CLINICAL COMPETENCY COMMITTEE POLICY

I. Introduction

1. As part of the Next Accreditation System (NAS), all ACGME accredited training programs must have clinical competency committees (CCC).

2. 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.

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

4. 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 ICU, OR or the ED.

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

II. Policy

1. All residency and fellowship programs must have clinical competency committees in accordance with ACGME requirements.

2. Clinical competency committees will meet with a frequency that may exceed that required by the ACGME but not less frequently.

3. Outcomes of the clinical competency committee will be reported to ACGME semiannually (during the ACGME designated windows).

4. Each residency and fellowship program must have its own policy for its CCC that is provided available for the GME office to review upon request.

III. Procedure

1. 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 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

2. 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. 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