

The New ACGME Clinical Learning Environment Review

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ACGME call for CLER volunteers

JUNE 2012

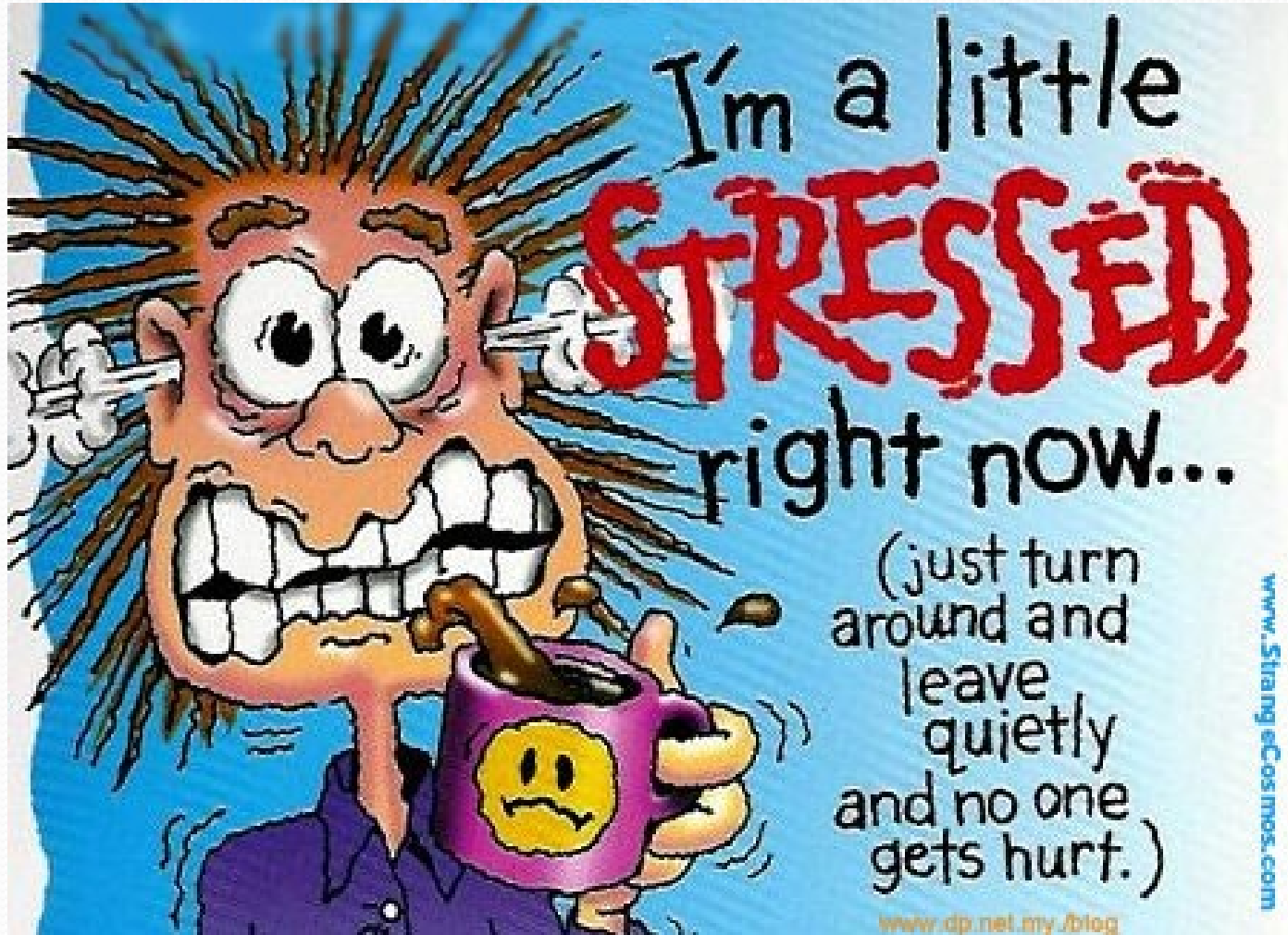
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Conference Call

- Kevin Weiss, MD and Robin Wagner, RN, MHSA
 - James P. Bagian, MD
- **How** the CLER visit would take place
- Documents in advance
- Proposed agenda/participants
- Walk-arounds with residents
- **And we'd like to come....**

JUNE 2012

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www.dp.net.my/blog

Getting the Word Out

Content of site visit and participants

- C-Suite, PD, AC, faculty, peer-selected residents
- ~1.5 days
- Focus on 6 areas
 - Resident involvement in **patient safety** and **quality improvement**
 - Resident **supervision** and supervision policies
 - **Transition of care**
 - **Duty hours and fatigue mitigation**
 - **Professionalism**

Resident Participation

- Senior level-comfortable answering questions
- Residents concerned they would say the wrong thing
 - Explained this visit was a “no risk” assessment
 - Be honest and forthcoming
 - Be proud of your program
 - Learning opportunity for resident

Sponsoring Institution Documents

- GME Organizational Chart
- GME Resident Supervision Policy
- GME Resident Duty Hour Policy
- TriHealth Patient Safety Protocol (approved by BoT)
- TriHealth Quality Strategy (approved by BoT)
- DIO's most recent annual report to the governance (BoT) and OMS
- List of residents on patient safety/quality committees

Institutional Oversight

In the past academic year, what % of residents in your institution's core specialties:

1. Had an opportunity to be part of multi-disciplinary inter-professional team to provide care?
2. Participated in QI projects to improve health outcomes?
3. Participated in patient safety projects?
4. Utilized electronic health records, including order entry and progress notes, in the direct care of patients?

*A team composed of physicians from one or more specialties, nurses and other health professionals, such as pharmacist, social workers, respiratory therapists, etc.

**Projects may be resident-initiated, program initiated, such as completing a Practice Improvement Module, or institution-initiated such as participation in an institutional effort to reduce central line-associated bloodstream infections, root cause analysis of errors or near miss events, etc.

Day 1-Wednesday June 13th

- Initial Meeting with DIO, GME Director, Peer-selected resident
- Meeting with C-Suite -1 hr
 - CLER Team Huddle-30 min
- Walk – around with a IM senior resident -1 hr
 - CLER Team Huddle-15 min
- CLER Team meeting w/Residents -1 hr
(2-peer-selected residents from each program)
 - CLER Team Huddle-30 min

Day 1

- Walk – around with a senior resident from Surgery-1.5 hrs
- Meet with core faculty (1-2 from each program)-1 hr
- Walk-around with a senior resident from OB/GYN-1.5 hrs
 - Last walk- around ended around 8:00pm
 - CLER Team Huddle off-site

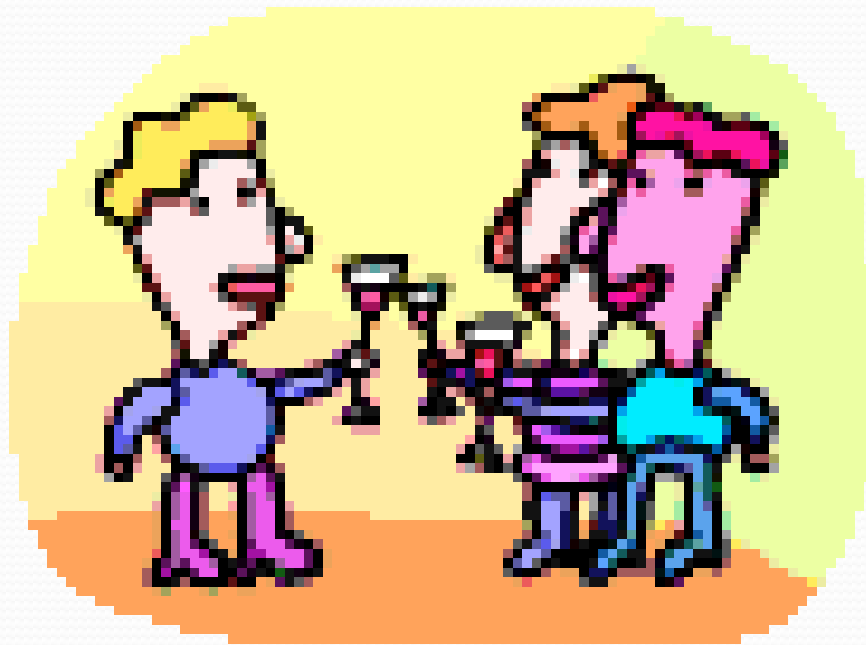
Day 2-Thursday, June 14th

- Check in with DIO and GME
- Meet with Program Directors -1 hr
 - CLER Team Huddle-1 hr
- Wrap-up with DIO, C-Suite, GME Director , one peer-selected resident -2 hrs
- Day 2 ends around 1:30pm

Wrap-up Session

- Resident reporting patient safety events
- Supervision concerns
- Residents knowledge/understanding of TriHealth quality goals
- Transition of Care
- Professionalism

After the Visit



Remember-Purpose of CLER

- To assess the GME learning environment of each sponsoring institution and its participating sites.
- CLER emphasizes the responsibility of the sponsoring institution for the quality and safety of the environment for learning and patient care.

Walk ArounDs-Floors, ED, OR, Clinic

Questions to clinical/ancillary staff regarding the learning environment

- Residents and faculty interactions
 - Do residents appear to have a comfort level in asking the attending questions without hesitation or fear of intimidation?
 - Do the residents appear to have a comfort level in calling the attending with questions regardless of time of day or day of the week?

Questions to clinical/ancillary staff

Event reporting

- Were they aware if residents reported near misses or other incidents freely in the reporting system?
- Do residents appear to fear retaliation or intimidation if they report an event?
- Do residents know how to report an event? Do residents report events?

Duty hours/fatigue mitigation

- Do residents appear to be well rested?

Questions to clinical/ancillary staff

Supervision

- Does there appear to be adequate supervision available to residents at all times? If not, what instances could supervision be improved?

Transition of care

- Is there a joint process for handoffs between residents and other healthcare providers?

**Asked ICU nurses about the interactions between faculty, residents, and nurses

Questions to Residents

Professionalism

- Do you report errors, near misses, or unsafe conditions?
- Do you feel safe in doing so?
- What happens after your report an event?
- How do you learn about scientific research requirements ?
 - taking credit for some else's work? Plagiarism?
- Misconduct while participating in or conducting quality assurance projects or scientific research?
- Falsifying any documentation?

Questions to Residents

Quality Improvement Projects - mandatory or optional?

Duty hours and safe working environment

- Were they aware of a duty hour limitation?
- How do they learn about duty hours and fatigue mitigation?

Transition of care

- Is faculty present during the transition of care?
- Does the transition of care take place electronically, verbal, or in person?
- Do residents sign-out with residents in other programs?

CLER Report

Received written report Tuesday, September 11th

- No “gotcha’s”, just more detail
- What we were doing well
- What we needed to improve

CLER Report was based on questions asked of the residents and clinical/ancillary staff

CLER Report

Contained an Overview of TriHealth as a S I
Six focus areas

- Resident involvement in
 - patient safety and impact of such
 - quality improvement to reduce disparities
- Resident supervision and supervision policies
- Transition of care
- Duty hours and fatigue mitigation
- Professionalism
- Option to Respond with Response Form

CLER Report

#1 Patient Safety

- Residents were inconsistent in their awareness and understanding of the hospital's system for reporting patient safety concerns including:
 1. what type of events should be reported
 2. who was responsible for reporting
 3. what mechanism should be used to report
- Of those interviewed, few residents had any direct experience filing a report using the hospital's online system; they seemed to defer to nurses to file reports.

CLER Report

#1 Patient Safety (continued)

Residents had little knowledge of what happens to patient safety reports once they are entered into the system.

- The resident interviews suggest that they receive inconsistent feedback as to the actions taken or final outcomes resulting from patient safety investigations

Patient Safety GME Response:

Contacted Director of Patient Safety

- Arranged in-service for all residents on reporting-system
 - Resident responsibility to report incidents
 - Incident report tracking ID
 - What happens after an incident is reported? Follow-up?
 - Retaliation
 - Residents to not want to spend the time to report
 - RCA's
 - Attend GMEC to discuss report options for PD

Administration looking to replace current system

- GME involvement in choosing a new system

CLER Report

2 Healthcare Quality

- In general, residents/fellows demonstrated little knowledge of the hospital's quality goals
- Residents were unclear as to how their individual projects related to the overall strategic plan

Healthcare Quality GME Response

AIAMC NI III participation

- Improve GME engagement in quality improvement
- Resident and Fellow-led Quality, Safety and Service Council
 - Subcommittee of GMEC
 - Resident QSS will report to the TriHealth QSS
- Each program selected 3 metrics to follow re: patient care quality
- IS to expand data warehouse with resident identifiers

CLER Report

#3 Transition of Care

- Each program had a standardized process
- No hospital-wide effort to standardize elements of hand-offs across different services
- Little inter-professional involvement in hand-offs between shifts
 - Nursing and residents/fellows maintain separate processes

Notable exception: ICU

Transition of Care GME Response

EMR introduced in June 2012

- Goals
 - Standardize the hand-off process
 - Multidisciplinary approach
 - OB currently piloting a process

CLER Report

#4 Supervision

- IM and OB/GYN residents raised concerns re: night supervision
 - IM PGY 2 ICU rotation
 - ICU attending physician are off-site
 - No hospitalist trained to cover ICU
 - OB/GYN
 - Potential lack of coverage if attending is called to the OR

Supervision GME Response

Internal Medicine

- Effective 7/1/12 a PGY 3 resident rotates in the ICU
- Pilot train hospitalists in CC for supervision at night/weekend
- July 2013 a nocturnest in the ICU

OB/GYN

- Revise faculty on-call arrangements
 - Second attending for back-up call
 - \$\$\$

CLER Report

#5 Professionalism

- Reporting issues of “perceived” issues of professionalism
 - Current chain of command **resident** to **chief** to **program director** to **GME leadership**
 - **NO appropriate alternative process/protocol** available to residents if situations might directly involve the chain of command
- Unclear if educational activities on topics of cheating, honesty in reporting, scientific integrity or mistreatment
 - No passive or active monitoring from GME leadership in these areas

Professionalism GME Response

- Code of Conduct added to the resident agreement starting July 1, 2012
- GME and TriHealth policies regarding professional behavior
- Research/QI projects undergo an administrative review process
 - DIO/VP of Medical Affairs & Director of Hatton Institute
 - Ensure research projects meet scientific integrity measures and honesty for research/publications



And eventually we'll get the
final report back from the
new CLER Committee

