ACC.16
65th Annual Scientific Session & Expo

Clinical Competency Committee Pitfalls and Tips

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AT THE INTERSECTION OF SCIENCE & CHANGE

#ACC16

CLINICAL COMPETENCY COMMITTEE

What is a Clinical Competency Committee?

Clinical Competency Committee: *"A required body comprising three or more members of the active teaching faculty who is advisory to the program director and reviews the progress of all residents in the program."*

- Required
- At least 3 active teaching faculty
- Reviews every fellow in the program
- Advisory to the Program Director

http://acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/ab_ACGMEglossary.pdf

Pitfall - The CCC Meeting Goes on Forever

Image source: http://www.kevinmd.com/blog/2014/08/epidemic-physician-burnout-heartbreaking.html

Solution - Streamline the CCC Workflow

- Divide and conquer
- Structured meeting
- Stay focused!

Image source: http://cliparts.co/cliparts/8T6/87g/8T687g8Rc.jpg

Solution - Divide and Conquer

- Assign a leader
- Identify core faculty to attend
- Before the full meeting:
  - Enlist key faculty to review fellows
  - Identify potential problems/ issues
  - Assign preliminary ACGME milestones

Image source: http://allcars.pw/brandsddwn-delegate.htm

Solution - Structure the Meeting

- Set a time limit!
- The leader moderates discussion
- Decide on a model for review: Problem Identification vs. Developmental

https://play.google.com/store/apps/details?id=com.sportstracklive.stopwatch

Two Paradigms That Characterize How Residency Program Directors Perceive Their Role and Processes for Evaluating Residents' Competence, From a Study of the Role of Clinical Competency Committees in Performance Assessment, University of California Schools of Medicine, 2013

Themes and subthemes	Problem identification model	Developmental model
Use of residents' performance data		
Variety of evaluation tools/data	• May be inaccurate or incomplete • Delayed • Difficult to synthesize; incompletely synthesized for committee	• Quantitative metrics • Benchmark or milestone for comparison of residents' performance • Time-consuming to synthesize and use
Clinical systems data	• "Red-flag" alerts • Hospital incident reports • Patient or nurse complaints	• Clinical systems and multisource feedback not typically described as integrated into performance review
Informally gathered data	• Hallway conversations, e-mails to program director or chief resident • Focus on performance concerns	• Not described
Committee member engagement		
Committee members' qualifications	• Teaching experience • Duration of time on the committee • General ability to gauge residents' performance	• Training for committee work • Knowledge of benchmarks and milestones • Use of national guidelines and tools to frame faculty development
Contributions to the credibility of the committee process	• Provide opinions about struggling residents • Support program director in making decisions • Reconcile conflicting information	• Assess residents' performance using benchmarks or milestones • Supplement milestones information with own comments
Decision making	• Decision making implicit, assumed for most residents	• Based on synthesized data • Compares performance versus milestones • Assumes range of performance among residents • Makes decision about advancement
Implications for residents		
Committee review consequences	• Focus on global performance • Minimal discussion of residents without concerns • High-performing residents discussed in context of award nominations, fellowship, and job recruitment, further praise	• Focus on performance in context of milestones • Individual areas of relative strength and weakness • Incorporates multiple domains of performance
Feedback received	• Resident receives feedback report; resident is responsible for figuring out how to respond • No follow-up of response to feedback at next meeting	• Feedback framed in developmental language • Feedback delivered in meeting by program director or longitudinal advisor
Dealing with risks	• Potential bias through information sharing among committee members • Faculty reluctance to document concerns in writing	• Transparency through clear communication of benchmarks or milestones to faculty and residents

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Solution - Structure the Meeting

- Each faculty summarizes their fellows and conveys any problems
- Open discuss committee (*but*…set a time limit)
- Keep minutes (program coordinator)
- ***Result: individual summaries with actionable feedback***

Stay Focused!

https://play.google.com/store/apps/details?id=com.sportstracklive.stopwatch

EVALUATION FORMS

What is a Bad Evaluation Form?

- Vague questions
- Too many questions
- No written comments
- Evaluation fatigue

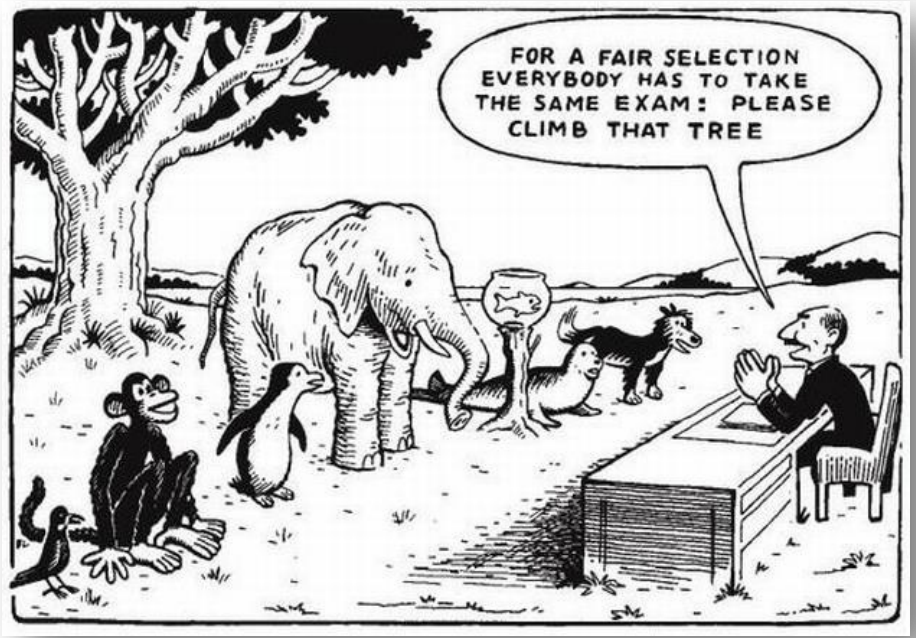
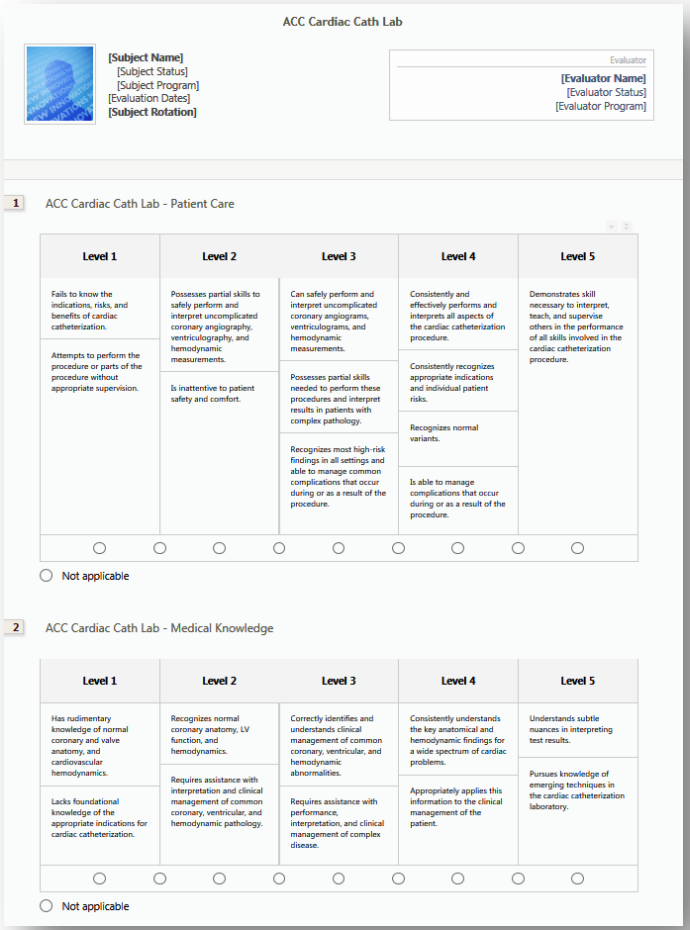


Image source: https://rlpearson67.wordpress.com/2013/08/06/are-we-asking-the-right-questions/

What is a Good Evaluation Form?

- Specific questions
- Relevant grading scale
- Brief
- Prompt for written input

Image source: https://blendedtoolkit.wisc.edu/wp-content/uploads/2015/09/evaluation__670-article-300x1971.png



ACC Cardiac Cath Lab

[Subject Name]
[Subject Status]
[Subject Program]
[Evaluation Dates]
[Subject Rotation]

Evaluator
[Evaluator Name]
[Evaluator Status]
[Evaluator Program]

1 ACC Cardiac Cath Lab - Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
Fails to know the indications, risks, and benefits of cardiac catheterization.	Possesses partial skills to safely perform and interpret uncomplicated coronary angiography, ventriculography, and hemodynamic measurements.	Can safely perform and interpret uncomplicated coronary angiograms, ventriculograms, and hemodynamic measurements.	Consistently and effectively performs and interprets all aspects of the cardiac catheterization procedure.	Demonstrates skill necessary to interpret, teach, and supervise others in the performance of all skills involved in the cardiac catheterization procedure.
Attempts to perform the procedure or parts of the procedure without appropriate supervision.	Is inattentive to patient safety and comfort.	Possesses partial skills needed to perform these procedures and interpret results in patients with complex pathology.	Consistently recognizes appropriate indications and individual patient risks.	
		Recognizes most high-risk findings in all settings and able to manage common complications that occur during or as a result of the procedure.	Recognizes normal variants.	
			Is able to manage complications that occur during or as a result of the procedure.	

Not applicable

2 ACC Cardiac Cath Lab - Medical Knowledge

Level 1	Level 2	Level 3	Level 4	Level 5
Has rudimentary knowledge of normal coronary and valve anatomy, and cardiovascular hemodynamics.	Recognizes normal coronary anatomy, LV function, and hemodynamics.	Correctly identifies and understands clinical management of common coronary, ventricular, and hemodynamic abnormalities.	Consistently understands the key anatomical and hemodynamic findings for a wide spectrum of cardiac problems.	Understands subtle nuances in interpreting test results.
Lacks foundational knowledge of the appropriate indications for cardiac catheterization.	Requires assistance with interpretation and clinical management of common coronary, ventricular, and hemodynamic pathology.	Requires assistance with performance, interpretation, and clinical management of complex disease.	Appropriately applies this information to the clinical management of the patient.	Pursues knowledge of emerging techniques in the cardiac catheterization laboratory.

Not applicable

STRENGTHS

7 ***What are the fellow's strengths?***

Comment

Remaining Characters: 5,000

AREAS FOR IMPROVEMENT

8 ***What areas can the fellow improve?***

Comment

Remaining Characters: 5,000

RECOMMENDATIONS

9 ***What are your recommendations for improvement?***

Comment

Remaining Characters: 5,000

http://www.acc.org/education-and-meetings/products-and-resources/fellowship-program-director-tools-and-resources

Continually Improve

- Design the evaluation
- Use it!
- Review the feedback
- Make improvements
- Repeat

Image source: http://blog.strauss-group.com/corporate_responsibility/the-spiral-gender-balance/

Tips for Success – Evaluation Forms

Barriers	Solutions
The questions don't apply	Use specific questions
Too many questions	Keep evaluations brief
No written comments	Ask for specific input
Not enough time	Customize

SETTLING DISAGREEMENTS

Pitfall - Disagreements on Fellow Performance

- Disagreement among faculty during the same rotation
- Disagreement among faculty between rotations
- Conveying information back to the fellow

Image source: http://quotesgram.com/disagreements-quotes/#nGA7lICA88

Faculty Disagreements - Same Rotation

- Disagreements can unmask opportunities for fellow growth
- Purposeful discussion
- Variable evaluations among faculty on one rotation can unmask fellow behavioral issues
  - Excessive moonlighting
  - Pursuing other opportunities (research meetings, personal issues)

Solution – Dive Deeper!

Faculty Disagreements - Different Rotations

- Disagreements can unmask opportunities for fellow growth
- Purposeful discussion
- Variable evaluations among rotations can unmask fellow learning deficits
  - Procedural skill deficits
  - Critical thinking deficits

Solution – Dive Deeper!

Conveying Disparate Information Back to a Fellow

- Use SWOT principle
  - Written CCC evaluation and
    - Individual meeting to convey CCC findings to fellows
    - Leveraging CCC information to develop individual fellow remediation plans

Solution – Use multiple methods

PROGRAM EVALUATION COMMITTEE

What is a Program Evaluation Committee?

- **Program Evaluation Committee:** *The program must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation.*

Required

At least 2 active teaching faculty and 1 fellow

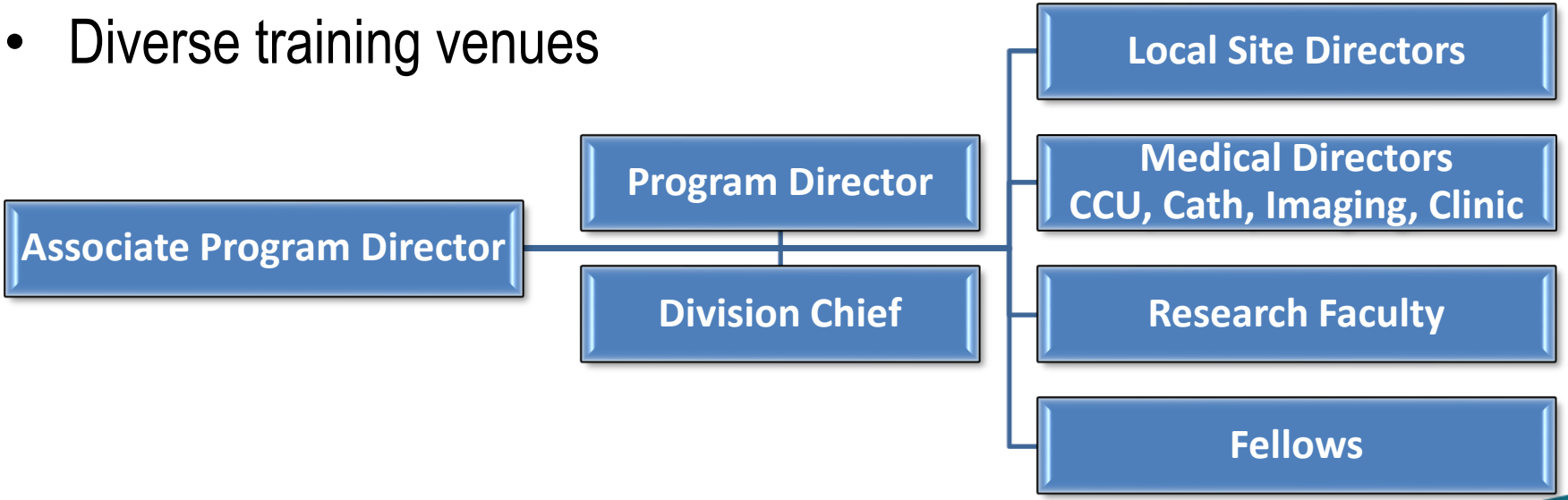
Reviews every aspect of the program

Appointed by the Program Director

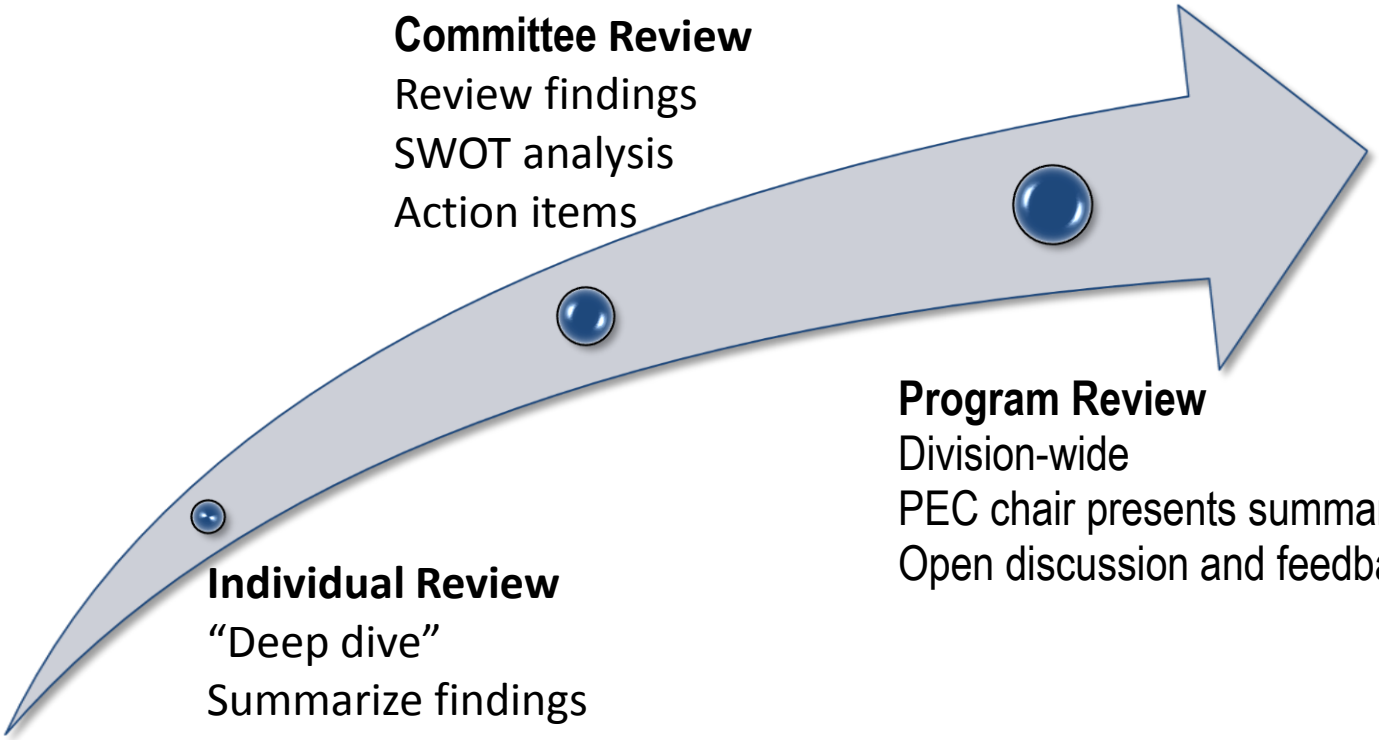
http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs_07012015.pdf

Committee Membership

- Diverse clinical experience
- Diverse teaching experience
- Diverse training venues



Optimize Committee Workflow



Individual Review
"Deep dive"
Summarize findings

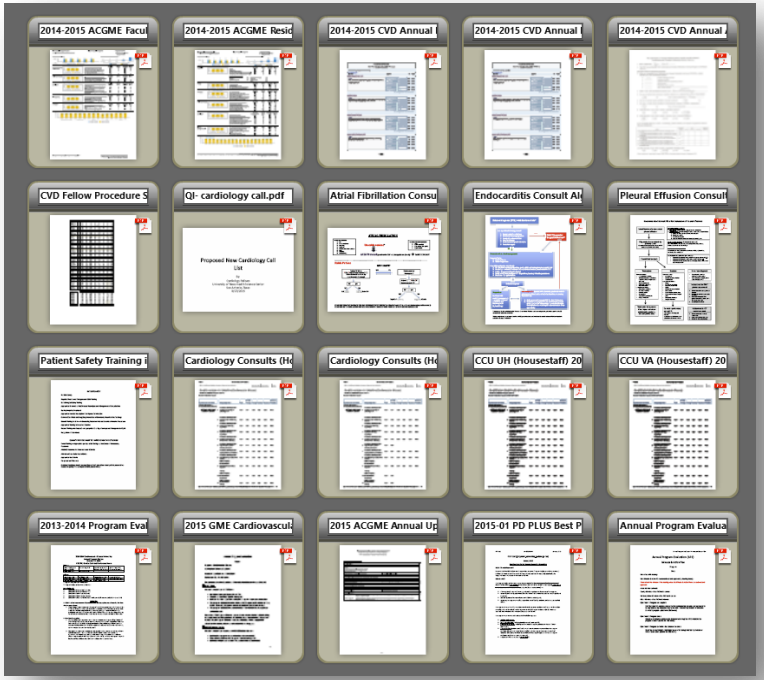
Program Review
Division-wide
PEC chair presents summary
Open discussion and feedback

Committee Review
Review findings
SWOT analysis
Action items

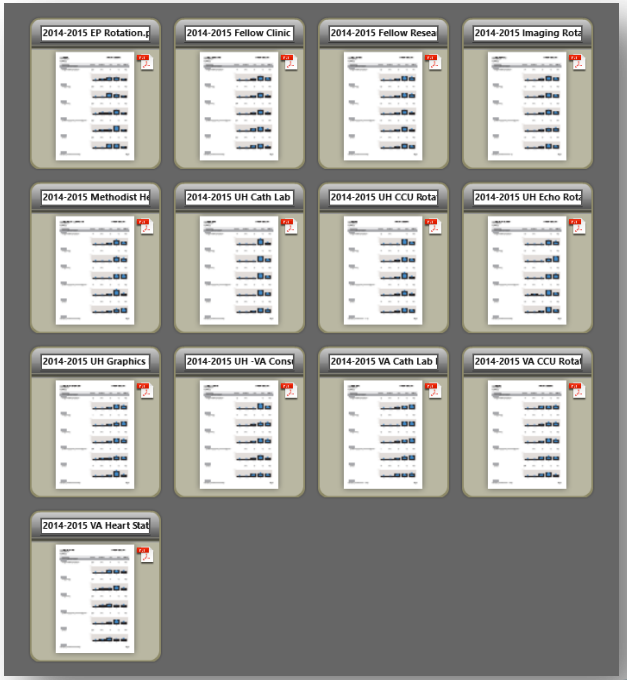
Annual Program Evaluation and Action Plan

Distribute Documents Electronically

Program Evaluations and Surveys



Rotation Evaluations



Summarize Complex Findings

CCU Resident/Intern Comments:

they come in to the hospital for long periods of time. Another concern I have is my experience with the ER interns. Although I cannot generalize, my experience has been that the majority of them are not interested at all in the rotation. They leave the hospital as soon as their shift is over even if the work is not done. They don't give check out to the resident or fellow. When the attending is teaching, they don't pay attention to what they are saying. They leave their work to attend codes or do procedures on patients not even on the service and when the shift is over they don't care the work is not done.

Too many attendings giving conflicting input contrasting with the current attending.

There were many inappropriate admissions that are often sent when the intern is alone from the hours of 7-9pm. Also with the high number of turnover, it definitely helps having more interns on service.

Lots of social work involved which takes up most of the time thus decreasing time for focussing on actual clinical medicine involved

Some admissions are inappropriate.

Interactions with the emergency department. I am told this is better than in years past, however, the friction between medicine/cardiology and the ED continues. It is often difficult to ask questions without being perceived as "obstructive", of which I was accused more than once. Several instances occurred where histories related to my by providers downstairs were either incorrect or untrue. I don't think they get enough credit for the 80-90% of the time that the initial assessment is correct, but I still think we have a long way to go to improve this relationship

The ER waits until after 6 pm (when the fellows leave) to dump inappropriate admissions, many of the patients were there at 8 am, for other reasons besides chest pain. Often the Cardiology service is admitting worsening anemia, AKI, volume overload from cirrhosis, chronic back pain, knee pain, blurry vision, or gastroenteritis. Often as a resident, you are admitting more than 10 new admits a day or more than 18 over 48 hours.

This is one of the only programs without critical care fellows in house and this should probably be re-addressed at some point. While autonomy is good, maybe it shouldn't be in the middle of the night with dying critically ill patients. As PGY-2s we're expected to handle more than board-certified internists practicing in the community. SAMMC residents when rotating with us frequently comment how ironic it is that we have medicine hospitalists in house to triage and staff out bread-and-butter medicine cases, but we don't even have fellows much less attendings to staff out critically ill patients or assist with procedures.

We often had continuing care of over 20 patients, The er knows the residents cannot triage the patients so they admit very inappropriate admits that do nothing but add to our already ACGME violating census. Admits include pyelonephritis, pe, si, heroin detox. Often they are young patients who mention chest pain on review of systems, the er knows the chest pain is low risk and the patient is ruled out Ed, but they want to admit for their secondary non cardiac diagnosis, that they are afraid will be rejected by the medicine hospitalist.

Long hours for the day resident, little time for reading, maybe check out time could be cut back to 6pm.

- ER Interns a problem
- Inappropriate ER Admissions
- Inappropriate ER Admissions
- Inappropriate ER Admissions
- No in house fellow/faculty
- Inappropriate ER Admissions

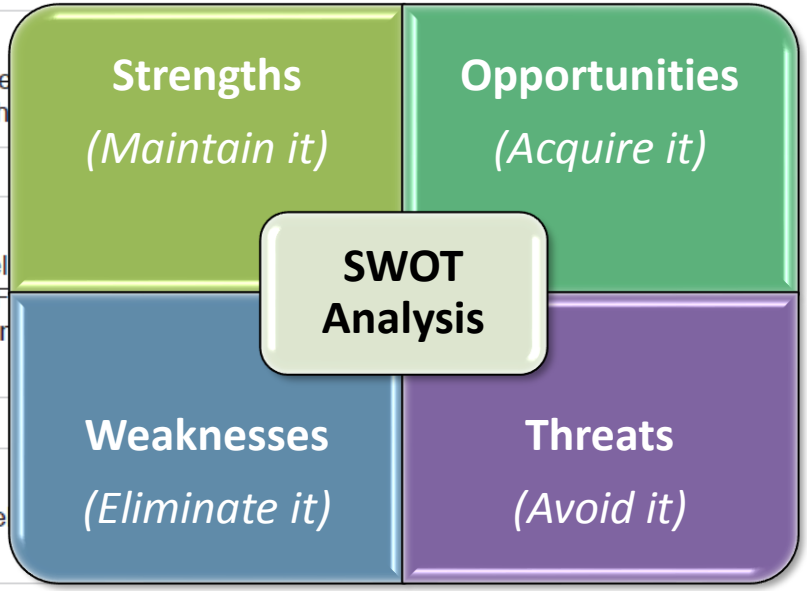
Use a SWOT Analysis

Catheterization Laboratory Rotation VA

Anonymous:
"Pleasant experience . I enjoyed more authority in the cath lab as a senior fe
independently. Friendly environment and I really enjoyed working in the cath

Anonymous:
"One of the best rotations. Review of films on a daily basis with faculty is hel
feedback is constructive and helped me improve techniques, panning, etc. F
allow independence to allow fellows to troubleshoot problems in a safe settir
especially the techs."

Anonymous:
"Enjoyed cath rotation at VA. Dr. Pham and Dr. Chilton served as role mode
evidence based teaching."



Tips for Success – Program Evaluation Committee

Barriers	Solutions
Lots of information to review	Make Individual assignments
Lengthy meetings	Summarize work to date
No written comments	Division-wide meeting

Thank you!
Questions?