



New York State Department of Health

2017 Health Care Disparities in New York State

A Report on Health Care Disparities for
Government Sponsored Insurance Programs

QARR Report Series
Issue 5 of 5

2017 Health Care Disparities in New York State

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Executive Summary

This report examines disparities in health care quality among New York State Medicaid members enrolled in the Medicaid Managed Care (MMC) program during the 2016 measurement year, which is referred to as the 2017 reporting year. The purpose is to identify priority health areas where disparities exist. This report can be used to inform quality improvement efforts in order to promote health equity for vulnerable populations in New York State.

Specifically, the report evaluates whether the disparities disproportionately affect the following vulnerable groups: racial/ethnic minorities, members with non-English as their spoken language, members with serious mental illness (SMI), members with a substance use disorder (SUD), members who received cash assistance, and members who received Supplemental Security Income (SSI). Definitions of these groups are described in detail on pages 6 and 7. Analyses in this report use 70 measures in the areas of adult health, women's preventive care, child health, and behavioral health (see appendix for details).

Priority Health Areas

Among the health areas examined in this report, several priority health areas have been identified which have evidence of disparities in quality of care among multiple priority populations. Examples of priority health areas and specific quality of care measures include:

- *Managing Chronic Conditions*: managing respiratory conditions and diabetes
- *Medication Management*: receiving and adhering to statin treatment among members with cardiovascular conditions and diabetes
- *Preventive Care*: annual dental visits for children and adults
- *Adult Behavioral Health*: adhering to antidepressants 3 and 6 months after diagnosis, receiving follow-up visits after hospitalization for mental illness within 7 and 30 days post-discharge, adhering to antipsychotics among members with schizophrenia, and initiating and engaging in treatment for alcohol or drug use
- *Caring for Children and Adolescents with Illnesses*: receiving appropriate testing for pharyngitis, ensuring that controller medications are 50% or more of total asthma medications, and adhering to asthma controller medication for at least 50% or 75% of the treatment period

Priority Populations

The Office of Quality and Patient Safety has classified specific vulnerable groups as priority populations in order to facilitate quality improvement. Evidence from this report shows that the following priority populations: members with a SUD, Black members, and members who received cash assistance in the MMC program experienced more negative health results during the 2017 reporting year than the respective reference populations (i.e., members without a SUD, White members, and members who did not receive cash assistance). Although other priority populations (SSI, Asian, Hispanic, SMI, and members with non-English as their spoken language) had similar or better results than their respective reference groups on the majority of measures, disparities continue to exist for these groups in particular areas.

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Identifying Disparities in Quality Results

A disparity is identified when there is a statistically significant difference in results between a vulnerable group and their reference group, after controlling for other individual characteristics (i.e., race, spoken language, mental health status, disability status, substance use and socioeconomic status). For example, when comparing health results for members with versus without a substance use disorder (SUD), if the results for members with a SUD are statistically significantly lower than the results for members without a SUD (while taking into account members' individual characteristics) members with a SUD would be categorized as having a "worse result" (a.k.a., a health disparity) on that measure.

Greatest Evidence of Health Disparities

- Members with an SUD had the greatest evidence of health disparities: 59% of their measure results were worse than the members without an SUD. This population had worse results on all measures regarding managing respiratory conditions (e.g., COPD and asthma).
- Black members had worse results than White members on 37% of the measures. Most of the lower results were found in managing medications (e.g., statin therapy), adult behavioral health (e.g., adhering to psychotropic medications, receiving follow-up care), and caring for children with illnesses (e.g., managing asthma).
- Members who received cash assistance had worse results than members who did not receive cash assistance on 34% of the measures. Women who received cash assistance had worse women's health results on the majority of measures than women who did not receive cash assistance. Additionally, women who received cash assistance also had a greater number of worse results compared to their reference group than women from any other priority population (i.e., racial/ethnic minorities, SMI, SUD, SSI, or ESL) in this report. Children and adolescent members with cash assistance had lower rates on children and adolescents preventive care measures (e.g., well-child and dental visits, and female adolescents unnecessarily screened for cervical cancer).

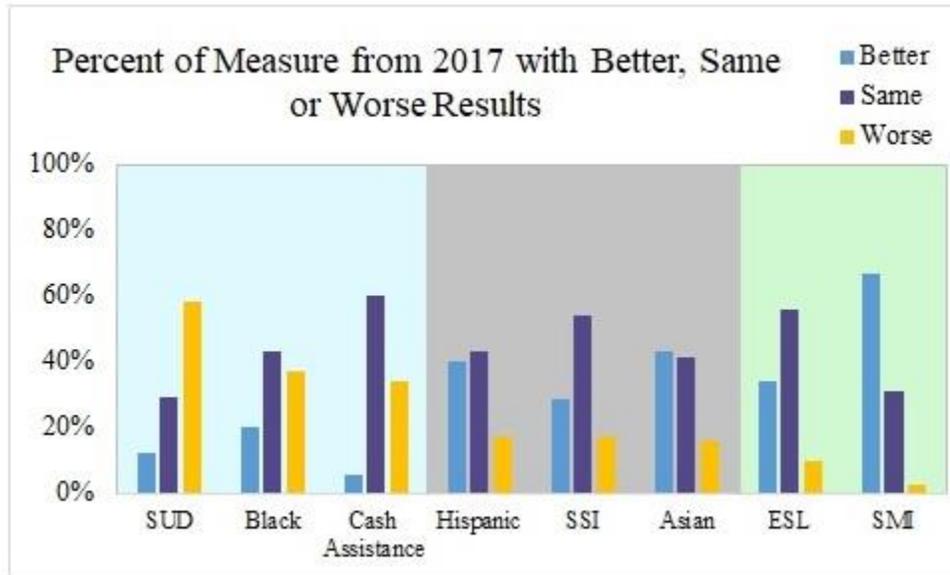
Moderate Evidence of Health Disparities

- Hispanic and Asian members as well as members who received SSI had moderate evidence of health disparities. Compared to their reference group (White members and members who did not receive SSI respectively), the percentage of measures with worse results ranged from 16-17%.

Least Evidence of Health Disparities

- Members with non-English as their spoken language, and members with SMI had the least evidence of health disparities. The two groups had worse results than their reference groups (i.e., members with English as their spoken language and members without SMI respectively) on 3-10% of measures.

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Note: These results represent the number of measures where priority populations had the better, same, or worse performance compared to the reference populations during the 2017 reporting year. For example, racial/ethnic minority groups' health results are compared to the racial/ethnic majority reference group of Whites. The priority populations in the graph above are organized according to the percent of measures for which they had worse results than their reference group (e.g., members with substance use disorder had the highest percent and serious mental illness had the lowest percent).

Further investigation of the underlying drivers that promote inequity in these areas can help to develop a focused strategy to promote health equity for all the populations in New York State. In order to address the issues efficiently, efforts from national, state, and local organizations need to be integrated. Additionally, the New York State Department of Health will continue to work with health plans towards the goal of promoting health equity for vulnerable populations in New York State.

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Section 1: Overview

Background

According to the Centers for Disease Control and Prevention (CDC), health disparities are preventable differences in the burden of disease, injury, violence, and opportunities to achieve optimal health that are experienced by vulnerable populations.

Health disparities have been a public health concern for decades. Since 1980, the U.S. Department of Health and Human Services (DHHS) has developed *Healthy People* initiatives, a comprehensive set of national public health objectives – one of which includes decreasing health disparities. The Agency for Healthcare Research and Quality (AHRQ) has reported on disparities in health care quality based on racial, ethnic, and socioeconomic status since 2002 in the National Healthcare Quality and Disparities Report.

The Office of Quality and Patient Safety at the New York State Department of Health (NYSDOH) recognizes the importance of understanding the impact of health disparities and continuously monitors the disparities in quality of care among members enrolled in the Medicaid Managed Care (MMC) program. These reports are published at: https://www.health.ny.gov/health_care/managed_care/reports/index.htm

Additional incentive to examine health disparities has been provided by the Center for Medicare and Medicaid Services which recently released “Improving the Quality of Care for Medicaid Beneficiaries,” Medicaid and CHIP Managed Care Final Rule (CMS-2390-F, 2016). This final rule explains that each state should design a plan to identify, evaluate, and reduce health disparities in order to support key quality goals.

New York State Medicaid Managed Care program and Priority Populations

The New York State Medicaid Managed Care (NYS MMC) program provided health insurance coverage to close to five million people during the 2017 reporting year. For this report, members from HIV Special Needs Plans were included in this analysis, but Medicaid members enrolled in Managed Long Term Care (MLTC), Health and Recovery Plans (HARPs), and Fee for Service (FFS) were not included in these results. The program encompasses a racially and ethnically diverse population across the state: White members represented 27%, Black members represent 18%, Hispanic members represented 15%, and Asians represented 12%. In this population, female members represented 54% and males represented 46%. Of all the members, 39% were children who were 17 years of age or younger, 36% were between 18 and 44 years of age, 20% were between 45 and 64 years of age, and 5% were 65 years of age or older.

Priority populations in this report were based on the groups specified by AHRQ in the 2013 National Healthcare Disparities Report. Specifically, they include racial/ethnic minorities, members with non-English as their spoken language, members with cash assistance (low-income members), members with serious mental illness (SMI), members with a substance use disorder (SUD), and members who received Supplemental Security Income (SSI). See the graphic on page 5 to learn more about the prevalence of these priority populations in the NYS MMC population during the 2017 reporting year.

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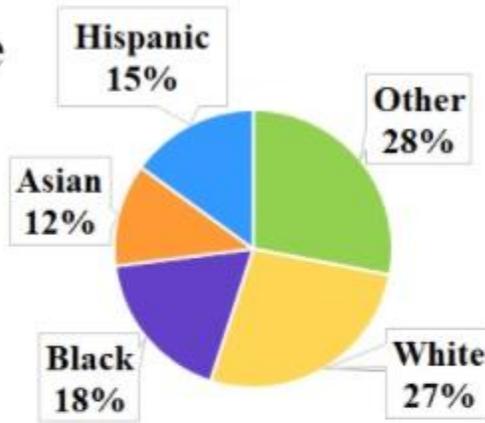
Demographic Description of Priority Populations in NYS MMC during 2017 Reporting Year



26%

Members with Non-English as Spoken Language

Race



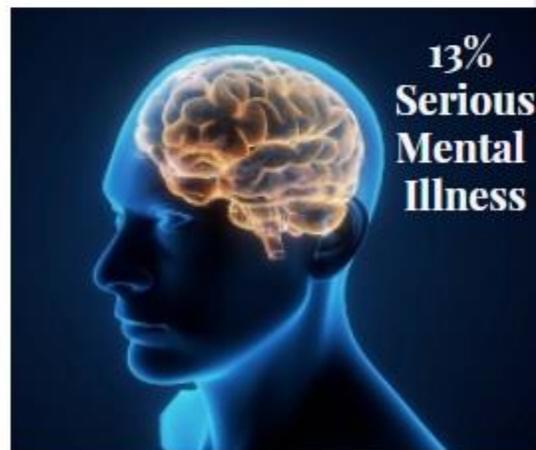
34% Members received Cash Assistance



7% of Members had a substance use disorder



12% Members received Supplemental Security Income



<http://www.health.ny.gov>

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Section 2: Data Source and Methods

Data Source

QARR Data: As a means to monitor managed care plan performance and improve the quality of care provided to New York State residents, the NYSDOH implemented a public reporting system in 1994 known as the Quality Assurance Reporting Requirements (QARR). QARR data is largely based on measures of quality developed and published by the National Committee for Quality Assurance (NCQA) in the Healthcare Effectiveness Data and Information Set (HEDIS®). QARR also includes information collected using a national satisfaction survey methodology called CAHPS® (Consumer Assessment of Healthcare Providers and Systems). CAHPS® data is collected every year for commercial enrollees. The NYSDOH sponsors a CAHPS® survey for both adults and children enrolled in Medicaid Managed Care and Child Health Plus every two years. The most recent survey for adults was done in late 2015, and the most recent survey for children was done in late 2016. The managed care plans are required to submit quality performance data each year to the Department. These data are published annually in a series of reports and consumer guides that are available on the NYSDOH web site:

https://www.health.ny.gov/health_care/managed_care/reports/index.htm

This report primarily focuses on QARR data from reporting year 2017, which reflects service provided during the 2016 measurement year.

Priority Populations Identified by Demographic Characteristics: Demographic characteristics were extracted from Medicaid member information collected during Medicaid enrollment and were linked to QARR member level data.

- **Race/Ethnicity** is defined as mutually exclusive categories of Asian/Pacific Islander, Black, Hispanic, White, or Other. It is possible for a member to denote that they belong to more than one race. Therefore, for purposes of this data, an algorithm was developed to ensure each member was assigned to just one race/ethnicity category. A member who self-identifies as Hispanic is defined as Hispanic, regardless of any other races noted. White race includes non-Hispanic whites without any other race noted. Similarly, Blacks and Asians include only non-Hispanic single race categorizations. Members of multiple races, Native Americans, and Unknown race/ethnicity are assigned to the category “Other Race/Ethnicity.”
- **Cash Assistance** is a program to help needy members and their families who are unable to work, cannot find a job, or have a job that does not pay enough to cover expenses. There are two major programs: family assistance or safety net. The cash assistance may be for housing (rent subsidies), utilities, emergency needs, temporary housing, or food assistance. Cash assistance is a marker of lower socioeconomic status as well as risk.
- **Non-English as their spoken language** is defined as members who self-reported that English is not their spoken language.
- **Serious mental illness (SMI)** is defined as an adult with serious and persistent mental illness and includes members who are 18 years of age and older and whose health profile (which includes diagnoses, procedures, and pharmacy utilization) over the past

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12 months places them in a major diagnostic category of mental diseases and disorders. Additionally, these members had to have at least one service in the past 12 months with a diagnosis of at least one of the following conditions: schizophrenia and other psychotic disorders, major depression and bipolar disorders, cyclothymic disorder, schizotypal, chronic hypomanic, borderline personality disorders, post-traumatic stress disorder, attention deficit disorder, or obsessive-compulsive disorder.

- **Substance Use Disorder (SUD)** is defined as an adult, 18 years of age and older, having had a claim for chemical dependency services (i.e., inpatient, intensive outpatient, partial hospitalization, outpatient, and emergency department) in the past 12 months with a diagnosis of chemical dependency.
- **Supplemental Security Income (SSI)** is a federal program whose members are largely aged, blind, or disabled. Individuals eligible for SSI receive cash assistance.

Detailed measure rates stratified by these characteristics are published on the NYSDOH open data portal:

<https://health.data.ny.gov/Health/Quality-Assurance-Reporting-Requirements-QARR-Heal/6mvg-6ik8>

Data Visualization Tool

Trends: Graphs showing selected measure-specific performance over time are presented at the beginning of each section. Due to changes in measure specifications and the addition of new measures, not all measures are trendable over time. Only measures with available data during the 2014-2017 reporting year were included. These results represent the number of measures where vulnerable populations had statistically significantly better, same, or worse performance compared to the reference populations.

Charts: Bar charts examining the relationship between priority populations are presented. These results represent the number of measures where vulnerable populations had results that were better, same, or worse compared to the reference populations during the 2017 reporting year. For example, racial/ethnic minority groups' health results are compared to the racial/ethnic majority reference group of Whites. The comparisons were adjusted by regression to assess whether the difference between the vulnerable populations versus the reference groups was statistically significant.

Health Areas Examined

The health areas are listed below and are described in greater detail in the appendices.

- *Adult Health:* managing preventive care and acute illness, managing cardiovascular conditions, managing respiratory conditions, managing diabetes, managing medications, and HIV/AIDS comprehensive care
- *Adult Behavioral Health:* adhere to antidepressants after receiving diagnosis, follow-up visit after being discharged from the hospital for mental illness, diabetes and cardiovascular monitoring for members with schizophrenia, and initiating and engaging in alcohol or other drug dependence treatment

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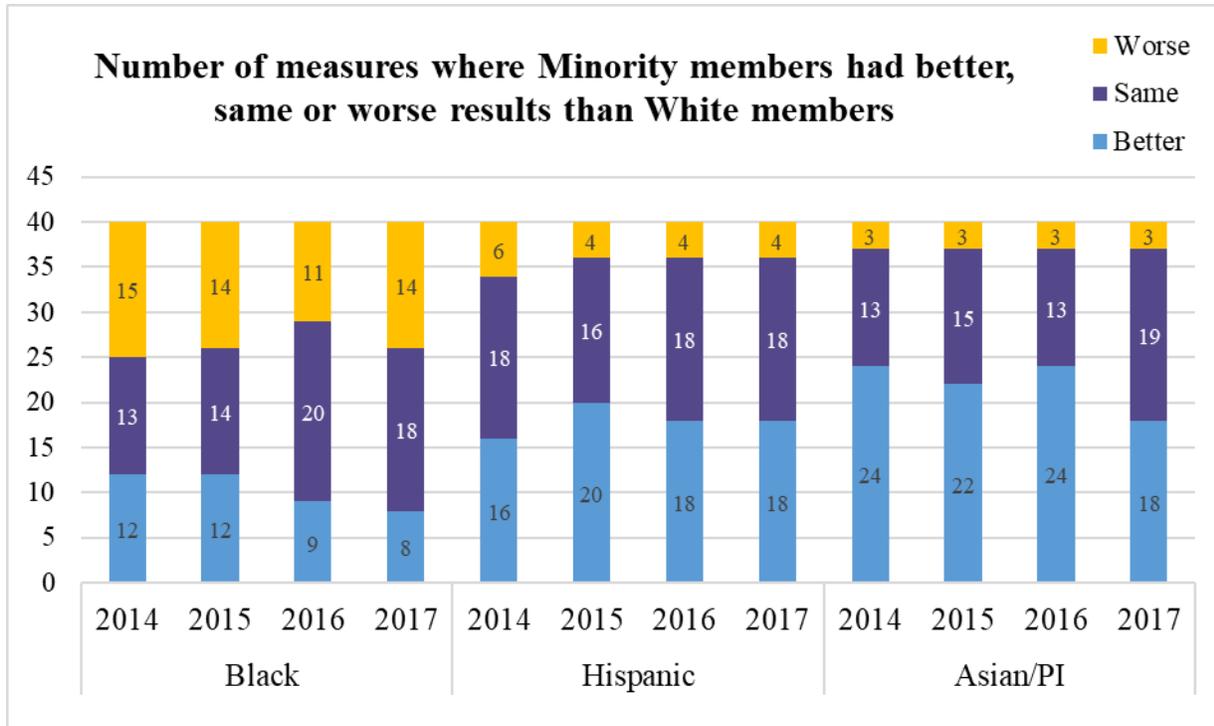
- *Child and Adolescent Health*: children preventive care, caring for children and adolescents with illness, and preventive counseling for children and adolescents
- *Preventive Care for Women*: cancer and chlamydia screening, prenatal and postpartum care
- *Child and Adolescent Behavioral Health*: metabolic monitoring for children and adolescents taking antipsychotics, follow-up care for children prescribed an ADHD medication, use of multiple concurrent antipsychotics in children and adolescents, and initiating and engaging in alcohol or other drug dependence treatment

For each vulnerable group, we identify priority health areas where there are notable health disparities.

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Section 3: Racial/Ethnic Disparities and Health Areas

Trend over time (2014-2017) for Racial and Ethnic Minority Members

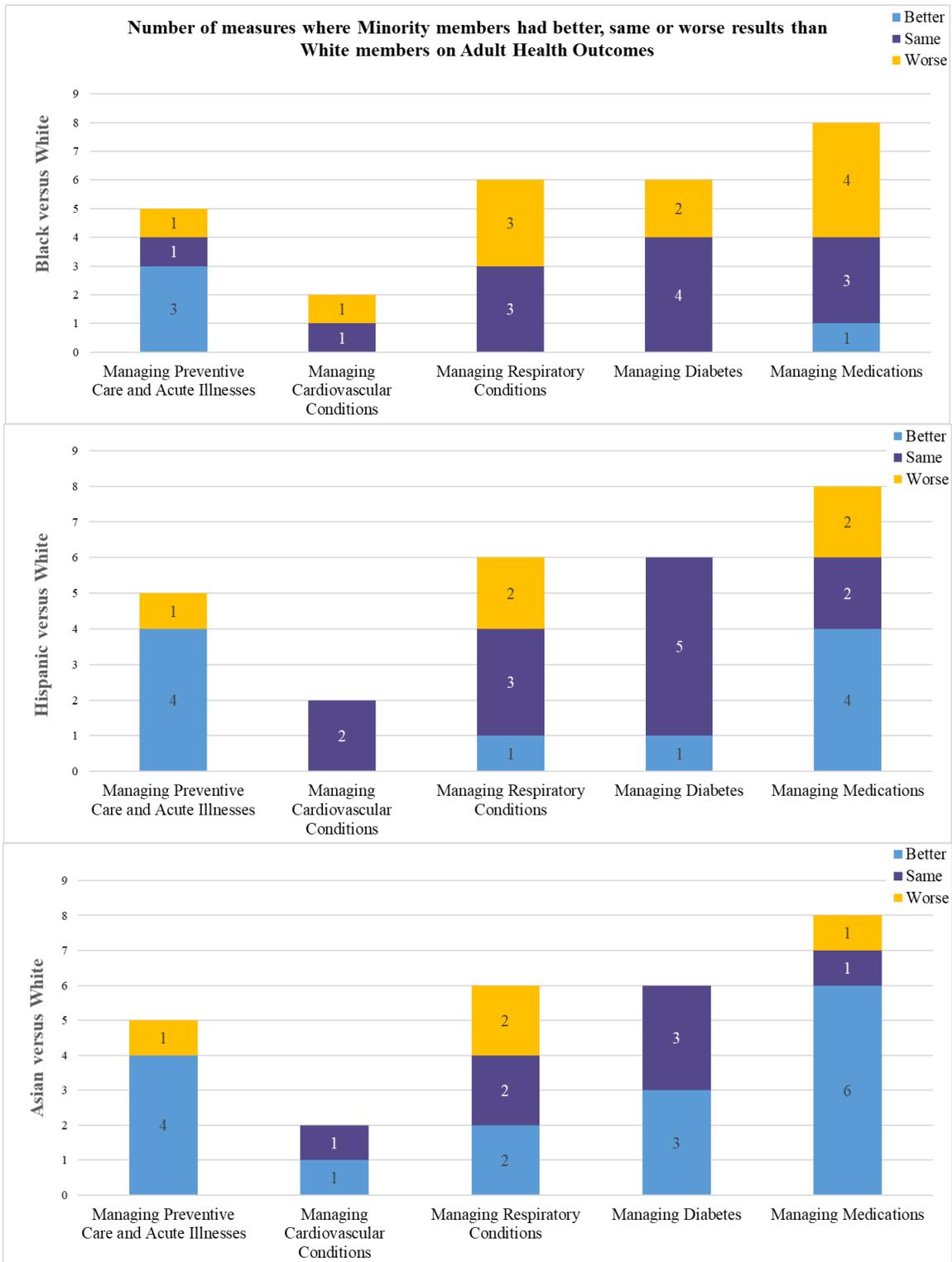


HIGHLIGHTS

- Compared to White members, all three racial/ethnic minority groups have similar or better results for the majority of the measures. However, Black members had a higher proportion of worse results (34% on average) than Asian (8%) and Hispanic members (11%) between 2014-2017.
- While the number of measures where Asian members had worse results than White members has remained stable from 2014-2017, there was a noticeable improvement observed for Hispanic members since 2015. The number of measures where Black members have had worse results than White members has varied over the last four years.

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Disparities in Adult Health for Racial and Ethnic Minority Members during the 2017 Reporting Year



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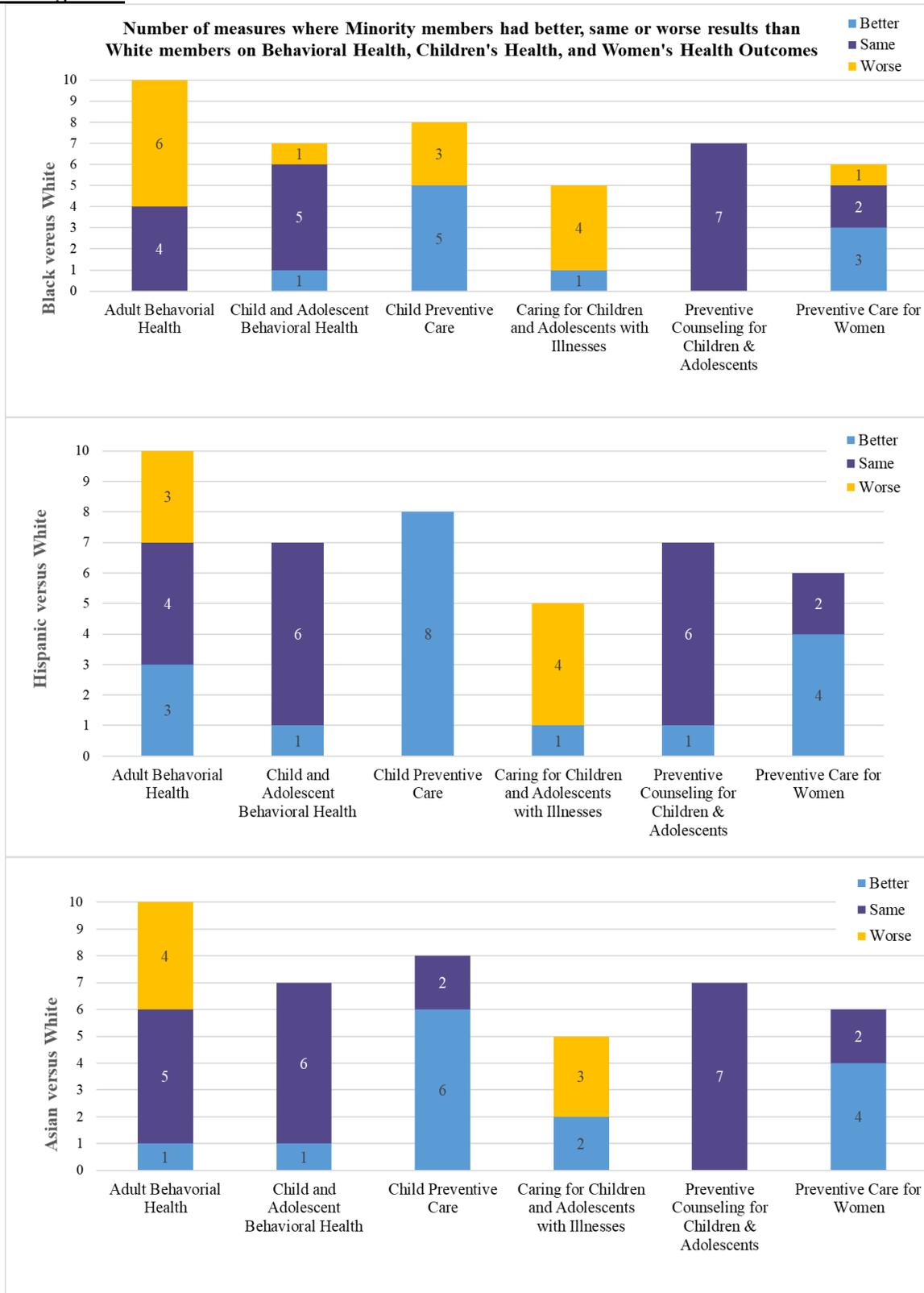
Priority Health Areas

Adult Health Results for Racial and Ethnic Minority Members

- All racial minority groups were less likely to have an annual dental exam and had lower rates on two asthma medication measures than White members.
- Additionally, Black members were less likely than White members to use a beta-blocker after a heart attack, and had worse diabetes results (i.e., less likely to have their blood pressure and blood glucose under control). Black members with diabetes or cardiovascular conditions were less likely than White members to receive, and adhere to statin therapy.
- Hispanic members with diabetes or cardiovascular conditions were more likely to receive statin therapy than White members, but were less likely to adhere to taking the medication.

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Disparities in Other Health Areas for Racial and Ethnic Minority Members during the 2017 Reporting Year



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Priority Health Areas

Adult Behavioral Health Results for Racial and Ethnic Minority Members

- All minority members were less likely to remain on antidepressants three months and six months after being diagnosed with depression than were White members.
- Black members were also less likely to receive a follow-up visit within seven days and thirty days of being discharged from the hospital for mental illness than White members.
- Black and Hispanic members with schizophrenia had lower rates of adherence to antipsychotic medications than White members with schizophrenia.
- Asian members were less likely to initiate and engage in treatment for alcohol and other drugs; whereas, Black members had similar rates of initiating treatment but were less likely to be continually engaged in treatment than White members.

Children's Health Results for Racial and Ethnic Minority Members

- All minority groups were found to have worse performance on measures related to caring for children and adolescents with illnesses (i.e., asthma and pharyngitis) than White children. The only exception was that Asian children were more likely than White children to have asthma controller medications comprise 50% or more of their total asthma medications.
- All children and adolescents from minority groups had similar rates of preventive counseling as White children. However, Hispanic children were more likely to receive nutrition counseling.
- The data suggests that Black children and adolescents have less access to providers for well-child visits, adolescent well-child visits, and annual dental visits, and are less likely to have a follow-up visit after they initially begin taking medication for ADHD.

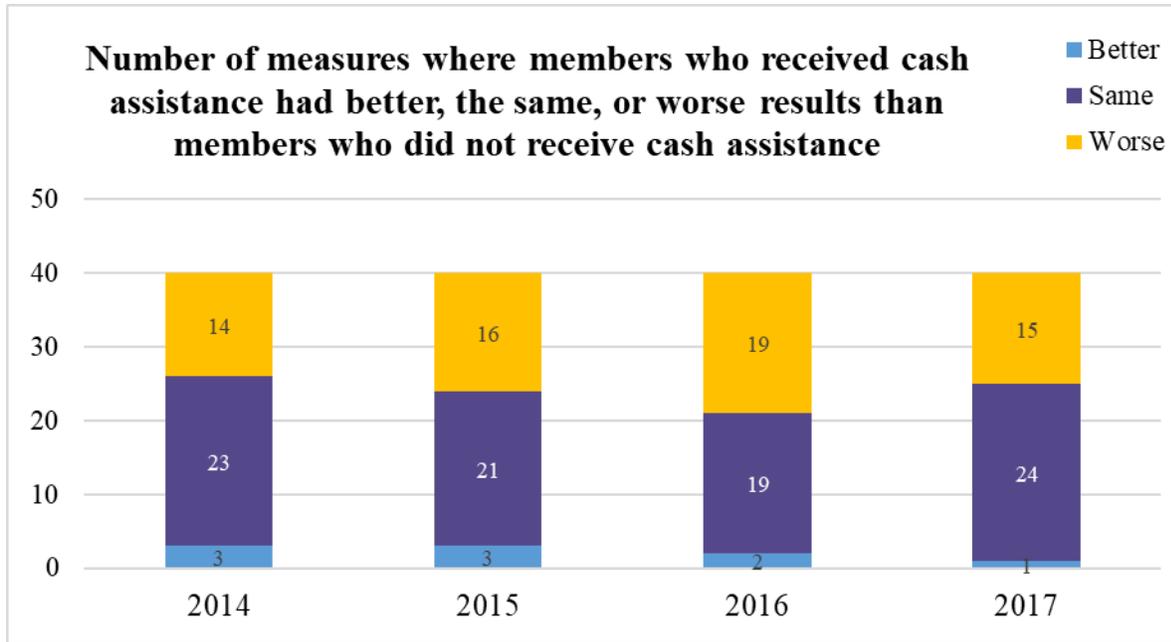
Women's Health Results for Racial and Ethnic Minority Members

- Women from all minority groups were as likely or more likely to receive screening for chlamydia, cervical cancer, and breast cancer than were White women.
- Additionally, women from minority groups were as likely or more likely to have timely and frequent prenatal care. However, Black women were less likely to receive postpartum care.

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Section 4: Disparities Among Other Priority Populations

Trend over Time (2014-2017) for Members Who Received Cash Assistance

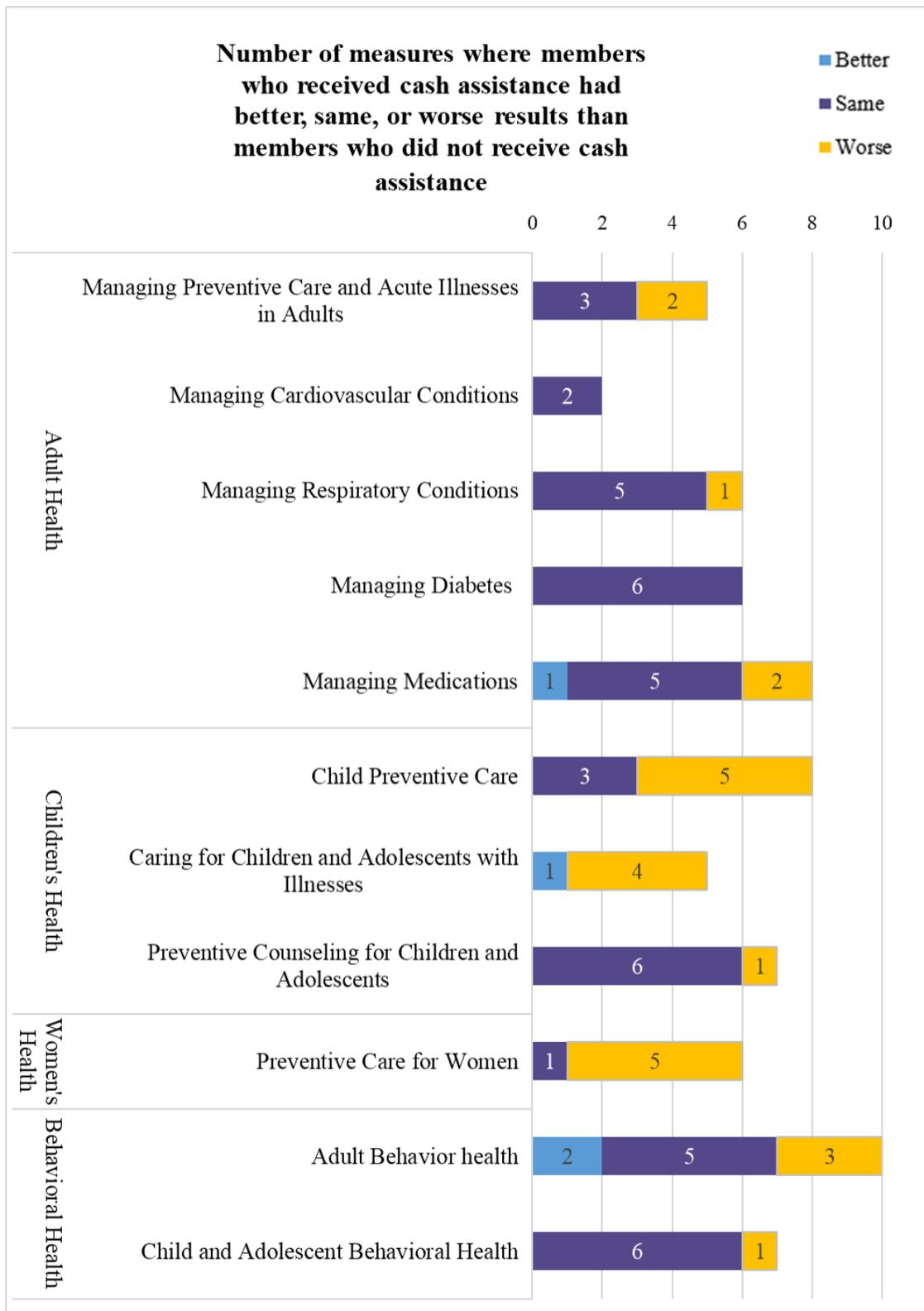


HIGHLIGHTS

- Members who received cash assistance had worse results on 40% of measures than members who did not receive cash assistance across 2014-2017.
- While there was an increase in the number of measures where members with cash assistance had worse results from 2014-2016, there was a slight decrease in 2017.

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Disparities in Health Areas for Members Who Received Cash Assistance during the 2017 Reporting Year



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Priority Health Areas

Adult Health Results for Members Who Received Cash Assistance

- Members who received cash assistance were less likely to receive preventive care (e.g., having their BMI assessed or having colorectal screening) than those who didn't receive cash assistance. However, members with diabetes or cardiovascular conditions who received cash assistance were less likely to adhere to using statin therapy than members with diabetes or cardiovascular conditions who did not receive cash assistance.
- Members who received cash assistance did not differ from members who did not receive cash assistance on most cardiovascular, respiratory, and diabetes measures.

Women's Health Results for Members Who Received Cash Assistance

- Women who received cash assistance had worse women's health results on the majority of measures than women who did not receive cash assistance (i.e., less likely to be screened for cervical and breast cancer, and had lower rates of timely and frequent prenatal care, as well as postpartum care). Women who received cash assistance also had a greater number of worse results compared to their reference group than women from any other priority population (i.e., women that were racial/ethnic minorities, that had SMI, SUD, SSI, or ESL) in this report.

Children's Health Results for Members Who Received Cash Assistance

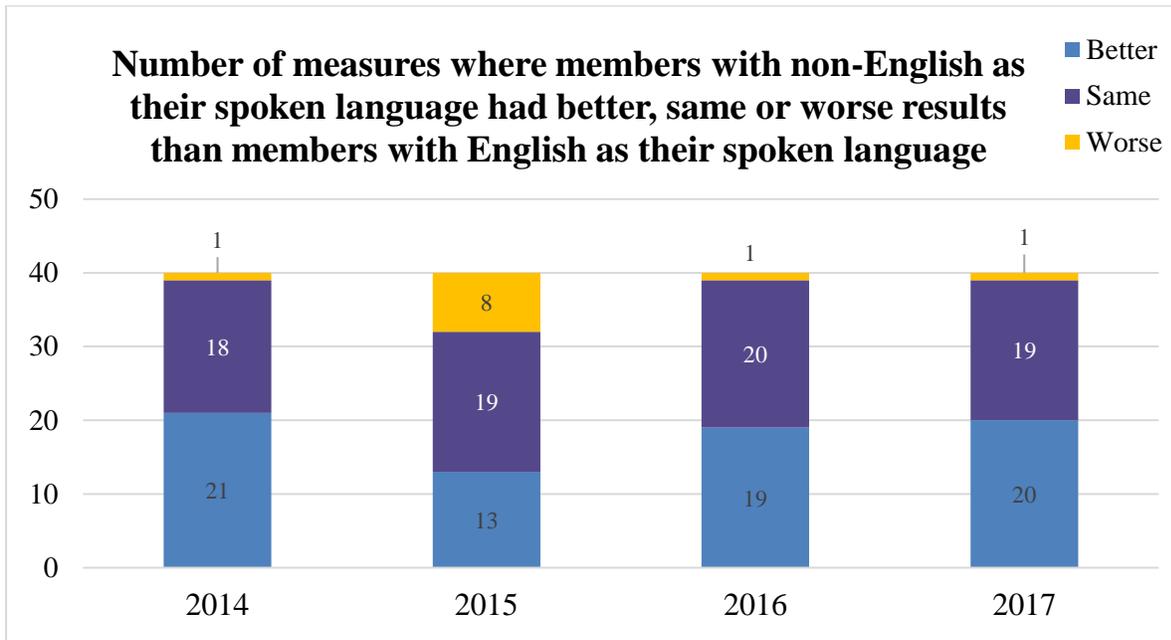
- Children who received cash assistance were less likely to receive preventive care (i.e., all well-child visits, adolescent well-child visits, and annual dental visits). They were also more likely to be screened unnecessarily for cervical cancer and were less likely to be appropriately tested for pharyngitis than children who do not receive cash assistance.

Behavioral Health Results for Members Who Received Cash Assistance

- Adult members who received cash assistance were less likely to receive a follow-up visit after being discharged from the hospital for mental illness than members who did not receive cash assistance, and members with schizophrenia who received cash assistance were less likely to adhere to antipsychotic medication than members with schizophrenia who did not receive cash assistance. However, members who received cash assistance were more likely to initiate and engage in treatment for alcohol or other drugs than members who did not receive cash assistance.
- Children and adolescents who received cash assistance were significantly less likely to be metabolically monitored while taking antipsychotics than those who did not receive cash assistance. Children and adolescents who received cash assistance were the only priority population (i.e., children and adolescents that were racial/ethnic minorities, that received SSI, and that had ESL) who had worse rates of metabolic monitoring than their reference group.

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Trend over Time (2014-2017) for Members with Non-English as their Spoken Language

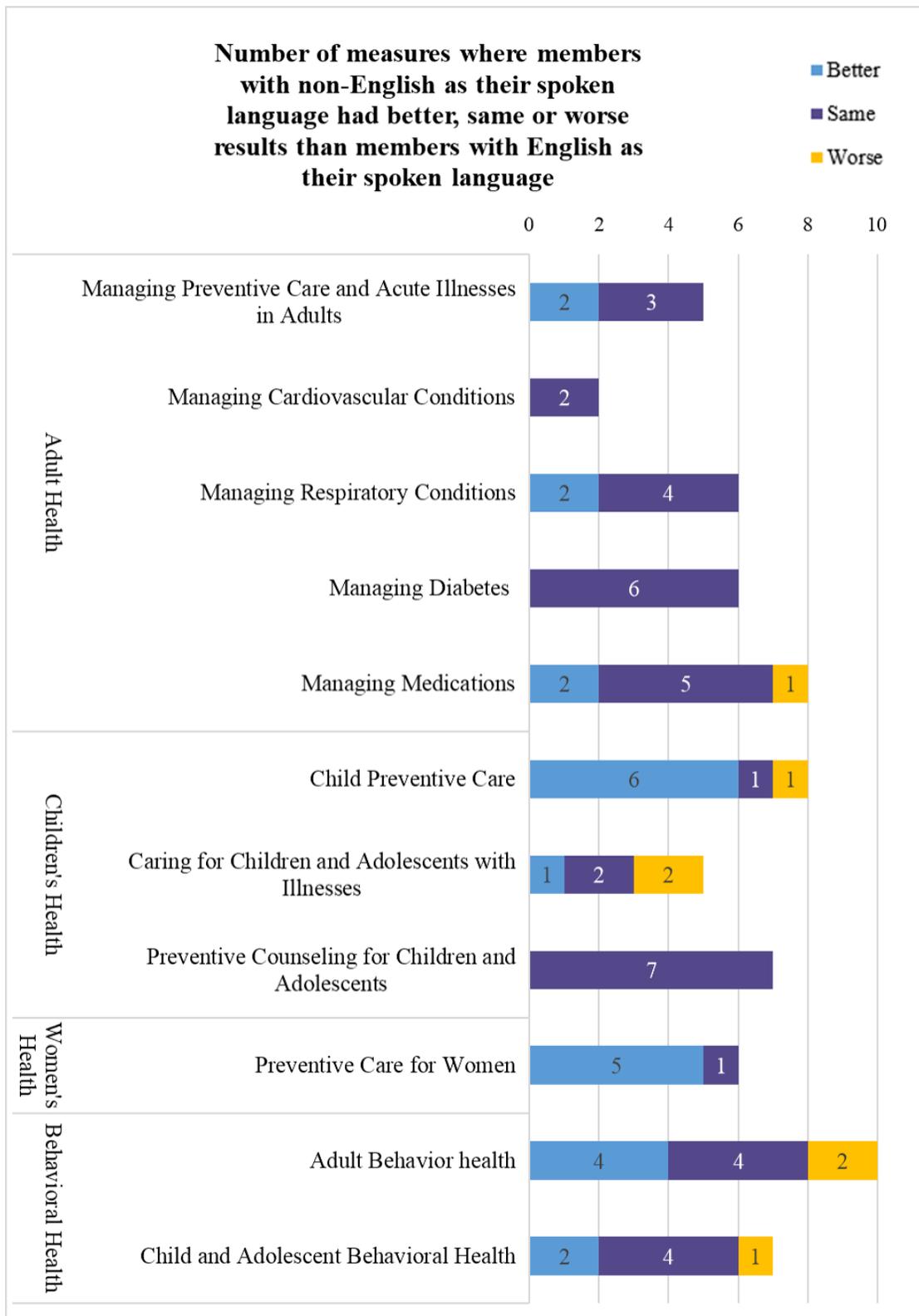


HIGHLIGHTS

- Disparities were observed in less than 10% of the measures among members with non-English as their spoken language compared to members with English as their spoken language in MMC.
- Although there was an increase in the number of worse results for this population in 2015, this has decreased in 2016 and 2017.

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Disparities in Health Areas for Members with non-English as their Spoken Language during the 2017 Reporting Year



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Priority Health Areas

Adult Health Results for Members with non-English as their Spoken Language

- Members with non-English as their spoken language had similar or better results as members with English as spoken language on the majority of adult health measures (i.e., preventive care, diabetes, cardiovascular, respiratory and managing medication).

Child Health Results for Members with non-English as their Spoken Language

- Children and adolescents with non-English as their spoken language were as likely to receive preventive counseling as children with English as their spoken language.
- Children and adolescents with non-English as their spoken language had better results on most preventive care measures (i.e., greater child immunization, annual dental visits and well-child visits) than children and adolescents with English as their spoken language. The only exception was that adolescent females with non-English as their spoken language were more likely to be screened unnecessarily for cervical cancer than members with English as their spoken language.

Women's Health Results for Members with non-English as their Spoken Language

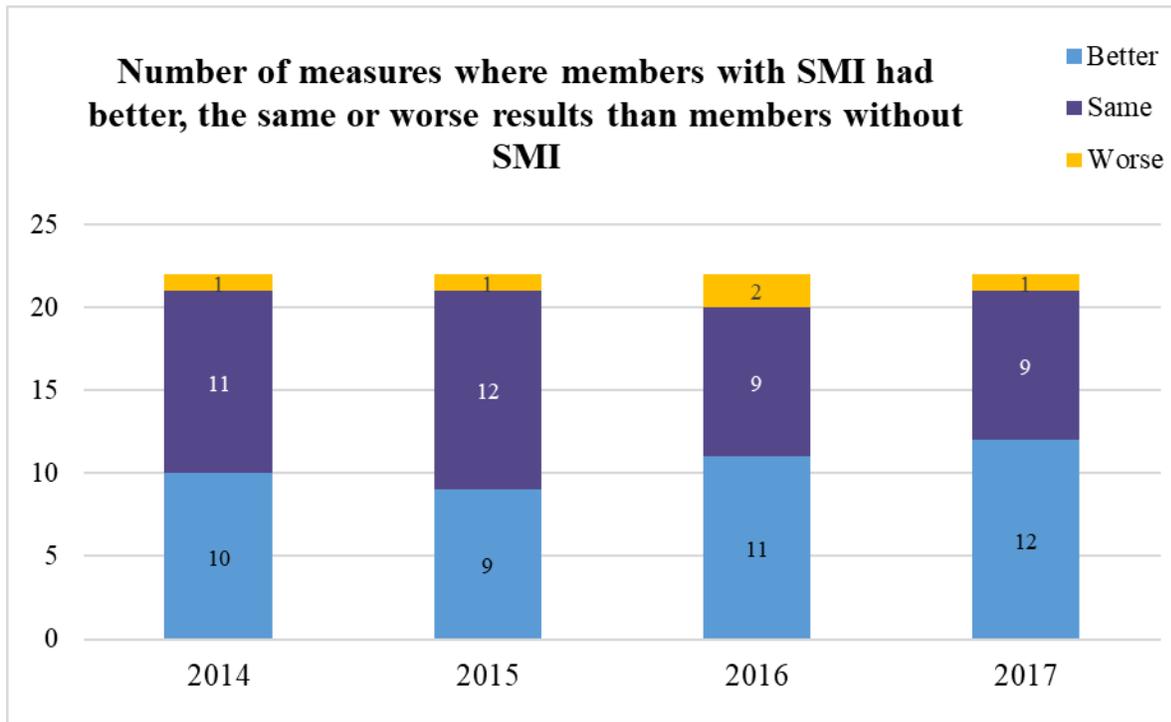
- Women with non-English as their spoken language had better results on the majority of women's health measures than women with English as their spoken language. Women with non-English as their spoken language were more likely to be screened for breast cancer and chlamydia and were more likely to receive timely and frequent prenatal care and postnatal care.
- Additionally, women with non-English as their spoken language had better results on more women's health measures compared to their reference group (i.e., women with English as their spoken language) than any other female priority population (i.e., women in racial/ethnic minorities, women with SMI, SUD, SSI, or cash assistance) in this report.

Behavioral Health Results for Members with non-English as their Spoken Language

- Adult members with non-English as their spoken language had similar or better results on many of the mental health measures. However, adult members with non-English as their spoken language were less likely to initiate and engage in treatment for alcohol or other drugs than members with English as their spoken language.
- Children and adolescents with non-English as their spoken language were more likely to have follow-up visits after taking ADHD medications, but children and adolescents who were on antipsychotics with non-English as their spoken language were less likely to receive first-line psychosocial care than those with English as their spoken language.

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Trend over Time (2014-2017) for Members with Serious Mental Illness (SMI)



HIGHLIGHTS

- Members with SMI had similar or better results than members without SMI on 94% of the measures.
- Although the rates have been relatively stable over time, the number of measures where members with SMI had better results than members without SMI has gradually increased from 2015 to 2017.

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Disparities in Health Areas for Members with Serious Mental Illness during the 2017 Reporting Year



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Priority Health Areas

Adult Health Results for Members with Serious Mental Illness

- Members with SMI had better results than members without SMI on most of the diabetes (i.e., receiving appropriate testing, and controlling blood pressure and blood glucose) and respiratory measures (i.e., using medications to control asthma and COPD).
- Although members with SMI tend to have better results in terms of managing medications than members without SMI, members with rheumatoid arthritis were less likely to be dispensed an anti-rheumatic drug than members without SMI.

Women's Health Results for Members with Serious Mental Illness

- Women with SMI were more likely to be screened for cervical and breast cancer than women without SMI. Prenatal and postnatal results were similar between women with and without SMI.

Behavioral Health Results for Members with Serious Mental Illness

- Members with SMI were more likely to have mental health follow-up visits within 7 and 30 days after hospitalization, and were more likely to initiate and engage in treatment for alcohol or other drugs.

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Trend over Time (2014-2017) for Members Who Received Supplemental Security Income (SSI)

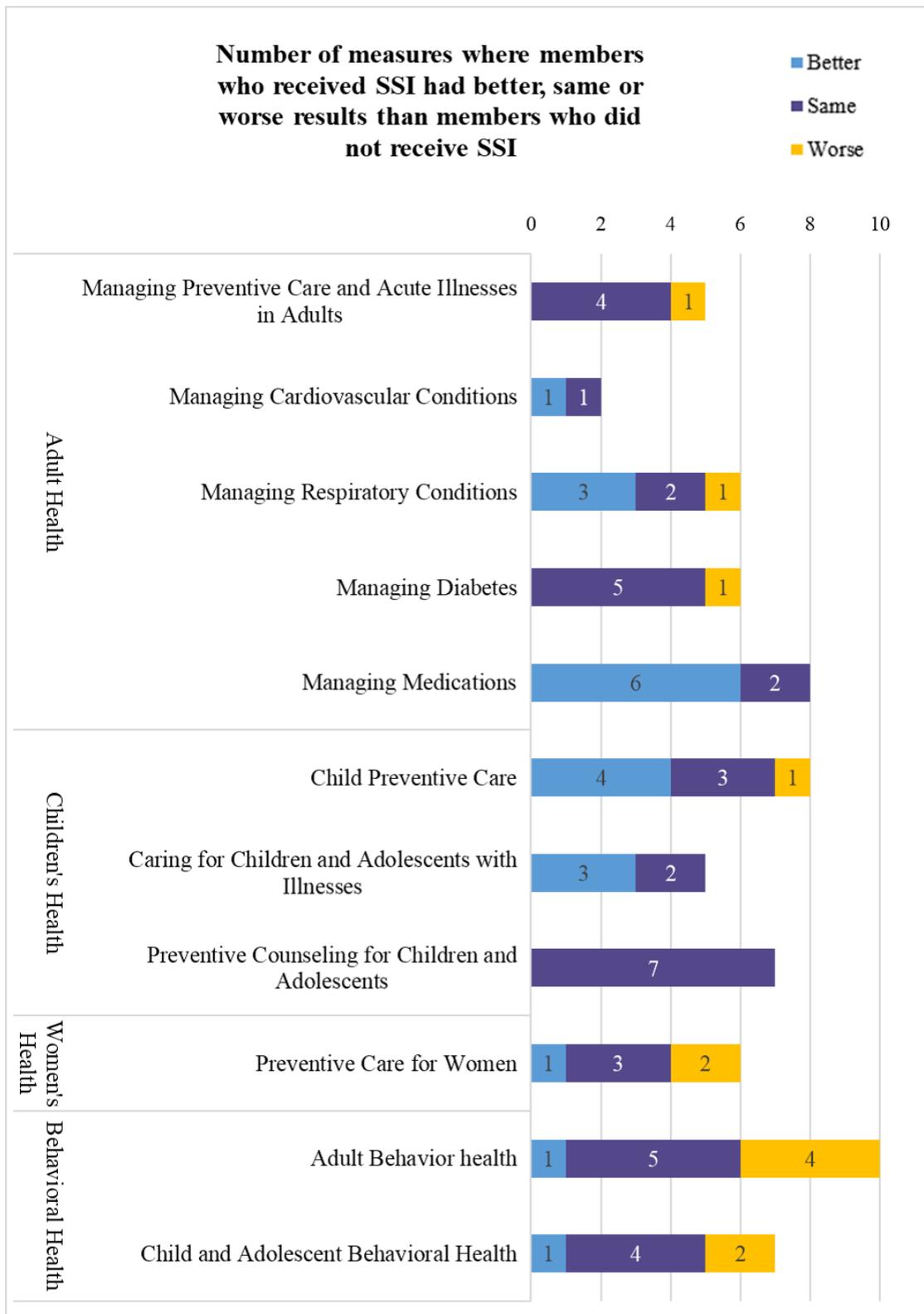


HIGHLIGHTS

- Members who received SSI had similar results as members who did not receive SSI on 66% of measures.
- Although there was an increase from 2014 to 2016 in the number of measures where members who received SSI had worse results than members who did not receive SSI, this number decreased in 2017.

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Disparities in Health Areas for Members Who Received Supplemental Security Income during the 2017 Reporting Year



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Priority Health Areas

Adult Health Results for Members Who Received Supplemental Security Income

- Members with SSI had similar or better results to members without SSI on the majority of measures related to managing chronic conditions (i.e., preventive care, cardiovascular and respiratory conditions, and diabetes).
- However, members with SSI were less likely to have an annual dental visit and were less likely to have spirometry testing to assess and diagnosis COPD than members who did not receive SSI.

Women's Health Results for Members Who Received Supplemental Security Income

- This population had lower performance than members who did not receive SSI on chlamydia screening and breast cancer screening but had similar results on cervical cancer screening, prenatal and postpartum measures.

Children's Health Results for Members Who Received Supplemental Security Income

- Children who received SSI were less likely to have an annual dental exam than children who did not receive SSI.

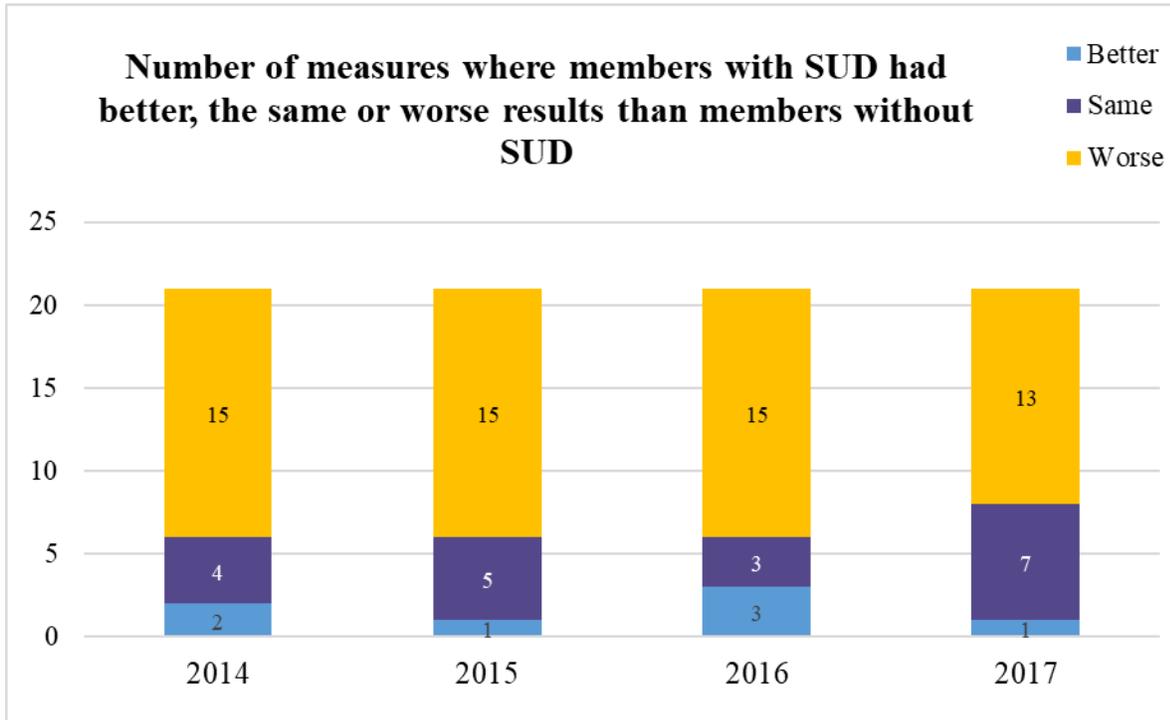
Behavioral Health Results for Members Who Received Supplemental Security Income

- Adult members who received SSI were less likely to have a follow-up visit after hospitalization for mental illness within 7 and 30 days after being discharged. They were also less likely than members who did not receive SSI to initiate or engage in treatment for alcohol or other drugs.
- Children and adolescents who received SSI was the only children and adolescent priority population (i.e., children and adolescents that were racial/ethnic minorities, children and adolescents with SMI, SUD, ESL or cash assistance) that was more likely to be on multiple concurrent anti-psychotics than their reference group (i.e., children who did not receive SSI).¹ Children and adolescents who were on antipsychotics and received SSI were also less likely to receive first-line psychosocial care than children and adolescents who were on antipsychotics and did not receive SSI.

¹ The American Academy of Child and Adolescent Psychiatry recommends that clinicians avoid the use of multiple concurrent antipsychotic medications for children and adolescents due to physical side effects.

2017 Health Care Disparities in New York State

Trend over Time (2014-2017) for Members with a Substance Use Disorder (SUD)



HIGHLIGHTS

- Members with a substance use disorder had the greatest evidence of health disparities from 2014-2017 across all of the priority populations in MMC. They had worse results than members without a substance use disorder on 69% of measures.
- Within this last year, there was a slight decrease in the numbers of measures where members with SUD had worse results and slightly more measures with results that are similar to members without SUD.

2017 Health Care Disparities in New York State

Disparities in Health Areas for Members with a Substance Use Disorder during the 2017 Reporting Year



2017 Health Care Disparities in New York State

Priority Health Areas

Adult Health Results for Members with a Substance Use Disorder

- Members with an SUD had worse results on every measure related to managing respiratory conditions (i.e., COPD and asthma) and 50% of measures related to managing diabetes, but had similar results on managing cardiovascular conditions as members without an SUD.
- Although this population was more likely to have annual monitoring for ace-inhibitors, digoxin, and diuretics than members without an SUD, members with an SUD and cardiovascular conditions or diabetes were less likely to receive and adhere to statin therapy than members with cardiovascular conditions or diabetes but without an SUD.²

Women's Health Results for Members with a Substance Use Disorder

- Women with an SUD had lower breast cancer screening rates, were less likely to receive frequent prenatal care visits, and were less likely to receive postpartum care than women without an SUD. However, women with an SUD did not differ from women without an SUD in terms of the timeliness of the prenatal care that they received.

Behavioral Health Results for Members with a Substance Use Disorder

- Adults with an SUD had worse results than members without an SUD on the majority of mental health measures (i.e., follow-up after hospitalization for mental illness, and adherence to antidepressants after diagnosis).
- Additionally, members with an SUD who also have schizophrenia are less likely to adhere to antipsychotic medications, and members with an SUD who have schizophrenia and diabetes were less likely to have diabetes monitoring than members without an SUD.

² Since statin use is contraindicated for individuals with active liver disease or who drink more than two alcoholic beverages per day, physicians may prescribe non-statin medications to control cholesterol levels in patients with substance use disorders.

2017 Health Care Disparities in New York State

APPENDIX

Priority Health Area	Domain	Measure
Adult Health	Managing Preventive Care and Acute Illnesses in Adults	Adult BMI Assessment
		Annual Dental Visit
		Use of Imaging Studies for Low Back Pain
		Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis
		Colon Cancer Screening
	Managing Cardiovascular Conditions	Controlling High Blood Pressure
		Persistence of Beta-Blocker Treatment
	Managing Respiratory Conditions	Asthma Medication Ratio (Ages 19-64)
		Use of Spirometry Testing in the Assessment and Diagnosis of COPD
		Pharmacotherapy Management of COPD Exacerbation- Bronchodilator
		Pharmacotherapy Management of COPD Exacerbation- Corticosteroid
		Medication Management for People with Asthma 50% Days Covered (Ages 19-64)
		Medication Management for People with Asthma 75% Days Covered (Ages 19-64)
	Managing Diabetes	HbA1c Testing
		Dilated Eye Exam
		Nephropathy Screening
		Poor HbA1c Control
		Blood Pressure Controlled (<140/90 mm/Hg)
		HbA1C Control (<8.0%)
	Managing Medications	Drug Therapy for Rheumatoid Arthritis
		Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs
		Annual Monitoring for Patients on Persistent Medications- Digoxin
		Annual Monitoring for Patients on Persistent Medications- Diuretics
		Statin Therapy for Patients with Cardiovascular Disease - Received
		Statin Therapy for Patients with Cardiovascular Disease - Adherent
		Statin Therapy for Patients with Diabetes - Received
		Statin Therapy for Patients with Diabetes - Adherent

2017 Health Care Disparities in New York State

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Children's Health	Child Preventive Care	Childhood Immunization Status (Combo 3)
		Adolescent Immunization Combo 1
		Lead Testing
		Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)
		Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life
		Adolescent Well-Care Visits
		Annual Dental Visit
		Non-Recommended Cervical Cancer Screening in Adolescent Females
	Caring for Children and Adolescents with Illnesses	Appropriate Treatment for Upper Respiratory Infection (URI)
		Appropriate Testing for Pharyngitis
		Asthma Medication Ratio (Ages 5-18)
		Medication Management for People with Asthma 50% Days Covered (Ages 5-18)
		Medication Management for People with Asthma 75% Days Covered (Ages 5-18)
	Preventive Counseling for Children and Adolescents	Weight Assessment- BMI Percentile
		Counseling for Nutrition
		Counseling for Physical Activity
		Assessment, Counseling, or Education: Sexual Activity
		Assessment, Counseling, or Education: Depression
		Assessment, Counseling, or Education: Tobacco Use
		Assessment, Counseling, or Education: Alcohol and Other Drug Use
Women's Health	Preventive Care for Women	Timeliness of Prenatal Care
		Postpartum Care
		Frequency of Ongoing Prenatal Care
		Breast Cancer Screening
		Cervical Cancer Screening
		Chlamydia Screening (Ages 16-24)

2017 Health Care Disparities in New York State

APPENDIX

Behavioral Health	Adult Behavioral Health	Antidepressant Medication Management-Effective Acute Phase Treatment
		Antidepressant Medication Management-Effective Continuation Phase Treatment
		Follow-Up After Hospitalization for Mental Illness Within 7 Days
		Follow-Up After Hospitalization for Mental Illness Within 30 Days
		Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
		Diabetes Monitoring for People with Diabetes and Schizophrenia
		Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds
		Adherence to Antipsychotic Medications for Individuals with Schizophrenia
		Initiation of Alcohol & Other Drug Dependence Treatment (Ages 18+ Years)
		Engagement of Alcohol & Other Drug Dependence Treatment (Ages 18+ Years)
		Child and Adolescent Behavioral Health
	Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	
	Metabolic Monitoring for Children and Adolescents on Antipsychotics	
	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	
	Initiation of Alcohol & Other Drug Dependence Treatment (Ages 13-17 Years)	
	Engagement of Alcohol & Other Drug Dependence Treatment (Ages 13-17 Years)	