UNIVERSITY OF MANITOBA | MAX RADY COLLEGE OF MEDICINE Rady Faculty of Health Sciences

Bachelor of Science in Medicine Degree Program End of Term Final Report

Office of Graduate and Advanced Degrees Education in Medicine Max Rady College of Medicine
Rady Faculty of Health Sciences
University of Manitoba

Student Name: Derek Fisk

Date: 06/29/22

Project Title: Multi-stakeholder validation of Entrustable Professional Activities in FM-Care of the Elderly and RCPSC Geriatrics

Primary Supervisor Name: Dr. Jose Francois

Department: Family Medicine

Co-Supervisor Name: Dr. Phil St. John

Department: Internal Medicine: Geriatrics

Summary (250 words max single spaced):

Entrustable Professional Activities (EPAs) have become widely used within Competency-Based Medical Education (CBME) for the training and evaluation of residents. Little is known about the effectiveness of incorporating multiple stakeholder groups in the validation of EPAs. Through online focus groups consisting of five distinct stakeholder groups, we seek to validate two EPA frameworks: one for the University of Manitoba Care of the Elderly (CoE) Enhanced Skills program, and one for Canadian Geriatrics Specialty Programs. Participants were recruited to take part in one of five online focus groups, one for each stakeholder group (physician faculty, residents, non-physician healthcare professionals, administrators/managers, and patients). Each group met one time for 90 minutes over ZOOM. Meeting transcripts were coded using NVivo using codes that were formulated iteratively by the research team. The themes arising from stakeholder feedback suggest that successful EPAs must neither be too specific nor too expansive in scope, clearly delineate appropriate

S[redacted]e Primary S[redacted]

Ackn[redacted]s: I gratefully acknowledge the sole or p[redacted]m:

H.T. Thorlakson Foundation
Dean, College of Medicine
Research Manitoba

Manitoba Medical Service Foundation (MMSF)
Vice-Dean, Research Rady FHS
Health Sciences Centre Research Foundation
Heart and Stroke Foundation

Introduction and Background:

Over the last two decades, Competency-Based Medical Education (CBME) has been widely adopted into medical training programs across the globe. [1] CBME aims to "graduate health professionals who can practice at a defined level of proficiency, in accord with local conditions, to meet local needs, in a system of fixed outcomes". [2] A trainee's progress through a competency-based program largely depends on their demonstration of an established set of standards (i.e., competencies). [3] Competencies characterize a professional's abilities in a broad sense, using words such as "knowledge, professional attitude [and] communication skills." [4] Due to their abstract nature, implementing competencies into the training and assessment of trainees has proven to be a significant challenge. [5] To remedy this perceived problem, the concept of Entrustable Professional Activities (EPAs) was introduced into medical education. [6]

"EPAs are tasks or responsibilities that faculty entrust to a trainee to execute once he or she has obtained adequate competence". [4] They are "units of work" [4] that find their place at the "does" level of Miller's Pyramid of Assessment (knows, knows how, shows how, does). [7] EPAs have inspired a shift away from high-stakes formative assessments, and towards multiple low-stakes, EPA-based assessments. [8] In recent years, it has become increasingly evident that physicians require more than knowledge and expertise to offer exceptional care to patients. A good doctor must also "practice with professionalism and societal responsiveness, based on shared decision-making and in optimal collaboration within teams and the health care system at large." [5] One way of fostering social accountability, interprofessional collaboration, and system-based practice in our future physicians is by acquiring input from various stakeholders in the healthcare system on the EPA frameworks used to guide resident training.

Insufficient efforts to consult relevant stakeholders has contributed to the failure of many policies and programs in the past [9] – a teachable lesson for those developing and implementing EPA frameworks today. Regrettably, stakeholder involvement in the context of competency-based program development has focused mainly on physician perspectives. [10] According to the World Health Organization (WHO), socially accountable programs should be built to consider not only health professionals, but also academic institutions, health administrators, policy makers and communities. [11] Specific examples of stakeholders that have been consulted in CBME include residents, physician faculty, nurses, administrators, and patients. [12] However, each study has tended to only consider a limited number of distinct stakeholder groups. In addition, only a few studies have directly involved patients in the evaluation of EPAs. [13,14]

In Canada, two groups of physicians that specialize in the care of older patients are Geriatricians and, more recently, Care of the Elderly (CoE) physicians. Physicians who complete a two-year residency in Family Medicine can opt to pursue an additional year of training that grants a Certificate of Added Competence in CoE. CoE physicians, then, are family physicians who are trained to provide more advanced care to elderly patients, particularly those with complex needs. They also "augment and support the care provided by other family physicians, other specialists, and other care providers typically around issues of frailty, complexity, comorbidity, medication assessment and management, and functional decline in the elderly." [15] On the other hand, those completing a 3-year residency in Internal Medicine can become Geriatricians through the Royal College of Physicians and Surgeons of Canada's 2-year Geriatrics Specialty Program. The longer duration of the Geriatrics Specialty Program prepares Geriatricians to claim the role of specialists that other physicians can consult in issues related to the care of elderly patients. [16]

EPA frameworks exist both for CoE and Geriatrics Specialty programs in Canada. The University of Manitoba Department of Family Medicine has recently articulated a framework of EPAs for its Enhanced Skills CoE Program. The EPAs were developed in 2018 by a group of CoE physicians, Geriatricians, and learners led by a senior medical educator. Following an extensive review of existing competency frameworks, the group identified and articulated 10 EPAs that were introduced in the 2019-2020

academic year. The RCPSC Geriatrics Specialty Program also has a list of EPAs that were developed by the Royal College's Geriatric Medicine Committee. [17] Contrary to the 1-year CoE program, the Geriatrics EPAs were divided into four stages through which residents progress over the two years. These stages are Transition to Discipline, Foundations of Discipline, Core of Discipline and Transition to Practice. Two Special Assessment EPAs also exist which Geriatrics residents can work towards over the two years of training.

The present study aims to explore the perceptions of a variety of stakeholder groups regarding the relevance and comprehensiveness of the EPA frameworks developed for the University of Manitoba Family Medicine CoE and RCPSC Geriatrics Specialty residency training programs.

Materials and Methods:

Participants from stakeholder groups of interest were recruited to participate in stakeholder-specific focus groups. The focus groups included physician faculty, residents, administrators/managers, non-physician health care professionals and patients/their family members (referred to as the "patient group"). Study invitations were distributed to potential participants by email. Faculty members were contacted directly through readily available faculty listings. For the remaining stakeholder groups, email invitations were distributed by residency program directors, administrators within the regional health authority, professional colleges, and Local Health Interest Groups (LHIGs). Both CoE physicians and Geriatricians were invited to take part in the physician faculty group. Co-investigators were excluded from the sampling frame. The resident group was unique in that it consisted of individuals both in- and out-of-province due to an insufficient number of current Manitoba trainees in these programs. The patient group was defined as patients over the age of 60 who have received or are currently receiving care, as well as family members of individuals who fit this description. The number and characteristics of individuals representing each stakeholder group are detailed in Table 1.

The two EPA frameworks were distributed to the participants more than one week in advance of their focus group meeting. Each focus group met online over ZOOM® for a single 90-minute meeting. Group sessions were facilitated by either the principal investigator or a medical student using a semi-structured interview script. Each focus group was asked the same questions regarding each EPA framework: "Do you feel they describe common tasks that a Care of the Elderly Physician performs?", "Are there EPAs that you do not regard as a key activity that a graduating physician should be able to perform independently by the end of the training?" and "Are there additional EPAs that you think should be included?". As the final question, participants were asked to share their thoughts on whether the frameworks "reflect (or do not reflect) the overlapping and complementary scopes of practice of these two [disciplines]." All meetings were recorded through ZOOM® and transcribed using NVivo® (QSR international, Doncaster, Victoria, Australia). Transcripts were later reviewed for errors and anonymized to protect confidentiality.

The results from each focus meeting were discussed by the research team to identify themes and their corresponding codes that would be used in data analysis. Transcripts were then coded using NVivo®. The coding structure was refined iteratively after each focus group session. Results were analyzed comparatively to explore agreements, gaps and other differences between stakeholder groups' perspectives.

All participants were required to sign a consent form in advance of their focus group meeting. No incentives were given for participation and all data collected was anonymized. Ethics approval was granted from the Health Research Ethics Board at the University of Manitoba (Bannatyne Campus) (HS24748 (H2021:114[CM5])).

Results:

Characteristics of the participants are shown in Table 1. All stakeholder feedback received for each EPA of the two EPA frameworks is summarized in Tables 2 and 3.

In addition to the participants' evaluation of each EPA, 4 broader themes arose which serve as lessons for future initiatives in EPA development: Specific vs. Broad, Wording Changes, Interprofessional Functioning, and Advocacy.

Theme: Specific vs. Broad:

Comments coded to the Specific vs. Broad theme were made by the faculty, resident, and administrator/manager groups. There was a strong consensus among stakeholder groups that, while many CoE EPAs were vague or poorly defined, the Geriatrics EPAs were excessively detailed. The potential impacts of EPAs being defined too broadly or narrowly were categorized into two subthemes: Operationalization and Setting.

Subtheme: Operationalization:

The resident and faculty groups expressed concerns that some EPAs would suffer shortcomings in their implementation and use in trainee evaluation (i.e., operationalization). For CoE, many EPAs were found to be ambiguous in terms of how they were to be assessed. On the other hand, the Geriatrics EPAs tended to receive comments regarding the fine-tuning of operationalization and unnecessary administrative burden. For example, a member of the physician faculty group made the following comment regarding the CoE EPAs:

"But the Family Medicine [EPAs] are too broad. So, in [EPA] two, you could easily just do five falls and not be evaluated on your dementia management because there's nothing to say it has to be at least two dementias, two falls, two incontinence two of this."

Regarding CoE EPA 6, "coordinate healthcare and healthcare transitions for older adults with multi-morbidity and multiple providers," a resident wondered whether it could be realistically evaluated.

"It's just harder to potentially get feedback [on] a system-level basis. For example, I have discharged patients … but you don't really get direct feedback on your discharge summaries. A lot of the time, you might get feedback, but you'll get feedback from your attending who also discharged the patient and didn't see them in follow up later."

Contrary to the general consensus that the vagueness of CoE EPAs was problematic, one resident suggested this vagueness could ultimately facilitate the operationalization of some EPAs.

"Sometimes when you get to the specifics of an EPA, for example, for dementia assessment, you need like one vascular, one Alzheimer's, one Lewy body … If a resident is generally good with dementia management, there's a lot of correlation between being good at vascular versus Alzheimer's versus Lewy body, et cetera, and the specific need to get each of those EPAs on target can be quite tricky, especially [since] Manitoba has a smaller catchment area."

Regarding evaluations that residents undergo during the Geriatrics program, a resident had the following to say:

"… I think there's two for Comprehensive Geriatric Assessments (CGAs), one for team meetings and one for family meetings. And some in my class found that these can be quite redundant, especially when we already have an EPA that we feel like we are already being evaluated on basically a daily basis … And these EPAs… they're almost so microscopic to the point where they're providing a day-to-day variation of how you do."

Subtheme: Setting:

The physician faculty group highlighted the importance of some EPAs encompassing different settings. One EPA that physician faculty thought should be elaborated by setting was CoE EPA 6.

"For expanding on [EPA] 6, just defining examples of transition so that, again, it's not just acute care."

Virtual care was an important setting identified by the physician faculty group in light of changes that the COVID-19 pandemic has had on the delivery of healthcare.

"I think if you just get a little bit more specific in the evaluations, that this should at least include one virtual encounter."

Theme: Wording Changes

Thoughts related to the wording of EPAs were raised by all stakeholder groups. Many of these comments were for the purposes of social accountability, congruence with language used in other specialties and clarifying expectations for residents at different stages of training.

Regarding CoE EPA 4, "assisting patients and families and clarifying the goals of care and making decisions," a patient said the following:

"[Something] I would like to see in there is that it's a little more inclusive. Many people have different definitions of family, so it doesn't necessarily have to be a son or daughter or mother. So, I would like to see that wording changed to something like significant other."

According to the physician faculty group, the three Geriatrics EPAs devoted to comprehensive Geriatric assessments (CGAs) in Transition to Discipline, Foundations and Core poorly define the mastery that residents should have with CGAs at different stages of their training.

"But the difference between *initiating* a CGA versus *performing* a CGA and *managing* older adults with CGA … that language is causing a fair amount of confusion [about] what's different between one and the other. There's some work being done to try and change the language to clearly differentiate what's different about what the trainee is doing in month one versus what we're looking for in month six…"

Theme: Interprofessional Functioning:

While comments related to interprofessional functioning were raised by the residents group, the vast majority of such comments came, unsurprisingly, from the healthcare professionals group. This feedback was invaluable and highlighted ways the EPA frameworks could be modified to optimize patient care through interprofessional collaboration. Several EPAs were identified to this end. For example, one member of the health care professionals group said,

"Reading [CoE EPA] 3 … collaborating with pharmacy – I think – is so important when talking about medication review, because to be honest … in long-term care … ninety-nine percent of the time, it's the pharmacist who is the one who's identifying all these medications."

Interestingly, multiple residents advocated that other allied health professionals be allowed to evaluate and sign-off on residents completing certain EPAs.

"I think allied health professionals should also be allowed to submit EPAs because … we're [not] dealing with physicians all the time. We're also working within a multidisciplinary team. And yet their input - I feel - would be very helpful for improving what I do on a daily basis."

Theme: Advocacy:

All stakeholder groups made remarks on the theme of patient advocacy. These thoughts were further categorized into four subthemes: Systems-based Practice, Social Contexts, Social Determinants and Transitions in Care.

The patient, manager/administrator and faculty groups all proposed an EPA be added to the CoE and Geriatrics frameworks that involves an awareness of locally available programs and resources. A representative quote comes from the administrator/manager group:

"I wonder possibly about being aware of the supports that are available to seniors… [for example], knowing what programs are in your area."

The manager/administrator, patient and healthcare professionals groups suggested that these EPA frameworks also require trainees to integrate an understanding of social contexts into their practice, particularly as it pertains to palliative care. A participant in the patient group said,

"Especially here in Manitoba, we live with a very large indigenous population… So I think cultural awareness is really, really important."

Similarly, members of the patient and faculty groups indicated that trainees should be required to demonstrate some EPAs with an understanding of the social determinants of health. Regarding CoE EPA 2, "prevent, diagnose and manage common (key) geriatric conditions," a member of the patient group said,

"Say, someone's income is very low and they're lacking housing, they may present as having a problem with their hip or something. But if they had housing, stable housing, then maybe a lot of things would be a lot better, or if they had a secure source of food."

The health care professional, manager/administrator and resident groups indicated that CoE EPA 6 could be modified to optimize the continuity of care provided by future CoE physicians. For example, a member of the administrator/manager group said,

"Those steps of transition can be real gaping holes where things are missed … If physicians can be really mindful of that and follow up and say, you were recently at the hospital, tell me what were the things they you home with? What are you using now?"

Do the EPA frameworks showcase the overlap and differences between CoE and Geriatrics?

In general, stakeholders found that the CoE and Geriatrics EPA frameworks were successful in comprehensively defining each specialty. However, when asked whether the frameworks “reflect the overlapping and complementary scopes of practice,” some members of the administrator/manager and physician faculty groups were unsure.

One member of the administrator/manager group suggested a way to make the distinction clearer to other professionals in the health care field.

“I keep picturing a chart where we have what’s the same and what’s different in the two professions, and maybe that’s an ultimate goal, but I feel like we need to compare and contrast.”

One key distinction portrayed by the CoE and Geriatrics frameworks was in regard to capability as specialists in managing complex presentations. The resident, physician faculty and healthcare professionals group all identified complexity as a hallmark of the Geriatrics framework. One example comes from the resident group:

″What I find is probably a big difference ... is maybe that level of complexity ... the utility of the core internal medicine background when managing complex comorbidities ... family physicians and probably more so rural or northern family physicians can be very well-equipped as well. But I think there′s still a difference into the level of ... how comfortable one can be into managing sometimes highly comorbid patients from the internal medicine perspective.″

Another unique role of Geriatricians identified was their role as teachers in the field. A member of the administrator/manager group had the following to say:

″Definitely the focus of the Geriatricians in [Core EPA] 11 is teaching other learners, so there is a requirement to have trainees and to have a very active role in the training of others. That′s such a core component of the work that they do. And it impacts every area of service where they work because trainees are a part of how they deliver their service.″

Ideas for Additional EPAs:

All stakeholder groups were asked, "Are there additional EPAs that you think should be included?" Their responses to this question, and the specific stakeholder group(s) they come from, are summarized below. The stakeholder feedback received could be integrated into extant EPAs or used to formulate new ones.

EPAs for both CoE and Geriatrics frameworks:

- Screen for addiction and counsel elderly patients with substance abuse disorder (patient, health care professionals and resident groups).
- Demonstrate an awareness of local programs available to elderly patients and advocate for their patient’s access to such services (administrator/manager, patient and physician faculty groups).
- Offer trauma-informed care (patient group).

- Identify elderly patients experiencing social isolation and propose appropriate solutions (healthcare professionals group).
- Offer patient care virtually (physician faculty group).
- Provide care that is inclusive to LGBTQ+ patients (patient group).
- Have discussions with patients about sexuality and intimacy (health care professionals).
- Being proficient enough in long-term care to potentially serve as a medical director at a personal care home (physician faculty).

EPAs for CoE only:

- Offer culturally competent care, especially in the setting of palliative care (physician faculty, administrator/manager, healthcare professionals and residents).
- Identify when patient presentations are beyond the scope of the physician's expertise, and consult with or refer to appropriate specialists (e.g., a Geriatrician) (residents and physician faculty groups)
- Begin discussions with patients about medical assistance in dying (MAID) (patient group).
- Offer support to patients who have experienced the loss of a loved one (patient group).
- Be aware of the social determinants of health relative to older adults (patients, physician faculty).

EPAs for Geriatrics only:

- Certify patients under the mental health act (residents).
- Draft medicolegal documents that may be used in court (residents).
- Facilitate code status discussions with patients and their family (residents)
- Educate staff on Geriatrics topics (administrator/manager).

Discussion:

We conducted a multi-stakeholder consultation to assess EPA frameworks for the CoE and Geriatrics Specialty programs. Four themes arose from the focus group meetings: Specific vs. Broad, Wording Changes, Interprofessional Functioning and Advocacy. In addition, we received feedback on each individual EPA, suggestions for additional EPAs and an assessment on how the EPA frameworks contrast the two disciplines.

Themes

Feedback coded under Specific vs. Broad and its subthemes (Operationalization and Setting) indicate that the wording and/or scope of many CoE EPAs were overly broad, while Geriatrics EPAs were too detailed. This finding represents a commonly encountered challenge in EPA development; EPAs must be delicately balanced to provide the necessary specificity to standardize training, while being "broad and flexible enough to reflect the wide range of residents' complex and unique clinical experiences." [5,18] Addressing shortcomings in this area is critical in ensuring the development of successful EPAs. For example, faculty are often hesitant to entrust residents to perform EPAs with less supervision when their wording is ambiguously broad. [19] Under the subtheme of setting, one important topic raised was the need for residents of all sorts to be trained in providing virtual care amidst the ongoing COVID-19 pandemic. Past work on the experiences of residents with virtual care highlights significant challenges due to the limitations of virtual communication with patients. [20] Future work could investigate whether training residents to use virtual care as effectively as possible could help bridge such gaps.

Stakeholders suggested changes to the wording of some EPAs. Some of these recommendations were aimed to make terminology consistent with that used by other specialties. Since language inconsistencies have been the bottleneck of introducing CBME into training program [21], unifying any language incongruencies should be of high priority. Other wording changes were aimed toward making the EPAs more inclusive to the fully diversity of patients that residents will serve throughout their careers. It has been shown that the words used by health care practitioners significantly affect how patients perceive the inclusivity of the clinical environment. [22] Therefore, EPAs should ensure that residents are trained to provide care effectively and sensitively to patients of all backgrounds and orientations. Lastly, a point raised by the physician faculty group serves as a lesson for future initiatives in EPA development. Namely, that evaluating a single skill (e.g., CGAs) at multiple stages of resident training can confuse evaluators when it comes to what is expected of residents at each stage. Future EPA frameworks ought to clearly delineate the expectations for each stage of training in situations such as these.

Although CoE EPA 8 and Geriatrics Foundations EPA 2 involve collaboration with other professionals, many comments were directed toward specific EPAs on the theme of Interprofessional Functioning. Taken together, the input received suggests that integrating interprofessional functioning into multiple EPAs may be a superior approach compared to teaching the skill as a distinct EPA. Graduating residents may not be aware of the specific contexts in which involving other health care professionals would be in the best interest of patients. Integrating interprofessional collaboration into multiple EPAs could provide the granularity necessary for residents to collaborate with other professionals when appropriate.

All participants were asked whether the two EPA frameworks properly contrasted the work of CoE physicians and Geriatricians. A common impression among stakeholders was that the Geriatrics EPAs appropriately characterize Geriatricians as physicians who are better able to manage elderly patients with greater co-morbidity and complex presentations. However, other comments showcase persisting confusion about the overlap and distinctions between CoE physicians and Geriatricians. Surprisingly, this uncertainty was expressed by even the physician faculty and administrator/manager groups. As the number of CoE physicians increases in the coming years, educational campaigns and messaging will be important to help inform all healthcare professionals about these two similar yet distinct disciplines.

Contributions of Stakeholder Groups

The unique yet overlapping contributions of the stakeholder groups shed light on what roles different stakeholders may be able to play in the validation of EPA frameworks.

The faculty, resident and administrator/manager group made comments regarding EPA scope (i.e., Specific vs. Broad). The only stakeholder group to bring forward setting-related concerns was the faculty group. Therefore, the development of EPAs that comprehensively assess residents on their performance in different clinical contexts might depend on a thorough consultation of appropriate faculty members. Thoughts on how EPAs would be operationalized only surfaced during the faculty and resident groups. Since the educational and clinical practicalities of EPAs most directly affect residents and their preceptors, it is unsurprising that these stakeholders are most apt to comment on EPA operationalization. For example, resident focus groups have brought attention to instances where EPAs have worsened workloads and compromised educational experiences. [23] The only comment on the theme of Specific vs. Broad that came from the administrator/manager group was a neutral statement recognizing the broadness of the CoE EPAs' descriptions. Overall, then, the faculty and resident groups were the primary stakeholder groups able to provide insight into how the scope of various EPAs could be improved.

As previously mentioned, all stakeholder groups touched on the theme of patient advocacy. Of note, there was significant overlap between the subthemes of advocacy that the stakeholder groups touched on. In other words, no subtheme was exclusive to a specific stakeholder group. However, there were differences

in the emphasis that stakeholder groups placed on each subtheme and patient advocacy as a whole. By far, the most attention to advocacy-related themes was given by the patient group. The patient group's contributions were unique in this area. Participants shared many stories and examples of how physicians can offer suboptimal care by failing to identify important patient characteristics and circumstances. Our findings corroborate earlier work which found patient feedback on EPAs to be complementary to that of physicians but provide many unique details on trainee expectations. [13] Therefore, future efforts in EPA development should not depend on other stakeholder groups (e.g., faculty) to adequately represent the expectations patients have of soon-to-be practicing physicians.

Limitations & Strengths

It is important to consider some noteworthy limitations of the methods used in this study. First, focus group studies are traditionally limited by self-response and social desirability bias. [24] Ensuring each focus group is homogenously composed of only one stakeholder group partially reduced the effects of social desirability bias (e.g., compared to having residents and physician faculty participate in the same focus groups). Second, "errors of omission" (i.e., participants having ideas that they would like to have shared but were not triggered by reading the items on a list) can occur when participants are tasked with giving feedback on a list of EPAs. [12] In addition, we may have been unable to meet thematic saturation due to the limited sample size of each stakeholder group. For example, El-Haddad et al. found that thematic saturation was achieved when assessing an EPA framework with the participation of fourteen patients in focus groups. [13] In comparison, our patient focus group consisted of 7 participants. Our administrator/manager group was the lowest, at four participants. Also of concern, the representation of Geriatricians was significantly greater than that of CoE physicians - being six to one, respectively.

However, the suboptimal sample sizes of each stakeholder group may have been offset by the breadth of stakeholder groups consulted, consisting of 30 total participants. The feedback received was diverse and will be pivotal in revising the EPA framework to be clearer, and more effective, patient-centred, collaborative, and socially accountable. The quality of the feedback received through these focus groups is attributed to the unique perspectives and values each stakeholder group offered.

Recommendations

In the future, residency programs would strongly benefit from consulting physician faculty, residents, health care professionals, administrators/managers and patients in the development of their EPA frameworks. We suggest that this consultation occurs early in the process before EPAs are implemented, but after faculty have finished developing a draft of EPAs. Frequent revisions to existing frameworks can cause "change fatigue" in the context of medical education. [25] In addition, CoE and Geriatrics residency programs could also enhance their programs by considering the numerous suggestions our stakeholders made for EPA modifications and additions. Lastly, future research could evaluate whether EPAs refined by multiple stakeholders affect the experiences of faculty and residents and the quality of care that patients receive.

Tables:

Table 1. Demographic Composition of Stakeholder Focus Groups

Stakeholder Group	Group Composition
Physician Faculty	6 Geriatricians 1 CoE Physician

Current Trainees	2 Geriatrics Trainees (in-province) 2 Geriatrics Trainees (out-of-province) 1 CoE Trainee (in-province)
Non-physician health care professionals	4 Physiotherapists 1 Psychiatric Nurse 2 Registered Nurses
Administrators and Managers	2 Managers 2 Administrators
Patients	6 Patients 1 Family Member

Table 2. Stakeholder Feedback Regarding Ten Care of the Elderly Entrustable Professional Activities.

EPA number	EPA Title	Results
1.	Provide patient-centered care of the older adult that optimizes function and/or well-being.	- Agreement that the scope of this EPA is too broad. - EPA 1 could possibly be removed - Comprehensive Geriatric Assessment should be included in the title due to its significance. - Team-based care (particularly involving Occupational Therapists and/or Physiotherapists) should be emphasized to improve function and well-being for patients.
2.	Prevent, diagnose and manage common (key) geriatric conditions.	- EPA2 may be redundant, having been largely taught during core family medicine residency. - "Geriatric conditions" could be replaced with "geriatric syndromes" to be congruent with the RCPSC Geriatrics program EPAs. - Difficulties operationalizing EPA 2 were expected. Separating "assessing cognition" and "managing dementia" into two separate EPAs was suggested. - EPA2 should be evaluated in multiple settings, including long-term care. - Trainees ought to also recognize how social determinants of health are implicated in the prevention, diagnosis and management of key geriatric syndromes. - EPA2 should also include evaluating loneliness and social health.
3.	Provide comprehensive medication review to maximize benefit and minimize number of	- Trainees should also be able to communicate to patients the reasons they are taking each medication and ensure that the patient is able to take their medication.

	medications and adverse events.	- EPA 3 should also include counselling patients on the appropriate use of natural health products and their drug interactions. - EPA 3 should require trainees to work with allied health professionals and/or family members to ensure medications are being taken consistently and properly. - Trainees should learn to collaborate with pharmacists when doing medication reviews.
4.	Assist patients and families in clarifying goals of care and making care decisions.	- Healthcare professionals group strongly endorsed this EPA. - EPA4 should ensure trainees can give realistic expectations regarding prognosis to patients early in their care. - This EPA should be made inclusive to patients who have non-family members as the primary collaborators in the patient's care.
5.	Provide palliative and end-of-life care for older adults.	- This EPA should also include coordinating palliative care in a culturally appropriate way (e.g., integrating traditional healing practices). - Arranging medical assistance in dying (MAID) should fall under the responsibilities of Geriatricians, but CoE physicians should mention it as an option for patients when appropriate. - This EPA should be evaluated across multiple settings, including long-term care.
6.	Coordinate healthcare and healthcare transitions for older adults with multi-morbidity and multiple providers.	- Healthcare professionals group strongly endorsed this EPA. - CoE physicians should be trained to follow up with patients after being discharged to ensure medications are appropriate while living at home. - Residents group had concerns expressed over how EPA 6 would be evaluated. For example, residents have experienced difficulties obtaining feedback from preceptors on discharge summaries. - Facilitating transitions is a significant part of the family medicine program and, therefore, EPA6 may be redundant. - This EPA should be elaborated to specify examples of transition such that the EPA is not limited to acute care.
7.	Provide geriatric consultation and co-management.	- EPA 7 should be evaluated in both in- and outpatient settings, including long-term care and virtual care.
8.	Collaborate and work effectively as a leader or member of an inter-professional healthcare team.	- Healthcare professionals group appreciated this EPA. - EPA8 could be merged with EPA1, so that physicians work with other professionals to optimize patient well-being.
9.	Advance the quality and safety of health care for the elderly through the application of quality	- Administrator/manager group supported this EPA considerably. - EPA9 may be redundant, as participating in quality improvement is part of core family medicine residency. - EPA9 may not be feasible in a one-year program.

	improvement and/or research.	- Physician faculty found quality improvement important, particularly in its ability to help prevent burnout. Being required to do a "small project" in quality improvement was suggested. - This EPA should be broadened to include other non-research-related academic activities. - EPA 9 could include contributing to the development/revisions of health policy.
10.	Teach the principles of care of the elderly and aging-related health care issues to health professionals, patients, families, health care providers and others in the community.	- Patient group widely agreed that EPA 10 is important in the "professional development of any kind of doctor."

Table 3. Stakeholder Feedback Regarding Entrustable Professional Activities for the RCPSC Geriatrics Specialty Program. All EPAs that did not receive specific feedback are excluded. EPAs were abbreviated as: TD = Transition to Discipline, F = Foundations, C = Core, TP = Transition to Practice, SA = Special Assessment. All EPAs are mandatory with the exception of TP3.

EPA number	EPA Title	Results
TD1	Initiating a comprehensive geriatric assessment (CGA) and identifying common geriatric syndromes	- Expectations for *initiating* a CGA early in the program should be clearly distinguished from *performing* (F1) and *managing* a patient (C1) with CGA
TD2	Assessing and proposing management for older adults with common Internal Medicine conditions	- TD2 is worded vaguely and may not be necessary.
F2	Diagnosing and managing older patients with common medical conditions	- F2 may be redundant due to other EPAs that focus on diagnosis and management.
F3	Assessing, diagnosing and managing common neuro-cognitive disorders with typical presentations	- Management of neuro-cognitive conditions should involve collaboration with other specialists and allied health professionals. - Strongly recommended that residents not be expected to communicate these diagnoses until the Core block of training. Instead, they should be learning this skill by observation at this point.

F6	Assessing and managing patients with a fall risk	- The patient group found this EPA important. - Geriatricians should involve physiotherapists and occupational therapists a patient's recovery and prevention of future falls. - Trainees should be able to counsel patients on non-pharmacological prevention of falls (e.g., fall mats, food and lifestyle changes). - Can require knowledge of how social determinants of health affect fall risk.
C1	Managing older adults with functional decline using comprehensive geriatric assessment (CGA)	- Similar to TD2, expectations during Core surrounding skill-level with CGAs should be better defined.
C3	Determining patients' capacity for decision-making	- Geriatricians should also be able to advocate for patients and educate colleagues in matters relating to patient capacity for decision making.
C4	Assessing and managing patients with complex and/or uncommon neuro-cognitive presentations	- Requirements for completing this EPA should take into account the high degree of overlap between assessing and managing these conditions. Requiring residents to demonstrate this EPA for each of the conditions listed may be redundant.
C5	Assessing and managing behavioural and psychological symptoms of dementia (BPSD)	- Physician faculty agreed that the management of BPSD and other complex presentations should be expected during Core and not earlier.
C6	Preventing and managing delirium	- Instead of dividing delirium between F4 and C6, delirium could be covered solely in Foundations for simplicity. A similar approach could be taken for other simpler conditions/presentations.
C9	Assessing and managing complex psycho-social issues unique to vulnerable older adults	- The patient group appreciated cultural competency being part of this EPA and suggested that it be part of a CoE EPA as well.
C10	Running family and team meetings	- C10 should be inclusive to patients who have non-family individuals as the primary collaborators in a patient's care. - This EPA may not be necessary, as other health care professionals are frequently the leaders of team meetings.
C11	Teaching other learners	- This EPA is particularly important to the work of Geriatricians – even more so than for CoE physicians.
TP1	Managing the Geriatrician's Practice	- There is confusion surrounding how TP1 should be taught and evaluated given the many settings Geriatricians practice in. Residents are also currently not being given protected time for this EPA.
TP2	Contributing to the improvement of health care delivery for older	- TP2 reflects the role Geriatricians frequently have in health care teams.

	people in teams, organizations, and systems	
TP3	Planning and completing personalized training experiences aligned with career plans and/or specific learning needs	- Confusion about what this EPA means. - Skepticism about how many trainees truly do this elective EPA.
SA1	Developing and implementing a continuing personal development plan geared to setting of future practice	- The physician faculty group had significant concern about SA1. There was confusion about how residency programs should help students accomplish this EPA. - This EPA could be replaced by providing a package of resources to help graduates adapt to practice and plan their next career steps.
SA2	Advancing Geriatric Medicine through scholarly work	- SA2 is appropriate because Geriatricians are commonly involved in scholarly work.

REFERENCES

1. Van Melle E, Hall AK, Schumacher DJ, et al. Capturing outcomes of competency-based medical education: The call and the challenge. *Med Teach*. 2021;43(7):794-800. doi:10.1080/0142159X.2021.1925640
2. Ten Cate O, Balmer DF, Caretta-Weyer H, Hatala R, Hennus MP, West DC. Entrustable Professional Activities and Entrustment Decision Making: A Development and Research Agenda for the Next Decade. *Acad Med*. 2021;96(7):S96-S104. doi:10.1097/ACM.0000000000004106
3. Ten Cate O, Schwartz A, Chen HC. Assessing Trainees and Making Entrustment Decisions: On the Nature and Use of Entrustment-Supervision Scales. *Acad Med*. 2020;95(11):1662-1669. doi:10.1097/ACM.0000000000003427
4. Ten Cate O. AM Last Page: What entrustable professional activities add to a competency-based curriculum. *Acad Med*. 2014;89(4):691. doi:10.1097/ACM.0000000000000161
5. Van Loon KA, Driessen EW, Teunissen PW, Scheele F. Experiences with EPAs, potential benefits and pitfalls. *Med Teach*. 2014;36(8):698-702. doi:10.3109/0142159X.2014.909588
6. Lohenry KC, Brenneman A, Goldgar C, et al. Entrustable professional activities: A new direction for PA education? *J Physician Assist Educ*. 2017;28(1):33-40. doi:10.1097/JPA.0000000000000105
7. Ten Cate O, Carraccio C, Damodaran A, et al. Entrustment Decision Making: Extending Miller's Pyramid. *Acad Med*. 2021;96(2):199-204. doi:10.1097/ACM.0000000000003800
8. Ten Cate O, Scheele F, Ten Cate TJ. Viewpoint: Competency-based postgraduate training: Can we bridge the gap between theory and clinical practice? *Acad Med*. 2007;82(6):542-547. doi:10.1097/ACM.0b013e31805559c7
9. Bryson J, Humphrey HH, Affairs P. What to do when stakeholders matter : A guide to stakeholder identification and analysis techniques What To Do When Stakeholders Matter : A Guide to Stakeholder Identification and Analysis Techniques By University of Minnesota Visiting Professor for 2002-. 2016;(January 2004).
10. Graham MJ, Naqvi Z, Encandela JA, et al. What indicates competency in systems based practice? An analysis of perspective consistency among healthcare team members. *Adv Heal Sci Educ*. 2009;14(2):187-203. doi:10.1007/s10459-008-9106-6
11. Boelen C. *Towards Unity for Health : Challenges and Opportunities for Partnership in Health Development : A Working Paper*.; 2000.
12. Smith CS, Morris M, Francovich C, et al. A multisite, multistakeholder validation of the accreditation council for graduate medical education competencies. *Acad Med*. 2013;88(7):997-1001. doi:10.1097/ACM.0b013e3182951efc
13. El-Haddad C, Damodaran A, McNeil HP, Hu W. A Patient-Centered Approach to

Developing Entrustable Professional Activities. *Acad Med*. 2017;92(6):800-808. doi:10.1097/ACM.0000000000001616

14. Bramley AL, McKenna L. Entrustable professional activities in entry-level health professional education: A scoping review. *Med Educ Rev*. 2021;55(9):1011-1032. doi:https://doi-org.uml.idm.oclc.org/10.1111/medu.14539
15. Hall J, Aalamian A, Akil B, et al. *Residency Training Profile for Family Medicine and Enhanced Skills Programs Leading to Certificates of Added Competence*.; 2021. https://www.cfpc.ca/CFPC/media/Resources/Education/Residency-Training-Profile-ENG.pdf
16. The Royal College of Physicians and Surgeons of Canada. *Objectives of Training in the Subspecialty of Geriatric Medicine*. Vol 322.; 2001. doi:10.1136/bmj.322.7278.86
17. The Royal College of Physicians and Surgeons of Canada. *Entrustable Professional Activity Guide: Geriatric Medicine*.; 2018.
18. Martin L, Sibbald M, Brandt Vegas D, Russell D, Govaerts M. The impact of entrustment assessments on feedback and learning: Trainee perspectives. *Med Educ*. 2020;54(4):328-336. doi:10.1111/medu.14047
19. Emke AR, Park YS, Srinivasan S, Tekian A. Workplace-Based Assessments Using Pediatric Critical Care Entrustable Professional Activities. *J Grad Med Educ*. 2019;11(4):430-438. doi:10.4300/JGME-D-18-01006.1
20. Smith N, Newton C, Barbacuta D, Tseng OL-I. An unexpected transition to virtual care: family medicine residents' experience during the COVID-19 panfile:///Users/derekfisk/Desktop/Virtual Care.pdfdemic. *BMC Prim Care*. 2022;23(1):1-9. doi:10.1186/s12875-022-01728-5
21. Englander R, Frank JR, Carraccio C, Sherbino J, Ross S, Snell L. Toward a shared language for competency-based medical education. *Med Teach*. 2017;39(6):582-587. doi:10.1080/0142159X.2017.1315066
22. Shetty G, Sehovic I, Green BL, Schabath MB, Ph D. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) Perceptions and Health Care Experiences. *J Gay Lesbian Soc*. 2019;27(2). doi:10.1080/10538720.2015.1022273.Lesbian
23. Branfield Day L, Miles A, Ginsburg S, Melvin L. Resident Perceptions of Assessment and Feedback in Competency-Based Medical Education: A Focus Group Study of One Internal Medicine Residency Program. *Acad Med*. 2020;95(11):1712-1717. doi:10.1097/ACM.0000000000003315
24. Sheth M, Woods RW, Slanetz PJ, Klein K, Fornari A, Lewis P. Development of Breast Imaging Speci fi c Entrustable Professional Technique. *Acad Radiol*. 2019;26(5):591-596. doi:10.1016/j.acra.2018.10.023
25. Marty AP, Schmelzer S, Thomasin RA, et al. Agreement between trainees and supervisors on first-year entrustable professional activities for anaesthesia training. *Br J Anaesth*. 2020;125(1):98-103. doi:10.1016/j.bja.2020.04.009