Workshop Topics

‣ Impact of Healthcare disparities

‣ Methods used in health education to influence provider's attitudes and clinical behaviors

‣ Cultural humility vs. cultural competence – a complementary approach

‣ Pilot study with Migrant Farm Workers

# Healthcare Disparities: They really do exist!

▸ IOM 2003 *Unequal Treatment*
Landmark review of data, indicating disparities in care:

◦ "*Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patient's insurance status and income, are controlled.*"

▪ *(IOM's "Unequal Treatment", 2003 p. 1)*

Disparities in Cardiovascular Care
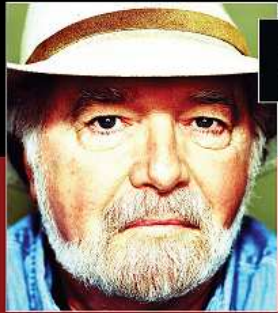
Chest Pain. Identical Symptoms. Matching Histories.

AAPA

Which Patient Doesn't Get the Appropriate Tests?

for more information: www.stop-disparities.org

▸ African Americans are 28% more likely to die from CV disease than whites

(American Heart Association 2011)

▸ Resident physicians prescribe thrombolytics more often for white patients than for black patients

(Green, *Journal of General Internal Medicine*, 2007; 22:1231–1238)

Disparities in Treatment of Pain

Same Injury.   Same Hospital.   Same Provider.

AAPA

Which Patient Gets 50% Less Pain Medication At Discharge?
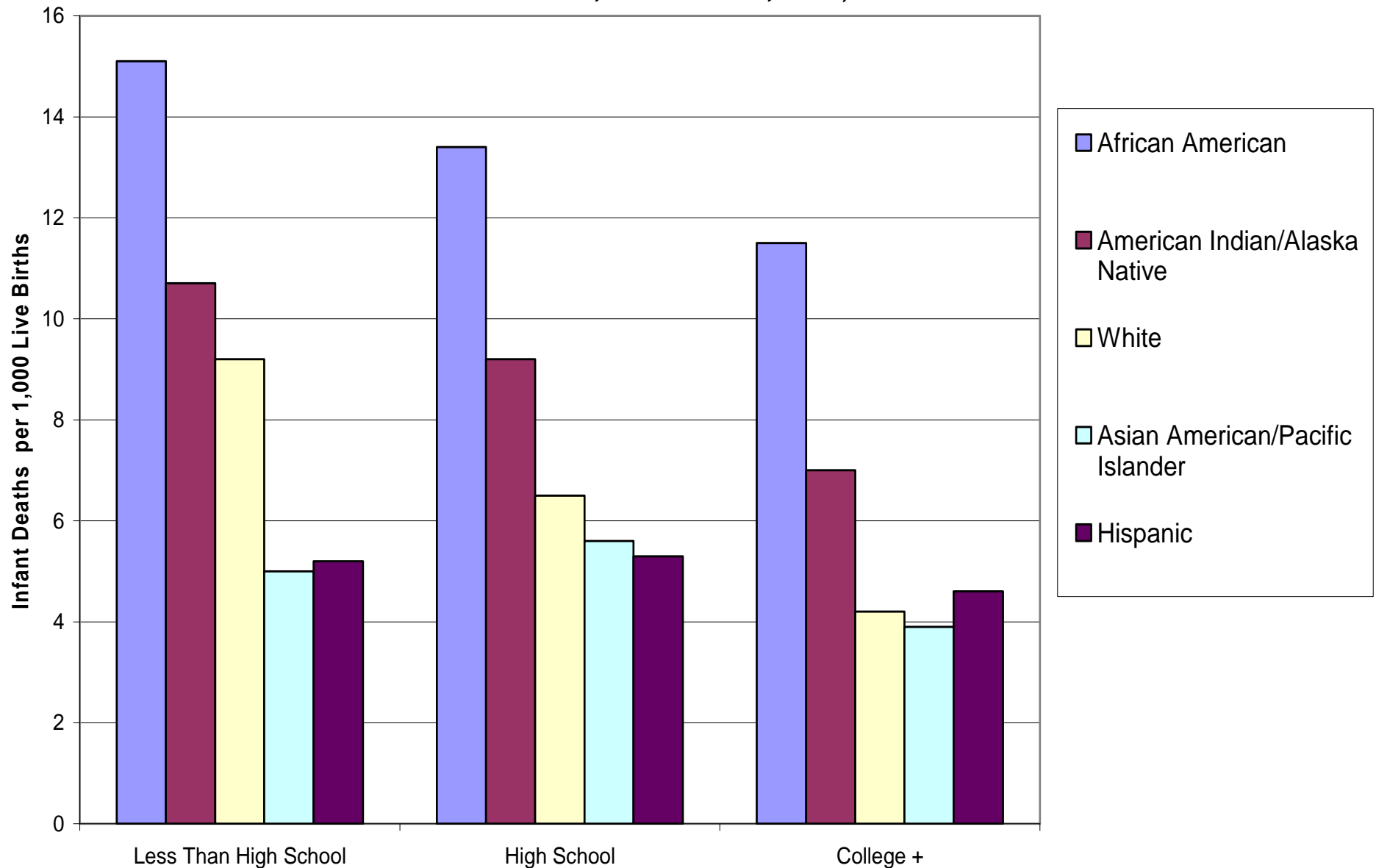
for more information: www.stop-disparities.org

▸ **White patients are significantly more likely to receive an opioid prescription for long-bone fracture than black, Hispanic and Asian patients.**

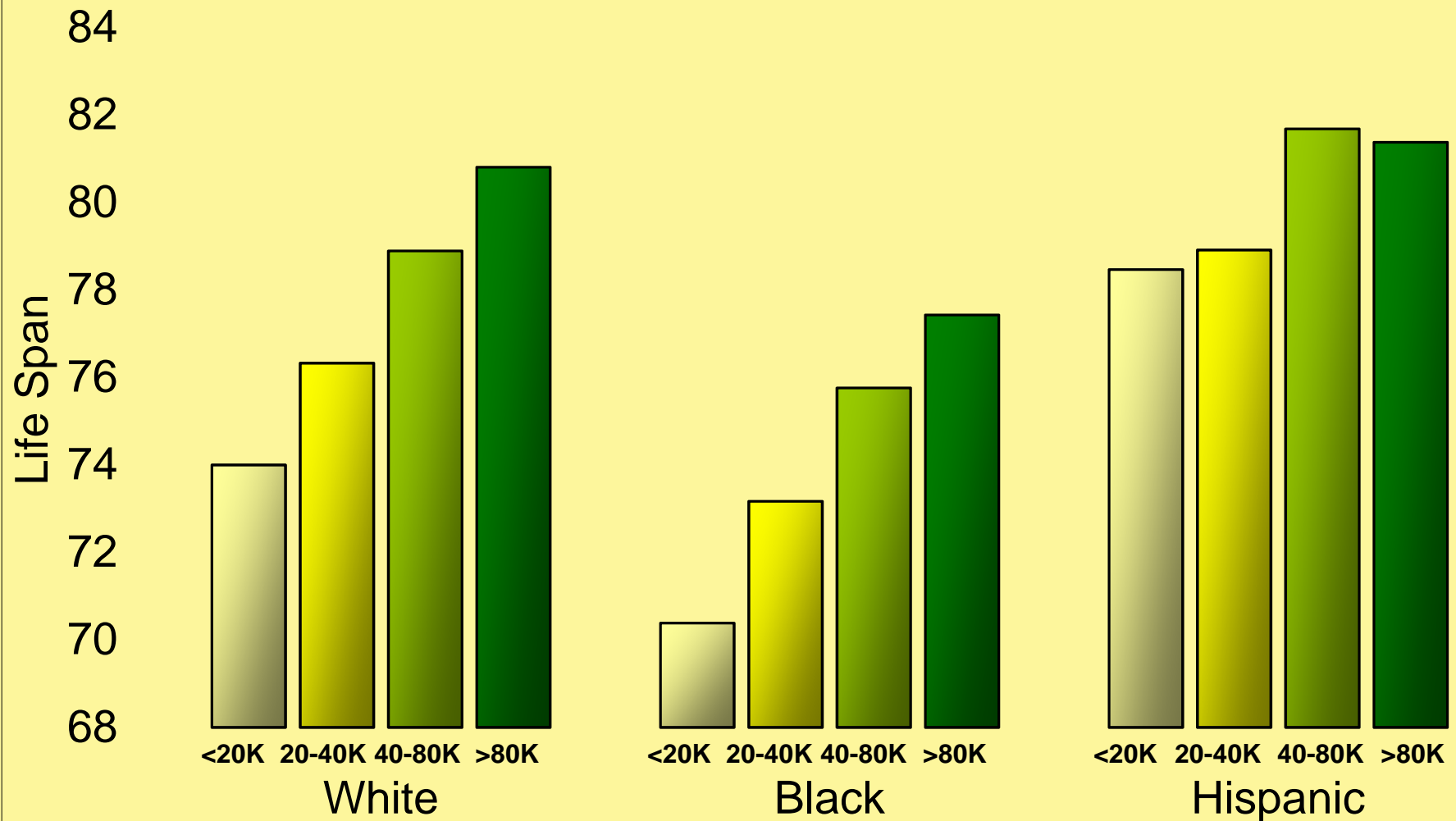(Fletcher et al., JAMA *. 2008;299(1):70-78).

Infant Mortality Rates for Mothers Age 20 and Over by Race/Ethnicity and Education, 2001-2003

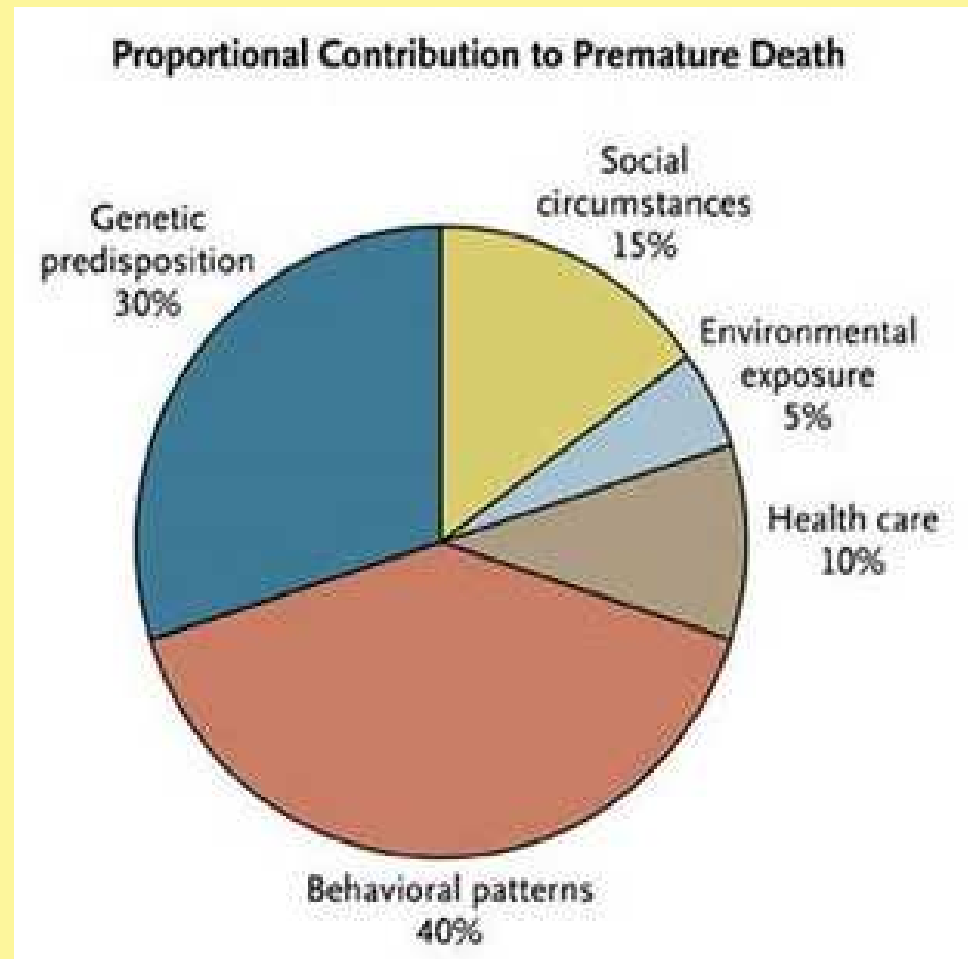Source: *Health, United States, 2006*, Table 20

Life Expectancy by Income and Race

Life Span

84
82
80
78
76
74
72
70
68

| <20K | 20-40K | 40-80K | >80K |

White

| <20K | 20-40K | 40-80K | >80K |

Black

| <20K | 20-40K | 40-80K | >80K |

Hispanic

Determinants of Health

▸ **Contributions to health outcomes:**

- Physical environment
- Health services
- Social environment
  - Stress-related?
- Biology and genetics
- Individual behavior

Proportional Contribution to Premature Death

- Genetic predisposition 30%
- Social circumstances 15%
- Environmental exposure 5%
- Health care 10%
- Behavioral patterns 40%

Where to from here?

- Empirical evidence has solidly documented health care disparities within the US.

- Disparities occur on multiple levels:
    - Societal level
    - Patient level
    - Health care systems level
    - Provider level

- What steps can we take to make a difference?

Potential Sources of Disparities

- Societal level
  - Income
  - Education
  - Racism
  - Stress

- Solutions at this level

Potential Sources of Disparities

- **Patient level**
  - Patient preferences
  - Treatment refusal
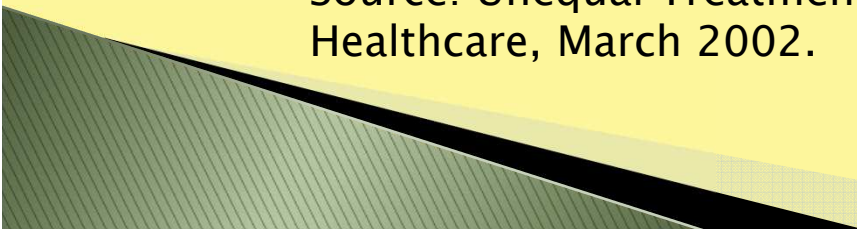 - Care seeking behaviors and attitudes

- **Solutions at this level**

Source: Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, March 2002.

Potential Sources of Disparities

- Health Care systems level
  - Lack of interpretation and translation services
  - Time pressures on physicians
  - Geographic availability of health care institutions
  - Changes in the financing and delivery of services

- Solutions at this level
  - i.e. health care reform

Source: Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, March 2002.

Potential Sources of Disparities

Unconscious Racial Stereotyping = Unequal Treatment.

Which Patient Gets Your Best Care?

for more information: www.stop-disparities.org

- ▶ **Provider level**
  - ◦ Bias
  - ◦ Clinical uncertainty
  - ◦ Beliefs/stereotypes about the behavior or health of minority patients

- ▶ Solutions at this level

Source: Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, March 2002.

Definitions

- **Stereotyping** = distorted generalization
  - Judgment of a group, without looking at the individual

- **Prejudice** = seeing differences as weaknesses
  - Suspicion, intolerance or irrational hatred of others

- **Bias** = tendency or preference towards a particular group
  - Interferes with ability to be impartial or objective
  - *Bias is not inherently evil or negative*
  - *Bias is often implicit and unconscious*

Ethnocentrism

- The belief that one's own cultural view is the superior or most prominent view

- Occurs when we use our own cultural biases (or culturally biased information) to interpret another's beliefs or behaviors

- Ethnocentrism consequences
  ◦ Non-adherence to medical treatment recommendations
  ◦ Poor medical outcomes
  ◦ Disrespect
  ◦ Stereotyping

"Implicit Bias"

- Implicit bias = those that we carry without awareness or conscious direction

- Research indicates:
  - Implicit biases are pervasive
  - People are often unaware of their implicit biases
  - Ordinary people harbor negative associations in relation to various groups

- Implicit biases predict behavior

Biased Behavior

- On parts of patients, providers and institutions
  - Often unconscious
  - May have "best intentions"
  - Implicit bias does not equal implicit malice
- Outlier Behaviors
  - Easy to know what is grossly unethical or unacceptable in our society
  - Harder to know what is unacceptable to an individual

Exercises

- "Changing Images"

- "Project Implicit" demo

Educating Health Professionals

- Changes in professional standards
  - Led to changes in curriculum
- Goal
  - To deliver competent care to patients from diverse cultural backgrounds
- Concept of cultural competency
  - IOM: "… an understanding of the cultural belief systems that may assist or hinder effective health care delivery"
  - Emphasized need for knowledge of cultural differences
  - Skills that allow an individual to increase understanding and appreciation of core cultural issues ("hot buttons")

What have your experiences been?

- Encountering bias and discrimination

- Helping others overcome discrimination/bias

- Pedagogical strategies

Methodologies for CCCE

- **Role modeling**
  - Simulations
  - Standardized patients
  - Videos

- **Immersion approaches**
  - Clinical experiences with diverse populations
  - Community service with diverse populations

- **Anthropologic approaches**
  - Learning cultural characteristics of patient groups

- **Template approaches**
  - Patient centered approach
  - Models for cross cultural communication

(Dykes DC, White AA; Clin Orthop Relat Res; 2011;469:1813–1816)

Cultural Competency Education— Pitfalls

- ## Focus on information
  - ◦ "endpoint" in acquisition of knowledge
  - ◦ Increase in knowledge without a change in attitude and behavior has little value

- ## Emphasis on differences may lead to more stereotyping/bias (Stone, Moskowitz: Medical Education, 2011; 45: 768–776)

- ## No evidence that "teaching" cultural competence leads to a reduction of healthcare disparities (Kelly: *Journal of Physician Assistant Education,* 2011 22:4; 38–43)

Cultural Humility

- Definition

  - *"It is a process that requires humility as individuals engage in self-reflection and self-critique as lifelong learners and reflective practitioners.*

  - *It is a process that requires humility in how physicians bring into check the power imbalances that exist in the dynamics of physician-patient communication by using patient-focused interviewing and care.*

  - *And it is a process that requires humility to develop and maintain mutually respectful and dynamic partnerships with communities on behalf of individual patients and communities ...."*

  - (Tervalon et al., *Journal of Health Care for the Poor and Underserved vol. 9, no. 2, 1998)*

Keys to Fostering Cultural Humility

Self-reflection & self-critique— a lifelong , active process with no endpoint

- ◦ "Know thyself"
  - • Essential before one can delve into patient's belief system

- ◦ Recognition of inherent power in provider-patient relationship

- ◦ Need to develop tolerance of unfamiliar behaviors

- ◦ Flexible and humble enough to let go of stereotypes and assess each patient individually

Keys to Fostering Cultural Humility

- **Patient-focused interviewing and care**
  - Less controlling, less authoritative style
    - Changing the power imbalance
  - Emphasis on patient's agenda and values
  - Creation of atmosphere to enable patient's telling of their "story"
    - Listening!
    - Focus on individual patient and not stereotype
  - Eliminates need for mastery of each group's health beliefs

Keys to Fostering Cultural Humility

- Community-based Care and Advocacy
  - Recognition that expertise with regard to health can be found outside of the academic medical center or even outside the practice of Western medicine
    - Determinants of health
    - Community health priorities

  - Immersion in community partnerships
    - Not just revolving around health

QIAN Model

▸ "Humbleness"

  ◦ Q = importance of self-Questioning and critique
  ◦ I = bi-directional cultural Immersion
  ◦ A = mutually Active listening
  ◦ N = flexibility of Negotiation

Chang, Simon, Dong; Adv in Health Sci Educ; 2012, 17:269-278

The Contact "Hypothesis"
Allport (1954)

▸ **Friendly intergroup contact reduces intergroup prejudice**
  ◦ Explicit bias
  ◦ 50+ years of research

  (Pettigrew & Tropp; Journal of Personality and Social Psychology ; 2006, Vol. 90 No. 5, 751-783)

▸ **What about implicit bias?**
  ◦ Intergroup contact reduced implicit prejudice among low-status groups
    • i.e. Blacks toward Whites, but not Whites toward Blacks
    • (Henry, & Hardin;; Psychological Science; 2006, V 17, No 10 862-868.)

Our Study

Purpose: Evaluate whether perceptions among future health care professionals toward Latino migrant workers and their associated health care challenges could be improved via short-term, meaningful exposure ("contact hypothesis")

Background

Attitudes of health care professionals based on biases, stereotypes of patients may result in adverse outcomes.

e.g. Patients of Hispanic origin have been shown to experience longer wait times and less positive interactions with health professionals than non-Hispanic Caucasians.

Negative attitudes by providers impact treatment, such as withholding treatment or suboptimal care in general.

In Michigan….

Michigan Migrant Farm Workers Statistics

1 migrant worker
is needed for every five to six acres of crops

13k local migrant workers
are available for contact, dropping from 18,000 in the past two years

100 percent
of migrant farm workers have papers, but 30 - 40 percent are usually undocumented

850 migrant camps
in Michigan are inspected for quality and safety

98 percent
of Michigan migrant houses that are inspected mid-season do not meet compliance

Michigan Commission of Agriculture and Rural Development—Dec. 2011

Target Population: WMU Physician Assistant students

Recruitment: In Sept. 2012 students were recruited via email and in-class. None of the participants were informed of the *exact nature* of the study, only that it involved health care with diverse populations.

Phase I

- Student were provided with parallel cases of a middle-aged Mexican migrant worker with diabetes and similarly aged white blue-color work with high blood pressure.

- As the cases unfolded, students were asked various questions about their willingness as health care professionals to accept traditional approaches used by these patients, e.g. prickly cactus, gingko blioba.

- Additional items included questions of responsibility for *cost, deservingness of care*

Phase II

Students were driven through migrant camps west of Kalamazoo. Several migrant farm worker families were picked up and rode with students to the local community center.

 With the use of interpreters, students shared a traditional meal with the workers. After the meal, the workers discussed their daily lives, work experiences and the multiple challenges with the health care system.

Workers also shared information about the use of traditional healers and remedies in Mexican culture.

A drive through area camps

Phase III

- Students completed the questionnaire again (same cases) related to the two male patients, one Latino, one white.

- They were also provided with a debriefing from the experience and opportunities to share with others in the group about their observations.

Preliminary findings

▸ Trend toward a more tolerant perspective of cultural preferences.

▸ For example, at Phase I (pre-test), the least "Westernized" option, *Garlic and Nopale (prickly cactus)* for the treatment of diabetes was ranked as the 6th or last choice for treatment by 90% of participants (n=9), at Phase III (post-test) only 70% (n=7) viewed this as last.

RANK	TREATMENT OPTION	MEDICAL EFFECTIVENESS	LIKELINESS OF PATIENT ADHERENCE TO TREATMENT PLAN
	Insulin, metformin, diet and exercise	++++	+
	Insulin, metformin, garlic, nopale, diet and exercise	++++	+
	Higher dose of Metformin, diet and exercise	+++	++
	Higher dose of Metformin, garlic, nopale, diet and exercise	+++	+++
	Garlic, nopale, diet and exercise	++	++++
	Garlic, nopale alone	+	++++

Perceived Value

"Definitely brought to light some of the things we do not necessarily think of due to lack of exposure."

"No doubt this experience will stay with me when I have patients of my own."

"Very rewarding. Helped me understand this culture better."

"Eye opening to see hard working people not get the help they deserved and needed."

Summary

▸ Health Disparities have a major impact on life expectancy and health-related quality in general.

▸ The underlying biases that underlie health disparities can exist on a macro (e.g. societal discrimination) or micro-level (e.g. health providers)

▸ Biases can often be implicit or not readily recognized

▸ In addition to cultural competency training, cultural *humility*, with a strong emphasis on self reflection is needed to reduce individual bias.

▸ Short-term exposure with diverse groups that is meaningful and interactive holds promise for changing perceptions and fostering tolerance.

References

- Burgess DJ, VanRyn M, Crowley-Matoka M, Malat J: *Understanding the Provider Contribution to Race/Ethnicity Disparities in Pain Treatment: Insights from Dual Process Models of Stereotyping;* Pain Medicine; 2006; 7: No. 5
- Chang, Simon, Dong; *Integrating Cultural Humility into Health Care Professional Education and Training;* Adv in Health Sci Educ; 2012, 17:269-278
- Dykes DC; White AA, *Culturally Competent Care Pedagogy – What Works?* Clin Orthop Relat Res; 2011; 469: 1813-1816
- Fletcher et al., JAMA . 2008;299(1):70-78
- Green: *Physicians and its Prediction of Thrombolysis Decisions for Black and White Patient;* Journal of General Internal Medicine 2007; 22:1231-1238
- Henry, & Hardin; *The Contact Hypothesis Revisited: Status Bias in the Reduction of Implicit Prjudice in the US and Lebanon*; Psychological Science; 2006, V 17, No 10 862-868.
- Institute of Medicine*: Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, March 2002

More References

- Kelly: *Exploring the Theoretical Framework of Cultural Competency Training*; Journal of Physician Assistant Education, 2011 22:4; 38-43
- Pettigrew TF, Tropp LR: *A Meta-Analytic Test of Intergroup Contact Theory;* Journal of Personality and Social Psychology, 2006; 90: 5: 751-783
- Project Implicit. https://implicit harvard edu/implicit/demo/ 2012
- Stone J, Moskowitz GB: *Non-conscious bias in medical decision making: what can be done to reduce it;* Medical Education 2011; 45: 768-776
- Teal CR, Shada RE, Gill AC, Thompson BM, Fruge E, Villarreal GB, Haidet P: *When Best Intentions Aren't Enough: Helping Medical Students Develop Strategies for Managing Bias about Patients;* Journal of General Internal Medicine 2010; 25(Suppl 2):115-8
- Tervalon, M., Murray-Garcia, J: *Cultural Humility vs. Cultural Competence: A Critical Discussion in Defining Physician Training Outcomes in Multicultural Education;* Journal of Health Care for the Poor and Underserved 1998; 92: 117-125.