CLER in Small Program Sponsoring Institutions

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Objectives

- Provide updates on progress of CLER cycles
- Present a brief overview of the background and structure of CLER
- **Address features of CLER process unique to small program sponsoring institution**
- Present an overview of the CLER Pathways to Excellence and other program components

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Please send questions to cler@acgme.org

CLER Cycles

Cycle 1 of CLER visits

- Focused on the larger sponsoring institutions – those with at least one participating site with three or more core residency programs (n = 298)
- One participating site per sponsoring institution
- Conducted alpha testing – Summer 2012
- Launched September 2012
- Completed March 2015

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CLER Cycles

- Cycle 2 of CLER visits
  - Second visit to multi-program sponsoring institutions (began March 2015)
  - First visit to “small program” sponsoring institutions
    - In general, sponsoring institutions for which all participating sites have fewer than three core residency programs, including single program sponsoring institutions

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Overview of CLER

The actions of the ACGME must fulfill the social contract, and must cause sponsors to maintain an educational environment that assures:

- the safety and quality of care for patients under the care of residents today
- the safety and quality of care of the patients under the care of our graduates in their future practice
- the provision of a humanistic educational environment where residents are taught to manifest professionalism and effacement of self interest to meet the needs of their patients

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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL REPORT

The Next GME Accreditation System — Rationale and Benefits

Thomas J. Nasca, M.D., M.A.C.P., Ingrid Philibert, Ph.D., M.B.A., Timothy Brigham, Ph.D., M.Div., and Timothy C. Flynn, M.D.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) introduced the six domains of clinical competency to the profession,[1] and in 2009, it began a multiyear process of restructuring its accreditation system to be based on educational outcomes in these competencies. The result of this effort is the Next Accreditation System (NAS), scheduled for phased implementation beginning in July 2013. The aims of the NAS are threefold: to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME's movement toward accreditation on the basis of educational outcomes, and to reduce the burden associated with the current structure and process-based approach.

LIMITATIONS OF THE CURRENT SYSTEM

When the ACGME was established in 1981, the GME environment was facing two major stresses: variability in the quality of resident education[8] and the emerging formalization of subspecialty education. In response, the ACGME's approach emphasized program structure, increased the amount and quality of formal teaching, fostered a balance between service and education, promoted resident evaluation and feedback, and required financial and benefit support for trainees. These dimensions were incorporated into program requirements that became increasingly more specific during the next 30 years.

The results have been largely salutary. Perfor-

NEJM. 2012.366;11:1051-1056.

The Building Blocks or Components of The ACGME Accreditation System

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Background

- From the 2009-2010 ACGME Duty Hours Task Force
  - **"Sponsor Visit Program"**
    - To the National Advisory Committee
      - Use first round of visits and reports solely for baseline data and learning – *not an accreditation visit*
        - To the CLER Site Visit

VIEWPOINT

The Clinical Learning Environment

The Foundation of Graduate Medical Education

Kevin B. Weiss, MD

James P. Bagian, MD

Thomas J. Nasca, MD

More than a decade after the Institute of Medicine reported problems with the quality and safety of US health care,[1,2] formal training of the health care workforce in quality and patient safety is still inadequate. A recently released survey of hospital leaders from the American Hospital Association[3] (AHA) highlighted the need to educate US physicians

including ACGME staff and volunteer site visitors from other sponsoring institutions and involve discussions and observations with hospital executive leadership (including the chief executive officer), resident physicians, faculty, graduate medical education leadership, nursing, and other hospital staff. These visits are designed to stimulate improvement in residents' engagement in the 6 focus areas and, as such, are intentionally not directly linked to accreditation.

Site visitors gain knowledge about residents' engagement in the 6 focus areas through group meetings and visits in clinical service areas. Group meetings involve structured interviews with residents, faculty, and program

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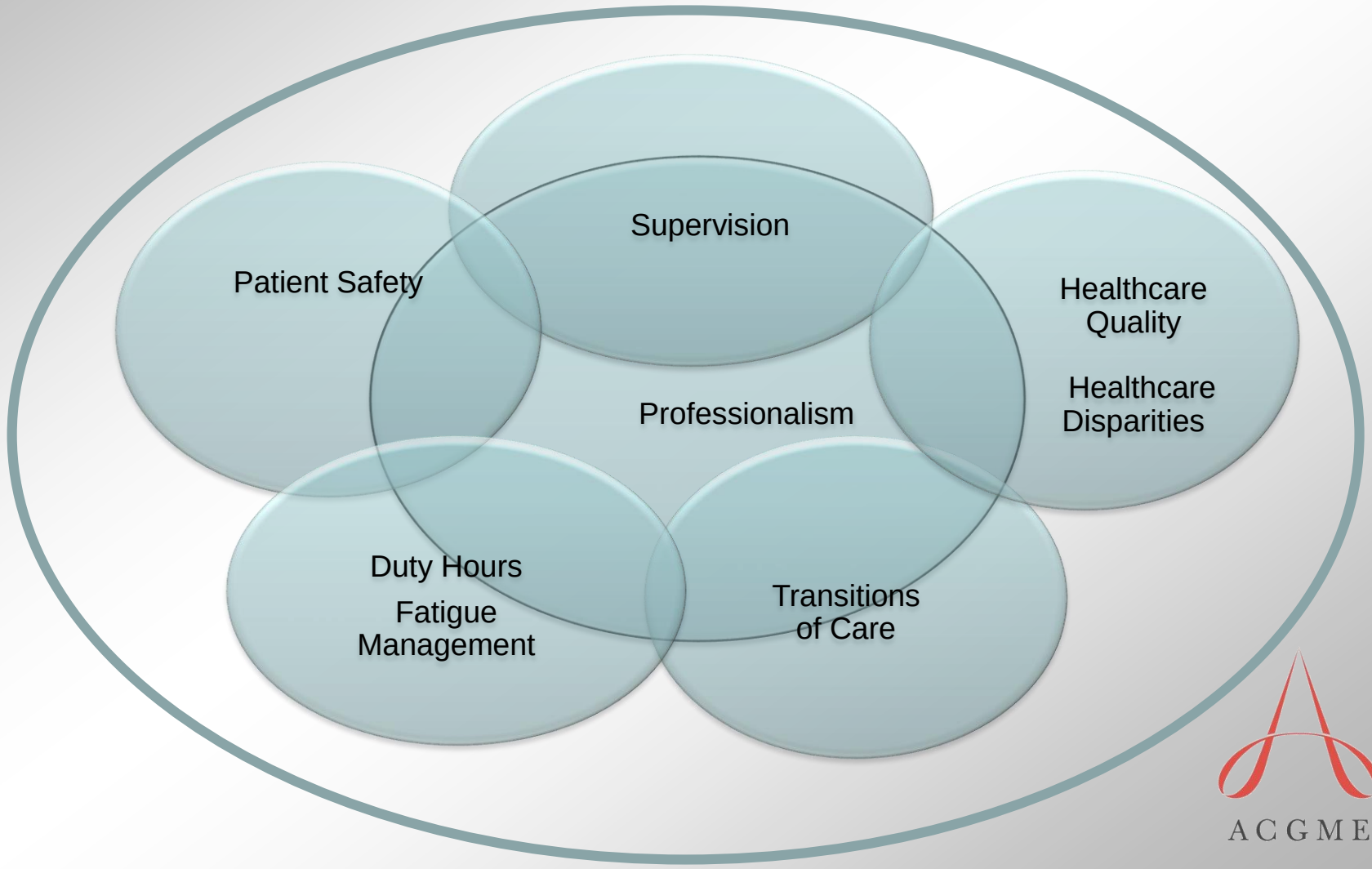
CLER Focus Areas



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Program Components

- Site Visit Program
- Evaluation Committee
- Faculty/Professional Development

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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?

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CLER Visits

Intended to provide:

- Formative feedback, indications of areas ripe for future work
- Aha's! Reflections that inform learning and promote voluntary improvement efforts
- A basis for empiric understanding of what is possible

Not intended to provide:

- Gotcha's
- New stealth accreditation requirements

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CLER Visits

Links to accreditation:

- Sponsoring institutions must have CLER visit every 18-24 months
- DIO and CEO of participating site must be present for initial and exit interviews
- Collective knowledge from CLER will likely inform future institutional requirements (raising the floor)
- Exception(s): identification of potential egregious violations involving threats to patient safety or resident safety/well being

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Scheduling the Site Visit

- Short notice scheduling; no less than 10 days notice

- Allowed a limited number of passes
  - Cycle 1 >90% scheduled on 1st or 2nd attempt
  - Cycle 2 allows for four attempts to schedule
  - Failure to schedule could result in administrative probation

Scheduling the Site Visit

- Blackout dates:
  - General (e.g., holidays, June 25-July 5)
  - Site-specific "avoid dates"
    - 4th quarter ADS opens to allow DIOs to request "avoid dates" for the upcoming calendar year
    - Separate process for submitting dates for remainder of 2015 (details will be sent via e-mail)

Visits to Small Program Sponsoring Institutions

Clinical Learning Environment Review (CLER) Program

Multi-Program Institution

- +/- 290 institutions
- 3 or more core programs
- Usually includes fellowships
- Cycle 1 completed
- Cycle 2 underway

Small Program Institution

- +/- 400 institutions
- 2 or fewer core programs
- Could include fellowships
- Cycle 1 in development
- Site visits will begin September 2015
- Additional programs onboarding under single GME accreditation system

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Approximate numbers

All Small Programs	No. of Progs.	Size per number of residents	No. of Progs.
Two person visit	~25%	Single core program	~230
One or two person visit	~50%	Two cores, no subspecialty (ies)	~60
One person visit	~25%	Single subspecialty program	~60
Programs with 10 residents or less	~75	Core(s) and subspecialty(ies) programs	~125

CLER Site Visits

Small/single program sponsoring institutions

- *In development*
  - Collecting input from key stakeholders (DIO/PD focus groups, interviews)
  - Adapting the protocol to a range of sizes and environments
- Pilot testing will begin in August 2015, full roll-out in September 2015

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Types of Small Program Sponsoring Institutions

- Type A: hospital/medical center and ambulatory site less than 30 minutes driving time (door to door), two-day visit

- Type B: hospital/medical center and ambulatory site greater than 30 minutes driving time (door to door), two-day visit

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Types of Small Program Sponsoring Institutions

- Type C: Ambulatory site and no hospital/medical center. 1.5-day visit

  e.g., with patient care – dermatology clinic

- Type D: Hospital/medical center and no ambulatory site. 1.5-day visit

  e.g., without direct patient care – pathology program

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Types of Small Program Sponsoring Institutions

Type E: Very small programs with one or two residents/fellows

e.g., blood bank, medical examiner's office

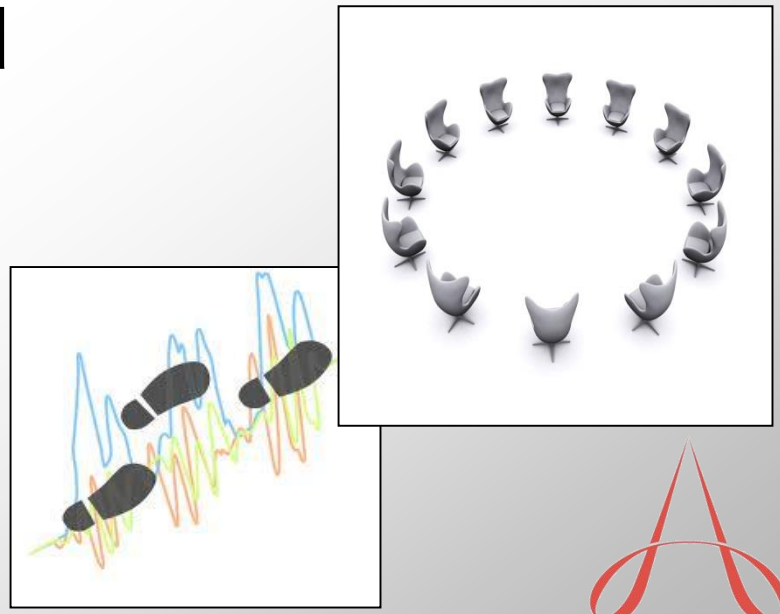
Main Components of the CLER Visit

I. Bookend meetings with senior leadership

II. Group meetings with residents, core faculty members, and program directors

III. Walking rounds

IV. Team huddles



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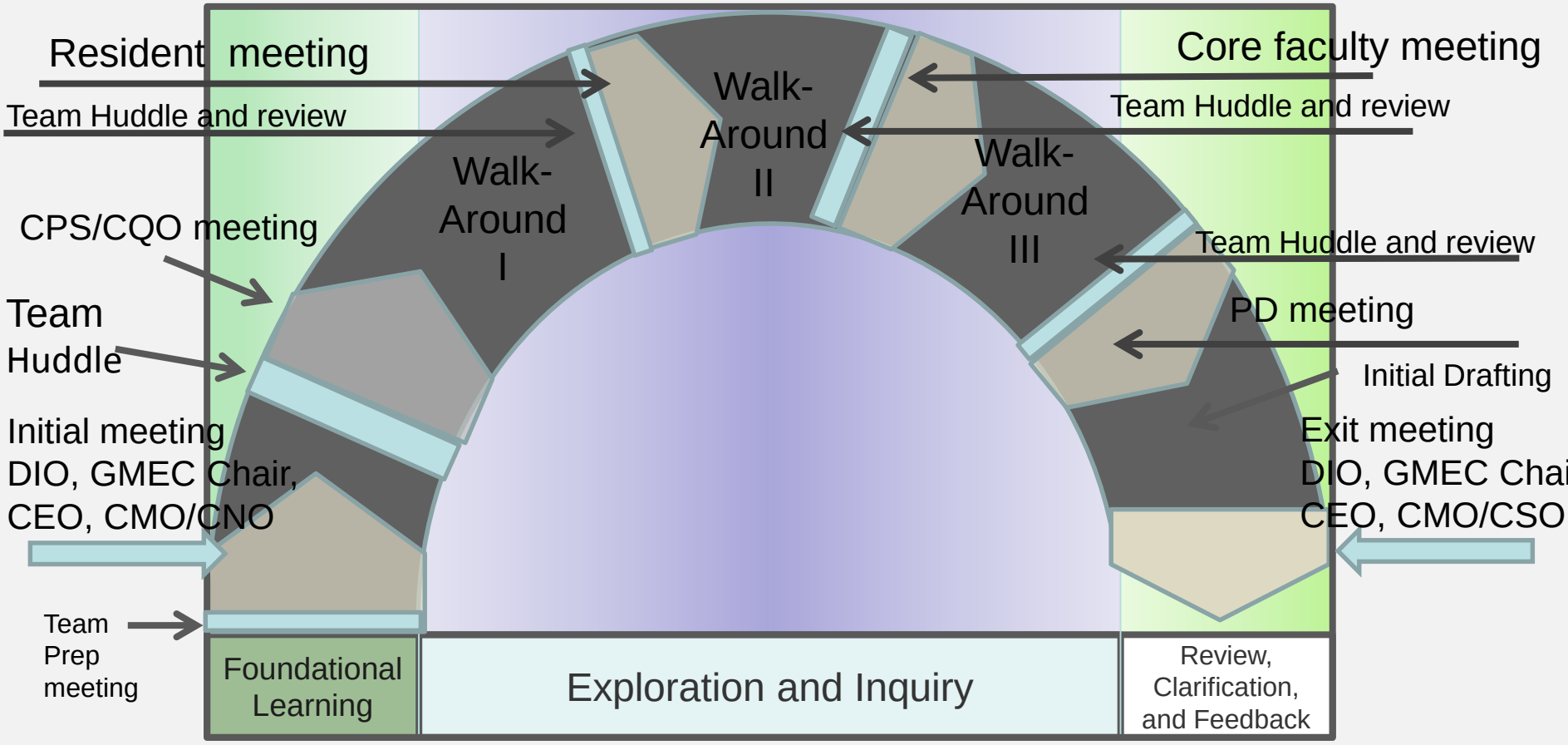
SCHEMATIC OF FLOW OF CLER SITE VISIT



Three Phases of Visit

Note: Each walk around has resident host/escort, opportunity for contact with nursing staff and other health professionals.

Site Visit Protocol

Similarities/Adaptations

- All visits will address the six focus areas using the same basic structure
  - The timing of the meetings/interviews and order of the agenda may vary

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Site Visit Protocol

Similarities/Adaptations (cont.)

- All visits require the CEO and DIO to be present for the initial and exit meetings
  - The composition of the leadership team may vary as to whether the program is hospital-based vs. ambulatory care-based
  - The lead site visitor will work with the DIO to identify the appropriate members of senior leadership to participate in the meetings

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Site Visit Protocol

Similarities/Adaptations (cont.)

- All visits will include meetings with residents/fellows, faculty members, and program director(s)
- All visits will include both qualitative and quantitative assessment
  - Use of the Audience Response System and report out of ARS data will vary

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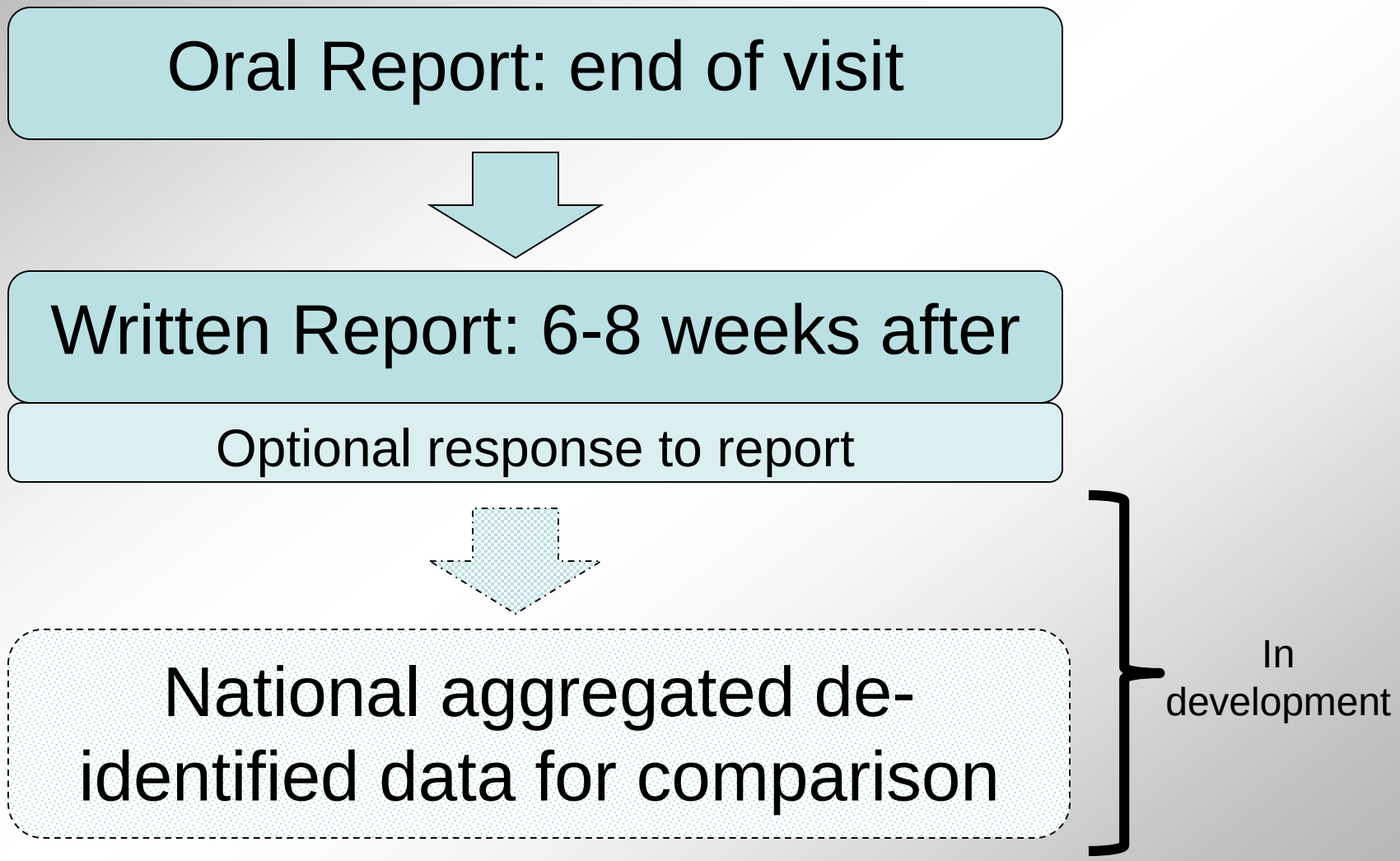
CLER Evaluation Process*



* Approved by CLER Evaluation Committee 10/2012

Optimizing the CLER Experience

- Not an accreditation visit; no citations; minimal preparation around logistics
- It's not about the review, it's about what happens in between the reviews
- Identifies potential opportunities to improve resident /fellow engagement at that clinical site

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Other Components of CLER

Program Components

- Site Visit Program
- Evaluation Committee
- Faculty/Professional Development

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CLER Evaluation Committee

- Includes national expertise in GME and the six focus areas
- Co-Chairs:
  - James Bagian, MD and Kevin Weiss, MD
- Meets quarterly
- Receives data from site visits

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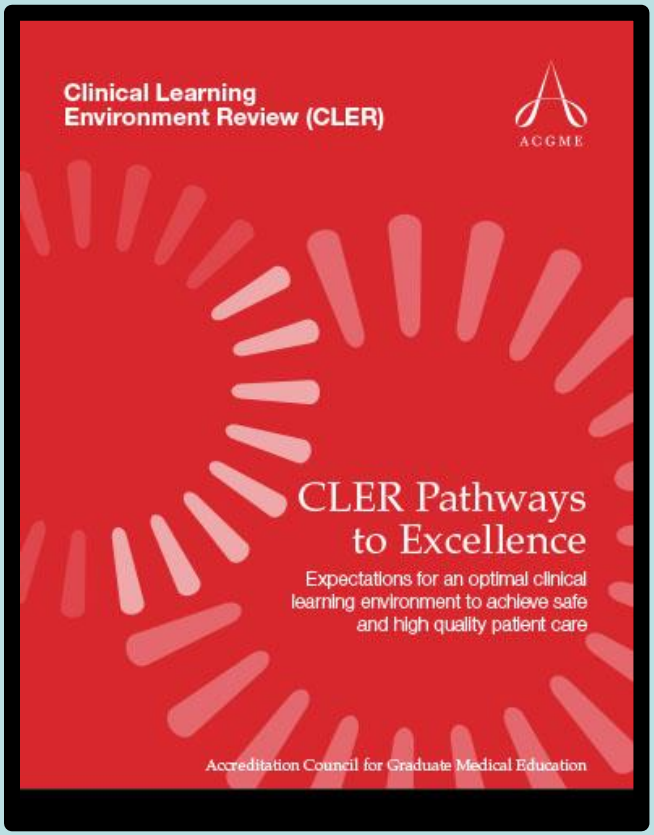
CLER Pathways to Excellence

Expert Input

Experience from CLER visits

Published Literature



CLER Pathways to Excellence

- Guidance document
  - For both GME and senior leadership of clinical site
- Framework
  - Six focus areas
    - Multiple Pathways for each focus area
      - One or more properties for each Pathway

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PS Pathway 1: Reporting of adverse events, close calls

Properties include:

- Residents, fellows, faculty members, and other clinical staff members (nurses, pharmacists, etc). Know how to report patient safety events at the clinical site.

The focus will be on the proportion of individuals who know how to report

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CLER Pathways to Excellence

- Initially based on expert input, evidence, and early experiences from CLER program; will evolve over time to an empirically-driven set of guidance statements based on what is possible

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CLER Pathways to Excellence

- Pathways form the framework for site visit assessments

- Serve as basis for comparative feedback and—when used in aggregate—provides national measures of progress

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Program Components

- Site Visit Program
- Evaluation Committee
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Faculty/Professional Development

- Exploring and encouraging alignments and collaborations among key stakeholder organizations
  - National Collaborative for Improving the Clinical Learning Environment
  - Other ACGME initiatives in development

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Clinical Learning Environment Review

A journey