Thinking Outside the Box: How to Advance Health Equity and Care Quality in the Pediatric Medical Home

A webinar series brought to you by the National Center for Medical Home Implementation

Changing Perception: How to Build Cultural Competence and Humility

May 12, 2016

Noon – 1 pm Central

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U43MC09134. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
Changing Perception: How to Build Cultural Competence and Humility

brought to you by the National Center for Medical Home Implementation

Moderator:
Joan Jeung, MD, MS, FAAP
Fellow, Commonwealth Fund
Mongan Fellowship in Minority Health Policy
Harvard Medical School
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Objectives

• Define “cultural diversity” and discuss the importance of recognizing cultural diversity among all patients, families, and clinicians.

• Describe how acknowledging and minimizing unconscious biases can improve cultural competence and quality of care among pediatric health professionals and the patients and families they serve.

• Identify evidence-based and evidence-informed tools, strategies, and promising practices that improve culturally competent health care delivery, including cultural humility.
Changing Perception: How to Build Cultural Competence and Humility

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Faculty:
Joseph Betancourt, MD, MPH
Director
The Disparities Solutions Center
Massachusetts General Hospital
The Premise

- We strive to delivery quality care to all
- Communication matters
- It is harder to communicate with some than others, especially across cultures
- Now more than ever before, we need to be skilled at communicating and **conveying lots of information** in a **short amount of time**, often in critical situations
The Premise

- When we are ineffective, we get frustrated, and patients receive lower quality of care
- If we are to deliver quality care, we must be skilled at communicating and care for all patients
- This requires a skill set, or check-list, to assure we are prepared and able
Key Principles

• Culture is broadly defined (not just race/ethnicity)
• We all have culture
• There is great variation within cultural groups
Challenges to Communicating Across Cultures

• Impact of Sociocultural Factors on Health Beliefs, Behaviors, and Treatment
  • Variation in symptom presentation
  • Expectations of care
  • Ability to maneuver within the system
  • Diagnostic and treatment choices
Some Patients Face Greater Difficulty in Communicating with Caregivers

Percent of adults with one or more communication problems*

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>19%</td>
</tr>
<tr>
<td>White</td>
<td>16%</td>
</tr>
<tr>
<td>African American</td>
<td>23%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>33%</td>
</tr>
<tr>
<td>Asian American</td>
<td>27%</td>
</tr>
</tbody>
</table>

Base: Adults with health care visit in past two years.
* Problems include understanding caregiver, feeling they listened, or having questions but did not ask.

Source: The Commonwealth Fund Health Care Quality Survey.
Challenges to Communicating Across Cultures: Mistrust

Kaiser Family Foundation Survey

Future unfair Tx based on race/ethnicity

- Whites: 15
- Blacks: 35
- Latinos: 36

Past unfair Tx based on race/ethnicity

- Whites: 22
- Blacks: 65
- Latinos: 58
Challenges to Communicating Across Cultures: Stereotyping

- **Automatic aspects**
  - Group → Individual

- **Cognitive Misers**
  - Cognitive shortcuts to save resources; principle of “least effort”

- **Primal**
  - Race, gender, age

- **Activated most when**
  - Stressed
  - Under time constraints
  - Multitasking
Medscape Lifestyle Report 2016: Physician Bias

Do You Have Any Biases Toward Patients?

- Emergency Medicine: 62%
- Orthopedics: 50%
- Psychiatry & Mental Health: 48%
- Family Medicine: 47%
- Ob/Gyn: 47%
- Anesthesiology: 44%
- Plastic Surgery: 43%
- Pediatrics: 43%
- Neurology: 42%
- Internal Medicine: 40%
- Dermatology: 40%
- Surgery: 40%
- Infectious Disease: 38%
- Urology: 35%
- Rheumatology: 34%
- Critical Care: 33%
- Ophthalmology: 33%
- Gastroenterology: 32%
- Diabetes & Endocrinology: 31%
- Pulmonary Medicine: 29%
- Oncology: 27%
- Nephrology: 25%
- Radiology: 22%
- Cardiology: 22%
- Pathology: 10%

Medscape Lifestyle Report 2016: Physician Bias

Disparities in Healthcare 2002

- Racial/Ethnic disparities found across a wide range of health care settings, disease areas, and clinical services, even when various cofounders (SES, insurance) controlled for.
• **Findings:**
  - Many sources contribute to disparities: no one suspect, no one solution

• **Recommendations:**
  - Cultural Competence training for all health care professionals.
Addressing Stereotypes

- Understand mechanism
- Identify conditioning
- Double check clinical decision making
- Build success in diverse teams
- Use skills to avoid reifying stereotypes
A Timely Focus on Value: The Talking Cure for Health Care

- Lack of communication can hurt the quality of care and drive up costs.
- Communication closely linked to:
  - Transition and readmissions
  - Patient experience and safety
  - Test ordering
  - Adherence
- Key health stakeholders are extremely interested in improving communication
Strategies for Cross Cultural Communication

Goal

• To improve our ability to effectively communicate with and care for patients from diverse social and cultural backgrounds.
Changing Perception: How to Build Cultural Competence and Humility

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Faculty:
Glenn Flores, MD, FAAP
Distinguished Chair of Health Policy Research
Medica Research Institute
Achieving Cultural Competency in Pediatric Care: A Data-Driven Approach
Why is Cultural Competence so Important to Healthcare?

- World’s population of 7.3 billion people inhabits 191 countries and speaks over 6,000 languages
- Racial/ethnic minority children comprise 48% of US children, equivalent to 35 million
- Census projections indicate that minority children will outnumber white children by 2018
- From 2000-2010, white children in America declined by 4.3 million, while Latino and Asian/Pacific Islander children increased by 5.5 million
- In 2011, for first time in nation’s history, minority births (50.4%) outnumbered white births (49.6%)
Why is Cultural Competence so Important to Healthcare?

- Mounting evidence demonstrates profound impact culture can have on clinical care
- Failure to achieve cultural competency can have serious clinical consequences
  - Access to healthcare
  - Health status
  - Use of health services
  - Patient-physician communication
  - Satisfaction with care
  - Medication adherence
  - Quality and patient safety
Normative Cultural Values

• Definition
  ▪ Beliefs, ideas, and behaviors that particular cultural group, on average, values and expects in interpersonal interactions
Example: Navajo Concept of *Hozhooji*

- Important to think and speak in positive way
- Thought and language have power to shape reality and control events
- Expectation: communication between healers and patients will embody concept of positive thoughts and words
- Negative thoughts and words cause harm
Clinical Consequences of *Hozhooji*

- Lack of awareness of *hozhooji* can cause inadequate discussion of medical risks, miscommunication about advanced directives, and failure to obtain informed consent.
- Example: Navajo patient told by surgeon in all operations there’s risk of not waking up; patient viewed this to be death sentence, so refused to consent to surgery.
- 86% of Navajo patients in one study said advance-care planning dangerous violation of traditional Navajo values, and many would not discuss issue because they felt it too dangerous (Carrese & Rhodes, *JAMA* 1995;274:826-829)
Language Barriers: English Proficiency in US

- Between 1990 and 2014
  - Number of people in US speaking language other than English at home rose from 31.8 million to 63.1 million
  - Number of Americans limited in English proficiency (LEP) grew from 14 million to 25.6 million
    - LEP = self-rated English speaking ability of less than “very well”
- 11.8 million school-age children (22%) speak language other than English at home
  - Number which has tripled since 1979
Pediatric Residents Often Poorly Communicate with LEP Families

Study of major pediatric residency program (*Pediatrics* 2003;111:e569-e573) found:

- 68% of residents spoke little or no Spanish
- 53% of non-Spanish-proficient residents used inadequate language skills in patient care often or daily
- Many residents reported LEP families under their care never or only “sometimes” understood their child’s
  - Diagnosis (53%)
  - Medications (28%)
  - Discharge instructions (43%)
  - Follow-up plan (40%)
- 80% avoided all communication with LEP families
- Although all agreed hospital interpreters effective, 75% reported never/only sometimes using hospital interpreters
Impact of Language Barriers in Pharmacies

Study of 128 pharmacies in major US city (Pediatrics 2007;120:e225-e235) found

- 47% of pharmacies can never or only sometimes prepare non-English-language (NEL) prescription labels
- Over half of pharmacies (54%) never or only sometimes can provide NEL information packets
- About 2/3 of pharmacies (64%) never or only sometimes can orally communicate in NELs
Hazards of Using Ad Hoc Interpreters


Examples:

<table>
<thead>
<tr>
<th>MD: “We think there is a 40% chance that the treatment will prolong your life”</th>
<th>Interp: “The treatment will prolong your life”</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD: “The doxy could hurt your heart”</td>
<td>Interp: “The doxy can give you pain”</td>
</tr>
<tr>
<td>MD: “The results of these tests lead me to conclude that you do have breast cancer”</td>
<td>Interp: “This test will tell me if you have cancer”</td>
</tr>
<tr>
<td>MD: “One important thing that you have going for you is the fact that the cancer has probably been caught early”</td>
<td>Interp: “One important thing is the fact that the cancer is working quickly in your body”</td>
</tr>
</tbody>
</table>
**Multiple Omissions & False Fluency Errors:**

**12 y.o. with Dizziness & No Interpreter**

(NEJM 2006;355:229)

**Mother:** La semana pasada a él le dio mucho mareo y no tenía fiebre ni nada, y la familia por parte de papá todos padecen de diabetes.

**Doctor:** Uh-hum

**Mother:** A mi me da miedo porque él lo que estaba mareado, mareado, mareado y no tenía fiebre ni nada.

**Doctor:** Ok. So she’s saying you look kind of yellow, is that what she’s saying?

**Patient:** ¿Es que si me ví amarillo?

**Mother:** Estaba como mareado, como pálido.

**Patient:** Is it that I looked yellow?

**Patient:** Like I was like paralyzed, something like that.
Quality and Patient Safety


- Twofold increased risk (OR, 2.3; 95% CI, 1.1–4.8) of serious medical events in Spanish-speaking patients requesting interpreter vs. those not requesting interpreter

- Serious medical events included
  - 10-fold medication errors
  - Missed or delayed diagnoses
  - Diagnostic procedures performed on wrong patient
  - Wrong diagnostic procedure performed
  - Administration of breast milk to wrong patient
Quality and Patient Safety

• A 2-year-old fractured her clavicle after falling off her tricycle; a resident physician misinterpreted 2 Spanish words, diagnosed child abuse, and contacted Department of Social Services, who, without an interpreter, had mother sign over custody of her 2 children (Flores et al., *J Peds* 2000)

• 10-month-old girl with iron-deficiency anemia given 13-fold overdose of iron and hospitalized for iron intoxication after her LEP parents given medication instructions and prescription only in English (parents gave 15 ml of iron elixir based on prescription label that read: “15 mg per 0.6 ml, 1.2 ml daily”) (Flores, *AHRQ M&M*, 2006)

• Misinterpretation of single Spanish word (“intoxicado”) in Florida case resulted in 18-year-old’s quadriplegia after being misdiagnosed with drug overdose; patient’s hematomas, brain-stem compression, and paralysis due to a ruptured aneurysm, and hospital paid $71 million in malpractice settlement (Harsham, *Medical Economics*, 1984)
Access to appropriate language services positively impacts health outcomes (Flores. Med Care Res Rev 2005;62:255-299)

- In children presenting to ED (Hampers & McNulty), LEP patients with professional interpreters did not differ from EP patients in test costs or use of IV hydration, and had lower likelihood of testing

- In adult patients with hypertension and diabetes (Pérez-Stable et al)
  - Health status, physical functioning, psychological well-being, health perceptions, and pain scores higher in those with language concordant vs. discordant physicians
Juan was a 6-month-old, previously healthy male who presented to a children’s hospital ED with new onset vomiting and diarrhea. The triage history given by mom was interpreted by Juan’s 12-year-old sister. The sister stated that the patient had 4 dirty diapers and 3 episodes of vomiting that day. Juan was triaged to a non-urgent level of care in which documentation stated he had vomited 7 times that day with no diarrhea. He was discharged shortly thereafter with a diagnosis of vomiting and instructions in English only for “pedialyte PO ad lib.”
Case: Juan

- 3 days later, Juan returned to ED
  - In severe distress
  - With new onset of bloody stools
- Juan admitted to hospital
- Juan died 6 hours later of septic shock
Folk Illnesses

- Definition
  - Culturally constructed diagnostic categories commonly recognized by ethnic group
- Symptoms often overlap with important biomedical conditions
- First provider contact may not be clinician
- Some folk remedies harmful or even fatal
- Satisfaction with care and adherence can depend on accepting response of healthcare provider
Example: Latino Folk Illness- *Empacho*

- Food or saliva believed to get “stuck” in stomach because of dietary indiscretion
  - Eating in excess
  - Eating wrong food or at wrong time
- Among Puerto Ricans in Hartford, 90% of parents knew of *empacho*, and 64% said child in household had suffered from it in past (Pachter et al. *Medical Anthropol* 1992;13:285-299)
**Empacho**

- Symptoms: vomiting, diarrhea, anorexia, bloating, fever
- Symptoms overlap with biomedical conditions
  - Gastroenteritis
  - Milk allergy/formula intolerance
  - GI obstruction
  - Intussusception
  - Appendicitis
First Provider Contact for Empacho Not Usually MD

- Treatment choice among parents whose child had empacho (Pachter et al. ‘92)
  - Santiguadora, 77%
  - Home remedy, 58%
  - Doctor visit, 37%
- Only 9% of parents reported MD as initial choice for treatment
- 85% of those visiting MD for empacho sought another form of therapy after
Empacho Treatments: Harmless

- Dietary restriction
- Teas
- Abdominal massage with warm oil
- Treatment by folk healers (*santiguadora, sobadora, or curandero*), or parents
Empacho Treatments: Harmful or Fatal

• Mexican families may treat with powders containing high concentrations of lead (*greta, azarcón, albayalde*)
  - Lead content varies from 70% to 97%
  - Multiple cases of severe lead toxicity have been reported, with outcomes that include
    - Lead levels as high as 124 μg/dl
    - Severe lead encephalopathy
    - Death
• Use of lead-based *empacho* remedies in certain communities as high as 35% in Mexico and 11% in US
Other Folk Illnesses with Potentially Harmful Treatments
(Ped Emerg Care 2002;18:271-84)

- In Bangladesh, Pakistan, and Sri Lanka, folk illnesses associated with infant diarrhea (dud haga, nazar, and eshwaha) include beliefs that mother’s breast milk poisoned and breastfeeding must be discontinued, placing infant at greater risk of
  - Dehydration
  - Mortality
- For diarrhea accompanying Swazi folk illness umphezulu, traditional “vaccination” (kugata) may be performed, in which shallow cuts made with razor blade (usually not sterilized), then rubbed with ashes
Patient/Parent Beliefs

- **Definition**
  - Cultural group’s beliefs about disease causality (excluding folk illnesses)
  - Home treatments associated with these beliefs
Many Home Treatments Have Findings Easily Confused with Child Abuse *(Ped Emerg Care 2002;18:271-84)*

Example: cupping or *ventosas*

- **Procedure:** create vacuum in cup by burning alcohol over inverted cup, then place cup on affected anatomy
- **Practicing culture/ethnicity:** Latinos, Russians
- **Symptoms treated:** Pain, fever, poor appetite, and congestion
- **Clinical presentation:** Patterned circular erythema, petechiae, and occasional burns
Serious Morbidity and Fatalities from Harmful Patient/Parent Beliefs/Practices

• Lipoid pneumonia and bronchiectasis
  ▪ Due to application of butter or oil to nostrils or oropharynx of infants in India and Saudi Arabia to clean airway and treat respiratory infections (Døssing et al., *Europ J Epidemiology* 1995;11:141-144; Riff et al., *Ann Saudi Med* 1990;10:378-382)

• Opiate toxicity in infants
  ▪ Due to Hmong treatment of diarrhea and fever with enema or capsule made from opium seeds (Rubio et al., *Vet Hum Toxicol* 1987;29:323-325)
Biased Provider Practices Can Affect Clinical Care

- Biased attitudes and practices of some healthcare providers can have profound impact on clinical care
  - Access to care
  - Impaired diagnostic evaluations
  - Lower quality of care
  - Causing and perpetuating racial/ethnic disparities in healthcare
Example: Provider Practices in Child-Abuse Evaluations

- In study of 388 children 0-3 years old hospitalized for skull or long-bone fractures, among those 1-3 years old, minority children significantly more likely than white children to:
  - Have skeletal survey performed  
    (adjusted odds = 8.8; 95% CI, 3.5-22.0)  
  - Be reported to Child Protective Services for suspected abuse  
    (adjusted odds = 4.3; 95% CI, 1.6-11.4)  
    (Lane et al. *JAMA* 2002;288:1603-9)
Model: Achieving Cultural Competency in Pediatrics
(Flores. *J Pediatrics* 2000;136;14-23)

- Cultural competency achieved by:
  - Recognizing and appropriately addressing cultural issues that affect clinical care of patients and families in your practice
- Model components include:
  - Normative cultural values
  - Language issues
  - Folk illnesses
  - Patient and parent beliefs
  - Provider practices
Using Model as Tool to Achieve Cultural Competency

Normative Cultural Values
- Identify those that affect care
- Accommodate for these values in clinical encounter

Language Issues
- Access trained professional interpreters for LEP patients/families unless fluent in patient’s 1st language
- Ensure comprehensive language access, including multilingual receptionists and phone trees for making appointments, and multilingual signage, consent forms, patient information materials, and prescriptions
- Encourage efforts to increase foreign language skills of staff and English skills of LEP patients (for free or low-cost parent English classes: www.literacydirectory.org)
Model: Cultural Competency

Folk Illnesses
- Recognize those that affect care in your practice (partner with traditional healers and folk medicine stores)
- Suggest harmless alternatives to harmful folk remedies
- Accommodate non-judgmentally into clinical encounter
- Integrate into treatment plan whenever possible

Patient/Parent Beliefs
- Identify those that affect care (ask parents about their perspectives on child’s illness)
- Suggest harmless alternatives to harmful remedies
- Carefully explain etiology and treatment rationale for biomedical conditions
Model: Cultural Competency

Provider Practices

• Maintain vigilance for racial/ethnic disparities in
  ▪ Screening
  ▪ Prescriptions
  ▪ Procedures
  ▪ Outcomes

• When disparities occur
  ▪ Determine problem source
  ▪ Address practices that might be responsible
Does Culturally Competent Care Make A Difference?

- Yes! Study of cultural competency policies and other predictors of asthma-care quality for Medicaid-insured children (Lieu et al. Pediatrics 2004;114:e102-10) found:
  - In multivariable analyses, patients of practice sites with highest cultural competence scores
    - Less likely to underuse preventive asthma medications (OR, 0.15; 95% CI, 0.06-0.41 for highest vs. lowest categories)
    - Had significantly better parent ratings of overall quality of asthma care
Conclusions

- Failure to provide culturally competent pediatric care can have serious clinical consequences, including patient injury and death.
- Use of data-driven model can allow you to achieve cultural competency.
- Highest quality of care and best outcomes attained by culturally competent clinicians.
Resources

- National Center for Medical Home Implementation
- Strategies to Enhance Care for Hispanic Children and Youth with Special Health Care Needs
- AAP Culturally Effective Care Toolkit
- AAP Immigrant Child Health Toolkit
- Cultural Cues: Tips for Clinicians
- Growing Your Capacity to Engage Diverse Communities (Family Voices)
Resources

- Implicit Association Tests
- Disparities Solutions Center
- National Center for Cultural Competence (Georgetown University)
- Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care
- Center for Linguistic and Cultural Competency in Health Care
- Think Cultural Health (US Department of Health and Human Services, Office of Minority Health)
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