The Overview of the CLER Program: CLER National Report of Findings 2018

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Introduction

Since its inception in 2012, the Clinical Learning Environment Review (CLER) Program has had at its core a commitment to formative assessment and feedback regarding graduate medical education (GME) engagement in 6 important, cross-cutting areas of focus—patient safety; health care quality; care transitions; supervision; fatigue management, mitigation, and duty hours; and professionalism. CLER's formative approach recognizes that, although there are shared elements, each hospital, medical center, and ambulatory care site that serves as a clinical learning environment (CLE) for resident and fellow physicians has a unique set of internal and external factors that influence the development and implementation of that CLE's strategic goals aimed at improving patient care.

As in the *CLER National Report of Findings 2016*, the CLER Program continues to refer to CLEs as living and breathing entities—the embodiment of all of the individuals within these settings that influence and imprint upon these early learners. The CLER Program relies on the power of the information it provides 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 Sponsoring Institution (SI) must periodically complete a site visit. The 2016 *National Report* provided information on the CLER Program's background and structure.[1]

The CLER Site Visit Process and Changes to the CLER Site Visit Protocol

In the second set of visits to SIs with 3 or more core residency programs, the structure of the site visit remained essentially unchanged. The site visitors met with GME and executive leadership and the CLE's leaders in patient safety and health care quality; held group interview sessions with residents and fellows, faculty physicians, and program directors; and had numerous conversations with various members of the clinical care team while on walking rounds within the CLE.

For the second set of visits, the CLER Site Visitors used Protocol 2.0, which was similar but not identical to the version used in the first set of visits (ie, Protocol 1.0). Whereas the majority of the questions remained constant, Protocol 2.0 included new questions to explore important topics in greater depth. In addition, it included several other changes to enhance the quality of the information gathered as part of the CLER Program's commitment to a model of continual improvement:

- In the first set of visits, the protocol questions were developed and implemented before the *CLER Pathways to Excellence* guidance document, version 1.0,[2] was published. In developing Protocol 2.0, the CLER Program staff reviewed, and modified when necessary, each question from Protocol 1.0 to ensure alignment with the *Pathways* document.

- In Protocol 1.0, the CLER Site Visitors conducted informal interviews with the designated institutional officials (DIOs) of the SIs. In reviewing the information received from these informal interviews, the CLER Program staff recognized that DIOs have important and unique perspectives that often aligned with, yet were different from, the perspectives of the faculty members and program directors who comprised GME leadership. To capture these perspectives, the CLER Program created an interview and data collection tool specific to DIOs.

- In Protocol 1.0, the CLER Program's exploration of the focus area of fatigue management, mitigation, and duty hours concentrated mainly on fatigue and the CLE's approach to understanding and managing fatigue among residents, fellows, and faculty members. The interviews in the first set of visits revealed an important connection between fatigue and the potential for burnout. To explore this issue in greater depth, the CLER Program included additional questions on fatigue and new questions about burnout in Protocol 2.0.

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The CLER Evaluation Committee

In Protocol 2.0, the CLER Evaluation Committee continued to provide 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 Protocol 2.0, the committee reviewed and provided guidance on the changes described in the previous section. They also reviewed the data resulting from the site visits and brought an external voice in response to the findings—presented here as overarching themes and challenges and opportunities. Their views and commentary on the significance of the overarching themes and the challenges and opportunities are reflected in the discussion sections of this report.

Reporting the Findings and Organization of the Report

This report includes data from the second set of visits to 287 participating sites of SIs accredited by the Accreditation Council for Graduate Medical Education with 3 or more core residency programs. Similar to the first report of findings, this report presents several different perspectives, including overarching themes, highlights of the challenges and opportunities in each of the 6 CLER Focus Areas, and detailed findings, as well as a new section that examines changes since the last set of CLER visits. The CLER Program will present the findings from the initial visits to SIs with 2 or fewer core residency programs in a separate report scheduled for release in 2019.

References

[1] Wagner R, Patow C, Newton R, Casey BR, Koh NJ, Weiss KB; CLER Program. The overview of the CLER Program: CLER National Report of Findings 2016. *J Grad Med Educ*. 2016;8(2 suppl 1):11–14.

[2] Weiss KB, Bagian JP, Wagner R. CLER Pathways to Excellence: expectations for an optimal clinical learning environment [executive summary]. *J Grad Med Educ*. 2014;6(3):610–611.

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