The Overarching Themes from the CLER National Report of Findings 2016

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Introduction

The initial visits of the Clinical Learning Environment Review (CLER) Program revealed a number of findings that appeared to be common across many of the clinical learning environments (CLEs) and six focus areas. The CLER protocol did not directly assess for these overarching themes. To derive them, the CLER staff generated a list of findings that were common to many CLEs and presented them to the CLER Evaluation Committee.[1] The Committee then prioritized and selected the four overarching themes listed below, all of which they believed could provide graduate medical education (GME) and CLEs with opportunities for high-leverage improvement.

Below, each finding is presented in highlighted text, followed by a brief discussion in which the members of the CLER Evaluation Committee share their thoughts on the finding's relevance and the importance of taking a systems-based approach to improving the CLE.

Overarching Themes

1. **Clinical learning environments vary in their approach to and capacity for addressing patient safety and health care quality, and the degree to which they engage residents and fellows in these areas.**

Discussion

Important concepts associated with effective health care learning and high reliability systems[2] are in various stages of adoption across our nation's teaching hospitals and medical centers. As related to patient safety and health care quality, these concepts are seldom part of the clinical experiential education of residents and fellows.

The current situation undervalues residents and fellows, as well as other learners, as key members of the team and potential contributors to the improvement of the health care delivery system. To be successful team members, residents and fellows must learn to continually engage and collaborate with other clinical and non-clinical staff to reduce risk to patients and improve quality of care. With this training they will be ready to become leaders in effecting meaningful change, both in their current roles and as future leaders.

2. **Clinical learning environments vary in their approach to implementing GME. In many clinical learning environments, GME is largely developed and implemented independently of the organization's other areas of strategic planning and focus.**

Discussion

The executive leaders of clinical sites and the leaders of GME have an opportunity to improve patient care by enhancing collaboration to ensure that they both achieve a common set of patient-centered goals while providing an optimal GME learning experience.

At many teaching hospitals and medical centers, GME appears to be viewed as an activity that is limited to meeting the educational component of the mission statement and service needs of their organization. Often, GME leaders and activities are not fully integrated or resourced to support the organization's strategic goals for improving patient care. When that happens, GME operates in a "silo" and is viewed as an independent activity rather than a critical instrument for delivering and improving patient care. As a result, residents and fellows are not typically considered in the design of, nor routinely incorporated into, the quality and safety systems of the CLE.

Education and delivery should not be treated as two separate entities but rather as one system united in the common goal in improving the health of the patients they serve.[3] GME leaders often develop strategic

plans for residency and fellowship training that would benefit from input from the executive leadership of the hospitals and medical centers in which the training occurs. Similarly, executive leaders of these organizations adopt strategic plans that are aimed at improving system performance without engaging the problem-solving skills of GME.

As front-line providers of patient care, resident, fellow, and faculty physicians are an untapped resource that could contribute greatly to systems-based improvements in patient care. Integrated strategic planning would help bring their skills to bear on important shared goals.

> **3. Clinical learning environments vary in the extent to which they invest in continually educating, training, and integrating faculty members and program directors in the areas of health care quality, patient safety, and other systems-based initiatives.**

Discussion

Investment in ongoing training of faculty members and program directors will ensure that these physicians have the competencies to teach, encourage, and lead residents and fellows in understanding and applying the principles of highly functioning health care learning organizations.

Program directors and faculty members are role models for residents and fellows in training. They also serve as role models for other physician and non-physician staff. Many program directors and faculty members were recruited for expertise in their medical specialty and were never themselves instructed on how to participate in or lead quality improvement activities. To be role models in patient safety and health care quality improvement, they would benefit from training in these principles and day-to-day application in patient care. They also need additional skills in teaching and evaluating residents and fellows in these areas. Often, faculty development efforts are principally targeted to core faculty members, yet it is important to recognize that other full-time, part-time, and volunteer faculty members also serve as role models.

Enhancing faculty experience in applying key concepts such as those associated with high reliability systems can only improve the quality, safety, and value of patient care in these CLEs.

> **4. Clinical learning environments vary in the degree to which they coordinate and implement educational resources across the health care professions.**

Discussion

While much resident and fellow learning is specialty-specific, the findings suggest that there are a number of essential learning activities related to patient care that are common within the CLE. Examples include care transitions, communication protocols, team training, standard workflows, population and community needs, and cultural competency. Many of these common learning experiences are fundamental to patient care and would benefit from resident, fellow, and faculty physician participation, as well as input from other specialties and health professionals.

To maximize the benefit of shared learning, GME training should be aligned with other professional learning activities such as continuing medical education, continuing education activities for nursing, pharmacy and other health care professionals, and training activities supported by the human resources department.[4]

The findings also suggest that access to and coordination of resources such as simulation centers and interprofessional learning activities are highly variable. Additionally, GME offices appear to lack the resources to support broad-reaching ongoing educational activities around health-systems issues such as health care quality and patient safety. As a result, training in these areas tends to be intermittent and often is limited to annual orientation events, research poster days, or required annual online modules.

Delegating training to individual residency programs without an overall plan and commitment to adequately resource and coordinate these efforts can lead to undesired variability in resident and fellow knowledge and skills, both across specialties and across the institution.

[1] Koh NJ, Wagner R, Weiss KB; CLER Program. The methodology for the CLER National Report of Findings 2016. *J Grad Med Educ*. 2016;8(2 suppl 1):15–20.

[2] Olsen L, Aisner D, McGinnis JM, eds. *The Learning Healthcare System: Workshop Summary (IOM Roundtable on Evidence-Based Medicine)*. Washington, DC: National Academy Press; 2007.

[3] Cox M, Naylor M. Transforming patient care: aligning interprofessional education with clinical practice redesign. In: Proceedings of a Conference Sponsored by the Josiah Macy Jr. Foundation; Jan 17–20, 2013; Atlanta, Georgia.

[4] Weinstein D. Ensuring an effective physician workforce for the United States, the content and format. In: Proceedings of a Conference Sponsored by the Josiah Macy Jr. Foundation; May 2011; Atlanta, Georgia.