

CBME RETREAT Nov. 9th 2022 - Follow Up
URGENT PROBLEMS AND RECOMMENDED STRATEGIES

[Keynote: Dr. Nancy Dudek, Programmatic Assessment in CBD](#)

After presentation of the national CBD Pulse Survey results, Resident Pulse Survey results from RDoc/RCPSC, and our internal CBME Resident Experience Survey 2022, participants actively worked in small groups represented by key roles in CBME/CBD (Program Directors, CBD Leads, Competence Committee Chairs, Residents, Academic Coaches, Program Administrators, Education Leads, PGME, Associate Dean, CBME Lead, CBME Committee Chairs). The large group reviewed the urgent problems listed below and the 5 things to stop and start doing in CBD, identified by the RC Evaluation working group. Discussion in small groups continued with the goals to understand the problem better, consider root causes, and potential solutions. The recommended strategies generated by the groups are listed below and will be reviewed by CBME Implementation, CBME Evaluation, CBME Faculty and Learner Development Committees, and the Resident Lead Committee for integration into committee activities.

Focusing extensively on EPAs and EPA assessment over coaching/feedback

- Engage learners in identifying misconceptions and identifying learning needs;
- Create a culture of growth mindset by encouraging residents to ask/accept EPA
 - observations as means to safe and independent practice of the competency and
 - preparation for other assessments, this helps prevent waiting for a (4 or 5);
- Encourage '5' with faculty (EPAs are designed to be achieved at a 5 by stage)
- Each EPA will be able to be set individually at a 4 or 5, when set up in MedSIS
 - programs will be notified;
- Monitor feedback and scores by faculty;
- Emphasize EPAs are only one part (observation and feedback helps prepare for summative/exams);
- Monitor how many EPAs are enough (determine individual progression) rather than have each resident complete 'recommended' number by College – consider adjusting over time if data reveals pattern;
- Confirm with resident the progress bar doesn't necessarily reach 100% if they are evaluated to progress by a CC who reviews more than just EPA observations;
- Staff can refuse to complete an EPA form if resident has already seen the patient and resident is informed they are to arrange at start of rotation or clinical day, pt encounter;
- Faculty are not triggering – assign a number of EPAs to trigger to lighten burden;

Residents and supervisors struggle to understand the scores/scale/single observations

- Provide examples of what the different scores mean by your discipline;
- If no actionable feedback required and you're simple commenting to extend training, the score should be a 5;
- Explain to faculty the scale is retrospective, only relates to what they just observed that day, there is no prognostication of what that resident would do next time;
- Use terms EPA observation rather than EPA assessment: they are only completing observations – only the CC determines when an EPA is achieved.

Clinical supervisory set up does not facilitate expected EPAs

- Build into template, curriculum map – consider business/use voice to text so feedback is captured in system when spoken to resident;
- Merit points for successful EPA completion/submission – quality fdback, appropriate scoring, resident feedback on value of learning;
- Examples from similar successful programs would be helpful.

Residents ‘hold off’ for high 0- scores (4 or 5)

- EPA scores of 2 and 3 shouldn’t be required to show progression of resident as long as multiple EPAs are being obtained;
- Should go back to the faculty (why are they only giving out 4 or 5)
 - We will have faculty identifier added to program data excel export for monitoring scoring and expiry rates;
- Every EPA should be observed and scored to differentiate what is known from what needs to be worked on;
- Set min/max number of EPAs that can be triggered per day.

Learners see EPAs as a ‘checklist’ to get done which demotivates the resident

- Determine key features of a situation and where it works in the curriculum to make it meaningful;
- Provide clear education and expectations to faculty supervisors regarding coaching and feedback, repeat with program eval data;
- Number of EPAs (i.e., one per day, 3 per week depending on total)
- Quality of comments (examples, review and feedback to faculty/staff)
- Reward ‘champions’ by celebrating successes (great observation for resident and staff and learning outcomes are achieved)
- What does the coaching conversation sound like? What goals for which EPA? occurs before pt encounter?
- Letter to faculty regarding feedback;
- EPA cards/rotation – template on CBME website, under Resources>Communication Toolkit;
- Thematic analysis of narrative;
- Promote voice to text for efficiency, simple demo, takes a few mins, MedSIS training videos on site;
- Consider feedback without an EPA (form free feedback Fridays ‘FFFF’).

Residents concerned about wasting faculty time

- Faculty to meet with residents 5-10 minutes before start of rotation or block to see what EPAs can be achieved with daily work (encourage faculty to ask resident what EPA could be achieved today);
- Look for gaps throughout the day (may only need 5 mins);
- Be explicit that they are receiving feedback and enter in the moment – use voice to text

CCs to attend to growth curve and use of narrative over numbers

- Transparency on what is reviewed by CC;
- Culture of ‘support’ VS evaluation – not all reviews are progression decisions, aim is to keep them on track and ensure clinical and non-clinical learning objectives and opportunities;
- Understanding their overall progress/concrete guidance;

- Two-minute video on CCs for residents' observation (broad dissemination);
- News out of CBME office

Quotas (all)

- Individualize progression, CCs may promote based on 4 scores, narrative if all other assessment results can defend the decision;
- Close tracking /analysis of how many EPA observations are typically required (patterns) and if less than recommended (progress bar is set to '5' scores on recommended number);
- Make data available; EPA excel export, Learning summary report, Academic Coach report;
- MedSIS – reports, expanding program export to include faculty, resident identifier to assist with tracking and feedback;
- Data Visualization dashboards in the works for at-a-glance views of resident data;
- EPA reviews- need to hear what is problematic
- Faculty and residents use EPA cards/rotation reducing cognitive load, template downloadable from Communication Toolkit on CBME website;
- Faculty 'learn' EPAs (2-3) so they focus on for the time they have resident;
- Curriculum map for trainees – 'Year at a Glance' informs them what's coming up;
- Keep EPAs simple- what is the focus and goal, decide on learning goal before pt encounter;
- Program focus groups-resident and faculty annual retreats

TOWN HALL DISCUSSION Nov. 11/22: Reducing Resident Burden

- Emphasize coaching, EPA observation is opportunity for feedback to get them to safe and independent practice and achievement of the competency and it also benefits them with other summative assessments
 - They tend to wait for the 4 or 5 (and rush as the rotation shortens causing stress) so getting observations is a great way to prepare for all assessments and initial lower numbers are ok and reflect learning (we've heard that once that comes from their PD they relax);
- Residents trigger 80-90% of EPA obs (get some of them and then some expire – huge source of stress) some programs assign faculty a number to trigger, determine which rotations work best for learning opportunity - too busy and hard to complete? Share the 'At a Glance' curriculum map with residents so they know what is coming up;
- Attend the Curriculum and Assessment mapping working in early Feb. 23 to refine your assessment map, consider where in curriculum/rotations EPAs fit well or revise based on experience;
- The more immediate (ideally in the moment) the better the feedback and less likely to expire – the farther out it goes to hard to recall useful – at retreat it was day of ideal but possible within a few days (Note the expiry is set to 2 wks currently because of covid – it was 14 days and we were going to lower to 10) –
- Faculty/supervisors get a reminder of pending EPAs every Wed – you'll be able to see fac identifiers in your program export data soon (adding a few fields)
- If in a busy unit try to have the coaching/feedback aligned with competency at least even if it isn't scored – voice to text works really well on the EPA forms on mobile (takes a few mins only so they can speak into when actually giving their feedback – no need to repeat)
- Send targets based on total # of EPAs - achieve 1 per day/3 per week depending

- Emphasize that it's multiple EPA observations from a variety of coach supervisors and others (MSF) and a collation assessment data that the CC uses for status reviews and progress deliberations
- Summative compliance mindset so ticking boxes to get them done and miss the learning opportunity - faculty trigger - some use a predefined number, monitor, some PDs meet with them, professionalism issue?
- Progress bar – big source of stress - currently set to 5 for CVs and **recommended** number of observations - changing to set each epa to a 4 or 5 (progress bar may move faster if no high expiry rate) – have to monitor expiries – noted in your export – We are working to get fac identifier, resident identifier in export
- Chasing faculty to complete and actually SUBMIT- admin burden - shared triggering, make it meaningful by tying to competency and the work of the day before beginning
- Residents might wait to feel 'ready' for an epa observation and run out of time in rotation to complete
- Orient to CC - share what data is used, not all CC mtgs are progression decisions,
- If they have all the EPAs they many not progress for other reasons (summative, professionalism, etc)
- Consider modifying ITARS and refining your program of assessment to what collects what you/CC need, reduce redundancy and duplication (curr/assessment mapping working in early Feb/23 in the works)
- Encourage time with their academic coach to prepare for review, Learner Summary Report a great capture of current status (all EPAs, milestones, ITARs, WBAs, narrative)
- Academic coaches as primary reviewer is encouraged as they know the resident well and can help the CC get beyond numbers to growth curve for both those that are progressing and those that need a modified learning plan to achieve EPA (not always remediation) just need additional clinical learning opp to get EPA
- Voice to text, bookmark medSIS on mobile is appears more like an app and voice to text to complete EPA form on the spot (resident can complete top of form so supervisor enters only score, milestones narrative)
- Use milestones to inform what to coach/observe – if EPA is completed in part which is fine – having milestones ticked off helps the next pick up.