Instructions for completing the Annual Program Evaluation (APE)

PROCESS

- Convene a meeting of the **Program Evaluation Committee (PEC)** prior to the end of the academic year. This committee must:
  - consist of at least one trainee and two faculty members, at least one of whom is a core faculty member;
  - discuss all required elements contained in the APE form, and then distribute the completed APE document and Action Plan to the members of the teaching faculty and trainees.
- Submit the APE form, along with the Multi-Year Action Plan, to the GME Office via email.
- Save your APE and Action Plans annually on your shared drive, as you will need to refer to these documents during the **Self-Study process**.

DOCUMENTS TO REVIEW WHILE PREPARING THE APE FORM

- The **ACGME Resident/Fellow and Faculty Surveys** are available in ADS for most programs and should be used as one of the elements of program assessment.
- Action Plan from the previous academic year
- Internal, written evaluations of the program by trainees and faculty
- In Service Exam Data
- Board Pass Rates
- Refer to the "*High-Value Data*" document for a suggested document list

DOCUMENTS TO SUBMIT TO THE GME OFFICE (due July 19, 2024)

Please submit via email to mgbgmeoffice@mgb.org:

- **Completed APE Form**
- **Multi-Year Action Plan**: the "APE AP Multi-Year" template should be used for documenting multiple years of action plans. Please submit the last two years of action plans (AY23 and AY24) on this form and **save an electronic version for your records**.

For questions, please contact the accreditation manager assigned to your program.

ADDITIONAL GUIDANCE FOR ANSWERING APE QUESTIONS

Q3. Program aims

Per CPR IV.A.1(Core), the curriculum must contain a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates.

As described in Step 2 of the Self-Study preparation process: Aims are program and institutional leaders' views of key expectations for the program, as well as how the program differentiates itself from other programs in the same specialty/subspecialty. Aims may focus on the types of trainees recruited by the program, or on preparing graduates for particular careers (clinical practice, academics, research, or primary/generalist care). Aims may also include other objectives, such as care for underserved patients, health policy or advocacy, population health, or generating new knowledge.

Q6. Challenges/Threats to the Program

As described in Step 4 of the Self-Study preparation process: Threats are largely beyond the program's control and come in many forms. They could result from a change in support for resident/fellow education at the national level, from changing priorities at the institutional or state level, or from local factors, such as erosion of a primary ambulatory system based on voluntary faculty. The benefit of assessing program threats is that plans can be developed to mitigate their effect.

Q7. Opportunities for the Program:

As described in Step 4 of the Self-Study preparation process: Opportunities are external factors that are not entirely under the control of the program, but if acted on, will help the program flourish. Opportunities take many forms, such as access to expanded populations for ambulatory care at a local health center, partnering with an institution with a simulation center, or availability of new clinical or educational technology through agreements with external parties.

Q8. Program Curriculum:

Programs should review their curriculum, including Goals and Objectives, annually and may utilize feedback from the Clinical Competency Committee (CCC) as part of this review. Examples of curriculum changes may include: addition/deletion/modification to rotations, electives and didactics (e.g., subspecialty-specific or inter-specialty conferences; quality improvement, patient safety, and healthcare disparity topics; preparation for in-training exams or the Boards); changes to patient care or procedural experiences (e.g., changes to clinic frequency; patient population diversity; education in a community hospital setting); updates to goals and objectives; etc.