Delivering Culturally and Linguistically Appropriate Care for Patients

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Financial Disclosures – Employment with Critical Measures, LLC

Learning Objectives

- Define cultural and linguistic responsiveness
- Explain the need for culturally and linguistically responsive patient care
- Identify strategies for providing culturally and linguistically responsive patient care

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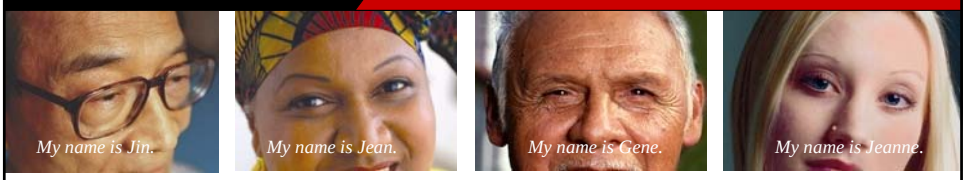

Do you know me?

Delivering Culturally and Linguistically Appropriate Care at NMDP

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Presentation Overview

- Three Demographic Megatrends
- What is Cross-Cultural Health Care?
  - Racial and Ethnic Disparities
  - Language Access
  - Global Medicine
- Managing Unconscious Bias
- Implications for NMDP
- New Skills for the Culturally Competent Health Care Worker

Three Key Demographic Megatrends

Changing Demographics – United States

- Between now and the year 2050, almost 90% of U.S. population growth will come from Asian Americans, African-Americans and Hispanic-Americans.
- Today, people of color are already a majority in 48 of the nation's 100 largest cities.
- Today, five states have "minority majorities." They include: California, Hawaii, New Mexico, Texas and Florida.
- Five other states: Maryland, Mississippi, Georgia, New York and Arizona have non-white populations around 40%.

Source: "The Emerging Minority Marketplace: Minority Population Growth 1995-2050." U.S. Census Bureau September 21, 1999.

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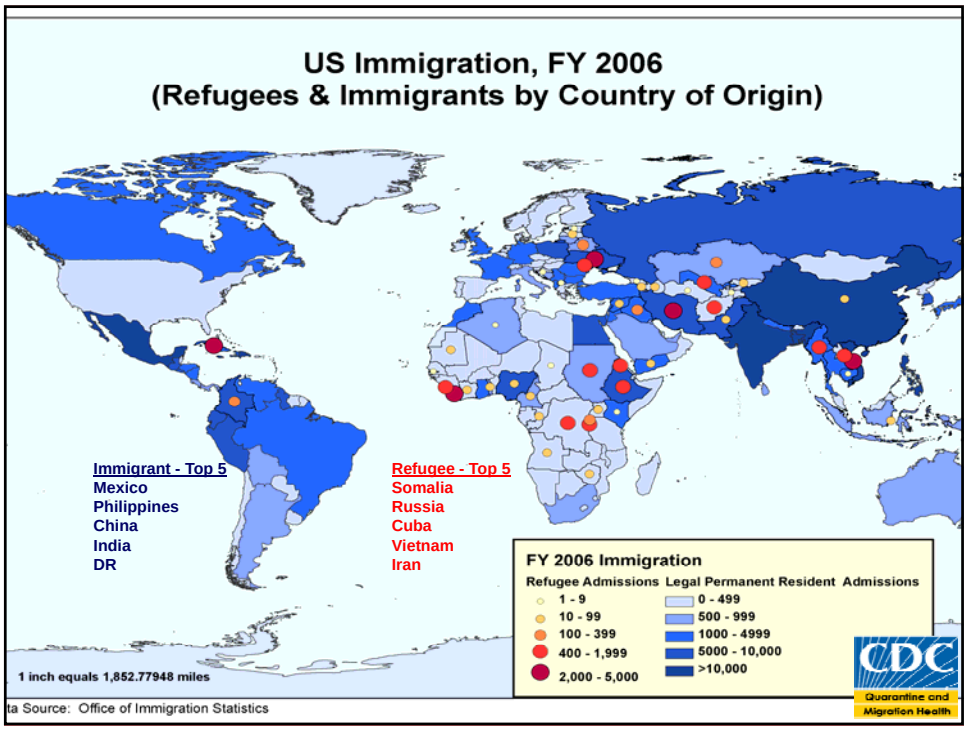
Trends in U.S. Immigration

- 1 of 10 global citizens today is a migrant.
- Immigration to the U.S. has tripled in the last 30 years.
- During the 1990s, the U.S. received over 13 million immigrants – the largest number in our nation's history.
- We broke even that mark during the last decade.
- Significantly, most immigrants today no longer come from Western European nations with whom we have the most in common historically….

Source: The Economics of Necessity: Economic Report of the President Underscores the Importance of Immigration. American Immigration Law Foundation



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Immigrants' Top Countries of Origin - 2009

	Minnesota*		United States
1.	Somalia	1.	Mexico
2.	Ethiopia	2.	China
3.	Kenya	3.	Philippines
4.	Liberia	4.	India
5.	Mexico	5.	Dominican Republic
6.	Burma	6.	Cuba
7.	India	7.	Vietnam
8.	Thailand	8.	Columbia
9.	China	9.	South Korea
10.	Vietnam	10.	Haiti

Source: U.S. Department of Homeland Security, Star Tribune, 5-16-2010

Immigrants Bring New Cultural Influences

- Religion: Islam is now the fastest growing religion in the U.S.
- Language: 18.7 percent of Americans 5 years old and older speak a language other than English at home, with nearly half of those claiming to speak English less than "very well."
- America is now more linguistically diverse than Western Europe.
- 43% of California's population now speaks a language other than English at home.

What is Cross-Cultural Healthcare?

What is Cultural Competence in Healthcare?

1. Racial and Ethnic Disparities in Patient Outcomes
2. Providing Language Access to LEP Patients/Families
   A. Medical - Quality/Safety Issue
   B. Legal - Civil Rights Issue (Title VI, ADA)
3. Medical Disparities resulting from Globally Mobile Populations

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People of Color Driving U.S. Health Insurance Market

Total U.S. Pop. With Insurance (Millions/Non-Medicare)

Demographic Group	1990	2001	Growth	%
White (non Hispanic)	140.7	144.6	3.9	3%
Hispanic	13.2	22.7	9.5	72%
African-American	21.7	25.4	3.7	17%
Asian	5.3	9.3	4.0	76%
Other	0.9	0.8	(0.1)	(10%)
Total	181.8	202.8	21.0	12%
Total People of Color	41.1	58.2	17.1	42%
"Minority Share"	23%	29%	81%	

Source: Census Data: Dr. Tango Analysis

Institute of Medicine Finds Racial and Ethnic Disparities in Quality of Care

- People of Color receive lower-quality health care than whites do, even when insurance status, income, age and severity of conditions are comparable.
- People of Color more likely to be treated with disrespect by the health care system and more likely to believe that they would receive better care if they were of a different race.
- Major disparities found in many key diagnostic areas: cardiovascular disease, cancer, stroke, kidney dialysis, HIV/AIDS, asthma, diabetes, mental health, maternal and child health.
- The overall death rate for blacks today is comparable to the white death rate of thirty years ago. 100,000 blacks die each year who would not die if the death rates were equivalent.

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Racial Disparities Have Worsened Since Issuance of the IOM Report

- It has now been seven years since the Institute of Medicine issued its clarion call for improving the quality of healthcare for the nation's minorities.
- While some strides have been made, quality gaps continue. A recent Agency for Healthcare Research and Quality (AHRQ) report notes that over 60 percent of disparities in quality of care have stayed the same or worsened for blacks, Asians and poor populations while nearly 60 percent of disparities, including but not limited to quality issues have stayed the same or worsened for Hispanics.

Racial Disparities Costs Nation $57 Billion Per Year

- Racial health disparities in infant mortality, chronic disease and many other metrics cost the U.S. health system more than $57 billion a year, according to a report authored by researchers from Johns Hopkins University and the University of Maryland. (Joint Center for Political and Economic Studies (a Washington, D.C. think-tank) September, 2009)

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Few Hospitals Collect Race/Ethnicity Data and Tie it to Quality/Outcomes.

- NPHHI asked hospitals that collect race and ethnicity data whether they used it to assess and compare quality of care, utilization of health services, health outcomes or patient satisfaction across their different patient populations.
- Sadly, less than 20 percent of surveyed hospitals collect patient race and ethnicity information and tie it to patient outcomes and quality improvement.

Even Fewer Physicians Receive Patient Race/Ethnicity Data.

- Newly released data (Feb. 10, 2010) from a national survey of over 4,700 physicians commissioned by the Robert Wood Johnson Foundation found that:
- Less than one in four physicians (23%) indicated that they receive reports on patient demographics such as race or ethnicity.
- Nearly nine out of 10 physicians lacked a formal means to assess the quality of care provided to patients across racial and ethnic groups.
- Only 11.8 percent of physicians reported access to reports on the quality of care they provide stratified by patient race or ethnicity.

See: Modest and Uneven: Physicians Efforts to Reduce Racial and Ethnic Disparities (Center for Studying Health System Change, Feb. 10, 2010)

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Medical Case for Language Access in Healthcare – Improved Quality, Safety

1. Language barriers are associated with poor quality of care in emergency departments; inadequate communication of diagnosis, treatment and prescribed medication; and higher rates of medical errors.
2. According to one study, no interpreter was used in 46% of emergency department cases involving patients with LEP.
3. Few clinicians receive training in working with interpreters; only 23 percent of U.S. teaching hospitals provide any such training and most make it optional.

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Medical Case for Language Access in Healthcare – Improved Quality, Safety

4. Glenn Flores conducted research on mistakes by inadequately trained interpreters. His results showed:
    - An average of 31 mistakes per doctor-patient visit
    - Two-thirds could have negative consequences for patients
5. According to the Joint Commission, fully half of LEP patients who reported adverse events experienced some degree of physical harm – compared to less than a third of English speaking patients.
6. The same report found that the rate at which LEP patients suffered permanent or severe harm or death was more than twice that of English-speaking patients.

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U.S. Patient Satisfaction Data – Language

1. Research has highlighted that patients with limited English proficiency (LEP) have more difficulty communicating with health care providers and are less satisfied with the care they receive than those who are proficient in English.
2. Studies show that the perceived quality of the interpreter is strongly associated with patients' assessments of quality of care overall.
3. Patients who needed and got an interpreter rated their hospital experience and the care they received more positively than those patients who needed an interpreter but did not get one. Other studies have found that linguistic minorities of any race reported worse care than did English-speaking racial and ethnic minorities.

More Hospitals Seeing LEP Patients

1. More hospitals are seeing LEP patients.
   A. 80% of American hospitals encounter LEP frequently.
   B. 43% of hospitals encounter LEP patients daily, 20% of hospitals encounter LEP patients weekly,17% of hospitals encounter LEP patients monthly.
2. Yet less than 30 percent of U.S. hospitals have quality improvement efforts underway to improve the quality of their language access programs.

More Physicians Seeing Non-English Speaking Patients

1. While nearly 97 percent of physicians have at least some non-English speaking patients, only slightly more than half of physicians (56%) were in practices that provided interpreter services in 2008.
2. Likewise, 22 percent of physicians indicated that their practice has IT capable of reporting patients' preferred language but only a third of these physicians (7%) routinely used this capacity.
3. Nearly half (48.6%) of all U.S. physicians in 2008 reported that difficulty communicating with patients because of language or cultural barriers was at least a minor problem affecting their ability to provide high quality care. Modest and Uneven, Feb. 10, 2010.

More Physicians Seeing Non-English Speaking Patients

Table 1

U.S. Physicians Implementing Select Tools Aimed at Reducing Racial/Ethnic Disparities, 2008

Practice Provides Interpreter Services[1]	55.8%
Practice Provides Patient-Education Materials in Languages other than English[2]	40.1
Physician Received Training in Minority Health[3]	40.3
Physician Receives Reports on Own Patients' Demographic Characteristics[3]	23.2
Information Technology to Access Patients' Preferred Language is Available and Used Routinely[4]	7.3
Physician Receives Reports on Quality of Care for Own Minority Patients[3]	11.8

[1] Excludes physicians who reported having no non-English speaking patients.

[2] Population consists of physicians whose practices treat at least one of the following chronic conditions: diabetes, asthma, depression, congestive heart failure. Population excludes physicians who report having no non-English speaking patients.

[3] Excludes physicians who report having no minority patients.

Source: HSC 2008 Health Tracking Physician Survey

Who Is Entitled to Receive Language Access Services?

- Two major groups have language access rights: LEP under Title VI and Deaf and Hard of Hearing under ADA.
- More language access litigation under ADA than Title VI. Typical focus: hospitals.
- No private right of action under Title VI. Alexander v. Sandoval, 121 S.Ct. 1511 (2001).
- Plaintiffs may allege intentional discrimination.
- Do not have to be U.S. citizen to have language access rights under Title VI ("persons").
- Language access rights not limited to patients.

Legal Issues Associated With Language Access

- Informed Consent – invalid if not obtained by qualified interpreter. See: Quintero v. Encarnacion, Lexis 30228, 10th Cir. 2000; Snyder v. Ash, 596 N.E.2d 518 (1991)
- Breach of Provider's Duty to Warn
- Breach of Patient's Privacy Rights (HIPAA)
- Medical Malpractice – language access violations are civil rights violations which are typically not covered by medical malpractice insurance.
- EMTALA Violations – hospital emergency departments
- State Pharmacy Laws – counseling obligation

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Language Access Settlements

1. A hospital was ordered to pay a $71 million damage award because a patient was not treated promptly for a ruptured artery. The paramedics interpreted a 22 year-old Spanish-speaking patient's complaint of "intoxicado" as meaning that he was "intoxicated" rather than "nauseated", and the hospital delayed a neurological evaluation while doing a drug and alcohol workup. The patient ended up a quadriplegic. See: P. Harham, A Misinterpreted Word Worth $71 Million, Medical Economics, 289-92 (June 1984).
2. In a 2008 New Jersey case, a physician refused to honor a patient's request to employ an American Sign Language (ASL) interpreter because the interpreter's charges would exceed the physician's hourly rate. The physician was required to pay a $400,000 jury verdict in the patient's favor as a result.
3. In a 2010 Minnesota case, North Memorial Hospital agreed to pay $105,000 to settle charges that two disabled patients were not provided access to qualified sign language interpreters. One of the patients had to read lips or write notes to communicate with doctors and nurses, despite his repeated requests for an interpreter. The same patient did not learn that his wife had terminal cancer until three months after the fact due to the lack of interpreters.

Common Title VI Violations

- Failure to provide **any** language access services.
- Failure to provide **competent** interpreters.
- Failing to translate "vital documents" into patients preferred written languages.
- Failure to provide language access in **correct language**.
- Failure to provide language access services in a **timely** manner.
- **Charging** patients for language access services.
- **Insisting that patients provide their own interpreters**. (Conditioning the receipt of medical services on patients providing their own interpreter.)
- **Failing to inform** patients of their legal right to language access services at no cost to them.

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Key Findings from NHeLP Study On Medical Malpractice (2010).

1. Study examined the experience of one large med-mal carrier from January 2005 to May 2009.
2. Selected carrier provides med-mal insurance to providers in 6 Western U.S. states (California, Oregon, Washington, Idaho, Alaska and Hawaii.)
3. Examined 1,373 medical malpractice lawsuits and settlements. 35 of these claims (2.5%) had contested language access issues.
4. The Carrier paid $2,289,000 in damages or settlements and $2,793,000 in legal fees on the 35 claims. ($5 M total, or $142,857 per case.)

Key Findings from New NHeLP Study On Medical Malpractice (cont'd).

5. The cases resulted in many patients suffering death and irreparable harm. Two children and three adults died. In one case, a child was used as an interpreter before suffering fatal respiratory arrest. In other cases, a patient was rendered comatose, one underwent a leg amputation and a child suffered major organ damage.
6. In 32 of the 35 cases, the health care providers did not use competent interpreters. In 12 cases, family members or friends were used as interpreters, including minor children in two cases.
7. 12 claims involved defective informed consent forms or failure to translate vital medical/legal documents & discharge instructions.
8. Nearly all of the cases demonstrated poor documentation of a patient's limited English proficiency or the need for an interpreter.

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Globally Mobile Populations Require Globally Competent Physicians

- Patient care for international migrants and medical education for clinicians who care for them have not kept pace with world population growth and mobility, resulting in inequities in care and patient outcomes for globally mobile populations.
- Refugees and immigrants have widely disparate health concerns and socioeconomic status. Because they migrate from underdeveloped countries, they also have much in common.
- These include more infectious diseases, fewer chronic health concerns initially, language, cultural and structural barriers to care, and all too often, health care providers and health delivery systems less than adequately prepared to care for globally mobile populations.

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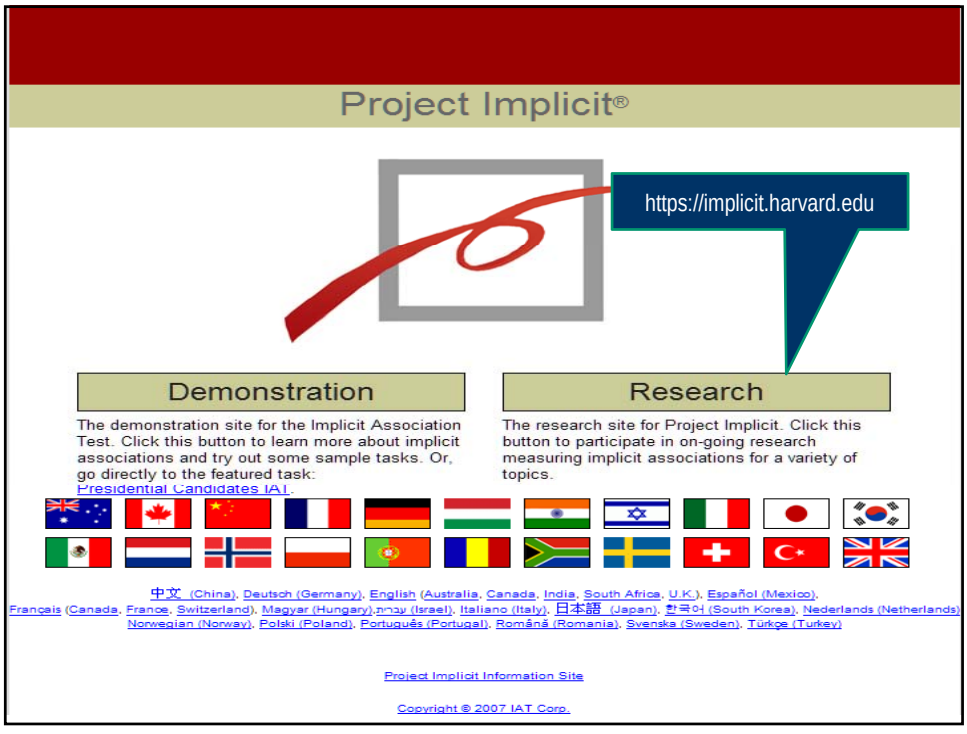
Impact of Culture on Quality/Safety - Examples

- Hmong immigrant patient with long history of smoking and COPD was treated with steroids. Patient died. Autopsy revealed that patient had an infectious, parasitic disease (Strongyloides). Treating the condition with steroids disseminated the disease and killed the patient. Treating physicians never asked about country of origin or investigated diseases from Asia that look like COPD.
- Anglo-American female patient presented with fever and flu-like symptoms. Treated for flu, her conditions continued to worsen. Result: patient had acquired malaria from a recent humanitarian trip to Haiti where she had helped earthquake victims.

Cultural Competence Timeline

2000	CLAS Standards Adopted (1st National Standards)
2002	Institute of Medicine Report "Unequal Treatment" - Disparities
2004	AAMC requires every U.S. medical school to teach cross-cultural medicine.
04-06	Three states modify physician licensing laws to require additional training in cross-cultural medicine. (CA, WA, NJ)
2007	Joint Commission requires collection of patient language information.
2009-10	Joint Commission, NCQA and the National Quality Forum announce new cultural competence standards. Efforts will focus on language access from standpoint of patient quality, safety.
2010	Affordable Care Act signed into law by President Obama.
2013	Revised CLAS Standards released. (April 2013)
2013	Implementation of Affordable Care Act begins.

Unconscious Bias: The Evidence



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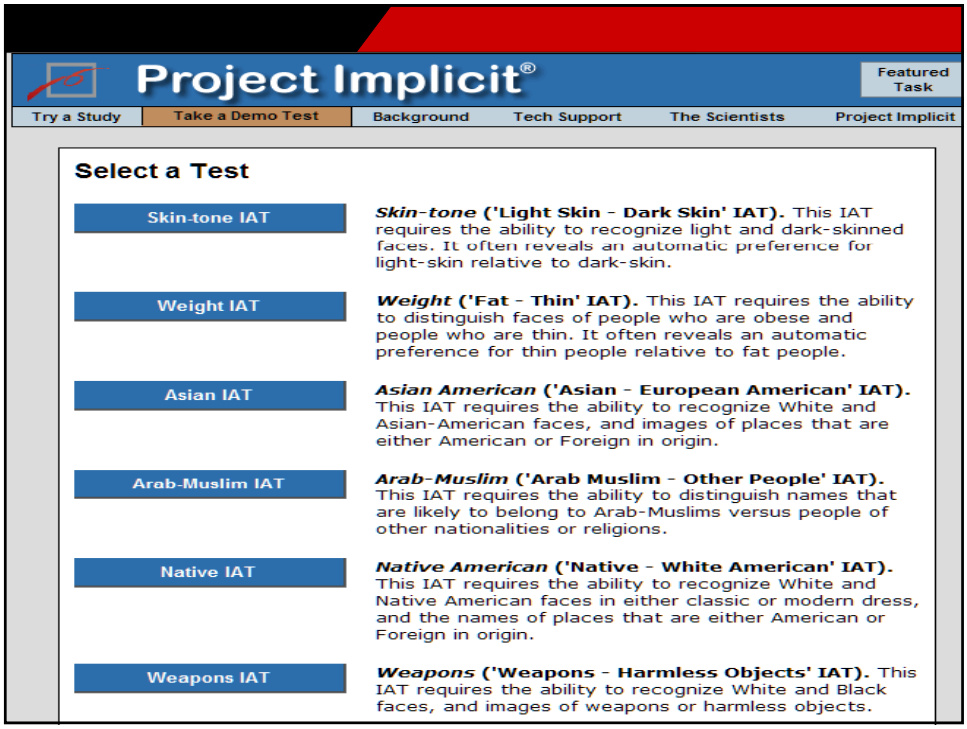

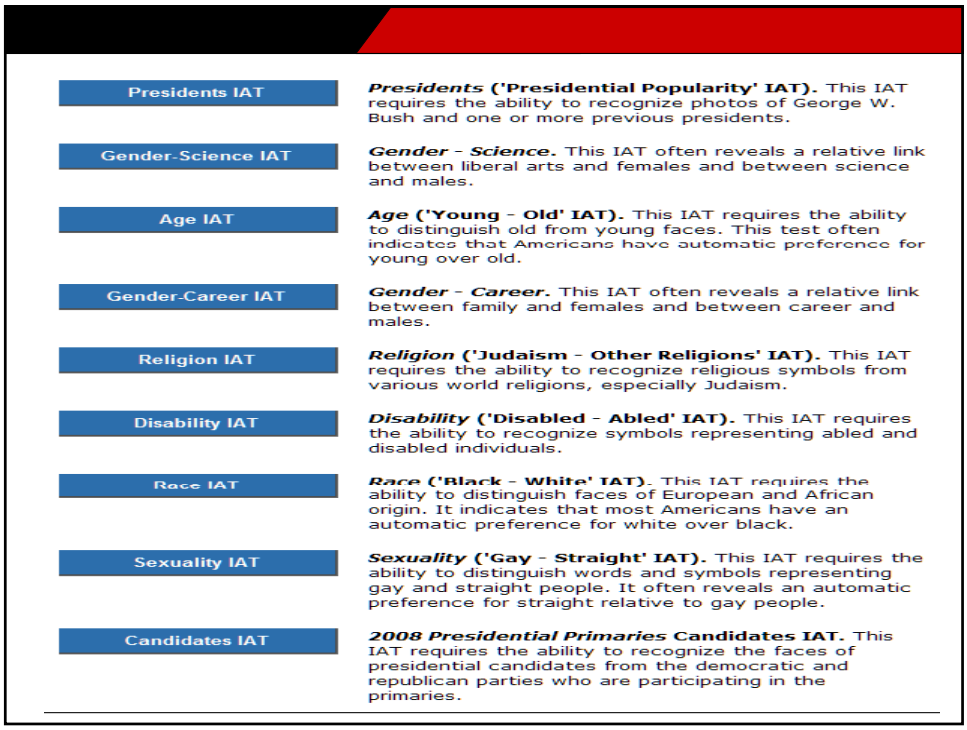

Awareness: New Research re: Bias

1. In the past, bias was regarded as aberrant, conscious and intentional.
2. Today, we understand that bias is normative, unconscious and largely unintentional.
3. Social Cognition Theory establishes that mental categories and personal experiences become "hard-wired" into cognitive functioning.
4. Take the Implicit Association Test on the Web at: http://implicit.harvard.edu

Awareness: Bias Impacts Decisions

5. Unconscious biases are mostly triggered by primary factors such as race, gender and age.
6. Biases most likely to be activated by:
   - stress
   - time constraints
   - multi-tasking
   - need for closure
7. Question: to what extent do implicit biases impact physicians clinical decision-making?

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

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

New Study Finds Unconscious Bias in M.D. Decision-making

- Emergency room doctors in the study were told two men, one white and one African-American, were each 50 years old and complained of chest pain. The patients were not actually real people, but rather computer-generated images seen by the doctors only on a monitor.
- After the doctors in the study evaluated the two simulated patients, they were then given an implicit association test examining unconscious racial biases.
- The result was most of the doctors were more likely to prescribe a potentially life-saving, clot-busting treatment for the white patients than for the African-American patient.
- The study, by the Disparities Solutions Center, affiliated with Harvard University and Masschusetts General Hospital, is the first to deal with unconscious racial bias and how it can lead to inferior care for African-American patients. It was published in the online edition of the Journal of General Internal Medicine in June, 2007.

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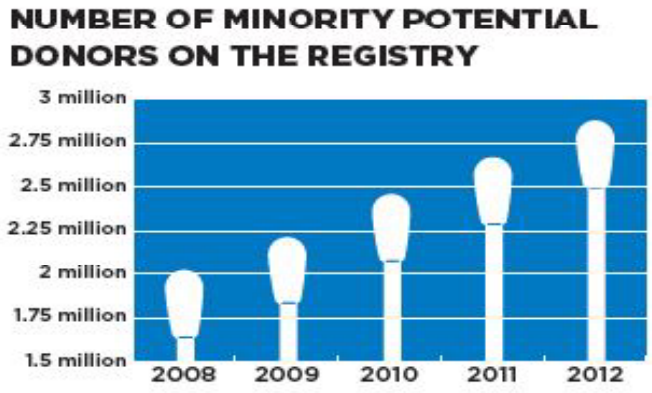
Bias in Transplant Decisions?

- More than 100,000 Americans are waiting for lifesaving operations. Minorities are nearly half as likely to receive organs, even though they are more likely to need them.
- Blacks in America donate organs (13 percent) at about the same rate as their percentage of the general population (14%) but they represent 35% of those on the kidney transplant waiting lists
- In 2008, 4,638 people died waiting for kidney transplants, and 1,542 of them were black. In other words, 33 percent of deaths on the kidney waiting list were black patients.

Implications for NMDP – Progress in Increasing Potential Minority Donors



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Implications – But Substantial Racial & Ethnic Disparities Remain

- Despite the large number of registered potential donors, the NMDP and unrelated HSC registries worldwide continue to face difficulties in identifying matched donors for some patients – particularly racial/ethnic minorities.
- A recent investigation found that while approximately 79% of Whites searching the NMDP registry find at least one 8 of 8 HLA allele-matched potential donor, only 50% of Asian/Pacific Islanders, 44% of Hispanics and 33% of African Americans find a similarly HLA-matched potential donor.
- Donor attrition rates from the NMDP registry are much higher for racial/ethnic minority groups than they are for non-minorities (60% attrition for minority groups versus 40% for Whites)

Implications for NMDP

- Compared to Whites, minorities reported:
  - More religious objections to donations (AA, HIS, API, AI);
  - Less trust that HSC's would be allocated equitably (AA, API);
  - More concerns about donation (HIS, API); and
  - A greater likelihood of having been discouraged from donating (API)

  See: Race and Ethnicity in Decisions About Unrelated Hematopoietic Stem Cell Donation, Galen E. Switzer, Jessica G. Bruce, et. al. Prepublished online December 20, 2012 at bloodjournal.hematologylibrary.org

Cross-Cultural Blood Beliefs

- Jehovah's Witnesses - believe that blood represents life and is, therefore, sacred. Most health care professionals value the life of the physical body. In refusing blood, the Jehovah's Witness is valuing the life of the soul over that of the physical body. Jehovah's Witnesses do not eat blood or accept transfusions of whole blood or its four major components namely, red blood cells, white blood cells, platelets (thrombocytes), and whole plasma. Social consequences: if an individual who is a member of a very tight knit conservative group of Jehovah's Witnesses accepts blood, the act might lead to rejection by his or her entire social network. In extreme cases, parents have abandoned their children after a child was given a court-ordered blood transfusion.

Cross-Cultural Blood Beliefs

- Islam - Consumption of food containing blood is forbidden by Islamic dietary laws. This is derived from the statement in the Qur'an, sura Al-Ma'ida (5:3): "Forbidden to you (for food) are: dead meat, blood, the flesh of swine, and that on which hath been invoked the name of other than Allah." Blood is considered as unclean and in Islam cleanliness is part of the faith, hence there are specific methods to obtain physical and ritual status of cleanliness once bleeding has occurred. Specific rules and prohibitions apply to menstruation, postnatal bleeding and irregular vaginal bleeding.

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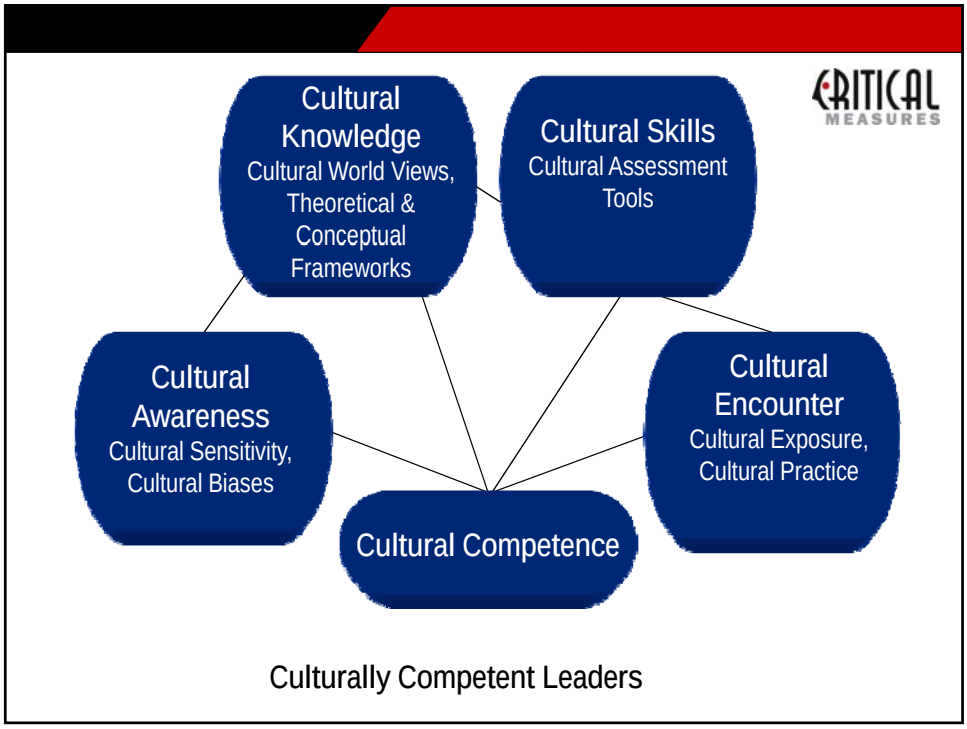
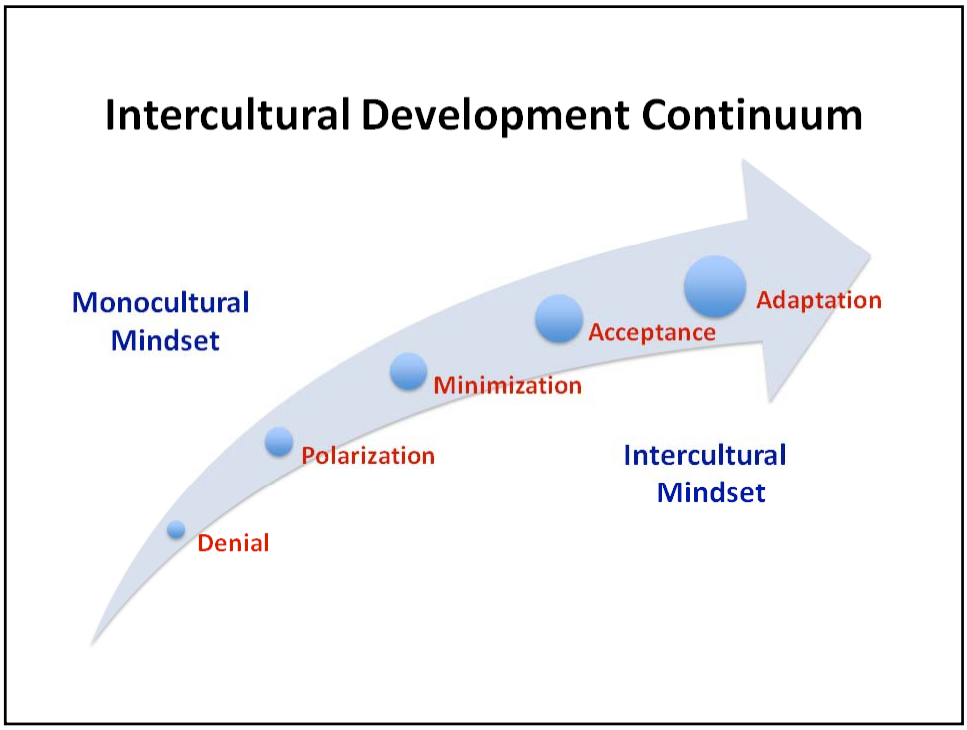
Cross-Cultural Blood Beliefs

- Judaism -There is nothing in Jewish law that would preclude a person from benefiting from a blood transfusion (or donating blood, for that matter).
- Furthermore, according to Jewish belief, saving a life is one of the most important mitzvot (commandments), overriding nearly all of the others. (The exceptions are murder, certain sexual offenses, and idol-worship—we cannot transgress these even to save a life.) Therefore, if a blood transfusion is deemed medically necessary, then it is not only permissible but obligatory.
- In Judaism, blood cannot be consumed even in the smallest quantity (Leviticus 3:17 and elsewhere); this is reflected in Jewish dietary laws (Kashrut). Blood is purged from meat by salting and soaking in water.

Cultural Competence – New Skills For Health Care Workers



Culturally Competent Leaders



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The Culturally Competent Healthcare Worker: Skills

- Culturally inquisitive, manages own biases
- Capable of perspective shifting
- Hires, retains, manages and mentors diverse workforce
- Trust building with diverse employees
- Cross-cultural communication
- Teambuilding
- Cross-cultural conflict resolution
- Issue-spots diversity-related employment matters that could create liability
- Masters the art of complaint handling

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