes that may include but are not limited to:

- ***Disparities*** in laws and regulations impacting public health
- ***Disparities*** in the criminal justice system
- ***Disparities*** in access to resources, including, but not limited to, healthy food, safe housing, public safety and environments free of excess pollution
- ***Disparities*** in access to quality health care

Not all of the Commission's wide-reaching duties as promulgated in PA 21-35 correlate to REL data collection by health care providers using EHR systems and state systems collecting data in the context of health care; this document is focused on REL data collection into those systems. The Commission is charged with reporting reductions in measurable health disparities based on race and ethnicity to the CGA Joint Committees for health care utilization and outcome indicators that include:

- Health insurance coverage rates
- Pregnancy and infant health outcomes
- Emergency room visits and deaths related to conditions associated with exposure to environmental pollutants, including respiratory ailments

- Quality of life
- Life expectancy
- Lead poisoning
- Access to adequate healthy nutrition
- Self-reported well-being surveys

Office of Health Strategy

Connecticut's REL strategies have been informed by the work of the OHS Community and Clinical Integration Program (CCIP), born from Connecticut's State Innovation Model (SIM) testing grant, a multi-year investment in healthcare payment and delivery transformation made by the Centers for Medicare and Medicaid Innovation (CMMI). OHS directs numerous ongoing initiatives established by SIM. OHS also provides oversight and coordination for statewide health IT and health information exchange (HIE) strategies.

Public Act 21-35 directs OHS to establish common REL data collection standards using the U.S. Office of Management and Budget (OMB) standards for race and ethnicity data, and using the International Organization for Standardization (ISO) standards for language data. In 2021 OHS developed the REL Implementation Plan (Version 1.0) and the REL Data Collection Standards (Version 1.0). In 2022, minor updates made to both documents created Versions 2.0 and 2.1. The release of this REL Master Toolkit includes the REL Implementation Plan (Version 3.0) and the REL Data Collection Standards Document (Version 3.0). OHS will support ongoing synchronization of the REL implementation resources in the REL Master Toolkit, with all documents available on the OHS website in the REL Online Resource Library.

OHS is committed to robust and inclusive stakeholder engagement to gather input on new or revised guidance documents and feedback on current REL standards. In addition to developing and maintaining the REL Data Collection Standards, the REL Implementation Plan, and the other resources included in the REL Master Toolkit, OHS also facilitates collaborative activities among state agencies impacted by the REL data collection requirements. Monthly meetings are organized and staffed by OHS to support shared learnings, collect progress notes, identify challenges, discuss standards that may need to be updated, and brainstorm training and communication strategies.

Provider organizations impacted by Connecticut's REL data collection mandate are invited to participate in a variety of engagement activities with other providers for peer-to-peer learning opportunities, communication training roundtables, and facilitated Q&A webinars. Provider engagement activities will be led by Yale University's Equity Research and Innovation Center (Yale ERIC) through generous support from the Connecticut Health Foundation.

OHS will facilitate online provider information sessions by leveraging relationships with provider associations, community groups, members of the Health IT Advisory Council, Connie staff, the Health Care Cabinet, the Consumer Advisory Council, the Cost Growth Benchmark Stakeholder Advisory Board, and other stakeholder groups willing to share information about REL data collection requirements for the elimination of

racial and ethnic health disparities. Feedback collected during provider engagement activities will inform future iterations of the resources in the REL Master Toolkit.
OHS appreciates comments and insights from all interested parties. Please send questions and other communications to OHS@ct.gov.

State Agencies, Boards, and Commissions Subject to REL Data Collection

Collection of REL data is mandatory for "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. The following chart, which may be expanded, provides an initial list of agencies identified.

Department of Aging and Disability Services
Department of Children and Families
Department of Correction
Department of Developmental Services
Department of Mental Health and Addiction Services
Department of Public Health
Department of Social Services
Department of Veterans Affairs
Office of the Chief Medical Examiner
Office of Health Strategy

Guidance for Implementers of REL Data Collection Standards

The following guidance categories and topics are intended to support provider organizations and state agencies required to collect REL data. Some guidance may not apply to every organization.

A key principle underlying the REL initiative is self-reporting of data by patients/clients to health care providers and state agency programs. It is important that provider organizations, state agencies, boards, commissions, or contractors do not assume or judge any individual's ethnic and racial identity or written and spoken language without asking. It is also important to avoid making assumptions about the person based upon shared membership. While some federal programs may require "observed" values of race and/or ethnicity to be noted within a form when an individual does not elect to self-report race and ethnicity data, Connecticut's REL program is intended to include self-reported data only.

- **Legal and Regulatory Compliance**

  Legal Preparation: Review PA 21-35 and become familiar with the REL data standards. Conduct a comprehensive review of the specific legal requirements and regulations governing the collection of race, ethnicity, and language data, including any recent updates or amendments. Refer to the *Document History* table that follows the *Table of Contents* for updates and/or amendments to this document.

  Legal Counsel: Consider seeking legal counsel and/or engaging consulting support with expertise in data privacy and civil rights to provide guidance on compliance with the law. Consider whether your organization or agency is subject to other federal and state laws that may impact the organization or agency's collection of REL data.

- **Data Collection Framework**

Data Sources: Identify the channels and interactions where data collection will take place, including but not limited to application forms, patient surveys, assessment forms, and online patient portals connected to an electronic health record (EHR). Identify touchpoints and interactions with patients or clients where data collection will occur, such as in registration forms, intake forms, and as part of an (EHR).

Data Collection Processes and Procedures: Establish clear procedures within the organization for data collection, including how to ask questions related to race, ethnicity, and language, and how to record patient/client/consumer responses. (See FAQ and Examples below).

Data Categories: Determine the specific data categories for race, ethnicity, and language; ensure alignment with the definitions provided in this document.

- **Data Privacy and Security**

Informed Consent: Inform patients or clients of the purpose of data collection, ensure their understanding, and emphasize that providing this information is voluntary.

Privacy Policy: Develop or update a comprehensive privacy policy that outlines how collected data will be used, stored, and protected. Ensure the policy complies with state and federal data protection laws and clearly outlines the purpose of data collection, how data will be used, stored, and protected, and individuals' rights regarding their data.

- **Staff Training and Awareness**

Training: Conduct thorough training sessions for staff responsible for data collection, focusing on the importance of collecting data accurately and in a non-discriminatory manner.

Cultural Sensitivity: Provide cultural sensitivity training to staff to ensure respectful and unbiased interactions during data collection.

- **Data Collection Tools**

Survey and Application Design: Design or modify data collection tools, such as surveys and application forms, to include the required granular data fields for race, ethnicity, and language.

Language Access: Data collection materials should be available in multiple languages to accommodate patient/client populations. Consider recording document translations.

Telephone/In-Person Interviews: Develop or revise interview scripts including prompts on how and when to probe. Consider using interpreter services.

Digital Forms: Develop or modify electronic forms within an EHR system and other data collection platforms to include the required granular data fields for race, ethnicity, and language.

Paper Forms: Modifying existing paper forms to collect granular race, ethnicity, and language data from clients requires careful consideration of the form's design, the questions in a form, and form instructions to ensure accurate data collection, in compliance with REL data collection requirements, and demonstrating cultural sensitivity to potential patient or client concerns. OHS language

standards do not require an organization or agency to list the 700+languages on paper intake forms. While it is important to be inclusive and provide language assistance to individuals with diverse language preferences, it is not practical or necessary to list every language spoken worldwide on a form.

- **Principles for Language Standards**

Identification of Key Languages: Identify and include the most commonly spoken languages in the organization's service area. These will be the languages most likely to be regularly encountered.

Use of Standardized Codes: Use standardized language codes and abbreviations to represent languages. This supports standard data collection and reporting.

Language Assistance Services: Intake and registration forms should include information about the availability of language assistance services, such as interpretation and translation for individuals with limited English proficiency (LEP).

Clear Language Preference Section: Include a section in an intake or registration form where individuals can specify their preferred language for communication. This allows collection of important language data from each individual patient or client.

Translations: If applicable, provide translated versions of the intake or registration forms in the languages most commonly spoken by the population served. These translations should be double checked, if possible, to ensure translations are accurate and culturally appropriate.

Training and Awareness: Train staff and contractors to ensure understanding of the importance of collecting accurate language data and how to offer language assistance services to LEP individuals.

Continuous Improvement: Regularly review the organization's or agency's intake and registration forms for potential changes to forms, with language assistance practices based on feedback, changing demographics, and emerging best practices.

- **Modification of Existing Forms**

Evaluate Current Forms: Review the organization's or agency's existing paper forms to assess how race, ethnicity, and language data is currently collected. Identify areas that need modification

Redesign the Forms: Create new form sections or modify existing ones to include the necessary data fields. Consider the following:

- **Race and Ethnicity:** Design clear checkboxes or fill-in-the-blank spaces for clients to select or specify their race and ethnicity.
- **Language:** Include a section for clients to indicate their preferred language(s) for spoken and written communication.
- **Provide Clear Instructions:** Add concise and easy-to-understand instructions at the beginning of the form, explaining the purpose of collecting this information, emphasizing its voluntary nature, and assuring confidentiality.
- **Offer "Prefer Not to Say" Option:** Include an option for clients who prefer not to disclose their race, ethnicity, or language.
- **Cultural Sensitivity:** Ensure that the form uses respectful and culturally sensitive language

when addressing these topics.

- **Review and Test:** Carefully review the modified forms to ensure they are clear, unambiguous, and free from errors. Consider testing the forms with a small group of clients for feedback.
- **Update Data Processing Procedures:** Ensure that the organization's or agency's data processing procedures are aligned with the modified forms. Verify that data collection personnel are trained on how to use the updated forms.
- **Data Security Protocols:** Data collection and storage procedures must comply with federal and state laws for safeguarding collected data; industry best practices should be followed at all times.

Launch and Training: Introduce modified forms for use by the organization or agency. Provide training to staff responsible for collecting data, emphasizing sensitivity and accuracy.

Monitor and Adapt: Continuously monitor the collection process and forms' effectiveness. Collect feedback from clients and staff to identify any issues or areas for improvement.

Communication: Inform clients through various communication channels about the updated forms and the reasons for collecting this data, including website announcements, signage, and in-person explanations.

Evaluation: Periodically assess the effectiveness of the modified forms in collecting granular race, ethnicity, and language data. Adjust as needed.

Data Collection Procedures

Data Collection Procedures: Establish clear, standard procedures for data collection, including scripts for staff and guidelines for recording patient or client responses.

Clear Non-Discrimination Polices: Emphasize the importance of non-discrimination and inform the individuals that providing REL information is voluntary. When asking patients to provide race, ethnicity, and language data, it is important to be sensitive, clear, and respectful.

Data Validation and Quality Assurance

Validation Process: Implement data validation checks for consistency and error detection to ensure data is accurate and conforms to defined categories.

Quality Assurance: Conduct regular quality assurance checks and audits of the data collection process to monitor accuracy and address any issues promptly.

Reporting and Analysis

Data Analysis: Develop data analysis protocols to extract meaningful insights, identify disparities, and assess compliance with legal requirements and data conformance to standards.

Reporting: Generate periodic reports on race, ethnicity, and language data, including trends and analysis, and make these reports available to relevant stakeholders as required by law.

- **Public Awareness and Communication with Community Organizations**

  Community Engagement: Engage with communities and individuals through public awareness campaigns, meetings, or forums to explain the importance of collecting this data and how it will be used to promote equity and inclusivity.

  Transparency: Maintain transparency by openly sharing your objectives, methodologies, and progress in data collection with stakeholders and the public.

- **Continuous Improvement**

  Feedback Mechanisms: Establish feedback mechanisms for staff, respondents, and stakeholders to provide input on the data collection process and suggest improvements.

  Evaluation: Periodically evaluate the effectiveness of the data collection efforts, considering feedback and emerging best practices.

- **Monitoring and Compliance**

  Regularly monitor data collection efforts to ensure ongoing compliance with legal mandates and adapt to any changes or updates in the law.

- **Evaluation and Reporting**

  Periodically evaluate the effectiveness of the implementation plan and report progress, findings, and adjustments to relevant authorities or stakeholders, as required by law.

- **Budget and Resources**

  Allocate sufficient budget, staffing, and resources to support the effective implementation of the plan, including staff training, technology infrastructure, and security measures.

- **Review and Adapt**

  Regularly review and adapt the implementation plan to address any changing legal requirements, technological advancements, or emerging best practices in data collection and privacy.

Examples of Questions and Response Options

When REL data is being collected from patients or clients it is important to emphasize that providing REL information is voluntary and will not be shared or used outside the permitted purposes of HIPAA. It is recommended that a brief explanation be provided of why REL data collection is important, such as emphasizing the opportunities for improving health care quality and ensuring culturally competent care.

Question Options	Example Statements to Patients or Clients and Suggested Response Fields
Questions for Collecting Race and Ethnicity	"We are committed to providing the best possible care for all our patients. To help us better understand your health care needs, please indicate your race and ethnicity. This information is voluntary and will be kept confidential." ▪ Race: [Dropdown menu with options] ▪ Ethnicity: [Dropdown menu with options]
Alternative Questions for Collecting Race and Ethnicity	"Please select the category or categories that best describe your race and your ethnicity. This information is voluntary and will be kept confidential." ▪ Race: [Checkbox options for race categories] ▪ Ethnicity: [Dropdown menu with ethnicity options]
Question with Open Text Field for Collecting Race/Ethnicity	"To ensure that we provide culturally sensitive care, please share your race and ethnicity with us. You may also describe it in your own words if you prefer. This information is voluntary and will be kept confidential." ▪ Race/Ethnicity: [Open text field]
Question for Collecting Language Data	"In what language(s) do you prefer to communicate regarding your care? This helps us ensure effective communication during your visits. This information is voluntary and will be kept confidential." ▪ Language(s): [Open text field or dropdown menu]
Combined Question for Collecting Race, Ethnicity, and Language	"We are committed to providing personalized care. To assist us in tailoring our services to your needs, please provide the following information. This data is voluntary and will be kept confidential." ▪ Race: [Dropdown menu with options] ▪ Ethnicity: [Dropdown menu with options] ▪ Preferred Language(s): [Open text field or dropdown menu]
Alternative Combined Question for Collecting Race, Ethnicity, and Language	"We respect your unique identity and cultural preferences. Please answer the following questions to help us serve you better. Your responses will be kept confidential." ▪ Race: [Dropdown menu with options] ▪ Ethnicity: [Dropdown menu with options] ▪ Preferred Language(s): [Open text field or dropdown menu]

REL Data Collection Implementation Plan

For Provider Organizations, State Agencies, Contractors, Boards, Commissions, and Contractors

Definitions and Descriptions

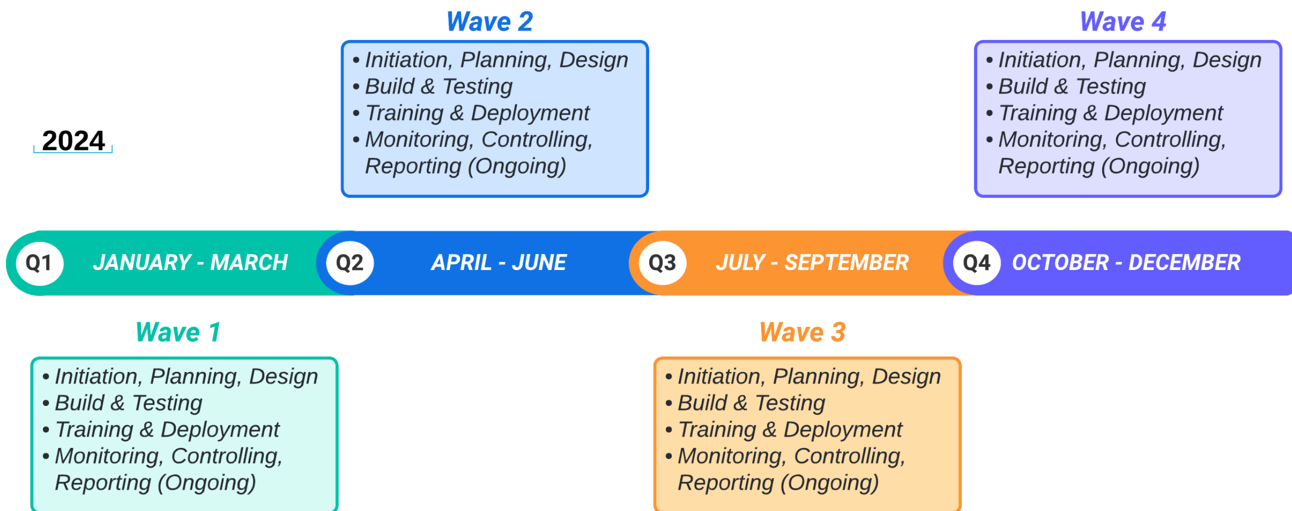
- **Race:** A social construct linked to perceived biological differences demarcated by characteristics, such as skin color, hair type, eye shape. OMB requires five minimum categories: American Indian or Alaska Native, Asian, Black, or African American, Native Hawaiian or Other Pacific Islander, and 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 the ability to select multiple races. The CCIP standard expands the ethnicity subcategories, includes the options to write in one or more ethnicities, "other" and "decline to identify," and defines 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 English proficiency and the specific language spoken is appropriate for the point of health care delivery.

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 International Organization for Standards (ISO) has designated the Library of Congress ISO 639 Joint Advisory Committee (ISO 639/JAC) to maintain the alpha-3 language code standard. Connecticut has adopted the REL the ISO 639-2/639-5 for language data collection standards. 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."

Timeline

Implementors of the REL data collection framework are encouraged to plan their project resourcing to begin during the earliest calendar quarter that is feasible during 2024. To foster a supportive and collaborative environment among implementors, OHS recommends for project plans to generally be aligned with the suggested activity domains per the accompanying timeline. Detailed descriptions of the domains are described below.



Activity Domains and Tasks for Implementing REL Standards

The organizations impacted by PA 21-35 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…[and] Each health care provider with an electronic health record system capable of connecting to and participating in the Statewide Health Information Exchange as specified in section 17b-59e of the general statutes.” Every organization will have different resource availability in terms of skillsets and bandwidth, and many organizations will have dependencies on the availability of a resource from their EHR vendor or other information technology solution provider that will need to make changes to the system to accommodate the REL collection and any associated development needs, (i.e., prompts, scripts, screens, reports, etc.) that may be needed or desired by the provider organization or state agency. The following activity domains with associated tasks are intended as guides for implementors’ planning purposes.

Planning Activity Domain

Any project requiring organizational change must have executive-level support and a clear understanding of the project roles, the anticipated timeline, and the budget required for the project to be successful. The REL implementation team for any provider organization or agency should begin with a kick-off meeting to ensure shared understandings and the commitment of a project sponsor with executive oversight of the team's progress. It is recommended to begin with a draft project charter at the kick-off stage, and to consider the project planning domain work to be concluded once a detailed project plan has been approved, resources have been assigned and budget has been allocated.

Planning Tasks

- Develop a project charter
- Create a Roles and Responsibilities Matrix for Implementation Project Team (example below).
- Set project team meeting schedule
- Identify impacted systems that contain REL data
- Identify and define REL data model changes to impacted systems
- Determine resources needed for REL implementation
- Identify security and privacy requirements
- Identify all staff who work with REL data and responsibility regarding REL data
- Identify staff training needs
- Identify workflow changes to facilitate REL data collection according to new standards
- Create budget for implementation cost to update systems, workflow changes, and training on REL standards
- Create a project plan

Recommended Roles for a REL Implementation Project Team

Role	Name	Expected Weekly Time Commitment	Email, Slack, Teams etc. Contact Info
Executive Sponsor			
Project Manager			
Business/Systems Analysts			
Database Manager			
Developers			
Security/Compliance Officer			
Testers			
Implementation Manager			
Trainer			

Design Activity Domain

The design domain will most likely require the participation of a technical resource from the EHR or data system vendor to create many of the documents listed below, with participation of the REL Implementation Project Team to help inform system requirements and to conduct thorough reviews of all vendor-developed documents prior to signing of on any technical decisions. This is domain when a user focus group may be useful to review options for the user interface (UI). This is also the time to consider the organization's reporting needs associated with the REL data collection, so reports can be produced without special effort, if possible.

Design Tasks

- Design solution to address security and privacy requirements
- Design database monitoring tools
- Design updates to data model to accommodate new values for REL standard compliance
- Design solutions to satisfy data integration of the REL Data Collection Standards as specified in Version 3.0; harmonize changes if an earlier version of REL Data Standards was previously implemented
- Design new documentation for data model, data protocols etc.
- Design document management protocol pertaining to REL updates
- Update operational reporting requirements impacted by new REL standards
- Design data quality strategy
- Design user interface mock-up
- Design acceptance criteria based on design requirements

Build and Test Activity Domain

The build and test domain will likely involve the EHR or data system vendor to build the REL Data Collection Standards into the patient/client registration and/or intake workflows. It is important to conduct rigorous testing (likely automated test scripts and user acceptance testing) before moving any new system code into the production environment. If the provider organization is fully connected to Connie's HIE infrastructure and sending data on an automated schedule, it will be important to include testing for REL data submission to Connie. If possible, make a point to schedule this step well in advance of the system upgrade, to ensure a resource is available to assist from Connie.

Build and Test Action Steps

- Build updates to data model
- Build pre- and post-production environments
- Build new documentation for data model, data protocols, etc.
- Build document management protocol

- Build protocol for REL Data Collection Standards as specified in Version 3.0; harmonize changes if an earlier version of REL Data Standards was previously built
- Build data quality strategy including building controls

Training and Deployment Activity Domain

The solution should not be deployed in the production environment until training has been completed by all relevant staff. In a large organization, it is recommended to identify a couple of "super users" in each department or staff unit who can help trouble user-related issues. It is a best practice to have a single unit be trained on new workflows related to the collection of REL data prior to launching a training protocol across the enterprise. This will help to ensure that the training materials are easy to understand and to adjust training documentation if needed. This step is impractical in small organizations. For organizations where some or all of the REL data collection will take place outside of an organization's physical location, such as a home health provider organization, it would be optimal to hold an informal check-in meeting for staff after a couple of weeks requesting REL data from patients/clients. This would provide a forum for staff to share their experiences asking for REL data and allow for peer-to-peer learning to increase staff confidence in managing patient or client questions or concerns.

Training and Deployment Action Steps

- Identify cohorts to be trained, e.g., social workers, physicians, medical support personnel
- Identify training delivery method (Train-the-Trainer, recorded video, online content, printed content, proficiency checks); create training content
- Set training schedule
- Develop training report (a spreadsheet may suffice) with names and dates of completed training
- Incorporate training into new employee onboarding and training processes

Monitoring, Maintenance, and Reporting Activity Domain: Ongoing

It is important for organizations to have an assigned "owner" for monitoring adherence to new data collection protocols and to take steps to remediate data quality issues, if found. Shortly after the upgraded system goes live, a check with Connie should be done to make sure the REL data is being received by the HIE as expected (and hopefully, as testing had confirmed previously). Ongoing monitoring for consistency of REL data collection should be an assigned role for every organization, Positive feedback (verbal or written acknowledgement, or some type of gamification with small rewards) may be helpful for staff to develop the habit of asking patients and clients for their self-reported REL data.

Monitoring, Maintenance, and Reporting Action Steps

- Develop a framework for assessing REL data quality
- Developing a data quality assessment
- Perform root cause analysis for data quality issues identified
- Identify current challenges to collecting REL data after solution deployment
- Measure and monitor data quality
- Identify, deliberate, and execute remedies/improvements
- Adherence to new workflow and standards
- Develop data validations
- Develop validation to ensure that the data is self-reported
- Sending REL data, disability, and insurance status to the HIE where applicable

Frequently Asked Questions (FAQs)

For Use by Health Care Provider Organizations, State Agencies, and Others When Collecting Race, Ethnicity, and Language Data From Patients and Clients

The following list of Frequently Asked Questions (FAQs) is a resource for provider organizations and state agencies to share with patients and clients about the collection of race, ethnicity, and language data as part of an intake or patient registration process. The FAQs are intended as a stand-alone communication tool for patients and clients by provider organizations that have implemented REL data collection processes as a common practice within the EHR patient registration workflows.

Q: Why is it important for provider organizations and agencies to collect granular race, ethnicity, and language data?

A: Collecting granular data on race, ethnicity, and language data is essential for several reasons. Individual data can inform strategies and interventions to support better care and services. Aggregated data on population groups can support the identification of health care disparities and inequities. For example, race and ethnicity data could help policymakers determine where community investments would have the greatest impact on racial health disparities. Collection of this data helps health care organizations meet the needs of diverse patient populations.

Q: What is the difference between granular and non-granular race, ethnicity, and language data collection?

A: Granular data collection involves gathering more detailed and specific information about an individual's race, ethnicity, and language, using standardized categories that allow for more precise reporting and analysis. Non-granular collection may use broad categories that provide less detailed information.

Q: Are patients or clients required to provide race, ethnicity, and language information?

A: Providing race, ethnicity, and language data is completely voluntary. Patients and clients have the right to decline to answer these questions if they wish.

Q: How will my race, ethnicity, and language data be used?

A: Collected data is primarily used for statistical analysis and reporting to identify health care disparities, improve patient care, and ensure compliance with health care equity regulations. It is also used to tailor health care services to the unique needs of different populations.

Q: How will my privacy and confidentiality be protected?

A: Provider organizations and agencies are committed to safeguarding your data privacy. A federal

privacy law known as HIPAA ensures that your race, ethnicity, and language data can only be for health care-related purposes.

Q: Can I update my race, ethnicity, and language information if it changes?

A: Yes, you can update your race, ethnicity, and language information at any time.

Q: What if I don't know my race or ethnicity information?

A: If you are unsure about your race or ethnicity, you can leave those fields blank or ask a health care provider for assistance. You are not required to provide this information if you do not know it or do not wish to share it.

Q: Will providing this information affect my care or eligibility for services?

A: Providing race, ethnicity, and language data does not impact your eligibility for services or affect your care negatively. The collection of race, ethnicity, and language data is done solely to improve the quality of health care services by addressing health disparities.

Q: How can I be sure that my data will be used responsibly and ethically?

A: Health care organizations and agencies are bound by strict ethical and legal guidelines regarding the use of your data. They are committed to using your data in a responsible manner to understand and address health disparities and improve health care services.

Q: Who should I contact if I have questions or concerns about the data collection process?

A: If you have questions or concerns about the data collection process, your health care provider's privacy officer or clinic administration staff should be able to help answer your questions.

Public Act 21-35 Sec. 11 Codified as C.G.S. §19a-754d

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.

Race, Ethnicity and Language Data Standards

As mentioned throughout this document, PA 21-35 directs OHS to establish common REL data collection standards using the U.S. Office of Management and Budget (OMB) standards for race and ethnicity data, and using the International Organization for Standardization (ISO) standards for language data. **The REL Standards Document can be found at the end of this document.**

Sources:
Title page image sourced from: https://www.fultonschools.org/Page/662

OHS CONNECTICUT Office of Health Strategy

RACE, ETHNICITY, LANGUAGE (REL)
DATA COLLECTION STANDARDS

Version 3.0

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Updates to the Standards after September 2023 release of Version 2.1

Version	Worksheet Name	Update
REL Data Collections Standards Document Version 3.0	PA 21-35 § 11	Update statutory reference
	Race Standards	Delete "for database use only" and clarify category purpose
	Ethnicity Standards	Define Spaniard
		Delete "for database use only" and clarify category purpose
		Added "Latine" to the Latin American ethnicity category and combined race/ethnicity standards to comply with newly enabled PA 23-133 §1, i.e. "Hispanic/Latino/Latina/**Latine**/Spanish"
		Corrected spelling of ethnicity code E703 from "Columbian" to "Colombian"
	Race/Ethnicity Standards	Deleted "for database use only" and clarify category purpose
	CT Languages ISO_639	Deleted redundant row labeled as "Portugese"
		Added "Unknown" category with code "und"
		Added "English" to list of languages with code "eng". Added "Spanish" to list of languages with code "spa"

BACKGROUND AND DEFINITIONS

Statute: Public Act 21-35 Section 11

Enacted in 2021, the ultimate goal of Public Act 21-35: An Act Equalizing Comprehensive Access to Mental, Behavioral and Physical Health Care in Response to the Pandemic, in its entirety:

> “It shall be the goal of the state 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.”**

Public Act 21-35 Section 11, requires the Office of Health Strategy (OHS), to develop race, ethnicity and language (REL) data collection standards in alignment with the OHS Community and Clinical Integration Program (CCIP) recommendations [1], US Office of Management and Budget (OMB)[2], and International Organization for Standardization (ISO) [3,4] standards, that will enable aggregation and disaggregations. The public act also requires OHS, in consultations with health equity experts, state agencies and health care providers to create an implementation plan for collection changes for state agencies and their partners by January 2022.

This document is OHS' and partner state agencies' effort to provide definitions, collection standards and crosswalks for existing and new collection of REL data.

Race and ethnicity are two significant and separate concepts for describing an individual or a population and defined as follows:

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 aligned with the OMB minimum standard.
Go to race standards

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 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 aligned with the OMB minimum standard.
Go to ethnicity standards

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.[5] In recognition of this and also that some current REL data collection may be to information systems that collect race/ethnicity in a single field, this document provides the crosswalk to facilitate that collection in alignment with the CCIP standard.
Go to race/ethnicity standards

BACKGROUND AND DEFINITIONS

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 English proficiency and the specific language spoken is appropriate for the point of health care delivery.[5] The ISO has designated the Library of Congress ISO 639 Joint Advisory Committee (ISO 639/JAC) to maintain the alpha-3 language code standard.[3,4] This document utilizes the ISO 639-2/639-5, the most current coding version, and ISO country codes[6] 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."[7] Many individuals may not have a spoken language, for example, individuals with speaking disabilities or use an alternative communications device. In such cases, sign language or alternative communication devices may be written in, using "Other" on the data collection form or media and the form of communication media indicated.

Below are additional resources used to inform development of this document.

Footnote

1.Recommendations for Granular Race & Ethnicity Data Collection: CCIP

2. Office of Management and Budget. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity

3. International Organization for Standardization: ISO 639 Language Codes

4. Library of Congress International Organization for Standardization 639 /Joint Advisory Committee (ISO 639/JAC)

5. HHS Explanation of Data Standards for Race, Ethnicity, Sex, Primary Language, and Disability

6. International Organization for Standardization Country Codes

7. US Census Bureau Speak English Less Than Well In CT

Additional Resources

8. A Roadmap for Race, Ethnicity, and Language Data Collection and Use in Connecticut

9. CY2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1753-P)

10. San Francisco Guidelines (described as a "recommended standard" and includes rules for "mapping and transformation" crosswalks

11. An Update from the Equitable Data Working Group | The White House

12. An Equity Agenda for the Fields of Health Care Quality Improvement

13. Connecticut Department of Public Health Policies and Procedures for Collecting Sociodemographic Data

14. Office of Management and Budget standards

15. Mock RE Data

16. Mock RE Data Sample Aggregation

17. Sample visualizations

PUBLIC ACT 21-35 Sec. 11, now codified as C.G.S. §19a-754d

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;

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(4) Provide the option to individuals to refuse to identify with any ethnic or racial designations;

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(C) the number or percentage of individuals who identify with multiple ethnic or racial designations; and
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(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.

RACE STANDARDS

Self-identification of race, and one or more categories may be selected

*This category cannot be used for cases when an individual self-identifies multiple races.

** This category is to be used by the collecting provider or entity only and not to be made available for patient/client to select.

CCIP Race Code	CCIP Race Description	OMB Standards Race Code	OMB Standards Race Description
R100	**American Indian or Alaska Native**	**1**	**American Indian or Alaska Native**
R101	Alaska Native	1	American Indian or Alaska Native
R102	Cherokee	1	American Indian or Alaska Native
R103	Iroquois	1	American Indian or Alaska Native
R104	Mashantucket Pequot	1	American Indian or Alaska Native
R105	Mohegan	1	American Indian or Alaska Native
R106	Other American Indian/Alaska Native	1	American Indian or Alaska Native
R200	**Asian**	**2**	**Asian**
R201	Asian Indian	2	Asian Indian
R202	Bangladeshi	2	Asian
R203	Burmese	2	Asian
R204	Cambodian	2	Asian
R205	Chinese	2	Chinese
R206	Filipino	2	Filipino
R207	Hmong	2	Asian
R208	Indonesian	2	Asian
R209	Japanese	2	Japanese
R210	Korean	2	Korean
R211	Laotian	2	Asian
R212	Malaysian	2	Asian
R213	Nepalese	2	Asian
R214	Pakistani	2	Asian
R215	Sri Lankan	2	Asian
R216	Taiwanese	2	Asian
R217	Thai	2	Asian
R218	Vietnamese	2	Vietnamese
R219	Other Asian	2	Other Asian
R300	**Black or African American**	**3**	**Black or African American**
R301	African	3	Black or African American
R302	African American	3	Black or African American
R303	Dominican	3	Black or African American
R304	Haitian	3	Black or African American
R305	Jamaican	3	Black or African American
R306	West Indian	3	Black or African American
R307	Other Black or African American	3	Black or African American
R400	**Native Hawaiian or Other Pacific Islander**	**4**	**Native Hawaiian or Other Pacific Islander**
R401	Guamanian or Chamorro	4	Native Hawaiian or Other Pacific Islander

RACE STANDARDS

Self-identification of race, and one or more categories may be selected
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CCIP Race Code	CCIP Race Description	OMB Standards Race Code	OMB Standards Race Description
R402	Native Hawaiian	4	Native Hawaiian or Other Pacific Islander
R403	Samoan	4	Native Hawaiian or Other Pacific Islander
R404	Other Pacific Islander	4	Native Hawaiian or Other Pacific Islander
R500	**White**	**5**	**White**
R501	Arab	5	White
R502	European	5	White
R503	Middle Eastern or Northern African	5	White
R504	Portuguese	5	White
R505	Other White	5	White
R600	**Some other race***		
R601	Some other race1*		
R602	Some other race2*		
R603	Some other race3*		
R900	**Decline to Identify**		
R901	Unknown/Unsure/Not disclosed		
R902	Unable to collect**		

Go to Race Definition

ETHNICITY STANDARDS

Self-identification of ethnicity, and one or more categories may be selected

+ Native or inhabitant of Spain
*This category cannot be used for cases when an individual self-identifies multiple ethnicities.
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***All standards are according to CCIP except that the E700 includes the requirements of PA 23-133.

CCIP Ethnicity code	CCIP Ethnicity Description***	OMB Standards Ethnicity Code	OMB Standards Ethnicity Description
E700	**Hispanic/Latino/Latina/Latine/Spanish origin (20)**	**6**	**Hispanice/Latino/a/Spanish origin**
E701	Argentinian	6	Hispanice/Latino/a/Spanish origin
E702	Chilean	6	Hispanice/Latino/a/Spanish origin
E703	Colombian	6	Hispanice/Latino/a/Spanish origin
E704	Cuban	6	Cuban
E705	Dominican	6	Hispanice/Latino/a/Spanish origin
E706	Ecuadorian	6	Hispanice/Latino/a/Spanish origin
E707	Guatemalan	6	Hispanice/Latino/a/Spanish origin
E708	Honduran	6	Hispanice/Latino/a/Spanish origin
E709	Mexican, Mexican American, Chicano/a	6	Mexican, Mexican American, Chicano/a
E710	Nicaraguan	6	Hispanice/Latino/a/Spanish origin
E711	Panamanian	6	Hispanice/Latino/a/Spanish origin
E712	Peruvian	6	Hispanice/Latino/a/Spanish origin
E713	Puerto Rican	6	Puerto Rican
E714	Salvadorian	6	Hispanice/Latino/a/Spanish origin
E715	Spaniard+	6	Hispanice/Latino/a/Spanish origin
E716	Spanish	6	Hispanice/Latino/a/Spanish origin
E717	Uruguayan	6	Hispanice/Latino/a/Spanish origin
E718	Venezuelan	6	Hispanice/Latino/a/Spanish origin
E719	Other Hispanic/Spanish	6	Another Hispanic/Latino/Latina/Latine/Spanish origin
E800	**Not Hispanic/Latino/Latina/Latine/Spanish c**	**7**	**Not of Hispanic/Latino/a/Spanish origin**
E801	Other ethnicity1*		
E802	Other ethnicity2*		
E803	Other ethnicity3*		
E900	**Decline to Identify**		
E901	Unknown/Unsure/Not disclosed		
E902	Unable to collect**		

Go to Ethnicity Definition

RACE/ETHNICITY STANDARDS

Self-identification of race/ethnicity, and one or more categories may be selected

*This category cannot be used for cases when an individual self-identifies multiple races and/or ethnicities.

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***All standards are according to CCIP except that the E700 includes the requirements of PA 23-133.

CCIP Race/ Ethnicity Code	CCIP Race Code	CCIP Race/Ethnicity Description***	OMB Standards Race/ Ethnicity Code	OMB Standards Race/Ethnicity Description
C100	**E700**	**Hispanic/Latino/Latina/Latine/Spanish**	**6**	**Hispanic/Latino/a/Spanish origin**
C101	E701	Argentinian	6	Hispanic/Latino/a/Spanish origin
C102	E702	Chilean	6	Hispanic/Latino/a/Spanish origin
C103	E703	Colombian	6	Hispanic/Latino/a/Spanish origin
C104	E704	Cuban	6	Hispanic/Latino/a/Spanish origin
C105	E705	Dominican	6	Hispanic/Latino/a/Spanish origin
C106	E706	Ecuadorian	6	Hispanic/Latino/a/Spanish origin
C107	E707	Guatemalan	6	Hispanic/Latino/a/Spanish origin
C108	E708	Honduran	6	Hispanic/Latino/a/Spanish origin
C109	E709	Mexican, Mexican American, Chicano/a	6	Hispanic/Latino/a/Spanish origin
C110	E710	Nicaraguan	6	Hispanic/Latino/a/Spanish origin
C111	E711	Panamanian	6	Hispanic/Latino/a/Spanish origin
C112	E712	Peruvian	6	Hispanic/Latino/a/Spanish origin
C113	E713	Puerto Rican	6	Hispanic/Latino/a/Spanish origin
C114	E714	Salvadorian	6	Hispanic/Latino/a/Spanish origin
C115	E715	Spaniard	6	Hispanic/Latino/a/Spanish origin
C116	E716	Spanish	6	Hispanic/Latino/a/Spanish origin
C117	E717	Uruguayan	6	Hispanic/Latino/a/Spanish origin
C118	E718	Venezuelan	6	Hispanic/Latino/a/Spanish origin
C119	E719	Other Spanish	6	Another Hispanic, Latino, Latina, Latine or Spanish origin
C200	**E800**	**Not Hispanic/Latino/Latina/Latine/Spanish**	**7**	**Not of Hispanic/Latino/a/Spanish origin**
C201	E801	Other ethnicity1*	7	Other Ethnicity
C202	E802	Other ethnicity2	7	Other Ethnicity
C203	E803	Other ethnicity3	7	Other Ethnicity

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CCIP Race/ Ethnicity Code	CCIP Race Code	CCIP Race/Ethnicity Description***	OMB Standards Race/ Ethnicity Code	OMB Standards Race/Ethnicity Description
C300	**R100**	**American Indian or Alaska Native**	**1**	**American Indian or Alaska Native**
C301	R101	Alaska Native	1	American Indian or Alaska Native
C302	R102	Cherokee	1	American Indian or Alaska Native
C303	R103	Iroquois	1	American Indian or Alaska Native
C304	R104	Mashantucket Pequot	1	American Indian or Alaska Native
C305	R105	Mohegan	1	American Indian or Alaska Native
C306	R106	Other American Indian or Alaska Native	1	American Indian or Alaska Native
C400	**R200**	**Asian**	**2**	**Asian**
C401	R201	Asian Indian	2	Asian Indian
C402	R202	Bangladeshi	2	Asian
C403	R203	Burmese	2	Asian
C404	R204	Cambodian	2	Asian
C405	R205	Chinese	2	Chinese
C406	R206	Filipino	2	Filipino
C407	R207	Hmong	2	Asian
C408	R208	Indonesian	2	Asian
C409	R209	Japanese	2	Japanese
C410	R210	Korean	2	Korean
C411	R211	Laotian	2	Asian
C412	R212	Malaysian	2	Asian
C413	R213	Nepalese	2	Asian
C414	R214	Pakistani	2	Asian
C415	R215	Sri Lankan	2	Asian
C416	R216	Taiwanese	2	Asian
C417	R217	Thai	2	Asian
C418	R218	Vietnamese	2	Vietnamese

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CCIP Race/ Ethnicity Code	CCIP Race Code	CCIP Race/Ethnicity Description***	OMB Standards Race/ Ethnicity Code	OMB Standards Race/Ethnicity Description
C419	R219	Other Asian	2	Other Asian
C500	**R300**	**Black or African American**	**3**	**Black or African American**
C501	R301	African	3	Black or African American
C502	R302	African American	3	Black or African American
C503	R303	Dominican	3	Black or African American
C504	R304	Haitian	3	Black or African American
C505	R305	Jamaican	3	Black or African American
C506	R306	West Indian	3	Black or African American
C507	R307	Other Black or African American	3	Black or African American
C600	**R400**	**Native Hawaiian or Other Pacific Islander**	**4**	**Native Hawaiian or Other Pacific Islander**
C601	R401	Guamanian or Chamorro	4	Native Hawaiian or Other Pacific Islander
C602	R402	Native Hawaiian	4	Native Hawaiian or Other Pacific Islander
C603	R403	Samoan	4	Native Hawaiian or Other Pacific Islander
C604	R404	Other Pacific Islander	4	Native Hawaiian or Other Pacific Islander
C700	**R500**	**White**	**5**	**White**
C701	R501	Arab	5	White
C702	R502	European	5	White
C703	R503	Middle Eastern or Northern African	5	White
C704	R504	Portuguese	5	White
C705	R505	Other White	5	White
C800	**R600**	**Some other race***		**Some other race**
C801	R601	Some other race1*		Some other race
C802	R602	Some other race2*		Some other race
C803	R603	Some other race3*		Some other race
C900	R900 and E900	Decline to Identify Race and Ethnicity		Decline to Identify Race and Ethnicity
C900	R900	Decline to Identify Race		Decline to Identify Race

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CCIP Race/ Ethnicity Code	CCIP Race Code	CCIP Race/Ethnicity Description***	OMB Standards Race/ Ethnicity Code	OMB Standards Race/Ethnicity Description
C900	E900	Decline to Identify Ethnicity		Decline to Identify Ethnicity
C901	R901	Unknown/Unsure/Not disclosed Race		Unknown/Unsure/Not disclosed Race
C901	E901	Unknown/Unsure/Not disclosed Ethnicity		Unknown/Unsure/Not disclosed Ethnicity
C902	R902 and E902	Unable to collect Race and Ethnicity**		Unable to collect

Note: While OMB allows two formats for the race and Hispanic ethnicity questions—one combining both race and Hispanic ethnicity in a single question and the other asking about them in two separate questions, with the Hispanic ethnicity question being asked first—OMB explicitly prefers the latter two-question.

PRIMARY LANGUAGE

Data Standard for Primary Language Spoken

How well do you speak English? (5 years old or older)

a. ____Very well
b. ____Well
c. ____Not well
d. ____Not at all
e.____Decline to Identify

Data Collection For Language Spoken:
1. Do you speak a language other than English at home?

1 Yes
2 No
3 Decline to Identify

For persons speaking a language other than English (answering yes to the question above):

2. What is this language? (5 years old or older)

a. ____Spanish
b. ____Other Language (Identify)
c. ____Decline to Identify

Go to Language Standards

INTERNATIONAL ORGANISATION FOR STANDARDIZATION (ISO) LANGUAGE STANDARDS

*Note alternate form of communication, e.g., a communication device.

Sources:
ISO 639 Code Tables | ISO 639-3 (sil.org)
ISO 639-2 Language Code List - Codes for the representation of names of languages (Library of
ISO 639-5 Identifier : Codes for the representation of names of languages (ISO 639-5 Registration
https://portal.ct.gov/-/media/DEMHS/_docs/Plans-and-Publications/EHSP0087--
https://libguides.ctstatelibrary.org/dld/welcomemultilingual/censusinfo

		ISO 3166-1 AND ISO 3166-3)		
ISO English name of Language	ISO 639-2/ 639-5 Identifier	Country	Alpha-3 code Identifier	Numeric Identifier
Adangme	ada	Ghana	GHA	288
Afar	aar	Djibouti	DJI	262
Afrikaans	afr	South Africa	ZAF	710
Afro-Asiatic languages	afa	Other African		
Akan	aka	Ghana	GHA	288
Albanian	sqi	Albania	ALB	8
Algonquian languages	alg	United State of America	USA	840
American sign language	sgn	United States of America	USA	840
Canadian sign language	sgn	Canada	CAN	124
Amharic	amh	Ethiopia	ETH	231
Arabic	ara	Algeria, Comoros, Chad, Egypt, Djibouti, Morocco, etc		
Armenian	hye	Armenia	ARM	51
Aromanian, Arumanian, Macedo-Romanian	rup	Romania	ROU	642
Baltic-salvic languages	bat	Ukraine	UKR	804
Bambara	bam	Mali	MLI	466
Bantu languages	bnt	Tanzania	TZA	834
Bedawiyet, Beja	bej	Eritrea	ERI	232
Bemba (Zambia)	bem	Zambia	ZMB	894
Bengali	ben	Bangladesh	BGD	50
Bengali	ben	India, Bangladesh		
Berber languages	ber	Algeria, Cameroon, Morocco		
Bihari languages	bih	India	IND	356
Bulgarian	bul	Bulgaria	BGR	100
Burmese	bur	Myanmar	MMR	104
Cantonese		China	CHN	156
Catalan, Valencian	cat	Andorra	AND	20
Celtic languages	cel	Ireland	IRL	372
Central Sudanic languages	csu	Uganda	UGA	800
Chadic languages	cdc	Cameroon	CMR	120
Chagatai	chg	Tanzania	TZA	834
Chamorro	cha	Guam, US Island	GUM	316
Cherokee	chr	Cherokee Nation, US	USA	840
Chewa, Chichewa, Nyanja	nya	Zimbabwe	ZWE	716
Chinese	zho	China	CHN	156

INTERNATIONAL ORGANISATION FOR STANDARDIZATION (ISO) LANGUAGE STANDARDS

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https://libguides.ctstatelibrary.org/dld/welcomemultilingual/censusinfo

		ISO 3166-1 AND ISO 3166-3)		
ISO English name of Language	**ISO 639-2/ 639-5 Identifier**	**Country**	**Alpha-3 code Identifier**	**Numeric Identifier**
Cornish	con	United Kingdom of Great Britain, Northern Ireland (the)	GBR	826
Creoles and pidgins, English based	cpe	Jamaica	JAM	388
Creoles and pidgins, French based	cpf	Réunion	REU	638
Czech	ces	Czech Republic	CZE	203
Dagaari Dioula	dgd	Burkina Faso	BFA	854
Danish	dan	Denmark	DNK	208
Dardic		Pakistan, Afghanistan		
Dutch, Flemish	dut	Netherland	NLD	528
E. Punjabi		India	IND	356
English	eng	Antigua and Barbuda Australia The Bahamas Barbados Belize Canada Dominca Grenada Guyana Ireland Jamaica Malta New Zealand St. Kitts and Nevis St. Lucia St. Vincent and the Grenadines Trinidad and Tobago United Kingdom United States of America		
English based creoles and pidgins	cpe	Other Native North American		
Eskimo-Aleut languages	esx	Alaska, NW Territories, Quebec		
Ewe	ewe	Ghana	GHA	288
Fang (Equatorial Guinea)	fan	Equatorial Guinea	GNQ	226
Fanti	fat	Ghana	GHA	288
Faroese	fao	Faoe Islands	FRO	234
Filipino	fil	Philipines	PHL	608
Fon	fon	Benin	BEN	204

INTERNATIONAL ORGANISATION FOR STANDARDIZATION (ISO) LANGUAGE STANDARDS

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ISO 639-5 Identifier : Codes for the representation of names of languages (ISO 639-5 Registration
https://portal.ct.gov/-/media/DEMHS/_docs/Plans-and-Publications/EHSP0087--
https://libguides.ctstatelibrary.org/dld/welcomemultilingual/censusinfo

		ISO 3166-1 AND ISO 3166-3)		
ISO English name of Language	**ISO 639-2/ 639-5 Identifier**	**Country**	**Alpha-3 code Identifier**	**Numeric Identifier**
French (incl.Patois, Cajun)	roa	France, Canada, DR Congo, Madagascar, multiple countries	FRA	250
Fula	ful	Ghana	GHA	288
Ga	gaa	Ghana	GHA	288
Gaelic, Scottish Gaelic	gla	United Kingdom of Great Britain, Northern Ireland (the)	GBR	826
Gbaya	gba	Central African Republic		
Germanic languages	gem	Germany	DEU	276
Gikuyu, Kikuyu	kik	Kenya	KEN	404
Gothic	got	Other German		
Greek languages	grk	Greece	GRC	300
Gujarati	guj	India	IND	356
Haitian creole	cpf	Haiti	HTI	332
Hausa	hau	Nigeria	NGA	566
Hawaiian	haw	United State of America	USA	840
Hebrew	heb	Israel	ISR	376
Himachali languages, Western Pahari languages	him	India	IND	356
Hindi	hin	India	IND	356
Hmong		China	CHN	156
Hmong-Mien languages	hmx	China	CHN	156
Hungarian	hun	Hungary	HUN	348
Icelandic	ice	Iceland	ISL	352
Igbo	ibo	Nigeria	NGA	566
Indonesian	ind	Indonesia	IDN	360
Iranian languages	ira	Iran (Islamic Republic of)	IRN	364
Irish	gle	Republic of Ireland	IRL	372
Iroquian languages	iro	Iroquois, USA	USA	840
Italian	ita	Italy	ITA	380
Japanese (family)	jpx	Japan	JPN	392
Kanuri	kau	Nigeria	NGA	566
Kinyarwanda	kin	Rwanda	RWA	646
Korean	kor	Korea	KOR	410
Kurdish	ckb	Iran, Iraq, Syria Turkey		
Lao	lao	Laos	LAO	418
Latvian	lav	Latvia	LVA	428
Lingala	lin	Congo Republic-Brazzaville	COD	180

INTERNATIONAL ORGANISATION FOR STANDARDIZATION (ISO) LANGUAGE STANDARDS

*Note alternate form of communication, e.g., a communication device.

Sources:
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ISO 639-2 Language Code List - Codes for the representation of names of languages (Library of
ISO 639-5 Identifier : Codes for the representation of names of languages (ISO 639-5 Registration
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https://libguides.ctstatelibrary.org/dld/welcomemultilingual/censusinfo

		ISO 3166-1 AND ISO 3166-3)		
ISO English name of Language	ISO 639-2/ 639-5 Identifier	Country	Alpha-3 code Identifier	Numeric Identifier
Lozi	loz	Zambia	ZMB	894
Lunda	lun	Zambia	ZMB	894
Madarin Chinese	cmn	China	CHN	156
Malagasy	mlg	Madagascar	MDG	450
Malay	may	Malaysia	MYS	458
Manx	glv	Isle of Man	IMN	833
Maori	mri	New Zealand	NZL	554
Marathi	mar	India	IND	356
Minnan		Taiwan (Province of China)	TWN	158
Mon-Khmer languages	mkh	Cambodian	KHM	116
Navaho, Navajo	nav	North American Indian	USA	840
Nepali	nep	Nepal	NPL	524
Netherlandic		Netherlands	NLD	528
North Ndebele	nde	Mozambique	MOZ	508
Northern Sotho, Pedi, Sepedi	nso	South Africa	ZAF	710
Norwegian	nor	Norway	NOR	578
Nubian languages	nub	Sudan	SDN	729
Occitan	oci	Spain	ESP	724
Odiai	bhf	Indian	IND	356
Pahari	bfz	India	IND	356
Pashto, Pushto	pus	Pakistan, Afghanistan, Iran		
Persian	fas	Iran (Islamic Republic of)	IRN	364
Polish	pol	Poland	POL	616
Portuguese	por	Portugal Brazil, Mozambique		
Portuguese-based creoles and pidgins	cpp	Angola, Brazil, Cape Verde, East Timor, Guinea Bissau, Mozambique		
Rajasthani	raj	India, Pakistan		
Rarotongan	rar	Cook Islands Maori	COK	184
Russian	rus	Russia	RUS	643
Samoan	smo	American Samoa	ASM	16
Samoan	smo	Samoa	WSM	882
Serbo-Croatian	hbs	Bosnia, Serbia, Croatia, Montenegro		
Shona	sna	Zimbabwe	ZWE	716

INTERNATIONAL ORGANISATION FOR STANDARDIZATION (ISO) LANGUAGE STANDARDS

*Note alternate form of communication, e.g., a communication device.

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ISO 639 Code Tables | ISO 639-3 (sil.org)
ISO 639-2 Language Code List - Codes for the representation of names of languages (Library of
ISO 639-5 Identifier : Codes for the representation of names of languages (ISO 639-5 Registration
https://portal.ct.gov/-/media/DEMHS/_docs/Plans-and-Publications/EHSP0087--
https://libguides.ctstatelibrary.org/dld/welcomemultilingual/censusinfo

		ISO 3166-1 AND ISO 3166-3)		
ISO English name of Language	ISO 639-2/ 639-5 Identifier	Country	Alpha-3 code Identifier	Numeric Identifier
Sindhi	snd	Pakistan, India		
Sinhala, Sinhalese	sin	Sri Lanka	LKA	144
Sino-Tibetan languages	sit	China	CHN	156
Slovak	slk	Slovakia	SVK	703
Somali	som	Djibouti, Somalia	SOM	706
Soninke	snk	Mauritania	MRT	478
South Ndebele	nbl	Zimbabwe	ZWE	716
Spanish	spa	Argentina Bolivia Chile Colombia Costa Rica Cuba Dominican Republic Ecuador El Salvador Guatemala Honduras Mexico Nicaragua Panama Paraguy Peru Uruguay Venezuela Puerto Rico Spain Equitorial Guinea		
Swahili	swa	Tanzania, Kenya, Uganda, Rwanda		
Swedish	swe	Sweden, Finland		
Tagalog	tgl	Philippines	PHL	608
Tahitian	tah	French Polynesia	PYF	258
Tajiki Arabic	abh	Tajikistan	TJK	762
Tamil	tam	Réunion	REU	638
Thai	tha	Thailand	THA	764
Tigre	tig	Eritrea	ERI	232
Tigrinya	tir	Eritrea	ERI	232
Tiv	tiv	Nigeria	NGA	566

INTERNATIONAL ORGANISATION FOR STANDARDIZATION (ISO) LANGUAGE STANDARDS

*Note alternate form of communication, e.g., a communication device.

Sources:
ISO 639 Code Tables | ISO 639-3 (sil.org)
ISO 639-2 Language Code List - Codes for the representation of names of languages (Library of
ISO 639-5 Identifier : Codes for the representation of names of languages (ISO 639-5 Registration
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https://libguides.ctstatelibrary.org/dld/welcomemultilingual/censusinfo

		ISO 3166-1 AND ISO 3166-3)		
ISO English name of Language	ISO 639-2/ 639-5 Identifier	Country	Alpha-3 code Identifier	Numeric Identifier
Tonga (Tonga Islands)	ton	Zambia	ZMB	894
Tswana	tsn	Zimbabwe	ZWE	716
Twi	twi	Ghana	GHA	288
Urdu	urd	Pakistan, India		
Venda	ven	Zimbabwe	ZWE	716
Vietnamese	vie	Vietnam	VNM	704
Welsh	cym	United Kingdom of Great Britain, Northern Ireland (the)	GBR	826
Wolof	wol	Gambia	GMB	270
Xhosa	xho	South Africa	ZAF	710
Yoruba	yor	Nigeria, Benin		
Yiddish	yid	Israel, Russia, United States of America		
Zulu	zul	South Africa	ZAF	710
Other*	oth*	Type of communication device		
Unknown	und	Undetermined		

Go to Language Definition

Office of Management and Budget (OMB) REL Standards

I and II. Race and Ethnicity

Ethnicity Data Standard	Categories
Are you Hispanic, Latino/a, or Spanish origin	
(One or more categories may be selected)	
a. ___No, not of Hispanic, Latino/a, or Spanish origin	
b. ___Yes, Mexican, Mexican American, Chicano/a	These categories roll-up to the Hispanic or Latino category of the OMB standard
c. ___Yes, Puerto Rican	
d. ___Yes, Cuban	
e. ___Yes, another Hispanic, Latino, or Spanish origin	

Race Data Standard	Categories
What is your race?	
(One or more categories may be selected)	
a. ___White	These categories are part of the current OMB standard
b. ___Black or African American	
c. ___American Indian or Alaska Native	
d. ___Asian Indian	These categories roll-up to the Asian category of the OMB standard
e. ___Chinese	
f. ___Filipino	
g. ___Japanese	
h. ___Korean	
i. ___Vietnamese	
j. ___Other Asian	
k. ___Native Hawaiian	These categories roll-up to the Native Hawaiian or Other Pacific Islander category of the OMB standard
l. ___Guamanian or Chamorro	
m. ___Samoan	
n. ___Other Pacific Islander	

III. Sex

Sex Data Standard
What is your sex?
a. ___Male
b. ___Female

IV. Primary Language

Data Standard for Primary Language

How well do you speak English? (5 years old or older)

- ***a. ___Very well***
- ***b. ___Well***
- ***c. ___Not well***
- ***d. ___Not at all***

Data Collection for Language Spoken (Optional)

1. Do you speak a language other than English at home? (5 years old or older)

- ***a. ___Yes***
- ***b. ___No***

For persons speaking a language other than English (answering yes to the question above):

2. What is this language? (5 years old or older)

- ***a. ___Spanish***
- ***b. ___Other Language (Identify)***

V. Disability Status

Data Standard for Disability Status

1. Are you deaf or do you have serious difficulty hearing?
- ***a. ___Yes***
- ***b. ___No***

2. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
- ***a. ___Yes***
- ***b. ___No***

3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)
- ***a. ___Yes***
- ***b. ___No***

4. Do you have serious difficulty walking or climbing stairs? (5 years old or older)
- ***a. ___Yes***
- ***b. ___No***

5. Do you have difficulty dressing or bathing? (5 years old or older)
- ***a. ___Yes***
- ***b. ___No***

6. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)
- ***a. ___Yes***
- ***b. ___No***

HHS Implementation Guide
Final HHS Standards
Explanation of HHS Standards

MOCK DATA SET FOR AGGREGATION

ID	Race1	Race2	Race3	Race4	Race5	Hispanic, NonHispanic, Decline to Identify, Blank/UNK, Other)
1	O					H
2	DTI					DTI
3	NHOPI					UNK
4	A	AIAN	O			NH
5	B/AA					NH
6	W					NH
7	UNK					UNK
8	B/AA	O				H
9	AIAN					NH
10	W					NH
11	W					H
12	O					NH
13	Unk					H
14	DTI					DTI
15	B/AA	W				NH
16	UNK					UNK
17	A					NH
18	O					H
19	W					NH
20	B/AA					NH
21	B/AA					H
22	NHOPI					NH
23	W					NH
24	O					NH
25	DTI					H
26	A					NH
27	O					O
28	W					NH
29	B/AA					H
30	W					H
31	B/AA					NH
32	A					NH
33	O					H
34	W					NH
35	B/AA					NH
36	DTI					H
37	DTI					DTI
38	AIAN					NH
39	W					NH
40	B/AA					UNK
41	W					NH

MOCK DATA SET FOR AGGREGATION

ID	Race1	Race2	Race3	Race4	Race5	Hispanic, NonHispanic, Decline to Identify, Blank/UNK, Other)
42	B/AA					NH
43	B/AA					H
44	B/AA					NH
45	W					H
46	UNK					NH
47	UNK					UNK
48	DTI					H
49	W					O
50	W					NH
51	B/AA					O
52	O					H
53	A					NH
54	O					H
55	W					NH
56	B/AA					NH
57	DTI					UNK
58	W					H
59	B/AA					NH
60	AIAN					NH
61	W					NH
62	B/AA					NH
63	O					H
64	UNK					UNK
65	O					NH
66	W					NH
67	UNK					H
68	W					H
69	W					NH
70	B/AA					UNK
71	A					NH
72	UNK					UNK
73	O					H
74	O					NH
75	W					NH
76	AIAN	B/AA				NH
77	O					UNK
78	UNK					H
79	DTI					DTI
80	B/AA					NH
81	NHOPI	W				O
82	W					H

MOCK DATA SET FOR AGGREGATION

ID	Race1	Race2	Race3	Race4	Race5	Hispanic, NonHispanic, Decline to Identify, Blank/UNK, Other)
83	B/AA					NH
84	A					DTI
85	O					H
86	DTI					UNK
87	UNK					NH
88	UNK					H
89	W					NH
90	B/AA	O				H
91	B/AA					NH
92	W					UNK
93	A	B/AA				NH
94	DTI					UNK
95	W					UNK
96	B/AA					O
97	A	W				NH
98	AIAN					NH
99	W					H
100	O					NH

NOTES + CAVEATS
1. Consider responses that are incongruent or nullifying (e.g., Hispanic "N", but selection/notation of a specific Hispanic ethnicity)
2. Multirace order (e.g., Race 1 v. Race 2) in this datasheet is alphabetical - does not purport to designate a particular possible value of identify expression
3. Consider OMB + OMH Standards
4. Consider the purpose and nature of the analysis
5. Consider data presentation and reporting thresholds

KEY Race	
A	Asian
AIAN	American Indian/Alaskan Native
B/AA	Black/African American
DTI	Decline To Identify
NHOPI	Native Hawaiian or Other Pacific Islander
O	Other Race
UNK	Blank/Missing
W	White
T/MR	Two or more races

Ethnicity	
H	Hispanic/Latino/a/Spanish
NH	Not Hispanic/Latino/a/Spanish
O	Other Ethnicity
T/MRE	Two or more ethnicities
DTI	Declined to Identify
UNK	Unknown

MOCK DATA SET AGGREGATION EXAMPLES

NOTES + CAVEATS

When reporting race/ethnicity data, for consistency over time:

1. Consider and document responses that are incongruent or nullifying (e.g., Hispanic "N", but selection/notation of a specific Hispanic ethnicity).

2. Indicate multirace order (e.g., Race 1 v. Race 2) such as in the mock dataset which is alphabetical, does not purport to designate a particular possible value to an expressed identity.

3. Consider Office of Management and Budget + Office of Minority Health Standards.

4. Consider the purpose and nature of the analysis being provided (provide relevant examples as template)

5. Consider data presentation and reporting thresholds for public reporting (group should set standards through emails and can be put into the documentations as agencies may have cell suppression guidelines, but can provide baseline in documentation e.g. federal HHS, HIPAA, inferential disclosure for federal educational rules).
DCF - simple practice standard i.e. <10 suppressed, use guidelines as minimum required; and agency specific recommendations
DPH - adopts federal standards of <11 rule ; Vital Statisitics utilizes less stringent rules, imposes a standard of <11 for crosstabs, but not frequencies, crosstabs for race/ethnicity and geography, have exceptions
OHS - CAR § 19a-167g-94 requires suppression for cell sizes <6; CGS § 19a-654 requires HIPAA suppression guidelines for patient data; suppression for claims data is >11 in alignment with Centers of Medicare and Medicaid Services (CMS) data use agreement.

KEY

Race	
A	Asian
AIAN	American Indian/Alaskan Native
B/AA	Black/African American
DTI	Decline To Identify
NHOPI	Native Hawaiian Other Pacific Islander
O	Other Race
UNK	Blank/Missing
W	White
T/MR	Two or More Races

Ethnicity	
H	Hispanic/Latino/a/Spanish
NH	Not Hispanic/Latino/a/Spanish
O	Other Ethnicity
T/MRE	Two or More Ethnicities
DTI	Declined to Identify
UNK	Unknown

MOCK DATA SET AGGREGATION EXAMPLES

EXAMPLE 1

RACE[2]	Race Alone[1] #	Race Alone[1] % of Total
American Indian or Alaska Native	5	5%
Asian	6	6%
Black or African American	19	19%
Native Hawaiian or Other Pacific Islander	1	1%
White	25	25%
Two or More Races[3]	8	8%
Other	15	15%
Declined to Identify/Unknown	21	21%
TOTAL	100	100%

ETHNICITY[2]	Ethnicity Alone[1] #	Ethnicity Alone[1] % of Total
Hispanic/Latino/a/Spanish	27	27%
Not Hispanic/Latino/a/Spanish	54	54%
Other Ethnicities	0	0%
Two or More Ethnicities	0	0%
Declined to Identify/Unknown	19	19%
TOTAL	100	100%

SITUATIONAL

Two or More Races[++]	
Race Reported in Combination with Other Race(s)	# of Times
American Indian or Alaska Native	2
Asian	3
Black or African American	5
Native Hawaiian or Other Pacific Islander	1
White	3
Other	0
Refused to Identify/Unknown	2

MOCK DATA SET AGGREGATION EXAMPLES

EXAMPLE 2

	Race and Ethnicity	
RACE/ETHNICITY[2]	#	% of Total
American Indian or Alaska Native, Non-Hispanic	4	4%
Asian, Non-Hispanic	6	6%
Black or African American, Non-Hispanic	16	16%
Native Hawaiian/Other Pacific Islander, Non-Hispanic	3	3%
White, Non-Hispanic	18	18%
Two or More Races, Non-Hispanic	6	6%
Other	7	7%
Declined to Identify/Unknown[4]	13	13%
Hispanic, All Races[5]	27	27%
TOTAL	100	100%

Source: *CT REL Mock Data Set For Aggregation*

SITUATIONAL

Two or More Races and Non-Hispanic[++]	
Race Reported in Combination with Other Race(s)	# of Times
American Indian or Alaska Native, Non-Hispanic	1
Asian, Non-Hispanic	2
Black or African American, Non-Hispanic	0
Native Hawaiian/Other Pacific Islander, Non-Hispanic	1
White, Non-Hispanic	3
Two or More Races, Non-Hispanic	0
Other	0
Declined to Identify/Unknown	0

FOOTNOTES:

[1] Mutually exclusive and exhaustive categories representing unique counts of individual in the data, patient/client or service area population. If there are state or federal reporting thresholds, a category may be combined into "Other" and footnoted to indicate why a unique racial/ethnic category count is not included. For example, if the reporting threshold is six, then AIAN and NHOPI categories must be combined with "Other". The associated footnote would say "Includes AIAN and NHOPI, counts of which are lower than the Regulations of CT Agencies Section § 19a-167g-94 minimum threshold to be report separately." Note the inclusion of the minimum threshold rule being adhered to e.g., CT patient confidentiality statutes/regulations, HIPAA standards, CMS standards, etc.

[2] Race, ethnicity, or race/ethnicity combination are mutually exclusive categories including "other," "declined to identify," "unknown," and counts of which must sum up to the data, patient/client or service area population.

[3] Unique counts of Individuals that select multiple races. For example, an individual that selects Black and White is counted only once.

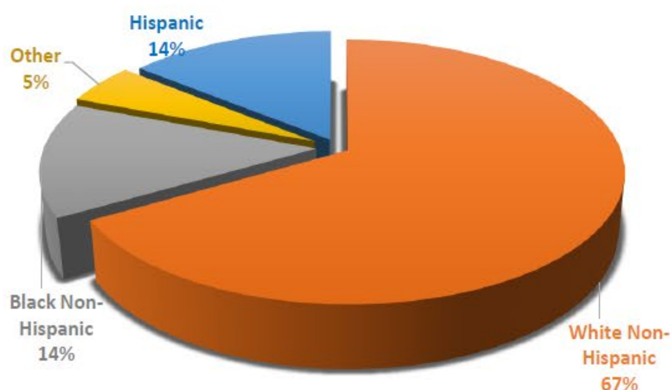
[4] If an individual selects no race, multiple races or "declined to identify" and Hispanic/Latino ethnicity, then include individual in count for "Hispanic, all Races."

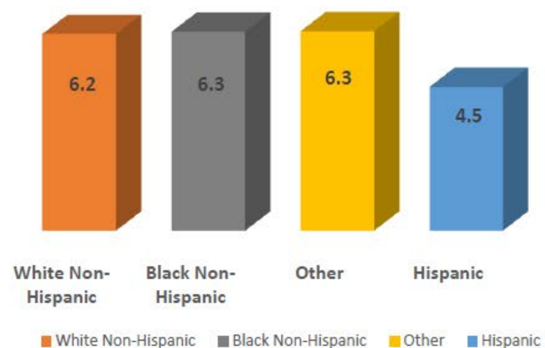
[5] Unique counts of individuals that select any race(s) AND Hispanic/Latino ethnicity.

++ Not a useful aggregation, as the counts represent individuals in "two or more races" population and the number of times each individual selected a race or ethnicity in combination with another race(s) or ethnicity. Provision of such a table is situational, depending on the purpose and use. The utility of this table(s) also depends on if the "two or more" category is a significant share of the data, patient/client or service area population. The table(s)successfully capture distinct races/ethnicities to guide decisionmaking on targetting populations in the multi-race group that may be facing health inequities.

FY 2019 Trauma Patients by Race/Ethnicity and Average Hospital Stay

- ❖Over two-thirds of trauma patients were White Non-Hispanics.
- ❖Hispanic had shorter average hospital stays compared to White non-Hispanics and Black non-Hispanics, i.e., 4.5 days vs. 6.0 days.



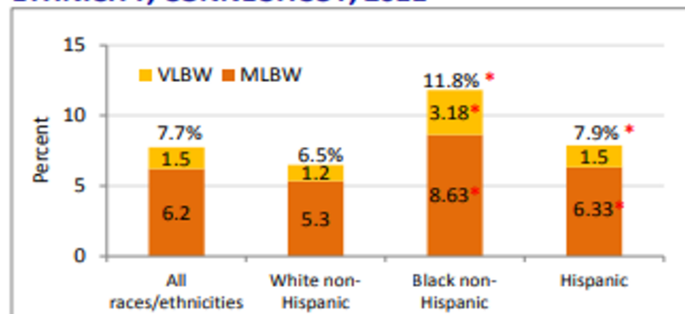


Source: CT Office of Health Strategy. June 8, 2021. Trauma Activation Fee Presentation Part II to CT Health Care Cabinet.
https://portal.ct.gov/OHS/Content/Health-Care-Cabinet/Meeting-Agendas/June-8-2021

OHS CONNECTICUT Office of Health Strategy

CT Race/Ethnicity Low Birthweight Births

Fig. 40. PERCENT OF LOW BIRTHWEIGHT BIRTHS, BY LOW BIRTHWEIGHT STATUS AND RACE AND ETHNICITY, CONNECTICUT, 2011



Note: VLBW indicates very low birthweight and MLBW indicates moderate low birthweight. * Indicates significantly higher VLBW and MLBW for black non-Hispanics and significantly higher MLBW for Hispanics ($p<0.05$).
Source: Connecticut Department of Public Health.

Birth Outcomes

Rationale

Preterm births (less than 37 weeks), low birthweight births (less than 2,500 grams (5 lbs 8 oz)), and very low birthweight births (less than 1,500 grams (3 lbs 5 oz)) are important predictors of infant survival and well-being.[8] Risk for infant illness and death increases with lower birthweight, which, in turn, is associated with gestational age (the number of weeks between conception and birth).[9] There are conspicuous disparities in birth outcomes among Connecticut residents, particularly for singleton, non-Hispanic black and singleton, Hispanic infants. Enhancing access to screening, preconception, prenatal, and postpartum (after delivery) care improves the potential for healthy infant and child well-being for all population groups.

OBJECTIVE MICH-5
Reduce by 10% the proportion of low birthweight and very low birthweight among singleton births.

Target Population(s)	Baseline	2020 Target	Data Source
Connecticut Overall	6.5% VLBW (2010)	5.9%	Connecticut Department of Public Health, Vital Statistics, Registration Reports, Table 3
	8.0% LBW (2010)	7.2%	

Strategies*

Advocacy and Policy
- Address implementation of health promotion efforts.
- Promote Social Equity.
- Improve access to healthcare for women before, during, and after pregnancy.

Partnership and Collaboration
- Address quality of care for all women and infants.
- Address improving maternal risk screening for all women of reproductive age.
- Enhance service integration for women and infants.

Surveillance
- Develop data systems to understand and inform efforts.

OBJECTIVE MICH-6
Reduce by 10% the proportion of live singleton births delivered at less than 37 weeks gestation.

Target Population(s)	Baseline	2020 Target	Data Source
Connecticut Overall	8% (2011)	7.2%	Connecticut Department of Public Health, Vital Statistics, Registration Reports, Table 3.

Strategies*

Advocacy and Policy
- Address implementation of health promotion efforts.
- Promote Social Equity.

Source: CT Department of Public Health. 2014. Healthy Connecticut 2020: State Health Assessment and Health Improvement Plan.
https://portal.ct.gov/DPH/State-Health-Planning/Healthy-Connecticut/Healthy-People---Healthy-Connecticut

Healthcare Cost Growth Benchmark Spending Variation

Reports 9 and 10: Spend and Trend by Demographic Variable

- ED use is also more common among residents of communities with a lower percentage of white residents, as are some chronic conditions.

Decile	Percentage white	Median family income	PMPM (adj.)	ED visit rate (adj.)	Percentage with condition: One or more conditions	Two or more conditions	Hyper-tension	Diabetes	Asthma
All	**0 – 100**	**$97,310**	**$526.69**	**494**	**0.48**	**0.25**	**15.5**	**6.3**	**3.8**
1	0 – 31	$45,663	$545.33	736	0.51	0.30	22.2	11.8	5.6
2	31 – 50	$68,060	$561.26	606	0.49	0.27	18.1	8.6	4.5
3	50 – 61	$82,466	$562.29	591	0.50	0.28	17.3	7.9	4.6
4	61 – 71	$105,442	$494.28	477	0.48	0.26	15.2	6.7	3.7
5	71 – 77	$103,407	$497.68	494	0.48	0.26	16.1	6.6	3.9
6	77 – 82	$122,067	$499.30	434	0.47	0.25	14.1	5.4	3.5
7	83 – 87	$149,181	$506.68	413	0.46	0.23	13.6	5.0	3.5
8	87 – 91	$127,302	$481.19	457	0.47	0.24	14.1	5.0	3.4
9	91 – 94	$118,223	$484.70	493	0.48	0.25	14.7	5.0	3.5
10	94 – 100	$112,875	$526.69	476	0.49	0.26	15.4	5.1	3.7
Ratio of 1st to 10th decile		0.40	1.09	1.55	1.03	1.17	1.44	2.33	1.51

Source: Connecticut Office of Health Strategy. (2021, January 21). *CT Commercial Cost Trends*. Analysis of the Connecticut commercial market performed by Mathematica.