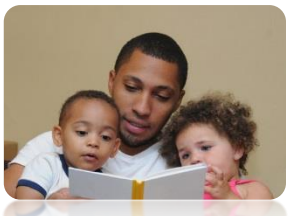
Health Equity and Inequity

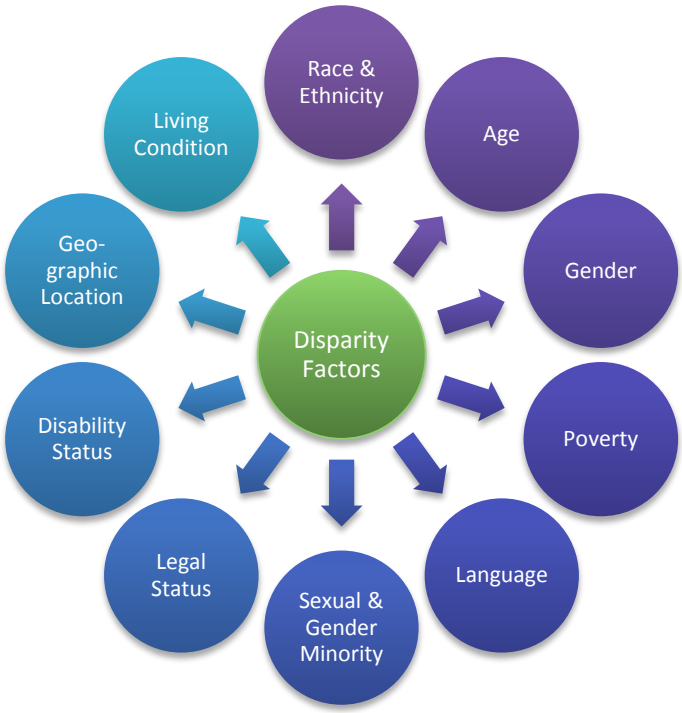
Within the Connecticut Medicaid Behavioral Health Service System



DEFINITION

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

CONTRIBUTING FACTORS



TERMINOLOGY

The CT BHP uses the generally preferred terms by those who self-identify in each category for race and ethnicity: Alaskan Native, American Indian, Asian, Black, Hispanic, Multi-Racial, Pacific Islander, and White.

LITERATURE REVIEW

Why are some groups less likely to utilize health care services or have poorer health outcomes or experiences of care? The literature indicates that the known and suspected causes of health disparity include inequities in policy, practice, and various social conditions as depicted in the graphic to the left. Major findings from the literature are described below.

Race and Ethnicity – Minority populations are generally less likely to access behavioral health services although there are differences in underlying rates of behavioral health disorder.

Disability – In the US, individuals treated in the public mental health system die 13 to 30 years earlier than the norm for each state.

Gender and Sexual Minorities – LGBTQ Youth are at higher risk for victimization, suicide and other poor health outcomes than those in the sexual or gender majority.

Homelessness – A recent CT DPH report indicated that in 2013, 40% of homeless individuals had a mental illness and 55% experienced chronic substance abuse.

Language – Hispanic and Asian/Pacific Islanders with limited English proficiency are significantly less likely to access behavioral health care than those within the same race/ethnicity that do speak English. Other non-English speaking groups are also significantly affected.

Gender – Compared to men, women are more likely to be diagnosed with depression or anxiety problems and are more likely to seek and receive treatment.

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KEY INFORMANTS & FOCUS GROUPS

Interviews were conducted with 17 key informants from various professions and fields (advocates, state agencies, academic, public health, etc.) with specific expertise, experience or perspective on health disparities in CT.

Common Themes and Recommendations:

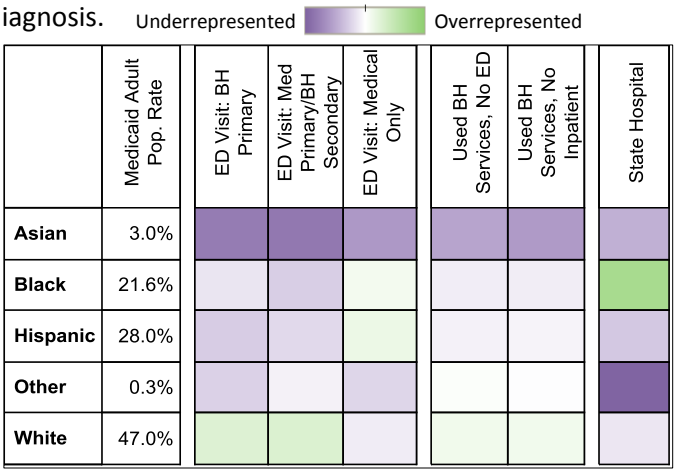
- Need for family-based approach to treatment, including more outreach in natural community settings
- A robust data infrastructure, including data integration across systems, and better recording of various demographics such as disabilities, gender identity, sexual orientations, educational attainment, etc.
- Improved outcomes tracking by demographic groups
- Increased access to clinical services in a preferred language and/or availability of translation services
- Provide cultural and linguistic competency training
- Develop community-based outreach to underserved populations to reduce stigma and improve health literacy
- Improved holistic approach to engaging and assessing client strengths, including better coordination across medical, educational, and behavioral health systems
- Measurement-based care to track feedback and progress
- Need for more peers in the behavioral health delivery system

Additionally, five focus groups with 34 young adult and adult Medicaid members revealed the following:

- Experiences of discrimination, lack of resources, and inadequate outreach in the provision of behavioral health services for Blacks, Hispanics, and those who are LGBTQ were reported by the focus groups
- Focus group participants called for better language services, a workforce that better reflects those being served, and improved cultural competency training among other suggested improvements

CONNECTICUT FINDINGS

Fewer Minorities Accessing Care – In comparison to their numbers in Medicaid, Blacks, Asians, and Hispanics are disproportionality underrepresented (purple) in populations who utilize any behavioral health service, as well as those that utilize the Emergency Department (with a behavioral health diagnosis) and inpatient services. Blacks and Hispanics were disproportionately overrepresented (green) among visits to the ED with a medical vs. a behavioral health diagnosis.



State Hospital Utilization – Blacks were disproportionally overrepresented (green) in state psychiatric hospital bed use.

Gender Effects – Women were generally underrepresented in those receiving Medicaid funded behavioral health services despite national data indicating that women have higher prevalence rates for the most common mental health disorders (e.g. anxiety/depression) and in most systems, tend to be higher users of behavioral health services in comparison to men.

Age Effects – Adults aged 45-54 tended to be overrepresented in behavioral health service utilization at all levels of care while those in the 18-25 year old age range were disproportionately underrepresented.

TOP RECOMMENDATIONS

Members

- Increased representation in committees and organizations that oversee and advocate for behavioral health services
- Greater involvement of family members in care

Service Providers

- Implementation of National Standards (CLAS)
- Increase use of peers and/or community navigators
- Provide more services in natural community settings

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- Implementation of National Standards (CLAS)
- Develop, track, trend and disseminate health equity metrics (utilization, outcomes, etc.)

State Agencies (DMHAS, DCF, DSS)

- Implementation of National Standards (CLAS)
- Expand the collection of data across agencies to include gender identity, sexual orientation, income, etc.

This brief summarizes the key points of a more extensive clinical study of the same title submitted in 2015 and was made possible through the collaborative effort of the Connecticut Behavioral Health Partnership. If you are interested in further information on this topic or are interested in a presentation to your group, committee, or agency, please contact Dr. Bert Plant, Ph.D. at Robert.Plant@beaconhealthoptions.com.