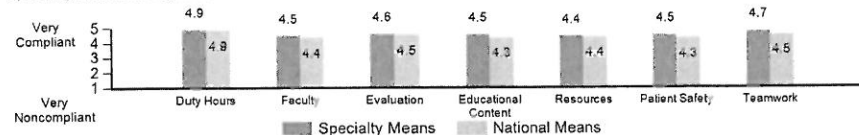
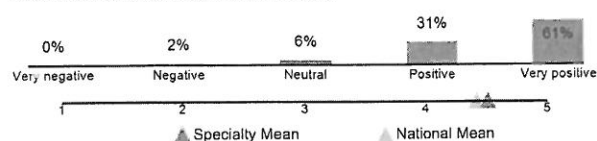


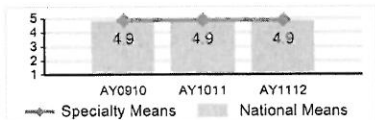
Specialty Means at-a-glance



Residents' overall evaluation of the program



Duty Hours



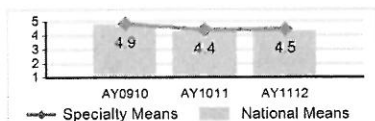
- 80 hours
- 1 day free in 7
- In-house call every 3rd night
- Night float no more than 6 nights
- 8 hours between duty periods (differs by level of training)
- Continuous hours scheduled (differs by level of training)

	% Compliant	Mean	National
80 hours	98%	4.9	4.8
1 day free in 7	99%	4.9	4.9
In-house call every 3rd night	99%	4.9	5.0
Night float no more than 6 nights	100%	5.0	5.0
8 hours between duty periods (differs by level of training)	99%	4.9	4.7
Continuous hours scheduled (differs by level of training)	96%	4.8	4.8

Reasons for exceeding duty hours:

Patient needs	4%	Cover other's work	1%
Paperwork	2%	Night float	0%
Ed. Experience	2%	Schedule conflict	2%
		Other	2%

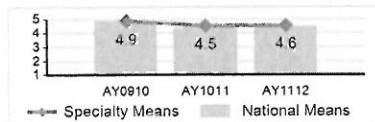
Faculty



- Sufficient supervision
- Appropriate supervision
- Sufficient instruction
- Faculty and staff interested
- Faculty and staff create environment of inquiry

	% Compliant	Mean	National
Sufficient supervision	96%	4.5	4.4
Appropriate supervision	98%	4.8	4.7
Sufficient instruction	91%	4.3	4.2
Faculty and staff interested	90%	4.4	4.3
Faculty and staff create environment of inquiry	88%	4.3	4.2

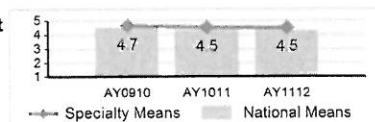
Evaluation



- Access evaluations
- Evaluate faculty
- Evaluations of faculty confidential
- Evaluate program
- Evaluations of program confidential
- Program uses evaluations to improve
- Satisfied with feedback after assignments

	% Compliant	Mean	National
Access evaluations	99%	5.0	5.0
Evaluate faculty	100%	5.0	5.0
Evaluations of faculty confidential	90%	4.4	4.3
Evaluate program	99%	5.0	4.9
Evaluations of program confidential	93%	4.4	4.3
Program uses evaluations to improve	80%	4.2	4.0
Satisfied with feedback after assignments	80%	4.1	4.0

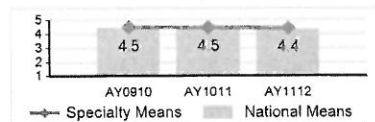
Educational Content



- Provided goals and objectives for assignments
- Instructed to manage fatigue
- Satisfied with scholarly activities
- Appropriate balance for education
- Education (not) compromised by service
- Supervisors delegate appropriately
- Given data to show personal clinical effectiveness
- Variety of patients

	% Compliant	Mean	National
Provided goals and objectives for assignments	98%	4.9	4.9
Instructed to manage fatigue	96%	4.9	4.8
Satisfied with scholarly activities	90%	4.4	4.1
Appropriate balance for education	90%	4.4	4.2
Education (not) compromised by service	87%	4.3	4.0
Supervisors delegate appropriately	91%	4.3	4.2
Given data to show personal clinical effectiveness	77%	4.1	3.6
Variety of patients	96%	4.8	4.9

Resources

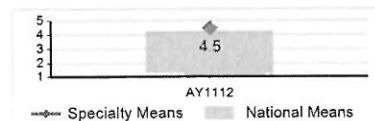


- Access to reference materials
- Electronic medical record in hospital*
- Electronic medical record in ambulatory*
- Electronic medical records integrated*
- Electronic medical record effective in daily clinical work
- Way to transition care when fatigued
- Satisfied with process to deal with problems and concerns
- Education (not) compromised by other trainees
- Residents can raise concerns without fear

	% Compliant / % Yes*	Mean	National
Access to reference materials	100%	5.0	5.0
Electronic medical record in hospital*	93%	4.7	4.6
Electronic medical record in ambulatory*	76%	4.0	4.5
Electronic medical records integrated*	71%	4.8	4.7
Electronic medical record effective in daily clinical work	97%	4.2	4.1
Way to transition care when fatigued	88%	4.5	4.2
Satisfied with process to deal with problems and concerns	83%	4.2	4.2
Education (not) compromised by other trainees	87%	4.4	4.5
Residents can raise concerns without fear	83%	4.3	4.2

*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

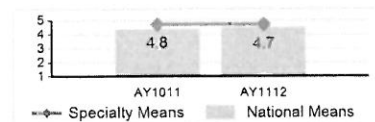
Patient Safety



- Tell patients of respective role of residents
- Culture reinforces patient safety responsibility
- Participated in quality improvement
- Information (not) lost during shift changes

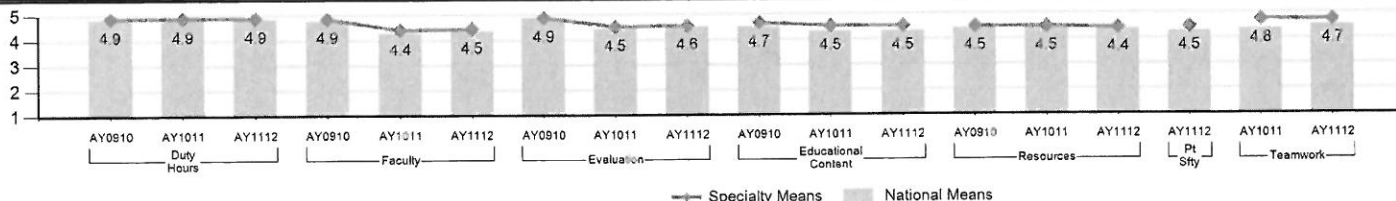
	% Compliant	Mean	National
Tell patients of respective role of residents	100%	4.7	4.5
Culture reinforces patient safety responsibility	100%	4.6	4.5
Participated in quality improvement	93%	4.7	4.0
Information (not) lost during shift changes	97%	4.0	4.0

Teamwork

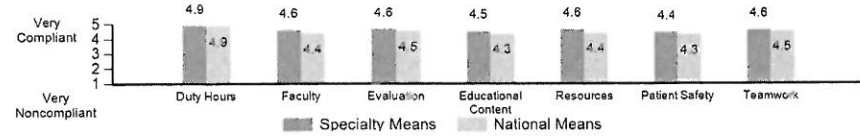


- Work in interprofessional teams
- Effectively work in interprofessional teams

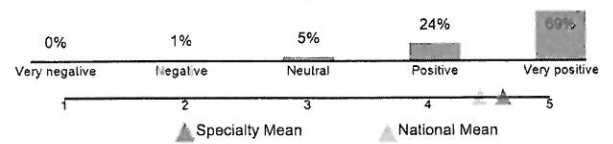
	% Compliant	Mean	National
Work in interprofessional teams	100%	4.9	4.6
Effectively work in interprofessional teams	100%	4.6	4.4



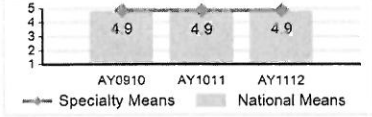
Specialty Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

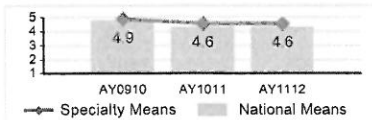


	% Compliant	Mean	National
80 hours	98%	4.9	4.8
1 day free in 7	98%	4.9	4.9
In-house call every 3rd night	100%	5.0	5.0
Night float no more than 6 nights	100%	5.0	5.0
8 hours between duty periods (differs by level of training)	99%	4.6	4.7
Continuous hours scheduled (differs by level of training)	99%	4.9	4.8

Reasons for exceeding duty hours:

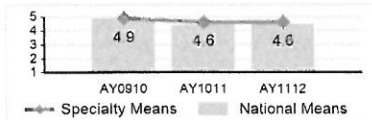
Patient needs	2%	Cover other's work	1%
Paperwork	1%	Night float	0%
Ed. Experience	2%	Schedule conflict	1%
		Other	1%

Faculty



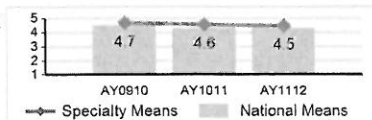
	% Compliant	Mean	National
Sufficient supervision	98%	4.6	4.4
Appropriate supervision	99%	4.8	4.7
Sufficient instruction	93%	4.5	4.2
Faculty and staff interested	91%	4.5	4.3
Faculty and staff create environment of inquiry	87%	4.4	4.2

Evaluation



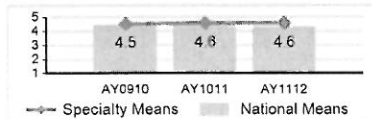
	% Compliant	Mean	National
Access evaluations	99%	5.0	5.0
Evaluate faculty	99%	5.0	5.0
Evaluations of faculty confidential	88%	4.4	4.3
Evaluate program	99%	5.0	4.9
Evaluations of program confidential	90%	4.5	4.3
Program uses evaluations to improve	83%	4.3	4.0
Satisfied with feedback after assignments	85%	4.3	4.0

Educational Content



	% Compliant	Mean	National
Provided goals and objectives for assignments	99%	5.0	4.9
Instructed to manage fatigue	99%	4.9	4.8
Satisfied with scholarly activities	88%	4.4	4.1
Appropriate balance for education	90%	4.5	4.2
Education (not) compromised by service	81%	4.3	4.0
Supervisors delegate appropriately	88%	4.2	4.2
Given data to show personal clinical effectiveness	68%	3.7	3.6
Variety of patients	99%	5.0	4.9

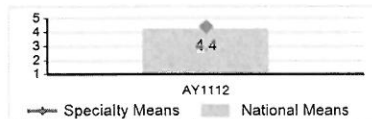
Resources



	% Compliant / % Yes*	Mean	National
Access to reference materials	99%	5.0	5.0
Electronic medical record in hospital*	93%	4.7	4.6
Electronic medical record in ambulatory*	91%	4.6	4.5
Electronic medical records integrated*	85%	4.9	4.7
Electronic medical record effective in daily clinical work	96%	4.3	4.1
Way to transition care when fatigued	95%	4.8	4.2
Satisfied with process to deal with problems and concerns	87%	4.4	4.2
Education (not) compromised by other trainees	95%	4.7	4.5
Residents can raise concerns without fear	90%	4.5	4.2

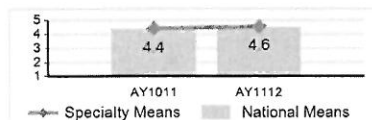
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

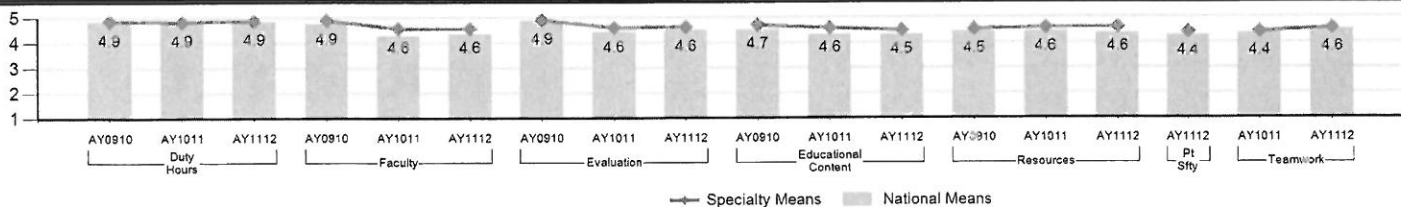


	% Compliant	Mean	National
Tell patients of respective role of residents	99%	4.6	4.5
Culture reinforces patient safety responsibility	100%	4.7	4.5
Participated in quality improvement	76%	4.1	4.0
Information (not) lost during shift changes	98%	4.3	4.0

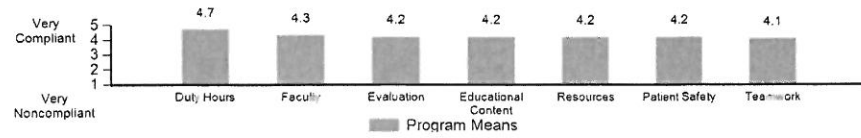
Teamwork



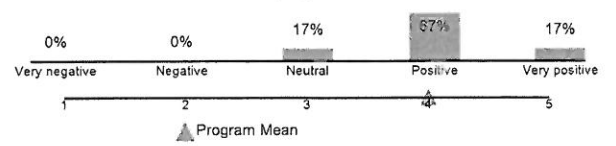
	% Compliant	Mean	National
Work in interprofessional teams	99%	4.6	4.6
Effectively work in interprofessional teams	99%	4.5	4.4



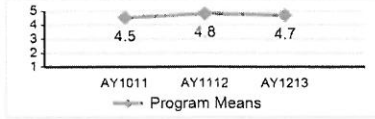
Program Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

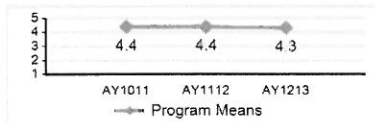


Requirement	% Compliant	Mean
80 hours	100%	4.7
1 day free in 7	100%	4.8
In-house call every 3rd night	100%	5.0
Night float no more than 6 nights	100%	5.0
8 hours between duty periods (differs by level of training)	83%	3.8
Continuous hours scheduled (differs by level of training)	100%	5.0

Reasons for exceeding duty hours:

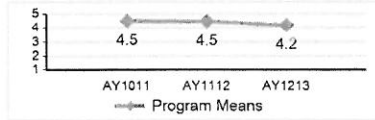
Reason	Percentage	Reason	Percentage
Patient needs	17%	Cover other's work	0%
Paperwork	0%	Night float	0%
Ed. Experience	0%	Schedule conflict	0%
		Other	0%

Faculty



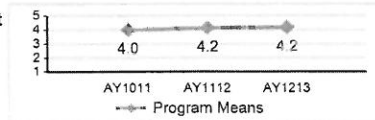
Requirement	% Compliant	Mean
Sufficient supervision	100%	4.3
Appropriate supervision	83%	4.3
Sufficient instruction	100%	4.3
Faculty and staff interested	100%	4.5
Faculty and staff create environment of inquiry	83%	4.2

Evaluation



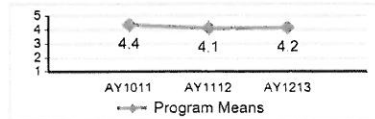
Requirement	% Compliant	Mean
Access evaluations	100%	5.0
Evaluate faculty	100%	5.0
Evaluations of faculty confidential	67%	3.8
Evaluate program	100%	5.0
Evaluations of program confidential	50%	3.7
Program uses evaluations to improve	50%	3.5
Satisfied with feedback after assignments	67%	3.3

Educational Content



Requirement	% Compliant	Mean
Provided goals and objectives for assignments	100%	5.0
Instructed to manage fatigue	100%	5.0
Satisfied with scholarly activities	67%	4.0
Appropriate balance for education	83%	4.0
Education (not) compromised by service	67%	3.5
Supervisors delegate appropriately	100%	4.8
Given data to show personal clinical effectiveness	33%	2.3
Variety of patients	100%	5.0

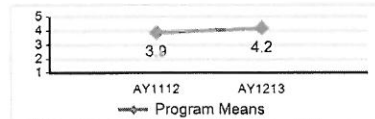
Resources



Requirement	% Compliant / % Yes*	Mean
Access to reference materials	100%	5.0
Electronic medical record in hospital*	100%	5.0
Electronic medical record in ambulatory*	100%	5.0
Electronic medical records integrated*	100%	5.0
Electronic medical record effective in daily clinical work	83%	3.5
Way to transition care when fatigued	83%	4.3
Satisfied with process to deal with problems and concerns	67%	3.5
Education (not) compromised by other trainees	100%	4.8
Residents can raise concerns without fear	67%	3.8

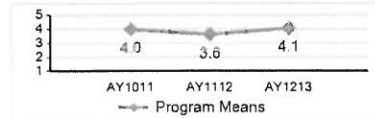
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

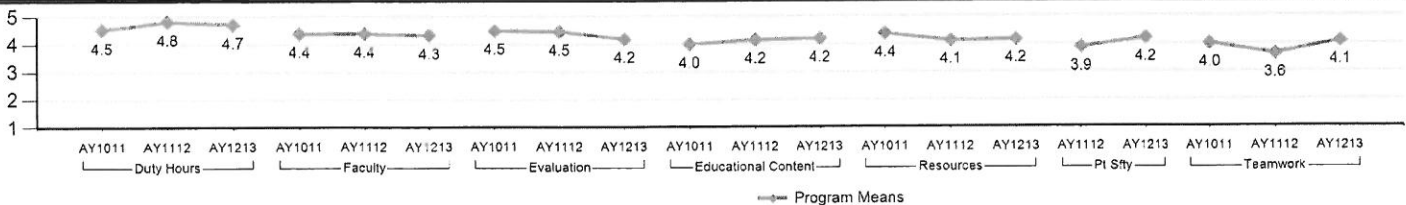


Requirement	% Compliant	Mean
Tell patients of respective role of residents	100%	4.7
Culture reinforces patient safety responsibility	100%	4.3
Participated in quality improvement	67%	3.7
Information (not) lost during shift changes	100%	4.2

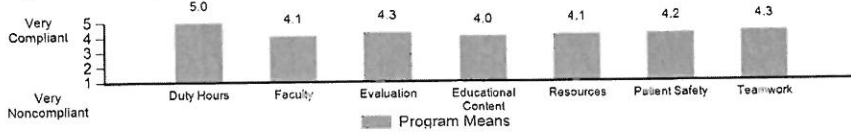
Teamwork



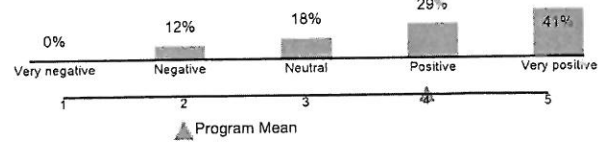
Requirement	% Compliant	Mean
Work in interprofessional teams	100%	4.3
Effectively work in interprofessional teams	100%	3.8



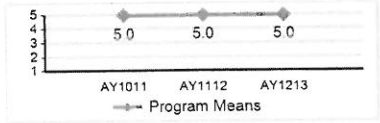
Program Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

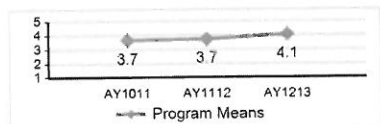


	% Compliant	Mean
80 hours	100%	5.0
1 day free in 7	100%	4.9
In-house call every 3rd night	100%	5.0
Night float no more than 6 nights	100%	4.9
8 hours between duty periods (differs by level of training)	100%	5.0
Continuous hours scheduled (differs by level of training)	100%	5.0

Reasons for exceeding duty hours:

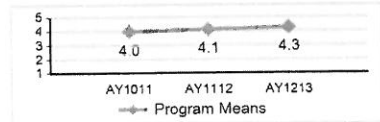
Reason	%	Reason	%
Patient needs	0%	Cover other's work	0%
Paperwork	0%	Night float	0%
Ed. Experience	0%	Schedule conflict	0%
		Other	0%

Faculty



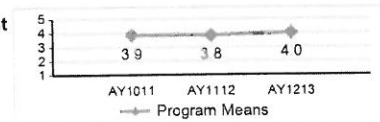
	% Compliant	Mean
Sufficient supervision	88%	4.5
Appropriate supervision	100%	4.6
Sufficient instruction	53%	3.8
Faculty and staff interested	59%	3.8
Faculty and staff create environment of inquiry	41%	3.5

Evaluation



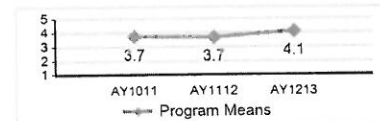
	% Compliant	Mean
Access evaluations	100%	5.0
Evaluate faculty	100%	5.0
Evaluations of faculty confidential	82%	4.0
Evaluate program	100%	5.0
Evaluations of program confidential	76%	4.0
Program uses evaluations to improve	53%	3.5
Satisfied with feedback after assignments	53%	3.5

Educational Content



	% Compliant	Mean
Provided goals and objectives for assignments	100%	5.0
Instructed to manage fatigue	100%	5.0
Satisfied with scholarly activities	71%	3.9
Appropriate balance for education	65%	3.8
Education (not) compromised by service	53%	3.5
Supervisors delegate appropriately	94%	4.3
Given data to show personal clinical effectiveness	35%	2.4
Variety of patients	82%	4.3

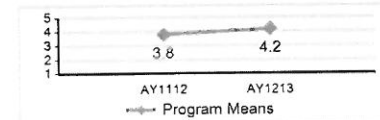
Resources



	% Compliant / % Yes*	Mean
Access to reference materials	100%	5.0
Electronic medical record in hospital*	100%	5.0
Electronic medical record in ambulatory*	88%	4.5
Electronic medical records integrated*	82%	4.8
Electronic medical record effective in daily clinical work	88%	3.7
Way to transition care when fatigued	71%	3.8
Satisfied with process to deal with problems and concerns	88%	4.2
Education (not) compromised by other trainees	88%	4.2
Residents can raise concerns without fear	59%	3.8

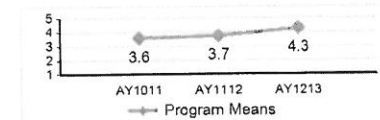
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

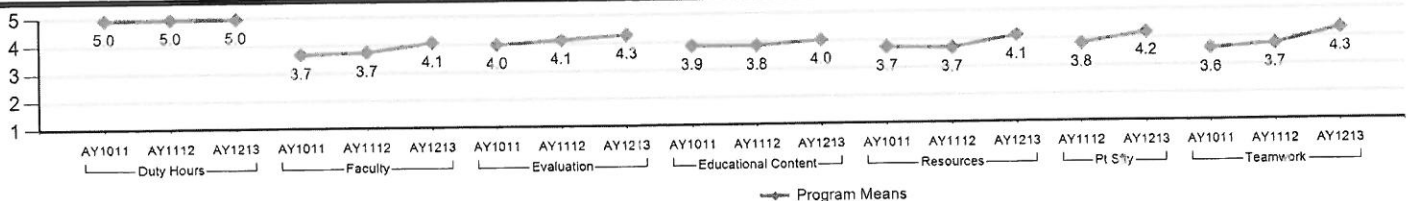


	% Compliant	Mean
Tell patients of respective role of residents	94%	4.2
Culture reinforces patient safety responsibility	100%	4.4
Participated in quality improvement	76%	4.1
Information (not) lost during shift changes	100%	4.1

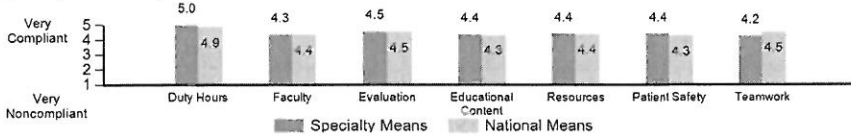
Teamwork



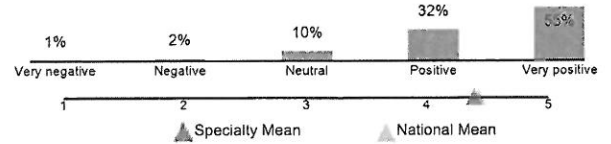
	% Compliant	Mean
Work in interprofessional teams	94%	4.4
Effectively work in interprofessional teams	100%	4.2



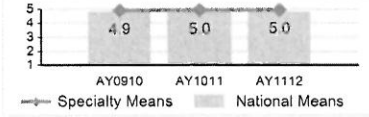
Specialty Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

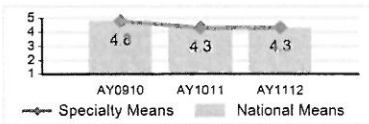


	% Compliant	Mean	National
80 hours	100%	5.0	4.8
1 day free in 7	100%	5.0	4.9
In-house call every 3rd night	100%	5.0	5.0
Night float no more than 6 nights	99%	5.0	5.0
8 hours between duty periods (differs by level of training)	99%	4.9	4.7
Continuous hours scheduled (differs by level of training)	100%	5.0	4.8

Reasons for exceeding duty hours:

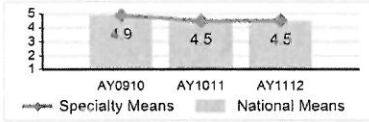
Patient needs	0%	Cover other's work	0%
Paperwork	0%	Night float	1%
Ed. Experience	0%	Schedule conflict	0%
		Other	0%

Faculty



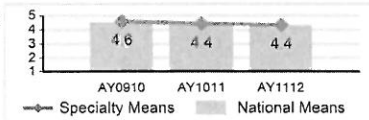
	% Compliant	Mean	National
Sufficient supervision	93%	4.4	4.4
Appropriate supervision	97%	4.7	4.7
Sufficient instruction	88%	4.3	4.2
Faculty and staff interested	84%	4.2	4.3
Faculty and staff create environment of inquiry	80%	4.1	4.2

Evaluation



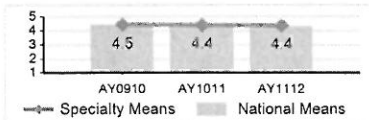
	% Compliant	Mean	National
Access evaluations	100%	5.0	5.0
Evaluate faculty	99%	5.0	5.0
Evaluations of faculty confidential	86%	4.3	4.3
Evaluate program	99%	5.0	4.9
Evaluations of program confidential	88%	4.4	4.3
Program uses evaluations to improve	75%	4.0	4.0
Satisfied with feedback after assignments	76%	4.0	4.0

Educational Content



	% Compliant	Mean	National
Provided goals and objectives for assignments	98%	4.9	4.9
Instructed to manage fatigue	97%	4.9	4.8
Satisfied with scholarly activities	82%	4.2	4.1
Appropriate balance for education	88%	4.4	4.2
Education (not) compromised by service	83%	4.2	4.0
Supervisors delegate appropriately	92%	4.3	4.2
Given data to show personal clinical effectiveness	60%	3.4	3.6
Variety of patients	90%	4.6	4.9

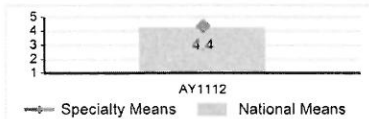
Resources



	% Compliant / % Yes*	Mean	National
Access to reference materials	99%	5.0	5.0
Electronic medical record in hospital*	96%	4.8	4.6
Electronic medical record in ambulatory*	92%	4.7	4.5
Electronic medical records integrated*	87%	4.8	4.7
Electronic medical record effective in daily clinical work	95%	4.1	4.1
Way to transition care when fatigued	82%	4.3	4.2
Satisfied with process to deal with problems and concerns	84%	4.2	4.2
Education (not) compromised by other trainees	93%	4.5	4.5
Residents can raise concerns without fear	83%	4.3	4.2

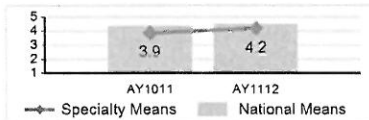
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

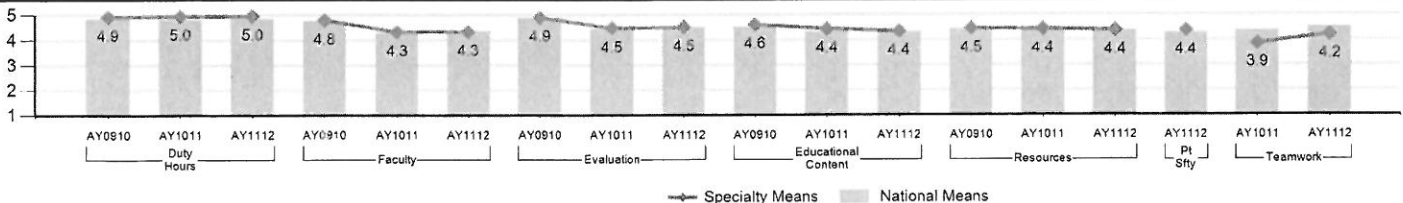


	% Compliant	Mean	National
Tell patients of respective role of residents	96%	4.4	4.5
Culture reinforces patient safety responsibility	99%	4.5	4.5
Participated in quality improvement	81%	4.3	4.0
Information (not) lost during shift changes	99%	4.4	4.0

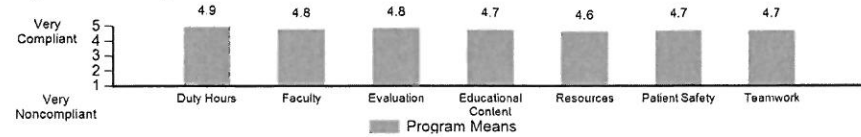
Teamwork



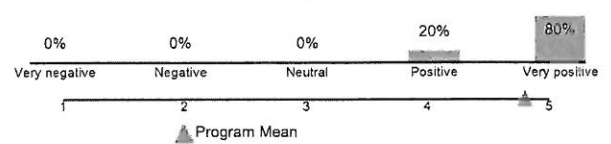
	% Compliant	Mean	National
Work in interprofessional teams	90%	4.1	4.6
Effectively work in interprofessional teams	99%	4.4	4.4



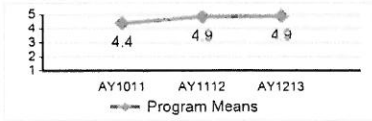
Program Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

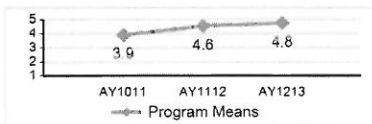


Requirement	% Compliant	Mean
80 hours	100%	4.9
1 day free in 7	100%	5.0
In-house call every 3rd night	100%	5.0
Night float no more than 6 nights	100%	5.0
8 hours between duty periods (differs by level of training)	100%	4.6
Continuous hours scheduled (differs by level of training)	100%	5.0

Reasons for exceeding duty hours:

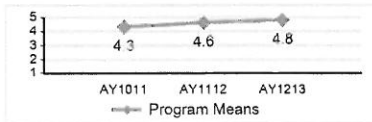
Reason	%	Reason	%
Patient needs	0%	Cover other's work	0%
Paperwork	0%	Night float	0%
Ed. Experience	0%	Schedule conflict	0%
		Other	0%

Faculty



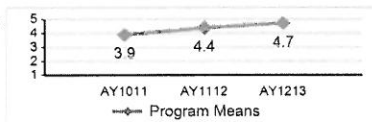
Requirement	% Compliant	Mean
Sufficient supervision	100%	4.8
Appropriate supervision	100%	4.9
Sufficient instruction	100%	4.7
Faculty and staff interested	100%	4.6
Faculty and staff create environment of inquiry	100%	4.8

Evaluation



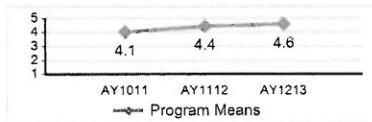
Requirement	% Compliant	Mean
Access evaluations	100%	5.0
Evaluate faculty	100%	5.0
Evaluations of faculty confidential	100%	4.8
Evaluate program	100%	5.0
Evaluations of program confidential	100%	4.8
Program uses evaluations to improve	100%	4.6
Satisfied with feedback after assignments	100%	4.6

Educational Content



Requirement	% Compliant	Mean
Provided goals and objectives for assignments	100%	5.0
Instructed to manage fatigue	100%	5.0
Satisfied with scholarly activities	100%	5.0
Appropriate balance for education	90%	4.5
Education (not) compromised by service	90%	4.4
Supervisors delegate appropriately	100%	4.8
Given data to show personal clinical effectiveness	80%	4.2
Variety of patients	100%	5.0

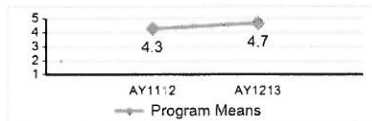
Resources



Requirement	% Compliant / % Yes*	Mean
Access to reference materials	100%	5.0
Electronic medical record in hospital*	100%	5.0
Electronic medical record in ambulatory*	100%	5.0
Electronic medical records integrated*	100%	5.0
Electronic medical record effective in daily clinical work	100%	4.0
Way to transition care when fatigued	90%	4.6
Satisfied with process to deal with problems and concerns	100%	4.6
Education (not) compromised by other trainees	100%	4.7
Residents can raise concerns without fear	100%	4.7

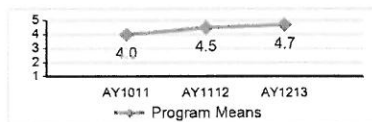
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

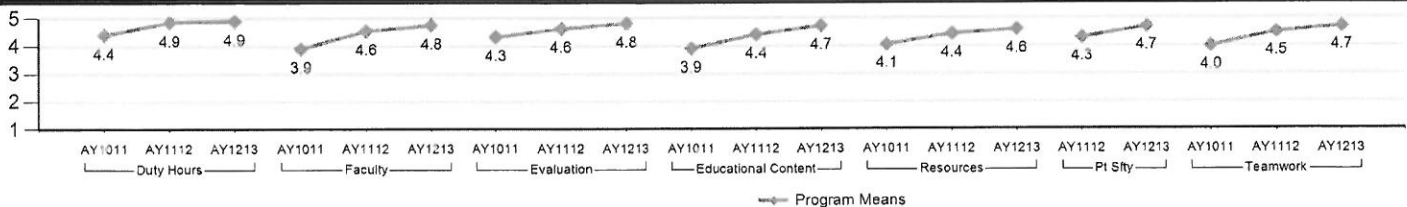


Requirement	% Compliant	Mean
Tell patients of respective role of residents	100%	4.7
Culture reinforces patient safety responsibility	100%	4.8
Participated in quality improvement	90%	4.6
Information (not) lost during shift changes	100%	4.7

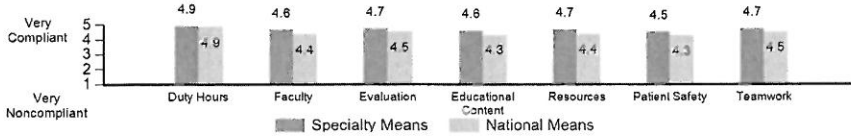
Teamwork



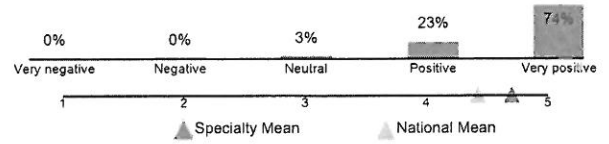
Requirement	% Compliant	Mean
Work in interprofessional teams	100%	4.8
Effectively work in interprofessional teams	100%	4.6



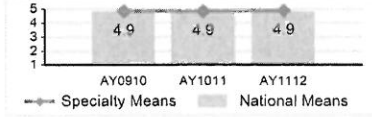
Specialty Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

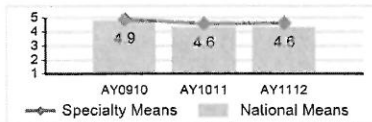


	% Compliant	Mean	National
80 hours	98%	4.9	4.8
1 day free in 7	99%	4.9	4.9
In-house call every 3rd night	100%	5.0	5.0
Night float no more than 6 nights	100%	5.0	5.0
8 hours between duty periods (differs by level of training)	97%	4.7	4.7
Continuous hours scheduled (differs by level of training)	99%	4.9	4.8

Reasons for exceeding duty hours:

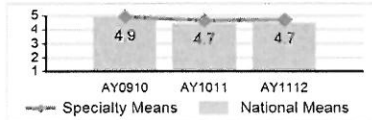
Patient needs	3%	Cover other's work	1%
Paperwork	3%	Night float	1%
Ed. Experience	2%	Schedule conflict	1%
		Other	1%

Faculty



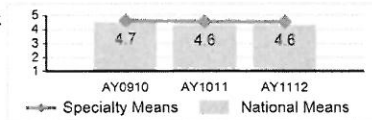
	% Compliant	Mean	National
Sufficient supervision	98%	4.6	4.4
Appropriate supervision	99%	4.8	4.7
Sufficient instruction	95%	4.6	4.2
Faculty and staff interested	95%	4.6	4.3
Faculty and staff create environment of inquiry	93%	4.6	4.2

Evaluation



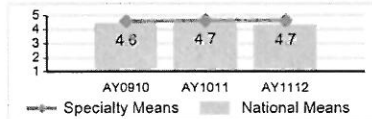
	% Compliant	Mean	National
Access evaluations	99%	5.0	5.0
Evaluate faculty	99%	5.0	5.0
Evaluations of faculty confidential	94%	4.6	4.3
Evaluate program	99%	5.0	4.9
Evaluations of program confidential	95%	4.6	4.3
Program uses evaluations to improve	90%	4.5	4.0
Satisfied with feedback after assignments	89%	4.4	4.0

Educational Content



	% Compliant	Mean	National
Provided goals and objectives for assignments	98%	4.9	4.9
Instructed to manage fatigue	98%	4.9	4.8
Satisfied with scholarly activities	93%	4.6	4.1
Appropriate balance for education	92%	4.5	4.2
Education (not) compromised by service	86%	4.3	4.0
Supervisors delegate appropriately	93%	4.5	4.2
Given data to show personal clinical effectiveness	71%	3.8	3.6
Variety of patients	99%	5.0	4.9

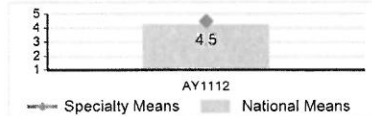
Resources



	% Compliant / % Yes*	Mean	National
Access to reference materials	100%	5.0	5.0
Electronic medical record in hospital*	95%	4.8	4.6
Electronic medical record in ambulatory*	93%	4.7	4.5
Electronic medical records integrated*	85%	4.8	4.7
Electronic medical record effective in daily clinical work	97%	4.3	4.1
Way to transition care when fatigued	93%	4.7	4.2
Satisfied with process to deal with problems and concerns	93%	4.6	4.2
Education (not) compromised by other trainees	97%	4.8	4.5
Residents can raise concerns without fear	92%	4.6	4.2

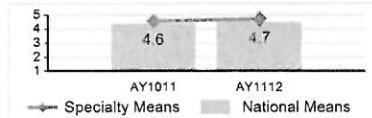
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

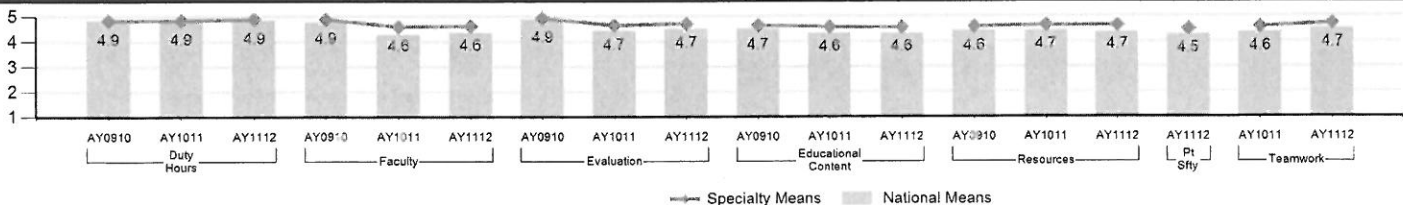


	% Compliant	Mean	National
Tell patients of respective role of residents	99%	4.6	4.5
Culture reinforces patient safety responsibility	100%	4.7	4.5
Participated in quality improvement	83%	4.3	4.0
Information (not) lost during shift changes	99%	4.4	4.0

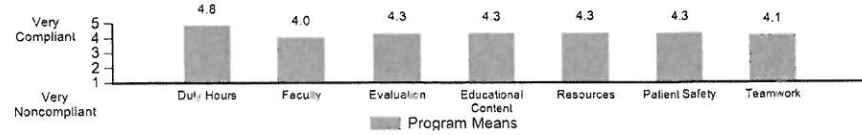
Teamwork



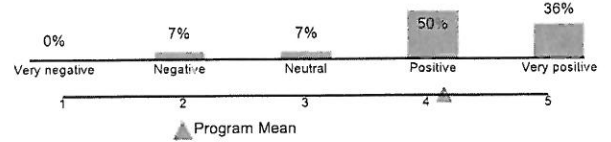
	% Compliant	Mean	National
Work in interprofessional teams	99%	4.8	4.6
Effectively work in interprofessional teams	100%	4.7	4.4



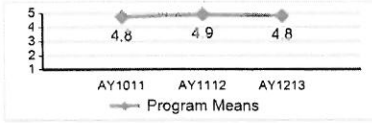
Program Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

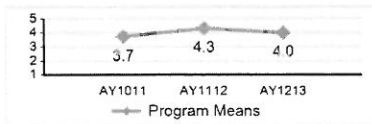


80 hours	100%	4.9
1 day free in 7	100%	4.9
In-house call every 3rd night	100%	5.0
Night float no more than 6 nights	100%	5.0
8 hours between duty periods (differs by level of training)	100%	4.6
Continuous hours scheduled (differs by level of training)	100%	4.7

Reasons for exceeding duty hours:

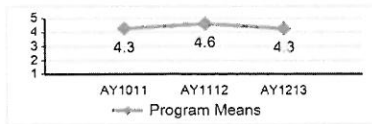
Patient needs	0%	Cover other's work	0%
Paperwork	0%	Night float	0%
Ed. Experience	0%	Schedule conflict	0%
		Other	0%

Faculty



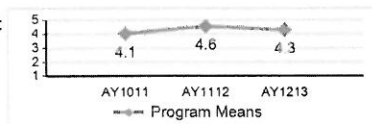
Sufficient supervision	93%	4.1
Appropriate supervision	100%	4.6
Sufficient instruction	71%	3.9
Faculty and staff interested	79%	4.0
Faculty and staff create environment of inquiry	50%	3.4

Evaluation



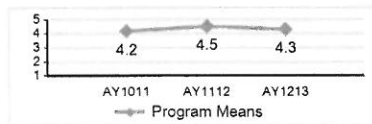
Access evaluations	100%	5.0
Evaluate faculty	100%	5.0
Evaluations of faculty confidential	71%	3.7
Evaluate program	100%	5.0
Evaluations of program confidential	79%	3.8
Program uses evaluations to improve	71%	3.7
Satisfied with feedback after assignments	64%	3.8

Educational Content



Provided goals and objectives for assignments	100%	5.0
Instructed to manage fatigue	100%	5.0
Satisfied with scholarly activities	71%	3.8
Appropriate balance for education	79%	4.0
Education (not) compromised by service	71%	3.9
Supervisors delegate appropriately	100%	4.6
Given data to show personal clinical effectiveness	57%	3.3
Variety of patients	100%	5.0

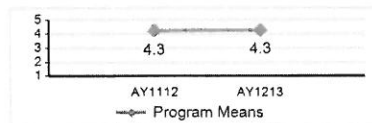
Resources



Access to reference materials	100%	5.0
Electronic medical record in hospital*	100%	5.0
Electronic medical record in ambulatory*	100%	5.0
Electronic medical records integrated*	100%	5.0
Electronic medical record effective in daily clinical work	100%	3.9
Way to transition care when fatigued	93%	4.7
Satisfied with process to deal with problems and concerns	64%	3.8
Education (not) compromised by other trainees	100%	4.6
Residents can raise concerns without fear	79%	4.0

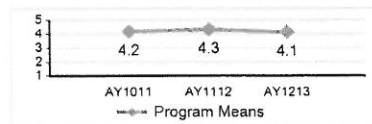
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

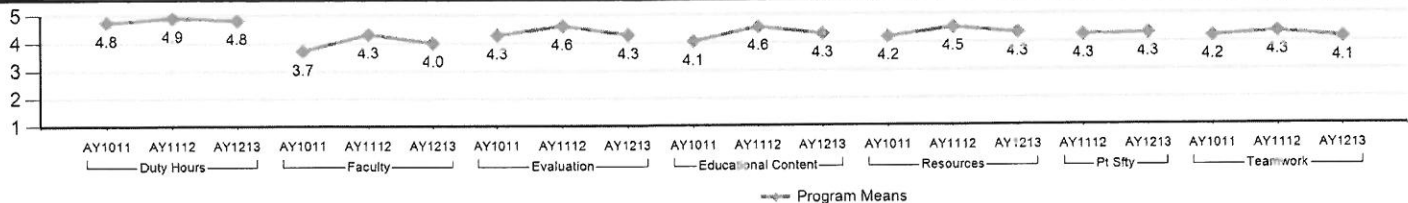


Tell patients of respective role of residents	93%	4.1
Culture reinforces patient safety responsibility	100%	4.4
Participated in quality improvement	100%	5.0
Information (not) lost during shift changes	100%	3.7

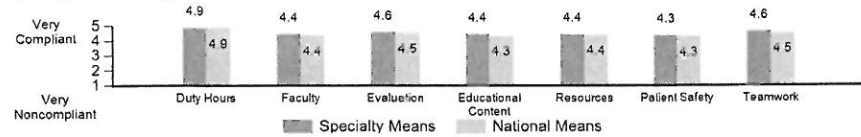
Teamwork



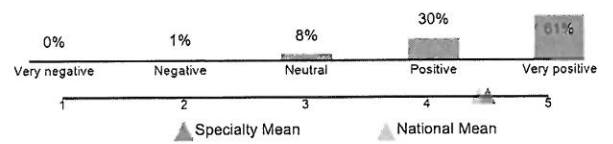
Work in interprofessional teams	100%	4.2
Effectively work in interprofessional teams	100%	4.1



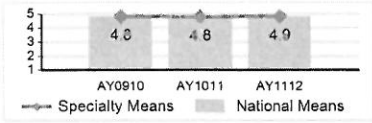
Specialty Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

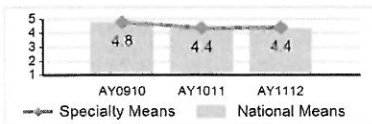


Requirement	% Compliant	Mean	National
80 hours	97%	4.7	4.8
1 day free in 7	97%	4.8	4.9
In-house call every 3rd night	100%	5.0	5.0
Night float no more than 6 nights	99%	5.0	5.0
8 hours between duty periods (differs by level of training)	98%	4.8	4.7
Continuous hours scheduled (differs by level of training)	98%	4.8	4.8

Reasons for exceeding duty hours:

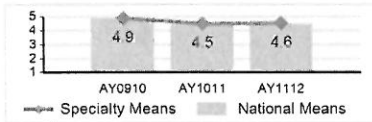
Patient needs	4%	Cover other's work	2%
Paperwork	6%	Night float	2%
Ed. Experience	2%	Schedule conflict	2%
		Other	1%

Faculty



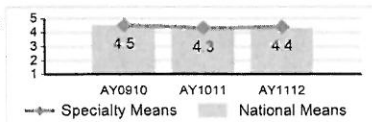
Requirement	% Compliant	Mean	National
Sufficient supervision	96%	4.5	4.4
Appropriate supervision	98%	4.8	4.7
Sufficient instruction	90%	4.3	4.2
Faculty and staff interested	90%	4.4	4.3
Faculty and staff create environment of inquiry	85%	4.2	4.2

Evaluation



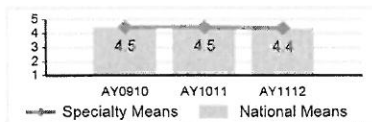
Requirement	% Compliant	Mean	National
Access evaluations	99%	5.0	5.0
Evaluate faculty	99%	5.0	5.0
Evaluations of faculty confidential	90%	4.4	4.3
Evaluate program	99%	5.0	4.9
Evaluations of program confidential	91%	4.4	4.3
Program uses evaluations to improve	81%	4.2	4.0
Satisfied with feedback after assignments	74%	4.0	4.0

Educational Content



Requirement	% Compliant	Mean	National
Provided goals and objectives for assignments	98%	4.9	4.9
Instructed to manage fatigue	95%	4.8	4.8
Satisfied with scholarly activities	81%	4.1	4.1
Appropriate balance for education	86%	4.3	4.2
Education (not) compromised by service	78%	4.1	4.0
Supervisors delegate appropriately	90%	4.3	4.2
Given data to show personal clinical effectiveness	72%	3.9	3.6
Variety of patients	99%	4.9	4.9

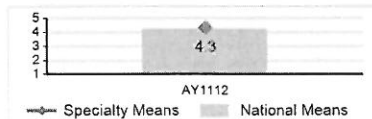
Resources



Requirement	% Compliant / % Yes*	Mean	National
Access to reference materials	100%	5.0	5.0
Electronic medical record in hospital*	87%	4.5	4.6
Electronic medical record in ambulatory*	81%	4.2	4.5
Electronic medical records integrated*	68%	4.7	4.7
Electronic medical record effective in daily clinical work	94%	4.1	4.1
Way to transition care when fatigued	80%	4.2	4.2
Satisfied with process to deal with problems and concerns	82%	4.2	4.2
Education (not) compromised by other trainees	92%	4.6	4.5
Residents can raise concerns without fear	86%	4.3	4.2

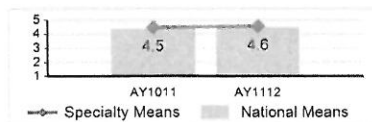
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

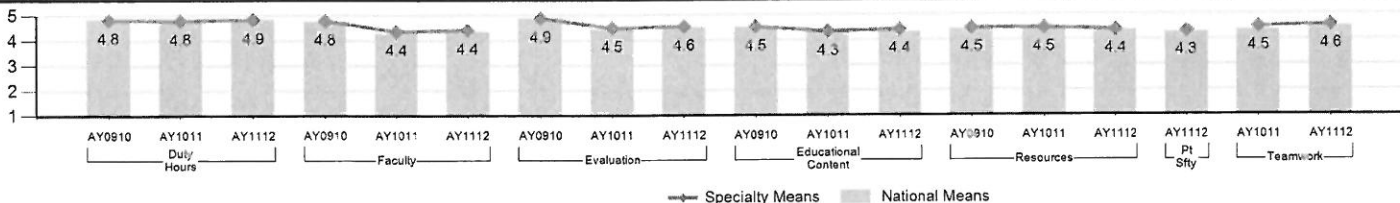


Requirement	% Compliant	Mean	National
Tell patients of respective role of residents	99%	4.6	4.5
Culture reinforces patient safety responsibility	100%	4.6	4.5
Participated in quality improvement	79%	4.1	4.0
Information (not) lost during shift changes	99%	4.1	4.0

Teamwork

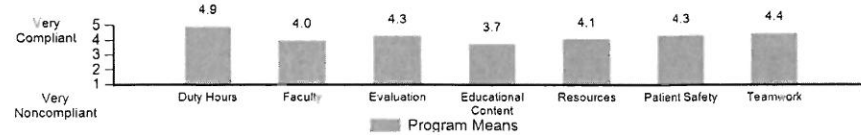


Requirement	% Compliant	Mean	National
Work in interprofessional teams	99%	4.7	4.6
Effectively work in interprofessional teams	99%	4.5	4.4

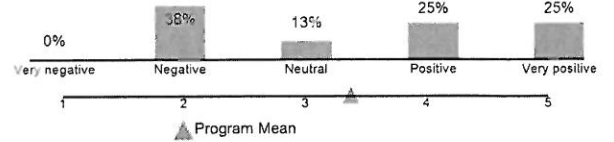


Aggregate reports are available only to programs with 4 or more residents / fellows if a 70.0% response rate is reached.

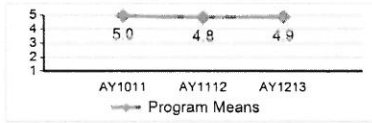
Program Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

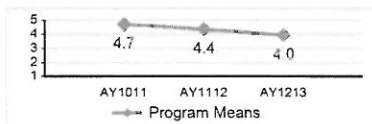


Requirement	% Compliant	Mean
80 hours	100%	4.9
1 day free in 7	100%	5.0
In-house call every 3rd night	100%	5.0
Night float no more than 6 nights	100%	5.0
8 hours between duty periods (differs by level of training)	100%	5.0
Continuous hours scheduled (differs by level of training)	75%	4.5

Reasons for exceeding duty hours:

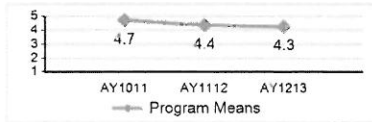
Reason	Percentage	Reason	Percentage
Patient needs	25%	Cover other's work	0%
Paperwork	25%	Night float	0%
Ed. Experience	13%	Schedule conflict	13%
		Other	13%

Faculty



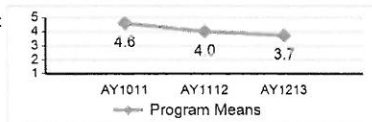
Requirement	% Compliant	Mean
Sufficient supervision	75%	4.0
Appropriate supervision	88%	4.4
Sufficient instruction	75%	4.0
Faculty and staff interested	63%	3.6
Faculty and staff create environment of inquiry	63%	3.8

Evaluation



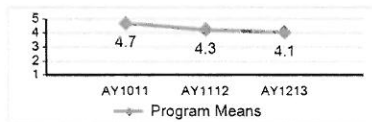
Requirement	% Compliant	Mean
Access evaluations	100%	5.0
Evaluate faculty	100%	5.0
Evaluations of faculty confidential	88%	4.3
Evaluate program	88%	4.5
Evaluations of program confidential	75%	4.1
Program uses evaluations to improve	38%	3.4
Satisfied with feedback after assignments	50%	3.6

Educational Content



Requirement	% Compliant	Mean
Provided goals and objectives for assignments	100%	5.0
Instructed to manage fatigue	75%	4.0
Satisfied with scholarly activities	38%	3.0
Appropriate balance for education	88%	4.0
Education (not) compromised by service	38%	3.0
Supervisors delegate appropriately	100%	4.4
Given data to show personal clinical effectiveness	13%	1.5
Variety of patients	100%	5.0

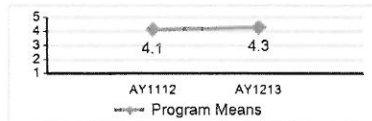
Resources



Requirement	% Compliant / % Yes*	Mean
Access to reference materials	100%	5.0
Electronic medical record in hospital*	100%	5.0
Electronic medical record in ambulatory*	100%	5.0
Electronic medical records integrated*	100%	5.0
Electronic medical record effective in daily clinical work	88%	3.5
Way to transition care when fatigued	88%	4.5
Satisfied with process to deal with problems and concerns	50%	3.4
Education (not) compromised by other trainees	100%	4.9
Residents can raise concerns without fear	63%	3.1

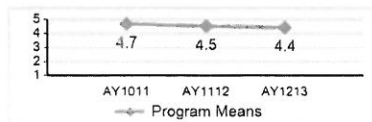
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

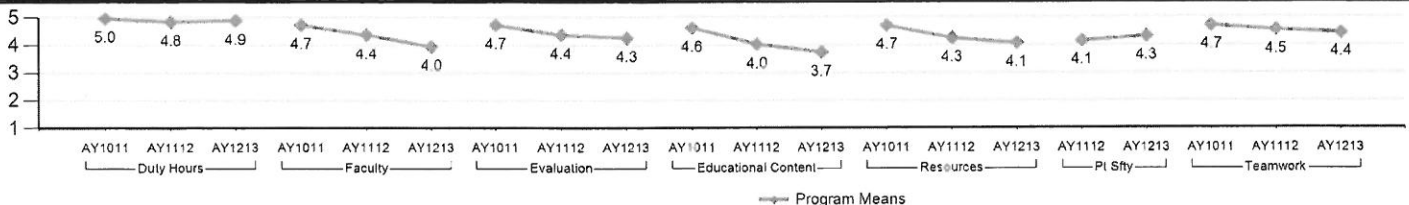


Requirement	% Compliant	Mean
Tell patients of respective role of residents	100%	4.6
Culture reinforces patient safety responsibility	100%	4.1
Participated in quality improvement	100%	5.0
Information (not) lost during shift changes	88%	3.5

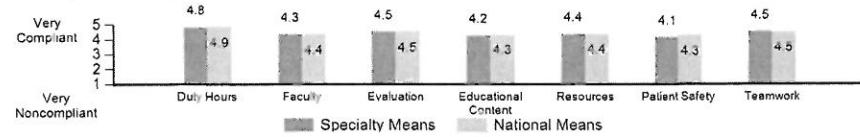
Teamwork



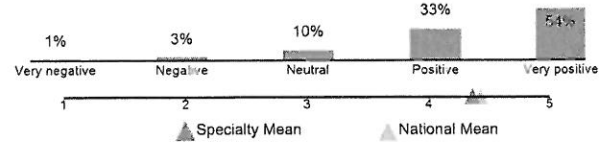
Requirement	% Compliant	Mean
Work in interprofessional teams	100%	4.6
Effectively work in interprofessional teams	100%	4.3



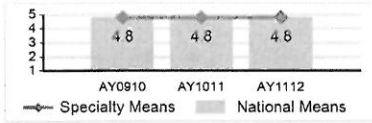
Specialty Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

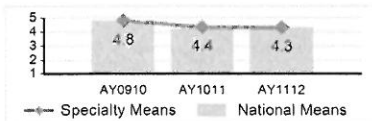


Requirement	% Compliant	Mean	National
80 hours	95%	4.7	4.8
1 day free in 7	97%	4.8	4.9
In-house call every 3rd night	99%	4.9	5.0
Night float no more than 6 nights	99%	5.0	5.0
8 hours between duty periods (differs by level of training)	97%	4.8	4.7
Continuous hours scheduled (differs by level of training)	94%	4.7	4.8

Reasons for exceeding duty hours:

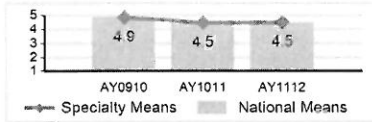
Patient needs	7%	Cover other's work	3%
Paperwork	9%	Night float	2%
Ed. Experience	2%	Schedule conflict	2%
		Other	3%

Faculty



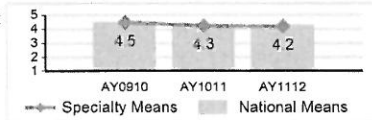
Requirement	% Compliant	Mean	National
Sufficient supervision	91%	4.3	4.4
Appropriate supervision	96%	4.7	4.7
Sufficient instruction	88%	4.3	4.2
Faculty and staff interested	86%	4.3	4.3
Faculty and staff create environment of inquiry	82%	4.2	4.2

Evaluation



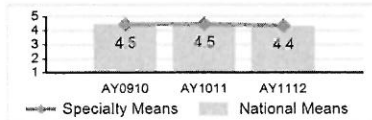
Requirement	% Compliant	Mean	National
Access evaluations	99%	5.0	5.0
Evaluate faculty	99%	5.0	5.0
Evaluations of faculty confidential	87%	4.3	4.3
Evaluate program	98%	4.9	4.9
Evaluations of program confidential	88%	4.3	4.3
Program uses evaluations to improve	75%	4.0	4.0
Satisfied with feedback after assignments	76%	4.0	4.0

Educational Content



Requirement	% Compliant	Mean	National
Provided goals and objectives for assignments	95%	4.8	4.9
Instructed to manage fatigue	93%	4.7	4.8
Satisfied with scholarly activities	76%	4.0	4.1
Appropriate balance for education	80%	4.1	4.2
Education (not) compromised by service	65%	3.8	4.0
Supervisors delegate appropriately	91%	4.2	4.2
Given data to show personal clinical effectiveness	60%	3.4	3.6
Variety of patients	96%	4.9	4.9

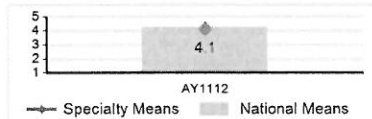
Resources



Requirement	% Compliant / % Yes*	Mean	National
Access to reference materials	99%	5.0	5.0
Electronic medical record in hospital*	92%	4.7	4.6
Electronic medical record in ambulatory*	92%	4.7	4.5
Electronic medical records integrated*	82%	4.8	4.7
Electronic medical record effective in daily clinical work	95%	4.1	4.1
Way to transition care when fatigued	79%	4.2	4.2
Satisfied with process to deal with problems and concerns	80%	4.1	4.2
Education (not) compromised by other trainees	95%	4.6	4.5
Residents can raise concerns without fear	82%	4.2	4.2

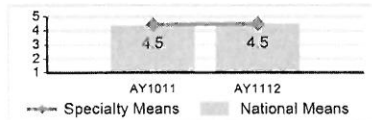
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

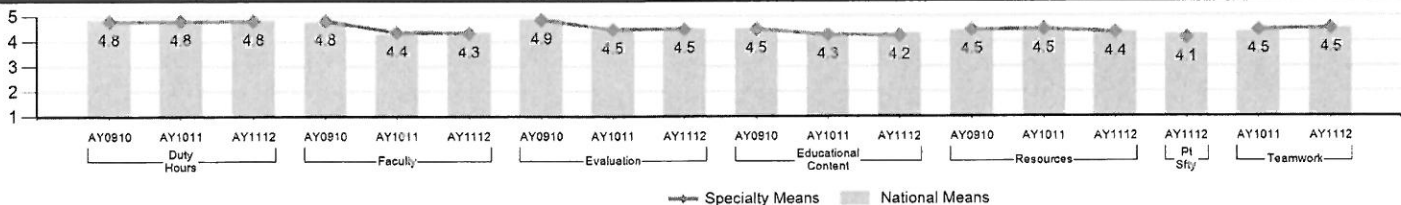


Requirement	% Compliant	Mean	National
Tell patients of respective role of residents	99%	4.5	4.5
Culture reinforces patient safety responsibility	99%	4.4	4.5
Participated in quality improvement	65%	3.6	4.0
Information (not) lost during shift changes	97%	4.0	4.0

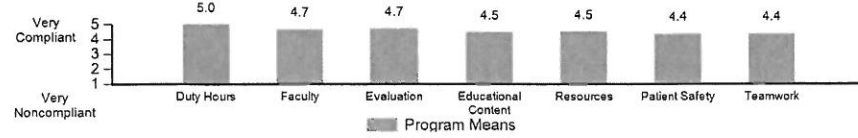
Teamwork



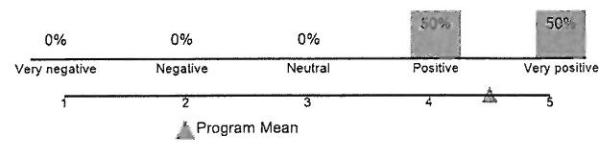
Requirement	% Compliant	Mean	National
Work in interprofessional teams	99%	4.6	4.6
Effectively work in interprofessional teams	99%	4.4	4.4



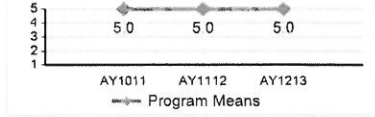
Program Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

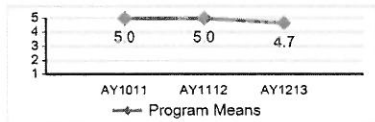


Requirement	% Compliant	Mean
80 hours	100%	5.0
1 day free in 7	100%	5.0
In-house call every 3rd night	100%	5.0
Night float no more than 6 nights	100%	5.0
8 hours between duty periods (differs by level of training)	100%	5.0
Continuous hours scheduled (differs by level of training)	100%	5.0

Reasons for exceeding duty hours:

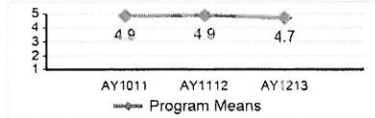
Reason	%	Reason	%
Patient needs	0%	Cover other's work	0%
Paperwork	0%	Night float	0%
Ed. Experience	0%	Schedule conflict	0%
		Other	0%

Faculty



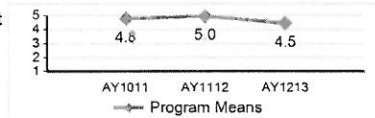
Requirement	% Compliant	Mean
Sufficient supervision	100%	4.5
Appropriate supervision	100%	5.0
Sufficient instruction	100%	4.8
Faculty and staff interested	100%	4.8
Faculty and staff create environment of inquiry	100%	4.3

Evaluation



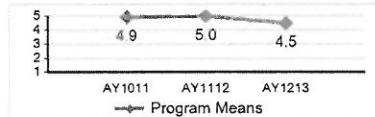
Requirement	% Compliant	Mean
Access evaluations	100%	5.0
Evaluate faculty	100%	5.0
Evaluations of faculty confidential	100%	4.8
Evaluate program	100%	5.0
Evaluations of program confidential	100%	4.5
Program uses evaluations to improve	100%	4.3
Satisfied with feedback after assignments	100%	4.5

Educational Content



Requirement	% Compliant	Mean
Provided goals and objectives for assignments	100%	5.0
Instructed to manage fatigue	100%	5.0
Satisfied with scholarly activities	100%	4.3
Appropriate balance for education	100%	4.3
Education (not) compromised by service	100%	4.3
Supervisors delegate appropriately	100%	5.0
Given data to show personal clinical effectiveness	50%	3.0
Variety of patients	100%	5.0

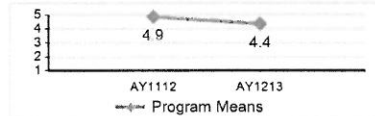
Resources



Requirement	% Compliant / % Yes*	Mean
Access to reference materials	100%	5.0
Electronic medical record in hospital*	100%	5.0
Electronic medical record in ambulatory*	100%	5.0
Electronic medical records integrated*	100%	5.0
Electronic medical record effective in daily clinical work	100%	4.0
Way to transition care when fatigued	100%	5.0
Satisfied with process to deal with problems and concerns	75%	4.0
Education (not) compromised by other trainees	100%	4.8
Residents can raise concerns without fear	100%	4.3

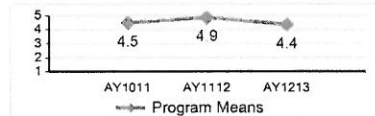
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

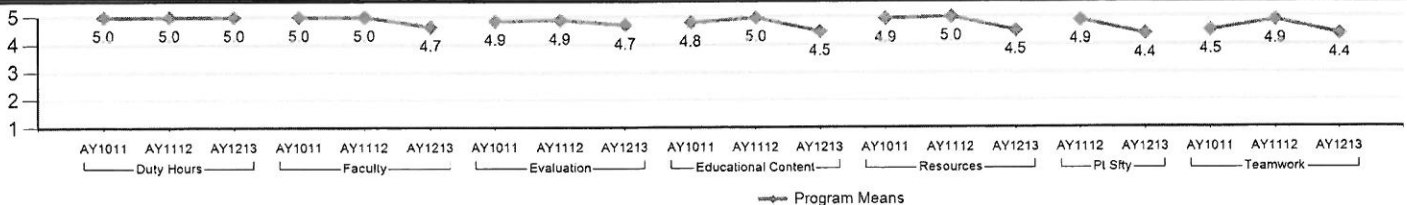


Requirement	% Compliant	Mean
Tell patients of respective role of residents	100%	5.0
Culture reinforces patient safety responsibility	100%	4.5
Participated in quality improvement	75%	4.0
Information (not) lost during shift changes	100%	4.0

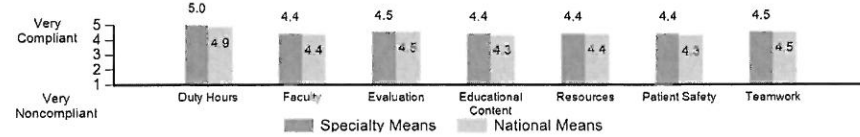
Teamwork



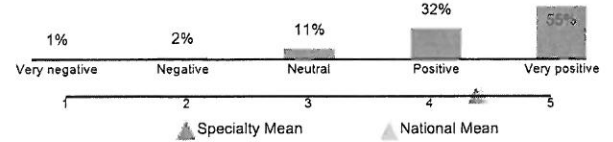
Requirement	% Compliant	Mean
Work in interprofessional teams	100%	4.8
Effectively work in interprofessional teams	100%	4.0



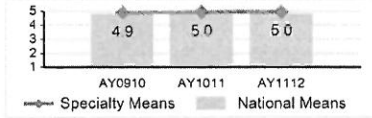
Specialty Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

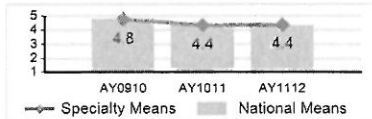


Requirement	% Compliant	Mean	National
80 hours	99%	5.0	4.8
1 day free in 7	100%	5.0	4.9
In-house call every 3rd night	100%	5.0	5.0
Night float no more than 6 nights	100%	5.0	5.0
8 hours between duty periods (differs by level of training)	99%	4.9	4.7
Continuous hours scheduled (differs by level of training)	100%	5.0	4.8

Reasons for exceeding duty hours:

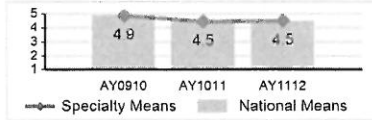
Patient needs	0%	Cover other's work	0%
Paperwork	1%	Night float	0%
Ed. Experience	0%	Schedule conflict	1%
		Other	0%

Faculty



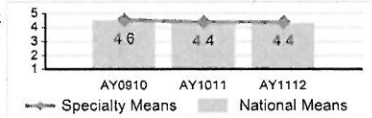
Requirement	% Compliant	Mean	National
Sufficient supervision	90%	4.3	4.4
Appropriate supervision	95%	4.6	4.7
Sufficient instruction	89%	4.3	4.2
Faculty and staff interested	91%	4.4	4.3
Faculty and staff create environment of inquiry	86%	4.3	4.2

Evaluation



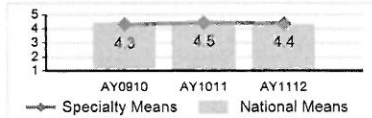
Requirement	% Compliant	Mean	National
Access evaluations	99%	5.0	5.0
Evaluate faculty	99%	5.0	5.0
Evaluations of faculty confidential	85%	4.2	4.3
Evaluate program	99%	5.0	4.9
Evaluations of program confidential	86%	4.3	4.3
Program uses evaluations to improve	79%	4.1	4.0
Satisfied with feedback after assignments	82%	4.1	4.0

Educational Content



Requirement	% Compliant	Mean	National
Provided goals and objectives for assignments	97%	4.9	4.9
Instructed to manage fatigue	97%	4.9	4.8
Satisfied with scholarly activities	84%	4.2	4.1
Appropriate balance for education	87%	4.3	4.2
Education (not) compromised by service	82%	4.2	4.0
Supervisors delegate appropriately	90%	4.3	4.2
Given data to show personal clinical effectiveness	63%	3.5	3.6
Variety of patients	98%	4.9	4.9

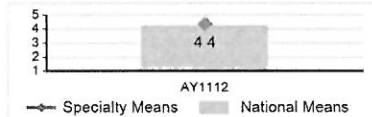
Resources



Requirement	% Compliant / % Yes*	Mean	National
Access to reference materials	99%	5.0	5.0
Electronic medical record in hospital*	86%	4.4	4.6
Electronic medical record in ambulatory*	75%	4.0	4.5
Electronic medical records integrated*	64%	4.7	4.7
Electronic medical record effective in daily clinical work	94%	4.1	4.1
Way to transition care when fatigued	81%	4.2	4.2
Satisfied with process to deal with problems and concerns	82%	4.2	4.2
Education (not) compromised by other trainees	96%	4.7	4.5
Residents can raise concerns without fear	81%	4.2	4.2

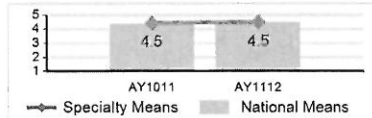
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

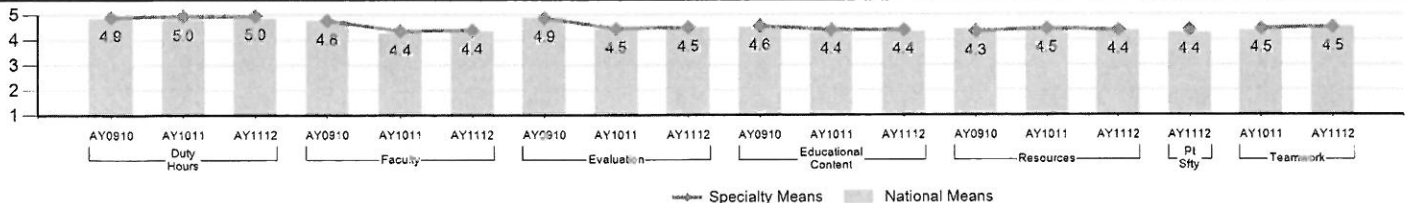


Requirement	% Compliant	Mean	National
Tell patients of respective role of residents	100%	4.7	4.5
Culture reinforces patient safety responsibility	99%	4.6	4.5
Participated in quality improvement	77%	4.1	4.0
Information (not) lost during shift changes	98%	4.3	4.0

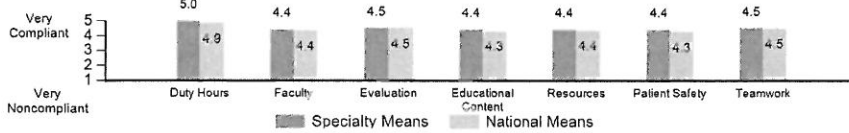
Teamwork



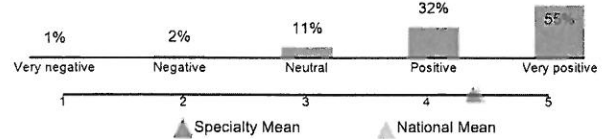
Requirement	% Compliant	Mean	National
Work in interprofessional teams	99%	4.7	4.6
Effectively work in interprofessional teams	99%	4.4	4.4



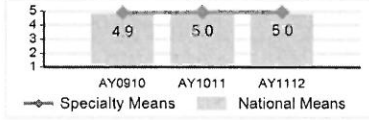
Specialty Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

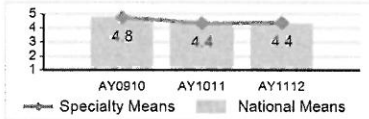


	% Compliant	Mean	National
80 hours	99%	5.0	4.8
1 day free in 7	100%	5.0	4.9
In-house call every 3rd night	100%	5.0	5.0
Night float no more than 6 nights	100%	5.0	5.0
8 hours between duty periods (differs by level of training)	99%	4.9	4.7
Continuous hours scheduled (differs by level of training)	100%	5.0	4.8

Reasons for exceeding duty hours:

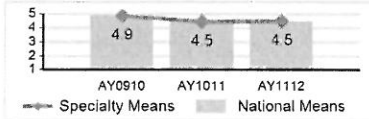
Patient needs	0%	Cover other's work	0%
Paperwork	1%	Night float	0%
Ed. Experience	0%	Schedule conflict	1%
		Other	0%

Faculty



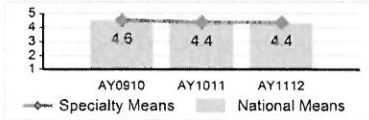
	% Compliant	Mean	National
Sufficient supervision	90%	4.3	4.4
Appropriate supervision	95%	4.6	4.7
Sufficient instruction	88%	4.3	4.2
Faculty and staff interested	91%	4.4	4.3
Faculty and staff create environment of inquiry	86%	4.3	4.2

Evaluation



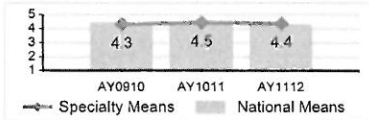
	% Compliant	Mean	National
Access evaluations	99%	5.0	5.0
Evaluate faculty	99%	5.0	5.0
Evaluations of faculty confidential	85%	4.2	4.3
Evaluate program	99%	5.0	4.9
Evaluations of program confidential	86%	4.3	4.3
Program uses evaluations to improve	79%	4.1	4.0
Satisfied with feedback after assignments	82%	4.1	4.0

Educational Content



	% Compliant	Mean	National
Provided goals and objectives for assignments	97%	4.9	4.9
Instructed to manage fatigue	97%	4.9	4.8
Satisfied with scholarly activities	84%	4.2	4.1
Appropriate balance for education	87%	4.3	4.2
Education (not) compromised by service	82%	4.2	4.0
Supervisors delegate appropriately	90%	4.3	4.2
Given data to show personal clinical effectiveness	63%	3.5	3.6
Variety of patients	98%	4.9	4.9

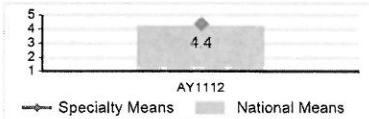
Resources



	% Compliant / % Yes*	Mean	National
Access to reference materials	99%	5.0	5.0
Electronic medical record in hospital*	86%	4.4	4.6
Electronic medical record in ambulatory*	75%	4.0	4.5
Electronic medical records integrated*	64%	4.7	4.7
Electronic medical record effective in daily clinical work	94%	4.1	4.1
Way to transition care when fatigued	81%	4.2	4.2
Satisfied with process to deal with problems and concerns	82%	4.2	4.2
Education (not) compromised by other trainees	96%	4.7	4.5
Residents can raise concerns without fear	81%	4.2	4.2

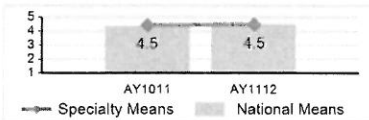
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

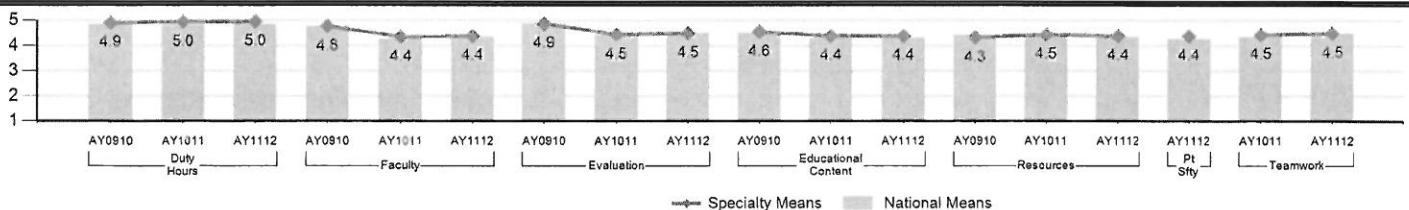


	% Compliant	Mean	National
Tell patients of respective role of residents	100%	4.7	4.5
Culture reinforces patient safety responsibility	99%	4.6	4.5
Participated in quality improvement	77%	4.1	4.0
Information (not) lost during shift changes	98%	4.3	4.0

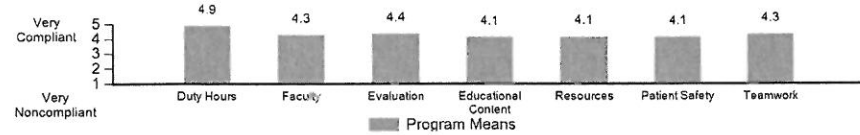
Teamwork



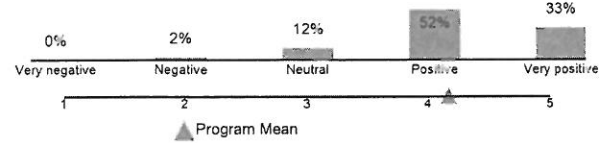
	% Compliant	Mean	National
Work in interprofessional teams	99%	4.7	4.6
Effectively work in interprofessional teams	99%	4.4	4.4



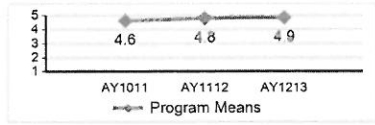
Program Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

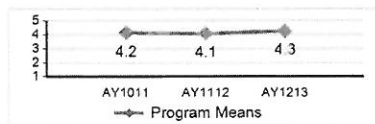


Requirement	% Compliant	Mean
80 hours	100%	4.7
1 day free in 7	98%	4.8
In-house call every 3rd night	100%	5.0
Night float no more than 6 nights	98%	5.0
8 hours between duty periods (differs by level of training)	98%	4.8
Continuous hours scheduled (differs by level of training)	100%	4.9

Reasons for exceeding duty hours:

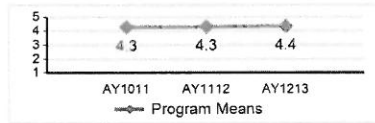
Patient needs	2%	Cover other's work	5%
Paperwork	7%	Night float	2%
Ed. Experience	2%	Schedule conflict	2%
		Other	0%

Faculty



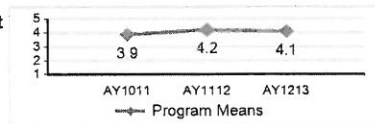
Requirement	% Compliant	Mean
Sufficient supervision	98%	4.2
Appropriate supervision	100%	4.6
Sufficient instruction	90%	3.9
Faculty and staff interested	98%	4.4
Faculty and staff create environment of inquiry	81%	4.1

Evaluation



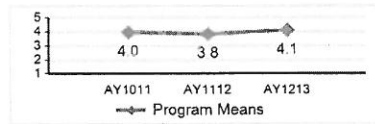
Requirement	% Compliant	Mean
Access evaluations	98%	4.9
Evaluate faculty	100%	5.0
Evaluations of faculty confidential	86%	4.3
Evaluate program	95%	4.8
Evaluations of program confidential	83%	4.2
Program uses evaluations to improve	48%	3.5
Satisfied with feedback after assignments	71%	3.8

Educational Content



Requirement	% Compliant	Mean
Provided goals and objectives for assignments	100%	5.0
Instructed to manage fatigue	100%	5.0
Satisfied with scholarly activities	67%	3.6
Appropriate balance for education	64%	3.7
Education (not) compromised by service	45%	3.5
Supervisors delegate appropriately	98%	4.5
Given data to show personal clinical effectiveness	40%	2.6
Variety of patients	98%	4.9

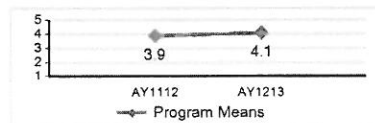
Resources



Requirement	% Compliant / % Yes*	Mean
Access to reference materials	100%	5.0
Electronic medical record in hospital*	100%	5.0
Electronic medical record in ambulatory*	100%	5.0
Electronic medical records integrated*	95%	4.8
Electronic medical record effective in daily clinical work	93%	3.5
Way to transition care when fatigued	76%	4.0
Satisfied with process to deal with problems and concerns	81%	4.1
Education (not) compromised by other trainees	86%	4.2
Residents can raise concerns without fear	71%	3.9

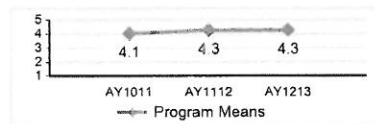
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

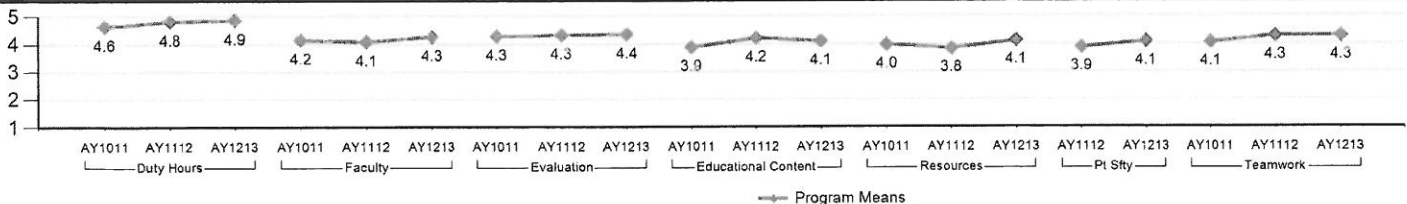


Requirement	% Compliant	Mean
Tell patients of respective role of residents	98%	4.4
Culture reinforces patient safety responsibility	100%	4.2
Participated in quality improvement	88%	4.5
Information (not) lost during shift changes	86%	3.2

Teamwork



Requirement	% Compliant	Mean
Work in interprofessional teams	100%	4.6
Effectively work in interprofessional teams	100%	4.0



I feel well prepared to perform the following procedures <i>without</i> supervision:	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Lumbar puncture	0.0%	0.0%	0.0%	15.4%	84.6%
Bag and mask ventilation	0.0%	0.0%	0.0%	7.7%	92.3%
Administer immunizations	0.0%	15.4%	30.8%	15.4%	38.5%
Neonatal endotracheal intubation	7.7%	0.0%	0.0%	30.8%	61.5%
Neonatal delivery room resuscitation	0.0%	0.0%	7.7%	53.8%	38.5%
Peripheral intravenous catheter placement	0.0%	15.4%	38.5%	38.5%	7.7%
Umbilical catheter placement	0.0%	0.0%	0.0%	76.9%	23.1%
Simple laceration repair (simple suturing)	0.0%	0.0%	0.0%	46.2%	53.8%
Bladder catheterization	0.0%	0.0%	23.1%	30.8%	46.2%
Incision and drainage of an abscess	0.0%	7.7%	0.0%	30.8%	61.5%
Reduction of simple joint dislocations	7.7%	15.4%	38.5%	38.5%	0.0%
Simple removal of a foreign body	0.0%	0.0%	15.4%	61.5%	23.1%
Temporary splinting of a fracture	7.7%	15.4%	15.4%	53.8%	7.7%

I feel well prepared to perform the following patient care activities <i>without</i> supervision:	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Provide healthcare maintenance for infants, children, and adolescents	0.0%	0.0%	0.0%	23.1%	76.9%
Care for well newborns	0.0%	0.0%	0.0%	23.1%	76.9%
Manage otherwise well pediatric patients having acute illnesses	0.0%	0.0%	0.0%	23.1%	76.9%
Resuscitate, stabilize, and triage pediatric patients with severe illness	0.0%	0.0%	7.7%	69.2%	23.1%
Recognize and assist in the management of common behavior/mental health problems	0.0%	7.7%	7.7%	53.8%	30.8%

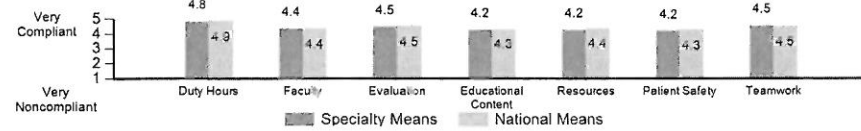
Thinking about your clinical experiences in this program, and all the patients you have cared for, how satisfied are you with each of the following?	Not at all satisfied	Slightly satisfied	Somewhat satisfied	Very satisfied	Extremely satisfied
Patient volume – the number of patients you have seen	0.0%	0.0%	15.4%	69.2%	15.4%
Range of patient ages	0.0%	0.0%	0.0%	69.2%	30.8%
Variety of medical conditions	0.0%	0.0%	15.4%	53.8%	30.8%
The extent to which you are allowed to assume progressive responsibility in the care of patients	0.0%	0.0%	0.0%	61.5%	38.5%

How satisfied are you with the educational experiences in your training program to help you achieve competence in the following patient care skills?	Not at all satisfied	Slightly satisfied	Somewhat satisfied	Very satisfied	Extremely satisfied
Gather essential and accurate information about patients under your care	0.0%	0.0%	7.7%	23.1%	69.2%
Organize and properly prioritize patient care tasks for which you are responsible	0.0%	0.0%	7.7%	30.8%	61.5%
Efficiently and safely transfer patients under your care to another provider	0.0%	0.0%	7.7%	46.2%	46.2%
Make diagnostic decisions about patients under your care	0.0%	0.0%	0.0%	46.2%	53.8%
Develop and carry out management plans	0.0%	0.0%	7.7%	38.5%	53.8%

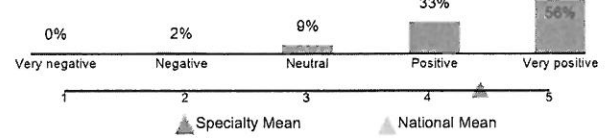
How satisfied are you with each of the following aspects of your longitudinal outpatient experience?	Not at all satisfied	Slightly satisfied	Somewhat satisfied	Very satisfied	Extremely satisfied
The number of patients you see	0.0%	0.0%	15.4%	69.2%	15.4%
The age range of patients you care for	0.0%	7.7%	7.7%	61.5%	23.1%
The variety of medical conditions in the patients you care for	0.0%	7.7%	23.1%	61.5%	7.7%
Your opportunity to learn about the range of normal child development and behavior	0.0%	0.0%	15.4%	53.8%	30.8%
Your opportunity to learn to coordinate the care of patients with complex medical conditions	0.0%	0.0%	23.1%	61.5%	15.4%
The balance between supervision and independence when you are seeing patients	0.0%	0.0%	7.7%	53.8%	38.5%
The extent to which you consider the patients you see in continuity clinic to be your patients	7.7%	7.7%	23.1%	46.2%	15.4%

Overall, I am well prepared to competently practice general pediatrics.	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
	0.0%	0.0%	0.0%	53.8%	46.2%

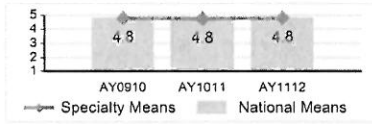
Specialty Means at-a-glance



Residents' overall evaluation of the program



Duty Hours

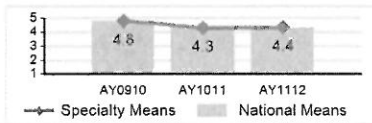


	% Compliant	Mean	National
80 hours	95%	4.7	4.8
1 day free in 7	97%	4.8	4.9
In-house call every 3rd night	99%	5.0	5.0
Night float no more than 6 nights	99%	5.0	5.0
8 hours between duty periods (differs by level of training)	97%	4.8	4.7
Continuous hours scheduled (differs by level of training)	94%	4.7	4.8

Reasons for exceeding duty hours:

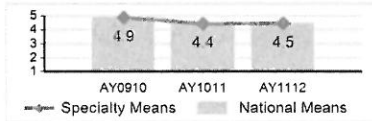
Patient needs	7%	Cover other's work	3%
Paperwork	11%	Night float	3%
Ed. Experience	2%	Schedule conflict	2%
		Other	2%

Faculty



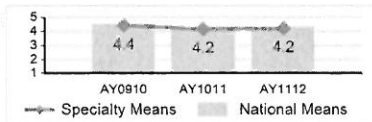
	% Compliant	Mean	National
Sufficient supervision	94%	4.3	4.4
Appropriate supervision	97%	4.7	4.7
Sufficient instruction	88%	4.2	4.2
Faculty and staff interested	90%	4.4	4.3
Faculty and staff create environment of inquiry	83%	4.2	4.2

Evaluation



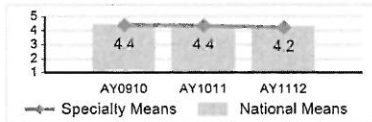
	% Compliant	Mean	National
Access evaluations	99%	5.0	5.0
Evaluate faculty	100%	5.0	5.0
Evaluations of faculty confidential	88%	4.3	4.3
Evaluate program	98%	4.9	4.9
Evaluations of program confidential	89%	4.3	4.3
Program uses evaluations to improve	73%	4.0	4.0
Satisfied with feedback after assignments	68%	3.8	4.0

Educational Content



	% Compliant	Mean	National
Provided goals and objectives for assignments	97%	4.9	4.9
Instructed to manage fatigue	92%	4.7	4.8
Satisfied with scholarly activities	73%	3.9	4.1
Appropriate balance for education	79%	4.1	4.2
Education (not) compromised by service	62%	3.7	4.0
Supervisors delegate appropriately	92%	4.2	4.2
Given data to show personal clinical effectiveness	62%	3.5	3.6
Variety of patients	99%	5.0	4.9

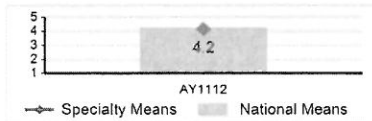
Resources



	% Compliant / % Yes*	Mean	National
Access to reference materials	99%	5.0	5.0
Electronic medical record in hospital*	86%	4.4	4.6
Electronic medical record in ambulatory*	78%	4.1	4.5
Electronic medical records integrated*	61%	4.5	4.7
Electronic medical record effective in daily clinical work	95%	4.0	4.1
Way to transition care when fatigued	70%	3.8	4.2
Satisfied with process to deal with problems and concerns	80%	4.1	4.2
Education (not) compromised by other trainees	85%	4.3	4.5
Residents can raise concerns without fear	84%	4.3	4.2

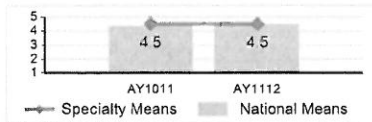
*Responses options are Yes or No. These responses are not included in the Program Means and are not considered non-compliant responses.

Patient Safety

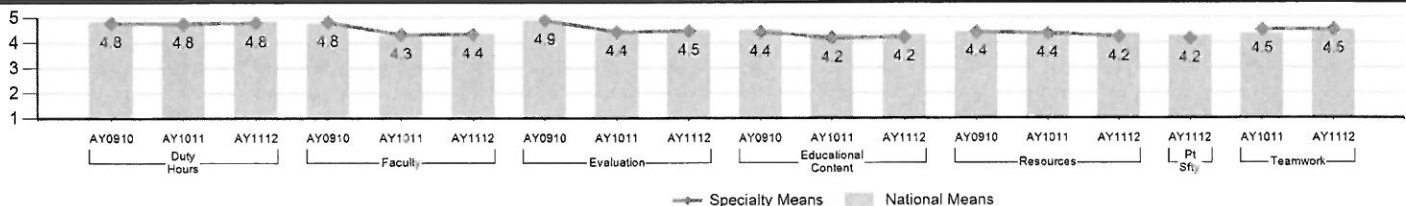


	% Compliant	Mean	National
Tell patients of respective role of residents	99%	4.5	4.5
Culture reinforces patient safety responsibility	99%	4.4	4.5
Participated in quality improvement	76%	4.0	4.0
Information (not) lost during shift changes	96%	3.7	4.0

Teamwork



	% Compliant	Mean	National
Work in interprofessional teams	100%	4.7	4.6
Effectively work in interprofessional teams	99%	4.3	4.4



Moore, Walter

From: Moore, Walter
Sent: Wednesday, April 03, 2013 4:57 PM
To: Haburchak, David; Merchen, Lee; Fulcher, Mark; Forney, Paul; Dahl, Julie; Shiver, Stephen; Reynolds, Bradford; Moore, Walter; Wynn, James; Holsten, Steven; Hawkins, Michael; Walp, Holly; Stephens, Mary; Stephenson, Patricia Joy; Covin, Janet; 'Ewald, Frank W.'
Cc: Madaio, Michael; Howell, Charles; Schwartz, Richard; Chutkan, Norman; Buckley, Peter; Foley, Jeffrey; Hobbs, Joseph; Scott, Steven; Kanto, William
Subject: Meeting April 17, 2013 in BI580 (Medicine Conference Room) 5th floor (5West)

ALL:

I have worked with COL Ramage to set up a meeting of the DEEAMC program directors and GME leadership to meet and interact with MCG/GRMC program directors and GME leadership. The military attendees are listed below. I am looking to have departmental leadership and training program counterparts from our respective training programs to be represented at this meeting that is scheduled from 1100-1300 (11:00- 1:00 PM) for a box lunch session.

The meeting will focus on common GME issues and possible rotational training opportunities for resident training between the two medical centers. There are a significant number of residents currently cross training at our respective institutions and there appear to be opportunities to expand this training.

DDEAMC senior GME leaders:

COL John Devine	Orthopedics
COL Michael Quinn	Internal Medicine
LTC Cletus Arciero	General Surgery
LTC Keith Fincher	Transitional Year
MAJ Ed Farnell	Family Medicine (acting)
LTC Ron Torres	Emergency Medicine
LTC Steve Currier	Emergency Medicine
COL Anthony Ramage	DIO

I would appreciate and RSVP in advance of the meeting (by April 12, 2013) for the number of lunches to be ordered for the meeting. We will also need information from attendees on any dietary restrictions. We are planning on light sandwiches and salads. More information will be forthcoming with respect to the agenda topics to specifically to be discussed. More to follow.

Walter Moore, MD
Senior Associate Dean for GME and VA Affairs

Moore, Walter

From: Shiver, Stephen
Sent: Thursday, April 04, 2013 1:05 PM
To: Moore, Walter
Cc: Shiver, Stephen; Reynolds, Bradford
Subject: Re: EM Fellowships

Thanks very much
SS

Sent from my iPhone

On Apr 4, 2013, at 1:04 PM, "Moore, Walter" <WMOORE@gru.edu> wrote:

All of your message below is accurate except we must technically have the GMEC support the non ACGME fellowships in a set of minutes that asks you to affirm the fellowships do not detract from the core approved ACGME program. I will put this on the agenda for the April 15, 2013 GMEC meeting. We must also endorse the new non-ACGME program EMS Fellowship as once again not detracting from the ACGME approved core residency program. I do not see any problems but I do want the technical aspects covered from an ACGME perspective.

From: Shiver, Stephen
Sent: Thursday, April 04, 2013 12:59 PM
To: Moore, Walter
Cc: Reynolds, Bradford
Subject: Re: EM Fellowships

Walt,

Here is what I have found out:

Matt Lyon's comments:

Prior to beginning the non-ACGME fellowships we were told from the GME office that we did not go through them (as they were not ACGME approved fellowships). Educational oversight from an academic standpoint is provided by the Vice Chairman for Academic Programs (me) and the Academic Executive Committee. Administrative support is provided at the departmental level and the finances for each fellowship is described in each of the fellowship programs (administered by the department's business manager, Amy Shultz).

Phillip Coule's comments:

We will making application for the EMS Fellowship Accreditation by the 1 July deadline. It will start as a non-ACGME accredited fellowship and will become accredited assuming successful application review in the fall (paper review only) with an effective date of accreditation of 1 July.

Thanks and let me know if you need anything else.

SS

Stephen A. Shiver, MD
Residency Program Director
Associate Professor
Department of Emergency Medicine
Georgia Regents University
1120 15th Street , AF1006
Augusta, Ga 30912
Office- 706-721-2613
Fax- 706-721-9081

From: <Moore>, Walter <WMOORE@gru.edu>
Date: Wednesday, April 3, 2013 4:43 PM
To: "Shiver, Stephen" <SSHIVER@gru.edu>
Cc: "Reynolds, Bradford" <BREYNOLDS@gru.edu>, "Davis, Janelle" <REDAVIS@gru.edu>
Subject: RE: EM Fellowships

Steve,

Thank you. Who provides the oversight, administrative and HR support for these fellows? Has the GMEC approved all of these fellowships?

Walt

From: Shiver, Stephen
Sent: Wednesday, April 03, 2013 4:41 PM
To: Moore, Walter
Cc: Reynolds, Bradford; Davis, Janelle
Subject: EM Fellowships

Walt,

I heard from Janelle that you had some questions re existing fellowships in the Department of EM. At present, we have fellowships in International Medicine, Emergency Ultrasound, Wilderness Medicine, and Pediatric Emergency Medicine. An EMS Fellowship is scheduled to start July 1.

The only fellowship above that would be ACGME accredited would be Pediatric EM. My understanding is that EMS will be coming under the ACGME umbrella July 1. The EMS program that is being set up in the department is not ACGME approved; many programs across the country are not at this point. I suspect that there will be a transition period and that the EMS will need to be ACGME approved in the future.

I am not directly supervising any of the above. I am happy, however, to try to answer any questions, etc.

SS

Stephen A. Shiver, MD
Residency Program Director
Associate Professor
Department of Emergency Medicine
Georgia Health Science University



Medical College of Georgia

March 27, 2013

Dear Colleagues:

We would like to extend a personal invitation to you to attend our annual Medical College of Georgia State of the College Address on **Friday, May 3, 2012, at Noon in the Natalie & Lansing B. Lee, Jr. Auditorium**, held during the Medical College of Georgia Faculty Senate meeting.

During this address, *MCG's 185 Year Legacy and Future: People Make it Happen*, we will highlight the many extraordinary accomplishments of our faculty, residents, students, and staff as well as the collective achievements of the Medical College of Georgia during the past year. This has been an incredibly productive year and it will be hard to narrow down what to include. *Lunch will be served to the first 200 guests.*

We look forward to seeing you on May 3rd. We are hoping for a great turnout as we shine a light on our medical school. We know your schedule is busy and wanted to give you advance notice of this year's event.

Many thanks for your support and leadership.

Warm Regards,

A handwritten signature in cursive script that reads "Peter Buckley".

Peter F. Buckley, MD
Dean, Medical College of Georgia

Moore, Walter

From: ACGME Communications <ACGMECommunications@acgme.org>
Sent: Monday, April 08, 2013 1:15 PM
Subject: ACGME e-Communication - April 8, 2013



**Accreditation Council for
Graduate Medical Education**

e-Communication

April 8, 2013

Jump to: [Urology News](#) | [Leadership Skills Training for Chief Residents](#)

Next Accreditation System Phase II – Review and Comment

The Next Accreditation System



In preparation for the Next Accreditation System (NAS), the Common Program Requirements were categorized as core, detail, and outcome requirements. Subsequently, the specialties moving forward with implementation of the NAS in July 2014 (Phase II) must categorize the specialty-specific requirements. The following sets of requirements have been categorized, and are posted for [review and comment](#) on the ACGME's NAS microsite, www.acgme-nas.org. Deadlines for comment submissions and all additional relevant information can be found on the links provided.

- [Pediatric Surgery and Vascular Surgery](#) (subspecialties of [Surgery](#))
- [Thoracic Surgery](#) and Congenital Cardiac Surgery

Review Committee News—Urology

The Review Committee for Urology has posted a new document, [Copy of Institutional Case Report Form](#), under the "Program Resources" heading on its [web page](#).

Leadership Skills Training Programs for Chief Residents

Workshop registration for the Leadership Skills Training Programs for Chief Residents reached capacity for five of 10 scheduled programs.

Limited space is available for the following workshops:

- April 23-25 Multi-specialty workshop in Redondo Beach, CA
- June 10-13 Pediatric Chief Resident Workshop in Philadelphia, PA
- July 9-12 Multi-specialty program in Chicago, IL

Program details with corresponding registration deadlines can be viewed [here](#).

Questions about the ACGME e-Communication should be sent to acgmecommunications@acgme.org.

**Accreditation Council for
Graduate Medical Education**

515 North State Street
Suite 2000

Chicago, Illinois 60654

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The ACGME is a private, non-profit, professional organization responsible for the accreditation of nearly 9,000 residency education programs and about 700 institutions that sponsor these programs in the United States. Residency programs educate over 116,000 resident physicians in 135 specialties and subspecialties. The ACGME's mission is to improve health care by assessing and advancing the quality of resident physicians' education through exemplary accreditation.

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Key Dates for Phase I Specialties Operating under the Next Accreditation System

Phase I Specialties include Emergency Medicine, Internal Medicine, Pediatrics, Neurological Surgery, Orthopaedic Surgery, Diagnostic Radiology, Urology and their subspecialties.

Month and Year	ACGME Activities	Program and Institutional Activities
Spring 2012	<ul style="list-style-type: none"> Common Program Requirements and Program Requirements for Phase I specialties categorized into detail processes, core processes, and outcomes Site visits for Phase I programs with cycle length of 3, 4, and 5 years are moved into next accreditation model 	
July 1, 2012 – June 30, 2013 (Different Intervals throughout year, by specialty)		<ul style="list-style-type: none"> Phase I Programs provide data including the annual ADS update, the resident survey, the faculty survey, case log data, and data on scholarly activities
July and August 2012	<ul style="list-style-type: none"> Alpha Testing of the Environment Review (CLER) process 	
September 2012	<ul style="list-style-type: none"> Beta Testing of Clinical Learning Environment Review (CLER) visits begin 	
December 2012	<ul style="list-style-type: none"> Milestones are published for all Core Specialties 	
March 2013	<ul style="list-style-type: none"> Final site visits in the current accreditation system are completed for Phase I programs newly accredited or with a short cycle length 	
June 2013		<ul style="list-style-type: none"> Phase I Programs form Clinical Competence Committee and faculty prepares to assess Milestones
July 2013	<ul style="list-style-type: none"> Phase I specialties and subspecialties begin operating under next accreditation system 	
July 2013	<ul style="list-style-type: none"> Subspecialty Milestone development begins 	<ul style="list-style-type: none"> Phase I Milestones assessments begin for core programs
Fall 2013	<ul style="list-style-type: none"> RRCs in Phase I specialties review annual data from Academic Year (AY) 2012-2013 	
December 2013		<ul style="list-style-type: none"> Programs in Phase I submit the first set of Milestone assessments to ACGME
June 2014		<ul style="list-style-type: none"> Programs in Phase I submit the second set of Milestone assessments to ACGME
Fall 2014	<ul style="list-style-type: none"> RRCs in Phase I specialties review annual data from AY 2013-2014 First self-study site visits for Phase I programs with a 2014 self-study date 	

Institutional Oversight: Aligning the Next System and Revised Requirements

Linda B. Andrews, MD, Chair, IRC

Peter C. Nalin, MD, Vice Chair, IRC

Lawrence M. Opas, MD, Chair, IRC Requirement Workgroup

Patricia M. Surdyk, PhD, Executive Director, IRC

Kevin B. Weiss, MD, MPH, Senior Vice President, Institutional Section



Learning Objectives

- Identify characteristics of institutional oversight in the NAS;
- Compare current and proposed versions of the Institutional Requirements (IRs); and
- Audit GME institutional policies and GMEC processes and procedures to anticipate changes resulting from transition to NAS.



Anatomy of a Revision

- Request for ideas from the community
- **Draft #1:** ACGME Requirement Development Team
- **Draft #2:** Post for review and comment
- **Draft #3:** Institutional Review Committee (IRC) response to comments with proposed changes
- **Draft #4:** Initial submission to ACGME Committee on Requirements, including responses to all comments
- **Draft #5:** Final submission in response to ACGME Committee on Requirements' comments



Anatomy of a Revision *(cont'd)*



***ACGME Committee on Requirements meeting,
ACGME Board of Directors, June 2013;
Effective date, July 2014***



DISCLAIMER

The material in these slides is based on the draft submitted by the IRC to the ACGME Committee on Requirements. Although likely not substantive, there still may be editorial revisions to the final approved version. Therefore, this presentation deliberately does not cite specific Requirement language.

Moral of the Story

DO NOT make any changes until final version is posted after the June 2013 ACGME Board Meeting!

Requirements in NAS

- **Core:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.
- **Detail:** Statements that describe a specific structure, resource, or process for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.
- **Outcome:** Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.



Coming in NAS

- Single-program institutional review
 - Coming, but not yet
 - Under discussion by IRC; will obviously involve accommodation in some areas



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Rules from the (Me)ssenger



Special Recognition

- Anne Down
- IRC Requirements Workgroup
 - Charles C. Daschbach, MD, MPH
 - Christopher M. Veramakis, MD
- Andrew M. Thomas, MD



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Guiding Principles

- Most Sponsoring Institutions (SIs) institutions already in substantial compliance with the revised IRs
- Revised IRs maintain authority and core responsibilities of DIO and GMEC
- Effort to enhance document organization



NOT in proposed IRs

- Institutional agreements
 - Master affiliation agreements (MAAs)
 - Program letters of agreements (PLAs)
- DIO designee
- Annual Report (as you know it now)
- Specific requirement for ensuring communication between program directors and sites
- Internal Review



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Institutional Requirements (7/14): By Section

- I. Structure for Educational Oversight
- II. Institutional Resources
- III. Institutional Processes
- IV. Institutional GME Policies and Procedures



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Section Headings

CURRENT

- I. Institutional Organization and Responsibilities
- II. Institutional Responsibilities for Residents
- III. GMEC
- IV. Internal Review

PROPOSED

- I. Structure for Educational Oversight
- II. Institutional Resources
- III. Institutional Processes
- IV. Institutional GMEC Policies and Procedures



Remember! Revised IRs posted 7/1/13; effective 7/1/14

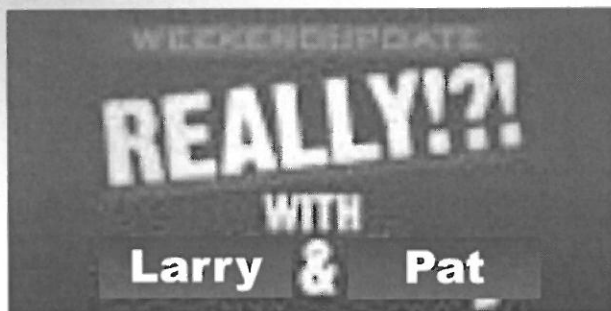
Institutional Requirements (7/14): Section I

- I. Structure for Educational Oversight
 - Sponsoring Institution
 - GMEC
 - Membership
 - Meetings and Attendance
 - Responsibilities



Remember! Revised IRs posted 7/1/13; effective 7/1/14

No New Emphasis



Core Principles

...nothing new under the sun...

- One SI has ultimate authority and responsibility for its ACGME-accredited programs.
- Statement of commitment still exists, (signed by DIO, SI executive, Governing Body every 5 years).
 - DIO and SI could be one person in some SIs
- The DIO and GMEC have authority and responsibility for oversight and administration of programs.



Remember! Revised IRs posted 7/1/13; effective 7/1/14

New Emphasis

- The SI bears responsibility for the learning and working environment. Assignments of residents/fellows must be to learning and working environments that facilitate patient safety and healthcare quality.



Remember! Revised IRs posted 7/1/13; effective 7/1/14

New Emphasis *(cont'd)*

- DIO and GMEC responsibility for ongoing institutional and program quality improvement
 - **OVERSIGHT** (*NOT conduct*) of programs' annual evaluation and improvement process (Common Program Requirement)
 - Annual Institutional Review (AIR)
 - GMEC Special Review



Remember! Revised IRs posted 7/1/13; effective 7/1/14

New Emphasis *(cont'd)*

- Annual Institutional Review (AIR)
 - Performance indicators (*Core*)
 - Institutional self-study results (*Detail*)
 - Program self-study results (*Detail*)
 - Survey results (*Detail*)
 - Monitoring procedures for action plans (*Core*)
 - Executive summary to Governing Body (*Core*)



Remember! Revised IRs posted 7/1/13; effective 7/1/14

New Emphasis *(cont'd)*

- GMEC Special Review (*Core*)
 - Is NOT the current Internal Review
 - IS a review for underperforming programs as per GMEC criteria
 - Results in a report that describes:
 - Quality improvement goals
 - Corrective actions
 - Process for monitoring of outcomes



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Specific Guidance

- **GMEC membership**
 - Quality improvement/safety officer or designee
 - Subcommittees
 - Peer-select resident membership for required functions of GMEC
 - Activities must be reviewed and approved by GMEC
- **GMEC meetings**
 - Minimum—once every quarter
 - Resident/fellow attendance



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Institutional Requirements (7/14): Section II

- ii. Institutional Resources
 - Institutional GME Resources and Operations
 - Program Administration
 - Educational Tools
 - Learning and Working Environment



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Core Principles

...nothing new under the sun...

- The SI ensures support for the DIO and GME operations.
- The SI in collaboration with each ACGME-accredited program, ensures support for program-specific operations.



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Specific Guidance

- Specific mention of support for program directors, core faculty, program coordinators
- Reference to professional development for DIOs and core faculty
- Resident forum
 - Allowance for other “platforms”
 - Ability to meet without administration



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Institutional Requirements (7/14): Section III

III. Institutional Processes

- Institutional Oversight for Patient Care in the Learning and Working Environment
- Resident/Fellow Agreement of Appointment/Contract



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Core Principles

...slightly new under the sun...

- Institutional “grounding” for “six focus areas” from the Common Program Requirements
 - Patient Safety
 - Quality Improvement
 - Transitions of care
 - Supervision
 - Duty hours, fatigue management and mitigation
 - Professionalism



Remember! Revised IRs posted 7/1/13; effective 7/1/14

New Emphasis

- The SI is responsible for oversight and documentation of resident/fellow engagement in improvement processes within the learning and working environment.



Remember! Revised IRs posted 7/1/13; effective 7/1/14

Specific Guidance

(remember the IRD?)

- Q2a Briefly describe at least two (and no more than five) representative initiatives undertaken by the Sponsoring Institution and/or its GME programs to facilitate residents' professional, ethical, and personal development. Include if and how any or all of the following were involved in implementing each of these initiatives:
- the Graduate Medical Education Committee (GMEC);
 - the GME Office; and,
 - individual residency/fellowship programs.

Remember! Revised IRs posted 7/1/13; effective 7/1/14

Specific Guidance

(remember the IRD?)

Q2b Briefly describe at least two (and no more than five) representative initiatives involving residents undertaken by the Sponsoring Institution and/or its GME programs to support safe and appropriate patient care, including specific information regarding the following:

- the relationship of these initiatives to GME programs within the institution;
- the involvement of the GMEC, the GME Office, and/or individual residency/fellowship programs in the implementation of these initiatives; and,
- the use of curricular elements, evaluation methods, or supervision practices to facilitate these initiatives.

Remember! Revised IRs posted 7/1/13, effective 7/1/14

Institutional Requirements (7/14): Section IV

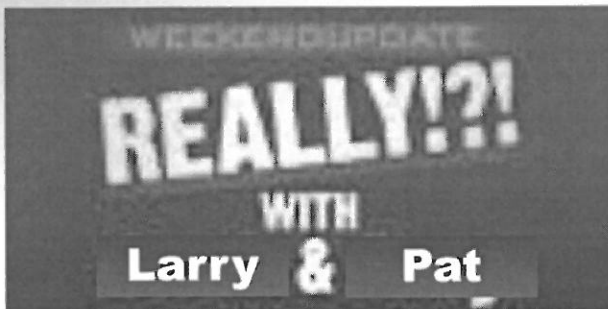
IV. Institutional GME Policies and Procedures

- Renewal and Promotion
- Resident/Fellow Recruitment
- Grievance, Due Process, and Appeals
- Professional Liability Insurance
- Health and Disability Insurance
- Vacations and Leaves of Absence
- Resident Services
- Supervision
- Duty Hours
- Vendors
- Non-competition
- Disasters
- Closures and Reductions

Remember! Revised IRs posted 7/1/13, effective 7/1/14



No New Emphasis



Core Principles

...nothing new under the sun...

- The DIO and GMEC develop, implement, and maintain institutional policies and procedures.

Remember! Revised IRs posted 7/1/13, effective 7/1/14



Specific Guidance

- Health insurance on the first day of insurance eligibility
 - If not the first day required to report then **access** to interim coverage must be provided.



Remember! Revised IRs posted 7/1/13; effective 7/1/14

What's Next?

- Institutional self-study template
- Institutional self-study date assignments
- IRD for applications
- **Final reminder**
 - Don't make any changes until after ACGME Board of Directors meeting in June 2013
 - New requirements effective July 1, 2014



Internal Review

- It has gone 'bye 'bye, and I am doing the same.
- Thank you for not throwing



It's QUESTION TIME!!

The Revised ACGME Policies & Procedures: A Primer for DIOs

Linda B. Andrews, MD, Chair, IRC
Patricia M. Surdyk, PhD, Executive Director, IRC
Tami S. Walters, Director, Governance, Appeals, Policies & Procedures



Learning Objectives

- List key revisions in the ACGME Policies and Procedures that correspond with the responsibilities of DIOs and GME coordinators
- Determine which institutional GMEC and GME Office policies and procedures will likely require revision to align with changes in the ACGME Policies and Procedures



Oversight

I.A.2 (7/14 revision)

The Sponsoring Institution must be in substantial compliance with the ACGME Institutional Requirements and must ensure that its ACGME-accredited programs are in substantial compliance with the ACGME **Institutional, Common, and specialty/subspecialty-specific Program Requirements**, as well as the **ACGME Policies and Procedures**. (Outcome)



The Next Accreditation System

Recent News

- **ACGME Board Approves Policies and Procedures for the Next Accreditation System** (1/14/13)
- **ACGME Board Approves Policies and Procedures for the Next Accreditation System** (1/14/13)
- **ACGME Board Approves Policies and Procedures for the Next Accreditation System** (1/14/13)
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- **ACGME Board Approves Policies and Procedures for the Next Accreditation System** (1/14/13)

Perspectives on the Next Accreditation System

- **Thomas J. Ross, MD, MS**, Chair, ACGME Board
- **Patricia M. Surdyk, PhD**, Executive Director, ACGME
- **John H. Garwood, MD**, President, American College of Surgeons
- **Eric H. Stein, MD**, President, American College of Physicians
- **Carl A. Hay, MD, PhD**, President, American College of Radiology
- **John H. Garwood, MD**, President, American College of Surgeons
- **Kevin M. Wacker, MD**, President, American College of Surgeons



ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

POLICIES AND PROCEDURES

Approved: June 11, 2012
Additional Revisions Approved: September 29, 2012
(Effective: July 1, 2013)

ACGME Approved: 6/29/12
ACGME Approved: 6/11/12 (NAS)
ACGME Approved: 2/5/2011
ACGME Approved: 9/27/2010
ACGME Approved: 2/8/2010
ACGME Approved: 5/14/2009
ACGME Approved: 8/15/2009
ACGME Approved: 2/8/2009

ACGME Policies and Procedures
(Subject 15.00)

SPONSORING INSTITUTIONS



P & P

Sponsoring Institutions (SIs)

- No longer divided into multiple or single program sponsors
- Must achieve and maintain accreditation in order to sponsor accredited programs



P & P

Independent Subspecialty Programs

- Effective July 1, 2013, ACGME will no longer accredit new independent subspecialty programs
- Current independent subspecialty programs must:
 - Operate under the oversight of an SI accredited by the ACGME
 - Associate with a core residency program within the SI



Primer

DIO/GMEC/GME Staff

- Development of implications for IRC review of existing single-program institutions currently underway
- Potential changes in institutional responsibility toward some independent subspecialties



ACGME Policies and Procedures
(Section 17.00, Subject 17.10)

THE ACCREDITATION PROCESS



P & P

The ACGME accredits GME programs and sponsoring institutions based on:

- the demonstration of continuous oversight of processes and outcomes of education, and,
- substantial compliance with accreditation standards, through the review of annually acquired information.



Primer

DIO/GMEC/GME Staff

- Professional development related to implications of “continuous” accreditation model for:
 - GMEC
 - GME coordinators, office staff
 - Program directors
 - Program coordinators



ACGME Policies and Procedures
(Subject 17.00, Sections 17.20-17.30)

SITE VISITS



P & P

Types of Accreditation Site Visits

- Focused
- Full
- Self-study
- * Alleged egregious violations



P & P

Focused Site Visits

- Assess selected aspects of a program/SI identified by a Review Committee:
 - To address aspects of the program/SI that require attention or follow-up as identified during annual review of data
 - To evaluate merits of a complaint
 - To diagnose/explore underlying deterioration in selected aspects of the program/SI as identified during annual review of data or through another indicator



P & P

Full Site Visits

- May be scheduled:
 - To review an application
 - When review of continuous data identifies broad issues and/or concerns
 - For other serious conditions or situations at the discretion of a Review Committee
- Must be scheduled:
 - At the end of initial accreditation



Self Study Visits

- Occur every 10 years
- Describe how the program/SI creates an effective learning and working environment
- Describe how the learning environment supports desired educational outcomes
- Provide an analysis of strengths, weaknesses, and plans for improvement



Self Study Visits *(cont'd)*

- Site visitor verifies and clarifies that the self-study document offers an objective, factual description of the learning environment
- Site visit report verifies educational outcomes and their measurements and how processes and the learning environment contribute to these outcomes



Site Visits for Alleged Egregious Violations

- May be conducted at any time during the maintenance of accreditation process
- Size and membership of site visit team as well as format and scope of visit is determined by the CEO



Additional Site Visit Facts

- Conducted by individual members or teams of ACGME Field Staff
- May be "announced" or have limited announcement
- Use documents prepared specifically for the site visit, e.g., focused documents prepared to describe & clarify selected aspects of program as directed by Review Committee






Additional Site Visit Facts (cont'd)

- May involve site visitor participation in program activities, e.g., morning reports, simulation-based education, other activities in the learning environment
- May conclude with suggestions or ideas for innovative practices by site visitor based on knowledge of practices in other programs that support an effective working and learning environment



Primer

- New mindset: *episodic* \Rightarrow *continuous*
- Information management

ACGME	DIO/GMEC
	Low maintenance
	High maintenance <small>(GMEC Special Review included in revised Institutional Requirements, to be approved 7/14)</small>
	

- Scheduling function (no more worries about mid-cycle, however...)



ACGME Policies and Procedures
(Section, 17.00, Subject 17.60-17.70)

CONTINUOUS ACCREDITATION



Continuous Accreditation

- In the accreditation process, all programs and sponsoring institutions will be reviewed annually by the relevant Review Committee.
- The Review Committee will confer an accreditation decision of Continued Accreditation based on satisfactory ongoing performance of the program.
- When a program's performance is deemed unsatisfactory, or when performance parameters are unclear, the Review Committee may change the program's accreditation status or request a site visit and/or additional information prior to rendering a decision.



P & P

Accreditation Information: *Annual (for programs)*

- ADS Annual Update
- Resident Survey
- *Faculty Survey*
- *Milestone Data*
- Board exam performance
- Case log data
- Hospital accreditation data
- Faculty & resident scholarly activity/productivity
- Other



P & P

Accreditation Information: *Episodic (for programs & SIs)*

- ACGME complaints
- Verified public information
- Historical accreditation decision/citations



P & P

Review of Annual Data: *Decisions Available to RCs/IRC*

- Confirm existing accreditation status based on data review
- Change existing status based on data review
- Request clarifying information prior to rendering an accreditation decision
 - Request progress report
 - Request focused site visit
 - Request full site visit



P & P




Along with an accreditation *decision...*

- ... a Review Committee may:
 - Recognize and commend exemplary performance or innovations
 - Identify opportunities for improvement
 - Identify concerning trends
 - Issue citations
 - Continue previous citations
 - Acknowledge correction of previous citations
 - Increase or reduce resident complement



Primer

- New mindset: *episodic* → *continuous*
- Information management

ACGME	DIO/GMEC
	Low maintenance
	High maintenance
	(GMEC Special Review included in revised Institutional Requirements, to be approved 7/14)

- Scheduling function (no more worries about mid-cycle, however...)



ACGME Policies and Procedures
(Subject 18.00)

ACCREDITATION ACTIONS



Accreditation Status Options

Core and Subspecialty

Application	Initial Accreditation
	Initial Accreditation with warning
	Accreditation Withheld
Existing Programs/SIs	Continued Accreditation
	Continued Accreditation with warning
	Probationary Accreditation (<i>does not exceed 2 years</i>)
	Withdrawal of Accreditation (<i>does not require probation first</i>)
	Administrative Withdrawal

Notes

- Adverse actions no longer proposed.
- Expedited withdrawal no longer an option.



Other Actions

- Voluntary withdrawal (*Section 18.70*)
- Reductions in resident complement (*Section 18.80*)
- Progress reports (*Section 18.91*)
- Participating sites (*Section 18.92*)
- Change of sponsorship (*Section 18.94*)



Primer

- Institutional actions will parallel program actions.
- Institutional annual data collection will include program summary; other data to be identified by IRC.
- Institutional self-study visits will likely not start until at least 2015.

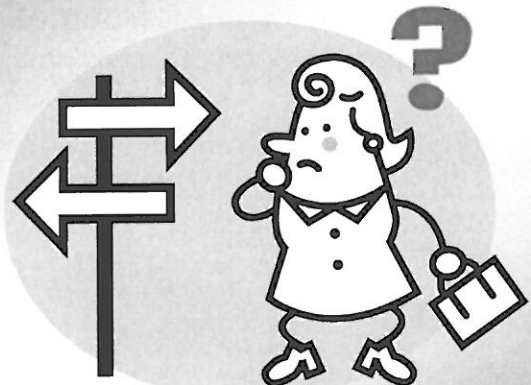


Take Home Points

- Change your mindset.
- Develop new information management systems in the GME Office (*experience with Phase I specialties will help in this regard*).
 - Accommodate different types of site visits
 - Track program self-study visits
- Provide program director and faculty development
 - Engage Phase I program directors



THANK YOU



12 Things You Should Know about The Next Accreditation System

Mary Lieh-Lai MD, Louis Ling MD, John Potts MD
Senior Vice-Presidents, Accreditation
ACGME

ACGME Annual Education Conference
Orlando, FL
2 March 2013



Next Accreditation System

- Background & rationale
- Goals
- Structural overview
- Program Perspective
- Institutional perspective
- Timeline



Disclosures



Next Accreditation System

1. When does this happen?



NAS Timeline

Phase I specialties

- Diagnostic Radiology
- Emergency Medicine
- Internal Medicine
- Neurological Surgery
- Orthopaedic surgery
- Pediatrics
- Urology

JGME 2012; 4:399



NAS Timeline: Phase 1 Specialties

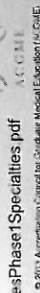
- **Spring 2012:**
 - Most programs with > 2 year cycles moved into NAS
- **July 2012 – June 2013**
 - Phase 1 programs report annual data
- **January 2013**
 - Milestones published for Phase 1 core specialties
- **Spring 2013**
 - Identify and train CCCs
- **July 2013: Go live**



NAS Timeline: Phase 2 Specialties

- Spring 2013:
 - Most programs with > 2 year cycles moved into NAS
- July 1, 2013 – June 30, 2014
 - Programs report annual data
- Spring 2014
 - Identify and train CCCs
- July 2014: Go live

<http://www.acgme-nas.org/assets/pdf/Key/Dates/Phase1Specialties.pdf>



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Next Accreditation System

2. Why are we doing it?



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Why are we doing NAS?

- Help produce physicians for 21st century
- Accredited programs based on outcomes
- Reduce administrative burden of accreditation



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Why are we doing NAS?

- Free good programs to innovate
- Assist underperforming programs to improve
- Realize the promise of the Outcomes
- Provide public accountability for outcomes
- Reduce the burden of accreditation



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Next Accreditation System

3. How does this reduce burden?



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Some Data Reviewed by RRC

Most already in place

- ✓ Annual ADS Update
- ✓ Program Characteristics – Structure and resources
- ✓ Program Changes – PD / core faculty / residents
 - Scholarly Activity – Faculty and residents
 - Omission of data
- ✓ Board Pass Rate – 3-5 year rolling averages
- ✓ Resident Survey – Common and specialty elements
- ✓ Clinical Experience – Case logs or other
- ✓ Semi-Annual Resident Evaluation and Feedback
 - Milestones
- Faculty Survey
- Ten year self-study



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Reduced Burden

- Standards revised every ten years
- No PIF's
- Scheduled (self-study) visits q ten years
- Focused site visits only for "issues"

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A.C.G.M.E.

Reduced Burden

- "Infernal Review" no longer required in NAS
- GMEC roles
 - Annual institutional review
 - Oversight of Annual Program Evaluations
 - Special Review for underperforming programs

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A.C.G.M.E.

Streamlined ADS Annual Update

- 33 questions removed
- 14 questions simplified
- Very few essay questions
- Self-reported board pass rate removed
- Faculty CVs removed
- 11 MCQ or Y/N questions added

LM

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A.C.G.M.E.

Current PIF Faculty CV

© 2013 Accreditation Council for Graduate Medical Education (ACGME)

Scholarly Activity Template

Scholarly Activity as Performance Indicator

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Faculty Scholarly Activity

Pub Med IDs (assigned by PubMed) for articles published between 7/1/2011 and 6/30/2012. List up to 4.

Enter Pub Med ID #s

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A.C.G.M.E.

Faculty Scholarly Activity

Faculty Scholarly Activity	Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2011 and 6/30/2012	Conference Presentations	3
----------------------------	---	--------------------------	---

Enter a number

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Faculty Scholarly Activity

Faculty Scholarly Activity	Number of other presentations given (grand rounds invited professors), materials developed (such as computer-based modules), or work presented in non-peer review publications between 7/1/2011 and 6/30/2012	Other Presentations	1
----------------------------	---	---------------------	---

Enter a number

ACCM
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Faculty Scholarly Activity

Faculty Scholarly Activity	Number of chapters or textbooks published between 7/1/2011 and 6/30/2012	Chapters / Textbooks	1
----------------------------	--	----------------------	---

Enter a number

ACCM
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Faculty Scholarly Activity

Faculty Scholarly Activity	Number of grants for which faculty member had a leadership role (PI, Co-PI, or site director) between 7/1/2011 and 6/30/2012	Grant Leadership	3
----------------------------	--	------------------	---

Enter a number

ACCM
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Faculty Scholarly Activity

Faculty Scholarly Activity	Had an active leadership role (such as serving on committees or governing boards) in national medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2011 and 6/30/2012	Leadership or Peer-Review Role	Y
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Answer Yes or No

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Faculty Scholarly Activity

Faculty Scholarly Activity	Between 7/1/2011 and 6/30/2012, held responsibility for seminar, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials, assessment of participants' performance) for any didactic training within the sponsoring institution or program. This includes training modules for medical students, residents, fellows and other health professionals. This does not include single presentations such as individual lectures or conferences.	Teaching Formal Courses	N
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Answer Yes or No

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Scholarly Activity Template

Scholarly Activity as Performance Indicator

Template for Scholarly Activity		Other Category		Learning / Self-Review		Examine	
Faculty Specialty	Activity	Year	Value	Year	Value	Year	Value
Subtotal Scholarly Activity (Total)	Publications						
	Abstracts						
	Presentations						
	Books						
	Chapters						
	Editorial						
	Peer Review						
	Other						

Scholarly Activity Template

- For each core faculty* member enter:
 - x Pub Med ID's
 - Four numbers
 - Answer two Y/N questions
- * Core Faculty defined as spending 15 hrs/wk
- For each resident with scholarly activity enter:
 - x Pub Med ID's
 - Two numbers
 - Answer two Y/N question

Next Accreditation System

4. How Can Programs Innovate?

How Can Programs Innovate?

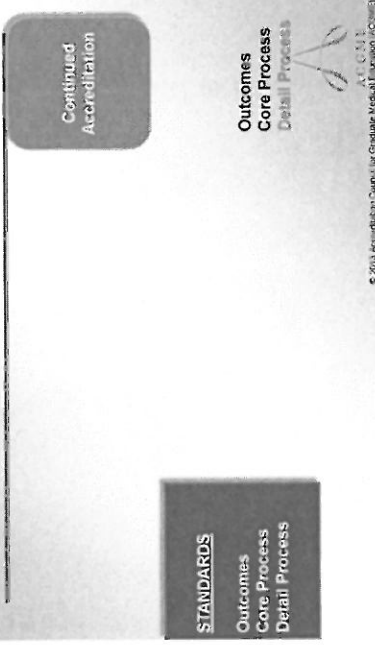
- Program Requirements classified:
 - Outcome
 - Core
 - Detail
- Programs in good standing*:
 - May freely innovate in detail standards

* "Green Bucket"

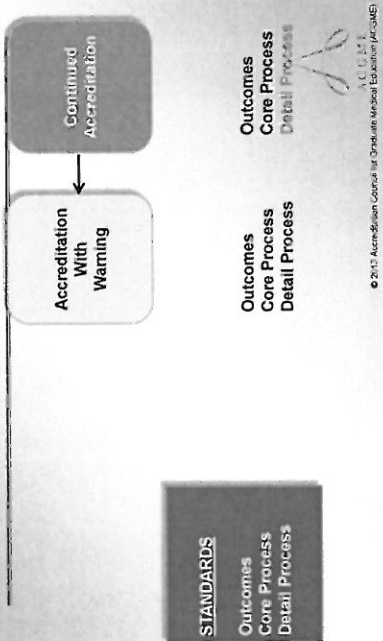
Next Accreditation System

5. What's the big picture?

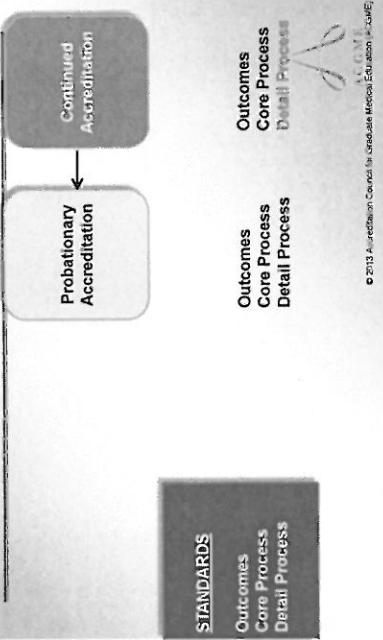
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



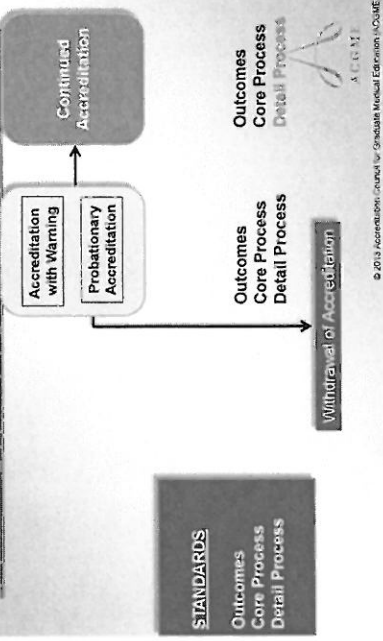
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



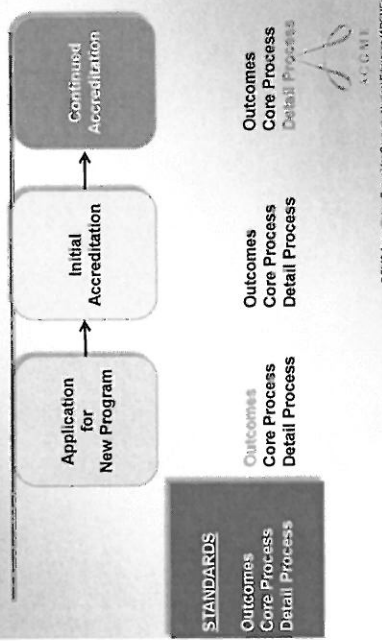
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



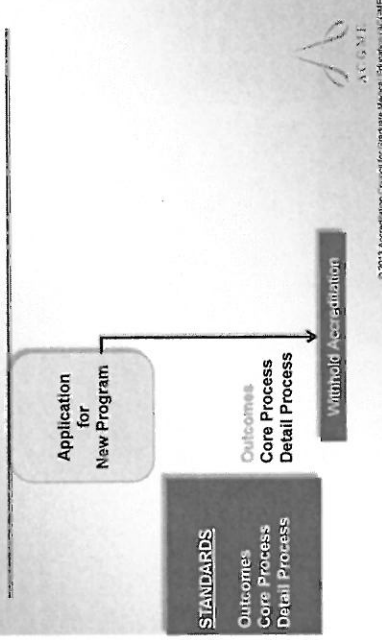
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



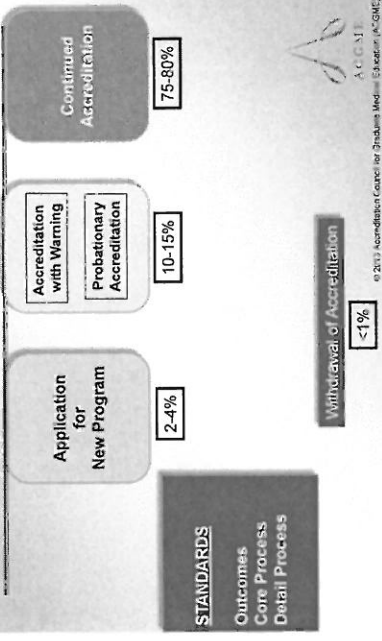
Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



Conceptual Model of Standards Implementation Across the Continuum of Programs in a Specialty



Next Accreditation System

6. What Happens at My Program?

LM

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What Happens at My Program?

- Annual data submission
- Annual Program Evaluation (PR V.C.)
- Self-study visit every ten years
- Other possible actions:
 - Progress reports for potential problems
 - Focused site visit
 - Full site visit
 - Site visit for potential egregious violations

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What Happens at My Program?

- Core and subspecialty programs together
- Independent subspecialty programs subject to:
 - Program Requirements and program review
 - Institutional Requirements and institutional review
 - CLER visits
- No new independent sub. programs after 7/2013

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NAS: Annual Data Submission

Year 1
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun

Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun

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NAS: Annual Data Submission

Year 1
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun

Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun

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NAS: Annual Data Submission

Year 1
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun

ADS Update Yr 1

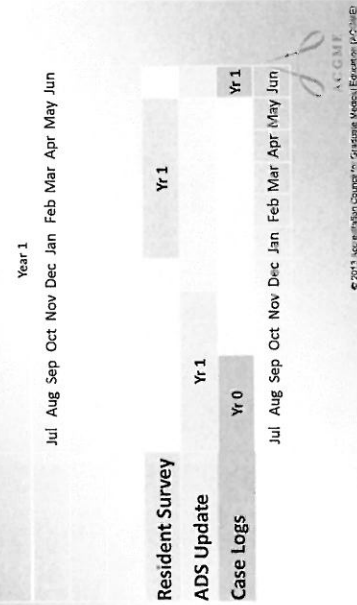
Case Logs Yr 0

Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun

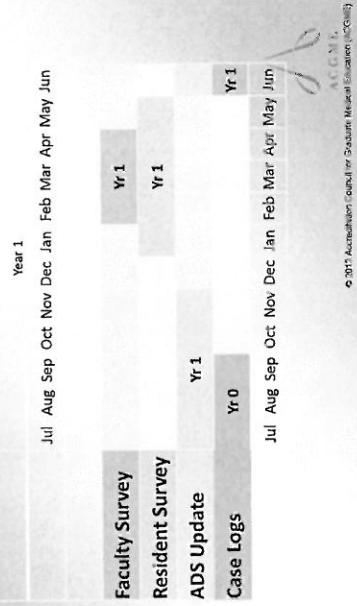
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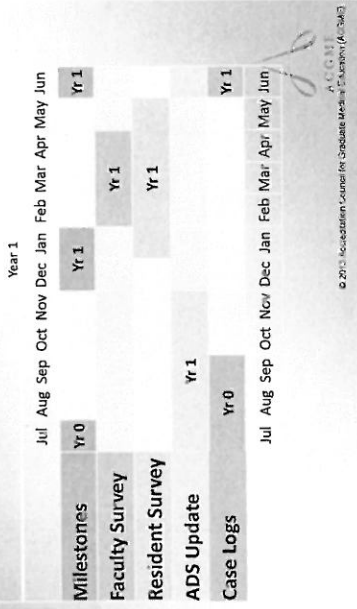
NAS: Annual Data Submission



NAS: Annual Data Submission



NAS: Annual Data Submission



Next Accreditation System

7. What is a self-study visit?

LL

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What is a Self-Study Visit?

- Not fully developed
- Scheduled every ten years
- Conducted by a team of visitors
- Minimal document preparation
- Interview residents, faculty, leadership

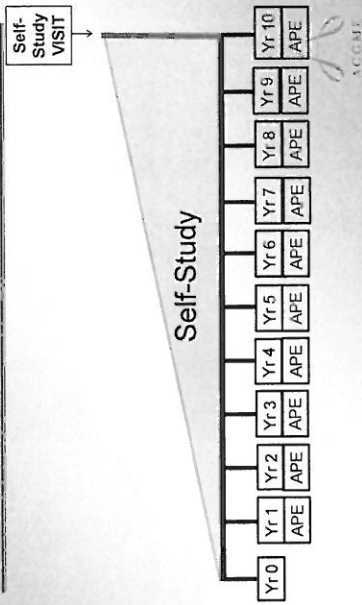
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What is a Self-Study Visit?

- Examine annual program evaluations
 - Response to citations
 - Faculty development
- Focus: Continuous improvement in program
- Learn future goals of program
- May verify compliance with Core requirements

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Ten Year Self-Study Visit



Next Accreditation System

8. What is a focused site visit?

What is a Focused Site Visit?

- Assesses *selected* aspects of a program and may be used:
 - to address *potential* problems identified during review of annually submitted data;
 - to diagnose factors underlying deterioration in a program's performance
 - to evaluate a complaint against a program
- LL
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What is a Focused Site Visit?

- Minimal notification given
 - Minimal document preparation expected
 - Team of site visitors
 - Specific program area(s) investigated as instructed by the RRC
- LL
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Next Accreditation System

9. When do full site-visits occur?

When do Full Site Visits Occur?

- Application for new program
 - At the end of the initial accreditation period
 - RRC identifies broad issues / concerns
 - Other serious conditions or situations identified by the RRC
- LL
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Next Accreditation System

10. When is my program reviewed?

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When Is My Program Reviewed?

- Each program reviewed at *least* annually
- NAS is a continuous accreditation process
 - Review of annually submitted data
 - Supplemented by:
 - Reports of self-study visits every ten years
 - Progress reports (when requested)
 - Reports of site visits (as necessary)

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NAS: RRC Meeting Timeline

Year	1	2	3	4	5	6	7	8	9	10	11	12
Review annual data <u>all</u> programs												
											Yr 1	
												Yr 2

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NAS: RRC Meeting Timeline

Year	1	2	3	4	5	6	7	8	9	10	11	12
Review annual data <u>all</u> programs												
Review Self-Studies												

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When Is My Program Reviewed?

- "Cycle Lengths" will not be used
- Programs will receive feedback from RRC each time they are reviewed
- Status:
 - Continued Accreditation
 - Accreditation with Warning
 - Probationary Accreditation
 - Withdrawal of Accreditation

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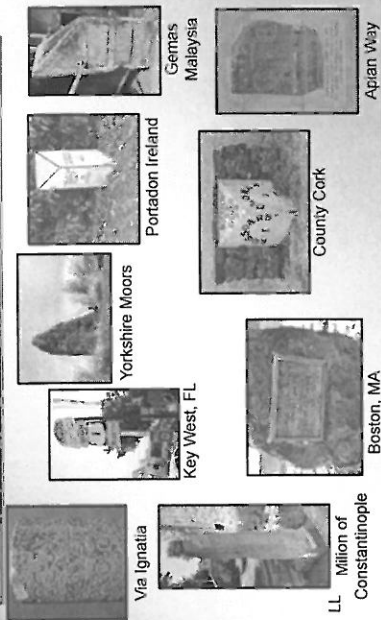
NAS: RRC Meeting Timeline

Year	1	2	3	4	5	6	7	8	9	10	11	12
Review annual data <u>all</u> programs												
Review information from requested PRs and SVs												
Review Self-Studies												
Review information from requested PRs and SVs												

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Milestones



LL

11. Milestones?

- Why?
- What?
- Who?
- When?

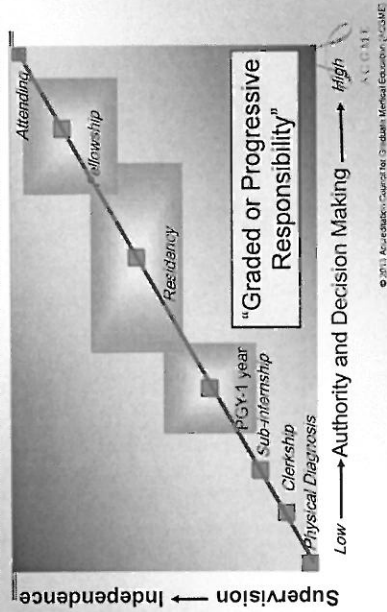


Milestones

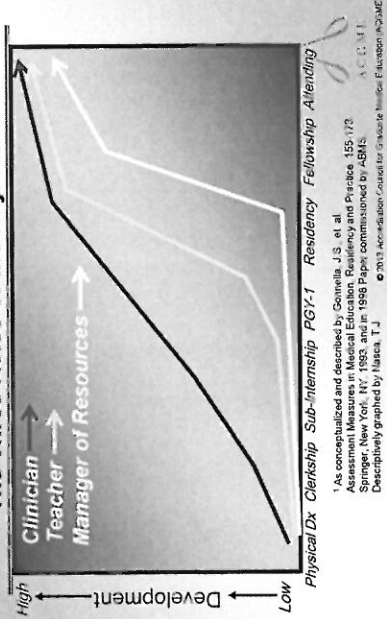
- Why?
- What?
- Who?
- When?



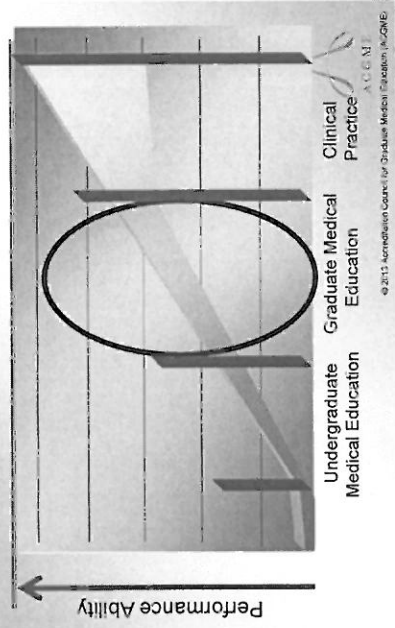
The Continuum of Clinical Professional Development



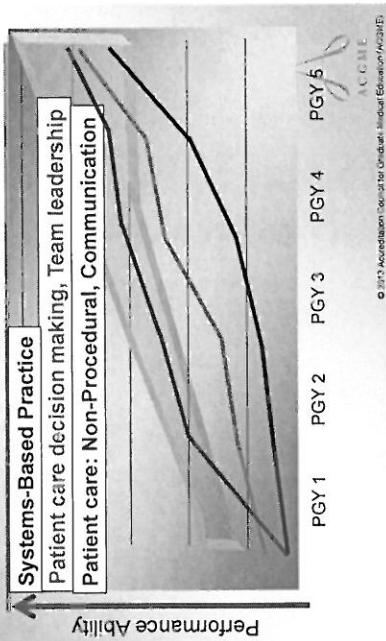
The Continuum of Professional Development The Three Roles of the Physician¹



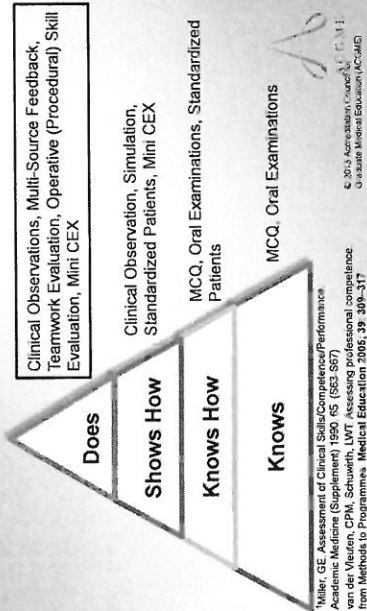
Clinical Professional Development



Professional Development in a 5 year program



Miller's¹ Pyramid of Clinical Competence



Move from Numbers to Narratives

- Numerical systems produce range restriction
- Narratives:
 - easily discerned by faculty
 - shown to produce data without range restriction¹

¹Hodges and others
Most recent reference: Regehr, et al. Using "Standardized Narratives" to Explore New Ways to Represent Faculty Opinions of Resident Performance Academic Medicine. 2012. 87(4). 419-427.

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Milestones

- Why?
- What?
- Who?
- When?

Milestones

- Created by each specialty
- Organized under six domains of clinical competency
- Observable steps on continuum of increasing ability
- Describes the track of a resident learner
- Provide framework & language to describe progress
- Articulates shared understanding of expectations

ACGME Goals for Milestones

- Permit fruition of the promise of "Outcomes"
- Track what is important
- Use *existing tools* for *observations*
- Clinical Competence Committee *triangulates* progress of each resident
 - Essential for valid and reliable clinical evaluation system
- RRCs track de-identified aggregate data
- ABMS Board may track the identified individual

Milestones

- The Milestones are NOT an evaluation tool
- Milestones are a reporting instrument

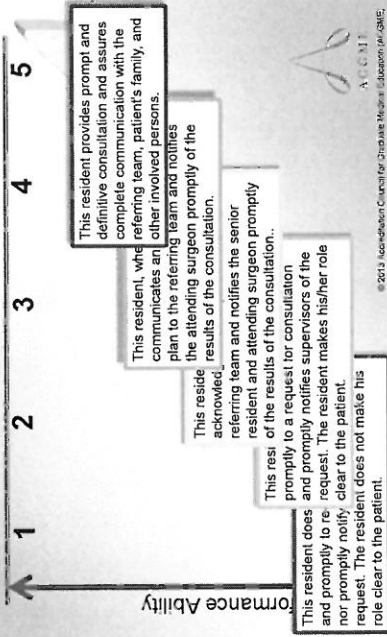


ACGME Goals for Milestones

- Specialty specific normative data
- Common expectations for individual resident progress
- Development of specialty specific evaluation tools

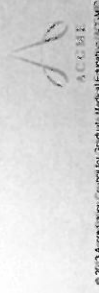


The “Envelope of Expectations” Professionalism

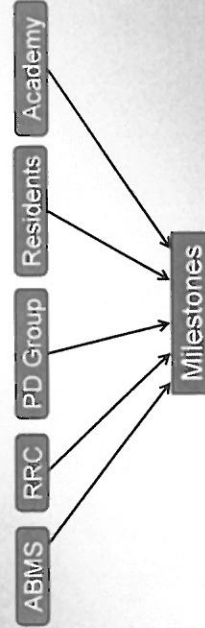


Milestones

- Why?
- What?
- Who?
- When?

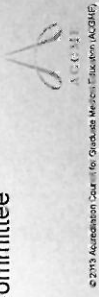


Creation of Milestones

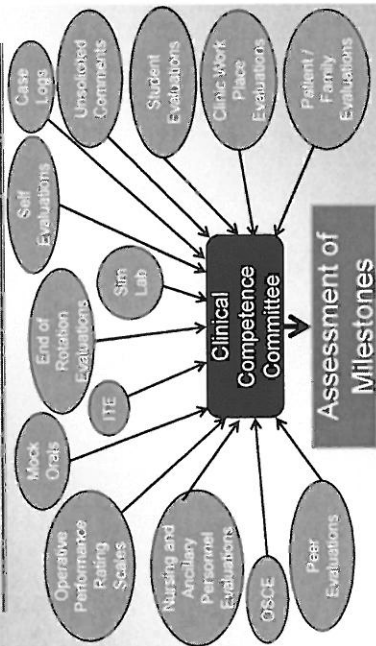


Key Elements of Quality Evaluation of Miller's “Does”

- Trained observers
- Common understanding of the expectations
- Sensitive “eye” to key elements
- Consistent evaluation of levels of performance
- Requires certain number of observations
- Interpreter/Synthesizer Experts
- Clinical Competency Committee



Clinical Competence Committee



CCC: How many faculty?

- Ideally five (or more) for broad consensus
- Recognize small programs may have fewer
- May have to pre-review before discussion

CCC: Who should be on it?

- Decision for PD
- Consider:
 - Representation from each major site
 - Subspecialty representation
 - Dedication to education

CCC: How does it work?

- Understand the milestones & their use
- Leave personal bias at the door
- Review all evaluations for each resident
- “Consider the source(s)”
- For each resident, decide for each milestone the narrative that best fits that resident

Professionalism Milestones

Level	1	2	3	4	5
a.) Honesty, integrity and ethical behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.) Responsibility and follow through on tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.) Humanistic behaviors of respect, compassion and empathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.) Receiving and giving feedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LM

Professionalism Milestones

Level	1	2	3	4	5
a.) Honesty, integrity and ethical behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.) Responsibility and follow through on tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.) Humanistic behaviors of respect, compassion and empathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.) Receiving and giving feedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Resident frequently fails to recognize or actively avoids opportunities for compassion or empathy. On occasion demonstrates lack of respect, or overt disrespect for patients, family members, or other members of the health care team

Professionalism Milestones

Level	1	2	3	4	5
a.) Honesty, integrity and ethical behavior	○	○	○	○	○
b.) Responsibility and follow through on tasks	○	○	○	○	○
c.) Humanistic behaviors of respect, compassion and empathy	○	○	○	○	○
d.) Receiving and giving feedback	○	○	○	○	○

c.) Humanistic behaviors of respect, compassion and empathy
Resident demonstrates compassion and empathy in care of some patients, but lacks the skills to apply them in more complex clinical situations or settings. Occasionally requires guidance in how to show respect for patients, family members, or other members of the health care team.

d.) Receiving and giving feedback
Resident seeks out opportunities to demonstrate compassion and empathy in the care of all patients, and demonstrates respect and is sensitive to the needs and concerns of all patients, family members, and members of the health care team.

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Professionalism Milestones

Level	1	2	3	4	5
a.) Honesty, integrity and ethical behavior	○	○	○	○	○
b.) Responsibility and follow through on tasks	○	○	○	○	○
c.) Humanistic behaviors of respect, compassion and empathy	○	○	○	○	○
d.) Receiving and giving feedback	○	○	○	○	○

c.) Humanistic behaviors of respect, compassion and empathy
Resident seeks out opportunities to demonstrate compassion and empathy in the care of all patients, and demonstrates respect and is sensitive to the needs and concerns of all patients, family members, and members of the health care team.

d.) Receiving and giving feedback
Resident seeks out opportunities to demonstrate compassion and empathy in the care of all patients, and demonstrates respect and is sensitive to the needs and concerns of all patients, family members, and members of the health care team.

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CCC: How does it work?

- The CCC be very important agents for Faculty Development by giving feedback to evaluators

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Milestones

- Why?
- What?
- Who?
- When?

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Milestones: When?

Publication:

- Phase 1 Programs: Jan 2013
- Phase 2 Programs: Dec 2013

Implementation:

- Phase 1 Programs: AY 2013
- Phase 2 Programs: AY 2014

Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun

Milestones

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12. What about those CLER visits?

LL

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CLER Visits

Clinical
Learning
Environment
Review

- JGME 2012; 4:396-8
- ACGME Webinar 12/13/2012

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CLER Visits: Focus

- Patient Safety
- Quality Improvement
- Transitions in Care
- Supervision
- DH Oversight / Fatigue Management
- Professionalism

JGME 2012; 4:396-8

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CLER Visits: Context

- Resources
- Faculty
- Residents
- Measures
- Improvement

JGME 2012; 4:396-8

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CLER Visits: Structure

- Multiple site visitors
- Meetings:
 - 'C' suite
 - Quality / Safety Officers
 - Program Directors
 - Faculty
 - Residents
- 'Walk Arounds'

JGME 2012; 4:396-8

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CLER Program

- Five pilot visits (apha testing)
- 1st Cycle: approximately 400 multi-program SI's, beta testing began September 2012
- Institutions to be visited q 18 months
- Giving formative feedback
- Aggregate data to inform standards

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CLER Program

- Focus on institutional environment – *not* individual programs
- During site visit PD role limited to:
 - Facilitating peer selection of residents
 - Participation in group interview

JGME 2012; 4:396-8

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NAS Summary

- Rationale
- Reduced program burden
- Program innovation
- Program activities
- Program accreditation
- Site Visits
- Milestones
- CLER process

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Future Educational Sessions

- Future ACGME webinars
 - Milestones
 - Self-study
 - Phase 1 specialties
- Previous webinars available for review at:
<http://www.acgme-nas.org/index.html>
under "ACGME Webinars".

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NAS Summary

Discussion

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Overview

As a component of its next accreditation system, the ACGME has established the CLER program to assess the graduate medical education (GME) learning environment of each sponsoring institution and its participating sites. CLER emphasizes the responsibility of the sponsoring institution for the quality and safety of the environment for learning and patient care, a key dimension of the 2011 ACGME Common Program Requirements. The intent of CLER is “to generate national data on program and institutional attributes that have a salutary effect on quality and safety in settings where residents learn and on the quality of care rendered after graduation.”¹

CLER provides frequent on-site sampling of the learning environment that will:

- Permit lengthening the interval for standard ACGME site visits of individual programs if other parameters of program performance are at the expected level;
- Emphasize elements of “new” competencies demanded by the public; and,
- Provide the opportunity for sponsoring institutions to demonstrate leadership in patient safety, quality improvement, and reduction in health care disparities.

The CLER program’s ultimate goal is to move from a major targeted focus on duty hours to that of broader focus on the GME learning environment and how it can deliver both high-quality physicians and higher quality, safer, patient care. In its initial phase, CLER data will not be used in accreditation decisions by the Institutional Review Committee (IRC).

CLER consists of three related activities:

- The **CLER site visit program** is used solely for providing feedback, learning, and helping to establish baselines for sponsoring institutions, the Evaluation Committee, and the IRC. The first cycle of visit findings will result in dissemination of salutary practices by the Evaluation Committee.
- The **CLER Evaluation Committee** includes a broad cross-section of individuals with expertise related to the aim of the CLER program. The Committee provides input to the design and implementation of CLER site visit activities and conducts evaluation review of sponsoring institutions that are visited during each cycle.
- The ACGME recognizes the great interest by sponsoring institutions to support **faculty development** in those areas on which the CLER program will focus (e.g., patient safety, health care quality, transitions of care, etc.). Therefore, as part of the CLER program, the ACGME will develop a program to support faculty development.

CLER assesses sponsoring institutions in the following six focus areas:

- **Patient Safety** – including opportunities for residents to report errors, unsafe conditions, and near misses, and to participate in inter-professional teams to promote and enhance safe care.

- **Quality Improvement** – including how sponsoring institutions engage residents in the use of data to improve systems of care, reduce health care disparities and improve patient outcomes.
- **Transitions in Care** – including how sponsoring institutions demonstrate effective standardization and oversight of transitions of care.
- **Supervision** – including how sponsoring institutions maintain and oversee policies of supervision concordant with ACGME requirements in an environment at both the institutional and program level that assures the absence of retribution.
- **Duty Hours Oversight, Fatigue Management and Mitigation** – including how sponsoring institutions: (i) demonstrate effective and meaningful oversight of duty hours across all residency programs institution-wide; (ii) design systems and provide settings that facilitate fatigue management and mitigation; and (iii) provide effective education of faculty members and residents in sleep, fatigue recognition, and fatigue mitigation.
- **Professionalism**—with regard to how sponsoring institutions educate for professionalism, monitor behavior on the part of residents and faculty and respond to issues concerning: (i) accurate reporting of program information; (ii) integrity in fulfilling educational and professional responsibilities; and (iii) veracity in scholarly pursuits.

The initial round of CLER evaluations will seek answers to the following central questions:

- **Who and what form the infrastructure of a Sponsoring Institution’s clinical learning environment?** What organizational structures and administrative and clinical processes do the SI and its major participating sites have in place to support GME learning in each of the six focus areas?
- **How integrated is the GME leadership and faculty within the SI’s current clinical learning environment infrastructure?** What is the role of GME leadership and faculty to support resident and fellow learning in each of the six areas?
- **How engaged are the residents and fellows in using the SI’s current clinical learning environment infrastructure?** How comprehensive is the involvement of residents and fellows in using these structures and processes to support their learning in each of the six areas?
- **How does the SI determine the success of its efforts to integrate GME into the quality infrastructure?** From the perspective of the SI and its major participating sites, what are the measures of success in using this infrastructure and what was the level of success?
- **What areas have the Sponsoring Institution identified as opportunities for improvement?** From the perspective of the SI and its major participating sites (if different), what are seen as the opportunities for improving the quality and value of the current clinical learning environment infrastructure to support the six focus areas?

¹Nasca TJ, Philibert I, Brigham T, Flynn TC. The next GME accreditation system--rationale and benefits. *N Engl J Med.* 2012;366(11):1051-1056. [Epub 2012 Feb 22.] 06/10/2012 Ver. 1.0

The Clinical Learning Environment Review (CLER) Program

AAMC GRA Webinar October 3, 2012

Kevin B. Weiss, MD

Robin Wagner, RN, MHSA



2009-2010 ACGME “Duty Hours Task Force” “Task Force for Quality Care and Professionalism”

- Links adherence to duty hours policies and integrity in reporting to professional responsibilities for patient safety and healthcare quality
- Establishes importance of educating residents/fellows on institutional Patient Safety and Quality Improvement programs
- Assigns the institution the onus of responsibility for engaging and monitoring residents/fellows across targeted areas
- Recommends assessment in the form of a “Sponsor Visit Program”



Nasca, T.J., Day, S.H., Amis, E.S., for the ACGME Duty Hour Task Force. **ACGME Sounding Board: The New Recommendations on Duty Hours from the ACGME Task Force.** New England Journal of Medicine. 362 (25): e3(1-6). 2010. June 23, 2010.

National Advisory Committee Recommendations

- Link to accreditation, but not an “accreditation site visit”
- Include full-time staff and volunteer peers as site visitors
- Establish a process whereby reports are:
 - drafted by the Site Visit Team
 - reviewed and finalized by an “Evaluation Committee”
 - provided to the institution as a quality improvement tool, and to the Institutional Review Committee (IRC) as a “continuous data” element
- Use first round of visits and reports solely for the collection of baseline data, and to promote learning (for all) – *do not use for accreditation*



ACGME

Clinical Learning Environment Review (CLER) Program

- Integration of residents into institution's **Patient Safety** programs, and **demonstration of impact**
- Integration of residents into institution's **Quality Improvement** programs and efforts to **reduce Disparities in Health Care Delivery**, and **demonstration of impact**
- Establishment, implementation, and oversight of **Supervision** policies
- Oversight of **Transitions in Care**
- Oversight of **Duty Hours Policy, Fatigue Management and Mitigation**
- Education and monitoring of **Professionalism**



Clinical Learning Environment Review (CLER) Program

- Site Visit Program
- Evaluation Committee
- Support of Faculty Development



CLER Program

5 key questions for each site visit

- Who and what form the hospital/medical center's infrastructure designed to address the six focus areas?
- How integrated is the GME leadership and faculty in hospital/medical center efforts across the six focus areas?
- How engaged are the **residents and fellows**?
- How does the hospital/medical center determine the success of its efforts to integrate GME into the six focus areas?
- What are the areas the hospital/medical center has identified for improvement?



ACGME