ACGME

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

Clinical Competency Committees

A Guidebook for Programs

Kathryn Andolsek
Duke University

Jamie Padmore
Medstar- Georgetown

Karen E. Hauer
UCSF

Eric Holmboe
ACGME

This information is current as of January 2015

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Executive Summary

The Clinical Competency Committee (CCC) is a structure that has emerged as an essential component of the evaluation process in graduate medical education. While some specialties and programs have utilized CCCs for years, this structure is new to many others. Likewise, with the emergence of the CCC as a required component of accreditation (ACGME Common Program Requirements), even seasoned programs and committees are facing questions regarding structure, function, and process.

The purpose of this manual is to provide designated institutional officials (DIOs), program directors, faculty members, CCC members, coordinators, and residents and fellows with information and practical advice regarding the structure, implementation, function, and utility of a well-functioning CCC. The materials were prepared for both individual learning and application in a group setting. It is our intent that programs will be able to utilize these materials to have meaningful faculty conversations and development on CCC functions and outcomes, and greater transparency with residents and fellows on the nature of assessment in competency-based education.

This manual provides information related to the following topics:

1. CCC purpose
2. Structure and membership
3. Meeting preparation
4. Running the meeting
5. Post-meeting documentation and follow-up
6. Legal issues and considerations
7. Annotated bibliography
8. Q&A

There are several appendices included that contain tools for programs and CCCs to utilize. We have also provided a robust reference list to support the various aspects of CCCs, including assessment, feedback, documentation, group dynamics, and outcomes.

We look forward to your feedback, and hope this manual provides you and your faculty with valuable information and tools to enhance your GME program.

(1/2015)

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Introduction

A **Clinical Competency Committee** (CCC) is the Accreditation Council for Graduate Medical Education (ACGME)-"*required body comprising three or more members of the active teaching faculty who is advisory to the program director and reviews the progress of all residents in the program.*"[1]

While some specialties have used a CCC for a number of years, the CCC represents a new structure and process to many other programs. The objectives of these materials are to help programs:

1. Recognize the role and purpose of the CCC for individual programs and in the ACGME's Next Accreditation System (NAS)
2. Design, create, and implement a CCC
3. Run an effective CCC meeting
4. Provide feedback to residents or fellows
5. Anticipate process questions and academic law considerations
6. Analyze evidence supporting CCCs to make the best choices for their own CCC process

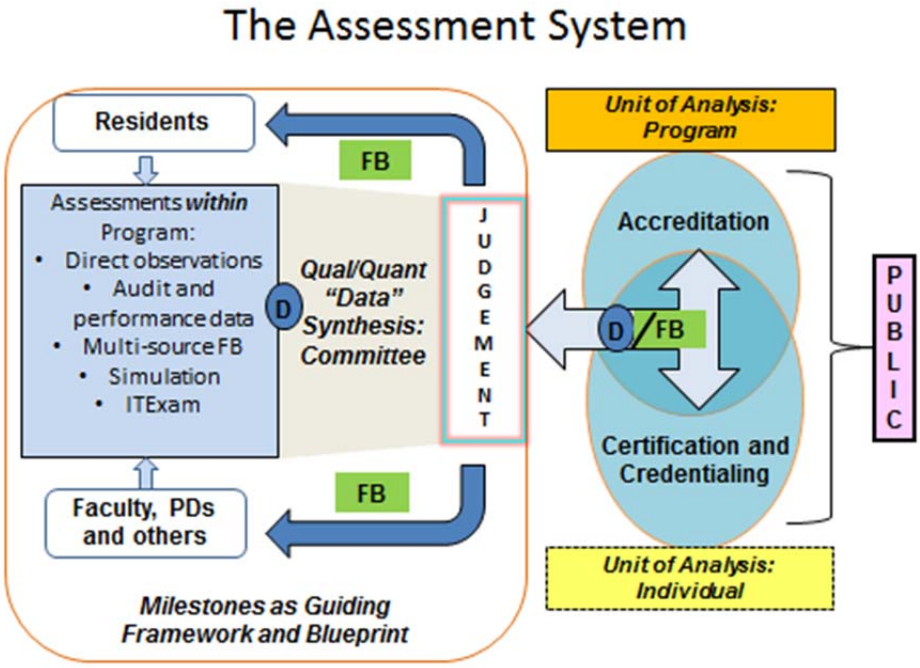
This guidebook is intended to be a practical and useful resource and professional development tool to help institutional and program leadership, coordinator(s), faculty members, and residents/fellows understand all aspects of CCCs. We encourage you to share these materials with your residency or fellowship program faculty and leadership, and use the exercises as part of faculty and coordinator professional development. These materials can be completed individually or in a group meeting. The guidebook also provides some suggestions for faculty development.

The CCC is an essential component, but still only one part, of a high performing residency or fellowship program. It contributes to an effective resident/fellow assessment "system" as outlined in Figure 1. In this figure, the CCC serves the important function to synthesize the multiple quantitative and qualitative assessments. This figure highlights several important points:

1. The CCC process will depend on the quality of the assessment program that includes a combination of assessment methods.[2]
2. Residents and fellows must be active agents in this system; guided self-directed assessment behaviors by the resident or fellow should be strongly encouraged.
3. The program director within a residency or fellowship program is the ultimate arbiter of whether a resident or fellow will enter unsupervised practice. The program will perform the majority of the assessments that will inform the final entrustment decision to graduate a resident or fellow from the program. This accountability cannot be over-emphasized: professional self-regulation depends heavily on the judgment of training programs, as manifest by the final evaluation and entrustment made by the program director.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Figure 1 *Structure of a High Performing Resident/Fellow Assessment System*



Residents = both residents and fellows
FB = Feedback loops
D = Assessment data and information
The model is more fully described in ***Appendix A***

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Part 1: Purpose of the CCC

Purpose of the Clinical Competency Committee (CCC) for the Program and the Next Accreditation System (NAS)

The CCC serves several purposes, for the program director, the program itself, the faculty, the residents/fellows, the ACGME, and the specialty. **See Table 1.** The ultimate purpose is to demonstrate our accountability as medical educators to the public, that our graduates will provide high quality, safe care to our patients and maintain the standards of the health care system.

Table 1 Purposes of a CCC

Purpose of CCC	
Program Director	□ Fulfill Public Accountability by ensuring: • Residents/fellows who successfully complete program can practice the specialty-specific core professional activities without supervision □ Create greater "buy-in" from a group of faculty members to make decisions regarding performance □ Enhance credibility of judgments about resident/fellow performance □ Facilitate role of "advocate" for the resident/fellow
Program	□ Develop shared mental model of what resident/fellow performance should "look like" and how it should be measured and assessed □ Ensure assessment tools sufficient to effectively determine performance across the competencies □ Increase quality, standardize expectations, and reduce variability in performance assessment □ Contribute to aggregate data that will allow programs to learn from each other by comparing residents' and fellows' judgments against national data □ Improve individual residents/fellows along developmental trajectory □ Serve as system for early identification of residents/fellows who are challenged □ Improve program □ Model "real time" faculty development
Faculty	□ Facilitate more effective assessment that may be easier for evaluators □ Help faculty develop a shared mental model of the competencies □ May result in simplified "more actionable" assessment tools to help faculty document more effectively and efficiently what they observe trainees doing in clinical settings
Resident/Fellow	□ Improve quality and amount of feedback; normalize constructive feedback □ Offer insight and perspectives of a group of faculty members □ Compare performance against established competency benchmarks (rather than only against peers in the same program) □ Allow earlier identification of sub-optimal performance that can improve remedial intervention □ Improve stretch goals for residents/fellows to achieve higher levels of performance □ Provide transparency around performance expectations

©2015 Accreditation Council for Graduate Medical Education (ACGME)

ACGME	□ Enhance progress toward competency-based education with outcomes data □ Establish national benchmarks for trajectory of resident/fellow skill acquisition □ Enhance identification of programs that need to improve (programs whose residents/fellows aren't making progress as compared to national peer group) □ Provide better measures for public accountability □ Provide feedback loop as to whether -- and when -- programs are able to meet expectations of the specialty RRC, thus enabling reasonable expectations □ Enable continuous quality improvement of residency/fellowship programs □ Document the effectiveness of the nation's GME efforts in provision of graduates prepared to meet the needs of the public.

The concept of CCCs is not just a US phenomenon. The United Kingdom instituted an *Annual Review of Competence Progression* in 2007.[3-4] The Canadian system also uses Residency Program Committees (RPC) and is exploring how to use a group process as part of its new Milestones-based GME system. CCCs are not new in the US; some programs, such as in internal medicine, used them in the 1980s, in concept, if not in name. The specialty of anesthesiology has implemented them within its residencies for many years and required, in collaboration with the American Board of Anesthesiology, that these programs participate in the submission of an evaluation of clinical competency of each resident twice yearly.

A program's creation of a CCC is, in itself, a "developmental" process. We will start with a brief review of current ACGME requirements for a CCC. Programs that already have a CCC may identify gaps and potential enhancements by comparing what they have in place to the requirements. For programs just beginning to institute a CCC, the next few pages offer a practical roadmap.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Part 2: CCC Structure and Membership

Designing and Creating a CCC

To design and create a CCC, it is useful to start with "the requirements." The ACGME's requirements for a CCC are in the Program Requirements—both the Common Program Requirements and all of the specialty Program Requirements. The ACGME Common Program Requirements (CPRs) stipulate the minimum requirements for CCCs in every residency and fellowship program. These are defined in the first section of CPR Section V, Evaluation. If a specialty has developed additional expectations for the CCC, they will be found in Section V.A. of the specialty-specific requirements. Other entities, such as the relevant American Board of Medical Specialties' boards, may add requirements as well. Once the CCC fulfills the Common and any core specialty-specific and Board requirements, programs are free to innovate!

Review Section V.A of your **specialty-specific Program Requirements** carefully. Compare them to **CPR** Section V.A.1., noting any differences. In addition to the Common and the specialty Program Requirements, the ACGME has provided additional guidance for CCCs in documents such as its Frequently Asked Questions (FAQs).

While there are no specific requirements for the CCC found in the Institutional Requirements (IR), there is at least one institutional requirement that may be useful to consider:

The sponsoring institution is responsible for programs' developing "promotion criteria" and criteria for non-renewal. In IR Section IV.B.2.d), it is required that the "conditions for reappointment and promotion to a subsequent PGY level" are elements necessary in an agreement of appointment.

CCCs may be an excellent mechanism to identify those criteria or, at the very least, to align Milestone performance with them. It is important to recognize that Milestones do not represent the totality of any discipline, but rather form a robust foundational core. Consider how Milestones fit into your program's criteria for promotion and/or renewal of a resident's/fellow's appointment, a Core Requirement. Remember, Milestones are intended to be used as a *formative* framework to guide curricula, assessment, and CCC deliberations in programs. Milestones will also ultimately guide and inform CCC deliberations that lead to a *summative* judgment for a resident's/fellow's promotion and graduation. However, Milestones *should not* be used as the sole criteria for these important decisions.

Questions to ask of your program include:

- Are any clarifications or adjustments in your criteria for promotion and/or non-renewal required?
- Are any changes in your agreement of appointment necessary to reflect Milestone reporting to the ACGME?

©2015 Accreditation Council for Graduate Medical Education (ACGME)

- Are any changes in your grievance policy necessary?

You may find you do not need to make any changes at all, but the development of a CCC provides an excellent opportunity to review your current performance standards, promotion criteria, and assessment processes, and align the Milestones and the CCC with them. Your DIO, Office of GME, Legal and HR resources may provide useful guidance.

How well do you know the CCC Requirements?

Appendix B is a multiple choice "quiz" on the current ACGME requirements for a CCC. Consider having your CCC members and key faculty leadership take this quiz as a fun faculty development exercise!

The ACGME's CCC requirements are fairly minimal (See Table 2). There are only **eight** requirements. Seven are "core" requirements, mandatory for all programs; one is a "detail" requirement, necessary only for new programs receiving Initial Accreditation and those with a status of Accreditation with Warning or Probationary Accreditation.

Table 2. CPR Requirements of a CCC

	Core	Detail	CPR Requirement
The program director must appoint CCC	**X**		V.A.1
Minimum of three program faculty members	**X**		V.A.1.a)
May include additional members: physician faculty members from same/other programs or other health professions with extensive contact and experience with residents/fellows in patient care and other health care settings	**X**		V.A.1.a).(1) V.A.1.a).(1).(a)
Chief residents who have completed a core residency program and are board-eligible in their specialty MAY be on CCC	**X**		V.A.1.a).(1).(b)
Must have written description of responsibilities	**X**		V.A.1.b)
Should review all resident/fellow evaluations semi-annually	**X**		V.a.1.b).(1).(a)
Should prepare and ensure reporting of Milestone evaluations of each resident/fellow semi-annually to the ACGME	**X**		V.a.1.b).(1).(b)
Should advise the program director regarding resident/fellow progress, including promotion, remediation, dismissal		**X**	V.a.1.b).(1).(c)

Appendix C contains a template which may help you design your CCC, by "walking you through" its various components. By "filling in the blanks" provided, you can generate a draft document that will help you fulfill the CPR for a "written description of the responsibilities" of the CCC. Some program directors may develop the written description of the CCC "on their own." Others will ask the CCC to create it as one of its initial activities as a group. Others may appoint a subset of the faculty, with or without resident/fellow representation. The template provides a checklist of items to consider.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Creating, developing and improving a CCC does require time and effort. Sharing best practices across programs and institutions, having strong institutional support from the DIO for shared resources across programs within an institution, and appreciating that there will be a 'learning curve for programs just now starting can facilitate the long term effectiveness of a CCC . Ultimately the CCC process will help residencies do what they have always been responsible for doing, but now with more structure and clearer purpose.

Creating and implementing a CCC provides the program with excellent opportunities to enhance two other ACGME requirements: 1) Annual Program Evaluation and Improvement; and, 2) Faculty Development. Faculty development will be needed at three levels: 1) the program director; 2) the engaged faculty members who join the CCC or Program Evaluation Committee (PEC); and, 3) the faculty members in the trenches who are not fully involved in educational programming or administration, but who are actively teaching and assessing. Each group will have different needs. Program directors and CCC members will need a deeper understanding of the Milestones, assessment, group process, and program evaluation; faculty members in the trenches need to understand what key elements of assessment information they need to contribute to the larger "whole" the program director and CCC will consider, and must be trained to use assessment methods and tools aligned with the purpose of the curricular experience they are supervising or overseeing.

Your PEC, which undertakes the annual program evaluation resulting in one or more improvements, may select implementing and/or improving the CCC as one of its enhancements for the academic year. If so, be certain the CCC improvement plan is reflected in the PEC's analysis and action plan(s).

The ACGME also expects program engagement in faculty development. Faculty development is one of the required program components reviewed by the PEC in the Annual Program Evaluation and Improvement process. The CCC faculty role will typically include the need for much faculty development. The ACGME has recognized that though "evaluation is a core faculty competency…. most (faculty) will need additional training in (the) evaluation process," to include evaluation process training (how to interpret aggregated evaluation data), understanding how many assessments are needed for each Milestone, assurance of data quality, and application of QI methods to the evaluation processes.[6] The CCC provides an opportunity for faculty development for other program faculty members, as well: to understand the CCC process and how its evaluations of residents/fellows fit into the overall assessment of resident/fellow performance using the Milestones.

General Principles:

The size of the residency or fellowship will affect constructing and running a CCC meeting. For purposes of this guidebook, "small programs" are considered to be those with fewer than 15 total learners; "medium programs" are considered to be those with 15-to-75 learners; "large programs" have more than 75 learners.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

One committee or more:

- Large programs: may need to have several CCCs ("sub-CCCs"); some may become experts in one "year" of the program (i.e., oversee all PGY-1s,), while others might focus on a program activity (i.e., responsible for the research component or the quality improvement component)
- If "sub-CCCs" are used, it is essential that they still have robust membership and review processes to ensure all residents and fellows are thoroughly reviewed, discussed, and provided with an opportunity to receive high quality feedback. There also needs to be a mechanism to integrate information from sub-CCCs, and ensure each sub-CCC is using the same standards and procedures.
- Medium or small programs: one CCC can likely oversee all residents/fellows, but again, it will depend on the curricular design of the program and local resources.

Committee membership:

- The program director must appoint the CCC, which at a minimum has three program physician faculty members as its members. Three is considered the smallest number essential for a good discussion. The program director should select faculty members who teach and observe residents/fellows, but also consider how non-physician faculty members can provide valuable input.
- The program director may appoint additional members who must be **physician faculty members** (CPR V.A.1.a.(1).(a)) for the same or other programs, or other "health professionals who have extensive experience with the program's residents in patient care and other health care settings (e.g., nurses, physician assistants, nurse practitioners, social workers, etc.)."
- Chief residents who have completed a core residency program and are board-eligible in their specialty may serve on the CCC (CPR V.A.1.a)/(1).(b)). Chiefs who are residents within the same ACGME program (the chief title distinguishing their final year of training) should not serve on the CCC. It is important to make sure any chief who is selected is comfortable with this role. The chief may be too personally close to residents to be candid and objective in this summative evaluation activity.
- Role of advisors/mentors: an ACGME-hosted webinar indicated advisors and mentors should be "excluded" from CCC deliberations. This prohibition is not reflected in the CPRs. 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. They may also be able to convey the impressions of the CCC to their residents/fellows.
- "Right size" – large enough to reflect diversity of perspectives; small enough to be "manageable" in terms of faculty development about CCC role, and participation in meeting discussions

©2015 Accreditation Council for Graduate Medical Education (ACGME)

- "Right people" – CCC members must be committed and able to attend all or nearly all meetings; erratic attendance will not allow the continuity critical to assess resident/fellow performance over time. Each member must be willing to make honest decisions, even when it's tough.
- Term limits: Consider whether appointments should be "in perpetuity," or for a defined term limit. "In perpetuity" appointments should be coupled with regular addition of new members for fresh perspectives; if enacting term limits, consider staggering appointments so that not everyone turns over at once.
- Residents cannot serve on the CCC unless, in your program, a "chief resident" is really a member of the faculty and "not a resident." Having residents responsible for the high-stakes decisions regarding their colleagues is not allowed. On the other hand, residents have a major role in providing input into the competencies of their peers through the multi-source/multi-rater assessment process (previously also called "360-degree feedback").
- Non-physician program staff members cannot serve on the CCC, but can attend to provide support to the CCC. Special considerations:
    - Small programs may have a challenging time identifying individuals for the CCC as many of these programs also have a limited number of faculty members. Many fellowships will find themselves in this position. In addition to program faculty members, consider inviting faculty members from other disciplines or settings for which the learner provides substantial consultation. Many small programs are also tied to specific clinical settings; consider inviting non-physician faculty members from these settings who have ongoing contact with the learner to sit on the CCC (e.g., a nurse leader from a dialysis unit for a nephrology fellowship program, a nurse anesthetist for a surgery fellowship, or a discharge planner from a specific clinical unit).
    - Medium programs may also encounter some of the same problems as small programs, and may still need to use a sub-committee process to facilitate CCC deliberations.
- Role/responsibility of each CCC member: French et. al. present Guidelines for Committee Members:[7]
    - Know role on the committee
    - Follow-through with assigned tasks
    - Be educated on purpose and responsibilities of the committee, Milestones, the review process, and committee guidelines
    - Do "one's part" to maintain a collegial atmosphere within the committee
    - Ensure own "voice" is heard

Appendix D lists additional details. These include the essential requirement for confidentiality. Larger CCCs may assign members a subset of the residents/fellows to review in advance of a meeting. It will be important to identify **who** will convey the CCC results to the program director (if not in attendance) and to the resident/fellow.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Committee chair:
Some Boards or Review Committees may place restrictions on "who can chair." The American Board of Anesthesiology, for example, doesn't allow the program director to chair the CCC.[8] Others are silent on this issue. Think through who would be the right chair for your program: the program director? the associate program director? another faculty member? a rotating responsibility among members? Select the individual who will best solicit broad input regarding resident/fellow performance and ensure all voices are heard. French et. al. present Guidelines for Committee Chairs:[9]

- Be Milestones expert for the committee
- Encourage a positive working environment and open communication from all members
- Ensure members know their roles, as well as the Milestones and the review process/guidelines
- Keep meetings on task and move towards the common goal
- Make certain the coordinator or designated member maintains documentation and meeting minutes

In addition, the CCC chair should be familiar and comfortable with effective group process (see Part 4, *Running the CCC Meeting,* below) and major assessment methods.

Program director role:
There is no mandatory role for the program director, and he or she can be chair (unless the program is in anesthesia), member, or observer, or not attend at all.[10] If present, he or she should not "detract" from the participation of other team members by prematurely inserting his or her perspective on a given resident's/fellow's performance. In the same way, the program director shouldn't determine the Milestone performance of each resident/fellow and then bring these to the CCC for ratification. The CCC should be able to perform its assessment of resident/fellow competency, judged against the Milestones, to convey to the program director. If the program director is present at CCC meetings, he or she should make sure other CCC members' voices are encouraged (e.g., asking other members to discuss residents/fellows and reach consensus decisions before adding his or her own comments). Some program directors find it very useful to have another faculty chair the CCC; so they can function better as the resident advocate and mentor and avoid the resident viewing the CCC judgments as "only" those of the program director. On the other hand, the program director indeed has the final responsibility for reporting and determining the Milestone developmental level for each resident/fellow. The program director should also ensure the residents/fellows are aware of the Milestones which have been reported to the ACGME. The program director has the final responsibility for determining Milestone acquisition, and reporting to the ACGME.

Coordinator Role:
The coordinator is not a CCC member, and will not be "judging" resident performance. Nonetheless, a coordinator can have a major role before, during, and following a CCC meeting. Before the meeting, the coordinator can help

©2015 Accreditation Council for Graduate Medical Education (ACGME)

prepare and organize the data for the CCC. During the meeting, he/she may take minutes and capture key aspects of the discussion. Following the meeting, he/she can be part of communicating the results to the program director (if not in attendance), scheduling meetings with residents/fellows and the program director or the designated faculty member to review the decisions, including Milestone status, and assisting the Program Director in submitting Milestone information on each resident/fellow to the ACGME. Coordinators can also provide feedback through the program's assessment system, such as participating in multi-source assessment instruments.

Meetings:
Logistics of meetings should include location frequency and length. CCCs may wish to meet more frequently than the minimum CPR requirement of "twice yearly," especially during the committee's developmental phase.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Part 3: Preparing for Effective CCC Meetings

Preparing for a CCC Meeting

Developing a Shared Mental Model

Perhaps the most important aspect of preparing for a CCC meeting is to make sure the members develop a shared mental model of what resident/fellow performance looks like, and understand their roles and responsibilities on the committee, as well as how the CCC operates to judge resident/fellow performance. This may necessitate a "meeting before the meeting," or allocating sufficient time at the beginning of the first CCC meeting for this discussion. Having a written description of the CCC process, and providing faculty development for committee members will facilitate this process. Some programs find it useful to discuss a relevant article at the CCC meeting as part of faculty development.. See the references and annotated bibliography for some suggestions.

Faculty members should reach a common understanding on the meaning of the narratives of each milestone in the context of their specialty. This will almost always require group conversation. It may be worthwhile to have each faculty member perform self-assessment using the specialty-specific Milestones as a faculty development exercise. Faculty members should be trained to compare each resident's/fellow's performance to the Milestones as a whole, not just to the performance of other or 'typical' residents/fellows in the program. The committee may also benefit from individually assessing one or more recent program graduates using the Milestones, and then discussing as a CCC to determine a group consensus.

Inventory Where Milestones are Represented in the Program

CCCs should inventory (or review an inventory conducted by others) where each milestone is currently taught and assessed in the program. Teaching may occur on a specific rotation, or in the context of a program activity, such as "leading a Morbidity & Mortality rounds."

The inventory should help to identify gaps in both curriculum and assessment: 1) milestones for which the program has no good learning opportunities or assessment tool in place at the present time; 2) rotations/activities the program believes add value, but for which there is no milestone. The CCC can identify how to best address these gaps, perhaps by delegating the review to a designated faculty member.

The assessment information and data that inform CCC deliberations should follow several key principles:

- The assessment program will need to include multiple forms of assessment and utilize multiple assessors. No single assessment method or tool is sufficient to judge something as varied and complex as clinical competence.
- The combination of assessments will depend to some extent on the specific needs of the specialty and the local context.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

- Core methods of assessments should include direct observation of a specific component (e.g., care of individual patients, procedures, etc.), multi-source feedback, multiple choice test/in-service examination, longitudinal evaluations (e.g., rotational evaluation forms), audit of clinical performance, and simulation. The specific assessment tools used will depend on the specialty and local context. The key point to remember is that the true assessment "instrument" is not the tool or form itself, but rather the individual using it. The tool or form simply guides the individual performing the assessment.
- Faculty members and others involved in assessing residents/fellows will need training in the use of the selected assessment tools.

Preparing for specific CCC Meetings

Another key pre-meeting activity is preparing the assessment data for review. It is important to plan how all assessment information, including information that occurs at the meeting, and from information gained through hallway conversations or other informal sources, will be collected and summarized. Larger CCCs may assign members a subset of the residents/fellows for whom to review the assessment information in advance and prepare a preliminary review. That member may be responsible for reviewing all measures of the assigned residents'/fellows' performance, and preparing a synopsis that is brought to the meeting and discussed among all members. Some programs have individual members complete milestones assessments on each resident and have the coordinator aggregate the information in advance of the meeting.

Suggested practices:

1. synthesize performance information (done by the coordinator or assigned CCC member) in advance of meeting
2. share written performance information about individual residents'/fellows' performance during the CCC meeting (e.g., in a handout, a projection in the room)
3. train CCC members on how to interpret aggregated, synthesized performance information about individual residents/fellows

Coordinators can have key roles in scheduling and coordinating CCC meetings. They may aggregate data sources on each resident/fellow electronically or on paper and create resident/fellow summaries or snapshots of performance, which may be easier for committee members to use in the meetings. Coordinators can prepare and distribute any necessary information to CCC members in advance. However, if this occurs, it is critical that CCC members maintain the confidentiality of the information. Failure to do so will undermine trust in the Milestones and the CCC process.

Many resident management systems (RMS) have tools available to aggregate evaluations, such as spider graphs and dashboards. Some programs document their CCC deliberations through their RMS. The RMS can create a Milestone evaluation composite, which can be shared electronically with the resident/fellow and stored with all of the other resident/fellow evaluations.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Key Point: Whatever method is used to "pre-digest" and organize the data for review, programs should ensure processes and/or standard protocols are in place to ensure a systematic, consistent approach to the pre-review and the meeting preparation process. Programs ***should not*** simply use statistical means (i.e., averages) or a single type of data to make CCC determinations. As noted above, the Milestones do not represent the totality of the discipline, and informed human judgment is still a critical component of the CCC process. Much important and useful assessment information is attained through effective group discussion at the CCC meeting.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Part 4: The CCC Meeting

Running a CCC Meeting

How a CCC meeting is conducted can have a significant impact on decisions and judgments. Effective group process has been shown in multiple fields, including medical education, to produce better decisions. For example, Schwind and colleagues found a significant proportion of problematic performances among surgery residents were only uncovered through group discussion.[11] Hemmer and colleagues found important professionalism deficiencies of medical students during internal medicine clerkships were only discovered during formal, planned group discussions.[12] Thomas and colleagues found that group discussion before completing rotational evaluation forms for internal medicine residents produced higher reliability and better discrimination of performance.[13]

Provided below is guidance on running a successful meeting and pitfalls to avoid.

1. Diverse, more heterogeneous groups tend to make better decisions (see ***Part 2: CCC Structure and Membership***)

2. The "starting point" of the CCC will have a significant impact on the ultimate judgment and decision. There are several processes that can affect that starting point:

    a. The committee should have a clear sense of purpose and of the charge of the CCC, and understand the group's role in the assessment system.
    b. It is very important to avoid coming to the meeting with a decision already pre-determined; i.e. using the CCC to simply confirm a "verdict" about a resident or fellow from one's opinion or a set of data. This undermines group process.
    c. Shared mental models are very helpful in group process (see ***Part 3: Preparing for Effective CCC Meetings***). The CCC should spend time discussing each committee member's interpretation of the Milestones and be able to describe examples of performance.
    d. Spend time discussing how the group will work together so as to develop group cohesiveness. One simple technique is to create group "touchstones." Touchstones are simply principles of engagement the group agrees to observe and to which members hold each other accountable. For example, one touchstone might be "all member opinions will be considered respectfully."

3. The CCC should use a consistent, systematic process for each meeting.
    a. Diverse opinions should be invited and encouraged. Research shows that minority opinions, even when "wrong," can lead to better decisions.
    b. Issues of hierarchy and psychological size can negatively affect group decision-making. This is particularly a risk when a more senior faculty

©2015 Accreditation Council for Graduate Medical Education (ACGME)

member serves as CCC chair. It is critical to minimize effects of hierarchy. One clear measure of the effectiveness of the CCC is the willingness of all members to speak up.

   i. A simple technique to reduce the negative effects of hierarchy is to always start with the most "junior" person or the person most at risk in the hierarchical chain.
   ii. The CCC chair should, as a general rule, state his/her opinion last.
   iii. The PD should avoid stating his/her opinion early on, if at all, depending on their role with the CCC

c. Research shows that the more performance information that is available to groups the better the quality of the decisions.
   i. The CCC should carefully consider how information is prepared and presented in the group (see ***Part 3: Preparing for Effective CCC Meetings***). While some pre-synthesis is necessary and important, the underlying data that informed the pre-synthesis should be available to the committee for discussion if needed.
d. Longer discussions tend to produce better decisions and will also likely produce better feedback. Time pressure or trying to cover too many residents/fellows in one meeting can produce lower quality decisions. Be sure to give the CCC adequate time for discussion, especially for residents/fellows-in-difficulty. However, even the best residents/fellows can grow professionally and improve, so be careful not to short-change your more talented learners who will also benefit from robust feedback and the committee's providing them with some "stretch goals."
e. Have a structure to the meeting discussions rather than only an open forum for members to share their general comments about each resident/fellow.
f. If possible, share information in multiple formats, not just verbally. Projecting data at the meeting or having a written summary can be helpful.
g. If a resident has not rotated through an experience over the past six months that hinders the CCC in making a determination on one of the milestones, the CCC should maintain the milestone judgment from the previous reporting period.
h. Committee members will likely bring information about many residents and fellows not captured on completed assessment tools and forms. The CCC provides a forum to hear this previously unshared information. This information is critical to making a robust overall assessment of each resident's or fellow's progress. However, if a program finds that most of the useful information comes from CCC discussion and is not written down on any assessment forms, it should consider revising its assessment tools or processes and/or faculty development to solicit better written/recorded information.
i. Consider asking one person to offer an opposing or different view, to help represent all possible perspectives.
j. A quick debrief at the end of each CCC meeting can also help to improve group process. The leader can simply ask: "What worked well

©2015 Accreditation Council for Graduate Medical Education (ACGME)

in today's meeting?" "What did not work well during this meeting?" "What would you improve and how?" This technique builds continuous quality improvement into the CCC process, and can help encourage relationships and trust.

4. Post-meeting
    a. The discussion about each resident/fellow should be captured and documented. The discussion and judgments of the CCC are legitimate and important assessment information and should become part of the resident's/fellow's record. This information should also serve as the template for the feedback session with each resident/fellow.
    b. Transparency is an important principle in the Next Accreditation System and the Milestones. Accurately documenting and sharing the key components and judgments with residents and fellows is a critical aspect of this principle.
    c. All residents/fellows should receive timely feedback after CCC meetings, not just those for whom the CCC has concerns.

5. Cautions
    a. Good group process can clearly lead to better decisions and judgments. However, as expected, poor group process can lead to suboptimal decisions.
    b. One risk is the phenomenon of "group think." Group think can occur when the group overly favors cohesiveness, unanimity, and the desire to avoid confrontation. Group think can also occur with more senior leaders or committee chairs with strong opinions, especially if they suppress other opinions and discussion. As noted above, it is desirable for the CCC chair to state his/her opinion last.
    c. Do not allow the program director and/or Department Chair to share his/her preformed decisions regarding residents'/fellows' performance on the Milestones before all of the other group members have had an opportunity to discuss

It will be beneficial to identify the process used to obtain feedback from the CCC regarding the process itself. Early on, there will be quick "Aha" moments. A few minutes of debriefing at the end of the meeting can identify how the next meeting might be modified. CCCs will increasingly assess the program's performance as well as individual residents/fellows. In assessing resident/fellow performance against the Milestones, it will become clear what's missing from the program's assessment "tool kit" and the utility of the tools the program has in place. CCC deliberations can generate behaviorally-specific feedback that will be useful to learners. But CCCs will also identify feedback useful for faculty. Some faculty members will be recognized as role models for the timeliness, quality, and quantity of their evaluations. The CCC can help these faculty members be recognized, perhaps as part of promotion and tenure or through incentives. Others may be tapped to coach faculty members whose evaluations could be improved. The CCC, therefore, has an important role in the continuous educational quality improvement of faculty members and the program, in addition to its role in assessing resident/fellow performance.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

In conclusion, research supports the importance of well-structured, systematic processes for groups such as a CCC. Effective group process, capturing the "wisdom of the crowd," enhances the probability of better judgments around resident and fellow professional development. Systematic process can also help develop shared mental models among committee members, a condition that will be important in most effectively using the Milestones to judge learner development with the competencies.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Part 5: After the CCC Meeting Concludes

Providing Feedback to the Resident or Fellow

Feedback to the resident or fellow is an essential activity of the Milestones assessment system. Research has clearly shown that feedback is one of the most effective educational tools faculty members and programs have to help residents and fellows learn and improve.[14] Milestones should be used to help residents and fellows develop action plans and adjustments to their learning activities and curriculum. Feedback sessions should be conducted in person. Research is clear that interpreting and understanding multi-source performance data, as represented by the Milestones, should be facilitated and guided by a trusted advisor.[14]

Basic features of high quality feedback:

1. Timeliness. The results of the CCC deliberations and Milestone determinations should be shared with the resident or fellow soon after the meeting has occurred.
2. Specificity. The Milestones help to facilitate this criterion by providing descriptive narrative. However, as noted above, the Milestones do not represent the totality of a discipline, and many other important points of feedback will likely arise in the CCC meeting that should also be captured and shared with the resident or fellow. Generalities (often called "minimal" feedback), such as "you're doing great," or, "should read more," etc., are not helpful in promoting professional development, especially in the context of Milestones data.
3. Balance reinforcing ("positive") and corrective ("negative") feedback. It is important to include both in specific terms. An imbalance between too much reinforcing or conversely corrective feedback can undermine the effectiveness. The popular feedback sandwich (*positive-negative-positive*) is actually not very effective and not routinely recommended (see *Ask-Discuss-Ask* below). Models for giving feedback are provided below.
4. Learner reaction and reflection. It is very important to allow the resident or fellow to react to and reflect on the feedback and Milestones data. The two models provided below are excellent ways to facilitate this process. Reaction and reflection help garner resident/fellow buy-in and development of action plans.
5. Action plans. Creating and executing an action plan after Milestones review is critical to professional development and is often neglected in feedback. As Boud and Molloy argue, feedback hasn't occurred until the learner has actually attempted an action or change with the information. Feedback is more than just information giving and dissemination.[14]
6. feedback should start with where the resident/fellow was at the last feedback meeting and a review of the action plans created then.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Models for Milestones Feedback

Ask-Discuss-Ask (Konopasek)
Developed by Dr. Lyuba Konopasek of New York-Presbyterian Hospital, this is a nice feedback model building on the basic principles above that can also be routinely used with other assessments. It improves on the feedback sandwich model using a more interactive approach. To set up this conversation, a resident/fellow can complete his/her own self-assessment using the Milestones prior to the feedback session. The feedback session begins with the faculty member *asking* the learner to assess how he/she thinks he/she is doing. The faculty advisor then shares ("*discusses*") the results and determinations of the CCC and compares and contrasts the resident's/fellow's self-assessment with that of the CCC to facilitate a conversation about strengths and weaknesses. The "discuss" stage should be a two-way interactive dialogue between the faculty advisor and resident/fellow; it should not be just an "information dump" from faculty advisor to learner. The advisor then *asks* the resident/fellow for his/her impressions, reflections, and reactions. The final and essential activity is for the faculty advisor and learner to work together to create and complete an action plan.

R2C2 Model (Sargeant)
This model was developed by Joan Sargeant and colleagues, who specifically included feedback sessions that involved the review of multi-source performance data, such as multi-source feedback and clinical performance measures, in their research. The model builds on robust educational theory. The steps of the model are:

> **R**apport Building: In this initial stage the faculty member should build rapport and establish the relationship; if the same person is delivering the feedback after each CCC meeting, this step is facilitated and can be abbreviated in subsequent feedback meetings. The goal of this stage is to explain the purpose of the assessment (e.g., the Milestones), engage the resident/fellow, and establish the credibility of the assessment. At this stage you want to outline and negotiate the agenda with the learner to ensure issues he/she wishes to discuss are surfaced during the review of the Milestones data, discuss what the process means to him/her, and confirm that the session should lead to an action plan.
>
> Explore **R**eaction: The next stage is to explore reactions, emotions, and perceptions of the Milestones report. If the resident/fellow has completed a self-assessment of the Milestones (see above), emotion and reaction are likely around areas of both concordance and especially discordance between his/her impressions of his/her performance and those of the CCC and program. These concordances and especially discordances should be explored. The goal of this stage is to ensure the resident/fellow feels heard and that his/her views are respected, even if there is disagreement.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Explore **C**ontent: In this stage explore how and what the resident/fellow understands about the Milestones data. In this stage you want to ensure the resident/fellow fully understands the meaning of the data and how he/she can use it for action plans and professional development. Helping the resident/fellow also understand how the various assessments are used to inform the Milestones may also be helpful.

Coach for Performance Change: In this last stage, the faculty member facilitates and engages the resident/fellow in "change talk" and the creation of an action plan.

One more observation of the R2C2 model – emotion, reaction, or misinterpretation can arise at any time during a session, so you may need to "loop back" to explore reactions or content.[15]

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Part 6: Legal Issues and Considerations

The CCC can be an extremely beneficial structure to support legal constructs required for academic decision-making. There are two Supreme Court decisions that provide the context and framework for academic due process (See **Key Legal Cases Supporting Professional Judgment in GME**).

Academic Due Process consists of three components:

1. Notice (of deficiencies); and,
2. Opportunity to cure; and,
3. A careful and deliberate decision-making process.

The reasonable decision-making process *is* the CCC; that is, a regularly called meeting of the faculty for the purpose of discussing student (resident/fellow) performance. In both *Missouri v. Horowitz* ("Horowitz") and *Michigan v. Ewing* ("Ewing"), the faculty evaluation committee was identified as being a core component of the reasonable decision-making process. The Ewing case further supported the idea that a faculty decision-making committee providing academic performance decisions that are conscientious and made with careful deliberation (i.e., they are not arbitrary or capricious) constitutes reasonable decision-making. When making academic decisions regarding resident/fellow performance, promotion, or dismissal, the CCC provides the structure recognized by the highest court in academic cases.

Documentation

When defending a legal case, temporal documentation of events, actions, or conversations is very helpful in proving whether or not something actually happened. While there is no law that requires evaluations or performance feedback to be written, the ACGME requires written rotational evaluations and semi-annual evaluations of performance. Of course, it is natural within an academic clinical setting that a faculty member provides a resident/fellow with routine verbal feedback. Although it is not recorded, this verbal feedback constitutes notice and opportunity to cure.

While it is always helpful to have written performance documentation, lack thereof should not deter evaluators from doing the right thing and utilizing this information as part of the overall evaluation process. One critical role of the CCC is to elicit feedback from faculty members regarding performance in a variety of settings and situations, and for the faculty to discuss performance based on individual experiences and opinions. This discussion is the heart of the CCC, and should not be discounted just because there is not a rotational evaluation or other assessment tool or form to support the discussion. Research shows that the discussion among the faculty members in the CCC often provides more accurate and robust information regarding learner performance than the written evaluation alone, which may not represent a complete view of actual performance.[11-13]

©2015 Accreditation Council for Graduate Medical Education (ACGME)

These discussions are not only valuable to the formation of individual performance evaluations, but also to demonstrate a "fair and reasonable decision-making process" by the program.
The documentation of the CCC meeting itself can be one of the most valuable documents to an institution when defending a resident/fellow dismissal or adverse action. The ACGME does not have any requirement as to how the CCC meeting should be documented. However, many programs will find it worthwhile to retain minutes of the CCC meeting. These minutes may include::

1. A written document reflecting the discussion of each resident's/fellow's performance.
2. A concise summary of each resident's/fellow's performance and any action or follow-up items.
3. Confidential (i.e., not shared with anyone other than the resident/fellow, CCC, and program leadership).
4. Archived in accordance with the institution's document retention policy in consultation with legal counsel.

Some institutions may prefer #1 to be brief and use the milestones reported to ACCGME as #2.

Decision Process
The ACGME requires the CCC to make recommendations on resident/fellow performance to the program director for review and action; thus, the CCC is not the final decision maker. The program director is the final decision maker. However, in most situations, the feedback and consensus of the CCC is critical in informing the program director of the faculty's expert opinion regarding progress and promotion.

In general, discussions of the CCC will lead to a "consensus" decision. That is, after presentation of all data, and engagement of the members in a discussion of their experience with, and opinion regarding, the progress of a resident/fellow, the Milestone assessment will be reached by "consensus." As Milestones are designed to guide a developmental judgment, CCCs should not vote on individual subcompetencies and milestones.

However the CCC may find a situation in which strongly held differing opinions that are not modified through discussion fails to result in consensus. The Chair must recognize and be prepared for this circumstance. The CCC should discuss this at the outset and consider describing how they will proceed in the written description of the CCC. The ACGME provides no specific guidance in this setting. The committee should establish its own policy in this regard, and apply it consistently taking into account input from the DIO and legal office. We strongly discourage voting as a decisional approach, we recognize decisions regarding remediation, probation and promotion can be difficult and programs may resort to voting. If programs do choose to use voting, it is very important to be clear about what exactly the vote means from the outset. Is the vote that the performance is not at expected competence or is the vote to recommend a disciplinary action,

©2015 Accreditation Council for Graduate Medical Education (ACGME)

remediation or dismissal? With these mechanisms in place and followed, fundamental fairness to both residents/fellows and committee members is provided, and challenges to process consistency and fairness are prospectively addressed.

Peer-Review Privilege
Peer-review statutes fall under state law, and thus vary from state to state. However, in general, peer-review privilege has some common tenets that generally do not apply to CCCs and resident/fellow performance evaluation.

Generally speaking, peer-review privilege:
- protects discussion of clinical performance for the purpose of internal quality assessment, not evaluation and decisions communicated to external parties; and,
- Applies to in-person meetings where the information is maintained internally, not communicated outside of the peer-review process (such as to clinical advisors, other departments, or external agencies).

Each institution should review its peer-review statute with its legal counsel to determine if it should be applied to the CCC.

Notwithstanding a program's natural tendency to want to maintain strict confidentiality, if conducted in accordance with these Guidelines, the discussions and recommendations of the CCC are generally helpful when defending a program's decision to dismiss a resident/fellow. Carefully prepared CCC minutes can provide one of the strongest legal defenses to support dismissal actions.

Appeals and Due Process
The members of the faculty must be encouraged to provide candid and robust evaluations that are reflective of actual performance. Evaluations are based on each faculty member's observations, judgments, and expectations. A faculty member should complete evaluations in an honest and good-faith effort to provide feedback to the resident/fellow with the goal of identifying both strengths and deficiencies in order for the resident/fellow to improve academic performance.

Programs should be aware that allowing residents/fellows to appeal performance evaluations (rotational evaluations, semi-annual evaluations, etc.) can send a message to the residents/fellows that faculty or program director feedback is negotiable. It can also suggest to faculty members and program directors that their feedback, usually critical feedback, can be subject to scrutiny and overturned if a resident/fellow complains. Programs should discuss with legal counsel the impact of allowing residents/fellows to appeal performance evaluations or academic evaluation decisions.

The ACGME does encourage programs to allow actions such as probation, termination, or non-promotion, resulting from CCC decisions to be eligible for

©2015 Accreditation Council for Graduate Medical Education (ACGME)

appeal to ensure the department and institution follows the policies they have in place regarding the decision-making process.

Key Legal Cases Supporting Professional Judgment in GME

University of Missouri v. Horowitz (1978)

Board of Curators of Univ. of Mo. v. Horowitz, 435 U.S. 78, 98 S. Ct. 948, 55 L. Ed. 2d 124 (1978).

Case Summary: Ms. Horowitz excelled in her first two years of medical school, but received criticism from the faculty as she began her clinical rotations. She was provided feedback in her rotational evaluations regarding her attendance, slovenly appearance, hygiene, and bedside manner. Despite feedback, Ms. Horowitz's behavior did not improve. The school's faculty evaluation committee ultimately recommended her dismissal from medical school. Ms. Horowitz appealed the decision to the Dean. The Dean allowed Ms. Horowitz the opportunity to be evaluated by seven independent physicians. At the conclusion of the rotations, the faculty provided feedback to the Dean of varied opinion. Based on the feedback of the independent faculty evaluators, the Dean upheld the dismissal decision. This case and the issue of academic due process were ultimately argued in front of the Supreme Court. The Court supported the University's decision based on the following:

- Ms. Horowitz was provided **notice** of her deficiencies through private verbal feedback and her rotational evaluations.
- Ms. Horowitz was provided an **opportunity to cure** her deficiencies.
- The **decision was made carefully and deliberately**. The regularly called meeting of the faculty, called for the purpose of evaluating academic performance, was noted as being a reasonable decision-making process consisting of faculty members, expected to evaluate student performance.
- The Court decision noted that under this particular set of circumstances the rotation with the seven physicians was much more process than was due.

University of Michigan vs. Ewing, (1985)

Regents of Univ. of Mich. v. Ewing, 474 U.S. 214, 106 S. Ct. 507, 88 L. Ed. 2d 523 (1985).

Case summary: Mr. Ewing was enrolled in the six-year BS/MD program. After four years, he was eligible to write the NBME Step 1 exam. Mr. Ewing failed the exam and was subsequently dismissed from medical school. He sued, citing at least 11 other students who failed the exam and were allowed to stay enrolled in school and retake the test; some were allowed to retake the exam three and four times. The decision to dismiss Mr. Ewing was made by the faculty committee charged with reviewing academic performance. This committee reviewed Mr. Ewing's entire academic record and determined that based on his overall performance (including several incompletes, required repeats of courses, and the lowest score ever recorded on the NBME exam at this school), he did not have the ability or aptitude required of a physician and had no chance of succeeding. The Court sided with the school noting:

1. "The narrow avenue for judicial review of the substance of academic decisions precludes any conclusion that such decision was a substantial

©2015 Accreditation Council for Graduate Medical Education (ACGME)

departure from accepted academic norms as to demonstrate the faculty did not exercise professional judgment";

2. The decision-making process was "**conscientious and made with careful deliberation**," citing the regularly called faculty meeting structure, the *Promotion & Review Board*;
3. The faculty rightly reviewed Mr. Ewing's **entire academic record**, not just a single test, rotation, or incident, to provide context to the decision.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Part 7: Opportunities

The CCC offers many excellent opportunities for continuous educational quality improvement. For the resident/fellow, it offers insight and perspectives of a group of faculty members, and comparison of an individual's performance to a national standard, the Milestones. For the entire program, the CCC serves as an early warning system should a resident/fellow fail to progress, and therefore identifies an opportunity for remediation. For the faculty, CCCs can be an opportunity to balance out the "hawks" and the "doves," and to develop a more standardized, consistent explicit approach to expectations of resident/fellow performance. More importantly, through longitudinal dialogue and repeated sessions, faculty members can develop a better shared mental model of competence and reduce the variability in assessment judgments.

CCCs can present an excellent opportunity to simplify a program's assessment tools. It will quickly identify which assessments are most useful, and where there are gaps. A program may be able to eliminate administrative burden. It may not be feasible or necessary for faculty members to complete multipage evaluation forms, for example. The CCC can identify what is useful for to arrive at faculty consensus. As said earlier, **the true assessment instrument is not the tool or form, it is the faculty member(s) or others using it**. CCCs can help to identify barriers and impediments to effective faculty evaluations and create faculty development or other interventions.

The CCC will also help identify gaps in a program, as well as opportunities to improve program components (e.g., curricula, rotation schedules, supervision, and mentorship).

We welcome feedback on this Guidebook and encourage you to share your own best practices regarding your CCC with your colleagues so we can continue to learn.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

References

1. ACGME Glossary of Terms July 1, 2014 accessed July 6, 2014 http://acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/ab_ACGMEglossary.pdf
2. Van der Vleuten CPM, Schuwirth LWT, Driessen EW, Dijkstra J, Tigelaar D, Baartman LKJ, van Tartwijk J. A model for programmatic assessment fit for purpose. Med Teach. 2012; 34: 205–214
3. Annual Review of Competence Progression http://www.gmc-uk.org/education/competence_progression_review.asp
4. Black D. Clinical Medicine 2013, Vol 13, No 6: 570–2
5. ACGME Institutional Requirements
6. Faculty development for CCC members Accessed February 20th, 2013 at http://www.acgme-nas.org/assets/pdf/NASFAQs.pdf
7. French JC Dannefer EF Colbert CY. Figure 2. Guidelines for Committee Members. A Systematic Approach Toward Building a Fully Operational Clinical Competency Committee. J Surg Educ. 2014 May 27. pii: S1931-7204(14)00107-X. doi: 10.1016/j.jsurg.2014.04.005. [Epub ahead of print]
8. Cohen NH. "Assessing Clinical Competence What is the Role for the Anesthesia Board info "ABA requires each residency to file an Evaluation of Clinical Competency in January & July to ABA for any resident who spent any portion of prior 6 months in clinical anesthesia training …"Certificate of Clinical Competency" attesting to satisfactory clinical competence during final period of training"
   The residency must:
   - Develop & manage evaluation system from multiple sources
   - Manage faculty advisor system (mentorship and feedback)

   Neal H Cohen MD MPH MS "Assessing Clinical Competence What is the Role for the Program Director"
9. Figure 2. Guidelines for Committee Members. A Systematic Approach Toward Building a Fully Operational Clinical Competency Committee. J Surg Educ. 2014 May 27. pii: S1931-7204(14)00107-X. doi: 10.1016/j.jsurg.2014.04.005. [Epub ahead of print]
10. Role of Program Director. Frequency Asked Questions accessed ACGME website:http://www.acgme.org/acgmeweb/Portals/0/PDFs/FAQ/CCC_PEC_FAQs.pdf
11. Schwind CJ, Williams RG, Boehler ML, Dunnington GL. Do individual attendings' post-rotation performance ratings detect residents' clinical performance deficiencies? Acad Med. 2004 May;79(5):453-7.
12. Hemmer PA, Hawkins R, Jackson JL, Pangaro LN. Assessing how well three evaluation methods detect deficiencies in medical students' professionalism in two settings of an internal medicine clerkship. Acad Med. 2000;75:167-73.
13. Thomas MR, Beckman TJ, Mauck KF, Cha SS, Thomas KG. Group assessments of resident physicians improve reliability and decrease halo error. J Gen Intern Med. 2011; 26: 759-64.
14. Boud D and Molloy E. Feedback in Higher and Professional Education. Routledge. Sydney. 2013.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

15. Sargeant J, et; al. Evidence-based facilitated feedback: Using the R-2 C-2 model to enhance feedback acceptance and use. Presented at the Association for Medical Education in Europe. Prague, 2013.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Part 7: Annotated Bibliography

- Hemmer PA, Hawkins R, Jackson JL, Pangaro LN. Assessing how well three evaluation methods detect deficiencies in medical students' professionalism in two settings of an internal medicine clerkship. Acad Med. 2000 Feb;75(2):167-73.

This study compared three methods (standard checklists, written comments, and comments from formal evaluation sessions) in detecting student deficiencies in internal medicine clerkships at the Uniformed Services University of the Health Systems (USUHS). The framework for the formal evaluation sessions is RIME (**R**eporter-**I**nterpreter-**M**anager-**E**ducator). The authors found the face-to-face, formal evaluation sessions significantly improved the detection of unprofessional behavior, and that 25% of professionalism concerns were only identified at the formal evaluation session.

- Battistone MJ, Milne C, Sande MA, Pangaro LN, Hemmer PA, Shomaker TS. The feasibility and acceptability of implementing formal evaluation sessions and using descriptive vocabulary to assess student performance on a clinical clerkship. Teach Learn Med. 2002 Winter;14(1):5-10.

This study tested the group evaluation technique used in the USUHS RIME model (see Hemmer) in a setting outside of the military, and found the residents and faculty members who participated in the descriptive evaluation sessions provided more valid evaluations and the majority of students found the RIME system helpful or more helpful compared to their previous evaluation system.

- Schwind CJ, Williams RG, Boehler ML, Dunnington GL. Do individual attendings' post-rotation performance ratings detect residents' clinical performance deficiencies? Acad Med. 2004 May;79(5):453-7.

In this study the authors found in a surgery program that only 0.7% of evaluation form ratings (of 1,986 individual post-rotation ratings) nominally noted a deficit. Eighteen percent (18%) of residents determined to have some deficiency requiring remediation received no post-rotation performance ratings indicating that deficiency. Written comments on post-rotation evaluation forms detected deficits more accurately than did numeric ratings. The largest percentage of performance deficiencies only became apparent when the attending physicians discussed performance at the annual evaluation meetings. The conclusion of the authors was that, “annual evaluation meetings may help identifying patterns of residents' behavior not previously apparent to individual faculty and provide additional information about residents' performance deficiencies.”

- Williams RG, Schwind CJ, Dunnington GL, Fortune J, Rogers D, Boehler M. The effects of group dynamics on resident progress committee deliberations. Teach Learn Med. 2005 Spring;17(2):96-100.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

This study in a single surgery residency found no evidence of “feeding frenzy” or piling on (problem of negative group think) in committee deliberations about residents.

- Regehr G, Ginsburg S, Herold J, Hatala R, Eva K, Oulanova O. Using "standardized narratives" to explore new ways to represent faculty opinions of resident performance. Acad Med. 2012 Apr;87(4):419-27.

While not directly related to group process and Clinical Competency Committees, this study used narratives to describe levels of performance and asked faculty members to rank residents using the narrative performance profiles. The authors found a small group of faculty members (14 after initial development) that used a set of 16 narratives led to better discrimination of “excellent,” “competent,” and “problematic” performance. This provides some indirect support for using narratives in the Milestones, although it should be noted that these were more holistic, combined narratives and not de-aggregated narratives.

- Surowiecki J. The Wisdom of Crowds. Why the many are smarter than the few. Anchor Books. 2004. New York.

This is a fun book highlighting the research and evidence of how good group process can lead to better decisions. A number of important principles are discussed, such as the need for diversity of members of a committee, allowing for minority opinions to be heard, and using an evidence-based group process to avoid problems such as confirmation bias.

- Sanfey H, DaRosa DA, Hickson GB, Williams B, Sudan R, Boehler ML, Klingensmith ME, Klamen D, Mellinger J, Hebert JC, Richard KM, Roberts NK, Schwind CJ, Williams RG, Sachdeva AK, Dunnington Gl. Pursing Professional Accountability: An Evidence Based Approach to Addressing Residents with Behavioral Problems . *Arch Surg.* 2012;147(7):642-647.

This presents practical highlights from a think tank held at the American College of Surgeons by medical and nursing leaders involved in resident education; individuals with expertise in academic law, mental health issues, learning deficiencies, and disruptive physicians; and surgical residents. The value of a CCC is emphasized. Meeting participants noted that the amount of time spent discussing a resident is frequently a measure of the severity of the problem.

- Yao DC, Wright SM. National survey of internal medicine residency program directors regarding problem residents. *JAMA*. 2000;284(9):1099-1104

An internal medicine study in which only 31% of program directors identified a problem resident from a written evaluation; in 75% of cases, program directors first became aware through verbal complaints by faculty members.

- Dudek NL Marks MB Wood TJ Dojeiji S Bandiera G Hatala R Cooke L Sandownik L. Quality evaluation reports: Can a faculty development program make a difference? Med Teach 2012;34:e725-731

©2015 Accreditation Council for Graduate Medical Education (ACGME)

In this study, a three-hour interactive faculty development program improved the quality of faculty written evaluations. The authors noted, “assessor training is a key component of high quality assessment… there is evidence to suggest that faculty can be trained to improve the quality of their assessments.”

- George BC. Teitelbaum EN, Darosa DA, Hungness ES, Meyerson SL, Fryer JP, Schuller M, Zwischenberger JB. Duration of faculty training needed to ensure reliable performance ratings. J Surg Educ 2013 Nov-Dec;70(6):703-8. Epub 2013 Aug 15.

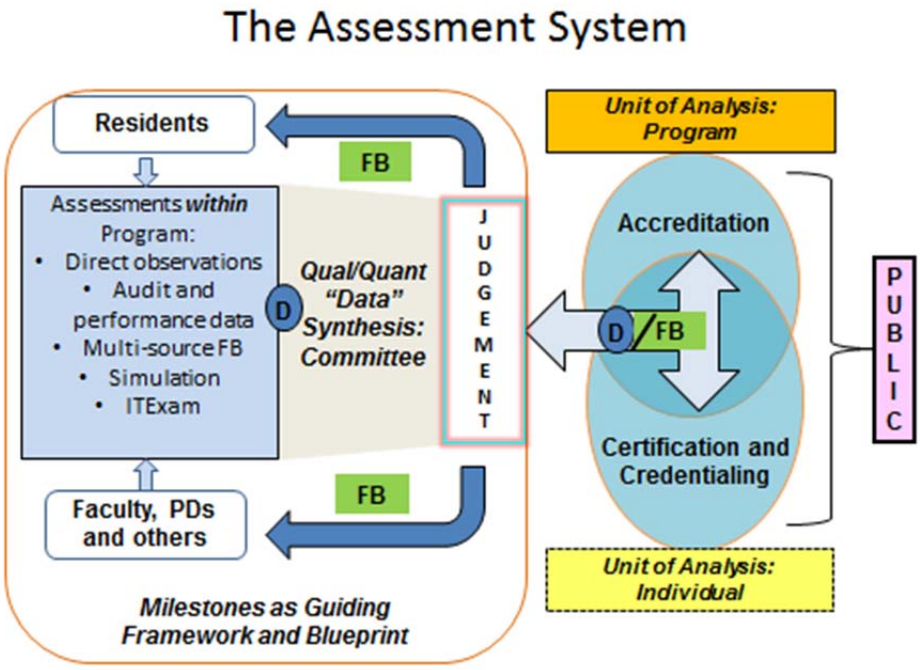
One good hour of faculty development may be as good as four in helping faculty members improve their evaluations. This study adapted “frame of reference” (FOR) training, a process used in other fields to improve raters assessing performance indicators associated with points along a rating scale. The authors compared two faculty development programs for surgical faculty: one was a one-hour program; the second was a four-hour program. The groups were not significantly different in their subsequent ratings of video clips of residents at different levels.

- Williams RG, Sanfey H, Chen X, Dunnington GL. A controlled study to determine measurement conditions necessary for a reliable and collaborative formative assessment. Annals of Surgery 2012:177-187.

This study found that five-to-seven members appear to make up an effective size for group process when making formative assessments. As noted by the authors, this group size helps “balance out idiosyncrasies in judges’ ratings.” Rater idiosyncrasies affect all raters to a degree, and group process can help maximize the strengths and weaknesses of rater idiosyncrasy.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Appendix A: The High Performing Residency Assessment System



At the program level, residents/fellows are assessed routinely through a combination of many assessment tools. These include: direct observations; global evaluation; audits and review of clinical performance data; multisource feedback from team members, including peers, nurses, patients, and family; simulation; in-service training examinations (ITE); self-assessment; and others. Increasingly, Milestones and entrustable professional activities (EPAs) are used as a guiding framework and "blueprint" for expected performance. Assessment tools are selected intentionally to allow routine, frequent, formative feedback to the resident/fellow to affirm areas of successful performance and to highlight those aspects they need to improve. The CCC is the committee which synthesizes data; quantitative from in-service exams and clinical performance audits, and qualitative from observers and co-workers. Using the Milestones, the committee forms a consensus decision, or a judgment, regarding each resident's/fellow's performance. The CCC provides those conclusions to the program director, which makes the final determination on residents'/fellows' Milestone "level" at least twice yearly. These are provided to the pertinent ACGME Review Committee and, in some cases, the pertinent specialty boards. The ACGME's unit of analysis is the *program*, and the Review Committees use aggregate Milestone information comparing a program with all residents/fellows in the given specialty. The comparison against these benchmarks serves as one source of input into the ACGME's determination of program quality and accreditation decisions. The Unit of Analysis is the "individual" for certification and credentialing entities. Collectively, all of us—residents/fellows, faculty members/program directors/programs, the ACGME, and certification and credentialing entities—are accountable to the public for honest assessments of resident/fellow performance and truthful verification of their readiness to progress

©2015 Accreditation Council for Graduate Medical Education (ACGME)

to independent practice. Data (D) is essential for the entire system in engage in continuous quality improvement, especially to create meaningful feedback (FB) loops within the program and also back to programs from the ACGME. Programs and residents and fellows can currently download their Milestone report after each reporting period.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Appendix B: CCC Quiz

1. Requirements for a CCC are found in:

   A. The ACGME Common Program Requirements
   B. The ACGME Institutional Requirements
   C. Both
   D. Neither

2. Which of the following requirements of CCCs is an ACGME "core requirement"?

   A. Include faculty from other programs and non-physician members of the health care team
   B. Advise the program director regarding resident progress, including promotions, remediation and dismissal
   C. Have a written description of the CCCs responsibilities
   D. Allow residents to exercise a grievance process if they disagree with the milestone determination of the CCC

3. The minimum number of CCC members is

   A. 1
   B. 2
   C. 3
   D. 4
   E. All divisions/subspecialties must be represented
   F. None of the above; there are no specific requirements on the numbers needed

4. Who of the following should ALWAYS Chair the CCC?

   A. Program Director
   B. Associate Program Director
   C. Department Chair
   D. DIO
   E. Head, GMEC
   F. Most senior faculty member on the committee
   G. None of the above

5. The CCC must include:

   A. Patients
   B. Nurses
   C. Peer-selected residents or fellows
   D. Members of the program faculty
   E. Program director
   F. All of the above
   G. None of the above

©2015 Accreditation Council for Graduate Medical Education (ACGME)

6. How many residents/fellows **must** participate on the CCC?

   A. 0
   B. 1
   C. At least one peer-selected resident or fellow
   D. At least one from every year of the program
   E. At least one chief resident

7. CCC members:

   A. Provide a consensus on each resident/fellows' performance
   B. Only consider residents/fellows who need remediation
   C. Only review residents/fellows in their final year of the program
   D. Only review some of the competencies and not others
   E. None of the above

8. According to the ACGME, faculty development for CCC members includes (more than one correct answer is possible):

   A. Knowing their potential legal liability
   B. Giving "bad news" to the resident/fellow after the Milestone determination has been made
   C. Reaching a common agreement of Milestone narrative meaning
   D. Determining how many assessments are needed for any given milestone
   E. Applying QI principles to the evaluation process
   F. Knowing the best remediation strategies for certain Milestone performance deficits

9. A specialist (different specialty than the resident) evaluates a resident on a specialty service as performing poorly. The CCC should:

   A. Use the grade provided by the specialist
   B. Not consider the evaluation as it came from a different specialty as the program
   C. Take the evaluation and apply it with other data to judge the resident's performance on the program-specific Milestones
   D. Vote whether the evaluation seems accurate and should be included in the overall review of the resident's performance

10. The CCC must:

    A. Review all resident/fellow evaluations semiannually
    B. Submit milestones summaries to the ACGME
    C. Meet with each resident/fellow to discuss his/her progress on the Milestones
    D. Design and implement any remediation plan necessary (and mentor the resident/fellow throughout)

©2015 Accreditation Council for Graduate Medical Education (ACGME)

11. According to the ACGME, the minutes of the CCC must be:

    A. Fully transcribed
    B. Retained as a summary of all residents/fellows
    C. Retained only as a summary of the sub-optimally performing residents/fellows
    D. None of the above

12. According to the ACGME, a resident must be able to exercise a grievance process/due process ("appeal") if he/she disagrees with the CCC regarding the Milestones determination it plans to report to the ACGME.

    A. True
    B. False
    C. It depends

13. A resident has not rotated through an experience over the past six months that hinders the CCC in making a determination on one of the milestones. The CCC should:

    A. Leave that milestone blank
    B. Drop back a level from the resident's prior rating
    C. Indicate the same level as the previous reporting period,
    D. Report that level as an "average" of the milestone levels that can be determined.

14. Who makes the final decision on a resident's/fellow's Milestone level?

    A. The CCC
    B. The resident's/fellow's advisor
    C. The resident/fellow him- or herself
    D. The ACGME
    E. The program director

15. In order to serve on a CCC, a chief resident MUST:

    A. Have completed the core program and be board-*eligible* or board certified in the specialty
    B. Have completed the core program and be board-*certified* in the specialty
    C. Still be in the core program and in the last year of training
    D. None of the above; a chief resident CANNOT be on a CCC

©2015 Accreditation Council for Graduate Medical Education (ACGME)

16. Program coordinators:

    A. Should serve as voting members of CCCs
    B. Can manage submission of Milestone data for the ACGME
    C. Should NOT attend the CCC meeting
    D. None of the above

Modified from an earlier table presented by Andolsek KM and Nagler A at the 2013 ACGME Annual Educational Conference

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Appendix B: Quiz Answers

1. A
2. C
3. C
4. G
5. D
6. A
7. A
8. C, D, E
9. C
10. A
11. D
12. B
13. C
14. E
15. A
16. B

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Appendix C: Design your CCC: Creating and Describing your CCC

Element	Describe your CCC on this element
Committee Membership • Appointed by program director • Minimum of three faculty members • Size—"enough" but committed and able to get to meetings • Who on your faculty is best able to take on this role? (i.e., sufficient resident/fellow contact; need for subspecialty representation) • Other members? (at the prerogative of and appointed by program director) • Physician faculty members from same or other program(s) • Health professions with extensive contact and experience with the program's residents/fellows in patient care and other health care settings • Chief residents who have completed core program and are board-eligible/certified in the specialty • Term Limits? (Two years? The duration of the residency/fellowship?) • Staggered appointments? (May be useful to plan overlap among those joining the committee and leaving it)	
Chair • Are there requirements/restrictions imposed from the specialty board or Review Committee regarding who can chair (or not; e.g., anesthesiology program director cannot chair per American Board of Anesthesiology)? If no external requirements/restrictions: • Consider pros and cons of who is best positioned for this role (goal is to ensure all voices are heard—if program director chairs, will everyone simply defer to him/her) • Program director? • Associate program director? • Another faculty member? • Rotating among members?	
Role/Responsibility of *each* member • Where is this information summarized/documented, and how is it conveyed to CCC members? • Confidentiality • Meeting attendance • Term length • Participation in required professional development around this role • Necessary preparation in advance of meeting (is each member assigned a subset of residents/fellows to review in advance?) • How do members "prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME" (CPR V.A.1.b).(1).(b)) • Who conveys results to program director (if the program director is not in attendance at a meeting)?	

©2015 Accreditation Council for Graduate Medical Education (ACGME)

• Who conveys results to each resident/fellow? • Who is responsible for any remediation plan (a member of CCC, or is this referred to another individual or group within residency/fellowship?)	
Role of the Program Director • Chair (or not) • A member • An observer (perhaps he/she only attends but refrains from providing input) • Not present • Provides feedback from CCC to the residents/fellows (or not)	
Role of Residents/Fellows • Residents are <u>not</u> members of the CCC • In some programs chief residents are faculty members, and not considered trainees; in this case it may be appropriate to include them • Residents/fellows are commonly asked to provide multi-rater feedback on their peers; this information is typically used by the CCC as one assessment of resident/fellow performance on the competencies of Interpersonal and Communication Skills and Professionalism	
(Potential) Role of the Coordinator <u>Pre-meeting</u> Schedule meeting and location Notify attendees Aggregating data sources (electronically or on paper) Providing information to members before the meeting so they can engage in any pre-work Summarizing data, preparing "scorecards" or "snapshots" <u>At the meeting</u> Provide any information needed by committee members Take minutes Document any necessary information to resident/fellow record Record recommendations on each resident/fellow by milestone <u>Post-meeting</u> Communicate results to program director (if not present) Schedule meetings with residents/fellows and program director and/or designated faculty member(s) to review CCC decisions, including Milestone status With program director, submit Milestone information on each resident/fellow to the ACGME	
Shared Mental Model • How do CCC members develop a shared mental model of performance? • <u>What faculty development needs do they have</u>? • Reaching a common agreement of milestones narrative meanings • Determining how many assessments (and of what type) are needed for any given milestone • Determining how to aggregate/interpret data • Applying QI principles to the evaluation process • How is this provided? Documented? • Who is responsible for providing? • How is any lack of consensus among members managed?	

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Consider asking CCC members to self-assess their own performance using your specialty's milestones.	
Meetings • When? • Where? • How frequently? at least twice yearly for most specialties; could be more frequently, e.g., monthly, quarterly • How long are meetings? • What is necessary prep to be completed ahead of meetings, and who contributes to it? What is deliverable and who is responsible?	
How the work of the CCC will be distributed? Some CCCs may be responsible for all the residents/fellows Others may be responsible for a subset of the residents/fellows, (e.g., all PGY-1s, or the research component of all of the fellows) In a large program, there may be CCCs that each review a specific subset of the residents/fellows (e.g., three sub-committees of the CCCs each review 1/3 of the residents/fellows)	
Consensus vs. Voting • Preferable to have CCC reach consensus and not vote • How are disagreements among CCC members managed? Documents? • program director is the final decision maker • Guidance from institutional Human Resources/Legal on how this is managed/reflected	
Integrating assessments from faculty members external to the program If a faculty member not from the program makes an assessment on resident/fellow performance with which the CCC disagrees, it is expected that CCC will take data from evaluations and apply them to the Milestones to judge the progress of residents/fellows The CCC will have the advantage of knowing how each of the specialists evaluated the residents/fellows and can apply that knowledge as it marks residents'/fellows' progress on the Milestones	
Minutes • What information is captured at the meeting electronically vs. in writing? How is it retained? • Are there institutional policies that address how this information is retained (i.e., where? in what format/ for what duration?)?	
Measures of Assessment/Tools used by the CCC • <u>Existing resident assessment data</u> • What are these? • How many different types of tools (e.g., multirater, in-service training exam, chart audit of clinical performance) • How are these assessments documented? • How are these assessment shared with residents/fellows? • Are there challenges (e.g., faculty members not completing assessments; milestones for which no assessment is currently done)? Can the CCC work with the program to solve these issues?	

©2015 Accreditation Council for Graduate Medical Education (ACGME)

• Faculty observations • How are these organized (global end-of-rotation evaluation, checklist from a procedure, simulation, standardized patient)? • How are these documented? • Used in provision of feedback to residents/fellows? • Data from Milestone assessments • Are these observations captured in such a way that they provide useful input in Milestone assessments	
Inventory of milestones • Where is each taught in the curriculum? • How/where/by whom/ is each assessed? • What are the gaps in teaching and assessment and what are the plans for addressing them?	
Are there expectations the program has of residents/fellows that aren't captured in current specialty milestone(s)? • How are these communicated to residents/fellows? To faculty members? • How are these assessed and documented**?**	
If a resident/fellow is performing sub-optimally: • Is the CCC (or a member of the CCC) responsible for a remediation plan? Another member/group of faculty members? What are the options for remediation? • Intensify mentoring • Additional readings/structured reading plan • Skill lab/simulation experiences • Added rotations • Repeat rotations/activities • Extend education • Counseling to consider another specialty/profession • If the CCC is responsible for remediation, how does it avoid conflicts of interest in "judging" the success of its own educational intervention(s)?	
Transparency of the CCC process • How do you describe the CCC process to your residents/fellows and faculty members (e.g., program manual, web page)? • Is the description of the CCC process up to date and reflective of actual process?	
If a resident/fellow disagrees with a CCC assessment: Review with Human Resources and Legal the desirability of a grievance process in this instance (not required by the ACGME) Courts (in general) support faculty decisions "Made at routine meeting for the purpose of evaluation" "Shared understanding of performance" "Reasonable process" Residents given notice (of deficiency) and "opportunity to cure" (ameliorates) Conscientious decision making Take into account the entire performance record	
How do the Milestones fit into promotion	

©2015 Accreditation Council for Graduate Medical Education (ACGME)

criteria? ACGME institutional requirement IV.C.1: *"sponsoring institution must have a policy" that requires each of its programs to determine the criteria for promotion and/or renewal of appointment…"* How do the Milestones fits into your program's criteria for promotion and/or renewal of a resident's/fellow's appointment? Based upon your review: • Do you need to make any adjustments in your criteria for promotion and/or non-renewal? • Do you need to change your agreement of appointment to reflect Milestone reporting to the ACGME? • Do you wish to modify your grievance policy? *You may not need to make any changes at all, but this is an excellent opportunity to review your current processes and ensure they align.*	
Using the CCC in continuous educational quality improvement • Following the CCC meeting, it may be useful to debrief • What types of assessments were particularly helpful to the CCC in making decisions on resident/fellow performance? • Who among the faculty members generated the most useful assessments (e.g., from explicit behaviorally-specific narrative comments) • Do the residents/fellows consistently demonstrate challenges in their performance on a small subset of the Milestones? (If so, this may be either a curricular issue or the lack of an effective assessment tool) • What did the program learn from the CCC experience to help improve the overall educational and assessment process? (e.g., simplifying the assessment system; applying examples from the most useful assessment formats to those that were least useful) • What can the program learn from its best assessors? How can they acknowledge/reward/use these faculty members as role models? How can these faculty members' practices be transferred to other faculty members? • Based on this debrief, identify at least one way to improve assessment in your program • Specify who will do what with, and what exact timeline to implement the change • Follow up on results of the improvement at the next CCC meeting • Did all faculty members feel able to honestly represent their views on each resident/fellow? What impeded/facilitated this ability, and can enhancements be identified?	

Modified from an earlier table presented by Andolsek KM and Nagler A at the 2013 ACGME Annual Educational Conference

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Appendix D: Additional CBME References

1. Amin Z. Purposeful Assessment Medical Education 2012 Jan 46(1)::4-7
2. Aagaard E Kane GC Conforti L Hood S. Caverzagie KM Smith C Chick DA Holmboe ES Iobst WF. Early feedback on the use of the internal medicine reporting milestones in assessment of resident performance J Grad Educ. 2013 Sep;5(3):433-8
3. Albanese MA. Challenges in using rater judgments in medical education. J Eval Clin Pract. 2000;6:305–19.
4. Baker K. Determining resident clinical performance: Getting beyond the noise. Anesthesiology. 2011;115(4):862-878.
5. Black D. Revalidation for trainees and the annual review of Competency Progression (ARCP) Clinical Medicine 2013;13 (6):570-2
6. Bonnema RA, Spencer AL. Remediating residents: Determining when enough is enough. *Academic Internal Medicine Insight* 2012;10(4):6-7.
7. Carr SJ. Assessing clinical competency in medical house officers: how and why should we do it? Postgrad Med J. 2004;80(940):63-6.
8. Carraccio C, Wolfsthal SD, Englander R, Ferentz K, Martin C. Shifting paradigms: From Flexner to competencies. Acad Med. 2002; 77(5):361-367.
9. Cohen GS, Henry NL, Dodd PE. A self-study of clinical evaluation in the McMaster clerkship. *Med Teach* 1990;12:265-272
10. Cohen GS, Blumberg P, Ryan NC, Sullivan PL. Do final grades reflect written qualitative evaluation of student performance? *Teach Learn Med* 1993;5:10-15.
11. David DA, Mazmanian PE, Fordis M, Van Harrison R, Thorpe KE, Perrier L. Accuracy of physician self-assessment compared with observed measures of competence: A systematic review. JAMA. 2006;296(9):1094-102.
12. Downing SM. Threats to the validity of clinical teaching assessments: What about rater error? Med Educ. 2005;39:353–5
13. Dudek NL Marks MB Regehr G. Failure to fail: the perspectives of clinical supervisors. Acad Med 2005 Oct;80(10 Suppl)S84-7
14. Dudek NL, Marks MB, Wood TJ, et al. Quality evaluation reports: Can a faculty development program make a difference? *Med Teach* 2012; 34:e725-e731.
15. Friedlander RB Green V Padmore J Richard K. Legal Issues in Residency Training. (Pps. 8-35). The Life Curriculum Teachers Guide 2
16. Gaglione MM, Moores L, Pangaro L, & Hemmer P. Does group discussion of student clerkship performance at an education committee affect an individual committee member's decisions? *Acad Med* 2005;80(10):S55-S58.
17. Gifford KA Fall LH Doctor coach: a deliberate practice approach to teaching and learning clinical skills. Acad Med 2014; feb;89(2):272-6
18. Ginsburg S, McIlroy J, Oulanova O, Eva K, Regehr G. Toward authentic clinical evaluation: Pitfalls in the pursuit of competency. Acad Med. 2010;85:780–6.
19. Ginsburg S Eva K Regehr G. Do in-training evaluation reports deserve their bad reputations? A study of the reliability and predictive ability of ITER scores and narrative comments. Acad Med 2013 Oct;88(10):1539-44

©2015 Accreditation Council for Graduate Medical Education (ACGME)

20. Ginsburg S McIllroy J Oulanova O Eva K Regehr G. Toward authentic clinical evaluation: pitfalls in the pursue of competency. Acad Med 2010 May;85(5):780-6
21. Greaves JD, Grant J: Watching anesthetists work: Using the professional judgment of consultants to assess the developing clinical competence of trainees. Br J Anaesth. 2000;84:525–33
22. Govaerts MJ, van der Vleuten CP, Schuwirth LW, Muijtiens AM. Broadening perspectives on clinical performance assessment: Rethinking the nature of in-training assessment. Adv Health Sc Educ Theory Pract. 2007;12(2):239-260.
23. Hamdy H, Prasad K, Anderson MB, Scherpbier A, Williams R, Zwierstra R, Cuddihy H. BEME systematic review: Predictive values of measurements obtained in medical schools and future performance in medical practice. Med Teach. 2006;28:103–16
24. Hamby H Prasad K Williams R Salih FA. Reliability and validity of the direct observation clinical encounter validation (DOCEE) Med Ed 2003:37:205-212
25. Hattie J, Timperley H. The power of feedback. Rev Educ Res. 2007;77(1):81-112.
26. Hatala R, Norman GR. In-training evaluation during an internal medicine clerkship. *Acad Med* 1999;74(10):S118-S120.
27. Hauer KE, Mazotti L, O'Brien B, Hemmer PA, Tong L. Faculty verbal evaluations reveal strategies used to promote medical student performance. Med Educ Online. 2011; 10.3402/meo.v16i0.6354. Epub 2011
28. Hemmer PA, Hawkins R, Jackson JL. Assessing how well three evaluation methods detect deficiencies in medical students' professionalism in two settings of an internal medicine clerkship. Acad Med. 2000;75(2):167-73
29. Herbers JE Jr, Noel GL, Cooper GS, Harvey J, Pangaro LN, Weaver MJ. How accurate are faculty evaluations of clinical competence? J Gen Intern Med. 1989;4:202–8
30. Hodges B. Assessment in the post-psychometric ear: Learning to love the subjective and collective , Medical Teacher 2013; Jul 35(7):564-8
31. Holmboe ES: Faculty and the observation of trainees' clinical skills: Problems and opportunities. Acad Med. 2004;79:16–22
32. Holmboe ES, Hawkins RE. Methods for revaluating the clinical competence of residents in internal medicine: a review. Ann Intern Med. 1998;129(1):42-8.
33. Holmboe ES, Sherbino J, Long DM, Swing SR, Frank JR. The role of assessing in competency-based medical education. Med Teach. 2010;32:676-682.
34. Holmboe ES, Ward DS, Reznick RK, Katsufrakis PJ, Leslie KM, Patel VL, Ray DD, Nelson EA. Faculty Development in Assessment: Noel GL, The missing link in competency-based medical education. Acad Med. 2011;86(4):460-467.
35. Herbert JE Jr, Caplow MP, Cooper GS, Pangaro LN, Harvey J. How well do internal medicine faculty members evaluate the clinical skills of residents? Ann Intern Med. 1992;117:757–65.
36. Iobst WF Caverzagie KJ Milestones and Competency Based Medical Education AGA Institute hkttp://dx.doi.org/10.1053.j.gastro.2013.09.029
37. Issenberg SB, McGaghie WC, Waugh RA. Computers and evaluation of clinical competence. Ann Intern Med. 1999;130(3):244-5.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

38. Ketteler ER Auyang ED Beard KE McBride EL McKee R Russell JC Szoka NL Nelson MT Competency Champions in the clinical competency committee: a successful strategy to implement milestone evaluations and competency coaching. J Surg Educ. 2014 Jan-Feb;71(1):36-8
39. Kogan JR, Holmboe ES, Hauer KE. Tools for direct observation and assessment of clinical skills of medical trainees: A systematic review. JAMA. 2009;302:1316–26..
40. Langsley DG. Medical competence and performance assessment. A new era. JAMA. 1991;266(7):977-80.
41. Lavin B, Pangaro L. Internship ratings as a validity outcome measure for an evaluation system to identify inadequate clerkship performance. Acad Med 1998;73(9):998-1002.
42. Littlefield JH, DaRosa DA, Anderson KD, Bell RM, Nicholas GG, Wolfson PJ. Accuracy of surgery clerkship performance raters. *Acad Med* 1991;66:S16-S18.
43. Lurie SJ, Mooney CJ, Lyness JM. Measurement of the general competencies of the accreditation council for graduate medical education: A systematic review. Acad Med. 2009;84:301–9.
44. Miller A, Archer J. Impact of workplace based assessment on doctors' education and performance: a systematic review. BMJ. 2010; 341:c5064.
45. Miller A, Archer J. Impact of workplace based assessment on doctors' education and performance: a systematic review. *BMJ* 2010;341:c5064
46. Nasca TJ, Philibert I, Brigham T, Flynn TC. The Next Accreditation System – Rationale and Benefits. N Engl J Med. 2012;366(11):1051-1056.
47. Pangaro L. A new vocabulary and other innovations for improving descriptive in-training evaluations. Acad Med.1999;74(11):1203-7.
48. Regehr G, Ginsburg S, Herold J, Hatala R, Eva K, Oulanova O. Using "standardized narratives" to explore new ways to represent faculty opinions of resident performance. Acad Med. 2012;87(4):419-27.
49. Sanfey H Ketchum J Bartlett J Markwell S Meier A Williams R Dunnington G Verification of proficiency in basic skills for postgraduate year 1 residents. Surgery 2010;148:759-67
50. Scavone BM, Sproviero MT, McCarthy RJ, Wong CA, Sullivan JT, Siddall VJ, Wade LD. Development of an objective scoring system for measurement of resident performance on the human patient simulator. Anesthesiology. 2006;105:260–6.
51. Schwind CJ, Williams RG, Boehler ML, Dunnington GL. Do individual attending post-rotation performance ratings detect resident clinical performance deficiencies? *Acad Med* 2004;79:453-457.
52. Stillman PL, Swanson DB, Smee S, Stillman AE, Ebert TH, Emmel VS, Caslowitz J, Greene HL, Hamolsky M, Hatem C, Levenson DJ, Levin R, Levinson G, Ley B, Morgan GJ, Parrino T, Robinson S, Willms J. Assessing clinical skills of residents with standardized patients. Ann Intern Med. 1986;105:762–71.
53. Swing SR, Clyman SG, Holmboe ES, Williams RG. Advancing Resident Assessment in Graduate Medical Education. J Grad Med Educ. 2009;1(2):278-86.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

54. Swing SR; International CBME Collaborators. Perspectives on competency-based medical education from the learning sciences. Med Teach. 2010;32(8):663-8.
55. Tesser A, Rosen S. The reluctance to transmit bad news. In: Berkowitz L (ed). *Advances in Experiential Social Psychology*, vol. 8. New York: Academic Press, 1975. P. 193-232.
56. Tonesk X, Buchanan RG. An AAMC pilot study by 10 medical schools of clinical evaluation of students. *J Med Educ* 1987;62:707-718.
57. Wilkinson JR, Crossley JG, Wragg A, Mills P, Cowan G, Wade W. Implementing workplace-based assessment across the medical specialties in the United Kingdom. Med Educ. 2008;42(4):364-73.
58. Williams RG, Klamen DA, McGaghie WC. Cognitive, social and environmental sources of bias in clinical performance ratings Teaching and Learning in Med. 2003;15(4):270-292.
59. Williams RG, Sanfey H, Chen X, Dunnington GL. A controlled study to determine measurement conditions necessary for a reliable and valid operative performance assessment. Annals of Surg. 2012;256(1):177-187
60. Williams RG, Verhulst SJ, Colliver JA, Dunnington GL. Assuring the reliability of resident performance appraisals: More items or more observations? *Surgery* 2005;137:141-147.
61. Williams RG, Dunnington GL, Klamen DL. Forecasting resident performance – Partly cloudy. *Acad Med* 2005;80(5):415-422.
62. Williams RG, Klamen DA, McGaghie WC. Cognitive, social and environmental sources of bias in clinical performance ratings. *Learn Med* 2003;15(4):270-292.
63. Williams RG, Sanfey H, Chen X, Dunnington GL. A controlled study to determine measurement conditions necessary for a reliable and collaborative formative assessment. *Annals of Surgery* 2012:177-187
64. Williams RG, Schwind CJ, Dunnington GL, Fortune J, Rogers DA, Boehler ML. The effects of group dynamics on resident progress committee deliberations. *Teach Learn Med* 2005;17:96-100.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

Appendix E: Case Studies

Mini case studies/FAQs/common dilemmas/challenging situations/promising practices

1. **Program director, "Dr. C," is an accomplished clinician and well regarded educator. Dr. C recruits several faculty members to the newly-constituted CCC, but decides to chair the committee to ensure everything occurs correctly and meets ACGME expectations.**

Program directors and programs should think carefully about the role of the program director in the CCC. The American Board of Anesthesiology precludes the program director from serving as chair. The other Boards and the ACGME are silent on this issue. Even if there are no rules, it is worthwhile to think through the role of the program director on the committee. The intent of the CCC is to ensure all faculty members feel comfortable discussing each resident's/fellow's performance. If the program director is the chair, how comfortable and motivated are the faculty members expressing their own opinions, versus deferring to the program director who may "know" many more details about the residents/fellows. Do the faculty members essentially rubber-stamp the program director's view? Or can they provide independent and important judgments necessary to create a valid consensus, maximizing the strengths of the process, which depend on several, independent, thoughtful faculty members weighing in?

As with any group process, the program should think strategically about how to create an atmosphere in the CCC in which all participants feel they can and should speak candidly and that their opinions will be valued. This committee should be one of the most important committees in a department, and should be known as a place where faculty members can speak freely and honestly regarding learner performance in a setting that is supportive, confidential, and structured. Think intentionally about ways to reduce a hierarchy, perhaps having more junior faculty members speak first. A faculty chair other than the program director may help facilitate this process.

In situations where the program director needs to chair the committee, consider having him/her speak last, after all committee members have provided meaningful input based on their own observations and experiences. The program director can be a participant or an observer or not present at all, although many programs will find it beneficial for the program director to be present to at least observe and hear the conversations regarding resident/fellow performance.

2. **The residency program has 90 residents in a three-year program. The CCC has its first meeting and can't imagine faculty members having sufficient time to meaningfully review all 90 residents in a practical manner.**

There are several options for CCC structure, and since structure is not dictated by the ACGME, this is an area for programs to be flexible and innovative.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

- Some CCCs accomplish this by meeting more frequently—perhaps three separate meetings at which 30 residents each are considered.
- Large programs may have separate CCCs for each PGY cohort (i.e., one for the first-years, one for the PGY-2s, and one for the PGY-3s). Programs using this model may have the individual CCCs follow their cohort across all years of the program, or develop expertise in the particular curriculum year.
- Some programs may organize their CCCs around specific activities (e.g., one CCC to assess the QI activities, one for the research activities, one for ambulatory versus inpatient activities, etc.).
- Some CCCs have organized similarly to an Institutional Review Board (IRB), where one or two members will review a resident's/fellow's performance in detail prior to the meeting and present their assessments and recommendations to the committee at the meeting, soliciting feedback from the group.

  Programs will gain efficiency by having the CCC think through its expectations of performance and identify what program assessments best speak to these. When gaps in assessment tools are identified, it can help the program address them. CCC members will benefit from faculty development on the Milestones, and on how best to assess resident/fellow performance. Whatever methods are chosen, the program coordinator plays a critical role in organizing and providing the right information to the CCC and its members.

3. The program wants to "democratize" the CCC to reflect resident input by inviting its chief resident to attend.

Some chiefs are still considered residents, while other chiefs are considered faculty members. The ACGME precludes a ***resident*** (whether or not a chief) from being on the committee. The rationale is that residents are colleagues of their fellow residents, and it can be challenging to have them in a situation in which they engage in high-stakes performance evaluation of these colleagues. The ACGME allows a chief who has completed a core residency and is eligible for board certification in his/her specialty to be a CCC member.

Though technically possible to have a faculty-level chief resident as part of the CCC, the same concern may lead the program to not include such a resident—they are often just a year away from being a resident themselves and know the residents very well, and it may be too challenging to engage in the required tasks of the CCC. On the other hand, input from all residents on their peers is desirable and may be an important source of data for CCCs, particularly in resident Professionalism and Communication and Interpersonal Skills milestones. The program can accomplish this by having regular resident peer feedback as part of its multi-source/multi-rater evaluation process. Likewise, residents can have a forum to discuss peer performance and/or send concerns or accolades to the CCC for review and inclusion in the faculty process.

4. The CCC wants to thoroughly document its process and keep extensive minutes.

©2015 Accreditation Council for Graduate Medical Education (ACGME)

At a minimum, the program director will record the CCC consensus and report resident/fellow performance on the Milestones to the ACGME. How much of the discussion that informs the Milestones decision is up to the individual program. Specific, behavioral feedback that would help a resident/fellow improve can be conveyed as with any program evaluation. This information can be shared with the resident/fellow as part of his/her twice-yearly evaluation meeting with the program director, an assigned CCC member, or his/her advisor. The assessment data used by the CCC to develop its consensus should already be available to the resident/fellow for review. A written document reflecting the discussion of each resident's/fellow's performance should be:

1. A concise summary of each resident's/fellow's performance and any action or follow-up items
2. Confidential
3. Archived for several years*

*The program should consult with its Human Resources and Legal experts to understand what should be retained, where it should be archived, and for how long.

5. The CCC and the program director disagree on the Milestone performance of a particular resident/fellow.

The ACGME Common Program Requirements expect the CCC to provide input, but the program director to make the final decision on resident/fellow performance against the specialty-specific Milestones.

6. The CCC wants its faculty members to be more comfortable and candid in their deliberations, and decides not to share its decision on resident/fellow performance on the Milestones with the residents themselves.

Residents/fellows should be informed and aware of the Milestones performance summary the program director is submitting to the ACGME. Currently, the ACGME requires programs to have the resident/fellow sign a copy of what is submitted, and to keep that in the resident's/fellow's performance file. It is expected that programs will use this as an opportunity to provide feedback to residents/fellows on their performance, and to discuss what is needed to get them to the next level.

7. A resident doesn't agree with the CCC, and asks it to change its assessment.

**See text on appeals, p. 22
The ACGME expects the program to have a written description of its CCC and its process. This example is an important item that should be included in the description so that residents/fellows and the faculty are clear on what a resident/fellow should do if he/she disagrees with the CCC or the program assessment. Program policies and procedures should differentiate the situations

©2015 Accreditation Council for Graduate Medical Education (ACGME)

in which a resident/fellow can exercise due process and grievance procedures. Some would separate an evaluation, such as the CCC consensus, from a program decision. For instance, a resident/fellow may not be able to have the CCC decision reviewed, but should be able to appeal any program decision regarding non-promotion, non-renewal, or dismissal that arose from a CCC decision.

©2015 Accreditation Council for Graduate Medical Education (ACGME)