Disparities in Health Care Provision and Outcomes – Thinking Beyond Cultural Competence

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Outline

• Brief history of health disparities
• Disparities in adult neurogenic communication disorders outcomes
• Contributors to disparities in adult neurogenic communication disorders outcomes
• Exploring the role of cultural competence and diversity in SLP
• Novel strategies and considerations to reduce disparities in adult neurogenic disorders

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Objectives

• Participants will be able to describe the historical state of health disparities in the US.
• Participants will be able to describe the nature of disparities in adult neurogenic communication outcomes.
• Participants will be able to verbalize strategies to reduce disparities in adult neurogenic communication outcomes.

Race and Health Outcomes: Historical Perspectives and Implications for Aphasia Outcomes

• 2000 – Congress passed the Minority Health and Health Disparities Research and Education Act of 2000 (Public Law 106-525)
• Authorized the Institute of Medicine’s (IOM) landmark study “Unequal Treatment” documenting longstanding disparities in healthcare across a variety of settings and health conditions.
• The report also noted that racial minorities were far less likely to receive routine medical procedures, were more likely to experience lower quality healthcare services, but more likely to receive lower limb amputations and other less desirable treatment options for diabetes and other conditions.

Unequal Treatment:
Confronting Racial and Ethnic Disparities in Healthcare

• Disparities consistently found across a wide range of disease areas and clinical services
• Disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account
• Disparities are found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals, etc.
• Disparities in care are associated with higher mortality among minorities
Unequal Treatment

Race and Health Outcomes: Historical Perspectives and Implications for Aphasia Outcomes

• 2010 - Patient Protection and Affordable Care Act (PPACA) designed to reduce the nation’s continually rising healthcare costs by emphasizing coverage, costs, and care.

• PPACA also designed to reduce healthcare disparities by improving access to health care for all US citizens

10-year General Inflation vs Healthcare Inflation Rates

How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care

Key Highlights

• The ACA’s coverage expansions have led to historic reductions in racial disparities in access to healthcare since 2013 but progress has stalled. In some cases, ended since 2016.

• The gap between black and white adult uninsured rates dropped by 1 percentage point, with the difference between Hispanic and white uninsured rates dropping by 4 percentage points.

• Disparities remained in both states that expanded Medicaid eligibility and in those that did not. In expansion states, all three groups had better overall access to care than they did in nonexpansion states, and there were generally smaller differences between whites and the four minority groups.

• Five years after the ACA’s implementation, black adults living in states that expanded Medicaid saw coverage rates and access to care improve somewhat on average as compared to what white adults in nonexpansion states did.

• White adults living in states that expanded Medicaid had benefited significantly from the health insurance expansion, they disproportionately helped reduce the 19 states that had expanded their programs.

Disparities are Not New
Disparities in Aphasia

Aphasia Outcomes

• Aphasia is a communication disorder resulting from an impairment of language, affecting the production or comprehension of speech and the ability to read or write. Aphasia is always due to injury to the brain-most commonly from a stroke, particularly in older individuals. But brain injuries resulting in aphasia may also arise from head trauma, from brain tumors, or from infections.

• There is believe to be ~2,500,000 people in the US living with aphasia
  • Aphasia in North America (2010)

What is the impact of aphasia?

• “Life satisfaction is a global assessment of a person's quality of life according to his chosen criteria (Shin & Johnson, 1978, p. 478).”
• “Understanding life satisfaction among PWA is important as it reflects the individual's response to this life changing communication disorder.”
• “Life satisfaction is not a stable construct. Even in the absence of a life changing event such as the onset of aphasia, life satisfaction is not unwavering.”
• “Aphasia is a communication disability contributes to reduced life participation...resulting in reduced life satisfaction.”
• “Factors that influence life satisfaction among PWA include:
  • Post-stroke depression
  • Post-stroke declining health
  • Changes in social support post-stroke.”

How common is aphasia?

How Costly is Aphasia?

Disparity Factor 1 – Race/Ethnicity
Race and Aphasia Clinical Outcomes

Race and Aphasia Clinical Outcomes

Race and Aphasia Clinical Outcomes

Race and Service Utilization

The Impact of Rural Residence in America

- Many rural residents are self-employed or engage in jobs that do not provide health insurance, leaving them with no access to regular healthcare.
- Life expectancy is lower in rural counties due to an inadequate number of healthcare providers.
- Healthcare delivery in rural areas is influenced by population density, the remoteness of these communities and regional cultural norms.
- Unique characteristics of rural communities can translate into rural-urban differences in health, disease, and disease-related outcomes

Rural Residence in NC: Implications for Speech-Language Pathology

- 88 of 100 counties in NC are rural
- Rural SLP service providers are limited due to high vacancy rates, high turnover rates and long delays in hiring SLPs in rural areas.
- NC has five SLP clinical training programs but SLPs tend to largely reside and provide care in urban areas.

Urban-Rural Differences in Service Utilization and Costs of Care for Racial-Ethnic Groups Hospitalized with Post-Stroke Aphasia

- Objective: To use discharge data from hospital discharge data to examine the influence of patient residence (rural vs. urban) and care efficacy on service utilization and cost of care among PWA.
- Participants: Individuals with post-stroke aphasia
- Main Outcomes Measures: Length of stay, speech-language pathology service utilization, costs of care
- Methods: 2011-2012 Medicare Cost and Utilization Project (HCUP) Discharge Database (DB) data were analyzed to examine the impact of rural/urban residence on lengths of stay (LOS), speech-language pathology (SLP) service utilization, and costs of care among White and Hispanic PWA (Rural or Non-Rural, Urban or Non-Urban).
- Results: Both rural and urban White PWA experienced longer stays when controlling for demographics, illness severity, and the hospital where they received care. Rural Whites experienced longer LOS, required greater SLP services, and incurred higher costs than urban Whites, and Whites across all residential groups incurred greater costs, but LOS was attenuated when controlling for hospital site. These differences were attenuated when controlling for the hospital where they received care.
- Conclusions: For PWA, rural residence has a larger impact on average total medical costs, SLP service utilization, and LOS than residence in urban areas. This is likely due to higher costs associated with rural hospital settings and service in rural care, yet rural SLP reimbursement is lower. Future studies are required to explore potential factors such as quality of care.

Step 1 – Understand there is no easy solution

Addressing Disparities in the Field of SLP

The JAMA Network

AND THERE ARE CONFLICTS IN GOALS, OBJECTIVES AND BELIEFS/ATTITUDES

Medicine’s Triangle of Conflicting Expectations

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Step 2 – Understand we must think beyond culture competence

Improving Cultural Competence to Reduce Health Disparities for Priority Populations

- A lack of conceptual clarity around cultural competence persists in the field and the research community. There is confusion about what cultural competence means, and different ways in which it is conceptualized and operationalized. This confusion leads to disagreement regarding the topic areas and practices in which a provider should train to attain cultural competence. The populations to which the term cultural competence applies are also ill-defined. Cultural competence is often seen as encompassing only racial and ethnic differences, omitting other marginalized population groups who are ethnically and racially similar to a provider but who are at risk for stigmatization or discrimination, are different in other identities, or have differences in healthcare needs that result in health disparities.

Improving Cultural Competence to Reduce Health Disparities for Priority Populations

- The most popular and most well studied type of cultural competence intervention is cultural competency training for healthcare providers. Two general approaches have been used in creating educational interventions to address cultural competence: programs aimed at improving knowledge that is group-specific, and programs that apply generic or universal models. Concerns have been raised about cultural competency programs that use a group-specific approach to teach providers about the attitudes, values, and beliefs of a specific cultural group leading to stereotyping and oversimplifying the diversity within a particular priority group. The universal approach to training proposes that cultural competence can be taught through reflective awareness, empathy, active listening techniques, and the cognitive mechanisms contributing to cultural insensitivity or blindness, such as implicit biases or stereotype threat. Therefore, of interest is identifying the effect of varying types of cultural competence training on patient-level outcomes.

Improve Cultural Competence To Reduce Health Disparities (AHQ 2016)

- Objective: To examine existing system-, clinic-, provider-, and individual-level interventions to improve culturally appropriate health care for people with disabilities; lesbian, gay, bisexual, and transgender (LGBT) populations; and racial/ethnic minority populations.

- Methods: Ovid MEDLINE®, PsycINFO®, Ovid Embase®, and the Cochrane SPIC (Effective Practice and Organisation of Care) register; hand searches of references of relevant studies.

- Results: Over 37,000 unpublished English language citations were reviewed; 54 unique studies were identified as of June 2015; 29 randomized controlled trials (RCTs) and 5 observational studies for individuals with disabilities; 19 RCTs (6 manuscripts) and 3 observational studies for LGBT populations; and 34 RCTs (13 manuscripts), 4 observational studies, and 2 systematic reviews for members of racial and ethnic minorities. Interventions fell into four broad categories: (1) provider trainings and education; (2) interventions promoting attention to an established protocol or the delivery of an established protocol to meet the needs of a target population; (3) modification of clinic structure to improve the comfort and accessibility of healthcare for minority populations; and (4) interventions aimed at providing culturally competent care at the point of service.

- Conclusion: Educational programs and trainings to improve professional students’ and providers’ cultural competence behavior are the most prevalent type of cultural competence intervention.
Improving Cultural Competence to Reduce Health Disparities (AHRQ 2016)

- Conclusions
- None of the included studies measured the effect of cultural competence interventions on health care disparities.
- Most of the training interventions measured changes in professional attitudes toward the population of interest but did not measure the downstream effect of changing provider beliefs on the care delivered to patients. Interventions that altered existing protocols empowered patients to interact with the formal health care system, or prompted provider behavior at the point of care were more likely to measure patient-centered outcomes. The medium or high risk of bias of the included studies, the heterogeneity of populations, and the lack of measurement consensus prohibited pooling estimates of commenting about efficacy in a meaningful or interpretable way. The term “cultural competence” is not well defined.
- Many studies used a single-source approach to assessing cultural competence, which included patient-provider interaction. However, patient-centered or individualized care. There are many gaps in the literature; many large subpopulations are not represented.

Available at: https://effectivehealthcare.ahrq.gov/default.aspx

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ASHA-Cultural Competence

- Developing cultural competence is a dynamic and complex process requiring ongoing self-assessment and continuous expansion of one’s cultural knowledge. It evolves over time, beginning with an understanding of one’s own culture, continuing through interactions with individuals from various cultures, and extending through one’s own lifelong learning.
- Clinical approaches—such as interview style, assessment tools, and therapeutic techniques—that are appropriate for one individual may not be appropriate for another. It is important to recognize that the unique influence of an individual’s cultural and linguistic background may change over time and according to circumstance (e.g., interactions in the workplace, with authority figures, within a social context), necessitating adjustments in clinical approaches.

Available at: https://www.asha.org/PRP SpecificTopic.aspx?folderid=8589935230&section=Overview

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ASHA-Cultural Competence

- Developing cultural competence is an ongoing process. It involves self-awareness and cultural humility, and it may require audioscripts and TLPs to recognize what they do not know about the languages and cultures of the individuals, families, and communities they serve. As a result, they may seek out culture-specific knowledge and experience in these areas. The culturally competent clinician has the ability to:
  - simultaneously appreciate cultural patterns and individual variation;
  - engage in cultural self-awareness to assess cultural biases and improve self-awareness;
  - utilize evidence-based practice to include client/patient/family characteristics, clinician expertise, and empirical evidence in clinical decisions;
  - understand the communication contexts and needs of clients/patients and their families by considering communication disorders within a social context (Kohnert, 2008).
- Developing cultural competence includes:
  - self-assessment, including a review of the clinician’s personal history, values, beliefs, and biases;
  - an understanding of how these factors might influence perceptions of communication abilities and patterns; and
  - an understanding of how personal perceptions might influence interactions and service delivery to a variety of clients/patients/families.

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Step 3 – Understand the complexity of issues beyond cultural competence

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Cultural Competence

- Understanding upstream effects
- Understanding how families, social networks and other support impact outcomes (positively and negatively)
- Understanding the reality of evidence-based practice and the impact on clinical outcomes

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Towards an Understanding of Racial Differences in Post-stroke Disability

Stroke-related “upstream factors” associated with racial differences in stroke outcomes that potentially influence aphasia outcomes

The Impact of Belief and Attitudes about Healthcare use

It’s not always cost of care
• Social networks, or the structure and “connectedness” of interpersonal relationships associated with an individual, are known to influence neurological outcomes for conditions such as stroke.
  - Evidence from animal research has shown that social environments are critical to recovery from ischemic stroke.
  - Social networks change frequently after stroke leaving PWA in isolation and feeling disconnected from society due to a combination of communication issues and general disability.
  - Friendships existing at the onset of stroke and aphasia are critical to the lives and recovery of PWA

Evidence-Based Practice and Aphasia

Commonly Utilized “Disconnected” Approach

Revised Approach Bringing Together Four Key Elements

Conclusions

• Disparities in speech-language-cognitive outcomes are multidimensional
  - Patient/family
  - Providers
  - Systems
• Cultural competence is just one aspect of complex plan that will be needed to reduce disparities in speech-language cognitive outcomes
• Systematic and programmatic research related to disparities is urgently needed to identify the best strategies to reduce the disparity gap
Conclusions

• There are no simple solutions

If we knew what it was we were doing, it would not be called research, would it?

(Albert Einstein)

Works Cited


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Works Cited-cont.