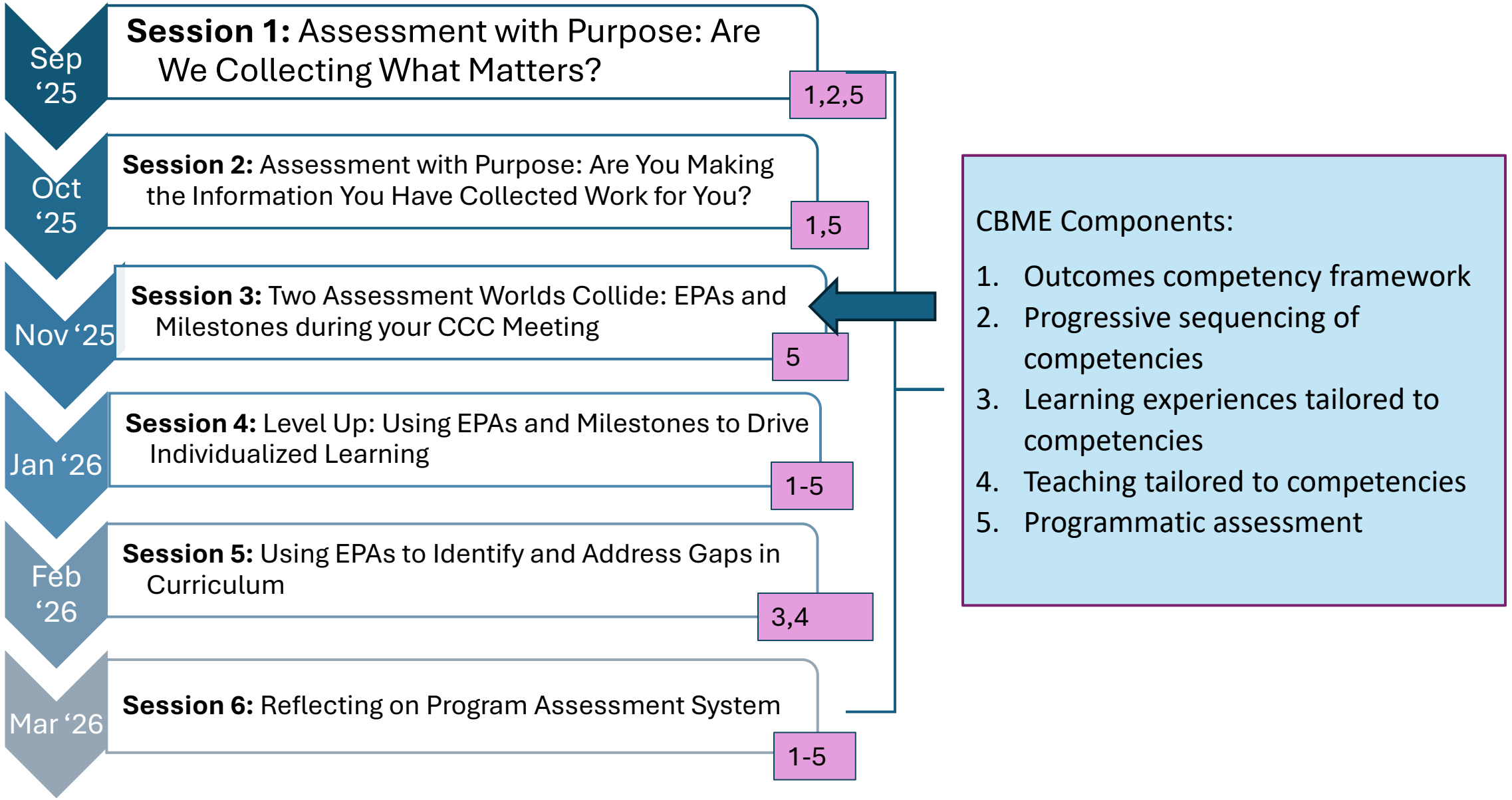
EPA Virtual Café Series: Before, During and After CCC

Hosted by your APPD Assessment Learning Community

2025-2026


Sep '25
Session 1: Assessment with Purpose: Are We Collecting What Matters?
1,2,5
Oct '25
Session 2: Assessment with Purpose: Are You Making the Information You Have Collected Work for You?
1,5
Nov '25
Session 3: Two Assessment Worlds Collide: EPAs and Milestones during your CCC Meeting
5
Jan '26
Session 4: Level Up: Using EPAs and Milestones to Drive Individualized Learning
1-5
Feb '26
Session 5: Using EPAs to Identify and Address Gaps in Curriculum
3,4
Mar '26
Session 6: Reflecting on Program Assessment System
1-5
CBME Components:
1. Outcomes competency framework
2. Progressive sequencing of competencies
3. Learning experiences tailored to competencies
4. Teaching tailored to competencies
5. Programmatic assessment

Two Assessment Worlds Collide

Transitioning to an Entrustment-forward CCC

Sara Multerer, MD

Suzie Reed, MD

Jen Di Rocco, DO



Objectives

- Articulate strategies for faculty development of CCC members regarding the lens of milestones v. EPA assessments
- Differentiate trust, trustworthiness and entrustment in assessing medical trainees
- Discuss approaches to incorporating both milestones and EPA assignments into discussions for trainee review within a CCC meeting
- Brainstorm solutions for sticky situations involving CCC discussions with both EPA and milestone assessments

Current State: Learner Case – PGY1

	Average	Range	Self
PC	3.4	3.0-5.0	4.0
MK	2.9	2.0-5.0	4.0
ICS	4.5	4.0-5.0	4.0
Prof	4.5	4.0-5.0	4.0
SBP	3	3.0	3.0
PBLI	3	3.0	3.0

Conference attendance: 78%
ITE 136 (national avg 142)
Logged one procedure
No work hour violations

Faculty Summary: Eager to learn, great attitude, works hard, can work on confidence, often had to wait until late in the day for notes – maybe efficiency, needs to keep reading

Peer Summary: Team player, great attitude, a joy to work with

Nurse Summary: Respectful of nurses, lacks confidence

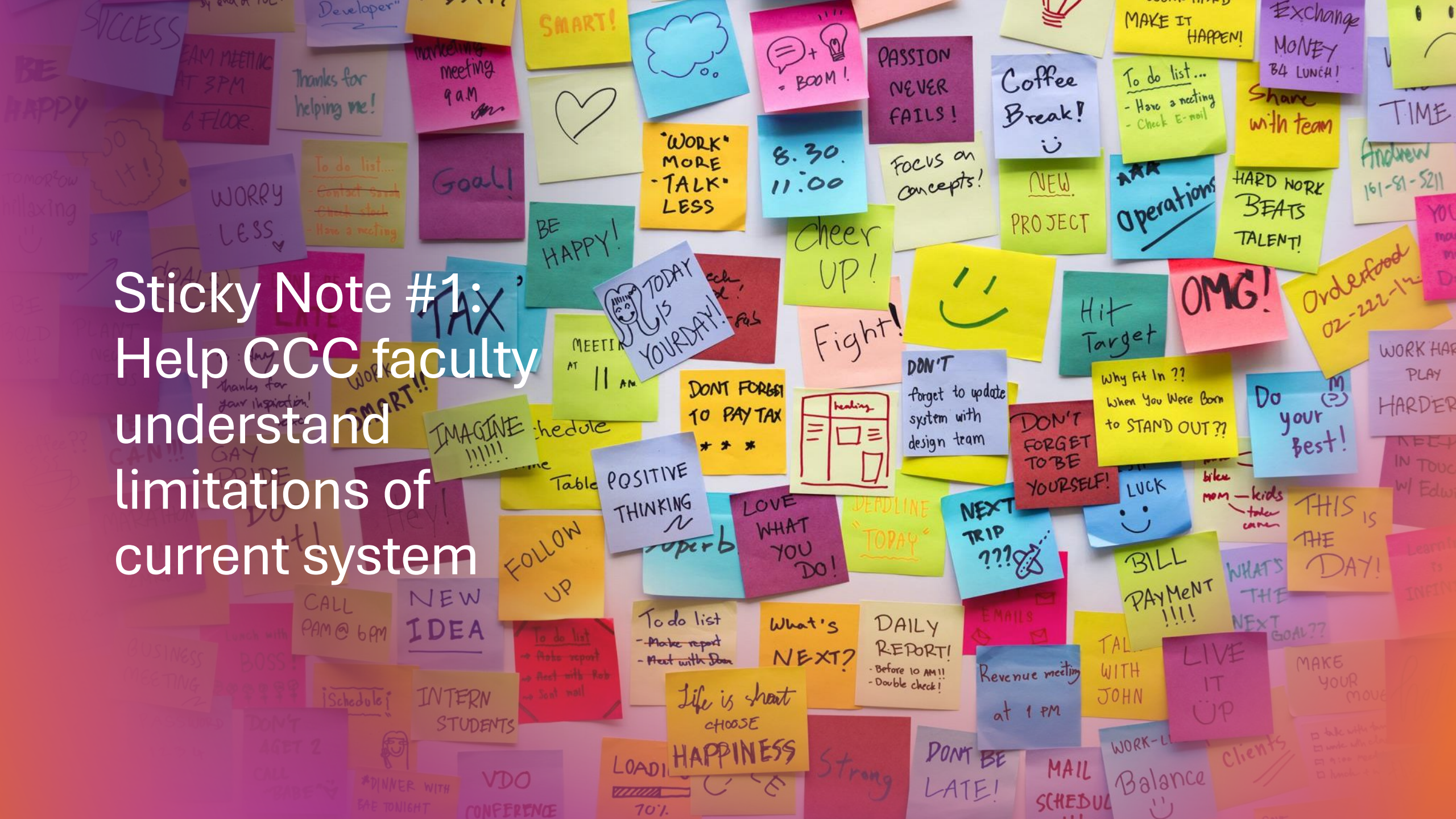
Patient Summary: I had to wait for 3 hours in the ER, seems sweet though

Self Assessment: "I'm enjoying residency and I feel like things are going well! I know I have things I can improve on but haven't gotten much feedback."

Current State: Learner Case – PGY 1

Patient Care 4: Clinical Reasoning				
Level 1	Level 2	Level 3	Level 4	Level 5
Presents clinical facts (e.g., history, exam, tests, consultations) in the order they were elicited	Generates an unfocused differential diagnosis based on the clinical facts	Organizes clinical facts to compare and contrast diagnoses being considered, resulting in a prioritized differential diagnosis	Integrates clinical facts into a unifying diagnosis(es); reappraises in real time to avoid diagnostic error	Role models and coaches the organization of clinical facts to develop a prioritized differential diagnosis, including life threatening diagnoses, atypical presentations, and complex clinical presentations
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐


EVERYTHING'S MADE UP,
AND THE POINTS DON'T MATTER!
imgflip.com


Sticky Note #1:
Help CCC faculty understand limitations of current system

+/- of Milestones-Based Programs

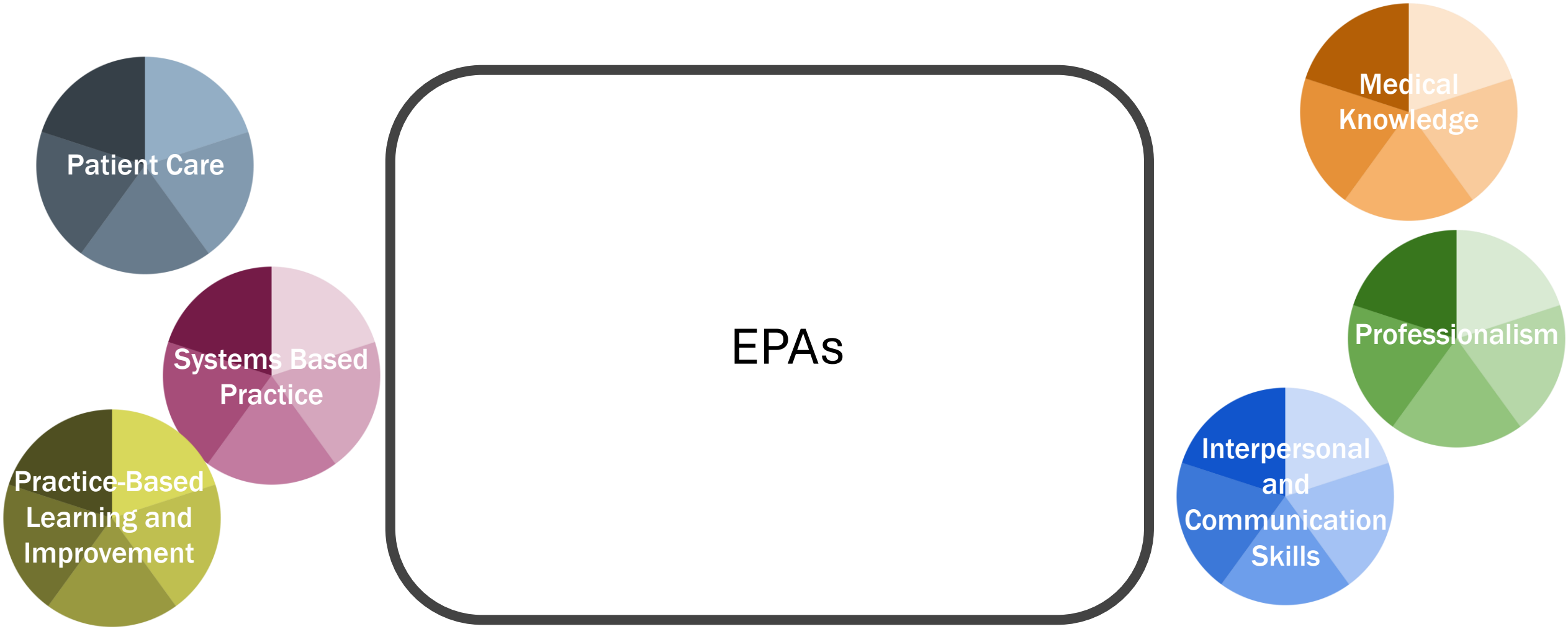
Limitations

- Focus on small isolated tasks
- Incomplete bigger picture
- Concepts/jargon may not resonate with frontline faculty
- Patient needs not at the forefront

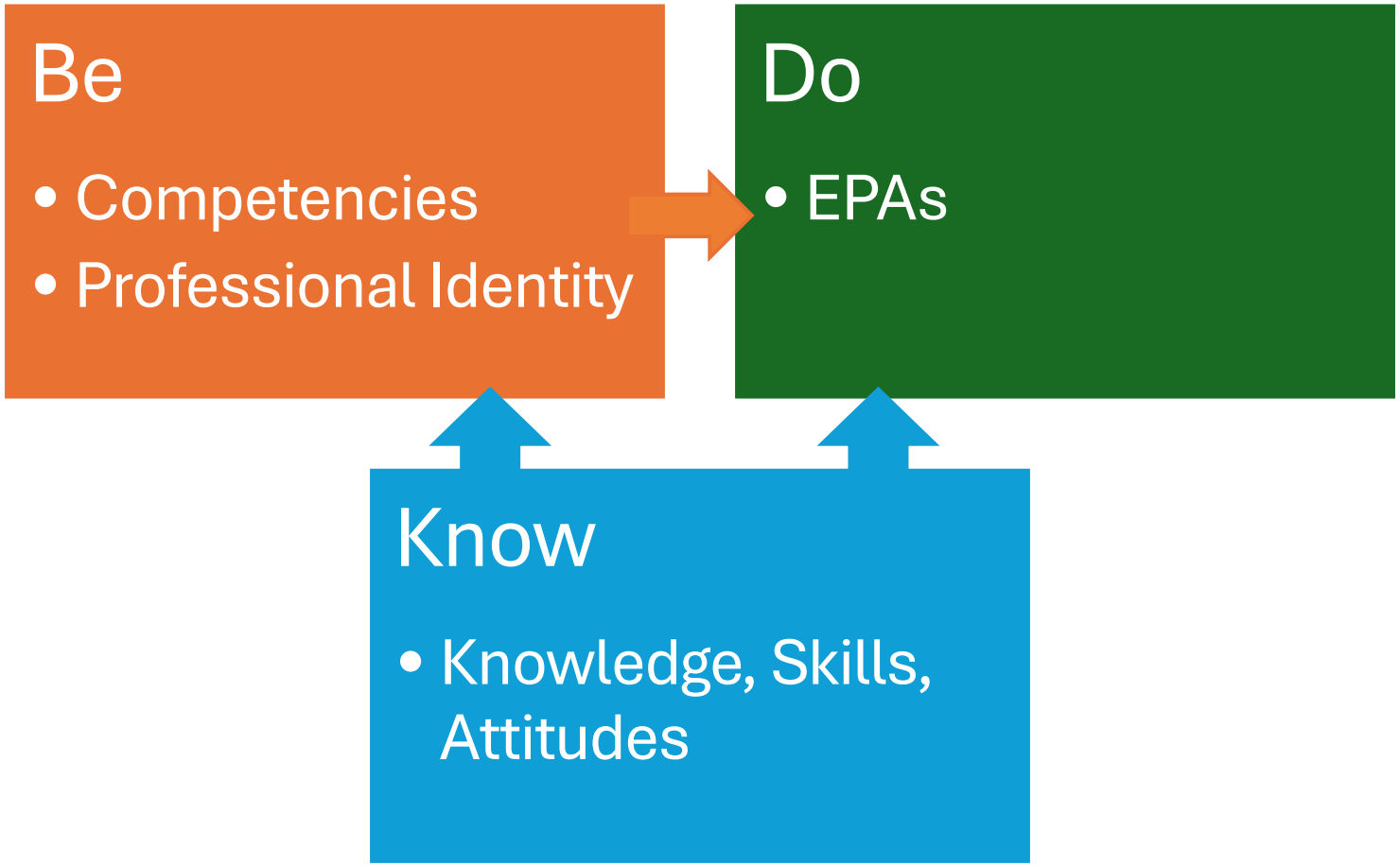
Value

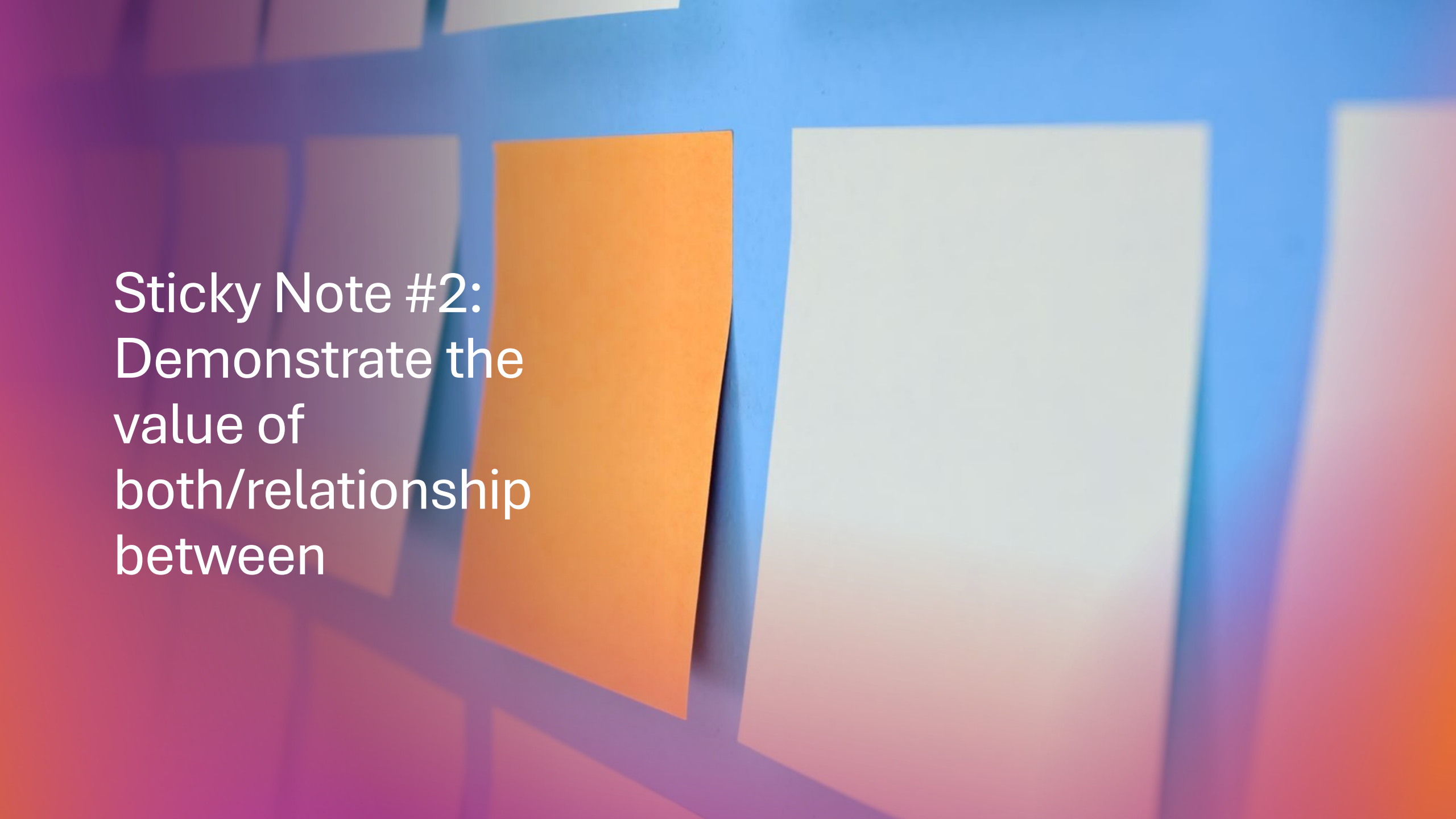
- Useful for discrete strengths and weaknesses of individual residents
- Helpful for remediation
- Rubric demonstrates progress

How do EPAs relate to Competencies and Milestones?



Another Relationship View




Sticky Note #2:
Demonstrate the
value of
both/relationship
between

Entrustment Scale

Level 1	Observation only/Supervisor performs
Level 2	Supervisor required to be present a. Perform as coactivity with supervisor b. Supervisor in the room and ready to step in
Level 3	Supervisor does not need to be physically present but needs to be readily available a. Close support and oversight b. Moderate support and oversight
Level 4	Supervisor can be distantly available (minimal support/oversight)
Level 5	Supervisor not needed, can teach others

Changing the Scales

Retrospective	Prospective
• I had to do it • I had to talk them through • I had to prompt them from time to time • I needed to be there just in case • I did not need to be there	• Not yet ready to practice • Ready to practice with supervisor in the room and actively helping • Ready to practice with supervisor nearby • Ready to practice with supervisor not immediately nearby • Supervisor not needed and can teach others



Sticky Note
#3 Introduce the new scale/concepts of entrustment

Sticky Situation: Entrustment Disagreement

Attending	EPA	Entrustment level	Comments
Becky	Executing Clinical Handovers Within and Across Settings	2	Didn't mention that the family has an iguana as a pet
Becky		2	Should have ordered follow up electrolytes for this AM
Becky		2	I uncovered more history when I saw the patient
Sam		3	Gathered and reported all information. Appropriately asked for help when unsure about how to proceed.
Sam		3	Identified a sicker asthmatic and reassessed before hand-off. Gave good update on changes but could have been more proactive in escalating care.
Sam		4	Thorough and concise handover for a moderately complex patient. Looked up guidelines to guide decisions
Jeff		5	Strong work
Jeff		5	Thorough
Jeff		4	Good job
Average		**3.3**	

A Matter of Trust

Trust

- The willingness of a party to be vulnerable to the actions of another

Trustworthiness

- Qualities of an individual that might lead one to trust them

To Entrust

- Confide the care of a person to another person

Presumptive Trust

- Based on credentials

Initial Trust

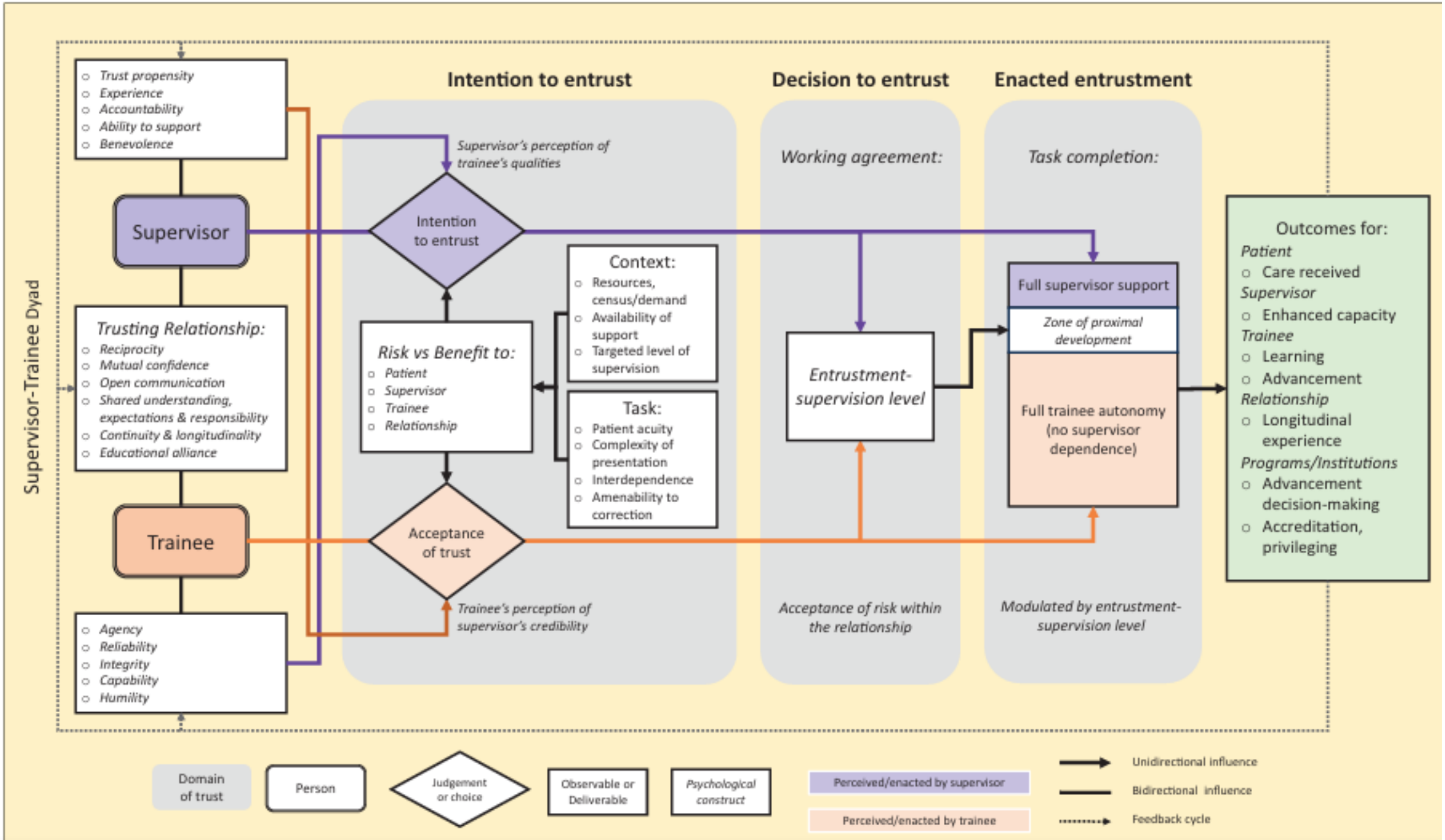
- First impression

Grounded Trust

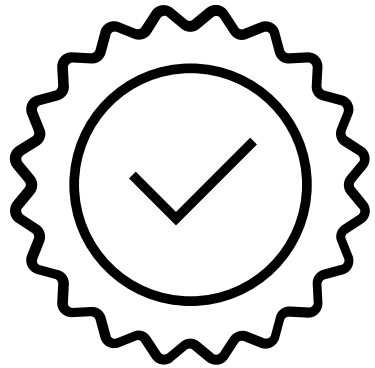
- Based on experience

Trustworthiness

Agency	Proactivity toward work, team, safety, development
Reliability	Conscientious, predictable, accountable, responsible
Integrity	Truthful, benevolent, patient-centered
Capability	Knowledge and skill, experience, adaptive expertise
Humility	Knows limits, asks for help, receptive to feedback


Supervisor-Trainee Dyad
Trust propensity
Experience
Accountability
Ability to support
Benevolence
Supervisor
Trusting Relationship:
Reciprocity
Mutual confidence
Open communication
Shared understanding, expectations & responsibility
Continuity & longitudinality
Educational alliance
Trainee
Agency
Reliability
Integrity
Capability
Humility
Intention to entrust
Decision to entrust
Enacted entrustment
Supervisor's perception of trainee's qualities
Intention to entrust
Risk vs Benefit to:
Patient
Supervisor
Trainee
Relationship
Context:
Resources, census/demand
Availability of support
Targeted level of supervision
Task:
Patient acuity
Complexity of presentation
Interdependence
Amenability to correction
Acceptance of trust
Trainee's perception of supervisor's credibility
Working agreement:
Entrustment-supervision level
Acceptance of risk within the relationship
Task completion:
Full supervisor support
Zone of proximal development
Full trainee autonomy (no supervisor dependence)
Modulated by entrustment-supervision level
Outcomes for:
Patient
Care received
Supervisor
Enhanced capacity
Trainee
Learning
Advancement
Relationship
Longitudinal experience
Programs/Institutions
Advancement decision-making
Accreditation, privileging
Domain of trust
Person
Judgement or choice
Observable or Deliverable
Psychological construct
Perceived/enacted by supervisor
Perceived/enacted by trainee
Unidirectional influence
Bidirectional influence
Feedback cycle

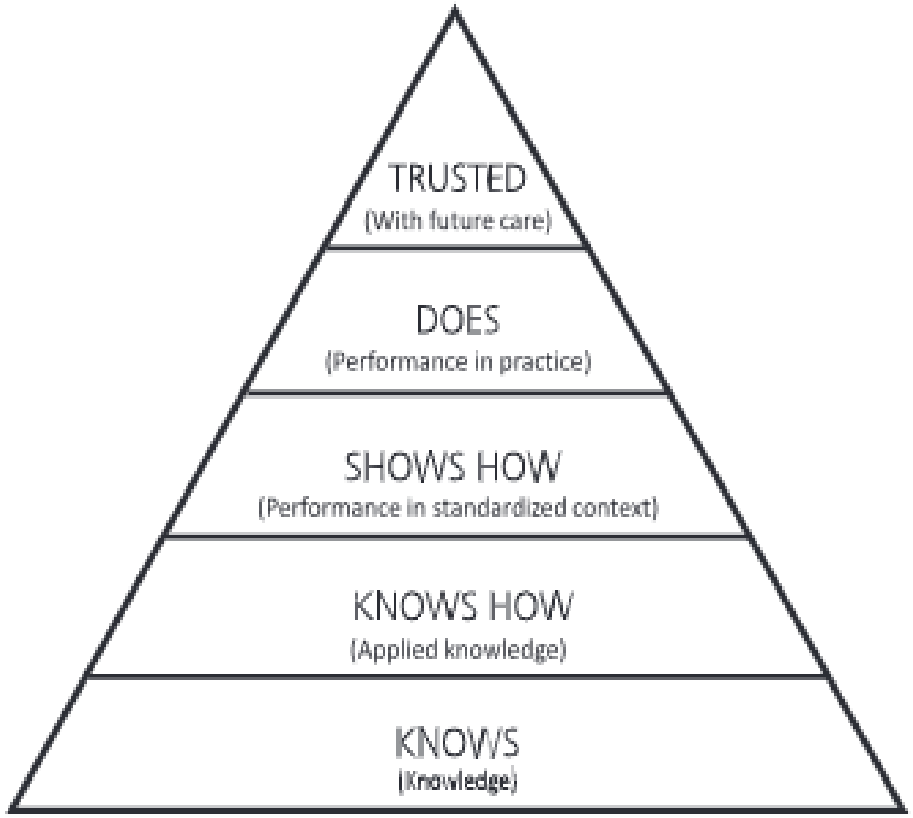
Sticky Note for Trust

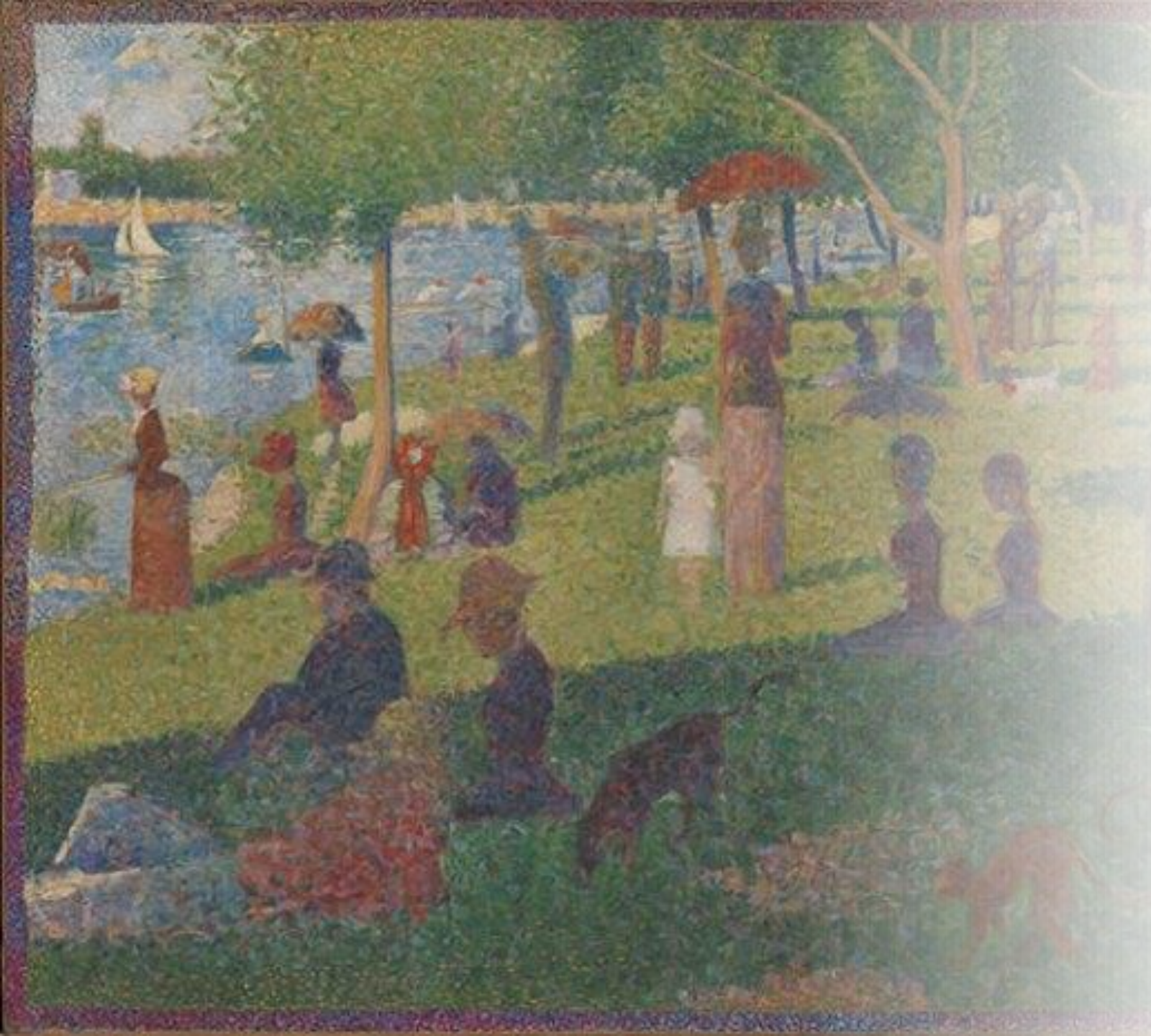


- Ad Hoc entrustment looks different than summative entrustment
  - In the moment trust will depend on many contextual factors
  - Summative entrustment
    - Sufficient information to guide for future, not yet encountered scenarios.
    - Will never be risk-free
- Look for evidence of "ARICH" in your comments
- More complex/higher risk tasks require more data collection

Prospective Entrustment

"It implies the readiness of educators to accept the inherent risks involved in health care tasks and the judgment that the learner has enough experience to act appropriately when facing unexpected challenges. "





Data Collection

- Programmatic Assessment
- Many and varied observations
- Aggregation of data from multiple sources
- Individual encounters ultimately come together to inform the larger picture

Here you are, sitting in your CCC



Resident 1: let's discuss!



You have:
A few rotation EPAs
A few SIMPLs
A few milestones
A few narrative comments
Some pieces of objective data

You don't have:
Comprehensive data for either all EPAs or all milestones

The Challenge: the data hodgepodge



Too little data → can't assess confidently

Haphazard data → can't synthesize meaningfully



CCC Goal: fair, defensible, developmental decisions

Why data gaps happen



- Too few completed evaluations
- Uneven rotation exposure/evaluation distribution
- Faculty not documenting observations
- Technical or workflow barriers in data entry
- Resident absences or leaves

How data are fragmented

- Multiple tools: EPAs, milestones, narrative
- Data scattered across platforms or dashboards
- Inconsistent language between tools
- Volume ≠ clarity



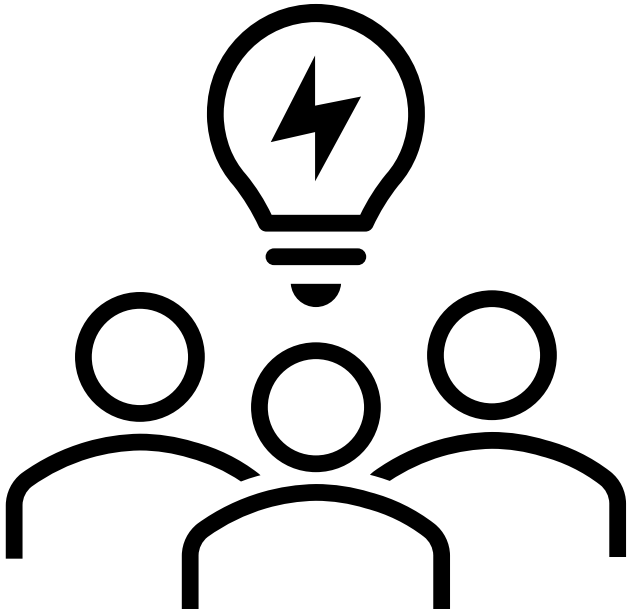
Risks of insufficient data



Guessing might mean:

- Premature or biased decisions
- Inaccurate milestone ratings
- Resident frustration or perceived unfairness
- Program risk during accreditation reviews
- Loss of CCC credibility

Making sense of scattered data



Start with the purpose:

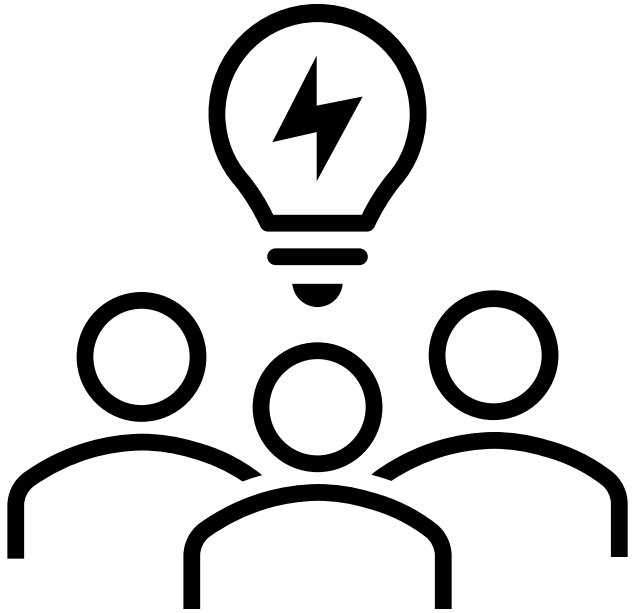
Readiness for unsupervised practice

Look for convergence across data sources:

- EPA entrustment levels
- Milestone trends
- Narrative themes
- Summarize patterns rather than data points

When there is sparse data

- Review all available inputs, even informal
- Solicit targeted faculty feedback
- Defer or mark as 'insufficient evidence' if needed
- Create follow-up plan: focused observations
- Emphasize developmental feedback to resident

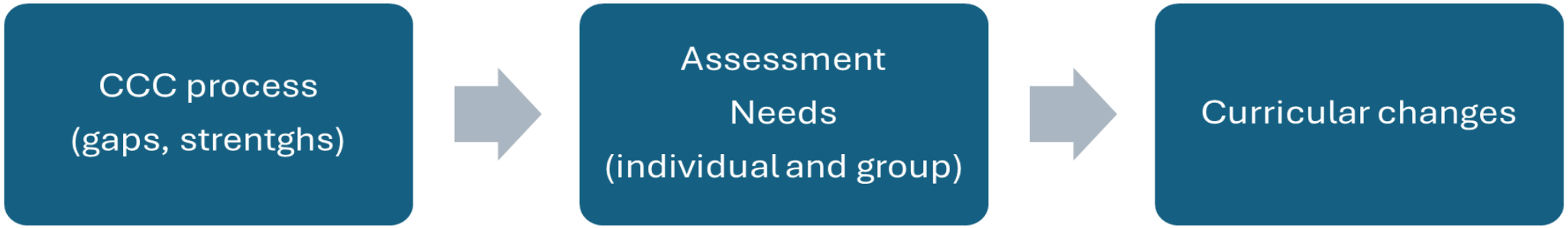


Short term:
The Individual Resident

Options for CCC decision:

- Mark “insufficient data” for certain competencies
- Assign a targeted assessment plan
- Schedule follow-up CCC review
- Communicate transparently with and engage the resident
- Emphasize developmental intent
- *does your CCC need to meet more often???





Long term: What do you need to make it better for next time?

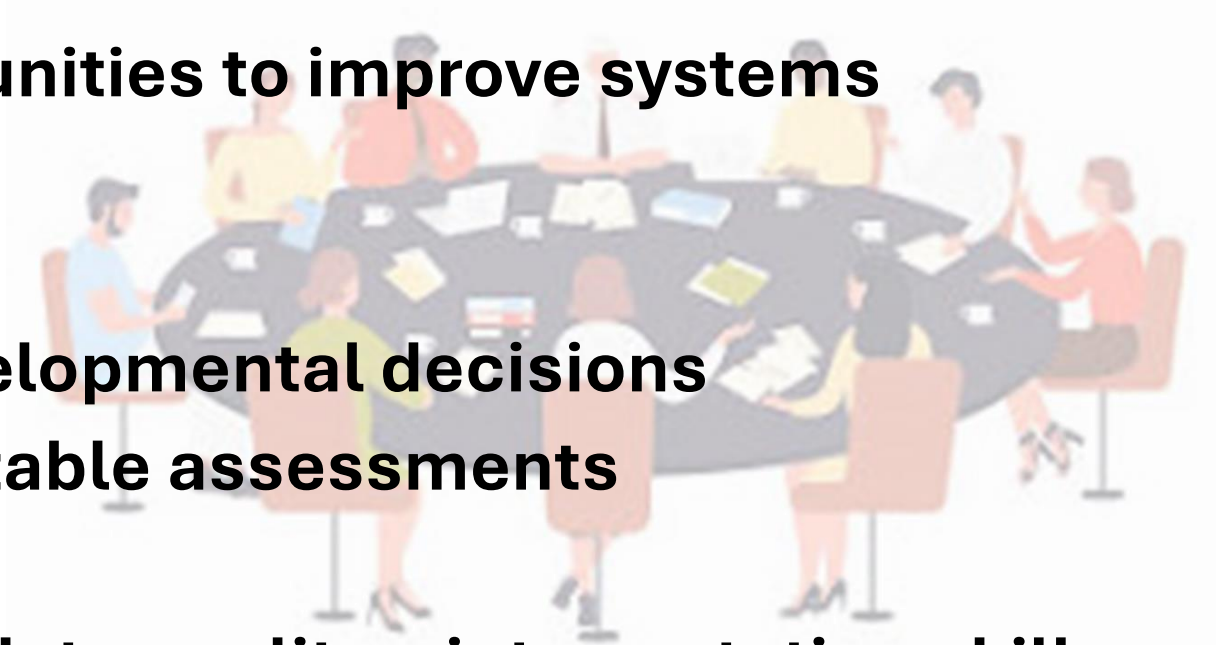
- Strengthen data capture systems (dashboards, CCC reports)
- Use the CBME Data Hub!
- Train faculty on timely, specific assessments
- Standardize evaluation expectations
- Increase observation frequency
- Assign CCC “data stewards” to track completeness
- Build culture of continuous documentation

*what curricular changes are needed??

Take-Home Points

- **It’s acceptable to say “we don’t know yet” — if you have a plan!**

- **Data gaps are opportunities to improve systems**



- **Strive for:**

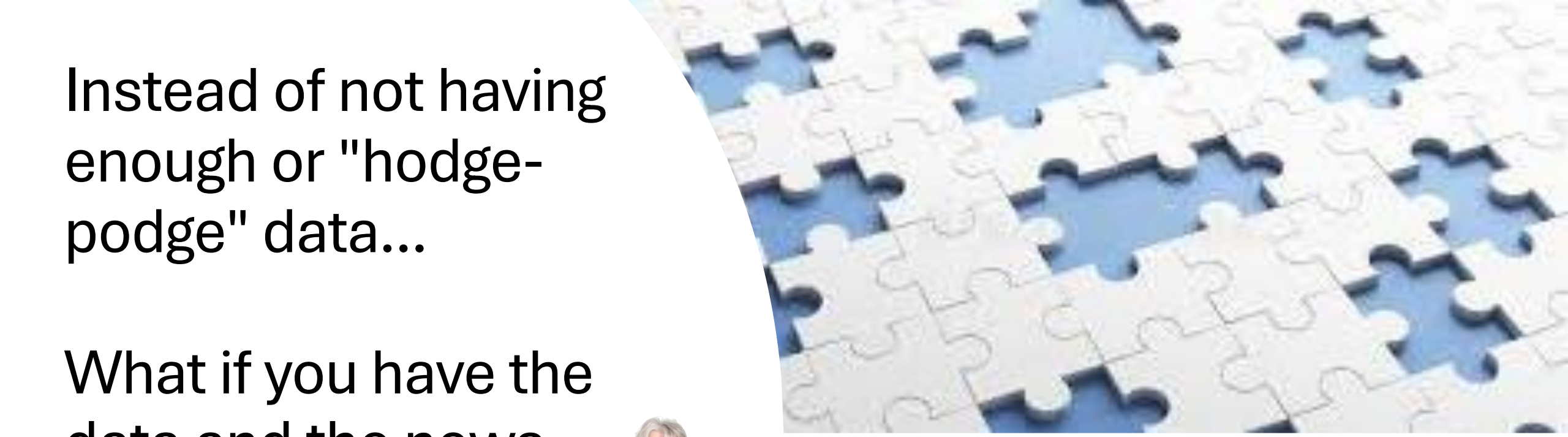
---Fair, defensible, developmental decisions

---Consistent and equitable assessments

- **CCC effectiveness = data quality × interpretation skill**

Instead of not having enough or "hodge-podge" data...

What if you have the data and the news isn't good?





Resident #2: The PGY-3 who is not (yet) trusted



- Fall CCC – Transition meeting
  - When converting from milestones only to including EPAs in performance discussions, the committee recognizes a third-year resident is not trusted in many key areas
  - Resident is already on a program-generated learning plan
  - Recognition that we are running out of time



Committee who "Crosswalked" Growing Pains



Chin up, CCC! The twelve streamlined EPAs are now how it's done done done! ♪♫

THE AMERICAN BOARD *of* PEDIATRICS
Certifying excellence in pediatrics – for a healthier tomorrow



General Pediatrics EPAs

1. Providing Preventative Primary Care for Children of All Ages
2. Providing Comprehensive Primary Care for Children With Complex, Chronic, or Special Health Care Needs
3. Managing Patients With Common Acute Diagnoses
4. Assessing and Managing Patients With Common Behavior and Mental Health Concerns
5. Caring for the Newborn Prior to Discharge
6. Recognizing a Patient Who Requires Subspecialty Medical or Surgical Care, Providing Initial Management, and Seeking Referral or Consultation
7. Recognizing a Severely Ill Patient, Providing Initial Management, and Mobilizing Resources Needed for Continued Care
8. Executing Clinical Handovers Within or Across Settings
9. Performing the Common Procedures of the General Pediatrician
10. Leading Interprofessional Teams to Provide Collaborative, Family-Centered Care
11. Promoting Equitable Care at the Level of Each Individual Patient and the Population to Address Racism and Other Contributors to Health Inequities
12. Utilizing Technology and Information Sources to Enhance Learning and Patient Care

https://www.abp.org/sites/public/files/pdf/epas-general-pediatrics-summary.pdf

DistributionofMilestones2.0andEPAsinEvals .XLSX

File Edit View Insert Format Data Tools Help

100% $ %

C2

	A
1	**2.0 Mileston**
28	EPA1 Provide Pediatric Consultation
29	EPA2 Recommended Health Screening
30	EPA3 Care for Well Newborn
31	EPA4 Manage Acute Diagnoses
32	EPA5 Provide a Medical Home for Well Child
33	EPA6 Chronic/Complex Needs Medical Hom
34	EPA7 Surgical Management/Referral
35	EPA8 Transition to Adult Care
36	EPA9 Manage Behavior/Mental Health Prob
37	EPA10 Resuscitate and Stabilize
38	EPA11 Manage Info for Learning and Pt Care
39	EPA12 Refer Patients who need Consultatior
40	EPA13 Fiscally Sound, Equitable Practice
41	EPA14 QI Plus
42	EPA15 Lead Interprofessional Team
43	EPA16 Handovers to Another Provider
44	EPA17 Procedures of General Pediatrician
45	
46	**Total EPAs Per Rotation**
47	



Evaluation Process for AY 2025-2026

SIMPL;EPA +brief summative NI	NI; milestones
ED	NICU
Ambulatory	Intermediate Nursery
Continuity Clinic (no summative on NI)	PICU
Wards (including DF/NF)	Development
Nursery (no summative on NI)	H/O
Adolescent (no summative on NI)	ID
Mental Health - CC (Summative on SIMPL)	Mental Health PGY 1 (2 wks)
	QI
	R3E
	Subspecialty Rotations; IC Rotations

CCC wrapping minds around the transition from the prior distribution of EPAs and Milestones throughout the program to current state

					ED intern	ED	Hem/Onc	ID
					1	1		1
					1	1	1	1
					1	1		
						1		1
						1		
							1	1
					1	1		1
						1		1
						1		
							1	1
PROF3: Accountability/Conscientiousness	1	1	1		1	1		
PROF4: Well-Being								
ICS1: Pt and Family Centered Communication		1	1	1			1	
ICS2: Interprofessional and Team Communication						1	1	

Shared in the Meeting: Faculty Review Summary

Back to our PGY-3…

CCC faculty reviewer packet of materials has changed to also include frontline workplace assessment data

(as well as "traditional" evaluations and other portfolio elements)

CCC Meeting Summary Template

To be completed by CCC and forwarded to PD for review and secure storage

Program: Pediatrics	**Date of CCC**: 10/22/25
Resident Name: Samuel L. O'Bloomer	**Year in program**: 3

The CCC reviewed and discussed the following *(check if done):*

☒ Duty Hour Monitoring
☒ Procedure Case Logs and/or Clinic #s (☐N/A)
☐ Met SMART Goals in Prior Individualized Learning Plan (ILP)
☐ Scholarly Activity
☒ QI/PS Participation
☒ All Evaluations (medical students, peers, faculty/preceptors 360 - staff, patients, clinics, nursing, etc.)
☒ Resident/Fellow Performance (incl. ITE & overall achievement of Milestones and EPAs)
☐ Other (please list):

Identified Strengths:

Dr. O'Bloomer is well-liked by nurses, families and faculty. He has been very invested in launching a QI project to improve parent-provider communication in his continuity clinic. He has been improving in his ITE score each year. He is actively completing his procedure requirements.

Opportunities for growth:

Dr. O'Bloomer needs to build his medical knowledge which will help him improve his assessments and plans for his patients, which are not at a level expected for a third year resident. His ITE score has only a 60% predicted pass rate for the boards. Dr. O'Bloomer's organization and efficiency also needs to improve for him to be an effective team leader, including attention to detail. He would benefit from additional time on rotations that could help him practice these skills, such as ED, NICU and Wards.

-Noted learning plan in existence focusing on building medical knowledge and clinical reasoning

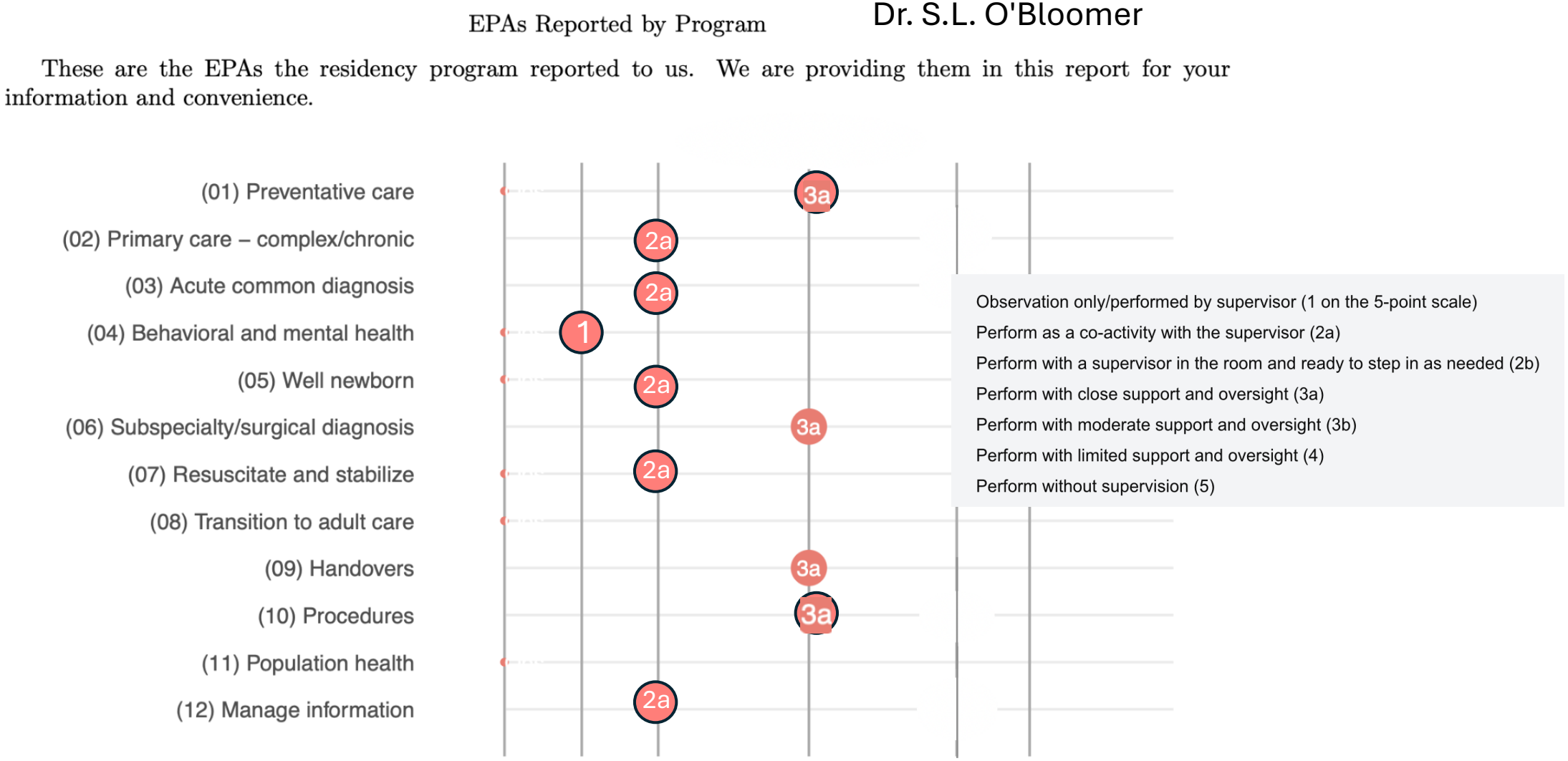
-Increased responsibility as PGY-3 has highlighted deficiencies further

-Recognition of potential halo effect bias in earlier years of training

Shown in the Meeting: EPA Visual from APPD CBME Datahub

Dr. S.L. O'Bloomer

Composite EPA data from frontline workplace based assessments from individual encounters and end of rotation summaries



Uh oh…and where did these numbers come from, anyway?

CCC Sidebar Discussion: Recognition that some EPAs glean the most data from rotations in PGY-1 year…

(Growing Pains, Part 2)

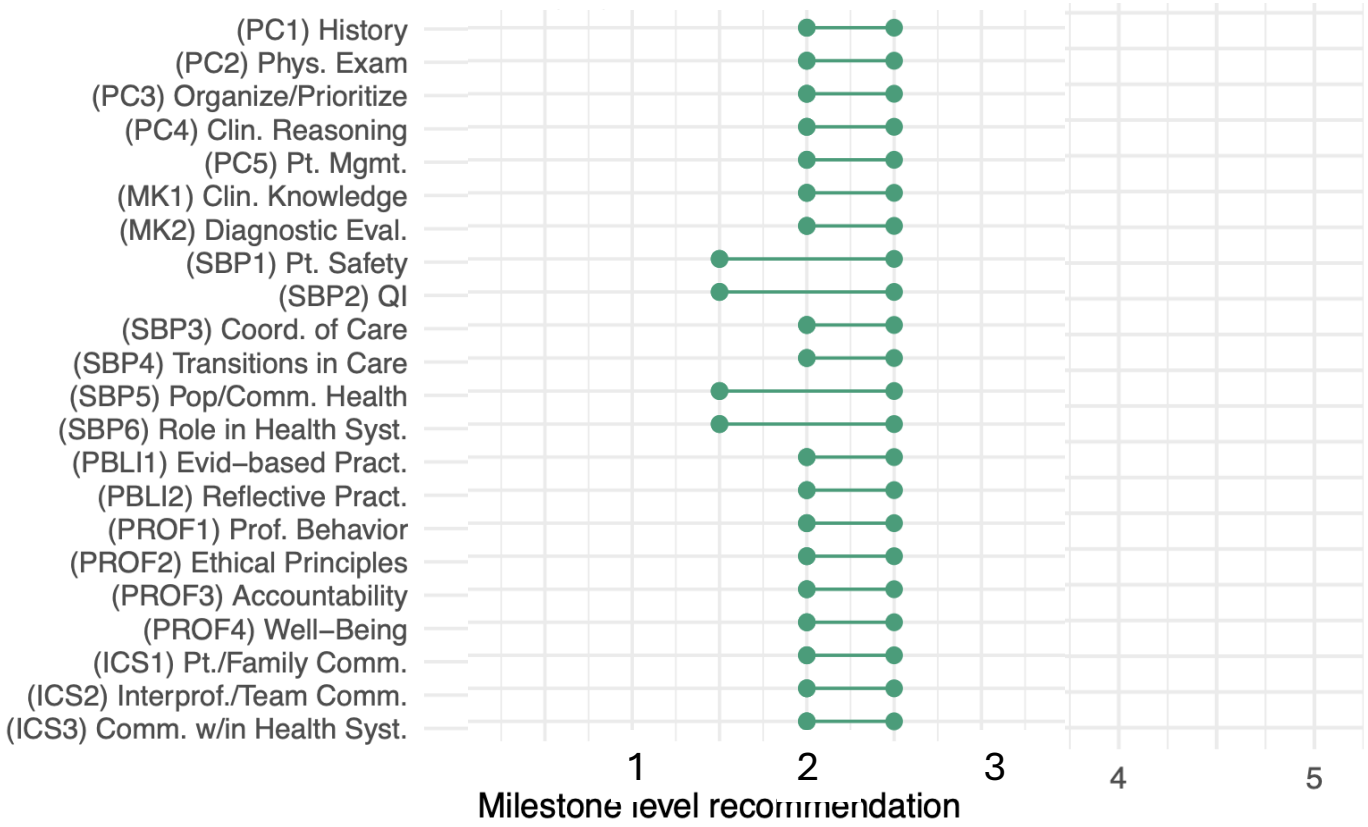
- Nursery (and some may never do it again during residency)
  - EPA 5 (Well Newborn) data from two years ago when this first EPA rolled out in program
- Developmental/Behavioral Peds
  - Retrofit EPA 4 (Behavioral and Mental Health) based on rotation evaluation comments (EPAs were not being assessed in this rotation at that time)
- Subspecialty (i.e. Heme/Onc, ID)
  - i.e. EPA 11 (Population Health)—but were not assessing this on front line when resident went through and committee finds it difficult to assess/assign

Shown in the Meeting: ACGME Pediatric Milestones Output from APPD CBME Datahub

General Pediatrics EPAs and Milestones Crosswalk

Based on the EPAs reported these are the recommended General Pediatrics milestone levels for

Dr. S.L. O'Bloomer



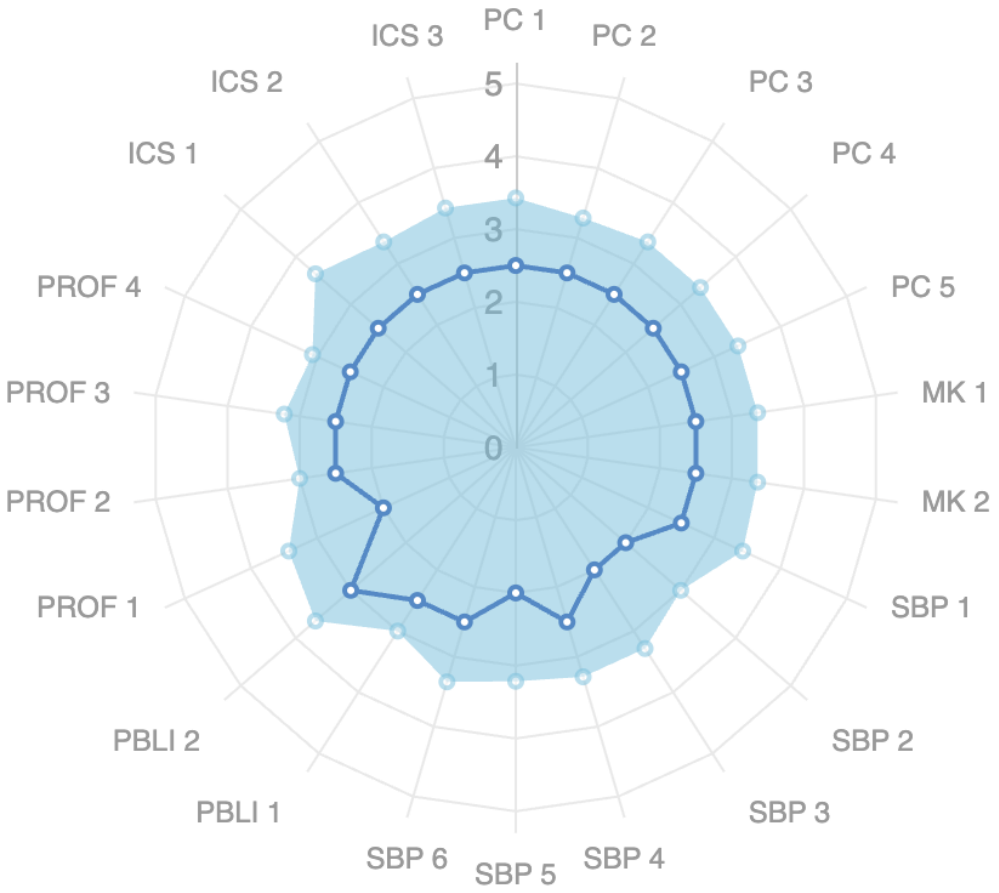


Shown in the Meeting: Frontline Milestones from Evaluations

New Innovations Milestones Web (dark blue line) with peer comparison (light blue shaded area)

Resident with significantly low performance

Corroborates with the CBME Datahub Crosswalk Output





Committee Wonders:

- How did we not catch this earlier?
- How might we adjust our curricula, assessment and early monitoring to avoid this with future trainees?

What to do about this PGY-3 resident?



- Targeted discussions with continuity clinic and wards preceptors regarding specifics of entrustment → drill down to key skills, identify specific milestones for focus?
- Intensive coaching and 1:1 observations by chief resident for six months?
- Assign formal probation and ask GME/hospital for more $$ to extend training?
- Pull off all supervisory responsibilities, lower patient caps, focus on the basics?
- ~~Allow resident to progress and hope for the best?~~

Sticky Discussion Qs

What are your ideas for handling the hawks, doves, etc. Even with entrustment?

How have you handled situations with not enough data?

Do you have brilliant methods for synthesizing all the data?

Is "good enough" OK when they are about to graduate?



Join us for Session 4!

Level Up: Using EPAs and Milestones to Drive Individualized Learning

1/15/26 from 3-4pm EST

Homework for the Holidays

- In anticipation of January session with Drs. David Stewart and Will Sasser:

How do EPAs and milestones *actually* shape individualized learning in your program?

Join us for the rest of our series!

- Sep ‘25 — **Session 1:** Assessment with Purpose: Are We Collecting What Matters?
- Oct ‘25 — **Session 2:** Assessment with Purpose: Are You Making the Information You Have Collected Work for You?
- Nov ‘25 — **Session 3:** Two Assessment Worlds Collide: EPAs and Milestones during your CCC Meeting
- Jan ‘26 — **Session 4:** Level Up: Using EPAs and Milestones to Drive Individualized Learning
- Feb ‘26 — **Session 5:** Using EPAs to Identify and Address Gaps in Curriculum
- Mar ‘26 — **Session 6:** Reflecting on Program Assessment System



Want to learn more and get more involved?

Become a CBME Champion

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