A Systematic Approach Toward Building a Fully Operational Clinical Competency Committee

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BACKGROUND: The Accreditation Council for Graduate Medical Education has offered minimal guidelines for the creation and implementation of clinical competency committees (CCCs). As surgical residency programs may differ greatly in terms of size and structure, requirements that are too specific throughout the process could place some programs at a great disadvantage.

OBJECTIVE: The purpose of this article is to address some of the common considerations all surgery residency programs will face. The creation of standard operating procedures for the CCCs will allow each committee to develop internal consistency, improve productivity, maintain efficiency and quality control, facilitate training of new committee members, and cross-train other faculty and residents on the key processes to provide transparency.

METHODS: This article offers recommendations on the 3 key areas of CCC implementation: the prereview, resident milestone review, and the postreview processes. Specific components related to shifting culture, committee membership and terms, assessing available evidence, and review dissemination are outlined, and example scenarios are provided throughout the article.

CONCLUSION: With the implementation of CCCs and the milestones project, residency programs have an opportunity to improve the overall quality of decision making regarding residents' promotion to the next training level or independent practice. CCCs will undoubtedly be confronted with numerous challenges, as they implement the milestones project and are faced with the need to make multiple changes. Therefore, implementing milestones should be viewed as a goal to be accomplished over the long term. (J Surg 71:e22-e27. © 2014 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

KEY WORDS: clinical competency committee, milestones, resident education, assessment, next accreditation system

COMPETENCIES: Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Systems-Based Practice

INTRODUCTION

The Accreditation Council for Graduate Medical Education (ACGME) has offered minimal guidelines for the creation and implementation of clinical competency committees (CCCs) (Fig. 1).[1,2] As surgical residency programs may differ greatly in terms of size and structure, requirements that are too specific throughout the process could place some programs at a disadvantage. Minimal guidelines enable each program to find a process that will work for them. However, programs large and small will encounter similar issues and basic time points when certain decisions will need to be made. Those programs in phase 1 of the Next Accreditation System[3] report that developing a step-by-step process increases the likelihood that programs will benefit from implementing milestones.[4,5] The purpose of this article is to address some of the common considerations all surgery residency programs will face.

Rules of Engagement

For most residency programs, the implementation of the Next Accreditation System represents a significant culture shift from conventional practice in the conduct of assessment activities. This shift affects structures and practices on multiple levels. First, residency programs will begin to use

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V.A.1.	The program director must appoint the Clinical Competency Committee. (Core)
V.A.1.a)	At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)
V.A.1.a).(1)	Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. (Detail)
V.A.1.b)	There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)
V.A.1.b).(1)	The Clinical Competency Committee should:
V.A.1.b).(1).(a)	review all resident evaluations semi-annually; (Core)
V.A.1.b).(1).(b)	prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)
V.A.1.b).(1).(c)	advise the program director regarding resident progress, including promotion, remediation, and dismissal. (Detail)

FIGURE 1. ACGME common program requirements regarding clinical competency committees.

milestones to measure resident performance at key developmental points. Second, recommendations pertaining to resident progress, promotion, and remediation will be made by specially trained and formally designated teams. Third, members of CCCs, often of differing status or even profession, will need to develop working relationships in which all perspectives are considered important and respected, and where differences of opinion are viewed as data to be processed for purposes of making better decisions. In implementing milestones, CCCs will confront multiple challenges that may require action beyond the scope of the committee. Yet to be effective, they will need to advocate for change. Committee members will undoubtedly discover that evidence needed for decision making is frequently lacking, assessment quality suffers because faculty have not made the transition from Likert scales to milestones, and curricular changes or additional assessment methods are needed. Setting the stage for a clear understanding of the mission and function of the CCC—anticipating these challenges—has the potential to enhance the curriculum and assessment processes, as well as focus more attention on supporting the professional growth of the resident. The first step, however, requires careful attention to setting up the committee and establishing a review process.

PREREVIEW PROCESS

Committee Membership

The ACGME defines minimum CCC size[1] as 3 members, giving larger programs leeway for increased membership. Regardless of size, a committee chair should be identified early in the process. Specific guidelines for the committee chair are listed in Figure 2 and roles and responsibilities for all members in Figure 3. The role of the program director in the committee is undefined and must be considered on a case-by-case basis. In certain situations, inclusion of the program director as a CCC member could potentially influence the overall openness of the committee and the fairness of decision making. Program directors have a vested interest and may lack objectivity. For example, too many residents being assessed at low levels may illustrate a program flaw for which the program director is ultimately responsible. Contrarily, program directors have information that may be critically important to take into consideration, such as when poor performance occurs during a family illness or personal crisis, such as divorce.

Membership Terms

The length of membership terms is undefined by the ACGME. Some larger programs may be able to utilize term limits or rotate members, whereas smaller programs may have to keep the same members. Caution needs to be maintained if members are rotated on/off the committee frequently. Committee member education on the

- Be the milestones expert for your 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 committee documentation and meeting minutes.

FIGURE 2. Guidelines for committee chairs.

- Know your role on the committee and follow through with assigned tasks.
- Be educated on the milestones, the review process, and the committee guidelines.
- Do your part to maintain a collegial atmosphere within the committee.
- Ensure your "voice" is heard.

FIGURE 3. Guidelines for committee members.

milestones and evaluation processes is vital, and numerous changes in membership could affect rater reliability.

Membership Composition

In addition to at least 3 core faculty members, faculty from other programs or nonphysician faculty may be asked to become members of the CCC. Reasons cited for including nonresidency faculty include the ability to offer a potentially unbiased view of the residents and the addition of someone with a background that could be particularly helpful to the review process (e.g., PhD educators). The addition of a member who is familiar with the residency curriculum but has no specific opinion of residents personally or professionally can be highly beneficial with regard to potential bias or challenges to milestone evaluations brought about by a resident. Legal issues may arise when the ultimate recommendation to the program director may be to hold back or remove someone from their residency program.

Meeting Frequency

Although required to meet twice a year to complete milestone reviews, all CCCs should meet frequently during the initial planning stage. These early meetings should focus on committee milestone education and review process procedures. Time should also be spent developing agreed-upon guidelines or standard operating procedures for the committee to operate efficiently. Once the frequency of meetings is determined, committees might consider setting a minimum standard for members' attendance to maintain engagement and be able to reach a quorum on any key decisions.

Milestone Education

Not only do the CCC members need to be aware of and educated on the milestones, but the residents and non-CCC faculty need to be as well. Milestone education needs to be more than a cursory presentation of the criteria. In-depth discussions of each area need to be carried out to ensure that all stakeholders fully comprehend the intent of the milestones and how the milestone evaluation process will occur. Transparency of the process is a key component toward ensuring others that the guidelines are fair, are efficient, and maintain quality control.

Mapping and Gap Determination

Regardless of how committees decide to conduct the first review (e.g., all committee members review the same resident and compare notes and each member reviews a different resident and compares general findings with the other members), assessment tools currently in use need to be mapped to the milestones, and gaps in the assessment system will need to be identified. For example, an operative assessment form used in a general surgery residency program could lack the detailed components of the Patient Care 3[6] competency. After CCC members complete the initial review, members may determine a "hole" in the current assessment system. Notification would need to be made to either the person or committee responsible for altering the current form to fit more closely with the details needed to make a milestone assessment of residents. Mapping and adjustment of assessment tools will take a significant amount of time. Having multiple data points for each milestone (end-of-rotation evaluations, 360° evaluations, research or quality improvement (QI) project involvement, etc) will strengthen the validity[7,8] of milestone evaluations. Collaboration between residency programs, both within and outside the institution, can help ease some of the burden.

Protected Time for Faculty

The milestone review process will involve more than semiannual meetings. Initial meetings will need to be frequent to determine a functional method of evaluation. Subsequent meetings will be needed to aid in refining the review process and offering continued education/faculty development for the committee members. All committee members will require protected time to make the milestone review process meaningful. Departments that commit the time and resources to their committees will have a better understanding of the progress residents are making and can therefore make necessary curricular adjustments.

REVIEW PROCESS

Resident Assignment

The ACGME has not stipulated how resident reviews are to occur. Thus, there is no "right way" to assign resident reviews to members. The size of the residency program will greatly influence the way in which residents are assigned for review. Smaller programs may be able to assign multiple members to provide in-depth reviews on each resident. Larger programs may have to assign only 1 committee member for each in-depth resident review with CCC members, who can then report their findings to the entire

committee. Multiple reviewers or a committee-wide review will provide a certain level of "checks and balances" needed to maintain intrarater and interrater reliability. For example, in a residency program with a 6-member CCC and 60 residents to review across a 5-year program, the coordinator could randomly assign each resident to a committee member so that each would have roughly the same number of residents from the same level to review. The CCC member would then be responsible for completing an in-depth review on their assigned residents and then reporting their findings to the entire committee. Other committee members can then weigh in with their thoughts on the review, a questioning period can ensue, and a consensus decision can be reached. Each committee member could then be responsible for completing all subsequent, in-depth reviews for the same residents.

Items to be Reviewed

When contemplating the initial review process, decisions need to be made regarding the time period associated with data to be reviewed. The evaluation process can be time intensive when it comes to senior-level residents. To get a clear picture of where each resident stands with regard to meeting milestones for each competency, a complete review of assessment data may be necessary. If the resident does not rotate on a service every year, problems may not be apparent. The potential exists for a resident to be weak with regard to competencies that are typically met on only 1 service.

Weighing the Evidence

Once evidence for review has been determined, committees are tasked with potentially synthesizing data from multiple assessments or sources. For instance, in the case of medical knowledge, American Board of Surgery In-Training Examination scores and faculty assessments of medical knowledge will undoubtedly be available. For systems-based practice milestones, residents may have been assessed via 360° evaluations, but they may also have records indicating they had satisfactorily completed a QI project. Committees will need to consider whether weighing of evidence is needed. If so, how much weight will be placed on different types of evidence? Will everything be given equal weight? Will faculty evaluations be given more weight? How much will 360° evaluations count? The number and types of evidence committees are confronted with will greatly influence this decision. Many programs will find it difficult to add weight to certain evaluations when limited data exist overall. Whatever the final determination, each member of the committee will need to adhere to the process so that some level of interrater reliability is met.

Use of Resident Management System

Resident management systems (New Innovations, MedHub, etc) can greatly affect the efficiency of your committee. Giving committee members a source to pull all data from will save valuable time during the review process. Working with a knowledgeable committee coordinator can make this process even smoother, if he or she can learn to use the system based on milestone-related functionalities, specifically the ability to generate milestone reports for each resident. If the coordinator can ensure the data are entered and maintained in an organized fashion, more time can be spent by the committee on reviewing the data and not searching for it.

Internal Consistency and Efficiency

When the ultimate decision could be to recommend dismissal from a program, great care needs to be taken to ensure the resident milestone evaluation process is well thought out and fair. Each reviewer needs to maintain consistency across all resident reviews when determining progress on milestones. They need to be aware that the potential for bias (both positive and negative) can exist. A refresher session on evaluating residents within competency-based frameworks may need to be offered, as some faculty may continue to compare residents to each other or national norms, rather than assessing whether residents have met predefined standards and are achieving the outcomes expected.[9] Having a well-defined review process can help create consistency, and continued education and team exercises (like periodic "resident case reviews") can be helpful. Efficiencies need to be built into the review methodology; even in the best situations, only so much protected time can be devoted to resident reviews.

Discussions need to be held to determine how to handle discrepant data in the review process. For example, a resident may have high marks on medical knowledge across all faculty evaluations, but he or she may score extremely low on end-of-rotation oral examinations or on in-training exams. How much data and of what quality will be needed to "raise a red flag" about a particular resident? In the end, committees may spend 80% of their time discussing only 20% of the residents being reviewed.

POSTREVIEW PROCESS

Dissemination of Evaluations to Program Director and Residents

If the program director is a member of the CCC or sits in on meetings as an observer (or even recorder of minutes), the notification of recommendations by the committee can be handled quickly. If the program director is not present for meetings, a more formal notification process will be required. The dissemination of milestone evaluations to the

residents will be the larger issue. According to the ACGME common program requirements,[1] the committee is required to prepare and report milestone evaluations for residents to the ACGME semiannually. The committee is also required to notify the program director of residents' progress in meeting milestones and the committee's recommendations for promotion, remediation, and dismissal based on review of resident files. In terms of ACGME mandates,[1] the CCC has no defined direct role in sharing evaluations with residents; rather, program directors will need to decide how and when to share information pertaining to residents' progress in meeting all competency requirements, as defined by their progress toward meeting the residency program's milestones. As feedback is critical in professional growth, CCC involvement might provide useful information for improving the review process.

Appeals Process and Legal Issues

Even if the evaluation of a resident is agreed upon by the entire committee and program director, residents may disagree with the findings and want to challenge a milestone evaluation. Committees need to outline an appeals process so that it provides residents with an opportunity to have a voice in their review, but yet still give the committee time to report the evaluations back to the ACGME. As stated earlier, when the ultimate decision could be to recommend removing a resident from a program or even recommending remediation, the potential for legal issues may arise. Each committee needs to be familiar with the laws regarding discoverable documentation, and these will vary from state to state. Contacting the institution's legal department should be part of the initial steps for each committee.

Remediation and the Curriculum

As the reviews progress, programs may find it necessary to develop a "tool kit" for milestone remediation. Although each resident is different, common problems over the years may arise (for example, suboptimal progress in meeting milestones related to the medical knowledge competency or technical skills). If these issues are widespread across numerous residents, a gap in the curriculum may exist and programs may need to review and revise the curriculum to properly meet resident needs. Programs may benefit from having go-to faculty who can serve as champions for curriculum-related pieces, such as Surgical Council on Resident Education modules or QI projects. Development of a case log to standardize and formalize remediation expectations when similar issues arise will ensure equal treatment of all residents.

Maintenance of the Committee and Process

Each committee member is responsible for ensuring the maintenance of the process and informing the committee chair if troubles arise. At minimum, a yearly process review should be carried out by the committee. Feedback from the faculty outside the committee and the residents should also be gathered. A yearly introduction to learning and assessment within a competency-based framework and the role of milestones in assessing resident progress will be needed for all incoming interns and all new faculty. Refresher faculty development offerings are recommended as well.

CONCLUSION

With the implementation of CCCs and the milestones project, residency programs have an opportunity to improve the overall quality of decision making regarding residents' promotion to the next training level or independent practice. The milestones project will theoretically allow faculty on CCCs to take a step back and reevaluate the quality of the information being used in these decisions and then potentially enhance assessment efforts. A byproduct of this should be enhanced feedback to learners, where assessment for learning is emphasized. CCCs will undoubtedly be confronted with numerous challenges, as they implement the milestones project and are faced with the need to make multiple changes. Therefore, implementing milestones should be viewed as a goal to be accomplished over the long term. To avoid a superficial approach and take advantage of the opportunity for significant change, CCCs should be encouraged to develop a multiyear strategic plan that is shared with and approved by the entire department.

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