CPSO

Peer & Practice Assessment Handbook

Psychiatry

Version 1.03 (December 2022)

Acknowledgments

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Peer Assessment Handbook: Psychiatry

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Introduction to Peer and Practice Assessment

1.1 Purpose of Peer and Practice Assessment

Peer and Practice 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 the Peer Assessment program is to:

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

Peer Assessments are 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

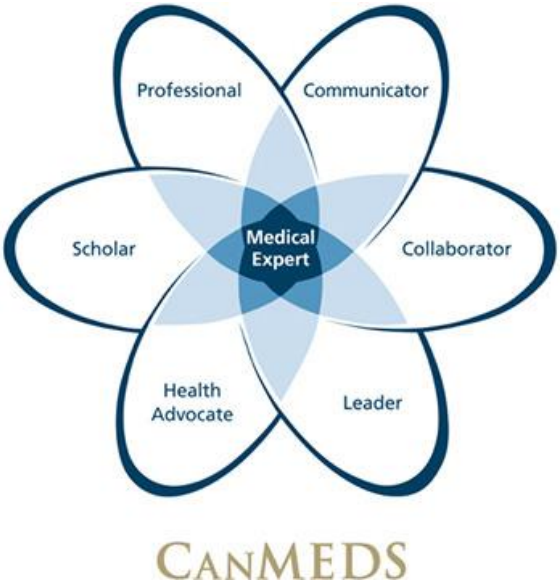
The Peer and Practice Assessment program has been operational since 1980 and thousands of physicians have been assessed. In 2012, the CPSO began an initiative to redesign the program to better align it with its primary purpose of encouraging continuous quality improvement for all physicians. Particular 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 handbook.

The Peer and Practice 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

[2] Copyright 2015 The Royal College of Physicians and Surgeons of Canada. http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e. Reproduced with permission.

1.4 How to use the Peer and Practice Assessment Handbook

This handbook is designed to be a resource for both assessors and physicians undergoing a peer assessment. It describes the assessment process and 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 listed under "Scope Specific Assessment Tools" at:

https://www.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Assessments/Peer-Assessment

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

https://www.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Assessments

2. 2. Peer Assessment Process

Peer Assessments are conducted by trained assessors who are physicians practicing in the same scope as the assessed physician. Assessments take place at the assessed physician's workplace and involve a review of patient records and a discussion with the physician. The assessor completes a report about the assessed physician's practice that is then submitted to the CPSO and reviewed by a committee. The assessed physician receives a copy of the report and a letter outlining any potential follow up. Details of each step in this process are 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 on specific criteria (e.g., at 70 years of age).
- All physicians to be assessed complete a general Physician Questionnaire to provide details about his/her practice. This information is shared with the assessor to aid in providing a context for the assessment.
- A CPSO Assessment Coordinator matches an assessor to the physician based on relevant practice details.

B. Pre-visit Telephone Discussion

- In advance of the assessment, the assessor initiates a telephone discussion with the physician to be assessed.
- During this discussion, the assessor reviews the assessment process and outlines the physician's responsibility for preparing patient records that will be reviewed during the assessment. The assessor may also ask for further clarification about the physician's practice and respond to questions or concerns the physician may have. The assessor and physician will then set a date for the assessment.
- 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 available if questions arise**. The physician must also set aside time at the end of the visit for the assessment discussion. 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 <u>each record</u> using the **patient record summary** (section 5.1).

E. Physician Discussion

- In addition to reviewing patient records, the assessor has a discussion with the physician 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 and highlight opportunities for practice improvement including Continuing Professional Development (CPD) activities.

B. The **scoring rubrics** (section 4.2) can be used as an informational tool during this time.

Phase 3 - After the Assessment

F. *Assessment Report*

- The assessor completes a **peer assessment report** (see section 5.2) based on the information collected through the patient record review and physician discussion.
- This report 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 assessor uses the **scoring rubrics** (see section 4.2) to guide this process. The scoring rubrics define the elements of quality and evaluation criteria used during assessments within a given specialty or discipline. They are intended to be broadly applicable across diverse patient care interactions and provide an extensive framework for evaluating care and documentation.

- The assessor submits the assessment report and the patient record summaries to the CPSO for review.
- The CPSO 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 CPSO committee comprised of physicians and elected public members. The QAC reviews assessment reports and provides additional feedback to assessed physicians, either recommending no further action or directing follow-up to ensure physicians are meeting the standard of practice in Ontario.
- Whereas the assessor is responsible for collecting information during the on-site assessment and providing immediate feedback to assessed physicians, the QAC is responsible for reviewing assessment reports and deciding the outcome of the assessment.
- If potential concerns are identified, the assessed physician is provided an opportunity to address those concerns prior to any further action being taken by the QAC (e.g. reassessment).
- 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

- As part of the effort to continuously improve the Peer Assessment program, feedback is sought from assessed physicians about the impact of the assessments on their practices.
- All assessed physicians are asked to complete a Post-Assessment Questionnaire, which is provided by the assessor following the assessment.

3. Assessment Tools and Protocols

3.1 Patient Record Selection Protocol

A structured, discipline-specific method is used for selecting and reviewing patient records. This *Patient Record Selection Protocol* 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 Psychiatry:

In total, 10-15 patient records will be selected (5-10 by the physician to be assessed and 5-10 by the assessor), as follows:

1. **In advance of the assessment**
   a. The **physician to be assessed** will**:**
      - Select 10 records that represent his/her scope of practice and include a combination of new assessments and follow-up notes. Where possible (and relevant), 6 of the records should be comprised of:
        - 2 records that demonstrate a recent admission (to hospital or psychiatric service)
        - 2 records that demonstrate evidence of communication/involvement with a primary care clinician (e.g., consult notes)
        - 2 records that demonstrate a treatment termination disposition process
      - Provide 10 records for patients seen during a one-week period (or an interval specified by the assessor in advance of the assessment, ideally preceding the notification of assessment or phone call from the assessor).

2. **On the day of the assessment**
   a. The **physician to be assessed** will**:**
      - Be prepared to provide an overview of how patient records are organized (EMR and/or paper) to orient the assessor
      - Retrieve additional patient records as specified by the assessor
   b. The **assessor** will:
      - Review a total of 10 patient records:
        - 5-10 records selected by the physician to be assessed, as per above
        - 5-10 records selected by the assessor, seen by the physician during a particular week, selected at the assessor's discretion, as per above

- Review patient records with sufficient attention to practice patterns within and across records to establish a reliable impression of the care provided

3.2 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 topics which cannot be determined from reviewing patient records or to clarify issues that 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 provides the assessed physician with specific information about their practice from a peer. Assessors review areas of appropriate care, discuss any issues 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. The CPD/Practice Improvement Resources section of the CPSO's CPD webpages may also be shared for additional educational resources: www.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Continuing-Professional-Development/.

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 circumstances of the assessed physician.

Discussion Themes for Psychiatry:

1. Consent and capacity
    - How do you usually document patient capacity and patient or SDM consent?
2. Patient termination procedures
    - What is the most common reason for why your patients are terminated?
    - Do you have a standard procedure to manage patient termination?
3. Protocol for medication samples
    - Do you dispense samples?
    - How do you record provision of samples?
    - How are samples stored?
    - How do you dispose of expired samples?
4. Assessment of patient safety and risk
    - What are the most common risks in your practice?
    - How do you document your risk assessments?
5. Boundaries (as relevant to conditions treated, patient populations, practice setting)
6. Confidentiality issues (as relevant to conditions treated, patient populations, practice setting: e.g., secrets in couples therapy, consent in minors)
7. Risk management (e.g., legal obligation to deliver Mental Health Act forms)
    - What are your resources when you face a challenging situation from a risk perspective (e.g., disagreements with care plans, patient and family complaints, uncertain clinical situations regarding capacity/certifiability)?

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. Follow-up & Monitoring 8. Documentation for Continuity of Care

The *Scoring Rubrics* (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 evaluation criteria and sought feedback from practicing physicians and selected physician organizations to ensure their relevance and appropriateness. The criteria in the rubrics are periodically reviewed to ensure they are up-to-date.

Assessors use the scoring rubrics 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

IMPORTANT NOTE: 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 medical expertise and professional judgement to determine which elements of quality are relevant for a given patient interaction.

CPSO POLICIES: Many elements of quality are linked to specific CPSO policies (e.g., Medical Records, Prescribing Drugs, etc.). Key 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 policy will always 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:

NOTE: Collecting relevant history information described below may be done in a single patient visit or may occur across multiple patient visits, as appropriate.

1) Demographic information was documented, including:

a. Age / date of birth
b. Gender information
c. Patient contact information

2) Reasons for assessment/consultation were documented, including **relevant details** of:

a. Referral information
b. Chief complaint(s)
c. Source of history information (e.g., patient (noting whether alone or in presence of others, e.g., family), interpreter, family member/substitute decision maker, Ambulance Call Report, long-term care staff)
d. Assessment of children, patients with dementia/intellectual deficits; collateral information sought from reliable historians/caretakers
e. Comment on reliability of alternative sources was made as appropriate

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

a. Past medical conditions / medical comorbidities (e.g., thyroid disease in patients with depression, Type II diabetes, metabolic syndrome, hypercholesteralemia, hypertension, CAD)
b. Past and ongoing medical treatment and surgeries
c. Allergies and sensitivities (medications, food, environment)
d. Family medical histories

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

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

a. Drug coverage

5) Psychiatric/psychological histories were documented, including **relevant details** of:

a. Educational and occupational history
b. History of present illness and relevant co-morbidities including symptom temporal features and significant negatives related to presenting problem
c. Functional ability and impact of illness on functioning
d. Past psychiatric history
e. Alcohol and other substance use with extent, duration, sequelae (including prescription and OTC drugs as well as marijuana, cigarettes, alcohol and "street drugs")
f. Developmental, psychosocial and cultural history (e.g., Zarghami, Rouhani & Abdollahi (2016). Treatment of Postpartum Mood in Iran, *American Journal of Psychiatry, 173*, 1177-1178.)
g. Relationship history (including trauma and attachment style)
h. Family psychiatric history and evidence for any diagnoses reported (i.e. "Mother was repeatedly suicidal" as supportive of depression)
i. Patient's perception/understanding of factors they believe to be associated with the onset and perpetuation of their illness/symptoms
j. Safety concerns (i.e., assessment of suicidality, potential for aggressive behaviour or danger to others)

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: • Chief complaints were not always clearly labelled • Histories contained required information, but were disorganized • Allergies were not always 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: • Histories lacks sufficient details to confirm diagnoses and differential diagnoses • Biological medical histories were incomplete
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: • Biological factors, such as medical conditions and current prescribed medications which may pose contraindications with plan and management, were not inquired about in one or more records • Significant co-morbidities that may affect treatment (i.e., history of manic symptoms in depression or family psychiatric history or history of suicide attempts) were not included in one or more records • Suicidal and/or homicidal ideation were not probed about or documented sufficiently in one or more records

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:

1) Mental Status Examinations (MSEs) were completed and documented, including **relevant details*** of:

a. Appearance and hygiene (self-neglect, if present)
b. Movements and behaviour
c. Social interaction/rapport
d. Observed affect/mood (range, responsively, stability)
e. Thought flow, form and coherence
f. Thought content, including psychosis and harm to self or others
g. Perception, including distortions and hallucinations
h. Cognition, including orientation, attention, concentration and short-term, recent and remote memory; MMSE or MoCA, if relevant; implications for driving, child care
i. Insight, judgement and motivation for change

2) Physical examinations, **when relevant**, were:

a. Completed relevant to the treatment context and treatment plan (e.g. blood pressure, pulse and weight monitoring in patients with ADHD)
b. Documented results if completed by another clinician

**The constituent elements of examinations are determined by the needs of the patient and nature of care provided (e.g., initial consultation versus subsequent visit for established patient)*

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: • Mental Status Examinations were sometimes incomplete
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: • Mental Status Exams were often not detailed/specific enough to support diagnoses (i.e. evidence was often not cited for conclusions drawn) • MSE templates were often used without updating of important information to adequately reflect changes in patient statuses
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: • Homicidal/suicidal ideation/psychosis was not assessed, when relevant, in one or more records • Mental Status Exams were not documented, or were disorganized or lacked sufficient detail which could result in safety issues, in one or more records

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:

1) Investigations were **selected** appropriately, as demonstrated by:

a. Alignment with presenting conditions, histories, examinations, questionnaires, and psychological tests
b. Consideration of differential diagnosis
c. Review of previous investigations and findings, as relevant
d. Urgency (e.g., life-threatening conditions prioritized)
e. Judicious use of resources

2) Investigations were **reviewed** appropriately, **if relevant**, as demonstrated by:

a. Accuracy of interpretations
b. Pertinent normal and abnormal information noted for consideration in management plans
c. Copies of laboratory reports with documented evidence they have been reviewed and appropriate action has been taken

3) Investigations delegated to primary care providers were **followed-up,** where appropriate, to ensure tests were completed

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: • Flow charts were typically not used to record results and monitor values over time
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: For psychiatrists prescribing medications: • Investigations were not appropriate for the patients' demographic profile, condition, or medication history (e.g., ECGs not done for patients prescribed over 40mg of citalopram or 20mg of Escitalopram) For all psychiatrists: • Investigations were not comprehensive enough to effectively explore medical factors in psychiatric presentations (e.g., thyroid studies)
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: For psychiatrists prescribing medications: • Relevant laboratory tests were not completed by either the physician or the family doctor in one or more records • Important screenings were not performed in one or more records (e.g., patients on atypical anti-psychotic medication not screened for metabolic syndrome) • Biological investigations were not completed (e.g., protocol not followed for patients on Clozapine, white blood cells not investigated for patients on Carbamazepine)

DIAGNOSIS:

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

Key CPSO Policies: Medical Records

ELEMENTS OF QUALITY:

1) Diagnostic conclusions were appropriate, as demonstrated by:

a. Consideration of information provided by the patient/other informants/reports
b. Psychiatrist's clinical observations
c. Formulation of patient presentation reflecting biological, psychological, social, spiritual, and cultural factors, when relevant

2) Diagnoses and risk summaries were appropriate, as demonstrated by:

a. Assessment of risk (e.g., neglect of self-care or care of dependents (including postpartum), self-harm, suicidality, harm to others (postpartum harm to baby, driving, elder abuse))
b. Medical conditions significant to differential diagnosis of psychiatric conditions were ruled out (e.g., in cases of depression, iron deficiency, thyroid conditions and chronic diseases have been considered)
c. Provisional diagnoses consistent with recent version of DSM or ICD criteria (considering co-morbidities and differential diagnoses)
d. Outlining of key factors in development of patient's current presentation (i.e. biological, psychological, social, cultural) where appropriate
e. Documentation reasonably supporting diagnosis and evaluation of risk as necessary

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: • Significant exclusions of diagnoses were not always explained
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: • Differential diagnoses were often not included or were based on limited information • Concurrent physical illnesses were not included when relevant
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: • Diagnoses were not documented • Diagnoses were often not consistent with recent DSM or ICD criteria • Diagnoses were consistently inappropriate based on 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 Consent to Treatment

ELEMENTS OF QUALITY:

1) Management plans were **developed** appropriately, as demonstrated by:

a. **Intervention Selection:**
   I. Alignment of treatment plans with histories, examinations, and results of investigations
   II. Consideration of treatment of the "whole person" (preference, goals, values, desire for confidentiality), i.e., mental and physical health from a bio-psycho-social perspective including consideration of socio-economic factors, as appropriate
   III. Spiritual components and influence on mental health considered as relevant (e.g. aboriginal mental health, symptom expression, protective factors in suicide risk)
   IV. Evidence-based psychological treatments were chosen consistent with diagnosis and patient characteristics including: intellectual capacity, insight and motivation for treatment
   V. Selection of optimal treatment modalities, short-term vs. long-term or referral to another clinician: outlined with justification or rationale provided

b. **Risk Management, as relevant**
   I. Statement of overall level of intentional harm or risk (non-suicidal, suicidal, violence) with reference to: patient plan or use of lethal means; history of self-harm/violence, potentiating risk factors, warning signs, protective factors, and/or significant loss of family or friends
   II. In cases of immediate and long-term mitigation of risk of self-harm and/or violence, types of interventions undertaken were documented (i.e. psycho-educational, psychological, psychosocial, pharmacological, medical, judicial, Mental Health Act forms)

c. **Informing Patients**
   I. Rationale for diagnosis and management plan discussed with patients
   II. When different types of psychological therapy were considered, these therapy alternatives were discussed with patients (e.g., availability and accessibility)
   III. Instances where resources are lacking to provide optimal care were discussed with patients
   IV. Name of substitute decision maker (if applicable)

d. **Involving other care providers**
   I. When patient is negatively impacted by social determinants of health, consultation with social worker or other allied health provider considered (if not undertaken, reasons for not proceeding were documented, e.g. lack of availability or funding)
   II. Identification of a clinician responsible for managing the patient's medical needs (if not done, an explanation was provided, e.g. not available, options exhausted)

2) Management plans were **implemented** and **recorded** appropriately, with **relevant details** of:

a. **Intervention Goals and Outcomes**

b. **Patient Involvement**
   I. Provision of explanations to patients regarding management plan, options, risks, benefits and potential side effects to enable an informed consent (family involvement where necessary, e.g., children, individuals with cognitive impairment)
   II. Provision of advice and education material to patients and, as appropriate, family

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: • Specialists (e.g., neurologists, psychologists, occupational therapists, etc.) were not always consulted when relevant and available
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: • Management plans often did not address biological and/or psychosocial needs • Records often lacked periodic review of progress • The physician(s) responsible for managing the medical needs of patients was often not identified or documented when relevant • Capacity to consent were not considered in one or more records when relevant
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: • Risk assessment and intervention, when relevant, was not documented in one or more records • Boundary violations were evident in one or more records

MEDICATION:

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

Key CPSO Policies: Medical Records Prescribing Drugs Consent to Treatment

ELEMENTS OF QUALITY:

1) Medications were selected appropriately considering:

a. Diagnosis
b. Treatment goals
c. Evidence-based treatment guidelines
d. Patient characteristics e.g., age, sex, sensitivity/allergy profile
    I. Where appropriate, there was evidence of up to date ECG, EEG, imaging (e.g., for starting stimulant, if family history of sudden death, ECG)
    II. Where appropriate, pregnancy was ruled out, especially when prescribing mood stabilisers
    III. Where appropriate, patient use of herbal or naturopathic remedies noted and considered

2) Prescriptions were comprehensively documented, including **relevant details** of:

a. Name of medication
b. Dosage
c. Quantity/repeats
d. Route

3) Medication Flow Sheets/EMR, when used, were completed appropriately to enhance the record, including time frame for medication reassessment and appropriate plan for monitoring medication side effects

4) Information provided to patients was appropriate, including **relevant details** of

a. Indications
b. Material risks* and benefits
c. Side effects (nuisance and serious)
d. Contraindications and precautions

e. Indications for follow-up (e.g., symptoms and what to do if side effects occur)

5) Medication monitoring was appropriate, as demonstrated by**:**

a. Ongoing tests, examinations, and investigations
b. Medication list updated with changes and rationale for changes
c. Medication side effects monitored at appropriate intervals
d. Responsible persons identified for monitoring medications, as appropriate
e. Substance misuse issues addressed, as appropriate
f. Consideration of adjunctive treatments and complementary medicine (prescribed, delegated or referred)

**Material risks are those that a reasonable person would find important to consider when making decisions regarding treatment options.*

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: • Records sometimes did not specify when medications were used off-label (e.g., antidepressants in child psychiatry or antipsychotics for sleep) • Patient-oriented education materials were not provided to patients and/or care givers when relevant • Medication flow charts were not used consistently • Informed consent documentation did not effectively summarize consent process
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: • Elements of informed consent process were not reviewed with patients • Medication side effects were not consistently monitored or documented but the likelihood of adverse outcomes was low • Incomplete monitoring of patients on atypical antipsychotic medications • Discussion regarding risks and benefits of medication and/or medication side effects (both nuisance and serious) 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: • Medication type or dose was incorrect for the condition in one or more records • Medications with dangerous interactions or contraindications were given to one or more patients • Essential monitoring of patients' reactions to medications (i.e., metabolic factors, height, weight, WBC, blood pressure) was not completed in one or more records • Medication side effects were not monitored in cases where there was potential for serious harm (e.g., metabolic monitoring with atypical antipsychotic medication)

FOLLOW-UP & MONITORING:

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

Key CPSO Policies: Medical Records Test Results Management

ELEMENTS OF QUALITY:

1) Patient monitoring and follow-up were appropriate, as demonstrated by:

a. A regularly updated periodic review (which may be facilitated by a Cumulative Patient Profile), with

attention to patients' emotional stability, course of illness, substance abuse, relevant functional evaluation (e.g., work/school), and with MSEs recorded, as appropriate

b. Appropriate functional evaluation (e.g., work/school; sociability; home responsibilities) and note of appropriate letters completed (e.g., disability or financial)
c. Description of patients' suitability and response to initial trial of treatment
d. Description of ongoing goals for treatment and regularly noted progress related to these goals with an expectation, when possible, as to end point for treatment, as appropriate/possible
e. Documentation of patients' opinion of how they might know when they feel better
f. Completion of ongoing assessments (e.g., suicidal risk assessment, target symptoms, and standardized rating scales)
g. Use of an organized, systematic psychotherapy progress record documenting each contact, specific to the mode of therapy (see Appendix C for an example for psychodynamic psychotherapy))
h. Relevant follow up with new medical symptoms
i. Appropriate action when patients withdrew from treatment unexpectedly (e.g., patients at risk)
j. Reconsideration of diagnosis and treatment plan when patients were not improving
k. Documented follow-up to ER visit (clinical note or phone call)
l. Appropriate transfer of care or shared care is evident, when relevant

2) Therapeutic process monitoring was appropriate, as demonstrated by:

a. Boundaries of therapist-patient relationship addressed as appropriate
b. Comments on the therapeutic alliance and the patients' motivation/adherence with the treatment 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: • Patients' support systems were not always assessed or documented • Summaries of psychotherapy (i.e., patient input, therapist input, and patient response to intervention/therapy) could be more detailed
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: • Records did not include periodic review of the treatment plans or consideration of alternatives when progress was not being made • Rationale for changes in management plans or medications was not always clearly documented • Therapist's intervention/input was often not documented • Records did not clearly indicate details of ongoing follow-up plans (i.e., relevant conditions, treatment goals, timelines) and/or which physicians were responsible for follow up • Ongoing indicators of improvement (e.g., response to treatment) were not consistently 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: • Ongoing risk assessments and interventions, when relevant, were not documented in one or more records (e.g., there were no discussions of suicidal behaviours or MSEs completed after an attempt)

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:

1) Communication with referring sources was effective, as demonstrated by:

a. Provision of copies of assessments and discharge summaries
b. Provision of periodic progress reports of long term therapy patients
c. Identification of physicians responsible for specific aspects of patient monitoring and follow-up
d. Prompt alerts regarding important changes in diagnosis, health status or therapeutic regimen

2) Communication with the healthcare team, when relevant, was recorded and included **relevant details** of:

a. Details of contacts with other physicians and care providers
b. Documentation of shared lab tests

3) Transfer and discharge information was complete, including **relevant details** of:

a. Diagnosis
b. Treatments provided and patient response including benefit and side effect risk
c. Indication of the patients' comfort or concerns with transfer of care or termination
d. Risks or concerns about the patient (specifically harm to self and/or others)
e. New medications and/or medication changes
f. New referrals
g. Recommendations for continued and future management including agencies that may be involved

4) Documentation completed in accordance with CPSO Medical Records policy:

a. Information was legible, complete, accurate, and presented in a systematic and chronological manner
b. 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
c. Abbreviations were appropriate (i.e., no potential for confused interpretation by the range of health care providers who might need to access the record)
d. Physician-patient encounters, including telephone contact, were documented, dated and, in the case of shared records, it is clear who made the entry
e. Most responsible physician ensures trainee entries were accurate
f. 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: • Psychotherapy notes were poorly formatted • Documentation was difficult to follow, though understandable with effort • Patients' comfort or concerns with transfer of care or termination was not always indicated
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: • Psychotherapy notes were disorganized • Referral sources and/or primary care providers were not always notified of material changes in patients' status • Periodic progress reports were missing or incomplete for long term therapy patients • Family doctors or specialists were not always communicated with regarding pertinent recommendations and updates (e.g., for patients with medical issues, sleep apnea, etc.)

	• Summaries of treatment were not always provided to referral sources and/or primary care providers when applicable • Details relating to future management were not consistently documented • Information (i.e., letters, copies of assessments, notice of changes in patients' status, discharge summaries) was not consistently provided to referral source and/or primary care providers • Email and/or telephone communication was often not recorded
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: • Documentation was illegible • Documentation was not chronological • Physicians responsible for essential aspects of care during or following psychiatry treatment were not identified for patients and/or referral sources • Medications were often not logged properly • Mandatory reporting procedures were often not considered/followed • Discussions relating to termination plan were not documented when applicable • Recommendations regarding ongoing mental health care were not consistently provided to patients upon transfer of care or termination

5. Assessment Templates

5.1 Patient Record Summary

The *Patient Record Summaries* are records of each patient chart reviewed during the assessment. These 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 inform the Peer Assessment Report and are attached to the final report submitted to the CPSO. This package is reviewed by the Quality Assurance Committee and is 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 discussion with the physician. 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), this should be clarified with the physician before proceeding to ensure that pertinent information is not stored in a different section of the chart / EMR.

<u>How to complete the summaries</u>

1. *Patient Identifier*: Patient initials or record number. Do not use full patient names.
2. *Date of Birth*: Patient's date of birth.
3. *Date of Visit / Date Range of Record Reviewed*: The range of dates that were reviewed within the chart. If only a specific visit/interaction was reviewed, that date should be entered.
4. *Presenting Problem of Patient/Clinical Issue*: The reason for the patient's care.
5. *Comments/Concerns/Recommendations:* This section, which is divided into the eight assessment domains, is where pertinent information about the chart should be recorded. <u>Comments do not need to be made for every assessment domain</u>; 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.
6. *Key Positives/Concerns and Clarification from Discussion with Physician (if relevant)*: A brief statement about whether or not concerns were found in the record. Exemplary documentation and care 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 SUMMARY TEMPLATE

Chart #1

Selector of patient record ❑ Assessed Physician ❑ Assessor

Patient Identifier (Initials/Chart Number):

Date of Birth (dd/mm/yyyy):	Gender:

Date of Visit (dd/mm/yyyy):

Presenting Problem of Patient/Clinical Issue:

Comments / Concerns / Recommendations:

History
Examination
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. This report template guides the format of the report, which includes relevant background information about the physician's practice, areas of appropriate care, areas for improvement, and 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 is then provided to the assessed physician.

Instructions to Assessors for completing the Peer Assessment Report:

The Peer Assessment Report is completed after all the patient records have been reviewed and the discussion with the assessed physician has taken place. The report provides 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:* The assessed physician's name, CPSO number, and scope of practice that was assessed. The assessed physician's initials are inserted in the footer at the bottom left of the page (this will automatically be copied onto all subsequent pages).
2. *Assessment Information:* The assessor's 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, the amount of time spent completing the patient record review and the amount of time spent discussing with the physician. The assessor signs the form when completed.
3. *Relevant Background Information*: 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 context for the assessment findings.

4. *Ratings & Comments*: For each assessment domain, a rating (1, 2, or 3) is given based on the assessor's overall assessment of the physician's practice. The scoring rubrics guide assessors' decisions about ratings. Ratings are 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*: A brief summary of the positive aspects of the physician's practice, as they relate to the elements of quality in the scoring rubrics, in order to validate and encourage continued effort in these areas. Optional suggestions for practice improvement (where the base provision of care and documentation are appropriate) or suggestions for professional development can be included.
    ii. *Specific Concerns Requiring Attention and Recommendations for Practice Change*: If a score of "2" (moderate improvement needed) or "3" (significant improvement needed) is assigned, the specific concerns that resulted in that score should be described here. When outlining concerns, include both the nature and extent of the concerns, as well as specific recommendations for improvement in this area. When relevant, reference should be made to instances of the concern found in specific patient record summaries. Clear and concise narrative details regarding a concern assist the Quality Assurance Committee in understanding the issues in order to make valid decisions and recommendations.
5. *Summative Comments*: A brief summary of the assessor's overall assessment of the physician's practice across all eight domains including aspects of quality care and any areas of concern. Assessors will 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.

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.

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.			
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.			
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.			
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.			
Rating:	**1** ❑	**2** ❑	**3** ❑
Areas of Quality Care and Suggestions for Quality Improvement: Specific Concerns and Recommendations Requiring Attention:			
Follow-Up & Monitoring: The ongoing observation and assessment of the patient's progress to assess treatment efficacy and need for treatment change or termination.			
Rating:	**1** ❑	**2** ❑	**3** ❑
Areas of Quality Care and Suggestions for Quality Improvement: Specific Concerns and Recommendations Requiring Attention:			
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.			
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 educationally valuable 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, described below:

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 rating scale was developed and assessors populated discipline-specific examples for each score to provide comprehensive scoring rubrics for assessing performance. 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' judgement.

Using simulated records and the discipline-specific scoring rubrics, assessors mad ratings anonymously and then were presented with the ratings of all other assessors to view their consistency with each other. They then discussed any disagreement by sharing their unique perspective on the case and each made a new rating until an acceptable level of agreement was met. Through this exercise, assessors identified areas of penitential inconsistency in their interpretations and actively worked 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 Ontario physicians within the discipline (i.e., psychiatry) 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 (e.g., the Ontario Psychiatric Association) were contacted and invited 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 is being conducted to systematically collect data on the effectiveness of the program. The evaluation consists 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.

Reference:

Hodwitz, K., Tays, W., & Reardon, R. (2018). Redeveloping a workplace-based assessment program for physician's using Kane's validity framework. *Canadian Medical Education Journal*, *9*(3), e14-e24.

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 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.

Appendix C – Psychotherapy Monitoring Template

Example Elements of a Psychodynamic Psychotherapy / Psychoanalysis Contact Monitoring Record:

- Start time / Stop time:
- Patient's reflections since previous session(s):
- Narrative and process summary:
- Intervention:
- Response of patient:
- Transference:
- Countertransference:
- Schematics and diagrams:
- Subjective:
- Objective:
- Mental Status Examination:
- Assessment:
- Prognosis / Plan:
- Supervision/speculations/collegial-clinical seminars & discussions/reflections: