Ensuring Cultural Competency in New York State Health Care Reform

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Dear colleagues:

Please read and consider closely this paper on cultural competence and health reform--with a special emphasis on behavioral health. The paper provides an excellent briefing on changes underway in health care and behavioral healthcare, as well as an expert summary of key issues and recommendations in Cultural Competence. These perspectives are integrated in a report that leaders at every level can use to improve care.

In mental health, quality care cannot be delivered without cultural competence. There is no better way to describe this than by quoting former Surgeon General Dr. David Satcher: "When it comes to mental health, culture counts" (emphasis added). Mental health concerns are expressed in thinking, emotion and personality. They are strongly linked to our history, our family, our experiences. We need mental health care that is aligned with who we are.

Perhaps some of the time, cultural competence can be unconscious...for example, if a therapist is treating a consumer who has the same background and experiences that she does, their shared culture may provide a good starting point. But in a state as diverse as New York, we must also work to build cultural competence...by respecting diversity, attracting a health care workforce as diverse as the communities we serve, assuring linguistic accessibility for our services--as Governor Cuomo has directed--and making cultural competence a foundation of our approach to recovery. I hope you find this paper a valuable resource.

Sincerely,

Michael F. Hogan, Ph.D.
Commissioner

Executive Summary New York State (NYS) has initiated health care system reform in accordance with mandates found in the federal Patient Protection and Affordable Care Act that are expected to transform the organization and delivery of mental health care services. The Medicaid Redesign initiative aims to improve quality of care and reduce costs by transitioning Medicaid clients to managed care plans and enrolling those with complex needs and high costs into newly formed integrated care models. Regional Behavioral Health Organizations have been introduced to facilitate the transition and local Health Homes to deliver the care. Given the growing diversity of the population of NYS, cultural competency (CC) should be at the forefront of reform activities. Care of clients from the traditionally underserved racial/ethnic groups may be unnecessarily compromised if these service models are not culturally competent. The White Paper summarizes the current evidence showing that CC activities help improve these groups' access to, engagement with, and retention in mental health care as well as enhance the quality of their care. We also review evidence indicating that CC activities help lower costs through the use of bilingual clinicians and culturally adapted interventions, and reduce the risk of medical errors and malpractice. To help ensure cultural competence in the various service components of the emerging models, the Paper provides specific recommendations for activities that should be undertaken to ensure cultural competence. Organizational activities that set the stage for cultural competency include having a CC plan, organizing a CC advisory committee, recruiting and hiring culturally diverse staff (including peers), and providing training on CC to staff at all levels. More specific activities that are recommended include:

For RBHOs and HHs serving clients from underserved cultural groups

- Enhance data collection systems to allow more specific identification of cultural groups
- Develop centralized interpreter services
- Translate relevant documents
- Disseminate CC health promotion materials to communities in coverage areas
- Disseminate 'vetted' training materials for CC training to community providers/network partners
- Assess performance measures of the quality of care provided by community providers/network partners specifically with respect to underserved cultural groups
- Assess CC of community providers/network partners and provide them with actionable feedback
- Promote the use of evidence-based practices (EBPs) that have evidence for the cultural populations served
- Assist providers in adopting and adapting culturally-relevant EBPs

For HH Network Partners serving clients from underserved cultural groups

- Conduct client and family cultural assessments
- Ensure language and communication competencies of staff
- Develop programmatic strategies for trust building and stigma reduction
- Provide services in culturally appropriate milieus
- Involve family or consumer-valued persons in the care process, as desired by consumer
- Ensure that referrals for care and social supports are CC
- Provide linkages to culturally-valued community supports (e.g., churches, clubs)
- Monitor outcomes by cultural group

Chapter I. Rationale for Cultural Competence in Health Care Reform

A. Introduction

New York State has initiated health care system changes in compliance with mandates found in the Federal Patient Protection Affordable Care Act (PPACA) that will lead to transformations in the organization and delivery of mental health care services. Ensuring the cultural competence of the emerging service models is particularly important for persons with behavioral health care disorders, as their engagement and retention in care may be unnecessarily impeded if cultural accommodations are not included. Given the growing diversity of the population of NYS, cultural competency needs to be at the forefront of reform activities.

Cultural Competence:

Culture **refers to integrated patterns of human behavior and cognition that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of a particular social group (e.g., ethnic or racial group, faith community, language group).**

Cultural Competence **in an individual or organization implies having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.**

Adapted from Anderson et al., 2003

The goals of cultural competence in the delivery of health care are consonant with the 'Triple Aims' of health care reform articulated by Donald Berwick, former director of the Center of Medicaid and Medicare Services (Berwick, 2008): namely, to improve population health, increase quality of care, and reduce costs. Providing prevention care that is culturally competent care is essential for the improvement of a population's mental health. Cultural competence increases access and engagement into needed services for members of underserved racial and ethnic groups and for persons with limited English proficiency. Providing culturally competent care improves service quality and outcomes because diagnoses are more accurately made, consumer - caregiver communication is improved, and services are tailored to consumer needs and preferences. While implementation of certain cultural competence activities, such as interpreter services, may result in additional initial costs, these will be more than offset by benefits accrued from increased engagement, such as lower outreach costs, fewer missed visits, decreased use of possibly inappropriate and expensive care, such as emergency and inpatient services, increased consumer productivity, and reduced family burden.

PPACA has included several broad-based and fundamental provisions for introducing cultural competence activities that should help reduce disparities in health care delivery, beginning with the requirement to include consumers' race, ethnicity, and language in all data collection. These data will help fulfill requirements for stratified data analyses of quality measures required of federally sponsored programs. There are also various federal grants with provisions to increase the number of underrepresented minorities in the health care workforce; to support innovative prevention and treatment strategies; and to conduct outreach to underserved and minority populations (Legal Notes, George Washington University School of Public Health and Health Services, Vol 3 Issue 1, 2011).

The purpose of this White Paper is to demonstrate why health care reform in New York State must include implementation of culturally competent care. This paper also discusses ways in which cultural competence activities can be integrated from inception into the State's newly emerging care delivery models and how this imperative enhances the likelihood of achieving PPACA goals.

The rationale for attending to cultural competence in New York State is discussed below in terms of the diversity of the population and the federal and state legal and regulatory requirements. A brief summary is given of current health care reform initiatives at the federal level and in New York State that will need to incorporate cultural competence in their design. Chapter II describes the scientific evidence for cultural competence activities in promoting access, quality, and lower costs. Chapter III suggests ways in which the goals of these reform initiatives can be achieved by ensuring the infusion of cultural competence into reform models. Chapter IV contains the report's conclusions.

Cultural Group that should be the special focus of a health care system:

Cultural Group **is a group of people with shared activities, ideas, and traditions, which are reinforced by members of the group (Collins, 2009).**

Cultural Group of special focus of a health care system
The interaction between the current procedures and services of the health care system and the socio-cultural features of the group result in limitations in service access or participation by members of the cultural group.

Examples include: underserved racial/ethnic groups; lesbian, gay, bisexual, and transgendered communities, limited English proficiency populations, and

Persons with Limited English Proficiency:

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English (US LEP, 2012).

B. Rationale

i. *Diversity of the New York State Population*

The rationale for the promotion of cultural competence (CC) in health care reform in New York State (NYS) is clear. NYS is an increasingly multicultural state. According to the 2010 Census, about 18% of the NYS population is Hispanic/Latino, 16% African American, 7% Asian American, and 11% other non-White, non-Hispanic race or two or more races; these groups together comprise 52% of the State's population. Furthermore, the immigrant population is growing: about 22% of the NYS population is foreign-born, up from 16% in 1990.

Cultural groups that require special attention from a health care system (see box) comprise an ever-increasing proportion of the persons served in the NYS public mental health system. Service organization and delivery often need to be tailored culturally in order to facilitate these groups' engagement in and benefit from services. In the non-inpatient system, in 2009 in a typical week, approximately 174,000 persons were served, of whom 24% were Black, non-Hispanic, 22% Hispanic, and 2% Asian, non-Hispanic. Non-inpatient annual treated prevalence rates for Blacks and Hispanics exceed those of Whites (Siegel, et al. 2011). Average daily census figures for inpatient services indicate substantially higher population-based rates of Blacks than other groups in inpatient care (Donahue, et al, 2011).

ii. Federal and State Policies and Regulations

Federal and state policies and regulations ensure that the health care provided in New York State is culturally competent (Carter-Pokras, et al, 2004). Relevant federal regulations include Title VI of the Civil Rights Act of 1964, which states, in part, that "no person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (Civil Rights Act, 1964). The US Department of Health and Human Services (HHS) requires that entities receiving financial assistance from HHS provide "meaningful access" for patients with limited English proficiency (LEP) at no cost to the client (US DoJ, 2000). In December 2000, the HHS Office of Minority Health published standards for culturally and linguistically appropriate services (CLAS) (US DHHS, 2000). Adherence to the HHS CLAS standards is a requirement for the accreditation of hospitals and medical schools (Carter-Pokras, et al, 2004). Moreover, reducing health care disparities is a goal of the PPACA (US Congress, 2010). In addition to federal regulations, national governing bodies, including The Joint Commission (TJC) and the National Committee for Quality Assurance (NCQA), also have standards for cultural competence that facilities and managed care plans, respectively, must adhere to as part of their accreditation process.

NYS has repeatedly renewed its commitment to providing culturally competent care, as recently demonstrated by Governor Cuomo's October 2011 directive requiring that all state agencies provide essential public documents (e.g. forms, instructions) in the six most common languages spoken in NYS, as well as access to interpreter services in the constituent's native language. Furthermore, state agencies are required to submit a Language Access Plan (90 days after issuance of the order, and every two years thereafter) detailing the agency's compliance, including documentation of interpreter access, number of forms translated and number of languages, the number of bilingual employees, and employee training plans (New York State Office of the Governor, 2011). Additionally, in 2010, NYS adopted a Patient's Bill of Rights which stipulates that patients have the right to be active participants in their health care. This is defined to include the ability to review and have access to all important and appropriate treatment information, delivered in a manner the patient can comprehend and can utilize to make an informed decision. Furthermore, addressing disparities and improving language access are key components of the New York State Office of Mental Health (OMH) Strategic Plan (NYS OMH, 2012), and have been incorporated into the recent Medicaid Redesign (Cohen and Karpati, 2011) and Health Home initiatives (NYS DOH, 2012a).

To better understand and meet the needs of the cultural groups served by the NYS public mental health system, OMH has provided infrastructure for increasing the CC of its services. It has established a Bureau of Cultural Competency as well as two Centers of Excellence in CC Mental Health at the Nathan Kline Institute and New York State Psychiatric Institute. The Centers develop and disseminate numerous products such as assessment tools, instruments, new services, and educational materials to provide specific steps, desirable behaviors, and considered responses for improving services for cultural groups at the organizational, program, intervention, provider, and consumer levels of a health care system. All these products as well as new ones that will need to be developed for new service models have an important place in health care reform.

C. The New Landscape Under Health Care Reform

To contextualize the recommendations for CC activities to be incorporated into health care reform, a description of these reform efforts is provided. This chapter describes these efforts at the federal level (PPACA) and current steps being taken at the state level (Medicaid reform, including the new organizational entities Regional Behavioral Health Organizations and Health Homes).

i. Patient Protection and Affordable Care Act (PPACA

Signed into law in March, 2010, PPACA proposes a wide array of changes to the US health care system that impact all members of the population, including those with and without existing health insurance coverage. To improve access, PPACA proposes ways to increase coverage for all economic strata of the population: introducing expanded eligibility criteria for Medicaid enrollment; proposing models for increasing availability of health insurance for those without insurance through federal or state-organized health benefit exchanges, and reforming the delivery and payment of Medicare services. With respect to persons with complex health and mental health needs –including persons with severe psychiatric disorders—PPACA proposes models of care that coordinate the multiple components of care they require (Kaiser Family Foundation, 2010) with the goal of improving quality and reducing costs.

Recommendations of MRT Health Disparities Work Group of most relevance to persons with behavioral health conditions

- **Enhance data collection/metrics to measure disparities**
- **Improve language access**
- **Promote language accessible prescriptions**
- **Conduct targeted CC training for health care workforce**
- **Ensure full access to Medicaid mental health medications**
- **Enhance services for youth in transition with psychiatric disabilities**
- **Promote population health through coverage of community-based chronic disease preventive services**

ii. Medicaid Reform in New York State.

In compliance with impending mandated changes and aiming to reduce costs, New York State (NYS) has embarked on a redesign of its Medicaid program, currently the largest single item in the state budget. In 2009, approximately $50 billion was spent on Medicaid by the state, county, and federal governments (Medicaid Institute, 2010), serving almost 5 million beneficiaries. Twenty percent of these beneficiaries account for 75% of the program's expenditures and among these 40% are diagnosed with mental illness and chemical dependency (Rosenthal, NYAPRS, 2011). The NYS Department of Health (DOH) estimates that there are 975,000 high-cost Medicaid enrollees with multiple chronic illnesses (NYS DOH, 2011b). Over 400,000 are Medicaid recipients with behavioral health problems, and at least half of these are people of color. Complex cases have high costs and cross-sector health care needs requiring coordination across multiple provider agencies.

A Medicaid Redesign Team (MRT) was formed to provide an action plan to lower health care costs, improve patient outcomes and reduce health disparities. Care coordination, particularly of the high cost users, and reduction in spending are critical elements of redesign. Towards this end, the plan aims to end the state's Medicaid fee-for service system and replace it with a variety of integrated care management systems. Phase I of reform which has begun includes the initiation of a global Medicaid Spending Cap. (NYS DOH, 2012c). In 2011, slightly fewer than three million of Medicaid-eligible beneficiaries, or 66% of all NYS Medicaid recipients, were enrolled in managed care plans (NYS DOH, 2011b).

An MRT subcommittee examined opportunities for disparity reduction. In their final report, they made 14 recommendations, seven of which (see call out box) are directly applicable to persons from cultural groups with behavioral health conditions (NYS DOH, 2011a). In this report, we suggest other activities to promote CC for inclusion into emerging health care models in NYS. Given the multicultural composition of the NYS Medicaid population, CC activities will work to ensure that PPACA goals are met for all.

NYS has begun the process of integrating services by developing an organizational framework for the delivery and funding of health care. Health Homes (HHs) are being selected for the management of integrated and coordinated care for persons who are considered to be complex cases because of their co-morbidities and consequent need for simultaneous behavioral services, other health care services, and other community-based support. Regional Behavioral Health Organizations (RBHOs) are being put in place across the state to oversee these new delivery entities particularly by monitoring the utilization and delivery of Medicaid-covered services. Future steps in NYS include moving all Medicaid behavioral health services into specialty managed care.

Figure 1 depicts the structural organization of Medicaid managed care services for complex cases expected to be fully implemented by 2014. Cultural competency activities can promote the achievement of PPACA goals and are required at the multiple levels of this model: at RBHOs/Managed Care Organizations, at Health Homes, at programs under HHs, and by the caregivers in these programs.

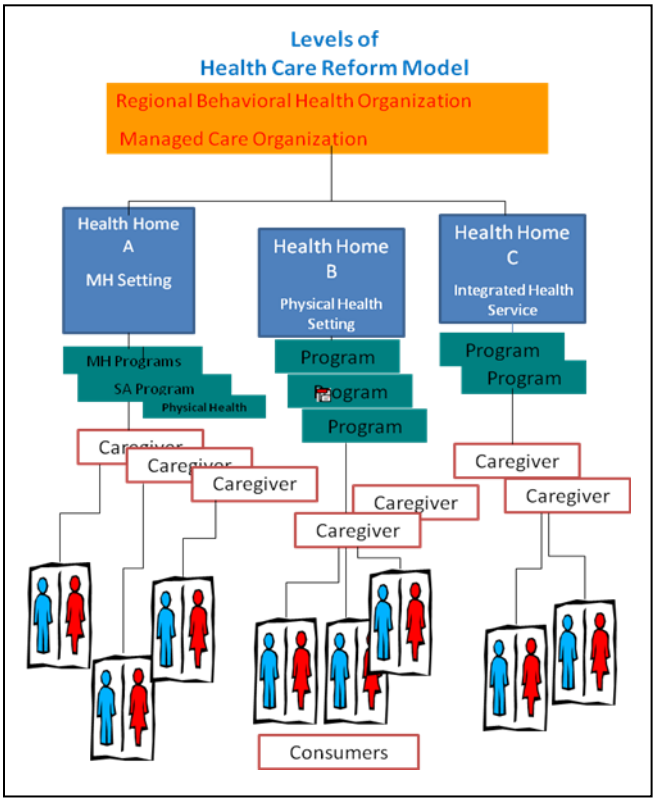

Figure 1

Regional Behavioral Health Organizations

The state has contracted with five behavioral health management organizations that together will provide coverage across the state. The contracts to the RBHOs are intended to facilitate the transition of all Medicaid clients to managed care plans covering integrated physical and behavioral health by 2014. RBHOs will monitor behavioral health inpatient length of stay, and work with hospitals to ensure effective discharge plans and prompt linkages to outpatient providers. They are also to profile the performance of the community providers (NYS BHO Regional Forum, 2011). In the second phase of the move to greater managed care organization, RBHOs will be replaced by a limited number of Specialized Managed Care Plans, Special Needs Managed Care Plans, and Accountable Care Organizations (ACOs) providing and managing behavioral health services.

Health Homes (HHs)

In 2010, as part of PPACA, the Social Security Act was amended to allow states the option of implementing Health Homes for Medicaid enrollees with chronic conditions. PPACA will provide time-limited dollars to set up the administrative aspects of these new organizations. NYS has chosen this option for its high-cost/high-need Medicaid enrollees with chronic medical/behavioral health conditions. A request for proposals to demonstrate the availability of the organizational structures and consortia was issued early in 2011 and selection of health homes and funding began in January, 2012 (NYS DOH, 2012b). Through consortia of network partners comprised of medical, mental health, and chemical dependency treatment providers, social workers, nurses, and other care providers in HHs are required to provide coordinated, comprehensive medical and behavioral health care and linkages to community-based social service providers.

Care managers in the HHs will ensure that enrollees receive all needed medical, behavioral, and social services in accordance with a single care management plan. Care coordinators (navigators), distinct from care managers, will coordinate services and be responsible for sharing information with providers about beneficiaries' past and current health issues, their providers and their response and follow-up with medications and treatments. HH care coordination services will either be directly provided by the HH or subcontracted. Network partners will continue to bill on a Medicaid fee-for-service basis and the HH will be paid an adjusted care management fee until 2014 when all services are to be reimbursed based on fixed payments per case (USDHHS, 2010).

The myriad reforms are resulting in a fundamental change in the way behavioral health care services are delivered in New York, with consumers of mental health services receiving integrated care from Health Homes, and with RBHOs coordinating and managing behavioral health care. It is vital that these new health care delivery systems continue to incorporate cultural competence into their service delivery, to ensure that the goals of improved access, quality, and cost containment are attained. There is evidence discussed below that CC activities can help achieve these goals.

Chapter II. Current Evidence for the Contribution of CC Activities to Improving Access to Care, Engagement in Care, Quality of Care, and Lower Costs

After defining health care reform efforts in the previous chapter, we now provide evidence as to how CC activities improve access to and engagement in care, quality of care, and lower costs of care, for racially and ethnically diverse populations. In Chapter III, we will provide recommendations for specific activities that can be undertaken as part of health care reform that would promote the goals of access, quality, and lower costs.

A. Access to Care, Engagement, and Retention

i. Access to Care

Culturally competent outreach is vitally important for ensuring access to care. Racial and ethnic minorities and LEP persons have lower utilization of mental health services than non-Hispanic whites (Parcesepe et al, 2011), which stem from a variety of factors, including differences in the definition of mental illness and limited knowledge about the availability of mental health services (Kutner et al, 2006), lower socioeconomic status (Copeland and Butler, 2007), mistrust of providers (Armstrong et al, 2007) and experiences with stigma in the health care system (Nadeem et al, 2007). Successful, culturally-competent outreach strategies include involvement of the family, as well as trusted community leaders, such as clergy (Siegel et al, 2011). Other strategies include outreach activities conducted locally in the community, with outreach workers speaking, and providing materials, in the reader's native language (Abreu and Hynes, 2009).

ii. Engagement and Retention

Cultural adaptations are defined as "the systematic modification of an evidence-based treatment (EBT) to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal et al., 2009). A number of studies have found that adapting established interventions and evidence-based practices in a culturally competent manner can result in improvements in engagement and retention. For example, pilot studies of cultural adaptations of EBTs including Motivational Interviewing (MI), Multifamily Group (MFG) and Parent Management Training (PMT) have all found evidence of increased adherence and retention, compared to patients receiving standard care (Lewis-Fernández et al, in press, Kopelowicz et al, 2012, Domenech-Rodríguez et al, 2011). Guides are available to help providers and agencies in adaptations emphasizing the importance of consumers and community persons from the cultural group in the process (Samuels et al, 2009).

Benefits of Culturally Competent Care

Access, Engagement, Retention
- **Active outreach and enrollment**
- **Improved engagement, adherence, retention in care**

Quality
- **Improved outcomes of care**
- **Improved patient-provider communication**
- **Reduced risk of medical errors and malpractice**

Cost
- **Bilingual clinicians shown to result in lower costs**
- **Culturally adapted interventions associated with benefits that outweigh costs**
- **Reduced provision of unnecessary services**
- **Reduced malpractice risk**

B. Quality of Care

i. Improvements in Clinical Outcomes and Functioning

In addition to the evidence on engagement and retention, a number of studies have demonstrated that culturally adapted mental health treatments result in improvements in outcomes (Griner and Smith, 2006). For example, culturally adapted MFG has been associated with fewer hospitalizations and longer time to rehospitalization (Kopelowicz et al, 2012). Culturally adapted cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) have been associated with decreases in depression symptoms for children and adolescents (Benish et al, 2011, Roselló et al, 2008, Miranda et al, 2005, Roselló and Bernal, 1999). Furthermore, there is evidence that treatments, when comprised of more culturally adapted intervention elements, are more effective (Smith et al., 2011).

ii. Improved Communication

While cultural competence is a key component of effective health care in all areas, it is especially crucial in mental health, where communication is "the principal investigative and therapeutic tool" for provision of services (Farooq and Fear, 2003). For this reason, providing avenues for effective communication is essential for ensuring correct clinical information, as well as educating consumers and their families for whom mental health services are rare or non-existent and, among immigrants, often highly stigmatized in their cultures of origin (Musser-Granski and Carrillo, 1997). Numerous studies have shown that when effective culturally competent interpretation is available in health care settings, this results in higher rates of client satisfaction, increased adherence with appointments and medications, greater treatment response (Carter-Pokras et al, 2004), better patient recall of information given during the appointment, and the patient asking the provider more questions in order to better participate in the care (Crane, 1997). All of these are linked to better quality of care. Furthermore, cultural differences between consumers and providers can lead to an environment of misunderstanding and mistrust that result in the consumer disengaging from care (NYSPI-CECC, 2012).

iii. Reduced Risk of Medical Errors

Poor communication between consumers and providers can lead to medical errors. A study by The Joint Commission (TJC, formerly the Joint Commission on Accreditation of Healthcare Organizations, JCAHO) found that 65% of medical errors can be traced to communication problems (Goode et al, 2006). Another study found that children in families with language barriers are more likely to experience medical errors than children in families without language barriers (Cohen et al, 2005). Information obtained from non-English speaking consumers or poorly trained interpreters can be inaccurate and include errors such as omission, condensation, and substitution (Vasquez and Javier, 1991).

iv. Reduced Risk of Misdiagnosis

Cultural barriers between consumers and providers can lead to misdiagnosis (Parcesepe et al, 2011). Studies have shown that consumers with limited English proficiency have higher rates of misdiagnosis than proficient English speakers, due to impaired communication with providers (Dysart-Gale, 2007). African Americans, in particular, have higher rates of misdiagnosis of schizophrenia than non-Hispanic whites, possibly due to providers misinterpreting distrust as paranoia, under-detection of mood disorders in the African American population, provider biases, and miscommunication between consumer and provider (Hamton, 2007; Minsky et al, 2003). Misdiagnosis can lead to unnecessary, ineffective, and harmful provision of services or, alternatively, to untreated health care needs. Persons with untreated mental health problems, in turn, have increased risk of poor social outcomes, such as incarceration or homelessness. Furthermore, poor outcomes following misdiagnosis can result in legal liability of providers.

C. Costs of Care

i. Cost-Effectiveness

Although limited data are available on the cost-effectiveness of culturally competent mental health interventions, the available evidence suggests that increased costs from culturally competent treatment methods are worthwhile due to resulting improvements in health outcomes. The availability of bilingual clinicians has been shown to result in cost savings: a recent study found that having a Spanish-speaking attending physician on an inpatient medical unit resulted in decreased emergency department visits after discharge, thus reducing costs by $92 per Spanish-speaking consumer (Jacobs et al, 2007). Furthermore, a number of studies have shown that providing access to interpreters results in cost savings, since the costs of the interpretation are recouped later by shorter visits, fewer tests and medications, fewer emergency department visits, and lower overall charges (Masland et al, 2010). Other studies have found that, in instances where evidence of cost savings cannot be documented, culturally competent practices are worthwhile due to increased benefits in health and quality of life. For example, the Partners in Care initiative, a randomized control trial of medication and therapy interventions for depression, adapted for Hispanic and African American consumers, found that adapted therapy was associated with significantly fewer depression days for Hispanics, at an additional cost that was significantly lower than that for care provided to White consumers (Schoenbaum et al 2004). A study of culturally adapted pharmacotherapy and CBT found that, although costs were higher, depressive symptoms were significantly lower for low-income minority women, and so the intervention overall was cost-effective compared to the alternative, community referral (Revicki et al 2005).

ii. Reduced Risk of Unnecessary Provision of Services

There is evidence that providers may order more tests and procedures when they do not understand the consumer's language, background or cultural style of communication, leading to higher medical costs. This phenomenon is referred to as the "Language Barrier Premium" (Carter-Pokras et al., 2004). For instance, physicians who cannot communicate adequately with a consumer may adopt a cautious treatment regimen (Carter-Pokras et al, 2004) by ordering more tests (Waxman and Levitt, 2000) and being more likely to admit the person to the hospital (Hampers and McNulty, 2002). Furthermore, persons with language barriers are more commonly seen in emergency departments due to the concentration of interpreters in these settings, in which costs incurred are generally higher than in primary care clinics (Bernstein et al., 2002).

iii. Reduced Risk of Malpractice Lawsuits

A number of malpractice cases stemming from poor communication between consumers and providers have resulted in sizable awards and settlements. In 2003, a lawsuit on behalf of LEP consumers in Brooklyn for violation of the Civil Rights Act and New York State laws on access to interpreter services resulted in a settlement of an undisclosed amount (Goode et al., 2006). Furthermore, in August 2011, Legal Services NYC, a legal advocacy group, filed a lawsuit against the City of New York in State Supreme Court for denying LEP citizens access to Medicaid and Food Stamps because of their inability to communicate in English (Brooklyn Eagle, 2011). In addition to the cases in NYS, a number of malpractice cases in other states have resulted in substantial settlements for inaccurate translations in medical settings or lack of access to interpreter services (Carter-Pokras et al, 2004; Ku and Flores 2005; Carbone et al 2003; Musser-Granski and Carillo, 1997).

Ensuring that mental health services are culturally competent is a priority of OMH not simply to comply with federal and state mandates, but also because CC results in better patient outcomes, including engagement, adherence, retention, reduced emergency department use, and the provision of cost-effective care. Furthermore, there are substantial risks of not providing culturally competent services, such as unnecessary provision of services, misdiagnoses, and medical errors due to poor communication between the consumer and the provider. Finally, inadequate access to interpreter services, in particular, has lead to substantial malpractice settlements. As NYS begins to implement health care reform, on a national level through PPACA, and on a state level through Medicaid redesign, it will be crucial to ensure that the new systems of care use culturally competent methods to ensure that OMH continues to provide effective care, and minimizes its legal and financial risks.

Chapter III. Infusing Cultural Competence into Health Care Reform Initiatives

Recommendations for all participating behavioral health care organizations

- **Have a CC plan**
- **Have a CC advisory committee**
- **Recruit, hire, and retain culturally diverse staff including peer staff**
- **Provide training and disseminate educational materials on CC to staff at all levels**

Specific recommendations for how health care organizations (RBHOs, managed care companies, Health Homes and Health Home partners) can ensure that any reform activities are being implemented in a CC manner are provided here. Some are based directly on the scientific evidence outlined in Chapter II. For example, the recommendation to hire and train CC staff, particularly bilingual clinicians, is linked to the evidence that this results in increasing access and engagement, and lowering costs of care. The recommendation for training providers in CC methods of care, e.g., using culturally adapted evidence-based treatment practices, is also based on evidence of improved engagement and greater impact on symptoms and levels of functioning. The recommendation regarding the availability of language interpreters is linked to evidence of a decreased risk of communication errors and a reduction in the provision of unnecessary services (e.g. the Language Barrier Premium mentioned in Chapter II, where impaired communication may lead providers to order more tests and procedures), which in turn have been shown to increase costs. Furthermore, these recommendations will allow agencies to remain compliant with NYS Executive Order 26, which requires state agencies to develop Language Access Plans that document their efforts to provide interpretation, translated forms, staff training and bilingual staff.

For other recommendations, the scientific evidence is limited, but there is community and practice-based evidence for the relevance of the activity in the promotion of CC. The BCC and CECCs have drawn on their collective experience working with clinicians, agencies, and providers to formulate these recommendations.

A. Organizational Activities

Organizations such as RBHOs, managed care companies, and HHs can play a critical role in ensuring the CC of the services being offered to persons with behavioral health care disorders. Medicaid dollars allocated to organizations for administrative costs should cover the cost of conducting centralized CC activities from which all network partners could benefit, such as, for RBHOs: interpreter services, translation of documents, annual CC assessments with feedback to providers, and enhanced data collection and report generation to enable better identification of cultural groups and appraisals of their needs. Their performance measurement of behavioral health care partners should include an assessment of their CC. This also allows entities to remain compliant with the accreditation requirements regarding CC set out by The Joint Commission and NCQA, as well as ensuring compliance with federal and state regulations for entities receiving federal or state funding.

HHs care management fees need to be sufficient to allow them to cover the costs of basic CC activities, such as having a CC committee for cultural input on service delivery and coordination, and to establish mechanisms for ensuring that care management and care coordination is conducted with CC (e.g., involve family members when appropriate, provide culturally and linguistically appropriate patient education materials, assist in navigating between mental health and primary care services). Community outreach can be pursued through stigma-reduction and health promotion campaigns at the community level, presentations at churches and community centers, and by developing task forces with local community and opinion leaders from cultural groups. Additional funding for training of peers from cultural groups to serve as care coordinators is strongly recommended as evidence is mounting that they can be highly effective in promoting engagement, retention, and care coordination in integrated mental health, substance abuse, and physical health services (Clarke et al., 2000; Pfeiffer et al., 2011).

HHs should institute procedures to ensure that all services in their provider network are CC. Including peer services in the network is desirable as peers can provide key outreach, prevention, support, and diversion services. HHs can educate their network partners on special cultural requirements of care delivery to the cultural groups they serve. Network partners should receive CC training that could be vetted and standardized by the HH. As part of performance measurement, HHs should annually assess network partners on their CC. This will ensure compliance with NYS Executive Order 26. Public mental health settings with higher scores on linguistic and service accommodation (e.g., having interpreters, bilingual staff, and translated forms), as assessed in a CC assessment scale developed by NKI-CECC, had reduced disparities in engagement and retention among Hispanic outpatients (Siegel et al, 2011). Furthermore, organizations should seek feedback on their assessments in order to ensure that the information learned is used to assess strengths and address challenges. This feedback option is an essential element of a continuous quality improvement approach that enhances organizational learning, and is a key element of implementing culturally-appropriate EBTs (Rubenstein et al, 2002, IHI, 2004).

Recommendations for Centralized Activities of RBHOs and HHs

- **Enhance data collection systems to allow more specific identification of cultural groups**
- **Develop centralized interpreter services**
- **Translate relevant documents**
- **Disseminate CC health promotion materials to communities in coverage areas**
- **Disseminate 'vetted' training materials for CC training to community providers/network partners**
- **Assess performance measures of the quality of care provided by community providers/network partners specifically with respect to underserved cultural groups**
- **Assess CC of community providers/network partners and provide them with actionable feedback**
- **Promote the use of evidence-based practices (EBPs) that have evidence for the cultural populations served**
- **Assist providers in adopting and adapting culturally-relevant EBPs**

B. Activities for Network Partners

Behavioral health care network partners consist of individual providers, programs, clinics, and hospitals. While CC activities introduced at the organizational levels of RBHOs and HHs are expected to result in greater cultural competence at the level of providers, there are specific CC strategies that can be targeted to the delivery of direct care. These include closer-to-the-ground activities to promote access, engagement, and retention of clients in culturally appropriate ways. Direct care providers should be required to conduct cultural assessments, such as the Cultural Formulation Interview currently being field-tested for inclusion in DSM-5, of covered clients so that services can be accommodated to their needs (Lewis-Fernández, 2009). CC training should directly address staff communication competencies in addition to language competencies with respect to the cultural groups served. Care coordination among services and supports should take into account the CC of these providers and organizations with respect to the culture of the consumer. Cultural peers can be extremely helpful in trust building and stigma reduction as well as providing advice on communication competencies. Partners need to monitor the outcomes of their services with respect to a cultural group's perspective of what constitutes a 'good' outcome (Siegel, Haugland, et al, 2011).

Recommendations for Centralized Activities of Network Partners

- **Conduct client and family cultural assessments**
- **Ensure language and communication competencies of staff**
- **Develop programmatic strategies for trust building and stigma reduction**
- **Provide services in culturally appropriate milieus**
- **Involve family or consumer-valued persons in the care process, as desired by consumer**
- **Ensure referrals for care and social supports are CC**
- **Provide linkages to culturally-valued community supports (e.g., churches, clubs)**
- **Monitor outcomes by cultural group**

Chapter IV. Conclusions and Resources

CC activities are required to meet both the intrinsic goals of CC for NYS as well as those of health care reform. In NYS, where people of color comprise more than 50% of consumers served in the public mental health system, the necessity of these activities is affirmed. Dollars spent to conduct these activities will be more than cost-offset by the benefits that accrue from more effective care. Adding to the case to be made for CC activities is the fact that the risks of limited CC can result in poorer care and legal liability.

Organizations seeking to design and implement CC activities can take advantage of a myriad of resources. The NYS OMH supports a Bureau of Cultural Competence (BCC), which provides training to state agencies and facilities and can direct entities to resources, for example, for interpretation and translation needs. Advocacy organizations, such as the New York Association of Psychiatric Rehabilitation Services (NYAPRS), also disseminate materials that may be useful to entities developing CC materials (http://www.nyaprs.org). The US DHHS Office of Minority Health provides Continuing Medical Education (CME) credit for physicians and health care providers and supports a website with information on compliance with federal mandates (https://cccm.thinkculturalhealth.hhs.gov/). Georgetown University also maintains the National Center for Cultural Competence, which provides training and assessment materials for providers and health care facilities (http://nccc.georgetown.edu/). The BCC (http://www.omh.ny.gov/omhweb/cultural_competence/), along with the Centers of Excellence in Cultural Competence (CECCs) at Nathan Kline Institute (http://cecc.rfmh.org) and New York State Psychiatric Institute, (http://nyspi.org/culturalcompetence) are continuing to identify and disseminate resources across the state.

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