

The ACGME Resident Survey Aggregate Reports: An Analysis and Assessment of Overall Program Compliance

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Abstract

Background The Accreditation Council for Graduate Medical Education (ACGME) uses a 29-question Resident Survey for yearly residency program assessments. This article describes methodology for aggregating Resident Survey data into 5 discrete areas of program performance for use in the accreditation process. This article also describes methodology for setting thresholds that may assist Residency Review Committees in identifying programs with potential compliance problems.

Methods A team of ACGME staff and Residency Review Committee chairpersons reviewed the survey for content and proposed thresholds (through a modified Angoff procedure) that would indicate problematic program functioning.

Results Interrater agreement was high for the 5 content areas and for the threshold values (percentage of noncompliant residents), indicating that programs above these thresholds may warrant follow-up by the accrediting organization. Comparison of the Angoff procedure and the actual distribution of the data revealed that the Angoff thresholds were extremely similar to 1 standard deviation above the content area mean.

Conclusion Data from the ACGME Resident Survey may be aggregated into internally consistent and consensually valid areas that may help Residency Review Committees make more targeted and specific judgments about program compliance.

Background

Residents' evaluation of their program is an important source of information about program quality and resident satisfaction. The Accreditation Council for Graduate Medical Education (ACGME) currently uses the 29-question Resident Survey for yearly residency program assessments. Although these data are necessarily limited to residents' and fellows' point of view, the information collected via the survey is congruent with the areas most frequently cited in program reviews and has been found to be highly predictive of Residency Review Committee (RRC) accreditation actions.¹

In the current accreditation process, RRCs generally use the Resident Survey results during program review only after the findings have been verified by a site visit.² The survey results display individual resident response frequencies, reflecting programs' substantial compliance or noncompliance. This article details the methodology and creation of aggregate data reports that facilitate comparison

of a particular program's responses with the national cohort. An important element of the methodology is the aggregation of individual survey questions into domains of program functioning, including availability of resources and compliance with the duty hour requirements. These aggregate reports would allow RRCs to receive an interim (between site visits) assessment of the program, noting any problematic issues that might require further investigation from the RRC.

Methods

A panel of 8 ACGME staff (data analysts, senior staff, and executive directors) convened to discuss methods for aggregating data from the Resident Survey. In addition, all members of the ACGME Council of Review Chairs (CRC, comprising all RRC chairpersons) were asked to participate. Of this group, 24 of the 26 members submitted data.

Initial efforts focused on setting a priori thresholds for each individual item using an Angoff methodology, a commonly used standard-setting technique for determining test pass and fail rates.³ Data were summarized from the 2007 and 2008 Resident Surveys and were made available to all raters. These data were the population percentage of noncompliant residents for each item. Participating raters were asked to indicate, for each item, the category or area of residency education (based on the item content), the importance of each item (on a 3-point scale), and the

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DOI: 10.4300/JGME-D-09-00062.1

TABLE 1 PERCENTAGE NONCOMPLIANT THRESHOLDS, IMPORTANCE, AND CATEGORY ASSIGNED FOR EACH RESIDENT SURVEY ITEM			
Survey Item	Average Percentage Threshold Assigned by Raters	Importance	Category
1. Do the faculty spend sufficient time TEACHING residents/fellows in your program?	17.50	2.00	FA
2. Do the faculty spend sufficient time SUPERVISING the residents/fellows in your program?	14.38	2.00	FA
3. Do your faculty members regularly participate in organized clinical discussions?	20.75	1.25	FA
4. Do your faculty members regularly participate in rounds?	20.00	1.63	FA
5. Do your faculty members regularly participate in journal clubs?	25.63	1.00	FA
6. Do your faculty members regularly participate in conferences?	20.63	1.25	FA
7. Do you have the opportunity to confidentially evaluate your FACULTY, in writing or electronically, at least once a year?	17.50	1.88	EV
8. Do you have the opportunity to confidentially evaluate your overall PROGRAM, in writing or electronically, at least once a year?	18.75	2.00	EV
9. Has your program provided you access to, either by hard copy or electronically, written goals and objectives for the program overall?	20.63	1.38	EC
10. Has your program provided you access to, either by hard copy or electronically, written goals and objectives for each rotation and major assignment?	19.38	1.75	EC
11. Do you receive written or electronic feedback on your performance for each rotation and major assignment?	16.25	1.75	EV
12. Are you able to review your current and previous performance evaluations upon request?	17.25	1.50	EV
13. Have you had sufficient education (from your program, your hospital(s), your institution, or your faculty) to recognize and counteract the signs of fatigue and sleep deprivation?	21.88	1.13	EC
14. Does your program offer you the opportunity to participate in research or scholarly activities?	20.00	1.13	EC
15. Have residents/fellows had the opportunity to assess the program for the purposes of program improvement?	23.75	1.38	EV
16. To what extent do trainees who are not part of your program (such as residents from other specialties, subspecialty fellows, PhD students and nurse practitioners) interfere with your education?	28.75	1.25	RE
17. Are mechanisms within the institution available to you so that you may raise and resolve issues without fear of intimidation or retaliation?	27.50	1.63	RE
18. How often are you able to access, either in print or electronic format, the specialty specific and other reference materials that you need?	25.00	1.63	RE
19. Do your rotations and other major assignments emphasize clinical education over any other concerns, such as fulfilling service obligations?	27.50	1.75	EC

TABLE 1 CONTINUED

Survey Item	Average Percentage Threshold Assigned by Raters	Importance	Category
20. Duty hours must be limited to 80 hours per week (88 for those programs having duty hour exceptions), averaged over a 4-week period, inclusive of all in-house call activities.	16.25	2.00	DH
21. Residents and fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call.	16.88	1.88	DH
22. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.	20.00	1.88	DH
23. In-house call must occur no more frequently than every third night, averaged over a 4-week period.	18.13	1.75	DH
24. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents and fellows may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care.	17.50	2.00	DH
25. No new patients may be accepted after 24 hours of continuous duty.	22.50	1.63	DH
26. At-home call must not be so frequent as to preclude rest and reasonable personal time for each resident/fellow.	16.88	1.88	DH
27. Residents/fellows taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.	16.88	2.00	DH
28. When residents and fellows are called into the hospital from home, the hours they spend in-house are counted toward the 80-hour limit. (The limit is 88 hours for those programs with duty hour exceptions.)	18.75	1.63	DH
29. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours. (This limit is 88 hours for those programs with duty hour exceptions.)	25.00	1.25	DH

Abbreviations: FA, Faculty; DH, Duty Hours; EC, Educational Content; EV, Evaluation; RE, Resources.

threshold (or cutoff value) for the percentage of noncompliant residents that would be of concern to the RRC (ie, result in a progress report, further investigation, or, potentially, a citation). After the initial rating and discussion, staff submitted final ratings for each item. Although some discussion occurred among members of the CRC, this group submitted final ratings only.

No differences were found between staff and CRC ratings; all *t* tests for each item's percentage noncompliant and importance were not significantly different between the 2 groups. TABLE 1 summarizes the staff ratings. Combined staff and CRC ratings gave means between 19.03 and 20.75 for all the items.

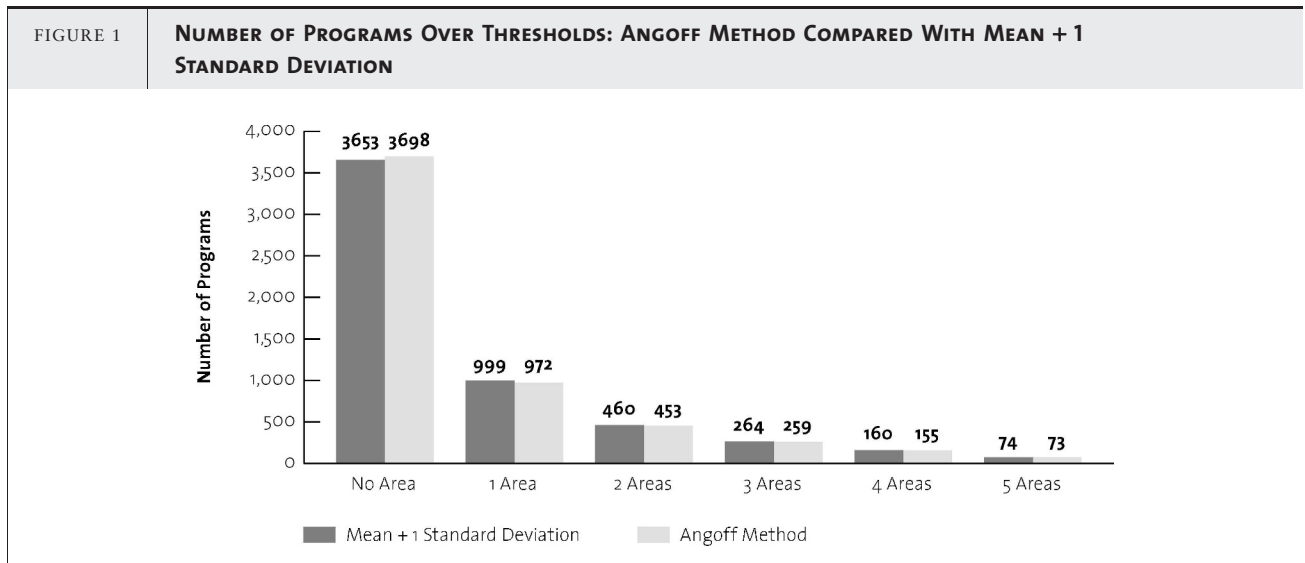
Item Categories

The response categories for the items were Faculty, Evaluation, Educational Content, Resources, and Duty

Hours. These are areas of the Common Program Requirements, as well as common citation categories.

Raters consistently placed the 29 Resident Survey items into 1 of the 5 categories previously noted. For 22 of the items, the category agreement was at least 90%; 10 of the items were at 100% agreement (for categorization as Duty Hours). In the other 7 items, 4 were assigned the majority category (having 70% or greater agreement). The 3 remaining items were almost evenly split between 2 categories. A subgroup of the raters decided the final categorization of these items.

Fleiss generalized kappa for the categories ranged from .72 to 1.00, with an overall kappa of .93, showing very strong interrater agreements.⁴ Because staff results did not differ significantly from the chair ratings, we report only staff ratings so as to reduce the number of raters included, as an increase in raters may inflate agreement statistics.



Grouping the Resident Survey data into these 5 categories, we found acceptable Cronbach alphas indicating internal consistency for each of the 5 categories, with 4 of the categories having alphas of .89 or greater. The alpha for Resources was lower, but still acceptable at .59.⁵ The low alpha for Resources is possibly related to the relatively small number of items (3) in this group.

Item Importance

The importance of each item was highly correlated (an average r of $-.52$) with item thresholds (described later). Raters assigned the most important items the lowest percentage threshold. TABLE 1 shows the average (across raters) importance for each item. Because importance was simply the inverse of item thresholds, importance was eliminated from further calculations.

Item Thresholds of Noncompliance

Raters assigned relatively uniform percentages (those that would be of concern), although the items ranged from 5% to 75%. This may indicate the relative importance for each item; some items would need to have large percentages of noncompliant responses (eg, 75%) to be of concern to the RRC, while others may be so important that a small percentage of noncompliant resident response would be of concern.

The ratings showed high interrater agreement for each of the items (Cronbach alphas ranged from .71 to .96).⁶

Computation of Cutoff Scores Based on the Angoff Procedure

Cutoff means (values at or beyond which would indicate serious issues with the item) ranged from 14.4% to 28.8%.

We computed noncompliance for each item (percentage noncompliance) in the combined 2007 and 2008 samples of

the Resident Survey. This combined sample included every accredited core program and every accredited subspecialty program having at least 4 fellows ($N = 5\,610$). For those items with 2 response options (eg, Yes or No), noncompliance was calculated as the simple percentage of the noncompliant response (No). For items with more than 2 response options (eg, Sometimes, Always, Never), the noncompliance was the weighted percentage of noncompliance, such that the most extreme (eg, Never) noncompliant value was assigned 1 and the least extreme noncompliant response (eg, Sometimes) was assigned 5. In this way, we conservatively computed item noncompliance so that the most noncompliant responses were weighted most heavily. In these data there are at most 2 noncompliant responses for each question.

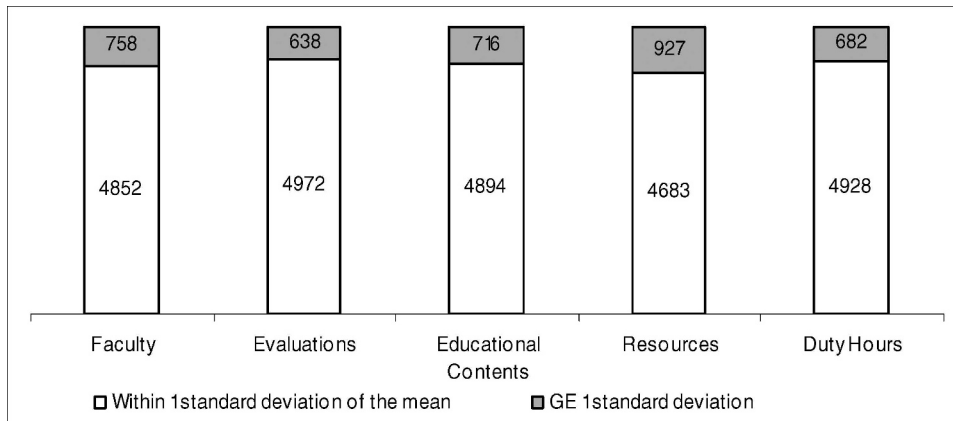
Each of the Resident Survey items' actual data (percentage noncompliance) was then compared with the rater-determined thresholds. If a program's response was at or above the threshold, the program was flagged (ie, given a score of "1") on that item. Then, the scores were summed by category, so that each program had a score ranging from 0 (the program did not exceed the threshold on *any* of the items of this category) to the maximum number of questions in the aggregated category (the program exceeded the threshold on *all* the items in this category).

This method resulted in a relatively high percentage of programs flagged, 45% of programs for some categories. To ensure a conservative estimate, we selected the cutoff as having at least 2 questions above the threshold.

Comparing the Angoff Cutoffs With Those Based Solely in the Data

In conjunction with the a priori Angoff procedure for determining thresholds in the Resident Survey, we also examined a more data-driven approach. Using the

FIGURE 2 NUMBER OF PROGRAMS ABOVE MEAN + 1 STANDARD DEVIATION



categories from the Angoff procedure, we calculated means (based on the noncompliant responses previously described) by category, for the combined 2007 and 2008 samples of the Resident Survey. We also calculated standard deviations around these means, and took 1 standard deviation above the mean (on any of the 5 categories) as our initial threshold.

The Angoff procedure and the mean + 1 standard deviation yielded remarkably similar results. The number of programs above the cutoff points is the same as those above the 1 standard deviation mean for noncompliance rates.

FIGURE 1 shows the 2 methods.

Given the similarity of the results with the 2 methods, the data-driven approach is preferable. First, the thresholds are derived solely from available data and rely on no expert judgments or calculations based on estimates of RRC actions. Second, the metric of mean + 1 standard deviation is readily understood and robust. Third, and perhaps most

importantly, this approach allows for examination of the distribution of the data (eg, how far away is the value from the mean, how far beyond one standard deviation), rather than a binary decision point (is the program mean above the Angoff cutoff).

For these reasons, we have selected the mean + 1 standard deviation in the 5 areas as our metric to determine potential noncompliance in the Resident Survey. FIGURE 2 shows the number of programs beyond the mean + 1 SD for each area, and FIGURE 3 shows the actual means and standard deviations for each area.

Results

Producing Summary Reports for use of the RRCs

As well as providing more succinct information for each program (in the 5 areas and based on the population of programs) at the time of review, we created reports, by

FIGURE 3 MEAN NONCOMPLIANCE FOR EACH AREA, WITH STANDARD DEVIATION SHOWN

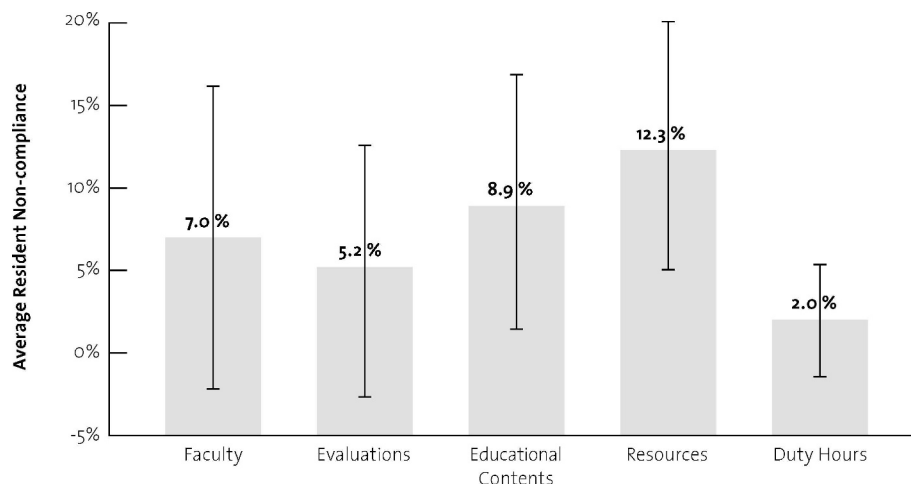
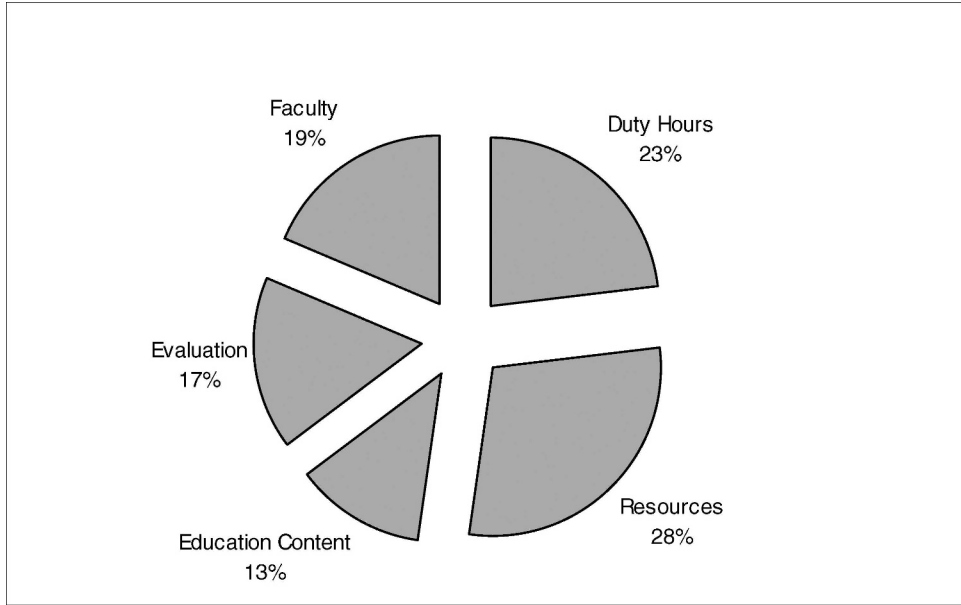


FIGURE 4 DISTRIBUTION OF NONCOMPLIANT AREAS FOR THOSE PROGRAMS HAVING ONLY ONE AREA ABOVE A THRESHOLD



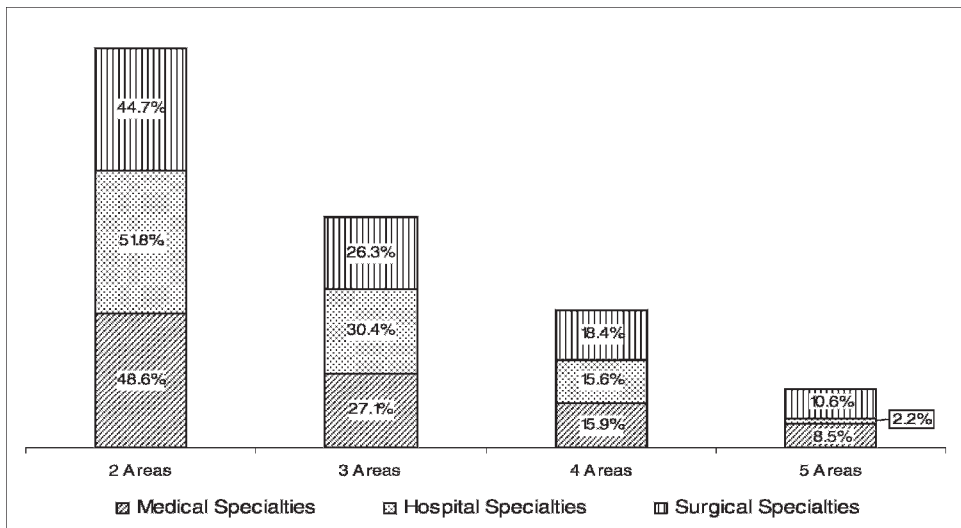
specialty, for the use of each RRC. These reports, based on the most recent available data, provide the RRCs with the most extreme (and thus the most potentially noncompliant) outliers in the survey.

Applying this methodology to the 2007 and 2008 Resident Survey administrations (N = 5 610 programs), 1 957 programs fall above the established thresholds; of these, 51% are programs in the “above only 1 threshold” category (FIGURE 1). Further exploration of the data show that these “1 threshold only” programs account

for as many as 75% of programs in a particular specialty, suggesting that this criterion may be too stringent. FIGURE 4 lists the areas and percentage of programs having each of these “1 threshold only” programs.

To be as conservative as possible in bringing only those most extreme noncompliant programs to the attention of the RRC, we produced reports for each RRC that included only programs having at least 2 areas above the thresholds. The reports for each RRC are sorted by most to least noncompliant, and are accessible using a secured

FIGURE 5 PERCENTAGE OF PROGRAMS HAVING 2, 3, 4, OR 5 AREAS ABOVE THE THRESHOLDS



Accreditation Data System log-in. The reports are currently available and may be accessed under the Resident Survey Reports heading in the Accreditation Data System, under Resident Survey Threshold Reports.

There are differences by specialty grouping for the threshold areas. FIGURE 5 shows the percentages of programs having at least 2 areas above the threshold by specialty groups (Medical, Hospital, or Surgical). Despite these differences, particularly at the “5 areas above threshold” level, the percentages of programs at each level are comparable across the specialty groups.

Conclusion

This analysis is important because aggregate reports can help RRCs make more informed decisions. Although single-item reports are useful, the aggregate data offer areas or patterns of noncompliance. To provide the RRCs with the most accurate and current data available, reports will include only the most recent set of Resident Survey data. For

the 2009 administration of the Resident Survey, new population-based means and standard deviations are calculated, and any programs at 2 thresholds or higher will appear on interactive (searchable) reports, with RRC users able to drill down into the data. These reports will be updated at the end of each Resident Survey data collection period.

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