CLER: Updates and Reflections

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IHI Course: Graduate Medical Education: Focusing on quality and safety in a clinical learning environment

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CLER Program Updates
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Three main components:

• Site Visits

• CLER Evaluation Committee

• Faculty and Professional Development
CLER Site Visits

Two areas of focus:

• Completing cycle 1

• Planning for cycle 2 and beyond

CLER Site Visits

Cycle 1: Baseline visits to sponsoring institutions (SIs) with more than 2 core programs

• Approximately 235 visits (of 291) completed to date

• Anticipate finishing 1st quarter of 2015
CLER Site Visits

Planning for Cycle 2 and beyond:

• Protocol 2.0
  • Feedback from DIO site visit responses
  • Crosswalk to Pathways document
  • Cognitive interviews
  • Design of sub-protocols (patient, Board, OR)
• Small and single program sponsoring institutions

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CLER Site Visits

Planning for Cycle 2 and beyond:

• Ongoing recruitment/staffing (field staff, administrative core)

• Review of pilot volunteer site visitor program

• Impact of single accreditation system

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CLER Evaluation Committee

CLER Pathways to Excellence

• Form the framework for site visit assessments

• Provide guidance for GME and senior leadership

• Promote conversations
CLER Evaluation Committee

Review and report of CLER data

- Preparing national report of findings based on first cycle of visits--planned release in 2015

- Will include data as well as reflections from the CLER Evaluation Committee

Additional Levers for Change

- Issue briefs, publications, position papers

- Presentations at national meetings

- Recommendations to IRC, RRCs (based on aggregate, de-identified data)
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CLER Faculty and Professional Development

• Multistakeholder meetings (IHI, AAMC, AIAMC, AHME, ABMS, TJC, ACPE, OPDA, etc.)

• Opportunities for alignment and collaboration in providing resources to the GME community

• Collective focus on improving the clinical learning environment (CLE) --exploring mechanisms to work together to implement levers for change
Global General Reflections

- CEOs and executive leadership working under enormous pressure to adapt to a rapidly changing external environment
- Extraordinary clinical leadership
- Very enthusiastic GME community
- Community of nurses are very supportive of GME
- Resident engagement is variable, but improving
Global General Reflections

• Large variability in executive leadership in:
  • General knowledge about GME
  • Understanding the value of integrating residents in organizations’ PS/QI efforts

• Similarly, large variability in GME leadership:
  • Understanding of patient safety and QI structure and processes
  • Understanding interactions of complex systems in the health care environment

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Global General Reflections

• Understanding of CLE has improved since beginning of cycle 1
  • Conversations between GME and senior leadership
  • Resident knowledge of focus areas
  • Resident engagement in PS/QI infrastructure

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Early Impressions

Patient Safety

- Variability in maturity of institutions’ approaches to patient safety issues

- Low engagement in resident and faculty reporting
- Roles in reporting often not well defined between residents and nursing
- Variable engagement of residents in investigations, most often as ‘reporters’
- Departmental M&M often used, seldom reflects a robust RCA-like process
Early Impressions

Healthcare Quality

• Often variable alignment in what are perceived as institutional priorities among hospital leadership, GME leadership, faculty, and residents
• Often residents and fellows have only rudimentary knowledge of QI methods used

Variation in resident and faculty participation in QI across programs and institutions

• Variable alignment (often little) between resident projects and the clinical site’s priorities
• Limited engagement of residents in interprofessional institutional QI initiatives
Early Impressions

Reducing Healthcare Disparities

• Majority of focus centers on providing access
• Highly variable training in cultural competency
• Almost no efforts to study variations in care for vulnerable patient populations

Early Impressions

Transitions in Care

• Some examples of what appear to be high quality transitions
• More often examples of variability in the quality of transitions; including process, training, and oversight of resident hand-offs
• Commonly cited vulnerabilities include transitions at change of duty, from ED to floor, in and out of ICU's, and at discharge

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Early Impressions

Supervision

- Examples of both under and over supervision
- Knowledge of need for direct supervision appears to be limited to GME faculty; nurses most often without objective way to know of resident need for supervision
- Not infrequent that residents/fellows report issues in supervision; even when faculty/PD’s believe supervision is always present

Early Impressions

Duty Hours/Fatigue Management

- Focus is on fatigue as related to duty hours and not on more general causes of fatigue
- Concerns about duty hour requirements
- Consistent emphasis on education; variable evidence of effective management strategies
- When present, nurses often the ones who see it
- A palpable amount of faculty fatigue
Early Impressions

Professionalism

• To date, most residents report being in a culture of openness for bringing forth concerns
• Variable degree of monitoring by clinical site
• Often measureable amount of problems in professional behavior--sometimes residents, sometimes faculty, sometimes nursing

Some group thinking on CLER
Patient safety in a clinical learning environment: a case example

Moderate size medical center with 400 bed acute care teaching hospital. This represents results of an “average” interview with a resident/fellow—in this case a second year anesthesiology resident:

“About 3 months ago I had a patient to whom I accidentally administered the wrong dose of fentanyl during a procedure. The patient developed severe hypotension and the procedure had to be temporarily halted until we could get her BP back up. My attending was close by—he was in the next OR and responded quickly. Ultimately there was no harm to the patient.

The reason I believe this happened is that during procedures fentanyl needs to be diluted differently depending on the route of administration—either via syringe, or via a 250cc IV drip. We do this dilution during the procedure while we are monitoring the patient and sometimes things get challenging.

I reported the event as part of our department’s M&M process. I am not sure if an online report was filed, I expect the nurse did that. My attending and I discussed this and I was told to re-review fentanyl dosing procedures and in the future be more careful.”
Let’s Discuss

GME

CLE

Hospital

Discussions and activities within GME

Strategic planning involving GME

Strategic planning outside of GME
• So what are the best practices?