

Directed Education Committee (DEC) as process for Individualized Education Plans (IEP) for Residents with Struggles: Analysis with RE-AIM Framework

Erum Azhar

Creighton University East Valley Obstetrics & Gynecology Residency Program

Hadia Khan

hadia.khan900@commonspirit.org

Creighton University School of Medicine

Hamna Salimi

WellSpan Good Samaritan Hospital Family Medicine Residency Program

Mahanoor Raza

WellSpan Good Samaritan Hospital Family Medicine Residency Program

Kaylette Jenkins

WellSpan Good Samaritan Hospital Family Medicine Residency Program

Benjamin Ihms

Creighton University School of Medicine

Laila Younes

Creighton University School of Medicine

Abdul Waheed

Creighton University School of Medicine

Research Article

Keywords: RE-AIM, Process Improvement, struggling learner, resident remediation, Individualized Education Plan, Resident Improvement Plan, Clinical Competency Committee

Posted Date: October 12th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-10922285/v1>

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Additional Declarations: No competing interests reported.

Abstract

Background

Program directors and resident advisors serving as both evaluators and advocates for struggling residents face documented role conflict and rater bias, and Clinical Competency Committees (CCCs) tasked with collective remediation decisions face significant time and resource burdens. This study describes and evaluates the Directed Education Committee (DEC), a delegated CCC subcommittee developed to support residents with academic or clinical struggles through individualized education plans (IEPs), using the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework.

Methods

This retrospective, mixed-methods study evaluated DEC over its first five years (Academic Year 2018–2023) at a family medicine residency program. Content analysis of faculty and CCC meeting minutes, using relational content analysis and cognitive mapping, assessed role delineation, cognitive dissonance, learner perception, resident-faculty relationships, and legal/compliance considerations before and after DEC implementation. Quantitative data on resident demographics and outcomes were analyzed using Chi-square and Fisher's exact tests, with significance set at $\alpha < 0.05$.

Results

Over the study period, DEC supported 15 of 37 total residents (38% utilization), developing more than 50 IEPs comprising approximately 500 learning objectives. Only 3 residents (20%) experienced an adverse action (formal remediation, probation, or unsuccessful graduation); the remaining residents achieved competency in their identified area of struggle. No statistically significant associations were found between DEC enrollment, successful IEP completion, or adverse action and resident gender or race. Faculty focus group data indicated that DEC's structural separation of evaluator, advocate, and content-expert roles reduced role confusion and distributed legal/documentation risk compared to traditional program director- or advisor-led approaches.

Conclusions

DEC offers a structurally distinct, feasible alternative to traditional resident remediation models by formally separating evaluation, advocacy, and content-expertise functions within a delegated CCC subcommittee. This approach may be adaptable to other residency programs seeking to formalize support for struggling residents.

Introduction

Medical residency programs are inherently demanding, often placing significant stress on residents. To ensure residents can provide high-quality patient care, it is crucial to have a structured program to support those who are struggling. Identifying these residents and offering appropriate help is essential.

Residency Program Directors and Clinical Competency Committees (CCCs) face a considerable challenge in identifying and assisting residents experiencing academic or clinical difficulties, a challenge documented across multiple specialties and program types (1, 2). The Accreditation Council for Graduate Medical Education (ACGME) mandates CCCs for accreditation purposes and for various resident assessments and decisions (3). These committees are tasked with evaluating resident performance and progress toward unsupervised practice, utilizing structured assessment methods and competency milestones as criteria (4, 5).

A well-designed and effective process is vital for ensuring residents' academic growth, maintaining patient safety, and promoting resident well-being (6). When a CCC or faculty member identifies a resident with substantial difficulties, traditional approaches typically involve the program director, sometimes with a resident advisor (7, 8), or entire CCCs collaboratively developing and implementing an Individualized Education Plan (IEP), Performance Improvement Plan (PIP), or Remediation Plan.

Both of these traditional approaches present significant challenges. Program directors and resident advisors may lack specific expertise in the resident's struggling area or core competency, and they might have unconscious biases (9, 3). Feedback from a single authority figure, such as the program director, can introduce a power imbalance between the program director and the resident, which may unintentionally hamper open communication and effective support; such power differentials can affect how feedback is received and integrated (10). A resident advisor, on the other hand, may experience cognitive conflict or dissonance, leading to confusion about their role as the resident's educational advocate versus their role in evaluation and improvement (9, 3). Additionally, when CCC members collectively take on this task, it can represent a significant drain on faculty time and resources.

To address these challenges, a well-developed framework is essential for providing resident feedback and improving resident outcomes. The authors propose the "Directed Education Committee (DEC)" as an effective and efficient solution. The DEC aims to serve as an alternative support system for struggling residents by developing tailored IEPs and minimizing cognitive bias.

The Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework is a widely used planning and evaluation tool, particularly in public health, behavioral science, and implementation science, used to understand the impact or effectiveness of a program or intervention (11). The RE-AIM framework emphasizes five key dimensions, evaluated at both the individual level and organizational level (11). These five dimensions provide a comprehensive approach to evaluating an intervention's impact and feasibility: Reach, the extent to which the target population participates; Effectiveness, the impact on individual outcomes; Adoption, the proportion of settings that implement the program or

policy; Implementation, the fidelity and consistency of delivery; and Maintenance, the extent to which the program or policy becomes institutionalized as part of routine organizational practice (11).

This manuscript aims to analyze the effectiveness of the DEC framework in supporting struggling residents by applying the RE-AIM framework.

Methods

Study Design & Study Setting:

This is a retrospective review of DEC by using mixed methods by utilizing the RE-AIM framework. The DEC developed as a delegated subcommittee of the Clinical Competency Committee (CCC) in a family medicine residency program. This study evaluates the program for the initial five years which spans from Academic Year (AY) 2018 through 2023 at WellSpan Good Samaritan Hospital Family Medicine Residency Program. WellSpan Good Samaritan Hospital Family Medicine Residency Program is a medium size program in the discipline. At the time when DEC was implemented, the program was accredited by the Accreditation Council for Graduate Medical Education (ACGME) with a total complement of 21 residents. This hospital has been a site of family medicine residency for more than 30 years at the time of this study. This program is the only accredited graduate medical education (GME) program in this community hospital. This program was established in 2014 after the previous program had moved to another location by the prior GME sponsor.

This study was determined by the WellSpan Health Institutional Review Board (IRB) as IRB exempt via notification number 2173829-2. There was no informed consent involved. Individual resident level data was de-identified when provided to this study team. The study followed the SQUIRE 2.0 guidelines (12). As this study evaluated a complete historical cohort rather than a sampled population, no a priori power calculation was performed; potential limitations related to statistical power are addressed in the Discussion. The RE-AIM framework was used for both implementation and evaluation of this project.

Context of DEC Program Development & Implementation

At baseline, the program had a proto-CCC consisting of faculty and program director. The program director was central to the process of evaluation, assessment, and improvement. This included development of improvement plans including enrichment, remediation, and probation. As the ACGME accreditation requirements were being implemented in the program, a fully functional CCC was established. The discussions in the faculty meeting and review literature provided further impetus for creation of an innovative pathway for enrichment and improvement for residents who struggled with their development and meeting the expected milestones. Figure 1 summarizes the structural and cultural context of DEC's emergence, organized by RE-AIM component.

It was intended to help residents struggling to achieve the expected milestones. Figure 2 provides a schematic of how the DEC worked.

Data Collection & Analysis

This is a mixed method study where data were collected to generate a comprehensive understanding of implementation and outcomes of the DEC process. A content analysis was done on the minute notes from general faculty meetings and CCC meetings. These faculty forums provided insights from the focussed discussions regarding the resident improvement and remediation process pre and post implementation of DEC. A relational content analysis method was used to understand and analyze the data. Cognitive mapping was performed for proximity of the discussion content to the following elements/concepts before and after implementation of DEC.

- Role delineation Versus Role Confusion of Advisor
- Cognitive convergence Versus Cognitive dissonance of Program Director involvement
- Learner perception of the process
- Resident & Faculty relationships within the program
- Compliance/Legal implication

Quantitative data were collected on the demographics of residents overall in the program as well as who underwent the DEC process. The outcomes were also charted according to gender, race, and the ACGME core competency of the learning objectives or training deficits. Chi-square and Fisher's exact test were performed for inferential statistics to determine associations between the outcomes and demographic characteristics. Fisher's exact test was used in place of the Chi-square test where expected cell counts were below 5. Statistical data analysis was performed using JMP Pro 19. An alpha of < 0.05 was used for statistical significance. The findings were interpreted using Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) Framework.

Results

Reach

Over the past five years, our program has successfully implemented the DEC framework which started in the academic year 2018. Table 1 shows some common characteristics of residents training in the residency program during this time.

Table 1
Demographic characteristics of residents training in the program during the study period, by race, medical school type, and gender.

Characteristics	Category	Number (%)
Race	Asian	20 (54%)
	White	8 (22%)
	African American	7 (19%)
	Latino	2 (5%)
	Other	0 (0%)
Medical School Attended	LCME Accredited	5 (14%)
	COCA Accredited	19 (51%)
	IMG	13 (35%)
Gender	Male	18 (49%)
	Female	19 (51%)
LCME: Liaison Committee on Medical Education, COCA: Commission on Osteopathic Colleges Accreditation, IMG: International Medical Graduate		

Once the CCC has identified the struggling resident, the DEC then identifies the actual learning issue and makes recommendations for improvement. The improvement/education plan can be used for residents who are underperforming or overachieving residents.

The reach of this intervention involved 15 residents as well as faculty members at one residency program.

Effectiveness

Over 50 IEPs with 500 learning objectives were developed with the DEC framework. The implementation of the DEC framework resulted in positive outcomes, with only three adverse actions involving official remediation or probation/unsuccessful from graduating from the program. All other residents achieved competency in their area of struggle.

Adoption

Adoption refers to the proportion of the target population who actually begin using the intervention or program and is a measure of how many people initially participate.

In the case of this study, 15 of the 37 total residents who were part of the program during this timeframe were enrolled in the intervention or about a 38% utilization rate. Table 2 presents enrollment, successful

completion, and adverse action outcomes by gender and race. Statistical associations between these outcomes and resident demographic and training characteristics, including ACGME core competency, are further examined in Table 4.

Table 2

Adoption and outcomes of the DEC framework by gender and race, including enrollment, successful IEP completion and graduation, and adverse action, AY2018–2023.

Parameter	Numbers
Gender of the Resident in DEC	9/20 Males versus 6/29 Females
Gender of the successful IEP and graduation from the program	8/9 Males versus 5/6 Females
Gender of the resident in DEC with any adverse action	1/9 Males versus 2/6 Females
Race of the resident in DEC	3/15 White versus 12/34 Non-White
Race of the successful IEP and graduation from the program	3/3 White versus 10/12 Non-White
Race of the resident in DEC with any adverse action	1/3 White versus 2/12 Non-White

Faculty participation was limited to a permanent DEC Chair and behavioral health faculty as consultants, and then the rest of the committee was individualized to each struggling learner. Every DEC included the resident’s assigned faculty advisor as part of the team. Occasionally, individuals with expertise outside the core faculty were asked to serve on the DEC.

Implementation

Implementation refers to how consistently the intervention is delivered in real-world settings. It considers factors like the fidelity of the intervention, the time and resources required for implementation, and the challenges encountered during delivery. The decision was made to apply the intervention to all residents who were identified as struggling to meet their learning objectives.

The permanent chair develops and provides leadership and expertise related to learners with struggles, while the behavioral health faculty offers insights into the resident's learning style, motivations, and potential barriers. The resident advisor represents the resident's perspective and serves as an advocate for resident education by providing valuable context for understanding their challenges. Finally, the invited expert contributes specialized knowledge in the resident's area of struggle, ensuring that the IEP is tailored to their specific needs (Fig. 3).

Maintenance

Maintenance refers to the long-term effects of the intervention. It assesses how long the positive effects of the intervention last, both at the individual and population levels, and what strategies are needed to

sustain those effects over time.

By having a single core faculty member be a permanent chair for the DEC, there is consistency and reliability year over year. As long as there continues to be support from the PD, this committee is sustainable long term.

We performed a faculty focus group session pre- and post-implementation of the DEC framework as part of our routine annual faculty development. The responses of faculty opinions were recorded on paper. The responses are grouped in themes/constructs for both pre- and post-implementation and are presented in Table 3.

Table 3

Comparison of traditional resident support approaches versus the DEC framework across role clarity, plan usage, program relationships, and legal/documentation risk.

Element	Traditional Approach	DEC Framework
Advisor in CCC & Meeting with Advisee	Cognitive Dissonance & Role Confusion with assessments	Assessor, Advisor, DEC Members separated
Resident with struggles identified by CCC and improvement advised	Program Director (PD) manages performance	Committee with permanent chair & members with expertise
Improvement/Education Plan	Almost always signals trouble	Could be used for underperforming or overachieving residents
Resident & Program Relationship	PD & Advisor confused as "enforcers" of plan and evaluators simultaneously	PD serves as "enforcer," advisor as "advocate" and witness, CCC evaluator, and DEC as improvement advisor
Legal	Concerns about blind spots; one or two people at risk of accusations of bias, discrimination, or retaliation; large concerns regarding sound documentation	Risk of accusations of bias, discrimination, or retaliation distributed among multiple; less documentation concerns

Over the subsequent five years, this DEC supported 15 residents with struggles at different stages of training (Fig. 4). The DEC furnished over 50 IEPs featuring approximately 500 learning objectives with key evaluation/monitoring mechanisms and additional resources.

This collaborative approach has resulted in positive outcomes, with only three adverse actions involving official remediation, and/or probation/unsuccessful in graduating from the program. All other residents achieved competency in their area of struggle, demonstrating the effectiveness of the DEC framework in avoiding conflicts of interest and cognitive strain.

Statistical comparisons by gender, race, and ACGME core competency are presented in Table 4.

Table 4

Adoption and outcomes of the DEC framework by gender, race, and ACGME core competency, with Chi-square/Fisher's exact test p-values, AY2018–2023.

Parameter/Predictor	Numbers	p-Value from Chi-square/Fisher's Exact Test
Gender of the Resident in DEC	9/20 Males versus 6/29 Females	0.069
Gender of the successful IEP and graduation from the program	8/9 Males versus 5/6 Females	0.93
Gender of the resident in DEC with any adverse action	1/9 Males versus 2/6 Females	0.39
Race of the resident in DEC	3/15 White versus 12/34 Non-White	0.42
Race of the successful IEP and graduation from the program	3/3 White versus 10/12 Non-White	0.84
Race of the resident in DEC with any adverse action	1/3 White versus 2/12 Non-White	0.61
ACGME Core Competency predictor of unsuccessful IEP and adverse action	Professionalism 3/3 versus others 14/15	0.9

Discussion

This five-year retrospective evaluation of the Directed Education Committee (DEC) demonstrates that a structurally formalized, delegated subcommittee model can support residents with significant struggles while limiting adverse academic outcomes: only 3 of 15 residents (20%) experienced an adverse action, with the remaining residents achieving competency in their identified area of difficulty. Applying the RE-AIM framework allowed us to characterize not only the outcomes of the DEC model but also its reach, adoption pattern, and the structural mechanics that differentiate it from more commonly described approaches to resident remediation.

Addressing role conflict through structural separation

The central design rationale for DEC, separating the roles of evaluator, advocate, and content expert, is supported by prior literature documenting that these roles are frequently conflated in conventional CCC and advisor-based models. Woods et al. found that faculty serving as resident advisors at Duke's internal medicine program described their role in explicitly administrative and evaluative terms, as "evaluators, monitors, and administrators," despite also being expected to function as advocates and mentors (9). Similarly, Schumacher et al.'s multisite study of CCC member review processes found that individual reviewer characteristics, including whether a member had provided feedback directly to residents after CCC meetings, were independently associated with the milestone levels and supervisory recommendations they assigned (3). DEC's structural separation of the permanent chair, behavioral

health consultant, resident's own advisor, and subject-matter expert is designed specifically to distribute this risk across roles with distinct, non-overlapping functions, rather than relying on a single individual to simultaneously evaluate, advocate for, and remediate the same resident.

Situating DEC among existing remediation structures

DEC's closest structural analogue in the published literature is the three-party liaison model described for radiology remediation, in which a resident, program director, and a faculty educational liaison with content expertise in the area of difficulty form a working alliance to construct and monitor a remediation plan (13). That model shares DEC's use of a designated content expert but lacks a standing behavioral health consultant and does not operate as a formally delegated CCC subcommittee with a permanent chair. More recently, Goldhamer et al. have argued that CCCs should move toward a "growth model" in which individualized learning plans are co-produced with the resident and updated iteratively, rather than treating an IEP as a one-time response to identified deficits (14). This call aligns closely with DEC's iterative IEP process, which produced over 50 IEPs and approximately 500 learning objectives across the study period.

Behavioral health integration

DEC's inclusion of a standing behavioral health faculty consultant reflects a growing recognition that clinical performance deficits frequently co-occur with underlying mental health conditions. Warburton and Shahane found that 38% of learners referred to a centralized remediation program had an identifiable mental health condition contributing to their performance deficit, with anxiety being most common, and that professionalism was the most frequently identified deficit among learners with a mental health condition (15). Embedding behavioral health expertise as a standing DEC role, rather than as a downstream referral triggered only after a deficit is identified, may allow earlier recognition of these overlapping contributors within the IEP development process itself.

Comparison of outcomes

Our finding that 80% of DEC-supported residents avoided any adverse action is broadly consistent with outcomes reported for other structured remediation approaches. Guerrasio and Aagaard reported that 96% of learners with clinical reasoning deficits passed post-remediation reassessment, with 72% graduating or continuing in good standing, using a ten-step structured remediation curriculum (16). DEC's outcomes are somewhat more conservative by comparison, which may reflect differences in referral population (DEC supported residents across all ACGME core competencies rather than clinical reasoning specifically) and DEC's inclusion of high-acuity cases, including three residents who required formal remediation, probation, or did not successfully graduate.

Equity considerations

Our adoption data showed no statistically significant association between DEC enrollment and either resident gender ($p = 0.069$) or race ($p = 0.42$), nor between demographic characteristics and successful IEP completion or adverse action. While reassuring, these analyses were likely underpowered given the

small sample (15 residents), and should be interpreted as descriptive rather than conclusive evidence of equitable access or outcomes.

Strengths and limitations

This study benefits from five years of longitudinal data, a mixed-methods design incorporating both content analysis of faculty focus groups and quantitative outcome data, and application of a well-established implementation science framework that allowed systematic evaluation across multiple dimensions of program performance, consistent with current guidance on RE-AIM's flexible, pragmatic application (17). Limitations include the single-institution, single-specialty design, which limits generalizability; the modest sample size (15 residents over five years), which constrains statistical power for subgroup analyses; and the retrospective nature of the faculty focus group data, which relied on paper-recorded responses rather than a validated survey instrument. As noted in French et al.'s guidance on CCC implementation, structures that rely on distributing review responsibility across multiple committee members, as DEC does, require significant protected faculty time, which may limit feasibility for smaller programs with fewer available content experts (18).

Future directions

Multi-institutional replication, particularly at smaller or community-based programs with more limited access to subject-matter experts, would help establish whether DEC's structural benefits are transferable outside a setting with strong regional academic affiliations. We also plan to explore DEC's applicability to high-performing residents seeking enrichment, extending the model's IEP function beyond remediation.

Conclusion

The Directed Education Committee offers a structurally distinct alternative to traditional program director- or advisor-led approaches for supporting residents with academic or clinical struggles. By separating the roles of evaluator, advocate, and content expert into a delegated CCC subcommittee, DEC reduces the role conflict and cognitive dissonance documented in conventional remediation models, while distributing legal and documentation risk across multiple faculty members rather than concentrating it in one or two individuals. Over five years, this framework supported 15 residents through more than 50 individualized education plans, with the large majority achieving competency in their identified area of struggle. These findings suggest that a dedicated, role-differentiated subcommittee is a feasible and effective mechanism for individualizing resident support, with potential for adaptation at other residency programs, particularly those seeking to formalize their CCC's approach to struggling learners.

Declarations

Ethics approval and consent to participate

This study was reviewed by the WellSpan Health Institutional Review Board (IRB) and determined to be exempt (notification number 2173829-2). As this was a retrospective review of de-identified, existing programmatic data, individual informed consent was not required and was not obtained.

Consent for publication

Not applicable. This manuscript does not contain any individual person's data, images, or identifiable information.

Use of AI tools

An AI language model was used to assist with typographical error checking, reference formatting, and prose editing during manuscript preparation. All scientific content, data interpretation, and conclusions are the sole responsibility of the human authors, who reviewed and take full accountability for the final manuscript.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Author Contribution

The authors confirm contribution to the paper as follows: A.W. and E.A. contributed to study conception. A.W., E.A., B.I., L.Y., H.K., and H.S. designed the layout of the manuscript. H.S., A.W., E.A., and H.K. wrote the initial draft of the manuscript. M.R., K.J., and A.W. collected the data. A.W. and E.A. analyzed the data. All authors were involved in interpretation of the results. E.A., A.W., B.I., K.J., M.R., H.K., and L.Y. edited the manuscript. All authors contributed intellectually and edited the manuscript to final shape. All authors read and approved the final manuscript. H.K and E.A. are the corresponding authors. K.J. is the Principal Investigator (PI). E.A., K.J., and A.W. have supervisory roles and are responsible for the integrity of the work.

Acknowledgement

The authors thank Julie Alvarez, DO, for her contributions to the design and initial drafting of the manuscript.

Availability of data and materials

The datasets generated and/or analyzed during the current study contain potentially identifiable resident-level information and are therefore not publicly available due to institutional and resident privacy considerations. The dataset(s) supporting the conclusions of this article is(are) included within the article (and its additional file(s)).

.Competing interests

The authors declare that they have no competing interests.

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Figures

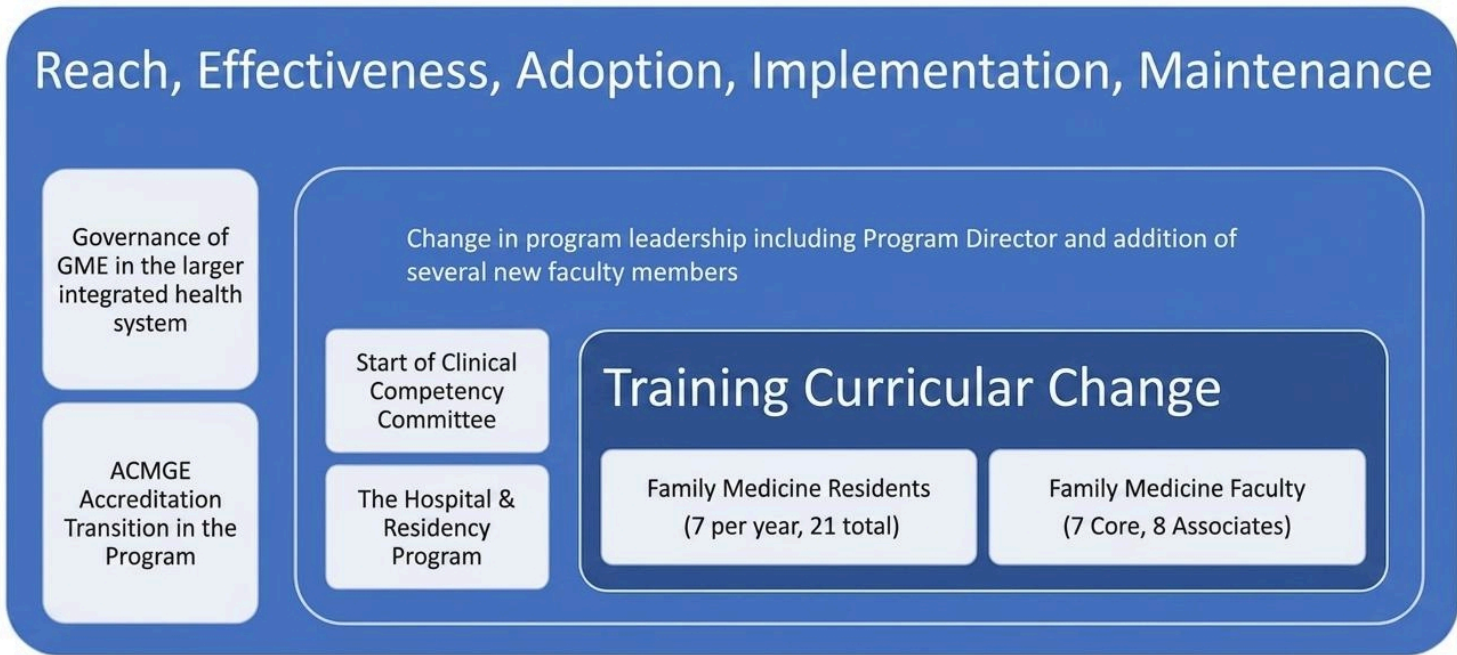


Figure 1

Contextual factors present during DEC's development, organized by RE-AIM component.

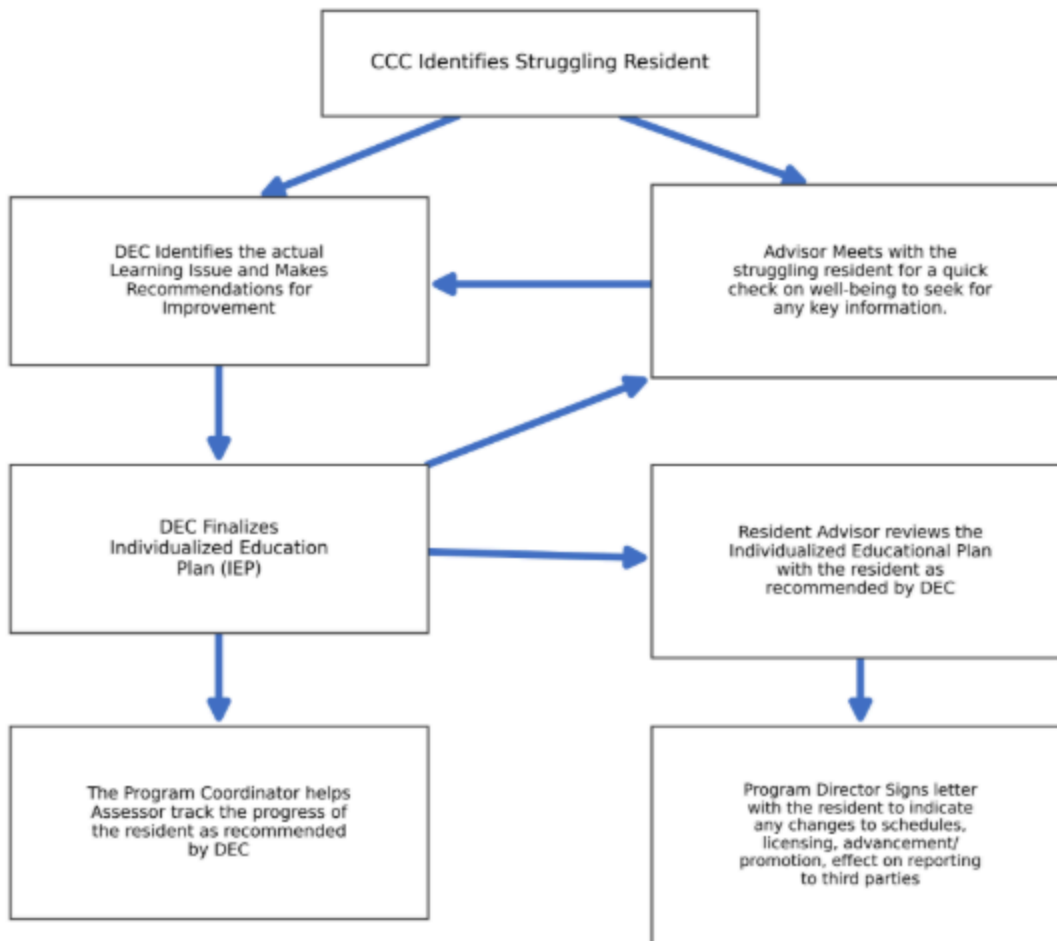


Figure 2

DEC workflow, from CCC identification of a struggling resident through IEP finalization and downstream tracking.

Directed Education Committee

Subject: Plan for Resident Improvement for J. J. SMX, D.O.
Initial Date: 08/02/19, Revised from 05/15/19, Re-evaluation date: Next CCC in October 2019 or sooner
Chair of DEC: Dr. Younes Behavioral Health Education Specialist: Dr. Nicole Pfaff

Committee members: Dr. Waheed, Dr. Kamboj, Dr. Muhiire-Ntaki. **Summary:** Overall, the conclusions of the Clinical Competency Committee reflect some concerns about the following and recommends **official remediation for the highlighted**

Core Competency	Concerns	Specific Learning Objectives	Monitoring Mechanism	Resources
Patient Care	Insufficient exams and/or insufficient history on patients - continued concerns, most concerns regarding exam findings missed Assessment and plan not at expected level - continued concerns Lack of initiative during a rapid response - improved on some days and lapses on other days Lack of documentation of patient progress including clinically worrisome changes on IER strip of a laboring patient	Must do pre-charting at home, and then pre-cepting with attending for every clinic session. Will participate in one-on-one teaching session on physical exam and inpatient scenarios. Will ask attendings for help if unsure how to do for every patient. Will document all patient encounters in EMR appropriately. Will not leave patients unattended when assigned for care. Will document all patient encounters in EMR appropriately. Will not leave patients unattended when assigned for care.	Shift card evaluation by faculty targeting objectives Adult et documentation 2 chart per week	Individualized 1.1 preceptor NOTED goal for documentation of clinical encounters Feedback from chart studies
Medical Knowledge	-----	-----	-----	-----
Systems-Based Practice	Poor in-basket management - continued concern	In-basket items will be checked daily. Patient calls, medication refills, lab results and open notes will be addressed within 15 hours. Will ask attendings for help if not sure how to double a work. Will not defer emergency tasks in nursing.	Shift card & monthly evaluation by faculty targeting objectives Weekly Resident and faculty denigrant in-basket report if inpatient protect manager	Review of policy and procedure for in-basket management with medical director Access to preceptor of the day for questions Formal principal for prioritization review with advisor and direct observation-feedback by advisor on one shift
Practice-Based Learning and Improvement	Resistant to resistances from peers - progressing?	Demonstrate openness to feedback from peers, attendings, and staff Demonstrate self-enormous regulation when constructive feedback is provided and perceived as negative information	Confidential reports to PD Peer-evaluation	Review feedback module in STFM Review Conflict management module at STFM Role play feedback with advisor and behavioral health faculty
Professionalism	On phone during conference - unsure if progressing, concerns about stepping out for phone staff Does not attend morning conference consistently - improving Missing in action on shift of night float where laboring patients were not attended to properly and posed potential of compromised patient care Did not respond to nurses with pages regarding an actively laboring patient Unable to recognize self-impairment	Will demonstrate attention to personal wellness by trying hard to get enough sleep and show up on time, well prepared. Will follow through recommended steps for self-impairment recognition and management including a professional health evaluation. Will not miss attending patient care when assigned on a shift. Will answer all pages promptly. Will follow fatigue prevention, recognition, and mitigation policy including taking necessary steps to call back, or resident if fatigued instead of simply unifying the action of ignoring patients.	Confidential reports to PD Monthly faculty evaluations Peer-evaluations Shift card evaluations by faculty	Resident resigns recognition/inspiration and wellness strong Recorded sensor on sleep deprivation Time to see Personal Physician Employee Encouragement Program Confidential wellness check-ins with behavioral health faculty
Communication	At times organizes with supervising resident or attending - improved Lack of feedback - improved	Demonstrate openness to feedback from peers, attendings, and staff Demonstrate self-enormous regulation when constructive feedback is provided and perceived as negative information.	Confidential reports to PD Peer-evaluation	Review feedback module at STFM Review Conflict management module at STFM Role play feedback with advisor and behavioral health faculty

I have read and understand the above and acknowledge that I have received a copy.

J. J. SMX, D.O. _____ 10/08/2018 _____ Sukhjeet K. Kamboj, MD, FAAFP _____
Resident: _____ Date _____ Advisor: _____
Respectfully Submitted By: Sally A. Bachman, Sr Residency Program Coordinator

Figure 3

Sample individualized education plan (IEP) developed through the DEC process

Number of Residents with struggles & DEC Help

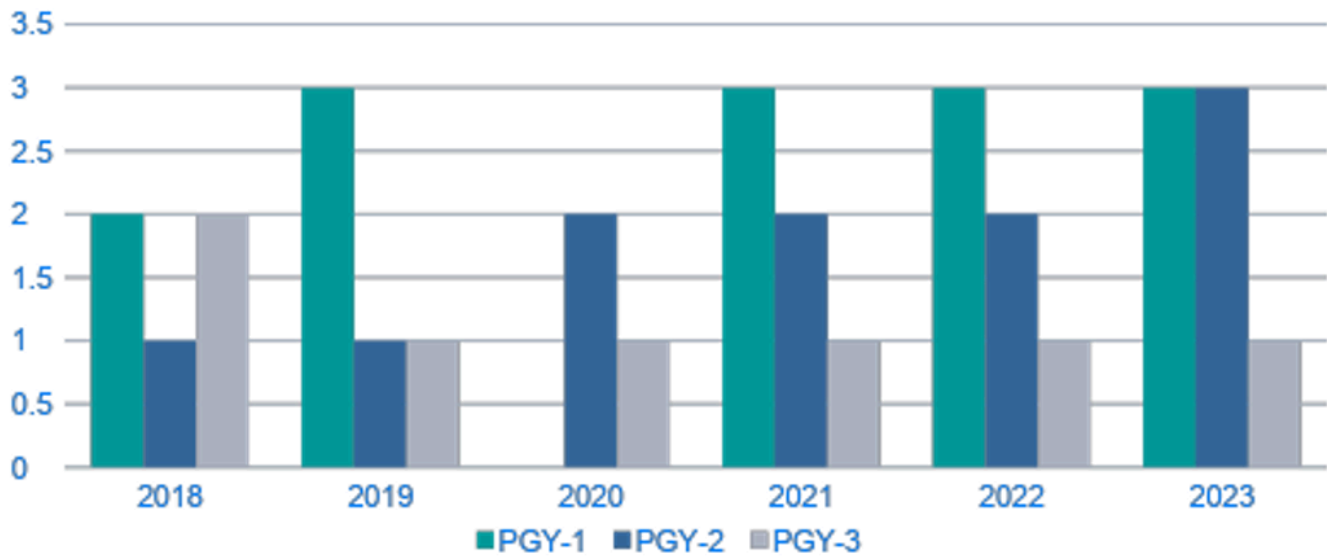


Figure 4

Number of residents with struggles by PGY level and year, 2018–2023