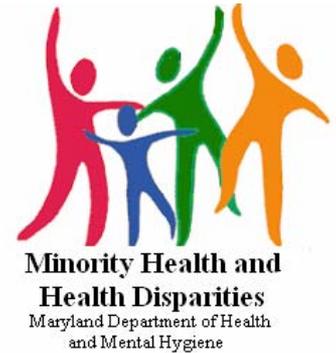




Department of Health and Mental Hygiene



MARYLAND HEALTH QUALITY AND COST COUNCIL

**COUNCIL MEETING
September 5, 2008**

Office of Minority Health and Health Disparities

“QUALITY INITIATIVES”

**Carlessia A. Hussein, RN, DRPH
Director, MHHD**

**David Mann, MD, PhD
Director, Health Data**

DHMH DEPARTMENT ASSESSMENT – SYSTEMS CHANGE

PROBLEM:

- Maryland continues to experience significant minority health disparities
- Minority health disparities generate unnecessary health care costs
- Maryland lacks sufficient focus on measurably reducing health disparities

MAJOR HEALTH DISPARITIES: *(Maryland Highlights)*

- Infant Mortality *(three times higher for Blacks than Whites)*
- Cardiovascular Disease *(accounts for 25% of all mortality disparity)*
- Cancer *(mortality disparity cut in half 2000 to 2005)*
- Chronic Diseases [e.g. asthma, diabetes] *(2 to 3-fold higher Black mortality)*
- HIV / AIDS *(16-fold Black and 5-fold Hispanic incidence)*
- Mental Health *(this is an area of data challenges)*

GOALS:

- Conduct an assessment of the status of each disparity
- Develop and publish a plan of action to increase the pace of reducing disparities
- Implement focused plans that target the reduction of minority health disparities

Minority Health and Health Disparities Initiative

STATUTORY AUTHORITY:

- HB 86 (2004) Maryland Office of Minority Health and Health Disparities
- HB 883 (2003 Health Care Services Disparities Prevention Act)
- HHS, Office of Minority Health five-year Health Disparities Partnership Grant

METHODOLOGY:

- Collaborate with and provide technical assistance to program leadership
- Conduct demonstration Pilot Projects in jurisdictions with high minority disparities
- Publish “Promising Practices for Reducing Health Disparities”

SUCSESSES:

- Established an oversight Task Force of senior level staff
- Held 15 technical assistance meetings with a number of departmental programs
- Conducting three health disparities demonstration projects in the State

CHALLENGES:

- Programs lack awareness of the disparities role in health quality and cost
- Programs lack health disparities data and staff expertise to analyze and interpret
- Programs reluctant to set minority Managing-For-Results Objectives (MFRs)

Minority Health and Health Disparities Initiative

WORKFORCE DIVERSITY AND CULTURAL COMPETENCY

PROBLEM:

- *African Americans, American Indians, Hispanics, and some Asians are underrepresented in the Maryland health workforce. For example, among Maryland non-Federal physicians*
 - 5% are African American (estimated 30% of Maryland population)
 - 2% are Hispanic/Latino Americans (estimated 6% of Maryland population)
 - Almost none are American Indian (estimated 0.4% of Maryland population)
 - 9% are Asian Americans (estimated 5% of Maryland population)
- *Health workforce is not prepared to meet the needs of patients from a variety of cultures*
 - Few health facilities provide training in cultural sensitivity and cultural competence
 - Lack of diversity at top levels throughout the health care system, limits awareness
 - The number of minorities and future users of Maryland health care system is growing

GOALS:

- Improve patient-provider communication when minorities interact with the health care system
- Increase health literacy among patient populations, improving adherence to treatment

STATUTORY AUTHORITY:

- HB 86 (2004) Maryland Office of Minority Health and Health Disparities Act
- HB 883 (2003) Health Care Services Disparities Prevention Act
- HHS, Office of Minority Health five-year Health Disparities Partnership Grant

Minority Health and Health Disparities Initiative

METHODOLOGY:

- Partner with Medical, Dental, Pharmacy & Nursing (B.S.) schools to increase minorities
- Partner with DHMH Health Professions Boards to increase cultural competency training
- Partner with community hospitals to set up cultural competency training programs
- Survey health professionals regarding their awareness/knowledge of cultural competency
- Collaborate with State commissions on higher education (MHEC, MICU) and HBCUs
- Explore collaborations with the Sullivan Alliance and the MD Hospital Association

SUCSESSES:

- Piloting study on health provider's attitudes, perceptions & practices for cultural competency
- Assisting three community hospitals to build cultural competency programs
- Ongoing work with health professions' schools shows progress

CHALLENGES:

- High competitive atmosphere between health profession schools slows partnership building
- Health disparities awareness and partnership building is time intensive and will take years.

Minority Health and Health Disparities Initiative

HEALTH DISPARITIES DATA

PROBLEM:

- Minorities have high disease frequency, low treatment success with high suffering/death
- Health data to examine these differences are not always available and/or adequate

GOALS:

- Improve the availability of data by race and ethnicity
- Produce meaningful analysis to identify disparities, track root causes and monitor progress

STATUTORY AUTHORITY:

- HB 86 (2004) Maryland Office of Minority Health and Health Disparities Act
- HB 883 (2003) Health Care Services Disparities Prevention Act
- HHS, Office of Minority Health five-year Health Disparities Partnership Grant

Minority Health and Health Disparities Initiative

METHODOLOGY:

- Promote development of standard definitions for race and ethnicity
- Promote development of standard methods for collecting race and ethnicity
- Promote standard method for data analysis, e.g. using age-adjustment

SUCSESSES:

- Publication of the Maryland Chartbook of Minority Health and Health Disparities Data
- Publication of periodic Health Disparities Highlights that show trends and progress
- Provision of data assistance to DHMH programs, local health departments and others
- Jurisdiction-specific data is available for selected health disparities and for some groups

CHALLENGES

- Data requirements imposed by federal grants do not lead to consistent reporting
- Race and ethnicity missing in data systems reduces validity in analyses
- Standardization of collection and analysis calls for major systems retooling and resources
- Small groups and small jurisdictions present data stability issues

HEALTH DISPARITIES DATA Example #1: Ambulatory Care Sensitive Conditions Analysis

PROBLEM:

- Minorities have higher utilization of expensive emergency room and hospital admission services, that can be prevented with better outpatient treatment success

RESPONSE:

- Maryland Health Care Commission, with MHHD support, has contracted an analysis of admission rates for ambulatory care sensitive conditions in Maryland (Medicare data).

GOALS:

- Refine the methodology, provide re-usable programming code for additional analyses
- Demonstrate the feasibility and utility of this analytic approach in Maryland
- Identify groups with high rates of potentially preventable hospital admissions

STATUS:

- Conditions analyzed: Diabetes, Chronic Lung Disease, Asthma, Hypertension, Congestive Heart Failure, Dehydration, Bacterial Pneumonia, and Urinary Tract Infection.
- Analysis is in its final stages; report due in Fall of 2008

HEALTH DISPARITIES DATA Example #2: Methodology for Cost of Disparities

PROBLEM:

- Minorities have higher utilization of expensive emergency room and hospital admission services, that can be prevented with better outpatient success
- Can the excess expense be quantified, to help make the case for investing in preventing this excess utilization?

RESPONSE:

- MHHD has developed a method for using Maryland prevalence data (from Behavioral Risk Factor Surveillance System) and Maryland utilization data (from Health Services Cost Review Commission) to estimate cost of disparity

EXAMPLE OF RESULTS:

- In 2004, just in Medicaid, there were **two million dollars** of excess asthma admission costs due to the disparity in outpatient treatment success in asthma between African Americans and Whites.