Lessons Learned and Future Directions: CLER National Report of Findings 2018

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Lessons Learned

The Clinical Learning Environment Review (CLER) Program is designed as a formative evaluative experience for the more than 800 Accreditation Council for Graduate Medical Education (ACGME) institutions that sponsor graduate medical education (GME). The CLER Site Visits assess how the clinical learning environments (CLEs) of these Sponsoring Institutions (SIs) are performing in 6 focus areas of importance to ACGME. The *CLER National Report of Findings 2016*[1] included findings from the first cycle of CLER Site Visits, which were conducted at the nearly 300 SIs that sponsor 3 or more core residency programs. The current report presents findings for the second cycle of visits to that same group of CLEs; for each CLE, the second CLER Site Visit took place approximately 24 months after the first. In addition to an update of findings, this report contains a first look at a 2-point analysis and some insights into the types of efforts underway to improve the nation's CLEs.

Similar to the first report released in 2016, the *CLER National Report of Findings 2018* notes a large degree of variability across the 6 CLER Focus Areas—both within and across CLEs. However, for the first time, it also provides some indications of the directionality of the variation. Variability can be the result of positive forces seeking to bring about change. It can also be a sign of processes that are inefficient or ineffective, thereby representing opportunities for improvement.

A noteworthy example of improvement in overall performance is seen in the area of patient safety. The 2018 report notes that many CLEs demonstrated an increase in resident and fellow reporting of patient safety events between the first and second CLER visit. Whereas the degree of overall improvement was modest at the national level, at the individual level, a number of CLEs demonstrated high rates (eg, > 90%) of resident and fellow reporting of patient safety events.

Ideally, CLEs who have demonstrated improvements will serve as role models for others by identifying and disseminating the practices that led to their success. When this role modeling happens, the variability both within and between CLEs will likely decrease and the overall national performance will improve. ACGME is seeking to better understand some of these successful practices through the Pursuing Excellence Initiative (PEI).[2] Currently, 9 SIs are involved in a PEI collaborative effort to dramatically enhance the degree to which first-year resident and fellow physicians engage with their CLE to address and improve patient safety. It will be important to share the progress of these SIs as they identify successful models for involving residents and fellows in the CLE's infrastructure for addressing patient safety. Over the next few years, ACGME will sponsor PEI learning collaboratives in some of the other Focus Areas as well.

One of the biggest lessons learned in the second set of visits to these nearly 300 CLEs has been the positive effect that the CLER Program appears to be having on enhancing the dialog between GME leaders and the executive leaders of the health care systems that serve as CLEs for residency and fellowship programs. While this report's second overarching theme notes that GME continues to be somewhat insulated from CLEs' other areas of strategic planning and focus, feedback from GME leadership indicates that new and more substantial conversations are occurring between GME and CLE leadership. These new conversations indicate a pattern of collaboration that reaches beyond GME's traditional roles of fulfilling the CLE's educational mission and serving as a key component of the CLE's clinical workforce. The new conversations appear to be examining how GME can better align with the CLE's mission to deliver the best patient care and meet the new patient safety and quality performance standards that have emerged in the current health care environment.

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This report also provides new information that can be used to improve the training experience for resident and fellow physicians. For example, in the area of professionalism, the CLER Program explored several selected topics such as chronic disruptive behavior and managing issues of authorship on scholarly manuscripts. This information is being assessed and reported to stimulate discussions as to whether expectations for professional behavior are consistently practiced within CLEs. Reports from the CLER visits suggest these findings are gaining the attention of health system leadership.

Future Directions

The findings of the CLER Site Visits continue to shine an important light on how residents and fellows learn in the context of delivering patient care. The collective findings from the CLER Site Visits indicate that the attributes of high-performing CLEs may be directly associated with the concepts of high-performing learning health systems.[3,4]

The first set of CLER visits identified that, often, nurses, residents, and fellows work in parallel rather than in an integrated fashion. This was evidenced by the reported lack of collaborative educational or learning experiences and was highlighted as one of the overarching themes in the first CLER *National Report*.[5] This same theme is noted in this second report and is the impetus for evolving one of the CLER Focus Areas (care transitions) to a new area called "teaming" that will be incorporated into future versions of the CLER Site Visit protocol. It is important to note that in this evolution, the CLER Program will not lose the essential elements associated with transitions of care. Rather, these elements will be redistributed and assessed in the context of relevant Focus Areas such as patient safety and supervision.

Teaming is one of a number of important attributes of a high-performing learning health system. Over time, it is anticipated that the CLER Program 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 GME experience and the quality of health care in general. The efforts of the National Academy of Medicine and other related work in the areas of learning health systems and high-reliability organizations[3,4] indicate that GME will likely benefit from CLEs who have explicitly focused their organizational efforts on operationalizing and sustaining these concepts.

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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. One mechanism for doing so will be the introduction of subprotocols to enhance the regular site visit process. The first of these subprotocols will focus on the operative and procedural areas, and 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 it affects the quality of 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.

In a final note, the CLER Program would not be possible without the efforts of a large supportive community. The authors of this report thank many members of that community including: the ACGME Board of Directors for its continued interest in the ongoing development of this program; the CLER Program staff—both employed staff and those members of the GME community who have volunteered their time on visits; the members of the CLER Evaluation Committee; other programs within the ACGME who have helped support CLER; and most importantly, all of the individuals within the nation's SIs and CLEs who have helped organize and participate in the CLER visits.

References

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