CLER National Report of Findings 2019: The Clinical Learning Environments of Smaller Sponsoring Institutions

Baretta R. Casey, MD, MPH, FAAFP
John Patrick T. Co, MD, MPH, CPPS, FAAP
Kevin B. Weiss, MD
CLER Program and the CLER Evaluation Committee

The Accreditation Council for Graduate Medical Education (ACGME) Clinical Learning Environment Review (CLER) Program is pleased to announce the release of the CLER National Report of Findings 2019.[1] This special report includes initial data on the nation's smaller sponsoring institutions (SIs) or those with 2 or fewer core residency programs (TABLE).[1] As part of its dedication to safe, quality patient care and the education of future physicians, the CLER Program periodically visits clinical learning environments (CLEs) of ACGME-accredited SIs to provide formative assessment and feedback in the 6 CLER Focus Areas: patient safety; health care quality; care transitions; supervision; fatigue management, mitigation, and duty hours; and professionalism.[2] As with the 2016 and 2018 CLER national reports of findings,[3,4] which included data from site visits to larger SIs (ie, those with 2 or more core residency programs), the 2019 National Report reveals challenges and opportunities when it comes to graduate medical education (GME) engagement in the CLER Focus Areas. The report also includes insights from the CLER Evaluation Committee on the findings' importance and implications for patient care and physician training.

When visiting CLEs of the smaller SIs, the CLER Program found that these settings had a number of notable features. For example, these clinical sites often serve the nation's most vulnerable rural and intercity patient populations. In addition, CLE executive leaders and GME leaders may fulfill more than 1 leadership role within the organization (eg, the chief executive officer may also be the designated institutional official, or the designated institutional official may also be a program director). Furthermore, for most of the smaller SIs, resident and fellow training occurred in both the inpatient and ambulatory care settings; many times, these settings were in 2 distant locations.[1]

Although the CLER Site Visit protocol was nearly identical for both the larger and smaller SIs, these features of the smaller SIs required slight modification to the site visit structure and content.[1] The modifications included additional time on the site visit agenda to travel between the inpatient and ambulatory care settings and minor changes to a few questions and scenarios to fit the setting. In addition, executive and GME leaders with more than 1 leadership role were asked to designate another individual to participate in the program director group meeting. Due to the small number of faculty members and program directors at the smaller SIs, combining data from group meetings helped to maintain confidentiality.

Overall, the first set of visits to the smaller SIs[1] revealed many of the same overarching themes that emerged from visits to the larger SIs.[5,6] For example, CLEs varied in their approach to engaging residents and fellows in patient safety and health care quality. In discussing the importance and implications of this theme, the CLER Evaluation Committee noted that this variation calls for CLEs to assess how they engage and build competency of the entire clinical care team, including residents and fellows, in patient safety and quality improvement. In addition, the committee noted how the dynamic nature of US health care necessitates an enhanced interprofessional, systems-based approach to learning and practice in the nation's CLEs.

The CLER Program did note a new overarching theme for the CLEs of these smaller SIs: the education and experiential learning regarding health care quality for residents and fellows largely appeared to occur in the ambulatory care setting. In addition, resident and fellow training appeared to focus more on health care quality than on patient safety.[1] As noted by the CLER Evaluation Committee, although patient safety events and quality improvement projects may vary depending on the setting, the basic principles and methods of patient safety and quality

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TABLE
General Characteristics of Clinical Learning Environments of Smaller Sponsoring Institutions Visited[a]

Characteristic	Clinical Learning Environments, No. (%)[b]
Region	
Northeast	64 (24)
Midwest	62 (23)
South	76 (28)
West	60 (22)
Territory[c]	8 (3)
Type of ownership	
Nongovernment, not-for-profit	178 (71)
Investor-owned, for-profit	31 (12)
Government, federal	13 (5)
Government, nonfederal	29 (12)

[a] Based on the 2015 American Hospital Association Annual Survey.
[b] Percentages do not total 100 because of rounding.
[c] Limited to 8 clinical learning environments in Puerto Rico.

are the same for all CLEs across all settings. The committee noted the importance of residents and fellows receiving high-quality training in patient safety and quality whether they are in an inpatient or ambulatory care setting. The addition of this consistency in training will prepare residents and fellows to address patient safety and quality issues across the continuum of care, ensuring safe, high-quality care for patients.

The findings for the smaller SIs also highlight other opportunities to improve resident and fellow engagement in the CLER Focus Areas. For example, while many residents and fellows were aware of their CLE's patient safety event reporting system and indicated having experienced an adverse event, near miss/close call, or unsafe condition, they were less likely to enter these events into their CLE's reporting system.[1] In their discussion of this finding, the CLER Evaluation Committee noted opportunities to increase resident and fellow use of the patient safety event reporting system to help inform systems-based efforts to improve patient care. They noted that such opportunities apply to all CLEs, including those of smaller SIs where residents and fellows may be more comfortable reporting patient safety events through the chain of command or addressing such events locally.

Another noteworthy finding from the visits to the smaller SIs is the lack of resident and fellow engagement in sustainable systems-based efforts to identify and eliminate health care disparities.[1] The CLER Evaluation Committee highlighted how enhanced resident and fellow engagement in this area can benefit both the learner and the organization. They noted, by engaging in these systems-based efforts, residents and fellows can recognize the complexity of factors that contribute to health care disparities and develop the skills necessary to address these challenges in the CLE and throughout their career.

In keeping with its model of quality improvement, the CLER Program will continue to seek new ways to improve the information it provides to CLEs and the GME community. Beginning with the 2020 report, the CLER Program will present all of the CLER's findings—for both the smaller and larger SIs—in a single biennial report. Future CLER national reports will also include a new focus area on "teaming" and insights from subprotocols focused on the operational and procedural areas, the patient perspective, and governance.

As can be seen in the program's first 3 national reports,[1,7,8] CLEs have an important opportunity to join with the GME community to shape how the physicians of tomorrow deliver patient care. The CLER Program looks forward to seeing how its formative feedback can serve as a tool to help CLEs on their journey to ensure safe, high-quality care in an ever-changing landscape.

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Baretta R. Casey, MD, MPH, FAAFP, served as Regional Vice President, Clinical Learning Environment Review (CLER) Program, Accreditation Council for Graduate Medical Education (ACGME) from October 2013 to March 2019; **John Patrick T. Co, MD, MPH, CPPS, FAAP,** is Designated Institutional Official, Brigham and Women's and Massachusetts General Hospitals, and Director of Graduate Medical Education, Partners Healthcare; **Kevin B. Weiss, MD,** is Chief Officer, Sponsoring Institutions and CLER Programs, ACGME; on behalf of the CLER Program and the CLER Evaluation Committee. Drs Co and Weiss are co-chairs of the CLER Evaluation Committee.

Corresponding author: Kevin B. Weiss, MD, Accreditation Council for Graduate Medical Education, 401 N Michigan Avenue, Suite 2000, Chicago, IL 60611, kweiss@acgme.org