PROGRAM ADMINISTRATORS NATIONAL ADVISORY COMMITTEE
TELECONFERENCE #2 – SEPTEMBER 22, 2016
1000-1130 (OTTAWA TIME)

Co-chairs: Cynthia Abbott, Royal College; Charlene Wainwright, University of Toronto

Guest Presenter: Jolanta Karpinski, Royal College

Attendees: Bernice Baumgart, Toronto; Sharon Cameron, McMaster; Jennifer Collins, Memorial; Tara de Castro, Manitoba; Stacey Dickinson, Calgary; Carol Dow, McMaster; Jeanine Dice, Saskatchewan; Julie Ghatalia, Ottawa; Daniel Johnston, Toronto; Julie Lane, McGill; Ana Malbrecht, Western; Scott Lewis, BC; Micheline McDonald, Queen's; Jeanine MacRow, Queen's; Cyndy MacKenzie, NOSM, Sue Murray, McMaster, Kim Nicholas, Alberta, Kimberly Nitz, Western; Paula Nixon, Toronto; Jen Railer, Queen's; Nady Robidas, Sherbrooke; Krystyna Schornagel, Saskatchewan; Jeanne Sheldon, Calgary; Cathy Torchia, McGill; Luiza Shamkulova, BC; Sara Wilson, NOSM

Regrets: Leah Arsenault, Ottawa U; Karen Fedato, Calgary; Naomie Gauthier, Sherbrooke; Melissa Franzmann, Manitoba; Margaret Garnier, Dalhousie; Sheila Reid, Dalhousie; Marvel Sampson, RC; Ginette Snook, Ottawa

ACTION ITEMS

- Distribute a list of the schools that have CBD leads and their contact information
- ask Jolanta if her slides can be used by committee members

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1. ***Welcome and Introductions***

Welcome to all participants, introductions will take place later in the call to accommodate the guest presenter's timeline.

2. ***Competence by Design 101 – Jolanta Karpinski***

Societal Needs - Competence by design (CBD) is linked to a movement in medical education called competency based medical education (CBME). This is an approach to medical education that starts from societal needs.

As part of CBD we stop asking doctors "what do you think a resident needs to learn in a training program?" and we start asking the specialty committees what Canada needs from their specialty. To do this we get them to think about the patient population - how it is changing; how the unique geography of Canada affects how we deliver health care and how that affects their discipline. We must start to think beyond the academic teaching centres and look at what we need to improve health care education in Canada. This is the underlying rationale for CBD. Ultimately we take the ideas of what society needs from a physician and express them in the CanMEDS framework.

Stages of physician development (see attached competence continuum) – The CBD initiative reconfigures specialist education into a series of integrated stages, known as the CBD Competence Continuum. Specific, distinct, integrated stages of training are employed

to mark increasing progression on a continuum of competence. There are seven stages overall, four of which are aligned specifically with residency education: transition to discipline, foundations of discipline, core of discipline, and transition to practice

As part of the CBD transition process, we ask the Specialty Committees to think about residency at the different stages and what the focus should be at each stage. At the transition to discipline stage the focus is orientation - getting to know the resident, the resident getting to know the teaching site etc.; at transition to practice the focus is getting someone to work on their own, to be independent without the support structure of the teaching hospital. Currently we tend to think of residents as PGY1, PGY2, PGY3, when we use those words we envision different expectations of their abilities; in the future you will be talking about residents in the stages instead of the PG years. This will be more meaningful and more explicit in what the resident is expected to do.

Entrustable Professional Activities (EPA's) – these are another organizing structure for how we think of what a specific specialty does and what we can focus on that residents can do over a training program. These are tasks in the clinical setting that a resident can do (potentially with limited supervision) once they have had enough learning, supervision, assessment and experience. In Canada, CBD is using EPAs specific to the stage, it might be a simple task where they are being trusted to go out on their own and get information. Later it will be a more difficult task with supervision, your level of responsibility is that you can now do this task. Disciplines are asked to think of the tasks as having a start and an end so they can be observable, the supervisor could focus on one particular thing and coach them on that (linked to the CanMEDS framework). For example in medicine this could be likened to residents running a code by themselves, in non-medical settings it would be like having your G1 license, where drivers are trusted to drive under certain identified circumstances.

EPA's are linked to the stage of training. A resident that is in a foundation stage should be able to do X at this point of their training and do it on their own, if they can't do it on their own they are not ready to progress to the next stage.

Entrustment – supervisors decide how much responsibility the resident can have, "based on what I saw today you can do this on your own, you have demonstrated the skills and are ready to progress and are trusted to do it on your own.."

Assessment is an important part of learning - We want assessment to be seen as a motivator for residents; we want them to see their clinical work as an important part of their learning (it's not just what they read but also that clinical work is a big part of the learning). We'll also refocus our teachers' and supervisors' thinking so that they'll see assessement as an important tool for them to use within patient care. They will be making multiple observations, but the observations will be a bit more discrete than they are today (not like a long FITER). With CBD observers will be asked to fill out smaller forms, multiple times, but based on one patient. It's the multiple observations that provide the resident with ongoing feedback and it provides the program with information on how the resident(s) are progressing. Some field testing is happening now and we hear that it is generally well received.

Jolanta reminded the group that family medicine has been using a similar approach (i.e. field notes) for a while, the students find the feedback to be quite good and it helps them to have a good handle on their skills/gaps at any given time. They feel they have a good sense of what their competencies are and what they need to learn next. In terms of volume of work, the requirement in Family Medicine is to have a certain number of field notes per month, it's not necessarily daily; observers may have to fill out one field note per student per week.

Research shows that since field notes have been implemented both the resident and the supervisor enjoy this type of feedback, it allows the resident to get feedback instantly. We not only identify what they need to improve, we also point out what they did well and what areas they need to focus on. Residents get to see their global performance across that month or two months.

Some programs in Canada are already doing something around frequent feedback – encounter cards, daily forms, and for these programs CBD won't be such a big change (it'll be a refocus - instead of focusing on the day it might be focusing on the patient). Programs that don't provide regular feedback will find the change bigger – ultimately, how this is viewed by faculty will be different in different programs.

Each observationwill give you a biopsy of how the resident is progressing. Ultimately all the information is synthesized and brought to a competence committee to determine how the resident is progressing. The competence committee makes a group decision based on the data. Competence committees will review each resident at least 2 times per year. Bigger programs may have to meet more often than smaller programs. There are already some programs that have an evaluation subcommittee of their RPC – we see the competence committee as similar.

Cohort workshops – we have 68 specialties/sub-specialties at the RC so we chose an approach where we work with a specific number of disciplines each year and have a multi-year rollout over 5-8 cohorts. We have 15 disciplines that have started the CBD transition and another 3 will be added this year. There is a schedule of when each discipline comes to the College for their workshops. The specialty committees are all aware of this schedule.

We tried to mix it up and organize things so that sub specialties are scheduled right after their specialty. Most disciplines are still in the "waiting room" and are learning about CBD while others are starting to get ready, looking at special projects or tackling special questions. Some disciplines (18) are in the middle of doing their designs, they are coming to the workshops; all program directors are invited and funded to come to these workshops, they are here for 3 days at a time, usually twice at 6 month intervals. Workshop 1 they learn about the stages and EPAs; Workshop 2 they talk about assessments and what it will mean for their rotations.

In closing, Jolanta suggested that each person look at what stage their program is at now and see what can be done to get ready. She also suggested checking out the eportfolio webinars, and connecting with the CBD lead at your schools.

Summary of Questions and Answers

Q – when our 1st cohort starts we'll be running two different types of training programs, how will we balance the old cohort with the new model?

- Some programs that have made major changes to their training report that there is a bit of conflict between old vs new trainees (i.e. there is some jealousy or rivalry between the old and new). Some residents in the new program feel that they are under the microscope all the time and those in the old one feel like they are being ignored or missing opportunities offered to trainees in the new system. This is something that has been identified as we are thinking through implementation. Perhaps a topic for a future call would be to ask a PA from a discipline that is transitioning to give a presentation on their experience dealing with the double cohort.

Q – in neurology the IMGs do core neurology at the beginning of the year and the other pgy 1s do their rotations at the back of the year. Is there a way to differentiate between when we can schedule without transitioning everyone at once? In our small program we have to limit where they can take service, it might leave gaps in the remaining years and we would have to make drastic changes.

- There is no question the new standards (stages and EPAs) will affect your programs. The kinds of rotations that are needed might change, or the timing of the rotations during the years of training may be different. It depends on how the specialty committee sequences the learning experiences and EPAs This is also a concern that we have heard from program directors and is a part of the piece around implementation; that is taking the national plan that is built at the CBD workshops and putting into practice in a specific program. In this case, the question is how do we rejig schedules that have worked for a long time?
- One thing to remember is that the timeframes for the Stages are fairly long; for example foundations is typically at least 6 months even in a 2 year program or in longer programs up to 18 months. So although certain EPAs or learning experiences are linked to a specific stage, individual programs have flexibility in how they are spread out within that stage and how they juggle the residents at different sites.

Q – Sometimes the problem is with the supervisor not willing to trust the trainee – for example in lab medicine staff have a hard time giving up the responsibly, they are the ones that sign the final report. How do we change the culture for them?

- When residents graduate they don't feel ready for independent practice, they feel that it is too big a change from their experience in residency. The system isn't providing residents with an opportunity to develop their confidence and a sense of autonomy. Making faculty aware of their impact on residents' perceived readiness is an important first step. This is one of the reasons we've created the transition to practice stage, which has its own discipline-specific competencies that will guide learners and observers. It'll also take time for residents and faculty to adjust.

Q - There are always certain people within the department that have a hard time completing assessments on time. How can we stress that completion of assessments has to be done in a timely manner across the board?

- That's true, fortunately we're not asking them to do more of the same types of assessments. The way we are doing assessments is changing, which should make it easier for supervisors to do their assessments more frequently and with less reminding.

Q - Where do EPA's originate from?

- Each specialty will have the same EPA's across the country, they are developed by the specialty committee.

Q - What is the implementation plan from the Royal College for faculty development, learner development and seeing if we are assessing them correctly?

- As specialties work through the CBD transition process, their need for faculty development changes. At the start, we provide Specialty Committees with faculty development that is focused on developing new competency based standards and assessment tools. This faculty development happens in a very traditional way (i.e. primarily at and between the CBD workshops). As specialties get closer to implementation though, their needs start to change and this helps us identify the local skills gaps / needs, which we can then work to address. Our current approach is to develop new resources and tools that others can use to support local implementation. Each university and even within the university programs there is a lot of variability with regard to need and expectations for support. The Royal College will not be able to provide custom resources for each program and each school. For this reason, the RC will provide flexible faculty development resources that can be used by local leads (e.g. local faculty development offices, local CBD leads, etc). We are now working on tools to support assessment and changing the culture so that teachers understand the importance of that feedback.

- We have the Meantime Guide for people who want to get ready while waiting for the changes.

Q – Can the competence committee be amalgamated with the RPC committee or does it have to be a separate committee?

- The idea is that they'll be separate committees/meetings but small disciplines might use the same people. Ideally the competence committee is not chaired by the program directors, but the program director is a member of the competence committee.

Q - Is there consensus on whether we all have to use the eportfolio or will there be an alternative?

- This is still under review, hopefully we will have a better response in the next 6 months.

Q - We have faculty who find it difficult to get their evaluations in. Getting these people to do this more often may require more discipline around this, would this come from the program, the division or the RC?

- Typically, it takes a couple of years between starting to work with a discipline and when things actually get transitioned. One of the things that the RC is doing to

support the change is the eportfolio. If your program decides to use it, it means a new tool that you need to learn, but it will be a source of information. You will be able to run reports that tell you who has outstanding evaluations (e.g. how many, how often, etc). Your program can decide how it wants to use this data and whether it can be a carrot or stick to encourage compliance.

- This seems to be a problem that is across the board. At Western we are thinking to include their performance as evaluators as part of their score card, so that their performance reviewed by their Chairs will include how they are performing within the requirements of the evaluation process. With the increased frequency of assessments this may be a bigger problem so we think we need to include this in their assessment as faculty on various services.

Q – Is the eportfolio going to be user friendly on mobile devices?

- The plan is for it to be when it goes live next July. It is going to evolve over time, there's a plan to communicate about how best to move forward with the eportfolio after more discussions with the PG Deans.

Q – Have any PA's been involved with the development process for the eportfolio?

- PAs are field testing so they have an opportunity to give feedback on what works and what doesn't. This PA NAC is also an avenue to bring forward concerns about the changes. If you have thoughts and concerns that are not covered in a call please contact Cynthia so that she can bring them forward to the appropriate people.

Q - Ortho is coming on line in 2018, surgical foundations next year in 2017. Ortho is concerned that they won't be ready for the transition.

- Please send Cynthia a note expressing these concerns and she will follow up (cabbott@royalcollege.ca).

3. Committee Introductions

Cynthia and Charlene introduced themselves as co-chairs and asked people attending their first call to introduce themselves. Cynthia mentioned that it was very interesting to hear the different perspectives and encouraged members to bring forward their concerns and that she would bring them back to the appropriate members of the RC. She then asked if there were any questions on the role of the committee? There was a question regarding the line of reporting and how recommendations that we make at this committee get reported and to whom? Cynthia reminded the group that our committee is not a decision making body. The RC has created the committee for engagement - to create avenues for communication and understanding. While we don't have a mandate to make recommendations, Cynthia explained that she conveys the perspectives of the PAs to the members of the CBD steering committee; Another suggestion was to share the organizational structure of all involved in the different aspects of CBD - PG Deans working groups, Program Directors National Advisory Committee, etc. Cynthia responded that we don't have a document that outlines all of these groups.

4. Future Meetings and Topic Suggestions

- Eportfolio demo as a group with field testers to give feedback on what they are finding. Have discussion on how we can use the tools for the processes within the context of CBD. Cynthia noted that there is some discussions at the PG Dean level about the use of the eportfolio and who will be using it. We will look at the best time to have an eportfolio demonstration, we don't want to have the discussions too soon and need to wait until the PG Deans have weighed in. If the timing isn't right to have this demo at the November 2 call we will have it at a future call.
- Hear from some of the disciplines that have started and hear about lessons learned, about the PA role and involvement in the process and any tips on how to support the program directors and committees. Charlene from medical oncology and Carol from Otolaryngology agreed to present on this topic.
- Sara Wilson, NOSM suggested a presentation on "Where do you begin" and offered to give a presentation on mapping out clinical programs, etc.
- Difference between the new and old cohorts and how people are managing the double cohort feature. Julie Ghatalia from Ottawa U anesthesia program offered to present on the differences of the CBD stream and traditional stream and how we balance them.
- How to support a new program director through the transition.

The call adjourned at 1140.