SAMHSA’s Office of Behavioral Health Equity

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Director, Office of Behavioral Health Equity
Georgetown TA Center Webinar – Nov 17, 2011
Office of Behavioral Health Equity (OBHE)

- Authorizing Legislation: Affordable Care Act Section 10334
- Appoint a Director who reports directly to the Agency Administrator
- OMH Offices are coordinated by the HHS Office of the Assistant Secretary for Health and the Director of the HHS OMH
- Secretary designates an appropriate amount of funds to each OMH from the agency appropriations
- Report to Congress, March 2011 then biennially
Within DHHS, Six “Offices of Minority Health”

- Agency for Healthcare Quality and Research
- Centers for Disease Control and Prevention
- Centers for Medicare and Medicaid Services
- Food and Drug Administration
- Health Resources and Services Administration
- SAMHSA

Elevated NIH/National Center for Minority Health and Health Disparities to an “Institute”
Moved Office of Minority Health into Secretary’s Office
Vision & Mission of OBHE

• **Vision**
  All populations will have equal access to high quality behavioral health care.

• **Mission**
  To reduce the impact of substance abuse and mental illness on populations that experience behavioral health disparities by improving access to quality services and supports that enable individuals and families to thrive, participate in and contribute to healthy communities

• **Website:** [http://www.samhsa.gov/about/obhe.aspx](http://www.samhsa.gov/about/obhe.aspx) (SAMHSA/About Us)
Key Policy Drivers for OBHE

1. HHS Secretary’s Strategic Action Plan to Reduce Racial and Ethnic Health Disparities
2. 2011 National Stakeholder Strategy for Achieving Health Equity
3. National Prevention Strategy
4. Data Collection and Disparities; Federal Data and Section 4302 of ACA
5. SAMHSA Strategic Initiatives
6. White House Executive Orders
1. HHS Secretary’s Strategic Action Plan to Reduce Racial and Ethnic Health Disparities


• Overarching Priorities
  – Assess impact of all HHS policies, programs to reduce disparities (health disparity impact statements in grants)
  – Use of data to improve health of minority groups (map high need disparity areas and HHS investments)
  – Measure/incentivize better health care quality for minority groups (SAMHSA/CMS measures related to burden of depression)
  – “ensure access to quality, culturally competent care for vulnerable populations…..”
  – Social determinants and health impact in all policies
  – Released April 8, 2011
2. 2011 National Stakeholder Strategy for Achieving Health Equity

1. Awareness of significance of health disparities…..
2. Leadership
3. Health System and Life Experience… to improve outcomes
4. Cultural and Linguistic Competency and diversity of the health related workforce…..
5. Data, Research, and Evaluation…..

Regional Health Equity Groups

http://minorityhealth.hhs.gov/npa/templates/content.aspx?lv1=1& lvlid=33&ID=286

• National Prevention Council; Advisory Group on Prevention, Health Promotion & Integrative and Public Health

• 4th (of 4) Strategic Direction: Elimination of Health Disparities
  – Strategic focus on communities at greatest risk
  – Improve access to quality care
  – Increase capacity of prevention workforce
  – Support research
  – Standardize data collection

• 7th (of 7) Priority: Mental and Emotional Well-being

• [link](http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf)
4. Data and Disparities: ACA Provision: Section 4302

- Guidelines for federal collection of race, ethnicity and language data
- Review methodology for language threshold determination
- Expectation of data collection, disaggregation and analysis by race and ethnicity
- New Standards Released
The Agency for Healthcare Research and Quality (AHRQ) has been publishing two annual reports since 2003:

• National Healthcare Quality Report (NHQR)
• National Healthcare Disparities Report (NHDR)

– Since inception has shown that nearly two-thirds of the measures of disparity in quality of care are not improving for Blacks, Asians, and Hispanics in the United States (includes mental health and HIV)
Trends in Disparities

Quality of Care

Access to Care
Disparities in 2009
(AHRQ, Natl Health Disparities Report, 2009)

Quality of Care

Access to Care
## American Indian/Alaska Native Native Mortality Rates Disparities

(Indian Health Service Data)

<table>
<thead>
<tr>
<th>Cause</th>
<th>AI/AN Rate 2004-2006</th>
<th>US All Races Rate 2005</th>
<th>Ratio: AI/AN to US All Races</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALL CAUSES</strong></td>
<td>980.0</td>
<td>798.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Alcohol Induced</td>
<td>43.0</td>
<td>7.0</td>
<td>6.1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>68.1</td>
<td>24.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Injuries</td>
<td>93.8</td>
<td>39.1</td>
<td>2.4</td>
</tr>
<tr>
<td>Homicide</td>
<td>11.7</td>
<td>6.1</td>
<td>1.9</td>
</tr>
<tr>
<td>Suicide</td>
<td>19.8</td>
<td>10.9</td>
<td>1.8</td>
</tr>
<tr>
<td>Pneumonia/Influenza</td>
<td>27.1</td>
<td>20.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Infant Deaths</td>
<td>8.0</td>
<td>6.9</td>
<td>1.2</td>
</tr>
</tbody>
</table>

*Per 100,000 population*
Suicide Rates by Ethnicity and Age Group -- United States, 2003-2007

(A. Crosby, CDC, 2011)

Graph showing suicide rates by ethnicity and age group in the United States from 2003 to 2007, with data from A. Crosby at the CDC in 2011.
Latina/o Adolescent Suicidal Risk Behaviors

Percentage of Students by Race/Ethnicity and Sex

- **Felt Sad or Hopeless**
  - Latino Female: 44%
  - Latino Male: 25.9%
  - Black Female: 30.8%
  - Black Male: 21.7%
  - White Female: 19.6%
  - White Male: 23.4%

- **Seriously Considered**
  - Latino Female: 12.9%
  - Latino Male: 21.2%
  - Black Female: 14.7%
  - Black Male: 10.3%
  - White Female: 12%
  - White Male: 20.7%

- **Made a Suicide Plan**
  - Latino Female: 14.6%
  - Latino Male: 12.4%
  - Black Female: 8.4%
  - Black Male: 18.6%
  - White Female: 13.9%
  - White Male: 18.6%

**Source:** Centers for Disease Control and Prevention, 2004. Data from: self-report survey. 15,214 students, grades 9-12: administered February-December 2003; 43 states
Percentage of Past Month Illicit Drug Use among Persons Aged 12 or Older, by Race/Ethnicity*:
2004 and 2005

Had at Least One Major Depressive Episode (MDE) in Lifetime and Receipt of Treatment in the Past Year for Depression among Persons Aged 12 to 17 by Race/Ethnicity: Percentages 2005 (NSDUH)

Note: Where no estimate was reported due to low precision 0.0 was used.
5. SAMHSA Strategic Initiatives

- Prevention of Substance Abuse and Mental Illness
- Trauma and Justice
- Military Families
- Recovery Support
- Health Reform
- Health Information Technology
- Data, Outcomes and Quality
- Public Awareness and Support
Examples of OBHE Priority Action Steps within SI’s

- **Prevention:**
  - Action Alliance for Suicide Prevention: task force focus on Tribal youth; increased focus on Latino youth
  - LGBT Youth and Family Acceptance Project – policy and best practice guidelines for health/behavioral health providers
  - National Dialogue on the Role of BH in Public Life and outreach to vulnerable and diverse populations

- **Trauma and Justice**
  - Trauma and African American young people and child welfare
  - Juvenile Justice Policy Academy – diversion and disproportionality
Examples of OBHE Priority Action Steps in SI’s

- **Health Reform**
  - Identify enrollment issues and effective strategies to reach ethnic and racial minority populations
  - Health Homes for diverse populations

- **Data, Outcomes and Quality**
  - Provide disparity impact statements in all grants

- **Public Awareness and Support**
  - Create disparities communication plan to ensure information development and dissemination, public campaigns are inclusive of diverse communities
Health Coverage Distribution of the Non-Elderly by Race/Ethnicity, 2009

- **White, non-Hispanic**: 74% Employer Coverage, 13% Medicaid or Other Public Coverage, 13% Uninsured
  - Total: 166.4 million

- **Asian**: 69% Employer Coverage, 12% Medicaid or Other Public Coverage, 19% Uninsured
  - Total: 11.7 million

- **Two or More Races**: 59% Employer Coverage, 27% Medicaid or Other Public Coverage, 14% Uninsured
  - Total: 4.3 million

- **NHUPI**: 55% Employer Coverage, 28% Medicaid or Other Public Coverage, 17% Uninsured
  - Total: 0.7 million

- **Black, non-Hispanic**: 50% Employer Coverage, 30% Medicaid or Other Public Coverage, 20% Uninsured
  - Total: 33.3 million

- **American Indian/Alaska Native**: 44% Employer Coverage, 28% Medicaid or Other Public Coverage, 28% Uninsured
  - Total: 1.7 million

- **Hispanic**: 42% Employer Coverage, 26% Medicaid or Other Public Coverage, 32% Uninsured
  - Total: 44.7 million

SAMHSA’s Office of Behavioral Health Equity: 5-Part Plan

1. Data Strategy (disparity impact statement in grants/contracts)
2. Communications Strategy (access and info)
3. Policy Strategy (build on policy levers)
4. Practice and Workforce Innovations
5. Customer Service (trusted broker of information to stakeholders)
### Vision: All populations have equitable access to high quality behavioral health care

#### Federal Policy Drivers:
- DHHS Strategic Action Plan
- White House Minority Initiatives
- AHRQ Disparities Report
- ACA
- SAMHSA Strategic Initiatives
- Social Determinants
- CLAS Standards
- Healthy People 2020

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Impacts</th>
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<tbody>
<tr>
<td>Vision: All populations have equitable access to high quality behavioral health care</td>
<td>SAMHSA’s measurement data guides program planning to address disparities</td>
<td>1. Data Strategy</td>
<td>Disparity access, quality and outcome impact statements for SAMHSA grants</td>
<td>Continuous grant program improvement reduces disparities</td>
<td>Attention to disparities is routinely incorporated into SAMHSA policies and practices</td>
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<td></td>
<td>Increased awareness and access to information re BH disparities</td>
<td>2. Communication Strategy</td>
<td>Communication Plan with OC builds on OBHE webpage, social media, public campaigns and SI’s Policy vehicles – SI, RFAs, budgets – have disparity requirements</td>
<td>Increased engagement in SAMHSA and public strategies to attain BH equity</td>
<td>Greater awareness of BH disparities among communities, practitioners and policy makers leads to new solutions</td>
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<tr>
<td></td>
<td>Disparities are part of SAMHSA policy and funding initiatives</td>
<td>3. Policy Strategy</td>
<td>Disparity-focused action steps in Strategic Initiatives and HHS policy documents; funds to support OBHE activities</td>
<td>SAMHSA’s program and budget policies reflect disparities data</td>
<td>Community-based practitioners and provider organizations have increased capacity to provide evidence-based and adapted behavioral health interventions.</td>
</tr>
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<td>Innovative, cost effective training strategies contribute to quality diverse workforce</td>
<td>4. Quality Practice and Workforce Development Strategy</td>
<td>NNED supports over 100 providers in culturally appropriate interventions</td>
<td>Increased number of community providers serving diverse populations trained in evidence-based, adapted, and practice-based interventions and programs</td>
<td>Improved practice and policies that reduce BH disparities and promote BH equity at community, state and federal level is common practice</td>
</tr>
<tr>
<td></td>
<td>OBHE is trusted broker of BH disparity and equity information and experts</td>
<td>5. Customer Service Strategy</td>
<td>OBHE provides timely response with information, presentations, TA, and collaborations</td>
<td>SAMHSA provides leadership and is viewed as a leader in behavioral health disparity/equity</td>
<td></td>
</tr>
</tbody>
</table>
National Network to Eliminate Disparities in Behavioral Health (NNED)

Purpose: To build a national network of diverse racial, ethnic, cultural and sexual minority communities and organizations to promote policies, practices, standards and research to eliminate behavioral health disparities.

Web address: www.nned.net
National Network to Eliminate Disparities in Behavioral Health

Striving for behavioral health equity for all individuals, families, and communities.

A Nation Free of Disparities in Health and Health Care


FULL STORY

RECENT NEWS

- Study Suggests Flaw In Methods Used To Measure Racial Health Disparities (posted 4/27)
- PBS's Independent Lens Premieres Documentary on Two Spirits 6/14
- IOM Releases Report to Help Focus Action Aimed at Achieving Healthy People 2020 Goals (posted 4/6)
- Indian Youth Suicide Crisis Baffles Fort Peck (posted 3/29)
Key Operations of the NNED

• Provide a network structure for the sharing, dissemination, and uptake of effective practices among community-based providers and organizations
• Provide a structure for peer training and technical assistance
• Foster researcher-provider collaborations
• Launching an “Innovations Exchange” (Virtual Collaboratory)
• Develop and support Communities of Practice
• Provides virtual workspace

NNED Learn 2012
National Network to Eliminate Disparities (NNED) 2008-2011

2008 – 35 Community-based Organizations
2009 – 134 CBOs; 39 Affiliates
2010 – 320 CBOs; 335 Affiliates
2011 – 464 CBOs; 701 Affiliates
State/Federal Dialogues re Disparities

• AHRQ Healthcare Cost and Utilization Project (HCUP) Reports (selected)
  – Assessing the Costs of Racial and Ethnic Health Disparities: State Experience, June 2011
  – [Link](http://www.hcup-us.ahrq.gov/reports/r_e_disparities.jsp)
Multi-factor View of the Public’s Health (Marmot, W.H.O. 2011)

- Economic & Social Opportunities and Resources (reflected in income, education, and racial or ethnic group)
- Living & Working Conditions in Homes and Communities
- Medical Care
- Personal Behavior

HEALTH