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INNOVATIONS IN THE CCC

within INNOVATIVE APPROACHES TO THE MUNDANE 560

Richard Bounds, MD and Jordan Spector, MD

1. SCOPE OF THE PROBLEM

Innumerable challenges for CCC directors

A. Protected Time for Faculty

i. Meeting length – it takes a lot of time to get through all resident evaluations

ii. Meeting frequency – CCC must evaluate all residents q 6 months, logistically difficult to protect time for all committee members

B. Data for CCC

i. What data warrants inclusion into the analysis?

ii. What constitutes *valid* data to truly reflect learner skills and development

2. WHAT IS THE CURRENT APPROACH TO THE CCC AT YOUR INSTITUTION?

A. Previous descriptive study in AEM by Doty et al sought to describe "best practices" in format and process of the CCC: how is the EM CCC run across the country? [1]

B. Current speakers sought to duplicate that analysis and expand upon it to highlight conceptual differences in the various approaches to the design and practice of the EM CCC.

Thanks to many of you for participating in our survey on the CORD listserve!

	How do EM Programs structure their CCC? - Doty et al. 2015	CCC Innovations for CORD 2017
Meetings/year	53% Quarterly 37% Monthly	Mean 4/year Range Monthly - Semi-Annual
Hours/Mtg	2-3 hours	3-4 hours
Committee Members	Avg 7-8 Range 3-15	Avg 8-9 Range 3-25
Primary focus of CCC analysis	Milestones Summary – 94%	Narrative Summaries – 51% *Only 14% think milestones are the most valuable piece*

3. Developmental vs. Problem identification approach to the CCC

Hauer, et al described two paradigms used to describe and assess resident competence within the CCC [2]

A. **PROBLEM IDENTIFICATION** model for learner assessment/analysis

i. Identifies and remediates resident deficiencies
ii. Focuses on problems, concerns, and red flags
iii. Feedback largely derives from faculty comments, narratives and anecdotes
iv. Overall evaluations based on opinions and judgments of CCC members

B. DEVELOPMENTAL approach to learner assessment/analysis

i. Comprehensively evaluates all residents and plots skills along a continuum
ii. Closely resembles the approach of the EM Milestones Project
iii. Employs quantitative rating scales for a broad array of clinical skills
iv. Strives for objective, standardized data on resident skills

4. THREE BEST PRACTICES FOR YOUR CCC (BASED ON SURVEY W/ 155 RESPONDENTS)

A. The approach <u>*before*</u> the meeting differs from the approach <u>*at*</u> the meeting.

i. Individual residents are reviewed by assigned CCC faculty members <u>prior to</u> the meeting. A comprehensive review of resident data (shift-cards, procedure logs, milestones, etc.) ensures that every learner is systematically evaluated in depth – consistent with the <u>*Developmental model*</u> of learner assessment.

1. *Those residents who are performing "just fine" (per faculty assessment) still receive a thorough assessment <u>before</u> the meeting.*
2. *Strengths and points for improvement are identified and summarized.*

ii. Faculty present their summary of each resident at the CCC meeting. Group discussion incorporates CCC members' opinions, interpretation of data, and personal observations of the residents – consistent with the <u>*Problem Identification*</u> approach.

1. *For residents "on track" there may be minimal discussion, but all agree on (or edit) the strengths and points for improvement.*
2. *More time will naturally be spent on those residents who are struggling, and might require enhanced mentorship or guidance.*

B. Meetings are most effective when organized <u>by PGY class</u>

i. The Developmental approach (pre-meeting) allows the faculty to establish "norms" or benchmarks for each milestone. This allows CCC members to easily identify those residents performing at the expected level, and those residents who are outliers (both high and low performers).

ii. Permits residency leadership to perform <u>programmatic assessment</u>, identifying strengths and weaknesses of the curriculum and of the clinical experience for each PGY year (i.e. experience with burn management, LP opportunities, etc)

C. Each CCC meeting should be viewed as an opportunity for <u>faculty development</u> in medical education.

i. Specifically direct faculty on the myriad resources to perform thorough evaluation of the learner:

- *Filtering and summarizing milestones data, interpreting narrative comments to 'separate the wheat from the chaff'*
- *Focused and efficient group discussion to emphasize learner growth and development (rather than recitation of serial anecdotes)*
- *'Diagnosing the learner' - feedback specific to the learner and stage of training*
- *Formulating feedback in an accessible and non-threatening manner for the learner*
- *Deriving and implementing individualized learning plans to address knowledge gaps and deficient skills*

ii. Thinking of your CCC in this way creates a renewed focus *on the faculty*, rather than just the residents.

- *Junior faculty on the CCC develop skills in MedEd just by participating in the CCC,*

performing resident review, and contributing to the dialogue led by senior faculty

- *Design a paradigm that values contributions from all CCC members – i.e. promote input from junior members first in discussions, followed by more senior faculty. A structure where the PD and CCC Chair contribute to the dialogue last promotes a more comprehensive review of learners.*
- *Additional education in competency-based medical education, effective feedback provision, and program evaluation may incentivize faculty to sit on the CCC, rather than regard it as another tedious 'task of the job'.*

In summary, these 3 Best Practices allow the achievement of 3 purposes:

1. **Resident Evaluation**: pre-meeting preparation uses the developmental approach, then the valuable time for group discussion focuses on personal observations, interpretation of narratives, and formulation of individualized learning plans
2. **Program Assessment**: establishing benchmarks for each class allows you to pick out the outliers, but also identify areas for improvement in the curriculum
3. **Faculty Development:** engage faculty members by fostering open discussion and focusing on their own skill development throughout the process

REFERENCES

1. *Doty et al Acad Emerg Med. 2015 Oct 16. doi: 10.1111/acem.12804. [PMID 26473693]*
2. *Hauer et al - Acad Med. 2015 Aug;90(8):1084-92. doi: 10.1097/ACM.0000000000000736.*