CLER NATIONAL REPORT OF FINDINGS 2019

INITIAL VISITS TO SPONSORING INSTITUTIONS WITH 2 OR FEWER CORE RESIDENCY PROGRAMS

EXECUTIVE SUMMARY

ACGME
Accreditation Council for Graduate Medical Education

CLER
Clinical Learning Environment Review

Through this first set of visits to the smaller Sponsoring Institutions, the CLER Program has learned that, overall, clinical learning environments are largely facing the same issues–regardless of size, setting, and other features.

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INTRODUCTION

Since implementing the Clinical Learning Environment Review (CLER) Program more than 7 years ago, the Accreditation Council for Graduate Medical Education (ACGME) and the nearly 800 ACGME-accredited Sponsoring Institutions (SIs) have rapidly gained new knowledge about the clinical learning environments (CLEs) that host graduate medical education (GME). By periodically visiting ACGME-accredited SIs and providing formative feedback, the CLER Program serves to heighten awareness about how residents and fellows engage in the 6 CLER Focus Areas[1]:

- Patient safety
- Health care quality (including health care disparities)
- Care transitions
- Supervision
- Fatigue management, mitigation, and duty hours
- Professionalism

The 2016 and 2018 CLER national reports included findings for larger ACGME-accredited SIs, or those with more than 2 core programs.[2,3] The *CLER National Report of Findings 2019*[4] includes a new set of insights into the CLEs associated with 270 ACGME-accredited SIs that have 2 or fewer core programs. The overarching themes of the 2019 report[5] are to a large degree consistent with prior reports of the larger SIs.[6,7] In addition, the 2019 findings reveal that CLEs affiliated with smaller SIs have many of the same challenges and opportunities across the 6 CLER Focus Areas as CLEs of larger SIs.[8] For example, resident and fellow recognition and reporting of patient safety events into the clinical site's patient safety event reporting system varied across CLEs. In addition, CLEs, regardless of size, appear to have similar challenges with regard to GME engagement in transitions of care and professionalism.

BACKGROUND

The CLER Program has at its core a commitment to formative assessment and feedback regarding GME engagement in the 6 CLER Focus Areas. By conducting periodic site visits and providing formative feedback to hospitals, medical centers, and ambulatory care sites that serve as CLEs for resident and fellow physicians, the CLER Program aims to stimulate conversations and motivate CLEs to build upon their strengths and internally address opportunities for improvement. The CLER Program's primary link to accreditation is that every SI accredited by the ACGME must periodically complete a CLER Site Visit.

From the inception of the CLER Program, the CLER Evaluation Committee has provided oversight of and guidance for all aspects of program development. The committee is composed of members with expertise in patient safety and health care quality improvement, as well as GME and executive

leadership of hospitals and medical centers (eg, chief medical officer, chief nursing officer). The committee also includes postgraduate physician representation and public members.

For the 2019 report, the committee reviewed the data from the smaller SI site visits and brought an external voice in response to the findings–presented in the *National Report*'s sections on overarching themes and challenges and opportunities in the CLER Focus Areas.

METHODS

Collectively, the 270 SIs visited in the first set of visits oversaw 560 ACGME-accredited residency and fellowship programs. These smaller SIs accounted for 7.7% of all residents and fellows in ACGME-accredited programs–with a median (range) of 28 (1–144) trainees per SI.

Approximately 28% of the CLEs were located in the Southern region of the United States, 23.7% in the Northeast, 23.0% in the Midwest, and 22.2% in the West. The sites ranged in size from 41 to 1111 acute care beds (median=295). The majority (70.9%) were nongovernment, not-for-profit organizations; 12.4% were investor owned, for profit; 11.6% were government, nonfederal; and 5.2% were government, federal (*Figure*).

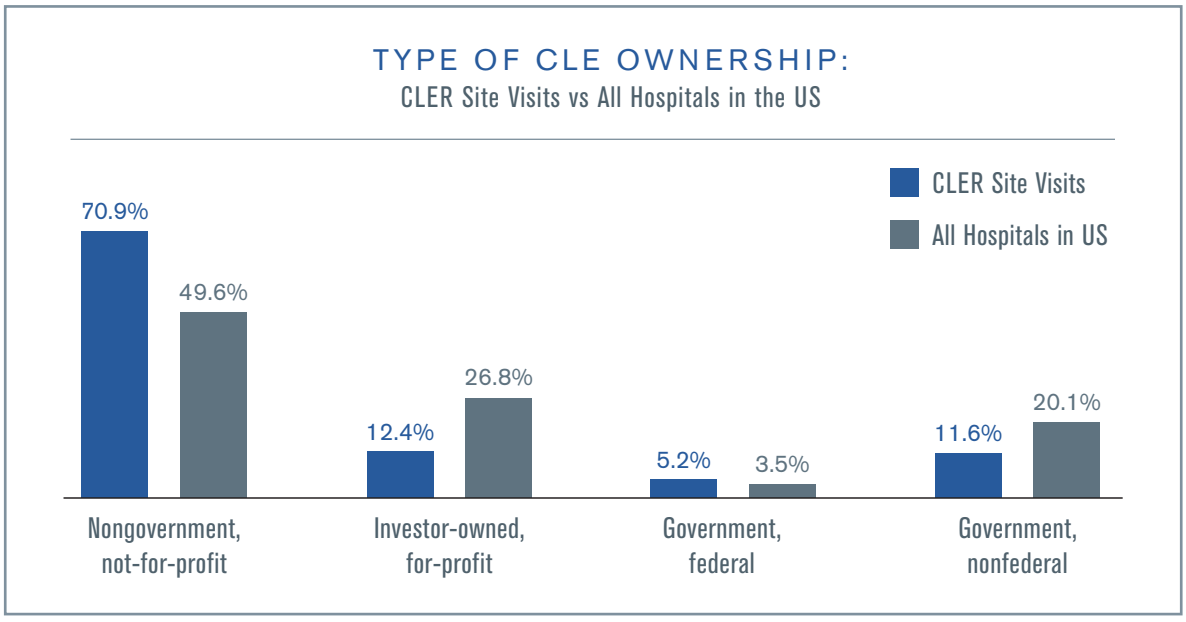

Figure. Type of Clinical Learning Environment Ownership: Clinical Learning Environment Review (CLER) Site Visits Versus All Hospitals in the United States (US)

For the majority of the 270 smaller SIs, the CLER Site Visit occurred at the hospital or medical center that served as the major participating clinical site for the SI. At many of these sites, the CLER Site Visitors spent time in both inpatient and affiliated ambulatory care practices. For a small proportion of the SIs, the site visit was conducted exclusively in the ambulatory care setting, including teaching health centers administered by the Health Resources and Services Administration. Additionally, for a small number of SIs, the site visit was exclusive to an ambulatory care site if the major participating site in an inpatient setting had been visited for a CLER Site Visit for a different SI.

In recognizing that the visits to the smaller SIs involved spending time in both inpatient and affiliated ambulatory care practices or solely in an ambulatory care setting, the CLER Program modified the protocol and site visit process as needed to accommodate these conditions and other unique aspects of the smaller SIs. Overall, these modifications were minor (eg, length of the site visit, site visit agenda). See the full *National Report* for detailed information on these changes.[9]

In total, the CLER Site Visit teams interviewed more than 1000 members of executive leadership (including chief executive officers), 1840 residents and fellows, 1789 core faculty members, and 459 program directors of ACGME-accredited programs in the group meetings. Additionally, the CLER teams interviewed the CLEs' leadership in patient safety and health care quality and thousands of residents, fellows, faculty members, nurses, pharmacists, social workers, and other health care professionals while on walking rounds in the clinical areas.

These findings are based on a mixed methods approach to data gathering and analysis to improve the accuracy of the findings by combining quantitative, descriptive, and qualitative evidence in

WHO WAS INTERVIEWED?

more than 1000 members of executive leadership
including chief executive officers

1840 residents and fellows

1789 core faculty members

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and thousands of others

a complementary manner. Data sources include responses to closed-ended questions collected through an electronic audience response system, open-ended discussion questions, and interviews on walking rounds. As such, some of the findings are represented quantitatively while others are described qualitatively.

Preliminary review of the results revealed that the overarching themes (ie, broad, high-level observations) and the challenges and opportunities (ie, findings) in the CLER Focus Areas were similar to those presented in the *CLER National Report of Findings 2018*.[3,7] Due to the similarities, the CLER Program adopted a modified approach to the development of the overarching themes and findings in the CLER Focus Areas for this report.

In the 2018 *National Report*,[10] the overarching themes and findings in the CLER Focus Areas were determined in 3 stages. First, the CLER Program staff asked each CLER Site Visitor to identify the overarching themes and the challenges and opportunities in each of the Focus Areas based on their summative experiences and observations. The CLER Program staff systematically analyzed the content of all responses to discern common themes and note salient concepts. Next, the CLER Site Visitors reviewed and commented on the results and offered additional findings by consensus. Lastly, the members of the CLER Evaluation Committee reviewed the results and developed a set of commentaries on the importance of the findings and their impact on patient care and physician training. The work of the committee was achieved by consensus.

For this report, the CLER Program staff asked the CLER Site Visitors to confirm or modify the 2018 overarching themes and findings in the CLER Focus Areas based on their overall observations from the site visits to the smaller SIs. The CLER Evaluation Committee then reviewed the results and modified the commentaries as needed.

As part of this modified approach, the CLER Site Visitors also had the opportunity to identify new overarching themes and findings in the CLER Focus Areas, which were developed following the steps described above for the 2018 *National Report*. Similarly, the CLER Evaluation Committee developed new commentaries by engaging in the same process described above.

OVERARCHING THEMES

As in the first 2 CLER national reports, this report of the smaller SIs reveals a number of overarching themes that cut across the CLER Focus Areas. In general, this first set of CLER Site Visits to the smaller SIs revealed 4 overarching themes that have carried forward since CLER's 2016 national report (ie, themes 1 through 4).[6] Theme 6 has carried forward from the 2018 national report.[3,7] Theme 5 is a new observation. These themes highlight how CLEs continue to face significant challenges in implementing change at the speed and magnitude needed to keep pace with, or ideally anticipate, the future of health care delivery.

- **Theme 1:** Clinical learning environments vary in their approach to and capacity for addressing patient safety and health care quality. In many clinical learning environments, organizational efforts to engage residents in these areas are emerging. Compared with that of residents, there appears to be less focus on participation of fellows in the clinical learning environment's quality and safety activities.

- **Theme 2:** Clinical learning environments 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 clinical learning environments, graduate medical education is largely developed and implemented independently of the organization's other areas of strategic planning and focus.

- **Theme 3:** A limited number of clinical learning environments have designed and implemented educational programs to ensure that all graduate medical education faculty members and program directors have the knowledge, skills, and attitudes necessary for their respective roles in training residents and fellows in patient safety and quality improvement.

- **Theme 4:** Clinical learning environments vary in the degree to which they coordinate and implement interprofessional collaborative learning in the context of delivering patient care.

- **Theme 5:** Across clinical learning environments of smaller Sponsoring Institutions, residents' and fellows' experience in health care quality efforts appears to take place within ambulatory care settings. Their experience in health care quality within inpatient settings appears to be less prevalent. In these ambulatory care settings, resident and fellow training also appears to focus more on health care quality than on patient safety.

- **Theme 6:** Health care system consolidation and the concomitant organizational changes in infrastructure, governance, priorities, and values are creating new challenges for clinical learning environments to align graduate medical education with initiatives to improve patient care.

CHALLENGES AND OPPORTUNITIES IN THE CLER FOCUS AREAS

The following findings in the CLER Focus Areas, presented as challenges and opportunities, are integral to the nation's understanding of the current condition of how CLEs are engaging residents and fellows in the CLER Focus Areas. They also provide insight on how CLEs can take important steps to purposely enhance the connection between GME and optimal patient care. By disseminating these findings, the CLER Program aims to stimulate conversations that result in efforts to improve the quality of the learning environment and patient care.

See the full *National Report* for commentary on the significance of these findings and a more comprehensive look at the findings in both narrative and graphic form.[4]

PATIENT SAFETY

Finding 1: In general, residents and fellows were aware of their clinical learning environment's (CLE's) process for reporting patient safety events. Some residents and fellows appeared to have used their CLE's patient safety event reporting 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.

Finding 2: In general, residents, fellows, and nurses lacked clarity and awareness of the range of reportable patient safety events, including what defines a near miss/close call.

When queried, residents, fellows, and nurses also appeared to vary in their understanding of how their clinical learning environment used the reporting of adverse events and near misses/close calls to improve systems of care.

Finding 3: Across clinical learning environments, a limited number of residents, fellows, and faculty members participated in interprofessional, interdisciplinary, systems-based improvement efforts, such as patient safety event reviews and analyses.

Many residency and fellowship programs used scheduled departmental morbidity and mortality (ie, M&M) conferences, case conferences, or grand rounds as the primary means of engaging residents and fellows in analyzing patient safety events rather than real-time interprofessional patient safety investigations.

HEALTH CARE QUALITY

Finding 1: Although most residents and fellows indicated that they participate in quality improvement (QI) projects, many interviewed appeared to have a limited knowledge of QI concepts and of the specific methods and approaches to QI employed by the clinical learning environment.

Finding 2: In many clinical learning environments, resident and fellow engagement in quality improvement (QI) appeared to be limited to implementing solutions prescribed by the CLE or the resident's or fellow's department. When residents and fellows participated in QI projects, many of the projects did not align with the CLE's overall goals, were limited in scope, or lacked all of the components of a complete QI cycle.

A limited number of CLEs integrated QI as part of system-wide efforts to provide residents and fellows with experiential learning aimed at achieving sustained improvements in patient care.

Finding 3: In most clinical learning environments, residents and fellows appeared to have limited participation in interprofessional quality improvement teams.

Finding 4: Across clinical learning environments, 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.

Finding 5: In a few clinical learning environments, the graduate medical education community has established resident and fellow work groups (such as committees) to increase resident and fellow engagement in quality improvement (QI). Of these work groups, few were integrated with the clinical learning environment's formal QI processes.

Occasionally, residents and fellows served on departmental QI committees; fewer were involved in institutional QI committees. If assigned to these committees, many had limited opportunities for meaningful participation.

HEALTH CARE DISPARITIES

Finding 1: Generally, across clinical learning environments, residents and fellows indicated awareness of and were able to describe populations served by the clinical site that were at risk for health care disparities.

Finding 2: Few clinical learning environments appeared to have a formal strategy to address health care disparities or a systematic approach to identify variability in the care or clinical outcomes of their patient populations at risk for health care disparities. A limited number of clinical learning environments were engaged in comprehensive efforts to identify and eliminate health care disparities in a systematic manner; it was uncommon for residents and fellows, faculty members, or program directors to be involved in these efforts.

Finding 3: In addressing health care disparities, many clinical learning environments focused primarily on specific issues such as improving access to care or meeting regulatory requirements. When residents and fellows engaged in addressing health care disparities, it was most often at the level of enhancing patient care access through providing direct service; it was uncommon for them to participate in other systems-based solutions to eliminate health care disparities.

Finding 4: Generally, residents and fellows reported that learning about cultural competency happened informally while providing clinical care. Across most clinical learning environments, formal education and training on cultural competency did not address the specific populations served by the institution.

CARE TRANSITIONS

Finding 1: Most clinical learning environments did not appear to have a standardized approach for facilitating resident and fellow change-of-duty handoffs. There appeared to be little understanding of the difference between standardization and uniformity.

In general, residents and fellows lacked awareness and understanding of the importance of standardizing essential elements of the handoff process.

Templates or tools were frequently used to facilitate the handoffs. Across programs and the clinical learning environment, the use of and type of templates varied. It appeared that residents most often engaged in face-to-face handoffs; fellows often conducted handoffs by telephone or e-mail.

Finding 2: Residents, fellows, and nurses expressed concerns that communication during transitions of care was often incomplete or inaccurate and created risk to patient safety. Examples included transitions from the emergency department to inpatient care, from service to service in inpatient settings, from inpatient care to outpatient care, and from one hospital to another, as well as transitions involving skilled nursing facilities or rehabilitation settings.

A standardized, organization-wide approach to training in and managing transitions in care between clinical services assigned to resident and fellow teams (eg, emergency department to inpatient care, operating room to intensive care unit, intensive care unit to floor, and medicine to surgery) was uncommon across clinical learning environments.

Finding 3: Across clinical learning environments, a limited number of programs appeared to use formal criteria to assess residents' and fellows' skills in change-of-duty handoffs. Across programs, it was uncommon to find faculty members consistently engaged in direct observation of resident and fellow change-of-duty handoffs. When faculty members were involved, the level of engagement and the process for supervision varied. Little or no monitoring of change-of-duty handoffs by graduate medical education leadership, executive leadership, or patient safety and quality leaders of the clinical learning environment was reported.

SUPERVISION

Finding 1: Across most clinical learning environments, residents, fellows, and faculty members reported an overall culture of adequate supervision within the graduate medical education community.

Clinical learning environments also faced challenges of under- and oversupervision.

- Residents, fellows, faculty members, and program directors perceived that undersupervision occurred mainly during times of high acuity, high patient volume, nights and weekends when the number of faculty members available to supervise was limited, and when the demands of competing clinical responsibilities exceeded the capacity of faculty members to provide adequate supervision.
- Faculty members and program directors perceived that external factors were contributing to oversupervision that impeded resident and fellow readiness for clinical practice after training. The most common reasons given for concerns regarding oversupervision related to billing rules and medical liability concerns.

Finding 2: Across many clinical learning environments, residents and fellows expressed concerns about their peers providing consultative services without adequate supervision, leading to patient safety vulnerabilities.

Finding 3: Across many clinical learning environments, residents and fellows expressed reluctance to request help from the attending physician, noncore faculty, and consultants 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.

Finding 4: Many clinical learning environments made efforts to implement online systems by which nurses and other clinical staff members could verify the competency of an individual resident or fellow to perform various patient procedures without direct supervision. When an online system was available, nurses were not aware of its existence, did not know how to access it, or rarely used it.

Across many clinical learning environments, nurses indicated that, in the absence of an attending physician, they relied on familiarity, trust, or year of training.

Finding 5: Residents and fellows, faculty members, program directors, graduate medical education leadership, patient safety leadership, and executive leadership varied in their awareness of patient safety events related to supervision.

In general, the executive leadership and the patient safety and quality leaders of the clinical learning environments indicated that they did not actively monitor supervision of residents and fellows. They indicated that monitoring is limited to retrospective review of patient safety events. Responsibility for resident and fellow supervision was viewed as primarily the purview of the graduate medical education community. Across clinical learning environments, some program directors reported having managed issues related to resident and fellow supervision within the past year that resulted in a patient safety event.

FATIGUE MANAGEMENT, MITIGATION, AND DUTY HOURS

Finding 1: When provided with a scenario of being maximally fatigued 2 hours before sign-off, across clinical learning environments, some residents and fellows reported that they would continue to work until their sign-off rather than expect to be taken off duty. When presented with the same scenario, faculty members and program directors were less likely to express the belief that residents and fellows would continue to work under such circumstances.

Finding 2: In many clinical learning environments, 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 nonphysician 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.

Finding 3: In general, clinical learning environments had developed and implemented some form of fatigue management for residents and fellows. Mitigation focused mainly on provision of sleeping facilities (eg, designated call rooms) and transportation options (eg, taxi services).

A limited number of clinical learning environments had systematic strategies and solutions that focused on prevention, recognition, and effective mitigation of fatigue and burnout. If strategies existed, they were generally in response to an event related to fatigue or burnout.

PROFESSIONALISM

Finding 1: In many clinical learning environments, graduate medical education and executive leadership expressed intolerance for behaviors that are considered unprofessional. Across some clinical learning environments, residents, fellows, and clinical staff described witnessing or experiencing incidents of disrespectful or disruptive behavior on the part of attending physicians, residents, fellows, nurses, or other clinical staff. These findings ranged from descriptions of isolated incidents to reports of disrespectful behavior that was persistent or chronic in nature.

Finding 2: Residents and fellows reported instances of feeling pressured to compromise their integrity to satisfy an authority figure.

Finding 3: Across clinical learning environments, residents and fellows described experiencing professionalism issues in obtaining consultation services (eg, delays or lack of responsiveness to providing assistance in patient care, disrespectful communication in response to requests).

Finding 4: Generally, residents and fellows appeared to be aware of the mechanisms and resources available to resolve perceived mistreatment if seeking assistance beyond those offered by the graduate medical education program. The perceived effectiveness of the institution's response varied across CLEs.

Occasionally, residents and fellows indicated that they would not report mistreatment out of concern for adverse consequences of reporting.

Finding 5: Across clinical learning environments, some residents and fellows reported documenting history and physical findings in a patient's health record that they did not personally elicit (such as copying and pasting in the electronic health record without proper attribution).

LESSONS LEARNED

Through this first set of visits to the smaller SIs, the CLER Program has learned that, overall, CLEs are largely facing the same issues—regardless of size, setting, and other features.

This CLER *National Report* of the smaller SIs also highlights the important role that ambulatory care environments play in the resident and fellow experience. As with the report of the larger SIs, it reveals a large degree of variability both within and across CLEs in each of the 6 CLER Focus Areas. This variability can be the result of CLE efforts to bring about positive change. It can also be a sign of CLE processes that are inefficient or ineffective, thereby representing opportunities for improvement.

FUTURE DIRECTIONS

Built on a model of quality improvement, the CLER Program will continue to explore new opportunities to provide the nation's CLEs with information they can use to simultaneously optimize learning and patient care. For example, based on the finding that CLEs lack interprofessional collaborative educational or learning experiences (see overarching theme 4, p. 7), the CLER Program will be examining how the concept of "teaming" can highlight important attributes of a high-performing learning health system and CLE. The CLER Program anticipates that, over time, it will deepen its exploration of how CLEs invest in, deliberately design, and monitor new models to promote learning and performance within clinical care teams—thereby strengthening the association between the quality of the GME experience and the quality of patient care in general.

To date, the CLER Site Visit findings shine an important light on how residents and fellows learn in the context of delivering patient care in extremely busy health care systems. These findings indicate the need to better understand attributes of high-performing CLEs that may be associated with health systems seeking to define themselves as high-performing learning health systems. The efforts of the National Academy of Medicine and other related work in the areas of learning health systems and high-reliability organizations[11,12] indicate that GME will likely benefit from CLEs who have explicitly focused their organizational efforts on operationalizing and sustaining these concepts.

Beginning in 2020, the CLER Program will present findings from both larger and smaller SIs in a single biennial report. This change will allow CLER to streamline its site visit operations as well as explore the findings as they apply to all SIs, regardless of size and setting. In addition, CLER will report findings of subprotocols recently introduced to enhance the regular site visit process. The first of these subprotocols focuses on the operative and procedural areas; a second subprotocol will provide insights from the patient perspective.

In the future, the CLER Program will also explore the perspective of governance and governing bodies' understanding of the mission and goals of their CLEs—particularly as they relate to GME. The CLER Program will also seek to deepen understanding of the structure and function of medical education across the medical continuum, specifically lifelong learning as seen through continuing professional development.

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