

The Purpose, Structure, and Process of Clinical Competency Committees: Guidance for Members and Program Directors

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Residency and fellowship program leaders have been called on to implement the tenets of competency-based medical education,¹ which include the use of the Milestones.² The Accreditation Council for Graduate Medical Education (ACGME) requires training programs to develop clinical competency committees (CCCs).³ The ACGME defines a CCC as “a required body comprising 3 or more members of the active teaching faculty that is advisory to the program director and reviews the progress of all residents or fellows in the program.”⁴ This primary role of CCCs is described in the ACGME Common Program Requirements (CPRs).⁵ However, programs require ongoing guidance on how best to implement systems to use Milestones and assess trainees’ progress within a CCC. In this perspective, we aim to supplement the *ACGME Guidebook on Clinical Competency Committees* by providing a summary of key points for the implementation of these committees.³ This information can benefit both new and experienced programs as they engage in ongoing quality improvement to achieve highly effective CCCs that enhance trainee competence and learning.

The Purpose of the CCC

In 2013, the ACGME launched the Next Accreditation System which requires residency programs to adopt the use of Milestones as a framework for assessment² and develop CCCs. The primary purpose of CCCs is to serve as decision-making groups that render judgements about trainees’ performance on their specialty-specific Milestones. This charge to CCCs highlights their importance in realizing the tenets of programmatic assessment, including the need to synthesize assessment data of different formats (both quantitative and qualitative) collected from various assessors and contexts, over different

points in time in order to sample trainees’ clinical performance.⁶

CCCs make recommendations to program directors (PDs) by using effective practices for small group process⁷ through structured discussions designed to review all available assessment data and allow for all members to share their knowledge about a given trainee’s performance. CCCs work closely with PDs to provide defensible Milestone ratings and recommendations on trainees’ trajectories and advancement through training. Ultimately, the purpose of the CCC is to assist programs in determining a trainee’s clinical competence and readiness for unsupervised practice to ensure effective and safe patient care.³

In addition to the primary role of the CCC outlined in the CPRs, these committees serve important secondary roles (TABLE). Because of the critical position of the CCC in the assessment system as the gateway for all assessment data, it interfaces with key stakeholders including trainees, program and institutional leaders, core faculty, and the ACGME. Therefore, programs and CCC chairs should capitalize on the knowledge and expertise that their CCCs develop to enhance components of the assessment system and beyond, such as identifying curriculum gaps and redundancies, and promoting faculty improvement.³ The TABLE summarizes the responsibilities of the CCC and the roles CCCs play beyond the CPRs, including practical examples and descriptions of both the primary and secondary roles.

The CCC process can also ultimately impact patient care. A thoughtful and robust review of trainee performance through group discussion demonstrates enhanced identification of performance deficiencies that were not previously noted or understood during individual faculty review.^{7,8} Several studies have shown that faculty are hesitant to provide candid or truthful performance evaluations in writing, or even directly to the trainee, but are more likely to discuss with their faculty peers.^{9–11} This opportunity for discussion is at the heart of the CCC. Earlier identification of performance deficiencies

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TABLE

Primary and Secondary Roles of the Clinical Competency Committee (CCC)

CPR No.	Roles	Example(s)
Primary Roles		
CPR V.A.3.b).(1) ⁵	CCCs must: Review all resident evaluations at least semiannually;	Most CCCs meet more frequently to review resident performance.
CPR V.A.3.b).(2) ⁵	Determine each resident's progress on achievement of the specialty-specific Milestones; and	A Milestone assessment is required within 12 weeks of matriculation.
CPR V.A.3.b).(3) ⁵	Meet prior to the residents' semiannual evaluations and advise the PD regarding each resident's progress.	Information provided by the CCC should inform the PD's semiannual evaluation.
Secondary Roles		
CPR III.C. ⁵	Resident transfers: Programs must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestone evaluations upon matriculation.	CCCs may assist the PD with assessing prior performance of a resident using competency-based performance evaluations and expectations of the program.
CPR V.C.1.c).(6).(a–d) ⁵	Contribute to the Annual Program Evaluation: “The Program Evaluation Committee should consider...aggregate resident achievement on the milestones...and graduate performance.”	CCCs can create a Milestones Map (a document tracking where each Milestone is taught and assessed) to identify curricular gaps and redundancies. This map can guide the annual program evaluation. Likewise, CCCs can utilize data to reflect on graduate performance.
CPR II.B.g).(4) ⁵	Faculty development (for all faculty including CCC members): “...pursue faculty development designed to enhance their skills at least annually...as educators...in patient care based on their practice-based learning and improvement efforts.”	CCCs are uniquely positioned to review all assessments submitted by core faculty. In the course of this review, they can identify any problems with the quality of the data, trainees who are struggling, and inadequacies at the level of the training program (eg, curricular gaps). ³¹ Providing the PD with information regarding the quality of these assessments can inform faculty development for the program. CCCs can also explain their role to both faculty and learners and aim for transparency in performing their work.
IR I.B.4.a).(3–4). ³¹	Quality improvement of the assessment system.	By reviewing their Milestone ratings and other evaluations in aggregate, CCCs can identify trends in the ratings and initiate conversations to explain these trends. CCCs can share such information with their graduate medical education committee to assist the latter in its role to assess the effectiveness of the curricula of their training programs (see ACGME Institutional Requirements).
	Continuous educational quality improvement.	CCCs can offer insights to residents about expected performance on the Milestones, and work with core faculty and the program to develop shared mental models of how the quality of assessment data can be improved. ³⁰
	Create or optimize assessment and evaluation tools.	CCCs can make recommendations to the program regarding the need to modify or create assessment tools. ³⁰

Abbreviations: CPR, common program requirement; PD, program director; ACGME, Accreditation Council for Graduate Medical Education.

allows for interventions that can ultimately benefit patient care.

CCC Structure and Membership

The PD is responsible for appointing CCC members. The chair, appointed by the program director, must be an expert in Milestones and learner assessment as well as group process and establishing a positive committee culture.^{3,12} Membership must comprise a minimum of 3 faculty, including at least one from the core faculty group (faculty designated by the program director to have significant roles in teaching and assessing residents).⁵ Other members may be faculty from the same or another program or health profession who have contact with learners in the program. Depending on program size, the program may choose to create subcommittees based on cohorts such as postgraduate year or a longitudinally followed subset.^{13–15} Another option to consider is thematic subcommittees, based on certain competencies, requirements, or tracks within a program. While subcommittees can allow for more in-depth discussion of learners' development, the program must ensure that they all operate with a shared understanding of expectations, rules, and procedures. Program leadership must create a mechanism to synthesize information from the subcommittees into the work of the overall CCC.

The CCC chair should be an educator active in the training program.³ While the PD may chair the CCC, appointing another educator as chair distributes workload and enables the chair to develop focused expertise in graduate medical education (GME), Milestones, CCC requirements, and committee processes.¹⁴ Effective chair qualities include skills in leading group processes, facilitating discussion, and realizing collaborative decision making, while balancing thoroughness and efficiency.^{7,16,17} A PD who does not chair the CCC may attend CCC meetings, ideally for the purpose of listening and learning about trainee performance. The PD should defer to the chair as the leader of the meeting itself.

In order to promote fair, unbiased decision-making, the CCC membership must represent the diverse teachers who observe, supervise, and work with residents and fellows. To maximize the benefits of diverse members for decision-making, key considerations are as follows.

Requirements

The membership must include one core faculty member.⁵ For programs with osteopathic recognition and osteopathic-focused trainees, 2 osteopathic-focused faculty members must serve on the CCC,

and the director of osteopathic education (or a designee) must also participate.¹⁸

The goal is to constitute a committee large enough to bring varied opinions but small enough that all members can meaningfully contribute. Five to 10 individuals are optimal.^{19,20}

Diversity

Heterogeneous groups can outperform homogeneous groups in terms of the range of decision options and consequences of decisions that they consider.²¹ Decisions can include judgments about residents' and fellows' readiness for supervisory roles, performance on particular competencies and Milestones, or need for remediation.²² In a CCC, member diversity can entail academic rank, gender, race/ethnicity, program role, professional focus, and health profession.⁷ Other members may include a chief resident who is in an additional year of postgraduate training and can bring insights from the near-peer perspective, an interprofessional colleague who works with residents (eg, nurse, social worker) or a public member to represent patients' perspectives.²³

Administrative Support

The program coordinator, while not a member of the CCC, may attend to provide valuable support for data management and record keeping. As an observer, the program coordinator may provide feedback to the chair or members about their adherence to committee procedures, time management, and use of available data.

Duration of Membership

Balancing the expertise built through experience on the CCC with new members can be facilitated through term limits staggered among members so that the membership rotates.

CCC Processes

The operational mechanics of the CCC should not be underestimated. Meetings can be resource intensive in terms of preparation, time (for faculty members), and follow-up. Constructing logistics that lead to effective resource utilization is critical.

Meeting Schedule

The CCC is required to meet at least twice annually, prior to the semiannual Milestones assessment deadline.⁵ However, some CCCs meet more regularly, especially those within larger and more complex programs. A routine meeting schedule may optimize

establishing a shared mental model,²⁴ enhance the frequency of feedback to trainees, and provide a better opportunity to identify patterns of performance.

Processes for Rigorous Evaluation

The CCC should also establish processes that allow for both rigorous evaluation of trainees and effective time management. High-performing resident assessment systems consist of multiple inputs and outputs, with an organized process for data synthesis.²⁴ The balance between high performance and time efficiency may be difficult for programs to achieve. There are many options to explore including pre-assignment of performance review to certain members to present at the meeting or creation of learning dashboards and metrics. The program coordinator plays a key role in preparing and organizing data for CCC review and discussion. This role of the program coordinator can be instrumental in the preparation of a time-effective meeting. Additionally, some programs may also have an educational specialist (Masters or PhD educator) who can further enhance the preparation of assessment data for decision-making purposes.

Optimizing Decision-Making Processes

Decision-making processes are multifaceted and integral to performance evaluation, and therefore several factors must be considered in order to optimize decision-making. Regardless of how the CCC reviews individual performance data, the process of conversation in decision-making deserves consideration. Hemmer and Kelly identified the power of the CCC conversation to clarify, calibrate, coordinate, and collaborate.²⁵ Performance data will be both quantitative and qualitative. As part of the committee process, the chair should consider how power dynamics impact discussion and decision-making, and be mindful of the order in which member input is solicited (eg, asking newer or more junior members to contribute first, before more senior influential members).⁷ Edgar and colleagues elaborate on the development of a shared mental model in decision-making.²⁶ Faculty development is a foundational element of establishing CCC process and decision-making.²⁷ CCCs have traditionally been oriented toward a problem identification model, focused on identifying those trainees who are struggling; however, many CCCs now strive for a developmental model that reviews all trainees in the spirit of the Next Accreditation System and focuses on multiple domains of performance for the purpose of driving feedback and learning.²⁸

Communication and Follow-Up

The CCC makes recommendations to the PD who in turn makes final determinations of performance actions including extension of training, non-renewal, or dismissal.^{5,29} The feedback generated by the CCC regarding learner performance, both strengths and weaknesses/concerns, should be communicated to the learner.³ In some programs, the PD conducts this information sharing, whereas in other larger programs, a system of advisors may relay this information. This feedback should engage trainees in discussion and self-reflection about their performance, ultimately empowering them to adjust their learning and behaviors.

Documentation

Meeting minutes should be prepared to memorialize CCC decisions and recommendations on learner performance.³ A concise summary of learner performance, including strengths, concerns, and the need for remedial action, should be confidentially documented and archived for purposes of continuity and follow-up. This documentation should not be verbatim, but instead an accurate summary of the discussion. Padmore and colleagues discuss legal implications and peer-review privilege specific to this documentation.²⁹

Conclusions

A developed and mature CCC can serve multiple purposes of high value to a GME program. When structured properly, the CCC assesses learner standards, measures performance, and identifies programmatic modifications necessary for learner achievement. While the purpose, structure, and processes of the CCC may vary among programs, this article summarizes key considerations for how the CCC is operationalized. Because there is not one single solution, programs should consider models that work best for the size and scope of their program, while assuring that all ACGME requirements are met and that they are engaging in continuous assessment of their own outcomes and effectiveness.

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