Patients, Profits, Pressures, and Professionalism
Gene Farley Lectureship

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Objectives

1. Understand and prioritize patient and family-centered care in a culturally-diverse environment
2. Recognize the drivers influencing the healthcare industry today
3. Identify the impact of industry transformation on physicians and the health care team
4. Preserve integrity and professionalism in the midst of the storms

Case Study

- Ms. S is 54 years old, works as a nurse, cares for her disabled mother, two teen/ish children, and is the back-up babysitter for her 2 year old granddaughter
- She is active in her church ladies' group
- Because of increased expenses and her older daughter moving back home, she has taken an extra part-time job to help with expenses
- Ms. S has felt stressed and overwhelmed for many months now, gets most of her comfort from cooking and eating with friends, and cannot remember the last time she did any regular exercise

Case Study (2)

- Ms. S has been feeling tired lately – even when she goes to bed early, she does not feel rested when she awakens
- She finds herself urinating more frequently and even gets up to urinate at least begun having a little wine with meals to relax herself and has restarted an old smoking habit she quit more than 5 years ago
- She is having increasingly frequent episodes of mid-epigastric abdominal pain that improves somewhat when she ingests antacid tablets
- Her daughter thinks she should talk to someone about these symptoms…

Case Study (3)

- Although her daughter makes her an appointment to see her physician, Ms. S becomes impatient while waiting for the physician, and just asks for a prescription medication to help her abdominal pain
- She leaves the physician's office with a prescription for Ranitidine and goes to work her part-time job
- Her daughter calls her best friend – and asks her what she should do? She is worried that she will lose her mother just like she lost her aunt who died of a stroke at age 57 two years ago
- ?????

Case Study (4)

- Ms. S calls her daughter the next afternoon saying she felt nauseous when she arrived at work, but worked with several patients, grabbed bites of MacDonald's hamburgers a co-worker picked up. She vomited multiple times throughout the shift and is now in the emergency department of the local hospital.
- What do you think is going on?

Identifying Chronic Illness

- ~50% of people with chronic illness have multiple conditions
- But there are many deficiencies in the management of diseases such as diabetes, heart disease, depression, asthma and others.
- Those deficiencies include:
  - Rushed practitioners not following established practice guidelines
  - Lack of care coordination
  - Lack of active follow-up to ensure the best outcomes
  - Patients untrained to manage their illnesses

Who is likely to be providing care for Ms. S?

The Millennial Generation, or simply Millennials

- The generation of people born between the early 1980s and the early 2000s (1982-2000).
- Also known as Generation Y, because it comes after Generation X — those people between the early 1960s and the 1980s.
- Has also been called the Peter Pan or Boomerang Generation because of the propensity of some to move back in with their parents, perhaps due to economic constraints,
- Growing tendency to delay some of the typical adulthood rites of passage like marriage or starting a career.
- http://www.livescience.com/38061-millennials-generation-y.html

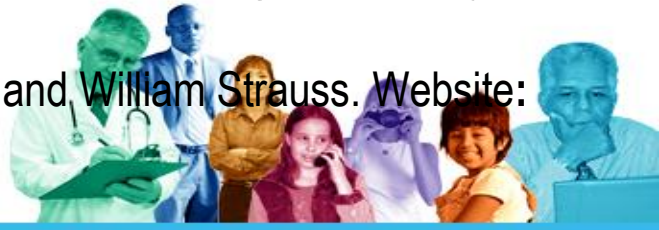
Millennials

- High educational debt
- Reared under duty hours regulations
- Attended college with few first generation college students – so grew up surrounded by professionals
- Represent the smartest, healthiest, and wealthiest….caring for citizens who live at a time of increasing wage and income disparities

Millennial characteristics

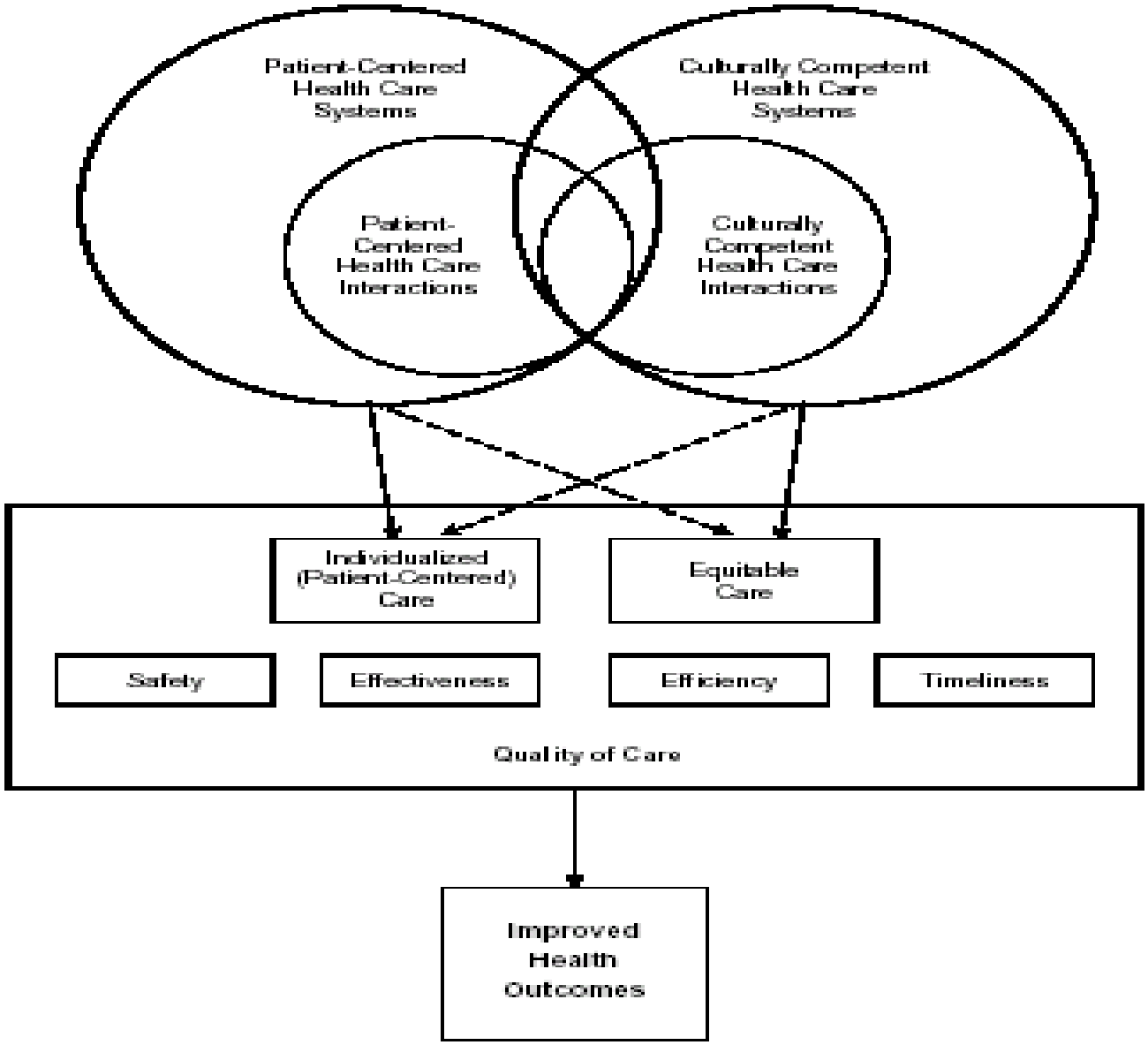
- **Special -** Have always been treated as special and important
- **Sheltered -** Highly protected as children
- **Confident -** They are motivated, goal-oriented, and confident in themselves and the future.
- **Team-Oriented -** They are group oriented rather than being individualists.
- **Achieving -** Grade points are rising with this generation; focus on getting good grades, hard work, involvement in extracurricular activities, etc. is resulting in higher achievement levels
- **Pressured -** Tightly scheduled as children and used to having every hour of their day filled with structured activity.
- **Conventional -** Respectful to the point of not questioning authority.

- Resource: **Millennials Go To College** (2003) by Neil Howe and William Strauss. Website: **www.lifecourse.com**



Spirit of confidence, self-sufficiency, privilege

Figure 1. Patient-Centeredness and Cultural Competence Integral to Health Care Quality



Components of Cross-Cultural Health Care*

*Lonner and Mayeno LY Encouraging more culturally &linguistically competent practices in mainstream health care organizations,
2007, http://www.calendow.org/Collection_Publications.aspx?coll_id=46&ItemID=322#

Cultural Determinants

- Age
- Gender
- Family
- Race
- Ethnicity
- Language
- Nationality
- Religion

CULTURALLY RELATED FACTORS

- Ability/disability
- Geography
- Sexual Orientation
- Vocation
- Education
- Socioeconomic status

- Health care organizational culture has a profound effect on the capacity as well as the commitment to provide culturally competent care

“If you ask a shoemaker to make a hat, it will remarkably resemble a shoe”

“To a hammer, everything looks like a nail”

Multiple Cultures

- Health care culture
- Academic culture
- Political culture
- ??? Geographic; Ivy League; Big Ten

- Sacks P. Class rules: the fiction of egalitarian higher education. Chronicle of Higher Education. http://chronicle.com/article/Class-Rules-the-Fiction-of/6152; accessed 4/15/2010

Case of Ms H – a Muslim woman with IUFD

Cultural Humility

- A lifelong commitment to self-evaluation and self-critique
- Redressing the power imbalances in the patient-physician dynamic
- Developing mutually beneficial partnerships with communities on behalf of individuals and defined populations

Tervalon M, Murray-Garcia J: "Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education, "Journal of Health Care for the Poor and Underserved 1998; 9(2):117-124.

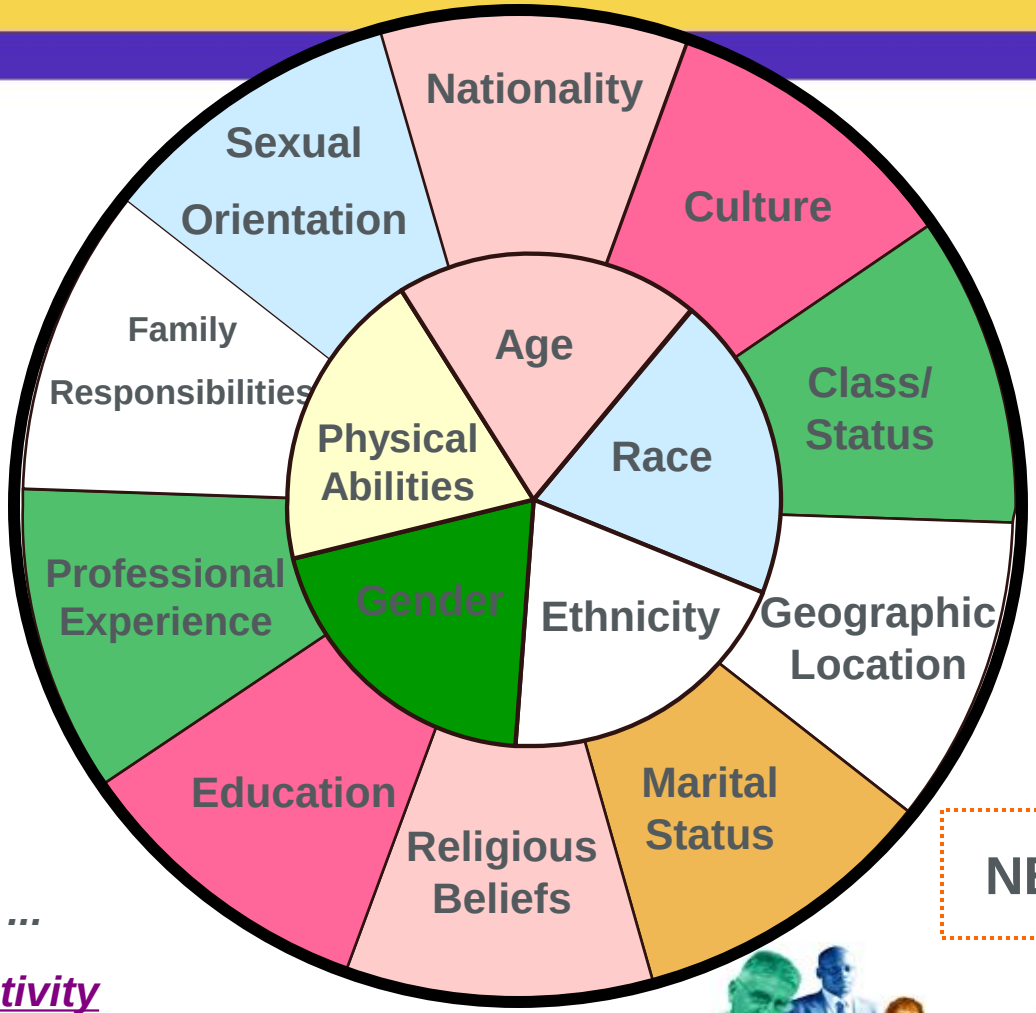
Within - Group Diversity

is often greater than

Between - Group Diversity

The Diversity Kaleidoscope

All aspects of an individual are recognized as contributing to diversity



NEOMED

A Diverse Workforce Offers ...

Marketing Advantage

Insight and cultural sensitivity, ability to tap diverse markets

Creativity

More alternatives and higher quality solutions.

Cross-Cultural Skills

Enhances global competency and the capability to function in diverse cultural environments

Continuum of Cultural Competence

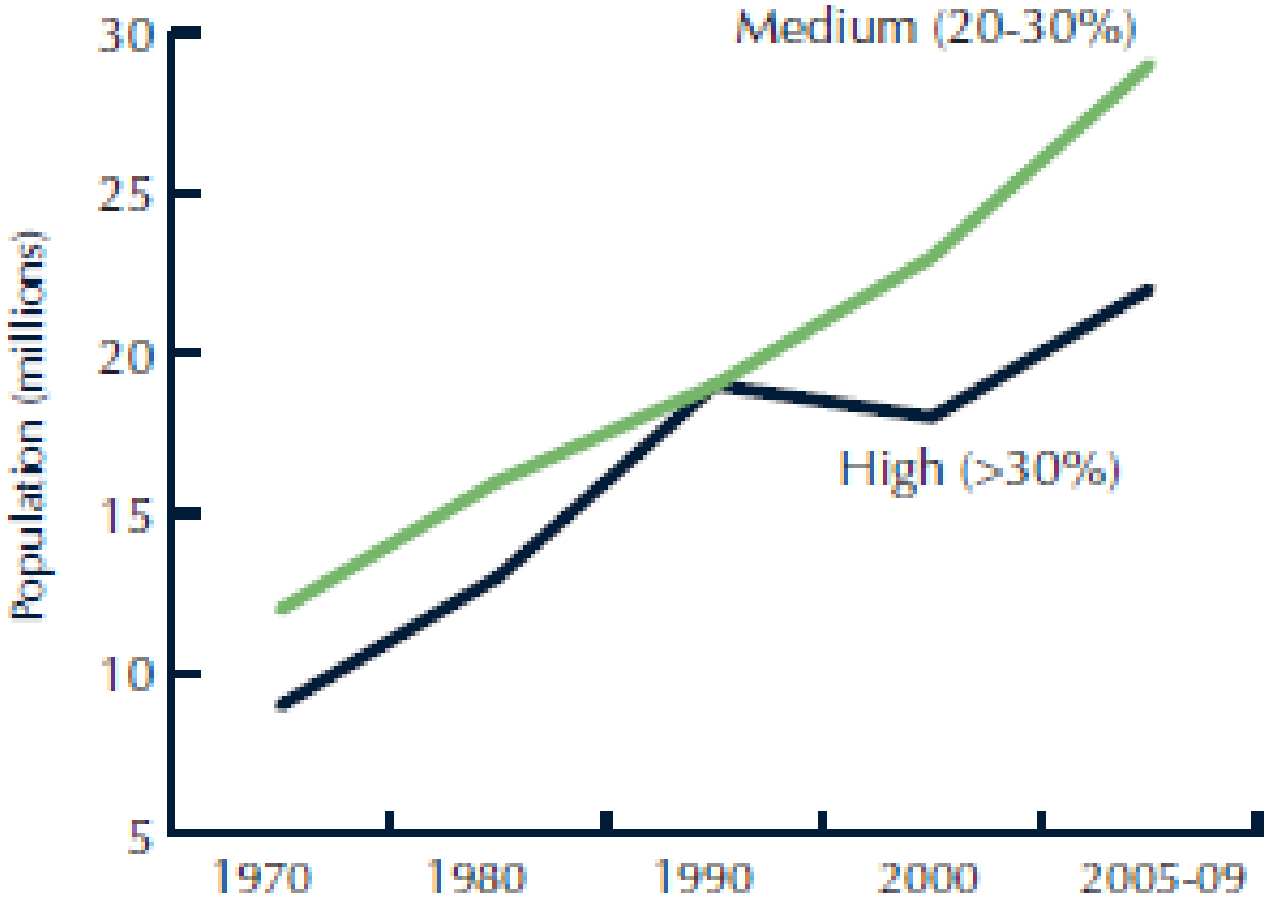
Cultural destructiveness	Attitudes, policies and practices destructive to cultures and individuals, e.g. Native American boarding schools, Tuskegee Syphilis Study
Cultural incapacity	Maintain biases and lacks capacity to work with diverse communities, e.g. discriminatory hiring practices
Cultural blindness	Belief that "all people are the same," ignores strengths, differences, and encourages assimilation, e.g. lack of language signs
Cultural pre-competence	Recognize weaknesses and initial attempts through hires, outreach, training, etc. -- some commitment and some action
Cultural competence	Accept and respect differences, continually assesses competence, active hiring, training. Commitment to policy and action
Cultural proficiency	Holds culture in high esteem, advocates for cultural competence throughout the system

Socioeconomic Disparities in Health

- National data of 5 child and 6 adult health indicators
- Those with lowest income and least educated were consistently least healthy
- Gradient patterns seen often among non-Hispanic Blacks and Whites and less consistently among Hispanics
- Health in the US is often, though not invariably, patterned strongly along both socioeconomic and racial/ethnic lines

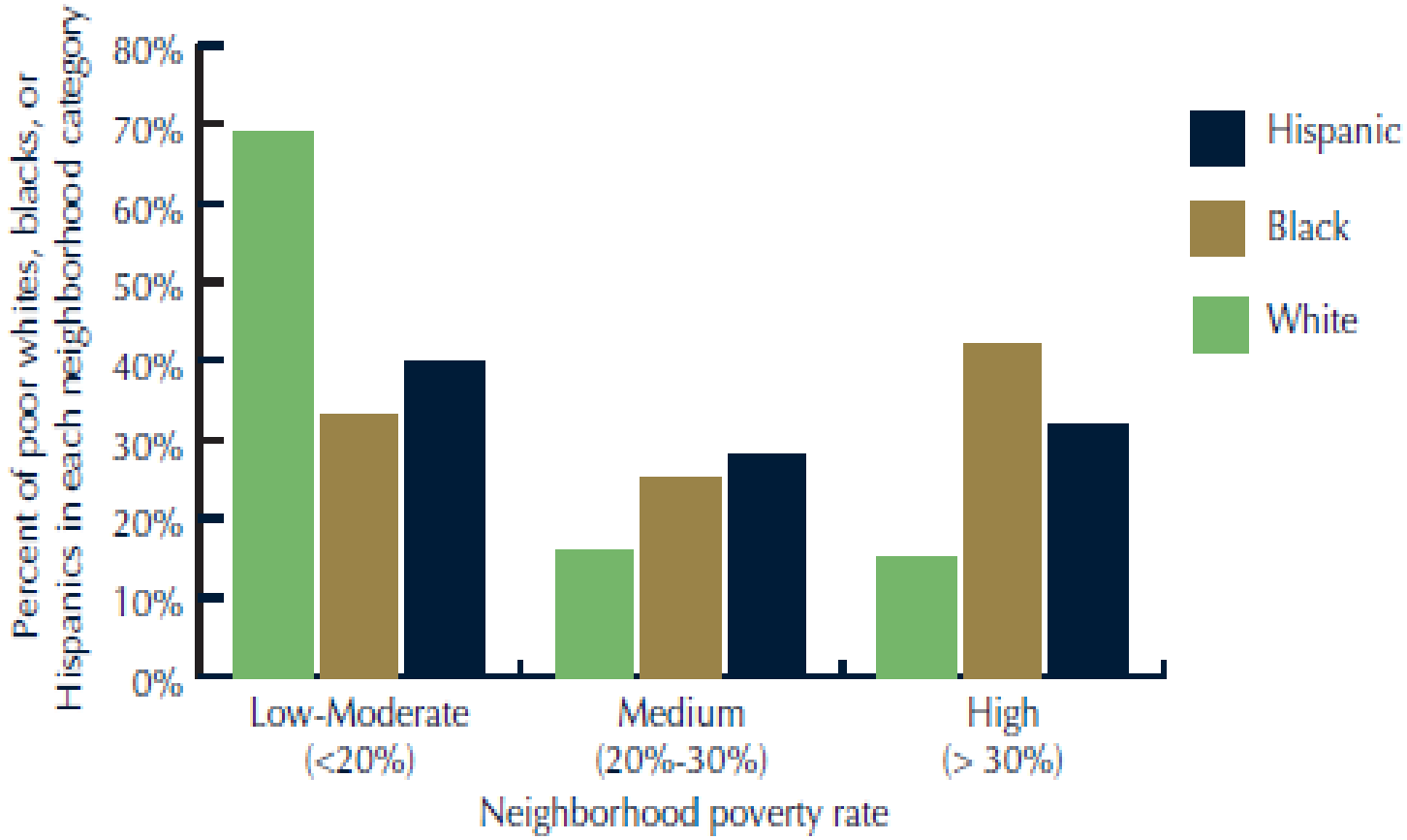
Braveman PA, Cubbin C, Egerter S, et al. Socioeconomic disparities in health in the US: what the patterns tell us. Am J Public Health 2010 Apr 1:100 Suppl 1:S186-96

Figure 2. Population rising in high- and medium-poverty tracts



Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors' calculations.

Figure 9. Poor African Americans, Hispanics live disproportionately in high-poverty neighborhoods



Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors' calculations.

Segregated Spaces, Risky Places: The Effects of Racial Segregation on Health Inequalities

1. Between 2000 and 2010, residential segregation by race declined – but did not disappear – with respect to African Americans and Hispanics. Racial segregation in housing persistent pattern nationwide;
2. Segregation continued predictor of significant health disparities -- as measured by divergent rates of infant mortality – in comparisons between African Americans and whites and between Hispanics and whites;

Updates previously published findings - relationship between residential segregation and racial disparities in infant mortality rates across U.S. cities (LaVeist 1989, 1993).

- http://www.jointcenter.org/sites/default/files/upload/research/files/Segregated%20Spaces-web.pdf

Segregated Spaces, Risky Places: The Effects of Racial Segregation on Health Inequalities

3. Although residential segregation is decreasing, the relationship between segregation and infant mortality disparities has intensified; and
4. Simulations of effect of segregation on racial gaps in infant mortality rates → complete black-white residential integration would result in at least two fewer black infant deaths (2.31) per 1000 live births. With full integration, Hispanics would have a lower rate of infant mortality rate than whites.

- http://www.jointcenter.org/sites/default/files/upload/research/files/Segregated%20Spaces-web.pdf

Place Matters

Are racial and ethnic disparities in five selected health status measures associated with the racial composition and poverty level of neighborhoods?

- The primary findings from the second study :

- *Place matters and it makes a significant difference for 3 out of 5 common health indicators, including*
  - *(a) general health,*
  - *(b) mental health and*
  - *(c) diabetes.*

- http://www.jointcenter.org/sites/default/files/upload/research/files/Segregated%20Spaces-web.pdf

A Lost Decade: Neighborhood Poverty and the Urban Crisis of the 2000s

- The second study (Pendall, et al) tested whether the correlation between segregation and health disparities varies more in accordance with the racial composition of neighborhoods or the concentration of neighborhood poverty.
- Data from the 2006 Medical Expenditure Panel Study (MEPS) along with zip code level data from the 2000 US Census (Summary File 1) were used to examine the relationships between segregation, concentrated poverty and racial and ethnic health inequalities.

- http://www.jointcenter.org/sites/default/files/upload/research/files/Segregated%20Spaces-web.pdf

Neighborhood Poverty

- Community-level poverty - more important to health status than neighborhood racial composition.
- After controlling for concentrated poverty - health status advantages for whites decreased in comparison with blacks and Hispanics.
- Policy makers should address the problems associated with concentrated poverty.

- http://www.jointcenter.org/sites/default/files/upload/research/files/Segregated%20Spaces-web.pdf

Case Study (5)

- Ms. S's Physical Exam in the ED
  - BP 170/98, HR 88, T 37, R 16, Weight 80 kg, BMI 32
  - Skin is damp and she is sitting up on bed, anxious, and uncomfortable
  - Neck supple without distended neck veins; Carotid pulses strong without bruits
  - Lungs clear to auscultation and percussion
  - Tachycardic, no murmurs or ectopy
  - Abdomen obese, soft, generalized tenderness to palpation without organomegaly or rebound
  - Extremities without deformities or edema

Case Study (6)

- Ms. S
  - Glucose = 315
  - Urinalysis – unremarkable
  - Hemoglobin = 14
  - Total cholesterol = 250
  - CXR – No evidence or cardiomegaly, pulmonary inflitrates
  - Electrocardiogram – No acute changes or ventricular enlargement
  - Abdominal ultrasound – Gall stones

What factors affect caring for Ms. S?

What factors influenced the care of the Muslim patient (Ms H)?

Case Study (7)

- Factors affecting care of Ms. S
  - Patient resistance to care
  - Multiple clinical issues
  - Work schedule between 2 jobs
  - Need for acute and chronic care
  - Need for patient education
  - Need to engage her family
  - Need for health care system support

Case Study (8)

- Factors affecting care of Ms. H
  - Patient non-traditional religious mores
  - Discomfort (cultural incompetence) with this minority group
  - Urgency of situation and care by multiple providers
  - Documentation of important info lost in a voluminous EMR
  - Impact of state regulations
  - Need for health care system support

Problems with Current Disease Management Efforts

- Emphasis on physician, not system, not individual behavior
- Lack of integration across care settings hindering quality care –
  - Use of urgicare centers and emergency departments rather than one primary care clinician
- Available interventions not being used successfully
- Commonalities across chronic conditions unappreciated
  - Multiple conditions respond to diet and exercise

Family Medicine for America's Health:

Four year plan to transform our health care system and ensure the health of all Americans. Specifically, we aim to:

1. Increase **patient accessibility** to their primary care team, including remote access to patient records, electronic communication with their care team and availability after hours.

2. Encourage every practice to have a **patient advisory council** or similar mechanism to facilitate meaningful and ongoing patient engagement.

3. Increase **transparency in pricing of health care services** and educate patients to better understand cost of care.

4. Integrate **public and mental health into the Patient-Centered Medical Home** (PCMH) and add care managers, health coaches and population health professionals to the primary care team. Incorporate training to practice in a team-based setting into graduate medical education.

5. Support policies that drive **at least 40 percent of medical students toward primary care specialties** with the goal of increasing the number of primary care physicians by a minimum of 52,000 by 2025.

6.Sunset fee-for-service payment in primary care. Work with public and private payers to adopt a uniform and simplified model of comprehensive payment that encourages front-end investment in expanded practice infrastructure and technology, rewards Triple Aim goals (better care, better health and lower costs) and supports broad, team-based care. Support efforts to drive HHS goal of having 85 percent of Medicare payments tied to quality or value by 2016 and 90 percent by 2018.

Washington Post September 16, 2015

Number of Americans who lack health insurance took big dip in 2014

The proportion of Americans who lack health insurance took a big dip last year, with nearly 9 million people gaining coverage since 2013, according to federal figures announced Wednesday. The figures from an annual Census survey found that the share of people across the country who were uninsured fell from 13.1 percent in 2013 to 10.4 percent last year.

Spreading health insurance to more Americans was a main purpose of the 2010 Affordable Care Act. But from the outset, it was clear that it would take years for firm evidence to materialize of whether the law was succeeding at that goal.

The two big strategies built into the law to widen access to health coverage — insurance exchanges selling private health plans to people who cannot get insurance through a job, and an expansion of Medicaid for people with lower incomes — took effect at the start of 2014.

Strategies for Achieving a Culturally Competent Organization

- Environmental assessment
- Institutional team to monitor the environment
- Case-by-case counseling
- Public health assessment of the community
- Team building activities

Perform Cultural Self-Assessment

- Organization assesses and understands its own culture
  - The shared values, beliefs, language that are used, images and themes explored in conversation and the various rituals of daily work
- Examine how the organization's culture interfaces with that of the staff and community
  - Is this an institution that honors and demands intolerance to acts of racism, sexism or some other "isms" or has it systematically actively or passively allowed or even promoted these "isms"

Institutionalize Cultural Knowledge

- Educate staff on the cultural groups that the organization serves
  - History, traditions, language, values, family systems
- Incorporate cultural knowledge into service delivery
- Training in and development of systems to manage medical and social issues
  - Female interpreters for Muslim women
- Provide language appropriate resources, referrals

Barriers to Achieving a Culturally-Competent Organization

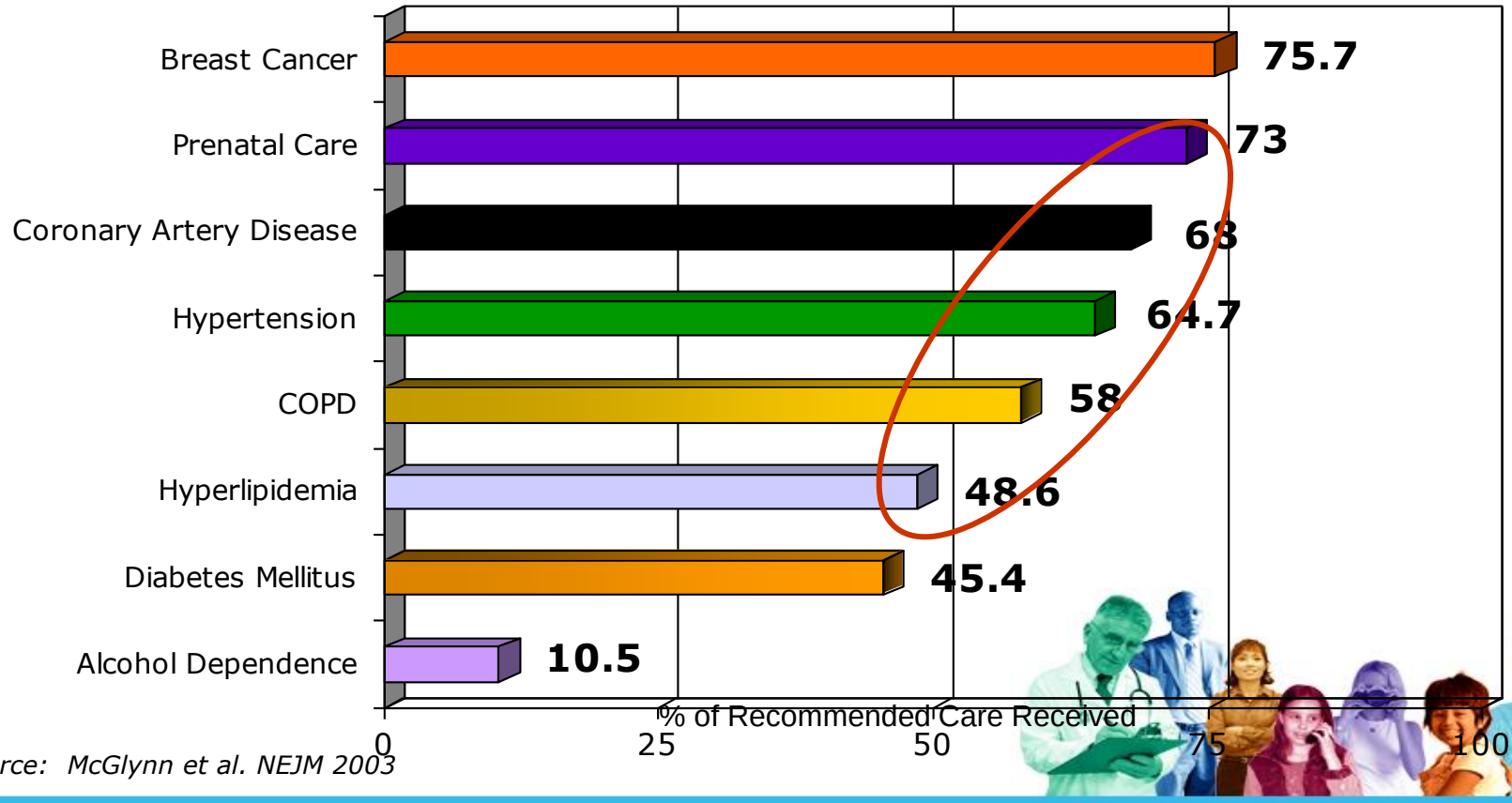
- People
- External forces (e.g., regulations)
- Internal pressures (e.g., bias, historical insults, stress, ignorance)
- Limited resources
- Lack of willpower
- Unfocused leadership

Importance of Community

- Recognition of who they are – cultural mix
- Addressing historical hurts
- Enlisting their support
- Valuing and using their input

What do these environmental changes mean for those in academic medicine?

Adherence to recommended care is low for chronic conditions



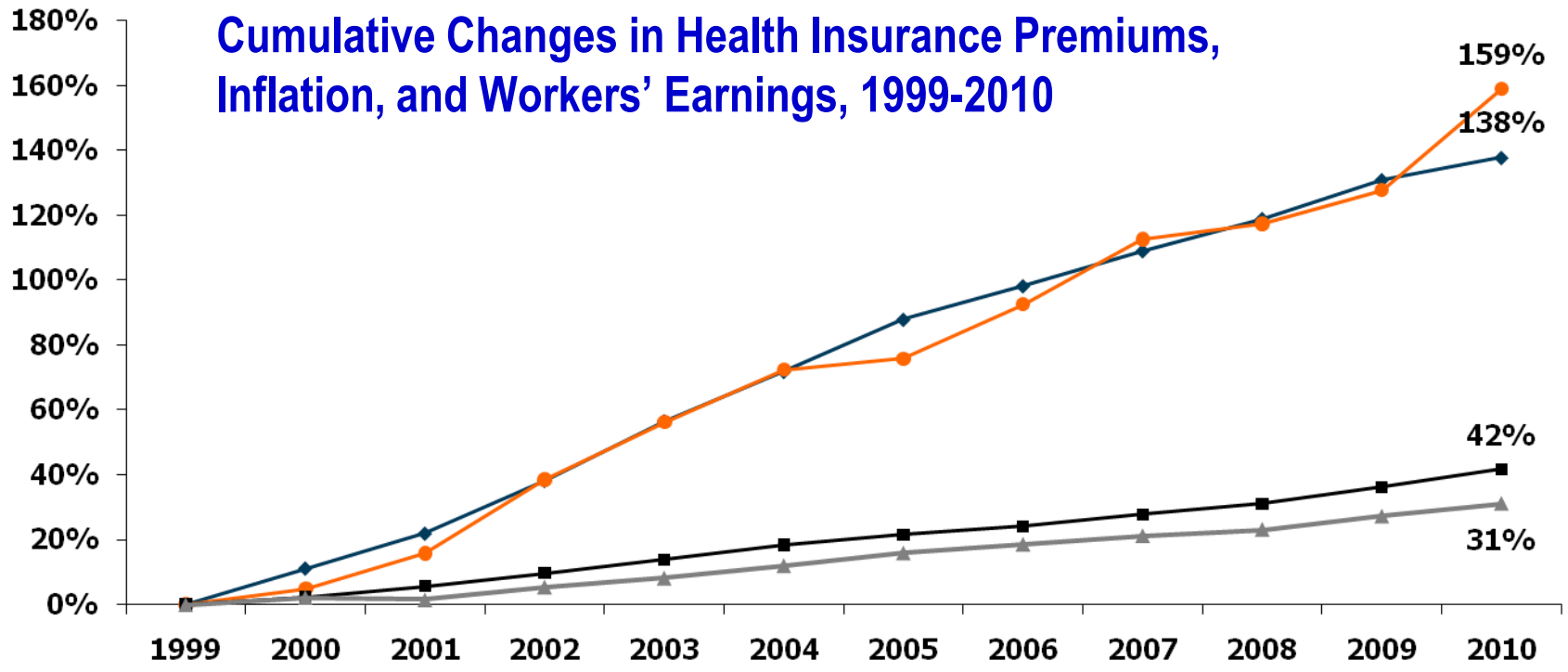
Source: McGlynn et al. NEJM 2003

The toll on patients is high: US Data

CONDITION	SHORTFALL IN CARE	AVOIDABLE TOLL
Diabetes	Average blood sugar not measured for 24%	29,000 kidney failures 2,600 blind
Colorectal cancer	62% not screened	9,600 deaths
Pneumonia	36% of elderly didn't receive vaccine	10,000 deaths
Heart attack	39% to 55% didn't receive needed medications	37,000 deaths
Hypertension	Less than 65% received indicated care	68,000 deaths

Source: Elizabeth McGlynn, et al. “The Quality of Health Care Delivered to Adults in the US.” NEJM 2003; 348:2635-45

Insurance Cost Growth Quadruple the Rate of Wages and Inflation



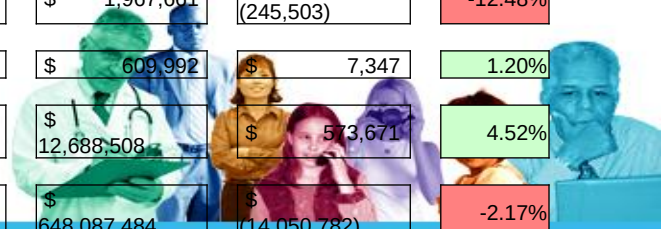
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2010. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2010; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2010 (April to April).

Daily System Charge Report

September 15, 2015

> -2% of budget

	Month to Date Gross Charges				Year to Date Gross Charges			
	Actual	Budget	Variance to Budget	% Variance	Actual	Budget	Variance to Budget	% Variance
UPP	$ 88,502,099	$ 94,551,343	$ (6,049,244)	-6.40%	$ 470,443,459	$ 482,344,185	$ (11,900,726)	-2.47%
CMI	$ 17,885,124	$ 19,516,381	$ (1,631,257)	-8.36%	$ 97,155,747	$ 97,775,372	$ (619,625)	-0.63%
RFP	$ 1,046,904	$ 1,061,087	$ (14,183)	-1.34%	$ 5,429,330	$ 5,424,181	$ 5,149	0.09%
ERMI	$ 6,123,887	$ 6,781,973	$ (658,086)	-9.70%	$ 35,362,134	$ 37,011,650	$ (1,649,516)	-4.46%
EPN	$ 636,561	$ 712,510	$ (75,949)	-10.66%	$ 3,562,904	$ 3,523,345	$ 39,559	1.12%
TRISTATE	$ 1,167,310	$ 1,272,187	$ (104,877)	-8.24%	$ 6,481,452	$ 6,742,591	$ (261,139)	-3.87%
DONOHUE	$ 339,840	$ 423,361	$ (83,521)	-19.73%	$ 1,722,158	$ 1,967,661	$ (245,503)	-12.48%
COMPLETE CARE	$ 127,792	$ 119,438	$ 8,354	6.99%	$ 617,339	$ 609,992	$ 7,347	1.20%
TRI RIVERS SURGICAL	$ 2,833,919	$ 2,549,876	$ 284,043	11.14%	$ 13,262,179	$ 12,688,508	$ 573,671	4.52%
Total PSD	$ 118,663,436	$ 126,988,155	$ (8,324,719)	-6.56%	$ 634,036,702	$ 648,087,484	$ (14,050,782)	-2.17%



Daily Departmental Charges

September 15, 2015

> -2% of budget

Business Unit	MTD Actual (Net of Delays)	MTD Budget	Variance Over / (Under) Budget	Percentage Over / (Under) Budget	YTD Actual	YTD Budget	Variance Over / (Under) Budget	Percentage Over / (Under) Budget
Anesthesiology	13,492,609	14,653,761	(1,161,152)	-7.92%	71,478,120	76,506,801	(5,028,681)	-6.57%
Cardiothoracic Surgery	884,220	1,012,356	(128,136)	-12.66%	4,998,098	5,272,449	(274,351)	-5.20%
Critical Care Medicine	2,883,228	3,058,555	(175,327)	-5.73%	15,012,930	15,261,623	(248,693)	-1.63%
HVI - Cardiology	4,425,910	4,794,590	(368,680)	-7.69%	24,293,239	24,808,841	(515,602)	-2.08%
Dermatology	1,399,041	1,195,297	203,744	17.05%	6,387,923	6,167,585	220,338	3.57%
Emergency Medicine	2,733,317	3,092,381	(359,064)	-11.61%	14,940,602	15,267,268	(326,666)	-2.14%
Family Medicine	161,113	137,971	23,142	16.77%	719,876	731,898	(12,022)	-1.64%
HVI - Cardiac Surgery	1,784,367	1,804,747	(20,380)	-1.13%	8,904,881	9,364,204	(459,323)	-4.91%
Internal Medicine	7,070,149	7,670,319	(600,170)	-7.82%	40,309,535	39,447,216	862,319	2.19%
Neurology	1,665,238	1,882,676	(217,438)	-11.55%	9,146,742	9,498,615	(351,873)	-3.70%
Neurosurgery	3,773,168	4,579,461	(806,293)	-17.61%	21,020,833	21,702,227	(681,394)	-3.14%
Ophthalmology	2,010,687	2,084,941	(74,254)	-3.56%	11,221,014	10,873,363	347,651	3.20%
Orthopaedics	4,691,691	5,348,806	(657,115)	-12.29%	24,538,936	27,666,486	(3,127,550)	-11.30%
Otolaryngology	2,574,018	2,575,947	(1,929)	-0.07%	14,157,503	14,569,377	(411,874)	-2.83%
Pathology**	3,301,383	3,373,390	(72,007)	-2.13%	17,354,501	17,013,817	340,684	2.00%
Pediatrics	6,729,578	6,559,897	169,681	2.59%	32,653,718	32,521,219	132,499	0.41%
PM&R	696,053	992,286	(296,233)	-29.85%	4,460,750	4,973,944	(513,194)	-10.32%
Psychiatry	843,844	790,887	52,957	6.70%	4,512,768	4,197,116	315,652	7.52%
Radiology	9,468,493	9,751,374	(282,881)	-2.90%	49,580,390	49,974,796	(394,406)	-0.79%
Radiotherapy	424,360	276,992	147,368	53.20%	1,994,620	2,037,832	(43,212)	-2.12%
Surgery	6,176,024	6,474,753	(298,729)	-4.61%	33,632,079	33,602,180	29,899	0.09%
UPP Plastic Surgery	1,211,191	996,278	214,913	21.57%	5,398,356	5,283,709	114,647	2.17%
UPP Urgent Care Centers	1,377,907	1,398,478	(20,571)	-1.47%	6,858,029	7,631,995	(773,966)	-10.14%
UPP Urology	1,969,691	2,194,902	(225,211)	-10.26%	10,507,774	10,140,386	367,388	3.62%
Womens Health	6,754,819	7,850,298	(1,095,479)	-13.95%	36,360,242	37,829,238	(1,468,996)	-3.88%
Total UPP	$ 88,502,099	$ 94,551,343	$ (6,049,244)	-6.40%	$ 470,443,459	$ 482,344,185	$ (11,900,726)	-2.47%

Current Health Care Environment

- Psychosocially and medically complex patients
- Culturally-diverse patients – with special needs – often unfunded and unmeasured (as opposed to core measures and meaningful use criteria)
- Socioeconomically challenges – health insurance industry transferring more cost to increasingly financially vulnerable patients
- Changing provider workforce – Millennials, Duty Hours regulatory environment

Decision making by non-clinicians

SUCCESS REQUIRES - Multipronged, interdisciplinary approach requiring collaboration and support

Respond and Adapt to Diversity

- Monitor changing demographics and community needs of the community
- Involve community representatives in planning quality improvement efforts
- Make changes in the system to address the specific needs of the organization and the community
- Be willing to negotiate and compromise to achieve improved and realistic outcomes
- Be clear about what is not flexible and why

Handling Generational Issues

- Improving mentoring
- Redefine the ideal worker
- Provide focused career development
- Encourage discussion with leaders and teams to understand differences in thinking and problem-solving

Bickel J, Brown AJ., "Generation X: Implications for Faculty Recruitment and Development in AHCs, *Acad Med.,* 1005, 80:205-210

Implement Patient-Centered Medical Homes

- Comprehensive care
- Patient-centered
- Coordinated care
- Accessible services
- Quality and safety

- https://pcmh.ahrq.gov/page/defining-pcmh

Unlikely Partners

Compassionate Collaborators

Promote Workforce Diversity

"Effective participation by members of all racial and ethnic groups in the civic life of our nation is essential if the dream of one nation, indivisible, is to be realized."

Justice O'Connor, in Grutter v. Bollinger

“Knowing is not enough; we must apply.

Willing is not enough; we must do.”

Goethe


11 9'31

QUESTIONS?????