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Healthy People, Healthy States: Promising Practices to Address Health Disparities

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Executive Summary

In their pursuit to improve the overall health of state residents while being good stewards of taxpayer dollars, state health policymakers are prioritizing strategies to understand and mitigate health disparities. The costs of unaddressed health disparities are substantial both to people with unmet needs — in their opportunity for optimal health, quality of life, and economic success — and to the overall economy due to avoidable costs and financial waste. A recent analysis estimates the cost at [\\$320 billion annually](#) — substantially limiting efforts to bend the health care cost growth curve.

Some states are taking a comprehensive approach and concurrently executing multi-pronged strategies to reduce health disparities, while others are implementing targeted approaches that may build on each other sequentially. Targeted efforts may focus on reducing barriers to equal access to quality health care on broader community-led and population-based approaches. It is well-documented that health outcomes are largely determined by social, economic, and environmental factors and that the bulk of health care dollars are spent on costly health care services.

Promising state practices to address disparities include updated data strategies to identify and target needed policy interventions, population-based approaches that build on local partnerships to empower community-led efforts and manage trust, and transformative statewide strategies that reshape government business practices and financing approaches.

This resource is intended to provide state policymakers with a suite of state approaches to address health disparities — from targeted to cross-agency comprehensive strategies. Each section below comprises best practices and state examples from a geographically diverse set of states to guide state policymakers to the opportunity that best suits their states' needs and capacity. Also included is a lexicon, recognizing the importance of common definitions in this domain, along with links to key tools and resources. The three sections are:

- Data Strategies to Understand and Address Health Disparities
- Partnerships to Address Health Disparities
- Shifting the Health Disparities Paradigm

“Equity is not just for one particular population, but for all groups experiencing disparities.”

(TN State Official)

A NOTE ON TERMINOLOGY:

Agreed-upon terms are essential to aligning state, local, and private efforts to addressing health disparities. Many states use longstanding federal definitions or have used surveys or established task forces (comprised of multiple partners, including communities served) to provide foundational terminology from which to approach the work. State agencies are investing in staff trainings and workshops that promote language standards to be used both internally and externally to the agency — reflecting the importance of language. In this resource, the terms “health disparities” and “unmet need” are used throughout. As noted in the [Appendix](#), we use the Centers for Disease Control and Prevention definition of “health disparities,” which is “preventable difference in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.” Where a state uses other terms, such as “health equity,” in the description of its efforts, that language is preserved to respect the state interest.

Introduction

Despite advances in medicine, technology, and public health fostering overall improved health in the U.S. over the past century, disparities in health outcomes persist, and some have deepened. On the policy front, the 1980s brought renewed federal effort to secure fair opportunities for improved health for all and a national strategy to identify and reduce health disparities under the [Healthy People 2000 initiative](#) (currently Healthy People 2030).¹ Federal and state policy work to achieve those aims had been incremental until recent years when advances in data and technology allowed systematic analysis of demographic and socioeconomic differences in how well and how long people live. Measurement of health disparities has evolved to include both differences in health outcomes (such as maternal mortality, infant mortality, heart disease, and life expectancy) and in drivers of poor health outcomes (such as educational attainment, food security, care avoidance due to cost, and economic mobility), leading to the burgeoning work of tying social drivers of health (SDOH), also known as social determinants of health, to broader health policy solutions.² Undoubtedly, the COVID-19 pandemic crystalized and further accelerated these efforts. Many states employed targeted, community-guided interventions to alleviate disproportionate burdens on target populations and are now building on effective strategies to secure long-term health and economic resilience of communities across their states. The urgency for cost-effective approaches is clear. A recent analysis indicated that unaddressed health disparities carry a substantial economic as well as individual cost — with some estimates at \$320 billion annually.³

“Everyone talks about going back to normal. Going back to normal means more disparity.”

(State Agency Director)

The bidirectional relationship between healthy communities and healthy economies is reflected in state recovery approaches in a variety of ways. Some states are taking comprehensive whole-government approaches, and others are looking toward stepwise and targeted approaches to address, reduce, or eliminate health disparities. For example, some states are modifying their internal standards of business across government agencies, while others are focused on strengthening data quality, taking community engagement and investment approaches, or by targeting specific disparities and their root causes of disproportionately poor outcomes.

This resource is intended to provide state policymakers with a suite of state approaches to address health disparities — from targeted to cross-agency comprehensive strategies. The strategies are organized into subsections that can be read as stand-alone resources as well as part of the overarching document. The sections are:

- Data Strategies to Understand and Address Health Disparities
- Partnerships to Address Health Disparities
- Shifting the Health Disparities Paradigm

The sections comprise best practices and state examples from a geographically diverse set of states to guide state policymakers to the opportunity that best suits their states' needs and capacity.

[Appendix A](#) provides a glossary of terms used throughout this document and additional tools and resources to support actionable approaches.

“Everyone wants to see the “me” within the “we” of the data.”

(AK State Official)



Data Strategies to Understand and Address Health Disparities

High-quality data and an intentional data strategy are foundational to identifying disparities and unmet needs, shaping policies to improve the health of all residents, and selecting and monitoring progress toward goals. States are modifying data collection, analysis, and interpretation approaches to effectively capture and address differences in health outcomes by population (including geographic, demographic, and socioeconomic variability). Some are carefully improving data collection processes, tools, and analytics to adequately collect and disaggregate data by demographic, socioeconomic, geographic, and other variables on a more granular level than before. Other states are analyzing data already available to them to take first passes at informing policy and to begin getting feedback from various partners and interested parties. As with all data strategies, awareness of data gaps and potential misinterpretations should be built into this approach to effectively guide policy and programming. Regardless, most experts note that striking the right balance between securing data quality and determining when data are complete enough to advance

policymaking can be challenging — suggesting a continuous quality improvement approach. States are simultaneously working to improve quality of data collection and analysis and using available data to begin shaping the policy landscape.

Improving Data Quality and Transparency to Capture Health Disparities

Standardized assessment tools and data stratification approaches improve the accuracy of identifying health disparities. National efforts to standardize are useful to inform state approaches. For example, in the health care arena, states are leveraging National Committee for Quality Assurance (NCQA) HEDIS measures and requiring Medicaid and commercial health plans to report stratified HEDIS measures.⁴ In the public health arena, states are increasingly using tools such as the Centers for Disease Control and Prevention’s (CDC’s) Social Vulnerability Index to help identify at-risk communities in need of targeted response. States are also investing in data dashboards or portals to improve transparency. Dashboards and portals centralize data in an accessible format, often in the form of maps and charts, which allow end users to identify disparities by zip code or investigate health disparity data trends. This strategy creates transparency and opportunity for feedback and engagement in the quality improvement process. Utah’s chief information officer notes the state is using “customer” feedback data to improve processes rather than having state employees “sit around in a room and think to themselves how to improve.”⁵

State examples provided below detail some of these approaches.



Indiana is working to “remove barriers to access and opportunity for all Hoosiers” through the [Indiana Equity Data Portal](#). This data portal was developed in response to [Governor Eric J. Holcomb’s priorities for the Office of the Chief of Equity, Inclusion, and Opportunity Officer](#)

and was developed collaboratively with the [Management Performance Hub](#) and the departments of Health, Family Social Services Administration Child Services, State Police, Corrections, Education, Higher Education, and Workforce Development. The portal includes data on equity related to state efforts in health, public safety, social services, education, workforce, and others. Data collected since February 2020 can be viewed cumulatively or by month for the whole state and point-in-time by county. The table below displays included metrics.

Indiana Equity Data Portal Metrics

Dashboard	Metrics
Health	<ul style="list-style-type: none"> • COVID-19 cases and deaths • Infant mortality • Births and preterm births • Rate of pregnant people not receiving early prenatal care
Public safety	<ul style="list-style-type: none"> • Arrests • Re-arrests • Recidivism
Social services	<ul style="list-style-type: none"> • Health and wellness (in the past 12 months) • Not enough money for food • Utilities shut off • Fear of not having stable housing • Problems getting child care • Cost prevented seeing a doctor • Transportation prevented seeing a doctor • Need help reading hospital materials • Fear of being hurt in home • Actively seeking work (last four weeks) • Not regularly exercising • Children entering Department of Child Services care • Children currently in the care of the Department of Child Services
Education	<ul style="list-style-type: none"> • High school graduation rate • Educational attainment
Workforce	<ul style="list-style-type: none"> • Unemployment rate • Unemployment insurance claimants • Workforce-ready grant-funded enrollments • Median household income



Informed by **Utah** Governor Spencer J. Cox's [One Utah Roadmap](#) and the urgent need for data-informed COVID-19 response, the Utah Department of Health and Human Services (DHHS) [Office of Health Equity](#) (OHE) prioritized a suite of data collection, analysis, and reporting initiatives.

OHE developed uniform [data collection standards for race and ethnicity information](#) reportable to DHHS, including a [primer on the importance of standardizing, collecting, and reporting race and ethnicity information](#) and how the information could be used by policymakers. OHE packaged the standards in [easy-to-follow instructions](#) for providers and community-based organizations.



Minnesota addressed vaccine access inequities through investment in equity data infrastructure to better prioritize resources. The state created the [Minnesota Electronic Health Record COVID Consortium](#), comprised of health system partners to aggregate data from their electronic health records to paint a picture of COVID-19-related statistics statewide. Those data provided 93.4 percent of race/ethnicity and 98.9 percent of geographical data on vaccination uptake, along with data on infections and hospitalizations, and were broken down by race, ethnicity, need for interpreter services, and other variables. The state created a Vaccine Equity Metric by combining immunization uptake data with CDC's [Social Vulnerability Index](#) (SVI), a tool to prioritize the most disadvantaged communities in emergency response planning, to guide the vaccine equity strategy. [A sample report](#) shows the analysis of combined SVI and demographic data. Implementation relied on partnerships with [COVID community coordinators, diverse media vendors, and community-based organizations](#), as well as Medicaid managed care plans to prioritize outreach to identified communities. Through this approach, [managed care partners reported](#) a greater percentage of outreach to their eligible members living in the most disadvantaged areas (SVI quartile 1).



Tennessee is developing an Interstate Hospital Discharge Data Exchange Project to better describe the health needs of Tennessee's rural populations and inform interstate exchange of services. The project was developed to address gaps in the state's discharge data, recognizing that many patients living near the border of Tennessee and another state have the option to go to a hospital that is in either state. When patients opt to get care outside Tennessee, the Tennessee hospital discharge dataset is incomplete. Tennessee intends to use this information to help identify and alleviate health inequities, especially for rural populations, which are disproportionally impacted by this data gap, by improving public health programming, locating areas of disease prevalence, and determining community needs accurately. This is a collaboration between Tennessee's Office of Healthcare Statistics, along with Connecticut, Georgia, Kentucky, New Hampshire, North Carolina, Mississippi, South Carolina, and Virginia to exchange [hospital discharge data](#) for patients from 2011 to 2020. The exchange began for some states in January 2023 and will be used to gather data for Tennessee residents who sought medical treatment at out-of-state hospitals and provide data about the reciprocal states' residents who were treated in Tennessee.



North Dakota's Community Engagement (CE) Unit Strategic Plan seeks to "improve data collecting and tracking processes for health equity initiatives" by December 31, 2023.⁶ To achieve this, the state is collecting data to identify population and demographic needs, redesigning survey questions so they are health equity-based, and partnering with the health department's

statistics and performance team to help implement these changes.⁷ The plan includes steps to integrate community-based feedback on collected data.⁸ North Dakota will be able to better work with communities to ensure that their health needs are accurately identified and addressed.⁹



South Carolina's Department of Health and Environmental Control (DHEC) established an Office of Diversity, Equity, and Inclusion (DEI) under the authority of the director of public health, with a focus on strengthening partnerships and increasing awareness of community-driven work to eliminate health disparities. A key pillar of that effort is to improve actionable, community-level public health data, including through the state's [Live Healthy South Carolina](#) dashboard and [current tracking of disparities in health outcomes data](#). The dashboard provides county-level health data to promote a healthy life for all in South Carolina. The agency also initiated [Community Data Walks](#) as an interactive approach for communities to discuss local-level data reflecting gaps in health through a health equity lens.

Social Drivers of Health and Health Disparities: Using Data to Capture the Intersect and Inform Policy

Disparities in health outcomes are largely attributable to differences in conditions in which people live, play, work, and worship, otherwise known as the social drivers of health (SDOH).¹⁰ As data availability and analyses mature, states are determining the intersect among SDOH, demographic, and geographic data and developing more specific intervention approaches based on disaggregated data. Data quality and data-sharing issues are challenging, but state SDOH policy priorities are helping accelerate cross-sector data sharing, adoption of technologies that foster information exchange, and best practices that facilitate exchange while preserving privacy.

To better identify and address health disparities, states are collecting SDOH data through a variety of sources, including community health needs assessments and community health improvement plans, managed care organization assessment tools, health care provider screening tools, social service provider assessment tools, and others.

Innovations in state Medicaid programs provide a good signal for state health policy direction and related data strategy needs. A recent scan of state Medicaid programs shows that 35 (of 47 reporting) states are including disparity initiatives in their Medicaid programs and 32 states are including specific health disparities outcome metrics. Of the 47 reporting states, 35 states have incorporated SDOH requirements into their Medicaid managed care (MCO) contracts,¹¹ and several have moved to enhanced reporting using SDOH metrics in predictive analytics.¹² Additionally, numerous states

“People want to see themselves in data.”

(AK State Official)

across the country (including Arizona, California, Colorado, Hawaii, Kentucky, Louisiana, Minnesota, Nevada, Ohio, Oregon, Tennessee, Virginia, Washington, West Virginia, and Wisconsin) are integrating strategies to [address health disparities in MCO contracts](#) — either directly through incentives or through training, hiring practices, and reporting.¹³ Some states are specifically requiring MCOs to achieve the [NCQA Health Equity Accreditation](#), a new measurement framework for Medicaid.

Relatedly, SDOH approaches rely on timely information exchange among health and social sectors. State health information exchanges and closed-loop referral platforms to drive whole-person care approaches are proliferating to meet this challenge (for example, in [Arizona](#)). A full analysis of these technological advances is beyond the scope of this resource, but they are pivotal in connecting socioeconomically disadvantaged people to needed services and supports and foster collaboration among systems to sustain whole-person care approaches.

State examples highlight different SDOH and equity data approaches. [See also the [Profiles of Pioneering Models](#) section for detailed state examples.]



Iowa's Department of Health and Human Services developed the [Social Determinants of Health \(SDOH\) Dashboard](#) in 2021. Thirteen measures embedded in the annual Medicaid Health Risk Assessment are used to gather the self-identified needs of Medicaid members. Access to transportation, material needs, stress, oral health care, and health confidence are among the list of measures. Data are disaggregated by race, age, gender, and county of residence. As a sample use case, these survey data were used to identify gaps in education about the state's extensive dental benefit, providing outreach to members on its availability and eliminating misunderstandings.



Arizona Health Care Cost Containment System (AHCCCS) revamped its [AHCCCS Health Equity Committee](#), which is tasked with understanding health disparities and developing strategies to ensure health equity for all AHCCCS (Medicaid) members. The committee's scope is identifying health disparities within AHCCCS eligible and AHCCCS members through utilization and quality improvement data. In addition, AHCCCS addresses SDOH through its [Complete Care initiative](#), [Targeted Investments \(TI\) Program](#), and [American Indian Health Program](#). The state's [Medicaid 1115 demonstration waiver application was approved](#) in October 2022 and includes a variety of approaches to addressing SDOH and intersecting health disparities. As part of the renewal request, Arizona included a Targeted Investments 2.0 (TI 2.0) proposal and a housing and health opportunities (H2O) approach. Targeted Investments incentivizes providers to integrate physical and behavioral health. TI 2.0 extends the provider incentive funding to further integration efforts, including a range of initiatives aimed at addressing SDOH. The [TI 2.0 initiative](#)

builds on years of state investment in addressing homelessness and housing instability — as a priority SDOH intervention — by strengthening outreach to vulnerable Medicaid members, enhancing access to services that support a member’s success in housing (tenancy supports), and reimbursing for transitional housing approaches.



Ohio has developed the [InnovateOhio Platform](#), which combines data systems, allows data sharing, and creates “a common and standard digital platform promoting mobility and accessibility for the benefit of state agencies and programs” under [executive order](#) by the governor.

A key priority is [BroadbandOhio](#), which works to address [disparities related to internet access](#) across the state. In addition to improving digital literacy and economic participation, expanding broadband is also cited as [necessary to increasing access to telehealth services](#), especially for patients living in rural areas. [DataOhio](#), one of many [initiatives](#) advanced through this platform, provides publicly accessible [datasets](#) to help [inform policymaking across the state](#). Implementation and evaluation thereof requires both state and local-level data collection.



The [Connecticut Housing Engagement and Support Services](#) (CHESS) program combines Medicaid health coverage with a range of housing services for people experiencing homelessness and chronic health issues. Beacon Health Options, the state’s contracted Administrative Services

Organization for behavioral health, developed an algorithm to determine need and eligibility using Medicaid and the Homeless Management Information System. Several iterations of the algorithm revealed a strategy to reduce race and ethnicity bias and improve equitable access. Improvements were linked to the addition of the number of lifetime days spent in shelter to a diagnosis-based comorbidity index that predicts those most likely to become seriously ill or die in the coming year.



Tennessee leveraged its 2021 re-procurement process for Medicaid Managed Care partners to advance data-driven community investment. As part of this application process, MCOs were required to submit a data-informed

plan outlining how they would use funds to reinvest in the communities they serve. TennCare’s Medicaid contract includes requirements for Medicaid Managed Care partners to demonstrate how they address SDOH using data-driven methods. Medicaid Managed care partners are also required to be [NCQA health equity accredited](#) to promote use of data in addressing social needs among TennCare populations.

“The more we can have community at the table, we are going to have better outcomes.”

(TN State Official)



Partnerships to Address Health Disparities

Successful approaches to address health disparities rely on state agency collaboration and partnership with communities to identify and align resources and efforts toward common goals. Providing state agencies the tools they need to effectively engage their communities is a critical aspect of this goal. In the state of Washington, the Department of Health published a [Community Engagement Guide](#) that lays out expectations for agencies but also provides them with the tools and resources to adhere to those expectations; this can be a good model for states seeking to provide such a resource to their agencies. The second phase of Louisiana's comprehensive initiative includes the creation of equitable community engagement practices (see state example below for more detail).¹⁴

States either forged or revitalized partnerships with credible messengers in communities during the COVID-19 pandemic to identify and act on community-specific needs. For example, Alaska health officials [partnered with fishing captains](#) to deliver

“Moving at the speed of trust.”

(AK State Official)

information and connect their communities to resources. The Tennessee Health Disparity Task Force of 800 community partners worked together to address health disparities by disseminating information, linking people to requested resources, and building trust, in part through storytelling and exchange of personal narratives.¹⁵ Washington, DC partnered with faith-based community leaders and faith institutions and community-based organizations such as a [Faith in Vaccine initiative](#), where places of worship hosted vaccine clinics.¹⁶ Michigan's [Health Equity Roadmap](#) incorporates community member voices otherwise not captured in quantitative approaches into its analysis of routine standardized measures of a variety of health data.

Below are various state examples of population-based initiatives and community-based partnerships designed to address health disparities.



Louisiana developed a [Health Equity Roadmap](#) to integrate health equity throughout the Louisiana Department of Health's (LDH's) practices and to address inequities exacerbated by the pandemic. The roadmap was spearheaded by the [Bureau of Community Partnerships and Health Equity](#) and created internal and cross-agency accountability by establishing health equity action teams and health equity ambassadors in program offices. The first iteration of the roadmap provided a community engagement framework describing suggested action steps for building community partnerships between LDH and community-based organizations. The action steps included exploring partnerships with the Louisiana Community Health Outreach Network, developing public health internships for local university students, and reviewing data and needs assessments.

The second phase of the roadmap continued to emphasize community engagement principles. The action steps for this phase included creating a Review, Advise, and Inform Board comprised of community members from diverse demographics to provide feedback to LDH, working with a newly appointed community engagement officer to develop a Community Engagement Toolkit as part of LDH's business plan, and assessing data and information-sharing efforts.



Utah's Office of Health Equity (OHE) identified people from racial and ethnic minority communities who experienced higher rates of COVID-19 cases, hospitalizations, and deaths and therefore may benefit from enhanced supports and resources. OHE partnered with community health workers employed by community-based organizations and local health departments to gather qualitative information about barriers community members were facing. Those partnerships were also leveraged to provide low-barrier testing, access to vaccines, and screening and referrals for SDOH. With new funding from CDC, this program will be expanded statewide through partnerships with 21 community-based organizations and the 13 local health districts.¹⁷ Utah's COVID-19 response also used the states' existing

[Health Improvement Index](#), a composite measure of SDOH by geographic area, to identify priority and higher-risk populations as part of its vaccination distribution process.¹⁸



Alaska addresses health inequities through a community-based lens with direct partner and shareholder input. This is reflected in Alaska's State Health Improvement Plan, [Healthy Alaskans 2030](#), and the [Healthy and Equitable Communities](#) Strategic Plan, which were developed in collaboration with the [Alaska Native Tribal Health Consortium](#) to directly incorporate Tribal communities' perspectives. In addition to these strategic plans, state officials built strong and trusting relationships with community leaders of geographically isolated fishing communities to partner on addressing community pandemic response needs. Beyond geographic isolation, the Alaska's [Health Equity Index](#) visualizes demographic data across the state to further illustrate and shape policy around the social determinants that are affecting vulnerable populations.



Maryland's Health Equity Resource Act provides \$45 million in grants over three years to evidence-based, community-led efforts in designated underserved communities that experience disparities and/or poor health outcomes. In addition, the RELIEF Act (SB496) provided \$14 million for the grant program, which provides two years of initial funding to assist applicants in becoming a Health Equity Resource Community (HERC), also known as Pathways to Health Equity. Grantees are expected to implement programs that reduce health disparities, improve health outcomes, improve access to primary care, promote primary and secondary prevention services, and/or reduce health care costs and hospital admissions and readmissions. HERC/Pathways are both issued by the Maryland [Community Health Resources Commission](#) (CHRC), which is an independent commission within the Maryland Department of Health created to expand access to health care services in underserved communities. The Office of Minority Health and Health Disparities provides technical assistance to the CHRC in implementing the programs.



In 2021, the **District of Columbia's Office of Health Equity** (OHE) held its first Health Equity Summit for the District after engaging residents in planning efforts called "Community Conversations," open dialogues designed for communities to share their concerns and perspectives on health and SDOH. Three of the [Health Equity Summit's six recommendations](#) for the District promote community engagement: sustain a whole-of-community response, prioritize community-engaged practices to include investments in community listening and valuing lived experience, and anchor equity efforts in collaborative, multi-sectoral action in government and community.

Other key OHE initiatives include:

- The OHE's [Healing Futures Fellowship](#) program, a capacity-building and public health approach to address injury and violence prevention.
- DC's partnership with [Howard University](#), a local Historically Black College and University, to establish the Five Centers of Excellence, which will provide care and services tailored to the specific needs of the community and will focus on sickle cell disease, women's health, oral health, trauma and violence prevention, and substance use and co-occurring disorders.
- Supporting Howard University in a new hospital construction with a \$225 million 20-year tax abatement, \$25 million in infrastructure support, and \$26.6 million to support the Five Centers of Excellence.



North Dakota leveraged CDC funding to rapidly develop a robust [Community Engagement Unit](#) by implementing its strategic plan, [Addressing COVID-19 in Special Populations](#), to eradicate pandemic inequities and expanding department staffing to hire four Tribal health liaisons who build trusting relationships with Tribal communities across the state. The Community Engagement Unit was also able to hire for positions such as community engagement specialist, community engagement training coordinator, community engagement immunization coordinator, and a community liaison for underserved groups such as rural, new American, foreign-born, and immigrant populations. These positions, along with efforts focused in the COVID-19 strategic plan, place emphasis on working directly with communities through advisory boards, community-based organizations, education, and a multitude of other efforts.



New Mexico provided two years of funding to the County and Tribal [Health Councils](#) using [CDC COVID-19 Disparity grant](#) dollars. The state and Tribal Health Councils collaboratively developed the [Community Rebuilding Initiative](#) with a focus on capacity building so health councils can foster healthy communities. Year one provided support for vaccination activities in rural, Tribal, and higher-risk populations. Year two will focus on community rebuilding and equity. Program activities include establishing health equity committees, assessing internal capacity, creating action plans, data collection and community input, developing goals, and cultivating partnerships.



Shifting the Health Disparities Paradigm

States are shifting the health disparities paradigm from the more narrow focus on chronic condition interventions to cross-agency/cross-sector approaches to identifying and addressing health disparities. Many are changing how government and state partners do business.¹⁹ Transformative strategies fold in leadership; data strategy; financing and funding approaches; community collaborations aimed at planning, implementing, and evaluating community-level solutions; and communications strategies. Transformation at the agency or whole government level can also include establishing organizational policies that address health disparities, systemic and shared accountability, designing culturally appropriate health care, and diversifying decision-makers.

Leadership and vision are key to driving reforms. Transformative strategies evoke change, and leadership can communicate the vision for the change in strategy, mobilize resources, establish a governmental culture shift, and support communication and resource alignment across agencies and with private partners. Leadership support at the community level also plays a key role in transforming state health

disparities strategies, which ties to community interest and capacity. Internally, state health disparities strategies are being promoted through state agency hiring, training, promotion, and policy-making practices. Some states are emphasizing recruiting a workforce that reflects the communities being served²⁰ and offering current staff opportunities to evaluate practices to recalibrate and implement new policies that promote equity.²¹ Policy approaches and strategic planning initiatives are driving cross-agency collaboration with dual purposes of addressing health disparities and changing state agency culture. This is reflected in internal and external-facing reforms such as agency staff implicit bias trainings, developing health disparities/health equity advisory positions and groups, and reprioritizing direct community outreach.²²

The linchpin for community engagement is successful communication, and some states are reconsidering their messaging, outreach, and funding approaches, tailoring them to reflect more inclusive social narratives.²³ Establishing a glossary of terms or a lexicon ensures a shared understanding of terminology.²⁴ This can help build and strengthen trusting relationships between communities and state officials and can be accomplished, in part, by using language that is relevant and accessible to the intended audience.²⁵

Below are examples of multi-pronged state approaches that knit together leadership, vision, communication strategies, and complementary internal and external reforms.



In **Minnesota**, leadership and common vision have been key drivers in the Minnesota Department of Health's (MDH) successful transition to an equity lens throughout the entire state. In 2013, the Minnesota legislature directed MDH and its partners to complete and submit a [report on](#)

[advancing health equity in the state](#), and in 2022 the MDH commissioner championed the creation of, and funding for, the [new Health Equity Bureau](#), which now houses the department's [Center for Health Equity](#). With input from MDH's [Health Equity Advisory and Leadership \(HEAL\) Council](#) and [Internal Health Equity Advisory & Leadership Team Hub](#) (I-HEALTH), the bureau functions as a network hub of information, technical assistance and training, resources, and leadership across all MDH and the state enterprise. The Center for Health Equity works closely to support local public health through the [Health Equity Networks](#) and with priority populations to improve access to vaccination, testing, masks, and information through community engagement and contracts and grants to community-based organizations. The state has also worked to expand inclusive messaging and communication during the COVID-19 pandemic by partnering with [diverse media contractors](#) to create [COVID-19 health resources](#). As a result, information and messaging regarding COVID-19 was developed in direct collaboration with community members and disseminated through local and culturally based news outlets to build trust and provide health information that is "[culturally relevant, linguistically appropriate, and accurate](#)."



Indiana Governor Eric Holcomb delivered an address in which he committed to concrete actions to improve equity in the state, including creating a new cabinet-level position of chief equity, inclusion, and opportunity officer, in response to disparities in COVID-19-related deaths and the killings of unarmed Black men and women. The inaugural chief equity, inclusion, and opportunity officer set six strategic pillars, including addressing K–12 literacy rates and post-pandemic learning loss of historically underrepresented students; supporting entrepreneurship and access to capital for diverse businesses; using equity-focused, data-driven, and evidence-based methods to improve quality of life outcomes for historically underrepresented populations; and creating a pathway to sustainability of the office beyond the Holcomb administration. Additionally, to assist statewide diversity, equity, and inclusion (DEI) officers with their efforts, the chief equity, inclusion, and opportunity officer has since developed a [Diversity, Equity and Inclusion Strategic Communications Toolkit](#) to guide DEI leaders across all state agencies. The toolkit outlines several priorities, including:

- Creating a common definition of diversity, equity, and inclusion.
- A commitment to meeting everyone where they are, centering civility, respect, and empathy in discussions, and using inclusive language.
- Securing leadership buy-in of DEI goals by supplementing data with qualitative information from the community.
- Creating a formal advisory council from a coalition of supporters across the state in the business, nonprofit, education, and faith communities to ground the state's work in the needs of the community and inform legislative proposals.



Ohio Governor Mike DeWine created the [Minority Health Strike Force](#) in 2020, in response to the significant health inequities exposed by the COVID-19 pandemic, and provided a [plan of action](#). Through the strike force, Ohio leveraged community feedback from virtual community forums, town hall meetings, and a community needs assessment performed by the Ohio State University College of Public Health, pairing equity goals (better health outcomes for communities of color) with equity-based processes aimed to transform the health system. Using data and population health measurements, the strike force highlighted gaps in the current system to identify need, then linked that need to a [vision of the future](#) and 34 recommended actionable steps broken down into five areas. Efforts also included a commitment to the state and local government hiring a workforce that represents the state's demographics, as communities of color are underrepresented in many key areas.



Wisconsin's [Climate and Health Program](#), housed within the Department of Health Services, has created resources to address the effects of [rising heat](#) and other extreme weather events through a health disparities-based lens. Governor Tony Evers also [announced the development of the Wisconsin Environmental Equity Tool](#) in October 2021. Four state agencies, including the [Department of Health Services](#), [Department of Administration](#), [Wisconsin Economic Development Corporation](#), and [Department of Natural Resources](#), are collaborating on this project. Drawing from resources created by California, Maryland, and Washington state, the [Wisconsin Environmental Equity Tool](#) will serve to visualize health, environmental, climate change, and socioeconomic data to “[assess environmental and public health needs statewide](#)” through an accessible online platform. While this resource is still in development, project leaders regularly meet with community members to best tailor the resource to address health and environmental inequities.

Profiles of Pioneering Models

Several states are viewed as pioneers in transforming state systems to reduce or eliminate health disparities. Approaches vary, but all hinge on leveraging financing, incentivizing new payment and delivery approaches, and prioritizing community-identified needs. Detailed case examples of four states — Rhode Island, North Carolina, Oregon, and Washington — are provided below. These examples represent often decades-long capacity building, cross-sector engagement, and state-community infrastructure-building approaches. States interested in comprehensive health disparities transformation may consider these approaches, where deep policy work also reflects lessons learned and opportunities for future learning through continuous quality improvement.

Rhode Island

Recognizing a pattern of inadequate investment in upstream interventions and barriers to community engagement and reducing health inequities, the Rhode Island Department of Health (RIDOH) created the [Health Equity Zone](#) (HEZ) initiative in 2015. HEZs are equity-centered, place-based, community-led platforms to address the SDOH. Each Health Equity Zone is led by a collaborative that represents the diversity of the community and is tasked with conducting a needs and assets assessment and developing and implementing an action plan to address the root causes of health inequity in that community. The model engages residents in efforts to eliminate poverty and repair injustices in education, health, criminal justice, and transportation systems.

Traditional public health funding mechanisms are siloed and targeted for specific programs, with each source accompanied by its own often conflicting or duplicating requirements. RIDOH determined that for HEZs to be successful and not limited

by funding sources, the state needed to take on the responsibility of identifying and braiding funding to support specific HEZ initiatives.²⁶ Braided funds come from federal, state, and philanthropic foundation grants and are allocated based on need, eligibility, appropriateness, and competitiveness of the application. RIDOH ensures that HEZs have adequate funds for infrastructure and start-up costs, as well as project-based funding, and assists HEZs with securing external funding to support long-term sustainability. RIDOH also provides support in the form of training and technical assistance to ensure implementation is in line with core public health principles.²⁷

To measure outcomes, RIDOH uses the [Rhode Island Health Equity Measures](#), which include measures relating to integrated health care, community resilience and engagement, physical environment, socioeconomic, and community trauma. In the first four years of the HEZ initiative, [reported outcomes include](#):

- 44 percent decrease in childhood lead poisoning
- 24 percent decrease in teen pregnancy
- 13 percent decrease in feelings of loneliness
- 5–7 percent decrease in body weight
- 40 percent increase in redemption of SNAP farmers market incentives
- 36 percent increase in access to fruits and vegetables
- 163 percent increase in community engagement

HEZs, which by their nature were embedded in the community, were poised to quickly respond to critical needs relating to the COVID-19 pandemic, beginning in 2020.²⁸

HEZs became essential resources for providing information, offering testing and vaccines, and connecting individuals to services and supports. HEZs received CARES Act funding to support these efforts in June 2020. Similarly, as Rhode Island began thinking about recovery and allocating [State and Local Fiscal Recovery Funds \(Rhode Island was allocated \\$1.2 billion\)](#), RIDOH prioritized recovery with an equity, choice, and community-engagement focus. Rhode Island officials mapped the various American Rescue Plan funding streams and associated requirements to determine how funds could be allocated and braided to match state recovery planning objectives. RIDOH initiatives prioritize behavioral health, early childhood initiatives, housing, and support to small business.

Rhode Island is currently charting a path forward for expanding the impact of place-based strategies and sustaining HEZs long term. The state plans to phase in [community participatory budgeting](#), a democratic process in which facilitators assist members of the community in identifying community priorities and resource allocation. [Participatory budgeting](#) engages community members upstream to develop, vote

on, and implement a public budget that includes prioritizing community needs. [This approach is used by 600 state and local governments](#) across the country and promotes individual civic engagement through decision-making for how public funds are budgeted. This is a critical piece of [Rhode Island's efforts](#) to provide community members with decision-making power over resources supporting community-identified needs and health improvement efforts.

North Carolina

In 2015, North Carolina's legislature passed Session Law 2015-245 (with amendments in 2016 and 2018) to implement managed care in the Medicaid program. The North Carolina Department of Health and Human Services (NCDHHS) embarked on an extensive "stakeholder feedback process" that informed their approach, including the importance of addressing SDOH.

As NCDHHS embarked on the major transformation of the Medicaid program, it identified four initial priority domains of SDOH that underpin their approach: food, housing, transportation, and interpersonal safety and toxic stress. Through a wide-ranging set of initiatives, including a [Section 1115 Demonstration Waiver](#) approved in 2018 by CMS, NCDHHS created a statewide framework and infrastructure to address SDOH for North Carolinians most in need of support. North Carolina's approach emphasizes the innovation already happening in the private sector and provides the infrastructure and support necessary to build on those innovations. Specific activities and initiatives include:

- An [interactive map](#) includes demographic and SDOH indicators by local health department regions.
- While screening for unmet health-related social needs are not required, NCDHHS developed [standardized screening questions](#) that providers may use.
- [NCCARE360, a statewide resource platform](#), connects individuals with identified needs to community resources and tracks and monitors referrals.
- [Healthy Opportunity Pilots](#) evaluate providing non-medical evidence-based interventions to Medicaid enrollees in need of services related to SDOH. The program includes up to \$650 million over five years for three regions of the state; \$100 million of that can be used for capacity building. NCDHHS expects to serve approximately 25,000 to 50,000 beneficiaries through the pilots.
- Community input to inform recommendations to build an infrastructure to support [community health workers](#), including through a standardized curriculum and certification process. In addition, NCDHHS has partnered with the University of North Carolina School of Social Work to implement course development and certification for peer support specialists.

To learn more about North Carolina Healthy Opportunities, please visit the [NCDHHS website](#).

Oregon

The Oregon Health Authority (OHA) has a singular bold goal: to eliminate health inequities in Oregon by 2030. To achieve this goal, OHA first set out to develop a common language and define what health equity means for the state.

OHA's Health Equity Definition

“Oregon will establish a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address the equitable distribution or redistribution of resources and power; and recognizing, reconciling and rectifying historical and contemporary injustices.”

OHA's [Equity and Inclusion Division](#) works “with diverse communities to eliminate health gaps and promote optimal health in Oregon.” OHA identified that its success depended on trusting relationships with community members and community-based organizations (CBOs), not just to define health equity for the state but also to reach the goal of eliminating health inequities. Therefore, OHA prioritizes authentic inclusion of community voices in the policymaking process. The division is guided by the Community Advisory Council and collaborates with the Health Equity Committee. The Health Equity Committee was established in 2017 by the Oregon Health Policy Board (OHPB) to develop policy that proactively promotes health equity. Members include representatives from CBOs, federal qualified health centers, universities, coordinated care organizations, hospital and health systems, Tribes, and members of the community. OHA and the division support 10 [Regional Health Equity Coalitions](#), which are autonomous, community-led groups that build on the strengths of local communities to increase health equity for underserved and underrepresented populations. In addition, in April 2022 OHA [launched a new program to fund CBOs to address local priorities and meet health equity goals](#). Between April and June 2022, OHA awarded \$31 million to 147 CBOs.

OHA also operates the Medicaid program and identified the state's accountable care organizations (coordinated care organizations, or CCOs, in Oregon) as an important locus of action. CCOs were originally implemented in Oregon in 2012 to integrate physical, behavioral health, and other types of care and to provide flexibility to support

new patient-centered models of care and reduce health disparities. Partnerships between CCOs and CBOs have been central to the initiative since the beginning. In January 2020, Oregon launched a second phase of its CCO program, CCO 2.0, with the [goal of improving the behavioral health system](#), increasing value, addressing SDOH and health equity, and maintaining sustainable cost growth.

In 2017, Oregon's governor and legislature asked the OHPB to build on its initial work by identifying specific policy changes that would increase CCO focus (and spending) on addressing health equity and SDOH in their communities. [Policy changes that emerged from this process](#) included embedding requirements that fostered CCO-CBO partnerships in the CCO selection process and 2020 CCO contract, as well as modifying CCO planning and state oversight activities. The contract now indicates that the CCO's community advisory council (CAC) must play a role in directing the CCO's investments in social determinants of health and equity and in the CCO's community benefit initiatives.

In 2018, the legislature also passed [HB 4018](#), which requires CCOs to spend a portion of their previous year's net income or reserves on services to address health disparities and SDOH in line with the CCO's community health improvement plan, beginning in 2021. The OHPB [recommended specific policies](#) to guide the implementation of HB 4018, including requiring the CACs to have a role in spending, requiring alignment with a statewide housing priority, and requiring a portion of the funding go directly to SDOH and equity partners through a formal agreement. Oregon renamed this legislative requirement the [Supporting Health for All through REinvestment \(SHARE\) Initiative](#).

In September 2022, CMS approved [amendments](#) that further Oregon's goals, including expanded continuous eligibility for children and coverage of targeted clinically appropriate health-related social needs.

For additional details, please see OHA's [legislation](#), [administrative rules](#), [contractor selection process](#), and contracts.

Washington

Washington Governor Jay Inslee and the state legislature initiated a whole-of-government approach to equity beginning in April 2020 when they partnered to create the [Washington State Office of Equity](#). The Office of Equity promotes access to equitable opportunities, supports state agencies, partners with internal and external partners to develop a strategic plan and outcome measures, and reports on the effectiveness of programs in reducing disparities. In December 2020, Inslee [committed to actions to support Washington becoming an anti-racist state](#). The Office of Health Equity worked with thousands of community members, state employees, and other

partners to inform the [first five-year Washington State Pro-Equity Anti-Racism \(PEAR\) Plan & Playbook](#). The PEAR Plan & Playbook created a unified vision for the whole of government, goals for the state, and a step-by-step playbook for implementing PEAR. It also established the PEAR Equity Impact Review framework to inform any proposed changes to policy, programs, or practices.

Washington state identified 15 [determinants of equity](#) that guide the Office of Equity's goals and expected outcomes:

1. Affordable, healthy, local food
2. Access to health and human services
3. Access to parks, recreation, and natural resources
4. Transportation and mobility
5. Housing and home ownership
6. Community and public safety
7. Early childhood development
8. Economic justice
9. Equity in state and local practices
10. Equity in justice systems and laws
11. Equity in jobs and job training
12. Healthy built and natural environments
13. Quality education
14. Strong, vibrant neighborhoods
15. Digital equity

In March 2022, Gov. Inslee signed [Executive Order 22-04](#), which directs the Office of Equity to communicate the PEAR Plan & Playbook to all state agencies, support state agencies in developing and implementing their own PEAR plans, and hold agencies accountable to and publicly report on performance measures. Through the same executive order, state agencies were charged with developing, implementing, and reporting on agency-specific PEAR Strategic Action Plans; establishing a [PEAR team](#); and partnering with those affected by the agencies' programs and policies to complete a [PEAR Equity Impact Review](#).

The Washington State Health Care Authority (HCA) submitted its [PEAR Strategic Action Plan](#) in 2022. It established four service lines: leadership operations and services, data strategy and reporting, engagement and community partnerships, and HCA workforce equity. In addition, HCA established a PEAR team representing each division across the agency, a PEAR Community Advisory Team, and PEAR workstream teams for each of the four service lines. The Washington Department of Health (DOH) defines health equity as “when all people have the opportunity to achieve their full health potential” and recognizes that not everyone in the state currently has that opportunity. The DOH embedded equity as a cornerstone value for the department and central to its vision and actions in its August 2022 [Transformational Plan](#).

“Leadership buy-in is truly needed, or equity practices are futile.”

(ND State Official)

Appendices

Appendix A. Glossary of Terms

Braided Funding: Weaving together funding from multiple sources to support a single initiative in a way that each funding source remains distinguishable. Source: [Centers for Disease Control and Prevention \(CDC\)](#)

Health: Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Source: [World Health Organization](#)

Health Equity: Attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes. Source: [Centers for Medicare & Medicaid Services](#)

Health Disparities: Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Source: [Centers for Disease Control and Prevention](#)

Population Health: The health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but they can also be other groups such as employees, ethnic groups, people with disabilities, prisoners, or any other defined group. Source: [Institute for Healthcare Improvement](#)

Public Health: The science of protecting and improving the health of people and their communities. This work is achieved by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing, and responding to infectious diseases. Source: [CDC Foundation](#)

Social Drivers of Health: Drivers that begin upstream with structural discrimination which results in differences in social determinants of health (SDOH), health-related social needs (HRSN), access to care, and, finally, differential quality of care within the health care system [Source: Office of the Assistant Secretary for Planning and Evaluation](#)

Unmet Needs: Delay or nonreceipt of needed medical care, nonreceipt of needed prescription drugs, or nonreceipt of needed dental care during the past 12 months due to cost. Source: [Centers for Disease Control and Prevention](#)

Appendix B. Compliance — Collecting Race and Ethnicity Data*

Compliance (NOTE: THIS SECTION IS DESCRIPTIVE AND NOT INTENDED TO SERVE AS LEGAL ADVICE)

There is growing consensus that accurate and complete collection of race and ethnicity data is a key element to addressing health equity.²⁹ State health policy leaders may consider regulation a barrier to collecting race and ethnicity data in their health equity program development.

Common Misperceptions about Race and Ethnicity Data Collection

There is a common misperception that federal civil rights law prevents states from collecting race and ethnicity data. Title VI of the Civil Rights Act of 1964 (Civil Rights Act) bars discrimination against protected classes in any programs receiving federal funds.³⁰ For several decades, legal scholars have agreed that the Civil Rights Act does not prohibit the collection of data on race and ethnicity. In 2006, the George Washington University School of Public Health stated that the Civil Rights Act “creates no legal liability for health care providers who collect and report health care quality data by race and ethnicity, when such an effort is undertaken as part of an overall program of quality improvement and not as a subterfuge for impermissible purpose under the law.”³¹

The Patient Protection and Affordable Care Act of 2010 (ACA) also prohibits discrimination against protected persons in health care.³² Further, the ACA strengthens federal data collection by requiring the Department of Health and Human Services to collect data to track health disparities under Medicaid, Medicare, and Children’s Health Insurance Programs.³³ Subsequent guidance promulgated under the ACA clarified that data collection is not required in the Medicaid enrollment process and that questions pertaining to race, ethnicity, and language must be clearly identified as optional.³⁴ The ACA’s data collection requirements also do not extend to the private insurance market.³⁵

Data Collection

Many states have specific regulations on the collection of race and ethnicity data. Four states (California, Maryland, New Hampshire, and New Jersey) prohibit the collection of race and ethnicity data on all insurance application forms.³⁶ Five states (Connecticut, Iowa, Minnesota, South Dakota, and Washington) have specified, as part of their prior approval processes for insurance forms, that forms containing any inquiry about the race or ethnicity of an applicant or covered individual will either be disapproved or carefully scrutinized, even though those states do not prohibit the collection of such data.³⁷ Three of those states — Connecticut, Minnesota, and South Dakota — disapprove requests from plans or insurers to collect racial, ethnic, and socioeconomic data. Two of the states — Iowa and Washington — use their prior approval process to scrutinize any request to collect racial, ethnic, and socioeconomic data to prevent harmful uses.

In the above examples, the states' regulations are aimed at preventing discriminatory redlining and are not intended to be a barrier to collecting race and ethnicity data.³⁸ States with these regulations do permit collection of data on race and ethnicity after enrollment.³⁹ These regulations also do not apply in the context of data collection as part of quality improvement in health care.⁴⁰ State leaders may consider working with insurance carriers to collect race and ethnicity data post-enrollment in compliance with state regulations.

In addition, each state has its own laws protecting patient health information. State officials may consult state and federal regulations on collecting health information.⁴¹ To ensure compliance with these regulations, state leaders may consider including the release of race and ethnicity data in their data-sharing agreements.⁴² States can look to the interagency data-sharing agreement set forth between the Centers for Medicare and Medicaid Services, Health Resources and Services Administration, and the Centers for Disease Control and Prevention.⁴³

Data Collection Standards

Across federal and state governments, categories for race and ethnicity lack standardization, making data analysis difficult. Currently, the two prominent federal standards used in health care are the standards set by 1997 Office of Management and Budget (OMB) federal rule⁴⁴ and the 2011 standards by the Department of Health and Human Services (HHS) Office of the Assistance Secretary for Planning and Evaluation.⁴⁵ A comparison of the two standards is outlined below.

	OMB, 1997	HHS, 2011
Race*	White	White
	Black or African American	Black or African American
	American Indian or Alaska Native	American Indian or Alaska Native
	Asian	Asian, Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian
	Native Hawaiian or Other Pacific Islander	Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander
Ethnicity*	Hispanic or Latino	Yes, Mexican, Mexican American, Chicano/a Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino/a, or Spanish origin
	Not Hispanic or Latino	No, not of Hispanic, Latino/a, or Spanish origin

Download data

Note: *OMB 1997 and HHS 2011 permit the reporting of more than one race; HHS 2011 also permits people to select one or more ethnicities.

Data: Cara James et al., “[Federal Action Is Needed to Improve Race and Ethnicity Data in Health Programs](#)” (Grantmakers In Health and National Committee for Quality Assurance, October 2021).

Source: Cara James et al., “Modernizing Race and Ethnicity Data in Our Federal Health Programs,” To the Point (blog), Commonwealth Fund, October 26, 2021. <https://doi.org/10.26099/NZ4R-G375>

While neither standard is considered fully complete, the HHS 2011 standard is considered the gold standard for health care.⁴⁶

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