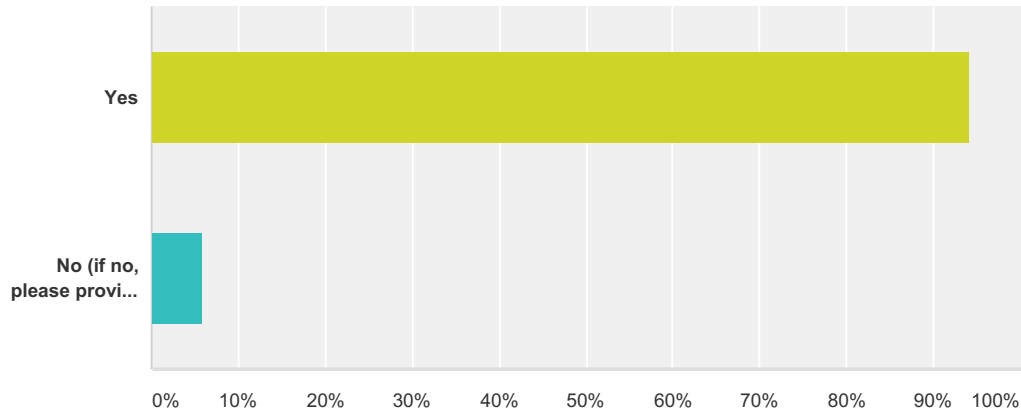## Q1 Do you agree with AADPRT's response to the ACGME regarding the proposed revisions of the Common Program Requirements, Section VI?

N=705   Answered: 103   Skipped: 1

Answer Choices	Responses	
Yes	**94.17%**	97
No (if no, please provide comment below)	**5.83%**	6
Total		**103**

#	No, I propose the following changes to the response:	Date
1	Very thoughtful and useful comments by AADPRT. Thanks for the hard work on this!	12/7/2016 4:49 PM
2	I agree with the submission. It is very thorough. I'd like to second the following points; I agree that Patient Safety and Quality Improvement metrics should be consolidated in one area of milestones. I think we also need to realistic about the institutional buy-in that is required for these programs to work well. At my institution it is very difficult to get multi-disciplinary (ie non-physician) input in these sorts of projects. Most of us are up to our necks in HEDIS and HBIPS and all other the other federally-mandated measures, and the ACGME risks piling on even more requirements. Residency programs are not capable of forcing an institution to commit resources to patient safety/ quality improvement. Likewise, responsibility for faculty well-being belongs at the level of departments, not residency programs.	12/7/2016 3:41 PM
3	I believe the response to lines 425 - 427 should be much stronger. The only appropriate venue for urgent and emergent mental health care is an emergency room. I know of no safe, appropriately staffed, out patient mental health clinic open 24/7. I would never see a patient after hours in my own clinic as it is a boundary crossing. I understand in some parts of the country mental health LIP's are in house 24/7, but not in Virginia. My department of psychiatry would not be able to staff such a service for multiple reasons.	12/6/2016 4:58 PM
4	I agree with all - except for the proposed change regarding safety event reporting at alternative sites. I believe that residents should be familiar with how to file a safety report at every site they are assigned. They will gain from seeing how this is done differently (and perhaps better) at some sites than at others. This will better prepare them for independent practice - and they will bring more to the table as future safety leaders from having had this broader exposure in safety reporting.	12/6/2016 1:34 PM
5	Excellent response. The ACGGME continues to confuse aspirational issues with our abilities to assess performance, It would be impossible for a program director address all of the issue ACGME suggests..	12/6/2016 7:51 AM
6	Overall excellent response. Agree with everything except below: section VI c 1e(1) While I appreciate the ongoing battle we need to continue with licensing boards regarding reporting mental illness I believe Program Directors should encourage faculty and other allied professionals to inform Program about residents who are struggling with depression, substance abuse, etc. Not doing so contributes to culture of stigma.	12/6/2016 7:28 AM

7	Terrific work from AADPRT!!!	12/2/2016 4:10 PM
8	Please note grammatical issue: on #11 398-400 VI.C.1.d).1 .....We "would" that this is also an opportunity	11/30/2016 4:43 PM
9	The requirements for quality improvement exceed residency oversight and belong with CLER rather than CPR.	11/30/2016 12:59 PM
10	Beautifully written response. Well done! I also was concerned about references to residency training ensuring certain things about residents' "future practice." That seems beyond the scope of what we can reasonably do.	11/30/2016 10:58 AM
11	I would just like to comment that the responsibilities for program directors keesp increasing adn these guidelines require much more programmatic development. Perhaps AADPR could also comment on the amount of protected time re	11/30/2016 9:54 AM
12	Nice work. I concur, especially on the undue burden the revisions place on the program and program director.	11/30/2016 9:38 AM
13	I think this was well-written, clear, and comprehensive. I'm impressed!	11/30/2016 9:14 AM
14	Continuing to allow and expect RRC-specific and potentially more specialty definitive requirements is crucial. In psychiatry, this is probably best highlighted with the term "supervision" - I believe we are the only specialty that includes longitudinal and individual expectations for supervision focusing on things like boundaries, interpersonal relationships and self-understanding, beyond the specific moment of patient care decision making. Unless specified well by the RRC it will undoubtedly be eliminated by the finance side of health care. We need to be more relevant and a part of the house of medicine, but not lose what gives us value to our patients and our colleagues.	11/30/2016 8:20 AM
15	For section 11 of the individual comment section, there may be a word missing: "...We would (???) that this is also an opportunity for residents to demonstrate appropriate professionalism and communication..."	11/30/2016 3:59 AM
16	In general, I think that the response is excellent. And I do agree that these requirements should be the responsibility of the institution and not the individual programs. However, I am concerned that in the response, we do not emphasize enough that the requirements themselves are generally excellent but that we that they must be the primary responsibility of the institution with expected follow up by the programs. I do like the idea of adding validated scales for anxiety since I agree that they may be helpful. Regarding the faculty issues, I think the correct response should be that these are the responsibility of both the institution and the specific departments (eg the department chair as opposed to the program director). In fact, I will be recommending more language regarding faculty since if faculty well being, resilience and burnout are not addressed, all of these measures will fail. Thanks for reviewing this so carefully.	11/29/2016 8:51 PM
17	Trivial suggestions: 10: programS should be plural 11: word left out--"we would _____ that..." Very well crafted response.	11/29/2016 7:50 PM