ORIGINAL RESEARCH

Multi-Stakeholder Validation of an Entrustable Professional Activities Framework for Canadian Geriatrics Residency Programs*

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ABSTRACT

Background

Entrustable Professional Activities (EPAs) have become a cornerstone for an increasing number of competency-based medical education programs. Today, frameworks of EPAs are being used in most, if not all, medical specialties. These frameworks can break a discipline down to its constituting tasks, and structure the training and evaluation of residents. In 2018, The Royal College of Physicians and Surgeons of Canada created an EPA framework for Geriatric Specialty residency programs nationwide. The present study aims to evaluate this EPA framework through focus groups consisting of several stakeholder groups.

Methods

Participants were recruited to be part of one of five focus groups—one for each stakeholder group of interest. The five focus groups consisted of: physician faculty, residents, allied health professionals, administrators/managers, and patients. Each focus group met once virtually over ZOOM® for no longer than 90 minutes. Meeting transcripts were iteratively coded based on emerging themes, and were compared for similarities and gaps between stakeholder perspectives.

Results

Multi-stakeholder consultation yielded feedback on many specific EPAs, suggestions for new EPAs, and additional input which gave rise to four themes: (i) EPA scope, (ii) Operationalization, (iii) Interprofessional Collaboration, and (iv) Patient Advocacy. Lastly, we received their thoughts on how the framework defines Geriatrics relative to the work of Care of the Elderly physicians in Canada.

Conclusions

Consulting a variety of stakeholder groups generates a robust and diverse supply of feedback that holistically augments EPA frameworks to be more practical, appropriate, socially accountable and patient-centred.

Key words: competency-based medical education, geriatric medicine, focus group, care of the elderly, stakeholder

INTRODUCTION

Competency-based Medical Education (CBME) has been widely adopted by residency programs across all specialties and across the globe.(1) CBME gets its name from competencies, which are abilities deemed necessary for a trainee to demonstrate before being trusted with unsupervised practice.(2) Competencies embody the knowledge, skills, and attitudes (KSAs) required to perform the necessary tasks of a profession.(3) The broad and theoretical nature of competencies was once the bottleneck of CBME due to their lack of practicality in the assessment of trainees.(4) The concept of Entrustable Professional Activities (EPAs) was designed to remedy this problem.(4) An EPA is "a discrete profession-specific task (or bundle of tasks), typically an identifiable act of patient care, which requires the integration of multiple competencies (including vital knowledge, appropriate skills and attitudes)".(5) Frameworks (i.e., lists) of EPAs can serve as a "curriculum blueprint to define a specialty and guide educators and learners in determining the desired outcomes of training".(6) EPAs can also be the basis for increased autonomy and decreased need for supervision as learners grow in their ability to perform individual EPAs.

**This manuscript presents results from focus group meetings which considered two EPA frameworks: one for a Family Medicine Care of the Elderly Enhanced Skills program, and one for the RCPSC Geriatrics Specialty program. A manuscript dedicated to the CoE framework has been published by another journal, while this manuscript covers results relevant to the Geriatrics Specialty Program.*

[7] Within the larger context of CBME, residents' performance of EPAs have shown moderate-to-strong correlation with their performance of competency milestones.[8]

In Canada, residents completing a three-year Internal Medicine residency program can become Geriatricians by completing a two-year specialization in Geriatrics. In 2018, The Royal College of Physicians and Surgeons of Canada (RCPSC) formulated an EPA framework for Geriatrics Specialty Programs across the country (https://deptmedicine.utoronto.ca/sites/default/files/Royal%20college%20EPAs%20document.pdf). On July 1 2019, the EPA framework was implemented by Geriatrics residency training programs across the country. The EPAs were developed by the Royal College's Geriatric Medicine Committee.[9] The list of EPAs was divided by four stages through which residents progress over the two years. Ordered from first to last, these stages are (i) Transition to Discipline, (ii) Foundations of Discipline, (iii) Core of Discipline, and (iv) Transition to Practice. In addition, two "Special Assessment" EPAs were included that residents can work toward over the two years. After the timeframe of this study, the RCPSC made minor revisions to the framework on July 1, 2023.

There continues to be significant variability in the methods used to develop, implement, and assess EPAs.[10] One method used to evaluate and refine (i.e., validate) EPA frameworks is by opening them to the criticism of relevant stakeholders. Stakeholder input has been utilized in a variety of ways to develop and evaluate EPA frameworks, including modified Delphi procedures, focus groups, surveys, and individual interviews.[11-14] Among these various methods, multi-stakeholder focus groups have demonstrated the ability to improve the content validity of EPA frameworks.[14] The format of focus groups garners open-ended feedback while allowing stakeholders to critique and expand on each other's ideas and colleagues in ways not possible with surveys or modified Delphi procedures. The majority of previous studies have either primarily focused on physician perspectives,[15] or featured a small number of distinct stakeholder groups.

The present study seeks to evaluate the soundness of the RCPSC Geriatrics Specialty Program EPA framework through the consultation of five distinct stakeholder groups.

METHODS

For the purposes of this study, stakeholders were defined as individuals who benefit directly or indirectly from resident education. The five stakeholder groups identified were physician faculty, residents, administrators/managers, allied health professionals, and patients. The distribution of invitations and conducting of focus group meetings all occurred between June and August 2021. All participants, except for those in the resident group, were required to live in the province of Manitoba. Each focus group was homogenously composed of individuals from the same stakeholder group. Invitations to take part were distributed via email. No incentives were offered for participation in the study. Invitations for stakeholder groups were shared by residency program directors, Local Health Interest Groups (LHIGs), and administrators in professional colleges and the Winnipeg Regional Health Authority, and through online faculty listings. For the physician faculty group, Geriatricians, as well as Care of the Elderly (CoE) physicians, were eligible to participate. CoE family physicians are further trained for one year in providing care to older patients, especially those with complex presentations.[16] Participation in the resident group was extended to trainees in other provinces due to the insufficient number of current trainees in Manitoba, Canada. The patient group was defined as patients over the age of 60 who have received, or are currently receiving, care (e.g., inpatient, outpatient, specialist or generalist), as well as family members of individuals who fit this description. The demographic composition of each stakeholder group is showcased in Table 1.

Participants were required to sign a consent form and review the Geriatrics EPA framework (RCPSC Geriatrics 2019 version 1.0) and an EPA framework for the province's Care of the Elderly residency program (University of Manitoba 2018 version 1.0) prior to participation. Focus group meetings were conducted online through ZOOM®. Each focus group had a single meeting lasting no more than 90 minutes. All focus groups were led by a medical student or the principal investigator using the same semi-structured interview script (see Appendix). The interview script starts by providing introductory information to participants about both residency programs, EPAs and CMBE. The questions asked regarding the EPA framework were: "Do you feel they describe common tasks that a Geriatrician performs?"; "Are there EPAs that you do not regard as a key activity that a Geriatrician should be able to perform independently by the end of the training?"; and "Are there additional EPAs that you think should be included?" Finally, participants were asked to compare the framework to another one made for local CoE residents and comment on whether the frameworks "reflect (or do not reflect) the overlapping and complementary

TABLE 1.
Demographic composition of focus groups

Stakeholder Group	*Group Composition*
Physician Faculty	6 Geriatricians 1 CoE Physician
Residents	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/ Managers	2 Managers 2 Administrators
Patients	6 Patients 1 Family Member

scopes of practice of these two [disciplines]." The feedback received about the University of Manitoba CoE residency EPA framework was separately reported in our previous study.[17] Each meeting was recorded through ZOOM and transcribed using NVivo® (QSR international, Doncaster, Victoria, Australia). Meeting transcripts were anonymized and transcription errors corrected.

The coding structure for transcripts was iteratively defined by the research team after each focus group meeting. NVivo was also used to code all meeting transcripts. Comparative analysis was performed to identify agreements and differences between the comments and themes arising from the five stakeholder groups.

Ethics approval was received from the Health Research Ethics Board at the University of Manitoba (HS24748 (H2021:114[CM5])).

RESULTS

In general, all stakeholder groups found that the RCPSC Geriatrics EPA framework successfully and comprehensively showcased the professional tasks of Geriatricians. Stakeholders also made remarks directed to specific EPAs, as summarized in Appendix Table A1.

Suggestions for EPA Additions

When asked, "Are there additional EPAs that you think should be included?", participants had a plethora of valuable suggestions to share—some of which were attested to by multiple stakeholder groups. These suggestions, shown in Table 2, could be integrated into extant EPAs, or used to formulate new ones.

Four themes emerged during the stakeholder focus group meetings. Of note, no theme was specific to only one stakeholder group. The themes that arose are Scope, Operationalization, Interprofessional Collaboration, and Patient Advocacy.

Theme: Scope

EPA scope, defined here as the appropriateness of detail an EPA uses to describe a task(s), was a significant theme that arose in the physician faculty and resident groups. In almost every instance an EPA's scope was discussed, the Geriatrics EPAs were found to be excessively detailed. This was found to be a pitfall of the EPA framework.

A member of the physician faculty group said:

> "Each EPA has a lot of specifics around how they're assessed… they're very narrow. So [for] delirium, it has to be at least one case hyperactive, in one case hypoactive and one case mixed… We probably got too in the weeds."

A resident provided insight on why the level of detail with which the EPAs were written may not be necessary.

> "Sometimes when you get to the specifics of an EPA—for example, for dementia assessment—you need 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, etc."

TABLE 2.
Additions proposed by stakeholder for the RCPSC Geriatrics EPA Framework

Proposed EPA Addition	*Stakeholder Groups*
Demonstrate an awareness of local programs available to older adults and advocate for their patient's access to such services	Administrator/Manager Patients Physician Faculty
Screen for addiction and counsel older adults with substance abuse disorder	Patients Health-Care Professionals Residents
Provide trauma-informed care	Patients
Certify patients under the Mental Health Act	Residents
Draft medicolegal documents that may be used in court	Residents
Identify and assist patients experiencing social isolation	Health-Care Professionals
Offer patient care virtually	Physician Faculty
Provide care that is inclusive to LGBTQ+ patients	Patients
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
Facilitate code status discussions with patients and their family	Residents
Educate staff on Geriatrics topics	Administrator/Manager

Theme: Operationalization

Comments regarding how EPAs are used to evaluate residents (i.e., operationalization) came from the resident and physician faculty groups. Although the specificity (i.e., scope) of EPAs were thought to create challenges in the evaluation of residents, operationalization-related comments showcased distinct ways the framework could be challenging to implement in a practical manner.

> For example: "Something I found very difficult … is the burden of EPAs when you're trying to get a preceptor to sign off on these things… [And] in terms of the quantity of presentations, that can sometimes be difficult to achieve. I think [it is] more important to demonstrate competence and mastery of that skill rather than expecting someone to see three or four of these sometimes-rare conditions."

The physician faculty group also identified a large-scale issue with how the three EPAs devoted to comprehensive geriatric assessments (CGAs) were meant to be evaluated at different stages of training.

> "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."

Theme: Interprofessional Collaboration

The need to collaborate with other specialists and allied health professionals was highlighted by the patient, resident, and health-care professionals groups. Appropriately, the group that was most vocal on this theme was the health-care professionals group. As shown in Table 2, the health-care professionals group highlighted several EPAs that could be best accomplished alongside other members of the health-care team.

For example, a member of the health-care professionals group said the following about fall risk assessments:

> "About the falls, I would think that … there should be consultation with other allied health professionals. The physician will see the client in their office. But when you're assessing fall risk, you really have to see a client in their environment… So that's where allied health will come in."

Interestingly, multiple residents proposed the idea of allied health professionals being 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: Patient Advocacy

All stakeholder groups made remarks on the theme of patient advocacy. This theme was a primary focus of the patient group, who provided unique insight from a personal perspective.

One example voiced by the patient, physician faculty, and administrator/manager groups was the need for trainees to learn how to help patients navigate health services that they require.

A member of the patient group said:

> "[At a local clinic], you walk in the door and there is dental, medical, mental health. And you just sort of stand there and go… "what do I do? … People need to be aware that they can access a program before it's useful."

Similarly, a member of the administrator/manager group envisioned Geriatricians advocating for their patients' access to the supports and services they need at a larger scale.

> "The role of advocacy for seniors in Geriatrics… [for example, with] all the things that happened recently with COVID-19 and long-term care and senior supports … that will be quite important for someone who specializes in Geriatrics to be advocating for support and facilities and whatever is needed for the group of patients."

Defining Geriatrics vs. Care of the Elderly

Finally, stakeholders were asked to compare the Geriatrics EPA framework with one made for CoE trainees and share their opinions on whether the frameworks "reflect (or do not reflect) the overlapping and complementary scopes of practice of these two [disciplines]".

Both the administrator/manager and physician faculty groups suggested that the relative scopes of practice for CoE physicians and Geriatricians were unclear based on the frameworks alone. However, the frameworks created a consensus among stakeholder groups that CoE physicians are equipped to provide care to older adults in urban and rural outpatient settings, but should refer patients with complex presentations to Geriatricians. Consequently, many stakeholders suggested that CoE EPA frameworks must require trainees to acknowledge the limits of their knowledge and refer to Geriatricians or other specialists when appropriate. Lastly, the administrator/manager group highlighted that Geriatricians have a unique role in teaching and training medical students and residents in Geriatric care.

DISCUSSION

Findings

In general, the EPA framework was well-received among stakeholders and was found to comprehensively describe the specialty. The constructive feedback obtained appears to remain applicable to the framework after the changes made on July 1, 2023. The most crucial areas for improvement are some of the last EPAs in Transition to Discipline and Special Assessment. These issues are primarily rooted in a lack of instruction on how those EPAs ought to be evaluated and how programs should assist residents in accomplishing them. On the other hand, the theme of EPA scope suggests that other EPAs may benefit from the opposite treatment: simplifying

the scope of EPAs to make the framework more practical and realistic in the evaluation of residents. An important goal in EPA development is to achieve a "delicate balance" that comprehensively lays out the tasks of a discipline without losing a "holistic view of the profession".[18] The RCPSC is now making strides toward this goal, allowing program competence committees to treat the outlined number of observations for each EPA as a guideline and not a necessity when making entrustment decisions.[19]

The question, "Are there additional EPAs that you think should be included?" yielded an abundance of ideas that could augment the EPA framework, including the most updated July 1, 2023, version. One suggestion made by three stakeholder groups was to incorporate addressing substance use in older patients. Not only are the rates of substance use in seniors growing rapidly, but physicians frequently fail to identify it, or misdiagnose it in older patients as a consequence of co-morbidities.[20] Thus, the importance of Geriatricians being well-equipped to recognize and address harmful substance/medication use cannot be overstated. Another timely suggestion was the integration of virtual care into the framework in response to the COVID-19 pandemic. Intentionally and adequately training residents in virtual care is important, based on the challenges and limitations residents have experienced with virtual care during the pandemic[21] and virtually deliverable forms of cognitive testing that have emerged.[22] Furthermore, delivering care over the phone became a pivotal means of making care accessible to patients during pandemic-related lockdowns, and also decreases barriers to care for older adults with frailty or mobility issues.[23] Of course, adopting even more EPAs would place more burden upon trainees and faculty; a balance between practicality and comprehensiveness is needed.

While the RCPSC specialty committees that design EPA frameworks consisted of member Geriatricians and occasionally residents,[24] our study featured five stakeholder groups each making valuable and unique contributions. There were some overlaps observed between the groups' contributions which shed light on the roles these stakeholder groups can have in the development and validation of future EPA frameworks. For example, the physician faculty and resident groups identified EPAs that – in their experience – were redundant, excessively detailed, or difficult to assess. Another overlap was between the physician faculty and patient groups, which both frequently paid attention to ensuring high-quality care for patients of all backgrounds and social contexts. Yet, the patient group was able to share from their personal experiences as receivers of care and make specific suggestions on how future Geriatricians could offer better care than what they have received. Similar to other work, we have found that patients are crucial to consult due to their unique perspectives and expectations that physicians cannot solely represent.[13] Lastly, the administrator/manager and health-care professionals groups made several suggestions to help make future Geriatricians more effective in their work with other members of the health-care team, and in the health-care system at large.

Taken together, physician faculty and residents uniquely augment EPAs in their practicality and appropriateness, while involving patients, health-care professionals and administrators/managers permitted our study to go the extra mile to envision how future physicians can be more socially accountable and efficiently work with other health-care professionals to optimize patient care.

Limitations

The study design was limited by the low number of residents, administrators/managers, and CoE physicians and could have benefitted from recruitment of other allied health professionals (e.g., social work, occupational therapy). Ideally, the number of stakeholder groups consulted in this study may have compensated for the lower participation numbers in these groups. Second, after all focus group meetings, some EPAs ultimately received no feedback and cannot be assumed to have been satisfactory to all stakeholders. Lastly, lists of EPAs are a source of "errors of omission," which are when the limited number of EPAs fail to trigger all important aspects of a stakeholder's perspective.[15]

Recommendations

Going forward, future research should continue to evaluate the utility of multi-stakeholder consultation in developing and revising EPA frameworks. Such studies could benefit from involving a greater number of participants from all stakeholder groups to the extent needed to achieve thematic saturation for each stakeholder group. In the future, the RCPSC and other regulatory colleges can holistically augment future iterations of their EPA frameworks using similar methods that involve multiple stakeholders in the development or revision of EPAs prior to their implementation. As well, the tasks of Geriatricians continue to evolve, and it will be essential to match the EPAs to the evolving role of Geriatricians.

CONCLUSION

Multi-stakeholder consultation provides a variety of robust feedback that can significantly enhance EPA frameworks. Such feedback can even help restructure a discipline to be more patient-centred, collaborative, and socially accountable.

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Not applicable.

CONFLICT OF INTEREST DISCLOSURES

BC and DF were medical students at the Max Rady College of Medicine at the time of the study. PS is a board member of Age and Opportunity (unremunerated) and has received speaking honorarium from the University of Ottawa. He was a member of the Specialty Committee for Geriatric Medicine (Royal College) at the time of the introduction of BD. JF has no competing interests to declare.

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APPENDIX A. Focus group intervention guide

FOCUS GROUP INTERVIEW GUIDE

Moderator Introduction and Purpose of Group (5 minutes)
Hello. My name is **[name]**. I'd like to start off by thanking each of you for taking time to participate today. We'll be here for about 90 minutes.

The reason we're here today is to discuss educational frameworks that support the training of family medicine and specialty residents in the area of Care of the Elderly and Geriatrics.

I'm going to lead our discussion today. I will be asking you questions and then encouraging and moderating our discussion.

I also would like you to know this focus group will be tape recorded. The identities of all participants will remain confidential. The recording allows us to revisit our discussion for the purposes of developing research papers and presentations.

GROUND RULES (5 MINUTES)
To allow our conversation to flow more freely, I'd like to go over some ground rules.

1. *Only one person speaks at a time. This is doubly important as our goal is to make a written transcript of our conversation today. It is difficult to capture everyone's experience and perspective on our audio recording if there are multiple interruptions.*
2. *If possible, we ask that you have your cameras on for the duration of the meeting to facilitate our discussion.*
3. *Please avoid side conversations in the chat function*
4. *Everyone doesn't have to answer every single question, but I'd like to hear from each of you today as the discussion progresses.*
5. *This is a confidential discussion in that I will not report your names or who said what to your colleagues or supervisors. Names of participants will not even be included in the final report about this meeting. It also means, except for the report that will be written, what is said in this meeting stays in this meeting.*
6. *We stress confidentiality because we want an open discussion. We want all of you to feel free to comment on each other's remarks without fear your comments will be repeated later and possibly taken out of context.*
7. *There are no "wrong answers," just different opinions. Say what is true for you, even if you're the only one who feels that way. Don't let the group sway you. But if you do change your mind, let me know.*
8. *To conserve everyone's confidentiality, we would also ask that you not discuss thecontent of today's focus group outside of this session.*
9. *Let me know if you need a break, we can pause our discussion so no one misses out.*
10. *Are there any questions?*

INTRODUCTION OF PARTICIPANTS (10 MINUTES)
Before we start, I'd like to know a little about each of you. Please tell me:

1. *Your name*
2. *What your role is with **[organization]***

FOCUS GROUP DISCUSSION (65 MINUTES)
The facilitator provides a brief overview of the training program for the FM Care of the Elderly and the RCPSC Geriatrics.

Care of the Elderly:

CoE: Physicians who have completed the Core Family Medicine Residency Program can elect to take ONE extra year of training, getting a certificate of added competence (CAC) in the Care of the Elderly (CoE). "Family physicians with CACs in CoE who are recognized with the CCFP (COE) Special Designation, are system leaders and champions in their communities. They work with other family physicians, colleagues from other specialties, and other care providers to increase the capacity for the provision of care to elderly adults through direct patient care, consultations, peer support, and education. Family physicians with CACs in Care of the Elderly provide care to the older adult population and to patients with illnesses that are common in the elderly population… They are committed to the delivery of accessible, high-quality, comprehensive, and continuous front-line health care… They 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. They use the principles of comprehensive geriatric assessments in all clinical encounters" (45).

Royal College: After finishing their General Internal Medicine residency program, internists can do a 2 YEAR specialization in Geriatrics to become a Geriatrician. "Geriatric Medicine deals with the prevention, diagnosis, treatment, remedial and social aspects of illness in older people, mainly patients 75 years of age or more. Most certified specialists take academic positions in medical schools. A typical day consists of a mix of patient care activities, education/teaching, administration and research. Specialists in geriatric medicine are expected to be competent consultants, with a well-founded knowledge of geriatrics, who are capable of establishing an effective professional relationship with older patients. Geriatricians work with other members of the health care team to prevent illness and restore an ill, disabled older person to a level of optimal ability and, wherever possible, return the person to an independent life at home."

The facilitator provides a brief overview of Competency Based Medical Education and Entrustable Professional Activities (EPAs)

Questions for the group:

1. *When you look at the list of EPAs for the FM-Care of the Elderly Program:*
   a. *Do you feel they describe common tasks that a Care of the Elderly Family Physician performs?*
   b. *Are there EPAs that you do not regard as a key activity that a graduating Care of they Elderly Family Physician should be able to perform independently by the end of the training?*
   c. *Are there additional EPAs that you think should be included?*
2. *When you look at the list of EPAs for the RCPSC Geriatrics Program:*
   a. *Do you feel they describe common tasks that a Geriatrician performs?*
   b. *Are there EPAs that you do not regard as a key activity that a graduating Geriatrician should be able to perform independently by the end of the training?*
   c. *Are there additional EPAs that you think should be included?*
3. *Can I get your thoughts on how these 2 frameworks reflect (or do not reflect) the overlapping and complementary scopes of practice of these 2 groups?*
4. *Are there other comments you would like to make today?*

CLOSING (5 MINUTES)

Thanks for coming today and sharing your perspectives. Your comments have given us lots of different ways to see this issue. If anyone has not filled out the consent forms, please fill them out and send them to Derek Fisk so we can have them on file. I thank you for your time.

APPENDIX TABLE A1 (part 1 of 2). Stakeholder feedback regarding entrustable professional activities (EPAs)[a] for the Royal College of Physicians and Surgeons of Canada (RCPSC) Geriatrics Specialty Program

EPA Number	*EPA Title*	*Results*
TD1	Initiating a comprehensive geriatric assessment (CGA) and identifying common geriatric syndromes	R & PF: 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	R: TD2 is worded vaguely and may not be necessary.
F2	Diagnosing and managing older patients with common medical conditions	R: 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	P: Management of neuro-cognitive conditions should involve collaboration with other specialists and allied health professionals. PF: 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 during Foundations.

APPENDIX TABLE A1 (part 2 of 2). Stakeholder feedback regarding entrustable professional activities (EPAs)[a] for the Royal College of Physicians and Surgeons of Canada (RCPSC) Geriatrics Specialty Program

EPA Number	*EPA Title*	*Results*
F6	Assessing and managing patients with a fall risk	P: This EPA is important. HP: Geriatricians should involve physiotherapists and occupational therapists in patients' recovery and prevention of future falls. HP: Trainees should be able to counsel patients on non-pharmacological prevention of falls (e.g., fall mats, food and lifestyle changes). P: Can require knowledge of how social determinants of health affect fall risk.
C1	Managing older adults with functional decline using comprehensive geriatric assessment (CGA)	PF: As stated regarding TD1, expectations for trainees should be better defined.
C3	Determining patients' capacity for decision-making	AM: 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	R: 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)	PF: Agreement that the management of BPSD and other complex presentations should be expected during Core and not earlier.
C6	Preventing and managing delirium	PF: 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	P: Appreciated cultural competency being part of this EPA.
C10	Running family and team meetings	P: C10 should be inclusive to patients who have non-family individuals as the primary collaborators in a patient's care. R: This EPA may not be necessary, as other healthcare professionals are frequently the leaders of team meetings.
C11	Teaching other learners	AM: This EPA is particularly important for Geriatricians to be able to perform – even more so than for CoE physicians.
TP1	Managing the Geriatrician's Practice	R: 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 people in teams, organizations, and systems	AM: TP2 reflects the role Geriatricians frequently have in health care teams.
TP3	Planning and completing personalized training experiences aligned with career plans and/or specific learning needs (*ELECTIVE*)	R: Confusion about what this EPA means. R: 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	PF: Significant concern expressed about SA1 along with 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	AM: SA2 is appropriate because Geriatricians are commonly involved in scholarly work.

[a]All EPAs that did not receive specific feedback are not shown; all EPAs are mandatory except for TP3.
TD = Transition to Discipline, F = Foundations, C = Core, TP = Transition to Practice, SA = Special Assessment, PF = Physician Faculty, R = Residents, P = Patients, HP = Health-care Professionals, AM = Administrators/Managers.