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A Racial Impact Analysis of HB 1075/SB 201

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A Racial Impact Analysis of HB 1075/SB 201

A project of the Minority Political
Leadership Institute Class of 2012

Prepared by: Patrice Banks, Cydney Neville, L. Sookyung Oh, and Keith Rogers Jr.

Project Description

The economic and social consequences of untreated (or under-treated) substance abuse among minors are significant. This report provides a racial impact analysis of HB 1075/SB 201, legislation approved in the 2012 General Assembly session that seeks to improve access and use of substance and alcohol services by minors. In short, this policy could go a long way to ensure that families are properly educated about these life-changing (and life-saving) programs; however our analysis raises concerns related to cultural competency that may serve to undermine the legislation's goal. Virginia is incredibly diverse and its communities vary widely with its assets and risks. In this vein, we offer concrete recommendations to maximize the policy's racial equity. Our analysis also sheds light on the ongoing challenge Virginia's state agencies have had to address cultural competency within its services. Additional research is necessary to determine what service gaps may exist, which would increase or decrease the racial equity impact. By answering these questions, Virginia will be better prepared to further reduce alcohol and substance abuse by all minors.

Legislative Overview

Summary

Introduced by Delegate Timothy Hugo and Senator David Marsden and winning unanimous approval in the Virginia House and Senate, HB 1075 and SB 201 is legislation that requires hospitals to educate patients, and in certain circumstances their families, about follow-up care, treatment, and services upon discharge. The bill also requires community services boards to provide information to hospitals about alcohol and substance abuse services available to minors. The effective date of the legislation is July 1, 2012.

Prior to this legislation, there was no state requirement on the part of hospitals to inform and educate the patient and their family about substance and alcohol abuse follow-up care, treatment, and services. The Virginia Hospital & Healthcare Association states that such discharge planning is already in place because it a requirement as part of hospital's accreditation process with The Joint Commission (P. Speidell, personal communication, October 5, 2012). However since accreditation standards can change, putting this mandate into the state code ensures that hospitals must follow it.

Community services boards (CSBs) had no state mandate to collaborate with hospitals to provide those institutions with information about alcohol and substance abuse services available to minors. CSBs are uniquely resourced to provide this information since they act as a single point-of-entry for individuals seeking services, including community-based mental health, developmental, and substance abuse services to individuals with mental health or substance use disorders, intellectual disability, or co-occurring disorders. Currently there are 39 CSBs across the Commonwealth, and they hold performance contracts with the state to develop and deliver these services.

For individuals who were already in the CSB system, they were already entitled to a comprehensive person-centered discharge plan. HB 1075/SB201 attempts to build more state support for minors and their families who do not have case management through the publicly-funded CSB system and may be seeking private treatment for alcohol and substance use directly

at licensed hospitals. HB 1075/SB 201 amends Chapter 5 of Title 32.1 relating to hospital discharge procedures and coordination of services for preadmission screening and discharge planning to mandate that community services boards and hospitals collaborate, and that hospitals distribute information about alcohol and substance abuse services available to minors upon discharge of substance abuse treatment.

A) 32.1-137.02: Hospital discharge procedures, to Title 32.1 Health, Chapter 5 on “Regulation of Medical Care Facilities and Services.” The amendment states: “*Before a hospital discharges a patient, it shall, to the extent allowed pursuant to state and federal law, inform and educate the patient, and his family when it is involved in decision making or ongoing care, about his follow-up care, treatment, and services.*”

B) 37.2-505: Coordination of services for preadmission screening and discharge planning, to Title 37.2 Behavioral Health and Developmental Services. The amendment states: “*4. Provide information, if available, to all hospitals licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 about alcohol and substance abuse services available to minors.*”

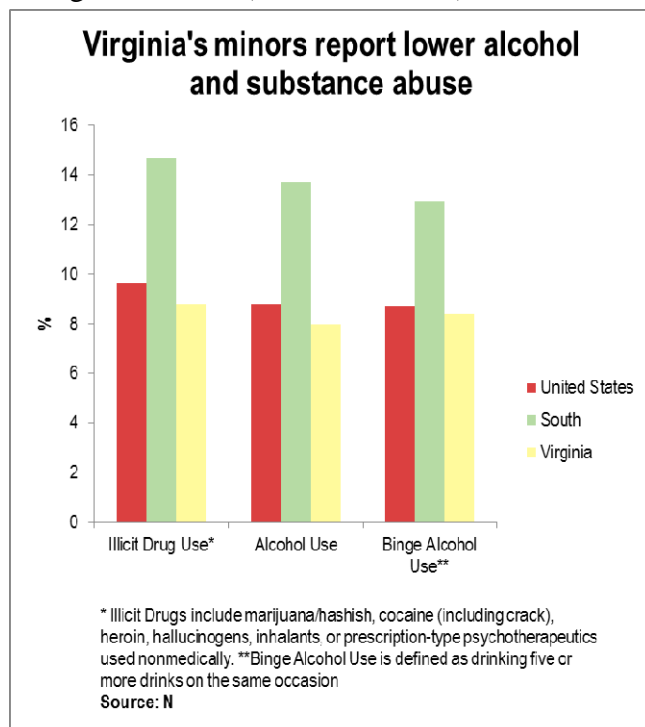
However, the legislation does not specify that such education and information be tailored to the person’s gender, race, ethnicity, or culture.

Background

Substance and alcohol abuse is a serious problem in Virginia, including by minors. The economic costs of substance abuse to the Commonwealth of Virginia are substantial. JLARC estimated that in 2006, states and localities spent more than \$613 million to cover costs related to public safety and health care. In addition, spending for substance abuse services amounted to \$102 million, which were borne by state and local governments (JLARC, 2008, i).

While the state’s rates are lower than the national average and that of all Southern states, in some measures, we are doing worse than our neighbors. Tennessee, Kentucky, and Georgia have lower rates of illicit drug use. Virginia has the highest rate of binge alcohol use among those states, as well as Maryland, the District of Columbia, North Carolina, and West Virginia (SAMSHA, 2011b).

HB 1075/SB 201, known as Alicia’s Compass, is legislation that was directly inspired by a true story. In 2008, Alicia Lannes, a 19-year old, died due to a heroin overdose in Northern Virginia. As told by her parents, they felt ill-equipped to manage their daughter’s addiction because they did not know about available

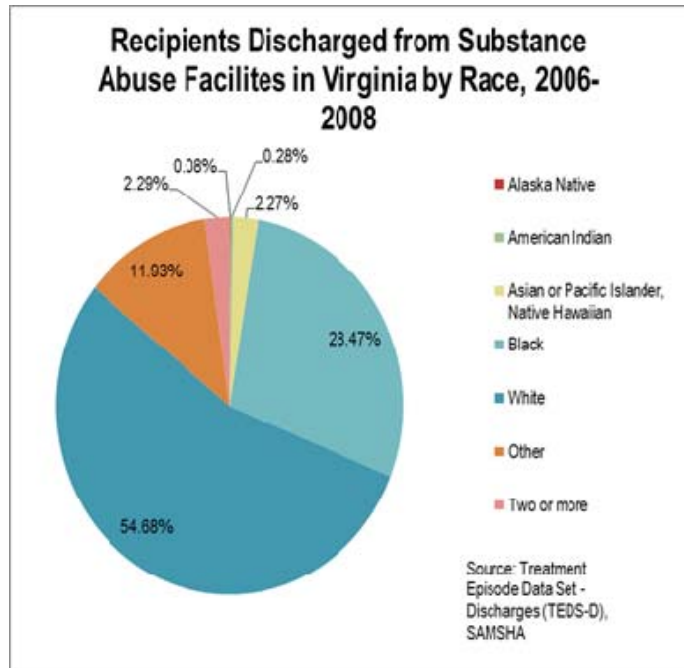


resources. Said Lannes: “We thought that there would be some ramifications for overdosing. And what we found is that they basically just wrap you up in a blanket and send you out the door.” (Stachyra, 2012).

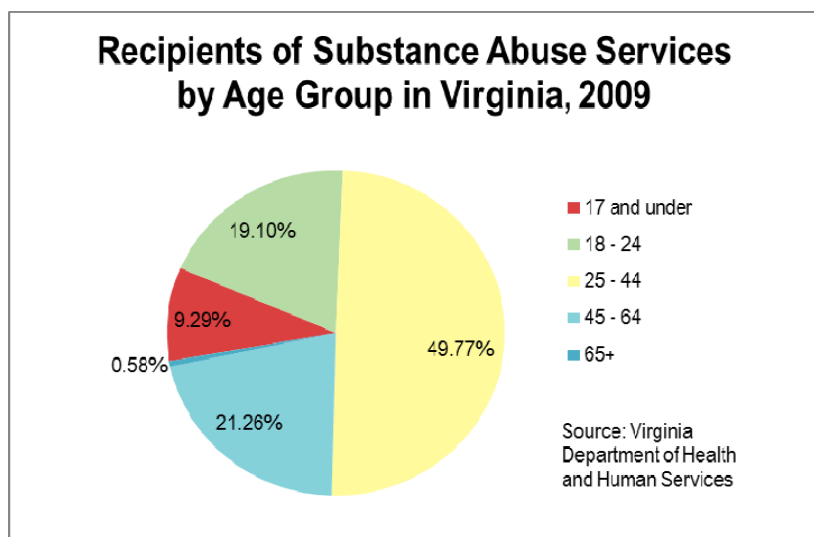
Racial Impact Analysis/ Impact on Minority Communities in Virginia

Who is affected by the legislation and to what extent?

Minors who are treated for substance abuse at hospitals are the direct beneficiaries of this legislation. In terms of prevalence of abuse, we could not identify any state-level data. Nationally, the prevalence of substance abuse is highest among American Indians or Alaska Natives (16%), followed by Hispanics (9.7%), Whites (8.9%), African Americans (8.2%), Native Hawaiians or Other Pacific Islanders (5.6%) and Asians (4.1%). (SAMSHA, 2011a) In other words, prevalence is similar among Hispanics, Whites, and African Americans; high for American Indians or Alaska Natives; and low for Asian Americans, Native Hawaiians, and Pacific Islanders.



To understand the impact to communities of color, it was not a straightforward exercise. What we could find at the state level either disaggregated admissions or treatment by race or by age, but not both. In 2009, 40,723 consumers received substance abuse services in Virginia, of which 9.29% were minors, or individuals under the age of 17 (Hazel, 2010, p. 37).



In Virginia, the distribution of clients receiving substance abuse services from community services boards by race in 2006 were: White - 59%, African American - 31%, Other - 6%, Unknown - 2%, Asian - 1%, Alaska Native 1%. (JLARC, 2008, p. 17). While the percent breakdowns are different, the general ranking by race of substance abuse treatment recipients are similar compared nationally and statewide.

As stated earlier, data that provides a more nuanced look at substance abuse recipients by race and age is not reported by the state in annual reports or surveys. Relying on national data sets, we found that between 2006 and 2008, over 33% of individuals between the ages of 12 and 17 and who were discharged from alcohol or drug treatment in Virginia facilities that report to individual state administrative data systems are from communities of color/minority communities (SAMSHA TEDS, 2006-2008). However this estimate is imperfect because it does not capture the total universe of minors in Virginia that received alcohol or substance abuse treatment.

What are the anticipated racial impacts of the legislation?

Based on interviews with key stakeholders, many expressed difficulty in defining the racial impact because they view the legislation simply as a mandate to disseminate information. However what those stakeholders may not be considering is communities have unique needs, a phenomenon that have seen and explored through the course of the Minority Political Leadership Institute. According to the Surgeon General, the cumulative effects of history, racism, discrimination, violence, poverty, and all barriers to care contribute to the mental health disparities of racial and ethnic minorities (DHHS, 2001, p. 1).

Successful implementation of the legislation depends on the hospital's ability to incorporate race, ethnicity, and culture in the discharge planning; in other words, the hospital's discharge process should be evaluated for its cultural competency. A one-size-fits-all program will fail to substantially address substance and alcohol abuse because race, ethnicity, and culture influence access to and utilization of services; awareness of the problem; knowledge of treatment options; and the quality of care. Such

What is cultural competency? In a paper published by the Department of Behavioral Health and Developmental Services System (DBHDS), cultural competence:

requires that organizations have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally. In addition, cultural competence requires that organization and individuals have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, adapt to diversity and the cultural contexts of the communities they serve, and incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities. Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (Perkins, 2008, p. 5).

In sum, cultural competence is when individuals and organizations are aware and respectful of the diverse beliefs, values, and life experiences of others and incorporate those elements into policy and service development and delivery.

Culture can be defined quite broadly and cultural competency can be assessed on a number of factors. What this report does not look into for example is geographic locations, proximity to the services and access to transportation, the person's ability to manage time, hours of operation of the service providers, and how that impacts access to services. Instead, we will highlight how communities of color and immigrant communities may face additional barriers at the time of

receiving information of treatment options, as well as their capacity to access those services because of income, language, literacy, and health insurance coverage.

Income

In 2011, the DBHDS reported that people with substance abuse disorders wait an average of almost 19 days for services. In addition, “[i]ndividuals don’t always receive services that are intensive enough or that are proven to be effective – and many do not receive the services they need because those services do not exist at all (DBHDS, 2011a, p. iv). The publicly-funded system is severely strained.

Race	Median Income	Poverty Rate
All	61,882	11.5%
White, non-Hispanic	67,164	8.6%
Black/African American	43,649	19.0%
Asian	86,801	8.7%
Native Hawaiian/Pacific Islander	69,869	no data
American Indian/Alaskan Native	47,512	14.1%
Latino	56,782	17.8%
Source: 2011 American Community Survey, 1-year estimates		

For low-income minors and their families, treatment options are likely to be limited to this public system. What we know about income and poverty in Virginia is that communities of color persistently have lower incomes and higher poverty rates. African American households earn less than \$24,000 than White households. The poverty rate of African American households is more than twice that of White households. Such disparities are also present among the American Indian/Alaskan Native and Latino communities (see table above).

Since we do not know anything of the services that hospitals will be recommending to minors and their families, we cannot conclusively state that this racial impact will occur. However, given that the publicly-funded service delivery system is fragmented, low-income ethnic and racial minorities have limited financial resources and insurance coverage which impacts their access to affordable treatment options.

Language

According to the latest Census estimates, 14.9% of Virginians speak a language other than English at home. What is of more interest is understanding how many speak English less than “very well.” Nearly 6 percent of Virginia’s total population speaks English less than “very

Speak English less than "very well"	# of individuals	Share of total VA population
Spanish	216,855	2.90%
Other Indo-European languages	69,478	0.90%
Asian and Pacific Islander language	107,904	1.40%
Other languages	26,875	0.40%
Source: 2011 American Community Survey, 1-year estimates		

well.” Their inability to speak English “well” creates barriers to access by impairing their ability to develop trust and mutual respect with the hospital staff and understanding the educational documents printed in English. These language barriers have serious implications for health outcomes and quality of care. According to the National Health Care Disparities Report, the

overall proportion of adults whose health providers sometimes or never listened carefully, explained things, showed respect, and spent enough time with them was higher among individuals who speak a foreign language at home compared with individuals who speak English at home (NAMI, 2006, p. 1). Improving communication between health care professionals and patients is paramount in establishing rapport and providing quality care. According to the 1964 Civil Rights Act, service providers receiving federal financial assistance (Medicare and Medicaid) are obligated to ensure that people with limited English proficiency have meaningful and equal access to services (DHHS, 2001, Improve access to treatment section, para. 1).

Education

In addition, discharge planners and service providers must be able to provide services not only to people with limited English proficiency, but they need to strive to meet levels of: illiteracy, and other disabilities that require interpreters, sign language, braille, and other alternative means of communication. Statewide, the adult illiteracy rate is 12%. (Weldon Cooper Center, 2010, p. 1).

Health Insurance Coverage

HB 1075/SB 201 specifically highlights that it is the hospital that must provide information about services. Research generally shows that people who are uninsured are less likely to seek treatment at hospitals, and instead go to a free community health clinic, self-treat, or seek no treatment whatsoever. 12.5% of all Virginians are no health insurance coverage. Every community of color has higher rates of noncoverage than Whites. Again, this disparity in coverage sets up a dangerous disparity later down the road with successful substance abuse treatment.

Race	# Uninsured	Uninsured Rate
White	573,584	10.40%
Black or African American	238,888	15.80%
American Indian and Alaska Native	4,630	20.10%
Asian	70,460	15.60%
Other	63,229	37.40%
Two or more races	31,123	13.30%
Source: 2011 American Community Survey, 1-year estimates		

Recommendations

Following the racial impact analysis, our recommendations are the following:

1. Expand youth and young adult data. Publicize substance and alcohol abuse data by race, and ideally by race and age, in existing public reports, such as the Virginia Department of Behavioral Health and Developmental Services’ Biennial Report on Substance Abuse Services. If not already being done, also collect information about primary language spoken by the minor. Our group also supports previous recommendations by the DBHDS that Virginia enhance youth substance use consumption and consequence data on a local and regional level. (DBHDS, 2011b).
2. Use evidence based professional guidelines and surveys to assess the cultural competency capacity of Virginia’s publicly-funded and privately-funded substance and alcohol programs that serve minors. In addition to race, culture, and ethnicity, include linguistic capacity, readability of educational documents, and affordable treatment options.

3. Provide cultural competency trainings for employees of hospitals, including how to access language services and cross-cultural conflict resolution.

4. When the CSBs provide information to hospitals about alcohol and substance abuse services, ensure that there is some set of programs that are free or low-cost for people with lower-income or have no health insurance coverage. Program descriptions should also indicate languages spoken at those programs.

5. Ensure that materials are available in multiple languages and that language assistance is available at hospitals.

Process Observations/ Reflections

Confident and eager to embark upon the new challenge, MPLI Team 1 created and signed the Team Project Development document in May. Armed with strategies to resolve conflict, manage individual work styles, and negotiate decision making, the task of analyzing the racial impact of HB 1075 began. As the project unfolded, we were challenged by finding time to work on the assignment, flexibility, punctuality, and communication. We soon realized that groups are dynamic and everyone has their own work style and that a team project cannot be done in a silo. Despite our challenges, we were able to reconvene at the Congressional Black Caucus Convention in Washington, DC. Recharged and committed to excellence, we were able to have an honest and open dialogue about the process, capitalize on our strengths, take advantage of the interdisciplinary approaches, and adhere to the established deadlines. The project began to gain momentum and we were able to effectively use document sharing technology, conference calls, and humor to refine the document.

Conclusion

HB 1075/SB 201 was created in an effort to educate and include minors and their families in the hospital discharge process. Despite its intention of inclusion, it could create barriers to implementation if existing inequities in access due to income, language, education, and health insurance coverage among racial and ethnic minorities are not addressed. Our research demonstrates that despite the growing number of racial and ethnic minorities in the United States, they continue to be overrepresented in factors that lead to health disparities. In order for legislation such as HB 1075/SB 201 to be effective in changing health outcomes, policy makers, stakeholders, health professionals, service providers, families, and individuals must address the issues of race, ethnicity, and culture and how it impacts how people access and utilize services; gain knowledge and awareness of the problem and treatment options; and the quality of care.

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Racial Impact Analysis: HB 1075

Presented by: Ms. Patrice Banks
Ms. Cydny Neville
Ms. Sookyung Oh
Mr. Keith Rogers


Hypothetically

What would you do?



Hypothetically

What would you do?



Meet Alicia Lannes



Photo courtesy of www.fairfaxtimes.com

Alicia's Story



Alicia's Compass

Alicia's family did not want her struggles to be in vain, so here is what they did...

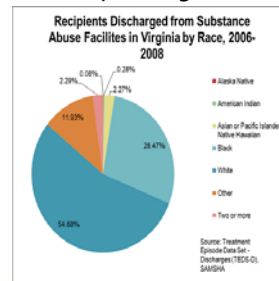
with some assistance from the Sully District Supervisor Michael Frey, Delegate Tim Hugo, and Senator Dave Marsden.

Introducing HB 1075

- ▶ "It is a shame that a young person's tragic death is what is required to improve our services and improve communication to those who are suffering from substance abuse. This bill is the first small step towards that end," Del. Marsden
- ▶ "Any young person struggling with substance or alcohol abuse should be given the support and resources necessary to recover and restore their path towards a healthy, successful life," Del. Hugo

Racial Impact Issues

- ▶ *Who is affected by the legislation and to what extent?*



Racial Impact Issues (cont'd)

- ▶ Language Barriers

Speak English less than "very well"	# of individuals	Share of total VA population
Spanish	216,855	2.90%
Other Indo-European languages	69,478	0.90%
Asian and Pacific Islander language	107,904	1.40%
Other languages	26,875	0.40%

Source: 2011 American Community Survey, 1-year estimates

Racial Impact Issues (cont'd)

- ▶ Insurance

Race	# Uninsured	Uninsured Rate
White	573,584	10.40%
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Other	63,229	37.40%
Two or more races	31,123	13.30%

Source: 2011 American Community Survey, 1-year estimates

Recommendations

- ▶ Expand youth and young adult data.
- ▶ Assess the cultural competencies associated with HB1075.
- ▶ Community Service Boards should provide a resource of programs to hospitals, to share with patients when discharged.
- ▶ Ensure that materials are available in multiple languages and that language assistance is available at hospitals.

Conclusion

Community leaders must educate, advocate, and normalize treatment and recovery so that the people who need treatment and services receive them. Creating ethical, culturally sensitive organizations and policies that promote a variety of treatment options, programs, and services will improve health outcomes for individuals, families and communities.

Discussion

