**Annual Program Evaluation (APE) Action Plans List**

Use this template for documenting and tracking Action Plans from your Annual Program Evaluations from year-to-year. This will create a summary of improvements achieved, and a working list of areas still needing attention. This format is recommended by CU GME to facilitate your ACGME Self-Study and to prepare for your 10-year site visit. **Per ACGME V.C.1.e, these action plans must be distributed to and discussed with your program’s residents/fellows, and teaching faculty, and must be submitted to the DIO (CU GME).**

**NOTE: To mark the checkboxes, click the checkbox. To uncheck, click the checkbox again.**

**2022-2023 Action Plans**

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|  | **Issue/Area for Improvement identified in your** **2022–2023 APE** | **Issue/Area for Improvement Origin**  | **Action Plan (as designed by Program Evaluation Committee)** | **Designated Individual(s) Responsible**  | **Expected Resolution(Outcome Measurement** **& Date)** | **Current Status(Resolved, Partially Resolved,** **Not Resolved)** **To be completed in 2024** |
| 1 | **Internal Work Hours Reporting** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[x]  **Other:**  | **80-hour work week:**For the past year, we had 5 reports of residents violating the 80-hour work week. Two occurred early in the University MICU and one of those was directly related to patient care, the other occurred very early in the year and resident efficiency was noted to contribute. Two occurred at the VA and administrative burden was noted as a contributor. We continue to work with VA leadership and administration to reduce administrative burden while working at the VA. The final report occurred on CHF during a time of high volume and high intensiveness of patient care. We will be more intentional moving forward to closely monitor patient volumes on CHF and find ways to off-load intern patient volumes if work hours are threatened. Furthermore, we are developing new curriculum around efficiency with note writing, chart review and task management to improve overall resident efficiency. Part of this was incorporated into our residency basecamp – our specialized 10-day hands-on training program which we start the new academic year with. | PD, APDs, Core Faculty, CMRs | We will continue to monitor work hours on a monthly basis – both with our formal duty hour reporting as well as with our rotation evaluations, of note we have not had any reported violations since October | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year**  |
| 2 | **Internal Work Hours Reporting** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[x]  **Other:** | **Less than 8 hours off between educational experiences:**There were 3 total reports of residents receiving less than 8 hours off between clinical work. All of which occurred on the cardiology service and were reported in the fall. Since that time, adjustments to the cardiology shift hours and work schedule have been made and since these changes, we have had no further reports. We will continue to monitor this closely. | PD, APDs, Core Faculty, CMRs | We will continue to monitor work hours on a monthly basis with both the formal duty hour reporting as well as with our rotation evaluations; of note we have not had any reported violations since October when we made our adjustments | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year**  |
| 3 | **GME Performance Dashboard: ITE Performance** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[x]  **Other:** | **ITE Percentile Met Program’s Expectations** We intentionally choose a very high cutoff for our ITE percentile to identify any learners who may struggle with test taking and may be at risk for Board failure at an early stage in their residency.  We also intentionally do not tell the residents to study for this.  We approach this as a self-assessment to identify potential medical knowledge gaps.  For anyone who is below the 30th percentile, we do come up with an intensive study plan to best prepare them for taking Boards after completion of residency.   Our Board pass rate for that past two years with this approach has been 100%. | PD, APDs | After ITE scores are received, APDs will again meet with anyone with <30th percentile to determine study plan | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
| 4 | **CUSOM Housestaff Association Survey****Hesitation or** **Discomfort Contacting Attending****Superisor** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[x]  **Housestaff Assn. Survey**[ ]  **Other:** | **Hesitation/Discomfort Contacting Attending Supervisor**This feedback from the Housestaff Association Survey emphasized that this is mainly happening on our critical care rotations with the highest number of concerns from the VA MICU, the DH ICU and CICU with emphasis on overnight supervision. In terms of the VA MICU, after hearing this feedback directly from the residents, we removed our residents from participation in overnight ICU care as we agreed that our residents did not have adequate supervision or support and we felt that that situation required immediate action to ensure resident safety. At present, we have no plans to return residents to overnight shifts in the VA ICU, our residents are only present in the VA ICU during day shifts with direct attending supervision.In terms of the DH ICU and CICU, these are two rotations that do not have dedicated in-house attending coverage. Last year we attempted to formalize the process by which residents communicate with fellows (who are their direct supervisors) overnight by setting clearer expectations for both fellow and residents and also setting check in times. This year we plan to make this process even more robust with an in-person check-in every evening that the fellow is in-house, and a mandatory phone check-in when the fellow is not in-house. In addition, for the CICU there is now an in-house intensivist available for support at all times. We will work to set new expectations as to when the residents should call for this additional support. We will also start conversations with our partnering institutions regarding 24hr in-house attending coverage for these services.We also acknowledge that this feedback is coming from some of the rotations on which we have our highest number of attending microaggression reports coming from. This is likely contributing to this culture of hesitation. See action plan below for how we are addressing that. | PD, APDs, CMRs | Site APDs and CMRs will check in with residents on a monthly basis to see how this new process is working to ensure residents always feel comfortable contacting their supervisor | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year**  |
|  | **CUSOM Housestaff Association Survey****Adverse event/near miss/unsafe condition** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[x]  **Housestaff Assn. Survey**[ ]  **Other:** | **Witness or experience adverse event, near miss/close call, or unsafe condition resulting from inadequate supervision/fatigue.**Per above, we are addressing what we believe are the factors contributing to inadequate supervision by working to create a safe working environment in particular on our intensive care rotations overnight. Per below, we are changing our education to our residents how to better handle sleep deprivation and potential impact on work.We have removed all 24hr call shifts from our program as of this academic year which should significantly reduce occasions of severe fatigue and potentially unsafe working conditions. | PD, APDs, Core Faculty, CMRs | Site APDs and CMRs will check in with residents on a monthly basis to monitor for such events  | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **CUSOM Housestaff Association Survey****Jeopardy System** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[x]  **Housestaff Assn. Survey**[ ]  **Other:** | **Equity within our jeopardy system:**There were concerns raised by the residents regarding how our jeopardy system is set up and utilized in terms of use of mental health days, payback, and equity across residents.Based on the feedback, we have already implemented some changes to our jeopardy system (we have removed “back-up jeopardy” and added clarity to our jeopardy communication) but acknowledge that more work is needed, in particular as it pertains to how to make use of jeopardy system for mental health days fair. We plan to get resident input on this process as this topic has been selected to be one of our Resident Program Evaluation sessions. We will make additional changes based on that resident input. | PD, APDs, CMRs, RPEC resident leaders, administrative team | After we hold our resident-led Residency Program Evaluation Committee session we will make changes based on resident input and then will continue to monitor this monthly. | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **CUSOM Housestaff Association Survey****UCHealth****Care for the Community** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[x]  **Housestaff Assn. Survey**[ ]  **Other:** | **UCHealth’s care for underserved and underinsured patients**There were concerns raised about the way in which UCHealth approaches care for some members of the Aurora Community as well as underserved and underinsured patients in this state and region. We will continue to partner with the hospital system to advocate for increased access to healthcare in our hospital system for ALL patients. One of the ways that we intend to do this is to increase resident representation on hospital committees so that the resident voice can be more present during decision making. We also hope to start to work together with UCHealth on some community engagement projects such as the work that UCHealth is doing with Aurora Public Schools to increase interest in careers in healthcare and help mentor students through that process. We hope that through improved community engagement and partnerships with UCHealth, we can help to positively impact the community | PD, APDs, Core Faculty, CMRs, Residents | Given the complexities of this topic, we anticipate that this will be an ongoing issue for many years to come | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **CUSOM Housestaff Association Survey****Leave Policy** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[x]  **Housestaff Assn. Survey**[ ]  **Other:** | **FMLA – Maternity/paternity leave**Last year our housestaff association survey indicated a need for increased communication and transparency around our parental leave policy. This year, we provided optional information sessions around our parental leave options during our protected educational time. Program leadership participated in a working group to address parental leave at a GME level.While we did not receive any specific comments regarding our parental leave policy, we received only received a Satisfactory respond on the HSA survey therefore we will continue to work on this by including additional communication around our leave policies in our residency newsletter. In addition, we have developed a Mental Health Leave Plan. This will allow us to take a systematic approach to mental health leave as we did see an increase in the number of residents needing higher attention to their mental health. This plan includes ensuring immediate connection to mental health providers, and providing residents with different options regarding leave time. | PD, APDs, administrative team | We will continue to see feedback from every resident who seeks leave from the program to learn ways in which we can improve our process. | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
| 5 | **IMRP Resident Evaluation Survey** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[x]  **Other:** | **The following were items that were identified on our internal IMRP Resident Survey*** Compensation (salary, retirement match, funding for research, stipend for phones, etc): While compensation is not under the control of the residency program, we do hope to partner in meaningful ways with the new DIO and Housestaff Association leaders in order to continue to advocate for change in compensation. We have encouraged our residents to seek representation on the Housestaff Association so that our residents can be involved in those conversations.
* Advocacy at the GME/Institutional Level: It was recently announced that current DIO, Dr. Rumack, will be stepping down. We intend to work with the new DIO to ensure that we are aligned in the ways in which we advocate for all residents on this campus, including our own.
* Microaggressions and Harassment: see below for action plan, this a major focus area for the residency program
* Schedule (lack of control, ability to personalize): We acknowledge that residency can be a challenging time due to lack of control over schedules. Every year we attempt to increase the ways in which we can give residents agency and control over certain aspects of their schedules. It is a long-term goal for the program to allow further individualization of schedules to match career plans. In this next academic year we hope to increase resident presence on subspecialty services as we feel that this is the largest gap in terms of personalization for fellowship-bound residents.
* Curriculum (women's health, care for LGBTQIA+): Women’s health will be an area of focus for the curriculum committee and we will work to ensure a more robust representation of women’s health topics and LGBTQIA topics in our formal curriculum. We are also working with each continuity clinic site to ensure adequate clinical training in and exposure to women’s health and LGBTQIA+ care.
* Fix Jeopardy: see above, we have a plan in place to make adjustments to our jeopardy system based on resident feedback and guidance
 | PD, APDs, CMRs, administrative team | Some of these issues will like be ongoing for years as they are not within our direct control and are very complex issues but we will continue to monitor our progress towards change every year | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
| 6 | **IMRP Faculty Evaluation Survey** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[x]  **Other:** | **On our internal IMRP faculty survey we asked faculty members was that we could make them more satisfied with the ways in which they are evaluated as educators. We received feedback that their interactions with residents are too brief, the evaluations are too short and are often delays and they often times don’t receive anything at all or the feedback is so delayed that they cannot make change.**Adding more structure to our entire evaluation process is a primary focus for the program from this coming academic year. As part of this focus, we are creating timelines and systems to ensure evaluations are both being sent in a timely manner, received, and then distributed back to faculty. We will provide the feedback to service line directors regarding the desire for longer periods of time that faculty work with residents as we agree that in most cases, this is too brief. We will continue to make adjustments to our evaluations to focus on comments rather than radio buttons. | PD, APDs, administrative team | Because of the complexity of creating an ideal faculty evaluation system with many factors that are external to our program, we suspect that this will be an ongoing process | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
| 7 | **Evaluation System, Timely Completion** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[x]  **Other:** | **Evaluations: Resident evaluations must be completed by Faculty in MedHub after each rotation (at least quarterly for rotations > 3 months). Resident Evaluations must be completed in MedHub within 2 weeks.**Per above, adding more structure to our entire evaluation process is a primary focus for the program. In terms of timely completion of evaluations by faculty members, we have done a lot of work in recent years to simplify the evaluations the faculty are completing and ensure optimal timing of delivery. We send out multiple reminders to faculty members to encourage timely completion. Because we remain below our goal despite these efforts, we are moving towards including timely completion of evaluations as part of faculty PRISM reviews to more strongly encourage timely completion and emphasize to faculty members the importance of timely completion. We also hope to partner with Division and Department leadership to work towards using evaluation completion as one of the measures by which it is decided which faculty should attend on teaching services. | PD, APDs, administrative team | We continue to monitor evaluation completion by faculty members every 2 weeks. We hope that by this coming end of calendar year, we will have a process by which we will include timely completion rate in faculty Prism reviews for 2024 | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
| … | **ACGME Survey****Hand-Off Process** | [x]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[ ]  **Other:** | **Previous: Information not lost during shift changes, patients transfers, or the hand-off process**We acknowledge that residents may interpret this question in a number of different ways including outside hospital transfers, internal hospital transfers between services and hand-offs at shift change. We do hope to better understand from the residents where they feel the biggest issues are in terms of information being lost so that we can better direct our interventions. Regardless, unfortunately this has been noted as an issue on our ACGME survey in the past as well. Until we gather more information we will focus our efforts on hand-offs at shift changes as we suspect that that is the biggest concern for our residents. We have already instituted a handoff curriculum and have added structure to our handoff process at each hospital site. We feel that two of the main components of our current system that are missing are consistent supervision of the process and mechanism for consistent feedback. We have asked each site director and chief resident to present current state of the hand off process for each service line at our September Program Evaluation Committee and present recommendations to improve supervision and feedback on this progress on a regular basis. From there, we hope to enact change.In terms of outside hospital transfers, we are working to get all our residents access to CORHIO which will allow our residents to access health information from external healthcare systems. | PD, Site APD and CMR, resident leads | By October we hope to have a new system in place at each hospital site to ensure both regular supervision and process by which residents will consistent feedback on this process. | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **ACGME Survey****Sleep Deprivation Survey** | [x]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[ ]  **Other:** | **Instruction on minimizing effects of sleep deprivation** While we do have all residents complete a module regarding sleep deprivation, it is clear that this is not sufficient. We believe that the sleep module (and most sleep deprivation education for residents) has focused on the impact of 24-hr call on fatigue. However our residents experience a very different impact on sleep cycles from longer periods of long day or nights shifts in a row. This year we plan to add additional education to our Wednesday didactic series regarding the impact of this different sleep deprivation and ways to address this.We plan to add reminders about using Lyft and Uber services when residents are too fatigued to drive and then residency will reimburse for this. We also plan to add reminders about where call rooms are located at each of our hospital sites. We will add this to all our inpatient rotation orientations as well as to the Housestaff Meeting. | PD, APD | We plan to increase messaging immediately regarding call rooms and ride servicesWe hope to have a new sleep deprivation module ready by February | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **ACGME Survey** **Admitting Volumes** | [x]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[ ]  **Other:** | **Intern patient admitting volumes:**Admitting more than 5 new patients plus 2 transfers in 24 hoursAdmitting more than 8 new patients in 48 hoursResponsible for the ongoing care of more than 10 patientsThese should be never events. We have asked each site APD and CMR to review admitting processes and algorithms to ensure that this is not inadvertently happening. We will increase efforts to get feedback from interns every month to determine if there are reasons this is happening without our knowledge and to understand what is causing these events.We do suspect that some interns are not aware that patients that they pick up in the morning from overnight admissions do NOT count as a new patient. We will provide the interns with clarity regarding this rule. | PD, APDs, CMRs | We have already asked each core clinical site to review their admitting processes and will monitor this monthly | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **ACGME Survey** **Admitting Volumes** | [x]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[ ]  **Other:** | **Resident patient admitting volumes:**If supervising more than one intern, how often responsible for more than 10 patients plus 4 transfers in 24 hours.  If supervising one intern, how often are you responsible for ongoing care of more than 14 patients. If you are supervising more than one R1, how often are you responsible for the supervision or admission of more than 16 new patients in 48 hours (excluding night float)? If you are supervising more than one R1, how often are you responsible for the ongoing care of more than 20 patients (excluding night and other cross-coverage situations)? These should be never events. We have asked each site APD and CMR to review admitting processes and algorithms to ensure that this is not inadvertently happening. We will increase efforts to get feedback from residents every month to determine if there are reasons this is happening without our knowledge and to understand what is causing these events.Again we do suspect that some residents may not be aware that overnight admissions that are picked up in the morning do not count towards new patient numbers. We will work to clarify this with the residents. | PD, APDs, CMRs |  | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **Noted on multiple surveys****Microaggressions and Harassments** | [x]  **ACGME Resident Survey**[x]  **ACGME Faculty Survey**[x]  **Housestaff Assn. Survey**[ ]  **Other:** | **Residents experiencing abuse, harassment, mistreatment, discrimination or coercion**This was one of our main focus areas for the program this past year. In response to ongoing reports that our residents continue to experience and witness microaggressions and harassment, we took a systematic approach to addressing this. In terms of reporting such events, we now have multiple avenues by which residents can report events to the program including an anonymous reporting portal, having resident and faculty confidential liaisons, and we added a question to each of our rotation evaluations asking if residents had experienced or witnessed such events during the rotation. This has led to a significant increase in the number of events reported which we feel is more representative of what is actually happening. In order to address these behaviors, we have significantly increased efforts at the faculty level to increase the number of our faculty who have undergone upstander training and are moving towards making this a requirement to be a teaching faculty member. All our residents receive upstander training. We now have identified the official reporting structures for unprofessional behavior in each our of hospital systems so that we can work with our hospital partners to address behaviors coming from hospital staff. We are regularly meeting with nursing leadership at Denver Health as nurse-resident interactions is one of our top priority focus areas. We have engaged Division leadership and the Office of Professionalism to address ongoing unprofessional behaviors from attendings. We share data regarding microaggression/harassment reports and ongoing efforts to address these events at both our in-person monthly resident meetings as well as in our monthly resident newsletter. This will continue to be one of our main areas of focus moving forward. We have a committee of residents, faculty and program leadership that meet monthly to continue work on this topic. | PD, APDs, core faculty, CMRs, residents | Our microaggressions and Harassment Working Group will continue to meet on a monthly basis to review all microaggressions and harassments reports for the past block and to review site-specific initiatives to continue to address these | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **Residency Internal Program Survey, Housestaff Association Survey****DEI** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[x]  **Other:** | **Diversity, Equity, and Inclusion**Our Diversity, Equity and Inclusion task force continues to meet on a monthly basis to discuss ways in which we can continue to recruit, retain, and create safe learning environments for residents of diverse backgrounds. As part of this, our DEI APD Dr. Farajpour Bakhitiari will be organizing regular dinners welcoming trainees and faculty members from diverse backgrounds to share their experiences and make connections. Each dinner will have a different area of focus but all residents and faculty will be welcome to all events. We hope to work with Co-WIP (a state-funded program at DH that will work to help IMGs enter residency). We will continue to partner local and national minority organizations This year, our residency program leadership team will do a special training session in order to achieve individual Foundations in Equity Certificates which is being offered by the campus’s Health Equity in Action Lab. This training will focus on implicit bias, microaggressions and allyship, the myth of meritocracy and holistic review. We are also having our residents engage in additional DEI training through a new and innovative curriculum that involves DEI-focused simulation cases and allows interprofessional teams of healthcare professionals and learners to gain skills, knowledge, and comfort in improving trust and communication with marginalized and minoritized patients. The goal of this curriculum is to impact attitudes related to bias, stereotypes, and racism in medicine. | PD, APDs, core faculty, CMRs, residents | Our DEI working group will continue to meet on a monthly basis to ensure that we continue to progress with our goals.We know that efforts towards ensuring a truly diverse, equitable and inclusive training environment will forever be ongoing | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **Residency Internal Program Survey****Housestaff Association Survey****Resident Wellness** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[x]  **Housestaff Assn. Survey**[x]  **Other:** | **Resident Wellness** In the past year, we expanded access to a specialized physician coaching program to include all residents in our program. This year we are increasing the content offerings in our “More than Medicine” curriculum in the intern year which will include sessions on defining values, processing emotions, pride and strengths, and forming healthy habits.We are continuing our highly successful PCP and mental health appointment programs through which we ensure that each intern gets set up with a primary care doctor during the first couple of months of residency in order to ensure access to healthcare during training. We also offer all interns an opt-out mental health appointment during the middle of the first year of training to encourage engagement with mental health resources. We have ongoing partnerships with the Resident Student Mental Health clinic on campus as well as Willow Grove, an external mental health practice to further support residents in need of mental health resources and support. | PD, APDs, core faculty, CMRs, residents | Our APD focused on Wellness, Dr. Mann will continue to meet with resident wellness representatives on a regular basis.We know that efforts towards ensuring resident wellness will likely be necessary for many years to decades therefore we will continue this work for the foreseeable future | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **Program Identified****Community****Engagement** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[x]  **Other:** | **Community Engagement**We are actively working on a plan to enhance resident involvement with community engagement opportunities. Our plan is to have each resident participate in a longitudinal community engagement project with a community partner as part of their residency training. We have identified refugee health and housing insecurity as areas of focus for our community partners. We intend to make these community engagement partnerships based on continuity clinic site. The goal for this academic year is to build the community engagement curriculum that will be delivered in the intern year and to set up partnerships such that upper levels can start to actively engage in the next academic year | PD, APDs, core faculty, CMRs, residents | Our Community Engagement working group will continue to meet on a monthly basis to ensure that we continue to progress with our goals.We anticipate that it will take approximately 3 years to get our community engagement program fully functional | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **ACGME Survey****Time with patients** | [x]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[ ]  **Other:** | **Time to Interact with Patients**This was a new finding on our ACGME survey but we are not surprised by this finding. We suspect that there are many complex contributors to this. We suspect that efficiency with note writing, inefficiencies in our healthcare systems, pressure to see more patients, and increased availability of copious medical records are all contributors in addition to many more. This year, we plan to start to address this in the following ways:1. We have already added a question on our rotation evaluations to inquire whether or not residents had adequate time to interact with patients on that rotation. This will help us to better understand the rotations/clinical environments in which limited time with patients is most pronounced. We will use this information to target future interventions on the most significant outliers.
2. We do think that inefficiencies with note writing and chart review do contribute to this. Therefore we will work to develop a more intentional curriculum to each interns and residents how to be more succinct, efficient and targeted with note writing and chart review. We are also hoping that in the future, we will able to leverage advancements in artificial intelligence to reduce some of the administrative burden of documentation.
3. We suspect that because of the increasing pressures in healthcare to be efficient (and also with the threat of duty hour violations) we worry that previous messaging may have deterred trainees from spending additional time with patients when able. We will change some of our messaging during rotations to encourage residents to optimize their time to allow them to spend maximal amounts of time with patients, especially during key transitions in their health (for example at the time of hospital discharge).
 | PD, APDs, CMRs | We have already added this question to our rotation evaluations. In 2 months we will start to look at data from this question to better understand the rotations on which this is most prominent.We hope to have a more intentional curriculum developed and delivered during our Wednesday educational sessions in the next 6 months. | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **ACGME Survey and Housestaff Association Survey****Time for appointments** | [x]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[x]  **Housestaff Assn. Survey**[ ]  **Other:** | **Time to attend personal appointments**While we do already provide protected time every week for residents to attend personal appointments during each clinic block, we do understand that there are limitations to use of that time that we are trying to better understand. Based on some of the feedback that we have received, we believe that the biggest barrier to residents taking time to attend personal appointments is a culture of not wanting to ask for help or being uncomfortable asking for coverage/help. We plan to send clearer message to the residents in a variety of ways in order to strongly encourage residents to take time for appointments when they need to. We will add this messaging to our rotation orientations, to our monthly Housestaff Meetings and we will be intentional about including conversations around this in our More than Medicine Curriculum. We have already modified our Program policy regarding time for personal appointments to more clearly encourage residents to take time for appointments related to their health and wellbeing.We do think that unavailability of the necessary medical appointments during the available time is likely another contributor. | PD, APDs, CMRs | We plan to improve our messaging around this starting in September and will informally monitor this on a monthly basis based on feedback to CMRs | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **ACGME Survey****Interprofessional Teamwork** | [x]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[ ]  **Other:** | **Interprofessional teamwork skills modeled or taught**As part of an effort to begin to better understand and then address this issue, we recently named our first core faculty member who is not a physician. Nurse practitioner Anna Drum Oden who is a critical member of the VA Continuity Clinic leadership team has agreed to be a core faculty member, member of our clinical competency committee, and help guide the program on this specific issue.Upon review of this issue at our Annual Program Evaluation, we have realized that while we do have a fair number of required rotations in which our residents routinely work with APPs (including CHF, hepatology, BMT, DH ICU, HTT), we have not previously included any specific curriculum or education on how to best work together with APPs. We plan to add this to the curriculum and educational series during these rotations.We also suspect that our residents do not always recognize the different clinical environments in which they are working in interprofessional teams such as continuity clinic. We will be more intentional in our continuity clinics to emphasize the interprofessional nature of clinic and also add education around ways to optimize the interprofessional team.  | PD, APDs, CMRs | We have already started to work on developing a curriculum around interprofessional teams and will work over the following year to consistently message on this topic | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **ACGME Survey****Feedback from faculty members** | [x]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[x]  **Other:** | **Satisfied with faculty members' feedback**We suspect that the main driver for this finding is that the residents are not receiving completed evaluations in MedHub in a timely manner a significant portion of the time. This is a focus are for the program per above. We believe that this measure will improve if we can increase the percentage of timely completion of faculty evaluations. However we also acknowledge that this issue is likely complex with many contributing factors. We have seen a significant increase in the numbers of teaching faculty across the Department which in many cases means limited teaching opportunities per faculty member. We currently are limited in the ways in which we can provide faculty members who have been noted to be the most effective educations additional teaching time. Moving forward we have started to work with Division and Departmental leadership to identify ways in which we can work towards smaller numbers of teaching faculty members. We then hope to provide faculty development and additional resources to those teaching faculty so that they can be highly effective in their roles as educators and providing feedback to residents. | PD, APDs, Administrative Team | We continue to monitor evaluation completion by faculty members every 2 weeks. We hope that by this coming end of calendar year, we will have a process by which we will include timely completion rate in faculty Prism reviews for 2024 | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **ACGME Survey****Unprofessional Faculty Behavior** | [ ]  **ACGME Resident Survey**[x]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[ ]  **Other:** | **Faculty members act unprofessionally**We believe that this feedback is in line with and relates to the reports of residents experiencing and witnessing microaggressions and harassment. We know based on data from our reporting systems that many of these behaviors do come from faculty members. We have been working to develop a process to address these behaviors. Moving forward, any faculty member who acts unprofessionally will be asked to meet with the program director. If further events occur, the program will then involve Division Leadership, then the Office of Professionalism and then the Chair the Department if the behaviors continue, with an escalation of reporting with each event. | PD, APDs | Our microaggressions and Harassment Working Group will continue to meet on a monthly basis to review all microaggressions and harassments reports for the past block and will quickly escalate any concerns per our new process | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **Self Identified****Program Resources** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[x]  **Other:** | **Are sufficient resources in place to enhance the program’s ability to provide required expertise and educational experiences?**The increasing complexities of Graduate Medical Education and the complexities of our healthcare systems has put significant stressors and additional work load on both our administrative staff and our faculty/program leadership. In order to continue the high quality, innovative educational experiences the program will need both additional administrative support as well as increased protected time for faculty and program leadership. We will continue to work with the department and hospital systems to advocate for additional support.  | **PD, APDs** | **We anticipate that this will be an going process for many years** | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |
|  | **Self Identified****Program/Funding Resources** | [ ]  **ACGME Resident Survey**[ ]  **ACGME Faculty Survey**[ ]  **Housestaff Assn. Survey**[ ]  **Other:** | **Are sufficient resources in place to enhance the program’s ability to provide innovative educational curriculum and achieve our goal to increase resident engagement in the communities we serve?**With our current funding for administrative support as well as the lack of funding provided to allow for educational experiences external to our core clinical sites, we believe that we will not be able to provide our residents with the experience with community engagement that we believe that they need in order to be leaders in their community. We hope to work with our hospital partners to increase support for external experiences. We also hope to add additional administrative support so that we can continue to innovate in terms of our curriculum. | **PD, APDs** | **We anticipate that this will be an going process for many years** | [ ]  **Resolved**[ ]  **Partly Resolved**[ ]  **Carry over to following year** |