

**MARSHALL UNIVERSITY
JOAN C. EDWARDS SCHOOL OF MEDICINE
GRADUATE MEDICAL EDUCATION**

POLICY ON SPECIAL REVIEW PROCESS

SECTION 1. STATEMENT AND SCOPE OF POLICY

This policy is to comply with the Accreditation Council for Graduate Medical Education (ACGME) requirement that the Graduate Medical Education Committee (GMEC) must develop, implement and oversee a process for a Special Program Review (SPR) for accredited Residency and Fellowship programs.

To insure compliance, this policy establishes a Quality and Accreditation Subcommittee (QAS) who shall to oversee the Special Review Process under the guidance of the GMEC and Designated Institutional Official. The QAS will use a protocol for a Special Review and report its findings, quality improvement goals, the corrective actions, and the process to the GMEC who will monitor the SPR outcomes. The policy also establishes criteria for an Abbreviated Special Review and a Full Special Review.

SECTION 2. PROCEDURE/PROCESS

- 2.1. In fulfillment of the ACGME institutional accreditation requirement mandating oversight of the SPR process, the GMEC shall establish a Quality and Accreditation Subcommittee (QAS).
- 2.2. The subcommittee will be comprised of a balanced mix of the School of Medicine Dean or his/her designee, Residency/Fellowship Program Directors, Program Coordinators, faculty, department chairs, Residents/Fellows who serve on the GMEC, the Designated Institutional Official (DIO), Office of Graduate Medical Education staff and physician and/or non-physician hospital administrators including but not limited to safety and quality improvement staff.
- 2.3. The DIO, on behalf of the GMEC, shall appoint particular QAS members to conduct Special Program Reviews of specific Residency or Fellowship Programs while ensuring a balanced mix of members stipulated in 2.2 above.
 - 2.3.1. Each SPR committee must include at least one faculty and one Resident/Fellow who also serves on the GMEC.
 - 2.3.2. Members of the subcommittee are not permitted to serve on a Special Review of a program in which they are a faculty member or Resident/Fellow.

- 2.3.3. The DIO and/or the GMEC may activate a QAS to conduct either an Abbreviated or Full Special Review if deemed necessary and appropriate based upon provisions of this policy.
- 2.3.4. If members of an Abbreviated Special Review Subcommittee recommend to the DIO that a Full Special Review is warranted, the DIO may so grant if deemed appropriate.
- 2.4. The Subcommittee will be charged to:
 - 2.4.1. Perform Abbreviated and/ or Full SPRs;
 - 2.4.2. Evaluate and approve SPRs;
 - 2.4.3. Prepare a Written Report regarding SPR findings;
 - 2.4.4. Present Findings to GMEC; and,
 - 2.4.5. Monitor the quality improvement goals and Report Corrective Measures Taken by the Program back to the GMEC.
- 2.5. The Subcommittee will act under the direction of the GMEC and will review an ACGME-accredited program to assess program compliance with the:
 - 2.5.1. Common Program Requirements;
 - 2.5.2. Specialty-specific Program Requirements;
 - 2.5.3. ACGME Institutional Requirements; and the
 - 2.5.4. Clinical Learning Environment Review (CLER) Pathways to Excellence; and,
 - 2.5.5. Next Accreditation System (NAS)
- 2.6. The SPR committee must also appraise, but not be limited to:
 - 2.6.1. Overall educational goals and objectives of the program.
 - 2.6.2. Effectiveness of the program in meeting these goals and objectives.
 - 2.6.3. Any identified challenges or obstacles to the program's ability to meet these educational objectives.
 - 2.6.4. Effectiveness of the program in addressing areas of concern noted in previous ACGME communications and/or accreditation letters, previous Annual Program Reviews, and any previous SPRs (if applicable).
 - 2.6.5. Effectiveness of the program in implementing processes that link relevant educational outcomes with program improvement.
 - 2.6.6. Competency-based rotation- and assignment-specific goals and objectives.
 - 2.6.7. Content of didactic conference schedule, journal clubs, and grand rounds.
 - 2.6.8. Program policies and procedures.
 - 2.6.9. Specialty Board Certification requirements.
 - 2.6.10. Maintenance of Certification (MOC)
 - 2.6.11. Program quality indicators
 - 2.6.12. Previous annual program review minutes and follow-up on action plans.

- 2.7. Materials and data to be used in the review process must include those program documents specified in the SPR and any other data and/or documents the SPR committee considers of assistance in meeting its charge.
- 2.8. The subcommittee is expected to interview the Program Director, the program coordinator, faculty, and Residents/Fellows from each level of training in the program.
- 2.9. Other staff within the clinical setting and other individuals from outside the program may also be deemed appropriate for interview by the subcommittee.
- 2.10. The review must follow the written protocol as outlined in Section 6 below, including the start date, closure date and pertinent findings.
- 2.11. Once the report has been drafted by the QAS, the Subcommittee will meet with the Program Director to review its findings.
- 2.12. The Program Director will respond to the QAS draft report. The QAS may consider the Program's Director's response and update the report accordingly prior to its final report to GMEC.
- 2.13. The QAS chair will make periodic and timely reports of subcommittee deliberations, recommendations, and actions to the full body of the GMEC as deemed necessary and appropriate by the DIO.
- 2.14. The SPR may direct Program Directors to resources to address identified issues or offer potential solutions to remedy noncompliance.
- 2.15. The review of the SPR must be documented in the QAS and GMEC minutes.

SECTION 3. SPECIAL PROGRAM REVIEW INTERNAL AND EXTERNAL CRITERIA

- 3.1. The GMEC will identify underperformance through established criteria. This may include, but is not limited to internal and external criteria.
- 3.2. **Internal criteria** may include but not be limited to the following:
 - 3.2.1. A pattern of program director attrition.
 - 3.2.2. Adequacy of the research environment, opportunities for scholarly activity and publication rates.
 - 3.2.3. Program-specific issues or concerns identified by the hospital, department or program administration, GMEC, GME Office, or the DIO.

- 3.2.4. Concerns identified and communicated to the Dean, GME Office, the DIO and/or QAS by Residents/Fellows, hospital staff, or Hospital or Medical School faculty or administration.
- 3.2.5. Patient case data indicating that the minimum requirements are not being met.
- 3.2.6. Procedural documentation indicating that the minimum requirements are not being met.
- 3.2.7. Concerns identified on internal surveys, including graduation and/or GMEC/ Office of GME surveys.
- 3.2.8. Failure to submit GMEC required data on or before identified deadlines.
- 3.2.9. Annual Program Self-Assessment and improvement efforts in:
 - 3.2.9.a. Resident performance using aggregate resident data/feedback;
 - 3.2.9.b. Faculty Development opportunities; and,
 - 3.2.9.c. Program quality initiatives and resident involvement in patient safety and quality projects.
- 3.2.10. The presence and adequacy of policies which govern the workings of the individual programs. This includes policies and protocols from the ACGME site visit check list which includes but is not limited to:
 - 3.2.10.a. Policy for supervision of Residents/Fellows addressing faculty responsibility and progressive responsibility
 - 3.2.10.b. Program policies addressing resident duty hours and work environment
 - 3.2.10.c. Program policies addressing resident duty hours and work environment
 - 3.2.10.d. Moonlighting policy
 - 3.2.10.e. Transfer/hand off protocols
 - 3.2.10.f. Sample schedules that inform all health care providers names and contact information for attending and Residents/Fellows

- 3.2.10.g Protocols defining common circumstances which would require faculty involvement (i.e. ICU transfers) by PGY level.
- 3.2.10.h. Protocol and sample documents for episodes when Residents/Fellows remain on-duty beyond scheduled hours
- 3.2.10.i. Policies to ensure that Residents/Fellows have adequate rest between duty periods and after in-house call (showing differences by PGY level).

3.3. **External criteria** may include but not be limited to the following:

- 3.3.1. Concerns identified by the QAS related to the annual web ADS information submitted by programs
 - 3.3.1.a. Board Pass Rates below the minimum required by the supervising Residency Review Committee (RRC)
 - 3.3.1.b. Procedural case log data from the ACGME of recent graduates indicating that minimum requirements are not being met
 - 3.3.1.c. Patient case data from the ACGME of recent graduates indicating that minimum requirements are not being met
- 3.3.2. Concerns identified by the QAS on the ACGME faculty survey, including but not limited to
 - 3.3.2.a. Mean score less than three in two or more of the seven categories
 - 3.3.2.b. Two responses with less than 50% compliance any of the seven categories
 - 3.3.2.c. A pattern of significant downward trends since the last survey
 - 3.3.2.d. Survey completion rate below 70%.
- 3.3.3. Concerns identified by the RRC including, but not limited to ACGME request for progress report related to concerns identified on the Resident or Faculty Survey.
- 3.3.4. Failure to submit ACGME required data on or before identified deadlines
- 3.3.5. Failure to maintain ACGME Continued Accreditation by being placed on Probation or issued Continued Accreditation with Warnings

- 3.3.6. Compliance with Common, Institutional and Program Specific ACGME/ RRC Requirements. This includes assessing how the Program addresses:
 - 3.3.6.a. Professionalism, Personal Responsibility and Patient Safety
 - 3.3.6.b. Transitions of Care
 - 3.3.6.c. Alertness Management/Fatigue Mitigation
 - 3.3.6.d. Resident Supervision
 - 3.3.6.e. Teamwork
 - 3.3.6.f. Resident Duty Hours and Work Environment
 - 3.3.6.g. Resident involvement in patient safety and quality improvement initiatives
- 3.3.7. Concerns raised by the National Resident Matching Process (NRMP), including but not limited to gender and diversity concerns, USMLE Board Score averages and match rates.

SECTION 4. DOCUMENTATION TO BE USED

- 4.1. Documentation used in the evaluation process must include but not be limited to:
 - 4.1.1. Common, Institutional and Program Requirements from the ACGME.
 - 4.1.2. Letters of accreditation from previous ACGME surveys.
 - 4.1.3. Reports from previous internal/special reviews of the program.
 - 4.1.4. All correspondence between the program and the ACGME (i.e. progress reports, etc.).
 - 4.1.5. Annual Program Reviews
 - 4.1.6. Results from the annual ACGME resident surveys.
 - 4.1.7. Results from the annual programmatic and exit surveys.
 - 4.1.8. Information from interviews and surveys conducted with the Program Director, the faculty, peer selected Residents/Fellows and any other individual deemed appropriate by the Special Review Committee.

- 4.2. Additional documentation may be required should the Subcommittee or full Committee deem necessary and appropriate.

SECTION 5. ABBREVIATED SPECIAL PROGRAM REPORT

- 5.1. In the event that a program does not demonstrate ability to successfully meet two of the following items, the QAS will automatically activate an Abbreviated Special Program Report to address underperformance areas, establish quality improvement goals, the corrective actions, and the process for GMEC monitoring to ensure corrective measures:
 - 5.1.1. Board Pass Rates below the minimum required by the supervising Residency Review Committee (RRC);
 - 5.1.2. Procedural case log volume from the ACGME of recent graduates indicating that minimum requirements are not being met;
 - 5.1.3. Patient case (clinical experience) data from the ACGME of recent graduates indicating that minimum requirements are not being met;
 - 5.1.4. Concerns identified by the QAS on the ACGME faculty survey, including but not limited to:
 - 5.1.4.a. Mean score less than three in two or more of the seven categories;
 - 5.1.4.b. Two responses with less than 50% compliance any of the seven categories;
 - 5.1.4.c. A pattern of significant downward trends since the last survey;
 - 5.1.4.d. Survey completion rate below 70%;
 - 5.1.4.e. Deviations from expected results in standard performance related to Milestones; or,
 - 5.1.4.f. Deviations from expected results in standard performance related to Competencies.
 - 5.1.5. Concerns identified by the RRC including, but not limited to ACGME request for progress report related to concerns identified on the Resident or Faculty Survey.
 - 5.1.6. Failure to submit ACGME required data on or before identified deadlines.
 - 5.1.7. Failure to maintain ACGME Continued Accreditation by being placed on Probation or issued Continued Accreditation with Warning.
 - 5.1.8. Failure to comply with Common, Institutional and Program Specific ACGME/ RRC Requirements. This includes assessing how the Program addresses:

- 5.1.8.a. Professionalism, Personal Responsibility and Patient Safety
- 5.1.8.b. Transitions of Care
- 5.1.8.c. Alertness Management/Fatigue Mitigation
- 5.1.8.d. Resident Supervision
- 5.1.8.e. Teamwork
- 5.1.8.f. Resident Duty Hours and Work Environment
- 5.1.8.g. Resident involvement in patient safety and quality improvement initiatives

5.1.9. Failure to maintain appropriate faculty supervision and teaching.

5.1.10. Significant program level changes, resident and faculty attrition, and/or frequent leadership turnover.

5.2. The QAS will automatically activate an Abbreviated Special Program Report to address the occurrence of an alleged egregious violation or a catastrophic programmatic event.

SECTION 6. FORMAT FOR ABBREVIATED/ FULL SPECIAL PROGRAM REPORT

6.1. Each Abbreviated and/or Full Special Program Report must be written and contain, at a minimum, the following:

6.1.1. Name of the program reviewed, name of program director, accreditation status, length of training, date of next self- study, the dates of the review, closure date, and date of review and approval of the report by the Quality and Accreditation Subcommittee and date of review and approval of full GMEC.

6.1.2. Names and titles of the review committee members including identification of Residents/Fellows and indication of PGY level.

6.1.3. Brief description of the Special Review Process including who was interviewed (specific names will not be included in the final report to protect confidentiality, but will be maintained in the GME office for verification purposes) and the documents reviewed.

6.1.4. List of the areas of noncompliance or any concerns or comments from the previous ACGME accreditation letter and last site visit and/or SPR with a summary of how the program and/or institution addressed each one.

6.1.5. Sufficient documentation to demonstrate that a focused review was conducted and was based on the GMEC's SPR protocol.

- 6.1.6. Brief description of any recommendation, and other issues or areas of concern noted by the Special Review committee in addition to previous RRC citations.
 - 6.1.7. Identification of any areas of non-compliance or concerns identified as action items for internal follow-up and review by the GMEC.
 - 6.1.8. Response from Program Director to findings in the report. GME Office staff and the chair of the review committee will meet with the program director to share findings of the draft report and discuss next steps including presentation to, and approval by, the GMEC and any action item follow-up that may be indicated.
- 6.2. Final Recommendations/Requirements to the GMEC must include a request for a progress report with a recommended timeframe.
 - 6.3. The GMEC must approve the QAS Subcommittee Report and established timeframe for the Program's submission of progress reports.

SECTION 7. NEW PROGRAMS

- 7.1. All new programs must undergo an Abbreviated Special Review prior to the program enrolling a Resident/Fellow.
- 7.2. A second Full Special Review will be conducted within the second-six-month period of the Resident's/Fellow's first year in the program.

SECTION .8. REPORT PROCESS

- 8.1. The summary report will be presented by the Special Review Committee Chair/ or DIO in his/her absence at the subsequent GMEC meeting.
- 8.2. The GME Committee will review and discuss the findings. The Program Director will have the opportunity to respond to the findings in the final report.
- 8.3. A copy of the final report will be given to the Program Director and also maintained in the Office of Graduate Medical Education.
- 8.4. If deficiencies are found during the Special Review, the Program Director must prepare and maintain a written plan of action to document initiatives to improve performance in the area(s) of deficiency.
- 8.5. The Program Director will be required to provide a progress report to the GMEC addressing deficiencies, areas of concern and progress made on the plan of

action. The timeframe for this report will be determined by the QAS subcommittee.

SECTION 9. SHARING SPR REPORT RESULTS WITH FACULTY AND RESIDENTS/FELLOWS

- 9.1 To complete the review process, the Program Director must share the results of the Special Program Review with all Residents/Fellows and faculty in the program.
- 9.2. Discussion of the report and any action items must also be included as part of the Annual Program Review and Improvement process and in appropriate faculty and Resident/Fellow minutes.

SECTION 10. OUTCOMES

10.1 The following outcomes may result from the Annual Program Review process:

- 10.1.1. Revised overall educational goals of the program
- 10.1.2. Revised competency-based rotation- and assignment-specific goals and objectives
- 10.1.3. Revised content of didactic conference schedule, journal club, grand rounds
- 10.1.4. Revised program policies and procedures
- 10.1.5. Revised evaluation system
- 10.1.6. Revised annual program review process
- 10.1.7. Revised clinical competency committee policy and/or procedures
- 10.1.8. New or revised Resident/Fellow Portfolio and Individual Learning Plan (ILP) templates
- 10.1.9. New or revised Faculty Teaching Portfolio template.
- 10.1.10. Evaluation of teaching faculty and recommendation to department regarding continued participation in the teaching program.
- 10.1.11. Updated Program Information Form (PIF)
- 10.1.12. Development of Educational Innovation Project (EIP)

10.2. Other outcomes may result from the Annual Program Review process as deemed necessary and appropriate.

SECTION 11. MONITORING OF SPECIAL REVIEW OUTCOMES

All Abbreviated and Special Review Outcomes will be monitored by the QAS, the DIO, the Office of GME and/or the GMEC to assess progress toward resolving action items.

Effective Date: **August 1, 2014**

Approved by GMEC: July 22, 2014

Approved by DIO: July 23, 2014