Eliminating Disparities through the Integration of Behavioral Health and Primary Care Services for Racial and Ethnic Minority Populations, Including Individuals with Limited English Proficiency

A Literature Review Report

September 2012
Prepared by:

Authors:
Katherine Sanchez, LCSW, PhD;
Teresa Chapa, PhD, MPA;
Rick Ybarra, MA; and
Octavio N. Martinez, Jr., MD, MPH, MBA

This review of the literature report is based on research conducted by Sanchez, et al. in partnership with the Hogg Foundation. The findings and conclusions in this document are those of the authors, and do not necessarily represent the views of the Office of Minority Health, the U.S. Department of Health and Human Services or the Hogg Foundation for Mental Health.

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Suggested Citation
About the Authors:

Dr. Katherine Sanchez is an assistant professor at The University of Texas at Arlington and her research area of interest is in integrated health care and the provision of socio-culturally, linguistically adapted models for the treatment of comorbid mental and physical illness.

Dr. Teresa Chapa is a senior policy advisor for mental health with the U.S. Department of Health and Human Services’ Office of Minority Health.

Rick Ybarra is a program officer for the Hogg Foundation for Mental Health at The University of Texas at Austin and leads the foundation’s integrated health care grant programs and project activities.

Dr. Octavio N. Martinez, Jr., is the executive director of the Hogg Foundation for Mental Health, associate vice president of the Division of Diversity and Community Engagement and a clinical professor at the School of Social Work at The University of Texas at Austin.
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Introduction

Since the U.S. Surgeon General’s report on mental health (1999) declared mind and body to be inseparable, integrated health care 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 health care for racial and ethnic minority populations and individuals with limited English proficiency (LEP) and, as such, it has become the portal for identifying undiagnosed or untreated behavioral health disorders. Many reasons have been cited for this trend, including lack of access to mental health specialists, income and insurance issues, stigma surrounding mental illness, and the trust of the relationship with the family physician (President’s New Freedom Commission on Mental Health, 2003; Unutzer, Schoenbaum, Druss, & Katon, 2006). Various elements of integrated health care appear to have particular appeal for achieving greater outcomes with different minority groups (Dwight-Johnson et al., 2010; Ell et al., 2010; Jackson-Triche et al., 2000), with the most successful elements of this approach addressing the socio-cultural needs of the target population, such as family involvement in treatment (Bao et al., 2011). Empirical evidence of the overall effectiveness of integrated health care in reducing disparities among racial and ethnic minority populations and improving outcomes is limited due to a lack of available data collection and analyses using racial and ethnic population demographics as criteria (Bao et al., 2011; Butler et al., 2008). Nonetheless, promising practices using key strategies exist and are being successfully implemented by integrated health care programs (Sanchez, Chapa, Ybarra, & Martinez, 2012; Sanchez & Watt, In press).

The Institute of Medicine (2003) report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, concluded that a variety of health care system issues appear to contribute to the persistence of health disparities for ethnic minority populations. Minority populations are underrepresented in health care professions and among those that are providing care, they are less likely to be board certified than are physicians who treat non-Hispanic white patients. In addition, access to high-quality subspecialists, diagnostic imaging and emergency hospital admissions is difficult to secure for ethnic minority populations. Finally, minority communities often have fewer sources of health care than non-Hispanic white communities or none at all (Institute of Medicine, 2003). Racial and ethnic disparities in health care do not occur in isolation (Alliance for Health Reform, 2006). They are part of the larger framework of discrimination and racism that exists in everyday American life.

This report is an examination of critical material, which includes reports and articles from peer and non-peer reviewed publications, compiles the available evidence from practice and summarizes the knowledge base on cultural and linguistic competence in health care delivery. The report served to inform a national consensus meeting to develop recommendations on the most promising approaches for engaging racial and ethnic minority populations and persons with LEP in integrated health care to improve health outcomes and reduce health and mental health disparities.
Methods

In order to develop the literature review, all available literature on integrated health care with racial and ethnic minorities and limited English proficient (LEP) populations, including publications in peer-reviewed journals and non-peer reviewed journals and books, scientific reports, abstracts, white papers, fact sheets and any other appropriate source, was examined. The review focused on the grey literature to identify sources for critical material, retrieve reports and unpublished articles, and compile the available evidence not produced by commercial publishers for consideration of the most promising actions for engaging racial and ethnic minority populations with LEP in best practices in integrated health care.

The primary sources for the grey literature that were used included The Grey Literature Report, Science.gov and GreyNet.org. The Grey Literature Report is a bimonthly publication by the New York Academy of Medicine Library which indexes materials in health services research, health and science policy, public health, and the health of vulnerable and special populations with a focus on unindexed publications not available through normal, commercial distribution channels. Materials in the collection are published by government agencies, nonprofit and non-governmental organizations, universities, independent research centers and international organizations. The materials include case studies, conference proceedings, discussion papers, fact sheets, government documents, issue briefs, research reports, statistical reports and white papers. Similarly, Science.gov and GreyNet.org provide access to 50 million pages of authoritative selected science information provided by U.S. government agencies, including research and development results.

Additionally, a search was conducted to identify standards and strategies that have been recommended by organizations whose work encompasses advocacy and representation of vulnerable populations. These organizations included the U.S. Office of Minority Health (OMH), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), Mental Health America (MHA), the National Association on Mental Illness (NAMI), the National Asian American Pacific Islander Mental Health Association (NAAPIMHA), the National Hispanic Medical Association (NHMA), and the National Alliance for Hispanic Health. The organizations were scanned for reports, fact sheets, annotated bibliographies and tool kits for implementation of culturally competent standards of care for racial and ethnic minority populations to include LEP individuals.
Integrated Health Care

There exists an extensive body of research documenting the high prevalence of mental health disorders being treated in primary care settings (Bower & Gilbody, 2005; Unutzer et al., 2006). Racial and ethnic minority populations, in particular, are more likely to receive mental health care in primary care settings (Chapa, 2004). A great deal of research has been devoted to the study of efficacious interventions for the treatment of common mental disorders. However, there is a lack of available studies for many racial and ethnic minority groups (U.S. Department of Health and Human Services, 2001). African Americans, for example, are often undercounted in household surveys because of overrepresentation in institutional settings such as jails, shelters and foster care (Davis, 2011). The lack of studies is a particular concern for racial and ethnic minorities, and limited English proficient (LEP) populations. The first contact with a health care provider is typically in a primary care setting and, thus, individuals are likely to receive their mental health care in primary care settings.

Assessment measures of mental health often lack validity in racial and ethnic minority populations (U.S. Department of Health and Human Services, 2001). Immigrant and LEP populations have varying cultural constructs for how stress, distress and health are described, and since they represent a small percentage of the population, they are often completely eliminated from studies due to high cost for screening or a categorical lump into “other” status. Many household surveys are conducted in English only and the issue of mistrust of government, either historical or from their country of origin, can be a significant influence and result in a failure to include segments of the U.S. population in research studies (U.S. Department of Health and Human Services, 2001).

According to the landmark Mental Health: Report of the Surgeon General (1999), major depression is the second leading cause of disability and premature mortality in the United States. Also near the top of the rankings are bipolar disorder, schizophrenia, obsessive-compulsive disorder and other anxiety disorders. The World Health Organization (2011) estimates mental disorders collectively account for more than 13 percent of the global burden of disease from all causes and are associated with the highest rates of unemployment of all disabilities. More than one million suicides occur annually worldwide, and suicide is one of the leading causes of preventable death in the United States (U.S. Department of Health and Human Services, 1999; World Health Organization, 2009). Suicide disproportionately affects minority populations, especially youth. For example, thoughts of suicide are higher among Latino adolescents, and Latina adolescents are significantly more likely to have attempted suicide (Flores et al., 2002; Gulbas et al., 2011; Pena et al.; Zayas, 2011). American Indian/Alaska Native males ages 15 to 24 years have the highest rate of suicide of all groups and Chinese women over the age of 65 have the highest reported suicide rate within their age cohort (Centers for Disease Control and Prevention, 2007). The Surgeon General’s report (1999) conveyed two essential messages regarding mental illness; one is that “mental health is fundamental to health” and the other is that “mental disorders are real health conditions” (p. xii).

The President’s New Freedom Commission on Mental Health (2003) was charged with conducting a comprehensive review of the mental health care delivery system in the United States. The commission found that people from racial and ethnic minority groups and other underserved populations are particularly unlikely to receive specialty mental health care treatment. One goal that emerged from the commission’s final report concerned early mental health screening and treatment in multiple settings. In order to achieve that goal, the commission recommended integrated health care strategies for the
identification and treatment of mental disorders across the life span, implemented in primary care settings, and reimbursed by public and private insurers (President’s New Freedom Commission on Mental Health, 2003). The President’s New Freedom Commission also stated with certainty that cultural and linguistic competence are essential to improving the mental health care system (President’s New Freedom Commission on Mental Health, 2003).

Integrated health care refers to a comprehensive, multi-disciplinary approach to health care, which, as with other chronic conditions, has proven to be effective in the detection and management of mental health disorders. Although integrated care approaches vary in terms of the best means of achieving integration, some essential elements include systematic clinical care management provided by a social worker, registered nurse or other licensed mental health provider, proactive follow-up and outcome monitoring. It is a systematic approach that often involves the integration of a care manager with psychiatric consultation and primary care physician oversight to more proactively treat mental health problems, such as depression and anxiety (Unutzer et al., 2006).

The care manager is the linchpin of the model, whose primary function is to manage the mental health disorders of patients and facilitate communication between the primary care providers and the mental health specialist (Thielke, Vannoy, & Unutzer, 2007). The chief roles of the care manager include educating patients, involving and supporting treatment decisions, encouraging medication adherence, monitoring treatment outcomes, providing brief counseling and facilitating consultation with the psychiatrist as needed (Oxman, Dietrich, & Schulberg, 2003, 2005). The functions of the care manager can address significant barriers to treatment such as stigma, limited knowledge of mental health disorders, poor doctor-patient communication, and treatment engagement and adherence, which disproportionately affect racial and ethnic minorities (Bao et al., 2011). However, those functions may be limited unless culture-specific strategies are employed to engage and retain minority patients in treatment (Bao et al., 2011).

In an effort to describe and assess models of integrated care, the level of integration into community settings and to describe barriers to successful programs, the Agency for Healthcare Research and Quality (AHRQ) (Butler et al., 2008) produced a comprehensive report based on several data sources, which included literature not traditionally found in peer reviewed journals. The report’s findings suggest, in general, that integrated health care achieved positive outcomes. However, similar to other meta-analyses, it was difficult to discern if certain elements of integrated care resulted in improved outcomes or whether an overall increased attention to mental health in the primary care setting resulted in the improved outcomes.

Certainly, the AHRQ concluded that programs that responded to patient preferences for psychotherapy, as opposed to medication, were associated with long-term improvements in depression scores for a minority population (Butler et al., 2008). Financial barriers remain a significant concern to long-term implementation. A critical question, yet to be answered by meta-analyses, clinical trials, case studies and systematic literature reviews, is who benefits from integrated care? Although the evidence is strong, the specific elements, disease conditions and minority and vulnerable populations which are best served by integrated care, are not well understood because of a lack of data on specific populations and lack of minority inclusion in research studies (Butler et al., 2008).
Health Disparities

Language accessibility and linguistic sensitivity are essential elements to the treatment of mental and physical health disorders (Brach & Chevarley, 2008). Accurate screening, diagnosis and treatment are entirely dependent on a linguistically accurate interview. Having a physician that does not speak the patient’s language is an independent predictor of poor control of chronic disease and a significant contributor to health disparities, lack of patient satisfaction, and poor-quality patient education and understanding of their disorder (Fernandez et al., 2011; Ngo-Metzger, Sorkin, & Phillips, 2009). The language barriers, which obstruct effective communication, result in an added perception of lack of respect and interest in the patient on the part of the provider (Ida, SooHoo, & Chapa, 2012).

A 2001 Commonwealth Fund survey found that adult minority, non-English speaking patients have communication difficulties with their primary care physicians which result in difficulties understanding instructions about their health (Doty & Ives, 2002). Low English proficiency (LEP) is associated with reports of poor quality of primary care, an absence of a source of care, and a lack of continuity of care (Pippins, Alegria, & Haas, 2007). Additionally, LEP patients who report having a physician who does not speak their native language were less likely to adequately comprehend medical situations, and more likely to report trouble understanding labels and adverse medication reactions (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005).

Lack of English fluency is associated with reduced health care use (Fiscella, Franks, Doescher, & Saver, 2002). LEP individuals are less likely to self-identify a need for mental health services, which subsequently predicts lifetime mental health care use and results in longer duration of untreated disorders (Bauer, Chen, & Alegria, 2010). The lack of perceived need for treatment, particularly among Latino and Asian Americans, is thought to be related to a number of cultural factors such as somatization of stress, reliance on family and social networks for support instead of medical providers, and low health literacy in general. The magnitude of the language barrier as it contributes to disparities in health and mental health care is likely to increase as the population grows.

The recognition of language barriers to adequate health care can be described as the first of what have become many efforts at recognizing and describing health disparities that exist in the United States. In 1985, the U.S. Department of Health and Human Services released the first landmark report documenting the health status of blacks, Hispanics, Asian Pacific Islanders and Native Americans. For the first time, the comprehensive report described the “persistent, significant health inequities” affecting minorities in the United States (Heckler, 1985). As a result, the Office of Minority Health (OMH) was created in 1986 and is one of the most significant outcomes of the Secretary’s Task Force Report on Black and Minority Health (Heckler, 1985). The office is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. OMH was reauthorized by the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148).

Years later, the National Center on Minority Health and Health Disparities (NCMHD) was established by the passage of the Minority Health and Health Disparities Research and Education Act of 2000 (P.L. 106-525) and was signed by the President of the United States on November 22, 2000. The goals and purposes of the center, now an institute, include assessing the National Institute of Health (NIH) efforts to reduce health disparities through an integrated, multi-disciplinary research agenda (National Institute on Minority Health and Health Disparities, 2012). Finally, in 2001, the Surgeon General’s report (2001), Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report
to the Surgeon General, Mental Health 1999, described very serious disparities that exist in the delivery of mental health services to racial and ethnic minority populations (U.S. Department of Health and Human Services, 2001).

The Institute of Medicine (2003) report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, demonstrated that there is significant evidence that racial and ethnic minority populations in the U.S. are less likely to receive a variety of medical services, from routine procedures to appropriate cardiac medications and bypass surgery. They are, however, more likely to have limb amputations as a result of diabetes and experience a lower quality of health services overall. These disparities for racial minorities were consistent even when controlling for insurance status, income, age and education level (Institute of Medicine, 2003). Disparities in the provision of quality mental health treatments for people of color is the same (National Alliance on Mental Illness, 2007).

In the years since the Heckler report, the U.S. Department of Health and Human Services (HHS) has responded with a number of initiatives intended to address and reduce racial and ethnic disparities in health. In 2004, responding to national leaders in minority behavioral health, the Office of Minority Health was asked to examine mental health in primary care settings for racial and ethnic minority populations, consider strengths and challenges, and make recommendations (Chapa, 2004). During the past decade, several states received awards from the Centers for Disease Control and Prevention to develop Racial and Ethnic Approaches to Community Health (REACH) demonstration projects. Innovative and progressive programs were funded, including faith-based initiatives, community-based participatory research methods, interventions to improve self-management of chronic disease and a variety of screening and prevention efforts to address health disparities for racial and ethnic minority groups (Centers for Disease Control and Prevention, 2011b). Unfortunately, mental health was not one of the health priority areas targeted by REACH.

In 2011, the Secretary for the U.S. HHS Kathleen Sebelius released the first ever Action Plan to Reduce Health Disparities: A Nation Free of Disparities in Health and Health Care. This represented the first significant effort to identify and describe opportunities built into the Patient Protection and Affordable Care Act (PPACA), also known as ACA, other federal initiatives and infrastructure to measure and reduce racial and ethnic health disparities (U.S. Department of Health and Human Services, 2011). The plan represents a commitment to effectively address racial and ethnic disparities by continuously assessing the impact of all federal policies and programs, and to implement evidence-based best practices to reduce disparities. The structure of the Disparities Action Plan includes four overarching secretarial priorities, five goals and 29 “high impact” actions that are assigned to a lead federal agency with a timeline and a projected completion date. The Disparities Action Plan represents an important opportunity for the Office of Minority Health leadership within HHS.

In March 2010, President Obama signed the landmark Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148), of which important disparities provisions were included to improve access, affordability and quality of care for low-income Americans. It includes a special focus on racial and ethnic minorities. By improving access to primary care, availability of community-based programs, and investment in infrastructure such as workforce diversification and training, the ACA focuses on prevention and lays a strong foundation for reducing health disparities by making improvements through coordinated, preventive care. The ACA includes provisions related to disparities reduction and health equity (http://www.healthcare.gov).
Despite decades of efforts to improve and protect the health of racial and ethnic minority populations, disparities persist. Additionally, essential public awareness of the existence of disparities such as provider access, health insurance and the cost of health care remains low. Although it appears around 60 percent of Americans are aware of disparities facing African Americans and Hispanics, Asian Americans/Pacific Islanders are perceived as being as healthy as non-Hispanic whites (NORC at the University of Chicago, 2010). Public awareness and knowledge of health disparities that exist for racial and ethnic minority populations is essential for policy makers and decision makers to mobilize action to achieve equity (NORC at the University of Chicago, 2010).
Behavioral Health Disparities

To try to describe entire racial and ethnic groups as a monolithic population can, in and of itself, function as a barrier to providing proper health care to individuals (Weinick, Jacobs, Stone, Ortega, & Burstin, 2004). Differences in cultural and social identities of various racial and ethnic groups, although somewhat heterogeneous because of demographic factors like age and length of time in U.S., are also strongly related to their identification with their country of origin (Velez-Ibanez, 2004). Misconceptions about homogeneity of a given ethnic group, like Hispanic or Asian American, can contribute to inequalities in the availability, use and quality of healthcare services. Many differences can be found in the countries and cultures of origin of the residents of the United States. Different cultures recognize, accept, diagnose and treat mental health concerns in significantly different ways (Weinick et al., 2004).

Asian Americans, Native Hawaiian and Pacific Islanders (AANHPI), for example, often consider the expression of mental illness as a personal weakness and are more likely than westerners to express emotional distress through physical symptoms (National Asian American Pacific Islander Mental Health Association, 2011). Shame and stigma are thought to be powerful barriers to seeking treatment for mental health or addictions for Asian Americans. AANHPI populations are less likely to report mental health concerns to friends and family. Adding to the complexity of the issue is the severe trauma experienced by Southeast Asians prior to migration to the U.S., which has resulted in high rates of post-traumatic stress disorder and major depression among some groups. Similar to other minority populations in the United States, economic factors and lack of awareness of mental health issues and services are barriers to care (National Asian American Pacific Islander Mental Health Association, 2011).

Similar to Latinos, AANHPI communities report high levels of dissatisfaction with health care services because of language and cultural barriers, which can lead to poor health outcomes. These negative perceptions of the health care system have implications for the entire community (Ida et al., 2012). AANHPI populations view health in terms of the whole person and often find medical advice contradicts their personal beliefs. Failure to recognize cultural beliefs and traditions leads to high levels of frustration for patients, misdiagnosis, ineffective treatment and, ultimately, lack of follow through for both behavioral and physical health care plans that fail to consider the whole person (Ida et al., 2012).

For many Latinos, response to depression treatment may require a considerable amount of time to reach remission (as much as two-and-a-half years) (Interian, Ang, Gara, Rodriguez, & Vega, 2011). Additionally, relapse rates are high and the slow response to treatment may explain the premature discontinuation of medication by patients. Intractable symptoms and slow recovery leave minority populations with a considerable disease burden for a substantial length of time compared to non-Latino whites (Gonzalez, Tarraf, Whitfield, & Vega, 2010; Interian et al., 2011).

Previous studies suggest slight advantages in mental health, possibly protective factors, of Hispanic immigrants in spite of otherwise greater economic and health disparities (Eschbach, Ostir, Patel, Markides, & Goodwin, 2004; Vega et al., 1998). In fact, the results of several studies indicate that Mexican-born Hispanics have better mental health than do U.S.-born Mexican Americans and the U.S. population overall (U.S. Department of Health and Human Services, 2001). However, those advantages are essentially eliminated for second-generation immigrant populations. Interestingly, bilingual Latinos appear healthier when interviewed in Spanish than when interviewed in English (Changing Minds Advancing Mental Health for Hispanics, 2002).

There are close to 14 million African Americans with a diagnosable mental illness (Davis, 2011). African Americans tend to delay seeking help for mental
health concerns and rarely utilize formal behavioral health services. When they do seek help, it is often from informal sources such as friends, churches and ministers. When they get professional health or behavioral health care, African Americans are more likely to obtain that care from primary care physicians and emergency rooms, and have documented poor compliance with treatment after service (Davis, 2011).

Disparities in behavioral health treatment between African Americans and non-Hispanic whites have been documented in inpatient psychiatric care, with African Americans being significantly more likely to be hospitalized. Delay in seeking professional treatment, high rates of readmission and incorrect diagnosis are thought to contribute to these differences. For African Americans, the lack of culturally sensitive providers and geographic underrepresentation of clinicians are significant barriers to access. Finally, African Americans are thought to comprise over 40 percent of the homeless population, among whom serious mental illness occurs at stunningly high rates (U.S. Department of Health and Human Services, 2001).

Low use of antidepressant medication, poor doctor patient communication (DPC) and persistent stigma around issues of mental illness are key barriers to the treatment of depression in racial and ethnic minority populations (Cooper et al., 2003; Interian et al., 2011; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). Additionally, there appears to be a general mistrust of medical providers which arises from historical persecution, documented abuse and perceived mistreatment in health care settings because of race or ethnic background (U.S. Department of Health and Human Services, 2001). Racial and ethnic minority populations initiate antidepressant medication treatment at a much lower rate than non-Hispanic whites, and are more likely to discontinue their treatment for depression without consulting their physician, in spite of being equally likely as non-Hispanic whites to have received a medication prescription from their primary care provider (Warden et al., 2007).

The recent Center for Disease Control and Prevention (2011a) action plan to integrate mental health care with chronic disease prevention found that people from ethnic minority populations who have diagnosed disorders of any type often face problems accessing medical care. Limited English-language proficiency, limited medical literacy, geographic inaccessibility and lack of medical insurance are all more common among immigrants, minority populations and people in rural areas. Citizenship status clearly has an impact on what extent an individual can seek medical treatment, as does the level of acculturation, and duration of residence in the U.S. (Weinick et al., 2004).
Social Determinants of Health

Cultural competence is one of many factors affecting health disparities among racial and ethnic minority populations. Recent public health efforts, particularly in the past decade, have identified a select array of conditions in which people live that are significantly affecting health. Referred to as the social determinants of health, the list includes community design, housing, employment, access to health care, access to healthy foods, environmental pollutants and occupational safety (Ramirez, Baker, & Metzler, 2008). Simply put, location matters. The inequitable impact of the environmental and social conditions in which people live has a significant effect on the persistent and pervasive health disparities plaguing racial and ethnic minority populations. The social determinants of health include income, education and neighborhood. The social determinants that are attributable to increased death rates include low education level, racial segregation, low social support and poverty (Galea, Tracy, Hoggatt, DiMaggio, & Karpati, 2011).

Summarizing the recent work on social determinants, differences in education and income are a better explanation for poor health than any other factors. Adults without a high school diploma are three times as likely as those with a college education to die before age 65 (Bravemen & Egerter, 2008; Institute of Medicine, 2001). The high school dropout rate is 18.3 percent among Hispanics, 9.9 percent among blacks and 4.8 percent among non-Hispanic whites. The proportion of Hispanic adults with less than seven years of elementary school education is twenty times that of non-Hispanic whites (DeNavas-Walt, Proctor, & Smith, 2010). As of 2009, white households had twenty times the net worth of black households (Taylor, Kochhar, Fry, Velasco, & Motel, 2011). The social determinants play a significant role in patient/consumer health literacy skills, and are critical for understanding basic health education communications and messaging.

The social determinants of health include societal conditions and psychosocial factors, such as opportunities for employment, hopefulness and freedom from racism. U.S. adults living in poverty are more than five times as likely to report being in fair or poor health compared to adults with incomes at least four times the federal poverty level (Heron et al., 2009). These determinants are thought to impact health indirectly through their influence on health-promoting behaviors. Racial and ethnic minority populations are more likely to live in conditions that put their health at risk.

The systematic and unequal distribution of resources critical to optimal health, such as access to healthy food or a safe environment in which to exercise, has a significant impact on populations marginalized by low socio-economic status and geographic location (Ramirez et al., 2008). Low-income areas have one-third fewer grocery stores than higher income neighborhoods. Additionally, corner stores and gas stations typically charge one and a half times the price of similar items in grocery stores (International City/County Management Association, 2006). Not having an automobile or adequate public transportation can reduce access to affordable, healthy food. Less expensive, more accessible foods are often high in calories and fat. Limited time and knowledge of food preparation can increase demand and consumption of prepackaged or processed foods (International City/County Management Association, 2006).

Efforts to promote health equity by addressing the social determinants of health in research are critical, yet tricky to tease out. Recent findings presented at the American Association for Cancer Research (Kaplan, 2011) suggest an association between high stress levels and aggressive forms of breast cancer, and that black and Latina women tend to have higher stress levels than non-Hispanic white women. Researchers describe the components of “psychosocial
stressed,” including anxiety and isolation that might take a toll on the physical health of women and lead to more aggressive cancers. However, they acknowledge the limitations of their findings, explaining that the diagnosis of an aggressive cancer might have generated the high stress levels found in the study.
Cultural and Linguistic Competency

It is widely believed that interventions designed to address disparities in the delivery of services to racial and ethnic minority populations have had such a limited impact on outcomes in health care equity largely because factors at the organizational and institutional level have not been addressed. According to the U.S. Department of Health and Human Services (Office of Minority Health, 2001), cultural and linguistic competence is “a set of congruent behaviors, attitudes, and policies that come together . . . that enables effective work in cross-cultural situations” (p. 4). Culturally competent, patient-centered care is essential to improve the quality of health care and reduce health disparities.

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care were issued by the U.S. Department of Health and Human Services Office of Minority Health (OMH) to direct health care organizations to provide culturally competent care, language access services and organizational support for cultural competence (Office of Minority Health, 2001). The CLAS Standards, which have been adopted by health care accrediting organizations, require assurance of meaningful access, equitable and effective treatment, and culturally and linguistically appropriate services to meet the needs of racial and ethnic minority populations. Four of the mandates apply to all organizations that receive federal funding such as Medicare and Medicaid, and nine are guidelines recommended by the OMH for adoption. All of the CLAS Standards are suitable for use throughout the health care system, by credentialing agencies, health insurance organizations, patients, advocates and the community in general (Office of Minority Health, 2001; Wu, Erickson, & Kennedy, 2009).

Most recently, Ell, Katon and colleagues (2010; 2011) successfully implemented culturally and linguistically competent integrated care models, which address depression and psychosocial and economic stressors that have proven successful in Hispanic patients with diabetes and cancer. Yeung and colleagues (2010) also examined a culturally sensitive collaborative treatment model based on Katon’s model for the treatment of depression in primary care. Both frameworks for providing integrated health care to meet the needs of the study population assumed patients’ health beliefs and treatment adherence were informed not only by their culture but also by powerful social constructs and systemic barriers to care.

The integrated health care intervention designed by Ell, Katon and colleagues (2009) proactively addressed systemic barriers by using Spanish-speaking recruiters and interviewers, adapting study intervention materials for literacy and cultural content, reimbursing patients for completing outcome interviews and covering transportation expenses. The
intervention consisted of bilingual master’s-level social workers serving as care managers. The intervention also provided training in cultural competency for all staff, support groups in Spanish and English, and a supplemental patient navigation intervention to address clinic and system communication barriers, facilitate access to community resources, and locate patients who had missed appointments (Ell et al., 2009). Yeung, et al. (2010) implemented similar strategies but put a special emphasis on the screening and outreach components since there were significant cultural barriers to overcome in the Chinese immigrant community regarding stigma. They also assessed the patients’ illness narrative to understand how people conceptualize their illness while reframing Western definitions of depression into terms that were more culturally relevant.

Finally, in the interventions designed by Ell, et al. (2009) and Yeung, et al. (2010), patients were provided their choice in first-line treatment preference, of which psychotherapy alone was an option, instead of antidepressant medication. Additionally, patients were offered the opportunity to include family members in treatment, if preferred, with a particular focus on linking problem-solving skills and patient education to depression self-management and socioeconomic stressors created by their illness. Consistent with language access competency, patient education and homework materials were linguistically, idiomatically and literacy-level appropriate (Ell et al., 2009; Yeung et al., 2010).
Workforce

Cultural competence in the delivery of mental health services for racial and ethnic minority populations has a profound effect on access to and quality of mental health care (National Alliance on Mental Illness, 2007). Key to the delivery of culturally and linguistically competent care is a diverse workforce that also represents the population. The availability of a properly trained mental health workforce is among the most pressing health care issues facing the nation, especially in rural, border and frontier areas (The Annapolis Coalition on the Behavioral Health Workforce, 2007). Lack of diversity among the health care workforce is thought to be a significant contributor to disparities in health care among ethnic minority and LEP populations because it limits availability and meaningful access to culturally and linguistically competent care (Chapa & Acosta, 2010; Vega et al., 2007).

The 2001 Surgeon General’s supplemental report on mental health stated that racial and ethnic minority populations continue to be critically underrepresented relative to their proportion of the U.S. population within the core mental health professions – psychiatry, psychology, social work, counseling, and psychiatric nursing (U.S. Department of Health and Human Services, 2001). Most of the health professions are less ethnically diverse than the U.S. population and the lack of minority representation in professional training programs and in the workforce is an important factor in mental health disparities (Hogg Foundation for Mental Health, 2007; Sullivan, 2004).

The Sullivan Commission (2004) suggested that racial and ethnic minority populations feel intentionally excluded from the health care system because it bears so little resemblance to the diverse populations of mainstream America that it is intended to serve.

One important step toward addressing the behavioral health workforce shortage was the recent U.S. Department of Health and Human Service Office of Minority Health initiative Movilizandonos por Nuestro Futuro: Strategic Development of a Mental Health Workforce for Latinos (Chapa & Acosta, 2010), the first roundtable discussion for developing a mental health workforce for Latinos. Movilizandonos (Chapa & Acosta, 2010) also recommended creating and implementing policies, such as the allotment of student loan forgiveness programs for clinical professions critical to enhancing the quality of research and services for health promotion, prevention and treatment. Finally, the initiative culminated with the formation of the Alliance for Latino Behavioral Health Workforce Development whose charge is to develop and monitor an educational awareness and advocacy plan to implement the recommendations with stakeholder support from public-private partnerships. Similar efforts on workforce development for integrated care and building a culturally and linguistically competent workforce include, Integrated Care for Asian American, Native Hawaiian and Pacific Islander Communities: A Blueprint for Action (Ida, D., SooHoo, J, & Chapa, T, 2012) and Pathways to Integrated Healthcare: Strategies for African American Communities and Organizations (Davis, K., 2011). All three consensus documents outline the need and suggestions for developing a multidisciplinary workforce, including increasing minority leadership in key health and behavioral health positions. Finally, diversifying the workforce is essential to train the next generation of providers and to develop culturally competent, evidence-based interventions.

The Annapolis Coalition on the Behavioral Health Workforce (2007) suggested that the role of the consumer in behavioral health treatment is changing, with a strong trend toward self-management, peer support and empowerment of consumers. This is true in behavioral health as well as in medicine. Access to information over the internet has dramatically changed the role of the patient and has provided new opportunities for true partnership and collaboration.
between patients and providers. Expanding the role of communities and individuals to promote recovery and wellness is essential (The Annapolis Coalition on the Behavioral Health Workforce, 2007). The Annapolis Coalition also recommended other, non-traditional methods of workforce development. Non-traditional methods include using consumers/patients/family members in training and incorporating technology such as teleconferencing and distance learning to reach culturally, linguistically or geographically isolated communities.

The use of community health workers (CHW) and promotores de salud is on the rise across the country in urban, rural, and in many towns along the U.S./Mexico border. They work with diverse racial, ethnic and linguistic groups to promote health and behavioral health, and serve as cultural brokers that bridge patients and community health providers (Waitzkin et al., 2010; Williams, 2001). Also known as community lay workers, outreach workers, patient navigators, lay health educators, as well as many other titles, they represent trusted members of the community that are recruited to provide health education and screening services in underserved ethnic communities (Office of Minority Health, 2012; Waitzkin et al., 2010). Although often enlisted to serve a variety of functions in community and health, the role of the CHW, or promotora, in mental health and substance use screening and care can be especially effective in reducing barriers by communicating in the language of the patient and providing insight to the problem at hand and the treatments prescribed. By integrating themselves into the community-based health clinic, the CHW/promotora can help reduce stigma, enhance patient engagement and facilitate the warm handoff to a provider of trust, and represent an important part of the solution to a culturally and linguistically competent workforce (Office of Minority Health, 2012).
Applying Cultural Competence to an Evidence-based Framework

Using the Institute of Medicine (IOM) (2001) report, *Crossing the Quality Chasm*, the Commonwealth Fund (Betancourt, 2006) examined the six IOM principles of quality to understand how cultural competence ties into depression care management (DCM) and how those efforts can, in turn, address disparities. Specifically, the Commonwealth Fund report identified key components of integrated health care in which certain aspects of cultural competence could be linked in order to improve quality and lead to reductions in health disparities for racial and ethnic minority populations (Betancourt, 2006). For example, patient registries are an essential component of integrated health care, but in a culturally competent approach such registries would be stratified by race, ethnicity and language in order to better identify vulnerable populations at risk for dropping out of care. Another key integrated care strategy is communication outside of the traditional office visit. In a culturally competent model, that communication would be language adapted, including health literacy modifications, and perhaps even encompass alternative health beliefs.

Culturally and linguistically competent, patient-centered care is essential to improve the quality of health care and reduce health disparities (Office of Minority Health, 2001; The Commonwealth Fund, 2001; U.S. Department of Health and Human Services, 2011). Adult minority, non-English speaking patients have communication difficulties with their primary care physicians which result in difficulties understanding instructions about their health (Doty & Ives, 2002). Moreover, in spite of efforts to use interpreter services, more errors occur with ad hoc, untrained interpreters which can have serious consequences for patients with mental disorders (Flores, 2005).

The Commonwealth Fund report (Betancourt, 2006) further describes culturally competent interventions that reduce barriers to integrated health care, such as addressing patient fears and concerns around medications, and issues related to the patient’s ability at self-management of disease in relation to their social context, which could include their physical environment and ability to exercise. Finally, sorting clinical performance feedback from patients by race, ethnicity and language would help identify trends and issues among distinct populations (Betancourt, 2006).

Access to care is affected by poor outreach campaigns to eligible communities, lack of availability of materials in a variety of languages, and the fear of retribution and reporting to the government of their immigration status that immigrants have when applying for public benefits. Flores (2002) identifies other access to care barriers such as poverty, low parental education, transportation problems and excessive wait times. Integrated health care offered in a culturally competent, patient-centered framework needs to address root causes of health disparities and reduce individual, provider and system barriers through the use of extensive cultural competency training (Betancourt, 2006; Ell et al., 2009).
Conclusion

New models of integrated health care to meet the needs of racial and ethnic minority populations should provide culturally and linguistically competent care and increase access through practice, system and community level adaptations and initiatives. For patients struggling with stigma and fears about antidepressant medication, doctor-patient communication can be improved by adopting patient-centered communication. Incorporating the patient in treatment, eliciting preferences, and having the physician communicate an understanding of and empathy for stigma issues related to antidepressant medication, have been identified as optimal practices for reducing mental health disparities (Interian et al., 2011).

The development of interdisciplinary physical and behavioral health training programs that focus on models of integrated primary care, such as medical homes, team management of chronic disease and specific models that integrate physical and mental health services, are examples of partnerships designed to reduce minority health disparities (Martinez et al., 2012). Other workforce development strategies include ethnic minority patient navigators, community lay health workers and health advocates that reach out to the community to provide education, self-management skills and support.

There is a lack of scientific evidence for integrated health care offered in a culturally competent, patient-centered framework that adequately addresses key concerns and barriers that most affect populations at greater risk for marginal mental health and substance use care, especially racial and ethnic minority populations and those with limited English proficiency. The identification of the critical components of successful integrated health care models for racial and ethnic minorities, with an emphasis on cultural coping behaviors and provider language fluency, is essential to eliminating disparities in health care.

Achieving optimal health will require the inclusion of non-clinical strategies (Smedley, 2008). It will require improved coordination of relevant agencies and organizations, whose activities address determinants of health (education, housing, agriculture, employment, health). Finding ways to increase the availability of healthy, affordable food in underserved communities (encouraging major grocery chains and farmers’ markets to locate in such communities) is essential. It will require community-level interventions for health promotion (tobacco control programs, exercise initiatives, diabetes self-management) and school-based strategies to improve graduation rates and reverse obesity trends (Smedley, 2008). In integrated care settings, it will require assisting patients with careful navigation between the myriad of systems.

Despite an extensive body of evidence in the research literature demonstrating the effectiveness of integrated health care, implementation in various “real world” settings presents a number of barriers. Currently, the issues regarding dissemination and sustainability of the integrated care model(s) are at the forefront of health care discussions among researchers, practitioners and policy makers (Katon, Unutzer, Wells, & Jones, 2010). To successfully translate the existing research on integrated health care into practice with vulnerable populations will require additional guidance and input from the community, consumers of health and behavioral health care and their family members, as well as national experts in the fields of health, mental health, substance use/abuse and cultural and linguistic competency. The financial incentives, practice transformation and policy change necessary for broad implementation and sustainability to improve health status and eliminate disparities for racial and ethnic minority communities will require persistent commitment from local, state and national leaders and will be equally, if not more, challenging than creating the research evidence base itself.
References


