The Import of Cultural Competency and Language Preference in Total Joint Arthroplasty Utilization Rates

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The Import of Cultural Competency and Language Preference in Total Joint Arthroplasty Utilization Rates

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Introduction

In 2002, the Institute of Medicine (IOM) report Unequal Treatment outlined in stark terms what an ever-growing body of evidence had been suggesting: members of racial and ethnic minorities are subject to gross healthcare disparities across numerous disease states and healthcare services1. Included among this litany of disparities is underutilization of total joint arthroplasty (TJA) — including both total knee arthroplasty (TKA) and total hip arthroplasty (THA) — among Hispanic American (HA) patients1,2,3,4,5, Similar underutilization rates have been better documented and explored concerning African American (AA) patients versus non-Hispanic white (NHW) patients in the past6,7,8,9. However, the mechanism of these underutilization rates remains less clear and is not necessarily generalized to HA patients. Thus, while marked TJA underutilization has been noted among HA patients, the factors driving and perpetuating this disparity are less understood.

Methods

This study sought to localize the primary point or points along the progression series at which Hispanic American patients were most likely to cease advancement as (1) a matter of patient-based values-centered care and/or (2) satisfactory treatment with conservative and/or complementary and alternative medicine treatment options. The timing of this progression is a key determinant of quality of care. AA and HA patients have worse preoperative or Latina — well above the national demographics of 17.1 percent — Allentown, Pennsylvania presents an opportunity to examine the dynamics that lead to TJA underutilization. This study sought to document the progression of steps that escalates to TJA and to assess the contributing factors that manifest as TJA rates.

TJA Progression Model

The model is constructed to incorporate the subjective point at which the patient experiences pain, functional impairment, disability, and/or decreased quality of life of a self-prescribed significant nature to seek medical treatment. Once the morbidity threshold is reached, the patient may begin to progress towards the surgery threshold. Progression through this chain of events may be accelerated or impeded by both system factors and patient family-factors. System factors are those mediators directly and indirectly related to the patient’s interaction with the health care system. Patient and family factors are those attributes that mediate the patient’s decision-making process. The likelihood of TJA increases as the patient moves across this gradient as the patient exercises conservative and complementary or alternative treatment options.

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Literature cited:


Findings and Future Directions

Two consistent trends were identified. (1) Familiarity with TJA as a treatment option is a key mediator of willingness to undergo TJA. (2) There is a stigma against surgery in many Hispanic and Latin cultures. First, personal familiarity with TJA increases the likelihood of undergoing TJA10. Every PCP interviewed noted that they have never had a HA patient bring up surgery as a treatment option for knee and/or hip pain. Conversely, NHW patients frequently asked questions about TJA. This lack of familiarity with TJA among HA patients is not unsurprising given the TJA utilization rate disparity. Moreover, the disparity is widening11. Multiple providers noted what one physician described as a “self-perpetuating cycle”. HA patients are less likely to undergo TJA, thus HA patients as a whole are less likely to have a friend or family member who has undergone the procedure — i.e., lack of familiarity. Those HA patients who do undergo TJA tend to have worse preoperative functionality, and therefore their postoperative performance is objectively worse. Thus, HA patients who do have familiarity with TJA are more likely to have a negative impact of its efficacy.

Second, one of the physicians stated a stigma against surgery in his Hispanic culture: “Surgery equals death.” This challenge of cross-cultural care is explained through Kleinman’s explanatory model of sickness, which identifies the “different cognitive and value orientations” of the patient and the physician shaped by diverse aspects of culture12. Language is the most fundamental mediator of this explanatory model. The interviews and the literature suggest that this motivates two behaviors by HA patients: (1) they are more likely to rate their health worse than NHW patients2,9 and (2) racial and ethnic concordance increases when patients communicate with care when cultural paradigms are shared13. This study sought to understand how culturally derived patient-based values among Hispanic and Latino patients mediate TJA underutilization rates. Interviews of healthcare providers in Allentown, Pennsylvania, provide qualitative evidence for the import of cultural competency as necessary to optimizing quality of care. TJA underutilization rates among HA patients remain when adjusted for age, sex, insurance status, socioeconomic status, and severity of osteoarthritis14.