

The Clinical Learning Environment Review

Program engagement in patient safety and quality improvement

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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



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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**?*

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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

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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

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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



- first full week of March •

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- **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.

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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

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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

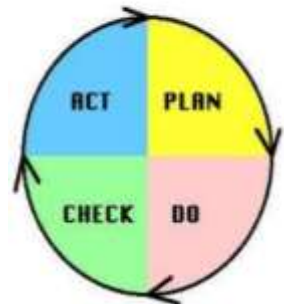
Health Care Quality: results

- 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

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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).



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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).



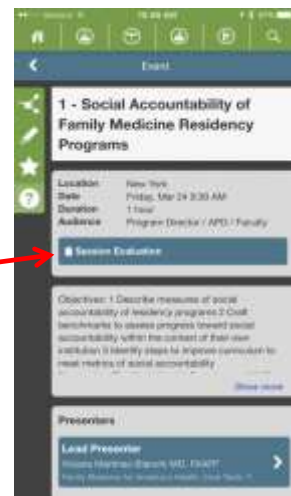
Social Q & A

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Please...
Complete the
session evaluation.

Thank you.



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Resources

- CLER Pathways to Excellence (ACGME):
 - https://www.acgme.org/acgmeweb/Portals/0/PDFs/CLER/CLER_Brochure.pdf
- CLER Issue Briefs:
 - <https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER>

Resources

- NPSF “Unmet Needs”
 - <http://www.npsf.org/?page=unmetneeds>
- NPSF “Free From Harm”
 - <http://www.npsf.org/?page=freefromharm>



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