AHA Team Training

Equity in Health Care: Putting Patients First

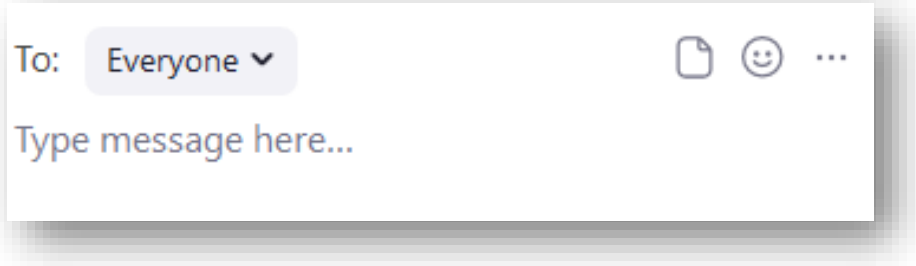
August 14, 2024

American Hospital Association™
Advancing Health in America

AHA CENTER FOR HEALTH INNOVATION

Rules of Engagement

- **Audio for the webinar can be accessed in two ways: 1) through your computer speakers or 2) dialing in by phone –** *listen only mode*
- **Q&A session will be held at the end of the presentation**
  - Written questions are encouraged throughout the presentation
  - To submit a question, type it into the Chat Area and send it at any time
- **Other notable Zoom features:**
  - This session is being recorded, the chat will not be included in the recording
  - Utilize the chat throughout the webinar. To chat everyone, make sure your chat reflects the picture below**:**



American Hospital Association™
Advancing Health in America

AHA CENTER FOR HEALTH INNOVATION

Continuing Education Credit

To receive 1.0 CE credit hour for this webinar, you must:

- **Create a Duke OneLink account.** You only need to create an account once – you may use it for all future webinars. Instructions will be chatted in and/or you may find them in your registration confirmation email.
  - Step 1: Register for a OneLink account
  - Step 2: Activate your account and ***confirm your mobile number***
- **Text RUMPUR to (919) 213-8033 after 1:00 pm ET today – 24-hour window**

In support of improving patient care, the Duke University Health System Department of Clinical Education and Professional Development is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing education for the health care team.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

DukeHealth

American Hospital Association™
Advancing Health in America

AHA CENTER FOR HEALTH INNOVATION

Upcoming Team Training Events

Courses

- *In-person* TeamSTEPPS Master Training
  - September 25-26 at Houston Methodist
  - October 8-9 at Tulane
  - October 21-22 at Northwell
  - December 5-6 at UCLA
- *Virtual* TeamSTEPPS Master Training
  - September 19-November 7

Webinars

- The Critical Role of Nurse Managers in Nurse Retention, August 28 sponsored by Relias
- Innovative Care: The Value of the Virtual Nurse in a Pediatric Hospital, September 11
- A Clinical and Culinary Guide to Healthy Hospital Food, September 26 sponsored by PCRM

American Hospital Association™
Advancing Health in America

AHA CENTER FOR HEALTH INNOVATION

Custom TeamSTEPPS Advisory Services at Your Organization

TeamSTEPPS Master Training Course

Using a train-the-trainer model, **we give you the foundational tools** and concepts, and train your staff through this **two-day training** program. You will gain a team of Master Trainers ready to teach others in your organization.

Comprehensive TeamSTEPPS Programs

We help you along the way. After delivery of the two-day Master Training course, we continue to work with your team for **3-6 months**, building the internal capacity to hardwire TeamSTEPPS throughout your organization.

Learn More »

> Our relationship with the TeamSTEPPS faculty and the on-site trainings were both phenomenal. **They did a great job of meeting us where we were** and customized a program that really helped us gain clarity about the problem we're trying to solve.
>
> – **Melissa Riffe-Guyer**
> Executive Director,
> Culture Cone Health

American Hospital Association™
Advancing Health in America

AHA CENTER FOR HEALTH INNOVATION

5

Today's Presenter

Founder & President Mauvareen Beverley, MD, PLLC
Patient Engagement and Cultural Competence Specialist
Author

American Hospital Association™
Advancing Health in America

AHA CENTER FOR HEALTH INNOVATION

Improving the Patient Engagement and Experience: Roadmap

Background

- Health care delivery systems are evolving with a focus on changing patient behavior in order to improve access, utilization and health outcomes.
- Less attention has been paid to the needed behavioral changes of health care professionals as our attitudes impact patient care.
- This program is comprehensive in its approach and is designed to improve patient care and experience in a culturally competent manner.

Purpose

We as health care professionals and executive leaders need to recognize that our beliefs and attitudes, conscious or unconscious can have a positive or negative impact on:

- Patient care
- Compliance
- Patient experience
- Self management
- Health outcomes

Learning Objectives

- Increase empathy
- Respect and understand the individual's cultural

  beliefs regarding their health
- Prevent judgmental behavior directed at patients
- Prevent disparate care
- Maintain patient dignity
- Improve the health outcomes for diverse patient populations, focusing on the Elderly Black Population

Improving The Patient Engagement and Experience: Training Roadmap

How Do We As Healthcare Administrators and Professionals Want To Be Viewed

- Professional
- Knowledgeable
- Honest
- Caring
- Open Minded
- Non-Judgmental
- Problem Solver
- Culturally Competent

Identifying Our Cultural Beliefs and Attitudes

What do we as individuals' value?

- Self
- Family
- Work
- Integrity
- Religion/Culture/Ethnicity
- Finance
- Health
- Fun and Recreation
- Privacy
- Dignity & Respect
- **Choices**

Are Patients Really Different From Us as Individuals?

Patients as individuals also value:

- Family
- Work
- Character
- Religion/Culture/Ethnicity
- Finance
- Health
- Fun and Recreation
- Privacy
- Dignity & Respect
- **Choices**

Improving The Patient Engagement and Experience: Training Roadmap

The Common Thread

Amid this diversity, what do patients have in common?

- They don't have choices about their diseases.
- Once diagnosed accurately, the disease is NON-NEGOTIABLE. They can't give the disease back.
- In case of chronic conditions, the disease and its symptoms may remain with patients for life.
- Patients may be forced to change their lifestyle and/or job as a result of the disease.
- Temporary or permanent loss of control over one's Life.
- At any point in our lives, we as health professionals may become patients.

Language of Negativity: Does it reflect high Patient Value?

- **Non-Compliant/Non-Adherent label without asking "WHY"**
- **"Frequent Flyer..."** No Longer Human
- **"High Utilizer..."** Gaming the system and deserving of punishment
- **"Drug Seekers..."** An unfair characterization of patients with SCD

This creates a culture of callous disregard and can possibly contribute to poor health outcomes

Language of Negativity cont'd

- **What percent of patients gets these negative labels?** 10%? 20%? 50%?

- **Does negative labeling increase healthcare costs?**

- **Does the care given lack:**
  - Genuine interest in the individual
  - Empathy
  - Constructive dialogue and information sharing
  - Willingness to educate patients

Counter Productive Thought Process

Documentation rarely if ever addresses the "WHY" when Non-Compliant/Non-Adherent is used.

Physician and nurses are trained to ask questions.

- Not asking "Why" is counter to Medical Training and analytical thought processes.

Example:

- 37-year-old Male/Female non- adherent with medications
  - Name of medication may not be stated
  - Reason may not be given

Language of Negativity – Its Impact

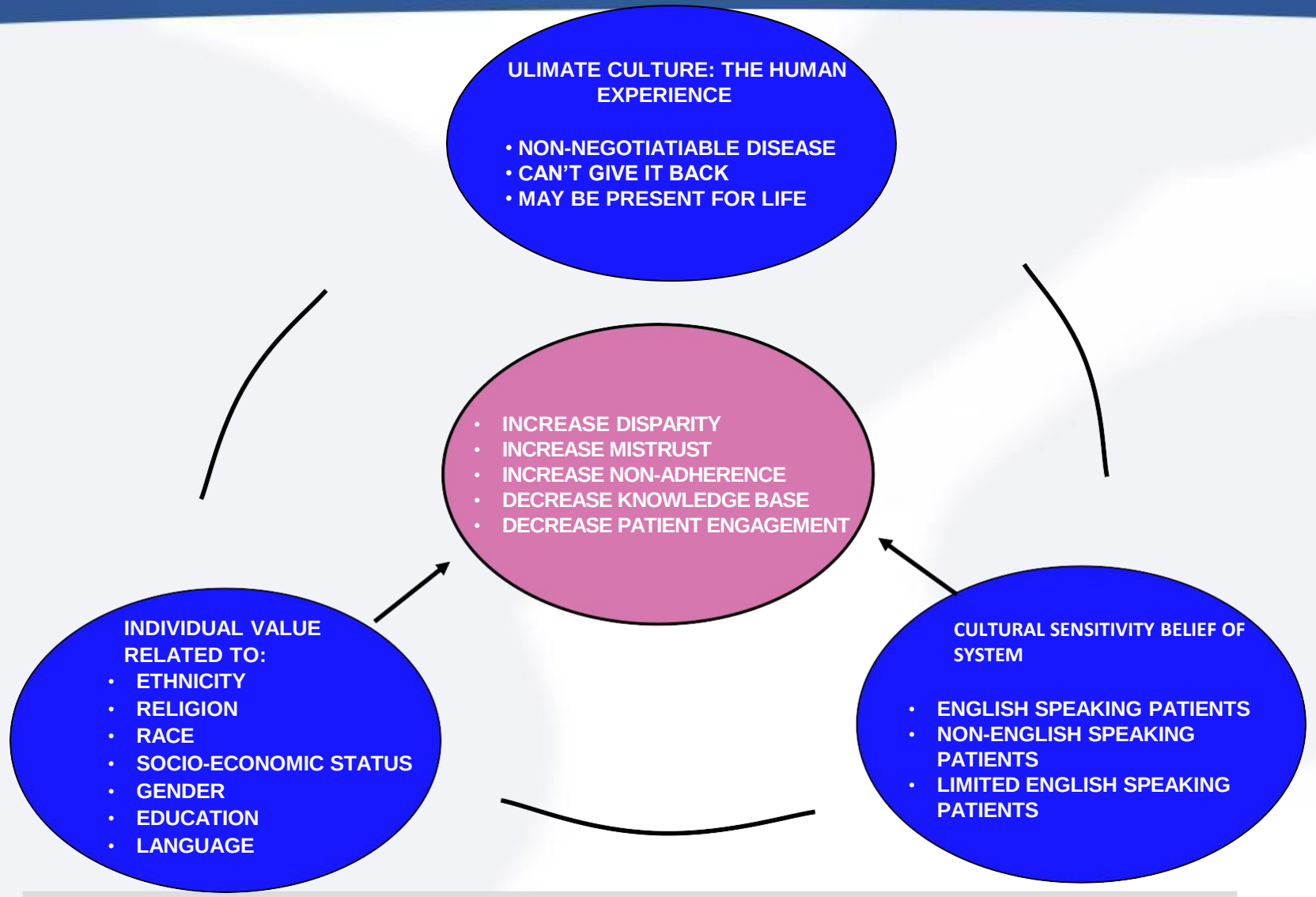
Negative Language May:

- Cause potential adverse health outcomes
- Cause repetitive emergency department visits
- Cause increased readmissions
- Increase the health burden for patients

The Importance of Social History

- Is it comprehensive in describing the individual?
- Is the individual only being defined as: Nondrinker, nonsmoker or no toxic substance?
- The combination of non-compliant/non-adherent without asking “Why” coupled with “no toxic substance” is now defining a human being.
- That individual is no longer valued. However, we are taught in medical school what should be included in social history.
- If one's perception of the individual is the same as the reality, then there is an opportunity to make necessary changes but if one's perception is different from the reality, we run the risk of increasing disparity in care and health outcomes.

The Human Experience



Eradicating Misperceptions and Fallacies

Perception

Vs.

Reality

Perception vs. Reality

The COVID Pandemic has shed a bright light on the long-standing numerous health inequities experienced by Black Americans across the US. The Black Population has the highest COVID-19 death rate.

Perception:
The prevailing thought is that it's a result of poverty, lack of access to care, social determinants of health and comorbidities.

Reality:

- **For example, Prince George County in Maryland, one of the wealthiest Black upper class communities in the nation has some of the highest COVID-19 mortality.**
- **Brooklyn, NY with a large black population, 13 hospitals inclusive of 3 public and 1 state hospital and extensive public transportation has the highest COVID associated deaths in NYC.**
- **Public Transportation employees who dies were predominately Black who were union workers with the average salary approximately $50.000.00, with pensions and health coverage.**
- **"We still see stark racial disparities even at high income levels," said Tanjala Purnell, associate director of the John Hopkins Center for Health Equity. "People say,"Oh, minorities are dying because they're poor. We know that's not the case"**

Myth

Sickle Cell Patients have a higher degree of drug addiction than the general population

Fact

- Opioid addiction for Sickle Cell patients ranges from 0.5% to 8% vs. 3% to 16% in patients with other chronic pain syndromes.

- Behaviors often described in patients with sickle cell disease, such as requesting a specific dose of opioid or requesting that the opioid be administered intravenously, may be normative in patients who have experienced a history of under treatment of pain

- Less indicative of abuse than behaviors such as illicit drug use or using opioids for symptoms other than pain.

Treatment of Sickle Cell Pain Fostering Trust and Justice William T. Zempsky, MD

JAMA. 2009;302(22):2479-2480.

Electronic Health Records: Can negative Information Go Viral?

- Is there a positive or negative association with the patient experience?
- Will EHR improve health outcomes when fed negative terminology in describing patients?
- Will the receiving MD, subspecialist, nurse, social workers & receptionist want to engage patients that are described as frequent flyers, non-compliant/non-adherent, and drug seekers?

Cultural Competency

- Cultural Competency is defined as the ability of providers and organizations to effectively deliver health care services that meet social, cultural, and linguisticsneeds of patients.

- A culturally competent healthcare system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities.

King's County Hospital Center - African Ancestry is Front and Center

- **Ninety-three (93%) of the population is of African ancestry**
  - 50% of patients are from Caribbean
  - 39% are African American
  - 4% Hispanic

- **Patients of non-African ancestry are**
  - 3% White
  - 4% Other

Patient Demographics

- **Approximately 80% to 90% of African American patients are from North and South Carolina**
- **Top 4 Caribbean islands where our patients are from**
  - Jamaica
  - Trinidad
  - Haiti
  - Guyana
- **3 Most Common Languages**
  - English
  - Hatian Creole
  - Spanish

African American Migration History From North & South Carolina to New York

- By 1900, significant portions of the African American population had begun migrating from North and South Carolina to New York to escape the atrocities of lynching, the Ku Klux Klan and Jim Crow Laws (1876-1965).

- Just 35 years after the Emancipation Proclamation, African American communities had already begun to thrive. One community was the city of Wilmington, North Carolina, which thrived economically until the massacre of 1898.

King's County Hospital Congestive Heart Failure Readmission Prevention Interdisciplinary Task Force

2011-2014

CHF Readmission Prevention Task Force: Multidisciplinary Team's Community

Daily Questions and Answers:

- Who is the Individual
- What are the Fears Factors
- What is important to the Individual
- Where is the individual in the acceptance of the disease

The Team's Philosophy:

- Not to be judgmental
- Never use the word non-compliant without asking the patient "why"
- Improve Patient Engagement & Cultural Competency
- Identify African American/ Afro Caribbean
- Recognize and heighten Patient Value

Results of the CHF Inter-disciplinary Team

Interdisciplinary team included:

- Hospitalist
- Social Workers
- Dietitians
- Pharmacists
- Care and Case Managers
- Homecare Agency
- Clerical Associate
- Consultant-Cardiologists
- Nurses
- Patients

The Results:

- **Readmission for CHF patients decreased from 30% to 18.7% in a little less than 2 years.**
- **Results: 30% as per the Kings Medical Director**
- **18.7%: Medical and Professional Affairs**

Patient Voices

THEY ARE IN OUR HOSPITAL BEDS

AND NOT IN OUR HISTORY BOOKS

HERE ARE THEIR STORIES!

Patient Voices

83 y/o African American female originally from South Carolina who:

- Had seven brothers
- Family were sharecroppers
- She stated “My family Picked cotton on a plantation that was not ours”
- She also stated-I had to be in the field by sunup
- My family picked 400 to 500 pounds of cotton a day and had to walk 10 miles to a segregated school

Patient Voices cont'd

Question: How could you walk 10 miles to school?

- **Answer: If you wanted an education, you had to walk.**
- **She completed primary, junior high, and high school.**
- **Attended Voorhees College "I did not get in until the second try".**

Patient Voices cont'd

Married in 1948 and had two children (sons).

Both her children graduated from college and went on to become engineers.

Patient Voices cont'd

- She attended City College and graduated as a dietitian.
- Later became a registered nutritionist and retired in the 1980s.
- Salary at retirement, $200 dollars per week and she said, "Others made more."
- Religion: Baptist

Patient Voices cont'd

- 84 y/o African American female initially from South Carolina said: My parents were a step away From slavery and my grandparents were slaves.
- 82 y/o African American who states on a weekday that "What I am most concerned about is that I will not be able to go to church on Sunday."
- Role of Religion in the Black Elderly Population and Clinical Care is Pivotal

Patient Voices cont'd

78 y/o African American female initially from South Carolina who was dissatisfied with her hospital experience stated, "I picked cotton in the south. I paid my dues, and I don't deserve to be treated this way."

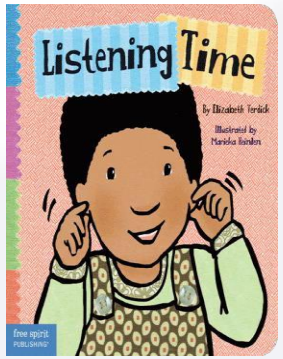
How many of us in healthcare understands her point of reference that's of a cultural origin?

Improving The Patient Engagement and Experience: Training Roadmap

Need For A New Approach And Communication With Patients

New Focus:

Ask the Question: What is the patient not saying that the health care providers are not hearing?



- I am embarrassed to talk about my living arrangements
- I have not accepted the disease
- I don’t understand what you are saying
- I can’t afford the medications
- I am scared to death about my condition
- I am worried about the impact on my job and finance
- I don’t trust the medicines and I’m going to try home remedies

Need for a New Approach and Communication with Patients cont'd

What is the Physician, Nurse or Care Manager not saying that the patient is hearing?

- I am not smart enough to understand my disease.
- I am in the low literacy group, therefore I have low intelligence capability.
- You don't think I am going to follow your instructions.
- "You people" don't usually follow instructions.
- You don't see the need to value and understand my cultural beliefs.
- You don't see me as valuable like you.

Result…I may not receive the empathy, time and resources to help me improve my health.

Need For A New Approach And Communication With Patients Cont'd

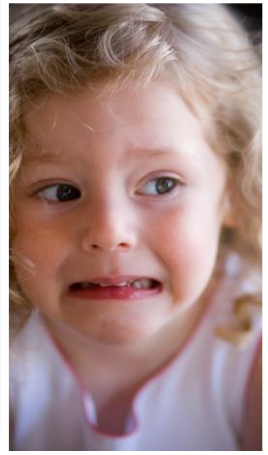
New Focus:

- **Ask the Questions:**
  - What is the patient not saying that we are not hearing?
  - What are we not saying that patient is hearing?
- **Maintain patient dignity while asking probing questions about medical history, personal habits and behaviors**
- **Body Language - universal communication tool in a diverse patient population**
- **Continuous improvement in cultural competence**
- **Be conscious about the time required for patient to come to terms and accept his or her disease**
- **Understand that Patients have no choice but to accept their diagnosis and they may need help coping with the disease and its impact on their lives and the lives of their loved ones**

Fear Factor -The Universal Thread

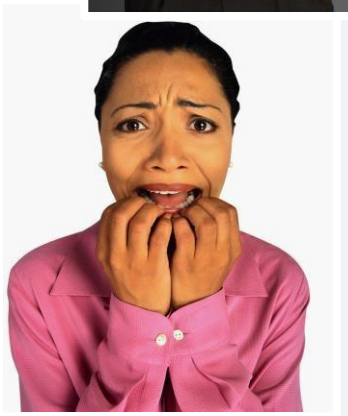
Am I going to die

- Will the treatment make me feel worse?
- Will I get better?
- Can I have a normal life?
- Is it MY fault?
- Did God do this to me?



Family Fear Factor

- I don't have the resources to do this alone.
- I don't know if I can give the medications. What if I make a mistake?
- I cannot live with myself if I made my family member worse.
- Can I afford not going back to work to care for a family member?
- What do I do if something goes wrong. Who can I call?



Patient Comments: Fear Factor

- Medication side effects may elicit more fear and discomfort than the disease itself.
- You are on your own after leaving the doctor's office.
- If the information about the side effects of the medication was not clearly communicated during the doctor's visit, patients may not take their medication once the pharmacist explains the side effects.
- Patients may now be considered "NON-COMPLIANT".
- Patient may be perceived as not caring about their own health.

“Can you value my culture if you don’t value me as an individual?”

Low Patient Value Can Possibly:

- Turn competent professionals into incompetent professionals
- Create a culture of callous disregard
- Impact image of the institution
- Compromise patient safety
- Cause preventable adverse events

If the patient is not valued then:

- I may be detached from the patient engagement process.
- I may not obtain the required consents.
- I may not be as effective in explaining medical issues and medication as well as I am capable of and should do.
- I may not engage the family.
- I may (un)intentionally influence other staff behavior.
- I may (un)intentionally substitute “Do no harm” for harm.

Patient Centered Care

Can we really call ourselves
“A Patient-Centered Medical Home” if:

- we continue to use negative language to describe individuals that are obtaining their medical care at our institutions?
- we don’t apply the rules of cultural competence in delivering care to this community?

Who are our Patients?

- Not only are they English speaking and American born, but they are also from different countries, speak several languages, and may have different religious beliefs.
- Have different expectations regarding their health care needs and the role of health care providers.
- May have different beliefs about the use of western medicine versus herbal and/or home remedies.

The Individual with a Disease Vs. The Disease Label

Care Management is about caring for individuals with one or more diseases and as a result, improve the health of the population.

Care Management is not about broad brushing a disease to a group of individuals.

Example: Diabetes

- When one says “Diabetic”, it may suggest “all diabetics are the same.” The disease is the same, but the individuals with the disease are different.

For example:

- A diabetic mother with two children
- A diabetic father who works 12 hours shift
- A diabetic grandmother who vehemently believes that she should leave the disease in ‘God’s Hands”

Improving The Patient Engagement and Experience: Training Roadmap

Challenges I

Not to have patient choose between:

- Health and Family
- Health and Culture
- Health and Religious Beliefs
- Health and Finance
- Health and Education

Challenges II

To understand the human response and time required to accept a new diagnosis, we may need to engage in discussions about anger, denial, religious/cultural beliefs and depression.

Challenge III

Understanding the role of Historical Racism and Inequities of Healthcare Systems towards African Americans.

Patient Concerns:

- They are not telling me what's wrong
- They don't treat me the same as Caucasians
- I don't really believe what they say

Possible Response: "You may not believe it, but you need to listen to me for your own health."

Preferred Response: *"Would you like to tell me about your or your family's' experience with the healthcare system. Based on what you have just told me, I can empathize and understand why you feel that way. Here is why this experience is different."*

Challenge IV

Immigrant Perspective:

- I should not question the doctor since he/she knows and understands health more than anyone
- All immigrants are not undocumented or uninsured
- Limited English proficiency and accents are not indicators of intelligence

For Low English Proficiency patients:

- **Possible Responses:** "Please repeat what I just said." or "Did you understand?" or "What part didn't you understand?"
- **Preferred Responses:** *"I would like you to tell me whether you understood my instructions, as I may not have explained it as clearly as I should. Giving me feedback will also help me improve my communication with other patients."*

Challenge V

Senior Citizen Perception

- No longer of value
- Living on borrowed time
- Only limited communication is needed

Mental Health

- The patient is a substance abuser - He or she is at fault, therefore he or she is of? Human value.
- They are “Frequent Flyers” abusing resources, falling on the floor and don’t know how to behave like a human being.
- If they would only take their medications, they would not have “The Problem.”
- Seekers and abusers of certain prescription drugs.

Challenge VI

Staff Challenges

What kind of patient do you have difficulty with engaging in the care process?

- Is it non-verbal or non-communicative patient?
- Is it the angry patient?
- Is it _____?

Your comfort level with patients who are:

- African Americans/African Descent
- Hispanic
- Asian
- Caucasian
- American Indian

Improving The Patient Engagement and Experience: Training Roadmap

Cultural Sensitivity:
A Bi-Directional Approach

- Foreign medical/clinical graduates to American patients
- American clinician to Foreign Born patients
- American clinician to American patients who are culturally different from themselves
- The English-speaking population is currently left out of the cultural competence requirement and conversation
- Need to understand the role of race/gender in the American culture and race and/or gender in foreign cultures

Cultural Sensitivity
Towards Foreign Born Patients

American clinicians need to understand cultural norms that are different from American norms.

This includes:

- The role of the caregiver
- The caregiver may not be the decision maker in other cultures
- The role of clinicians in other societies
- Example: “I Say, You Do" philosophy

Physician's Approach to the Common Thread

American and foreign-born clinicians can develop a shared understanding:

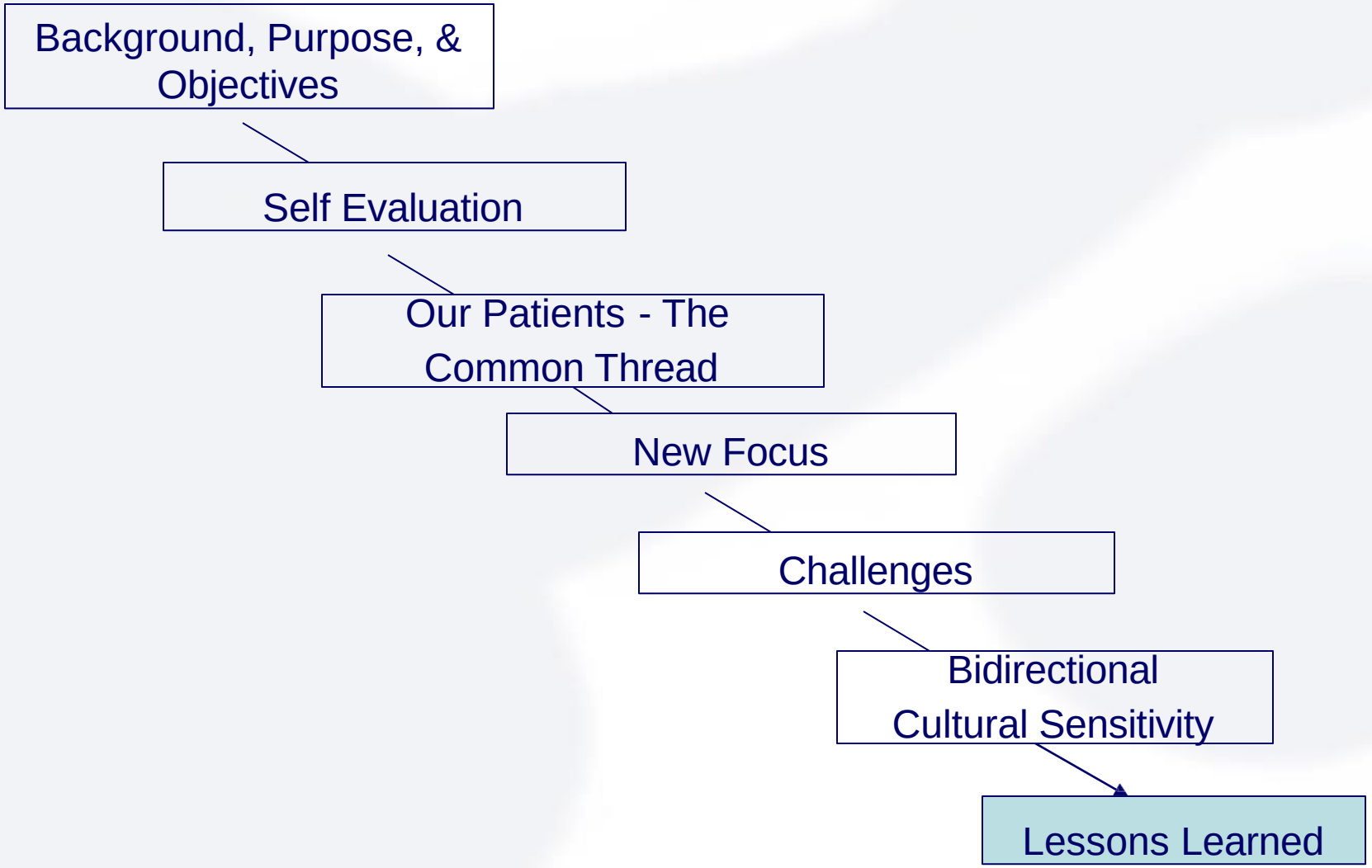
- Patients irrespective of birthplace, language, religious beliefs, and appearance, voluntarily came to our institutions
- May have received a diagnosis that they did not want and one which is non-negotiable
- The possibility of the disease being a life-long burden requires major lifestyle changes
- Appreciation that there maybe a need to understand where the patient is in acceptance of the disease

Patient Centered Care

Patient Centered Care starts with:

- Giving the Patient the Benefit of the doubt
- Being non-judgmental
- Increased empathy
- Elimination of negative labels, such as high utilizers, drug seekers, frequent flyers, non-compliant without knowing or asking “WHY”
- Recognition that the average healthcare professional is healthier than the patient population and most have never been hospitalized

Improving The Patient Engagement and Experience: Training Roadmap



What Have We Learned?

- Behavioral change start with healthcare professionals and executives
- Professionals and patients share the same human concerns and emotions
- Illness trumps religion, ethnicity, race, gender, and culture
- Historical trauma can influence patient behavior
- Terms such as Frequent Flyers, Non-Compliant/Non- Adherent used over time in a health care setting towards patients can create a culture of callous disregard
- A culture of callous disregard can negatively impact patient health and safety and thus affect patient compliance
- We all can become patients at any given point and time

Staff instructions from a patient

For me to change from the "Bush Tea," you have to:

- Tell me the severity of why you want to add 1-2 medications
- If you want me to take 3-4 medications, you have to personalize it, man!

Patient centered care - who knew!

Communication

During a patient's two-week follow-up appointment with his cardiologist, he informed me, his doctor, that he was having trouble with one of his medications.

“Which one ?” I asked.

“The patch. The nurse told me to put on a new one every six hours and now I'm running out of places to put it!”

I had him quickly undress and discovered what I hoped I wouldn't see. Yes, the man had over fifty patches on his body! Now, the instructions include removal of the old patch before applying a new one.

Current African American History

As we improve our communication with our patients and each other, it may help to know that Henry Sampson, Jr:

- Invented the Gamma Cell for mobile phones and wireless communication.
- 1st African American to obtain PhD in Nuclear Engineering in the United States.
- Communication has power.

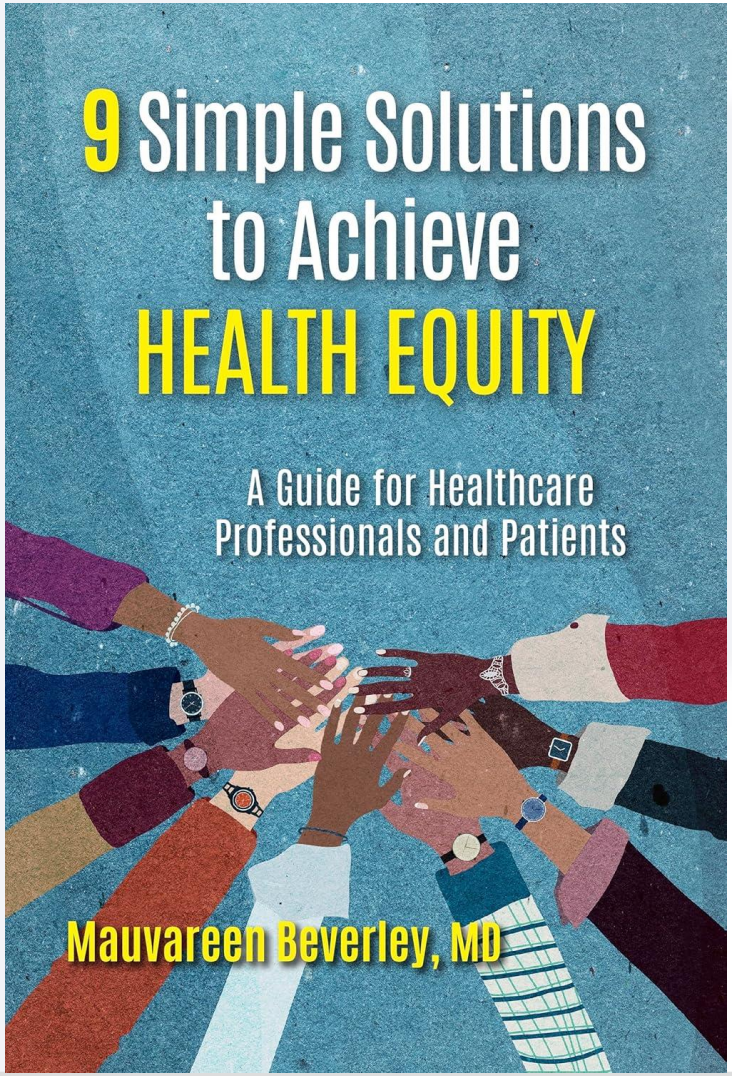
Memorable Quotes

- ***Difficult patients are not just born, they are in part, created by their passage through the medical system. Not only has this system failed to cure, it may have done unpleasant things to make matters worse.***

  (*Disorders of Hemoglobin Steinberg at al 2001-Pg. 697, Hartrick and Pitcher, 1995)*

- ***It is more important to know the person who has the disease than the disease who has the person*** (Hippocrates)

Questions?



Order the eBook now:
https://www.amazon.com/dp/B0D73NNN2V

Get the paperback:
https://www.amazon.com/dp/B0D73NNN2V

My website:
drbeverley.com

Contact information:
Mbeverleymd@gmail.com

Final Reminders

- **Evaluation**
  - Please complete the evaluation form that appears on your screen once the webinar ends
- **Continuing Education**
  - Create a Duke OneLink account if you have not done so
    - Instructions can be downloaded from the Files pod or your registration confirmation email
  - **Text RUMPUR to (919) 213-8033 within 24 hours**

AHA Team Training

Questions? Stay in Touch!

www.aha.org/teamtraining

Email: teamtraining@aha.org • **Phone: (312) 422-2609**

American Hospital Association™
Advancing Health in America

AHA CENTER FOR HEALTH INNOVATION