CLER National Report of Findings 2021: Characterizing the Present and Informing the Future

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It has been 5 years since the release of the first *CLER National Report of Findings*, which focused on the larger Sponsoring Institutions, encompassing data from 297 clinical sites. In contrast, this National Report presents findings from 566 clinical learning environments (CLEs) associated with Accreditation Council for Graduate Medical Education (ACGME) Sponsoring Institutions (both large and small).[1] It provides a number of insights as to how hospitals, medical centers, ambulatory care sites, and other clinical settings serve as teaching environments for the approximately 145 000 resident and fellow physicians participating in more than 12 000 ACGME-accredited programs. This report has several unique features that will inform the ACGME, the graduate medical education (GME) community, and the public about these important environments where learning occurs in the context of providing patient care. First, both larger and smaller Sponsoring Institutions concurrently participated in CLER site visits in a single time period for the first time. Second, the report presents trends across several of the CLER Focus Areas for a subset of approximately 240 CLEs that have completed 3 CLER visits. Third, the report includes findings from institutions that achieved ACGME accreditation status through the Single Accreditation System and progressed past initial accreditation. Last, the report reflects findings of a new focus area called Well-Being.

The findings demonstrate that CLEs exhibit some common features with regard to the focus areas, irrespective of CLE bed size (ie, acute bed count), geographic location, or the type of ownership of the clinical site. The findings also suggest that there are some notable differences seen in the focus areas based on CLE characteristics. For example, there were significant differences in the percentage of residents and fellows who reported (1) participating in a quality improvement project linked to one or more of the clinical site's quality improvement goals; (2) following a standardized process for handoffs between shifts that included a standardized written template for communication; and (3) that based upon their experience at the clinical site, faculty members often or always disclose whether or not they have potential conflicts of interests during each of their clinical rotations. Over time the CLER Program will be seeking to both understand these differences and identify successful, albeit potentially different, approaches to optimizing the various CLEs across the range of ACGME-accredited Sponsoring Institutions.

As noted earlier, this report provides a first look at trends across 3 time periods for a subset of Sponsoring Institutions whose principal CLE participated in 3 successive CLER visits. The size and scope of this analysis is aided by a small set of questions that remained the same in all 3 cycles of CLER visits. Some interesting observations emerged from this view. Specifically, there has been demonstrable improvement in GME involvement in addressing patient safety. Patient safety has been a major focus of the CLER visits and the attention to this important and critical area of health care is reflected in the signs of improvement. Overall, CLEs appear to have dramatically increased their attention to resident and fellow access to and use of patient safety event reporting systems. For example, in Cycle 1, approximately one-third of the CLEs indicated they tracked the number of patient safety event reports submitted by residents and fellows; in Cycle 3, the percentage had increased to 80%. Similarly, there has been a nearly 20% relative increase in the percentage of residents and fellows who reported into their CLE's patient safety event reporting system.

This report also highlights areas in need of additional attention—specifically in engaging residents and fellows in patient safety event analysis, which has not improved across the 3 cycles. The lessons learned from the CLER Program's Pursuing Excellence Pathway Leaders Patient Safety Collaborative[2] and the Program Directors' Patient Safety and Quality Educators Network (a collaborative effort of

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the ACGME, Project ECHO, and the Organization of Program Director Associations) provide an evidence base and new approaches to addressing this challenging and important finding.

The findings related to health care disparities, while more modest, indicate for the first time that CLEs are starting to recognize the importance of this issue. During the site visits, more CEOs and their executive teams were starting to have open discussions on the need to examine risks for health care disparities within the populations served in the CLE. It is important to remember that these findings reflect conversations held with the CLE executive leaders prior to the start of the COVID-19 pandemic. It will be informative to see how the commitment to and success in elimination of disparities may improve in the next cycle of visits given the high degree of visibility of health care disparities revealed by the COVID-19 pandemic.

For several of the CLER Focus Areas, the report presents trends that show no change and in some cases trends in an undesirable direction. These findings will be the source of important reflection and possible intervention as they are further studied.

The report also identifies some new challenges. In examining the approximately 50% of residents and fellows interviewed who reported encountering a physician (attending physician or consultant) that made them feel uncomfortable when requesting assistance, the report notes this was more prevalent among the residents who were earlier in their postgraduate training. These findings indicate both suboptimal educational experiences, inadequate implementation of appropriate supervision and mentoring, and challenges to the culture of safety and patient care.

Along similar lines, of the one-third of residents and fellows interviewed who reported that they would "power through" to hand off even if they were impaired by fatigue, most were in their early years of postgraduate training.

One of the key areas highlighted in this report is the new focus area of well-being. Well-being is 1 of the 4 elements of the quadruple aim and is integral to the ACGME's mission.[3] In 2017, the ACGME joined with the National Academy of Medicine and other members of the health care and medical education community in ongoing efforts to address clinician well-being and resilience—specifically the challenges posed by the rapid changes in health care organizations and in patient needs.[4] This report presents the first national data that characterizes many aspects of well-being within the nation's CLEs. In gathering the data, the CLER Site Visitors focused on 4 priority areas as delineated in the *CLER Pathways to Excellence*, version 2.0[5]—work/life balance, fatigue, burnout, and support of those at risk of or demonstrating self-harm.

While the report reveals a number of interesting findings on well-being, 2 issues are particularly noteworthy. The first is not formally reflected in the findings, rather it relates to observations of the CLER site visitors. As part of the site visit protocol, the CLER team asked to meet with the individuals responsible for leading the CLE's efforts to address well-being. The site visitors informally noted that a variety of individuals attended these meetings. They noted the well-being representatives could often speak to isolated well-being activities for individuals or professions. However, absent from these conversations was a cohesive effort on the part of the CLE to implement a common strategy to address the well-being of the clinical care team. The other issue relates to the finding noting the types of interventions that were being planned or implemented in the CLEs. The finding noted examples of new efforts to identify individuals at risk, especially efforts to identify residents and fellows, and efforts to build resilience in the clinical care team. There were few examples of CLEs that were able to describe a strategy or substantive efforts to address the system-based factors that were creating challenges to well-being.

As with just about everyone else during 2020–2021, the COVID-19 pandemic has caused the ACGME CLER team to reflect on opportunities to better understand the impact of this catastrophic societal challenge. In response, the CLER Program has launched a specially designed site visit to understand the pandemic's impact on the CLEs.[6]

Looking forward, the CLER Program is seeking to use the knowledge from this and prior reports to inform a metamorphosis and transformation of thinking in how to best assess, understand, and inspire the CLEs of ACGME Sponsoring Institutions. This will include efforts to advance CLER site visit program's configuration to build on the experiences of the CLER-COVID protocol, possibly retaining some of the new features such as a sampling approach to selecting Sponsoring Institutions and CLEs visited, maintaining the new model of additional advanced notification for scheduling, incorporating new surveys for executive leadership, and possibly integrating some component of remote interviews. Any changes to the site visit protocol will still need to retain in-person visits to facilitate walking rounds. The impromptu conversations that happen on the walking rounds of the floors and service areas of the CLEs provide essential perspectives and insights from other members of the clinical care team (eg, nurses, pharmacists, social workers, respiratory technicians)

and additional members of the GME community who do not participate in the formal group meetings.

As modeled in the CLER Program's *Pursuing Excellence* initiative, the CLER Program will continue to seek opportunities to use the information gained from this report and future visits to provide the GME and CLE leadership with the knowledge and tools to advance improvements in their CLEs. The aggregate information in this and past CLER National Reports will also serve as an evidence base to inform the upcoming major revision of the ACGME Institutional Requirements.

Of final note, the CLER Program will also be undertaking efforts to transform its body of work to increasingly focus on an outcomes-oriented perspective of CLE performance. There are currently a number of efforts nationally to assess the quality of care provided in the many types of CLEs that host GME. The National Academy of Medicine recognizes attention to health care outcomes to be a major priority if the United States is to achieve the goal of better health at lower cost.[7] Through the CLER Program, the ACGME will be exploring the resources available to better align and integrate GME performance with this national direction of measuring health care quality outcomes. While this effort is in its early stages, over time this will be an essential tool to aid the ACGME's ability to provide the best possible formative feedback to the GME community and their CLEs to optimize learning and patient care in the framework of the quadruple aim.

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