



CLER PATHWAYS TO EXCELLENCE

EXPECTATIONS FOR AN OPTIMAL
CLINICAL LEARNING ENVIRONMENT TO ACHIEVE
SAFE AND HIGH-QUALITY PATIENT CARE

VERSION 2.0



ACGME

Accreditation Council for
Graduate Medical Education

CLER Pathways Version 2.0

The Clinical Learning Environment Review (CLER) Program is pleased to present Version 2.0 of *CLER Pathways to Excellence: Expectations for an Optimal Clinical Learning Environment to Achieve Safe and High-Quality Patient Care*. The *Pathways* document continues to serve as a tool for promoting discussions and actions to optimize the clinical learning environment (CLE). This version frames each of the pathways and properties from the health system's perspective, recognizing that health care organizations create and are therefore primarily responsible for the CLE. This focus emphasizes the importance of the interface between graduate medical education (GME) and the hospitals, medical centers, and ambulatory sites that serve as CLEs.

This version of the *Pathways* also places greater emphasis on the clinical care team (and resident and fellow physicians as members of the team). In addition to noting the role of the clinical care team throughout the document, Version 2.0 introduces a new CLER Focus Area called Teaming. The concept of teaming recognizes the dynamic and fluid nature of the many individuals of the clinical care team that come together in the course of providing patient care to achieve a common vision and goals. It also recognizes the benefits of purposeful interactions that allow team members to quickly identify and capitalize on their various professional strengths –coordinating care that is both safe and efficient. This new Focus Area also expressly recognizes and explores the CLE's perspective on the patient's role in teaming. Teaming replaces the previous Focus Area called Care Transitions; the properties from Care Transitions were either retired or redistributed as properties of the other five CLER Focus Areas.

These updates reflect the CLER Program's commitment to continuous improvement toward the goal of optimizing the delivery of safe, high-quality patient care.

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Introduction

In the late 1990s, the National Academy of Medicine (formerly the Institute of Medicine) conducted a multiyear project to examine the quality of health care in the United States.¹ The result of that effort was a series of reports^{2,3} that highlighted serious patient safety concerns, variability in the quality of care, and continuing health care disparities. More than 20 years after the release of those reports, the overall progress in improving the nation's health care has been slow.

The physician workforce is one of the key levers to improving health care. A 2012 survey of hospital leaders conducted by the American Hospital Association found that newly trained physicians were deficient in the areas of communication, use of systems-based practices, and interprofessional teamwork and highlighted the need to educate US physicians, residents, and fellows to address quality improvement.⁴

More than 135,000 resident and fellow physicians train in US teaching hospitals, medical centers, and other clinical settings.⁵ These individuals work on the front lines of patient care. In this role, they need to be prepared to recognize patient safety events and intervene when appropriate, to champion performance improvement efforts, and to work effectively in interprofessional^a teams on systems-based issues such as transitions in patient care. This next generation of physicians needs the skills to be able to lead changes in our nation's health care organizations, both large and small.

The ACGME recognizes the public's need for a physician workforce capable of meeting the requirements of a rapidly evolving health care environment. Efforts to address those needs began in the late 1990s when the ACGME, collaborating with the American Board of Medical Specialties, established six core competencies and designed and implemented a framework for attaining the skills needed for the modern practice of medicine. This framework drives both the educational curriculum and the evaluation of outcomes for residents and fellows. As a subsequent step in the evolution of GME, the ACGME implemented the Next Accreditation System as its current model of accreditation.⁶ The Next Accreditation System emphasizes outcomes of resident and fellow learning, assessed through a set of performance measures, including the Milestones, which indicate the individual's progress toward independent practice. Other examples of these measures include: clinical experience as evidenced through the Case Logs, scholarly activity, and pass rates for specialty certification.

^a The CLER Program considers "interprofessional" as interactions (e.g., patient care, learning) that involve individuals from two or more clinical professions.

The CLER Program

The ACGME established the CLER Program in 2012⁷ to provide GME leaders and executive leaders of hospitals, medical centers, and other clinical settings with formative feedback aimed at improving patient care while optimizing the CLE in six important cross-cutting areas such as patient safety and health care quality.

The CLER Program conducts site visits to the hospitals, medical centers, and other clinical settings of ACGME-accredited institutions that host residency and fellowship programs.⁸ During these visits, CLER Field Representatives meet with the organization's executive leadership (e.g., chief executive officer, chief medical officer, chief nursing officer); the organization's leaders in patient safety, health care quality, and well-being; leaders of GME; and groups of residents and fellows, faculty members, and program directors. Additionally, the CLER site visit teams conduct Walking Rounds on various patient floors, units, and service areas to gather input from other members of the clinical care team regarding how the organization functions as a learning environment.

At the conclusion of each visit, the CLER Field Representatives meet with the organization's executive leadership to share their observations of resident and fellow engagement in the Focus Areas. It is through this feedback that the ACGME seeks to improve both physician education and the quality of patient care within these organizations.

The CLER Program is separate and distinct from nearly all accreditation activities. Two essential elements connect the CLER Program with the rest of the accreditation process: (1) each Sponsoring Institution is required to periodically undergo a CLER site visit every 24 (± 6) months; and (2) the chief executive officer and the leader of GME (specifically the designated institutional official) of the clinical site must attend the opening and closing sessions of the CLER site visit.

The CLER Program is built on a model of continuous quality improvement. Its purpose is to evaluate, encourage, and promote improvements in the CLE. The CLER Program provides sites with three types of formative feedback: (1) an oral report at the end of the site visit; (2) a written narrative report summarizing the observations of the CLER Field Representative(s); and (3) reports that provide

national aggregated and de-identified data displayed along a continuum of progress toward achieving optimal resident and fellow engagement in the CLER Focus Areas.

The individual CLER site visit reports are kept confidential. The National Reports of aggregated, de-identified CLER Program data are shared publicly and used to inform future US residency and fellowship accreditation policies, procedures, and requirements.

Developing the CLER Pathways

The *CLER Pathways to Excellence*⁹ document serves a tool to promote discussions and actions to optimize the CLE, furthering the aim of the CLER Program. The ACGME presents the CLER pathways as expectations rather than requirements, anticipating that CLEs will strive to meet or exceed these expectations in their efforts to provide the best care to patients and to produce the highest quality physician workforce.

The ACGME's CLER Evaluation Committee, a group that provides oversight and guidance on all aspects of the CLER Program, develops each version of the *CLER Pathways to Excellence*. The committee's members represent a broad range of perspectives and are selected based on their national and international expertise in areas of patient safety, health care quality, hospital leadership, GME, and patient perspectives. Their continued input, combined with that of the CLER Field Representatives, GME leadership, the executive leadership of Sponsoring Institutions and other clinical sites, and the community—as well as what is learned from the data generated by the CLER site visits—helps to evolve each version of the *CLER Pathways to Excellence* to reflect the current state of GME and the health care system.

Using the CLER Pathways' Framework

The *CLER Pathways to Excellence* provides a framework for clinical sites to use in their continuing efforts to prepare the clinical care team to deliver consistently safe, high-quality patient care. Central to the document is a series of pathways for each of the six CLER Focus Areas, which are essential to creating an optimal CLE. In turn, each pathway has a series of key properties that can be used to assess resident, fellow, and faculty member engagement within the learning environment.

For example, the Patient Safety Focus Area has seven defined pathways. The first is:

PS Pathway 1: Education on patient safety

Five properties are attached to this pathway—each designed to assess the GME connection to the structures and processes the CLE has put in place to promote safe, high-quality patient care. The first is:

The clinical learning environment:

a. Provides residents, fellows, and faculty members with interprofessional, experiential training on the principles and practices of patient safety.

In total, Version 2.0 of the *Pathways* document presents six Focus Areas, 34 pathways, and 139 properties. Because the scope and number of pathways and properties are more than can be covered at one time, the CLER Program will not assess all of these elements on every CLER site visit. The CLER Program and the CLER Evaluation Committee hope that CLEs will find valuable guidance in all of the items, regardless of whether they are formally assessed.

Version 2.0 of *Pathways* recognizes the CLE is a shared space, encompassing both early and lifelong learners across the professions. As such, the document focuses on the clinical care team and emphasizes the interdependence of roles and the importance of modeling optimal behaviors for early learners. It also recognizes the key role of patients and caregivers in partnering with the care team to achieve optimal outcomes.

The majority of the pathways and their properties cannot be achieved without a close partnership between the GME leadership and the highest level of executive leadership at the clinical site. The feedback from the CLER Program will assist institutions in prioritizing and acting on opportunities to improve the CLE for resident and fellow physicians and—ultimately—the quality of patient care.

Informing the Accreditation Process

As noted earlier, the CLER Program provides formative feedback—to individual clinical sites, the ACGME, and the public. The *CLER Pathways to Excellence* document is a tool for assessing the present and simultaneously envisioning and planning for the future. By setting expectations for an optimal CLE, the

pathways and properties serve to stimulate conversations that lead to innovation and improvements in service of both patients and learners. The *CLER Pathways* differ from the ACGME Common Program Requirements and the Institutional Requirements in that they are not utilized to determine the accreditation status of Sponsoring Institutions and their residency programs.

The CLER Program is designed to inform the Common Program Requirements and Institutional Requirements in aggregate. The CLER Evaluation Committee periodically reviews the cumulative data from the CLER site visits, along with emerging research in the six Focus Areas, and uses the information to reassess the pathways, revise them as needed, and make recommendations, as appropriate, regarding potential changes to GME accreditation requirements. As elements of the *CLER Pathways to Excellence* migrate to requirements, these elements are removed from future versions of the document and replaced with new areas for exploration. In this manner, the CLER Program serves as a catalyst to continually inform accreditation, while striving for excellence in patient safety and health care quality.

Striving for Excellence

The CLER Evaluation Committee and, ultimately, the ACGME Board of Directors continually monitor the progress of the CLER Program. Success associated with the *CLER Pathways to Excellence* is assessed by tracking aggregated data over time and mapping progress along the pathways toward the goal of achieving optimal engagement.

The *CLER Pathways to Excellence* is intended to accelerate national conversations among educators, health care leadership, policy makers, and patients as to the importance of continually assessing and improving the environments in which the US physician workforce trains, as well as the role of GME in promoting safe, high-quality patient care.

Patient Safety (PS)

The optimal clinical learning environment continually provides experiences that residents and fellows need to engage with the clinical site's efforts to address patient safety. It is important that the clinical site has processes to identify and implement sustainable, systems-based improvements to address patient safety vulnerabilities and that such processes engage interprofessional teams as part of ongoing efforts to deliver the safest and highest quality patient care.²

PS Pathway 1: Education on patient safety

The clinical learning environment:

- a. Provides residents, fellows, and faculty members with interprofessional, experiential training on the principles and practices of patient safety.
- b. Ensures that faculty members are proficient in the application of principles and practices of patient safety.
- c. Engages residents and fellows in patient safety educational activities in which the clinical site's systems-based challenges are presented and techniques for designing and implementing system changes are discussed.
- d. Provides residents, fellows, and faculty members with education on the clinical site's proactive risk assessments (e.g., failure mode and effects analysis).
- e. Ensures that the clinical site's patient safety education program is developed collaboratively by patient safety officers, residents, fellows, faculty members, nurses, and other members of the clinical care team.

PS Pathway 2: Culture of safety

The clinical learning environment:

- a. Regularly conducts a culture of safety survey with all members of the clinical care team to identify opportunities for improvement and shares results across the organization.
- b. Establishes formal risk-based mechanisms to identify hazards, monitor for potential vulnerabilities, and ensure patient safety.
- c. Creates and sustains a fair and just culture for reporting patient safety events for the purposes of systems improvement.
- d. Maintains mechanisms to provide second-victim emotional support to the clinical care team involved in patient safety events.
- e. Directly reaches out to residents and fellows involved in patient safety events to provide second-victim emotional support.

PS Pathway 3: Reporting of adverse events, near misses/close calls, and unsafe conditions

The clinical learning environment:

- a. Provides the clinical care team, including residents, fellows, and faculty members, with education on the types of vulnerabilities and range of reportable patient safety events.
- b. Ensures that the clinical care team, including residents, fellows, and faculty members, knows the benefits of reporting patient safety events to improve patient care at the clinical site.
- c. Ensures that residents, fellows, and faculty members know that it is their responsibility to report patient safety events into the clinical site's central reporting system rather than delegating this responsibility.
- d. Captures patient safety events reported by residents, fellows, and faculty members via any mechanism (e.g., online, telephone calls, chain of command) in the clinical site's central reporting system.
- e. Provides GME leadership (routinely) and the clinical site's governing body (at least annually) with information on patient safety events reported by residents, fellows, and faculty members.

PS Pathway 4: Experience in patient safety event investigations and follow-up

The clinical learning environment:

- a. Ensures that residents and fellows engage in interprofessional, experiential patient safety event investigations that include analysis, implementation of an action plan, and monitoring for continuous improvement related to patient care.
- b. Provides direct feedback to members of the clinical care team, including residents and fellows, on the outcomes resulting from personally reporting a patient safety event.
- c. Shares lessons learned from patient safety investigations across the organization with all members of the clinical care team, including residents and fellows.

PS Pathway 5: Clinical site monitoring of resident, fellow, and faculty member engagement in patient safety

The clinical learning environment:

- a. Monitors resident, fellow, and faculty member reporting of patient safety events.
- b. Monitors resident, fellow, and faculty member participation in patient safety event investigations.
- c. Uses data from monitoring resident, fellow, and faculty member patient safety reports to develop and implement actions that improve patient care.
- d. Monitors resident, fellow, and faculty member participation in implementing action plans resulting from patient safety event investigations.

PS Pathway 6: Resident and fellow education and experience in disclosure of events

The clinical learning environment:

- a. Provides residents and fellows with experiential training with their faculty members (e.g., simulated or authentic patient care experience) in the clinical site's process for disclosing patient safety events to patients and families.
- b. Ensures that residents and fellows are involved with faculty members in disclosing patient safety events to patients and families at the clinical site.

PS Pathway 7: Resident, fellow, and faculty member engagement in care transitions

The clinical learning environment:

- a. Provides residents, fellows, and faculty members with simulated or real-time interprofessional training on communication to optimize transitions of care at the clinical site.
- b. Ensures that residents, fellows, and faculty members use a common clinical site-based process for change-of-duty hand-offs.
- c. Ensures that residents, fellows, and faculty members use a standardized direct verbal communication process for patient transfers between services and locations at the clinical site.
- d. Involves residents, fellows, and program directors in the development and implementation of strategies to improve transitions of care.
- e. Monitors transitions of patient care managed by residents and fellows.

Health Care Quality (HQ)

The optimal clinical learning environment provides experiential and interprofessional training in all phases of quality improvement aligned with the quality goals of the clinical site.³ In this way, it ensures that residents and fellows engage with the entire cycle of quality improvement—from planning through implementation and reassessment.

HQ Pathway 1: Education on quality improvement

The clinical learning environment:

- a. Ensures that residents, fellows, and faculty members are familiar with the clinical site's priorities and goals for quality improvement.
- b. Provides the clinical care team, including residents, fellows, and faculty members with ongoing education and training on quality improvement that involves experiential learning and interprofessional teams.
- c. Engages residents, fellows, and faculty members in quality improvement educational activities where the clinical site's systems-based challenges are presented, and techniques for designing and implementing systems changes are demonstrated.
- d. Ensures that the clinical site's quality improvement education program is developed collaboratively by quality officers, residents, fellows, faculty members, nurses, and other members of the clinical care team to reflect the clinical site's quality program's priorities and goals.
- e. Ensures the integration of quality improvement processes and lessons learned into the daily workflow of clinical care.

HQ Pathway 2: Resident and fellow engagement in quality improvement activities

The clinical learning environment:

- a. Provides opportunities for residents and fellows to actively engage in interprofessional quality improvement.
- b. Ensures that residents and fellows actively engage in interprofessional quality improvement that is aligned and integrated with the clinical site's priorities for sustained improvements in patient care.
- c. Maintains a central repository for all quality improvement projects, including resident- and fellow-led projects, to monitor progress and assess the quality of the projects.
- d. Shares quality improvement outcomes with all members of the clinical care team, including residents and fellows, across the organization.

HQ Pathway 3: Data on quality metrics

The clinical learning environment:

- a. Provides the clinical care team, including residents and fellows, with clinical site-level quality metrics and benchmarks.
- b. Provides the clinical care team, including residents and fellows, with aggregated data on quality metrics and benchmarks related to their patient populations.
- c. Provides the clinical care team, including residents and fellows, with data on quality metrics and benchmarks specific to the patients for whom they provide direct patient care.
- d. Ensures that the clinical care team, including residents, fellows, and faculty members, can interpret data on quality metrics and benchmarks.

HQ Pathway 4: Resident and fellow engagement in the clinical site's quality improvement planning process

The clinical learning environment:

- a. Engages residents, fellows, and faculty members in strategic planning for quality improvement.
- b. Engages residents, fellows, and faculty members in interprofessional service-line, departmental, and clinical site-wide quality improvement committees.
- c. Periodically reviews resident and fellow quality improvement projects to integrate with the clinical site's quality improvement planning process.

HQ Pathway 5: Resident, fellow, and faculty member education on eliminating health care disparities

The clinical learning environment:

- a. Provides the clinical care team, including residents, fellows, and faculty members with education on the differences between health disparities and health care disparities.
- b. Ensures that residents, fellows, and faculty members know the clinical site's priorities for addressing health care disparities.
- c. Educates residents, fellows, and faculty members on identifying and eliminating health care disparities among specific patient populations receiving care at the clinical site.
- d. Maintains a process that informs residents, fellows, and faculty members on the clinical site's process for identifying and eliminating health care disparities.

HQ Pathway 6: Resident, fellow, and faculty member engagement in clinical site initiatives to eliminate health care disparities

The clinical learning environment:

- a. Engages residents, fellows, and faculty members in defining strategies and priorities to eliminate health care disparities among its patient population.
- b. Identifies and shares information with residents, fellows, and faculty members on the social determinants of health for its patient population.
- c. Provides residents, fellows, and faculty members with quality metrics data on health care disparities grouped by its patient population.
- d. Provides opportunities for residents, fellows, and faculty members to engage in interprofessional quality improvement projects focused on eliminating health care disparities among its patient population.
- e. Monitors the outcomes of quality improvement initiatives aimed at eliminating health care disparities among its patient population.

HQ Pathway 7: Residents, fellows, and faculty members deliver care that demonstrates cultural humility

The clinical learning environment:

- a. Provides residents, fellows, and faculty members continual training in cultural humility relevant to the patient population served by the clinical site.
- b. Ensures that the clinical care team, including residents, fellows, and faculty members, delivers care that incorporates the views of culturally diverse patient populations.

Teaming (T)

The optimal clinical learning environment supports high-performance teaming. The concept of teaming recognizes the dynamic and fluid nature of the many individuals of the clinical care team that come together in the course of providing patient care to achieve a common vision and goals.¹⁰ Teaming recognizes the benefits of purposeful interactions in which team members quickly identify and capitalize on their various professional strengths—coordinating care that is both safe and efficient. The team members collaborate and share accountability to achieve outstanding results.

T Pathway 1: Clinical learning environment promotes teaming as an essential part of interprofessional learning and development

The clinical learning environment:

- a. Maintains an organizational strategy to promote interprofessional learning on teaming.
- b. Provides continual interprofessional educational programming on teaming that engages residents, fellows, and faculty members.
- c. Ensures the development and maintenance of interprofessional skills on teaming that engages residents, fellows, and faculty members.
- d. Ensures continual interprofessional learning on teaming that engages residents, fellows, and faculty members across the continuum of patient care and at all care delivery sites.
- e. Engages in continual goal-setting and monitoring of interprofessional learning on teaming.

T Pathway 2: Clinical learning environment demonstrates high-performance teaming

The clinical learning environment:

- a. Ensures that patient care planning by residents, fellows, and faculty members (e.g., diagnostic and treatment strategies) is conducted in the context of interprofessional teams.
- b. Ensures that transitions in care conducted by residents, fellows, and faculty members (e.g., change-of-duty hand-offs, transfers of patients between services and locations) involves, as appropriate, interprofessional teams.
- c. Engages residents, fellows, and faculty members in interprofessional performance improvement activities, including patient safety and quality improvement, across service lines and health care settings.
- d. Ensures that patient care processes are designed with interprofessional collaborative input, including the GME community.

T Pathway 3: Clinical learning environment engages patients* to achieve high-performance teaming

The clinical learning environment:

- a. Maintains a strategy to engage patients as part of its effort to ensure high-performance teaming.
- b. Ensures that patients are engaged with their clinical care team in decisions related to their care.
- c. Engages patients in the development and revision of the clinical site's policies and procedures on patient care in which residents and fellows are involved (e.g., duty hours, supervision, informed consent).
- d. Ensures that patients are involved, as appropriate, in resident and fellow care transitions (e.g., change-of-duty hand-offs).

T Pathway 4: Clinical learning environment maintains the necessary system supports to ensure high-performance teaming

The clinical learning environment:

- a. Provides professional development resources to ensure interprofessional learning and high-performance teaming that includes residents, fellows, and faculty members.
- b. Provides interprofessional resources to support teaming activities within and across service lines and health care settings.
- c. Monitors the use of interprofessional resources to support high-performance teaming.
- d. Ensures that information technology personnel are integrated into interprofessional teams and that resources are available to support high-performance teaming.
- e. Demonstrates how it engages the clinical care team, including residents, fellows, and faculty members, in integrating artificial intelligence (e.g., decision support) to support high-performance teaming.
- f. Monitors the degree of patient engagement in the design and practice of teaming.

* "Patient" can include family members, caregivers, patient legal representatives, and others.

Supervision (S)

The optimal clinical learning environment provides all members of the clinical care team and patients with mechanisms to raise supervision concerns. It also continuously monitors resident and fellow supervision to implement actions that enhance patient safety.¹¹ For each resident and fellow, GME encompasses progressive levels of supervision throughout the educational program.

S Pathway 1: Education on supervision

The clinical learning environment:

- a. Educates the clinical care team, including residents, fellows, and faculty members, on GME expectations for supervision and progressive autonomy throughout the residency and fellowship experience.
- b. Educates residents, fellows, and faculty members on the clinical site's expectations on how GME provides effective supervision of patient care.

S Pathway 2: Culture of supervision

The clinical learning environment:

- a. Ensures that residents and fellows receive adequate supervision as defined by the clinical site.
- b. Maintains a culture of supervision such that residents and fellows feel safe and supported in requesting assistance in the delivery of patient care.
- c. Fosters a supportive and nonpunitive culture of supervision for members of the clinical care team to report concerns about resident and fellow supervision.
- d. Ensures that mechanisms are in place for the clinical care team, including residents and fellows, to escalate supervision concerns in real-time.
- e. Establishes expectations for and monitors the quality of supervision of consultative services provided by residents and fellows.

S Pathway 3: Roles of clinical staff members other than physicians in resident and fellow supervision

The clinical learning environment:

- a. Ensures that clinical staff members other than physicians act on concerns related to the supervision of residents and fellows.
- b. Ensures that clinical staff members other than physicians are knowledgeable about the clinical site's expectations for supervision and progressive autonomy throughout the residency and fellowship experience.
- c. Periodically assesses the perceptions of clinical staff members other than physicians that the clinical site provides residents and fellows with a supportive culture for requesting assistance from supervising physicians.
- d. Ensures that clinical staff members other than physicians escalate concerns when supervision policies and procedures are not followed at the clinical site.

S Pathway 4: Patient* perspectives on graduate medical education supervision

The clinical learning environment:

- a. Ensures that patients understand the roles and are able to identify the names of attending physicians, residents, and fellows caring for them at the clinical site.
- b. Ensures that patients have adequate contact with the resident and fellow team caring for them at the clinical site.
- c. Communicates to patients the mechanism for them to directly contact the attending physician in charge of their care about concerns with supervision.
- d. Includes patients' perceptions in monitoring adequate supervision of residents and fellows.

* "Patient" can include family members, caregivers, patient legal representatives, and others.

S Pathway 5: Clinical site monitoring of resident and fellow supervision and workload

The clinical learning environment:

- a. Maintains information systems, accessible by the clinical care team, to verify the level of supervision required for residents and fellows to perform specific patient procedures.
- b. Monitors the use of systems to verify the level of supervision required for residents and fellows to perform specific patient procedures.
- c. Ensures that mechanisms are in place to systematically monitor and expeditiously address potential patient care vulnerabilities due to resident and fellow supervision.
- d. Monitors for patient care vulnerabilities due to the impact of faculty workload on resident and fellow supervision to formulate and implement strategies to mitigate the vulnerabilities.
- e. Monitors and assesses faculty member supervision of resident and fellow transfers of patient care, including change-of-duty and between services and locations at the clinical site.

Well-being (WB) – SELECTED TOPICS

The optimal clinical learning environment is engaged in systematic and institutional strategies and processes to cultivate and sustain the well-being of both its patients and its clinical care team.¹² The delivery of safe and high-quality patient care on a consistent and sustainable basis can be rendered only when the clinical learning environment ensures the well-being of clinical care providers. The following pathways and properties reflect selected topics in this area.

WB Pathway 1: Clinical learning environment promotes well-being across the clinical care team to ensure safe and high-quality patient care

- a. The clinical site creates a supportive clinical care community that is free of stigma, that is safe, and that embraces, promotes, and supports well-being.
- b. Leadership engages front-line health care providers in designing and developing priorities and strategies that support well-being.
- c. The clinical site builds awareness and educates the clinical care team on the risks, signs, symptoms, and recognition of fatigue in the context of patient care specific to the clinical site.
- d. The clinical site builds awareness and educates the clinical care team on the risks, signs, symptoms, and recognition of burnout in the context of patient care specific to the clinical site.
- e. Clinical learning environment and GME leadership demonstrate behaviors that promote well-being, thereby serving as role models for the clinical care team.

WB Pathway 2: Clinical learning environment demonstrates specific efforts to promote the well-being of residents, fellows, and faculty members

- a. Leadership engages residents, fellows, and faculty members in designing, developing, and continually stewarding priorities and strategies that support well-being.
- b. The clinical learning environment demonstrates continuous effort to support programs and activities that enhance the physical and emotional well-being of residents, fellows, and faculty members.

WB Pathway 3: Clinical learning environment promotes an environment where residents, fellows, and faculty members can maintain their personal well-being while fulfilling their professional obligations

The clinical learning environment:

- a. Establishes organizational expectations for resident, fellow, and faculty member workload—duration and intensity—consistent with safe and high-quality care for their patients and the educational needs of GME.
- b. Identifies and monitors patient care activities by residents, fellows, and faculty members that exceed the expectations of duration and intensity (volume and complexity) set by the clinical learning environment.
- c. Demonstrates continued improvement efforts to eliminate work-related activities that exceed the expectations of duration and intensity (volume and complexity) set by the clinical learning environment.
- d. Seeks and implements longitudinal approaches to enhance residents, fellows, and faculty members' ability to balance their personal needs with that of their work-related responsibilities.

WB Pathway 4: Clinical learning environment demonstrates system-based actions for preventing, eliminating, or mitigating impediments to the well-being of residents, fellows, and faculty members

The clinical learning environment:

- a. Promotes resilience training that is interprofessional and includes residents, fellows, and faculty members to ensure the safe and effective care of their patients.
- b. Ensures that systems are in place to actively recognize and mitigate fatigue among residents, fellows, and faculty members.
- c. Ensures that systems are in place to actively recognize and alleviate burnout among residents, fellows, and faculty members.
- d. Identifies GME-related systems and processes that may impede well-being in the clinical learning environment and works with the Sponsoring Institution to eliminate these impediments.
- e. Identifies clinical site-related systems and processes that may impede well-being in the clinical learning environment and works to eliminate these impediments.

WB Pathway 5: Clinical learning environment demonstrates mechanisms for identification, early intervention, and ongoing support of residents, fellows, and faculty members who are at risk of or demonstrating self-harm

The clinical learning environment:

- a. Builds awareness and educates the clinical care team on the risks, signs, symptoms, and recognition of those who are at risk of or demonstrating self-harm.
- b. Ensures confidentiality and actively facilitates early detection of residents, fellows, and faculty members at risk of or demonstrating self-harm.
- c. Establishes systems or processes that provide residents, fellows, and faculty members at risk of or demonstrating self-harm confidential access to treatment and other related services that are commensurate with occupational and personal needs.
- d. Effectively addresses the emotional needs of its residents, fellows, and faculty members in relation to catastrophic work-related events (in the course of patient care or among the members of the clinical care team).

WB Pathway 6: Clinical learning environment monitors its effectiveness at achieving the well-being of the clinical care team

The clinical learning environment:

- a. Actively monitors and assesses the effectiveness of its efforts to promote the optimal integration of work with personal needs related to self, family, friends, and community.
- b. Actively monitors and assesses the effectiveness of its efforts to eliminate harm to patients due to clinician fatigue.
- c. Actively monitors and assesses the effectiveness of its efforts to eliminate harm to patients due to clinician burnout.
- d. Actively monitors and assesses the effectiveness of its efforts to assess and provide care for those who are at risk of or demonstrating self-harm.

Professionalism (PR) – SELECTED TOPICS

The optimal clinical learning environment recognizes that attitudes, beliefs, and skills related to professionalism directly impact the quality and safety of patient care. It has mechanisms in place for reporting concerns around professionalism, periodic assessment of concerns and identification of potential vulnerabilities, and the provision of feedback and education related to resulting actions.¹³ The following pathways and properties reflect selected topics in this area.

PR Pathway 1: Education on professionalism

The clinical learning environment:

- a. Educates the clinical care team, including residents, fellows, and faculty members, on the clinical site's expectations for professional conduct in an interprofessional environment.
- b. Educates the clinical care team, including residents, fellows, and faculty members, on clinical site, regional, and national issues of professionalism (e.g., appropriate use of copyrighted material, documentation practices).

PR Pathway 2: Culture of professionalism

The clinical learning environment:

- a. Promotes a culture of professionalism that supports honesty, integrity, and respectful treatment of others.
- b. Ensures that residents and fellows follow the clinical site's policies, procedures, and professional guidelines when documenting (e.g., work hours, moonlighting, Case Log reporting).
- c. Ensures that residents, fellows, and faculty members follow the clinical site's policies, procedures, and professional guidelines when documenting in the electronic medical record—with special attention to documentation of clinical information that is based on direct assessment or appropriately attributed information.
- d. Ensures a culture of professionalism in which residents and fellows immediately report any unsafe conditions in patient care, drawing the clinical care team's attention to unsafe events in progress (e.g., "stop the line").
- e. Provides mechanisms for members of the clinical care team, including residents, fellows, and faculty members, to report concerns about professionalism without retaliation.
- f. Ensures that residents, fellows, and faculty members engage in timely, direct, and respectful communication in the development of patient care plans among primary and consulting teams.

PR Pathway 3: Conflicts of interest

The clinical learning environment:

- a. Educates residents and fellows on its conflict of interest policies and potential issues related to patient care, including the clinical site's conflicts of interest.
- b. Educates residents and fellows on how the clinical site supports residents and fellows in managing conflicts of interests that they encounter.
- c. Ensures that residents, fellows, and faculty members disclose potential conflicts of interest throughout resident and fellow education and patient care.
- d. Maintains databases on resident, fellow, and faculty member potential conflicts of interest (e.g., research funding, commercial interests) that are accessible to the clinical care team.
- e. Assesses patient safety events for issues related to resident, fellow, and faculty member conflicts of interest.

PR Pathway 4: Patient* perceptions of professional care

The clinical learning environment:

- a. Educates residents, fellows, and faculty members on how patient experience data on professionalism are used to improve patient care.
- b. Routinely provides residents, fellows, and faculty members with patient experience data on professionalism at the clinical site.

PR Pathway 5: Clinical site monitoring of professionalism

The clinical learning environment:

- a. Routinely assesses the culture of professionalism and uses that information to continuously improve the clinical site.
- b. Monitors documentation practices related to resident, fellow, and faculty member use of the electronic medical record and other sources of patient health information.
- c. Monitors for the appropriate use of copyrighted material available to the public as part of education efforts around in-service and board examinations.
- d. Monitors for accurate reporting of resident and fellow work hours.
- e. Effectively addresses reported behaviors of unprofessionalism and ensures that the clinical site is absent of chronic, persistent unprofessional behavior.

* "Patient" can include family members, caregivers, patient legal representatives, and others.

References

1. The Quality of Health Care in America. National Academy of Medicine website. <http://www.nationalacademies.org/hmd/Activities/Quality/QualityHealthCareAmerica.aspx>.
2. Institute of Medicine. *To Err Is Human*. Washington, DC: National Academies Press; 2000. doi:10.17226/9728
3. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press; 2001. doi:10.17226/10027
4. Combes J, Arespachochaga E. *Lifelong Learning Physician Competency Development*. Chicago, IL: American Hospital Association's Physician Leadership Forum; 2012.
5. Accreditation Council for Graduate Medical Education. *ACGME 2017-2018 Annual Report*. Chicago, IL: Author; 2018. <https://www.acgme.org/Portals/0/PDFs/2017-18AnnualReport.pdf>.
6. Nasca TJ, Philibert I, Brigham T, Flynn TC. The Next GME Accreditation System – rationale and benefits. *N Engl J Med*. 2012;366(11):1051–1056.
7. Weiss KB, Bagian JP, Nasca TJ. The clinical learning environment: the foundation of graduate medical education. *JAMA*. 2013;309(16):1688. doi:10.1097/JGME.0000000000000284
8. Weiss KB, Wagner R, Nasca TJ. Development, testing, and implementation of the ACGME Clinical Learning Environment Review (CLER) Program. *J Grad Med Educ*. 2013;4(3):396–398. doi:10.4300/jgme-04-03-31
9. Weiss KB, Bagian JP, Wagner R. CLER Pathways to Excellence: Expectations for an Optimal Clinical Learning Environment [executive summary]. *J Grad Med Educ*. 2014;6(3):610–611. doi:10.4300/JGME-D-14-00348.1
10. Edmondson AC. *Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy*. San Francisco, CA: Jossey-Bass; 2012.
11. Accreditation Council for Graduate Medical Education. *Common Program Requirements*. Chicago, IL; 2017. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf.
12. Dzau, VJ; Kirch, DG; Nasca TJ. To care is human—collectively confronting the clinician-burnout crisis. *N Engl J Med*. 2018;378(4):312–314.
13. American Board of Internal Medicine; ACP Foundation; European Federation of Internal Medicine. *Medical Professionalism in the New Millennium: A Physician Charter*. Philadelphia, PA; 2005.

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