UH GME Clinical Competency Committee Guidelines

For further details/requirements, please refer to the ACGME CCC Guidebook
(please refer to the last appendix in the guidebook for the CCC self-assessment checklist of best practices)
The goal of this document is to focus on supporting all residents throughout their training. Individual Learning Plans (ILPs) should be developed for all trainees as one component of the overall assessment process to identify and target personal goals (ACGME, Common Program Requirements 2021, V.A.1.d).(2)).

- **Composition**:
  - The CCC should include a minimum of three (3) program faculty members, at least one (1) of whom is a core faculty member
  - Suggest engaged faculty who work directly with the residents/fellows
  - Recommend including representatives from linked fellowships in the primary program CCC and vice versa
  - The PD should attend in an observer role; the PD should ***not*** Chair the committee or lead discussions
  - ACGME CCC Guidebook - p. 11

- **Meeting Frequency**:
  - A minimum of twice per academic year
  - Recommend having more frequent meetings as needed during the year
  - Create a timeline for gathering all resources to inform 360-degree reviews in performance (see p.2)
  - Distribute 360-degree reviews for CCC members to review prior to meetings to allow for focused discussion and decision-making

- **Responsibilities:**
  - To review individual resident/fellow performance using 360 degree resources (see list below for suggestions)
  - To note trends in the aggregate milestones (growth/progression across PGY- levels, any areas of stalled progression by class or by program as a whole that may reflect a curricular gap). Share this de-identified data with the PEC for curricular development as needed.

- **Decisions**:
  - When making decisions, the CCC should **not** call it a "vote" as the committee is making ***recommendations*** to the Program Director regarding residents/fellows
  - Documentation and comments should be summative, fact-based, and not directly attributable to any specific individual (e.g. use general terms to capture the outcome). Discussions and decisions should not be recorded as a "tally vote."
  - ACGME CCC Guidebook - p. 21

- **New Innovations**:
  - Suggest using the "Portfolio" feature in New Innovations to manage resident reviews which can be used for Program Directors, Advisors, and CCC reviews
  - Individual programs may ask HRP to "consult" with optimizing New Innovation features

- **Meeting Documentation**:

- Use standardized language
- Should include a discussion of how milestone ratings are translated numerically
- Use the milestone verbiage for consistency
- Record-keeping should include the overall decision and should **NOT** include detailed specifics from faculty and should **NOT** be called formal minutes (e.g. "summary notes").
- Summaries should be included for individual progress of all residents, not only for those who are underperforming.

- **Follow up with Resident/Fellow**:
  - Provide both written and verbal communication of CCC meeting summaries/outcomes for each resident/fellow in the program
  - Advisor/Semi-Annual Meetings with the Program Directors
  - All residents should develop an Individualized Learning Plan (ILP) and revise based on CCC input *(*ACGME, Common Program Requirements 2021, V.A.1.d).(2)

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Examples of 360 Resources

1. Advisor Input
2. Clinical Performance:
   - Direct Observations
   - Outcomes
3. In-Training Examination Scores
4. Interactions with the Program
5. Patient Experience Data
6. Procedure Logs
7. Rotation Evaluations
8. Self-Assessment Data
9. Simulation performance
10. Team Member Data: students, peers, nurses/MAs
11. Video Logs

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Additional CCC Resources

1. *Cognitive Demands and Bias: Challenges Facing Clinical Competency Committees*
(2017 resource that includes a link to a downloadable bias activity that could be used in CCC)

2. *The role of previously undocumented data in the assessment of medical trainees in clinical competency committees* and *Is the proof in the PUDding? Reflections on previously undocumented data (PUD) in clinical competency committees*
(Address the undocumented conversations/feedback that happen in CCC)

3. *Group Assessment of Resident Performance: Valuable for Program Director Judgment?*
(The importance of shared mental modeling)

4. *Design and Evaluation of a Clinical Competency Committee*
(Evaluating a CCC)

5. *The Science of Effective Group Process: Lessons for Clinical Competency Committees* and *Creating a High-Quality Faculty Orientation and Ongoing Member Development Curriculum for the Clinical Competency Committee*
(Abstracts available pending publication in April 2022)