Fulfilling the Promise for Every Single Patient:

Positively Impacting the Patient Experience

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The Myth of Equal Treatment
So, what’s the big deal?
South Carolina’s not *that* diverse, right?

The USA Today Diversity Index
2010

Greenville County: 47
Richland County: 55
Dillon County: 57
Saluda County: 55
Orangeburg County: 51
Charleston County: 55
Beaufort County: 51

So, what’s the big deal? Unequal Treatment

- Commissioned by Congress. Published in 2003.
- Found significant variation in rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable.
- U.S. racial and ethnic minorities experience a lower quality of health services and are less likely to receive even routine medical procedures.
- Several major recommendations were made, including to ensure racial/ethnic diversity within the healthcare workforce.
So, what’s the big deal?
**Skyrocketing Costs & Changing Reimbursement**

- According to a study by the Joint Center Health Policy Institute, between 2003 and 2006 the combined costs of health inequalities and premature death in the United States were $1.24 trillion.

- Increasingly, health care providers will be reimbursed for their ability to ensure adherence to care and better patient outcomes.

So, what’s the big deal?
**Unequal Care**

- Minority patients are receive lower-quality health care than whites.
  - Less likely to receive kidney dialysis or transplants
  - More likely to receive less desirable procedures, such as lower-limb amputations for diabetes.

Source: Robert Wood Johnson Foundation
So, what’s the big deal?

*Unequal Outcomes*

What if a 747 crashed every day in the U.S.?

Evidence Linking Communication to Outcomes
(A Case for Culturally Competent Care)

- Communication
- Patient Satisfaction
- Adherence
- Health Outcomes
  - Reduction of health and health care disparities
  - More cost-effective navigation through health care system

Adapted from: Smedley et al. (2003). Unequal Treatment
But are all of these inequalities intentional?
How many triangles do you see?

The “New Science” of Unconscious Bias
Unconscious Bias

- Unconscious bias is defined as social stereotypes about certain groups of people that individuals form outside of their own conscious awareness

- Almost everyone has it
  - It stems from our natural tendency to organize our social worlds by categorizing

- One of the most common measures of unconscious bias is the Harvard Implicit Association Test:
  
  www.implicit.harvard.edu

Unconscious Bias is Pervasive

Influences hiring, evaluation, daily interactions, and much more.

Unconscious gender bias is found in nearly everyone.

In general, people favor men, whites, youth, and physically able.
Hiring “Karen” or “Brian”

- **Study**: CV of a real psychologist (one at entry and one at tenure level) sent to 238 psychologists randomly selected from the APA directory (Steinpreis et al, 1999)
  - Each CV randomly assigned name of “Brian Miller” or “Karen Miller”

- **Findings**
  - Evaluators were significantly more likely to hire “Brian” at entry level and to evaluate him more positively on research, teaching, and service.
  - At the tenure level
    - Evaluators were equally likely to tenure men and women
    - Four times more likely to include cautionary comments on CV’s with the female name

* Slide provided by AAMC. Used with permission.

Hiring “Emily” or “Lakisha”

- **Study**: Fictitious resumes (n=4,890) sent in response to 1,300 actual help wanted ads in Boston and Chicago for sales and clerical positions (Bertrain and Mullainathan, 2004)
  - Resumes adapted from those on career websites
    - 2 high quality, 2 low quality
    - African American- or white-sounding names randomly assigned

- **Findings**
  - Callback rate
    - 10.0% for resumes with white-sounding names
    - 6.6% for resumes with African American-sounding names
  - 50% difference solely attributable to name manipulation
  - For “white-sounding” names, the applicants with better qualifications elicited 30% more callbacks than those with lower qualifications. For “African American-sounding” names, however, applicants with better qualifications only received 9% more callbacks.

* Slide provided by AAMC. Used with permission.
NBA Referees and Racial Bias

Study reveals that NBA refs call more fouls on players of a different race than their own race.


Why is unconscious bias such a big deal in healthcare?
The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization

- 720 physicians viewed recorded interviews
- Reviewed data about a hypothetical patient
- The physicians then made recommendations about that patient's care

Source: Schulman et. al. NEJM 1999;340:618.

The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization

- Women (OR = 0.60) and blacks (OR = 0.60) were less likely to be referred for cardiac catheterization than men and whites, respectively.
- Black women were significantly less likely to be referred for catheterization than white men (OR= 0.4)

Source: Schulman et. al. NEJM 1999;340:618.
Unconscious Bias: When Is It in Action?

Situations characterized by:
- time pressure
- resource constraints
- high cognitive demand

Unconscious biases tend to have influence when there is a need for “cognitive shortcuts” and lack of full information.
Even if we tackle bias, is that alone going to ensure a great experience for every single patient?

Understanding Healthcare Communication Through the Lens of Culture:

*Why does communication break down more easily across cultures?*
Intercultural Conflict Style Model

1. Discussion Style
   - North America
e.g. United States (European American), Canada
   - Europe
e.g. Great Britain, Sweden, Norway, Denmark, Germany
   - Asia Pacific
e.g. Australia, New Zealand

2. Engagement Style
   - North America
e.g. United States (African American)
   - Europe
e.g. Greece, Italy, Spain
   - Asia
e.g. Russia
   - Middle East
e.g. Israel

3. Accommodation Style
   - North America
e.g. Native American
   - Latin America
e.g. Mexico, Guatemala, Peru
   - Asia
e.g. China, Japan, Thailand, Indonesia, Malaysia

4. Dynamic Style
   - Arab Middle East
e.g. Kuwait, Egypt, Saudi Arabia, Lebanon
   - Asia
e.g. Pakistan

Intercultural Conflict Style Model

EMOTIONAL RESTRAINT
EMOTIONAL EXPRESSIVENESS

Adding to Your Toolbox for Communication

The ESFT Model of Culturally Competent Care:
A Tool to Ensure Quality Cross-Cultural Communication

- Explanatory Model of Health and Illness
- Social and Environmental Factors
- Fears and concerns
- Therapeutic Contracting (Treatment)

The ESFT Model of Culturally Competent Care

- **Explanatory Model of Health and Illness**
  - What do you think caused your problem?
  - Why do you think it started when it did?
  - How does it affect you?
  - What worries you most?
  - What kind of treatment do you think you should receive?


The ESFT Model (con’t.)

- **Social and Environmental Factors**
  - How do you get your medications?
  - Are they difficult to afford?
  - How quickly do you get them?
  - Do you have help getting them if you need it?

The ESFT Model (con’t.)

• **F**ears and concerns
  – Does this medication sound okay to you?
  – Are you concerned with the dosage?
  – Have you heard anything about this medication?
  – Are you worried about the side effects?


The ESFT Model (con’t.)

• **T**herapeutic Contracting (Treatment)
  – Do you understand how to take the medication?
  – Can you tell me how you’ll take it?

Practice **reframing** the old questions to make it **safer** to:

- Ask questions
- Express Confusion
- Say “no” or disagree
- Reveal fear

“Are you taking your medication?”

“A lot of people have concerns about taking this medication. Tell me about what concerns you have.”

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**What is Cultural Competence in Health Care?**

- Valuing diversity
- Having the capacity for cultural self assessment
- Being conscious of the dynamics inherent when cultures interact
- Having institutionalized cultural knowledge
- Having developed adaptations of service delivery reflecting an understanding of cultural diversity.

*Toward a Culturally Competent System of Care, 1989*
Fulfilling the Promise for Every Single Patient:
A CALL TO ACTION

Rule #1: Know thy patients first

Fulfilling the Promise for Every Single Patient:
A CALL TO ACTION

Rule #2: Don’t measure whether things are going well by how frequently patients complain (or don’t complain).

Not all patients communicate their needs in the same way (or at all).
Fulfilling the Promise for Every Single Patient: A CALL TO ACTION

Rule #3: Shore up language access in person, on forms, and on signage.

Fulfilling the Promise for Every Single Patient: A CALL TO ACTION

Rule #4: Examine your patient satisfaction by race, ethnicity, and language.
Fulfilling the Promise for Every Single Patient: A CALL TO ACTION

Rule #5: Ensure your quality assurance committee examines quality metrics and outcomes by race, ethnicity, and language.

Great patient care is about designing great systems of checks and balances.

Fulfilling the Promise for Every Single Patient: A CALL TO ACTION

Rule #6: Adapt services to meet the needs of key constituencies within your patient population.
Fulfilling the Promise for Every Single Patient: A CALL TO ACTION

Rule #7: Practice being a patient in your own facility.

What happens when management is not around?

It’s in your hands....

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