CULTURAL COMPETENCY AND THE ALIGNMENT TO HEALTH EQUITY

PREPARED BY:
SHARON C. ALLEN, MBA, CDM

MARKETING AND OPERATIONS EXECUTIVE, AUTHOR
ADJUNCT BUSINESS FACULTY, COLUMBIA COLLEGE OF MISSOURI

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PRESENTATION OUTLINE

- Cultural Competency in Healthcare Defined
- Equity of Care Pledge Data – New Jersey
- Cultural Competency Training – Strategies, Tools and Techniques
- An unconscious bias self assessment
- Correlation of culturally competent workforce and health equity
- Tools and resources to address unconscious bias

CULTURAL COMPETENCY DEFINED

Individual values, beliefs, and behaviors about health and well-being are shaped by various factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation.

Cultural competence in health care is broadly defined as the ability of providers and organizations to understand and integrate these factors into the delivery and structure of the health care system.

Source: https://hpi.georgetown.edu/agingsociety/pubhtml/cultural/cultural.html, www.diversityconnection.org and http://medical-dictionary.thefreedictionary.com/cultural+competence

UNCONSCIOUS BIAS TEST

Look at the word and select the option that first comes to your mind.

DOCTOR

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

NURSE

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

POLICE OFFICER

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

FIRE PATROL

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

UNCONSCIOUS BIAS TEST

Look at the word and select the option that first comes to your mind.

JANITOR

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

WAITRESS

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

MAID

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

TEACHER

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

UNCONSCIOUS BIAS TEST

Look at the word and select the option that first comes to your mind.

SCIENTIST

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

CEO

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

PRIEST

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

CARPENTER

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

UNCONSCIOUS BIAS TEST

Look at the word and select the option that first comes to your mind.

UNWED MOTHER

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

MARRIED MAN

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

UNINSURED PATIENT

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

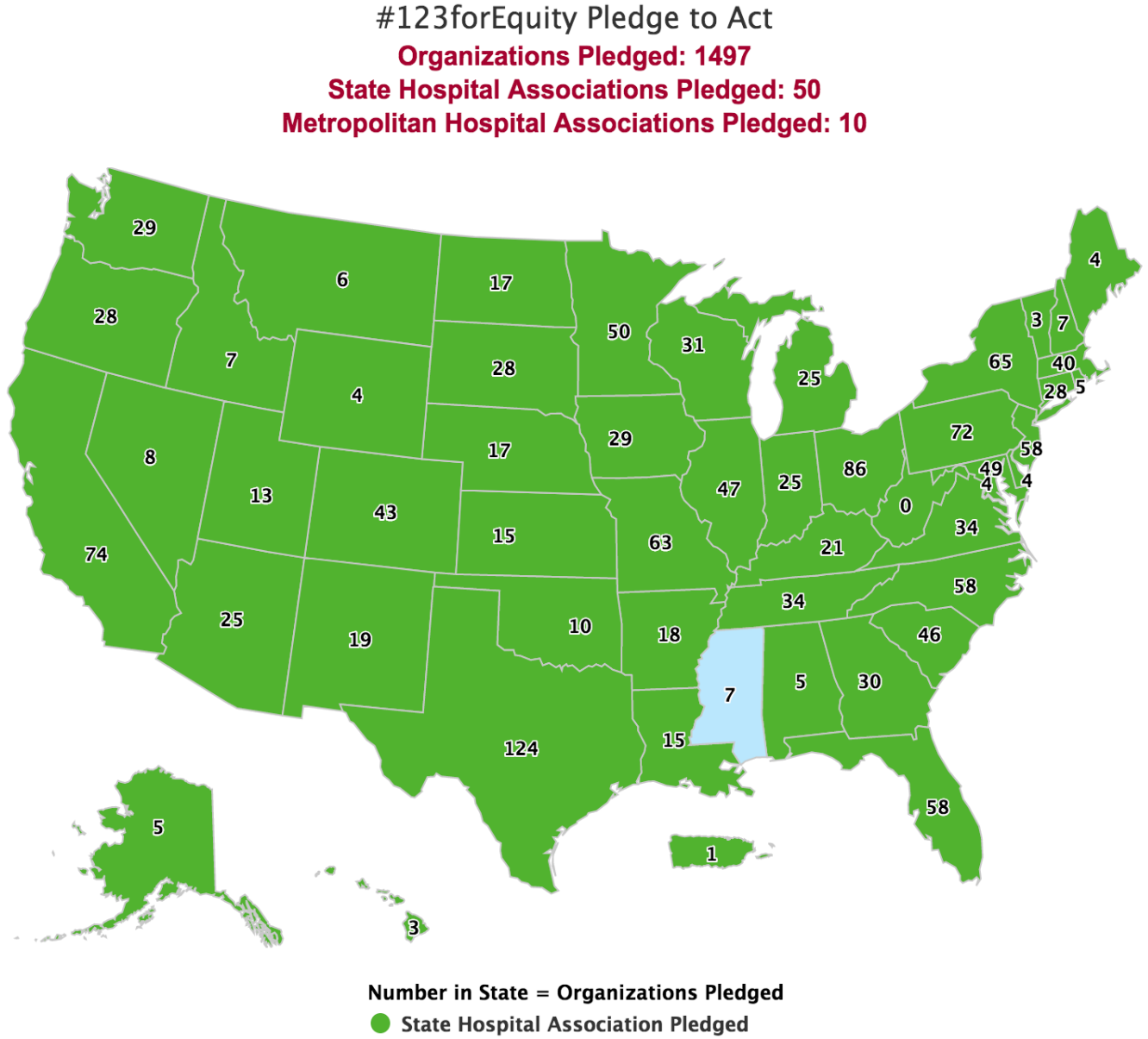
OPIOD ADDICT

a) White Male
b) White Female
c) Black Male
d) Black Female
e) Hispanic Male
f) Hispanic Female
g) Asian Male
h) Asian Female

WORKING DEFINITIONS

- **Health disparities** can be defined as inequalities that exist when members of certain population groups do not benefit from the same health status as other groups.
- Evolving definition of **diversity --** inclusive of race, ethnicity, language preference, disability status, gender identity, sexual orientation, veteran status, and socioeconomic factors.
- **Health equity** is the attainment of the highest level of health for all people.

Source: https://www.healthypeople.gov



American Hospital Association

#123forEquity Pledge to Act campaign

New Jersey:

- 88% of total NJ hospitals pledged at 58
- Ranked among top 10 states who have pledged nationwide
- Increase in cultural competency is one of the pledge goals

- **NJ is the eighth most diverse state in the US**
- **45% of population is non-white**

ACHIEVING THE #123FOR EQUITY PLEDGE GOAL

Opportunity for Goal 2: Increase Cultural Competency Training

As reported in the 2015 AHA's Diversity and Disparities Survey, 85% of hospitals provide cultural competency training. Cultural competency training should include four components:

- Awareness of one's own cultural worldview
- Attitude and biases toward cultural differences
- Knowledge of different cultural practices and worldviews
- Cross-cultural skills

Top 5 languages spoken in NEW JERSEY other than English:

Spanish | Chinese | Portuguese | Tagalog | Italian

Incorporate Culturally and Linguistically Appropriate Services (CLAS) Standards in training and use qualified interpreters and translators

CULTURAL COMPETENCY TRAINING CONTENT

Training Content in More Detail:

- Initiatives focused on conducting community assessments
- Mechanisms for community and patient feedback
- Systems for patient racial/ethnic and language preference data collection
- Quality measures for diverse patient populations
- Culturally and linguistically appropriate health education materials and health promotion and disease prevention interventions (CLAS)

ACHIEVING THE #123FOR EQUITY PLEDGE GOAL

Opportunity for Goal 3: Increase diversity in leadership and governance

1. Hospital boards and C-Suite should reflect patient population served

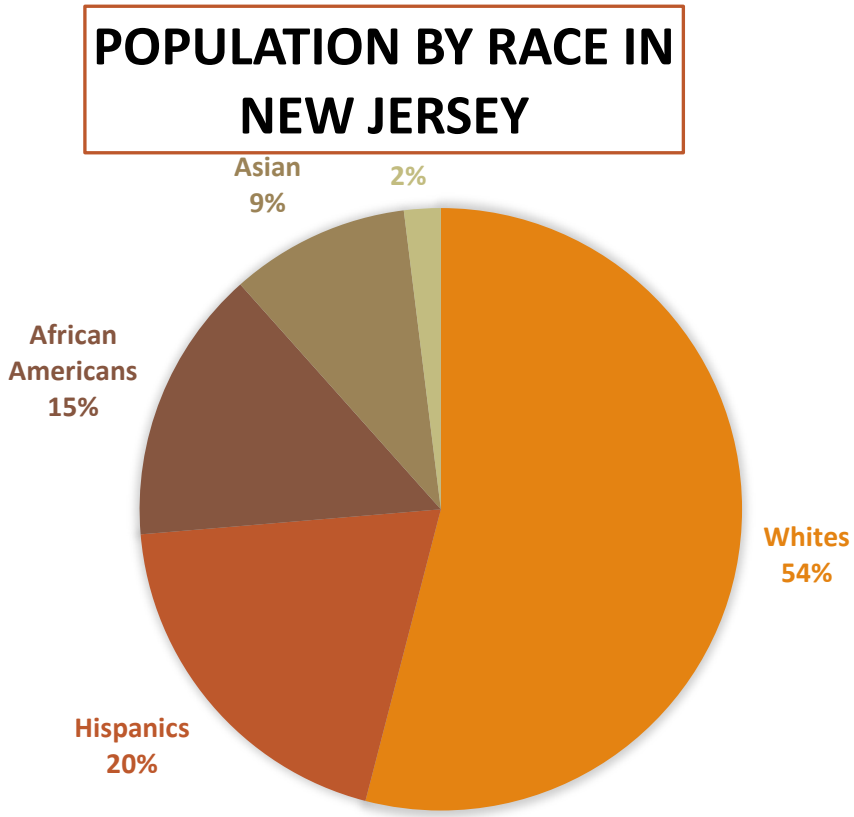
   Diversity comes is varies forms:

   Education, Religion, LGBTQ, Income, Veteran Status, Disability, etc.

2. Good business decision
   - Can Improve patient satisfaction scores
   - Control costs
   - Builds trust of patient and provider for improved behavioral health

3. Resources:

   http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf



TIPS TO ACHIEVE CULTURAL COMPETENCE

Maximize diversity: Should align with community and population served

- Develop and deploy cultural competency training throughout the organization
- Create and/or enhance affinity group programs for leadership development
- Recruit, hire and promote minorities in the health care workforce
  - Set metrics to ensure success
- Build community partnerships and include them in the organization's planning and quality improvement projects

BARRIERS TO CULTURALLY COMPETENT CARE

- Lack of collaboration and communication among providers, organizations, and systems

  Leads to:

  - Patients with a higher risk of having negative health consequences,
  - receiving poor quality care
  - being dissatisfied with their care

- Lack of diversity in healthcare leadership
  - 14% of hospital boards are diverse and 15% of the C-Suite is diverse *(American Hospital Assoc.)*
- Systems of care poorly designed to meet the needs of diverse patient populations
- Poor communication between providers and patients of different racial, ethnic, or cultural backgrounds

PATIENT DISSATISFACTION DUE TO LOW WORKFORCE CULTURAL COMPETENCE

Why should this matter:

People with chronic conditions require more health services; thus, greater need for health care system:

- The quality of patient-physician interactions is lower among non-White patients, particularly Latinos and Asian Americans.
- Lower quality patient-physician interactions are associated with lower overall satisfaction with health care.
- African Americans, Latinos, and Asian Americans, are more likely than Whites to report that they believe they would have received better care if they had been of a different race or ethnicity
- African Americans are more likely than other minority groups to feel that they were treated disrespectfully during a health care visit
  - Spoken to rudely
  - Talked down to
  - Ignored
- Compared to other minority groups, Asian Americans are least likely to feel that their doctor understood their background and values and are most likely to report that their doctor looked down on them

https://www.cdc.gov/chronicdisease/overview/index.htm

CHRONIC ILLNESS DATA

Top 10 Leading Causes of Death in NJ
1. **Heart Disease ***
2. **Cancers ***
3. **Stroke ***
4. Respiratory Disease
5. Unintentional Injuries
6. **Diabetes ***
7. Alzheimer's Disease
8. Septicemia
9. Kidney Disease
10. Flu and Pneumonia

The most common, costly, and preventable of all health problems.

- As of 2012, about half of all adults—117 million people—had one or more chronic health conditions.
- **One in four adults had two or more chronic health conditions.**
  Seven of the top 10 causes of death in 2014 were chronic diseases.
- Two of these chronic diseases—heart disease and cancer—together accounted for nearly 46% of all deaths.
- **Obesity is a serious health concern. During 2011–2014, more than one-third of adults (36%), or about 84 million people, were obese (defined as body mass index [BMI] ≥30 kg/m2).**
- About one in six youths (17%) aged 2 to 19 years was obese (BMI ≥95th percentile).
- **Arthritis is the most common cause of disability.4 Of the 54 million adults with doctor-diagnosed arthritis, more than 23 million say they have trouble with their usual activities because of arthritis.**
- Diabetes is the leading cause of kidney failure, lower-limb amputations other than those caused by injury, and new cases of blindness among adults.

* Chronic Illness

COST OF CHRONIC ILLNESS

- In the United States, chronic diseases and conditions and the health risk behaviors that cause them account for most health care costs.
- Eighty-six percent of the nation's $2.7 trillion annual health care expenditures are for people with chronic and mental health conditions. These costs can be reduced.
  - Total annual cardiovascular disease costs to the nation averaged $316.1 billion in 2012–2013. Of this amount, $189.7 billion was for direct medical expenses and $126.4 billion was for lost productivity costs (from premature death).
  - Cancer care cost $157 billion in 2010 dollars.19The total estimated cost of diagnosed diabetes in 2012 was $245 billion, including $176 billion in direct medical costs and $69 billion in decreased productivity. Decreased productivity includes costs associated with people being absent from work, being less productive while at work, or not being able to work at all because of diabetes.
  - The total cost of arthritis and related conditions was about $128 billion in 2003. Of this amount, nearly $81 billion was for direct medical costs and $47 billion was for indirect costs associated with lost earnings.
  - Medical costs linked to obesity were estimated to be $147 billion in 2008.
    - Annual medical costs for people who were obese were $1,429 higher than those for people of normal weight in 2006
  - For the years 2009–2012, economic cost due to smoking is estimated to be at least $300 billion a year.
    - This cost includes nearly $170 billion in direct medical care for adults and more than $156 billion for lost productivity from premature death estimated from 2005 through 2009
  - The economic costs of drinking too much alcohol were estimated to be $249 billion, or $2.05 a drink, in 2010. Most of these costs were due to binge drinking and resulted from losses in workplace productivity, health care expenses, and crimes related to excessive drinking.

https://www.cdc.gov/chronicdisease/overview/index.htm

MAKING THE LINK TO HEALTH EQUITY

Increase in Cultural Competence

- Can increase access to quality care for all patient populations
  - Increase HCAHP Scores
  - Reduce readmissions rates
- Used as a business strategy to attract new patients and market share
  - Enhance image within the community
  - Improve community relations and expand community partnerships
  - Set and track metrics to diversify leadership and governance

CULTURAL COMPETENCY TEST

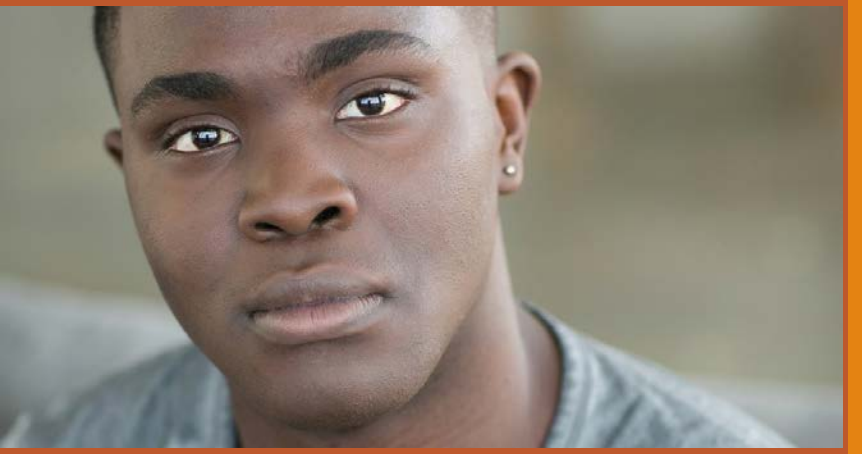
- Through a patient scenario, test your level of cultural competence.
- There is no good or bad score, it just measures what you know
- Be honest and don't overthink your response

Jimmy Washington

Jimmy is a 29 year-old, African American male who entered the emergency department with a complaint of left leg pain and inability to ambulate. He states his injury occurred after jumping off a six-foot wall.

X-rays show a spiral, mildly displaced mid-shaft tibia fracture. There are no other injuries. His compartments are soft, and he has no pain with passive stretch, but he is in significant pain due to his injury.

His pain complaints are well-documented by both the emergency physician and in the nursing notes.



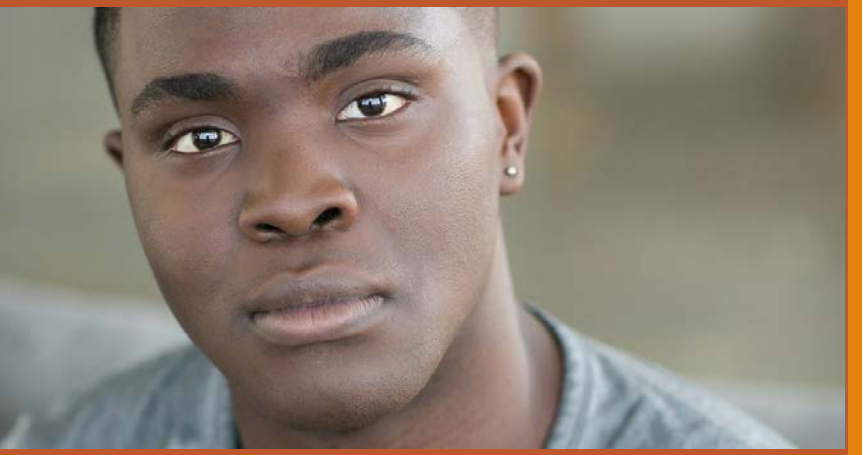
Question 1:
Jimmy requests medication to help the pain. As the clinician, your examination shows no clinical evidence of compartment syndrome. His chart reveals that he has received no form of pain medication. You think:

a. It is appropriate to continue withholding pain medication due to ongoing concern about compartment syndrome.

b. The patient is exhibiting drug-seeking behavior and therefore, you withhold pain medication.

c. The patient probably received pain medication in the ER, as is customary for the most long-bone fractures. You consult with the emergency room physician to see if the chart is in error.

d. The patient likely received less pain medication than he should have. You consult with the emergency physician regarding appropriate pain management.

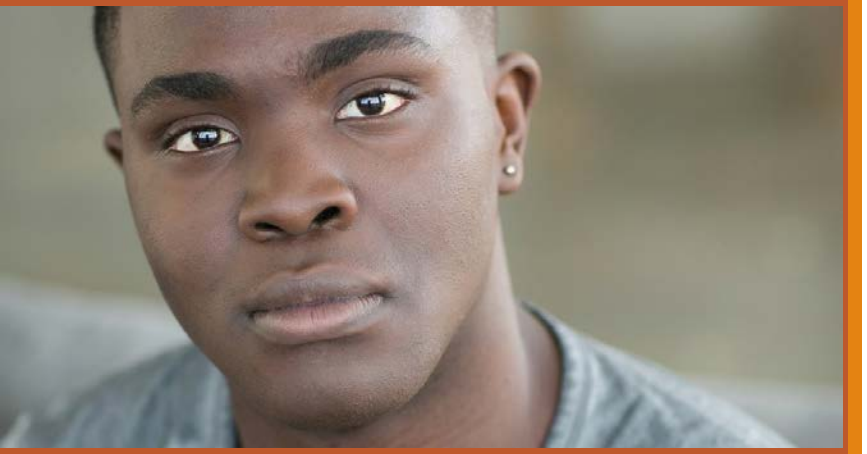


D: The patient likely received less pain me han he should have. You consult with the emergency physician regarding appropriate pain management

There is a statistical likelihood that Joe received less pain medication than others with the same injury and complaints. A retrospective review of emergency patients with isolated long-bone factures showed white patients were more like to receive analgesics from the emergency physician than African American patients (74% vs 57%), despite similar assessments of pain.

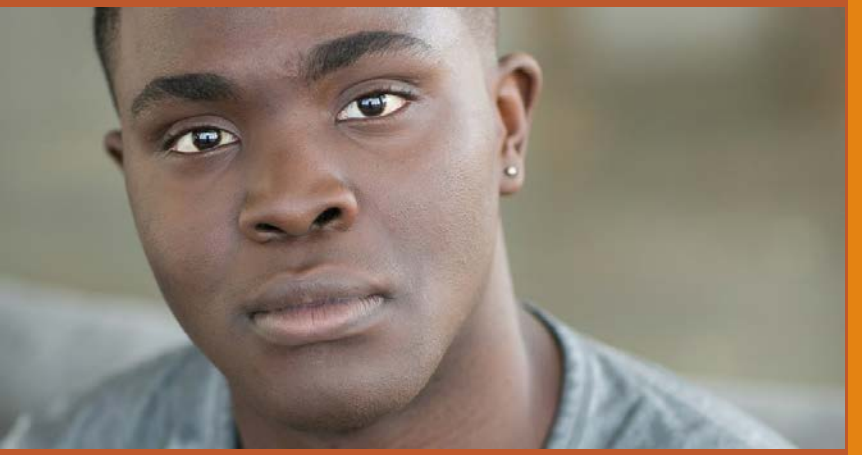
The risk of receiving no analgesic was 66% greater for African American patients than white patients. African American patients receiving any form of analgesia were less likely to receive narcotics than white patients.

This underscores the influence of ethnicity on physicians' perceptions and treatment of patients.



Question 2:
Jimmy seems overly concerned with the possibility of amputation; stating, “You’re not going to cut my leg off,” as he has ‘seen happen before’ to his friends and relatives. Although his injury is not severe, you believe his fear to be:

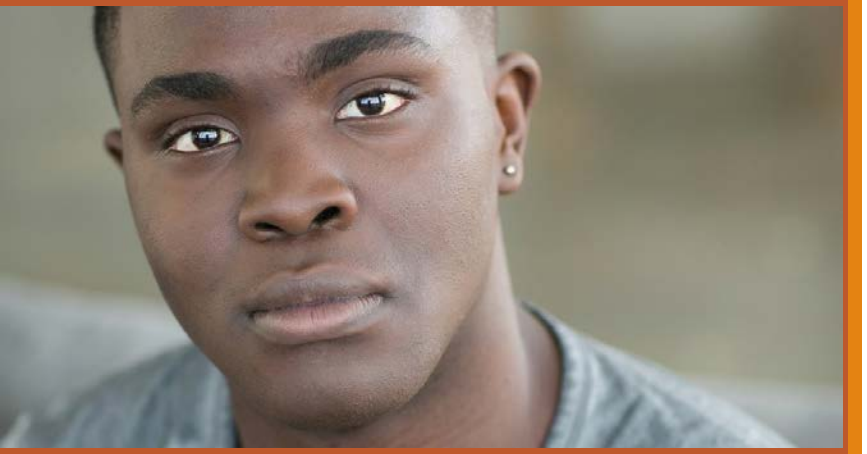
a. Unrealistic given the injury but not unfounded
b. Based on things he has seen in movies and television.
c. Based on general mistrust of medical care, but not specifically related to fears of amputation.
d. A result of too much pain medication



A: Unrealistic given the injury but not unfounded

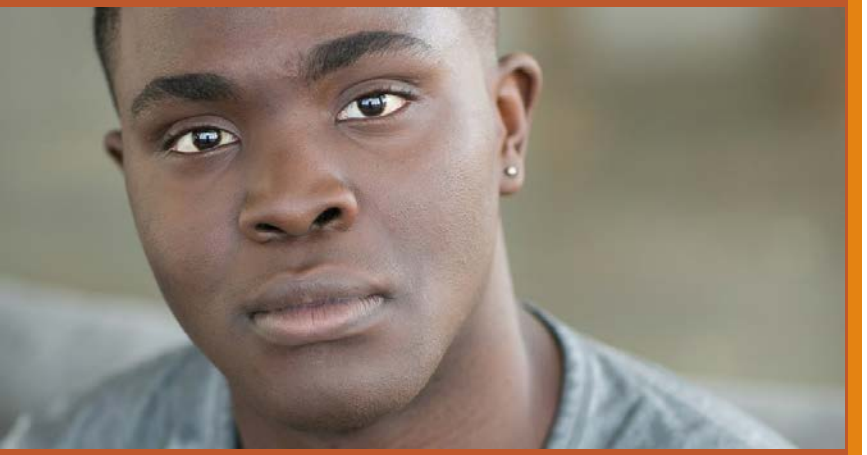
Jimmy's concerns, while not warranted given his injury, are not entirely unfounded. African-Americans with diabetes and/or peripheral vascular disease are more likely to be treated with amputation than limb salvage compared to white patients with similar disease processes.

This exacerbates many African Americans perceptions about lower extremity problems frequently leading to amputation. He might have some exposure to this situation via friend and family. Although there is a general mistrust of medial care, in the African American community, Jimmy's concern is specifically related to his fear of amputation. It is important to calm his fears and explain the differences between his condition and conditions that may require amputation.



Question 3:
When you begin to discuss the treatment options with the patient and mention that surgery may be a possibility, he tells you he is concerned about surgery because he has “low blood.” You interpret this to mean that he has:

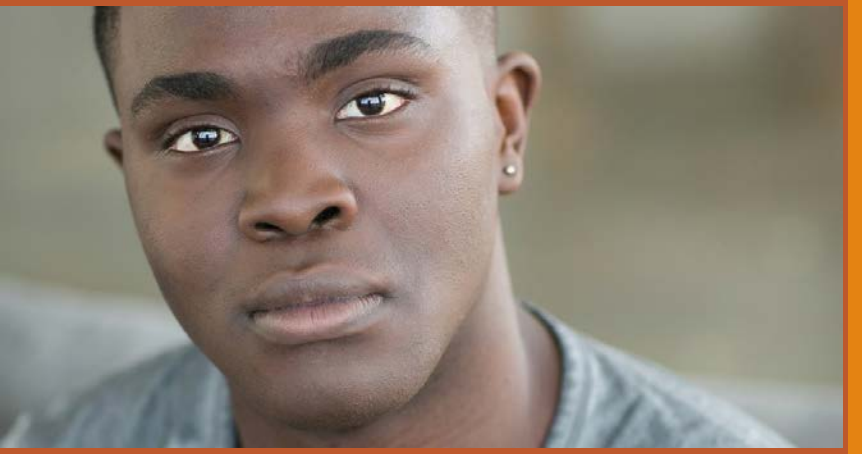
a. Hypotension
b. Hypoglycemia
c. Diabetes
d. Anemia



Answer

D: Anemia

In the African-American community, it is common to refer to anemia as “low blood.” This term does not relate to either low blood pressure or low blood sugar.



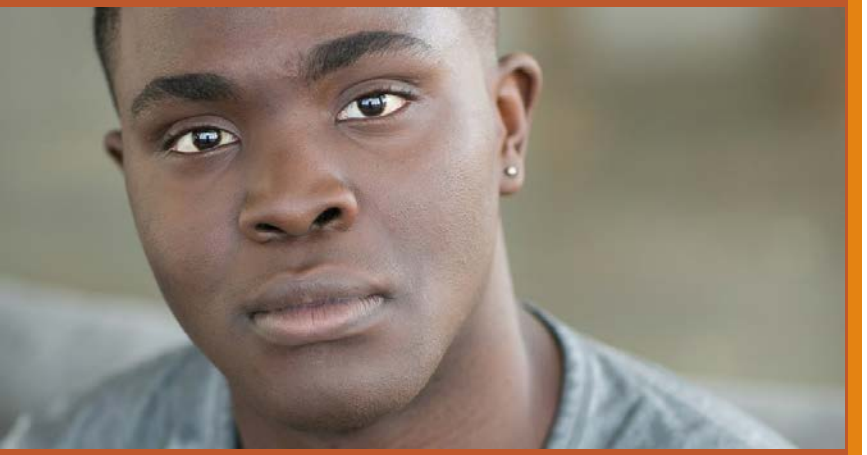
Question 4:
You decide the injury can be managed without surgery and you discuss a non-operative treatment plan with the patient. Despite the patient expressing understanding of the plan, you are concerned about this commitment to follow your recommendations and his ability to comply with non-weight bearing activity. Although compliance concerns generally apply to all patients, you must consider that your perception of the patient:

a. May vary solely due to the fact that the patients is African-American

b. Would be highly unlikely to vary solely due to the fact the patient is African-American

c. Are more influenced by the patient's socioeconomic status than by his race or ethnicity.

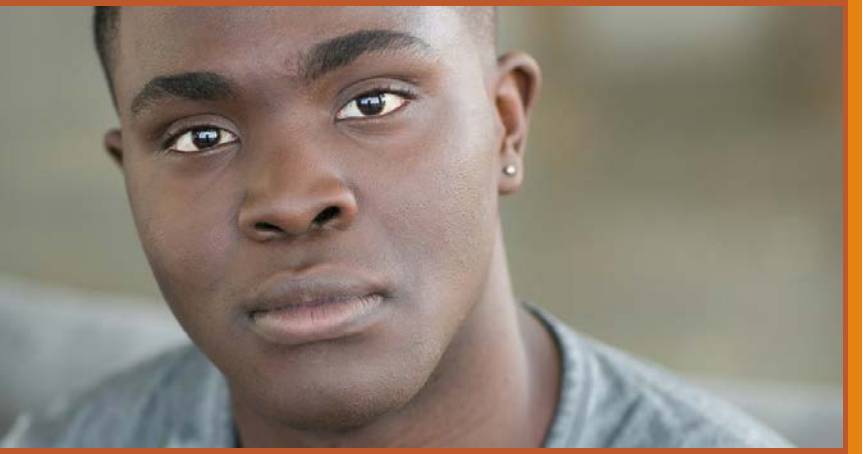
d. Are more influenced by the patient's gender than his race and ethnicity.



A: May vary solely due to the fact that the patients is African-American

Studies examining physicians' perceptions of and attitudes toward patients have shown significant differences based on ethnicity. A study of post-angiogram patients showed physicians having negative perceptions of African-American patients on a number of issues, rating them as 'less intelligent, less educated, more likely to participate in …(rehabilitation), than white patients."

This perception can results in a "self-fulfilling prophecy" with the physician's expectations about the patient causing him/her to behave in a way that results in the patient responding as expected, confirming the physician's negative perception.



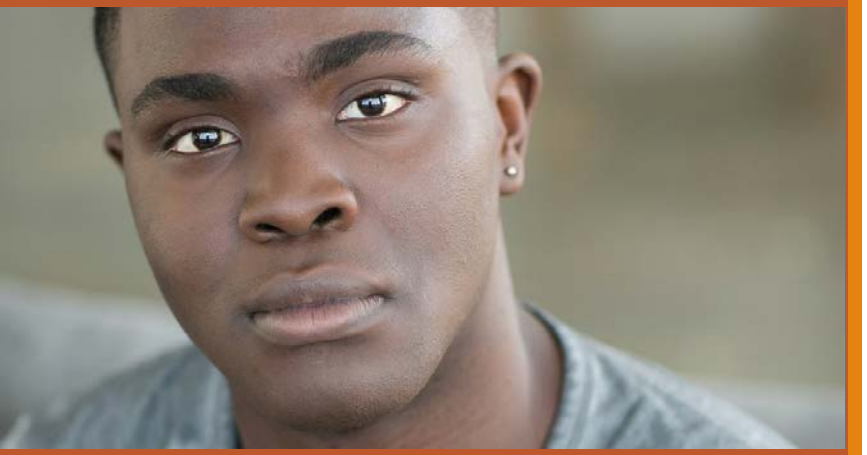
Question 5:
The patient is somewhat annoyed and expresses to you that you are not giving him all the information he desires and you are not treating him well. What should you do?

a. Chalk it up to personality conflict and refer him to another physician

b. Write everything down so he has all your diagnoses and treatment recommendations in writing and he can't argue that he hasn't received answers or complete information.

c. Practice for 4Es of physician and patient communication

d. Attempt to discuss his condition and treatment with a family member so they can help calm him down



Answer

C: Practice for 4Es of physician and patient communication

The AAOS/Bayer Institute Communication Skills Mentoring Program provides guidelines for practicing the “4Es”

Empathize | Engage | Educate | Enlist

Attempting to establish a partnership with your patients can result in increased compliance and participation by the patient. This is especially important in the treatment of minorities, since studies show minority patients are less likely to engender empathic responses from, establish rapport with, and receive sufficient information from physicians.

These characteristics of doctor-patient interactions are linked to patient satisfaction, compliance and outcomes.

African American patients are likely to perceive their physician interactions differently than white patients, with African Americans four times more likely than whites to believe racial discrimination is common in doctors’ offices and nearly three times more likely as whites to believe African Americans receive a lower quality of healthcare than white patients.

CULTURAL COMPETENCY RESOURCES

- Tips for engage various patient subcultures:

https://www.aaos.org/ccc/resources.html

  - https://www.aaos.org/ccc/assets/pdfs/tsAfricanAmerican.pdf
  - https://www.aaos.org/ccc/assets/pdfs/isAmericanIndian.pdf
  - https://www.aaos.org/ccc/assets/pdfs/tsAsian.pdf
  - https://www.aaos.org/ccc/assets/pdfs/tsHispanic.pdf
  - https://www.aaos.org/ccc/assets/pdfs/tsFaith.pdf
  - https://www.aaos.org/ccc/assets/pdfs/tsGender.pdf

- County Health Rankings: http://www.countyhealthrankings.org/app/new-jersey/2017/overview

THANK YOU!