Improving Quality Through Cultural Competence: Delivering Quality Care to Diverse Populations

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Outline

- Disparities, Quality and Cultural Competence
- Resident and Clinician Perspectives
- Lessons from the Field
Disparities, Quality and Cultural Competence
Disparities in Health Care 2002
Racial/Ethnic disparities found across a wide range of health care settings, disease areas, and clinical services, even when various confounders (SES, insurance) controlled for.

Findings: Many sources contribute to disparities—no one suspect, no one solution

- Provider-Patient Communication
- Stereotyping
- Mistrust

Rec: Cultural Competence training for all health care professionals
Quality Health Care

- Health care should be
  - Safe
  - Effective
  - Patient-centered
  - Timely
  - Efficient
  - Equitable
Cross-Cultural Care
Implications for Quality, Cost, Safety

- Research has shown that being inattentive to cross-cultural issues has an impact on quality, cost, and safety. For example:

  - Patients with limited English proficiency (LEP) and racial/ethnic minorities more likely to suffer from adverse events, and these adverse events have greater clinical consequences

  - Communication problems most frequent cause of serious adverse events; communication compromised by language barriers, cultural differences, low health literacy, all important issues for minorities

Result: Increased length of stay; additional procedures, costs
Cross-Cultural Care
Implications for Quality, Cost, Safety

- In presence of communication difficulties (i.e. due to language barriers or cultural barriers) providers may tend to order expensive tests (CT Scans) for conditions that could be diagnosed through history-taking.

- Patients with limited-English proficiency have longer hospital stays for some common medical and surgical conditions (USA, CP, CABG, CVA, DM, Colorectal Surg, Elec THR) than their counterparts.

Result: Increased length of stay, test ordering.
Cross-Cultural Care
Implications for Quality, Cost, Safety

- Minorities more likely to be readmitted for certain chronic conditions—such as congestive heart failure—than their white counterparts.
- Minorities—even when controlling for insurance status—may be at greater risk for ambulatory case sensitive/avoidable hospitalizations for chronic conditions (hypertension, asthma)
- Pay-for-performance contracts have started including provisions that look to address racial and ethnic disparities in health care—it is expected this trend will become more widespread over time (MA DMA CLAS P4P)

Result: Increased ACS admissions, readmissions
There are multiple liability exposures that when there is a failure to address the root causes for disparities, such as:

- Patient comprehension of their medical condition, treatment plan, discharge instructions, complications and follow-up;
- Ineffective or improper use of medications or serious medication errors;
- Improper preparation for tests and procedures, and
- Poor or inadequate informed consent
Accreditation, Quality Measures, HC Reform

- Joint Commission: New cultural competence accreditation standards
- National Quality Forum: Released cultural competence quality measures
- Health Care Reform: Funding for Cross-Cultural Training
Resident and Clinician Perspectives
Residents Preparedness to Care for Diverse Populations
JAMA 2005

- Residents located in programs affiliated with 160 academic health center hospitals
- Final year of training
- N=2047 (RR=60%)
- Seven Specialties
  1) Emergency Med (EM)
  2) Family Med (FM)
  3) Internal Med (IM)
  4) OB/GYN
  5) Pediatrics (Ped)
  6) Psychiatry (PSY)
  7) General Surgery (Surg)
Good News – The “Buy-In” is There

97% of residents feel that it is “moderately” or “very important” for physicians in their specialty “to consider the patient’s culture when providing care”.
\[\begin{array}{|l|c|}
\hline
\text{Consequences} & \text{Residents Who Said Often} \\
\hline
\text{Longer than average visits} & 41\% \\
\text{Non-compliance w/ treatment} & 20\% \\
\text{Delays obtaining consent} & 18\% \\
\text{Unnecessary visits} & 14\% \\
\text{Unnecessary tests} & 9\% \\
\text{Unnecessary hospitalization} & 5\% \\
\hline
\end{array}\]
Many Residents Feel Unprepared to Deliver Specific Components of Cross-Cultural Care

“How prepared do you feel to care for [following types of] patients (or pediatric patients’ families)…? [% Very or Somewhat Unprepared]

<table>
<thead>
<tr>
<th>General</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Culture different from own</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Racial/ethnic minority</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Health beliefs at odds w/ Western medicine</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>With distrust of U.S. health system</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Limited English proficiency</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>New immigrants</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Whose religious beliefs affect treatment</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>Who use alternative/complementary medicine</td>
<td>26%</td>
</tr>
</tbody>
</table>
Training Matters: Residents with Little Instruction During Residency Much More Likely to Perceive Low Skill Levels

<table>
<thead>
<tr>
<th>Skill Level</th>
<th>None/Vy Little Instruct’n</th>
<th>A Lot of Instruct’n</th>
</tr>
</thead>
<tbody>
<tr>
<td>How patients want to be addressed</td>
<td>10%</td>
<td>1%</td>
</tr>
<tr>
<td>Assess understanding of illness</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>Identify relevant religious beliefs</td>
<td>40%</td>
<td>2%</td>
</tr>
<tr>
<td>Identify relevant cultural customs</td>
<td>38%</td>
<td>5%</td>
</tr>
<tr>
<td>Work with interpreter</td>
<td>18%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>
Problems when Delivering Cross-Cultural Care

<table>
<thead>
<tr>
<th>Problem</th>
<th>Moderate Problem</th>
<th>Big Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack Experience</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>Lack Time</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Inadequate Training</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>Lack Role Models</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>Dismissive Attitudes of Attending</td>
<td>13</td>
<td>4</td>
</tr>
</tbody>
</table>
Physicians Perspectives on Cross-Cultural Care

- Online survey of clinicians to get their perspectives on how cultural issues impact health care delivery
- Collaboration led by QuantiaMD’s (www.quantiamd.com) Doctor-Patient Relationship Interest Group
- 4334 respondents from all 50 states, 2011
- Largest responders: CA, NY, PA, FL, IL
Figure 7: How often do you believe cultural barriers have compromised care and service to your patients?

N = 4331
Impact of Cultural Factors on Visit Time

Figure 10: Compared with an average appointment, how much time do you spend with a patient who speaks limited English or faces a cultural barrier?

- 73% More time than an average patient
- 20% The same time as an average patient
- 7% Less time than an average patient

N = 4327

www.quantiamd.com
Lessons from the Field
Our Experience in E-Learning

– Goal: To improve quality, address disparities, and achieve equity through cross-cultural education

– Developed Quality Interactions
  ◆ Portfolio of e-learning programs

– Extensive Experience in the Field

– Have trained 100,000 healthcare professionals
  ◆ Top hospitals, health plans, health professions schools throughout country
Model for Cross-Cultural Care: A Patient-Based Approach

- Awareness of Cultural and Social Factors
- Elicit Factors
- Negotiate Models
- Implement Management Strategies

Avoid stereotypes and build trust

Tools and skills necessary to provide quality care to any patient we see, regardless of race, ethnicity, culture, class or language proficiency.
MGH Health Care Provider Training

- Quality Interactions Cross-Cultural Training offered as option as part of MGPO QI Incentive in Q3 2009; case-based, evidence-based, interactive e-learning program which allows learners to develop a skill set to provide quality to patients of diverse cultural backgrounds
- 987 doctors completed; more than 88% said program increased awareness of issues, would improve care they provide to patients, and would recommend to colleagues; average pretest score 51%, posttest score 83%

Available at: http://www.qualityinteractions.org/prod_overview/clinical_program_features.html.
MGH Staff Training

- Quality Interactions Cross-Cultural Training to 3000 frontline staff
- Improves communication with patients, between colleagues
- Focuses on:
  - Respecting Diversity
  - Communicating Clearly
  - Understanding Difference
  - Engaging the Individual

[Image of the ResCUE model]

Available at: http://www.qualityinteractions.org/prod_overview/clinical_program_features.html.
Course Evaluation - Clinical
35,208 learners

- The information presented increased my awareness/understanding of the subject
- The information presented will influence how I practice
- The information presented will help me improve patient care
- Overall, the program met my expectations
- I would recommend this program to my colleagues

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Course Evaluation - Healthcare Staff
57,016 learners

- The information presented increased my awareness/understanding of the subject
- The information presented will influence how I communicate across cultures
- The information presented will help me in my everyday work
- Overall, the program met my expectations
- I would recommend this program to my colleagues

Percentage

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Improvement in knowledge

% Correct

Pretest

Protest

Score

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**Diabetes Coaching / Case Management**

“ESFT model” to Promote Adherence via Tailored Education / Intervention

**E = Exp Model**
- How do you understand diabetes?
- What do you think will help control your condition?
- How do you view your treatment?

**S = Soc Risk**
- Do you have trouble getting your medications (including affording, getting to pharmacy, etc.)?

**F = Fears/Concerns**
- Do you have any specific fears or concerns (side effects, rumors, dose) about your meds?
- What other things do you do to control your blood sugar (home remedies, other providers)?

**T**
- Can you tell me your plan for controlling your blood sugar?

**P: Playback**
- • Provide education targeted to patient
- • Distribute educational material on diabetes (language/literacy appropriate)
- • Document and Assist
- • Education targeted to patient fear/concern
- • Verify other meds/providers, rule out contraindications, discuss diet; negotiate
- • Review with patient

**Formal Feedback to PCP via EMR**
Diabetes Control Improving for All:
Gap between Whites and Latinos Closing

* Chelsea Diabetes Management Program began in first quarter of 2007; in 2008 received Diabetes Coalition of MA Programs of Excellence Award
Key Lessons: What our experience tells us…

- E-Learning allows for extensive training of a large group of people in a short amount of time with a set of uniform skills.

- Messaging is *key*: generalize, link to quality, value-added.

- E-Learning needs to be:
  - Case-based, interactive, and create teachable moments
  - Provide personalized feedback
  - Longitudinal (with boosters) and have option for blending

- Clinical programs need to be:
  - Realistic, easy to maneuver
  - Linked to evidence-based guidelines and peer-reviewed literature

- Health Staff Programs need to be:
  - Interactive yet basic, not overwhelming
  - Provide skills to communicate with *all*
Summary

- Being inattentive to cross-cultural issues has a direct impact on quality and safety.

- Improving cultural competence will lead to higher quality care for diverse populations.

- There are multiple strategies for creating culturally-competent organizations; initiatives need to be strategic, practical, actionable, and messaging and communications are key.
Thank You

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www.mghdisparitiessolutions.org