Improving Clinical Outcomes: Cultural Competency in Eye Care

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Disclosure Statement:
Nothing to disclose
• Different from typical clinical CE
• Be inquisitive
• Be self-reflective
• Be humble

Picture from: https://thisispublichealth.org/app/uploads/2015/02/TIPH.png
Objectives

- Increased self-awareness
- Increased receptivity to diverse patient populations
- Begin to recognize and question your assumptions, biases, and stereotypes
- Begin to pursue therapeutic alliances with patients

Gilbert, M.J. (2001)
My wake up call

- 62 year old Fijian (iTaukei) woman
Why start with ethnicity?

• What do you think when you hear “Fijian”?
• What does this tell us about the relationship between the patient and the optometrist?
• Patient-provider concordance?
Non-concordance

<table>
<thead>
<tr>
<th>Patient</th>
<th>Optometrist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>iTaukei</td>
<td>Caucasian/North American</td>
</tr>
<tr>
<td>Early 60s</td>
<td>Early 30s</td>
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<tr>
<td>Fijian speaking</td>
<td>English speaking</td>
</tr>
<tr>
<td>Limited education</td>
<td>Highly (Western) educated</td>
</tr>
<tr>
<td>Impoverished</td>
<td>(Relatively) High socioeconomic status</td>
</tr>
</tbody>
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Does any of the above matter? Clinically?
An example of cultural incompetence

- 58 year old Fijian woman
  - Red painful right eye x 1 day
  - Grandchild poked her in eye the previous evening
- POHx
  - Uses ready made spectacles for near work
  - No other previous eye or vision problems
- PMHx
  - DM x “9 years”
  - Bilateral below knee amputation (x 1 year)
Objective findings

- VA OD 20/40 OS 20/30
- Poor cooperation with slit lamp exam
- 1+ perilimbal injection OD
- Small corneal abrasion superior cornea OD with mild corneal edema (no infiltrate)
- No AC reaction
Assessment and Plan

- Corneal abrasion OD
- Chloramphenicol qid
- RTC 1 day
Day 2

- Patient reports no change
- Reports using drop as directed
- VA OD 20/50 OS 20/30
- No change in corneal abrasion, increased corneal edema, 1+ diffuse SPK
- Plan: Continue chloramphenicol qid, RTC 1 day
Day 3

- Patient reports no change, using drop as directed
- VA OD 20/80, OS 20/30
- Epithelium around corneal abrasion appears irregular, increased corneal edema, 2-3+ diffuse spk, 1+ cells in anterior chamber

- What did I miss? What would you do differently?
Lessons learned

• Poorly communicated treatment plan
• Poorly taken case history
• **Poor understanding of patient’s perspective on her illness and it’s treatment**
Cultural competency

• “The ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.”

Betancourt, JR., et al. (2002)
Why is cultural competence important when practicing in the US?

- Demographics
- Health disparities
- Quality
- Practice management

ASCO (2008)
Diversity in the United States

- By 2050, 54% of US residents will be of racial/ethnic minority groups
  - 34% in 2008
- By 2060 Asian alone population expected to increase by 128%
- Hispanic population expected to increase by 115% (becoming 29% of the population)
- More than 90 ethnic groups in the US
- 42 million foreign born individuals
  - 50% report speaking English less than ‘very well’

Chou, CF., et al. (2012); Colby, SL., Ortman, JM. (2015); Gambino, CP., et al. (2014)
Why cultural competence?

- Demographics
- Health disparities
- Quality
- Practice management

ASCO (2008)
Health disparities

- “The quantity that separates a group from a specified reference point on a particular measure of health that is expressed in terms of a rate, percentage, mean, or some other quantitative measure.”

Keppel, K., et al. (2005)
Disparities exist within

- Race/ethnicity
- Gender
- Socioeconomic status
- Spoken language
- Disability
- Geographic location
- Sexual orientation

Zhang, X., et al. (2013)
Racial/ethnic disparities

- Over 175 studies documenting racial/ethnic disparities in the US
- Both health and health care disparities
Health and health care disparities

• Health disparity
  – Greater incidence of health-related conditions within racial and ethnic groups

• Health care disparity
  – Differences in the preventative, diagnostic, and treatment services offered to people with similar health conditions

Kaiser Permanente (2009)
Health disparities

• Minority groups suffer disproportionately from:
  – Cardiovascular disease
  – Diabetes
  – Asthma
  – Cancer
  – and more

Health care disparities

- Utilization of cardiac diagnostic and therapeutic procedures
- Prescription for analgesia for pain control
- Surgical treatment of lung cancer
- Referral to renal transplantation
- Treatment of pneumonia and congestive heart failure

Eye health and vision disparities

• Prevalence of diabetic retinopathy higher among non-Hispanic blacks than among non-Hispanic whites
  – 50% of AA c.f 19% of whites (type 2, 40-69 yo)
  – Native Americans have higher rate of retinopathy c.f. whites
  – Hispanics with DM have 56% higher rate of eye problems c.f. whites
• Non-Hispanic whites have higher prevalence of cataract surgery than non-Hispanic blacks
• Non-Hispanic blacks have a higher prevalence of glaucoma
• White patients (with DM) are more likely to receive an eye exam followed by African Americans and then Hispanics

Eye health and vision disparities

• Increased rates of blindness and VI in minority groups
  – Poor minorities at greatest risk
• Less likely to use screening or eye care services
• Less likely to receive treatment once diagnosed
• Adolescents
  – Odds of VI greater non-Hispanic blacks (1.66), Hispanics (1.96), and “Other” (2.06)
    than non-Hispanic whites
    • Inadequate screening, poor access, lack of compliance, inadequate resources
• “Hispanics”
  – Lower utilization of eye care services
  – Heterogeneity within the Hispanic subgroup, however.

Racial/ethnic disparities

- Over 175 studies documenting racial/ethnic disparities in the US

- Why do these disparities exist?
  - SES?
  - Education?
  - High risk jobs?
  - Poor environment?
  - Health insurance?
Yes, but no!

• These are important social determinants of health, but…

• Even when controlling for SES, insurance, site of care, stage of disease, comorbidity, age, and other confounders racial/ethnic disparities remain

• Sociocultural factors play a role
Culture

• “Integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups.”

AAMC (2005)
Influence of culture

• Among the root causes of disparities are patients’
  – Health beliefs
  – Values
  – Preferences
  – Behaviors
  – Language

Health system level contributions

• Three major levels of health care at which sociocultural barriers occur:
  – Organizational
  – Structural
  – Clinical

Organizational barriers

• “Health care systems and structural processes of care are shaped by the leadership that designs them and the workforce that carries them out.”

Organizational barriers

- Comprised of
  - Institutional leadership
  - Health care workforce

- Availability and acceptability of health care for racial/ethnic minorities hinges on the degree to which the nation’s health care leadership and workforce reflect the racial/ethnic composition of the general population

Organizational barriers

• Lack of diversity results in structural policies, procedures, and delivery systems inappropriately designed or poorly suited to serve diverse patient populations

Examples of organizational barriers

- Limited clinical hours that don’t account for community work patterns
- Bureaucratic intake process
- Long waiting time to make appointments
- Long waiting times at the time of appointment

Health system level contributions

• Three major levels of health care at which sociocultural barriers occur:
  – Organizational
  – Structural
  – Clinical
Structural barriers

- Disparity occurs when patients are forced to obtain care from health systems that are complex, underfunded, bureaucratic, and archaic in design

Examples of structural barriers

- Lack of interpreter services
- Lack of culturally/linguistically appropriate health education materials
  - Associated with patient dissatisfaction, poor comprehension and compliance and **ineffective or lower quality care**

Health system level contributions

- Three major levels of health care at which sociocultural barriers occur:
  - Organizational
  - Structural
  - Clinical

Clinical barriers

• The interaction between provider and patient (or family)
• Occur when sociocultural differences are not fully accepted, appreciated, explored, or understood
• Patients may have different socioculturally-based health beliefs
  – Home remedies
  – Attitudes toward medical care
  – Levels of trust in doctors and the health care system

Cultural differences

• Include:
  – Variations in recognition of symptoms
  – Thresholds of seeking care
  – Ability to communicate with a provider who understands meaning
  – Ability to understand treatment plan
  – Expectations of care

• These influence both patient and provider decision-making

Cultural Competency

As a clinical activity
Addressing sociocultural barriers

• Sociocultural barriers, and, therefore, racial/ethnic disparities, can be addressed within a clinical encounter, by providing culturally competent care
Cultural competency

• “The ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.”

Betancourt, JR., et al. (2002)
Culturally competent provider

- Recognizes the importance of social and cultural influences on patients
- Understands and respect patients’ values, beliefs and expectations
- Is aware of their own assumptions and value systems (as well as those of the medical system)
- Is able to adapt care to be congruent with patient’s expectations and preferences.

Betancourt, JR., et al. (2002)
Developing cultural competency

• Is a process of growth
  – Will always be improving
• Cultural knowledge is not sufficient
  – Stereotyping
  – Changing cultures
• Must be attuned to cultural cues
• A clinical encounter should encompass attitudes and norms about sickness, clinical relationships and healing activities
  – Use this information to negotiate treatment plans
LEARN

- Listen with sympathy and understanding to the patient’s perception of the problem
- Explain your perceptions of the problem
- Acknowledge and discuss the differences and similarities
- Recommend treatment
- Negotiate agreement

Berlin, EA., Fowkes, WC. (1983)
Another case

- Common cultural difference
- 17 year old male of Russian origin
- CC: Constant distance blur OU x unknown onset
- LEE: First
Pertinent objective findings

• DX VA sc: 20/150+2  20/100-
• Pinhole: 20/40+220/40+2
• AR: -2.25-0.50×113
  -2.50-0.25×052
• MRx:    -2.25-0.25×100  20/20-2
         -2.25-0.25×060  20/20-2
• NRA: +2.75 net
• Ocular health unremarkable
Negotiation

• Health education completed with patient and parent understanding
• Rx printed and hand on doorknob
• “Please reduce the prescription. We don’t want to have the whole prescription.”

• Listen with sympathy and understanding to the patient’s perception of the problem
• Explain your perceptions of the problem
• Acknowledge and discuss the differences and similarities
• Recommend treatment
• Negotiate agreement
The four habits model

• 58 year old Fijian woman
  – Red painful right eye x 1 day
  – Grandchild poked her in eye the previous evening
The four habits model

• Invest in the beginning
• Elicit the patient's perspective
• Demonstrate empathy
• Invest in the end

The Permanente Medical Group (2011)
Case DS

• 48 year old, Hispanic male
• CC: Blurry vision at near
  – no glasses
  – increases font when noticing problems
• LEE: about 5-6 years ago
Case cont...

- DM diagnosed X 5-6 years
  - trying to control with diet
  - doesn't monitor blood sugar
  - doesn’t see physician with any regularity
  - can tell when blood sugar is not good because he feels sluggish
Diabetes advisor

• Patient’s wife advises him on how to control his condition
  – a Doctor of Eastern Medicine (?)

• States he has made significant improvement in the past two years
  – weight loss
  – notes patient has a high tolerance to medical problems
    • example: hit foot with sledge hammer
  – not willing to discuss any other aspects of current treatment plan or future goals
Fundus

- Mild NPDR
Case cont...

- At initial exam, patient refused referral to a primary care physician
- At spectacle dispense, patient refused to have any conversation about DM
Kleinman’s tool

- What do you call your problem?
- What name does it have?
- What do you think caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you?
- How does it work?
- How severe is it?
- Will it have a short or long course?
- What do you fear most about your disorder?
- What are the chief problems that your sickness has caused for you?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from the treatment?
Dear Negotiation,

I would like to raise a concern. I am writing on reducing our daily dose by half a pill. Of course, I assume you will not agree.

The need for this is quite apparent when it comes to our daily routine. I would like to suggest, at least at 25% of the dose, if at all possible, cutting the pill in half to ease the process. Alternatively, adjusting the dosage might be the best option.

Where you are referring to, please consider giving these to a pharmacist and cut by 1/4th. It will make it easier to use.

For Nebellar and Hypogonals:
1. Remove cylinder from meter using 2003. Place cylinder in holder (holder L.P.5026) while maintaining at least 200. If this is not possible, place the cylinder in a holder until further steps can be taken.
2. Remove Nebellar from meter.
3. Hypogonals: Place the hypogonals in a holder and use.

For Freshly prepared, duration can be longer as well.

Thank you for your support.

[Signature]
Why are we studying cultural competence?

- Disparities
- Demographics
- Quality
- Practice management

ASCO (2008)
Quality

- Cultural competency allows provider to collect necessary information to make timely and appropriate diagnoses and negotiate treatment plans which will more likely be followed
- It reduces delays in care-seeking
- Fosters compatibility with biomedicine and cultural health practices
Why are we studying cultural competence?

- Disparities
- Demographics
- Quality
- Practice management

ASCO (2008)
Practice management

- Competitive edge
- Decrease likelihood of malpractice
By another name

• Cultural humility
• Patient-centered care
Taking action
EYECARE

- Considering how cultural competency can address the three aspects of sociocultural barriers in our practices
- Evaluate
- Yield
- Explore
- Communicate
- Acknowledge
- Re-evaluate
- Execute

Jenkins, LB. (2005)
Evaluate

- Beliefs
- Biases
- Prejudices
- Assumptions

- Of ourselves (and our employees)!
- These are often formed from our cultural standpoint
- Want to avoid cultural imposition
  - Imposing our beliefs, values, and patterns on another culture

Jenkins, LB. (2005)
Yield

• To, and surrender all, preconceived prejudices and biases toward different cultures
• Set aside past experiences, learned behaviors, and stereotypes about different cultures
• Desire to be flexible and open must be present

Jenkins, LB. (2005)
Explore

- Cultural groups’ health-related beliefs
- Patients’ world views
- But be aware of intra-cultural variation

Jenkins, LB. (2005)
Communicate

• Assess patient’s linguistic needs and communication styles
• Translation?
  – Who is an appropriate translator?

Jenkins, LB. (2005)
Acknowledge

• That traditional western medicine and alternative medicines can coexist
• Provider bias can influence the interaction with the patient, and the way patients perceive care

Jenkins, LB. (2005)
Re-evaluate

• Current policies, procedures, vision statements, and mission statements to be more inclusive and respectful of all cultures

• An interaction of three cultures
  – Provider
  – Patient
  – Organization

Jenkins, LB. (2005)
Execute

• A proactive, culturally sensitive plan

Jenkins, LB. (2005)
Conclusion

• Every encounter is a cross-cultural encounter
• Must value diversity
• Must understand own biases
• Knowing facts about specific ethnic groups is insufficient to understand the individual patient
• Identify systemic or organizational barriers to access and use of services by our patients and be proactive within our practice environment to eliminate these barriers
The new golden rule

• Treat others as they wish to be treated
Questions?

• mattgpearce@gmail.com
References

- Chou, CF et al. (2012). Disparities in Eye Care Utilization Among the United States Adults With Visual Impairment: Findings From the Behavioral Risk Factor Surveillance System 2006-2009. AJO, 154(6), S45-S52
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