STATE DOCUMENTATION OF RACIAL AND ETHNIC HEALTH DISPARITIES TO INFORM STRATEGIC ACTION: 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.[1,2] Since 2003, the Agency for Healthcare Research and Quality (AHRQ) within the U.S. Department of Health and Human Services, has published the *National Healthcare Disparities Report* (NHDR) to track disparities and progress in reducing them. NHDR data has consistently shown that health care quality varies by population; the 2009 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.[3] Disparities result in life-years lost as well as subsequent health issues that likely could have been prevented with high-quality care.[4]

States are 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.[5] 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.[6,7] States are now undertaking these activities within the context of federal health reform, which became law in Spring 2010.[8] The Patient Protection and Affordable Care Act (ACA) includes a number of provisions that have the potential to help reduce disparities in health status and health care access. For example, ACA directs states to collect information and data regarding disparities.[9]

---

[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] Smedley, B., Stith, A. and A. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: National Academies Press, 2003).

[3] Agency for Healthcare Research and Quality. *National Healthcare Disparities Report, 2009*. Rockville, MD: March 2010. (Accessed October 21, 2010.). http://www.ahrq.gov/qual/nhdr09/nhdr09.pdf.

[4] LaVeist, T., Gaskin, D., and Richard, P. *The Economic Burden of Health Inequalities in the United States*. Washington, DC: Joint Center for Political and Economic Studies, September 2009. (Accessed October 21, 2010.) http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf.

[5] 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.

[6] 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.

[7] 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.

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

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

The National Academy for State Health Policy (NASHP) undertook an effort to more comprehensively explore states' identification, documentation and action on race/ethnicity data. This document summarizes themes and lessons from eight states identified as leaders in 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.

Methodology

The eight featured states were identified through an environmental scan of all 50 states and the District of Columbia to identify leaders in the use of patient race/ethnicity data, defined as those with state government-produced disparities documents meeting the following criteria: published in 2007 or later; data-driven; addressing *health care* disparities; and with evidence of state action based on the document.

After identifying a preliminary list of documents and verifying with state officials the accuracy and completeness of the search, NASHP, AHRQ, and Thomson Reuters selected eight states that best met the aforementioned criteria, with consideration also given to profiling states from different regions of the country. NASHP then held informal conversations with the authors of the states' document(s) and others involved in creating or using the document(s).

This summary synthesizes themes and lessons from data-driven disparities documents created by Colorado, Connecticut, Georgia, Maryland, New Jersey, New Mexico, Rhode Island, and Utah (Table 1). The full report, which provides more detail about these state documents, is available on AHRQ's website.[10]

Featured States' Documents

When using data to document disparities and inform action, the eight featured states primarily produce three different categories of documents:

- **Data reports**: Compile race/ethnicity-specific metrics and performance measures to identify disparities that need to be addressed, but often provide little in the way of action steps.

- **Action plans**: Propose steps to move toward health equity, as opposed to focusing on documenting disparities.

- **Combination of action plan and data report**: Presents both action steps and data either in a single document or in separate-yet-complementary documents. Many featured states with an action plan also have a companion data report.

---

[10] Hanlon C, Rosenthal J, and Hinkle L. *State Documentation of Racial and Ethnic Health 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.

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

Data Sources

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. Data sources commonly used and listed as helpful include the Behavioral Risk Factor Surveillance System (BRFSS), state registries for conditions such as cancer or HIV, and vital records, which contain data about births and deaths. Just over half of featured states (5) use hospital discharge data, and just under half (3) use emergency department data.

All featured states indicated that socioeconomic status data are an important resource 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 used socioeconomic data in some form; however the availability and, therefore, degree of use varied.

Indicators Presented, Unit(s) of Analysis, and Comparison Rate(s)

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 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.

Four of the eight states studied display data broken down by county in their data reports. These are the states with larger populations: Georgia, New Jersey, Maryland, and Colorado. The featured states with smaller populations generally have limited county data. Nevertheless, Rhode Island and Connecticut have used geo-mapping to examine disparities in communities. 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.

In order to compare health status and health outcomes between racial and ethnic minority populations, states use absolute and/or relative rates. These rates provide different types of information.[11] Relative rates are more commonly presented by the featured states than absolute rates. The availability of data and standard protocols also influence state decisions about methods.

Races and Ethnicities

Reviewed state data reports only varied slightly 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. Additionally, while each of the states has 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.

Additionally, states define races differently. Utah, for example, follows the federal standard of including Native Hawaiians in the Pacific Islander population and including Alaska Natives with Native Americans. 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," while Colorado uses both the term "American Indians" and "Native Americans."

Most featured states 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.

Health Topics and Conditions

[11] 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): 22. (Accessed October 21, 2010.) http://seer.cancer.gov/publications/disparities/.

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. 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.

Cost of Disparities

The impact of disparities is of great interest to featured states. Some already measure this while others are exploring ways to do so. States calculate costs both in years of potential life lost, and in financial terms of additional spending on health care services. Georgia, for example, calculated years of potential life lost for each county because it made for an effective message on disparities. Maryland looked at the cost of disparities in terms of monetary value, calculating the "excess cost" to the state incurred both by Medicare and by all-payers. The state noted that this is a valuable metric because it shows that there is a financial or economic benefit to reducing disparity rates. Connecticut calculates costs in terms of days away from work and human loss.

Report Card Data

Both Georgia and New Mexico compiled data into "report cards" or publications that categorize data by letter grades; however they did so in different ways. Georgia graded each county in different categories. New Mexico, which has a smaller population than Georgia, focused its report card on the state level and graded the disparity ratio for each ethnicity by condition. New Mexico calculates ratios using the population with the best rate for a condition as a comparison. Both states grade on an A-F scale. The grades in New Mexico's report card were initially interpreted as reflecting 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, New Mexico re-worded the explanation of the grading system.

State Processes to Develop Data Reports and Action Plans

Despite the use of varying processes to develop their disparities data reports and action plans, all featured states' efforts require and rely on collaboration. Featured states work collaboratively with (a) sister departments as well as with state academic institutions for assistance with data analysis, (b) community-based coalitions or organizations to help with community outreach, and (c) other private partners such as hospital associations that house hospital discharge data, and foundations, which provide financial support. Featured states often engage partnership councils to advise on statewide minority health improvement efforts, and to 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 on Disparities Data Documents

All of the featured states have taken action on their disparities data reports, and they have clear plans for future action. Specific examples of state actions include:

- **Making the case for national or federal funding.** Connecticut's Comprehensive Cancer program used information from the state disparities report to apply for CDC funding for a colorectal cancer screening program. Utah's maternal and child health program used information within the state's report to apply for a grant to address disparities.

- **Conducting outreach to stakeholders**. 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 Mexico held awareness action forums to discuss action to address four specific indicators; the state also shares its report card at state legislative sessions.

- **Informing new or existing public health projects**. States provide grants to local communities to address disparities described in state reports. New Mexico issues mini-grants based on its report card. Groups submit proposals to address one of the indicators in the state's report. 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.

- **Publishing or planning new documents.** States update or complement previous reports with fact sheets, or brief summaries with detailed information about health disparities for specific racial and ethnic minority populations. Rhode Island published four minority health fact sheets with data for African Americans, Asians and Pacific Islanders, Hispanics/Latinos, and Native Americans. In response to community feedback, Georgia is currently working on a disparities report about Asian populations.

- **Strengthening internal, state government processes to address disparities in more strategic, streamlined, and comprehensive ways**. Colorado is implementing a survey to evaluate how the state's disparities plan is being used by state agencies. New Jersey established coding guidelines on race and ethnicity data as a direct result of its strategic plan.

Tracking Progress and Evaluating Impact

Due primarily to 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. Because 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.

Connecting Documents to Broader Reform Efforts

The Patient Protection and Affordable Care Act (ACA) includes provisions that could have a significant impact on health disparities.[12] [13] 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. 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.[14] 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 featured 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 Office of Minority Health, which may be beneficial, and that HIT initiatives that could help in reducing disparities are also supported by health care reform.

States Benefit from Sharing Strategies

Every state featured looked to other states when crafting their disparities documents. Featured states specifically mentioned North Carolina, Massachusetts, Minnesota and Ohio. Additionally, NASHP identified noteworthy activity in Arizona, California, Michigan, and Virginia.

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.

[12] "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.)
[13] D.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.
[14] National Academy for State Health Policy. "State Refor(u)m." (Accessed September 27, 2010). www.statereforum.org.

- 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.
- 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 cannot act alone if states are to achieve health equity.

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. All of the featured states have developed methods for reporting health disparities and have taken concrete steps towards reducing the disparities that exist within their borders. Their lessons 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, such as through provisions in health care reform, may provide momentum for state action.