CLER
Clinical Learning
Environment Review

NATIONAL REPORT OF FINDINGS 2016

ISSUE BRIEF No.4

HEALTH CARE DISPARITIES

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Issue Briefs

The CLER Program presents this series of Issue Briefs to supplement the *CLER National Report of Findings 2016*.

Each issue in the series features one of the focus areas of the CLER Program—supplementing the key challenges and opportunities highlighted in the National Report and enhancing the discussion as to their relevance and potential impact on GME and patient care.

In both the National Report and the Issue Briefs, the findings are based on data collected during the CLER site visits, including responses to closed-ended questions collected via an audience response system, open-ended structured interviews with the clinical site's executive leaders and leaders in patient safety and health care quality, and information gathered from the many individuals interviewed during walking rounds of the site's clinical units.

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Background

The ACGME established the CLER Program to provide formative feedback that presents graduate medical education (GME) leaders and the executive leadership of the clinical learning environments (CLEs) for GME with information on six areas of focus: **patient safety, health care quality, care transitions, supervision, duty hours/fatigue management and mitigation, and professionalism.**[1,2,3]

The *CLER National Report of Findings 2016*[4] presents information from the first set of CLER site visits to participating sites of 297 ACGME-accredited Sponsoring Institutions of residency and fellowship programs. These visits, conducted from September 2012 through March 2015, focused primarily on teaching hospitals, medical centers, and ambulatory sites that host three or more core residency programs.

In the group sessions conducted during these visits, the CLER teams collectively interviewed more than 1,000 members of executive leadership (including CEOs), 8,755 residents and fellows, 7,740 core faculty members, and 5,599 program directors of ACGME-accredited programs in the group sessions. Additionally, the CLER teams interviewed the CLEs' leadership in patient safety and health care quality and thousands of residents and fellows, faculty members, nurses, pharmacists, social workers, and other care professionals while on walking rounds of the clinical areas.

OVERARCHING THEMES OF THE NATIONAL REPORT OF FINDINGS

The initial visits of the CLER Program revealed a number of findings that appeared to be common across many of the CLEs and six focus areas:

- Clinical learning environments vary in their approach to and capacity for addressing patient safety and health care quality, and the degree to which they engage residents and fellows in these areas.
- Clinical learning environments vary in their approach to implementing GME. In many clinical learning environments, GME is largely developed and implemented independently of the organization's other areas of strategic planning and focus.
- Clinical learning environments vary in the extent to which they invest in continually educating, training, and integrating faculty members and program directors in the areas of health care quality, patient safety, and other systems-based initiatives.
- Clinical learning environments vary in the degree to which they coordinate and implement educational resources across the health care professions.

In addition to serving as a basis for the overarching themes, the initial CLER visits sought to establish baseline structural and operational characteristics of the clinical sites, as well as their training practices in the six focus areas. In future cycles, the CLER Program will also seek to understand how the sites identify and prioritize areas for improvement and assess progress over time.

Health Care Disparities

A STORY FROM THE FIELD

A senior emergency medicine resident in a large hospital related the following story. "A few months ago I cared for a homeless patient with schizophrenia who came to our emergency room. He was awake and alert but extremely weak. We worked him up and with the exception of an unexplained tachycardia and mild orthostatic hypotension, we could not find any reason to admit him. We gave him some fluids and a prescription for antibiotics. We discharged him after arranging a place for him to stay at a local shelter.

Two days later I was at work when he was brought back to our Emergency Department in cardiopulmonary arrest and he didn't make it. It turned out he had developed massive pneumonia. In his pants pocket was the antibiotic prescription and instructions on how to get to the shelter.

This was not the only experience like this I have had during my training. We really try the best we can to take care of all of our patients, but some require resources beyond what we have available."

When asked about how to avoid this in the future, the resident stated that this case was discussed at their ED's morbidity and mortality conference. The solution proposed was to be able to admit patients in similar condition. The faculty members thought this would not likely be implemented. The resident noted that to his knowledge, the department had not made changes in patient care related to this patient experience.

There are many aspects to this story that elicit a sense of discomfort about the care experienced by the patient and the resident's experience in learning how to mitigate a similar outcome in the future. The story highlights how potentially avoidable adverse events can result from a lack of contextual understanding of a patient's situation, and how that lack of understanding can impact appropriate patient care. This misunderstanding can result in trainees failing to take action that could reduce the likelihood of a patient experiencing an adverse event or suboptimal care.

The story illustrates that there are special populations with special needs. While there are generic solutions that might serve to provide high quality care for most patients, some populations may require different systems-based solutions. Supporting residents and fellows to feel empowered to take on quality improvement efforts for special populations is critical to improving our nation's health care.

The *CLER National Report of Findings 2016*[4] presents data on resident and fellow engagement in the CLE's strategies for addressing health care disparities. This Issue Brief highlights selected information found in the National Report, expands upon the findings in the Challenges and Opportunities section, and enhances the Discussion section.

Selected Findings

Figure 1 presents data based on group interviews with residents and fellows, and highlights the current range of resident and fellow involvement in addressing health care disparities. Across CLEs, a median of 60% (IQR=43-76%) of the residents and fellows interviewed reported knowing their CLE's priorities in the area of health care disparities.

Figure 2 presents the percentage of CLEs with some type of cultural competency training for residents and fellows. Approximately 30% of all CLEs had some type of training in cultural competency that was tailored to the population they serve.

These findings underscore the challenges for CLEs and GME around the issue of health care disparities. The data demonstrates variability in knowledge and a lack of comprehensive training on this issue.

Figure 1

Percentage of residents and fellows who reported knowing the clinical site's priorities with regard to addressing health care disparities

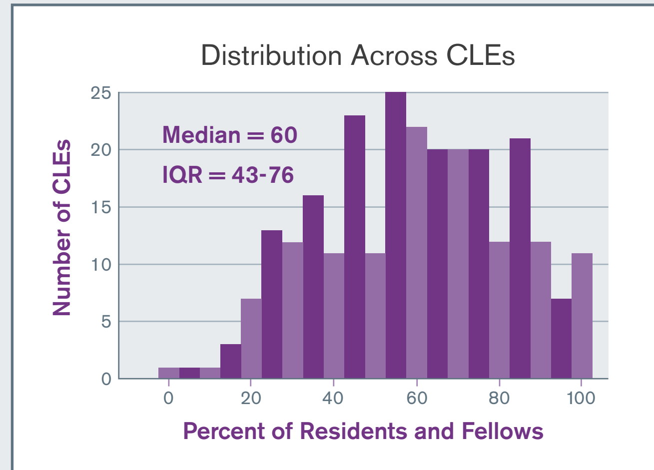
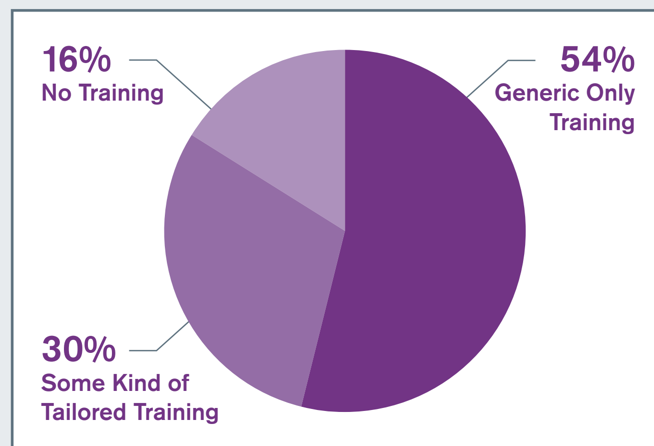


Figure 2

Percentage of CLEs with cultural competency training for residents and fellows



Challenges and Opportunities

For the National Report, the members of the CLER Evaluation Committee reviewed aggregated data and selected three to four key findings to highlight and discuss. The following section expands upon the information presented in the National Report to include additional selected findings and a more in-depth discussion regarding the potential impact on patient care and resident and fellow education.

Few CLEs appeared to have a formal strategy for addressing health care disparities or a systematic approach to identifying variability in the care provided to or clinical outcomes of their known vulnerable patient populations.

- It was uncommon for the leadership in health care quality to describe performance measurement or quality improvement efforts designed to address health care disparities, and similarly uncommon for residents, faculty members, or program directors to be involved in institutional efforts to improve health care quality in this area.
- Few CLEs collect, analyze, and disseminate data and information that would help residents, fellows, and faculty members understand the degree of health care disparity experienced by the populations served by the CLE and appropriately modify care plans in order to achieve the desired clinical results and decrease the resulting disparities in clinical care.

In addressing health care disparities, many CLEs were focused on specific issues, such as improving access to care for low-income patients, or meeting regulatory requirements, such as interpreter services or community needs assessments. When the CLEs involved residents and fellows in addressing health care disparities, it was most often at the level of providing direct service to select patients (such as those at low-income, community-based clinics) or providing care in the context of short-term community outreach projects (e.g., health fairs).

Across most CLEs, education and training on health care disparities and cultural competency was largely generic, and often did not address the specific populations served by the institution. Generally, across CLEs, residents and fellows reported that learning about health care disparities and cultural competency was happening in an ad hoc manner.

- Most residents and fellows described receiving basic instruction on cultural competency. Occasionally, residents indicated that their programs provided experiential learning in cultural competency, for example, simulations that illustrate the impact of social determinants on health and health care, visits to neighborhoods where patients live, education about social services, and teaching by representatives of community groups.

Many residents and fellows, faculty members, and program directors were able to describe the demographics of the populations served by their CLEs and the populations that may be particularly vulnerable to health care disparities.

In many CLEs, the executive leadership's description of their vulnerable populations did not align with the populations identified by the residents, fellows, faculty members, and program directors.

Across CLEs, residents, fellows, faculty members, and program directors were seldom aware of the CLE's priorities for improving health care disparities.

- In general, residents, fellows, and faculty members appeared to have a narrow understanding of the concept of health care disparities. They were principally focused on access to care with limited awareness of any differences in outcomes across the special populations they served and the resulting impact such differences could have on the care provided to these patients. When residents, fellows, and faculty members were asked about how health care disparities are addressed in the CLE, common responses included, "Everyone is treated equally," or, "The hospital provides care for the uninsured," or, "They provide access to social workers and translators."

Across CLEs, awareness of institutional research projects in health care disparities was very limited, and generally restricted to interested faculty members, often at their affiliated medical school or school of public health. In many CLEs, efforts to address health care disparities were based on external funding for research projects. The most common example was funding through the federal government (e.g., the National Institutes of Health) or national foundations (e.g., the Robert Wood Johnson Foundation). Occasionally, residents and fellows described participating in quality improvement activities addressing issues of health care disparities. Few CLEs indicated that they were directly funding resident and fellow quality improvement projects to address health care disparities.

A number of CLEs have affiliated with a university-based center for the study of health disparities. These efforts are most commonly focused on research or community-based health assessments. The efforts did not appear to educate residents and fellows about the health care disparities they may encounter in the patient populations served by the CLE, or to couple this with experiential learning of how to achieve better outcomes in these patient populations.

Discussion

There are differences in health care and health outcomes among various populations and sub-populations within the United States. Residents and fellows should be aware of these disparities and participate in efforts to eliminate them.[5,6] While access to care—limited by financial constraints, workforce shortages, and geographic challenges—is an important contributing factor to health care disparities, it is not the only factor. There are many socio-cultural and economic barriers that affect patient care. The CLER site visits found that few CLEs have a well-defined or easily articulated formal strategy to routinely monitor and address health care disparities among the patients they serve. As a result, residents and fellows may not learn how to best manage these issues later in their careers.

CLEs need to ensure that their residents and fellows learn to recognize health care disparities and strive for optimal outcomes for all patients, especially those in potentially vulnerable populations. As front-line caregivers, residents and fellows are a valuable resource for formulating strategies on these matters. They can assist the CLEs in addressing not only low-income populations, but also those that experience differences in access or outcome based on gender, race, ethnicity, sexual orientation, health literacy, primary language, disability, geography, and other factors.

The diverse, often vulnerable, patient populations served by CLEs also provide an important opportunity for teaching residents and fellows to be respectful of patients' cultural differences and beliefs, and the social determinants of health. In learning cultural competence, residents and fellows would benefit from moving beyond one-time educational activities to a more formal, longitudinal, curricular-based program of progressive educational activities that continues throughout training. Similarly, they may benefit from experiential learning within a community context for some of the culturally unique groups in the local environment. These experiences would prepare them not only to address the disparities they face today but other unknown challenges that will arise in their future careers.

When asked how the CLE is addressing issues of health care disparities, executive leadership as well as residents, fellows, and faculty members commonly responded, "We treat all patients the same." Simplifying the complex issues around eliminating health care disparities in this manner risks providing the GME community with a general sense that health care disparities are for the most part adequately managed, without any supportive data to affirm these statements. The objective is not to have identical treatment, but rather treatment that is tailored to achieve similar results.

Residents and fellows have direct contact with patients and their families. As such, they are in an excellent position to be a critical member of any team working to solve health care disparities. In the absence of robust discussions about these issues both within and across CLEs, residents, fellows, and other health care professionals commonly relayed how they had taken it upon themselves to develop special and often unique solutions to address the needs

of individual patients. In general, CLEs do not appear to be capturing these unique and individual approaches for the purpose of developing and implementing robust, systems-based solutions for patient populations with similar special needs. While encouraging residents and fellows to seek unique solutions may be helpful in addressing immediate patient needs, it does not give them the leadership skills to guide systems-based solutions to complex health care challenges.

There also appears to be a general lack of understanding both within the GME community and among the clinical leadership of the CLEs as to what constitutes health care disparities in their patient populations. To date, there are few ACGME requirements addressing resident and fellow experience with regard to health care disparities. Residency and fellowship programs appear to vary in their approaches to training on this issue, and it is uncommon for Sponsoring Institutions to have robust educational efforts in this area.

In the course of their training, residents and fellows often rotate through multiple CLEs—each with its own special combination of vulnerable patient populations who may be at risk for health care disparities.

In considering patient outcomes, it is important to note that patients at risk for disparities are likely to require differences in care that are tailored to their specific needs—based not only on their biological differences, but also on other social determinants of health (e.g., personal social support networks, economic factors, cultural factors, safe housing, local food markets, etc.).

Many residents and fellows suggested that their knowledge and skills around the care of special populations within their CLE are currently based on ad hoc learning at the point of care with little actual dedicated education efforts provided by the CLE. At present, it appears to be largely left to the individual learner to synthesize the variability in approaches to managing disparities in health care outcomes.

Conclusion and Next Steps

Eliminating health care disparities in the US is a national concern.[5,6] Overall, the findings from this first set of CLER site visits suggests that there is currently a substantive deficiency in preparing residents and fellows to both identify and address disparities in health care outcomes, as well as ways to minimize or eliminate them.

Unlike the other areas of focus in the CLER Program, there is a general lack of agreement as to how GME could address this area. The experience from the CLER site visits compellingly suggests that there may be an important opportunity to improve patient care by enhancing resident and fellow knowledge and skills in health care quality improvement aimed at eliminating health care disparities.

The *CLER Pathways to Excellence*[7] outlines some expectations related to physician training in the area of health care disparities. However, in having national conversations, it is essential to involve other members of the health care team, as well as input from other key stakeholders both within health care and from the populations most affected.

Next steps are to better define the knowledge and skills needed to recognize, address, and eliminate disparities in health care outcomes and identify how they could best be achieved during the GME experience. Additionally, the CLER data suggest that there is a need to define the expectations for CLEs with regard to demonstrating health care improvement efforts aimed at eliminating disparities in health care outcomes.

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4 Nasca TJ. Introduction to the CLER National Report of Findings 2016. *J Grad Med Educ.* 2016;8(2 suppl 1):7-9.

5 Smedley BD, Stith AY, Nelson AR, eds. Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: National Academy Press, 2002.

6 2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy. Rockville, MD: Agency for Healthcare Research and Quality; April 2016. AHRQ Pub. No. 16-0015.

7 The Accreditation Council for Graduate Medical Education (ACGME). CLER Pathways to Excellence: expectations for an optimal clinical learning environment to achieve safe and high quality patient care. ACGME website. https://www.acgme.org/acgmeweb/Portals/0/PDFs/CLER/CLER_Brochure.pdf. Accessed July 15, 2016.

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