Accreditation Council for Graduate Medical Education

International Association of Medical Science Educators (IAMSE)
Winter 2019 WAS Series
January 24, 2019

The Learning Environment During Residency

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Disclosures

Board of Directors, American Board of Pediatrics Foundation

Associate Editor, Quality Reports, *Pediatrics*

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Learning Objectives

- Describe the history, rationale, and goals of the ACGME Clinical Learning Environment Review (CLER) program
- Describe CLER Site Visits
- Summarize the CLER National Report of Findings 2018
  - Overarching themes
  - Changes and trends between 1st and 2nd cycle of visits
  - Challenges and opportunities in the CLER Focus Areas
- Q&A

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Definition of "Learning Environment"

Learning environment refers to the social interactions, organizational cultures and structures, and physical and virtual spaces that surround and shape participants' experiences, perceptions, and learning.

Definition of "Learners"

In a continuously learning and improving health system, every participant is both a learner and a teacher. Participants include undergraduate and graduate health professions students, trainees, and researchers enrolled in formal educational programs as well as practitioners, educators, administrators, staff, patients, families, and community members.

Improving Environments for Learning in the Health Professions

Macy Foundation Conference, April 15-18, 2018

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The actions of the ACGME must fulfill the social contract, and must cause sponsors to maintain an educational environment that assures:

- the safety and quality of care for patients under the care of residents today
- the safety and quality of care of the patients under the care of our graduates in their future practice
- the provision of a humanistic educational environment where residents are taught to manifest professionalism and effacement of self interest to meet the needs of their patients

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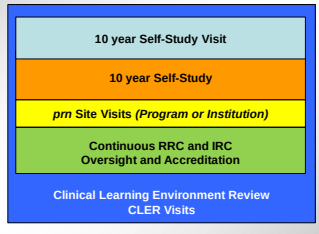
The Building Blocks or Components of The ACGME Accreditation System



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Background

- From the 2009-2010 ACGME Duty Hours Task Force
  - **"Sponsor Visit Program"**
    - To the National Advisory Committee
      - Use first round of visits and reports solely for baseline data and learning – *not an accreditation visit*
        - To the CLER Site Visit

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VIEWPOINT

The Clinical Learning Environment

The Foundation of Graduate Medical Education

Kevin B. Weiss, MD
James P. Bagian, MD
Thomas J. Nasca, MD

MORE THAN A DECADE AFTER THE INSTITUTE OF Medicine reported problems with the quality and safety of US health care,[1,2] formal training of the health care workforce in quality and patient safety is still inadequate. A recently released survey of hospital leaders from the American Hospital Association[3] (AHA) highlighted the need to educate US physicians including ACGME staff and volunteer site visitors from other sponsoring institutions and involve discussions and observations with hospital executive leadership (including the chief executive officer), resident physicians, faculty, graduate medical education leadership, nursing, and other hospital staff. These visits are designed to stimulate improvement in residents' engagement in the 6 focus areas and, as such, are intentionally not directly linked to accreditation.

Site visitors gain knowledge about residents' engagement in the 6 focus areas through group meetings and visits in clinical service areas. Group meetings involve structured interviews with residents, faculty, and program

JAMA, April 24, 2013—Vol 309, No. 16

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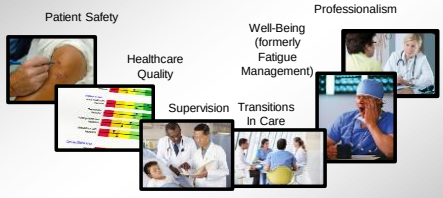
CLER Six Focus Areas



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Three Components to the CLER Program

- **Site Visits** – Provide sites with formative feedback to assist with development in the 6 focus areas.
- **National Data** – Track aggregated data over time and map the forward progress along each pathway toward the goal of achieving optimal engagement.
- **Learning Community** – Develop resources to educate and support faculty and executive leadership across focus areas in collaboration with other key organizations.

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CLER Program
5 key questions for each site visit

- Who and what form the hospital/medical center's infrastructure designed to address the six focus areas?
- How integrated is the GME leadership and faculty in hospital/medical center efforts across the six focus areas?
- How engaged are the **residents and fellows**?
- How does the hospital/medical center determine the success of its efforts to integrate GME into the six focus areas?
- What are the areas the hospital/medical center has identified for improvement?

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CLER Visits

Intended to provide:

- Formative feedback, indications of areas ripe for future work
- Aha's! Reflections that inform learning and promote voluntary improvement efforts
- A basis for empiric understanding of what is possible

Not intended to provide:

- Gotcha's
- New stealth accreditation requirements

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CLER Visits

Links to accreditation:

- Sponsoring institutions (SI) must have a CLER visit every 18-24 months
- DIO and CEO of participating site must be present for initial and exit interviews
- Collective knowledge from CLER will likely inform future institutional requirements (raising the floor)
- Exception(s): identification of potential egregious violations involving threats to patient safety or resident safety/well being

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CLER Cycles

Cycle 1 of CLER visits

- Focus on SI's which have at least one participating site with 3 or more core residency programs (n = 298)
- One participating site per sponsoring institution

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CLER Cycles

- Cycle 2 of CLER visits
  - Second visit to multi-program sponsoring institutions (began in Spring 2015)
  - First visit to "small program" sponsoring institutions
    - SI's for which all participating sites have less than three core residency programs including single program sponsoring institutions

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CLER Site Visits

- Each visit, 2-3 days duration
- 1-4 site visitors for each visit (including volunteers)
- Volunteer Site Visitor Program
  - Advances interaction with GME community through a new social learning network
  - Provides additional infrastructure
  - Recruits from leadership in GME, 'C-suite,' and patient safety and healthcare quality leadership

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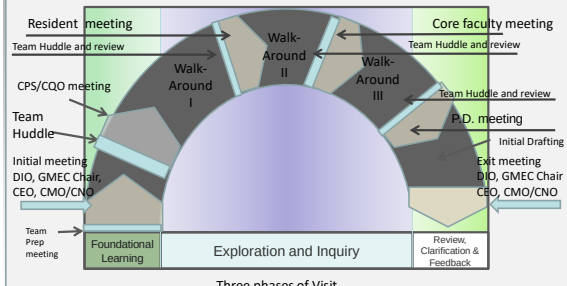
SCHEMATIC OF FLOW OF CLER SITE VISIT
(for visits to multi-program SIs)



Three phases of Visit

Note: each walk around accompanied by resident host/escort, opportunity for staff (e.g. nurses) and patient contact (future). As yet, uncertain of role of hospital/medical center governance

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Main Components of the CLER Visit

I. Bookend meetings with senior leadership

II. Group meetings with residents, core faculty and program directors

III. Walking rounds

IV. Team huddles

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Senior Leadership Meetings

- C-Suite
  - CEO required (no designees)
    - Focus on CEO of participating site
  - CMO, CNO (requested)
  - COO, CFO, Dean (optional)
- GME leadership
  - DIO required (no designees)
  - GMEC Chair
  - Resident member of the Graduate Medical Education Committee (GMEC)

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Patient Safety/Quality Officer, CIO Meetings

- Two meetings
  - Day 1: review of language for safety and quality
  - Day 2: review of resident/fellow engagement
- Identify staff distinct from the CMO
  - individual who tracks patient safety reporting (often risk management)
  - individual most closely associated with tracking quality indicators

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Residents, Faculty, Program Directors Meetings

- Seek broad representation of the **programs at that clinical site**
- May include proportionally more individuals from larger programs
- When possible, fill the room (up to 30 per meeting)

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CLER Evaluation Committee

- Includes national expertise in GME and the six focus areas
- Meets quarterly
- Receives data from site visits

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Evaluation Committee Members

- John Patrick T. Co, MD, MPH, FAAP, CPPS (Co-Chair)
- Kevin B. Weiss, MD, MPH (Co-Chair)-SVP, ACGME
- Robert Higgins, MD, Senior Academic Chair, Department of OB/GYN, Carolinas HealthCare System
- Lynne Kirk, MD, MACP, Professor, Internal Medicine, The University of Texas Southwestern Medical Center
- Catherine M. Kuhn, MD, DIO, Duke University Hospital and Health System
- Tanya Lord, PhD, MPH, Director, Patient and Family Engagement, Foundation for Health Communities
- David Markenson, MD, MBA, FAAP, FACEP, New York Medical College
- David Mayer, MD, Corporate Vice President, Quality and Safety, MedStar
- Marjorie Wiggins, RN, MBA, DNP(c), NEA-BC-SVP, Patient Services and Chief Nursing Officer
- Ronald Wyatt, MD, MHA-Chief Quality Officer, Hamad Medical Corporation
- **Resident Members**
- Lindsay Dale, MD, OB/GYN
- Anai Kothari, MD, MS, Surgery

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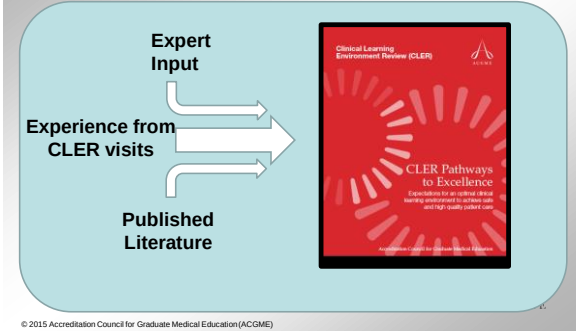
CLER Pathways to Excellence



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CLER Pathways to Excellence

- Guidance document
  - For both GME and Senior leadership of clinical site
- Framework
  - Six focus areas
    - Multiple Pathways for each focus area
      - One or more properties for each Pathway

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CLER Pathways to Excellence

PATIENT SAFETY

PS Pathway 1: Reporting of adverse events, close calls (near misses)

Reporting is an important mechanism to identify patient safety vulnerabilities. A robust reporting system is essential for the success of any patient safety program.

Properties include:

- Residents, fellows, faculty members, and other clinical staff members (nurses, pharmacists, etc.) know how to report patient safety events at the clinical site.
  The focus will be on the proportion of individuals who know how to report.
- Residents, fellows, faculty members, and other clinical staff members know their roles and responsibilities in reporting patient safety events at the clinical site.
  The focus will be on the proportion of individuals who know their roles and responsibilities in reporting.

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PS Pathway 1: Reporting of adverse events, close calls (near misses)

Properties include:

- Residents, fellows, faculty members, and other clinical staff members (nurses, pharmacists, etc.). Know how to report patient safety events at the clinical site.

The focus will be on the proportion of individuals who know how to report

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CLER National Report of Findings 2018

PDF copies available at www.acgme.org/cler

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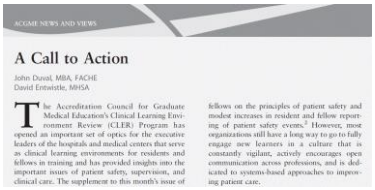
Journal of Graduate Medical Education

Current Issue of JGME *(August 2018)*

In This Issue



ACGME NEWS AND VIEWS

A Call to Action

John Duval, MBA, FACHE
David Entwistle, MHSA

The Accreditation Council for Graduate Medical Education's Clinical Learning Environment Review (CLER) Program has opened an important set of optics for the executive leaders of the hospitals and medical centers that serve as clinical learning environments for residents and fellows in training and has provided insights into the important issues of patient safety, supervision, and clinical care. The supplement to this month's issue of fellows on the principles of patient safety and modest increases in resident and fellow reporting of patient safety events.[2] However, most organizations still have a long way to go to fully engage new learners in a culture that is constantly vigilant, actively encourages open communication across professions, and is dedicated to systems-based approaches to improving patient care.

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The CLER National Report of Findings 2018

- **Second** set of visits to 287 clinical learning environments (CLEs) of Sponsoring Institutions with 3 or more core residency programs
- Visits conducted between March 2015 to June 2017
- Interviewed:
  - *More than 1600 members of executive leadership*
  - *9262 residents and fellows*
  - *8164 core faculty members*
  - *6034 program directors*
  - *Thousands of nurses and other health care professionals*

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Selected Characteristics of Residents and Fellows in the Group Interviews

Characteristic	Residents and Fellows, % (N = 9262)
Gender	
Male	55.9
Female	44.1
Level of Training	
PGY-1	1.8
PGY-2	22.4
PGY-3	28.4
PGY-4+	47.4
Specialty Group	
Medical	52.2
Surgical	25.8
Hospital-based	22.0

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Framework for considering the findings

- Overarching Themes
- Changes Since the First Cycle of CLER Visits: Trends in the CLER Focus Areas
- Challenges and Opportunities in the CLER Focus Areas
  - *Based on **quantitative** and **qualitative** results drawn from the summative observations of CLER site visits*

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Overarching Themes

The first 4 themes build upon those in the first National Report and the last 2 present new observations.

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Overarching Themes

Theme 1: CLEs vary in their *approach to and capacity for addressing patient safety and health care quality*. In many CLEs, organizational efforts to engage residents in these areas are emerging. In comparison to residents, there appears to be less focus on participation of fellows in the CLE's quality and safety activities.

Theme 2: CLEs vary in how they align and collaborate with graduate medical education in developing the organization's strategic goals aimed at improving patient care. In many CLEs, *graduate medical education is largely developed and implemented independently of the organization's other areas of strategic planning and focus*.

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Overarching Themes

Theme 3: A limited number of CLEs have designed and implemented educational programs to ensure that all graduate medical education *faculty members and program directors have the knowledge, skills, and attitudes necessary for their respective roles in training residents and fellows in patient safety and quality improvement.*

Theme 4: CLEs vary in the degree to which they *coordinate and implement interprofessional collaborative learning in the context of delivering patient care*.

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Overarching Themes

(New observations from the second set of CLER site visits)

Theme 5: In general, CLEs lack the *mechanisms to identify and eliminate organizational factors that contribute to burnout*. CLEs vary in their awareness of the extent of burnout among health care professionals and its impact on patient safety. A limited number of CLEs appear to be addressing burnout as a priority.

Theme 6: *Health care system consolidation and the concomitant organizational changes* in infrastructure, governance, priorities, and values are creating new challenges for CLEs to align graduate medical education with initiatives to improve patient care.

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Patient Safety at a Glance

Median Percentage Differences on Selected Measures in Patient Safety Between Cycle 1 and Cycle 2 of Clinical Learning Environment Review Visits Based on Resident and Fellow Responses to Closed-Ended Questions in Group Interviews

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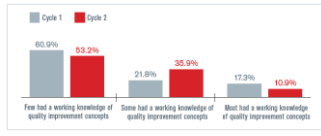
Health Care Quality at a Glance



Percentage of Clinical Learning Environments by Proportion of Resident and Fellow Knowledge of Basic Quality Improvement Concepts: Change Between Cycle 1 and Cycle 2 of Clinical Learning Environment Review Visits

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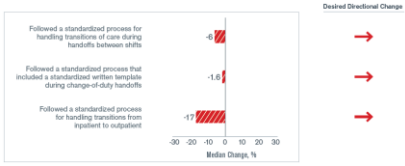
Care Transitions at a Glance



Median Percentage Differences on Selected Measures in Care Transitions Between Cycle 1 and Cycle 2 of Clinical Learning Environment Review Visits Based on Resident and Fellow Responses to Closed-Ended Questions in Group Interviews

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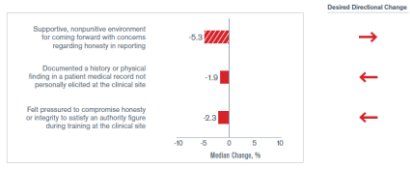
Professionalism at a Glance



Median Percentage Differences on Selected Measures in Professionalism Between Cycle 1 and Cycle 2 of Clinical Learning Environment Review Visits Based on Resident and Fellow Responses to Closed-Ended Questions in Group Interviews

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Challenges and Opportunities

Understanding and addressing the challenges and opportunities that CLEs are facing is integral to the nation's understanding of how CLEs are engaging residents and fellows in the Focus Areas.

They also provide insight on how CLEs can continuously take important steps designed to purposely enhance the connection between GME and optimal patient care.

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Challenges and Opportunities**

There were a number of challenges and opportunities in each of the focus areas:

- *Patient Safety: 3*
- *Health Care Quality: 5*
- *Health Care Disparities: 4*
- *Care Transitions: 3*
- *Supervision: 5*
- *Fatigue Management, Mitigation, and Duty Hours: 3*
- *Professionalism: 4*

A few highlights……

Please note that the selected findings are based on both quantitative and qualitative results drawn from the summative observations of CLER site visits

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Challenges and Opportunities

Patient Safety:

In general, residents and fellows were aware of their CLE's process for reporting patient safety events. Some residents and fellows appeared to have used the system.

Residents and fellows appeared to be most comfortable reporting through the chain-of-command and resolving issues at the local or departmental level. Often, these events did not appear to be entered into the CLE's patient safety event reporting system.

When residents or fellows did file a report, or when they had others file it for them, many received little or no feedback from the CLE.

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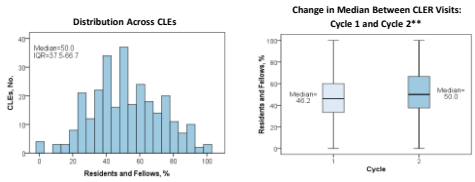
Percentage of Residents and Fellows Who Reported Experiencing an Adverse Event, Near Miss/Close Call, or Unsafe Condition and Submitted a Report Through the Clinical Site's Reporting System



**Statistically significant at *P*<.01

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Challenges and Opportunities

Health Care Quality:

Across CLEs, a limited number of residents and fellows reported access to data on quality metrics and benchmarks for the purposes of quality improvement, including data on outcomes of care for the population of patients for whom they are providing care.

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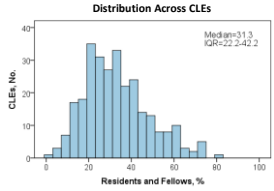
Percentage of Residents and Fellows Who Reported Receiving Aggregated or Benchmarked Quality Performance Data About the Care of Their Own Patients



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Challenges and Opportunities

Supervision:

Across many CLEs, residents and fellows expressed reluctance to request help from the attending physician or to report concerns regarding supervision.

Residents and fellows were hesitant to ask for assistance for several reasons, including:

- a lack of understanding about when to escalate concerns to a supervisor;
- an unwillingness to appear unprepared by asking for assistance;
- a fear of retaliation;
- a sense of shame;
- and concerns of pushback from peers, attending physicians, and consultants.

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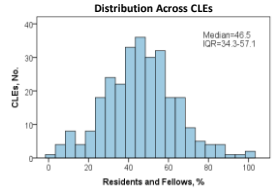
Percentage of Residents and Fellows Who Reported Encountering a Physician (Attending Physicians or Consultants) Who Made Them Feel Uncomfortable When Requesting Assistance



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Challenges and Opportunities

Fatigue Management, Mitigation, and Duty Hours:

In many CLEs, **residents and fellows** described witnessing signs of burnout in a number of their colleagues.

The main contributors to resident and fellow burnout related to high patient volume, patient acuity, and non-physician responsibilities. Also, residents and fellows reported observing signs of burnout among faculty members and program directors.

Faculty members and program directors reported the same contributing factors identified by residents and fellows and emphasized clinical productivity pressures, extensive documentation requirements, inadequate clinical and administrative support, and the overall challenge of balancing teaching, research, administrative responsibilities, and patient care.

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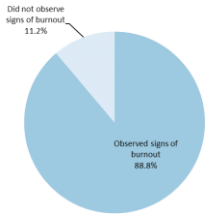
Percentage of CLEs Where Residents and Fellows Reported Observing Some Signs of Burnout Among Faculty Members and Program Directors



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Recent Changes/Future Directions

- Transition from Fatigue Management to Well-Being as a focus area
- Subprotocols *(operative areas, patient perspective, governance)*
- Pursuing Excellence Initiative (PEI)
  - Sharing lessons learned, disseminating successful practices
- New focus area on "Teaming"

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Questions?

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