Accommodating the Many Facets of Difference: Patient Assessments of Providers' Sensitivity to Culture and Other Factors Impacting the Quality of Clinical Services in a Large, Diverse Medicaid Health Plan

Accreditation of Medi-Cal, Healthy Kids and Healthy Families Program.

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Presenter Disclosures

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(1) The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

I am employed as a Senior Biostatistician at L.A. Care Health Plan – the Local Initiative Health Authority of Los Angeles County, California.

L.A. Care is a public entity competing with commercial insurers in the Medicaid and S-CHIP markets in L.A. County.

Notes:
CAHPS® is a registered trade name of the Agency for Healthcare Research and Quality (AHRQ).
HEDIS® is a registered trade name of the National Committee for Quality Assurance (NCQA).

Outline

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I. Learning Objectives

1. Describe patient-reported prevalence of cultural insensitivity among urban Medicaid providers and staff.

   "How big is the problem of cultural insensitivity?"

2. Contrast the prevalence of cultural sensitivity problems for adults versus pediatric patients.

   "What category of patients notices the problem most?"

3. Assess impact of cultural sensitivity problems on patient ratings of the quality of ambulatory care and services.

   "Does the problem impact the quality of health care and services?"

4. Discuss the comparative rank of cultural sensitivity versus other categories of difference (age, gender, disability, income, etc.) that impact doctor/patient communication.

   "Which differences most commonly concern patients?"

II. Background – L.A. Care Health Plan

Large, diverse membership in Los Angeles, California:

- Mostly Medicaid, urban, 2/3rd pediatric, often Spanish-speaking.
- Roughly 21% of Medicaid managed care population in California.
- Roughly 2.1% of Medicaid managed care population in the U.S.
- Roughly 1-in-14 L.A. County residents is an L.A. Care member.
- Mostly Medicaid, some S-CHIP, SNP, and special programs.
- Serves 10 distinct language concentrations ("threshold languages"): Spanish, English, Armenian, Korean, Cambodian, Chinese, Russian, Vietnamese, Farsi, Tagalog.
- Mostly urban and suburban; 1 semi-rural region in the high desert.

III. Defining Cultural Competence

- No universal definition. Kaiser Family Foundation (2003)
- Most definitions focus on the necessity of the provider recognizing differences and adapting the care accordingly. Johnson *et al* (2004)
- "Cultural competency is the ability to interact successfully with patients from various ethnic and/or cultural groups." CVAHEC (2007)
- "'**Cultural competence'** is the demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. But perhaps the most significant aspect of this concept is the inclusion and integration of the three areas that are usually considered separately when they are considered at all." (Lavizzo-Mourey and Mackenzie, 1996, cited in Kaiser Family Foundation 2003)
- "Cultural competence in health care describes 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 *et al* (2002)
- The study in this paper seeks patient ratings of doctors' need for awareness on 12 dimensions identifying key demographic differences.

IV. Design – Using CAHPS Health Plan Survey for Analysis of Diversity and Access Issues

- Cultural competence as a component in health care quality has an active and growing body of literature, but is often conceptual and indirect:
  - Inferring causation from *disparities in outcomes*, and *discordance* (demographic differences between patients and their doctors).

- Direct objective evidence of disparate service would be ideal.
  - Using subjective patient perceptions as a fallback to indicate effect.
  - Using impact on patient adherence as a mixed indicator of harm.

- Using member assessments on annual CAHPS survey to measure doctors' and clinic staffs' cultural competence:
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS).
  - Supplemental question asking whether providers and clinic staff need training on how to work with patients of difference cultures, races, ages, genders, etc.
  - Added from 2008 to 2011 and pooled over time.

IV. L.A. Care Question Added to CAHPS: Sensitivity to Differences

56/82p. Doctors and staff can be trained to understand differences that people have, when working with patients of a different race or gender, or when working with old or young patients, etc.

Does anyone at the clinic -- your personal doctor, or the nurses, or the office staff -- need any of the following types of training to improve the treatment and service that [you receive/your child receives]? *(Check all that apply.)*

Adult	Child	Responses – pooled from 2006-2011
53.2%	35.7%	overall --My doctor and the clinic staff do not need any of these types of training.
46.8%	**64.3%**	**Those who reported diversity training needs among their providers:**
32.5%	41.3%	(a) Training on how to work with people of a different race.
27.9%	32.9%	(b) Training on how to work with people from a different culture.
55.8%	51.6%	(c) Training on customer service. (Added for contrast as a construct validity check.)
19.2%	14.2%	(d) Training on how to work with women.
6.3%	5.5%	(e) Training on how to work with men.
24.0%	17.6%	(f) Training on how to work with older people.
25.5%	34.3%	(g) Training on how to work with young children.
22.8%	22.0%	(h) Training on how to work with people with physical disabilities.
23.6%	22.5%	(i) Training on how to work with people with learning disabilities.
17.0%	12.5%	(j) Training on how to work with people of different sexual orientations.
33.5%	32.8%	(k) Training on how to work with people who have limited income.
7.5%	6.9%	(l) Training on how to work with people of different religions or beliefs.
12.3%	11.9%	(m) Other training (Please specify): _____.

V. Results: Correlation Among Facets of Sensitivity -- Adults

- Diversity categories are well-correlated but distinct. Race is most distinct.
- Four likely clusters: race/culture, gender, disabilities, and age.
- Sexual orientation appears most often with other facets of diversity.

Category of difference needing training: A non-diversity topic -- "customer service" -- is included for comparison/control.

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)
(a) Race		**0.651**	0.430	0.489	0.424	0.443	0.441	0.411	0.418	0.409	0.470	0.276
(b) Culture			0.432	0.562	0.518	0.567	0.488	0.505	0.527	0.518	0.472	0.465
(c) Customer service				0.421	0.395	0.400	0.423	0.362	0.366	0.382	0.423	0.293
(d) Women					**0.738**	**0.624**	0.583	0.574	0.575	**0.647**	0.501	0.511
(e) Men						**0.638**	**0.607**	0.562	**0.610**	**0.652**	0.429	0.506
(f) Older people							**0.613**	**0.643**	**0.643**	**0.602**	0.505	0.558
(g) Young children								**0.601**	**0.600**	0.569	0.482	0.448
(h) Physical disabilities									**0.741**	**0.657**	0.481	0.504
(i) Learning disabilities										**0.676**	0.527	0.514
(j) Sexual orientation											0.528	0.587
(k) Limited income												0.425
(l) Religion/beliefs												

(Weak is good.)

These correlations cohere, yet exhibit logical distinctions, suggesting that members understand and differentiate meaningfully among these categories.

Areas of difference are binary data (0,1) tested for correlation using Pearson's r. Most are correlated at p<0.0001, aided by large sample size.
J. Cohen (1988) suggested interpreting correlations as "large" (>=0.500), "medium" (>=0.300) and "small" (<0.100).
Given the high degree of correlation, the following tiers are coded: **bold** (>=0.600), plain (>=0.400) , gray (<0.400).

Similar (Higher) Correlation Among Facets of Sensitivity for Parents

- Diversity categories are well-correlated but distinct. Race is most distinct.
- Four likely clusters: race/culture, gender, disabilities, age, religion.
- Sexual orientation appears most often with other facets of diversity.

Category of difference needing training: A non-diversity topic -- "customer service" -- is included for comparison/control.

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)
(a) Race		**0.650**	0.399	0.429	0.410	0.428	0.457	0.429	0.422	0.379	0.463	0.382
(b) Culture			0.409	0.537	0.512	0.525	0.492	0.512	0.501	0.484	0.520	0.501
(c) Customer service				0.419	0.390	0.380	0.434	0.390	0.360	0.339	0.404	0.359
(d) Women					**0.864**	**0.679**	0.516	**0.621**	**0.609**	**0.654**	0.509	**0.627**
(e) Men						**0.751**	0.525	**0.635**	**0.627**	**0.693**	0.522	0.658
(f) Older people							0.530	**0.700**	**0.664**	**0.684**	0.516	0.658
(g) Young children								0.567	0.534	0.504	0.510	0.518
(h) Physical disabilities									**0.748**	**0.676**	0.524	**0.661**
(i) Learning disabilities										**0.694**	**0.540**	**0.632**
(j) Sexual orientation											0.515	**0.726**
(k) Limited income												0.564
(l) Religion/beliefs												

(Weak is good.)

No strong confusion of diversity training with general customer service .

Areas of difference are binary data (0,1) tested for correlation using Pearson's r. All are correlated at p<0.0001, aided by large sample size.
J. Cohen (1988) suggested interpreting correlations as "large" (>=0.500), "medium" (>=0.300) and "small" (<0.100).
Given the high degree of correlation, the following tiers are coded: **bold** (>=0.600), plain (>=0.400) , gray (<0.400).

Correlation of Diversity Measures with Health Plan Ratings -- Adults

- Provider communication (respect, listening, spending time, etc.) had the strongest correlation with perceiving need sensitivity training for providers.
- Insensitivity on race, culture, income and women lower the ratings most.

Category needing training:	Rating of Health Plan QA35	Rating of Health Care QA12	Rating of Doctor QA21	Doctor communication (index)
(a) Race	-0.086***	-0.102***	-0.134***	**-0.160*** **
(b) Culture	-0.058	-0.104***	-0.132***	**-0.175*** **
(c) Customer service	-0.144***	-0.208***	-0.174***	-0.235***
(d) Women	-0.052	-0.084*	-0.115***	-0.104**
(e) Men	0.026	-0.007	0.017	-0.001
(f) Older people	-0.037	-0.039	-0.034	-0.073
(g) Young children	-0.016	-0.062	-0.081*	-0.055
(h) Physical disabilities	-0.019	-0.035	-0.033	-0.048
(i) Learning disabilities	-0.016	-0.017	-0.017	-0.028
(j) Sexual orientation	-0.012	-0.002	-0.055	-0.033
(k) Limited income	-0.115***	-0.131***	-0.111***	-0.144***
(l) Religion/beliefs	-0.016	0.008	0.009	-0.035

Customer service is moderately correlated as expected.

Diversity training offers slight gains in accreditation scores among adult members.

Areas of difference are binary data (0,1) tested for correlation using Pearson's r.

Given the low degree of correlation, the following tiers are coded: as absolute values of: **bold** (<=0.015), plain (>0.015<=0.100) , gray (>0.100).

Using a Bonferroni correction for 16 comparisons, significance is denoted as follows: * for p=0.05, ** for p=0.01, and *** for p=0.001.

Correlation of Diversity Measures with Health Plan Ratings – Parents

- Parents focused on skills with children, and on customer service.
- Correlations were less strong for parents of children in Medicaid.
- Insensitivity on race, culture, and income remained as themes.

Category needing training:	Rating of Health Plan QC54	Rating of Health Care QC13	Rating of Doctor QC39	Doctor communication (index)
(a) Race	-0.100***	-0.110***	-0.101***	-0.127***
(b) Culture	-0.082***	-0.077**	-0.067*	-0.091***
(c) Customer service	-0.126***	**-0.179*** **	**-0.153*** **	**-0.184*** **
(d) Women	-0.050	-0.068*	-0.024	-0.051
(e) Men	-0.009	-0.032	-0.014	-0.034
(f) Older people	-0.032	0.034	-0.011	-0.041
(g) Young children	-0.088***	-0.133***	-0.102***	**-0.164*** **
(h) Physical disabilities	-0.045	-0.031	-0.017	-0.066
(i) Learning disabilities	-0.041	-0.031	-0.015	-0.059
(j) Sexual orientation	-0.032	-0.025	-0.019	-0.036
(k) Limited income	-0.090***	-0.077***	-0.079***	-0.095***
(l) Religion/beliefs	-0.038	-0.035	-0.011	-0.042

Customer service is moderately correlated as expected.

Diversity training offers less gain among parents / children – but training doctors on working with children has some payoff.

Areas of difference are binary data (0,1) tested for correlation using Pearson's r. Most are correlated at p<0.0001, aided by large sample size. Given the low degree of correlation, the following tiers are coded: as absolute values of: **bold** (<=0.015), plain (>0.015<=0.100) , gray (>0.100).

VI. Poor Diversity Skills Lower Performance Measures that Health Plan Administrators Care About – (Adults)

Hypothesis: Patients' perceptions about their doctors' needing diversity training are *inversely* related to the ratings that patients give on services:

- CAHPS ratings are used in annual accreditation of health plans, and are published in comparisons of health plans' performance for prospective members. Tying to these ratings may help cultural and linguistic programs inform resource-allocation decisions.

We created a *cultural competence index* (race, culture, religion[a]), and found significant associations between training needs and lower CAHPS ratings:

- Health Plan Rating (QA35): significant (X^{**2}_{CMH} 16.4362 at p<.0001, reject BDT p=0.5243).[b]
- All Health Care Rating (QA12): significant (X^{**2}_{CMH} 18.0378 at p<.0001, reject BDT p=0.5582).
- Rating Doctor (QA21): signif. (X^{**2}_{CMH} 37.7752 at p<.0001, *accept BDT p=0.0435* – not anomalous).[c]

We created a *customer competence index* for the other 9 facets of diversity:

- Health Plan Rating: significant (X^{**2}_{CMH} 51.8497 at p<.0001, reject BDT p=0.6075).
- All Health Care Rating: significant (X^{**2}_{CMH} 68.6840 at p<.0001, reject BDT p=0.9005).
- Rating of Doctor: significant (X^{**2}_{CMH} 73.6976 at p<.0001, reject BDT p=0.5470).

[a] L.A. Care Health Plan has a diverse membership tied to Latin America, Asia, the Middle East, and other regions, including populations which culture and religion interact with U.S. healthcare practices and laws.
[b] Testing whether deficiencies in diversity skills are associated with lower scores in health plan ratings: Using Cochran-Mantel-Haenszel (CMH at p<=0.05), to control for any effects of pooling survey years, and Breslow-Day test (p>0.05) for homogeneity of odds ratios across survey years.
[c] Wherever Breslow-Day yielded p<=0.05, each stratum (year) was examined for reversed relationships or a single year driving the pooled score.

VI. Sensitivity Training Gaps Lower Performance Measures that Health Plan Administrators Care About – (Parents)

Hypothesis: Patients' perceptions about their doctors' needing diversity training are *inversely* related to the ratings that patients give on services:

- In Medicaid, CAHPS ratings are sometimes used by External Quality Review Organizations (EQROs) to advise state agencies on improvements needed by health plans. In Medicare, CAHPS ratings can affect compensation.

We created a *cultural competence index* (race, culture, religion[a]), and found significant associations between training needs and lower CAHPS ratings:

- Health Plan Rating (QC54): significant (X^{**2}_{CMH} 38.3849 at p<.0001, reject BDT p=0.3562).[b]
- All Health Care Rating (QC13): significant (X^{**2}_{CMH} 29.4374 at p<.0001, reject BDT p=0.1092).
- Rating Doctor (QC39): significant (X^{**2}_{CMH} 28.5707at p<.0001, accept BDT p=0.6575, some instability).[c]

We created a *customer competence index* from the other 9 facets of diversity:

- Health Plan Rating: significant (X^{**2}_{CMH} 86.2098 at p<.0001, reject BDT p=0.9450).
- All Health Care Rating: significant (X^{**2}_{CMH} 105.1266 at p<.0001, reject BDT p=0.0807).
- Rating of Doctor: significant (X^{**2}_{CMH} 131.4346 at p<.0001, reject BDT p=0.5977).

[a] L.A. Care Health Plan has a diverse membership tied to Latin America, Asia, the Middle East, and other regions, including populations which culture and religion interact with U.S. healthcare practices and laws.
[b] Testing whether deficiencies in diversity skills are associated with lower scores in health plan ratings: Using Cochran-Mantel-Haenszel (CMH at p<=0.05), to control for any effects of pooling survey years, and Breslow-Day test (p>0.05) for homogeneity of odds ratios across survey years.
[c] Wherever Breslow-Day yielded p<=0.05, each stratum (year) was examined for reversed relationships or a single year driving the pooled score.

VII. Recap of Learning Objectives

1. Describe patient-reported prevalence of cultural or racial insensitivity among urban Medicaid providers and staff.
   - **Many adults (28%) and parents (33%) reported need for cultural sensitivity training for doctors and staff, *but most did not.***
   - **Many adults (33%) and parents (41%) reported need for racial sensitivity training.**
   - For comparison, note that customer service dominated the training needs reported by adults (56%) and parents (52%).
   - If patients are reluctant or unsure how to phrase criticisms, surveys can undercount:
     - Hence we surveyed numerous proxies (communication, discourtesy, disrespect, etc.) through which patients can convey diversity concerns.
     - Many adults (47%) and parents (64%) noted 1+ subjects on which providers and staff need sensitivity or diversity training.
2. Contrast the prevalence of cultural sensitivity problems for adults versus pediatric patients.
   - Parents were more likely to report the need for cultural sensitivity training, and the need for racial sensitivity training of doctors and clinic staffs.
   - In the 12 diversity-related dimensions surveyed, *adults (9 items) were more likely than parents (3 items) to note diversity-training needs for their doctors and staffs.*

Recap of Learning Objectives, Cont.

3. Assess impact of cultural sensitivity problems on patients' ratings of the quality of ambulatory care and services.
   - Analysis showed evidence that **diversity barriers are associated with negative scores on member ratings of health plan services.**
4. Discuss the comparative rank of cultural sensitivity versus other categories of difference (age, gender, disability, income, etc.) that impact doctor/patient communication.
   - Adult Medicaid members were slightly more likely to report doctors'/staffs' need for sensitivity training for *working with people of limited income*, than training on *cultural sensitivity or racial sensitivity* – but all three topics were in the upper tier of training needs.
   - **Parents of children on Medicaid were most likely to report the need for racial sensitivity training for doctors/staffs.** Sensitivity in *working with young children* was the second most common need mentioned, followed by cultural sensitivity training, and trailed closely by training on *working with people with limited income*.

VIII. Actionability – Opportunities Going Forward

In the budgetary climate facing Medicaid plans, piggyback diversity-related content onto processes and activities that will occur anyway:

1. Briefing member feedback from CAHPS in staff meetings.
2. Add questions to CAHPS re. culture, language & health promotion.
3. Attach detailed language and ethnicity codes to CAHPS data for analysis.
4. Include CAHPS content in periodic Group Needs Assessments.

Language barriers may compound problems on various dimensions of diversity:

5. Cultural sensitivity is a required component in CME provider education programs. L.A. Care website offers online CME with a financial incentive.
6. Place interpreter access questions into a large-sample survey for a pay-for-performance (P4P) program. Seeking to report results at medical group level.
7. Providing telephonic interpreters at no cost: Trained clinic staff how to use. Promoted via articles in provider newsletters; language access cards for patients.

Use provider network training programs as venue for conveying diversity training:

8. Use member surveys as foundation for customer service training program.
   - Target front line clinic staff, office managers, and doctors.
9. Identify members' issues for gap analysis, and to tailor the training program.
10. Use member ratings to measure service quality for program evaluation.

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Related briefings:

Thinking CAHPS: Using patient surveys to correlate providers' cultural competence with patients' health literacy, 2008-2011. APHA 10/30/2011, Session 2073.0 Medical Care (Primary Care) Poster Session #2 – Cultural Competence and Health Literacy.

Online discussion on using CAHPS to improve quality of service:

http://groups.yahoo.com/group/member_satisfaction
member_satisfaction-subscribe@yahoogroups.com