

### Resident and Fellow Evaluation Policy

- Scope:** All UW residencies and fellowships accredited by the Accreditation Council for Graduate Medical Education (ACGME) and sponsored by the UW School of Medicine.
- Purpose:** Establish UW GME expectations and highlight relevant ACGME Common Program Requirements (CPRs) required for robust program evaluation systems.
- Policy:** UW GME ACGME accredited programs must develop and implement a robust evaluation system for residents and fellows (inclusively referred to as “residents” hereafter) that meets the requirements of the ACGME as outlined in the Common Program Requirements (CPRs). Residents should be active agents in this system, and guided self-directed assessment behaviors by the resident should be strongly encouraged throughout.

Resident performance evaluation must include

- Feedback: Ongoing information provided regarding aspects of resident’s performance, knowledge, or understanding.
- Evaluation:
  - Formative Evaluation: Monitoring resident learning. Identifying areas of improvement in order to provide feedback. Assessment *for* learning.
  - Summative Evaluation: Evaluating resident’s learning by comparing the residents against the goals and objectives of the rotation and program, respectively. Assessment *of* learning.
- Final Evaluation [*CPR V.A.2.a).(2).(b)*]: Verification that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.

*Feedback and Evaluation* designate both formative and summative evaluations the program provides as well as feedback each resident receives *while in the program*. *Final Evaluation* is an evaluation the program provides for residents *upon completion of the program*.

#### **Feedback and Evaluation [*CPR V.A.1*]**

##### *Feedback and End-of-Rotation/End-of-Educational Assignment Evaluation*

Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment [*CPR V.A.1.a*]. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

Evaluation must be documented at the completion of the assignment [*CPR V.A.1.b*]. For block rotations of greater than three months in duration, evaluation must be documented at least every three months [*CPR V.A.1.b).(1)*]. For programs that do not have defined rotations, written evaluations by faculty must be documented and provided to trainees at least every three months. For one-year fellowship programs, evaluations must be completed at least every three months. Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion [*CPR V.A.1.b).(2)*]. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

End-of-rotation/end-of-educational assignment evaluations have both summative and formative components. The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones [CPR V.A. 1.c]. The program must use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members) [CPR V.A. 1.c.(1)]; and provide that information to the Clinical Competency Committee (CCC) for its synthesis of progressive resident performance and improvement toward unsupervised practice [CPR V.A. 1.c.(2)].

#### Semi-Annual Evaluation of Performance

The program director or their designee, with input from the CCC, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones [CPR V.A. 1.d.(1)]; and assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth [CPR V.A. 1.d.(2)]<sup>2</sup>. Residents who experience difficulties with achieving progress along the Milestones require intervention to address specific deficiencies. The program director or designee, with input from the CCC, must develop plans for residents failing to progress, following [institutional policies and procedures](#) [CPR V.A. 1.d.(3)]<sup>3</sup>

The CCC must review all resident evaluations at least semi-annually, determine each resident's progress on achievement of the specialty-specific Milestones, and meet prior to the resident's semi-annual evaluations and advise the program director regarding each resident's progress [CPR V.A. 3.b.(1).(2).(3)]. The semi-annual evaluation must be considered as a part of the advancement process in accordance with the program's established advancement and promotion criteria.

#### Annual Evaluation of Performance

At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable [CPR V.A. 1.e)]<sup>1</sup>. End-of-year evaluations may also include formative components.

Throughout training, residents must demonstrate competence in professionalism, patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, systems-based practice [CPR IV.B. 1.a),b),c), d),e),f)]

#### **Final Evaluation [CPR V.A.2]**

The program director must provide a final evaluation for each resident upon completion of the program [CPR V.A.2.a)]. The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program [CPR V.A.2.a).(1)]. The final evaluation must (1) consider recommendations from the CCC [CPR V.A.2.a).(2).(c)]; and (2) verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice [CPR V.A.2.a).(2).(b)].

#### **Evaluation Data Maintenance and Resident Access to Evaluations**

The evaluations of a resident's performance must be accessible for review by the resident [CPR V.A. 1.f)]<sup>4</sup>. The final evaluation must become part of the resident's permanent record maintained by the institution and must be accessible for review by the resident in accordance with [institutional policy](#) [CPR V.A.2.a).(2).(a).]; and be shared with the resident upon completion of the program [CPR V.A.2.a).(2).(d)]. Evaluations must be completed using Residency Management System. If the program uses a different

evaluation system (e.g., eMetrics, REDCap), the evaluation data must be migrated into the Residency Management System.

### **Program Directors' Responsibilities**

The program director must have responsibility, authority, and accountability for evaluation and promotion of residents, disciplinary action, supervision of residents, and resident evaluation in the context of patient care [CPR II.A.4.]. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members [CPR VI.A.2.d)]. The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones [CPR VI.A.2.d).(1)].

**Attachment:** Final Evaluation Template  
Evaluation Guidelines

### **References:**

<sup>1</sup>Not applicable for one-year fellowship programs.

<sup>2</sup>One-year fellowship programs are exempt from this requirement.

<sup>3</sup>In the one-year fellowship CPR document, this requirement is included in [V.A.1.d).(2)].

<sup>4</sup>In the one-year fellowship CPR document, this requirement is included in [V.A.1.e)].

**University of Washington <Program Name> Program**

**Final Evaluation**

**Name of Resident:**

**Program Director:**

**Dates of Training:**

**Recommendation:**

Based upon a composite evaluation by the University of Washington <Department and/or Division>, <Program Name>, I, <Program Director's Name>, with input from Clinical Competency Committee, verify that Dr. <has/has not> demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.

**Additional Explanation or Comments:**

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**Program Director Signature**

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**Date**

**Verification of Training:** Our records show that this physician served in the following training program (s) at the University of Washington School of Medicine:

Program Name	Dates of Training		ACGME approved?		Successfully completed program?	
			Yes	No	Yes	No
Prelim year in	From	To	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residency in	From	To	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fellowship in	From	To	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fellowship in	From	To	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	From	To	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Optional statement of any deviation from standard training sequence or comments:

**Ability to Practice Medicine:**

To the best of my knowledge, no conditions exist that would impair the above referenced Resident’s ability to practice in this specialty without direct supervision.

Explanation or Comments:

**Reportable Actions for Academic Deficiencies:**

To the best of my knowledge, the above referenced Resident was not the subject of any reportable actions for academic deficiencies at this institution.

Explanation or Comments:

**Findings of Misconduct:**

To the best of my knowledge, during the dates of training at this institution, the above referenced Resident was not found by the University of Washington School of Medicine to have committed any misconduct.

Explanation or Comments:

**Professional Liability:**

To the best of my knowledge, the above referenced Resident  was or  was not a defendant in any malpractice legal action during residency training.

Explanation or Comments:

**Clinical Privileges/Procedures:**

Based on the education the above referenced Resident received from the \_\_\_\_\_ residency program, the Resident is recommended for the \_\_\_\_\_ certifying examination administered by the American Board of \_\_\_\_\_

Explanation or Comments:

**Evaluation:**

The following is derived from a composite of multiple evaluations by supervisors in this Resident’s rotations during residency training. The evaluation is based upon the Accreditation Council for Graduate Medical Education (ACGME) General Competencies, which define the essential components of clinical competence.

- 1. *Medical Knowledge*** about established and evolving biomedical, clinical and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Competent     Competent with Reservation     Not Competent

Explanation or Comments:

- 2. *Patient Care/Clinical Skills*** that are compassionate, appropriate and effective for the treatment of health problems and the promotion of health.

Competent     Competent with Reservation     Not Competent

Explanation or Comments:

**Procedures (if applicable)**

- Procedure 1:             Competent     Competent with Reservation     Not Competent
- Procedure 2:             Competent     Competent with Reservation     Not Competent
- Procedure 3:             Competent     Competent with Reservation     Not Competent
- Procedure 4:             Competent     Competent with Reservation     Not Competent
- Procedure 5:             Competent     Competent with Reservation     Not Competent

Explanation or Comments:

**3. *Professionalism/Ethical Conduct as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.***

- Competent     Competent with Reservation     Not Competent

Explanation or Comments:

**4. *Communication and Interpersonal Skills that result in effective information exchange and teaming with patients, their families and other health professionals.***

- Competent     Competent with Reservation     Not Competent

Explanation or Comments:



**5. *Practice Based Learning and Improvement*** that involves investigation and evaluation of their own patient appraisal and assimilation of scientific evidence and improvements in patient care.

- Competent    Competent with Reservation    Not Competent

Explanation or Comments:

**6. *Systems-Based Practice*** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

- Competent    Competent with Reservation    Not Competent

Explanation or Comments:

**Optional Summary Comments:**

**Acknowledgement:**

I have reviewed this evaluation with the Program Director or designee. I understand that this form will, in most cases, be utilized as the confidential verification and summative evaluation, in lieu of other forms, when requests for verification of my residency program and/or requests for references are received by the University of Washington School of Medicine. I hereby consent to the release of this document when such requests are received.

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**Resident Signature**

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**Date**

## **Resident and Fellow Evaluation Guidelines**

The following guidebooks provide program directors with information and specific suggestions for implementing the expectations articulated in the GME Resident and Fellow Evaluation Policy. The UW GME guidelines add to the ACGME Guideline documents for residents, for Milestones, and for Clinical Competency Committees (CCC):

- [ACGME Milestones Guidebook for Residents and Fellows](#), June 2017. This should be distributed to each incoming resident during program orientation sessions each year.
- [ACGME Milestones Guidebook](#), 2016.
- [ACGME Clinical Competency Committees: A Guidebook for Programs](#) (2<sup>nd</sup> Edition), 2017.

## **FEEDBACK AND EVALUATION**

### **Feedback**

Feedback is ongoing verbal or written information provided regarding aspects of resident's performance, knowledge, or understanding. Feedback outlines how residents performed; why their performance exceeds, meets, or fails to meet expectations or criteria; and how they can improve their performance. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to identify areas for improvement. Providing detailed feedback based on the Milestones encourages residents to monitor their own learning progress. Faculty members empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Faculty members must establish feedback as an expected and frequent educational routine. Each program is strongly encouraged to develop a mechanism to track frequency and quality of faculty feedback.

### **Formative Evaluation**

Formative evaluation (or assessment *for* learning) documents progressive development over time and informs the on-going learning process for the resident, faculty, program director, and institution. Assessment tools should be aligned with published goals and objectives, the relevant specialty-specific Milestones for each rotation and educational assignment, program clinical and procedural objectives, and, as applicable, the specialty specific Entrustable Professional Activities (EPAs).<sup>1</sup>

Goals of Formative Evaluation in GME:

- Provide a rigorous and transparent evaluation system for residents.
- Maximize resident performance improvement through frequent and meaningful feedback – verbal and written -- providing concrete suggestions to promote learning.
- Support a learning environment that nurtures individual learner growth and development.
- Provide data to continuously improve program, learning, teaching, curriculum, evaluation instruments, and, ultimately, outcomes.

To meet these goals, programs are expected to use a multi-faceted approach with multiple instruments, assessors, and observations. These approaches may include verbal and written feedback on direct or indirect observation assessments (i.e. for clinics, consults, procedures, and/or labs), end-of-rotation/shift/assignment evaluations (with specialty-specific Milestones and EPAs recommended as the units of measure), multi-source feedback, evaluations of presentations at conferences, semi-annual assessments, individual learning plans (ILP), portfolios and self-reflections on learning, in-training exams, case/procedure logs, as well as other types of evaluations. Programs must (1) ensure assessment tools

sufficient to effectively determine performance across the competencies; and (2) increase quality, standardize expectations, and reduce variability in performance assessment.<sup>2</sup>

#### Entrustable Professional Activities (EPAs)

EPAs are “units of professional work practice, defined as tasks or responsibilities” that a supervisor can “trust” the resident to perform competently without supervision (autonomously) by the end of training.<sup>1</sup> pg.157 EPAs are (1) a work-based evaluation framework based on the critical activities that, when taken together, constitute a specialty; and (2) framed around recognizable professional activities that can be readily understood and assessed by faculty in the specialty. These professional activities address multiple competencies, as they reflect the complex real world work of physicians.<sup>3</sup>

An example of an Internal Medicine EPA evaluated with an entrustment scale might be: “*I trust this resident to present a complex, critically ill patient in a logical and concise manner as part of ICU rounds* a) with complete supervision; b) with partial supervision; c) with minimal supervision; d) Independently; and e) as a teacher or expert.”<sup>4</sup>

Faculty have found using EPAs to be an intuitive and efficient way to evaluate residents in the workplace. EPA-based evaluations are frequently used at the end of rotations or the end of a period of time a faculty has been working with a resident. Because EPA-based evaluations depend on observing work in practice, they are more easily completed by faculty -- and more meaningful for residents -- immediately following the observation. [See [UW GME Intranet for more information on EPAs.](#)]

#### Frequency of Evaluation

A sufficient number and variety of documented evaluations should be completed within each 6-month semi-annual period. Completion by a variety of faculty and other members of the health care team and/or program will help ensure reliable judgments by the CCC. Frequency and number of evaluations depends on the specialty area and evaluation type. See frequency guidelines by assessment type below:

- Approximately ten (10) documented *direct observation assessments* a year at a minimum (e.g., a distribution of “Mini-CEX-like” assessments, direct observation of procedural skills assessments, inpatient consult assessments).<sup>5</sup> These can be brief yet specific summaries of conversations faculty have had with a resident on the next steps for performance improvement or checklists with narrative comments.
- One (1) Multi-Source Feedback round per year at a minimum. A *round* is defined as the collection of a number of assessment instruments throughout the year from individuals in direct contact with the resident, including supervisors, peers, self, nurses, allied health professionals, and patients.
- A number of end-of-rotation evaluations (tailored to the objectives of the rotation, shift, or assignment) constructed around specialty-specific Milestones and EPAs at the completion of each rotation or educational assignment.

Or,

A minimum one (1) documented *quarterly evaluation* (total four evaluations per year), also based on objectives and specialty-specific Milestones and EPAs, if the program does not have defined rotations. (A best practice is to tailor quarterly evaluations to specific educational experiences during the quarter.) See [\[UW GME Intranet for sample assessment tools.\]](#)

Feedback from faculty members in the context of routine clinical care should be frequent. Program directors are responsible for ensuring that faculty are aware of evaluation expectations, the evaluation instruments, and the educational rationale underlying each evaluation type. Program directors must also ensure that faculty complete resident assessment and evaluation forms in the Residency Management System within days of the end of the rotation/educational assignment or quarter and preferably immediately.

#### Rationale

Frequent, documented workplace assessments provide a longitudinal record of individual progress enabling residents to visualize their learning over time, and assessors to similarly judge and provide evidence of the performance improvement of the resident. Providing frequent and specific verbal and written feedback to the resident supports an overall positive learning environment and reinforces an educational culture in which feedback *for* learning is the norm.

There is no perfect evaluation instrument. However, evidence indicates that combinations of multiple assessment types, with multiple raters and multiple observations, provide reliable judgments of performance. Research supports that continuously training faculty in evaluation and feedback as well as utilizing multiple instruments (such as those listed above) provide a feasible and reliable method for high-stakes judgments.<sup>5</sup>

In addition, it is assumed that faculty will provide pedagogically sound and frequent feedback.<sup>6,7</sup> Feedback -- both written and verbal -- should (1) be directed toward observed specific behaviors, actions or skills; (2) be provided within minutes or hours; and (3) specify next steps for performance improvement. In addition, faculty are expected to demonstrate consistency between their verbal and written evaluations. (For a UW Medicine systematic approach to verbal feedback, see the Prepare to [ADAPT Framework](#).)<sup>8</sup>

Frequent formative assessment also enables programs to identify struggling residents earlier in their training. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Struggling residents will need more intensive guidance and support than those performing at a higher level. Even for those performing at a higher level, a comprehensive evaluation system enables them to identify a wider range of areas in which they can improve.

#### Evaluation Data Maintenance

A number of UW programs are using web-based applications to record direct observation feedback, as well as resident reflections on the experience (e.g. eMetrics, REDCap), which are then recorded in the Residency Management System. Often, residents initiate these requests for feedback. For programs with paper-based direct observation forms, residents also assume responsibility for requesting faculty feedback. In this case, the paper forms are commonly provided to the residents who then present the form to the faculty for completion; completed forms are entered into the Residency Management System. Other programs ask residents to keep a personal log of the verbal feedback they receive. (For more suggestions on ways to capture verbal feedback, see the Prepare to [ADAPT Framework](#).) Regardless of the record-keeping process programs adopt, if faculty feedback from direct observations is to be documented, it must be completed within hours of the observation to ensure specificity, accuracy, and usefulness for the resident.

#### Case and Procedure Logs

As case and procedure logs record the number of cases or procedures performed, they document an aspect of training and practice that is associated with competence in the medical, diagnostic, and surgical procedures essential for the area of practice. Considered in combination with direct observation assessments of procedures, the logs and evaluations of the procedures together can provide a picture of the level of competency.

#### Semi-annual Evaluation of Performance

The program director or designee, with input from the CCC, will (1) meet at least semi-annually with each resident to review all documented performance records, plans and evidence of scholarly activity (if applicable), case and procedure logs, and other performance indicators, including the most recent CCC milestone report; and (2) assist residents in developing an ILP.

During the semi-annual meeting, residents will be asked to reflect on their performance and progress, and make plans with the director or designee to address current and future training needs. Based on the

collection of work (i.e. portfolio or dossier), evidence of experience and work accomplished, and the resident's ILP, the program director or designee will provide guidance and academic advice to enable the resident to meet program performance expectations by re-setting learning and improvement goals (e.g., within the ILP). These semi-annual meetings should support the development of the self-assessment skills necessary for life-long and autonomous learning.

#### Academic Remediation

The literature offers multiple remediation models that minimize academic probation or dismissal<sup>9,10</sup>. Some of the key components of these successful models include standardized processes to identify residents' areas for improvement, resident interview, screening for underlying medical and mental health issues, deliberate practice, specific and targeted feedback, and resident reflection. The [UW GME Resident/Fellow Remediation Policy and Grievance Procedure](#) provides specifics on remediation process.

#### Accessibility of Evaluations

To provide transparency and fairness, all evaluation instruments must be distributed and purpose explained to residents at the beginning of the training year, rotation, or educational experience (along with the relevant goals and objectives) and whenever there are revisions or changes to the evaluation instruments or processes. In addition, all completed and documented evaluations of resident performance must be accessible to residents on the Residency Management System or in their files.

#### Faculty Development in Evaluation

Faculty members should understand how their evaluations of individual residents contribute to the larger aggregate of information the program director and CCC will consider. Therefore, faculty members must participate in faculty development related to their skills as educators, particularly in the area of assessment and feedback, and to engage actively with the educational program. Faculty must be trained by the program to use evaluation methods and tools aligned with the purpose of the curricular experience they are supervising or overseeing.<sup>2,pg 10</sup> In-depth faculty development training sessions can be useful, along with shorter, continuous training on the appropriate use and interpretation of assessment forms.<sup>2,7,8,11</sup>

### **Summative Evaluation**

At least annually, there must be a summative evaluation of each resident. Summative evaluation, or evaluations of learning, is utilized to make decisions about promotion to the next level of training. This evaluation may vary in form by specialty program. Summative evaluations must be finalized within four weeks of completion of yearly training requirements. These documents must (1) be stored in the Residency Management System or in the resident's file; (2) be accessible to the resident for review; and (3) include all the elements articulated in the ACGME CPR.

### **FINAL EVALUATION**

"Final evaluation" designates an assessment conducted upon resident's completion of the program. This document must be finalized within four weeks of completion of all training requirements. Final evaluation may vary in form by specialty program. The document used for a final evaluation must (1) be stored in the Residency Management System or in the resident's permanent file; (2) be shared with the resident upon completion of the program; and (3) include all the elements articulated in the ACGME CPR.

### **References**

<sup>1</sup> ten Cate O. Nuts and Bolts of Entrustable Professional Activities. *J Grad Med Educ.* 2013; 5: 157-158.

<sup>2</sup> ACGME Clinical Competency Committee Guidebook, 2<sup>nd</sup> Edition. ACGME Website.  
<http://www.acgme.org/What-We-Do/Accreditation/Milestones/Resources> Accessed March 17, 2019.

- <sup>3</sup> Caverzagie KJ, Gooney TG, Hemmer PA, Berkowitz L. The Development of Entrustable Professional Activities for Internal Medicine Residency Training: A Report From the Education Redesign Committee of the Alliance for Academic Internal Medicine. *Acad Med*. 2015; 90(4):479-484.
- <sup>4</sup> Demystifying Entrustable Professional Activities (EPAs) Worksheet. UW GME Intranet Website, Assessment and Evaluation System, Feedback and Evaluation: <https://depts.washington.edu/uwsom/graduate-medical-education/acgme-common-program-requirements-cpr-resources/va-resident-evaluation>. Accessed March 20, 2019.
- <sup>5</sup> Moonen van Loon JMW, Overeem K, Donkers HJLM, van der Vleuten CPM, Dressen EW. Composite reliability of a workplace-based assessment toolbox for post graduate medical education. *Adv in Health Sci Educ*; published online: 15 March, 2013, Accessed June 4, 2013.
- <sup>6</sup> Lefroy J, Watling C, Teunissen PW, Brand P. Guidelines: the do's, don'ts and don't knows of feedback for clinical education. *Perspect Med Educ*. 2015; 4:284-299.
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- <sup>8</sup> Prepare to ADAPT™ Feedback Framework. UW Medicine Website. <http://www.uwmedicine.org/adaptfeedback>. Accessed March 20, 2019.
- <sup>9</sup> Warburton KM, Goren E, Dine C.J. Comprehensive assessment of struggling learners referred to a graduate medical education remediation program. *J Grad Med Educ*. 2017; 9(6): 763-767.
- <sup>10</sup> Guerrasio, J, Garrity, M, Aagaard, E.M. Learner deficits and academic outcomes of medical students, residents, fellows, and attending physicians referred to a remediation program, 2006-2012. *Acad Med*. 2014; 89(2):352-358.
- <sup>11</sup> Johnston SS, Bohannon IA, Joyner BD. Mini-Sessions on Assessment for Continuous Faculty Development. *J Grad Med Educ*. 2014; 6(4): 779-780.