UNIVERSITY OF IOWA HOSPITALS AND CLINICS

POLICY AND PROCEDURES FOR THE INTERNAL REVIEW OF RESIDENCY AND FELLOWSHIP PROGRAMS

To ensure the continuing high quality of graduate medical education programs at the UIHC and to satisfy ACGME requirements, the UIHC Graduate Medical Education Committee (GMEC) developed, implemented and oversees the following internal review protocol for all ACGME-accredited residency and fellowship programs. The term "resident" used in this policy shall refer to residents and fellows at all house staff levels.

The GME Internal Review Coordinator shall establish an Internal Review Committee (IRC) for each internal review. The following requirements shall be met:

1. IRC Membership. The membership of each IRC will be comprised of:
   a. One faculty member from the UIHC but not from the program under review;
   b. One resident from UIHC but not from the program under review;
   c. Other members external to the program as deemed appropriate by the Internal Review Coordinator; and
   d. Administrators from UIHC, but external to the program as deemed appropriate by the Internal Review Coordinator.

2. Frequency. Internal Reviews shall be conducted as follows:
   a. Regular midpoint review: Each internal review shall be in process and documented in the GMEC minutes by approximately the midpoint of the program's accreditation cycle. The accreditation cycle is calculated from the date of the meeting at which the final accreditation action was taken to the time of the next site visit, or as otherwise specified by the ACGME or the program's RRC.
   b. Empty program: If a program has no enrolled residents at the scheduled time for a midpoint review, a modified review shall be conducted as described in paragraph 5.b.1) of this policy. Within six months of a resident's enrolling in the program, a regular internal review shall be conducted, as specified in 5.b.2) of this policy.
   c) As needed: At any time, as deemed appropriate by the GMEC or DIO, an internal review shall be conducted.

3. Assessment Items. At a minimum, the IRC's analysis should include an assessment of:
   a. The program's compliance with its respective specialty/subspecialty RRC standards, the ACGME Common Program Requirements, and the ACGME Institutional Requirements;
   b. The educational objectives of the program and the program's effectiveness in meeting those objectives;
   c. Educational and financial resources;
   d. The effectiveness in addressing areas of noncompliance and concerns from previous ACGME accreditation letters of notification and from previous internal reviews;
   e. The effectiveness of educational outcomes in the ACGME general competencies;

f. The effectiveness of each program in using evaluation tools and outcome measures to assess a resident's level of competence in each of the ACGME general competencies; and

g. Annual program improvement efforts in:
   1) resident performance using aggregated resident data;
   2) faculty development;
   3) graduate performance, including performance of program graduates on the certification examination; and
   4) program quality, evidencing that:
      a) residents and faculty have the opportunity to evaluate the program confidentially and in writing at least annually; and
      b) the program uses the results of residents' assessments of the program together with other program evaluation results to improve the program.

4. <u>Materials and Data</u>. The following must be used in the review and assessment process:
   a. ACGME Common, specialty/subspecialty-specific program requirements, and Institutional Requirements in effect at the time of the review;
   b. Previous ACGME accreditation notification letters sent to the program and progress reports sent to the respective RRC;
   c. Previous internal review reports;
   d. Previous annual evaluations of the program; and
   d. Results from internal or external resident surveys, if available.

5. <u>Interviews</u>. The IRC must:
   a. Meet with the Program Director;
   b. Meet with all house staff members, if possible, from the program, with at least one from each level (who is peer-selected if not all are available). When a program has no residents at the mid-point of the review cycle:
      1) the IRC must conduct a modified internal review that ensures that the following have been maintained:
         a) adequate faculty;
         b) staff resources;
         c) clinical volume; and
         d) other necessary curricular elements to ensure substantial compliance with the ACGME Institutional, Common, and program-specific requirements have been maintained
      2) the IRC must then complete a regular internal review within the first six-month period after enrolling a resident in a previously empty program;
   c. Meet with key faculty members; and
   d. Meet with other individuals as deemed appropriate by the IRC, including but not limited to professional staff members associated with the program and faculty from other departments.

6. <u>Report</u>. Upon completion of its analysis, the IRC shall prepare a final report given to the GMEC for review and discussion. The report shall contain the following:
   a. Name of the program reviewed;
   b. Date the review was conducted;
   c. Date the report was initially presented to and reviewed by the GMEC;
   d. Names and titles of the IRC members;
   e. Description of how the internal review process was conducted;
   f. Identification of groups/individuals who were interviewed;

g. List of the documents reviewed;
h. Sufficient documentation to demonstrate that a comprehensive review followed the protocol described in this policy;
i. List of the areas of the citations and areas of noncompliance or any concerns or comments from the previous ACGME accreditation letter of notification with a summary of how the program and/or institution subsequently addressed each one; and
j. Recommendations, as appropriate, to ensure that the program makes sufficient progress to comply with ACGME, RRC, and UIHC requirements. The GMEC and DIO must monitor any required follow-up, to be given to the GMEC at future date specified in the report.

7. Report Distribution. The final internal review of each program, along with supporting documentation, shall be confidential and filed in the GME Office by the Internal Review Coordinator. An aggregate summary of the programs reviewed each year will be presented to the University Hospital Advisory Committee, which includes the CEO/Director of UIHC and the Dean of the Carver College of Medicine. Copies of the final report shall be distributed to the following:
   a. Program Director;
   b. Clinical Department Head;
   c. Dean of the Carver College of Medicine;
   d. CEO/Director of UIHC;
   e. GME Director/DIO; and
   f. Administrative Director of GME.

   Additionally, it is recognized that UIHC must comply with ACGME requirements regarding the submission of such reports for each training program as part of the ACGME Institutional Review Document or other applicable ACGME or UIHC mandate.

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