

7-15-2017

Eliminating Mental and Physical Health Disparities Through Culturally and Linguistically Centered Integrated Healthcare

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Recommended Citation

Martinez, Octavio N. Jr. (2017) "Eliminating Mental and Physical Health Disparities Through Culturally and Linguistically Centered Integrated Healthcare," *Journal of Family Strengths*: Vol. 17 : Iss. 1 , Article 10.

Available at: <http://digitalcommons.library.tmc.edu/jfs/vol17/iss1/10>

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Since the U.S. Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999) declared mind and body to be inseparable, integrated healthcare has been gaining significant momentum across the nation as a preferred approach to care for people with comorbid physical health and mental health conditions. Primary care settings often are the gateway to healthcare for racial and ethnic minority populations and individuals with limited English proficiency (LEP), and as such, primary care has become the portal for identifying undiagnosed or untreated behavioral health disorders. This provides an opportunity to address mental and physical health disparities and achieve health equity through a culturally and linguistically centered integrated health care delivery model.

Systemic lupus erythematosus (SLE) exemplifies the need for a culturally and linguistically centered integrated healthcare approach. Why? Because SLE is a chronic inflammatory autoimmune disorder that affects multiple organ systems, including the central nervous system, psychiatric symptoms occur in half of SLE patients before diagnosis of the disease. Depression and cognitive dysfunction (impaired attention, memory deficits, impaired executive functions) are the most common symptoms before physical symptoms are noticed. Add to this the fact that 80% to 90% of SLE patients are women and that SLE affects 1 in 1,000 white women while affecting 1 in 250 African American women, and the result in today's health care environment is a disparity in care (Bartels & Muller, 2016; Ramachandran, 2016).

Today's healthcare environment is one in which the majority of behavioral health issues (mental health disorders and substance use disorders) present in primary care. While racial and ethnic minorities prefer primary care, primary care does not have the appropriately skilled workforce or infrastructure to address the community's needs. Our understanding and evidence of the current environment and of healthcare disparities has been building over the decades. Recent landmark reports have advanced our understanding, including the first Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999) by Dr. David Satcher. Dr. Satcher followed this with a supplement released in 2001 entitled *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services, 2001). Then in 2002, the Institute of Medicine (IOM, now known as the National Academy of Medicine) released *Unequal Treatment* (Institute of Medicine, 2003). This IOM report in conjunction with the two Surgeon General's reports brought healthcare disparities to the attention of the nation and led to the creation of *The National Healthcare Disparities Report* by the Agency for Healthcare Research and Quality (AHRQ) (Agency for Healthcare Research and Quality, 2016). This is an

annual report first released in 2003; in 2014, it was combined with the *National Healthcare Quality Report* to create the *National Healthcare Quality and Disparities Report*. Yet despite this focus, little progress has occurred in eliminating healthcare disparities. This is a significant and critical issue.

Additional variables that are highly significant for primary health and mental health are the following: 1) the acceptability and use of mental health services are highly governed by cultural attitudes, beliefs, and practices; 2) the current science base around psychiatric diagnosis and treatment is derived from research primarily involving European-origin populations; and 3) ethnic and minority populations face many increasing challenges around mental illness and substance use, such as lower access to services and evidence-based treatments, higher burdens of morbidity, and a multitude of social determinant stressors. Additional factors that affect all populations, but especially racial and ethnic minorities, low socioeconomic status individuals, and rural populations, include, but are not limited, to the following: stigma, geographic inaccessibility, inadequate built environment, provider shortages, network insufficiency, lack of provider language capacity, inappropriate use of interpreter services, lack of culturally relevant meaningful competent services, poor doctor-patient communication (DPC), poor treatment engagement, health illiteracy, the fact that most mental health and behavioral health clinics do not have expertise in providing primary care, and the fact that most primary care settings do not have expertise in providing robust behavioral health services.

And even when we do have the tools, implementation is challenging. For example, approximately one out of every five hospitals still does not meet any of the language-related Culturally and Linguistically Appropriate Service Standards; and only about the same percentage of hospitals are collecting race, ethnicity, and language preference (REAL) data at the first patient encounter and using the data to assess gaps in care (Diamond, Wilson-Stronks, & Jacobs, 2010; American Hospital Association & Institute for Diversity in Health Management, 2012). This is especially quite telling when you take into consideration the impact our dysfunctional healthcare system is having on our youth. Suicide disproportionately affects minority children and youth. The suicide rate for African American children, ages 5 to 11, has doubled in the last two decades; and American Indian/Alaska Native males, ages 18 to 24, have the highest rate of suicide of all comparable groups (Jiang, Mitran, Miniño, & Ni, 2015; Storrs, 2015). Our current systems and policies are creating an entire generation of disenfranchised, marginalized individuals. African American, Hispanic/Latino, and/or American Indian children are disproportionately

represented in our child welfare system (Child Welfare Information Gateway, 2016), while an inordinate number of children and youth in the juvenile justice system are African American and Hispanic/Latino. In fact, youth of color are more likely to be arrested, prosecuted, sentenced, and incarcerated compared to their white peers. In 2013, Black youth were four times as likely as White youth to be incarcerated, Native American youth were three times as likely, and Hispanic/Latino youth were twice as likely (The W. Haywood Burns Institute for Juvenile Justice Fairness & Equity, 2016). What kind of message does this send to our youth and our society? How does America expect to remain globally competitive when so many of its youth are facing overwhelming odds to become healthy, happy, productive individuals of society?

The State of Health Disparities

In fact, racial-ethnic disparities in children's mental health treatment persist even within systems of care. A study by Popescu, Xu, Krivelyova, and Ettner (2015) assessed racial-ethnic differences in 3,920 children enrolled in systems of care under the Children's Mental Health Initiative (CMHI). Compared to non-Hispanic White children, African American children had lower odds of using any individual psychotherapy, family and group psychotherapy, and medication monitoring. Users of services had lower utilization of individual psychotherapy, family and group psychotherapy, and inpatient care. Hispanic/Latino children had lower odds of receiving medication monitoring and assessment and evaluation services. Users had lower utilization of individual psychotherapy and family and group psychotherapy. A different study published in 2016 in *Psychiatric Services* by Coleman et al. presented the finding that racial-ethnic differences in psychiatric diagnoses and treatment persist for adults as well. The study evaluated 11 private, not-for-profit U.S. healthcare delivery systems, which are part of the Mental Health Research Network, a consortium of research centers that have a mission to improve the management of mental health conditions. The participating healthcare systems had a combined 7.5 million patients 18 years of age or older. Major findings of this study included the fact that non-Hispanic White patients were significantly more likely than other racial-ethnic groups to receive medication; non-Hispanic Blacks were almost twice as likely as non-Hispanic Whites to be diagnosed with schizophrenia and were significantly less likely to receive medication for treatment; and the overall rate of psychotherapy treatment for people with serious mental illness was very low across all race-ethnicities. It is disturbing that in the 21st century in the United States, even when we have created initiatives like the CMHI and a research network dedicated to

improving mental health conditions, significant healthcare disparities persist.

An Integrated Healthcare Vision

What is to be done? First and foremost, one must have a vision. In this case, my vision is a culturally and linguistically centered healthcare system for all – a healthcare system whose core principles include respect for the whole person across the lifespan; a healthcare system that prevention and early intervention methods; a system that is strengths-based, trauma-informed, and recovery-focused; a system that achieves health equity. In essence, I am advocating for a healthcare system that is person-, family-, and community-centered. Within that vision, I believe that a truly integrated healthcare (IHC) delivery model plays a key role. IHC is a holistic approach that brings together physical health issues and behavioral health issues under one rubric. An IHC delivery model is not the complete answer to eliminating physical and behavioral healthcare disparities, but it is an important piece of the puzzle. IHC has great potential if done well to respond to current and projected demographic needs and address the long-standing disparities in health status for people of diverse racial, ethnic, socioeconomic, geographic, and cultural backgrounds. It can help achieve not only the “Triple Aim” (Institute for Healthcare Improvement, 2017) but in fact the “Quaternary Aim”: improve quality of services and outcomes, enhance the patient experience of care, decrease cost, and increase engagement. Equally important is the role IHC can play in continuing to diminish and eventually eliminate the stigma associated with mental illness and substance use disorders.

The IHC model presented here has six key components: an interdisciplinary team component, a patient-centered component, a population-focused component, a stepped care component, a care management functions component, and an outcomes-based feedback with quality improvement component. The interdisciplinary team approach must be real team collaboration and not just co-location. It is a team consisting of professionals who are regarded as equals regardless of their background or skill set. All members of the team are respected and recognized for what they bring to the table. The team is part of an environment that recognizes team building and implementation support as well as ongoing team member training in team skills. The patient-centered component consists of patient/consumer and family education and self-management supports and incorporates patient/consumer preferences, needs, and strengths. Population-focused healthcare includes three levels of prevention: primary, secondary, and tertiary. Throughout these three levels, the team can focus

on the health of the identified population, invest upstream, base decisions on evidence, apply multiple strategies to act on the determinants of health, collaborate across levels and sectors, increase accountability for health outcomes, and employ mechanisms to engage patients/consumers about taking a part in improving their health. Examples of specific tools are the use of a patient registry and the development of effective practice guidelines. Stepped care is important because it allows the flexible use of identified resources. As acuity increases, so do the resources and vice versa. In stepped care, individual and caseload summaries facilitate measurement-based practice and treatment to target. This requires the use of validated rating instruments and adjusting the treatment plan based on symptom measures. Care management functions are critical as they provide systematic outreach and utilize structured templates to facilitate efficient/effective clinical encounters. Close follow-up and monitoring are key to preventing relapse. Outcomes-based feedback and quality improvement provide accountability and help to reinforce cultural and linguistic skills. The main purpose of these activities should be not to punish the team members but in fact to provide data to the team members to identify weaknesses or gaps and reward well-done interventions.

Examples

In addition to having a vision, one needs to be solutions-oriented. The Hogg Foundation for Mental Health has been advancing IHC since 2006. And in 2010 the foundation partnered with the Office of Minority Health, U.S. Department of Health and Human Services, to address the intersection between IHC and cultural and linguistic competency (CLC). This led to the development and implementation of several deliverables. First, a literature review—“Eliminating Disparities Through the Integration of Behavioral Health and Primary Care Services for Racial and Ethnic Minorities, Including Populations with Limited English Proficiency: A Literature Review Report”—was conducted to examine the evidence base and literature of integrated healthcare regarding racial and ethnic minorities and populations with LEP (Sanchez, Chapa, Ybarra, & Martinez, 2012a). This literature review was then disseminated to a select group of leading national experts for review and consideration, setting the stage for a robust dialogue to take place at a national consensus meeting. The two-day consensus meeting was held on November 7 and 8, 2011. Recognized experts in the fields of health, mental health and addictions, integrated care, and cultural and linguistic competency met to share best practices, offer insights, and provide recommendations to help create national models to improve integrated healthcare for racial and ethnic minority and LEP

populations. The consensus statements and recommendations were compiled into a report—“Enhancing the Delivery of Health Care: Eliminating Health Disparities Through a Culturally and Linguistically Centered Integrated Health Care Approach”—and released in June, 2012 (Sanchez, Chapa, Ybarra, & Martinez, 2012b). Earlier in 2012, on February 6, the Hogg Foundation hosted a national funders’ meeting to discuss ways foundations could support IHC, and on the following day, February 7, it hosted a one-day conference, “Quality Health Care for All: Eliminating Racial and Ethnic Disparities Through Integrated Health Care.” The meeting with interested foundations led to a collaboration with Grantmakers In Health; in 2013, a funders’ report, *A Window of Opportunity*, was released to help foundations fund in IHC (Grantmakers In Health & Hogg Foundation for Mental Health, 2013).

A framework for improving access to care for traditionally underserved racial and ethnic minority communities resulted from these activities. The framework proposes the concept of the integrated care organization (ICO). An ICO is not just in the community but is in fact truly part of the community. The ICO at all levels from the front desk to the executive suite is culturally and linguistically competent, is responsive to the community it serves, and is a member of a learning community, be it formal or informal, with other community stakeholders to address the social determinants that contribute to disparities. The framework envisions expanding services beyond the traditional domains of health and behavioral healthcare delivery systems to address health disparities and achieve health equity. Efforts to eliminate health disparities must incorporate strategies for addressing the social determinants of health, such as location of the integrated healthcare center, availability of transportation, hours of operation, and levels of acculturation, socioeconomic status, community centeredness, and health literacy. The development of a multidisciplinary, culturally and linguistically competent workforce is essential. The treatment team must be an integrated care team (ICT), one that is multidisciplinary and cross-trained in physical and behavioral health. Treatment planning must be person- and family-centered in order to increase engagement in the elements of integrated care. And though the objective of the ICO is to decrease health disparities, the goal should be health equity and improved individual, family, and community quality of life (Sanchez, 2012b; Sanchez, Chapa, Ybarra, & Martinez, 2014; Sanchez, Ybarra, Chapa, & Martinez, 2016).

Though culturally and linguistically centered IHC delivery systems are not the norm, there are examples of such efforts across the United States. The Nuka System of Care is one such example. In Anchorage,

Alaska, the Southcentral Foundation has created a system of care by Alaska Native people for Alaska Native people to achieve physical, mental, emotional, and spiritual wellness. “Nuka” refers to the whole healthcare system and is an Alaska Native word used for strong, giant structures and living things. The relationship-based Nuka System of Care is comprised of organizational strategies and processes (medical, behavioral, dental, and traditional practices) as well as supporting infrastructures that work together in relationship to support wellness. Patients are known as “customer-owners” because Southcentral works exclusively for Alaska Natives, who provide extensive advisory roles in the hospital’s and clinics’ management and policies. The Southcentral Foundation assumed the clinical responsibilities of the Indian Health Service under the Indian Self-Determination and Education Assistance Act of 1975. In 2011, Southcentral Foundation received the highest presidential honor for performance excellence, the Malcolm Baldrige National Quality Award. Donald M. Berwick, MD, MPP, former Administrator for Centers for Medicare and Medicaid Services, has said of the Nuka System of Care, “I think it’s the leading example of health care redesign in the nation, maybe the world” (Southcentral Foundation, 2017).

Routine clinic appointments consist of meeting with a team of four persons who all sit together in an open area. There are no physicians’ offices or nurses’ stations in the clinic. The team includes a primary care physician, a doctor’s assistant, a nurse, and an individual who helps individuals coordinate future appointments and navigate through the medical center. Clinical options include Native Alaskan traditional healing, which is available at a person’s request and encouraged as a complement to Western medical treatment. Southcentral and Nuka perceive wellness as individual-, family-, and community-based. Every Southcentral employee is trained on how to communicate well with others and how to share stories about one’s personal character and life journey. One of Nuka’s core discoveries is that staff members who know each other well function optimally and understand the importance of trying to know their customer-owners—and because they know how important this is, they’ll take the time to get to know the people whom they are serving (Southcentral Foundation, 2017)

Another example is the culturally centered model of behavioral health being developed and implemented by The Satcher Health Leadership Institute at Morehouse School of Medicine’s Division of Behavioral Health. This initiative is a private and public partnership that involves a network of demonstration sites in integrated practice engaged in system-based quality improvements to increase access to quality

behavioral healthcare, improve health outcomes, reduce mental health stigma, and advance behavioral health equity. This project led to the development of the Transformative Leadership in Integrated Care Curriculum designed to facilitate implementation of integrated care models in community mental health and primary care centers in Georgia. Partners include the Georgia Department of Behavioral Health and Developmental Disabilities, Kaiser Permanente, Grady Health System (Asa G. Yancey Health Center, North Fulton Health Center, East Point Health Center, and Main Hospital Yellow Pod), St. Joseph's Mercy Care, Cobb County Community Service Board, McIntosh Trail Community Service Board, and Fulton County Department of Behavioral Health and Developmental Disabilities (The Satcher Health Leadership Institute, 2016).

In Texas, a similar model, the Sandra Joy Anderson Community Health and Wellness Center, is being developed through a partnership between Huston-Tillotson University (a private historically Black university) and the University of Texas at Austin's Dell Medical School. Additional partners include CommUnityCare (CUC) and Austin Travis County Integral Care (ATCIC). The Center is dedicated to helping underserved residents of Austin gain access to healthcare, and it will offer both medical and behavioral health care services in a primary care setting. The partnership is dedicated to implementing an integrated healthcare model that addresses health disparities, achieves wellness, increases the number of minority physicians in Central Texas, and combines training and research programs between the two universities (The University of Texas at Austin Dell Medical School, 2016).

Research

Regarding research about culturally and linguistically centered integrated healthcare, there is still much to be tested; however, what research has been published indicates great promise. A project in San Diego County showed interesting results. Project Dulce is a diabetes care and education program throughout San Diego County, California. It is a program with a nurse-led team (medical assistant and dietitian) in collaboration with primary care providers. It includes peer educator training; has an electronic diabetes registry to track patient care, monitor compliance, and report clinical outcomes; and has extensive sociocultural research to adapt its education curriculum, which has over 20 topics related to diabetes care in 8 languages. Study participants were from a low-income predominantly Spanish-speaking Latino population. Key components of the initiative included adding a bilingual/bicultural depression care manager, screening for depression using the Patient Health Questionnaire-9 (PHQ-9), and

providing patient education about depression and behavioral activation. Results included discovering that 33% of patients with diabetes had symptoms of major depression, PHQ-9 scores declined an average of 7.5 points from baseline to 6-month follow-up, and diabetes self-management activities improved (Gilmer, Walker, Johnson, Philis-Tsimikas, & Unützer, 2008).

“Culturally Sensitive Collaborative Treatment for Depressed Chinese Americans in Primary Care” by Yeung et al. is a 2010 study conducted at South Cove Community Health Center in Boston, Massachusetts. The patient population is 94% Chinese Americans with financial, language, and cultural barriers to healthcare. The researchers designed the Culturally Sensitive Collaborative Treatment (CSCT) model, which included systematic depression screening with the Chinese Bilingual Patient Health Questionnaire-9 (CB-PHQ-9); contact after screening (if the individual screened positive, a CB-PHQ-9 \geq 10); an Engagement Interview Protocol (EIP), through which in addition to a standard psychiatric interview, clinicians explored patients’ illness beliefs and measured their perceived level of stigma regarding illness; and a bilingual care manager. The CSCT model had a nearly 7-fold increase in treatment rate among depressed Chinese Americans in primary care. Before CSCT, only 6.5% of depressed patients in the clinic received treatment. With CSCT, 43% of untreated Chinese American patients with major depression were recognized and engaged in treatment (Yeung et al., 2010).

“Does Integrated Behavioral Health Care Reduce Mental Health Disparities for Latinos? Initial Findings” by Bridges et al. (2014) explored whether IBHC service referrals, utilization, and outcomes were comparable for Latinos and non-Latino White primary care patients in Arkansas. The study looked at 793 patients seen for behavioral health services in 2 primary care clinics during a 10.5-month period. The most common presentations were depression (22%), anxiety (19%), and adjustment disorders (13%). The results of the study showed that both groups had comparable utilization rates, comparable and clinically significant improvements in symptoms, and expression of high satisfaction with integrated behavioral services (Bridges et al., 2014).

Sustainability

From a humanistic and ethical construct, integrating physical and behavioral health seems self-evident. However, the United States of America is a capitalist society; therefore, financial sustainability is quite important. Though there is much work to be done to align financial incentives and reimbursement models, multiple studies indicate that IHC is

not only sustainable but is much more cost effective than the status quo. For example, the Milliman report commissioned by the American Psychiatric Association concluded that integrating medical and behavioral care could save \$26 to \$48 billion annually in healthcare costs (Melek, Norris, & Paulus, 2014). Furthermore, the economic ramifications of a culturally and linguistically centered integrated healthcare delivery system are also showing financial effectiveness. A recently released study indicates that the benefits far outweigh the costs. “The Costs and Benefits of Reducing Racial-Ethnic Disparities in Mental Health Care” by Cook, Liu, Lessios, Loder, and McGuire (2015) concluded that reducing disparities in mental healthcare access for racial and ethnic minorities would lead to subsequent reductions in inpatient general medical expenditures. The researchers looked at data on 6,206 people with mental illness from the 2004-2010 Medical Expenditures Panel Survey. The authors stated that providing additional care to approximately 1.3 million Blacks and 1.1 million Hispanic/Latinos with mental illness potentially would save \$1 billion in inpatient general medical expenditures (Cook, Liu, Lessios, Loder, & McGuire, 2015).

Concluding Remarks

In addition to what has been highlighted, it is important to recognize that the elimination of all healthcare disparities will require a multisystem approach. We need to advance culturally and linguistically centered integrated healthcare programs and related policies within the education, healthcare, and legal systems as well. If we expect to truly make a difference, we need to emphasize the importance of early relationships that are safe, stable, and nurturing and promote strong families and communities. To facilitate this approach, an ecobiodevelopmental framework would be of great benefit because such a framework would incorporate prevention and mental health promotion and ensure translation of recent advances in neuroscience, genomics, molecular biology, and the social sciences into tools for everyday practice (Garner et al., 2012). Eliminating health disparities and achieving health equity would help to ensure we achieve a healthcare system that is person-, family-, and community-centered. Such a healthcare system is a worthy goal from which we would all benefit.

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