Clinical Competency Committee:

ACGME Requirements and a Case Study of University Residency Programs

Joanne K. Baker D.O. FACOI, FAODME, FHM, FACP

Professor, Internal Medicine

WMU Homer Stryker M.D. School of Medicine

Western Michigan University
Homer Stryker M.D.
School of Medicine

No Financial Disclosures

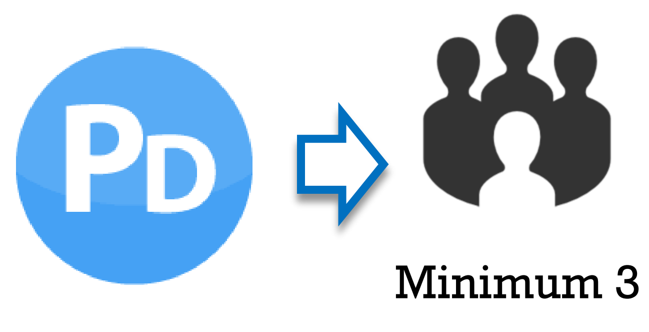
Objectives

- Provide the ACGME framework for the Clinical Competency Committee (CCC) and the requirements for programs.
- Demonstrate examples of the structure, function and process of the CCC in university based residency programs
- Reflect on lessons learned after 6 years of meetings.

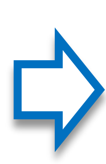
Clinical Competency Committee (CCC)

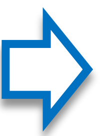
- The CCC is the ACGME required body comprising three or more members of the active teaching faculty who is advisory to the program director and reviews the process of all residents in the program.
- The ultimate purpose is to demonstrate accountability as medical educators to the public, that graduates will provide high quality, safe care to patients and maintain the standards of the health care system.

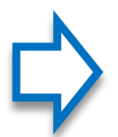
Requirements of a CCC



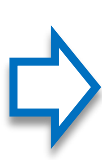
Minimum 3





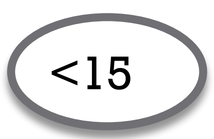


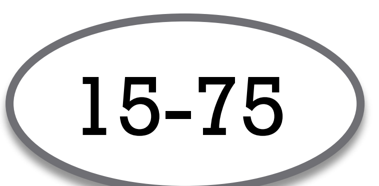
Responsibilities

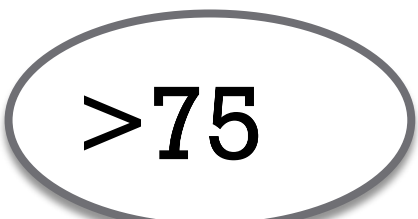


CCC structure

- Frequency of meetings – minimum of twice yearly but some may find it helpful to meet more often
- Large Programs may need more than one CCC and could be by PGY year or clinical location site or how best the program feels to divide up into groups.







Program Director (PD)

- There is no mandatory role for the program director, and he or she can be chair, member, observer, or not attend at all.
  - Anesthesiology RRC does not allow the program director to chair the CCC, other RRC's are silent

- The PD has the final decision on milestones, as he/she has the authority for the summative decisions relative to resident promotion and graduation.

Academic Emergency Medicine
Official Journal of the Society for Academic Emergency Medicine

BRIEF REPORT

How Do Emergency Medicine Residency Programs Structure Their Clinical Competency Committees? A Survey

Christopher I. Doty, MD, Lynn P. Roppolo, MD, Shellie Asher, MD, MS, Jason P. Seamon, DO, MHS, Rahul Bhat, MD, Stephanie Taft, MD, Autumn Graham, MD, and James Willis, MD

ACADEMIC EMERGENCY MEDICINE 2015;22:1351–1354 © 2015 by the Society for Academic Emergency Medicine

80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%

APD
Core Faculty
PD

116 of 160 EM programs responded

Other Findings

- CCC average size 7.4 with range of 3-15
- 53.1% CCC met quarterly and 37% monthly
- 36% had resident faculty mentor/advisor discuss or present the patient

Program Administrators (PA)

- Assist
- Communicating
- Capture
- No Judgements

CCC Assessment Information

- Milestones were not meant to be stand-alone assessments.
- Some may choose to use all milestones on their end of rotation evaluations.

Drawback of Milestones as Evaluations

- Cognitive overload for evaluators, especially community faculty
- Faculty may feel pressured to evaluate a milestone they didn't observe – leading to "straight lining" and "halo effects"

Core Methods of Assessments-examples

- Direct Observation of specific components
- Multi-source feedback
- In-service examination
- Longitudinal evaluations
- Clinic performance

Competency	Method	Example
Patient Care		
	Simulation	Partial task trainers for procedures; virtual reality
	Standardized patient	Objective standardized clinical exams (OSCEs)
	Clinical performance review	Medical record audits using quality and safety measures
	Procedure log with assessment of competency	Surgical case logs with/without entrustment scales
	Faculty evaluations	Evaluation forms using developmental, supervision, or entrustment scales
Medical Knowledge		
	In-training Examination (ITE)	Most specialties now have an ITE provided either by their certification board or a specialty society
	Work-based assessments of medical knowledge	SNAPPS framework; mini-clinical evaluation exercise (MiniCEX)
	Oral-guided chart review	Chart-stimulated recall
Interpersonal and Communication Skills		
	Multi-source feedback (MSF)/ "multirater"/360°	Some tools available; most home grown
	Patient survey	CAHPS suite of survey tools www.ahrq.gov/cahps/index.html

Practice-based Learning and Improvement		
	Self-assessment	Milestones self-assessment followed by a compare/contrast review of CCC Milestones ratings with a mentor or advisor
	Evaluation of resident teaching skills	Evaluation forms
Professionalism		
	Contribution to institution's "error reporting"	Spontaneous error reporting; root cause analysis
	Multi source feedback (MSF)/"multirater"/360°	Some tools available; most home grown.
	Patient survey	CAHPS suite of survey tools
Systems-based Practice		
	Quality improvement (QI) project	Can judge quality of a QI project using several tools; can measure impact of QI project through clinical performance measures
	Contribution to institution's "error reporting"	Spontaneous error reporting; root cause analysis

How do clinical competency committees use different sources of data to assess residents' performance on the internal medicine milestones? A mixed methods pilot study

Andem Ekpenyong[a], Elizabeth Baker[a], Ilene Harris[b], Ara Tekian[b], Richard Abrams[a], Shalini Reddy[c] and Yoon Soo Park[b]

[a]Internal Medicine, Rush University Medical Center, Chicago, IL, USA; [b]Medical Education, University of Illinois, Chicago, Chicago, IL, USA; [c]Internal Medicine, University of Chicago Pritzker School of Medicine, Chicago, IL, USA

MEDICAL TEACHER, 2017
VOL. 39, NO. 10, 1074–1083
https://doi.org/10.1080/0142159X.2017.1353070

CCC Member Weights for Different Assessments

Mean Weight % ± 95% Confidence Intervals

0 5 10 15 20 25 30 35 40

Evaluation Comments Peers Personal Subcommittee Whole

Figure 1. Mean relative weights (%) for different types of assessments[1–7]: Data aggregated over reporting periods (Mean ±95% confidence intervals). Note: 1. "Evaluation" is mean rotation evaluation ratings (completed by faculty raters): Mean = 37%, SD = 21%. 2. "Comments" is comments made in rotation evaluation forms: Mean = 27%, SD = 11%. 3. "Peers" is information from faculty peers: Mean = 9%, SD = 4%. 4. "Personal" is CCC member personal experience with trainees: Mean = 14%, SD = 11%. 5. "Subcommittee" is perspectives from CCC subcommittee meeting discussion: Mean = 8%, SD = 3%. 6. "Whole" is perspectives from CCC whole group meeting discussion: Mean = 6%, SD = 5%. 7. Others included in the survey; all CCC members reported 0% weight in this category.

A Multicenter Prospective Comparison of the Accreditation Council for Graduate Medical Education Milestones: Clinical Competency Committee vs. Resident Self-Assessment

Journal of Surgical Education • *Volume 74/Number 6* • *November/December 2017*

Rotation evaluations
Operative evaluations
Word of mouth by CCC members that have recently rotated with the resident
Resident peer evaluations
ABSITE results
Operative log
Nursing evaluations
Program director 6 month reviews
Prior Milestones evaluation (6 months prior)
Duty hour documentation
Research / Academic productivity
Conference attendance rate
Patient evaluations
Clerical staff evaluations
Validated clinical evaluation tools (ie OSCEs)
Simulation lab experiences/evaluations
Resident self-assessment
FES / FLS
Medical student evaluations

0 1 2 3 4

FIGURE 3. Mean impact rating for each factor included in resident assessment by clinical competency committee (0 = no impact and 4 = high impact).

Cognitive Demands and Bias: Challenges Facing Clinical Competency Committees

Chandlee C. Dickey, MD
Christopher Thomas, MD
Usama Feroze, MD
Firas Nakshabandi, MD
Barbara Cannon, MD

Journal of Graduate Medical Education, April 2017

Examples of Bias That Can Occur During Clinical Competency Committee (CCC) Deliberations

Bias	Definition	Example
Anchoring	Holding on to an initial observation or opinion and not acknowledging changes.	A poor patient history and physical examination performance by someone in PGY-1 may "anchor" in an attending's mind and result in assigning a level that is too low later in residency.
Availability	Giving preference to data that are more recent or more memorable.	In a CCC meeting, an attending may give more weight to his or her own observations of a resident than to observations of attendings from other rotations.
Bandwagon	Believing things because others do.	Faculty member mentions an insignificant mishap by a resident, and other members join in and mention other minor mishaps that would not have been described otherwise.
Confirmation	Focusing on data that confirm an opinion and overlooking evidence that refutes it.	Faculty member with a negative opinion of a resident recalls a single instance of prescribing error and neglects the 99% of prescriptions written correctly.
Framing effect	Forming an opinion based on how data are presented.	Training director may frame a CCC task as demonstrating to the ACGME that the program is strong. Faculty may feel pressure to adjust level determinations and overrate residents in the later years of their training.

Groupthink	Judgment influenced by overreliance on consensus.	CCC members may choose not to challenge a level determination in order to preserve group camaraderie. Some committee members, such as senior faculty or the training director, may exert undue influence over other committee members.[1,11]
Overconfidence	Having greater faith in one's ability to make a judgment than is justified.	CCC members may have too little data to determine a milestone level, yet feel comfortable selecting a level.
Reliance on gist	Judgments based more on context than on specific observation or measurement.[12]	A member may think, "This is a strong resident; 2.5 is appropriate," rather than detailing specific information gathered from evaluations to support choosing that level.
Selection	Relying on partial information that is not truly random or representative.	A faculty member may meet the training director by chance in the hallway and describe a resident's minor breach of professionalism. Had he or she not met the training director, the story might not have been relayed. Now the training director may place too much emphasis on the event during CCC discussions.
Visceral	Judgment influenced by emotions rather than objective data.	A "favored" or personally attractive resident may receive a higher level than another resident for a similar performance.

Case Review of 9 Residency Programs

- Emergency Medicine
- Family Medicine
- General Surgery
- Internal Medicine
- Medicine/Pediatrics
- Obstetrics/Gynecology
- Orthopedic Surgery
- Pediatrics
- Psychiatry

Emergency Medicine - 55 Residents and 23 Milestones

Resident

Does the Resident Complete Their Own Milestones?
Yes

Who Completes Milestones?
3-4 Faculty complete on each class of residents. Average scores presented to CCC

Who is the CCC?
PD chair,
13 Core faculty Small Group Discussion with PD making final assessment

Frequency of Meetings?
Meets 2 times per year

Who Reviews Final Milestones with Resident?
PD reviews with the resident at next biannual meeting

Lessons Learned in Emergency Medicine

- Overall, happy with the process, but is working on a way to cut down on the amount of paperwork that comes from New Innovations to prepare for the CCC
- Has been helpful in identifying the struggles of a resident earlier

Family Medicine - 24 Residents and 27 Milestones

Resident

Does the Resident Complete Their Own Milestones?

Yes

Who Completes Milestones?

Advisor present data on resident at CCC and the group completes milestones together

Who is the CCC?

PD chair and 5 core faculty

Frequency of Meetings?

Meets 4 times per year, review all residents each meeting with formal milestones at 2 of them

Who Reviews Final Milestones with Resident?

Advisor reviews with the resident after milestones finalized

Advisors and Mentors

- Role of advisors/mentors: There are some viewpoints that suggest that Advisor/Mentors should be excluded. This prohibition is not reflected in the Common Program Requirements
- Program directors may want to consider whether there is an inherent conflict of interest in a faculty member being an advocate for a resident/fellow (as his/her advisor mentor) and "judging" performance (as a CCC Member)
- On the other hand, advisors and mentors may benefit from being observers to the CCC and hearing or contributing information to the discussion.

Family Medicine - 24 Residents and 27 Milestones

Who Reviews Final Milestones with Resident?
Advisor reviews with the resident after milestones finalized

Resident

Does the Resident Complete Their Own Milestones?
Yes

Who Completes Milestones?
Advisor present data on resident at CCC and the group completes milestones together

Who is the CCC?
PD chair and 5 core faculty

Frequency of Meetings?
Meets 4 times per year, review all residents each meeting with formal milestones at 2 of them

Lessons Learned in Family Medicine

- Started with resident doing a self-evaluation first year and then stopped, found it valuable and it was added in year 4.
- Looking to the change the process so less work at the CCC and more work ahead of time
- Happy with the process and it helped to identify weaknesses in the program with the QI process
- Uses the non-milestone meetings to review ILP progress and residents with areas of concern.

General Surgery - 20 Residents and 16 Milestones

Who Reviews Final Milestones with Resident?
PD reviews with the resident the CCC milestones and resident self evaluation

Resident

Does the Resident Complete Their Own Milestones?
Yes

Who Completes Milestones?
All members of CCC complete milestone on each resident. Average score presented at CCC

Who is the CCC?
4 Core faculty and select community faculty

Frequency of Meetings?
Meets 2 times per year

Lessons learned in General Surgery

- Learned over time to have the members complete their milestones ahead of time and then program coordinator compiles an average score for each milestone for each resident. The CCC is used to add comments to each residents progress.
- Overall happy with the more specific and concrete feedback to the resident

Internal Medicine- 35 Residents and 22 Milestones

Resident

Does the Resident Complete Their Own Milestones?

Yes

Who Completes Milestones?

Mentor completes with resident prior to CCC and then presents to the CCC for group decision

Who is the CCC?

All IM core faculty and community faculty invited

Frequency of Meetings?

Meets 2 times per year

Who Reviews Final Milestones with Resident?

Mentor reviews final milestones and CCC feedback form after

Clinical Competency Committee (CCC) Feedback to the Resident

Date:

Resident: PGY:

Overview of any changes to the Milestones as identified between resident and Mentor

Identified Areas of Strength

Identified Areas to Improve

Resident ____ Date____________

(Signature)

Faculty ____ Date____________

(Signature)

Addition to Milestones form for clarification

Med Student	New PGY 1	Mid-PGY 1	Early PGY 2	Mid-PGY 2	Early PGY 3	Graduating PGY 3	Physician in Practice	Exemplary Physician
1	2	3	4	5	6	7	8	9

1. Gathers and synthesizes essential and accurate information to define each patient's clinical problem(s). (PC1)				
Critical Deficiencies			**Ready for unsupervised practice**	**Aspirational**
Does not collect accurate historical data Does not use physical exam to confirm history Relies exclusively on documentation of others to generate own database or differential diagnosis Fails to recognize patient's central clinical problems Fails to recognize potentially life threatening problems	Inconsistently able to acquire accurate historical information in an organized fashion Does not perform an appropriately thorough physical exam or misses key physical exam findings Does not seek or is overly reliant on secondary data Inconsistently recognizes patients' central clinical problem or develops limited differential diagnoses	Consistently acquires accurate and relevant histories from patients Seeks and obtains data from secondary sources when needed Consistently performs accurate and appropriately thorough physical exams Uses collected data to define a patient's central clinical problem(s)	Acquires accurate histories from patients in an efficient, prioritized, and hypothesis-driven fashion Performs accurate physical exams that are targeted to the patient's complaints Synthesizes data to generate a prioritized differential diagnosis and problem list Effectively uses history and physical examination skills to minimize the need for further diagnostic testing	Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis Identifies subtle or unusual physical exam findings Efficiently utilizes all sources of secondary data to inform differential diagnosis Role models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic testing

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Comments:

Med Student 1	New PGY 1 2	Mid-PGY 1 3	Early PGY 2 4	Mid-PGY 2 5	Early PGY 3 6	Graduating PGY 3 7	Physician in Practice 8	Exemplary Physician 9

Osteopathic Milestones

PGY 1	late PGY 1	PGY 2	early PGY 3	Graduating PGY 3		NMM Fellow	In Practice	Exemplary Physician
1	2	3	4	5	6	7	8	9

Patient Care 1: Osteopathic Principles for Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
Describes the inclusion of osteopathic principles, including the four tenets, when caring for patients Incorporates osteopathic principles when obtaining a history, performing an examination, synthesizing a differential diagnosis, and devising a patient care plan with direct assistance from supervisor	Incorporates osteopathic principles, including the four tenets, to promote health and wellness in patients with common conditions Incorporates osteopathic principles when obtaining a history, performing an examination, interpreting diagnostic testing, synthesizing a differential diagnosis, and devising a patient care plan, with supervision	Independently incorporates osteopathic principles to include the four tenets to promote health and wellness in patients with complex or chronic conditions Independently incorporates osteopathic principles when obtaining a history, performing an examination, interpreting diagnostic testing, synthesizing a differential diagnosis, and devising a patient care plan for patients with common conditions	Mentors others to incorporate osteopathic principles to promote health and wellness Independently incorporates osteopathic principles when obtaining a history, performing an examination, interpreting diagnostic testing, synthesizing a differential diagnosis, and devising a patient care plan for patients with multiple comorbidities	Role models and teaches the effective use of osteopathic tenets to optimize patient health Role models and teaches the effective use of osteopathic focused history, exam, and treatment to minimize the need for further diagnostic testing or intervention

Comments:

Not Yet Achieved level 1

PGY 1	late PGY 1	PGY 2	early PGY 3	Graduating PGY 3		NMM Fellow	In Practice	Exemplary Physician
1	2	3	4	5	6	7	8	9

Lessons Learned in Internal Medicine

- Addition of the clarification scale on milestones has been well received by both faculty and residents and provided more consistent grading across both faculty and residents.
- Increased satisfaction in the Milestones process with use of the CCC feedback form and feedback given soon after the CCC meeting

Obstetrics/Gynecology - 16 Residents and 28 Milestones

Who Reviews Final Milestones with Resident?
Mentor and resident review at next semi-annual meeting with PD present if concerns

Resident

Does the Resident Complete Their Own Milestones?
No

Who Completes Milestones?
Mentor completes milestones and then presents to CCC

Who is the CCC?
PD absent, 2 core faculty and 2 community faculty

Frequency of Meetings?
Meets 2 times per year

Lessons Learned

- First year of residency program
- Expect to adapt as the program grows

Pediatrics - 24 Residents and 21 Milestones

Who Reviews Final Milestones with Resident?
Mentor, PD and resident review at semi-annual meeting held after CCC

Resident

Does the Resident Complete Their Own Milestones?
Yes

Who Completes Milestones?
Non-mentor faculty completes prior to CCC and presents evaluation to the group. The group makes final decision.

Who is the CCC?
APD chairs, PD present, faculty and 2 community faculty

Frequency of Meetings?
Meets 2 times per year with multiple sessions each time

Lessons Learned in Pediatrics

- PD likes the self-evaluation with the ILP and resident completes prior to mentor meeting.
- Program Administrator takes notes on all comments made with the CCC and shares them with PD, mentor and Resident
- Likes the efficiency of feedback that is given to the resident and faculty.

Medicine/Pediatrics- 16 Residents and 22/21 Milestones

Who Reviews Final Milestones with Resident?
*Mentor meets with the resident
CCC Feedback form used

Resident

Does the Resident Complete Their Own Milestones?
Yes for both

Who Completes Milestones?
Mentor completes after meeting with Resident & review self-eval.
Presents to both CCC's

Who is the CCC?
Med/Peds faculty meet with the IM CCC (see previous) and Pediatric CCC (see previous)

Frequency of Meetings?
Twice a year – all residents at both CCC and files milestones from June CCC

Lessons Learned in Med/Peds

- Likes to have the milestones completed twice a year and have more than MedPeds faculty provide feedback.
- Downside is the amount of paperwork with twice the volume of milestones to complete and data to review.

Psychiatry- 24 Residents and 23 Milestones

Resident

Does the Resident Complete Their Own Milestones?
Yes

Who Completes Milestones?
Supervisor reviews all data and completes milestones after meet with resident

Who is the CCC?
PD chairs 2 CCC – CCC grouped by supervisor. Half meet in afternoon, other half in evening

Frequency of Meetings?
Each CCC Meets 2 times per year

Who Reviews Final Milestones with Resident?
PD reviews with the resident at biannual meeting then they meet with supervisor

Lessons Learned in Psychiatry

- Concern over descriptors used in the milestones, however they are in process of being updated.
- Has been helpful in identifying areas of deficiency earlier, giving more time to work on them.
- Has been helpful in a data format when a struggling resident had to be released from the program. Clear areas of deficiencies where identified and a committee decision instead of PD alone.

Orthopedics- 15 Residents and 41 Milestones

Resident

Does the Resident Complete Their Own Milestones?
No

Who Completes Milestones?
All Members of the CCC evaluate each resident pre- meeting. Each resident is reviewed at the CCC

Who is the CCC?
Ortho Chair chairs the meeting, PD observer with all core faculty required and 20-30 community faculty requested

Frequency of Meetings?
Twice a year

Who Reviews Final Milestones with Resident?
PD meets with the resident at their biannual meeting

Lessons Learned in Orthopedics

- Due to some of the very specific milestones, they have added some of those into rotation specific evaluations.
- Added Research projects into the most recent CCC
- Sees frustration on a national level with the RRC decision to have 41 milestones and over some of the specific milestones

Final Comments

- 8 of the 9 programs have found the milestones to be helpful and have had them reveal areas of deficiency in a resident earlier on and have provided more concrete areas to review with the resident.
- 1 of the 9 programs found the process of CCC meetings with faculty comments documented and the milestone documentations were helpful in releasing a struggling resident from a program. Better illustrated where the resident was not improving. It showed a department decision and not just the program director.
- Most of the programs have identified areas within the residency program that could be improved upon.
- Most programs have found the resident completing their own milestones to be revealing as well and to stimulate better discussion with the resident.

References

- Program Directors at WMU Homer Stryker M.D. School of Medicine
- ACGME Clinical Competency Committees Guide, current as of September, 2017
- Laura Edgar, EdD, CAE. Vice President, Milestones Development, ACGME
- How do CCC's use different sources of data to assess resident's performance on the IM milestones. Medical Teacher 39:10, 1074-1083
- Reviewing Residents' Competence: A Qualitative Study of the Role of CCC in Performance Assessment. Academic Med Aug 2015, Vol 90(8) p 1084-1092
- Multicenter Prospective Comparison of the ACGME Milestones: CCC vs Resident Self-Assessment Journal of Surgical Education 2017 APDS Spring Meeting e8
- Thresholds and Interpretations: How CCCs identify pediatric residents with performance concerns. Medical Teacher 40:1, 70-79.
- How Do Emergency Medicine Residency Programs Structure their CCC? A Survey. Academic Emergency Medicine November 2015, Vol 22 No 11
- Using the ACGME Milestones for Resident Self-Evaluation and Faculty Engagement Journal of Surgical Education Vol 73 (6) 2016
- Cognitive Demands and Bias: Challenges Facing Clinical Competency Committees
- Perspectives. Journal of Graduate Medical Education April 2017

joanne.baker@med.wmich.edu

please email me if you would like a copy of my slides

QUESTIONS???