**Annual Program Evaluation**

**Completed by the Program Evaluation Committee**

**2022-2023 Academic Year**

**Due by July 31, 2023**

**Instructions:**

* **Complete this document** as prompted and **upload** the completed APE to[**MedHub**](https://cuanschutz.medhub.com/index.mh)**:** Home Page  Program Accreditation  Annual Program Evaluation  Attach File
* **Complete the companion Action Plan List** & **upload** it to MedHub as described above.
* Per ACGME V.C.1.e, these documents, once completed, must be distributed to and discussed with your program’s residents/fellows, and teaching faculty, and must be submitted to the DIO (CU GME).

**Table of Contents:**

1. [Program Name and PEC Information](#Program_name_PEC)
2. [Program AIMS, Strengths, Opportunities, and Threats](#AIMS)
3. [ACGME Citations and/or Areas for Improvement (AFI)](#ACGME_Citations)
4. [Program Requirements](#PGM_REQS)
5. [Formal Systematic Evaluation of the Curriculum](#CURRICULUM)
6. [Resident Evaluation and Performance](#RES_EVAL)
7. [Faculty Evaluation and Development](#FACULTY)
8. [Graduate Performance](#GRAD_PERFORM)
9. [Program Quality](#PGM_QUAL)

1. [Quality Improvement and Patient Safety](#QIPS)
2. [Transitions of Care](#Transition)
3. [Well-Being](#WB)
4. [Diversity Activities](#DIVERSITY)
5. [Policy Review](#Policy)
6. [Program Under-Represented in Medicine (URiM) Statistics](#URIM)

|  |  |  |
| --- | --- | --- |
| **PROGRAM NAME:** | **Internal Medicine** | |
| **Program Evaluation Committee (PEC) Meeting Date:** | | **August 9, 2023 PEC**  **May 10 and June 7, 2023 Resident Focused PECs** |
| **Program Evaluation Committee Chair:** | | **Geoffrey Connors, M.D.** |
| **Date and method by which this completed 2022-2023 APE form and action plans were shared with the teaching faculty and residents, per ACGME Common Program Requirements V.C.1.e:** | | **Executive summary of findings as well as complete action plans will be included in September 2023 Residency Newsletter** |

|  |
| --- |
| **The Program Evaluation Committee (PEC) documents formal, systematic evaluation of the program through this Annual Program Evaluation. This document also serves as the meeting minutes.** |

|  |  |  |  |
| --- | --- | --- | --- |
| **PROGRAM EVALUATION COMMITTEE - Annual Program Meeting Attendance** | | | |
| **Program Director:** | **Geoffrey Connors, M.D.** | **Program Coordinator(s):** | **Jennifer Weber** |
| **The following teaching faculty members participated in the meeting (add more rows if necessary):**  ***At least 2 faculty members, one of whom is core, must attend. Consider also Associate PDs, Site Directors.*** | | | |
| **Name** |  | **Name** | **Title** |
| **Dr. Lisa Davis** | **Associate Program Dir.** | **Dr. CJ Mowry** | **Chief Medical Resident** |
| **Dr. Hoda Farajpour Bakhtiari** | **Associate Program Dir.** | **Dr. Apoorva Ram** | **Chief Medical Resident** |
| **Dr. Emily Gottenborg** | **Associate Program Dir.** | **Dr. Lynne Rosenberg** | **Chief Medical Resident** |
| **Dr. Sarah Haeger** | **Chief Medical Resident** | **Dr. Katie Suddarth** | **Associate Program Dir.** |
| **Dr. Dan Heppe** | **Associate Program Dir.** | **Dr. Sam Thielen** | **Chief Medical Resident** |
| **Dr. Kate Jankousky** | **Chief Medical Resident** | **Dr. Lisa Thompson** | **Clinic Director** |
| **Dr. Julia Limes** | **Associate Program Dir.** | **Dr. Julie Venci** | **MedPeds Program Dir.** |
| **Dr. Adrienne Mann** | **Associate Program Dir.** | **Dr. Evan Zehr** | **Chief Medical Resident** |
| **Dr. Neelam Mistry** | **Core Faculty** |  |  |
| **The following residents/fellows participated in the meeting (add more rows if necessary):**  ***At least one resident/fellow must participate unless program had none during this particular academic year.*** | | | |
| **Name** | **PGY level** | **Name** | **PGY level** |
| Becker, Brittany | 2 | Alonzo, Ryan | 3 |
| Beilke, Sarah | 2 | Arar, Amr | 3 |
| Bellantoni, Julia | 2 | Buehler, Anna | 3 |
| Bianchina, Nicholas | 2 | Calzia, Megan | 3 |
| Camp, Corinne | 2 | Carver, Chelsea | 3 |
| Carlson, Daniel | 2 | Collier, Priscilla | 3 |
| Dammann, Carston | 2 | Davis, Christian | 3 |
| DeQuillfeldt, Natalie | 2 | Drumright, Ben | 3 |
| Enright, Connor | 2 | Galatowitsch, John | 3 |
| Enright, Connor | 2 | Harris, Tyler | 3 |
| Ferraro, Stephen | 2 | Haussmann, Alana | 3 |
| Fischer, Cristina | 2 | Hayden, Alex | 3 |
| Fuher, Ally | 2 | Hayden, Alex | 3 |
| Gil, Kellen | 2 | Haynes, Julia | 3 |
| Gilbert, Jason | 2 | Heilman, Alex | 3 |
| Gu, Kayla | 2 | Hibshman, Madison | 3 |
| Ho, Josh | 2 | Huber, Kathryn | 3 |
| Leyba, Katarina | 2 | Huber, Kathryn | 3 |
| Ma, Irvin | 2 | Kirelik, Danielle | 3 |
| Meyer, Marita | 2 | Lipsey, Jonathan | 3 |
| Mohan, Rahul | 2 | Long, Colleen | 3 |
| Moreira Protastio, Tais | 2 | Loy, Dorothy | 3 |
| Ni, Kevin | 2 | Marcy, Daniele | 3 |
| Paap, Alex | 2 | Mayer, Megan | 3 |
| Patel, Vivek | 2 | Minor, Noah | 3 |
| Pham, Andrew | 2 | Morgan, Nicholas | 3 |
| Reese, Tyler | 2 | Mowry, Christopher | 3 |
| Rockey, Nathan | 2 | Nguyen, Michael | 3 |
| Roda, Gavriel | 2 | Overholt, Luc | 3 |
| Rodriguez, Laura | 2 | Pangilinan, Jayce | 3 |
| Roy, Savannah | 2 | Pham, Vy | 3 |
| Santos, Jennifer | 2 | Samuel, Anna | 3 |
| Sawyer, Katlyn | 2 | Steinberg, Lila | 3 |
| Schott, Cody | 2 | Sundaram, Kavin | 3 |
| Shamapant, Nikhil | 2 | Svet, Mark | 3 |
| Titus, Ben | 2 | Urban, Jacqueline | 3 |
| Zheng, Bang | 2 | Vukovic, Nemanja | 3 |
|  |  | Williams, Robert Jordan | 3 |
|  |  | Yamamura, Katie | 3 |

|  |  |
| --- | --- |
| **CUSOM Sponsoring Institution Mission:**  **Per ACGME Educational Program Requirements (section IV.A), the program's AIMS must align with the overall mission of the Sponsoring Institution, needs of the community it serves, and the desired distinctive capabilities of its graduates.**  **The mission of the Sponsoring Institution, University of Colorado School of Medicine (CUSOM), is to provide Colorado, the nation and the world with programs of excellence:**   * **Education - through the provision of educational programs to medical students, allied health students, graduate students and housestaff, practicing health professionals and the public at large;** * **Research - through the development of new knowledge in the basic and clinical sciences, as well as in health policy and health care education;** * **Patient Care - through state-of-the-art clinical programs which reflect the unique educational environment of the University, as well as the needs of the patients it serves and,** * **Community Service - through sharing the School’s expertise and knowledge to enhance the broader community, including our affiliated institutions, other healthcare professionals, alumni and other colleagues, and citizens of the state.** | |
| **PROGRAM AIMS:**  **ACGME guide for this discussion:**    **Aims are program and institutional leaders’ views of key expectations for the program, and how it differentiates itself from other programs in the same specialty/subspecialty. Aims must align with the overall mission of the Sponsoring Institution, CUSOM. Aims may focus on:**   * **The types of trainees recruited into the program** * **Training for particular careers (clinical practice, academics, research, primary/generalist care)** * **Other objectives, such as care for underserved patients, health policy or advocacy, population health, or generating new knowledge**   **Program aims should generally take a longer-term strategic view, but they also may change over time, in response to factors such as local or national demand for a resident workforce with certain capabilities, or new opportunities to train residents and fellows in a different setting.** | |
| **The Program’s AIMS, as identified by the PEC, are as follows:** | |
| **1** | We aim to cultivate the next generation of expert clinicians – leaders who will provide outstanding patient care while transforming healthcare through biomedical discovery, educational innovation, optimization of health systems, and advocacy on behalf of those we serve. |
| **2** | We aim to provide residents an individualized training experience which will allow them to focus on their particular career aspirations in order to best prepare them for their future careers. |
| **3** | We aim to provide a robust clinical training experience that will adequately prepare any resident for any future challenges. |
| **4** | We aim to provide a diversity of clinical training environments in terms of patient populations, healthcare systems and clinical experiences. |
| **5** | We aim to create a training environment that values and ensures inclusion and diversity. We aim to support, retain and recruit residents, faculty and staff from diverse backgrounds and identities so that our program reflects the communities we serve. |
| **6** | We aim to instill in our residents the qualities of a physician that we most value: empathy, inquiry, dedication, humility, responsibility and professionalism in order to best prepare them to care for the communities they will serve. |

|  |
| --- |
| **Program Activities to Advance the AIMS:**  **(Describe current activities that have been or are being initiated to promote or further these AIMS.)** |
| 1. We aim to cultivate the next generation of expert clinicians – leaders who will provide outstanding patient care while transforming healthcare through biomedical discovery, educational innovation, optimization of health systems, and advocacy on behalf of those we serve.   This aim highlights the core goal for our program – to create physicians who will lead the future of healthcare. We emphasize these guiding principles in all aspects of our training – in the clinical work, in our didactics and in the mentors and educators that teach our residents. A number of years ago our program transitioned to the 4+4 block schedule which was critical to advancing this core aim.  Our 4+4 schedule provides protected time for research and education, ensuring that these missions are balanced with our clinical training.    In addition, we have a number of pathways within our residency.  Each resident gets core training in each of these areas of focus which align with our aims: Health Equity, Advocacy and Policy; Research and Investigation; Medical Education; Global Health; and Medical Leadership.  Residents are given the opportunity to get advanced training in one of these focus areas.   1. We aim to provide residents an individualized training experience which will allow them to focus on their particular career aspirations in order to best prepare them for their future careers.   Our program allows residents to personalize their training experience in a number of ways.  We have 4 tracks within our program: Categorical (for fellowship bound residents), Primary Care, Hospitalist, and Physician Scientist.    In addition, each of our residents selects one of our five pathways to get additional focused training in while receiving core training in each area (Health Equity, Advocacy and Policy; Research and Investigation; Medical Education; Global Health; and Medical Leadership).  Furthermore, our residents are able to select their own longitudinal subspecialty clinic experience based on career aspirations.  This year, we are starting conversations around how to further individualize the clinical experiences for our residents to best align with future career.   1. We aim to provide a robust clinical training experience that will adequately prepare any resident for any future challenges.   We feel that one of our biggest strengths as a program is graded and intentional advances in autonomy throughout training.   We have been very deliberate with our inpatient experiences to ensure that at each level of training our residents have the appropriate balance of autonomy and supervision. We do this by selecting specific core rotations for our residents to do in different years of training.  In the ambulatory setting, we are intentional as well in terms of our graded increases in patient volumes and degrees of supervision.  Furthermore, we are deliberate in the types of clinical experiences our residents get to ensure a wide breadth of clinical experiences, ensuring that each resident spends time at each of our core clinical sites.   1. We aim to provide a diversity of clinical training environments in terms of patient populations, healthcare systems and clinical experiences.   We are fortunate as a training program to have four healthcare systems in which our residents train – University of Colorado Hospital (the region’s only major academic medical center), Denver Health (a nationally recognized safety net hospital serving the patients of Denver), the Rocky Mountain VA Medical Center (serving veterans from the region) and Rose Medical Center (a private hospital in which our residents get training in the emergency room).  Furthermore, we have seven different continuity clinic sites geographically located throughout Denver and Aurora.    We ensure that each resident spends time at each of our core clinical sites so that they experience each of these very different healthcare systems and training environments. Each of these healthcare systems also serves a different and unique patient population.   1. We aim to create a training environment that values and ensures inclusion and diversity.   We aim to support, retain and recruit residents, faculty and staff from diverse backgrounds and identities so that our program reflects the communities we serve.   This has been a top priority for the program for a number of years. We have used a holistic review approach to our recruitment process for many years in order to increase diversity of backgrounds and experiences in our residents. We also created a Diversity, Equity and Inclusion working group (with program leadership, chief residents and residents) which meets monthly to address and implement change in order to ensure that we are creating a diverse and inclusive program.  This year, our residency program leadership team will do a special training session in order to achieve individual Foundations in Equity Certificates.  This program 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.     Also new this year, our residents will 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.  Finally, we know that persons of diverse backgrounds and identities are at greater risk for experiencing microaggressions and harassment at work. Addressing these events has been a major focus for the program for the past year and we know this is critical to ensuring a safe and inclusive training environment. We created a new policy around microaggressions and harassment, we created multiple avenues for residents to report such events, we have a new process for handling any concerns, we are meeting regularly with hospital leadership to engage in conversations around these events and have increased upstander training for residents and faculty. This will remain a focus area for the program moving forward.   1. We aim to instill in our residents the qualities of a physician that we most value: empathy, inquiry, dedication, humility, responsibility and professionalism in order to best prepare them to care for the communities they will serve.   We approach achieving this aim in a number of different ways. Our “More than Medicine” longitudinal curriculum helps residents to better understand and process many of the emotions and values that impact us as physicians. We feel that the focus areas for the program in terms of the pathways and our working groups demonstrate to the residents some of these key values in terms of caring for the communities we serve. Finally we believe that having program leadership and teaching attendings that model these behaviors is critical and perhaps the most important action to achieve this aim. |

|  |
| --- |
| **PROGRAM STRENGTHS:**  **The Program’s STRENGTHS, as identified by the PEC, are as follows:** |
| * Quality of the residents * Diversity of training sites including University Hospital with quaternary care, VA, and city/county hospital Denver Health   + All training sites have state-of-the-art facilities   + The diversity of training sites allows for rich clinical opportunities (any type of patient, any type of condition)   + Academic medical center of the state/region * Diversity of patient populations * Breadth of educational opportunities and exposure to subspecialty training * Culture of intentional autonomy and support * Opportunities for personalization of educational experience   + Diversity of training tracks (categorical, primary care, hospitalist and physician scientist)   + Diversity of areas of focus including medical education, research, health equities, and global health * 4+4 Schedule allowing for balanced educational opportunities (both ambulatory and inpatient) and early career development * Protected time for scholarship, structured mentorship for scholarship * Quality of our teaching faculty * Communication, flexibility, adaptability * Effective and supportive leadership team * Responsiveness to feedback, multiple avenues to provide feedback * Highly functional and supportive administrative team and program coordinator * Intentionality of the training program * Intentionality of the overall curriculum including recent additions to educational program such as expanded POCUS and procedural training, career development, additional palliative care and addiction medicine experiences * Wellness   + Opt-out PCP and mental health appointments for interns   + More than Medicine Committee offerings   + Coaching program   + Support for residents needing sick time and/or leave, parental leave * Board Pass Rate * Elimination of 24-hr call in the past academic year |

|  |
| --- |
| **PROGRAM OPPORTUNITIES:**  **ACGME Guide for this discussion:**  **Opportunities are external factors that are not entirely under the control of the program, but if acted upon, will help the program flourish. Think of opportunities as strengths you were not yet aware of, or that the program has not yet used. Opportunities take many forms, such as:**   * **Access to expanded populations for ambulatory care at a local health center  Partnership with CUSOM Academy of Medical Educators, Center for Advancing Professional Excellence, or other simulation center, other collaborations** * **Availability of new clinical or educational technology through agreements with external parties**   **(Consider: What will take the program to the next level?)**  **Please align opportunities with program's AIMS as much as possible.** |
| **The Program’s OPPORTUNITIES, as identified by the PEC, are as follows:** |
| * Growth of the system and possibilities for new educational opportunities - Tower 3 at University Hospital, the expansion of UC Health across the state, the expanding Denver Health system * Personalized medicine * Denver location and surrounding Rocky Mountain Region * Engagement with medical students in new LIC model, opportunities for mentorship and advising * Personalization of education/training based on career path * Opportunities for partnerships with other graduate level education in Denver (business school, law school) * Community engagement with focus on advocacy and health equity * Research opportunities on campus * Competency based training * Global Health opportunities * Opportunities to participate in gender-affirming care, treatment of substance use disorder, women’s health and reproductive medicine * Better financial support for residents (retirement funds, cell phone reimbursement) * Better support for residents with families (affordable childcare on campus, appropriately equipped lactation facilities) |

|  |
| --- |
| **PROGRAM THREATS:**  **ACGME Guide for this discussion:**  **Threats also are largely beyond the control of the program, and like opportunities, come in many forms. They could result from:**   * **Change in support for education at the national level** * **Changing priorities at the institutional or state levels, or from local factors, such as erosion of a primary ambulatory system based on voluntary faculty**   **The benefit of assessing program threats is that plans can be developed to mitigate their effect.**  **List the Program’s real or potential significant THREATS, and what the program is doing to mitigate these THREATS. Please align threats with program's AIMS as much as possible.** |
| **List the Program’s real or potential significant THREATS, as identified by the PEC, and what the program is doing to mitigate these THREATS:** |
| 1. Growth of the healthcare systems we train in and region  * Third tower, continuously expanding University of Colorado Health System * Increased pressure to help staff clinic and hospital volume * Impact on faculty and support staff in terms of burnout and turnover   We have taken a number of steps to mitigate the threats of the growing healthcare system and community in which we train including:   * Frequent meetings between program leadership and hospital administration in order to ensure that we are aligned in terms of the capacity of our residents and program and better understand and future asks that might be made of the residency program * Have ongoing conversations with hospital administration to make sure we aligned in terms of both the clinical and educational mission of the institution * Partner with hospital leadership and administration to ensure that we are maximizing the coverage that our residents are providing in a safe manner  1. Funding and Program Financial Pressures  * Budgetary limitations and increased financial pressures post-COVID * Uncertainty of Denver Health’s financial stability * Lack of diversity of funding streams: since funding sources are hospital based, limits experiences outside our current healthcare systems * We have a 1-yr budget, so we have to justify our expenses annually – can’t plan 5 years out. * Lack of control over the money that the DOM is getting to support education * Mismatch between NIH funding and push to get residents and faculty engaged in research   We continue to work with the DOM, SOM and hospital administration to ensure adequate funding to maintain the high quality of our education. We plan to increase efforts around alternative funding sources that may help to decrease dependency on traditional resources which are out of our control.   1. Resident Financial Pressures  * Increased cost of living in Denver (including housing, childcare) * Mechanisms/structure to help residents advocate for salary increases and retirement funding * Increased financial pressures at the individual level (cost of personal cell-phone use, medical school and college debt)   We continue to advocate on behalf of our residents to ensure appropriate compensation and salary increases to match increased cost of living. We continue to encourage our residents to take leadership roles within Housestaff Association to also advocate for themselves and their colleagues.   1. Lack of prioritization of the educational missions at the Rocky Mountain VA Medical Center   In recent years it has become increasingly unclear how the educational mission is prioritized at the Rocky Mountain VA Medical Center. There have been a number of events and situations that have demonstrated that the educational mission is threatened including:   * New leadership that made significant changes without appropriate stakeholder engagement and that threatened safe learning environments * Continued unrealistic and unsupported asks around resident time reporting in terms of administrative burden * Lack of commitment to providing basic requirements for residents (for example acceptable badging process, provision of adequate food options) * Reduced number of clinical educational opportunities which limit the number of residents that we can send to the VA   We continue to attempt to communicate with VA leadership around these ongoing issues and attempt to be better aligned in our missions. We continue to communicate regularly with the DOM, SOM and GME regarding these ongoing issues in an attempt to work together to address these issues.   1. Changing Political Landscape  * Recent Supreme Court decision regarding affirmative action directly threats our mission to recruit and retain physicians of diverse backgrounds and identities to have a workforce that reflects the communities we serve * Roe vs Wade being overturned which potentially threatens our ability to appropriately care for women and educate our residents around women’s health initiatives * Lack of adequate gun control measures continue to impact the patient populations we care for * Continued severe ethnic, racial and socioeconomic health disparities impacting the patients we serve   We feel that the best way to mitigate these potential political threats that impact healthcare and the health systems in which our residents work is to train our residents on health advocacy and policy. This is already a part of our structured Wednesday Educational Curriculum. We have new leadership for our Health Equity, Advocacy and Policy Pathway which we hope will help to augment efforts in this area. Two of our focus areas for the program are Community Engagement and Diversity, Equity and Inclusion. |

|  |
| --- |
| **A****CGME CITATIONS and/or AREAS FOR IMPROVEMENT (AFI)/CONCERNING TRENDS**  **This section is to ensure that the program addresses areas of non-compliance with ACGME standards.**  **Current GME Process: Upon receipt of ACGME Letters of Notification (LON) that reflect Citations and/or Areas for Improvement (AFI)/Concerning Trends, GME prompts programs to respond to GMEC in the form of a Progress Report. This Progress Report ensures the program’s accountability to ACGME, GMEC, and ultimately guides the program in posting its final response in ACGME ADS.**  **The PEC’s Task here is to review any ACGME Letter of Notification and GMEC Progress Report for your program during the 2022-2023 Academic Year. If relevant, provide an update below to the latest Progress Report.** |
| **ACGME Citation(s) (Check as applicable)**   * + **NOTE: To mark the checkboxes, click the checkbox. To uncheck, click the checkbox again.** |
| Letters from ACGME received in 2022-2023 were retrieved from [ADS](https://apps.acgme.org/connect/login?ReturnUrl=%252fconnect%252f) and reviewed by the PEC  Were any citations received from ACGME?  No  Yes  If yes, check all that apply:  PEC discussed the ACGME LON issued on \_\_(date)\_\_, as well as resulting GMEC Progress Report(s).  Per GMEC, citations have been fully addressed  GMEC Progress Report is currently in process |
| **ACGME Area(s) for Improvement/Concerning Trend(s) (Check as applicable)** |
| Letters from ACGME received in 2022-2023 were retrieved from [ADS](https://apps.acgme.org/connect/login?ReturnUrl=%252fconnect%252f) and reviewed by the PEC  Were any Areas for Improvement (AFI), Concerns, or Comments received from ACGME?  No  Yes  If yes, check all that apply:  PEC discussed the ACGME LON issued on \_\_(date)\_\_, as well as resulting GMEC Progress Report(s).  Per GMEC, all issues have been fully addressed  GMEC Progress Report is currently in process |

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

**Where ACTION PLAN REQUIRED is checked, enter the action plan on the companion Action Plan Template.**

|  |  |
| --- | --- |
| **PROGRAM REQUIREMENTS** | |
| **The program must review ACGME Specialty Program Requirements to ensure compliance with all current ACGME requirements. Was the program out of compliance with any requirements?** | **Yes – ACTION PLAN REQ’D**  No |
| **Did faculty and residents participate in scholarly activity, according to the ACGME specialty-specific requirements in IV.D.2 and IV.D.3, and does the current data in ACGME ADS accurately reflect this?** | Yes  **No – ACTION PLAN REQ’D** |
| **Does the Program Director receive the financial support and/or protected time required by ACGME for their *non-clinical administration* of the program, as specified in the specialty-specific Program Requirements? Is the % FTE accurately reflected in ADS? Refer to** [**this table**](https://www.acgme.org/globalassets/pdfs/specialty-specific-requirement-topics/dio-dedicated_time_program_leadership_2022.pdf) **for your program leadership’s required % FTE.** | Yes  **No – ACTION PLAN REQ’D** |
| **Do(es) the Program Coordinator(s) receive the amount of dedicated time for this program required by ACGME, as specified in the specialty-specific Program Requirements? Refer to** [**this table**](https://www.acgme.org/globalassets/pdfs/specialty-specific-requirement-topics/dio-dedicated_time_coordinator_2022.pdf) **for your program coordinator’s required % FTE.** | Yes  Total PC FTE for this program is 7  Program Coordinator name(s):  Nicole Canterbury  Elle Contreras  Matt Konjoian  Mary Meadows  Kendra Burghardt  Kendra Lewis  Jefferson Velasco  Jennifer Weber  **No – ACTION PLAN REQ’D** |
| **Do(es) the Program Coordinator(s) serve as Program Coordinator(s) for any other programs (ACGME or non-ACGME)?** | Yes  No |
| **If yes, list program name(s) and FTE allocated for each of these programs. For each non-ACGME program, a minimum of 0.3 FTE is required.** |  |

|  |  |
| --- | --- |
| **F****ORMAL SYSTEMATIC EVALUATION OF THE CURRICULUM** | |
| **Goals & Objectives: 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. Do all rotations provide *up-to-date* *rotation-specific* goals and objectives?** | Yes  **No – ACTION PLAN REQ’D** |
| **Based on the PEC's review of the program's aggregate resident achievement of the Milestones, were any deficiencies identified that require modification to the curriculum?** | **Yes – ACTION PLAN REQ’D**  No |

|  |  |  |  |
| --- | --- | --- | --- |
| **FACULTY EVALUATION & DEVELOPMENT** | | | |
| **Does the Program Director evaluate each faculty member's performance as it relates to the educational program at least annually?** | | | Yes  **No – ACTION PLAN REQ’D** |
| **Does the evaluation include each of the following aspects that are required by ACGME?:**  **- faculty member's clinical teaching abilities**  **- engagement with the educational program**  **- participation in faculty development related to their skills as an educator**  **- clinical performance**  **- professionalism**  **- scholarly activities**  **- written, anonymous, and confidential evaluations by the residents** | | | Yes  **No – ACTION PLAN REQ’D** |
| **Do faculty members receive feedback on their evaluations at least annually?** | | | Yes  **No – ACTION PLAN REQ’D** |
| **If yes, from whom? Check all that apply.** | | | Program Director  Section/Division Chief  Department Chair  Other: |
| **Are results of the aggregate faculty educational evaluations incorporated into program-wide faculty development plans?** | | | Yes  **No – ACTION PLAN REQ’D** |
| **As program director, do you identify faculty development opportunities to enhance their skills at least annually in all the following areas (examples of faculty development can be found** [**here**](https://medschool.cuanschutz.edu/docs/librariesprovider101/gme-document-librar/misc/faculty-development-examples-2022.docx?sfvrsn=6c8cb5ba_4)**):** | | | |
| **As educators and evaluators** | Yes  **No – ACTION PLAN REQUIRED** | **In fostering their own & their residents' well-being** | Yes  **No – ACTION PLAN REQ’D** |
| **In quality improvement, eliminating health inequities, & patient safety** | Yes  **No – ACTION PLAN REQUIRED** | **In patient care based on their practice-based learning & improvement efforts** | Yes  **No – ACTION PLAN REQ’D** |
| **Board Certification: Are ALL physician Faculty members listed in ACGME ADS board certified in the appropriate ABMS (sub)specialty?** | | | Yes  No |
| **Board Certification: If No, is either of the following true? 1) A letter of RRC acceptance of equivalent qualifications is on file for each physician; or, 2) Each physician is identified as “board-eligible,” is scheduled to sit for the exam and date of exam is reflected in ADS.** | | | Yes  **No – ACTION PLAN REQ’D** |

|  |  |
| --- | --- |
| **RESIDENT EVALUATION & PERFORMANCE** | |
| **ADS Case Logs:  In reviewing the actual ADS data, did all 2023 graduates log in ADS the minimum number of cases required by ACGME?** | Yes  **No – ACTION PLAN REQ’D**  N/A not required in ADS |
| **Case Logs:  Did all 2023 graduates satisfy the minimum numbers required by your ABMS Board?** | Yes  **No – ACTION PLAN REQ’D**  N/A not required |
| **Case Logs: Are cases equally distributed among Residents?** | Yes  **No – ACTION PLAN REQ’D**  N/A not required |
| **Evaluations: Resident evaluations must be completed by Faculty in MedHub after each rotation (at least quarterly for rotations > 3 months). Refer to your most recent quarterly completion report. Was your program at or above 80% compliant for the 2022-2023 Academic Year?** | Yes  **No – ACTION PLAN REQ’D** |
| **ITE: Is there a national In-Training Exam (ITE) for your (sub)specialty?** | Yes  No |
| **ITE: If yes, does your program use it?** | Yes  **No – ACTION PLAN REQ’D** |
| **ITE: If no, does your program use an internal ITE?** | Yes  No |
| **ITE: If the program uses the national ITE, specify the percentile set by program, below which the Resident requires remediation. (Percentile indicates percentage of Residents in relevant peer group who received the same or lower score.)** | <80th  <30th  <70th  <20th  <60th  <10th  <50th  Other  <40th |
| **If program answered “Other,” explain the metric:**  **(Recommendations: Scoring below national mean for PGY level or scoring near or below passing rate necessary to pass national board exam.)** | |
|  | |
| **Number of residents that met your program's expectation for the ITE during the 2022-2023 Academic Year? Use the metric set in the previous question when answering this question (# of trainees).** | 5 |
| **Number of residents that did not meet your program's expectation for the ITE during the 2022-2023 Academic Year? Use the metric set in the previous question when answering this question (# of trainees).** | **106** |
| **Additional comments:** | |
|  | |
| **What is the program doing to remediate the residents who did not meet your program’s expectation in the 2022-2023 year?**  **Recommendations:**   * **Proactive learning plan with regular (i.e., monthly) check-ins with faculty coach** * **Set up meeting with Dr. Nida Awadallah, Director for Student and Resident Remediation (**[**nida.awadallah@cuanschutz.edu**](mailto:nida.awadallah@cuanschutz.edu)**), if the resident meets one of the following criteria:**   + **The resident is within 1 year of taking the board exam, or**   + **The resident has been on a learning plan for 6 months or more without meeting goals** * **Focused Review (carol.rumack@cuanschutz.edu)** | Check all that apply  Individual learning plan  GME remediation expert   consultation  Focused Review  If none of the above, please contact Dr. Nida Awadallah  N/A – No ITE exam given  N/A – All residents met program expectations |
| **Does the program have a formal didactic curriculum that is tailored to the top 15 clinical diagnoses and board examination frequently-tested topics in your specialty?** | Yes  **No – ACTION PLAN REQ’D** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **GRADUA****TE PERFORMANCE ON BOARD EXAM FOR YOUR (SUB)SPECIALTY** | | | | | | |
| **Does the program's graduate board certification pass rate meet or exceed ACGME Program Requirements? [Refer to ACGME requirements specific to the specialty to ensure graduate performance on the certification exam is monitored/tracked.] This does not apply to the qualifying exam - just the final certifying exam.** | | | | | Yes  **No – ACTION PLAN REQ’D**  N/A – No Boards for Subspecialty | |
| ***Program* Board Pass Rate: Provide your program’s 3-year board certification pass rate for first time takers below. Write N/A in the appropriate spaces if your specialty’s board examinations are every other year, or if none took the board examinations, or if no board certification exists for your program’s subspecialty.** | | | | | | |
| **Year (adjust years as needed)** | **How many 1st time takers took the board certification exam (# of trainees)?** | | **How many 1st time takers passed (# of trainees)?** | | | **Percent of 1st time takers who passed (%)?** |
| **2020** | 57 | | 56 | | | 99% |
| **2021** | 54 | | 54 | | | 100% |
| **2022** | 46 | | 46 | | | 100% |
| ***National Average subspecialty initial certification* Board Pass Rate (not your program’s pass rate): Provide the national 3-year board certification pass rate for first time takers below. Write N/A in the appropriate spaces if your board examinations are every other year. This data can usually be obtained from public Board websites; for example, the** [**ABIM**](https://www.abim.org/~/media/ABIM%20Public/Files/pdf/statistics-data/certification-pass-rates.pdf) **,** [**ABP**](https://www.abp.org/content/exam-pass-rates)**,** [**ABPN**](https://www.abpn.com/about/facts-and-statistics/)**,** [**ABR**](https://www.theabr.org/diagnostic-radiology/initial-certification/core-exam/scoring-and-results#results)**,** [**ABSurgery**](https://absurgerydata.shinyapps.io/PassRates/)**, or** [**ABPath**](https://www.abpath.org/images/Annual_Reports/2019-ABPath-Annual-Report.pdf) **newsletters & annual reports. If you cannot locate it, contact your ABMS Board.** | | | | | | |
| **2020 Percent of  1st time takers who passed**  **(National Average – *not* your program)** | | **2021 Percent of  1st time takers who passed**  **(National Average – *not* your program)** | | **2022 Percent of  1st time takers who passed**  **(National Average – *not* your program)** | | |
| 93% | | 88% | | 88% | | |

|  |  |
| --- | --- |
| **PR****OGRAM QUALITY** | |
| **2023 ACGME *Resident* Survey: An Action Plan must be developed to address each item where the program's result is both greater than 5% below the national average AND below 90% compliance. Did your program have any items that are both greater than 5% below the national average AND below 90% compliance?** | **Yes – ACTION PLAN REQ’D**  No |
| **2023 ACGME *Faculty* Survey: An Action Plan must be developed to address each item where the program's result is both greater than 5% below the national average AND below 90% compliance. Did your program have any items that are both greater than 5% below the national average AND below 90% compliance?** | **Yes – ACTION PLAN(S) REQ’D**  No |
| **CUSOM Housestaff Association (HSA) Survey: Were there any issues identified in the most recent results that require the program's attention? Email** [**Sally Robben**](mailto:SALLY.ROBBEN@CUANSCHUTZ.EDU) **for your program’s results.** | **Yes – ACTION PLAN REQ’D**  No  Results not provided |
| **Did your program provide all Residents and Faculty with a form to confidentially evaluate the program in writing?** | Yes  **No – ACTION PLAN REQ’D** |
| **If yes, which system does your program use to deliver the confidential evaluations (i.e. MedHub)?** | **SurveyMonkey** |
| **On what date(s) were the evaluations delivered?** | **May 30, 2023** |
| **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?** | **Yes – ACTION PLAN REQ’D**  No |
| **In reviewing your 2021-2022 GME-issued dashboard, did your program create a formal action plan for each item in the “GME Oversight” section and add those action plans to your Action Plan List?** | Yes  **No – ACTION PLAN REQ’D**  X N/A – no “GME Oversight” action items on dashboard |
| **Resources: Are sufficient resources in place to enhance the program's ability to provide required expertise and educational experiences?** | Yes  **No – ACTION PLAN REQ’D** |

|  |  |
| --- | --- |
| **TRANSITIONS OF CARE** | |
| **What formal process(es) does the program use for Transitions of Care? Check all that apply.** | I-PASS  SBAR  SIGNOUT  Other: \_\_\_\_  **None – ACTION PLAN REQ’D** |

|  |  |
| --- | --- |
| **POLICY REVIEW** | |
| **Program Handbook & Policy Manual: Have all policies been updated/created and in compliance with the 2023-2024 GME Program Handbook & Policy Manual requirements?** | Yes  **No – Policies will be updated** |

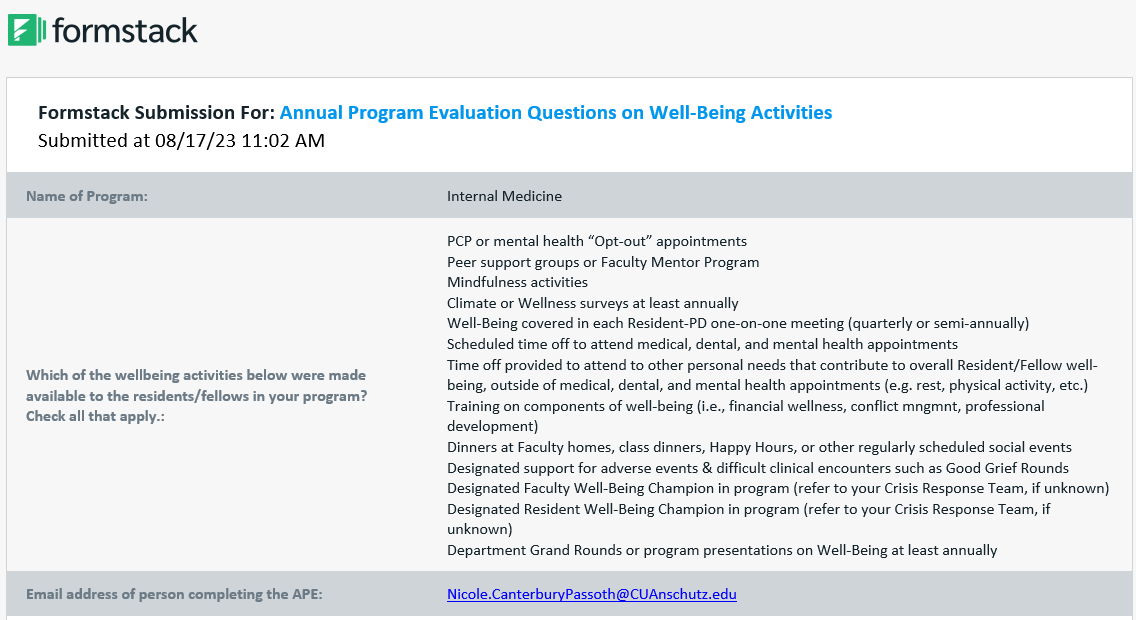
|  |
| --- |
| **QUALITY IMPROVEMENT AND PATIENT SAFETY** |

Complete the questions at this [link](https://ucdenverdata.formstack.com/forms/gme_quality_and_safety_ape). Once you click “submit” your responses will be sent to you via email. Paste them into this section of your APE.

|  |  |
| --- | --- |
| **Program:** | Medicine - Internal Medicine |
| **Q1: Do your trainees participate in a regularly scheduled Collaborative Case Review, regularly scheduled case review, or M&M conference?:** | Yes |
| **Q1 : If no, please explain why your trainees do not participate in a Collaborative Case Review, regularly scheduled case review or M&M conference::** |  |
| **Q1 : ACTION PLAN REQUIRED- Please explain how your program plans to incorporate a regularly scheduled case review going forward::** |  |
| **Q1: If yes, are your case review or M&M conferences multidisciplinary or Physician and APP only?:** | Multidisciplinary |
| **Q1: If yes, do your case review or M&M conferences identify systems factors that contributed to the adverse event/poor outcome?:** | Yes |
| **Q1: If no, please explain the format/structure of the case review::** |  |
| **Q1: If yes, are interventions to prevent future harm discussed at your case review or M&M conferences?:** | Yes |
| **Q1: If no, please explain the format/structure of the case review: :** |  |
| **Q2: Are your trainees instructed how to submit patient safety reports through each of the hospital/health systems’ reporting systems?:** | Yes |
| **Q2: If no, please explain why your trainees do not receive instruction on submitting patient safety reports::** |  |
| **Q2: ACTION PLAN REQUIRED- Please explain how your program plans to provide this instruction going forward: :** |  |
| **Q2: If yes, describe the instruction your trainees receive on submitting patient safety reports? :** | Residents are instructed how to submit patient safety reports at each site during the rotation orientation at each site. Attendings also reinforce and support submitting reports as patient safety events occur. |
| **Q3: Does your program ENCOURAGE your trainees to submit patient safety reports through each of the hospital/health systems’ reporting systems?:** | Yes |
| **Q3: If no, please explain why your trainees are not encouraged to submit patient safety reports?:** |  |
| **Q4: Did your residents attend any sessions hosted by the GME/IHQSE Quality and Safety Academy?:** | No |
| **Q4: If no, what Quality Improvement & Patient Safety education did your trainees receive this year?:** | Our residents receive the IHQSE curriculum from our Hospitalist faculty during our Wednesday Education Sessions. The Quality and Safety Academy would be a redundancy in curriculum. |
| **Q5: Did your trainees participate in any Quality Improvement/Patient Safety Projects this year?:** | Yes |
| **Q5: If no, please explain why your trainees did not participate in any Quality Improvement/Patient Safety projects this year?:** |  |
| **Q5: If yes, what Quality Improvement projects did your trainees participate in this year? :** | Our residents participate in the GME Quality and Safety Project as well as QI projects as part of their clinic.   Specific projects include:   - Improve management of diabetes among patient panel, specifically by reducing the number of patients with an HbA1c>9.  - Increase tobacco screening in panel by 25%, and to offer NRT or tobacco cessation clinic consult to all patients that screened positive for active tobacco use.  - Increase LDCT lung cancer screening in panel by > 10%.  - By March 2023, >75% of patients with a CAN score >=85 will have an advance directive on file in CPRS.  - By April 2023, complete a comprehensive scoping review using methodology outlined by the Joanna Briggs Institute to broadly survey the literature regarding measures of physician workload including: patients cared for, task load, cognitive load, and complexity of patients. Seek to understand how workload is defined and measured, the effects of workload on providers/patients/health systems, and the existing gaps in the literature.  - Decrease the amount of clinical reminders that go un-addressed/postponed to the next visit by 50%.  - By the end of the year increase pneumococcal vaccination rate > 90% in patients older than 65.  - Increase the number of Shingrix vaccinations on panel by 10% through targeted discussion about the vaccine during visits.  - Increase the rate of age-appropriate colon cancer screening in continuity clinic by the end of R1 year.  - By April 2023, 70% of patients who carry a diagnosis of diabetes mellitus with albuminuria will have been prescribed RAAS inhibition.  - Among patients who are obese (defined as BMI>30), perform patient outreach (preferably in person or via phone call but if unreachable then by letter) discussing weight loss and offering Move! referral for weight loss. Complete 100% outreach by April 2022 with an emphasis being on in person consultation.  - To deprescribe steroid inhalers for COPD patients who don't have an indication  - Over 50% of patients in panel with BP>140/90 will be started on home telehealth for closer monitoring of blood pressure by April 2023  - Reduce length of stay for patients on hospital medicine services by 0.5 days by May 2023 by implementing a validated natriuresis based diuretic protocol for Med 3/4 and HMS 4 teams.  - Increase awareness around obesity medicine by pulling in at least 5 new patients and adding "obesity" to their list of diagnoses.  - Decrease overnight sleep interruptions by 25% in the ACE Unit w/in 6 months of rolling out sleep protection protocol and increase the use of the "no vitals at night" order, a proxy process measure for use of the protocol, from 4% to 20% within 6 months. Improve the subjective experience of patients in the hospital by way of qualitative survey using standard sleep quality metrics.  - Increase enrollment of eligible patients for lung cancer screening who are not already enrolled by 75% by June 2023.  - Improve implementation of no vitals overnight order y 20% for individuals it is indicated  - For patients between the age 35-65 with a diagnosis of T2DM as of 11/1/2022, aim to increase screening for liver fibrosis using FIB4 score from 14% to at least 75% by 4/2023.  - Increase % CPAP usage in patients seen in clinic with moderate to severe OSA within the last year by 15% by June 2023  - By the start of third clinic block, at least 75% of panel will be up to date on cholesterol screening and on appropriate therapy according to the ACC/AHA guidelines.  -To quantify and qualify malignancy screening barriers at RMR VA  - Identify the number of patients at the VA resident primary care clinic who would qualify for lung cancer screenings with the most up to date USPSTF guidelines and ensure that they are enrolled into the lung cancer screening program.  - By June 2023, increase the percentage of all veterans on panel > 50 years old who are vaccinated against shingles by 50%.  - Ensuring that 100% of all patients with a diagnosis of COPD, asthma, or obstructive lung disease either have or are newly referred for PFTs in the last 5 years by June 2023. Secondary aim is to refer 100% of patients who already have PFTs in the last 5 years and have severe COPD (FEV1 <50%) to pulmonology by June 2023.  - Improve cervical cancer screening rates using a universal Primary Care checklist at all visits  - Decrease Post Thoracentesis CXR Utilization  - Increase the % of patients 65 years or older, who are partially vaccinated for pneumonia to complete their vaccine series by 50% by June 2023  - Ensure that 100% of all patients with a diagnosis of COPD, asthma, or obstructive lung disease either have or are newly referred for PFTs in the last 5 years by June 2023.  - To figure out if one can change salutations in CPRS for transgender patients, and update salutations for patients in panel as relevant.  - Ensure that at least 80% of my new intake appointments between the ages of 45-75 YO are up to date on colon cancer screening by June 2023.  - Reviewed personal and clinic level data on primary care metrics. This was pulled through the dashboard and expanded using SlicerDicer to evaluate individual patients and specific associated demographics. Reviewed barriers to cancer screening and brainstormed ways to reduce barriers. Reviewed modalities for cancer screening and the associated sensitivity/specificity of these tests. Reviewed trends in our primary care outcomes to review benefits of interventions.  - Reviewed personal quality improvement measures, looked specifically at resident clinic and then all PCP clinics at Anschutz. Discussed barriers to cancer screening in non-English speaking patients. Conducted individual chart review and then looked at which patient populations were not getting their cancer screening. Discussed different types of colon cancer screening and the epidemiology revolving around each test. Brainstormed ideas and possible ways to implement tools for non-English speaking patients to easily schedule their colonoscopy.  - Reviewed personal and clinic wide rates of primary care metrics. Completed individual chart review to determine barriers to scheduling routine screening tests for various populations. Discussed different types of screening tests and epidemiology surrounding those tests. Reviewed steps patient's much take to schedule and complete testing.  - Reviewed rates of primary care metrics at clinic level and at personal panel level. Evaluated barriers to obtaining cancer screening for non-English speaking patients through evaluating screening data based on langue. Looked at processes for obtaining and scheduling tests. Discussed which tests have non English directions/explanations. Looked at various types of cancer screening tests and epidemiology associated with each.  - We identified disparities in care including lower rates of completion of screening in patient in whom English wasn't their primary language.  -Reviewed sensitivity and specificity of colorectal screening modalities.  -Reviewed potential disparities in mammograms, but focused on colorectal cancer screening.  - Looked into disparities of colorectal cancer screening and what these disparities could be secondary to. Looked at personal patient panel to identify patients who were not up to date on colon cancer screening. Compared sensitivity and specificity of the different tests for screening for colon cancer. Evaluated mammogram screening for our clinic but did not find this be as lacking as colon cancer screening.  - Evaluated how many patients met indication for colon cancer screening then examining reasons that patients did not receive their screening. Looked to minimize barriers for each situation. Increased awareness to providers that simply did not order screening tests. Increased outreach using ancillary staff to remind patients who had standing orders. Started the process of creating a standardized Spanish form with instructions and explanations of colon cancer screening to remove language barriers as a cause of decreased colon cancer screening.  - Evaluated patient panels for success with colon cancer screening. Evaluated disparities in this population and who was more likely to get screening. Did individual outreach with patients in panel to encourage screening. Identified barriers to obtaining colon cancer screening including no Spanish options for scheduling. Also discovered many people do not receive scheduling calls. Compared sensitivity and specificity of different cancer screening modalities.  - Compared screening options for colonoscopy and how realistic these are for our patients.  - Looked at colon cancer screening disparities data. People who spoke Spanish, were of non-white ethnicity had fewer colonoscopies. Brainstormed factors that led to fewer colonoscopies completed. Turns out that it was not the lack of ordering, but rather the lack of scheduling. Looked at sensitivity and specificity of various colon cancer screening protocols. Turns out that Cologuard was completed around 60% of the time compared to 30% in colonoscopies. We reached out to patients via MHC to schedule colonoscopies.  -Depression screen and follow up is consistently highest performing metric on Tableau. Attribute much of this to the work of our MAs who are sure to ask our patients the PHQ2 and give them the PHQ9 paperwork if they screen positive. Make sure to ask most patients about mood at their initial appointment, which makes it easy to refer them to our behavioral health team. Quite effective and connected well with our behavioral health providers, with good outcomes for patients.  - Focusing on the number of patients with a1c <9. Main contributor is the population making up patient panel. Generally a younger group and people that have been seen in clinic at least once. Work of prior residents that passed down these patients did a good job of managing their diabetes. Been able to get some patients with poorly controlled diabetes into clinic multiple times this year and get things on the right track.  - Over the clinic average for "depression and follow up plan if positive". Included a dotphrase to pull in the PHQ4 to notes so don’t forget to address it and then use the assessment dotphrase to document the discussion. Frequently refer patients to BHC even if we do not have time to address mental health in that clinic visit  - Diabetes kidney. Always order it and sometimes order it a month earlier if it's due soon, given the patient won't be see again for several months. However, everything in flux as when they expire and are due for repeat, where best QI metric becomes worst and vice versa.  - Best metrics are breast cancer screening and depression screening. Influenced by the systems in place that prompt for these measures, including BPAs and MA-driven protocol for screening patients while rooming.  - HbA1c goal <9. Identified patients not at goal and applied more intensive glucose control strategies with the help of newer medications (SGLT-2 and GLP-1s), before needing to advance to insulin. Have been able to get RN (for DM teaching) and pharmacy (medication titration) involved early.  - Hypertension - provide patients with blood pressure cuffs from clinic and show them how to use it in office  - Breast cancer screening (80%). Routinely address with patients - when to start screening, how often, evaluating for family history of breast cancer, explaining the process of a mammogram if they have not had one before.  - Cervical cancer screening. Intentional outreach to patients even if they would schedule with a different provider.  - Behavioral health screening. MAs have a good workflow of doing the screening questionnaire as part of their rooming process, integrated flag in Epic that reminds to address this with patients.  - Per Tableau, performing most strongly on breast cancer screening (88.9% of eligible patients screened appropriately). Contributing factors include the BPA triggered by EPIC coupled with my counseling of patients on the purpose of screening tests and explanation of the process of getting a mammogram completed.  - Cervical cancer screening. Increased personal % from 56% to 72%. Reached out and messaged or called every patient that was overdue for a pap and worked to get them scheduled. |
| **Q6: Do your residents receive individual or group practice data?:** | Yes |
| **Q6: If no, please explain why your residents do not receive individual or group practice data?:** |  |
| **Q6: ACTION PLAN REQUIRED- Please provide an action plan for how your program can provide group practice data::** |  |
| **Q6: If yes, what individual or group practice data did your trainees receive and how do they use this to guide improvement?:** | In continuity clinic, each resident receives and reviews individual practice data from their personal patient panel. They review this data as part of their Quality Improvement project based in clinic and come up with ways in which they can improve the quality of care they provide based on personal practice as well as systems changes. They also consider the impacts of Social Determinants of Heath on their patient panel and practice data.   On the inpatient rotations, residents receive monthly data reports in our housestaff meeting. This includes total number of patients seen that month on the wards, readmission rates, length of stay, case mix index, mortality, and the percentage of ICU transfers for each medicine wards team. They also receive data on some of our quality metrics, including the number of patients who have a MDPOA form filled out and hospital discharge follow up scheduled. |
| **Q6: If yes, does this data include information about healthcare inequities in the patient population?:** | Yes |
| **Q6: If no, why does this data NOT include information about healthcare inequities?:** |  |
| **Q6: If yes, do your residents use this data to guide improvement?:** | Yes |
| **Q7: What formal process(es) does the program use for Transitions of Care? Check all that apply.:** | I-PASS |
| **Q7: What method or process(es) does the program use for Transitions of Care? :** |  |
| **Q7: ACTION PLAN REQUIRED - please provide an action plan for how your program will address Transitions of Care::** |  |
| **Program Coordinator Name:** | Jennifer Weber |
| **Email address of person completing the APE:** | [Nicole.CanterburyPassoth@CUAnschutz.edu](mailto:Nicole.CanterburyPassoth@CUAnschutz.edu) |

|  |
| --- |
| **WELL-BEIN****G** |

Complete the questions at this [link](https://ucdenverdata.formstack.com/forms/wellbeing_ape). Once you click “submit” your responses will be sent to you via email. Paste them into this section of your APE.



|  |
| --- |
| **DIVERSITY** |

Complete the questions at this [link](https://ucdenverdata.formstack.com/forms/diversity_ape). Once you click “submit” your responses will be sent to you via email. Paste them into this section of your APE.

|  |  |
| --- | --- |
| **Name of Program:** | Internal Medicine |
| **Does your program participate in Holistic Review of Applications:** | Yes |
| **Check all that apply :** | Change in Step Score Cut Offs, or weight allotted  Blinded portions of ERAS application (picture, age, name, etc.) to combat implicit bias |
| **Do Faculty Search Committee members undergo Unconscious/Implicit Bias training:** | Yes |
| **Frequency of Faculty Search Committee Unconscious/Implicit Bias Training:** | Annual training |
| **Does your program participate in a Second Look program?:** | Yes |
| **Check all that apply:** | CU Second Look  Department-specific Second Look |
| **Describe your Department-specific Second Look :** | It is a fully virtual half day where interviewees join noon conference, meet with residents, faculty, and the program director again. Last year our schedule was as follows:   Panel with leadership (Dr. Chopra, Dr. Flores, Dr. Connors, Dr. Farajpour Bakhtiari)- 10:00 AM -11:00 AM  Panel with minority faculty- 11:00 AM -11:50 AM  Noon conference 12:00 PM - 1:00 PM  Panel with chief residents- 1:00 PM - 2:00 PM  Happy hour with residents later in the afternoon. Faculty including Dr. Farajpour Bakhtiari were excluded from the happy hour to provide a more relaxed and safer environment for applicants to ask questions.   This was all held virtually and overall it was successful and applicants had ample opportunities to ask questions. |
| **Do individuals participating in Resident/Fellow recruitment participate in Unconscious Bias training :** | Yes |
| **Resident/Fellow Recruitment Unconscious Bias training is completed by::** | Residency/Fellowship ERAS screeners  Residency/Fellowship Recruitment Interviewers  Residency/Fellowship Rank/Selection Committee |
| **Frequency of Resident/Fellow Recruitment Unconscious Bias training completed by Residency/Fellowship ERAS screeners:** | Annual training |
| **Frequency of Resident/Fellow Recruitment Unconscious Bias training completed by Residency/Fellowship Rank/Selection Committee members:** | Annual training |
| **Implicit Bias, Upstander, or Micro-aggression training (or similar) is completed by:** | all core faculty in program  all residents/fellows in program |
| **In which of these other diversity & inclusion activities below does your program participate? Check all that apply.:** | Program or Department Diversity Council/Committee  Healthcare inequity education formal didactic (non-clinical)  DEI topics included in formal trainee education  Outreach to HBCU, SNMA, LMSA\* (or similar) to actively recruit candidates  Diversity & Inclusion leadership appointed in Department (such as Vice Chair)\*\*  Other DEI initiatives not listed (please include all so we can add to our GME website) |
| **Approximate hours annually of Healthcare inequity education formal didactic (non-clinical):** | 8 |
| **Describe in more detail your program's outreach to diverse communities locally to alleviate disparities :** |  |
| **Approximate hours annually of DEI topics included in formal trainee education:** | 4 |
| **Describe in more detail your program's pipeline or mentoring programs for URiM students:** |  |
| **Describe in more detail your program's retention/mentoring support for the URiM candidates successfully recruited:** |  |
| **Approximate hours annually of Department-wide Cultural Humility, Cultural Responsiveness training:** |  |
| **Describe your other DEI initiatives:** | This year, our residency program leadership team will do a special training session in order to achieve individual Foundations in Equity Certificates. This program 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. Also new this year, our residents will 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. |
| **:** |  |
| **List ideas for trainings and/or workshops you would like to see in 2023-2024 for the GME community:** | None |
| **Email address of person completing the APE:** | [Nicole.CanterburyPassoth@CUAnschutz.edu](mailto:Nicole.CanterburyPassoth@CUAnschutz.edu) |

|  |
| --- |
| **URiM (Underrepresented in Medicine) DATA FOR THE OFFICE OF DIVERSITY & INCLUSION** |

Complete the questions at this [link](https://ucdenverdata.formstack.com/forms/urim_ape).

**Please share your feedback about this year’s GME Annual Program Evaluation template** [**here**](https://ucdenver.co1.qualtrics.com/jfe/form/SV_7UM2i3SBj8jUyBo)**.**