Health Disparities

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January 16, 2007

The Honorable Thomas V. Mike Miller, Jr., President of the Senate
The Honorable Michael E. Busch, Speaker of the House of Delegates
Members, Maryland General Assembly

Ladies and Gentlemen:

Racial and ethnic minorities in Maryland, and throughout the United States, experience higher incidence rates of diseases and higher mortality rates from those diseases than Whites. The decisive report detailing the extent of health disparities nationally is the 2002 Institute of Medicine's (IOM) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* report. As a result of the IOM report, the focus for the study of health disparities shifted from the confirmation of the existence of health care disparities to solutions for reducing or eliminating disparities.

Maryland colleges and universities have been researching health disparities, and the State government has become involved with addressing the issue in Maryland. During the 2004 legislative session, legislation passed that created the Maryland Office of Minority Health and Health Disparities (OMHHD) within the Department of Health and Mental Hygiene. OMHHD is charged with examining health disparities and minority health issues in Maryland.

In response to the Maryland General Assembly's continuing interest in health disparities, the Department of Legislative Services prepared this report to examine the extent of health disparities and emerging health disparities issues. The report concludes with recommendations that the General Assembly may want to consider in its further discussions on health disparities.

I trust this report will prove useful to you as the General Assembly considers any legislation that may be introduced during the 2007 session.

For further information on this report, please contact Lisa M. Campbell, Lisa A. Daigle, or David A. Smulski of the Office of Policy Analysis at 410-946-5510.

Sincerely,

Karl S. Aro
Executive Director

Contents

Chapter 1. Introduction and Background

Documented health disparities exist in the United States and Maryland among racial and ethnic minority populations. What are less clear are the causes of these disparities and the solutions for reducing and eliminating health disparities. The purpose of this report is to provide a resource for members and staff of the Maryland General Assembly who wish to become knowledgeable on health disparities generally and in Maryland.

Research Activities and Report Organization

In developing this report, Department of Legislative Services (DLS) staff met with Department of Health and Mental Hygiene staff, Maryland Health Care Commission staff, and faculty from various universities located in Maryland. DLS staff reviewed the statutes pertaining to the programs which are the focus of this report and reviewed legislation that could affect the relevant programs. In addition, DLS conducted literature reviews, reviewed federal and other state programs, and analyzed State and federal data.

This report reviews health disparities among racial and ethnic minorities. This chapter includes an introduction and provides some background on the topic. Chapter 2 offers a health disparity primer by providing an overview of health disparities, reviews studies and reports on health disparities, and summarizes other state efforts. Chapter 3 describes Maryland's health disparity programs and initiatives. Chapter 4 reviews Maryland data on health disparities. Finally, Chapter 5 includes discussions of issues for possible consideration by the State and the General Assembly.

A Brief History of Federal Activities

Health disparities have been investigated by researchers for many years. Academic interest, however, started in earnest during the 1990s with a large number of studies documenting health disparities by race, ethnicity, income, and disease. In response to the increasing concerns with health disparities, multiple federal entities were established to address health disparities. In fact, almost every major health organization, such as the National Cancer Institute and American Medical Association, have developed information on health disparities.

While the bulk of academic research has documented health disparities and the problems associated with these disparities, it is generally left to government to develop the policies and strategies needed to reduce or eliminate health disparities. The first federal program to address health disparities was established in 1986 by the United States Department of Health and Human Services (HHS). HHS' Office of Minority Health's purpose, as specified on its web page, "is to improve and protect the health of ethnic and racial minority populations through the

development of health policies and programs that will eliminate health disparities." In addition, in 1998 the Advisory Committee on Minority Health was established within HHS to advise the Secretary on issues pertaining to the health of racial and ethnic minorities. The advisory committee and the HHS office must work together to develop policies and provide advice to the Secretary on minority health issues.

In order to carry out its duties, the HHS office employs regional staff, operates a resource center, and operates the Center for Cultural and Linguistic Competence in Health Care. The HHS office also cooperates with other federal entities, including the Centers for Disease Control and Prevention's (CDC) Office for Minority Health, and the National Institutes of Health's (NIH) National Center on Minority Health and Health Disparities, to address health disparities across the country. Lastly, the CDC office distributes grants, runs campaigns, and holds conferences, all with the purposes of creating awareness of, and preventing, health disparities.

The CDC followed HHS' lead by establishing its Office of Minority Health in 1988. As detailed on its web page, the CDC office "promotes health and quality of life by preventing and controlling the disproportionate burden of disease, injury, and disability among racial and ethnic minority populations." As opposed to the broad mission of the HHS office, the CDC office focuses on more tangible disease aspects of health disparities, which are otherwise known as health status disparities. The CDC office coordinates presidential initiatives with HHS initiatives, supports research and development, reports on the health of racial and ethnic minorities, and develops partnerships between government and private organizations.

In 1990, encouraged by the United States Congress, NIH established the Office of Research on Minority Health, now known as the National Center on Minority Health and Health Disparities. The web page for the NIH center states its mission as "to promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities." As opposed to the CDC office's role of providing disease-specific information, the NIH center's purpose is to promote and support research regarding racial and ethnic minority health disparities. To accomplish its mission the NIH center awards research grants and partners with other NIH institutes to conduct research on health disparities. The NIH center ultimately hopes to develop and integrate a national research agenda focusing on health disparities.

A Brief Maryland History

Most states also recognize that health disparities exist and have created programs or initiatives to address the problems associated with health disparities. Taking their lead from the federal government, most states have instituted similar approaches. Universities and colleges in Maryland have been researching health disparities, and more recently, the State government has become involved with addressing health disparities in Maryland.

During the 2004 legislative session, legislation passed that created the Maryland Office of Minority Health and Health Disparities (OMHHD) within the Department of Health and Mental Hygiene. OMHHD is charged with examining health disparities and minority health issues in Maryland. Among its many duties spelled out in legislation, OMHHD may provide grants to community-based organizations and historically black colleges and universities and to collaborate with those institutions. Other legislative initiatives and the specific roles and duties of OMHHD will be discussed in Chapter 3 of this report.

Chapter 2. A Health Disparities Primer

State policymakers face the issue of health disparities as they consider proposals to improve the health status of its residents and the health care systems that support them. Voluminous data and research establish the existence of health disparities. This chapter provides a basic description of the issue, including a review of major initiatives and research, and other state initiatives.

Health Disparities Defined

There is general agreement as to the racial and ethnic groups of greatest concern in matters of health. For this purpose, the federal government includes as racial and ethnic minorities persons who are American Indian, Alaska Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian and Other Pacific Islander. In the legislation that created the Maryland Office of Minority Health and Health Disparities, "minority persons" in Maryland include African Americans, Hispanics, Asian and Pacific Islanders, and American Indians.

However, what constitutes health disparity varies widely and can be quite complicated. The most influential study to date, the 2002 Institute of Medicine's (IOM) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, defined health disparities as "racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention." The report further defined "preferences" to be "patient choices regarding health care that are based on a full and accurate understanding of treatment options." The report divided "differences" in the quality of health care into three categories:

- clinical need and patient preferences;
- the legal and regulatory environment under which the health care system operates; and
- discrimination.

The IOM chose to study any differences in health care quality that occurred in the second and third items on the above list in order to determine the existence of a health care disparity.

A 2002 analysis from the University of Maryland School of Medicine's Department of Epidemiology and Preventive Medicine entitled *What is a "Health Disparity"?* pointed out that health disparity could have a number of different meanings. While health disparity is commonly used in the United States, in areas outside the United States "health inequity" or "health inequality" are more common descriptors.

Regardless of where one lives there are documented differences in the morbidity or incidence of certain diseases or conditions among the various racial and ethnic minority groups in the United States. There are also perceptions that persons of the various racial and ethnic groups may be treated differently in the health care system. Further, to the extent these differences favor one group over another, a disparity may exist.

Specifically then what are "health disparities?" The current thinking among researchers who study health disparities distinguishes between health status disparities and health care disparities:

- health status disparities occur when a racial or ethnic minority group shows a higher incidence of illness, injury, disability, or mortality; and

- health care disparities occur when a racial or ethnic minority group is determined to have different insurance coverage and access to health care, as well as other factors that could affect health care quality that are not due to a health status disparity.

Some research focuses either exclusively on health status disparities or health care disparities. Taken together, both health status and health care disparities may be considered health disparities.

For this report, "health disparities" is used generally as described above, when the report discusses research or includes more detailed analyses, and then the specific type of health disparity will be used.

Federal Initiatives

Healthy People 2010

Guiding most federal actions regarding health disparities is the Healthy People 2010 Initiative. The United States Department of Health and Human Services (HHS) Office of Minority Health and the Centers for Disease Control and Prevention (CDC) Office of Minority Health have specific roles to play regarding implementation of Healthy People 2010. The HHS office monitors compliance with initiative goals concerning minority health. The CDC office has responsibility for several specific indicators included in the initiative as they relate to minority health. Certain centers within the National Institutes of Health are also involved with the initiative.

The Healthy People 2010 Initiative is actually a rolling concept that started with a 1979 Surgeon General's report entitled *Healthy People*. The 1979 Surgeon General's report and other reports including *Promoting Health/Preventing Disease: Objectives of a Nation*, and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, resulted in the

federal government establishing criteria that could be used by all levels of government to increase the overall health of United States citizens. The previous initiatives have evolved into the current guide now known as the *Healthy People 2010* Initiative.

Healthy People 2010 is purported to be the prevention and health promotion agenda for the nation. The agenda was jointly developed by federal, state, and local agencies; businesses and nonprofit health organizations; and community organizations. The two basic goals for *Healthy People 2010* are increasing the quality and years of healthy life and eliminating health disparities. The path to achieving the goals moves along 28 focus areas, each with its own goal statement, ranging from cancer to food safety.

In addition to the goals and focus areas, *Healthy People 2010* identifies several leading health indicators that represent significant public health concerns across the nation. As specified on the CDC web site, the indicators include physical activity; overweight and obesity; tobacco use; substance abuse; responsible sexual behavior; mental health; injury and violence; environmental quality; immunization; and access to health care. Progress on any of the focus areas or the health indicators should reflect not only the relative health of Americans but should also reduce or eliminate health disparities.

REACH 2010

As part of its efforts to meet the goals of *Healthy People 2010*, the CDC has established *Racial and Ethnic Approaches to Community Health 2010* (*REACH 2010*). *REACH 2010*, begun in 1999, is CDC's main effort designed to eliminate health disparities. Keys to *REACH 2010* are six identified areas through which racial and ethnic minorities experience significant health status disparities. According to the CDC web site, "these six health areas were selected for emphasis because they reflect areas of disparity that are known to affect multiple racial and ethnic minority groups at all life stages." These six areas, which serve as the basis for most state efforts or initiatives addressing health disparities, include:

- infant mortality;
- deficits in breast and cervical cancer screening and management;
- cardiovascular diseases;
- diabetes;
- HIV infections and AIDS; and
- child and adult immunizations.

Institute of Medicine Report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*

As noted in Chapter 1, academic studies demonstrating the existence of health disparities for racial or ethnic minorities are plentiful. In 1999, responding to the many concerns raised by these studies, Congress requested that the Institute of Medicine (IOM) determine the differences in the types and quality of health care received by racial and ethnic minorities in the United States and explore contributory factors to these inequities. The IOM was specifically requested to:

- "assess the extent of racial and ethnic differences in health care that are not otherwise attributable to known factors such as access to care;

- evaluate potential sources of racial and ethnic disparities in health care, including the role of bias, discrimination, and stereotyping at the individual, institutional, and health system levels; and

- provide recommendations regarding interventions to eliminate health care disparities."[1]

The IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, was completed in 2002 and has become the benchmark for subsequent reports on health care disparities. As a result of the IOM report, the focus for the study of health disparities shifted from the confirmation of the existence of health care disparities to stratigies for reducing or eliminating disparities.

The IOM report demonstrated that a consistent body of research provides evidence that racial and ethnic minorities experience a lower quality of health services, even after controlling for socioeconomic differences and other health care access-related factors. The IOM report also concluded that the research indicated significant variations in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable.

The IOM report determined that health care disparities are found in several disease areas. Studies demonstrate racial and ethnic differences in cardiovascular care, cancer diagnostic testing and treatment, diabetes care, end-stage renal disease and kidney transplantation, pediatric care and maternal and child health, mental health, and rehabilitative and nursing home services. The IOM study committee also determined that many factors may be involved in racial and ethnic health care disparities, beyond access-related factors, including patients themselves, health care providers, and health care systems.

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[1] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002).

The IOM's recommendations for reducing racial and ethnic disparities in health care included increasing awareness of racial and ethnic disparities in health care among the general public, health care providers, and key stakeholders.

Agency for Health Care Research and Quality, 2005 National Health Care Disparities Report

As part of an ongoing initiative, the federal Agency for Health Care Research and Quality (AHRQ) publishes an annual report providing a comprehensive national overview of disparities in health care among racial, ethnic, and socioeconomic groups in the United States and tracks the success of initiatives to reduce and eliminate disparities. AHRQ tracks disparities in the quality of health care and the access to health care. The major themes highlighted in the *2005 National Healthcare Disparities Report* were:

- disparities still exist;
- some disparities are diminishing;
- opportunities for improvement remain; and
- information about disparities is improving.[2]

In summary, AHRQ demonstrated that the nation has made some progress in the elimination of health disparities among racial and ethnic minorities, but there is still a long way to go. The AHRQ report found that disparities still exist in almost all facets of health care, including quality and access, the type of health care received, and varying conditions and care settings. Although disparities still exist throughout the health care continuum, for some racial minorities, the quality of care and access to care is improving.

Unequal Care and Treatment

While there is much data supporting health *status* disparities, the information supporting health *care* disparities is largely anecdotal or based on observation. Studies that have attempted to measure unequal care and treatment often have inconclusive results. The IOM report also addressed health care disparities. The IOM report identified three possible factors that could create health care disparities: patient level factors; health care systems level factors; and care process level factors.

[2] National Healthcare Disparities Report, Agency for Health Care Research and Quality (2005).

The Patient

Patient level factors are associated with the behavior of the patient in seeking health care. According to the IOM report, "these [patient] behaviors and attitudes develop as a result of poor cultural matches between minority patients and providers, mistrust, misunderstanding of provider instructions, poor prior interactions with health care systems, or lack of knowledge of the best use of health care services." The IOM report concluded though that these patient behaviors and attitudes are not significant reasons for health care disparities.

The IOM report also pointed out that there is some speculation that biologically based racial differences could justify differential treatment of a racial or ethnic minority group. Again, the research indicated that these differences do not cause health disparities. The IOM report concluded that a "majority of studies document disparities in health care services and disease areas when interventions are equally effective across population groups – making the "racial differences" hypothesis an unlikely explanation for observed disparities in care."

The Health Care System

The second factor that could lead to health care disparities is the health care system itself, some of which may or may not be controllable. The IOM report posited that "aspects of health systems – such as the ways in which systems are organized and financed, and the availability of services – may exert different effects on patient care, particularly for racial and ethnic minorities." Language barriers were mentioned as one potential contributor to health care disparities for certain racial and ethnic minorities. Language barriers could be exacerbated by the time pressure health care professionals often face in the performance of their jobs. In addition, the location of the health care institution or facility may also affect the use of services by racial and ethnic minorities. Finally, the movement of Medicaid recipients into managed care by many states may have disrupted traditional health care services used by racial and ethnic minorities.

The Health Care Process

Perhaps the major, and most controversial, factor resulting in health care disparities are care process factors. These factors include bias, stereotyping, and clinical uncertainty, which all could affect the behavior of practitioners toward racial and ethnic minorities. The IOM report conjectured that "patients might also react to providers' behavior associated with these practices in a way that also contributes to disparities." The IOM report determined that at the time of the study, "little research has been conducted to elucidate how patient race or ethnicity may influence physician decision-making and how these influences affect the quality of care provided." Nevertheless, IOM attempted to use the information and data that was available to suggest that this factor could lead to health care disparities.

The IOM report observed that physicians approach every patient with some "clinical uncertainty." A doctor's experience, observations, and the severity of a patient's illness determine the course of treatment of a patient. If a physician's clinical uncertainty is higher for a particular patient, the physician could rely on a prior experience with a similar patient. To the extent that the similar patient was a racial or ethnic minority, that experience could affect how the physician treats the existing patient. Over-reliance on prior experiences could lead to health disparities for racial and ethnic minority patients.

Research has demonstrated that "stereotyping" exists and has persisted. According to the IOM report, "stereotyping can be defined as the process by which people use social categories (*e.g.*, race, sex) in acquiring, processing, and recalling information about others." Stereotyping may be unconscious or overt, but the extent of its existence could affect health care provider and patient behavior leading to health care disparities.

Bias or prejudice, like stereotyping, may shape a person's views or opinions of others. Although few view prejudice favorably, there is enough research to suggest that it is still common in the United States. The IOM report acknowledged that prejudice may exist in health care but also relayed that "the vast majority of health care providers find prejudice morally abhorrent and at odds with their professional values." The IOM report continued that "health care providers, like other members of society, may not recognize manifestations of prejudice in their own behavior."

At the time of the IOM report, there was as yet no evidence demonstrating that bias directly affected providers' care for racial or ethnic minority patients. Nevertheless, a body of research has shown that provider "feelings" may be influenced by racial and ethnic minority patients.

Other Research

The IOM report referenced several studies that attempted to address provider "feelings." The most influential study was a 1999 study by Schulman, et al., which video taped actors portraying White male patients and female patients, and Black male patients and female patients, interacting with physicians. The Schulman study found that White and Black male "patients," as well as White female "patients," were likely to be referred for cardiac catheterization at similar rates. Black female "patients," however, received much lower rates of referral for catheterization, even though all groups exhibited the same symptoms. The general conclusion of the study was that a physician's treatment recommendations may be influenced by a patient's race and sex.

Other studies and researchers have also attempted to document health care disparities particularly in the area of hospital care, since there is a large amount of hospital administrative data available. As reported in the *American Journal of Medicine*, an article assessed whether there was an association between patient race and ethnicity and problems with a patient's experience with hospital service. This article found that "after adjustment for demographic and

hospital characteristics, Black patients reported more problems with respect for their preferences compared to Whites." Particularly, Black patients reported that they had more problems when discharged from surgical services and Latinos reported that they had more problems when discharged from obstetrical services. The article's authors, however, found that there were no racial or ethnic differences when patients were discharged from medical services.

Research Problems

Studies that specifically attempted to document health care disparities also listed several problems with the research. Schulman, et al., reported that other factors could have affected physician decisions regarding catheterization such as women could have worse outcomes than men. Also, Schulman, et al., had no way to assess physician bias, and the measuring instrument and sample size – the physicians were all attending a national conference – may have limited the study. Hicks, et al., reported that the survey they used was originally used by the hospital to measure only quality of care and that the response rate was characteristically low for these types of analyses. In addition, Hicks, et al., could not compare the racial and ethnic distribution of the study participants with non-responders to the survey.

The mechanisms of how bias, stereotyping, and uncertainty, directly affect health care have yet to be fully understood. The IOM report concluded that, "while the relationship between race or ethnicity and treatment decisions is complex and may be influenced by gender, providers' perceptions and attitudes toward patients are influenced by patient race or ethnicity, often in subtle ways." Another factor that could enter into the provider patient interaction is the patient's response to the provider. Again, little research is available to conclude that patient response affects provider actions. It is reasonable to conjecture that both provider and patient perceptions could affect provider and patient interactions.

An Alternative View?

As mentioned previously a large body of research indicates that health disparities exist. Not all research has indicated, however, that the main cause for substandard care for racial and ethnic minorities is health disparities. A March 16, 2006, *New England Journal of Medicine* article by Asch, et al., stated that Americans may not always receive recommended health care, but "the extent to which the quality of health care varies among sociodemographic group is unknown."

Asch, et al., recognized that Americans do not receive all recommended health care and that there is little geographic variation regarding that rate. The researchers also indicated that there may be statistically significant differences for certain population subgroups when the receipt of health care is not optimal. Asch, et al., took a larger view of the problem by reporting that the statistical differences were a subset of a "profound and systemic nature of the quality of care problem." Some key findings of the study included:

- women generally receive better care than men;
- the proportion of preventative care declines with age, while the proportion of follow-up care increases with age;
- health insurance status was generally unrelated to quality of care; and
- Blacks had higher quality health care scores than Whites, when controlling for other sociodemographic characteristics, health status, and the use of inpatient and outpatient services.

Asch, et al., also listed some study limitations such as the quality of the medical records they used and that certain individuals' experience with the health care system may deter racial and ethnic minorities from obtaining care. The researchers concluded that by limiting the focus on specific problems, such as racial and ethnic health disparities, the greater need may be missed, which in their view is that "problems with the quality of care is widespread and systemic and require a systemwide approach."

Other State Initiatives

According to the HHS office's web site, almost all states have established initiatives addressing health disparities. Thirty-four states have created specific minority health offices in their health departments. Two states have gone further and established minority mental health offices in their mental health divisions. Nine states have minority commissions, centers, or programs that address minority health. Eight states and the District of Columbia have no specific initiative addressing health disparities.

As for the states around Maryland, Virginia also has an Office of Minority Health. The Virginia office develops policy, assesses programs, conducts cultural competency training, and performs community outreach. Pennsylvania does not have a specific office or function that addresses health disparities. Pennsylvania's Department of Health's web site, however, devotes considerable attention to the topic of health disparities. Delaware's Division of Public Health has an Office of Minority Health. West Virginia has a relatively small minority population, but it does have a Minority Health Program in its Department of Health and Human Resources' Division of Rural Health.

The Maryland Office of Minority Health and Health Disparities identified what it considers as "promising practices" in several other states. **Exhibit 2.1** lists selected states and their promising practices that address health disparities.

Exhibit 2.1
Other Selected State Promising Practices

State	Program or Initiative
California	In Los Angeles a Latino HIV/AIDS Awareness Task Force is providing education and awareness classes at local churches to reduce the incidence of HIV/AIDS for Latinos. The state Medicaid program requires that managed care organizations provide appropriate cultural and linguistic services and that contracts include anti-discrimination measures. California requires that University of California regents report on medical student recruitment from underserved areas.
Massachusetts	The Department of Health requires that hospitals provide translation services. Posters must be displayed in hospitals relaying that "you have the right to a medical interpreter at no cost to you" in over 30 languages. In addition, the legislature passed a law requiring a competent interpreter for non-English speaking emergency room patients.
Michigan	Michigan's Medicaid program provides funds to various community organizations to target specific racial or ethnic group health conditions. In addition, the Medicaid program requires managed care organizations to initiate programs that would reduce health disparities, and Michigan also analyzes data across racial and ethnic minorities to identify system, community, and individual health disparities.
New Jersey	The state Medicaid program requires that managed care organizations provide appropriate cultural and linguistic services and that contracts include anti-discrimination measures. New Jersey uses its Certificate of Need program to encourage the expansion of facilities into underserved racial and ethnic minority communities and to address racial and ethnic health disparities. New Jersey recently enacted legislation mandating that state-licensed physicians receive cultural competency training.

Exhibit 2.1 (cont'd)
Other Selected State Promising Practices

North Carolina	Through a diabetes control program, North Carolina develops interventions designed to reach African Americans with diabetes and partners with the General Baptist State Convention and the state Office of Minority Health and Health Disparities to conduct programs for African American congregations. The control program also develops public service announcements for radio stations with large African American audiences and works with community hospitals in medically underserved areas. The Office of Minority Health and Health Disparities administers the legislatively established Community-Focused Eliminating Health Disparities Initiative. The initiative is a grant program designed to build the capacity of local health departments, American Indian tribes, faith-based organizations, and community-based organizations, with the goal of eliminating racial and ethnic minority health disparities.

Source: Department of Health and Mental Hygiene

Chapter 3. Health Disparities Initiatives and Programs in Maryland

The History of Health Disparities Initiatives in Maryland

Two decades ago, Maryland recognized health disparities in minorities as an important public health issue for the State. As early as 2000, Maryland began identifying and tracking statewide health objectives to improve the overall health of its citizens. Many State programs, though not specifically targeted to minority populations, can have a positive impact on minority health in Maryland, for example school-based health centers and immigrant health initiatives. Key State initiatives to focus on the elimination of health disparities are shown in **Exhibit 3.1**.

Exhibit 3.1
Key Health Disparities Initiatives and Programs in Maryland

Date	Action
1986	The Governor's Commission on Black and Minority Health, established by executive order to examine the programs and laws relating to the health status of Maryland's minority citizens
2000	Healthy Maryland – Project 2010, a Department of Health and Mental Hygiene initiative to identify and track statewide health objectives
2000	Establishment of Minority Outreach and Technical Assistance for the purpose of organizing minority participation in the Cigarette Restitution Fund program
2001	Maryland Health Improvement Plan, developed to promote the public health agenda for Maryland
2002	Healthy Maryland Chart Book, a continuation of Healthy Maryland – Project 2010 and a baseline perspective for monitoring Maryland's health status
2004	The establishment of the Maryland Office of Minority Health and Health Disparities

Source: *Maryland Office of Minority Health and Health Disparities Annual Report, 2005*; Office of Minority Health and Health Disparities; Department of Legislative Services

For the past decade, the General Assembly has considered legislation to address health disparities in racial and ethnic minorities. **Exhibit 3.2** details statutory changes that specifically address health disparities in Maryland. Collectively, the legislation has significantly raised awareness on the issue of health disparities in racial and ethnic minorities in Maryland. For example, the establishment of the Office of Minority Health and Health Disparities (OMHHD) within the Department of Health and Mental Hygiene (DHMH) provided a central entity to coordinate State efforts on eliminating health disparities in Maryland. In addition, the Health Care Disparities Policy Report Card established a mechanism to provide the State with necessary data on racial and ethnic health disparities in Maryland.

Exhibit 3.2
Legislation Addressing Health Disparities

Year	Chapter	Change
1990	JR 3	Establishes the Governor's Commission on Black Males to study the nature and extent of problems facing Black males, including limited access to health care.
2000	17 and 18	Establishes Minority Outreach and Technical Assistance to organize minority participation in the Cigarette Restitution Fund program. Minority Outreach and Technical Assistance distributes competitive grants to minority community-based organizations throughout the State to provide outreach to minorities regarding cancer and tobacco-use awareness, education, prevention, and screening. (See section on the Cigarette Restitution Fund program on page 23 of this report.)
2002	162	Requires the Maryland Health Care Foundation[3] to promote public awareness of the need to reduce health disparities associated with poverty, gender, and race. The legislation authorizes the foundation to provide grants to programs addressing health care disparities. In addition, the legislation requires the foundation to consider geographical balance by county and region in providing grants and developing programs. The geographical balance must include consideration of the following factors: the percentage of uninsured individuals; the extent of health disparities; and the existence of programs and services addressing the needs of the uninsured and underinsured in the geographic area.

[3] The Maryland Health Care Foundation was established in 1997 to support efforts to increase and improve access to quality health care for the uninsured, underinsured, and medically underserved residents of Maryland. The Maryland Health Care Foundation was terminated effective June 1, 2004 (Chapter 262 of 2004).

Exhibit 3.2 (cont'd)
Legislation Addressing Health Disparities

Year	Chapter	Change
2003	453	Encourages courses or seminars that address the identification and elimination of health care services disparities of minority populations as part of curriculum courses or seminars offered or required by institutions of higher education; continuing education requirements for health care providers; and continuing education programs offered by hospitals for hospital staff and health care practitioners. The legislation requires DHMH, in consultation with the Maryland Health Care Foundation and other organizations, to develop and implement a plan to reduce health care disparities based on gender, race, ethnicity, and poverty. The bill also requires the entities to: • examine continuing education programs offered by hospitals and physician organizations that are focused on health care disparities and continuing education requirements of health occupation boards; • determine the content of a model course or seminar that addresses health care services disparities of minority populations; • assess the feasibility of requiring certain health care providers to take the course or seminar; and • identify the oversight that would be required by a health occupation board in order to determine compliance with continuing education requirements concerning health care disparities.
2004	319 and 443	Establishes the Office of Minority Health and Health Disparities within DHMH. (See section on OMHHD on page 21 of this report.)

Exhibit 3.2 (cont'd)
Legislation Addressing Health Disparities

Year	Chapter	Change
2006	450	Requires OMHHD, in collaboration with the Maryland Health Care Commission, to annually publish a "Health Care Disparities Policy Report Card" on DHMH's web site and make the information available in writing upon request. The report card must include an analysis on racial and ethnic variations in insurance coverage for low-income, nonelderly individuals; the racial and ethnic composition of the physician population compared to the composition of the State's population; and the racial and ethnic disparities in morbidity and mortality rates based on race and ethnicity for certain diseases and conditions. In addition, the Maryland Health Care Commission must also incorporate racial and ethnic variations in its report cards for health maintenance organizations, nursing homes, hospitals, and ambulatory surgical centers.
2006	497	Requires the Family Health Administration, in consultation with OMHHD to provide technical assistance to qualified community-based entities for a pilot program that addresses cultural competency training of health care providers, with an emphasis on community-based providers; and health outcomes and community-based models for targeting health outcomes as determined by tracking indicators relating to the specific health care needs of the population in a specified area.
2006	221 and 222	Establishes a Nurse Support Program Assistance Fund in the Maryland Higher Education Commission to be used for grants that will help to increase the number of bedside nurses in Maryland hospitals. A portion of the competitive grants must be used to attract and retain minorities in the nursing and nursing faculty fields.
2006	379	Establishes the Statewide Commission on the Shortage in the Health Care Workforce within DHMH to study the shortage of health care workers in the State, including identifying methods to recruit minorities into the health care workforce.
2006	358	Requires DHMH, in consultation with OMHHD, to submit a report on adult sickle cell anemia.

Source: Department of Legislative Services

Maryland Office of Minority Health and Health Disparities

In 2004, OMHHD was created within DHMH to advocate for improving minority health care in Maryland. The legislation specifically required OMHHD to assist the Secretary of Health and Mental Hygiene in identifying, coordinating, and establishing priorities for programs, services, and resources that Maryland should provide for minority health and health disparities. The legislation also requires OMHHD to assist in identifying and reviewing health promotion and disease prevention strategies relating to the leading health causes of death and disability among minority populations and to develop a strategic plan to improve public services and programs targeting minorities.

Under the legislation, OMHHD was required to conduct research and serve as a clearinghouse and resource library for information about minority health and health disparities, to develop grant-awarding criteria for programs to improve minority health care, and to apply for and accept any grant available for programs related to minority health and health disparities. OMHHD was also required to develop a statewide plan for increasing the number of racial and ethnic minority health care professionals and to work with universities and colleges of medicine, nursing, pharmacy, and dentistry in Maryland and other health care professional training programs to develop courses with cultural competency, sensitivity, and health literacy to address racial and ethnic disparities in health care.

Finally, the legislation required OMHHD to develop and implement model public and private partnerships in racial and ethnic minority communities for health awareness campaigns and to improve the access, acceptability, and use of public health services. OMHHD is required to seek to create a statewide alliance with community-based agencies and organizations, historically black colleges and universities, health care facilities, health care provider organizations, managed care organizations, and pharmaceutical manufacturers.

OMHHD Initiatives

OMHHD has made significant progress since its establishment in 2004. Shortly after its creation, OMHHD launched the Health Care Disparities Initiative web site at www.mdhealthdisparities.org to serve as a clearinghouse and resource library for minority health and health disparities. This comprehensive web site contains information on health disparities, including minority health disparities data, minority resources, and grant opportunities. To assist in the review of health disparities data, OMHHD initiated a re-analysis of State health data to quantify racial and ethnic health disparities in Maryland.

One of OMHHD's major initiatives is to develop a statewide plan to eliminate health disparities. The Maryland Plan to Eliminate Minority Health Disparities will be the result of comments and recommendations gathered from stakeholders throughout the State on how health disparities are impacting the lives of our citizens and what actions can be taken to improve the health of Marylanders. The statewide plan, which is expected to be published in early 2007, will

include information on issues relating to health disparities, such as health professional education, health disparities data, resources for reducing disparities, and access to quality health care.

OMHHD staffed four statewide committees that were formed to discuss health disparities in Maryland. These committees produced the Maryland Statewide Committee Executive Summary and Recommendations Report. These four committees also are assisting in the review of the statewide plan.

OMHHD has been active in bringing members of various racial and ethnic communities together to collect information on racial and ethnic minorities in Maryland. Specifically, OMHHD held two Native American Health Roundtable meetings to develop recommendations for addressing health challenges facing Maryland's Native Americans and produced the Maryland Native American Health Roundtable Recommendations. OMHHD held one Latino/Hispanic Health Roundtable. In addition, OMHHD held six town hall meetings in various jurisdictions around the State, including Frederick, Waldorf, Salisbury, Denton, Rockville, and Baltimore to gather more diverse input from minority populations and persons in rural and distant geographic locations and produced the Maryland Town Hall Meeting Executive Summary and Recommendations. Since 2004, OMHHD has held an annual Statewide Health Disparities Conference which provided recommendations for reducing disparities. Collectively, the recommendations from the statewide conferences, town hall meetings, and health round tables will be incorporated in the Maryland Plan to Eliminate Minority Health Disparities.

Consistent with the requirement that OMHHD apply for and accept grants from the federal government, OMHHD received a $785,750 five-year grant entitled, "State Partnership to Improve Minority Health," from the United States Department of Health and Human Services, Office of Minority Health, to improve minority health in Maryland.[4] The grant will be used to pursue two goals aimed at improving minority health in Maryland: increasing health workforce diversity; and conducting a self-assessment within DHMH in order to develop a plan of action to increase the focus on reducing minority health disparities. Specifically, the health workforce diversity project will aim to increase minority graduates from health professional schools and partner with these schools to promote workforce diversity. The DHMH internal self-assessment will identify assets and gaps to enhance agency activities to reduce minority health disparities and formalize health disparities reporting.

Finally, the Family Health Administration (a division of DHMH), in consultation with OMHHD, has made significant progress in establishing a cultural competency pilot program. The pilot program will include qualified community-based entities to address cultural competency training of health care providers and health outcomes relating to the health care needs of a defined minority population in underserved areas of Maryland.

[4] DHMH Press Release, September 29, 2005, at http://dhmh.state.md.us/publ-rel/html/2005/pr092905.htm.

Maryland Cigarette Restitution Fund Program

In 2000, Minority Outreach and Technical Assistance (MOTA) was established as part of the statewide public health component of the Cigarette Restitution Fund (CRF) program. MOTA was enacted for the purpose of organizing minority participation in the CRF program. MOTA targets African Americans, Native Americans, Asians, Hispanic/Latinos, and women. Specifically, the legislation requires DHMH to provide outreach and technical assistance to African American and other minority communities targeted by the tobacco industry to organize their effective participation in the CRF program and the State's network of community health coalitions for both the tobacco and cancer programs. Community health coalitions have been established by local health officers to advise and assist them in the formulation of comprehensive Tobacco and Cancer plans and the implementation and evaluation of these programs. Minority participation in local community health coalitions is intended to enhance the efforts of local health departments to decrease the incidence of cancer and cancer deaths and the prevention and control of tobacco use in minority communities throughout the State.

MOTA distributes competitive grants to minority community-based organizations throughout the State. Grant funds are used to provide outreach to minorities regarding cancer and tobacco-use awareness, education, prevention, and screening. Minority outreach is accomplished primarily through community events held at shopping centers, churches, and community centers.

Maryland Environmental Justice Program

The United States Environmental Protection Agency (EPA) defines environmental justice as:

> "The fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies. Fair treatment means that no group of people including a racial, ethnic, or socioeconomic group should bear a disproportionate share of the negative environmental consequences resulting from industrial, municipal, and commercial operations or the execution of federal, state, local, and tribal programs and policies."[5]

[5] United States Environmental Protection Agency, Final Guidance for Incorporating Environmental Justice Concerns in EPA's NEPA Compliance Analyses, April 1998.

Maryland's definition, which builds on the EPA's definition, specifically notes that all citizens of the State, regardless of race, income, culture, and social status, should have equal protection from environmental and public health hazards.[6]

In 1997, the General Assembly established the Maryland Advisory Council on Environmental Justice (MACEJ).[7] The primary purpose of MACEJ was to examine issues relating to environmental justice and make recommendations on environmental justice issues to the Governor, General Assembly, and State and local governments. In fulfilling its charge, several concerns were raised about potential environmental justice issues such as lead poisoning, increased asthmatic levels and other respiratory concerns, communication, living and working conditions, public involvement and outreach, drugs, and inequities/disparities.

In 2003, the General Assembly established the Commission on Environmental Justice and Sustainable Communities.[8] The responsibilities of the commission include reviewing and analyzing the impact of current State laws and policies on the issue of environmental justice and sustainable communities; assessing the adequacy of State and local laws to address the issue; coordinating with the Children's Environmental Health and Protection Advisory Council on recommendations; developing criteria to assess whether communities may be experiencing environmental justice issues; and recommending options to the Governor for addressing issues, concerns, or problems related to environmental justice.

Centers for Health Disparities in Academic Institutions in Maryland

University of Maryland Center for Health Disparities

The University of Maryland School of Medicine's Center for Health Disparities works to identify racial, ethnic, and geographic health disparities throughout the State and partners with communities to address those disparities. In 2000, the university received a five-year grant from the National Cancer Institute (NCI) to create the Maryland Special Populations Network (MSPN) program. Through this program, the university began creating a regional community-based network to address health disparities. This grant led to the creation of the Maryland Statewide Health Network, supported with CRF program funds, which focuses on underserved urban and rural areas by providing programs addressing cancer and tobacco-related diseases, conducting faculty and community outreach and research, and increasing residents' awareness of clinical trials in which they may be eligible to participate. The network has 32 telemedicine sites throughout the State that are used for health care provider continuing education activities, consultations, community education activities, faculty research projects, and other clinical and administrative purposes.

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[6] Section 1-701(a) of the Environment Article.

[7] Chapter 741 of 1997.

[8] Chapter 460 of 2003. The commission was previously established by Executive Order on January 1, 2001.

In 2003, the university received a grant from the National Institutes of Health's (NIH) National Center on Minority Health and Health Disparities to host a Comprehensive Center on Health Disparities Research, Training, and Outreach in partnership with the University of Maryland Eastern Shore to support research on cancer, renal/kidney disease, eye diseases, and mental health at each institution.

In 2005, the School of Medicine's Center for Health Disparities received another five-year Maryland Regional Community Network program grant from NCI, replacing MSPN, to continue its focus on community-based participatory research on specific cancers (such as breast, cervical, colorectal, liver, and prostate), as well as tobacco cessation and clinical trials awareness activities.

In 2004, the School of Medicine received the Department of Health and Human Services' Best Practices Award for the work of the Center for Health Disparities and Eastern Shore Oncology. They increased the number of community-based clinical trials on the rural Eastern Shore and increased participation in clinical trials among minority and underserved populations through provider and consumer education, outreach, and training. This best practice has become a national model.

The Morgan Center for Health Disparities Solutions

The Morgan Center for Health Disparities Solutions is dedicated to increasing and sustaining the diversity of health practitioners and researchers who work to eliminate health disparities in Maryland. Consistent with this goal, the Morgan Center has initiated several projects to facilitate education and training. One initiative that the Morgan Center is involved in is *Community Fellows in Health Disparities*, a program that is open to community leaders who are interested in working to improve the health profiles of local communities. Community participants can improve the relationship between Morgan State and the Baltimore community by arranging for students and faculty to become involved in activities in community organizations and by working to develop new relationships and programs that will improve the economic, health and social well-being of selected populations and communities. Another initiative that the Morgan Center has been involved in is the *Personal and Academic Training for Careers in Health*, which is a program to increase the number of underrepresented minority high school students from Baltimore City who are interested in health care professions and who have expressed an interest in pursuing a career related to health disparities.

The Morgan Center implements programs that work to change attitudes and increase awareness and facilitate education and training. The Morgan Center is supporting the implementation of an Elementary Neuroscience Literacy Program "Brain Explorers" in the Baltimore City School System. This program is designed to educate elementary school children about a variety of basic science concepts using the brain and body as the central focus. The program aims to provide a foundation of knowledge so that these students can better appreciate how drugs affect the body. The Morgan Center also is collaborating with Open Gates Health

Center, a full-service, community-based health clinic in Baltimore to provide outreach and education to minorities. The Morgan Center also has worked on initiatives for the prevention of obesity among children in Baltimore and African American college students.

Hopkins Center for Health Disparities Solutions

The Hopkins Center for Health Disparities Solutions (HCHDS) is dedicated to the elimination of disparities in health and health care among racial and ethnic populations, socioeconomic groups, and geopolitical categories such as urban, rural, and suburban populations. HCHDS conducts research with the goals of advancing knowledge on the causes of health disparities and developing interventions to eliminate disparities. HCHDS has worked with Morgan State University, John Hopkins Center for Hospital Finance and Management, Welch Center for Prevention, Epidemiology and Clinical Research, University of Maryland School of Pharmacy, the Kaiser Family Foundation, Johns Hopkins School of Medicine, as well as other entities to meet the common objective of gaining a better understanding of disparities in health and health care.

While the center has several past and ongoing research efforts that focus on various health disparities and related issues, the cornerstone project of the HCHDS is the *Exploring Health Disparities in Integrated Communities* (EHDIC) Study. The EHDIC Study is a multi-site analysis designed to examine the nature of health status disparities within community samples without race differences in socioeconomic status or socio-environmental risk exposures. This design of using racially-integrated communities allows epidemiologic research on health disparities to be conducted while eliminating the three most common challenges of such research: the unavailability of data sources capable of supporting comparative analysis, racial segregation, and confounding of race and socioeconomic status.

The first site of the EHDIC Study consisted of two census tracts located in Southwest Baltimore. The *Southwest Baltimore Community Health Project* (SWB) was a collaborative research effort between Morgan State University and the Johns Hopkins Bloomberg School of Public Health under the Morgan/Hopkins Center for Health Disparities Solutions (CHDS). In 2003, with funding from Pfizer pharmaceuticals, CHDS had a team of researchers conduct interviews with southwest Baltimore community residents in order to gather information on health behavior, psychosocial factors and health care access and utilization. The SWB Study was a survey of adult residents from a low-income urban community in Maryland. This study found that race differences in social and environmental risk exposure is partly accountable for race differences in health status.

Another ongoing HCHDS study is the *Commonwealth Fund Minority Health Survey Project*. Minority and low-income patients are more likely to use "safety net" hospitals - primarily public hospitals and major teaching hospitals - than White and more affluent patients. In 2005, HCHDS received a grant from the Commonwealth Fund to determine which hospitals provide the best care to minority and low-income patients, and which characteristics and best practices are associated with hospitals serving these populations.

In addition to research, HCHDS also provides other activities that are consistent with the center's theme, "Exploration and Intervention for Health Equality." The HCHDS has established several educational programs that serve to increase awareness of and enhance research activities involving health disparities. HCHDS also has worked with various community-based organizations to provide outreach and education to Baltimore communities. Initiatives that HCHDS has worked on include outreach programs to increase the awareness of health disparities among young adults through music and poetry, provide health care resources to communities, and provide information on the value of nutrition and methods to obtain healthy eating practices.

Morgan/Hopkins Center for Health Disparities Solutions

In October 2002, researchers from Morgan State University and the Johns Hopkins Bloomberg School of Public Health received a $6 million grant from NIH under the Centers of Excellence in Partnerships for Community Outreach, Research on Health Disparities and Training (Project EXPORT) program. The purpose of the grant is to support health disparities research and establish a research center on health disparities. The center, which is named the Center for Health Disparities Solutions (CHDS), focuses on projects to study disparities in racial and ethnic groups, urban and rural populations, and income and social classes. CHDS is designated as a national Comprehensive Center of Excellence in Health Disparities by the National Center for Minority Health and Health Disparities of the National Institutes of Health.

Chapter 4. Maryland Health Disparities Data

Introduction

Racial and ethnic health disparities have been documented in Maryland, as well as every state across the nation. This chapter provides Maryland specific data on health disparities from a variety of State, federal, and non-profit organization sources including disease incidence and prevalence rates and mortality rates. Incidence rates track the newly diagnosed cases of a reported disease, while prevalence rates track the overall number of people diagnosed as living with a reported disease. The mortality rates examined include overall mortality rates for Blacks as compared to Whites by county, infant mortality rates statewide, and mortality rates by disease.

Most of the following tables use age-adjusted data to show the racial and ethnic health disparities. Using age-adjusted data is necessary because many chronic diseases have higher prevalence and mortality rates for individuals at older ages. It also is necessary because minorities as a group are younger than non-minorities as a group. Where age-adjusted data were not readily available, this report examined data by the following age groups: 18-44, 45-64, and 65 and older. In many cases, data were grouped in several year increments to examine racial and ethnic health disparities. Grouping data by several years also evened out any spikes that are not part of an overall trend.

Contributing Factors to Health Status in Maryland

The United Health Foundation ranked Maryland thirty-second in its 2006 rankings of overall population health by state.[9] Because combined racial and ethnic minority populations are expected to make up an increasingly larger proportion of the population in coming years, reducing racial and ethnic disparities is an important factor for Maryland to have a healthier population. Data provided by the Maryland Vital Statistics Administration within the Department of Health and Mental Hygiene (DHMH) indicated that, in 2005, minorities accounted for 40.3 percent of Maryland's population, an increase of 2.4 percentage points from 2003. According to DHMH, if current trends continue, minorities could be 50 percent or more of the population in Maryland by 2010.

Racial and ethnic health disparities exist in part due to the prevalence of health risk factors, the incidence of disease, mortality rates, and access to quality health care services. Health risk factors can be the result of several factors, such as genetics and biological factors, social and economic factors, and racial discrimination.[10] The increased prevalence of health risk factors contribute to poor health among racial and ethnic minority populations. **Exhibit 4.1**

[9] A rank of 1 indicates the healthiest state and a rank of 50 the least healthy state, based on how far the state falls above or below the national average, on the health indicator.

[10] David R. Williams, *Race in the Health of America: Problems, Issues, and Directions* (2003).

Exhibit 4.1
Health Risk Factors, Maryland
2006

	Data	Rank in Nation**
Risk Factors – Personal Behaviors		
Prevalence of Smoking	18.9% of Marylanders (⇓ from 2005)	11
Prevalence of Obesity*	24.4% of Marylanders (⇑ from 2005)	25
Risk Factors – Community Environment		
Lack of Health Insurance	14.2% without health insurance (⇓ from 2005)	24
Risk Factors – Health Policies		
Adequacy of prenatal care	70.1% of pregnant women	38

*Body Mass Index of 30.0 or higher

**A rank of 1 indicated the healthiest state and a rank of 50 the least healthy state, based on how far the state falls above or below the national average, on the health indicator.

Source: United Health Foundation – *America's Health Rankings™ 2006* at www.unitedhealthfoundation.org

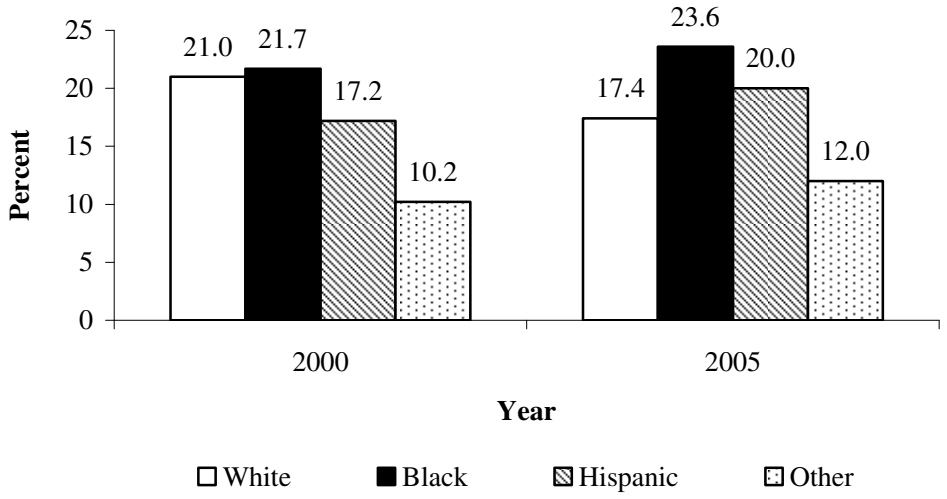
details information that measures various health risk factors associated with personal behaviors, community environment, and health policies in Maryland.

Prevalence of Smoking

While the United Health Foundation's data illustrated that the overall smoking rate for Maryland decreased in 2006, the rates of smoking for racial and ethnic minorities increased as shown in **Exhibit 4.2**. It has been suggested that the tobacco industry targets minority populations when advertising and promoting tobacco products.[11] This could influence tobacco use among racial and ethnic minorities in Maryland. In 2005, data collected from the United States Centers for Disease Control and Prevention showed that the African American and the Hispanic population in Maryland were more likely to smoke than the White population. In addition, smoking amongst Whites fell from 2000 to 2005 while rising among other groups.

[11] United States Department of Health and Human Services, *Tobacco Use Among U.S. Racial/Ethnic Minority Groups – African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General* (1998).

Exhibit 4.2
Adult Smoking Prevalence by Race and Ethnicity, Maryland 2000 and 2005



Source: Behavioral Risk Factor Surveillance System* Survey Data, 2000 and 2005

*The Behavioral Risk Factor Surveillance System is an ongoing, state-based telephone surveillance system supported by the Centers for Disease Control and Prevention. Through a series of telephone interviews, states uniformly collect data on behaviors and conditions that affect adult health.

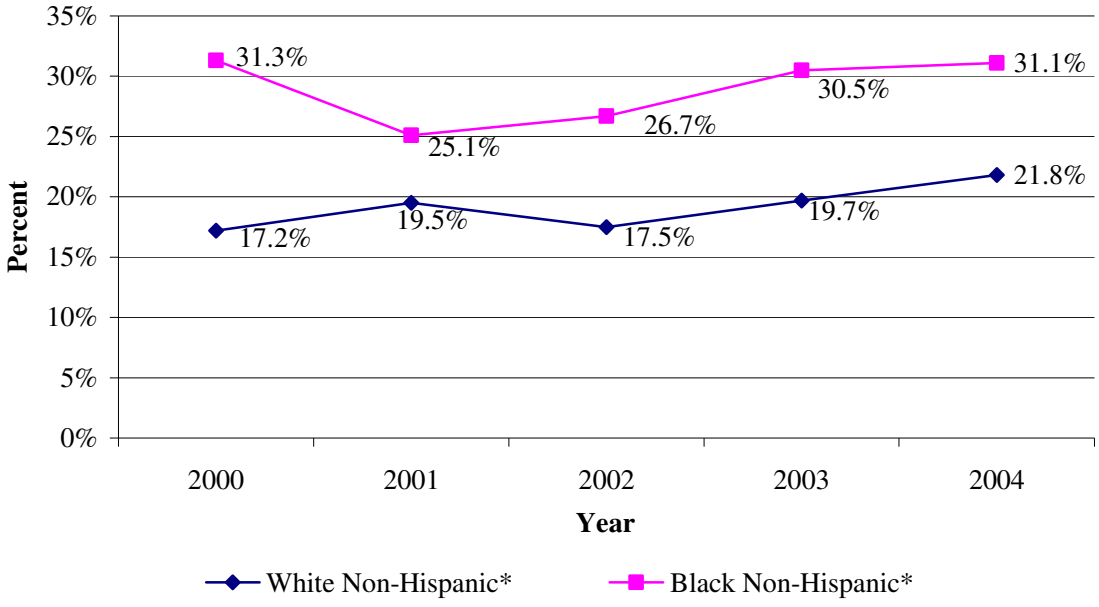
This increased rate of smoking may be linked to substantially higher rates of mortality and morbidity from all causes, including heart disease, stroke, and smoking-related cancers.

Prevalence of Obesity

As shown in Exhibit 4.1, the data showed that 24.4 percent of the population of Maryland was obese, placing Maryland's ranking at 25 in the country on this indicator. This was a slight increase from the 2005 rate of 23.9 percent of the State's population, in which Maryland ranked 32 in the country. In fact, as shown in **Exhibit 4.3**, obesity rates have increased between 2002 and 2004 for both Non-Hispanic White and Black populations in Maryland.

As indicated in Exhibit 4.3, obesity rates have increased for the Black Non-Hispanic population in Maryland. Similarly, across the country, there is concern about rising obesity rates

Exhibit 4.3
Prevalence* of Obesity, Adults Age 18+, by Non-Hispanic Whites or Blacks, Maryland 2000-2004**



*Not age-adjusted
**Body Mass Index of 30.0 or higher

Source: Maryland BRFSS interactive web site *http://marylandbrfss.org/* 2000-2004

in racial and ethnic minority populations.[12] Many obesity-related diseases including diabetes, hypertension, cancer, and heart disease are found in higher rates among various members of racial and ethnic minorities compared to Whites. Cultural factors related to dietary choices, physical activity, and acceptance of excess weight among African Americans and other racial and ethnic groups appear to play a role in obesity.

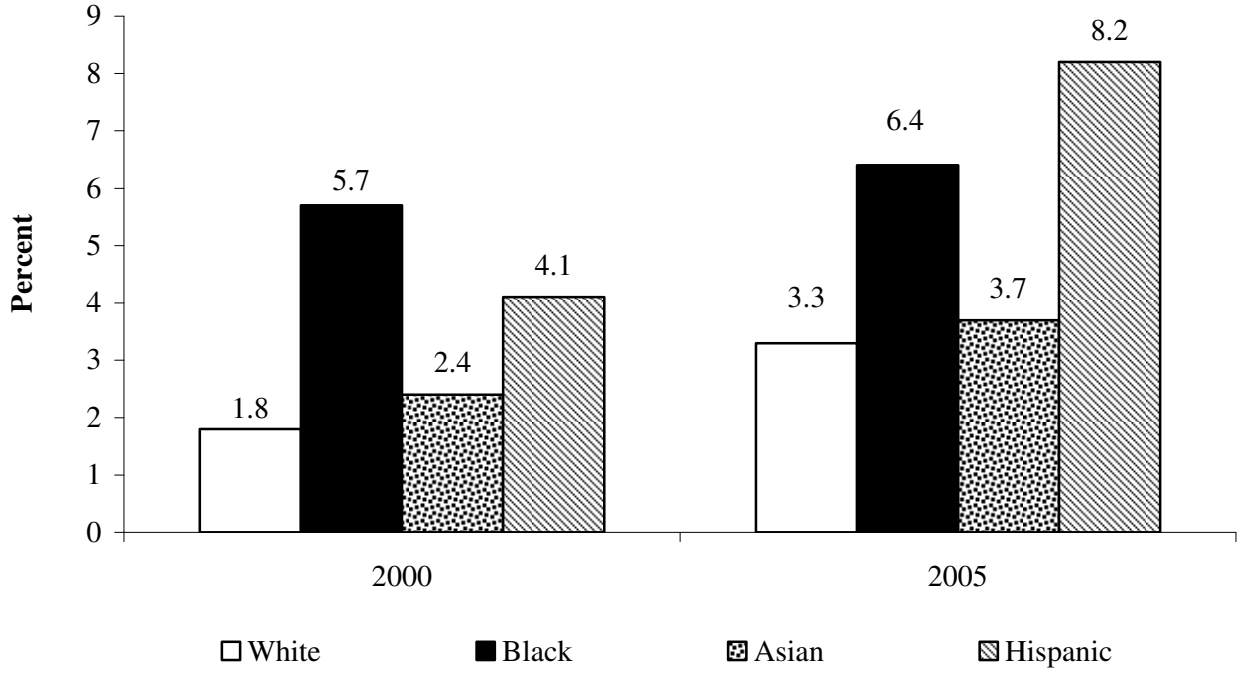
Prenatal Care

As shown in Exhibit 4.1, 70.1 percent of pregnant women in Maryland received adequate prenatal care, placing Maryland's ranking at 38 in the country.

[12] S. Kumanyika, *Special Issues Regarding Obesity in Minority Populations*, Annals of Internal Medicine, Vol. 119, Issue 7 Part 2, page 650, October 1993.

As shown in **Exhibit 4.4**, in 2005, compared to White women, the percent of births to women receiving late or no prenatal care was about two times higher for Black women and about two and half times higher for Hispanic women. From 2000 to 2005, the number of births to Hispanic women receiving late or no prenatal care doubled from 4.1 percent to 8.2 percent.

Exhibit 4.4
Percentage of Births to Women Receiving Late or No Prenatal Care* by Race and Ethnicity, Maryland, 2000 and 2005**



*Care began in the third trimester.
**Includes all persons of Hispanic origin of any race.

Source: Maryland Vital Statistics Report, 2000-2004; Maryland Vital Statistics Preliminary Report, 2005

A recent study published in the medical journal, Obstetrics & Gynecology, suggested that the prenatal care system in the United States does not adequately address racial and ethnic disparities in women's health. The study determined that even though minorities have greater access to prenatal care, the care that is being provided "remains insufficient in its present form for minority women."[13]

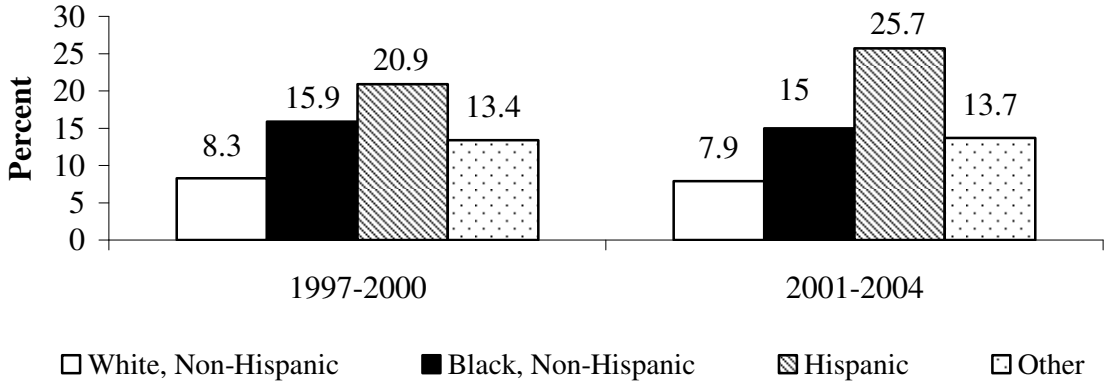
[13] Healy, Andrew J., *Racial Inequality Persists When It Comes to Prenatal Care*, Obstetrics & Gynecology, March 2006.

Lack of Health Insurance

Access to health care, as defined by the Institute of Medicine, means "the timely use of personal health services to achieve the best possible health outcomes."[14] Lack of health insurance coverage is a major factor in access to health care. Access to health care can be viewed on multiple levels: access in the health care system; access to a physical location to receive needed services; and access to providers who meet the needs of individual patients.[15]

As shown in Exhibit 4.1, the data showed that 14.2 percent of the Maryland population was without health insurance, which placed Maryland's ranking at 24 in the country. This is a decrease from the 2005 rate of 14.6 percent when Maryland ranked 30 in the country. As shown in **Exhibit 4.5**, the Black, Non-Hispanic population in Maryland was almost twice as likely to be uninsured as the White, Non-Hispanic population. In addition, the Hispanic population was over three times as likely to be uninsured as the White, Non-Hispanic population.

Exhibit 4.5
Percent of Marylanders by Race and Ethnicity
Who Do Not Have Health Insurance Coverage



Source: Maryland Behavioral Risk Factor Surveillance System interactive web site: *http://marylandbrfss.org/* 2000 – 2004

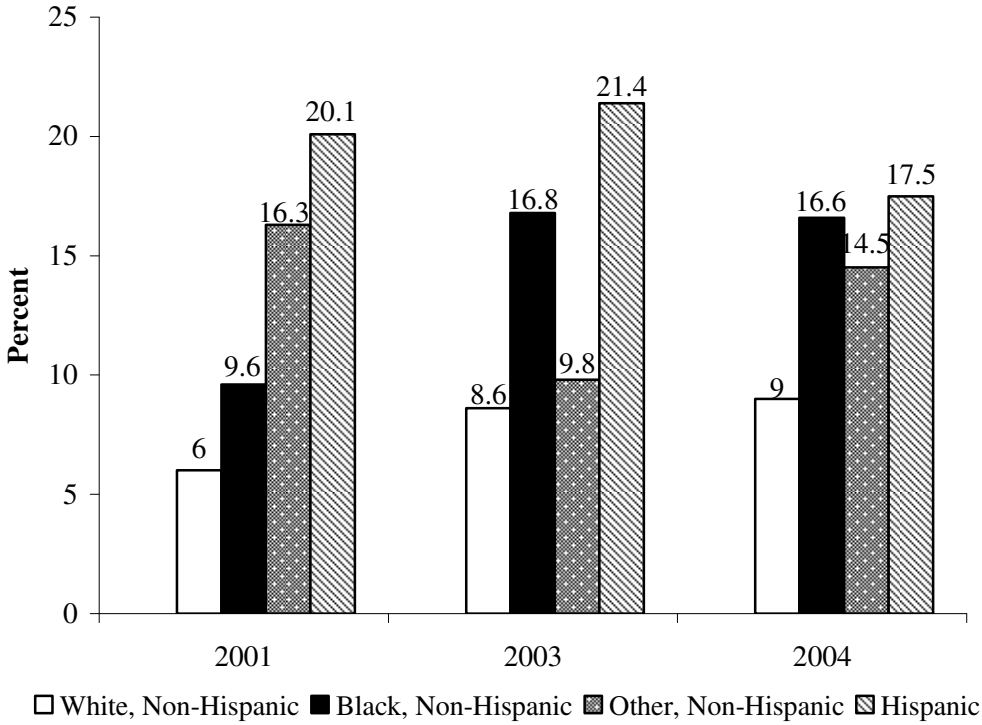
[14] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002).

[15] Bierman A, Magari ES, Jette AM, et al., *Assessing Access as a First Step toward Improving the Quality of Care for Very Old Adults*, J Ambul Care Manage, 121(3): 17-26, July 1998.

Unaffordable Health Care

Another factor contributing to health disparities is whether individuals can afford to see a doctor. The Hispanic population was the most likely to be unable to afford to see a doctor, although the percentage of Hispanics who could not afford to see a doctor fell by 3 percent over the four-year period, as shown in **Exhibit 4.6**. Meanwhile, for Black, Non-Hispanics, the percentage of adults who were unable to afford to see a doctor nearly doubled over the same period. At the same time, the percentage of White, Non-Hispanics who could not afford to see a doctor increased by 3 percent.

Exhibit 4.6
Percent of Marylanders by Race and Ethnicity
Who Could Not Afford to See a Doctor in the Past 12 Months
2001-2004



Note: Data for 2002 are not available because the questionnaire used did not ask the question: "Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"

Source: Maryland Behavioral Risk Factor Surveillance System, 2001-2004

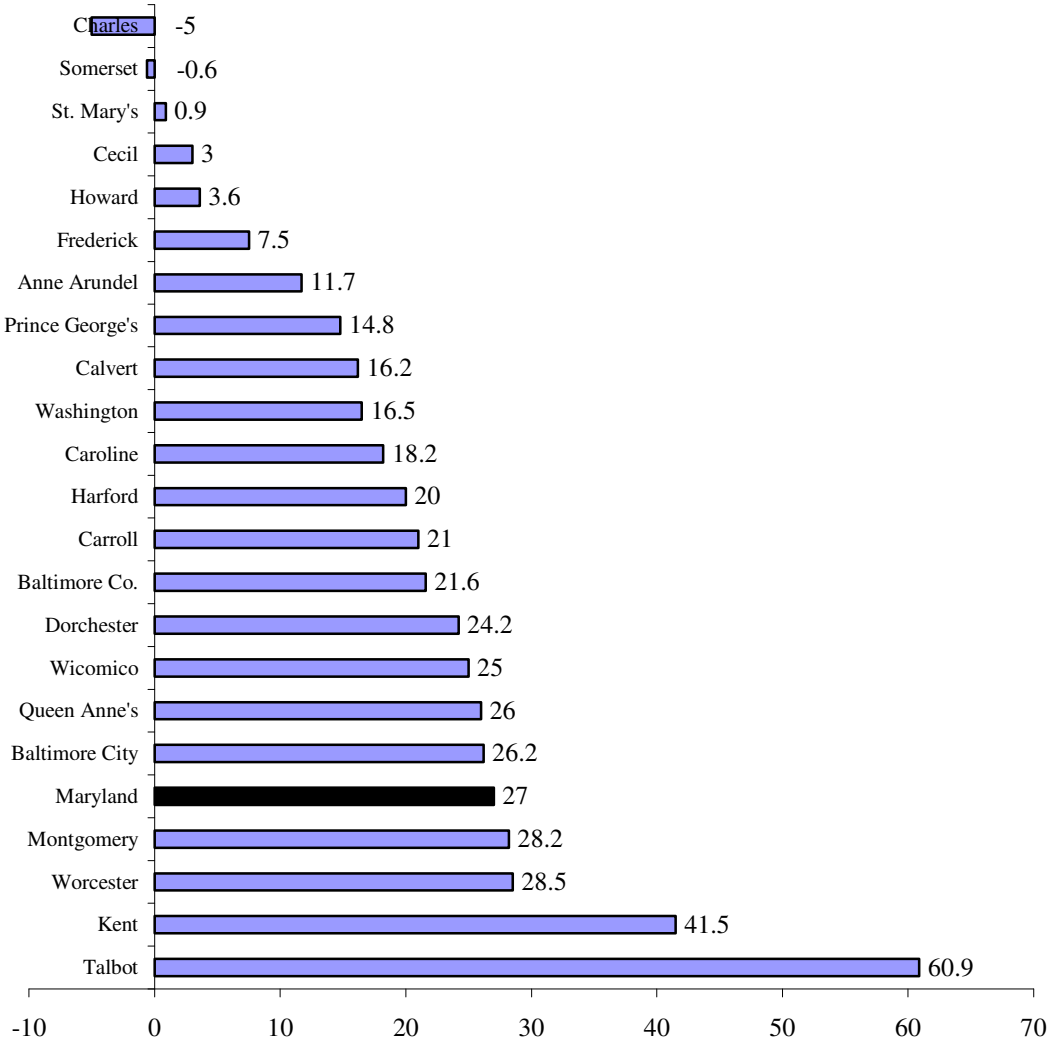
Health Status Disparities

This part of the chapter examines health status disparities in Maryland, including mortality by county for Blacks, infant mortality, and specific disease incidence and mortality rates. In almost every case, the data showed that minorities have a higher mortality rate than Whites and higher incidences of the diseases examined.

Excess Black Mortality

In 20 Maryland counties, Blacks had a higher mortality rate than Whites from 2003 through 2005, as shown in **Exhibit 4.7**. Three years of data for this exhibit is combined so that any unusual increases in a particular year that are not part of an overall trend do not skew the results. Among the counties for which age-adjusted mortality rates could be calculated, Talbot County showed the greatest disparity between Blacks and Whites, with the Black mortality rate at 60.9 percent greater than the White mortality rate. On the other end of the spectrum, Blacks had lower mortality rates than Whites in Charles County (5 percent lower for Blacks than Whites) and Somerset County (0.6 percent lower for Blacks than Whites). Statewide, Blacks had a 27 percent greater mortality rate than Whites. Age-adjusted rates could not be calculated for Allegany and Garrett counties because the number of decedents was too small to calculate adjusted rates.

Exhibit 4.7
Percent Excess* Black Age-adjusted Mortality by Political Subdivision, Maryland, 2003-2005



*Compared with Whites.

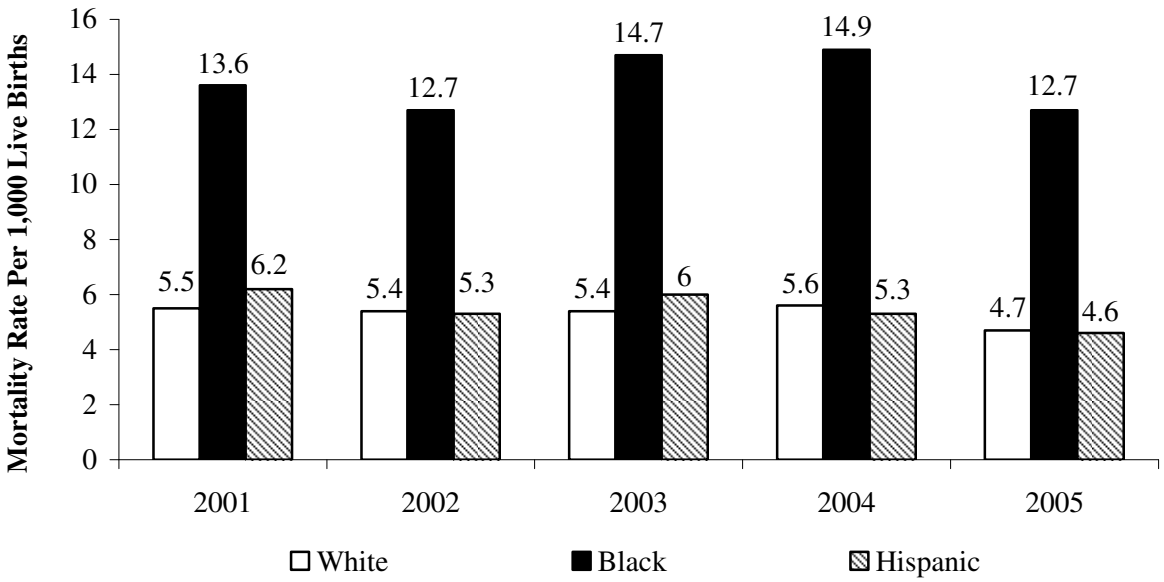
Note: Figures could not be prepared for Allegany and Garrett counties because the number of Black decedents was too small to calculate adjusted rates.

Source: Vital Statistics Administration, Department of Health and Mental Hygiene, 2006

Infant Mortality

The United Health Foundation's 2006 report ranks Maryland 44 in the country for infant mortality, as measured by infant deaths per 1,000 live births. This is an improvement over the 2005 ranking in which Maryland was ranked 46. Infant mortality rates statewide were three times higher in 2005 for Black infants than White and Hispanic infants. As shown in **Exhibit 4.8**, the infant mortality rate was 12.7 per thousand live births for Blacks compared to 4.7 for Whites and 4.6 for Hispanics. Over the five-year period, the infant mortality rate for Blacks has fluctuated but remained much higher than the rates for Whites and Hispanics.

Exhibit 4.8
Infant Mortality Rates in Maryland by Race and Hispanic Origin
2001-2005



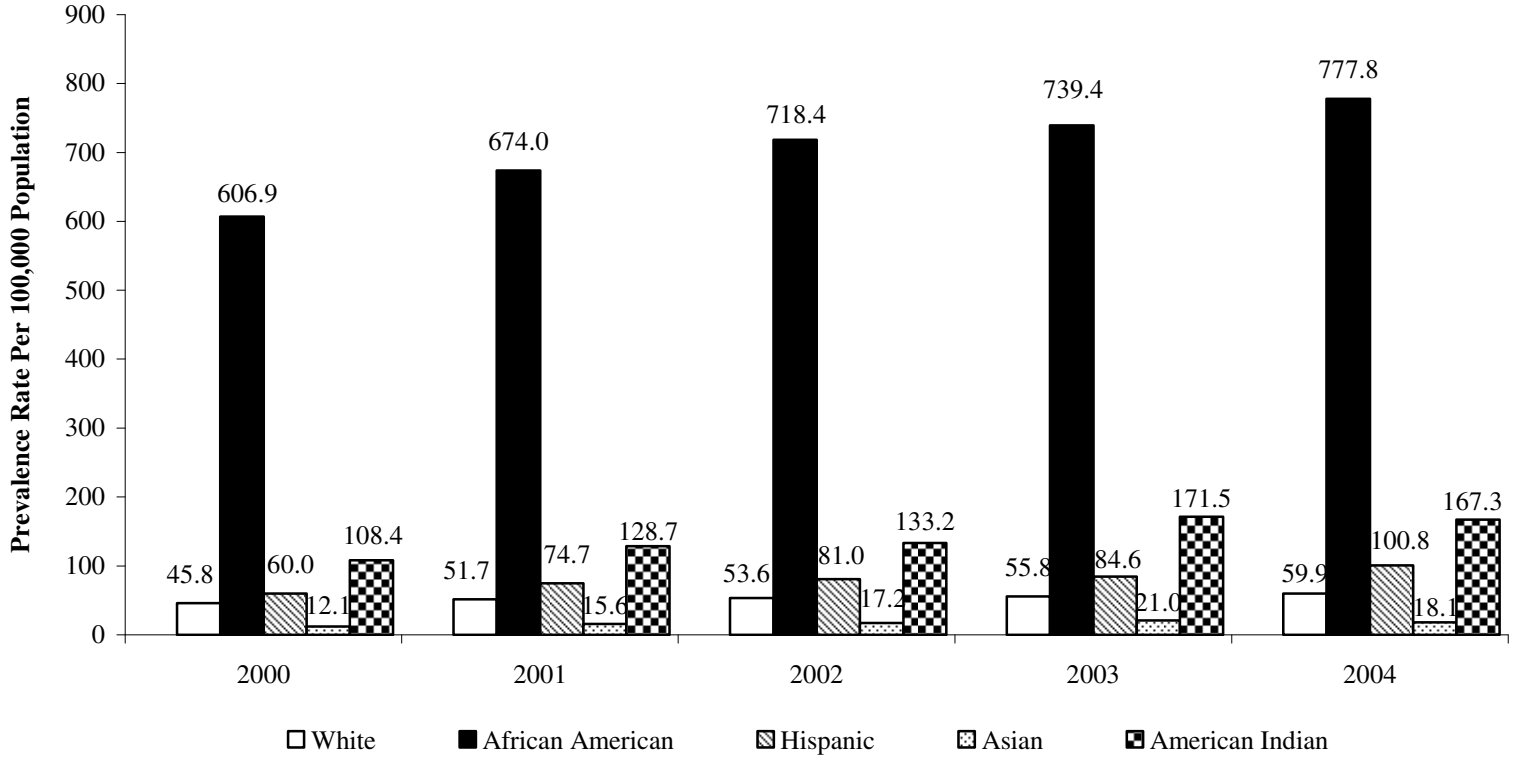
Note: Data for Hispanics are included in the data for each race. The Hispanic infant mortality rate includes all deaths to Hispanics of any race.

Source: Maryland Vital Statistics Preliminary Report, 2005

HIV and AIDS

As demonstrated in **Exhibit 4.9**, HIV and AIDS prevalence rates in Maryland from 2000 through 2004 showed a significant disparity between Blacks and every other racial and ethnic group. The rate of Blacks living with HIV and AIDS has progressively increased from 2000 to 2004. In 2004, the prevalence rate for Blacks was 13 times greater than for Whites.

Exhibit 4.9
HIV + AIDS Prevalence Age-adjusted Rate in Maryland by Race and Ethnicity
2000-2004



Source: AIDS Administration, Department of Health and Mental Hygiene, 2006

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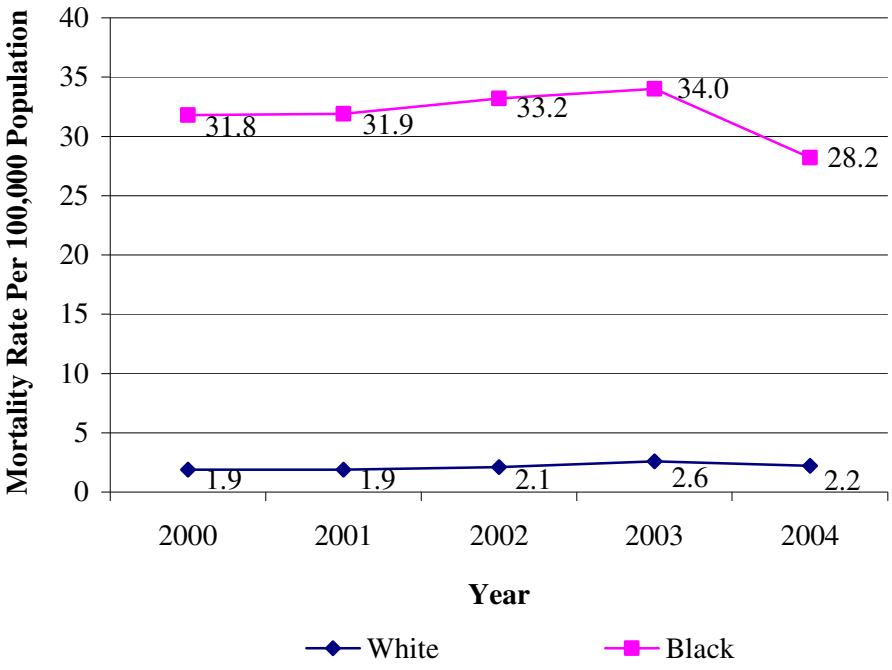
During the same five-year time period, the HIV age-adjusted mortality rate for Blacks declined, as shown in **Exhibit 4.10**. The mortality rate for Whites increased slightly in the same time period. Although fewer Blacks are dying from HIV, the mortality rate in 2004 was 12.8 times higher for Blacks than Whites.

Exhibit 4.10
HIV Age-adjusted Mortality Rate in Maryland by Race
2000-2004

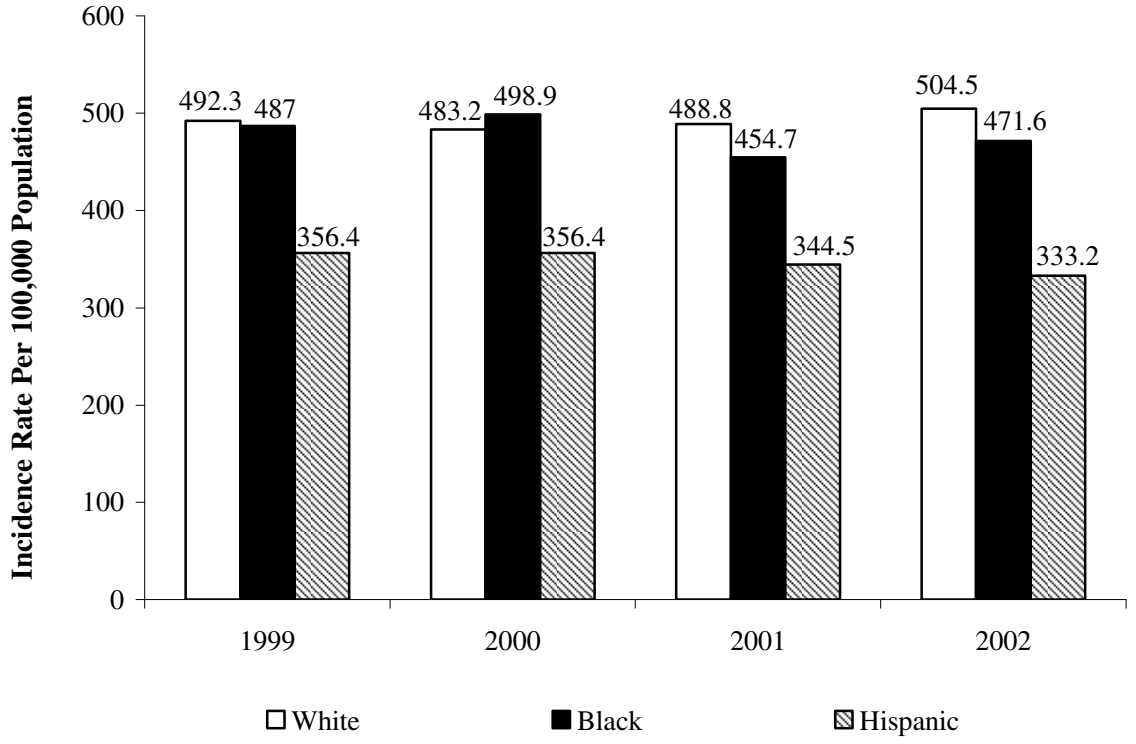


Source: Maryland Vital Statistics Annual Report, 2004

Cancer

The United Health Foundation's 2006 report ranked Maryland 29 in the country for cancer deaths. This is a significant improvement from the 2003 ranking in which Maryland was ranked 49 in the country.[16] As shown in **Exhibit 4.11,** the age-adjusted incidence rate for all invasive cancers (cancers that have spread beyond the layer of tissue in which it started) declined for Blacks from 1999 to 2002. The rate for Whites increased during that same period, while the cancer incidence rate declined for Hispanics.

Exhibit 4.11
Invasive Cancer Age-adjusted Incidence Rate in Maryland, by Race and Ethnicity
1999-2002

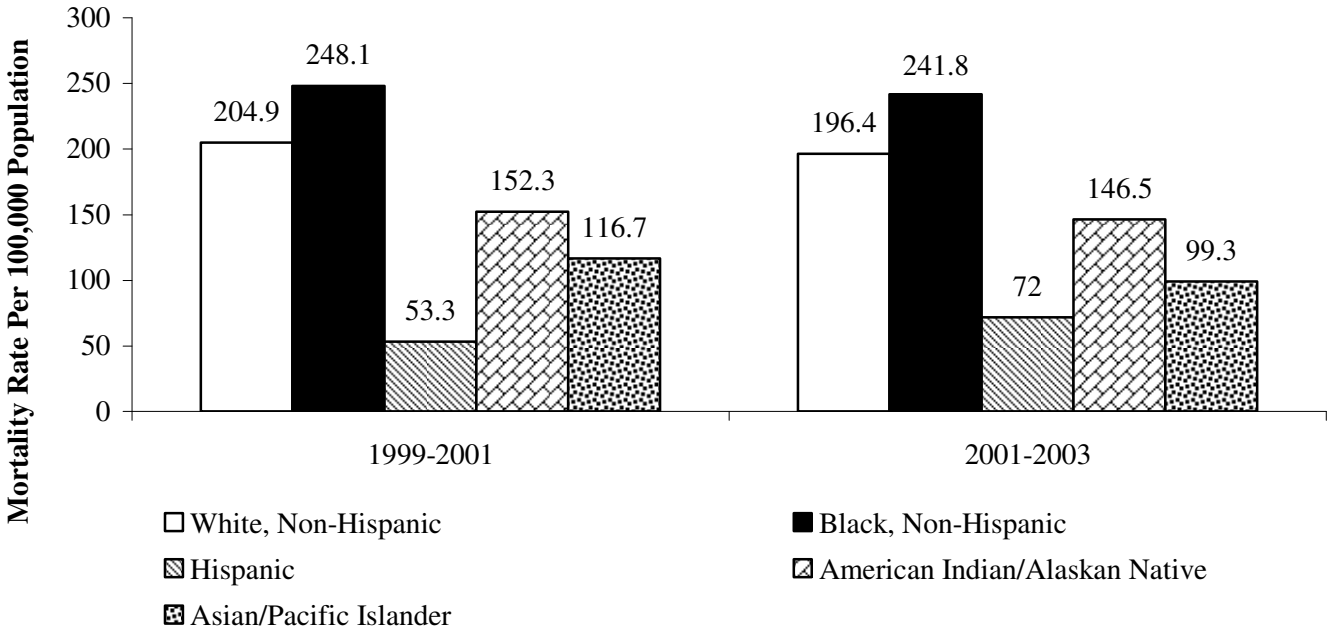


Source: United States Cancer Statistics: 1999-2002 Incidence and Mortality Web-based Report; United States Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute, 2005

[16] In the United Health Foundation's 2004 and 2005 report, Maryland was ranked 29 and 32, respectively.

Although the age-adjusted mortality rate for all cancers for Blacks also declined from 1999 to 2003, Blacks had a higher rate compared to every other ethnic group, as shown in **Exhibit 4.12**. In years 2001 through 2003, the mortality rate for Blacks was 1.2 times greater than for Whites. The mortality rate increased for Hispanics during the same period.

Exhibit 4.12
Adult All Cancer Age-adjusted Mortality Rate in Maryland by Race and Ethnicity



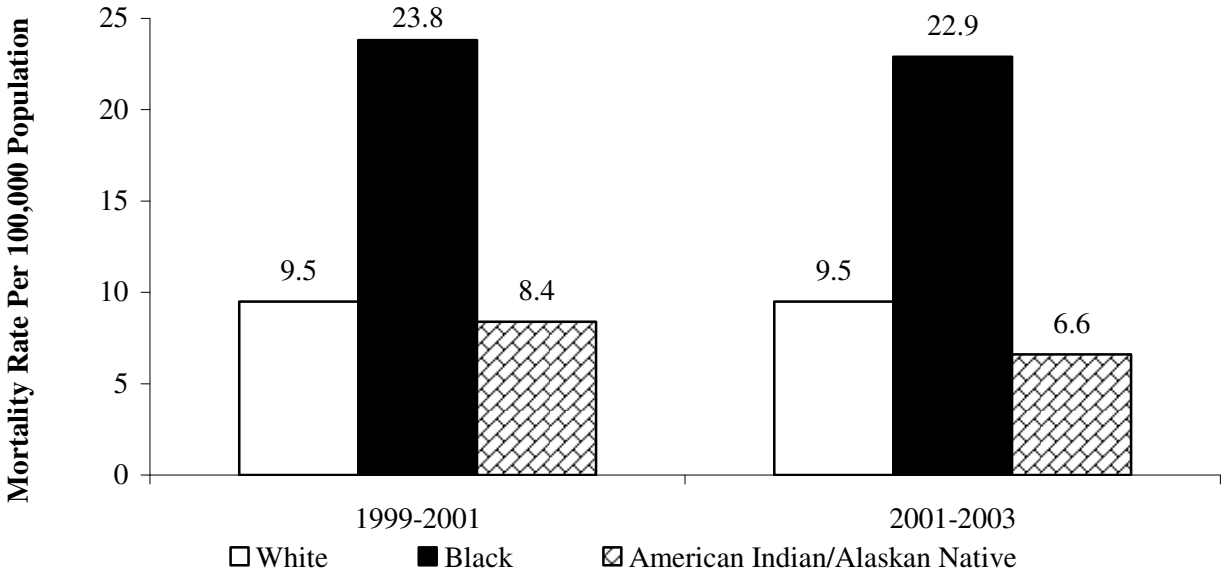
Source: Adult mortality by cause: United States/State, 1999-2003 National Vital Statistics System, Centers for Disease Control and Prevention/National Center for Health Statistics

Kidney Disease

There was a large disparity between the mortality rate for Black adults with kidney disease and the mortality rates for White adults and American Indian/Alaskan Native adults, as

shown in **Exhibit 4.13**. The Black mortality rate decreased slightly from years 1999-2001 to 2001-2003, but it was 2.4 times greater for Blacks than Whites in 2001-2003. The mortality rate declined for American Indian/Alaskan Native adults between the two periods.

Exhibit 4.13
Adult Kidney Disease Age-adjusted Mortality Rate in Maryland by Race



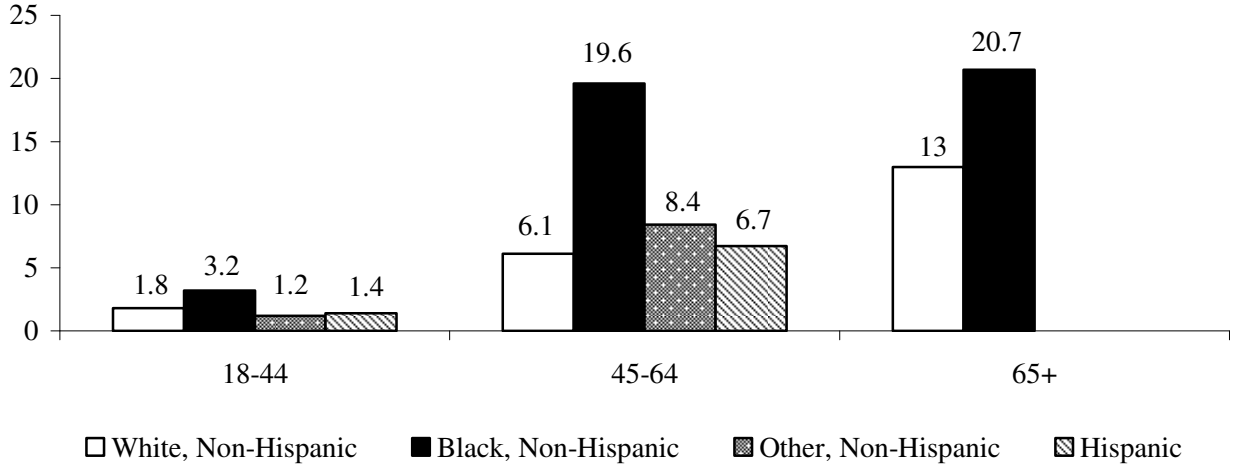
Source: Adult mortality by cause: United States/State 1999-2003, National Vital Statistics System, Center for Disease Control and Prevention/National Center for Health Statistics

Diabetes

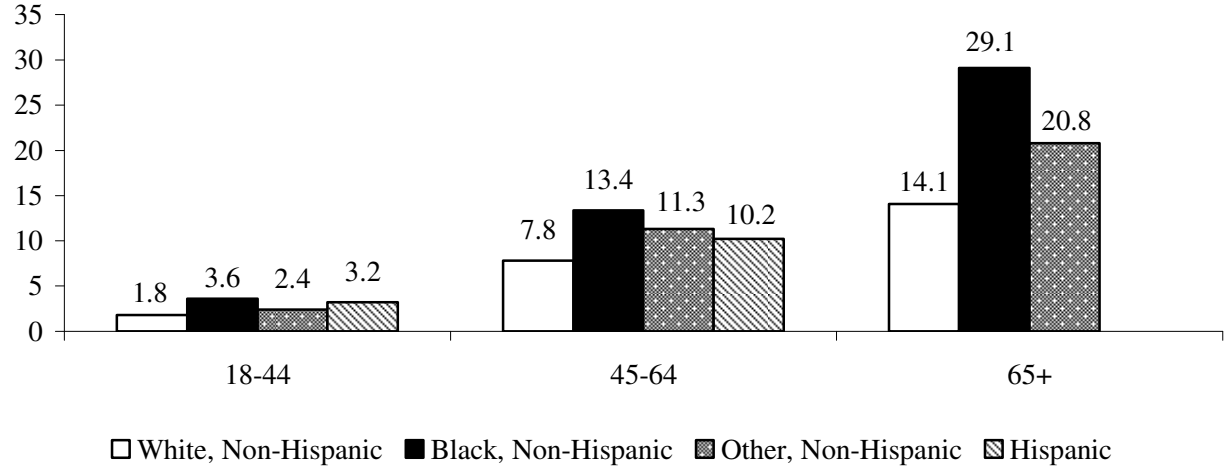
Blacks of any age group were more likely to be told by a doctor that they have diabetes, as shown in **Exhibit 4.14**. When comparing the data by age group, the percent of Blacks who were told they had diabetes increased for people ages 18-44 and 65 or older between the two periods. However, for Blacks ages 45-64, the percent of Blacks told they have diabetes declined.

From 2001 to 2004, the diabetes mortality rate while falling for both groups, remained higher for Blacks than Whites, as shown in **Exhibit 4.15**. In 2000, the diabetes age-adjusted mortality rate was 2.3 times greater for Blacks than Whites. In 2004, the diabetes age-adjusted mortality rate was 2.1 times greater for Blacks than Whites.

Exhibit 4.14
Percent of Maryland Residents Told by a Doctor That They Have Diabetes, by Race and Ethnicity
1997-2000



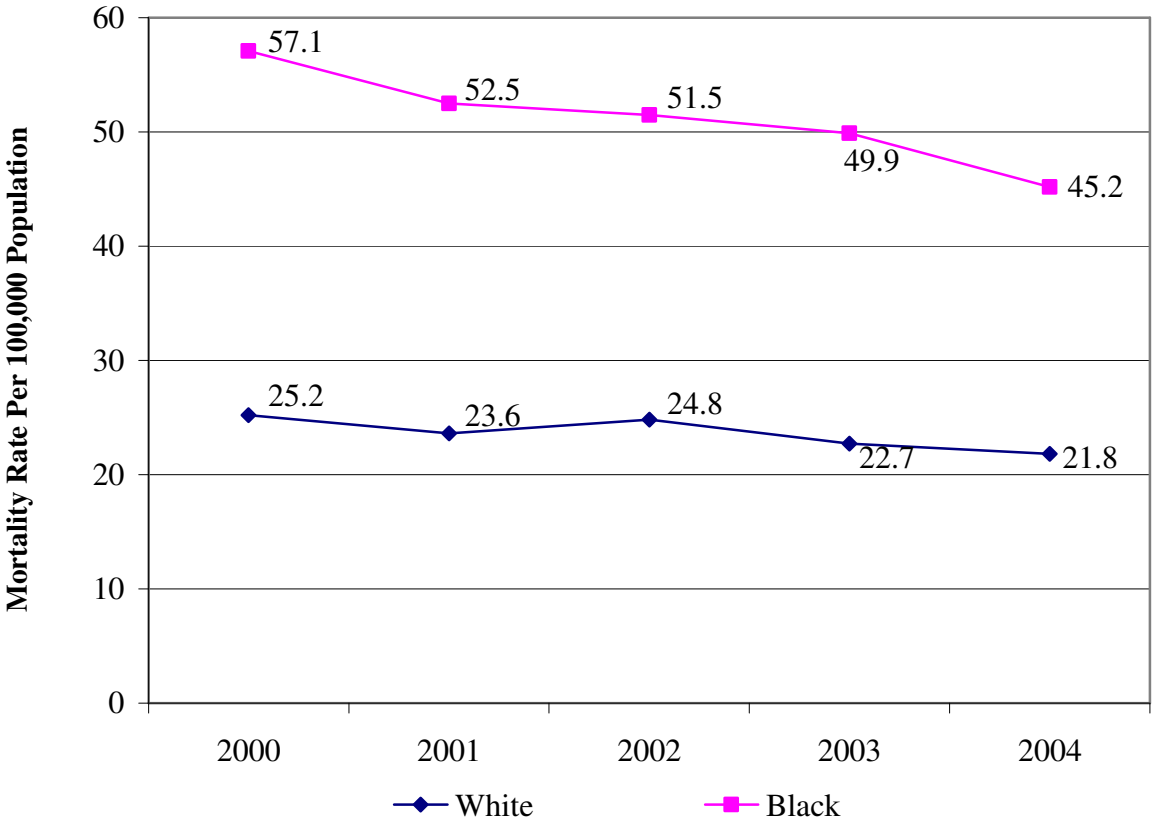
2001-2004



Note: For Hispanic age 65+, there was not enough data in this category. For other, non-Hispanic age 65+ (1997-2000), there was not enough data in this category.

Source: Maryland Behavioral Risk Factor Surveillance System, 2001-2004

Exhibit 4.15
Diabetes Age-adjusted Mortality Rate in Maryland by Race
2000-2004

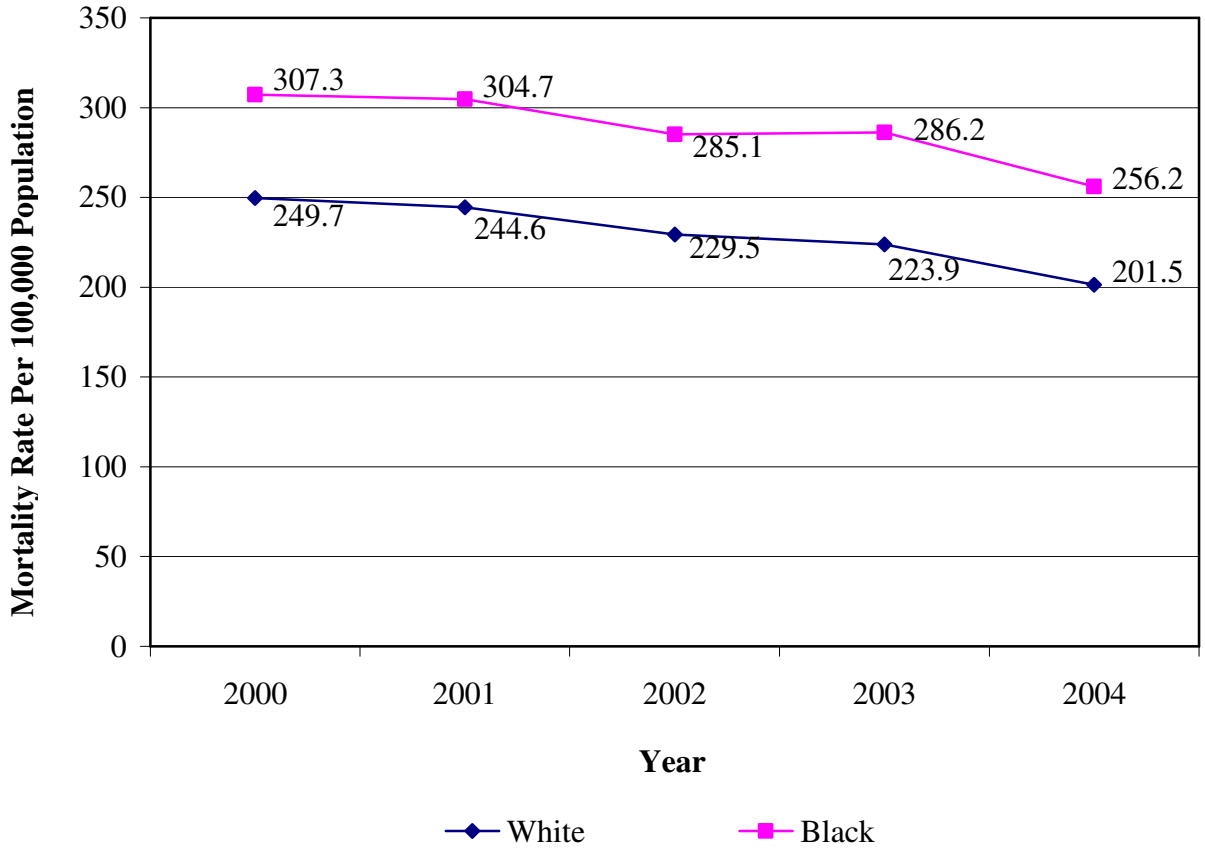


Source: Maryland Vital Statistics Annual Report 2004

Heart Diseases

The United Health Foundation's 2006 report ranks Maryland 27 in the country for cardiovascular deaths. This is an improvement from the 2005 ranking in which Maryland was ranked 29 in the country for cardiovascular deaths. The mortality rate for diseases of the heart for both Blacks and Whites declined from 2000 to 2004. However, a disparity between the groups continues as well, as shown in **Exhibit 4.16**. Although the mortality rate for Blacks fell from 2000 to 2004, in the final year, the mortality rate for Blacks was 1.3 times greater than for Whites.

Exhibit 4.16
Heart Diseases Age-adjusted Mortality Rate in Maryland by Race 2000-2004



Source: Maryland Vital Statistics Annual Report, 2004

Chapter 5. Emerging Issues

During the course of developing this report, the Department of Legislative Services (DLS) has identified certain items that could warrant further consideration or monitoring by the General Assembly.

2006 *Joint Chairmen's Report* Committee Narrative

As stated previously, the Office of Minority Health and Health Disparities (OMHHD) was established two years ago in the Department of Health and Mental Hygiene (DHMH). OMHHD also has many responsibilities, as spelled out in legislation that established the office and in subsequent legislation. However, OMHHD has yet to develop baseline measures to chart its progress in reducing or eliminating health disparities, which should be incorporated into its managing for results submittals. Nor has the office begun outreach efforts with the business community.

At the same time, the following narrative was adopted in the 2006 *Joint Chairmen's Report*.

> "It is the intent of the committees that the Department of Health and Mental Hygiene's Family Health Administration shall increase funding for the Office of Minority Health and Health Disparities to $1,000,000 beginning in fiscal 2008. This additional funding shall be used to provide grants to community-based organizations and historically black colleges and universities to conduct research, demonstration, and evaluation projects for targeted at-risk racial and ethnic minority populations and to support ongoing community-based programs that are designed to reduce or eliminate racial and ethnic health disparities in the State."

If the Governor agrees with the intent of the General Assembly, OMHHD could receive additional funds to issue grants as specified in the narrative. A reasonable question would be is OMHHD ready to administer a grant program should the funds be included in the fiscal 2008 budget in addition to its other duties? OMHHD does have grant criteria in place for distributing Cigarette Restitution funds, but the criteria are limited to smoking cessation and cancer control. While OMHHD has a model, it would need to develop a new set of parameters to distribute grants given the variety and nature of health disparities afflicting racial and ethnic minorities.

OMHHD has plans to internally assess and evaluate many of its activities. Periodic outside monitoring and evaluation of OMHHD should be a priority given the sensitive nature of the topics the office addresses. OMHHD should also consider setting priorities for awarding grants. As stated earlier in this report, much research has already been done documenting the existence of health disparities nationwide and in Maryland. In addition, many federal grants are available to conduct health disparity research. **The major criteria considered by OMHHD**

when rating and awarding grants should be to target proposals that eliminate or reduce health disparities rather than proposals to conduct additional research.

Increasing Minority Health Care Workers

One way to address health disparities is to increase the racial and ethnic diversity in the health care profession. The Institute of Medicine's (IOM) 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, identified several reasons why increasing minority representation in the health professions is important:

- Racial and ethnic minority individuals are more likely to receive medical care from non-White physicians.

- Racial and ethnic minority physicians are more likely to practice medicine in minority and underserved communities.

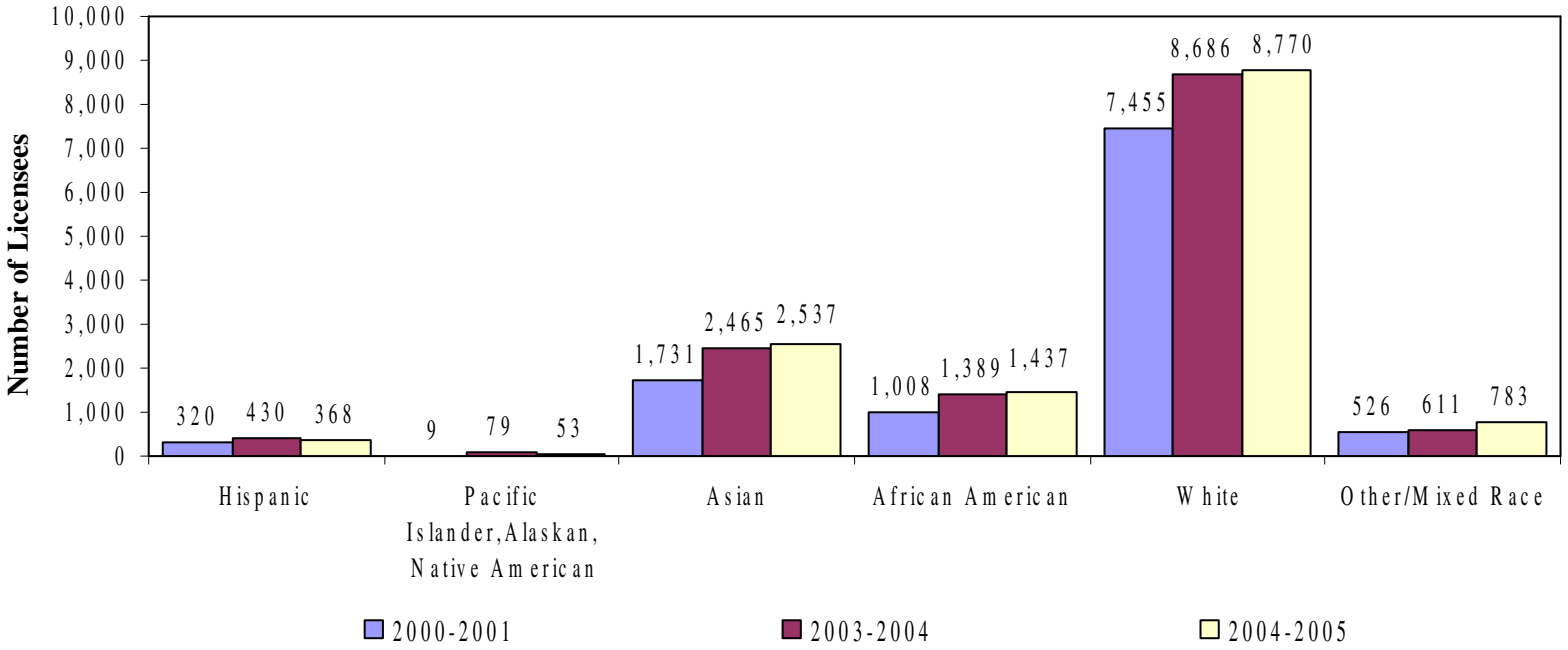
- When recruiting racial and ethnic minorities to participate in clinical research, health professionals who are from racial and ethnic minority groups themselves were generally more successful in those efforts.

- An understanding of cultural, social, and economic factors are as important in treating a patient as a health care provider's competence in the field. By having health professional faculty and students who are racially and ethnically diverse, the students will develop the necessary cultural competencies to treat patients from racial and ethnic groups different from their own.

- Health professionals from minority and underserved groups may be better able to gear health services to minority populations.

A review of the Maryland Health Care Commission's (MHCC) physician license renewal database which contains data on non-federal physicians practicing full-time in Maryland showed an increase in renewals from 2000 to 2005 for every racial and ethnic group, as detailed in **Exhibit 5.1**. The number of full-time, renewing African American physicians increased during this time period by 42.6 percent, while the number of White physicians increased by 17.6 percent. However, when comparing the two groups, there were 6.1 times more White physicians than African American physicians in 2004-2005. Asian physicians have closed the disparity gap with White physicians a little further. The number of Asian physicians increased 46.6 percent over the same time period, although there were 3.5 times more White physicians than Asian physicians in 2004-2005.

Exhibit 5.1
Full-time* Non-federal Maryland Practicing Doctors
Physician License Renewal Database
2000-2005



*Full-time means practicing 30 hours or more per week.

Note: Data is grouped in two-year increments because physician licenses are renewed biennially. Data does not include 2002 license renewals because there is a problem with the data from that year that MHCC is correcting. Racial categories include Hispanics. Data includes physicians whose primary or secondary office is in Maryland. The number of physicians included in this exhibit represents between 60 and 65 percent of all physicians renew Maryland licenses.

Source: Maryland Health Care Commission, 2006

Disparities among renewing licensed physicians were similar to disparities among the 2004 and 2005 graduates of Maryland medical schools: the Johns Hopkins University School of Medicine; the University of Maryland School of Medicine; and the Uniformed Services University of the Health Sciences F. Edward Herbert School of Medicine. As shown in **Exhibit 5.2** when looking at all of the schools combined in 2005, there were 13.1 times more White medical school graduates than Black medical school graduates. The disparity was considerably lower when comparing White medical school graduates and Asian medical school graduates; there were three times more White medical school graduates than Asian medical school graduates in 2005. Among the 2004 medical school graduates, the disparities were similar when comparing the three racial groups. In that year, there were 11.9 times more White medical school graduates than Black medical school graduates and 3.8 times more White medical school graduates than Asian medical school graduates.

American Dental Association (ADA) data showed a broad gap between White active licensed dentists in Maryland and active licensed dentists in other racial and ethnic groups, as shown in **Exhibit 5.3**. In the 2004 to 2005 period, there were 3.4 times more White dentists than Black dentists and 6.9 times more White dentists than Asian dentists. ADA began including racial and ethnic data by state in its annual compilation of licensees in 2004, so trend data is not available. DLS was unable to collect this racial and ethnic identifying information from the State Board of Dental Examiners because the board does not collect that information on its license application.

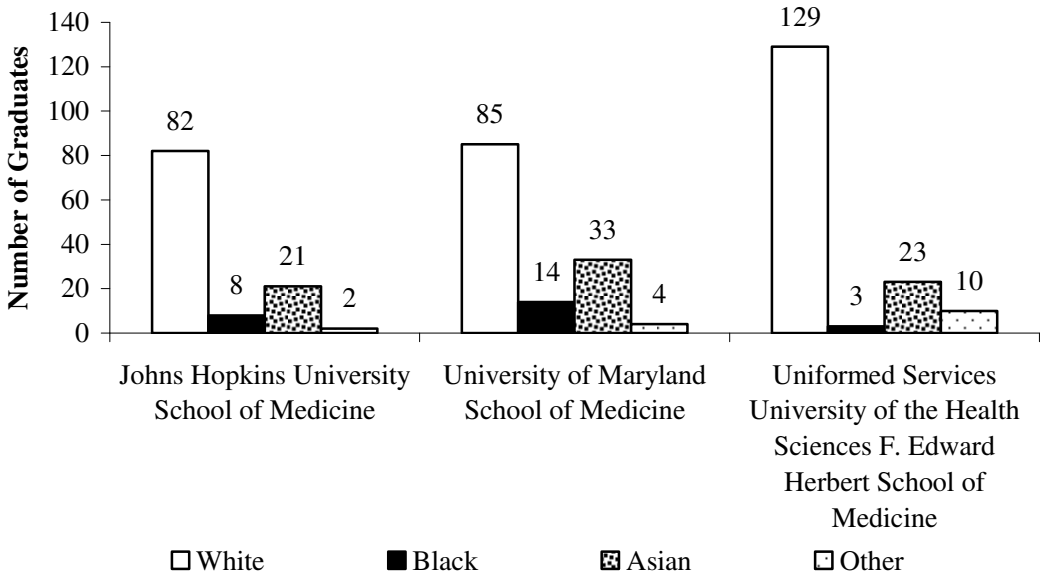
Maryland has already attempted to address the health care workforce disparity. As mentioned in Chapter 3, Chapter 579 of 2006 required DHMH to study the shortage of health care workers, including identifying methods to recruit minorities into those professions. Similarly, Chapters 221 and 222 required the use of competitive grants to increase the number of minority nurses in Maryland.

To facilitate the collection of data concerning health care workforce disparities, the health occupations boards currently not asking licensees to report their race and ethnicity on license and license renewal applications should begin doing so. Without that information, it is impossible for the State to examine the extent of the racial and ethnic disparity among health care professionals and whether progress in reducing that disparity is made.

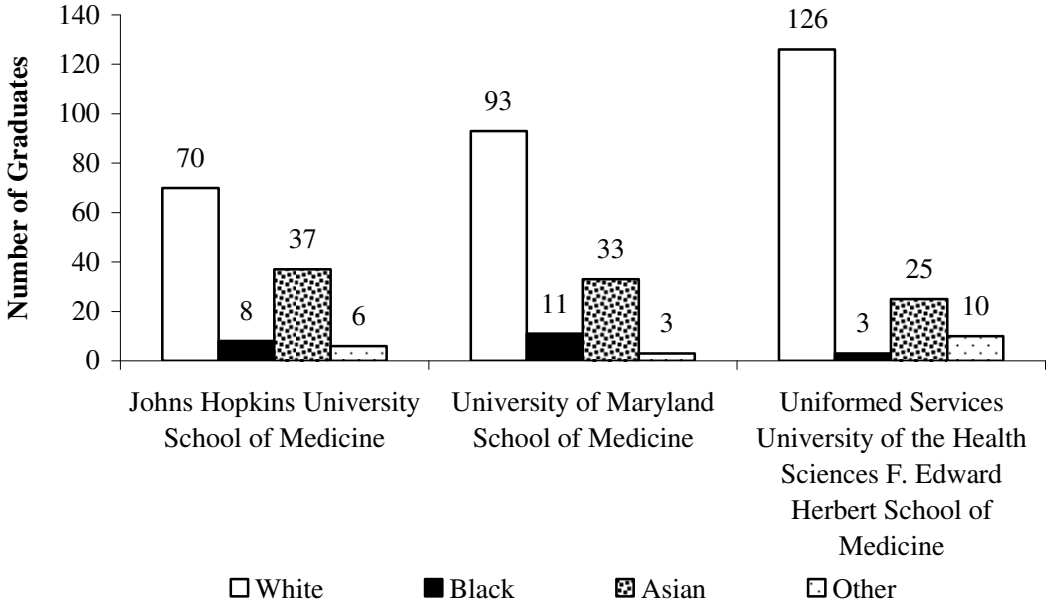
Increasing Cultural Competency

Increasing minority representation among health care professionals is just one strategy to reduce health disparities. Another strategy to reduce health disparities is to increase health care professionals' understanding of people from different cultures, otherwise known as increasing cultural competency.

Exhibit 5.2
Maryland Medical School Graduates by Race and Ethnicity
2004



2005



Note: Certain applicants could indicate races and ethnicities in combination or alone.

Source: Association of American Medical Colleges

Exhibit 5.3
Active Maryland Licensed Dentists by Race and Ethnicity

	2004-2005
White	3,880
African American/Black	1,139
Asian	566
American Indian	11
Hispanic	122
Unknown	1,270
Total	**6,988**

Note: Data includes American Dental Association members and non-members. ADA did not begin breaking down racial and ethnic licensee data by state until 2004.

Source: 2004 and 2005 American Dental Association Dentist Masterfile

In a 2001 report, the federal Department of Health and Human Services defined cultural and linguistic competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations." In examining cultural competence programs, the report found that the most successful programs:

- define culture broadly beyond race, language, and ethnicity to include other subcategories that are based on shared attributes or shared life experiences;
- value clients' cultural beliefs;
- recognize the complexity in language interpretation such as linguistic variation within a cultural group, the cultural variation within a language group, and the variation of literacy levels in all language groups;
- facilitate learning between providers and communities;
- involve the community in defining and addressing service needs;
- collaborate with other agencies, such as medical school residency programs;
- professionalize staff hiring and training; and

- institutionalize cultural competence by making it a part of strategic planning, include sustainable funding sources for cultural competence staffing and activities, and design cultural competence activities in a way that they can be replicated.

Maryland already is examining cultural competency concerns. Chapter 497 of 2006 required DHMH to assist community-based entities developing pilot programs to address health care provider cultural competency training and targeted health outcomes. **DHMH should share the pilot program results with the General Assembly and the health care community and should encourage the replication of successful programs**.

Collecting and Reporting Racial and Ethnic Data

Information is important to addressing quality improvement in health care. The IOM Report expressed the opinion that "[s]tandardized data collection is critically important in efforts to understand and eliminate racial and ethnic disparities in health care".[17]

One source of data on racial and ethnic minorities is the federal government. The federal government collects data on race and ethnicity in its health care programs and requires states providing care under the State Children's Health Insurance Plan to report race and ethnicity data. In addition, the Centers for Medicare and Medicaid obtain racial and ethnic data about Medicare beneficiaries.

Another source of racial and ethnic data relating to health care are health insurers and managed care organizations. The collection of race and ethnicity data by managed care organizations is governed by federal and state law. There are no federal laws that prohibit the collection of this data. Title VI of the 1964 Civil Rights Act, the federal law prohibiting discrimination, creates no legal liability for health care providers who collect and report health care quality data by race and ethnicity when the collection and reporting is undertaken as part of a quality improvement program. State laws regarding the collection and reporting of racial and ethnic data is varied, but the vast majority of states permit the collection of racial and ethnic data by health insurers, health care plans, or health providers.[18] In addition, the majority of states provide protection against the use of this information by prohibiting discrimination based on race or ethnicity. Many states also have provisions of law protecting the confidentiality of personal information that is collected under the health care system.

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[17] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002).

[18] National Health Law Program and the Office of Minority Health, *Assessment of State Laws, Regulations and Practices Affecting the Collection and Reporting of Racial and Ethnic Data by Health Insurers and Managed Care Plans* (2001).

Maryland is one of only four states that prohibit insurers from collecting data on race and ethnicity. The other three states are California, New Hampshire, and New Jersey. In Maryland, the provision of law prohibiting insurers from collecting data on race and ethnicity states that:

> "An insurer or insurance producer may not make an inquiry about race, creed, color, or national origin in an insurance form, questionnaire, or other manner or requesting general information *that relates to an application for insurance*."(emphasis added).[19]

An argument has been made that this prohibition on data collection by insurers is applicable to when the information is collected as opposed to whether the information can be collected at all.[20] While this interpretation would allow for the collection of racial and ethnic data by insurers and managed care organizations at points in time other than in relation to the application for insurance, generally this provision has been interpreted as an outright prohibition on the collection of racial and ethnic data.

The collection of race and ethnicity data is not a new issue for the Maryland General Assembly. Chapter 450 of 2006 required OMHHD, in collaboration with MHCC, to annually publish a "Health Care Disparities Policy Report Card," including the collection of the racial and ethnic data. The legislation also requires MHCC to incorporate racial and ethnic variations in its existing report cards for health maintenance organizations, nursing homes, and hospitals and ambulatory surgical centers.

Although the passage of this legislation requires the collection of data on racial and ethnic variations from various health care providers, the statutory language requires the collection of this data only "to the extent feasible." Therefore, the data on racial and ethnic variations from health insurers may not be included, in which case the data will be inconsistent and incomplete. With the Maryland provision prohibiting the collection of racial and ethnic data, it is unclear whether health insurers are collecting this information.

The collection of racial and ethnic data in Maryland is vital to several of the functions of OMHHD. For example, two of the specified duties of OMHHD are to:

- identify, coordinate, and establish priorities for programs, services, and resources that Maryland should provide for minority health and health disparities issues; and

- identify and review health promotion and disease prevention strategies relating to the leading health causes of death and disability among minority populations.

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[19] Section 27-501(c) of the Insurance Article.

[20] Karen Llanos and Lindsay Palmer, *Using Data on Race and Ethnicity to Improve Health Care Quality for Medicaid Beneficiaries*, Center for Health Care Strategies, June 2006.

Keys to successfully establishing priorities and determining the leading health causes of death and disability are dependent on the availability of consistent and reliable data on racial and ethnic minority populations. Health plans across the country are using racial and ethnic data to address preventive care issues within specific populations and to identify populations at higher risk for certain conditions. In addition, health plans are using racial and ethnic data to determine the consistency of delivered care, to design culturally appropriate educational communications, and to implement quality improvement programs that address the unique needs of racial and ethnic minorities. **The General Assembly should consider legislation to amend the law prohibiting insurers from collecting race and ethnicity data**.

Addressing Mental Health Disparities

Disparities also exist among racial groups when examining individuals' mental health. Although prevalence rates for each mental disorder were not known within a particular minority population, a 2001 Surgeon General report found evidence that the rate of mental illnesses among minorities (21 percent) was similar to the rate across the United States. However, the report determined that disparities were found among minorities when it comes to access to and treatment of mental illnesses as well as other factors contributing to mental illnesses.

The report found that individuals from most minority groups were less likely to use mental health services than Whites and that when minorities do use those services, they receive poorer quality care than Whites. There also were many barriers for minorities to receiving mental health care including:

- the cost of care;
- societal stigma of people who receive mental health treatment;
- the fragmented organization of mental health services;
- clinicians' lack of awareness of cultural issues, bias, or inability to speak the client's language;
- clients fear and mistrust of mental health treatment; and
- racism and discrimination.

The Surgeon General recommended that anyone that has a mental disorder or who thinks they have a mental disorder should seek help. More specifically for minorities, the Surgeon General made the following recommendations:

- continuing mental health research that includes racial and ethnic minorities and addresses ethnic- or cultural-specific interventions;

- improving the access to treatment for racial and ethnic minorities geographically, by integrating primary health care with mental health care, ensuring clients with limited English proficiency have equal access to benefits and services, and coordinating and integrating mental health services for high-need populations;

- reducing barriers to mental health treatment by ensuring parity in mental health insurance coverage between minorities and Whites, extending health insurance for the uninsured, examining the costs and benefits of culturally appropriate services, and reducing barriers in managed care;

- improving the quality of mental health services available to racial and ethnic minorities by ensuring evidence-based treatment; developing and evaluating culturally responsive services; and engaging consumers, families, and communities in developing services;

- improving minority representation among mental health providers, researchers, administrators, policymakers, and consumer and family organizations; and

- promoting mental health in communities by working to reduce social problems such as racism, discrimination, community violence, and poverty; building on community supports such as spirituality, positive ethnic identity, traditional values, educational attainment, and local leadership; and strengthening families.

Maryland is one of seven states awarded a $13.5 million Mental Health Transformation Grant from the federal Substance Abuse and Mental Health Services Administration. The grant is intended to improve the quality of mental health services in Maryland and assure cultural competency in the delivery of those services to diverse populations. In addition, the Office of Minority Health and Health Disparities is assembling data to identify any mental health disparities that may exist in Maryland.