The Clinical Learning Environment Review

Program engagement in patient safety and quality improvement

Disclosures

- We have no conflicts of interest to report regarding this presentation.
Poll question 1
What is your program’s current level of involvement in CLER activities?
A. Not yet started
B. Discussing them, but limited action planning
C. Have started implementing one of more action items
D. Robust education and implementation of experiential activities in at least one area

Goals
• Discuss initial CLER findings as they relate to what GME programs are doing.
• Identify opportunities for enhanced engagement between your institution and program(s), with a focus on Patient Safety and Quality Initiatives.
Agenda

- Introductions
- Overview (5 minutes)
- Discussion of 2 specific areas: patient safety; quality improvement (10 minutes)
- Small group work (15 minutes)
- Small group debrief (15 minutes)
- Anticipate home activity/action (5 minutes)
- Overview of additional areas (5 minutes)
- Wrap-up, resources and evaluation (2-3 minutes)

What is CLER?

“The Clinical Learning Environment Review (CLER) is a mechanism by which the ACGME assesses a Sponsoring Institution (SI) to evaluate its commitment to developing a culture of quality, patient safety, and performance improvement for both resident education and patient care.”
CLER Focus Areas

- Professionalism
- Supervision
- Healthcare Quality
- Healthcare Disparities
- Transitions of Care
- Patient Safety
- WELLBEING
  - Duty Hours
  - Fatigue Management

CLER: Five Key Questions

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

• Site visits
  – 11/16: 120/400 SPSIs completed
• National data aggregation
• Developing a Learning Community

CLER overall initial learnings

• Variable approaches of institutions to these areas
• Variable engagement of learners
• Variable engagement of faculty/program
• Programs often not connected to organizational plans
• Variable inter-professional interactions
Approaching CLER: our concerns

- “One more thing to have to do….”
- History of limited effective engagement of the SI with its sponsored program.
- For family medicine and primary care training, little integration of inpatient and outpatient goals and strategies.
- Lack of resources (espec IT) locally to facilitate the changed expectations.
- Burden of CLER visit itself.

So why do this?

- Support national efforts addressing patient safety, quality improvement, and reduction in health care disparities.
- Emphasizes the responsibility of the SI for the quality and safety of the environment for learning and patient care.
- Increase resident knowledge of and participation in safety activities and quality improvement.
- Intent to improve physician integration into quality and safety goals after graduation.
Patient Safety

- Top priority: forming the learning culture/SAFETY culture
  - Patient safety as a science
  - Non-punitive approaches
  - Focus on systems solutions, sustainability
- Support the healthcare workforce
  - Tools/training
  - Working conditions, respect, fatigue, apology, conflict resolution
  - Dashboards

Patient Safety: Education

- Residents/faculty:
  - Residents aware of process (median 97%), and could name institutional priorities (median 75%), but few used PSN systems (median 18%)
  - Little understanding of what defines a Patient Safety Event
    - Near misses/close calls seldom considered
  - Most common: use of training modules; but often unable to describe content, and lacked basics on terminology, principles, and methods:
    - Most common events; existing prevention strategies
    - How to report, where to seek assistance
Patient Safety: Reporting

• Residents:
  – Little understanding of system f/u of reports and process
    • How institutions use PSN reports to improve systems of care
  – Feedback inconsistent, discouraging future reporting
  – Need to understand VALUE of reporting, espec near misses/close calls

Patient Safety: Review

• Residents:
  – Limited participation in improvement activities and investigations ("experiential learning")
    • Confusion between peer review and patient safety investigations
    • M&Ms not connected to patient safety system, and often not conducted to same level of rigor, particularly in developing action plans and monitoring outcomes
    • Little interprofessional or interdisciplinary interaction
  – Most experiential learning was through informal conversations or M&M; infrequent participation in formal institutional investigation.
  – Limited inter-professional or inter-disciplinary engagement.
Preparing for CLER: patient safety

- Include residents in real, meaningful experiences:
  - Patient safety reporting.
    - Discuss WHAT should be reported (near misses, close calls, events without harm, unexpected deteriorations, procedural complications)
  - Follow up with them on periodic systems reporting and goals.
  - Train in inter-professional time-outs.
  - Involve in specific event analysis.

Poll question 2

- What are you currently doing in your program in patient safety?
  - Use of module for basic training of residents.
  - More intensive education in patient safety.
  - Involving residents in committees or meetings regarding patient safety.
  - Having residents participate in event debriefs.
  - Other
Health Care Quality

• Goal: design systems that move learners along a path from initial exposure to the concepts of QI, to comprehensive, experiential learning that prepares them to continue QI work throughout their careers.

Health Care Quality

• Four areas:
  – Res/fac awareness of institutional HC QI priorities
  – Knowledge of HC QI terminology and methods
  – Engagement in QI activities
  – Involvement in developing and implementing QI strategies
Health Care Quality: results

• Quality initiatives not always aligned between Institution and Program.
• When they are aligned, mostly on performance improvement measures
  – Hand hygiene, hospital-acquired infections, readmissions, pt experience

Health Care Quality: results

• Most residents knew of institutional QI priorities, but fewer could name them.
• Most residents report participating in QI projects, but many could not describe concepts and methods such as PDSA, often focusing on “fixes” alone.
  – Demonstration of skills is essential
  – Residents rarely are able to participate in full cycle of an improvement effort
Health Care Quality: results

• Residents often have limited participation in inter-professional QI teams (median 75%)
• Problems with data access for QI
  – Issues with periodic vs rapid-cycle data
  – Median 66% have access, more likely if alignment with institution

Preparing for CLER: quality

– Educate residents and faculty in system quality goals and priorities.
– Engage residents in LEAN/RPIW teams, PDSA cycles, or other process, and train them in that methodology.
– Engage residents and faculty when possible in institutional task forces, committees, or initiatives regarding quality (and safety).
– Work with SI leadership, including safety and quality officers (one should be on GMEC).
Poll question 3

• What are you currently doing in your program in quality improvement?
  – Use of module for basic training of residents.
  – More intensive education in QI systems.
  – Involving residents in committees or meetings regarding QI.
  – Having residents participate in QI initiatives.
  – Having residents lead inter-professional QI cycle.
  – Other

Small group discussion

• Pick one area in PS or QI that you most want to focus on
• Small groups of 3 persons
• 15 minutes:
  – Each person to take 5 minutes to discuss what your program/institution is doing in the specific area, what’s working, where you are having barriers
  – Change to next person.
Small group discussion debrief

• What ideas did you hear about what programs are doing?
• What barriers exist, and how are programs trying to overcome them?
• What do you see as priorities and opportunities for your program for this next year?

Taking ideas home

• What one specific idea will you take home from today to incorporate patient safety and/or quality improvement engagement for your residents and faculty?
Health Care Disparities

• Few institutions have formal strategy for addressing HCD for known vulnerable populations.
• Most common approaches were focusing on specific issues (access) or meeting regulatory requirements (interpreter services).
• Education about HCD largely generic, and not addressing local needs.

Care Transitions

• Most institutions did not have a standardized approach for hand-offs
  – Change of duty
  – Between departments (ED to inpt, ICU to floor, OR to floor, consults, etc.)
  – In- and out-of hospital
• Faculty uncommonly observed hand-offs to assure skills/quality.
Professionalism

• Most had received education.
• Some institutions reporting incidents of disruptive or disrespectful behavior.
• Lack of clarity about process residents would follow to seek assistance outside of the GME if needed.

Wellbeing

• Most programs have implemented some strategies to monitor/mitigate fatigue in learners.
• Fatigue related to factors other than work hours
• Faculty reporting more fatigue
• Over-interpretation of duty hours discouraging use of approved exceptions
Preparing for CLER: overall themes

• Build relationships between health system leadership and GME programs
  – Clinical integration into health system
  – Patient safety/quality promotion
• Participate in health systems’ goals and initiative development
• Educate leadership on CLER process

Poll Question:
Enter your email address to be included in any follow-up communication from the presenter(s).
Please...

Complete the session evaluation.

Thank you.
Resources

• CLER Pathways to Excellence (ACGME):
  – https://www.acgme.org/acgmeweb/Portals/0/PDFs/CLER/CLER_Brochure.pdf
• CLER Issue Briefs:

Resources

• NPSF “Unmet Needs”
  – http://www.npsf.org/?page=unmetneeds
• NPSF “Free From Harm”
  – http://www.npsf.org/?page=freenfromharm