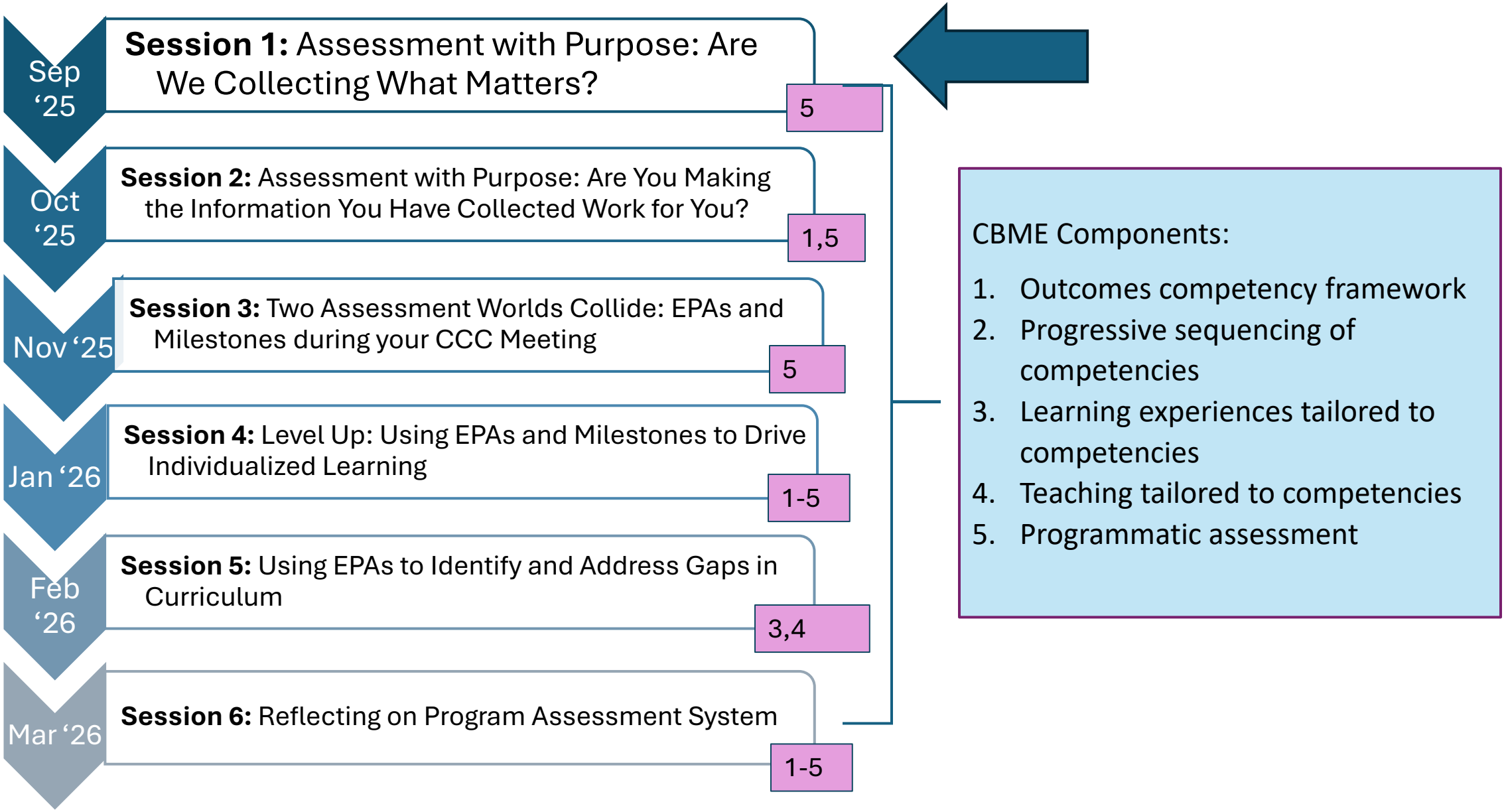
EPA Virtual Café Series: Before, During and After CCC

Hosted by your APPD Assessment Learning Community

2025-2026


Sep '25
Session 1: Assessment with Purpose: Are We Collecting What Matters?
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

Assessment with Purpose: Are We Collecting What Matters?

Catherine Hart, Med
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David A Stewart, MD
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Meghan O'Connor, MD
University of Utah
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Objectives



Define the principles and benefits of programmatic assessment



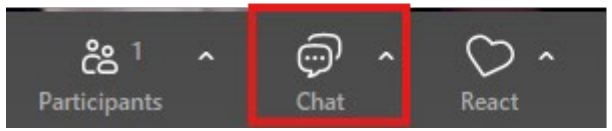
Identify key sources of frontline data aligned with pediatric EPAs that support strong CCC decisions



Share practical strategies and examples for building systems to collect high-quality frontline data aligned with pediatric EPAs

Assessment vs Evaluation

What's the difference?





OF Learning or *FOR* Learning?

Assessment OF Learning

Offered at the end of activity
Summative
Evaluative; assigns value
Measurement of success
Used for grading or reporting

Evaluation

Assessment FOR Learning

Offered during activity
Ongoing; formative
Objective; avoids judgment
Collection of data
Used for continuous improvement

Assessment



Perspect Med Educ (2017) 6:211–215
DOI 10.1007/s40037-017-0345-1

COMMENTARY

What programmatic assessment in medical education can learn from healthcare

L. Schuwirth[1,2] · C. van der Vleuten[2] · S. J. Durning[1,3]

Published online: 10 April 2017
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Background

A new approach to assessment is emerging in medical education, called programmatic assessment. Programmatic assessment is an approach in which routine information about the learner's competence and progress is continually collected, analyzed and, where needed, complemented with purposively collected additional assessment information, with the intent to both maximally inform the learner and their mentor and allow for high-stakes decisions at the end of a training phase. For this, a variety of assessment instruments are usually used [1–3]. Programmatic assessment is being used in various medical school settings around the world and it is also becoming more popular in graduate medical education and continuing professional development [4–6]. Programmatic assessment is quite different from more traditional assessment programs with the typical 'module-test' building blocks focussing almost entirely on assessment *of* learning. We think that programmatic assessment actually makes more sense from various perspectives and we want to use analogies with clinical medicine to explain why we think so. Therefore, we will begin with a brief description of the programmatic assessment approach and then we will use analogies to help explain the rationale behind it. We do not intend to use these analogies as evidence for the validity of programmatic assessment as an assessment approach – there is an emerging body of research with that remit – but we merely seek to explain the concepts of programmatic assessment using a more medical narrative.

In the programmatic assessment approach, each assessment produces meaningful feedback to the learner. This feedback may be quantitative, qualitative or both. Each individual assessment is not initially meant for 'high-stakes' decision-making, but has to be used by the learner to analyze their own performance, formulate concrete learning goals and demonstrably attain them. Individual assessments are used as components that are to be collected, for example in a portfolio, and then analyzed by a faculty member or committee into a rich diagnostic picture that will allow defensible high-stakes decisions. Typically, all information is periodically reviewed by an assessment committee for summative decisions, combining information from various sources in a way that is meaningful by content [1, 2, 7]. So, for example, results on parts of a multiple-choice examination may be combined with parts of a mini-CEX or OSCE examination to draw conclusions as to the examinee's progress in a domain of performance. Based on this review, remediation plans are provided. A continuous dialogue between the learner and a dedicated staff member (called either mentor, supervisor or coach in different institutes) further scaffolds the focus on feedback, analysis of competence development, remediation and personal development. Instead of a conventional assessment such as taking a high-stakes multiple-choice examination followed by a pass-fail decision, programmatic assessment addresses both the attained competence levels and their developmental processes. There are similarities with normal practice in healthcare and therefore, in this paper, we will present five

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Competency-based Medical Education (CBME)

Outcomes-based competency framework

Progressive sequencing

Learning experiences focused on the competencies

Teaching tailored to the competencies

Programmatic Assessment

Van Melle *Acad Med*. Jul 2019

Formative

serving to form something, especially having a profound and lasting influence on a person's development

Definition from Oxford Languages

“Great job today! You’re doing really well, but your pedaling needs improvement!”

Assessment *of* Learning



On the street:

“You kept your wheel straight by holding the handlebars square. Now, once you get moving, look up and find your pedals.

Called out after seat release:

“Look up and find your pedals!”

Assessment *for* Learning



What is Deliberate Practice?

"DP is based on the theory that expert performance results from deliberately engaging in and choosing activities that improve and maintain high performance. It involves repeated practice on tasks and immediate feedback on performance that allows individuals to focus their training on weaknesses while also refining other aspects of performance."



Surg Endosc (2015) 29:3154–3162
DOI 10.1007/s00464-014-4042-4

Deliberate practice enhances quality of laparoscopic surgical performance in a randomized controlled trial: from arrested development to expert performance

Daniel A. Hashimoto · Pramudith Sirimanna · Ernest D. Gomez · Laura Beyer-Berjot · K. A. Ericsson · Noel N. Williams · Ara Darzi · Rajesh Aggarwal

Received: 30 June 2014 / Accepted: 11 December 2014 / Published online: 25 December 2014
© Springer Science+Business Media New York 2014

Abstract
Background This study investigated whether deliberate practice leads to an increase in surgical quality in virtual reality (VR) laparoscopic cholecystectomies (LC). Previous research has suggested that sustained DP is effective in surgical training.
Methods Fourteen residents were randomized into deliberate practice ($n = 7$) or control training ($n = 7$). Both groups performed ten sessions of two VR LCs. Each session, the DP group was assigned 30 min of DP activities in between LCs while the control group viewed educational videos or read journal articles. Performance was assessed on speed and dexterity; quality was rated with global (GRS) and procedure-specific (PSRS) rating scales. All participants then performed five porcine LCs.
Results Both groups improved over 20 VR LCs in time, dexterity, and global rating scales (all $p < 0.05$). After 20 LCs, there were no differences in speed or dexterity between groups. The DP group achieved higher quality of VR surgical performance than control for GRS (26 vs. 20, $p = 0.001$) and PSRS (18 vs. 15, $p = 0.001$). For VR cases, DP subjects plateaued at GRS = 25 after ten cases and control group at GRS = 20 after five cases. At completion of VR training, 100 % of the DP group reached target quality of performance (GRS $\geq$ 21) compared with 30 % in the control group. There were no significant differences for improvements in time or dexterity over five porcine LCs.
Conclusion This study suggests that DP leads to higher quality performance in VR LC than standard training alone. Standard training may leave individuals in a state of "arrested development" compared with DP.

Keywords Education · Imaging & VR · Cholecystectomy

Current changes within modern delivery of health care have been driven by an increased awareness of patien safety [1]. Reports that surgical adverse events account fo two-thirds of all adverse events are only surpassed by da suggesting that half are preventable [2]. The literature h demonstrated that technical faults account for a lar majority of these errors [3, 4]. These facts, along with increase in public and political expectations, have led to

Preliminary results of this paper were presented at the Surgical Forum of the 2013 Annual Clinical Congress of the American College of Surgeons in Washington, DC, on October 9, 2013.

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Impact of Deliberate Practice

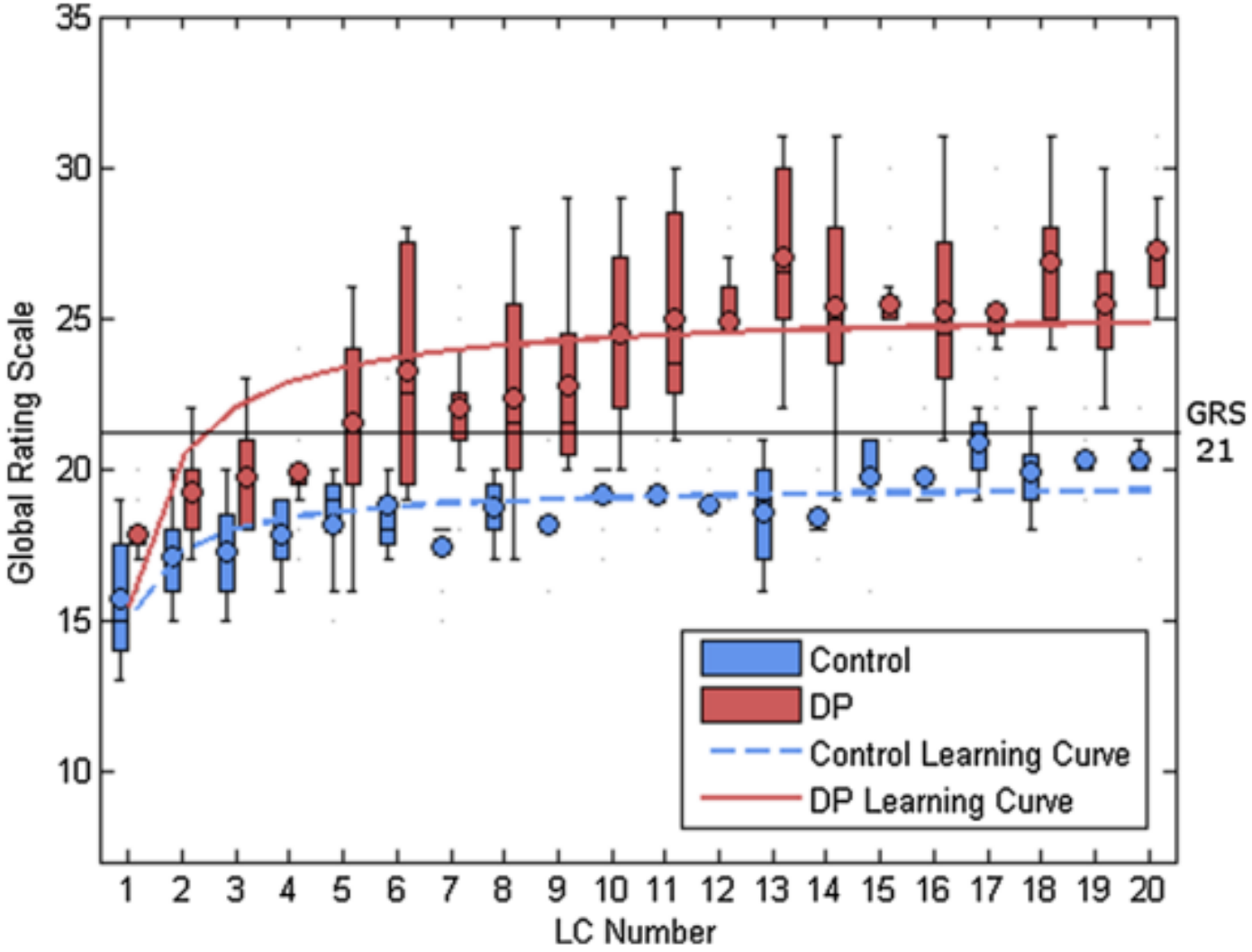


Fig. 2 Learning curve and box-and-whisker plot demonstrating greater improvement of DP group in quality of surgical performance versus control

What is Deliberate Practice?

"that which involves concentration and attention directed at effortful practice that is guided by specific feedback on improving performance"

Hashimoto, D.A., Sirimanna, P., Gomez, E.D., Beyer-Berjot, L. Ericsson, K.A., Williams, N.N., Darzi. A., Aggarwal, R. Deliberate practice enhance quality of laparoscopic surgical performance in a randomized controlled trial: from arrested development to expert performance.

Let’s Look at an EPA

Managing Patients With Common Acute Diagnoses

- Gathering essential information through history, physical examination, and review of available information in the health record
- Using clinical reasoning to develop a differential diagnosis and plan for diagnostic evaluation
- Creating and refining evidence-based comprehensive and individualized management plans that are tailored to illness severity and use shared decision-making
- Engaging subspecialists and other health professionals as needed to optimize patient care
- Educating the patient and caregiver and co-creating follow-up plans
- Communicating the assessment, diagnosis, and management plan

End-of Rotation Evaluation:

You consistently demonstrated competence in managing patients with common acute diagnoses and reliably gathered essential information through thorough history-taking and physical exams. Your clinical reasoning is sound, and you developed appropriate differential diagnoses and diagnostic plans. Your communication with patients and families could use improvement to ensure their understanding.



After a patient visit:

I noticed a wide variety of history questions that showed broad consideration of factors. Your history-taking and physical exam led to an accurate diagnosis and management plan. You can continue to work on using fewer technical terms in conversation with patients and families and pause for questions at regular intervals.





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COMMENTARY

What programmatic assessment in medical education can learn from healthcare

L. Schuwirth[1,2] · C. van der Vleuten[2] · S. J. Durning[1,3]

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Background

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Growth-Oriented Learning
(Attitude towards Continuous Improvement)

Increases psychological safety

Supports goal-setting and reflection

Decreases risk of “overweighting”

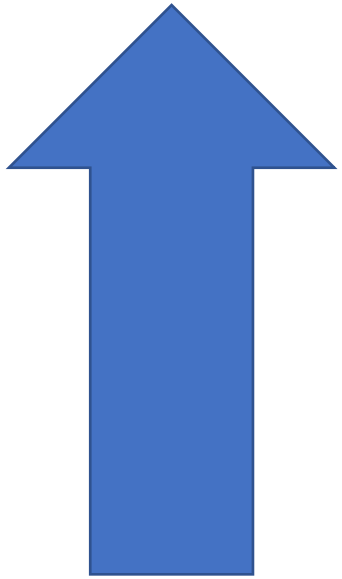


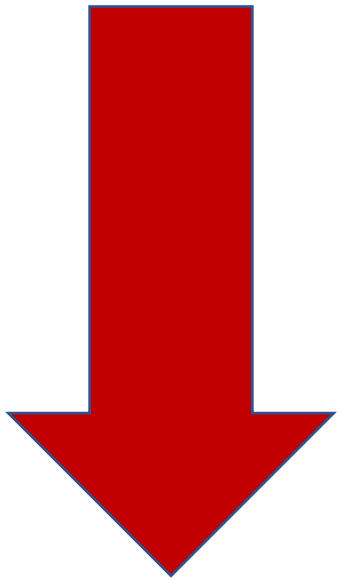
Equity

Increases variety of perspectives

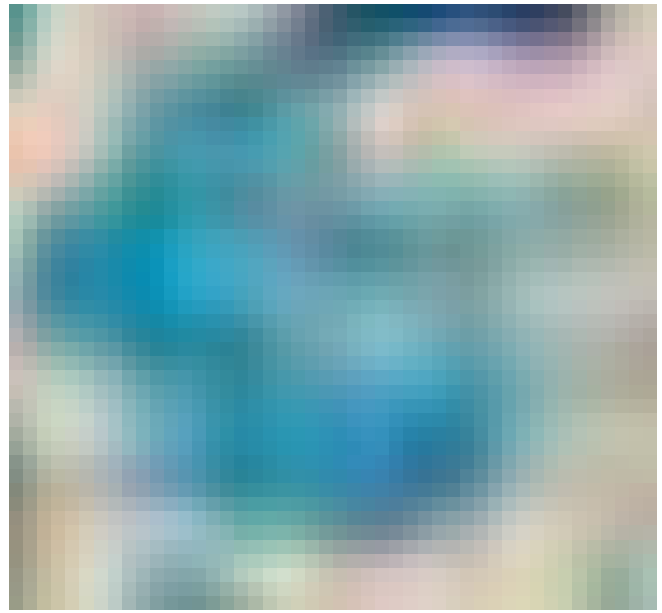
Increases variety of environments

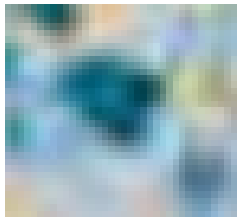
Increases variety of data types

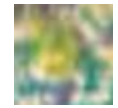


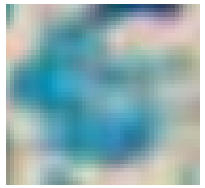


Decreases risk of “labeling” and other preconceived ideas about learners





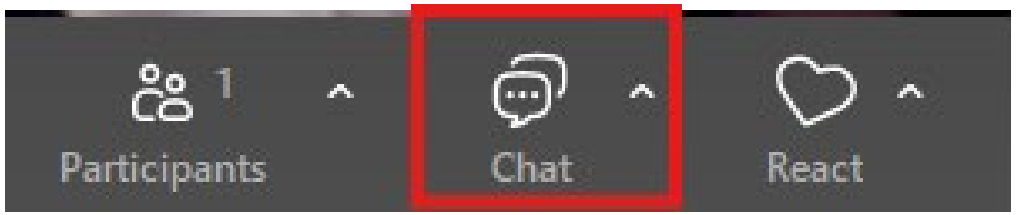








Reflection Questions



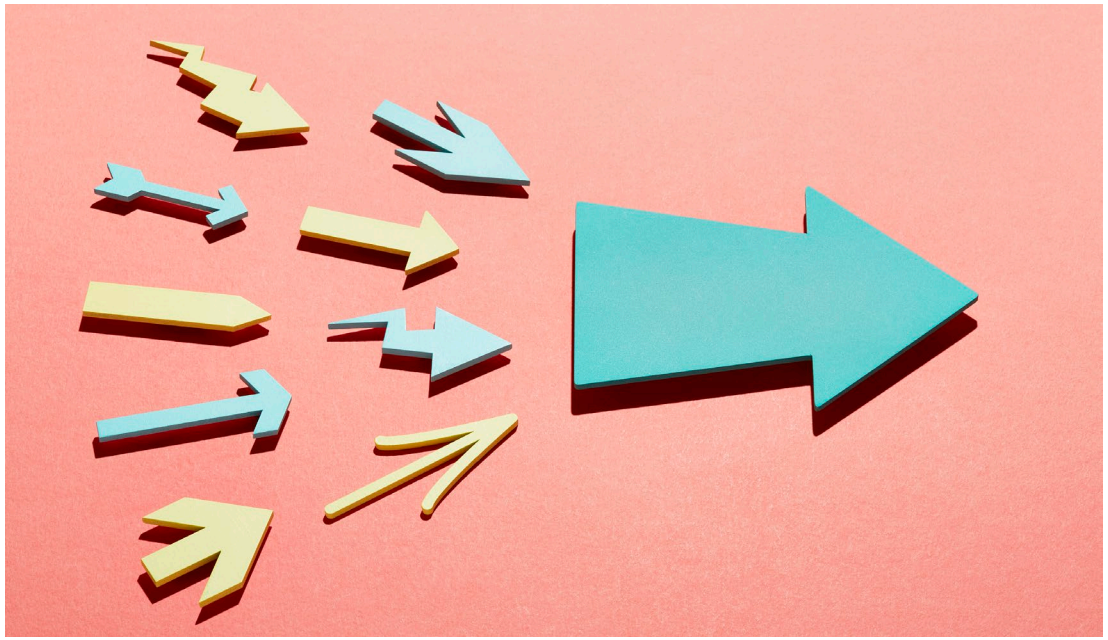
Other than faculty evaluations, what forms of assessment are you using to collect data about your trainees?

On a scale of 1 – 5, how often are trainees getting formative feedback *for* learning? 1 = rarely / 5 = constantly

Sources of Information in Programmatic Assessment

What data is collected to support trainees in their development and inform CCC decision-making?

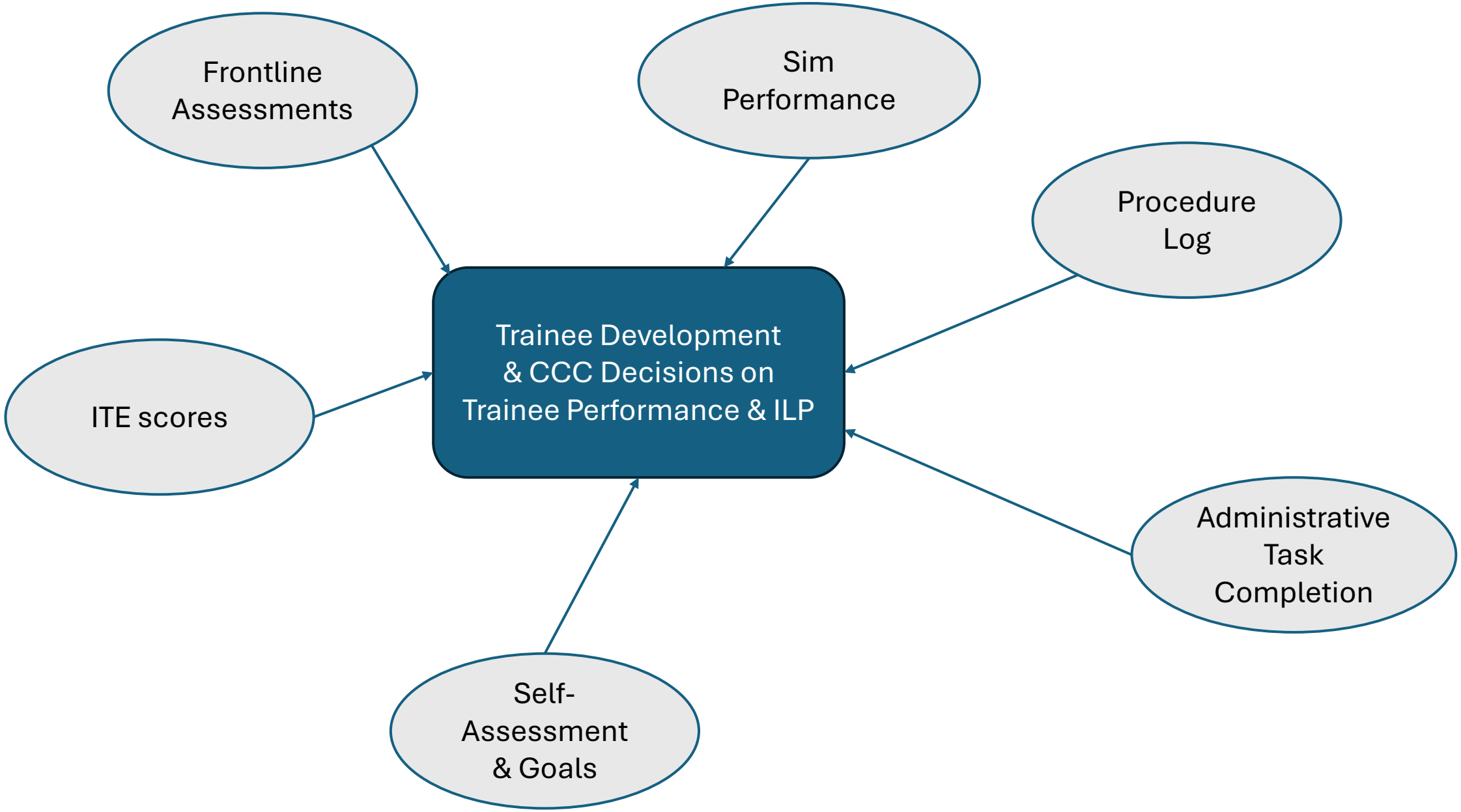


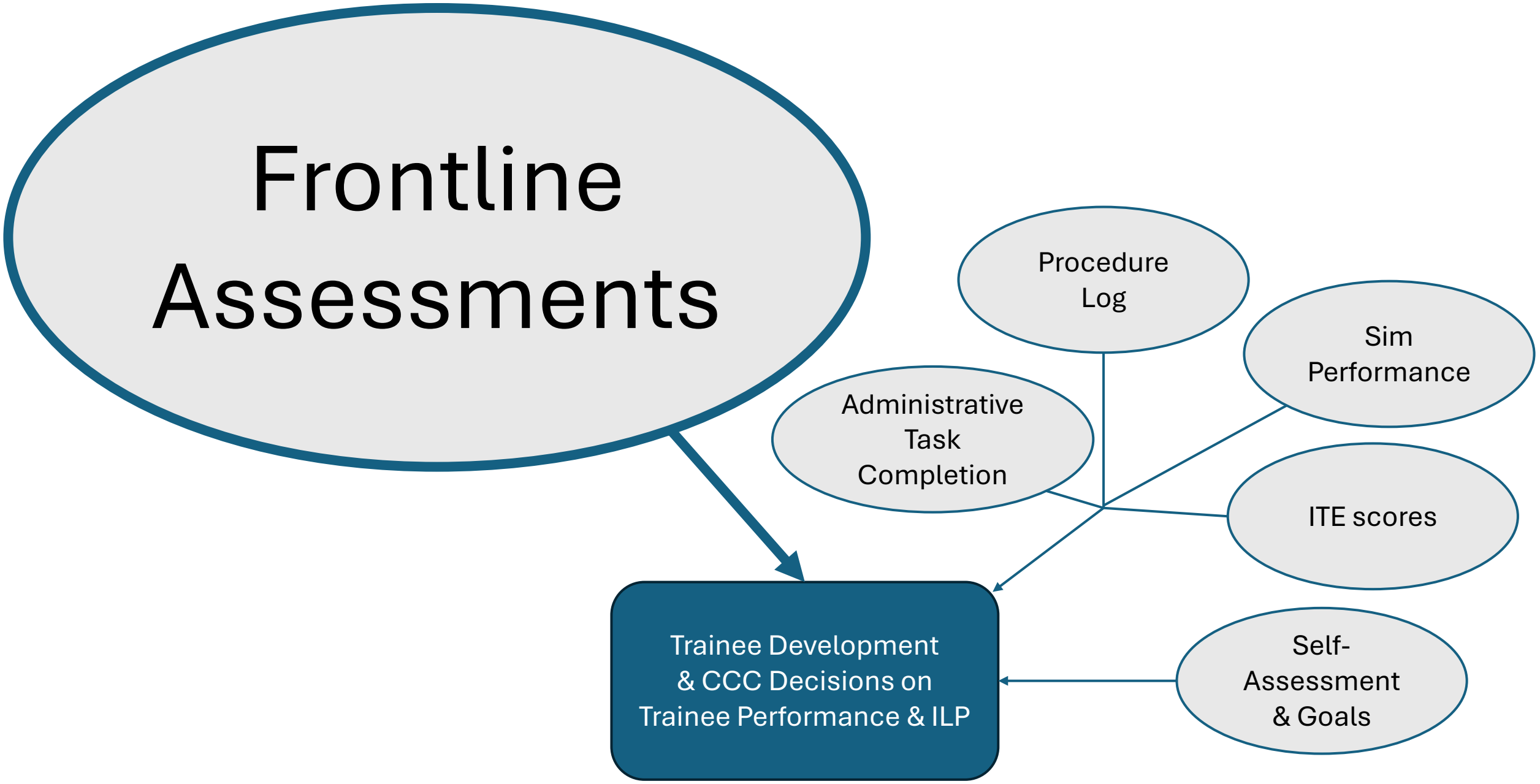


Programmatic Assessment: How will the trainee, CCC, and program use this information?

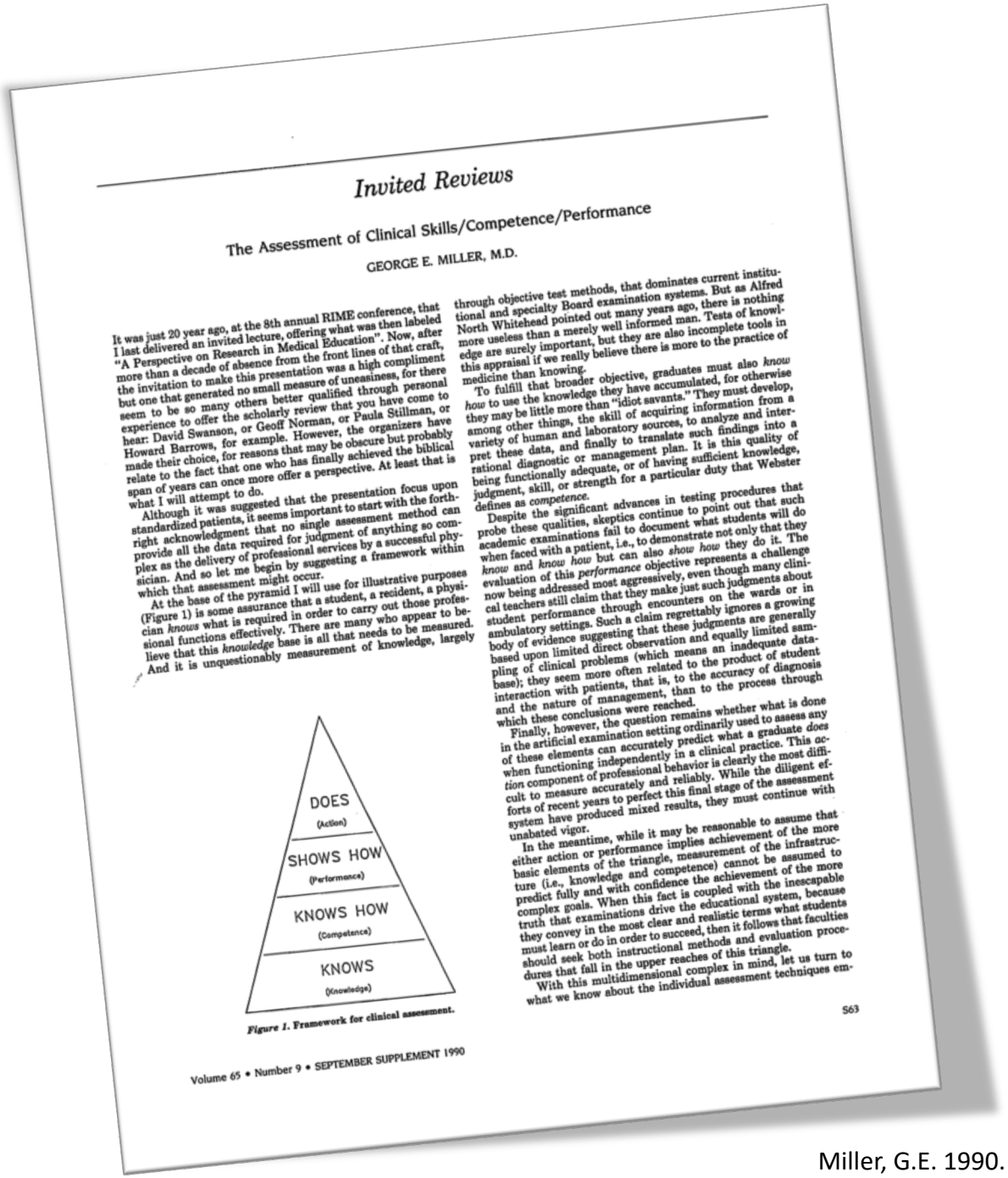
- Optimize learning & support growth of each trainee
- Make informed decisions about advancement
- Contribute to program improvements

Holmboe & Iobst,. ACGME Assessment Guidebook, 2020


Frontline Assessments
Sim Performance
Procedure Log
ITE scores
Trainee Development & CCC Decisions on Trainee Performance & ILP
Administrative Task Completion
Self-Assessment & Goals


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Holmboe & lobst,. ACGME Assessment Guidebook, 2020



Invited Reviews

The Assessment of Clinical Skills/Competence/Performance

GEORGE E. MILLER, M.D.

It was just 20 year ago, at the 8th annual RIME conference, that I last delivered an invited lecture, offering what was then labeled "A Perspective on Research in Medical Education". Now, after more than a decade of absence from the front lines of that craft, the invitation to make this presentation was a high compliment but one that generated no small measure of uneasiness, for there seem to be so many others better qualified through personal experience to offer the scholarly review that you have come to hear: David Swanson, or Geoff Norman, or Paula Stillman, or Howard Barrows, for example. However, the organizers have made their choice, for reasons that may be obscure but probably relate to the fact that one who has finally achieved the biblical span of years can once more offer a perspective. At least that is what I will attempt to do.

Although it was suggested that the presentation focus upon standardized patients, it seems important to start with the forthright acknowledgment that no single assessment method can provide all the data required for judgment of anything so complex as the delivery of professional services by a successful physician. And so let me begin by suggesting a framework within which that assessment might occur.

At the base of the pyramid I will use for illustrative purposes (Figure 1) is some assurance that a student, a recident, a physician *knows* what is required in order to carry out those professional functions effectively. There are many who appear to believe that this *knowledge* base is all that needs to be measured. And it is unquestionably measurement of knowledge, largely through objective test methods, that dominates current institutional and specialty Board examination systems. But as Alfred North Whitehead pointed out many years ago, there is nothing more useless than a merely well informed man. Tests of knowledge are surely important, but they are also incomplete tools in this appraisal if we really believe there is more to the practice of medicine than knowing.

To fulfill that broader objective, graduates must also *know how* to use the knowledge they have accumulated, for otherwise they may be little more than "idiot savants." They must develop, among other things, the skill of acquiring information from a variety of human and laboratory sources, to analyze and interpret these data, and finally to translate such findings into a rational diagnostic or management plan. It is this quality of being functionally adequate, or of having sufficient knowledge, judgment, skill, or strength for a particular duty that Webster defines as *competence*.

Despite the significant advances in testing procedures that probe these qualities, skeptics continue to point out that such academic examinations fail to document what students will do when faced with a patient, i.e., to demonstrate not only that they *know* and *know how* but can also *show how* they do it. The evaluation of this *performance* objective represents a challenge now being addressed most aggressively, even though many clinical teachers still claim that they make just such judgments about student performance through encounters on the wards or in ambulatory settings. Such a claim regrettably ignores a growing body of evidence suggesting that these judgments are generally based upon limited direct observation and equally limited sampling of clinical problems (which means an inadequate database); they seem more often related to the product of student interaction with patients, that is, to the accuracy of diagnosis and the nature of management, than to the process through which these conclusions were reached.

Finally, however, the question remains whether what is done in the artificial examination setting ordinarily used to assess any of these elements can accurately predict what a graduate *does* when functioning independently in a clinical practice. This *action* component of professional behavior is clearly the most difficult to measure accurately and reliably. While the diligent efforts of recent years to perfect this final stage of the assessment system have produced mixed results, they must continue with unabated vigor.

In the meantime, while it may be reasonable to assume that either action or performance implies achievement of the more basic elements of the triangle, measurement of the infrastructure (i.e., knowledge and competence) cannot be assumed to predict fully and with confidence the achievement of the more complex goals. When this fact is coupled with the inescapable truth that examinations drive the educational system, because they convey in the most clear and realistic terms what students must learn or do in order to succeed, then it follows that faculties should seek both instructional methods and evaluation procedures that fall in the upper reaches of this triangle.

With this multidimensional complex in mind, let us turn to what we know about the individual assessment techniques em-

Figure 1. Framework for clinical assessment.

Volume 65 • Number 9 • SEPTEMBER SUPPLEMENT 1990

"While the diligent efforts of recent years to perfect this final stage of the assessment system have produced mixed results, they must continue with unabated vigor."

Miller, G.E. 1990. "The Assessment of Clinical Skills/Competence/Performance." Academic Medicine 65(9):S63-67.

Workplace-Based Assessments

- Single patient encounter
- Based on observations
- Focused & Concrete
- Formative
- Low-stakes assessments that can inform higher stakes decisions

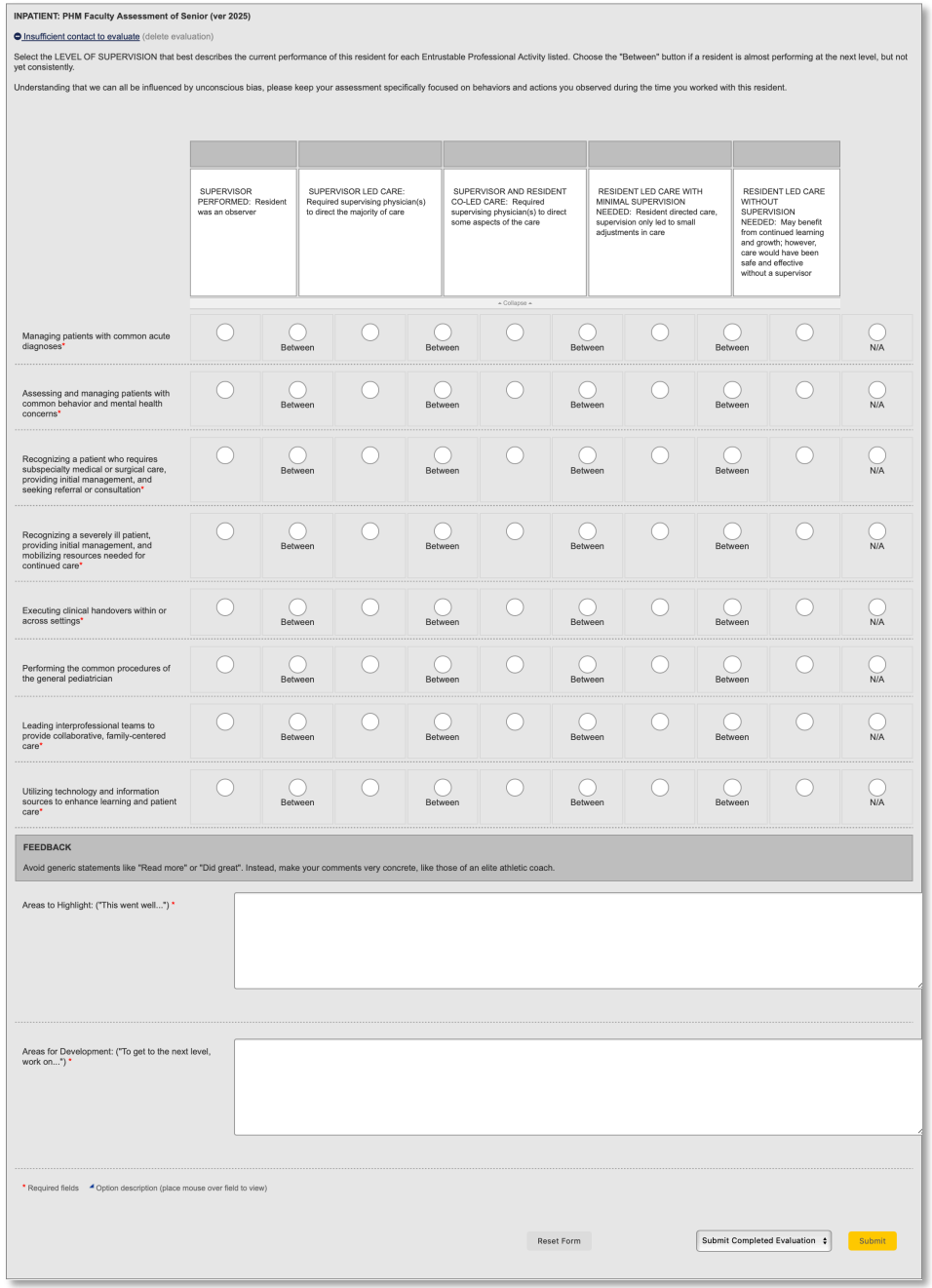


medhub

NEW INNOVATIONS

Summative Assessments

- End-of-shift or End-of-week (vs. End-of-rotation)
- Single Assessors (vs. Group)
- Challenges:
  - Longer forms
  - Not timely feedback
  - Often lacks concrete data
  - More room for bias



INPATIENT: PHM Faculty Assessment of Senior (ver 2025)

Insufficient contact to evaluate (delete evaluation)

Select the LEVEL OF SUPERVISION that best describes the current performance of this resident for each Entrustable Professional Activity listed. Choose the "Between" button if a resident is almost performing at the next level, but not yet consistently.

Understanding that we can all be influenced by unconscious bias, please keep your assessment specifically focused on behaviors and actions you observed during the time you worked with this resident.

	SUPERVISOR PERFORMED: Resident was an observer		SUPERVISOR LED CARE: Required supervising physician(s) to direct the majority of care		SUPERVISOR AND RESIDENT CO-LED CARE: Required supervising physician(s) to direct some aspects of the care		RESIDENT LED CARE WITH MINIMAL SUPERVISION NEEDED: Resident directed care, supervision only led to small adjustments in care		RESIDENT LED CARE WITHOUT SUPERVISION NEEDED: May benefit from continued learning and growth; however, care would have been safe and effective without a supervisor	
Managing patients with common acute diagnoses*		Between		Between		Between		Between		N/A
Assessing and managing patients with common behavior and mental health concerns*		Between		Between		Between		Between		N/A
Recognizing a patient who requires subspecialty medical or surgical care, providing initial management, and seeking referral or consultation*		Between		Between		Between		Between		N/A
Recognizing a severely ill patient, providing initial management, and mobilizing resources needed for continued care*		Between		Between		Between		Between		N/A
Executing clinical handovers within or across settings*		Between		Between		Between		Between		N/A
Performing the common procedures of the general pediatrician		Between		Between		Between		Between		N/A
Leading interprofessional teams to provide collaborative, family-centered care*		Between		Between		Between		Between		N/A
Utilizing technology and information sources to enhance learning and patient care*		Between		Between		Between		Between		N/A

FEEDBACK

Avoid generic statements like "Read more" or "Did great". Instead, make your comments very concrete, like those of an elite athletic coach.

Areas to Highlight: ("This went well...") *

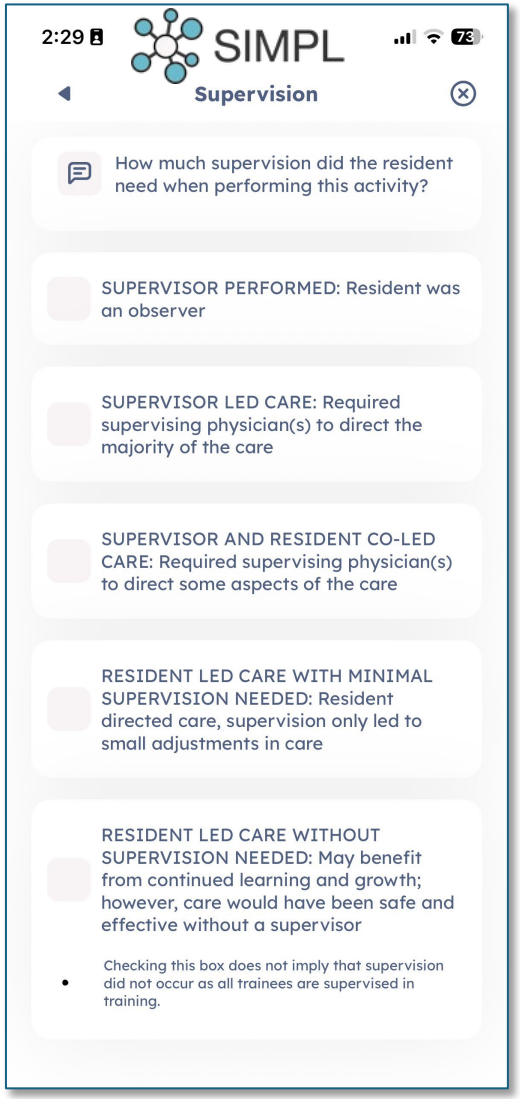
Areas for Development: ("To get to the next level, work on...") *

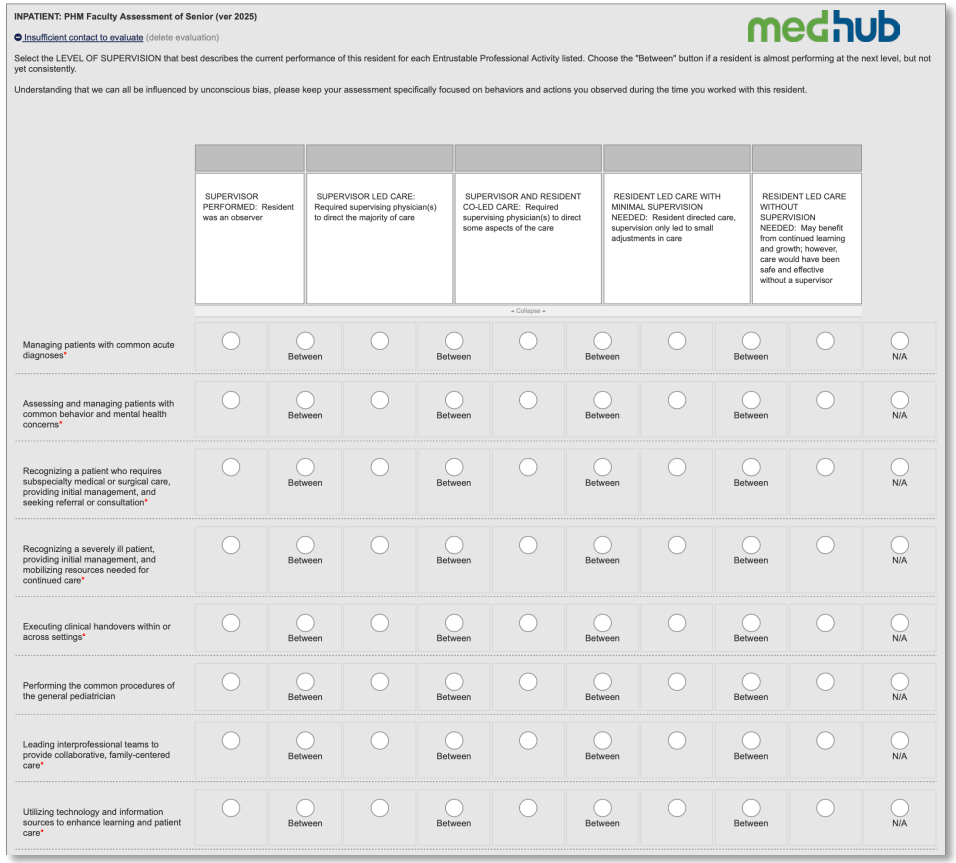
* Required fields Option description (place mouse over field to view)

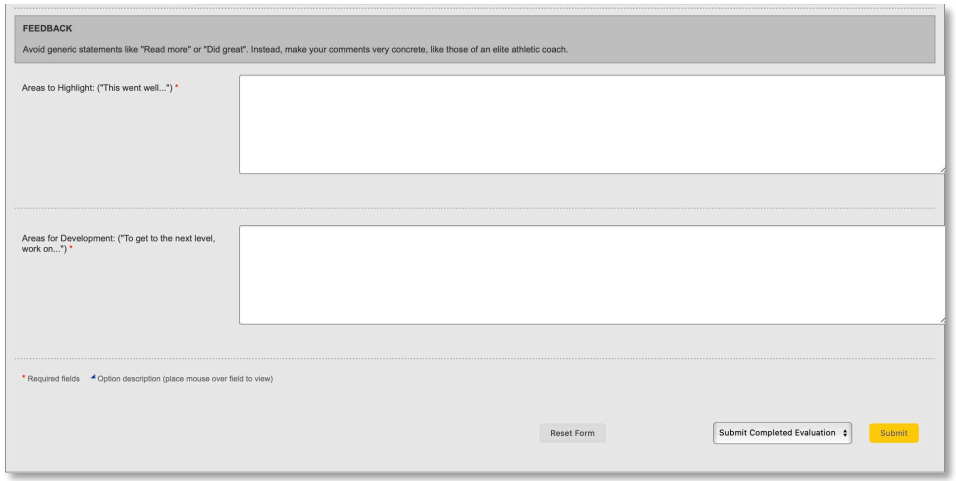
Reset Form Submit Completed Evaluation Submit

Faculty Assessments

- **EPA Supervision Ratings**
- ACGME Competencies (or ABP KSA) / Milestone Ratings
- Narrative Comments







Cross-Cutting Knowledge, Skills, and Abilities (KSAs)

RECOGNIZING LIMITS AND SEEKING HELP: Recognizing personal limitations in knowledge and skills and actively seeking assistance as necessary to provide optimal care for patients and families.

MAINTAINING PROFESSIONALISM: Recognizing a sense of duty to patients, upholding ethical standards, and performing professional obligations promptly and accurately

PROVIDING PATIENT- AND FAMILY-CENTERED CARE: Engaging in patient- and family-centered care and shared decision-making by collaborating with, supporting, educating, and empowering families in a manner that families feel heard and valued as partners in their care

COMMUNICATING CLEARLY AND RESPECTFULLY: Communicating clearly and respectfully with patients, families, and all members of the interprofessional team in a professional manner that ensures that families feel heard, valued, and well-informed, in particular during times of uncertainty

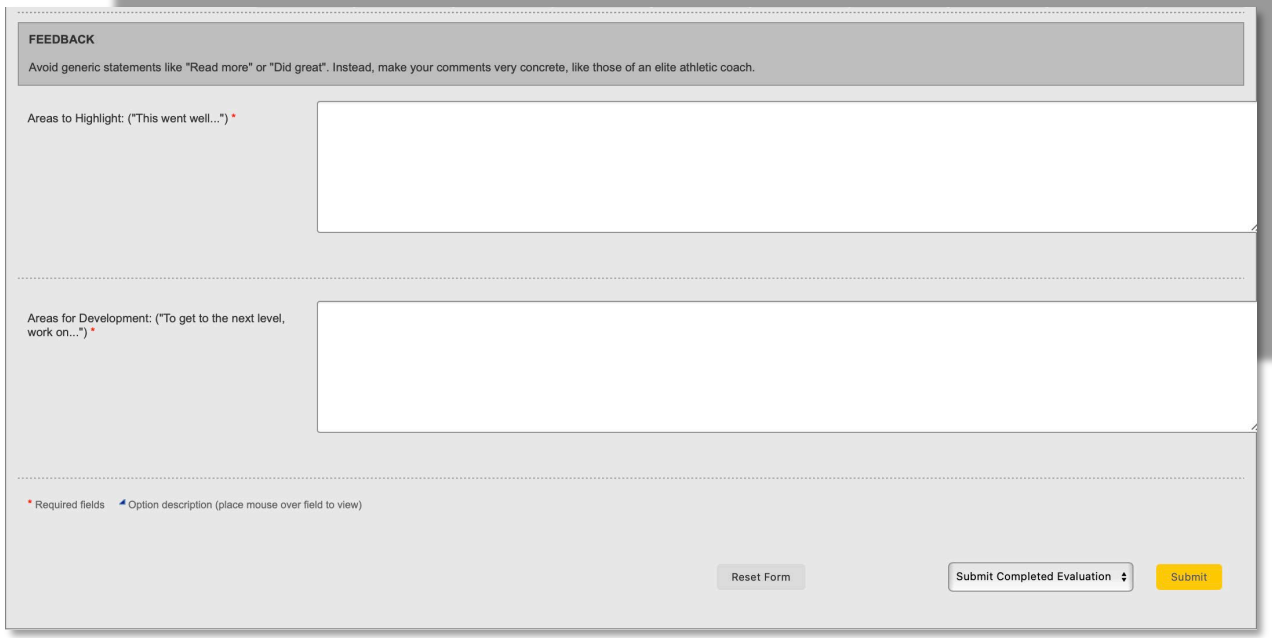
PROMOTING HEALTH EQUITY: Providing equitable care by delivering culturally and linguistically appropriate health information, demonstrating cultural humility, mitigating personal and structural bias, and addressing social determinants of health

COMMITTING TO LIFELONG LEARNING: Striving to continuously improve and learn, including filling knowledge gaps and evolving practice based on new technology, evidence, and standards of care

PROVIDING HIGH-VALUE CARE: Making evidence-based care decisions through shared decision-making with patients and caregivers that maximizes value through consideration of benefits, risks, patient/caregiver needs and priorities, and cost

Peer Assessments

- **ACGME Competencies (or ABP KSA) / Milestone Ratings**
- Be wary of EPA Supervision Ratings with peers
- Narrative Comments
- Different peer roles can offer different perspectives



Other Frontline Assessments

- Students
  - Education Skills
  - Leadership Skills
  - Professionalism
- Staff
  - Competencies or KSAs?
- Patients & Families



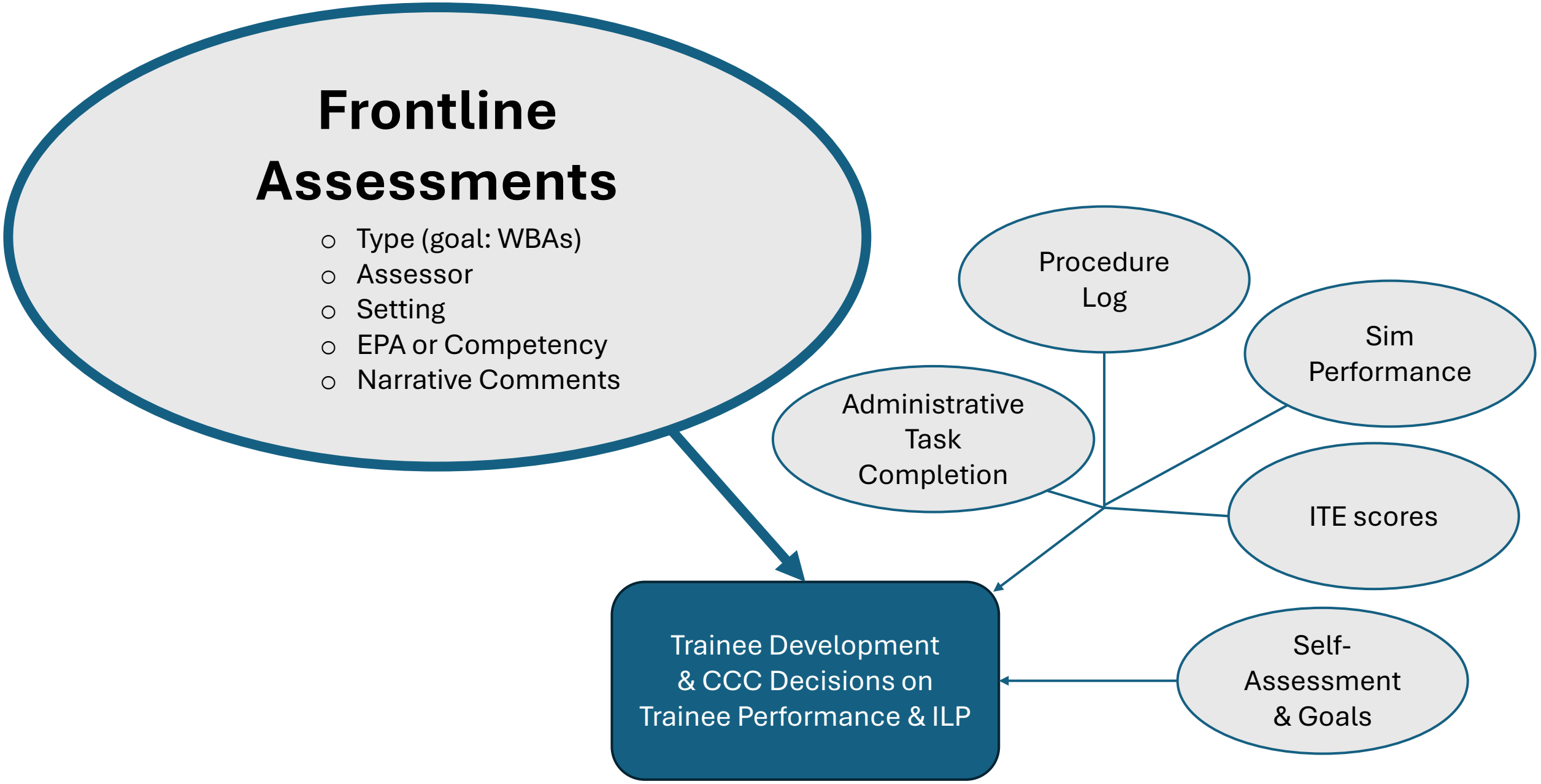
Adjust Assessments for Curriculum and Setting

Newborn Nursery
- ✓ Assessors: Faculty
- ✓ Type: WBA
- ✓ EPAs 1, 3, & 5 for faculty
- ✓ Narrative comments

Primary Care Clinic
- ✓ Assessors: Faculty
- ✓ Types: WBA and Longitudinal/Summative
- ✓ EPAs 1-12
- ✓ Narrative comments

Neonatal ICU
- ✓ Assessors: Faculty & Peers
- ✓ Types: WBA for faculty and summative for peer
- ✓ EPAs 6-12 for faculty
- ✓ SBP & ICS for peer
- ✓ Narrative comments




Frontline Assessments
Type (goal: WBAs)
Assessor
Setting
EPA or Competency
Narrative Comments
Procedure Log
Sim Performance
Administrative Task Completion
ITE scores
Trainee Development & CCC Decisions on Trainee Performance & ILP
Self-Assessment & Goals

Creating a program of assessment

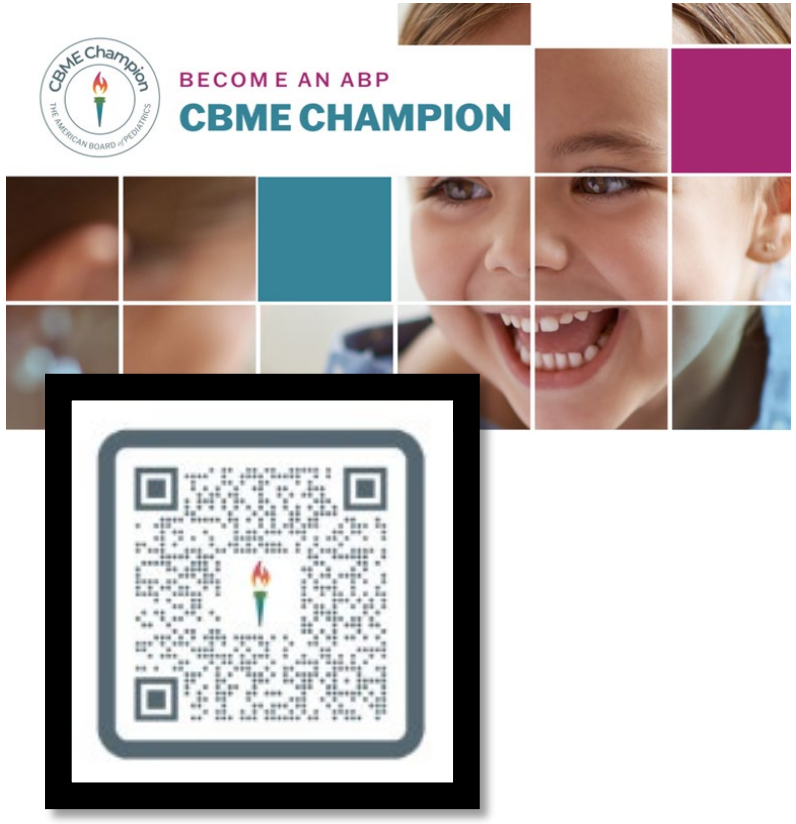
“Putting it all together”


Let’s Practice!

Scenario:

- CH, DS, and MO are program leaders for a medium-sized general pediatrics residency program
- We are committed to competency-based medical education!
- We attended the APPD Assessment Learning Community's 24-25 Virtual Café Series on implementing EPAs
- Joined the ABP's CBME Champions & watched some of their presentations that highlight CBME in action!





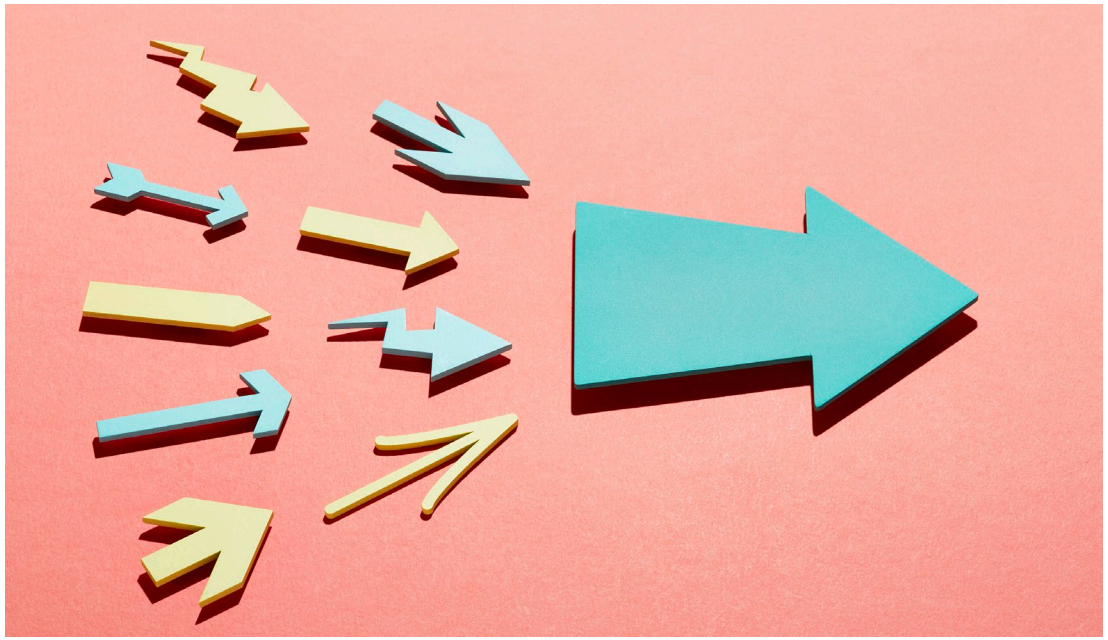


Scenario:

We’re ready to create our assessment system!

Review/Develop our Goals





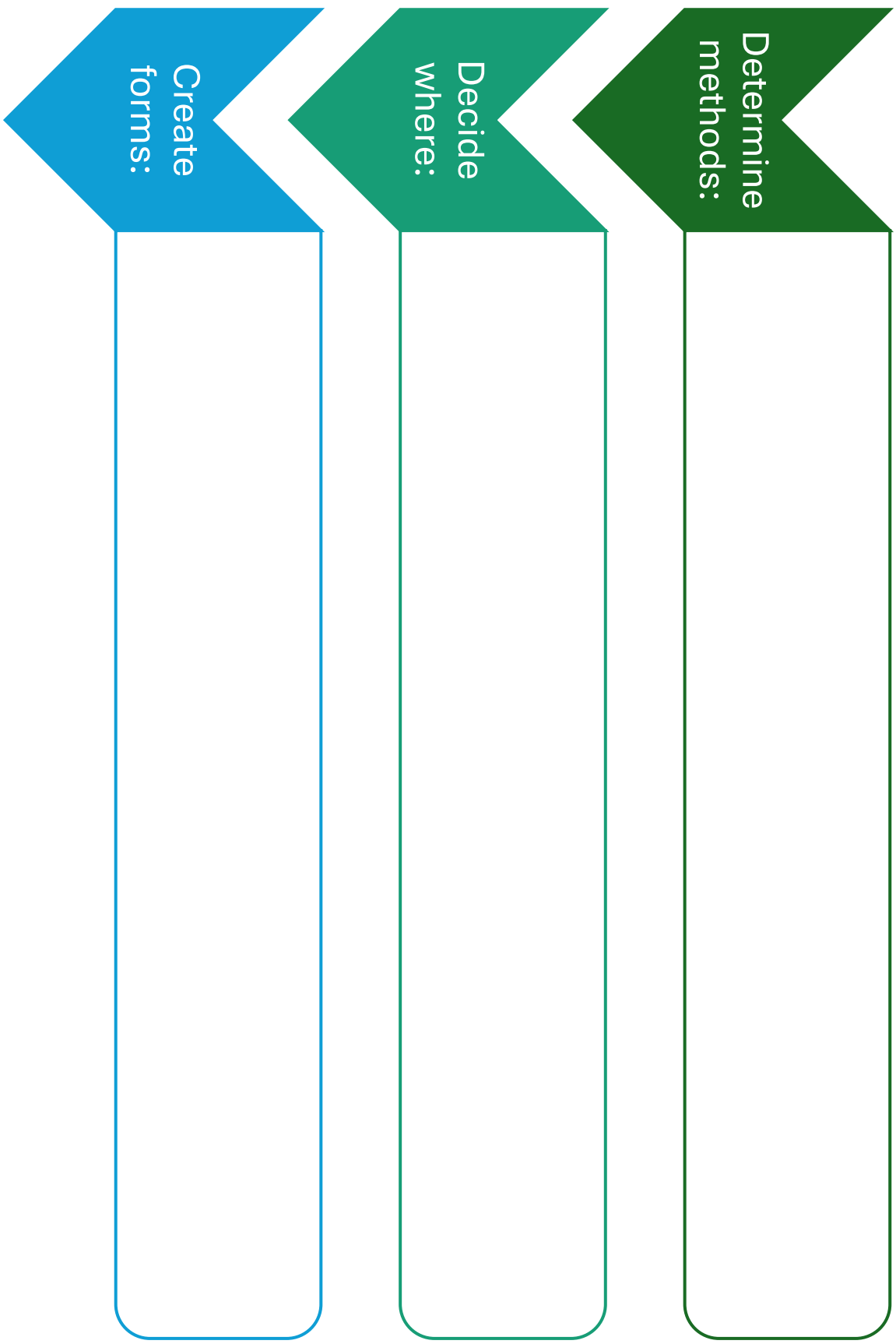
Goals of the Assessment System in a CBME Program

- Optimize learning & support growth of each trainee
- Make informed and defensible CCC decisions
  - Progression and advancement within the program
  - Readiness to perform the activities unsupervised
- Contribute to program improvements

Our program of assessment goals:

1. Provide clear and transparent expectations
2. Prepare residents for unsupervised practice of the general pediatrics EPAs, supporting graduated responsibility
3. Use feedback, self-reflection and coaching to support development
4. Use assessment information and the ILP to track progress and identify facilitators & barriers to the individual resident's growth, allowing for individualization of their learning
5. Support growth-oriented learning
6. Perform holistic and equitable review of all residents
7. Strive for continuous improvement of the assessment system & residency program curricula

Building our Program of Assessment



Building our Program of Assessment

Determine methods:

- EPAs/KSAs: Workplace-based assessments, end-of-rotation evaluations, SIMs, case logs?



Step 1: Determine Methods

Step 1: Determine methods

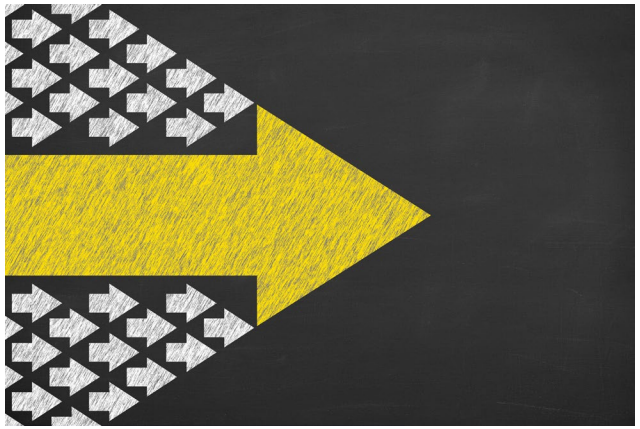
What assessment types will capture the EPA or KSA best?

	WBA	End of week eval	Peer Assessment	360	Student Evals	Case logs	Procedure log	Sim experiences	ITE	Self-assessment
Providing **preventative primary care** for children of all ages	X	X				X				X
Providing **comprehensive primary care for children with complex**, chronic, or special health care needs	X	X				X				X
Managing patients with **common acute diagnoses**	X	X				X				X
Assessing and managing patients with **common behavior and mental health** concerns	X	X				X				X
Caring for the **newborn** prior to discharge	X	X				X				X
Recognizing a patient who requires subspecialty medical or surgical care, providing initial management, and seeking **referral or consultation**	X	X				X				X
Recognizing a **severely ill patient**, providing initial management, and mobilizing resources needed for continued care	X	X						X		X
Executing clinical **handovers** within or across settings	X	X	X	X						X
Performing the common **procedures** of the general pediatrician	X	X					X	X		X
Leading members of an interprofessional team to provide collaborative, family-centered care	X	X			X			X		X
Promoting **equitable care** at the level of each individual patient and the population to address racism and other contributors to health inequities	X	X								X
Utilizing **technology and information sources** to enhance learning & patient care	X	X			X					X
Recognizing limits and seeking help	X	X	X	X				X		X
Maintain professionalism	X	X	X	X	X					X
Providing patient- and family-centered care	X	X		X						X
Communicating clearly and respectfully	X	X	X	X	X			X		X
Promoting health equity	X	X		X						X
Committing to lifelong learning	X	X	X	X						X
Providing high-value care	X	X		X						X
Medical Knowledge	X	X						X	X	

Step 2: Determine methods

Assessment Methods that stood out to us:

- **WBAs**
- Peer assessments
- End-of-rotation evaluations



Our plan:

- EPAs- faculty WBAs
- KSAs- faculty WBAs & peer assessments

Building our Program of Assessment

Determine methods:

- EPAs/KSAs: Workplace-based assessments, end-of-rotation evaluations, SIMs, case logs?

Decide where:

- Assessment Mapping

*Tip: Are there EPAs/KSAs that are harder to assess or more limited? Can be helpful to start there.



Step 2: Decide where

Revisit our curriculum map

Where do the residents practice this EPA?

List your program's rotations/educational experiences across the top. Then go through each EPA and KSA. In which experiences are the residents getting exposure to each EPA?	Nursery	Continuity Clinic	Wards	PICU	NICU	ER		
Providing **preventative primary care** for children of all ages	X	X	X					
Providing **comprehensive primary care for children with complex**, chronic, or special health care needs		X	X					
Managing patients with **common acute diagnoses**	X	X	X			X		
Assessing and managing patients with **common behavior and mental health** concerns		X	X			X		
Caring for the **newborn** prior to discharge	X							
Recognizing a patient who requires subspecialty medical or surgical care, providing initial management, and seeking **referral or consultation**	X	X	X	X	X	X		
Recognizing a **severely ill patient**, providing initial management, and mobilizing resources needed for continued care	X	X	X	X	X	X		
Executing clinical **handovers** within or across settings	X	X	X	X	X	X		
Performing the common **procedures** of the general pediatrician	X	X	X	X	X	X		
Leading members of an interprofessional team to provide collaborative, family-centered care	X	X	X					
Promoting **equitable care** at the level of each individual patient and the population to address racism and other contributors to health inequities	X	X	X	X	X	X		
Utilizing **technology and information sources** to enhance learning & patient care	X	X	X	X	X	X		

Check out the past virtual café that covers curriculum mapping on the APPD website. EPA Education Series: Session 3. 11/12/2024



Our "where" considerations: What EPAs/KSAs do we want to highlight/assess in each location?

- Ensure broad input across contexts, environments, and acuity
- Limit to a few in each area to simplify faculty development
- Focus on the expectations of a general pediatrician

Our plan:

Setting/rotation	EPAs to target
Continuity clinic	Primary care, complex primary care, Common acute diagnoses, behavior/mental health, procedures
Nursery	Newborn care, common acute diagnoses, referral/consultation
Wards	Common acute diagnoses, behavior/mental health, consult/refer, handover, procedure, information/tech, severely ill, equitable care, lead a team
NICU/PICU	consult/refer, handover, information/tech, severely ill, equitable care
ER	Common acute diagnoses, behavior/mental health, consult/refer, handover, procedure, information/tech, severely ill, equitable care

Collecting Assessments – making sure we have enough data with our WBA system

- Utilize technology to collect our assessments
- Encourage both faculty & trainee to initiate the forms
- Create a dashboard for trainee's and their coaches to be able to track
- Set up coaching meetings with residents q3m to review progress and highlight EPAs/KSAs that need more data

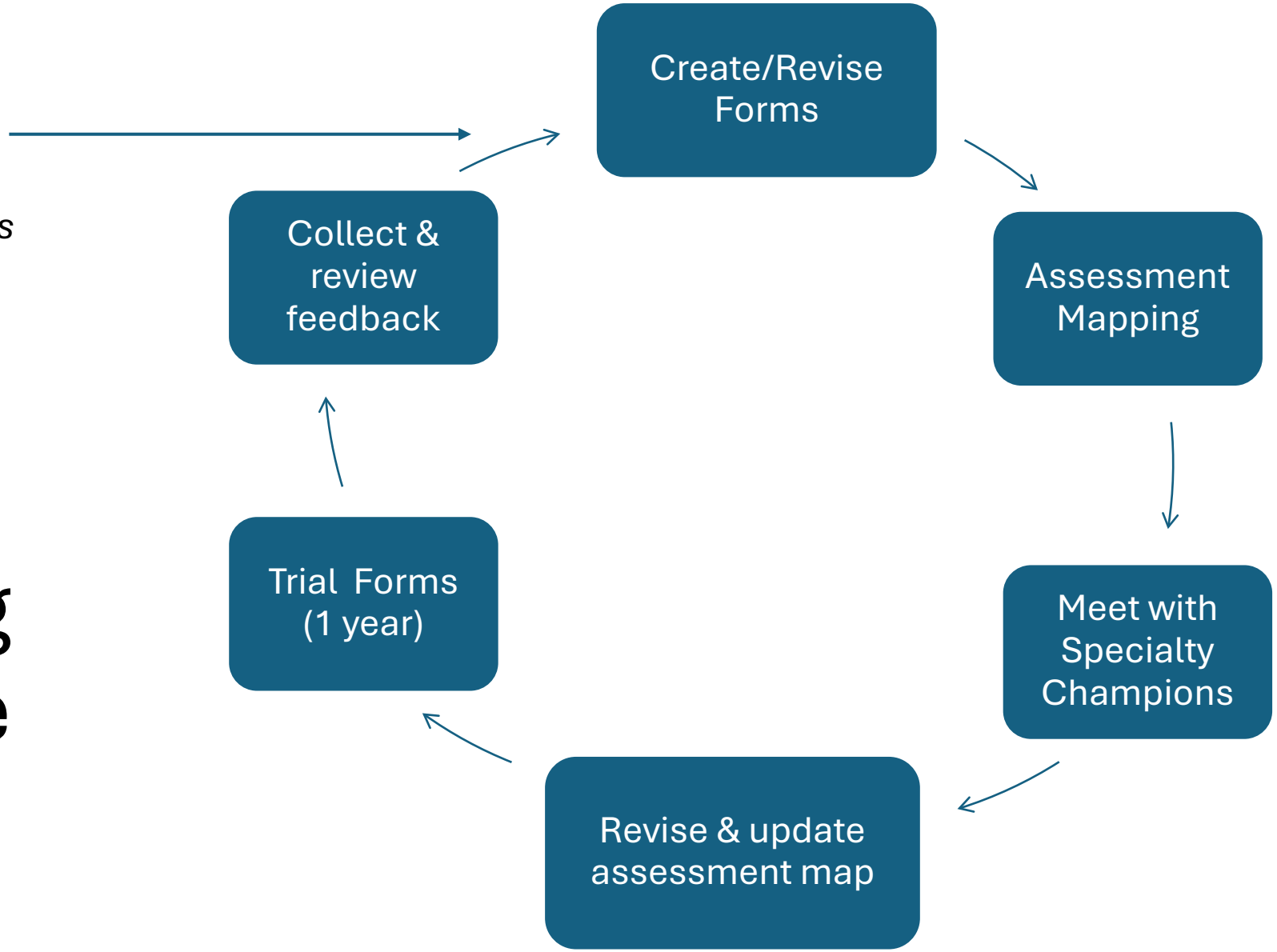
If we weren't using WBAs...

(or we wanted to supplement our system of WBAs with summative assessments)

Curriculum Mapping

- *Where do the residents practice this EPA?*
- *How many observers/evaluators of this EPA are needed?*
- *Which EPAs are more limited in where they are practiced?*

Incorporating EPAs into the Assessment Forms



Assessment Map

	Continuity	NICU	Nursery	PIC
1	1		1	
2	1	1		
3	1		1	
4	1			

	Block 1		Block 2	
PGY-1	Outpatient Subspecialty	AMB	Wards	AMB
PGY-2	Wards - Hem/Onc	AMB	NICU	AMB
PGY-3	Admit Resident	AMB	Outpatient Subspecialty	AMB

KSA3		1	
KSA4	1	1	
KSA5		1	
KSA6			
KSA7			

EPA	PGY1	PGY2	PGY3	Total
1	5	5	5	15
2	5	5	5	15
3	9	9	9	18
4	8	6	8	14
5	4	6	0	6
6	8	8	8	16
7	6	8	8	16
8	16	14	10	24
9	3	4	4	8
10	2	5	7	12
11	8	9	8	17
12	10	10	10	20

Building our Program of Assessment

Determine methods:

- EPAs/KSAs: Workplace-based assessments, end-of-rotation evaluations, SIMs, case logs?

Decide where:

- Assessment Mapping

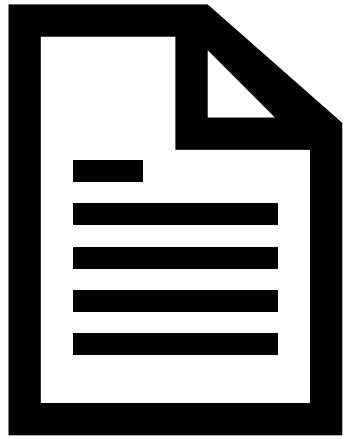
*Tip: Are there EPAs that are harder to assess or more limited? Can be helpful to start there.

Create the forms

- Simple, quick, and clear
- Encourage behavior-based comments
- Use in-the-moment bias mitigation strategies

*Tip: Borrow from others!!!

Step 3:
Create forms



Creating our WBA forms – Structure/ Components

- Assessment framing statement
- Pick 1 EPA or KSA
- Supervision scale (for faculty only)
- Narrative Comment box with instructions to promote behavior-based comments

Assessment Framing Statement - options

- Recognizing that we can all be influenced by unconscious bias, please keep your assessment specifically focused on behaviors and actions you observed while working with the resident.
- Being mindful of how unconscious bias can shape evaluations, please concentrate your assessment on the resident's demonstrated behaviors and actions in the workplace.
- Acknowledging that we all have unconscious biases, please concentrate your feedback on the observable behaviors and actions of the resident during your interactions.

1. Assessment Framing Statement

- **Recognizing that we can all be influenced by unconscious bias, please keep your assessment specifically focused on behaviors and actions you observed while working with the resident.**
- Being mindful of how unconscious bias can shape evaluations, please concentrate your assessment on the resident's demonstrated behaviors and actions in the workplace.
- Acknowledging that we all have unconscious biases, please concentrate your feedback on the observable behaviors and actions of the resident during your interactions.

2. Pick an EPA/KSA Strategies

Limit the options to the EPAs/KSAs we highlighted before in our “determine where” step

Narrow the EPA by asking a few questions (age, diagnosis)

3. Supervision Scale: retrospect

Scale:
"I had to do" i.e., Re
"I had to talk them t
"I had to prompt the
prompting.
"I needed to be there
and/or situations, un
"I did not need to be
input may have been

ACGME supervision levels (ACGME Common Program	Entrustment scales adapted for pathology from O-SCORE[14] and OCAT[18]		
	Procedure-based EPAs (*i.e., autopsy procedure, frozen*	Situation based/clinical problem-solving (*i.e.,*	Reporting based (*i.e., peripheral*

How much supervision did the resident need when performing this activity?

- ○ SUPERVISOR PERFORMED: Resident was an observer
- ○ SUPERVISOR LED CARE: Required supervising physician(s) to direct the majority of the care
- ○ SUPERVISOR AND RESIDENT CO-LED CARE: Required supervising physician(s) to direct some aspects of the care
- ○ RESIDENT LED CARE WITH MINIMAL SUPERVISION NEEDED: Resident directed care, supervision only led to small adjustments in care
- ○ RESIDENT LED CARE WITHOUT SUPERVISION NEEDED: May benefit from continued learning and growth; however, care would have been safe and effective without a supervisor
  Checking this box does not imply that supervision did not occur as all trainees are supervised in training.

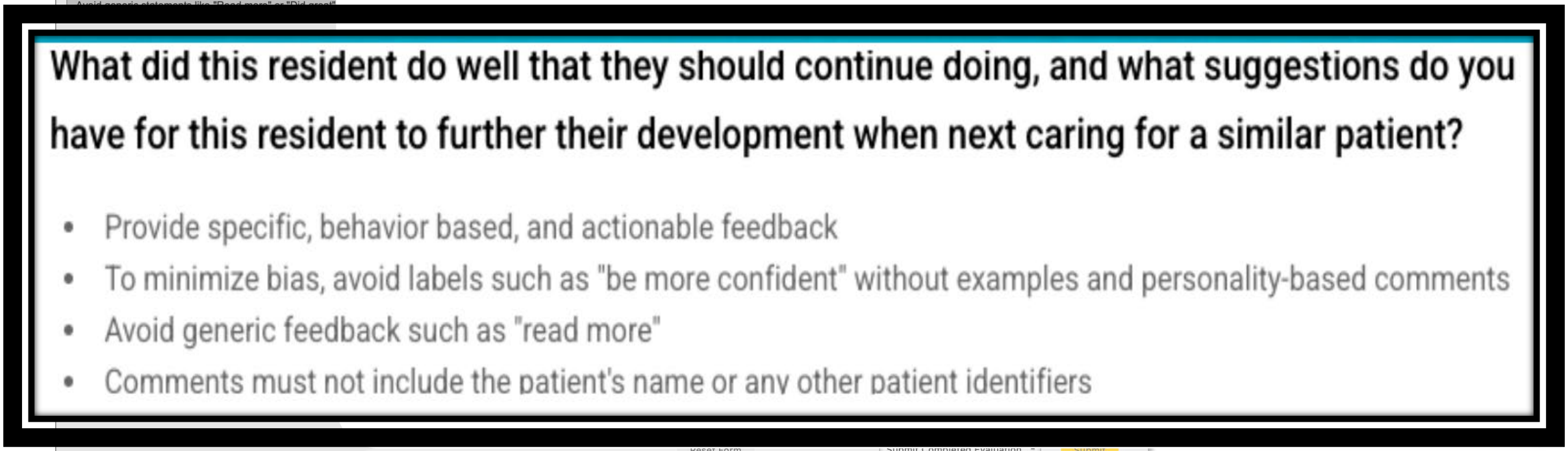
[1]Tavares et al. J Grad Med Educ. 2022

[2]Bryant et al. Acad Pathol. 2024

[3] https://www.abp.org/cbme-simpl

4. Narrative Comment Prompt

Prompt to encourage behavior-based comments



[1]University of Michigan Pediatric Residency Program 2025

[2]https://www.abp.org/cbme-simpl

Our WBA Form

(based heavily on the SIMPL WBA form)

Recognizing that we can all be influenced by unconscious bias, please keep your assessment specifically focused on behaviors and actions you observed while working with the resident

Pick EPA – answer a couple quick questions to narrow the EPA

How much supervision did the resident need when performing this activity?

- ○ SUPERVISOR PERFORMED: Resident was an observer
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- ○ RESIDENT LED CARE WITHOUT SUPERVISION NEEDED: May benefit from continued learning and growth; however, care would have been safe and effective without a supervisor
  Checking this box does not imply that supervision did not occur as all trainees are supervised in training.

What did this resident do well that they should continue doing, and what suggestions do you have for this resident to further their development when next caring for a similar patient?

- Provide specific, behavior based, and actionable feedback

Check out the SIMPL pilot to see an example of WBA forms using the pediatric EPAs.
https://www.abp.org/cbme-simpl

Creating WBA forms – Tips

- Make them simple!
- Make them quick!
- Limit the EPAs assessable in one setting
- Consider narrowing the scope of the EPA
- Encourage behavior-based narrative comments
- Use bias mitigation strategies



Our End-of Rotation or End-of-Week Form

Recognizing that we can all be influenced by unconscious bias, please keep your assessment specifically focused on behaviors and actions you observed while working with the resident

5 EPAs

How much supervision did this resident need when performing this activity?

SUPERVISOR PERFORMED: Resident was an observer	SUPERVISOR LED CARE: Required supervising physician(s) to direct the majority of care	SUPERVISOR AND RESIDENT CO-LED CARE: Required supervising physician(s) to direct some aspects of the care	RESIDENT LED CARE WITH MINIMAL SUPERVISION NEEDED: Resident directed care, supervision only led to small adjustments in care	RESIDENT LED CARE WITHOUT SUPERVISION NEEDED: May benefit from continued learning and growth; however, care would have been safe and effective without a supervisor

What did this resident do well, and they should continue doing? What suggestions do you have for this resident to further their development?

Building our Program of Assessment

Determine methods:

- EPAs/KSAs: Workplace-based assessments, end-of-rotation evaluations, SIMs, case logs?

Decide where:

- Assessment Mapping

*Tip: Are there competencies that are harder to assess or more limited? Can be helpful to start there.

Create forms

- Simple, quick, and clear
- Encourage behavior-based comments
- Use bias mitigation strategies

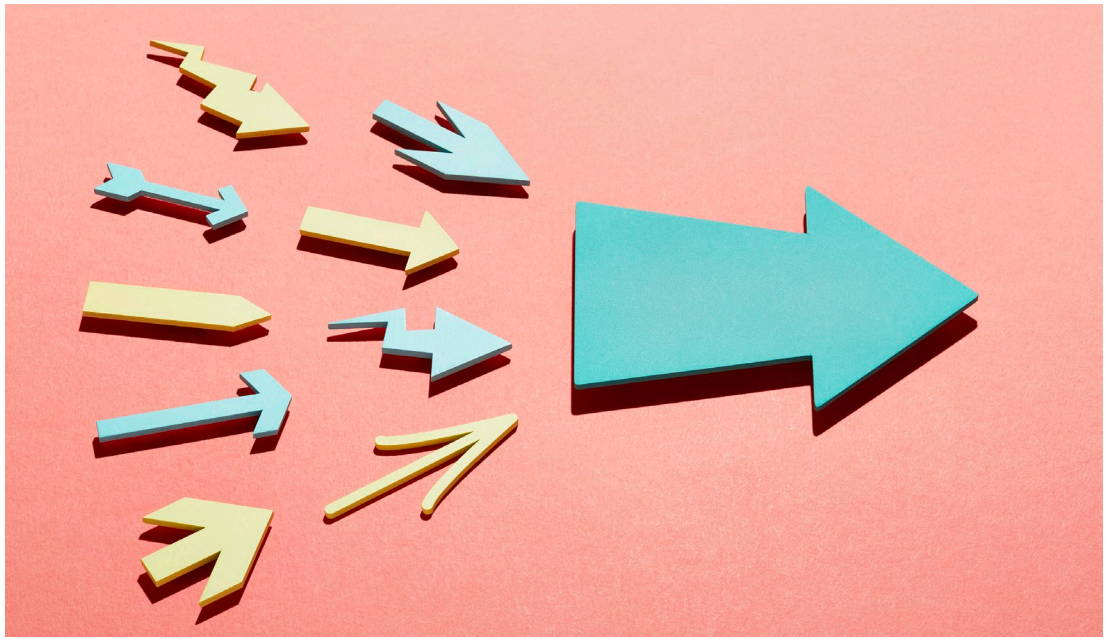
*Tip: Borrow from others!!!

Programmatic Assessment

- Multiple data points
- Multiple assessors
- Over time
- Varied methods
- Used to guide learning







Goals of the Assessment System in a CBME Program

- Optimize learning & support growth of each trainee
- Make informed and defensible CCC decisions
  - Progression and advancement within the program
  - Readiness to perform the activities unsupervised
- Contribute to program improvements

Launch our assessment system

Plan for iterative improvements



Our program of assessment goals:

1. Provide clear and transparent expectations
2. Prepare residents for unsupervised practice of the general pediatrics EPAs, supporting graduated responsibility
3. Use feedback, self-reflection and coaching to support development
4. Use assessment information and the ILP to track progress and identify facilitators & barriers to the individual resident's growth, allowing for individualization of their learning
5. Support growth-oriented learning
6. Perform holistic and equitable review of all residents
7. Strive for continuous improvement of the assessment system & residency program curricula

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7. Strive for continuous improvement of the assessment system & residency program curricula

Creating the culture

Promoting growth-oriented learning environments



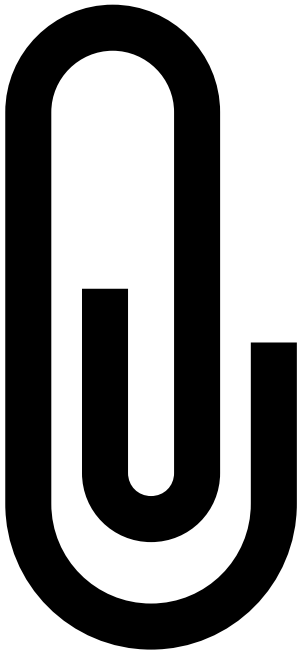


Promoting a growth-oriented learning environment: Learner & faculty development

- Promote a shared understanding of expectations
- Encourage partnership to:
  - Promote trust
  - Provide honest feedback
  - Identify learning opportunities

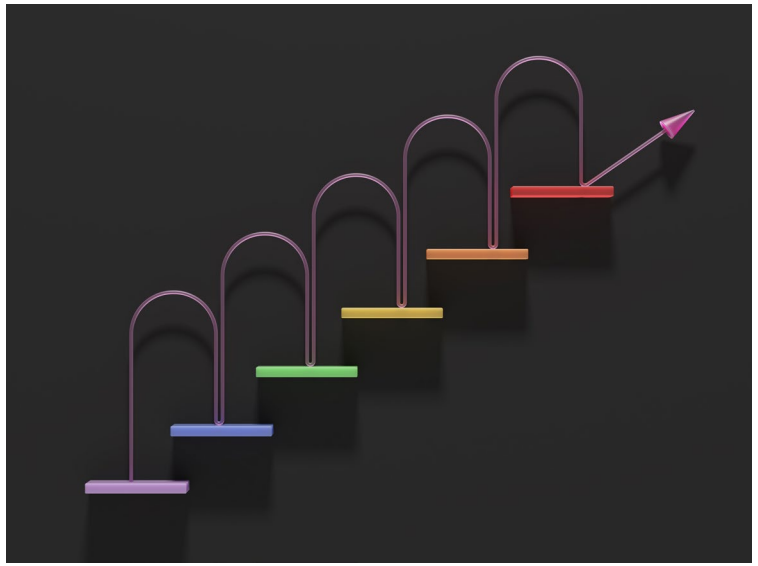
Our approach to faculty development

- Identified CBME champions in each division
- Presented at a division meeting
- Wrote a blurb for the monthly faculty newsletter
- Attached resources to the assessment forms



Faculty Development Topics

- What is CBME? Why CBME?
- What are the expected outcomes of training (EPAs)
- How to teach to the individual
  - Based on current development and towards the expected goals
- How to give feedback
- How to assess



Residents/Fellows Topics

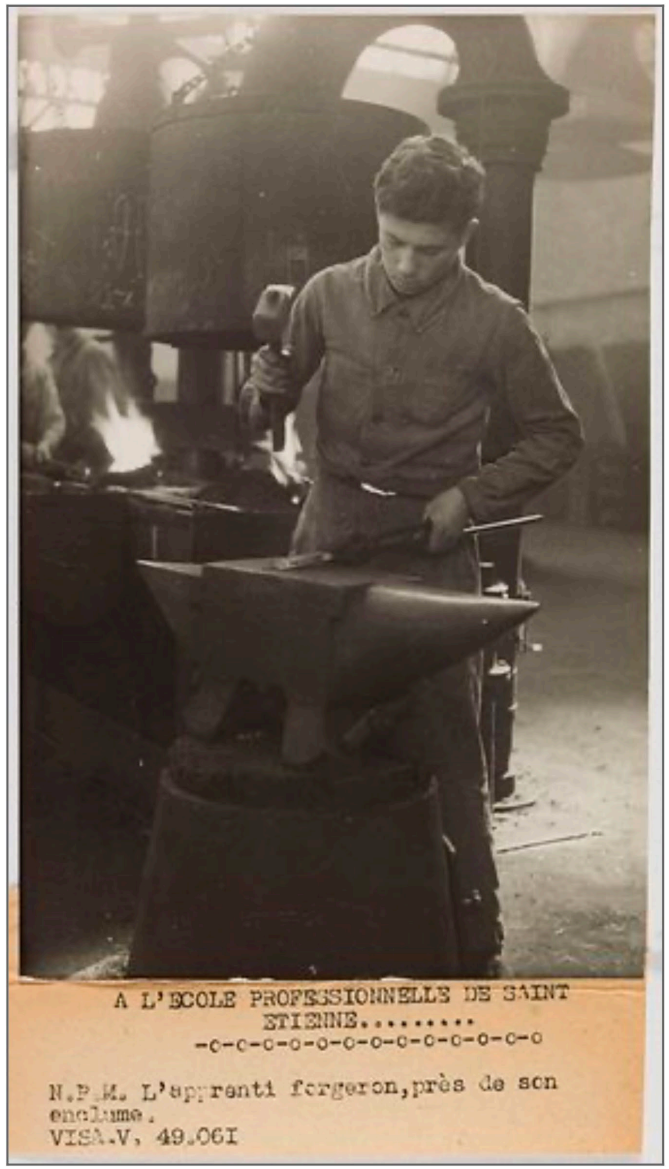
- Promote a shared understanding of expectations
- Support growth mindset/break away from performance mindset
- Promote and support self-reflection
- Provide instruction on how to get the most out of feedback/assessment



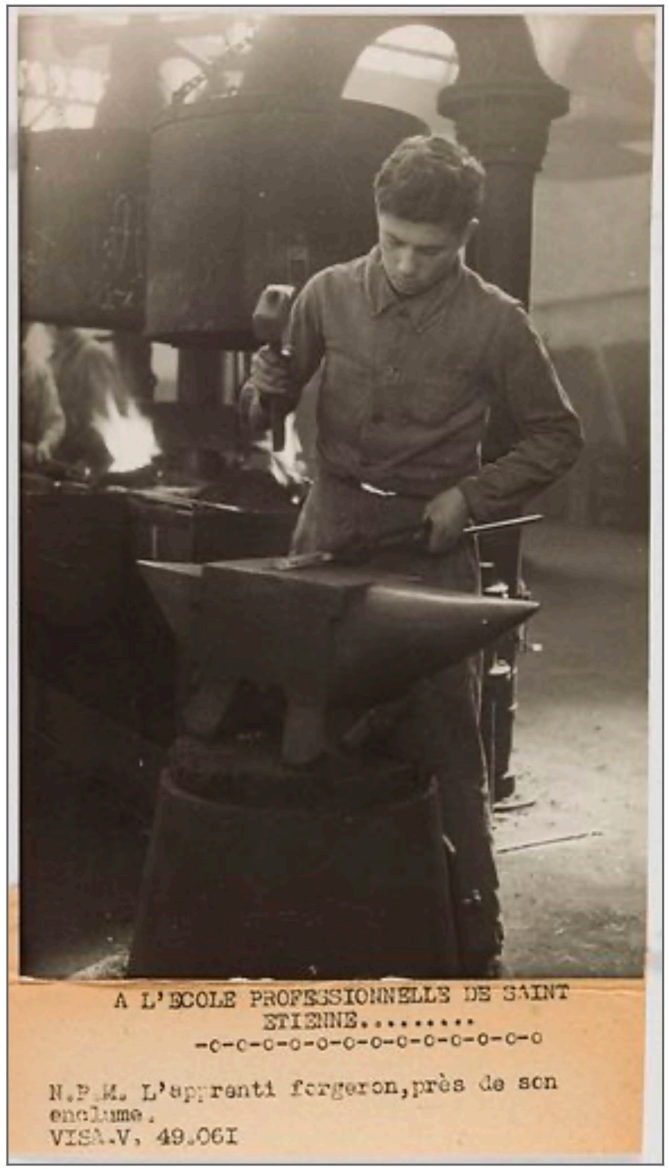
Trainee Education Goals: Introduce Early & Reinforce Often

Start with orientation!

Residency is an apprenticeship. Your goal is to build skills!



You need LOTS of formative feedback to refine your skills.



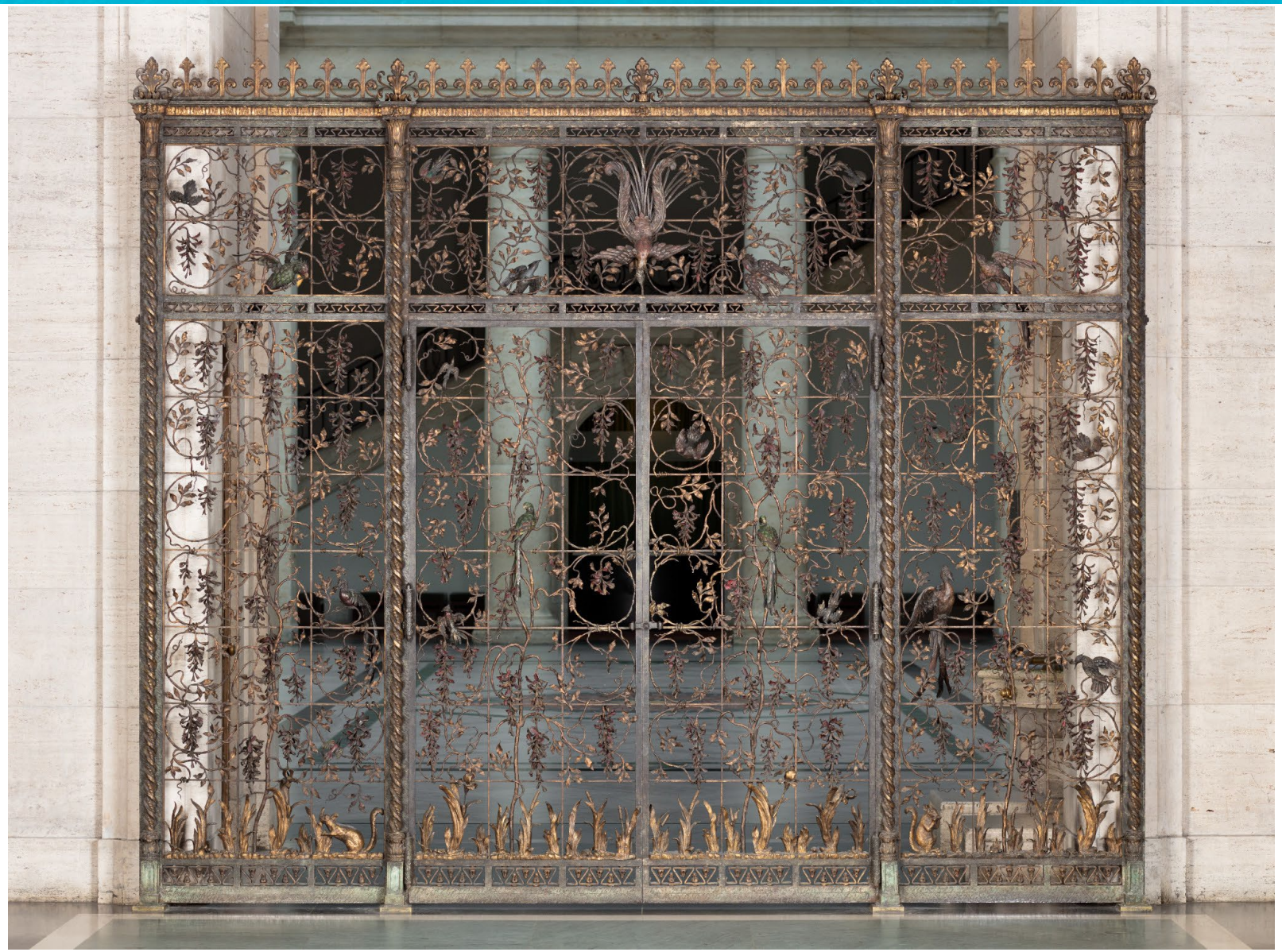


Your aim is to achieve a certain level of competency…



…on your longer journey to mastery.





Key Takeaways



- There is a difference between assessment ***of*** learning and assessment ***for*** learning.
- Frequent, varied, and low-stakes assessment (programmatic assessment) with corresponding feedback to the learner increases **learning opportunities** and efficiency, **improves the learning environment, and promotes equity**.
- Programmatic assessment is a core component of **CBME**
- Programmatic assessment can be used to individualize learning and **support growth of each trainee**, **make informed CCC decisions about advancement** & contribute to curriculum/assessment improvements in the program
    - Stay tuned to the remainder of the EPA Education Series for sessions that cover all these topics!



Session 2!

Assessment with Purpose: Are You Making the Information You Have Collected Work for You?

10/1/25 3-4PM ET

Your homework for Session 2:

Before the next session: *Now that you've collected your data…how are you bringing it together? Take a moment to review your program's pre-CCC preparation processes and data reviews*.

Come ready to share insights and learn together!

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