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From the Association of Family Medicine Residency Directors

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FROM FAMILY MEDICINE MILESTONES TO ENTRUSTABLE PROFESSIONAL ACTIVITIES (EPAS)

Since publication of the 2 Institute of Medicine reports, *To Err is Human*[1] and *Crossing the Quality Chasm*,[2] the public and government expect and demand higher quality and safer patient care. To accomplish its mission of improving health care by assessing and advancing the quality of resident physicians' education,[3] the Accreditation Council for Graduate Medical Education (ACGME) encouraged competency-based education with the creation of 6 core competencies. Recently, the ACGME created the milestones, which emphasize competency-based developmental outcomes. The family medicine milestones, to become effective July 1, 2014, consist of 22 outcomes based on the 6 core competencies.

A mandate for family medicine residency programs is to ensure their graduates are able to provide safe health care to their patients. As programs begin to implement the milestones, an emerging complimentary theme is the entrustable professional activity (EPA), which is a way to translate competencies into clinical practice.[4] Collectively, a set of EPAs for family medicine constitute the core clinical activities of a family physician,[5] ie, what does a family physician do in practice and how do we know a graduate is competent to independently and safely practice those activities? Going beyond a checklist of behaviors, EPAs define the "knowledge, skills, and attitudes" integrated across the competency domains and the work that a family physician does.[4]

As family medicine is such a rigorous and diverse specialty, constructing a comprehensive list of EPAs is indeed a daunting task. One educator recommends a graduate medical education program have no more than 20 to 30 EPAs that are clear but not too detailed.[6] An initial attempt at defining EPAs in family medicine included a list of 76 items that mostly focused on the ambulatory setting.[6] Ideally, EPAs should be independently executable within a given time frame as well as observable and measurable.[4] Ultimately, the EPAs should be a list of what the public can expect from their family physicians. Currently, a committee of family medicine leaders is drafting a list of EPAs for our specialty. They are expected to release the list this fall–intentionally coinciding with the anticipated Family Medicine for America's Health report.

The emergence of EPAs in family medicine is intended to support the milestones, and it is important to note their differences. Milestones follow each competency along a developmental continuum. While milestones detail individual competencies, real care delivery requires integration of these abilities in a more complex manner.[5] For example, an EPA on care for the underserved/vulnerable patient would require a resident (on multiple occasions) to demonstrate knowledge of population health, advocacy, and cost awareness, and to employ team-based care, utilize IT resources, etc. Proficiency in an EPA requires mastery of several competencies, and goes well beyond ACGME program requirements, time spent on rotations, or patient numbers. The EPA assessments are based on specific observable activities throughout residency and not just a general impression.

EPAs can also be used to drive curriculum development at the residency level. Program directors should use EPAs as they are intended to strengthen professional standards, improve patient safety, and enhance outcomes. The implementation of EPAs is not meant to be burdensome; rather, they should help programs bridge the gap between initial competency-based assessments and real-world practice. EPAs will be particularly helpful for family medicine faculty who struggle with Likert scale numerical ratings.

We are in an exciting time in family medicine education as we look to incorporating milestones and EPAs into our residency programs. Implementation should produce higher quality graduates who will provide safe, quality care to their patients and communities.

Natasha Bhuyan, MD and W. Fred Miser, MD;
Gretchen M. Dickson, MD, MBA; James W. Jarvis, MD;
Lisa Maxwell, MD; Michael Mazzone, MD;
Karen Mitchell, MD; Stephen Schultz, MD;
Todd Shaffer, MD, MBA; Michael Tuggy, MD

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From the North American Primary Care Research Group

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PRIMARY CARE RESEARCH PRIORITIES IDENTIFIED AND SHARED WITH STAKEHOLDERS

This past spring, NAPCRG shared its views on what direction funding agencies should take when determining priorities in primary care research.

In the United States, letters were sent to leadership at the Agency for Healthcare Quality and Research (AHRQ) and the Patient-Centered Outcomes Research Institute (PCORI), and in Canada letters were sent to the Canadian Institutes of Health Research and Fonds de recherché du Quebec – Sante.

The following summarizes the priorities outlined for the United States as included in the letter sent to AHRQ and PCORI.

Primary Care Research Through Practice-based Research Networks (PBRNs)

The majority of research funding supports research of 1 specific disease, organ system, cellular or chemical process, and is not related to issues surrounding the total needs of a real life patient in primary care. Not only does the majority of health care take place in the primary care setting, this setting is the key interface between the patient and the primary care provider. The importance of what happens in that space is crucial to improving care, improving outcomes, reducing errors, and realizing meaningful patient-centered outcomes research. NAPCRG sees an unmet need in strong funding support for research that is conducted with and by primary care practices and their patients—essentially what PBRNs do.

Practice Transformation

Very little is known about important topics such as how primary care services are best organized, how new technologies impact care, how to maximize and prioritize care, how to introduce and disseminate new discoveries so they work in real life, and how patients can best decide how and when to seek care. We know from our members and our patients that the need is great to understand what works for patients and practices. Part of this transformation includes the establishment of and reliance on interprofessional teams for training and patient care. More research into best practices related to this integration is needed in both the training and practice arenas. Transforming primary care practices to be effective medical homes for our patients should be a key priority—and one that can only be accomplished with studies in the primary care environment.

Patient Quality and Safety in Non-Hospital Settings

We are all aware of the research related to the many improvements in patient care in hospital settings, and the continued work in this area. Our patients tell us that one of the key areas that is problematic for them is in the non-hospital setting. For example, the communication between specialist and patient and primary care provider is an area that needs work to understand how to improve. Improved methods for engaging patients in the management of their health conditions is a key area that needs further study. Patient-centered outcomes research informs the evidence needed for guidelines that we can trust, but the voice of patients in the development of clinical practice guidelines remains a promise unfulfilled.

Multimorbidity Research

More attention and research needs to be directed to the "real-life" patient; the one who doesn't have diabetes alone, for example, but also has cardiovascular disease, as well as renal disease. In 2000, an estimated 60 million Americans had multiple chronic conditions. By 2020, an estimated 81 million people will have multiple chronic conditions. In addition, care for people with chronic conditions is expected to consume 80% of the resources of publicly funded health insurance programs by 2020. When private and public expenditures are combined, 51% of total expenditures are for those with multiple chronic conditions.[1] More research funding and attention needs to be directed at multimorbidity research.

Mental and Behavioral Health Provision in Communities and Primary Care Practices

Research addressing best practices for integrated mental and behavioral health provision in communities and primary care practices, and ways to increase the uptake of these models in primary care practices is needed. As a 2011 Robert Wood Johnson policy brief states,