The CLER Program
One element of ACGME’s Next Accreditation System
In July 2003 the Accreditation Council for Graduate Medical Education (ACGME) enacted resident duty-hour standards for all accredited programs that sought to integrate limits on resident hours within the larger set of ACGME standards. The aim of these standards was to promote high-quality learning and safe care in teaching institutions.\(^1\) When the standards were established, the intention was to comply with “the rules” or violating the standard by remaining with a sick patient when they believe it is their professional responsibility.\(^3\) Of added concern are reports suggesting that the 2003 limits did not increase residents’ hours of sleep\(^4\) or reduce fatigue\(^5,6\) and that the added time created under the new standards is not being used by residents...
<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Institution</th>
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</thead>
<tbody>
<tr>
<td>Carolyn Clancy, MD</td>
<td>Director, Agency for Healthcare Research and Quality</td>
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<tr>
<td>James Bagian, MD</td>
<td>Director, Veterans Administration National Patient Safety Center</td>
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<tr>
<td>Kevin Weiss, MD</td>
<td>President, American Board of Medical Specialties</td>
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<tr>
<td>Joann Conroy, MD</td>
<td>Chief Health Care Officer, Association of American Medical Colleges</td>
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<tr>
<td>John Combes, MD</td>
<td>Senior Vice President, American Hospital Association</td>
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<tr>
<td>Paul Schyve, MD</td>
<td>Senior Vice President, The Joint Commission</td>
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<tr>
<td>Donald Goldmann, MD</td>
<td>Senior Vice President, Institute for Health Care Improvement</td>
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<td>David Nash, MD MBA</td>
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<td>Carl Patow, MD MPH</td>
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<td>Robert Wachter, MD</td>
<td>Assoc Chairman, Department of Medicine, UCSF</td>
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<tr>
<td>Timothy Flynn, MD</td>
<td>Senior Associate Dean for Clinical Affairs, Chief Medical Officer, Univ. of Florida and Shands Medical Center</td>
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<tr>
<td>Baretta Casey, MD MPH</td>
<td>Dir. for the Univ. of Kentucky Cntr for Excellence in Rural Health</td>
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<tr>
<td>John Duval, MBA</td>
<td>Chief Executive Officer, Medical College of Virginia Hospitals</td>
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<tr>
<td>Timothy Goldfarb</td>
<td>Chief Executive Officer, Shands Medical Center</td>
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<tr>
<td>Paige Amidon, MBA</td>
<td>Vice President, Health Programs. Consumers Union</td>
</tr>
<tr>
<td>Carmen Hooker Odom, MRP</td>
<td>President, Milbank Memorial Fund</td>
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<tr>
<td>Thomas Nasca MD</td>
<td>ACGME Convener</td>
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</tbody>
</table>
CLER Focus Areas

- Patient Safety
- Duty Hours Fatigue Management
- Healthcare Quality
- Healthcare Disparities
- Supervision
- Transitions of Care
- Professionalism
Clinical Learning Environment Review (CLER) Program

• First Cycle
  • 380+ Sponsoring Institutions with multiple programs
    • Used solely for feedback, learning, and establishment of baseline information
  • Identification of salutary practices
CLER Program
5 key questions for each site visit

- Who and what form the hospital/medical center’s infrastructure designed to address the six focus areas?
- How integrated is the GME leadership and faculty in hospital/medical center efforts across the six focus areas?
- How engaged are the residents and fellows?
- How does the hospital/medical center determine the success of its efforts to integrate GME into the six focus areas?
- What are the areas the hospital/medical center has identified for improvement?
Three phases of Visit

- **Walk-Around I**
- **Walk-Around II**
- **Walk-Around III**

Note: each walk around accompanied by resident host/escort, opportunity for staff (e.g. nurses) and patient contact (future). As yet, uncertain of role of interview with governance interview.
CLER Evaluation Process*

1. Site Visit Report
   - Initial feedback
   - Institutional response (optional)

2. Copy of report sent back to institution, allow for response
   - Possible egregious violation

3. CLER Program Staff Preparation for Committee Review
   - Completeness and attachment of any institutional response

* CLER Evaluation Process* - Approved by CLER Evaluation Committee 10/2012

CLER Sponsoring Institution
Site Visit (Cycle I n=380+)

Committee Report (final)

Cycle I: To IRC (aggregate, de-identified)
### Example of possible template for categorizing CLER engagement

<table>
<thead>
<tr>
<th>Patient Safety</th>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident reporting of adverse events</td>
<td>All residents are aware of and expected to report events</td>
<td>Some residents are reporting events and near misses</td>
<td>Most residents are reporting events and near misses</td>
<td>Nearly all residents are reporting events and near misses</td>
</tr>
<tr>
<td>Education on patient safety</td>
<td></td>
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<tr>
<td>Learning environment culture of safety</td>
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<tr>
<td>Resident experience with safety investigations</td>
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</tbody>
</table>
CLER Feedback

• What they are intended for:
  • Aha’s! Experiences that inform learning
  • Guides for voluntary improvement efforts
  • A progressive set of activities for higher performance in organizational engagement in GME
  • Basis for empiric understanding of what is possible
  • Indicate areas ripe for future work

• What they are not intended for:
  • Gotcha’s
  • New stealth accreditation requirements
CLER Program: alpha and early beta visits
Early Impressions

• Experience:
  • >400 residents
  • >300 faculty
  • >200 program directors
  • Hospital leadership
  • Numerous nurses and other care providers

• Caveats/disclaimers
  • 15 visits
  • Nearly all volunteering institutions
  • Early use of site visit protocol
Early Impressions

- Patient Safety
  - Variability in residents knowledge of when, what and how to report
- Healthcare Quality
  - Degree of resident participation in QI varies across programs
  - Variable alignment with the clinical site’s priorities
  - Disparities initiatives focus on access; little attention to measuring variability or impact
Early Impressions

- Transitions of Care
  - Primary focus on hand-off for change of duty
  - Variability in process and oversight of resident hand-offs

- Supervision
  - Examples of both under and over supervision
  - Knowledge of need for direct supervision appears to be limited to GME faculty
Early Impressions

- Duty Hours/Fatigue Management
  - Consistent emphasis on education; variable evidence of effective management strategies

- Professionalism
  - To date, most residents report being in a culture of openness for bringing forth concerns regarding honesty in reporting
  - Variable monitoring by participating site
Some key observations

• Learning begins before visit and continues after the site visit
• Attempt to “prep” individuals with “right” answers may not work
• The concept of ACGME providing formative feedback not judgment is different
• In post-visit planning of improvement do not try to “boil the ocean.”
A couple of additional thoughts

- Significant variability in participating site’s leadership view of the strategic value of GME in advancing patient safety and care improvement
A couple of additional thoughts

- Significant variability in participating site’s leadership view of the strategic role of GME in advancing patient safety and care improvement
Some of the next steps in development of CLER Site Visits

- Continue to refine protocol
- Increase site visit staff
- Align with CLER Evaluation expectations
- Implement quality management process
- Test new sub-protocols
  - Unique/special S.I.’s (e.g. Military, VA, Children’s Hospitals)
  - Patient encounters
  - Contact with governance
  - SI site visits to multiple participating sites
The CLER Program

One element of ACGME’s Next Accreditation System
ACGME CLER Site Visit for TriHealth

Richard Welling, MD
VP of Medical Education/Academic Affairs
Designated Institutional Official
TriHealth
Cincinnati, OH
March 2013
ACGME’s First Alpha Test CLER Site Visit
Prior Notification

6 days to go..
Prior to Visit Requested Documents

- S I - TriHealth GME Organizational Chart
- S I - Supervision Policy
- S I - Duty Hour Policy
- S I - Patient Safety Protocol (approved by BOT)
- S I - Quality Strategy (approved by BOT)
- DIO’s most recent annual report to S I governance (BOT) and (OMS)
Days of the Visit: Meeting with C-Suite, Peer Selected Residents, GME Admin. Staff
Walk-Arounds
Questions on Walk-Arounds

- How did residents report safety events?
- Quality Improvement Projects - mandatory or optional?
- Asked all programs their transitions of care method
  - Were faculty present?
  - Electronic or verbal?
  - Sign-out with residents in other programs?
Wrap up

- C- Suite Representatives
- GME Administration
- Peer-Selected Residents
- DIO

Overview of the visit, some initial findings and recommendations
Two weeks after CLER visit notification letter of ACGME Institutional Site Visit
ACGME Institutional Accreditation Site Visit
4 months after CLER visit
Differences: Institutional vs. CLER Visit

- Institutional Visit:
  - Accreditation
  - Document Review
    - Policies and Procedures
    - GMEC Minutes
  - One Room
  - Notification Letter
    - Months later
  - Response only if solicited

- CLER Visit:
  - Observational
    - Walk-Arounds
      - 60 – 90 minutes
      - Each Specialty
    - Throughout Learning Environment
  - CLER site visit draft report
    - Within six weeks
  - Response Optional
IRC Next Meeting
April 10-12, 2013
Six Weeks After CLER Visit: Draft CLER Site Visit Report

Overview
- Patient Safety
- Healthcare Quality
- Supervision
- Transitions of Care
- Duty Hours/Fatigue Mitigation
- Professionalism
CLER Site Visit Report

Observations by Site Team

- Strong support of AIAMC’s National Initiatives
- Resident education in reporting lapses in safety events
- GME participating in Corporate QI/ Safety initiatives
- Transition of Care: Multidisciplinary implementation of hand-offs and consistency between services
- Potential Supervision Issues
Response is Optional

- Response sent to CLER Evaluation Committee for review next meeting
- Final report sent 4 - 6 months
- Start over 18 - 24 months
1) Residents Participate in Corporate QI and Pt. Safety

TriHealth/Good Samaritan & Bethesda North Hospitals

OPERATION SUPPORT OF QUALITY IMPROVEMENT & PATIENT SAFETY PLAN FOR GRADUATE MEDICAL EDUCATION (GME) February 2013
1) Residents Participate in Corporate QI and Pt. Safety

- Resident Quality, Safety, Service (QSS) Council
- Define Clinical and Academic Metrics
- Present as other service lines to TriHealth QSS
- CMO becoming an active and voting member of GMEC
2) Supervision

- Hospitalist:
  - Critical care training
  - Cover ICU at night for resident supervision
- Dedicated Gyn Faculty on call for Gyn Emergencies
  - Primary OB call would not have to leave L&D for Gyn emergencies
3) Transition of Care

- Sign out process is now in EPIC (EMR) and is standardized across all services

- OB pilot project:
  - Multidisciplinary team hand off 2x per day
    - OB anesthesia
    - Newborn Peds
    - Nursing
    - Faculty
    - Residents
Overall: A good learning experience for us that resulted in QI in GME
CLER Impressions
Atlantic Health System

Jeff Levine, PhD
DIO
It’s An Open Book Test

- Familiarize yourself with the website: [http://www.acgme-nas.org/cler.html](http://www.acgme-nas.org/cler.html)

- If you’re already meeting Common Program Requirements, you’re in good shape

- Get your documents together now
  - Org chart
  - Etc.

- Meet with your C suite and explain the process (e.g. short notice, walk arounds), the expectations of them and the purpose of the visit
Be Buddhist

β View the visit as an wonderful opportunity to get feedback from experts without risk. Live in the moment.

β When asked, “How to I prepare my faculty and residents?” reply “Tell them to just answer all questions honestly and completely. We want an accurate picture of how we’re doing. Just take a deep, cleansing breath.”
The AHS Visit

- Sitting in a NJCTH meeting when email arrived
- Asked myself, “Should I have volunteered for the beta group?”
- Visit scheduled for October 29 – 30
- Got to work on the schedule immediately
  - Rooms
  - C suite members
  - Program directors, faculty, residents
New dates: November 27 - 28

Site surveyors:

Kevin Weiss, MD
Robin Wagner, RN
Louis Ling, MD

We’re from the ACGME and we’re here to help. Felt nothing like a site survey
Impressions

- The site surveyors will work a lot harder than the DIO on those visit days
- They will strive to get an accurate picture of the clinical learning environment
- No one was intimidated or made to feel that they were being scrutinized
- There were no surprises
Outcomes

- 9 page letter outlining findings
- Actionable items
  - Discovered that our error reporting system isn’t working
    - Under-reporting
    - Thought of as punitive and not as a patient safety process
    - No feedback given and thus underutilized
  - There was little ‘ownership’ by residents of hospital QI processes.
  - Discovered that nurses have no clue how to access our database about resident “credentialed” procedures
Next steps – CLER visit as a QI activity

- Created actionable item grid
- Meetings scheduled with Patient Safety and Quality Departments – Chief Safety Officer
- Create subcommittees of our GMEC to address focus areas
  - Resident representatives on each subcommittee
- Adding error reporting to resident orientation (from Director, Risk Management)
- Adding member of Quality Department to GMEC will make program directors, faculty, and residents aware of and involved with hospital/system-wide quality initiatives
- Use visit as leverage to stay involved with leadership
## Actionable Item Grid

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Findings</th>
<th>Response</th>
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<tbody>
<tr>
<td>Patient Safety</td>
<td>It is unclear as to whether safety event reporting is aggregated via any type of common process. Patient safety event reporting appears to be inconsistent within and across programs. In general, Quantros is used to “report on” individuals, i.e. it is considered punitive.</td>
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<tr>
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<td>There was no mention of discussions focused on near misses and there appeared to be no consistent transfer of information of events discussed in M&amp;Ms into Quantros or any other centralized repository.</td>
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<td>In general, the residents/fellows, faculty, and nurses interviewed were inconsistent in their understanding of who should report patient safety events, when they should be reported, and the most appropriate methods or mechanisms to use in reporting. There appeared to be no clear policies for reporting events, and lack of enthusiasm by faculty and program directors to support use of the Quantros system.</td>
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</table>
Keys to Success

- Think big picture (hospital/system) re: your quality initiatives
- Improve communication between programs and between hospital administration and GME
- Get your policies in order now, e.g. Transition of Care Policy
- Develop relationship with C suite members and establish the importance of GME to patient safety and quality