AETC AIDS Education & Training Center Program

Jefferson Health®

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Living in the Borderlands: Intercultural-Communication

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Overview

- Define Health Disparities
- Examine HIV-related Health Disparities in Men who have Sex with Men, Cisgender and Transgender Women, and Youth
- Explore Socio-Cultural Barriers to Care and Affects Patient-Provider Communication
- Define Cultural Awareness, Cultural Competence, and Cultural Humility
- Introduce a Toolkit to Improve Patient-Provider Interactions and Promote Cultural Humility
- Questions and Comments

Health Care Disparities

- Healthy People 2020 defines a health disparity as "***a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.***
- Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their ***racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion***."

Source: Accessed on 04/22/19 from https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Transgender Women

- Some studies indicate that the rate of HIV prevalence among transgender women could be as high as 28%, compared to an overall HIV prevalence rate in the United States of approximately 0.4 to 0.9%.
  - Higher percentages of newly identified HIV-positive test results were found among black transgender women (51%) than among white (11%) or Latina (29%) transgender women.
- Although MSM and transgender women have similar CD4 counts at diagnosis, transgender women were found to have delayed linkage to care and lower viral suppression rates than MSM.

Source: Literature Review on HIV-Related Disparities to Implement a National Quality Improvement Initiative: end+disparities ECHO Collaborative Accessed on 04/22/19 from https://targethiv.org/sites/default/files/EDEC-Literature-Review.pdf

Cisgender Women

- When comparing groups by race/ethnicity, gender, and transmission category, the fourth largest number of all new HIV infections in the United States in 2015 (4,142) occurred among African American women with heterosexual contact
  - In females who fall into the transmission category of heterosexual contact and have been diagnosed with HIV, African-American women have the highest rates of PLWH not having reached viral suppression
- The CDC reports that of all women living with HIV, only 55% were retained in care and only 30% had achieved viral suppression.
- Of the total number of estimated new HIV infections among women in 2014, 61% (4,524) were in African Americans, 19% (1,431) were in white people, and 15% (1,131) were in Latinas.

Source: Literature Review on HIV-Related Disparities to Implement a National Quality Improvement Initiative: end+disparities ECHO Collaborative Accessed on 04/22/19 from https://targethiv.org/sites/default/files/EDEC-Literature-Review.pdf

Men who have Sex with Men

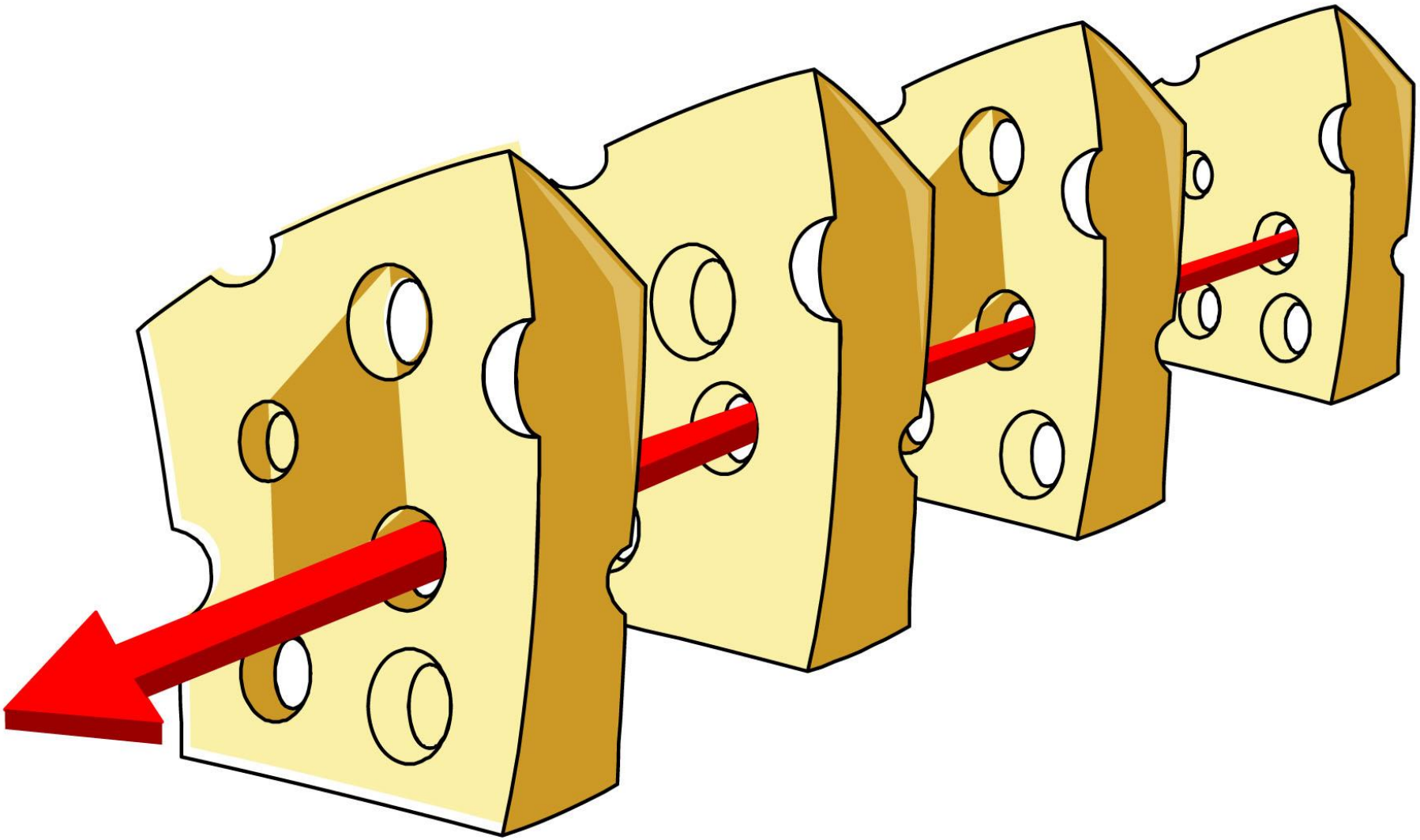
- MSM represent approximately 2% of the U.S. population, yet they accounted for 70% of all new HIV infections in 2014.
  - In 2015, black MSM accounted for more new HIV infections as white MSM, despite the overall black population being significantly smaller.
- Among those with diagnosed HIV infection, an estimated 47% of white MSM are virally suppressed, as opposed to 28% of black MSM and 37% of Hispanic MSM.

Source: Literature Review on HIV-Related Disparities to Implement a National Quality Improvement Initiative: end+disparities ECHO Collaborative Accessed on 04/22/19 from https://targethiv.org/sites/default/files/EDEC-Literature-Review.pdf

Youth

- Youth accounted for an estimated 22% (8,804) of all new HIV infections in 2015, meaning more than one in five new HIV diagnoses were among persons aged 13 to 24 years.
- Young black people (aged 13 to 19) were 64% of young people diagnosed with HIV in 2015, yet only represented 14% of the total youth population in the United States.
- Young MSM accounted for 80% of new HIV infections among Youth in 2014 and 27% of new infections among all MSM in 2010.
- Data that suggest that less than 6% of Youth living with HIV are virally suppressed, compared to the overall viral suppression rate of 30%.

Source: Literature Review on HIV-Related Disparities to Implement a National Quality Improvement Initiative: end+disparities ECHO Collaborative Accessed on 04/22/19 from https://targethiv.org/sites/default/files/EDEC-Literature-Review.pdf



Define the Problem

SOCIOCULTURAL BARRIERS TO HEALTH CARE OUTCOMES FOR RACIAL AND ETHNIC MINORITIES

Sociocultural Barriers for Racial and Ethnic Minorities

- Organizational Barriers
- Structural Barriers
- **Clinical Barriers**

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. I. (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public health reports.

Organizational Barriers

- **Leadership and Workforce Representation**[1]
  - Institutional Leadership
    - Medical Schools, Public Health Schools, and City and County Health officers
  - Health Care Workforce
- Centers the lived experience of minority professionals in discussions of curriculum and programming
- Improvements in self-rated quality of care and patient satisfaction and combats implicit bias

1. Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. I. (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public health reports.

Structural Barriers[1]

- *Structural Barriers arise when patients are faced with the challenge of obtaining health care from systems that are complex, underfunded, bureaucratic, or archaic in design.*
  - Lack of Interpreter Services
  - Bureaucratic intake processes and long waiting times
  - Referrals to Specialists and Continuity of Care

1. Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. I. (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public health reports.

Clinical Barriers[1]

- *Clinical barriers have to do with the interaction between the health care provider and the patient or family.*
- They occur when **sociocultural differences** between patient and provider are not fully **accepted, appreciated, explored, or understood.**
  - These include patient health beliefs, medical practices, attitudes towards medical care, and levels of trust in doctors and the health care system
- Cultural and linguistic barriers in the clinical encounter negatively affect communication and trust, this leads to **patient dissatisfaction, poor adherence, and poorer health outcomes.**

1. Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. I. (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public health reports.

Shared-Decision Making

- Improving the process and quality of decision making requires physicians to understand the degree to which patients desire—or are able—to participate in decision making.
- The idea of making one's own healthcare treatment decision, or of "sharing" that decision with one's provider, may be a difficult concept to those patients who either lack trust in the health system or believe that physicians are "supposed" to make decisions; and these patients may be those who come from different racial/ethnic or cultural backgrounds.

Hawley, Sarah T., and Arden M. Morris. "Cultural challenges to engaging patients in shared decision making." Patient education and counseling 100.1 (2017): 18-24.

Recommendations to Address Disparities

- Evaluate the racial climate, investigate reports of subtle or overt discrimination and unfair treatment, and identify and work to transform formal and informal norms that ignore and/or support racism.
- Establish monitoring systems in which processes and outcomes of care can be compared by patient race.
- Give care units and, where appropriate, individual clinicians, equity-specific targeted feedback.
- When inequities are found, support creative solutions for remediation and create accountability for improvement.

Van Ryn, Michelle, et al. "The impact of racism on clinician cognition, behavior, and clinical decision making." Du Bois review: social science research on race 8.1 (2011): 199-218.

Recommendations to Address Disparities

- Implement work policies and clinic procedures that protect clinicians from cognitive load and promote positive emotions.
- Promote racial diversity at all levels of the organizational hierarchy and support positive intergroup contact.
- Implement and evaluate training that ensures that clinicians have the knowledge and skills needed to prevent racial biases from affecting the quality of care they provide: **self-awareness regarding implicit biases, perspective-taking skills, emotional-regulation skills, and partnership-building skills.**

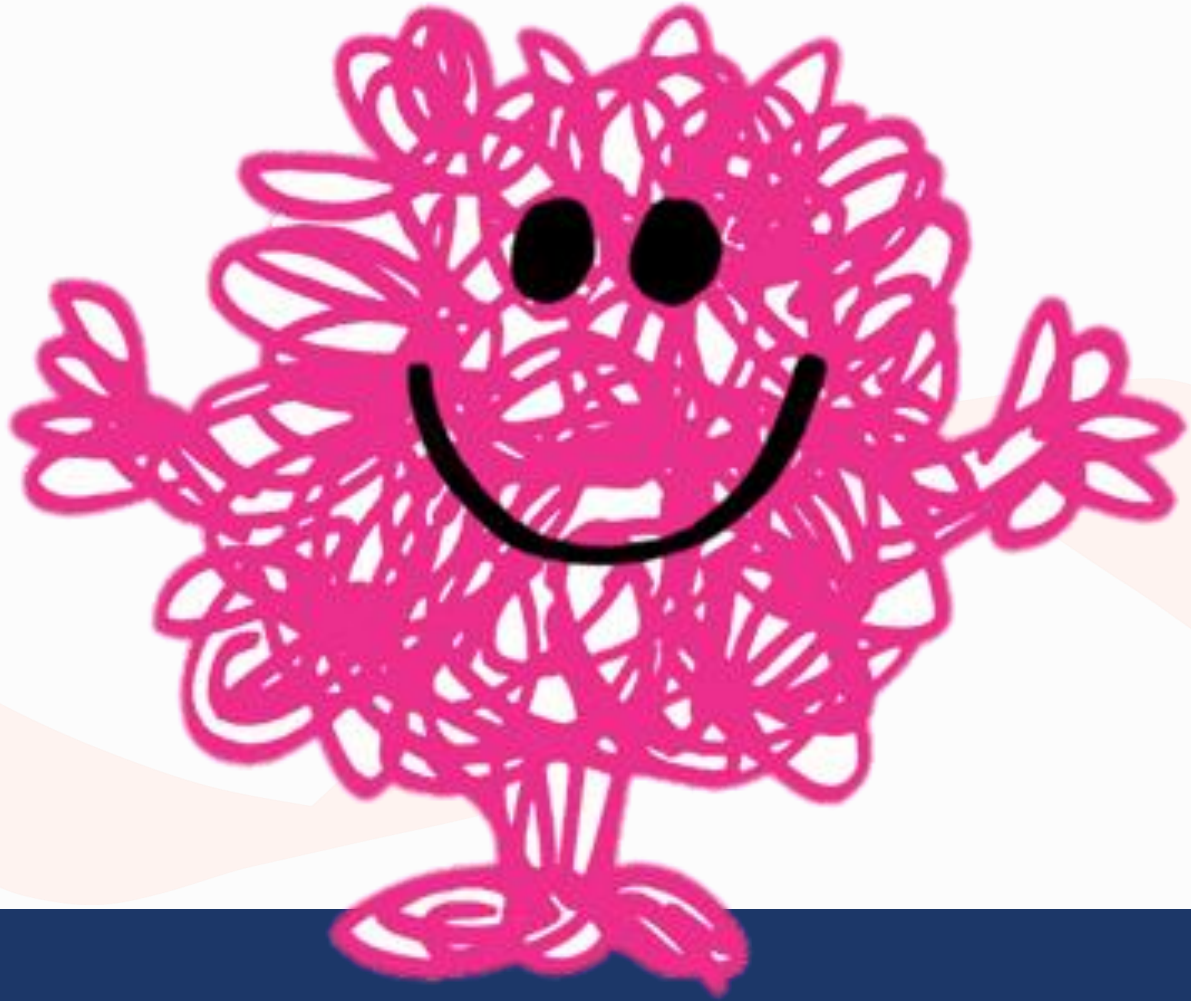
Van Ryn, Michelle, et al. "The impact of racism on clinician cognition, behavior, and clinical decision making." Du Bois review: social science research on race 8.1 (2011): 199-218.

Change the Conversation

Gain Knowledge, Skills, and Abilities

CULTURAL EFFECTIVENESS

Culture is messy right now.



Cultural Awareness

Cultural Awareness is being cognizant, observant, and conscious of similarities and differences among and between cultural groups.

Source: https://nccc.georgetown.edu/curricula/awareness/index.html Accessed On: 030119

Cultural Awareness

- Having a firm grasp of what culture is and what it is not
- Having insight into intracultural variation
- Understanding how people acquire their cultures and culture's important role in personal identities, life ways, and mental and physical health of individuals and communities;
- Being conscious of one's own culturally shaped values, beliefs, perceptions, and biases
- Observing one's reactions to people whose cultures differ from one's own and reflecting upon these responses
- Seeking and participating in meaningful interactions with people of differing cultural backgrounds.

Source: https://nccc.georgetown.edu/curricula/awareness/index.html Accessed On: 030119

Cultural Competency

- *Cultural and linguistic competence is a set of congruent **behaviors**, **attitudes**, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.*
  - Competence is *"the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, **emotions**, **values**, and **reflection** in daily practice for the benefit of the individual and the community being served"*

American Institutes for Research. (2002). Teaching cultural competence in health care: A review of current concepts, policies and practices. Report prepared for the Office of Minority Health. Washington, DC: Author.

Cultural Competence Implementation

- Often categorical approaches to diversity
  - Brief lectures on large cultural identifies
    - Can lead to stereotyping
  - Diminishes the full expression of identities
- Often little or no attention to building skills through practice and simulations
- "*The equating of cultural competence with simply having completed a past series of training sessions is an inadequate and potentially harmful model of professional development …* "[1]

1. Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of health care for the poor and underserved, 9(2), 117-125.

Health Care as a Cultural Borderland

January 2018 Lancet Perspective by Cheryl Mattingly, PhD

Posits the idea that health care actually takes place somewhere in the space between clinic, community and patient.

Perspectives

The art of medicine

Health care as a cultural borderland

As a clinician, how do you best care for patients from a wide variety of backgrounds? Cultural diversity is not merely a matter of pluralism or multiculturalism; it is often accompanied by unequal or inadequate health care. Very often, cultural diversity and health disparity go hand in hand. As a response to such inequities, various forms of cultural competence training are now viewed as an essential curriculum component in medical education programmes and a key element of effective practice. However, these educational innovations have also come under fire. Some critiques centre upon that vexed and elusive concept "culture".

Is there a better way to frame the task of offering health care to culturally diverse populations? One suggestion is to rethink what we mean by culture. In the disciplines of anthropology, cultural studies, and subaltern studies, the term culture has come to be reconceived not as a bounded and homogeneous whole but as a fractious and porous borderland. Culture emerges as something one travels through as much as lives in. In these border characterisations, culture is recast as a contested, mutable, noisy public sphere, a global marketplace rather than some common property, set of beliefs, or the like that belong to or characterise various uniquely demarcated groups. This perspective has foregrounded the political and the conflictual—culture as a process of "Othering"—but it has also attended to connections, often surprising, that arise in the exchanges and transactions among diverse communities and commodities.

This concept of culture could help to reimagine the clinical space. What if we considered the clinic as a cultural borderland or as part of a much larger borderland? Might cultural competence come to look rather different from—or more than—becoming acquainted with various cultural belief patterns presumed to characterise the thinking and values of minority populations? When it comes to chronic health conditions, when a great deal is expected of both the patient and family caregivers, the clinic is just one setting within a border community of care that extends far beyond the health-care setting. This, of course, is not news to clinicians. But it suggests something rather profound for what cultural competence might mean. If one takes seriously the fact that not only clinicians but also patients, families, and, often, a host of other actors are part of a health-delivery community and that health care lives in a border space between clinic, home, and community contexts, then it is possible to pose the cultural competence question a bit differently: how can this porous and changeable community improve its competence in communicating with one another and partnering up?

This notion of a cultural borderland is especially compelling when you consider the clinical encounter from the perspectives of patients and families. For my colleagues and me, it was highlighted through a long-term ethnographic study we did in Los Angeles, CA, USA. For 15 years we followed a cohort of African American families raising children with chronic medical conditions that require frequent interactions with health care providers. Culture as a borderland of both friction and community building is an illuminating idea when it comes to their experiences.

Parents often spend an enormous amount of time taking children to distant hospital sites to see specialists, which can mean hours on public transport or battling clogged freeways by car. As a site of travel, certain spaces that may not appear central to health care emerge as focal points of contact between patients and the health-care system. Waiting rooms, for example, are liminal spaces in which families and patients not only spend a great deal of time but try to learn how to navigate their interactions with such critical gatekeepers as hospital receptionists or emergency room staff.

While parents and children in our study certainly learned a great deal of what one might call clinical content—how to give injections, how to do physical therapy exercises at home, how to put on splints and operate wheelchairs, what common side-effects of medications might be—this kind of medical knowledge is only a small part of what they must master. They also cultivate a plethora of other skills to try to overcome

Mattingly, C. (2018). The art of medicine Health care as a cultural borderland.

Health Care as a Cultural Borderland

If one takes seriously the fact that not only clinicians but also patients, families, and often, a host of other actors are part of the health-delivery community and that health care lives in a border space between clinic, home, and community contexts – then it is possible to pose the cultural competency question a bit differently:

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Health Care as a Cultural Borderland

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Mattingly, C. (2018). The art of medicine Health care as a cultural borderland.

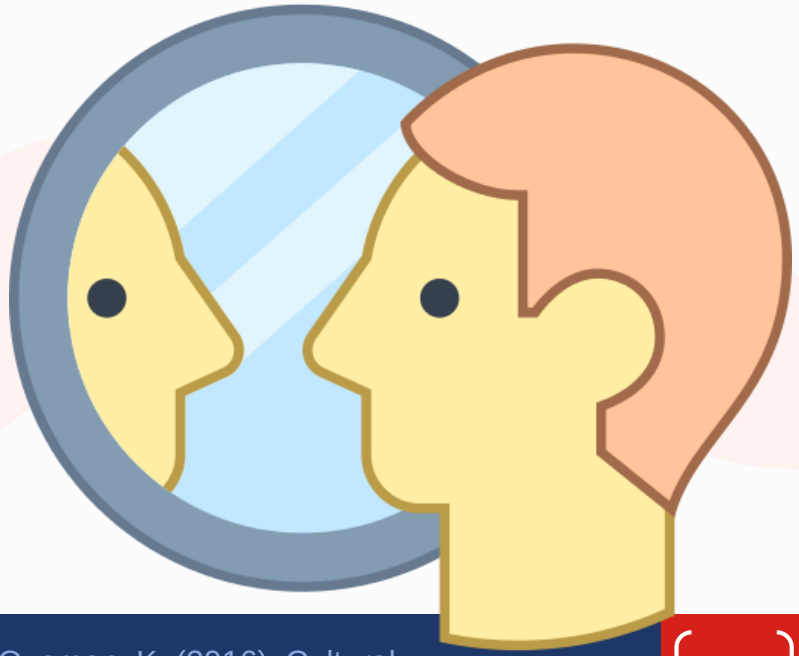
Cultural Humility

Cultural Humility is a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals.

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. Journal of Transcultural Nursing, 27(3), 210-217.

Attributes of Cultural Humility

- Openness
- Self-Awareness
- Egoless
- Supportive Interaction
- Self-Reflection and Critique



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Outcomes of Cultural Humility

- Mutual Empowerment
- Partnerships
- Respect
- Optimal Care
- Lifelong Learning

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. Journal of Transcultural Nursing, 27(3), 210-217.

Develop Skills

ADDRESSING CLINICAL BARRIERS TO CULTURALLY RESPONSIVE CARE

Communication Burden

Antecedents of Cultural Humility

Diversity

Power Imbalance

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. Journal of Transcultural Nursing, 27(3), 210-217.

Communication Responsibility

Intercultural Communication Skills

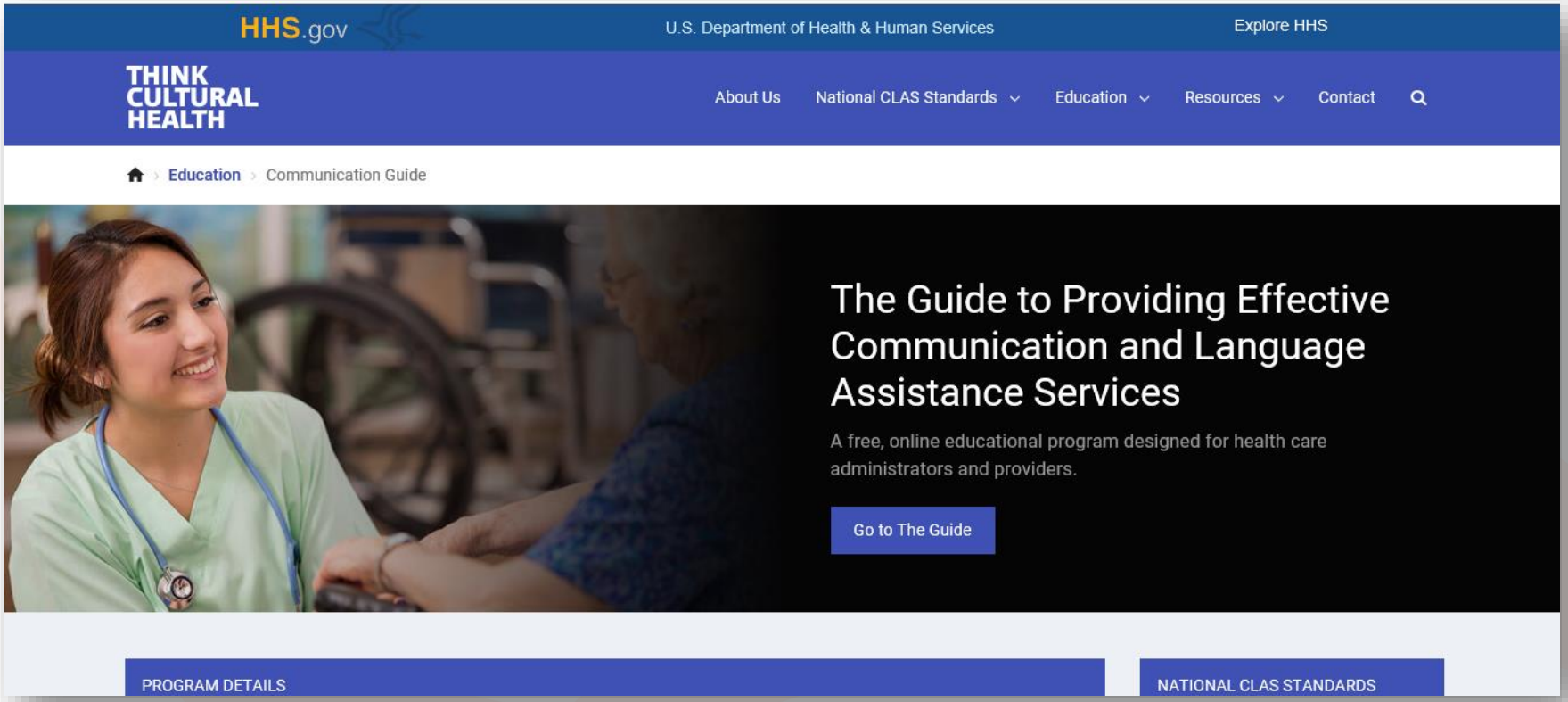
"Ultimately, some balance of cross-cultural knowledge and communication skills seems to be the best approach to cultural competence education and training."

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. I. (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public health reports.

The Guide

IMPROVING THE QUALITY OF PATIENT-PROVIDER RELATIONSHIPS TO ADDRESS BARRIERS TO CARE

Office of Minority Health



Source: https://www.thinkculturalhealth.hhs.gov/education/communication-guide
Accessed on: 030119

The Guide

- The Guide to Providing Effective Communication and Language Assistance Services
- e-Learning Platform
- Target Audience
  - Health care providers (or those providing direct care and services)
  - Health care administrators
  - Health care executives

Source: https://www.thinkculturalhealth.hhs.gov/education/communication-guide
Accessed on: 030119

Tools and Skills

- The health care administrator track covers:
  - Conducting organizational self-assessments
  - Planning effective communication and language assistance services
  - Implementing effective communication and language assistance services
  - Evaluating communication and language assistance services
- The health care provider track covers:
  - Cross-cultural communication skills
  - Verbal communication strategies
  - Written communication strategies
  - Notice of communication and language assistance services

Source: https://www.thinkculturalhealth.hhs.gov/education/communication-guide
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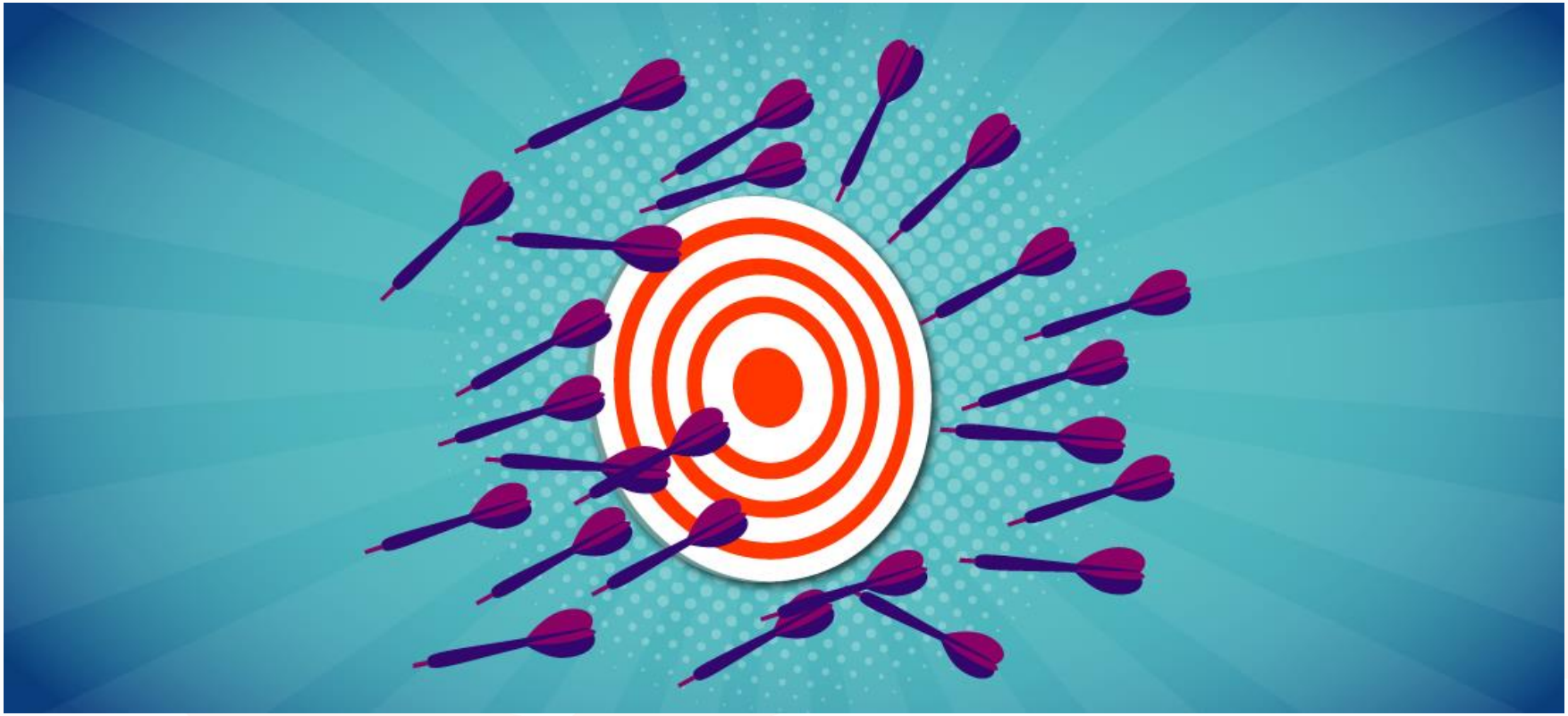
Practice Builds Competency



Focus on Feedback

Questions or Comments

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