Behavioral Health Equity in an Era of Parity

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Welcome

- Introduction and Learning Objectives
- Behavioral Health Disparities in the Nation
- Reducing Barriers to Treatment
- Opportunities for Change – Pursuit of Health Equity
Learning Objectives:

• To identify behavioral health disparities which are an impediment to achieving health equity in our communities.

• Eliminating barriers and challenges facing individuals and providers.

• What opportunities for change are taking place to reduce disparities, work towards parity and health equity.
"Much like health care reform, realizing comparable insurance coverage for mental health and substance use disorders (known as parity) has been a long time coming.

Recognizing mental health and substance use disorder treatment as integral to health underpins the significance of providing parity in coverage of treatment for mental and substance use disorders and other medical conditions.”

(Frank, 2016)
The building blocks and future of behavioral health parity will profoundly benefit the system of care when informed by a disparities impact statement to address the underlying behavioral health disparities affecting individuals across the U.S.
Demographic Context

- U.S. IS GETTING OLDER
- U.S. CONTINUES TO GROW
- U.S. IS INCREASING MORE DIVERSE
On July 1, 2014 - 37.2% of the U.S. Population was:
• 17.4% Hispanic or Latino
• 13.2% African American
• 5.4% Asians American
• 1.2% American Indian and Alaskan Native
• Source: https://www.census.gov/quickfacts/table/PST045215/00

On June 18, 2016 there were 323,801,534 people in the U.S.

By 2040, there will be 380,219,000 people in the US
http://www.census.gov/population/international/data/idb/informationGateway.php
By 2050, 54 percent of the population will be minorities.

By 2050, the U.S. population is expected to be 439 million.

By the number of residents older than 65 will more than double.

The most dramatic gain is the Hispanic population. It is projected to nearly triple, from 46.7 million to 132.8 million, from 2008 through 2050, "Thus, one in three U.S. residents would be Hispanic."

U.S. Census, 2016
BEHAVIORAL HEALTH DISPARITIES

• States with the lowest prevalence of mental illness and highest rates of access to care include:
  - Massachusetts, Vermont, Maine, North Dakota, and Delaware.

• States with the highest prevalence of mental illness and lowest rates of access to care include:
  - Arizona, Mississippi, Nevada, Washington, and Louisiana.

(Mental Health America, 2015)
BEHAVIORAL HEALTH DISPARITIES

• States with the lowest prevalence of mental illness and highest rates of access to care:
  ➢ For adults include: Massachusetts, New Jersey, Hawaii, Maryland, and Connecticut.
  ➢ For youth include: Vermont, North Dakota, Wisconsin, Iowa and Maine.

(Mental Health America, 2015)
BEHAVIORAL HEALTH DISPARITIES

• States with the highest prevalence of mental illness and lowest rates of access to care:
  
  ➢ For adults include: Mississippi, Arizona, Oklahoma, Arkansas, and Washington.

  ➢ For youth include: Nevada, New Mexico, Montana, Louisiana, and Washington.

(Mental Health America, 2015)
• States with highest rates of access to mental health care (rank 1-5) are:
  - Vermont, Massachusetts, Maine, Delaware and Iowa.

• States with lowest rates of access to mental health care (rank 47-51) are:
  - Nevada, Mississippi, Alabama, Louisiana, and Texas.

(Mental Health America, 2015)
In 2014, the highest suicide rate (19.3) was among people 85 years or older. The second highest rate (19.2) occurred in those between 45 and 64 years of age.

Younger groups have had consistently lower suicide rates than middle-aged and older adults.

In 2014, adolescents and young adults aged 15 to 24 had a suicide rate of 11.6.

(AFSP, 2014)
• In 2014, the highest U.S. suicide rate (14.7) was among Whites and the second highest rate (10.9) was among American Indians and Alaska Natives.

• Much lower and roughly similar rates were found among Hispanics (6.3), Asians and Pacific Islanders (5.9), and Blacks (5.5).

(AFSP, 2014)
BEHAVIORAL HEALTH DISPARITIES

• Health Professional Shortage Areas (HPSA)
  As of June 19, 2014: There are currently approximately 6,100 designated Primary Care HPSAs.

• When there are 3,500 or more people per primary care physician, an area is eligible to be designated as a primary care HPSA.

   (HRSA, 2014)
There are currently approximately 4,000 Mental Health HPSAs. When there are 30,000 or more people per psychiatrist, an area is eligible to be designated as a mental health HPSA.

It would take approximately 2,800 additional psychiatrists to eliminate the current mental health HPSA designations.

(HRSA, 2014)
REDUCE BARRIERS TO TREATMENT

- Organization and financing of services have impeded access and availability for racial and ethnic minorities.

- Racial and ethnic minorities do not use mental health services at rates comparable to those of whites or in proportion to the prevalence of mental illness in either minority populations or the general population.

- Research suggests that cost and lack of health insurance, fragmentation of services, culturally mediated stigma or patterns of help-seeking, mistrust of specialty mental health services, and the insensitivity of many mental health care systems, all discourage racial and ethnic minorities' use of mental health care.

- Reducing financial barriers and making services more accessible to minority communities should be aims within any effort to reduce mental health disparities. Shame, stigma, discrimination, and mistrust also keep racial and ethnic minorities from seeking treatment when it is needed.

REDUCING BARRIERS TO TREATMENT

- Minorities are less likely than whites to have health insurance and to have the ability to pay for mental health services.
- Across racial and ethnic groups, lack of health insurance is a significant financial barrier to getting needed mental health care.
- Even for people with health insurance, whether public or private insurance, there are greater restrictions on coverage for mental disorders than for other illnesses.
- This inequity, known as lack of parity in mental health coverage, needs to be corrected.
- Another important step toward removing the financial barriers that contribute to unequal access to needed mental health care is the extension of publicly supported health care coverage to children who are poor and near poor.


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EXTEND HEALTH INSURANCE FOR THE UNINSURED

• Approximately 43 million Americans have no health insurance.
• Federal and State parity laws and steps to equalize health and mental health benefits in public insurance programs will do little to reduce barriers for the millions of working poor who do not qualify for public benefits, yet do not have private insurance.
• Today, the Nation’s patchwork of health insurance programs leaves more than one person in seven with no means to pay for health care other than by out-of-pocket and charity payments.
• The consequences of the patchwork are many holes in the health care system through which a disproportionately greater number of poor, sick, rural, and distressed minority families frequently fall.


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Improving the behavioral health programs in the US

• Understanding and sensitivity to historical adversity and trauma as it relates to multicultural practices with high-risk populations.

• Researchers must conceive and evaluate other explanations also differences in access to insurance, in levels of illness or patterns of symptom expression, in health-risk behaviors, beliefs, preferences, and help-seeking traditions can also explain disparities.


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HEALTH CARE REFORM CHANGES

• The Affordable Care Act’s (ACA) coverage expansion benefited hospitals financially by helping create an overall decline nationwide in uncompensated care from $34.9 billion to $28.9 billion in 2014.

• Nearly all of the decline happened in Medicaid expansion states, while uncompensated care costs were $10.8 billion in 2014, down $5.7 billion, or 35% from 2013 the year before ACA coverage expansions took effect.

(Kaiser Family Foundation, 2016)
The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.
OPPORTUNITIES FOR CHANGE

• Research demonstrates that coverage alone is not enough to improve health outcomes and achieve health equity.

• There is growing recognition of the importance of not only integrating and coordinating services across providers and settings within the health care system, but also connecting and integrating health care with social supports and services that address the broad range of social and environmental factors that impact individuals’ and communities’ health and well-being.

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OPPORTUNITIES FOR CHANGE

• Given the importance of social determinants on health and health equity and the new opportunities provided by the ACA, a range of initiatives to address social determinants of health are emerging at the federal, state, local, and provider level.

• These include initiatives designed to assess and address health impacts in other policy areas as well as efforts to integrate social determinants into the health care system.

• In particular, many new initiatives within Medicaid include a focus on social determinants, given the program’s role serving a diverse population with complex needs.

(Heiman and Artiga, 2015).
Research is essential to examine the efficacy of ethnic- or culture-specific interventions for minority populations and their effectiveness in clinical practice settings. Improvements should consider:

- Preventive interventions
- Studies the roles of culture, race, and ethnicity in mental health
- Improving access to treatment
- Improving geographic access
- Integrating mental health and primary care
- Ensuring language access
- Coordinating and integrating mental health services for high-need populations


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O P P O R T U N I T I E S F O R C H A N G E

Adoption of the Enhanced National Culturally and Linguistically Appropriate Services (CLAS) Standards

1. Principal Standard
2. Governance, Leadership and Workforce
3. Communication and Language Assistance
4. Engagement, Continuous Improvement and Accountability

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OPPORTUNITIES FOR CHANGE

Cultural Competency Training and CLAS Standards - Think Culture.gov
OPPORTUNITIES FOR CHANGE

• Only legislative activity on cultural competency training

• Only enacted legislation on cultural competency training

• Only state-sponsored National CLAS Standards implementation activities

• Legislation (either legislative activity or enacted legislation) on cultural competency training and state-sponsored National CLAS Standards implementation activities were not identified via Internet searches

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OPPORTUNITIES FOR CHANGE

- HHS Action Plan to Reduce Racial and Ethnic Health Disparities addresses the need to transform the current healthcare system and building a high-value healthcare system requires insuring the uninsured, making coverage more secure for those who have it, and improving quality of care for all.

- The 2010 Affordable Care Act offers the potential to meet these goals and address the needs of racial and ethnic minority populations.

  The ACA will:
  a. allows those with preexisting conditions (first children and eventually everyone) to gain and keep coverage;
  b. ends lifetime limits on care;
  c. covers preventive services. These once limited services are now part of future healthcare for those in need of mental health services.

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(Minorityhealth, 2015).
OPPORTUNITIES FOR CHANGE

• The opportunities to reduce disparities in access to primary care services and care coordination will require an increase the proportion of persons with a usual primary care provider and patient-centered health care, including behavioral health.

• HRSA will award 350 New Access Point grant awards to support new health center service delivery sites in medically underserved areas.

(Minorityhealth, 2015)
• HRSA is working to increase the diversity and cultural competency of clinicians, including the behavioral health workforce.

• HRSA will develop a plan for targeted recruitment of students from backgrounds that are underrepresented in the healthcare workforce.
  ➢ Activities will include implementing innovative strategies to encourage student interest in primary care and application to the NHSC scholarship program.

• HRSA will develop new approaches for reaching minority health professions students before they enter the job market through the loan repayment program.

• HRSA will assess the results of targeted efforts to expand outreach, mentorship, partnership, and recruitment practices (Minorityhealth, 2015).
OPPORTUNITIES FOR CHANGE

• Through the newly funded Center for Integrated Health Solutions (CIHS) that works with higher-education institutes, SAMHSA will grow a diverse workforce to provide services in integrated primary care and behavioral health settings for vulnerable populations.

• Utilizing its National Network to Eliminate Disparities in Behavioral Health (NNED), SAMHSA will launch two new Communities of Practice for providers. This includes accessing virtual training and technical assistance to implement evidence-based behavioral health interventions focused on trauma and trauma-related disorders geared to minority populations.

(Minorityhealth, 2015)
OPPORTUNITIES FOR CHANGE

On March 15, 2016, S.2680 was introduced in the United States Senate by Senator Lamar Alexander. Titled The Mental Health Reform Act of 2016, the bill proposes that:

a. **Ensure that mental health programs are effectively serving those with mental illness**: The bill will improve coordination between federal agencies and departments that provide services for individuals with mental illness, and will improve accountability and evaluation of mental health programs.

b. **Help states meet the needs of those suffering from mental illness**: This bill helps ensure that federal dollars support states in providing quality mental health care for individuals suffering from mental illness by updating the Community Mental Health Services block grant for states.

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OPPORTUNITIES FOR CHANGE

c. Ensure that the federal government promotes the use of evidence-based and promising best practices: The bill requires that the federal agencies and programs involved in mental health policy incorporate the most up-to-date approaches for treating mental illness, and requires that agency leadership include mental health professionals who have practical clinical experience.

d. Increase access to mental health care: The bill increases access to care for individuals including veterans, homeless individuals, women, and children. It also helps improve the training for those who care for those with mental illnesses. It promotes better enforcement of existing mental health parity laws.

(Minorityhealth, 2015)
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