January 2014 Version

AFMC INTERIM ACCREDITATION SURVEY GUIDE

FOR INTERIM ACCREDITATION SURVEYS
CONDUCTED IN THE 2013-2014 ACADEMIC YEAR

For additional information, contact:

Secretariat
Committee on Accreditation of Canadian Medical Schools
Association of Faculties of Medicine of Canada
265 Carling Avenue, Suite 800
Ottawa, Ontario, Canada K1S 2E1
Claudine LeQuellec (Claudine@afmc.ca)
Telephone: 613-730-0687 Fax: 613-730-1196

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1. CREATION OF THE AFMC INTERIM ACCREDITATION REVIEW PROCESS

The Interim Accreditation Review Process (IRP) is an activity of the AFMC and is supported exclusively by AFMC Council of Deans and each Canadian Faculty of Medicine/Medical school. The AFMC Interim Review Process is completely independent of the formal accreditation activities of the CACMS and the Liaison Committee on Medical Education (LCME).

Rationale

The existing eight year interval between full survey accreditation visits has proven to be too long for the majority of schools to remain in full compliance with all ~128 standards. The faculties of medicine and the CACMS and the LCME direct their attention to the areas of noncompliance and transition identified at the time of the visit and almost all of the follow-up tends to focus on a few standards. During the same intervening time period the standards undergo continuous review and revision and there are frequently changes in the organization and leadership within the faculty, the educational program itself, clinical teachers, size and characteristics of the student body, nature and location of health care delivery, and societal expectations of the profession. It is not surprising that keeping on top of all the accreditation standards is extremely challenging. While the formal mechanism of addressing areas of noncompliance must continue, the AFMC Council of Deans have approved the establishment of a parallel and mandatory interim systematic review of all aspects of the medical school operation encompassed by the full range of accreditation standards. The adoption of a mandatory Interim Survey Review Process will:

a) enable earlier detection of emerging problems in a specific standard,
b) enhance the identification of critical issues that require more immediate attention,
c) allow for development of an expanded body of local expertise thereby enhancing the degree of understanding of the mechanism and rationale of the accreditation process, resulting in continuing improvement of medical education programs and in better compliance with the standards;
d) perhaps of greatest importance, it would allow the development of a culture of continuous quality improvement that will supplement the present system of formal review.

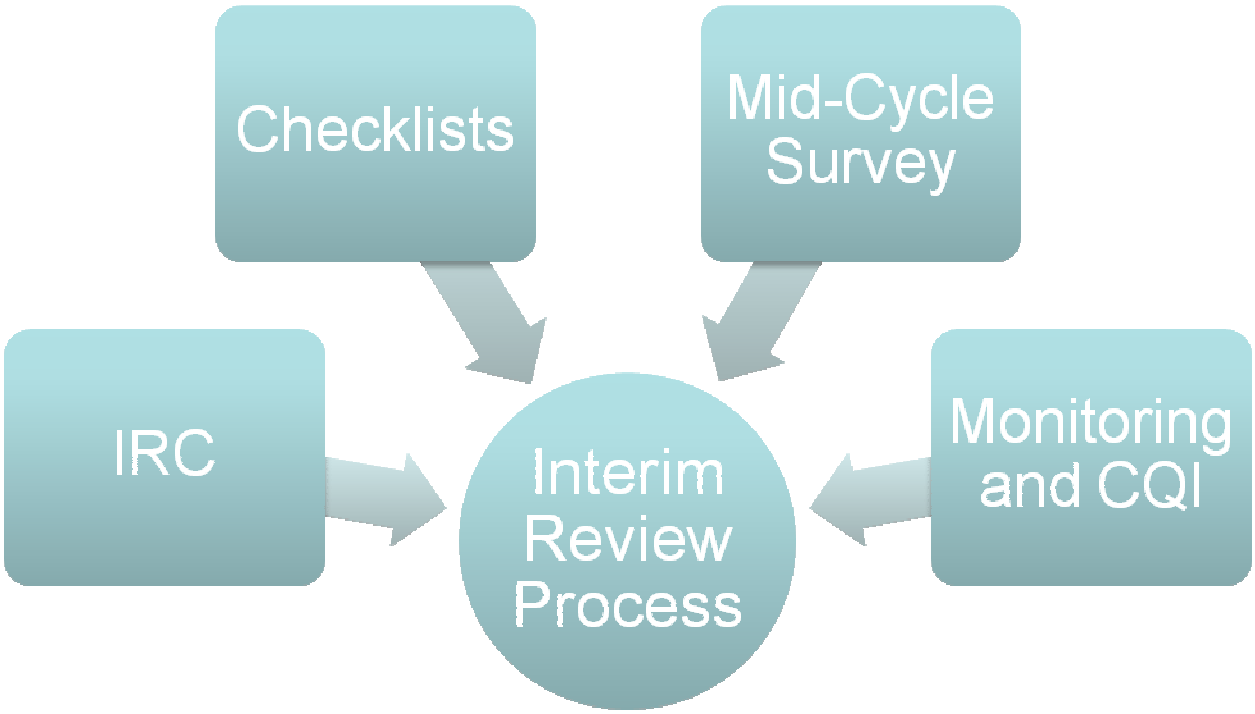
The AFMC Council of Deans has approved the implementation of an organized interim review and survey that will take place at or near the mid-point between formal CACMS/LCME surveys i.e. four years after the last full survey. It will involve a ~6-9 month period of faculty preparation. A report will be generated as a result of the interim survey review process that will enumerate areas where the school may not be in compliance with accreditation standards and indicate the specific aspects of the standard for which the requirements are not fully met. In addition, as a result of the interim survey, recommendations as to how to address areas of noncompliance and transition will be generated. The interim review survey report is formative and confidential (i.e. not shared with CACMS or the LCME) in contrast to the formal CACMS/LCME survey report which is summative in nature. In addition to a focused interim survey, it is anticipated that each school will be up-to-date with ongoing changes in standards and reviewing its compliance with the existing standards on a continuous basis.

The Secretariat of the Committee on the Accreditation of Canadian Medical Schools (CACMS) has been authorized to assist in the development of the materials, implementation of the process and support of the AFMC Interim Review Coordinators.

AFMC Council of Deans, Working Group on Accreditation
December 2009

2. OVERVIEW OF THE AFMC INTERIM ACCREDITATION REVIEW PROCESS

The elements of the AFMC Interim Review Process (IRP) are illustrated below: the **Interim Review Coordinator (IRC)** i.e., a Faculty member who serves as the point person on accreditation; **Checklists** for each accreditation standard; an **Interim Survey** taking place at the half-way point of the 8 year accreditation cycle followed by **Continuous Quality Improvement.**



Interim Review Coordinator (IRC)

As a first step, faculty members were appointed by each dean as the point-person on accreditation in each of the 17 Canadian medical schools. At the present time, all IRCs have responsibility for CACMS/LCME accreditation i.e., they are the Faculty Accreditation Leads in their school, some also have PG responsibility and some are the Directors of an Office of Quality Improvement. Almost all IRCs report to the dean or the most senior education dean. The IRC is a member of the curriculum oversight committee and/or other key committees. In many schools, accreditation is a standing item on the agendas. An IRC is expected to serve as the External IRC on the Interim Accreditation Survey at another Canadian medical school. IRCs meet twice annually to debrief on their activities and provide feedback to improve the process.

Checklists

First developed in November 2010 and updated annually, the Checklists are based on the most recent documents used in the accreditation process and reflect the recent decisions of the CACMS and the LCME. Each checklist is a tool that permits the faculty to determine if the educational program meets the requirements of the acceditation standard. It is expected that the school's IRC, the Interim Survey Committee and the participating external IRC will complete and/or evaluate the checklists using the most conservative judgement. If areas of Noncompliance, or areas in Compliance with a need for Monitoring

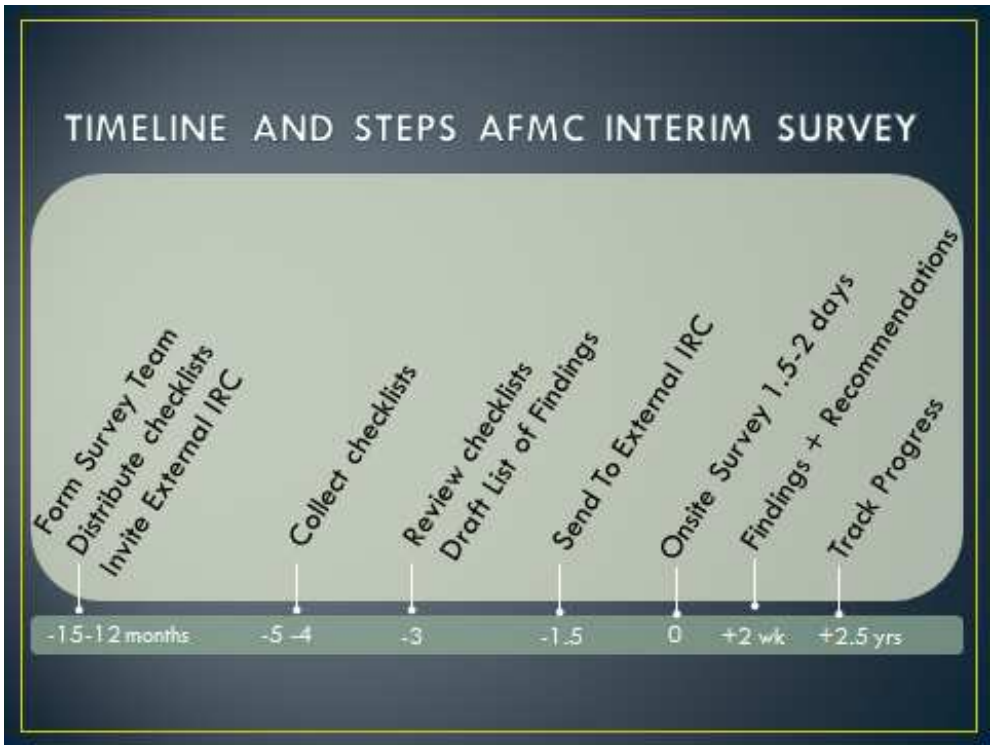
are not brought forward during the Interim Accreditation Survey, one of the main goals of the process i.e., assisting the school in maintaining compliance with accreditation standards, will not be achieved. The format and use of checklists are described in the next section of the guide.

Interim Survey Team

The Interim Survey Team consists of the faculty IRC as Chair, an External IRC (the role of the External IRC is described in more detail in the Guide), and faculty and student members. Minimally membership should consist of: three internal faculty members (one basic-science, one clinical science and one clinical teaching) and two medical students (one pre-clerkship/junior and one clerkship/senior). It may be advisable to add more faculty members (e.g. three more) and students (2 more) to ensure that a minimum of three faculty members and one student are present at each meeting. Two of our first medical schools to conduct their Interim Surveys have found a benefit in having selected a junior student for their Interim survey who subsequently participated in a leadership role in the Independent Student Analysis for their next full survey. See Example Terms of Reference Appendix C.

Interim Accreditation Survey (Mid-Cycle)

The Timeline and Steps in the AFMC Interim Accreditation Survey are illustrated below and is described in detail in this Guide. Although the AFMC Council of Deans Working Group on Accreditation thought the process would require 6-9 months, real world experience has shown that the process takes approximately 12-15 months. The team decides if further information needs to be collected particularly from and about students. A student survey or focus groups may provide the necessary information. Checklists are assigned and distributed to the individuals most responsible for that aspect of the program. The completed checklists are reviewed and an assessment of compliance is determined. A list is kept of those standards with which the program may be in Noncompliance, or where there is a question about compliance or Compliance in need of Monitoring. The draft list of findings and all the checklists are sent to the External IRC about 6 weeks before the onsite survey.



Onsite Survey

Over a ~1.5-2 day period, the team meets with faculty and administrators with primary responsibility for each area requiring improvement. Together they generate recommendations on how to correct the identified deficiency.

Interim Report and Follow-up

The Interim Accreditation Report is entirely FORMATIVE and belongs to the faculty (Format and content is described in detail in this Guide). It is a list of all areas that require improvement or monitoring and recommendations on what needs to be done and by whom. The report also indicates priorities and timelines for how the work should be carried out. The school's IRC monitors each area and reports to the Dean or Senior Education Dean, and key faculty committees on progress in addressing deficiencies. Monitoring continues and leads into the start of the Institutional Self Study (ISS) for the next full survey. The full Quality Improvement Cycle that includes the CACMS/LCME preparation and full survey, and the AFMC Interim Accreditation Review Process with the Interim Accreditation Survey is illustrated below.

3. FORMAT AND USE OF AFMC INTERIM REVIEW CHECKLISTS

Checklists have been developed for each of the LCME/CACMS accreditation standards using the most recent versions of the following resources:

1. LCME Functions and Structure of a Medical School
   - Standards and the annotations
2. The LCME Medical Education Database
3. The Survey Report Writing Guide (LCME)
4. Guide to the Institutional Self-Study (LCME)

5. Canadian Graduation Questionnaire
6. Recent decisions of the CACMS and the LCME
7. Feedback from IRCs based on use

The checklists are updated annually to remain in alignment with changes in the standards and how they are interpreted. Each AFMC Checklist consists of a series of statements that translate each requirement of the standard into an action that the faculty of medicine must be doing, or have done, to be in compliance. The statements generally follow the order of topics as they appear in the standard and the annotation. Expectations of the accreditation committees can also be found in the Data Collection Instrument (previously called the Medical Education Database), the Survey Report Writing Guide, and the Guide to the Institutional Self-Study and are reflected in the AFMC Checklists. The statements in the checklists reflect recent decisions by the CACMS and the LCME. Examples of good practice, quality check benchmarks and explanatory notes and definitions e.g., hidden curriculum, are also provided in some checklists to facilitate better understanding of the requirements of the standard.

Each checklist is a tool that permits the faculty to determine if the program is meeting the requirements of the accreditation standard. This guide uses the language of summative CACMS/LCME accreditation. i.e., Compliance, Compliance with a need for Monitoring and Noncompliance. Some faculty members, senior administrators, and administrative staff may find this type of language to be negative and external. Depending on the culture of the medical school, the IRC may find it more acceptable to the faculty to use other language such as "areas in need of improvement" in place of areas of Noncompliance, or areas of Compliance with the need for Monitoring. It is expected that the school's IRC, the Interim Survey Committee and the participating external IRC will complete and/or evaluate the checklists using the most conservative judgement. <u>If areas of Noncompliance or those in Compliance with the need for Monitoring are not brought forward during the Interim Accreditation Survey, one of the main goals of the process i.e., assisting the school in maintaining compliance with accreditation standards, will not be achieved.</u>

Following each statement in the checklist is a check box for YES or NO, and a box for Requirements not fully met, Comments and Recommendations. For the majority of standards (see below), the program must meet all the elements of each standard i.e. answer YES to all of the statements, in order to be judged to be in compliance with that standard. If there is any part of a statement that the school is not currently doing, then a check should be made in the NO box. If the NO box is checked it means that the program is either in noncompliance or that the program is in compliance with a need for monitoring (See Definitions below) with that standard. A brief statement about the requirement that is not met should be entered into the comment field. In either case, action is required by the faculty to address all areas of noncompliance and areas in compliance with a need for monitoring.

It is recommended that the location of a policy (e.g. website URL, office) and the name and the position of the person who is responsible for a particular aspect of the standard be entered into the comment box. This should be done for all checklist statements whether the program is meeting the requirement or not. This information will greatly facilitate follow-up for the Interim Survey and the conduct of the next Institutional Self-Study for a CACMS/LCME accreditation survey.

4. DEFINITIONS USED IN ACCREDITATION

Areas of Noncompliance

Findings of noncompliance represent the Interim Survey Team's judgment that the program does not fully meet the requirements of a standard based on a review of the completed checklists at the time of the Interim Accreditation Survey Visit. For the majority of standards, if the NO box has been checked on any statement in a checklist, this means that the educational program is not in compliance with that standard e.g., ER-9 Affiliation agreements; ED-10 Behavioural and socioeconomic subjects, ED-18 Elective opportunities. There are several standards that require

specific outcomes in order for the program to be judged to be in compliance, e.g., ED-2 Required clinical experiences and monitoring, ED-8, Comparability across instructional sites, MS-18 Academic counselling, MS-19 Career counselling. Some of these standards can be identified by the presence of the word "effective" in the standard or the annotation. In other cases, the checklist contains a requirement for documentation or evidence to support the finding of compliance. If the program has recently developed a policy or implemented a new system, those elements of the checklist would receive a check in YES box. If insufficient time has elapsed since the change was made such that evidence does not yet exist that the policy is effective or the system has produced the desired outcome, those boxes would receive a check in the NO box. For these types of standards, the finding would be called an Area in Compliance with a need for Monitoring (see next).

Regardless of whether the finding is that of Noncompliance or In Compliance with a need for Monitoring, action must be taken by the faculty to move the program into compliance or maintain compliance with these standards.

Areas in Compliance with a need for Monitoring

There are two types of findings/situations that will be identified as Areas in Compliance with a need for Monitoring. The first type of Area In Compliance with a need for Monitoring exists when the medical education program has the required policy, process, resource, or system in place, but there is insufficient evidence that it is effective. Therefore, monitoring is required to ensure that the desired outcome has been achieved.

For example in relation to ED-2: Required clinical experiences and monitoring, the following have been done: the required encounters have been defined, the level of student responsibility is stipulated and the clinical setting specified. These lists have been reviewed, and approved by the curriculum oversight committee and are in use for the current students who are five months into the clerkship year. A monitoring system is in place, however, until the students complete the year, the percent of students who have had the expected clinical experience is not known.

The second type of area in compliance with a need for monitoring is when the medical education program is currently in compliance with all elements of the standard i.e., YES has been checked for each statement, however, known circumstances exist that could lead to future noncompliance (formerly "Areas in transition").

Examples of this second type of area in compliance with a need for monitoring include: recurring decreases in a major funding source (e.g., provincial funding or practice plan revenues), uncertainties regarding reorganization of the school's administrative leadership, or anticipated decreases in the number of faculty (e.g., through retirements).

See Appendix A to this guide for more information and examples to better understand both types of in compliance with a need for monitoring and noncompliance.

5. OVERVIEW OF THE REPORT OF AN AFMC INTERIM ACCREDITATION SURVEY

Brief Description

This guide is offered as a recommended format and content of the AFMC Interim Accreditation Survey Report to maximize the utility of the information and assist the faculty in achieving and maintaining compliance with accreditation standards. It is intentionally designed to address all of the

LCME/CACMS standards as they are reviewed in a full survey report. This has been done to ensure that the program is reviewed and evaluated in a systematic and rigorous manner.

It is recommended that the report will include a very brief summary of prior CACMS/LCME findings and required follow-up since that last full survey, a description of the timeline and the AFMC Interim Accreditation Survey as implemented within the faculty, a list of individuals who participated and a description of student participation, data sources and data collected.
The body of the report is a list of all the areas in need of improvement (i.e., Noncompliance and areas in Compliance with the need for Monitoring) identified by the AFMC Interim Review Survey Team with recommendations to address each issue.

Note: If areas of Noncompliance, or Compliance with the need for Monitoring identified by the CACMS/LCME are being actively addressed and monitored by other individuals in the faculty, these standards could be removed from the standards reviewed during the Interim Accreditation Survey. However, if the focus of the CACMS/LCME follow-up is limited to only a few components of the standard, it may be wise to include the standard in the Interim Accreditation Survey.

Appendix A
All completed checklists organized by sections of standards. For each area in need of improvement (areas of noncompliance and area in compliance with a need for monitoring) include any relevant data or documentation that is evidence of noncompliance or the requirement for monitoring. The documentation may be in the form of policies, data or other narrative information. **Please note that all of the tables currently included in the Survey Report Writing Guide for CACMS/LCME surveys for the academic year 13-14 are noted in Section IX of this document. IRCs are strongly urged at a minimum to complete these tables and use them in completing the checklists when judging compliance with the relevant standards.**

Appendix B
Student derived data including the most recent Canadian Graduation Questionnaire that was used in the Interim Accreditation Survey to judge compliance with standards

Important Note
The following paragraph should be included in the AFMC Interim Accreditation Survey Report:

> **IMPORTANT NOTE:** The findings and recommendations that follow represent the professional judgment of the AFMC Interim Accreditation Survey Team's assessment of compliance with accreditation standards. The findings and recommendations are exclusively FORMATIVE and will not be communicated to the CACMS or the LCME. The report and its recommendations are intended to assist the faculty in achieving and maintaining compliance with accreditation standards. The faculty may use and share these findings in whatever way it deems appropriate. The Interim Survey Report and tracking of subsequent follow-up on standards can serve as the information source for the ISS self study, inform the generation of the medical education database, and the Institutional Self-Study Report. It should be kept in mind that it is possible that the AFMC Interim Accreditation Survey may have failed to identify areas of non-compliance or areas in compliance with a need for monitoring. In addition, a finding of compliance with particular standards at the time of the Interim Accreditation Survey does not mean that the program will remain in compliance until the time of the CACMS/LCME full survey. Continuous quality improvement and monitoring of compliance with standards are needed.
>
> **AVIS IMPORTANT :** Les conclusions et recommandations qui figurent ci-après traduisent le jugement professionnel émis par l'équipe de l'AFMC chargée de la visite d'agrément intérimaire dans le cadre de son évaluation du degré de conformité aux normes d'agrément. Ces conclusions et recommandations sont de nature exclusivement FORMATIVE et ne seront pas communiquées

au CAFMC ou au LCME. Le rapport et ses recommandations ont pour mandat d'aider la faculté à atteindre et à maintenir un degré de conformité aux normes d'agrément. La faculté peut utiliser et partager ces conclusions de la manière qu'elle jugera appropriée. Le rapport de visite intérimaire et l'examen du suivi subséquent relativement aux normes peuvent servir de source d'information pour l'auto-évaluation institutionnelle, la création de la base de données en éducation médicale et l'évaluation du rapport d'auto-évaluation institutionnel. On devrait garder à l'esprit qu'il est possible que, dans le cadre de la visite d'agrément intérimaire, l'AFMC n'ait pas réussi à déterminer des secteurs de non-conformité ou des secteurs conformes, mais faisant l'objet d'une surveillance. En outre, un constat de conformité à des normes précises au moment de la visite d'agrément intérimaire ne signifie pas que le programme conservera son degré de conformité jusqu'au moment de la visite complète par le CAFMC/ LCME. Une amélioration continue de la qualité et un contrôle de la conformité aux normes sont nécessaires.

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Recommended Table of Contents for the Interim Accreditation Survey Report

1. Brief summary of the CACMS/LCME last full survey findings, and required follow-up

2. Description of the AFMC Interim Review Process
   I. Orientation of the External IRC
   II. Timeline and Steps of the AFMC Interim Review Process
   III. Composition of the AFMC Interim Review Survey Team
   IV. List of all individuals participating in the AFMC IRP
   V. List of all individuals who met with the AFMC Interim Review Survey Team or the schedule of the Onsite Visit

3. Description of student participation, data sources and data collection

4. List of the AFMC Interim Review Survey Team Findings and Recommendations

   Areas of Noncompliance and Areas in Compliance with a need for Monitoring (or whatever terms the school wishes to use in its place) organized as follows:

   I. INSTITUTIONAL SETTING STANDARDS

   II. EDUCATIONAL PROGRAM STANDARDS

   III. MEDICAL STUDENTS STANDARDS

   IV. FACULTY STANDARDS

   V. EDUCATIONAL RESOURCES STANDARDS

5. Appendix A
   All completed checklists organized by sections of standards.

6. Appendix B
   Student data including the most recent Canadian Graduation Questionnaire

6. DETAILED DESCRIPTION OF THE AFMC INTERIM REVIEW SURVEY PROCESS

I. Role of the external IRC: The external IRC is an IRC at another medical school who is chosen by the faculty's IRC in consultation with their dean and/or senior faculty leadership. An individual who serves as an external IRC for an Interim Accreditation Survey becomes ineligible to serve on a CACMS/LCME survey team for that school. The policy for the selection of survey team members for formal CACMS/LCME accreditation normally excludes faculty within the same province. The reason being, that schools may be /are competing for resources, and/or may be collaborating, either of which constitutes a conflict of interest. Since IRCs would not be permitted to serve on CACMS/LCME survey teams for other schools in the same province, faculties are actually encouraged to select the external IRC in their own province. If in the future, an individual is asked to serve on a CACMS/LCME survey team on a school for which they had been the external IRC, they would declare a conflict of interest. The CACMS Secretariat Office and the school having the CACMS/LCME survey visit would review the composition of the survey team and identify if a person had been an external IRC for a previous Interim Accreditation Survey in that eight year cycle. Therefore, there are several safety checks in the system to keep track of these conflicts of interest. It must be noted that the external IRC is obliged to keep confidential everything that is learned through the experience and review of documents associated with the Interim Accreditation Survey. Explicit information about the school's policies and practices and the extent to which the program may be meeting the requirements of accreditation standards must be kept strictly confidential.

The work of the external IRC begins about 4-6 weeks before the onsite interim survey. The work consists of reviewing the draft list of findings and the completed checklists to provide feedback and questions to the faculty IRC about the identified areas in need of improvement and those that the Interim Survey team had not identified as needing improvement about which the external IRC has questions for discussion prior to and during the onsite survey **i.e., all of the completed checklists, associated tables and the most recent CGQ**. The external IRC can be helpful in developing the questions that will be used to guide discussion during the onsite survey. It may be useful to have the external IRC lead the questioning and discussions at the time of the onsite survey. The Faculty IRC and the External IRC should collaborate in finalizing the list of findings. To ensure that the recommendations are meaningful and feasible for implementation at the school, the Faculty IRC should take the lead in developing the recommendations with input from the external IRC. The time commitment of the external IRC to participate in the Interim Accreditation Survey of another school is approximately 5-6 days which includes preparation before the survey, the onsite survey and reviewing and finalizing the report.

Ideally the IRC of each faculty should serve as an external IRC for an Interim Accreditation Survey once before an IRC is asked to be an external for the second time. This practice is meant to allow each IRC the opportunity to function in this capacity. The website provides the list of Interim Surveys and the external IRCs who have participated or are scheduled to participate in the next 12 months. The travel, hotel and food expenses of the external IRC for the onsite survey are provided by the school having the Interim Survey. No other compensation is expected to be provided.

II. Orientation of the External IRC

In the Interim Survey Report include a brief description of the orientation provided to the external IRC.

Before the onsite visit, the faculty's IRC (Chair of the Interim Survey Team) should orient the external IRC to the educational program and its context. The orientation should be sufficient for the external IRC to participate in the discussion at the time of the onsite survey and to make informed recommendations along with the survey team. It is recommended that the orientation include a brief description of the educational program including its overall design and number of sites where the program is implemented (if distributed); the basic structure of the pre-clerkship and clerkship and whether a longitudinal integrated

clerkship is offered as part of the program. Schematics showing the placement of courses and clerkships within each academic period and a schematic of a typical week showing the types of activities and time students spend in each may be useful. The orientation should also include information on the type of Admissions process used (e.g., structured interviews with teams consisting of one faculty member, one community person and one senior medical student or a Multi-Mini-Interview Process consisting of x stations) and the organization of the Student Affairs Office. For distributed programs the external IRC should be informed of how the Admissions process is carried out at each campus and how student services are provided at each distributed site.

III. Timeline and Steps of the AFMC Interim Accreditation Survey

In the Interim Survey Report provide a brief description of the AFMC Interim Accreditation Survey followed by the school and the approximate amount of time devoted to each step.

i. The following is the Recommended Timeline and Steps of the AFMC Interim Accreditation Survey and is offered as a guide:

T = Time of the AFMC Interim Accreditation Onsite Survey

T-15- 12 months

Chair of the Interim Review Team (Faculty's IRC)

a) The Chair in consultation with senior faculty leadership, will appoint the AFMC Interim Accreditation Survey Team- See Example Terms of Reference APPENDIX C.

- Minimally membership should consist of: three internal faculty members (one basic-science, one clinical science and one clinical teaching) and two medical students (one pre-clerkship/junior and one clerkship/senior). It may be advisable to add more faculty members (e.g. three more) and students (2 more) to ensure that a minimum of three faculty members and one student are present at each meeting.
- Invites the External IRC who will be a member of the Interim Survey Team
- Note: Administrative support will be required to conduct an Interim Accreditation Survey. Based on the experience of the schools that have implemented or are implementing the process, administrative time has ranged from 0.2-0.5 FTE.

b) Select tentative date of the Interim Accreditation Onsite Survey

c) Assign relevant AFMC Checklists to members of the Interim survey team, or faculty, administrators and students. **Review the tables in this guide for each section of standards. Some of these tables are present only in the CACMS/LCME Full Survey Report Writing Guide (there are statements in bold indicating these tables) and it is important that the school review the data in this format as it will be used by a formal accreditation survey team to make a judgment of compliance with those standards**.

d) Review relevant existing student data e.g., internal student evaluation data, Canadian Graduation Questionnaire (CGQ) and determine if additional information from students is required and the best means to obtain it e.g. survey, focus groups. The process should be initiated at this time (See Appendix B for a sample student survey).

T-5-4 months

a) Collect and begin to compile the completed checklists

b) Review the results of any new sources of student input e.g., Student Survey or focus groups.

T-3 months

Interim Accreditation Survey Team under the leadership of the Chair:

a) Review the results of the student input collected for the Interim Accreditation Survey. Review the completed checklists that refer to student data, and determine if there is compliance with those elements of the standard. Analyze the completed checklists, which have been cross-referenced to the student data, to create a summary checklist for each standard. Keep a list of all checklists where areas of noncompliance or areas in compliance with a need for monitoring have been identified or where uncertainty exists. Collect the necessary documentation to support the identification of Noncompliance or in Compliance with a need for Monitoring for each standard. For convenience, some of the sources of data (e.g. specific tables) have been included under the name of the standard in the writing guide. The checklist itself will be a guide as to what data or documents should be included with the checklist. In many cases the completed checklist may be sufficient.

b) Generate the first draft of the list of interim survey team findings and recommendations

c) Compile the student input in Appendix B

T-1.5 -1 month

a) The Chair should ensure that the external IRC is oriented to the program as described above before the time of the onsite survey

b) The Chair sends the draft list of findings and Appendices (**i.e. all of the completed checklists and associated tables**) and the most recent CGQ to the External IRC

c) Chair and the external IRC: Plan the Onsite survey i.e. identify faculty groups to discuss all areas in need of improvement (i.e., Non-compliance and areas in Compliance with a need for Monitoring) identified in the interim. Focus should be placed on those standards where recommendations are not well developed and/or faculty/administrator greater engagement is necessary. Develop questions to be used to facilitate discussion during the onsite survey.

T = Time of the AFMC Interim Accreditation Onsite Survey

The recommended duration of the onsite visit is 1.5~2 days. Although the visit may be conducted in less time, most of the IRCs who have completed the process have recommended more than 1.5 days in order to include an exit meeting with the dean and senior education deans, as well as consolidating decisions and discussions that took place during the sessions with faculty, administrators and students.

a) Interim Accreditation Survey Team meets with faculty and administrators with responsibility for the program where areas in need of improvement (i.e., noncompliance and areas in compliance with a need for monitoring) were identified. The purpose of the meetings is to gain a better understanding of the requirements of the specific standards and to generate recommendations to effectively address them.

b) Interim Survey Team refines the List of Findings and Recommendations based on meetings with faculty/administrators and students.

c) Exit Session: At the end of the onsite visit, the IRCs who have completed the process recommend a face to face session of the team and the Dean and/or Senior Education Dean and others that the Dean wishes to participate. The team may choose to review a few key findings and recommendations with this senior leadership team or review all of the findings. Since an Interim Survey is likely to identify more areas where the faulty would like to improve, it will take some time to become accustomed to receiving the results of an Interim Survey. The report will contain the full list of findings and recommendations.

T + 2-4 weeks or less:

a) The faculty IRC in collaboration with the external IRC finalizes the List of the AFMC Interim Survey Team Findings and Recommendations (See page 11 section on the external IRC).

T +2 -4 weeks

The Chair of the Interim Survey Team (faculty's IRC) transmits the report (and Appendices) to the dean for distribution to the Senior/Vice Dean of Education for review and action by the undergraduate education committee and all other relevant faculty, administrative, hospital and community personnel. Formal presentations of the findings to the curriculum oversight committee and appropriate committees of the dean, department heads and other educational leadership as well as faculty involved in the educational program and students are strongly recommended.

T + 2.5 years

Until the time of the beginning of the CACMS/LCME Institutional self-study, the faculty IRC will track and report follow-up in improving the specific areas (i.e., achievement of Compliance with areas of Noncompliance and areas in Compliance with a need for Monitoring) identified by the Interim Survey and will communicate the program's status on a regular basis to the Dean and/or Senior Education Dean/Vice dean of education and the committee with responsibility for the educational program (e.g. Curriculum Committee).

The use of the Interim Survey Report and tracking of subsequent follow-up on standards to serve as an information source for the ISS self study, inform the generation of the medical education database, and the ISS Report is currently being studied by the first medical schools that conducted the Interim Accreditation Survey and are preparing for the CACMS/LCME full survey.

IV. Composition of the AFMC Interim Accreditation Survey Team

Provide the names of the members of the AFMC Interview Review Survey Team in this section of the report.

For example:

Membership of the AFMC Interim Accreditation Survey Team was as follows:

Chair:

Name of the Faculty's IRC
Pierce Brosnan, M.D. (Medicine)
Year 3 Chair,
Faculty of Medicine
University of Western Canada

External IRC:

Name of the External IRC
Julia Roberts, M.D. (Psychiatry)
Former Associate Dean for Curriculum

University of Province
Three or more Faculty Members: (Specialty/Discipline)
Biomedical Sciences
Clinical Sciences
Clinical Teaching
See note on page 12.
Two or more Student Members:
Junior/Preclerkship
Senior/Clerkship
See note on pages 5 and 12.

V. List of individuals who participated in the AFMC Interim Accreditation Survey

List the names of all individuals who completed checklists or provided information used during the AFMC Interview Process in this section of the report. If possible, identify as faculty, administrative staff or students and their departmental affiliation if relevant.

VI. List of individuals who met with the Survey Team
List of individuals who met with the AFMC Interim Accreditation Survey Team/or Schedule of the Onsite Visit

Provide a list of names of all individuals who met with the Interim Survey Team during the onsite visit or the schedule of the onsite visit in this section of the report. This information will likely be more useful to the faculty if the role in the educational program is included with the name of each individual.

VII. Description of Student Participation, Data Sources and Data Collection

In this section of the report, describe student participation in the AFMC Interim Accreditation Survey, the existing sources of student data used by the AFMC Interim Survey Team e.g., internal survey data, CGQ, and any additional data collected specifically for the Interim Survey. Describe how the student data was used in completing the checklists.

Include in Appendix B a summary of student data (quantitative and qualitative) or the location within the faculty where this can be found (may also be a URL to copies of reports, etc.), the most recent copy of the CGQ, and the results of any student survey or focus groups. Include a blank copy of an Interim Student Survey and focus group questions if used.

The CACMS/LCME survey team and the two accrediting bodies use the results of student-derived data in decision-making regarding accreditation status of an educational program. Two key sources of student opinion/satisfaction data used in accreditation are the Canadian Graduation Questionnaire (CGQ) and the CACMS/LCME Accreditation Student Survey. The Appendix B to this writing guide has a copy of the CACMS/LCME Accreditation Student Survey. Depending on the evaluation resources available within an individual Faculty of Medicine, and the participation rate of its medical students in the CGQ, the collection of student data may be needed as part of the AFMC Interim Review Process. A particular challenge exists for programs with distributed campuses especially those with longitudinal integrated community clerkships with small numbers of students at geographically separate sites to know if the program and student support services are effectively delivered. A number of the AFMC Checklists refer to student knowledge and/or satisfaction. If the faculty currently does not collect this type of information, it would be wise to do so for the Interim Review Process. The CACMS/LCME Accreditation Student Survey may be modified to address the gaps in existing internal data. The two questions on mistreatment (42 and 43) will not provide sufficient information to understand any problems and generate recommendations to address them. It is recommended that the questions in the mistreatment section of the CGQ be used with or without modification to yield more useful results. It is also recommended that the Interim Survey Team review the questions on the CGQ with respect to student health and all of the support services in identifying the type of information that needs to be collected. The Interim Survey Team may decide to use a survey, focus groups or a combination of both to obtain valid and reliable student input. Student members of the Interim Survey Team should participate in the generation of survey or focus group questions. It is anticipated that the student members of the Interim Review Survey Team would be liaisons with the student body in promoting participation in any surveys or focus groups. The process used should not be elaborate or time consuming for the students. An efficient approach could include the collection and analysis of data by the faculty administration in producing the Summary of Student data for the Interim Survey that is to be included in Appendix B of the Report. The completed summary checklists for each area of noncompliance included in the body of this report should reflect existing and any new student data collected for the AFMC IRP. Quantitative or qualitative student data that supports the finding of noncompliance should be included with the checklist.

VIII. CACMS/LCME Accreditation Survey(s)

List the key findings of noncompliance and areas in compliance with a need for monitoring (previously called areas in transition) that were identified during the most recent full CACMS/LCME accreditation survey and the committees' action and required follow-up. If there was a recent limited survey, or Secretariat Fact-Finding Visit include these findings too. Use bullets, paraphrase, or combine items, as needed to be succinct.

Pay particular attention to these areas of Noncompliance and areas in Compliance with a need for Monitoring during the Interim Review Process to judge progress in achieving compliance with the specific standards. If these areas are being actively followed by other individuals they may be removed from the areas reviewed during the Interim Accreditation Survey.

Provide enough information that identifies the element(s) of each standard with which the program did not meet requirements or about which concern was expressed in the case of standards in compliance with monitoring.

IX. Interim Survey Team Findings and Recommendations

The aim of the AFMC Interim Review Process is to create a culture of continuous quality improvement (CQI) where faculties take ownership of the process such that critical self-appraisal coupled with self-improvement takes the place of external judgment and a culture of blame. Creating a CQI culture is not an easy transition. Although the IRCs have been prepared for their roles and can work in an environment using the language of summative CACMS/LCME accreditation e.g., Noncompliance, most faculty members see this type of designation as negative and external. Framing the report using other language such as "areas in need of improvement" rather than areas of Noncompliance and Compliance with the need for Monitoring may be useful approach. **Regardless of what terms are used, the description of the areas in need of improvement (i.e., areas of Noncompliance and Compliance with a need for Monitoring) should indicate the extent of the problem e.g., specific courses or clerkships, indicate if this problem was identified on a previous CACMS/LCME accreditation survey and any progress underway that is being made to resolve the problem.**

- Under the heading "Areas in need of Improvement" (i.e., areas of Noncompliance" (See Definitions pages 3-4), list all standards where the Interim Accreditation Survey team finds that the program does not fully meet the requirements with the accreditation standard based on the AFMC checklists. For each area, indicate what element of the standard is not fully met (from the Checklist) and the recommendations arising from the onsite survey as to how to address the specific issue. A systematic "who-must/should do-what" type of wording of the recommendations may be useful for subsequent listing, tabulation and distribution of actions expected from each key stakeholder. Indicating the priority of addressing the area of noncompliance and the timeline will clarify expectations. Some examples are provided in the sample list.

- Under the heading "Areas in need of Monitoring" (i.e., Compliance with a need for monitoring) (See pages 3-4) list standards for which the Interim Survey Team identified that the program is currently in compliance because there is a policy, process or system in place (YES checked for these elements) however, NO boxes have been checked related to an outcome or effectiveness because insufficient time has elapsed for these data to have been available. Also include under this heading, standards where all the checkboxes are YES, however, there are known circumstances that could lead to future noncompliance. For each standard include what data are required, how it will be collected, who will collect and review it and when these data will be

available. Include any other recommendations to put the program in compliance. A systematic "who-must/should do-what" type of wording of the recommendations may be useful for subsequent listing, tabulation and distribution of actions expected from each key stakeholder. Indicating the priority of addressing the areas in need of monitoring (i.e. areas of compliance with a need for monitoring) and the timeline will clarify expectations.

Sample and format Template:

1. List of Interim Survey Team Findings and Recommendations

INSTITUTIONAL SETTING STANDARDS

Areas in Need of Improvement (Areas of Noncompliance)

IS-16 Diversity of Faculty, students and staff

Finding: The faculty has not defined its programmatic and institutional goals for diversity, which is the foundation requirement of this standard. Since the program does not meet this basic requirement of the standard, it currently does not meet the other requirements of this standard.

Recommendation: Although there has been much discussion within the faculty, students, staff and the community about the importance of diversity in the institution and the program, the Director of the Office of Diversity and Equity must proceed with the next step of defining the policies, goals (categories and targets) related to diversity (including gender, race, culture and socioeconomic). These policies, goals and objectives will need to go through a formal approval process. In addition, a plan must be developed to put into practice the goals for diversity into the following areas: student recruitment, selection and financial aid; the educational program; faculty/staff recruitment, employment and retention; faculty development; and liaison activities with community organizations. A plan to track the achievement of the goals for diversity must be developed, and monitored.

High Priority given the degree of improvement required (noncompliance) with this standard. The work should begin as soon as possible and must be accomplished within the next two years.

EDUCATIONAL PROGRAM STANDARDS

Areas in Need of Improvement (Areas of Noncompliance)

ED-2 Required clinical experience and monitoring

Finding: Faculty in Obstetrics and Gynecology have not defined the required clinical encounters and procedures. Therefore all other elements of this standard are not being met.

Recommendations: This finding indicates that the curriculum oversight committee and the year 3 committee are not fulfilling their responsibility to ensure that the program meets the requirements of ED-2. The curriculum oversight committee and the year 3 committee should ensure that the requirements of ED-2 are clearly communicated to the rotation directors and to the students and assistance provided as needed to implement and support the process. The Clerkship Director

must meet with the director of the OBG rotation to discuss the requirements of ED-2. She should suggest a meeting with the clerkship director in the Internal Medicine Rotation to share the process by which the ED-2 list was created, how the level of student responsibility and the clinical setting were determined, and how the system was successfully implemented. Currently, in the Internal Medicine Rotation, all students at the three teaching hospitals have the required clinical encounters and procedures, and there is real-time monitoring across instructional sites. The Clerkship Director should work with the director of the Obstetrics and Gynecology rotation to determine faculty development needs to begin implementing the necessary changes. Students will need to be informed in writing by the director of the OBG rotation and/or verbally reminded by the local coordinator of the rotation of the required clinical encounters and procedures and the monitoring process. Follow-up will be needed by the director of the OBG rotation and ultimately by the Clerkship Director and the curriculum oversight committee to ensure that changes are successfully implemented. Real-time, ongoing monitoring in all rotations and across all sites is required from the Clerkship Director to ensure that students have the required clinical experiences and are re-directed to other clinical settings as needed. The curriculum oversight committee and the year 3 committee must review the completion rates of all the required clinical encounters and procedures and the frequency with which students are re-directed to other clinical settings or are completing the requirement by means other than direct patient experience.

High Priority. This was an area of noncompliance at the time of the last full survey and must be fully corrected with evidence that the standard is met in all rotations across all sites. The list needs to be produced, approved and put into use at the beginning of the next academic year to permit collection of data for the next two years to ensure that the students have the required clinical experience in this and all disciplines. Rapid correction of the problem is needed so that the database year prior to the full survey will show that the program is in compliance with this standard.

ED-8 Comparability across instructional sites

Finding: Because the required clinical experience has not been defined in the Obstetrics and Gynecology rotation and therefore is not being monitored at the three teaching hospitals, it is not possible to determine if student educational experience is comparable.

Recommendations: Once the faculty identified above has taken steps to meet the requirements of ED-2, completion of required clinical encounters and procedures in the Obstetrics and Gynecology rotation should be analyzed by the director of the rotation and the Clerkship Director to determine if student educational experience is comparable across the three teaching hospitals. Ongoing monitoring by the clerkship committee and review by the curriculum oversight committee/undergraduate curriculum committee of required clinical experiences and in all rotations across all instructional sites is necessary to remain in compliance with this standard.

High Priority. Because this is linked to ED-2 which was an area of noncompliance at the time of the last full survey, the priority and timeline are the same as that of ED-2.

ED-27 Direct Observation of student performance

Finding: Only 60% of students in the Surgery rotation currently indicate they have been observed by faculty.

Recommendation: The director of the Surgery rotation should enlist the assistance of other clerkship directors to share the process they use to ensure that students are observed e.g., mini-CEX used in the Psychiatry rotation. The director of the surgery rotation should identify other resources including faculty development that are needed in order to meet this requirement. The Clerkship Director and the curriculum oversight committee should ensure that director of the Surgery rotation receives the support necessary to meet the requirements of this standard. The clerkship committee and the curriculum oversight committee must review data documenting direct observation of student performance and take the steps necessary to ensure that students are consistently observed in all clerkships across all instructional sites.

ED-31 Mid-course and clerkship feedback

Finding: Less than 70% of students in the Cardiovascular Block and the year 2 Clinical skills receive formal mid-course feedback from their tutors. Approximately 80% of students in the Surgery and 85% of students in the Pediatrics rotations receive formal mid-clerkship feedback.

Recommendation: Discussions with course and clerkship faculty with the Interim Accreditation Survey team revealed the lack of a clear policy on the requirement for the provision of mid-course and mid-clerkship feedback. The team also learned of a need for faculty development and more explicit expectations regarding the provision of feedback to support tutors and preceptors in fulfilling this expectation. The curriculum oversight committee must develop or disseminate any existing policy or system that ensures the provision of mid-course and mid-clerkship feedback. A meeting of the directors of the above-mentioned courses and rotations with the course director in the Endocrinology Block would be beneficial since nearly 100% of students report receiving formal mid-course feedback. Likewise a meeting with the Director of the Psychiatry rotation would be beneficial as nearly 100% of students report receiving formal mid-clerkship feedback in that rotation. After a plan is developed and implemented to address the problem, monitoring and feedback to the directors of these courses and clerkships about the improvement in meeting this requirement are recommended. The curriculum oversight committee and the most appropriate curriculum sub-committee must monitor the provision of mid-course and mid-clerkship feedback and take steps to ensure that it occurs.

ED-38 Monitoring academic and clinical work hours

Finding: Students at Mercy Hospital and City Medical Center note that they are expected to be on duty longer hours than the residents.

Recommendation: The Undergraduate Curriculum Committee should review its policy on the amount of time students should spend in educational activities and patient care including night call. It should then review the mechanism the Clerkship Director uses to monitor the amount of time students spend in required educational activities and the steps taken to ensure that there is sufficient time for independent learning and that patient and student safety are not compromised. Finally, the Clerkship Director and the directors of the rotations at Mercy Hospital and City Medical Center should correct identified problems and follow-up to ensure that the monitoring system is effective in upholding the faculty policy.

Areas in Need of Monitoring (Areas in Compliance with a need for Monitoring)

Finding: The faculty is planning to develop a new distributed campus in New City, This Province. The full four-year curriculum will be implemented in September 2015. Currently, clerkship rotations have been piloted in all the disciplines and the new site will have capacity for the 40 students when the first class begins clerkship in August 2017.

Compliance with a large number of standards in all five sections is affected by the development of this new campus. The names and numbers of standards are too many to enumerate.

Recommendation: Planning must take accreditation standards into consideration to ensure that the appropriate administrative structures, processes, procedures, services, facilities and people are put in place as the new campus is developed. The IRC in collaboration with the Dean/Vice Dean Education will ensure that responsibility is delegated to the appropriate individuals to oversee that requirements of specific accreditation standards are addressed. Systematic review of the plan with respect to accreditation standards should take place appropriately every 3 months leading up to, and following the completion of the ER-1 template for submission to the CACMS and LCME by December 15, 2014.

MEDICAL STUDENT STANDARDS

Areas in Need of Improvement (Areas of Noncompliance)
Areas in Need of Monitoring (Areas in Compliance with a need for monitoring)

FACULTY STANDARDS

Areas in Need of Improvement (Areas of Noncompliance)
Areas in Need of Monitoring (Areas in Compliance with a need for Monitoring)

FA-2 Sufficient Faculty

Finding: Currently there are sufficient faculty in all the biomedical and clinical departments to deliver the educational program. However, the university is planning to introduce an early retirement option for faculty and to implement a hiring freeze for the next year.

Recommendation: The vice dean/senior education dean in collaboration with the dean must engage in discussions with the department heads/chairs to be fully informed of the potential impact of these two changes and to take steps to ensure that there are sufficient faculty to deliver the program despite these changes e.g., other contractual/payment options, freeing other faculty members to take on more teaching responsibilities (“master teachers”), introducing new teaching modalities that could reduce the number of faculty in particular disciplines needed to support student learning, The dean’s office or appropriate vice or associate dean should monitor faculty numbers and track faculty who have opted for early retirement as well as monitoring participation of faculty in teaching in the MD program.

EDUCATIONAL RESOURCES STANDARDS

Areas in Need of Improvement (Areas of Noncompliance)
Areas in Need of Monitoring (Areas in Compliance with a need for Monitoring)

X. APPENDIX A OF THE INTERIM SURVEY REPORT
5. ALL COMPLETED CHECKLISTS WITH ACCOMPANYING DOCUMENTATION
I. Institutional Setting Standards Checklists

Include in this section all completed checklists. After each checklist include the documentation necessary to support the identification of Noncompliance and areas in Compliance with a need for Monitoring. For convenience, all of the relevant sources of data (e.g. specific tables) have been identified for each standard. The checklist itself and the corresponding questions in the CACMS/LCME medical education database should be a guide as to what data or documents should be included with the checklist. It is recommended that you complete the tables for those standards where areas of noncompliance or compliance with a need for monitoring are identified. For geographically distributed programs, complete all tables and provide all requested information for each campus only for those checklists where areas of noncompliance or areas in compliance with a need for monitoring.

IRCs are strongly urged to complete at a minimum the tables that appear in the most recent Survey Report Writing Guide for CACMS/LCME full surveys. These tables are indicated in each section with a sentence in bold font. Please note it may be necessary to complete the database tables or other tables included in this section in order to evaluate the program's compliance with the requirements of the standard.

The text in parentheses refers to specific parts of the CACMS/LCME Data Collection Instrument (previously called the medical education database). These tables and descriptions of requested information can be accessed online: http://www.lcme.org/publications -under DCI (Data Collection Instrument for schools surveyed in 2013-14.

AFMC Institutional Setting Standards Checklists

IS-1	Strategic Planning Provide a brief description of the mission and goals for the medical education program, patient care and research
IS-4	Faculty/institutional by-laws
IS-5	Institutional conflict of interest policies
IS-6	Terms of appointment of governing board members
IS-7	Faculty/administrative officer appointments
IS-8	Accessibility of the university president/institutional officials Organizational chart(s) showing relationship of medical school to university and clinical affiliates
IS-9	Authority/responsibility for the program
IS-10	Qualifications of the dean Dean's position description and brief résumé (Database IS-10)
IS-11	Administrative structure Organizational chart for dean's office (Database IS-11)
IS-12	Academic Environment/Residents train where medical students learn Table showing enrollment in graduate programs in basic sciences (Database IS-12) Table(s) showing number of residents by specialty (Database IS-12A)
IS-13	Research and scholarship, institutional goals/priorities
IS-14	Research/scholarly opportunities for medical students
IS-14-A	Service Learning
IS-16	Diversity of Faculty, students and staff Table illustrating the diversity categories chosen by the school and the percentage of students, faculty, and staff in each category (Database IS-16)

II. Educational Program Standards Checklists

Include in this section all completed checklists. After each checklist include the documentation necessary to support the identification of noncompliance and areas in compliance with a need for monitoring. For convenience, all of the relevant sources of data (e.g. specific tables) have been identified for each standard. The checklist itself and the corresponding questions in the CACMS/LCME medical education database should be a guide as to what data or documents should be included with the checklist. It is recommended that you complete the tables for those standards where areas of noncompliance or compliance with a need for monitoring are identified. For geographically distributed programs, complete all tables and provide all requested information for each campus only for those checklists where areas of noncompliance or areas in compliance with a need for monitoring.

Please note it may be necessary to complete the database tables or other tables included in this section in order to evaluate the program's compliance with the requirements of the standard.

Note: Programs offering a longitudinal integrated clerkship (ICC), should complete the relevant tables for each ICC site.

The text in parentheses refers to specific parts of the CACMS/LCME Data Collection Instrument (previously called the medical education database). These tables and descriptions of requested information can be accessed online: http://www.lcme.org/publications -under DCI (Data Collection Instrument for schools surveyed in 2013-14.

AFMC Educational Program Standards Checklists

ED-1: Educational program objectives
ED-1-A: Format of the objectives
The educational program objectives linked to competencies expected of a physician (Database ED-1A)
Complete the following table showing the general competencies expected of graduates, educational program (institutional learning) objectives related to each competency, and any outcome measure(s) indicating achievement of each listed objective. Add rows to the table as needed. (Database ED-1, 1-A)

General Competency	**Educational Program Objective(s)**	**Assessment methods/data used to show student achievement of the competency by year and by curricular component (Outcome Measure(s))**

ED-2 Required clinical experiences and monitoring
The required clinical experiences, level of responsibility and appropriate clinical setting (total) (Database ED-2)
ED-3 Dissemination of the educational program objectives
ED-4 Duration of the educational program
ED-5 General professional education
ED-5-A Active learning, independent study and lifelong learning

It may be useful to complete these tables to evaluate compliance with the standard. It is recommended that these tables be completed if areas of noncompliance or areas in compliance with a need for monitoring are identified using the AFMC Checklist..

Years One and Two

For the required courses in years one and two, complete the tables in the report that include total scheduled hours and hours by instructional format. If one or more courses employ other instructional methods not accounted for in the table, describe them in the specific narrative for those courses. Also refer to the schematic diagram of the curriculum, which may be included as a figure either in the text or the Appendix C. If one or more separate tracks exist, create similar tables and descriptions of the courses in each track.

These two tables are in the Survey Report Writing Guide 13-14

YEAR ONE

Course	Formal Instructional Hours					
	Lecture	Lab	Small Groups*	Patient Contact	Other†	Total

- Includes case-based or problem solving sessions

† Describe

YEAR TWO

Course	Formal Instructional Hours					
	Lecture	Lab	Small Groups*	Patient Contact	Other†	Total

- Includes case-based or problem solving sessions

† Describe

ED-6 Critical judgment, and problem-solving skills instruction (See also ED-28)

ED-7 Current concepts in biomedical and clinical sciences
ED-8 Comparability across instructional sites
If areas of noncompliance are identified using the AFMC ED-8 checklist the relevant information from the tables under ED-16, ED-26 should be provided.
ED-9 Notification of the LCME and CACMS of a major curriculum change
ED-10 Behavioural and socioeconomic subjects
The table of subjects required for accreditation (Database ED-10)
ED-11 Biomedical sciences, public and population health disciplines
Completion of this table with the most recent data from the CGQ.
This table is now in the Survey Report Writing Guide 13-14

Basic Science Disciplines	% Rating Preparation for Clinical Clerkship Rotations as Excellent or Good	National % Rating Preparation for Clinical Rotations as Excellent or Good
Biochemistry		
Genetics		
Gross Anatomy		
Immunology		
Microbiology		
Pathology		
Pathophysiology		
Pharmacology		
Physiology		

ED-12 Exercises in applying the scientific method
ED-13 Inclusion of all organ systems, and prevention and treatment of health problems
ED-14 Primary care experience
ED-15 Clinical experience in the contemporary core clinical disciplines
Note: If areas of noncompliance are identified using the AFMC ED-15 checklist the relevant information from the table under ED-15 should be provided.
Complete of the following two tables using data from the most recent CGQ.
These tables are now in the Survey Report Writing Guide 13-14

Topic	Percent of respondents indicating that instruction was:		
	Inadequate	Appropriate	Excessive
Health promotion and disease prevention			
Determinants of health including social determinants			

	Percent of respondents who agree + strongly disagree "When presented with a variety of patients I am confident that I have the knowledge and skills to":
Develop an appropriate differential diagnosis	
Develop an appropriate management plan	

ED-16 Inpatient and outpatient clinical experience

Note: If areas of noncompliance are identified with the AFMC ED-16 checklist the following information should be included with the checklist:

Years Three and Four

For the required clerkships in years three and four, complete the following tables. "Formal instruction" refers to the sum of lecture hours, conference time, and teaching rounds for all students; report either an average or range as appropriate, and note any major site-specific variations in the narrative description of the clerkship.

These Tables are in the Survey Report Writing Guide 13-14.

YEAR THREE

Course or Clerkship	Total wks	% Amb.	# Sites used*	Typical hrs/wk of formal instruction**	Patient Criteria† (Y/N)	Patient log‡ (Y/N)

*Include the number of sites used for inpatient teaching and the number of sites used for outpatient teaching in the clerkship in the following format: # inpatient / # outpatient

**Sum of lectures, conferences, and teaching rounds; show the range of hours if there is significant variation across sites

† Have criteria for patient encounters and procedures been defined i.e., types of patients, level of student responsibility and the clinical setting?

‡ Is a log kept of patient encounters and procedures by students and is it monitored by the faculty?

YEAR FOUR

Course or Clerkship	Total wks	% Amb.	# Sites used*	Typical hrs/wk of formal instruction**	Patient criteria† (Y/N)	Patient log‡ (Y/N)

*Include the number of sites used for inpatient teaching and the number of sites used for outpatient teaching in the clerkship in the following format: # inpatient / # outpatient

**Sum of lectures, conferences, and teaching rounds; show the range of hours if there is significant variation across sites

† Have criteria for patient encounters and procedures been defined i.e., types of patients, level of student responsibility and the clinical setting?

‡ Is a log kept of patient encounters and procedures by students and is it monitored by the faculty?

ED-17	Multidisciplinary clinical experience and diagnostic clinical services
ED-17-A	Clinical and translational research
ED-18	Elective opportunities
ED-19	Communication skills education
ED-19A	Interprofessional collaborative practice skills

ED-20 Common societal problems
ED-21 Cultural competence
ED-22 Awareness of biases and health disparities
ED-23 Medical ethics education, breaches and remediation

Recommend the completion of the following table using data from the most recent CGQ. Note this table covers other standards e.g. ED-5, ED-19, ED-20, ED-21, and indirectly to ED-33.

This table is in the Survey Report Writing Guide 13-14.

I am confident that I have the knowledge and skills to following:	% Responding Agree/Strongly Agree
Clinical skills required to begin a residency program	
Communicate effectively with patients and their families	
Communicate with physicians	
Communicate with other health professionals	
Incorporate evidence-informed decision-making into patient care	
Reason clinically	
Fundamental understanding of the issues in the social sciences of medicine	
Include ethical issues into decision-making	
I appropriately trained to care for individuals from backgrounds different from my own	
The following beliefs/values and behaviours were emphasized in your medical education program: The value of honesty and integrity in all professional interactions	
A commitment to advocate at all times the interest of one's patients over one's own interests	

Topic	Percent of respondents indicating that instruction was:		
	Inadequate	Appropriate	Excessive
Behavioural sciences			
Family/Domestic violence			
Drug and alcohol abuse			
Ethics/ Humanism			
Professionalism			

ED-24 Resident preparation

This table is in the Survey Report Writing Guide 13-14.

Complete the following table indicating support for resident participation in medical student education:

Clerkship	Objectives provided to residents (Y/N) and describe how the objectives are provided	Departmental programs for teaching & assessment skills (Y/N) and summarize the programs available to residents	Resident participation monitored (Y/N) and describe how and by whom participation is monitored
Emergency Medicine			
Family Medicine			
Internal Medicine			
Obstetrics-Gynecology			
Pediatrics			
Psychiatry			
Surgery			

ED-25 Clinical supervision and faculty appointments

ED-25-A Clinical supervision ensures student and patient safety

ED-26 Variety of Assessment Measures

If areas of noncompliance are identified using the AFMC ED-26 checklist the following information should be provided.

The next three tables are in the Survey Report Writing Guide 13-14.

Student Assessment

YEAR ONE

Course	# of Exams	Written Exams	Lab or Practical Exams	Faculty/ Resident Rating*	OSCE/SP Exam	Paper or Oral Pres.	Other†

* Include evaluations by faculty members or residents in clinical experiences and in small-group sessions (e.g., a facilitator evaluation in small group or case-based teaching)

† Describe the specifics in the report narrative

YEAR TWO

	# of Exams	Written	Lab or Practical	Faculty/ Resident	OSCE/S	Paper or Oral	Other†

Course		Exams	Exams	Rating*	P Exam	Pres.	

* Include evaluations by faculty members or residents in clinical experiences and in small group sessions (e.g., a facilitator evaluation in small group or case-based teaching)
† Describe the specifics in the report narrative

YEARS THREE AND FOUR

Course or Clerkship	Written Exams	Oral Exam or Presentation	Faculty/ Resident Rating	Clerkship OSCE/SP Exams	Other*	Clinical Skills Observed (Y/N)†	Mid-Course Feedback (Y/N)

* Describe the specifics in the report narrative
† Are all students observed performing core clinical skills? (yes or no)

Summarize the methods used to evaluate student performance in the preclinical and clinical disciplines. Comment on whether the assessment methods in place assess the problem solving, clinical reasoning, communication, and other skills, behaviors, and attitudes needed in subsequent medical training and

ED-27 Direct observation of student performance

If areas of noncompliance are identified using the AFMC ED-27 checklist, the relevant information from the table under ED-16 should be provided. Please note that there is redundancy in the Survey Report Guide 13-14 on information regarding the observation of clinical skills. The first table relates to ED-31 and indirectly to ED-33.

The next two tables are in the Survey Report Writing Guide 13-14.

Clerkship	Objectives[1] (Y/N)	% Observed/ History[2] (National %)	% Observed/ Physical[2] (National %)	% of students receiving sufficient feedback[3]	Percent of students receiving clerkship grades in Six weeks	Student Satisfaction (National Norm)[4]
Emergency Medicine						
Family Medicine						
Internal Medicine						
Obstetrics-						

Gynecology						
Pediatrics						
Psychiatry						
Surgery						

1. Are there learning objectives (not a list of topics covered) for the clerkship?
2. Provide data from the CGQ on the percent of students who report being observed performing a history and a physical examination (ED-27)
3. Do students receive mid-clerkship feedback? –ED-31 the faculty needs to provide evidence.
4. Provide data on student satisfaction with the quality of the clerkship (ED-47), CGQ (include National %) this relates to curriculum management ED-33.

Rotation	School % agreeing they were observed		National % agreeing they were observed	
	History	Physical Examination	History	Physical Examination
Emergency Medicine				
Family Medicine				
Internal Medicine				
Obstetrics-Gynecology				
Pediatrics				
Psychiatry				
Surgery				

ED-28 Assessment of problem solving, clinical reasoning and communication skills
ED-29 Standards of achievement
ED-30 Formative and summative assessment. Note that this table also pertains to ED-1, ED-24 and ED-33. Complete the table for Year One and Year Two.

These two tables are now in the Survey Report Writing Guide for 13-14.

Courses and Clerkships	Objectives (Y/N)[1]	Formative Assessment[2] (Y/N)	Narrative Assessment[3] (Y/N)	Students' Rating(s) of Course or clerkship[4] (national norms for clerkships)	Residents/ graduate students used as teachers/ supervisors[5] (Y/N)

1. Are there learning objectives for the course that are provided to students?
2. Do students have opportunities for formative assessment to test their knowledge/skills?
3. Do students receive a narrative assessment (text that describes the student's performance and provides guidance on areas that could be improved) for either formative or summative purposes?
4. Indicate the source of the student rating (either CGQ or internally collected data). Describe what is being rated (course quality, preparation for clerkship). More than one rating can be provided (expand the table)

5. Are residents and/or graduate students used as teachers/supervisors? See also ED-24.

ED-31 Mid-course and clerkship feedback
See table under ED-27

ED-32 Narrative feedback
See table under ED-30

ED-33 Curriculum management
The organizational chart for management of the curriculum (Database ED-33). Please note, that the schematic should show the subcommittees of the curriculum committee and how the committees that oversee the actual running of the curriculum report to the curriculum committee. The curriculum committee must have authority over the curriculum.

ED-34 Design and implementation of the curriculum

ED-35 Systematic review of the curriculum

ED-36 Authority for, and sufficient resources to manage and evaluate the program

ED-37 Monitoring curriculum content

ED-38 Monitoring academic and clinical work hours

ED-39 Responsibility of the chief academic officer

ED-40 Academic leadership is administratively responsible to the chief academic officer
For each geographically separate program, describe the phase(s) of the curriculum involved (e.g., the first two years, the third and fourth years, or all four years) and the average number of students (i.e., proportion of a given class) at each site, including the "main campus," for each curricular year. Provide an organizational chart describing the relationship between the central medical school campus and each distributed campus administrations. The senior academic leader at each distributed campus must report to the dean of the medical school.

ED-41 Functional integration of faculty
For distributed programs, describe the mechanism and/or provide illustrations that show the integration of faculty, administrative staff and departments in order to achieve comparable educational experiences and methods of student assessment

ED-42 Single standard for promotion and graduation

ED-43 Assignment of students to instructional sites/educational tracks

ED-44 Equivalence of student services

ED-46 Program evaluation
The outcomes used to determine educational program effectiveness (Database ED-46) MCC Qualifying Exam Part 1 performance data (number of students examined, percent passing, mean total score, mean national total score) for first-time takers for the three most recently available years. Persistent poor performance or declining performance would be taken as evidence that the curriculum committee was not exercising its responsibility for the quality of the curriculum and has the authority to make the necessary changes to improve the educational program.

ED-47 Student evaluation data use in program improvement. Note if student satisfaction in courses or clerkships that persist for two or years since this will point to a failure of the curriculum committee to demonstrate that it is responsible for the quality of the curriculum and has the authority to make the necessary changes to improve the educational program.

III. Medical Students Standards Checklists

Include in this section all completed checklists. After each checklist include the documentation necessary to support the identification of noncompliance and areas in compliance with a need for monitoring. For convenience, all of the relevant sources of data (e.g. specific tables) have been identified for each standard. The checklist itself and the corresponding questions in the CACMS/LCME medical education database should be a guide as to what data or documents should be included with the checklist. It is recommended that you complete the tables for those standards where areas of noncompliance or compliance with a need for monitoring are identified. For geographically distributed programs, complete all tables and provide all requested information for each campus only for those checklists where areas of noncompliance or areas in compliance with a need for monitoring.

IRCs are strongly urged to complete at a minimum the tables that appear in the most recent Survey Report Writing Guide for CACMS/LCME full surveys. These tables are indicated in each section with a sentence in bold font. Please note it may be necessary to complete the database tables or other tables included in this section in order to evaluate the program's compliance with the requirements of the standard.

The text in parentheses refers to specific parts of the CACMS/LCME Data Collection Instrument (previously called the medical education database). These tables and descriptions of requested information can be accessed online: http://www.lcme.org/publications -under DCI (Data Collection Instrument for schools surveyed in 2013-14.

AFMC Medical Students Standards Checklists

MS-1	Broad-based premedical education
MS-2	Essential pre-requisite courses
MS-3	Selection criteria, policies and procedures/Accessibility of information
MS-11	Catalog/informational materials
MS-4	Admissions Committee
MS-5	Determination of entering class size If areas of noncompliance are identified using AFMC Checklist MS-5, provide: a) The mean MCAT scores (if required) and premedical GPAs for past three entering classes (Database Medical Students Key Indicators Part A) b) Student enrollment by class year (Database MS-5)
MS-6	Personal/professional admission criteria
MS-7	Admission selection is free of political or financial influence
MS-8	Medical student diversity/pipeline programs
MS-9	Technical standards for students with disabilities
MS-10	Program information materials
MS-11	Combined with MS-3
MS-12	Elective students can not compromise experience of enrolled students
MS-13	Transfer students' qualifications
MS-14	Advanced standing of transfer students
MS-15	Transfer into the final year of the program
MS-16	Visiting student verification and tracking
MS-17	Visiting student qualifications
MS-18	Academic advising Table of the number of students who left school, exhibited academic difficulty, or took a leave of absence since the time of the last full survey (Database MS-18)

MS-19	Career counselling Sample of a completed Medical Student Performance Record with no personal identifiers (Database MS-19)
MS-20	Oversight of extramural electives
MS-21	Residency application process
MS-22	Provision of MSPR
MS-23	Financial aid/debt counseling (CGQ recent data)
MS-24	Student educational debt (CGQ recent data)
MS-25	Tuition/fees refund policy
MS-26	Personal counseling and well-being programs
MS-27	Access to health care services
MS-27-A	Mental health/sensitive health service providers
MS-28	Access to disability insurance
MS-29	Immunization guidelines
MS-30	Infectious/environmental hazards exposure policies
MS-31	Anti-Discrimination policy
MS-31-A	Professionalism/Learning environment/Hidden curriculum
MS-32	Student mistreatment
MS-33	Policies/procedures for assessment, promotion and graduation
MS-34	Appeal process
MS-35	Confidentiality of student records
MS-36	Student access to and ability to challenge their records
MS-37	Study space/lounge areas/personal storage space

IV. Faculty Standards Checklists

Include in this section all completed checklists. After each checklist include the documentation necessary to support the identification of noncompliance and areas in compliance with a need for monitoring. For convenience, all of the relevant sources of data (e.g. specific tables) have been identified for each standard. The checklist itself and the corresponding questions in the CACMS/LCME medical education database should be a guide as to what data or documents should be included with the checklist. It is recommended that you complete the tables for those standards where areas of noncompliance or compliance with a need for monitoring are identified. For geographically distributed programs, complete all tables and provide all requested information for each campus only for those checklists where areas of noncompliance or areas in compliance with a need for monitoring.

IRCs are strongly urged to complete at a minimum the tables that appear in the most recent Survey Report Writing Guide for CACMS/LCME full surveys. These tables are indicated in each section with a sentence in bold font. Please note it may be necessary to complete the database tables or other tables included in this section in order to evaluate the program's compliance with the requirements of the standard.

The text in parentheses refers to specific parts of the CACMS/LCME Data Collection Instrument (previously called the medical education database). These tables and descriptions of requested information can be accessed online: http://www.lcme.org/publications -under DCI (Data Collection Instrument for schools surveyed in 2013-14.

AFMC Faculty Standards Checklists

FA-2 Sufficient Faculty

If areas of Noncompliance are identified using the Checklist, the following information should be provided in this section of the report along with the FA-2 Checklist.

a) Complete the following table with data from the previous full survey and the current interim survey:
This table is in the Survey Report Writing Guide 13-14.

	[Previous Full Survey Year] †	[Interim Survey Year]*
Entering class size		
Total enrollment		
Residents and fellows		
Full-time basic science faculty		
Full-time clinical faculty		

b) Complete the following table:
For geographically distributed programs, complete a table for each campus.

Tables showing the current numbers of full-time, part-time, and volunteer faculty members in basic science and clinical disciplines, by department and total

Academic Year	# of Faculty FTEs in Basic Science Departments	Full-Time Faculty		Part-Time Faculty		Volunteer Faculty	
		Basic Science	Clinical	Basic Science	Clinical	Basic Science	Clinical
2010-11							
2011-12							
2012-13							
2013-14							

c) The table of teaching responsibilities by department (Database FA-2 in the database)

FA-3	Positions based on achievement
FA-7	Appointment, advancement, tenure and dismissal policies
FA-4	Commitment to enhance teaching skills
FA-5	Scholarly productivity
	The table on faculty scholarly productivity (Database FA-5)
FA-6	Faculty must make decisions on admissions, promotion, and graduation and provide academic and career counseling for students (no checklist required)
	See check lists for MS-4, MS-18, MS-19 and MS-33
FA-7	See FA-3
FA-8	Faculty conflict of interest policies
FA-9	Documentation of appointment, responsibilities, communications and benefits
FA-10	Feedback on academic performance and career mentoring
FA-11	Professional development for education and research
FA-12	Determination of policies for the educational program
	The table of all major medical school faculty committees (Database FA-12)
FA-13	Involvement in determining policies for the educational program
FA-14	Participation in establishing programmatic and institutional policies/practices

V. Educational Resources Standards Checklists

Include in this section all completed checklists. After each checklist include the documentation necessary to support the identification of noncompliance and areas in compliance with a need for monitoring. For convenience, all of the relevant sources of data (e.g. specific tables) have been identified for each standard. The checklist itself and the corresponding questions in the CACMS/LCME medical education database should be a guide as to what data or documents should be included with the checklist. It is recommended that you complete the tables for those standards where areas of noncompliance or compliance with a need for monitoring are identified. For geographically distributed programs, complete all tables and provide all requested information for each campus only for those checklists where areas of noncompliance or areas in compliance with a need for monitoring.

IRCs are strongly urged to complete at a minimum the tables that appear in the most recent Survey Report Writing Guide for CACMS/LCME full surveys. These tables are indicated in each section with a sentence in bold font. Please note it may be necessary to complete the database tables or other tables included in this section in order to evaluate the program's compliance with the requirements of the standard.

The text in parentheses refers to specific parts of the CACMS/LCME Data Collection Instrument (previously called the medical education database). These tables and descriptions of requested information can be accessed online: http://www.lcme.org/publications -under DCI (Data Collection Instrument for schools surveyed in 2013-14.

AFMC Educational Resources Standards Checklists

ER-1 Notification of LCME and CACMS of an increase in student number or a decrease in educational resources
If relevant, provide a brief discussion of any planned changes in medical student enrollment or institutional resources.

ER-2 Financial resources
If areas of noncompliance are identified using the AFMC Checklist provide the following information with the ER-2 checklist:

a) Four-year Revenue and Expenditure Summary and the current AFMC Canadian Faculty of Medicine Financial Survey including your school's responses to the related "Overview of Organization and Financial Characteristics" survey

b) Table A **Note this table is in the Survey Report Writing Guide 13-14.**

Table A ($ Millions Canadian)

	[Previous Full Survey Year]	[Interim Survey Year]
Total revenue from student and trainee fees[1]		
Total revenue from the university		
Total revenue from provincial ministries		
Total revenue from federal government		
Research awards, grants and contracts		
Research grant overhead funds		
Practice plan/Alternate Funding Plan/Billing Group		
Hospital or Health Authority Revenue		
Gifts and Endowments[2]		

Other revenues[3]		
Total revenues		

Note: Revenue information should be based on Canadian Faculty of Medicine Financial Survey (CFMFS) responses submitted annually to the Association of Faculties of Medicine of Canada.
1- CFMFS, Schedule A, line items 1.4, 1.4.1, 1.4.2
2- CFMFS, Schedule A, line item 1.7, and Schedule B, line items 1-3
3- CFMFS, Schedule A, line items 1.8, 1.9, 1.11, 1.12, 1.13, 1.14, 2.4

c) Table B
Breakdown of revenue sources for the medical school as a whole compared to other Canadian medical schools.
This table is in the Survey Report Writing Guide 13-14.

Table B
MEDICAL SCHOOL REVENUE SOURCES
($ in Millions Canadian)

Source	(2012-2013)*	% of total revenues	% of total revenues All Canadian schools
Tuition and fees	$	%	3.1%
Provincial and University Funding	$	%	11.6%
Federal Funding	$	%	0.6%
Grants & contracts (direct)	$	%	22.3%
Indirect cost recoveries	$	%	5.9%
Practice plans	$	%	33.5%
Gifts and endowments	$	%	3.0%
Hospitals	$	%	15.1%
Other revenues	$	%	4.9%
Total revenue	$		
Total expenses & transfers	$		

* Insert final financial data from the year just prior to the Interim Survey i.e., 12-13, if not possible, use 2011-12 and indicate on the table the year from which the data was derived.

ER-3 Impact of financial resources on admission of students and faculty activities
ER-4 Facilities needed to fulfill the mission of the school
The table(s) of teaching facilities (Database ER-4)
Table of faculty offices and research labs (Database ER-4)

ER-5 Security systems and disaster planning
ER-6 Resources for clinical instructions (patient mix, location and numbers)
Summary data and associated tables for each clinical teaching site (Database ER-6)
ER-7 Clinical instructional facilities/information resources
Summary data and associated tables for each clinical teaching site (Database ER-7)
ER-8 Residents train and participate as teachers
ER-9 Affiliation agreements
Master affiliation agreement or sample copy (Database ER-9)

This table is in the Survey Report Writing Guide 13-14.

For each site used for required inpatient clerkship rotations, check if there is a signed affiliation agreement and if the agreement specifies the listed elements:

Clinical Teaching Site used for required clinical learning experiences (e.g., clerkship rotations	Signed Affiliation Agreement	Guarantees Student/Faculty Access to Resources	Statement of the Primacy of the Medical Education Program	Role of Medical Education Program in Faculty Appointment/ Assignment	Specification of Responsibility for Treatment/Follow-up of Student Occupational Exposure

Note if the affiliation agreement for each site or an associated MOU specifies the joint responsibility of the medical school and its clinical partner for the learning environment (MS-31-A).
This aspect of MS-31-A is now covered under ER-9.

ER-10 Authority for the educational program at clinical sites
ER-11 Library resources
The tables of library facilities and holdings,(Database ER-11)

ER-12 Library staff
The table of library staff (Database ER-12)
ER-13 Information technology resources
ER-14 Information technology staff
Table of technology staff (Database ER-14)

X. APPENDIX B

Summary of Student Data

Provide a summary of student data (quantitative and qualitative) or the location within the faculty where this can be found (may also be a URL to copies of reports etc.), the most recent copy of the CGQ, and the results of any student survey or focus groups. Include a blank copy an Interim Student Survey and focus group questions if used.

7. APPENDIX A TO THE AFMC INTERIM ACCREDITATION SURVEY GUIDE

Sample Cases Judging Compliance

In its review of survey reports and follow-up status reports, the Liaison Committee on Medical Education (LCME) and the Committee on the Accreditation of Canadian Medical Schools (CACMS) makes a determination of a medical education program's compliance with accreditation standards. At its June 2011 meeting, the LCME approved the implementation of a new category of compliance that has been defined as "in compliance, with monitoring." In parallel, the LCME adopted the following definitions associated with the terms "in compliance" and "noncompliance" with accreditation standards:

Noncompliance:

The medical education program has not met one or more of the requirements of the standard: The required policy, process, resource, or system either is not in place or is in place, but has been found to be ineffective.

In Compliance with the need for Monitoring:

1) The medical education program has the required policy, process, resource, or system in place, but there is insufficient evidence to indicate that it is effective. Therefore, monitoring is required to ensure that the desired outcome has been achieved.

   OR

2) The medical education program is currently in compliance with the standard, but known circumstances exist that could lead to future noncompliance (*formerly "area in transition").*

In Compliance:

The required policy, process, resource, or system is in place and, if required by the standard, there is evidence to indicate that it is effective.

The new terminology was used by the CACMS and the LCME in the letters of accreditation sent to medical schools, beginning with the September and October 2011 meetings. The CACMS and the LCME believe that the revised definitions provide enhanced clarity. Please do not hesitate to contact the CACMS Secretariat via Claudine LeQuellec with questions or concerns.

NOTE: Answer guide for these cases is provided at the end of Case #4.

Case # 1

In the 2012-2013 academic year, students at school "A" were given access to the AAMC Careers in Medicine program and had a variety of shadowing experiences in years one and two of the curriculum. Activities in years three and four were limited to one required meeting for each student with the associate dean for student affairs related to the development of the MSPE and voluntary meetings with clinical advisors.

For the 2012-2013 academic year, the school hired a counselor with the responsibility to implement a

system of career counseling. By the February 2013 survey visit, the counselor had created a plan for a four-year longitudinal career counseling program, with required sessions in years one through four and a process to assign all third and fourth year students to trained faculty advisors to assist them in career choice, as well as several required informational sessions for all third and fourth-year students. The required programs for first, third, and fourth-year students had been implemented, with good student attendance and feedback, and faculty advisors had been assigned and were meeting with students.

Responding students from school A to the GQ had reported low satisfaction with career counseling (45% satisfied for 2010, 54% satisfied for 2011, and 52% satisfied for 2012, all below the national average).

What is your assessment of the school's compliance with standard MS-19:

_____ In Compliance

_____ In Compliance with a need for Monitoring

_____ Noncompliance

Case # 2

School "B has a full survey visit in January 2013. In the independent student analysis, 36% of respondents were dissatisfied with financial aid counseling and 15% were neutral. The medical school hired a financial aid counselor who took up his duties in October of 2012. By the time of the survey visit, the counselor had begun to develop a plan for a series of financial aid and debt management seminars for students in all classes.

What is your assessment of the school's compliance with standard MS-23?

_____ In Compliance

_____ In Compliance with a need for Monitoring

_____ Noncompliance

Case # 3

At the Amador School of Medicine, based on information in the independent student analysis, the following percentages of students reported receiving mid-clerkship feedback during the 2012-2013 academic year:

Obstetrics-Gynecology	93%
Internal Medicine	61%
Surgery	88%
Pediatrics	86%
Family Medicine	100%
Psychiatry	80%

What is your assessment of the school's compliance with standard ED-31?

_____ In Compliance

_____ In Compliance with a need for Monitoring

_____ Noncompliance

Case # 4

The University of Delaware School of Medicine has an integrated curriculum in the preclinical years. The curriculum includes faculty members from the basic and clinical sciences as lecturers and small group discussion leaders and also uses basic scientists as content resources for medical students. The survey team noted that the number of basic science faculty across disciplines was barely sufficient for the needs of the curriculum and that these faculty were feeling "stretched." To deal with budgetary constraints, the medical school was planning to introduce an early retirement option for faculty and to implement a hiring freeze for the next fiscal year. The number of basic scientists who might participate in the early retirement plan over the next two to three years was unknown at the time of the survey visit.

What is your assessment of the school's compliance with FA-2?

_____ In Compliance

_____ In Compliance with a need for Monitoring

_____ Noncompliance

Answers:

Case #1 MS-19 In Compliance with a need for Monitoring
The system has been put in place but it is too early to determine if it is effective. Using an airline analogy, the plane has landed but the data on the quality of the flight, experience and satisfaction of the passengers with the entire flight is not yet available. Please note that the school collected student satisfaction data on the components it was implementing which allowed the decision of Compliance with the need for Monitoring. If no data had been available it would have been more difficult to say that CM had been achieved.

Case #2 MS-23 Noncompliance
The system is not in place and current outcome measures i.e. student satisfaction measures indicate that financial aid and debt management counseling is not effective. Using the airline analogy, the school has hired a pilot, has built a plane and the flight plan has been developed, but the plane has not taken off. Therefore the system is not in place.

Case #3 ED-31 Noncompliance
The percentage of students receiving mid-clerkship feedback in the Internal Medicine rotation does not meet the requirements of the standard. Improvement could also be made in the Psychiatry, Pediatrics and Surgery rotations.
It is a bit difficult to frame this in terms of an airline analogy, however I will try. In this case, the airline has the expected number of planes, and flight plans have been filed and approved. Planes are expected to fly at full capacity. Some planes are not flying at full capacity.

Case #4 FA-2 In compliance with a need for Monitoring
Although the number of basic scientists is barely adequate- it is adequate. The impact of the early retirement plan on the number of basic scientists is not known such that monitoring is needed.
Using the airline analogy, the number of airplanes currently needed to move passengers and freight on the required routes is sufficient, however a plan to take older planes out of service may affect the ability to do the work currently accomplished by the airline.

8. APPENDIX B TO THE INTERIM SURVEY REPORT WRITING GUIDE

LCME/CACMS Accreditation Student Survey

Note: It is recommended that you use the Likert scale to conform to that used in the Faculty of Medicine and the CGQ e.g. 1-5 with 1= Strongly Disagree, 2= Disagree, 3 = Neither Disagree or Agree, 4 = Agree and 5 = Strongly Agree, and NA (not applicable) to render the results more understandable.

The two questions on mistreatment (42 and 43) will not provide sufficient information to understand any problems and generate recommendations to address them. It is recommended that the questions in the mistreatment section of the CGQ be used with or without modification to yield more useful results. It is also recommended that the faculty review the questions on the CGQ with respect to student health and all of the support services in producing the Interim Review Student Survey.

Sample Student Opinion Survey for the Independent Student Analysis

Note: Students are required to use the questions provided below and should feel free to modify this sample survey, as needed, to reflect the distinctive characteristics of the school. Questions may be added to address other issues that may be of particular importance to the school's students. All required courses and clinical learning experiences must be evaluated for the survey team to have the information that is needed to judge the program's compliance with accreditation standards.

Please circle the number indicating your level of satisfaction or agreement, using the following scale:

1 = Very Dissatisfied/Strongly Disagree
2 = Dissatisfied/Disagree
3 = Neither satisfied or dissatisfied Neither Disagree or Agree
4 = Satisfied/Agree
5 = Very satisfied/Strongly Agree
N/A = Not applicable/Did not access

STUDENT-FACULTY-ADMINISTRATION RELATIONSHIPS

1.	Availability and accessibility of medical school faculty	1	2	3	4	5	N/A
2.	Availability and accessibility of medical school administration	1	2	3	4	5	NA
3.	Administration awareness of student problems	1	2	3	4	5	NA
4.	Administration responsiveness to student concerns	1	2	3	4	5	NA
5.	Participation of students on key medical school committees	1	2	3	4	5	NA

STUDENT SUPPORT

6.	Availability of academic counseling	1	2	3	4	5	NA
7.	Adequacy of academic counseling	1	2	3	4	5	NA
8.	Availability of tutorial help	1	2	3	4	5	NA
9.	Adequacy of tutorial help	1	2	3	4	5	NA
10.	Availability of counseling for personal problems	1	2	3	4	5	NA
11.	Adequacy of counseling for personal problems	1	2	3	4	5	NA
12.	Confidentiality of counseling for personal problems	1	2	3	4	5	NA
13.	Availability of counseling about medical careers	1	2	3	4	5	NA
14.	Adequacy of counseling about medical careers	1	2	3	4	5	NA
15.	Availability of financial aid administrative services	1	2	3	4	5	NA
16.	Adequacy of financial aid administrative services	1	2	3	4	5	NA
17.	Availability of debt management counseling	1	2	3	4	5	NA
18.	Adequacy of debt management counseling	1	2	3	4	5	NA

STUDENT HEALTH

19.	Ease of access to student health services	1	2	3	4	5	NA
20.	Adequacy of student health services	1	2	3	4	5	NA
21.	Availability of student health insurance	1	2	3	4	5	NA
22.	Availability of disability insurance	1	2	3	4	5	NA
23.	Adequacy of education about prevention and exposure to infectious and environmental hazards	1	2	3	4	5	NA

LIBRARY AND ELECTRONIC LEARNING RESOURCES

24.	Accessibility of library services	1	2	3	4	5	NA
25.	Quality of library services	1	2	3	4	5	NA
26.	Adequacy of library holdings and instructional resources	1	2	3	4	5	NA
27.	Ease of access to library holdings and instructional resources	1	2	3	4	5	NA
28.	Adequacy and accessibility of computers	1	2	3	4	5	NA
29.	Adequacy of computer learning resources	1	2	3	4	5	NA
30.	Utility of school or departmental websites	1	2	3	4	5	NA

LEARNING ENVIRONMENT

31.	Adequacy of lecture hall, large-group classroom facilities	1	2	3	4	5	NA
32.	Adequacy of small group teaching space	1	2	3	4	5	NA
33.	Adequacy of student study space	1	2	3	4	5	NA
34.	Adequacy of student relaxation space	1	2	3	4	5	NA
35.	Clarity of student advancement and graduation policies	1	2	3	4	5	NA
36.	Clarity of policies and procedures for disciplinary action	1	2	3	4	5	NA
37.	Access to student records for review and challenge	1	2	3	4	5	NA
38.	Diversity of the student body	1	2	3	4	5	NA
39.	Faculty diversity	1	2	3	4	5	NA
40.	Adequacy of systems for personal safety	1	2	3	4	5	NA
41.	Access to secure storage space for belongings	1	2	3	4	5	NA
42.	Adequacy of policies/procedures for addressing student mistreatment	1	2	3	4	5	NA
43.	Adequacy of educational activities to prevent student mistreatment	1	2	3	4	5	NA
44.	Educational environment fosters collegiality/respect	1	2	3	4	5	NA

EDUCATIONAL PROGRAM AS A WHOLE

45.	Utility of the educational program objectives for learning	1	2	3	4	5	NA
46.	Overall quality of the first-year/academic period curriculum	1	2	3	4	5	NA
47.	Coordination/integration of content in the first year	1	2	3	4	5	NA
48.	Overall quality of the second-year/academic period curriculum	1	2	3	4	5	NA
49.	Coordination/integration of content in the second year	1	2	3	4	5	NA
50.	Quality of clinical skills instruction in the first/second years	1	2	3	4	5	NA
51.	Appropriateness of teaching methods in the first and second years	1	2	3	4	5	NA
52.	Opportunities to engage in self-directed, independent learning in the first and second years	1	2	3	4	5	NA
53.	Appropriateness of methods to assess student achievement in the first and second years	1	2	3	4	5	NA
54.	Overall quality of the third and fourth years	1	2	3	4	5	NA
55.	Effectiveness of methods for assessing clinical skills in clerkships	1	2	3	4	5	NA
56.	Availability of patients for clinical teaching	1	2	3	4	5	NA
57.	Overall workload in the first and second years	1	2	3	4	5	NA
58.	Overall workload in the third (clerkship) year	1	2	3	4	5	NA
59.	Ability to provide input on course/clerkship quality	1	2	3	4	5	NA
60.	School responsiveness to student feedback about teaching	1	2	3	4	5	NA

Please circle the number indicating your level of satisfaction, using the following scale:

1 = Very Dissatisfied/Strongly Disagree
2 = Dissatisfied/Disagree
3 = Neither satisfied or dissatisfied, Neither Agree or Disagree
4 = Satisfied/Agree
5 = Very satisfied/Strongly Agree
NA = No opportunity to observe/No opinion

FIRST- AND SECOND-YEAR/ACADEMIC PERIOD COURSES*

Course 1: Clarity and appropriate use of objectives	1	2	3	4	5	NA
Course 1: General course organization	1	2	3	4	5	NA
Course 1: Quality of teaching	1	2	3	4	5	NA
Course 1: Academic workload/demands on student time	1	2	3	4	5	NA
Course 1: Appropriateness of teaching methods	1	2	3	4	5	NA
Course 1: Incorporation of clinically relevant material	1	2	3	4	5	NA
Course 1: Feedback about your progress in learning the material	1	2	3	4	5	NA
Course 1: Fairness of exams and grading	1	2	3	4	5	NA
Course 1: Helpfulness in preparing you for clerkships	1	2	3	4	5	NA
Course 1: Helpfulness in preparing you for USMLE exams	1	2	3	4	5	NA
Course 1: Overall course quality	1	2	3	4	5	NA

(Repeat for all required courses)

*** Insert course names to reflect your school's curriculum**

THIRD- AND FOURTH-YEAR COURSES AND CLERKSHIPS*

Clerkship 1: Clarity and appropriate use of objectives	1	2	3	4	5	NA
Clerkship 1: General clerkship organization	1	2	3	4	5	NA
Clerkship 1: Quality of faculty teaching	1	2	3	4	5	NA
Clerkship 1: Quality of resident teaching	1	2	3	4	5	NA
Clerkship 1: Academic and clinical workload/time to study	1	2	3	4	5	NA
Clerkship 1: Variety of patient experiences	1	2	3	4	5	NA
Clerkship 1: Level of involvement in patient care	1	2	3	4	5	NA
Clerkship 1: Faculty/resident supervision of patient care activities	1	2	3	4	5	NA
Clerkship 1: Emphasis and feedback on development of clinical skills	1	2	3	4	5	NA
Clerkship 1: Observation of clinical skills	1	2	3	4	5	NA
Clerkship 1: Feedback about your performance during the clerkship	1	2	3	4	5	NA
Clerkship 1: Fairness of exams and grading	1	2	3	4	5	NA
Clerkship 1: Helpfulness in preparing you for USMLE exams	1	2	3	4	5	NA
Clerkship 1: Timeliness of grade-reporting	1	2	3	4	5	NA
Clerkship 1: Overall clerkship quality	1	2	3	4	5	NA

(Repeat for each required clerkship and course)

*** Insert course or clerkship titles to reflect your school's curriculum**

9. APPENDIX C TO THE INTERIM SURVEY REPORT WRITING GUIDE

Interim Accreditation Survey Team

Example Terms of Reference

The following Terms of Reference have been developed by several of the AFMC IRCs some of whom have conducted an Interim Accreditation Survey and other IRCs who felt that consensus on the composition and function of the Interim Accreditation Survey Team would be helpful in recruiting faculty members, administrative staff and students to participate as members of the Interim Accreditation Survey Team and ensure that the process works optimally. This document is meant to serve as a guide and not a requirement. IRCs should feel free to modify the terms of reference to best suit the conditions at their school.

Note: Some schools have constituted a Standing Accreditation Review Committee that conducts the Interim Accreditation Survey and also participates in ongoing review of formal accreditation activities.

MEMBERSHIP

- Chair: Interim Review Coordinator
- External IRC: to be chosen by the school
    - Note: Invite the External IRC early when the survey visit is set, however the External IRC does not participate until about four to six weeks before the visit
- Committee of 5-6 faculty (clinical teaching, clinical sciences, basic sciences (biomedical and/or behavioral)).
- 4 students (2 junior[1] and 2 senior to maximize likelihood of 2 students at each meeting)
- Administrative Support[2] : Project Manager/Accreditation Review Coordinator/Administrator/Assistant

MANDATE

- Review data available for completion of checklists for each standard with particular attention to where student feedback data is required
- Judge adequacy of data for completion of checklists; request additional data if required
- Determine what type of, and how student feedback should be obtained e.g., student-led survey, focus groups
- Distribute checklists to appropriate faculty or administrators with responsibility for specific areas in the program e.g. Checklists for ED-33, 35 and 37 to the Curriculum Committee and to any administrative support units[3]
- Complete some checklists based on the appropriate data
- Review checklists completed by other faculty members and administrators
- On basis of checklists, decide on probable compliance with standard
    - If necessary, request additional information or meetings with faculty and/or administrators
- Recommend and/or revise actions to achieve compliance in cases where it appears necessary, or refer matter to another office or group for these recommendations
- Participate in the onsite survey (1.5-2 days) during which areas in need of improvement and plans to address them are further developed and areas in need of monitoring and how that should be done are confirmed

- Review draft Interim Accreditation Survey report and contribute to final recommendations to address areas in need of improvement and monitoring, including priority, timelines and responsible individuals.
- Provide feedback on Interim Review process

MEETINGS

The Interim Survey Team will meet once per month for the first 5-7 months and then twice monthly until the time of the onsite visit for about 1.5-2 hours. Minutes of all meetings will be kept.

1. Note: involvement of junior students helps with corporate knowledge within the student body for the next full CACMS/LCME survey.
2. Note: The above titles reflect those within schools that have conducted an Interim Survey. The type(s) and title(s) of the administrative support will differ across the schools and reflect the available resources.
3. These faculty members or administrators should indicate on the checklist, the source and location of data and/or policies and ways to achieve compliance in cases where deficiencies are noted i.e., where No has been checked.