Overview of Health Care Disparities in Maryland

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Office of Minority Health and Health Disparities
Maryland Department of Health and Mental Hygiene
Office of Minority Health and Health Disparities (MHHD)

- Established in 2004, Health General Article Sect. 20-1001-1007
- Purpose: Be an advocate for the improvement of minority health
- Structure: Located in Office of and reports to the MD Secretary of Health
- Minority: African Americans, Asians, Hispanic/Latinos, Native Americans
Health Disparities - Health Equity

• In Nation
  – Care Quality & Access are Suboptimal
  - Especially for Minority & Low income
  - Quality Improving – Disparities is Not
  - Disparities Race, Ethnicity, SES Present

• In Maryland
  – Maryland is the 6th most diverse state
  – Some progress reducing mortality disparities
  – Large & costly healthcare use disparities remain
Health Equity Model

- Data Collection, Analysis & Reporting
- Outreach & Inclusion of Minority Persons
- Cultural, Linguistic & Health Literacy
- Workforce Diversity
- Attention to Social Determinants of Health
Functions and Results

- Published MD Health Disparities Plan
- Published MD Health Disparities Data
- Convened Eight Statewide Conferences
- Funded 20 Disparities Projects in State
- Partnered - Health Academic Institutions
- Received HHS Minority Grant since 2005
- Assist to Reduce Cancer Disparities 63%
Functions and Results

- Health Care Reform Statewide Planning
- Disparities Presentations
- H1N1 Swine Flu Statewide Outreach
- MD Disparities Workgroup – Dean Reece
- Legislative Review for Impact on Minorities
- Promoting Awareness - Website/Database
- Social Media/Marketing Health Messages
Health Equity 2012

• Implement MD Health Improvement and Disparities Reduction Act of 2012
  - Health Enterprise Zones
  - Reduce Disparities – Collect R/E Data
  - Hospitals Tract Disparities Reduction
  - Provider Increase Cultural Competency
  - Academic Institutions Report Cultural Courses
  - Standards for Analysis of R/E Data
### Maryland Population by Race and Hispanic Ethnicity, 2010 Census

<table>
<thead>
<tr>
<th>Race, regardless of Hispanic Ethnicity:</th>
<th>Maryland</th>
<th>% of MD</th>
<th>Race alone or multiple</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>5,773,552</td>
<td>100.0%</td>
<td>60.4%</td>
</tr>
<tr>
<td><strong>Race, regardless of Hispanic Ethnicity:</strong></td>
<td></td>
<td></td>
<td>30.9%</td>
</tr>
<tr>
<td>White (one race)</td>
<td>3,359,284</td>
<td>58.2%</td>
<td>60.4%</td>
</tr>
<tr>
<td>Black (one race)</td>
<td>1,700,298</td>
<td>29.4%</td>
<td>30.9%</td>
</tr>
<tr>
<td>American Indian (one race)</td>
<td>20,420</td>
<td>0.4%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Asian (one race)</td>
<td>318,853</td>
<td>5.5%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Hawaiian or Pacific Islander (one race)</td>
<td>3,157</td>
<td>0.1%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other race (one race)</td>
<td>206,832</td>
<td>3.6%</td>
<td></td>
</tr>
<tr>
<td>Two or more races</td>
<td>164,708</td>
<td>2.9%</td>
<td></td>
</tr>
<tr>
<td><strong>Hispanic Ethnicity, regardless of Race:</strong></td>
<td>470,632</td>
<td>8.2%</td>
<td></td>
</tr>
</tbody>
</table>


**Maryland Population Data**
Health Disparities Data Themes

• Health Status Disparities:
  – Disease mortality rates
  – Disease frequency (incidence & prevalence)
  – Disease risk factor prevalence
  – Social determinants of health (place matters)

• Health Care Disparities
  – Health insurance rates
  – Health care utilization rates
  – Health care quality metrics
## Selected Racial and Ethnic Health Disparities in Maryland

*(Shows how many times higher the minority rate is compared to the White rate)*

<table>
<thead>
<tr>
<th></th>
<th>Infant mortality</th>
<th>Late prenatal care</th>
<th>End-stage kidney disease</th>
<th>No health Insurance</th>
<th>New HIV case rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or African American</td>
<td>2.8</td>
<td>2.9</td>
<td>3.0</td>
<td>1.9</td>
<td>11.8</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>0.9</td>
<td>1.0</td>
<td>1.3</td>
<td>1.3</td>
<td>0.5</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>2.3</td>
<td>1.0</td>
<td>3.0</td>
<td><em>Not Reported</em></td>
<td>2.2</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>0.8</td>
<td>2.2</td>
<td>1.3</td>
<td>4.4</td>
<td>3.6</td>
</tr>
</tbody>
</table>
Blacks or African Americans experience significant disparities in infant mortality, late prenatal care, end-stage kidney disease, and new cases of HIV, as well as in other areas.

Hispanics or Latinos experience significant disparities related to lack of health insurance, and new cases of HIV, and disparities in late prenatal care, end stage kidney disease, as well as in other areas.

American Indians or Alaska Natives experience disparities in infant mortality, end-stage kidney disease, and new cases of HIV, as well as in other areas.

Asians or Pacific Islanders experience disparities in end-stage kidney disease and lack of health insurance, as well as in other areas.
Age-Adjusted All-Cause Mortality (rate per 100,000) by Black or White Race and by Jurisdiction, Maryland 2004-2006 Pooled

Age-adjusted death rates for Blacks could not be calculated for Garrett County

Source: CDC Wonder Mortality Data 2004-2006
## Mortality Rate Disparities

### Black and White Mortality Rates for Selected Conditions and Geographies

<table>
<thead>
<tr>
<th>Condition</th>
<th>US</th>
<th>MD</th>
<th>Balt City</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Heart Disease</strong></td>
<td><strong>Age-adjusted Mort Rates / 100K population</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black 2005-07 CDC Wonder</td>
<td>258.6</td>
<td>252.3</td>
<td>290.9</td>
</tr>
<tr>
<td>White 2005-07 CDC Wonder</td>
<td>197.4</td>
<td>199.0</td>
<td>267.0</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td><strong>Age-adjusted Mort Rates / 100K population</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black 2005-07 CDC Wonder</td>
<td>218.5</td>
<td>209.7</td>
<td>239.5</td>
</tr>
<tr>
<td>White 2005-07 CDC Wonder</td>
<td>180.0</td>
<td>182.6</td>
<td>210.8</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td><strong>Age-adjusted Mort Rates / 100K population</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black 2005-07 CDC Wonder</td>
<td>44.9</td>
<td>41.1</td>
<td>44.3</td>
</tr>
<tr>
<td>White 2005-07 CDC Wonder</td>
<td>21.4</td>
<td>19.4</td>
<td>26.7</td>
</tr>
<tr>
<td><strong>HIV/AIDS</strong></td>
<td><strong>Age-adjusted Mort Rates / 100K population</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black 2005-07 CDC Wonder</td>
<td>18.4</td>
<td>24.9</td>
<td>59.4</td>
</tr>
<tr>
<td>White 2005-07 CDC Wonder</td>
<td>2.1</td>
<td>1.6</td>
<td>8.1</td>
</tr>
</tbody>
</table>

### Infant Mortality

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Black 2005-07 CDC Wonder</td>
<td>13.5</td>
<td>IMR 2004-06</td>
</tr>
<tr>
<td>White 2005-07 CDC Wonder</td>
<td>5.7</td>
<td>IMR 2008-10</td>
</tr>
</tbody>
</table>
**Disease and Risk Factor Disparities in Maryland**

**End-stage Kidney Disease.** Vs. Whites, new case rate is:
- 3.0 times higher for Blacks and American Indians
- 1.3 times higher for Asians and Hispanics

**Diabetes.** Vs. Non Hispanic Whites, % with dx of diabetes is:
- 2.0 times higher for Blacks

**High Blood Pressure.** Vs. Non-Hispanic Whites, % with a dx of high blood pressure is:
- 1.5 times higher for Blacks

**Obesity.** Vs. Non-Hispanic Whites, % with obesity is:
- 1.5 times higher for Blacks
Most Maryland Uninsured are Racial/Ethnic Minority

Minorities as % of Uninsured
Adults 18+, BRFSS 2010: 465,414 estimated uninsured

All Racial/Ethnic Minorities 63.5%
Black or African American 40.5%

Minorities as % of Uninsured
Adults 18-64, BRFSS 2010: 454,528 estimated uninsured

All Racial/Ethnic Minorities 64.0%
Black or African American 40.7%
Employment-based insurance rates tend to differ by race/ethnicity. Less than half of Hispanics have employment-based coverage, resulting in the highest uninsured rate (40%). The employment-based rate for Blacks (non-Hispanic) is higher, but it lags behind the rates for non-Hispanic Whites and Asians/Others, yielding an uninsured rate for Blacks that is higher than the rate for Whites but not statistically different from the uninsured rate for Asians/Others. Blacks are the most likely to have Medicaid and other public coverage. None of the rates for Whites and Asians/Others are significantly different (the Asian/Other sample is relatively small). The State’s uninsured rates for racial/ethnic groups differ from the national averages (data not shown) for all racial/ethnic groups, with lower rates for Whites (9% versus 13%), Blacks (17% versus 21%), and Asians/Others (12% versus 19%), and a higher rate for Hispanics (40% versus 33%).
Un-insurance by Race/ethnicity

Proportion of Adults without Health Insurance
(at the Time of the Survey), Maryland BRFSS 2006-2010

All minority rates are statistically different
from the Non-Hispanic White Rate

- Non-Hispanic White: 7.2%
- Non-Hispanic Black: 15.0%
- Non-Hispanic Other: 10.1%
- Hispanic: 38.6%
## Physicians by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race or Ethnicity</th>
<th>Physicians reporting some heritage of the specified race or ethnicity</th>
<th>% of physicians reporting some heritage</th>
<th>% of population in the specified race or ethnicity</th>
<th>compared to the % of population, % of physicians is</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009-10</td>
<td>2007</td>
<td>2009-10</td>
<td>2007</td>
</tr>
<tr>
<td>White</td>
<td>9748</td>
<td>9023</td>
<td>60.4%</td>
<td>62.3%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1900</td>
<td>1634</td>
<td>11.8%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>565</td>
<td>469</td>
<td>3.5%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>3349</td>
<td>2822</td>
<td>20.7%</td>
<td>19.5%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>61</td>
<td>61</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>824</td>
<td>747</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Physicians</td>
<td>16,141</td>
<td>14,481</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Preventable Hospital Admissions


• Black vs. White disparities in admissions for conditions where good outpatient care should prevent most admissions (Ambulatory Care Sensitive Conditions or ACSCs):
  – **Asthma:** 2 to 3 times higher depending on age
    • 49% to 67% of Black admissions are excess due to disparity
  – **Diabetes:** 2.4 to 4.6 times higher depending on type
    • 57% to 78% of Black admissions are excess due to disparity
  – **Hypertension:** 4.5 times higher for Blacks
    • 78% of Black admissions are excess due to disparity
### Black vs. White Admission Rate Disparities for Selected Conditions

(AHRQ Prevention Quality Indicators, AKA Ambulatory Care Sensitive Conditions)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Metric</th>
<th>United States</th>
<th>Maryland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina without procedure (age 18+)</td>
<td>Rate ratio</td>
<td>1.81</td>
<td>1.36</td>
</tr>
<tr>
<td></td>
<td>Rate diff / 100K</td>
<td>20.9</td>
<td>17.3</td>
</tr>
<tr>
<td>Congestive Heart Failure (age 18+)</td>
<td>Rate ratio</td>
<td>2.75</td>
<td>2.55</td>
</tr>
<tr>
<td></td>
<td>Rate diff / 100K</td>
<td>610.0</td>
<td>545.4</td>
</tr>
<tr>
<td>Hypertension (age 18+)</td>
<td>Rate ratio</td>
<td>5.33</td>
<td>4.52</td>
</tr>
<tr>
<td></td>
<td>Rate diff / 100K</td>
<td>170.9</td>
<td>156.3</td>
</tr>
<tr>
<td>Diabetes with long-term comp (age 18+)</td>
<td>Rate ratio</td>
<td>3.64</td>
<td>2.86</td>
</tr>
<tr>
<td></td>
<td>Rate diff / 100K</td>
<td>237.1</td>
<td>189.5</td>
</tr>
<tr>
<td>Diabetes, uncontrolled no comp (age 18+)</td>
<td>Rate ratio</td>
<td>5.12</td>
<td>4.63</td>
</tr>
<tr>
<td></td>
<td>Rate diff / 100K</td>
<td>52.30</td>
<td>36.63</td>
</tr>
<tr>
<td>Asthma (age 18+)</td>
<td>Rate ratio</td>
<td>3.36</td>
<td>2.71</td>
</tr>
<tr>
<td></td>
<td>Rate diff / 100K</td>
<td>211.1</td>
<td>197.3</td>
</tr>
</tbody>
</table>

**Source:** [http://statesnapshots.ahrq.gov/snaps10/SnapsController?menuId=47&state=MD&action=disparities&level=80](http://statesnapshots.ahrq.gov/snaps10/SnapsController?menuId=47&state=MD&action=disparities&level=80)
Details on Asthma

Black vs. White Disparity Ratios for Adults with Asthma, Maryland 2006

Source: MARYLAND BRFSS, HSCRC, Vital Statistics Administration
Rates are age adjusted to 2000 U.S. standard population

Source: This figure is Figure 8-5 from the DHMH report Asthma in Maryland 2007
Cost of Disparities

A recent report* found that nationally, health disparities among racial and ethnic minorities accounted for:

$229 billion in direct medical costs for the four-year period 2003 to 2006.

Maryland’s share of this cost of disparities is estimated to be between $1 billion and $2 billion per year.

Analysis of the hospital cost of excess hospital admissions for Blacks in Maryland (compared to White admission rates) has revealed about $0.5 billion of excess cost.

Progress in Disparity Elimination

- Between 2000 and 2009 the gaps between the Black and White age-adjusted death rates (Black rate minus White rate) were reduced as follows:
  - For All-cause Mortality, the gap was reduced by 39%
  - For Cancer Mortality, the gap was reduced by 63%
  - For Heart Disease Mortality, the gap was reduced by 6%
  - For Stroke Mortality, the gap was reduced by 43%
  - For Diabetes Mortality, the gap was reduced by 46%
  - For HIV/AIDS Mortality, the gap was reduced by 46%
## HBE Proposed Certification Policy

### Issuer Requirements

<table>
<thead>
<tr>
<th>Race/Ethnicity/Language/Interpreter/Cultural Competence “RELICC” Data Tracking</th>
<th>Use the MHCC RELICC (eValue8) tool to track and report data so that disparities can be analyzed and addressed in future years. For 2013 and 2014 use MHCC results. For 2015 and beyond report Exchange specific results. Note: Data would be used internally only and not displayed on the consumer portal.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity of Care Procedures</td>
<td>Topic to be addressed by the Continuity of Care Advisory Committee.</td>
</tr>
</tbody>
</table>
How Should Racial, Ethnic and Language Data be Used?

• Direct Quotation from RELICC (eValue8) 1.7.3
• 1: Assess adequacy of language assistance to meet members’ needs
• 2: Calculate HEDIS or other clinical quality performance measures by race, ethnicity, or language
• 3: Calculate CAHPS or other measures of member experience by race, ethnicity, or language
• 4: Identify areas for quality improvement/disease management/health education/promotion
• 5: Share with enrollees to enable them to select concordant clinicians
How Should Racial, Ethnic and Language Data be Used? (2)

- Direct Quotation from RELICC (eValue8) 1.7.3 continued
- 6: Share with provider network to assist them in providing language assistance and culturally competent care
- 7: Set benchmarks (e.g., target goals for reducing measured disparities in preventive or diagnostic care)
- 8: Determine provider performance bonuses and/or contract renewals (e.g., based on evidence of disparity outlier status)
- 9: Analyze disenrollment patterns
- 10: Develop disease management or other outreach programs that are culturally sensitive
Contact Information

Office of Minority Health and Health Disparities
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 500
Baltimore, Maryland 21201

Website: www.dhmh.maryland.gov/mhhd

Health Disparities Plan:

Phone: 410-767-7117
Fax: 410-333-5100

Email: healthdisparities@dhmh.state.md.us