



John R. Kasich, Governor
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June 2015

A BUSINESS CASE FOR PROMOTING EQUITY

IN THE BEHAVIORAL HEALTH CARE SYSTEM THROUGH
CULTURAL AND LINGUISTIC COMPETENCY



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TABLE OF CONTENTS

LETTER FROM DIRECTOR PLOUCK	4
PROJECT OVERVIEW	5
HEALTH EQUITY STATEMENT	6
UNDERSTANDING CULTURAL AND LINGUISTIC COMPETENCE	7
Defining Cultural Competence	7
Meeting National Compliance Requirements	8
Prioritizing Quality in a Changing Market	8
OHIO DEMOGRAPHICS, SOCIAL DETERMINANTS AND BEHAVIORAL HEALTH DISPARITIES	9
BUSINESS CASE RATIONALE	10
Address the Human Element to Reduce Health Disparities	10
Adapt the Business Model to Decrease Health Care Costs	10
Capitalize on Incentives to Provide Culturally Competent Care	11
Build Community Coalitions for Continuous Learning	12
Embrace a Holistic Culture of Health	12
Recruit and Retain a Diverse Workforce	12
DEFINITIONS	14
REFERENCES	15



Promoting wellness and recovery

John R. Kasich, Governor • Tracy J. Plouck, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

Dear OhioMHAS stakeholder:

I am pleased to announce the release of the Ohio Department of Mental Health and Addiction Services *Business Case for Promoting Equity* recently developed by the Disparities and Cultural Competency (DACC) Advisory Committee. This business case document is a major component of the department's *2020 Strategic Vision* focused on increasing awareness of and reducing disparities in the behavioral health care system.

It is our intent to share this resource for the purpose of improving system knowledge of how inefficient and ineffective services can result in higher cost when serving diverse populations. I believe that the *Business Case for Promoting Equity* is a tool that can be used to prompt further exploration of prevention, treatment and recovery services that will benefit all Ohioans. Please review this document and use it as a resource to guide policy development to improve health equity.

Sincerely,

A handwritten signature in blue ink, appearing to read "Tracy J. Plouck", is written over a light blue circular background.

Tracy J. Plouck
Director

**Special thanks to the members of the Disparities and Cultural Competence Advisory Committee
Business Case Sub-Committee**

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PROJECT OVERVIEW

The *Business Case for Promoting Equity in the Behavioral Healthcare System through Cultural and Linguistic Competency* is an action step from the Ohio Department of Mental Health and Addiction Services' (OhioMHAS) cultural and linguistic competence plan. It is a component of the department's vision to set service equity as a priority in the public behavioral health system by 2020. The business case is one of four objectives identified by the Disparities and Cultural Competency (DACC) Advisory Committee. The DACC Advisory Committee selected the business case as one of its core objectives because of the opportunity it provides to enhance system stakeholder knowledge about disparities, inefficiencies and cost as it relates to treatment and service inequities.

Disparities and Cultural Competency (DACC) Advisory Committee

OhioMHAS convened the DACC Advisory Committee to address disparities that impact Ohioans across the lifespan. The creation of DACC was one of four strategies identified in OhioMHAS's strategic plan to address health disparities. The DACC Advisory Committee is composed of OhioMHAS program staff, external community organizations and state department representatives from the Ohio Commission on Minority Health, the Ohio Department of Health, and the Commission on Latino Affairs. OhioMHAS staff participants represent the department's key organizational areas, ranging from services for children to recovery services and community supports. External members represent community partner organizations such as the Ohio Asian American Health Coalition, Multiethnic Advocates for Cultural Competence, the Ohio Empowerment Coalition, Ohio Citizen Advocates for Addiction Recovery, the National Alliance on Mental Illness of Ohio, the Ohio Association of County Behavioral Health Authorities, the Ohio Council of Behavioral Health and Family Services Providers, the Native American Indian Center of Central Ohio and Drug-Free Action Alliance.

The DACC Advisory Committee's goal is to eliminate disparities and move towards health equity. To that end, the Committee identified these four actions to undertake in the next five years:

- *Identify core quality indicators to effectively track and monitor performance*
- *Develop a business case for cultural and linguistic competency*
- *Create a cultural and linguistic competence plan*
- *Identify best and promising practices based on lessons learned and develop a promising practice resource bank/learning community*

OhioMHAS and the DACC Advisory Committee recognize that the public behavioral health system spans collaborations inclusive of OhioMHAS' Central Office and Regional Psychiatric Hospitals, medical-surgical hospitals, federally qualified health centers, behavioral health boards and providers, managed care companies, insurance companies and health/human services state departments. These partners have an important stake in improving the health outcomes of diverse populations most adversely impacted by health and behavioral health disparities. It is this understanding which drives OhioMHAS and DACC efforts to use the business case for improving cross-systems engagement to achieve health equity.

HEALTH EQUITY STATEMENT

OhioMHAS is committed to supporting, endorsing and encouraging community system partners – including county and state entities – to identify, initiate and implement culturally and linguistically appropriate services for all customers and recipients of care. The department believes improving culturally and linguistically appropriate services enhances the effectiveness and efficiency of behavioral health treatment and supportive services. Ineffective services and inefficient treatments exacerbate a client’s problems, requiring a higher level of care. Ineffective services and treatments, consequently, carry higher costs for the organization, for taxpayers and for society. The implementation of cultural and linguistic competence strategies provides a framework through which the state and collaborative partners are able to reduce cost while offering person-centered care to diverse populations.

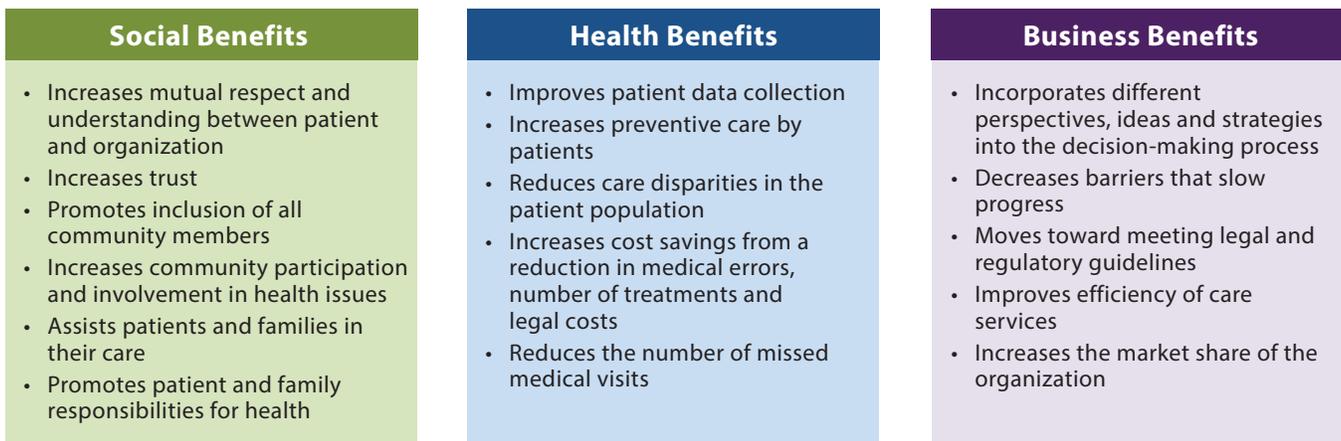
OhioMHAS is committed to meeting the behavioral health and wellness needs of Ohioans in all their diversity. The department has dedicated itself to providing services and programs that are appropriate and accessible to our customers, who encompass a broad range of human differences such as disability, age, educational level, ethnicity, gender, geographic origin, race, religion, sexual orientation, socio-economic status and beliefs.

OhioMHAS is committed to overcoming treatment and service inequities because it realizes that some populations experience disparities at a higher rate when compared to the general population.

The U.S. Department of Health and Human Services’ National Partnership for Action to End Health Disparities (2011) defines health equity as “the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.” Currently, many individuals are unable to attain their highest level of health and OhioMHAS recognizes that a systems approach is needed to improve health care delivery and treatment outcomes for individuals disproportionately impacted by service inequities.

According to Health Research and Educational Trust (2013), cultural and linguistic competence in a care system produces numerous benefits (see Figure 1) for the organization, patients and community. These benefits include improved health outcomes, increased respect, mutual understanding from patients and increased participation from the local community. In addition, organizations that are culturally competent may have lower costs and fewer care disparities.

Figure 1



Source: American Hospital Association, 2013

UNDERSTANDING CULTURAL & LINGUISTIC COMPETENCY

A person's health is said to be a product not only of biological factors, but also of the social, economic and environmental climate in which he or she lives. Factors such as education, income, employment, housing, safety and the availability of quality provider/hospital services have a significant impact on an individual's ability to obtain optimal health. When individuals experience significant barriers with these social determinants of health, disparities emerge. A remedy to reducing health disparities is addressing social determinants. Cultural and linguistic competency should be a key component of the process.

Resistance to identifying cultural and linguistic competence strategies can take many forms. Over the years, these common responses have been heard:

"This is special treatment for a small group of people."

"This is a rural area. We don't have any minorities here."

"Our staff has already been trained in diversity and sensitivity."

"Our services are available to everyone."

"It's an unfunded mandate. We're not getting paid for this."

"There are higher priorities. Our system lacks the basic services."

"These requirements are prescriptive and administratively burdensome."

Comments such as these represent the greatest obstacles to implementing cultural and linguistic competence. The misconception that the concept is limited to race or that Ohio is limited in diversity, can lead organizations away from opportunities to improve the quality of their care. All behavioral health constituents (i.e.; patient, provider, board and state government) share responsibility in understanding why cultural and linguistic competence is important and how it should be addressed at the state and local level.

Defining Cultural Competence

Cultural competence is a concept inclusive of race, ethnicity and cultural group identification. It is defined by the State of Ohio as:

A continuous learning process that builds knowledge, awareness, skills, and capacity to identify, understand, and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.

While many professionals understand the diversity intrinsic to the concept of race and ethnicity, the same cannot be said for the concept of culture. According to Wenger (1993), culture represents a system of collectively held values, beliefs and practices of a group which guides decisions and actions. These components of an individual's uniqueness can shape views of the behavioral health system and impact help-seeking. Culture constitutes a significant part of race and ethnic group distinctiveness and sometimes may reflect a more prominent role in an individual's identity. In Ohio, cultural groups may include those living in poverty; gay, lesbian, bi-sexual and transgender (GLBT) individuals; Amish and Appalachian communities; and, deaf or hard of hearing individuals. Factors such as socio-economic status, sexual orientation, geography and language can determine world views inherent to culture.

Cultural and linguistic competency includes responding to the unique needs of an individual by utilizing the person's background as a tool to assist with the treatment, intervention or support service process. For the organization, cultural and linguistic competence ensures the ability to provide equal access to

appropriate care. Knowledge of local and regional race, ethnic and cultural groups enable the behavioral health workforce to gain the cross-cultural skills necessary to deliver quality services.

Meeting National Compliance Requirements

Cultural and linguistic competence is increasingly required by state and federal law. Government agencies rely on rules, policy guidelines and accreditation to set standards and monitor compliance. The Joint Commission (TJC), which accredits hospitals and other health care institutions; the Commission on Accreditation of Rehabilitation Facilities (CARF), a nonprofit accreditor of health and human services; and the National Committee for Quality Assurance (NCQA), which accredits behavioral health managed-care organizations, have all issued standards that require cultural and linguistic competence.

The U.S. Department of Justice, Civil Rights Division is responsible for regulating and monitoring Title VI of the Civil Rights Act of 1964, requiring language accessibility. The Americans with Disabilities Act of 1990 prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities and transportation. Agencies and organizations receiving federal funds must adhere to these regulations. Similarly, the Substance Abuse and Mental Health Services Administration (SAMHSA) requires state governments and local entities implementing SAMHSA-funded programs to adherence to cultural and linguistic competency. To that end, grant recipients are required to submit a Disparities Impact Statement illustrating how historically marginalized populations will be served. Grant recipients are also required to submit a proposal within their Disparities Impact Statement demonstrating how the U.S. Department of Health and Human Services' Enhanced Culturally and Linguistically Appropriate Service (CLAS) Standards will be adopted.

Prioritizing Quality in a Changing Market

U.S. and Ohio demographics are changing rapidly. These emerging dynamics present new market opportunities for behavioral health and bring more complex service demands. To succeed in these new market conditions, Ohio's behavioral health care system must invest in research; recruit a more diverse workforce and enhance its competency; identify innovative treatment and service modalities; identify new community-based partnerships; and incorporate feedback from people with lived experience. Such steps will position the system to address prevailing issues like unnecessary systemic cost, treatment disparities, access barriers and legal/accreditation compliance.

Research suggests that after implementing culturally and linguistically appropriate services there are substantial increases in provider knowledge/skill acquisition and improvements in provider attitudes towards diverse patient populations (Beach et al., 2004). Studies also indicate that patient satisfaction increases when culturally and linguistically appropriate services are delivered (Beach et al., 2004). At the organizational level, hospitals and clinics that support effective communication by addressing CLAS Standards have been shown to have higher patient reported quality of care and more trust in the organization (Wynia, Johnson, McCoy, Passmore, Griffin & Osborn, 2010). Preliminary research has shown a positive impact of CLAS Standards on patient outcomes (Lie, Lee-Rey, Gomez, Bereknyel & Braddock, 2010), and a growing body of evidence illustrates the effectiveness of culturally and linguistically appropriate services in improving the quality of care and services received by individuals (Beach et al., 2004; Goode et al., 2006).

Achieving a vision in which all Ohioans have an equal opportunity to receive good health care is in direct alignment with the Ohio Office of Health Transformation (OHT) goals to achieve better health, better care and cost savings through improvement. OHT has prioritized health equity as a key issue that must be addressed to reach these goals. Behavioral health stakeholders must begin a similar process in treatment and service for the system to improve and eliminate disparities.

OHIO DEMOGRAPHICS, SOCIAL DETERMINANTS & BEHAVIORAL HEALTH DISPARITIES

Ohio's population is estimated at close to 11.5 million. According to the Ohio Development Services Agency, non-white citizens comprise 19 percent of Ohio's total population. This reflects a 20 percent increase since 2000. The number of immigrants in Ohio increased 33 percent since 2000. Ohio's Hispanic population grew by 63 percent and the Asian population by 45 percent. African Americans, the largest non-white population in Ohio, experienced an increase of 20 percent since 2000.

More than 450,000 foreign-born people live in Ohio, which equals 4 percent of state residents. Of that group, 51 percent were naturalized U.S. citizens and 89 percent entered the country before the year 2010. Most foreign-born residents of Ohio come from Asia (39.5 percent), Europe (24.6 percent) and Latin America (19.8 percent).

Diversity of spoken and native language is also evident. In 2012, among people at least five years old living in Ohio, 7 percent spoke a language other than English at home. Of those, 34 percent spoke Spanish, 37.3 percent spoke other Indo-European languages and 16.6 percent spoke Asian and Pacific Islander languages. Thirty-five percent reported that they did not speak English "very well."

Tseng and Streltzer (2008) found significant economic cost and burden to the public sector as a result of health inequities, health disparities and an inadequate focus to issues of cultural competence especially in behavioral health care systems.

Nationally, non-white citizens comprise 37 percent of the population – up 34 percent since 2000. The non-Hispanic, white population is currently the largest segment, representing more than half of the total. However, by 2060 the share of this group is projected to decrease to 44 percent as its population falls and the collective non-white population is expected to outpace the white segment beginning in 2044.

In using demographic data to identify disparities, we must understand its relationship to social determinants of health. Social determinants are the economic and social conditions that influence differences in health status. Today, whites comprise a higher number of individuals in some key social determinant categories. However, in many instances, the proportion of white representation in a specific category is lower than its overall percentage of the Ohio population.

For example, the most recent population data estimated that non-Hispanic whites comprised the majority (64 percent) of Ohio's 1,797,000 citizens who are considered poor. Of the remaining individuals living in poverty, African Americans represented 25 percent, Hispanics 6 percent, people of two or more races 4 percent, Asian and Pacific Islanders 1 percent, and American Indians and Alaskan Natives less than 1 percent. In this example, nearly all of the non-white demographic groups were disproportionately over-represented in poverty when compared to their population in the state. This type of assessment is important because it enables researchers, clinicians and other professionals to determine which populations are most at-risk and in need of specific services.

Laveist and Gaskins 2009 study "The Economic Burden of Health Inequalities in the United States" found that approximately 30.6% of direct medical care expenditures for Hispanics, African Americans and Asians were excess costs due to health inequities and premature deaths at a cost of \$1.24 trillion dollars.

There is evidence that African Americans and Hispanic/Latinos are disproportionately over-represented in Ohio jails and prisons and under-represented in institutions of higher learning. Community issues of income disparity, a lack of safety and no access to resources (e.g., transportation, affordable housing) are contributing factors. Similarly, there are key disparities within the behavioral health system that

professionals should be aware of to improve quality in the delivery of services. For example, African Americans, Hispanic/Latinos, American Indians and Asian Americans are less likely to receive needed treatment. Community stigma and the lack of culturally competent behavioral health providers are consistently cited as reasons these populations are less likely to engage the system. When they are treated for a mental health condition, many are at a higher risk of a schizophrenia diagnosis. In the case of African Americans, there is a higher likelihood of unsuccessful treatment outcomes.

If strategic measures are not taken in the behavioral health system, we can only expect these trends to worsen as the non-white population in Ohio continues to grow.

BUSINESS CASE RATIONALE

The business case for cultural and linguistic competence can be approached from various dimensions. Much of the critical focus is on access to care, quality of care, and exploring ways for cost savings and improved outcomes. As an advocate for this concept, OhioMHAS believes that all behavioral health stakeholders (employers, professionals and community members) should look at critical variables at the patient-level, systems-level and process-level, while keeping in mind financial incentives, collaborative partnership and assessment of community health needs. OhioMHAS has identified six key areas of focus.

1. Address the Human Element to Reduce Health Disparities

The Institute of Medicine (IOM) Unequal Treatment report organizes factors contributing to health disparities into three categories: a) patient-level variables (e.g., socioeconomic status, language barriers and poor health literacy); b) health care systems-level variables (e.g., organizational and financial complexity and geographic location of the health care facility); and c) care process-level variables (e.g., characteristics of an individual provider, such as some physicians may have a racial or ethnic bias).

Employers, especially, would find helpful the often-cited 2008 article titled *The Triple Aim: Health, Care, and Cost*, which states that improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations and reducing per capita costs of health care. Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an “integrator”) that accepts responsibility for all three aims for that population. The integrator’s role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management and macro-system integration.

The Triple Aim authors also point out that a large part of costs in complex systems of care are due to lack of health literacy. Health literacy is the capacity to understand basic health information and make appropriate health decisions. Tens of millions of Americans have limited health literacy – a fact that poses major challenges for the delivery of high-quality care. This is one reason why recent federal policy initiatives, including the Affordable Care Act of 2010, the Department of Health and Human Services’ National Action Plan to Improve Health Literacy and the Plain Writing Act of 2010 have brought health literacy to the forefront.

2. Adapt the Business Model to Decrease Health Care Costs

Berwick and Nolan (2008) highlight five types of financing and competitive dynamics purveyed by governments and payers that would help to accelerate interest in *The Triple Aim* and progress towards it: (1) global budget caps on total health care spending for designated populations; (2) measurement of and fixed accountability for the health status and health needs of designated populations; (3) improved standardized measures of care and per capita costs across sites and through time that are transparent;

(4) changes in payment such that the financial gains from reduction of per capita costs are shared among those who pay for care and those who can and should invest in further improvements; and (5) changes in professional education accreditation to ensure that clinicians are capable of changing and improving their processes of care.

A 2003 report that National Business Group on Health (NBGH) prepared for the federal government provides some discussion on the business case regarding health disparities and the impact on large employers. The following chart in the report presents the rationale for why companies are making it their business:



Source: NBGH (2003)

NBGH argues that there are multiple incentives for large employers to launch initiatives to reduce race/ethnic health disparities. Two are major financial incentives of specific relevance the business case.

Potentially decreased direct costs. Preventive and diagnostic strategies may be effective in reducing serious costly health problems among non-white members of the workforce before they develop and/or aid in treating them more appropriately once manifested. The implication here is that this would help to reduce the total expenditures large employers assume for chronic health or behavioral conditions.

Potentially decreased indirect costs. NBGH contends that since non-white populations account for a large portion of the workforce, employers have a vested interest in ensuring that health care treatment and services are of good quality and value. This is important because when employees receive inadequate health care services, this triggers a number of indirect costs (e.g., absenteeism, lowered productivity) leading to higher medical and other costs as a result of disability benefits, stress on other employees and quality loss.

3. Capitalize on Incentives to Provide Culturally Competent Care

Health care organizations have four interrelated incentives to provide culturally competent care. **The first incentive** is to appeal to diverse consumers to enlarge their market share. Since non-white Americans constitute a large and growing part of the health care market, by advertising their cultural competence, health care organizations and insurance companies could attract their business. **The second incentive** is to increase their performance on quality measures of interest to private purchasers, particularly in competitive markets. **The third incentive** is that Medicare, Medicaid and other public purchasers are placing increased emphasis on cultural and linguistic competency as a standard of quality care. **The fourth incentive** is improved cost-effectiveness in patient care. For example, health literacy provided in a culturally appropriate way would promote preventive screening and provide motivation to adopt a healthier lifestyle. Cultural competence has the potential to change both clinician and patient behavior in ways that result in the provision of more appropriate services. Therefore, hiring bilingual staff or interpreters could be a cost-effective intervention, permitting more accurate medical histories to be taken and eliminating unnecessary testing that may be ordered simply because of a communication barrier between the patient and service provider.

4. Build Community Coalitions for Continuous Learning

No individual can be deeply familiar with all of the cultural beliefs that affect health and behavior in Ohio's diverse communities. An individual administrator, leader or professional cannot be culturally competent alone. It requires organizational commitment.

We must work together to create a service delivery structure and environment where cultural competence is possible, and strategy is formed to reduce health care inequities. Treatment recommendations must take into account cultural differences. As health care purchasers, employers should work with all health care partners to tackle disparities. According to NBGH's *Employer's Guide to Reducing Racial & Ethnic Health Disparities in the Workplace*: "... an employer must hold its data partners, such as health plans and wellness/health promotion vendors, accountable for customizing plan designs and health and productivity programs that economically support the health and cultural needs of an employer's diverse workforce."

5. Embrace a Holistic Culture of Health

Health Research & Educational Trust (HRET) and Robert Wood Johnson Foundation (RWJF) are working together on hospital-based strategies for creating a Culture of Health. RWJF has proposed four interrelated areas of action: a) social cohesion and shared value of health; b) multisectoral collaboration to build health partnerships; c) improved and equitable opportunity for healthy choices and environments; and d) improved quality, efficiency and equity of health and health care systems.

To monitor progress in creating a culture of behavioral health that focuses on equity, the first step should be based on community health needs assessments. Such assessments help to capture vulnerable population footprint, core indicators and full health or behavioral health indicators.

A holistic approach to the delivery of behavioral health care can have several components. One focus could be on interpreter services to improve communication between people who speak different languages. Another would be recruitment and retention of a culturally diverse clinical staff that is reflective of the communities being served. A third approach would be conducting training programs that change attitudes and help educate practitioners and other staff on effective cross-cultural interactions. Tap into community health liaisons who could provide ways to improve associated access to care and communication between providers and patients. In addition, incorporate culturally specific and sensitive messages into health promotion efforts through literature, websites and events to encourage healthy behaviors. Finally, assess organizational accommodations, physical environments and assessment procedures to enhance sensitivity to the unique needs of the diverse populations served.

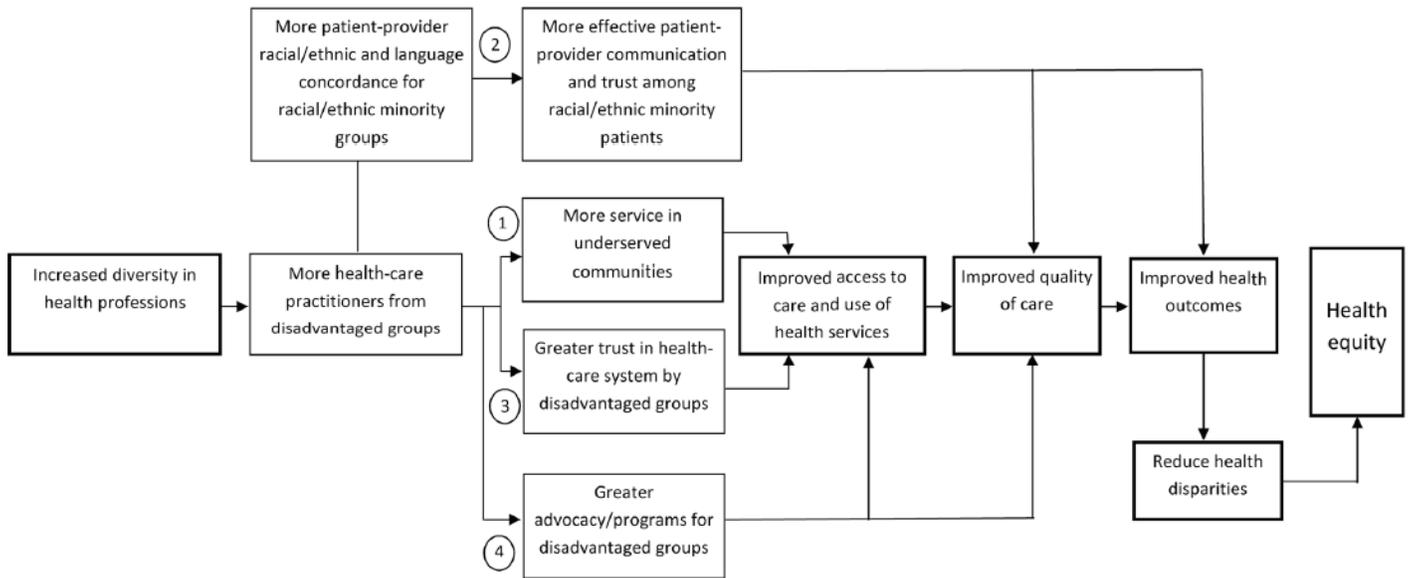
6. Recruit and Retain a Diverse Workforce

There is much literature that addresses the role of a diverse workforce in improving health equity. The U.S. Department of Health and Human Services' Office of Minority Health advocates for cultural competency in the health care system and strong community-level approaches to improving health and health care for all. It argues that increasing underrepresented groups within the health care workforce supports the diversity of values and beliefs of the entire population and heightens cultural awareness in health care service delivery.

NBGH states that it makes sense for large employers in their effort to reduce health disparities also to consider workforce incentives, such as: (a) retention in the workforce of racial and ethnic minority employees; (b) ensuring a healthy workforce in the future; (c) benefits to health insurance companies (such as, enhancing effectiveness and quality of health care services, attracting minority consumers, appealing to private purchasers with diverse workforce).

One study (Williams et al. 2014) goes further to provide a conceptual model that utilizes the social determinants of health framework to link nursing workforce diversity and care quality and access to two critical population health indicators – health disparities and health equity. The proposed model of this study suggests that a diverse nursing workforce can provide increased access to quality health care and health resources for all populations, and is a necessary precursor to reduce health disparities and achieve health equity (see figure below).

Expanded conceptual model linking health professions diversity to health disparity and health equity outcomes, 2012



Adapted from: Department of Health and Human Services (US), Health Resources and Services Administration, Bureau of Health Professions. The rationale for diversity in the health professions: a review of the evidence. Rockville (MD); HHS; 2006.

SUMMARY

Cultural and linguistic competence improves an organization's sustainability by reinforcing the value of diversity, flexibility and responsiveness. Culturally responsive organizational strategies and clinical services can help mitigate organizational risk and provide cost-effective treatment, in part by matching services to client needs more appropriately at the earliest point.

In preparation for this report, the DACC Business Case Subcommittee members reviewed pertinent literature specifically to articulate the various incentives and demonstrated cost benefit to employers and stakeholders in the behavioral health community in providing culturally and linguistically competent services. The business case rationale, especially of the reduced direct and indirect costs, is a critical one.

One recent SAMHSA report states that cultural competence and culturally responsive services are important in the behavioral health field because these skills can improve client engagement in services, therapeutic relationships between clients and providers, and treatment retention and outcomes. Cultural competence is an essential ingredient in decreasing disparities in behavioral health and its development can have far-reaching effects not only for clients, but also for providers and communities.

DEFINITIONS

Cultural Competence State of Ohio Definition: A continuous learning process that builds knowledge, awareness, skills, and capacity to identify, understand, and respect the unique beliefs, values, customs, languages, abilities, and traditions of all Ohioans in order to develop policies to promote effective programs and services.

According to the National Stakeholder Strategy for Achieving Health Equity, the terms health inequality, health disparity, health care disparity and health inequity are widely used, often without clarification of meaning. Therefore, in an effort to distinguish between these terms, in this National Stakeholder Strategy:

Health inequality is the “difference in health status or in the distribution of health determinants between different population groups.”¹

Health disparity a particular type of health difference that is closely linked with social, economic and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health-based on their racial and/or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.²

Health care disparity relates to “differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions. These differences would include the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels.”³

Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.⁴

¹ World Health Organization. Health Impact Assessment (HIA), glossary of terms used, definition of “health inequality.” <http://www.who.int/hia/about/glos/en/index1.html>. Accessed on January 1, 2011.

² The reference should just be: Definition formulated by the National Partnership for Action to End Health Disparities’ Federal Interagency Health Equity Team (FIHET) and Healthy People 2020.

³ Smedley B, Stith A, and Nelson A, eds. Washington, DC: Institute of Medicine; 2010. Unequal Treatment: Confronting racial and ethnic disparities in health care. <http://www.nap.edu/openbook.php?isbn=030908265X>. Published 2003. Accessed on January 21, 2011.

⁴ Definition formulated by the FIHET for the National Stakeholder Strategy.

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