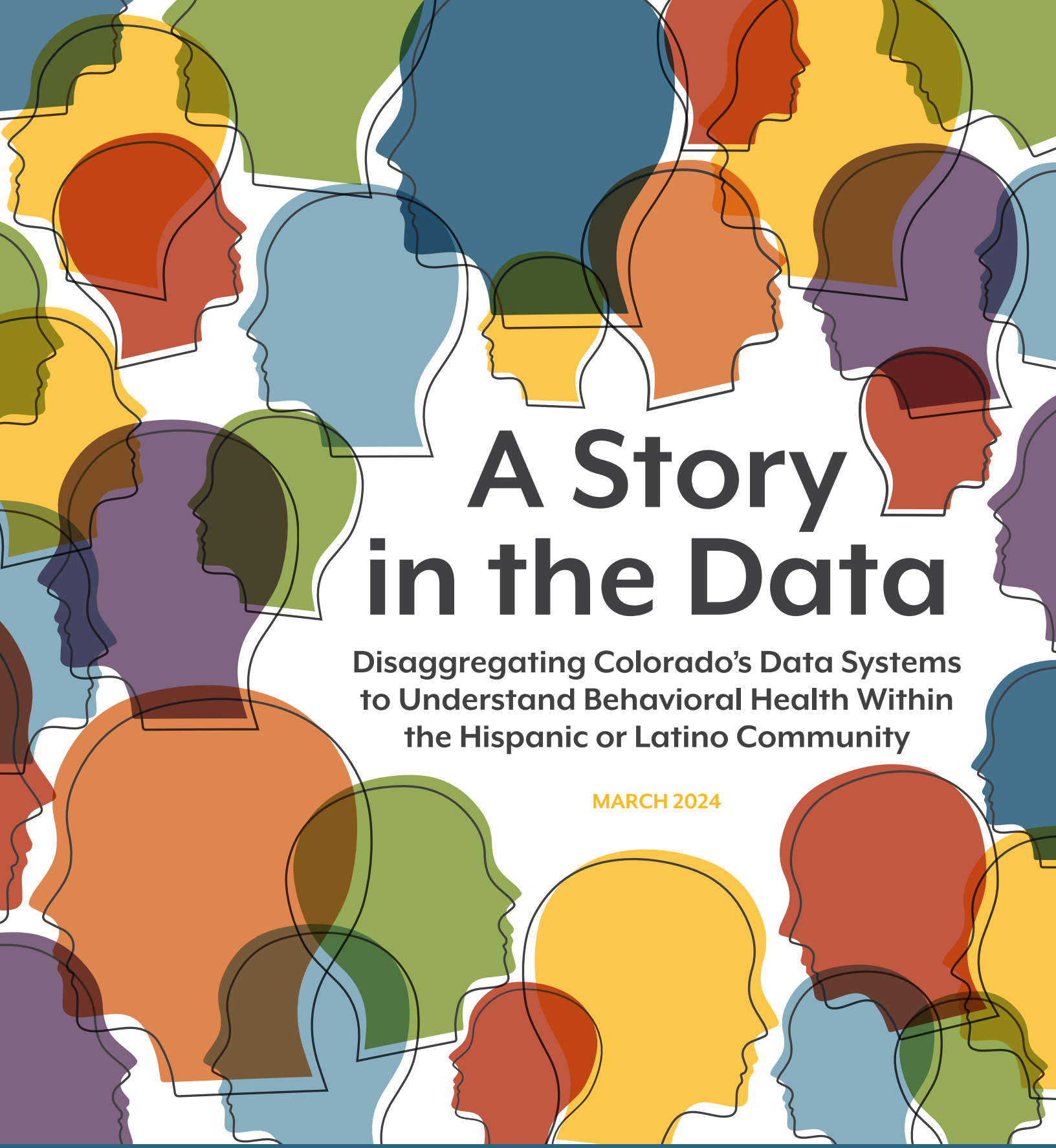


A Story in the Data

Disaggregating Colorado's Data Systems to Understand Behavioral Health Within the Hispanic or Latino Community

MARCH 2024

COLORADO **HEALTH** INSTITUTE

Informing Strategy. Advancing Health.

A Story in the Data

Disaggregating Colorado's Data Systems to Understand Behavioral Health Within the Hispanic or Latino Community

UCLA Center for Health Policy Research

The Colorado Health Institute thanks AJ Scheitler, EdD, Ninez Ponce, MPP, PhD, and Susan Babey, PhD, at the UCLA Center for Health Policy Research for their guidance and support of this project. CHI also thanks the community members who shared their personal stories and experiences, which provided important context that shaped this report. CHI completed this work with support from the Robert Wood Johnson Foundation.

Executive Summary

A new analysis by the Colorado Health Institute (CHI) found differences in how people engage with behavioral health care. Data show that within the Hispanic or Latino community, there are many unique identities that have different patterns of accessing behavioral health care.

Behavioral health care access has been at the forefront of policy and decision-making as many more people sought treatment during and after the COVID-19 pandemic. Understanding access and use among distinct populations in Colorado is equally important, as many people face barriers that make it difficult, or often seemingly impossible, to get care.

In partnership with the University of California, Los Angeles (UCLA) Center for Health Policy Research, CHI has worked the last three years to explore strategies to disaggregate racial and ethnic data within Colorado's major health data systems. The goal of this process is to understand whether members of the Hispanic or Latino community in Colorado have access to important behavioral health care services.

CHI has approached this work in three phases. Phase I assessed methods to disaggregate data. In Phase II, CHI applied predictive modelling methods developed from Phase I and analyzed the confidence and reliability of those methods. In Phase III, CHI used the models developed in the first two phases to understand behavioral health care use, diagnosis, and mode of delivery. The two major datasets that were analyzed in Phase III are:

- Colorado All Payer Claims Database (CO APCD)
- Colorado Health Observation Regional Database Service (CHORDS)

CHI engaged with community groups and behavioral health providers during Phase III to better understand the implications of disaggregated data, questions that arose about these data, and possible considerations around policies or programs to address differences in behavioral health access. CHI thanks those community members for their participation.

Their thoughtful responses and critiques raised awareness of key issues impacting communities in Colorado and what could be done to address them moving forward.

Key findings and reflections from the third phase of CHI's analysis include:

- ***Hispanic or Latino community members have similar rates of behavioral health diagnoses compared with the state average, though there are some differences across specific groups.***
- ***However, Hispanic or Latino community members are not accessing behavioral health care to the same degree as the Colorado average.***
- ***Many in Colorado used telemedicine services the last few years, and those who are Hispanic or Latino were no exception. Hispanic or Latino Coloradans were more likely to use telemedicine than the state average. However, these visits were less likely to be related to behavioral health care.***

This information will be shared with community partners, decision-makers, and other stakeholders to ensure the findings are getting to those who can use them. Next phases of work could focus on the cost burden of behavioral health services on different communities in Colorado. Future phases of work could also focus on disaggregating racial or ethnic data for other groups, such as Asian identity, another diverse community in our state.

Introduction

Why This Work Matters

According to the 2021 Colorado Health Access Survey (CHAS), more Coloradans than ever report that they experience poor mental health. About one in four Coloradans said they experienced eight or more poor mental health days in the last month. Impacts from the COVID-19 pandemic, such as isolation, job loss, or death and illness, affected and continue to affect many people and their mental health.

Members of racial and ethnic minority populations experienced the pandemic differently, with many people of color especially impacted by the fallout from COVID. Their rates of suicide disproportionately increased between 2010 and 2020 compared with their white peers. Paired with a lack of culturally relevant and responsive treatment and structural barriers to accessing care, many people of color were unable to get the kind of behavioral health care that they needed. Given that many cannot get needed care, this could also mean many have mental health or substance use issues that have gone undiagnosed.[1]

Based on data from the 2021 CHAS, Coloradans who speak Spanish as their preferred language were less likely to use health care services in the last year compared with English speakers.[2] Spanish speakers were also more likely to face barriers to getting treatment. The 2022 American Community Survey found that about 16% of the state's population age 5 and older speak a language other than English at home.[3] Ensuring that people have access to timely, responsive, and culturally relevant care is vital.

Another important factor is the cost of health care coverage. Members of the Hispanic or Latino community in Colorado are much more likely to be uninsured compared with their white counterparts, according to the CHAS.[4] Many of these individuals might not get needed care because they don't have health insurance and can't afford expensive medical or behavioral health bills.

Members of racial and ethnic minority groups face historical and systemically rooted inequities in the United States that continue to create health, social, and economic disparities. In general, data sources used to analyze these disparities rely on only a handful of racial and ethnic categories, including American Indian or Alaska Native, African American or Black, Asian, Native Hawaiian or Other Pacific Islander, Hispanic or Latino, and White. These broad categories do not reveal the unique perspectives, experiences, and cultural significance of specific ethnic or racial communities. Data disaggregation can be used to showcase these often unknown or overlooked communities.

Data disaggregation is the method of taking information about a large group and describing this information for more specific populations. This method helps researchers and decision-makers understand trends or patterns that might have otherwise been missed. Culture, identity, race, national origin, and ethnicity are incredibly complex and influence how someone interacts within social, economic, and political environments. Identity can also change over time and adapt to societal shifts in how we speak, understand, and relate to new experiences.

Coloradans who speak Spanish as their preferred language were less likely to use health care services in the last year compared with English speakers. Spanish speakers were also more likely to face barriers to getting treatment.

Disaggregating data plays a critical role in advancing health equity. A person's unique lived experience and identity are often lost when information about them is aggregated into a less meaningful racial or ethnic category. This aggregation can hide an existing inequity that might perpetually be unacknowledged.[5]

Over the past three years, CHI, in partnership with the UCLA Center for Health Policy Research with funding from the Robert Wood Johnson Foundation, has investigated ways to use data disaggregation to better understand Colorado's communities and identify conditions that create barriers to accessing care, poor health outcomes, and utilization of preventive and other health care services. CHI's efforts have focused on the state's large Hispanic or Latino community.

Based on the 2022 American Community Survey (ACS), about 1.3 million people in Colorado identify as Hispanic or Latino, about a fourth of the state's population.[6] This is a unique and diverse community. For example, nearly 58,000 people identify as Central American, 54,000 as South American, and about 47,000 as Puerto Rican.[7] And these are just a few of the distinctive communities that call Colorado home. Each of these communities has its own views about decisions that affect its members, their representation in Colorado's systems at large, and how they interact with these systems, including health care.

Additional objectives of this work include elevating the communities represented in the data and informing organizations, policymakers, and other decision-makers who might not be familiar with the challenges these communities face. Ensuring communities that need behavioral health care have access to it is integral to helping people live healthy, vibrant lives.

Where We Have Been

During the first phase of work, completed in June 2021, CHI investigated potential approaches to disaggregating data. This phase produced a roadmap for using predictive modelling to disaggregate data in Colorado's data systems. During this phase, CHI also added items about disaggregated racial and ethnic identities to the CHAS to collect information to use in future phases.

In the second phase of work, completed in January 2023, CHI developed statistical models using the CHAS to predict the likelihood that an individual identified as a specific identity within the Hispanic or Latino community. The identities that were available on the CHAS to investigate included Caribbean or Central American, Chicano, Latinx, Mexican or Mexican American, Spanish American, or South American. Models that provided CHI with enough statistical confidence and certainty to accurately predict an identity as an outcome were Caribbean or Central American, South American, and Spanish American. For more information on the statistical modelling methods, please refer to the accompanying Phase II report. For more information on definitions of the four behavioral health conditions, refer to the accompanying Phase III methods document.

CHI applied these models to two Colorado health care data systems to disaggregate the racial and ethnic data within them. These data systems are the CHORDS, which brings together data from many Front Range health systems' electronic health records, and the Colorado All Payer Claims Database (CO APCD), a collection of claims data managed by the Center for Improving Value in Health Care. Using predictive models, CHI was able to research behavioral health diagnoses, utilization of services, and how treatment was delivered for these three distinct identities within the Hispanic or Latino communities — Caribbean or Central American, South American, and Spanish American.

Where We Are

In the third phase of work, CHI applied the regression models and predicted which people may identify as a unique Hispanic or Latino identity. Using these predictions, CHI was able to research behavioral health diagnoses, utilization of services, and how behavioral care was delivered for these distinct identities.

CHI sought to answer the following research questions:

- How do behavioral health diagnoses differ among people who identify as Hispanic or Latino?
- How does behavioral health care utilization of services differ among people who identify as Hispanic or Latino?
- Are there differences in the mode in which care is delivered among Hispanic or Latino identities (telehealth vs. in-person visits)?

Providing Context to the Data

Data without context cannot tell the entire story. CHI also engaged with community groups and members to better understand what differences in outcomes, utilization, and other aspects of behavioral health care mean for the Hispanic or Latino community in the state. Stories and context paint a more holistic picture of what behavioral health looks like and how access is impacted across our diverse communities. CHI thanks these community members for sharing their experiences with us.

Overview of Data Sources

The Colorado Health Observation Regional Health Data Service (CHORDS): CHORDS is a network of health systems and providers that uses electronic health record (EHR) data to identify health trends and support public health evaluation and monitoring efforts. Fourteen providers and health systems participate in the CHORDS network, supporting chronic disease surveillance across Colorado's counties. CHORDS data are mostly representative of the metro Denver region of the state, which includes Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson counties. Data are also only representative of people seeking health care services and are not a random sample of the underlying population.

The Colorado All Payer Claims Database (CO APCD): The CO APCD comprehensive claims dataset involves most insured people in Colorado and includes more than 40 commercial payers, Medicaid, and Medicare. The CO APCD is a state-legislated, secure health care claims database. The sophistication and scale of the database continually grows, with millions of claims submitted each month by health insurance payers representing over 70% of medically covered lives in Colorado. Submission of Employee Retirement Income Security Act-based self-insured employer claims is voluntary, so most data generated from Employee Retirement Income Security Act-based self-insured entities are not included in the database. Individuals lacking health insurance are also not represented in the CO APCD. This could impact the generalizability of some of the estimates and may require limiting of the datasets when linking.

When discussing these two datasets throughout the report, claims data will refer to the CO APCD dataset, while health visit data will refer to the CHORDS dataset. The term patients refers to those Coloradans who received health care services and whose data are included in the CHORDS and CO APCD databases.

Considerations

Both datasets provide an incredible amount of information. The CHORDS is more limited to specific counties in Colorado, whereas the CO APCD only represents the insured population, with some insurance coverage types not always included. A single visit to a doctor or therapist may involve more than one procedure. Data from CO APCD have been aggregated to a primary diagnosis code, representing the main reason a patient sought care. This could result in some claims not showing that a behavioral health service was included in the visit if the person originally made an appointment for another reason, or multiple issues were brought up during the visit. Claims and health visits data included duplicate individuals, as the same person could seek care more than once in a given year and from multiple providers. This means that there could be multiple visits or claims included for the same individual.

Between the CHORDS and CO APCD data, there are often differences between the two datasets for the same ethnic identity. This can be due to many factors. For example, CHORDS is regional and includes a few community mental health centers (CMHCs), but not all of them. These CMHCs may serve some communities more than others, whereas the CO APCD is statewide.

Demographic information is not always reported, which may result in a lower number of visits with accurate racial or ethnic data. Conditions that were studied in the CO APCD match the same parameters provided by CHORDS partners for how they define certain behavioral health conditions. These parameters are outlined in the accompanying methodology document. These include depression, anxiety, bipolar disorder, and substance use disorder. Many more behavioral health conditions and diagnoses exist, but this report will be limited to those four. A 95% confidence interval was provided in the tables to understand key differences.

A Community Behavioral Health Care Analysis: Diagnoses, Utilization, and Telemedicine

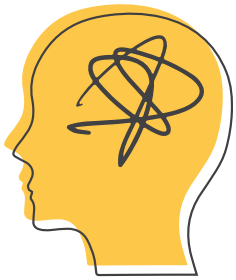
Behavioral Health Diagnoses within the Hispanic or Latino Community

Access to behavioral health services is integral in reducing more acute issues over a person's lifetime as early intervention can reduce negative outcomes. However, many barriers can limit someone's ability to engage with the behavioral health system. Information on behavioral health diagnoses from claims and health visit data is outlined in the following sections.

Depression

About 12% to 13% of patients in Colorado had a depression diagnosis between 2016 and 2021, based on billed claims and health visit data (see Figure 1). About 11% to 13% of Hispanic or Latino patients had a depression diagnosis. Overall rates of depression for the Hispanic or Latino community varied across the two datasets. Based on the claims data, Caribbean or Central American patients had the highest rate of depression (14.3%). However, based on health visit data, they had a lower rate of depression (7.3%). These percentages represent nearly 88,000 Hispanic or Latino people who are living with a depression diagnosis across the state, based on claims data.

Anxiety

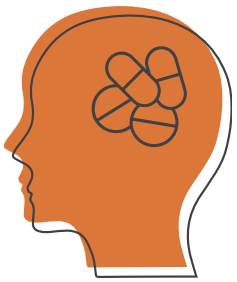


About 13% to 14% of patients in Colorado had an anxiety diagnosis based on the claims and health visit data (see Figure 2). Within the Hispanic or Latino community, there were some differences to highlight. Caribbean or Central American patients had a slightly higher rate based on the claims data (16.7%), but a lower rate based on health visit data (9.2%). Based on the health visit data, Spanish American patients had a higher rate of anxiety (14.7%), but a lower rate based on claims data (12.3%). These percentages represent over 95,000 Hispanic or Latino people living with anxiety.

Bipolar Disorder

About 2% to 3% of patients had a bipolar disorder diagnosis in Colorado based on the claims and health visit data between 2016 to 2021 (see Figure 3). This is a similar observation for Hispanic or Latino patients. Within the Hispanic or Latino community, there is some variability. Caribbean or Central American patients had a slightly higher rate according to the claims data (3.2%), but a much lower rate compared with the health visit data (0.5%). This can also be seen for South American individuals as well (2.7% compared to 0.6%, respectively).

Substance Use Disorder



About 1% to 3% of Colorado patients had a substance use disorder diagnosis between 2016 and 2021 based on the claims and health visit data (see Figure 4). About 2% to 3% of Hispanic or Latino patients had a substance use diagnosis during this same time period. There are some differences within the Hispanic or Latino identities. Caribbean or Central American individuals had a higher rate of substance use diagnosis based on claims data (2.2%), while the Spanish American group had a higher rate based on both claims and health visit data (1.8% to 6.7%, respectively).

Figure 1. Percentage With a Depression Diagnosis by Hispanic or Latino Identity, 2016-2021

Population	CO APCD		CHORDS	
	Number	Percentage (Confidence Interval)	Number	Percentage (Confidence Interval)
Colorado	**633,490**	**12.66% (12.63%, 12.69%)**	**204,734**	**12.26% (12.21%, 12.31%)**
Hispanic or Latino	**87,596**	**13.15% (13.07%, 13.23%)**	**52,673**	**10.97% (10.89%, 11.06%)**
Caribbean or Central American	29,871	14.34% (14.19%, 14.49%)	8,763	7.33% (7.19%, 7.48%)
South American	6,313	13.91% (13.56%, 14.23%)	7,545	10.28% (10.07%, 10.50%)
Spanish American	8,533	13.43% (13.16%, 13.69%)	7,453	14.02% (13.72%, 14.31%)

Figure 2. Percentage With an Anxiety Diagnosis by Hispanic or Latino Identity, 2016-2021

Population	CO APCD		CHORDS	
	Number	Percentage (Confidence Interval)	Number	Percentage (Confidence Interval)
Colorado	**661,175**	**13.21% (13.18%, 13.24%)**	**233,571**	**13.98% (13.93%, 14.04%)**
Hispanic or Latino	**95,187**	**14.29% (14.20%, 14.37%)**	**62,292**	**12.98% (12.88%, 13.07%)**
Caribbean or Central American	34,872	16.74% (16.58%, 16.90%)	10,982	9.19% (9.03%, 9.36%)
South American	6,711	14.79% (14.46%, 15.11%)	8,015	10.93% (10.70%, 11.15%)
Spanish American	7,837	12.33% (12.08%, 12.59%)	7,818	14.70% (14.40%, 15.01%)

Figure 3. Percentage With a Bipolar Disorder by Hispanic or Latino Identity, 2016-2021

Population	CO APCD		CHORDS	
	Number	Percentage (Confidence Interval)	Number	Percentage (Confidence Interval)
Colorado	**140,742**	**2.81% (2.80%, 2.83%)**	**39,012**	**2.34% (2.31%, 2.36%)**
Hispanic or Latino	**18,239**	**2.74% (2.70%, 2.78%)**	**7,919**	**1.65% (1.61%, 1.69%)**
Caribbean or Central American	6,587	3.16% (3.09%, 3.24%)	571	0.48% (0.44%, 0.52%)
South American	1,202	2.65% (2.50%, 2.80%)	416	0.57% (0.51%, 0.62%)
Spanish American	1,361	2.14% (2.03%, 2.25%)	1,430	2.69% (2.55%, 2.83%)

Figure 4. Percentage With a Substance Use Disorder by Hispanic or Latino Identity, 2016-2021

Population	CO APCD		CHORDS	
	Number	Percentage (Confidence Interval)	Number	Percentage (Confidence Interval)
Colorado	**52,803**	**1.06% (1.05%, 1.06%)**	**44,962**	**2.69% (2.67%, 2.72%)**
Hispanic or Latino	**9,891**	**1.48% (1.46%, 1.51%)**	**13,200**	**2.75% (2.70%, 2.80%)**
Caribbean or Central American	4,504	2.16% (2.10%, 2.22%)	1,999	1.67% (1.60%, 1.75%)
South American	257	0.57% (0.50%, 0.64%)	1,762	2.40% (2.29%, 2.51%)
Spanish American	1,129	1.78% (1.67%, 1.88%)	3,538	6.65% (6.44%, 6.87%)

Use of Care by the Hispanic or Latino Community

CHI used the claims data to understand more about behavioral health care use within the Hispanic or Latino community between 2019 and 2021. Figure 5 describes the percentage and number of claims billed related to behavioral health diagnoses involving specific Hispanic or Latino communities.

In many instances, claims involving specific Hispanic or Latino communities were less likely to be related to behavioral health care. For example, 2.5% of total claims statewide were related to depression diagnoses between 2019 and 2021. Claims involving Hispanic or Latino patients were less likely to be related to a depression diagnosis, at 1.5%. Within the Hispanic or Latino community, claims involving Spanish American patients were much lower, at 0.8%, while those who were South American had a rate closer to the state average, at 2.1%.

This is a comparable finding across other behavioral health diagnoses. One difference is claims related to a substance use diagnosis. Claims involving a patient who was Central American or Caribbean were more likely to be related to a substance use disorder (0.3%) compared with the state or other Hispanic or Latino identities.

Average Number of Visits

Data reflecting the average number of visits per behavioral health condition can be used to illustrate how often populations engage with the health care system to treat a certain condition. However, a person might be limited to the number of visits per year under their insurance coverage. For example, Medicaid in Colorado covers six short-term behavioral health visits in a primary care setting per fiscal year.[8] This could impact how many visits individuals seek for a given condition; exceeding that limit may result in out-of-pocket costs that might be too expensive for people or families to pay.

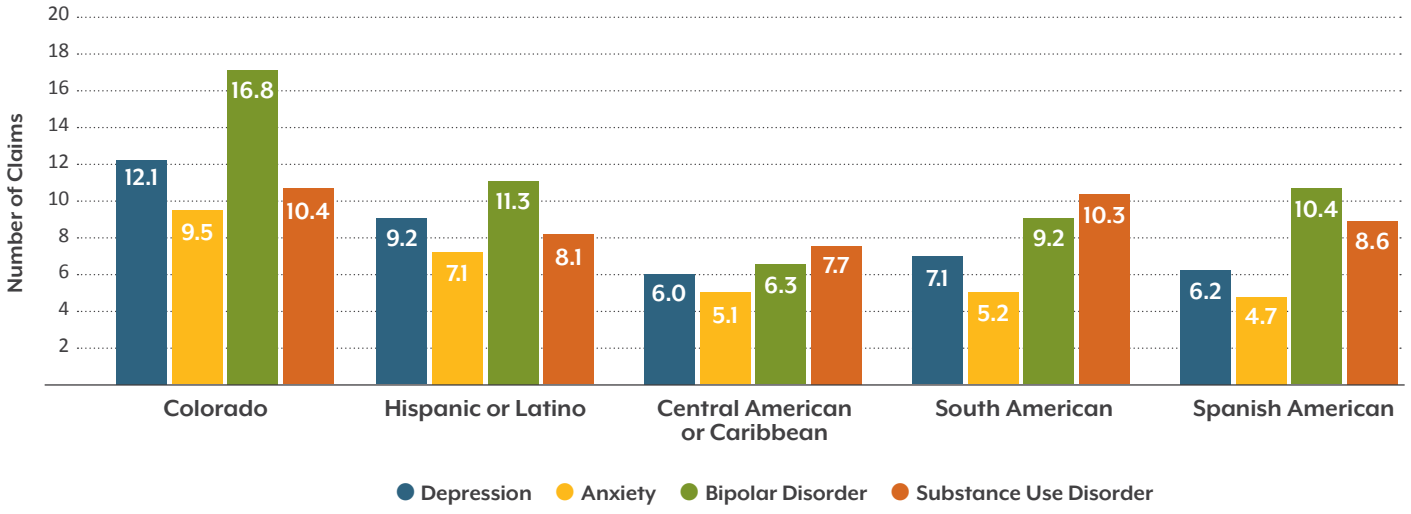
Figure 6 displays the average number of claims billed for individuals for each of the four behavioral health conditions studied. These include individuals who had at least one claim billed for the given behavioral health condition. In Colorado, about 12 claims were billed per person with a depression diagnosis between 2019 and 2021. This compares with about 17 claims billed per person for a bipolar disorder and about 10 claims billed per person for those with anxiety or a substance use disorder.

Figure 5. Percentage and Number of Claims That Were Related to Specific Behavioral Health Conditions Involving Hispanic or Latino Community Members, 2019-2021

Population	Depression		Anxiety	
	Number	Percentage (Confidence Interval)	Number	Percentage (Confidence Interval)
Colorado	**4,429,794**	**2.45% (2.44%, 2.45%)**	**4,012,582**	**2.22% (2.21%, 2.22%)**
Hispanic or Latino	**181,901**	**1.45% (1.44%, 1.46%)**	**172,775**	**1.38% (1.37%, 1.38%)**
Caribbean or Central American	41,424	1.46% (1.45%, 1.47%)	47,682	1.68% (1.67%, 1.70%)
South American	16,931	2.06% (2.03%, 2.09%)	14,434	1.76% (1.73%, 1.79%)
Spanish American	12,098	0.81% (0.80%, 0.82%)	8,496	0.57% (0.56%, 0.58%)

Population	Bipolar Disorder		Substance Use Disorder	
	Number	Percentage (Confidence Interval)	Number	Percentage (Confidence Interval)
Colorado	**1,277,133**	**0.71% (0.70%, 0.71%)**	**383,840**	**0.21% (0.21%, 0.21%)**
Hispanic or Latino	**32,927**	**0.26% (0.26%, 0.27%)**	**21,106**	**0.17% (0.17%, 0.17%)**
Caribbean or Central American	6,366	0.22% (0.22%, 0.23%)	9,619	0.34% (0.33%, 0.35%)
South American	3,225	0.39% (0.38%, 0.41%)	676	0.08% (0.08%, 0.09%)
Spanish American	2,068	0.14% (0.13%, 0.14%)	1,730	0.12% (0.11%, 0.12%)

Figure 6. Average Number of Claims Billed per Person for Behavioral Health Conditions by Hispanic or Latino Identity, 2019-2021



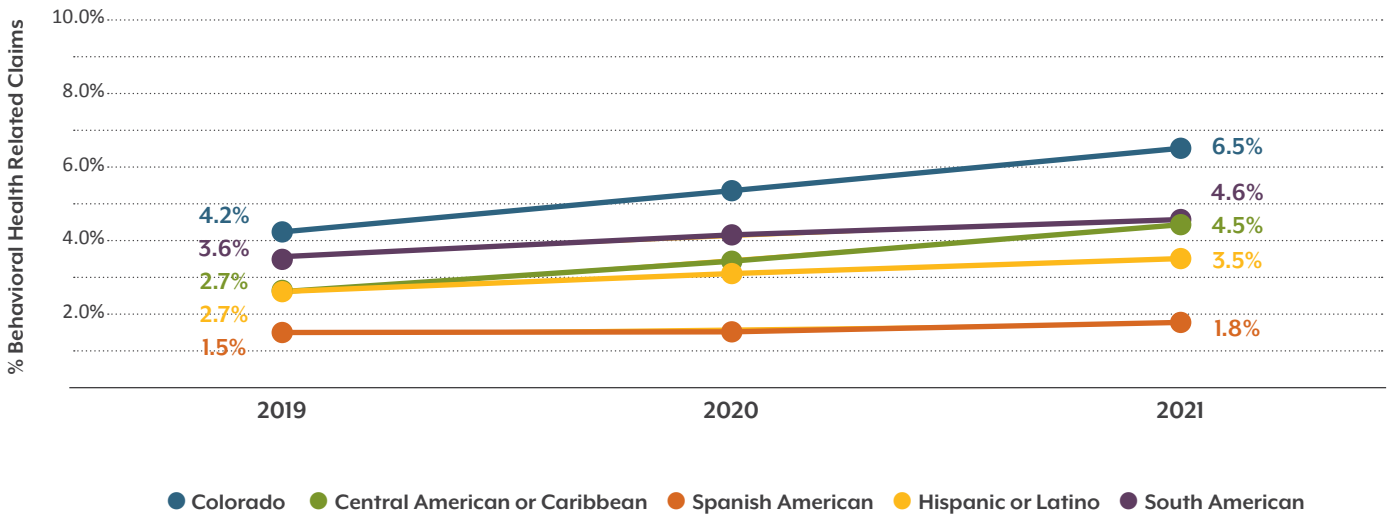
Hispanic or Latino individuals had a lower average number of claims billed per person for each of the four behavioral health conditions compared to the state average. And within the Hispanic or Latino community, average number of claims were lower. Central American or Caribbean and Spanish American people had about six claims for depression-related diagnoses, half the average of the state. Those who were Central American or Caribbean had about six claims billed for bipolar disorder, nearly a third of the state average for this same condition. All identities besides those who were South American had fewer visits billed for a substance use disorder.

Utilization Over Time

The COVID-19 pandemic had a big impact on people's behavioral health, leading to increased need for services from 2020 onward. Measuring service utilization before and after the pandemic is important to understand this increased need and to pinpoint differences in the use of available services. Behavioral health care utilization increased over time, with the number of claims billed for depression, anxiety, bipolar disorder, and substance use increasing between 2019 and 2021 (see Figure 7).

For Colorado, the percentage of claims related to the four conditions increased from 4.2% to 6.5% over the three-year period. For the overall Hispanic or Latino community, the increase was from 2.7% to 3.5%. Within the Hispanic or Latino community, however, there wasn't as much of an uptick in claims billed for the four conditions. Claims related to behavioral health care involving Spanish American individuals stayed consistent at less than 2% of all claims. South American and Central American or Caribbean individuals saw small increases, with claims rising to a little under 5%, higher than the overall Hispanic or Latino rate. However, overall, the Hispanic or Latino community has utilized care to a lesser degree than the overall state population according to the claims data.

Figure 7. Percentage of Claims That Were Behavioral Health Related by Hispanic or Latino Identity, 2019-2021*



*Behavioral health claims from the CO APCD were defined as those with a primary diagnosis of depression, anxiety, bipolar disorder, or substance use disorder.

How Care Is Delivered: Use of Telemedicine in Behavioral Health Care

Delivery of behavioral health care has changed over time. The COVID-19 pandemic expanded telemedicine services across Colorado and the country. Care via telemedicine can reduce some barriers, including limited access to transportation, time off from work, or child care. However, that does not mean telemedicine is perfect. Individuals still need a secure, reliable internet connection. Additionally, translation services for telemedicine in one's preferred language may not be consistent across providers and health care systems. Data from the CHORDS were used in the following sections.

Overall Use of Telemedicine by the Hispanic or Latino Community

Increased availability and better infrastructure have made telemedicine a good option for many patients during and after the COVID-19 pandemic. In Colorado, about 2.9% of people within the health visit data had at least one visit using telemedicine — for any type of health care service — between 2016 and 2021 compared with nearly 6% for Hispanic or Latino patients (see Figure 8). However, within this community, people were less likely to have used telemedicine, as each of the three identities had lower rates of telemedicine use during this time frame.

Figure 8. Percentage of Patients Who Have Had at Least One Telemedicine Visit by Hispanic or Latino Identity, 2016-2021

Population	Number	Percentage
Colorado	**48,692**	**2.92% (2.89%, 2.94%)**
Hispanic or Latino	**27,380**	**5.70% (5.64%, 5.77%)**
Caribbean or Central American	2,809	2.35% (2.27%, 2.44%)
South American	1,228	1.67% (1.58%, 1.77%)
Spanish American	1,280	2.41% (2.28%, 2.54%)

Throughout the pandemic, many providers had to transition to online care due to shutdowns and other issues. Between 2019 and 2021, telemedicine visits increased from less than 1% to over 3% (see Figure 9). The highest rates were seen during the pandemic (over 4%), but rates of telemedicine use still exceed pre-pandemic rates.

Compared to the state, Hispanic or Latino patients' visits were more likely to be conducted using telemedicine, increasing from about 2% in 2019 to over 6% in 2021. However, rates for identities within the Hispanic or Latino community were lower, with South American patients' health visits conducted using telemedicine the lowest at less than 1% in 2021.

Figure 9. Percentage of Health Visits That Were Delivered Using Telemedicine by Hispanic or Latino Identity, 2019-2021

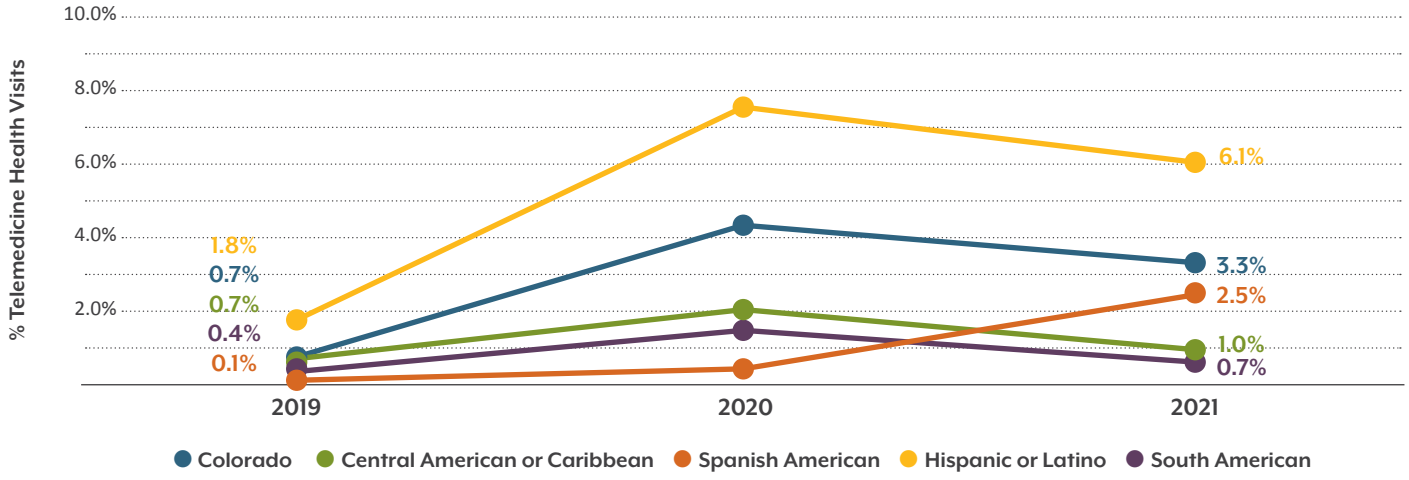
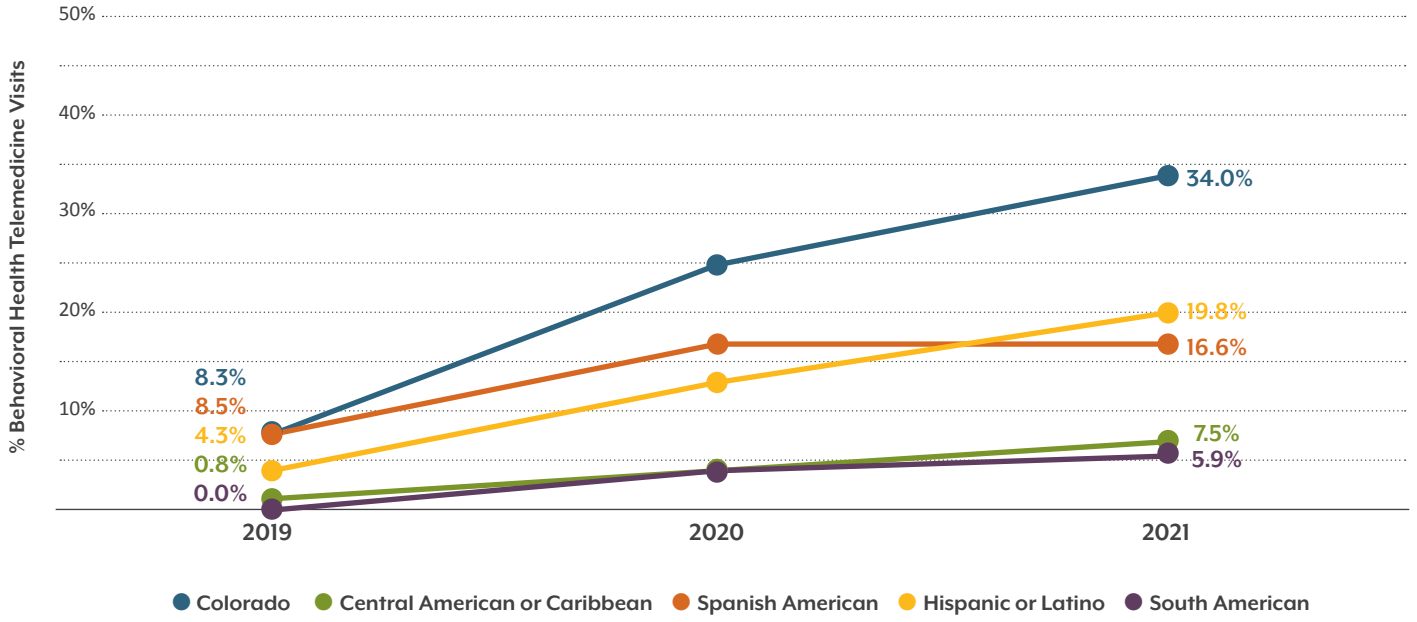


Figure 10. Percentage of Telemedicine Visits That Were Behavioral Health-Related by Hispanic or Latino Identity, 2019-2021



The percentage of behavioral health-related telemedicine visits has also risen over time (see Figure 10). In 2021, about one in three (34%) telemedicine visits were related to behavioral health. About one in five (20%) telemedicine visits provided to Hispanic or Latino patients were related to behavioral health — far less than the state average. Even fewer telemedicine visits — less than 10% — involved someone who was Caribbean or Central American or South American.

Although many Hispanic or Latino patients have used telemedicine since 2016, these visits appear less likely to be for behavioral health reasons. This could speak to people's preference of receiving in-person care for their behavioral health condition. Other factors at play could involve cultural relevancy. This could be any number of things, like whether the health visit includes translation or interpretation services as well as whether a person feels their provider can relate to their experiences or is culturally responsive. Systemic and structural barriers are also at play, as many processes and policies are often not created to include everyone. These factors are discussed in more detail in the next section.

Discussion

A Similar Story for Diagnosis, but a Different Story for Access

In many cases, patients in the Hispanic or Latino community had similar diagnosis rates of behavioral health conditions compared with the state average. There is variability, as Hispanic or Latino identities were diagnosed with these behavioral health issues at higher rates than the state. However, they often had lower rates of accessing care. The barriers that keep care out of reach are well documented. Cost is one of them. Many community members live at lower incomes than other racial or ethnic groups, making it a challenge to get affordable health care coverage.[9] As a result, they may forgo care to avoid crippling medical bills.

In addition, the health care system may not be seen as a welcoming place. Nationally, a recent Pew Research Center survey found that more than half of Hispanic or Latino adults reported that they have had one or more negative experiences in a health

care setting. About a quarter believed they received inferior care compared with others, and about another quarter reported they felt they were treated with less respect. Within the Hispanic or Latino community, those who also identified as Black were more likely to report negative experiences than white Hispanic or Latino adults.[10] These negative experiences speak to people facing discrimination when seeking health care, making it more likely that they stop engaging with the health care system.

Language and communication also play a key role. According to the Pew Research Center, about 60% of Hispanic or Latino immigrants reported they preferred a Spanish-speaking health care provider, feeling that their needs would be better met by this provider.[10] However, only about 7% of providers across the country are Hispanic or Latino.[10] So, although some providers may speak Spanish, if they are white, they may not understand the cultural or dialectical nuance of the person seeking care. This can make it very difficult for people of color to find a provider who not only speaks their language but also understands their culture and experience.

Providing Context to the Data

CHI spoke to many community members in Colorado who shared their own stories about accessing care. They talked about language gaps, lack of insurance coverage, and the need for providers who understand their cultural experiences and challenges. CHI also engaged with health care providers to hear their views about people trying, and often failing, to get the kind of care they need.

Stories from Community Members

For Hispanic or Latino individuals in Colorado with mental health conditions, access to needed services is not easy, and getting quality and culturally relevant care can be an even greater obstacle. One person said it took months to get an appointment with a provider who spoke their language. Even though they finally found a Spanish speaker, this provider was white, and the care provided was missing a lot of cultural contexts specific to their needs. An example of this is how different Spanish-speaking culture may speak about their health. Not only are there dialectical differences across regions throughout South American, Central American, and the Caribbean, these areas have also different histories with what institutionalized mental health care looks like, how much they trust it, and whether they are willing to engage with a similar system elsewhere.

Patient privacy is also an issue. One person said their mother did not feel comfortable speaking to relatives who provided translation services about her health condition, which reduced the quality of the visit and didn't address all of her needs. Another person talked about getting care from multiple providers. Each new provider had to be brought up to speed regarding this person's experiences. They felt exhausted having to retell sometimes very difficult stories that impacted their health.

The mental health system in the United States is rooted in Westernized culture that some Hispanic or Latino individuals don't see themselves in. Many behavioral health providers are white and may not understand the nuances of their patients' cultural and social experience. Along these lines, interviewees cited the importance of liberation psychology, which challenges traditional Western beliefs and offers an alternative that addresses oppression experienced by individuals and groups.[11]

Another interesting observation identified by a community member was the impact of assimilation from one culture into another over time. They spoke of how different generations of a family may have distinct behavioral health impacts based on their experience assimilating into United States culture. Those of the first generation have different experiences than ones who might be second, third, fourth, and so on. The kinds of behavioral health issues that might come up for one generation may be

entirely different from another based on their lived environment, how long the family has been in the United States, and how far removed they are from the first generation. How the behavioral health system meets the needs of these distinct generations is an important component of responsive behavioral health care to consider.

One of the biggest impacts on community members was the cost of and access to quality insurance coverage. One person shared their experience of living with a mental health condition. For many years, their condition was manageable. However, they experienced setbacks that required more intervention. This led to expensive health care visits with their behavioral health provider and additional prescription costs. Another community member voiced a similar concern, saying they held several jobs, none of which provided health care coverage. The cost of buying insurance through the individual marketplace was too high, leaving them with no choice but to access care through clinics that sometimes have long waitlists.

Stories from Health Care Providers

Providers CHI spoke with raised similar concerns. One provider discussed the availability of behavioral health screenings in a patient's preferred language. These forms are typically provided only in English, leading to a "lost in translation" situation. Many non-English speakers may not understand what they're signing or filling out on the forms provided and often get misdiagnosed as a result. And many times, the only available interpreters speak Spanish, which doesn't meet the needs of other language groups that the provider serves.

One provider also noted that doctors seem to be brusque with patients who don't speak English. They don't gather as much information because the visit is often frustrating for both sides when there's a communication breakdown between the provider and the patient. In such a situation, the patient may not get the same level of care due to a language barrier or cultural biases.

A provider also highlighted access to coverage. Many people aren't eligible for Medicaid or other government-sponsored programs, leaving them without many options. Another provider — who primarily serves youth in Adams County — indicated that their patients tended to be white, despite a more racially and ethnically diverse county population when compared to the state. This caused the provider to question what barriers prevented youth of other racial and ethnic identities from seeking services. For example, clinic operating hours were noted as a barrier to access. One provider said they expanded hours beyond the 8 a.m. to 5 p.m. work schedule to allow more people to get needed treatment.

Policy and Programmatic Considerations

Access to interpretation and translation services is an important issue. This goes beyond having translators who speak Spanish; it means having translators and interpreters who understand the cultural and dialectical contexts of people seeking care. Beyond language services, ensuring that provider networks rid themselves of any cultural or racial bias they may hold will reduce negative interactions between patients and providers.[12,13] A long-term shift involves diversifying the behavioral health workforce. A short-term goal is training current behavioral health networks to respond responsibly to the cultural perspectives of each person they serve.

Another aspect to consider is understanding the kinds of trauma that a patient may have experienced. Migration patterns over time have created diverse groups within the Hispanic or Latino community in Colorado. One person's or family's reason for coming to the United States can be very different from another's. Understanding what a person is bringing with them into a behavioral health visit is important context.

The data provided in this report doesn't fully capture the different ways a person can receive behavioral health care. Many people receive help through peer support, which may provide a more responsive and inclusive alternative for people who have had negative experiences in the classic behavioral health care setting.[14] Understanding and integrating more peer support services, as well as funding them, could be a short-term approach to help bolster the behavioral health care system.

Future Directions

Over the last three years, CHI has increased its knowledge and expertise in data disaggregation techniques to create a more equity-driven approach to research. Our data disaggregation efforts have focused on the Hispanic or Latino community, but these methods could be used to further understand and elevate issues impacting other diverse communities. Another future direction could be using the 2023 CHAS data and combining it with the 2021 results to further refine the predictive models of disaggregation to identify health care patterns of more groups within the Hispanic or Latino community.

Conclusion

Many Hispanic or Latino community members have been diagnosed with a behavioral health condition. However, many more are not accessing care to the same degree as others in the state. The behavioral health care system, much like the health care system in general, is complex. Obtaining care can be out of reach, especially when one does not have insurance coverage to help pay for services. It is important to create spaces and systems in which people can see themselves and feel included. Creating these spaces within the health care system is very important to ensuring that people continue using behavioral health care to meet their needs. Taking this information into the communities will help organizations, like CHI, understand more about the needed next steps to reduce barriers and the burden placed on community members trying to get help. The system should work for the individual, not the other way around.

Lindsey Whittington, *Lead Author*

Jeff Bontrager, Rachel Bowyer, Emily Leung, and Robbin Meneses contributed to this report

Endnotes

[1] Panchal, et al. Five Key Findings on Mental Health and Substance Use Disorders by Race/Ethnicity. (2022) https://www.kff.org/mental-health/issue-brief/five-key-findings-on-mental-health-and-substance-use-disorders-by-race-ethnicity/#:~:text=WONDER%20Online%20Database.-,Overall%20rates%20of%20mental%20illness%20and%20substance%20use%20disorder%20are,compared%20to%20their%20White%20peers

[2] Colorado Health Institute. Language and Culturally Responsive Care in Colorado: Barriers, Access, and Room for Improvement. (2022) https://www.coloradohealthinstitute.org/research/language-and-culturally-responsive-care-colorado

[3] United States Census Bureau. American Community Survey, 2022: ACS 1-Year Estimates Data Profiles. S1601 Language Spoken at Home dataset. (2023) https://data.census.gov/table/ACSST1Y2022.S1601?q=language&g=040XX00US08

[4] Colorado Health Institute. 2021 Colorado Health Access Survey. (2021)

[5] Kauh T, et al. The Critical Role of Racial/Ethnic Data Disaggregation for Health Equity. (2021) Population Research Policy Review. (40 (1): 1-7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7791160/

[6] United States Census Bureau. American Community Survey, 2022: ACS 1-Year Estimates. DP05 ACS Demographic and Housing Estimates dataset. (2023) https://data.census.gov/table/ACSDP1Y2022.DP05?q=hispanic+or+latino+&g=040XX00US08

[7] United States Census Bureau. American Community Survey, 2022: ACS 1-Year Estimates. B03001 Hispanic or Latino Origin by Specific Origin dataset. (2023) https://data.census.gov/table/ACSDT1Y2022.B03001?q=hispanic+or+latino+

[8] Colorado Department of Health Care Policy and Financing. Behavioral Health Fee-for-Service (FFS) Benefits. (2023) https://hcpf.colorado.gov/behavioral-ffs

[9] United States National Research Council on Hispanics in the United States. Hispanics and the Future of America. (2006) National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK19910/#:~:text=Hispanics%20of%20Mexican%20origin%20are,a%20physician%20visit%20(P%20%3C%20

[10] Funk C, and Lopez M. Hispanic Americans' experiences with health care. Pew Research Center. (2022) https://www.pewresearch.org/science/2022/06/14/hispanic-americans-experiences-with-health-care/

[11] Hocoy D, et al. Liberation Psychologies: An Invitation to Dialogue. (2023) Pacifica Graduate Institute. https://www.pacifica.edu/degree-program/community-liberation-ecopsychology/what-is-liberation-psychology/

[12] Nair L., and Adetayo, O. Cultural Competence and Ethnic Diversity in Healthcare. (2019) International Open Access Journal of the American Society of Plastic Surgeons. 7(5). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6571328/

[13] Colorado Health Institute. Diverse State, Diverse Needs: Coloradans' Needs and Experiences Highlight Demand for Culturally Responsive Care. (2022) https://www.coloradohealthinstitute.org/research/culturally-responsive-care-Colorado#:~:text=In%202021%2C%20policymakers%20passed%20the,of%20the%20community%20it%20serves

[14] Naslund J, et al. (2016). The future of mental health care: peer-to-peer support and social media. Epidemiology and Psychiatric Sciences, 25(2): 113-122. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4830464/#:~:text=Identifying%20with%20a%20social%20group,social%20integration%20(Davidson%20et%20al

1999 Broadway, Suite 600 • Denver, CO 80202 • 303.831.4200
coloradohealthinstitute.org