Linking Cultural Competence to Functional Life Outcomes in Mental Health Care Settings

Georgia Michalopoulou, Ph.D.; Pamela Falzarano, M.A.; Michael Butkus, Ph.D.; Lori Zeman, Ph.D.; Judy Vershave, COTA; Cynthia Arfken, Ph.D.

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Minorities in the United States have well-documented health disparities. Cultural barriers and biases by health care providers may contribute to lower quality of services which may contribute to these disparities. However, evidence linking cultural competency and health outcomes is lacking. This study, part of an ongoing quality improvement effort, tested the mediation hypothesis that patients' perception of provider cultural competency indirectly influences patients' health outcomes through process of care. Data were from patient satisfaction surveys collected in seven mental health clinics (n=94 minority patients). Consistent with our hypothesis, patients' perception of clinicians' cultural competency was indirectly associated with patients' self-reported improvements in social interactions, improvements in performance at work or school, and improvements in managing life problems through the patients' experience of respect, trust, and communication with the clinician. These findings indicate that process of care characteristics during the clinical encounter influence patients' perceptions of clinicians' cultural competency and affect functional outcomes.

Key Words: Cultural competency ■ Ethnic health disparities ■ Clinician-patient Trust ■ Communication ■ Respect

Correspondence: Georgia Michalopoulou, Ph.D, e-mail: gmichalo@med.wayne.edu. All authors can be reached at telephone: 313-745-4491; fax: 313-993-0282.

INTRODUCTION

Racial and ethnic minority groups experience worse health status and increased health risks compared to non-Hispanic White Americans.[1,2] These disparities are consistent across a range of illnesses and services, including both physical and mental health.[1,3,4] Social determinants contribute to these observed differences but do not completely explain them. For example, African Americans have poorer health status and receive a lower quality of health care than non-Hispanic White Americans even when patients' insurance status and income, two important individual-level measures of social determinants, are controlled.[1,4,5] Another contributor to these observed differences are cultural barriers between clinicians and patients.[1,5-8] These barriers may result in communication difficulties,[9-11] lack of trust,[12-19] and patient feeling disrespected.[12,20] These difficulties in the clinical interaction are considered process of care deficiencies and have been associated with reduced patient satisfaction and other measures of health status.[5,21-24]

One approach to bridge cultural barriers, although not yet proven to consistently affect outcomes[25] is to match clinicians to patients by race. Some research studies have shown African Americans tend to prefer clinicians of the same race and they rate those clinicians as providing better interpersonal care than other clinicians.[6,26-28] However, given that the workforce does not reflect the multitude of cultural, racial and ethnic groups, matching for individual patients is very difficult. To provide high quality care, the goal should be for every clinician to be able to provide culturally competent care to every patient.

In previous research, we found higher patient perception of clinicians' cultural competency (defined as cultural knowledge, cultural awareness and cultural skill based on a model created by Sue et al. 1996) was associated with greater satisfaction with care.[29] Greater satisfaction with care in turn appears to be related to process of care variables.[14,23,30] Thus clinicians' cultural competency impact on health outcomes may be mediated by process of care measures. However, we could not find any research that explicitly addressed this hypothesis.

In the field of mental health it is explicitly recognized that treatment is dependent on the clinician- patient relationship (i.e. therapeutic alliance).[31,32] This vital relationship is based upon mutual trust, respect and open communication between the clinician and the patient. The characteristics of this relationship are related to health outcomes.[33] One measure, trust, is positively associated with self-reported health status, symptom improvement, quality of life, willingness to seek care, use of preventive screening recommendations, and adherence to treatment.[16,17,34-38] Another process of care measure, communication, has been shown to elicit greater disclosure of concerns from patients.[39,40] These processes of care characteristics are routinely included in patient satisfaction surveys of mental health clinics.

Desirable outcomes in the mental health field include the patient-centric functional ability to live independently and fulfill role obligations.[41] These outcomes specifically cover independent self care, activities of daily living, social interactions and work/school roles.[42-44] Besides being valued outcomes by patients, they are used by clinicians, administrators and auditors to gauge patient improvement. As such, these functional measures are also routinely included in patient satisfaction surveys of mental health clinics.

To test the mediation hypothesis that patient perspectives of clinician's cultural competency is associated with health outcomes through process of care, we will construct models

using data from patient surveys of satisfaction collected within mental health settings. Based on our preliminary studies and those of others, we propose that perceived cultural competency is indirectly associated with patients' functional outcomes through measures of trust, communication and respect as perceived by patients during clinical interactions.

Method Participants:

As part of ongoing quality control, patient satisfaction is monitored at seven university-affiliated outpatient mental health programs in the Detroit Michigan metropolitan area using short satisfaction surveys. Two of the programs provide care to children and adolescents, and five programs provide care to adults.

Patients' demographics and patients' report of the clinicians' race were included in the survey. No information is available on whether the parent of patients or the patient completed the survey. For this analysis, 20 non-Hispanic white American respondents were eliminated from the sample. Among the minority sample (n=94), we coded the visit as patient-clinician race concordant (14.9%) or discordant. Table 1 summarizes characteristics of patients across the seven clinics. Overall, 54.3% were female and 82% were African Americans.

PROCEDURE:

Patients are encouraged but not required to complete the anonymous survey. At the child/adolescent sites, the parents of the children are encouraged to complete the survey. Organizationally, the goal is for each clinic to hand out surveys to patients during designated times and to collect at least 25 surveys for each period. 119 surveys were completed in the fall of 2011 and they were analyzed for this study. This study was approved by Wayne State University Institutional Review Board.

MEASURES:

The patient satisfaction survey consisted of 22 items measuring various aspects of care (e.g., patient-clinician communication, patient clinician trust, functional life outcomes and cultural competency) (Table 2). Limited demographic information (age, gender, ethnicity of patient, perceived race and ethnicity of clinician) was collected.

Perceived cultural competency was measured using three questions selected from a nine-item measure developed and validated by the investigators in an independent sample.[45] The original measure was adapted from the guidelines for measuring cultural competency in mental health clinician settings.[46] The conceptual scheme includes three hypothesized domains of clinician competency: (1) *Cultural knowledge* measures clinicians' knowledge of a given culture, including its characteristics, worldviews and expectations; (2) *Cultural awareness* describes clinicians' sensitivity to their cultural biases and how such biases may influence their perceptions of patients; and (3) *Cultural skill* encompasses a clinician's ability to interact effectively with patients in a culturally relevant manner. For the brief satisfaction survey used in this study, cultural competency items with high face validity from each of the above domains were selected. Each item was measured on a Likert scale ranging from strongly disagree (1) to strongly agree (5). For the 94 surveys, the three items had an internal reliability of .87 when summed to form a scale. However the number of valid observations dropped from 90 for cultural skill alone to 71 when combining all three items. To utilize the item most commonly reported by patients, we measured the cultural skill item only. For this item, the distribution had a bimodal distribution of "strongly agree" (45.2%) or "strongly disagree" (54.8%). Based upon this information, we dichotomized the variable as "strongly agree" or "not strongly agree".

Seven process of care variables were included in the survey to measure patient trust in the clinician, perceived respect during the clinical interaction, and patient–clinician communication (Table 2). Missing data were minimal ranging from 0 for understand (*The therapist/doctor helped us understand the problem*), confidences (*The therapist/doctor*

Table 1: Participant Characteristics (N=94)

Demographics	**%**
Female	54.3%
Race/ethnicity African American	87.2%
Asian	4.3%
Middle Eastern American Indian Hispanic	3.2% 2.1% 2.1%
Specific clinician encounter	
Race concordant with physician	13.8%