The Clinical Competency Committee Planning, Formation and Implementation: Practical Advice and Interactive Discussion
Format of this Session

- Thanks to a talented group of presenters
- “Works in Progress”
- Sharing of ideas
- Interactive Discussion
- Topics developed from APPD survey of our membership
Pre-Implementation

- Establishing Goals for a CCC
- Organization of a CCC
- Faculty Development
- Organizing your data
Implementation

- Practical Logistics of a CCC
- Role of the Residency Coordinator
- Interpreting assessment data
- Integration with the Program Evaluation Committee
Discussion Groups

- Faculty Development – Studio E
- Role of the Residency Coordinator – Studio C
- Implementation Strategies – Studio B
- Feedback and Remediation – Salons 1-3
OVERVIEW OF THE
CLINICAL COMPETENCE COMMITTEE

Establishing Goals

Adam Pallant, MD/PhD
Alpert School of Medicine of Brown University
APPD National Meeting, Fall 2013
Arlington, VA
CCC-WHO AND WHY?

- Key questions to ask yourself
  - Who are the constituents that your CCC serves?
    - Program Director
    - DIO
    - Institution
    - ACGME
    - Residents
    - Society

"WHO" do you serve?
WHAT DO YOU MOST WANT THE CCC TO ACCOMPLISH?

- CCC can serve many different purposes
  - “Resident report card”
  - Milestones
  - Remediation committee
  - Disciplinary action
  - Faculty development

**Remember**
Goals should be:
1. Specific.
2. Exciting.
Selection of committee members may be the most important component of success!

- Senior vs. junior faculty?
- Potent faculty vs. friendly faculty?
- Chiefs, PD, APD?
- Resident peers?
- Non-physician faculty?
- Non-faculty?
RULES OF THE ROAD

- Who is in charge?
- Who prepares and presents the data?
- Consensus or vote?
- What role does program leadership play?
SCOPE OF WORK

- Frequency of meetings
- Special cases
- Evaluation of all residents or select?
- Creating a report card or “passing bar?”
- Submitting milestones grades to the ACGME?
Ensure that the mission, vision, and scope of the CCC activity are transparent

Diplomacy and confidentiality are critical

Successful outcomes depend upon integrity and trust in the process
What is the CCC role in initiating remediation or disciplinary action?

Does the CCC have a written due process policy (usually institutional)?

What is the process to initiate and follow-through on actions initiated by CCC?
Consider creating your own rules and methods amongst those that you have chosen to be on your CCC team.

GOOD LUCK!
Organizing Your Clinical Competency Committee

APPD Fall Meeting
October 2013
John G. Frohna, MD, MPH
University of Wisconsin
Topics To Be Discussed

- ACGME Requirements
- Member Selection
- Role of program leadership
- Role of chief residents
- Roles of non-physician providers
- Committee Leadership
ACGME Requirements

• Must be a written description of the responsibilities of the CCC

• The CCC should:
  • Review all resident evaluations semi-annually; *(Core)*
  • Prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; *(Core)*
  • Advise the program director for resident progress, including promotion, remediation, and dismissal. *(Detail)*
Member Selection

- Core faculty vs broader range of experience
- How “independent”?  
- No time limit to membership
- We have opted to have the CCC be a subset of our PEC, representing range of rotations (ICU, inpatient, subspecialties, general pediatrics)
Member Selection

- Key Characteristics for Members:
  - Must have intimate knowledge of milestones and should have time and interest to participate fully
  - Need to have experience observing the residents in action
Role of Program Leadership

- **APDs should be on the CCC**
  - Often represent key areas where residents work
  - Invested in resident education
  - Know the residents well

- **Chief Residents could be on the CCC**
  - Bring an important perspective and can also be a representative of the residents as a whole
Issues of Bias Again

- To truly represent an assessment of what the residents actually do, “insider” bias must be limited as much as possible.
- While the evaluations may not always present the full picture, the CCC must work from formal documentation of concerns.
Role of Non-Physician Member

- Worth considering such a person
- Role depends on their other roles in the program
  - PhD Educator: may facilitate discussions; keep the focus on the milestone reporting; advise about resident difficulties / remediation plan
  - Coordinator: Contribute info on professionalism and other competencies
  - Nurse: brings valuable perspective to feed into reporting; can bridge the inter-professional gaps in education
Committee Leadership

- ACGME’s view(s)
- Options
  - PD as Chair
  - APD as Chair
  - Other member as Chair
ACGME’s Current FAQ

- The requirements regarding the CCC do not preclude or limit a program director’s participation on the CCC. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director’s other roles as resident advocate, advisor, and confidante; the impact of the program director’s presence on the other CCC members’ discussions and decisions; the size of the program faculty; and other program-relevant factors.
- The program director has final responsibility for the program's evaluation and promotion decisions.
# Program Director as Chair

<table>
<thead>
<tr>
<th>Pro</th>
<th>Con</th>
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<tbody>
<tr>
<td>- Most able to take on this role now</td>
<td>- May unknowingly influence the outcome or the free flow of information</td>
</tr>
<tr>
<td>- Has time and (relative) expertise</td>
<td>- Personal bias about a resident may influence discussions and/or decisions</td>
</tr>
<tr>
<td>- Has the most knowledge about the residents</td>
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<tr>
<td>- Meetings may possibly be more efficient</td>
<td></td>
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<tr>
<td>- The buck stops here</td>
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</tbody>
</table>
**Associate Program Director as Chair**

**Pro**
- Know milestones and invested in education
- Great faculty development opportunity
- Separates the decisions from the program director
- Prevents PD inaction
- Program director can be “advisory”

**Con**
- May not have the right skills
- May not have enough time
- Program director has flexibility to alter recommendation
### Other Member as Chair

<table>
<thead>
<tr>
<th>Pro</th>
<th>Con</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Less risk of “insider” bias</td>
<td>- Need someone with experience, skills, and knowledge</td>
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<tr>
<td>- Can function most independently from the program</td>
<td>- More time investment upfront</td>
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<td>- Separates decisions from program leadership</td>
<td>- May have to compensate for this time</td>
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<tr>
<td>- Program director can be “advisory”</td>
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</table>
Defining the Time Commitment

- ~ 1 hour per resident
- 166 residents at 1 hour 2X a year =
  - 42 days per year or
  - 336 hours per year or
  - 5 eight hour days each week for 2 months
Effective Use of Faculty Time

- Pre-work before CCC
  - NIH type review with a 1° and 2° reviewer
  - Interpretation and synthesis of some or all data
- Length of discussions during CCC
- Frequency of meetings (must be at least twice)
- Faculty development needs
- Time for coaching and feedback
- Relationship building with trainees
- Observation
How Can We Reward or Incentivize Faculty

- Leadership roles
- Titles
- Educational time (EVUs)
- Stipends/bonuses
- Support for teaching awards
- Opportunities for educational scholarship
- CME
Methods of Faculty Development

- Educational retreats
- Workshops
- “Lunch and learn” sessions
- Incorporate learning into the time that the CCC meets to discuss learners
- Podcasts/webinars
- Relevant readings and other types of homework
- Videos
What I hear, I forget. What I hear and see, I remember a little. What I hear, see, and ask questions about or discuss with someone else, I begin to understand. What I hear, see, discuss, and do, I acquire knowledge and skill. What I teach to another, I master.

Silberman, 1996
Topics for Faculty Development

- Introduction to competency based training and the milestones
- Evaluation principles
- Shared mental models
- Integrating and synthesizing data
- Providing feedback for growth
Topics for Faculty Development

- Facilitating reflection and self-assessment
- Direct observation skills
- Helping learners change behavior
- Teaching learners how to set goals to improve
- Evaluation forms and rating scales
- Working with problem and marginal students
Faculty Development in Assessment – the ABIM program

- Direct observation of clinical competence
- Effective feedback
- Systems approach to evaluation
- Rating scales and evaluation forms
Faculty Development is NOT just for the CCC

- Other health care providers
- Faculty not on the CCC
- Residents
- Leadership
Revisit Topics for Clarification and Knowledge/Skill Gaps

What is the “muddiest point” in today’s presentation?
Advantages of a “Mock” Clinical Competency Meeting

- Gives faculty time to practice
- Provide more realistic time estimates
- Identify data gaps
- Provides a time for faculty development
- Identify faculty disagreement on the milestones or milestone meaning
- Identify thresholds for concern or commendation
- Feedback practice
TRANSFORM
your
Thinking
Longitudinal Ongoing Faculty Development is Crucial
Assessment Information:
How Do You Use It, Where Does it Come From, and What Do You Do With It?

Dan Schumacher, MD, MEd
Associate Program Director
Director, Competency-based Learning and Assessment
Boston Combined Residency Program
How Do You Use Information Coming In?

- Train CCC to look for ways to “double-count”

Openness to feedback

Seeking help with needed

Identifying improvement opportunities

PBLI 1, PBLI 2, PBLI 3, PBLI 4, Prof 4 (help seeking), Prof 5 (trustworthiness)
How Do You Use Information Coming In?

- Use systems to map the assessment items you use to spatially be next to their relevant competencies for CCC deliberations
How Do You Use Information Coming In?

• How do you use information coming in to place residents where they actually fall along the milestones continuum?

Assessors

CCC Members
How Do You Use Information Coming In?

• How do you use information coming in to place residents where they actually fall along the milestones continuum?

Shared Mental Model!

CCC Members

Your Assessors
Who Should Provide Information?

• Those who directly observe residents
• Faculty
  – How much do they directly observe?
  – Ex: history taking vs. clinical reasoning
• Nurses
  – Interprofessional teamwork, organization and prioritization, communication with families, etc
• Residents
  – Handovers, professional identity development, organization and communication, etc
• Unit clerks, Social Workers, others
  – Interprofessional teamwork, communication with families, etc
Who Should Provide Information?

• How do you gather assessment information from other members of the healthcare team?
• What tools?
• What training?
• How do you weight this information?
  – Are other assessors more accurate than faculty?
What Do You Do With Info Coming From CCC Deliberations?

• Report it (I have a feeling you will do this)
• Feed it back to the residents!
Feeding Back CCC Deliberations to Residents

• The goal of CBME and milestones-based assessment is twofold
  – Ensure to all that our trainees are prepared for unsupervised practice
  – Help learners take the next steps in their development through defining current and future states

• Who?
  – CCC members, chiefs, PD/APDs?
  – Pair with advisors?

• How?
  – Frequency of meetings (depends on performance)
  – Professional development plan (both for areas of “typical” development as well as areas in need of focus)
  – Training needed to do it well (e.g., fostering a sense of competence and relatedness)
Figure 1 Forces and factors in developing the master learner.

Schumacher, Englander, Carraccio. Acad Med.
RUNNING AN EFFICIENT AND EFFECTIVE CCC

Betty Staples, MD
Duke University Hospital

LET’S GET REAL: PRACTICAL LOGISTICS

Adam Pallant, MD/PhD
Alpert Medical School of Brown University
OBJECTIVES

- Identify key components of an effective CCC
- Describe one system to organize these components
- Recognize that a CCC can accomplish more than designation of milestones
- List a few potential pitfalls that committee may encounter
- Recognize the realities of getting this started
**Key Components**

- Dedicated personnel for committee
- Clearly identified assessments
- Data to evaluate progress
- Excellent preparation
- Efficient strategy for presentation
PERSONNEL- DUKE ADVISOR SYSTEM

- Core group of faculty
- PD, APDs, Vice-Chair for Education
  - Approximately 13 each
- Work with resident for 3 years
- Assist with remediation
- Assist with Letters of Recommendation
- Intimate knowledge of program’s requirements
PERSONNEL- DUKE ADVISOR SYSTEM

- Requires parallel mentor system
- Identify mentor to assist with career planning
- Research project, networking, fellowship application
CCC Personnel - Add a Few Others

- Representatives from across rotations
- PD/APDS
  - Hospitalist
  - Primary Care
  - Subspecialty
- Additional faculty
  - PICU
  - ED
- Chief Residents
ASSESSMENTS

- Progress on Milestones
- ITE
- Procedural competency
- Quality Improvement Project
- Scholarly project
- Individualized curriculum
- Career planning
DISSEMINATION OF EXPECTATIONS

- PD/APD Meeting to set expectations annually
- Milestone self-assessment
  - Enhance understanding of milestone tools
- Program Director Meeting with each resident
  - Provide checklist of expectations
DATA

- Milestone based evaluations
- Electronic evaluation system pulls together aggregate data
- Level specific norms
  - Eventually ACGME
  - Can look at peer data relative to individual from evaluation system
  - Set by PD and APDs after review of averages
EXCELLENT PRE-MEETING PREP

- Advisor/ Resident meets = Transparency
- Resident completes milestone self-assessment
- Review milestone data from aggregated evaluations with peer norms
  - Opportunity to provide data on “personal clinical effectiveness”
- Fill out draft of CCC milestone evaluation
- Review progress on other expectations
  - ITE, procedures, Individualized curriculum, mentor
**Pre-Meeting Prep**

- PD discusses with all advisors who they would like additional time for.
- Order of discussion → Sickest residents first
TIME TO MEET

- Dates set 12 months in advance
  - Three meetings a year: November, February, May
- Advisor presents advisees
- Has pre-completed evaluation of 21 milestones to project with peer-referenced norms.
- Focus on aspects of performance that are outliers
  - either high or low
- CCC approves final milestone assessment
TIME TO MEET

- In addition to milestone assessment....
- CCC discusses strategies for remediation and performance enhancement.
- Also assists with other expectations
  - Identification of mentors, QI projects, etc.
PITFALLS

- Massive Evaluation overhaul
- Depends on sophistication of electronic evaluation system
- Limited data now for establishment of norms
- Losing comments on evaluations
- Still spend too much time on milestones and lose richness of CCC discussion
- CCC is depending on advisor to generate preliminary milestone assessment.
TIME TO GET REAL!!

- Just how much time will this take?
- Is there any way to “support” the faculty that will pour their efforts into this activity?
- What will be the prime focus of your CCC?
  - Evaluation
  - Remediation
  - Milestone reports
  - Written feedback
TIME TO DO SOME MATH

- 21 Milestones
  - x how many residents?
  - x how many times a year?
    - Adam’s residency of 70 = 2940 buttons per year
    - Assuming 10 seconds per radio button =
    - 8+ hours per year entering data
  - Multiply that number by 2.4 for full milestone roll-out

[Image: LOOK AT ALL THIS WORK I HAVEN'T DONE YET]
TIME TO MAKE IT WORK

- Assign milestone scoring to a team of individuals
- Modify some/all of your evaluation forms
- Automate the data collection
- Purchase software from proprietary company
- What else?
TIME TO PRIORITIZE

- What gets done in advance of a CCC meeting?
- Who does the footwork and preparation?
- How will you manage your time, esp. with “strong performers”
- Can you do all that you hope to?
TIME TO SET GROUND RULES

- Who is in charge of the group, and to whom does the CCC report?
- What role does the PD play?
- How do you manage conflicts or differences of opinion?
TRUE CONFESSIONS OF A PROGRAM DIRECTOR

- Current plans and expectations at Brown...at least for starters
- Some case scenarios we are managing right now.
Clinical Competency Committee
The Role of Residency Coordinators

APPD Fall Meeting
Friday, October 4, 2013
Samantha Comarnitsky, MPA
Agenda

- “Disclaimers”
- My Role in the CCC
- Variety of Information
  - Numbers
  - Document Layouts
  - Support Items
- Plan for the Future
Disclaimers

- Numerical data
- System is a work in progress
  - Rubric for evaluations
  - Weight of milestones
- Technology change
- Continual reviews of residents
My Process

- Our CCC
- Adjust Evaluations
- Embrace Technology
- Compile Multisource Components
- Meet with CCC Chair and PD
- Assemble Committee Packets
- Support Discussion
- Document
## Variety of Information

<table>
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<tr>
<th>Preparation Time</th>
<th>Medium</th>
<th>Potential Impact of Information</th>
<th>High</th>
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<tbody>
<tr>
<td>High</td>
<td>• Clinic numbers</td>
<td>• Quantitative Information</td>
<td>• Qualitative Information</td>
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<tr>
<td></td>
<td>• Resident ILPs</td>
<td>• Evaluation Scores</td>
<td>• Multi Source Comments</td>
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<tr>
<td></td>
<td>• Procedures</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Scholarly Projects</td>
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<tr>
<td></td>
<td>• Professionalism</td>
<td></td>
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<tr>
<td>Medium</td>
<td>• Step Scores</td>
<td></td>
<td>• ITE Scores</td>
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<td>• ITE Scores</td>
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<td>• Burnout Scores</td>
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</table>
Show Me the Numbers

- Timeline and Progress
- What makes the most sense?
  - Average
  - Range
  - Standard Deviation
- Class Comparisons
- National Statistics – only time will tell
# Highlight Concerns

<table>
<thead>
<tr>
<th>Milestone</th>
<th>ITE</th>
<th>ICS1</th>
<th>ICS2</th>
<th>MK1</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
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<td>230</td>
<td>4.20</td>
<td>3.15</td>
<td>3.80</td>
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<td>4.00</td>
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<td>Doc Strange</td>
<td>330</td>
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<td>0</td>
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<td>Average</td>
<td>4.4</td>
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<td>4.5</td>
<td>4.4</td>
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<td>1.1</td>
<td>0.8</td>
<td>1.1</td>
<td>1.3</td>
<td>1.5</td>
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<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
<td>3.1</td>
<td>2.6</td>
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Additional Questions

- Number of evaluations
- Non-evaluated questions
- Variation from evaluator

<table>
<thead>
<tr>
<th>Milestone</th>
<th>ICS2</th>
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<tr>
<td>Super Man</td>
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<tr>
<td>2 Stnd Dev</td>
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</tr>
<tr>
<td>&quot;Below&quot; 2 Stnd Dev</td>
<td>3.4</td>
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</table>
Qualitative Information

Example: “Though she had a problem toward the beginning of the rotation in seeking help when needed, she did show some improvement in it as the rotation progressed.”

Things to consider:
- “Average” of comments
- Level of Training/Time of Year
- Correlation to numerical early warning
The Plan

- Review evaluations and questions
  - Map questions to milestones
  - Adjust parameters for early warnings
- Do not fear the technology
- Develop a year-long process
- Adjust tracking forms
- Take comfort in waiting & learning
It’s ok to not have all the answers…

We cannot direct the wind but we can adjust the sails.

-Unknown*

*a.k.a. Samantha Comarnitsky*
Assessment When the Stakes Are High: Challenges of Interpreting Assessment Data and Implications for Clinical Competency Committees

Daniel C. West, MD
University of California, San Francisco
Clinical Competency Committee Session, APPD
October 4, 2013
Plan

1. Requirements for high-stakes decision making
2. Review validity (and reliability) and how do you know it when you see it
3. Thoughts about how a CCC should approach interpreting assessment data
Competency-Based Medical Education

*Interpreting Assessment Data*

- Competency-based medical education requires high-stakes decisions...
  - For the trainee
  - For the program
  - For patients
- Decisions are only as good as the information used to make them
- Need to use data with validity evidence that can withstand scrutiny
Validity

What it is and what it is not

- Validity is based on evidence
  - Supports (or refutes) interpretation of the results

- Assessment tools **not** inherently valid or invalid
  - *Cannot* validate an assessment tool

- Hypothesis driven
  - Test hypothesized interpretation/meaning of data generated by an assessment

Validity Evidence

*Sources and types of evidence to test validity hypotheses*

- 5 sources of validity evidence:
  - Content, Response process, Internal structure, Relationship to other variables, Consequences
- Requires multiple, but not necessarily all sources
- Some assessments might require greater emphasis on one source over another
# Validity Evidence

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<th>Category</th>
<th>Validity Test</th>
<th>Example Methods</th>
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<tbody>
<tr>
<td>Content</td>
<td>• <em>Evidence</em> items match what is intended to be measured</td>
<td>Content expert review&lt;br&gt;Delphi ratings&lt;br&gt;Focus groups</td>
</tr>
<tr>
<td>Response process</td>
<td>• Quality control of data collection process, accuracy of reports, etc.</td>
<td>Response rate&lt;br&gt;System training&lt;br&gt;Data entry quality</td>
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<tr>
<td>Internal Structure</td>
<td>• Relationship of scores to measures of similar and dissimilar skills</td>
<td>Cronbach alpha&lt;br&gt;Factor analysis&lt;br&gt;G-study/D-study</td>
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<tr>
<td></td>
<td>• Reliability/Reproducibility</td>
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<tr>
<td>Relationship to</td>
<td>• Test hypothesized relationship with other assessment measures</td>
<td>Correlation&lt;br&gt;Univariate tests&lt;br&gt;Multivariate regression</td>
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<tr>
<td>other variables</td>
<td>• Confirmatory/counter-confirmatory</td>
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<tr>
<td>Consequences</td>
<td>• Impact of score interpretation on trainee, program, society</td>
<td>Passing rates&lt;br&gt;Reliability at cut score&lt;br&gt;Impact of false +/-</td>
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</table>
Content Validity

Examples

- *Evidence* that items in assessment are inclusive and *match* skill to be measured
- Pediatric Milestones are great example of expert review and consensus
- Delphi ratings allow for quantitative measure
  - Content validity index
  - Asymmetric confidence intervals
Relationship to Other Variables

Multivariate regression model for PedSCO data gathering domain

<table>
<thead>
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<th>Variable</th>
<th>Regression Coefficient</th>
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<td>-0.29, 0.49</td>
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Reliability and Measurement

All measurements have error

- Error defined as:
  - *Variability* in measured score for reasons other than differences in what you are trying to measure.

- Goal of reliability studies is to measure error and identify ways to minimize it.

$$\text{Measured Score} = \text{Real score} + \text{Error}$$
### Common Sources of Error (i.e. Variability)
*These can interact with each other*

<table>
<thead>
<tr>
<th>Source of Variability</th>
<th>Definition or Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learner</strong></td>
<td>Difference in skill, characteristic, or knowledge from one resident to another</td>
</tr>
<tr>
<td><strong>Rater</strong></td>
<td>Training, perspective, knowledge, ability, or bias of one faculty rater relative to another</td>
</tr>
<tr>
<td><strong>Assessment Occasion</strong></td>
<td>Variation in performance from one day to another due to conditions unique to that day (independent of learner or rater)</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Variation in performance unique to clinical setting (e.g. inpatient, outpatient, critical care units, etc.)</td>
</tr>
<tr>
<td><strong>Item</strong></td>
<td>Some questions more difficult or easier than others; Some attributes easier or harder to rate</td>
</tr>
</tbody>
</table>
Generalizability study

Data Gathering: Resident x Rater x Item

<table>
<thead>
<tr>
<th>Source of variance</th>
<th>Variance component</th>
<th>% of variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident (P)</td>
<td>0.56</td>
<td>37</td>
</tr>
<tr>
<td>Rater (R)</td>
<td>0.40</td>
<td>26</td>
</tr>
<tr>
<td>Item (I)</td>
<td>0.02</td>
<td>0</td>
</tr>
<tr>
<td>P * R</td>
<td>0.39</td>
<td>26</td>
</tr>
<tr>
<td>P * I</td>
<td>0.00</td>
<td>0</td>
</tr>
<tr>
<td>R * I</td>
<td>0.01</td>
<td>0</td>
</tr>
<tr>
<td>P * O * I</td>
<td>0.16</td>
<td>10</td>
</tr>
</tbody>
</table>

Decision Study

What if scenario

<table>
<thead>
<tr>
<th>Number of Raters</th>
<th>G-Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.73</td>
</tr>
<tr>
<td>2</td>
<td>0.76</td>
</tr>
<tr>
<td>3</td>
<td>0.80</td>
</tr>
</tbody>
</table>
Interpretation of Assessment Data

Drawing valid conclusions during transition

- Understand the validity evidence supporting the assessment methods you use
  - Be careful about conclusions from data with limited validity evidence
  - When in doubt, get more data

- Participate in the development of validity evidence
  - Many, but not all, will need large sample sizes
Strategies for making high stakes decisions

- Develop shared mental model of the validity evidence of your assessments
- Expert consensus can greatly enhance reliability (i.e. reconcile rater differences)
- Group consensus can be powerful…usually for the better…sometimes for the worse
- Remember the limitations of our current system…this is likely to be better
Summary

- High-stakes decision making requires robust validity evidence
- Validity is based on multiple sources of evidence and is hypothesis driven
  - Validity is a property of the interpretation of the scores...not the tool
  - Requires multiple sources of evidence to support or refute proposed interpretation
- Use caution in this time of transition
Program Evaluation Committee: Relationship to the CCC

Nancy D. Spector, M.D.
October 4, 2013
Overview

• Review ACGME Program Requirements
  – Program Evaluation Committee
  – Clinical Competency Committee
• Discuss intersecting and overlapping areas
• Consider existing program structure to accommodate these new committees
• Examine a conceptual model for program evaluation
Program Evaluation Committee

• Must be composed of at least 2 faculty members and 1 resident and have a written description of responsibilities

• Should participate in
  – Planning, developing, implementing, and evaluating the educational activities
  – Reviewing and revising competency-based goals and objectives
  – Addressing issues of non-compliance
  – Reviewing evaluations of residents and faculty
Program Evaluation Committee

• Performs a formal Annual Program Evaluation (APE)

• Monitors and tracks
  – Resident performance
  – Faculty development
  – Graduate performance
  – Program quality
  – Progress on previous year’s action plan

• Creates a program improvement plan annually
Interactions and information flow between the Clinical Competency Committee and the Program Evaluation Committee
Intersecting and Overlapping Areas

• Review of resident evaluations at CCC
  – May identify curricular gaps
  – Provide program improvement opportunities

Informs Annual Program Evaluation and Action Plan created by the Program Evaluation Committee
Residency Program Training Committee (RPTC)
Boston Combined Residency Program in Pediatrics

RPTC Executive Committee

Program Evaluation Committee

- Inpatient Care Committee
- Subspecialty Committee
- Ambulatory Committee
- Intensive Care Committee
- Individualized Curriculum Committee

RPTC Executive Committee functions as the Program Evaluation Committee
Existing Program Structure and Potential Renovations

- Evaluation Committee
  - Resident Evaluation System
  - Resident Advising System
  - Milestones Assessment System
  - Chief Resident Families

- Clinical Competency Committee
  - Faculty advisors
  - Chief residents
  - Program directors
  - CCC faculty
5 Steps Conceptual Model

1. Determine evaluation need
   - Why?
     • Specified in ACGME Program Requirements

2. Determine evaluation focus
   - What?
     • Residency program

3. Determine evaluation methodology
   - When, Where, How and What?
     • Pertains to the evaluation data collected and how it will be analyzed

5 Steps Conceptual Model

4. Present evaluation results
   – Who and When?
     • Formal meeting or retreat

5. Document evaluation results
   – How?
     • Annual Program Evaluation

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• Bob Vinci
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• Blair Dickinson
• Mario Cruz
Discussion and Questions