What Can (Must) GME do to Reduce Healthcare Disparities?

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Leo S. Morales, M.D., Ph.D., M.P.H.
Professor and Chief Diversity Officer
UW School of Medicine
Agenda

• ACGME and CLER Requirements
• Definitions: social determinants of health and healthcare disparities
• Collecting health equity data
• Develop health disparities project opportunities
• Develop a health disparities curriculum
• Offer faculty development on health equity/disparities
• Increase resident and faculty diversity
• Advanced training in health equity/disparities
• Discussion
Evolving AGCME Requirements
Effective July 1, 2019

• Common Program Requirements
  • Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.
  • **Education in Quality Improvement.** Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.
  • **Engagement in Quality Improvement Activities.** This should include activities aimed at reducing health care disparities.
CLER Pathways to Excellence
Focus Area: Quality Improvement

• *Pathway 5*: Resident/fellow and faculty member education on reducing health care disparities
  • 5.1 Residents/fellows and faculty members receive *education on identifying and reducing health care disparities* relevant to the patient population served by the clinical site.
  • 5.2 Residents/fellows and faculty members receive *training in cultural competency* relevant to the patient population served by the clinical site.
  • 5.3 Residents/fellows and faculty members know the *clinical site’s priorities for addressing health care disparities*.
CLER Pathways …

• **Pathway 6:** Resident/fellow engagement in clinical site initiatives to address health care disparities.
  
  • 6.1 Residents/fellows are engaged in QI activities addressing health care disparities for the vulnerable populations served by the clinical site.
Social Determinants of Health

Health/Wellbeing
- Physical
- Emotional
- Social
- Spiritual
Household Income and Life Expectancy in the United States

The richest American men live 15 years longer than the poorest 1 percent.

Race- and Ethnicity-Adjusted Life Expectancy for 40-Year-Olds by Household Income, 2001-2014

Education

King County
- LT HS education: 7.5%
  - White: 3.5%
  - Black: 13.4%
  - Hispanic: 30.1%
  - American Indian/Alaska Native: 19.5%
Poverty

King County
• Poverty 10.7%
  • White: 7.1%
  • Black: 28%
  • Hispanic: 19.1%
  • American Indian/Alaska Native: 23.2%
Health Insurance

King County
• Uninsured: 8.3%
  • 5.7%
  • Black: 11.8%
  • Hispanic: 22.6%
  • American Indian/Alaska Native: 22.6%
To identify geographic areas of need, King County census tracts were rank-ordered from highest to lowest percent of adults by the areas noted above. The tracts were then divided into 10 groups. Dark reds show tracts with the highest rates; dark blues show tracts with lowest rates (note: the Life Expectancy map ranks shortest in dark red to longest in dark blue).
Life Expectancy at Birth, Both Sexes, 2014

Source: Institute for Health Metrics and Evaluation
Equality versus Equity in Health and Healthcare

Equity is complex…

• Equity requires allocating resources according to need
• Need must be defined and measured
• Achieving equity may require additional resources
Healthcare Disparities

• Health disparity and health inequality are synonyms; disparity is used more often in the United States, while other countries use inequality. For over 25 years in the fields of public health and medicine, they have referred to plausibly avoidable, systematic health differences adversely affecting economically or socially disadvantaged groups.

• Health disparities/inequalities are how we measure progress toward health equity. Health equity is the underlying principle that motivates action to eliminate health disparities/inequalities.

Health and Healthcare Disparities

Figure 1. Major domains contributing to racial differences and disparities in quality of care and clinical outcomes for patients with chronic kidney disease. Based on a conceptual model in Smedley et al.6
Percentage of residents and fellows who reported knowing the clinical site’s priorities with regard to addressing healthcare disparities.
Percentage of CLEs with cultural competency training for residents and fellows

16% No Training
54% Generic Only Training
30% Some Kind of Tailored Training

“The data demonstrates variability in knowledge and a lack of comprehensive training on this issue [health disparities].”

Creating Opportunities for Health Equity Quality Improvement Projects

  • Conference speakers: Leo Morales and Paula Huston
  • Small groups discussions with faculty and residents
    • Chronic diseases (Rudy Rodriguez)
    • Palliative and end-of-life care (Erin Kross)
    • Infectious diseases (Paul Pottinger)
    • Injury prevention (Monica Vavilala)
    • Language access (Yvonne Simpson)
    • Surgical care (Dave Flum)
    • LGBTQ health (Corinne Heinen)
Palliative and End-of-Life Care

• Access to inpatient palliative care services – We are interested in better understanding whether there are differences in access to inpatient palliative care services across racial/ethnic/other groups within particular disease states (metastatic cancer, advance heart failure, etc.).

• Communication and language access – Recognizing that high-quality communication is an important component of palliative and end-of-life care, we are interesting in exploring potential disparities in care for non-English speakers.

• Pain and symptom management – Could examine pain assessments or pain control at the end-of-life, perhaps in patients dying in the hospital on comfort measures only, across different racial/ethnic groups.
Health System Health Equity Data

• Race and ethnicity*
  • Hispanic/Latino ethnicity separately from race
  • Asian subgroups
• Preferred language* and English proficiency
• Patient experience surveys
• Sexual orientation
• Gender including non-binary gender
• Disability/ability, veteran, other marginalized status groups

*ACA meaningful use criteria
Relative Disparity Index \((D_{\text{relative}}) = \frac{R_i}{R_{\text{ref}}}\)

\(R_i\) = how often a quality measure isn’t happening in the group of interest (e.g. African American);

\(R_{\text{ref}}\) = how often a quality measure isn’t happening in the reference group (e.g. white)

Ex: Good glucose control is happening in 67% of African Americans (but not in 33%)
Good glucose control is happening in 74% of whites (but not in 26%)

\[
\text{Glucose control } D_{\text{relative}} = \frac{33\% \text{ among African American}}{25\% \text{ among white}} = 1.3
\]

\(D_{\text{relative}} > 1\) means there is disparity in care
Disparity Index (African American vs. White), by clinic

*data points with <10 patients are not shown
Disparity Index (American Indians & Alaska Natives vs. White), by clinic

*data points with <10 patients are not shown
Disparity Index (Spanish speakers vs. non-Spanish speakers), by clinic

*data points with <10 patients are not shown
Disparity Index in Cancer Screening (Marginalized population vs. White)

*data points with <10 patients are not shown*

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<thead>
<tr>
<th>Cancer Screening</th>
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<tr>
<td>Colon Cancer Screening</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>6</td>
<td>1</td>
</tr>
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</table>
Disparity Index in Diabetes Management
(Marginalized population vs. White)

<table>
<thead>
<tr>
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<tr>
<td>A1c Control</td>
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</tr>
<tr>
<td>BP Control</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Eye Screening</td>
<td>6</td>
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</table>

*data points with <10 patients are not shown*
Health Equity Core Curriculum-1

• 5.1 Education on identifying and reducing health care disparities
  • Social determinants of health
  • Health and healthcare disparities in the US
  • Principles of community engagement
  • Theories of behavior change
  • Health policy and advocacy
  • Observational and experimental study designs
  • Qualitative research methods
  • Population genetics: ancestry-informative markers (AIMs) and epigenetics
Health Equity Core Curriculum-2

- 5.2 Training in cultural competency (cultural humility)
  - Practice of critical self-reflection
  - Race and racism in US medicine and healthcare
  - Non-binary gender and sexual orientation
  - Cross-cultural communication
  - The role of implicit bias in clinical decision making and teaching
  - Working with interpreters and LEP patients
  - Refugee and immigrant healthcare
Health Equity Core Curriculum-3

• 5.3 Residents/fellows and faculty members know the clinical site’s priorities for addressing health care disparities; and

• 6.1 Residents/fellows are engaged in QI activities addressing health care disparities for the vulnerable populations served by the clinical site.
  • Access to health equity dashboard (quality metrics by population groups)
  • Education in quality improvement methods
  • Mentored quality improvement projects addressing health disparities in the health system where residents train → Learning Health System
Learning Health Systems

- Have leaders who are committed to a culture of continuous learning and improvement.
- Systematically gather and apply evidence in real-time to guide care.
- Employ IT methods to share new evidence with clinicians to improve decision-making.
- Promote the inclusion of patients as vital members of the learning team.
- Capture and analyze data and care experiences to improve care.
- Continually assess outcomes refine processes and training to create a feedback cycle for learning and improvement.
- Identify and address disparities in care using a systems-oriented approach resulting in more equitable care and outcomes.
Increasing Residency Program Diversity

• Residency and fellowships in the context of a faculty pipeline
  • Developing faculty positions with focus on health equity: clinical, teaching and research

• Developing healthcare equity tracks within residency programs
  • Health equity curriculum
  • Clinical experiences in underserved communities
  • Global to local clinical experiences

• Pipeline programs
  • Mentoring UW medical students from diverse backgrounds
  • Summer research opportunities for medical students on healthcare equity
  • Funded sub-internship programs for visiting medical students
Faculty Development

• Many medical school faculty lack exposure to the concepts and science related to health and healthcare disparities.

• Limited curricula for the education of medical school faculty on health and healthcare disparities.

• Possible learning objectives for faculty curriculum:
  • Understand attitudes such as mistrust, subconscious bias and stereotyping that practitioners and/or patients may bring to the clinical encounter;
  • Attain knowledge of the existence and magnitude of healthcare disparities, including the multi-factorial etiologies of and the multiple solutions required to eliminate them; and
  • Acquire the skills to effectively communicate and negotiate interracial perspectives on healthcare disparities, including trust-building and the use of key tools to improve communication.
Advanced Training in Health Equity

• Commonwealth Fund Scholarship in Minority Health Policy at Harvard
• Harold Amos Medical Faculty Development Program (RWJF)
• Robert Wood Johnson Foundation Clinical Scholars Program
• Resource Centers for Minority Aging Research (RCMAR)
• National Institute on Minority Health and Health Disparities (NIMHD)
  • Career Development: K01, K08, K23, K99/R00
  • Research: R01, R21, R03, R15, R41/R42, R43/R44, R13
Discussion

Comments:
Leo Morales, MD, PhD
ism2010@uw.edu