Maryland: A Sense of Urgency

Although Maryland enjoys the third highest median income in the United States, the state suffers from some glaring health disparities that primarily affect the racial and ethnic minorities who make up nearly 42 percent of its population. But with renewed interest in health equity, the state is moving ahead aggressively to reduce disparities and improve healthcare for all Marylanders.

African Americans, who comprise 30 percent of the Maryland populations, have infant mortality rates almost three times higher than whites, and the incidence of new HIV infections is almost 12 times the rate for whites. Age adjusted death rates from all causes also are 1.25 percent higher.

Hispanics and Latinos comprise 6.7 percent of Maryland's population, but they also show significant health disparities. Compared to rates for whites, the rate of end-stage kidney disease is 1.3 times higher and the rate of new HIV cases is 4 times higher.

However, following the release of the latest "Chartbook of Minority Health and Minority Health Disparities Data" statistics, Maryland is now fighting back against health inequity using a variety of tools, ranging from targeted programs and a new State Health Improvement Process (SHIP) to 2012 legislation calling for new Health Enterprise Zones.

"Health equity has become an increasingly important priority, with legislators and community advocates working hard to increase awareness," says Carlessia Hussein, the state Office of Minority Health and Health Disparities (MHHD) director.

A time for action

MHHD, which reports to Joshua Sharfstein, MD, secretary of the Department of Health and Mental Hygiene (DHMH), has helped spearhead the state's health equity campaign since the Maryland legislature authorized it in 2004. MHHD's 2010 action plan describes progress in several areas, including racial and ethnic data collection, collaborations and outreach, work force diversity and cultural competency, health department assessment and systems change, legislation, and MHHD-funded grant and pilot projects.

Among its accomplishments, MHHD has helped other DHMH programs address health disparities, such as those dealing with chronic disease and maternal and child health. It also has developed partnerships with educational institutions on work force diversity and developed data to help local health departments and community groups focus on the most pressing disparity problems in their areas. In addition, MHHD sponsors annual health disparities conferences, including an October 2011 event that discussed strategies to develop a pipeline of health professionals with diverse racial and ethnic backgrounds.

Hussein is also responsible for administering part of the monies from the state's annual $200 million cigarette restitution fund program, established after the 1998 multi-state settlement with the tobacco

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companies. In 1998, attorneys general representing 46 states, the District of Columbia, and five U.S. territories signed an agreement with the major cigarette companies to settle all state lawsuits seeking to recover the Medicaid costs of treating smokers. The Master Settlement Agreement contractually obliges manufacturers to make annual payments totaling a proposed estimate of $206 billion through 2025, and imposes some restrictions on tobacco advertising, marketing, and promotion. Hussein believes the education, outreach, and screening efforts that these funds support in minority communities have played a major role in cutting the African American cancer mortality disparity by 50 percent.

In addition, MHHD has been providing $500,000 annually since 2007 for pilot programs aimed at two of the biggest health disparities affecting African Americans in Maryland: infant mortality and chronic cardiovascular disease. For example, a Baltimore City pilot incorporates a community coalition and lay community health workers to educate minority residents about the importance of cardiovascular screening. In Prince George's Country, where ethnic/racial groups comprise 82 percent of the population, a program that offers outreach and enhanced clinical services for at-risk pregnant women utilizes similar strategies to meet its audience.

Hussein says it is difficult to demonstrate the cost effectiveness of such pilot programs, but that health inequity costs too much to let it go unaddressed. "We do know very well the high costs to the state of not moving forward on health equity, such as higher Medicaid costs, excessive use of expensive emergency room services, and the high end-stage hospital costs for patients who might well have been successfully treated much earlier with proper preventive care," she says.

As the MHHD office looks ahead to the next five years, it has established work groups to implement action plans in five key areas by 2013:

- Raising awareness about health disparities.
- Strengthening health equity leadership.
- Improving health outcomes for racial and ethnic minorities.
- Building cultural competency in the health work force.
- Honing research and evaluation techniques.

This year, these five work groups are helping Maryland implement the Health Improvement and Disparities Reduction Act of 2012, which places health equity at the top of Maryland's health agenda. Diverse groups of stakeholders and community leaders are combining their efforts to implement innovative measures to make health equity a reality in Maryland.

Momentum from health reform

In addition to its five action plan work groups, MHHD has provided key racial and ethnic health data and other assistance to a new health disparities work group chaired by University of Maryland School of Medicine Dean E. Albert Reece, MD. The work group, which grew out of Lt. Gov. Anthony Brown's health quality and cost council, issued a January 2012 report that made three major recommendations:

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- **Health Enterprise Zones (HEZ)**. Modeled after the Harlem children's zone and promise neighborhood programs, this initiative would encourage community organizations to apply for funds to improve health in areas that have high rates of chronic disease or inadequate access to care. The Health Improvement and Disparities Reduction Act will establish these zones and the work group expects two to four pilot zones to be established by fiscal year 2013 with $4 million in initial funding.
- **Maryland Health Innovation Prize**. This new financial award would recognize an individual, organization, or coalition responsible for successful efforts in reducing health disparities. Programs would be evaluated in large part on their capacity to be replicated in other parts of the state.
- **Racial and Ethnic Tracking of Performance Incentive Data**. As part of healthcare reform, healthcare providers will get financial incentives based on performance data. This recommendation would require that the incentives be based on race-specific or ethnic specific performance.

After these recommendations were released, Maryland delegate Shirley Nathan-Pulliam, a long-time health equity advocate, said that the state has come a long way since she first began pushing the issue in the legislature 18 years ago. "Back then, no one wanted to listen," recalls Nathan-Pulliam. "Now Gov. O' Malley talks about health disparities in his state of the state address and Lt. Gov. Brown has become a champion of the issue."

Still, Nathan-Pulliam cautions that the state needs to take careful steps when implementing new programs, such as HEZs. "We need to be very selective in the areas we choose for the pilot programs so that we can really see true benefits, including measuring such factors as cultural competency and the quality of care in models like patient-centered medical homes."

Hussein adds that it is very important to drill down and gather solid data on race and ethnicity on a local basis when shaping new health equity strategies. "Otherwise, we are left with the same 'one size fits all' approaches that have not worked well in the past."

A variety of solutions

Maryland's newly launched state health improvement process (SHIP) is also rooted in the belief that health equity efforts require strong local involvement. Led by DHMH Deputy Secretary for Public Health Services Frances Phillips, SHIP aims to evaluate local health coalitions' performances against 39 key indicators that drive health costs and outcomes while challenging local health officers and their coalition partners to attack the dominant health problems in their localities

With the help of $500,000 in seed money from the Maryland Hospital Association, 17 local health improvement coalitions were formed throughout the state in 2011. DHMH provided area-specific health data—including disparity information—to each of them as a starting point both for planning and

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building public-private collaboration. DHMH also identified 28 critical measures of racial/ethnic health disparities and set expectations for significant and sustained progress in reducing them.

"This local data on disparities can be a very powerful wake-up call for leaders of local coalitions," says Phillips. She cites the example of rural Calvert County, where the local coalition altered its health improvement priorities after seeing data on African-American men's very high rate of hospital admissions for hypertension and heart disease.

As it pursues its health improvement plans, DHMH is challenging the coalitions to establish partnerships with local hospitals, schools, colleges, businesses, and charities. "The emphasis is on sustainability," says Phillips, "and I am very pleased with the support that coalitions are getting so far."

The Community Health Resources Commission (CHRC) office is working closely with both SHIP and the MHHD. Approved by the Maryland General Assembly in 2005, the commission serves as a quasi-independent body within DHMH. As its primary responsibility, the commission helps support 16 federally-funded community health centers, as well as free clinics and other providers that serve as the safety net for low-income individuals who lack adequate healthcare. Such patients include a large share of the 800,000 Marylanders who don't have health insurance.

Supported by special community benefit funds from insurance premiums paid to the nonprofit insurance carrier CareFirst, a unit of Blue Cross Blue Shield, CHRC has awarded 93 grants totaling $22.6 million for health programs across Maryland over the last six years. The grants have served nearly 100,000 Marylanders and leveraged $9.6 million in additional federal and private/non-profit resources. Major areas of focus include infant mortality, substance abuse, expanded behavioral health services, increased access to dental services and primary care, and information technology for safety net providers.

When reviewing grant applications, the commission works closely with Phillips and Hussein to align priorities, avoid duplication, and target areas of greatest unmet need, says CHRC Executive Director Mark Luckner. "My mission is to ensure that every single dollar is spent wisely. To do otherwise would be unconscionable in today's environment."

Luckner notes that the commission requires grant recipients to submit reports twice a year that show actual progress against projections. For example, a program aimed at reducing infant mortality might document the number of women receiving prenatal care in the first trimester of pregnancy. "If performance is too far off projections, we can withhold funding," explains Luckner.

DHMH experts and independent consultants work with CHRC to review proposals for new grants based on 25 weighted criteria. Among the most important considerations: Is the program sustainable? Does it impact an area of critical need? Will it reduce health disparities? It is consistent with the state's health reform campaign?

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Beyond its own targeted grant programs, CHRC in February issued a call to local health improvement coalitions to submit proposals for a share of $600,000 in start-up grants for new programs under SHIP. "This implementation grant funding provided by the commission will drive action plans and innovation at the local level," says Phillips.

Early this year, CHRC submitted a report to the governor and Maryland general assembly outlining how the state could provide technical assistance and support to safety net providers as Maryland prepares to implement the Affordable Care Act. An estimated 350,000 Marylanders will gain access to more affordable health insurance coverage in 2014 as the state launches its new health benefit exchange. The state's Behavioral Risk Factor Surveillance System (BRFSS) survey shows that the percentage of African American Marylanders reporting no health insurance is more than two times that of whites, while the uninsured rate for Hispanics is nearly five times greater.

Even in a state that is wealthier than most, these initiatives and more are needed to make real progress reducing health disparities, state health officials say. "There is no one office or department that has all the knowledge and expertise to get the job done," says Dr. Hussein, "so we need to link arms and bring resources together. We have a chance in Maryland to do some extraordinary things, but it will take a 360-degree approach."

You can learn more about health equity initiatives in Maryland from these sources:

Maryland Department of Health and Mental Hygiene (DHMH)
http://www.dhmh.maryland.gov/SitePages/Home.aspx

DHMH Office of Minority Health and Health Disparities
http://www.dhmh.maryland.gov/mhhd/SitePages/Home.aspx

Maryland Plan to Eliminate Health Disparities (2010-2014)
http://www.dhmh.maryland.gov/mhhd/Documents/1stResource_2010.pdf

Health Disparities Workgroup Final Report and Recommendations (2012)
http://www.dhmh.maryland.gov/mhqcc/Documents/Health-Disparities-Workgroup-Report-1-12-2012.pdf

Health Care Disparities Policy Report Card (2010)
http://dhmh.maryland.gov/mhhd/Documents/Health-Care-Disparities-Policy-Report-Card.pdf

Maryland Chartbook of Minority Health and Minority Health Disparities Data (2009)
http://www.dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf

Maryland State Health Improvement Process (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx

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Maryland Community Health Resources Commission
http://dhmh.maryland.gov/mchrc/SitePages/Home.aspx

Maryland Health Benefit Exchange
http://www.dhmh.maryland.gov/healthreform/exchange/

Health Care Innovations Web Site
http://www.dhmh.maryland.gov/innovations/SitePages/Home.aspx

Web Portal for Small Businesses Choosing Health Insurance Programs
https://virtualcompare.benefitfocus.com/Platform/Default.aspx?ApplicationID=MarketplaceProto&PageID=Home%20page&TenantID=MHCC

Health Insurance Partnership for Small businesses
http://mhcc.maryland.gov/partnership/

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