Society, Culture, and Race in Clinical Care
Webinar Logistics

- All attendees will be automatically muted and in listen-only mode for the duration of the presentation
- Participation is highly encouraged!
  - The speaker will take questions at the end of the webinar.
  - Please submit your responses to the polls during the presentation.
  - Don’t forget the satisfaction survey following the webinar.
- All slides and the audio recording will be made available on our website following the presentation
  - http://www.nyp.org/pps/resources/pps-webinars
• **Bradley Matthys Moore, PhD**, Research and Partnerships Manager at The Lenox Hill Neighborhood House
Society, Culture, and Race in Clinical Care

New York-Presbyterian PPS
Cultural Competency / Health Literacy Work Group
NYP PPS Cultural Competency / Health Literacy
Tip Sheets, Webinars, and Online Resources

Tip Sheets and Webinars:
- Society, Culture, and Race in Clinical Care (Webinar 3/29/2017)
- Health Literacy (Webinar 4/20/2017 – Combined with Teach-Back)
- Teach-Back and Barriers to Adherence Discussion
- Gender Identity and Sexual Orientation (Webinar TBA)
- Disability (Webinar TBA)
- Linguistic Barriers (Webinar TBA)

Online Resources:
- NYP PPS Cultural Competency / Health Literacy web page
  http://www.nyp.org/pps/cultural-competency/training-resources
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  http://www.nyp.org/pps/resources/quality-interactions
- Healthify (Phased Implementation)
- HITE (Health Information Tool for Empowerment)
  https://www.hitesite.org/
“To speak a language is to take on a world, a culture.”

-Frantz Fanon
The Language and Culture of Health Care Provision

- A1C?
- FEV1?
- BMI?
- Medial or lateral?
- Gravid?
- Creatine kinase?
- Neoplasm?
- Anthroplasty?
- ICD 10?
- CPT?
- FQHC?
- EBM?

Randall Munroe, XKCD Comics, https://xkcd.com/1147/
...and Social Services

- SNAP?
- TANF?
- HEAP?
- CHIP?
- MI?
- 2010e?
- SP-SRO?
- NSI?
- PHQ9?
- FPL?
- MAGI?
Health Care Provision and Cross-Cultural Communication

- Clinical Diagnostics
- Patient’s Experience of Illness
- Treatment Plan
- Patient Symptoms

Diagram illustrates the process of health care provision and cross-cultural communication, involving clinical diagnostics, patient’s experience of illness, and treatment plan.
Situating the Illness Experience: The Case of East Harlem

Multiple data sources, Data2go, Community District 11, East Harlem. www.data2go.nyc
The Case of East Harlem: History, Housing, Racism, and Poverty

982 (1). Adequacy of Civic, Social, and Commercial Centers. These elements of comfortable living usually follow rather than precede development. Those centers serving the city or section in which the development is situated should be readily available to its occupants. Schools should be appropriate to the needs of the new community and they should not be attended in large numbers by inharmonious racial groups. Employment centers, preferably diver-

1032. The borrower who acquires property for occupancy in a location inhabited by a class or race of people that may impair his interest in the property—and thereby affect his motivation—should be ascribed a lower rating in this feature to reflect the diminishing importance of the property to the borrower. Diminishing importance from this source may reduce motivation to a degree justifying rejection of the borrower in this feature. A borrower who

Underwriting Manual: Underwriting Analysis under Title II, Section 203 of the National Housing Act, United States Federal Housing Administration, 1938.

The Case of East Harlem: Disinvestment, Community Disruption, and Planned Development, 1930-1980


East Harlem has the second highest concentration of public housing in the nation – 24 NYCHA Housing Developments were built in the area between the 1940s and 1980s. Map New Directions: A 197-A Plan for Manhattan Community District 11 (Revised 1999)
The Case of East Harlem: Socioeconomic Impacts of a Racist Policy

**American Human Development Index (AHD):**
3.97

- **Inequality:**
  - Gini Coefficient of Income Inequality: 0.59
  - (The higher the score, the more unequal income distribution is in an area)

**Housing Assets:**
- NYC avg 69.5%
- NYC avg 30.5%

**Poverty:**
- 32.6% Poverty (% of households with incomes below poverty)
- 33.6% Elderly Poverty (% of adults 65 and older)
- 22.4% Poverty (% of households with incomes below NYC CEO poverty line)
- 39,196 Poverty (# of individuals in households with incomes below poverty)
- -11.7% Households in Poverty: Change Since 1999 (% change)
- 11,462 Child Poverty (# of children under 18 in households with incomes below poverty)
- 12.7% Employed Workers with Income Below Poverty Level (%)

**Homelessness:**
- NYC avg 3.3
- NYC avg 10.9

Multiple data sources, Data2go, Manhattan Community District 11, East Harlem. www.data2go.nyc
East Harlem: Health Disparities

Hospitalizations due to stroke (per 100,000 adults)

- East Harlem: 401 (RANKS 12th)
- Greenwich Village and Soho: 140 (RANKS 59th)
- Manhattan: 264
- NYC: 319

Infant mortality rate (per 1,000 live births)

- East Harlem: 6.0 (RANKS 17th)
- Upper East Side: 1.0* (RANKS 59th)

Premature mortality rate (per 100,000 population)

- East Harlem: 301.0 (RANKS 51st)
- Financial District: 75.6 (RANKS 52nd)

Psychiatric hospitalizations (per 100,000 adults)

- East Harlem: 2,016 (RANKS 1st)
- Financial District: 259 (RANKS 59th)
- Manhattan: 755
- NYC: 684

Top causes of death and rates (per 100,000 population)

<table>
<thead>
<tr>
<th>Cause</th>
<th>East Harlem</th>
<th>Death Rate</th>
<th>New York City</th>
<th>Death Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>1,279</td>
<td>205.3</td>
<td>1</td>
<td>202.6</td>
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<tr>
<td>Cancer</td>
<td>1,099</td>
<td>180.2</td>
<td>2</td>
<td>156.7</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>216</td>
<td>35.3</td>
<td>2</td>
<td>20.6</td>
</tr>
<tr>
<td>Lower respiratory diseases</td>
<td>190</td>
<td>30.9</td>
<td>5</td>
<td>19.8</td>
</tr>
<tr>
<td>Flu/pneumonia</td>
<td>181</td>
<td>29.2</td>
<td>3</td>
<td>27.4</td>
</tr>
<tr>
<td>HIV</td>
<td>172</td>
<td>28.0</td>
<td>6</td>
<td>8.4</td>
</tr>
<tr>
<td>Stroke</td>
<td>149</td>
<td>24.0</td>
<td>9</td>
<td>18.8</td>
</tr>
<tr>
<td>Hypertension</td>
<td>135</td>
<td>21.6</td>
<td>8</td>
<td>11.4</td>
</tr>
<tr>
<td>Drug-related</td>
<td>103</td>
<td>16.6</td>
<td>9</td>
<td>8.6</td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
<td>89</td>
<td>13.8</td>
<td>11</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Percent who self-reported their own health as “excellent,” “very good” or “good”

- East Harlem: 70% (RANKS 48th)
- Upper East Side: 92% (RANKS 1st)
- Manhattan: 83%
- New York City: 78%

“Your zip code is a better predictor of health than your genetic code” – Melody Goodman, PhD
Population-Level Health Disparities in Access, Treatment, and Care


Health Care and Cross-Cultural Communication (Revisited)

Patient’s Experience of Illness

Clinical Diagnostics

Patient Symptoms

Treatment Plan
Recognizing the Complex Ecologies of the Illness Experience: Race, Culture, Society & Environment

<table>
<thead>
<tr>
<th>The Influence of Lived Experience: Illness Management and Health Behaviors Don’t Occur in a Vacuum</th>
</tr>
</thead>
</table>

- Stigma
- Racism/Sexism/Bigotry
- Limited Access/Work/Sick Time
- Financial Stress/Poverty
- Time Constraints
- Transportation Issues
- Family/Social Support
- Physical Accessibility
- Medical Skepticism
- Depression/Anger/Resentment/Anxiety
- Pill or Injection Burden/Adverse Side Effects/Complex Treatment Regime
- Misunderstanding/Inadequate Counselling
- Folk/Alternative/Traditional Remedies
- Different Cultural Understandings of Illness
- Environmental Constraints
- Lack of Provider Coordination
“Narrative humility acknowledges that our patients’ stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with…[it] allows clinicians to recognize that each story we hear holds elements that are unfamiliar—be they cultural, socioeconomic, sexual, religious, or idiosyncratically personal.”

General Tips on Cultural Competence: The NYP PPS Tip Sheet

- Create a welcoming clinical environment across cultures and groups (representation, accessibility, staffing).

- Treatment planning is shared decision making – seek out a patient’s healing beliefs and personal view of successful outcomes in treatment planning.

- Include family members in healthcare decisions when requested.

- Consider cultural, spiritual, and religious beliefs that may complement or conflict with standard medical care or treatment planning.

- Consider potential role of medical or scientific skepticism/mistrust in treatment planning.
General Tips on Cultural Competence: The NYP PPS Tip Sheet

Avoid racial, cultural, or ethnic assumptions about notions of health and healing:

– An individual’s visual, personal, and cultural identities can and do conflict.
– Specific population and sub-group level trends ≠ individual patient-level behavior, beliefs, or experiences.

Normalize and seek out common issues with treatment adherence during treatment planning:

– Example: “Some people have difficulty filling prescriptions. What kinds of issues might make it hard for you to get these medications?”
– Example: “Sometimes people have difficulty connecting with a regular doctor. What kinds of issues might make it hard to find a regular doctor?”
Six Step Model of Culturally Informed Care – Adapted from Arthur Kleinman & Peter Benson

1) Determine whether ethnic identity is an important part of the self.

2) Evaluate what is at stake for the patient and their family in this episode of illness.

3) Reconstruct the patient’s illness narrative, i.e., their own understanding of their illness.

4) Evaluate the potential role of psychosocial barriers and stressors in treatment.

5) Assess how culture, stereotypes, or bias may be impacting the clinical encounter or treatment planning.

6) Seek cultural sensitivity, yet avoid unnecessarily racial, ethnic, gendered, or sexual identity-based interpretations of treatment needs/difficulties.

“If we were to reduce the six steps of culturally informed care to one activity that even the busiest clinician should be able to find time to do, it would be to routinely ask patients (and where appropriate family members) what matters most to them in the experience of illness and treatment. The clinicians can then use that crucial information in thinking through treatment decisions and negotiating with patients.”

-Kleinman & Benson 2006
Teach-Back and Barriers to Adherence Discussion: Does the patient have the knowledge, ability, and opportunity to follow the treatment plan?
Questions?

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Upcoming Webinars from NYP PPS and Collaborators:

Register Here: http://www.nyp.org/pps/resources/pps-webinars

An Overview of the Health Home Serving Children
Tuesday, April 4, 2017 from 11:00 AM - 12:00 PM EST
This webinar will feature Jodi Saitowitz, LCSW, Executive Director of The Collaborative for Children and Families.

Health Literacy and Teach-Back Techniques: Overcoming Barriers to Adherence
Thursday, April 20, 2017 from 2:00 PM - 3:00 PM EST
This presentation will feature Dodi Meyer, MD, Director of Community Pediatrics and Associate Professor of Pediatrics at Columbia University Medical Center, and Emelin Martinez, Program Manager for the Health Education and Adult Literacy (HEAL) Program and Reach Out & Read at NewYork-Presbyterian Hospital.

Special Webinar Announcement from GNYHA/NYLag LegalHealth:
Understanding the Current Immigration Landscape for Patients
Thursday, March 30, 2017 from 3:00 - 4:30 PM EST
Register: https://join.onstreammedia.com/register/92762188/qaqm3zw

We want to hear from you! Please contact ppsmembership@nyp.org with any feedback.
Bradley Matthys Moore, PhD, Research and Partnerships Manager, Lenox Hill Neighborhood House, bmoore@lenoxhill.org

NYP PPS Cultural Competency and Health Literacy Workgroup:

ppsmembership@nyp.org