“Integrating Culture Into Integrated Care”

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Culture Influences Help Seeking

Culture influences help seeking behaviors and attitudes toward health care providers

- Latinos have less access to mental health services are less likely to receive needed care, and are more likely to receive poor quality care when treated than do whites.

- Asian and Pacific Islanders tend to delay help-seeking which may be due mistrust of the system and language barriers.

- African Americans tend to rely on family, religious and social communities rather than turning to health care professionals.
Culture is not talked about — much of it is taken for granted (much like the air we breathe), and what is taken for granted is not discussed. Also, since culture is widely shared, it is uninteresting to talk about what everybody shares. This means, however, that people have little practice in discussing how culture affects their behavior, and so are ill-prepared to explain their culture to others.

Levine, 2001
Let’s hear it from cultural sensitivity!
Cultural Differences

An office somewhere in South America...

Hours of Operation

12 noon to 9:30 P.M. MORE or LESS

Source: Levine, 2001
Culture Counts!

“The main message of this Supplement—that culture counts—should echo through the corridors and communities of this Nation. In today’s multicultural reality distinct culture and their relationship to the broader society are not just important for mental health and the mental health system, but for the broader health care system as well.”

Source: Culture, Race, and Ethnicity; A Supplement to Mental Health: A Report of the Surgeon General, 2001
Culture Counts!

Culture influences:

- How people communicate and manifest their symptoms
- Their style of coping
- Their willingness to seek treatment
- Their family and community support

Source: Culture, Race, and Ethnicity; A Supplement to Mental Health: A Report of the Surgeon General, 2001
Definition of Culture

- “Meanings, values, and behavioral norms that are learned and transmitted in society and within social groups.”
- Culture powerfully influences cognition, self-concept, feeling, and activities.
- Culture has a strong impact on diagnostic processes and treatment decisions.

Source: Guarnaccia, 2006
Language also Counts!

Language is the core medium for the communication, creation, and transmission of culture.

“Given the centrality of talking as a major form of mental health treatment, issues of language and culture appear particularly central in thinking about developing culturally competent mental health services” (Guarnaccia, et al., 1998; p. 424)
Never underestimate the importance of local knowledge.

USA
Football

BRAZIL
Football

AUSTRALIA
Football

HSBC
The world's local bank
Why Culture and Language Matter in the Delivery of Health Services

Culture patterns our thinking, feeling, and behavior in both obvious and subtle ways.

Culture plays a major role in determining:
- what we eat;
- how we work;
- how we relate;
- how we celebrate holidays and rituals;
- how we feel about life, death, and illness;
- how we recognize, interpret, label, and respond to illness;
- how we express and report our concerns;
- how we seek help.
Why Consider Culture and Language in Health Care

Attention to culture and language and its impact on health care can:

- improve the quality of health care;
- add to our understanding of health care solutions among diverse cultural groups;
- encourage a more holistic approach to healthcare within individual, family, and community-based systems.
Everyone has a culture...

Source: Taylor, NCRR, 2007
Why is important to integrate primary care and mental health care?
“People with serious mental illness served by the public mental health system die, on average, 25 years earlier than the general population.”

NASMHPD Morbidity and Mortality in People with Serious Mental Illness October 2006

“Adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that’s widened since the early ‘90s, when major mental disorders cut life spans by 10 to 15 years…”

USA Today, May 3, 2007
1. Comorbidities are the rule rather than the exception

2. Mental health in primary care:
   - Primary care is the main point of service delivery entry and where the patients are.
   - Primary care is the ‘de facto’ health care system for common mental disorders.

3. Medical care in mental health care settings:
   - Patients with severe mental disorders (SMI) receive poor medical care and die on average 25 years earlier than those without SMI.

Source: Unützer, 2010
Comorbidity

Definition: the presence of more than one mental disorder within the same period of time.

- 41%–65% of those reporting a lifetime substance disorder had at least one other psychiatric disorder.
- 51% reporting one or more psychiatric disorders also reported at least one substance disorder.
- 23% of those in the NCS sample had three or more lifetime disorders.

Source: Kessler, 2004
Mental Disorders are Rarely the only Health Problem

- Chronic Physical Pain: 25-50%
- Smoking, obesity, physical inactivity: 40-70%
- Mental Health/ Substance Abuse
- Cancer: 10 - 20%
- Neurologic Disorders: 10-20%
- Heart Disease: 10-30%
- Diabetes: 10-30%

Source: Unützer, 2010
Comorbidity is common in safety net populations

GA-U = General Assistance – Unemployable

Co-occurring Diagnoses and the GA-U Population

52 percent had substance abuse or mental illness identified
31 percent had a chronic physical condition only

Chronic Physical Condition

52 percent had substance abuse or mental illness identified
31 percent had a chronic physical condition only

Alcohol/Drug Problem

Mental Illness

52 percent had substance abuse or mental illness identified
31 percent had a chronic physical condition only

SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2003-04. Chronic physical and mental illness diagnosis groups derived from CDPS grouper

Source: Unützer, 2010
Childhood adversities may increase risks of early onset mental disorders, while both childhood adversities and early onset mental disorder may increase risks of a range of physical diseases in later life.

Source: Aguilar-Gaxiola, 2009; Simon, 2009
Almost half of the patients with diabetes identified in the Medi-Cal fee-for-service population had a co-morbid mental health condition, which may impair an individual’s ability to carry out diabetes-related self-management tasks and compromise overall health.

Medi-Cal fee-for-service beneficiaries (both with and without co-morbid mental health conditions) have lower rates of HbA1C and lipid panel monitoring in comparison with a national subset of Medicaid fee-for-service beneficiaries.

Source: http://files.medi-cal.ca.gov/pubsdoco/dur/articles/dured_21476.asp
Why Look at Mental-Physical Comorbidities

<table>
<thead>
<tr>
<th>HEDIS Measures</th>
<th>Medi-Cal fee-for-service beneficiaries with diabetes (n=132,033)</th>
<th>National Medicaid fee-for-service beneficiaries with diabetes (n=657,628)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With co-morbid mental health condition (n=60,339)</td>
<td>With co-morbid mental health condition (n=118,190)</td>
</tr>
<tr>
<td></td>
<td>Without co-morbid mental health condition (n=71,694)</td>
<td>Without co-morbid mental health condition (n=539,438)</td>
</tr>
<tr>
<td>At least one HbA1C screening during year</td>
<td>21.6%</td>
<td>43.8%</td>
</tr>
<tr>
<td></td>
<td>28.3%</td>
<td>47.0%</td>
</tr>
<tr>
<td>At least one LDL screening during year</td>
<td>18.4%</td>
<td>24.4%</td>
</tr>
<tr>
<td></td>
<td>25.6%</td>
<td>26.9%</td>
</tr>
</tbody>
</table>

Source: http://files.medi-cal.ca.gov/pubsdoco/dur/articles/dured_21476.asp
# Why Look at Mental-Physical Comorbidities

Table 1. Hemoglobin A1C (HbA1C) and lipid panel monitoring rates by additional demographic and clinical characteristics.

Green text = HIGHER rate than total population  
Red text = LOWER rate than total population

<table>
<thead>
<tr>
<th>Medi-Cal fee-for-service beneficiaries aged 18-64 with diabetes</th>
<th>HEDIS® Measures</th>
<th>At least one HbA1C screening during measurement year</th>
<th>At least one LDL screening during measurement year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population with complete demographic data available (n=132,021)</td>
<td></td>
<td>25.2%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Female (n=75,629)</td>
<td></td>
<td>25.9%</td>
<td>23.0%</td>
</tr>
<tr>
<td>• Male (n=56,392)</td>
<td></td>
<td>24.2%</td>
<td>21.4%</td>
</tr>
<tr>
<td>Concomitant use of anti-psychotic medication:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes (n=33,261)</td>
<td></td>
<td>40.0%</td>
<td>38.8%</td>
</tr>
<tr>
<td>• No (n=98,760)</td>
<td></td>
<td>23.3%</td>
<td>20.2%</td>
</tr>
<tr>
<td>Race/ethnicity:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• White, non-Hispanic (n=38,444)</td>
<td></td>
<td>29.2%</td>
<td>27.0%</td>
</tr>
<tr>
<td>• Other (n=30,130)</td>
<td></td>
<td>23.7%</td>
<td>21.5%</td>
</tr>
<tr>
<td>• Black (n=13,067)</td>
<td></td>
<td>23.3%</td>
<td>19.6%</td>
</tr>
<tr>
<td>• Hispanic (n=50,380)</td>
<td></td>
<td>21.7%</td>
<td>18.4%</td>
</tr>
</tbody>
</table>

Source: Table provided by Fingado, 2013
Where is Mental Health Care Received?

Of people with poorer mental health in the US:

- 50% --- Only see a Primary Care Physician
- 17% --- No visits
- 13% --- See both Primary Care and Mental Health
- 5% --- Only See a Mental Health Provider

Of those who see only primary care:

- 1/3rd will make only one visit
- Are more likely to have other health conditions

Source: England and Phillips, 2006
Why Seek MH Care in Primary Care?

- Most people seek help for MH problems in PC settings
- ~1/2 of all care for common psychiatric disorders happens in PC settings
- Diverse populations are even more likely to seek or receive care in PC than in specialty MH settings
- Limited access to public MH services
- Cultural beliefs and attitudes
- Limited availability of MH services, especially in rural areas

Source: Alexander, 2010
Overall Recommendations from the WHR 2001 Report

Steps that nations can take to promote better mental health:

1. Provide treatment in primary care
2. Make psychotropic drugs available
3. Give care in the community
4. Educate the public
5. Involve communities, families, and consumers
6. Establish national policies, programs, and legislation
7. Develop human resources
8. Link with other sectors
9. Monitor community mental health
10. Support more research
Benefits of Primary Care and Behavioral Health Integration

As a first point of contact, primary care:

- Is closer to home or work and more affordable than specialty care.
- Offers the possibility of cost-effective treatment, particularly with less severe mental disorders.
- Has the potential for early identification of symptoms and for coordination and continuity of care for both mental and physical disorders.
- Is perceived as less stigmatizing than specialty behavioral health settings.

Integrated Health Care

- Integrated health care is the **systematic coordination of physical and behavioral health care**.

- The idea is that physical and behavioral health problems often occur at the same time.

- It seeks to improve people's health by treating their physical and behavioral illnesses together.

Where to begin?

Integrated models begin with integrated concepts
An Integrated Concept

“Dealing equally with health care for mental, substance-use and general health conditions requires a fundamental change in how we as a society and health care system think about and respond to these problems and illnesses. Mental and substance-use problems and illnesses should not be viewed as separate from and unrelated to overall health and general health care.”

Harvey V. Fineberg, M.D., Ph.D.
President, Institute of Medicine
CONCLUSION

Improving care delivery and outcomes for any one depends upon improving care and outcomes for the others.

OVERARCHING RECOMMENDATION

Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body.
Bidirectional Integration

Integrating PC services into MH/SU settings

AND

Integrating MH/SU services into PC settings

In both cases, the services are not just provided, but coordinated with other care delivered in that setting

Source: Alexander, 2010
How do you approach a consumer from a different culture in primary care?

1. You may have had a chance to learn about, or cared for consumers from a certain community or country (i.e. recent immigrant group or an international patient)

2. You may have no clue...then what??
   - Be aware of key issues, and observe, and ask.
Cross-Cultural Education: Training Needs

- Skills for working with diverse patients with different conceptualizations about health and health care.
- Skills on how to use interpreters.
- Case-based learning.
Cross-Cultural Education: Challenges

- Difficult to learn about all cultures
- Difficulty speaking the patient’s language
- Limited amount of time with patients
- Complexity of issues
Cross-Cultural Care: A Patient-Centered Approach

1. Assess core cross-cultural issues
2. Explore the meaning of the illness
3. Determine the social context
4. Engage in negotiation
The Clinical Encounter

Patient’s Input
- Words
- Expressions of distress
- Affects
- Beliefs
- Health literacy

Clinician’s Understanding and Comprehension

Accurate Diagnosis

Adequate Treatment
The Clinical Encounter

Patient’s Input
- Words
- Expressions of distress
- Affects
- Beliefs
- Health literacy

Clinician’s Understanding and Comprehension

Misdiagnosis

No treatment or inappropriate Treatment

Prolonged Client’s Suffering and Increased Medical Costs
Meaning of the Illness: Identifying Explanatory Models

- Consumer’s conceptualizations of illness
- Consumer’s ideas about diagnostic procedures or treatments
Explanatory Model Questions

1. What do you think has caused your problem? How?

2. Why do you think it started when it did?

3. How does it affect you?

4. What worries you most? Severity? Duration?

5. What kind of treatment do you think you should receive? What result do you expect?
Consumer-Provider Negotiation

- Consumer’s model
- Biomedical model

Mutual understanding

Improved adherence

Source: Miller, 2005
ETHNICS Mnemonic: A Framework for Culturally Appropriate Care

- **Explanation**: why do you have this problem?
- **Treatment**: what have you tried for it?
- **Healers**: who else have you sought help from?
- **Negotiation**: how best do you think I can help you?
- **Intervention**: this is what I think needs to be done.
- **Collaboration**: how can we work together on this?
- **Spirituality**: what role does spirituality play in this?

Opportunities for Integrated Care

- **Integrated care** as a health delivery concept continues to gain momentum nationwide, attracting widespread attention throughout the health services community.

- Health care reform and parity legislation offer real opportunities for the successful implementation of innovative integrated care models.

- Integrated, or collaborative, care can change the current practice structure for mental health providers and provide a vehicle for payment reform that will benefit the entire behavioral health team.

Moving Towards Integrated Care

IDEAL
Collaborate Effectively

A GOOD START
Co-locate Services

TYPICAL
Refer for Consultation

WORST CASE
Compete

Source: Unützer, 2010
Collaborative Care’s Key Ingredients

- Primary care providers
- Care managers – Patient education & empowerment, ongoing monitoring, care/provider coordination
- Expert consultation (psychiatrists) for patients who are not improving
- Evidence-based treatments – Effective medication management, psychotherapy
- Systematic diagnosis and outcome tracking
- Stepped care
- Technology support – registries

Source: Unützer, 2010
Collaborative Care’s Key Ingredients

A notable key ingredient is absent

The Consumer/Patient

We need to actively engage the consumer/patient and his or her family
Even in an age of hype, calling something “the blockbuster drug of the century” grabs our attention. In this case, the “drug” is actually a concept—patient activation and engagement—that should have formed the heart of health care all along.

The topic of this thematic issue of Health Affairs, patient engagement is variously defined; the Institute for Healthcare Improvement describes it as “actions that people take for their health and to benefit from care.” Engagement’s close cousin is patient activation—“understanding one’s own role in the care process and having the knowledge, skills, and confidence to take on that role,” as Judith Hibbard and coauthors explain.

Demonstrations at Seattle-based Group Health and elsewhere have already shown that fully informed patients often choose less invasive and lower-cost treatments than their doctors recommend—and that variation in practice patterns among different physicians also narrows as a result.

But while many physicians have bought into shared decision making, others haven’t. Grace Lin and coauthors describe a largely unsuccessful attempt to spread the use of decision aids—typically, brochures or videos that spell out pros and cons of various treatment options and can lay the groundwork for discussions between patients and physicians. In their case study of five primary care practices in California, the effort ran into a number of obstacles—including some physicians’ reluctance to give up their traditional decision-making roles, their lack of training in communication, and their complaint that they simply lacked the time.

**OBSTACLES AND BARRIERS**

If clinicians’ attitudes sometimes stand in the way of patient engagement, it’s because they are worried about the potential for medical errors, rushed care, and concerns about miscommunication. And it’s not just doctors who have concerns; so do patients. Studies show that the average patient is not thoroughly informed about their condition, and that’s before the discussion of treatment options begins.

So, here’s a prescription for the patient engagement ‘blockbuster drug’ you’ve been searching for: a little more education and a lot more willingness to listen to the doctor you’re paying to be your doctor. Because even if the doctor can’t cure your disease, they can certainly cure your apathy towards managing your health and care.
What The Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences; Fewer Data On Costs

**ABSTRACT** Patient engagement is an increasingly important component of strategies to reform health care. In this article we review the available evidence of the contribution that patient activation—the skills and confidence that equip patients to become actively engaged in their health care—makes to health outcomes, costs, and patient experience. There is a growing body of evidence showing that patients who are more activated have better health outcomes and care experiences, but there is limited evidence to date about the impact on costs. Emerging evidence indicates that interventions that tailor support to the individual’s level of engagement...
How do people receiving integrated services feel about their care?

Consumers receiving integrated services report higher quality of life and greater satisfaction with:

- Access
- Attention to their treatment preferences
- Courtesy
- Coordination & continuity of care
- Overall care

In March 2010, President Obama signed into law the Affordable Care Act (ACA)
The Health Care Law is a Reality Now!

The Health Insurance Marketplace is Now Open

Enroll now in a plan that covers essential benefits, pre-existing conditions, and more.

OCT 1 Open Enrollment Begins
JAN 1 Coverage Begins
MAR 31 Open Enrollment Closes

Enroll now in a plan that covers essential benefits, pre-existing conditions, and more:

APPLY NOW

RECENT HEALTH CARE NEWS

October 1, 2013 at 10:40 AM EDT
What Does the Health Insurance Marketplace Mean for You?

September 30, 2013 at 6:10 PM EDT
Moms Champions
The Health Care Law is a Reality Now!

The Health Insurance Marketplace is Open!

Enroll now in a plan that covers essential benefits, pre-existing conditions, and more.

Plus, see if you qualify for lower costs.

APPLY NOW

WANT TO LEARN MORE FIRST? START HERE
Your excuses for not providing me coverage have been denied...
Healthcare reform legislation has linked the ability to demonstrate quality outcomes with managing costs.

Universal coverage, delivery system design, and payment reform make bidirectional integration of MH/SU services with healthcare more important than ever before, especially in systems that historically have served the safety net population.
Delivery System Reform: MH/SUD & General Health Integration

- Medicaid health home option (2011)
  - Definition of chronic condition determining eligibility for benefit includes MH and SUD
- Grants to support co-location of primary and specialty care in community behavioral health centers (2010)
- Grants for community health teams

$50 million for co-location and grants for FQHCs
Meds Alone Couldn't Bring Robert Back

Experts like to debate the effectiveness of new drugs, but they overlook a key element of recovery.

By Jay Neugeboren
Newsweek
The Power to Heal:
Due to the dedication of Dr. Pam, my brother has not had a recurrence for more than six years.

What had made a difference?

The Power of Connection...
"Robert telephoned. "Alan's leaving-Alan's leaving!" he kept screaming. Alan was my brother's social worker—a man to whom he was very attached and whom he had known for many years, from his long-term stay at another hospital."

After interviewing hundreds of former mental clients for a book, what made the difference was:

Source: Newsweek_February 6, 2006 issue.
“...they all -- every last one said that a key element was a relationship with a human being. Most of the time, this human being was a professional -- a social worker, a nurse, a doctor. Sometimes it was a clergyman or family member. In every instance, though, it was the presence in their lives of an individual who said, in effect, "I believe in your ability to recover, and I am going to stay with you until you do" that brought them back.”

Jay Neugeboren

“Imagining Robert: My Brother, Madness, and Survival”

Source: Newsweek_February 6, 2006 issue.
Words of Wisdom

"Every [person] is in certain respects
a. like all other [people],
b. like some other [people],
c. like no other [people]."

Kluckhon & Murray, 1953