



Karen Bullock

PHD LCSW FGSA APHSW-C
Endowed Professor of Social Work
Boston College

*Equity and Quality:
An Overview of the
Importance of DEI in
Quality Palliative Care*

Equity and Quality: An Overview of the Importance of DEI in Quality Palliative Care

Karen Bullock, PhD, LCSW, APHSW-C

Endowed Professor of Social Work

Boston College

2:10 PM/EST – 3:00 PM/EST

Disclosure

There are no other financial relationships with any commercial interest.

Learning Outcomes

Upon Completing this session, participants will be able to:

- Identify barriers and mediating factors influencing disparities among historically marginalized groups.
- Describe the importance of dismantling structural and systematic racism in serious illness care.
- Discuss a framework for critical self-assessment of ways to enact positive change with the appropriate resources to equitably and efficiently improve upon program performance.

Diversity, Equity and Inclusion (DEI)

in Health Care are Strategies, Values and Performance Outcomes



→ Health care quality is a level of value provided by health care resources, as determined by some measurement.

→ As with quality in other fields, it is an assessment of whether something is good enough and whether it is suitable for its purpose.

- Quality of care is **the degree to which health services for individuals and populations increase the likelihood of desired health outcomes.**
- It is based on evidence-based professional knowledge and is critical for achieving universal health coverage.

Introduction

- Racial inequities have become central in the national conversation about serious illness care during the Covid-19 pandemic.
- The constant exposure to the reality of health disparities across racial groups amplifies the need to make what has been invisible, visible.

- This presentation takes an evidence-based approach to (1) describing health care disparities, (2) discussing a framework for critical assessment of inequities in Hospice and Palliative Care; and (3) making pragmatic recommendations for addressing inequity.

NECESSARY, BUT INSUFFICIENT

- Starting conversations, in the midst of a global pandemic, about how we improve serious illness care, is laudable.
- Yet, insufficient for eliminating the root causes of health inequities, to improve quality of life and well-being of persons living with serious illness; and their families.

Significance

→ Long-standing structural and systemic health and social inequities put many Black and Brown people at risk of higher morbidity and mortality exposure than White people, during the COVID-19 pandemic.

Knowledge

→ The recent climate of social unrest and race-related health inequities during the COVID19 pandemic created the perfect storm that exacerbated disparities rooted in structural racism.

- In particular, people that self-report their race as Black had the highest death rate and the poorest survival outcomes for cancer and other serious illness, among all race/ethnic groups, in the United States, long before the pandemic.

American Cancer Society (2020)

Morbidity and Mortality

- The rate of HIV infection in some major cities are more than 6 times higher among Hispanic individuals than among White non-Hispanic individuals.⁴
- In some health reports, Asian residents are 15 times more likely than White residents to have Hepatitis B and twice as likely to have liver cancer.⁴
- Such health disparities are long-standing and pervasive in the U.S.

Current Climate

- The evidence on the disparate effects of COVID-19 provides a somber reminder of U.S. health care systems' failure to equitably serve populations that have been historically denied equal access.
- The pandemic creates an urgency to address such health inequities.
- Builds on the current climate of social unrest spawned by the racial justice movements that arose after the killing of George Floyd, other Black and Brown community residents, and most recently, Asian and Pacific Islanders.

Serious Illness Care and Racial Equity

→ Consider the historical barriers and mediating factors influencing disparities and inequities between diverse racial and ethnic groups and the experiences of White Anglo people of European heritage.

Historical Racism in Systems of Care



RACISM IN THE U.S. WAS LEGAL AND LETHAL.



[Image Credit - Stanford Medicine](#)

Evidence-Based Practice

→ It is important for quality care to be situated in historical contexts that name “Whiteness” and acknowledge the plethora of dominate frameworks and ideologies that serve to perpetuate structural and systemic racism.

Preliminary Research Study

→ In 2019, prior to COVID19, a study was conducted with undergraduate and graduate social work students focused on emotional intelligence, which is an important concept to consider alongside cultural competence teaching and training.

Preliminary Research Data Show

- Participants who self-identify as Black, Indigenous, Hispanic, Latino, Pacific-Islanders, Asian, and as non-White/non-Anglo heritage/nationality are more likely to report having experienced racism, frequently, including in systems of care.
- Those who identify as being of White (Anglo) descent are most likely to report not experiencing RACISM in the U.S. or its healthcare systems.

*Based on a survey of college students in various SW classes.

Palliative Care Education and Training in PWI(s)

- Taught in pre-dominantly White Institutions.
- Predominantly taught by White People.
- Perpetuating White-centric theoretical and conceptual models of knowledge, understanding and practice behaviors that teach clinicians and researchers that “race” is a risk factor for poor outcomes, with no practical or theoretical contribution to “racism.”

Inequities in Serious Illness Care

- Interrogate the ways that current policies and practices create and reproduce inequitable outcomes.
- Create greater access to culturally competent clinicians and researchers in healthcare settings where health equity is prioritized, not only in “theory,” but in practice.

- The legacy of racism continues to have a negative impact on Black and Brown [race] people living with serious illness and/or nearing the end of life. Structural racism has created barriers that we see and experience today as systemic racism.
- This perpetuates the lack of health literacy, poor communication options, a lack of culturally competent providers to offer culturally congruent care options to patients that have been historically excluded from various healthcare systems of care.

Addressing Inequities in Health Care

- It is important that we not excuse the fact that “everyone has implicit bias,” with immunity from the ethical responsibility to address inequitable structural and racist behaviors.
- Social Work Code of Ethics: “speak up and speak out” against injustices with confidence and competence.

Move Beyond Cultural Humility to Competency



- To achieve health equity, we must go beyond cultural humility and take action to remove barriers so that everyone has an equitable quality of life, until the end.

Equal access without Equity perpetuates
Disparity!

Baseline Cultural Competence

- The 3 key components of Cultural Competence are (1) Awareness, (2) Skills, and (3) Knowledge.
- A set of actionable skills, informed by a level of awareness that brings the “unconscious” to the “conscious” and builds knowledge that can be disseminated, taught and expounded upon through continuous learning (Bullock, et al., 2021).

Cultural Competence

- Awareness of atrocities that have inflicted upon Black people in healthcare systems in the US.
- Skills that facilitate culturally responsive behaviors.
- Knowledge that translates into action-oriented advocacy.
- I can't teach what I don't know! What is required to “think and do” something different?

PCQC: To Improve Quality of Serious Illness Care

- Encourage the collection of clinical data that examines cultural competence as performance outcome.
- Engage in continuing education to develop awareness, skills and knowledge for best practices.
- Be intentional about including historically marginalized populations in the palliative care workforce.

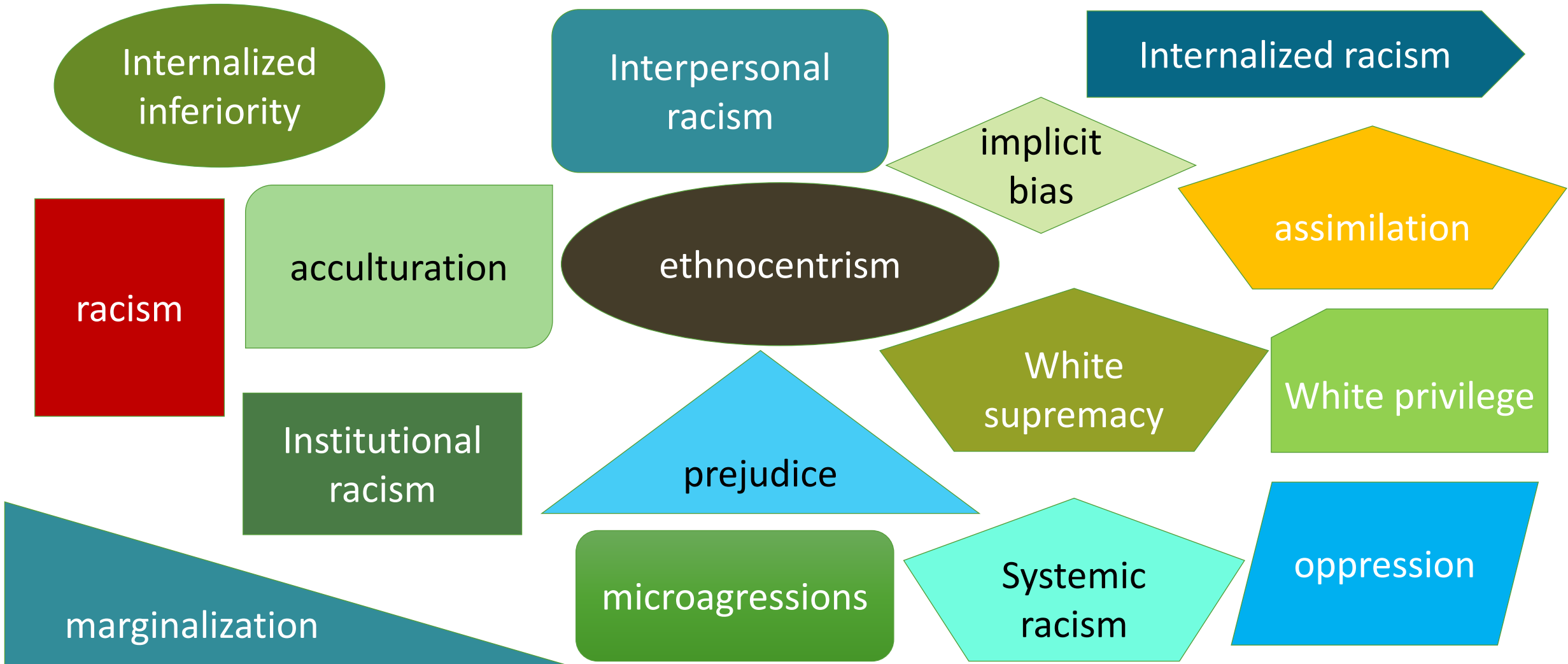
Cultural Competence

- The good news is that while some people do not feel they can become culturally competent, the data show that most can!
- We can learn how to practice effectively across cultures and increase our level of competence in providing equitable care.
- It is necessary to be “culturally humble.” Yet, is insufficient in to rest in that place of humility.

Pursuit of a New Normal in Quality Care

- Data collection [evidence] which includes patients and families that have been historically excluded and/or received inequitable care is novel and ambitious.
- PCQC, collectively, is uniquely equipped with the knowledge, skills and expertise to lead this charge!

WHERE SHALL WE BEGIN?



Cultural Competence: A Tool

Achieving Equity

Actionable

Measurable

Achievable

Improving Quality Palliative Care is a Journey



Thank You!

- Presenter(s) contact information:
 - Karen Bullock, PhD, LICSW, APHSW-C
 - Boston College
 - K.Bullock@bc.edu
 - <https://www.bc.edu/bc-web/schools/ssw/faculty/faculty-directory/karen-bullock.html>

References

- American Cancer Society (2020). Cancer facts & figures for African Americans. <https://www.cancer.org/research/cancer-facts-statistics/cancer-facts-figures-for-african-americans.html>
- Bullock, K. (2012). The influence of culture on end-of-life decision making. In Morrissey, M.B., & Jennings, B. (Eds.), *Partners in palliative care: Enhancing ethics at end of life* (pp. 82-97). New York: Routledge.
- Bullock, K., & Allison, H. (2015). Access to medical treatment for African American populations: The current evidence base. In Christ, G., C. Messner & Behar, L. (Eds.), *Handbook of oncology social work* (pp. 293-298). New York, NY: Oxford University Press.
- Cadet, T., Burke, S. L., Naseh, M., Grudzien, A., Kozak, R. S., Romeo, J., Bullock, K., & Davis, C. (2021). Examining the Family Support Role of Older Hispanics, African Americans, and Non-Hispanic Whites and Their Breast Cancer Screening Behaviors. *Social work in public health*, 36(1), 38–53. <https://doi.org/10.1080/19371918.2020.1852993>

References

Morrison, R. S., Meier, D. E., & Arnold, R. M. (2021). What's Wrong With Advance Care Planning?. *JAMA*, 326(16), 1575–1576. <https://doi.org/10.1001/jama.2021.16430>

Nedjat-Haiem, F. R., Cadet, T. J., Parada, H., Jr, Mishra, S. I., & Bullock, K. (2022). A National Survey of Social Workers Focusing on Attitudes, Knowledge, and Practice Behaviors for Educating Patients About Advance Directives: Implication During COVID19. *American Journal of Hospice & Palliative Care*, 39(6), 737–744.
<https://doi.org/10.1177/10499091211038503>

Nwando Olayiwola, J. et al., Making Anti-Racism A Core Value in Academic Medicine, *Health Affairs: Blog* (Mar. 25, 2021), <https://www.healthaffairs.org/doi/10.1377/hblog20200820.931674/full/>.

Paradies Y, Ben J, Denson N, et al. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLoS One*, 10(9):e0138511-e0138511.

References

Payne, R. (2016). Racially associated disparities in hospice and palliative care access: Acknowledging the facts while addressing the opportunities to improve. *Journal of Palliative Medicine*, 19(2), 131-133. <http://doi.org/10.1089/jpm.2015.0475>

QuickFacts United States, U.S. Census Bureau, <https://www.census.gov/quickfacts/fact/table/US/PST045219> (last visited Mar 23, 2021).

Sanders, J., Curtis, J.R., & Tulsky, J.A. (2018). Achieving goal-concordant care: A conceptual model and approach to measuring serious illness communication and its impact. *Journal of Palliative Medicine*, 21:S2, S-17-S-27.

Sevier, C.H., Fischer, J., & Bullock, K. (2020). Leaning in to serious illness care through stories and science. *North Carolina Medical Journal*, 81(4), 237-241.