Association between patient-provider racial and ethnic concordance and patient-centered communication in outpatient mental health clinics

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Background

By 2060, minorities will soon be the majority in the United States. However, the health of people of color is much worse than those of their white counterparts.

- **Black Americans** have higher infant mortality rates, they also have higher rates of mortality overall, and are 20% more likely to experience serious mental illness (i.e., major depression, attention deficit hyperactivity disorder, suicide, and posttraumatic stress disorder)
- **Latinos** have higher rates of mortality from diabetes, hypertension, and liver cirrhosis. With regards to mental health they also experience symptoms of depressions at two times the rate of whites.
- **Asians**, particularly recent immigrants, have lower chances of survival when it comes to breast cancer.
- **Native Americans** face similar threats from diabetes, obesity, and alcoholism.

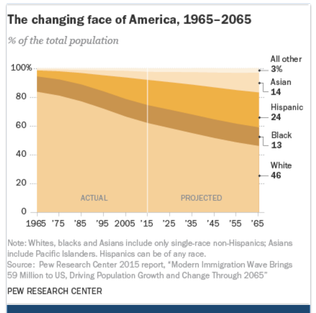

Figure 1. Pew Research Center projection of racial composition of the United States Population

Why does this issue exist?

- People of color also lack access to higher quality of care as they often live in areas of poverty that lack access to resources.
- People of color are more likely to be uninsured compared to whites, even under the ACA.
- Often times, providers also unconsciously or consciously discriminate against Latinos and Blacks with regards to appropriate care. In fact, Blacks and Latinos are half as likely to be prescribed pain meds when they are necessary for their pain levels.

Race/Ethnicity	Percent Uninsured
White	8%
Black	12%
Latino	17%
Other	9%

Table 3. 2015 rates of uninsurance by race according to the Kaiser Family Foundation

How do we fix this issue?

Patient-centeredness and particularly one aspect, patient-centered communication (PCC) has been found to improve health outcomes for patients in general. Additionally, racial and ethnic concordance has also been considered as a characteristic in patient and provider relationships that may improve patient outcomes. However, research regarding PCC and racial and ethnic concordance in behavioral health is scare.

Aims and Hypotheses

This thesis would like to address the gaps that exist in research surrounding patient-centered communication and racial and ethnic concordance in behavioral health.

This will be done by addressing the studies three **aims**:
(1) to assess differences in behavioral health providers identifying patient feelings for racially/ ethnically concordant versus racially/ethnically discordant groups

(2) to assess differences in providers accepting their patient's feelings for racially/ethnically concordant versus racially/ethnically discordant groups

(3) to assess differences in providers encouraging emotional expression for racially/ethnically concordant versus racially/ethnically discordant groups

This thesis hypothesizes that there will be significant differences in PCC behaviors among racially/ ethnically discordant and concordant groups.

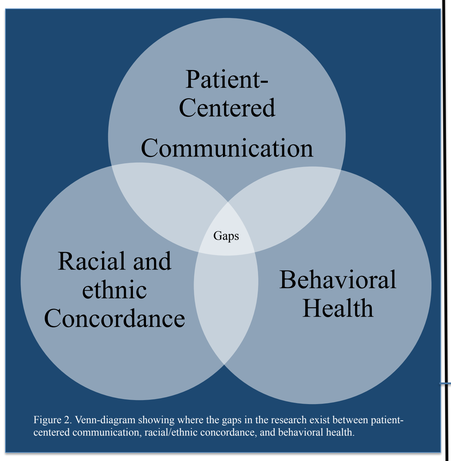

Figure 2. Venn-diagram showing where the gaps in the research exist between patient-centered communication, racial/ethnic concordance, and behavioral health.

Abstract

People of color, in the United States, experience worse health outcomes than their white counterparts. This thesis focuses on improving access to quality care. Patient-centered communication (PCC) has been identified in the literature as a provider characteristic central to providing quality care to patients. Some evidence suggests that racial/ethnic patient-provider concordance may be associated with increased PCC because of improved trust and mutual understanding between patient-provider matches. This thesis explores whether there was a difference in PCC between racial/ethnic concordant and discordant groups in a sample of behavioral health providers and their patients. This thesis utilized data from the "Effectiveness of DECIDE in Patient-Provider Communication, Therapeutic Alliance, and Care Coordination study". PCC was measured with the use of a coding system that examines a provider's ability to encourage expressive communication. Racial/Ethnic concordance was measured as whether or not patients and providers identified with the same racial or ethnic background. Three separate ANOVAs were conducted to analyze any relationship that may exist between groups (concordance or discordance) and the three measures of PCC. No significant differences were found between groups in any of the three items measuring aspects of PCC. This study was one of the first to examine racial/ethnic concordance and its impact on PCC in the behavioral health field. While there was no relationship between concordance and PCC, the overlap in the ability of these characteristics to increase perceived similarity and improve trust, remains important to the therapeutic function of behavioral health care. Both characteristics should continue to remain under consideration when it comes to improving quality of care.

Methods

This study conducts a secondary analysis of baseline data gathered from patients and providers participating in "Effectiveness of DECIDE in Patient-Provider Communication, Therapeutic Alliance, and Care Coordination" a Patient-Centered Outcomes Research Institute (P-CORI) funded project, grant #CD-12-11-4187, at the Disparities Research Unit (DRU) at the Massachusetts General Hospital.

Sample

The original study team recruited 74 behavioral health providers and 312 patients from outpatient community mental health clinics in Massachusetts.

66 of those behavioral health providers consented to have a baseline clinical session recorded. Then 92 patients (not involved in the full intervention study) were recruited from the provider's caseload only for the baseline clinical session. See figure 3 for a visual.

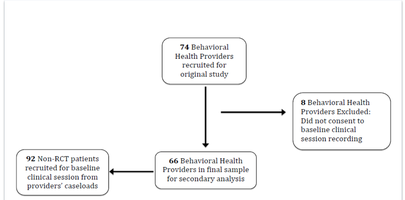

Figure 3. A flow chart indicating the behavioral health providers and patients who were recruited and used for the thesis sample

Measures

Patient-Centered Communication (PCC) is defined in this study through the use of the definition created by Epstein et al. (2005):

(1) understanding the patient's perspective which includes their feelings, concerns, and needs
(2) understanding the patient within their own psychosocial context
(3) working together to understand the patient's problems and what treatment would work best according to patient's values
(4) sharing power and responsibility with the patient

To measure PCC, with the use of the first part of this definition (i.e., understanding the patient's perspective which includes their feelings, concerns, and needs), this thesis used the instrument called "Provider Communication in Behavioral Health (PCBH)". This instrument was a coding system which consisted of an independent coder rating a clinical session. This thesis focused on the factor: Encourages expressive communication (EEC) which included three items.

- "identifies feelings"
- "accepts feelings"
- "encourages emotional expression"

Racial and Ethnic Concordance was measured by looking at how both the patient and behavioral health providers identified in terms of race and ethnicity. Race and ethnicity were reduced to four categories.

- Non-Latino White
- Latino
- Non-Latino Black
- Asian

Data Analysis

Descriptive Statistics

- Mean and Standard Deviation for continuous variables like age, educational attainment, specialty, and gender
- Frequency for groups (racial/ethnic concordant or discordant)
- Boxplots

Inferential Statistics

- Three one-way ANOVAs
- Three Non-Parametric Test – Independent Samples Mann-Whitney U Test

Results

Descriptive Statistics

Table 1. Demographic Characteristics of Patients (N = 92) and Behavioral Health Provider (N = 66)

		Patients N (%)	Providers N (%)
Gender			
	Female	56 (60.1%)	52 (78.8%)
	Male	36 (39.1%)	14 (21.2%)
	Missing	0	0
Race			
	Non-Latino White	35 (38.0%)	39 (59.1%)
	Latino	37 (40.2%)	13 (19.7%)
	Non-Latino Black	11 (12.0%)	3 (4.5%)
	Asian	9 (9.8%)	11 (16.7%)
	Missing	0	0
Patient Education			
	<6th grade	6 (6.5%)	-
	7th - 11th grade	20 (21.7%)	-
	12th grade	16 (17.4%)	-
	>12th grade	49 (53.3%)	-
	Missing	1	-
Behavioral Health Provider Specialty			
	Psychiatrist	-	17 (25.75%)
	Psychologist	-	14 (21.21%)
	Social Worker	-	22 (33.33%)
	Other	-	13 (19.70%)
	Missing	-	0
		Mean (SD)	**Mean (SD)**
Age		42.38 (14.06)	40.12(12.75)
	Missing	0	1

Table 2. Frequencies of Patient/Provider Matches in Racial/Ethnic Concordant or Discordant Groups

	N	%
Concordant	51	55.4%
Discordant	41	44.6%
Total	92	100%

As Table 1 suggests, patients and behavioral health providers were predominantly female. Most patients were either White or Latino, while the majority of providers were White. Additionally, most patients indicated their education level was at a high school level. The behavioral health providers were mostly social workers.

With Table 2, it is clear that most patients and behavioral health providers were in a racially/ ethnically concordant patient-provider relationship.

Inferential Statistics

Aim 1: One way ANOVA, **F (1,90) = .000, p = 1.000**; No significant differences in mean coder score for "identifying feelings" in patients/providers in concordant and discordant groups.
Independent Samples Mann-Whitney U Test, p = 0.752.

Aim 2: One way ANOVA, **F (1, 90) = .102, p = .750**; No significant differences in mean coder score for "accept feelings" in patients/providers in concordant and discordant groups.
Independent Samples Mann-Whitney U Test, p = .924

Aim 3: One way ANOVA, **F (1, 90) = .052, p = .820**; No significant differences in mean coder score for "encouraging emotional expression" in patient/providers in concordant and discordant groups.
Independent Samples Mann-Whitney U Test, p = .692

Discussion

Our hypotheses were found to be incorrect. Racially/Ethnically concordant groups were not associated with higher scores of PCC.

Possible reasons why?

- PCC measure was a proxy and only measured one aspect of the operational definition
- Different patient and provider races and ethnicities were captured
- Using a behavioral health provider sample rather than primary care providers

Limitations

- Behavioral health providers conveniently recruited
- PCC assessed through proxy and with a new measure (PCBH)
- Sample size, as we did not capture full range of race and ethnicity

Conclusions and Future Directions

While our null findings, suggest that racial and ethnic concordance are not associated with PCC, this thesis recommends that PCC

- should be added to the curriculum of behavioral health providers' trainings
- should remain under consideration to improve quality of care for people of color and behavioral patients across the board

Future directions should focus on

- investigating definitions of PCC that are relevant to specialty
- gathering a larger and more racially and ethnically diverse population when exploring effects of racial and ethnic concordance on PCC
- PCC measures that encompass a full operational definition
- longitudinal studies to address to see how REC affects health outcomes over time