

Cultural Competence: Improving Value and Increasing Access to Services

Purpose

Through a contract with the Virginia Association of Community Services Boards, Community Health Solutions developed a 'Community Return on Investment Model' for Virginia CSBs. Community Health Solutions provides knowledge, data, tools, training, and technical assistance on CSB priority topics to support CSBs in demonstrating the value they deliver to the communities they serve. Community Health Solutions received a request for research on the 'return on investment' in cultural competence programs from the Steering Committee for the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Office of Cultural & Linguistic Competence (CLC). The DBHDS CLC "leads efforts to provide improved services to multicultural consumers and works toward eliminating the disparities within the state's mental health, intellectual disability and substance-use disorder system."¹

Our summary finding is that the evidence for a quantifiable 'return on investment' in cultural competence is still evolving, but there are lessons learned in published research studies and innovative initiatives about the value of cultural competence. The purpose of this paper is to examine the evidence of the value of cultural competence policies and practices.

Introduction

Ethnic and minority populations often face barriers to access of appropriate health and behavioral health care. With the growing diversity of racial and ethnic groups in Virginia, service providers are challenged to provide quality care to populations with varying cultural backgrounds and language proficiencies.

Cultural competence plays an important role in how health and behavioral health services are provided. At a national level there are federal policies and regulations, such as the Patient Protection and Affordable Care Act, aimed at reducing health care disparities. The US Department of Health and Human Services Office of Minority Health established standards for Culturally and Linguistically Appropriate Services (National CLAS Standards), which can be used as a blueprint by individuals, health, and health care organizations. National recognition and accreditation programs, such as the National Committee for Quality Assurance and The Joint Commission, also incorporated cultural competence standards in the program requirements.

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At the state and local levels health and behavioral health service providers are working to adjust the way they provide services. The Virginia Department of Behavioral and Developmental Services' Office of Cultural and Linguistic Competence Annual Plan for 2013-2014 identified the following as state priorities: language service planning; workforce diversity and inclusion; organizational cultural

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competence training and consultation; and cultural and linguistic resource development.² Locally, providers are implementing strategies such as linguistic services, cultural competence staff trainings, and use of community outreach workers or cultural brokers.

Concurrently many health and behavioral health organizations are using patient-centered approaches to improve the quality of care provided. Cultural competence and patient-centered care are complementary approaches as they both aim to improve quality and remove barriers that can limit access to care. Together these two approaches can maximize an organization’s ability to provide care that is personalized and culturally appropriate. For example, the Joint Commission’s *Roadmap for Hospitals* recommends that “A hospital must embed effective communication, cultural competence, and patient- and family-centered care practices into the core activities of its system of care delivery—not considering them stand-alone initiatives—to truly meet the needs of the patients, families, and communities served.”³

This paper provides a summary of the existing literature about the value of cultural competence and innovative approaches to increasing access to care. The value of cultural competence can be defined broadly in terms of the social, health, and business benefits.

A Framework for Analyzing Value

Organizations that adopt cultural competence policies and practice can see a multitude of benefits for the organization, as well as benefits to the patients and community. These benefits may include increased patient engagement, health promotion, and engagement with community stakeholders. Benefits to the organization may include cost savings, care efficiency, and compliance with recognition, legal, and regulatory guidelines, as outlined below.⁴

Social Benefits	Health Benefits	Business Benefits
<ul style="list-style-type: none"> • Increases mutual respect and understanding between patient and organization • Increases trust • Promotes inclusion of all community members • Increases community participation and involvement in health issues • Assists patients and families in their care • Promotes patient and family responsibilities for health 	<ul style="list-style-type: none"> • Improves patient data collection • Increases preventive care by patients • Reduces care disparities in the patient population • Increases cost savings from a reduction in medical errors, number of treatments and legal costs • Reduces the number of missed medical visits 	<ul style="list-style-type: none"> • Incorporates different perspectives, ideas and strategies into the decision-making process • Decreases barriers that slow progress • Moves toward meeting legal and regulatory guidelines • Improves efficiency of care services • Increases the market share of the organization

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Practical Approaches for Demonstrating Value

Funders of cultural competency programs want to know that increased investment in training, materials, and personnel is worth the cost. Unfortunately, quantifiable measures of return on investment do not yet exist for cultural competency programs. Findings in a review published by the Cochrane Collaboration "showed some support for cultural competence education for health professionals. These findings are tentative, however, as the quality of the evidence was low and more data are needed."⁵ The National Center for Cultural Competence states, "Research has not kept pace [with] the current and emergent practices that exemplify cultural and linguistic competence in many health care and mental health programs.

Personnel within these programs are busy doing the work, which often provides little time for publishing and disseminating their remarkable work in the juried literature."⁶ In interpreting these findings, it is important to note that the general finding is lack of evidence to make either positive or negative statements about the cost-effectiveness of culturally competent practices. The absence of positive evidence for cost effectiveness not necessarily mean that culturally competent practice is economically inefficient.

How do providers and program managers demonstrate the value of cultural competency programs? Performance indicators that reflect improved communication and trust, culturally appropriate service delivery and access, and improved outcomes are one approach. A principle metric in the National CLAS Standards is to "provide effective, equitable, understandable, and respectful quality care and services."⁷ Health care organizations demonstrating cultural competence offer communication and language assistance; inform individuals of availability of a language assistant, ensure the competency of individuals providing language assistance; and provide easy-to-understand materials and signage.⁸

These standards have already been incorporated into legislation in other states, such as New York, where the value is clearly stated: "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."⁹ In addition to policies and regulations, program planners can consult lessons learned from innovative initiatives implemented across the country.

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Innovations in Cultural Competency

Evidence-based research on the "return on investment" of cultural competency is still evolving, despite the general consensus that the approach is necessary to improve health equity. The following examples demonstrate promising results from interventions that improve communication and increase access to education and services through implementation of cultural competency in health and behavioral health settings.

Source	Promising Practice	Key Strategies	Results
AHRQ Innovations Exchange	Academic and community coalition collaborated to develop a program to train community health workers (CHWs) to help Filipino Americans at high risk for cardiovascular disease take charge of their health.	<ul style="list-style-type: none"> • Enrollment during screenings at community organizations • Culturally adapted education and training by CHWs • Convenient locations and times • One-on-one coaching by CHWs • Referral to culturally competent providers 	<i>Compared with similar individuals receiving only written information, participants adhered more closely to their medication regimens, were more likely to attend medical appointments, and achieved better blood pressure control and greater reductions in body mass index (BMI).¹⁰</i>
AHRQ Innovations Exchange	Primary care physicians, bilingual psychiatrists, and care managers at a community health center used a culturally sensitive, collaborative treatment model to screen, evaluate, treat, and monitor Chinese-American patients with depression.	<ul style="list-style-type: none"> • Systematic screening • Telephone outreach to those testing positive • Culturally sensitive psychiatric assessment • Discussion and selection of usual care treatment options • Communication with treating professionals • Care management option 	<i>Before implementation of the program, only 6.5 percent of patients who screened positive for depression between 1999 and 2003 received psychiatric treatment. During the study, 43 percent of Chinese-American patients identified as having major depressive disorder engaged in treatment.¹¹</i>

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<p>AHRQ Innovations Exchange</p>	<p>An elder multicultural access and support services program used community health workers known as promotores to provide culturally competent mental health education and services to elderly racial and ethnic minorities.</p>	<ul style="list-style-type: none"> • Culturally tailored marketing and outreach • Culturally competent “promotores” • Building trust before enrolling • Culturally tailored education and counseling • Screening for Depression by “promotores” • Referral to language-concordant mental health providers • Transportation and translation services for appointments 	<p><i>This program enhanced access to mental health screening, referral, education, and peer support, leading to improved mental health status and health literacy.¹²</i></p>
<p>AHRQ Innovations Exchange</p>	<p>Two safety net clinics offered a socioculturally tailored program to treat depression in low-income Hispanic patients with diabetes.</p>	<ul style="list-style-type: none"> • Systematic screening to identify eligible individuals by bilingual study recruiters • Application of depression criteria and stepped-care algorithm • Review of treatment options with bilingual social worker • Weekly supervision by a consulting psychiatrist • Culturally tailored psychotherapy led by social worker • Communication with primary care physician <p>Ongoing monitoring to prevent relapse</p>	<p><i>The program improved long-term adherence to antidepressant medication, reduced depression-related symptoms, and increased patient satisfaction with depression care.¹³</i></p>

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<p>AHRQ Innovations Exchange</p>	<p>A health center uses bilingual medical assistants to serve as health coaches to chronically ill patients of similar ethnic or racial backgrounds; these medical assistants work as part of the medical home care team.</p>	<ul style="list-style-type: none"> • Health coaches embedded within teams • Team identification of those in need of health coaching • Initial introduction to linguistically and culturally congruent coach • Intense support until condition(s) under control • Ongoing monitoring after stabilization • Group educational classes 	<p><i>The program significantly improved the quality of disease management and clinical outcomes for those with diabetes, increasing the percentage of patients setting self-management goals, receiving recommended interventions, and meeting or exceeding established goals. The program has received very positive feedback from patients and center staff and has contributed to low turnover and to a reduction in overall health care costs, particularly emergency department (ED) costs.</i> ¹⁴</p>
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Source	Promising Practice	Key Strategies	Results
<p>The National Center for Cultural Competence</p>	<p>A National Health Service Corps (NHSC) site implemented a culturally acceptable, multi-faceted approach to integrate mental health services into primary care to address the need for mental health services for children.</p>	<ul style="list-style-type: none"> • The project contracted with social workers already working as cultural brokers in the community. • The project hired a psychiatrist to whom any of the primary care practices could refer patients. • The project worked with schools to create two school-based health centers to serve children and families. Physicians were required to live in the communities they served to increase acceptance. 	<p>The project saw the benefit of cultural brokering (1) a means to increase access and use of health and mental health services, (2) a recruitment and retention strategy that enabled clinicians to integrated into the community, and (3) an effective approach to engender trust within the Appalachian communities.</p>
<p>The National Center for Cultural Competence</p>	<p>A Federally Qualified Health Center (FQHC) in Washington D.C. used cultural brokers to bring services to locations where the homeless gather.</p>	<ul style="list-style-type: none"> • Clinicians travel weekly to provide primary care services to the homeless. • The project targets only those individuals who are drug users and are most at risk of HIV/AIDS. • Individuals who are homeless received free, confidential services including education, counseling, and testing for HIV/AIDS, sexually transmitted 	<p>As cultural brokers, the outreach workers have created a regular source of health for the individuals who are homeless and most at risk. Cultural brokering involves the outreach workers' knowledge and expertise in the delivery of a complex array of health care and mental health services and supports to the homeless</p>

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		<p>diseases, hepatitis B and C & TB, & medical & case management services.</p> <ul style="list-style-type: none"> • Staff return to sites to distribute test results. <p>Outreach workers function as cultural brokers & work to know individuals who are at highest risk. Over time outreach workers have become familiar with needle usage patterns among these individuals & the “street” jargon they use.</p>	<p>population.</p>
<p>The Robert Wood Johnson Foundation</p>	<p>Hablamos Juntos, a national interpreter demonstration project funded by the Robert Wood Johnson Foundation, was implemented in regions where the Latino population had recently increased.</p>	<ul style="list-style-type: none"> • All but two of the projects provided language access services in clinical health care settings, most commonly in emergency departments & ob/gynecology units, which are critical access points for Latino patients. • The primary goal for most of the projects was to increase the availability of medical interpreters. • One project developed a Patient Navigator model to allow interpreters to accompany patients between clinical departments. 	<p>Prior to this project general belief was that interpreters would disrupt consultations. Study found the opposite. Findings included:</p> <ul style="list-style-type: none"> • When aided by an interpreter, patients communicated better with doctors and staff. • Patients believed their care was lower quality when they did not receive an interpreter.
<p>Wilder Research</p>	<p>In the Wilder Research toolkit, “Social Return on Investment: Community Health Workers in Cancer Outreach”, the authors were able to demonstrate a 2.3 return on investment related to use of CHWs in cancer outreach</p>	<p>The main goal was to place the economic outcomes generated by CHWs in a cost benefit framework for measuring the Return on Investment (ROI) of this type of intervention. The ROI estimates reflect the net benefits for the whole society. The CHW context was framed as:</p> <ul style="list-style-type: none"> • CHWs influence the behavior of diverse and underserved populations toward health outcomes through prevention and navigation of the health system. • CHWs generate significant positive impacts in the 	<p><i>Community health workers generate lifetime benefits in the order of \$12,348 per person served by a CHW, or \$851,410 for every CHW that serves at least 69 individuals per year. These benefits include the value of additional years of life saved because of early screenings, additional taxes paid during those additional years, and savings from reduction in urgent care use...Many of the benefits of the work of CHWs do not materialize immediately. In fact, the biggest returns will</i></p>

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		<p>communities where they work.</p> <ul style="list-style-type: none"> • CHWs contribute to increased likelihood of earlier cancer screenings, including self-examinations and clinical tests such as mammography, Pap smears, and colorectal screening. <p>The above changed behaviors have economic consequences.</p>	<p><i>occur in the future with every year of life not lost generates a stream of benefits in the future. Furthermore, the positive consequences of increasing the chances of survival of a person may be in fact incalculable, and thus we think that any ROI in CHW's work is conservative.¹⁵</i></p>
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Conclusion

Across the nation, cultural competence policies and practices are changing the way health and behavioral health care is provided. In this new health care environment, providers are being asked to demonstrate the value of the services they deliver. Behavioral health providers looking to demonstrate the value of cultural competency programs can gain perspective by considering published research studies and innovative initiatives from other settings, with the qualifier that the evidence base is still evolving. The guidelines and lessons learned from other initiatives can be used to inform the design of local programs. Given that the evidence base is still developing, local evaluation will be important for demonstrating the value of cultural competence strategies in the behavioral health setting.

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Appendix A: References

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