The Learning Environment During Residency

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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

Definition of “Learning Environment”
Learning environment refers to the social interactions, organizational culture and structure, and physical and virtual spaces that surround and shape participant experience, 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.

Disclosures
Board of Directors, American Board of Pediatrics Foundation
Associate Editor, Quality Reports, Pediatrics

The Building Blocks or Components of The ACGME Accreditation System

10 year Self-Study Visit
10 year Self-Study
pm Site Visits (Program or Institution)
Continuous RRC and IRC Oversight and Accreditation
Clinical Learning Environment Review (CLER) Visits

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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

CLER Six Focus Areas

Patient Safety
Healthcare Quality
Well-Being (formerly Fatigue Management)
Supervision
Transitions In Care
Professionalism

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.

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
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

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

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

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

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
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)

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)

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

CLER Evaluation Committee

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

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
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...
selected characteristics of residents and fellows in the group interviews

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Residents and Fellows, % (N = 9262)</th>
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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.

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.

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.
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.
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.

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.

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.
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.

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”

Questions?