Making CLER – "CLEAR"

Preparing for the Clinical Learning Environment Review

Jenny Alexopulos, D.O.

Statewide CLER Director

OSU CHS

Disclosures/Conflict of Interest

- No Disclosures/Conflict of interest

What *is* CLER?

"The Clinical Learning Environment Review (CLER) is a mechanism by which the ACGME assesses a Sponsoring Institution (SI) to evaluate its commitment to **developing a culture of quality, patient safety, and performance improvement for both resident education and patient care**."

What *is* CLER?

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CLER Goals

- Increase resident knowledge of and participation in **safety activities** and **quality improvement**.
- Intent to improve physician integration into **quality and safety** goals after graduation.

CLER Goals

- **Support** national efforts addressing patient safety, quality improvement, and reduction in health care disparities.
- **Monitor** Sponsoring Institution maintenance of a clinical learning environment that promotes the six goals.
- **Emphasizes** the responsibility of the SI for the quality and safety of the environment for learning and patient

CLER Focus Areas

- Patient Safety
- Healthcare Quality
    - Healthcare Disparities
- **Professionalism**
- Clinical Learning Environment
    - Duty Hours
    - Fatigue Management
    - Wellness
- Transitions of Care ------Teaming
- Supervision

Key Questions

What step has your institution achieved?

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

What are we doing here at OSUMC?

CLER Subcommittee Chairs

- **Patient Safety** – Dr. Aaron Lane
- **Quality Improvement** – Dr. Crystal David and Dr. Kathy Cook
- **Professionalism** – Dr. Christopher Thurman
- **Wellbeing** – Dr. Jenny Alexopulos
- **Supervision** – Dr. Adam Bradley
- **Teaming** – Dr. Glennda Tiller

Patient Safety
Aaron Lane, D.O.-Chair

Health Care Quality
Crystal David, Pharm.D., BCPS-C0-Chair

Health Care-Quality
Kathy Cook, D.O.-Co-Chair

Teaming
Glennda Tiller, D.O.-Chair

Supervision
Adam Bradley, D.O.-Chair

Well-being
Jenny Alexopulos, D.O.-Chair & Statewide CLER Director

Professionalism
Christopher Thurman, D.O.-Chair

Patient Safety

- **2021 Hospital National Patient Safety Goals**

- Improve the accuracy of patient identification.
- Improve staff communication.
- Improve the safety of medication administration.
- Reduce patient harm associated with clinical alarm systems.
- Reduce the risk of healthcare-associated infections.
- Better identify patient safety risks in the hospital.
- Better prevent surgical mistakes.

- Joint Commission

10 Patient Safety Goals

1. Use two forms of patient identification
2. Reduce transfusion errors related to patient misidentification
3. Report critical results on a timely basis
4. Label Medications
5. Reduce harm from anticoagulant therapy
6. Hand Hygiene
7. Reduce Hospital Acquired Infections (HAIs)
8. Reconcile Medications
9. Identify Patients at risk for suicide
10. Prevent wrong patient, wrong site, and wrong procedure (Universal Protocol)

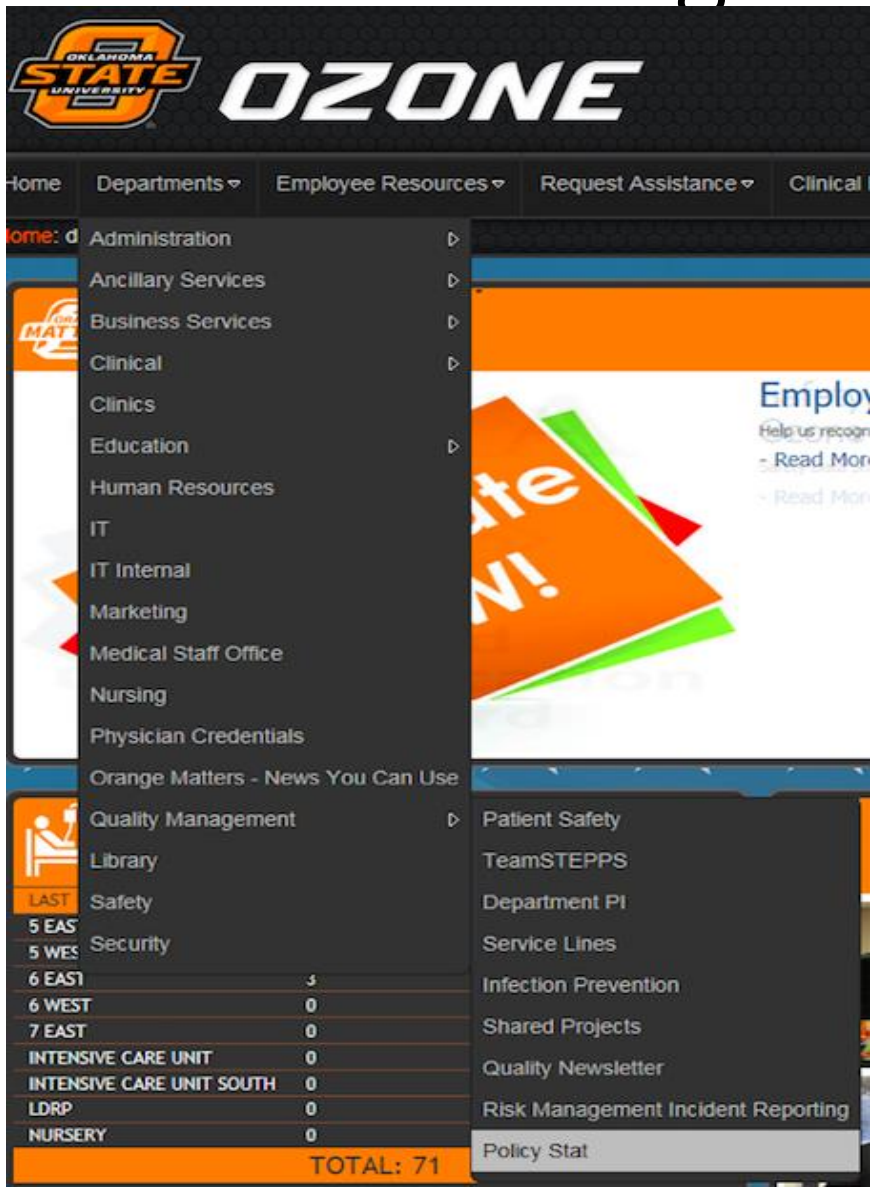
- Joint Commission

Patient Safety at OSUMC

- Risk Management Tool for Incident Reporting VERGE – monthly reports to programs
- Safety Event Team meetings
- Multidisciplinary Mortality & Morbidity conferences(departmental during pandemic)
- Healthstreams training
- Team care interdisciplinary rounds
- Clinical document improvement program (CDI)

How Do I Enter a Risk Management?

- Go to **Ozone**
- Click under **Departments**
- Click under **Quality Management**
- Click under **Risk Management Incident Reporting**



Risk Management Incident Reporting


Admission, Discharge, Transfer, Transport


Airway/ Anesthesia


AMA/LWOT


Behavior


Blood or Blood Product


Consent or Advance Directives


Deep Vein Thrombosis/Pulmonary


Device, Equipment or Supply


Fall


Healthcare Associated Infection


Laboratory


Medication/Other Substance


Nutrition and Diet


Other


Perinatal

Radiology


Security/Property


Skin Integrity/Pressure Injury


Surgery/Invasive Procedure


Patient Relations


Non-Patient Event


Employee Event

Powered by Verge Health Event Icons - Click the icon below to enter a report.

Oklahoma State University Medical Center

Incident Reporting Systems and Data

How many incidents are reported each year?

Adverse Events

Near Misses

Unsafe Conditions

% reported by staff?

% reported by faculty?

% reported by residents?

*** Looking for improvement in reporting year over year.

Adverse event

An injury that was caused by medical management (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both(Harvard Medical Practice Study)

Adverse events may be **preventable** or **nonpreventable.**

Preventable adverse events are defined as as "avoidable by any means currently available unless that means was not considered standard care."

Preventable adverse events are defined as "care that fell below the standard expected of physicians in their community."

Near Miss

- A near miss in medicine is an **event that might have resulted in harm** but the problem did not reach the patient because of timely intervention by healthcare providers or the patient or family, or due to good fortune. Near misses may also be referred to as "**close calls**" or "**good catches**."

Unsafe Condition

- Any **circumstance that increases the probability of a patient safety event**; includes a defective or deficient input to or environment of a care process that increases the risk of an unsafe act, care process failure or error, or patient safety event. An unsafe condition does not involve an identifiable patient.

Quality Improvement Programs

- Quality Improvement Education – **QI/Patient Safety Project Handbook**

https://health.okstate.edu/site-files/docs/osu-chs-quality-improvement- project-handbook-2020-ud.01.29.20.pdf

- Quality Projects captured as scholarly activity in **New Innovations**
- **QI/Patient Safety Poster Symposium Day** annually

  https://health.okstate.edu/gme/quality-symposium.html

  (inpatient and outpatient projects)
  http://online.fliphtml5.com/fvrnw/dmbj/
- **Monthly QI Newsletter**
- **Disaster Preparedness** in Healthstreams
- **Prevention of Hospital Acquired Infections**
- **Cultural Competency Training**

Current QI Projects at OSUMC

- **CLABSI** – Central Line-Associated Blood Stream Infections – Reduce CLABSI's via evidence-based practice interventions
- **CAUTI** – Catheter-Associated UTIs - Reduce CAUTI's via evidence-based practice interventions
- **CABG** – Improving care for the pt S/P CABG
- **Restraint** – Reduction in use and documentation compliance
- **Fall** – Fall Reduction Work Team/ Fall Response Team
- **SWAT** – Skin Wound Assessment Team – Reduce the incidence of pressure injuries
- **Sepsis** – Improving care for the patient with sepsis
- **UP Mobility** – Work team to enhance our patient's mobility and thus minimize negative consequences of immobility

Supervision

- **Semi-annual update of Resident Privileging** in New Innovations – available access to nursing staff
- **Annual resident survey** on perception of their level of supervision and monitoring
  - Two questions regarding Supervision are within the Annual Survey. The Annual Survey is only available to residents/fellows participating in the survey while they are taking it; therefore, questions cannot be seen.
- **Exit survey** question on resident preparedness for autonomous practice after graduation in their scope of practice
  - Do you feel you have demonstrated sufficient competence to enter practice without direct supervision? (Yes, Somewhat or No)
- **Patient Orientation Packet** to include identification and roles of house staff involved in their care
- **Interdisciplinary Simulation Training** – evolving

What are the Levels of Supervision and Who Should have Access?

Arterial Puncture	4	4	0	4/5 (80%)	Indirect Supervision: Available on site 6/14/2018
Arthrocentesis	0	0	0	0/5 (0%)	
Bladder Catherization *	1	1	0		
Bone Marrow A & Bx	1	1	0	1/5 (20%)	
Bronchoscopy	6	6	0		
Central Line - jugular	17	17	0	17/5 (100%)	Indirect Supervision: Available off site 4/12/2018
Central Line - subclavian	0	0	0	0/5 (0%)	
Chest Tube	0	0	0	0/5 (0%)	
Code Blue - ACLS needed	0	0	0	0/5 (0%)	
Esophagogastroduodenoscopy	0	0	0		
Exercise Tolerance Test	0	0	0		
Femoral Central Line	3	3	0	3/5 (60%)	Indirect Supervision: Available on site 7/23/2018

Direct Supervision –Supervising physician is physically present with the resident and patient.

Indirect Supervision with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision

Indirect Supervision with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

EVERYONE WHO PARTICIPATES IN PATIENT CARE SHOULD HAVE ACCESS

- **Oversight** – the supervising physician is available to provide review of procedures/encounters with feedback provided **after** care is delivered. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program

Nurse Access To Resident Privileging

- Link added in the navbar directly beneath Graduate Medical Education, as well as the left orange links on the Graduate Medical Education page itself
- https://ozone.osumc.net/education/medical/Pages/welcome.aspx

Log in as (no CAPS):

- Institution: **osu**
- User: **osunurse**
- Password: **osumc**

- Under **Procedure Search**, click on **Find personnel**

Transitions in Care

- **I-PASS Nomenclature** for patient handoffs
- **Computerized handoff** tool that structured within the medical record
- Faculty periodically **observe handoff** process and give feedback
- **Communication** to PD's and faculty

Verbal Handoff Assessment

Faculty Observation & Feedback Tool for Giver & Receiver

Observer Information:

Name:_____ Date: _ _/_ _/_ _ *(mm/dd/yy)* Obs. Start Time: **_ _ : _ _ am/pm** Obs. End Time: **_ _ : _ _ am/ pm**

How well do you know the patients whose handoff you are evaluating? ☐ Very well ☐ Somewhat well ☐ Not at all

Resident Information:

Name:_____ PGY Level:_____ Total number of patients discussed during the handoff:_____

Type of Handoff

1. Please indicate the type of handoff you observed (check one): ☐ Individual ☐ Team

How frequently did the resident receiving the handoff do the following:	**Never**	**Rarely**	**Sometimes**	**Usually**	**Always**
2. Verbalize a concise, accurate summary of each patient					
3. Appear focused, engaged, and demonstrate active listening skills.					

4. Rate your impression of the number of clarifying questions asked by the receiver:

☐ Insufficient number of questions ☐ Appropriate number of questions ☐ Excessive number of questions

5. What was especially effective about the handoff?	6. What aspect(s) of the handoff could be improved?	7. Additional comments:

8. Was resident given feedback within 24 hours of observing sign-out? ☐ Yes ☐ No

Observer Information:

Name:_____ Date: _ _/_ _/_ _ *(mm/dd/yy)* Obs. Start Time: **_ _ : _ _ am/pm** Obs. End Time: **_ _ : _ _ am/ pm**

How well do you know the patients whose handoff you are evaluating? ☐ Very well ☐ Somewhat well ☐ Not at all

Resident Information:

Name: _____ PGY Level: _____ Total number of patients discussed during the handoff : _____

Type of Handoff

1. Please indicate the type of handoff you observed: ☐ Individual ☐ Team

Situational Overview (Big Picture)

2. Was a situational overview provided by the resident giving the handoff (e.g. description of the ☐ Yes ☐ No
acuity of the patient to be presented, etc.)?

Indicate the frequency that the specific element of the mnemonic was used throughout the handoff.

Verbal Mnemonic	**Description**	**Never**	**Rarely**	**Sometimes**	**Usually**	**Always**
3. **I**llness Severity	Identification as stable, "watcher", or unstable					
4. **P**atient Summary	Summary statement, events leading up to admission, hospital course, ongoing assessment, plan					
5. **A**ction List	To do list; timeline and ownership					
6. **S**ituation Awareness/ Contingency Planning	Know what's going on; plan for what might happen					
7. **S**ynthesis by Receiver	Ensures receiver summarizes what was heard, asks questions, restates key action/to do items					

Rate the frequency with which the resident who gave the handoff did the following:	**Never**	**Rarely**	**Sometimes**	**Usually**	**Always**
8. Actively engages receiver to ensure shared understanding of patients (Encouraged questions, asked questions, considers learning style of receiver)					
9. Appropriately prioritizes key information, concerns, or actions					

Rate the frequency with which the resident who gave the handoff did the following:	**Never**	**Rarely**	**Occasionally**	**Fairly Often**	**Very Often**
10. Miscommunications or transfer of erroneous information					
11. Omissions of important information					
12. Tangential or unrelated conversation					

13. Rate your overall impression of the *pace* of the handoff:

☐ Very slow pace/ Very inefficient ☐ Slow pace/ Inefficient ☐ Optimally paced/ Efficient but not rushed ☐ Fast/pressured pace ☐ Very fast/pressured pace

14. What was especially effective about the handoff?	**15. What aspect(s) of the handoff could be improved?**	**16. Additional comments:**

17. Was the resident given feedback within 24 hours of your observation? ☐ Yes ☐ No

Printed Handoff Assessment

Faculty Observation and Feedback Tool

Date and time tool printed: _ _/_ _/_ _ *(mm/dd/yy)* _ _ **:** _ _ **AM / PM** **Service:** _____

1. How well do you know the patients on the printed handoff document? ☐ Very well ☐ Somewhat well ☐ Not at all

2. Number of patients on printed handoff document: _____

Indicate how frequently each element of the I-PASS mnemonic is present on the printed handoff document.

Mnemonic	Description	Never	Rarely	Sometimes	Usually	Always
3. **I**llness Severity	Identification as stable, "watcher", or unstable					
4. **P**atient Summary	Summary statement, events leading up to admission, hospital course, ongoing assessment, plan					
5. **A**ction List	To do list; timeline and ownership					
6. **S**ituation Awareness/ Contingency Planning	Know what's going on; plan for what might happen					
7. **S**ynthesis by Receiver	Written reminder to prompt receiver to summarize what was heard during verbal handoff					

8. How often are the following essential elements present and accurate on the printed handoff document:	**Never**	**Rarely**	**Sometimes**	**Usually**	**Always**
• Name • MRN • Room # • Weight • Age • Service / Team • Allergies • Medication name • Admission date					

Rate the frequency with which the printed tool had:	**Never**	**Rarely**	**Sometimes**	**Usually**	**Always**
9. Patient summary with clearly specified plan for remainder of admission					
10. To-do items with clear if/then format when appropriate					
11. To-do list restricted to items that should be accomplished on next shift					
12. High quality contingency plans documented for items not on to-do list					

13. Rate the length of the printed handoff document:

☐ Very excessive length ☐ Excessive length ☐Appropriate length ☐ Abbreviated length ☐Very abbreviated length

Rate the following:	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
14. Accuracy of Illness Severity Assessments					
15. Quality of Patient Summaries					

Rate the frequency with which the printed tool contained the following:	**Never**	**Rarely**	**Occasionally**	**Fairly Often**	**Very often**
16. Omissions of important information					
17. Irrelevant information					

18. **Did you observe any erroneous information on the printed tool?** ☐ Yes ☐ No

18a. If yes, how many times ____

19. What was especially effective about the printed tool?	**20. What aspect(s) of the printed tool could be improved?**	**21. Additional comments:**

21. Was resident given feedback within 24 hours of observation? ☐ Yes ☐ No

Teaming

- Places emphasis on strategies that promote **interprofessional interaction** around patient care

- Eg. Change of duty handoffs, transfers between service and locations

Duty Hours Policy, Fatigue Management and Mitigation (AKA CLE)

- All trainees required to log duty hours – 100% compliance –monitored by both program (PD) and GME/DIO
- Faculty/resident presentations on fatigue/mitigation
- Quiet call rooms for rest
- Burnout Survey
- Resident Gym Enhancements
- Program Specific Resident Wellness Champions

Wellbeing

https://health.okstate.edu/gme/cler.html

- Wellness Response Algorithm OSU-CHS
- 2 presentations/year on Grand Rounds schedule
- Wellness Flip Book
- Mentor/Mentee Program
- Residency specific wellness programs
- Faculty and Resident Wellness Champions
- Residency social functions
- Enhanced cafeteria options
- COM-Psych – 24/7 urgent and emergent

Wellness Response Algorithm

OSU-CHS

Rev. 10/21/2020

CHS Residents may make counseling appointments at
chscounselingservices.as.me
or by calling **918-561-1822**

Is the resident an imminent risk to self or others?

Yes

-Stay with the resident
-Get information: Name, emergency contact, current address
-Provide reassurance and support
-Contact OSU Security (918-625-8592) and notify them of the situation

Business hours:
- Call CHS-Counseling Services (Tulsa: 918-561-1822; Tahlequah 918-525-6350) or Dr. Kelly Dunn (918-497-9013)

After Hours:
-Tulsa: Call COPES with the resident (744-4800);
-Tahlequah: Call Grand Lake Mental Health (1-800-722-3611)
-Notify Emergency Contact

↓

After resident safety ensured, contact the **Wellness Support Team.**

No

Is the resident showing or reporting moderate or severe signs of distress?

Yes

Notify the Wellness Support Team (WST). Note URGENT Referral.

↓

Make a safety plan with the resident and provide Emergency Numbers/Resource List.

↓

If given permission, call their emergency contact with them.

No

Encourage resident to make an appointment with OSU-CHS counseling services or in the community
Encourage resident to contact the WST. Note non-urgent referral

Referrals to the **Wellness Response Team** can be made at:
medicine.okstate.edu/com/student-life/index.html
→ Click "Person of Concern"

Resources

- Guidance Resources
- Resident Wellness
- ComPsych 866-519-8354
- 10 free counseling sessions
- Community Care EAP: 918-594-5232
  - 1-800-221-3976
- COPES
  - 918-744-4800

Professionalism

#62854638 - Ethicsconcept. Hand take white ball with wordcloud and ethics..

- Main focus areas: **honesty, integrity, and mistreatment**
- Specific training in **ethical use of EHRs**: copy-and-paste, blow-in phrases
- **Professional Code of Conduct**
- **Conflict of Interest Declaration**
- **Patient's perception of professional Care**

Professionalism (including Honest and Accurate Reporting of Information, Scientific Integrity and Issues of Mistreatment)

Crucial Conversations Training 16 hrs

Residents and Nurse Managers Training

Hosp Nursing Staff next to be trained

Chief Resident Council

Professionalism Remediation Process

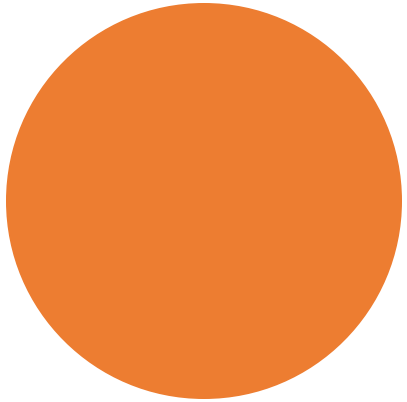
Scientific Integrity

- The condition resulting from adherence to professional values and practices when conducting, reporting, and applying the results of **scientific** activities that ensures objectivity, clarity, and reproducibility, and that provides insulation from bias, fabrication, falsification, plagiarism, inappropriate influence, political interference, censorship, and inadequate procedural and information security.

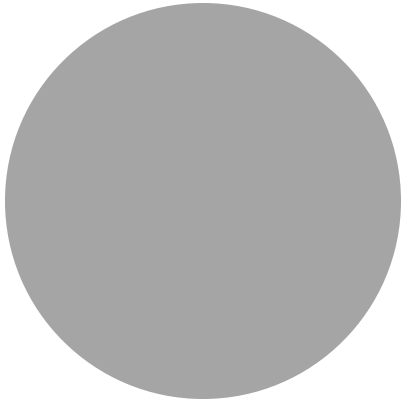
Financial Conflicts of Interest

Stock	Receipt	Receipt
Stock ownership in a public or private company	Receipt of payment for services including consulting work	Receipt of intellectual property rights are royalties

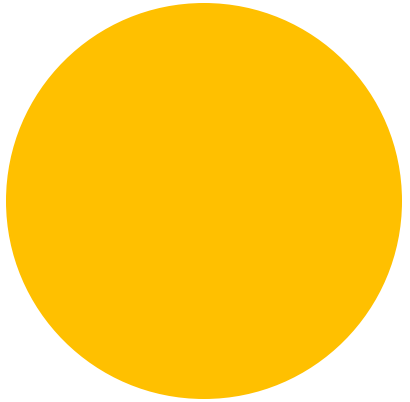
Non-Financial Conflicts of Interest



ACADEMIC CONFLICTS OF INTEREST

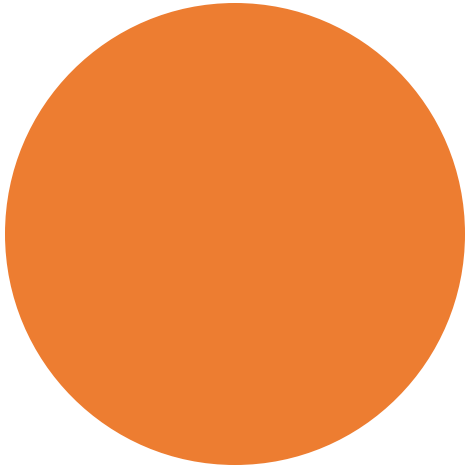


CONFLICTS OF CONSCIENCE

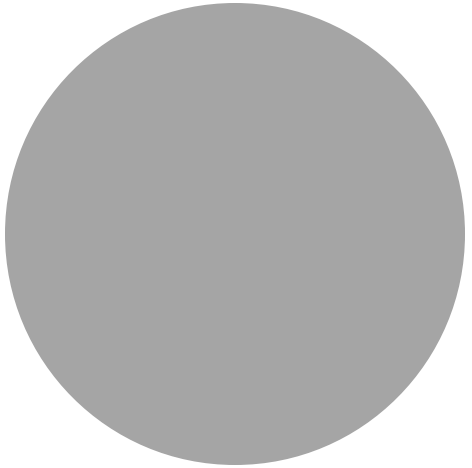


PERSONAL CONFLICTS OF INTEREST

EHR copy and Paste and Patient Safety



THE USE OF COPY AND PASTE MAY CONTRIBUTE TO THE INTRODUCTION OF INACCURATE INFORMATION WITHIN PATIENTS' RECORDS AND CLOUD THE JUDGMENT OF SUBSEQUENT PROVIDERS



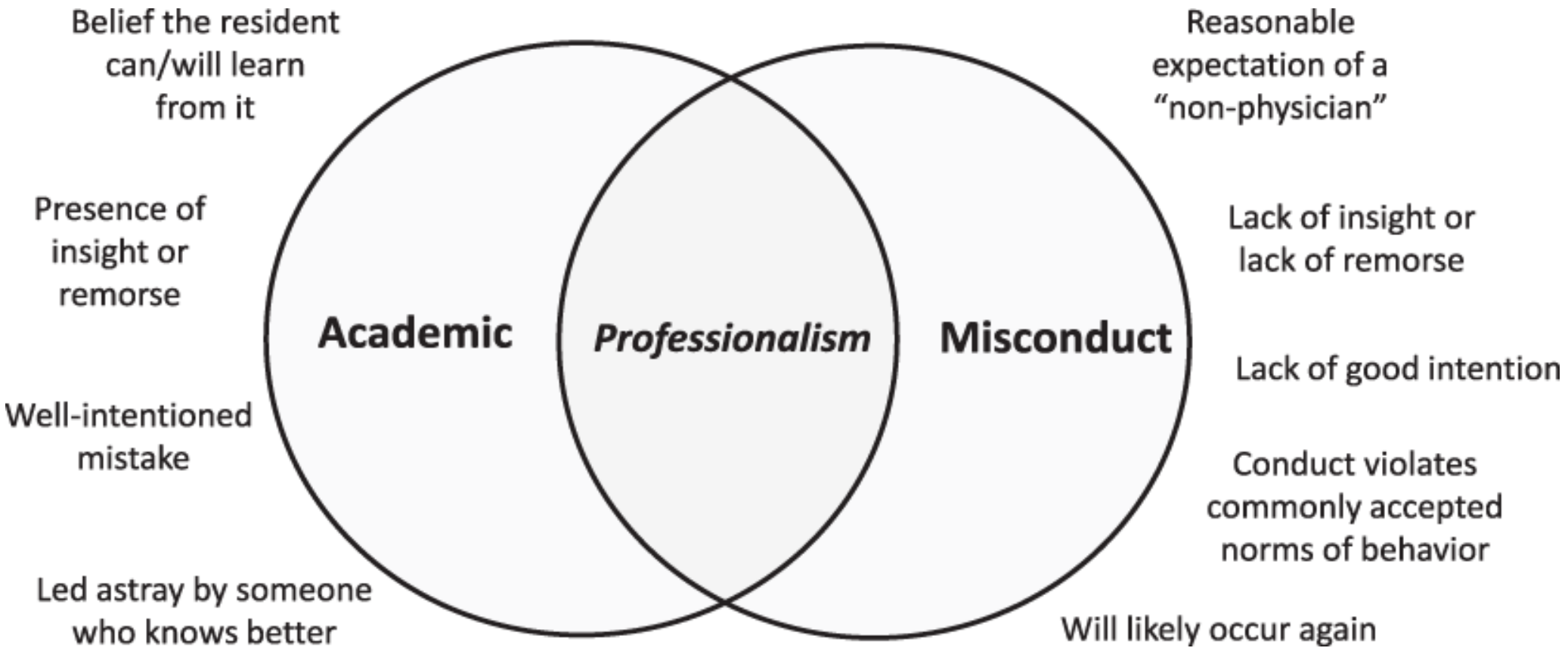
COPY AND PASTE ALSO MAKES IT EASY TO CREATE LONG, RAMBLING NOTES THAT DO NOT CLEARLY CONVEY THE CURRENT STATUS OF A PATIENT AND CAN, IN FACT, DISTRACT A READER FROM IMPORTANT CONCERNS.

Copy and Paste and Patient Safety

- A patient with an alleged history of "PE" (interpreted by the clinicians as pulmonary embolism) received an unnecessary CT scan to rule out a suspected "recurrence" of pulmonary embolus. As it happens, years earlier, the abbreviation "PE" had been used in the electronic note to indicate that the patient had had a physical examination, not a pulmonary embolism! In a vivid example of copy and paste, once the diagnosis of pulmonary embolism was mistakenly given to the patient, it lived on in the EHR.

Misconduct

- Behaviors where a reasonable person would know the behavior is wrong (e.g. drug use, diversion, lying, cheating, or stealing)
- PD’s will determine whether or not the resident 1)should have known the behavior was wrong 2)have the capacity to learn from their mistake and 3) has the ability to demonstrate proper conduct moving forward
- PD's will also weigh other factors such as seriousness of any harm resulting from the behavior or the potential of future harms should the behavior reoccur



Framework for Considering Behaviors as Deficiency in Academic Professionalism vs Misconduct

AOA Code of Conduct

- Non-maleficence – first, do no harm
- Acting as a positive role model
- Displaying respect in interactions with others
- Legal and ethical behavior
- **Appropriate management of potential conflicts of interest**
- **Beneficence** – a physician should act in the best interest of the patient/altruism/placing the needs of the patient first
- Autonomy – the patient has the right to refuse or choose their treatment
- **Dignity** – the patient (and the medical professional involved with their care) has the right to dignity, truthfulness and honesty
- Participation in self-evaluation programs and acceptance of constructive criticism from others.

AOA Pledge of Commitment

- I pledge to:
- Provide compassionate, quality care to my patients;
- Partner with them to promote health;
- Display integrity and professionalism throughout my career;
- Advance the philosophy, practice and science of osteopathic medicine;
- Continue life-long learning;
- Support my profession with loyalty in action, word and deed; and
- Live each day as an example of what an osteopathic physician should be.

HCAPS

HCAHPS **(the Hospital Consumer Assessment of Healthcare Providers and Systems) is a patient satisfaction survey required by CMS (the Centers for Medicare and Medicaid Services)** for all hospitals in the United States.

Voice of the patient

Publicly reported and impacts reputation

Reimbursement on results

27 questions

Doctor Communication - respect, listening skills and communication ability of doctors.

HCAPS - Doctor Communication Questions

Your Care from Doctors

- During this hospital stay, how often did doctors treat you with courtesy and respect?
- During this hospital stay, how often did doctors listen carefully to you?
- During this hospital stay, how often did doctors explain things in a way you could understand?

Significance of CLER

- CLER visits can be powerful tools to facilitate collaboration between SIs and programs on mutually beneficial goals and strategies regarding health care quality.
- CLER discussions can increase the value of the program to the Sponsoring Institution.

- **Without safety there is no quality**
- **Without quality there is no safety**
- **Without quality and safety there is little opportunity for improvement in patient care**

CLER Contacts

- Jenny Alexopulos D.O. - CLER Director jenny.alexopulos@okstate.edu
- Lisa Cummins R.N. - CLER Manager lisa.cummins@okstate.edu
- MeLyssa D. Bailey, B.A. - Executive Assistant III
  ACGME Administration melyssa.d.bailey@okstate.edu

References

- https://www.jgme.org/doi/pdf/10.4300/JGME-D-19-00724.1

- CLER Evaluation Committee. *CLER Pathways to Excellence: Expectations for an Optimal Clinical Learning Environment to Achieve Safe and High-Quality Patient Care, Version 2.0*. Chicago, IL: 2019. doi:https://doi.org/10.35425/ACGME.0003. [Google Scholar]