Many Hands Make Light Work: Maximizing the Efficiency of the CCC

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

Overview

- Brief review of the evolution of the Clinical Competency Committee (CCC)
- Review the importance of the evaluations feeding into the semi-annual review
- Note OTHER CCC responsibilities
- Describe our system which requires 4 hours per year to evaluate 36 residents
- Describe rationale for our system
- Offer strategies to enhance the efficiency of CCCs in other programs
- Learn from other best practices

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Brief history of the CCC

Next/New Accreditation System

- 2009 beginning of process
  - Based on 6 Core Competencies
- Three aims:
  - Prepare physicians to practice in 21st century
  - Accreditation based on educational outcomes
  - Reduce burden associated w/ current process

New Accreditation System

- Semi-annual evaluations of each resident
- NAS:
  - Phase I began July 2013
  - **Phase II began July 2014**
    - Semi-annual reporting to ACGME
    - First reports due December 2014

New Accreditation System

- Clinical Competency Committee (CCC)
  - ≥ 3 faculty members
  - Active in evaluation of residents
  - No resident members

Semi-Annual Reports

- Alpha Testing: 12 programs
  - Recommended:
    - 2 residents from each year – total 6 residents
    - Variety of residents – top, middle & bottom of class
    - CCC averaged 6-7 members
    - Reviewed on average 6 residents
    - Avg time: 60 min./resident (range 36-84 min)
    - 6 hours twice a year
    - 36 hours twice a year for us!

Semi-Annual Reports

- Beta Testing: 31 programs
  - Recommended:
    - 2 residents from each year – total 6 residents
    - Variety of residents – top, middle & bottom of class
    - CCC averaged 5-6 members
    - Reviewed on average 6 residents
    - Avg time: 88 min./resident (range 47-122 min)
    - 8 hours and 48 minutes twice a year
    - 52 hours and 48 minutes twice a year for us!

Other CCC Responsibilities

- Identify residents who may be struggling
- Review overall “gestalt” of how residents are doing (“faculty feedback forums”)
- Create IEPs for residents in need
- Residents w/ difficulties need more time
  - CCC starts dialogue and hands off to ResMan

The CCC Overhaul Process

- Step 1: Update evaluations
- Step 2: Streamline data compilation for advisors
- Step 3: Coach advisors on milestone completion
- Step 4: Restructure CCC format

Step 1: Update Evaluations

" I'VE PREPARED A SELF-EVALUATION WHICH YOU CAN REFER TO WHEN YOU DO MY ANNUAL REVIEW. "

Step 1: Update Evaluations

- Modify evaluations to feed semiannual report
- Evaluations were modified to relate to the milestones most likely to be observed during that rotation or clinical experience
- Structured rotation evaluations to capture milestones
- Evaluations managed in *New Innovations*

Rotation	# Milestones	Milestones
Amb Peds	5	PC-3, MK-2, PBL-2, C-2, C-3
BH	10	PC-2, MK-1, SBP-3, P-1, P-3, P-4, C-1, C-2, C-3, C-4
CH	4	PC-3, SBP-1, SBP-3, P-3,
Chief	7	SBP-4, PBL 3, P-2, P-3, P-4, C-3, C-4
CICU	5	PC-1, MK-1, MK-2, SBP-2, C-2
Derm	3	PC-5, MK-1, PBL-2
Elective	2-3	To be identified prior by resident prior to rotation start
EM	6	PC-1, PC-5, MK-1, MK-2, C-2, C-3
FMC	12	PC-5, MK-1, MK-2, SBP-1, SBP-2, PBL-1, P-1, P-2, P-3, C-1, C-2, C-3
FMOP	17	PC-2, PC-3, PC-4, PC-5, MK-1, MK-2, SBP-1, PBL-1, PBL-2, PBL-3, P-1, P-2, P-3, C-1, C-2, C-3, C-4
Fulton	10	PC-2, MK-1, MK-2, SBP-1, PBL-1, PBL-2, P-2, P-3, C-1, C-2,
Geriatrics	8	PC-2, PC-4, MK-1, SBP-2, SBP-4, C-1, C-2, C-3
GS	3	PC-5, MK-1, P-2
IPFM	20	PC-1, PC-2, PC-3, PC-4, PC-5, MK-1, MK-2, SBP-1, SBP-2, SBP-3, SBP-4, PBL-1, PBL-2, PBL-3, P-1, P-2, P-3, C-2, C-3, C-4
MICU	7	PC-1, PC-4, PC-5, MK-1, MK-2, SBP-1, C-2
NICU	5	PC-1, PC-5, MK-1, MK-2, SBP-2,
OB	4	PC-5, MK-1, C-2, C-3
Ortho	3	PC-5, MK-1, P-2
Peds	3	MK-1, SBP-4, P-4
PM	4	SBP-4, PBL-3, P-1, P-4
RSA	3	SBP-2, PBL-1, PBL-3
SM	4	PC-4, PC-5, MK-1,C-3
SS	3	PC-5, P-2, P-4
WBN	5	PC-3, PC-5, MK-1, C-2, C-4
WH	4	PC-2, PC-3, PC-5, MK-1
Advisor	3	PBL-2, P-1, P-4

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Step 2: Streamline data compilation for advisors

Streamline data

Streamlining Data

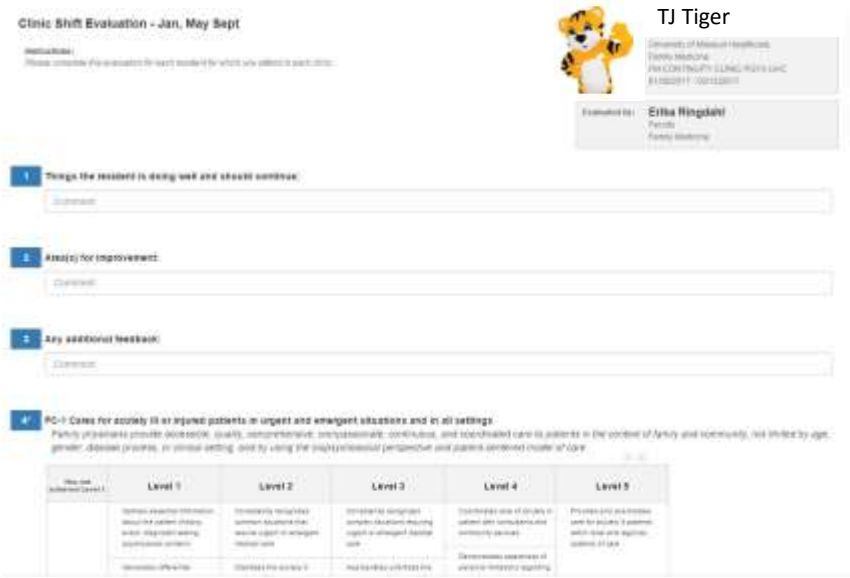
- Taking milestone data from multiple evaluators in multiple settings
- Comments from multiple rotations
- Outpatient “Shift Cards”
- Discussions from (non-review) CCC meetings

PC-1 Cares for acutely ill or injured patients in urgent and emergent situations and in all settings *Family physicians provide accessible, quality, comprehensive, compassionate, continuous, and coordinated care to patients in the context of family and community, not limited by age, gender, disease process, or clinical setting, and by using the biopsychosocial perspective and patient-centered model of care*

Has not achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Gathers essential information about the patient (history, exam, diagnostic testing, psychosocial context)	Consistently recognizes common situations that require urgent or emergent medical care	Consistently recognizes complex situations requiring urgent or emergent medical care	Coordinates care of acutely ill patient with consultants and community services	Provides and coordinates care for acutely ill patients within local and regional systems of care
	Generates differential	Stabilizes the acutely ill patient	Appropriately prioritizes	Demonstrates awareness of personal limitations	

AVG	PEER	PRIOR
2.28	2.29	N/A

View Details

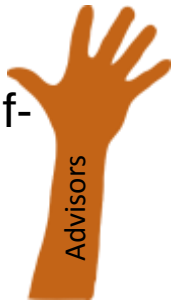


Streamlining Data

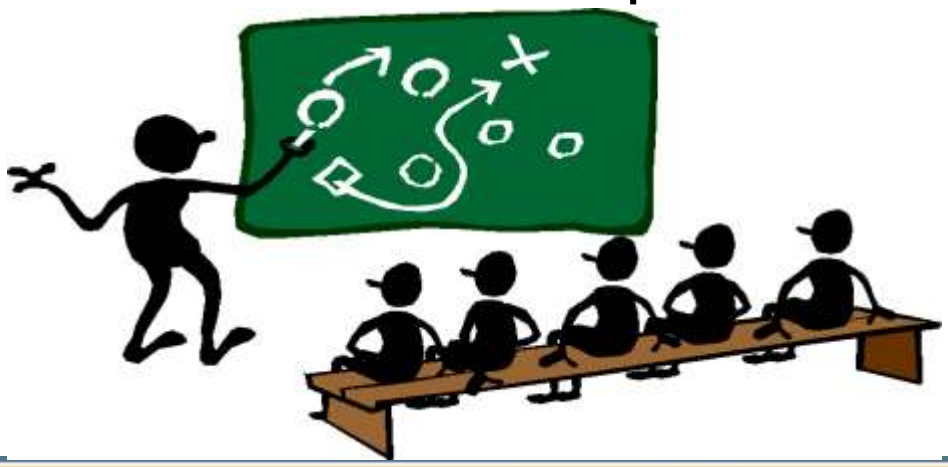
- Coordinator and staff are critical!
  - Troubleshooting attending issues
  - Eliciting feedback from external attendings
  - Troubleshooting attending issues
  - Troubleshooting NI issues
  - Prompting residents to self-evaluate
  - Troubleshooting attending issues

Current Process

- Work done in advance of meetings
  - Advisor reviews evaluations in New Innovations
  - Advisor meets with resident & reviews self-evaluations
  - Advisor drafts milestone report



Step 3: Coach advisors on milestone completion



Evolving Advisor Role

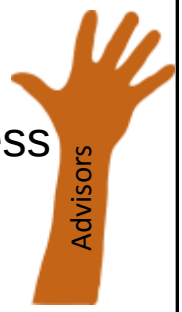
- Advisor criteria changed
  - Reliable
  - Efficient
  - Time available to fulfill expanded duties
- Accountability
  - If you don't do report, who will?
  - If you're not at meeting, who will present?

Evolving Advisor Role

- Advisor Time
  - 1-2 hours to meet w/ resident
  - 25-60 min. to draft report (median: 30 min.)
  - Two times per year
  - Ongoing mentorship duties in addition
  - We have to account for advisor time (from 5 to 20 hours/year)

Evolving Advisor Assessment Skills

- Work in progress
  - Advisors becoming more familiar w/ milestones
  - Continued discussions about group process
  - Ongoing faculty development



Step 4: Restructure CCC format

Our Experience

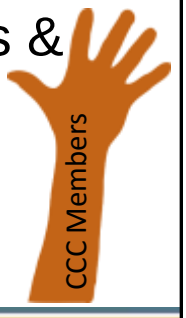
- Barriers – finding multiple protected days for many busy faculty to meet
- Are meetings the most efficient way to do this?

Our CCC

- Existing Resident Advisor Committee
  - Converted to CCC
    - Removed chief resident
    - 23 faculty plus PD
    - Behaviorist chairs the CCC
  - Meets 1 hour/month x 12 months/year

Who is the CCC?

- Size of CCC – large enough but not too large
- Our advisors practice in multiple clinics & have other clinical responsibilities (IPFM, FMC, etc.)



Our CCC

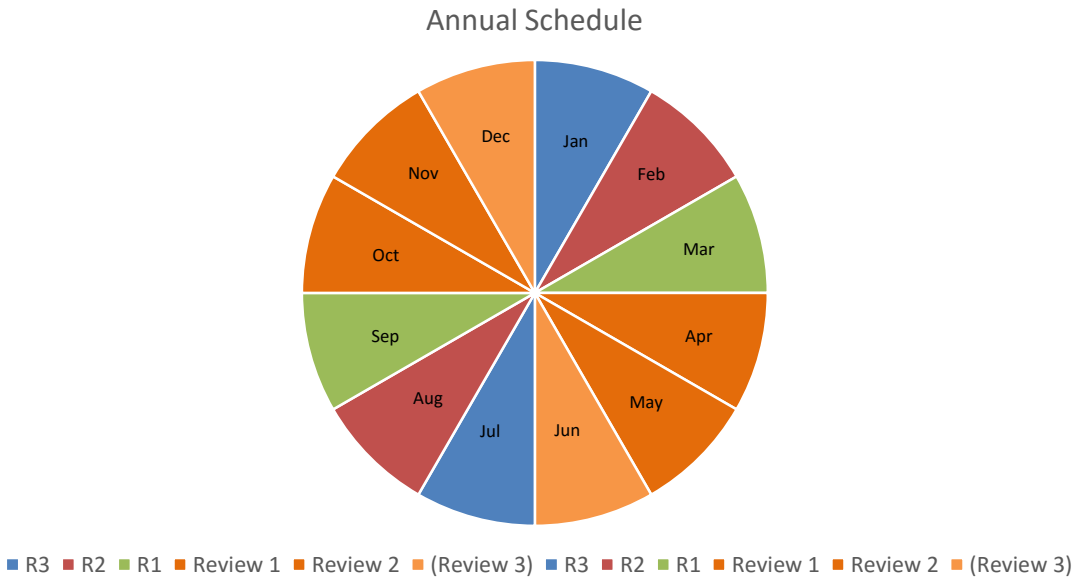
- Advisors
  - 1-3 residents per advisor
- Advisors make recommendations to CCC
- CCC makes recommendations to PD

Behaviorist Chairs CCC

- Neutral
- Trained at facilitation, psychometrics & evaluation
- Holds advisors accountable
- Assists coordinator with data management

Meeting Format

- Resident reviews divided into two 1-hour CCC meetings
  - Each meeting subdivided into 2 groups according to 4 continuity clinics
  - Meeting 1: residents 1-9 and 10-18
  - Meeting 2: residents 19-27 and 28-36
- 6 minutes per resident



Current Process

- Logistics
  - Tables set up conference-style
  - Resident agenda displayed and distributed in advance
  - Milestone reports copied for each group member
  - Milestone definitions copied for each group member

MK-1 Demonstrates medical knowledge of sufficient breadth and depth to practice family medicine

The practice of family medicine demands a broad and deep fund of knowledge to proficiently care for a diverse patient population with undifferentiated health care needs.

Has not achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Demonstrates the capacity to improve medical knowledge through targeted study	Uses the American Board of Family Medicine (ABFM) InTraining Examination or American College of Osteopathic Family Physicians (ACOFP) InService Examination resident scaled score to further guide his or her education	Achieves an ABFM In-Training Examination or ACOFP InService Examination resident scaled score predictive of passing the certification examination	Successfully completes ABFM requirements for certification	Maintains ABFM certification
		Demonstrates capacity to assess and act on personal learning needs	Achieves an ABFM In-Training Assessment resident scaled score predictive of passing the certification examination	Appropriately uses, performs, and interprets diagnostic tests and procedures	Demonstrates life-long learning

PC-1 Cares for acutely ill or injured patients in urgent and emergent situations and in all settings

4.5

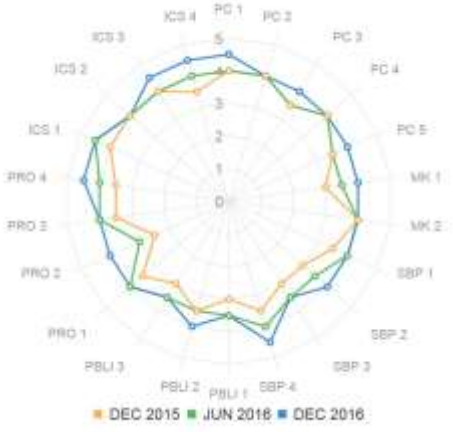
PC-2 Cares for patients with chronic conditions

4.0

PC-3 Partners with the patient, family, and community to improve health through disease prevention and health promotion

4.0

PC-4 Partners with the patient to address issues of ongoing signs, symptoms, or health concerns that remain over time without clear diagnosis despite evaluation and treatment, in a patient-centered, cost-effective manner



Summary of CCC meetings

- Meeting time reserved for advisor report and corrections are made as necessary
- CCC is divided into two groups according to frequency of contact with each resident
  - This allows twice as many residents to be reviewed in each meeting.

Summary of CCC meetings

- As a result, CCC meets for a total of 2 hours twice per year to complete 36 semi-annual reports
- Minimal disruption to the function of the CCC and maximizing information to inform the semi-annual reports
- 8 meetings/year are used to monitor progress of all residents and address those needing additional attention

Advantages

- More transparency in the evaluation of residents
- More efficient evaluations
- No additional meeting time required to create semiannual milestone reports

Limitations

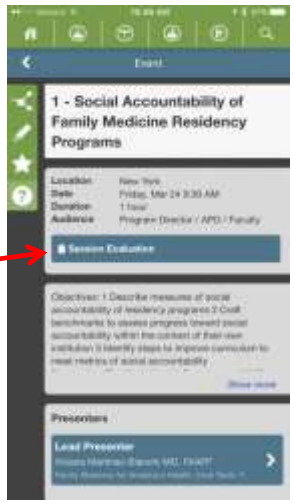
- Not much time for extra discussion if there is disagreement
- Some variability between groups in evaluation standards
  - Challenges w/ different ideas re: grading (give a 2 so have room to grow; no one is a 5, other response sets)
- Advising time taken to be evaluating
- 4 months/year other CCC duties are ignored

Questions?

Best practices?

Please…

Complete the session evaluation.



Thank you.

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