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Executive Summary

The United States struggles with inequities in healthcare access and health outcomes for people of color due to centuries of institutional and systemic racism and the persistence of racism in our systems and policies today.¹ Recently, some states and the federal government have committed to health equity as a policy priority and are actively acknowledging racism as a root cause of health disparities.² States and federal agencies have begun to identify disparities to inform policies and activities to reduce them. For example, some state agencies, such as the Massachusetts Executive Office of Health and Human Services and the Arizona Health Care Cost Containment System, are focusing on improving collection of race, ethnicity, and other demographic data and stratifying performance measures by these variables.³ Similarly, the Health Resources and Services Administration's Uniform Data System stratifies data at the federal level. However, there is no standard set of health equity measures or central source of state-specific health equity performance data.

This issue brief introduces a curated set of existing measures, which have been developed, tested, and are in use by national measurement bodies in areas where consumers experience disparate outcomes (for example, birth-related mortality rates for Black birthing people are disproportionately high). The measure set is intended for use by states to evaluate progress towards health equity. The measures in the *State Health Equity Measure Set* rely on publicly available data that states can use to assess their own performance and compare it to the performance of other states.

This measure set includes 10 population-level measures that gauge how health status varies by race and ethnicity. States can use these 10 measures to identify areas with opportunities for improvement. The measure set also includes 19 healthcare measures that assess how receipt of, and outcomes associated with, evidence-based healthcare services vary by race and ethnicity. States can use these 19 measures to inform interventions that strive to improve equity in healthcare access and outcomes. The combined *Measure Set* intentionally focuses on assessing performance for a state's entire population, rather than for a specific coverage category (e.g., Medicaid and commercial insurance).

The *State Health Equity Measure Set* excludes measures related to social determinants of health as such measures were outside the scope of the review for this effort.

Introduction

COVID-19 highlighted the longstanding, stark disparities in healthcare access and health outcomes for people of color. These communities experienced disproportionate hospitalizations and deaths during the coronavirus pandemic.⁴ Inequities in health outcomes are a consequence of centuries of institutional and structural racism, which persist today and are embedded within the country's healthcare system and other systems (e.g., housing, access to food) that impact health. In response, many states are committing to improve health equity as a policy priority and the Centers for Medicare & Medicaid Services (CMS) is actively encouraging all states to do so.

i**Definitions:**

Health equity: Everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, socioeconomic status, geography, or any other social barrier/factor.

Health inequities: Differences that are unfair and unjust without comparison to another group.

Health disparities: Avoidable differences in health outcomes experienced by people with one characteristic (e.g., race, gender, sexual orientation) as compared to the socially dominant group (e.g., White, male, cis-gender, heterosexual, etc.).⁵

As states and the federal government embark on explicit paths to reduce inequities, it is apparent that a common-means of measuring progress towards these goals is lacking. States, often through their health departments, have made some efforts to measure and report on health equity, but the field of health equity quality measures is relatively nascent. There is no standard set of measures curated for state use that focuses upon equity in healthcare processes and outcomes at the population, provider, or insurer level.

Disparities are measurable and can serve as a proxy to evaluate the presence and extent of inequities in a healthcare system. Even though there are several national and federal data sources that publicly stratify performance measures by race and ethnicity, they are incongruent and can be hard to navigate. There is no single source for states to consult to learn how they have performed and are performing with respect to health equity, including equitable provision of services, patient experience, outcomes of care, and health status.

The *State Health Equity Measure Set* introduced in this brief begins to fill that gap and facilitates state assessment and comparison. This *Measure Set* is targeted towards state health policy staff who are interested in promoting health equity. It highlights measures in areas with publicly available data that states can use to stratify their health data by race and ethnicity.⁶ This *Measure Set* focuses on aspects of care with known disparities at the national level, which states can use if they do not have the resources or capacity to identify state-specific disparities.⁷ States should, however, build capacity to stratify performance for all measures to identify priority areas to promote health equity within their populations.

The *State Health Equity Measure Set* includes **health status measures** that provide states with an opportunity to broadly assess how health status varies by race and ethnicity.⁸ States can then use **healthcare measures** to more closely examine how healthcare processes and outcomes, which can contribute to population-level status, differ by race and ethnicity. These two different types of measures can inform interventions aimed at reducing disparities across populations.

The *State Health Equity Measure Set* focuses solely on health status and healthcare measures. It does not include social determinants of health (SDOH), which the authors feel are best addressed through a separate effort given the breadth of available measures.⁹ States may choose to analyze variation in SDOH by race and ethnicity, as SDOH have significant impact on health status.¹⁰ States can best understand these data by considering the historical and cultural factors that impact access and outcomes for people of color seeking care in the United States (see more in *State Considerations When Adopting the State Health Equity Measure Set*).

States are simultaneously focused on improving collection of race, ethnicity, language, and disability status (RELD) data as well as sexual orientation, gender identity and sex (SOGIS) data by state agency, health plan, and provider to ensure they are complete, accurate, and self-identified. The Massachusetts Quality Measure Alignment Taskforce, for example, developed statewide standard categories to collect RELD and SOGIS data for use with Medicaid and commercial payers.¹¹

States are also stratifying performance measures by RELD, SOGIS and other variables to detect, and then reduce, disparities among subpopulations. States can use their internal data to more closely examine healthcare processes and outcomes to inform interventions to improve health equity.

Methodology

The following process was employed to create the *State Health Equity Measure Set*: develop measure selection criteria, identify measure topics with evidence of disparities in performance by race and ethnicity, identify national and federal data sources from which to search for measures, prepare candidate health equity measures, and select final health equity measures. The authors solicited feedback from an advisory group of state agency representatives and health equity measurement experts, including physicians, public health experts, and state Medicaid officials.

Measure Selection Criteria

The authors developed a set of criteria (*Appendix A*) to inform their research of candidate measures and to select final measures for inclusion in the *Measure Set*. The criteria ensured that measures focused on topics with known disparities (i.e., topics where the White population sees better access or outcomes than any other population), that were aligned with national objectives as outlined in Healthy People 2030,¹² and for which there are regularly published, publicly available data that could be stratified by race and ethnicity for most states.

Measure Topics

In consultation with an advisory group, the authors developed a list of measure topics with evidence of disparities in performance by race and ethnicity (*Appendix B*). We used this list to inform the research of candidate measures for the *Measure Set*.

Data Sources

The authors, in consultation with the advisory group, developed a list of national and federal data sources from which to research candidate measures (*Appendix C*). Sources that have state-specific data, can be stratified by race and ethnicity in a way that aligns with the Office of Management and Budget (OMB) standards,¹³ that have performance data available for multiple years, and that are updated at least annually were prioritized. Sources that had charts or tables displaying data and/or interactive visualizations were also prioritized.

Measure Selection

The authors researched candidate measures within each of the measure topics identified using the prioritized data sources. If there were measure topics with no candidate measures based on the prioritized data sources, we consulted additional data sources that may not be as comprehensive or easy-to-use for states with limited proficiency or resources in data analytics.

The authors scored measures against the measure selection criteria to inform the composition of the *State Health Equity Measure Set*. We considered several factors when selecting final measures in addition to the measure selection score, including: 1) whether states could use a data source's native tools to produce charts or tables stratifying a measure by race and ethnicity, 2) the balance of adult- and pediatric-focused measures, and 3) whether there were alternative measures available for a given measure topic.

State Health Equity Measure Set

States can use the *State Health Equity Measure Set* to track their progress in promoting health equity and compare their progress with other states. The *Measure Set* intentionally focuses on assessing data for a state's entire population, rather than for a specific coverage category (e.g., Medicaid or commercial insurance). As explained above, it excludes measures related to SDOH.

The *Measure Set* consists of two categories of measures:

- **Health status measures.** These are population-level measures (e.g., statewide obesity rate, opioid overdose death rate).
- **Healthcare measures.** These are measures that assess access to, receipt of, cost of, perception of, and outcomes associated with evidence-based healthcare services (e.g., avoided and/or foregone care, well-care visits).

The *Measure Set* includes separate tables for each category of measures. There are 10 health status measures and 19 healthcare measures, listed according to health domains (e.g., behavioral health, prevention). For each measure, there is an identified primary data source. Consistent with the measure selection criteria, primary data sources display state-specific data, stratified by race and ethnicity, and may include interactive graphics that compare state performance. There is also a secondary data source, which includes the raw data that states can use to perform additional “drill-down” analyses.

State Considerations When Adopting the State Health Equity Measure Set

States must be cognizant of how people of color are represented in healthcare data, as underrepresentation or overrepresentation may respectively temper or exacerbate the reporting of health disparities. These limitations are embedded in the data used to select measures for the *State Health Equity Measure Set*, as well as any additional analyses that states may wish to pursue on their own.

People of color can be *underrepresented* in data for several reasons. First, people of color have faced and continue to face barriers to accessing healthcare, which result in undercounting the prevalence of certain conditions or underestimating the disease burden within these populations.^{14,15} For example, if a Black individual with diabetes does not have access to a primary care provider, their diabetes would go undetected and that individual would not be captured in a diabetes prevalence rate despite having the condition.^{16,17} Second, providers may be more likely to identify people of color as having a specific condition as a result of biased assessments or prejudices based on race or social economic factors. For example, providers are more likely to attribute the behavior of Black youth to attention deficit hyperactivity disorder compared to their parents.¹⁸ Additionally, people of color may not report on their condition or their challenges accessing care due to fear of racial discrimination, stigmatization associated with a particular diagnosis or out of fear for being blamed for being too passive about their health.¹⁹⁻²² Third, provider discomfort with asking questions about race and ethnicity, compounded with implicit provider biases in diagnosis and treatment, may result in underrepresentation of people of color. For example, healthcare providers may not consistently ask for patient race and ethnicity information due to cultural and language barriers. In some instances, a provider may instead assume the patient’s race or ethnicity, which could influence the provider’s diagnosis or treatment plan. Fourth, people of color may be excluded from certain programs or outreach due to bias in healthcare algorithms such as deflating risk for people of color or attributing health outcomes to patient race or behavior rather than institutional or provider characteristics.^{23,24}

People of color may be *overrepresented* in performance data for certain conditions, particularly those pertaining to mental health. Researchers believe this may be attributed to provider bias, diagnostic criteria that fail to incorporate the perspectives of immigrant communities, or limited or ineffective communication with a provider about a patient’s health status due to cultural and language barriers or mistrust.²⁵ For example, Black men are more likely than other groups to receive a misdiagnosis of schizophrenia when expressing symptoms related to other mood disorders or post-traumatic stress disorder.²⁶

The challenges of under- and overrepresentation are systemic issues with healthcare data that do not have easy solutions but are vital to confront. By improving access to care for people of color, by strengthening the trust between the healthcare system and people of color through increasing representation of different races and ethnicities among providers and collaborating with trusted messengers, states can take action to begin to address some factors that lead to under- and overrepresentation of people of color in these measures. States should also consider the following factors when using the *State Health Equity Measure Set*.

1. The *State Health Equity Measure Set* allows states to assess their current circumstances and changes in health measures stratified by race and ethnicity. States may want to perform additional analyses to assess other variables (e.g., age, disability status, gender identity, income, sexual orientation). For example, age-adjusting infections and chronic disease data stratified by race and ethnicity often reveals earlier onset of preventable disease for some racial and ethnic groups.

2. States should assess whether there is sufficient denominator size when stratifying measure performance by one or more variables, especially in smaller states and for measures with small population sizes (e.g., children with mental health conditions). This is especially pertinent when using national survey data for healthcare measures, as there may be an insufficient sample size from which to draw conclusions. Small denominator and/or sample sizes can restrict a state's ability to conduct reliable measurement (e.g., compare data with other states, track changes over time, or assess the intersectionality between variables).
3. States should exercise caution when interpreting and reporting on the *Measure Set* so they do not inadvertently reinforce the idea that poor access and outcomes are a result of a specific subpopulation's actions. Structural and systemic factors embedded in historical and current policies, like racism, discrimination, and racial segregation, create conditions that negatively impact health for people of color. This, in turn, can lead to chronic stress that increases risk of developing chronic conditions that are unrelated to personal lifestyle choices.²⁷ States can also leverage asset-based framing when reporting findings, which promotes equity by highlighting the positive contributions of people of color.²⁸

The Massachusetts Department of Health includes contextual information when presenting data in its Health Equity Dashboard, which includes data visualizations for health indicators of interest (e.g., cancer mortality, chronic diseases, etc.).²⁹ Additionally, states can utilize resources from the University of California at Los Angeles' Center for the Study of Racism, Social Justice, and Health to contextualize measurement results.³⁰ The Center has a specific focus on the health implications of racism for diverse populations and includes a glossary of key terms frequently used in the health equity literature on racism.
4. With an improved understanding of health disparities across subpopulations, states can examine root causes of health disparities and then design and implement policy interventions to improve equity. There are several sources available to assist states in doing so, including:
 - a. The University of Minnesota's Inclusion, Diversity, Equity, and Access (IDEA) Resources page, which compiles resources such as guides for conducting research through an anti-racism lens, anti-racism reading lists, and clinical databases and information tools, such as a repository of cultural beliefs of different racial and ethnic groups related to health.³¹
 - b. The Massachusetts' Department of Public Health's Racial Equity Road Map, which outlines how to interpret health equity data and use these data to inform policy interventions.³²
 - c. SHVS' Health Equity resource page, which provides resources for states related to data and analysis, policy implementation, and more.³³ In addition, SHVS is developing a tool that states can use to evaluate the impact on health equity of a proposed policy or program.
 - d. Dr. Jamila Michener's Racial Equity and Policy (REAP) framework, which gives a conceptually sound and practical structure for assessing racial equity implications in health policy.³⁴

Operationalizing the State Health Equity Measure Set

There are several steps states can take to operationalize the *State Health Equity Measure Set*.

1. States can refer to the primary data source to obtain information and then compile each measure into a spreadsheet. They can include national performance, regional performance, and/or data from other states to serve as a benchmark.³⁵ States can also capture multiple years of data if they are interested in assessing changes over time. Of note, states may choose to supplement these national data sources with state-specific data (e.g., state-level surveys, analyses using multi-payer claims databases) that may be timelier and more comprehensive.

2. States should develop graphics or an accessible,³⁶ interactive dashboard to visualize health equity in their populations. States can refer to the interactive figures found in the [Chronic Disease Indicators Tool](#), the [CDC Disability and Health Data System](#) and the [March of Dimes PeriStats](#) for examples (see **Figure 1**). States can also consider how data visualization can help further their goals, such as creating infographics to raise awareness of disparities and how they have changed over time and to facilitate community engagement.
3. States may consider analyzing data to identify areas of opportunity and priority, such as measures where a specific population faces inequities relative to benchmark data.³⁷ If states have the analytic resources and sufficient denominator sizes to conduct additional “drill-down” analyses, they can explore how the intersectionality of multiple demographic variables (e.g., race and disability status) impact health equity.
4. States can use the *Measure Set*, including the analyses described above, to inform policy initiatives aimed at improving health equity and outcomes. In doing so, states should also be mindful to include the appropriate voices to govern and lead the process of selecting measures, gathering and analyzing data, and interpreting and reporting measures. Making this process community-driven ensures that states are conducting measurement in an equitable way, and limits the likelihood that policy initiatives exacerbate inequities, are ineffective, or have negative consequences for people of color.

An Example for How to Use the State Health Equity Measure Set

Figure 1 below from the March of Dimes PeriStats report stratifies infant mortality rates, a health status measure, by race and ethnicity and compares Georgia’s rates with those of the United States overall. The report shows that the infant mortality rate in Georgia is higher for Black infants as compared to Latino/a³⁸ and Asian/Pacific Islander infants.³⁹ It also shows the infant mortality rate for Black infants in Georgia is equal to the United States overall. Based on this information, Georgia could choose to prioritize its resources and pursue strategies aimed at reducing infant mortality rates among Black infants. Part of the strategic development process could include additional analyses to better understand:

1. The population at risk (e.g., is mortality highest for birthing people of a specific age band?).
2. National and state policies that may impact performance (e.g., is there a correlation between geographies that have been redlined or that have high rates of environmental pollution and geographies where mortality rates are highest?).
3. If there are specific healthcare processes, assessed through healthcare measures (e.g., *Inadequate Prenatal Care*), that are contributing to poor health status.
4. Strengths of the subpopulation that the state may be able to build upon to improve measures (e.g., has the community experiencing the disparity been engaged to help define solutions? Are there trusted messengers within a specific community that could help disseminate information or connect this population with available services?).

States can complement such measure analyses by engaging community when designing and implementing equity-focused strategies, which will improve the likelihood of designing successful and efficient interventions.⁴⁰

Figure 1: Infant Mortality Rates by Race and Ethnicity: Georgia and U.S., 2017-2019 Average

(Source: March of Dimes PeriStats report)



Conclusion

The *State Health Equity Measure Set* is a curated set of measures from national and federal data sources that allow states to compare their performance and track their performance over time on addressing disparities by race and ethnicity. States can use this *Measure Set* to inform program interventions and policies that are focused on reducing disparities in healthcare access, care delivery, and health outcomes for people of color.

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ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation (RWJF) is committed to improving health and health equity in the United States. In partnership with others, we are working to develop a Culture of Health rooted in equity that provides every individual with a fair and just opportunity to thrive, no matter who they are, where they live, or how much money they have.

Health is more than an absence of disease. It is a state of physical, mental, and emotional wellbeing. It reflects what takes place in our communities, where we live and work, where our children learn and play, and where we gather to worship. That is why RWJF focuses on identifying, illuminating, and addressing the barriers to health caused by structural racism and other forms of discrimination, including sexism, ableism, and prejudice based on sexual orientation.

We lean on evidence to advance health equity. We cultivate leaders who work individually and collectively across sectors to address health equity. We promote policies, practices, and systems-change to dismantle the structural barriers to wellbeing created by racism. And we work to amplify voices to shift national conversations and attitudes about health and health equity. Through our efforts, and the efforts of others, we will continue to strive toward a Culture of Health that benefits all. It is our legacy, it is our calling, and it is our honor.

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ABOUT BAILIT HEALTH

This issue brief was prepared by Deepti Kanneganti, Jessica Mar and Michael Bailit. Bailit Health is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see www.bailit-health.com.

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Appendix A. Measure Selection Criteria

The authors used the following criteria to inform their research of candidate measures and selection of measures for the *State Health Equity Measure Set*. These criteria are listed in no particular order.

Criteria for Choosing Individual Measures

1. Represents an opportunity to improve health equity, evaluated by performing an assessment of data and literature to identify disparities in performance by race and ethnicity.
2. Represents a topic that is a national priority, defined as topics that are included in the Healthy People 2030 objectives.¹²
3. The structure, process, or outcome being measured (a) has evidence of improving patient health and is consistent with clinical guidelines adopted by national professional societies and/or (b) has evidence demonstrating its impact on exacerbating or reducing health disparities.
4. The measure and associated measurement methods are valid and reliable at the data element and performance score level.⁴¹
5. Performance data are available for at least 75% of states (to ensure states can compare their population to other states).
6. Performance data are from a reputable, publicly available source, are available for at least three years, and there are current plans for continued measurement activity (to ensure states can track changes in performance over time).
7. If the measure is stratified by race and ethnicity, the data must, at a minimum, align with OMB standards (race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White; ethnicity: Hispanic or Latino).¹³ Measures with more detailed levels of stratification beyond the OMB standards (i.e., further stratifying Other Pacific Islander into Samoan, Guamanian or Chamorro, Tongan, etc.) are acceptable.

Criteria for Evaluating the Measure Set as a Whole

1. Taken as a whole, high performance on the proposed *Measure Set* should significantly advance the delivery system toward the goals of safe, timely, effective, efficient, equitable, patient-centered care.

Appendix B. Measure Topics with Evidence of Disparities in Performance by Race and Ethnicity

The authors primarily used the United Health Foundation's America's Health Rankings tool to identify measure topics with evidence of disparities in performance by race and ethnicity.⁴² The authors supplemented their initial list of measure topics with additional topics recommended by the advisory group. Of note, the authors focused on measures for the adult and pediatric populations, wherever available, and excluded measures related to SDOH.

1. Access to culturally appropriate services^{*43}
2. Asthma
3. Cancer, including but not limited to screening, morbidity and mortality
4. Cardiovascular health, including but not limited to heart disease and stroke
5. Diabetes
6. Environmental health and justice, including but not limited to lead screening and poisoning*
7. Immunizations
8. Infectious disease, including but not limited to HIV and sexually transmitted infections
9. Maternal and infant health, including but not limited to access to prenatal care, breast feeding and morbidity and mortality
10. Mental health
11. Obesity**
12. Oral health
13. Patient experience, including but not limited to avoided care due to bias and cost
14. Reproductive health, including but not limited to long-acting contraceptives
15. Substance use, including but not limited to frequent (versus occasional) drug use

*The authors were unable to identify measures that adequately met the criterion for these measure topics.

**The authors only found limited measures focused on obesity. Measures that assess body mass index (BMI) were not included due to the evidence that demonstrates that BMI is not accurate for some racial and ethnic groups.^{44,45} The current measure in the *Measure Set* assesses parental concern about a child's weight, which does not always correlate with obesity.

Appendix C. Data Sources

The authors consulted the data sources contained in the table below when researching candidate measures. The authors selected these data sources because they satisfied several predetermined requirements, such as data being available at the state level, functionality for stratification by race and ethnicity in a way that aligns with OMB standards, availability for multiple years and annual updating. For each measure, the authors identified primary data sources that have charts or tables that display performance and/or have interactive visualizations. The authors also identified a secondary data source, which includes the raw data that states can use to perform additional “drill-down” analyses.

The authors initially found, but ultimately excluded, several data sources that did not meet the predetermined requirements mentioned above. The authors also excluded data sources focused on SDOH, as that topic was out of scope for this project.

The authors, per the advisory group’s recommendation, also considered the completeness and accuracy of race and ethnicity data. Some data sources (e.g., the Behavioral Risk Factor Surveillance System) quantify how many respondents selected a given race and ethnicity category in the raw data and may include more granular race and ethnicity data. Of note, each source handled the “Unknown” or “Refused to Answer” responses differently.

Table C1: Prioritized Data Sources Used to Identify Candidate Measures

Prioritized Data Sources	
Agency for Healthcare Research and Quality (AHRQ) National Quality and Disparities Reports	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas Plus
AHRQ Healthcare Cost and Utilization Project (HCUP)	National Equity Atlas
America’s HIV Epidemic Analysis Dashboard (AHEAD)	National Health and Nutrition Examination Survey (NHANES)
Behavioral Risk Factor Surveillance System (BRFSS)	National Immunization Survey
CDC Disability and Health Data System (DHDS) Tool	National Survey on Children’s Health
CDC Wide-Ranging Online Data for Epidemiological Research (WONDER)	National Survey on Drug Use and Health
Center for Study of Racism	National Vital Statistics
Chronic Disease Indicators (CDI) Tool	State Health Access Data Assistance Center State Health Compare
Current Population Survey*	Youth Risk Behavior Surveillance System (YRBSS)
Morehouse Health Equity Tracker	

The authors considered, but ultimately did not use, the following data sources because they did not meet the predetermined requirements described above.

Table C2: Additional Data Sources Not Considered by the Authors

Additional Data Sources Not Considered	
AHRQ Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey	Medical Expenditures Panel Survey
American Community Survey	National Core Indicators
Annie E. Casey Foundation KIDS Count	National Health Interview Survey
CDC/Agency for Toxic Substances and Disease Registry (ATSDR) Social Vulnerability Index	Pregnancy Risk Assessment Monitoring System (PRAMS)
CMS Core Set of Adult and Child Health Care Quality Measures for Medicaid	Robert Wood Johnson Foundation County Health Rankings & Roadmaps
Community Resilience Estimates	Minority Profiles from US Department of Health and Human Services Office of Minority Health (HHS OMH)
Kaiser Family Foundation	U.S. Small-area Life Expectancy Estimates Project (USALEEP)
Mapping Medicare by Disparities	

*While the Advisory Group highly recommended the Current Population Survey, the authors did not prioritize the data source as a primary data source because the data are not as accessible as other data sources and did not include many healthcare and health status measures.

ENDNOTES

1. Radley DC, Baumgartner JC, Collins SR, Zephyrin L, Schneider EC. *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance*. New York: Commonwealth Fund; 2021. <https://www.commonwealthfund.org/publications/scorecard/2021/nov/achieving-racial-ethnic-equity-us-health-care-state-performance>. Accessed March 1, 2023.
2. The authors of this brief compared measurement data reflecting people of color and White populations to identify disparities, as detailed within.
3. Other states, like California, Minnesota, and Rhode Island, are also pursuing similar activities.
4. For more information, see: *Health Equity Considerations and Racial and Ethnic Minority Groups*. Atlanta: National Center for Immunization and Respiratory Diseases, Division of Viral Diseases, Centers for Disease Control and Prevention; updated July 2020. <https://stacks.cdc.gov/view/cdc/91049>. Accessed March 1, 2023.
5. Everett TD, Sathasivam D, Siegel K. *Talking about Anti-Racism and Health Equity: Discussing Racism*. NJ: State Health & Value Strategies; 2021. <https://www.shvs.org/wp-content/uploads/2021/08/Talking-About-Anti-Racism-Health-Equity-1-of-3.pdf>. Accessed March 1, 2023.
6. The health equity measure set does not include measures without publicly available data for most states. States may choose to supplement this measure set with additional health equity measures that address state priorities and for which the state has state-specific data (e.g., Oregon may choose to add its measure *Meaningful Access to Health Care Services for Persons with Limited English Proficiency*). If states add measures, it is important to note that there may not be external data against which a state can benchmark its performance.
7. The authors acknowledge that this state health equity measure set is subject to bias. Specifically, it may be impacted by the “streetlight effect,” which is when people search for something where it is easiest to do so. The authors recommend that states strive to stratify all measures to look for disparities. This holistic examination ensures that states prioritize resources to address disparities that are most relevant in their state, not disparities that may be most easily found.
8. Some measures could be classified as either a health status or healthcare measure. This brief focuses on using measures to evaluate progress towards health equity rather than categorization of measures.
9. Social determinants of health (SDOH) are “the conditions in the environment where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” For more information, see Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services. <https://health.gov/healthypeople>. Accessed March 1, 2023. Some states may refer to SDOH as health-related social needs (HRSN).
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16. People of color are more likely to be uninsured, which limits their ability to access healthcare. Specifically, American Indian and Alaskan Natives had the highest rate of uninsured individuals in 2021 (21%), followed by Latino/a (19%), Native Hawaiian and Pacific Islander (11%), and Black (11%) individuals. The rate of uninsured individuals for the White population was 7%. For more information, see: Hill L, Ndugga N, and Artiga S. *Key Data on Health and Health Care by Race and Ethnicity*. Kaiser Family Foundation. March 15, 2023. <https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity>. Accessed March 31, 2023.
17. Black individuals, American Indians, and Alaskan Natives are more likely than Whites to die from conditions that are treatable with timely access to healthcare (e.g., diabetes). For more information, see: Radley DC, et al. Further, Black adults are more likely to report having experienced discrimination or unfair judgement from a doctor, healthcare provider, or other staff. These experiences resulted in delayed or foregone care. For more information, see: Gonzalez D, Skopec L, McDaniel M, and Kenney GM. *Perceptions of Discrimination and Unfair Judgement While Seeking Health Care: Findings from September 11-28 Coronavirus Tracking Survey*. Washington, D.C.: Urban Institute; 2021. <https://www.urban.org/sites/default/files/publication/103953/perceptions-of-discrimination-and-unfair-judgment-whileseeking-health-care.pdf>. Accessed March 1, 2023.

18. For more information, see: Cénat JM, Blais-Rochette C, Morse C, et al. Prevalence and risk factors associated with attention-deficit/hyperactivity disorder among US black individuals: A systematic review and meta-analysis. *JAMA*. 2021;78(1):21-28.
19. In the 2003 Institute of Medicine report, *Unequal Treatment*, patients expressed fears that insurers may use patient demographic data to inform underwriting, or the practice of assessing how risky it is to provide insurance coverage for an individual, which may create barriers in accessing care. For more information, see: James C, Pamar S, Hudson Scholle S, et al. *Improving Data on Race and Ethnicity: A Roadmap to Measure and Advance Health Equity*. Washington, D.C.: Grantmakers In Health and the National Committee for Quality Assurance; 2021. <https://www.gih.org/wp-content/uploads/2021/12/GIH-Commonwealth-Fund-federal-data-reportpart-2.pdf>. Accessed March 1, 2023.
20. The practice of discriminating against certain populations is evident throughout history. The U.S. Public Health Service Syphilis Study at Tuskegee, for example, knowingly did not provide treatment for Black men with syphilis. The study also did not obtain informed consent from study participants. For more information, see: *The Syphilis Study at Tuskegee Timeline*. Centers for Disease Control and Prevention. <https://www.cdc.gov/tuskegee/timeline.htm>. Updated April 22, 2021. Accessed March 2023.
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22. The United States has a history of conducting forced sterilizations of tens of thousands of Black, Latino/a and Indigenous women in the 20th century. The practice of forced sterilizations persists today. Between 1997 and 2010, approximately 1,400 women were sterilized in California prisons. For more information, see: Stern A. *Forced Sterilization Policies in the U.S. Targeted Minorities and Those with Disabilities – and Lasted into the 21st Century*. Ann Arbor, MI: University of Michigan Institute for Healthcare Policy and Innovation; September 2020. <https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-thosedisabilities-and-lived-21st>. Accessed March 15, 2023.
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35. States may choose to pursue other approaches to benchmarking, such as comparing their performance to that of other countries or continents.
36. By accessible, the authors mean that these graphics are compliant with Section 508 standards, which state that people with disabilities should have access to information comparable to the access available to people without disabilities. For more information, see: IT Accessibility Laws and Policies. Section508.gov. <https://www.section508.gov/manage/laws-and-policies/>. Updated November 2022. Accessed March 28, 2023.
37. States may choose to focus on measures that exhibit fewer stark disparities across subpopulations, but that may impact a larger percentage of the population or that are expected to have a bigger impact on health outcomes.
38. Descriptions of racial/ethnic groups vary among authors. Each description represents a historical or political viewpoint. In reporting findings from independent research or publications, this issue brief has retained the terminologies used by the authors of those publications. This issue brief uses the terminology “Latino/a,” which differs from the March of Dimes’ terminology included in Figure 1.
39. Taylor E, Sayles J, Bailit M. Promising approaches to reducing disparities in birth-related health outcomes in Medicaid. State Health and Value Strategies. 2021. <https://www.shvs.org/wp-content/uploads/2021/11/Promising-Approaches-to-Reducing-Disparities-in-Birth-Related-Health-Outcomes-in-Medicaid.pdf>. Accessed March 28, 2023.
40. State Health and Value Strategies offers two companion issue briefs on community engagement: the first of which explains its importance and possible strategies to achieve it, and the second of which provides case studies of two states that addressed the challenges in doing so. See: Everett TD, Sathasivam D, Siegel K. Transformational community engagement to advance health equity. State Health and Value Strategies. 2023. https://www.shvs.org/wp-content/uploads/2023/03/SHVS_Transformational-Community-Engagement-to-Advance-Health-Equity.pdf. Accessed March 28, 2023. Everett TD, Sathasivam D, Siegel K. State examples of Medicaid community engagement strategies: two case studies. 2023. https://www.shvs.org/wp-content/uploads/2023/01/SHVS_State-Examples-of-Medicaid-Community-Engagement-Strategies.pdf. Accessed March 28, 2023.
41. For this purpose, the brief’s authors used the National Quality Forum definitions of validity and reliability: “Validity refers to the correctness of measurement: that the measure is, in fact, measuring what it intends to measure and that the results of the measurement allow users to make correct conclusions about the quality of care that is provided,” i.e., a higher score on a quality measure reflects higher quality; [Reliability] “addresses the precision of the measure; indicates ability to... distinguish differences between providers that are due to quality of care rather than chance.” For more information, see: National Quality Forum. *Key Points for Evaluating Scientific Acceptability*. Washington: National Quality Forum; 2020. https://www.qualityforum.org/Masuring_Performance/Scientific_Methods_Panel/Docs/Evaluation_Guidance.aspx. Accessed March 28, 2023.
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43. Examples of measures that would fall under this category are: 1) access to trained healthcare interpreters, credentialed community health workers, and other traditional healthcare workers; and 2) bilingual and medical healthcare providers.
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