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STATE DOCUMENTATION OF RACIAL AND ETHNIC HEALTH DISPARITIES TO INFORM STRATEGIC ACTION

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EXECUTIVE SUMMARY

Nearly a decade ago, the Institute of Medicine (IOM) issued a call to action to redesign the United States' health care system because Americans do not consistently receive high-quality, appropriate, evidence-based health care and instead experience avoidable delays, costs, complications, or errors in care. Subsequently, the IOM published a report showing that racial and ethnic minorities receive, on average, lower quality care than whites.

The Agency for Healthcare Research and Quality (AHRQ) within the U.S. Department of Health and Human Services is responsible for improving health care quality for Americans. Since 2003, it has published national data about the quality of the U.S. health care system in two annual reports: the *National Healthcare Quality Report* (NHQR) and the *National Healthcare Disparities Report* (NHDR). Since its inception, NHDR data has consistently shown that health care quality varies by population; the current edition concludes that nearly two-thirds of the measures of disparity in quality of care are not improving for Blacks, Asians, and Hispanics in the United States. This continuation of disparities in health status and health care is a problem that affects the entire country. Disparities result in life-years lost as well as subsequent health issues that likely could have been prevented with high-quality care.

As a subcontractor to Thomson Reuters, the National Academy for State Health Policy (NASHP) has supported AHRQ's Healthcare Cost and Utilization Project (HCUP), which is a family of health care databases and related software tools and products. This paper builds on a previous HCUP case study report about how states use race/ethnicity data from statewide hospital discharge databases to support activities to reduce disparities in health and health care. This report is an effort to more comprehensively explore states' identification, documentation and action on race/ethnicity data to highlight leading practices and inform the potential addition of new data to AHRQ's State Snapshots website, particularly the "Focus on Disparities" section.

For this report, NASHP conducted an environmental scan of all 50 states and the District of Columbia to identify leading states in the use of patient race/ethnicity data, defined as those with state-produced disparities documents meeting the following criteria:

- published in 2007 or later;
- data-driven;
- addressing *health care* disparities; and
- with evidence of state action on the document (i.e., use of information in document).

Eight states were identified as leaders in terms of their analysis and/or inclusion of data from state and federal sources in strategic plans and reports to address health disparities: **Colorado, Connecticut, Georgia, Maryland, New Jersey, New Mexico, Rhode Island,** and **Utah**. NASHP scheduled informal calls with the authors of the

states' document(s) and other people from the eight states who were involved in creating or using the document(s).

This report synthesizes themes and lessons from these eight states, including the following characteristics of their data-driven disparities documents: general category of document(s); data sources referenced and found to be most useful; indicators presented; units of analysis; role of the Office of Minority Health; public and private partners; connection to broader context of departmental or state activities to reduce disparities; and resulting action and future plans, e.g., for state health reform.

Every state profiled looked to other states when crafting their disparities documents; however, not every state with interesting activity in disparities reduction met the criteria for inclusion as a featured state in this report. Efforts in Arizona, California, Massachusetts, Michigan, Minnesota, North Carolina, Ohio, and Virginia either informed the work of featured states or were identified as being noteworthy during NASHP's environmental scan.

After reviewing featured states' documents and talking with officials from each of the eight featured states, several themes and lessons emerged.

- States use data documents -- including condition-specific reports, report cards, and action plans -- to identify and address disparities.

- States vary in data sources, units of analysis, and rates used to report health and health care disparities in their reports; however, they share many commonalities.

- States want and need additional data on disparities to develop strategies to improve health equity.

- States have distinct organizational approaches to documenting and addressing disparities.

- States rely on partnerships with stakeholders as critical to creating their data documents, plans, and report cards and acting on them.

- State reports include a focus on making data actionable.

- States need additional funding sources to focus on health and health care disparities.

- State Offices of Minority Health are important leaders in addressing disparities, but they cannot act alone if states are to achieve health equity.

Featured states take varied approaches to identifying, documenting, and acting on data related to racial and ethnic health and health care disparities. Nevertheless, they all emphasize the need for valid data to document disparities and collaboration for action

planning to improve health equity. The eight featured states have developed methods for reporting health disparities and have taken concrete steps toward reducing the disparities that exist within their borders. The successes, challenges, and methods of these states can provide guidance for states that are exploring ways to improve their health equity initiatives. Opportunities for funding and increased awareness and attention to these issues, through provisions for reducing disparities in health care reform and the National Partnership for Action, may provide momentum for state action.

BACKGROUND

Nearly a decade ago, the Institute of Medicine (IOM) issued a call to action to redesign the United States' health care system because Americans do not consistently receive high-quality, appropriate, evidence-based health care and instead experience avoidable delays, costs, complications, or errors in care.[1] Importantly, the IOM defined high-quality care as care that is safe, effective, patient-centered, timely, efficient, *and equitable*, meaning it "does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.[2] Subsequently, the IOM published a report confirming the existence of health care disparities or "racial or ethnic differences in the quality of health care that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention."[3] (see Figure 1). The report showed that racial and ethnic minorities receive, on average, lower quality care than whites. It provided multiple recommendations for improving the health care system, including collecting and reporting health care access and utilization data by race, ethnicity, and primary language, and using health care disparities measures to help measure performance.[4]

The Agency for Healthcare Research and Quality (AHRQ) within the U.S. Department of Health and Human Services is responsible for improving health care quality for Americans. Since 2003, it has published national data about the quality of the U.S. health care system in two annual reports: the *National Healthcare Quality Report* (NHQR) and the *National Healthcare Disparities Report* (NHDR). AHRQ also publishes state-specific health care disparities information from these reports on a companion "State Snapshots" website (http://statesnapshots.ahrq.gov).[5] The NHDR is specific to health care quality and access among particular populations, including racial and ethnic minorities.[6] Since its inception, NHDR data has consistently shown that health care quality varies by population; the current edition concludes that nearly two-thirds of the measures of disparity in quality of care are not improving for Blacks, Asians, and Hispanics in the United States.[7]

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[1] Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academies Press, 2001).
[2] Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academies Press, 2001), 6.
[3] Ibid, 3-4.
[4] Brian Smedley, Adrienne Stith, and Alan Nelson, eds*., Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: National Academies Press, 2003).
[5] National Healthcare Quality Report 2009 State Snapshots. http://statesnapshots.ahrq.gov/snaps09/index.jsp
[6] Agency for Healthcare Research and Quality. *National Healthcare Disparities Report, 2009*. Rockville, MD: March 2010. http://www.ahrq.gov/qual/nhdr09/nhdr09.pdf.
[7] Ibid, 6.

Figure 1: Health Disparity and Health Equity: Terms Defined

The terms "health disparity" and "health equity" are defined in many ways by many organizations. In general, "disparity" is used to refer to a difference, whereas "equity" indicates the absence of differences that are avoidable and unfair. The draft National Plan for Action of the National Partnership for Action to End Health Disparities offers the following definitions:

Health disparity: "…a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, cognitive, sensory or physical disability, sexual orientation, geographic location, or other characteristics historically linked to discrimination or exclusion."

Health equity: "…attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities."

Source: U.S. Department of Health & Human Services, The National Partnership for Action to End Health Disparities: *Changing Outcomes – Achieving Health Equity*, The National Plan for Action Draft as of February 17, 2010, 2-3. Available online: Hhttp://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlID=31H.

This continuation of disparities in health status and health care is a problem that affects the entire country. From both an ethical and pragmatic perspective, disparities are costly. They result in life-years lost as well as subsequent health issues that likely could have been prevented with high-quality care. It has been estimated that health disparities cost the United States $229 billion between 2003 and 2006.[8] Although much work remains to eliminate these disparities, there are a number of efforts underway to measure and address them at the federal and state level.[9]

Recent National Efforts

Two examples of national efforts to address disparities are the National Partnership for Action to End Health Disparities and provisions of the recently enacted federal health reform legislation.

[8] LaVeist, T., Gaskin, D., and Richard, P. *The Economic Burden of Health Inequalities in the United State*s. Washington, DC: Joint Center for Political and Economic Studies, September 2009. http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf. Date accessed: December 16, 2010.

[9] For additional examples, including the work of non-governmental groups, see Hanlon, C. and Raetzman S. *State Uses of Hospital Discharge Databases to Reduce Racial and Ethnic Disparities.* Online October 14, 2010. U.S. Agency for Healthcare Research and Quality (AHRQ). Available: http://www.hcup-us.ahrq.gov/reports.jsp.

In 1985, well before the publication of the IOM reports, the Secretary of Health and Human Services released a report about persistent gaps in health status among racial and ethnic minorities.[10] That document was the impetus for the creation of the Office of Minority Health (OMH) in the U.S. Department of Health and Human Services (as well as what is now called the Office of Minority Health and Health Disparities within the Centers for Disease Control and Prevention). The OMH is dedicated to improving the health status of racial and ethnic minorities, eliminating health disparities, and achieving health equity in this country. In addition to providing funding to entities ranging from state offices of minority health to community- and faith-based organizations, OMH houses a minority health resource center, and most recently, initiated the National Partnership for Action to End Health Disparities (NPA). The NPA is an effort to coordinate national strategies to eliminate health disparities and achieve health equity. One of the five NPA goals includes improving data availability. Under the NPA, OMH is creating a National Plan for Action, a roadmap for the elimination of health disparities. The draft plan was released in February 2010 for public comment and a final version is expected in 2011. The draft plan is the culmination of regional conversations and a national summit; it "captures the status of health disparities in our country and proposes 20 strategies for their elimination."[11] These strategies include the use of partnerships, cultural competence, better awareness, and research and data collection.

Additionally, in spring 2010 federal health care reform, known as the Patient Protection and Affordable Care Act (ACA), became law.[12] The ACA includes a number of provisions that have the potential to help reduce disparities in health status and health care access and quality. Between now and 2014, the ACA extends health insurance to millions of Americans, which is critical as people of color comprise one-third of the United States population yet account for one-half of the country's uninsured.[13]

ACA directs states to collect information and data regarding disparities.[14] For example, one provision stipulates: "No later than 2013, all federally-funded health programs and

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[10] Centers for Disease Control and Prevention, "Perspectives in Disease Prevention and Health Promotion Report of the Secretary's Task Force on Black and Minority Health," *Morbidity and Mortality Weekly Report* 35 (8) (February 28, 1986): 109-112. Available online: http://www.cdc.gov/mmwr/preview/mmwrhtml/00000688.htm.

[11] "The National Plan for Action Draft as of February 17, 2010," United States Department of Health and Human Services, available online: http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlID=31. Last modified February 17, 2010.

[12] Public Law 111–148 http://docs.house.gov/energycommerce/ACAcon.pdf.

[13] "Health Reform and Communities of Color: Implications for Racial and Ethnic Health Disparities," The Henry J. Kaiser Family Foundation, September 2010, 1. Available online: http://www.kff.org/healthreform/upload/8016-02.pdf. (Accessed September 27, 2010.)

[14] These ACA provisions complement other legislation, specifically the Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery and Reinvestment Act of 2009. HITECH contains a Meaningful Use Incentives Program administered by state Medicaid agencies; providers who can demonstrate the "meaningful use" of certified electronic health record technology receive incentive payments. Patient race, ethnicity, and preferred language are among the core elements of meaningful use. See Blumenthal, D. and M. Tavenner. "The 'Meaningful Use' Regulation for Electronic Health Records," *The New England Journal of Medicine*, 13 July 2010. http://healthcarereform.nejm.org/?p=3732&query=home (Accessed November 8, 2010).

population surveys…will be required to collect and report data on race, ethnicity, primary language, and other demographic characteristics identified as appropriate by the Secretary of Health and Human Services for reducing health disparities."[15]

ACA also includes a permanent reauthorization of the Indian Health Care Improvement Act to help meet the health care needs of American Indians and Alaska Natives, along with quality improvement provisions, such as the creation of national quality indicators that will be tracked by race and ethnicity.[16] Other provisions of the ACA that may be relevant to states include those that relate specifically to health care delivery (i.e., workforce diversity, cultural competence, aligning payment with quality rather than quantity of care) and others that reach beyond the health care system to influence social determinants of health (i.e., community transformation grants, public health initiatives).[17] Overall federal health reform "has the potential to seed, promote and guide diversity initiatives in this country for decades to come."[18]

NPA goals and provisions of the ACA that relate to collection and reporting of standardized data on race and ethnicity will help form a better understanding of health and health care disparities in order to tailor strategies to reduce these disparities. Data are critical to improvement, and effective use of data requires a commitment to collect it, a strategy to combine data from different sources, and selection of priority areas for analysis.

State Roles and Activities

Within the national context of reform and federal initiatives, states are also undertaking activities to improve the health status and quality of care for racial and ethnic minority populations. As of September 2010, all 50 states have a government office or entity dedicated to minority health or health equity.[19] Additionally, the number of data organizations participating in AHRQ's Healthcare Cost and Utilization Project that collect patient race/ethnicity data as part of their statewide hospital discharge databases has increased. As previous reports have shown, there are a number of noteworthy ways in which these hospital discharge data inform statewide efforts to reduce disparities.[20,21]

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[15] Andrulis et al., *Patient Protection and Affordable Care Act of 2010*, 2.
[16] "Health Reform and Communities of Color," Kaiser, 2.
[17] Dennis P. Andrulis et al., *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*, (Washington, DC: Joint Center for Political and Economic Studies, July 2010). (Accessed October 21, 2010.) http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.
[18] Ibid, 18.
[19] National Conference of State Legislatures. "State Profiles: Minority Health and Health Equity Offices." September 2010. (Accessed October 21, 2010.) http://www.ncsl.org/?tabid=14299.
[20] Hanlon, C. and Raetzman S. *State Uses of Hospital Discharge Databases to Reduce Racial and Ethnic Disparities.* Online October 14, 2010. U.S. Agency for Healthcare Research and Quality (AHRQ). Available: http://www.hcup-us.ahrq.gov/reports.jsp.
[21] Love D. *Case Studies of Uses of Data on Patient Race/Ethnicity from Statewide Hospital Discharge Databases*. Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, 2005. Contract # 290-00-004. Rockville, MD.

This paper focuses on eight states that the National Academy for State Health Policy (NASHP) identified as leaders in terms of their analysis and/or inclusion of data from state and federal sources in strategic plans and reports to address health disparities: Colorado, Connecticut, Georgia, Maryland, New Jersey, New Mexico, Rhode Island, and Utah. As with federal agencies, it has become increasingly clear to states that expanding access is only one aspect of health care reform; quality improvement and cost containment are critical to effectively and sustainably implement the components of reform that expand coverage and access to care.
This paper focuses on similarities and differences among data reports and strategic plans in featured states and details states' activity related to these documents. It highlights lessons states have learned in the process of creating their documents and using them to inform their efforts to address disparities in health and health care.

Methodology

As a subcontractor to Thomson Reuters, NASHP has supported AHRQ's Healthcare Cost and Utilization Project (HCUP). HCUP is a family of health care databases and related software tools and products. HCUP databases bring together the data collection efforts of state government organizations, hospital associations, and private data organizations (HCUP Partners) and the Federal government to create a national information resource of patient-level health care data that allow for research about an array of health policy issues at the national, state, and local levels. The objectives of HCUP are to create sources of national and state level all-payer health care data, produce a set of tools to facilitate the use of these data and other administrative data, and develop a collaborative partnership with organizations in each of the states that will increase the quality/use of health care data and research to inform decisions that will affect health care delivery.[22]

AHRQ has provided support to HCUP Partners through workgroups that facilitate information-sharing and peer learning about, among other topics, coding, collecting, and analyzing patient race/ethnicity data from hospital discharge databases. This paper builds on NASHP's work supporting the recent HCUP Workgroup on Analyzing State Discharge Data on Race-Ethnicity, primarily a case study report about how states use race/ethnicity data from statewide hospital discharge databases to support activities to reduce disparities in health and health care.[23] Through research for that report, it became clear that 1) states use a range of data sources other than hospital discharge databases to understand racial and ethnic health disparities; and 2) states often compile these data in strategic plans or data reports. This report is an effort to more comprehensively explore states' identification, documentation and action on race/ethnicity data to highlight leading practices and inform the potential addition of new

[22] "Overview of HCUP," Agency for Healthcare Quality and Research. (Accessed October 21, 2010.) http://www.hcup-us.ahrq.gov/overview.jsp.
[23] Hanlon, C. and Raetzman S. *State Uses of Hospital Discharge Databases to Reduce Racial and Ethnic Disparities.* Online October 14, 2010. U.S. Agency for Healthcare Research and Quality (AHRQ). Available: http://www.hcup-us.ahrq.gov/reports.jsp.

data to AHRQ's State Snapshots website, particularly the "Focus on Disparities" section, which currently includes only discharge data.

For this report, NASHP first contacted several experts on disparities reduction activities to learn about existing national and state efforts and help identify best practices in data-driven disparities reports. Key informants represented federal agencies (U.S. Department of Health and Human Services' Office of Minority Health, CDC Office of Minority Health and Health Disparities), a research organization (the Joint Center for Political and Economic Studies) and the national organization representing public health agencies (the Association of State and Territorial Health Officials or ASTHO). Key informants shared useful background materials and resources.[24]

NASHP simultaneously conducted an environmental scan of all 50 states and the District of Columbia to identify leaders in the use of patient race/ethnicity data. NASHP conducted an internet search of all states' health and/or minority health (if applicable) departments to find state-produced disparities documents meeting the following criteria:

- published in 2007 or later;
- data-driven;
- addressing *health care* disparities;[25] and
- with evidence of state action on the document (i.e., use of information in document).

After identifying a preliminary list of state documents that initially appeared to meet the above criteria, NASHP e-mailed directors of Departments of Health and Offices of Minority Health (where applicable) in each of the 50 states plus the District of Columbia. The directors were asked to verify the accuracy and completeness of a summary of the documents located by the search. After receiving feedback from states about their data reports and strategic plans, NASHP consulted with AHRQ and Thomson Reuters to finalize the selection of states to profile. NASHP selected eight states that best met the aforementioned criteria, with consideration also given to profiling states from different regions of the country. These states are: Colorado, Connecticut, Georgia, Maryland, New Jersey, New Mexico, Rhode Island, and Utah. NASHP then scheduled informal calls with the authors of the state document(s) and other people from the state who were involved in creating or using the document(s).

Some states that are doing noteworthy work to address disparities did not meet the particular criteria for this study and were not included among the eight that are featured. However, this paper briefly mentions some of these states and notes what makes them unique.

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[24] See, for example: Smedley, B. *Moving Toward Health Equity in New York: State Strategies to Eliminate Health Disparities*. A Report for the Minority Health Council, New York State Department of Health. 2009. (Accessed October 21, 2010.) http://www.health.state.ny.us/community/minority/docs/moving_toward_health_equity.pdf; and ASTHO State Health Equity Snapshot Map. (Accessed October 21, 2010.) http://astho.org/Programs/Health-Equity/State-Snapshots-Map/State-Snapshots/.

[25] AHRQ explicitly expressed interest in states that focus not only on health disparities (i.e., disparities in health status) but also on health care disparities (i.e., disparities in care).

The following sections synthesize themes and lessons from the eight featured states, including the following characteristics of their data-driven disparities documents:

- general category of document(s);
- data sources referenced and found to be most useful;
- indicators presented;
- units of analysis;
- role of the Office of Minority Health;
- public and private partners;
- connection to broader context of departmental or state activities to reduce disparities; and
- resulting action and future plans, e.g., for state health reform.

FEATURED STATES PRODUCE DATA REPORTS AND/OR ACTION PLANS

When it comes to using data to document disparities and inform action, featured states primarily produce three different categories of documents: action plans, data reports, or a combination of both. States sometimes use the terms differently. New Mexico and Georgia, for example, are unique in that they both issue "report cards" that grade disparity rates, yet New Mexico's document exclusively presents data while Georgia's document provides both data and action steps. It also is important to note that some states create reports that focus on disparities across a range of health issues and conditions, whereas others have a number of condition-specific reports that explicitly document racial/ethnic disparities. The latter are used by states separately to address disparities within a wide variety of health conditions, such as heart disease, diabetes, asthma, oral health, and HIV/AIDS.

The three main categories of documents states produce are described below.

- **Data report**: This type of document compiles race/ethnicity-specific metrics and performance measures to identify disparities that need to be addressed. One example is New Mexico's report card.[26] The data are presented by disease/condition, and the disparity rate is shown and then ranked on a scale of A-F depending on the rate. Data reports detail disparities but often provide little in the way of action steps.

- **Action plan**: These documents propose steps to move toward health equity, as opposed to focusing on documenting disparities. One example of an action plan is Rhode Island's document describing its programmatic efforts to address disparities.[27] This agency plan details the state's philosophical approach to disparities and informs Department of Health programs on how they are to approach and explicitly address disparities within their condition-specific plans.

- **Combination of action plan and data report**: In this approach, states present both action steps and data either in a single document or in separate-yet-complementary documents. Connecticut, for example, has one document that includes both data and action steps.[28] New Jersey follows this model as well, presenting data and action steps for 13 "Medical Priority Areas."[29] Utah, on the

[26] New Mexico Department of Health, *Racial and Ethnic Health Disparities Report Card*. Santa Fe, NM: 2010. Available online: http://nmhealth.org/dpp/2010ReportCard.pdf.
[27] Rhode Island Department of Health, *Minority Health Plan for Action*, Providence, RI: 2004. Available online: http://www.health.ri.gov/publications/actionplans/2004MinorityHealth.pdf.
[28] Alison Stratton, Margaret Hynes, and Ava Nepaul. *The 2009 Connecticut Health Disparities Report*, Hartford, CT: Connecticut Department of Public Health, 2009. Available online: http://www.ct.gov/dph/lib/dph/hisr/pdf/2009ct_healthdisparitiesreport.pdf.
[29] New Jersey Department of Health & Senior Services, Office of Minority and Multicultural Health. *Strategic Plan to Eliminate Health Disparities in New Jersey Update & Addendum* Trenton, NJ: 2010. Available online: http://www.state.nj.us/health/omh/documents/strategic_plan_2010.pdf.

other hand, has a data report[30] that breaks down disparities by race and ethnicity that informed a separate action plan with steps for addressing disparities.[31]

Common Elements of Data Reports and Action Plans

Most of the reviewed state data reports provide information about data sources, indicators, and limitations of the data. These documents also interpret the data to identify findings about disparities within the state. Additionally, many data reports feature a discussion on determinants of health, comparisons of metrics and performance measures by race/ethnicity (in some cases by income level), and some plans feature target values for metrics and measures. Report cards also focus on data and include a discussion and interpretation of the rating system (See "Report Card Data," page 25).

Action plans contain a different set of common elements. As the term implies, each action plan contains action steps aimed at reducing disparities. Several of the action plans reviewed suggest critical questions that should be addressed by state program officials, policy makers, and others in order to reduce disparities. The plans then make recommendations for steps to address these questions. Action plans often also set state goals. Action plans are less focused on data as a whole; several contain little data or only a brief overview, while some contain no data at all. Instead the focus of an action plan is to strategize the steps necessary to address the problem identified by the data report and to achieve any target outcomes. For this reason, many featured states that have an action plan for reducing disparities also have a companion data report (as illustrated in Table 1, below).

Table 1 describes the documents that NASHP reviewed in the profiled states. This table does not include every plan published by each state, though the plans that NASHP reviewed with states are representative of the work being done by the state. A more detailed list of state documents — as well as web links — can be found in Appendix A.

[30] Center for Multicultural Health, *Health Status by Race and Ethnicity: 2010.* Salt Lake City, UT: Utah Department of Health, 2010. Available online: http://health.utah.gov/cmh/data/healthstatus.pdf.
[31] Center for Multicultural Health, *Action Plan to Eliminate Racial/Ethnic Health Disparities in the State of Utah.* Salt Lake City, UT: Utah Department of Health, 2008. Available online: http://www.health.utah.gov/cmh/udoh/CMH%20Action%20Plan%20April%202008%20_website_.pdf.

Table 1: Reviewed Documents that Focus on Health and Health Care Disparities in Leading States, by Category (Action Plan and/or Data Report)

State	Document Title	Action Plan	Data Report
Colorado	*2008-2010 Office of Health Disparities Strategic Plan*	Y	N
	Racial and Ethnic Health Disparities in Colorado 2009	N	Y
	Colorado Health Disparities Strategic Plan 2008: Interagency Health Disparities Leadership Council	Y	N
Connecticut	*The 2009 Connecticut Health Disparities Report*	Y	Y
Georgia	*Health Disparities Report 2008: A County-Level Look at Health Outcomes for Minorities in Georgia*	Y	Y
Maryland	*Maryland Chartbook of Minority Health and Minority Health Disparities Data*	N	Y
	Maryland Plan to Eliminate Minority Health Disparities Plan of Action 2010-2014	Y	Y
New Jersey	*Strategic Plan to Eliminate Health Disparities in New Jersey March 2007*	Y	Y
	Strategic Plan to Eliminate Health Disparities in New Jersey Dec. 2007 Update	Y	N
	Strategic Plan to Eliminate Health Disparities in New Jersey: Update & Addendum	Y	Y
New Mexico	*Racial and Ethnic Health Disparities Report Card*	N	Y
Rhode Island	*Heart Disease and Stroke Prevention Rhode Island State Plan 2009*	Y	Y
	Reducing the Burden of Asthma in Rhode Island: Asthma State Plan, 2009-2014	Y	Y
	Minority Health Plan for Action	Y	N
Utah	*Health Status by Race and Ethnicity: 2010*	Y	Y
	Action Plan to Eliminate Racial/Ethnic Health Disparities in the State of Utah	Y	N

REVIEWED DATA REPORTS: A CLOSER LOOK AT THE DATA

Primary data collection and use of secondary data (including analysis and presentation in reports) play a vital part in the effort to address health disparities. In order to make effective policy and to develop useful plans, it is critical that the data accurately reflect where these gaps exist. A recent report by the Institute of Medicine (IOM) found that, "consistent methods for collecting and reporting health data by race, ethnicity, and language are essential to informing evidence-based disparity reduction initiatives."[32]

The states profiled had varying approaches to selecting data indicators. Maryland, New Mexico, and Connecticut each had one or more epidemiologists on staff to manage the data available and determine the appropriate indicators. Utah contacted various state health departments/programs for data and indicators to use for their disparities reports. Upon receiving the data and indicators, Utah's Office of Minority Health (OMH) then chose which indicators it felt were the best fit for the reports. Colorado convened a health disparities report advisory committee to determine the report sections and indicators. Committee members were involved from the beginning of the process and included: community-based organizations serving different racial and ethnic communities, health care providers, cultural competence experts, foundations, local health departments, Office of Health Disparities staff and state health department staff from different programs. Georgia brought in data collectors and an epidemiologist from outside the agency, including the Morehouse School of Medicine, to select the indicators used in the state's report. In New Jersey, indicators used in the disparities plan were primarily informed by the state's Healthy New Jersey (HNJ) 2010 indicators. When the disparity area examined did not have a corresponding HNJ indicator, programs used the data available to them to describe the disparity. Many of the data reflect a combination of HNJ and program selected indicators. Rhode Island let programs select the data indicators that they wish to use when coming up with their plans, though the State OMH does provide guidance to these programs.

The most commonly presented measures in reviewed states' data reports focus on mortality rates and the prevalence or incidence of risk factors/behaviors, such as smoking or physical inactivity; every featured state included measures from each category. Every featured state data report also included measures of health care access/utilization, such as avoidable hospitalizations or emergency department visits and receipt of recommended cancer screenings, physical exams or other health care services. Measures about access to or receipt of appropriate prenatal care were most common (6 states). See Table 2 for a more detailed list of measures included in featured states' reviewed data reports.

[32] Cheryl Ulmer, Bernadette McFadden, and David R. Nerenz. *Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement*. Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement, Institute of Medicine. In Andrulis et al., *Patient Protection and Affordable Care Act of 2010*, 2.

Table 2: Types of Measures Presented in Featured States' Data Reports

Measure		CO	CT	GA	MD	NJ	NM	RI	UT
Prevalence/Incidence of Conditions	(e.g., cancer rate, new cases of sexually transmitted infections)	✓	✓		✓	✓	✓	✓**	✓
Prevalence/Incidence of Risk Factors/ Behaviors	(e.g., smoking, low-term birth, exposure to second hand smoke, arrests for driving under the influence of drugs or alcohol)	✓	✓	✓	✓	✓	✓	✓*	✓
Access/Utilization	1. ER/ED use for ACSCs		✓	✓		✓			
	2. Hospitalization for ACSCs		✓	✓	✓			✓	
	3. Receipt of recommended treatment (e.g., cancer screening, routine medical checkup)	✓	✓				✓		✓
	4. Have health/dental insurance	✓	✓	✓	✓	✓			✓
	5. Access to health care providers (e.g., rate per 100K population, % of population vs. providers)		✓	✓					
	6. Pre-natal care		✓	✓	✓	✓	✓		✓
	7. Other: a. Regular/usual source of care (CO, UT) b. No access to needed care, ED as point of access to care (UT) c. Could not afford to see a doctor in year prior (MD) d. Access to translated materials and/or language services, if needed (NJ, CT)	✓			✓	✓			✓
Cost	1. Excess utilization				✓				
	2. Life years lost			✓					
	3. Days away from work		✓						
Mortality	(Death rate)	✓	✓	✓	✓	✓	✓	✓*	✓
Socioeconomic Status	1. Poverty	✓	✓	✓					✓
	2. Income	✓	✓	✓				✓**	✓
	3. Unemployment	✓		✓					
	4. Education		✓	✓				✓*	
Other	1. Provider diversity (CT, GA, NJ) 2. Protective factors (e.g., knowledge of risk factors) (UT)		✓	✓	✓	✓			✓

*ACSC – Ambulatory care sensitive condition (a condition for which hospitalization is avoidable with appropriate preventive care, e.g., diabetes, tooth pain)

Rhode Island: ✓** = Present in both Heart and Asthma plans, ✓* = Present only in Heart plan, ✓ = Present only in Asthma plan

Data Sources

States vary in data sources, unit of analysis, and rates used to report disparities in their health disparities reports (see Table 3). Many states indicated that the most valuable data was whatever told the story the best, or made the best case for the need to address the disparities. There were several data sources that were commonly used and listed as helpful. The first is Behavioral Risk Factor Surveillance System (BRFSS), "a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health access primarily related to chronic disease and injury."[33] The behaviors that are surveyed include tobacco use, alcohol use, and others that can affect health outcomes. States can use BRFSS to effectively chart trends in the population, identify health objectives, and develop appropriate public health policies in response to the results.[34] A second common source of data is state registries for conditions such as cancer or HIV. States also often use vital records, which contain data about births and deaths. Hospital discharge and emergency department data are other common sources of data. Just over half of profiled states (5) use hospital discharge data, and just under half (3) use emergency department data.

Other types of data that states use vary based on what the states and hospitals record and, therefore, are available. For example, New Jersey has an abundance of violent death data in its Violent Death Reporting System, which includes measures such as homicides, suicides, and vehicular accidents. The state has found this to be a valuable resource for its disparities reports. Additionally, New Jersey published a series of maps in its plan which provided a breakdown of minority populations by county, centers for primary care by legislative district, and acute care hospitals by legislative district. Maryland includes a map in every publication that comes from its Office of Minority Health and Health Disparities. The map shows the minority population breakdown by county. Maryland includes the map because it shows that racial and ethnic minority populations (and therefore any racial or ethnic disparities in health or health care) are not necessarily isolated to Baltimore City and Prince George's County (a suburb of Washington, D.C.), which had been a common misconception. Instead, this map shows that meeting the health needs of racial and ethnic minority groups by identifying and addressing disparities is indeed a statewide issue.

[33] "About the BRFSS," Centers for Disease Control and Prevention. (Accessed October 21, 2010.) http://www.cdc.gov/brfss/about.htm.
[34] Ibid.

*Table 3: Data Sources, Units of Analysis, and Rates in Reviewed State Data Reports**

State	Data Sources							Geographic Unit(s) of Analysis	Rate(s) (Absolute or Relative)
	BRFSS	*Vital Records*	*Hospital Discharge*	*ED/ER*	*Child Health Survey*	*Census^*	*Other*		
Colorado	Y	Y	N	N	Y	Y	Pregnancy Risk Assessment Monitoring System, Disease Incidence	State and County	Relative
Connecticut	Y	Y	Y	Y	N	Y	U.S. Department of Labor Survey of Occupational Injury and Illnesses,^ and Census of Fetal Occupational Injuries;^ Department of Public Health Infectious Disease Section; Lead Poisoning and Prevention Control Program Blood Lead Level Data, Child Oral Health Survey	State	Both
Georgia	Y	Y	Y	N	N	Y		County	Both
Maryland *Chartbook and Plan*	Y	Y	Y	N	N	Y	US Renal Data System^	State and County	Both
New Jersey *2007 Plan*	Y	Y	Y	Y	Y	Y	Violent Death Reporting System	State and County	Both
2010 Update and Addendum	Y	Y	N	Y	N	N		State	Both
New Mexico	Y	Y	N	N	Y	N	Infectious Disease Surveillance	State	Relative
Rhode Island *Heart Disease Plan*	Y	Y	N	Y	Y	N		State	Relative
Asthma Plan	Y	Y	Y	Y	Y	N		State	Relative
Utah	Y	Y	N	N	N	Y	Utah Department of Health Office of Public Health Assessment, Utah Healthcare Access Survey, Pregnancy Risk Assessment Monitoring System, Violent Death Reporting System, Cancer Registry	State	Absolute

*BRFSS – Behavioral Risk Factor Surveillance System, a state-based national health survey supported by CDC that monitors state-level prevalence of behavioral risk factors; Vital Records – Records of life events kept under governmental authority, including birth and death data and other related information; Hospital Discharge – Data related to information on inpatients at the time of hospital discharge; ED/ER – Emergency Department/Emergency Room Data, a registry of data collected and recorded from emergency room visits; Child Health Survey – state administered surveys to determine the health of children and youth; and Census – information from the United States Census Bureau.
^ Indicates a national data source.

AHRQ's State Snapshots

AHRQ's State Snapshots website (http://statesnapshots.ahrq.gov/snaps09/index.jsp) uses state-level data from the annual NHQR and NHDR reports as well as additional data analyses to describe the quality of care across and within states. In particular, quality of care measures by race and ethnicity within each state can be accessed through the "Focus on Disparities" section. This section compares state performance to the national average to result in a ranking that ranges from very weak to very strong state performance in quality of care for a given racial or ethnic group compared to Whites (Non-Hispanics).

This source of health disparities information was not cited in featured states' documents. In fact, most profiled states had very limited or no familiarity with this site and the "Focus on Disparities" Section. However, after visiting the site, states made suggestions for improving the usefulness of the information to them: adding more sources of data; including more race/ethnicity categories; and using more state-to-state comparisons.

Units of Analysis: Statewide vs. County Level

Four of the eight states studied display data broken down by county. These are the larger states: Georgia (pop. 9,829,211), New Jersey (8,707,739), Maryland (5,699,478), and Colorado (5,024,748).[35] Two states that did extensive county-level analysis, Georgia and Maryland, both did so because they found it helped make the case that health disparities are truly statewide problems that affect residents of every county. Georgia uses only county-level data to illustrate that health disparities are not only an urban issue in Atlanta but are far more widespread. Colorado's 2009 report and Maryland's Chartbook show the geographic breakdown of each minority group profiled. New Jersey's Department of Health and Senior Services' State Health Assessment Data (NJSHAD) System website provides geographic and county-level public health and health status information that complements data in state disparities reports (http://www4.state.nj.us/dhss-shad/home).

The smaller states — Connecticut (pop. 3,518,288), Utah (2,784,572), New Mexico (2,009,671), and Rhode Island (1,053,209) — generally have limited county data[36]. Nevertheless, Rhode Island has geomapped cigarette vendors in low income communities, and Connecticut has used geomapping to take a closer look at cities where minority populations are over-represented.

[35] All population data courtesy of the United States Census 2009 population estimate. (Accessed August 6, 2010.) http://quickfacts.census.gov/qfd/index.html.
[36] Ibid.

Comparing Population Rates

Identification of disparities requires comparison of groups in order to find gaps.[37] In order to compare health status and health outcomes between racial and ethnic minority populations, states use absolute and/or relative rates (see Figure 2). Either type of rate can be used to measure disparities, but they provide different types of information.[38] An absolute rate is a numerical value describing a single population (e.g., mortality), whereas a relative rate, often expressed in the form of a ratio, is derived from comparing the numerical value for one population with that for another population.

Relative rates are more commonly presented by the featured states than absolute rates (i.e., all states present relative rates while three use both). States determine the comparisons that will be most useful for them. In choosing between relative and absolute rates, featured states assessed the complexity of the information (i.e., their ability to explain it to the public), as well as which rate of comparison makes the best case for action. For example, Connecticut, Georgia, Maryland and New Jersey use both absolute and relative rates, having found that each provides useful information. Maryland added that ratio metrics are easier for the public to understand; however for understanding time trends in disparities, a difference metric is a better indicator of progress. State decisions are also influenced by availability of data and standard protocols.

Figure 2: Examples of Absolute and Relative Rates

Absolute: An absolute rate is a numerical value describing a single population; for example, any data that shows that a certain condition occurs in a number of people per 1,000 of a certain population is an absolute rate. These rates include: mortality rates, birth rates, and disease incidence rates (i.e., in Connecticut the HIV/AIDS incidence rate for Hispanics is 81.9 per 100,000).*

Relative: Relative rates are derived by comparing one measure to another, such as a state finding that African Americans have a diabetes incidence rate three times that of the White population; this resulting ratio is a relative rate. New Mexico's disparity ratios are another example (e.g., the youth obesity rate for American Indians is 2.2 times greater than the youth obesity rate of Whites).**

Sources: * *The 2009 Connecticut Health Disparities Report*, 81.
** *Racial and Ethnic Health Disparities Report Card*, 8.

[37] Sam Harper and John Lynch. *Methods for Measuring Cancer Disparities: Using Data Relevant to Healthy People 2010 Cancer-Related Objectives*. National Cancer Institute Surveillance Monograph Series, Number 6. NIH Publication No. 05-5777. Bethesda, MD (2005): 21. (Accessed October 21, 2010.) http://seer.cancer.gov/publications/disparities/.
[38] Ibid., 22.

Races and Ethnicities Covered

As shown in Table 4, reviewed state data reports only varied slightly from each other in the races/ethnicities for which metrics and measures were presented. These variations can generally be explained by the composition of the state's population, and by the data available for a particular racial/ethnic group. Georgia, for example, has limited data available on the Asian population, so there is a larger focus in the documents on the Hispanic/Latino and African American populations. Additionally, while each of the states have a Native American population, the western states (Colorado, New Mexico, and Utah) have larger Native American populations and generally have a larger focus on those groups in their plans. The two states that produced report cards (Georgia and New Mexico) graded disparities for each minority group, but did not produce separate report cards by race/ethnicity.

The table also shows that states define races differently. Utah, for example, includes Native Hawaiians in the Pacific Islander population and includes Alaska Natives with Native Americans, which is the federal standard. In Connecticut, however, these groups are not combined and the presentation of data specific to them depends on the indicator. Featured states also use different terms for similar populations. New Mexico uses the term "American Indians," where Colorado uses both the term "American Indians" and "Native Americans." The state documents provide more detail on how each race/ethnicity is defined.

Table 4: Races and Ethnicities Included in Reviewed State Disparities Reports

State	Black or African American	Hispanic/ Latino	Asian/Pacific Islander	Native American or American Indian	Notes
Colorado	Y	Y	Y	Y	
Connecticut	Y	Y	Y	Y	Inclusion of White, Alaska Native, Native Hawaiian and Pacific Islander depends on the indicator
Georgia	Y	Y	Y	Y	Inclusion of White, Multiracial, Native Hawaiian depends on the indicator
Maryland *Chartbook and Plan*	Y	Y	Y	Y	Native American includes Alaska Natives
New Jersey *2007 Plan and 2010 Update and Addendum*	Y	Y	Y	N	
New Mexico	Y	Y	Y	Y	
Rhode Island *Heart Disease Plan and Asthma Plan*	Y	Y	N	N	
Utah	Y	Y	Y	Y	American Indian includes Alaska Natives. Asian and Pacific Islander are reported separately. Native Hawaiian/Pacific Islander are reported together.

Health Topics and Conditions Covered

Table 5 shows the conditions addressed by disparities documents. The majority of states present data on heart disease/stroke, HIV/STDs, cancer, and maternal and child health care issues. Oral health and mental health are covered less often. In New Jersey, mental health programming and data fall outside the purview of the Department of Health and Senior Services, but the Office of Minority and Multicultural Health maintains contact with people designated to address disparities in mental health. Mental health indicators are being used for a forthcoming foreign-born report. Since all states use the BRFSS, there is a great deal of data featured across states on risk behaviors such as tobacco use, obesity, and alcohol/substance abuse.

Table 5: Health Topics Covered in Reviewed States' Data Reports

State	Heart Disease/ Stroke	Cancer	Asthma	Maternal and Child Health Care	Diabetes	HIV & STDs	Oral Health	Mental Health	All Cause or General Mortality	Other
Colorado	Y	Y	Y	Y	Y	Y	Y	Y	Y	Motor Vehicle Injury
Connecticut	Y	Y	Y	Y	Y	Y	Y	N	Y	
Georgia	N	Y	N	Y	N	Y	Y	Y	Y	
Maryland *Chartbook and Plan*	Y	Y	Y	Y	Y	Y	N	Y	Y	Tobacco Use, Obesity, Renal Disease
New Jersey *2007 Plan and 2010 Update and Addendum*	Y	Y	Y	Y	Y	Y	N	N	Y	Violent Deaths, Adult and Child Immunization, Renal Disease, Influenza and Pneumonia
New Mexico	N	Y	N	Y	Y	Y	N	N	N	Homicide, Motor Vehicle Injury, Suicide, Teen Births, Obesity, Tobacco Use, Alcohol Related Deaths, Pneumonia Vaccination, Pertussis
Rhode Island *Heart Disease Plan* *Asthma Plan*	Y		Y							
Utah	Y	Y	Y	Y	Y	Y	N	Y	N	Violent Death, Alcohol Abuse, Tobacco Use, Tuberculosis, Motor Vehicle Injury, Motor Vehicle Crash Death, Adult Immunization, Obesity

States Increasingly Turn to the Topic of Costs of Disparities

> *"The costs to the health system are significant when care for Georgia's uninsured people are uncompensated and the costs are absorbed by the health institutions. The cost of treating unhealthy patients in Georgia's emergency rooms is much higher than the cost of preventing health problems. When populations have disproportionately higher illness rates and higher uninsured rates, it results in higher costs to the health system overall."*
>
> *– 2008 Georgia Health Disparities Report*, 13

A data topic of great interest among featured states is the impact of disparities. Some of the profiled states (e.g., Georgia and Maryland) already measure the impact of disparities while several others are exploring ways to do so. Costs can be calculated both in years of potential life lost, and in financial terms of additional spending on health care services. Georgia calculated years of potential life lost (YPLL) – 75 for each county because it made for an effective message on disparities. Georgia defines and calculates (YPLL) – 75 as "the

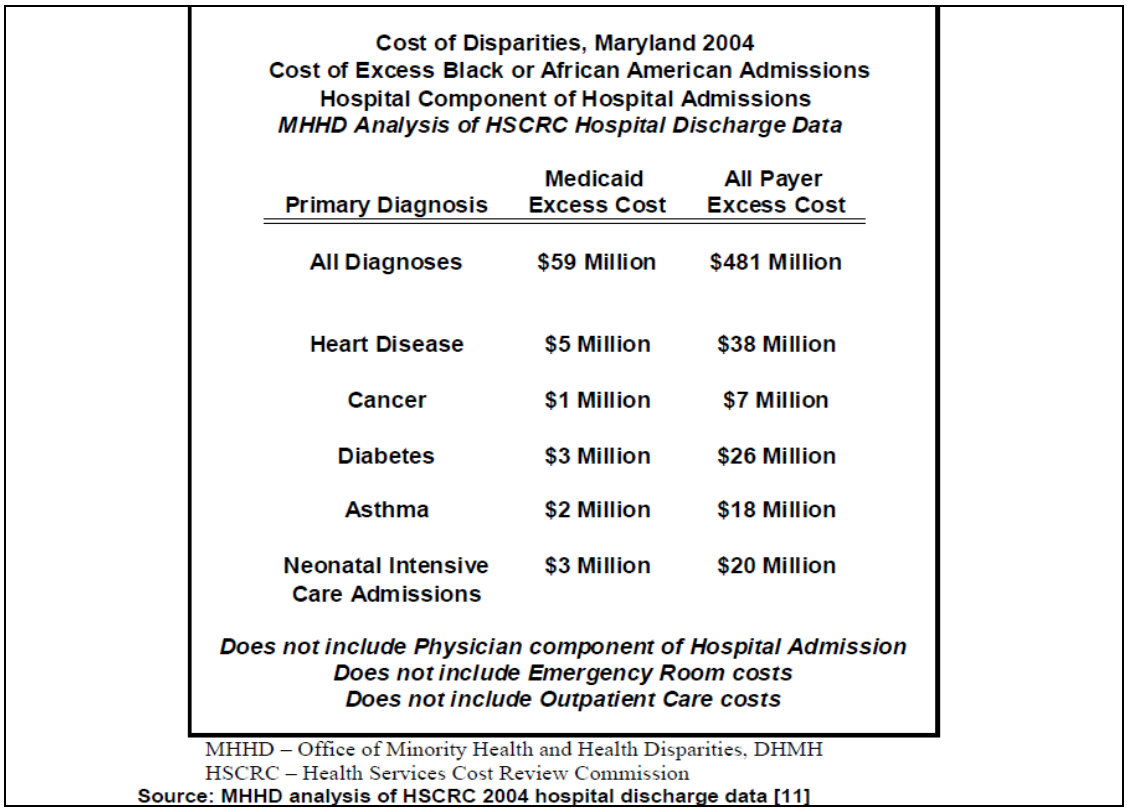
number of person-years of life lost due to deaths before age 75. Consider one African American male dying at age 54 (YPLL = 21 person years) and the disproportionate impact (lost grand-parenting, lost productivity and income, and lost wisdom of our elders) of the younger man's death on the African American community."[39] The state presented this metric for each county to show the human cost that health disparities can have on a population in a way other forms of information can not.

Maryland, on the other hand, looked at the cost of disparities in terms of monetary value. Using the state's hospital discharge data, Maryland calculates the "excess cost" to the state incurred both by Medicare, and by all-payers. Maryland calculates the cost of excess hospital admissions for all diagnoses incurred by the African American population ($59 million to Medicaid and $481 million to all payers), and breaks down the cost further to several specific diagnoses (i.e., cancer and asthma). These excess costs are associated with hospitalization related to the diagnoses seen in Figure 3.[40] The state noted that this is a valuable metric when it comes to addressing stakeholders and other interested parties. It shows these groups that there is a financial or economic benefit to reducing disparity rates.

[39] Debbie Hall et al., *Health Disparities Report 2008: A County-Level Look at Health Outcomes for Minorities in Georgia*, Georgia Department of Community Health's Office of Health Improvement and the Minority Health Council, 2008, 26.

[40] David Mann, Toyin Fatogun, and Carlessia Hussein. *Maryland Chartbook of Minority Health and Minority Health Disparities Data: With Sections on Gender-specific Health and Jurisdiction-specific Health*, Maryland Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene, December 2009, 34. Available online: http://www.dhmh.maryland.gov/hd/pdf/2010/Chartbook_2nd_Ed_Final_2010_04_28.pdf.

Figure 3: Hospital Cost of Excess Black or African American Hospital Admissions, Maryland, 2004



Cost of Disparities, Maryland 2004
Cost of Excess Black or African American Admissions
Hospital Component of Hospital Admissions
MHHD Analysis of HSCRC Hospital Discharge Data

Primary Diagnosis	Medicaid Excess Cost	All Payer Excess Cost
All Diagnoses	$59 Million	$481 Million
Heart Disease	$5 Million	$38 Million
Cancer	$1 Million	$7 Million
Diabetes	$3 Million	$26 Million
Asthma	$2 Million	$18 Million
Neonatal Intensive Care Admissions	$3 Million	$20 Million

Does not include Physician component of Hospital Admission
Does not include Emergency Room costs
Does not include Outpatient Care costs

MHHD – Office of Minority Health and Health Disparities, DHMH
HSCRC – Health Services Cost Review Commission
Source: MHHD analysis of HSCRC 2004 hospital discharge data [11]

Source: *Maryland Chartbook of Minority Health and Minority Health Disparities Data*, 2009, 33.

Connecticut calculates costs in terms of human loss and days away from work. For the former term Connecticut uses the metric "excess deaths, excess events," which it defines as, "those deaths that would not have occurred if one population subgroup (e.g. Black or male) had the same death rate as another subgroup (White or female)."[41] Connecticut uses the following formula to calculate excess deaths:

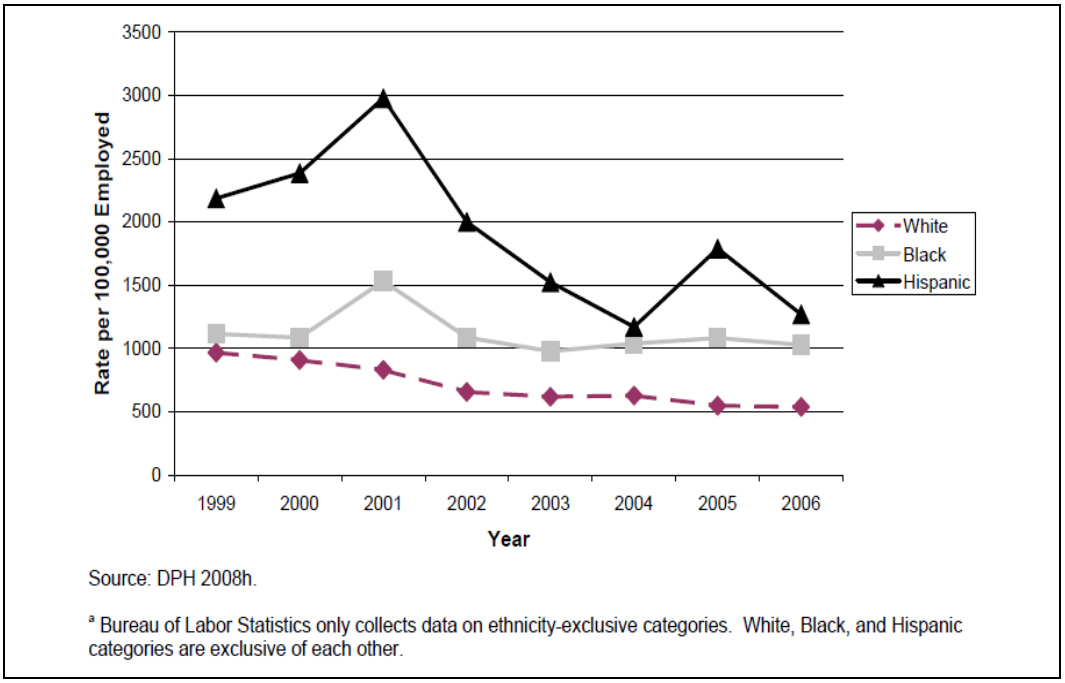
Excess deaths (or events) = Number of deaths (or events) x [1 – (1 / relative risk)][42]

This metric is similar to Georgia's use of YPLL. In calculating this metric, Connecticut was able to demonstrate that, "Compared with White residents, Blacks or African Americans had an estimated total of 376 excess deaths per year from 2000 to 2004."[43] Using Connecticut's formula and CDC WONDER mortality data, Maryland was able to calculate excess deaths in its state; one Maryland official believes every state could do the same thing.

[41] Stratton, Hynes, and Nepaul. *The 2009 Connecticut Health Disparities Report*, 172.
[42] Ibid., 173.
[43] Ibid., 144.

Additionally, Connecticut includes a graph which demonstrates the days away from work caused by injuries and illness in private industry by race or ethnicity.[44] The graph Connecticut includes in its report demonstrates that Hispanic and Black populations in Connecticut consistently experience days away from work at a higher rate than the White population.

Figure 4: Rate of Non-fatal Work-related Injuries and Illnesses Involving Days Away from Work, Connecticut—Private Industry, by Race or Ethnicity, 1999-2006



Source: Stratton, Hynes, and Nepaul. *The 2009 Connecticut Health Disparities Report*, 120.

Colorado has not yet established a metric for calculating the cost of disparities, however, the state recognizes the importance of the topic and discusses it in its *Racial and Ethnic Health Disparities in Colorado 2009* report:

> "Health disparities are costly in several senses of the term. They generate costs to the health-care system that could be reduced by the elimination of disparities. More importantly, poor health extracts a cost to individuals, families and communities by limiting the ability of people to realize their full potential."[45]

Eventually, Colorado would like to take the same approach as Maryland, to help make the case to policy makers and others for funding. Rhode Island, with the assistance of a consulting organization, is in the process of producing several fact sheets that analyze the costs of disparities associated with cardiovascular disease, diabetes, obesity and

[44] Stratton, Hynes, and Nepaul. *The 2009 Connecticut Health Disparities Report*, 120.
[45] Mauricio Palacio et al., *Racial and Ethnic Health Disparities in Colorado 2009*, Office of Health Disparities, Colorado Department of Public Health and Environment, 2009, 2. Available online: http://www.cdphe.state.co.us/ohd/ethnicdisparitiesreport/HD%202009%20LowRes.pdf.

sexually transmitted infections. The state is analyzing costs by race, ethnicity, and language spoken in terms of excess deaths, days of hospitalization, and burden of disease, along with excess or unnecessary medical charges and insurance claims. The documents will be published in 2011.

States Lack Data Indicators Needed to Develop a Comprehensive Understanding of Disparities

In addition to cost of disparities data, there were several other characteristics of data indicators that the profiled states expressed interest in for inclusion in future reports. Most states indicated that they want more of their data sources and indicators to be broken down by race/ethnicity. Georgia and Colorado, for example, have very little data on Asian Americans; Colorado would also like additional condition-specific data for American Indians. New Mexico indicated a need for more reliable hospital discharge data before including that data in its reports. Maryland lacks non-hospital-based outpatient administrative data broken down by race/ethnicity; race/ethnicity data are not currently included in the claims information received by the State from insurance companies for inclusion in the Statewide claims database.

Sometimes race/ethnicity data are available from a particular source but the specific fields or indicators are not exactly in line with what the state wants to include in its disparities document. For example, New Jersey is interested in including different immunization data than what is currently collected, so it has omitted this source from its reports thus far. New Jersey would need to move to an electronic birth record to facilitate better measurement of disparities in immunization rates. Mandatory reporters would need to be required to record race/ethnicity data in order for both immunization and STD disparities to be better captured. In Utah, the Department of Health would include substance abuse data in its reports, if the data were analyzed differently, such as by aggregating multiple years of data to decrease confidence intervals.

Use of Socioeconomic Data Is Contingent on Availability

All profiled states indicated that socioeconomic status data are an important resource for data reports about disparities since variables such as education level, income, and poverty correlate with the health of minorities, and racial and ethnic minorities are disproportionately represented among the poor. Most of the states use socioeconomic data in some form; however the availability and, therefore, the degree of use varies from state to state. New Jersey includes socioeconomic data as part of the overall demographic introduction to its reports and plans to do more with these data in the future. Connecticut had access to socioeconomic data from a federal source (the Census), but very few sources within the Department of Public Health consistently collect socioeconomic data. Georgia relies heavily on socioeconomic data from the Census, for example, persons below poverty and percent of adults having completed less than a ninth grade education.

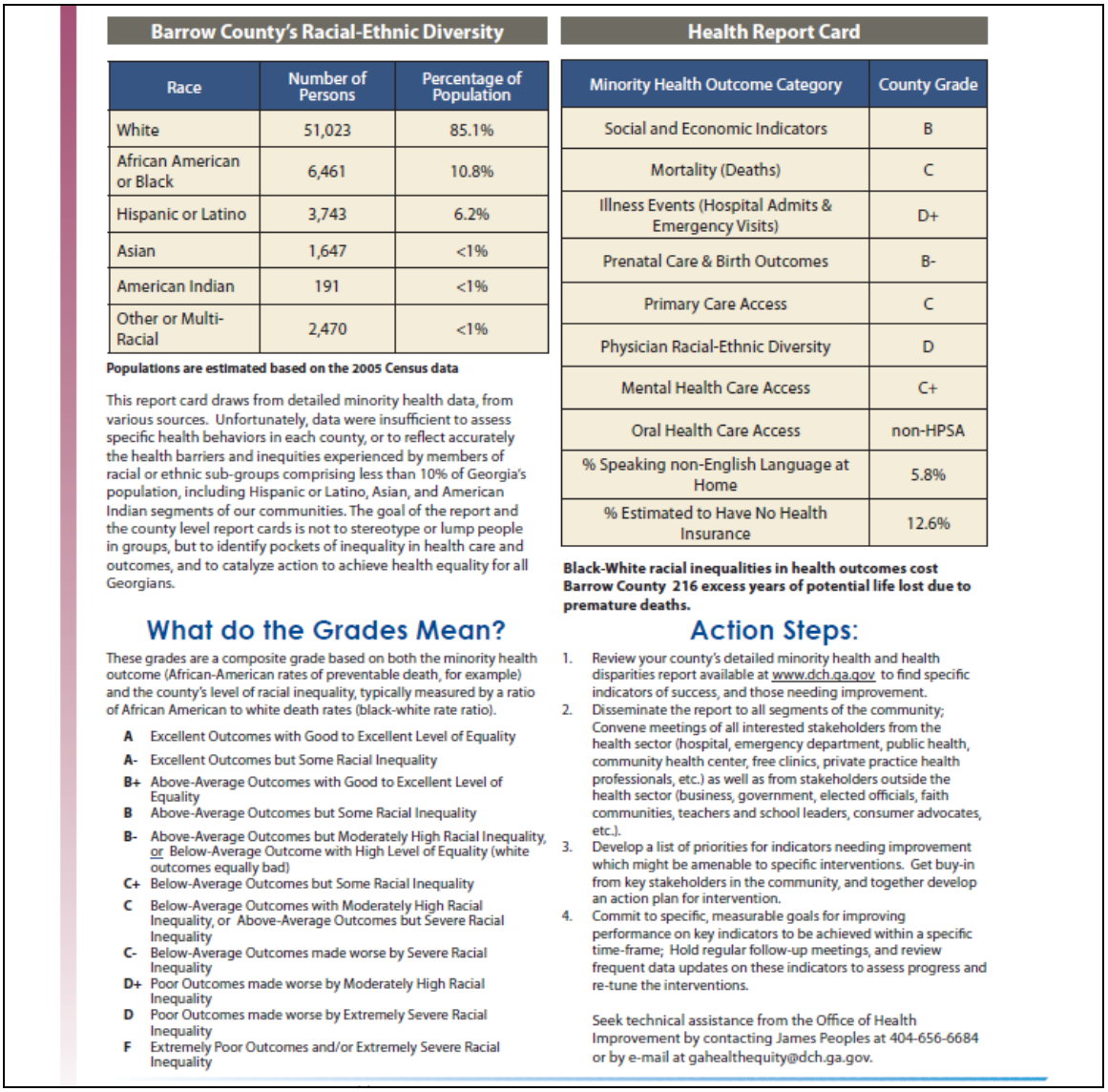
Report Card Data

Of the states profiled, both Georgia and New Mexico compile data into "report cards" or publications that categorize data into letter grades; however, they approach their respective report cards differently. Georgia examines the state on the county level and grades each county in a number of different categories that fall under four broader headings (Social and Economic, Mortality, Illness Events, and Birth Outcomes). New Mexico, being smaller than Georgia, focuses its report card on the state level and grades the disparity ratio for each ethnicity by condition (i.e., obesity, diabetes, infant mortality, etc.). New Mexico's grading system is also inspired by North Carolina (see Figure 8). One key difference in their otherwise-similar approaches, however, is that North Carolina's disparity rates are all calculated by comparing the rate of the minority group to the rate in the white population. New Mexico, on the other hand, calculates ratios using the population with the best rate for a condition as a comparison. New Mexico took this approach because the state's white population is not as large a percentage as many others, and the white population did not have the best rate on each condition.

Even though Georgia and New Mexico grade different metrics/measures and conditions, there are several similarities between the two. Both states grade on an A-F scale. For example, in Georgia, an A rate is given for "Excellent Black Performance or Outcome combined with High Level of Equality," and an F for, "Extremely Poor Black Performance or Outcome made worse by Very Severe Racial Inequality."[46] Figure 5 presents an example of part of a Georgia county report card.

[46] Georgia Department of Community Health, *Georgia Health Equity Initiative Health Disparities Report 2008: A County-Level Look at Health Outcomes for Minorities in Georgia* (Georgia Department of Community Health, Atlanta) 2008, 30.

Figure 5: Sample Georgia Minority Health Report Card: Barrow County



Barrow County's Racial-Ethnic Diversity

Race	Number of Persons	Percentage of Population
White	51,023	85.1%
African American or Black	6,461	10.8%
Hispanic or Latino	3,743	6.2%
Asian	1,647	<1%
American Indian	191	<1%
Other or Multi-Racial	2,470	<1%

Populations are estimated based on the 2005 Census data

This report card draws from detailed minority health data, from various sources. Unfortunately, data were insufficient to assess specific health behaviors in each county, or to reflect accurately the health barriers and inequities experienced by members of racial or ethnic sub-groups comprising less than 10% of Georgia's population, including Hispanic or Latino, Asian, and American Indian segments of our communities. The goal of the report and the county level report cards is not to stereotype or lump people in groups, but to identify pockets of inequality in health care and outcomes, and to catalyze action to achieve health equality for all Georgians.

Health Report Card

Minority Health Outcome Category	County Grade
Social and Economic Indicators	B
Mortality (Deaths)	C
Illness Events (Hospital Admits & Emergency Visits)	D+
Prenatal Care & Birth Outcomes	B-
Primary Care Access	C
Physician Racial-Ethnic Diversity	D
Mental Health Care Access	C+
Oral Health Care Access	non-HPSA
% Speaking non-English Language at Home	5.8%
% Estimated to Have No Health Insurance	12.6%

Black-White racial inequalities in health outcomes cost Barrow County 216 excess years of potential life lost due to premature deaths.

What do the Grades Mean?

These grades are a composite grade based on both the minority health outcome (African-American rates of preventable death, for example) and the county's level of racial inequality, typically measured by a ratio of African American to white death rates (black-white rate ratio).

- **A** Excellent Outcomes with Good to Excellent Level of Equality
- **A-** Excellent Outcomes but Some Racial Inequality
- **B+** Above-Average Outcomes with Good to Excellent Level of Equality
- **B** Above-Average Outcomes but Some Racial Inequality
- **B-** Above-Average Outcomes but Moderately High Racial Inequality, or Below-Average Outcome with High Level of Equality (white outcomes equally bad)
- **C+** Below-Average Outcomes but Some Racial Inequality
- **C** Below-Average Outcomes with Moderately High Racial Inequality, or Above-Average Outcomes but Severe Racial Inequality
- **C-** Below-Average Outcomes made worse by Severe Racial Inequality
- **D+** Poor Outcomes made worse by Moderately High Racial Inequality
- **D** Poor Outcomes made worse by Extremely Severe Racial Inequality
- **F** Extremely Poor Outcomes and/or Extremely Severe Racial Inequality

Action Steps:

1. Review your county's detailed minority health and health disparities report available at www.dch.ga.gov to find specific indicators of success, and those needing improvement.
2. Disseminate the report to all segments of the community; Convene meetings of all interested stakeholders from the health sector (hospital, emergency department, public health, community health center, free clinics, private practice health professionals, etc.) as well as from stakeholders outside the health sector (business, government, elected officials, faith communities, teachers and school leaders, consumer advocates, etc.).
3. Develop a list of priorities for indicators needing improvement which might be amenable to specific interventions. Get buy-in from key stakeholders in the community, and together develop an action plan for intervention.
4. Commit to specific, measurable goals for improving performance on key indicators to be achieved within a specific time-frame; Hold regular follow-up meetings, and review frequent data updates on these indicators to assess progress and re-tune the interventions.

Seek technical assistance from the Office of Health Improvement by contacting James Peoples at 404-656-6684 or by e-mail at gahealthequity@dch.ga.gov.

Source: *2008 Georgia Health Disparities Report*, 33.

Georgia, like New Mexico, chose to produce a report card because it felt that a report card would bring attention to the topic of health disparities. New Mexico also believed that a report card would be more meaningful to the public, and it would be better received than a plan, given a great number of existing plans. New Mexico initially found that the grades in the report card upset some community members who believed that the grade reflected upon the racial or ethnic population rather than the state's or health system's performance in meeting the health needs of the population. The state conducted outreach to communities about the meanings of the report card grades. Based on community feedback, New Mexico re-worded the explanation of the grading system in subsequent versions of the report card; "grade" was replaced by the phrase "health system effectiveness" as demonstrated in Figure 6, below.

*Figure 6: Changes in Wording from 2006-2007 in New Mexico's Report Cards As Demonstrated by the "Prenatal Care – Late or No Care" Measure**

<table>
<tr><th>2006 Wording</th><th>2007 Wording</th></tr>
<tr><td>
<table>
<tr><th>Race/Ethnicity</th><th>Grade</th><th>2003-2005 Rate (per 100)</th><th>Disparity Ratio</th></tr>
<tr><td>African American</td><td>A</td><td>30.9</td><td>1.4</td></tr>
<tr><td>American Indian</td><td>B</td><td>40.6</td><td>1.8</td></tr>
<tr><td>Asian/Pacific Islanders</td><td></td><td>22.5</td><td>1.0</td></tr>
<tr><td>Hispanic</td><td>A</td><td>32.5</td><td>1.4</td></tr>
<tr><td>White</td><td>A</td><td>22.7</td><td>1.0</td></tr>
</table>
</td><td>
<table>
<tr><th>Race/Ethnicity</th><th>Health System Effectiveness</th><th>2004-2006 Rate (per 100)</th><th>Disparity Ratio</th></tr>
<tr><td>African American</td><td>B</td><td>28.6</td><td>1.5</td></tr>
<tr><td>American Indian</td><td>C</td><td>40.3</td><td>2.1</td></tr>
<tr><td>Asian/Pacific Islanders</td><td>Reference Group</td><td>19.4</td><td>1.0</td></tr>
<tr><td>Hispanic</td><td>B</td><td>30.1</td><td>1.6</td></tr>
<tr><td>White</td><td>A</td><td>21.2</td><td>1.1</td></tr>
</table>
</td></tr>
<tr><td>"Grade: The grade category represents how well this population is doing compared to the population with the best rate. The grade column will be empty for the population with the best rate indicating it is the population to which all others are compared. Please note that grades are only related to the differences between population (disparity ratio) and are not an indication of how well or poorly New Mexico, overall, is doing in relation to the indicators."</td><td>"Health System Effectiveness: The Health System Effectiveness column reflects how well the health system is doing eliminating difference among populations by comparing each group to the population with the best rate. The reference group in this column will indicate that it is the population to which all others are compared. Please note that ratings are only related to the differences among populations (disparity ratio) and are not an indication of how well or poorly New Mexico, overall, is doing in relation to the indicators."</td></tr>
<tr><td>Source: New Mexico Department of Health. Racial and Ethnic Health Disparities Report Card, 2006, 4
http://www.health.state.nm.us/DPP/2006ReportCard.pdf.</td><td>Source: New Mexico Department of Health. Racial and Ethnic Health Disparities Report Card, 2007, 4-5.
http://www.health.state.nm.us/DPP/2007ReportCard.pdf.</td></tr>
</table>

*This measure indicates the rate at which women receive prenatal care late in pregnancy (after the third month) or not at all during pregnancy.

Several of the states profiled that have not developed report cards indicated that doing so would be of interest in the future.

STATE PROCESSES TO DEVELOP DATA REPORTS AND ACTION PLANS

The featured states use various processes to develop their disparities data reports and action plans, but all require and rely on collaboration. As the following sections describe, profiled states work collaboratively with sister departments as well as with private partners to compile data about racial and ethnic disparities into public documents; epidemiologists from both public and private entities are particularly important for selecting data indicators.

The states profiled vary in the role the State Office of Minority Health (OMH) plays in collecting and aggregating data and carrying out improvement strategies. At one end of a spectrum, the OMH has its own epidemiologists who collect or analyze data and report on disparities across a range of health conditions and health care issues in consultation with various programs and agencies. On the other end of the spectrum, the OMH plays a consultancy role to various programs and agencies. In this case, the programs are charged with setting goals for reducing disparities and collecting and aggregating their data to evaluate impact. The programs issue condition-specific reports rather than a more comprehensive report issued by the OMH. The examples below represent the continuum of approaches.

- The **Georgia** OMH uses a centralized process of data collection in which epidemiologists select indicators and analyze data for the disparities report. The State OMH publishes a single comprehensive report and initiates the work designed to reach the goals set forth in that plan. The state collaborates with various programs, but does not rely on each program to provide data or a plan to address disparities.

- **Rhode Island** mandates that projects conducted by all programs throughout the State Department of Health include provisions for addressing disparities. The Health Disparities and Access to Care Team has taken the philosophical approach that disparities is not a separate issue but rather needs to be woven through each program. Each program chooses its data sources, indicators, and initiatives, and publishes its own program-specific/disease-specific report. The Health Disparities and Access to Care Team provides guidance to the programs in developing performance measures and holds each program accountable for tracking and reporting back to the leadership of the health department. Within the Health Disparities and Access to Care Team, the Office of Minority Health produces periodic Minority Health Fact Sheets that present up-to-date data on select conditions and risk factors. (See Figure 7).

- Other states fall somewhere along a continuum. The **New Mexico** OMH, for example, consults with epidemiologists from within each program to select its data indicators. The state OMH then collects data from these programs to publish its report card. **Utah** went through a similar process in collecting data from programs to guide the state OMH office's work. **Connecticut's** Department of

Public Health received private funding to support “The Connecticut Health Disparities Project” and subsequently the development of a data report in consultation with DPH epidemiologists. The **New Jersey** Office of Minority and Multicultural Health (OMMH) collaborates primarily with the Department of Health and Senior Services (DHSS)’ Center for Health Statistics but also consults with data stewards in various programs throughout the department.

Featured States Rely on Public/Private Partnerships

A similarity among all of the states, regardless of how they structure their disparities work, is a strong reliance on private and/or public partnerships to produce data documents.

Academic Institutions

States frequently partner with state academic institutions for assistance with data analysis and collection. For example, Georgia partners with Georgia State University (GSU) and Morehouse School of Medicine; the latter is aiding in the primary collection of data for the Asian community. Georgia also partnered with GSU as one of its grantees to provide services to address legal needs encountered as a result of social determinants of health. Connecticut partners with the University of Connecticut, which has conducted geocoding to analyze births and deaths on the local level. Similarly, Rhode Island has collaborated with Brown University, and Maryland has worked with the University of Maryland and Johns Hopkins University.

Community Coalitions or Organizations

Critical partners for featured states are community-based coalitions or organizations that strive to reduce racial and ethnic disparities, such as NAACP state chapters, Native American interest groups, Hispanic groups, Asian groups, and groups that focus on reducing poverty. States consult with community groups before, during, and after the creation of disparities data reports and action plans to understand community priorities and help shape current or future documents. Maryland involves communities each step of the way in the creation of its documents. Before drafting its plan, staff members meet with various community groups representing different races/ethnicities to hear which issues they consider most pressing. Maryland undertakes this process to help establish a reputation and credibility with groups throughout the state. As a result, the state’s data and plan have been received well, and the state has fostered a network for outreach to communities on a variety of issues. Colorado works in partnership with community stakeholders, community-based organizations, the Minority Health Advisory Commission and the Interagency Health Disparities Leadership Council to develop its Colorado Health Disparities Strategic plan. Colorado’s health disparities report was developed with input from a diverse and multidisciplinary advisory group. Now several community groups in Colorado are working with the state to reduce disparities. New Jersey presents data to community groups upon request; the OMMH has also called

community members together, for example by hosting a series of roundtable discussions, to address various topics of interest. The OMMH joins community coalitions also engaged in initiatives to reduce health disparities statewide.

Community organization feedback also helps identify areas where documents can be improved. As previously noted, New Mexico changed its language describing the report card grading system after receiving community feedback. Georgia decided to develop a plan devoted to Asians after community organizations noted the need for inclusion of data about Asians. Georgia now aims to use a vetting process for future draft reports to solicit community feedback before finalizing the information for publication.

Other Private Partners

Other private partners identified by featured states include hospital associations that house hospital discharge data and foundations. In Connecticut, the disparities report came about as a result of a grant from the Connecticut Health Foundation, and the state has an arrangement with the Connecticut Hospital Association to access hospital discharge data for its report. Featured states use a number of funding mechanisms to develop their disparities data documents, and grants from organizations such as the Robert Wood Johnson Foundation and W.K. Kellogg Foundation have provided valuable support. Potential future partners include HCUP Partner organizations (data collection organizations other than hospital associations that participate in HCUP) and Medicaid agencies, with which profiled states have less strong relationships.

The impetus for each state's document demonstrates the need to engage partners beyond those listed above to include federal agencies, state agencies, and state legislators. New Jersey and Maryland's documents were authorized through state legislation. Georgia and Rhode Island's documents came out of departmental initiatives. New Mexico and Utah's documents were prepared under grants from the Federal OMH. Kaiser Permanente provided significant financial support for Colorado's health disparities report. Activities and support for the health disparities report and the Colorado Health Disparities Strategic plan were also part of a State Partnership grant from the Federal OMH.

One strategy featured states use to engage multiple private and public sector partners is partnership councils that provide guidance on various activities, such as data documents. For example, New Mexico convened a Report Card Advisory Council that included several epidemiologists and informed the data indicators used in the state's report card. In other states, councils advise on statewide minority health improvement efforts, however the partnerships also create a mechanism for collaboration across programs or departments to improve disparities data documents. Examples of councils include the Minority Health Advisory Council (GA), Minority Health Advisory Commission (CO, NJ), Interagency Health Disparities Leadership Council (CO), and Minority Health Advisory Committee (RI).

STATE ACTION BASED ON DISPARITIES DATA DOCUMENTS

All of the profiled states have taken action on their disparities data reports, and they have clear plans for future action. Their past and planned actions include: applying for national or federal grants; educating and engaging communities; establishing new or strengthening existing public health projects; producing additional related documents; and implementing new policies or strategies to assess and improve internal departmental operations. Many of the featured states have planned future action based on their reports, or are working on new reports. Several of the states indicated, however, that future action is contingent on funding, which is a challenge in the current economic climate.

A simple, yet powerful way featured states act on their disparities reports is by incorporating data and information into applications for national or federal grants to make the case for funding:

- **Connecticut's** Comprehensive Cancer program used information from the state disparities report to apply for CDC funding for a colorectal cancer screening program.

- **New Mexico** used the state's disparities report card for a grant application to the National Institutes of Health.

- **Utah's** maternal and child health program used information within the state's report to apply for a grant to address disparities.

Profiled states have also conducted outreach to stakeholders, particularly local communities, to inform them about the disparities documents:

- **Connecticut** presented its health disparities project activities to the first annual meeting of the Connecticut Multicultural Health Partnership in July 2008; and, subsequently, findings of the health disparities report have been shared with academic and community-based groups throughout the state, and at a regional and national conference.

- **Georgia's** Health Equity Initiative hosted town hall meetings called "community conversations" to discuss the findings of the county-level disparities report and gather community feedback.

- **New Jersey** held regional community roundtables throughout the state to engage community partners, get communities' perspectives, and find out about barriers to achieving health equity.

- **New Mexico** held awareness action forums to discuss action to address four specific indicators. The state also shares its report card at state legislative sessions and conducts outreach to legislators on this issue.

State disparities documents also inform new or existing public health projects. States provide grants to local communities to address disparities described in state reports.

- **Colorado** uses data from its health disparities report for its requests for applications for the health disparities grant program. Grantees use the disparities report for grant applications to the state as well as other funding sources.

- Given racial and ethnic disparities in cardiovascular diseases, **Connecticut** developed a cardiovascular public awareness program focusing on Black residents. The state's CDC funded heart disease and stroke prevention program supports a state recognition program for "HEARTSafe communities" throughout the state. Communities focus on improving heart attack signs and symptoms recognition and the importance of 911 to facilitate rapid emergency response in order to achieve heart safe status. Special funding will support development of this program in low-income urban communities beginning in 2011.

- **Georgia** developed a one million dollar Health Equity Grant program to support 9 public/private agencies and organizations to support and/or develop health disparities initiatives. The state is rolling out the Academy for Health Equity to help communities replicate the state's Health Equity Initiative.

- **Maryland** has a series of minority demonstration reduction projects underway in three jurisdictions. In addition, the Maryland Office of Minority Health and Health Disparities used some tobacco settlement funds for a Minority Outreach and Technical Assistance Program (MOTA). MOTA has educated minority communities about smoking cessation and cancer screening, and since July of 2010 has expanded the focus to include other major health disparities. MOTA also provides grants around the state for minority health projects.

- **New Jersey** has undertaken the Medical Interpreter Pilot Project to train bilingual hospital staff to be medical interpreters. The state has conducted training in northern and southern New Jersey, and has plans to continue the work in central New Jersey. The OMMH also funds and manages numerous community level interventions which aim to reduce disparities in asthma, diabetes and chronic disease management overall throughout the state.

- **New Mexico** issues mini-grants based on its report card. Groups submit proposals to address one of the indicators in the state's report.

- For more than a decade, **Rhode Island** has funded Minority Health Promotion Centers, minority-serving community-based organizations, to develop and implement health promotion and disease prevention activities to reduce health disparities in local settings.

- In **Utah**, the state's tobacco control program has used information from the disparities report to fund networks to promote tobacco control within specific populations.

Featured states have published or are planning new documents that update or complement previous reports. These include fact sheets, or brief summaries with detailed information about health disparities for specific racial and ethnic minority populations, as referenced in Figure 7.

- The Health Statistics Section at the **Colorado** Department of Public Health and Environment and one of the Health Disparities Grant Program Grantees, Project TEACH (Teaching Equity to Advance Community Health), developed a Colorado Health Disparities Regional Profiles site as an initiative in response to the health data needs of their communities. Data includes population characteristics, social determinants of health, perinatal and infant health, child health, adolescent health, adult health, cancer incidence, tobacco use among adults, and mortality.[47]

- In response to community feedback, **Georgia** is currently working on a disparities report about Asian populations, as the previous report focused mostly on the African American and Hispanic populations. About three percent of Georgia's population in 2005 was Asian.[48]

- **New Jersey** is working on a foreign-born health report that it hopes to publish this year. The state also will publish a plan to educate healthcare professionals and the public about chronic kidney disease, prevention, treatment and management which will provide information on the burden of the disease, existing health disparities, and its overall impact on New Jersey's population in 2011.

- **New Mexico** has issued an American Indian Health Disparities Report Card since 2008.[49]

- **Rhode Island** has geomapped the number of tobacco vendors in low income areas, and subsequently found that these particular vendor organizations target low income areas.

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[47] Colorado's regional profiles can be viewed in the following site: http://www.phitest.dphe.state.co.us/ColoradoHealthData/dispHealthProfiles.aspx. These 21 regions are aggregations of counties developed by the Health Statistics Section in partnership with state and local public health professionals. The regions were developed using statistical and demographic criteria. More information on the 21 regions is available by contacting Alyson Shupe, Health Statistics Section, CDPHE.

[48] Debbie Hall et al., *Georgia Health Disparities Report 2008*, 12.

[49] For example, see New Mexico Department of Health, *American Indian Health Disparities In New Mexico From The 2010 Racial and Ethnic Health Disparities Report Card*. Available online at: http://www.health.state.nm.us/DPP/2010AmericanIndianReportCard.pdf.

Figure 7: Fact Sheets

Several featured states have produced fact sheets that focus on disparities for specific populations. In follow up to its disparities report, **Colorado** created four health disparities data sheets about Hispanics/Latinos, African Americans/Blacks, American Indians, and Asians/Pacific Islanders. Similarly, **Rhode Island** published four minority health fact sheets with data for African Americans, Asians and Pacific Islanders, Hispanics/Latinos, and Native Americans. Both states' fact sheets include data on healthcare access, infectious disease, risk behaviors, demographics, and maternal and child health. **Utah** published Health Disparities Summaries 2009, which includes a set of fact sheets with infectious disease, alcohol abuse, mental health and violence data for African Americans/Blacks, Asians, Hispanics/Latinos, and Pacific Islanders. The series also includes six fact sheets with data on chronic conditions, reproductive health, injury, and lifestyle risk for different races and ethnicities. (See Appendix for links to referenced state fact sheets).

Finally, profiled states use their documents to strengthen internal processes to help state government address disparities in more strategic, streamlined, and comprehensive ways.

- The Interagency Health Disparities Council in **Colorado** is implementing a survey to evaluate how the state's disparities plan is being used by state agencies. The state is also exploring ways to conduct an impact evaluation because, to date, it has conducted only process evaluations.

- **Connecticut's** efforts to improve data reporting have included a survey of all Department of Public Health (DPH) state databases and the development of a Department of Public Health policy for collection of race, ethnicity, and other sociodemographic data. This policy, which will be implemented by 2012, establishes a standard that applies to all DPH databases. Connecticut also recently received $12.9 million to integrate health information technology in the state; as the state works to integrate its agencies' databases, it is also working to ensure that race/ethnicity data are standardized across databases.[50]

- **New Jersey's** DHSS established coding guidelines on race and ethnicity data as a direct result of its strategic plan. Additionally, the state is now requesting reporting on cultural sensitivity. New Jersey also instituted an annual Commissioner's Health Disparities Symposium for DHSS senior staff, grantees and other guests. Last year, the event included discussion of how DHSS can more fully integrate work to address disparities into all of its program areas. The state hosted a chronic disease summit in the fall of 2010, which focused on building partnerships within communities to reduce health disparities in various conditions by addressing the

[50]Additionally, the Connecticut Multicultural Health Partners Language Services Committee conducted a survey about language access services with the local health departments and community health centers in the state. Findings from the survey were published as a separate report ("Language Access Services Project") available online at http://www.ct.gov/dph/lib/dph/Language_Services_Report.pdf.

social determinants of health and examining physical, social, environmental, and policy areas where improvements can be made. Finally, DHSS produced a 2010 report summarizing findings from a self-assessment survey of its programs' health disparities activities and familiarity with the DHSS strategic plan.[51]

- As part of a departmental priority**, Rhode Island's** Department of Health internally tracks the performance of each of its programs on a variety of measures, including measures for disparities. The State Health Disparities and Access to Care team reports to the Director of the Department of Health semi-annually on department-wide disparities performance. The state is currently working on linking disparities data to its equity agenda and determining how the state should organize its work in each area. The state is now drafting health equity performance measures.

[51] New Jersey Department of Health & Senior Services' Office of Minority and Multicultural Health and Rutgers University Center for State Health Policy. *2009 Health Disparities Initiatives Self-Assessment Survey Report*, June 2010. http://www.state.nj.us/health/omh/documents/2009self_assessment_survey_report.pdf.

States Are Exploring Ways to Track Progress and Evaluate Impact

For several reasons, primarily limited funding and staffing, most of the states featured have not yet undertaken steps to evaluate the impact of their disparities reports; all are interested in doing so. Several of the featured states have taken steps to evaluate which programs have made progress in implementing initiatives to reduce disparities highlighted in documents, but evaluating progress for each individual measure is more difficult. States with more recent plans will need longer timeframes for evaluating results. In addition, since the causes of health disparities are varied and hard to disentangle, it is challenging to link improvement to specific interventions. However, featured states do have processes in place to track progress in reducing disparities (regardless of the causal factors):

- **Maryland** publishes trends in Black versus White disparity (expressed as a rate difference) in its Chartbook.

- The outcome measures outlined in **New Jersey's** Strategic Plan were closely aligned with the states' Healthy New Jersey 2010 agenda. Integrating the Healthy People 2020 agenda is a key focus area of the DHSS. The New Jersey OMH is working closely with the DHSS Center for Health Statistics to develop the 2020 agenda in New Jersey, with a clear emphasis on the elimination of health disparities as a goal of the initiative.

- **New Mexico** charts the trends in disparity rates across the various editions of its report card and reports a "disparity change score." These scores help the state identify which rates have improved and which have worsened, which is helpful in guiding the states' priorities for action.

- Each health program in **Rhode Island** that publishes disparities data has a baseline value, a target value, and a performance measure.

- **Utah** recently completed a report that compares baseline data from its 2005 report with the comparable rate in the 2010 report, and evaluates the differences.[52]

Disparities Reports Are Not Yet Fully Integrated into Broader State Health Reform Initiatives

As previously noted, the Patient Protection and Affordable Care Act (ACA) includes provisions that could have a significant impact on health disparities. The ACA provisions will influence state activities, for instance, by strengthening data collection and reporting mechanisms in the Medicaid and Children's Health Insurance Programs.

[52] Utah Department of Health, Center for Multicultural Health. *Moving Forward in 2010: Progress Toward Health Equity by Race and Ethnicity in Utah.* Available online: http://health.utah.gov/cmh/data/movingforward.pdf.

It is increasingly important for states to have a coordinated and streamlined approach to respond effectively to health care reform requirements and opportunities. Many states are developing interagency health reform coordinating bodies to facilitate planning and implementation of the ACA.[53] Representation on these councils could provide an opportunity to ensure that states integrate efforts to reduce health disparities into their comprehensive plans.

Although all of the states profiled are considering opportunities to integrate their initiatives into health care reform agendas, only a few states indicated that their current documents are being used to inform broader health care reform efforts within their states. Many states indicated that they are awaiting further health reform developments, and that it is too early to determine how their disparities initiatives will inform their states' health care reform agendas. Other states noted that ACA provides some leverage for the Federal OMH which may be beneficial, and that HIT initiatives that could help in reducing disparities are also supported by health care reform.

- The **Georgia** Department of Community Health plans to take an active role in health care reform discussions. The Department has noted that there are resources available through the ACA to assist community agencies to address health disparities, and the Department has made this known to its community partners. Georgia also noted that the ACA features provisions to enroll a greater number of people in health insurance programs and to improve health system performance, which are both key steps to reducing disparities.

- **Maryland** has a Health Reform Coordinating Council that will submit recommendations to the Governor in January 2011. The Maryland Office of Minority Health and Health Disparities has participated in the Council workgroups, and this has resulted in health disparities reduction strategies being included in the staff recommendations to the Council for their final document.

- In **New Jersey**, the Office of Minority and Multicultural Health drafted a summary of ACA provisions which are relevant to minority communities.

- **Rhode Island** has taken steps to determine how their current projects will integrate with health reform. The state acknowledges that health reform will play a role, though how large a role is unclear. The Lieutenant Governor has organized a task force to examine the opportunities and challenges of health care reform within the state. This task force is comprised of seven issue-focused workgroups; three are led by public health department members. One group is led by the team lead of Rhode Island's Health Disparities and Access to Care Team. The Health Disparities and Access to Care Team strives to make disparities a more fundamental tenant of policy recommendations as health reform is implemented.

[53] National Academy for State Health Policy, State Refor(u)m, www.statereforum.org, (Accessed September 28, 2010.)

States Benefit from Sharing Strategies

Not every state with interesting or noteworthy activity in disparities reduction met the criteria for inclusion as a featured state in this report; however, particularly relevant or frequently mentioned state activity is useful to note. Every state profiled looked to other states when crafting their disparities documents. Connecticut, for example, considered Rhode Island's data collection policy as a model in developing its own. Colorado looked to Rhode Island when working on its agency plan. Utah, in turn, has compared its reports to Colorado. Finally, New Jersey indicated that it has tried to model some of Maryland's reports. Profiled states also referenced other states, specifically North Carolina, Massachusetts, Minnesota and Ohio. Additionally, NASHP identified noteworthy activity in California, Michigan, Virginia, and Arizona. Brief information about each of these states' activities appears below or in Figure 8 (for North Carolina).

- **Arizona** has data profiles forthcoming on the health of various racial/ethnic populations within the state.[54]

- **California's** Department of Public Health (DPH) produces several condition-specific reports that emphasize health disparities, and DPH is in the process of updating its strategic plan for 2011-2014. Like Rhode Island, California supports health equity and health disparities work across all state programs.[55] A rather unique data source is the California Health Interview Survey (CHIS). CHIS, the largest state health survey in the country, collects detailed information about racial and ethnic minority populations as well as health care services in a variety of care settings.[56]

- **Massachusetts** (and the City of Boston) was noted for its work on Culturally and Linguistically Appropriate Services (CLAS) and its plan devoted to the subject: *Making CLAS Happen: Six Areas for Action*.[57] Massachusetts also instituted a policy that requires all hospitals in the state to collect more detailed race/ethnicity categories than previously required in the mandated hospital discharge data. This enables the state to be more nuanced in its data reporting.

- **Michigan** has published an agency self-assessment tool in order to measure efforts within the Department of Community Health to address health disparities.[58]

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[54] For more information about Arizona's Health Disparities work, please visit the Arizona Health Disparities Center online at: http://www.azdhs.gov/phs/healthdisparities/index.htm.
[55] For more information about California's Health Disparities work, please visit the California Office of Multicultural Health online at: http://www.cdph.ca.gov/programs/OMH/Pages/default.aspx.
[56] See "California Health Interview Survey." www.chis.ucla.edu/.
[57] For more information see *Making CLAS Happen: Six Areas for Action*, Massachusetts Department of Health, Office of Health Equity, June 2009. Available online: http://tinyurl.com/4gaxmsg.
[58] For more information see *2008 Health Disparities Report: Color Me Healthy*, Michigan Department of Community Health, February 2009. Available online: http://www.michigan.gov/documents/mdch/2008_Health_Disparities_Report_MDCH_2.16.09_271335_7.pdf.

- **Minnesota** was cited for its examples of program implementation and strong relationships with community organizations, particularly immigrant groups. Additionally, NASHP learned from its environmental scan that Minnesota has developed a health plan-level report for its public programs.[59]

- **Ohio** was the first state to create a State Office of Minority Health and has become a leader in a number of disparities activities. Ohio has plans that address disparities in infant mortality, diabetes, heart disease and stroke, and a summary report on priority populations that includes recommendations. Ohio, like several of the states profiled, has both data reports and action plans that are condition-specific. It does not have a statewide general disparities data report but rather highlights disparities data in condition-specific plans.[60]

- **Virginia's** 2008 Health Equity Report includes geocoding and Census-derived socioeconomic data for a strong focus on social determinants of health.[61] Additionally, Virginia is unique in its use of technology to engage stakeholders and communities on this report. On its website, the Office of Minority Health and Public Health Policy provides a video (and video transcript) about the report.[62] To inform its next report, Virginia has posted a link to an online survey to collect community feedback about the 2008 report and areas of interest for the upcoming (2010) report. Virginia also connects website visitors to the Advancing Health Equity in Virginia Social Network (http://healthequityinva.ning.com), an electronic forum for peer learning and information-sharing about topics covered in its reports.

[59] For more information see Anne M. Snowden et al., *2009 Health Care Disparities Report for Minnesota Health Care Programs: Comparing Medical Group Performance for Public and Private Purchasers Using Health Plan Data*, Minnesota Department of Human Services, 2009. Available online: http://mncm.org/site/upload/files/FINAL_2009_Health_Care_Disparities_Report_4.16.pdf.

[60] For more information see Janelle Edwards et al., *Addressing Disparities in Ohio's Priority Populations*, Ohio Department of Health, 2007. Available online: http://www.odh.ohio.gov/ASSETS/7DC49C286AC346C4B1837DF456C78C1F/summ%20and%20rec%2008.pdf.

[61] *Unequal Health Access Across the Commonwealth: A Snapshot.* Available online: http://www.vdh.state.va.us/healthpolicy/documents/health-equity-report-08.pdf.

[62] To review and download the Video and Video Transcript of the Virginia Department of Health's *2008 Health Equity*, please visit: *http*://www.vdh.state.va.us/healthpolicy/2008report.htm.

Figure 8: The North Carolina Experience

North Carolina was most frequently cited by the profiled states as a state with best practices to reduce health disparities. As a result, NASHP spoke with state officials to learn more about North Carolina's experience documenting racial and ethnic health disparities to inform strategic action.

North Carolina published its first report on disparities in 1987. Since that time, the state has produced multiple reports including its Women's Health Report Card and reports developed by its Healthy Carolinians group. Unlike many of the states profiled here, North Carolina does not have a single strategic plan, instead opting to use a combination of data profiles and a report card, with the latest iteration published in 2010.*

As these various data profiles and report cards evolved, so did North Carolina's cross-programmatic approach to addressing disparities. Like Rhode Island, North Carolina expects disparity reduction to be addressed by every program within the state health department. All programs are charged with setting goals, developing interventions, and measuring progress. The state Office of Minority Health (OMH) takes on a technical assistance role, working with programs within and outside of the health department (i.e., social services) that develop interventions to reduce health disparities among North Carolinians. Like the other states profiled, the North Carolina OMH understands the necessity for partnering with groups outside of the health department and state government in order to accomplish its objectives. Currently, North Carolina is working to finalize a reporting tool that will make performance measures consistent across various offices and divisions.

Data
North Carolina gets the majority of its data from the State Center for Health Statistics (BRFSS, discharge data, and Vital Statistics), the Census Center (demographic data), and other sources (disease information). The OMH has found the relationship with the State Center to be extremely advantageous for easy access to data.

In addition to the data that the state already uses, North Carolina, like several of the states profiled, is in the process of attempting to look at the cost of disparities and to reframe the case for disparities reduction to focus on the economic burden of disparities. The state has published a report on the Medicaid cost of diabetes within the state. An article on this issue was published in the *North Carolina Medical Journal*.** In addition to cost of disparities, North Carolina would also like to include access data, as well as mental health and substance abuse data.

Action
North Carolina has taken several action steps based on the reports issued by the state OMH. In 2005, the State Assembly established a $3 million grant program for communities. The majority of the funds for these projects go directly to faith-based organizations, community based organizations and American Indian tribes, with a small percentage of the funds going through traditional public health agencies. North Carolina historically has invested in nontraditional partners and is working to expand those partnerships through leadership development and community engagement strategies. The legislation also identified six focus areas based on the greatest disparities in the state. Finally the legislation stipulated that the funding engage the African American, Native American, and Hispanic/Latino populations. The funds for these projects generally go through the traditional local health department agency. North Carolina now is trying to reach beyond health departments to work with non-traditional partners.

The state enacted legislation in 2009 that requires hospitals to report self-reported race/ethnicity patient data.. This change took effect in January 2010. North Carolina hopes that this requirement will improve its disparities data.

Sources: *Office of Minority Health and Health Disparities and State Center for Health Statistics, *Racial and Ethnic Disparities in North Carolina: Report Card 2010*. Available online: Hhttp://www.epi.state.nc.us/SCHS/pdf/MinRptCard_WEB_062210.pdfH.
**Paul A. Buescher, J. Timothy Whitmire, and Barbara Pullen Smith. "Medical Care Costs for Diabetes Associated With Health Disparities Among Adult Medicaid Enrollees in North Carolina," *North Carolina Medical Journal* 71 (4) (July/August 2010): 319-324. Available online: Hhttp://www.ncmedicaljournal.com/archives/?medical-care-costs-for-diabetes-associated-with-health-disparities-among-adult-medicaid-

LESSONS LEARNED

After reviewing featured states' documents and talking with officials from each of these states, several themes and lessons emerged.

- **States use data documents — including condition-specific reports, report cards, and action plans — to identify and address disparities.** Data must be displayed in a way that illustrates the problem and inspires action. Most state data reports paint a picture of the nature of health and health care disparities in the state and include a focus on topics such as data sources, indicators, and limitations of the data. Report cards also focus on data and include a discussion and interpretation of the rating system. Action plans contain recommendations and action steps aimed at reducing disparities and often set state goals. Many featured states that have an action plan for reducing disparities also have a companion data report.

- **States vary in data sources, unit of analysis, and rates used to report health and health care disparities in their reports; however, they share many commonalities.** Most states use behavioral risk factor and vital records data. Just over half of states use hospital discharge data, and just under half use emergency department data. Four states provide data by county while four other states only report a state level of analysis. Relative rates are more common than absolute rates. States must determine the comparisons that will be most useful for them. State plans only varied slightly in the races/ethnicities that they included in their reports. The majority of states include data on heart disease/stroke, HIV/STDs, diabetes, and cancer. Oral and mental health disparities are covered less often. Since all states use the BRFSS, there is a great deal of data featured across states on risk behaviors such as tobacco use, obesity, and alcohol/substance abuse. Various maternal, prenatal, and child health care topics are also featured by the majority of states. Since hospital discharge and emergency department data are used less frequently, information on health care disparities is less available than data on health status disparities.

- **States want and need additional data on disparities to develop strategies to improve health equity.** States mentioned the need for data that is valid at the county level and for racial and ethnic subpopulations. They are also increasingly looking for data on the costs of disparities. Other areas of interest are race and ethnicity data on suicides and substance abuse and socioeconomic status data since variables such as education level, income, and poverty correlate with the health of minorities, and racial and ethnic minorities are disproportionately represented among the poor. Despite lack of available data in some areas, states note that this cannot become an excuse for not taking action.

- **States have distinct organizational approaches to documenting and addressing disparities.** State Offices of Minority Health (OMH) in some cases take responsibility for collecting and aggregating data and issuing reports; in

other cases, they provide guidance to various state agencies to undertake this process. In all cases, the OMH works collaboratively with partners to compile data about racial and ethnic disparities into public documents. Epidemiologists from both public and private entities are particularly important for selecting data indicators. States have used partnerships for assistance with collecting, sorting, and analyzing data; geocoding to track births and deaths on a local level; and training state OMH staff on geographic information systems (GIS) and geocoding.

- **States rely on partnerships with stakeholders as critical to creating their data documents, plans, and report cards and acting on them.** Many of the states profiled rely heavily on strong public/private partnerships and involve stakeholder and community groups throughout the entire process. Ownership of state disparities plans is shared among programs, offices, and stakeholders, including communities and racial and ethnic groups in the state. Disparities reports need to be developed with buy-in and support from the plan's audience. By identifying issues of greatest concern to the audience, state agencies can establish trust and credibility so that reports are well received and disseminated.

- **State reports include a focus on making data actionable**. All of the profiled states have taken action on their disparities data documents, and they have clear plans for future action. Their past and planned actions include: applying for national or federal grants; educating and engaging communities; establishing new or strengthening existing public health projects; producing additional related documents; and implementing new policies or strategies to assess and improve internal departmental operations. Many of the featured states have future action planned based on their reports, or are working on new reports. Several of the states indicated, however, that the action they take in the future is contingent on funding, which is a challenge in the current economic climate.

- **States need additional funding sources to focus on health and health care disparities.** In addition to various types of data that states lack, most states profiled referenced increased funding as critical to help improve their work on health disparities, particularly dedicated funding sources to focus on this issue. The profiled states that provide grants and mini-grants to communities indicated funding needs to keep grant programs operational.

- **State Offices of Minority Health are important leaders in addressing disparities, but they cannot act alone if states are to achieve health equity.** A theme among state reports and activities, both past and planned, is collaboration with other health department divisions, state departments, local entities, and private organizations in order to compile, analyze, publish, and act on data. States are increasingly interested in determinants of health, which affect sectors beyond health, such as education, transportation, housing, and environmental protection.

CONCLUSION

States take varied approaches to identifying, documenting, and acting on data related to racial and ethnic health and health care disparities. Nevertheless, they all emphasize the need for valid data to document disparities and collaboration for action planning to improve health equity. Whether through an action plan, data report (or report card), or a combination of these, all of these states have developed methods for reporting health disparities and have taken concrete steps toward reducing the disparities that exist within their borders.

Despite the work that these states are doing to improve health equity, the states recognize that there is more work to be done. States noted that disparities in health outcomes and access are very compelling issues, and it is important to inspire people to work together on the issue despite limited resources.

The successes, challenges, and methods of these states can provide guidance for states that are exploring ways to improve their health equity initiatives. Lessons learned by these states, such as the need for substantive stakeholder and community involvement, can also help states that are trying to improve. Opportunities for funding and increased awareness and attention to these issues, through provisions for reducing disparities in health care reform and the National Partnership for Action, may provide momentum for state action.

APPENDIX A

Below is a table featuring many of the disparities plans/reports that NASHP reviewed for each of the states profiled. All links were accurate as of December 2010.

State	Document Title	Year	**Topic** (General minority health/ disparities or Condition-specific)	Web Link
Colorado	*2008-2010 Office of Health Disparities Strategic Plan*	2008	General	http://www.cdphe.state.co.us/ohd/reportsandarticles/OHD08-10StrategicPlan.pdf
	Racial and Ethnic Health Disparities in Colorado 2009	2009	General	http://www.cdphe.state.co.us/ohd/ethnicdisparitiesreport/HD%202009%20LowRes.pdf
	Colorado Health Disparities Strategic Plan 2008: Interagency Health Disparities Leadership Council	2008	General	http://www.cdphe.state.co.us/ohd/reportsandarticles/IHDLCMonograph1.pdf
	2009 Health Disparities Data Sheets	2009	General for four populations	http://www.cdphe.state.co.us/hs/regionaldata/healthDisparitiesdata.html
Connecticut	*The 2009 Connecticut Health Disparities Report*	2009	General	http://www.ct.gov/dph/lib/dph/hisr/pdf/2009ct_healthdisparitiesreport.pdf
Georgia	*Health Disparities Report 2008: A County-Level Look at Health Outcomes for Minorities in Georgia*	2008	General	http://dch.georgia.gov/vgn/images/portal/cit_1210/5/49/111684019Georgia_Health_Equity_Initiative_Health_Disparities_Report_2008.pdf
Maryland	*Maryland Chartbook of Minority Health and Minority Health Disparities Data*	2009	General	http://www.dhmh.maryland.gov/hd/pdf/2010/Chartbook_2nd_Ed_Final_2010_04_28.pdf
	Maryland Plan to Eliminate Minority Health Disparities Plan of Action 2010-2014	2010	General	http://dhmh.maryland.gov/hd/pdf/2010/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf
New Jersey	*Strategic Plan to Eliminate Health Disparities in New Jersey 2007 Update*	2007	General	http://www.state.nj.us/health/omh/plan/documents/update07.pdf
	New Jersey Asthma Strategic Plan 2008-2013	2009	Condition (Asthma)	http://www.nj.gov/health/fhs/asthma/documents/asthma_strategic_plan2008-2013.pdf
	2009 Health Disparities Initiatives Self-Assessment Survey Report	2010	Progress report on existing NJ disparities initiatives.	http://www.state.nj.us/health/omh/documents/2009self_assessment_survey_report.pdf
	Strategic Plan to Eliminate Health Disparities in New Jersey: Update & Addendum	2010	General	http://www.state.nj.us/health/omh/documents/strategic_plan_2010.pdf
New Mexico	*Racial and Ethnic Health Disparities Report Card*	2010	General	http://nmhealth.org/dpp/2010ReportCard.pdf
	Racial and Ethnic Health Disparities Report Card	2009	General	http://nmhealth.org/dpp/2009ReportCard.pdf
	American Indian Health Disparities Report Card	2010	General	http://nmhealth.org/dpp/2010AmericanIndianReportCard.pdf

State	Document Title	Year	**Topic** (General minority health/ disparities or Condition-specific)	Web Link
Rhode Island	*Heart Disease and Stroke Prevention Rhode Island State Plan 2009*	2009	Condition (Heart Disease and Stroke)	http://www.health.ri.gov/publications/plans/2009HeartDiseaseAndStrokePrevention.pdf
	Reducing the Burden of Asthma in Rhode Island: Asthma State Plan, 2009-2014	2009	Condition (Asthma)	http://www.health.ri.gov/publications/plans/AsthmaStatePlan2009-2014.pdf
	Minority Health Plan for Action	2004	Agency Plan	http://www.health.ri.gov/publications/actionplans/2004MinorityHealth.pdf
	Minority Health Fact Sheets	2010	General	http://www.health.ri.gov/programs/minorityhealth/index.php
Utah	*Utah Health Disparities Summaries Series*	2009	General	http://health.utah.gov/cmh/data/disparitiessummary.html#chronic
	Health Status: by Race and Ethnicity	2010	General	http://health.utah.gov/cmh/data/healthstatus.pdf
	Action Plan to Eliminate Racial/Ethnic Health Disparities in the State of Utah	2008	General	http://www.health.utah.gov/cmh/udoh/CMH%20Action%20Plan%20April%202008%20_website_.pdf
	Moving Forward in 2010	2010	General	http://health.utah.gov/cmh/data/movingforward.pdf