@UofTPGME CBD NEWS

An occasional newsletter for Program Directors and PGME leaders and administrators

ISSUE 2 - March 2016

NEWS FROM THE PGME ASSOCIATE DEAN

IN THIS ISSUE

IN OUR NOVEMBER ISSUE, we started the conversation about how Competency Based Medical Education (CBME) and the Royal College Competence By Design (CBD) initiatives are moving forward at the University of Toronto. We encourage you to share this newsletter broadly to other interested faculty, your residents and other collaborators in residency education.

Increasingly, Canadian medical schools are identifying central leads for CBME. For PGME at U of T, the lead will be Dr. Susan Glover Takahashi. Dr. Glover Takahashi (aka Sue GT) has demonstrated leadership in large complex projects (e.g. Chair of Scientific Committee of FMEC-PG) and as the lead educator for Board of Examiners and Accreditation for the last decade. Her expertise in CBME extends beyond U of T as she was seconded by the Royal College in 2015 to be the Senior Scientific Editor of the new CanMEDS 2015 Tools Guide, which supports the implementation of CanMEDS 2015.

As of February 1st, Sue GT will lead the Education Innovations Group (i.e. Heidi Marcon, Lisa St. Amant, and Dr. Marla Nayer) to help organize and support the implementation of CBME across all PGME programs.

For PDs, this means that Catherine Moravac will be responsible for the Board of Examiners, and Learner Education Support, working with myself; and Laura Leigh Murgaski will be responsible for Accreditation and the Internal Review Committee, working with Dr. Linda Probyn.

It is worth noting that PGME teams are collaborating closely with the Royal College to identify possible technical solutions for implementing CBD (e.g. real-time clinical assessments of EPAs). In addition to working to understand the Royal College ePortfolio plans, the PGME team is concurrently investigating improvements to POWER to support CBD and have also recently licensed an online testing/assessment system to support the implementation of Cohort 1 this spring.

If you have any questions, do not hesitate to contact me or Sue GT via sglover.takahashi@utoronto.ca or cbme.pgme@utoronto.ca

Glen Bandiera, MD, FRCPC, MEd
Associate Dean, Postgraduate Medical Education
BandieraG@smh.ca

UPDATE FROM THE ROYAL COLLEGE

In mid December 2015, Dr. Ken Harris, Executive Director of Specialty Education and Deputy CEO of the Royal College, communicated to many groups involved in CBD the Royal College's decision to **slow down** the full launch of CBD for Cohort 1 disciplines (i.e. Medical Oncology and Otolaryngology – Head and Neck Surgery) that had been scheduled for July 2016. He noted that the Royal College remains committed to implementing CBD and the slower pace will allow the universities and the Royal College to implement a more staged approach.

The Royal College's decision to slow the CBD implementation was based on feedback from the postgraduate medicine partners expressing logistical, technological and resource concerns with the existing model and timeline. Many faculties have also indicated that they want to be more fully engaged in developing the CBD implementation strategy.

In the meantime, the Cohort 1 programs, are being encouraged to "test drive" various components of CBD so that the lessons learned will help inform and modify the broader implementation activities moving forward.

CBD COHORT 1: UNIVERSITY OF TORONTO COHORT 1 PROGRAMS ARE PROCEEDING TO IMPLEMENT CBD IN JULY 2016

OTOLARYNGOLOGY —HEAD AND NECK SURGERY (OHNS), under the leadership of its Program Director, Dr. Paolo Campisi (OHNS), started the faculty development process with a well-attended faculty workshop in late November 2015. Dr. Campisi is now working with the PGME Education Innovations Group to pilot test the implementation of CBD starting in July 2016. The challenge for this program will be to select 'enough' of the draft Entrustable Professional Activities (EPAs) for assessment in this first year of implementation in 2016-17.

For **MEDICAL ONCOLOGY** (Med Onc), Dr. Scott Berry is both the U of Toronto Program Director and the Chair of the Royal College Specialty Committee. Dr. Berry is superbly navigating the practical realities of implementing the drafted design documents as he works to maintain the integrity of 'what works' in his current program, including innovations and improvements that CBD can provide his program in 2016-17. Faculty development began at the January 2016 Medical Oncology Divisional Faculty Retreat where faculty provided practical advice and suggestions to guide implementation in 2016-17.

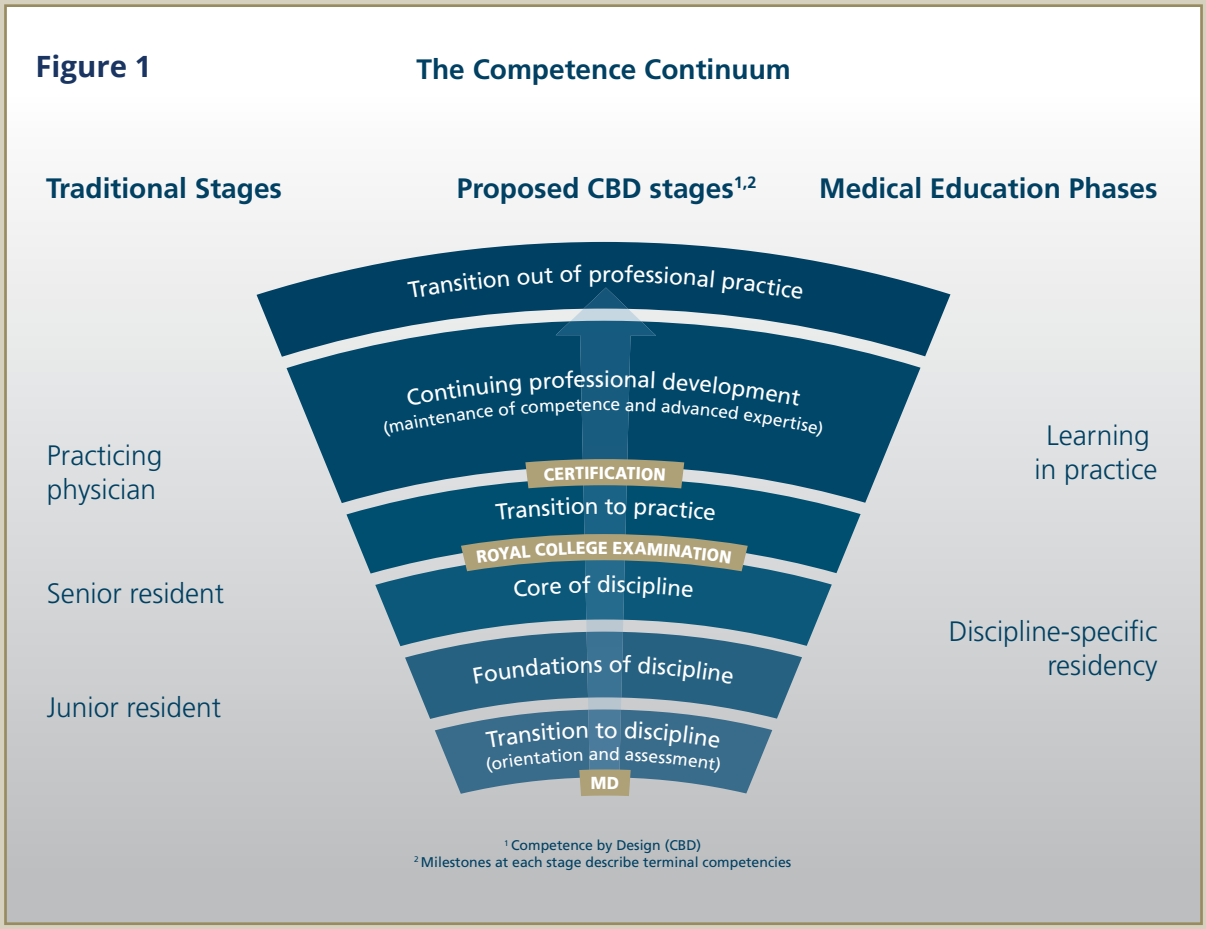
PLANS FOR OTHER COHORTS?

- **Stay tuned for updates about U of T's plans for Cohorts 2 & 3.**
- If you want to know what cohort your specialty is in, see: http://www.royalcollege.ca/rcsite/documents/dialogue/dialogue-15-4-e#vol15-4-cbd

THE COMPETENCE CONTINUUM reflects the developmental stages of professional practice (See Figure 1 below). In each stage, there will be specific milestones that a resident will be expected to demonstrate. The duration (e.g. weeks, blocks, months) for each stage is being determined by each specialty as part of their cohort plans for implementation of CBD.

- The first stage for residents is **Transition to Discipline** that will include an orientation to and demonstration of readiness for the autonomy of residency education.
- **Foundations**, the second stage of the continuum of residency education, is when the basics, including the most common and frequent patient problems of the specialty, are taught, learned, assessed and demonstrated.
- **Core** is the third stage of the continuum of residency education where the patient problems are increasingly complex and complicated and where the more rare patient problems are managed. It is anticipated that in the future the specialty exam will be administered near the end of the Core stage.
- The fourth and final stage of residency education is **Transition to Practice**, which focuses on ensuring residents' confidence and competence to practice within their discipline.

Figure 1 **The Competence Continuum**



[1] Competence by Design (CBD)
[2] Milestones at each stage describe terminal competencies

Continued

ENTRUSTABLE PROFESSIONAL ACTIVITIES (EPAS) are an approach to competency based medical education (CBME), which focus on 'real' clinical activities that are carried out in day-to-day practice.[1] Learners, teachers and assessors will focus on concrete critical clinical activities that provide insight to the residents' development, progress and proficiency.

The notion of 'trust' is not new to residency education as, each day, faculty members decide which patients or patient problems they assign to which residents. The aim of EPAs is to provide consistency to when, how and where specific activities of a discipline are taught, learned and assessed.

For example, in the Orthopedic Surgery competency-based program, the 5-year training program has about 20 modules completed over 3 phases (i.e. basic, advanced, complex). To be successful in each module, learners must demonstrate that they have the required knowledge (e.g. via written test), skills and abilities (e.g. via observed history/physical and the observed completion of a surgical procedure). In the Orthopedic Surgery program, their 'index' cases or EPAs are those that reflect increasing mastery of their discipline.

RC-ENTRUSTABLE PROFESSIONAL ACTIVITIES is the Royal College approach to EPAs. For the implementation of CBD, each specialty program must develop a list of important activities, which residents need to learn and perform. Example RC EPAs are: 'run a code', 'do procedure X', 'lead a meeting with a patient and their family disclosing serious news'. As well, each discipline is working to identify specific RC EPAs which teachers/faculty will "sign-off" on after direct observation, thereby entrusting that the residents will be able to perform the act independently.

REQUIRED TRAINING EXPERIENCES is a new Royal College document that is being developed for each of the programs transitioning into Competence by Design. This document includes the eligibility requirements for the discipline as well as the training experiences that are required or recommended for each of the 4 stages of the residency education competence continuum.

1 Ten Cate, O. and Scheele, F. (June 2007). Competency-Based Postgraduate Training: Can We Bridge the Gap between Theory and Clinical Practice? Academic Medicine, Vol. 82, No. 6.

CBME INNOVATORS AT THE UNIVERSITY OF TORONTO

This section highlights some of the CBME innovations that have been implemented by residency programs at the University of Toronto.

DIAGNOSTIC RADIOLOGY

The Diagnostic Radiology Program Director, Dr. Eric Bartlett, implemented a program to formally prepare the residents for their on-call experience. Called "buddy call", the program sets standards and requirements that the resident must meet before doing on-call service.

Before graduating from the "buddy call" system, the PGY2 residents must successfully pass the Program's first competency-based assessment tool, the **Emergency Radiology On-Line Simulator**. All residents sit this 4-hour examination that assesses various CanMEDS competencies within the simulated setting of a busy after-hours emergency radiology department.

Another innovation is the program's central and purposeful approach to support positive professional behaviour in residents, including attendance and engagement in clinical assignments. Dr. Bartlett has implemented formal structures to monitor, support and provide feedback on professional behaviours that the CBME literature links to effective clinical practice.

PALLIATIVE MEDICINE

Dr. Jeff Myers worked with national collaborators to develop and validate a set of 12 EPAs necessary for safe, effective practice of Palliative Medicine. In the 2014-15 academic year, working with local collaborators Dr. Dori Seccareccia, Dr. Giovanna Sirianni and the program's Assessment Committee, 3 of the 12 EPAs were pilot tested in the one year Palliative Medicine residency training program.

A structured program evaluation monitored the implementation of the EPAs so that adjustments and improvements could be made in real time to enhance the experiences of learners and faculty. Dr. Myers' careful program evaluation demonstrated 'best practices' in the implementation of a curricular innovation.

Dr. Myers' careful attention to just-in-time, focused faculty support is a 'shining star' for CBME implementation. A sample of Dr. Myers' 3-minute video, EPA 101, describing EPAs Medicine faculty is found at https://www.youtube.com/watch?v=hOw3-lqL9EY

DEPARTMENT OF SURGERY

The Department of Surgery embraced a Competency-Based Assessment (CBA) approach for all of the residency programs over the past 3 years. With the leadership of Dr. Ron Levine, the Postgraduate Director of Surgical Residency Education, each of the 11 surgical residency programs have inventoried and enhanced their resident assessments to ensure that they are using a wide variety of assessment tools, including structured, observed assessments of resident performance.

Other innovators to be described in the next issue:
Internal Medicine, Obstetrics & Gynaecology, and Plastic Surgery.

Others? Contact us about your CBME innovations so we can profile your program!

MYTH BUSTING

In this section we will briefly explore some of the CBD or CBME myths.

MYTH #1: CBD MEANS RESIDENTS WILL COME AND GO FROM CLINICAL SITES AT VARYING TIMES

FACT: The scheduling of CBD residents will continue to be done in advance, as per previous practice. Predictable schedules and resident assignments are important to learners, faculty and clinical sites and will continue with the implementation of CBD.

MYTH #2: CBD MEANS THAT RESIDENTS WILL BE DONE RESIDENCY 'EARLY'

FACT: In planning and implementing CBD, each discipline is estimating the 'usual' time period for completion of the RC-EPAs and the Specialty Training Requirements.

It is anticipated that most residents will finish in the *usual* time period with a small number needing more time to master the outcomes – which is similar to the current situation. It is anticipated that a small number of residents will master the outcomes more quickly than usual which will allow for further development through elective experiences.

For Cohort 1 programs:

- Medical Oncology, which is currently a 2 year subspecialty following 3 years and certification in Internal Medicine, anticipates that the usual time for residents to complete the CBD program will continue to be 2 years.
- OHNS, which is a 5 year training program, anticipates that the usual time for residents to complete the CBD program will continue to be 5 years.

MYTH #3: CBD MEANS THAT TRACKING RESIDENTS BY PGY YEARS WILL 'GO AWAY' DUE TO TRACKING RESIDENT PROGRESS ACROSS A CBD CONTINUUM

FACT: The tracking of progress across the competence continuum will be required to document a resident's progress.

In addition, given that funders, funding and payment schedules are based on a resident's year, and a negotiated agreement between PARO and CAHO, programs will need to monitor and document promotion from PGY year to year.

RESOURCES

OTHER RESOURCES FOR PDS, SITE DIRECTORS & PGME LEADERS:

- UTPGMExchange is the University of Toronto's collection of residency education tools including videos, workshop materials, and assessment tools for a variety of CanMEDS Roles. http://www.pgmexchange.utoronto.ca/login.php

  To access PGMExchange via your UTORID, contact pgme.exchange@utoronto.ca
- **CanMEDS Tools Guide** is a 'how to' with ready to use learning, teaching and assessment tools for CanMEDS 2015. PDs should contact cbme.pgme@utoronto.ca to get their complementary copy. Others can purchase through the Royal College or the PGME office at cbme.pgme@utoronto.ca
- **CanMEDs Interactive** is the online, ready to use version of CanMEDS 2015 Framework and many of the resources in the CanMEDs Tools Guide, found at http://canmeds.royalcollege.ca
- **PD handbook** is the RC resource on residency education. For more info, go to: http://www.royalcollege.ca/rcsite/canmeds/resources/canmeds-publications-e#program-directors-handbook

QUESTIONS?

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Contact: cbme.pgme@utoronto.ca

@UofTPGME

Postgraduate Medical Education
500 University Avenue, Suite 602,
Toronto, Ontario M5G 1V7 (University & Dundas)
Phone: 416-978-6976 Fax 416-978-7144

www.pgme.utoronto.ca