



Dear Program Director,

The AAMC Resident Readiness Survey provides a standardized process for program directors to provide feedback on the readiness of their residents for PGY-1 training. Please provide feedback on the PGY-1 resident named below.

The information collected from this survey is confidential. The identified data will be provided only to designated personnel at the medical school of graduation of each resident. In 2019, the AAMC Policies Regarding The Collection, Use, and Dissemination of Resident, Intern, Fellow, and Residency, Internship, and Fellowship Application Data were updated, in part, to explain to applicants using ERAS to apply to residency programs that the AAMC may collect individually-identified assessment information about their performance from their residency program, released in accordance with the program's institutional policies, and share such assessment information with the medical school from which the individual graduated; provided the medical school agrees that (i) it will protect the confidentiality of such data, (ii) it will not share the data with any third party, (iii) it will only use the data for the purpose of evaluating its processes, and (iv) it will not use such data for any personnel decisions about an individual, including (but not limited to) the individual's eligibility for being hired or promoted at the medical school or at any of the medical school's affiliated institutions. AAMC's use and release of such assessment information is subject to the AAMC Privacy Statement.

Your participation is voluntary, and this survey will take approximately 5 minutes to complete.

Resident: %[FNAME]Q18_1% %[LNAME]Q19_1%

During the transition to GME (0-6 months of PGY-1 year), did this resident meet overall performance expectations?

- Exceeded overall performance expectations
- Met overall performance expectations
- Did not meet overall performance expectations

Please elaborate on your response below:



Resident: %[FNAME]Q18_1% %[LNAME]Q19_1%

Please respond to the following global ratings using performance data from multiple sources, ideally during or immediately after the first 6-month ACGME Milestone reporting period. This is not intended to serve as a checklist or direct observation rating scale.

Please respond using the following guidance:
 Mark "Exceeded Expectations" if resident demonstrated all behaviors listed for the item with strength.
 Mark "Met Expectations" if all behaviors were demonstrated.
 Mark "Failed to Meet Expectations" if all OR some of the behaviors in the statement were not met.

During transition to GME, did this resident fail to meet, meet, or exceed expectations of an entering PGY1 resident for each of the following areas?

	Failed to Meet Expectations	Met Expectations	Exceeded Expectations	Not Enough Information to Determine	Not Applicable to My Program
Demonstrated professionalism when interacting with healthcare professionals and staff (altruism, compassion, honesty, confidentiality, and integrity).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demonstrated professionalism when interacting with patients and family members (altruism, compassion, honesty, confidentiality, and integrity).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Considered religious, ethnic, gender, educational and other differences in interacting with patients and other members of the health care team.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Admitted one's own errors and accepted responsibility for personal and professional development.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Performed overall tasks and responsibilities in an organized and timely manner with appropriate attention to detail.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demonstrated patient-centered interview skills.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Performed a clinically relevant and appropriately thorough physical exam pertinent to the setting and purpose of the visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Performed expected procedures of an entry resident, including obtaining consent for those procedures.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prioritized a differential diagnosis.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Failed to Meet Expectations	Met Expectations	Exceeded Expectations	Not Enough Information to Determine	Not Applicable to My Program
Recognized a patient requiring urgent or emergent care and initiated evaluation and management.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpreted results of basic studies and understood the implications and urgency of the results.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demonstrated how to access and use available evidence and incorporate patient preferences and values into delivery of care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Documented encounters in patient record.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Entered and discussed orders and prescriptions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provided oral presentation of clinical encounter.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Used communication strategies for safe and effective transitions of care and handoffs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Identified and reported system failures, patient safety concerns in a timely manner.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Resident: %[FNAME]Q18_1% %[LNAME]Q19_1%

Reflect on the information provided about this individual from the medical school including the MSPE before or during the transition to residency. Was the information provided useful?

- Yes
- Somewhat
- No

Please elaborate on your response below:

Do you recall the Medical Student Performance Evaluation (MSPE) for this resident?

- Yes
- No

Please provide any additional comments you have about this resident's readiness for training in your program:

Resident Readiness Survey Instrument Development

In 2018, the Association of American Medical Colleges (AAMC) convened a Task Force (Supplemental Digital Content [SDC] 3 : Task Force Roster) to explore, with broad input and feedback from key stakeholder groups (e.g., Organization of Program Director Associations [OPDA], AAMC Group on Resident Affairs [GRA], Association of American Colleges of Osteopathic Medicine [AACOM]), on the feasibility, logistic considerations and instrument content of a standardized Resident Readiness Survey (RRS) process. The Task Force, with diverse subject matter expertise, determined that optimal survey administration characteristics included electronic RRS administration, task integration into existing program director (PD) workflows and survey timing coinciding with the first Accreditation Council for Graduate Medical Education (ACGME) milestones reporting period (~ 6 months after Post Graduate Year (PGY) -1 training started). Optimal survey instrument characteristics and content, defined by the Task Force after extensive review of pre-existing school-specific surveys and related literature included brevity, competency-based and criterion- (rather than norm)-referenced content, and written comment options for PDs. Broad input was collected via focus groups with national meetings' (e.g., ACGME, AACOM) attendees and with OPDA, AAMC Group on Educational Affairs (GEA), AAMC (GRA), AAMC Group on Student Affairs (GSA), Organization of Student Representatives (OSR) and Organization of Resident Representatives (ORR), among others. Additional feedback was also collected from broad groups of UME-GME educators via two national surveys. The first was conducted March 2018 to collect information about the benefits, concerns, timing, and content of a national, standardized system for program directors to provide feedback on the readiness of their residents for PGY-1 training. The second was conducted October 2019 and intended to collect information about an early draft of the RRS.

Through this broad, iterative process, , the RRS instrument “version 1.0” was finalized (SDC1: Resident Readiness Survey Instrument).

Task Force Roster

Kathryn M. Andolsek MD, MPH. Professor, Family Medicine and Community Health, Assistant Dean, Duke University School of Medicine.

Dellyse M. Bright MD. Clinical Associate Professor, Family and Community Medicine, Wake Forest University School of Medicine, Residency Program Director of Family Medicine, [Carolinas Medical Center](#).

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Janice Herbert-Carter MD, MGA. Professor and Chair, Medical Education, Morehouse School of Medicine.

Joseph Jaeger PhD, MPH. Associate Vice President, Research; Chief Academic Officer. RWJ Barnabas Health Monmouth Medical Center.

Sara M. Lamb MD. Associate Professor, Internal Medicine and Adjunct Associate Professor, Pediatrics and Associate Dean for Education Curriculum, University of Utah School of Medicine.

Kimberly Lomis MD. Vice President for Undergraduate Medical Education Innovations, American Medical Association.

Hilit F. Mechaber MD Associate Professor, Medicine Senior Associate Dean for Student Affairs, University of Miami, Miller School of Medicine.

Sally A. Santen MD, PhD. Professor, Emergency Medicine and Professor, Medical Education at University of Cincinnati College of Medicine; Senior Associate Dean, Evaluation, Assessment and Scholarship, [Virginia Commonwealth University](#).

AAMC Resident Readiness Pilot Evaluation Survey

Dear RRS Pilot Participant,

Thank you for participating in year 1 of the Resident Readiness Survey (RRS) pilot. As mentioned in the executed participant agreement, we are collecting feedback about the pilot to better understand its utility and feasibility. This survey is one of our evaluation tools and we thank you in advance for your completion. Please note that just one survey per school is requested.

Completion should take less than 10 minutes. The responses you provide are classified as restricted. Restricted data may not be released with individual or institutional identification, except with permission. Responses will be stored securely by the AAMC. Access to your responses will be limited to key AAMC staff and data will only be shared in aggregate to any external audience.

The survey has been reviewed according to AAMC policies and procedures. If you have any questions about the survey, please contact residentreadiness@aamc.org.

Thank you again for your participation in this program.

Sincerely,

Lisa Howley, PhD, Senior Director, Academic Affairs

By continuing to complete the survey, you acknowledge that you have read the above and agree to participate.

(End of Page 1)

I. Overall Experience

Contact Information for Individual Completing Survey:

Name: _____

Title: _____

Email Address: _____

Would you recommend to other schools that they participate in the Resident Readiness Survey (RRS)?

- Yes
- No
- Unsure

Please briefly explain your response:

(End of Page 2)

II. Data Report

Did you access and view the AAMC RRS Data Report?

- Yes
- No

Was the report easy to interpret?

- Yes
- No

How can we improve the content of the report?

How can we improve the format of the report?

Destination: **Page 5** (Set in 3. (No))

(End of Page 3)

III. Use or Intended Use of Data

How did this report support curricular quality improvement efforts at your institution?

- A. It stimulated new curricular quality improvement efforts.
- B. It supported ongoing curricular quality improvement efforts.
- C. It is not being used for curricular quality improvement at this time.
- D. Unsure

What, if any, part of the UME curriculum was informed by the results of the RRS?
(select all that apply)

- A. Pre-clinical curriculum
- B. Clinical curriculum
- C. Simulation curriculum
- D. Professionalism curriculum
- E. Other (please explain): _____

As part of the AAMC RRS report, you were provided with comments from program directors about the utility of the Medical Student Performance Evaluation (MSPE) that was provided for your graduates. Are you (or anyone else at your school) considering changes to the MSPE as a result of this information?

- A. Yes
- B. No
- C. Not yet, but intend to make change/s
- D. Unsure

Please explain your answer:

(End of Page 4)

IV. Local Practices Prior to National Pilot

The following questions will be referring to surveys that may have been sent out by your institution before the AAMC RRS project about PGY1 residents. As a reminder, all pilot participants agreed to NOT send their own separate Program Director survey about PGY-1 graduates (class of 2020).

In the five years prior to the AAMC RRS pilot (i.e., for classes 2015-2019), did your institution send a survey(s) to Program Directors inquiring about the performance of your graduates during the PGY-1 year of training?

- A. Yes
- B. No
- C. Unsure

What was the primary purpose of that survey (why was it administered)?

What was the length of the most recent survey?

- A. <5 questions
- B. 5-10 questions
- C. 11-15 questions
- D. 16-20 questions
- E. >20 questions
- F. Unsure

What was the approximate response rate for the most recent survey?

- A. <25%
- B. 25-50%
- C. 51-75%
- D. >75%
- E. Unsure

Was the survey content the same over the last 5 years prior to the start of the AAMC pilot?

- A. Yes, we consistently sent the same survey.
- B. No, the survey content changed over the past 5 years.
- C. Unsure

Please estimate the approximate amount of time each year spent on the creation, distribution, collection, and analysis of this local survey (this estimate should represent the best estimate of the cumulative amount time spent by all faculty and staff aiding in this endeavor).

- A. <0.25 FTE
- B. 0.26 – 0.50 FTE
- C. 0.51 – 0.75 FTE
- D. 0.76 – 1.0 FTE
- E. 1.10 – 1.25 FTE
- F. 1.26 - 1.50 FTE
- G. 1.51 – 1.75FTE
- H. 1.76 - 2.0FTE
- I. > 2.0 FTE

Please provide any additional comments regarding the RRS pilot below:

(End of Page 5)

TABLE
Resident Readiness Survey Completion Data

Completion Rates	Year 1 and Year 2 Combined, Mean % (SD); # of Responding PDs	P value	Year 1 2020-2021 Mean % (SD); # of Responding PDs	Year 2 2021-2022 Mean % (SD); # of Responding PDs	Year 2 vs Year 1 Percentage Points Difference; (95% CI)	P value
RRS completion rate per PD, all responding PDs combined	90.9 (28.8); 3893		92.0 (23.1); 1786	90.6 (24.6); 2107	-1.4; (-2.9 to 0.1)	.07
RRS completion rate by number of RRSs sent to PD		<.001				
One RRS	100.0; 883		100.0; 529	100.0; 354		
2 to 4 RRSs	92.3 (25.9); 1,725		93.4 (19.0); 810	92.4 (20.4); 915	-1.0; (-2.9 to 0.8)	.27
5 to 9 RRSs	85.0 (35.8); 872		84.7 (30.7); 325	86.1 (29.8); 547	1.4; (-2.7 to 5.6)	.50
≥ 10 RRSs	76.3 (42.6); 413		66.9 (43.0); 122	81.9 (34.4); 291	15.0; (7.1 - 22.9)	<.001
	# of RRSs (% of 15,255 RRSs)^a		# of RRS (% of 5,567 RRSs)^a	# of RRS (% of 9,688 RRSs)^a		
Month in which RRS was initially opened						
November	367 (2.4)		367 (6.6)	N/A ^b		
December	3561 (23.3)		364 (6.5)	3197 (33.0)		
January	4268 (28.0)		2045 (36.7)	2223 (22.9)		
February	5161 (33.8)		2621 (47.1)	2540 (26.2)		
March	1898 (12.4)		170 (3.1)	1728 (17.8)		
Time spent on RRS completion, per survey						

	Mean (SD) Minutes; # of RRS		Mean (SD) Minutes; # of RRS	Mean (SD) Minutes; # of RRS	Difference, Minutes (95% CI)	
Minutes to completion, per survey ^c	2.3 (4.5); 13096		2.4 (4.6); 4763	2.3 (4.5); 8333	-0.10; (-0.26 to 0.06)	.23

Abbreviations: RRS, Resident Readiness Survey; PD, program director; N/A, not applicable.

^a Column percentages may not add up to 100.0 due to rounding.

^b As only 6.6% of completed year 1 RRSs were opened in November; year 2 program director invitations were not sent until December.

^c Minutes to completion per survey was calculated on the basis of time-stamp data for when the RRS was opened and when the RRS was submitted only for those RRSs that were open for less than one hour prior to completion. Completing the survey in under one hour assumes completion of the survey in “one sitting” and most completed RRSs were completed in under one hour (13,096/15,255; 85.8%). However, surveys that were initially opened and then completed hours, days or months later (ie, presumably not in “one sitting”) were purposefully excluded from these calculations.

TABLE
Postgraduate Year 1 Residents' Coverage Outcomes

Residents Covered	Year 1 and Year 2 Combined	P value	Year 1: 2020-2021	Year 2: 2021-2022	Percentage Points Difference (95% CI)	P value
Number of eligible PGY-1 residents at participating schools/number of all graduates of participating schools (% eligible) ^a	29084/32079 (90.7)		10712/12035 (89.0)	18372/20044 (91.7)	2.7 (2.0 to 3.3)	<.001
Number of covered PGY-1 residents/number of eligible PGY-1 residents (% coverage) ^a	15255/29084 (52.5)		5567/10712 (52.0)	9688/18372 (52.7)	0.7 (-0.4 to 2.0)	.21
Number of covered PGY-1 residents/number of eligible PGY-1 residents (% coverage) <i>by specialty</i> ^a		<.001				
Anesthesiology	781/1339 (58.3)		270/452 (59.7)	511/887 (57.6)	-2.1 (-7.7 to 3.4)	.46
Emergency medicine	1846/2732 (67.6)		614/985 (62.3)	1232/1747 (70.5)	8.2 (4.5 to 11.9)	<.001
Family medicine	1953/3238 (60.3)		723/1206 (60)	1230/2032 (60.5)	0.5 (-2.9 to 4.1)	.74
Internal medicine	2961/7973 (37.1)		1201/3033 (39.6)	1760/4940 (35.6)	-4.0 (-6.2 to -1.8)	<.001
Internal medicine-pediatrics	355/448 (79.2)		111/159 (69.8)	244/289 (84.4)	14.6 (6.3 to 22.9)	<.001
Neurologic surgery	126/227 (55.5)		44/79 (55.7)	82/148 (55.4)	-0.3 (-13.9 to 13.3)	.97
Neurology	155/426 (36.4)		57/143 (39.9)	98/283 (34.6)	-5.2 (-15.0 to 4.5)	.29
Obstetrics and gynecology	836/1511 (55.3)		349/545 (64.0)	487/966 (50.4)	-13.7 (-23.8 to -3.5)	<.001

Orthopedic surgery	529/981 (53.9)		209/382 (54.7)	320/599 (53.4)	-1.3 (-7.7 to 5.1)	.69
Other non-surgical specialties ^b	226/419 (53.9)		80/126 (63.5)	146/293 (49.8)	-13.6 (-18.7 to -8.5)	<.001
Otolaryngology	251/403 (62.3)		91/150 (60.7)	160/253 (63.2)	2.6 (-7.2 to 12.4)	.61
Pathology— <i>anatomic and clinical</i>	169/302 (56.0)		69/126 (54.8)	100/176 (56.8)	2.1 (-9.3 to 13.4)	.72
Pediatrics	1644/2793 (58.9)		570/1021 (55.8)	1074/1772 (60.6)	4.8 (1.0 to 8.6)	.01
Plastic surgery-integrated	104/205 (50.7)		37/75 (49.3)	67/130 (51.5)	2.2 (-12.0 to 16.4)	.76
Psychiatry	947/1777 (53.3)		335/657 (51.0)	612/1120 (54.6)	3.7 (-1.2 to 8.5)	.14
Surgery— <i>general</i>	1257/2352 (53.4)		426/856 (49.8)	831/1496 (55.5)	5.8 (1.6 to 10.0)	.007
Other surgical specialties ^c	71/137 (51.8)		23/54 (42.6)	48/83 (57.8)	15.2 (-1.7 to 32.2)	.08
Transitional year	774/1425 (54.3)		264/514 (51.4)	510/911 (56.0)	4.6 (-0.8 to 10.0)	.09
Urology	270/396 (68.2)		94/149 (63.1)	176/247 (71.3)	15.2 (-1.4 to 17.8)	.09
	Mean [SD]; Range N=208 Schools^d		Mean [SD]; Range N=77 Schools	Mean [SD]; Range N=131 Schools		
% coverage <i>per school</i>	52.9 [7.3] 28.7 to 75.8%		52.0 [7.9] 28.7 to 68.3%	53.5 [7.0] 38.7 to 75.8%	1.5 (-0.6 to -3.6)	.16

Abbreviations: PGY, postgraduate year; GME, graduate medical education.

^a Eligible PGY-1 residents are participating schools' graduates who had confirmed GME Track records and Electronic Residency Application Service (ERAS) acknowledgement records. The number of eligible PGY-1 residents is smaller than the number of graduates for the following reasons: Each school likely had a few graduates who did not enter GME, and, of those graduates who did enter GME, the Resident Readiness Survey process excluded graduates in GME without a confirmed GME Track record (GME Track data are confirmed for about 95% of physicians

in the database) and graduates with confirmed GME Track records but without ERAS records (~4% of GME Track PGY-1 residents do not have ERAS records. L. Roskovensky, BA, Association of American Medical Colleges, written communication, January 8, 2023.)

^b “Other nonsurgical specialties” includes child neurology, neurodevelopmental disabilities, dermatology, ophthalmology, osteopathic neuromusculoskeletal medicine, physical medicine and rehabilitation, psychiatry/family practice, psychiatry/neurology, radiology-diagnostic, emergency medicine/family medicine, emergency medicine/anesthesiology, internal medicine/dermatology, internal medicine/ emergency medicine, internal medicine/medical genetics, internal medicine/preventive medicine, internal medicine/psychiatry, pediatrics/anesthesiology, pediatrics/emergency medicine, pediatrics/medical genetics, pediatrics/physical medicine and rehabilitation, pediatrics/psychiatry/child and adolescent psychiatry, pediatric urology.

^c “Other surgical specialties” includes thoracic surgery-integrated and vascular surgery-integrated.

^d School decisions to participate were independent decisions made in each of 2 years; some schools participated in both year 1 and year 2; other schools participated in year 1 only or in year 2 only and some schools did not participate in either year. The total number of schools in both years combined is the sum of the number of schools in year 1 and the number of schools in year 2.