Disparities Workgroup Charge

• The Workgroup shall develop recommendations for best practices, monitoring, and financial incentives for the reduction of disparities in the health care system.

• These disparities may include:
  – Workforce
  – Quality of care within an office or hospital setting
  – Access to care within a health plan or health care system
  – Understanding of care within a health care setting
  – Others as determined by the Committee
Targeted Outcomes and Supporting Data

- For 14 ambulatory care measures used by AHRQ, all but one showed meaningfully worse Black rates than White rates.
  - Admission rates were as much as 4.5 times higher for Blacks for some conditions.
  - The percent of excess Black admissions due to disparity was as high as 78% for some conditions.

- The highest Black death rate was 1,211 deaths per 100,000 while the lowest Black death rate was 661 deaths per 100,000.

- The highest White death rate was 988 deaths per 100,000 while the lowest White death rate was 560 deaths per 100,000.
## Targeted Health Disparities

<table>
<thead>
<tr>
<th>Ambulatory Care Measures</th>
<th>Whites (Non-Hisp)</th>
<th>Blacks (Non-Hisp)</th>
<th>B/W Ratio</th>
<th>R Rank</th>
<th>B-W Differ</th>
<th>R Rank</th>
<th>Black % excess method 1</th>
<th>Black % excess method 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respiratory Disease</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions for chronic obstructive pulmonary disease per 100,000 population, age 18 and over</td>
<td>199.8</td>
<td>179.19</td>
<td>0.94</td>
<td>14</td>
<td>-11.81</td>
<td>14</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Bacterial pneumonia admissions per 100,000 population, age 18 and over</td>
<td>260.11</td>
<td>355.93</td>
<td>1.37</td>
<td>10</td>
<td>95.82</td>
<td>7</td>
<td>26.9%</td>
<td>26.9%</td>
</tr>
<tr>
<td>Pediatric asthma admissions per 100,000 population, ages 2-17</td>
<td>95.98</td>
<td>294.09</td>
<td>3.06</td>
<td>3</td>
<td>198.11</td>
<td>3</td>
<td>67.4%</td>
<td>67.4%</td>
</tr>
<tr>
<td>Asthma admissions per 100,000 population, age 18 and over</td>
<td>115.34</td>
<td>312.68</td>
<td>2.71</td>
<td>6</td>
<td>197.34</td>
<td>4</td>
<td>63.1%</td>
<td>63.1%</td>
</tr>
<tr>
<td>Asthma admissions per 100,000 population, age 65 and over</td>
<td>262.86</td>
<td>519.71</td>
<td>1.98</td>
<td>9</td>
<td>255.85</td>
<td>2</td>
<td>49.1%</td>
<td>49.1%</td>
</tr>
<tr>
<td>Immunization-preventable influenza admissions per 100,000 population, age 65 and over</td>
<td>23.51</td>
<td>24.33</td>
<td>1.03</td>
<td>13</td>
<td>0.82</td>
<td>13</td>
<td>3.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Heart Disease</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions for hypertension per 100,000 population, age 18 and over</td>
<td>44.39</td>
<td>200.66</td>
<td>4.52</td>
<td>2</td>
<td>156.27</td>
<td>6</td>
<td>77.9%</td>
<td>77.9%</td>
</tr>
<tr>
<td>Admissions for congestive heart failure per 100,000 population, age 18 and over</td>
<td>351.43</td>
<td>896.83</td>
<td>2.55</td>
<td>7</td>
<td>545.40</td>
<td>1</td>
<td>60.8%</td>
<td>60.8%</td>
</tr>
<tr>
<td>Admissions for angina without procedure per 100,000 population, age 18 and over</td>
<td>47.82</td>
<td>65.07</td>
<td>1.36</td>
<td>11</td>
<td>17.25</td>
<td>11</td>
<td>26.5%</td>
<td>26.5%</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions for diabetes with short-term complications per 100,000 population, ages 6-17</td>
<td>20.56</td>
<td>22.25</td>
<td>1.08</td>
<td>12</td>
<td>1.69</td>
<td>12</td>
<td>7.6%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Admissions for diabetes with short-term complications per 100,000 population, age 18 and over</td>
<td>45.09</td>
<td>134.31</td>
<td>2.91</td>
<td>4</td>
<td>88.22</td>
<td>8</td>
<td>65.7%</td>
<td>65.7%</td>
</tr>
<tr>
<td>Admissions for diabetes with long-term complications per 100,000 population, age 18 and over</td>
<td>101.63</td>
<td>291.09</td>
<td>2.86</td>
<td>5</td>
<td>189.48</td>
<td>5</td>
<td>65.1%</td>
<td>65.1%</td>
</tr>
<tr>
<td>Admissions for uncontrolled diabetes without complications per 100,000 population, age 18 and over</td>
<td>10.09</td>
<td>16.72</td>
<td>4.63</td>
<td>1</td>
<td>35.63</td>
<td>10</td>
<td>78.4%</td>
<td>78.4%</td>
</tr>
<tr>
<td>Lower extremity amputations among patients with diabetes per 100,000 population, age 18 and over</td>
<td>27.44</td>
<td>64.46</td>
<td>2.35</td>
<td>8</td>
<td>37.02</td>
<td>9</td>
<td>57.4%</td>
<td>57.4%</td>
</tr>
</tbody>
</table>
Health Intervention Targets

- Poor health outcomes in general and poor minority health outcomes in particular, result in part from the following modifiable factors:
  - Health Care Factors
  - Community Factors
  - Individual Factors
Proposed Interventions

1. Create Health Enterprise Zones (HEZ)

2. Create the “Maryland Health Innovation Prize”

3. Expand the scope of Maryland’s current reimbursement incentives for quality, and make them race and ethnicity-specific
Definition of the Health Enterprise Zone (HEZ)

- A Health Enterprise Zone (HEZ) is a geographic area in Maryland that is eligible for specific policy incentives and funding opportunities for both new and existing providers.
- HEZs will have poor health outcomes and/or documented health disparities.
- All-group, Group-specific, and Racial/Ethnic Minority metrics in the Zone exceed the Statewide metrics.
- Increased minority hospital admission and/or emergency department visit rates for Asthma, Diabetes, Hypertension, and other Ambulatory Care Sensitive Conditions (ACSC).
Expected Benefits of the HEZ

• Increased **supply and diversity** of the local health care workforce, especially in primary care

• Increased use of **community health workers**

• Improved **community leadership** development

• **Reduced** racial and ethnic **minority health disparities** and **improved minority health outcomes**

• **Reductions in preventable hospital admission** and/or **emergency department visit rates** for Asthma, Diabetes, Hypertension, and other ACSCs
Statute-based Incentives of the HEZ

- Statute-based incentives utilize policy-based financial incentives that are available to all eligible parties within HEZs.
  - Tax incentives (property and/or income and hiring credits)
  - Free or low rent use of city/county space for some term to set up or expand a practice
  - Funding and assistance with health information technology implementation
  - Loan assistance repayment programs for qualifying service in the HEZ
  - Funding and assistance with conversion to a Patient Centered Medical Home (PCMH)
Contract-based Incentives of the HEZ

• Contract-based interventions utilize a contract for services model to allocate funding to an HEZ that applies and is approved for funding.
  – Training and Deploying **Community Health Workers**
  – Providing financial assistance to providers for **language interpretation services**
  – Providing Cultural, Interpretation, and Health Literacy training to health care providers
  – Developing and supporting a **Community Coalition** and providing leadership training
HEZ Assessment Benchmarks

- Number of persons **newly enrolled in health insurance**
- Number of persons **receiving particular health services** (e.g. screening, treatment)
- Number **new providers** added to the HEZ
- Provider **workforce diversity** in the HEZ
- ACSC **hospitalization and emergency department visit rates** in the HEZ
- Healthcare Effectiveness Data and Information Set (HEDIS) measures
Maryland Health Innovation Prize (I-Prize)

• A financial reward and public recognition for an individual, group, organization, or coalition to acknowledge innovative health interventions.

• Model innovations can develop from outside the health care system that could have increased potential for resolving persistent health care delivery challenges.

• These prizes will be awarded for proven interventions that address both wide-ranging health disparities as well as those which may be unique to a particular community.
Expected Benefits of the I-Prize

• Innovations in community health and public health
• Innovations from the non-health sector
• Innovations from youth and young adults
• Improved health status in local minority communities
• Societal sectors outside of health care delivery could bring resources, value added, and partners whose collaboration addresses causal factors outside the health system.
• Reduced racial and ethnic minority health disparities and improved minority health outcomes
Implementation of the I-Prize

• An Accountable Organization needs to be identified or established to administer the Prize. This organization would be responsible for:
  – Engaging industries, businesses, and health delivery systems to participate in building “The Purse”
  – Defining the eligibility criteria for the Prize
  – Defining the criteria for ranking and selection among applicants
  – Reviewing materials submitted in support of nominees
  – Determining the periodic winner of the Prize
  – Disbursing funds to the Prize winners
CURRENT Tracking of Performance Incentive Data

- Health care performance data are or will be analyzed and incentive payments made (or potentially penalties assessed) to hospitals or providers based on the results.
  - Hospital Care Incentives (*Health Services Cost Review Commission*)
    - Quality Based Reimbursement
    - Maryland Hospital Acquired Conditions (MHAC)
    - Maryland Hospital Preventable Readmissions (MHPR)
    - Admission-Readmission Revenue (ARR) Hospital Payment Constraint Program
  - Primary Care Incentives (*Maryland Health Care Commission*)
    - Shared Savings Incentive in the Patient Centered Medical Home Program
PROPOSED Racial & Ethnic Tracking of Performance Incentive Data

- Implementation of racial/ethnic performance data tracking will require legislation directing the HSCRC and the MHCC to include racial and ethnic data as part of their data collection.

- As an alternative, the MHCC and HSCRC could establish a process and timeline to:
  - Study the feasibility of including racial/ethnic performance data tracking in quality incentive programs
  - Report data by race and ethnicity where feasible to the General Assembly by the 2013 session
  - Explain the limitations where data cannot be reported by race and ethnicity and describe necessary changes to overcome those limitations.
Expected Benefits of Racial & Ethnic Performance Data Tracking

• Improvement in minority health care quality

• Reduced racial and ethnic minority health disparities and improved minority health outcomes

• Reductions in preventable hospital admission and/or emergency department visit rates for Asthma, Diabetes, Hypertension, and other ACSCs

• Health care cost savings to private and public payers
Next Steps

• Health Quality and Cost Council reviews and endorses the Disparities Workgroup Report

• Approved report is submitted to the Governor as part of the Health Quality and Cost Council Annual Report

• Implementation of strategies via legislation or study
Special Thanks to the Workgroup Members

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