FAQ: Health care Workforce Reporting Program and REALD

This is a subset of FAQ from the REALD implementation guide. You can access the complete FAQ here.

Why is there an open-ended question in addition to the race and ethnic categories?

OARs require the use of an open-ended question to elicit an unprompted response. Having an option to answer an open-ended questions is important to people who do not like labels or have other identities outside of categories. The open-ended question provides a way to honor that and helps with data quality, before getting into categories. This question has three key advantages to understand who experience health inequities, as well as to ensure data quality. With this open-ended question, we can: 1. Cross-check the other selections to monitor data quality. 2. Identify new or emerging categories that may be useful to add in the future. 3. Know how a person self-describes their race and ethnicity, which may be useful for research and reporting purposes.

Why don't we just use the OMB federal standards? Why are the Race and Ethnicity categories combined in REALD?

The Office of Management and Budget (OMB) minimum standards require asking two questions about: 1) Hispanic or Latino ethnicity (Yes or No), and 2) Race in five broad "parent" categories: American Indian or Alaska Native (AIAN), Asian, Black or African American, Native Hawaiian or Other Pacific Islander (NHOPI), and White. There are several limitations with this: 1) the two-question approach produces some ambiguity for participants who identify as Hispanic or Latino, and 2) the collapsing of subgroups within the OMB race categories masks significant differences between subgroups.

In contrast, the REALD standard combines race and ethnic identity into one question. Our goal is to reduce confusion over the difference between race and ethnicity. It is also to improve data quality. The U.S. Census Bureau studied the combined race and ethnicity option. Their results suggest this approach reduces missing data and decreases selection of "some other race." It also produces higher consistency in race or ethnicity reporting among Hispanics.

Does the OMB allow this? Does REALD roll up into federal standards?

OMB encourages collection of more granular data, as long as categories can be rolled up into the OMB minimum categories. Further, most federal programs allow a combined question as long REALD categories can roll-up into OMB categories.

Why do we ask for primary racial or ethnic identity?

When a person reports more than one racial or ethnic identity, it is preferable to use the identity that reflects the person's primary racial or ethnic identity. This takes away the need for the analyst to rely heavily on the "multi" category in reporting or research. The "multi" option often masks differences within groups as well. That said, it is also important to recognize and consider those who identify as biracial or multi-racial.

Why the increased granularity in the Race and Ethnicity categories?

A limitation of the current federal OMB categories (with just six broad racial/ethnic categories) is that it

> *"…**mask important disparities** in health and health care. More discrete ethnicity groups, based on ancestry, **differ in the extent of risk factors, degree of health problems, quality of care received, and outcomes of care**. More granular ethnicity data could **inform the development and targeting of interventions** to ameliorate disparities in health care that contribute to poorer health*" (Ulmer et al., 2009, p. 31)

Granularity in data standards increases the validity of responses with people being able to better choose any category that reflects their racial and ethnic identities. For example, the option to identify as Vietnamese may be more acceptable than as "Asian" (Laws & Heckscher, 2002). If people do not "see" themselves in the REALD categories, they may say "other." There is a trade-off between an increase in validity that comes with granularity, and utility, as noted by Aspinall (2009).

Significant differences between subgroups of broader racial and ethnic categories make combining them misleading. The more we understand the nature of inequities, not only between groups (e.g., between individuals of European descent and those of African descent), but within groups (e.g., subgroups within the Hispanic group), the more we can explore and understand causal mechanisms (Commodore-Mensah, Himmelfarb, Agyemang, & Sumner, 2015).

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Aren't disability questions like those in the REALD considered protected medical information?

No. These questions focus on "functional limitations" rather than diagnosis, disability identity or impairments. It would be difficult to know the person's actual medical condition based on answers to these questions.

Why not just ask one disability question?

If we only asked one question, we would not be able to identify and address inequities of different groups of people with disabilities. Not all people with disabilities experience the same inequities. For example, we may find that there is underrepresentation among licensees with respect to hearing and vision limitations. it may be that people who are deaf or have serious difficulty hearing, are less likely to access training and education required for licensure. compared with other people with disabilities. This could prompt us to consider if this is due to communication challenges and limited outreach in the pipeline. As another example, it may be that people who are deaf or have serious difficulty hearing, are less likely to maintain employment, compared to non-disabled people and other people with disabilities. This data could prompt us to consider unique barriers identified by deaf and hard of hearing who work. There may be a separate set of barriers identified by hearing people using wheelchairs, for example. The seven questions help us consider differences among people with disabilities with respect to social and health inequities.

Why ask about age one acquired a condition/disability?

This follow-up question is to acknowledge that disability status can be both or either an upstream determinant of health or a health outcome. Further, one's exposure to social and educational inequities

(e.g., in educational attainment) is a function of when the person acquired their disability, and how long they have lived with a disability. For example, someone who became hard of hearing before the age of three will have a very different lived experience than someone who became hard of hearing later in life. This is due to differences in language acquisition and language access. This may result in inequities in educational attainment and consequently employment earnings. A study conducted by Loprest and Maag revealed that individuals who acquired a disability before age five, compared with those who acquired a disability later in life, as well as non-disabled people, were less likely to complete high school (2003). It is important to know about these differences within subgroups so we can improve the pipeline in STEM fields for example, with respect to students with disabilities, starting in middle and high school.

References

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