

California Mental Health Policy Forum

Increasing Cultural Competence and Diversity in the Workforce: A Road Map for Reducing Health Disparities

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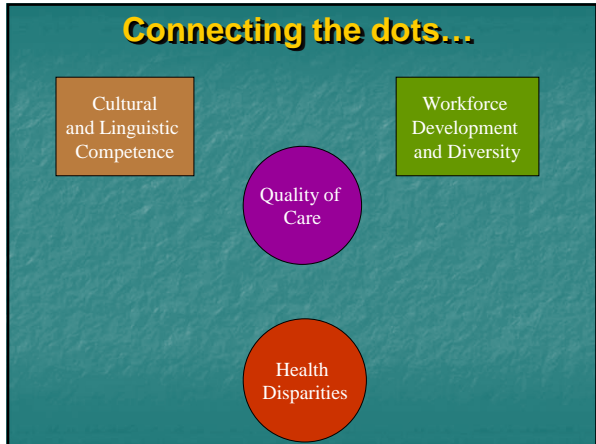
Newport Beach, CA
February 9, 2006

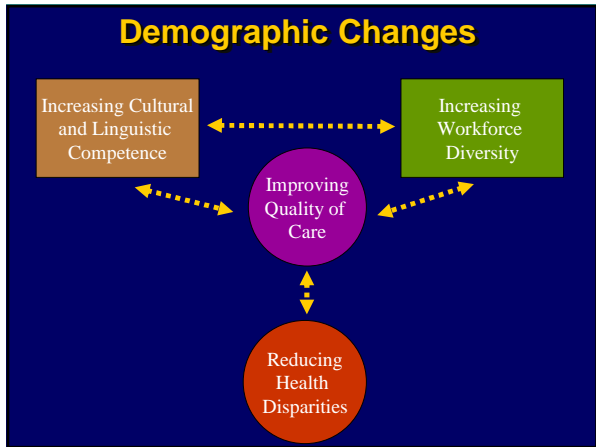
Let's hear it from cultural sensitivity!

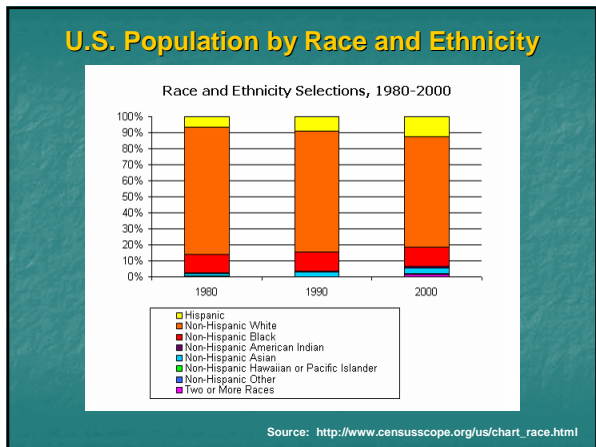


“The leadership and workforce of a culturally competent organization reflect the cultures of the people the organization serves. Within the organization, learning to understand, appreciate, and celebrate each other’s cultures, abilities, and life-situations is an **ongoing, conscious, and measured process.**”

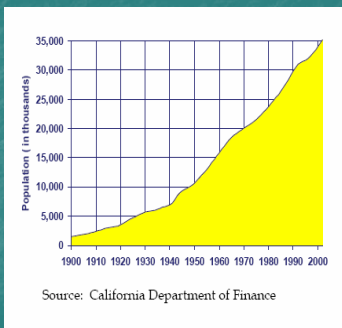
Ron D. Graybill, PhD
Community Outreach Director
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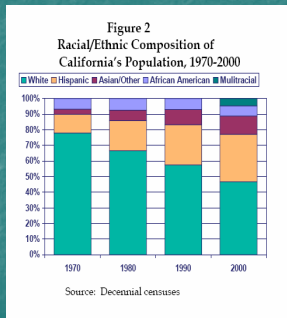


California's Population, 1990-2000



Source: Johnson, California's Demographic Future, Public Policy Institute of California, 2003

California's Population by Race and Ethnicity



- California leads the nation in diversity.
- As such, the state is challenged with a substantial leadership role in designing and maintaining services that achieve cultural and linguistic competency.

Source: Johnson, California's Demographic Future, Public Policy Institute of California, 2003

Challenges of Demographic Changes

- Workforce needs are changing with changing demographics...Are you ready for the next generation?
- Race/Ethnicity: Moving from a majority culture (1995), to diversity (2005), to multicultural (2025)

2005
Summary Report

California Demographic Futures

Projections to 2030, by Immigrant Generations,
Nativity, and Time of Arrival in U.S.

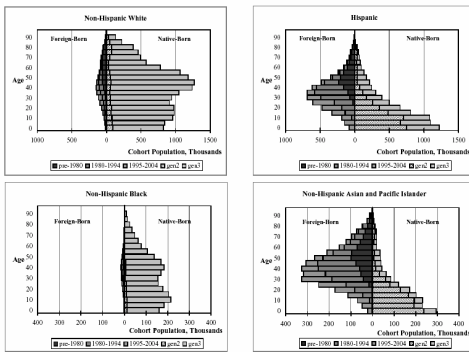
Dowell Myers
John Pitkin
Julie Park

January 2005

School of Policy, Planning, and Development
University of Southern California

www.usc.edu/schools/sppd/research/popdynamics

Exhibit 7
Age-Nativity Pyramids by Race and Hispanic-Origin
Population of California, 2005



Source: California Demographic Futures, version 3.0

Wish list...

- The mental health systems must respond to current and projected demographic changes California;
- The mental health system must develop a diverse, competency-based workforce invested in improving quality of care and outcomes;
- Evaluation of mental health programs is most informative when tailored to the needs of the service users;
- California must eliminate long-standing disparities in mental health care for people of diverse racial, ethnic and cultural backgrounds.

Issues in Workforce Development

- Finding and keeping a competency-based workforce is the biggest single challenge faced by most mental health services systems.
- It is not just a question of resources.
- Mental health services systems would be served well if they tackle workforce problems by looking creatively at how they use existing staff and from where they are recruiting new people.

Challenges for California's Workforce

- Insufficient numbers of staff;
- Unsatisfactory skill and proficiency levels;
- Inappropriate training to deal with a changed delivery environment;
- Racial and ethnic diversity;
- Racial and ethnic disparities in access to and quality of care.

Disparities in Health Care



- In 2002 the Institute of Medicine published *Unequal Treatment* which compiled research demonstrating substantial racial and ethnic variation in quality of health care.
- It brought healthcare disparities to the attention of the nation, placing the issue on the forefront of the nation's health policy agenda.

Source: "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care", IOM, 2002.

Disparities in Health Care



Distinction Between Health Disparities

- It is important to distinguish between disparities in
 - health status;
 - health care access;
 - quality of health care received; and
 - healthcare outcomes.
- The cause of each of these are likely related, but they are different phenomena.
- Thus, the solutions will likely be different.

Source: La Veist, Isaac, 2006

Factors Related to Disparities in Health Care

Disparities seem to be the end result of a complex set of causal factors that include:

- differential access to care;
- doctor-patient communication barriers and lack of trust;
- limited cultural competence of providers and health care organizations;
- patients' health beliefs and behavior;
- stereotypical thinking and biased decision-making among providers;
- problems with literacy and limited English proficiency; and
- differential access to high-quality hospitals and other facilities.

Source: Smedley, Stith, & Nelson, Eds. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington: National Academies Press.

Evidence of Racial and Ethnic Disparities in Healthcare

- Disparities are consistently found across a wide range of disease areas and clinical services.
- Disparities are found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals, etc.
- Disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account.
- Disparities in care are associated with higher mortality among minorities.

Source: Smedley, Stith, & Nelson, Eds. (2002). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Washington: National Academies Press.

Key Themes from the National Healthcare Disparities 2004 Report



For policymakers, clinicians, health system administrators, and community leaders:

- Disparities are pervasive;
- Improvement is possible;
- Gaps in information exist, especially for specific conditions and populations.

The National Healthcare Disparities 2005 Report



Tracks disparities in:

- Quality of healthcare:
 - Effectiveness
 - Patient safety
 - Timeliness
 - Patient-centeredness
- Access to care:
 - Facilitators and
 - Barriers to care and health care utilization

Key Themes from the National Healthcare Disparities 2005 Report

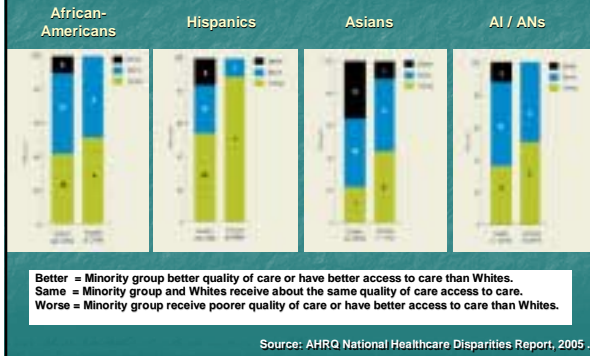


2005
National
Healthcare
Disparities
Report

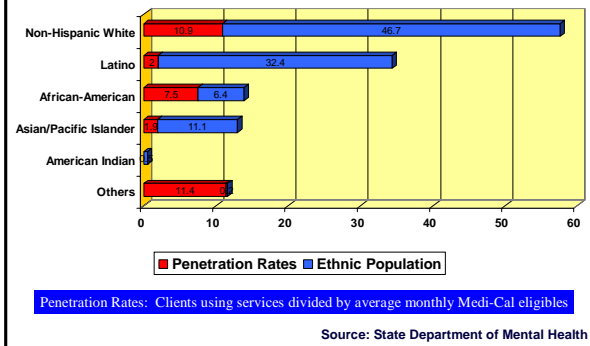
Key themes for policymakers, clinicians, health system administrators, and community leaders:

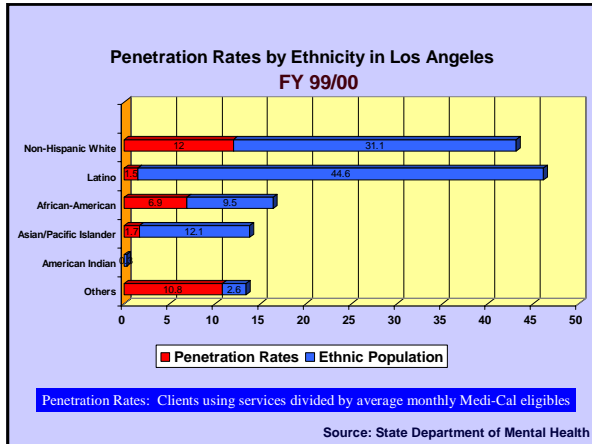
- Disparities still exist;
- Some disparities are diminishing;
- Opportunities for improvement remain;
- Information about disparities is improving.

Minority Groups Compared with Whites on Measures of Quality and Access



Penetration Rates by Ethnicity in California FY 99/00





MAPSS

Mexican American Prevalence and Services Survey (MAPSS)

NIMH: IRO1 MH51192-01

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WHERE IS MENTAL HEALTH CARE RECEIVED?

SERVICES UTILIZATION BY SPECIFIC PROVIDERS:

of those suffering ≥ 1 mental disorders in last 12-months:

- 8.8% received care in the *mental health* sector
- 18.4% in the *general medical* sector
- 12.7% in the *other professional* sector
- 3.1% in the *informal provider* sector
- Only 27% received care from *any* sector

MAPSS

RATES OF SERVICE UTILIZATION

- 37.5% of **U.S. born** received care
- 15.4% of **immigrants** received care
- 9% of **migrant agricultural** workers received care

Underutilization of Mental Health Services by Latinos

75-90 % of adult Latinos in need of mental health services fail to access such services

Source: Vega, Aguilar-Gaxiola

Barriers to Services

- Under-recognition of mental health problems
- Referral bias;
- Perceived need for care and expectations
- Cultural and linguistic insensitivity;
- Lack of insurance;
- Immigration patterns;
- Poverty;
- Service cutbacks.

Treatment Dropout and Retention

Latinos are more likely than Non-Hispanic Whites to terminate treatment prematurely, with as many as 60–75% of Latinos dropping out after just one session.

Source: McCabe, 2002

So, what's going on...

Underutilization raises questions about the ability of health systems to provide quality care to a diverse population.

What is quality of care?

The capacity to deliver safe, appropriate, timely, efficient, effective, and equitable treatment

Source: Crossing the Quality Chasm, IOM, 2001

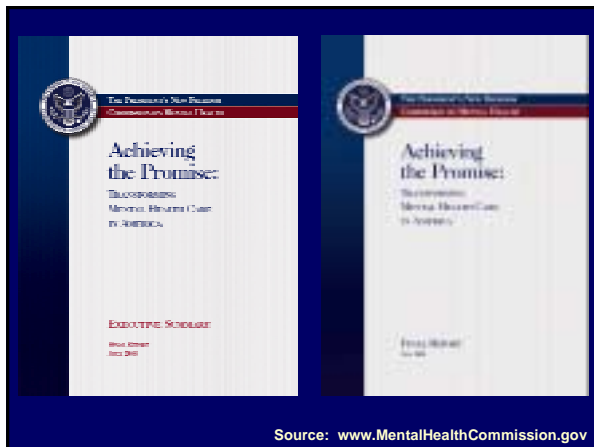


Source: Crossing the Quality Chasm, IOM, 2001

Crossing the Quality Chasm Conclusions

- There are serious problems in quality:
 - Between the health care we have and the care we could have lies not just a gap but a chasm.
- The problems come from poor systems...not bad people:
 - In its current form, habits, and environment, US health care is incapable of providing the public with the quality health care it expects and deserves.
- We can fix it... but it will require changes.


Source: Crossing the Quality Chasm, IOM, 2001




Source: www.MentalHealthCommission.gov

New Freedom Commission Conclusions

- Behavioral health systems in the United States are:
 - fragmented;
 - fraught with barriers;
 - leaving too many people seeking mental health care, with unmet needs.
- This is particularly true for minority populations who are often over represented in our nation's most vulnerable populations.



“Unfortunately, the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups.” (p. 49)



“While bold efforts to improve services for culturally diverse populations currently are underway, significant barriers still remain in access, quality, and outcomes of care for minorities.”(p. 49)

Aims for National Quality Improvement

- **Safety** -- As safe in health care as in our homes;
- **Effectiveness** -- Matching care to science; avoiding overuse of ineffective care and underuse of effective care;
- **Patient Centeredness** -- Honoring the individual, and respecting choice;
- **Timeliness** -- Less waiting for both patients and those who give care;
- **Efficiency** -- Reducing waste;
- **Equity** -- Closing racial and ethnic gaps in health status.

Source: Crossing the Quality Chasm, 2003; www.nap.edu

What are the obstacles?

- Cost
- Lack of knowledge
- Lack of acceptance by health professionals
- Organizational resistance

Source: Vega, 2005

Three Levels of Change Required

- Changing the care, itself;
- Changing the organizations that deliver care;
- Changing the environment that affects organizational and professional behavior.

Source: Berwick, 2003

Recommendations from the IOM's Unequal Treatment

- Increase awareness of racial/ethnic disparities in health care;
- Collect patient data by race/ethnicity;
- Increase diversity of the health care workforce;
- Integrate cross-cultural education into the training of all current and future health professionals;

Source: Smedley, Stith, & Nelson, Eds. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: National Academies Press.

Improving the Quality of Health Care for Mental and Substance-Use Conditions

"The M/SU workforce is not uniformly and sufficiently equipped in terms of its knowledge and skills, cultural diversity and understanding, geographic distribution, and supply to provide the access to and quality of M/SU services that consumers need. This has long been the case and persistently resistant to change despite recurring acknowledgements of the nature and magnitude of the problems, the recognition that major improvements should be made, and repetitive recommendations to do so." (p. 264)

Source: *Improving the Quality of Health Care for Mental and Substance-Use Conditions*; Quality Chasm Series, 2006

What is the Goal of Cultural Competency?

To improve the ability of health care providers to effectively communicate and care for patients from diverse social and cultural backgrounds

Cultural and Linguistic Competence is about improving Quality of Care

Source: Betancourt, 2005

The Need for Cultural Competence in Health Care (1)

- The perception of illness and disease and their causes varies by culture;
- Diverse belief systems exist related to health, healing and wellness;
- Culture influences help seeking behaviors and attitudes toward health care providers;

Source: Cohen & Goode, National Center for Cultural Competence, 1999

The Need for Cultural Competence in Health Care (2)

- Individual preferences affect traditional and non-traditional approaches to health care;
- Patients must overcome personal experiences of biases within health care systems, and;
- Health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system.

Source: Cohen & Goode, National Center for Cultural Competence, 1999

Latent Resistance to Cultural Competence

- It's fluff – minimal clinically relevant content, tokenism for minorities;
- You can't learn cultural competence in a training course, you learn it on your "grandmother's knee";
- No demonstrated effect on cost, patient satisfaction, effectiveness in retention, compliance, medical adherence, or clinical outcomes.

Source: Vega, 2005

Unrealistic Assumptions about Cultural Competence

- It can remedy all disparities in treatment;
- It is easily dispensed in short training sessions;
- Client outcomes can be improved without disturbing "business as usual" such as patient management routines of behavioral health providers;
- It won't cost much money;
- It satisfies the ethical requirement for responsiveness to diversity.

Source: Vega, 2005

Diversity in the Health Care Workforce

Improvements in mental health services aimed at maximizing recovery can only be achieved by a **well trained and diverse workforce** that is equipped to respond to the unmet mental health needs of **diverse consumers**.

Why Seek Greater Diversity?

Who Gets the Benefit?



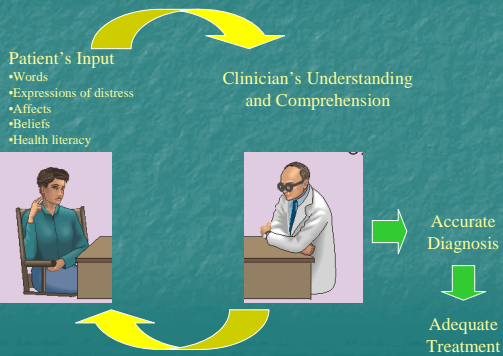
Benefits of Racial and Ethnic Diversity Among Health Professionals

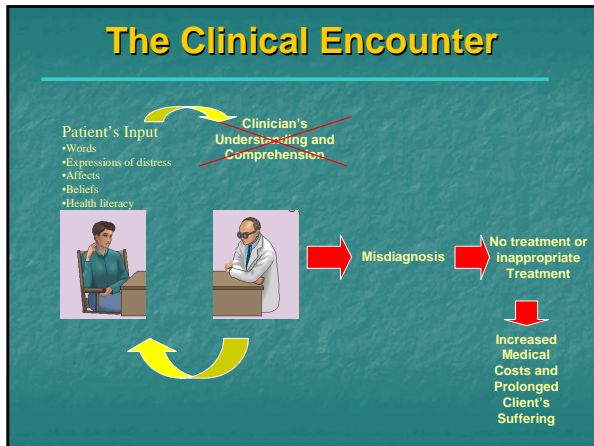
- Racial and ethnic minority health care providers are more likely to serve minority and medically underserved communities, thereby increasing access to care;
- Racial and ethnic minority patients report greater levels of satisfaction with care provided by minority health professionals;
- Racial and ethnic minority health care providers can help health systems in efforts to reduce cultural and linguistic barriers and improve cultural competence.

Reducing Disparities in Health Care

Improving Treatment Quality through Culturally and Linguistically Appropriate Care at the Clinical Encounter Level

The Clinical Encounter





Five Goals for Culturally and Linguistically Educated Health Professionals

- **Self-awareness.** This includes understanding one's own personal cultural values and beliefs and their impact on health and health care delivery.
- **Cross-cultural knowledge.** This includes understanding how beliefs, cultures, and ethnic practices influence health behavior and health status.
- **Language diversity.** This addresses the need to provide or advocate for information, referrals, and services in the language appropriate to the patient as well as the interpreters, when needed.

Source: http://www.dentalpipeline.org/home/697/curriculum_development-behavioral_sciences

Five Goals for Culturally and Linguistically Educated Health Professionals

- **Competence to deliver.** The ability to provide culturally and linguistically appropriate and competent services, programs, and interventions that meet the needs of the community of interest.
- **Advocacy.** The willingness to advocate for public policies that promote and support culturally and linguistically responsive services and the inclusion of representation and participation of individuals who reflect the diversity of our communities.

Source: http://www.dentalpipeline.org/home/697/curriculum_development-behavioral_sciences

Keeping it Alive!

- Cultural competence must fit healthcare organizational priorities even while it seeks to change them;
- Must not attach ourselves to the vehicle of “cultural competence” but to the goal of improving quality of care.

Source: Vega, 2005

So, What?

- How is this relevant to what you do?
- How does this information may guide restructuring services and supports for those with unmet needs and who have limited or no access to care?

Call for Action

You are “front line” policymakers and professionals who would be key to quality of care and helping reduce health care disparities in our current mental health care system.

What do you think that you can realistically do?
