

Assessment Across the Continuum: Aligning UME, GME and MOC Summary Report

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Background

Over the last decade there has been a shift from the Flexner model of medical education where there was a fixed time spent in training model with variable outcomes to one with fixed outcomes but variable time spent in training. The Accreditation Council for Graduate Medical Education's Outcome project was responsible for starting this shift along with organizations such as the American Board of Medical Specialties. Creating tools to assess the six competencies (professionalism, systems-based practice, practice-based learning, interpersonal and communication skills, medical knowledge and patient care) became challenging as the competencies were quite broad. The ACGME Milestones Project worked to define the competencies by identifying entrustable professional activities (EPAs) in each medical discipline such as in pediatrics. The focus on this session was on the development of EPAs at the beginning of training throughout the career of the physician. It was assumed that the EPAs had already been defined in a prior session.

Key Points from Presentation

Dr. Robert Englander began the presentation with a discussion on the shift in the paradigm to an outcomes-based education. As this shift to outcomes-based education became more of a reality in graduate medical education, the notion started spreading into the undergraduate medical education (UME) world and out into practice. The path from medical school to practice should be considered a developmental trajectory that would build mastery in the six competencies. Two other competencies are seen as critical in what makes a good doctor in health systems today. These are inter-professional collaboration and personal and professional development. The delineation of different performance levels is important in identifying the pediatric milestones. That is, these steps may begin with as student saying "I won't do it" to a student finally saying "yes I did it." There are challenges in establishing an assessment framework in which multiple methods of assessing a competency are desired. EPAs might be useful as the assessment framework but more research is needed in this area. An example of an EPA entering the clerkship space includes "communicate information relevant to patient's care with other members of the health care team." An EPA entering the residency space may be "give or receive a patient handover to transition care" whereas an EPA entering the pediatric and subspecialty space may be "facilitate handovers to another healthcare provider either within or across settings."

As most are in agreement about the requisite competencies of the 21st century physician, we have a potential unifying framework using the pediatric milestones for assessment of competence across the continuum of medical education. The question remains as to whether this framework can also be applied to the practice space.

Key Points from Breakout Session

Conceptually there was agreement that the competency framework is useful and milestones and EPAs are understandable once they have been developed in a discipline. Using the same framework throughout the continuum of a physician's career is advantageous in that it will be predictable, better accepted, built into the culture of practice, and should inspire physicians to improve. As the evaluation of these competencies is most successfully accomplished through many points of data collection and a variety of different assessments there may be too many competing mandates and not enough time to do this well in the practice setting. The practice environment is much more complex and unstandardized than the training environments and assessments feel more appropriate when tailored to the specific practice. There is a danger that because this is a difficult task some of the assessments would devolve into nothing but checklists and be seen by the physician as simply wasteful and "jumping through hoops."

Conclusions

It is important to build the competency framework into medicine first through medical school, residency training and then specialty training. Effective messaging about the importance of the competencies is critical. In addition, decentralizing the work so that the ABMS boards collaborate with health systems is essential. These are good next steps in the practice space. Pilot testing ideas with innovative practices and health systems seems like a reasonable approach to changing the paradigm and building the competency framework into the fabric of quality health care. A strong majority of conference attendees felt that the ABP should invest effort and resources into collaborations and initiatives that build bridges across traditional UME, GME, and MOC silos to create a continuum for purposes of assessment.