RESIDENT HANDBOOK
SECTION VI: ACADEMIC ACTIONS

CLINICAL COMPETENCY COMMITTEE POLICY

INTRODUCTION

I. As part of the Next Accreditation System (NAS), all Accreditation Council for Graduate Medical Education (ACGME) accredited training programs must have clinical competency committees (CCC).

II. The theory behind CCC is that assessment by a consensus of a diverse group of faculty reinforces when a resident is doing well and identifies areas of concern for a resident having problems.

III. Discussions of the CCC help differentiate poor performance in isolated situations from a pattern of poor performance.

IV. CCC helps clarify the areas of concern for a “problem resident” i.e. specific areas of deficiency, inability to function in different settings for example the intensive care unit (ICU), operating room (OR), or the emergency department (ED).

V. Process of CCC also allows departments to identify weaknesses in their educational curriculum, rotation schedules, and supervision.

POLICY

I. All residency and fellowship programs must have CCCs in accordance with ACGME requirements.

II. CCCs will meet with a frequency that may exceed that required by the ACGME but not less frequently.

III. Outcomes of the CCC will be reported to ACGME semiannually (during the ACGME-designated windows).

IV. Each residency and fellowship program must have its own policy for its CCC that is provided available for the Office of Graduate Medical Education (GME) to review upon request.

PROCEDURE

I. Each program will have a CCC with a structure that meets ACGME requirements:

   a. CCC are appointed by the program director and must include three faculty; program director may participate on the CCC

   b. Chair of the CCC who is not the program director or chair of the respective department is encouraged

   c. Membership of the CCC will vary by department size but must include at least three faculty (as above).

      i. Representatives from all divisions/services encouraged

      ii. Where there are multiple sites, representation from all sites encouraged

iii. Representation from junior and senior faculty encouraged

iv. In large departments, CCC may consider staggered terms for representatives

v. In small departments, CCC may include whole faculty

vi. Chief residents (embedded) and or residents in final year of training are not allowed

vii. Chief residents (in extra years of training may participate but not vote)

viii. CCC may include non-physicians

d. Requirements for membership:

i. All committee faculty must be actively involved in resident education

ii. All committee faculty must participate in committee deliberations regularly (75% of meetings)

iii. Advisors may contribute objective information to the discussion

iv. Feedback to trainees by the program director must be constructive and timely following meetings

II. Function of the CCC

a. Review all resident evaluations:

i. End of rotation evaluations

ii. Direct observation checklists for skills i.e. CVL placement, mini-CEX, other procedural skills

iii. 360^0 or multisource evaluations (nurses, colleagues, students, patients, other ancillary health care personnel)

iv. Semi-annual evaluations by the program director

v. Attendance records for conferences

vi. In-training examination (ITE) scores

vii. Professionalism score cards

viii. Procedure log

ix. Any other assessment information available (i.e. praise cards and concern cards)

b. Review all resident evaluations semiannually

i. Meet to discuss the evaluations

ii. Achieve consensus on residents' performances

iii. Complete the specialty specific milestones forms for each trainee

iv. Complete reporting to the ACGME semiannually

c. Make recommendations to the program director

i. Promotion

ii. Remediation

iii. Dismissal

Approved by Graduate Medical Education Committee April 2017