

The Committee on Racial and Ethnic Disparities
Meeting Minutes
Friday, May 4, 2007
12 noon – 1:30 pm

Attendees: Joseph Betancourt, Joan Quinlan, Michael Barry, Ellen Forman, Alexander Green, Suzanne Kim, Gregg Meyer, Roger Pasinski, Allison Rimm, Andrea Reid, Patricia Rowell, Thomas Sterne, Carmen Vega-Barachowitz, Andrew Warshaw, Katherine Flaherty, Jeffrey Collins, Barbara Chase, Wanda Vega, Maria-Pamela Janairo

I. Committee updates

a. Chelsea Colorectal Cancer Screening

- i. Alex Green presented on this project which is aimed at reducing the disparity between Latinos and non-white Latinos in colorectal screening rates. The qualitative portion of the study has been completed after interviewing 40 patients. From these interviews, 5 themes emerged as barriers to colonoscopy. These themes were used to train the navigator, as well as interpreters. The GI Department is working closely with Spanish translators and helping to ease the scheduling process for these patients. Joe wanted to thank Dr. Michael Barry for highlighting this disparity last year. Alex continued to thank Drs. Steve Atlas, Bruce Chabner, Jim Richter, Sanja Percac-Lima, Angelleen Peters-Lewis and Gloria Gamba for their involvement in this project. A qualitative paper is almost to completion and this abstract was presented as poster at the SGIM Conference in April. About 500 randomized patients will be included in the quantitative study.
- ii. Pat Rowell wanted to know if the project has narrowed down a particular time of day or week in which the colonoscopies will be done. Interpreter services will then plan ahead to ramp up interpreter services for those days.
- iii. Roger inquired about the names of the GI doctors who spoke Spanish. Alex will supply the names of the two fellows and the 1 or 2 attending physicians who speak Spanish. Alex further explained the randomization method for the quantitative study. Through the administrative database, the study will choose 500 patients in each group, with one group that will have coaching from a navigator and the other group which will have delayed coaching after a 6 month period.

b. Community Benefits:

- i. 3 National Experts reviews the portfolio of the Community Benefits Office. The key recommendations were:
 1. To incorporate community health into hospital mission, vision and strategic plan
 2. Create a governance structure – the first meeting was held in February and will meet 2-3 times a year
 3. Collaborate with clinical departments so they will develop their own community health priorities. Currently, the three departments that are Community Benefit is working with are Pediatrics, Obstetrics, and Psychiatry. Roger wanted to know if it was assumed that Medicine

departments were included. Joan elaborated that they are to work with subdivisions of Medicine, for example, the GI and cancer departments

4. Last three recommendations: dissemination, resource development, and communication, the plan is to get the word out through literature and the media. For development, in particular, an individual has been hired.

c. Disparities Legislation

- i. Joe reported first on the national disparities bill that is to be submitted shortly. This bill covers many of the recommendations of the IOM report, which includes data, interventions, and education to name a few.
- ii. Joe then discussed “The Act to Eliminate Racial and Ethnic Disparities in the Commonwealth,” a bill that will create a State Disparities Office. This bill will have a hearing at the State House on May 16th at 10am. Joe will send out more information about the legislation.

II. Chelsea Diabetes Disease Management Program

- a. Alex Green and Barbara Chase presented on this ongoing initiative

III. Experience with Race in the Healthcare Workplace

- a. Andrea Reid and Joe Betancourt presented on their editorial in Annals of Internal Medicine

Reducing Disparities in Diabetes Care

The Chelsea Diabetes Management Program

Alexander R. Green, MD, MPH

The Disparities Solutions Center

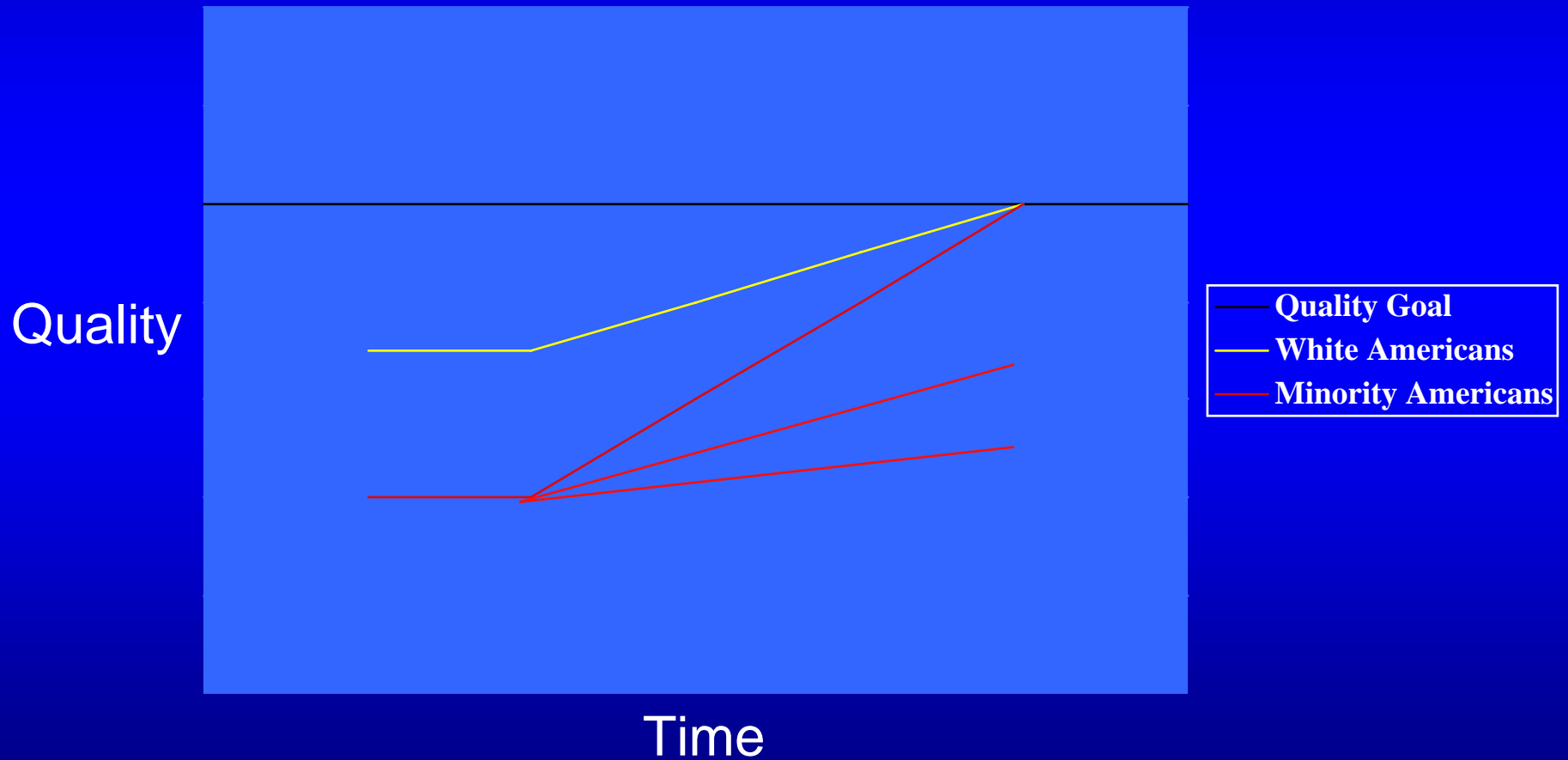
Barbara B. Chase, MS, APRN, BC

MGH Chelsea Health Center

Disparities in Diabetes Management

- Prevalence and complications of diabetes higher among Latinos and African-Americans vs. whites
- Diabetics at MGH Chelsea doing poorly on several quality indicators - Latinos worse than whites
- Of 1402 diabetics nearly 1/3 of Latinos and 1/4 of Whites had no HbA1c measured in past 9 months
- 41% of Latinos (246) and 23% of Whites (110) HgbA1c > 8

Quality improvement interventions and effect on racial/ethnic disparities



Cultural competence

- The ability to provide the highest quality of care to patients with diverse values, beliefs and behaviors, tailoring care to meet the individual patient's social, cultural and linguistic needs.
- Healthcare system and provider levels

Culturally competent QI disparities interventions

- The Chelsea Diabetes Management Program
- Colorectal Cancer Screening Patient Navigator Program

The MGH Chelsea Diabetes Management Program

A quality improvement / disparities reduction program with 3 primary components:

- Telephone outreach to increase rate of HbA1c testing
- Individual coaching to address patients' needs and concerns regarding diabetes self-management to improve HbA1c (bilingual and based on ESFT model)
- Group education model meeting ADA educational requirements (bilingual)

Coaching / Case Management Screening for Risk for Non-Adherence

- Explanatory Model
- Social Risk for Noncompliance
- Fears/Concerns about the Medication
- Therapeutic Contracting/Playback

* *Hypertension in Multicultural and Minority Populations: Linking Communication to Compliance.*

Betancourt JR, Carrillo JE, Green AR. Current Hypertension Reports. 1999; 1:482-488

MGPO Initiative - Chelsea

Results to date

- At MGH Chelsea: approx 246 Latinos and 110 Whites
HbA1c > 8 (need to stratify registry data by r/e)
- Since April 2006, 222 patients have received coaching -
151 Latino, 55 white, 16 other
- 924 total coaching visits (706 in person, 218 phone)
- Mean HbA1c decreased approx 1.3 points (10.4 to 9.1)
- 33% of pts with “poorly controlled” DM (HbA1c >8.0)
became “well controlled” < 8.0

Qualitative evaluation of barriers

- Lack of understanding of diabetes and management
- Language barriers in understanding directions from PCP
- Nutrition- lack of understanding of diabetic diet
- Lack of exercise and motivation to exercise

Qualitative evaluation of barriers

- Financial (many pts unemployed or have unstable jobs, can't afford healthy foods)
- Lack of family support (many live alone)
- Denial (Some pts are angry about diabetes and in denial)
- Mental Health (more than 50% report that depression is a major reason why they don't care for their diabetes)

My patient SM is an undocumented, illiterate Central American immigrant. She works in restaurant in the evening, has no phone, doesn't speak English, and lives in a crowded setting. We had not succeeded in getting her HgbA1c under 10, she had not kept 4 appointments in the past year, and we were unable to reach her. Eddie was able to find her, meet with her for coaching, arrange follow-up with a nurse practitioner and me. At her last visit, her understanding of diabetes was noticeably improved, she was checking her sugars more regularly, and her her blood sugars were in substantially better control. Nice work on his part.

--Skip Atkins, MD, PCP at MGH Chelsea

“What is remarkable about (the diabetes coach) is his willingness to help providers and patients, his ability to provide outreach and spend time, which PCPs may not have, his ability to identify and tackle barriers to care, as well as his multilingual skills. We are lucky to have him on our team.”

--Wynne Armand, MD, PCP at MGH Chelsea

Race and the Work Experiences of African Descent Physicians

Marcella Nunez Smith, M.D.

Leslie A. Curry, Ph.D.

JudyAnn Bigby, M.D.

David Berg, Ph.D.

Harlan M. Krumholz, M.D.

Elizabeth H. Bradley, Ph.D.

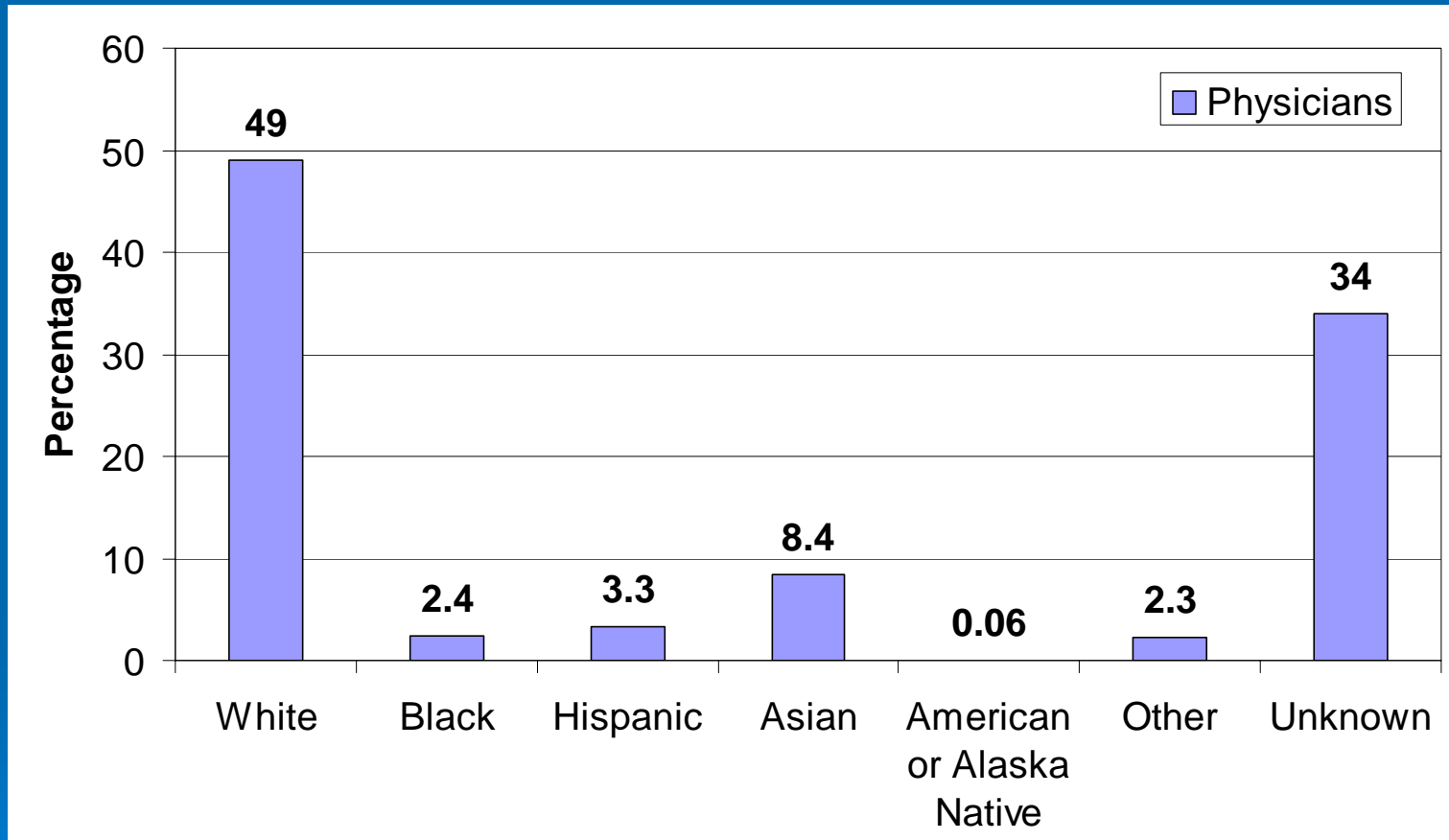


The Robert Wood Johnson Clinical Scholars Program

Yale University School of Medicine

Total U.S. Physicians by Race/Ethnicity, 2003

n=871,535



Note: At year-end 2003, the AMA had race/ethnicity data on almost three-fourths of all physicians in the US.

Source: *Physician Characteristics and Distribution in the US, 2005 Edition*. American Medical Association.

Background

- IOM (2004): “Increasing workforce diversity is a national priority.”
- Efforts largely focused on minority medical student recruitment
- Little known about the experiences of minority physicians post training
- Insight needed to successfully recruit, retain, and support a diverse physician workforce

Objective

Characterize the perceived influence of race on the experiences of practicing physicians of African descent in the healthcare workplace

Study Design

- Qualitative study
 - Practicing physicians (no trainees)
 - Different types of practice
 - All six New England states
- Purposeful selection (national, community-based physician organizations and databases)
- All invited physicians agreed to participate
- Individual interviews
 - In-person
 - Race concordant
 - Sample size determined by thematic saturation

Data Collection & Analysis

- Initial question: *“How do you think race influences your experiences at work?”*
- Professionally-prepared transcripts independently coded by 3 researchers
- Inter-coder reliability: 80%
- Atlas.ti 5.0: data organization and retrieval

Participant Characteristics

- Total number of physicians: 25
- Median age: 45 years (35-79)
- Academic: 10
- Specialties/subspecialties: 11
- Female: 14
- Sexual minorities: 3

Themes

1. Race permeates work experiences
2. Similar race-related experiences and challenges
3. Responses to perceived racism at work vary
4. Healthcare workplace often silent on race, and discriminatory behavior normalized
5. “Racial fatigue”, associated emotional and psychological stress, may impact career trajectory

Race permeates work experiences

I think race permeates every aspect of my job so... when I walk onto a ward or on the floor I'm a black guy before I'm the doctor. I'm still a black guy before I'm the guy in charge, before I'm the attending of record, so that permeates everything.

-general surgery, academic

The background of the slide features several concentric, light blue circular ripples that resemble water droplets hitting a surface, scattered across the lower half of the page.

Patient refusal of care

Patients rejecting my care is...fairly overt. We have just met and they want someone else. I do not think that most patients want to discriminate against me because I am African-American, but patients sometimes expect us not to do a good job or not to do as well as somebody else would do.

-internal medicine subspecialty, hospital-based practice

“Casting” into race representation role

At work...whenever they want to diversify something they call me. When they don't need that, when they would need someone purely for individual intellectual capacity, I am not the first person they think about.

-internal medicine, academic

The background of the slide features several decorative elements consisting of concentric circles, resembling ripples in water, rendered in a lighter shade of blue against the darker blue background.

Social and professional isolation

So that is what I do not see, us in those leadership pipelines, and that is what makes a tremendous difference in terms of diversity. We won't get invited to the picnic or to the dinner parties...and that is where those jobs come up...We're not in the corridors of power...We are not in those pipelines and it has nothing to do with intellectual capacity or ambition.

-internal medicine subspecialty, hospital-based practice

Workplace silent on race

We have, as a society, figured out ways to systematically deny that racism exists. And that structure is in the medical institutions that train us. There is no way to have a discussion about it because it has been decided that it doesn't exist.

-family medicine, public health

Normalization

I was (removed from) taking care of a [white] individual. We talked later, the division chief and I. The parents were uncomfortable with me taking care of their child...they told him they didn't think I would be capable because of race. That ended our conversation. What about next time?

-pediatrics, hospital-based practice

“Racial fatigue”

...There really is nobody addressing these issues, because nobody knows how to...and so you are left processing it by yourself... So that often just causes conflict that one has to manage in order to get the work done.

-family medicine, private practice

Summary

- Race impacts the professional lives of physicians of African descent
- Similar post-training experiences, mostly negative, across work settings and specialties
 - Difficulty finding mentors, being cast into specific roles, low expectations, discriminatory behavior, profession isolation
- Compounded given that healthcare workplace often silent on issues of race
- Potential personal and professional consequences of “racial fatigue”

Limitations

- Restricted to New England
 - Many not reflect the experiences of physicians in other geographic areas
- Restricted to practicing physicians
 - Trainees may have different or lesser challenges in the workplace
- Mix of private practice, community medicine, academics
- Hypothesis-generating
 - Further studies needed to evaluate

Editorial

The Context

- Minorities have different perspectives about race and race relations than their white counterparts
- Annals article mirrors the societal perspective
- IOM Report “In the Nation’s Compelling Interest”
 - Minorities remain drastically underrepresented in the health professions
 - Minority faculty
 - are less likely to hold senior academic rank, even when controlling for publications, grants, yrs of svc;
 - have lower career satisfaction;
 - perceive bias in recruitment and in promotion;
 - face structural barriers to academic success and professional satisfaction

Issues for Consideration

- Annals article demonstrates race matters in the healthcare workplace
 - Defines institutional climate
 - Makes people feel invisible, isolated and “cast”
 - Impacts mentorship, standards for success
 - Requires individuals have a “thick skin”
- And...healthcare workplace described as
 - Being silent on issues of race
 - Issues of race not openly discussed
 - Policies against discrimination not discussed, monitored, or enforced

Take-Home Points

- Organizations should acknowledge race matters
 - Create forums for open, honest dialogue; understanding, transparency and partnership
 - Leaders should facilitate these communications and make radar more sensitive
- Organizations should commit to diversity
 - Develop, mentor, and monitor progress of minorities
- Employees should be made aware of key issues
 - Training on stereotyping and prejudice
- Organizations should develop explicit, enforceable policies that identify and prohibit discrimination
 - Current mechanisms not effective; Ombudsman?
- Organizations should foster the development of diverse teams

MGH

Points for Discussion

- What is our reaction to this research?
- How do we stack up to the issues raised here?
- What do we do well? What are our successes?
- Areas for improvement? Where do we fall short?
- How can we become a national leader?