ACGME CLER Visit
USF and TGH
September 22-24, 2014

Results
Goals for Today

• Provide information on the CLER visit results
• Start dialog on how we can meet the CLER visit expectations
TGH CLER Site Visit

• During the CLER site visit to TGH, over 25 clinical locations were visited by the site visit team
  – The CLER visit included STC outpatient areas
  – Resident end-of-shift hand-offs were observed for two programs and two additional programs’ hand-off processes were reviewed in detail
CLER Evaluation Areas

- Patient Safety
- Quality Improvement
- Efforts to Reduce Disparities in Health Care Delivery
- Supervision
- Transitions in Care
- Duty Hours Policy, Fatigue Management and Mitigation
- Professionalism
Areas of Assessment

• Institutional infrastructure
• Leadership and faculty engagement
• Resident engagement in using the clinical site’s patient safety and quality structures and processes
Patient Safety

- 60% of the trainees had experienced an adverse event or near miss
- 11% reported the event themselves
- Most trainees had difficulty identifying the site for reporting patient safety events. Of those who were able to identify the site, none could demonstrate its use.
- The system does not allow for loop closure
Patient Safety

- Faculty and Program Directors referred to department-sponsored evaluations of patient safety events, such as M&M, rather than Safety Investigation reviews conducted with the hospital staff.
Patient Safety - Suggestions

• Residents/fellows suggested:
  – Increasing resident/fellow participation on committees
  – Providing better clarity about when initiatives are starting and encouraging resident/fellow participation early in the process
  – Providing protected time for resident/fellow participation in patient safety activities
  – Incorporating discussions about patient safety-related cases into case-based conferences
Patient Safety - Suggestions

• Faculty members suggested:
  – Increasing the number of residents/fellows assigned to quality and safety committees
  – Conducting interdisciplinary and interprofessional simulation training
  – Improving the ease of entering patient safety events
  – Ensuring event reporting is non-punitive
Patient Safety - Suggestions

• Program directors suggested:
  – Sharing the outcomes of patient safety investigations and initiatives across departments
  – Involving residents/fellows from all surgical specialties in operating room team training
  – Appointing residents/fellows as standing members of more patient safety committees
ACGME categories of CLER expectations

**Basic**

– All residents/fellows must have the opportunity to report errors, unsafe conditions, and near misses

– All residents/fellows must have the opportunity to participate in inter-professional quality improvement or root cause analysis teams
ACGME categories of CLER expectations

**Advanced**

- Institutionally approved patient safety goals derived from national/regional recommendations defined and communicated across the residents and faculty
- Residents and core faculty on institutional safety/quality committees
- Comprehensive involvement across multiple programs
- Occasional sporadic involvement of faculty and residents in patient safety activities (resident, faculty meeting, and walk around)
ACGME categories of CLER expectations

Role Model

– All the above, and faculty and resident leadership in patient safety activities (ascertainment from senior leadership meeting with verification)
– All residents/fellows having experiences in safety related activities
– Direct engagement of CEO/Exec Leadership Team with residents over patient safety issues
– Participate in broad dissemination of output in patient safety from core faculty and residents
What can we do to get us to Basic and beyond?
Health Care Quality

• Most residents/fellows interviewed appeared to have a limited knowledge of QI terminology and methods (for example, PDCA cycles)

• 45% of the residents/fellows in the group interviews indicated they have access to organized systems for collecting and analyzing data for the purpose of quality improvement
  – It appears that the primary source of such data is from national or regional specialty-specific databases
  – What data do you have that you can put in front of your trainees and teach them a QI process?
What are Health Disparities?

• **Health disparities** are differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.
  
  – How do programs understand these differences within the TGH patient population and address the differences?
Health Disparities

- 65% of the trainees, 48% of the faculty members and 75% of the program directors reported they knew the hospital’s priorities with regard to addressing healthcare disparities as:
  - Supporting clinics to care for patients without insurance
  - Having an inpatient elder care unit, serving as safety net hospital, providing social work support to assist patients in obtaining insurance, translation services...
Health Disparities

• “Tampa General Hospital does not appear to have a systematic approach to identifying variability in the care provided to or clinical outcomes of their known vulnerable patient populations.”
Transitions in Care

• 89% of trainees indicated they used a standardized process for sign-off and transfer of patient care during change of duty.

• During the walking rounds, the hand-off sessions observed varied in use of templates, style of template, level of detail relayed and the environment in which the hand-off occurred.

• The faculty members appeared to vary by specialty as to the degree and manner in which they monitored residents/fellows skills in conducting change of shift hand-offs.

— Can we standardize verbal and written handoff processes?
Supervision

• 28% of the residents/fellows reported that they had been placed in a situation or witnessed one of their peers in a situation with inadequate supervision

• 72% of the faculty members and 95% of the program directors felt they have an objective way of knowing which procedures a resident/fellow is allowed to perform with or without direct supervision

• 13% of the residents/fellows in the group interview reported they believed they have an objective way of knowing whether another resident/fellow is able to perform a specific procedure
Supervision - Scope of Practice

• “The hospital does not appear to have a system by which nurses and others can identify an individual resident’s competency to perform a clinical procedure... The documents appear to vary in format between programs; many programs did not appear to list specific procedures that a resident/fellow could perform without direct supervision. The nurses interviewed appeared to principally rely on familiarity, trust or the presence of more senior physicians during resident/fellow performance of procedures.”
10% of the residents/fellows thought the majority of patients would successfully identify the differences in roles of residents and attendings.

- Can we identify the Resident/Fellow by level?
- How can we improve SOP documents?
- How do we educate patients as to provider roles?
Duty Hours

• 32% of trainees said in a situation where they were maximally fatigued with two hours left on a shift they would keep working and try to power through it
Professionalism

• 43% of trainees report cutting and pasting history or physical findings in the EMR that they did not personally obtain.

• Residents reported programs sharing in-service exam and board questions
Next Steps

• Develop USF plan to address each area in the CLER report
• Educate GME community on implementation plans
• Reinforce good outcomes and behaviors
• ACGME CLER team will be back in 2016...
Making Change Happen....