Goals

- ACA Implications for Behavioral Health Services
- Medi-Cal Behavioral Health System of care in California
- A local county referral process
- Cultural Competency Care considerations
ACA Implications for Behavioral Health
Key Changes & Implications

• The ACA creates a coverage mandate for mental health and substance use disorder (MH/SUD) services, including behavioral health treatment services, as one of the 10 required Essential Health Benefits categories

• The ACA mandates parity between behavioral health and physical health benchmark coverage
  ➢ Treatment limitations and financial requirements may not be more restrictive than those imposed on other medical/surgical benefits
500,000+ uninsured California adults with mental health needs have been eligible for coverage since Jan 2014, according to an UCLA published study → Number in services currently???

Qualified adults without a disability will, for the first time, have access to MH/SUD services through Medi-Cal or subsidized insurance

The ACA takes a preventive approach
  - Provides access to rehabilitative and recovery-oriented mental health services to individuals before they become disabled
• **Section 29:** Adds additional mental health and substance use disorder services benefits all Medi-Cal populations. Benefits to be consistent with the statewide essential health benefits.

• **Section 30:** Requires Medi-Cal managed care plans to provide the added mental health benefits covered in the state plan, excluding those benefits that are already provided by county mental health plans.

• Started **January 1, 2014**
Cultural Competency Care Considerations
Total US Population = 300.7 M

(U.S. Census Bureau, 2010)

- White (Non-Hisp) 192.0 million 64.0%
- Latino/Hispanic 49.6 million 16.5%
- African American 40.2 million 13.4%
- Asian American 7.1 million 5.7%
- American Indian/Alaska Native 5.1 million 1.7%
- Native Hawaiian and other Pacific Islander 1.2 million .4%
- People of Color >113 million 37.6%

(Not counting all other ethnic/racial groups)
2010 Census Race Distribution

- White alone (223.6m) 72.4%
- Black alone (38.9m) 12.6%
- American Indian and Alaska Native alone (2.9m) 0.9%
- Asian alone (14.7m) 4.8%
- Native Hawaiian and Other Pacific Islander alone (0.5m) 0.2%
- Some Other Race alone (19.1m) 6.2%
- Two or More Races (9.0m) 2.9%

Total U.S. Population (308.7m)
Population Percent Change by County
California: 2000 to 2010

Source: U.S. Census Bureau, PL94-171. Map prepared by the California Department of Finance, Demographic Research Unit, 3/2011.
## Total CA Population = 37.3 M

(U.S. Census Bureau, 2010)

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Count (M)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (Non-Hisp)</td>
<td>7.5</td>
<td>20.1%</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>14.0</td>
<td>37.5%</td>
</tr>
<tr>
<td>African American</td>
<td>2.3</td>
<td>6.2%</td>
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<tr>
<td>Asian American</td>
<td>4.9</td>
<td>13.1%</td>
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<tr>
<td>American Indian/Alaska Native</td>
<td>0.4</td>
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<tr>
<td>Native Hawaiian and other Pacific</td>
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<td></td>
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<tr>
<td>Islander</td>
<td>0.1</td>
<td>.3%</td>
</tr>
<tr>
<td>Mixed races</td>
<td>1.9</td>
<td>5.1%</td>
</tr>
<tr>
<td>Others</td>
<td>6.3</td>
<td>16.9%</td>
</tr>
</tbody>
</table>

**People of Color >23.6 million 63.3%**

(Not counting other ethnic/racial groups)
CULTURE

- An integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations; is dynamic in nature

(National Center for Cultural Competence, 2006)
Elements and Components of Culture

- Languages and Dialects
- Cultural Awareness
- Nonverbal Communication
- Perspectives, World Views, Frames of Reference
- Community motivation & Social Identification
- Collective values, experience, beliefs, & behavioral Styles
Ethnic and Racial Health Disparities?

- Differences and inequalities among racial, ethnic, linguistic, and cultural groups in:
  - Risk and predisposition
  - Disease prevalence, health status, and diagnosis
  - Health care: differences in quality not due to access-related factors or clinical needs, preferences, and appropriateness of intervention
  - Health outcomes and mortality
Higher Death Rates: The Death Gap

- **African-Americans**
  - Heart disease and stroke, cancer (breast, lung, and prostate), diabetes, infant mortality, HIV/AIDS

- **Asian-Americans and Pacific Islanders**
  - Tuberculosis, stroke, cervical cancer

- **Latinos**
  - Diabetes, uncontrolled hypertension, HIV/AIDS

- **American Indians and Alaska Natives**
  - Diabetes, infant mortality

- **LGBTQ**
  - HIV/AIDS, heart disease (lesbian women), mental health, and substance abuse
Main Pillars of Cultural Competence

Language Access Services

Culturally Competent Care

Organizational Support
Language

- PA, Nurse Practitioner, etc
- Family member
- Professional interpreter
- Social worker
- Intern, med student

Appropriate in-language signage communicating the different services that are available
Culturally Competent Care

- **Due diligence on patient’s background**
  - Race, religion, support network, major pre-and post immigration trauma, etc
  - Inquire about alternative / folk treatments

- **Derive culturally appropriate course of inquiry**
  - "Do you believe that it's your destiny to have this condition, or do you believe it's your destiny not to have this condition?"
  - “What have you done so far to treat your ailment (eg, acupuncture, herbs, acupressure, etc)?"
Organizational Support

- Embrace the significant role played by family members while working with patients.
- Partner with community based physician and/or specialist clinics.
- Reach out to community centers, community leaders, religious center within ethnic neighborhoods.
- Have offices create bilingual maps showing the practice and its proximity to public transportation, major clinics, pharmacies, etc.
- However, be sensitive with the clinic’s name.
Organizational Support

- Implement standards like the *Culturally and Linguistically Appropriate Services (CLAS)* recommendations promulgated by the Office of Minority Health of the US Department of Health and Human Services (HHS)
  - The Office of Minority Health defines cultural competence as “the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter.”
Potential Solutions to Eliminate Racial and Ethnic Disparities

- Support capacity development
- Increase representation in research
- Promote outreach to and collaboration with communities
- Provide training in culturally appropriate care
- Establish cultural competence initiatives
CA Reducing Disparities Projects

- African American
- Asian American & Pacific Islanders
- Native American
- Latino
- LGBTQ

www.cahealthequity.org
Resources

www.minorityhealth.hhs.gov
www.nccc.georgetown.edu
www.glma.org
www.fenwayhealth.org
www.cahealthequity.org
www.samhsa.gov/term/Cultural-Competence
Workforce Diversity
Healthcare Workforce Diversity Advisory Council Report  
(Office of Statewide Health Planning and Development, 2008)

- Latinos comprise over a third of the state’s population, but they make up 5.7% of nurses, 5.2% of physicians, and 7.6% of psychologists in California (*census differences in 2014*)
- African-Americans comprise 5.9% of the state’s population but make up 4.5% of nurses and 3.2% of physicians.
- Current estimates indicate that roughly 9 out of every 10 physicians, dentists, and pharmacists in California is either White or Asian (didn’t account for Asian languages capability)
By 2014 the projected demand will exceed supply for pharmacy technicians by 119%, for dental hygienists by 122%, for physical therapist assistants by 178%, and for clinical laboratory scientists by 559%.

There will be an estimated need of 47,600 additional nurses by 2010 and 5,000-17,000 physicians by 2015 (as a response to saturation of nurses).
Overarching Recommendations

- Develop a comprehensive, multi-year strategy and implementation plan to advance health workforce and diversity in California
- Conduct a gap analysis to identify immediate opportunities to enhance workforce diversity
- Facilitate the effective implementation of the Healthcare Workforce Clearinghouse Program by building the capacity of departments, institutions, and agencies involved in the collection and reporting of health workforce and education data
- Institutionalize the Healthcare Workforce Diversity Advisory Council
Higher Education Recommendations

- Support local, regional, federal, and statewide public/private partnerships that promote collaborative efforts to increase the matriculation of underrepresented students in undergraduate and graduate programs
- Require health professions educational institutions to submit an annual report, as part of their annual budget report, regarding the admissions, retention, and attrition of underrepresented students and faculty, as well as formal plans and resource allocation to increase diversity and create a diverse learning environment
- Create incentives for health professions education institutions to recruit and retain faculty whose research focuses on health disparities and/or communities with disproportionate unmet health needs and/or health workforce development
Workforce Recommendations

- Pursue public/private partnerships to increase loan repayment availability for students and faculty (MHSA funding for mental health professionals)
- Pursue public/private partnerships to increase resident and clinical placements in rural and urban/inner city areas with disproportionate unmet health needs
Other areas to consider

- Increase in ethnic individual providers do not equal to increase in language capability
- Increase training in cultural competency in parallel with language courses
- Special attention to substance use treatment provider workforce
- Early career interest building
- Peers in recovery as a very viable workforce
Q & A