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DEPARTMENT OF HEALTH

Maryland Office of Minority Health and Health Disparities

16th Annual Health Equity Conference: "Achieving Health Equity and Cost Reductions Through Clinical-Community Partnerships"

The Business Case for Addressing Health Equity and Cost Reduction by Targeting Preventable Utilization

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The Dilemma of Sustainability in Public Health

- Funders always ask for a sustainability plan to keep interventions going after the end of grant funding.
- But if the mission is to provide services to those who are unable to buy those services for themselves, how can that be sustained?
  - It must be perpetually subsidized, or
  - It must save enough money to pay for itself … in which case it can become part of some organization's solvent business plan.
    - Those who reap the savings should pay for the program that creates the savings.

Preventable Utilization

- This refers to ED visits and hospital admissions that would not need to occur if everyone had access to and used high quality primary care. Some other names for this are:
  - Potentially Avoidable Utilization (PAU),
  - Ambulatory Care Sensitive Conditions (ACSC's)
  - Prevention Quality Indicators (PQI's)
- In health equity, we can extend this idea to the utilization that would not occur if rates in a disadvantaged group (minority, poor, etc.) were the same as an advantaged group (e.g. Whites, high income)

Preventing Chronic Disease Preventable Utilization

- There are three steps:
  - Getting into the provider's office
    - Insurance, transportation, local providers, etc.
  - Getting the right evidence-based treatment plan from the provider
  - Carrying out the treatment plan at home
    - Patient education, patient resources, and other patient support
    - *This third step is often the step forgotten by the system*

Preventable Utilization, Health Equity, and Cost

- What makes preventable utilization important enough to be the focus of a conference on health equity and a discussion of cost savings?
  - Utilization disparities are some of the largest racial and ethnic minority health disparities we have in Maryland.
    - In particular, for some conditions, Black utilization rates are between 3 and 4 times as high as White rates.

Preventable Utilization, Health Equity, and Cost

- **Utilization rate ratios of 3 to 4 mean that the percent of the Black utilization that is excess**
  - **Is between 67% and 75%**
- **Utilization rate ratios of 3 to 4 mean that for some categories of utilization, the percent of the total that is happening in the Black population**
  - **Is between 56% and 63%**
  - **Even though Blacks are only 30% of our population**
- ***(In Maryland, Asian and Hispanic utilization rates are generally similar to or lower than White rates)***

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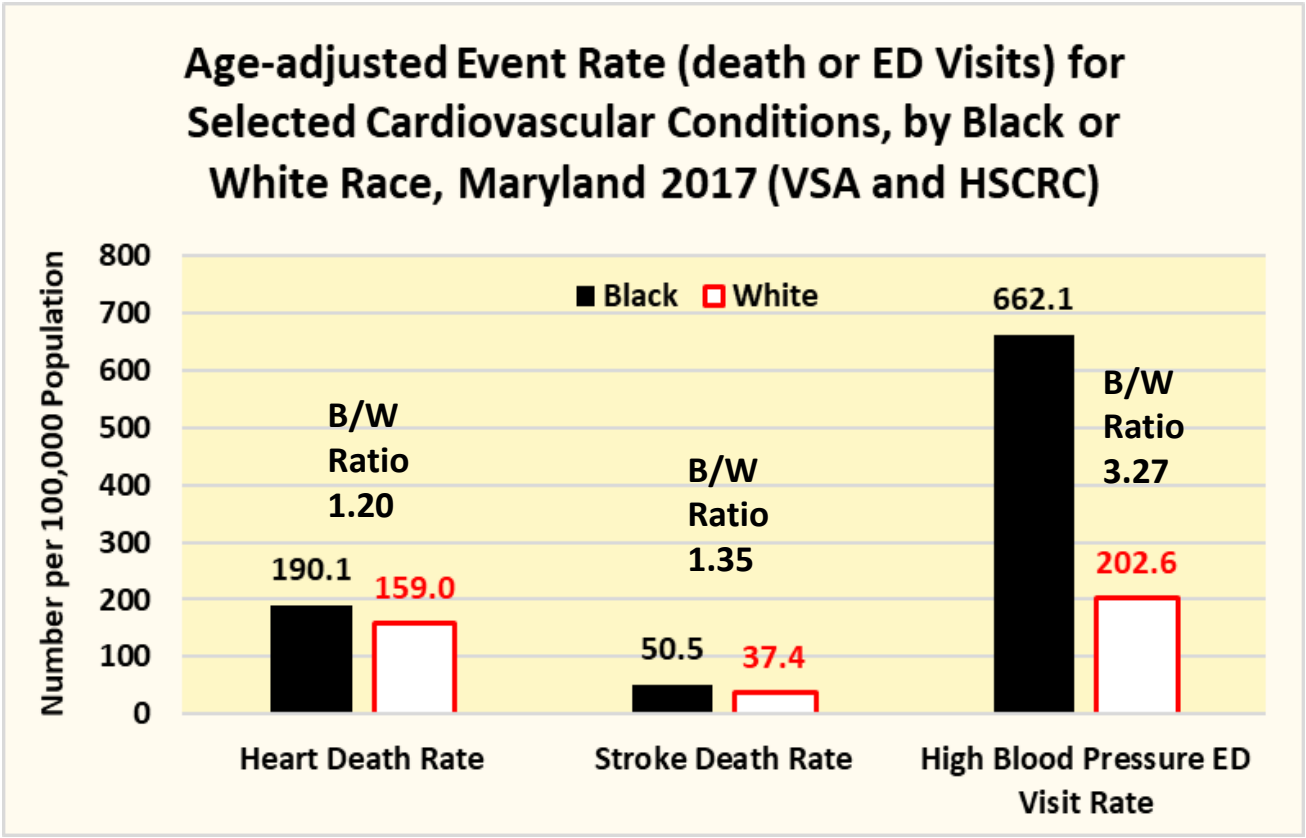
Black vs. White Cardiovascular Disease Disparities in Maryland



17% of Black Heart Disease Deaths are excess

26% of Black Stroke Deaths are excess

69% of Black High Blood Pressure ED visits are excess

Compared to what we would see if Black rates matched White rates

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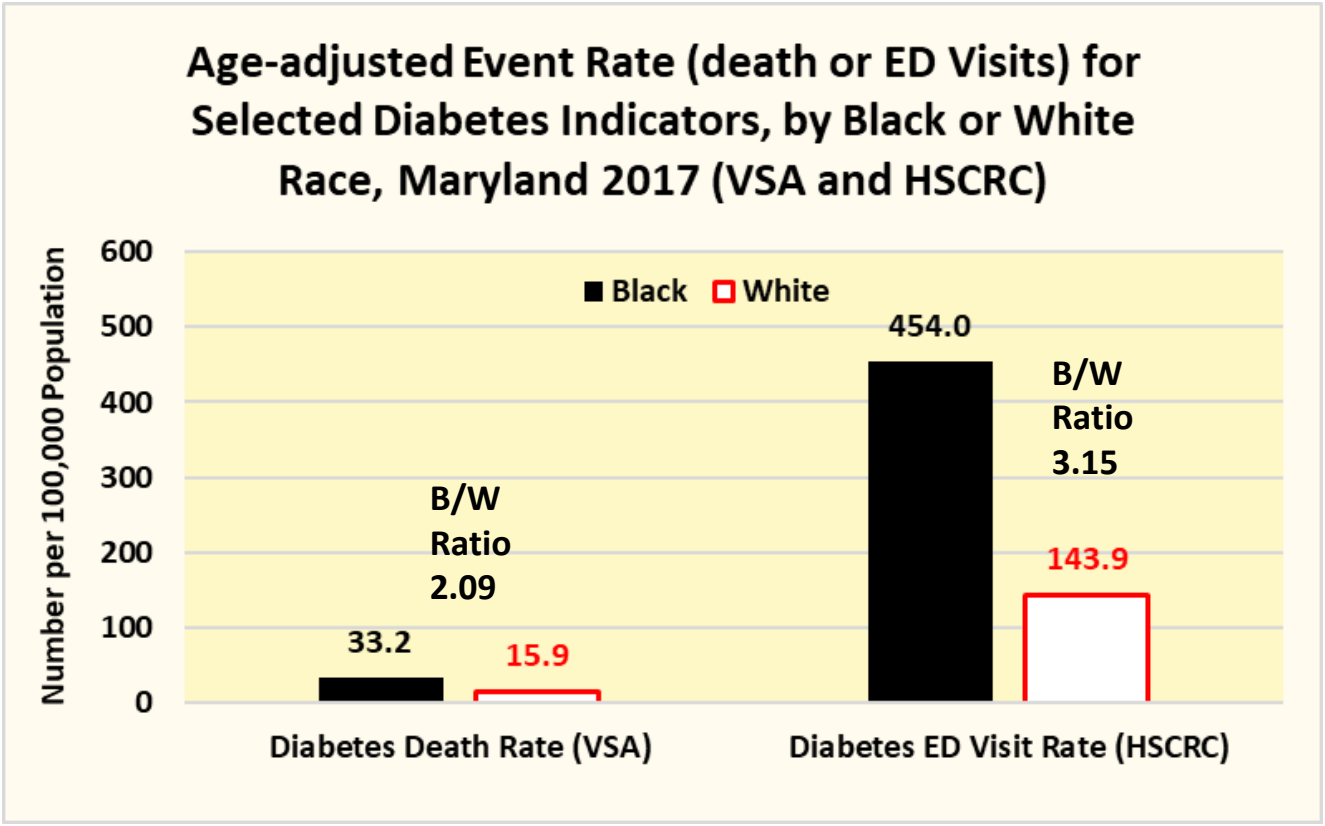
Black vs. White Diabetes Disparities in Maryland



52% of Black Diabetes Deaths are excess

68% of Black Diabetes ED visits are excess

Compared to what we would see if Black rates matched White rates

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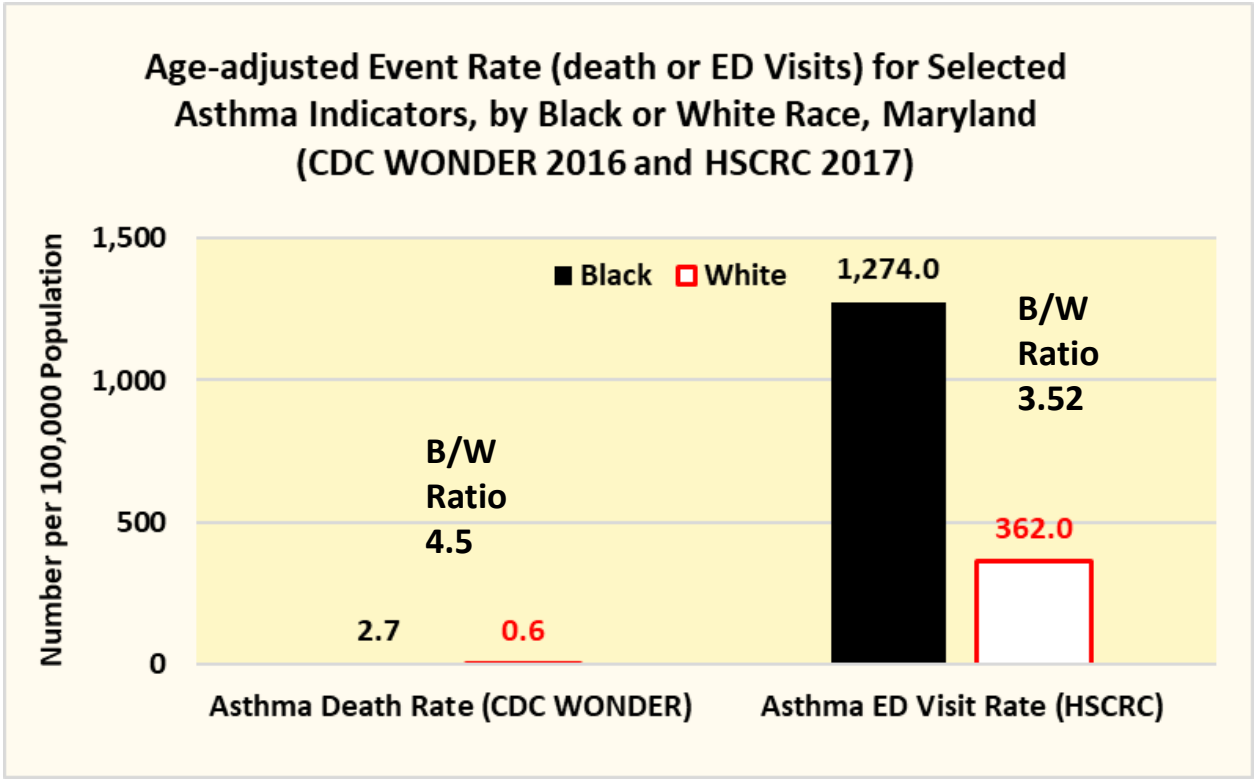
Black vs. White Asthma Disparities in Maryland



78% of Black Asthma Deaths are excess

72% of Black Asthma ED visits are excess

Compared to what we would see if Black rates matched White rates

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What Savings is 60% to 70% of Black ED Visits?

- Before global budgets, people and insurers paid fee for service PRICES to hospitals for each visit, and cost savings could be estimated from visit charges.
- Under global budgets, hospitals have a set budget for the year.
  - So what is saved from reducing preventable utilization is no longer the PRICES paid by insurers for avoided services
  - But now is the PRODUCTION COST to the hospital of providing those avoided services
  - Only the hospitals know that for sure

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Is There Enough Savings to Pay for Programs?

- That is the bottom-line question
- It depends on the program and the condition targeted
- It also depends on the reimbursement and incentive system structure for hospitals, medical practices, and Medicaid Managed Care Organizations (MCO's)
  - This panel addresses the reimbursement and incentive structure
  - After lunch we will hear from successful community-clinical collaborations doing this work on preventable utilization

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