The Overarching Themes From the CLER National Report of Findings 2018

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Introduction

As in the 2016 Clinical Learning Environment Review (CLER) National Report,[1] the 2018 report reveals a number of overarching themes that cut across the CLER Focus Areas.[2] The CLER protocol did not directly assess for these themes, the development of which is described elsewhere in this report.[3] These themes, which appear in highlighted text, are accompanied by discussion sections in which the CLER Evaluation Committee shares its thoughts on their relevance. The themes are numbered for easy reference within the report. These numbers do not suggest order or importance.

Overall Reflections of the CLER Evaluation Committee

In general, the 4 themes identified in 2016 carried forward in this cycle. Themes 1 through 4 in the section below expand upon those of the first national report. The last 2 present new observations. Together, they paint a picture of how many clinical learning environments (CLEs) are on the path to making positive change, albeit incremental. CLEs face significant challenges in implementing change at the speed and magnitude needed to keep pace with, or ideally anticipate, the future of health care delivery.

The unifying goal for health care systems is to consistently and reliably deliver patient care today that is the safest and highest quality possible. Health care systems that choose to serve as CLEs have the added responsibility of making certain that new learners acquire systems-orientated skills to ensure that the highest level of care is achieved for the patients of tomorrow.

Transformational change within a CLE requires a complete organizational commitment, with individuals modeling behavior that promotes improvements in the care of patients. For CLEs, this means joining with graduate medical education (GME) at all levels, from strategic planning, to faculty development, to the front lines of enhancing interprofessional team-based care. When positive relationships and alignment exist, educational and clinical programs may be able to demonstrate continued improvements in quality and safety.

Real investment in transformation will likely enhance quality of care and patient care outcomes, as well as create a thriving work climate—improving well-being, retention, and yielding overall benefit for the CLE.

Overarching Themes

Theme 1

Clinical learning environments vary in their approach to and capacity for addressing patient safety and health care quality. In many clinical learning environments, organizational efforts to engage residents in these areas are emerging. In comparison to residents, there appears to be less focus on participation of fellows in the clinical learning environment's quality and safety activities.

Discussion

The findings from this second set of CLER visits suggest a number of opportunities in the area of patient safety and quality improvement that would be likely to improve the quality of GME as well as patient care.

Acquiring competency in patient safety and quality improvement requires experiential learning. Therefore, engaging residents and fellows in the CLE's quality improvement and patient safety activities is essential. An optimal CLE has consistency of purpose and action with well-articulated strategies, well-defined tools and methods, and common agreement on the role of each member of the clinical team in the organization's patient safety and quality improvement efforts.

To ensure optimal experiential learning, CLEs would benefit from assessing their patient safety and quality improvement activities in the context of how well these programs build competency and capacity for individuals and clinical care teams—including residents, fellows, faculty members, and others such as nurses and pharmacists—to create sustainable, system-based solutions for improving care. High-performing CLEs will design their patient safety and quality improvement programs to engage learners in building their competencies in these areas.

The findings suggest that most hospitals, health systems, and ambulatory sites have operationalized their efforts to address patient safety and health care quality, principally in response to regulatory requirements and performance-based contracting. Success toward these operational objectives can easily co-exist with efforts to create an optimal learning environment that fosters competency of all clinical care team members—including residents and fellows. Optimizing patient safety and health care quality requires systems-based collaborative team efforts. Therefore, residents and fellows need to be exposed to interprofessional work in patient safety and quality improvement throughout their training. Solutions designed with input from all clinical care team members—including residents and fellows—are more likely to succeed if they take a systems-based approach.

The findings from the CLER visits also highlighted the need for ACGME-accredited subspecialty fellows to be more engaged in quality improvement and patient safety. Some may take the view that fellows should acquire all of the basic competencies in patient safety and quality improvement while in their core residency programs. However, there are a number of important reasons for fellows to engage in these efforts. First is the likely benefit to patient care. Fellows often care for sicker, more complex patients, and need to understand patient safety in this context. Additionally, from an educational perspective, fellows need to learn how to develop and apply patient safety and quality improvement tools and methods within their own subspecialty, which may be very different from the tools and methods used in their previous GME training. Lastly, fellows serve as essential role models for residents of the core residency programs. As role models, they need to develop the knowledge and skills needed to mentor junior colleagues toward professional competency in these areas.

Theme 2

Clinical learning environments vary in how they align and collaborate with graduate medical education in developing the organization's strategic goals aimed at improving patient care. In many clinical learning environments, graduate medical education is largely developed and implemented independently of the organization's other areas of strategic planning and focus.

Discussion

The findings from this set of CLER visits suggest that CLE executive leaders have made some efforts to use the information from the CLER experience to enhance the integration between the CLE and GME. These efforts appear to be nascent across most of the CLEs.

In CLEs where executive leaders have enhanced collaboration and integration with GME, they describe new successful activities that have improved patient care. Residents and fellows, who are at the frontlines of patient care, have an excellent knowledge of and ability to manage the patient care experience. These efforts to integrate the CLE and GME can also be viewed as an investment in the organization's clinical workforce.

The findings also suggest that one of the barriers to complete integration of GME and the CLE may be a lack of understanding of how the CLE governance process can help set the strategic direction for optimizing learning in the context of delivering patient care. One example is the absence of stated expectations for GME and other clinical learners in the organization's quality and safety plans.

CLE governance has an important role to play in ensuring that GME is integrated into the CLE's strategic goals for improving patient care. For example, governing bodies can identify how they view GME's contribution to developing its physician workforce or enhancing the CLE's prestige within their community. Engaging governing bodies in setting the strategic direction for the organization in its role as a CLE will serve to clarify the value of GME within the organization and the imperative to integrate GME in the development, implementation, and evaluation of strategic goals.

Theme 3

A limited number of clinical learning environments have designed and implemented educational programs to ensure that all graduate medical education faculty members and program directors have the knowledge, skills, and attitudes necessary for their respective roles in training residents and fellows in patient safety and quality improvement.

Discussion

To ensure high-quality education for its residents and fellows, it is essential for CLEs to ensure that their entire medical staff, particularly faculty members and program directors, are engaged in and able to provide a constructive role in teaching the sciences of patient safety and quality improvement.

Foremost, enhancing faculty knowledge and skills will lead to improved patient care. As faculty members strengthen their knowledge, skills, and participation in these areas, CLEs will likely see added value by creating a pool of mentors to draw upon year after year. In addition, the CLE will retain some of their residents after they complete their training, and these junior faculty members will begin their new roles already equipped with these essential skills. Finally, enhancing faculty members' skills in these areas will assist the CLE in achieving its key performance goals for improving patient safety and quality.

In addition, faculty development serves a dual purpose—achieving at minimum faculty competency to participate in efforts to improve patient safety and health care quality and ensuring faculty have the skills and competency to mentor residents and fellows in these areas.

There are both challenges and opportunities associated with implementing an organization-wide plan for faculty development in patient safety and quality improvement. If faculty and staff are to view patient safety and quality activities as an organizational priority, the CLE's executive leadership must message the importance of these efforts, emphasizing the connection to sustainable improvement. They must clearly support such messages with ongoing dedicated resources, successful programs, and accountable goals—all linked to professional advancement.

Executive leadership may also seek to accelerate their plan for faculty development by recruiting individuals with applicable skill sets (eg, patient safety managers, human factors engineers, improvement scientist, implementation coach) to teach important principles of patient safety and quality improvement and guide faculty through experiential learning.

Importantly, CLEs that invest in a robust plan for faculty development in patient safety and health care quality are likely to see a reduction in waste, medical liability, and patient harm.

Theme 4

Clinical learning environments vary in the degree to which they coordinate and implement interprofessional collaborative learning in the context of delivering patient care.

Discussion

In most CLEs, educational programming appears to focus primarily on acquisition of knowledge and skills specific to each profession. Physicians educate other physicians, nurses educate other nurses, pharmacists educate other pharmacists, etc. The current and evolving practice of medicine necessitates complex, collaborative team-oriented care and systems-based approaches to coordinating and evaluating health care delivery and outcomes. There are clear needs for interprofessional learning.

Interprofessional education provides a good foundation for learning across the professions based in undergraduate health care education.[4] There are also models of interprofessional collaborative practice that seek to address this need; however, for many clinicians this type of experience is limited if available at all. Many early learners enter into patient care environments with traditional cultures of siloed professional hierarchy that inhibit collaborative learning and practice.[5,6]

CLEs will excel in providing team-based, collaborative care through developing and implementing programs of interprofessional learning that occurs in the context of the patient care environment.

Highly functioning interprofessional CLEs (IP-CLEs) formally design plans to address interprofessional systems-based learning across the clinical workforce—for both early learners such as residents and fellows and learners in other stages of their professional careers. One of the hallmarks of an optimal IP-CLE is a robust collaborative practice model that incorporates structured interprofessional experiential learning as part of routine professional activities.[5,6] Such a model entails the ongoing attention, support, and oversight of the CLE's executive leaders.

Ultimately, robust interprofessional collaborative practice, as supported by a high-performing IP-CLE, has the potential to decrease serious patient safety events, increase trust in the clinical care team, improve patient care management and timeliness in care, and improve the efficiency and effectiveness of patient care. Such interprofessional learning can also improve the workforce experience, leading to better recruitment and retention and lower turnover.

Theme 5

In general, clinical learning environments lack the mechanisms to identify and eliminate organizational factors that contribute to burnout. Clinical learning environments vary in their awareness of the extent of burnout among health care professionals and its impact on patient safety. A limited number of clinical learning environments appear to be addressing burnout as a priority.

Discussion

This finding that emerged from the second set of CLER visits highlights important issues related to burnout within CLEs. Burnout can have a number of harmful effects on individual members of the clinical care team, the organization, and the patient. The cumulative effects of burnout in the CLE will result in care that is less effective, less efficient, less safe, and less satisfying for the patient and provider. In addition, it can lead to lower workforce productivity, high workforce turnover, premature exits from the workforce, and negative impacts on workers' careers and personal lives.

For faculty in particular, burnout not only negatively affects patient care and their personal lives, it also affects their capacity to teach and mentor effectively. From the perspective of residents and fellows, faculty burnout may negatively manifest itself in a number of ways—from decreased availability and interest in teaching, to suboptimal modeling of physician patient interactions, to being the recipient of anger, frustration, or other forms of unprofessional behavior.

Burnout has many systems-based implications and may be a manifestation of systems-based problems that are unaddressed. For these reasons, burnout needs to be addressed at the highest levels of the organization, including strategic planning by CLE executive leaders informed by the frontline clinical staff. Such strategic planning needs to focus keenly on primary prevention of burnout—not simply controlling symptoms—and may include efforts such as proactive monitoring to identify problems early on and collaborating with all involved to understand and address causes of burnout rooted in the CLE.

Faculty physicians and other health care professionals want to be in a CLE that actively seeks to evaluate the degree of burnout and prioritizes opportunities for improvement and clinician involvement that are relevant and specific to that working and learning environment. Such efforts will enable CLEs to attract and maintain high-quality talent and, ultimately, ensure the best possible patient care.

Theme 6

Health care system consolidation and the concomitant organizational changes in infrastructure, governance, priorities, and values are creating new challenges for clinical learning environments to align graduate medical education with initiatives to improve patient care.

Discussion

Health care in the United States is undergoing rapid evolution. One of the more notable changes is the degree and pace with which hospitals and other health care environments are consolidating and reorganizing. Often, this consolidation or reorganization reflects a strategic plan of growth through mergers or acquisitions to provide a wider range of health care services to address the movement from hospital-based care to ambulatory, community-based, and home-based services.

Although the reorganization of health care systems is not new, it is now happening at a very rapid pace, which can pose important challenges for GME specifically. Without careful planning, reorganizations place GME educational programming at risk (eg, supervision issues, disruptions to curriculum, ability to meet accreditation requirements); create challenges in the recruitment and retention of faculty and GME leadership; and create challenges in the recruitment of residents and fellows.

Reorganization in US health care also increases risks to patient safety and quality during the transitions due to disruptions and changes in leadership and services. Hospitals and other health care settings that serve as CLEs need to engage GME leadership in any plans for reorganization as early in the process as feasible to mitigate risk of disrupting GME and ensuring patient safety and optimal patient care experiences.

This period of health system reorganization provides an opportunity for GME programs and their respective CLEs to collaboratively define and improve the value that medical education brings to the organization. Furthermore, reorganizations are an optimal time to implement values that optimize the CLE such as collaboration, integration, and shared accountability and oversight—perhaps replacing what was formerly an ad hoc approach to these important principles. At times of reorganization, CLEs have the opportunity raise the bar and apply such principles broadly and consistently at a higher level.

References

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