CPSO

Peer & Practice Assessment Handbook

Emergency Medicine

Version 1.03 (December 2022)

Acknowledgments

Development of the Emergency Medicine Peer and Practice Assessment Handbook was only made possible through ongoing contributions of Ontario physicians who serve as Peer Assessors with the CPSO. In particular, we would like to recognize the dedication and many months of work contributed by the Emergency Medicine Peer Assessor Working Group.

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Peer Assessment Handbook: Emergency Medicine

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1. Introduction to Peer Assessment

1.1 Purpose of Peer Assessment

Peer Assessments are conducted by the College of Physicians and Surgeons of Ontario (CPSO) as part of its mandate under the Regulated Health Professions Act (RHPA) (Schedule 2, Section 80). The purpose of Peer Assessment is to:

"Promote continuous quality improvement by providing physicians with feedback to validate appropriate care and show opportunities for practice improvement."

Peer assessment is based on the premise that all practices have room for improvement, and is therefore intended to encourage continuous quality improvement for all physicians.

1.2 Development and Maintenance of Peer Assessment Tools

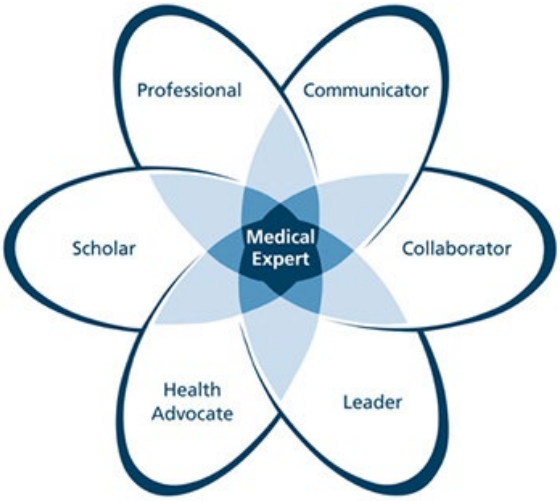
The peer assessment program has been operational since 1980 and thousands of physicians have been assessed. In 2012, the CPSO began an initiative to redesign its peer assessment program to better align the program with its primary purpose of encouraging continuous quality improvement for all physicians. Particular focus was given to supporting physicians in moving their practice from "good" to "excellent". This initiative led to the creation of the tools found in this Peer Assessment Handbook.

The Peer Assessment Handbook was developed by the CPSO in collaboration with peer assessors. Assessors provided the discipline-specific content expertise for establishing the elements of quality and evaluation criteria found within this handbook. External consultations by practising physicians and physician bodies were conducted to validate the content with respect to how quality is defined, how it should be evaluated, and how it might be improved. A brief overview of the development process and milestones for the Peer Redesign Initiative (including the external review process) can be found in **Appendix A**.

The CPSO's Research and Evaluation Department provided measurement expertise and established a rigorous validity framework for the peer assessment program. Specifically, attention was paid to optimizing the validity, reliability, acceptability, and educational impact of the program. In order to continue to improve the effectiveness of the peer assessment program, these tools and procedures are periodically reviewed and updated to ensure their validity and relevance.

1.3 CanMEDS in Peer Assessment

CanMEDS is a national competency-based framework for medical education that describes the abilities physicians require to effectively meet the needs of the people they serve. It was developed by the Royal College of Physicians and Surgeons of Canada[1] in the 1990s and organizes physician abilities thematically under seven roles: Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional. It was updated most recently in 2015 and now includes key milestones to describe the development of physician abilities across the continuum of their career starting at entry to residency, following them throughout practice, and finally into the transition out of professional practice.



[2]

The latest edition of CanMEDS, often referred to as CanMEDS 2015, was developed collaboratively by 13 Canadian medical education organizations. In May 2015, the CPSO formally adopted it as an organizing framework for physician education and assessment. From a regulatory perspective, CanMEDS complements much of the work of the CPSO, particularly with respect to The Practice Guide and CPSO policy. Furthermore, a key competency of the Professional Role identifies the responsibility of physicians to participate in physician-led regulation. For more information about how CanMEDS relates to Peer Assessment, please see **Appendix B**.

[1] Adapted from the CanMEDS Physician Competency Framework with permission of the Royal College of Physicians and Surgeons of Canada. Copyright © 2015

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1.4 How to use the Peer Assessment Handbook

The Handbook is designed to be a resource for both assessors and physicians undergoing assessment. It describes the peer assessment process and outlines evaluation criteria in order to guide assessors in consistently delivering structured peer assessments and to inform physicians who are anticipating a peer assessment about what to expect and how to prepare.

An electronic copy of this handbook, and the handbooks of other disciplines, can be found at:

https://www.cpso.on.ca/Member-Information/Assessments/Peer-Assessment-Redesign

In addition to the information provided in this handbook, the College's webpage dedicated to the Peer and Practice Assessment Program can be consulted:

http://www.cpso.on.ca/CPSO-Members/Peer-and-Practice-Assessment/The-Peer-and-Practice-Assessment-Process

2. Peer Assessment Process

Peer Assessments are conducted in a structured way, as described below:

Phase 1 - Before the Assessment

A. Physician and Assessor Selection

- A physician is selected for assessment and his/her eligibility is confirmed. Physicians can be selected at random or based on specific criteria (e.g., at 70 years of age)
- All physicians to be assessed complete a general Physician Questionnaire as well as **Discipline-Specific Pre-Assessment Questions** (see section 3.1) to provide details about his/her practice. This information is shared with the assessor to aid in providing a context for the assessment.
- A College Assessment Coordinator matches an assessor to the physician based on relevant practice details.

B. Pre-visit Telephone Discussion

- In advance of the site-visit, the assessor initiates a telephone discussion with the physician to be assessed.
- Relying on information from the Physician Questionnaire and the Discipline-Specific Pre-Assessment Questions, the assessor may ask for further clarification about the physician's practice as well as respond to questions or concerns the physician may have.
- As part of the discussion, the assessor reviews the purpose and process of the on-site assessment and the physician's responsibility for preparing/selecting patient records that will be reviewed during the assessment.
- The time and date of the assessment visit is confirmed. After discussing the planned assessment process, it should be clear when the physician is expected to be available on the day of the assessment. The physician can choose to see patients during the assessment record review **but must be accessible at all times if questions arise**. The physician must also set aside time at the end of the visit for the assessment discussion with the physician. Some assessors prefer to conduct the record review in an interactive fashion with the physician throughout the duration of the visit; **this will be clearly communicated by the assessor to the physician prior to the assessment date**.

Phase 2 - During the Assessment

C. Initial Discussion

- The assessment site visit begins with a discussion between the assessor and physician to review the assessment process, orient the assessor to the practice, and familiarize the assessor with the patient records.
- The initial discussion and orientation may include a review of the EMR and how to access all elements of the patient record.

D. Patient Record Review

- The assessor reviews a sample of the physician's patient records that have been selected using a discipline-specific **patient record selection protocol** (section 3.2).
- The assessor records notes for each record using the **patient record summary** (section 5.1).

E. Physician Discussion

- In addition to reviewing patient records, the assessor discussion with the physician takes place in order to:
  - Clarify issues which may have arisen during the record review.
  - Gather further information which cannot be accessed through the record review.
  - Provide feedback to validate appropriate care.
  - Discuss opportunities for practice improvement (the **scoring rubrics** [section 4.2]
  - Highlight opportunities for practice improvement including Continuing Professional Development.

Phase 3 - After the Assessment

F. *Assessment Report*

- The assessor reviews information collected through the patient record review and physician discussion to complete the **peer assessment report** (see section 5.2). This is comprised of a brief description of the background of the physician's practice, overall ratings and narrative comments for each of the assessment domains, as well as an overall narrative summary. The narrative comments of the assessor are particularly important for providing the specific examples of care and documentation that supported their decision making and suggestions for improvement to assessed physicians.
- The assessor uses two main resources to guide decision-making and feedback during the record review:

    - The **scoring rubric** (see section 4.2) defines the elements of quality and evaluation criteria used during assessments. The scoring rubrics are intended to be broadly applicable across diverse patient care interactions and provide an extensive framework for evaluating care and documentation within a practice discipline.
- The assessor submits the assessment report and patient record summaries to the College for review.
- The College sends a copy of the assessment report and patient record summaries to the assessed physician, along with a letter outlining the Quality Assurance Committee's decision.

G. Role of the Quality Assurance Committee (QAC)

- The QAC is a College committee comprised primarily of physicians with additional public members from the CPSO Council. The committee reviews assessment reports and provides additional feedback to assessed physicians, either recommending no further action or directing appropriate follow-up to ensure physicians are meeting the standard of practice in Ontario.
- For more information on the possible outcomes of QAC review, visit the CPSO Peer and Practice Assessment webpage.

H. Evaluating the Impact of Peer Assessments

- Ideally, peer assessments will provide feedback to physicians that prompts practice improvements.
- All assessed physicians are asked to provide feedback to the College about their assessment experience via a Post-Assessment Questionnaire. Physicians are asked to indicate if the assessment was useful, to identify if any quality improvement occurred as a result of the assessor's suggestions/recommendations for improvement, and to provide feedback about potential improvements to the peer assessment process.
- Physicians may also be asked to provide further feedback (via surveys or brief follow-up interviews conducted by the College's Research and Evaluation Department) to contribute to the ongoing evaluation of the peer assessment program.

3. Assessment Tools and Protocols

3.1 Discipline-Specific Pre-Assessment Questions

In total, physicians complete two questionnaires before their assessment. The first questionnaire (the "**Physician Questionnaire**" or PQ) provides the College with ***general*** practice information applicable to most physicians. A secondary set of questions, referred to as Discipline-Specific Pre-Assessment Questions, are appended to the PQ and focus on the assumed scope of practice to be assessed (e.g., family medicine, dermatology, psychiatry, walk-in clinic assessment, etc.,). This assumed scope of practice is based on the physician's credentials and information provided to the College during registration and membership renewal. **Discipline-Specific Pre-Assessment Questions** solicit discipline-specific information and may focus on a number of areas such as the physician's scope of practice within the assessed area, work environment, schedule, resources, and patient population(s). This information provides assessors with an understanding of the physician's work environment, prior to the assessment. A sample copy for **family medicine/general practice** is shown below.

Pre-Assessment Questions for Emergency Medicine:

A. Questions about the Physician:

1. How many Emergency Medicine shifts do you typically work per month?
2. How many patients do you typically see per shift?
3. What is the typical length of your shifts?
4. Please list the relevant Emergency Medicine CME activities you have engaged in during the last year.

B. Questions about the Hospital:

1. What is the annual number of emergency visits?
2. Is it a teaching hospital?

C. Additional Information

1. Is there anything else about you or your practice that you would like your assessor to know?

3.2 Patient Record Selection Protocol

A structured, discipline-specific method is used for selecting and reviewing patient records. This method ensures that a representative sample of records is chosen (i.e., selection includes a variety of conditions over a sufficient time period), and that records are reviewed systematically (i.e., specific sections of the records are examined).

Patient Record Selection Protocol for Emergency Medicine:

Patient Record Selection

Number of records: In total, the assessor will review approximately 15 patient records wherein the assessed physician provided the majority of care.

Timeframe: Records selected for review should reflect patient care within the last 12 months.

Selection Process:

- Prior to the assessment, the assessed physician will liaise with the Medical Records department to ensure that the assessor will have access to all necessary resources in order to review entire patient records (i.e., EMR, paper notes, summaries) at the time of the assessment. If a temporary EMR password will be required for the assessor, it should be set-up in advance of the assessment. The assessor will liaise with the physician to be assessed **and** the relevant Medical Records personnel as necessary to ensure that all aspects of patient record selection process are prepared for the assessment.
- On the day of the assessment, the assessed physician will be prepared to provide an overview of how patient records are organized (EMR and/or paper) to orient the assessor and be available to retrieve additional patient records, as requested.
- The assessor will select 15 patient records from the total number of patient records prepared where the assessed physician provided the majority of patient care. Please do not include patients who were primarily assessed by house staff. Of the types of records included (see below), ensure that 5 records are of patients admitted to hospital.

Types of Records Reviewed: When possible, 5 records for each of the presentations below should be identified in advance of the assessor arriving on-site for the assessment. The assessor will select and review for each presentation:

- Asthma
- Sepsis

- Non-ST Elevation Myocardial Infarction, Acute coronary syndrome
- Back pain
- Chest pain
- Eye pain / injury
- Abdominal pain
- Headache
- Fractures

Patient Record Review

The assessor will review patient records with sufficient attention to practice patterns within and across records to establish a reliable impression of the care provided.

Types of Records Reviewed in Specialized Emergency Departments

The assessor will use their discretion when selecting presentations in a specialized emergency department (e.g., Pediatric Emergency Medicine). Where appropriate, the assessor will substitute non-typical presentations listed above with presentations relevant to the particular specialized emergency department. This intention will be clearly communicated by the assessor in advance of the onsite assessment.

Patient Record Selection and Review for Reassessments

The CPSO Quality Assurance Committee may require a reassessment of a practice after completion of the initial assessment to assess whether recommended practice changes have been implemented. Reassessments follow the same broad and comprehensive assessment process as outlined in this handbook; however, specific patient care or documentation issues will be identified from the initial assessment by way of the assessment report and/or decision letter (e.g., improvement is needed regarding prenatal care, chronic condition management, clarity of documentation, etc.,).

During the reassessment, the assessor will pay particular attention to the issues identified in the previous assessment in order to provide an informed impression of whether those concerns were ameliorated. If required to accommodate this added focus in the reassessment, the assessor may adjust the “Types of Records” listed above to ensure they have sufficient information to address any issue or area of concern (e.g., if care for chest pain was a concern in the previous assessment, the assessor will use their judgement to decide if extra chest pain

records must be reviewed in order to provide an informed impression in the reassessment report).

Timeframe for records selected during reassessment: Records of care may be chosen during any point between the initial assessment and reassessment. Overall, records should be reviewed across a timeframe that allows the assessor to assess improvements in practice since the previous assessment.

Reassessment reporting: As with initial assessments, the assessor provides their impression in the assessment report regarding the quality of care and documentation observed during the reassessment. The assessor should also make a succinct statement in the reassessment report, as required, to make clear whether the standard of practice appears to be met for issues/concerns identified in the initial assessment (e.g., “The concerns related to chest pain care identified in the previous assessment were ameliorated”).

3.3 Physician Discussion Guide

Purpose

The Physician Discussion fulfills two essential components of the peer assessment:

1. *Gathering of information about the physician's practice*

As an information gathering technique, the Physician Discussion allows the assessor to explore issues and topics which cannot be determined from reviewing patient records. As well, the assessor may solicit information to clarify issues or questions which arose during the patient record review. This exchange is critical as the physician may provide an explanation which helps the assessor reach conclusions, particularly around determining where quality improvement may be required; e.g., "Is the problem one of inadequate record-keeping or is there an area where the process of care should be improved?"

2. *Provision of feedback to the physician to validate appropriate care and discuss opportunities for improvement*

As a feedback technique, the Physician discussion allows the assessed physician to receive specific information about their practice from a peer. Assessors will review areas of appropriate care, discuss any issues that were identified through the record review, and provide specific recommendations for improvement. Assessors may provide educational materials or quality improvement strategies to address identified issues and may recommend relevant Continuing Professional Development (CPD) opportunities. A listing of Global Resources for Family Medicine can also be reference in Appendix B; the CPD/Practice Improvement section of the CPSO website (www.cpso.on.ca/CPD/resources) may also be shared for additional educational resources.

Continuing Professional Development (CPD) is a requirement for all physicians. Prior to the assessment, the physician completes a questionnaire that provides the assessor with information about how the physician identifies and meets ongoing CPD needs. This topic may be further explored in the Physician discussion with respect to issues identified in the assessment. The assessor may also assist the physician in developing a self-directed CPD or quality improvement plan that is stimulated by feedback from the peer assessment.

Structure

Although information gathering starts from the first telephone call between the assessor and the physician, the Physician discussion refers specifically to the discussion conducted during the last approximately 60 to 90 minutes of the peer visit. Depending on assessor preference, there may be other one-on-one time requested (e.g., after the first few patient records are reviewed to address any questions about navigating the record or to provide clarification).

The physician discussion is semi-structured; some discussion themes are routinely explored and others develop naturally given the particular context and circumstances of the assessed physician.

Discussion Themes for Emergency Medicine:

1. What are the existing protocols for in-house management and/or transfer (for definitive care to specialized, designated centers') re: Code Stroke; Code STEMI; multi-system trauma; emergent vascular conditions or neurosurgical emergencies?
2. 'After hours', is the Emergency Physician responsible for admitting stable patients to hospital? Are standardized order sheets utilized?
3. What is the process of referral for emergency consultations in the ED and/or urgent referrals for outpatient assessment of particular conditions e.g. TIA?
4. What is the availability of next-day returns for specific investigations e.g. medical imaging studies that are not available during the patient's initial ED visit? Who is responsible for interpretation/follow-up of these investigations?
5. Are written discharge instructions available (either institution-specific or Internet-based)?
6. What is your quality assurance process for missed radiology reads, follow-up lab results after the patients have left the department?

4. Assessment Framework and Scoring Rubric

4.1 Peer Assessment Framework

The *Peer Assessment Framework* provides a structure for the assessment report and evaluation criteria. The framework consists of eight assessment domains organized into four broad categories borrowed from the "SOAP" format (see table below). Details of how these domains align with the CanMEDS framework can be found in **Appendix B**.

Subjective	Objective	Assessment	Plan
1. History	2. Examination 3. Investigation	4. Diagnosis	5. Management Plan 6. Medication 7. Monitoring (Reassessments & Disposition) 8. Discharge Instructions & Documentation for Continuity of Care

The *Scoring Rubric*s (listed in section 4.2) support consistency, discipline-specificity, and transparency in the assessment process. For each domain, high quality care is defined and specific evaluation criteria are provided to guide assessor evaluation. A working group of peer assessors developed the criteria and sought feedback from practising physicians and specified physician specialty organizations to ensure the relevance and appropriateness of the tools. The criteria in the rubric are periodically reviewed to ensure they are up-to-date.

Assessors use the scoring rubric to assist in their decision making when completing the assessment report. The rubrics are NOT intended to be used in "scoring" individual patient records, but rather to describe the overall trend in care, considering all information gathered during the patient records review and the physician discussion. The **global rating scores** for each of the 8 domains are expressed with a 3-point scale (see below). Narrative detail provided in the assessment report for each of the domains provides the critical information regarding validation of appropriate care and opportunities for improvement.

Global Rating Scores:

1 — Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor

2 — Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low

3 — Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected

4.2 Scoring Rubric: Emergency Medicine

IMPORTANT NOTES

The elements of quality listed below are intended to be extensive in order to apply to a diverse range of possible patient presentations. It is acknowledged that not every element of quality will be relevant for every medical record or patient visit. By following the caveat statements ("including relevant details of", "as required", etc.), the assessor will use their medical expertise and professional judgement to determine which elements of quality are relevant for a given patient interaction.

Documentation may include EMR and/or paper records or notes, depending on the protocols of the department. In EMRs that contain documentation from other sources (e.g., entire medication history is collected by triage nurse; test results automatically appended to EMR), the physician is not expected to exhaustively re-document this information. However, the physician's notes should document information which is relevant to the patient's presentation and which guided decisions regarding care (e.g., anticoagulants would be documented in a patient presenting with a head injury).

CPSO POLICIES: Many elements of quality are linked to specific College policies (e.g., Medical Records, Prescribing Drugs, etc.). Relevant College policies can be opened by clicking links in the header of each rubric. Where a perceived difference exists between the present content and CPSO policy, the relevant CPSO policy will take precedent.

HISTORY:

A record of information gathered through questioning the patient or others (e.g., family members, substitute decision-maker) and reviewing pertinent documents to determine the next steps in care.

Key CPSO Policies: Medical Records Confidentiality of Personal Health Information

ELEMENTS OF QUALITY:

A) Presenting illness histories were documented, including **relevant details** of:

- Onset and evolution
- Symptom description, duration, aggravating and relieving factors
- Pertinent positives and negatives
- Targeted functional inquiry
- Functional status (activities of daily living)
- Source of history information (e.g., patient, interpreter, family member, Ambulance Call Report, long-term care staff)

B) Review of systems was documented, as relevant

C) Medical histories were documented, including **relevant details** of:

- Past medical conditions / medical comorbidities / medical treatment and surgeries
- Disease-specific risk factors
- Immunization records
- Allergies and sensitivities (medications, food, environment)
- Family medical histories

D) Medication histories were documented, including **relevant details** of:

- Current and pertinent past medications
- Recent changes in medication (recent starts, discontinuations, dose changes)
- Pharmacological and non-pharmacological substance use and misuse (including herbal substance use as relevant)

E) When relevant, social histories were documented, including **relevant details** of:

- Education/Occupation
- Marital/relationship status
- Social support
- Lifestyle (smoking, exercise, use of recreational drugs/alcohol)
- Legal guardians (e.g., power of attorney) as relevant

F) When relevant, reproductive and sexual histories were documented, including **relevant details** of:

- Current activity
- Past or current pregnancies (Gravida, Term, Preterm, Abortion, Living – (GTPAL))
- Past or current sexually transmitted infections (STIs)
- Sexual orientation

G) When relevant, mental health histories were documented, including **relevant details** of:

- Past and current psychiatric conditions
- Previous treatments and/or hospitalizations
- Past or current family violence/abuse
- Assessment of suicidality/homicidality

EVALUATION CRITERIA:	
Score	**Opportunities for Improvement**
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • Social histories tended to lack detail • Family medical histories relevant to presenting complaints were sometimes not documented
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • Presenting illness histories sometimes lacked sufficient detail (e.g., regarding symptom onset and description, pertinent positives and negatives) • Review of systems were sometimes not adequately documented
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Presenting illness histories consistently lacked sufficient detail (e.g., regarding symptom onset and description, pertinent positives and negatives) • Risk factors for dangerous illnesses were often not documented • Current medications and medication histories were often not documented • Mental health histories and assessment of suicidality/homicidality were not documented when relevant

EXAMINATION:

Guided by the presenting problem, a systematic evaluation of the patient's physical and/or mental state.

Key CPSO Policies: Medical Records

ELEMENTS OF QUALITY:

A) Physical examinations were completed based on presenting complaint, with **relevant documentation** of:

- Vital signs, with abnormal vital signs reviewed/highlighted where appropriate
- Pertinent positive and negative findings
- Relevant descriptive information (e.g., dimensions indicating spread of cellulitis at presentation, location of rash)
- Patient scores (e.g., Glasgow Coma Scale, PERC), when relevant
- Neurovascular status referenced, as appropriate
- Sensitive examinations (rectal, genital, pelvic), as appropriate
- Point-of-care ultrasound findings (positive, negative, or indeterminate)
- General descriptor of patients (e.g., looks well, looks ill, agitated)

B) Mental health examinations were completed **when indicated**, with **relevant documentation** of:

- Mental health assessments (e.g., mood and affect (including risk of harm to self/others), appearance, behaviour, speech, thought process, thought content, cognition, insight and judgment)

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • Descriptions of examination findings sometimes lacked detail
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • System-specific details of examinations were often lacking (e.g., tonsillar exudate not documented for a patient with fever and a sore throat)
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Vital signs were often not documented, with abnormal findings highlighted • Pertinent positive and negative findings of examinations were consistently not documented • Mental Status Examinations were often not thorough or documented when relevant

INVESTIGATION:

Procedures or tests performed to detect, diagnose, or monitor disease processes and determine a course of treatment.

Key CPSO Policies: Medical Records Test Results Management

ELEMENTS OF QUALITY:

A) Investigations were **selected** appropriately, considering:

- Age, sex, histories, examinations and presenting conditions
- Differential diagnoses
- Review of previous investigations and findings as relevant
- Urgency (e.g., life-threatening conditions prioritized)
- Judicious use of resources, including appropriate use of clinical guidelines
- Clinical Decision Rules or practice guidelines (e.g., Well's score)

B) Investigations were **reviewed and documented** appropriately, considering:

- Accuracy of interpretations
- Pertinent normal and abnormal information noted for consideration in management plans

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • Rationale for the selection of investigations was occasionally unclear
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • Investigations were sometimes inappropriate or inadequate based on the presenting complaints or differential diagnoses • Investigation results were often not documented
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Investigations relevant to the presenting illnesses were consistently inappropriate or not ordered • Results of investigations were consistently not documented

DIAGNOSIS:

The identification of a possible disease, disorder, or injury in a patient.

Key CPSO Policies: Medical Records

ELEMENTS OF QUALITY:

A) Diagnostic conclusions were appropriate, considering:

- Alignment with histories, examinations, and investigations
- Differential diagnoses and consideration of most serious diseases

B) Differential or final diagnoses were **clearly stated**

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • Diagnoses occasionally lacked specificity and/or clarity
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • Final diagnoses were sometimes not supported by assessment details
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Final diagnoses were consistently not documented • Diagnoses were often inconsistent with documented histories, examinations and investigations

MANAGEMENT PLAN:

A plan of care tailored to the patient's needs that includes objectives, interventions, time frame for accomplishment and evaluation.

Key CPSO Policies: Medical Records

ELEMENTS OF QUALITY:

A) Management of patients while in the ER was appropriate, considering:

- "ABC's" managed with demonstrated support for airway, oxygenation, ventilation and circulatory status
- Appropriate timeliness to initiating treatment
- Prompt attention to critical results
- Any procedures while in the ER were appropriately performed and documented, for example:
  - Wound repair
  - Abscess drainage
  - Orthopedic manipulations
  - Airway management
  - Vascular access
  - Foreign body removal

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • Descriptions of procedures occasionally lacked detail
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low: • Patients were occasionally over-treated or under-treated • Rationale for management plans was often not clearly documented
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Patients were consistently over-treated or under-treated • Management in the ER was often inappropriate based on patient conditions • Urgent treatments (i.e., early administration ASA for patients with ischemic chest pain, or aggressive fluid resuscitation for patients with sepsis) were not initiated when appropriate • Appropriate procedures were often not performed when necessary (e.g., wound repair, foreign body removal) • Early airway intervention not initiated in a timely fashion when appropriate • Patients were not managed according to current guidelines

MEDICATION:

The prescribing, titrating and tapering of drugs to reach intended drug therapy goals.

Key CPSO Policies: Medical Records Prescribing Drugs

ELEMENTS OF QUALITY:

A) Medications were **selected appropriately** considering:

- Diagnosis
- Patient characteristics (e.g., age, sex, sensitivity/allergy profile)
- Treatment goals

B) Medication management of patients while in the ER was **appropriate**, as demonstrated by:

- Appropriate choice and dose of medications for early management of symptoms (pain, fever, vomiting)
- Early initiation of antibiotics for suspected sepsis
- Medication for procedural sedation demonstrated appropriate choice and dosing
- Appropriate use of narcotics

C) Prescriptions (given at discharge) were **appropriate**, including:

- Analgesia for acute pain
- Choice of antibiotics
- Limited prescriptions for chronic conditions (e.g., opioids for chronic pain)

D) Prescriptions (given at discharge) were **comprehensively documented** (if prescription duplicates not available), including **relevant details** of:

- Name/type of medication
- Dosage
- Quantity/repeats
- Route

E) Information provided to patients, when relevant, was appropriate with **relevant details** of:

- Pertinent risks and side effects (e.g., drowsiness)
- Precautions, if any (e.g., need to avoid alcohol if prescribing Metronidazole)

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • Medication doses were occasionally not documented
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • Discussions with patients about potential medication risks/important side effects were often not documented (e.g., telling patients who have received narcotics or sedatives not to drive)
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Medications prescribed were often inappropriate given patient conditions • Antibiotics were often not promptly initiated when appropriate (e.g., patients with sepsis, patients presenting with headache when meningoencephalitis suspected) • Significant risks or contraindications were not considered when prescribing medications in one or more cases (e.g., interaction with Coumadin) • Important medication information (e.g., quantity, dose, duration) was often not documented

MONITORING (REASSESSMENTS & DISPOSITION):

The ongoing observation and assessment of the patient's progress to assess treatment efficacy, need for treatment change, or transfer of care.

Key CPSO Policies: Medical Records Test Results Management

ELEMENTS OF QUALITY:

A) Re-assessments were appropriate and completed on a timely basis, when appropriate, considering:

- Changes in vital signs
- Completion of investigations
- Other changes in patients' status (e.g., increase in pain)

B) Disposition decisions (whether to refer, admit, discharge, or place in a CDU), were documented clearly, including**:**

- Appropriate and timely physician consultation requested, when appropriate
- Time of referral

C) Handovers were documented clearly, including**:**

- Details of which physician the patient is being passed onto
- Time of handover

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • Details of handovers were occasionally not documented • Reassessments were occasionally not documented
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • Details of handovers were often not documented • Reassessments were often not documented • Diagnostic reassessments were often not performed appropriately (e.g., repeat ECGs or repeat troponins)
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Reassessments after important therapeutic interventions (e.g., bolus infusions for shock) were consistently not documented • Details of handovers were consistently not documented • Failure to obtain timely consultations

DISCHARGE INSTRUCTIONS AND DOCUMENTATION FOR CONTINUITY OF CARE:

Documentation in the patient record/chart as well as other written communications, intended to share information with care providers or referring sources to ensure effective continuity of care.

Key CPSO Policies: Medical Records

ELEMENTS OF QUALITY:

A) Discharge Instructions and **Follow-up Arrangements:**

- Discharge instructions for patients regarding ongoing care (e.g., dressing changes) were detailed
- Documentation of follow-up instructions for patients (e.g., if patients should return to ER or whom patients should follow up with) were clear
- Documentation of any handout sheets were provided to patients (e.g., wound care or cast care)
- Indications for follow-up (e.g., what to do if side effects occur)

B) Documentation completed in accordance with **CPSO Medical Records** policy:

- Information was legible, complete, accurate, and presented in a systematic and chronological manner
- Clinical notes told the story of the patient's health care conditions and allowed other healthcare providers to read and understand the patient's health concerns or problems
- Abbreviations were appropriate (i.e., no potential for confused interpretation by the range of health care providers who might need to access the record)
- Physician-patient encounters, including telephone contact, were documented, dated, and in the case of shared records, it was clear who made the entry
- Most responsible physician ensured trainee entries were accurate
- Templates were used appropriately, including pre-populated templates

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: • Follow up instructions were occasionally not documented
2	**Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: • Discharge instructions or follow up arrangements were often not documented
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Discharge instructions and follow-up were consistently not documented • Discharge medications were inappropriate

5. Assessment Templates

5.1 Patient Record Summary

The Patient Record Summaries are records of each chart reviewed during the assessment. The templates provide a structure for the assessor's "field notes" so that pertinent issues can be noted and referred to during the physician discussion. When the physician provides additional information about issues discussed, the assessor will note this in the summary. Patient record summaries will inform the Peer Assessment Report and be attached to the final report submitted to the College. This package will be reviewed by the Quality Assurance Committee and will be provided to the assessed physician.

Instructions to Assessors for completing the Patient Record Summaries:

The Patient Record Summaries are completed during the record review and updated, if necessary, after the physician discussion. One summary should be completed for each chart reviewed. **Note:** If issues are identified early in the patient record review (i.e., documentation appears to be missing), you should clarify this with the physician before proceeding to ensure that pertinent information is not stored in a different section of the chart / EMR.

How to complete the summaries

- *Patient Identifier*: The identifier can be patient initials or a chart number. Full patient names should not be used.
- *Gender - Date of Birth*: Gender information and patient's date of birth.
- *Dates Reviewed*: The range of dates that were reviewed within the chart. If only a specific interaction was reviewed, that date should be entered.
- *Presenting Problem of Patient/Clinical Issue*: The reason for the patient's visit.
- *Comments/Concerns/Recommendations:* This section, which is divided into the eight assessment domains, is where pertinent information about the chart should be recorded. Comments do not need to be made for every assessment domain; only relevant details regarding quality of care and record keeping need to be included. If concerns are noted, the nature and the extent of the concern should be clearly articulated.
    - ❑ Specific elements of quality will be consistently addressed by the assessor for a given patient presentation (e.g., 'Asthma'). These specific elements are pre-

populated within the eight domains of the record summary template and can be "checked off" to convey that care and documentation related to that specific element is "satisfactory". If the checkbox is left blank for a specific element, the assessor will briefly include a comment to elaborate on any issue in the comment section for the relevant domain (e.g., History).

- *Key Positives/Concerns and Clarification from Discussion with Physician (if relevant)*: Include a brief statement about whether or not concerns were found in the record. Exemplary care and documentation can be recognized here (as appropriate). When follow-up discussion with the physician clarifies issues or concerns noted in a patient record summary, relevant clarifying information should be added.

Patient Record Summaries for Emergency Medicine:

NOTE: The Patient Record Summaries for Emergency Medicine are condition-specific, based on the presentations included in the patient record selection protocol. Critical elements of quality for these conditions have been highlighted in the Quality Improvement Resources and reflected as check boxes in the Patient Record Summaries.

PATIENT RECORD SUMMARY TEMPLATE

Chart #1

Patient Identifier (Initials/Chart Number):

Date of Birth (dd/mm/yyyy):

Date of Visit (dd/mm/yyyy):

Presenting Problem of Patient/Clinical Issue:

ASTHMA

Comments - Concerns - Recommendations Regarding Patient Care:

History

- ❑ Past medical history (triad of cough, dyspnea, wheezing and duration of symptoms)
- ❑ Triggers (environmental, infective, temperature, medication noncompliance)
- ❑ Previous need for BIPAP or intubation

Examination

- ❑ Accessory muscle use
- ❑ Wheezes/air entry or lack of

Investigation

Diagnosis

- ❑ Peak expiration flow measurement
- ❑ Need for O2, continuous pulse oximetry

Management Plan ❑ Administer O2
Medication ❑ Bronchodilator (short – salbutamol/anticholinegeric-ipratropium) ❑ Steriods (oral/IV) 5 day course or greater with tapered course
Follow-Up & Monitoring
Documentation for Continuity of Care
Specific Concerns: Clarification from Physician discussion (if relevant):

Presenting Problem of Patient/Clinical Issue:

SEPSIS

Comments - Concerns - Recommendations Regarding Patient Care:

History

Examination

- ❑ Examination considered various sources of fever (e.g., chest, skin, urine, neck, GI)

Investigation

- ❑ Thorough, appropriate investigations (i.e., blood cultures, serum lactate, chest x-ray, urinalysis, plus or minus CSF) to find source of sepsis

Diagnosis

Management Plan

- ❑ Ensured adequate fluid resuscitation

Medication

- ❑ Provided early treatment with suitable antibiotics

Follow-Up & Monitoring

Documentation for Continuity of Care

Specific Concerns:

Clarification from physician discussion (if relevant):

Presenting Problem of Patient/Clinical Issue:

NON-ST ELEVATION MYOCARDIAL INFARCTION (NSTEMI)

Comments - Concerns - Recommendations Regarding Patient Care:

History

- ❑ History of presenting chest symptoms including onset, location, radiation, frequency, activity level, associated symptoms (nausea, diaphoresis)
- ❑ Past cardiovascular history/ family history
- ❑ Cardiac risk factors

Examination

- ❑ Vital signs

Investigation

- ❑ Used appropriate investigations for ischemic chest pain (i.e., electrocardiogram (serial where appropriate) with documentation of results; biochemical markers (serial where appropriate))

Diagnosis

- ❑ High risk factors documented (e.g., symptoms at rest; pertinent ECG changes; evidence of new heart failure/murmur; hemodynamic instability; PCI in past 6 months; High risk score (TIMI/GRACE); Elevated Troponin)

Management Plan

- ❑ Use of appropriate and early treatment of ischemic chest pain including: O2, Nitrates, Morphine; early administration ASA; addition of second antiplatelet agent (e.g., clopidigrel, ticagrelor) for high risk patients; appropriate use of LMWH/Heparin

Medication

Follow-Up & Monitoring

Documentation for Continuity of Care

Specific Concerns:

Clarification from physician discussion (if relevant):

Presenting Problem of Patient/Clinical Issue:

BACK PAIN

Comments - Concerns - Recommendations Regarding Patient Care:

History

- ❑ Presentation of back pain including duration and radiation

Examination

- ❑ Assessment of vital signs, in particular presence of fever and bilateral blood pressures
- ❑ Neurological assessment (power, sensation, reflexes, rectal examination)
- ❑ Post Void Residual Bladder Scan if considering Cauda Equina (should be <150cc)
- ❑ Exams show consideration of aortic dissection, abdominal aneurysm or pancreatitis

Investigation

Diagnosis

Management Plan

Medication

Follow-Up & Monitoring

Documentation for Continuity of Care

Specific Concerns:

Clarification from physician discussion (if relevant):

Presenting Problem of Patient/Clinical Issue:

CHEST PAIN

Comments - Concerns - Recommendations Regarding Patient Care:

History

- ❑ Details of chest pain, including onset, type/location, duration, radiation, aggravating and alleviating factors

Examination

- ❑ Consideration of potentially life threatening causes (MI, pulmonary embolism, pneumothorax, esophageal rupture, aortic dissection)
- ❑ Assessment of vital signs

Investigation

Diagnosis

Management Plan

Medication

Follow-Up & Monitoring

Documentation for Continuity of Care

Specific Concerns:

Clarification from physician discussion (if relevant):

Presenting Problem of Patient/Clinical Issue:

EYE PAIN/INJURY

Comments - Concerns - Recommendations Regarding Patient Care:

History

- ❑ Previous ocular history

Examination

- ❑ Best corrected visual acuity (e.g., Snellen chart or equivalent; CF at __ ft; HM; LP)
- ❑ Pupil size, shape and reactivity (including testing for a RAPD where appropriate)
- ❑ Slit lamp exam
- ❑ Notes presence or absence of corneal abrasions, ulcers, or dendrites

Investigation
Diagnosis
Management Plan
Medication
Follow-Up & Monitoring ❑ As determined by findings, emergent *versus* urgent referral to ophthalmology
Documentation for Continuity of Care
Specific Concerns: Clarification from physician discussion (if relevant):

Presenting Problem of Patient/Clinical Issue:

ABDOMINAL PAIN

Comments - Concerns - Recommendations Regarding Patient Care:

History ❑ Associated symptoms documented (e.g., constitutional, urinary, genital, cardiac, respiratory if upper abdominal pain)
Examination ❑ Reasonable abdominal exam (which may include: palpation, light and deep palpation, percussion) ❑ Explored possibility of aortic aneurysm ❑ Searched for pregnancy in women of child-bearing age
Investigation
Diagnosis
Management Plan

- ❑ Included proper discharge instructions and follow-up

Medication

Follow-Up & Monitoring

Documentation for Continuity of Care

Specific Concerns:

Clarification from physician discussion (if relevant):

Presenting Problem of Patient/Clinical Issue:

HEADACHE

Comments - Concerns - Recommendations Regarding Patient Care:

History

- ❑ Onset, duration, radiation, associated neurological symptoms (e.g., aura, visual disturbance, nausea/vomiting) associated with current headache
- ❑ Past history of headaches

Examination

- ❑ Vital signs, including temperature
- ❑ GCS if any altered consciousness
- ❑ Thoroughly documented appropriate neurological examination and focused non-neurological examination including head and neck examination

Investigation

- ❑ Appropriate use and documentation of imaging, lumbar puncture and laboratory investigations with documentation of results

Diagnosis

- ❑ Documentation of diagnosis or differential diagnosis

Management Plan

Medication

- ❑ Early use of antibiotics +/- antivirals where meningoencephalitis suspected
- ❑ Avoidance of narcotics

Follow-Up & Monitoring

Documentation for Continuity of Care

- ❑ Documentation of discharge instructions

Specific Concerns:

Clarification from physician discussion (if relevant):

Presenting Problem of Patient/Clinical Issue:

FRACTURES

Comments - Concerns - Recommendations Regarding Patient Care:

History

Examination

- ❑ Thorough neurovascular examination (e.g., pulse, sensory and motor function)

Investigation

Diagnosis

Management Plan

Medication

Follow-Up & Monitoring

Documentation for Continuity of Care

Specific Concerns: Clarification from physician discussion (if relevant):

5.2 Peer Assessment Report

The Peer Assessment Report provides an overall summary of the assessment. The report template guides the format of the report. The report will include relevant background information about the physician's practice, highlight areas of appropriate care, detail areas for improvement across the eight assessment domains, summarize pertinent information from the physician discussion, and provide overall comments. The completed Peer Assessment Report (including the accompanying Patient Record Summaries) will be submitted to the CPSO. The report will be reviewed by the Quality Assurance Committee, who will use it to make a decision regarding the assessment; the Committee's decision along with the report will then be provided to the assessed physician.

Instructions to Assessors for completing the Peer Assessment Report:

The Peer Assessment Report should be completed after all the patient records have been reviewed and the discussion with the assessed physician has taken place. The report should provide a global summary of the assessed physician's practice taking into account all sources of information (i.e., the patient records and physician discussion).

How to complete the report

1. *Physician Demographic & Practice Information:* Insert the assessed physician's name, CPSO number and the scope of practice that was assessed. Insert the assessed physician's initials in the footer at the bottom left of the page (this will automatically be copied onto all subsequent pages).
2. *Assessment Information:* Insert your name, the date of the assessment and the address of the assessment (where the visit took place). In the boxes at the bottom right corner, insert the amount of time spent completing the patient record review and the amount of time spent in discussion with the physician. Sign the form when completed.
3. *Relevant Background Information*: Provide a brief description of pertinent contextual information about the physician's practice (e.g., clinical environment, relevant training and experience, type and scope of practice, key patient population characteristics, recent and/or and planned changes to practice). Information already included in Physician Questionnaire need not be repeated unless it provides specific information that informed the assessment.
4. *Ratings & Comments*: For each assessment domain, provide a rating (1, 2, or 3) based on your overall assessment of the physician's practice. The scoring rubrics should be used to guide your decision making about ratings. Ratings should be supported by narrative

comments and specific examples. The space for narrative detail for each assessment domain is divided into two sections:

i. *Areas of Quality Care and Suggestions for Quality Improvement*: Briefly summarize positive aspects of the physician's practice, as they relate to the elements of quality, in order to validate and encourage continued effort in these areas. Summarize optional suggestions for practice improvement and professional development.

ii. *Specific Concerns Requiring Attention and Recommendations for Remediation*: Describe specific concerns that were identified during the assessment, including both the nature and extent of the concerns, as well as specific recommendations for improvement in this area. When relevant, refer to examples in specific patient record summaries. Clear and concise narrative details are vital for the Quality Assurance Committee's understanding of the issues and ability to make valid decisions and recommendations.

5. *Summative Comments*: Provide a brief summary of your overall assessment of the physician's practice across all eight domains including aspects of quality care and any areas of concern. Provide a summary of all recommendations requiring attention. General comments about the assessment, the physician discussion, or perceptions regarding the physician's responsiveness to feedback and potential for self-directed improvement should be included here. If pervasive record keeping issues was a hindrance to evaluating quality of care, this can be noted here.

PEER ASSESSMENT REPORT TEMPLATE

Relevant Background Information:

Ratings and Comments

1 - Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor.

2 - Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low.

3 - Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected.

History: A record of information gathered through questioning the patient or others (e.g., family members, substitute decision-maker) and reviewing pertinent documents to determine the next steps in care.

- **Presenting illness histories**
- **Review of systems**
- **Medical histories**
- **Medication histories**
- **Social histories**
- **Reproductive and Sexual histories**
- **Mental Health histories**

Rating:	**1** ❑	**2** ❑	**3** ❑

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

Examination: Guided by the presenting problem, a systematic evaluation of the patient's physical and/or mental state.

• **Physical Examinations** • **Mental Health Examinations**			
Rating:	**1** ❑	**2** ❑	**3** ❑
Areas of Quality Care and Suggestions for Quality Improvement: Specific Concerns and Recommendations Requiring Attention:			
Investigation: Procedures or tests performed to detect, diagnose, or monitor disease processes and determine a course of treatment. • **Investigations selected appropriately** • **Investigations reviewed appropriately**			
Rating:	**1** ❑	**2** ❑	**3** ❑
Areas of Quality Care and Suggestions for Quality Improvement: Specific Concerns and Recommendations Requiring Attention:			
Diagnosis: The identification of a possible disease, disorder, or injury in a patient. • **Diagnostic conclusions** • **Differential and/or final diagnoses**			
Rating:	**1** ❑	**2** ❑	**3** ❑

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

Management Plan: A plan of care tailored to the patient's needs that includes objectives, interventions, time frame for accomplishment and evaluation.

- **Management of patients <u>while in the ER</u>**

Rating:	**1 ❑**	**2 ❑**	**3 ❑**

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

Medication: The prescribing, titrating and tapering of drugs to reach intended drug therapy goals.

- **Medications selected appropriately**
- **Medications management of patients while in the ER appropriate**
- **Prescriptions comprehensively documented**
- **Information provided to patients appropriate**

Rating:	**1 ❑**	**2 ❑**	**3 ❑**

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

Monitoring (Reassessments & Dispositions: The ongoing observation and assessment of the patient's progress to assess treatment efficacy and need for treatment change or termination.

- **Re-assessments completed on timely basis**
- **Disposition decisions documented**
- **Handovers documented**

Rating:	**1** ❑	**2** ❑	**3** ❑

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

Discharge Instructions for Continuity of Care: Documentation in the patient record/chart as well as other written communications, intended to share information with care providers or referring sources to ensure effective continuity of care.

- **Discharge instructions appropriate**
- **Follow-up arrangements appropriate**
- **Documentation adhered to the record keeping requirements specified by CPSO Policy**

Rating:	**1** ❑	**2** ❑	**3** ❑

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

Summative Comments

Provide a brief summary of your overall assessment of the physician's practice including aspects of quality care and any areas of concern. Provide a summary of all recommendations requiring attention and include your perceptions regarding the physician's responsiveness to feedback and potential for self-directed improvement.

Appendix A – Development and Evaluation Process

Background

In 2012, an initiative was undertaken at the CPSO to redevelop the peer assessment program. The goals of "Peer Assessment Redesign" were to create an assessment program that is speciality-specific, transparent, consistent, and aligned with its primary purpose to:

"Promote continuous quality improvement by providing physicians with feedback to validate appropriate care and show opportunities for practice improvement".

Development Process

The Peer Redesign initiative was led by the CPSO Research and Evaluation Department. Best practices in program development and evaluation, contemporary validity theory, and established criteria for high quality assessments were utilized to ensure the program was rigourous and educational for physicians. A collaborative approach was taken with experienced peer assessors from a cross section of medical disciplines throughout the development process so that the program would be rooted in realistic, accurate and fair expectations of quality care.

Development progressed through five stages:

1. Tool Development

Specialty-specific working groups of assessors drafted the assessment tools through iterative, consensus-building meetings. They first established an assessment framework (the assessment domains), then defined high quality care for their specialty for each domain. A three-point scale was developed for rating performance and assessors populated discipline-specific examples for each score to provide comprehensive scoring rubrics for assessor decision making. In addition to the scoring rubrics, assessors developed criteria for selecting patient records, discussion themes for the physician discussion.

2. Assessor Orientation and Feedback

All assessors within a specialty were then provided with an orientation to their discipline's assessment handbook. Assessors were given the opportunity to review the materials in detail and provide feedback via an online survey. All the feedback was consolidated, reviewed and implemented as appropriate.

3. *Assessor Training and Consensus Building*

Once all assessors had the opportunity to provide feedback about their specialty's handbook, they were brought together to test the tools in a simulated environment. The focus of these sessions was: 1) to train assessors in how to use the new tools (i.e., how to apply the scoring rubrics during an assessment), and 2) to build consensus in assessors' decision making.

Using simulated records and the discipline-specific scoring rubrics, assessors would make ratings anonymously and then be presented with the ratings of all other assessors to see their consistency with each other. They would then discuss any disagreement by sharing their unique perspective on the case and each make a new rating until an acceptable level of agreement was met. Through this exercise, assessors would identify areas of penitential inconsistency in their interpretations and actively work together to reach collective agreement. If it was found that aspects of the scoring rubrics were unclear or unhelpful for guiding decision making, refinements were made to the tools to enhance their utility.

Consensus-building training was also provided to the Quality Assurance Committee (QAC) to support consistency in their processes and application of evaluation criteria.

4. Internal and External Review

Each handbook then went through an extensive review process. Internally, the handbooks were reviewed by staff across the CPSO to ensure appropriate alignment with CPSO Policies and other initiatives. An external review was then carried out in two parts. First, all physicians within a specific discipline (e.g., Emergency Medicine physicians) were contacted by e-mail with a link to an online survey. The survey explained what the peer assessment program is, how and why it was redesigned, and the way quality care has been defined for their specialty via the scoring rubrics. Feedback was sought about whether or not the definitions of quality care were clear and appropriate for driving quality improvement; space was provided for narrative comments about suggestions for changes. Second, relevant physician organizations for that specialty were contacted and asked to provide feedback about the scoring rubrics and quality improvement resources. The feedback collected from both of the external review streams were collated and thematically analyzed. The tools were revised as needed to address the feedback received.

5. Implementation and Evaluation

As the new tools and processes are implemented into live assessments, a formal evaluation will be conducted to systematically collect data on the effectiveness of the program. The evaluation will consist of two arms: a *process evaluation* to monitor the implementation of the newly

developed assessment tools and processes; and an *outcome evaluation* to examine the impact of the redesigned assessment program on assessed physicians.

The process evaluation will ensure that the new tools are being used as intended and that the processes operate efficiently. Data for this will be collected from assessors, CPSO staff, and QAC members. The outcome evaluation will focus on examining the effects of the peer assessment program on assessed physicians. Data for this will be collected from assessed physicians three months after the completion of their assessment through a survey and/or a key informant interview. These complementary evaluations will inform further development and improvement of the program.

6. Continuous Improvement

The program will undergo continuous quality improvement will ensure that the processes are feasible and that the tools remain useful and relevant. For example, assessors will be convened at appropriate intervals (e.g., every three years) to review currency and relevance of the handbook. Regular feedback will also be systematically collected from staff and QAC members about the utility, feasibility, and acceptability of the program.

Appendix B – CanMEDS in Peer Assessment

The *Peer Assessment* addresses a range of CanMEDS roles across the eight domains and other assessment components as outlined in the table below.

		CanMEDS ROLES						
		Medical Expert	Communicator	Collaborator	Leader	Health Advocate	Scholar	Professional
PEER ASSESSMENT DOMAINS	1. History	✓	✓					
	2. Examination	✓	✓					
	3. Investigation	✓	✓	✓	✓			
	4. Diagnosis	✓	✓	✓				
	5. Management Plan	✓	✓	✓	✓	✓		
	6. Medication	✓	✓					
	7. Follow-up & Monitoring	✓	✓	✓		✓		
	8. Continuity of Care	✓	✓	✓				
PEER ASSESSMENT COMPONENTS	Pre-visit Questionnaire*				✓		✓	✓
	Discussion*				✓		✓	✓

** Leader, Scholar and Professional are addressed to varying degrees in the Pre-visit Questionnaire and Discussion.*

CanMEDS and Continuing Professional Development

CanMEDS is widely incorporated into Continuing Professional Development (CPD) activities that are accredited by the Royal College of Physicians and Surgeons of Canada and the CFPC. CanMEDS 2015 also includes a Competence Continuum that describes the development of physician abilities across the continuum of their career, including CPD (maintenance of competence and advanced expertise).

Furthermore, Key Competency 1 of the Scholar Role is fundamental in espousing the principles of lifelong learning and engagement that motivated the CPSO to make participation in CPD a regulatory requirement for physicians in Ontario: "*Physicians are able to engage in the continuous enhancement of their professional activities through ongoing learning*." CPSO members are required to participate in CPD that meets the requirements set by the RCPSC, the CFPC, or an approved third pathway.

The peer assessor may explore CPD with the physician, asking about the physician's current CPD needs and provide specific recommendations about CPD or quality improvement initiatives that relate to the assessment findings.