**Clinical Competency Committees (CCCs)**

**What is the role of the CCC in resident assessment?**

Each program is expected to form a CCC and begin to develop its members before the specialty transitions into the NAS (eg, for Phase I specialties before July 2013). The members of the CCC make a consensus decision on the progress of each resident. Initially, the CCCs will use existing resident assessment data and faculty member observations to inform their evaluations of residents. Beginning in AY 2013–14, the CCC assessments will use data from the milestone assessments.

A benefit of the CCC approach is that it will offer the resident evaluation process the insight and perspectives of a group of faculty members. The CCC will also serve as an early warning system if a resident fails to progress in the educational program, and will assist in his or her early identification and move toward improvement and remediation.

**What are the qualifications for CCC membership?**

CCC members should include core faculty members who have the opportunity to observe and evaluate residents, but may include other members such as assessment specialists and non-MD medical educators.

**What role should the program director have on the CCC?**

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 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.

**How should members of the CCCs be prepared for their assessment role?**

Evaluation is a core faculty member competency, but most faculty members will need added training in the evaluation process, including how to aggregate and interpret data. They will initially need to discuss the milestone narratives and reach a common agreement of their meaning. There are plans to develop training resources for CCCs. In addition, the individual CCCs and the community of educators at a given institution will also serve as a venue for faculty member discussion about resident evaluation, including how many assessments are needed for any given milestone, data quality, and the application of quality improvement principles to the evaluation process.

**How much work will be required by the CCC to conduct the semiannual resident assessments on the milestones?**

Pilot assessments on the milestones have found that it takes a significant amount of time (up to an hour) to conduct the milestone assessment for each resident the first time the evaluation is done, but that subsequent evaluations take less time, as CCC members become familiar with the milestones and their use.

**Should the milestone assessments be made by specialists during residents’ clinical rotations rather than semiannually by a committee?**

Faculty member specialists, and in some specialties, other health care personnel who contribute to 360-degree evaluations, will evaluate residents during rotations and assignments using the evaluation tools currently used by the program (and new ones
that may be added in the future). The CCC will take data from these evaluations and apply them to the milestones to mark the progress of residents. The CCC will have the advantage of knowing how each of the specialists evaluated residents and can apply that knowledge as it marks the residents’ progress on the milestones. Aggregate, de-identified information for all residents in the program will be reported to the ACGME.

**Should CCCs set a threshold for a resident to have remediation and possible separation?**

One of the goals of the Milestones Project is to be able to identify residents who are not progressing with their peers in one or more areas. In the early years of utilization of the milestones, the comparisons will be to a resident’s peers in a given program, and the thresholds will be set by the CCC. Interventions a program might consider include assigning a mentor with expertise in a given area of deficiency, additional required readings, sessions in a skills lab, and/or added rotations in a given area. If, after remediation, a resident still fails to advance sufficiently on one or more milestones, a CCC might consider extending education, or counseling the resident to consider another specialty or profession.