USF HEALTH MORSANI COLLEGE OF MEDICINE UNIVERSITY OF SOUTH FLORIDA

Entrustable Professional Activities: can the continuum between UME, GME and CME finally be bridged?

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Before we start…

- PD
- APD
- Coordinator
- Other

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Objectives

- To review recent publications on Entrustable Professional Activities
- To review how the Pediatrics community is using EPAs for UME, GME and CME
- To experiment with how the AAMC's core EPAs for residency apply to your field
- To explain how USF is looking to apply the EPAs to UME

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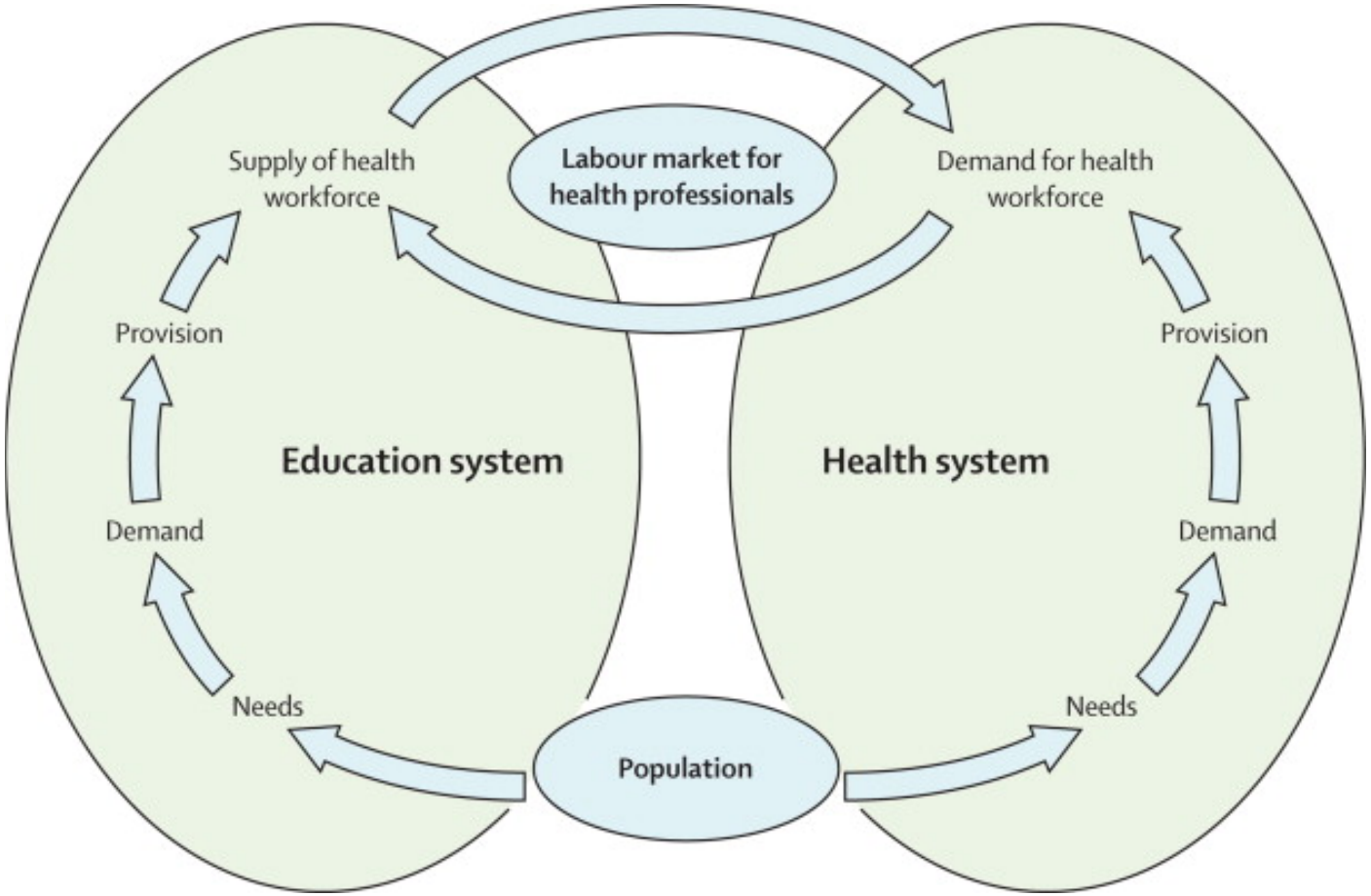
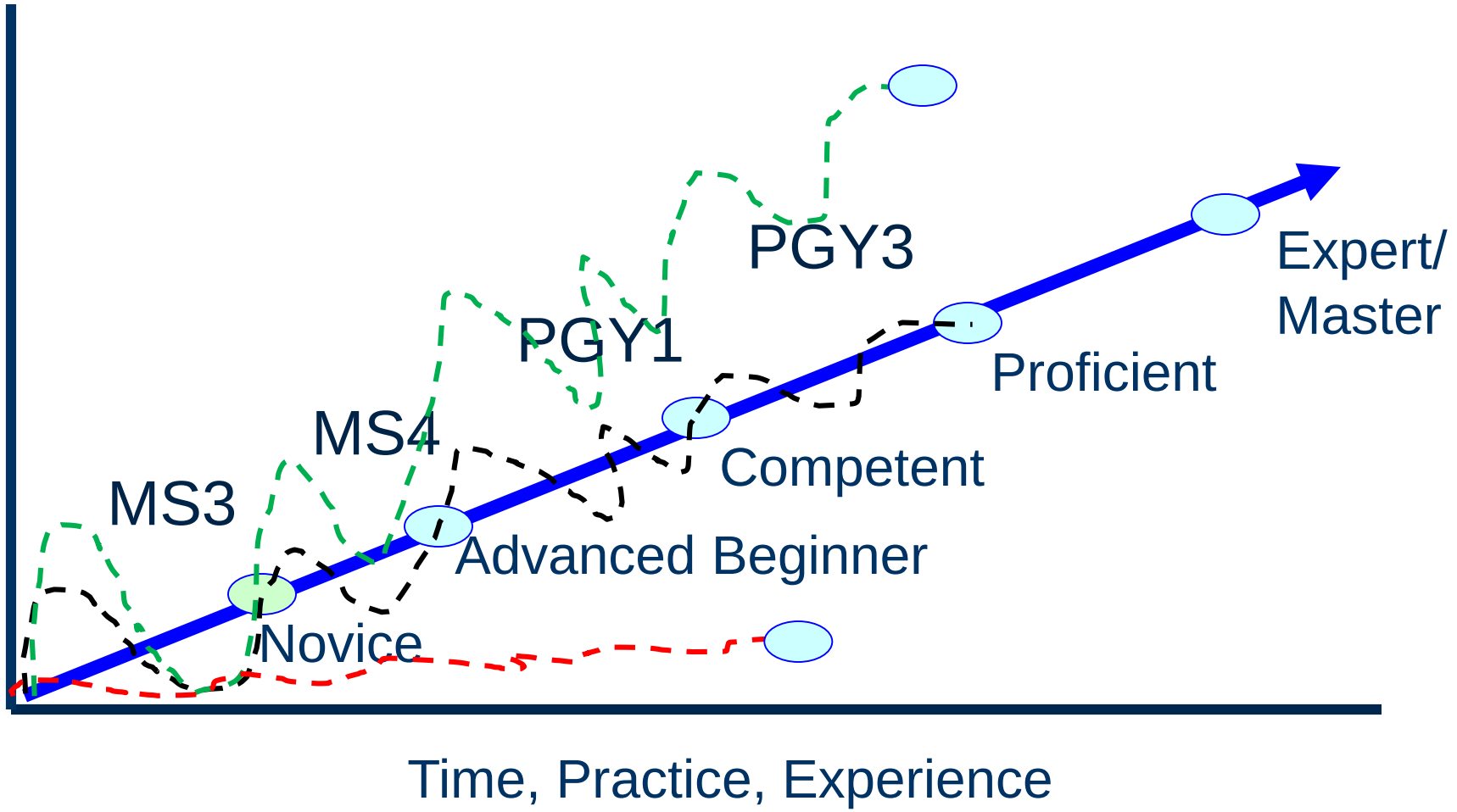


Frenk et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010 Dec 4;376(9756):1923-58

Dreyfus & Dreyfus Development Model



Carraccio CL et al. From the educational bench to the clinical bedside: translating the Dreyfus developmental model to the learning of clinical skills. Acad Med 2008;83:761-7

REVIEW OF THE LITERATURE

Trust and Risk: Damadaran et al

- Narrative review article of the literature on trust
- Databases: MEDLINE, ERIC, CINAHL, EMBASE, Proquest Central, Business Source Central, Google Scholar
- Searched: trust, medical, health, education
- Reviews from management, higher ed, medicine and medical education were all included

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A trusts B to do X

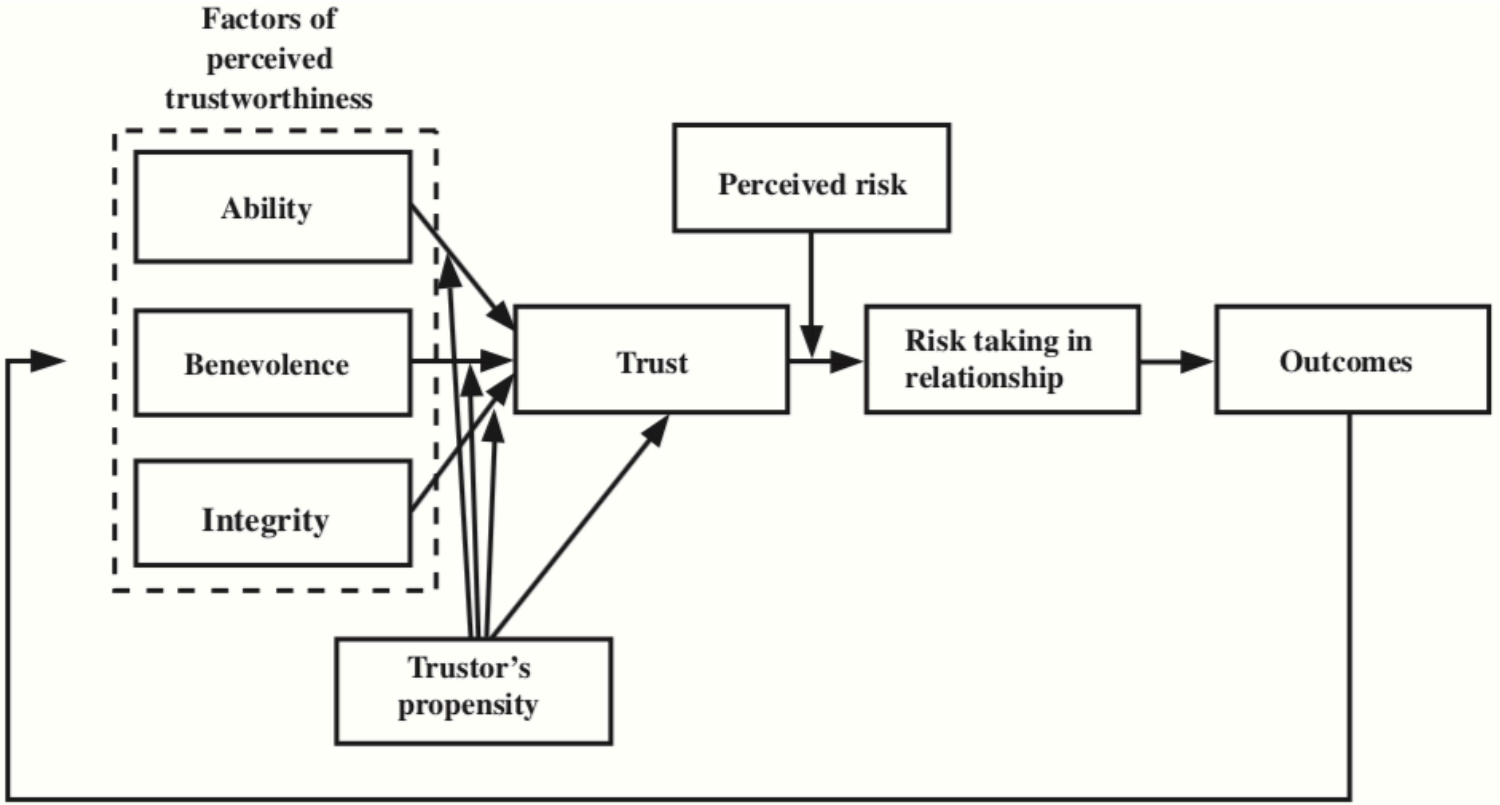

Figure 2 From Mayer *et al.*[15] Reproduced with the kind permission of the Academy of Management

Damadaran et al

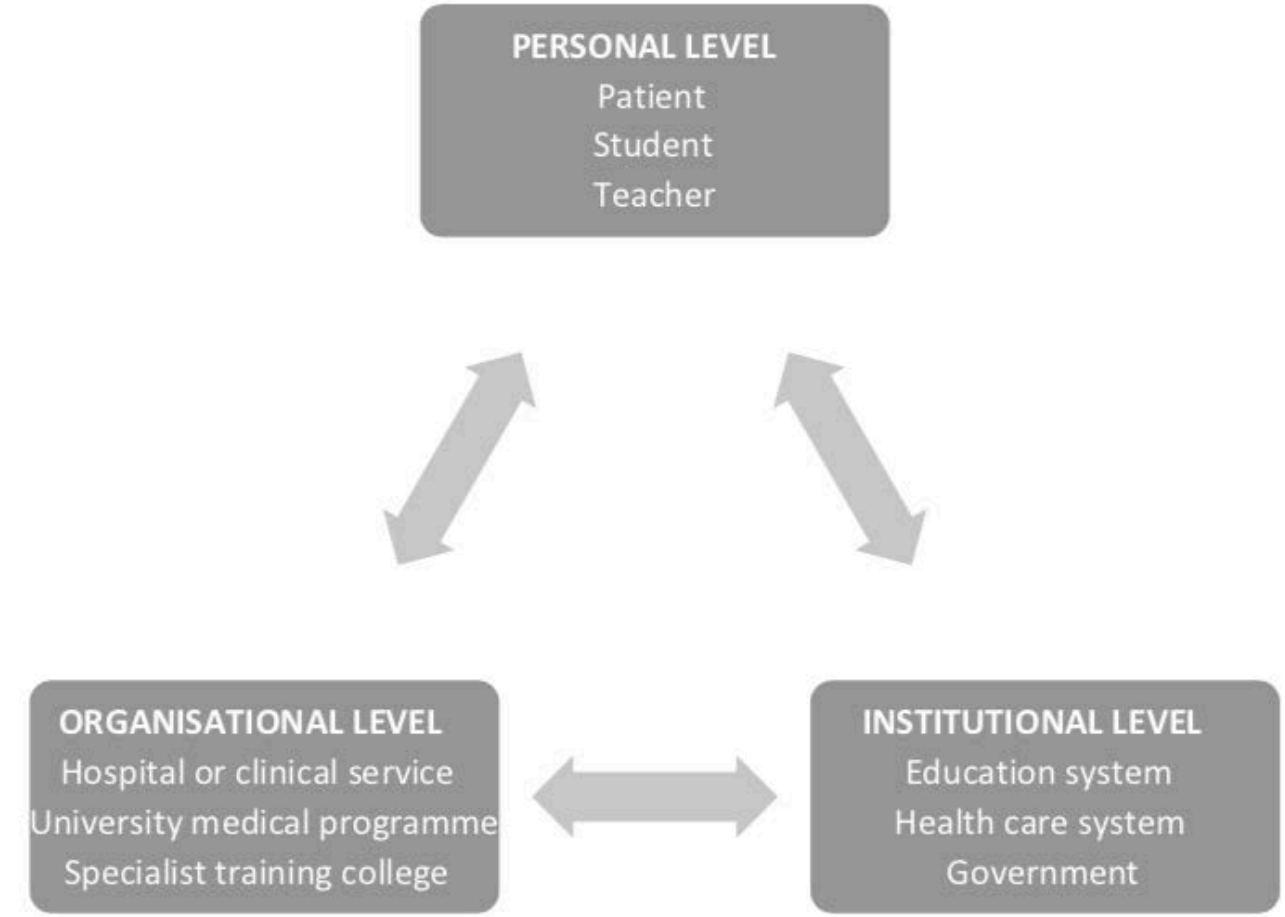

Figure 1 Relationships of trust in medical education. Arrows represent bidirectional relationships

Damadaran et al

Trust and Risk:Damadaran et al

- “The defining feature of trust is the trustor’s appreciation of risk and acceptance of vulnerability in the relationship.”
- Declaration of competence is an impartial certification and does not take into account the risk the supervisor is taking.

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Assessment and Entrustment: Dolan et al

- Question: will explicitly asking faculty about entrustment improve the quality of feedback given.
- Added: “Based on this observation, I trust that this student could independently perform an appropriate H&P on a future patient of similar complexity.” Not yet/Yet

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Assessment and Entrustment: Dolan et al

Table 2 Constructive Ratings and Feedback by Year

	AY 2015–16 (control), no. (%)	AY 2016–17 (intervention), no. (%)	*p* value*
Received a "target for improvement" rating	16/577 (3%)	28/662 (4%)	.17
Received a constructive rating**	16/577 (3%)	37/662 (6%)	<.05*
Received constructive narrative feedback	118/577 (20%)	240/662 (36%)	<.01*
Received both a constructive rating and constructive narrative feedback	6/577 (1%)	16/662 (2%)	.07

*Statistically significant results include those where $p = <0.05$

**Includes "target for improvement" for AY 15–16 and both "target for improvement" and "not yet" rating for AY 16–17

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Students' perception of feedback on EPAs: Duijn et al

- Qualitative, multicenter study
- Focus groups were done – moderated group discussion until no new ideas emerged
- Netherlands, MDs and DVM

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Students' perception of feedback on EPAs: Duijn et al

- Cases given:
  - C-section of a cow
  - Breaking bad news to a patient
  - "What do you perceive as meaningful feedback to optimally prepare for performing the presented EPA?"
  - "Which information sources should or could provide this feedback?"

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Students' perception of feedback on EPAs: Duijn et al

- Source: feedback provider must be credible, have experience, trustworthy
- Method: personal, safe LE, Pos & neg, written and oral
- Topic: clear instructions, focus' on improvement
- Timing: after direct observation
- Frequency: multiple occasions with the same preceptor

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Supervisors have to trust themselves first: Sheu et al

- 2 phase qualitative study using inductive content analysis
- Included: Internal medicine – UCSF, UPenn
  - 2nd/3rd year residents
  - Attendings (range of experience)
- Focus groups
- Transcripts reviewed for themes
  - 44 transcripts
  - 20 residents
  - 24 attendings (instructor → full professor)

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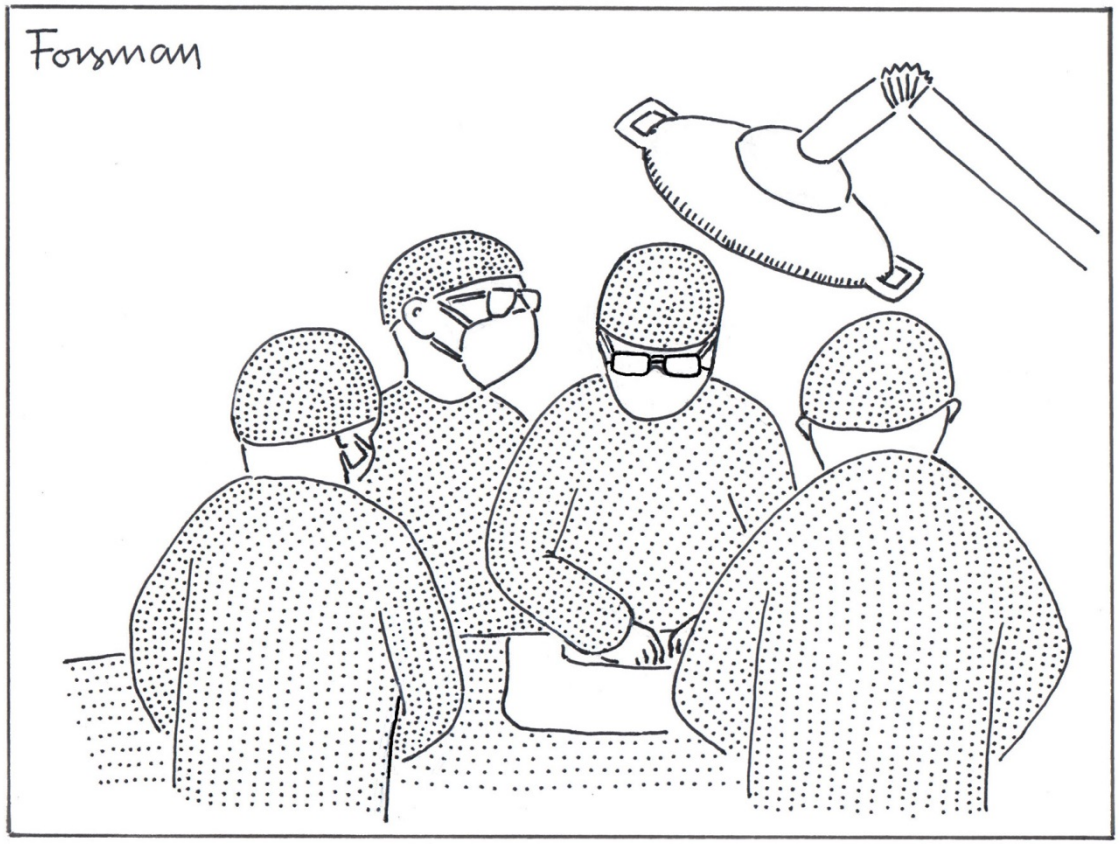
Figure 1 Four domains related to how supervisor experience influences trust and supervision (based on supervisor interviews), from a qualitative study of supervisor experience and approach to trust, University of California, San Francisco School of Medicine and University of Pennsylvania Perelman School of Medicine, 2013–2015



"We'll make a mess of this one, you need to learn how to handle a malpractice complaint."

AAMC CORE ENTRUSTABLE PROFESSIONAL ACTIVITIES

AAMC CEPAER pilot: Brown et al

- Started in 2014
- 10 medical schools
- The increased focus of competencies in GME → gap between PD expectations and UME delivery

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AAMC CEPAER pilot: Brown et al

- Principles to operationalize [*look familiar?*]
  - Formal entrustment via a trained group (*competency review committee*)
  - Base entrustment on longitudinal assessment
  - Need ad hoc workplace entrustment (*mini-CEX*)
  - Explicitly measure attributes of learners
  - Multimodal performance evidence, multiple assessors
  - Formative feedback
  - Learners are active participants

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AAMC CEPAER pilot: Brown et al

- Challenges [*look familiar?*]
  - Faculty availability, development and cost
  - Insufficient longitudinal clinical experiences
  - Scalability to a large medical school class
  - What assessment tools work?
  - Getting faculty to do evaluations

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AAMC Conference

- Still on pilots – they only are doing a few at a time
- No consensus on how to assess
- Unclear if residencies will accept if a medical school deems a student entrustable
- Is it worth the resources?

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How do the EPAs apply to you?

- Put a check box in the columns
  - I trust them: every intern is trusted to do the task
  - I trust them in certain situations: ie take a history of a patient unsupervised with pneumonia but not a patient with neutropenic fever after a bone marrow transplant
  - I trust some of them: ie I double check all of the orders of some of them, but not others
  - I would never trust them:

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Get into groups

- Were there any themes in your group?
  - Which EPAs was there agreement?
  - Which EPAs was there a lot of variation?
  - Take a few minutes then will report to the big group

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13 Core EPAs for Entering Residency:

- EPA 1: Gather a history and perform a physical examination
- EPA 2: Prioritize a differential diagnosis following a clinical encounter
- EPA 3: Recommend and interpret common diagnostic and screening tests
- EPA 4: Enter and discuss orders and prescriptions
- EPA 5: Document a clinical encounter in the patient record
- EPA 6: Provide an oral presentation of a clinical encounter
- EPA 7: Form clinical questions and retrieve evidence to advance patient care
- EPA 8: Give or receive a patient handover to transition care responsibility
- EPA 9: Collaborate as a member of an interprofessional team
- EPA 10: Recognize a patient requiring urgent or emergent care and initiate evaluation and management
- EPA 11: Obtain informed consent for tests and/or procedures
- EPA 12: Perform general procedures of a physician
- EPA 13: Identify system failures and contribute to a culture of safety and improvement

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Discussion

- Were there any themes in your group?
  - Which EPAs was there agreement?
  - Which EPAs was there a lot of variation?
  - Take a few minutes then will report to the big group

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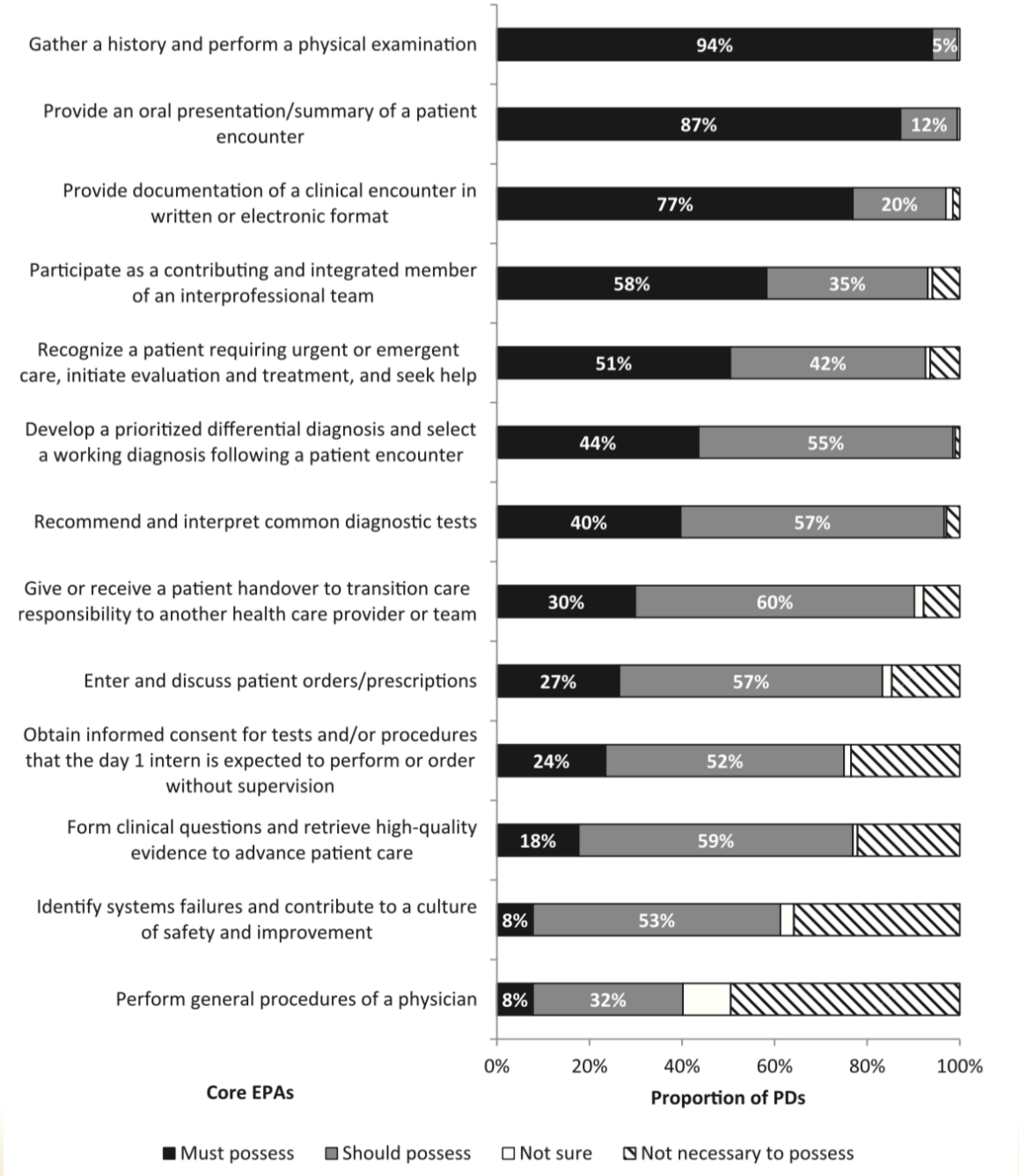
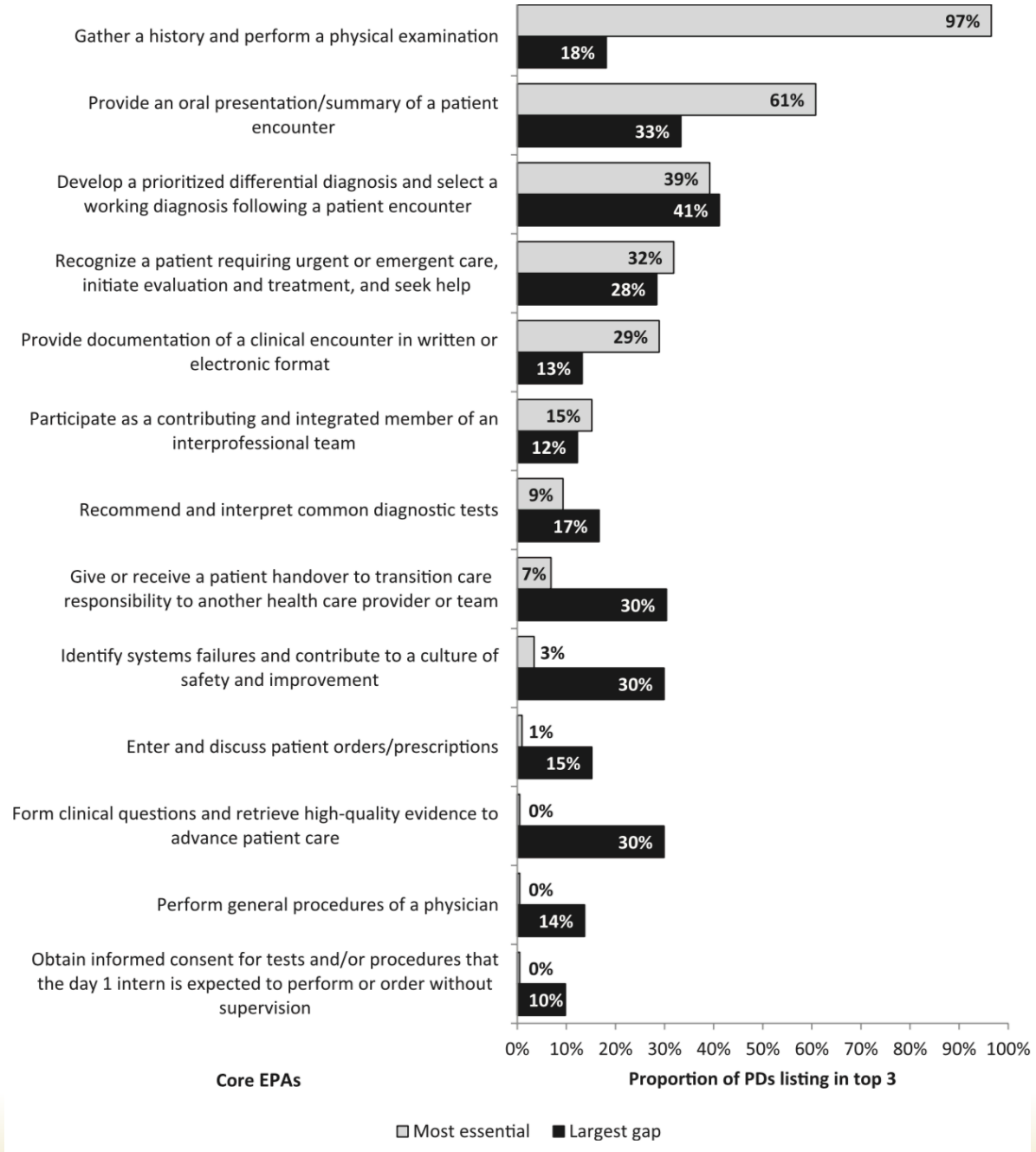


Internal Medicine Program Directors
n=204 out of 361 programs
57% response rate

2015 Association of Program Directors in Internal Medicine



IM PDs were asked to rank order:

1. The EPAs the top 3 EPAs that they viewed as most essential for new interns on Day 1
2. The EPAs they observed as having the largest performance gaps
3. What do you find surprising?
4. My thoughts
    1. UME needs to work on ddx
    2. Handoffs and EBM? This seems essential

What does your ideal intern look like?

- Example: Internal Medicine
  - H&P: intern can go to the ED and do an H&P. Get all relevant info, making sure to cross reference PMH and med list. Does a complete physical exam without being asked.
  - Knows the ddx of chest pain, SOB, abdominal pain
  - Can write orders accurately
  - Can do an LP, paracentesis supervised
  - Can tell when an unstable patient needs to go to ICU, can manage hypotension initially until help comes
  - Communicates with nurses re: what has happened overnight, checks with telemetry if appropriate (doesn't assume that no news is good news)

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Vision for USF UME and the EPAs

- Inventory the EPAs – what are we already doing?
  - Curriculum map
    - Search by session, course, program objective
    - Search by national content objective
    - PCRS, EPA cross reference

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Vision for USF UME and the EPAs

- Challenges
  - Is it really possible to sign off on all of the EPAs for all of the students in a meaningful way?
  - If it isn't how do we implement?

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Vision for USF UME and the EPAs

- General EPAs for all students
  - Students should be able to get an H&P on any patient
- Make some of the EPAs specialty specific
  - Each student maybe entrustable in a different procedure that is relevant to their specialty
- Define the context of the EPA
  - Entrust an intern to manage an unstable patient who is hypotense because of early sepsis but not an unstable patient who is in PEA arrest
  - What does “manage” mean? In the case of an unstable patient does it just mean calling for help?

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Partner with GME

- Partner with APD and PDs to get students to be entrustable in a discipline specific manner for some of the EPAs
- Goal: that USF students would be the “ideal” intern when they start with you

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Closing thoughts

- EPAs are a great idea
- How to assess?
- EPAs need a context
- We should expend our resources in a strategic manner so that we are giving residencies what they need. Entrustability does not need to looks the same in every student.

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