HEALTH CARE DISPARITIES

SIGNIFICANT ISSUE FOR EFFECTIVE INTERVENTION, TREATMENT AND RECOVERY – ORIENTED STRATEGIES

Prison and Jail Overcrowding Commission
Department of Mental Health and Addiction Services

November 4, 2004
Two Key Definitions

**Behavioral Healthcare:** Mental Health and Addiction Treatment Services

**Health disparities:** Systematic differences in health care practices and patterns of service utilization that are related to race, culture or gender and not due to a health condition
Men in the Criminal Justice System

- 94% of all inmates in U.S. state and federal prisons are men
- Black and Hispanic inmates constitute 62% of the prison population
- 16% have mental illness
- Policy implications:
  - Front Door – Jail Diversion
  - Back Door – Community Reentry
What is the CT Health Disparities Initiative?

Goals:

– Identify and reduce behavioral health disparities
– Improve quality of care by enhancing cultural competence
– Create sustained Systems Change
– Contribute to the body of scientific knowledge
U.S. Surgeon General on Mental Health: Culture, Race and Ethnicity

• Less access to, and availability of, mental health services
• Less likely to receive needed mental health services
• Those in treatment often receive a poorer quality care
• Underrepresented in mental health research
• Experience a greater burden of disability
Why Address Behavioral Health Disparities NOW

• Because the nation’s population is changing rapidly
• Because too many people lack health insurance – especially People of Color
• Because many People of Color are reliant upon public sector services
• Because health disparities are serious problems
• Because it’s the right thing to do!
Many People of Color are reliant upon public sector services

CT DMHAS Fiscal Year 2003 Data

Source: CT DMHAS eCura
Health Disparities

EXAMPLES
What about use of “New Generation” antipsychotics meds in a Connecticut state hospital?

- Patients receiving new generation antipsychotic meds increased significantly: 80% in FY99 to 87% in CY01

- **During FY99**: Significantly fewer African American patients received atypical meds (72% African American versus 82% among all other patients)

- **But During CY01**: Gap in use of newer meds closes (85% African Americans versus 87% among all other patients)
Disparities in Psychiatric Hospitalization Rates
Connecticut Data - Fiscal Year 2002

White: 80.1% (CT General Pop) 55.9% (Inpatient MH)
Black: 7.9% (CT General Pop) 23.9% (Inpatient MH)
Hispanic: 8.0% (CT General Pop) 15.1% (Inpatient MH)
Other: 4.0% (CT General Pop) 5.1% (Inpatient MH)

Blacks 3Xs more inpatient utilization
Latinos 2Xs more inpatient utilization

% Adults CT General Pop  Inpatient MH
Eliminating
Health Disparities
Improving Employment

Results from the “Voice Your Opinion 2000-2001” Connecticut Consumer Survey

Not Enrolled in Voc

- White (non-Hisp): 23.2%
- Black (non-Hisp): 11.9%
- Hispanic/Latino: 9.8%
Improving Employment

Results from the “Voice Your Opinion 2000-2001” Connecticut Consumer Survey

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<th>Group</th>
<th>Enrolled in Voc Programs</th>
<th>Not Enrolled in Voc</th>
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<td>Black (non-Hisp)</td>
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<tr>
<td>Hispanic/Latino</td>
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Legend:
- **Enrolled in Voc Programs**
- **Not Enrolled in Voc**
Culturally Specific Approach to Methadone Treatment

Impact of Latino Outreach Initiative

Latino Heroin User Admissions

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</table>
Access to Substance Abuse Treatment

Increased Treatment Admissions Among Latinos

Latino White Black Other

Health Disparities: Access

- Use of Emergency Rooms
- Criminal Justice Involvement
- Geographical Access
- Psychological Access
- Insurance Coverage
- Help Seeking Patterns
- Entering Treatment Later and Sicker
- Availability and Capacity of Treatment
- Program Receptiveness (User Friendliness)
Health Disparities: Client Engagement & Retention

• Treatment Completion (Drop Out Rate)
• Continuity of Care
• Length of Stay in Treatment
• Program Participation
• Client Satisfaction
• Mistrust of Programs
Health Disparities: Effective Treatment

- Mis-diagnosis
- Differential Treatment Outcomes
- Over and Under Medication
- Use of New Generation Medications
- Lack of Adaptation of Evidence-Based Practices
- Poor Adherence to Minimum Treatment Standards
- Quality of Treatment
Health Disparities: Support Resources in the Community

- Availability of Post Treatment Support in the Community
- Availability of Support and other Self-Help Groups
- Treatment Rates (Program availability) in the Community
- Availability of Alternatives to Formal Treatment
- Stigma of Mental Illness
What we should measure and why?

1. **Mine data** to identify the Health Disparity **Issues** in each of the **four Domains**:
   - **Access to Care**
   - **Client Engagement and Retention**
   - **Effectiveness of Treatment**
   - **Supports in the Community**

2. Implement culturally competent **Interventions** to eliminate those disparities

3. **Design and monitor** **Indicators** to measure progress toward reducing disparities and improving outcomes, and adjust interventions accordingly
The ACES Model

**Issues:**
- Geographical Access
- Psychological Access
- Physical Access
- Insurance Coverage

**Access**

**Client Engagement & Retention**
- Treatment Participation
- Admission Process
- Establishment of Trust

**Effective Tx Services**
- Therapeutic Relationship
- Quality Treatment Languages spoken

**Supports in Community**
- Indigenous Healers
- Ecological Perspective of Clients
- Community relationship

**Interventions:**
- Addressing Payer Issues
- Geographical Access
- Culturally Specific Programs
- Staff Selection

**Indicators:**
- Penetration Rates
- Geo Mapping
- Proportion in LOC
- Length of Stay
- Frequency of Visits
- Clinical Outcomes
- Treatment Completion
- Quality of Life Measure
- Relapse/Recidivism Rates

**OUTCOMES:**
- Motivational Enhancement Therapy (MET)
- Transcultural Approaches
- Hire bilingual therapists
- Faith Community connections
- Self-Help Groups

**Faith Community**

**Connections**

**Self-Help Groups**

**Indigenous Healers**

**Ecological Perspective of Clients**

**Community Relationship**

**Length of Stay**

**Frequency of Visits**

**Clinical Outcomes**

**Treatment Completion**

**Quality of Life Measure**

**Relapse/Recidivism Rates**
Multi-Level, Multi-Dimensional Approach

Eliminating Health Disparities means building Culturally Competent systems that are effective at all levels (i.e., practitioner, provider and systems), and focusing on dimensions beyond treatment characteristics that provide leverage to system administrators.

Levels
- Clinical (Practitioner)
- Program (Provider)
- System (Policy)

Dimensions
- Training
- Standard Setting
- Contracting
- Data systems/MIS
- Quality Management
- Clinical/Systems Policy
- Consumer Advocacy/ Input/Satisfaction
- Evaluating care
Use an Inclusive Definition of Evidence:
Levels/Types of Evidence

Evidence-Informed
Evidence-Based
Evidence-Supported
Evidence-Suggested
Evidence-Suggested

• Consensus driven, or based on agreement among experts.

• Based on values or a philosophical framework derived from experience, but may not yet have a strong basis of support in research meeting standards for scientific rigor.

• Provides a context for understanding the process by which outcomes occur.

• Based on qualitative data.
Evidence-Informed

• Evidence of the effectiveness of an intervention is inferred based on limited supporting data.
• Or, based on data derived from the replication of an EBP that has been modified or adapted to meet the needs of a specific population.
• Data is fed back into the system. New interventions are developed, traditional interventions are modified, and ineffective interventions are eliminated.
• Provides a template/framework for other systems to modify their programs and interventions.
Evidence-Supported

• Interventions that have demonstrated effectiveness through quasi-experimental studies (e.g., “Time Series” studies, or detailed program evaluations that include data on the impact of the programs or interventions).

• Data from administrative databases or quality improvement programs that shed light on the impact of the program or intervention.
Evidence-Based

• Interventions based on several randomized controlled studies and where at least one meta-analysis shows strong support for the practice.

• Results have a high level of confidence, due to randomized control factor.
Recommendations for Policy Framework

• Develop Cross System policy framework for Reducing Disparities

• Ensure that the Broad Range of Services necessary to meet the Needs of Diverse Populations, especially Community-Based Services

• Ensure that Resource Distribution matches identified needs in the system

• Bring together policy, community, provider and academic resources to plan, implement and evaluate health disparity strategies
Recommendations for Policy Framework cont’

• Ensure that racial/ethnic data is routinely collected, analyzed and used in all quality improvement efforts

• Systematically disseminate lessons learned and preferred culturally competent practices

• Implement workforce development strategy to ensure that there is racial/ethnic diversity at all levels within the service system
Take Home Messages

• Health disparities in behavioral health:
  – are important
  – can be eliminated

• We need to:
  – make an explicit link between Cultural Competency and Health Disparities
  – use a model to identify Issues, Indicators and Interventions