

Demographic Data Toolkit

Public Health — Seattle & King County



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Introduction

Public Health – Seattle and King County (PHSKC) needs access to sufficiently detailed and complete demographic information to understand who bears a disproportionate burden of illness and injury in our communities. This is essential to design effective, tailored interventions and track progress toward promoting health equity in collaboration with community partners.

However, many sources of health data include just 5 or fewer race and ethnicity categories, 2 gender categories, and little or no information about disability or other demographics that are critical to understanding health inequities. This hinders our ability to evaluate and address critical health needs and community priorities.

Community leaders across our county have expressed similar concerns, noting that categories such as Black, Hispanic, or Asian do little to illuminate specific health threats faced by the Somali, Puerto Rican, or Filipino communities, for example. People with disabilities, LGBTQI+ communities, and people experiencing homelessness are often invisibilized within health data. The need to improve demographic data is longstanding and aligns with our [declaration of racism as a public health crisis](#).² Changes are required across multiple health data systems, many of which are beyond PHSKC's control, to meet this need.

The purpose of this toolkit is to offer evidence-based, locally appropriate options and resources for collecting, analyzing, and reporting demographic data at Public Health – Seattle and King County. Types of demographic data addressed here include race, ethnicity, primary language, sexual orientation, gender identity, disability, housing instability, and homelessness status.

The purpose of this toolkit is to offer evidence-based, locally appropriate options and resources for collecting, analyzing, and reporting demographic data at Public Health – Seattle and King County.

We acknowledge that there are likely to be situations that require a different approach to demographic data collection, analysis, and reporting. For example, there may be an outbreak impacting a subset of community members where data needs are different or more granular. In these cases, members of the impacted community, those with knowledge of the health issue at hand, and data analysts may choose a different set of practices.

Demographic data alone cannot provide a complete story of health inequities, identity, or of the people served by PHSKC. Designing research and data collection in collaboration with community and using a mix of quantitative and qualitative methods will yield richer information that is more respectful, accurate and actionable than simply collecting demographic data.

PHSKC will update this document at least every two years to ensure that recommendations reflect the changing demographics of our county, community preferences, and the evolution of best practices in this field.

Best practices for demographic data collection

PHSKC uses data from many sources, including federal and state-level data, to understand and address health inequities in King County. We generally do not have the authority to modify data collected and reported to us by other entities. The best practices outlined here for data collection apply in situations where we can design and direct our own data collection activities.

Approach to data collection

When PHSKC is collecting demographic data, we recommend the following best practices:

- **To increase transparency and decrease missingness, explain why we are collecting demographic data.** You may simply say “collecting this data helps us to better understand who we are serving and improve our services,” or it may be better to offer more detailed information about the specific purpose of collecting the data, depending on the situation.
- **To respect individual privacy and reduce barriers to service while decreasing missingness, participants may decline to answer any question.** State up front that their decision to answer these questions will not change or impact the services they receive. It may be helpful to add a “decline to answer” option following the answer choices for each question. Exceptions may exist when these questions are being used to determine eligibility for a program designed for a specific population, such as LGBTQ+ individuals, people who speak a specific language, or another group. In these cases, state the purpose of the question upfront.
- **To respect individual dignity and identity and to ensure consistency and reliability, ask the person to answer the demographic questions about themselves.** Only when this is not possible, as in the case of a young child, a deceased person or a person experiencing a medical emergency impacting their ability to self-report, the next best-qualified available person may be asked. This should be someone with knowledge of the individual, such as a parent, caregiver, relative or friend.

Race and ethnicity

Whenever possible, we recommend collecting the following race and ethnicity data. These categories align with the [2023 Best Starts for Kids Health Survey](#),³ which was developed with input from King County communities and considers which populations have substantial representation in our county. They are also informed by best practices recommended by the [Oregon Health Authority's Race, Ethnicity, Language, and Disability \(REALD\) initiative](#),⁴ [PolicyLink](#),⁵ and the [National Committee for Quality Assurance](#).⁶ In 2024, the [Federal Office of Management and Budget \(OMB\) published new requirements for race and ethnicity data collection and reporting](#),⁷ including recommending collection of more detailed race and ethnicity data by default and setting new minimum standards. The categories included here align with the more detailed OMB default categories while also facilitating rollup to the minimum required categories.

Which categories describe you? Mark all that apply.

- American Indian or Alaska Native (specify name of tribe(s)): _____ *

*Before tribal affiliation is collected, refer to the [Urban Indian Health Institute \(UIHI\)'s guide on Best Practices for American Indian and Alaska Native Data Collection](#),⁸ and consider scheduling a consultation with UIHI.

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Another Asian group (specify): _____

- Black or African American
- Somali
- Ethiopian
- Another Black or African ancestral group (specify): _____

- Mexican, Mexican American, Chicano
- Cuban or Puerto Rican
- Another Hispanic or Latino/a/e/x or group (specify): _____

- Middle Eastern or North African

- Native Hawaiian
- Samoan
- Another Native Hawaiian or Pacific Islander group (specify): _____

- White

- Another race, ancestry, or ethnic origin (specify): _____

Note that these categories can be systematically consolidated for analysis if needed, allowing for combination or comparison with more limited datasets. Further discussion is in the data analysis section.

While we recommend collecting the detailed race and ethnicity categories above, in some situations, it may only be possible to collect a smaller number of race and ethnicity categories. In these cases, we recommend the following, which align with the 2024 OMB minimum required categories:

Which categories describe you? Mark all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino/a/e/x
- Middle Eastern or North African
- Native Hawaiian or Pacific Islander
- White
- Another race (specify): _____

Specific terminology used in survey instruments and data reports is actively evolving or under discussion and should be updated or edited according to community preferences whenever possible. Examples include preferences regarding the terms Hispanic, Latino, Latina, Latine and Latinx,⁹ and terminology for descendants of enslaved people from Africa such as Black, African American, American Freedmen, and American Descendants of Slavery.¹⁰ Terminology is interconnected with how race and ethnicity categories are constructed and understood by society and communities and will continue to change over time; this is likely to have implications not only for data collection, but also for analysis and reporting.

Primary language

We recommend using the following primary language question, which includes [King County's Tier 1-3 Languages](#)¹¹ as of 2021. These are the most spoken and most often requested languages in King County.

What language do you speak most often at home?

- Amharic
- Arabic
- Chinese
- Dari
- English
- Japanese
- Korean
- Marshallese
- Punjabi
- Russian
- Somali
- Spanish
- Tagalog
- Tigrinya
- Ukrainian
- Vietnamese
- Another language (specify): _____

For the Chinese language category, depending on how the data will be used, it may be helpful to collect information about the Chinese dialect group spoken, or whether traditional or simplified written Chinese is preferred.

In some situations, it may only be possible to collect a smaller number of primary language categories. In these cases, we recommend the following, in alignment with King County's Tier 1 and 2 languages.

What language do you speak most often at home?

- Amharic
- Arabic
- Chinese
- English

- Korean
- Russian
- Somali
- Spanish
- Tagalog
- Ukrainian
- Vietnamese
- Another language (specify): _____

Sexual orientation and gender identity

We recommend breaking sexual orientation and gender identity questions into two sections: gender identity and sexual orientation. The following questions draw from recommendations from thought and practice leaders including the [County of Los Angeles Department of Health](#),¹² the [San Francisco Department of Public Health](#),¹³ the [Consortium of Higher Education LGBT Professionals](#)¹⁴ and [Trans Student Educational Resources](#).¹⁵ One key difference between our recommendations and those of some of these organizations is that we only recommend collecting sex assigned at birth in the context of providing clinical services where this information is needed. Note that not all clinical services will require this information. This recommendation is based on feedback from gender diverse youth in King County in our [King County Community Health Needs Assessment 2018/2019: LGBTQ Community Spotlight](#)¹⁶ and our assessment of use cases for data. If possible, consult with community members before asking these questions about children under age 12 to better understand community preferences and frame questions accordingly.

What best describes your gender? Mark all that apply.

- Agender
- Genderqueer
- Gender fluid
- Man/Male
- Non-binary
- Questioning/unsure
- Transgender
- Trans man
- Trans woman
- Woman/Female
- Another gender (specify): _____

What is your sexual orientation? Mark all that apply:

- Asexual
- Bisexual
- Gay
- Straight (heterosexual)
- Lesbian
- Pansexual
- Queer
- Questioning/unsure
- Another sexual orientation (specify): _____

In some situations, it may only be possible to collect a smaller number of sexual orientation and gender identity questions. In these cases, we recommend the following, also in alignment with the [Consortium of Higher Education LGBT Resource Professionals](#).¹⁷

What is your gender? Mark all that apply.

- Genderqueer/non-binary
- Man/Male
- Transgender
- Woman/Female
- Another gender (specify): _____

What is your sexual orientation? Mark all that apply:

- Bisexual
- Gay
- Straight (heterosexual)
- Lesbian
- Queer
- Another sexual orientation (specify): _____

If it is necessary to provide specific clinical services, such as cervical cancer screening, you may choose to collect sex assigned at birth as follows. Not all clinical services necessitate collecting this information.

What was the sex recorded on your birth certificate?

- Female
- Male
- Another
- Unknown/not marked

Disability

When possible, we recommend including both a question about activities of daily living and a question about type of disability.

The following six activities of daily living questions come from the [American Community Survey \(ACS\) and are recommended by the CDC](#).¹⁸ The seventh and final question asking respondents to indicate whether they have any specific disabilities comes from a review of how disability rights organizations collect demographic data and is informed by feedback offered to PHSKC via the [Client Outcomes Reporting Engine](#).¹⁹ This question provides the opportunity for people with a disability to identify as such if they wish.

The order of the questions is important, with the six activities of daily living questions preceding the type of disability question.

Questions about activities of daily living:

Are you Deaf, or do you have serious difficulty hearing?

- Yes
- No

Are you blind, or do you have serious difficulty seeing, even when wearing glasses?

- Yes
- No

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)

- Yes
- No

Do you have serious difficulty walking or climbing stairs? (5 years old or older)

- Yes
- No

Do you have difficulty dressing or bathing? (5 years old or older)

- Yes
- No

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)

- Yes
- No

Question about types of disabilities:

Do you have any of the following? Mark all that apply:

- Developmental or intellectual disability
- Mental/behavioral health condition (depression, schizophrenia, substance use disorder, etc.)
- Mobility disability (use a wheelchair, walker, cane, prosthetic, etc.)
- Sensory disability (blindness, low vision, deafness, hard of hearing, etc.)
- Chronic illness (HIV/AIDS, diabetes, sickle cell disease, etc.)
- Communication disorder (speech impairment and/or language impairment)
- Learning disability (dyslexia, dyscalculia, etc.)
- Traumatic or acquired brain injury
- I have a disability but prefer not to specify
- Another disability, please specify: _____

In some situations, it may only be possible to collect a smaller number of disability questions. In these cases, we recommend collecting the six activities of daily living questions above whenever possible, followed by an open-ended question, as follows. Alternatively, asking the following open-ended question only, rather than the activities of daily living or specific disability question, may suffice in certain situations. Ensure that you have adequate time and resources to code and analyze answers to the following question before collecting it.

Do you have a disability?

- Yes (specify): _____
- No
- Unsure

Homelessness and housing instability

When possible, we recommend collecting the following homelessness and housing instability data. Note that questions about housing status may be particularly sensitive, with multiple situational, legal, and cultural reasons why people may choose not to disclose homelessness. Carefully consider your approach and seek additional guidance from homeless service providers when needed. These categories are in accordance with best practices under the [Public Health Service Act as outlined by the Federal Health Resources and Services Administration \(HRSA\)](#),²⁰ which are also utilized by PHSKC's [Healthcare for the Homeless Network \(HCHN\)](#). Note that HCHN has additional policies that supersede the recommendations below for its own providers.

Are you concerned about the stability of your living situation?

- Yes
- No

Where are you currently staying?

- Public housing, including transitional or supportive housing or treatment program
- Private housing, with or without financial assistance
- Shelter
- Streets or abandoned buildings
- Vehicle

- At the home of friends, family members or other contacts
- Another (specify): _____

If a respondent indicates that they are concerned about the stability of their living situation or are experiencing homelessness, in many circumstances it will be important to offer a referral to services. The following are referral options that can be further tailored to the situation:

Would you like a referral to shelter or housing services?

- Yes
 - If you are looking for immediate assistance and/or emergency shelter, call 2-1-1 or visit King County Crisis Connections at <https://www.crisisconnections.org/king-county-2-1-1/>. King County 2-1-1 connects you with a variety of support services. They can help you find shelter if you need it. You can also look for local shelters on ShelterApp. Learn more at <https://www.shelterapp.org/>
 - If you are staying in an emergency shelter, outside, or in a car and need help finding a long-term housing solution, Contact a [Regional Access Point](https://kcrha.org/regional-access-points) (RAP) at <https://kcrha.org/regional-access-points>. These entry points are resource centers where individuals and families experiencing homelessness can get help finding housing and other resources.
- No

Best practices for demographic data analysis

In general, when analyzing demographic data, the goal is to preserve the highest possible level of detail for better representation and understanding of King County communities. This can be challenging when numbers are small, or when working with data where only limited or consolidated categories are available to us.

PHSKC adheres to data requirements that include suppression for confidentiality, minimum sample size, minimum number in the numerator, secondary suppression, and number of geographic areas; see our [Assessment, Policy Development and Evaluation division's data presentation protocol](#)²¹ as an example. We also adhere to additional requirements included in data sharing agreements with partners. While following small numbers guidance for public dissemination/reporting, consider whether it would be informative to include small numbers in internal-only planning documents (and mark confidential/PHSKC only as needed).

At times, comparisons are needed between PHSKC data and federal, state, or other data where only highly aggregated categories are available. In these cases, consider presenting both the disaggregated data and the aggregated data used in the comparison.

The following paragraphs provide additional guidance for managing common situations like categorizing write-in information, analyzing data when multiple categories apply, and selecting appropriate denominators.

Working with write-in/free text information

When working with write-in or free text information, ask yourself the following questions:

- Can the information be classified into one of the existing response categories? If so, recode. (Race example: write-in response is “White European”. Recode into existing “White” response category.)
- Are there many responses that are similar, and could be classified together as a new category? If so, create a new category.
- What is the level of disaggregation needed for the project?
- What is the level of disaggregation possible with the data (may be iterative, due to small numbers/confidentiality considerations)?

Additionally, note that there are some write-in responses that cannot reliably be rolled up to a consolidated category. The National Academy of Science’s publication [“Race, Ethnicity, and](#)

[Language Data: Standardization for Health Care Quality Improvement](#)²² provides additional details about these responses; see table F1.

Working with data where multiple categories are selected

Depending on how the information will be used and shared, several different categorizations may apply. If you are collaborating with a community advisory group, it would be ideal to bring them into a discussion about how to approach this. Potential options include:

- Use the “Alone” and “alone or in combination” approach. “Alone” is defined as a response where only one category is selected. “Alone or in combination” is where more than one category may have been selected.
 - Example using OMB minimum race/ethnicity categories: a respondent who selects Asian Indian and Korean would be recoded into “Asian alone.” A respondent who selects American Indian and Korean would be recoded into “American Indian alone or in combination with another race” and “Asian alone or in combination with another race.”
 - Example using disability categories: a respondent who selects Deaf and blind would be counted as “Hearing alone or in combination with another disability” and “blind alone or in combination with another disability.”
 - Please note that this approach may be confusing if you are presenting a count of cases or distribution across different categories, as adding up the information from each row will lead to a number that is larger than the total number of cases.
- Include single categories and recode everyone who selects more than one into a “multiple” category. This may be necessary when comparing to state or federal reports. Even if you are doing this, consider using “alone or in combination” for groups that would otherwise have data suppressed or have a large portion of the population in “multiple.” In the case of race/ethnicity, this is especially relevant for American Indian/Alaska Native and Native Hawaiian/Pacific Islander groups.

Resolving conflicting sources of data

In cases that require resolving conflicting sources of data, we recommend applying the following guidelines to determine which source to use:

- Use the source that is self-identified rather than third party-identified.
- Use the source that is most recent.

- Use the source that is more reliable. Consult with PHSKC's Integrated Data Hub (IDH) Governance Council, which evaluates demographic data sources by quality and reliability (see appendix for contact information).

Leveraging population data for denominators

Denominators are needed to calculate rates or weight population-based survey data. Population data may not be available at the same level of disaggregation as the PHSKC-collected data (numerators or surveys). Sources of population data include:

- For race/ethnicity:
 - Population-level data for some categories are available from the [2022 ACS ancestry data](#).²³ Additionally, [Oregon REALD's implementation guide](#)²⁴ includes detailed methods for estimating granular racial and ethnic denominators using the ACS; see pages 94-96.
- For sexual orientation/gender identity:
 - Denominator data in this area is limited. The [ACS](#)²⁵ offers data on same-sex partners living together. The 2022 Washington [Behavioral Risk Factor Surveillance System \(BRFSS\)](#)²⁶ contains indicators related to sexual orientation and gender identity. Neither can be considered a robust source of denominator data.
- For disability:
 - [2022 ACS data](#)²⁷ includes types of disabilities.
 - [Communities of Opportunity offers a disability dashboard](#)²⁸ based on BRFSS data.
- For homelessness:
 - See [King County's 2022 Point in Time Count with additional cross-system analysis](#).²⁹
 - Additional related data is available from [the King County Regional Homelessness Authority's Web site](#).³⁰

If granular denominator data is not available, aggregate your numerator data to the higher level to match the denominator when presenting unweighted rates or proportions. If you are using the same granular data for both numerator and denominator but need to weight, use a more aggregated category for weighting purposes and apply it to all granular groups under that category.

Additional analysis resources for disability data

We recommend using the Oregon REALD analysis approach for disability data, as described on pages 97-99 of their [implementation guide](#).³¹ Briefly, this approach includes considering whether it makes sense to conduct analyses based on each disability type separately or combinations of disabilities for each person, or to create a composite variable. The purpose of the research question will help guide the choice of analysis.

Best practices for demographic data reporting

Considering our communities when we report data

It is important to consider the impact of our data presentation on the communities we serve. Whenever possible, we recommend partnering with community to develop questions for analysis and to present demographic data findings in a way that furthers our health promotion goals respectfully and collaboratively, taking a strength-based approach, and acknowledging the complexities that arise when we attempt to describe and quantify identity. There are resources available to guide partnering with community on research and data-related projects in the appendix.

When possible, we recommend including the following language in demographic data reports:

Public Health – Seattle and King County (PHSKC) serves a diverse group of people across King County, aiming to provide visibility to every person it serves. PHSKC strives to collect complete and accurate information for all participants/clients, using self-reported data whenever possible. However, demographic data alone cannot provide a complete story of people served by PHSKC. Additionally, please take care when interpreting this data as some people or communities may not identify with the demographic categories presented, or may be reluctant to share personal information with providers and/or public entities as a result of systemic racism, ableism and other forms of injustice.

Reporting third party-identified data

It is important to report demographic data that is self-identified whenever possible, to respect individual dignity and identity and to ensure consistency and reliability. In some cases, such as with young children, a deceased person, or a person experiencing a medical emergency impacting their ability to self-report, it may be necessary to consult the next best-qualified person. This should be someone with knowledge of the individual, such as a parent, caregiver, relative or friend. In these cases, we recommend labeling data as third party-identified so that it can be interpreted accordingly.

Data labeling

When reporting demographic data to the public, we recommend labeling categories using the terminology included in the data collection section above. In some situations, it may be necessary to use abbreviated labels, such as when generating graphs or charts. Remember to include footnotes under the graphs or tables with the full label or meaning of the abbreviation.

Race/ethnicity labels

Full label	Abbreviated label
American Indian or Alaska Native	AIAN
Asian Indian	Indian
Chinese	Chinese
Filipino	Filipino
Japanese	Japanese
Korean	Korean
Vietnamese	Vietnam
Another Asian group	Asian
Black or African American	Black
Somali	Somali
Ethiopian	Ethiopian
Another Black or African ancestral group	Black
Mexican, Mexican American, Chicano	Mexican
Cuban or Puerto Rican	Cuban/PR
Another Hispanic or Latino/a/e/x or group (specify)	Hispanic
Middle Eastern or North African	MENA
Native Hawaiian	Hawaiian
Samoan	Samoan
Another Native Hawaiian or Pacific Islander group	NHPI
White	White
Another race, ancestry, or ethnic origin	Another
Multiple race	Multiple

Primary language labels

Full label	Abbreviated label
Amharic	Amharic
Arabic	Arabic
Chinese	Chinese
Dari	Dari
English	English
Japanese	Japanese
Korean	Korean
Marshallese	Marshal
Punjabi	Punjabi
Russian	Russian
Somali	Somali
Spanish	Spanish
Tagalog	Tagalog
Tigrinya	Tigrinya
Ukrainian	Ukraine
Vietnamese	Vietnam
Vietnamese	Vietnam

Sexual orientation/gender identity labels

Full label	Abbreviated label
<i>Gender</i>	
Agender	Agender
Genderqueer	G Queer
Gender fluid	Fluid
Man/Male	Man
Non-binary	NB
Questioning/unsure	Unsure
Transgender	Trans
Trans man	Trans M
Trans woman	Trans W
Woman/Female	Woman
Another gender	Another
<i>Sexual orientation</i>	
Asexual	Asexual
Bisexual	Bisexual
Gay	Gay
Straight (heterosexual)	Straight
Lesbian	Lesbian
Pansexual	PS
Queer	Queer
Questioning/unsure	Unsure
Another sexual orientation	Another

Disability labels

Full label	Abbreviated label
Deaf, or serious difficulty hearing	Deaf
Blind, or serious difficulty seeing	Blind
Serious difficulty concentrating, remembering, or making decisions	Executive
Serious difficulty walking or climbing stairs	Walk/climb
Difficulty dressing or bathing	Dress/bathe
Difficulty doing errands alone such as visiting a doctor's office or shopping	Errands
Developmental or intellectual disability	Develop
Mental/behavioral health condition (depression, schizophrenia, substance use disorder, etc.)	MH/BH
Mobility disability (use a wheelchair, walker, cane, prosthetic, etc.)	Mobility
Sensory disability (blindness, low vision, deafness, hard of hearing, etc.)	Sensory
Chronic illness (HIV/AIDS, diabetes, sickle cell disease, etc.)	Illness
Communication disorder (speech impairment and/or language impairment)	Comm
Learning disability (dyslexia, dyscalculia, etc.)	Learning
Prefer not to specify	Not spec
Traumatic or acquired brain injury	TBI/ABI
Another disability, please specify:	Another

Homelessness and housing instability labels

Full label	Abbreviated label
Concerned about the stability of living situation	Concerned
Staying in public housing, including transitional or supportive housing or treatment program	Public
Staying in private housing, with or without financial assistance	Private
Staying in shelter	Shelter
Staying in streets or abandoned buildings	Streets
Staying in vehicle	Vehicle
Staying in home of friends, family members or other contacts	Doubled up
Another	Another

Color palates for graphs and charts

While there is currently no PHSKC department-wide standard for color palates for demographic data graphs and charts, avoid using colors that align with stereotypes or stigmas of race/ethnicity, gender, or other groupings, and ensure that color palates are accessible for people with color blindness. [Color Brewer](#)³² is an online resource for developing accessible color palates.

Appendix

We drew from several high-quality internal and external sources to develop these recommendations. For further reading on best practices in collecting, analyzing, and reporting demographic data, and the interrelated issue of collaborating with community to design and carry out health research, please see the following:

- **Best Starts for Kids Health Survey Data:**
<https://kingcounty.gov/en/legacy/depts/community-human-services/initiatives/best-starts-for-kids/dashboards/bskhs-combined.aspx>
- **Chicago Beyond's Why Am I Always Being Researched?** A guidebook for community organizations, researchers and funders to help us get from insufficient understanding to more authentic truth: <https://chicagobeyond.org/researchequity/>
- **The Integrated Data Hub (IDH) Governance Council of Public Health – Seattle and King County** evaluates demographic data sources by quality and reliability. Please contact Alastair Matheson for additional details at Alastair.Matheson@kingcounty.gov.
- **King County Community Health Needs Assessment 2018/2019: LGBTQ Community Spotlight:** <https://cdn.kingcounty.gov/-/media/depts/health/data/documents/CHNA-LGBTQ-Community-Spotlight.ashx>
- **The National Committee for Quality Assurance's Improving Data on Race and Ethnicity: A Roadmap to Measure and Advance Health Equity:** <https://www.ncqa.org/wp-content/uploads/2022/01/GIH-Commonwealth-Fund-federal-data-report-part-2-1.pdf>
- **The Oregon Health Authority's Race, Ethnicity, Language and Disability (REALD) policies and practices:** <https://www.oregon.gov/oha/ei/pages/reald.aspx>
- **PolicyLink's Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health:** <https://www.policylink.org/resources-tools/counting-a-diverse-nation>

- The Urban Indian Health Institute’s Best Practices for American Indian and Alaska Native Data Collection: <https://www.uihi.org/download/best-practices-for-american-indian-and-alaska-native-data-collection/>
- The Urban Indian Health Institute’s Guide to Addressing Racial Misclassification: <https://www.uihi.org/resources/addressing-racial-misclassification/>
- We All Count’s Project for Equity in Data Science: <https://weallcount.com/>

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