Anatomy of the CCC
New Programs and Leaders Track
March 31, 2019
11:15 am-12 pm

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Course Description:
The Clinical Competency Committee is now a regular component of our residency work in emergency medicine. Using our shared experience as well as that of our colleagues, we will review the structure of the CCC, and make recommendations for techniques you can use before, during, and after your meeting. Special attention will be given to processes that have been successfully implemented by emergency medicine programs. We will also review potential products of the CCC beyond the milestones and discuss ways to feed this information back to your faculty and residents.

Objectives:
1. Review the requirements and goals of the CCC
2. Present strategies that can be used prior to the CCC meeting to improve efficiency and workflow of the meeting
3. Review possible structures for your CCC meeting with attention to the use of data collection tools and structured presentations.
4. Identify output of the CCC beyond the milestones.
5. Suggest ways that you can bring the CCC data back to your residents and faculty.

Section 1: Pre-Meeting

1. ACGME Mandate/Rules/Guidance
    a. What is the goal of the CCC
        i. Review all resident evaluations semi-annually
        ii. Prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME
        iii. Advise the program director regarding resident progress, including promotion, remediation, and dismissal.
        iv. https://www.acgme.org/Portals/0/ACGMEClinicalCompetencyCommitteeGuidebook.pdf
    b. Minimal requirements of the CCC
        i. Appointed by the PD
        ii. ≥ 3 members of the program faculty
        iii. Written description of CCC responsibilities
2. Composition of the CCC
    a. CCC chair
        i. Often not the PD
        ii. Rotating the chair has benefits, but likely a longer-term rotation (2 to 3 years)
    b. CCC members
        i. Right Size the CCC Large enough to represent a diversity of perspectives, but small enough to be manageable
        ii. Committed to attend all or nearly all meetings
        iii. Committed to prep-work
        iv. Diversity: Race/Gender/Academic Interests → more 360^{O} view
        v. Collaborative
        vi. Flexible thinking → improved recommendations for resident improvement
        vii. Faculty Development Opportunity
    c. Term of service
        i. Long-Term Appointments
            1. APDs?
        ii. Term Limits
            1. Provide fresh perspective
            2. Formalized vs rotate 25-33% off the CCC annually
                a. Staggered rotating - don't want CCC to turn over all at once
3. Ground rules for the meeting
    a. Confidentiality
    b. Scope of material to cover
        i. Clinical/testing/box checking/professionalism
        ii. Wellness
            1. Work Stressors
            2. Personal issues/family/etc
    c. Red Flag Topics

        i. Comparisons with former / other residents - risks halo or anti-halo
        ii. Dress/Grooming - only when it comes to hospital policy or how it projects a resident's professionalism
        iii. Body Habitus
4. Information Available
    a. Data points that are available
        i. Shift cards, daily eval, monthly eval, event specific eval such as intubation or central line, nursing eval, peer, off-service
        ii. Procedure numbers / ultrasound numbers
        iii. Other venues: Sim, team training
        iv. In-service
        v. Research project
        vi. Administrative responsibilities: logging hours, logging procedures, ROSH review (required questions bank), faculty evals, etc
    b. Systems used for data collection
        i. NI, medhub, residency partner, myevaluations
        ii. Homegrown solutions such as Google Forms, Google Drive
5. Pre-meeting preparation
    a. Key to a successful CCC
    b. Faculty filling out a template eval before discussion / to spark discussion
    c. Admin prep - In-training, Procedure numbers, ultrasound numbers, lunch, etc
    d. Are milestones assigned prior to the meeting or at the meeting?
6. From the CORD Community (8 responses):
    a. Number of CCCs per year ranges from 2 to 7
    b. Duration ranges from 3 hours to 6 hours per meeting
    c. CCC Members review and draft a CCC eval ahead of time
        i. Sometimes it's the resident's advisor
        ii. Sometimes one or two faculty members are assigned a whole class
        iii. Sometimes residents are randomly assigned to CCC members
    d. New Innovations most commonly used
        i. Feels clunky
        ii. Output not always digestible
    e. Comments
        i. Faculty comments / written comments seem more helpful than milestone numbers
        ii. Some programs spend more time on under-performing residents
        iii. Administrative prep work is vitally important for a successful CCC

Section 2- Meeting

1. Schedule
    a. Number of meetings
    b. Timing of meetings
        i. Twice a year, quarterly, monthly
    c. 1 class per meeting or all classes

        i. Observation across programs at 1 teaching hospital identified 9.8 minutes of discussion/resident on average
        ii. 2 hours allows for 10-12 residents
    d. If multiple meetings, PGY3/4 first or last
        i. This may depend both on availability of data and the need to identify those in need of remediation with time to do so
        ii. Ex: Reviewing PGY3/4 residents with 2 months remaining in training does not allow time for remediation.
    e. What are others doing?
        i. 2 meetings per year, each 6 hours long and covering all classes
        ii. 7 interval meetings, 3 hours, all classes
        iii. 6 (8) meetings, twice per year for each class
2. Meeting Structure/Overview
    a. Is each resident presented?
        i. Organize by class, least concerning resident to most concerning, etc
        ii. Specific time allowed for discussion or natural flow of the meeting
    b. Structure may allow you to identify learning opportunities for each of your residents
        i. Avoid spending all your time on problem residents
        ii. Even high performers have areas they can improve on
    c. Can present each residents in a structured way
        i. Start with prior performance, then current assessment, any identified concerns, goals moving forward
    d. Some programs choose to review all residents on a specific milestone, then move to the next milestone
        i. May improve inter-rater reliability of scores
        ii. Can miss trends or concerns for a specific resident
3. Individual milestones vs global assessment
    a. Do you review/score each and every milestone or are these scored in advance
    b. Options for targeted presentation
        i. Highest and lowest milestones
        ii. Areas for improvement and strengths
        iii. Only those below an expected average or cutoff by PGY year
        iv. Changes from the prior CCC
            1. "Stable in 18, Improved in 3, regressed in 2"
    c. ACGME makes data available by specialty listing the avg/low/high for each milestone by PGY
        i. Can be used for faculty professional development
        ii. https://acgme.org/Portals/0/PDFs/Milestones/2018_Milestones_National_Report_2018-09-18_final.pdf?ver=2018-09-19-142602-030
4. Structured vs unstructured presentation

    a. Structured presentation can allow for more nuanced conversation
    b. Use a presentation tool to structure

        i. Ensures you identify both strengths and weaknesses for each resident
    c. Decide in advance the scope of the discussion and if each milestone will be covered
5. Data Presentation Tools
    a. How can you make the data available to all members of the CCC
        i. Does this improve the CCC meeting output
    b. NI Portfolio Review
    c. Google Sheet or other in-house solution
        i. Tool can be used to identify data points beyond the milestones
        ii. Using this during the meeting can help to structure the conversation as described above
6. What is the output goal of the meeting
    a. Score each milestone
    b. Identify high and low performing residents
    c. Identify those requiring remediation
    d. Create specific goals for each resident?
    e. Create a document faculty can use on shift to be aware of learning needs of the specific residents
    f. Identify gaps in the curriculum or assessment tools affecting all residents

Section 3: Post-Meeting

1. Organize/Interpret the Data
    a. Use spreadsheet software
    b. Examine data on the macro level; look for general trends and outliers by class
    c. Then examine data on a micro level
        i. how are individual residents progressing over time?
            1. if a score went down over time, take this very seriously and investigate all potential reasons
        ii. how are individual residents performing against their peers?
        iii. how are individual residents performing against their expected milestone levels for each subcomptency?
    d. Use conditional formatting -- provides a data-driven visual of who is ahead of the curve and who is lagging
    e. New Innovations “Portfolio” button is an excellent means of organizing CCC data/trends in a concise pictorial format
2. Delivering the Data to the Resident
    a. The semi-annual/CCC meeting with your residents may be the most important time you spend with them all year -- dedicate minimum 60 minutes to this
    b. What do residents know about CCC/Milestones scores? Survey results (n= 307):
        i. About ⅔ of residents understand why Milestones exist
            1. About half of PGY-1s understand why Milestones exist
        ii. About half of residents understand the Milestones scoring system
        iii. About ⅓ of residents agree that Milestones are important to assess their progression

c. Translating our knowledge of Milestones to the residents is necessary:
    i. What milestones are
        1. narrative descriptions of progress
        2. observable developmental steps
        3. allows for shared understanding of expectations and goal-setting
        4. framework for periodic assessment
    ii. What milestones are NOT:
        1. a complete determination of residents' abilities
        2. curricula
        3. all-encompassing assessment tools
    iii. Milestones scoring
        1. Level 1: Entry -- baseline level entering into residency
        2. Level 2: Mid-Program -- advancing, not yet at mid-residency level
        3. Level 3: Mid-Program -- demonstrating a majority of milestones
        4. Level 4: Graduation -- expected level for unsupervised practice
        5. Level 5: Beyond Target -- aspirational, awe-inspiring
    iv. Key point: not every resident progresses on a perfect linear trajectory
    v. The ACGME released "Milestones Guidebook for Residents and Fellows" which is an invaluable resource
    vi. Develop and implement a standardized means of delivering CCC information to all residents, so there is no variability among faculty

3. Use CCC Info to Plan for the Future
    a. Form a consensus decision to identify residents who may need a warning, remediation, probation, or termination
        i. CCC meetings allow for earlier identification of underperformers
    b. Identify potential gaps in curricula by analyzing the six core competencies