Integrating Learners into Quality Improvement And Patient Safety: Lessons from the C-Suite

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Learning Objectives

- Describe current ACGME CLER Program Expectations for engaging learners in organizational QI efforts.

- Engage organization leadership in developing strategies for teaching QI/PS while meeting ACGME CLER Program expectations.
Conflicts of Interest

- No financial interest in material presented.
- Employee of University of Rochester
- Member of ACGME Board of Directors
  - (Speaking from the point of view of Medical Center DIO, not ACGME)
The Building Blocks or Components of The “Next” Accreditation System

10 year Self-Study Visit

10 year Self-Study

*prn* Site Visits (*Program or Institution*)

Continuous RRC and IRC Oversight and Accreditation

Clinical Learning Environment Review
CLER Visits
Current Integration of GME and Patient Care in most Teaching Hospitals, Medical Centers, and Ambulatory Care Sites
Opportunity for Improving Integration of GME and Patient Care
The CLER Program

- Create a new conversation around the concept of the clinical learning environment
- Assess the current state of CLEs among ACGME accredited sponsoring institutions
- Provide feedback to the community to improve the state of CLEs
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, 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 (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
Improving Clinical Learning Environments for Tomorrow’s Physicians

Thomas J. Nasca, M.D., Kevin B. Weiss, M.D., and James P. Bagian, M.D.

“Approximately 2 months ago, I had a patient where I accidentally administered a wrong dose of fentanyl during a procedure. The patient developed severe hypotension, and the procedure had to be temporarily halted until we could get her blood pressure back up. My attending was close by. He responded quickly. Ultimately, no harm was done.

The reason I believe this happened is that during a procedure I’m sometimes required to administer fentanyl and must dilute it during the procedure. There are two dilutions, either to directly administer by syringe, or for use as an intravenous drip. We do this dilution while we are monitoring the patient was told to re-review the approach to dosing fentanyl during procedures and to be more careful.”

This experience was reported by a second-year anesthesiology resident, but dozens of similar patient-care experiences have been described to us by residents in various specialties during site visits that the Accreditation Council for Graduate Medical Education in the clinical environments in which this country’s 117,000 residents and fellows are immersed. Although the formal assessment of the CLER program’s first-year experience is not complete, the early findings indicate a generalized lack of resident engagement in a “systems-based practice” of medicine in the clinical environments in which they learn and provide clinical care. Solving this problem, we believe, will require a coordinated and concerted effort by both the leadership of graduate medical education (GME) and the executive leadership and governance of U.S.
CLER Six Focus Areas

Patient Safety

Healthcare Quality

Supervision

Transitions In Care

Professionalism

Fatigue Management
Focus Areas

- Integration of residents into institution’s **Patient Safety** programs, and demonstration of impact
- Integration of residents into institution’s **Quality Improvement** programs and efforts to reduce Disparities in Health Care Delivery, and demonstration of impact
- Establishment, implementation, and oversight of **Supervision** policies
- Oversight of **Transitions in Care**
- Oversight of **Duty Hours Policy, Fatigue Management and Mitigation**
- Education and monitoring of **Professionalism**
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

- Exploration and Inquiry
- Walk-Around I
- Walk-Around II
- Walk-Around III
- Core faculty meeting
- Team Huddle and review
- Initial Drafting
- Exit meeting DIO, GMEC Chair CEO, CMO/CNO
- Review, Clarification & Feedback
- Team Prep meeting
- Foundational Learning
- Initial meeting DIO, GMEC Chair, CEO, CMO/CNO
- Team Huddle
- CPS/CQO meeting
- Team Huddle and review
- Resident meeting

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 hospital/medical center governance.
CLER Evaluation Process*

1. Oral Report: end of visit
2. Written Report: 6-8 weeks after
   - Optional response to report

3. National aggregated de-identified data for comparison
   - In development

* Approved by CLER Evaluation Committee 10/2012
CLER Pathways to Excellence

Experience from CLER visits

Published Literature

Expert Input
PS Pathway 1: Reporting of adverse events, close calls (near misses)

Reporting is an important mechanism to identify patient safety vulnerabilities. A robust reporting system is essential for the success of any patient safety program.

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.

- Residents, fellows, faculty members, and other clinical staff members know their roles and responsibilities in reporting patient safety events at the clinical site.
  
  The focus will be on the proportion of individuals who know their roles and responsibilities in reporting.
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
CLER Program Updates

- Completed 298 visits (SI’s with >2 core programs)
  - Completion of cycle March 2015


- Started cycle 2, including smaller SIs
  - (approx. 400 with <3 core programs)
Release of the 2016 Report of Findings

February 2016

Issue Briefs to follow
Overarching Themes

• Clinical learning environments vary in their approaches to and capacity for addressing patient safety and health care quality, as well as the degree to which they engage resident and fellow physicians in addressing these areas.

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

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

• 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.
Focus Area Findings

Patient Safety

• Didactic training common, but limited experiential learning.
• Lack of knowledge regarding range of reportable events (close call/near miss).
• Limited patient event reporting by trainees and limited feedback received if reported.
• Limited participation in inter-professional/interdisciplinary safety event reviews and analysis.
Focus Area Findings

Health Care Quality

• Most trainees aware of health system’s QI priorities.
• Trainees have little knowledge of QI terminology and methods.
• Variable alignment between resident QI projects and clinical sites priorities.
• Limited participation in inter-professional QI teams.
Focus Area Findings

**Healthcare Disparities**

- Few CLE’s have formal or systematic strategy for addressing health care disparities.
- Majority of focus is on providing access.
- Learning about health care disparities and cultural competency was “ad-hoc”, general, and did not address the specific populations served by the institution.
Focus Area Findings

Care Transitions

• CLEs were working on redesigning transition processes regarding acute hospital to post-acute care, and trainees were occasionally involved.

• Occasionally CLEs were working towards a standardized organization-wide approach to managing inter-departmental patient transfers.

• Most CLEs did not have a standardized approach to facilitating trainee handoffs.

• A limited number of programs formally evaluate trainee hand-off competence.
Focus Area Findings

**Supervision**

- Examples of both under- and over-supervision.
- Not infrequently for trainees to report issues in supervision even when faculty/PD’s believe supervision is always present.
- Few CLEs have ways for nurses/staff to check residents required level of supervision for procedures.
- CLE’s safety and quality leaders do not actively monitor supervision of residents and fellows except retrospectively after a patient safety event had occurred.
Focus Area Findings

Fatigue Management, Mitigation, and Duty Hours

• CLEs have implemented duty hour standards and some fatigue management methods.
• In many CLEs, trainees noted fatigue-related factors other than duty hours (e.g. high volume or acuity).
• Faculty are fatigued.
• Concern exists regarding frequent handoffs.
Focus Area Findings

• Education is often online modules.
• Across CLEs, the incidents of disruptive or disrespect for behavior ranged from isolated to chronic, persistent and pervasive.
• Some trainees reported they have had to compromise their integrity to satisfy an authority figure; and in many CLEs, leadership was unaware of this perception.
• In most CLEs, there was lack of understanding of a process for trainees to follow to resolve perceived mistreatment (outside of typical GME methods).

Kevin Weiss, MD, ACGME, AHA Webinar, 4/27/16

What take home messages should we, as hospital or health system organizations, consider from the CLER findings to date?
Some Suggestions

• Pick out one of the overarching themes and work on it
• Pick a few (2-5) challenges and opportunities in the six focus areas and work on them
• Think strategically over tactically
• Engage interprofessional teams
• Include Program Directors in discussion
• Commit to enhancing the GME/CLE conversations, with accountable actions
“Imagine the systemic impact of having all of our graduates across all disciplines and across the health professions emerge from their training programs as experienced in the tools and methods of quality improvement and the science of patient safety as they are in their clinical specialties”

John Duval
CLER 2016 National Report of Findings
QUESTIONS?
UNIVERSITY of
ROCHESTER
MEDICAL CENTER

Medicine of the Highest Order