Thinking CAHPS: Using Patient Surveys to Correlate Providers' Cultural Competence With Patients' Health Literacy, 2008-2011

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

Session: **2073.0, Medical Care Section Poster Session #2**
Section: **Medical Care – Primary Care**
Topic: **Cultural Competence and Health Literacy**

October 30, 2011

Earl Leonard, M.S.
S. Rae Starr, M.Phil, M.OrgBehav.
Healthcare Outcomes & Analysis

Nai Kasick, MPH, CHES
Lenna Monte, MPH, CHES
Health Education, Cultural and Linguistic Services

Leticia Segura, MHA
Gwen Cathey
Provider Network Operations
L.A. Care Health Plan

L.A. Care HEALTH PLAN

Presenter Disclosures

S. Rae Starr

L.A. Care HEALTH PLAN

(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

I. Learning Objectives.

II. Background on L.A. Care Health Plan and CAHPS.

III. Defining Cultural Competence.

IV. Design: Measuring Doctors' Cultural Competence and Patients' Health Literacy on Annual CAHPS Surveys.

V. Analysis: Provider Cultural Sensitivity & Patient Health Literacy.

VI. Recap of Learning Objectives.

VII. Actionability: Opportunities Going Forward.

Contact Information. Sharing Knowledge on Quality Improvement.

I. Learning Objectives

1. Describe the proportion of patients who report that their doctors need cultural competency training.
2. Evaluate the association of providers' cultural competence and patients' health literacy and adherence to guidelines on seeking well-care.
3. Assess whether that association differs by patient age -- particularly for adult patients versus pediatric patients.
4. Assess whether that association differs by patient gender.
5. Describe how often cultural sensitivity issues arise in patients' own words on surveys in verbatim suggestions on how to improve health care.

.

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

There is no universal definition (Kaiser Family Foundation, 2003):

- "'**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)

There are more detailed definitions, but the following have an applied focus:

- 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)

IV. Design: Measuring Doctors' Cultural Competence and Patients' Health Literacy

- Independent variable: Assessing doctors' and clinic staffs' need for cultural sensitivity training as perceived by patients.
  - For thorough capture of the construct ("culture"), we included patients into the cohort who identified any of three kinds of sensitivity training needs: (a) Cultural; (b) racial; and (c) sensitivity regarding religion/beliefs.
- Dependent variable: Assessing patients' health literacy through self-reported reasons for not getting routine well-care checkups.
  - Setting a minimal and deliberately easy-to-attain bar for health literacy:
    - Awareness of the reasons for routine care and checkups.
    - Awareness of the risks and tradeoffs in not getting age-appropriate care, tests, treatments and screenings that either occur as part of well-care.
  - 3 levels of literacy reflected in reasons for missing routine care:
    - Intrinsic barriers reflect the *weakest reasons for missing routine care.*
    - Mixed reasons *potentially* reflect legitimate temporary tradeoffs.
    - Extrinsic reasons reflect *legitimate temporary tradeoffs against health risks.*
- Using case-level data to test for association.
- Pooling data over time (2008 to 2011) to improve statistical power.

Inferring Causality

- Inferring causality – two rival explanations:
  - *Patient as actor:* Patients may have poor health literacy and may therefore place low value on well-care.
  - *Doctor as actor:* The patient-centered medical care movement stresses the responsibility of the provider to engage patients in actively getting needed care.

  A positive association between provider cultural competence and patient health literacy implies that one of two models must be true:
    - *Patient-centered care (maintained hypothesis):* Culturally-competent doctors are more effective in engaging patients in adhering to clinical advice regarding well-care, or attracting adherent patients.
    - *Apathy (rival hypothesis):* Patients with low interest in well-care could be staying with providers who are culturally incompetent and placing few demands on them; remaining with those providers by default (ecological selection).
- Either explanation suggests the value of using well-care and cultural competence questions in tandem to target patients and doctors for intervention:
  - Informing doctors about the association between their degree of cultural awareness and member adherence with clinical advice.
  - Health education on the value and purposes of well-care.
  - Member education regarding the process for selecting and changing doctors.
  - Improving the information available to members regarding providers.

Patient-Reported Rates of Cultural Competency Training Needs

From 2006-2011, L.A. Care has added the following question to its annual CAHPS Survey of Member Experience:

56/82p. "Doctors and staff <u>can be trained</u> 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 <u>training</u> to improve the treatment and service that [you receive/your child receives]?" *(Check all that apply.)*

Adult	Child	Responses on Training Needs – pooled 2006-2011
53.2%	35.7% overall -- Doctor and the clinic staff do not need any of the 12 listed types of diversity training.	
46.8%	**64.3%**	**Those who reported at least one diversity training need among their providers.**
32.5%	**41.3%**	**(a) How to work with people of a different <u>race</u>.**
27.9%	**32.9%**	**(b) How to work with people from a different <u>culture</u>.**
7.5%	**6.9%**	**(l) How to work with people of <u>different religions or beliefs</u>.**

(Other categories of difference were examined separately, included *gender, age (young children, elderly); physical disabilities, learning disabilities, sexual orientation, limited income, religion/beliefs.)*

Low Health Literacy Manifest on Patient Reasons for Not Having a Well-Care Visits to the Doctor in the Last 12 Months

- Extrinsic reasons are classical barriers to access.
- Intrinsic reasons involve choice:
  - For the working poor, intrinsic reasons can reflect real and immediate barriers, but probably not constant for an entire year.
  - Intrinsic reasons imply that the opportunity to get routine health care was present, and was not exercised as a matter of choice or other priorities.

Reasons for no Checkup	ADULTS n	ADULTS Percent	PARENTS n	PARENTS Percent
Extrinsic	58	2.78%	89	2.45%
Intrinsic	523	**25.07%**	706	**19.41%**[a]
Mixed	118	5.66%	149	4.10%
No Barrier	1,387	**66.49%**	2,693	**74.04%**[a]

Within L.A. Care's Medicaid population, from 2008 to 2011:

- Most respondents reported no barriers to receiving routine care annually.
- Of the barriers noted, intrinsic reasons are reported far more frequently than extrinsic reasons as causes for not getting annual checkups.
- Note that parents are significantly less likely to offer reasons for not getting checkups for their children; *and are significantly less likely to offer intrinsic barriers.*

Intrinsic reasons imply solutions focused on health education.

[a] Difference of proportions test, two-tailed, a=0.05.

V. Analysis: Provider Cultural Sensitivity & Patient Health Literacy

Clear association found between patients' perception that providers need sensitivity training, and lower health literacy among patients (finding reasons – usually intrinsic -- for not getting routine checkups):

- Racial insensitivity by doctors impacts patients' health literacy & adherence:
  - Adults manifest increased propensity to offer intrinsic and extrinsic barriers to getting routine care (X^{**2}_{CMH} =24.033, p<.0001).[a,b] The effect was consistent across years, but was not steady and significant each year (possibly due to sample size).
  - Parents manifest a much stronger association (X^{**2}_{CMH} =92.778, p<.0001).[a,b]
- Cultural insensitivity by doctors impacts patients' health literacy and adherence:
  - Adults manifest increased propensity to offer intrinsic barriers to getting routine care (X^{**2}_{CMH} =24.614, p<.0001).[a,b] The effect had anomalies in some years (manifest more for mixed barriers than intrinsic barriers in 2011) – but was consistent from 2008-2010, and was significant in the pooled sample.
  - Parents again manifest a stronger association (X^{**2}_{CMH} =75.745, p<.0001).[a,b]
- Religious insensitivity by doctors impacts patients' health literacy and adherence:
  - Adults manifest increased propensity to offer intrinsic and mixed barriers to getting routine care (X^{**2}_{CMH} =11.022, p=0.0116).[a,b] Religion had the weakest sample (2 years).
  - Parents manifest an even stronger association (X^{**2}_{CMH} =30.280, p<.0001).[a,b]

Combining race, culture, and religion into a single index gave strongest association:

- For adults (X^{**2}_{CMH} =40.243, p<.0001)[a,b] and for parents (X^{**2}_{CMH} =103.807, p<.0001).

[a] Tests: Fisher's exact test (FET) for individual years. Used Cochran-Mantel-Haenszel (X^{**2}_{CMH} at p<=0.05) to control effects of pooling survey years. [b] Association is not uniformly strong across years, but is present overall.

VI. Recap of Learning Objectives

1. Describe the proportion of patients who report that their doctors need cultural competency training.
   - In L.A. Care's diverse patient population, most adults (53%) reported no diversity training needs among their providers, but most parents (64%) reported at least one area of need.
   - Many adults (28%) and parents (33%) reported need for cultural sensitivity training for doctors and staff.
   - Many adults (33%) and parents (41%) reported a need for racial sensitivity training.
2. Evaluate the association of providers' cultural competence and patients' health literacy and adherence to guidelines on seeking well-care.
   - **A statistically significant association was found between providers' cultural sensitivity and patients' propensity to offer reasons to miss routine care.**
   - Curiously, the effect was manifest most consistently for intrinsic (personal choice) reasons – but was also manifest for extrinsic and mixed reasons (which require the least rationalization).
   - It is possible that patients view their routine care as something desired more by the doctor for his/her own reasons and peace of mind – and are less invested in such visits, particularly if estranged from the doctor by race or culture.

Recap of Learning Objectives (Cont.)

3. Assess whether that association differs by patient age – particularly for adult patients versus pediatric patients.
   - Parents were significantly less prone to offer reasons to avoid well-care for their children on Medicaid.
   - Some parents noticed cultural insensitivity in their doctors and clinic staffs: ***Those parents were much more likely than adult Medicaid members who noticed insensitivity, to find reasons for not getting well-care for their children.***
4. Assess whether that association differs by patient gender.
   - This is pertinent because adults and parents in L.A. Care's Medicaid population are disproportionately female. However, gender is an unlikely covariate given the utter lack of a significant association between gender and the cultural competence measure, both for adults and parents on the child CAHPS survey.
5. Describe how often cultural sensitivity issues arise in patients' own words on surveys in verbatim suggestions on how to improve health care.
   - Comments on CAHPS rarely indicate overt racism or bias by providers, but sometimes indicate a generalized sense of getting different service:

     "I am Armenian and when I go to the doctor there are some mentalities. But I am a human being and a regular person. I am not stupid. I don't think it is because of my nationality but because they need more patience with everyone."

VII. Actionability: Opportunities Going Forward

In a future of tight resources in health care (staff, budgets), actions may focus on targets of opportunity: Innovations piggybacked on projects and required activities that must occur anyway.

- A department's first duty is to identify, measure, and report patients' use of well-care, and reasons for not getting routine care: *Put CAHPS analyses in front of decision-makers and health educators designing content for ongoing programs.*

CAHPS generally measures *effects and outcomes* (dependent variables that society wants to improve).

- This study demonstrates the value of adding conceptually-sound Supplemental Questions that measure *causes* (independent variables) by which to analyze what drives outcomes (such as low compliance with routine care standards).
- Further analysis will focus on identifying which demographic groups manifest the low health literacy in response to doctors' need for cultural sensitivity training – to educate providers on more effective ways to interact with patients.
- Departments in health plans are often reactive to measures in HEDIS and CAHPS. This analysis and the CAHPS questions on which it was based, were tailored for a particular department within the health plan. Continuous quality improvement (CQI) works best when functional departments and other process owners pro-actively design measures that they can use to improve quality of services in a data-driven way.

Contact Information –

S. Rae Starr, M.Phil, M.OrgBehav, Senior Biostatistician
L.A. Care Health Plan
RStarr@LACare.org, rae_starr@hotmail.com
213-694-1250 x-4190

Related briefing:

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. APHA 11/01/2011, Medical Care, Session 4395.0 Social Sciences in Health: Cultural Sensitivity in Clinical Settings & Encounters.

Online exchange on analytics and quality improvement:

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