



## Hispanic Health Council

Senator Gerratana, Representative Johnson, Members of the Public Health Committee:

My name is Jose Ortiz, I am President and CEO of the Hispanic Health Council, and I thank you for the opportunity to speak before you today in support of Proposed Bill No. 366, *AN ACT REQUIRING LICENSED SOCIAL WORKERS AND COUNSELORS TO COMPLETE CONTINUING EDUCATION COURSEWORK IN CULTURAL FOUNDATIONS*. The proposed bill expands the current requirement for medical doctors, including psychiatrists, to complete at least one hour of cultural competence training for initial licensure and licensure renewal. We are suggesting that the state require the same minimum level of training for Social Workers, Professional Counselor, Marital and Family Therapists and Drug and Alcohol Counselors, at least one hour of cultural competence training as part of the continuing education requirement for license renewal.

The basis for this bill is that cultural competence is a critically important element to effective healthcare interactions, and therefore has implications to health care costs, health status and health disparities. The landmark report "Unequal Treatment" released by the Institute of Medicine in 2003, provided results of their review of over 100 studies that assessed the quality of health care for racial and ethnic minorities across the U.S. The vast majority showed that minorities are less likely than whites to receive necessary services even when controlling for confounding variables such as income, education level and insurance status. The "Unequal Treatment" report concluded that "Some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may play a significant role" and recommends that "All current and future healthcare providers can benefit from cross-cultural education." Unfortunately, studies conducted since 2003 have consistently shown that this problem of healthcare disparities continues.

Given the critical nature of this situation, I advocated in my former role as Director of Multi-Cultural Affairs at the Connecticut Department of Mental Health and Addiction Services for the current law, which requires training of medical doctors – including psychiatrists. This was a good first step, but it is clearly not enough. My many years working in mental health and addiction services confirmed what the federal government has also documented – that there are disparities in behavioral health care similar to those identified in medical settings. Given the sensitive and very personal nature of social work and counseling, it is critically important that providers in this field have some mandated standard of cultural competence training.

We are suggesting a minimum of an hour of cultural competence training as part of the continuing education requirement for license renewal. At DMHAS, where I led the transformation of that state agency into a nationally recognized culturally competent

organization, I've witnessed the dramatic difference that this training can make in job performance and service outcomes. Mandated cultural competence training of social workers and counselors is one small, doable and significant step that can be taken towards achieving these kinds of service improvements. I urge you to support passage of Bill #366.

## I. Healthcare Disparities

What are healthcare disparities? What is the connection between healthcare disparities and cultural competence training?

Health Care Disparities: The landmark report "Unequal Treatment" released by the Institute of Medicine in 2003 confirmed disparities in health care which are defined as "racial and ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention."

The report provided results of reviewing over 100 studies that assessed the quality of health care for racial and ethnic minorities across the U.S. The vast majority of studies showed that minorities are less likely than whites to receive necessary services even when controlling for confounding variables.

Unequal Treatment was published ten years ago. Do these healthcare disparities still exist? Recent studies indicate that the findings of Unequal Treatment remain true ten years later. Examples include:

- The National Healthcare Disparities Report -2011 (U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) found that:
  - Previous NHDRs showed that Blacks had poorer quality of care and worse access to care than Whites for many measures tracked in the reports. Of all measures of health care quality and access that are tracked in the reports and support trends over time, Blacks had worse care than Whites in the most recent year for 67 measures. Most of these measures showed no significant change in disparities over time. Specific examples include that compared to Whites:
    - Black hospital patients with pneumonia were 1.6 times less likely to receive an initial antibiotic dose within six hours of hospital arrival.
    - Black hospital patients with heart attack are 1.6 time less likely to receive percutaneous coronary intervention within 90 minutes of arrival.
  - Previous NHDRs showed that Hispanics had poorer quality of care and worse access to care than non-Hispanic Whites for many measures that the reports track. Of all measures of health care quality and access that are tracked in the reports and support trends over time, Hispanics had worse care than non-Hispanic Whites in the most recent year for 63 measures. Most of these measures showed no significant change in disparities over time. Examples include that compared to Whites:
    - Hispanic long-term nursing home residents were 1.6 times less likely to be assessed for pneumococcal vaccination.

- Other specific recent examples of disparities in healthcare include:
  - The findings of a recently reported, federally-funded study by Georgetown University, in conjunction with the Rand Corporation and the University of Pennsylvania, which were published in the New England Journal of Medicine, indicate that physicians are far less likely to refer blacks and women than white men with identical complaints of chest pain to heart specialists for cardiac catheterization; and the authors of this study suggest that the difference in referral rates stems from racial and sexual biases;

Why are there disparities in health care?

The conclusions of the “Unequal Treatment” report include that “Some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may play a significant role.” Recommendations included that “All current and future healthcare providers can benefit from cross-cultural education.”

## II. Disparities in Mental Healthcare

Are there disparities in mental health care?

- In 2001 former Surgeon General Dr. David Satcher released *Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. This landmark report documented the lack of access and the poor quality of mental health care that people of color had been receiving when dealing with mental illness. The report discusses disparities in behavioral health services for members of racial and ethnic minority populations. People in these populations:
  - are less likely to have access to available mental health services;
  - are less likely to receive necessary mental health care;
  - often receive a poorer quality of treatment; and
  - are significantly underrepresented in mental health research.

Members of racial minority groups, including African Americans and Latinos, underuse mental health services and are more likely to delay seeking treatment. Consequently, in most cases, when such individuals seek mental health services they are at an acute stage of illness. This delay can result in a worsening of untreated illness and an increase in involuntary services. Generally, rates of mental disorders among people in most ethnic minority groups are similar to rates for Caucasians. However, members of minority populations are more likely to experience factors – such as racism, discrimination, violence and poverty – that may exacerbate mental illnesses.

The message of the Surgeon General was clear: culture counts and the mental health system was leaving thousands of Americans behind.

- Subsequent reports continued to highlight continued to highlight barriers to accessing mental health treatment and the poor quality of care received by ethnic/racial communities. These include: *Unequal Treatment* (IOM 2003), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003), the President's New Freedom Commission on Mental Health *Achieving the Promise: Transforming Mental Health Care in America* (2003), and the Agency for Healthcare Research and Quality *National Healthcare Disparities Report* (2005).

### III. Cultural Competence

- a. Cultural competence is defined as:
  - The ability to move beyond good intentions in cultural relations.
  - A lifelong process of acquiring knowledge, attitudes, values, and skills that helps one to:
  - Understand other cultures along with one's own culture;
  - Facilitate understanding among different cultures;
  - Confront the inconsistencies, biases and unconscious assumptions of these cultures; and
  - Take action to level the playing field. (Ryan and Parker 1999)
- b. A culturally competent healthcare system is defined as: one that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs.
- c. Within the behavioral health system (which addresses both mental illnesses and substance abuse), cultural competence must be a guiding principle, so that services are culturally sensitive and provide culturally appropriate prevention, outreach, assessment and intervention. (Temple University, [http://tucollaborative.org/pdfs/Toolkits Monographs Guidebooks/community inclusion/Cultural Competence in MH.pdf](http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/community_inclusion/Cultural_Competence_in_MH.pdf))

### IV. Cultural Competence Workforce Training

- a. Medical Providers (Including Psychiatrists)
  - Connecticut law currently mandates a minimum of one hour of training for licensure and licensure renewal for medical doctors and psychiatrists.
  - The public interest in providing quality health care to all segments of society dictates the need for a formal requirement that medical professionals be trained in culturally competent healthcare provision as a condition of licensure to practice medicine in New Jersey.
- b. Social Workers, Behavioral Health Providers and Drug and Alcohol Counselors
  - Connecticut does not currently mandate any cultural competence training for licensure and licensure renewal for Social Workers, Behavioral Health Providers and Drug and Alcohol Counselors

Profession	Current number of hours of continuing education dedicated to Cultural Competence training / number of hours of continuing education training per renewal period	With the passing of SB 366, number of hours of continuing education dedicated to Cultural Competence training / number of hours of continuing education training per renewal period
Professional Counselors	0 of 15 hours/year of continuing ed.	No less than 1 of 15 hours/year of continuing ed.
Clinical Social Workers	0 of 15 hours/year of continuing ed.	No less than 1 of 15 hours/year of continuing ed.
Alcohol and Drug Counselors	0 of 20 hours/year of continuing ed.	No less than 1 of 20 hours/year of continuing ed.
Marital and Family Therapists	0 of 15 hours/year of continuing ed.	No less than 1 of 15 hours/year of continuing ed.

#### V. Increasing Minority Population in U.S. and Connecticut

##### a. According to the National Healthcare Disparities Report:

- In 2010, about 41% of the U.S. population identified themselves as members of racial or ethnic minority groups. More than half of the growth in the total population of the United States between 2000 and 2010 was due to an increase in the Hispanic population. By 2050, it is projected that these groups will account for almost half of the U.S. population.
- For the 2010 U.S. census data, the Census Bureau reported that the United States had 42 million Blacks or African Americans (13.6% of the U.S. population); 50.4 million Hispanics or Latinos (16.3%); 17.3 million Asians (5.6%); 1.2 million Native Hawaiians and Other Pacific Islanders (NHOPIs) (0.4%); and 5.2 million American Indians and Alaska Natives (AI/ANs) (1.7%).

##### b. In Connecticut:

- In 2010, 28.8% defined themselves as members of racial or ethnic minority groups, increased from 22.5% in 2000.
- Connecticut's population is 77.57% White, down from 81.64% in 2010; 13.4% Hispanic, up from 9.4% in 2000; 10.14% Black, up from 9.1% in 2000; and 3.70% Asian, up from 2.42% in 2010.

VI. What is Patient-Centered Care and what is the connection between cultural competence and patient-centered care?

- a. In its 2001 report *Crossing the Quality Chasm*, the Institute of Medicine included patient-centeredness of care as one of its six domains of quality and "Aims for Improvement." Patient-centered care includes consideration of patient culture, as outlined in the definition below.
- "Patient-Centered Care is care that is "respectful of and responsive to individual patient preferences, needs, and values and ensures that patient values guide all clinical decisions." (IOM, 2001)
  - "Individual patient's culture, social context, and specific needs deserve respect, and the patient should play an active role in making decisions about his/her own care" (Institute for Healthcare Improvement, 2010).
  - Patient-centeredness will increase health care quality for all, and is particularly applicable for diverse populations.
  - Research has shown that "orienting the health system around the preferences and needs of patients has the potential to improve patients' satisfaction with care as well as their clinical outcomes." (Commonwealth Fund, 2010)