



EPA workshop

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NIHS



Entrustable Professional Activity

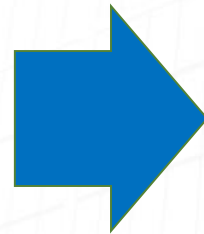
- **Definition:** Unit of professional practice (task) that can be fully entrusted to a trainee, once he or she **has demonstrated** the necessary competence to execute this activity unsupervised
- **Purpose:** To operationalize competency-based medical education through a stepwise and safe engagement of trainees in clinical practice – with a progressive (bounded) autonomy
- **Becoming competent:** Passing the threshold that allows for sufficient trust in the trainee to act unsupervised



Assumed trust vs EPA



Ad-hoc decisions of entrustment occur daily in clinical education



Summative decisions of entrustment are based on **multiple structured** workplace **assessments** and focus on increased autonomy





Competencies ↔ EPAs



Competencies	EPAs
<p>person-descriptors</p> <p>knowledge, skills, attitudes, values</p> <ul style="list-style-type: none"> • content expertise • health system knowledge • communication ability • management ability • professional attitude • scholarly skills 	<p>work-descriptors</p> <p>essential units of professional practice</p> <ul style="list-style-type: none"> • discharging patient • counselling patient • leading family meeting • designing treatment plan • Inserting central line • Resuscitating patient

Person



the **ability** to do something successfully or efficiently*

that **something** that is (trusted to be) done successfully or efficiently

*Oxford dictionary

Seniorization of Tasks in the Academic Medical Center: A Worrisome Trend

Ralph G Dacey Jr, MD, FACS, Thomas J Nasca, MD

For patient safety residents receive less opportunity to execute true responsibilities for patient care

- Poorly prepared for unsupervised practice
- Patient safety jeopardized after training

Table 1. Examples of Seniorization of Tasks in the Academic Medical Center

In trying to improve adherence to Surgical Care Improvement Project (SCIP) measures to remove bladder catheters in postoperative patients, a senior hospital administrator demands that attending surgeons (not surgical residents) be required to write the order to have catheters removed immediately after the operation.

The Centers for Medicare and Medicaid Services (CMS) requires that attending physicians personally sign orders to admit a patient to the hospital. A resident's signed order is not sufficient, even though that resident may have evaluated that patient in the emergency department and had been instructed to admit the patient.

A neurosurgery attending physician—not a resident—at a children's hospital is required to make the request for any MRI with conscious sedation done overnight.

Concerned about "inappropriate" requests for consultation, the ophthalmology service requires that requests for consultation on inpatients occur from attending to attending.

In attempting to decompress busy emergency departments and enhance timely decision making, a policy is established to have all communication about patient care occur between attendings.

Cardiology establishes a policy in which their consulting fellows—at night—will discuss their recommendations only with "an attending," not a resident.

At a major trauma center, attendings—not residents—are responsible for obtaining written informed consent before a patient can be brought to the operating room.



British Journal of Anaesthesia 112 (6): 1083–91 (2014)
Advance Access publication 17 March 2014 · doi:10.1093/bja/aeu052

BJA

QUALITY AND PATIENT SAFETY

Can I leave the theatre? A key to more reliable workplace-based assessment

J. M. Weller^{1,2*}, M. Misur², S. Nicolson², J. Morris³, S. Ure⁴, J. Crossley⁵ and B. Jolly⁶

EDITORIAL

Annals of Surgery, 2018

Entrustable Professional Activities

The Future of Competency-Based Education in Surgery May Already Be Here

Jacob A. Greenberg, MD, EdM and Rebecca M. Minter, MD



The philosophy of workplace-based assessment: *Retrospective (competence)* or *Prospective (EPA)*?

Does the trainee show mastery of the content, taught in courses and rotations?



Is the trainee ready to assume the expected responsibilities in future?

End of training



EPA Implementation Rational

Structural entrustment decisions **formally acknowledge** that a trainee has passed a threshold that allows for decreased supervision

Building a workplace curriculum around EPAs create a **longitudinal view** of each learner's performance via aggregated performance evidence

EPAs provide supervisors with a **solid justification** for delegating an activity to trainees

EPAs provide trainees with a full understanding of their **progress requirements** and professional tasks



Building and implementing EPAs

General rules

Each specialty or subspecialty defines EPAs that are best suited to ensure their residents/fellows progress through training appropriately

The number of EPAs for a specialty is determined by the Specialized Specialty Committee (NIHS)

The prerequisites for entrustment/ decreased supervision progression must be clearly defined and made available to trainees and faculty



Task1 - 1 minute

- Choose your program (sub)specialty



Building and Implementing EPAs

NIHS

- Database
- Electronic log system
- Logistic support
- Program quality assessment

Scientific Committees

- Build EPAs



Building EPAs

Define volume

The volume of all EPAs shall be sufficient to cover all (majority) aspects of (sub)specialty including:

- **Variety of pathology** (including age-specific particularities)
- **Variety of skills** (cognitive, surgical and other nonsurgical procedural)
- **Variety of encounters** (acute vs chronic, stable vs critical)



Building EPAs

For each EPA, there shall be clearly determined:

- Description of **Key function(s)**
- **Knowledge Skills Attitudes/milestones** needed for entrustment level
- **Assessment tools** including clinical environment variables
- **Expected PGY level** for progression
- **Basis for formal entrustment decision** (number of documented supervised encounters needed for progression)





EPA – medical (non-procedural) EPA

Title	Description	Required KSA/ milestones	Assessment tools	Basis for formal entrustment decision	When is the conditioned independent practice expected (PGY)
Broad domain					
EPA 1 (cognitive)	Key function 1	PCx, MKx, PLx, SPx, ICx, Px	Direct observation by faculty	Number of directly observed events	PGY x
	Key function 2		and/or	and/or	
	Key function 3		Competence test	Obtain competence	



Medicine
UNIVERSITY OF TORONTO

Internal Medicine

EPA COD-1: Assessing, diagnosing, and managing patients with **complex or atypical acute** medical presentations

Number of EPA assessments: Complete a minimum of 18 COD-1 EPA assessments by the end of PGY3.

Clinical scenarios: A variety of common medical conditions in the acute setting

Observation: At least 6 direct observations**, some in ambulatory care, covering each focus of care (initial assessment; diagnosis; management). At least 6 different assessors.

Success: Completion of the requirements above and entrustment (Autonomous or Excellence) for 18 acutely ill patient EPAs by the end of PGY3.

COD = core of discipline

https://deptmedicine.utoronto.ca/sites/default/files/curriculum_plan_for_pgy2_and_pgy3_cod_20-06-10.pdf



EPA – procedural (surgical and nonsurgical)

Title	Description	Required KSA/ milestones	Assessment tools	When is the conditioned independent practice expected (PGY)	Basis for formal entrustment decision
Broad domain					
EPA 2 (procedural)	Key function 1	PCx, MKx, PLx, SPx, ICx, Px	Case log/ OSATS	PGY x	Number of directly observed events
	Key function 2				
	Key function 3				



EPA: Performing uncomplicated cesarean sections

Key Features:

- Surgical skills demonstrated in performing an uncomplicated cesarean section
- Includes obtaining informed consent and documenting the operative report, planning pre- and post-operative care, including identifying the need for prophylaxis (anti-microbial or VTE).

Assessment:

- Part A: Procedural skills assessment form
 - Direct observation by OBGYN faculty. - At least 3 different OBGYN faculty
- Part B: Logbook of procedures submitted to Clinical Competence Committee

Basis for formal entrustment decision

- Collect 5 observations of achievement



Task 2: 2 minutes

Identify **one EPA** applicable to your program (sub)specialty

Task 3: 10 minutes

Describe the EPA into the table provided



Task 4: 1 minutes



Around the table identify **the following role players:**

- Institutional leadership (DIO/GMEC, CMO)
- Program director (PD)
- Faculty
- Trainee
- Coordinator
- Clinical Competence Committee (CCC)



Task 5: 3 minutes

List 2 important action needed for EPA implementation at

Institution leadership (DIO, CMO) level



Implementing EPAs Institution level

DIO/GMEC

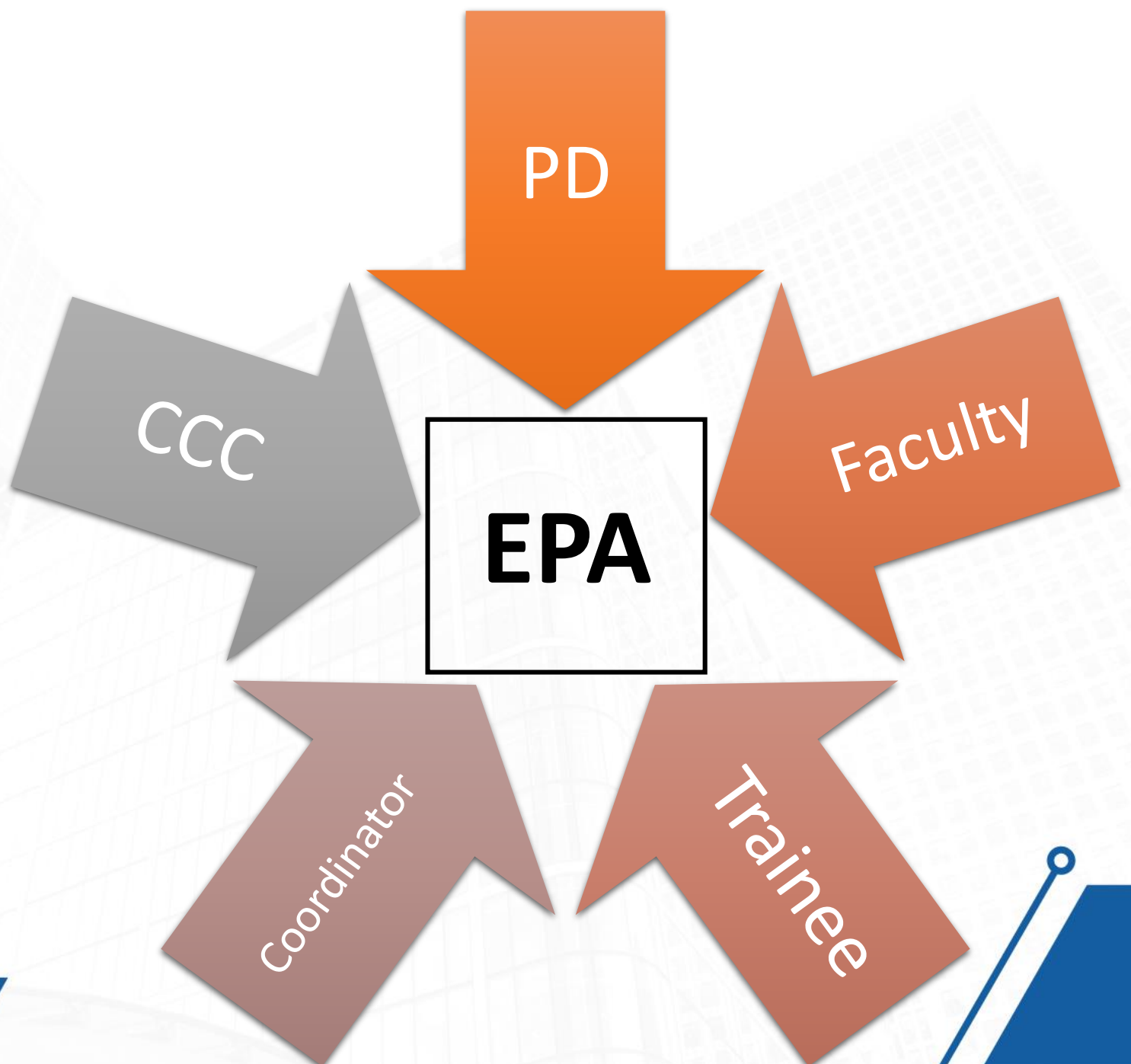
- Conduct faculty and trainee training
- Oversee implementation
- Adopt an EPA policy common to all PGME programs

Hospital administration

- EPA policy must be adopted and implemented throughout Sponsoring Institution and its participating sites
- EPA system is representing the privileging activities at the PMGE level



Implementing EPAs Program level





Task 6: 3 minutes

List 2 important action needed for EPA implementation at

Program director (PD) level



EPA implementation PD

1. Contribution to EPA building and maintenance through NIHS Scientific Committee
2. Implementing a curriculum built around EPAs
3. Maintain a transparent platform of implementation
4. Distribute all needed information to faculty and trainees



Task 7: 3 minutes

List 2 important action needed for EPA implementation at

Faculty (attending) level



EPA implementation Faculty

1. Supervision

2. Faculty assessments (formative):

- Should insure multiple information: (assessors, events, clinical environments)
- Must provide **immediate meaningful feedback** to the trainee
- For each EPA, there must be documented an adequate assessment form (cognitive or procedural)

Faculty Formative Assessment

EPA	Level of competence					
	0 Not Yet Assessable/ Not Yet Completed Level 1	1 Observation without execution even with direct supervision	2 Execution with direct supervision	3 Execution with reactive supervision i.e., on request quickly available	4 Supervision at Distance and/or post hoc	5 Trusted to perform without supervision Can supervise junior colleagues
EPA # 1 Cognitive	Required complete guidance or was unprepared	Has knowledge	Performed task under full supervision	Performed task under moderate supervision	Performed task with conditioned independency	Previous + Can teach and supervise
EPA # 2 Surgical: specific OSATS score	Required complete guidance or was unprepared	Assisted Has knowledge OSATS score	Performed with major/essential involvement from supervisor OSATS score	Performed with minimal/nonessential or no involvement from supervisor OSATS score	Can perform without supervisor present OSATS score	Can perform without supervisor present Can teach and supervise
EPA # 3 Nonsurgical procedural: Modified OSATS or another tool	Required complete guidance or was unprepared	Assisted	Performed with major/essential involvement from supervisor	Performed with minimal/nonessential or no involvement from supervisor	Can perform without supervisor present	Can perform without supervisor present Can teach and supervise



Task 8: 3 minutes

List 2 important action needed for EPA implementation at

Trainee level



EPA implementation Trainees

- Acknowledge all aspects regarding EPA
- Obtain an **assessment form or documentation** for all supervised activities as applicable to EPAs
- Ask for (if not voluntarily provided) immediate feedback
- Maintain the clinical activities record through logbooks
- Submit the assessment forms to coordinators
- Actively follow their progression towards entrustment



Task 9: 3 minutes

List 2 important action needed for EPA implementation at

Coordinator level



EPA implementation Coordinators

- Maintain all assessment records
- Prepare the EPA targeted assessments and present them to CCC meetings
- Maintain the updated correspondence before and after CCC meetings
- Maintain a record of CCC meeting minutes



Task 10: 3 minutes

List 2 important action needed for EPA implementation at

Clinical Competence Committee (CCC) level



EPA implementation CCC

1. CCC summative assessment:

Shall consider the level of proficiency for each observed encounter and the number of events executed at a certain level of supervision.

2. Propose to PD the level of entrustment for each EPA

3. Report negative gaps between the projected and achieved entrustment for each EPA/trainee

4. Analyze and propose to PD the advancement into next training level



EPA implementation PD close circle

- Based on CCC meeting recommendations PD will ultimately decide upon level of entrustment for each EPA/trainee
- The summative evaluation and final PD decision must be communicated and discussed with trainees
- All negative gaps must be analyzed, and a remediation plan must be formulated and implemented as needed
- Severe and/or multiple negative gaps, which are not remediated as planned, could be used as a basis for non promotion or even dismissal from the training program
- Final EPA report to trainee file, transparent to NIHS



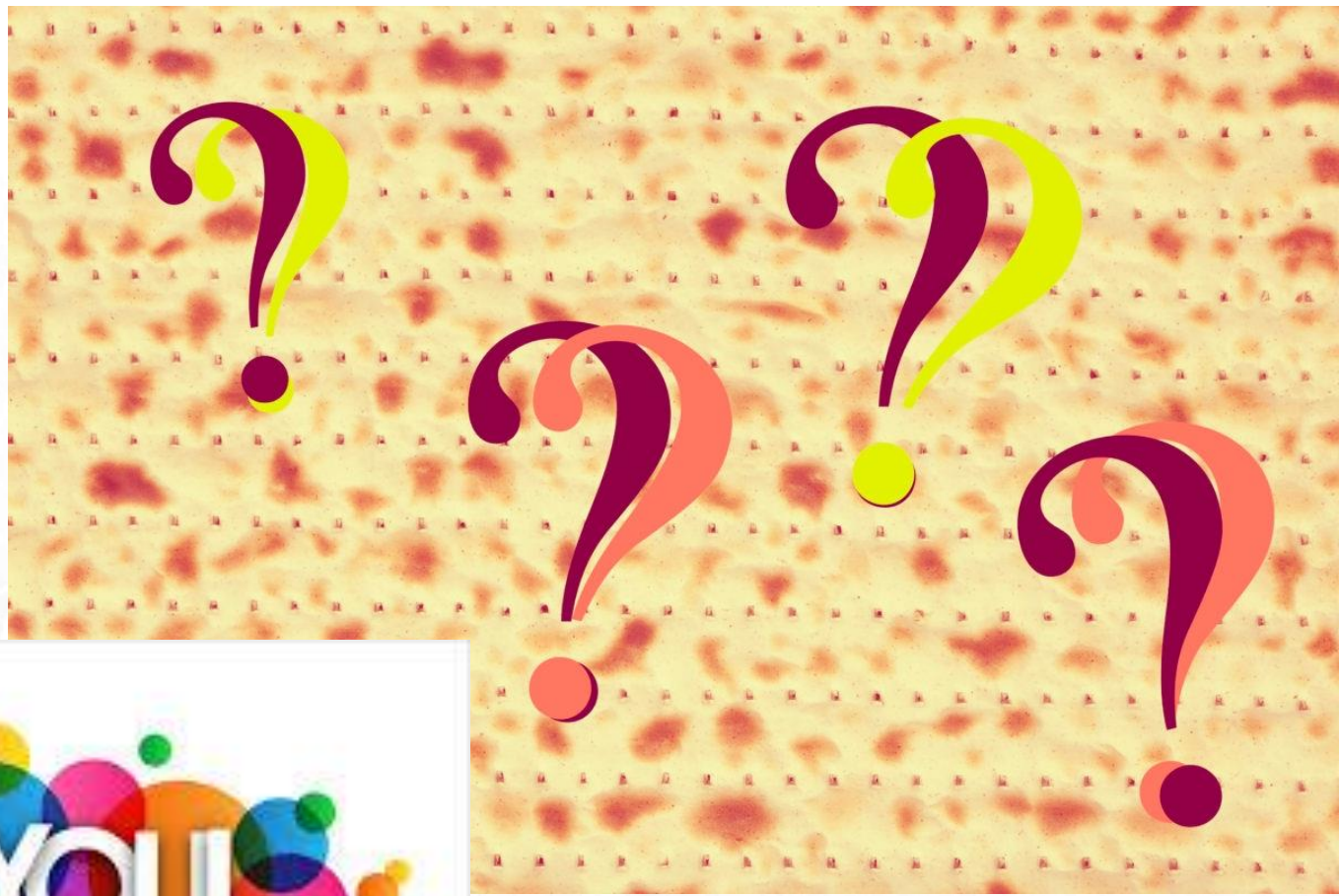
EPA reporting Trainee file

EPA	Level of confidence - entrustment						Date of entrustment/ PGY level
	Not yet assessable	1 Has knowledge but may not act	2 Act under full supervision	3 Act under moderate supervision	4 Act under conditioned independency	5 Act as supervisor and instructor	
EPA 1 Title: clinical activity							dd/mm/yy
							dd/mm/yy
							dd/mm/yy
							dd/mm/yy
							dd/mm/yy
							dd/mm/yy



Task 11: 3 minutes

List 2 most important benefits of EPA implementation



THANK YOU!