American Board of Surgery

Frequently Asked Questions about EPAs

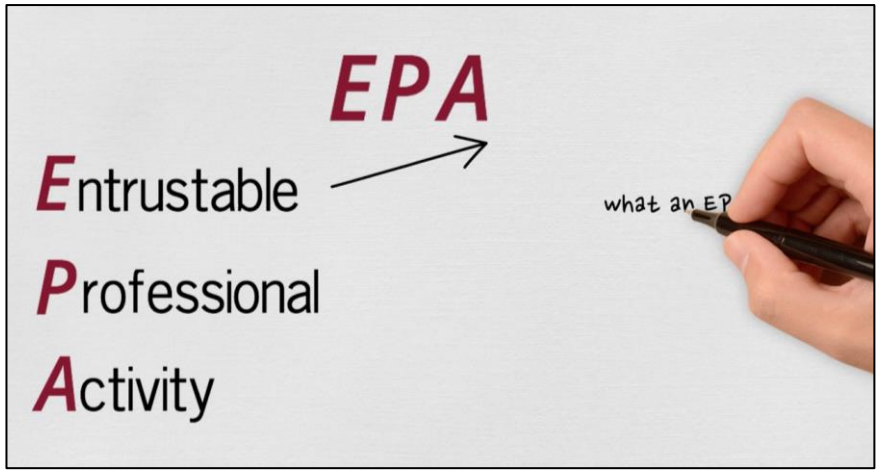
Updated April 2024

Why are EPAs being implemented? Because EPAs..

- Prioritize demonstrated competence as the outcome of training
- Create an efficient model for frequent formative feedback focused on progressive autonomy
- Establish a clinically relevant and relatable mechanism for assessment of resident competence
- May help mitigate assessment bias by anchoring assessment on discretely observed behaviors in daily clinical workflow
- Provide a common mental model for trainees and faculty for core training outcomes

What are the characteristics of an EPA? An EPA…

- Tool for competency-based medical education (CBME)
- Is part of regular clinical work of a surgeon
- Units of professional practice (tasks) that may be entrusted to a learner to execute unsupervised, once they have demonstrated the required competence
- Can be directly observed
- Involves the use of relevant knowledge, skills, and behaviors
- Enables a shift of focus from individual competencies to the work that must be done
- In conglomerate can define the core scope of a specialty



- Turns the equation to a partnership between learner and evaluator
  - Places emphasis on learner to seek out the evaluation opportunity
  - Asking evaluator to assess TRUST, changes the frame and conversation
  - Provide clear anchors for evaluator (as part of workflow) that are meaningful and substantial

How are EPAs observed and evaluated?

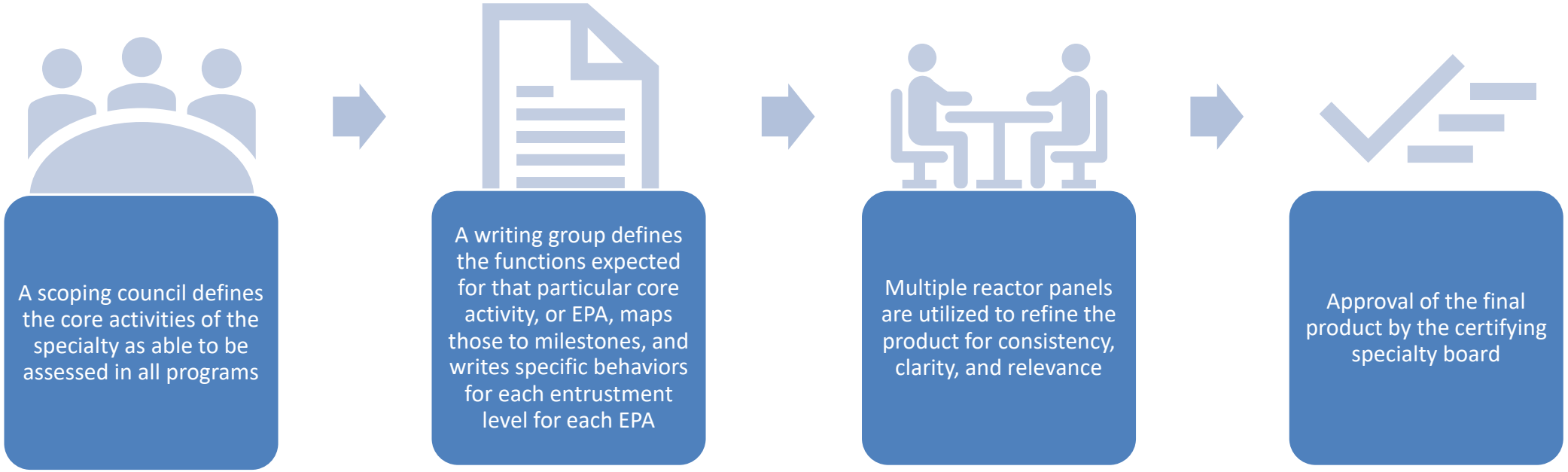
Entrustment Level	Framework
Limited Participation Knows information, has very basic skills	What a learner directly out of medical school should know. Attending can show and tell.
Direct Supervision Knows the steps of the task/operation but requires direction in executing, does not understand nuances of a basic case	The learner can use the tools but may not know exactly what, where or how to do it. Attending gives active help through the case to maintain forward progression.
Indirect Supervision Can do straightforward tasks/operations but will not recognize more complex variations, does not understand nuances of an advanced case	The learner can perform the task or operation in straightforward circumstances. Attending gives passive help. This may be while scrubbed for more complex cases or a check in for more routine cases.
Practice Ready Can manage more complex operations and take care of most cases	Can treat all patients with straightforward disease and has a strong understanding of surgical options and technique for less common scenarios. Attending is available at the request of the learner but not routinely needed for common presentations, though input may be needed for more complex presentations.

Example: Evaluate and manage a patient with gallbladder disease

Intra-Operative Phase

1	Limited Participation	Describes anatomic boundaries of hepatocystic triangle Difficulty coordinating hands to accomplish dissection of normal planes Can identify normal anatomic structures
2	Direct Supervision	Articulates critical view of safety but cannot reliably obtain it in the OR Sometimes does not use both hands in a coordinated manner, often tentative Removes gallbladder from liver bed with minimal assistance
3	Indirect Supervision	Obtains critical view of safety in routine cases Smooth instrument handling with effective use of both hands Performs cholangiography in straightforward cases
4	Practice Ready	Performs cholecystectomy and cholangiography in essentially all patients Recognizes when deviation from initial operative plan indicated Smooth movements but may lack economy of motion in difficult cases

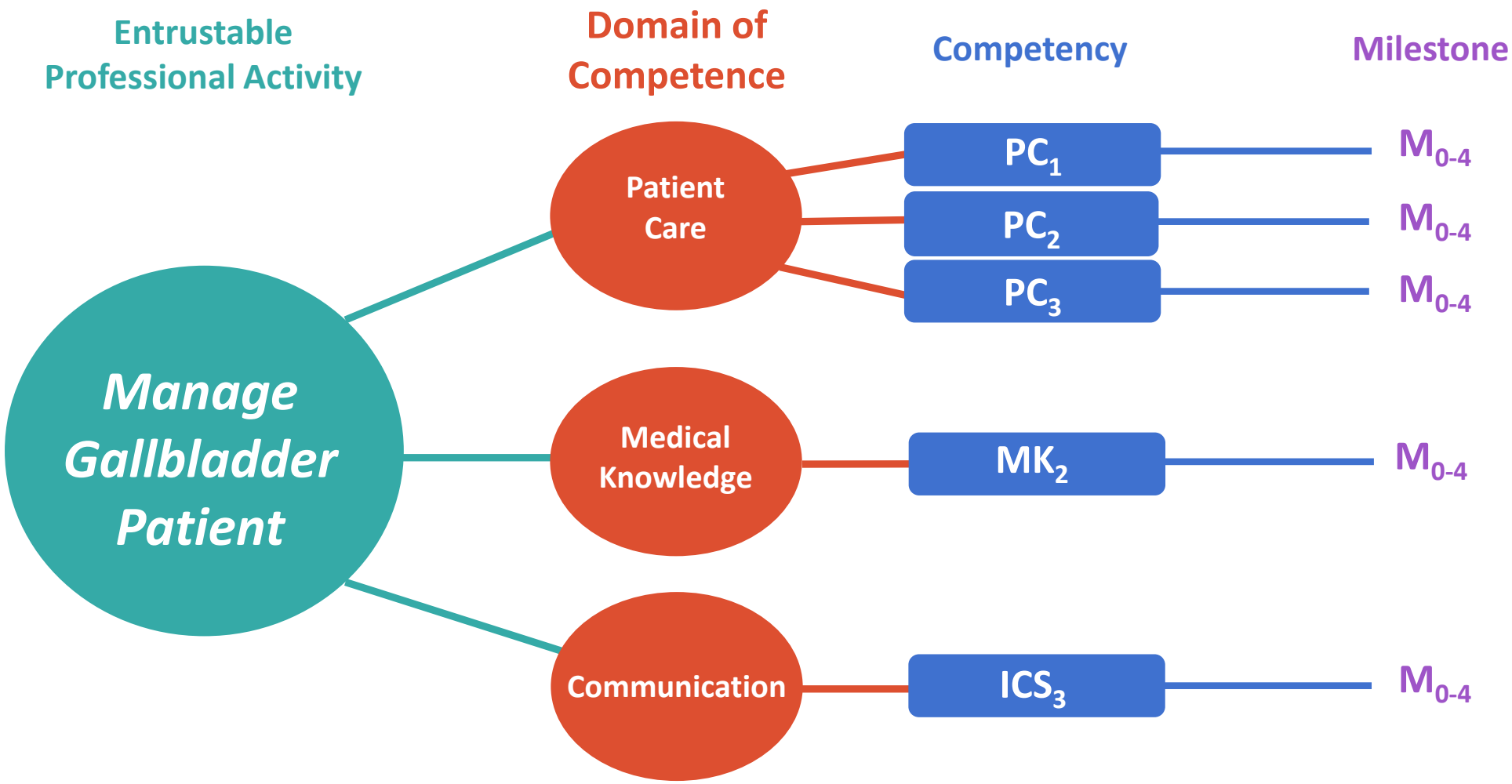
How are EPAs developed?



Do EPAs replace milestones and competencies?

- No; EPAs provide a means of assessing a trainee's progress towards autonomy and full entrustment in relevant clinical workflow contexts that reflect competence
- EPAs can be mapped to sub-competencies to inform milestones assessments by CCC's
- Programs should continue to use other assessments, particularly for sub-competencies that aren't easily observed in clinical workflow, and in line with RRC requirements

EPAs Incorporate and Reflect Competencies and Milestones



What are the general surgery EPAs?

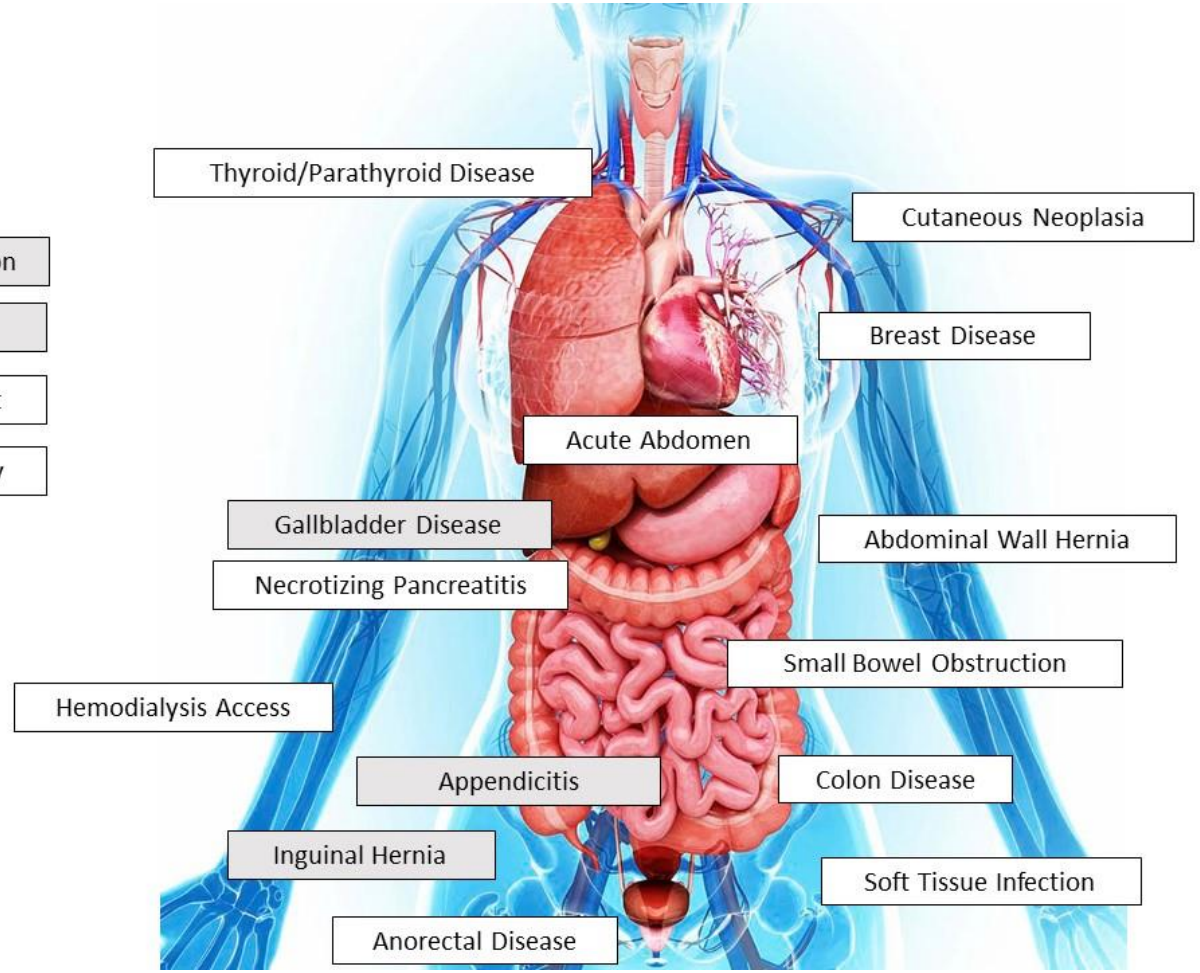
- Collectively, these are meant to define the core of the specialty as able to be assessed in all training programs
- Those in gray background were evaluated in pilot study 2018-20

Surgical Consultation

Trauma

Critically Ill Patient

Flexible Endoscopy



What are the vascular surgery EPAs?

1. Cerebrovascular disease
2. Dialysis access
3. Traumatic / iatrogenic vascular injury
4. Peripheral arterial aneurysm
5. Claudication
6. Chronic limb-threatening ischemia
7. Acute limb ischemia
8. Amputation
9. Chronic venous disease
10. Acute thromboembolic venous disease
11. Asymptomatic aortoiliac aneurysm
12. Symptomatic / ruptured aortoiliac aneurysm
13. Chronic mesenteric ischemia
14. Acute mesenteric ischemia
15. Type B Aortic Dissection

What about EPAs for the other ABS specialties?

- All ABS specialty boards are in the process of developing EPAs for their own specialty area.
- **Vascular Surgery Board:** 15 EPAs
  - Launching fall 2024
- **Pediatric Surgery Board:** 20 EPAs (19 required, 1 optional)
  - Planned launch summer/fall 2025
- **Trauma, Burns, and Surgical Critical Care Board:** 13 EPAs (9 required, 4 optional)
  - Planned launch summer/fall 2025
- **Complex General Surgical Oncology Board:** 12 EPAs
  - Planned launch summer/fall 2025

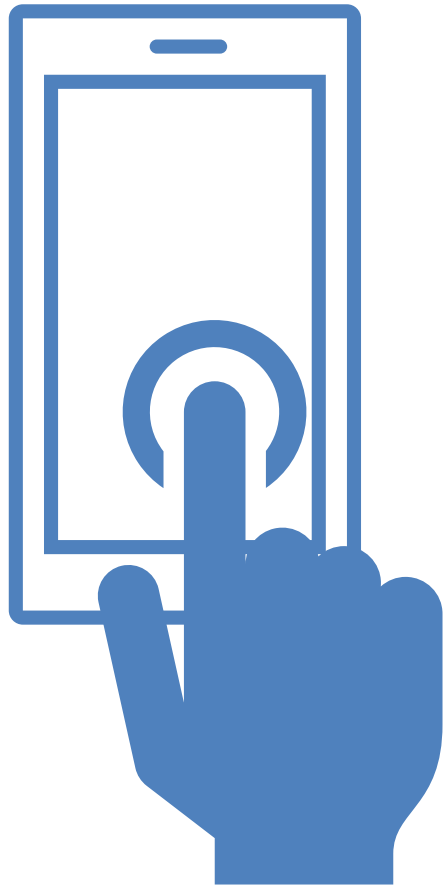
What about the mobile app?

How will trainees be assessed on EPAs?

- A mobile app is available to programs free of charge (sponsored by the ABS)
- Involves 4 possible entrustment levels, defined as the level of entrustment which would be granted to the trainee the next time based on what was just witnessed
- Involves multiple phases of care (e.g., preop, intraop, postop)

What does the app do?

- Utilizes drop down menus and behavioral anchors to allow efficient assessment
- Allows for additional narrative feedback via dictation or typing function
- Includes analytics for residents, faculty, CCC's, and program leadership to review



Can my program use an alternative collection method?

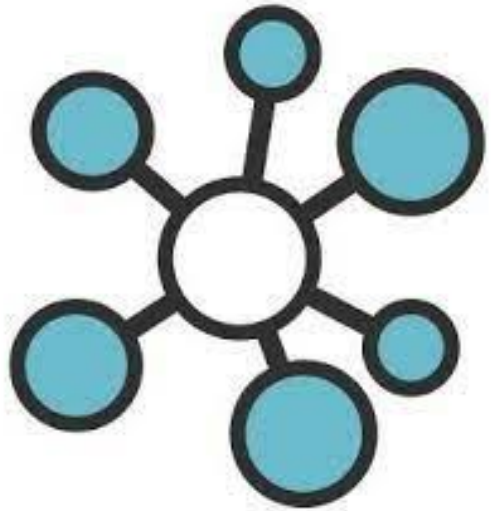
- Yes; programs may use whatever collection method they so choose
  - Programs will need to collect data via locally available electronic or other methods
    - EPA content has been published on the ABS website so that programs can create their own collection tool if necessary
- Trainees from programs so affected will still be required to turn in a composite EPA performance profile when they apply to take any written ABS initial certification examination (beginning with the 2028 GSQE or 2029 VSQE)

How will data be housed and processed?

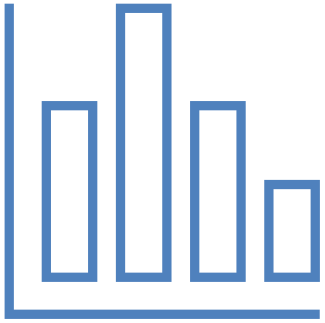
- The SIMPL Collaborative, as the app developer, provides secure data storage stakeholder-specific dashboards for trainees, program directors, faculty, and residency administrators
- The ABS does not have identified data until trainees turn in their composite EPA profile as a requirement for application to any written ABS initial certification examination (beginning with the 2028 GSQE and 2029 VSQE)

How will the ABS EPA app relate to the SIMPL OR operative assessment tool some programs are already using on a subscription model?

- The ABS EPA app can be accessed on a mobile device
  via the SIMPL app
- The ABS EPA app is being provided to all programs at the ABS's expense
  - This does not include the subscription service offered by the SIMPL Collaborative for the SIMPL OR operative assessment or any other subscription model products
  - Programs can choose to subscribe to these offerings separately with the SIMPL Collaborative



How will the data be useful to programs, trainees, and faculty?



Trainees will receive frequent formative feedback and behaviorally anchored data defining specific ways they can progress toward autonomous capability

Faculty will be able to see the entrustment profile of trainees they have not worked with recently to inform decisions on real time entrustment

CCC's will have multiple data points based on direct observation, in temporal proximity to the performance observed, across nearly all milestones to factor into summative CCC decision making

Program directors will have compiled data over the entire course of training on which to found attestations required at the completion of training

How will the ABS evaluate the adoption, impact and quality of this initiative?

- The ABS will monitor deidentified overall usage and engagement data by program
- The ABS will identify best practice models, and provide resources to programs struggling with implementation
- The ABS Research Committee has developed a research agenda
  - This committee will also review proposals to allow substantiation, refinement and critical review of the EPA model to guide future improvements and modifications

What does the ABS expect of programs regarding use of the EPA model?

- **ABS Exam Application:** All applicants to written ABS initial certification examinations **will be required** to turn in a composite profile across all EPAs when they apply for the exam
  - **General Surgery:** Beginning with the 2028 GSQE
  - **Vascular Surgery:** Beginning with the 2029 VSQE
  - **Other ABS specialties:** TBD
- **Every trainee should be assessed on every rotation**
- **All faculty should be trained to function as assessors** to promote reliability and validity of the assessment

How does the roll out of EPAs affect trainees other than those who will be applying to take the ABS GSQE in 2028 or VSQE in 2029?

- While the requirement for an EPA profile as part of the ABS QE application process will not occur until 2028 (general surgery) and 2029 (vascular surgery), **use of EPAs for trainees at all PGY-levels is strongly encouraged as a best practice strategy** to promote consistent habits of meaningful assessment and feedback, and to provide other assessment economies

- Beginning with the 2024 GSQE, to decrease administrative burden and in recognition of the changing educational environment in those programs who have already adopted EPAs:
  - PGY-5 residents who have been assessed using EPAs are not required to have completed the 6 operative and 6 clinical assessments that are required as part of the GSQE application
  - Current residents from U.S. programs who are actively engaged in EPAs (actively collecting assessments) are not required to complete the GME section of the application
  - Residents from programs who are not actively engaged in EPAs (have not collected any assessments), residents from Canadian programs, and residents who completed training prior to 2024 but did not apply to the GSQE previously will still be required to complete the GME section of the application

Specifically, are there requirements or recommendations for the number and distribution of assessments?

- Early data suggests 5-10 EPA microassessments may provide a foundation for CCC decision-making regarding entrustability for a given subcompetency domain
- A minimum of at least 2 EPA evaluations per week for each general surgery resident would provide approximately 50 evaluations/resident over 6 months to inform CCC meetings, and 500 data points over the course of training (in a five-year general surgery residency program)
- All EPAs should be mapped into program rotation structure
  - E.g., for general surgery, evaluate thyroid/parathyroid EPA during endocrine surgery rotation, consult EPA can essentially be evaluated during all rotations

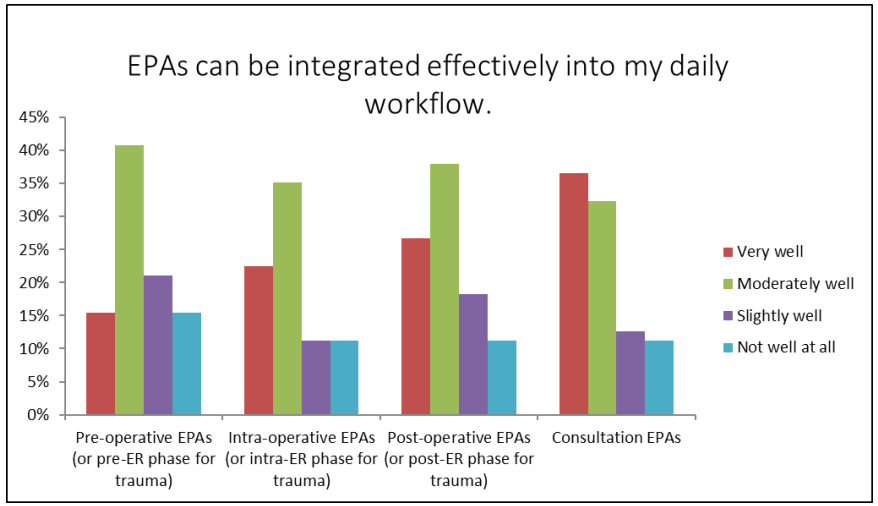
Will trainees be required to achieve autonomy in all of their specialty's EPAs in order to sit for their ABS exams?

- Yes, that is the goal for the core elements of the specialty in a competency-based model
- The EPA model should be seen as a continuous quality improvement strategy for the developing trainee; it charts a journey with frequent waypoints and doesn't just define the endpoint
  - A single assessment of competency will not be sufficient
- The specialty boards of the ABS will monitor progress and collective performance with EPAs over the next several years to further inform acceptable performance endpoints

Faculty are busy; what do EPAs accomplish to relieve rather than impose faculty and program burden?

- EPA use will allow elimination or attenuation of other assessment structures that are not based on immediate assessment of directly observed performance
- By engaging with EPAs, programs will readily accomplish a number of RRC and ACGME program requirements, including those related to meaningful trainee assessment and faculty development
- EPAs will make CCC discussions more efficient and grounded

Faculty Survey



- EPAs can be completed in 1-2 minutes or less on a mobile device and are efficient for faculty workflow
- Most faculty will only use 2-4 EPAs regularly as determined by their clinical practice activities

What are specific examples of faculty assessment burden that EPAs could help improve?

- General surgery programs actively utilizing EPAs:
  - Can **eliminate the ABS requirement of 6 operative and 6 clinical assessments** over the course of training
  - Will be able to provide a "global attestation" for approval of all trainees' written exam applications, as opposed to individual approvals for each resident
  - Will **not be required to complete GAGES evaluations** as part of the FEC requirement (due to use of Flexible Endoscopy EPA)
- Some programs have **significantly shortened their end of rotation evaluations to 2-5 focused questions**, given the breadth of data EPAs will have already covered
- Some programs noted **CCC meetings were shortened by 50-75%** when the discussions were informed by EPA frequent micro-assessment data

Can trainees complete EPAs on more junior trainees?

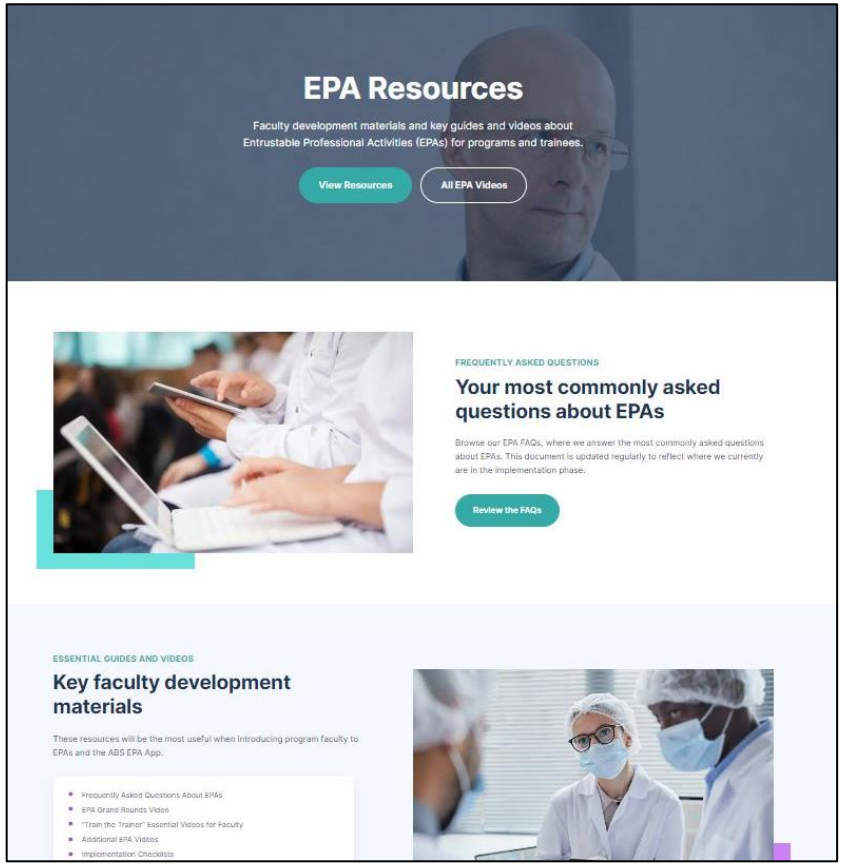
- ***Trainees may not function as a substitute for faculty in completing EPAs***
- Chief residents and senior fellows (general or vascular surgery) who have participated in EPA training and faculty development and have themselves been entrusted at the highest levels may complete EPAs on more junior residents to provide feedback IN ADDITION to that provided by the faculty member

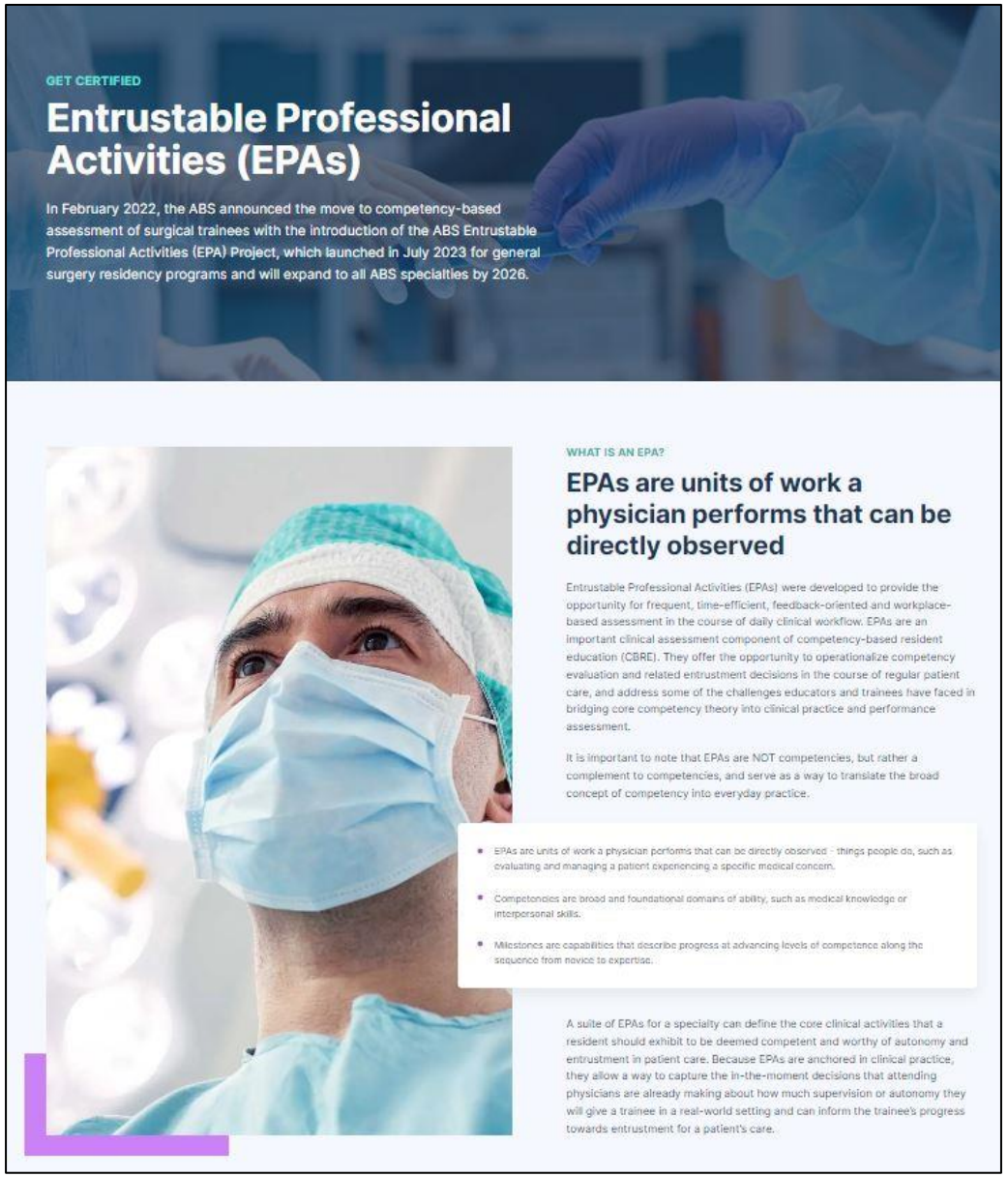
Who else besides surgical faculty and chief residents could complete an EPA assessment?

- Some programs have recruited hospitalists or emergency room physicians to complete EPAs for performances they are more likely to witness than a surgical faculty member might be; such faculty should be developed to perform the assessments similar to the surgical faculty
  - E.g., completion of a consult, or resuscitation of a nonoperative trauma patient
- APPs can complete EPAs if they have participated in EPA faculty development programs and are assessing behaviors they are entrusted to perform independently themselves
  - E.g., in general surgery, performing a consult or arranging a discharge for a postoperative patient

How will programs develop faculty and trainees for use of the EPAs?

- Engagement opportunities already available include recorded and ongoing webinars and townhalls, and participation in the ABS EPA Program Champions initiative
  - Become an ABS EPA Program Champion
  - Upcoming & Past ABS EPA Events
- The ABS has developed additional materials to prepare programs, faculty, and residents for implementation, including checklists, timelines, videos, train the trainer courses, and more
  - ABS EPA Resources





Questions?

Contact us at epas@absurgery.org

Don't forget to check out the new EPA section of the ABS website!