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Racial/Ethnic Differences in Initiation of and Engagement With Addictions Treatment Among Patients With Alcohol Use Disorders in the Veterans Health Administration☆,☆☆,★

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ABSTRACT

Objective: Specialty addictions treatment can improve outcomes for patients with alcohol use disorders (AUD). Thus, initiation of and engagement with specialty addictions treatment are considered quality care for patients with AUD. Previous studies have demonstrated racial/ethnic differences in alcohol-related care but whether differences exist in initiation of and engagement with specialty addictions treatment among patients with clinically recognized alcohol use disorders is unknown. We investigated racial/ethnic variation in initiation of and engagement with specialty addictions treatment in a national sample of Black, Hispanic, and White patients with clinically recognized alcohol use disorders (AUD) from the US Veterans Health Administration (VA).

Methods: National VA data were extracted for all Black, Hispanic, and White patients with a diagnosed AUD during fiscal year 2012. Mixed effects regression models estimated the odds of two measures of initiation (an initial visit within 180 days of diagnosis; and initiation defined consistent with Healthcare Effectiveness Data and Information Set (HEDIS) as a documented visit ≤14 days after index visit or inpatient admission), and three established measures of treatment engagement (≥3 visits within first month after initiation; ≥2 visits in each of the first 3 months after initiation; and ≥2 visits within 30 days of HEDIS initiation) for Black and Hispanic relative to White patients after adjustment for facility- and patient-level characteristics.

Results: Among 302,406 patients with AUD, 30% (90,879) initiated treatment within 180 days of diagnosis (38% Black, 32% Hispanic, and 27% White). Black patients were more likely to initiate treatment than Whites for both measures of initiation [odds ratio (OR) for initiation: 1.4, 95% confidence interval (CI) 1.4–1.4; OR for HEDIS initiation: 1.1, 95% CI: 1.1–1.1]. Hispanic patients were more likely than White patients to initiate treatment within 180 days (OR: 1.2, 95% CI 1.2–1.3) but HEDIS initiation did not differ between Hispanic and White patients. Engagement results varied depending on the measure but was more likely for Black patients relative to White for all measures (OR for engagement in first month: 1.1, 95% CI: 1.0–1.1; OR for engagement in first three months: 1.2, 95% CI: 1.1–1.2; OR for HEDIS measure: 1.1, 95% CI: 1.0–1.1), and did not differ between Hispanic and White patients.

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Conclusions: After accounting for facility- and patient-level characteristics, Black and Hispanic patients with AUD were more likely than Whites to initiate specialty addictions treatment, and Black patients were more likely than Whites to engage. Research is needed to understand underlying mechanisms and whether differences in initiation of and engagement with care influence health outcomes.

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1. Introduction

Alcohol use disorders (AUD) are common, with 7.2% of the US population meeting diagnostic criteria based on structured interviews (National Institute of Alcohol & Alcoholism, 2015), and associated with substantial morbidity and mortality (Roerecke & Rehm, 2013, 2014; Room, Babor, & Rehm, 2005). The prevalence of AUD varies by race/ethnicity, with White individuals more likely to have AUD than Black or Hispanic individuals (Chartier & Caetano, 2010; Grant et al., 2004). However, among people with AUD, the burden of alcohol-related consequences is borne disproportionately by racial/ethnic minorities (Chartier, Hesselbrock, & Hesselbrock, 2013; Mulia, Ye, Greenfield, & Zemore, 2009). Among people with AUD, Black and Hispanic individuals are more likely than White individuals to report alcohol-related consequences (e.g., workplace or legal) (Mulia et al., 2009; Schmidt, Greenfield, & Mulia, 2006) and to suffer from alcohol-related medical conditions, such as liver disease (Flores et al., 2008).

Specialty addictions treatment, including substance use disorder inpatient or outpatient treatment, is effective for patients with AUD (Dawson, Grant, Stinson, & Chou, 2006; Weisner, Matzger, & Kaskutas, 2003), but receipt of this care is generally low among individuals with AUD (Cohen, Feinn, Arias, & Kranzler, 2007; McGlynn et al., 2003). In the U.S., only 15% of people with AUD report receiving alcohol treatment (Cohen et al., 2007) and among VA patients in care, approximately 30% of patients with AUD receive treatment (Harris & Bowe, 2008; Harris, Bowe, Finney, & Humphreys, 2009).

Previous studies have identified multiple barriers to receipt of addictions treatment for individuals with AUD (Acevedo et al., 2012; Cohen et al., 2007). Because social conditions and access to resources, including health care, both serve as barriers to addictions treatment and vary across racial/ethnic groups in the US (Link & Phelan, 1995; Williams, 1999), receipt of addictions treatment may also vary across racial/ethnic groups. Because receipt of treatment for AUD may improve quality of life and reduce risk of adverse health outcomes (Dawson et al., 2006; Weisner et al., 2003), understanding whether addictions treatment is received equitably across racial/ethnic groups is important for efforts focused on decreasing racial/ethnic differences in alcohol-related outcomes.

The quality of treatment for AUD is often measured based on two dimensions: initiation of and engagement with addictions treatment (Harris, Humphreys, & Finney, 2007). Several previous studies, including one among patients from the Veterans Health Administration (VA), reported racial/ethnic differences in receipt of specialty care (Glass et al., 2010; Lê Cook & Alegría, 2011; Lo & Cheng, 2011; Weisner, Matzger, Tam, & Schmidt, 2002; Zemore et al., 2014). However, these studies have not examined racial/ethnic differences in dimensions of quality care (both initiation of and engagement in addictions treatment) among patients for whom addictions treatment is definitely indicated—those with clinically recognized AUD.

Additionally, racial/ethnic differences in dimensions of quality care may be confounded by a number of factors. A conceptual model describing pathways leading to racial/ethnic differences in alcohol-related care and outcomes (Williams, Lapham, et al., 2012), which is based on previous models of healthcare utilization (Aday & Andersen, 1974), depicts how race/ethnicity may affect utilization of addictions treatment. Race/Ethnicity, along with other predisposing characteristics (i.e., demographic and socio-economic factors such as gender), affect utilization of alcohol-related care by both determining available resources and influencing need for such services. Predisposing characteristics also influence enabling characteristics that determine resources (e.g., insurance status) and need characteristics including disease severity and comorbid conditions (e.g., drug use disorder), both of which influence receipt of alcohol-related care and outcomes as mediated or moderated by multiple levels of community and health-system factors. Therefore, the present study investigates variation in initiation of and engagement with addictions treatment in general medical and specialty settings across three major racial/ethnic groups represented in a large national sample of VA patients with clinically recognized AUD. We estimated patient-level differences in initiation and engagement as defined by quality metrics commonly used by healthcare systems to assess high quality care and adjusted for measured predisposing, enabling, and need characteristics that could confound racial/ethnic differences.

2. Materials and methods

2.1. Data source and study sample

Administrative data from the VA's National Patient Care Database were extracted for all VA patients who received outpatient or inpatient/residential care in VA during Fiscal Year (FY) 2012 (10/1/11–9/30/12), were 18 years or older, and had information regarding race/ethnicity documented (n = 4,790,035). Patients were included in the analytic sample for this study if they were documented to be Black, Hispanic, or White race/ethnicity (n = 4,666,403; 97% of all those with documented race/ethnicity) and to have a clinically recognized AUD, defined as documentation of International Classification of Diseases 9th Edition (ICD-9) diagnoses for alcohol abuse and dependence, as well as several alcohol-attributable conditions (e.g., alcoholic cirrhosis) in any clinical encounter during the fiscal year (n = 302,406; 6.5%) (diagnoses were not necessarily incident). This definition is consistent with the Healthcare Effectiveness Data and Information Set (HEDIS) denominator specification (National Committee for Quality Assurance, 2011), and includes alcohol-attributable conditions because AUD often goes unrecognized in clinical settings and, when recognized, is likely to be documented in varying ways. Patients with unknown race, and those documented to be Asian/Pacific Islander and American Indian/Alaska Native were excluded from this study because of small sample sizes, consistent with previous work (Williams, Bradley, Gupta, & Harris, 2012; Williams, Lapham, et al., 2012). This study was reviewed and approved by both the Internal Review Boards at Stanford University and the VA Palo Alto Healthcare System.

2.2. Measures

2.2.1. Main independent variable of interest

2.2.1.1. Race/Ethnicity. Race/Ethnicity was categorized as non-Hispanic Black, Hispanic, and non-Hispanic White, consistent with recommendations from the US Office of Management and Budget (Office of Budget and Management, 1997). Because patients could identify with multiple racial/ethnic groups, race/ethnicity was hierarchically coded, first as Hispanic ethnicity, and then as Black and then White, consistent with single-race/ethnicity classification by rarest to most common racial/ethnic groups (Mays, Ponce, Washington, & Cochran, 2003).