

Initial Request to Establish a New Program

Instructions: This one page form must be completed for non-ACGME accredited programs applying for initial approval of the GMEC. This form should not be used for subsequent internal reviews of programs approved by the GMEC.

Requesting Department: _____

Name of Program: _____

Duration of Program: _____

Proposed # of trainees per year of training: _____

If applicable, current # of residents in the program per year of training: _____

PGY starting level: PGY1 PGY2 PGY3 PGY4 PGY5 PGY6

PGY7 PGY8 and above

Proposed Start Date: _____

Indicate funding source (Click as appropriate):

Hospital, Name: _____ Department: _____

Grant: PI's Name: _____ Other (describe) _____

Will resident salaries differ from those provided in the other programs for each PGY level?

No Yes

(If the answer is yes, include an explanation):

Please attach copy of letter(s) or notice of awards that verify funding source and its duration.

Does this program have any graduates? Yes No

Are there ACGME requirements for this program? Yes No

Indicate the total number of faculty available for teaching in this program: _____

Submitted by:

Name: _____ Date: _____

Telephone: _____ Pager: _____ Email: _____

Approved by:

Name of Department Chair: _____

Signature of Department Chair: _____

If fellowship:

Name and signature of Division Chief: _____

Name of Program Director of core program: _____

Signature of Program Director of core program: _____

**FOR INTERNAL REVIEW OF
NON-ACGME ACCREDITED PROGRAMS**

Instructions: Complete this form for the initial review and subsequent review of non-ACGME-accredited programs.

A. ACCREDITATION INFORMATION

If your program is affiliated with a core ACGME program sponsored by Methodist, provide the following information.

Core Program Information		
Title of Core Program:		
Core Program Director:		
10 Digit ACGME Program ID#:		
Accreditation Status:	Effective Date:	
Next Review Date:	Last Review Date:	Cycle Length:
The signatures of the director of the program and the core program director attest to the completeness and accuracy of the information provided on these forms:		
Signature of Program Director (and Date):		
Signature of Core Program Director (and Date):		

1. Respond to previous Internal Review citation(s)

Provide a concise update on each previous citation and indicate how each has been addressed (if applicable). Do not answer if this is a new application.

2. Describe changes not mentioned above

Provide a concise update explaining any major changes, not described in your response to question # 1, to the program since the last internal review (for example, changes in program format, resident complement, program leadership, or participating sites). Do not answer if this is a new application.

3. Planned start date for the first class of residents (answer only if this is a new application)

B. PARTICIPATING SITES

PRIMARY SITE (Site #1)
Name:
Address:
City, State, Zip Code:
Clinical Site? <input type="checkbox"/> YES <input type="checkbox"/> NO
Type of Rotation (select one) Elective <input type="checkbox"/> Required <input type="checkbox"/> Both <input type="checkbox"/>
Length of Resident Rotations (in months)
CEO/Director/President's Name:
Joint Commission Accredited? <input type="checkbox"/> YES <input type="checkbox"/> NO
If no, explain:

The Program Director must submit any participating sites routinely providing an educational experience, required for all Residents. Duplicate as necessary.

PARTICIPATING SITE (Site #2)
Name:
Address:
City, State, Zip Code:
Integrated: <input type="checkbox"/> YES <input type="checkbox"/> NO
Does this site also sponsor its own program in this subspecialty? <input type="checkbox"/> YES <input type="checkbox"/> NO
Does it participate in any other ACGME-accredited programs in this subspecialty? <input type="checkbox"/> YES <input type="checkbox"/> NO
Distance between #2 & #1: Miles: Minutes:
Type of Rotation (select one) <input type="checkbox"/> Elective <input type="checkbox"/> Required <input type="checkbox"/> Both
Length of Resident Rotations (in months)
CEO/Director/President's Name:
Brief Educational Rationale:

C. FACULTY / RESOURCES

1. Program Director Information

Name:							
Title:							
Address:							
City, State, Zip code:							
Telephone:			FAX:		Email:		
Date First Appointed as Program Director:							
Principal Activity Devoted to Resident Education?					Yes:		No:
Term of Program Director Appointment:							
Date first appointed as faculty member in the program:							
Number of hours per week Director spends in:							
Clinical Supervision:		Administration:		Research:		Didactics/Teaching:	
Primary Specialty Board Certification:				Most Recent Year:			
Subspecialty Board Certification:				Most Recent Year:			
Number of years spent teaching in this subspecialty:							

- a) Is the program director familiar with and does he/she oversee compliance with GME policies and procedures as outlined in the GME Institutional Policies and Procedures (found at http://www.methodisthealth.com/tmhs/basic.do?channelId=1073830430&contentId=1073869162&contentType=GENERIC_CONTENT_TYPE)? () YES () NO
- b) Using the form provided in section C.3, provide a **one page** CV for the program director.

2. Physician Faculty Roster

List alphabetically and by site all physician faculty who devote at least 10 hours a week to resident education. Using the form provided in section C.3, supply a **one page** CV for each faculty listed.

Name (Position)	Degree	Based Mainly at Site #	Primary and Secondary Specialties / Field			Years as Faculty in Specialty	Average Hours Per Week Devoted to Resident Education
			Specialty / Field	Board Certification (Y/N)†	Recertification Date		
(PD)							

† Certification for the primary specialty refers to ABMS Board Certification. Certification for the subspecialty refers to ABMS sub-board certification.

3. Faculty Curriculum Vitae

First Name:					MI:		Last Name:		
Present Position:									
Graduate Medical Education Program Name(s); include all residencies and fellowships:									
Certification and Re- Certification Information						Current Licensure Data			
Specialty		Certification Year		Re-Certification Year		State		Date of Expiration (mm/yyyy)	
Academic Appointments - List the past ten years, beginning with your current position.									
Start Date (mm/yyyy)		End Date (mm/yyyy)		Description of Position(s)					
		Present							
Concise Summary of Role in Program:									
Current Professional Activities / Committees:									
Selected Bibliography - Most representative Peer Reviewed Publications / Journal Articles from the last 5 years (limit of 10):									
Selected Review Articles, Chapters and/or Textbooks (Limit of 10 in the last 5 years):									
Participation in Local, Regional, and National Activities / Presentations - Abstracts (Limit of 10 in the last 5 years):									
If not ABMS board certified, explain equivalent qualifications for Review Committee consideration:									

4. Non Physician Faculty Roster

List alphabetically the non-physician faculty who provide required instruction or supervision of residents in the program.

Name (Position)	Degree	Based Primarily at Site #	Subspecialty / Field	Role In Program	# of Years Teaching as Faculty in Subspecialty

5. Program Resources

- a) Do residents have access to specialty-specific and other appropriate reference material in print or electronic format? () YES () NO
- b) Concisely describe the technical, clerical, and other non-physician staff who provide support for the administrative and educational conduct of the program. Is the support of the program in this area satisfactory at all program sites?

D. RESIDENT APPOINTMENTS

- 1. Describe how residents will be informed about their assignments and duties during residency. [The answer must confirm that there are goals and objectives for each assignment and for each year, and that these will be readily available (hard copy, electronically, listserv, etc.) to all residents.]

- 2. Will there be other learners (such as residents from other specialties, subspecialty residents, nurse practitioners, PhD or MD students) in the program, sharing educational or clinical experiences with the residents? If yes, describe the impact those other learners will have on the program's residents.

- 3. Describe how the program will handle complaints or concerns the residents raise. (The answer must describe the mechanism by which individual residents can address concerns in a confidential and protected manner as well as steps taken to minimize fear of intimidation or retaliation.)

E. CURRENT RESIDENTS

List alphabetically all Residents actively enrolled in this program as of August 31 of current academic year.

Name	Program Start Date	Expected Completion Date	Year in Program	Specialty of Most Recent Prior GME	Has completed an ACGME-accredited specialty program (Y/N) If no, explain

a) Did you obtain documentation that each Resident has met the eligibility criteria?
 () YES () NO

F. EVALUATION (RESIDENTS, FACULTY, PROGRAM)

1. Are residents provided with a description of the skills and competencies that they should be able to demonstrate by the conclusion of the program? () YES () NO
2. Does the faculty provide formative feedback in a timely manner? () YES () NO
3. Describe how residents are informed of the performance criteria on which they will be evaluated.

Limit your response to 400 words.

4. Describe the mechanism used to provide the semiannual evaluations of residents (e.g., who meets with the residents and how the results are documented in resident files).

Limit your response to 400 words.

5. Describe the system for evaluating faculty performance as it relates to the educational program.

Limit your response to 400 words.

6. Describe the mechanisms used for program evaluation, including how the program uses aggregated results of the residents' performance and/or other program evaluation results to improve the program.

Limit your response to 600 words.

G. RESIDENT DUTY HOURS

1. Excluding call from home, what is the projected average number of hours on duty per week per resident?	
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2. What is the projected average number of days per week of in-house call (excluding home call and night float) which residents will be assigned?	
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3. Provide the program's duty hours policy in the attachments.

- How does the program monitor resident stress, including mental or emotional conditions inhibiting performance or learning?

H. Educational Program

- Concisely describe resident educational responsibilities for other residents, medical students, and allied health personnel.

- Describe the manner in which the program ensures that residents are provided with adequate opportunities to assume a major role in the continuing care of patients and have progressive responsibility.

- List the didactic conferences offered for resident education. Do not include specific conference schedules, posters, or advertisements. Use a separate page for conferences at participating institutions. Add rows as needed.

Conference Type: (Basic Science, Journal Club, Pathology, etc.)	<i>Required or Optional</i>	<i>Frequency</i>	Individual(s) or Department Responsible for Conducting Conference

- Comment on the levels of teaching staff participation and resident attendance at program conferences and related educational activities such as journal clubs.

- How does the program ensure that residents are provided with adequate opportunities to observe and to manage patients with a variety of problems and a variety of settings (such as inpatient, outpatient, and emergency department)?

I. Scholarly Activity

- List the staff who provide stimulation and supervision of clinical or laboratory research activity by residents and identify their particular area(s) of expertise.

2. Describe the time free of clinical duties that is provided for resident participation in clinical or laboratory research.

3. Describe the facilities and resources (including space, equipment, support personnel, funding) that are utilized to support resident research.

J. BLOCK DIAGRAM FOR THE RESIDENCY PROGRAM

Complete one for each year of the program and reproduce the diagram as needed. The name of the assignment should be descriptive. The block diagram **MUST** include the **SITE** where the educational assignment occurs. Provide a key for any abbreviations or acronyms used. Provide competency-based goals and objectives for each assignment at each year of training in the attachments.

Year: **PGY-**__

Month	Rotation Type	Site
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

ATTACHMENTS

Attach the following documents to the application:

1. Policy for supervision of residents (addresses residents' responsibilities for patient care and progressive responsibility for patient management and faculty responsibilities for supervision)
2. Program policies and procedures for residents' duty hours and work environment
3. Moonlighting policy
4. Overall educational goals for the program)
5. Competency-based goals and objectives for each assignment at each program year of training

The DIO is available to work with the Program Director to adapt Methodist Hospital (Houston) forms for evaluating residents, faculty, and programs. If the Program Director selects this option, no copies of these forms must be attached to the application.

Will the Program Director work with the DIO to adapt assessment forms in use at Methodist Hospital (Houston) for assessment of residents, faculty and program? () YES () NO

If no, then attach the following documents to the application:

1. A blank copy of the forms that will be used to evaluate residents at the completion of each assignment
2. Copies of tools the program will use to provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice
3. A blank copy of the form that will be used to document the semiannual evaluation of the residents with feedback
4. A blank copy of the final (summative) evaluation of residents, documenting performance during the final period of education and verifying that the resident has demonstrated sufficient competence to enter practice without direct supervision
5. A blank copy of the form that residents will use to evaluate the faculty
6. A blank copy of the form that residents will use to evaluate the program