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MDPCP Webinar Series

Health Equity, Social Justice, COVID-19 and the Provider's Role in the Solutions

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June 29, 2020

Health Equity and Health Disparity Basics

- **Original concept of health disparity:**
  - **A health difference due to disadvantage and discrimination**
  - **Therefore, unjust and unfair, and in need of resolution**
  - **Disparity and Health Inequity were synonymous terms**
  - **See** https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

- **More recent usage:**
  - **Disparity is being used to mean any difference**
  - **Inequity is being used to mean those that are unjust**
  - **Disparity and Inequity no longer synonymous**

Health Equity and Health Disparity Basics (2)

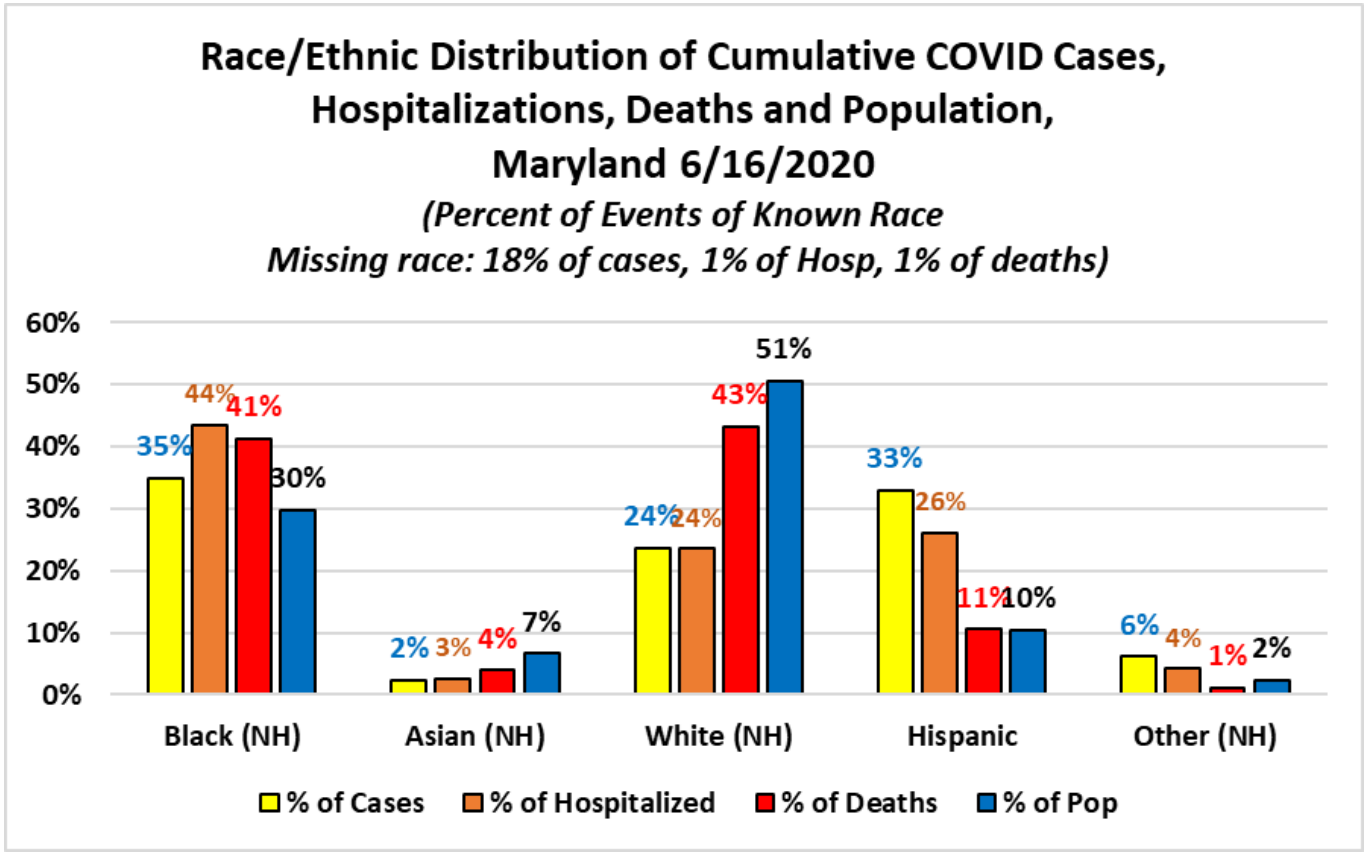
- **Health Equity: equal opportunity to achieve optimal health**
  - **Focus on the social determinants of health:**
  - **Education, employment, income, wealth distributions**
  - **Housing, food security, transportation, violence, justice system, etc.**

- **Health Disparities includes both**
  - **Health status disparities (next slide)**
  - **Health care disparities (differences in access and quality)**
    - **A process disparity**

Health Equity and Health Disparity Basics (3)

- Causal Chain of Health Status Disparities
  - Disparities in ultimate outcomes (death, morb, utiliz, cost)
  - Come from
    - Disparities in Disease Frequency (incidence or prevalence)
    - Disparities in bad outcomes per case
  - These in turn come from
    - Disparities in risk factors and preventive services
    - Disparities in treatment success among cases
  - And these, in turn are driven by Social Determinants of Health

Maryland Disparities in COVID Cases, Hosp, Deaths



Black excess in all three metrics vs population.

Whites low in all three metrics vs population, deaths high for case and hospital share.

Hispanics high in cases and hospital but not deaths

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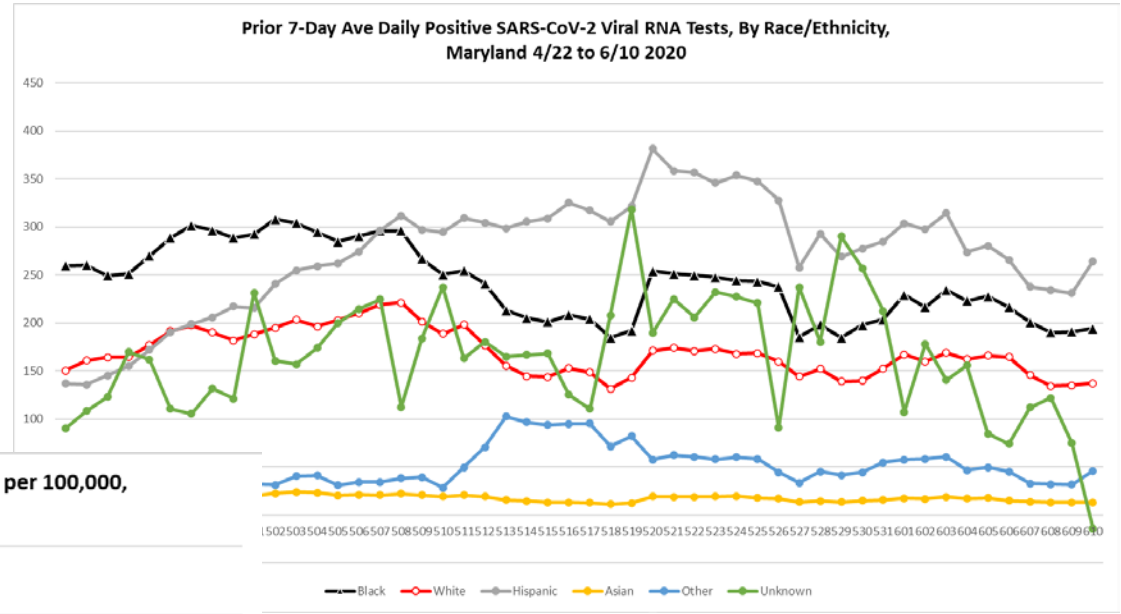
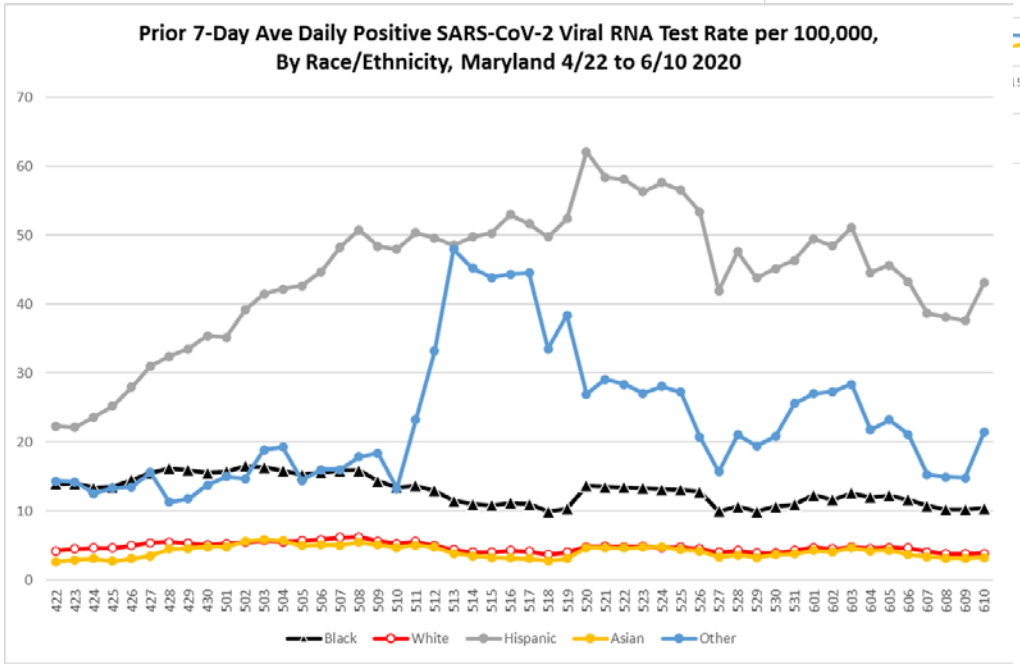
Maryland New Case Trends by Race/Ethnicity





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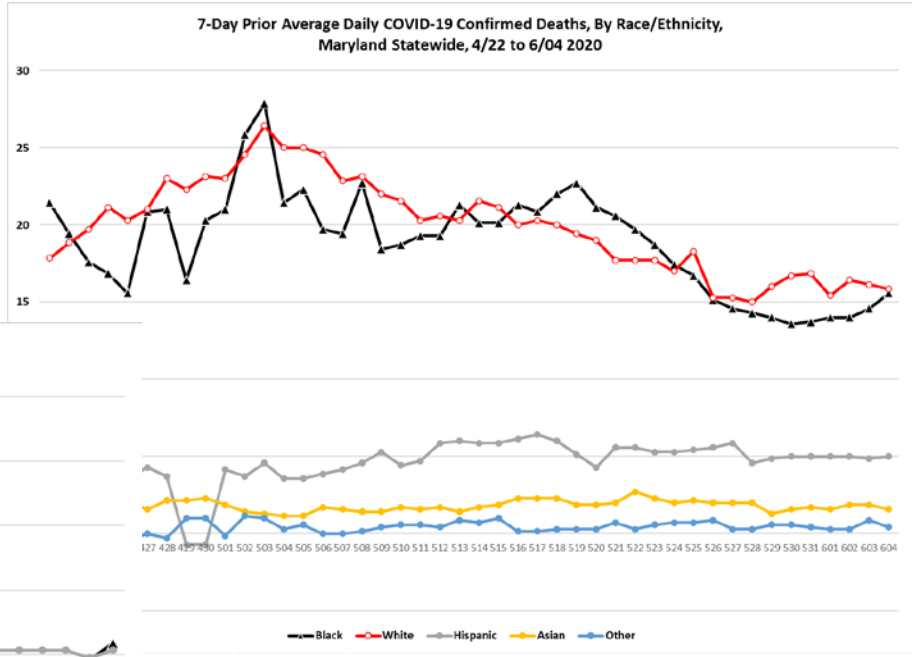
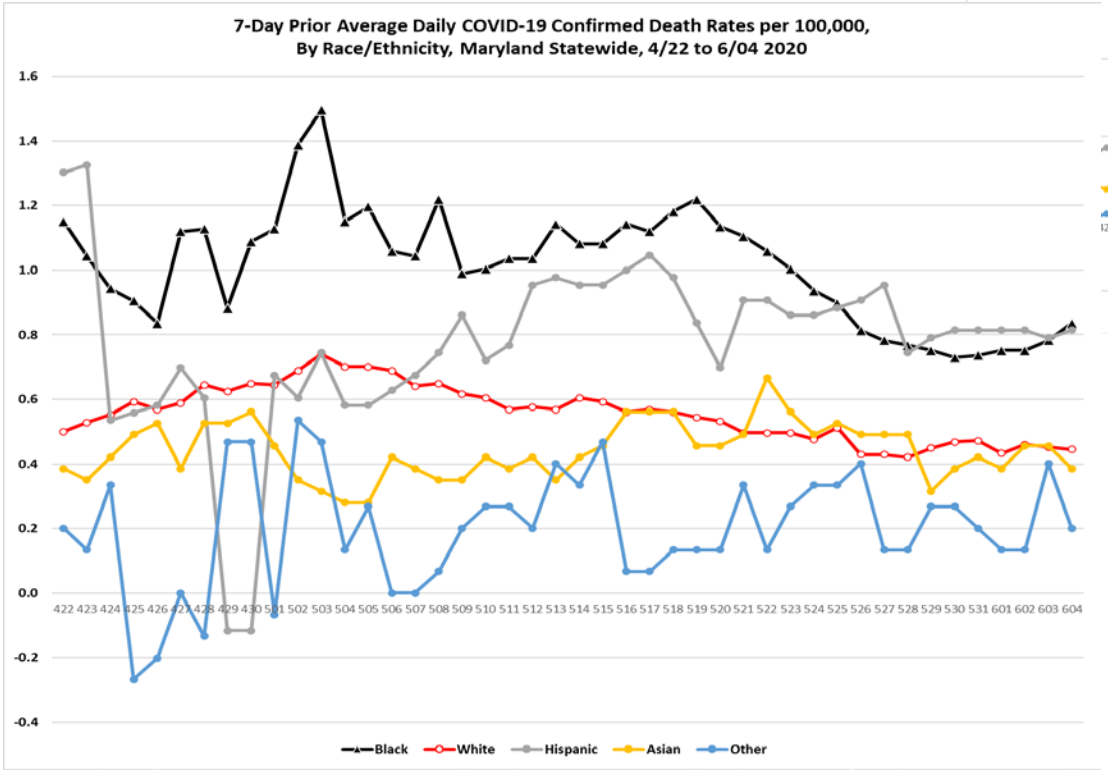
Maryland COVID Death Trends by Race/Ethnicity





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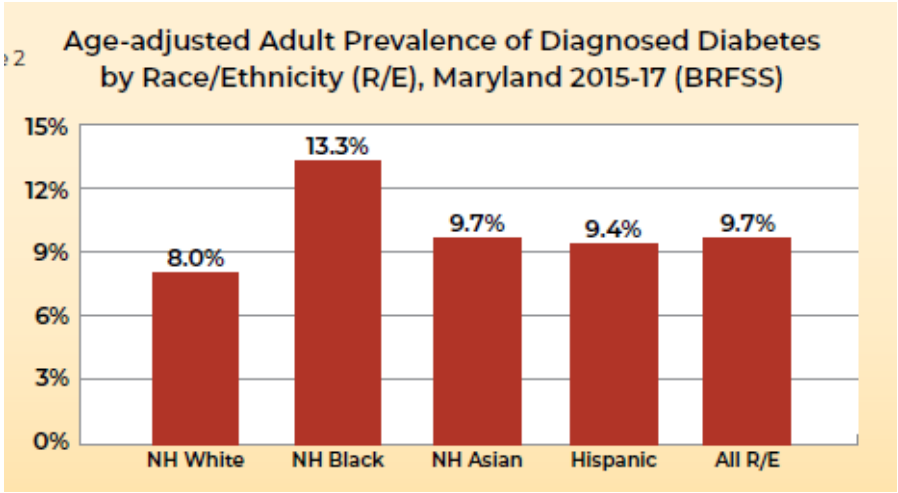
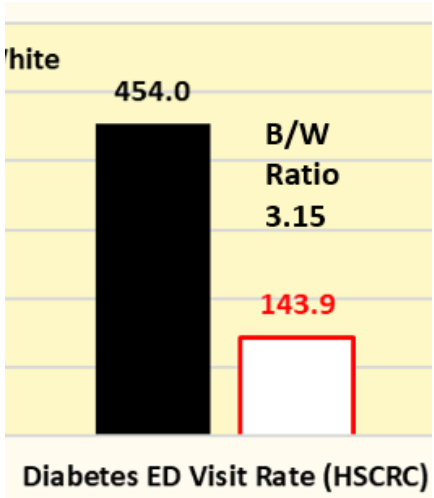
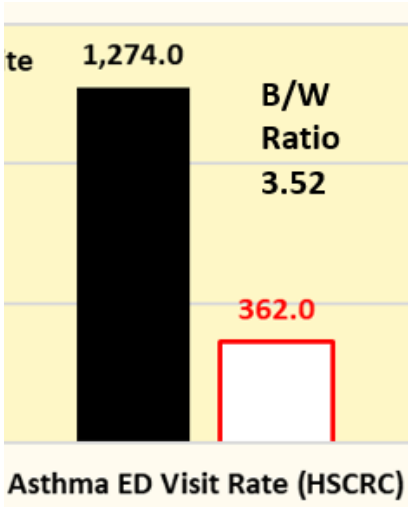
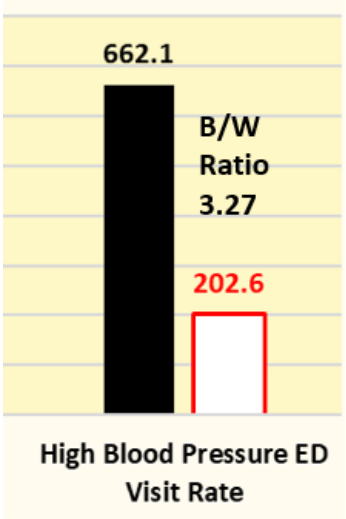
Maryland Disparities in COVID-19 Relevant Comorbidities









Black White

Minorities have higher disease prevalence for several relevant high-risk COVID comorbidities

And higher severity (seen in the huge ED visits disparities that exceed prevalence disparities)

Age-adjusted rate per 100,000 population, 2017 data, HSCRC

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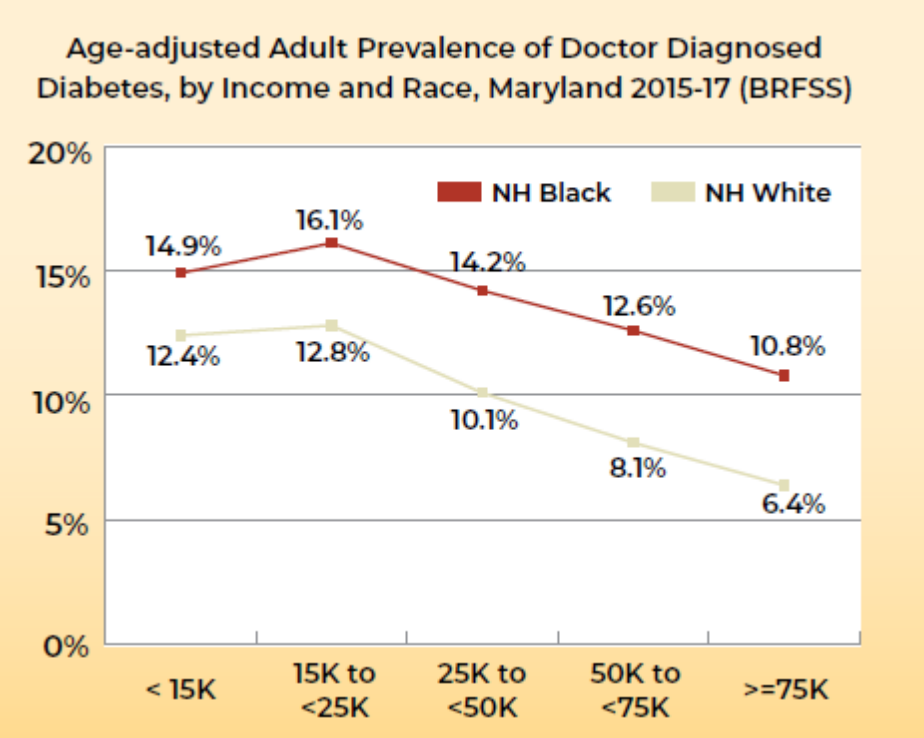
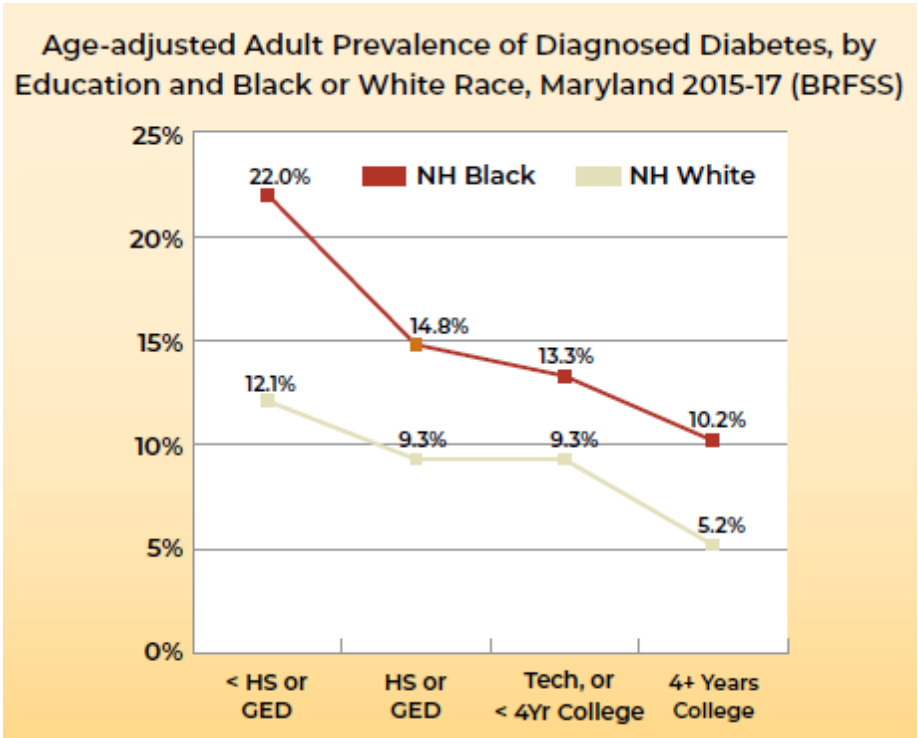
Role of Social Determinants: Diabetes Example





Income/Education matters regardless of race,
Race matters regardless of income/education.
Minorities have lower income/education, and do worse at every level of income/education.

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Reasons for Minority Excess COVID Events

- **Reasons for higher minority incidence:**
  - **More employment in essential occupations**
  - **Less ability to telework**
  - **More likely to be in larger, high density, multigenerational households**

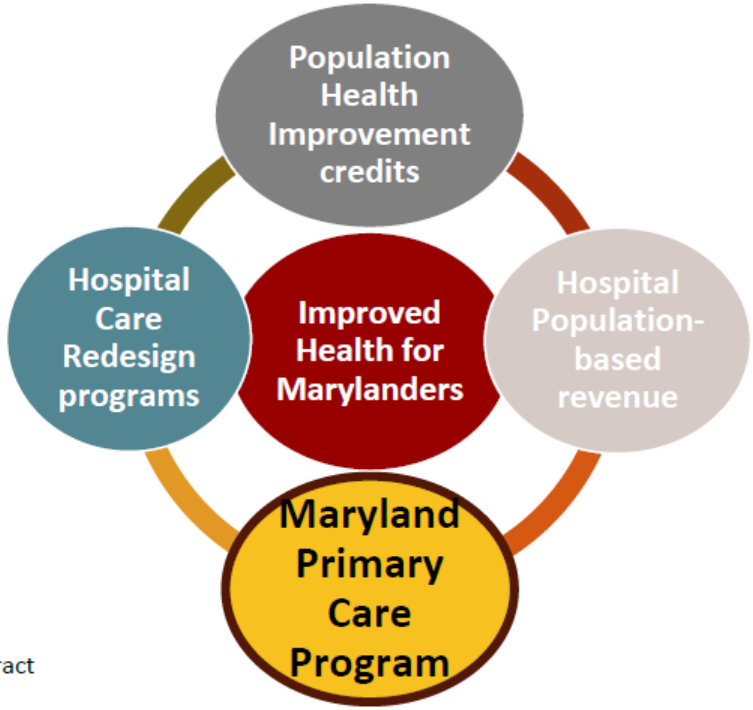
- **Reasons for higher minority severity once infected:**
  - **Higher general stress from violence, poverty and racism**
  - **Less access to resources from poverty and racism**
  - **Higher prevalence of comorbids (HTN, Diabetes, Asthma, etc.)**

Where Equity Fits in the MDPCP

Minorities, especially Blacks, are a disproportionate share of some expenditures

"Under this Model, CMS and the State will test whether **statewide health care delivery transformation,** together with population-based payments, improves population health and care outcomes for individuals while controlling the growth of Medicare Total Cost of Care"

Source: Maryland Model Contract



- Reduce Medicare expenditures by an annual run rate of $300m by 2023
- Innovate hospital/provider partnerships
- Gain credit for improving overall population health
- **Build a strong, effective primary care delivery system inclusive of medical, behavioral and social needs**

Equity = Improve outcomes equally for all racial/ethnic groups

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Where Equity Fits in the MDPCP (2)

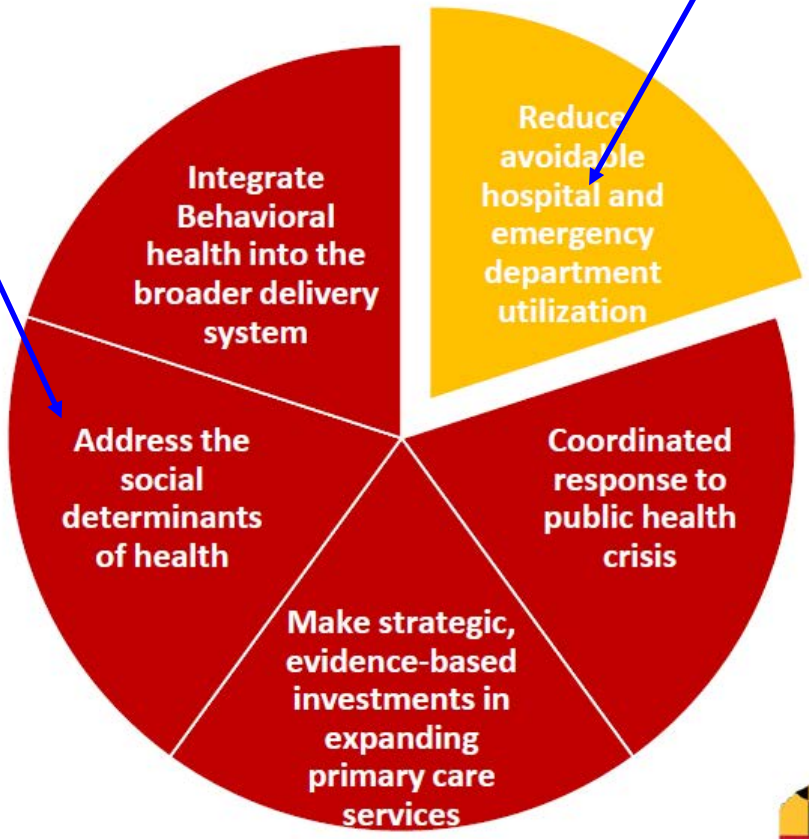
SDH are the key to primary prevention and Health Equity

Savings impacts are far in the future, making funding the effort more difficult

Subsidized investment by government, payers or philanthropy is often necessary

Provider role: identify and refer

Minorities, especially Blacks, are a disproportionate share of Preventable Utilization



High user focus can yield short-term ROI to fund the effort

Provider role:
*Track guideline adherence by R/E
*Identify individual patient barriers to adherence
*Refer to address barriers

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Where Equity Fits in the MDPCP (3)

2020 Performance Metrics

Quality

Electronic Clinical Quality Measures (eCQM) include:

- Outcome measures – Diabetes and Hypertension Control (NQF 0018 & 0059)

Patient Satisfaction

- Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) – survey of practice patients (NQF 0005)

Utilization

- Emergency department visits per 1,000 attributed beneficiaries (HEDIS)
- Hospitalizations per 1,000 attributed beneficiaries (HEDIS)

3 to 4 times as high for Blacks vs. Whites

The first rule of health disparities data is: "Any metric that is worth looking at, is worth looking at separately by racial/ethnic group."

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Equity Checklist for Providers and Practices

- **Root Causes: Social Determinants**
  - Practice should use an SDH needs screening tool
  - Practice should have a referral network for issues identified
  - Practice should assess completion of the referrals
- **Risk Factors: Health Behaviors**
  - Screen for diet, exercise, smoking, substance use
  - Counsel, treat or refer to behavior change programs
- **Risk Factors: Conditions**
  - Screen for HTN, Cholesterol, Diabetes, and Cancers
  - Identify unscreened patients to promote adherence
  - Monitor intervention adherence in screened positive
  - Identify and refer for adherence barriers

Equity Checklist for Providers and Practices

- Disease Management
  - Monitor intervention adherence and success in patients
  - Identify and refer for adherence barriers
  - Track NQF and HEDIS metrics by R/E if possible, using HER
  - Use CRISP to understand R/E profile of your hospital utilizers
  - Use CRISP to identify your high utilizers
  - Individualize home self-management support for high utilizers; consider using Community Health Workers
- Paying for it?
  - This can't be another managed care unfunded mandate
  - Whomever reaps the savings needs to pay for the work
  - Hopefully, you have clear fiscal incentives for the disease management high utilizer work

Where is the Health Equity in the Checklist?

- If you look for the problems, expect to find them disproportionately in minority populations.
- So you should automatically see a minority focus.
- The interventions to your minority patients will need to be tailored to their needs: culturally appropriate, translated as needed, appropriate health literacy level, and if possible, delivered by minority persons.
- The effort required to solve issues for minority patients may be greater than for White patients, since they face more barriers and disadvantage.