


# Workplace-Based Assessment in Psychiatry

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DONALD AND BARBARA  
ZUCKER SCHOOL *of* MEDICINE  
AT HOFSTRA/NORTHWELL

# Disclosures

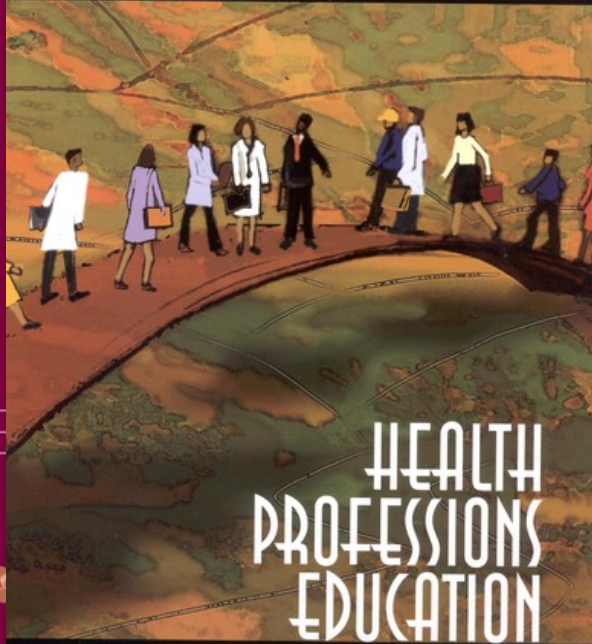
- None (  )

# Agenda

- Rationale – Outcomes Based Education
- Competency-Based Assessment – System's Approach
- Entrustable Professional Activities
- Workplace-Based Assessment



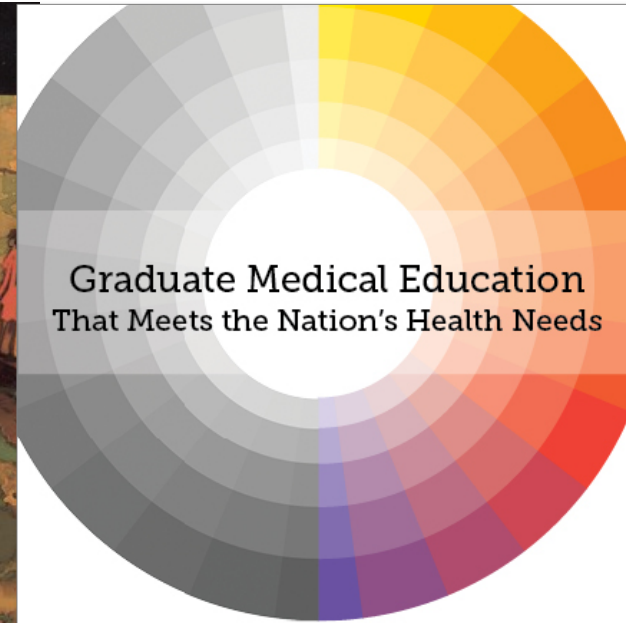
QUALITY CHASM SERIES



# HEALTH PROFESSIONS EDUCATION

A BRIDGE TO QUALITY

INSTITUTE OF MEDICINE  
OF THE NATIONAL ACADEMIES



## Graduate Medical Education That Meets the Nation's Health Needs

INSTITUTE OF MEDICINE  
OF THE NATIONAL ACADEMIES



### CLER PATHWAYS TO EXCELLENCE

Expectations for an optimal clinical  
learning environment to achieve safe  
and high quality patient care

Version 1.1



## Teaching for Quality

Integrating Quality Improvement and Patient Safety Across the  
Continuum of Medical Education

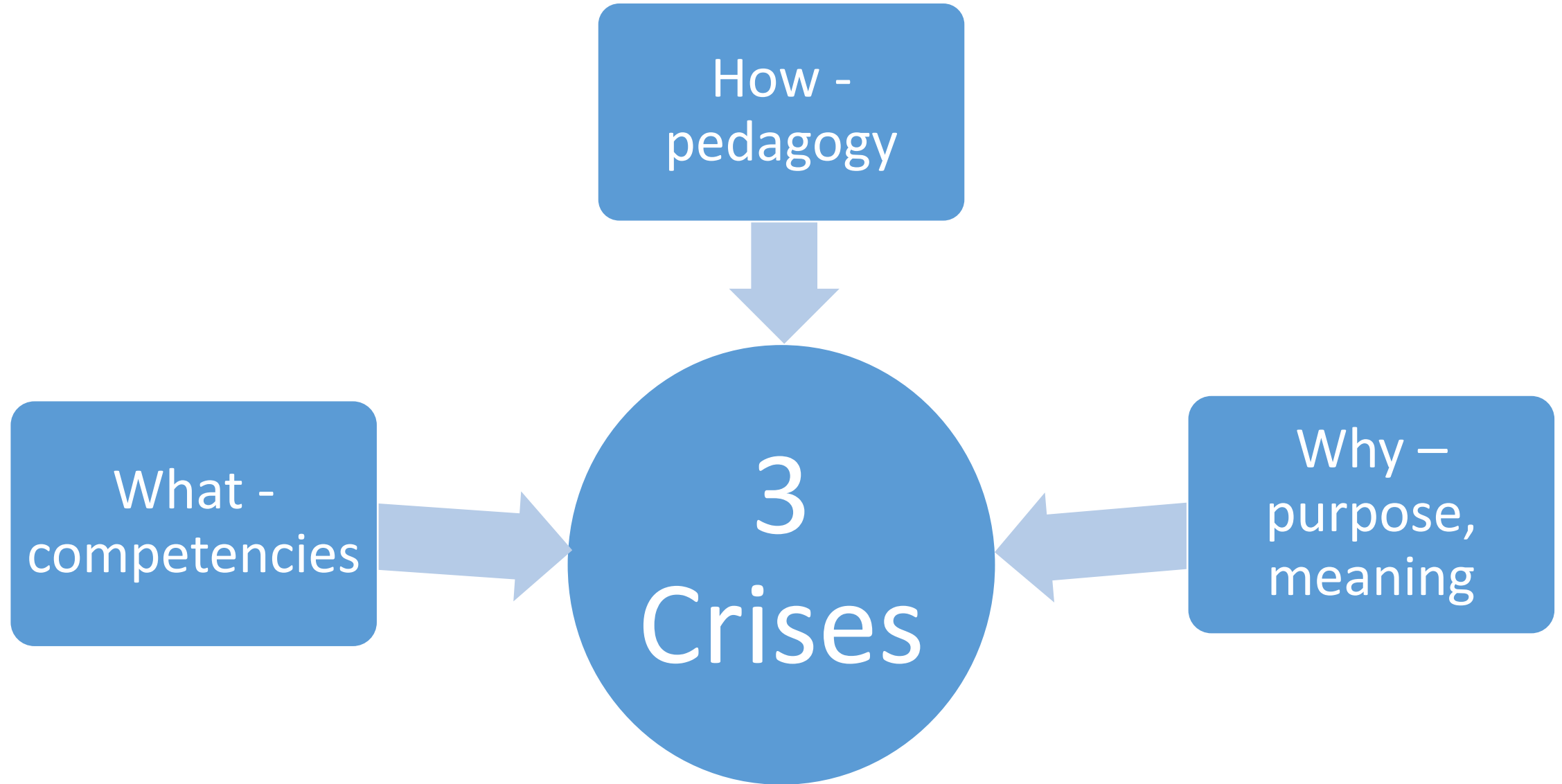
Report of an Expert Panel

January 2013

Learn  
Serve  
Lead

Association of  
American Medical Colleges

# Misalignment: Medical Education & Health System



Moving care from:

Episodic

Acute

Individual MD

Hospital

One Patient

Moving care to:

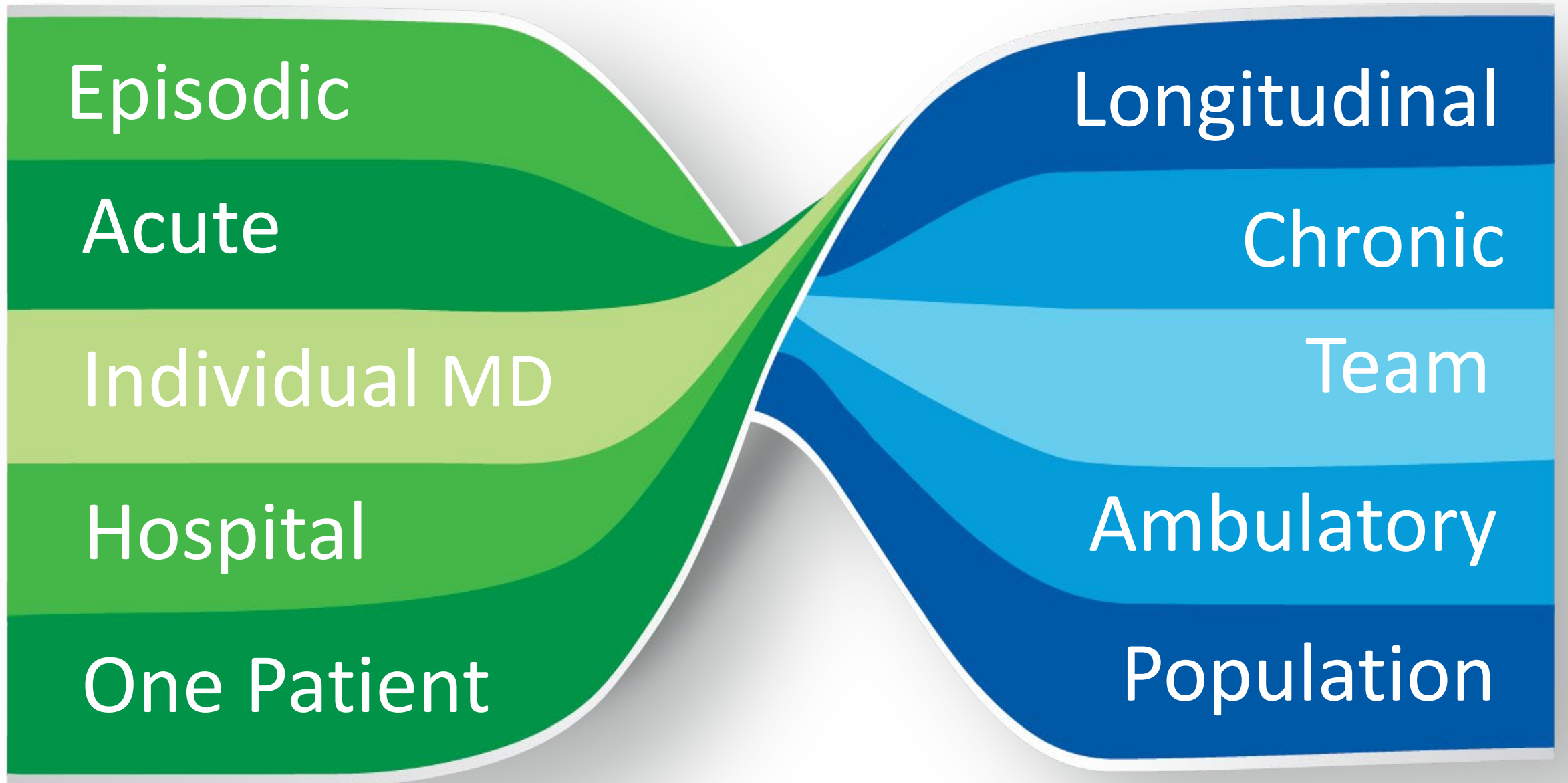
Longitudinal

Chronic

Team

Ambulatory

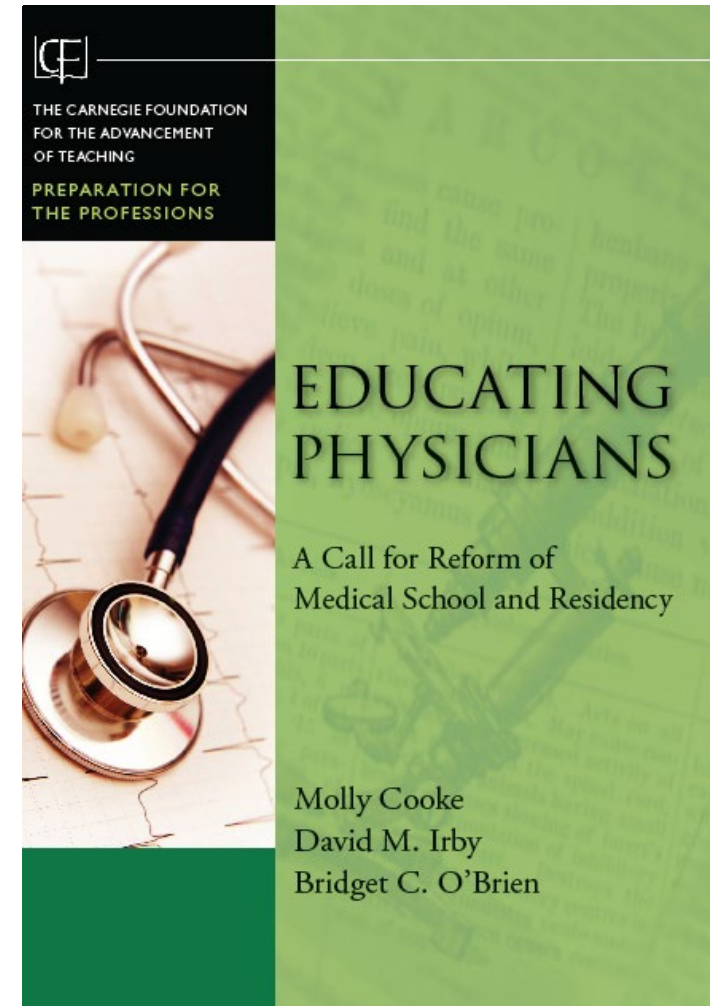
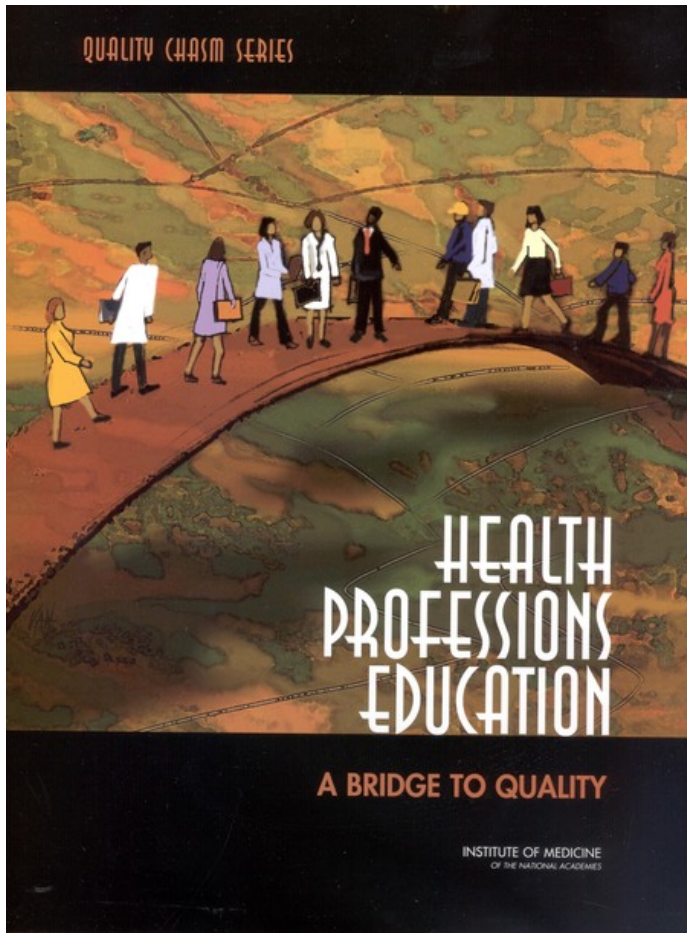
Population



# Competency Deficits – Graduating Residents

- Diagnostic Reasoning
- Patient Centered Communication (e.g., shared decision making)
- Interprofessional Team Collaboration
- Reflective practice, Practice-Based Learning
- Panel Management
- Patient Safety, QI, Process Improvement
- Measurement-Based Care

- Crosson FJ et al. Gaps in residency training should be addressed to better prepare doctors for a twenty-first-century delivery system. *Health Affairs*. 2011.
- Eden J, Berwick DM, Wilensky GR, Institute of Medicine (U.S.). *Graduate medical education that meets the nation's health needs*. 2014.





# Pedagogy Deficits - Consequences

- Inefficient

- training longer than necessary

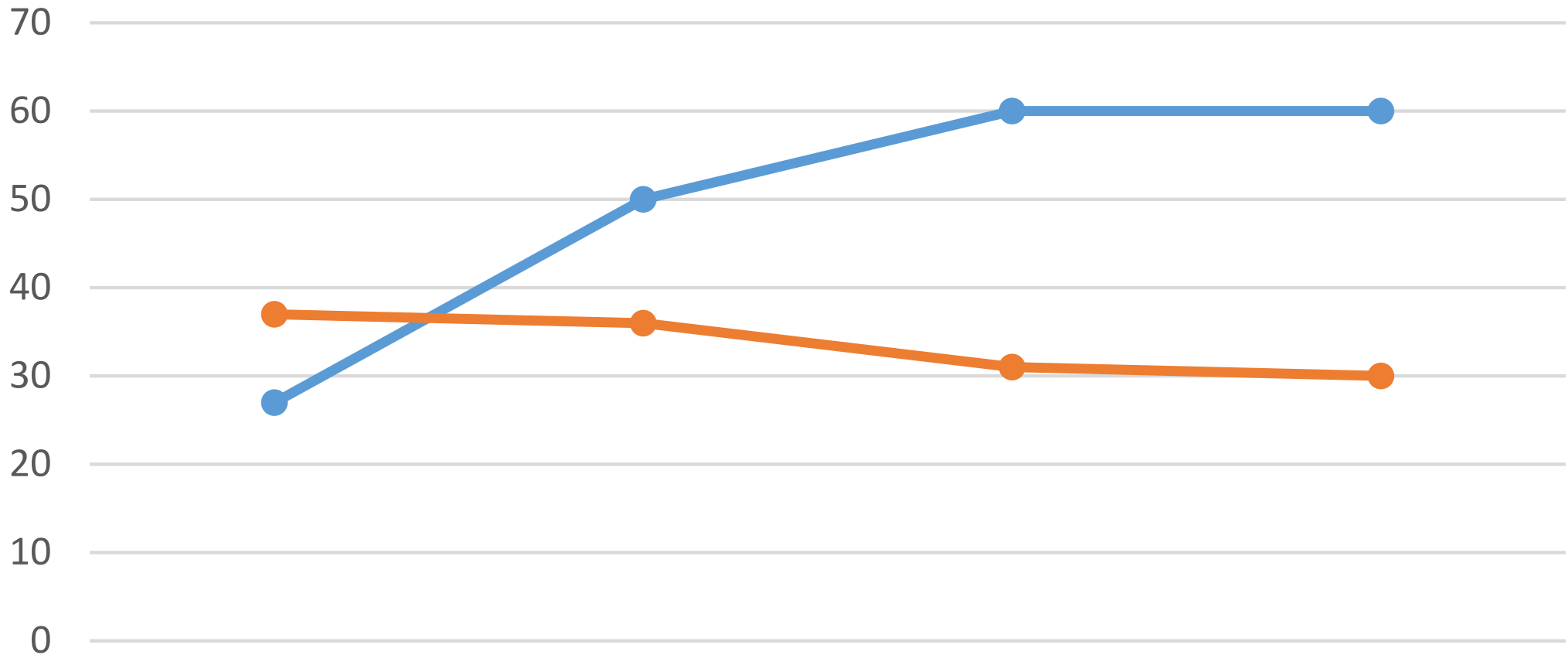
- Ineffective

- key competencies not learned

- Graduates not self-regulated learners

- Practice does not change with evidence

# Percent with Burnout



Matriculating  
Medical Students

Medical Students

Residents

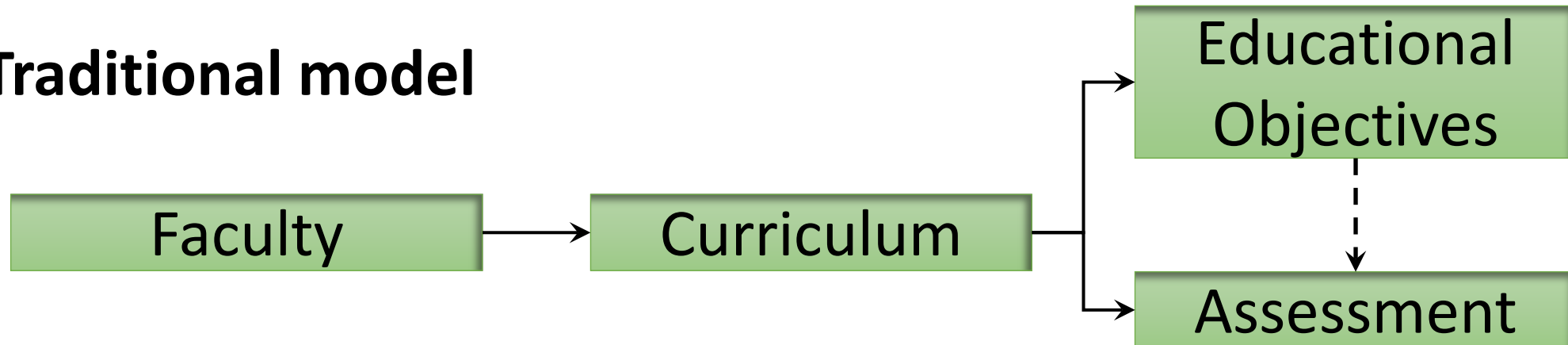
Early Career

—●— Physician by career stage

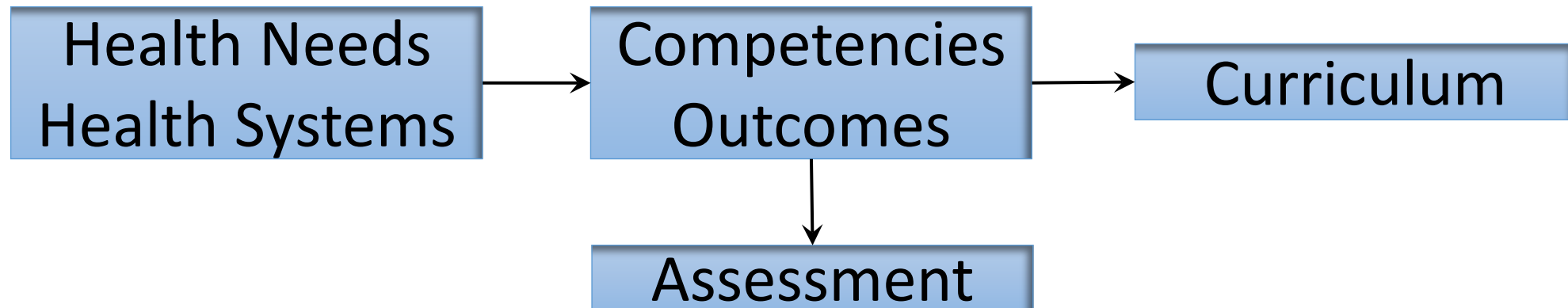
—●— Age similar college graduates

# Approach to Medical Education

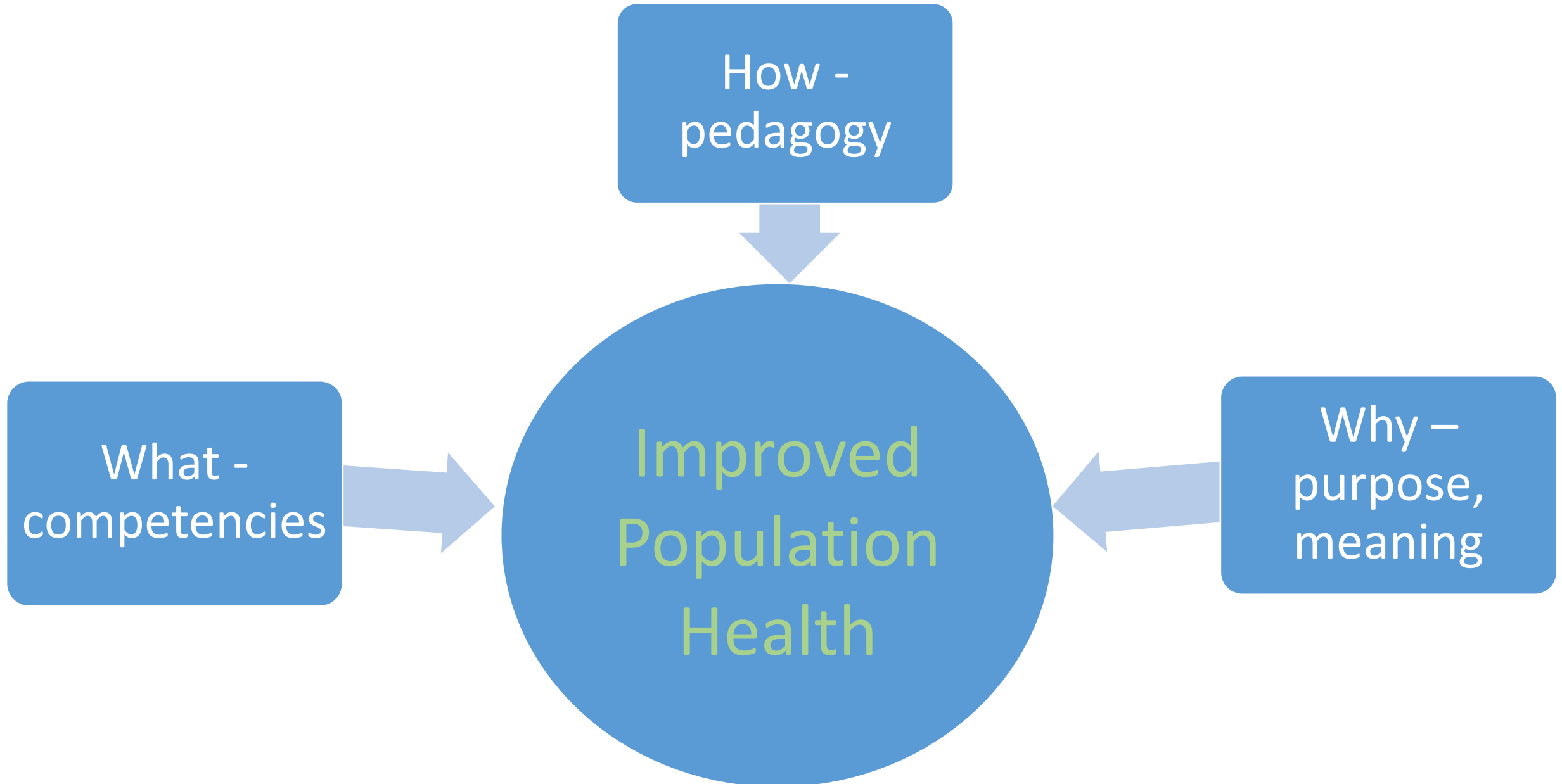
## Traditional model



## Competency-based educational model



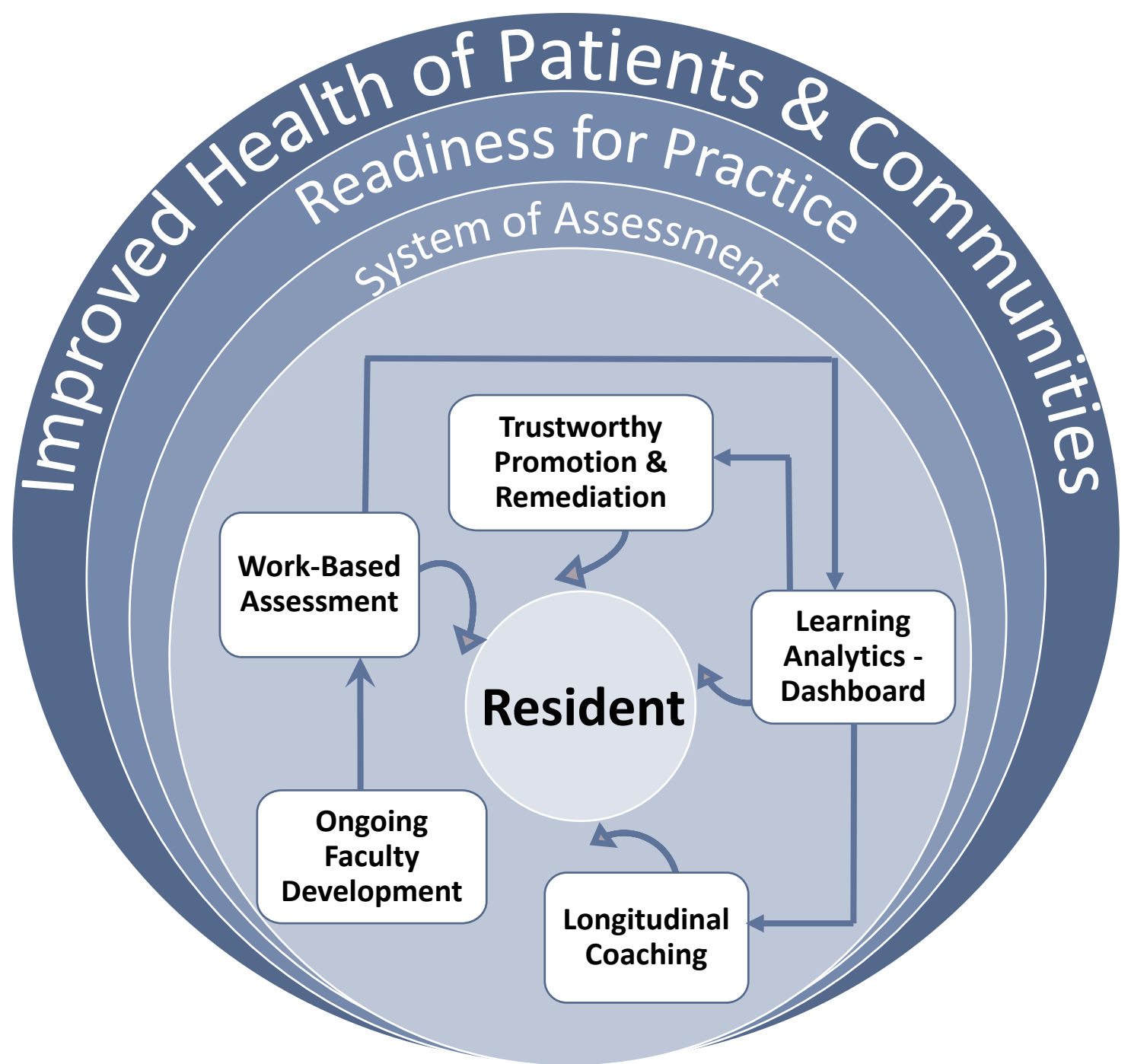
# Aligning Medical Education with Population Needs



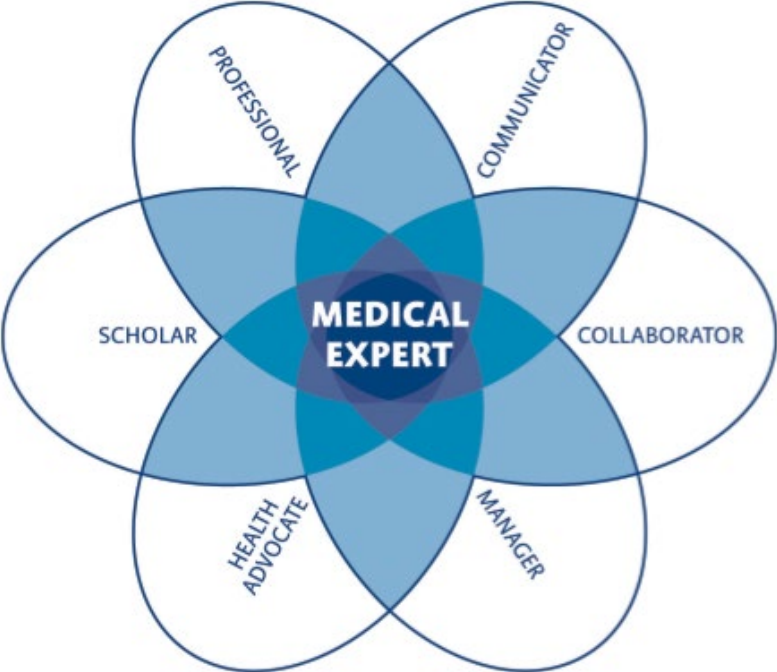
# The 'Catch' – All This Requires...

A system of assessment that promotes:

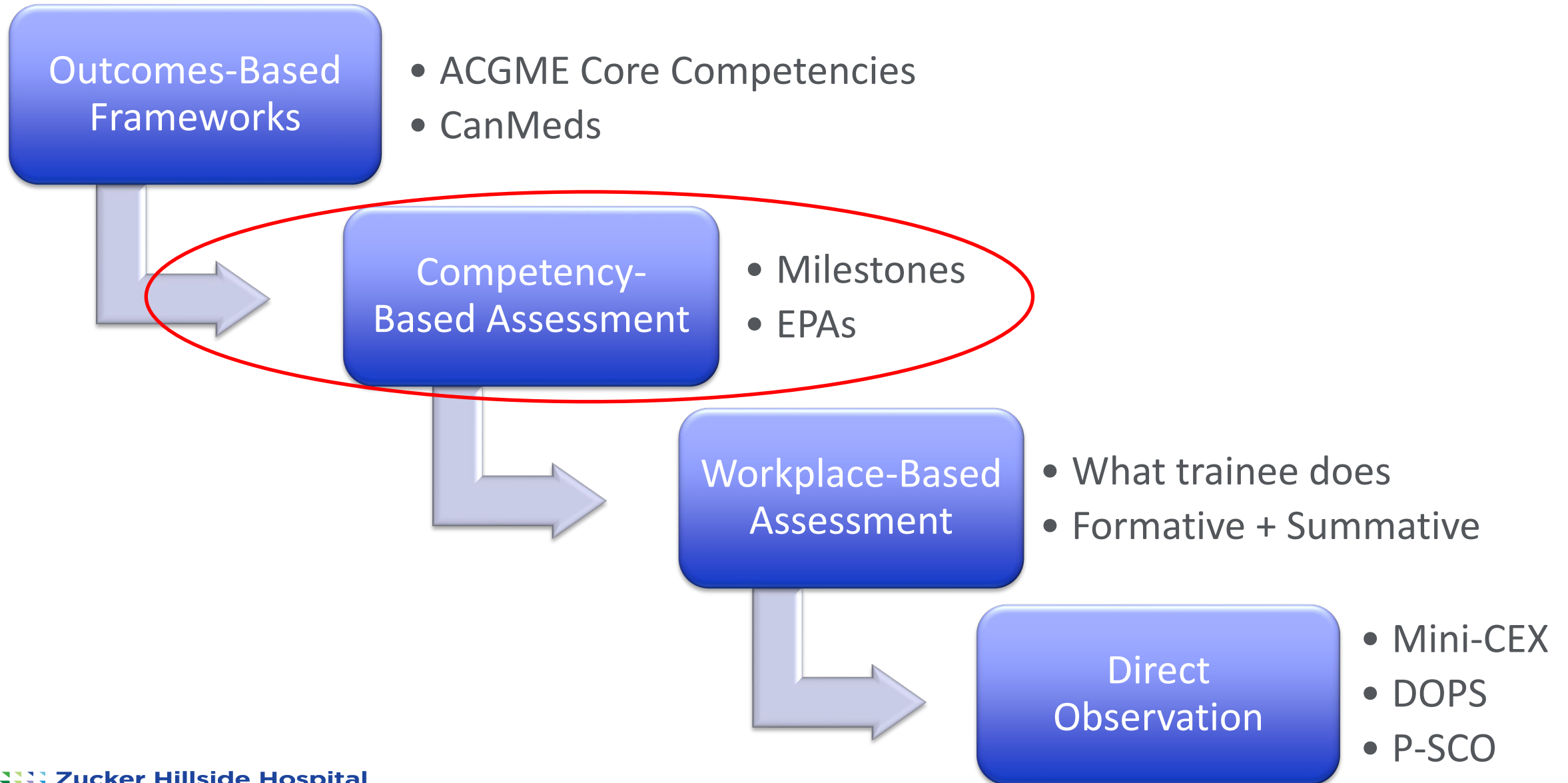
1. Self-regulated learning
2. Competency as determined by a trustworthy process



# ACGME Core Competencies



# Outcomes-Based Education



# Milestones

Competency Domain

Subcompetency

Thread Names

Thread for: "Development as a teacher" (all milestones with "A")

PBL13 Teaching					
A: Development as a teacher					
B: Observable teaching skills					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Recognizes role of physician as teacher	2.1/A Assumes a role in the clinical teaching of early learners	3.1/A Participates in activities designed to develop and improve teaching skills	4.1/A Gives formal didactic presentation to groups (e.g. Grand Rounds, case conference, journal club)	5.1/A Educates broader professional community and/or public (e.g. presents at regional or national meeting)
		2.2/B Communicates goals and objectives for instruction of early learners 2.3/B Evaluates and provides feedback to early learners	3.2/B Organizes content and methods for individual instruction for early learners	4.2/B Effectively uses feedback on teaching to improve teaching methods and approaches	5.2/B Organizes and develops curriculum materials
Comments:					

Milestone

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as **some** milestones in the higher level(s).



# The Challenge with Milestones:

- Too granular
  - overly reductionistic
- Too numerous
  - rater cognitive overload

“EPAs are units of professional practice that can be entrusted to a learner. Taken together, they represent the essential work of the profession.”

“A milestone is an observable marker of an individual's ability along a developmental continuum.”

EPAs

Domains of  
Competence

Competencies

Milestones

The Good Doctor:  
PUTTING IT ALL TOGETHER  
(Source: Carol Carraccio, MD)

# The Difference: Unit of Observation

## EPAs

Work-descriptors

Holistic (Lump)

Essential Professional Activities

- Perform a diagnostic interview
- Manage psychiatric illness with medications
- Assess and manage a psychiatric emergency
- Manage a panel of patients longitudinally

## Milestones

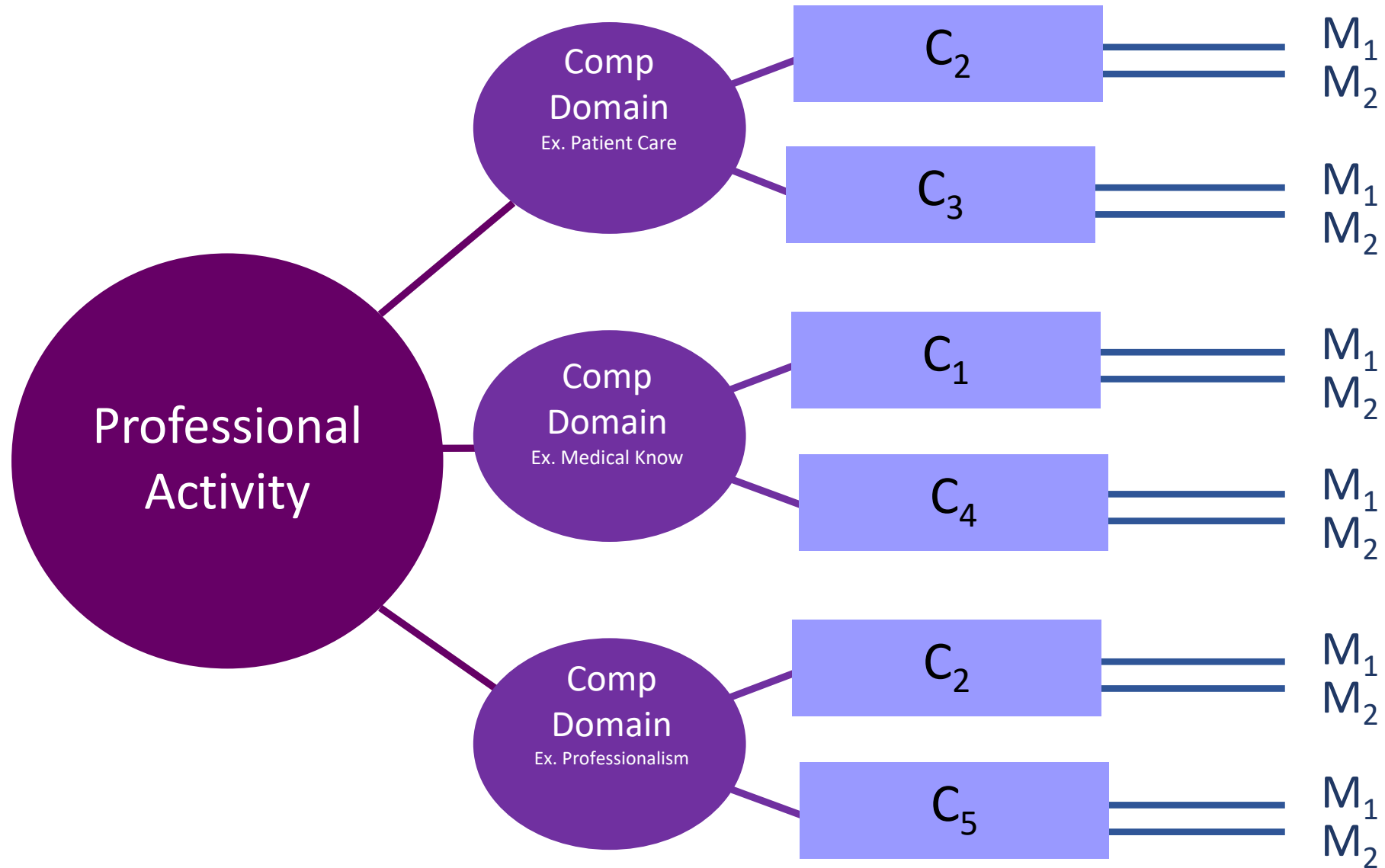
Person-descriptors

Deconstruct (Split)

Knowledge, skills, attitudes, values

- PC: Psychiatric Evaluation
- PC: Psychiatric Formulation
- PC: Treatment Planning
- MK: Psychopathology
- SBP: System Navigation
- ICS: Patient-Centered

# Focus on the Whole



# Levels of Entrustment

Level 1: Co-Treat

Level 2: May perform under direct supervision

Level 3: May perform under indirect supervision

Level 4: “Unsupervised” practice allowed

Level 5: May supervise others

# End-of-Training EPAs – Examples from GME

- Manage care of patients with chronic disease (IM)
- Care for a well newborn (pediatrics)
- Manage high risk childbirth (obstetrics & gynecology)
- Manage psychiatric emergencies (psychiatry)

# Entrustment as Assessment Construct

- Increases discrimination
- Improves inter-rater reliability
- Reduces # assessments required for generalizability (MCEx: 6->3)
- Decreases assessor workload approximately 50%

Weller JM et al. *B Jrn Anaesthesia* 2014.112(6):1083-91

Crossley J et al. *Med Educ* 2011;45:560-9

Grofton WT et al. *Acad Med* 2012;87:1401-7

Reckman J et al. *Acad Med* 2015; 91:186-90.

# Anesthesia Study

<b>Outcome</b>	<b>Traditional Scale</b>	<b>Supervision Scale</b>
<b>Variance due to trainee</b>	<b>9%</b>	<b>18%</b>
<b>Variance due to rater</b>	<b>40%</b>	<b>22%</b>
<b># of assessments for 0.7 reliability</b>	<b>&gt;50</b>	<b>6</b>



# Ad Hoc vs Summative Entrustment

- Ad hoc
  - Momentary decisions in clinic
  - For specific circumstance
  - Confirmed each time
- Summative
  - Formalized decision
  - Permission for less supervision going forward



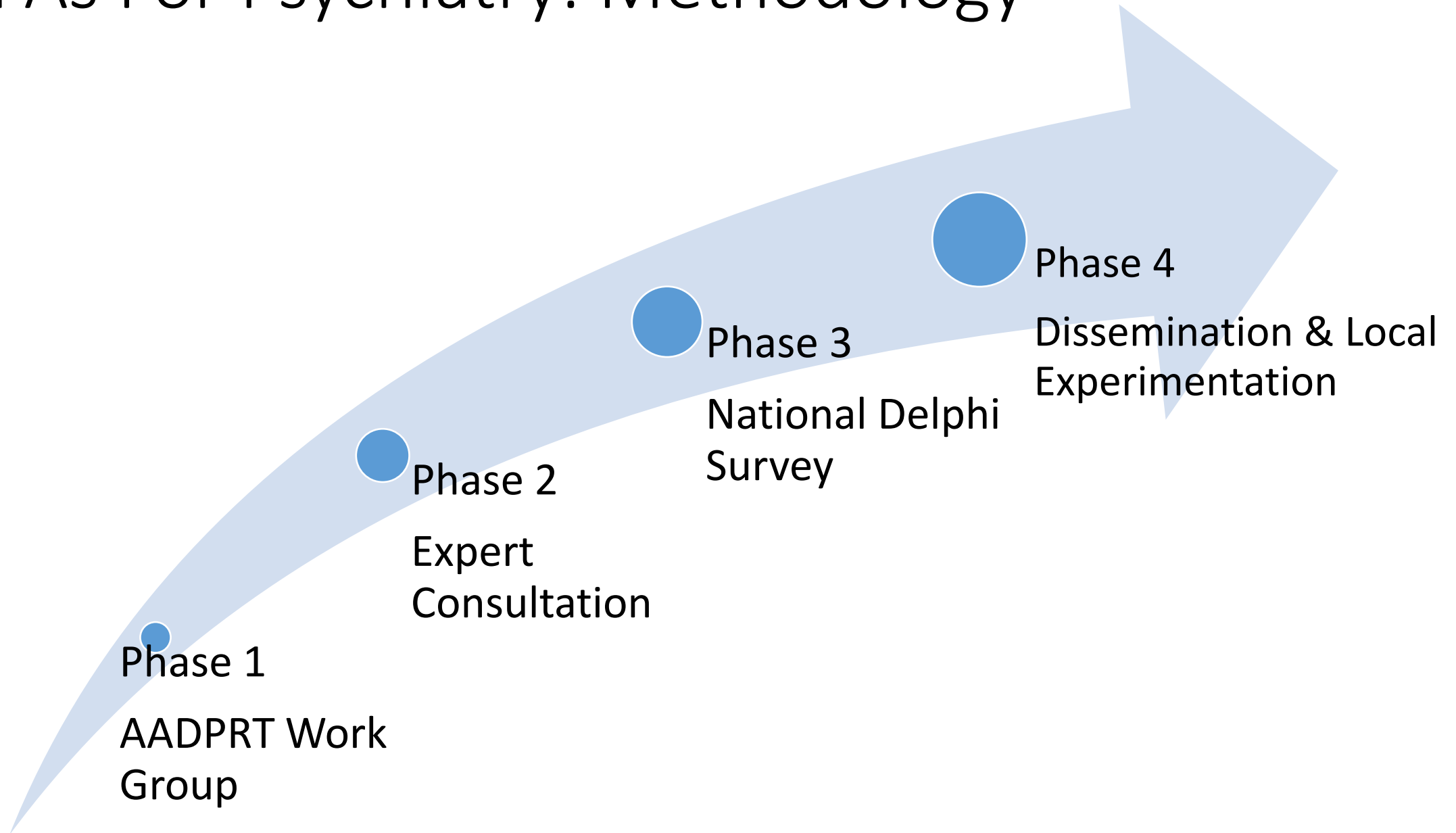
**Academic Medicine, Vol. 93, No. 7 / July 2018**

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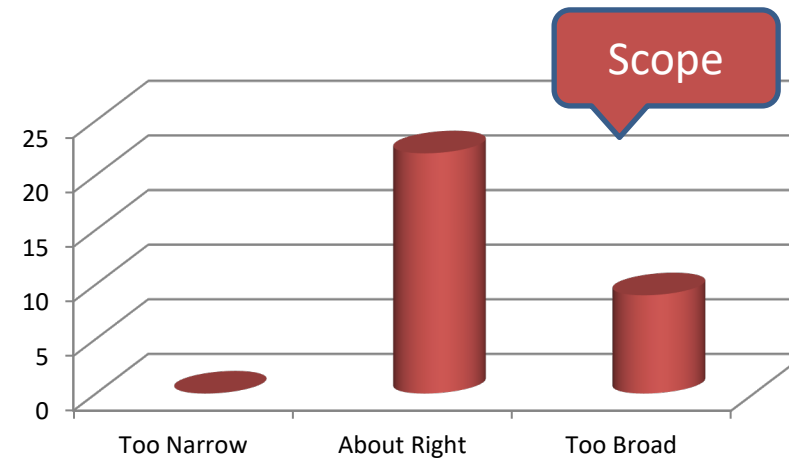
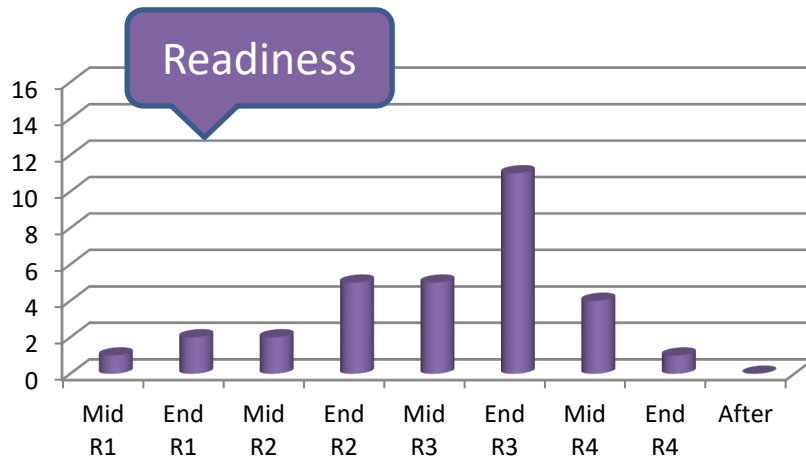
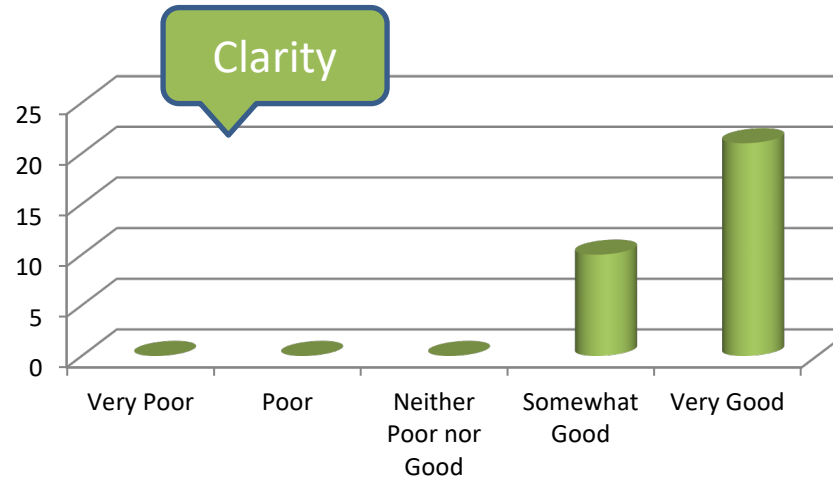
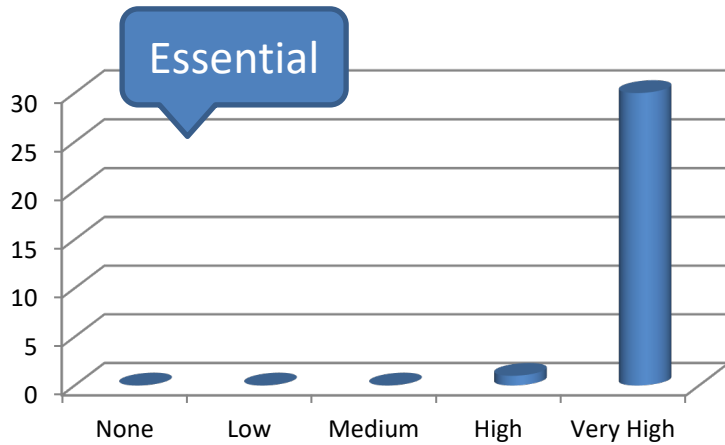
**Developing End-of-Training Entrustable  
Professional Activities for Psychiatry:  
Results and Methodological Lessons**

John Q. Young, MD, MPP, PhD, Caitlin Hasser, MD, Erick  
K. Hung, MD, Martin Kusz, Patricia S. O'Sullivan, EdD,  
Colin Stewart, MD, Andrea Weiss, MD, and Nancy  
Williams, MD

# EPAs For Psychiatry: Methodology



# EPA 1: Conduct Psychiatric Diagnostic Evaluation



Proposed EPA (title) <sup>b</sup>	CVI <sup>c</sup>	Mean	SD	95% CI <sup>d</sup>		Related competencies <sup>d</sup>
				Lower	Upper	
1. Manage psychiatric patients longitudinally	1.0	4.9	0.3	4.7	4.9	PC1, PC2, PC3, PC4, PC5, MK2, PBLI1, SBP1, SBP2, SBP3, PROF2, ICS1, ICS2
2. Manage psychiatric emergencies	1.0	4.9	0.3	4.7	4.9	PC1, PC2, PC3, MK2, MK6, PROF2
3. Conduct psychiatric diagnostic evaluations	1.0	4.8	0.4	4.6	4.9	PC1, PC2, PC3, MK1, MK2, MK3, MK4, MK5, PROF1, ICS2
4. Manage patient's psychiatric conditions with medications	1.0	4.7	0.8	4.5	4.9	PC3, PC5, MK5, PBLI1, PROF1, PROF2, ICS2
5. Manage involuntary commitment and treatment	1.0	4.6	0.5	4.4	4.8	PC1, PC2, PC3, MK2, MK6, SBP2, PROF1, PROF2, ICS1, ICS2
6. Assess and manage decision-making capacity	1.0	4.5	0.6	4.3	4.7	PC1, PC2, PC3, MK2, MK6, PROF1, PROF2, ICS1, ICS2
7. Manage transitions in care	1.0	4.5	0.6	4.2	4.7	MK2, SBP1, SBP2, SBP3, PROF2, ICS1
8. Provide psychiatric consultation to other clinicians or services	0.9	4.5	0.7	4.3	4.7	PC1, PC2, PC3, MK1, MK2, MK3, MK4, MK5, MK6, SBP2, SBP3, SBP4, PBLI3, PROF1, ICS1, ICS2
9. Provide supportive psychotherapy	0.9	4.4	0.6	4.1	4.6	PC3, PC4, MK2, MK4, PBLI1, PROF2
10. Lead an inter-professional health care team	0.8	4.3	0.7	4.0	4.5	PBLI3, PROF1, PROF2, ICS1
11. Provide cognitive behavioral therapy	0.8	4.2	0.7	3.9	4.4	PC3, PC4, MK2, MK4, PBLI1, PROF2
12. Provide psychodynamic psychotherapy	0.7	3.9	0.7	3.6	4.2	PC3, PC4, MK2, MK4, PBLI1, PROF2
13. Apply quality improvement methodologies	0.7	3.9	0.7	3.6	4.2	PBLI2

# Linkage to Milestones

EPA	PC1	PC2	PC3	PC4	PC5
	Eval	Formulation	Management	Psychotherapy	Somatic
Conduct Diagnostic Evaluation	X	X	X		
Manage Behavioral Emergencies	X	X	X		
Manage the Psychiatric Patient Longitudinally	X	X	X	X	X
Manage a Patient's Psychiatric Medications			X		X
Manage Transitions in Care					
Provide Supportive Psychotherapy			X	X	
Provide CBT Psychotherapy			X	X	
Provide Psychodynamic Psychotherapy			X	X	
Manage Involuntary Commitment and Treatment	X	X	X		
Obtain Informed Consent					
Manage Decision-Making Capacity	X	X	X		
Provide Psychiatric Consultation	X	X	X		
Apply Quality Improvement Methodologies					
Collaborate with Other Providers on Team					

# Validity Enhancing Strategies Relevant to Future Studies

- Employed multiple methods, including:
  - Consensus-driven, iterative group process for task force
  - Input from non-specialty experts
  - National Delphi survey of 31 experts with 80% response rate
- Provided frame of reference training (video and short article) to experts prior to participation in Delphi survey
- Stringent inclusion criteria – accounted for the influence of skewness with use of asymmetric confidence interval

# Validity Enhancing Strategies Relevant to Future Studies

Choice Points	Examples
Setting	Inpatient, C/L, ambulatory, emergency
Treatment modality	Medications, psychotherapy, neuromodulation
Disease specificity	Schizophrenia, bipolar disorder
Timeframe	Short-term vs. long-term
Complexity of patient	Simple vs. complex
Acuity of condition	Acute vs. chronic
Essential	Essential vs. elective
Level of specialization	UME vs. core GME vs. Psychiatry sub-specialty



# A *System* of Assessment: Components

1. Competency-based assessment framework - EPAs
2. Workplace-based assessment (WBA)
  - Tools
  - Direct Observation and Structured Feedback

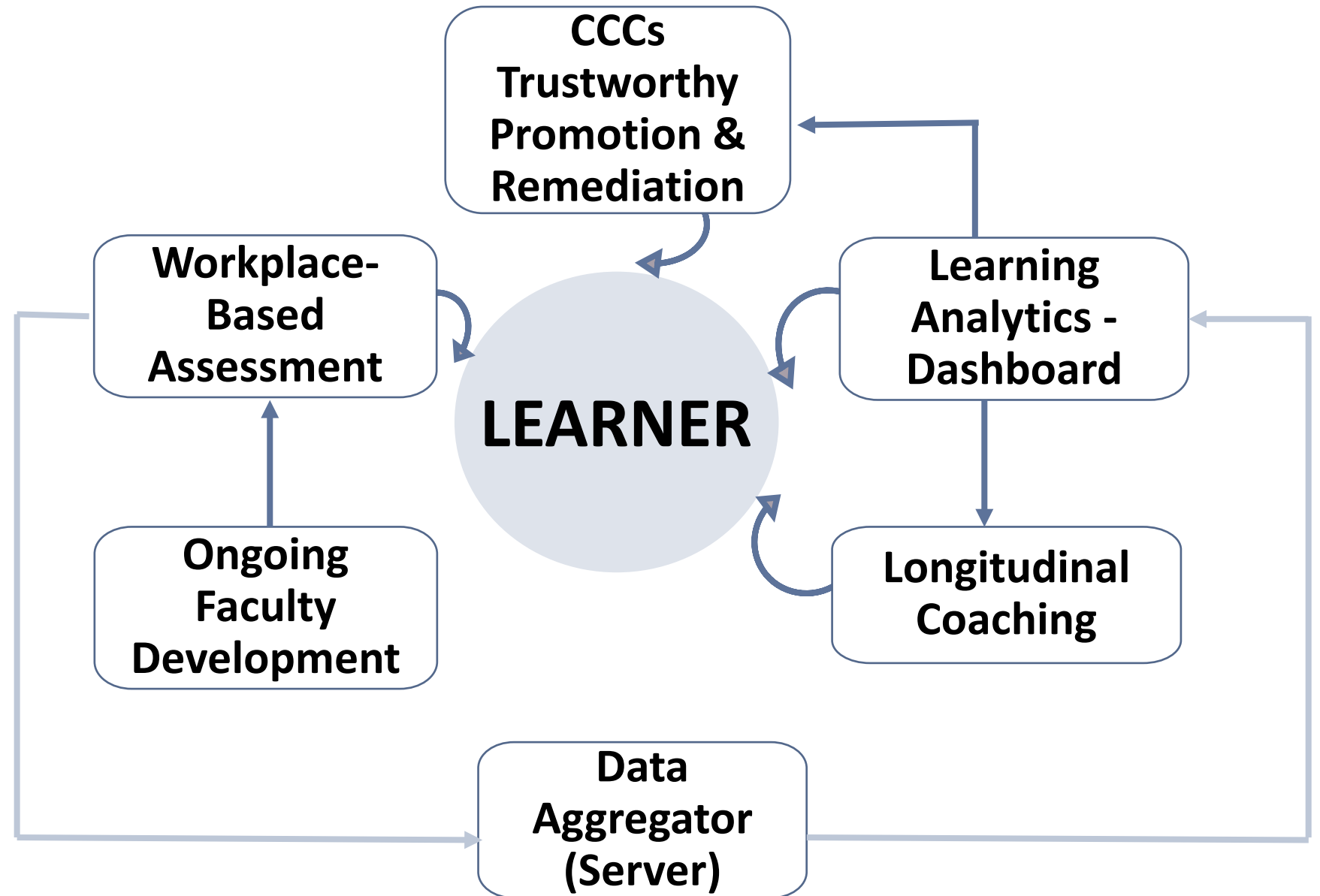
## Not Addressed Today

3. Learning Analytics
4. Faculty development
5. Longitudinal coaching
6. CCC

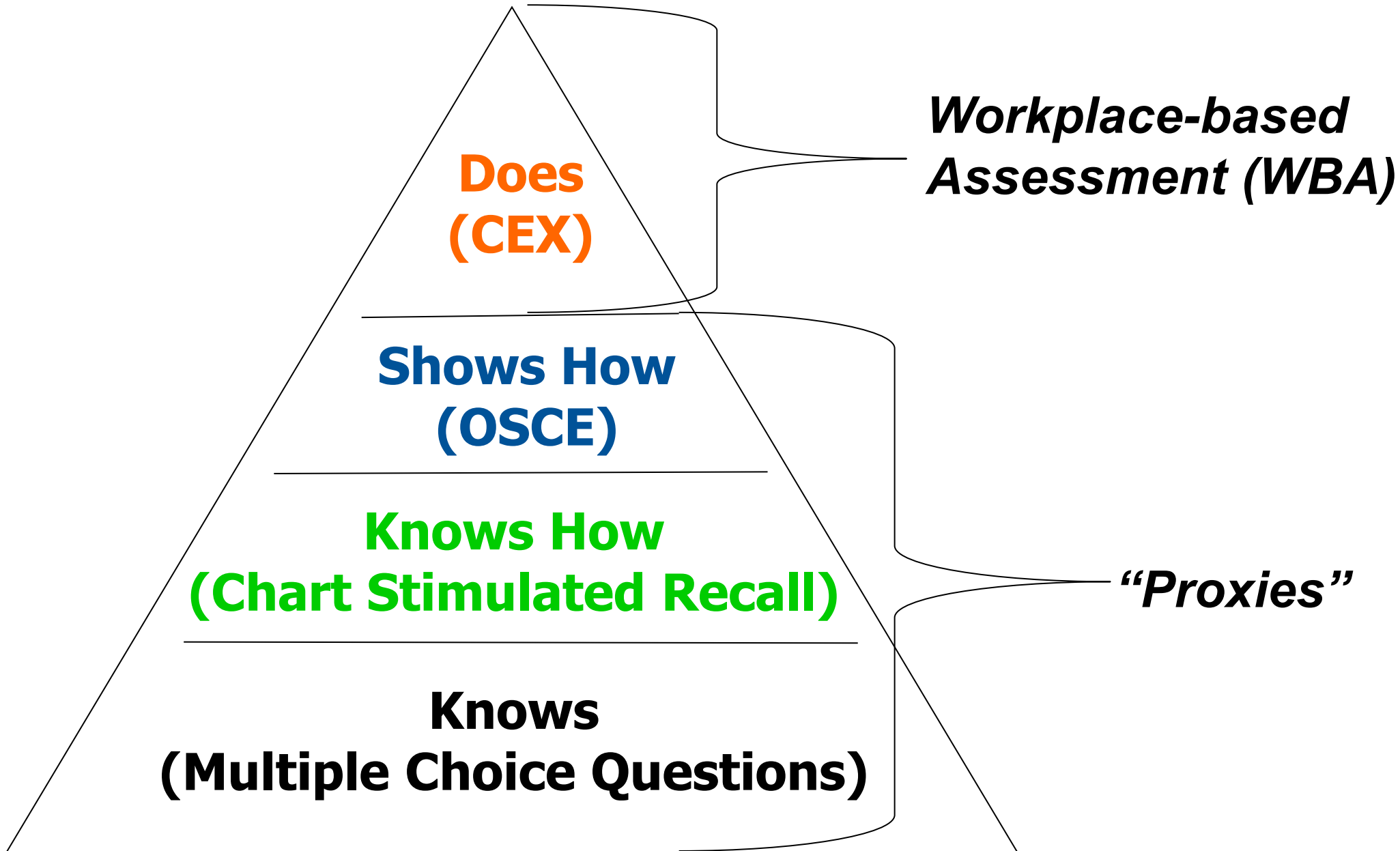
# Competency-Based Assessment System

Promotes

1. Self-regulated learners
2. Competency as judged by trustworthy process



# Miller Pyramid 1990



# Pedagogy: Deliberate Practice with Feedback

## What Do They Have in Common?



## Self-Assessment is Inaccurate



## Role of the Coach



## How do people become experts?

- Well defined, sequenced tasks
- Directly observed
- Informative feedback
- Self-Reflection
- Repetition
- Authentic
- Attends to motivation & endurance

*Ericsson KA et al. Psych Rev.1993.  
Gawande A. New Yorker. 2011*

# Feedback Characteristics that Enhance Learning

- Based on direct observation
- Soon after observation
- Specific, behaviorally oriented
- Situated in a safe interpersonal space
  - ✓ 'learning culture', 'conversation'
  - ✓ Perceives faculty's intention = to support
- Includes self-assessment
- Commitment to action/next step
- Written & verbal feedback
- Bidirectional, co-constructed conversation

# **Enter the P-SCO**

*Psychopharmacotherapy – Structured  
Clinical Observation Tool*

# Goals

- Promote growth (through feedback)



- Assess competence



- Improve the quality of care

# PSCOv1



Resident:

Attending:

Key feedback points - what done well and at least one task to work on:

- Overall EPA/Entrustment Rating (Level of Supervision)

- Narrative Comments

Assessment & Treatment	1	2	3	4	5
Solicits and addresses questions and concerns					
Modifies treatment as necessary (see back)					
Engages and educates patient in decisions about dx & tx					
Confirms shared understanding of plan					
Provides wellness and behavioral guidance (e.g., sleep hygiene)					
Addresses transitions in care					

Overall Rating: Pharmacotherapy Follow-Up Visit				
Based on this observation only and for cases of similar complexity and setting, I would recommend the following level of supervision for a pharmacotherapy follow-up visit (please circle one):				
Direct Full	Direct Partial	Indirect	Independent	Supervise Others

Areas of Strength (≥ 1):

Suggestions for Improvement (≥ 1):



# Program of Research: Validity Evidence for P-SCO

## **Unitary Model of Validity - Multiple Dimensions**

- Content
- Internal Structure
- Correlation with other Variables
- Response Process
- Consequences

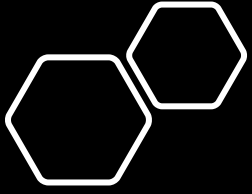
Messick. 1994; Downing et al. 2003.

# Study Set 1 – Content Validity Studies

(Data not shown today)

- 2 Studies (2011, 2018)
- 2018 builds on the 2011 study
  - Larger sample of experts
  - Stronger methodology (content validity index)

1. Young JQ et al. Performance Assessment of Pharmacotherapy: Results from a Content Validity Survey of the Psychopharmacotherapy-Structured Clinical Observation (P-SCO) Tool. *Acad Psychiatry*. 2018.
2. Young JQ et al. Development and initial testing of a structured clinical observation tool to assess pharmacotherapy competence. *Acad Psychiatry*. 2011.



# Study 2 Goals

- Internal Structure
- Correlation of Scores with Other Variables

Academic Psychiatry (2018) 42:759–764  
<https://doi.org/10.1007/s40596-018-0928-0>

EMPIRICAL REPORT



## Evidence for the Validity of the Psychopharmacotherapy-Structured Clinical Observation Tool: Results of a Factor and Time Series Analysis

John Q. Young<sup>1</sup> · Rehana Rasul<sup>2</sup> · Patricia S. O'Sullivan<sup>3</sup>

Received: 28 November 2017 / Accepted: 18 April 2018 / Published online: 27 June 2018  
© Academic Psychiatry 2018

# P-SCO Observations over 4 Academic Years

	<b>AY 1</b>	<b>AY 2</b>	<b>AY 3</b>	<b>AY 4</b>	<b>All Years</b>
<b>Total Observations</b>	127	144	147	176	601*
<b>Faculty</b>	8	8	8	8	11
<b># Residents</b>	16	15	16	17	64
<b>Mean # Obs/resident</b>	7.9	9.6	9.2	10.3	9.4
<b>% Residents with <math>\geq 8</math></b>	75	93	94	71	83

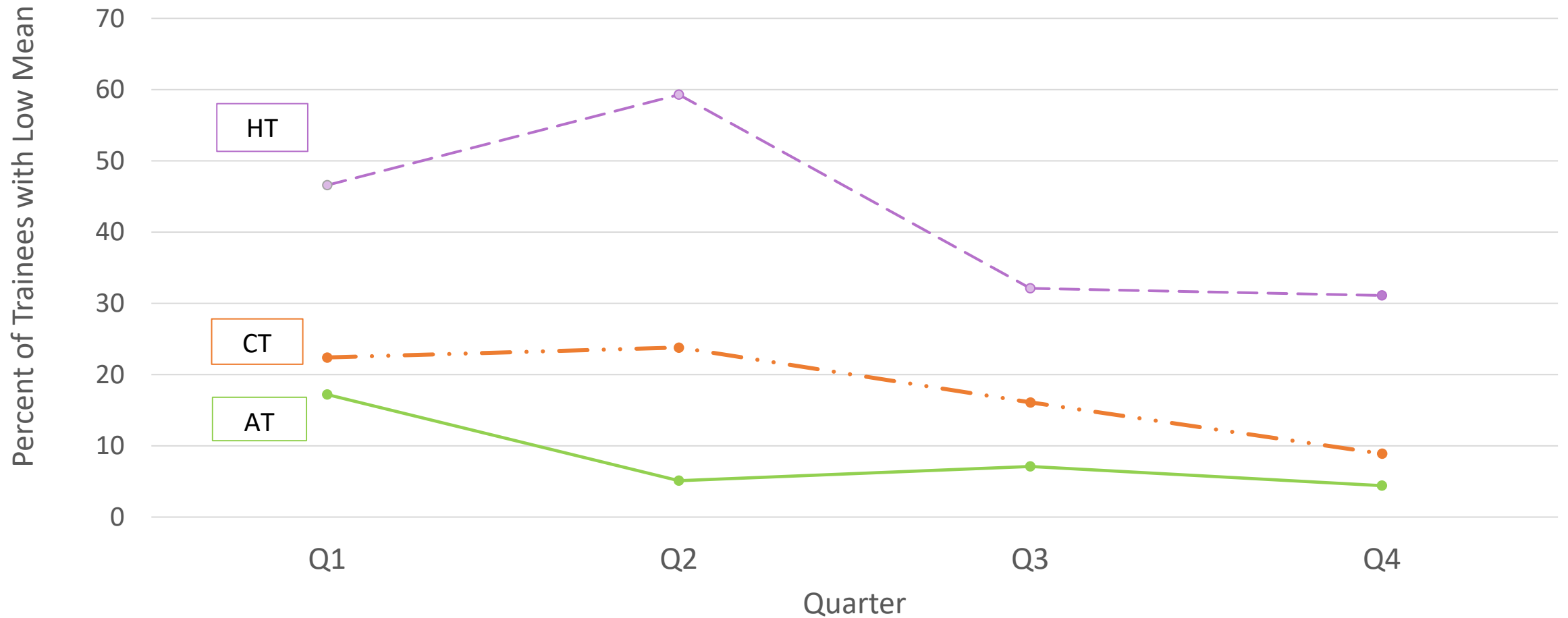
# Multi-Level Exploratory Factor Analysis

Item	AT	CT	HT
Establishes rapport	0.79	-0.1	-0.01
Greets patient	0.78	-0.05	0.07
Initial open ended question	0.60	0.09	0.1
Begins on time	0.53	0.15	0.14
Encourages ventilation	0.52	0.09	0.05
Solicits patient's questions	0.50	0.36	-0.07
Conveys hope	0.44	0.43	-0.12
Appropriate follow-up	0.43	0.34	0.14
MSE focused	0.34	0.27	0.23
Provides simple advice	0	0.76	-0.01
Educates patient	-0.05	0.75	0.12
Updates treatment plan	0.27	0.43	0.13
Assesses response	0.3	0.40	0.11
Monitors adverse effects	0.08	0.37	0.2
Interval history	0.24	0.33	0.15
Assesses substance use	-0.05	0	0.80
Assesses risk	0.08	0.01	0.58
Assesses adherence	-0.01	0.14	0.50
Inquires about other treaters	0.25	-0.07	0.49

	AT	CT	HT	Overall
<b>Proportion of variance</b>	0.22	0.17	0.11	0.50
<b>Cronbach's alpha</b>	0.90	0.84	0.74	0.90

# Effect of Time on Factor Score for AT, CT, HT

Represents data from EFA Study Table 4



# Study 2 Implications for Validity

- Further evidence of feasibility and sustainability
- 3 Underlying Constructs:
  - Affective Tasks, Cognitive Tasks, Hard Tasks
- Factor scores improve with experience over the academic year

# Study 2 Implications for Validity

- “Between Faculty” and “Between Resident” variance not significant (*data not shown today*)
- Hard Tasks: tasks with low scores even at the end of the year
  - Assessing adverse effects, adherence, substance use, & violence; asking about other treaters
  - Implications for curriculum





# Study 3 Goals – Narrative Comments

1. Quality
2. Themes
3. Congruence between the Comments and the Checklist Scores
  - Do they convey similar information?

Journal of Graduate Medical Education, October 2019

ORIGINAL RESEARCH

## Advancing our Understanding of Narrative Comments Generated by Direct Observation Tools: Lessons From the Psychopharmacotherapy- Structured Clinical Observation

John Q. Young, MD, MPP, PhD  
Rebekah Sugarman, AB  
Eric Holmboe, MD  
Patricia S. O'Sullivan, EdD

# Narrative Comments in Work-Based Assessment

- Most studies: End Rotation (ITERS) or MSF
  - Variable quality – often vague
  - Coded language common (e.g., ‘good’ means bottom quartile)
- Mini CEX
  - Verbal: specific but self assessment and action planning under-utilized
  - Written: no studies

Hatala R, Sawatsky AP, Dudek N, Ginsburg S, Cook DA. *Acad Med.* 2017  
Dudek NL, Marks MB, Wood TJ, Lee AC. *Med Educ.* 2008;42(8):816-822.

Ginsburg S, van der Vleuten CP, Eva KW, Lingard L. *Med Educ.* 2017  
Holmboe ES, Yepes M, Williams F, Huot SJ. *J Gen Intern Med.* 2004.  
Sebok-Syer SS, Klinger DA, Sherbino J, Chan TM. *Acad Med.* 2017.

# Study 2 Methods

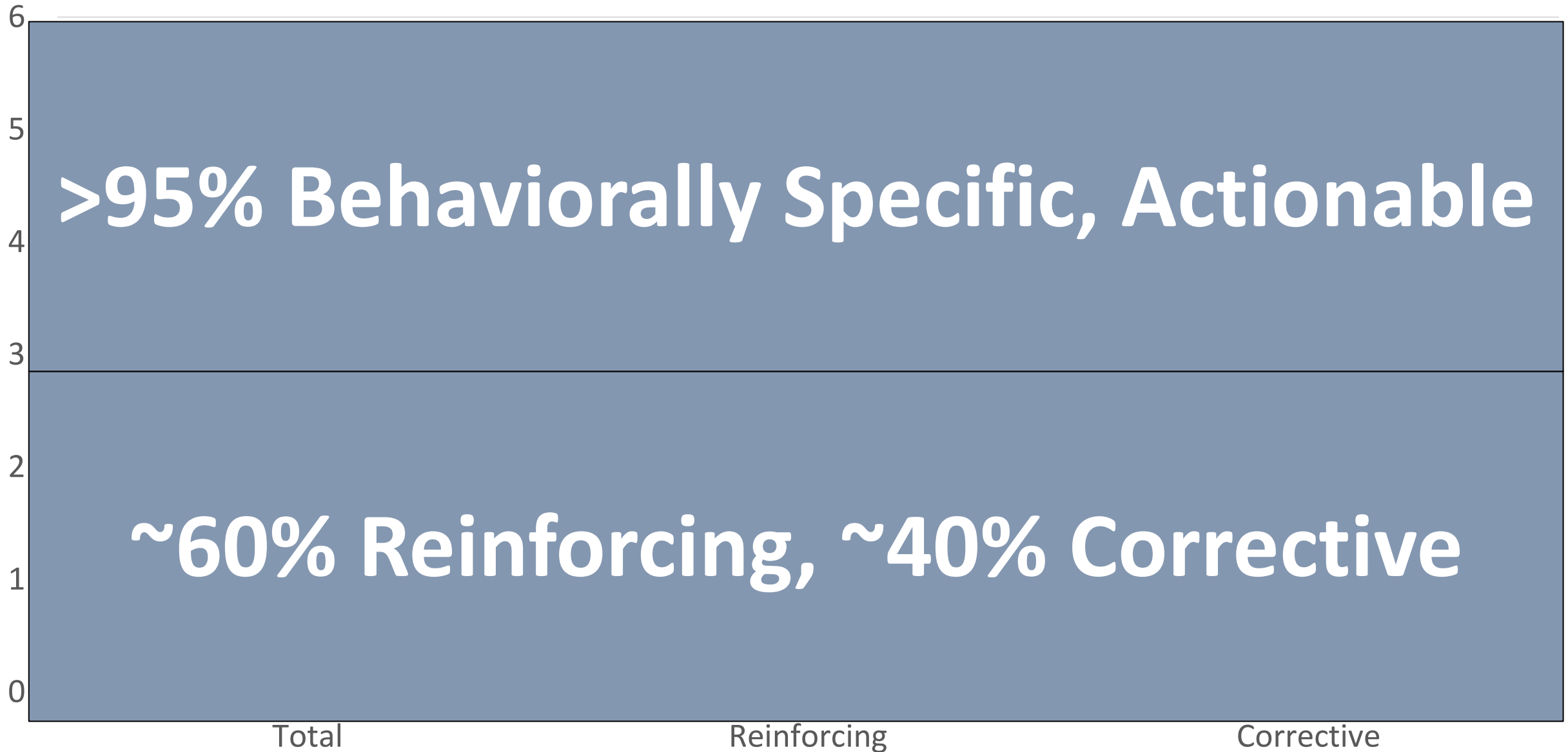
## **Sample**

- Same data set as Study 2
- Randomly sampled 25% of the completed P-SCOs from each academic year (2008-2011)
- Study sample = 152 out of 601 completed P-SCOs

## **Thematic Coding**

- Independently coded by 2 researchers
- Coding on 3 Axis:
  - ✓ Valence: Reinforcing, corrective, or unknown
  - ✓ Specificity: Specific or general
  - ✓ Content: Initial coding scheme developed and refined iteratively

# Mean Comments per Completed Observation (Total)



**>95% Behaviorally Specific, Actionable**

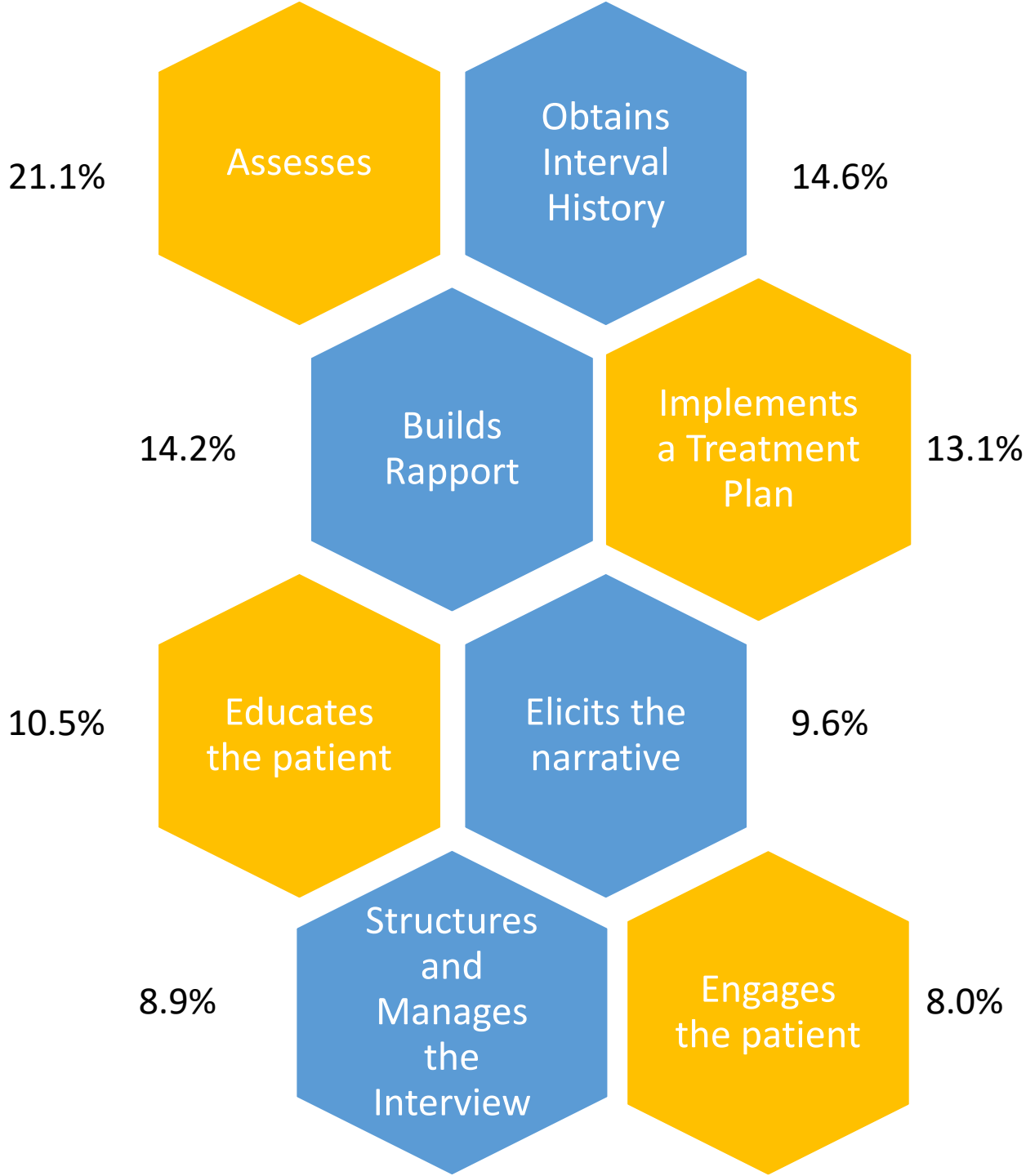
**~60% Reinforcing, ~40% Corrective**

Total

Reinforcing

Corrective

# Eight Primary Themes

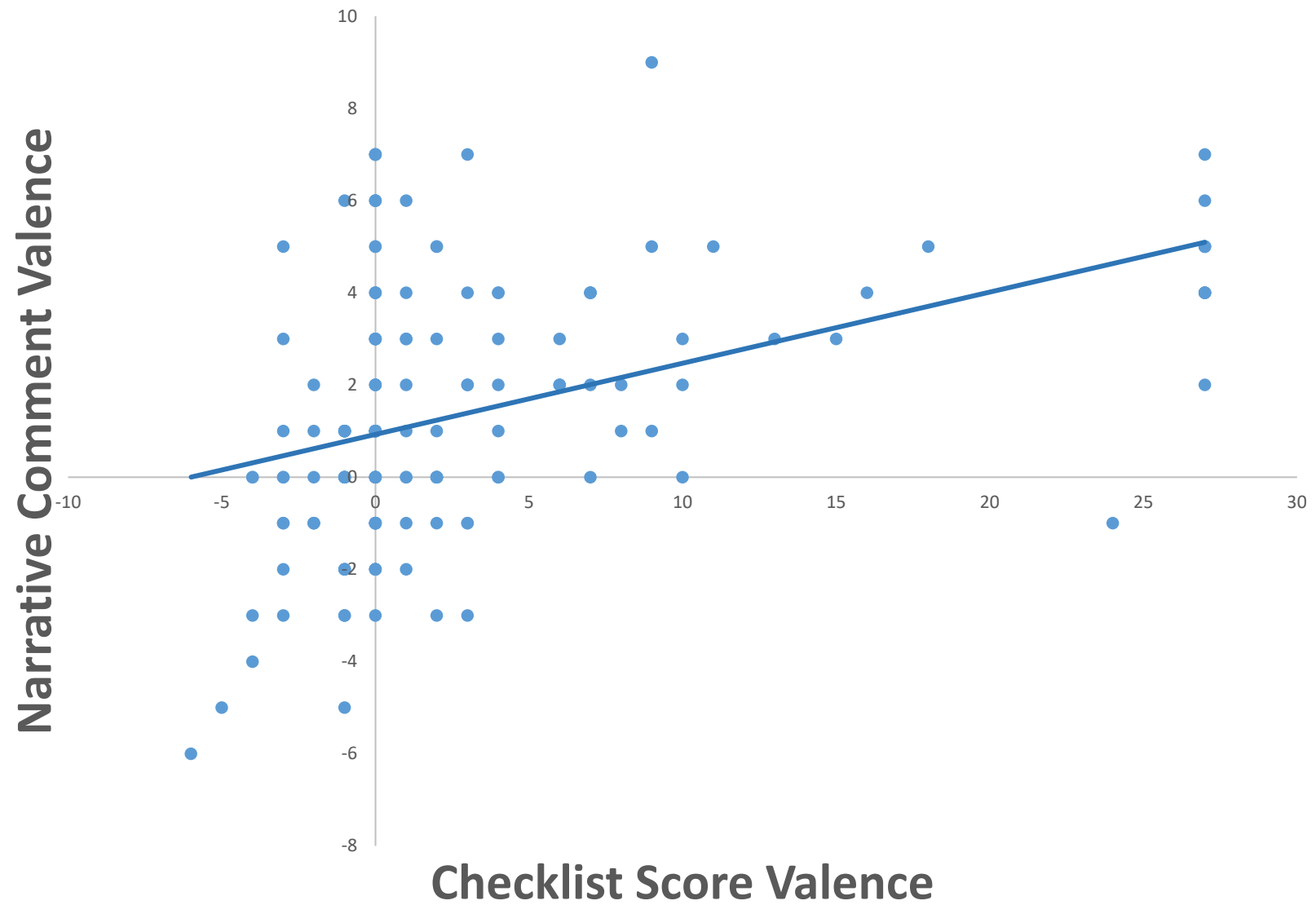


# Reinforcing

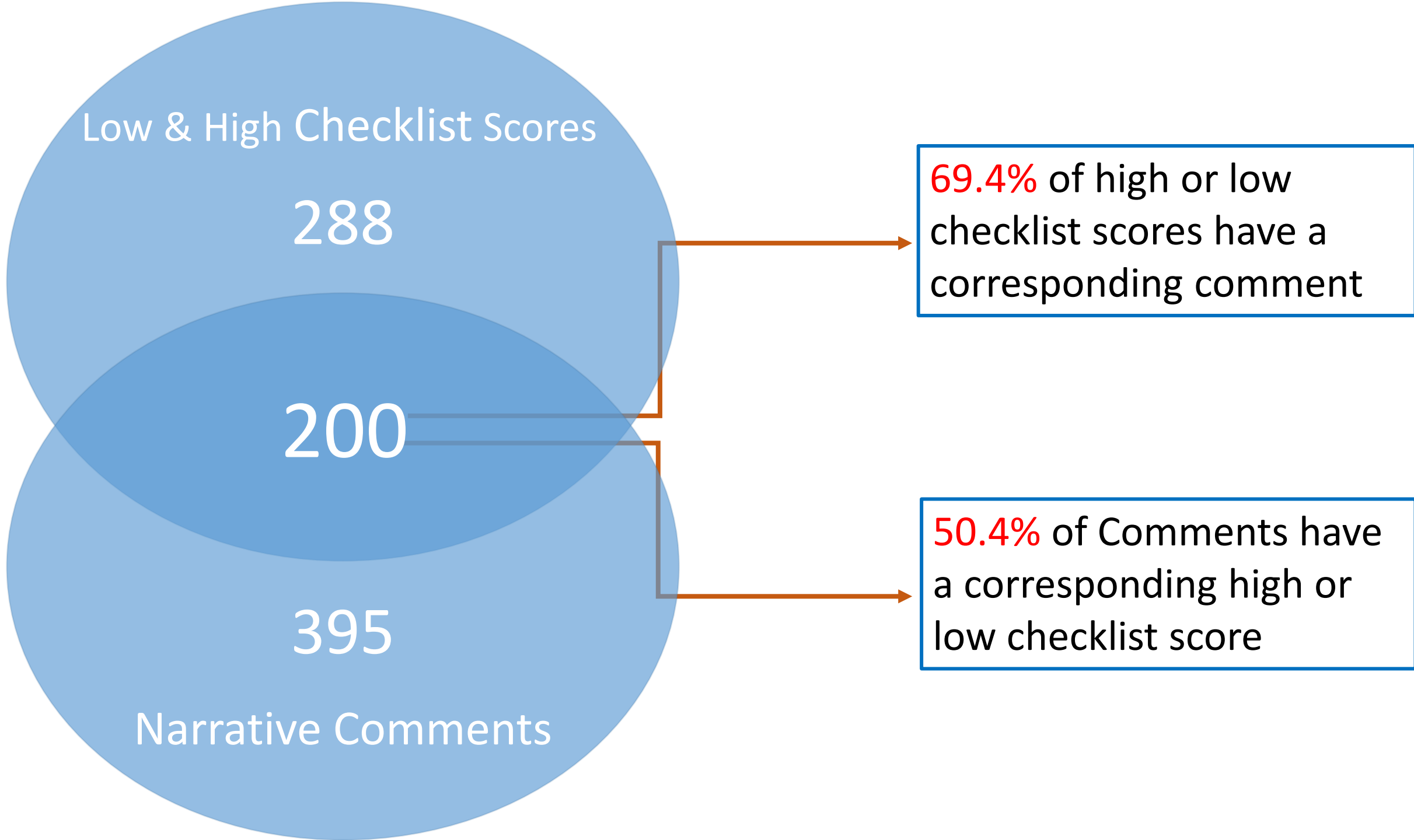
# Corrective

<b>Assesses</b>	<ul style="list-style-type: none"><li>• Excellent how followed up on passive positive SI that patient had expressed at last visit</li><li>• Good use of BDI (Beck Depression Index) to identify/target most significant symptoms</li></ul>	<ul style="list-style-type: none"><li>• Suicidality – ask what means by “not yet” – granted, patient said it in a light hearted manner</li><li>• Adherence: can ask “how many doses missed” rather than “have you missed” (Normalize behavior)</li></ul>
<b>Obtains an Interval History</b>	<ul style="list-style-type: none"><li>• Good combo of following patient's story but also asking him to amplify</li><li>• Done well: pursuing the temporal details of onset of various symptoms and order in which they appeared in order to organize diagnostic impressions</li><li>• Liked your reviewing patient's challenges in life: marriage, work, anxiety</li></ul>	<ul style="list-style-type: none"><li>• For sleep complaint develop structured history: when in bed, when awake, when wake-up, how long to fall asleep, when out of bed</li><li>• When taking interval history, consider asking about symptoms chronologically</li></ul>
<b>Builds Rapport</b>	<ul style="list-style-type: none"><li>• Ability to remember details of patients’ lives from session to session</li><li>• Masterful matching of her pace</li><li>• Excellent balance in session of giving patient space and time to express emotions</li><li>• Great eye contact</li></ul>	<ul style="list-style-type: none"><li>• Take more opportunity to follow-up with questions (about social issues ie. new daughter, work life) to build rapport</li><li>• The sequence of sentences with pause built tension / anxiety</li></ul>

# Congruence Checklist/Comments - Valence



Spearman rho =  
0.57, P < 0.001





# Key Functions of Narrative Comments

1. 'Explain', 'expand', 'interpret' low and high checklist scores
2. Provide unique feedback relative to the checklist scores
3. Identify constructs not adequately represented on the checklist
  - Engaging patients – shared decision making, exploring patient belief's about their illness
  - Managing and structuring the interview – transitions, time, endings

# Study 3 Validity Implications

- P-SCO generates high quality feedback – specific, actionable, mix of reinforcing and corrective
  - First study to date – comments from direct observation tool
  - Better than results reported for ITERS, Other WBAs
- [Significant ‘between faculty’ variance regarding number and valence of comments (*data now shown*)]

# Lessons

- Higher Expectations → ↑ Compliance

- Faculty: 1/month → ≥1/clinic
- Resident: ≥8/year → ≥ 12/year

- Culture Change

- Passive → active role for faculty
- ↑faculty consensus around priority competencies

- Improved feedback

- Specific and timely
- Re-enforcing & corrective
- Checklist & narrative
- Written and verbal

- Supporting curriculum in place

- Didactics and skills workshop
- Pre- and post-clinic case conference
- Reflective practice: self assessment

# Study 3: WBA on a Smartphone Platform

1. Feasibility

2. Utility

Young JQ, McClure M. Fast, Easy, and Good: Assessing Entrustable Professional Activities in Psychiatry Residents with a Mobile App. *Acad Med.* 2020.

Young JQ, Sugarman R, Schwartz J, McClure M, O'Sullivan PS. A mobile app to capture EPA assessment data: Utilizing the consolidated framework for implementation research to identify enablers and barriers to engagement.

*Perspectives on medical education.* 2020.

# Barriers to Workplace-Based Assessment

Competing Demands (Time)  
Inefficient Capture & Aggregation

Mobile Apps  
(e.g., O-SCORE, SIMPL)

Milestones - Granular

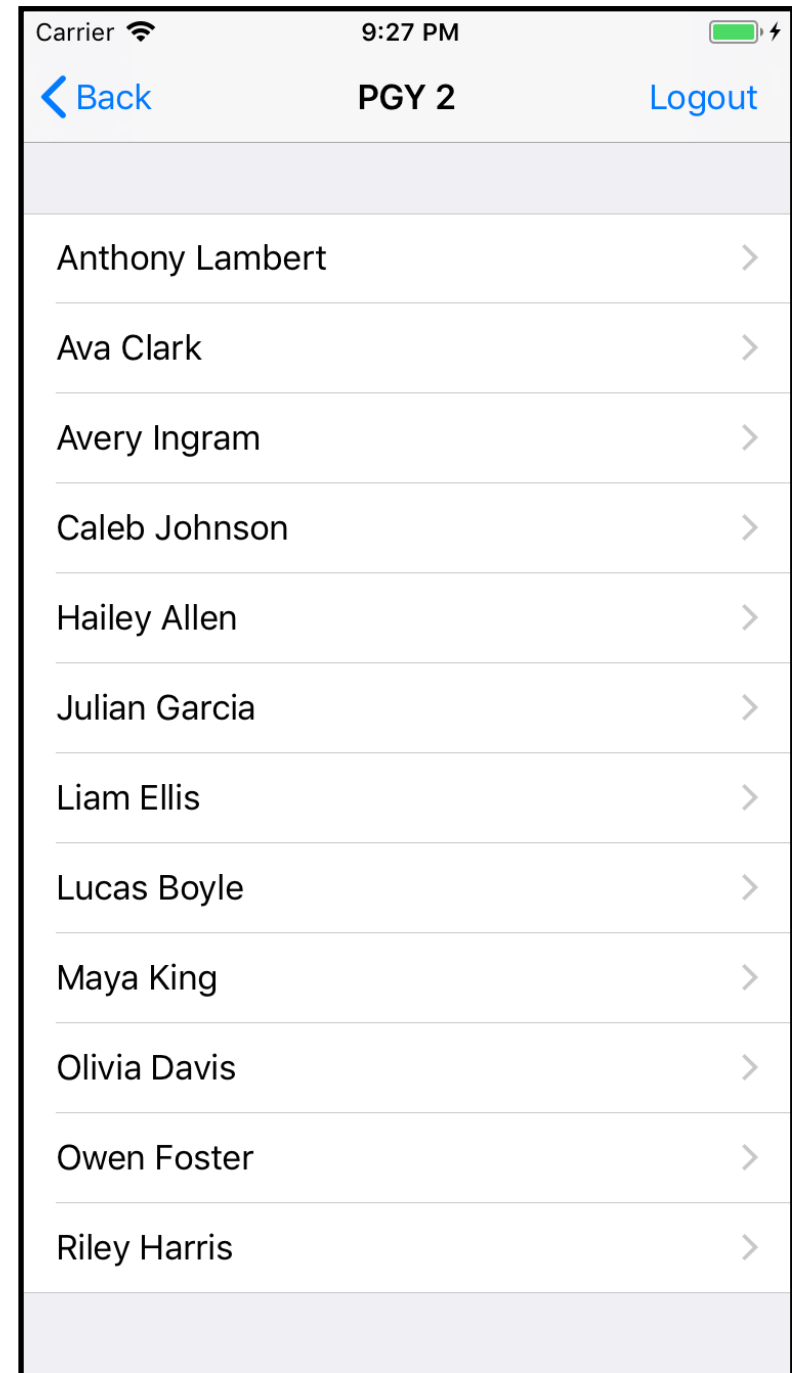
EPAs - Holistic



## Prior Study: Methods

- Design Process – iOS Human Interface Guidelines
  - Optimize End User Experience
  - Minimize screens, taps
- Pilot in PGY-2 Continuity Clinic
  - ½ day a week
  - Longitudinal Supervisor/Resident Dyad
- Goal = 10 completed observations per dyad over 9 months
- Outcomes
  - Utilization
  - Comment Quality
  - Correlation of Entrustment Scores with Resident Experience

# App opens with list of residents



# EPA App Workflow





# 3 Items to Complete

Carrier 9:28 PM

< PGY 2 Anthony Lambert

EPA >

LEVEL OF SUPERVISION

- Co-Treat ⓘ
- Direct Full ⓘ
- Direct Partial ⓘ
- Indirect ⓘ
- Independent ⓘ

FEEDBACK

One thing trainee can do to advance to the next level.

Submit

# Select an EPA



Carrier 9:29 PM

[← Anthony Lambert](#)

- Diagnostic Interview ⓘ
- ✓ Medication Management ⓘ
- Longitudinal Management ⓘ
- Manage Transitions in Care ⓘ
- Supportive Psychotherapy ⓘ
- CBT Psychotherapy ⓘ
- Psychodynamic Psychotherapy ⓘ
- Involuntary Commitment and Treat... ⓘ
- Assess Decision-Making Capacity ⓘ
- Provide Psychiatric Consultation ⓘ
- Apply Quality Improvement Metho... ⓘ
- Serve as a leader on interprofessio... ⓘ
- Manage Psychiatric Emergencies ⓘ



Additional information  
available as needed

Carrier 9:29 PM

[← Back](#)

### Manage a patient's psychiatric condition with medications

The graduating resident must be able to perform the central task of medication management, including the essential tasks of a medication visit or follow-up whether office-, tele-, or video-based. The task includes the interval history of present illness, measurement-based care, assessment, treatment planning, and referrals as needed. Embedded within this EPA are the competencies related to medication selection and titration as well as managing adverse effects and adherence and engaging the patient in treatment planning.

**Functions/Tasks (as indicated - not all tasks are always necessary/appropriate)**

- Performs a medication management visit or follow-up
- Initiates, titrates, and manages medication, duration, and dose in a collaborative manner with the patient based on best available evidence, risks and benefits, and relevant patient factors

Select "Level of Supervision"



Carrier 9:29 PM

< PGY 2 Anthony Lambert

EPA Medication Management >

LEVEL OF SUPERVISION

- Co-Treat (i)
- Direct Full (i)
- Direct Partial (i)
- Indirect (i)
- Independent (i)

FEEDBACK

One thing trainee can do to advance to the next level.

Submit

Enter text  
feedback  
(type or dictate)



Carrier 9:30 PM

< PGY 2 Anthony Lambert

Indirect ⓘ

Independent ⓘ

FEEDBACK

Start with open-ended questions.

Submit

I The Start

q w e r t y u i o p

a s d f g h j k l

⬆ z x c v b n m ⬇

123 😊 🗣 space return

Tap “Submit”

Carrier 9:31 PM

< PGY 2 Anthony Lambert

EPA Medication Management >


LEVEL OF SUPERVISION

Co-Treat	i
<input checked="" type="checkbox"/> Direct Fu	i
Direct Pa	i
Indirect	i
Indepen	i

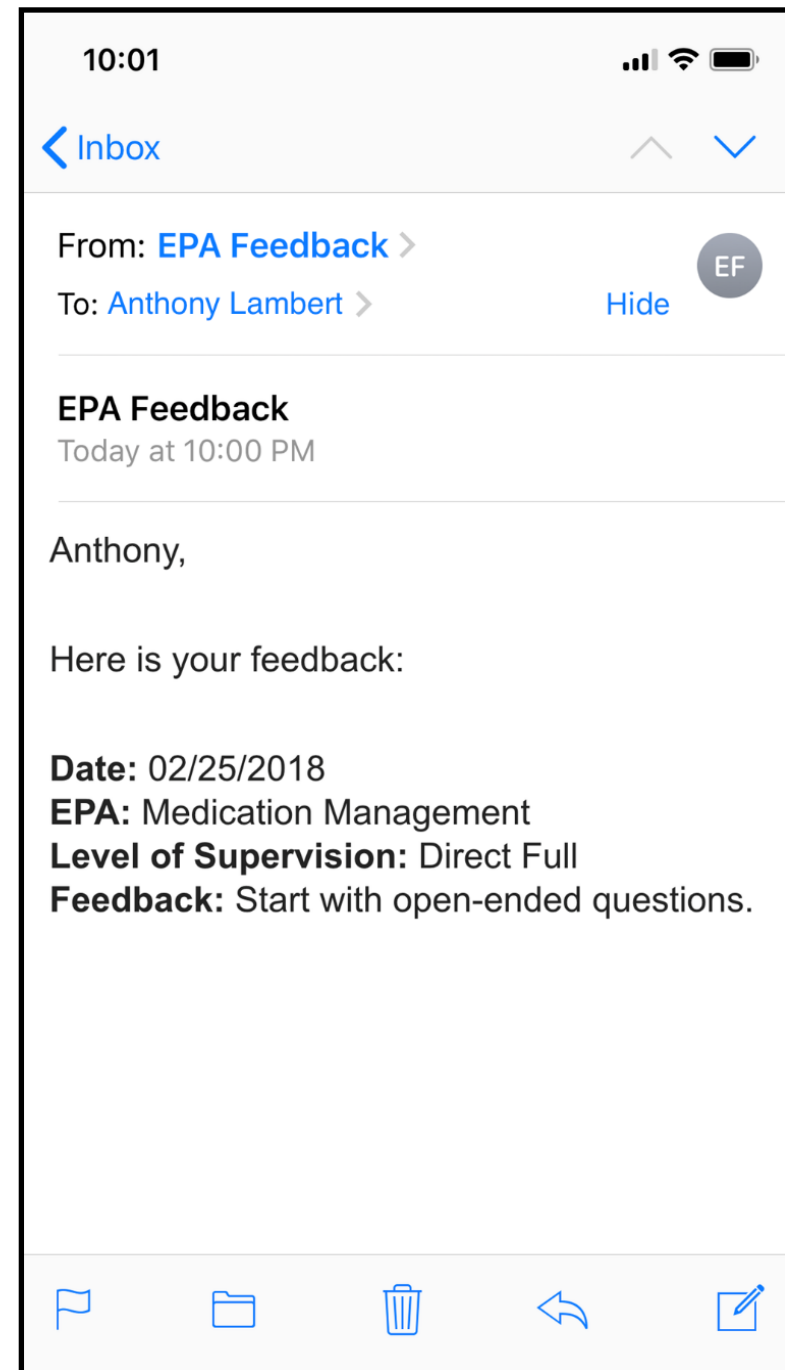
FEEDBACK

Start with open-ended questions.

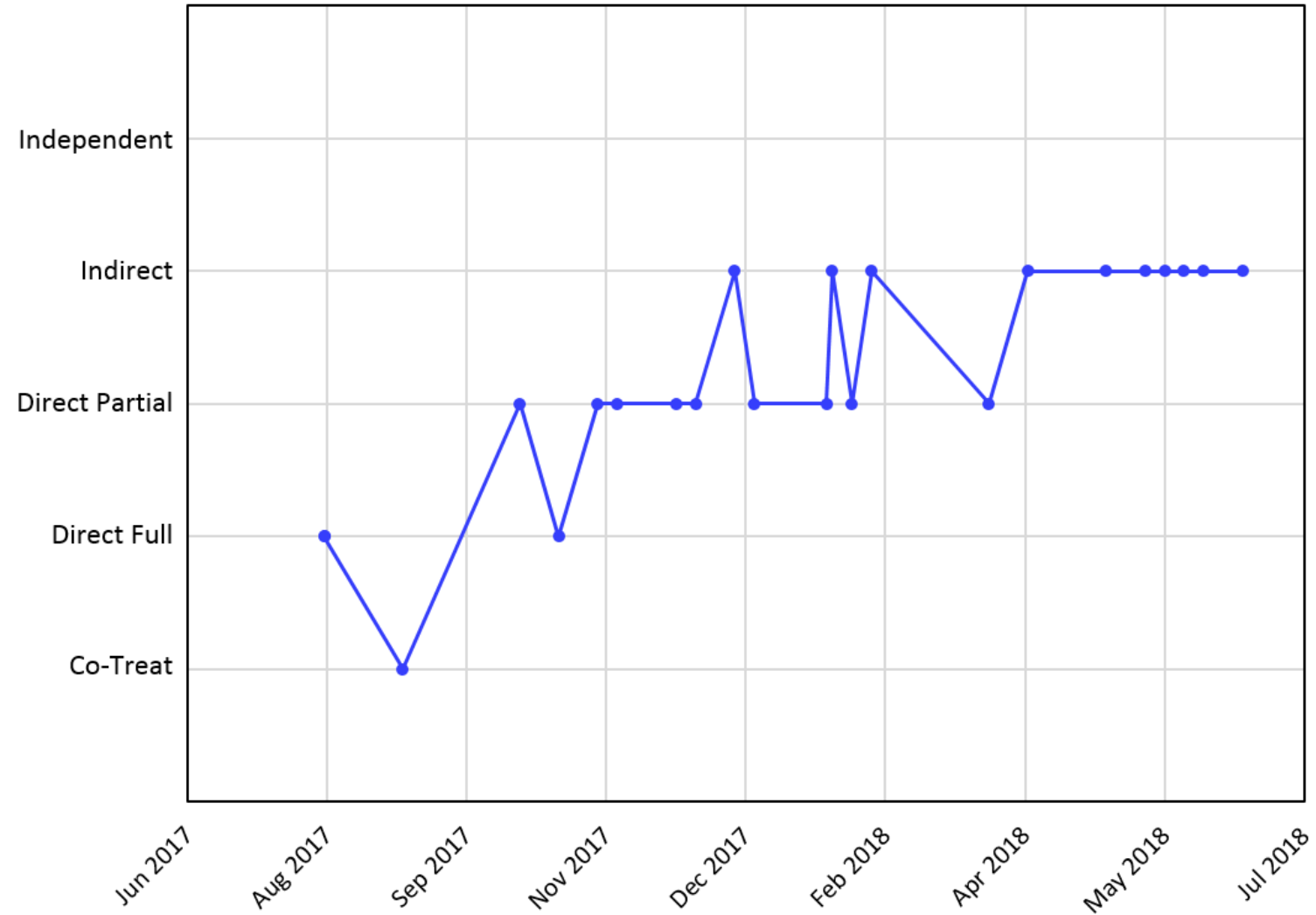
Submit



# Feedback emailed instantaneously to Resident, Attending, Program



# Run Charts: Progress over Time





# Initial Pilot Study – EPA App

## Utilization

- ✓ Time to complete: Median = 67 seconds

## Correlation of Entrustment Scores with Resident Experience

- ✓ Pearson's  $r = 0.43$ ,  $p < 0.001$

## High quality comments

- ✓ 1 per assessment
- ✓ 95% behaviorally specific and actionable

Young JQ, McClure M. Fast, Easy, and Good: Assessing Entrustable Professional Activities in Psychiatry Residents with a Mobile App. *Acad Med.* 2020.

# Results - Comment Quality

✓ 95% behaviorally specific and actionable

✓ 98% generated 1 comment

✓ 91% corrective

*“Screen for substance use”*

*“Work on explaining mechanism of SSRI to patient in simple terms”*

*“Review the AIMS”*

*“Ensure your stated treatment goals align with the patient’s”*

*“Always conduct a thorough risk assessment”*

*“Get patient’s overall subjective sense of progress, in addition to probing specific symptoms”*

# Implementation of WBA

- 'It's not just the tool!'

# Challenges with WBA

- Competing demands (time)
- Clumsy paper-based or desktop-based capture systems
- Poor understanding of purpose
- Inadequate training
- Low quality, unidirectional feedback
- Short duration supervisory relationships
- Fixed mindset cultures > hide weakness
- Trainees perceive assessment as summative even when intended as formative

## Challenges with WBA: The “Performance”

Medical learners value observation. But...

- They perform to perceived ‘checklist’
- They alter their behavior with the patient
- The encounter is experienced as inauthentic
- The resident then politely receives the feedback but dismisses the feedback because ‘that is not what they typically do’.

# Challenges with WBA

- Tick box, jump through the hoops exercise
- Ultimately – trivializes process

# Future Success of WBA Implementation

- Understand stakeholder experience
  - Reduce barriers to engagement
  - Increase enablers to engagement

# Direct Observation and Structured Feedback Program

- WBA tools with evidence for validity: EPA app + paper-based P-SCO
- Ongoing faculty and resident training –
  - direct observation – support resident autonomy
  - Performance dimensions, frame of reference
  - Feedback as bidirectional, co-constructed conversation
- Protected time for repeated observations and feedback within a
- Longitudinal supervisory relationship
- Faculty (not learner) initiates
- Program monitors faculty engagement

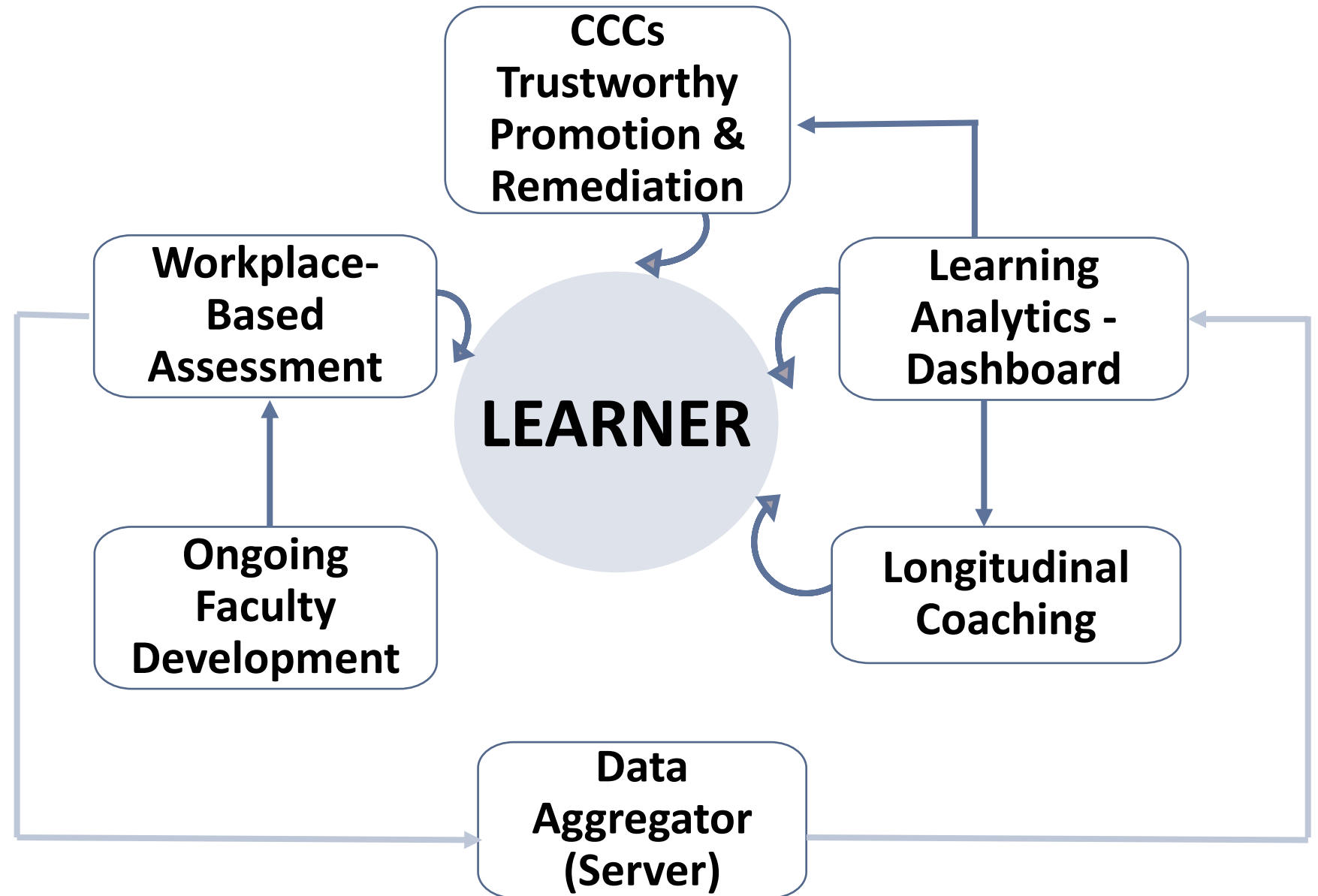


# Direct Observation with Structured Feedback Program (DOSFP)



# Competency-Based Assessment System

- Promotes
1. Self-regulated learners
  2. Competency as judged by trustworthy process

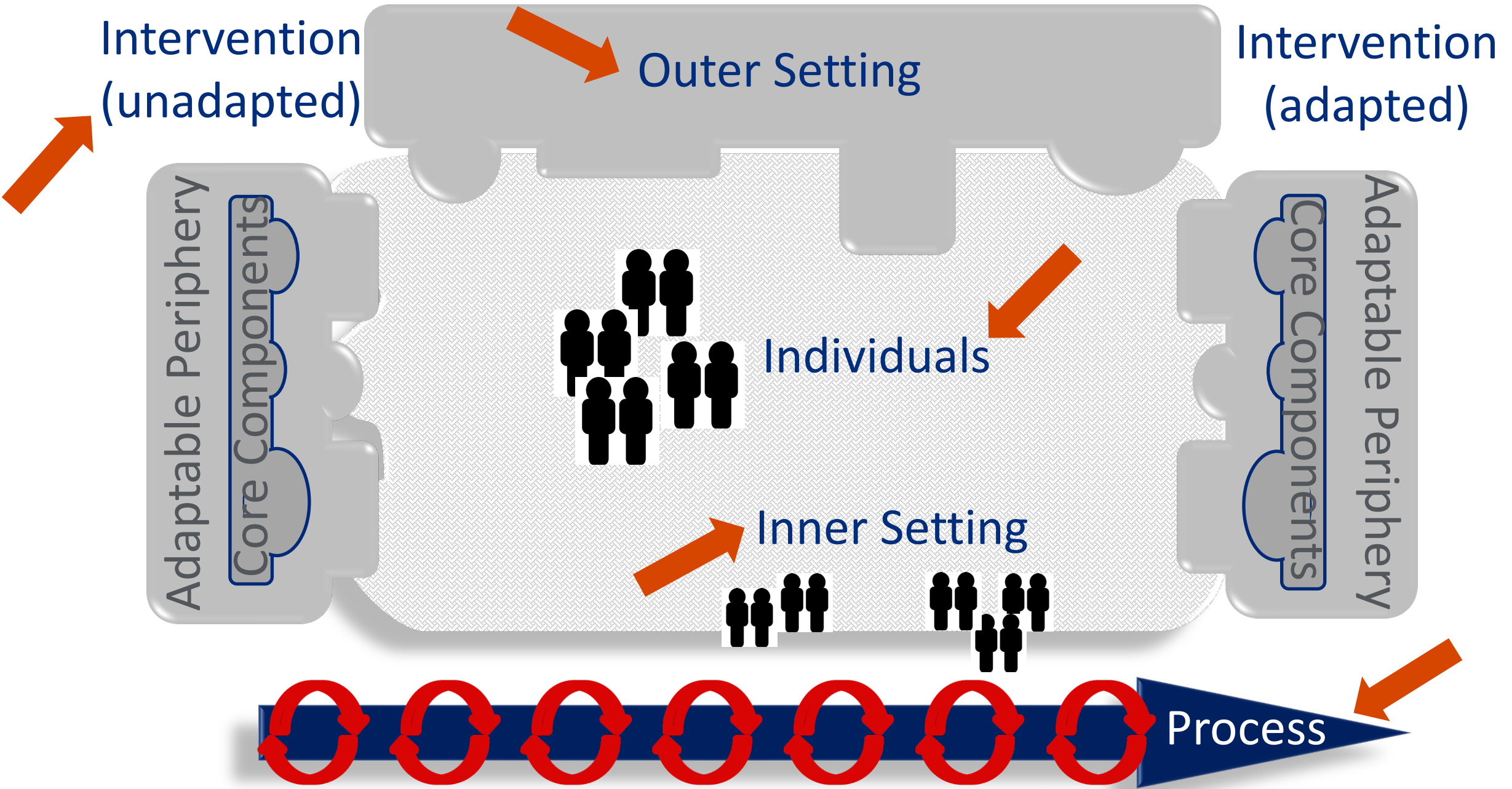


# Q1: What were the Enablers and Barriers to Engagement with the WBA Tools

- EPA App and P-SCO
- Implementation Science - Consolidated Framework for Implementation Research (CFIR)
  - Meta-theoretical framework
  - Examines implementation across 5 interacting domains

Young JQ, Sugarman R, Schwartz J, O'Sullivan PS. Faculty and Resident Engagement With a Workplace-Based Assessment Tool: Use of Implementation Science to Explore Enablers and Barriers. *Acad Med.* 2020.

Young JQ, Sugarman R, Schwartz J, McClure M, O'Sullivan PS. A mobile app to capture EPA assessment data: Utilizing the consolidated framework for implementation research to identify enablers and barriers to engagement. *Perspectives on medical education.* 2020.



# Intervention & Individual Characteristics – EPA App

Enablers	Barriers
<ul style="list-style-type: none"><li>+ Fast: less than 70 seconds to complete</li><li>+ Easy: intuitive, minimal clicks</li><li>+ Hassle free to submit – just tap</li><li>+ 1 distilled, corrective comment</li><li>+ Forces faculty to construct succinct, single take home message</li></ul>	<ul style="list-style-type: none"><li>– No space for reinforcing comments</li><li>– Only one comment, Sometimes not enough detail</li><li>– Some faculty did not understand EPA scale</li><li>– Faculty prefer paper-forms for note-taking during observation</li><li>– Some faculty: concerned patient might be offended</li></ul>

**Overall: focused, actionable, forest > trees**

# Intervention & Individual Characteristics – PSCO

## Enablers

- + Single page, easy to complete
- + Prompts both corrective and reinforcing
- + 5, balanced, detailed comments
- + Paper: easy to take notes during visit - aides recall for verbal/written feedback
- + Checklist: visual design, thoroughness > more specific feedback

## Barriers

- Residents perceive burdensome to faculty
- Paper: easy to lose, forget to submit, more difficult to monitor adherence
- Checklist: length, cumbersome
- More time to complete

+ **Overall: systematic, more thorough, trees > forest, more time, paper**

# Other Characteristics: EPA App & PSCO

## Common Enabling Factors

- Design user friendly
- Ongoing training for faculty and residents
- Alignment with organizational values
- Perception that tool improves feedback
- Faculty time protected
- Initiated by faculty

## Common Barriers

- Protected faculty time not sufficient
- Discomfort with identity threatening feedback
- Residents do not return to feedback after initial review

# Summary

*“I think something would be lost if only one was used to the exclusion of the other. I think it might be an ideal mix of primarily using the phone because of its ease of use and it’s ability to generate a lot of data, but then periodically doing the paper one because it reminds us of some trees, not just the forest.” (F\_1)*



# Q2: How did residents & faculty experience the DOSFP

- Interviewed faculty and residents
- Thematic coding of transcripts

# Key Findings

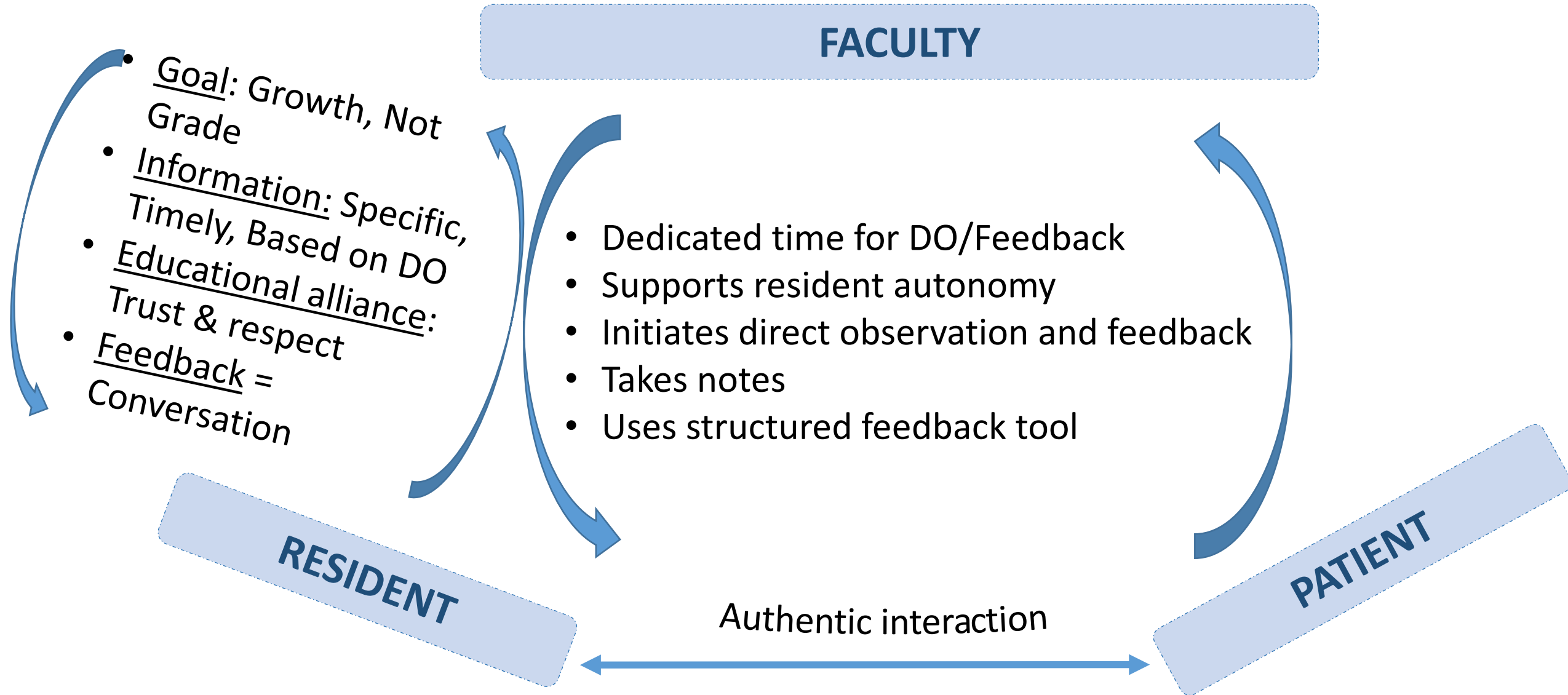
- Strong 'educational' alliance formed
- Alignment on goal: growth not grading
- Residents report authentic interactions with patients
- Residents describe feedback conversations as bidirectional
- Residents deemed feedback credible
- Residents discount certain types of disagreeable feedback

What do faculty and residents value most?

**But ...**

Faculty and residents believe that use of WBA tools, especially the checklist, improves what they care most about – verbal feedback

# Figure 1. Factors Facilitating Meaningful Feedback in the Direct Observation and Structured Feedback Program



# The affordances of relationship

Trust regarding intent

Time for sufficient observation

Better alignment of goals

Better understanding of developmental trajectory

Growing understanding of what works and what doesn't

“Shorthand” for tough conversations

# Conclusion

- Misalignment: ‘what’, ‘how’, ‘why’
- Redesigning medical education for population health
- EPAs as emerging assessment framework
- Work-based Assessment Tools
  - P-SCO & EPA App as exemplars
  - Enablers and barriers to engagement
- Impact of DOSFP on faculty/resident experience of feedback