Moving policy work beyond diversity to real equity

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How can DHS address health disparities among program participants of different ethnic backgrounds?

- Ethnic background impacts a person’s exposure to social risk factors and this needs to be taken into consideration.

- Historical trauma and other experiences the impact well-being of current and future generations.

- The results are changes to:
  - Access to family and community supports
  - Access to financial and other resources

- Ethnic background and culture also impact the service models that are effective for each population.
How can DHS address health disparities among program participants of different Ethnic backgrounds?

• It is DHS’ charge to reduce disparities and improve outcomes for the racial and ethnically diverse populations of the state.

• We have historically done this by addressing the prevalence of many social risk factors (e.g. poverty, homelessness, lack of health insurance).

• Social determinants of health
  • Family structure (including family composition)
  • Socio-economic indicators (income, neighborhood, homelessness)
  • Adult and Parental functioning (mental health, substance use, child protection, incarceration)
  • Immigration status, ethnicity, language
How can DHS address health disparities among program participants of different Ethnic backgrounds?

• DHS does not seek to institutionalize disparities by paying providers differently according to program participants’ racial or ethnic background. We sometimes include an additional payment for patients with other social risk factors (e.g. language barrier).
How can DHS address health disparities among program participants of different Ethnic backgrounds?

- We are getting better at thinking about designing, offering, and supporting services for ethnic groups that experience poor outcomes with mainstream services (e.g. finding more appropriate substance use treatment models than 12-step Christian models for American Indians)

Examples:

- Integrated Care for High Risk Pregnancies (ICHiRP)
  - American Indian partners
  - African American partners
- Native doula program
DHS program participants tend to participate in multiple programs

Number of children living in Minnesota, as well as those participating in DHS safety net programs, 2013

- All Children in Minnesota: N=1,282,594
- MHCP: N=420,538
- SNAP: N=299,935
- Child Protection: N=47,050
- MFIP/DW: N=112,852

Figure 1.1. Number of children living in Minnesota, as well as those participating in DHS safety net programs, 2013
Using our data in ways that help us see with a person-centered perspective

- Each program area has a different perspective on the strengths and needs of our common program participants. We’re working cross-program (and cross-agency) to serve our common participants more effectively.

- We’re linking our data across program areas to better understand how different programs intersect in participants’ lives and between all program areas.
Why is it so difficult to make progress on health disparities among people with social risk factors?

• DHS wants to fund providers who serve our most vulnerable participants fairly. We want to evaluate their participant outcomes fairly, which might mean adjusting for their higher level of need.
  • We don’t accept lower quality care for these recipients.
  • We won’t have poor outcomes in our most vulnerable participants to be disguised and overlooked.

• Funding for health care services is easier to access than funding for more upstream resources that could prevent medical conditions.

• Two generation approach. Adequately addressing the needs of children requires a two-generation (or more) approach, considering the ACEs literature. We address this in child welfare and children’s mental health, but need community integrated solutions. Getting to these solutions via our current funding pathways is at times challenging.

• ETHNIC BACKGROUND IS ASSOCIATED WITH HEALTH OUTCOMES THROUGH MANY, OVERLAPPING PATHWAYS.
Social Risk Factors

- With 1.2 million enrollees, Medicaid data can give an overview of Minnesotans who are living in poverty or are disabled.

- DHS has a lot of data on social risk factors, to a large degree because Minnesota DHS has more functions than most states.

- We pulled all the indicators we could find, using administrative data only:
  - Medicaid claims and encounter data
  - Medicaid enrollment data
  - Cash assistance data
  - Child protection data
  - Linked DHS data with MN Dept of Corrections administrative data
## Immigration and Language

### 2014 Medical Assistance participants

<table>
<thead>
<tr>
<th></th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immigrated to U.S.</td>
<td>15%</td>
<td>21% (Parent or child immigrated)</td>
</tr>
<tr>
<td>Language other than English</td>
<td>10%</td>
<td>12% (Parent language)</td>
</tr>
</tbody>
</table>
### Ethnic Background
#### 2014 Medical Assistance participants

<table>
<thead>
<tr>
<th></th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>White</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-immigrants</td>
<td>54%</td>
<td>37%</td>
</tr>
<tr>
<td>Immigrants</td>
<td>1%</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Black</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-immigrants</td>
<td>12%</td>
<td>15%</td>
</tr>
<tr>
<td>Immigrants</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Hispanic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-immigrants</td>
<td>3%</td>
<td>9%</td>
</tr>
<tr>
<td>Immigrants</td>
<td>1.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td><strong>Asian</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-immigrants</td>
<td>3%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Immigrants</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>American Indian</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-immigrants</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Immigrants</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
## Socio-Economic Indicators
### 2014 Medical Assistance participants

<table>
<thead>
<tr>
<th>Category</th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Income &lt; Poverty Level</td>
<td>75%</td>
<td>82%</td>
</tr>
<tr>
<td>Family Income &lt; 50% FPL</td>
<td>44%</td>
<td>51%</td>
</tr>
<tr>
<td>Lives in high poverty census tract (&gt; 20% of residents are poor)</td>
<td>28%</td>
<td>30%</td>
</tr>
<tr>
<td>Homeless in past year</td>
<td>7%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>
## Adult and Parental Functioning
### Child Medical Assistance participants

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious and Persistent Mental Illness</td>
<td>5.5%</td>
<td>5%</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Child Protection Involvement (5 years)</td>
<td>N/A</td>
<td>19%</td>
</tr>
<tr>
<td>History of Prison Incarceration</td>
<td>4%</td>
<td>1.6% (2014)</td>
</tr>
</tbody>
</table>

* Child is the unit of analysis
## Family Structure

### 2013 Child Medical Assistance participants

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent(s) are unmarried</td>
<td>63%</td>
</tr>
<tr>
<td>Parent(s) are under age 20</td>
<td>1%</td>
</tr>
<tr>
<td>Four + children in family</td>
<td>23%</td>
</tr>
<tr>
<td>Parent is disabled/very high medical expenses</td>
<td>8%</td>
</tr>
<tr>
<td>Sibling is medically complex</td>
<td>17%</td>
</tr>
</tbody>
</table>
Child Protection Involvement among American Indians

- Disproportionate representation of American Indian children in MN child protection systems.
- Among children on Medicaid, American Indian children are three times more likely than Whites to have child protection involvement.
- American Indian children also have much greater exposure to social risk factors.
Child Protection Involvement among American Indians

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>American Indian Children enrolled in Medicaid (N=12,120)</th>
<th>White Children enrolled in Medicaid (N=164,389)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental chemical dependency</td>
<td>37%</td>
<td>13%</td>
</tr>
<tr>
<td>Newborn opioid exposure, age 0-3 only</td>
<td>6%</td>
<td>1%</td>
</tr>
<tr>
<td>Parental Serious Mental Illness</td>
<td>19%</td>
<td>16%</td>
</tr>
<tr>
<td>Current homelessness</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Family poverty (100% FPG)</td>
<td>89%</td>
<td>78%</td>
</tr>
<tr>
<td>Unmarried parent</td>
<td>89%</td>
<td>61%</td>
</tr>
<tr>
<td>Four or more children</td>
<td>26%</td>
<td>17%</td>
</tr>
</tbody>
</table>

- Is the disproportionate involvement of American Indian children in child protection related to their greater exposure to social risk?
When controlling for demographics, ethnic community, and social risk factors, American Indian children are still more likely to have child protection involvement, but much less than before.

- Children age 0-3 are 45% more likely
- Children age 4-17 are 63% more likely.

Much stronger associations are found for children with:

- Parental chemical dependency (237% more likely)
- Newborn opioid exposure (149% more likely)
- Parental serious mental illness (103% more likely)
- Current homelessness (58% more likely)
Lessons for DHS

• Social risk factors do not explain all of the disproportionate representation
  • Work with communities to figure out what else is going on, and which resources or changes are needed.

• Social risk factors explain a lot of the disproportionate level of involvement of American Indian children in child protection
  • Invest in the resources that families need, such as chemical and mental health treatment, and housing.
  • When there is disparate access to these resources, address these disparities. Work with communities to find out if the usual service models meet their needs.
Which Medicaid enrollees experience the worst health disparities?

- Recent work to identify the social risk factors that are associated with the worst health disparities
- Outcome variables are
  - Health outcomes (e.g. mortality, asthma, Type 2 Diabetes)
  - Unnecessary high-cost health care (e.g. Potentially Preventable Hospital Stays)
Which Medicaid enrollees experience the worst health disparities?

• Social risk factors with especially poor health outcomes include:
  • Substance Use Disorder (children: parental substance use disorder)
  • Serious and Persistent Mental Illness (children: parental SPMI)
  • Deep poverty (<50% FPL)
  • Homelessness
  • History of prison incarceration

• Opportunity to focus funds upstream, so we may save money downstream in health care
How to reduce these disparities

Conduct literature reviews and stakeholder interviews to find out which interventions can improve the health of people with each of these social risk factors.

1) Innovative health care models
   • Health Care for the Homeless
   • Integrated Health Partnerships will receive a population-based payment which is tied to quality measures, and are adjusted for their attributed population’s medical and social risk

2) Interventions which address the social risk factors themselves
   • Improving access to housing and housing support services so people are no longer homeless

This will result in recommendations which can improve the health of enrollees with these risk factors.
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Wilder estimates that nearly **40,000** Minnesotans experience homelessness at least once over the course of a full year.

Wilder Research, 2015 Statewide Homeless Survey
Disproportionalities play out in homelessness

African Americans make up

5% of adults in Minnesota

39% of adult homeless population

Wilder Research, 2015
Statewide Homeless Survey
Disproportionalities play out in homelessness

American Indians make up

1% of adults in Minnesota

8% of adult homeless population

Wilder Research, 2015
Statewide Homeless Survey
Chronic health conditions of adults experiencing homelessness

21. Incidence and co-occurrence of health conditions among homeless adults

Total homeless adults surveyed: 6,273 (100%)
Proportion with none of these three disabilities: 1,525 (24%)
Proportion with multiple: 2,632 (42%)

- Serious mental illness (MI) 3,452 (55%)
- Chronic health conditions (CH) 3,229 (51%)
- MI ONLY 945 (15%)
- CH ONLY 1,020 (16%)
- CH & MI 1,406 (22%)
- CH & MI & SA 678 (11%)
- SA & MI 423 (7%)
- SA ONLY 151 (2%)
- SA & CH 125 (2%)
- Substance abuse disorder (SA) 1,377 (22%)
DHS has over 22 current programs that pay for some part of housing related services, yet many people are still unserved or under serve

- Housing Support (formerly known as GRH)
- MSA (MN Supplemental Aid) Housing Assistance
- Section 811
- Long-term homeless supportive services fund
- Housing with Supports for Adults with Serious Mental Illness (HSAMI)
- Housing access services
2017 Legislation gave

• DHS the authority to submit an application to the Center for Medicaid and Medicare for a platform to bill for housing related services

• Infrastructure grants to county and tribes to do the following:
  
  i. Outreach to people who are homeless or in institutions or segregated settings regarding housing options
  
  ii. Housing specialist to be expert on inventory of housing resources for the area (all housing – HUD, MHFA, DHS, public housing, private market, etc.)
  
  iii. Administration/monitoring of Housing Support

• Creation of a real time housing opening web site
Medicaid Housing Support Services benefit

• DHS received approval to seek authority from the federal government for a Medicaid Housing Support Services benefit

• Target population:
  • Disability and disabling condition AND
  • Housing instability

• Services:
  • Housing transition services
  • Tenancy sustaining services
Enrollment in DHS Supportive Housing

- Steady increase over time in supportive housing monthly enrollment
- Racial demographics somewhat reflective of homeless population in MN
Health Indicators of People Experiencing Homelessness

Homeless populations are:

• 17% more likely to have a potentially preventable hospitalization
• 65% more likely to have an ED visit could have been treated in primary care

• Literature finds that supportive housing programs for people with SUD or SPMI have a positive impact on their health and on overall health care costs

In a DHS study looking at our supportive housing participants

• Stability – 59% of cohort remained in Supportive Housing after two years
• ER Visits – People in supportive housing had 31% fewer ER visits two years after entering supportive housing, compared with before they had supportive housing
Thank You!

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651-431-3849
DHS Supportive Housing
People enrolled in Dec 2014 and Dec 2016

Each line is a person
N = 1,408 adults

Housing Types

Source: DHS Housing Division
Contact: Ben Van Hummik
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