Measuring the Clinical Learning Environment

Regina Russell, M.Ed. MA¹, Bill Cutrer, MD M. Ed.¹, Donald Brady, MD¹
Jesse Ehrenfeld, MD MPH¹, Betsy Kennedy, PhD RN², Kimberly Vinson, MD¹, Rebecca Swan, MD¹
Katie Houghton, M.Ed. MBA¹, Will Martinez, MD MPH¹, Cody Penrod, MD,¹ Bonnie M. Miller, MD MMHC¹
¹Vanderbilt University School of Medicine, ²Vanderbilt University School of Nursing

Ongoing Consortium projects

Master Adaptive Learner
Bill Cutrer, Martin Pusic, Larry Grupen and others are currently completing a book on aspects of the Master Adaptive Learner model. In addition, we are continuing to develop, implement and evaluate methods of deliberately teaching and applying the model in third and fourth year clinical rotations. We are also beginning to develop ideas about approaches to assessment.

Health Systems Science
Heather Ridinger represents the Foundations of Health Care Delivery team, which is continuing to refine the four-year longitudinal curricular element aimed at introducing health systems sciences to our students, including quality improvement, patient safety, interprofessional team work, health policy, and structural competence. Ongoing projects include measuring the impact of student QI projects, and determining the impact of HSS on professional identity formation, along with other consortium partners.

Compentency-based Assessment and Progress
The entire grant team continues to work on several aspects of competency-based assessment (CBA). A ‘Ready for Residency’ committee is exploring ways to analyze data from multiple sources, including milestones, EPAs, qualitative comments and standard grades, to determine readiness for post-graduate training. We have a special interest in measuring trustworthiness. We are also continuing faculty development efforts to increase confidence and reliability in use of CBA approaches.

The Interprofessional Clinical Learning Environment Report Card (I-CLERC)*

Key Domains

Improving the quality of the clinical learning environment is a major concern for all institutions and organizations involved in medical education. The LCME reaccreditation processes and ACGME's Clinical Learning Environment Review visits have pressed medical schools and sponsoring institutions to appropriately address negative experiences and promote more positive cultures for clinical learning.

In addition, overlaps exist between the characteristics of environments that are safe for learners and those that are safe for patients, such as “speaking up” culture. Finally, our clinical-learning environments are shared by multiple stakeholder groups, including medical students, nursing students, residents and fellows, faculty, staff and patients, all of whom measure their experiences with a variety of national and local surveys.

With this in mind, a group of faculty, staff, students, and residents began meeting five years ago to build a framework for measuring the clinical learning environment that would take into account multiple perspectives and create a holistic vision for positive learning environments. The group spent the first year defining the vision and determining the key domains based on a comprehensive literature review, expert opinion and educational enterprise priorities.

The core principles for measurements are to use existing data sources, prioritize sources with national or longitudinal benchmarking and those that could map to the identified domains. The second and third years were spent identifying specific items that matched each sub-domain and completing an annual survey for their students with items aligned with the AAMC Graduation Questionnaire and ACGME Annual Resident and Faculty surveys. Also, we added questions to medical school course evaluations to allow the identification of hotspots. Items about speaking up are particularly important given its centrality to improvement in all domains.

A fully populated I-CLERC has been created for the past two years and shared with leaders to identify the most critical areas of needed improvement. This year, the medical center charged a taskforce to review these reports and recommend actions to address ongoing areas of concern.

Institutional Contact

Regina Russell, M.Ed., MA : regina.russell@vanderbilt.edu
Bonnie M. Miller, MD MMHC: bonnie.m.miller@vanderbilt.edu
Bill Cutrer, MD M.Ed. : bill.cutrer@vanderbilt.edu

Grant team members

Bill Cutrer, MD M.Ed. Associate Dean for UME
Amy Fleming, MD MHPE, Associate Dean for Medical Student Affairs
Heather Ridinger, MD MHPE, Co-Director Foundations of Health Care Delivery
Anderson Spickard iii, MD MS, Assistant Dean for Education Design and Informatics
Jesse Ehrenfeld, MD MPH, Co-Director Foundations of Health Care Delivery
Mario Davidson, PhD, Assistant Professor of Biostatistics
Regina Russell, M.Ed., MA, Director Learning System Outcomes
Bonnie M. Miller, MD MMHC, Senior Associate Dean for Health Sciences Education VUSM, EVP for Educational Affairs VUMC

Need/Gap Addressed

Institutional Contact

Regina Russell, M.Ed., MA : regina.russell@vanderbilt.edu
Bonnie M. Miller, MD MMHC: bonnie.m.miller@vanderbilt.edu
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