**AAnnual Program Evaluation (APE) Action Plans and Follow-Up Template**

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.**

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|  | **Areas for Improvement identified in your** **2019–2020 APE** | **Action Plans (as designed by Program Evaluation Committee)** | Designated Individual Responsible  | **Expected Resolution(Outcome Measurement** **& Date)** | **Current Status(Resolved, Partially Resolved,** **Not Resolved)** **To be completed in 2021**  |
| 1 | **“Inpatient Medicine” section of the 2019 Resident Survey****We focused on items that had gotten worse since 2018 or >5% of residents answered unfavorably** | Overall Action Plan* Survey residents to better understand rotations that are still contributing to unfavorably responses (this was completed in July of 2020)
* Have in-person feedback sessions with residents to better understand rotations that are contributing to unfavorable responses (this was completed on July 22, 2020 and August 19, 2020)
* Have Chief Residents check daily census reports to closely monitor patient volumes, individual team census
* Create anonymous reporting portal on resident website to allow anonymous concerns regarding any problem areas including violation of patient volume rules
* Improve communication regarding changes already implemented or any future changes
 | PD, APDs, CMRs, Core Faculty |  | **Resolved** |
| 2 | **Item of AFI** | **Do supervising residents ever admit more >10 new pts in 24 hrs? 53% (2018) 🡪 55.9% (2019) 🡪 20.9% (2020)** - Gathered data that suggested that major offenders were DH ICU, U ICU, cardiology - Implemented modified drip system on all these rotations - Increased engagement of advanced practice providers when possible to off-load teaching services - Removed 24-hour call from U ICU, U wardsMost recent data suggests significant improvement although we will continue to monitor this very closely. | PD, APDs, CMRs, Core Faculty | Daily census will be tracked by Chief Residents each rotation and we will continue to get monthly feedback from the residents.October, 2020 | **Resolved** |
| 3 | **Item of AFI** | **Do supervising residents ever admit more than sixteen patients in 48 hours? (except during night float rotations) 9.3% (2018) 🡪 20% (2019) 🡪 3.7% (2020)**We suspect that this was occurring prior to the drip system changes on very heavy call nights or on services with rapid turnover prior to more strict cap guidelines. We also learned during one of our feedback sessions that some residents were interpreting this question to include patients handed off on the morning who were admitted overnight as well as new admissions. We clarified this with the residents and will provide increased communication regarding the intent of the question. Fortunately, this issue has significantly improved in our 2020 survey and resident feedback has been that this is no longer an issue. However, we will continue to monitor closely for a recurrence of this problem.  | PD, APDs, CMRs, Core Faculty | Daily census will be tracked by Chief Residents each rotation and we will continue to get monthly feedback from the residents.October, 2020 | **Resolved** |
| 4 | **Item of AFI** | **Does the supervising resident with one R1 ever have responsibility for the care of more than fourteen patients (excluding night and other cross-coverage situations)?** 18.5% (2018) 🡪 15.9% (2019) 🡪 11.2% (2020) - Based on survey data, this is most often an issue in ICUs, cardiology - Modified drip systems should significantly improve this (as is indicated by our 2020 data)  - Removal of UCH wards and UCH ICU 24-hour call should also prevent this from happening on those rotations moving forward- Feedback from resident sessions is that this issue is no longer happening following the modified drip implementation | PD, APDs, CMRs, Core Faculty | Daily census will be tracked by Chief Residents each rotation and we will continue to get monthly feedback from the residents.October, 2020 | **Resolved** |
| 5 | **Item of AFI** | **Do first-year residents ever have primary responsibility for the on-going care of more than ten patients (excluding night and other cross-coverage situations)?** 12.6% (2018) 🡪 10.4% (2019) 🡪 14.9 (2020) - Based on survey data and resident input, this is likely multifactorial and happening on high volume and rapid turnover services (U wards, DH wards, CCU) and also our rotations that previously included 24-hour callFor our high volume, rapid turnover services - This is an issue when the resident has a day off and there are more than 10 patients on the service. While we have clear expectations that during these circumstances, the attendings should take complete ownership for any patients above 10. However we need to reinforce this expectation and perform routine monitoring to ensure this is being adhered to. In addition, we will increase communication with nurses regarding this rule to ensure that on days off, nurses are going to the attending for questions regarding patients they are managing rather than the intern. - We will ensure that any attending that has any afternoon responsibilities still maintains ownership for any patients above 10 for team census on resident days off. - For CCU, this was happening when the post-call intern had more than 10 patients, their primary resident was off, and the buddy resident was not helping sufficiently to off-load the intern. We have already revised expectations with regards to the buddy role and will improve communication regarding that role. Since chief residents will be doing daily team census checks, any day that the post-call intern is solo and has more than 10 patients, the chief resident will do a check-in to ensure that the buddy role is functioning properly to offload the internIn terms of rotations with 24-hr call - for 2020-2021, we removed 24-hour call from our U ICU and U wards rotation - We instituted modified drip systems in our ICUs and cardiology rotation  | PD, APDs, CMRs, Core Faculty | Daily census will be tracked by Chief Residents each rotation and we will continue to get monthly feedback from the residents.October, 2020 | **Resolved** |
| 6 | **Item of AFI** | **Do first-year residents ever admit more than eight new patients in 48 hours (except during night float rotations)? 2.0% (2018) 🡪 6.4% (2019) 🡪 0.7% (2020)**We were very pleased to see improvement in this question on the 2020 survey. Again, we learned during one of our feedback sessions that some residents were interpreting this question to include patients handed off on the morning who were admitted overnight as well as new admissions. We clarified this with the residents and will provide increased communication regarding the intent of the question. However we do fear that this could still be on issue on services with rapid turnover therefore we will continue to closely monitor daily team census to ensure that this does not occur.   | PD, APDs, CMRs, Core Faculty | Daily census will be tracked by Chief Residents each rotation and we will continue to get monthly feedback from the residents.October, 2020 | **Resolved** |
| 7 | **Item of AFI** | **Do residents write all the orders for patients on the teaching service?****3.9% (2018) 🡪 4.2% (2019) 🡪 8.2% (2020)**Based on survey data and resident meetings, this was mainly occurring on two rotations: Presbyterian St. Luke’s (PSL) as well as our Congestive Heart Failure (CHF) service at University. Based on resident feedback, this was also rarely happening on University wards with surgery and ob/gyn occasionally writing orders on patients who were being followed by those services.In terns of PSL, we successfully transitioned our residency program out of PSL in July of 2020 therefore this will no longer be an issue.With regards to CHF, this has already been identified as a rotation that needs significant modification. This will be the focus of the first Resident Program Evaluation Committee (RPEC). Based on the outcome of the RPEC, we will work with the cardiology department to improve the rotation to minimize instances in which the Nurse Practitioners on the service write orders on patients being managed by interns.With regards to University wards, we will increase communication with ortho and ob/gyn service lines with regards to NOT writing orders on patients on the internal medicine service.We will continue to monitor this closely this year to ensure improvement with regular check-ins with the CMRs. | PD, APDs, CMRs, Core Faculty | We request feedback from residents on CHF and U Wards during each rotation.We will ask for feedback from the residents every month as to whether or not there are any other rotations on which this is happening.January, 2021 (following RPEC and time to implement changes) | **Resolved** |
| Non-AFI Action Plans from 2019-2020 - Resolved |
| 1 | **Continuation of Previous Actions Plans from GME Survey** | **Satisfied with faculty members’ feedback**This was a problem identified on last year’s survey as well. Response here is same as above.While we do feel that we made significant improvements to our feedback system this year, there is work that remains to be done. In addition, the revision of our evaluation process was not complete until Spring of 2020 therefore we do not feel that the most recent survey fully reflected our changes. We surveyed the residents to better understand the main drivers to this response and based on that data, we understand that getting timely in-person and written feedback is the main driver. * We revised all our rotation evaluations to more accurately reflect skill sets demonstrated on particular rotations and also made the evaluations more concise and user friendly so that they would be easier to complete
* We developed a new delivery system to ensure a more coordinated and accurate delivery for rotations across the program
* We have a new tracking system to closely monitor completion rate and have a system by which faculty with overdue evaluations will be contacted repeatedly until evaluations are completed
* We will continue to emphasize the importance of in-person timely feedback in addition to written feedback

**Update: We had an 80% program compliance rate for the 2020-2021 GME survey which was above the national average of 76%** | PD, APDs, CMRs, Core Faculty | We will continue to closely monitor our MedHub evaluation completions after each 4 week rotation We hope to get our return to above 80% by end of October of 2020 | **Resolved** |
| 2 |  | **Time to Interact with Patients**We plan to survey the residents and meet with them in person to better understand the main factors contributing to this response. We suspect that this is coming from increasing pressure from hospitals for early discharges as well as overall work compression due to duty hours, shift work, and increasing complexity of healthcare systems. We suspect that increasing time spent in front of the computer rather then in patient rooms is contributing. We also wonder about the impact of COVID on this given that on many of our inpatient services, only a single member of the team would directly interact with patients in order to preserve PPE and minimize risk. It is also possible that the shift to mostly virtual visit structures in the ambulatory setting impacted this given a decreased sense of connectedness to patients in the virtual setting. Finally, we suspect that the constant pressure to multi-task detracts from direct patient experience (ie writing orders, answering pages), etc. In addition to gathering more information about drivers for this issue by surveying our residents, we plan to:* Work with the hospitals regarding discharge planning to ensure that residents have sufficient support to be able to see patients and facilitate timely discharges
* Advocate for additional resources to help with care coordination such that residents can spend more time with direct patient care
* Ensure that patient work loads can be appropriately completed within scheduled duty hours
* We have already changed policy on our main inpatient COVID service such that residents will now be directly interacting with the patients
* We are transitioning back to predominantly in-person visits in most of our ambulatory care settings
* Increase awareness of residents and faculty regarding being present while with patients and work on ways to minimize distractions
* We will continue to monitor this throughout the year with regular check-ins with the residents

**Update: We had an 87% program compliance rate for the 2020-2021 GME survey which was on par for the national compliance rate of 89%** | PD, APDs, CMRs, Core Faculty | We will get monthly feedback from the residents regarding this issue.We hope to see improvements to this measure by January 2021 based on planned interventions. | **Resolved** |
| 3 |  | **Instruction on minimizing effects of sleep deprivation**While all our residents are required to take an on-line module reviewing sleep deprivation and fatigue awareness, these results indicate that we need to do additional training in this area. We plan to modify our on-line module to include a follow-up quiz to increase retention. Since our current method for delivery of this content is via an on-line module, we plan to add live instruction and guidance regarding sleep deprivation management during our Wednesday morning educational sessions.**Update: We had an 89% program compliance rate for the 2020-2021 GME survey which was above the national average of 85%** | PD, APDs, CMRs | We will survey the residents regarding this issue to ensure appropriate instruction.We hope to have resolution by January 2021 | **Resolved** |
| 4 |  | **Less than 14 hours free after 24 hour of work**While this should have been a never event based on the ways in which time off is scheduled post-call, for this upcoming year we have already removed 24hour call completely from two of the three remaining rotations that had 24-hour call. The DH ICU will be the only rotation remaining moving forward with 24-hour call. We will review this schedule to ensure that residents always have 14 hours off after their 24-hour call days. | PD, APDs, Core Faculty | We will have CMRs and site APDs review this on a monthly basis for all our inpatient rotations.We hope to have resolution by September, 2020 | **Resolved** |
| 5 |  | **Four or more days free in 28 days**We have intentionally created schedules for all our inpatient rotations to ensure at least four days free in 28 days. Based on this result, we will re-review all our inpatient ward schedules to ensure four days off in 28. In addition, in the past we counted the 24-hours free after residents transition off nights and onto days as a day off. Based on feedback from residents that this did not feel like a day off despite it being 24 hours, we will not count any of these night-to-day transition days as a day off.A review of our duty hours reporting for the past year revealed two potential violations of this rule. In the first case, the resident was counting 4 weeks that spanned two different rotations (the final two weeks of one rotation and the initial two weeks of the next rotation). The resident did indeed have 4 days off for the first rotation and 4 days off during the second rotation. In the second case, a resident did not count a 36-hour time period that she had off as a day off as it occurred following a night shift as she transitioned to a swing shift.We will continue to work on education and terminology regarding the days off rules. | PD, APDs, Core Faculty | We will have CMRs and site APDs review this on a monthly basis for all our inpatient rotations.We hope to have resolution by September, 2020 | **Resolved** |
| **Action Plans for Items Identified in 2019-2020 and Still Ongoing** |
| 1 |  | **80 hour work week**Old action plan: While we intentionally schedule all our rotations such that the total expected hours per week is well below 80 hours to ensure some flexibility should patient care take longer than anticipated, given the result of this recent survey, we will re-review all our scheduled shifts and identify places that are potentially at threat for a 80 hour work week violation. We will also continue to closely monitor our duty hour reports.A review of our duty hours reports for the past year indicate that 80-hour work violations occurred on DH ICU, U ICU, U Wards and PSL.* For U ICU and U wards, we removed 24hour call from these rotations completely. This should significantly reduce any chance of violating an 80-hour work week.
* For PSL, the residency transitioned out of this training site in July therefore this will not be an issue moving forward.
* For DH ICU, we believe that the new modified drip system should significantly reduce any chance for violation of the 80-hour work week. In addition, we have been in communication with leadership at Denver Health regarding increased patient volumes in the ICU which then can potentially lead to duty hour violations. The current plan to address this involves a multi-faceted approach including:
* Implement ICU divert when patient volumes hit a critical level (this is already happening)
* Move forward with hiring additional faculty members in the ICU
* Move forward with hiring additional APPs to staff non-teaching service
* Create non-teaching cardiology service

See below for updated action plan | PD, APDs, Core Faculty | We will continue to closely monitor our duty hours on a monthly basisWe hope to have resolution by December 2020 | **Partially Resolved****See new action plan below** |
| 2 | **Action Plan from 2018-2019 GME Performance Dashboard**  | **ITE Percentile Met Program’s Expectations** Old action plan: 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.  Of note, we 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.   Of note, our most recent Board pass rate was 100%. See below for updated action plan. | PD, APDs, Core Faculty  | We will continue to come up with an intensive study plan for anyone below the 30th percentile on the ITE  | **To be completed in 2021, Not Resolved** See Action Plan Below |
| 3 | **Formal Systematic Evaluation of the Curriculum**  | **G&Os:  The Program must ensure that specific competency-based Goals and Objectives for each educational experience (or rotation) designed to promote progress on a trajectory to autonomous practice, are available to residents & faculty.** Old action plan: Every year we request updated goals and objectives for every single educational experience however unfortunately there are some rotations for which we do not receive updated goals and objectives.  This year, the program director will be personally in charge of contacting rotation directors to ensure that this is completed.  If this cannot be completed by the rotation director then the program director will create goals and objectives in line with the educational experience for the rotation. See below for updated action plan | PD, APDs, Core Faculty, CMRs | We hope to have updated Goals and Objectives for each rotation by December of 2020  | **To be completed in 2021, Not Resolved** See Action Plan Below |
| 4 | **Program Quality** | **Based upon results of the Resident and Faculty written Evaluations of the Program sent out by the program, were any issues identified that require modification to the program?** In terms of the resident survey: * Anonymous Reporting: Many residents felt that there could be improved mechanisms to deliver anonymous feedback to the program.  Given this feedback, we have already started the process to add an anonymous reporting function to our residency program website and will be selecting Confidential Resident Liaisons for each residency class to facilitate communication.
* Increased transparency: Residents requested increased transparency when schedule changes occur (which was common during Stage 3 of the COVID pandemic).  Whenever we make a schedule change moving forward we will attempt to ensure an explanation is provided and will attempt to improve communication regarding residency wide rotational changes.
* 24-hour call: Many residents indicated that they would prefer to no longer have any 24-hour call experiences.  Given this feedback and after significant consideration of the benefits and risks of 24-hour call, we have removed 24-hour call from both our U MICU and U wards experiences.
* Curriculum: Residents noted that clarity could be provided in terms of the longitudinal educational goals for our Wednesday educational sessions curriculum.  It was also noted that there is some redundancy in terms of the content.  We plan to provide a more intentional big picture view of goals and objections for our Wednesday morning sessions and also will continue to work to ensure that there is no redundancy in the curriculum that is not intentional.

 In terms of the faculty survey: * Improved Communication and alternate forms of communication: Feedback from faculty members was that we could improve communication regarding happenings and changes within the program.  We plan to send more frequent program updates to faculty members and will also include short educational pearls in an attempt to provide a small amount of faculty development.
* Increased Independence: Some of our faculty noted that we could improve independence and patient ownership for our residents.  These are two very important skills in our opinion and we will continue to work on structural and educational changes that will hopefully promote independence, early autonomy, and patient ownership.
* Career development: While we feel that with the transition to 4+4 we made significant improvements in terms of opportunities for early career development, we will continue efforts to ensure that each resident has opportunities for early career exploration and sufficient mentorship/access to appropriate educational opportunities once career choice is determined no matter what choice that is.
 | PD, APDs, Core Faculty, CMRs |  | **To be completed in 2021, Not Resolved** See Action Plan Below |
| 5 |  | **Resident Evaluations must be completed in MedHub within 2 weeks**Previous action plan: This past year we revised all our rotation evaluations to make them easier to complete. We have a new delivery plan in place to ensure more appropriate timing for release of evaluations and more accurate matching of evaluation to responsible faculty member. We also have a new monitoring system in place to closely track incomplete evaluations and send frequent reminders to faculty members with outstanding evaluations until these are complete.Unfortunately due to the pandemic we do not have data for faculty evaluation completion rates for the third and fourth quarter of last year but once we have new data, we will continue to modify our plan with rapid changes until achieve 80% completion at 2 weeks.See below for updated action plan | PD, APDs, Core Faculty, CMRs | We will continue to closely monitor our MedHub evaluation completions on a monthly basis We hope to get our return to above 80% by end of October of 2020 | **Partially Resolved**See Action Plan Below |
|  | **Issue/Area for Improvement identified in your****2020–2021 APE** | **Action Plan (as designed by Program Evaluation Committee)** | **Designated Individual Responsible**  | **Expected Resolution(Outcome Measurement** **& Date)** | **Current Status(Resolved, Partially Resolved,** **Not Resolved)** **To be completed in 2022**  |
| 1 | **Action Plan from the 2020-2021 ACGME Resident Survey****Program Quality** | **Protected time to attend structured educational activities**While our residents do have a protected half day for educational activities each week during ambulatory blocks (every other rotation), based on input from the residents we understand that residents answered this question from the perspective of having protected time to attend noon conference. We believe that residents did not feel that they had protected time to attend this structured educational activity due to a number of different factors, all of which we will attempt to address this year:* Virtual conference - last year we were forced to hold most of our conferences virtually which definitely impacted resident ability to attend without interruption. Whenever allowed by COVID protocols, we plan to have in-person noon conferences to help increase attendance.
* Interruptions from nursing and other staff: this remains a significant issue. Each site has already started a robust educational initiative to ensure all interdisciplinary providers understand that the noon hour is protected educational time and that non-critical calls or notifications should not happen at that time. Nurse managers have been engaged with this initiative.
* Use of technology: we have already started to train residents on how to set their preferences in the Electronic Medical Record to indicate that they are not immediately available (except for emergencies) during the noon hour. Early feedback is that this approach has already been successful.
* Rounding time: we understand that a significant factor in whether or not residents can attend noon conference is when attendings are able to complete morning rounds therefore we will start a new initiative with expectations that morning rounds are completed by 11am to allow sufficient time for residents to attend noon conference.
 | PD, APDs, Core Faculty, CMRs | We will seek monthly input from the residents regarding their ability to attend noon conference. | **To be completed by end of 2021** |
| 2 | **Action Plan from 2019-2020 GME Performance Dashboard**  | **80 hour work week**On our ACGME resident survey, we performed quite well with at 97% compliance rate with the 80 hour work week (which is significantly above the 91% national average) however we did continue to have some isolated work-hour events over the past year that we have made structural changes to address. These violations occurred on the following services:* DH ICU
* VA Wards
* Cardiology (CICU)
* University ICU
* DH Wards

We have made some structural changes to address these issues. * DH ICU: in September we plan to transition away from any 28 hour calls which we think will eliminate all potential work hour violations at the DH ICU.
* Cardiology: we have restructured expectations around sharing patient volumes across teams as well as fellows off-setting resident work which we predict will address all work hour violations
* VA Wards: the VA wards schedule has been modified to create schedule that falls way below the 80 work week in terms of expected hours
* University ICU: the University ICU team structure has been modified to increase workload of advanced practice providers in order to decrease resident workload and eliminate duty hour violations. In addition, additional attending coverage will be added very soon which will facilitate shorter times to staffing and shorter rounding times which should eliminate any potential work hour violations.
* DH Wards: we added additional swing and night for Friday and Saturday night – this will greatly help us to adjust team and call structures which we feel will eliminate any future 80-hour work weeks
 | PD, APDs, Core Faculty, CMRs | We will continue to monitor our duty hour reports very carefully, we will also use alternative mechanisms to monitor duty hours as well such as with formal and informal feedback to CMRs, APDs and PD | **Some of the initial changes have already been implemented; we hope to have the entirety of these violations resolved by December of 2021**  |
|  |  | More than 28 consecutive hours worked* DH ICU: in September we plan to away from any 28 hour calls which we think will eliminate all potential work hour violations at the DH ICU.
* Cardiology (CICU): we have restructured expectations around sharing patient volumes across teams as well as fellows off-setting resident work which we predict will address all work hour violations
 | PD, APDs, Core Faculty, CMRs | We will continue to monitor our duty hour reports very carefully, we will also use alternative mechanisms to monitor duty hours as well such as with formal and informal feedback to CMRs, APD and PD | **Some of the initial changes have already been implemented; we hope to have the entirety of these violations resolved by December of 2021** |
|  |  | Less than 8 hours off between educational experiences* DH Wards: we added additional swing and night for Friday and Saturday night – this will greatly help us to adjust team and call structures which we feel will eliminate any future occurrences of having less than 8 hours off between educational experiences
 | PD, APDs, Core Faculty, CMRs | We will continue to monitor our duty hour reports very carefully, we will also use alternative mechanisms to monitor duty hours as well such as with formal and informal feedback to CMRs, APD and PD | **Some of the initial changes have already been implemented; we hope to have the entirety of these violations resolved by December of 2021** |
| 3 | **Action Plan from 2019-2020 GME Performance Dashboard**  | **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.  Of note, we 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.   Of note, our most recent Board pass rate was 99%.  | PD, APDs | We will continue to work with residents who have been identified as at risk for low ITE and Board scores and work with them on their medical knowledge | **To be completed in 2022** |
| 4 | **Formal Systematic Evaluation of the Curriculum**  | **G&Os:  The Program must ensure that specific competency-based Goals and Objectives for each educational experience (or rotation) designed to promote progress on a trajectory to autonomous practice, are available to residents & faculty.** We have created a new Curriculum task force which includes APDs, core faculty and chief residents. This group has already starting meeting once monthly to focus on all aspects of the residency curriculum. One major area of focus for this group will be to ensure updated learning goals and objectives for each rotation. We have developed a new tracking system for this information to facilitate maintenance of updates objectives. We are confident that we will have updating goal and objectives for each educational experience by the end of this calendar year. | PD, APDs, Core Faculty, CMRs | We will continue to monitor our progress on this project on a monthly basis | **To be completed by Dec, 2021** |
| 5 | **Program Quality** | **CUSOM Housestaff Association Survey: Were there any issues identified in the most recent results that require the program’s attention?**Professional Climate – inappropriate comments, sexist and racist, from patients, nursing and attendings at all sites.This feedback was very concerning to us as a program and is something that we take very seriously. Unfortunately without more specific data, it is hard to know where to target our interventions. Therefore, we will be adding a question to every single rotation eval asking residents whether or not they experienced or witnessed any inappropriate comments or micro-aggressions. We hope that this information will help us to better target services on which this is a problem. In addition, we will take the following action items:* Up-stander training: Some of our core faculty members at Denver Health are starting a new faculty development session on up-stander training that we hope to expand to all clinic sites and eventually inpatient attendings too.
* Anonymous reporting: we will remind residents and send out additional communications regarding the numerous avenues to report inappropriate comments and micro-aggressions (including the anonymous reporting portal on our website and use of our confidential resident and faculty liaisons)
* We will continue to develop our More than Medicine curriculum which includes training on micro-aggressions and inappropriate comments including how to address, process, and escalate concerns
 | PD, APDs, Core Faculty | We will review the feedback we receive on this issue from our rotation evals on a monthly basis. | **To be completed in 2022** |
| 6 | **Program Quality** | **Based upon results of the Resident and Faculty written Evaluations of the Program sent out by the program, were any issues identified that require modification to the program?** Resident Survey: the priority items from the resident survey:* Protection of time for noon conference – see above
* Modifications to overall curriculum and in particular WES curriculum: the residency program has created a curriculum working group that has been meeting monthly to review this feedback and improve all aspects of our curriculum
* Recreate sense of community and restart social initiatives post-pandemic restrictions: our Wellness working group and our More than Medicine resident group and both working to improve the social opportunities and sense of community
* Get rid of 24hr call: we have plans to make this happen in the DH ICU in September and have started discussions about what it would take to make this happen on the cardiology services

Faculty Survey: the priority items from the faculty survey include:* Improved communication: we will be getting some assistance from a program administrator who will help improve our regular communications and we will make an effort to ensure that we have accurate contact information for all our faculty members
* Increased autonomy and volume: preparedness for success following residency is one of our main goals therefore we take this feedback very seriously. We will meet to determine way that we can increase patient volumes, in particular for admissions, while remaining within our current caps
 | PD, APDs, Core Faculty, CMRs | We will reassess out progress at monthly meetings with CMRs, core faculty, APDs and PD | **To be completed by 2022** |
| 7 | **Resident Evaluation and Performance** | **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.**We have made significant adjustments to our overall evaluation system which has been reflected in the significant improvement in our most recent data (up to 65% timely completion rate) however we understand that this is still not at the target of 80%. These changes include* Revision of all our evaluations to make them simpler and easier to complete
* New process for ensuring that the correct evaluations go to the correct faculty members
* New reminder system to encourage timely completion of evaluations
* New tracking system to ensure that we are in regular communication with faculty members with delinquent evaluation
* We continue to make adjustments to the timing of delivery of evaluations in an effort to ensure highest yield of return on evaluation completion
 | PD, APDs, Core Faculty | We will continue to review our evaluation completion rate every 2 weeks  | **To be completed in 2022** |