Charts of Selected Black vs. White Chronic Disease SHIP Metrics:

Western Maryland Counties
(Allegany, Garrett, and Washington)

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Maryland Department of Health and Mental Hygiene

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Introduction

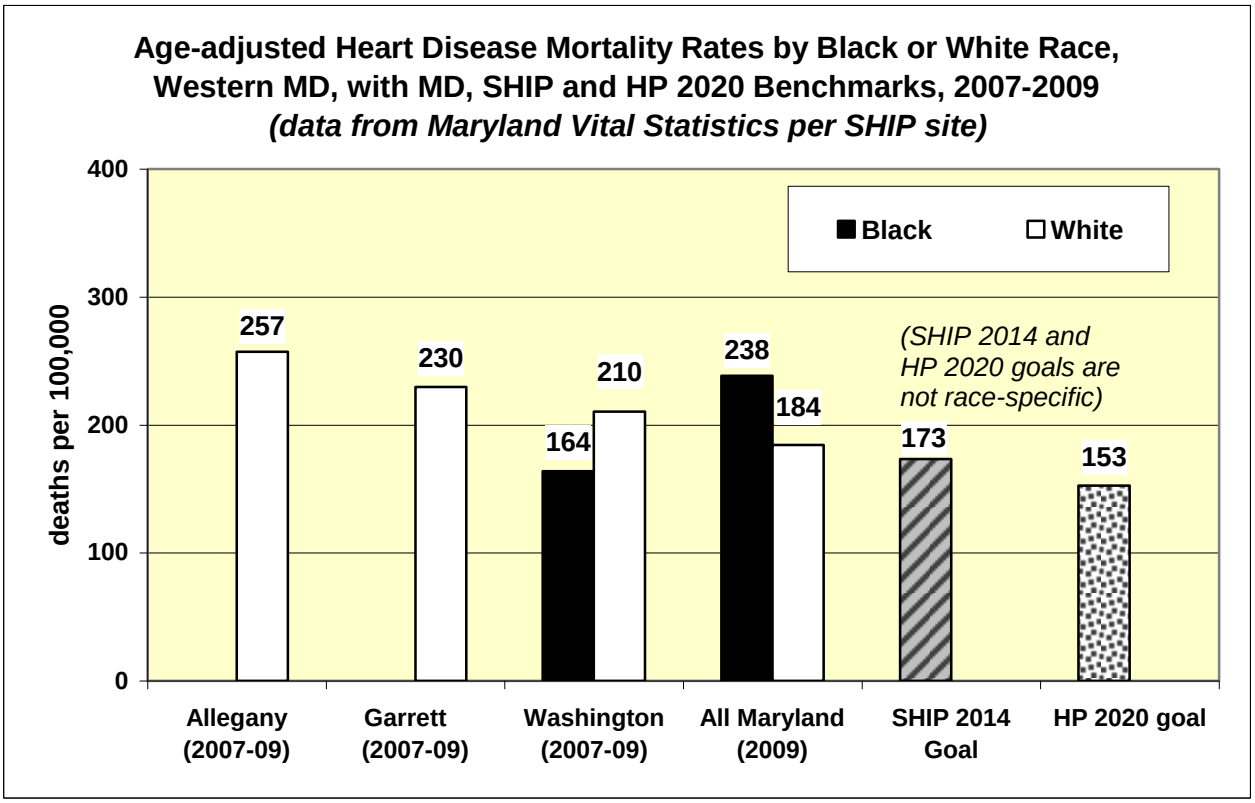
The Office of Minority Health and Health Disparities (MHHD) at the Department of Health and Mental Hygiene is committed to assisting the SHIP local planning groups in identifying issues of poor minority health and minority health disparities in their jurisdictions, and incorporating effective minority health improvement strategies into their local health improvement plans.

As a first step in this assistance process, MHHD is providing this document - *Charts of Selected Black vs. White Chronic Disease SHIP Metrics* - which provides a graphical display of the Black and White baseline values for selected chronic disease SHIP metrics in the Western Maryland counties. The included metrics are heart disease and cancer mortality rates, emergency department visits for diabetes, hypertension, and asthma, and the percent of adults at healthy weight or who are current smokers.

We have chosen to focus on these chronic disease metrics for two reasons. The first is that they represent leading causes of mortality (heart disease and cancer mortality, hypertension as a risk factor for stroke), leading causes of preventable utilization (diabetes, hypertension and asthma), or risk factors for a variety of chronic diseases (diabetes, hypertension, smoking and obesity). The second is that these metrics are consistent with the areas of emphasis of the Health Disparities Workgroup of the Maryland Health Quality and Cost Council. In their report, available at http://www.dhmh.maryland.gov/mhqcc/Documents/Health-Disparities-Workgroup-Report-1-12-2012.pdf , the Workgroup identified lung disease (especially asthma), cardiovascular disease, and diabetes as areas with exceptionally large disparities in preventable hospitalizations. Improving minority outcomes in these areas will both reduce disparities and result in cost savings.

It has been said that a picture is worth a thousand words. It is hoped that this graphical display of these local SHIP minority health metrics will help the local planning groups identify some of the important minority health issues in their jurisdictions.

Heart Disease Mortality

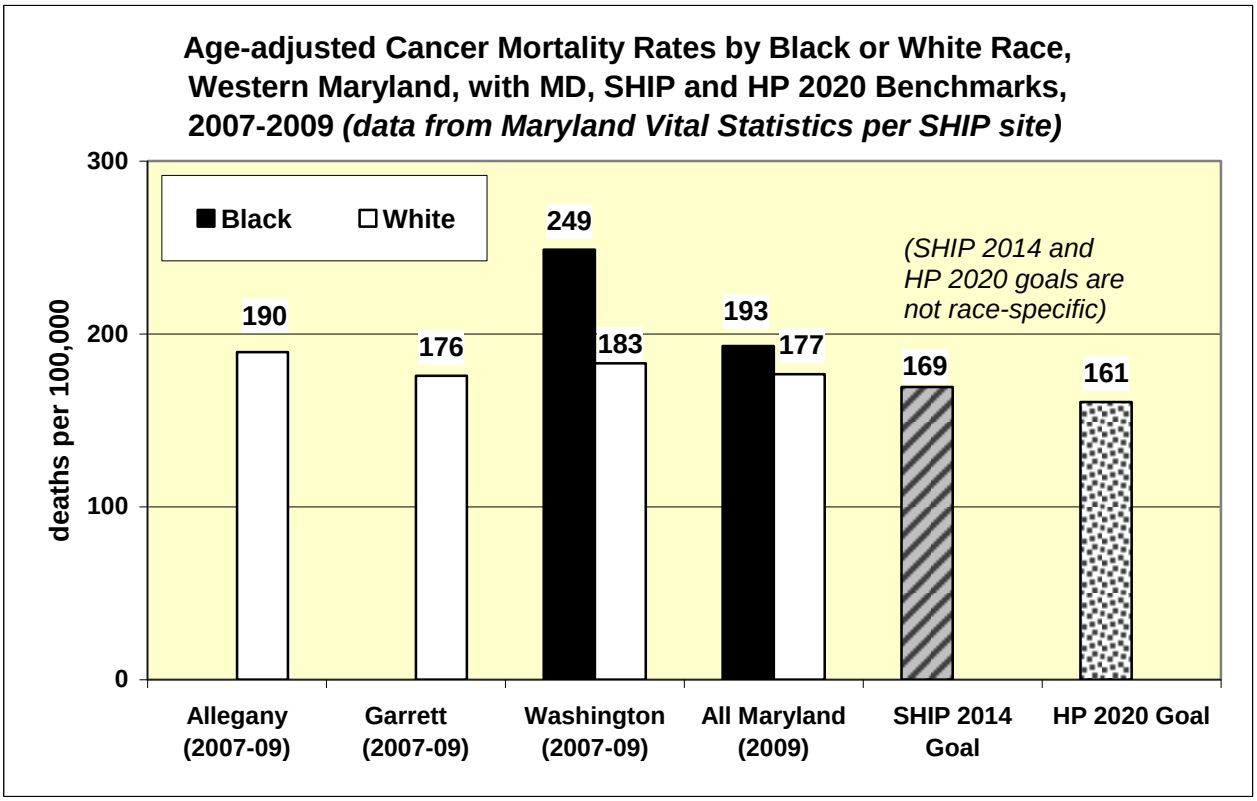


The chart above is a display of the heart disease mortality SHIP metric values (Objective 25) as published in the current SHIP County Health Profiles for the three Western Maryland Counties. Age-adjusted mortality rates are shown for Black or White race, along with the race-specific Maryland Statewide rates and the SHIP 2014 and HP 2020 goals for comparison. In Allegany and Garrett, where the Black populations are small, the number of deaths among Blacks in the three-year interval was too small to report a rate.

The only reportable county-level Black rate was in Washington County. That Black rate is considerably lower than the Statewide Black rate, is lower than the SHIP 2014 goal, and is not much higher than the HP 2020 goal. Year-to-year fluctuations in rates are considerable for this metric in Washington County, where the number of Black deaths ranges from 7 to 15 a year. This rate was as high as 393 for 2000-02, and as low as 132 for 2006-08 (CDC Wonder). Whether the current 164 is a low outlier or a reflection of truly good health remains to be seen.

White rates in all three counties are higher than the Statewide White rate, the SHIP 2014 goal and the HP 2020 goal. As will be seen later in this document, the White rates of hypertension and diabetes ED visits, adult smoking, and adults at healthy weight are in many cases worse than the Statewide White rates. These higher rates of heart disease risk factors contribute to the higher than Statewide heart disease mortality rates for Whites in Western Maryland.

Cancer Mortality

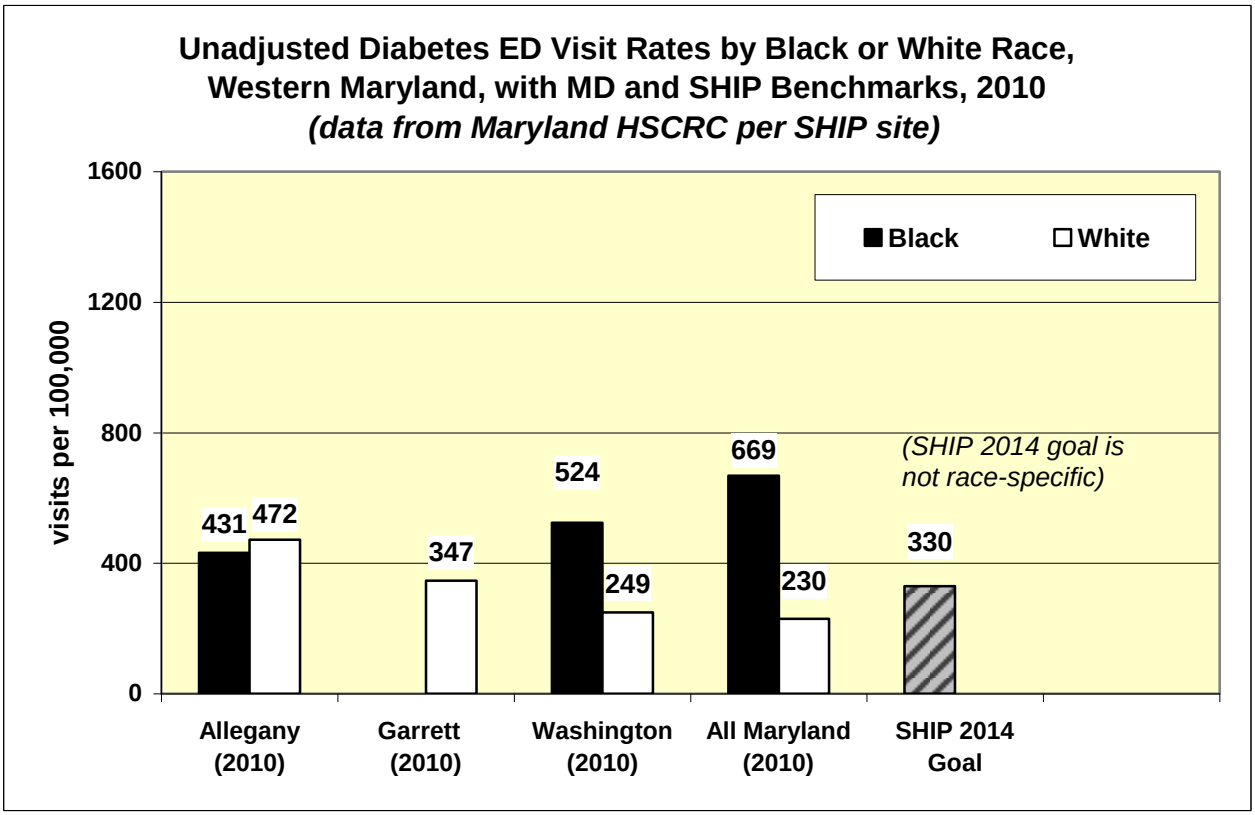


The chart above is a display of the cancer mortality SHIP metric values (Objective 26) as published in the current SHIP County Health Profiles for the three Western Maryland Counties. Age-adjusted mortality rates are shown for Black or White race, along with the race-specific Maryland Statewide rates and the SHIP 2014 and HP 2020 goals for comparison. In Allegany and Garrett, where the Black populations are small, the number of deaths among Blacks in the three-year interval was too small to report a rate.

The only reportable county-level Black rate was in Washington County. That Black rate is higher than the Statewide Black rate, the SHIP 2014 goal, the HP 2020 goal. Year-to-year fluctuations in rates are considerable for this metric in Washington County, where the number of Black deaths ranges from 4 to 14 a year. This rate was as high as 300 for 2003-05, and as low as 105 for 1999-2001 (CDC Wonder). The rate has been consistently over 250 for all three-year intervals from the 2003-2005 interval onward.

White rates in Allegany and Washington are higher than the Statewide White rate. All three counties are above the SHIP 2014 goal and the HP 2020 goal. Allegany and Washington have higher White smoking rates than the Statewide White rate, which contributes to their higher cancer mortality rates.

Diabetes ED Visits



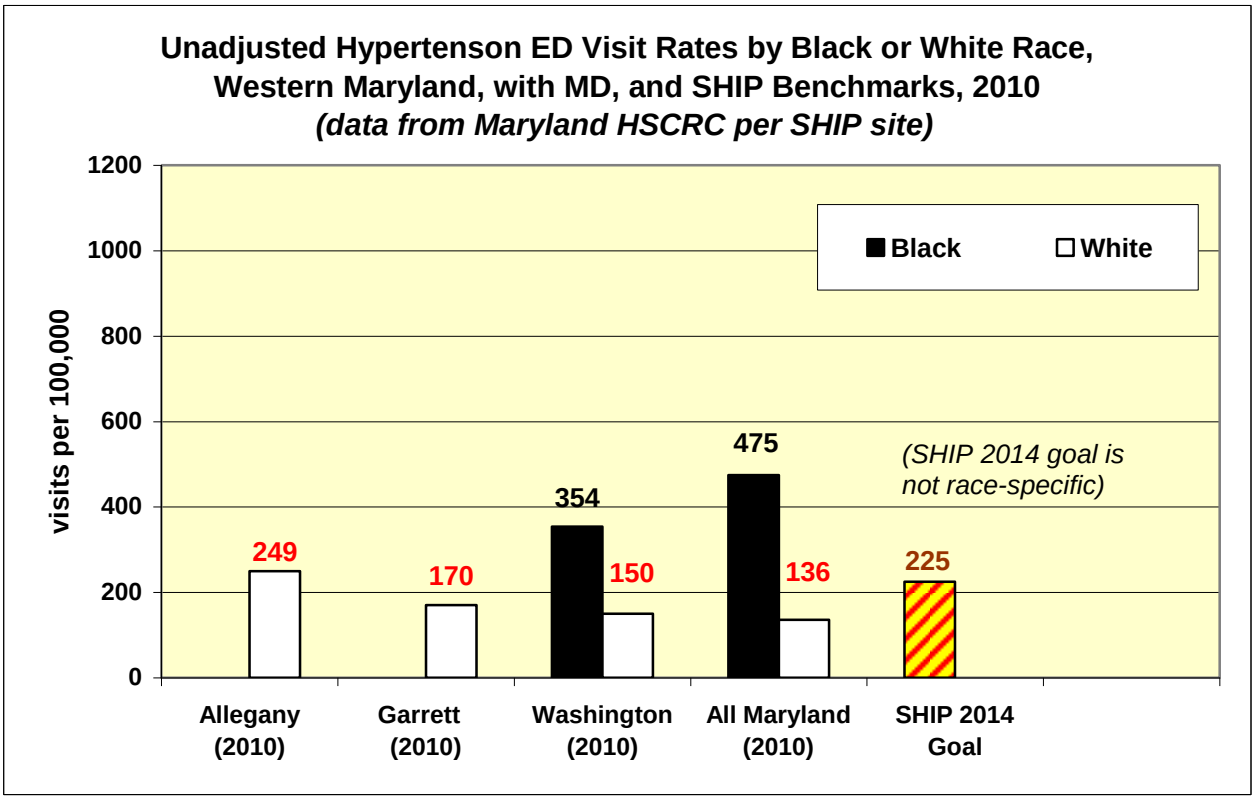
The chart above is a display of the Diabetes Emergency Department (ED) visit SHIP metric values (Objective 27) as published in the current SHIP County Health Profiles for the three Western Maryland Counties. Unadjusted ED visit rates are shown for Black or White race, along with race-specific Maryland Statewide rates and the SHIP 2014 goal. In Garrett, where the Black population is small, the number of ED visits for diabetes among Blacks was too small to report a rate.

There is one important consideration when interpreting ED visit rates. A low rate may represent good health and/or good disease control, but it may also represent limited access to care, incomplete collection of race and ethnicity (missing data) or may be due to a lot of care going out of state (not captured in the HSCRC data).

In Allegany and Washington, Black rates are lower than the Statewide Black rate. In Allegany, the Black rate is lower than the County White rate, an unusual finding for this metric. The possibility that these Black rates are artificially low due to data limitations must be considered.

White rates in all the counties are above the Statewide White rate. These rates too could be subject to underestimation, given that these counties have more of their borders shared with other states then shared with other Maryland counties. Uncounted out-of-state ED care is likely.

Hypertension ED Visits



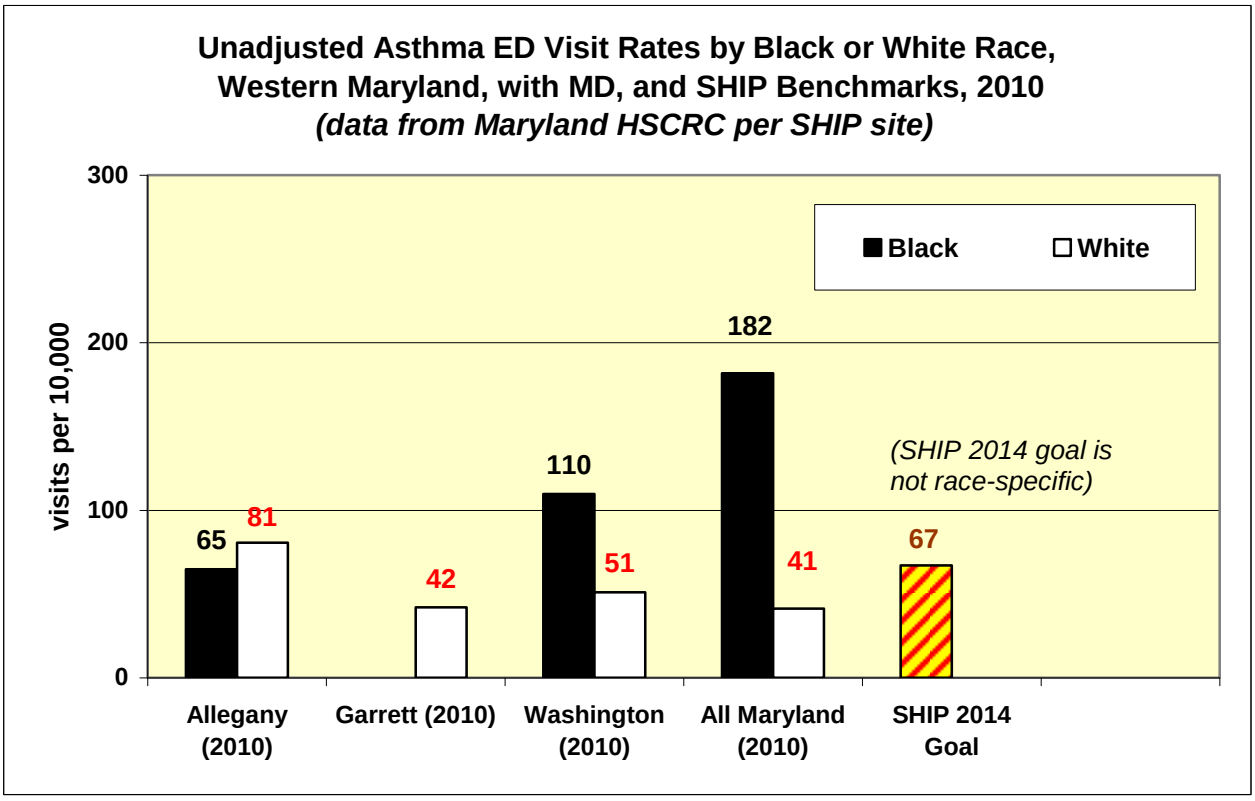
The chart above is a display of the Hypertension Emergency Department (ED) visit SHIP metric values (Objective 28) as published in the current SHIP County Health Profiles for the three Western Maryland Counties. Unadjusted ED visit rates are shown for Black or White race, along with the race-specific Maryland Statewide rates and the SHIP 2014 goal for comparison. In Allegany and Garrett, where the Black populations are small, the number of ED visits for hypertension among Blacks was too small to report a rate.

There is one important consideration when interpreting ED visit rates. A low rate may represent good health and/or good disease control, but it may also represent limited access to care, incomplete collection of race and ethnicity (missing data) or may be due to a lot of care going out of state (not captured in the HSCRC data).

In Washington County, the Black rate is lower than the Statewide Black rate, and higher than the County White rate. The possibility that this Black rate is artificially low due to data limitations must be considered.

White rates in all the counties are above the Statewide White rate. These rates too could be subject to underestimation, given that these counties have more of their borders shared with other states then shared with other Maryland counties. Uncounted out-of-state ED care is likely.

Asthma ED Visits



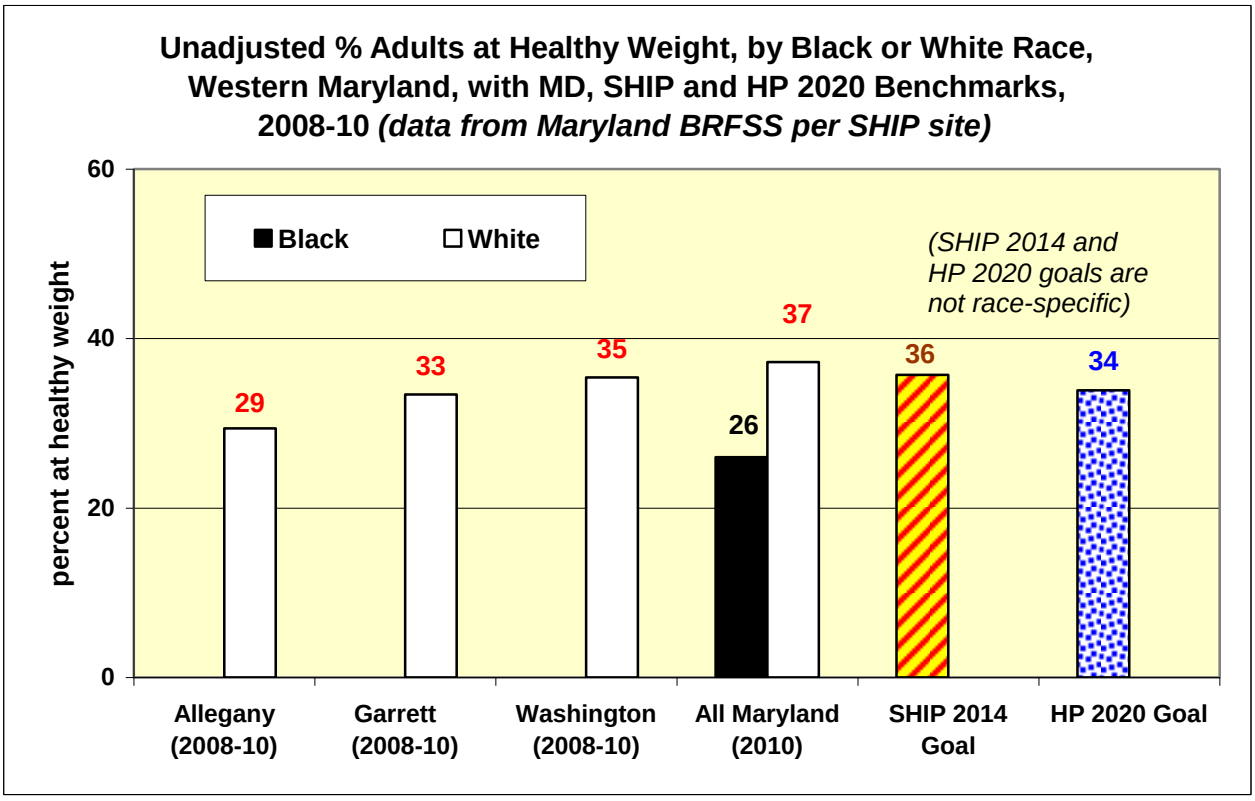
The chart above is a display of the Asthma Emergency Department (ED) visit SHIP metric values (Objective 17) as published in the current SHIP County Health Profiles for the three Western Maryland Counties. Unadjusted ED visit rates are shown for Black or White race, along with the race-specific Maryland Statewide rates and SHIP 2014 goal. In Garrett, where the Black population is small, the number of ED visits for asthma among Blacks was too small to report a rate.

There is one important consideration when interpreting ED visit rates. A low rate may represent good health and/or good disease control, but it may also represent limited access to care, incomplete collection of race and ethnicity (missing data) or may be due to a lot of care going out of state (not captured in the HSCRC data).

In Allegany and Washington, the Black rate is lower than the Statewide Black rate, considerably so in Allegany. In Washington the Black rate is higher than the County White rate, while in Allegany, it is lower that the County White rate. The possibility that these Black rates are artificially low due to data limitations must be considered.

White rates in all the counties are at or above the Statewide White rate. These rates too could be subject to underestimation, given that these counties have more of their borders shared with other states then shared with other Maryland counties. Uncounted out-of-state ED care is likely.

Adults at Healthy Weight

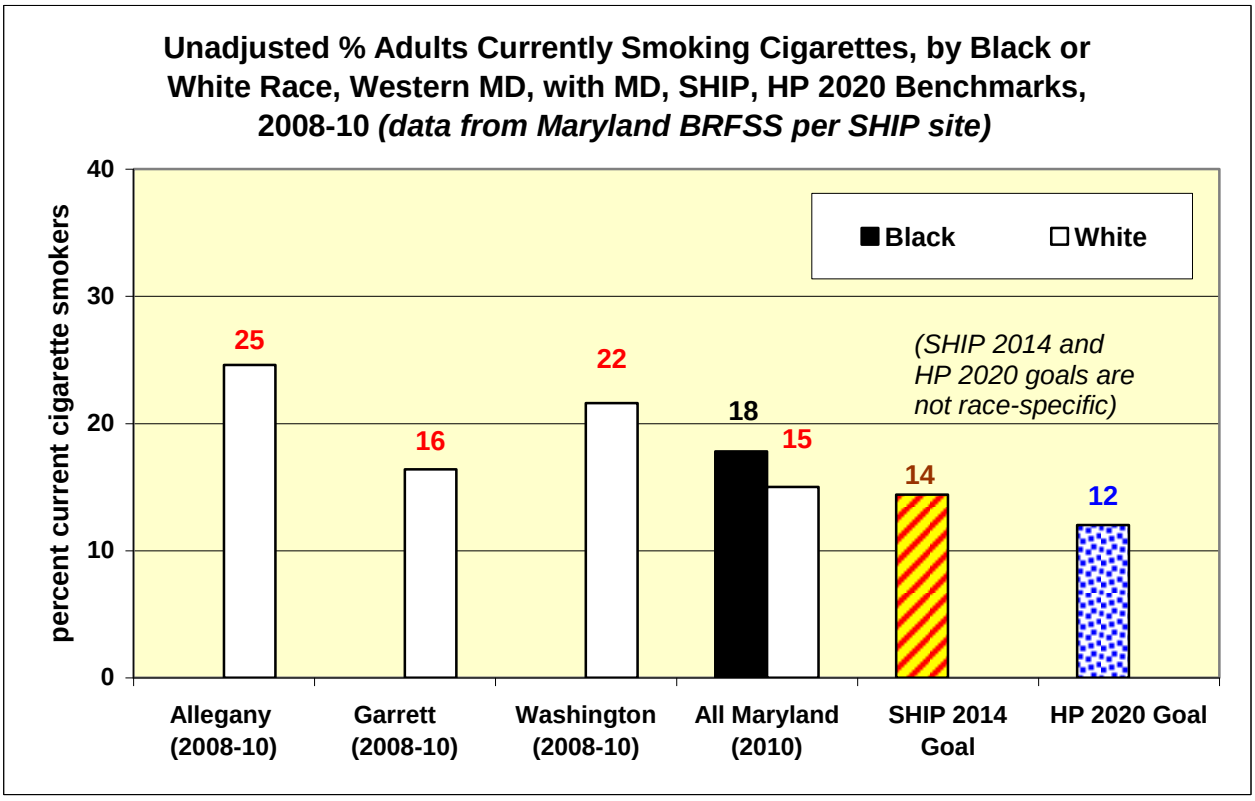


The chart above is a display of the adult at healthy weight SHIP metric values (Objective 30) as published in the current SHIP County Health Profiles for the three Western Maryland Counties. Unadjusted percent at healthy weight is shown for White race in each county, along with the race-specific Maryland Statewide rates and the SHIP 2014 and HP 2020 goals for comparison. The BRFSS sample sizes for Blacks in the Western Maryland counties are too small to permit reporting Black rates for this three-year period.

Unlike the other charts in this document, for this metric higher is better.

The White rates in all of the Western Maryland counties are lower than (worse than) the current Statewide White rate. Because of the sizable Black vs. White disparity in obesity Statewide and nationally, the non-race specific goals for SHIP and HP 2020 are lower than the current Maryland White rate. This suggests that a next step for the SHIP metric process should be setting race-specific goals that exceed the current performance of each race and that also accomplish a reduction in any racial or ethnic disparity.

Adult Cigarette Smoking



The chart above is a display of the current adult smoking at healthy weight SHIP metric values (Objective 32) as published in the current SHIP County Health Profiles for the three Western Maryland Counties. Unadjusted percent current smokers is shown for White race for each county, along with the race-specific Maryland Statewide rates and the SHIP 2014 and HP 2020 goals for comparison. The BRFSS sample sizes for Blacks in the Western Maryland counties are too small to permit reporting Black rates for this three-year period.

For White adults, in Garrett the smoking rate is similar to the Statewide White rate and slightly higher than the SHIP 2014 goal. In Allegany and Washington, the White rates are higher than the Statewide White rate. Given the importance of smoking as a risk factor for cardiovascular disease and cancer, reducing smoking rates in these two counties should be a priority.

Conclusions

Although minority data for Western Maryland are limited, the charts presented here show that some of the largest disparities between Black and White rates are seen for emergency department (ED) visit rates for diabetes, asthma and hypertension. In some cases, the Black rates for these visits are lower than corresponding White rates, and are uniformly lower than the Statewide Black rates. There is a potential for underestimation of both the Black and White visit rates in Western Maryland: there may be racial data collection limitations or out of state ED use leading to underestimation of visits. Access to care limitations might make low rates not truly reflective of the health of the population.

Black disparities cannot be assessed for adult healthy weight and adult smoking in any of the three counties. For Whites, adults at healthy weight is worse in Western Maryland than for the State, and smoking rates are higher than the Statewide rate in Allegany and Washington.

For heart disease mortality, Washington County has a Black rate lower than the Statewide Black rate. All three counties have White rates that are higher than the Statewide White rate. Generally worse than Statewide White rates for Diabetes ED visits, Hypertension ED visits, Adult Smoking and Adult Obesity probably contribute to these high mortality rates for Whites in Western Maryland.

For cancer mortality, Washington County has a Black rate sufficiently higher than the Statewide Black rate to produce a larger Black disparity than is see Statewide. Allegany and Washtington have White rates higher than the Statewide White rate.

The very large disparities in ED visit rates seen Statewide are one reason why the Health Disparities Workgroup of the Maryland Health Quality and Cost Council focused on disparities in ED visits and hospital admissions. These are also areas where successful interventions can show benefits in a relatively short time. Interventions that reduce rates of un-insurance, improve provider availability, and provide support for chronic disease self-care at home hold promise to reduce this preventable utilization. These programs need to be adapted to the unique cultural, linguistic, and health literacy needs of minority populations, and delivered to those communities in a targeted way.

There are five general strategies that can be applied to almost any intervention to improve its impact on minority populations:

1. Racial and ethnic data collection, analysis, and reporting;
2. Inclusion of minority persons in planning, and outreach to minority communities in the delivery of programs and services;
3. Cultural, linguistic, and health literacy competency of program staff and materials;
4. Racial and ethnic diversity of the program workforce; and
5. Attention to the social determinants of health.