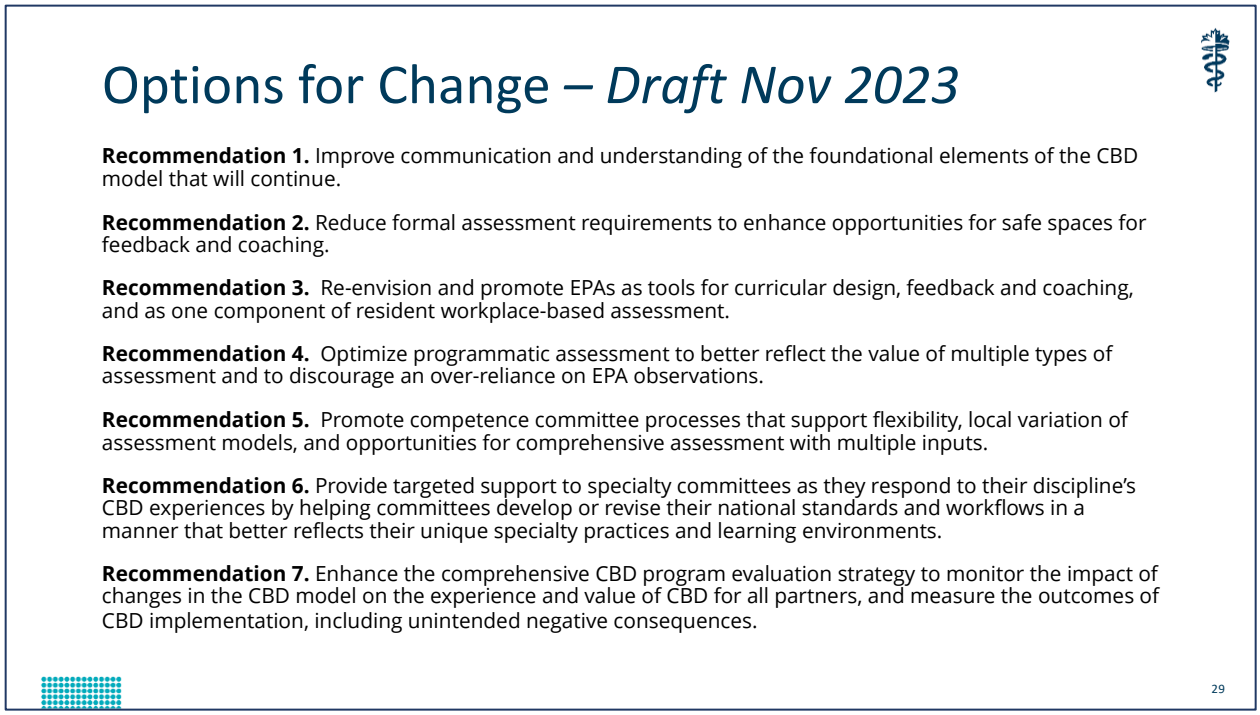
Options for Change – Consensus on Proposed Strategies Across Groups at CBME Retreat 2023

(PDs, CBD Leads, CC Chairs, PAs, Resident Leads, Academic Coaches)



Proposed strategies reaching group consensus (CBME Retreat, Nov. 22, 2023). Additional role-based input from all roles in CBME/CBD can be entered in the CBD 2.0 workbook (follow link).
1. Reduce assessment burden
a. Reduce EPAs, CVs – via Specialty Committees, **include CC Chairs in process, resident input**
i. Confirm for PDs they may reduce the recommended number of observations/# for an EPA independent of specialty committee approval (this can be done based on data review and easily edited in the eportfolio system, see *RC Adaptations to CBD*, April 2023);
ii. Consider removing EPA observations from TTD;
iii. Consider foregoing scoring of milestones, use on form for reference only, elective use by programs, ?convert milestones to a global/end of rotation checklist with narrative to complement and not replicate in the moment EPA observational data;
iv. Consider use of narrative-only EPA observations (no entrustment score);
v. Ensure EPAs can be observed on the rotation (curriculum and assessment mapping), plan for hard to achieve EPAs ahead;
vi. Consider which EPAs may not need to be observed e.g. handover;
b. Shift responsibility for EPA observation/completion to be shared with faculty
i. Hold faculty accountable for the completing EPA observations/feedback: consider a report card;

ii. Consider/share incentive options; e.g. merit pts for triggering/completion observations > to macfacts
iii. Assign manageable quotas/expectations for faculty to complete EPA observations while considering capacity across learning environments;
iv. Consider mandatory training (eModules) for clinical supervisors;
c. Academic Coaches review progress with resident prior to/subsequent to CC review– e.g. Learner Summary Report is efficient, can be triggered by faculty, PD, CC Chair, or resident;
i. Academic Coach report to CC Dashboard (dynamic updating);
ii. Resident self-reflection to CC Dashboard (dynamic updating);
iii. Promote Academic Coach role as primary reviewer to get below the numbers;
iv. Academic Coach involved in modifying learning plan ongoing with resident (process not an EEP);
d. **Enhance longitudinal assessment:** consider (modified) ITARS, end of rotation, daily log, with enhanced narrative to complement EPA observational data and other WBAs to reduce redundancy and duplication: Achieve a balanced program of assessment to ensure required data to CC;
2. Efficiencies of EPA Observations, assessment of competencies and RTEs
a. **Determine capacity** of what can be assessed in clinical environments 'in the moment' and longitudinally and align assessment tools and learning experiences (using EPAs as intended - curricular building blocks mapped to tailored assessments), review number of observations and reduce where possible;
b. **Determine if every EPA needs observation** (?Specialty Committee) AIM: fewer observations>higher quality feedback (evaluate this); some can be determined achieved without direct observation? Eg. handover
c. **Modify EPA forms: narrative to top**, scale below, milestones for reference only (programs may elect to score milestones but not required);
d. **Milestones** remain on the CBD form for reference only to guide competency-focused teaching – no scoring required but may be an option at the program level with collaboration from CC;
e. **Modify ITARS – consider a 'check list' at the end of rotation to capture core elements of EPA (?use milestones to map CanMEDS)**, emphasize use of all CBD forms e.g. Form 4, NB ITARS and WBAs roll up into the Learner Summary Report available in the system;
f. **Balance program of assessment** (EPA obs, ITARs, WBAs, Sim, OSCEs, etc) to gather data explicitly identified as required by the Competence Committee;
g. **Promote/train on mobile for immediate submission, reduce expiries;**
h. **Promote mobile for quick access** and desktop for full monitoring of progress (address resident MedSIS training needs and provide resources);
3. EPA observation vs. Entrustment assessment
a. Shift emphasis of 'EPA entrustment' determination to competency committee from clinical supervisor responsible for coaching/feedback;
b. Modify CBD Form 1, 2 = EPA Observation and Feedback Form (narrative at top, scale, milestones for reference only to inform coaching/feedback/narrative;
c. 1-2 EPAs/ week – manage EPA observation expectations, 2-yr subspecialities may be highter;

d. Ensure easy tracking of progress for PD, Resident, AC, CC Chair – expanded data exports, learner summary report, access to dashboards, ?data visualization dashboard
e. Explore opportunity to pilot changes in eportfolio before broad uptake;
f. More longitudinal indirect/cross stage assessments;
g. CC Chairs work as a community of practice - sharing best practices and processes, tools;
4. Reinforce faculty who are engaged – merit system, incentivize(?scalability), acknowledge faculty (separate from senior residents) triggering/submitting/providing quality feedback for merit by PD; e.g merit points for triggering and for submitting to complete the assessment preexpiry; share to MacFacts and up to Dept;
5. Reinforce completion rates/address barriers to EPA observation/completion – knowledge of system functionality/training requirements (resident/supervisor), plan for hard to achieve EPAs/exposures/SIM ahead;
6. Increase opportunities for sharing across programs: best practices, tools, strategies, CC processes; Communities of Practice (CC Chair, Academic Coaches)
7. Specialty Committees – document repository/ share tools nationally
a. CCs work with Specialty Committees on refined program of assessment;
b. Determine what's needed/fill gaps, match tools;
c. Share what works – share best practices (SCs>programs>across PG);
d. Resident input to SCs on EPA refinement;
8. Increase MSF, reduce bias, ensure data-informed decisions by CC;
a. Promote use of CC Review dashboard, training;
b. Upload MSF to CC review dashboard, promote Form 3;
9. Set exposure standards – ensure opportunity for clinical learning, review SC**;**
10. Ease EPA tracking and reporting;
a. Faculty do fewer/ high quality obs – encourage competence and confidence;
b. Modify CBD form, promote expanded EPA export;
i. **Global assessment** (?entrustment scale) – emphasize feedback and reduce performance orientation in the moment;
ii. **Consider which EPAs don't need direct observation 'in the moment'** – e.g. handover; can be assessed other ways

iii. **Entry checklist TTD instead**, core skills – no EPAs in first stage
iv. **Engage CC Chairs collaboration with Speciality Committee on what is most informative to decision-making** (review/versioning process);