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.”

Scope of Practice

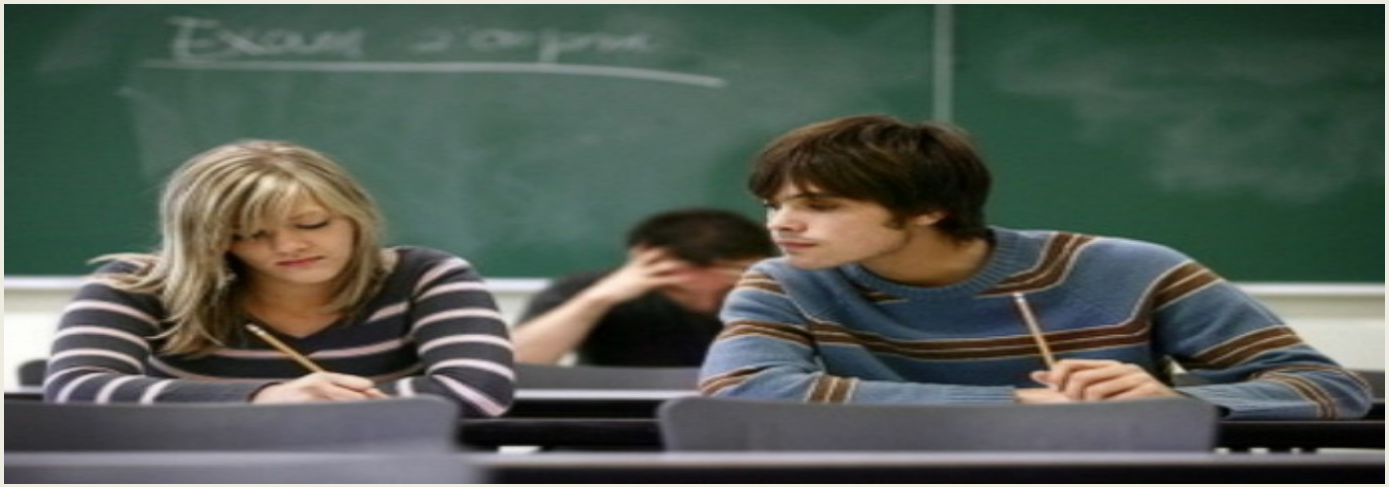
- 10% of the residents/fellows thought the majority of patients would successfully identify the differences in roles of residents and attendings
  - **Can we identify the Resident/Fellow by level?**
  - **How can we improve SOP documents?**
  - **How do we educate patients as to provider roles?**

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….