STEERING COMMITTEE MEETING MINUTES

DATE: February 4, 2021	TIME: 7:00am	LOCATION: Zoom

MEETING CALLED BY	J. Vergel de Dios, Director of CBME Implementation, PGME
ATTENDEES	A. Ens; A. Florendo-Cumbermack; A. Good; A. Power (guest); A. Zaki; B. Yan; C. Chan; C. Koerber; C. Newnham; D. Giroux; H. Iyer; J. Ciesla; J. Howard; J. Krista; J. Thain; J. Vergel de Dios; K. McLean; L. Champion; Michael Ott; Mary Ott; M. Walsh; P. Morris; P. Rasoulinejad; S. Dave; S. L. Kane; S. Lam T. Joy
REGRETS	M. Boulton
NOTE TAKER	Clarissa Koerber (clarissa.koerber@schulich.uwo.ca)

CALL TO ORDER & APPROVAL OF MINUTES

DISCUSSION	Meeting called to order by Dr. J. Vergel de Dios at 7:00am. December 2020 meeting minutes approved.

1. WELCOME GUESTS – DR. J. VERGEL DE DIOS

DISCUSSION	• Dr. J. Vergel de Dios reviewed the pre-meeting questions:
	  ○ Feedback on the draft Elentra data access and sharing policy?
	  ○ Review the 2021 program launch plan checklists (3) with associated questions
	• Dr. J. Vergel de Dios welcomed Dr. Adam Power, Department of Surgery Chair of Postgraduate Surgical Education Committee, to the meeting. Dr. A. Power submitted a letter on behalf of his committee advocating for the implementation of an Elentra desktop shortcut on hospital computers.

ACTION ITEMS	• None

2. ROYAL COLLEGE NATIONAL LEADS UPDATE – DR. J. VERGEL DE DIOS

DISCUSSION	• No update at this time as there has not been a Royal College National Leads meeting since the last Steering Committee meeting. • The next National Leads meeting is scheduled for February 16, 2021.
ACTION ITEMS	• None

3. 2021 PROGRAMS LAUNCH PLAN CHECKLIST – DR. J. VERGEL DE DIOS

DISCUSSION	• There are 9 programs scheduled to launch in July 2021 (including 2020 deferred programs). Three programs submitted their program launch plan checklists for review, including: Child & Adolescent Psychiatry, Clinical Pharmacology & Toxicology, and Pediatrics. Dr. J. Vergel de Dios opened the discussion up to the committee for general feedback and input on the following questions.
	  ○ Residents filling out their own forms?
	  ▪ Dr. H. Iyer (Nephrology) explained that experienced residents are comfortable in filling out assessment forms on their own and then sending them for review/comments, whereas newer residents prefer to have the assessor fill out the form in its entirety.
	  ▪ Dr. B. Yan (Gastroenterology) stated that some residents do fill in assessment forms on their own, which is okay, however there are instances where information may be exaggerated. He prefers the assessor to complete forms.

	▪ Dr. S. Dave (Urology) explained that after discussing as a division, it was decided that residents should not fill out most of the assessment form. Residents do fill out the initial contextual variables and case details, but not the remainder of the form. While there is the advantage of having residents self-reflect by filling out the form themselves, the problem is that residents do not like receiving a rating of 1-3. If a resident assigns themselves a 4-5 and are then downgraded to a 1-3, this is worse than getting a 1-3 in the first place. It also has the potential to skew assessments if an assessor does not assign a true score, based on the score that the resident assigned themselves (e.g., if a resident rates themselves as a 4 and the assessor believes them to be a 2, the consultant may be more inclined to assign a 3). ▪ Dr. S. Lam (Internal Medicine) explained that faculty are comfortable in signing off on an assessment if it reflects their own evaluation, however if this is not the case then they are not comfortable. As a result, residents are discouraged from filling out assessments. It would be interesting if faculty and residents could complete evaluations separately as this would allow for comparison of scores, however faculty should not see resident evaluations before completing the assessment. o Retrospectively residents asking for EPAs? ▪ Dr. J. Vergel de Dios clarified that this question refers to a situation where a faculty member was not aware that an assessment was going to be triggered and then receives an email requesting an EPA be completed. ▪ Dr. H. Iyer explained that in his program, most evaluations are triggered within a day and it is therefore clear which patient encounter is being assessed. There are rare instances when an EPA is triggered several days later which creates some confusion, however this issue has since been addressed. ▪ Dr. B. Yan explained that when they first transitioned to CBME, retrospective EPAs where staff do not sign off for months on end were quite common. Recently, there have been some instances in which residents send EPAs for patient encounters from several months ago. He explained that a stale date of 4 weeks is far too long, and that feedback is not useful if the EPA is not completed within 1-2 weeks from the encounter date. ▪ Dr. S. Dave explained that they do not allow retrospective EPAs. Residents are strongly encouraged to let the assessor know ahead of time that they plan to trigger an assessment. If an assessor is not aware, they are unlikely to complete it as they may not recall enough details to do so. ▪ Dr. S. Lam explained that it is not uncommon for residents to trigger EPAs retrospectively without prior notice. These are likely to expire as assessors do not recall the encounter or enough information to complete the assessment. o Success for off-service rotations? ▪ No comments o Faculty accountability? ▪ Dr. B. Yan stated that there have been instances where faculty were not signing off on EPA forms at all. Correcting this issue took several months, which included threatening to take away residents. o Recognition of faculty? ▪ Dr. B. Yan stated that faculty are recognized in division meetings through the use of assessor statistics. ▪ Dr. S. Dave stated that they have recently started recognizing faculty and feels that this can be improved upon. He would like to hear input from other programs. • Dr. J. Vergel de Dios emphasized that a conversation needs to take place within and/or between programs so that communication is clear on EPA triggering protocols and whether residents are to complete parts (if any) of an assessment form. In the past, the onus has often been on the resident, however the results of the resident feedback survey highlight the need for faculty to begin this conversation.
ACTION ITEMS	• None

4. REPORTING RESIDENT STATUSES – DR. J. VERGEL DE DIOS

DISCUSSION	• There is movement towards automating resident statuses within Elentra based on what the RPCSC has suggested that PGME requires for reporting requirements. Dr. J. Vergel de Dios will follow-up with the RCPSC as to whether these are guidelines or mandatory. New to CBME are "Progress is Accelerated" and "Failure to Progress". These statuses will require notification to the PGME office, specifically if it will shorten/extend the resident's end-of-training date. More information to be shared. Forms can be found in the LHSC Team site, and soon on the public website. • Dr. Michael Ott explained that as the Chair of Surgical Foundations, they use "Failure to Progress" quite frequently as a push for residents. In the beginning, approximately 40-50% are not accomplishing what is required and it is common for a large portion to be told they are failing to progress at the end of a meeting. However, this does not mean that they will not finish in the designated time frame. Therefore, it needs to be made clear what "Failure to Progress" means from a PGME perspective to avoid unnecessary paperwork. • Dr. J. Vergel de Dios asked the committee to consider how their programs use and define "Failure to Progress". • Dr. L. Champion explained that from a PGME perspective, we would need to be notified if there is an anticipated extension/shortening of the training period. One-offs of one EPA or block is not an issue. A policy will need to be written for the change in notification requirements. • Dr. S. Dave stated that in Urology, "Failure to Progress" is equal to the need to trigger remediation, or if there are concerns about professionalism.
ACTION ITEMS	• **Dr. J. Vergel de Dios to clarify with the RCPSC what is meant by "Failure to Progress" and discuss with the National Leads.** • **Programs are encouraged to decide what determines each status and to share the criteria with their residents.**

5. RAC-CBME UPDATE – DR. J. VERGEL DE DIOS, DR. A. ZAKI

DISCUSSION	• 5.1 Resident Survey
	  ○ Dr. A. Zaki provided an overview of the RAC-CBME Resident Survey results. The survey remained active from December 2020-January 2021. It contained a total of 22 questions and yielded approximately 200 responses, most of which were among PGY1 and PGY4 residents but had overall good responses from across the spectrum of years and programs. The survey was circulated to residents of all RCPSC programs, even those who have not yet transitioned to CBME as non-CBME residents may have completed EPAs or been on off-service rotations.
	  ○ The main takeaway points include:
	  ▪ Residents hope for more faculty initiative in completing and triggering EPAs. There continues to be issues with faculty knowing their PIN and Elentra login information.
	  ▪ 75% of respondents reported having completed EPAs for junior residents or clerks, with most having not received any training on how to give effective feedback. Residents hope for increased support in their dual role as both learners and teachers.
	  ▪ Residents hope that technical aspects of the Elentra system improves, which is actively being addressed.
	  ○ Dr. J. Vergel de Dios aims to devote more time to looking at survey results in detail over the next several meetings and recommends that all SC members read the report in the meantime, including all narrative comments. No data were removed; therefore, results are honest and transparent.
	• 5.2 Weekly Attending/Resident Feedback Meetings
	  ○ An issue that was identified in the RAC-CBME Resident Survey and interviews is that most of the time, the act of requesting EPAs does not fit the workflow and residents often feel like a burden. It was suggested that faculty and residents set aside a specified and agreed upon time each week to sit down to discuss progress and complete EPAs.

ACTION ITEMS	• **SC to read the RAC-CBME Resident Survey results.** • **SC to continue discussing the RAC-CBME Resident Survey results at the next meeting.** • **SC members to decide if a specific time per week, e.g. Thursdays at lunch or just after lunch, is established to help residents and faculty complete EPAs. This was suggested by RAC-CBME resident members, especially those on team-based rotations.**

6. ELENTRA UPDATE – P. MORRIS, A. GOOD, J. CIESLA

DISCUSSION

- Elentra Update
  - Due to time constraints, the Elentra update is provided below in written format:
    - Dashboard development is progressing well, and on schedule. The Elentra Logbook feature is being tested to ensure it will meet the needs of PGME's programs. So far it looks great; stay tuned for more information to be sent via email shortly. Preparations for the 2021 programs launching CBME are continuing, including the CV translation process, EPA assessment form building, pilot launches and training sessions.
- 6.1 EPA Evaluation Reports – Feedback
  - To be discussed at the next SC meeting.
- 6.2 Elentra Accessibility
  - J. Ciesla, Director of Schulich IS, continued the conversation from previous meetings concerning challenges with Elentra access in the hospital environment. While there is a strong desire to implement an Elentra desktop shortcut on thin client machines, the problem with this is that thin client machines are not designed to be running software locally. The thin client architecture is designed to run sessions/applications where the processing is handled primarily by a central server, running a modern web browser locally places all the load on the thin client device which has very limited hardware. Therefore, simple tasks such as accessing Elentra through a browser can cause usability problems. J. Ciesla spoke with senior hospital IT members, however they are unwilling to offer a shortcut. Doing so would mean they could potentially have to implement shortcuts for many other hospital staff applications, and their infrastructure cannot support this. Elentra is not designed to run on thin clients and until the infrastructure is updated, a shortcut is not a viable option. J. Ciesla explained that LHSC is looking at making changes to the thin client infrastructure, however this will most likely be a central server software and/or hardware update (not end client hardware) and will not address our issue fully.
  - J. Ciesla outlined two alternative options currently under consideration, including:
    - Starting up the desktop environment from the thin client machine. This will give a better user experience because the load of applications is transferred to a central server and not burdening the thin client machine which has a small amount of physical hardware (most smartphones have more storage and processing power than thin client machines). The anticipated upgrade may make this process even faster.
    - Another option is to use a tablet/smartphone to access Elentra in a mobile environment.
  - Dr. Michael Ott proposed that it may be worthwhile to have individuals from Schulich IS spend a day in the clinical setting as a disconnect exists between what is being described and how this would work into the workflow of clinical practice on a daily basis (e.g., would not have the ability to carry a tablet in the operating room and therefore must complete EPAs retrospectively on thin clients). J. Ciesla explained that it was assumed that thin clients were easily accessible, and he will take the opportunity to go into the clinical environment post-Covid. Dr. J. Vergel de Dios explained that it is difficult to find available computers, and most of the time she must use a nurse's computer.
  - Dr. M. Ott urged to not underestimate how much of a barrier this problem is to completing assessments. J. Ciesla explained that we do currently offer the web enhanced version of Elentra that can be accessed on a phone browser. While this option is not as good as a native app, this is something that they are looking into possibly developing in the future. However, it is not a simple rollout, there are many implications from a workflow and budgeting perspective to consider, as well as how it would affect the Elentra update schedule.
  - Dr. S. Dave explained that filling out an EPA is easier than triggering, therefore the burden of this issue falls mainly on residents.
  - Dr. J. Vergel de Dios confirmed that we are exploring the mobile experience which includes using browsers with a responsive mobile design. As of the RAC-CBME meeting on February 1, residents will be testing the Queen's Elentra app. While this app does not have local customizations, if the response is positive, we can further pursue developing an app with Schulich customizations.

ACTION ITEMS	• **P. Morris to provide a written Elentra update.** • **A. Good to gather EPA Evaluation Reports feedback at the next SC meeting.**

7. YOUR INNOVATIONS – DR. S. KANE	

DISCUSSION	• 5.1 IM Data & Research Study Results
	  ○ Dr. S. L. Kane presented Internal Medicine research data. The study looked at quality of written feedback across all EPAs between July 20119-May 2020. Quality variables were determined based on literature review. These included 1) Timeliness ≤ 7 days from encounter to completion 2) Task Specific Yes/ No 3) Actionability – very actionable, semi-actionable, not actionable 4) Polarity of Comment (positive, mixed, negative, neutral)– The study looked at a total of 1980 EPAs, which is an 80% completion rate across all EPAs during this time frame. EPAs were randomly assigned, and two assessors assessed each EPA independently for all for 4 quality indicators.
	  ○ **Assessor Role** Results show that 61% of EPAs were assessed by residents. For Internal Medicine, this can be a resident who is at least one PGY year ahead of the individual being assessed. 38% were assessed by faculty, and 1% by external reviewers.
	  ○ **Timeliness** The study looked at whether EPAs were completed in a timely fashion (7 days or less). Results show that 47% of EPAs met this target.
	  ○ The median time from patient encounter to trigger was 3 days. The median time from when an assessor receives the EPA trigger to completion is 2 days.
	  ○ **Task Oriented** Results show that 85% of the time, EPAs were providing task-oriented feedback.
	  ○ **Actionability** Not-actionable is when there is nothing that a resident could do differently going forward; semi-actionable is when there was a generic comment of an action to take; and very-actionable is when there is a specific action or skill mentioned. Results were very or semi actionable only 30% of the time
	  ○ Timely feedback was shown to be more actionable 26% of the time, versus not actionable 20% of the time.
	  ○ **Polarity**. Results show that residents received primarily positive feedback 83% of the time. From a coaching feedback point of view, it was expected that feedback would be mixed, however results show that mixed, negative, and neutral feedback was in the minority. Residents as assessors were more likely to give positive comments.
	  ○ Dr. T. Joy proposed that there is a need for faculty and resident development on how to best give feedback. Data shows that most feedback was positive, while mixed feedback may be more likely to lead to actionable messages. Dr. S. L. Kane agreed that feedback quality must improve at both the resident and faculty level.

ACTION ITEMS	• None

8. FEEDBACK AND COACHING WORKSHOP – DR. J. VERGEL DE DIOS	
DISCUSSION	• Dr. J. Vergel de Dios provided an update on the Feedback and Coaching workshop with Dr. Chris Watling. The event is currently open to all 2021 program faculty and residents. Depending on interest and capacity, we are hoping to open it up more widely. J. Vergel de Dios encouraged anyone who is interested in participating to reach out. More information to be shared over the coming weeks.
ACTION ITEMS	• **SC members to reach out if interested in participating in the Feedback and Coaching workshop.**

9. CBME INNOVATOR INCUBATOR WITH CERI – DR. J. VERGEL DE DIOS	
DISCUSSION	• Dr. J. Vergel de Dios provided an update on the Innovator Incubator with CERI. Dr. S. L. Kane's presentation is a perfect example of what can be presented at this event. It is an opportunity to share innovation projects, challenges, questions, or ideas. CERI scientists will be there to help. More information to be shared over the coming weeks.
ACTION ITEMS	• **SC members to reach out if interested in presenting or participating in the CBME Incubator with CERI.**

ADJOURNMENT & NEXT MEETING	
	Date and time of next meeting: April 1, 2021 at 7:00am