Diversity and Inclusion in Quality Patient Care

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Preface

Diversity and Inclusion in Quality Patient Care takes into consideration our multicultural society and the differences among patients. Above all, the book recognizes the influence of culture and the sensitive approach providers must take in delivering health care to the diverse groups they will encounter. As the population's demographics continue to change demographically, doctors, nurses, and other care providers will have to make quick decisions and provide appropriate treatment that patients of diverse backgrounds can respond to and understand.

The Monograph on Cultural Competency (editors Heron, Martin, Kazzi; http://www.med-ed.virginia.edu/courses/culture/), created in 2005 in partnership with the Council of Residency Directors (CORD) in Emergency Medicine and the Society for Academic Emergency Medicine's (SAEM) Diversity Interest Group (DIG), served as the framework for this book. Our authors have extensive backgrounds in emergency medicine, both in clinical and academic settings. Many of the contributing authors are members of the SAEM Academy for Diversity and Inclusion in Emergency Medicine (ADIEM), which was established in 2012. Three of the editors, Drs. Martin, Heron, and Moreno-Walton, are founding members of ADIEM and have served in key leadership positions on the ADIEM executive board. ADIEM members are committed to promoting diversity and inclusion in the emergency medicine (EM) professional workforce at all levels, furthering culturally competent delivery of emergency medical services, and eliminating healthcare disparities through research, education, and mentorship.

A growing body of research shows that a diverse workforce is more capable of relating to patients, detecting and addressing health disparities, and overcoming the challenges that face health care. We believe diversity and excellence are of equal importance, and that our healthcare workforce can't be excellent *without* diversity. Diversity accelerates our delivery of quality care to all people.

Failure to incorporate culture into the medical decision-making process can lead to misdiagnoses when prevalence of conditions among various cultural groups is not considered. This is evident when traditional remedies, understanding of illness and wellness, family dynamics, and neighborhood characteristics are not taken into account during the assessment and diagnostic phases of the physician-patient relationship.

In order to provide culturally appropriate care, healthcare providers must recognize the factors impeding cultural awareness, seek to understand the biases and traditions in medical education potentially fueling this phenomenon, and create a healthcare community open to individuals regardless of race, culture, sexual orientation, and religion and all things unique to each person. Clarity and understanding of these factors would lead to better communication of ideas and information between patients and their healthcare providers.

Included in the 33 chapters are teaching cases that provide real-life scenarios of various cultural groups who have presented to the emergency department. While these cases are representative, they are not exhaustive. They are presented in a similar format, highlighting attitudes and assumptions for the physician and for the patient and featuring appropriate Emergency Medicine Milestones that can serve as a useful guide in various educational settings.

Contributors to this book have a common hope of eliminating healthcare disparities and inequities and ensuring the delivery of culturally competent care. We realize that a curriculum on diversity and inclusion in quality patient care cannot be a "one size fits all" for every medical school, nursing school, residency, and physician assistant (PA) or nurse practitioner (NP) program. Therefore, we recommend that healthcare educators utilize this book as a resource to extract educational material specific for their programmatic and teaching needs.

We thank the many authors for their contributions. We also thank Leslie U. Walker and the staff of the University of Virginia Office for Diversity and Equity for their contributions in preparing this book.

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It is our hope that Diversity and Inclusion in Quality Patient Care will serve many healthcare providers, educators, and learners who will utilize the material.

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We acknowledge the hard work of Leslie U. Walker, research administrative assistant for UVa ODE, for her communication with the authors and publisher and for her keen editorial eye in reviewing this book.

Diversity and Inclusion in Quality Patient Care would not be possible without the strong contributions of the many authors who are dedicated to providing culturally competent care.

Contents

Editor Biographies

Marcus L. Martin, M.D. Dr. Marcus L. Martin is professor and past chair of the department of Emergency Medicine at the University of Virginia (UVa). He held the chair position from July 1996 to December 2006. Dr. Martin's emergency medicine responsibilities included the adult and pediatric emergency departments, chest pain unit, express care, Pegasus air ambulance, the Blue Ridge Poison Center, paramedic training program, emergency medicine residency program, and several emergency medicine fellowship programs. During his tenure at UVa, Dr. Martin served as assistant dean of the School of Medicine, assistant vice president for Diversity and Equity and associate vice president for Diversity and Equity, interim vice president and chief officer for Diversity and Equity, and, in 2011, appointed vice president and chief officer for Diversity and Equity. Dr. Martin is the principal investigator of the Virginia-North Carolina Alliance, a National Science Foundation-funded Louis Stokes Alliance for Minority Participation (LSAMP) program. He is the founder of Emergency Medicine Center for Education Research and Technology (EMCERT) and initiated the medical simulation program at the University of Virginia School of Medicine.

He earned his Bachelor of Science degrees in Pulp and Paper Technology (1970) and Chemical Engineering (1971) from North Carolina State University and was employed as a production chemical engineer at WESTVACO in Covington, Virginia. A member of the charter class of Eastern Virginia Medical School and the first African American graduate, he earned his medical degree in 1976.

Dr. Martin was commissioned by the US Public Health Service and later served as general medical officer at the Gallup Indian Medical Center in New Mexico. He completed emergency medicine residency training at the University of Cincinnati in 1981 and held a series of staff and administrative/teaching posts at Allegheny General Hospital in Pittsburgh.

He was a board member for 12 years and past president of the Society for Academic Emergency Medicine (SAEM). He is past president of the Council of Emergency Medicine Residency Directors. He is the recipient of the 2008 SAEM Diversity Interest Group Leadership Award, named the Marcus L. Martin, MD Leadership Award in his honor.

Sheryl L. Heron, M.D., M.P.H. Dr. Sheryl L. Heron is professor and vice chair of Administrative Affairs in the department of Emergency Medicine, the assistant dean for Medical Education and Student Affairs on the Grady Campus, and associate director of education and training for the Center for Injury Control at Emory University.

She attended Howard University College of Medicine and completed her emergency medicine residency training at Martin Luther King/Charles Drew Medical Center in 1996. Dr. Heron has lectured extensively on the medical response to Intimate Partner Violence, as well as Wellness/Work-Life Balance and Diversity/Disparate Care in Emergency Medicine.

She has received several awards including the 2011 Women's Resource Center's Champions for Change, Partnership against Domestic Violence's HOPE Award, the Woman in Medicine Award from the Council of Concerned Women of the National Medical Association, and the Gender Justice Award from the Commission on Family Violence and was named a hero of Emergency Medicine by the American College of Emergency Physicians.

Dr. Heron served as chair of the National Medical Association's Emergency Medicine section where she mentored several faculty, residents, and students in their career path within Emergency Medicine. Dr. Heron is the first recipient of the Marcus L. Martin, MD Leadership Award, presented during the SAEM annual meeting in Atlanta in 2009, and served as the inaugural president of the Academy for Diversity and Inclusion in Emergency Medicine (ADIEM) of SAEM.

Lisa Moreno-Walton, M.D., M.S., M.S.C.R. Dr. Lisa Moreno-Walton is the Nicolas Bazan Professor of Emergency Medicine, Department of Medicine, Section of Emergency Medicine, in the School of Medicine at Louisiana State University Health Sciences Center-New Orleans (LSUHSC-NO) and a member of the Board of Directors of American Academy of Emergency Medicine.

Dr. Moreno-Walton's academic and professional appointments are numerous. Along with her appointment as a full professor, she serves as Director, Division of Research, and Director of Diversity for the Section of Emergency Medicine at LSUHSC-NO, where she also directs the HIV and Hepatitis C testing programs. Dr. Moreno holds an academic appointment as clinical associate professor of surgery at Tulane University School of Medicine.

Prior to her appointment at LSUHSC-NO, Dr. Moreno served as a faculty physician in emergency medicine at North Bronx Health Care Network and at the Lincoln Medical and Mental Health Center, both in the Bronx, New York. She is board certified in Emergency Medicine and completed her residency training at the Jacobi-Montefiore program in the Bronx.

Dr. Moreno-Walton is the recipient of numerous teaching awards. She has developed graduate and postgraduate curricula for core content and research in emergency medicine and has mentored over 250 undergraduates and medical students, residents, and junior faculty to successful career development and research productivity.

Dr. Moreno-Walton earned a Master of Science in Clinical Research from Tulane University in June 2011. Since that time, she has been awarded 12 grants to study trauma, HIV, healthcare disparities, and most recently, hepatitis C virus.

She has given over 400 abstract presentations and 150 invited presentations and has more than 100 scholarly publications. Dr. Moreno has won 15 research awards and, in 2013, was named a National Institutes of Health PRIDE Research Scholar. She recently created a curriculum for developing emergency medicine research in resource-poor environments, a course which she teaches internationally. She lectures widely on the topics of cultural competency, healthcare disparities, HIV, and trauma.

Dr. Moreno-Walton wrote the charter to found the Academy of Diversity and Inclusion in Emergency Medicine (ADIEM), Society for Academic Emergency Medicine (SAEM), and continues to serve on its Board. In 2013, she was the recipient of the Marcus L. Martin, MD Leadership Award presented during the SAEM meeting in Atlanta, Georgia. In 2014, she was the only physician in the United States to receive the Alpha Omega Alpha Professionalism Award for her work to eliminate healthcare disparities.

Anna Walker Jones, B.A. Anna Walker Jones received her Bachelor of Arts in English from Davidson College in 2006. In summer 2016, she will receive her Associate Degree in Nursing from Piedmont Virginia Community College and her Bachelor of Science in Nursing from Old Dominion University. She began working at the UVa Office for Diversity and Equity in 2013. Prior to working at the Office for Diversity and Equity, she served as a coordinating editor at LexisNexis Legal and Professional. She served as managing editor for *UVa in St. Kitts and Nevis*, published in fall 2015.

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Part I
Chapters

Chapter 1
Defining Diversity in Quality Care

Marc A. Nivet and Malika Fair

Introduction

In executive offices of health care organizations around the world, leaders discuss improving quality of care and outcomes for changing patient populations. Meanwhile, human relations or diversity officers explore ways to recruit health professionals from different backgrounds to create a more culturally competent workforce. It is time to join these two conversations together and understand the role diversity can play in quality patient care.

The most cited reason for increasing diversity in the health professions is the need to address health disparities among minority populations. While diversity plays a critical role in achieving this aim, there is an even more compelling reason to strive for diversity in the health professions: to produce better outcomes for all patients.

The Relationship between Health Care Quality and Health Equity

The two Institute of Medicine (IOM) reports—*To Err is Human* (1999) and *Crossing the Quality Chasm* (2001)—pushed the quality conversation into the spotlight. While physicians and other health care professionals have historically prioritized quality, few took a systematic approach to measuring patient outcomes or comparing performance indicators. The reports shocked the public and the health professions into focusing attention on the inconsistent quality in the United States health system.

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The IOM defines quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" [1]. The Institute also defines the six aims or principles of quality care, now referred to as the six pillars: safe, effective, patient-centered, timely, efficient, and equitable [2]. This definition of quality is now widely accepted, and we have made strides towards improvement [3]. However, there has been more progress on some pillars than others, creating an imbalanced system and hampering our ability to achieve true quality.

One pillar that has lagged behind is health equity, or "equal access to available care for equal need, equal utilization for equal need, and equal quality for all" [3, 4]. Achieving health equity requires conditions in which people have the same opportunity for desired health outcomes and no one is disadvantaged by social position or circumstance. Until we see those "desired health outcomes" in all people—until we eliminate health disparities and achieve health equity—we cannot achieve true quality in health care.

Challenges to Health Equity and Quality Care

Major challenges face health care systems worldwide: shifts in patient demographics, uneven distribution of wealth and resources, health provider shortages, and unequal access to care [5–7]. In the USA, the Affordable Care Act presents opportunities to address these challenges, but increased access to health insurance does not guarantee equity of care [4, 8].

In 2012, minority births outnumbered those of whites for the first time, suggesting the demographics of the USA are quickly shifting. About half of the children under five are minorities, and predictions show that the country as a whole will be majority minority by 2043 [9, 10].

As the proportion of minorities in the USA grows, so does the urgency of addressing health disparities in these different groups. The Affordable Care Act and the expansion of Medicaid mean that more people who were previously excluded from our health system for financial reasons will now have increased access to care. This offers a true opportunity to improve the health of people in the USA. But financial coverage for care is only one part of the access and quality equation.

Without an intentional focus on health disparities and the gaps in care experienced by different segments of the patient population, the USA will miss this opportunity of improving health care for all. Countries around the globe face similar challenges and opportunities to deliver better and more equitable care to patients of diverse backgrounds [5].

Obstacles to Quality Care

According to the IOM, obstacles to quality care fall into three categories: underuse, overuse, and misuse. This framework can also be applied to health care disparities, or "differences in access to or availability of facilities and services" [11].

Underuse

Underuse results from difficulties accessing health care, but also from myths and misconceptions about minorities and their health care needs. Several studies have shown that physicians are less likely to prescribe adequate painkillers to minority and low-income patients [12]. A journal article published in 2013, based on data collected from the National Hospital Ambulatory Medical Care Survey from 2006 to 2009, showed that emergency department patients from low-income areas were less likely to receive opioid pain medications than those with similar pain levels from higher-income areas. Black and Hispanic patients were less likely to receive pain medication than white patients regardless of income level [13].

Overuse

In some cases, minority patients receive more of certain types of care. While better control of diabetes has led to lower rates of limb amputation, one study found the rate of limb amputation was five times higher among inner city African Americans when compared to suburban whites. The overuse of amputation (and underuse of aggressive treatment to preserve limbs) in these patients leads to increased disability and reduced quality of life [14].

Misuse

Some patients are less likely to receive standard of care than others. One study showed that black patients presenting for emergency care with the same chest-pain symptoms were less likely to receive the standard of care (EKG, aspirin, oxygen, and referral for catherization) than white patients [15].

Some of these inequities can be traced back to the underrepresentation of minorities in clinical studies. Even though most academic medical centers are located in urban areas surrounded by minority communities, these communities continue to be underrepresented in most studies [16]. Evidence-based guidelines for safe, efficient, and excellent care developed based on studies for a 70-kg white male may not apply to people who do not fit that description.

After revelations about the Tuskegee experiments (in which African American men were denied treatment for syphilis so that researchers could observe the natural course of the disease), many minorities were understandably apprehensive about participation in clinical trials. While that fear is waning now, there are still plenty of barriers for some populations to participate in health care research, such as transportation and the need to take off time from work. In addition, some factors most likely to facilitate participation in clinical research are physician communication and when "patients see themselves as similar to their physicians" [16, 17].

Benefits of Diversity

Diversity refers to the richness of human differences in socioeconomic status, race, ethnicity, language, nationality, sexual orientation, gender identity, religion, geography, abilities, age, personality, learning styles, and life experience [18]. When people of diverse backgrounds work together, their combined qualities, experiences, attributes, and skills can lead to innovative thinking and creative solutions to previously intractable challenges.

Merely putting people of different backgrounds together in the same place does not automatically benefit an organization or a society. Inclusion—the active, intentional, and ongoing engagement with diversity—is what brings out the benefits of diversity. We achieve inclusion by creating a climate and culture within an institution or a society that fosters belonging, respect, and value for all [18]. To unlock the benefits of diversity, we have to build an inclusive culture that leverages those differences for the greater good.

Combined with inclusion, diversity benefits quality of care in several different ways. A diverse health workforce is more able to deliver quality, patient-centered care to more people through:

- Improved access to care: Physicians from underrepresented groups are more likely to practice in areas that that are underserved, including rural areas and minority communities [19, 20].
- Improved learning environment: When people from different backgrounds learn or practice together, they become more comfortable asking each other questions and learning about different backgrounds. Then, they pull from those experiences when treating patients of different backgrounds [21].
- Increased cultural competence: Providers who are used to working with people from different backgrounds may recognize cultural differences more easily than providers who have worked only in homogeneous environments [22].
- Greater chance for physician–patient concordance: Patients who have some demographic concordance with their provider trust their physician more, have higher patient satisfaction ratings, and are more likely to adhere to treatment, which could lead to better outcomes. This is true when patient and provider are from the same race, but similar benefits derive if the provider speaks the same language or shares the same rural or urban background as the patient [17].
- Greater recognition of inequities in care: A more diverse workforce may recognize more readily when care is not being delivered equitably [23].

At the Association of American Medical Colleges (AAMC), we conduct surveys of medical students called the Matriculating Student Questionnaire and the Graduating Student Questionnaire. During the first week of medical school, students answer a series of questions about a wide range of topics, including their comfort in dealing with people who are different from them. Four years later, we ask the students the same questions to determine if their comfort level has changed. Our

results show that students attending schools with the greatest diversity have the greatest increase in their comfort levels, which translates to improved cultural competency and ability to communicate with people from different backgrounds. In addition, graduating medical students indicate that students who attend medical schools with greater classroom diversity feel more prepared to provide culturally competent care and are more confident in dealing with patients whose backgrounds are different from their own [22].

Mahzarin R. Banaji, Ph.D., professor of social ethics at Harvard University and author of *Blindspot: Hidden Biases of Good People*, explains that our brains work differently when we feel a connection with someone, whether it is because we share an ethnicity, alma mater, geographic location, language, or other attribute. We actually use the same areas of the brain that we use to think about ourselves—paving the way to more empathy and compassion for each other. But when we live and study and work only with people like us, hidden biases persist and affect how we interact with people from different backgrounds. While we cannot totally eliminate hidden bias, she says, we can create a diversity of biases that helps us identify and relate with more people [24]. These are the "Dividends of Diversity," and they will go a long way to addressing health disparities and addressing the equity side of the quality equation [8].

Scott E. Page, author of *The Difference*, takes this a step further. He contends that diversity, more than ability alone, leads to improved performance and innovation. He has conducted rigorous scientific research that shows that people from different backgrounds, heuristics, experiences, and attributes can solve complex problems more quickly and completely than a homogeneous group. He argues compellingly that diversity is a driver of excellence [25].

The lack of diversity among health care professionals allows disparities to continue not because white physicians do not care or are insensitive to the needs of patients who are different from them, but because increasing diversity expands our potential to find creative solutions to our health care challenges, mitigate against disparities, and improve care overall.

Conclusion

Our understanding of diversity is evolving. We have moved from a perceived competition between the ideals of diversity and quality to a construct in which diversity is co-equal with excellence. While once there was the perception that we had to abdicate some aspects of excellence to achieve diversity, we now realize that diversity and excellence are equally important. We often hear administrators state a goal to be "diverse and excellent." The next step is the realization that our health care workforce cannot be excellent *without* diversity, that diversity actually accelerates our pace to delivering excellent quality care for all people.

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Chapter 2
Racial/Ethnic Health Care Disparities and Inequities: Historical Perspectives

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Introduction

The five racial/ethnic categories of the US 1990 census were expanded to 14 categories for the 2000 census [1]. For the first time, people were allowed to choose more than one option. Seven million Americans identified themselves as more than one race (2.4 %). The US census at that time was estimated to be 75 % white, 12.5 % Hispanic, 12.3 % black, 3.6 % Asian, and 0.9 % Native American [2, 3]. The 2010 US Census illustrated even greater diversity and reported the US population to be 72 % white, 16 % Hispanic, 13 % black, 5 % Asian, and 0.9 % Native American [3]. Notable changes in the past decade include a 13 % increase in both Hispanic and Asian populations. By 2050, the US population is projected to be about 50 % white and 50 % comprising Asian, Hispanic, Native American, and African American [4]. Despite the rapidly changing ethnic/racial landscape in America, disparities in health care have perpetuated.

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