Introduction to the CLER National Report of Findings 2022: The COVID-19 Pandemic and Its Impact on the Clinical Learning Environment

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In the closing days of 2019, the world found itself bracing for the unknown impact of a newly discovered human illness now known as COVID-19. For nearly 3 years, this virus has caused a pandemic that has reached every corner of the globe.

As the COVID-19 pandemic stretched from months to years, the Accreditation Council for Graduate Medical Education (ACGME) strove to understand the impact of this virus on the US health care system and, more specifically, on graduate medical education (GME). The Clinical Learning Environment Review (CLER) Program was mobilized to assist the ACGME and the community as we strove to develop a better understanding of the sustained impact of the pandemic on the clinical learning environments (CLEs) of ACGME-accredited Sponsoring Institutions. To achieve this goal, the CLER team developed and implemented a unique protocol that focused on identifying any impact of the COVID-19 pandemic that would likely persist for at least 2 years.

The *CLER National Report of Findings 2022: The COVID-19 Pandemic and Its Impact on the Clinical Learning Environment* presents information gleaned from this specially commissioned set of site visits to 287 hospitals, medical centers, and other health care environments that serve as CLEs for ACGME-accredited Sponsoring Institutions. The findings represent a stratified random sample of the more than 750 eligible ACGME-accredited Sponsoring Institutions. As per other CLER protocols, site visits addressed only one CLE for each Sponsoring Institution in the sample. The visits were conducted between October 2020 and April 2022.

The COVID-19 pandemic has had a dynamic and unpredictable impact on society and health care environments. The site visits that are the basis of this report were conducted through pandemic time periods that included the early phases. Specifically, the visits covered (1) the time period prior to vaccine availability and prior to the emergence of a shared set of practices for treatment of the severely ill; (2) the time period during which vaccines and boosters were introduced and treatment of severely ill patients was becoming more standardized; and (3) the time period during which Delta and Omicron variants emerged (and their consequential impacts). The site visits were completed just before oral treatment agents were becoming widely available. Therefore, these findings must be viewed from the lens of CLEs that recently navigated these challenging times. Efforts were made to avoid visiting CLEs during acute surges of COVID-19 in their communities; as a result, it is difficult to fully understand how experiences with managing the pandemic's acute phases may have shaped their perceptions of the likely impact over the next 2 years.

With these challenges in mind, it is noteworthy that, collectively, these site visits allowed us to identify several important, and likely enduring, findings that warrant the attention of the GME community and CLE executive leaders. The full report identifies 8 overarching themes as listed below:

1. CLEs anticipated an ongoing need to develop and implement strategies to retain and rebuild their workforces into the future.
2. CLEs anticipated long-term changes in patient care delivery models based on the COVID-19 pandemic experience.
3. Few CLEs appeared to have a long-term strategy to address multiple system-level factors that impact the well-being of the clinical care team; most CLEs were primarily focused on individual resilience.
4. The COVID-19 pandemic had a unique impact on resident and fellow well-being with regard to their readiness for future practice.

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5. The disruptions associated with the COVID-19 pandemic were anticipated to have a long-term impact on faculty member workload and well-being.
6. The COVID-19 pandemic disrupted many aspects of didactic and experiential learning for residents and fellows, with anticipated long-term implications.
7. CLEs varied in anticipating and recognizing potential patient safety vulnerabilities resulting from the increased and accelerated use of telemedicine.
8. A limited number of CLEs appeared to have a formal strategy or systematic approach to identifying and eliminating health care disparities.

Each theme is described in detail in the body of the report, and each has an important bearing on the future of health care and GME. Collectively, these themes represent an opportunity for reflection on what was done well, as well as learning and improvement that will allow CLEs to face the aftermath of the pandemic and to prepare for the next global health care challenge.

As CLEs emerge from what everyone hopes have been the worst phases of the COVID-19 pandemic, it is likely that many hospitals, medical centers, and health care systems will endeavor to find a way back to some version of "normal" based on pre-pandemic health care and GME routines. However, it is important to recognize that the pandemic has created many opportunities and avenues to harvest and apply new approaches to learning and clinical practice. One example is the dramatic increase in the use of remote technology to facilitate clinical care and learning experiences. Many successful practices that emerged from use of remote technology can serve as a basis for rapid evolution in approaches to patient care and education. Similarly, major workforce disruptions have led to many innovations in how clinical care teams interact with each other, such as accelerated use of text or video communications, which potentially can streamline clinical care and provide new opportunities for learning. These advances in remote and asynchronous learning and clinical care must also be explored for their impact on community, group learning, culture, and identity formation of learners.

Additionally, the pandemic painfully exposed long-standing disparities in health care. This exposure serves as a clarion call to prioritize health care equity as a principal issue in US health care policy and practice, and it requires the explicit attention of the leadership and membership of health care systems and systems of education at all levels of the continuum for all professions.

This report also provides insights in the section on detailed findings and the accompanying appendices. For example, the report notes that 72.6% of residents and fellows interviewed reported changes in patient care processes at their clinical site, as a result of the pandemic, that they viewed as sustained improvements in health care. The detailed findings also note that 52.3% of residents and fellows interviewed who were postgraduate year 3 and above reported participating in an interprofessional investigation of a patient safety event.

The appendices also contain several notable findings that reflect gender differences. For example, for the clinical sites visited, female residents and fellows were more likely than males to report encountering a physician (attending physician or consultant) who made them feel uncomfortable when requesting assistance (48.0% vs 39.1%, respectively, $P<.001$). Females were also more likely than males to report issues regarding supervision of consults conducted by residents and fellows as a result of the pandemic (15.8% vs 11.0%, respectively, $P<.001$). Female residents and fellows were less likely than males to report that their clinical sites had services and resources to help them manage emotionally stressful patient care situations resulting from the pandemic (76.2% vs 82.8%, respectively, $P<.001$). These findings suggest important gender-specific challenges within CLEs related to diversity, equity, and inclusion that warrant further consideration.

In addition to the findings summarized in this report, the unique design of this specially commissioned set of CLER site visits provided the CLER Program with new insights resulting from innovations in how it conducts CLER visits. Examples of innovations included conducting group interviews via remote technology and reconfiguring the opening and closing meetings with executive leadership to be more conversational. Additionally, the CLER Program conducted the protocol on a sample of Sponsoring Institutions. Insights gained from these recent changes have been incorporated into the next CLER protocol that is currently underway.

The year ahead will be an exciting one for the CLER Program as it engages in a process of strategic transformation and metamorphosis. Throughout this transformation, CLER site visits will continue to serve as the foundation of the CLER Program. These visits provide a critically important evidence base for formative learning for the ACGME and the GME community, including their hospitals, medical centers, and health care systems.

The ACGME Department of Sponsoring Institutions and Clinical Learning Environment Programs, which houses the CLER Program, also will develop new programmatic activities designed to support GME leaders in enhancing their CLEs through collaborative social learning networks and sharing of multimedia resources and toolkits that can amplify successful practices tested in the GME/CLE community. The department is also in the process of designing a new formative learning resource for the nation's Sponsoring Institutions that identifies CLE outcomes that align with the Quadruple Aim[1,2] and support high-quality GME and patient care.

As US health care systems and the GME community emerge from the acute phases of the COVID-19 pandemic, there are new opportunities to take stock of the many lessons learned from its impact. The CLER Program trusts that the findings from this special site visit protocol will provide part of the road map on how to focus collective efforts toward harvesting some of the successful innovations in patient care delivery and GME that have emerged from the challenges posed by the pandemic.

References

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