POLICY

Area: Graduate Medical Education  Number: 719

Title: Internal Reviews of ACGME Accredited Residency Programs

It shall be the responsibility of the Graduate Medical Education Committee (GMEC) to review regularly all ACGME-accredited programs including subspecialty programs to assess their compliance with the Institutional Requirements, Common Program Requirements, and the Program-Specific Requirements of the ACGME Review Committees. These internal reviews shall be conducted at approximately the midpoint of each program’s accreditation cycle and according to the following protocol:

Procedure

1. All programs are notified by the DIO or Associate DIO at least 90 days prior to the date and time established by the ACGME for the internal review.

2. The GMEC shall appoint a specific internal review subcommittee for each program to be reviewed, with the following membership:
   a. one program director (external to the program being reviewed)
   b. one associate program director and/or one program director, within their first two years of appointment (external to the program being reviewed)
   c. two residents (external to the program being reviewed)
   d. one program coordinator (external to the program being reviewed)
   e. GME office representatives fulfilling the following responsibilities
      1) Associate DIO (or designee) - serves as permanent chair of Internal Review committees; responsible for establishing agenda, facilitating meeting, and drafting report
      2) GME coordinator - serves as support staff, assisting resource and materials access for committee
      3) Other members of GME office at discretion of chair
      4) Optional: one member of the clinical faculty, selected by a TMEF hospital Chief Medical Officer (rotating basis), preferably among members of the hospital’s Medical Executive Committee
      5) external consultants may be utilized as needed when requested by the subcommittee and approved by the GMEC
3. The internal review of each program shall be conducted in such a timely manner as to ensure that the internal review report is presented to the GMEC at approximately the midpoint of the review cycle; i.e., at the midpoint between the effective date on the ACGME letter of notification and the approximate date of the next site visit.
   a. When a program has no residents enrolled at the mid-point of the review cycle, the GMEC shall conduct a modified internal review.
   b. The modified internal review shall ensure the program has maintained adequate faculty and staff resources, clinical volume, and all other necessary curricular elements to be in compliance with all Institutional, Common Program, and Program-Specific Requirements.
   c. This modified review must be completed prior to the program as enrolling a resident.
   d. After a program enrolls a resident, the GMEC must complete an internal review within the second six-month period of the resident’s first year in the program.

4. In its review of the program, the subcommittee shall utilize:
   a. ACGME Program-Specific Requirements, and Institutional Requirements in effect at the time of the review;
   b. the most recent RRC Letter of Notification and any subsequent reports or correspondence with the RRC.
   c. the completed Common PIF
   d. the completed Specialty-specific PIF
   e. all documents required for a site visit (for complete list, see page ii of program’s Common PIF) including:
      - Overall educational goals for the program (CPR IV.A.1)
      - Competency-based goals and objectives for each assignment at each educational level (CPR IV.A.2)
      - Evaluations showing use of multiple evaluators (faculty, peers, patients, self, and other professional staff) (CPR V.A.1.b.(2))
      - Completed annual written confidential evaluations of faculty by the residents (CPR V.B. 3)
      - Completed annual written confidential evaluations of the program by the residents (CPR V.C.1.d.(1))
      - Completed annual written confidential evaluations of the program by the faculty (CPR V.C.1.d.(1))
      - Documentation of program evaluation and written improvement plan (CPR V.C)
   f. the 2 most recent ACGME Resident Surveys
g. the 2 most recent OU SCM Graduation Survey of residents for the program
h. the most recent OU SCM Graduation Questionnaire of students, section on resident
teaching for the program
i. report from the prior internal review;
j. report of all required procedures and clinical experiences, with program standard
and/or minimum for each, for all current residents and prior 2 graduating classes
k. report of In-Training Exam scores by PGY during prior 3 years
l. report of GME Coordinator audit of all resident files
m. most recent GME Performance Scorecard
n. report of all Participating Sites and PLAs, with signature dates
o. report of board exam performance for most recent 3 graduating classes
p. interviews with:
a. program director, associate program director(s), and program coordinator
b. key faculty,
c. at least one peer-selected resident from each level of training, and
d. other appropriate persons.
q. Other information at discretion of committee

4. The subcommittee shall evaluate:

a. compliance with the Common Program Requirements, Program-Specific
   Requirements, and Institutional Requirements of the ACGME;
b. educational objectives and effectiveness in meeting those objectives;
c. educational and financial resources;
d. effectiveness in addressing areas of non-compliance and concerns in previous
   ACGME accreditation letters of notification and previous internal reviews;
e. effectiveness in providing learning experiences that lead to achievement of
   educational outcomes in the ACGME general competencies;
f. effectiveness in using evaluation tools and outcome measures to assess a
   resident’s level of competence in each of the ACGME general competencies;
g. effectiveness of annual program improvement efforts in:
a. resident performance based on aggregated resident data
b. faculty development
c. graduate performance including performance of program graduates on the
   certification examination
d. program quality
h. policies on selection, evaluation, and promotion of residents, disciplinary action,
supervision of residents, duty hours, and moonlighting.
i. other areas/themes at discretion of GMEC

5. The subcommittee shall prepare and present to the GMEC for review and action a full
report of its findings, containing:
a. Prior to the report going to the GMEC, the DIO/Associate DIO shall discuss the report with the Program Director and respective Chair
b. the name and I.D. number of program reviewed and the date the report is approved by the GMEC;
c. the names and titles of the members of the internal review subcommittee;
d. a brief description of how the internal review process was conducted, including the list of the groups/individuals interviewed and the documents reviewed;
e. sufficient documentation to demonstrate that a comprehensive review followed this protocol;
f. an assessment of each citation from the most recent LON
g. a list of the findings, eg probable or definite noncompliance, and areas of concern, eg possible noncompliance
h. recommendations for specific actions to correct/improve all findings and concerns. Each recommended action should, whenever possible, be measurable with a timeline for completion, identification of required resources, and timeframe for reporting progress/results. (note: the goal is to provide objective verification of corrective/improvement efforts
6. The written report must be presented to the GMEC for approval at approximately the mid-point of the review cycle.

7. The Designated Institutional Official (DIO) and the GMEC will monitor the response by the program to actions recommended by the GMEC.

The DIO shall maintain a file of all full reports, report summaries, accreditation letters of notification, institutional letters of report, accreditation status, and scheduled times of review and shall advise the GMEC on all matters of accreditation.

GMEC approved: 04-1-2009
GMEC revision: 12-16-2010, 07-22-2011