HEALTH
EQUITY
SOLUTIONS

# Factsheet: States with REL collection mandates

Several states have included the collection of race, ethnicity and language data (REL) into their laws, regulations, or ordinances. These include the states of California, Massachusetts, Minnesota, North Carolina, Oregon, and the City of New York.

**California:** California has General Laws 8310.5, 8310.7, 8310.8, and 8310.9 that address REL data collection. The state created an inter-agency Health in All Policies (HiAP) Task Force and Department of Public Health's Office of Health Equity to collect and disseminate health equity data. HiAP Task Force brings together 22 state agencies, departments, and offices, with a common goal of working together to support a healthier and more sustainable California. The laws outline who must collect the data, which specific race and ethnic groups must be represented as well as how the data should be used and reported with specific outputs, provisions around confidentiality and the requirement to make the data publicly available.

**Massachusetts:** Massachusetts does not have specific laws outlining REL data collection but does have a series of written guidance from the Department of Public Health. MA guidance can be found here: http://www.mass.gov/eohhs/docs/dph/health-equity/race-ethnicity-language-data.pdf. There is currently a proposal in the MA legislature to disaggregate Asian ethnic data bill H. 3361.

**Minnesota:** Minnesota has a law 62U.02 that allows the Commissioner of the Department of Public Health to "stratify quality measures by race, ethnicity, preferred language, and country of origin beginning with five measures, and stratifying additional measures to the extent resources are available". Additional stratification "must be tested and evaluated through pilot projects prior to adding them to the statewide system. In determining whether to add additional sociodemographic factors and developing the methodology to be used, the commissioner shall consider the reporting burden on providers and determine whether there are alternative sources of data that could be used. The commissioner shall ensure that categories and data collection methods are developed in consultation with those communities impacted by health disparities using culturally appropriate community engagement principles and methods."

The Minnesota Department of Health prioritized these 5 health issues: Optimal Diabetes Care; Optimal Vascular Care; Optimal Asthma Care–Adult; Optimal Asthma Care–Child; and Colorectal Cancer Screening. Clinics were encouraged to expand on the OMB REL categories, and their patients could choose birth countries from a "Country of Origin" list of 188 countries. Patients were also asked to choose from a "Preferred Language" code list of 33 different languages but had no option to fill in “other” for languages of smaller subgroups. (Minnesota Community Measurement, 2017,5). Minnesota’s “Country of Origin” response represents a movement towards REL data disaggregation, even though it only applies to those who were born abroad, and not to their ethnic descendants---a problem for detecting inter-generational disease.

**North Carolina:** In 2008, the North Carolina legislature enacted a statute § 130A-16. Collection and reporting of race and ethnicity data. “All medical care providers required by the provisions of this Chapter to report to the Division of Public Health shall collect and document patient self-reported race and ethnicity data and shall include such data in their reports to the Division”. Legislation also requires that the contents of birth and death certificates in North Carolina “shall contain those items recommended by the federal agency responsible for national vital statistics, except as amended or changed by the State Registrar” (NCGA, 1983, 130a-102, 130a-116). Both the US Standard Certificates of Death and of Live Birth contain fairly expansive race and ethnicity categories (CDC, 2003). North Carolina’s adoption of the federal recommendations for birth and death certificates has created a rich source of REL data in the state, particularly the death certificates which reveal disproportionately high rates of premature deaths in minority ethnic populations.

**Oregon:** The Oregon Health Authority, Office of Equity and Inclusion established rules of uniform standards and practice for the collection of data on race, ethnicity and preferred spoken or signed and preferred written language and disability status by the Oregon Health Authority (“Authority”) and Department of Human Services (“Department”) as authorized by Oregon statute “**413.161 Collection of data on race, ethnicity, language and disability status**”. The statute outlines that the authority and the department “shall use the standards, to the greatest extent practicable, in surveys conducted and in all programs in which the authority or the department collects, records or reports such data. The authority and the department shall review and update the standards at least once every two years to ensure that the standards are efficient, uniform and consistent with best practices.” The racial and ethnic groups are specifically outlined for each of the 5 OMB categories. The stated purpose of the standards is to allow the Authority and Department to meet federal reporting expectations; compare Oregon’s progress with national trends; improve quality service delivery; and ensure equitable allocation of resources.

**New York City:** New York City’s data collection policies can be found within *Chapter 1. Mayor* of the New York City Charter under the rubric of Office of Operations. The following areas are required to collect such data: The department of social services, the administration for children’s services, the department of homeless services, the department of health and mental hygiene, the department for the aging, the department for youth and community development, the department of education, and any other agencies that collect demographic information via form documents from city residents seeking social services. It is interesting to note that the data being collected is not expressly referred to as “race,” but is rather framed as “ancestry and language spoken,” although there is a provision requiring an option for “multi-racial ancestry of ethnic origin.” (NYC Charter, Ch. 1, j-2) which indicates that the mandate covers what is traditionally thought of as REL data.