LEHIGH VALLEY HOSPITAL
Graduate Medical Education

GME Policy - Evaluation and Promotion

I. SCOPE:
Lehigh Valley Health Network (LVHN) adopts this policy for the following selected licensed entities:

☒ Lehigh Valley Hospital
☐ Lehigh Valley Hospital – Hazleton
☐ Lehigh Valley Hospital – Pocono
☐ Lehigh Valley Hospital – Schuylkill
☐ Transitional Skilled Unit
☐ Lehigh Valley Home Care
☐ Lehigh Valley Hospice
☐ Pocono VNA / Hospice
☐ Lehigh Valley Home Care – Schuylkill
☐ Lehigh Valley Home Care – Hazleton
☐ LVHN Children's Surgery Center

☐ LVHN Surgery Center – Tilghman
☐ Lehigh Valley Hospital – Coordinated Health Allentown
☐ Lehigh Valley Hospital – Coordinated Health Bethlehem
☐ LVHN East Stroudsburg Ambulatory Surgery Center
☐ LVHN Ambulatory Surgery Center of Lopatcong (in New Jersey)
Medical and Dental Resident and Fellow Physicians

II. POLICY:

Graduate Trainee Evaluation

In compliance with the ACGME Next Accreditation System (NAS) accreditation requirements, each ACGME-accredited residency/fellowship program must demonstrate that it has an effective plan for assessing resident/fellows performance throughout their training and for utilizing the results to improve resident/fellow performance to ensure that residents/fellows demonstrate achievement of the general competencies. Observable developmental milestones from novice to expert/master are now organized under the six domains of clinical competency: patient care; medical knowledge; practice-based learning; interpersonal and communication skills; professionalism and systems-based practice. Each training program must also adhere to their specialty- specific program requirements and milestones.

Non-ACGME accredited programs should adhere to their own accrediting body requirements and milestones, or requirements and milestones set forth by the hosting department/program, according to the following best practice principles.

A. The trainee's evaluation plan should include:

1. Methods that produce an accurate assessment of the resident's/fellow's competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice informed by the milestones;

2. A holistic evaluation process including reviews, as appropriate, of OSCEs, audit and performance data, simulation assessments, multisource feedback evaluations, ITE scores, oral exams, case logs or other performance measures to document progressive improvements in resident's/fellow's competence and performance. These evaluations will be synthesized by the Clinical Competency Committee (CCC) and milestone assessment will be made at least semi-annually.

3. Mechanisms for providing regular and timely performance feedback to residents/fellows that includes at least a written semiannual evaluation that is communicated to each resident/fellow in a timely manner;

4. Maintenance of a record of evaluation for each residents/fellows that is accessible to them.

B. The evaluation process is intended to establish standards for the resident's/fellow's performance and to indicate the resident's/fellow's ability to proceed to the next level of training. The process will, to the extent reasonably possible, provide early identification of deficiencies in the resident's/fellow's knowledge, skills or professionalism, and to the extent reasonably possible, allow remedial action to satisfactorily complete the requirements of the Program.

C. At least annually, residents/fellows will be provided links to the program -specific milestones and Entrustable Professional Activities (EPAs) designed to provide a blueprint for the resident's/fellow's development across the continuum of medical education.

D. Residents/fellows may be required to take the annual in-training examination or other knowledge assessments for their specific program.

E. Other acceptable performance standards will be determined by the Program Director and/or the CCC.

F. A Clinical Competency Committee

The CCC must be composed of at least three faculty members. The CCC will evaluate resident/fellow evaluations, synthesize data aggregates into the milestones and provide feedback to residents/fellows and submit reporting milestones to the ACGME semi-annually.

G. The CCC will recommend promotion, remediation, or dismissal for each resident/fellow in a program. ** (See Renewal/Non-Renewal of Resident Agreement policy)

H. Program Directors or their designees will provide direct feedback through personal conferences. It is the responsibility of the Program to advise the resident/fellow of his/her performance in the program at least semi-annually.

I. The Program Director must provide a final evaluation for each resident/fellow who completes the program. The evaluation must include a review of the resident's/fellow's performance during the final period of education and should verify that the resident/fellow has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's/fellow's permanent record maintained by the institution.

Faculty Evaluation

Each training program must adhere to their specialty-specific program requirements as outlined by ACGME/accreditation requirements or their accrediting institution.

The performance of the faculty must be evaluated by the program and/or department at intervals specified by their accreditation body. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. Annual written confidential evaluations by residents/fellows must be included in this process.

Residents/fellows are required to submit to the program director at least annually, confidential written evaluations of the faculty and of the educational experiences.

Program Evaluation

Each ACGME-accredited training program must have in place a formal Program Evaluation Committee (PED; equivalent to the annual review process that programs are already required to perform), that adheres to their specific program requirements, show that they are responding to areas of concern identified in the program review and that interventions are having the desired effect.

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

A. Representative program personnel (i.e. at least the program director, two representative faculty, and should include at least one trainee), must review program goals and objectives and the effectiveness of the program in achieving them. The group must have a written description of its responsibilities and regular documented meetings at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution and the residents'/fellow's confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes.

B. Outcome assessment

1. The program should use resident/fellow performance and outcomes assessment in its evaluation of the educational effectiveness of the training program.

2. The program should have in place a process for using resident/fellow performance assessment results together with other program evaluation results to improve the training program.

C. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness.

Evaluation of the Clinical Learning Environment

A key dimension of the ACGME Common Program Requirements is the Clinical Learning Environment Review (CLER Program) to assess the graduate medical education (GME) learning environment of each sponsoring institution and its participating sites.

CLER emphasizes the responsibility of the sponsoring institution for the quality and safety of the environment for learning and patient care in the following six focus areas:

A. **Patient Safety** – including opportunities for trainees to report errors, unsafe conditions, and near misses, and to participate in inter-professional teams to promote and enhance safe care.

B. **Health care Quality** – including how sponsoring institutions engage trainees in the use of data to improve systems of care, reduce health care disparities and improve patient outcomes.

C. **Care Transitions**– including how sponsoring institutions demonstrate effective standardization and oversight of transitions of care.

D. **Supervision** – including how sponsoring institutions maintain and oversee policies of supervision concordant with ACGME requirements in an environment at both the institutional and program level that assures the absence of retribution.

F. **Professionalism**—with regard to how sponsoring institutions educate for professionalism, monitor behavior on the part of trainees and faculty and respond to issues concerning: (i) accurate reporting of program information; (ii) integrity in fulfilling educational and professional responsibilities; and (iii) veracity in scholarly pursuits.

G. **Well-being** - The optimal clinical learning environment is engaged in systematic and institutional strategies and processes to cultivate and sustain the well-being of both its patients and its clinical care team.12 The delivery of safe and high-quality patient care on a consistent and sustainable basis can be rendered only when the clinical learning environment ensures the well-being of clinical care providers.

Support for faculty development in those areas in which the CLER program will focus to share best practices amongst programs will be directed by each CLER Site Visit Report.

III. DEFINITIONS: N/A

IV. PROCEDURE: N/A

V. REFERENCES: N/A

VI. ATTACHMENTS / FORMS: N/A

VII. DISCLAIMER:
This policy and the implementing procedures are intended to provide a description of recommended courses of action to comply with statutory or regulatory requirements and/or operational standards. It is recognized that there may be specific circumstances, not contemplated by laws or regulatory requirements that make compliance inappropriate. For advice in these circumstances, consult with the Departments of Risk Management and/or Legal Services, as appropriate.

VIII. REVIEW:
Origination: mm / yyyy
Review / Revision: mm / yyyy, mm / yyyy

Approved by the Graduate Medical Education Committee

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