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**USING REPORT CARDS TO MEASURE
RACIAL AND ETHNIC HEALTH DISPARITIES:
STATE EXPERIENCE**

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Using Report Cards to Measure Racial and Ethnic Health Disparities: State Experience

Introduction

State agencies identify, document, and act on data related to racial and ethnic health and health care disparities in a variety of ways.¹ Recently the Agency for Healthcare Research and Quality (AHRQ) published a report authored by the National Academy for State Health Policy (NASHP) that summarizes lessons from leading states in the documentation of racial and ethnic health disparities and use of findings to advance improvement.²

One type of document states produce is a “report card,” or a publication that uses data from race/ethnicity-specific measures to assign letter grades and provides a description of the rating system used.³ States such as Georgia, New Mexico, and North Carolina have chosen to produce report cards rather than a regular narrative report or an action plan for disparities reduction because they believe that the report card format is the best way to bring attention to the topic.⁴ Report cards take different formats; for example, Georgia provides county-specific letter grades, whereas New Mexico provides statewide letter grades. This issue brief focuses on New Mexico’s experience using report cards to measure racial and ethnic health disparities.

Report Card Background

New Mexico’s Department of Health has produced an annual *Racial and Ethnic Health Disparities Report Card* since 2006. The sixth, most recent, edition of New Mexico’s report card was published in September 2011. In addition, New Mexico has published Spanish versions of its report cards, and it has compiled the American Indian health disparities data into a separate report card to help raise awareness about the disparities facing this population in the state.⁵ A State Partnership Grant to Improve Minority

¹ The U.S. Department of Health and Human Services (HHS)’ Office of Minority Health defines disparities as “health differences...closely linked with social or economic disadvantage”. See: HHS. “Health Equity and Disparities – National Partnership for Action.”

<http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34>.

² Hanlon C, Rosenthal J, and Hinkle L. *State Documentation of Racial and Ethnic Disparities to Inform Strategic Action*. Online March 11, 2011. U.S. Agency for Healthcare Research and Quality (AHRQ). Available: <http://www.hcup-us.ahrq.gov/reports.jsp>.

³ Throughout this issue brief, “state” refers to offices of minority health, health departments, public health departments, and other state-level agencies that produce report cards and other disparities reports.

⁴ For Georgia’s report card, see 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.

⁵ New Mexico Department of Health. “NM Racial and Ethnic Health Disparities Report Card.” <http://www.health.state.nm.us/dpp/DPPRC.htm>

Health from the U.S. Department of Health and Human Services' Office of Minority Health funds the report card, which is modeled after North Carolina's report card.⁶ The report card is not an epidemiological report; it is intended to be user-friendly and to succinctly convey key disparities findings for the general public. The report card serves multiple purposes in New Mexico. It not only drives the activities of the Office of Health Equity and frames disparities reduction planning and related activities, but it also helps to increase internal (departmental program) and external awareness of health disparities. New Mexico's report card generates community feedback and suggestions for making improvement.

Report Card Contents

An advisory committee composed primarily of epidemiologists from within each of the Department of Health's programs helps select data indicators for New Mexico's report card. The report card presents five categories of data (maternal and child health, chronic disease, infectious disease, violence and injury, and risk behaviors) for five major racial and ethnic populations (African American, American Indian or Alaska Native, Asian or Pacific Islander, Hispanic, and White). The primary state and national data sources are vital statistics, the Behavioral Risk Factor Surveillance System, youth surveys, and infectious disease surveillance.

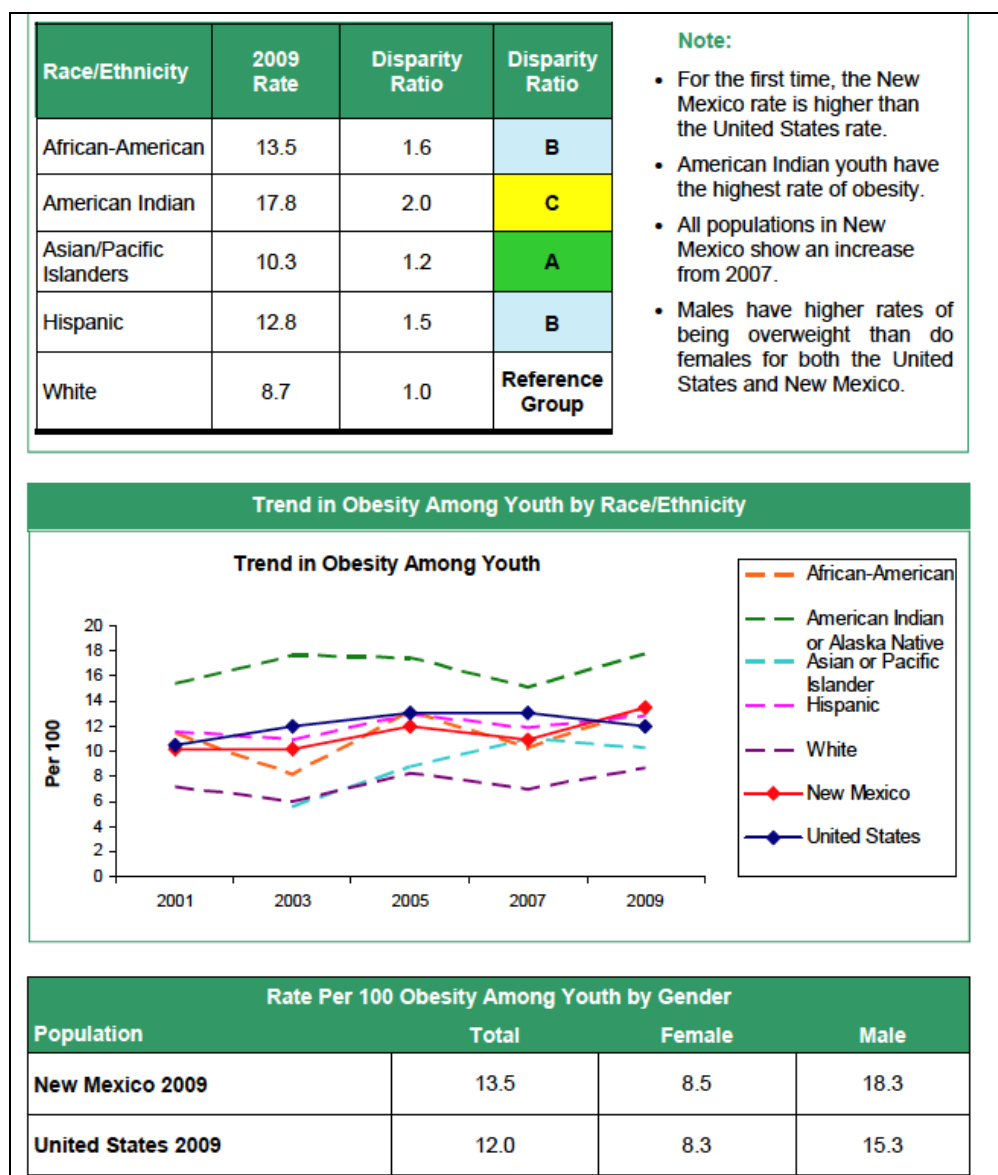
Report card measures assess risk factors and condition prevalence/incidence (e.g., youth obesity, chlamydia), mortality, and access to or receipt of appropriate care (e.g., adults 65 and older who did not have a pneumonia vaccination). An indicator for fall-related deaths for adults aged 65 and older was newly added in 2011. Each indicator is presented on a separate page. The page has a table showing the indicator rate for each race/ethnicity and a "disparity grade" (see methodology section), along with a trend chart with historical state-level rates by race/ethnicity, the state average rate, and the national rate. Bulleted take-away messages about the indicator accompany each table. See Figure A for an example of the presentation of an indicator.

New Mexico's report card begins with a brief summary of findings across indicators. The summary includes a list identifying the "largest disparities" or indicators with the greatest differences between racial and ethnic populations. The list identifies the indicator, the best and worst rates (and the populations that have them), and the disparity ratio. Indicators are listed in order of size of disparity. The list makes clear that in 2011, the largest disparity was for acute and chronic Hepatitis B; Asian/Pacific Islanders had 38.5 times the rate of Hepatitis B as Hispanics (the reference group).⁷

⁶ North Carolina's 2003, 2006, and 2010 report cards are available online. See: North Carolina Center for Health Statistics. "SCHS Racial and Ethnic Minority Health Data and Publications" <http://www.epi.state.nc.us/SCHS/data/minority.cfm>

⁷ New Mexico Department of Health. *Racial and Ethnic Health Disparities Report Card*, 2011,2.

Figure A: Sample New Mexico Report Card Indicator: Obesity Among Youth, 2011



Source: New Mexico Department of Health. *Racial and Ethnic Health Disparities Report Card*, 2011, 10.

The second part of the summary lists the worst indicator rates by population along with the indicators for which disparities changed since the previous report card.

The report card contents have changed over time to respond to community stakeholder suggestions. For example, national comparison data were added upon request. New Mexico also has found bright, consistent colors in tables and charts to be helpful to readers.

Report Card Methodology

For each report card indicator, New Mexico assigns a “disparity grade” of A through F for the five racial and ethnic populations. The grade is based on the disparity ratio, which is calculated by dividing the rate for a population by the rate of the population with the best rate (see Table 1, below). Although many states use the White population as the comparison group, New Mexico uses the population with the best (lowest rate) because the White population does not always have the best rate and because the White population is not a majority of the state’s population. Just over 40 percent of New Mexico’s population is White, which sets it apart from most states. However, as the United States population changes, more states may develop similar demographics.

Table 1: New Mexico Report Card Legend, 2011

| Disparity Grade (color shading) | Disparity Ratio | Meaning |
|--|------------------------|---|
| A (green) | 1.0 – 1.4 | Little or no disparity. |
| B (pale blue) | 1.5 – 1.9 | A disparity exists, should be monitored and may require intervention. |
| C (yellow) | 2.0 – 2.4 | The disparity requires intervention. |
| D (bright pink) | 2.5 – 2.9 | Major interventions are needed. |
| F (red) | >= 3.0 | Urgent interventions are needed. |

Source: New Mexico Department of Health. *Racial and Ethnic Health Disparities Report Card, 2011, 1.*

Disparity ratios and grades are only calculated for populations having at least 20 cases or events during the time period. The original report card did not include Asian/Pacific Islander and African American/Black population data on many indicators due to small numbers. Additional data were subsequently added as the populations increased; New Mexico aggregates data into a 3-year rolling average to be able to present data for small populations.

Community feedback has also shaped changes in the language and format of grading. New Mexico initially found that the grades 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. As a result, the state conducted outreach to communities about the meaning of the report card grades and revised the wording and presentation (see Figure B, below). In the most recent report card, the column with the letter grade has been moved further away from the race/ethnicity column.

Figure B: Changes in Wording and Presentation in New Mexico's Report Cards from 2006 to 2011 as Demonstrated by the "Prenatal Care – Late or No Care" Measure*

| 2006 Wording and Presentation | | | | 2011 Wording and Presentation | | | |
|--|--------------|---------------------------------|------------------------|--|---------------------------------|------------------------|------------------------|
| Race/Ethnicity | Grade | 2003-2005 Rate (per 100) | Disparity Ratio | Race/Ethnicity | 2008-2010 Rate (per 100) | Disparity Ratio | Disparity Grade |
| African American | A | 30.9 | 1.4 | African-American | 33.6 | 1.3 | A |
| American Indian | B | 40.6 | 1.8 | American Indian | 46.2 | 1.8 | B |
| Asian/Pacific Islanders | | 22.5 | 1.0 | Asian/Pacific Islanders | 30.9 | 1.2 | A |
| Hispanic | A | 32.5 | 1.4 | Hispanic | 33.9 | 1.3 | A |
| White | A | 22.7 | 1.0 | White | 26.3 | 1.0 | Reference Group |
| <p>"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."</p> | | | | <p>"Disparity Grade: The disparity grade column reflects how well the health system is doing in eliminating differences 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."</p> | | | |
| <p>Source: New Mexico Department of Health. <i>Racial and Ethnic Health Disparities Report Card</i>, 2006, 4. http://www.health.state.nm.us/DPP/2006ReportCard.pdf</p> | | | | <p>Source: New Mexico Department of Health. <i>Racial and Ethnic Health Disparities Report Card</i>, 2011, 1, 4.</p> | | | |

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

In addition to providing a disparity grade for each indicator, New Mexico charts the trends in disparity rates across the various editions of its report card and reports a "disparity change score" (or the difference in relative disparity of two sub-populations between two time periods). These scores help the state identify indicators in which the disparity between populations and the comparison group is getting better or worse, which then guides the state's priorities for action (see Figure C, below). The 2011 report card compares the 2003-2005 rates and ratios to 2008-2010.

Figure C: New Mexico Change in Disparity Score: Hepatitis B (Acute and Chronic), 2011

| Hepatitis B (Acute and Chronic) | | | | | | |
|--|------------------|-----------------|------------------|-----------------|---|--------------------------------|
| | 2003-2005 | | 2008-2010 | | | |
| Racial/Ethnic Group | Rate per 100,000 | Disparity Ratio | Rate per 100,000 | Disparity Ratio | Disparity Change Using Disparity Change Score | Disparity Increase or Decrease |
| African-American | 7.9 | * | 11.3 | * | Not Enough Data | |
| American Indian | 3.3 | * | 2.0 | * | Not Enough Data | |
| Asian/Pacific Islanders | 110.7 | 31.5 | 101.7 | 38.5 | 7.0 | Increase |
| Hispanic | 3.5 | 1.0 | 2.6 | 1.0 | 0.0 | No Change |
| White | 5.9 | 1.7 | 3.7 | 1.4 | -0.3 | Decrease |
| Index of Disparity | 1566 | | 1372 | | -194 | Decrease |
| * Rate based on less than 20 events, so no disparity ratio calculated. | | | | | | |

Source: New Mexico Department of Health. *Racial and Ethnic Health Disparities Report Card*, 2011, 30.

Report Card Use and Impact

State agencies use the New Mexico report cards in several ways. The state has issued mini-grants to communities to address indicators in the report card. The state has also used the report card for its own National Institutes of Health grant application. The report card is shared at state legislative sessions, and the state conducts outreach to legislators on the report card to ensure their awareness of the findings.

Department programs use the report card to focus their outreach efforts to populations with greatest need. Outreach to and engagement of stakeholders includes hosting forums to discuss action to address specific indicators. For example, based on findings, the teen pregnancy prevention program increased outreach to Hispanic youth, and the diabetes program increased outreach to American Indians. In addition, community members have taken the initiative to act on report card findings. Awareness of the high prevalence of Hepatitis B in Asian populations has energized Asian communities to distribute informational flyers at community events.

Lessons

Several lessons emerge from New Mexico's experience in using report cards to measure racial and ethnic health disparities. These include:

- **Solicit and incorporate community feedback.** Community forums and health fairs are opportunities to share report cards and gauge responses. New Mexico has strengthened its report card by incorporating suggestions from communities.

- **Know your audience.** New Mexico tailors its report card for the needs and interests of the general public. As a result, it strives to create user-friendly documents with visually pleasing aesthetic details. These features facilitate understanding, appeal and, therefore, action on the health issue by community stakeholders.
- **Understand the potential challenges of grading.** Letter grades provide a simple, memorable message that helps raise awareness. At the same time, confusion or lack of clarity about what is being graded can alienate stakeholders. Be clear about what the grade column reflects and the variety of factors that contribute to the grade.
- **Trend data where possible.** New Mexico trends national and state data by race/ethnicity (where available), compares indicator rates and disparity ratios across time periods, and provides narrative text about changes in disparities from past data. This information has helped community groups and department programs to identify topics and populations of greatest need, as well as areas of progress.
- **Do not hesitate to borrow good ideas.** New Mexico modeled its report card after North Carolina; in turn, Delaware has used New Mexico's. Starting from existing templates can save states time and allow them to incorporate lessons from peers.

Conclusion

State report cards that assign letter grades based on race/ethnicity-specific measures are one method that states can use to document and provoke action on data related to racial and ethnic health and health care disparities. New Mexico's experience demonstrates that report cards can be an effective way to convey key disparities findings for the general public and engage communities and other stakeholders in creating awareness and driving activities related to reduction of health disparities.