

Meeting the Primary Care Needs of Transgender Patients Through Simulation

Setting and Problem

Transgender people report high rates of discrimination and substandard care in many health care settings. This is attributed to a lack of provider training about, experience with, and knowledge of the needs of transgender patients. To address this, we developed a simulation experience for primary care residents to interact with transgender patients and learn to address their unique health needs.

Intervention

We developed a formative objective structured clinical examination (OSCE) case, which involved a transgender woman taking spironolactone and estradiol, who presents with hypertension and hyperkalemia in a primary care clinic. The patient is interested in having an orchiectomy. Case objectives were to explore and respect the patient's preferences regarding her treatment and to make a plan for managing her hypertension and hyperkalemia, while taking into account her values regarding her hormones.

The trained standardized patient (SP), a transgender actress, rated the resident's core communication, patient satisfaction, and case-specific skills, and provided verbal and written feedback along with the faculty observer. Case-specific items were developed based on guidelines for transgender health, as well as the clinical specifics of the case, and were rated using a behaviorally anchored scale. Learning objectives included asking patients their name, pronouns, and gender identity; discussing sexuality, sexual activity, and associated risks; and avoiding assumptions about hormone use or surgical treatments. After the OSCE, residents were surveyed on preparedness, perceived performance, and challenges for each case.

Twenty-three medicine residents completed the case. Summary scores were computed as a *well done* percentage for communication and patient satisfaction

items for this case, and then compared to all other cases. Frequencies of specific treatment practices are described, and SP and residents' comments about the case were explored.

Outcomes to Date

Overall communication score (89%) and patient satisfaction score (85%) for this case were not significantly different from the other 9 cases (79% communication score; 72% patient satisfaction score; $P > .05$).

Less than two-thirds of the residents made the patient feel comfortable (61%, 14 of 23) or asked directly about her gender identity (61%, 14 of 23). Many residents did effectively probe the patient for medically relevant information regarding her transition (58%, 14 of 24), and recognized the spironolactone as the cause of the dangerously high potassium and the importance of this medication to the patient. However, only 25% (6 of 24) discussed possible remedies for the high potassium and only 39% (9 of 23) offered treatment for hypertension.

Residents felt prepared for this case despite finding it challenging to discuss transgender identity and health issues. Faculty and SP feedback helped residents identify learning needs, including how to ask directly about transition, appropriate terminology, how to admit lack of knowledge to a patient, and putting aside preconceptions about a patient's identity.

Good communication skills allowed residents to overcome their lack of transgender-specific clinical acumen; however, most residents did not directly address the patient's gender identity and long-term goals of care. This demonstrates the importance of including a transgender case in our OSCE to identify and address a significant curricular gap.

Resources needed to implement this curriculum are a space to run the OSCE and a transgender-identified actor/actress, who we paid the standard fee we pay all SPs (\$25 per hour). We advocate for the use of transgender actors to play transgender roles, as their insights about patient experience are imperative to provide appropriate feedback. We recognize that finding transgender actors in some communities may be difficult and recommend partnering with local community centers to identify potential SPs.

Further variations are appropriate for any medical specialty. Qualitative feedback from learners indicated that even those who had baseline knowledge of the basics of care for transgender patients found that the opportunity to interact with a patient in a low-stakes setting increased learners' comfort during future real-world encounters.

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Creating Provider-Level Quality Reports for Residents to Improve the Clinical Learning Environment

Background

Access to personal performance data is hypothesized to drive engagement in quality improvement and lead to improved quality of care. In the Common Program Requirements, the Accreditation Council for Graduate Medical Education (ACGME) sets an expectation that residents receive specialty-specific data on quality metrics. During the Clinical Learning Environment Review the level of specificity of such data is assessed, with a goal that residents receive feedback regarding their individual performance. Compared to inpatient care, it is often easier to collect individual performance data in the outpatient setting, where patient care is more closely attributed to individual providers. Individual inpatient quality data are more difficult to

acquire due to complicated attribution and data collection strategies that focus on units/departments rather than providers/teams. On our institution's most recent ACGME survey, a mean of 64% of residents in core programs reported access to their own performance data, indicating opportunities for improvement.

Intervention

Through a partnership with our performance improvement department, we aimed to design a resident quality and safety report for all core programs, with the following criteria for success:

1. each residency program must be able to define its own attribution strategy so that subsequent review will be meaningful to learners;
2. reports must include individual performance for each metric, as well as patient identifiers so that learners can review their performance at the case level;
3. existing performance analysis infrastructure should be used to make the process resource neutral; and
4. metrics must align institutional and educational priorities.

We created a mandatory field in our electronic health record's discharge order where a *discharge resident* is specified by his or her unique institutional identifier. This field ties the selected individual to the administrative data for a given patient case. An attribution strategy was defined by each program director, and residents were educated at the program level. Using the same process that our institution employs for the preparation of faculty Ongoing Professional Practice Evaluations (OPPEs), which are a joint commission requirement, our performance improvement department abstracted inpatient provider-level quality data for residents.

Outcomes

Resident OPPE reports have been prepared for 16 core programs and include *average length of stay*, *30-day readmission rate*, *complications of care*, and *average variable cost*. Patient identifiers are included for all 30-day readmissions. Compliance in completing the "discharge resident" order field ranged from 17% to 99% (mean = 75%). Programs with low program director buy-in demonstrated poor compliance, illustrating the importance of engaging educational stakeholders. Program director concerns included whether OPPE reports can be modified to reflect team-based care models, whether attribution

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