

Health Disparities in the Medi-Cal Population

Acknowledgments/Contributors



ACKNOWLEDGMENTS

AUTHORS

The Department of Health Care Services (DHCS) would like to acknowledge the authors of Health Disparities in the Medi-Cal Population for their excellent work in developing these fact sheets and for their dedication to improving the health of Californians.

Desiree Backman, DrPH, MS, RD

Chief Prevention Officer
Office of the Medical Director
Department of Health Care Services
Senior Scientist
University of California Davis Health System
Institute for Population Health Improvement

Patricia A. Lee, PhD

Research Scientist III
Office of the Medical Director
Department of Health Care Services

CONTRIBUTORS

DHCS would also like to thank the following individuals for their significant contributions to these fact sheets, which could not have been completed without their input and involvement.

Monica Barr, MPH

Senior Statistician, UCSF Family PACT Evaluation
Bixby Center for Global Reproductive Health
University of California, San Francisco

Mary Bradsberry

Senior Statistician, UCSF Family PACT Evaluation
Bixby Center for Global Reproductive Health
University of California, San Francisco

Jennifer Byrne

Associate Governmental Program Analyst
Office of the Medical Director
Department of Health Care Services

Susannah Cohen, PhD

Research Scientist III
Information Management Division
Department of Health Care Services

[Link to Data Sources and Methods](#)

Health Disparities in the Medi-Cal Population

Acknowledgments/Contributors



CONTRIBUTORS CONTINUED

Mike Curtis, Ph.D.

Chief, Surveillance, Assessment and Program Development Section
Maternal, Child and Adolescent Health Division
California Department of Public Health

Mike Howell, MA

Database Administrator, UCSF Family PACT Evaluation
Bixby Center for Global Reproductive Health
University of California, San Francisco

Donna Lagarias, PhD

Research Scientist II
Information Management Division
Department of Health Care Services

Adrienne Lowe

Associate Governmental Program Analyst
Office of the Medical Director
Department of Health Care Services

Sandy K. Navarro, MS, GISP

Health Informaticist, UCSF Family PACT Evaluation
Bixby Center for Global Reproductive Health
University of California, San Francisco

Carina Saraiva, MPH

Research Scientist II
Maternal, Child and Adolescent Health Division
California Department of Public Health

Linette T. Scott, MD, MPH

Chief Medical Information Officer
Information Management Division
Department of Health Care Services

Health Disparities in the Medi-Cal Population

Services for Substance Use Disorders



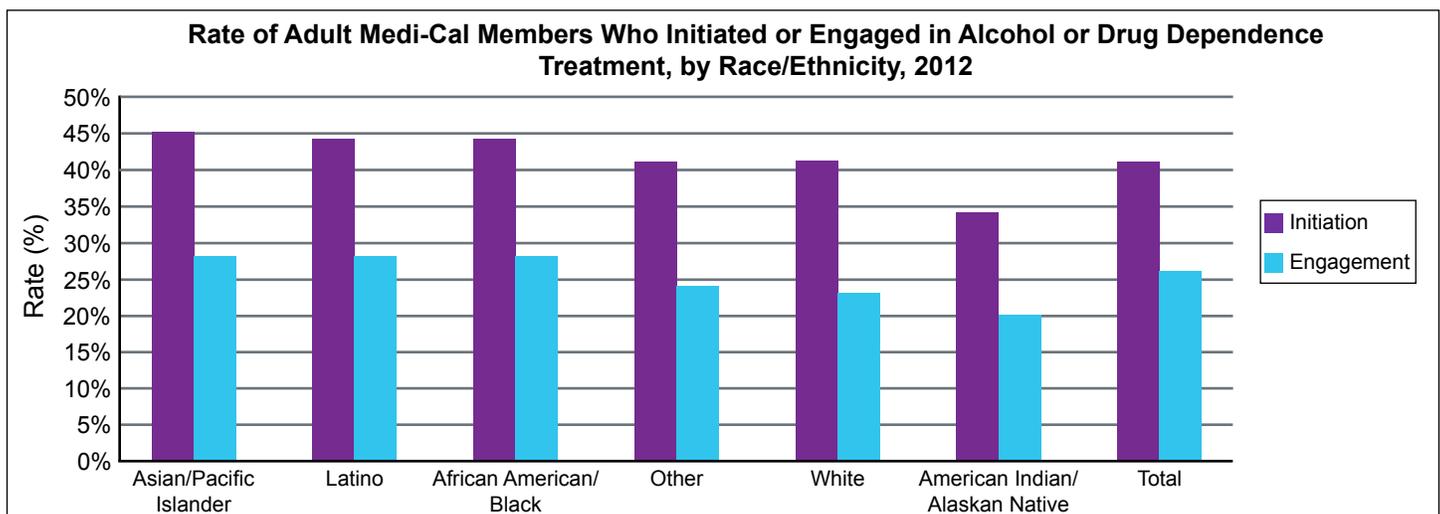
Substance use disorders are prevalent in the United States (U.S.) and a financial burden to the economy. It has been estimated that alcohol abuse costs the U.S. \$223 billion in 2006,¹ and drug abuse costs \$193 billion in 2007.² In 2013, 21.6 million Americans, aged 12 or older, reported substance use in the past year (8.2% of the U.S. population).³ About 17.3 million reported alcohol abuse and 6.9 million reported drug abuse.³ In California, 11.3% of adults reported drug use in the past month and 23.8% reported binge drinking.⁴ In addition to improving quality of life, treatment for substance use disorders can reduce the costs of drug- and alcohol-related crime, theft, and health care.⁵⁻⁶

In 2012, both national and California commercial health plans reported low rates of members initiating (39%⁷ and 29%,⁸ respectively) and engaging (14%⁷ and 10%,⁸ respectively) in alcohol and other drug dependence treatment. Initiation and engagement in alcohol and other drug dependence treatment was also low for Medicaid members (39% and 11%, respectively).⁷



Among Medi-Cal members, Asians/Pacific Islanders had the highest rate of initiation in alcohol or drug abuse treatment and American Indians/Alaskan Natives had the lowest rate (see Figure). American Indians/Alaskan Natives also had the lowest rate of engagement in alcohol or drug abuse treatment.

Figure



Source: Medi-Cal Management Information System/Decision Support System (MIS/DSS), 2012

Note: Members eligible for both Medicare and Medicaid were excluded

[Click to link to more detailed graph by race/ethnicity](#)

1. Bouchery E, Harwood H, Sacks J, Simon C, Brewer R. Economic costs of excessive alcohol consumptions in the U.S. *Am J Prev Med.* 2011;41(5):516-524.
2. National Drug Intelligence Center. The economic impact of illicit drug use on American society. United States of Justice. 2011. http://www.sertox.com.ar/img/item_full/Bouchery_2011.pdf. Accessed December 2014.
3. Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
4. Substance Abuse and Mental Health Services Administration. National survey on drug use and health: Comparison of 2011-2012 and 2012-2013 model-based prevalence estimates (50 states and the District of Columbia). <http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.pdf>. Accessed July 10 2015.
5. Centers for Disease Control and Prevention. Policy issues and challenges in substance abuse treatment. February 2002. <http://www.cdc.gov/idu/facts/PolicyFin.pdf>. Accessed November 2014.
6. Centers for Disease Control and Prevention. Excessive Drinking Costs U.S. \$223.5 Billion. <http://www.cdc.gov/Features/AlcoholConsumption/>. Accessed November 2014.
7. National Committee for Quality Assurance. Improving quality and patient experience. The state of health care quality, 2013 http://www.ncqa.org/Portals/0/State%20of%20Health%20Care/2013/The%20State%20of%20Health%20Care%20Quality%202013_Slides_10-22-13%20FINAL.pdf. Accessed September 2014.
8. NCQA's Quality Compass Data Base 2012. Washington, DC: The National Committee for Quality Assurance; 2012.

Link to Data Sources and Methods

Health Disparities in the Medi-Cal Population

Annual HIV Visit



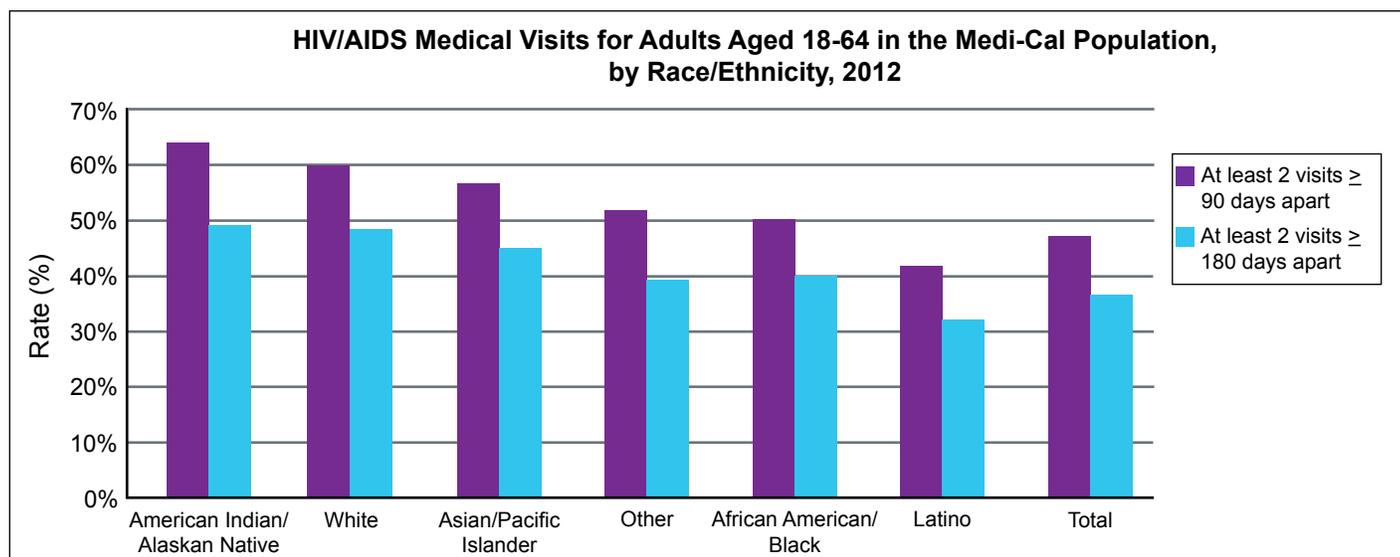
The Centers for Disease Control and Prevention Human Immunodeficiency Virus (HIV) surveillance report indicated that HIV continues to be a serious health issue.¹ It is estimated that 1,144,500 people, aged 13 and older, are living with HIV in the United States, including 180,900 who are unaware of their HIV status.¹ The highest prevalence rate is among African Americans/Blacks and Latinos, and the lowest rate is among Whites and Asians.¹ California has been significantly impacted by HIV/AIDS and, at the end of 2013, there were 218,075 people living with HIV/AIDS in the state.²

Routine medical visits for HIV patients are important for optimal care and treatment so their CD4 cell counts and HIV viral load can be monitored.³ Failing to access health care has been associated with increased mortality,⁴ low CD4 counts, and lack of prescribed antiretroviral therapy.³

Among HIV-positive California Medi-Cal adults, aged 18 to 64, American Indians/Alaskan Natives were more likely to have visited a doctor two or more times with a minimum of 90 days between visits (64%), and Latinos (42%) were least likely (see Figure).



Figure



Source: Medi-Cal Management Information System/Decision Support System (MIS/DSS), 2012

Note: Members eligible for both Medicare and Medicaid were excluded

[Click to link to more detailed graph by race/ethnicity](#)

- Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2011. HIV Surveillance Supplemental Report 2013;18(No. 5). http://www.cdc.gov/hiv/pdf/2011_Monitoring_HIV_Indicators_HSSR_FINAL.pdf. Published October 2013. Accessed November 2014.
- California Department of Public Health. HIV/AIDS surveillance in California. <http://www.cdph.ca.gov/programs/aids/Documents/SSQtr2Jun2010.pdf>. Accessed November 2014.
- Sullivan PS, Juhasz M, McNaghten AD, et al. Time to first annual HIV care visit and associated factors for patients in care for HIV infection in 10 US sites. *AIDS care*: 2011;23:10;1314-1320.
- Horberg MA, Hurley LB, Silverberg MJ. Missed office visits and risk of mortality among HIV-infected subjects in a large healthcare system in the United States. *AIDS Patient Care and STDs*. 2013;27(8);442-449.

Link to Data Sources and Methods

Health Disparities in the Medi-Cal Population

Mammography Screening



Breast cancer is the most common cancer among women.¹ In 2011, White women had the highest incidence of breast cancer, while African American/Black women had the highest mortality rate in the United States (U.S.).²

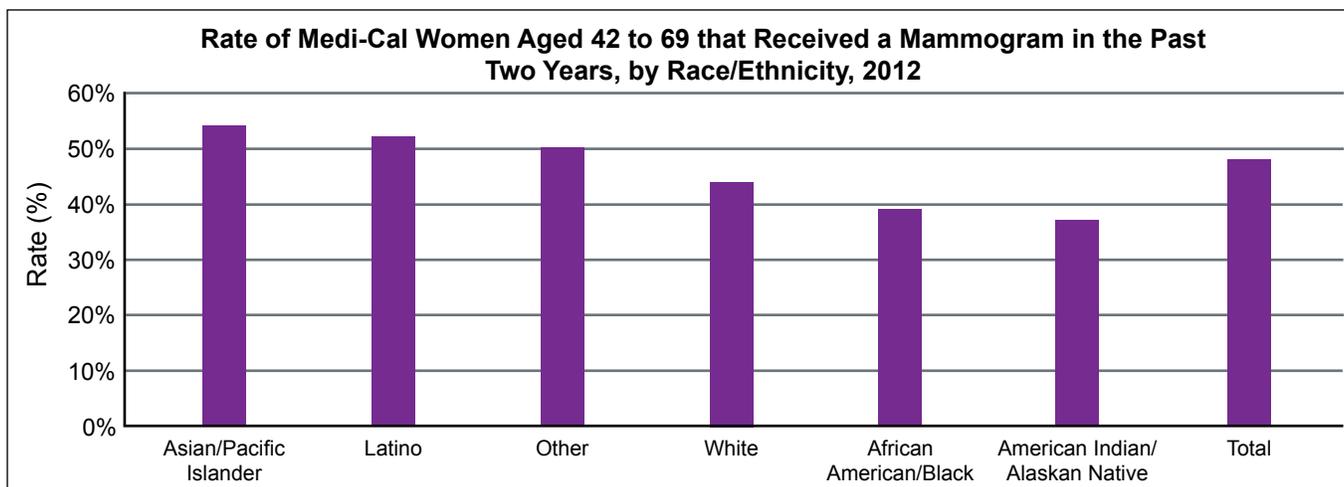
In 2011, the age-adjusted rate of breast cancer for California women was 122 per 100,000 women, with the incidence being highest in White women (123), followed by African American/Black (121) and Latino (92) women.³ African American/Black women had the highest mortality rate (32), while Latino women had the lowest (14).³



Getting mammograms regularly can lower the risk of dying from breast cancer.⁴ In 2012, rates of mammography screening for females, aged 42 to 69, enrolled in commercial plans both nationally⁵ and in California⁶ were higher (70% and 76%, respectively) than those enrolled in Medicaid (52%).⁵

In the California Medi-Cal population, rates for mammography screening (48%) were lower than those for commercial plans and Medicaid (see Figure). Asian/Pacific Islander women were more likely to have a mammogram in the past two years (54%), followed by Latino (52%), Other (50%), White (44%), African American/Black (39%), and American Indian/Alaskan Native (37%) women.

Figure



Source: Medi-Cal - Medi-Cal Management Information System/Decision Support System (MIS/DSS), 2012

Note: Members eligible for both Medicare and Medicaid were excluded

[Click to link to more detailed graph by race/ethnicity](#)

- Centers for Disease Control and Prevention. Breast cancer statistics. <http://www.cdc.gov/cancer/breast/statistics/index.htm>. Published September 2, 2014. Accessed September 19, 2014.
- Centers for Disease Control and Prevention. Breast cancer rates by race ethnicity. <http://www.cdc.gov/cancer/breast>. Published August 27, 2014. Accessed September 19, 2014.
- U.S. Cancer Statistics Working Group. United States cancer statistics: 1999-2011 incidence and mortality web-based report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2014. www.cdc.gov/uscs. Accessed September 2014.
- Centers for Disease Control and Prevention. Breast cancer screening rates. <http://www.cdc.gov/cancer/breast>. Published November 2, 2012. Accessed September 19, 2014.
- National Committee for Quality Assurance. Improving quality and patient experience. The state of health care quality, 2013. http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf. Accessed September 2014.
- NCQA's Quality Compass Data Base 2012. Washington, DC: The National Committee for Quality Assurance; 2012.

Link to Data Sources and Methods

Health Disparities in the Medi-Cal Population

Cervical Cancer Screening



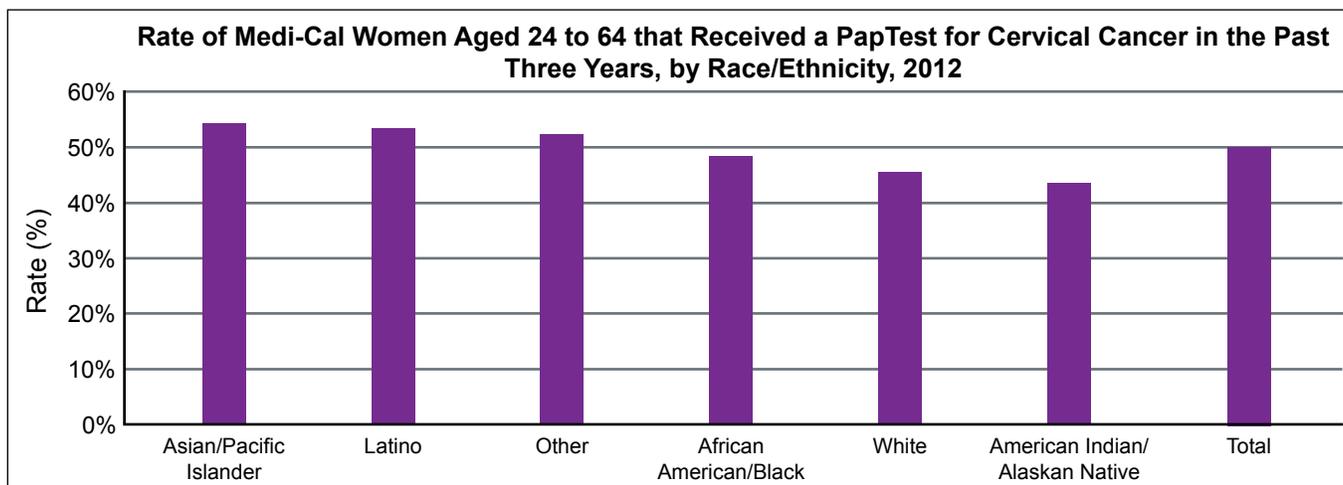
Cervical cancer was the leading cause of cancer deaths in women in the United States (U.S.) until increased Pap testing resulted in significant decreases in the number of cervical cancer cases and deaths.¹ In the U.S., Latino women are most likely to get cervical cancer, followed by African-Americans/Blacks, Whites, American Indians/Alaskan Natives, and Asians/Pacific Islanders.² Six out of 10 cervical cancers occurred in women who had never had a Pap test or who had not been screened in the past 5 years.³ Regular Pap testing can detect cervical cancer in its early stages, which is highly treatable.¹ The five-year relative survival rate for early stages of invasive cervical cancer is 93%.⁴

In 2012, rates of Pap test screening for women, aged 24 to 64, enrolled in commercial health plans both nationally⁵ and in California⁶ (76% and 81%, respectively) were higher than those enrolled in Medicaid (50%)⁵ and California Medi-Cal (50%).



In the California Medi-Cal population, aged 24 to 64, Asian/Pacific Islander women were more likely to have a Pap test in the past three years (54%), followed by Latino (53%), Other (52%), African American/Black (48%), White (45%), and American Indian/Alaskan Native (43%) women (see Figure).

Figure



Source: Medi-Cal Management Information System/Decision Support System (MIS/DSS), 2012

Note: Members eligible for both Medicare and Medicaid were excluded

[Click to link to more detailed graph by race/ethnicity](#)

1. American Cancer Society. Cervical cancer prevention and early detection. <http://www.cancer.org/acs/groups/cid/documents/webcontent/003167-pdf.pdf>. Published December 2014. Accessed July 2015.
2. Centers for Disease Control and Prevention. Cervical cancer rates by race and ethnicity. <http://www.cdc.gov/cancer/cervical/statistics/race.htm>. Published January 2008. Accessed December 2008.
3. Women with disabilities. Centers for Disease Control and Prevention Web site. <http://www.cdc.gov/ncbddd/disabilityandhealth/women.html>. Updated March 31 2014. Accessed July 2015.
4. National Cancer Institute. SEER Stat fact sheets: Cervical uteri cancer. <http://seer.cancer.gov/statfacts/html/cervix.html>. Accessed October 2014.
5. National Committee for Quality Assurance. Improving quality and patient experience. The state of health care quality, 2013 http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf. Accessed September 2014.
6. NCQA's Quality Compass Data Base 2012. Washington, DC: The National Committee for Quality Assurance; 2012.

Link to Data Sources and Methods

Health Disparities in the Medi-Cal Population

Chlamydia Screening



Chlamydia trachomatis is the most common sexually transmitted disease (STD) in the United States (U.S.).¹ According to the Centers for Disease Control and Prevention (CDC), 1,422,946 people were infected with chlamydia in 2012.¹ Chlamydia is more prevalent among females, ages 15 to 24.¹ In California, there are over 100,000 chlamydia cases among women every year.¹ Similar to the U.S., regardless of gender, the incidence of Chlamydia is highest among African Americans/Blacks and lowest among Asians/Pacific Islanders and Whites.²

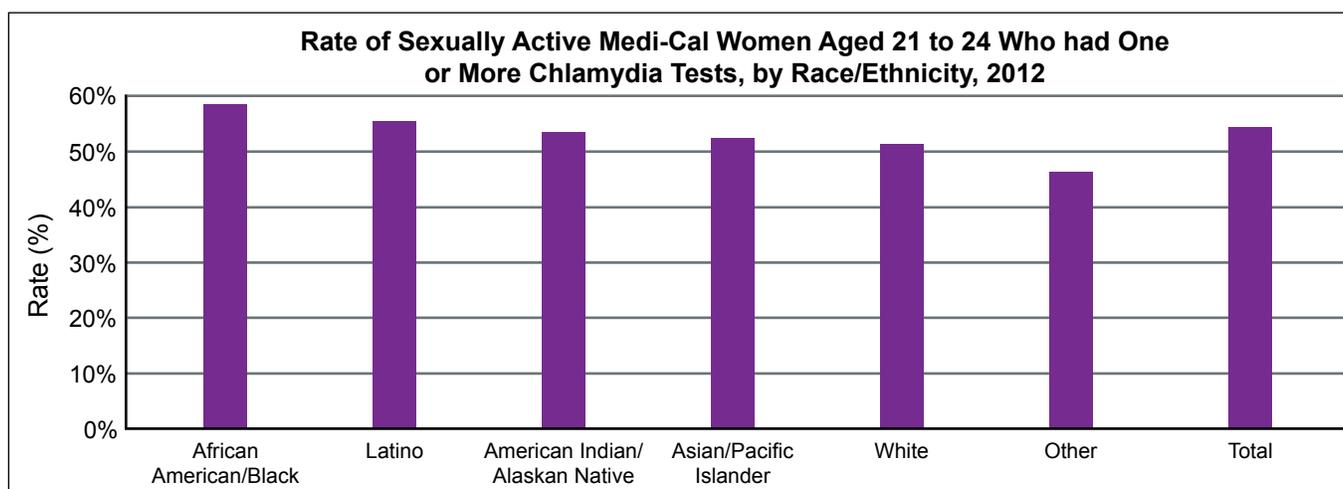
According to CDC, it is essential that sexually active young adults are routinely screened,³ since the majority of women who have chlamydia do not experience symptoms.⁴ The main objective of chlamydia screening is to prevent pelvic inflammatory disease, infertility, and ectopic pregnancy, all of which have very high rates of occurrence among women with untreated chlamydia infection.⁴

In 2012, rates of chlamydia screening for sexually active women, aged 21 to 24, enrolled in commercial health plans both nationally⁵ and in California⁶ (49% and 57%, respectively) were lower than those enrolled in Medicaid (64%).⁵



In the California Medi-Cal population, a little over half of the sexually active women, aged 21 to 24, had one or more chlamydia test (54%) in 2012 (see Figure). African American/Black women were more likely to have been screened for Chlamydia (58%), followed by Latino (55%), American Indian/Alaskan Native (53%), Asian/Pacific Islander (52%), White (51%), and Other women (46%).

Figure



Source: Medi-Cal Management Information System/Decision Support System (MIS/DSS), 2012

Note: Members eligible for both Medicare and Medicaid were excluded

[Click to link to more detailed graph by race/ethnicity](#)

1. Centers for Disease Control and Prevention. Chlamydia. <http://www.cdc.gov/std/stats12/chlamydia.htm>. Accessed November 2014.
2. California Department of Public Health. California STD Surveillance 2012 Data Graph Set. <http://www.cdph.ca.gov/data/statistics/Pages/STDDData.aspx>. Centers for Disease Control and Prevention. Sexually transmitted diseases treatment and guidelines, 2010. MMWR. 2010;59(No RR-12).
3. Centers for Disease Control and Prevention Chlamydia Fact Sheet. <http://www.cdc.gov/std/chlamydia/chlamydia-factsheet-june-2014.pdf>. Published January 23, 2014. Accessed October 2014.
4. Centers for Disease Control and Prevention Chlamydia Fact Sheet. Published January 23, 2014. <http://www.cdc.gov/std/chlamydia/chlamydia-factsheet-june-2014.pdf>. Accessed October 2014.
5. National Committee for Quality Assurance. Improving quality and patient experience. The state of health care quality, 2013 http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf. Accessed September 2014.
6. NCQA's Quality Compass Data Base 2012. Washington, DC: The National Committee for Quality Assurance; 2012.

Link to Data Sources and Methods

Health Disparities in the Medi-Cal Population

Postpartum Care Visits



Postpartum care is an important determinant of successful health and quality health care outcomes for women giving birth.¹ Postpartum visits can address any adverse effects associated with child birth, such as persistent bleeding, pain, and infections.² In California, 89% of women reported having a postpartum medical visit in 2011.³ Asians/Pacific Islanders (93%) reported the highest rate of having a postpartum visit, while Whites (86%) and African Americans/Blacks (84%) had the lowest.³

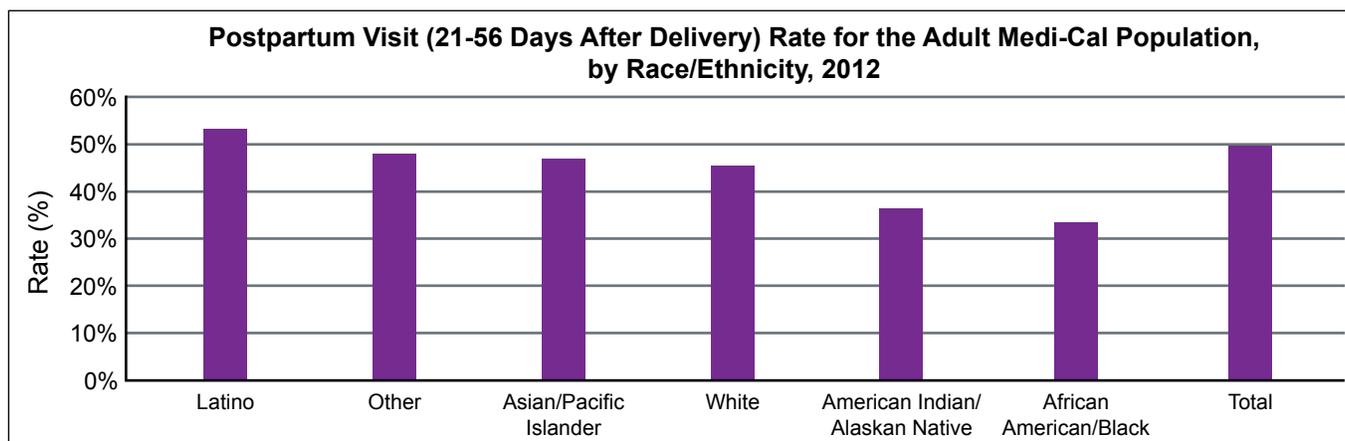
The postpartum visit is also a good time to assess and treat any emotional problems, particularly postpartum depression. In California, over 13% of women reported experiencing postpartum depression, with African Americans/Blacks reporting the highest rate (22%) and Whites (11%) reporting the lowest.³

In 2012, rates of timely postpartum care for members enrolled in commercial health plans both nationally⁴ and in California⁵ (80% and 87%, respectively) were higher than those enrolled in Medicaid (63%).⁴

In the California Medi-Cal population, slightly under 50% of women had a postpartum visit in 2012 (see Figure). Latino women were most likely to have a postpartum visit (53%), followed by Other (48%), Asian/Pacific Islander (47%), White (45%), American Indian/Alaskan Native (36%), and African American/Black women (33%).



Figure



Source: Medi-Cal Management Information System/Decision Support System (MIS/DSS), 2012

Note: Members eligible for both Medicare and Medicaid were excluded

[Click to link to more detailed graph by race/ethnicity](#)

1. Community First Health Plans. The importance of the postpartum visit. http://www.cfhp.com/News/Documents/The_Importance_of_the_Postpartum_Visit-062011.pdf. Accessed October 2014.
2. Ronsmans C, Scott S, Qomariyah SN, et al. Professional assistance during birth and maternal mortality in two Indonesian districts. *Bulletin of the World Health Organization*. 2009;87:416-423.
3. California Department of Public Health. MIHA Snapshot, California by Race/Ethnicity, 2011. Accessed October 2014.
4. National Committee for Quality Assurance. Improving quality and patient experience. The state of health care quality, 2013 http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf. Accessed September 2014.
5. NCQA's Quality Compass Data Base 2012. Washington, DC: The National Committee for Quality Assurance; 2012.

Link to Data Sources and Methods

Health Disparities in the Medi-Cal Population

Schizophrenia Medication Adherence

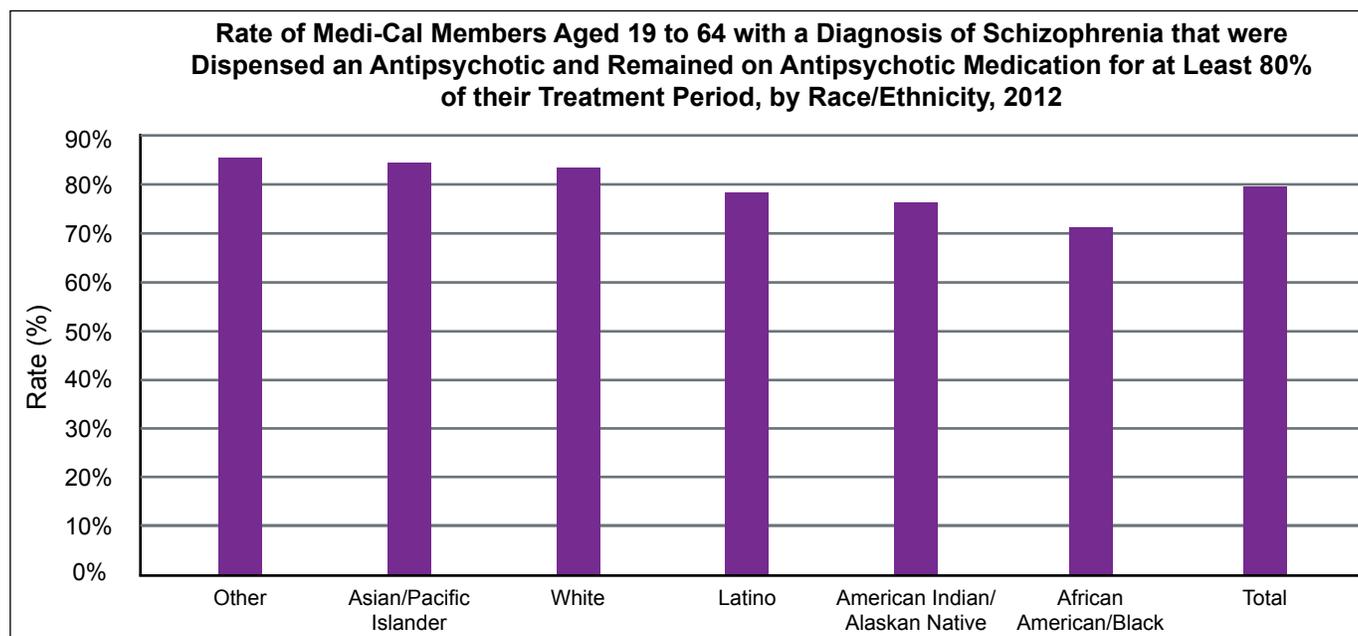


Survey research has found that approximately 1.1% of the adult American population has schizophrenia.¹ National claims data in 2002 estimated a prevalence of diagnosed schizophrenia of 5.1 per 1,000 lives.² People with schizophrenia have health care utilization rates above 60%.¹ The national overall cost of schizophrenia has been estimated at \$62.7 billion annually, of which \$22.7 billion were direct health care costs.² Antipsychotic medications have proven to be effective in treating this disorder and adherence to schizophrenia medication³ keeps symptoms under control and prevents relapse.⁴



In the California Medi-Cal population, nearly 80% of patients, aged 19 to 64, diagnosed with schizophrenia remained on their antipsychotic medication for at least 80% of their treatment period (see Figure). African American/Black patients were least likely to remain on their antipsychotic medication (71%), followed by American Indians/Alaskan Natives (76%), Latinos (78%), Whites (83%), Asians/Pacific Islanders (84%), and Others (85%).

Figure



Source: Medi-Cal Management Information System/Decision Support System (MIS/DSS), 2012

Note: Members eligible for both Medicare and Medicaid were excluded

[Click to link to more detailed graph by race/ethnicity](#)

1. Regier DA, Narrow WE, Rae DS. Et al. The de factor mental and additive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. Arch of General Psych. 1993. Feb;50(2):85-94.
2. Wu EQ, Shi L, Birnbaum H, et al. Annual prevalence of diagnosed schizophrenia in the USA: A claims data analysis approach. Psych Med. 2006;36:1535-1540.
3. Velligan DL, Lam F, Ereshefsy L, et al. Psychopharmacy: Perspectives on medication adherence and atypical antipsychotic medications. Psychiatr Serv. 2003;54:665-667.
4. National Institute of Mental Health. What is schizophrenia? Published 2009. <http://www.nimh.nih.gov/health/publications/schizophrenia/index.shtml>. Accessed June 14, 2013.

Link to Data Sources and Methods

Health Disparities in the Medi-Cal Population

Breastfeeding



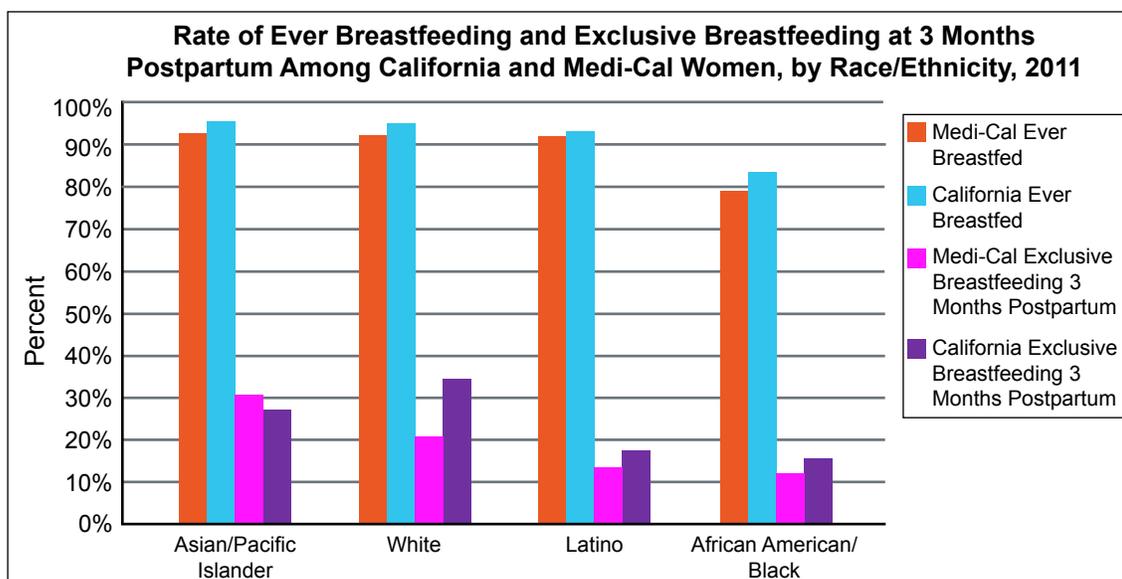
Breastfeeding is one of the most effective measures to prevent diseases among mothers and their infants.¹ The American Academy of Pediatrics and the World Health Organization recommend that a mother exclusively breastfeed for at least six months.² While 75% of mothers in the United States initiate breastfeeding, only 13% exclusively breastfeed at the end of six months.¹ Additionally, research has shown that breastfeeding rates among African Americans/Blacks are significantly lower.¹ However, women who reported giving birth in hospitals that supported breastfeeding were more likely to exclusively breastfeed at three months postpartum.³

Among California women, Asians/Pacific Islanders, Whites, and Latinos reported higher rates of having ever breastfed than African Americans/Blacks (see Figure). African Americans/Blacks and Latinos reported the lowest rates of exclusive breastfeeding three months after delivery as compared to Whites and Asians/Pacific Islanders.

Among California Medi-Cal women, African Americans/Blacks reported the lowest rate of having ever breastfed. Also, African Americans/Blacks and Latinos reported the lowest rates of exclusive breastfeeding three months after delivery. Overall, women with Medi-Cal were slightly less likely to report having breastfed than Californians in general, with the exception of exclusive breastfeeding at three months among Asians/Pacific Islanders.



Figure



Source: California Department of Public Health, Maternal, Child, and Adolescent Health Program, Maternal and Infant Health Assessment Survey, 2011 (www.cdph.ca.gov/miha).

1. U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011.
2. Feldman-Winter, L and Lawrence, R. Policy Statement: Breastfeeding and the Use of Human Milk. *Peds* 2012;129:e827-e841.
3. California Department of Public Health, Maternal, Child, and Adolescent Health Program. Hospital practices and breastfeeding fact sheet. Maternal and Infant Health Assessment Survey, 2010. <http://www.cdph.ca.gov/programs/mcah/Documents/MO-MIHABriefHospitalPracticesBreastfeeding.pdf>. Published January 2012. Accessed July 2013.

Link to Data Sources and Methods

Health Disparities in the Medi-Cal Population

Health Maintenance Organization



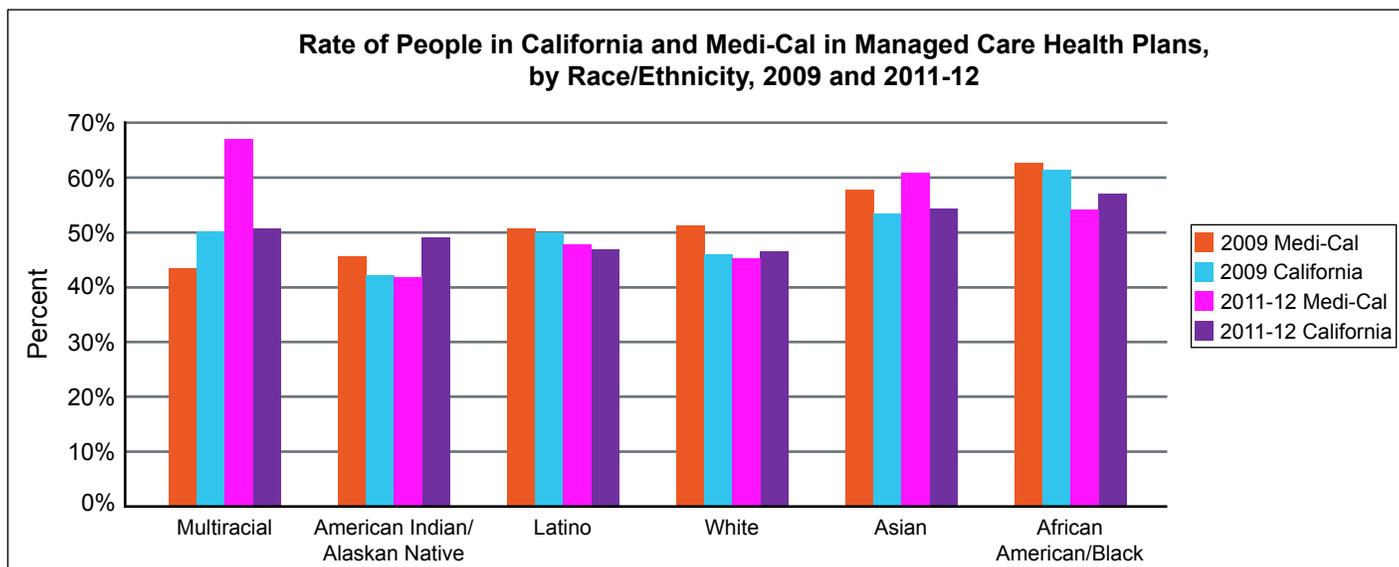
Many people in the United States are enrolled in some type of managed care plan (e.g., Health Maintenance Organization (HMO), preferred provider organization).¹ Participation in these plans enables people to have coordinated care, ongoing referrals to specialists, and access to an organized system of health care to obtain quality care.²⁻³ Research noted that health plans' ability to implement system-wide changes in care led to the prevention of neonatal group B streptococcal infections, improved public health tuberculosis surveillance, and a decrease in postoperative infections.³⁻⁴

Among Californians, American Indians/Alaskan Natives and Whites were the least likely to report being in a HMO, while African Americans were the most likely in both 2009 and 2011-12 (see Figure).

In the California Medi-Cal population, the Multiracial group (43%) and American Indians/Alaskan Natives (45%) were the least likely to report being in a HMO as compared to African Americans (62%) in 2009. However, in 2011-12, the Multiracial group (67%) was more likely to report being in a HMO as compared to American Indian/Alaskan Native (42%). Due to small sample sizes, the percentages for Native Hawaiians/Pacific Islanders were unreportable for Medi-Cal and California in general.



Figure



Source: AskCHIS, California Health Interview Survey, 2009 and 2011-12

1. MCOL. Current national managed care enrollment fact sheet, 2012. http://www.mcol.com/current_enrollment. Accessed March 12, 2014.
2. California Department of Health Care Services. Medi-Cal managed care program fact sheet- managed care models. www.dhcs.ca.gov/provgovpart/documents/MMCDModelFactSheet.pdf. Accessed March 10, 2014.
3. Platt R, Caldwell B. Can managed health care help manage health care-associated infections? *Emerg Infect Dis.* 2001;7(2):358-362.
4. Yokoe DS, Subramanian GS, Nardell E, Sharnprapapi S, McCray E, Platt R. Supplementing Tuberculosis surveillance in a health maintenance organization using automated data. *Emerg Infect Dis.* 1999;5:779-87.

Link to Data Sources and Methods