



# COMPETENCE BY DESIGN HANDBOOK

UNIVERSITY OF TORONTO  
DEPARTMENT OF PSYCHIATRY

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# TABLE OF CONTENTS

TABLE OF CONTENTS .....	2
HANDBOOK PURPOSE .....	3
GLOSSARY OF DEFINITIONS .....	4
WHAT IS CBD? .....	5
PSYCHIATRY COMPETENCE SUBCOMMITTEE .....	7
RATIONALE FOR TRANSITION TO CBD .....	8
WHAT IS AN EPA? .....	9
OUR EPAS THUS FAR... ..	13
ELENTA – HOW & WHEN TO USE IT... ..	15
ELENTA FOR CBD COACHES– HOW & WHEN TO USE IT.....	19
CLINICAL ROTATION STRUCTURE .....	25
EPA ATTEMPTS & ACHIEVEMENT: WHEN IN THE CONTINUUM? .....	26
OTHER METHODS OF ASSESSMENT .....	28
OTHER CHANGES TO THE PROGRAM (AND WHY) .....	29
CBD SUPPORTING STRUCTURES & COMMITTEES .....	30
FAQs.....	32
APPENDIX A: EPA & MILESTONE DETAILS .....	35
APPENDIX B: PROVIDING EFFECTIVE FEEDBACK .....	74
APPENDIX C: EVIDENCE-INFORMED FACILITATED FEEDBACK R2C2 .....	76
APPENDIX D: DETAILS OF CHANGES TO ROTATIONAL STRUCTURE .....	79
APPENDIX E: CBD SUBCOMMITTEES AND MEMBERSHIP.....	80

# HANDBOOK PURPOSE

The Competence by Design Handbook for the Department of Psychiatry provides guidance to faculty and residents on the changes underway for postgraduate medical education in our department.

The Handbook introduces the philosophy of Competency Based Medical Education and the 'Competence by Design' (CBD) model used by the Royal College of Physicians and Surgeons and by our Department. It also details the rationale for moving to this new model of training.

Details are included regarding changes to the tools for assessing residents during their clinical rotations including: the introduction of the EPA assessment process; the EPA tool; and, how the EPA assessments fit into the broader competency assessment of each resident. An overview of other changes including didactic curriculum renewal, the clinical rotation structure, and the Longitudinal Ambulatory Experience (LAE) are also included.

Appendices provide further information and details such as support information to better understand and implement the new role of 'resident coach.'

If you are interested in getting involved in the CBD initiative in the Department of Psychiatry or if you have any questions regarding this handbook or other CBD materials get in touch through the CBD e-mailbox at [cbd.psych@utoronto.ca](mailto:cbd.psych@utoronto.ca).

## GLOSSARY OF DEFINITIONS

CBME: Competency Based Medical Education	An outcomes-based approach to the design, implementation, assessment and evaluation of a medical education program using an organizing framework of competencies (© 2009 Royal College and The International CBME Collaborators)
CBD: Competence by Design	The Royal College branding of CBME.
Competencies	Observable, can be measured and assessed to ensure their acquisition, and integrate, knowledge, skills, values and attitudes.
Competence Subcommittee	The committee that considers if residents move on to the next stage of training based on assessments completed.
EPA: Entrustable Professional Activity	<p>An essential task of a "discipline" that an individual can be trusted to perform independently and safely in a given context.</p> <ul style="list-style-type: none"> <li>• Used for assessment</li> <li>• Encompasses multiple milestones</li> <li>• "What can I safely delegate?"</li> </ul> <p>E.g. Performing psychiatric assessments referencing a biopsychosocial approach, and developing basic differential diagnoses for patients with mental disorders.</p>
LAE: Longitudinal Ambulatory Experience	Ambulatory clinical rotation where residents provide ongoing care to a mix or low-to-high complexity patients. LAE is currently a mandatory requirement for PGY1-3s as well as our PGY4 pilot residents.
Milestones	Observable markers of an individual's ability. E.g. Establishes and maintains rapport and effective therapeutic alliance; History gathering is appropriately comprehensive to establish a diagnosis and inform a management plan; Adjusts interview content and style to the patient's presentation
TTD: Transition to Discipline	The first stage of the new model for training (for U of T psychiatry, the first three months of PGY1 including Springboard)
FOD: Foundations of Discipline	The second stage (for U of T psychiatry, the rest of PGY1 <u>and</u> PGY2 or 23 months)
COD: Core of Discipline	The third stage (for U of T psychiatry, PGY3 and PGY4 or 24 months)
TTP: Transition to Practice	The fourth stage (for U of T psychiatry, PGY5 or the final 12 months)

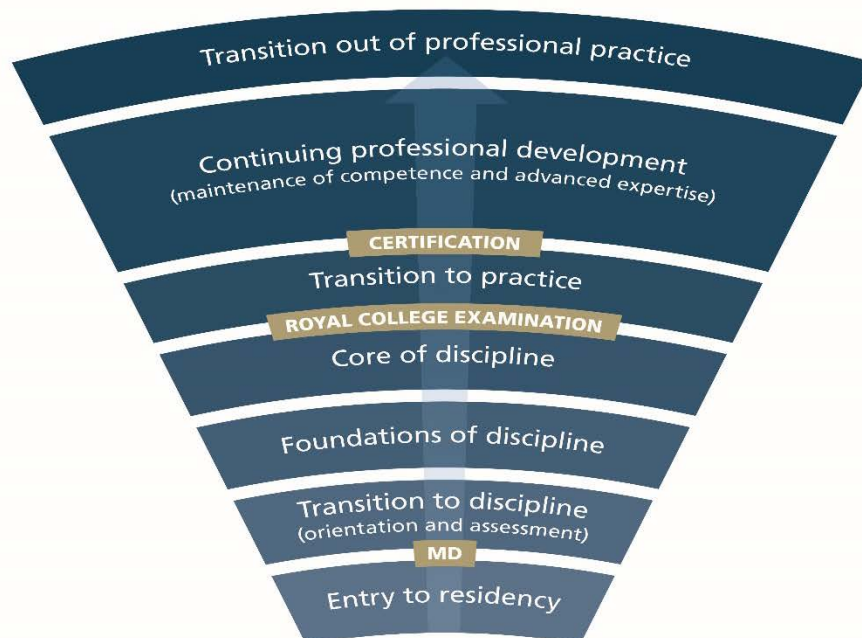
# WHAT IS CBD?

Competence by Design is the Royal College's model of Competency Based Medical Education and is the terminology for the competency based method of medical education that we are using in the Department of Psychiatry. It is a change to postgraduate residency training with the goal of enhancing patient care by improving resident learning and assessment.

CBD is a system of medical education that focuses on outcomes and is based on a framework of competencies. It organizes training into stages, provides guidance for teaching and learning at each stage and includes frequent, in the moment, low stakes assessments of competencies. The competency stages are assessed using a series of entrustable professional activities (EPAs) which are made up of measureable milestones. Residents must now demonstrate EPA competence in order to progress through their stages of training.

The Royal College has divided residency into different stages of training (see illustration below). Transition to Discipline is the first 3 months of PGY-1. Foundations of Discipline is rest of PGY-1 and PGY-2. Core of Discipline is PGY-3 and PGY-4. Transition to Practice is PGY-5.

## CBD<sup>1,2</sup> Competence Continuum



<sup>1</sup> Competence by Design (CBD)

<sup>2</sup> Milestones at each stage describe terminal competencies

**Who decides if the resident “passes” from one stage to the next?**

All assessments (EPAs, STACERs, tests/exams, etc.) are reviewed by the Psychiatry Competence Subcommittee, who will determine if a resident is making adequate progress. No single assessment (especially not a single EPA) will have undue influence on this decision. If a resident is not yet making adequate progress, they will be given extra time to learn the relevant areas (usually in what would have been their Personalized Learning Experience [PLEX] time).

# PSYCHIATRY COMPETENCE SUBCOMMITTEE

## **What is the Psychiatry Competence Subcommittee (PCS)?**

The Psychiatry Competence Subcommittee reviews and makes decisions related to the progress of residents enrolled in the University of Toronto, Competence Based Residency Program, in achieving the national standards established by the Royal College of Physicians and Surgeons of Canada. In absence of Royal College standards, the subcommittee shall use those standards approved by the University of Toronto, Psychiatry Residency Program Committee (PRPC). The Competence Subcommittee reports to and makes recommendations to the PRPC.

## **What does the PCS do?**

The purpose of the PCS is to ensure all learners achieve the requirements of discipline of psychiatry through synthesis and review of qualitative and quantitative assessment data (i.e. EPAs, STACERs, ITERs/ITARs etc.) and other data for each resident. The PCS meets at least every 6 months to provide feedback on progress/promotion as well as areas of strength and weakness.

## **Who are the members of the PCS?**

- Chair: Dr. Inbal Gafni
- Director, Postgraduate Medical Education: Dr. Mark Fefergrad
- Teaching faculty from the University of Toronto Psychiatry Residency Program
- Residents are not members of this committee
- At least 2 members of the PCS shall sit as either observers or voting members on the Resident Evaluation Subcommittee.

Members must not have a conflict of interest with the residents being reviewed.

## **How often does the PCS meet?**

The PCS meets at least twice a year, though more frequent meetings may be required based on the size of the program, and to support the resident needs and transition between stages.

## **Why is the Program Director involved?**

The Program Director is invited to attend all PCS meetings, and to review all documents and decisions rendered by the PCS. Status recommendations for specific residents will be flagged as needed for the Program Director's attention and if required the Program Director will meet with residents. Reporting to the PRPC occurs via the Program Director.

# RATIONALE FOR TRANSITION TO CBD

The following is the rationale provided by the Royal College of Physicians and Surgeons for the transition to CBD across the country.

"Canada's medical education system is exceptional, but there are gaps and challenges within the current model that need to be addressed. Currently, we assume that the more time a learner spends on an activity, the more the learner absorbs and excels. Evidence suggests that our methods of training and lifelong learning can be improved — that's where Competence by Design (CBD) comes in. The benefits of focusing on learning instead of time:

- Ensures competence, but teaches for excellence
- Supports physicians' skills and abilities to evolve throughout practice — enhancing care
- Responds to changing patient and societal needs
- Addresses gaps in the current system, like the "failure to fail" culture of resident education
- Reduces burden on faculties, promoting smoother credentialing and accreditation
- Increases accountability and promotes transparency in training

CBD helps specialists:

- Graduate without knowledge gaps
- Feel prepared for independent practice
- Receive timely and effective assessments and feedback
- Have a clear understanding of the learning objectives of their program
- Maintain needed clinical practice time
- Take a balanced approach to exam preparation
- Understand when new abilities and skills are needed in practice"\*

\*<http://www.royalcollege.ca/rcsite/cbd/rationale-why-cbd-e>



# WHAT IS AN EPA?

In Competence by Design, Entrustable Professional Activities (EPAs) are defined by the Royal College as: “authentic tasks of a discipline. A supervisor can delegate a task to a resident and observe their performance in the workplace. Over time, frequent observations of a trainee’s performance of an EPA, provide a comprehensive image of their competence and inform promotion decisions.” For example – “Developing and implementing management plans for patients with psychiatric presentations of low to medium complexity.”

EPAs are related to each stage of training (as illustrated in the CBD [Competency Continuum graphic](#) on page 3 - transition to discipline, foundations of discipline, core of discipline, transition to practice). EPAs are designed to be developmental — they go from smaller tasks to bigger tasks as trainees progress through the stages of training. Each EPA integrates a number of milestones from different CanMEDS roles; a bigger task may include more milestones and/or more complex milestones.”



Milestones, as described by the Royal College “provide learners and supervisors with discrete information about the relevant skills of the discipline. Milestones that have been linked to an EPA are the individual skills that are needed to perform that task. For the purposes of learning and improvement, a resident and supervisor can focus on the EPA as a whole, or examine the milestones linked to that EPA. Over time, this detail is needed to help guide feedback and coaching for improvement. Milestones allow you as an observer to pinpoint areas that trainees need to improve, in order for them to successfully and reliably complete the EPA.”

## **Resources**

1. View our EPA 101 video ([https://youtu.be/miwwESfp\\_IU](https://youtu.be/miwwESfp_IU)).
2. Background information on EPAs and the details of each EPA and its milestones appear in [Appendix A](#).

## How are EPAs Assessed?

You can assess an EPA using Elentra (<http://meded.utoronto.ca/>). Both faculty and residents can login to Elentra using their UTORid. More information can be found in the EPA Tool section in this Handbook. You will rate the resident's overall performance of the EPA, using this scale:

Intervention	Direction	Support	Entrustment	
			Competent	Proficient
<i>I had to complete some/all of the EPA task/activity</i>	<i>I needed to provide major redirection</i>	<i>I provide minor redirection to ensure safety/minimal competence</i>	<i>I didn't need to act (coaching aside) for safety/minimal competence</i>	<i>I viewed this performance as exemplar</i>

Please pay attention to the descriptions of each rating. If you are rating the resident in the "Entrustment" end of the scale, you are indicating that the resident can perform this task *independently and competently in future situations*. If you need to help the resident with the EPA in any way, then you should be rating the performance somewhere in the range of Intervention → Guidance. You will also be providing comments about what the resident did well and what they can improve. This feedback is highly valued by residents, particularly if it is specific.

## What are the resident requirements for completing EPAs?

Our expectations will be different based on when a resident entered residency. Generally, given that a resident may require multiple attempts at an EPA before becoming entrustable, residents should be attempting an average of 1 EPA per week. Consider suggesting to residents any opportunities you see for EPA completion.

**Pilot Residents (those who began residency in 2017, 2018, 2019):** Except for TTD EPAs (which only need to be completed once), these residents are expected to become "entrustable" in each EPA at least 3 times each training stage (see table below).

<b>2 Transition to Discipline (TTD) EPAs</b>	<b>First 3 months of PGY-1</b>
<b>5 Foundations of Discipline (FOD) EPAs</b>	PGY-1 through PGY-2
<b>11 Core of Discipline (COD) EPAs</b>	PGY-3 through PGY-4
<b>6 Transition to Practice (TTP) EPAs</b>	PGY-5

**Residents who entered residency in 2020:** The required number of attempts and entrustments will differ for each EPA. Refer to the table on the next page for more information.

EPA Code	EPA Name	# of total Required Attempts for EPA <sup>1</sup>	# of total Required Entrustments for EPA <sup>2</sup>
TTD1	<b>OBTAINING A PSYCHIATRIC HISTORY</b> to inform the preliminary diagnostic impression	2	1
TTD2	<b>COMMUNICATING CLINICAL ENCOUNTERS</b> in oral and written/electronic form	2	1
FOD1	Assessing, diagnosing and participating in the management of patients with <b>MEDICAL PRESENTATIONS</b> relevant to psychiatry	8	6
FOD2	<b>PERFORMING PSYCHIATRIC ASSESSMENTS</b> referencing a biopsychosocial approach, and developing basic differential diagnoses for patients with mental disorders	6	4
FOD3	Developing and implementing <b>MANAGEMENT PLANS</b> for patients with presentations of low to medium complexity	6	4
FOD4	Performing <b>RISK ASSESSMENTS</b> that inform the development of an acute safety plan for patients posing risk for harm to self or others	5	3
FOD5	Performing <b>CRITICAL APPRAISAL</b> and presenting psychiatric literature	2	2
COD1	Developing <b>COMPREHENSIVE</b> treatment/management <b>PLANS</b> for adult patients	8	5
COD2	Performing psychiatric assessments and providing differential diagnoses and management plans for <b>CHILDREN AND YOUTH</b>	6	4
COD3	Performing psychiatric assessments, and providing differential diagnoses and management plans for <b>OLDER ADULTS</b>	6	4
COD4	Developing comprehensive biopsychosocial <b>FORMULATIONS</b> for patients across the lifespan	8	5
COD5	Identifying, assessing, and managing emergent situations in psychiatric care across the lifespan ( <b>EMERGENCIES</b> )	8	3
COD6-A	Integrating the principles and skills of psychotherapy into patient care ( <b>PSYCHOTHERAPY MODALITY</b> )	10	6

<b>COD6-B</b>	Integrating the principles and skills of psychotherapy into patient care <b>(LOGBOOK)</b>		
<b>COD6-C</b>	Applying and integrating psychosocial skills and principles in general psychiatric care <b>(INTEGRATING PSYCHOTHERAPY SKILLS)</b>	3	3
<b>COD7-A</b>	Integrating the principles and skills of <b>NEUROSTIMULATION</b> into patient care: <b>SUITABILITY</b>	3	3
<b>COD7-B</b>	Integrating the principles and skills of <b>NEUROSTIMULATION</b> into patient care: <b>DELIVERY</b>	3	3
<b>COD8</b>	Integrating the principles and skills of <b>PSYCHOPHARMACOLOGY</b> into patient care	12	7
<b>COD9</b>	Applying relevant legislation and <b>LEGAL</b> principles to patient care and clinical practice	6	4
<b>COD10</b>	Providing <b>TEACHING</b> to students, residents, public and other health care professionals	4	3
<b>TTP1-A</b>	Managing the clinical and administrative aspects of a psychiatric practice: patient care <b>(PRACTICE MANAGEMENT - PATIENT)</b>	1	1
<b>TTP1-B</b>	Managing the clinical and administrative aspects of a psychiatric practice: working with the team <b>(PRACTICE MANAGEMENT - TEAM)</b>	2	2
<b>TTP2</b>	<b>SUPERVISING</b> junior <b>TRAINEES</b>	4	2
<b>TTP3-A</b>	Developing and implementing personalized training experiences geared to career plans or future practice: <b>DEVELOPING A LEARNING PLAN</b>	1	1
<b>TTP3-B</b>	Developing and implementing personalized training experiences geared to career plans or future practice: <b>IMPLEMENTING A TRAINING EXPERIENCE</b>	1	1
<b>TTP3-C</b>	Developing and implementing personalized training experiences geared to career plans or future practice: <b>REFLECTING ON LEARNING PLAN EFFICACY</b>	1	1

<sup>1</sup> Required Attempt values listed are the overall requirements for each EPA and not specific to a rotation.

<sup>2</sup> Entrustment values are general and not specific to a rotation.

# OUR EPAs THUS FAR...

We have adopted the Royal College of Physicians and Surgeons of Canada Entrustable Professional Activities (EPAs) as of July 2020. All EPAs and Milestones appear in [Appendix A](#).

## TRANSITION TO DISCIPLINE (TTD) (~months 1 - 3)

EPA #	EPA Description
<u>TTD-1</u>	<b>OBTAINING A PSYCHIATRIC HISTORY</b> to inform the preliminary diagnostic impression
<u>TTD-2</u>	<b>COMMUNICATING CLINICAL ENCOUNTERS</b> in oral and written/electronic form

## FOUNDATIONS OF DISCIPLINE (FOD) (~months 2 – 24)

EPA #	EPA Description
<u>FOD-1</u>	Assessing, diagnosing and participating in the management of patients with <b>MEDICAL PRESENTATIONS</b> relevant to psychiatry
<u>FOD-2</u>	<b>PERFORMING PSYCHIATRIC ASSESSMENTS</b> referencing a biopsychosocial approach, and developing basic differential diagnoses for patients with mental disorders
<u>FOD-3</u>	Developing and implementing <b>MANAGEMENT PLANS</b> for patients with presentations of low to medium complexity
<u>FOD-4</u>	Performing <b>RISK ASSESSMENTS</b> that inform the development of an acute safety plan for patients posing risk for harm to self or others
<u>FOD-5</u>	Performing <b>CRITICAL APPRAISAL</b> and presenting psychiatric literature

## CORE OF DISCIPLINE (FOD) (years 3 and 4)

EPA #	EPA Description
<u>COD-1</u>	Developing <b>COMPREHENSIVE</b> treatment/management <b>PLANS</b> for adult patients
<u>COD-2</u>	Performing psychiatric assessments and providing differential diagnoses and management plans for <b>CHILDREN AND YOUTH</b>
<u>COD-3</u>	Performing psychiatric assessments and providing differential diagnoses and management plans for <b>OLDER ADULTS</b>
<u>COD-4</u>	Developing comprehensive biopsychosocial <b>FORMULATIONS</b> for patients across the lifespan
<u>COD-5</u>	Identifying, assessing, and managing emergent situations in psychiatric care across the lifespan ( <b>EMERGENCIES</b> )
<u>COD-6A</u>	Integrating the principles and skills of psychotherapy into patient care ( <b>PSYCHOTHERAPY MODALITY</b> )

<u>COD-6B</u>	Integrating the principles and skills of psychotherapy into patient care <b>(LOGBOOK)</b>
<u>COD-6C</u>	Applying and integrating psychosocial skills and principles in general psychiatric care <b>(INTEGRATING PSYCHOTHERAPY SKILLS)</b>
<u>COD-7</u>	Integrating the principles and skills of <b>NEUROSTIMULATION</b> into patient care
<u>COD-8</u>	Integrating the principles and skills of <b>PSYCHOPHARMACOLOGY</b> into patient care
<u>COD-9</u>	Applying relevant legislation and <b>LEGAL</b> principles to patient care and clinical practice
<u>COD-10</u>	Providing <b>TEACHING</b> to students, residents, public and other health care professionals

### TRANSITION TO PRACTICE (TTP) (year 5)

<b>EPA #</b>	<b>EPA Description</b>
<u>TTP-1A</u>	Managing the clinical and administrative aspects of a psychiatric practice: patient care <b>(PRACTICE MANAGEMENT - PATIENT)</b>
<u>TTP-1B</u>	Managing the clinical and administrative aspects of a psychiatric practice: working with the team <b>(PRACTICE MANAGEMENT - TEAM)</b>
<u>TTP-2</u>	<b>SUPERVISING junior TRAINEES</b>
<u>TTP-3A</u>	Developing and implementing personalized training experiences geared to career plans or future practice: <b>DEVELOPING A LEARNING PLAN</b>
<u>TTP-3B</u>	Developing and implementing personalized training experiences geared to career plans or future practice: <b>IMPLEMENTING A TRAINING EXPERIENCE</b>
<u>TTP-3C</u>	Developing and implementing personalized training experiences geared to career plans or future practice: <b>REFLECTING ON LEARNING PLAN EFFICACY</b>

# ELENTRA – HOW & WHEN TO USE IT...

As discussed, an EPA is a task used to assess a resident's competency. As of July 2, 2020, we are using the University's Elentra platform for all EPA submissions. All CBD based residents and faculty will be able to access Elentra (<https://meded.utoronto.ca/>) via their UTORid login and password.

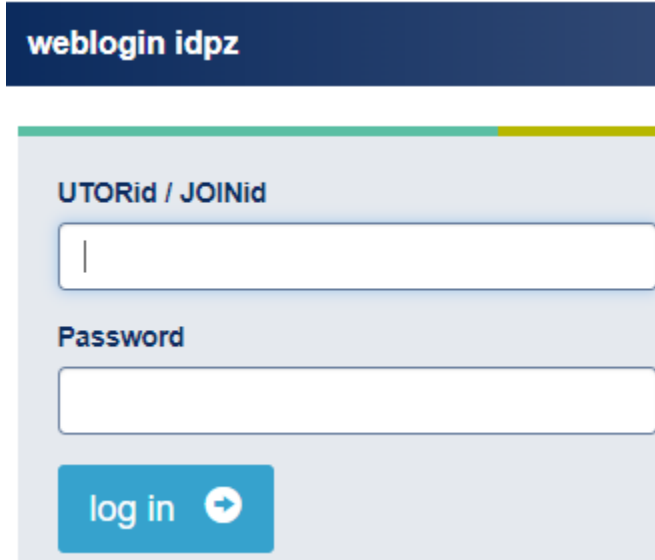
User guides are available via the PGME website - <http://cbme.postmd.utoronto.ca/u-of-t-cbme-faculty-resident-resources/references-resources/elentra-user-guides/>

To use the tool:

- 1.) **Plan** to assess a specific EPA prior to the in the moment observation.
- 2.) **Select and observe** the EPA.
- 3.) The supervisor **gives feedback** in person first, using the R2C2 model (See [Appendix B](#) for Providing Effective Feedback and [Appendix C](#) for the Evidence Informed R2C2 model of feedback).
- 4.) EPA completion is be done via Elentra using the UTORid of the resident or supervisor. You may use a phone, a computer or tablet.
- 5.) **Do supervisors have to assess in all associated EPA milestones?** At minimum, the supervisor needs to fill out the **OVERALL entrustment scale**. However, the individual can be assessed using the individual milestones.
  - If the resident is NOT entrustable, break it down into the milestones to find out where the resident can improve for the future.
  - Milestones do not need to be completed each time.
  - You may look to the milestones to help unpack the EPA if a resident is not Entrustable.

## **Elentra User Guide for Supervisors**

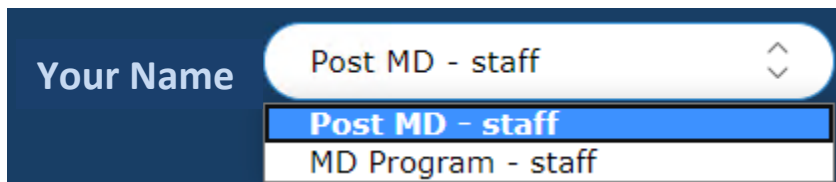
1. Go to the Elentra Website: <https://meded.utoronto.ca>
  - We recommend using the Google Chrome browser as it is the most compatible with Elentra.
2. To log in to Elentra, enter you UTORid and password and click "log in". You will be directed to the Elentra home page.

The image shows the Elentra login interface. At the top is a dark blue header with the text "weblogin idpz" in white. Below this is a light blue login box. Inside the box, there is a label "UTORid / JOINid" above a white input field. Below that is a label "Password" above another white input field. At the bottom of the box is a blue button with the text "log in" and a white right-pointing arrow icon.

**I don't remember my UTORid information (username/password).** Please connect with Tammy ([cbd.psych@utoronto.ca](mailto:cbd.psych@utoronto.ca)) for assistance.

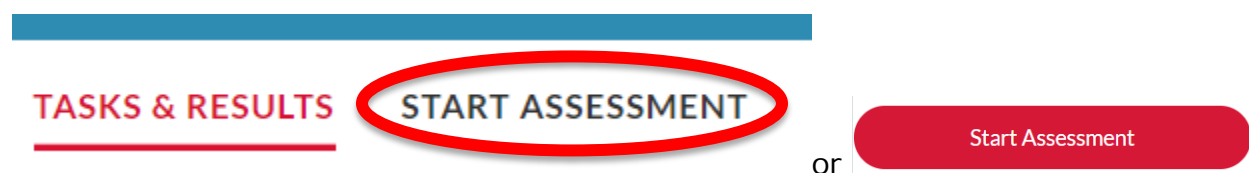
Note: If you are involved with the MD Program curriculum, you may need to toggle between profiles.

- At the top of your screen, navigate to the **up and down arrow** in the white box beside your name, this box contains the organization (MD or PostMD) and your role in the organization (staff, student, faculty)

The image shows a user profile dropdown menu. On the left, the text "Your Name" is displayed in white on a dark blue background. To the right is a white dropdown menu with a small up and down arrow icon. The menu is currently open, showing three options: "Post MD - staff" (highlighted in blue), "Post MD - staff", and "MD Program - staff".

Users can toggle back and forth between their different roles to access different programs or learners to complete appropriate assessments or carry out any other functions in the system without having to log out and log back in.

3. To start an assessment, select 'Start Assessment'. This option appears in the navigation menu at the top of your browser or as a red button.





4. Select the **"On Demand Workflow"**. In most cases, you will see **"Entrustable Professional Activity (EPA)"**. If you would like to complete a non-EPA assessment (Encounter Form), Note to File, or another assessment form type, please select **"Other Assessment Form"**.

- If using the resident's account, you will have to search for the appropriate assessor (supervisor).

- **Can't find an assessor?** Add an assessor by entering their first and last name and email address. Once an assessor has been added, they will always appear in the list.

- If using the supervisor's account, type in the resident's (assessee) name into the search box to narrow down the list. Once you find the resident's name, select for it by clicking on the circle.

- The Program field will auto populate based on the selected resident.
  - Note: if you are completing an EPA for a PGY1 resident, you will see "Psychiatry"; if you are working with a PGY2, 3 or pilot 4 resident, you will see "Psychiatry – Pilot".

5. Select the **"Date of Encounter"** and **"EPA"** you are assessing. Once an EPA has been selected, a list of Assessment Tools associated with that EPA will appear.

- For the most part, most of our EPAs only compromise of only one tool.
- If an EPA has multiple parts associated with it, you will see Part A and Part B. Select the appropriate tool.

Select **"Start Assessment"** to initiate the assessment via the selected assessment method.

EPAs with multiple parts:  
**COD6-** A & C  
**COD7-** A & B  
**TTP1-** A & B  
**TTP3-** A, B, C



The image shows a horizontal rectangular box representing a search or selection area. To the right of this box is a large red arrow pointing to the right. Further to the right is a blue button with the text "Start Assessment" in white.

6. Elentra has two **assessment methods**

Option 1: **Complete Now**: Supervisors will only see this method.

- This is the preferred method and can be done when the resident and assessor are in the same room.
  - i. Follow the prompts for information.
  - ii. Residents can be assessed using the individual milestones.
    - If the resident is NOT entrustable, break it down into the milestones to find out where the resident can improve for the future.
    - **Milestones do not need to be completed each time.**
    - You may look to the milestones to help unpack the EPA if a resident is not Entrustable.
  - iii. Tick off the appropriate rating in the **OVERALL entrustment scale**.

- iv. Narrative feedback – this is **often the most important and meaningful part. Be specific and constructive.**

**★TIP!** If using a mobile device, click the microphone icon and dictate your feedback.

- v. Once all sections have been completed and reviewed, select the **“Submit”** button to submit the form.



If the form has been successfully completed, the following message will appear:

Successfully completed the form. You will now be redirected to the Dashboard. This will happen automatically in 5 seconds or [click here](#) to continue.

Option 2: **Complete and Confirm:** Available to residents only.

- Residents can trigger an EPA to be sent to their supervisor for completion. This is a good option for virtual supervision or if a supervisor is called away for an emergency.
- **Residents are responsible for completing all demographic information** (site, setting, type of case/procedure, patient demographic, and complexity level of case) **and an assessment cue** to help the assessor remember the case/patient the EPA is for.
- Supervisors will be sent an email with a link to the specific EPA and have 48 hours to complete:

- vi. overall entrustment scale, and if necessary the milestones

- vii. Narrative feedback – this is **often the most important and meaningful part. Be specific and constructive.**

**★TIP!** If using a mobile device, click the microphone icon and dictate your feedback.

- viii. Once all sections have been completed and reviewed, select the **“Submit”** button to submit the form.



If the form has been successfully completed, the following message will appear:

Successfully completed the form. You will now be redirected to the Dashboard. This will happen automatically in 5 seconds or [click here](#) to continue.

# ELENTRA FOR CBD COACHES– HOW & WHEN TO USE IT...

As a CBD Coach, you should be meeting with your assigned coachees for bimonthly 30-minute check-ins to review EPA progress, ITARs/ITERs, and other outstanding performance items/issues. Please make sure that two of these check-in meetings take place in the few weeks prior to the bi-annual Psychiatry Competence Subcommittee meetings (i.e. November and May).


Generally, we suggest the following meeting frequency:

- 1) July/August – initial 1 hour meeting
- 2) October – pre-Competence Committee reviews (30mins)
- 3) December – post-Competence Committee (30mins)
- 4) February – 2 month check-in (30mins)
- 5) April – pre-Competence Committee reviews (30mins)
- 6) June – post-Competence Committee (30mins)

Each CBD Coach has their own Elentra account and can view their coachee's EPA progress and completion, this includes how many they have been entrustable on and how many attempts they have made.

## **How do I access and use Elentra?**

- 1) You can access Elentra by visiting: <http://meded.utoronto.ca/>
  - use your UTORid to log in.
  - We recommend using the Google Chrome browser as it is the most compatible with Elentra.
- 2) You will be able to see your coachee's EPA progress by navigating to your 'Tasks & Results Dashboard' and selecting 'My Learners'.
- 3) Select the appropriate resident from the available list. Each resident's profile contains a link to their CBME Dashboard. The dashboard will display a summary of the resident's progress for each EPA.



**Resident's Last name, First Name**  
 Resident's Email

PGY#

CBME ▶

Assessments ▶

### **CBMD Dashboard View**

You should see the below once you have selected the appropriate resident:

Log Meeting

Psychiatry
 

All



**Resident's Last name, First Name**  
 Resident's Email

Resident's Student #

Resident's Name
 

▼

Stages

Assessments 0

Pins

**A**
**Transition to Discipline**

EPA Plan for PGY1 TTD FOD

**E**

**B**

☐

D1

Obtaining a psychiatric history to inform the preliminary diagnostic impression for patients presenting with mental disorders

0 Assessments

▼

D2

Communicating clinical encounters in oral and written/electronic form

**C**

**D**

☐

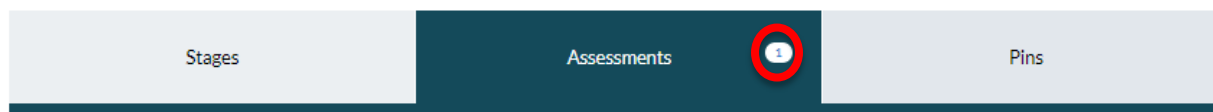
0 Assessments

▼

### **STAGES**

- A** – Indicates the competence stage
- B** – Indicates the status of stage completion. IF a resident has successfully completed a stage, it will be denoted by a grey checkmark.
- C** – Indicates the EPA. If you click on a specific EPA, it will take you to the resident's attempts on that EPA.
- D** – Indicated whether a resident has met the entrustment target for the EPA
- E** – Links to the EPA Plan for the indicated stage.

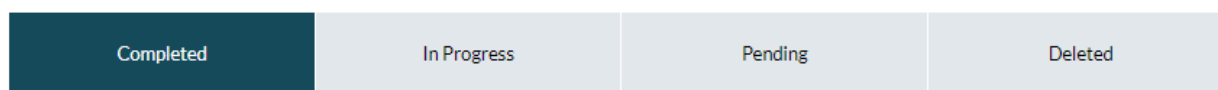
## ASSESSMENTS



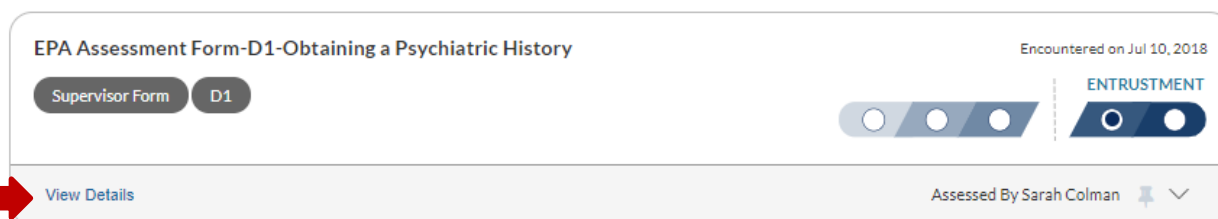
All EPA encounters for each learner will appear in the Assessments Tab. The number that appears beside Assessment will be the total # of EPAs the resident has in the system. Each encounter is contained within a tile.

Within the Assessment tab, you will be able to view the following:

- A) **Completed** – all completed EPAs will appear under this tab. You will be able to see which EPAs and their overall entrustment



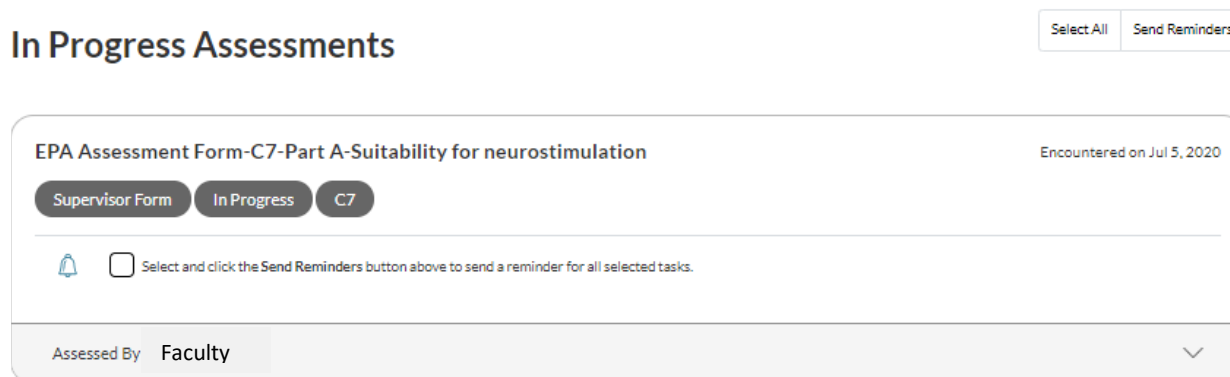
### Completed Assessments



If you select “View Details” in the EPA Encounter, you will be able to see the contextual variables for the encounter (rotation service, setting site, type of case/procedure, patient demographic, case complexity) as well as any milestone ratings, the OVERALL entrustment rating and the narrative data from the assessor.

- B) **In Progress** = any partially completed EPAs that the resident has triggered via the Complete and Confirm submission mode. Resident use this to help keep track of any triggered EPAs that have not been completed by their assessor.

### In Progress Assessments



- C) **Pending** = encounters that have been sent to the assessor for completion but have not yet been started by them.
- D) **Deleted** = any EPAs that have been deleted due to multiple reasons such as a duplicate EPA or the resident/faculty submitted the wrong EPA.

## Deleted Assessments

EPA Assessment Form-F1-Medical Presentations

Deleted by Tammy Mok | Jul 9, 2020

Supervisor Form

F1

ENTRUSTMENT

Assessed By Faculty

**PINS:** residents can pin specific Assessments for quick reference or other uses such as keeping track of specific feedback or areas of improvement.

## LOG MEETING (optional)

Coaches can use this optional feature to log their meetings with residents.

Psychiatry

All


Log Meeting

<div><div></div><div>Resident's Last name, First Name</div><div>Resident's Email</div></div>	Resident's Student #
--	----------------------

- 1) Click 'Log Meeting'

Any previously logged meetings will be available in the Advisor Meeting Log.

## Advisor Meeting Log



**Resident's Last name, First Name**

Resident's Email

Resident's Student #

[Log New Meeting](#)

Resident's name

DATE	COMMENTS	FILES	LOGGED BY	ACTIONS
Click the Log New Meeting button to log a meeting				

- 2) Click Log New Meeting and enter the date of your meeting and any comments you want to include.

## Add Meeting with Resident

Please note that you will be able to upload files to the meeting after you have created it.

Date of Meeting \*

Comments

Create Meeting

### Who has access?

The coach who composed the log, the learner involved and the Program Administrator and Program Director will be able to view any meeting logs.

We will not be using these during the Competence Committee reviews. Instead, we will continue to send out the (optional) Coach Feedback Form to solicit written feedback from coaches.

## **Coaching FAQ:**

- 1) **I am a new faculty member and/or I don't think I have a UTORid account.**

Please connect with Tammy ([cbd.psych@utoronto.ca](mailto:cbd.psych@utoronto.ca)) for assistance.

- 2) **I don't remember my UTORid information (username/password).**

Please connect with Tammy ([cbd.psych@utoronto.ca](mailto:cbd.psych@utoronto.ca)) for assistance.

- 3) **I can't see the residents that I am coaching.**

Please connect with Tammy ([cbd.psych@utoronto.ca](mailto:cbd.psych@utoronto.ca)).

- 4) **My resident has completed the same EPA several times. What can I do to encourage them to try a different one?**

If they only have one EPA (e.g. FOD1) done many times, encourage them to branch out and try for other EPAs. You can suggest what setting would work based on the EPA (e.g. Performing risk assessments in the ER).

- 5) **My resident has a high volume of EPAs, and has been deemed entrustable in many of them. What are the next steps?**

If they are significantly ahead with respect to numbers, and are already entrustable many times on most EPAs in their stage, encourage them to "reach forward" and start on the next stage of EPAs.

- 6) **Should I still be reviewing ITARs/ITERs with the coachee?**

Yes, review ITARs/ITERs (resident can provide these for your review) for any themes/patterns of growth/concern.

- 7) **My resident is unsure how they are progressing, what would you recommend?**

Have the resident self-assess how they are doing, and where they could benefit from more supervision. If you are unsure how to guide them, reach out to Sarah Colman ([sarah.colman@camh.ca](mailto:sarah.colman@camh.ca)).

- 8) **What is an ITAR? What is the difference between an ITAR and an ITER?**

ITARs are In Training Assessment Reports and are the new end of rotation assessment reports for some residents. ITARs are shorter than traditional ITERs and will allow narrative data to fill in the gaps that EPAs do not cover. All PGY1s will receive ITARs instead of ITERs in the 2020-2021 academic year. Both ITARs and ITERs will be completed via [POWER](#). Eventually all ITERs will be transitioned to ITARs.



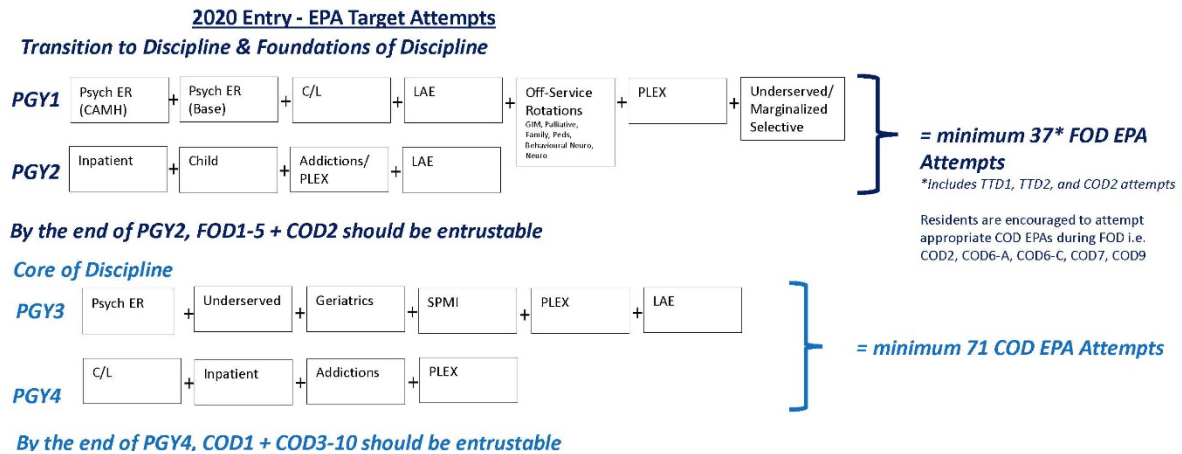
# CLINICAL ROTATION STRUCTURE

BLOCKS:	1	2	3	4	5	6	7	8	9	10	11	12	13
PGY1	Transition to Discipline (1 month)	Foundations of Discipline (23 months)											
	Springboard	Underser'd Comm	2 months Emergency Room Psychiatry	1 month C/L Psychiatry	1 month PLEX*	7 months Psychiatric Medicine							
		Longitudinal Ambulatory Experience											
PGY2	Academic	4 months Child Psychiatry			Academic	2 month Addictions/ 2 months PLEX*				Academic	4 months Inpatient		
		Longitudinal Ambulatory Experience											
PGY3	Core of Discipline (24 months)												
	1 month PLEX*	Academic	3 months Severe Persistent Mental Illness		2 months Emergency Room Psychiatry		2 months Underserved Community		Academic	4 months Geriatric			
	Longitudinal Ambulatory Experience												
PGY4	3 months Inpatient		Academic	3 months C/L Psychiatry			2 months Addictions		4 months PLEX*			Academic	
PGY5	Transition to Practice (12 months)												
	Academic	12 months Transition to Practice PLEX*											Academic
	Integrated Mental Health Care												

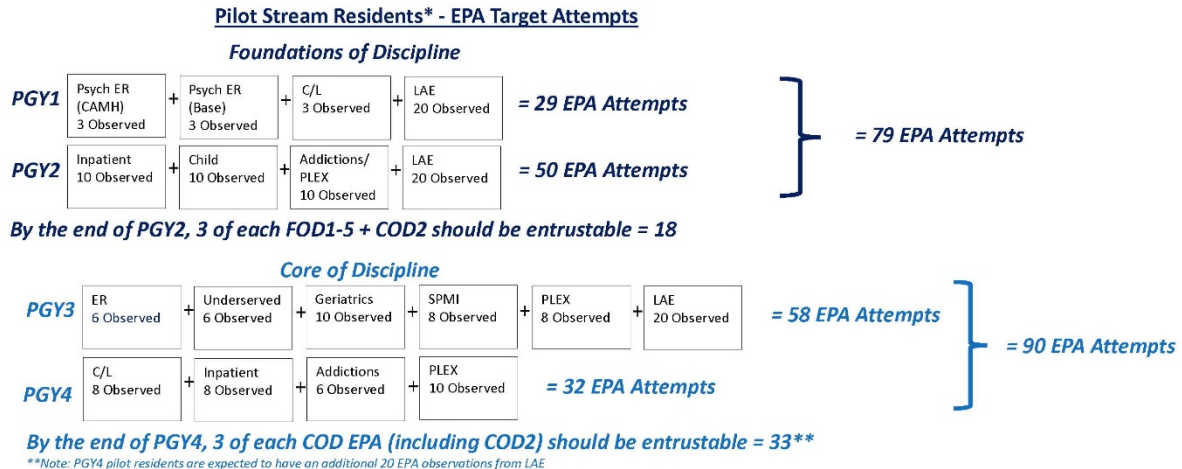
\*PLEX = Personalized Learning Experience

# EPA Attempts & Achievement: When in the Continuum?

The graphic below illustrates the target EPA attempts for PGY1s starting residency in 2020:



## Current PGY2s, PGY3 and PGY4 residents:



\*Residents who entered residency before July 2020



In months 2-12 of residency training (PGY1), the EPAs should be observed during all rotations. Generally, EPAs should be attempted on a weekly basis and every other week in the LAE. EPAs can be attempted as often as a resident wishes - more is always better. Residents are encouraged to complete EPAs during off-service rotations especially FOD1 as this deals with the assessment, diagnosis and

management of patients with medical presentations relevant psychiatry. We expect that residents complete their TTD entrustments by the first Competence Committee meeting, which is typically in November.

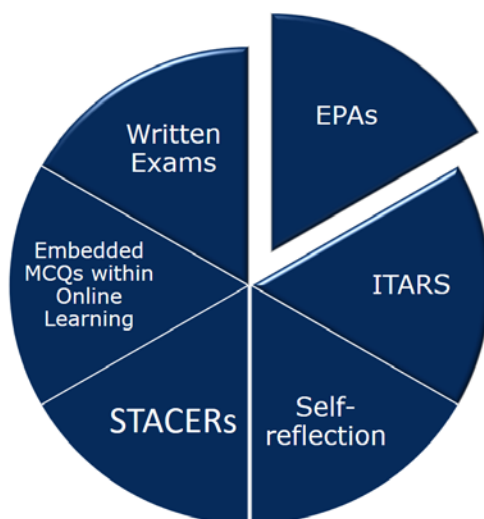
In months 13-24 (PGY2) the EPAs should be observed during all rotations including: Inpatient, Child, Addictions and PLEX. EPAs should be attempted on a weekly basis and every other week in the LAE.

### **ENTRUSTABLE?**

Residents are not expected to be entrustable on the FOD EPAs in the first few months of PGY1. However, residents should be attempting a variety of EPAs (not just FOD1 ten times) and making some progress along the entrustment scale of those being attempted.

## OTHER METHODS OF ASSESSMENT

CBD and the introduction of EPAs, does not negate the many methods of assessment that we have used historically and that have been introduced over the course of our residency training program. Rather, the tool adds depth and additional information to the overall assessment of the resident. Superior assessments often have multiple modalities. All of these modalities will potentially be used:



Some examples of additional resident assessment changes to anticipate include:

- In Training Assessment of Residents (ITARS), as they are now called with Assessment replacing the Evaluation term in the previous acronym (ITERS) will likely be shorter, with more of a narrative focus and fewer tick boxes.
- ITARs are In Training Assessment Reports and are the new end of rotation assessment reports for some residents. ITARs are shorter than traditional ITERS and will allow narrative data to fill in the gaps that EPAs do not cover. All PGY1s will receive ITARs instead of ITERS in the 2020-2021 academic year. Both ITARs and ITERS will be completed via [POWER](#). Eventually all ITERS will be transitioned to ITARs. Click [here](#) to see an example of a PGY1 ITAR.

# OTHER CHANGES TO THE PROGRAM (AND WHY)

## Didactic Curriculum Redesign

Over the next few years, we are taking a very close look at our current didactic lecture series. With the help of Educational Scientists from the Wilson Centre for Education, we are developing a curricular model to guide us. We are examining what the residents are currently learning and deciding, based on guiding principles (see [Appendix D](#)), what should stay as a didactic lecture, what should move online (E-module, a podcast) and what should be structured as self-directed learning or in-the-moment learning with supervisors. We are also looking for synergies with the undergraduate curriculum and collaborations with other universities, locally, provincially, nationally and internationally.

The timing of didactic lectures is moving as well – heavily weighted in PGY-1 during Springboard (July) and then intensives prior to rotations, and then monthly daylong learning experiences. Psychotherapy and psychopharmacology seminars are moving to local sites.

## Longitudinal Ambulatory Experience

The Longitudinal Ambulatory Experience is a patient and population centred educational model that is designed to allow residents the opportunity to follow patients over a period of time commensurate with the illness course of the individual rather than the artificial boundaries of a rotation.

In the first year, the LAE will take place within a half-day, closely supervised, setting. As residents move forward in their competency in PGY2- and PGY-3, the LAE will be a full day per week with increasing independence deemed appropriate for the individual resident. Primary supervisors will be a staff psychiatrist but senior residents may also take on a supervisory role. In more senior years (PGY-4 and PGY-5), the LAE becomes optional and the LAE can be tailored to a resident's areas of interest, in keeping with population needs, and provide an opportunity to develop specific expertise in an outpatient setting.

# CBD SUPPORTING STRUCTURES & COMMITTEES

It is crucially important that multiple stakeholders inform our transition to CBD. While the existing postgraduate education organizational chart has served us very well over the years, the innovations we aim to achieve require greater coordination and input.

The Royal College accreditation standards indicate: “All aspects of the residency program are collaboratively overseen by the program director and the residency program committee.” As such, PRPC (the Psychiatry Residency Program Committee) remains the ultimate deciding body. However, we have created a number of new subcommittees (see figure below) to help support their work during this period of change.

- 1) The *CBD Curriculum Subcommittee* oversees all elements of curriculum design and assessment including the Longitudinal Ambulatory Experience subgroup.
- 2) The *CBD Competency Subcommittee* looks at all assessments and other data for each resident at least every 6 months to provide feedback on progress/promotion as well as areas of strength and weakness.
- 3) The *CBD Faculty Development Subcommittee* is the group responsible for identifying and implementing any training required for the faculty involved in the creation or implementation of the CBD curriculum. As of January 2020, this group has been absorbed into the department’s general Faculty Development Committee.
- 4) The *CBD Learner Experience Subcommittee* is responsible for getting information both proactively and reactively from the resident body to ensure that the program is maximizing wellness for learners and minimizing any barriers/obstacles to success.
- 5) The *CBD Program Evaluation Subcommittee* is examining qualitative and quantitative data of the new CBD program. This data will be used to create academic products and to adjust the implementation as required.
- 6) The *CBD Operations Subcommittee* consists of the chairs of all of the above committees. This group meets monthly and attends to implementation needs as well as allowing for integration between the committees.
- 7) The *CBD Executive Advisory Subcommittee* consisted of various stakeholders including learners, physicians-in-chief, divisional leads, health systems experts and educational scientists. They met to provide input on various pedagogical and practical matters related to the transition to CBD so that multiple perspectives can be considered. This committee also served to provide another mechanism of

### Competency by Design Organization Chart



# FAQs

## **Q: What are the stages of the competence continuum?**

A: The stages of the competency continuum are illustrated [here](#). For the purposes of postgraduate education in psychiatry:

- *Transition to Discipline* equates with the first month of PGY1 = Springboard
- *Foundations of Discipline* equates with the subsequent 23 months (the majority of PGY1 and PGY2).
- *Core of Discipline* equates with PGY3 and PGY4
- *Transition to Practice* equates with PGY5

## **Q: Are EPAs the only way that residents are assessed?**

A: No – EPAs are one component. There are still many other methods of assessing residents, all of which are reviewed by the competence committee.

## **Q: Are there still rotation specific objectives in CBD?**

A: Please review the rotation specific objectives at the beginning of the rotations. For 2020-2021, each PGY-1 rotation will have a Rotation Plan. Supervisors for PGY-1 rotations should review the Rotation Plan with their residents at the beginning of each rotation. Eventually, all rotations will have an associated Rotation Plan.

## **Q: What is a Rotation Plan?**

A: A Rotation Plan is a short document outlining the focus of a rotation, the associated CBD stage, length, PGY level, and locations. We also reference the required, recommended and optional training experiences a rotation may have. Training Experiences are mandated by the Royal College of Physicians and Surgeons of Canada. In addition, a Rotation Plan will list the associated EPAs mapped to a rotation and will also outlined the number of encouraged entrustments for the rotation. Last but not least, 8-10 key objectives for a rotation are listed. Residents will be assessed on whether they meet the competencies of these key objectives on the ITAR.

## **Q: What is an ITAR?**

ITARs are In Training Assessment Reports. They are not summative evaluations like the ITER, rather they pick up any pieces that may have been missed from other forms of assessment. They're quick (generally less than 10 items). They also encourage more qualitative feedback.



**Q: How frequently do EPAs need to be observed?**

A: Each resident needs an EPA to be observed about once per week.

**Q: Does a resident need to be observed in the encounter to complete the EPA tool?**

A: For some EPAs, observation is essential. For others, the competency can be inferred from the presentation (e.g. reviewing the history or coming up with the diagnosis and plan).

**Q: Do all the milestones in an EPA need to be addressed at the time of the encounter?**

A: No – if a resident is entrusted with an EPA, then it is assumed the component milestones are achieved.

**Q: For the TTD1 and TTD2 EPAs, do the residents need both EPAs to be entrustable at the end of Springboard?**

A: The original intent was that residents would complete TTD1 and TTD2 and that these EPAs would be entrustable at the end of Springboard. However, feedback indicates that the residents have not consistently had opportunities to complete these EPAs. So...not to worry...these EPAs can be carried forward and be completed through the months subsequent to Springboard either during call or other rotations. We expect that residents have completed their TTD entrustments by the first Competence Committee meeting, which is typically in November. We will monitor progress and communicate if any further changes need to be made.

**Q: Will staff have their own accounts for Elentra?**

A: Yes –via their UTORid

**Q: Can a resident complete an EPA on another resident?**

A: Yes! You need at least 51% of your EPAs to be completed by faculty, but the other 49% can be completed by residents or other allied health professionals. This is a good opportunity for a senior resident to practice giving formative feedback.

**Q: I don't have a smart phone – what do I do?**

A: Join the 21<sup>st</sup> century. However, a computer or tablet can also be used.

**Q: Am I correct that supervisors still complete POWER evaluations in addition to signing off on EPAs for PGY1s? Is there a way to integrate both somehow or streamline?**

A: You are correct. ITARs and ITERs will both be available on POWER. PGY-1 ITARs will be available in July 2019 and the plan is to convert all ITERs to ITARs... it's coming! We are hoping it will all be streamlined on Elentra in the future.

**Q: What are coaches meant to do during the coaching sessions?**

A: Coaches are asked to review all assessments (EPAs, ITARs/ITERs, OSCE results, etc.) that the resident has received and work together on finding patterns/creating a learning plan.

**Q: This stuff is fascinating, where can I learn more?**

A: The Royal College website is a wealth of CBD information. Check it out!

<http://www.royalcollege.ca/rcsite/cbd/competence-by-design-cbd-e>

# APPENDIX A: EPA & MILESTONE DETAILS



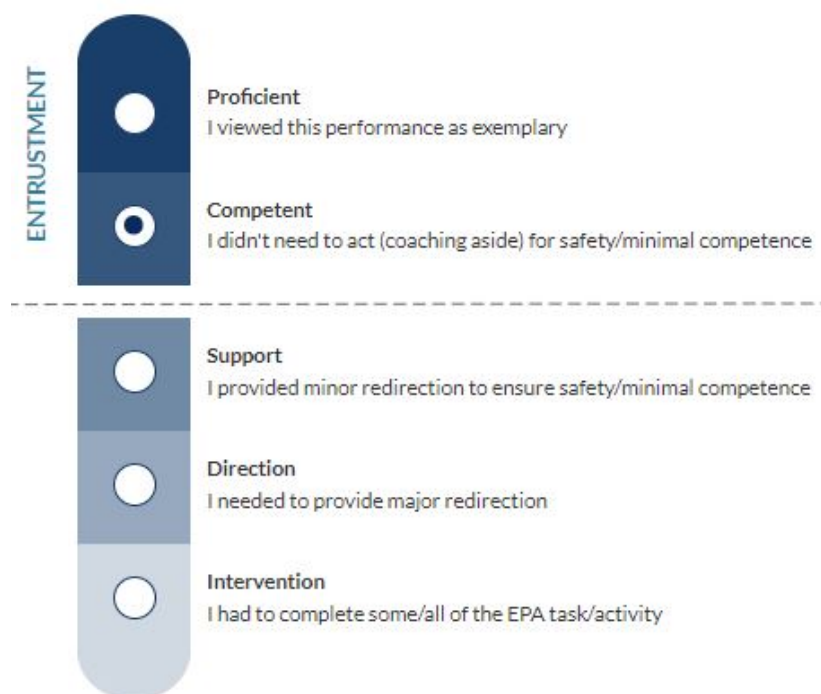
## Background on EPAs

Entrustable professional activities (EPAs) are a mandatory component of assessment in the Royal College's Competency by Design transformation. Assessors must make a determination about whether or not the given task can be performed independently or '*entrusted*' to the learner. 100% of EPAs must be completed according to the assessment guidelines in order for a resident to be eligible to complete their training.

EPAs are assessed through observation (ideally in a real clinical situation, but an appropriate simulation may be suitable in some instances). Most EPAs require multiple observations, from multiple observers with multiple patient populations across multiple settings.

Additional assessment tools beyond EPAs are both allowed and encouraged. We aim to have residents observed an average of once a week, performing one of the prescribed EPAs. Of note, the Competence Committee reviews all EPA observations and provides feedback with respect to progress or opportunities to improve.

Below is the OVERALL entrustment scale that appears in all EPAs:



## Transition to Discipline EPA #1

### Obtaining a psychiatric history to inform the preliminary diagnostic impression for patients presenting with mental disorders

#### Key Features:

- This EPA verifies medical school skills of obtaining a psychiatric history and synthesizing information for diagnosis.
- This includes clinical assessment skills, including a mental status examination and a focused physical/neurological exam if clinically indicated, and synthesizing a preliminary diagnostic impression in a patient of low complexity.
- This EPA may be observed in any psychiatry setting.

#### Assessment Plan:

Direct observation by psychiatrist/subspecialty psychiatrist, Core/TTP psychiatry/  
subspecialty psychiatry resident or fellow

Use Form 1. Form collects information on:

- Case type: anxiety disorder; cognitive disorder; mood disorder; neurodevelopmental disorder; personality disorder; psychotic disorder; substance use disorder; other
- 

Collect 2 observations of achievement

- At least 2 different case types
- At least 1 by psychiatrist

#### Relevant Milestones:

- 1 ME 1.3 Apply diagnostic classification systems for common mental disorders**
- 2 ME 2.2 Perform a clinically relevant history including ID, HPI, and PPH**
- 3 ME 2.2 Perform a focused physical and/or neurological exam as clinically relevant**
- 4 ME 2.2 Develop a differential diagnosis relevant to the patient's presentation**
- 5 ME 2.2 Conduct a mental status examination**
- 6 ME 2.4 Develop an initial management plan for common patient presentations**
- 7 COM 1.1 Convey empathy, respect, and compassion to facilitate trust and autonomy**
- 8 COM 1.4 Use appropriate non-verbal communication to demonstrate attentiveness, interest, and responsiveness to the patient and family**
- 9 COM 2.3 Seek and synthesize relevant information from other sources, including the patient's family, with the patient's consent**
- 10 COM 4.1 Conduct an interview, demonstrating cultural awareness**
- 11 P 1.1 Demonstrate awareness of the limits of one's own professional expertise**

## Transition to Discipline EPA #2

### Communicating clinical encounters in oral and written/electronic form

#### Key Features:

- This EPA includes presenting a case in a succinct and systematic manner, including all relevant details (such as mental status exam, issues of risk, information relevant to handover), and providing written/electronic documentation of the encounter and the management plan using a relevant structure and headings.
- This includes using appropriate psychiatric terms/phenomenology.
- This EPA does not include developing the management plan.
- The observation of this EPA is based on an oral presentation of an assessment and review of written/electronic documentation.
- This EPA may be observed using a clinical patient encounter, a standardized patient, a recorded encounter, a written case, or other formats.

#### Assessment Plan:

Direct observation of verbal presentation and review of written/electronic communication observation by a psychiatrist/psychiatric subspecialist, Core/TTP psychiatry/subspecialty resident or fellow or other attending physician

Use Form 1. Form collects information on:

- Portion observed (select all that apply): history; verbal presentation; written/electronic documentation

Collect 2 observations of achievement

- At least 1 of each presentation format, verbal and written
- At least 1 observation must be based on an interview that was observed
- At least 1 by a psychiatrist

#### Relevant Milestones:

- 1 **ME 2.2 Synthesize clinical information for presentation to supervisor**
- 2 **COM 5.1 Document the mental status exam accurately**
- 3 **COM 5.1 Document an accurate and up-to-date medication list**
- 4 **COM 5.1 Document information about patients and their medical conditions**
- 5 **COL 2.1 Convey information respectfully to referral source**
- 6 **COM 5.1 Organize information in appropriate sections within an electronic or written medical record**
- 7 **COL 3.2 Describe specific information required for safe handover during transitions in care**

## Foundations of Discipline EPA #1

### **Assessing, diagnosing and participating in the management of patients with medical presentations relevant to psychiatry**

#### Key Features:

- This EPA focuses on management of medical presentations relevant to psychiatry, and recognition and initial management of medical emergencies.
- Examples include the following: substance intoxication; overdose and withdrawal; endocrine and metabolic disorders; delirium; stroke; traumatic brain injury; acute MI, HTN, CHF, COPD, and neuropsychiatric presentations of medical illness (seizure disorder, movement disorders); MS; Huntington's; Parkinson's disease.
- This EPA includes performing a medical assessment, including a general physical exam and neurological assessment, and interpreting relevant investigations.

#### Assessment Plan:

Direct observation by psychiatrist, neurologist, internal medicine specialist/hospitalist, emergency medicine physician, pediatrician, geriatrician, family physician, physician assistant, nurse practitioner, or non-psychiatry Core or TTP resident

Use Form 1. Form collects information on:

- Medical emergency: yes; no
- Case type: substance intoxication; overdose and/or withdrawal; congestive heart failure; chronic obstructive pulmonary disease; endocrine or metabolic disorders; acute myocardial infarction; hypertension; delirium; neuropsychiatric presentations of medical illness (seizure disorder, movement disorders, MS, Huntington's, Parkinson's disease); stroke; traumatic brain injury; other presentation
- Setting: emergency; inpatient; outpatient
- Demographic: child; adolescent; adult; older adult
- Service: psychiatry; neurology; medicine (CTU, GIM, or Family Medicine); on-call experiences; emergency; other

Collect 8 observations of achievement

- At least 2 medical emergencies
- At least 1 substance intoxication
- At least 1 overdose and/or withdrawal
- At least 1 neuropsychiatric presentation
- At least 1 endocrine or metabolic disorder
- At least 4 different observers
- At least 3 by a supervising staff physician

Relevant Milestones:

- 1 **ME 1.3 Apply clinical and biomedical sciences to manage core patient presentations**
- 2 **COM 1.1 Communicate using a patient-centred approach that facilitates patient trust and autonomy and is characterized by empathy, respect, and compassion**
- 3 **COM 2.1 Conduct a patient-centred interview, gathering all relevant biomedical and psychosocial information**
- 4 **ME 2.2 Perform a medical assessment, including general physical exam and neurological assessment**
- 5 **ME 2.1 Differentiate stable and unstable patient presentations**
- 6 **ME 2.4 Develop a plan for initial management of a medical presentation**
- 7 **ME 1.6 Seek assistance in situations that are complex or new**
- 8 **ME 4.1 Ensure follow-up on results of investigation and response to treatment**
- 9 **COM 3.1 Use strategies to verify and validate the understanding of the patient and family with regard to the diagnosis, prognosis, and management plan**
- 10 **COM 4.1 Communicate with cultural awareness and sensitivity**
- 11 **COM 5.1 Document clinical encounters to adequately convey clinical reasoning and the rationale for decisions**
- 12 **COL 1.2 Describe the roles and scopes of practice of other health care professionals related to their discipline**
- 13 **P 1.1 Demonstrate awareness of the limits of one's own professional expertise**



## Foundations of Discipline EPA #2

### Performing psychiatric assessments referencing a biopsychosocial approach, developing basic differential diagnoses for patients with mental disorders

#### Key Features:

- This EPA focuses on establishing rapport/therapeutic alliance and performing psychiatric assessments using a biopsychosocial approach in order to develop a differential diagnosis which reflects an understanding of common conditions and co-morbidities.
- This EPA includes demonstrating an understanding of the impact of the biopsychosocial approach on diagnosis, assessment, management, and prognosis to improve patient-centered care.

#### Assessment Plan:

Direct observation by psychiatrist/psychiatry subspecialist, TTP psychiatry resident, Core/TTP psychiatry subspecialty resident, or psychiatry/psychiatry subspecialty fellow

Use Form 1. Form collects information on:

- Setting: emergency; inpatient unit; consultation liaison; outpatient; day hospital; community; assisted living; correctional; residential treatment centre; simulation
- Demographic: child; adolescent; adult; older adult
- Case type: anxiety disorder; cognitive disorder; mood disorder; personality disorder; psychotic disorder; substance use disorder; other
- Complexity: low; medium; high

Collect 6 observations of achievement

- At least 1 emergency setting
- At least 2 inpatient settings
- At least 2 outpatient settings
- At most 2 child and adolescent patients
- At most 2 older adult patients
- At least 3 different case types
- At least 2 by psychiatrists
- At least 3 different observers

#### Relevant Milestones:

- 1 **ME 1.3** Apply knowledge of psychiatry, including neuroscience, psychology, and nosology, to accurately assess and diagnose patients
- 2 **ME 1.3** Apply knowledge of the impact of biological, psychological, and social factors, including cultural factors, on the etiology and manifestation of mental disorders

- 3    **COM 1.1** Communicate using a patient-centred approach that facilitates patient trust and autonomy and is characterized by empathy, respect, and compassion
- 4    **COM 1.2 Optimize the physical environment for patient comfort, dignity, privacy, engagement, and safety**
- 5    **COM 1.4** Respond to patients' non-verbal communication and use appropriate non-verbal behaviours to enhance communication with patients
- 6    **COM 1.5 Recognize when personal feelings in an encounter are valuable clues to the patient's emotional state**
- 7    **COM 2.1** Conduct a patient-centred interview, gathering all relevant biomedical and psychosocial information
- 8    **COM 2.2 Focus the interview, managing the flow of the encounter while being attentive to the patient's cues and responses**
- 9    **COM 2.3 Seek and synthesize relevant information from other sources, including the patient's family, with the patient's consent**
- 10   **ME 2.2** Perform, interpret, and report mental status examination, including phenomenology
- 11   **ME 2.2 Develop a differential diagnosis relevant to the patient's presentation**
- 12   **COM 2.1** Integrate and synthesize information about the patient's beliefs, values, preferences, context, and expectations with biomedical and psychosocial information
- 13   **COM 3.1** Use strategies to verify and validate the understanding of the patient and family with regard to the diagnosis, prognosis, and management plan
- 14   **COM 5.1 Document information about patients and their medical conditions**
- 15   **COM 5.2** Demonstrate reflective listening, open-ended inquiry, empathy, and effective eye contact while using a written or electronic medical record
- 16   **P 1.1** Exhibit appropriate professional behaviours

## Foundations of Discipline EPA #3

### Developing and implementing management plans for patients with psychiatric presentations of low to medium complexity

#### Key Features:

- This EPA includes the implementation of the management plan.
- The observation of this EPA is based on the review of a management plan and observation of the resident's communication of the management plan to the patient.

#### Assessment Plan:

Direct and indirect observation by psychiatrist/psychiatric subspecialist, TTP psychiatry resident, Core/TTP psychiatry subspecialty resident, or psychiatry/psychiatry subspecialty fellow

Use Form 1. Form collects information on:

- Setting: emergency; inpatient unit; consultation liaison; outpatient; day hospital; community; assisted living; correctional; residential treatment centre; shared/collaborative care; simulation
- Case type: anxiety disorder; mood disorder; personality disorder; psychotic disorder; OCD; substance use disorder; trauma; other
- Demographic: child; adolescent; adult; older adult

Collect 6 observations of achievement

- At least 1 mood disorder
- At least 1 psychotic disorder
- At least 1 personality disorder
- At least 1 substance use disorder
- At least 1 of anxiety or trauma or OCD
- No more than 2 child or adolescent patients
- No more than 2 older adult patients
- At least 3 different observers
- At least 2 by psychiatrists

#### Relevant Milestones:

- 1 **ME 2.3** Establish goals of care
- 2 **ME 2.4** Develop and implement management plans that consider all of the patient's health problems and context
- 3 **ME 3.2** Describe the indications, contraindications, risks, and alternatives for a given treatment plan
- 4 **COM 1.1** Communicate using a patient-centred approach that facilitates patient trust and autonomy and is characterized by empathy, respect, and compassion
- 5 **ME 2.4** Prescribe first line psychotropic medicines

- 6 **ME 3.2** Obtain and document informed consent, under supervision
- 7 **ME 4.1 Develop plans for ongoing management and follow-up**
- 8 **ME 4.1 Coordinate care when multiple health care providers are involved**
- 9 **COM 5.1** Document clinical encounters to adequately convey clinical reasoning and the rationale for decisions
- 10 **COL 1.2** Describe the roles and scopes of practice of other health care professionals related to their discipline
- 11 **COL 1.2** Consult as needed with other health care professionals, including other physicians
- 12 **HA 1.1** Demonstrate an approach to working with patients to advocate for health services or resources
- 13 **S 2.5** Provide feedback to enhance learning and performance for learners
- 14 **P 3.1** Integrate appropriate components and aspects of mental health law into practice

## Foundations of Discipline EPA #4

### Performing risk assessments that inform the development of an acute safety plan for patients posing risk for harm to self or others

#### Key Features:

- The focus of this EPA is the appropriate assessment of risk and safety issues.
- This EPA includes developing an acute safety management plan. This may include focusing on risk factors for suicide, self-harm, and violence towards others in the assessment.
- This EPA involves consideration of mental health law and its application to patients at risk of harm to self or others.

#### Assessment Plan:

Direct observation by psychiatrist/subspecialty psychiatrist, TTP psychiatry resident, Core/TTP psychiatry subspecialty resident or psychiatry/psychiatry subspecialty fellow

Use Form 1. Form collects information on:

- Patient history: non-suicidal self-injury; history of violence or forensic involvement; active suicidal ideation or behaviour; active homicidal/violent ideation or violent behaviour; other issue
- Setting: emergency; inpatient unit; outpatient
- Demographic: child; adolescent; adult; older adult

Collect 5 observations of achievement

- At least 1 patient with non-suicidal self-injury
- At least 1 patient with active suicidal ideation or behavior
- At least 1 patient with active homicidal/violent ideation or violent behaviour
- No more than 1 child or adolescent patient
- No more than 1 older adult patient
- At least 3 by psychiatrists
- At least 3 different observers

#### Relevant Milestones:

- 1 COM 2.2 Manage the flow of challenging patient encounters**
- 2 COM 1.1 Recognize and manage one's own reaction to patients**
- 3 COM 2.1 Collect collateral information that informs diagnosis and management plan**
- 4 ME 2.2 Assess risk factors for violence, suicide, and self-harm, including modifiable and non-modifiable factors**
- 5 ME 3.2 Describe the indications, contraindications, risks, and alternatives for a given treatment plan**
- 6 ME 2.4 Develop and implement an acute safety management plan**
- 7 L 2.1 Consider appropriate use of resources when developing treatment plans**

- 8 **ME 5.2** Apply crisis intervention skills, including development of a safety plan, as appropriate
- 9 **P 3.1** Apply knowledge of the relevant codes, policies, standards, and laws governing physicians and the profession, including relevant mental health legislation
- 10 **COL 3.1** Identify patients requiring handover to other physicians or health care professionals
- 11 **COL 3.2** Provide a clinically relevant summary to the receiving physician or care team

## Foundations of Discipline EPA #5

### Performing critical appraisal and presenting psychiatric literature

#### Key Features:

- This EPA focuses on critical appraisal of literature in order to make appropriate clinical decisions and to encourage lifelong learning and acquisition of new knowledge and skills in the specialty.
- This EPA includes posing a clinically relevant question, performing a literature search, critically appraising the literature, and presenting in a group setting.
- This includes presentations such as grand rounds, journal club, case conference, M&M rounds or QI rounds.

#### Assessment plan:

Direct observation of presentation by supervisor, with input from audience Use Form 1.

Collect 2 observation of achievement

- At least 2 different observers

#### Relevant Milestones:

- 1 **S 3.1 Recognize uncertainty and knowledge gaps in clinical and other professional encounters relevant to their discipline**
- 2 **S 3.3 Assess the validity and risk of bias in a source of evidence**
- 3 **S 3.3 Interpret study findings, including a critique of their relevance to practice**
- 4 **S 3.3 Evaluate the applicability of evidence (i.e. external validity, generalizability)**
- 5 **S 4.2 Identify ethical principles in research**
- 6 **S 4.5 Summarize and communicate to colleagues, the public, or other interested parties, the findings of applicable research and scholarship**

## **Core of Discipline EPA #1**

### **Developing comprehensive treatment/management plans for adult patients**

#### Key Features:

- This EPA focuses on performing a psychiatric assessment, using psychological and neurobiological theories of psychiatric illness and personality development to guide the biopsychosocial interview, and gathering pertinent patient information in adult patients of medium to high complexity.
- This also includes synthesizing the information to develop a differential diagnosis and a comprehensive treatment/management plan that integrates psychopharmacology, psychotherapy, neurostimulation and social interventions, as appropriate.
- This EPA does not include delivery of the management plan.

#### Assessment plan:

Direct observation, case discussion and/or review of consult letter or other documents by psychiatrist/psychiatric subspecialist, TTP psychiatry resident, psychiatry fellow, Core/TTP psychiatry subspecialty resident, psychiatry subspecialty fellow

Use Form 1. Form collects information on:

- Setting: emergency; inpatient unit; consultation liaison; outpatient
- Case type (select all that apply): anxiety disorder; major depressive disorder; bipolar disorder; personality disorder; psychotic disorder; substance use disorder; intellectual disability; autism spectrum disorder; trauma; other
- Complexity: low; medium; high
- Observation (select all that apply): direct; case discussion; review of clinical documents

Collect 8 observations of achievement

- At least 2 emergency
- At least 2 inpatient
- At least 2 outpatient
- At least 2 consultation liaison
- At least 2 psychotic disorders
- At least 1 substance use disorder
- At least 1 anxiety disorder
- At least 1 history of trauma
- At least 1 major depressive disorder
- At least 1 bipolar disorder
- At least 1 personality disorder
- At least 1 intellectual disability/ autism spectrum disorder comorbidity
- At least 3 high complexity
- At least 5 direct observations with review of documentation
- At least 4 different observers
- At least 3 by psychiatrists



Relevant Milestones:

- 1 **ME 1.3** Apply knowledge of diagnostic criteria for mental health disorders
- 2 **ME 2.1** Consider clinical urgency, feasibility, availability of resources, and comorbidities in determining priorities to be addressed
- 3 **ME 2.2** Perform a psychiatric assessment, including a focused physical exam
- 4 **ME 2.2** Select appropriate investigations and interpret their results
- 5 **ME 2.2** Synthesize biological, psychological, and social information to determine a diagnosis
- 6 **ME 2.3** Establish goals of care
- 7 **ME 2.4** Develop and implement management plans that consider all of the patient's health problems and context
- 8 **ME 3.1** Integrate all sources of information to develop a procedural or therapeutic plan that is safe, patient-centred, and considers the risks and benefits of all approaches
- 9 **COM 1.6** Tailor approaches to decision-making to patient capacity, values, and preferences
- 10 **COM 3.1** Convey information on diagnosis and prognosis in a clear, compassionate, respectful, and objective manner
- 11 **P 1.1** Exhibit appropriate professional behaviours

## **Core of Discipline EPA #2**

### **Performing psychiatric assessments and providing differential diagnoses and management plans for children and youth**

#### Key Features:

- This EPA focuses on performing a developmentally informed psychiatric assessment, using knowledge of neurobiological, cognitive, behavioral, emotional, family and personality development to perform a comprehensive biopsychosocial interview involving the patient, family, and others.
- This also includes synthesizing the information to develop a differential diagnosis and management plan that integrates psychopharmacology, psychotherapy and social interventions as appropriate.
- The management plan should include considerations of parent or guardian guidance, referral resources, and basic pharmacological and psychotherapeutic interventions.
- This EPA does not include delivery of the management plan.

#### Assessment plan:

Direct observation, case discussion and/or review of consult letter or other by child and adolescent psychiatrist, psychiatrist, TTP psychiatry resident, Core/TTP child and adolescent psychiatry subspecialty resident, or psychiatry/child and adolescent psychiatry fellow

Use form 1. Form collects information on:

- Case type: anxiety disorder; mood disorder; attention deficit/hyperactivity disorder; autism spectrum disorder; intellectual disability; other neurodevelopmental disorder; personality disorder; psychotic disorder; substance use disorder; OCD; trauma; other presentation
- Co-morbidities (write-in):
- Setting: emergency; inpatient unit; consultation liaison; outpatient; community; residential treatment centre
- Complexity: low; medium; high
- Demographic: child 4-12 years; adolescent 13-18 years
- Observation (select all that apply): direct; case discussion; review of clinical documents

Collect 6 observations of achievement

- At least 1 mood disorder, anxiety disorder, or OCD
- At least 1 ADHD
- At least 1 abuse, neglect, or trauma
- At least 1 intellectual disability/autism spectrum disorder comorbidity
- At least 2 children 4-12 years
- At least 2 adolescents 13-18 years
- At least 4 direct observations, including review of documentation
- At least 3 different observers
- At least 2 observations by a child and adolescent psychiatrist

Relevant Milestones:

- 1 **ME 1.3 Apply knowledge of normal and abnormal physical, cognitive, emotional, and behavioural development**
- 2 **ME 2.2** Focus the clinical encounter, performing it in a time-effective manner without excluding key elements
- 3 **ME 2.2 Adapt the clinical assessment to the patient's developmental stage**
- 4 **ME 2.2 Synthesize biological, psychological, and social information to determine a diagnosis**
- 5 **ME 2.2** Elicit a history, perform a physical exam, select appropriate investigations, and interpret their results for the purpose of diagnosis and management, disease prevention, and health promotion
- 6 **ME 2.4 Develop and implement management plans that consider all of the patient's health problems and context**
- 7 **ME 3.2 Use shared decision-making in the consent process**
- 8 **COM 1.6 Tailor approaches to decision-making to patient capacity, values, and preferences**
- 9 **COM 2.1** Integrate, summarize, and present the biopsychosocial information obtained from a patient-centred interview
- 10 **COM 5.1 Document clinical encounters in an accurate, complete, timely, and accessible manner and in compliance with legal and privacy requirements**
- 11 **HA 1.1** Work with patients to address the determinants of health that affect them and their access to needed health services or resources
- 12 **P 3.1 Apply child welfare legislation, including mandatory reporting**

## **Core of Discipline EPA #3**

### **Performing psychiatric assessments and providing differential diagnoses and management plans for older adults**

#### Key Features:

- This EPA focuses on performing psychiatric assessments that adjust for potential cognitive and sensory decline, using the biopsychosocial model to guide the interview.
- This includes synthesizing the information to develop a differential diagnosis and management plan that integrates neurostimulation, psychopharmacology, psychotherapy, and social interventions, as appropriate, in older adult patients.
- This EPA includes new or persistent mood, anxiety, and psychotic disorders in older adults with or without co-morbid neurocognitive disorders.
- This EPA may include younger patients with early onset neurodegenerative or neurocognitive disorders such as Alzheimer's, and Behavioural and Psychological Symptoms of Dementia (BPSD).

#### Assessment plan:

Direct observation, case discussion and/or review of consult letter or other documentation by geriatric psychiatrist, psychiatrist, TTP psychiatry resident, Core or TTP geriatric psychiatry subspecialty resident, or psychiatry/geriatric psychiatry fellow

Use Form 1. Form collects information on:

- Case type (select all that apply): anxiety disorder; bereavement; major depressive disorder; bipolar disorder; neurocognitive disorder; BPSD; personality disorder; psychotic disorder; substance use disorder
- Co-morbidities (select all that apply): delirium; CVA/Vascular disease; frailty; acquired or traumatic brain injury; Parkinson's disease; other movement disorder; other; n/a
- Setting: emergency; inpatient unit; consultation liaison; outpatient; community; assisted living; palliative
- Complexity: low; medium; high
- Additional concerns: rationalization of polypharmacy; elder abuse; other; n/a
- Observation (select all that apply): direct; case discussion; review of clinical documents

Collect 6 observations of achievement

- At least 3 neurocognitive disorders, including at least 1 patient with BPSD
- At least 1 major depressive disorder and/or bereavement
- At least 1 anxiety disorder
- At least 1 case with rationalization of polypharmacy
- At least 2 different observers
- At least 4 direct observations including review of documentation
- At least 2 by a geriatric psychiatrist or psychiatrist with a special interest in older adult patients

Relevant Milestones:

- 1 **ME 1.3 Apply knowledge of normal and abnormal physical, cognitive, emotional, and behavioural development**
- 2 **ME 2.2 Perform a psychiatric assessment, including a focused physical exam**
- 3 **ME 2.2** Focus the clinical encounter, performing it in a time-effective manner without excluding key elements
- 4 **ME 2.2 Select appropriate investigations and interpret their results**
- 5 **ME 2.2** Synthesize biological, psychological, and social information to determine a diagnosis
- 6 **ME 2.4 Develop and implement management plans that consider all of the patient's health problems and context**
- 7 **ME 3.2** Use shared decision-making in the consent process
- 8 **COM 1.6 Tailor approaches to decision-making to patient capacity, values, and preferences**
- 9 **COM 5.1 Document clinical encounters in an accurate, complete, timely, and accessible manner and in compliance with legal and privacy requirements**
- 10 **HA 1.1 Work with patients to modify determinants of health**
- 11 **HA 1.1 Facilitate access to health services and resources**
- 12 **P 3.1 Apply relevant legislation, including capacity and neglected adults**

## Core of Discipline EPA #4

### Developing comprehensive biopsychosocial formulations for patients across the lifespan

#### Key Features:

- This EPA focuses on the development of the biopsychosocial formulation, including utilizing psychological theories and theories of personality development, applying knowledge of neuroscience, neurodevelopment, aging, genetics and epigenetics, and socioeconomic determinants of health.
- This EPA includes synthesis and presentation of a comprehensive biopsychosocial formulation in oral or written/electronic form.
- The observation of this EPA requires direct observation of the patient assessment in at least 3 cases.

#### Assessment plan:

Direct observation of oral presentation or review of written documentation of the formulation by a psychiatrist/psychiatric subspecialist, TTP psychiatry resident, Core/TTP psychiatry subspecialty resident, or psychiatry/psychiatry subspecialty fellow

Use form 1. Form collects information on:

- Demographic: child; adolescent; adult; older adult
- Setting: emergency; inpatient; consultation liaison; outpatient; community; day hospital; assisted living; correctional; residential treatment centre; school; simulation
- Assessment observed: yes; no
- Complexity: low; medium; high

Collect 8 observations of achievement

- At least 1 child
- At least 1 adolescent
- At least 4 adults
- At least 2 older adults
- No more than 2 in simulation setting
- At least 3 cases in which the supervisor has observed the assessment of the patient, of which at least 1 is an adult patient
- At least 3 high complexity
- At least 4 by psychiatrists
- At least 1 by a child and adolescent psychiatrist
- At least 1 by a geriatric psychiatrist

#### Relevant Milestones:

- 1 ME 1.3** Apply a broad base and depth of knowledge in neuroscience, neurodevelopment, aging, genetics, epigenetics in psychological theories, theories of

personality development, and socioeconomic determinants of health

- 2 **ME 2.2 Focus the clinical encounter, performing it in a time-effective manner without excluding key elements**
- 3 **COM 1.3** Recognize when the values, biases, or perspectives of patients, physicians, or other health care professionals may have an impact on the quality of care, and modify the approach to the patient accordingly
- 4 **ME 2.2 Identify and respond to predisposing, precipitating, perpetuating, and protective factors**
- 5 **COM 2.1 Integrate, summarize, and present the biopsychosocial information obtained from a patient-centred interview**
- 6 **ME 2.4 Use the biopsychosocial formulation to inform the management plan**
- 7 **COM 3.1 Convey the biopsychosocial formulation to patients**
- 8 **COM 5.1** Document clinical encounters in an accurate, complete, timely, and accessible manner and in compliance with legal and privacy requirements

## Core of Discipline EPA #5

### Identifying, assessing, and managing emergent situations in psychiatric care across the lifespan

#### Key Features:

- This EPA focuses on the assessment and management (i.e. pharmacological and non-pharmacological) of any psychiatric emergency and maintaining safety and minimizing risk to patients, self, and others.
- This includes presentations involving risk of harm to self or others, acute agitation and aggression, as well as other behavioural and emotional disturbances, and medical emergencies, such as acute dystonic reactions, delirium, catatonia, serotonin syndrome, neuroleptic malignant syndrome (NMS), etc.

#### Assessment Plan:

Direct observation by psychiatrist/psychiatric subspecialist, TTP psychiatry resident, Core/TTP psychiatry subspecialty resident, or psychiatry/psychiatry subspecialty fellow

Use Form 1. Form collects information on:

- Setting: emergency; inpatient unit; consultation liaison; outpatient; community; simulation
- Case type: acute agitation and aggression; other behavioural and/or emotional disturbance; active suicidal ideation; homicidal/violent ideation; risk of harm to others; medical emergency related to delirium; acute dystonic reaction; catatonia; serotonin syndrome; NMS; other condition
- Complexity: low; medium; high

Collect 8 observations of achievement

- At least 2 patients with acute agitation and aggression
- At least 2 patients with active suicidal ideation
- At least 1 patient with homicidal/violent ideation or risk of harm to others
- At least 2 patients with medical emergencies related to delirium
- At least 1 patient with acute dystonic reaction, catatonia, serotonin syndrome, or NMS (may be in a simulation setting)
- At least 3 observations by psychiatrist/psychiatric subspecialist

#### Relevant Milestones:

- 1 ME 2.1 Recognize instability and medical/psychiatric acuity in a clinical presentation**
- 2 ME 2.1 Recognize and manage patients at risk of harm to self or others and intervene to mitigate risk**



- 3 **ME 2.2** Focus the assessment performing it in a time-effective manner without excluding key elements
- 4 **ME 2.2** Assess risk of harm to self or others
- 5 **ME 3.1 Determine the most appropriate therapies and/or interventions to minimize risk**
- 6 **ME 2.4** Develop and implement a management plan
- 7 **ME 5.2 Apply policies, procedures, and evidence-based practices when dealing with patient, staff, and provider safety, including violent and potentially violent situations**
- 8 **ME 2.4** Determine the setting of care appropriate for the patient's health care needs
- 9 **ME 4.1** Determine the need, timing, and priority of referral to another physician and/or health care professional
- 10 **COM 3.1** Convey the rationale for decisions regarding involuntarily treatment and/or hospitalization
- 11 **COM 1.5** Recognize when strong emotions (such as, anger, fear, anxiety, or sadness) are affecting an interaction and respond appropriately
- 12 **COL 3.1 Provide emergent/urgent medical assistance for patients as necessary, arranging for referral and/or transport to appropriate medical facility**
- 13 **COL 3.2 Ensure communication of risk management plans**
- 14 **L 1.2** Assess and manage safety/risk for staff and care providers in all settings

## Core of Discipline EPA #6a

### Integrating the principles and skills of psychotherapy into patient care

#### Key Features:

- This EPA applies the knowledge and skills developed in psychotherapy to inform an assessment, and provide appropriate psychotherapeutic interventions and ongoing assessment of the patient's response to the intervention.
- This includes identifying and empathizing with the patient, developing a collaborative relationship with the patient and family, recognizing the importance of therapeutic alliance, recognizing and repairing tensions/ruptures in this alliance, and adapting the psychotherapeutic intervention to the individual patient context (trauma, culture, spiritual, social, biological).
- This also includes educating the patient and/or family on the rationale and therapeutic components of the prescribed psychotherapeutic intervention.
- This EPA includes delivery of individual Cognitive Behavioural Therapy (CBT), individual psychodynamic therapy, family or group therapy, and at least one other evidence-based psychotherapy.
- Long term psychodynamic therapy is recommended but not required for achievement.
- The observation of this EPA is divided into two parts: performing psychotherapy; a log of psychotherapy experiences.

#### Assessment plan:

##### Part A: Performing psychotherapy

Direct observation or review of audio, video or transcript by supervisor, TTP psychiatry resident or Core/TTP psychiatry subspecialty resident trained in selected modality, or other mental health professional trained in the modality

##### Use form 1: Form collects information on:

- Setting: emergency; inpatient unit; consultation liaison; outpatient
- Demographic: child; youth; adult; older adult
- Case type: anxiety disorder; eating disorder; mood disorder; obsessive compulsive disorder; personality disorder; psychotic disorder; substance use; trauma; other disorder
- Therapeutic modality: DBT; CBT; IPT; MI; mindfulness; psychodynamic (short term or long term); group therapy; family therapy; supportive therapy; emotion focused therapy (EFT); other
- Treatment: integrated; longitudinal

##### Collect 13 observations of achievement

- At least 3 psychodynamic psychotherapy sessions
- At least 3 CBT sessions
- At least 2 family or group therapy sessions
- At least 2 sessions in one other evidence-based modality
- At a 3 observations demonstrating integration of psychotherapeutic interventions in regular clinical care

## Part B: Logbook

Submit logbook of psychotherapy sessions and any other assessments (specific to the assessment of psychotherapy) required by program to Competence Committee

Logbooks tracks:

- Modality (write-in):
- Treatment (write-in):

## Relevant Milestones:

### Part A: Performing psychotherapy

- 1 **ME 1.3** Apply knowledge of the principles of psychotherapy to patient care
- 2 **ME 1.6** Adapt care as the complexity, uncertainty, and ambiguity of the patient's clinical situation evolves
- 3 **ME 2.2 Assess patient suitability for psychotherapy**
- 4 **ME 2.2** Assess patient response to psychotherapy
- 5 **ME 3.1 Select a psychotherapeutic modality and tailor the selected psychotherapy to the patient on the basis of an appropriate case formulation**
- 6 **ME 2.4** Integrate the selected psychotherapy with other treatment modalities
- 7 **ME 3.4 Deliver the psychotherapeutic intervention**
- 8 **ME 4.1** Establish plans for ongoing care
- 9 **COM 1.1 Establish, repair when necessary, and maintain a therapeutic alliance with the patient**
- 10 **COM 1.3** Recognize when the values, biases, or perspectives of patients, physicians, or other health care professionals may have an impact on the quality of care, and modify the approach to the patient accordingly
- 11 **COM 1.5 Recognize when strong emotions (such as, anger, fear, anxiety, or sadness) are affecting an interaction and respond appropriately**
- 12 **COM 1.5** Establish boundaries as needed in emotional situations
- 13 **COM 5.1** Adapt record keeping to the specific guidelines of their discipline and the clinical context
- 14 **COL 1.3** Integrate the patient's perspective and context into the collaborative care plan
- 15 **HA 1.2** Apply the principles of behaviour change during conversations with patients about adopting healthy behaviours
- 16 **P 1.1 Exhibit appropriate professional behaviours**



## **Core of Discipline EPA # 6b:**

### **Applying and Integrating Psychosocial Skills and Principles in General Psychiatric Care**

#### Key Features:

- This EPA applies the knowledge and skills developed in psychotherapy to inform a comprehensive assessment and treatment plan in general psychiatry and to integrate and apply a broad repertoire of psychosocial skills and principles with diverse populations in various clinical settings across the life span.
- This includes therapeutic communication and empathizing with the patient, developing a collaborative relationship with the patient, family, and care providers, recognizing the importance of therapeutic alliance, recognizing and repairing tensions/ruptures in this alliance, and adapting the psychotherapeutic intervention to the individual patient context (trauma, culture, spiritual, social, biological).
- This also includes educating the patient and/or family on the rationale and therapeutic components of the prescribed psychotherapeutic interventions and advancing continuity of collaborative care when needed.
- This EPA includes delivery and integration of psychotherapy interventions in general practice, e.g., DBT skills in crisis/ER, behavioural activation and group therapy on inpatient unit, family-based or relationship-centred interventions on geriatric, child, C/L, or inpatient rotations, supportive psychotherapy with SPMI patient, MI-based interventions with medication adherence and substance use

#### Assessment plan:

At least 3 observations demonstrating integration of psychotherapeutic interventions in regular clinical care

#### Relevant Milestones

1. Identify and empathize with patient's thoughts, emotions, vulnerabilities, needs, and strengths in context
2. Applies common factors and specific psychotherapy techniques (e.g. CBT/DBT/MI/psychodynamic/supportive/family therapy) outside of a discrete psychotherapy session.
3. Adapts approach to unique individual and cultural factors, trauma history, and illness trajectory including acuity, chronicity, complexity, and comorbidity
4. Facilitate the patient to overcome internal and external barriers in applying therapy skills
5. Build on patient's unique strengths and resources to promote empowerment, dignity, and recovery

## **Core of Discipline EPA #7:**

### **Integrating the principles and skills of neurostimulation into patient care**

#### Key Features:

- This EPA focuses on the application of neurostimulation modalities in the management of adult and older adult patients.
- This includes determining appropriateness of the intervention for the clinical scenario; identifying contraindications, risks, and benefits; completing pre-procedure workup; delivering ECT; managing and interpreting electroencephalography (EEG) as a part of ECT; providing follow-up care; and managing short and long term complications.
- This EPA also includes communicating with the patient and family about the procedure to guide consent, and dealing with stigma or cultural resistance related to acceptance of the proposed procedure.
- The observation of this EPA is divided into two parts: suitability for neurostimulation; delivery of neurostimulation.

#### Assessment plan:

Part A: Suitability for neurostimulation

Direct and indirect observation by psychiatrist

Use form 1. Form collects information on:

- Setting: inpatient unit; outpatient; simulation
- Demographic: adult; older adults
- Case type (write-in):
- Modality: ECT; rTMS; other evidence-based form of neurostimulation

Collect 3 observations of achievement

- At least 1 of each demographic
- At least 2 observations must be for ECT

Part B: Delivery of neurostimulation

Direct observation by psychiatrist or neurostimulation provider

Use form 1. Form collects information on:

- Demographic: adult; older adults
- Case type (write-in):
- Modality: ECT; rTMS; other evidence-based form of neurostimulation

Collect 3 observations of achievement

- At least 2 observations must be for ECT

### Relevant Milestones:

#### Part A: Suitability for neurostimulation

- 1 **ME 2.4** Develop and implement management plans that consider all of the patient's health problems and context
- 2 **ME 2.2 Assess a patient's suitability to proceed with neurostimulation**
- 3 **ME 3.2 Describe the indications, contraindications, risks, and alternatives for neurostimulation**
- 4 **COM 3.1 Provide information clearly and compassionately, checking for patient/family understanding**
- 5 **COM 4.3** Answer questions from the patient and/or family
- 6 **COM 4.3 Use communication skills and strategies that help the patient make an informed decision**
- 7 **ME 3.2** Use shared decision-making in the consent process
- 8 **ME 3.2 Obtain and document informed consent**
- 9 **ME 2.4 Anticipate peri-procedural issues and complications, and incorporate these considerations in the management plan**
- 10 **HA 1.2 Work with patients and their families to decrease stigma regarding neurostimulation treatments**

#### Part B: Delivery of neurostimulation

- 1 **ME 2.2 Assess a patient's suitability to proceed with neurostimulation**
- 2 **ME 3.2** Describe the indications, contraindications, risks, and alternatives for neurostimulation
- 3 **ME 3.2 Obtain and document informed consent**
- 4 **ME 3.4 Prepare and position the patient for the neurostimulation procedure**
- 5 **ME 3.4 Administer sedation and apply monitoring equipment to optimize patient safety and comfort**
- 6 **ME 3.4 Apply neurostimulation using appropriate techniques**
- 7 **COL 1.2 Communicate effectively with nurses and/or assistants during the procedure**
- 8 **ME 3.4 Document the encounter to adequately convey the procedure and outcome(s)**
- 9 **ME 3.4 Establish and implement a plan for post-procedure care**

## Core of Discipline EPA #8

### Integrating the principles and skills of psychopharmacology into patient care

#### Key Features:

- This EPA focuses on pharmacological management, and includes the prescription and monitoring of medications for adult patients as well as for children, adolescents, and older adults.
- This EPA includes obtaining informed consent and providing education for medication as appropriate across the lifespan, including in pregnancy, children, adolescents, and the elderly population (with varying levels of capacity).
- This EPA also includes advocating for access to medication.

#### Assessment plan:

Direct and indirect observation by psychiatrist/subspecialty psychiatrist, TTP psychiatry resident, Core/TTP psychiatry subspecialty resident, or psychiatry/psychiatry subspecialty fellow

Use Form 1. Form collects information on:

- Demographic: child; adolescent; adult; older adult
- Activity (select all that apply): starting and monitoring medication; medication management (including switching, augmenting, discontinuation); reviewing management; safe prescribing practice; de-prescribing
- Medication (select all that apply): serotonin specific reuptake inhibitor; serotonin-noradrenaline reuptake inhibitor; tricyclic antidepressant; antipsychotic; clozapine; long-acting injectable antipsychotic; anxiolytic; benzodiazepine; sedative/hypnotic; lithium; mood stabilizer; stimulant; cognitive enhancer; opioid agonist; agent to treat medication side effect; other
- Complexity factors: pregnancy; breast feeding; multiple medications; substitute decision maker; medical comorbidity; other

Collect 12 observations of achievement:

- At least 1 each starting and monitoring
  - o long-acting injectable antipsychotic
  - o oral antipsychotic
  - o sedative/hypnotic
- At least 2 starting and monitoring 2 different classes of antidepressants
- At least 1 each starting and/or monitoring
  - o lithium
  - o clozapine
- At least 1 each of managing



- benzodiazepine
  - opioid agonist therapy
  - mood stabilizer other than lithium
  - agent to treat medication-induced side effect
- At least 1 patient on multiple psychiatric medications
- At least 2 patients in the CL setting
- At least 2 child/adolescents, including starting and managing 1 stimulant
- At least 2 older adults, including 1 with a cognitive enhancer
- At least 1 pregnant or breastfeeding patient
- At least 5 observers
- At least 3 by psychiatrists

Relevant Milestones:

- 1 **ME 1.3 Apply knowledge of pharmacodynamics and pharmacokinetics at various developmental stages**
- 2 **ME 1.6** Adapt care as the complexity, uncertainty, and ambiguity of the patient's clinical situation evolves
- 3 **ME 3.2 Describe the indications, contraindications, risks, and alternatives for a given treatment plan**
- 4 **ME 2.2 Assess and monitor patient adherence and response to therapy**
- 5 **ME 2.2 Assess potential harmful or beneficial drug-drug interactions**
- 6 **ME 3.2** Use shared decision-making in the consent process
- 7 **ME 4.1 Establish plans for ongoing care**
- 8 **COM 5.1 Document prescriptions accurately in the patient's medical record, including the rationale for decisions**
- 9 **COL 1.2 Negotiate overlapping and shared care responsibilities with physicians and other colleagues in the health care professions in episodic and ongoing care**
- 10 **L 2.2** Apply evidence and management processes to achieve cost-appropriate care
- 11 **HA 1.1 Facilitate access to appropriate medications**
- 12 **P 1.4** Recognize and manage conflicts of interest in independent practice

## Core of Discipline EPA #9

### Applying relevant legislation and legal principles to patient care and clinical practice

#### Key Features:

- This EPA includes activities in which clinicians must apply legislation or ensure they employ a legally defensible approach in evaluation, diagnosis, and communication.
- Examples include the following: performing suicide and self-harm risk assessments; performing acute violence risk assessments; restricting rights of a patient; evaluating and defending an opinion for various capacities; obtaining and documenting informed consent; evaluating and communicating an opinion regarding restrictions and limitations relevant to disability; evaluating whether a duty exists to third parties.

#### Assessment plan:

Direct observation by psychiatrist/psychiatry subspecialist, TTP psychiatry resident, Core/TTP psychiatry subspecialty resident, or psychiatry/ psychiatry subspecialty fellow

Use Form 1. Form collects information on:

- Setting: emergency; inpatient unit; consultation liaison; outpatient; simulation
- Issue: capacity to consent to treatment; fitness to stand trial; financial capacity; testamentary capacity; capacity with respect to long-term care; MAID; disability; disclose information; restriction or limitation of rights; need for mandatory or discretionary reporting; other issue
- Initiating involuntary treatment or hospitalization: yes; no
- Complexity: low; medium; high

Collect 6 observations of achievement

- At least 2 capacity to consent to treatment in complex patients
- At least 2 restricting or limiting rights of a patient with the included due process protections such as initiating involuntary treatment and/or hospitalization
- At least 1 evaluation for restrictions/limitations relevant to disability
- At least 1 need for mandatory or discretionary reporting
- At least 4 by psychiatrists
- At least 2 different psychiatrist observers

#### Relevant Milestones:

- 1 ME 1.3 Apply knowledge of legal principles and legislation relevant to Psychiatry**
- 2 ME 2.2 Perform risk assessments, including for suicide, self-harm, and violence**
- 3 ME 3.2 Obtain and document informed consent**
- 4 ME 5.2 Adopt strategies that promote patient safety and address human and system**

factors

- 5 **ME 2.2 Assess a patient's decision-making capacity**
- 6 **COM 1.6** Tailor approaches to decision-making to patient capacity, values, and preferences
- 7 **COM 5.1 Document clinical encounters in an accurate, complete, timely, and accessible manner, and in compliance with legal and privacy requirements**
- 8 **P 3.1 Adhere to requirements for mandatory and discretionary reporting**
- 9 **P 3.1 Fulfil and adhere to the professional and ethical codes, standards of practice, and laws governing practice**

## Core of Discipline EPA #10

### Providing teaching for students, residents, the public and other health care professionals

#### Key Features:

- This EPA focuses on formal teaching presentations to diverse audiences such as patients, families, junior and senior learners, and other health professionals.
- This includes critical appraisal of relevant literature, adaptation of language and material to the needs of the audience, and effective presentation skills.

#### Assessment plan:

Direct observation by psychiatrist

Use Form 1. Form collects information on:

- Topic (write-in):
- Audience (select all that apply): residents/medical students; peers; psychiatrists; patients and/or families; public; other health care professional

Collect 4 observations of achievement

- At least 2 different audiences
- At least 2 different psychiatrist observers

#### Relevant Milestones:

- 1 **S 2.4** Identify the learning needs and desired learning outcomes of others
- 2 **ME 1.3 Apply a broad base and depth of knowledge in biopsychosocial sciences**
- 3 **S 2.4 Develop learning objectives for a teaching activity**
- 4 **S 3.3 Critically evaluate the literature**
- 5 **S 3.4** Integrate best evidence and clinical expertise
- 6 **S 2.4 Present the information in an organized manner**
- 7 **S 2.4 Use audiovisual aids effectively**
- 8 **S 2.4 Provide adequate time for questions and discussion**

## Transition to Practice EPA #1

### Managing the clinical and administrative aspects of a psychiatric practice

#### Key Features:

- This EPA focuses on the psychiatrist's role in the overall delivery of patient care.
- This includes evidence-informed decision-making across the breadth of psychiatric presentations and case complexity, and running the service or practice efficiently and in a manner consistent with sustainable practice and work-life balance.
- This also includes the administrative aspects of practice such as quality assurance and improvement, patient advocacy, and financial management; and the other responsibilities of an attending physician such as supporting the interprofessional team and maintaining a professional work environment.
- The observation of this EPA is divided into in two parts: patient care; working with the team.
- The patient care aspects of this EPA are based on at least one month of observation.

#### Assessment plan:

Part A: Patient care

Direct observation by supervising psychiatrist

Use form 1. Form collects information on:

- Setting: emergency; inpatient unit; consultation liaison; outpatient; community

Collect 1 observation of achievement

Part B: Working with the team

Collation of feedback from multiple observers by supervisor; observers may include other physicians, social workers, nurses, OT/PT, administrators, peers, junior residents, or subspecialty residents

Use Form 3. Form collects information on:

- Number of people providing input (write in):

Collect feedback at least twice and at least one month apart

- Each observation must include feedback from at least 2 observers

#### Relevant Milestones:

Part A: Patient care

#### **1 ME 1.1 Demonstrate responsibility and accountability for decisions regarding patient**

**care, acting in the role of junior attending**

- 2 **ME 1.5 Manage a caseload and prioritize urgent clinical issues**
- 3 **ME 1.4** Perform relevant and time-effective clinical assessments using a biopsychosocial approach
- 4 **ME 3.1** Determine the most appropriate procedures, therapies, or social interventions for the purpose of assessment and/or management
- 5 **S 3.4 Integrate best evidence, clinical expertise and relevant biopsychosocial determinants into decision-making**
- 6 **ME 2.4 Develop management plans that are relevant to the case and all the specific biopsychosocial determinants of the case**
- 7 **ME 4.1** Determine the need and timing for referral to another health care professional
- 8 **ME 4.1** Coordinate care when multiple health care providers are involved
- 9 **L 2.1** Allocate health care resources for optimal patient care
- 10 **P 4.2** Manage competing personal and professional priorities
- 11 **P. 4.1** Exhibit self-awareness and effectively manage influences on personal well-being and professional performance

Part B: Working with the team

- 1 **ME 1.1 Demonstrate responsibility and accountability for decisions regarding patient care, acting in the role of junior attending**
- 2 **COL 1.2** Make effective use of the scope and expertise of other health care professionals
- 3 **COL 2.1 Delegate tasks and responsibilities in an appropriate and respectful manner**
- 4 **COL 1.1** Respond appropriately to input from other health care professionals
- 5 **COL 1.3 Communicate effectively with other health care professionals**
- 6 **COL 2.1** Show respect toward collaborators
- 7 **HA 1.1** Facilitate access to health services and resources
- 8 **P 1.1** Respond punctually to requests from patients or other health care providers
- 9 **COM 1.5** Manage disagreements and emotionally charged conversations with patients and/or families
- 10 **P 1.1** Exhibit appropriate professional behaviours
- 11 **L 4.2** Run the service efficiently, safely, and effectively

## Transition to Practice EPA #2

### Supervising junior trainees

#### Key Features:

- This EPA focuses on providing appropriate supervision and opportunities for autonomy: triaging the level of supervision according to acuity, setting, and trainee and patient needs; delegating appropriately; and being available in case of emergency.
- This EPA also includes coaching junior trainees, assessing the performance of others, and providing feedback.

#### Assessment Plan:

Direct observation by psychiatrist/psychiatric subspecialist, with input from other health care professionals and learners

Use Form 1. Form collects information on:

- Setting: emergency; inpatient unit; consultation liaison; outpatient; community; on-call

Collect 4 observations of achievement

#### Relevant Milestones:

- 1 COL 2.1 Delegate tasks and responsibilities in an appropriate and respectful manner**
- 2 S 2.1 Use strategies for deliberate, positive role-modelling**
- 3 S 2.2 Ensure a safe learning environment for all members of the team**
- 4 S 2.3 Balance clinical supervision and graduated responsibility, ensuring the safety of patients and learners**
- 5 S 2.4 Provide formal and informal teaching for junior learners**
- 6 S 2.5 Provide useful, timely, constructive feedback**

### **Transition to Practice #3 EPA**

#### **Developing and implementing personalized training experience geared to career plans or future practice**

##### Key Features:

- This EPA focuses on recognizing gaps in performance, personal career goals, and/or needs of the intended practice setting, and developing and implementing a personalized training experience to address them.
- This may include developing further expertise in an area of interest such as a clinical focus, research, education scholarship, health advocacy, or administration.
- Achievement of this EPA includes a) providing a learning plan with rationale, personal needs assessment, and identification of the methods and activities necessary for its achievement; b) submission of evidence of achievement in each area/setting identified in the learning plan – the outcomes must be SMART (specific, measurable, achievable, relevant, timely); and c) reflection on the effectiveness of the plan's design for the trainee's development, highlighting strengths and areas for improvement and reflecting on how future learning plans can be improved.
- The observation of this EPA is divided into three parts: developing a learning plan; implementing a training experience; reflecting on learning.

##### Assessment Plan:

###### **Part A: Developing a learning plan**

Review of resident's submission of a reflective learning plan identifying activities to achieve by supervisor

Use Form 4.

Collect 1 observation of achievement

###### **Part B: Implementing a training experience**

Direct observation by supervisor

Use Form 1.

Collect 1 observation of achievement

###### **Part C: Reflecting on learning plan efficacy Review of resident's submission by supervisor**

Use Form 4.

Collect 1 observation of achievement



### Relevant Milestones:

#### Part A: Developing a learning plan

- 1 **P 2.1** Demonstrate a commitment to maintaining and enhancing competence
- 2 **S 1.2** Interpret data on personal performance to identify opportunities for learning and improvement
- 3 **L 4.2** Examine personal interests and career goals
- 4 **S 1.1** Define learning needs related to personal practice and/or career goals
- 5 **S 3.1** Generate focused questions that address practice uncertainty and knowledge gaps
- 6 **S 1.1** Create a learning plan that is feasible, includes clear deliverables and a plan for monitoring ongoing achievement
- 7 **S 1.1** Identify resources required to implement a personal learning plan
- 8 **L 4.2** Adjust educational experiences to gain competencies necessary for future practice

#### Part B: Implementing a training experience

- 1 **P 3.1** Fulfill and adhere to the professional and ethical codes, standards of practice, and laws governing practice
- 2 **L 4.1 Set priorities and manage time to integrate practice and personal life**
- 3 **L 4.2 Manage a career and a practice**
- 4 **S 1.3 Engage in collaborative learning to continuously improve personal practice and contribute to collective improvements in practice**
- 5 **P 2.1 Demonstrate a commitment to maintaining and enhancing competence**
- 6 **P 4.1 Exhibit self-awareness and effectively manage influences on personal well-being and professional performance**

#### Part C: Reflecting on learning plan efficacy

- 1 **P 2.1** Demonstrate a commitment to maintaining and enhancing competence
- 2 **S 1.2** Interpret data on personal performance to identify opportunities for learning and improvement
- 3 **S 1.1** Monitor and revise a personal learning plan to enhance professional practice

# APPENDIX B: PROVIDING EFFECTIVE FEEDBACK

*\*Components adapted from presentation from Dr. Amy N. Ship MD, Beth Israel Deaconess Hospital, Harvard Medical School*

## FEEDBACK:

Feedback is "... an informed, non-evaluative, objective appraisal of performance intended to improve... skills – rather than an estimate of the trainee's personal worth..."

- Jack Ende MD "Feedback in clinical medical education." JAMA 1983; 250(6):777-81.

## CHARACTERISTICS OF EFFECTIVE FEEDBACK:

- Expected
- Timely
- Based on first-hand observations or data
- Focused on specific behavior, not generalizations
- Deals with actions, not interpretations or presumed intentions
- Subjective data is labeled as such
- Frequent and digestible

## HOW TO GIVE FEEDBACK:

Consider R2C2 (attached in Appendix C): Evidence Informed Facilitated Feedback, a four stage process (Joan Sargeant, PhD)

1. Build rapport and relationship
2. Explore reactions to and perceptions of the assessment data
3. Explore resident understanding of the content of the data/report
4. Coach for performance change

## PROCESS:

### Before you meet

- Prepare for feedback
  - o Know what you want to say before you start
    - Why are you doing this? Check your intentions
    - Be clear about your goals (i.e. I want to give you feedback on your written records, specifically the progress notes you've written this week for patient XX.)

- Think of recent, detailed examples (of what is going well, and what isn't)
- Announce feedback: "I have some feedback for you. Would now be a good time to talk or later?"

#### During a feedback session

- Start open-ended and solicit self-assessment – "How do you think that went?"
- Listen – engage in **active listening**; reflect back what you hear...
- Choose your language carefully:
  - Use non-evaluative language (i.e. do not say, "Your history taking was great")
  - Be specific
  - Focus on actions, not personal traits
- Make feedback a two-way conversation, not a speech.
- Try to understand the learner's perspective
- Be ready for resistance – learners may not agree. Don't argue, use reflective listening

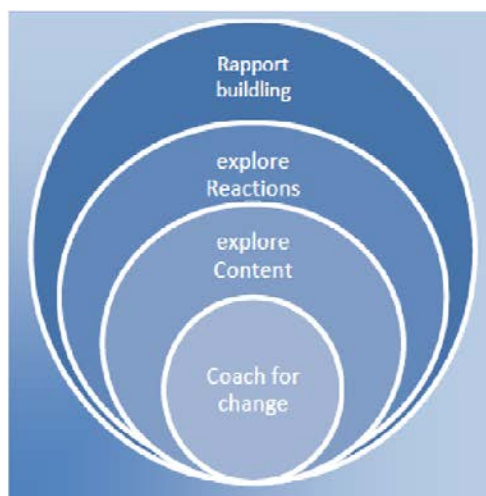
#### After providing feedback

- Do not expect instant change. Let the learner decide/explore how to change.
- Follow up – check what happens, try and catch them doing it right; consider developing a learner change plan
- Meet again – feedback is a process

#### Resources

1. [CBD Update June 4 2020 – Feedback Presentation Slides](#)
2. [CBD Update June 4 2020 – Feedback Presentation Video](#)

## APPENDIX C: EVIDENCE-INFORMED FACILITATED FEEDBACK R2C2



### Evidence-Informed Facilitated Feedback: R2C2

*R2C2 - A model for facilitating performance  
feedback and coaching for change*

Evidence-informed Feedback Research Team  
Funding:

SACME Endowment Fund 2011-13  
NBME Stemmler Foundation 2014-16

## Stage 1. Build rapport and relationship

*Goal: to engage the resident, build the relationship, and build mutual respect and trust*

- Explain the purpose of assessment report and interview; i.e., to provide:
  - A sense of how they're performing and a conversation about this;
  - A chance to describe their training and experiences;
  - Data that can lead to improvement.
- Outline the agenda to:
  - Review assessment data and gaps;
  - Discuss their reactions to the data and what it means to them;
  - Develop an action plan from the data.

### Stage 1 Strategies and sample phrases

- "How has the rotation gone for you? What did you enjoy, what challenged you about it?"
- "Tell me about your assessment and feedback experiences to date. What's been helpful and what hasn't?"
- How do you think you're doing? What are your strengths and opportunities to improve?
- "What would you hope to get out of this feedback discussion?"

Confirm what you're hearing; show respect; build trust; validate.

**Relationship-building is central and needs attention throughout the interview.**

## Stage 2. Explore reactions to and perceptions of the assessment data

*Goal: for resident to feel understood and that their views are heard and respected.*

### Stage 2 Strategies and sample phrases

- "What were your initial reactions? Anything particularly striking?"
- "Did anything in the report surprise you? Tell me more about that..."
- "How do these data compare with how you think you were doing? Any surprises?"

Negative reactions/surprises tend to be more frequently elicited by:

- Subjective data such as multisource feedback or assessment scores not supported by objective data
- Data identifying one is not doing as well as they thought.
- Comparative data, when one's scores are lower than the mean.

Be prepared for expression of negative reactions in these cases. Phrases to validate negative reactions & support:

- "You're not the first one to identify that as a stumbling block"
- "It's difficult to hear feedback that disconfirms how we see ourselves"
- "We're all trying to do our best and it's tough to hear when we're not hitting the mark"
- "We're going to work together"

### Stage 3. Explore resident understanding of the content of the data/report

*Goal: for the resident to be clear about what the assessment data mean and the opportunities suggested for change.*

#### Stage 3 Strategies and sample phrases

- *“Is there anything in the assessment report that doesn’t make sense to you?”*
- *“Anything you’re unclear about?”*
- *“Let’s go through section by section.”*
- *“Anything in section X that you’d like to explore further or comment on?”*
- *“Anything that struck you as something to focus on?”*
- *“Do you recognize a pattern?”*

A careful review of the assessment data and identification of performance gaps will guide Stage 4, Coaching.

## APPENDIX D: DETAILS OF CHANGES TO ROTATIONAL STRUCTURE

The changes in rotational structure related to CBD are largely to fulfill a few goals:

- 1) Increase the amount of overall elective/selective time in the program. This is useful to:
  - a) Improve resident autonomy/choice
  - b) Allow for more blocks of research time
  - c) Allow exceptional residents to pursue areas of interest in greater depth
  - d) Provide some flexibility for residents who may not have achieved their EPAs within their core rotations.
- 2) Increase access to rotations that are consistent with observation and CBD principles.
- 3) Increase rotations that will better train learners to meet societal needs.
- 4) Increase the opportunities for residents to return to a rotation at a later stage of training so they can focus on more advanced competencies.
- 5) Decrease the length of core rotations in a way that is consistent with resident feedback.
- 6) Bring the child sub-specialty rotation earlier into training so that there is a more developmental approach to mental illness and to allow residents interested in applying for the child sub-specialty more time to consider their decision and engage in additional elective time before the applications are due.
- 7) Provide access to a longitudinal clinic that will allow residents to treat patients beyond the length of individual rotations

Highlights consistent with the above principles include:

- 1) Returning to ER, addictions, underserved/marginalized selective and inpatient rotations at later stages of training
- 2) Increasing the overall amount of time in the ER
- 3) Development of a Longitudinal Ambulatory Experience for PGY1-3
- 4) Increased time with underserved and addictions populations
- 5) 3 new months of Personalized Learning Experience (PLEX) time in PGY3 and 4 new months of PLEX time in PGY4

# APPENDIX E: CBD SUBCOMMITTEES AND MEMBERSHIP

## **CBD OPERATIONS SUBCOMMITTEE**

### **CHAIR:**

- Sarah Colman
- Mark Fefergrad

### **MEMBERSHIP:**

- Deanna Chaukos
- Inbal Gafni
- Mary Preisman
- Hamza Riaz, PGY3
- John Teshima

## **CBD ASSESSMENT SUBCOMMITTEE**

### **CHAIR:**

- Deanna Chaukos

### **MEMBERSHIP:**

- |                           |                           |
|---------------------------|---------------------------|
| • Sacha Agrawal           | • Wiplove Lamba           |
| • Kaitlin Baenziger, PGY5 | • Jovana Martinovic       |
| • Sabrina Botsford, PGY4  | • Michael Neszt           |
| • Rachel Carr, PGY4       | • Arielle Salama          |
| • Malcolm Chan, PGY5      | • Adam Tasca              |
| • Sumeeta Chatterjee      | • Anupam Thakur           |
| • Amy Cheung              | • Selina Zeng, PGY3       |
| • Shaheen Darani          | • Yasmin Nasirzadeh, PGY3 |

## **CBD CURRICULUM SUBCOMMITTEE**

### **CHAIR**

- Mary Preisman

### **MEMBERSHIP**

- Sacha Agrawal
- Michaela Beder



- Jessica Braidek
- Tara Burra
- Sarah Colman
- Angela Golas
- Laura Kennedy
- Wiplove Lamba

- Robert Madan
- Robert McMaster
- Alpna Munshi
- Ronald Leung, PGY3
- Tamir Streiner, PGY3
- Chris Willer
- Gwyneth Zai

### **CBD COMPETENCE SUBCOMMITTEE**

#### **CHAIR:**

- Inbal Gafni

#### **MEMBERSHIP:**

- Petal Abdool
- Amina Ali
- Greg Chandler
- Deanna Chaukos
- Amy Cheung
- Sarah Colman
- Shaheen Darani
- Mark Fefergrad
- Amy Gajaria
- Smrita Grewal
- Mark Hanson
- Eileen La Croix
- Chloe Leon
- Joanne Leung-Yee
- Matthew Levy
- Susan Lieff
- Greg Lodenquai
- Michael Mak
- Kim Miller

- Rosanne Mills
- Michael Neszt
- Mary Preisman
- Ashwati Raghunath
- Kevin Rohani
- Andreia Scalco
- Christian Schulz-Quach
- Ilana Shawn
- Ivan Silver
- Sanjeev Sockalingam
- Glendon Tait
- Adrienne Tan
- Michael Tau
- John Teshima
- Carmen Wiebe
- Chris Willer

### **CBD LEARNER EXPERIENCE SUBCOMMITTEE**

#### **CHAIR**

- Deanna Chaukos
- Hamza Riaz, PGY3

#### **MEMBERSHIP**

- John Aoun – PGY3 SHSC
- Vanessa Aversa PGY3 SHSC

- Sheiry Dhillon PGY2 SMH
- Tanner Isinger – PGY3 SHSC
- Diana Kljenak – UHN Psychiatrist
- Geoffrey Leblond – PGY3 SMH
- David Lee – PGY3 SMH
- Ronald Leung PGY3 MSH
- Justan Lougheed – PGY3 SHSC
- Yasmin Nasirzadeh PGY3 MSH
- Jason Perdue – PGY3 SMH
- Houman Rashidian – PGY3 UHN
- Nikhita Singhal PGY2 UHN
- Tharshika Thangarasa PGY2 MSH
- Siqi Xue – PGY4 CBD Pilot

### **CBD PROGRAM EVALUATION SUBCOMMITTEE**

#### **CHAIR:**

- Mark Fefergrad

#### **MEMBERSHIP:**

- Evan Baker, PGY5
- Johnny Bozdarov, PGY3
- Amy Cheung
- Sarah Colman
- Bruce Fage
- Certina Ho
- Csilla Kalocsai
- Bushra Khan, PGY3
- Betty Lin
- Kathryn Parker
- Sanjeev Sockalingam
- Sophie Soklaridis
- Zenita Alidina