Health Equity and Inequity in the Connecticut Medicaid Behavioral Health Service System: A Report of the CTBHP

Overview

CTBHP Study of Health Equity and Inequity in the Medicaid Behavioral Health Service System

- ***DSS, DCF, & DMHAS directed Beacon to conduct a Health Equity Study during 2015.***

- ***The study was focused on Health Equity for Medicaid recipients and specifically focused on Behavioral Health, including mental health and substance abuse services.***

Definitions

Health Equity is defined as the realization of systems and conditions that provide all people with the opportunity to achieve good health through equitable access, quality, and outcomes of health care.

Health Disparities are differences in health care access, quality, or outcomes among distinct segments of the population that are systematic, avoidable, and unjust.

4 Methods of Investigation

1. Literature Review

2. Analysis of CT Data

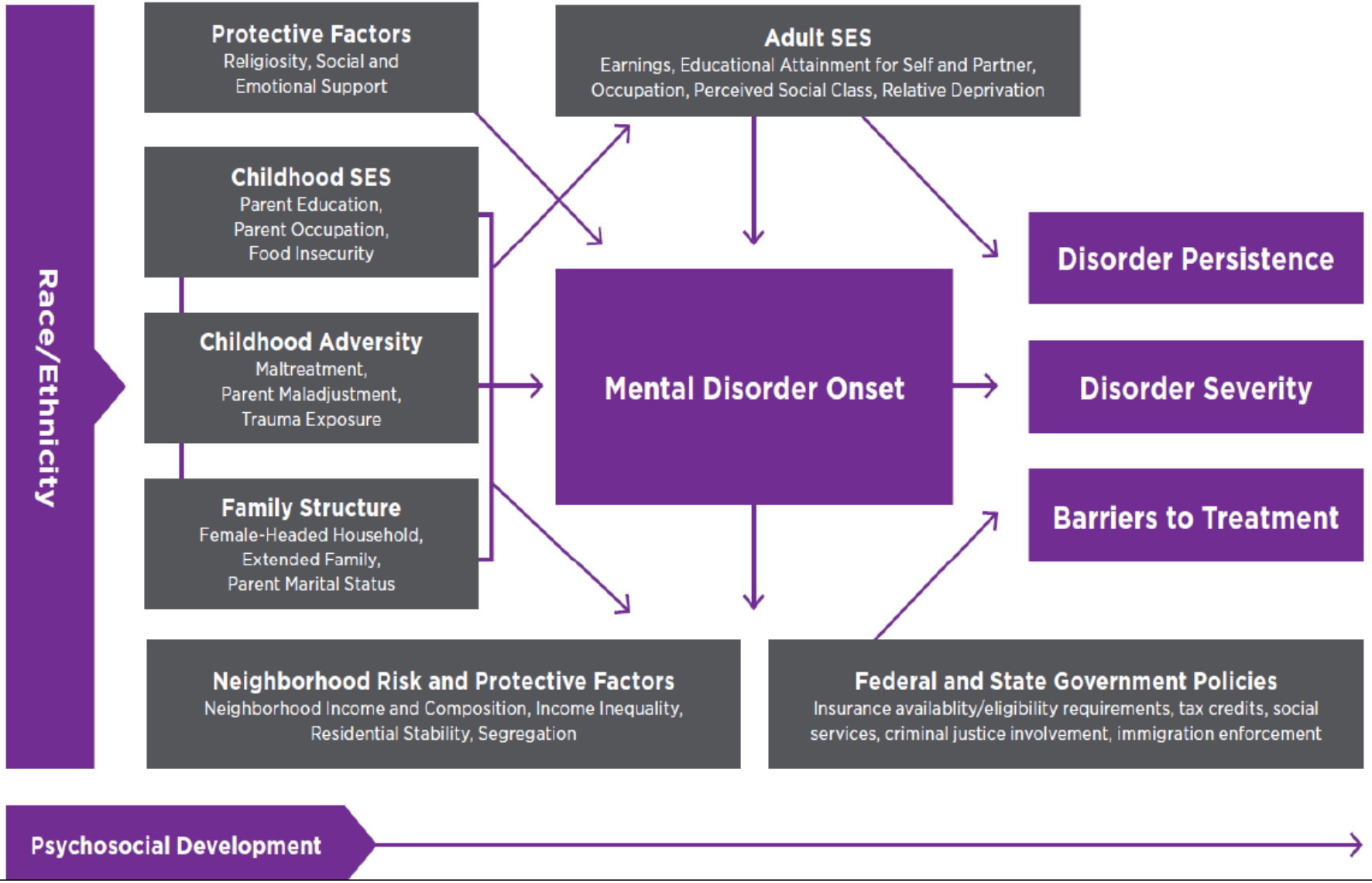
3. Consumer Focus Groups

4. Key Informant Interviews

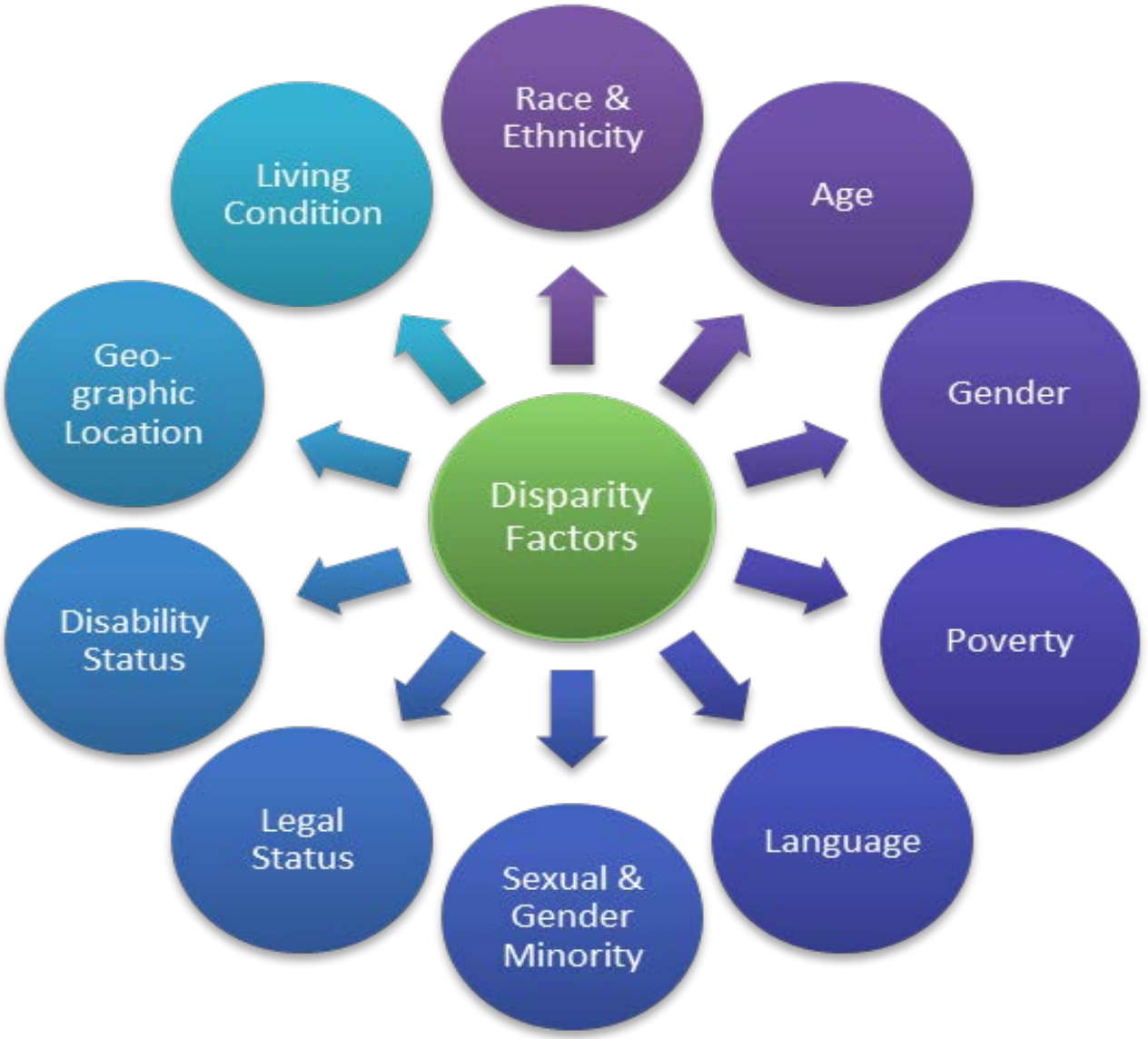
Literature Review

Health Disparity is a Complex Subject

Figure 1: Conceptual Model for Child Mental Health and Mental Health Service Disparities



Various groups, defined by demographic and social conditions experience disparity

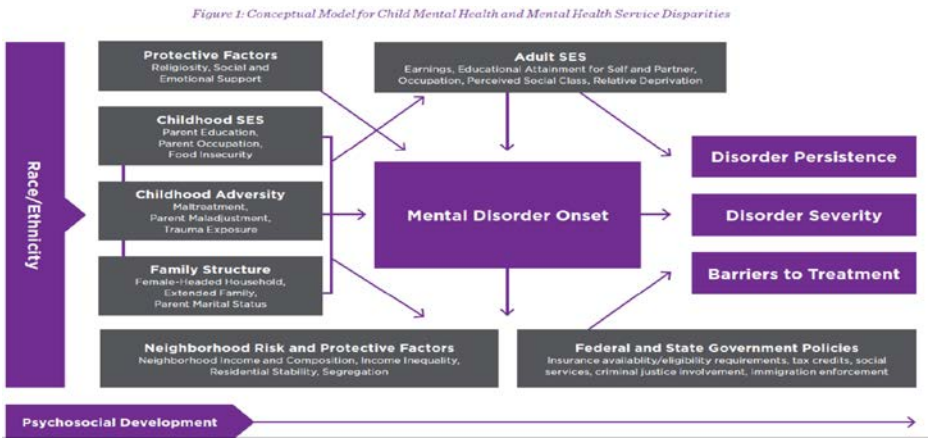


Literature Review - Take Aways

- **Racial and Ethnic Groups, particularly Blacks and Hispanics experience some of the most pronounced and significant disparities**
- **Other groups are significantly affected, including**
  - **smaller minority populations (Asians, immigrants, refugees)**
  - **Gender and Sexual Minorities**
  - **Individuals with disabilities, etc.**
- **Data and Metrics are needed to document disparity and track change over time**

Literature Review - Take Aways

- The causes of health disparity are complex, deeply rooted in societal institutions, and extend beyond the healthcare system.
- Although health disparities are unlikely to be eliminated without broader societal action, the healthcare system can and must act to eliminate or reduce them.



Connecticut Data Highlights

CT DATA HIGHLIGHTS - GENERAL

- **CTBHP reviewed data from prior reports that examined differences in utilization of services across gender, age, and race/ethnicity.**
- **Discrepancies were identified when the rate of service utilization by a subgroup (e.g. Asians, males, young adults) was either over or under the proportion of that group in the Medicaid Population.**
- **Not all observed discrepancies are necessarily disparities – example underutilization of the emergency department**
- **But we do need to question what may be behind patterns of disproportionate over or under utilization**

CT DATA HIGHLIGHTS – RACE & ETHNICITY

- **In general, Blacks, Asians, and Hispanics are underrepresented in populations who utilize any behavioral health service**
- **Minorities were also underrepresented in those that frequently utilize the ED, detoxification, and inpatient psychiatric services.**
- **Blacks and Hispanics were overrepresented among those that utilize the ED for Medical care**
- **and Blacks were disproportionately overrepresented in those that utilize State Hospital Beds.**

CT DATA HIGHLIGHTS – Gender

- **Women were generally underrepresented in those receiving Medicaid funded behavioral health services**
- **This finding is despite national data indicating;**
  - **a higher prevalence for women for the most common mental health disorders (Anxiety, Depression, and Stress Disorders).**
  - **in most systems, women are more likely than men to utilize behavioral health services**
- **This finding is concerning but may be partially explained by the predominance of substance abuse diagnoses in CT's behavioral health services system and the higher prevalence of substance abuse disorders among men**

CT DATA HIGHLIGHTS – Age

- **Adults aged 45-54 tended to be overrepresented in behavioral health service utilization at all levels of care**

- **Those adults in the 18-25 year old age range were disproportionately underrepresented in BH care utilization, despite comprising a significant portion of the Medicaid adult population**

Focus Groups

Focus Groups

- Five Focus Groups
  - Black adult & Black young adult (2)
  - Hispanic adult & Hispanic young adult (2)
  - LGBTQ adult (1)
- All Medicaid recipients with experience with behavioral health services
- Methods
  - Sessions audio & video taped
  - Translation services
  - Major themes summarized by multiple raters

Community Conversations and Meetings

- **Four Focus Groups**
  - **Youth**
  - **Family members**
  - **Providers**
  - **Advocates**
- **Community Conversation with multiple stakeholders**
- **Local/Regional community meetings**
- **Summary of themes and recommendations**

Focus Groups & Community Conversations

MAJOR THEMES

- Translation services
- Experiences of discrimination
- Need for outreach
- Increase use of peers
- LGBTQ friendly practitioners
- Location of services
- Cultural understanding
- Staff better reflecting clients served
- Staff turnover

Key Informant Interviews

Key Informants

- Patricia Baker
- Ellen Boynton
- Miriam Delphin-Rittmon
- Renee Coleman-Mitchell
- Margaret Hynes
- Judith Fifield
- Elizabeth Flanagan
- Cathy Foley-Geib & Louis Ando
- Danya Keene
- Robin McHaelen
- William Rivera
- Bonnie Roswig
- Susan Smith
- Victoria Veltri
- Beresford Wilson
- Roderick Winstead
- Alicia Woodsby

Summary of Key Informant Interviews

- 17 Key Informant Interviews
- Rich diversity of ideas and opinions
  - Multiple professions/fields (advocates, state agency, academic, public health, etc.)
  - affected groups focused on
  - types of disparity considered most important
  - variety of proposed strategies
- Common Themes
  - Need for better data and metrics
  - Need to address underlying social determinants
  - Outreach and Education
  - Training of Providers

Recommendations

General Considerations

- All Stakeholders share responsibility
  - Providers
  - Funders
  - System Managers
  - Beacon Health Options
  - Consumers-Members
  - Advocates & Policy Makers
- Solutions:
  - Must go beyond training
  - Must Involve Consumers
  - Must be measurable
  - Must focus on
    - Access
    - Outcomes &
    - Member Experience

Sample of Recommended Actions - Consumers

- Increased consumer representation/participation in committees and organizations that oversee and advocate for behavioral health services
- Greater involvement of family members in care
- Speak out against stigma

Sample of Recommended Actions Service Providers

- Implementation of CLAS Standards
- Increase use of Peers and/or Community Navigators
- Provide more services in natural community settings
- Promote primary and BH service integration to improve engagement

Sample of Recommended Actions – Beacon Health Options

- Implementation of Culturally and Linguistically Appropriate Service (CLAS) Standards
- Develop, track, trend and disseminate health equity metrics (utilization, outcomes, etc.)
- Develop materials to improve health literacy of members

Sample of Recommended Actions
State Agencies

- Implementation of National Standards (CLAS)
- Expand the collection of data across agencies to include gender identity, sexual orientation, income, disability status, etc.
- Promote greater participation by members that represent the diversity of those served

Discussion

Questions for Discussion

- What can the BHPOC do to address health disparities?
- What are CT providers currently doing to address healthcare disparities?
- Are there best practices in Connecticut that should be brought to scale?
- Where does the system stand regarding linguistic competency and which approaches show the most promise?
- Are there health equity initiatives that could be combined or coordinated to extend their reach or better utilize resources?

Youth Data

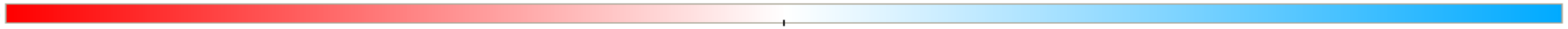
MEDICAID YOUTH HEALTH EQUITY DATA

Medicaid Youth Health Equity Data Summary Table

Normalized Variance from Youth Medicaid Population Rate - 2011-2012 Data

Demographic		Emergency Department Utilization by Diagnosis Indicator			Level of Care Utilization					Frequent Utilization - 3+ Visits	
	Medicaid Adult Population Rate	BH Primary	Med Primary/BH Secondary	Medical Only	BH Services w/o ED (adj) along Age	BH Services w/o Inpatient (adj) along Age	BH ED	Inpatient MH	State Hospital	BH ED 3+	Inpatient MH 3+
3 - 12	65.98%	-62.61%	-42.76%	4.78%	-14.41%	-19.11%	-50.47%	-63.26%	-86.99%	-59.28%	-61.83%
13 - 17	34.02%	121.44%	82.95%	-9.27%	27.94%	37.07%	97.91%	122.71%	168.75%	114.99%	119.94%
Female	48.89%	-2.20%	-12.30%	0.45%	-12.85%	-12.83%	-10.34%	1.23%	-10.71%	-5.28%	12.12%
Male	51.11%	2.11%	11.76%	-0.43%	12.29%	12.28%	9.89%	-1.18%	10.24%	5.05%	-11.59%
African American	20.87%	1.20%	-32.52%	-6.07%	-13.77%	-14.28%	-15.48%	-10.96%	28.72%	-14.95%	0.56%
Asian	3.18%	-70.22%	-76.92%	-46.22%	-65.04%	-65.23%	-65.71%	-67.00%	-88.26%	-81.79%	-61.16%
Caucasian	38.88%	14.80%	25.22%	-13.63%	17.20%	17.26%	18.54%	26.13%	0.76%	22.33%	25.10%
Hispanic	36.21%	-9.81%	-1.55%	22.87%	-4.93%	-4.63%	-5.04%	-15.98%	-8.29%	-7.41%	-20.90%
Other	0.86%	-25.91%	-1.55%	-28.75%	4.54%	2.47%	-7.50%	5.15%	-56.37%	-32.31%	-42.26%
Percent of Total Youth Population Utilizing the Service:					**20.73%**	**24.01%**	**4.53%**	**1.06%**	**0.11%**	**0.83%**	**0.16%**

Normalized Rate

-100.00%  100.00%

Note that the color in the table does not indicate statistical significance. *Data for the ED utilization by diagnosis is based on ED visits, not individual members, whereas the other measure are at the member-level. The study period for the data above was from CY 2011-2012. The population of members used in the study were those who were eligible for Medicaid on 12/31/12 and did not meet criteria for exclusion. Members excluded from the study included members with dual eligibility, D05, DCF Title XIX, or DCF Converted at any point during the study period and members ages 0-2. The final count of members included in the study was 539,700: 288,764 adults and 250,936 youth. Normalized rate defined the variance from the population rate divided by the population rate.

Chart Explained - Columns

- The first column shows the population rate for that group in Medicaid.
- Subsequent columns represent types or frequencies of BH service

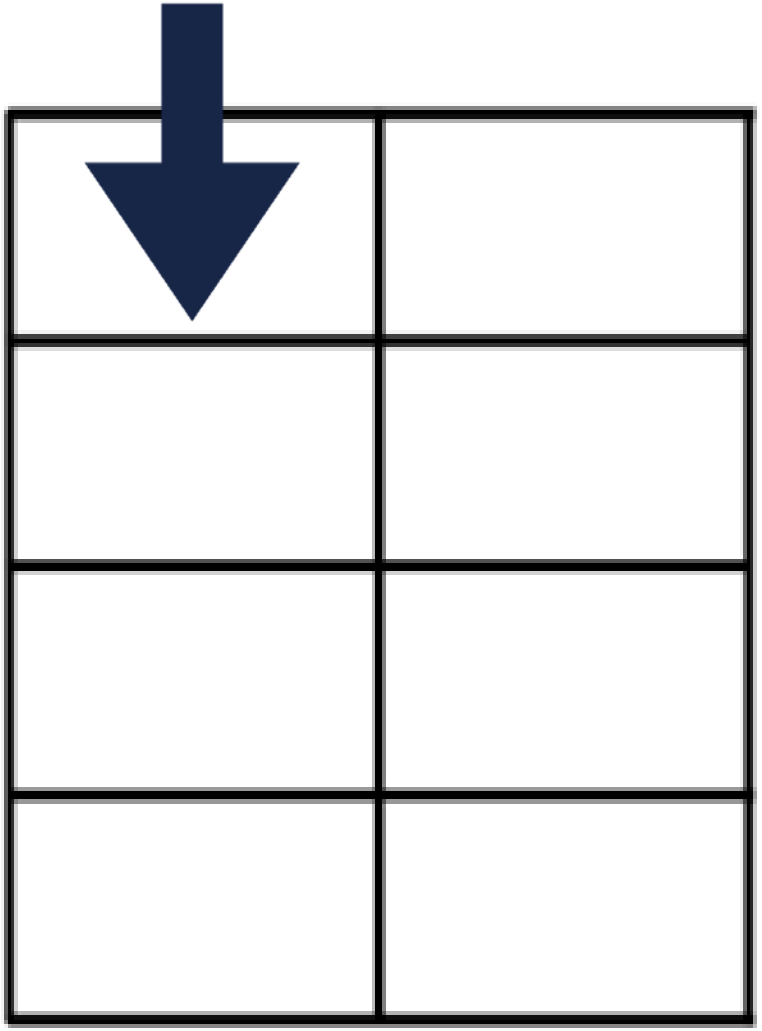
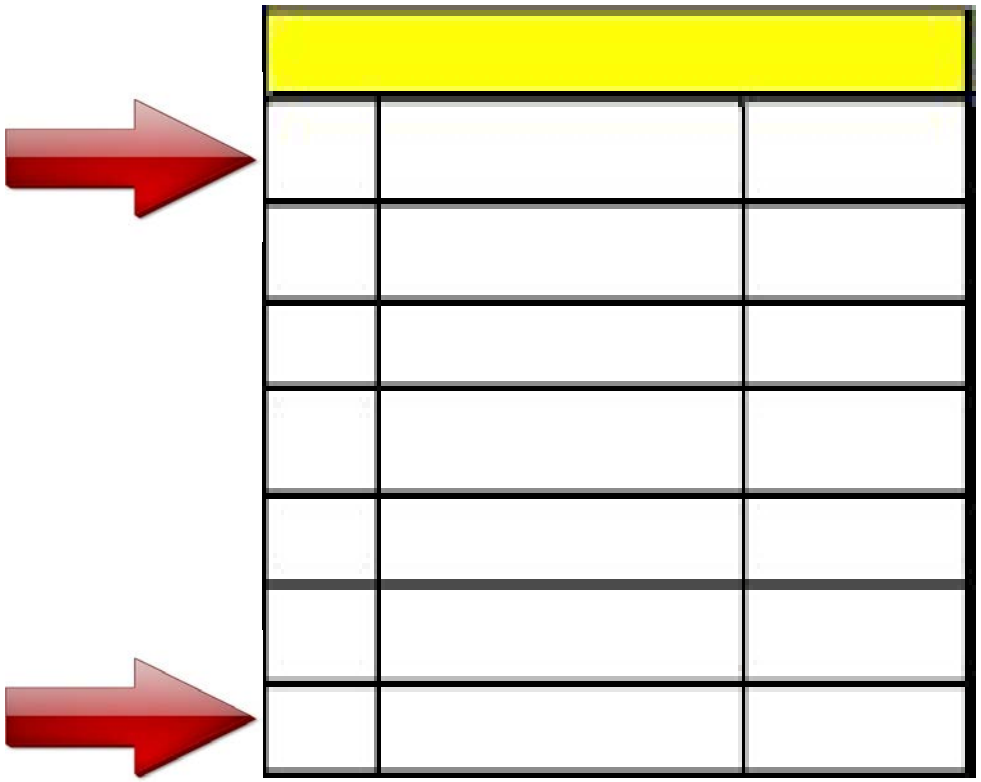


Chart Explained - Rows

- Rows represent various subgroups by age, gender and race/ethnicity
- The bottom Row is the percentage of the total youth Medicaid population utilizing the service



Shading and Negative and Positive Values

- Red Shading and a negative (-) value represent disproportionate under utilization
- Blue shading and a positive value represent disproportionate over-utilization
- The darker the shading the greater the disproportionality.

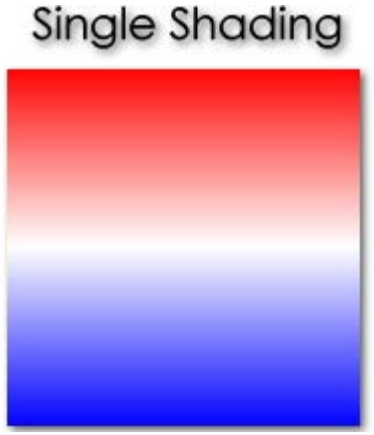


Chart Explained – Cell Values

- The value in each cell in the table represents
  - the percentage deviation of the observed utilization rate for a particular service type or frequency from the population rate for the particular subgroup
- For example, the first cell in the upper left hand corner of the table shows the population rate for the 3-12 year old age group to be 65.98%.
- The next column in the same row shows the value of -62.61% which indicates that the observed utilization rate for ED visits with a primary BH diagnosis by the 3-12 year old age group is approximately 63% lower than the population rate (24.67% - 65.98% = -41.31%/65.98%= -62.61%).

Why use percentages vs. Absolute Values?

- Percentages better reflect the degree of disproportionality
- Case 1 = Pop Rate = 50%, Utilization Rate = 40%, resulting in a -10% absolute discrepancy
- In Case 1, 20% of people are not getting services
- Case 2 – Pop Rate = 20%, Utilization Rate = 10%, resulting in a -10% absolute discrepancy
- In Case 2, 50% of eligible population are not getting services

Example - Asians

- Asians make up 3.18% of Youth Medicaid Population but their actual utilization of Medicaid services is below 1% in most instances
- Although a small population, on a percentage basis they have the lowest utilization rates.

Findings - Age

- Adolescents disproportionally utilize all types of Medicaid BH service
- Young Children (3-12) disproportionally over-utilize the ED for medical reasons

Findings - Gender

- Girls are generally disproportionately underrepresented across most service types and boys are disproportionately overrepresented.
- The exceptions are that both girls and boys utilize ED visits with a primary BH diagnosis, ED visits with a primary Medical diagnosis, and inpatient mental health services at rates consistent with their population rate.
- Girls deviate from the general pattern of disproportional underrepresentation in services given their relative overrepresentation in those that utilized inpatient care 3 times or more.

Findings - Race/Ethnicity

- Asian youth had the highest rates of disproportional underrepresentation across all service types.
- The Asian population has strikingly low rates of use of BH Services.
- This highlights the need to pay more attention to this smaller but poorly served population.

Findings - Race/Ethnicity

- Blacks disproportionally underutilize most service types with some exceptions
  - Blacks use the ED with a primary BH diagnosis, and Inpatient MH services 3 times or more, at rates comparable to their population rate.
  - Blacks disproportionally over-utilize Inpatient stays in the State Hospital.

Findings - Race/Ethnicity

- Hispanics disproportionally underutilize most service types but generally less so than Blacks
  - Hispanics significantly disproportionally over-utilize the ED for Medical reasons.

Findings - Race/Ethnicity

- Whites disproportionally over-utilize most service types with some exceptions
  - Whites use the State Hospital at rates relatively comparable to their Medicaid population rate
  - Whites disproportionally underutilize the ED for medical reasons.

Questions/Discussion