

SUBJECT Internal Review	POLICY NUMBER 100.004	PAGE 1 of 3
SOURCE Academic Affairs – Administration	ORIGINATION OR LAST REVISION DATE 11/08/07	EFFECTIVE DATE 12/11/07

I. POLICY

It is the policy of St. Joseph's Hospital and Medical Center (SJHMC) Academic Affairs that the Graduate Medical Education Committee (GMEC) is responsible for the development, implementation and oversight of the internal review process.

A. Internal Review Process

1. The Designated Institutional Official (DIO) is delegated by the GMEC to designate an internal review committee to review each ACGME-accredited program in the Sponsoring Institution. The internal review committee must include at least one faculty member and at least one resident, from within the institution but from GME programs other than the one that is being reviewed. Additional internal or external reviewers may be included on the internal review committee as determined by the GMEC. Administrators from outside the program may also be included.
2. Reviews must be conducted by approximately the midpoint between the effective date (date of the Residency Review Committee meeting) and the approximate date of the next site visit. The internal review is considered complete when the report is approved by the GMEC.
3. When a program has no residents enrolled at the mid-point of the review cycle, the following circumstances apply:
 - a. The GMEC must demonstrate continued oversight of those programs through a modified internal review that ensures the program has maintained adequate faculty and staff resources, clinical volume, and other necessary curricular elements required to be in substantial compliance with the Institutional, Common and specialty-specific Program Requirements prior to the program enrolling a residents.



- b. After enrolling a resident, an internal review must be completed within the second six-month period of the resident's first year in the program.
4. The review should assess each residency program's:
 - a. Compliance with the Common, specialty/subspecialty-specific Program, and Institutional Requirements;
 - b. Educational objectives and effectiveness in meeting those objectives;
 - c. Educational and financial resources;
 - d. Effectiveness in addressing areas of noncompliance and concerns in previous ACGME accreditation letters 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 in linking educational outcomes with program improvement;
 - h. Policies on selection, evaluation, and promotion of residents, disciplinary action, supervision of residents, duty hours, and moonlighting.
5. Materials and data to be used in the review process must include
 - a. The ACGME Common, specialty/subspecialty –specific Program, and Institutional Requirements in effect at the time of the review;
 - b. Accreditation letters of notification from previous ACGME reviews and progress reports sent to the respective RRC;
 - c. Reports from previous internal reviews of the program.
 - d. Residency evaluations of the faculty and the overall program;
 - e. Previous annual program evaluations; and
 - f. Results from internal or external resident surveys, if available
6. The internal review committee must conduct interviews with the program director, key faculty members, at least one peer-selected resident from each level of training in the program, residency coordinators, and other individuals deemed appropriate by the committee.

B. Internal Review Report

1. A written report of the internal review for each ACGME-accredited specialty and subspecialty program will be produced by the internal review committee and will contain the following:
 - a. The name of the program or subspecialty program reviewed and the date of the review;
 - b. The names and titles of the internal review committee members;
 - c. A brief description of how the internal review process was conducted, including the list of the groups/individuals interviewed and the documents reviewed;
 - d. Sufficient documentation to demonstrate that a comprehensive review was conducted and was based on the GMEC's internal review protocol;
 - e. A list of the citations and any concerns or comments from the previous ACGME accreditation letter of notification with a summary of how the program and/or institution addressed each item.
 - f. Follow up monitoring recommendations for the GMEC.

2. The written reports of each internal review must be presented to the GMEC for approval at approximately the mid-point of the review cycle. The DIO and the GMEC must monitor the response by the programs to actions recommended by the GMEC.

The Sponsoring Institution must submit the most recent internal review report for each training program as a part of the Institutional Review Document (IRD). If the institutional site visitor simultaneously conducts individual program reviews at the same time as the institutional review, the internal review reports for those programs must not be shared with the site visitor.

REVIEWED AND IN COMPLIANCE WITH:	DATE
ACGME	09/18/07
CHW	09/18/07
JCAHO	09/18/07
RISK/LEGAL	09/18/07
HUMAN RESOURCES	09/18/07
REVISED & APPROVED BY	
Policy/Procedure Committee	09/18/07
Organized Medical Staff	09/18/07
GMEC	12/11/07