Measuring Progress:
Competence-By-Design
in
Obstetrics & Gynaecology

CBD Faculty Development Day

Friday, April 12, 2019 @ 7:45 A.M. - 8:45 A.M.

Women's College Hospital, 76 Grenville St. C.L.
Burton Conference Centre, Auditorium Rm 2501

Dr. Michele Farrugia
Dr. Sue Glover Takahashi
Dr. Richard Pittini

Obstetrics & Gynaecology
UNIVERSITY OF TORONTO

Disclosures

- None to report

Thank-you!

- To the Department and Dr. John Kingdom
- To the CBD Committee
  - Chair: Dr. Janet Bodley
  - Faculty: Drs. Richard Pittini, Donna Steele, Nicolette Caccia, Lilian Gien, Wusun Paek
  - Residents: Drs. Alisha Olsthoorn, Anand Lakhani, Evan Tannenbaum
- To PGME
  - Dr. Sue Glover Takahashi and Lisa St. Amant
- To department staff
  - Jill Tomac, Nicole Patton

Goals and Objectives:

- To review the terminology for CBME/CD and the evidence to support this major curricular change.
- To describe how the developmental stages of CBD will influence postgraduate training
- To discuss how our CBD launch will integrate with ‘non-CBD’ trainees
- To review the curriculum map and contrast this with our current rotation schedule.


Reinventing the wheel.
Knowing *when* and *how*.

What is CBME & CBD?

- Competency-based medical education (CBME) is an outcomes-based approach to the design, implementation, assessment and evaluation of a medical education program using an organizing framework of competencies (e.g., CanMEDS 2015)

- Competence-by-Design (CBD) is the Royal College's version of CBME

What is CBD?

- Multi-year, transformational change initiative in specialty medical education;
- Focused on the learning continuum from the start of residency to retirement;
- Based on a competency model of education and assessment; and
- Designed to address societal health need and patient outcomes.

Why Competence by Design (CBD)? The Rationale

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OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL
DES MÉDECINS ET CHIRURGIENS DU CANADA

Competence by Design
EXCELLENCE ACROSS THE CONTINUUM

Why Change?

While Canada's medical education system is exceptional overall, there are **gaps** and **challenges** within the current model that need to be addressed.

Drivers for Change

- Potential for students to graduate with gaps in readiness-to-practice

DOCTOR AND PATIENT

Are Med School Grads Prepared to Practice Medicine?

By PAULINE W. CHEN, M.D. APRIL 24, 2014, 11:30 AM

Kevin Wolf/Associated Press

Third-year Georgetown medical students getting ready to meet with a patient/actor.

Via: http://well.blogs.nytimes.com

Issues within Current System

- New age of **accountability**

Image: www.rischiocalcolato.it

Drivers for Change

- Increased public concern and need to demonstrate continuing competence

NEWFOUNDLAND: HEALTH CARE

Suspended radiologist erred 708 times, review finds

TARA BRAUTIGAM
THE CANADIAN PRESS
NOVEMBER 1, 2007

ST. JOHN'S -- The work of a suspended Newfoundland radiologist was so poor that he missed glaring problems such as tumours, broken bones and cases of pneumonia, the chief of the province's largest health board said yesterday after an in-depth review of nearly 3,800 patient records.

As a result, some patients of Fred Kasirye may have missed potentially life-saving treatment, said Louise Jones, interim chief executive officer of the Eastern Health Authority.

"There have been pneumonias that have been missed, there's been fractures that have been missed, there's been some tumours that have been missed." M
did not go back to quantify that. We had over 5,000 r
the hands of the physicians and the patients themselv

Dr. Kasirye was hired at the Burin Peninsula Health
November. But in May, he was suspended without pa
concerns over his procedures and decision-making.

'I was defensive and overly confident,' pathologist confesses

Last Updated: Wednesday, January 30, 2008 | 6:14 PM ET
CBC News

Charles Smith confessed on Wednesday in Toronto to confidently professing in court that he had expertise in areas where his experience was in fact limited, which in at least one case led to false charges against a mother.

The public inquiry examining the disgraced pathologist's work heard details of inappropriate actions in several of his cases, from visiting a mother suspected of killing her child to expressing opinions about the traits of killer mothers to police and reporters.

Smith was asked questions about the case of Sharon, a seven-year-old who he concluded died of 80 scissor stab wounds.

Second-degree murder charges against the child's mother, Louise Reynolds of Kingston, Ont., were dropped after other experts later concluded the child was mauled by a dog.

Smith said he became involved in the case despite his lack of knowledge about lacerations at the insistence of Ontario's chief coroner's office.

"I certainly recognized that I had limited experience. I now

Charles Smith, shown framed by his lawyers at the public inquiry into his work, admitted to visiting the mother of

WEDNESDAY, JANUARY 30, 2008

A12 THE OTTAWA CITIZEN

Editorial

The pathology of Dr. Smith

harles Smith's long apol-
his failings as an expert
s might be making him
tter, but it's doing little to
e the rest of us.
he current Inquiry into
ic Forensic Pathology in
o, Dr. Smith is testifying,
trite fashion, about his
es. He's scheduled to
nswering questions at the
y for the rest of this week.
Smith was once consid-
n expert about the suspi-

Mr. Smith's own description of himself shows a man who was bad at his job and who persuaded himself that he wasn't. That shows something far worse than poor judgment. Everyone gets in over their head once in a while. What matters is having the wisdom to recognize own's one ignorance, and the grace to admit it, especially when the stakes are high. The stakes were dizzyingly high in Dr. Smith's field: his

Drivers for Change

- Prevalence of failure-to-fail culture

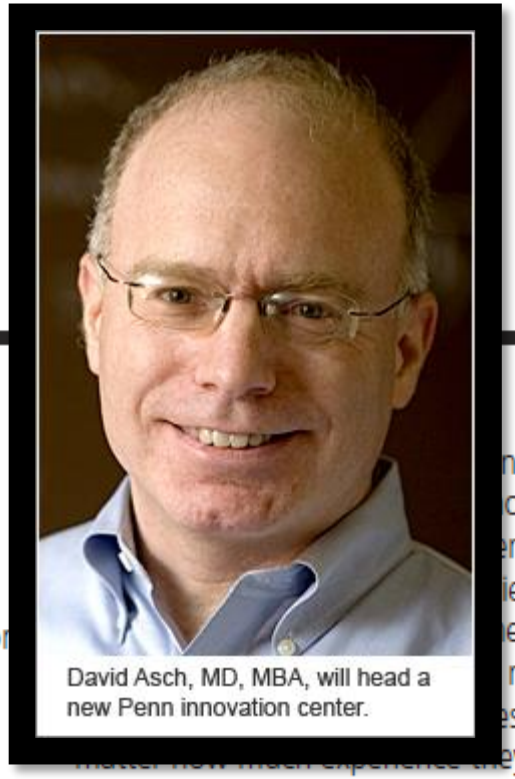
Drivers for Change

- Concerns about the "**tea-bag**" model of education which credentials physicians based on the time spent in training, not based on their achievement of necessary abilities.

Image: www.dreamstime.com

How Do You Deliver a Good Obstetrician? Outcome-Based Evaluation of Medical Education

David A. Asch, MD, Sean Nicholson, PhD, Sindhu K. Srinivas, MD, MSCE, Jeph Herrin, PhD, and Andrew J. Epstein, PhD, MPP



David Asch, MD, MBA, will head a new Penn innovation center.

Abstract

The goal of medical education is the production of a workforce capable of improving the health and health care of patients and populations, but it is hard to use a goal that lofty, that broad, and that distant as a standard against which to judge the success of schools or training programs or particular elements within them. For that reason, the evaluation of medical education often focuses on elements of its structure and process, or on the assessment of competencies that could be considered intermediate outcomes. These measures are more practical because they are easier to collect, and they are valuable when they reflect activities in important positions along the pathway to clinical outcomes. But they are all substitutes for measuring whether educational efforts produce doctors who take good care of patients.

The authors argue that the evaluation of medical education can become more closely tethered to the clinical outcomes medical education aims to achieve. They focus on a specific clinical

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matter
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ey have?

Does it matter how good they were to start? Each of these questions reflects a component of the production of a good obstetrician and, most important, defines a good obstetrician as one whose patients in the end do well.

Editor's Note: A commentary on this article by T.J. Nasca, K.B. Weiss, J.P. Bagian, and T.P. Brigham

programs by actual patient outcomes is not only more patient-centered, it better

Does It Matter Where the Obstetrician Trained?

Key Differences

- Time-informed instead of time defined
- Focuses on outcomes
  - ability to perform specific tasks – EPAs
- More direct observation with enhanced feedback
- Separates coaching from judgement
  - shifted to Competence Committee
- Easier for faculty to know what it is they are supposed to assess
- Shared responsibility between residents and faculty

We want our program to…..

- meet patient care and societal needs.
- ensure that residents are safe, ready for practice and have the competencies they need.
- provide more timely coaching feedback to residents.
- identify struggling learners at an earlier stage, when interventions are more likely to be effective.
- chip away at the culture of “failure to fail.”
- support residents to take ownership of their own learning and to develop lifelong learning skills.

The promise of CBD

- Enhanced flexibility in training
- Learner-centred
- Supervisor = coach
- Assessment for learning; low stakes
- Issues identified early
- Opportunity for innovation
- Transparent; standards well-described
- Standardization between training sites
- Resident promotion doesn’t rest with one person


U of T
RPC
Clinical Rotations
PGME
Specialty Committee
RCPSC
CBME committee
CCC
Hospitals

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CBD

What's Different for Residents & Faculty?

Susan Glover Takahashi, PhD

Director, Education & Research, PostMD Education

Integrated Senior Scholar – Centre for Faculty Development & PostMD Education

Lead, Faculty Development– CBME

Associate Professor, Department of Family and Community Medicine

Associate Professor, Dalla Lana School of Public Health

UT CBME / CBD

Overview

1. CBME/CBD – *3 years in*
2. Progress to date
3. Different content
4. Different processes

Looking back at progress

...over past 3 years

- Awareness higher about CBME/CBD
- Many involved, many conversations
- Building on the U of TCBME experiences
  - Triple C, Orthopedic Surgery, Psychiatry, Palliative Medicine
- How to build…more systemized nationally, at PGME, in departments
- Re-alignment of people, systems

What WE are focused on

➔ ➔ IMPROVEMENTS to PGME

1. **More accurate, varied and focused assessments**
2. **Improved frequency, transparency, and quality of data** for PD, faculty and residents, shared decision making
3. **Improved engagement of trainees** in learning activities, incl soliciting & incorporating feedback
4. **More confident and knowledgeable trainees** regarding their performance strengths and limitations

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REFRESHER:
Key CBD differences

1. **Developmental** approach
2. **TIME** is not THE parameter for success but is *part of* the considerations
3. **Assessment plan**
   - Focus on workplace assessments
   - Instead of G & O, focus on what can 'do' (i.e. EPAs)
4. '**Trust**' is explicitly assessed
5. Enhanced **feedback** & **coaching**

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Principles Guiding CBME @ U of T

- ☑ Quality of patient care and service delivery will not be adversely affected
- ☑ Workplace team functioning should not be negatively impacted
- ☑ Implementation will build on the excellence in residency education programs and practices

CBD @ U of T is a local PARTNERSHIP

1. **Residency Program**
   - –Director, Learners, Program Admin, Residency Program Committee, Site Directors
2. **Department**
   - –Chairs, Vice Chair Education, Division Chair, Faculty Development (FD) Lead
3. **PGME Office**
   - –PGME Assoc Dean, Post MD Dean, IT & Implementation teams, FD & Systems
4. **Hospitals**
   - – Cross hospital needs, systems support

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CBD @ U of T is a national PARTNERSHIP

- Specialty Committees & the Royal College
  → Program Directors

1) CBD Content
2) Faculty Development in CBD
3) Program Evaluation of CBD

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Overview

1. CBME/CBD – *3 years in*
2. **Progress to date**
3. Different content (EPAs, RTEs, SCRs)
4. Different processes

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CBD YEAR 1 (17-18) @ U of T

- **2** programs/specialties:

CBD YEAR 2 (18-19) @ U of T

- **14** programs/6 specialties

CBD YEAR 3 (19-20) @ U of T

- **23 programs**

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✓New or different

for residents & faculty & education leaders:

- More frequent observations and/or documentation of assessments
- Entrustment assessments (i.e. residents conducting and receiving)
- Culture of feedback & coaching skills
- Online platform
- Adjustments to workflow
- Learner handover
- Transparency of data
- Understanding the data
- Knowing how to act on the data

Overview

1. CBME/CBD – 3 years in
2. Progress to date
3. Different **content** (EPAs, RTEs, SCRs)
4. Different processes

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Different **content**

- Entrustment Professional Activities (EPAs)
- Training Experiences (RTEs)
- Specialty Competency Requirements (SCR)

Overview

1. What our CBME/CBD is focused on
2. Progress to date (cohorts & meantime work)
3. Different content (EPAs, RTEs, SCRs)
4. **Different processes** (entrustment, observations, online assessments, feedback & coaching, transparency, Competence Committee)
5. Questions

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Different **processes**

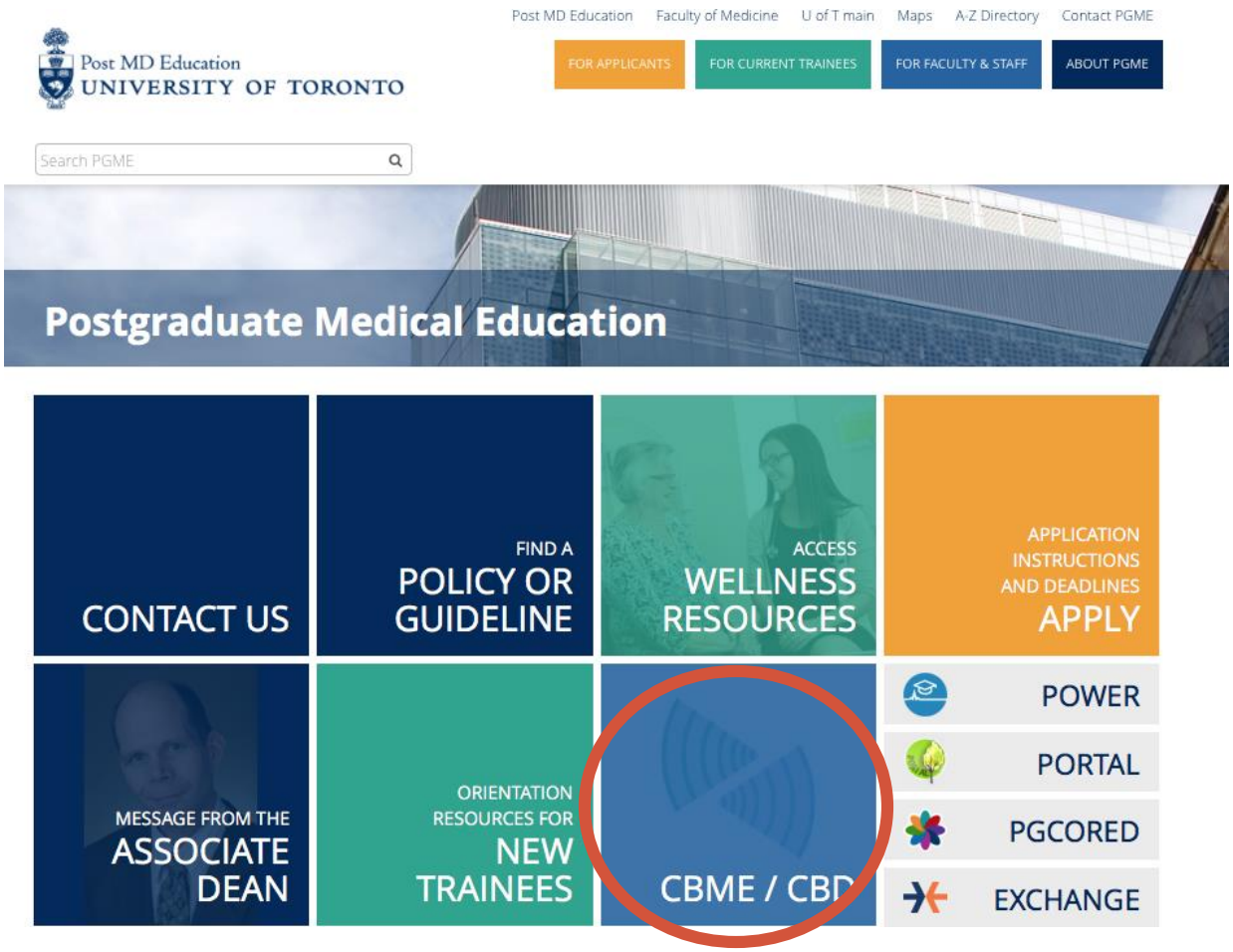
- Stages
- Entrustment
- Observations
- Online assessments
- Feedback & coaching culture
- Transparency including handover
- Competence Committee

…..**MUCH HARDER**

to change ***how*** **we learn, teach and assess**

RESOURCES:
PGME CBME/CBD WEBSITE

http://cbme.postmd.utoronto.ca/



Recap

1. CBME/CBD – *3 years in*
2. Progress to date
3. Different content
4. Different processes

Change is Underway…

CBD

What's an EPA?
Entrustable Professional Activity

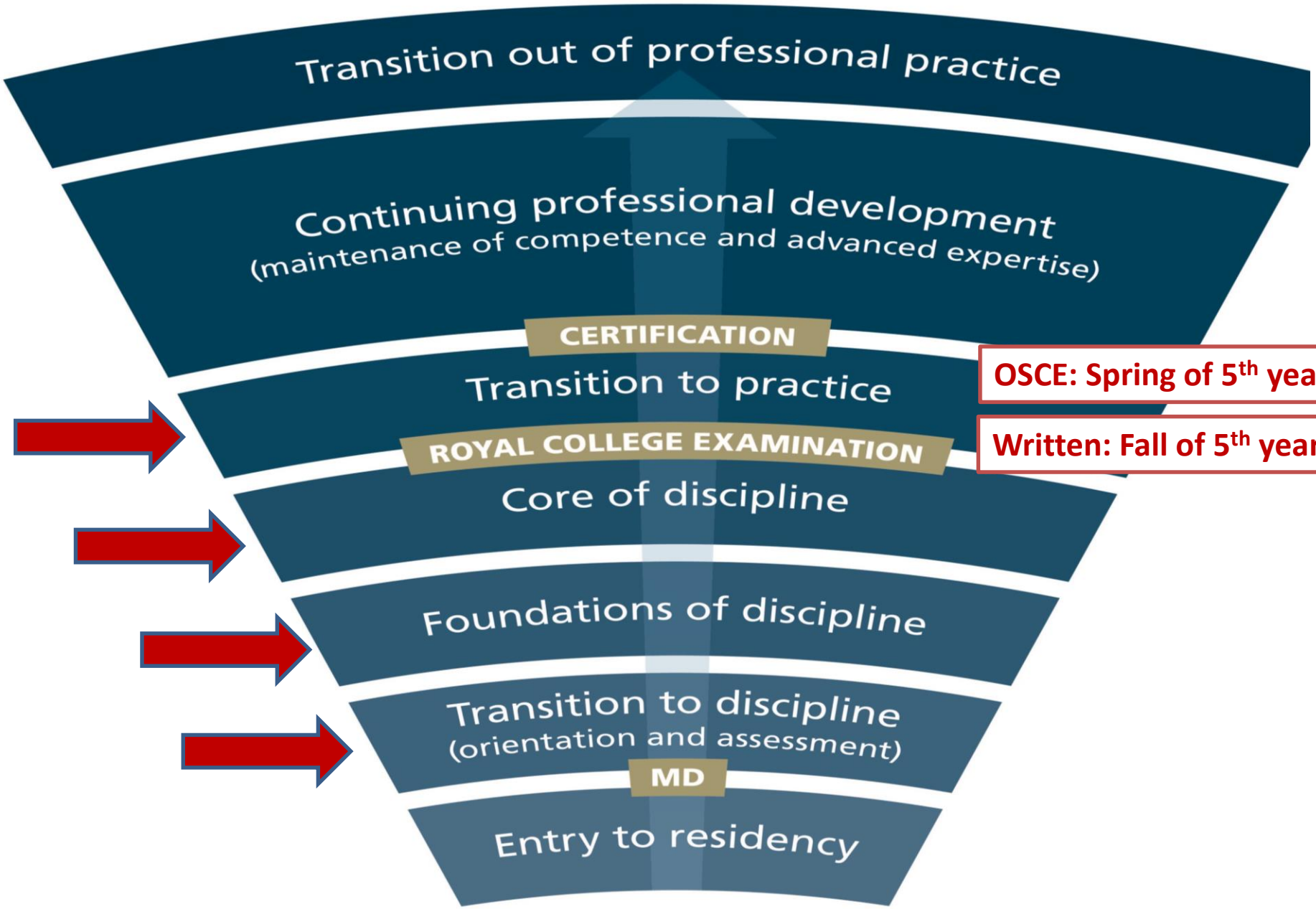
- Part of essential work for a qualified professional
- Requires specific knowledge, skill and attitude
- Acquired through training
- Leads to recognized output
- Observable and measurable
- Together, the EPA's constitute the core of the profession

Ten Cate et al., Acad Med 200; 82: 542-47

EPAs were defined by the national specialty committee for Ob/Gyn over three workshops facilitated by the Royal College

U of T was well represented

CBD[1,2] Competence Continuum



OSCE: Spring of 5th year

Written: Fall of 5th year

Entrustable Professional Activities - Key Concepts

The work that is done by a specialist

1. Professional activity
2. Stage specific
3. Progression
4. Entrustment

Transition to Discipline	Foundations of Discipline	Core of Discipline	Transition to Practice
3 months	21 months	30 months	6 months
1. Performing initial assessments for uncomplicated Ob patients 2. Performing an initial assessment of uncomplicated gynecologic patients Surgical Foundations EPAs: 7	1. Providing routine prenatal care to a low risk healthy population 2. Performing antenatal assessments of fetal well-being 3. Assessing and providing initial management for patients with common obstetric presentations 4. Managing labour and childbirth 5. Performing uncomplicated cesarean sections with a skilled assistant 6. Providing early postpartum care 7. Providing consultation and initial management for patients with urgent and emergent gynaecologic presentations 8. Counseling and management for patients requiring family planning 9. Providing consultation for patients with gynecologic conditions 10. Performing minor gynecologic operative procedures SA 1 Performing critical appraisal of health literature and initiating scholarly projects Surgical Foundations EPAs: 9	1. Providing preconception and antenatal care to women with high risk pregnancies 2. Managing patients with acute conditions presenting in the antenatal and perinatal period 3. Managing complex vaginal deliveries 4. Performing complex cesarean sections 5. Diagnosing and managing post-partum complications 6. Performing obstetric and gynecologic ultrasound 7. Providing definitive management for patients with acute gynaecologic emergencies 8. Providing care for patients with complex gynaecologic conditions and /or medical comorbidities 9. Assessing and initiating management for patients with reproductive challenges 10. Diagnosing and managing pediatric and adolescent patients with common gynaecologic conditions 11. Providing care for patients with pelvic floor dysfunction 12. Assessing, diagnosing and managing patients with chronic pelvic pain and sexual health concerns 13. Assessing and managing patients with gynaecologic malignancies 14. Performing advanced hysteroscopy 15. Performing major vaginal and vulvar procedures 16. Performing major laparoscopic gynecologic procedures 17. Performing major open abdominal gynecologic procedures 18. Managing patients with surgical complications 19. Managing the birthing unit	1. Managing complex patients, including those requiring longitudinal care 2. Discussing difficult news SA1 Conducting scholarly work SA2 Teaching and managing learners 33 EPAs 3 SAs

Performing initial assessments for uncomplicated obstetric patients

Key Features:

This EPA includes assessment, documentation, and case presentation, including a basic differential diagnosis and initial investigation of uncomplicated obstetric patients.

This EPA must be **observed** in a clinical setting

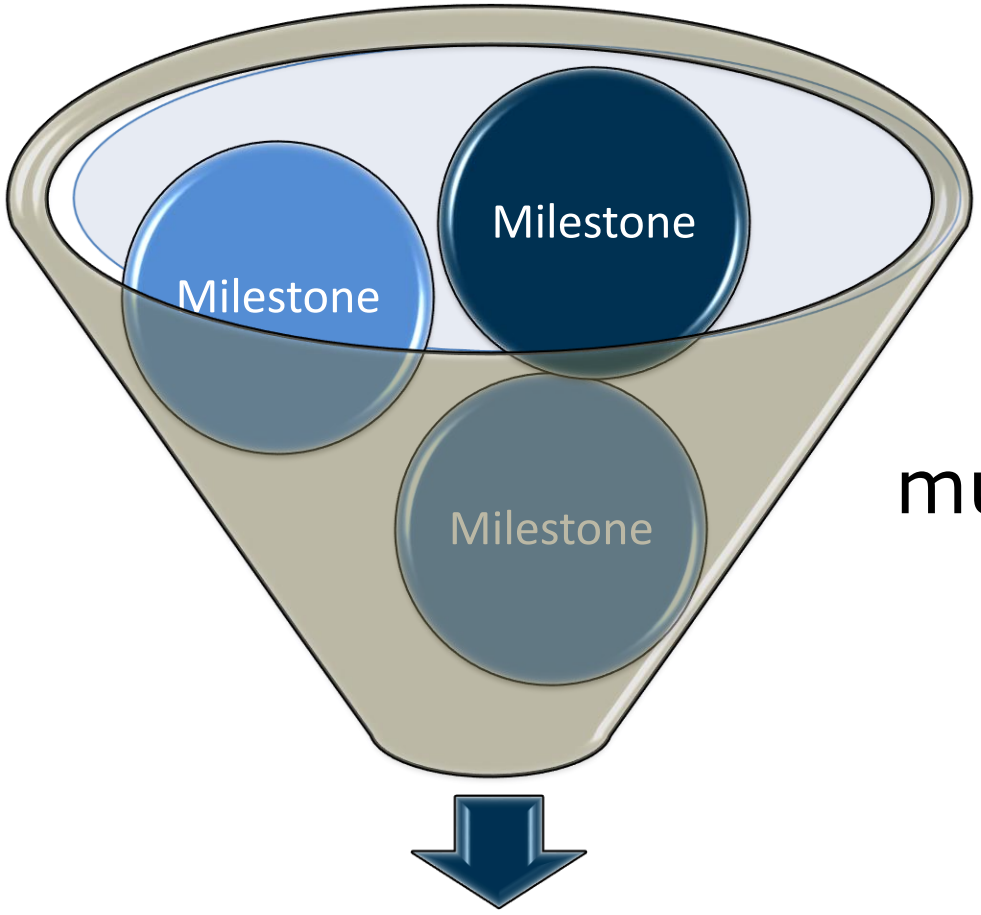
Assessment Plan:

Collect 3 observations of achievement

- At least 1 antepartum patient
- At least 1 intrapartum patient
- At least 2 observations by faculty

At least 3 different observers

Milestones within EPA

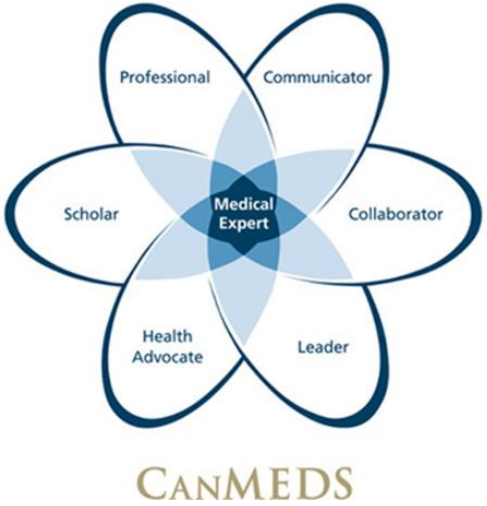


Each EPA **integrates** multiple milestones.

Milestone

A defined, observable marker of an individual's ability along a developmental continuum

- Marker of achievement
- CanMEDS 2015



EPA TTD 1

Performing initial assessments for uncomplicated obstetric patients

ME 2.2 Elicit a history and perform a physical exam that informs the diagnosis

ME 2.2 Develop a differential diagnosis relevant to the patient's presentation

ME 2.2 Select appropriate investigations based on the differential diagnosis

ME 2.4 Develop an initial management plan for common obstetric presentations

ME 3.3 Recognize and discuss the importance of the triaging and timing of a procedure or therapy

COM 1.1 Communicate using a patient-centred approach that facilitates patient trust and autonomy and is characterized by empathy, respect, and compassion

COM 1.2 Mitigate physical barriers to communication to optimize patient comfort, dignity, privacy, engagement, and safety

COM 1.4 Identify, verify, and validate non-verbal cues on the part of patients and their families

COM 2.2 Conduct a focused and efficient patient interview, managing the flow of the encounter while being attentive to the patient's cues and responses

COM 5.1 Organize information in appropriate sections within an electronic or written medical record

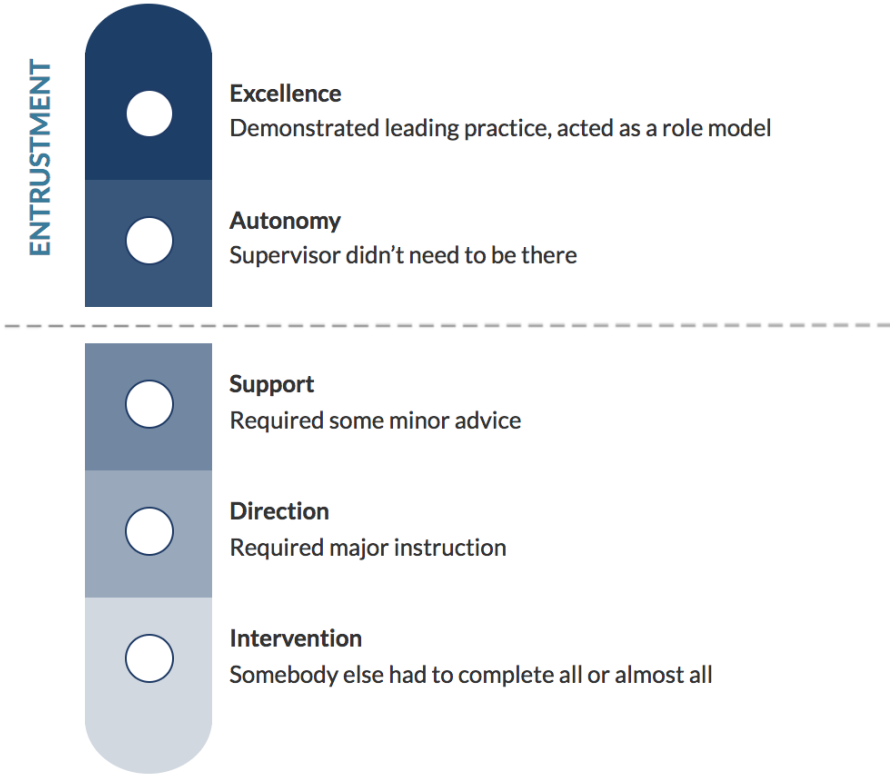
ME 2.2 Synthesize and organize clinical information for clear and succinct presentation to supervisor

COL 1.3 Discuss with the patient and family any plan for involving other health care professionals, including other physicians, in the patient's care

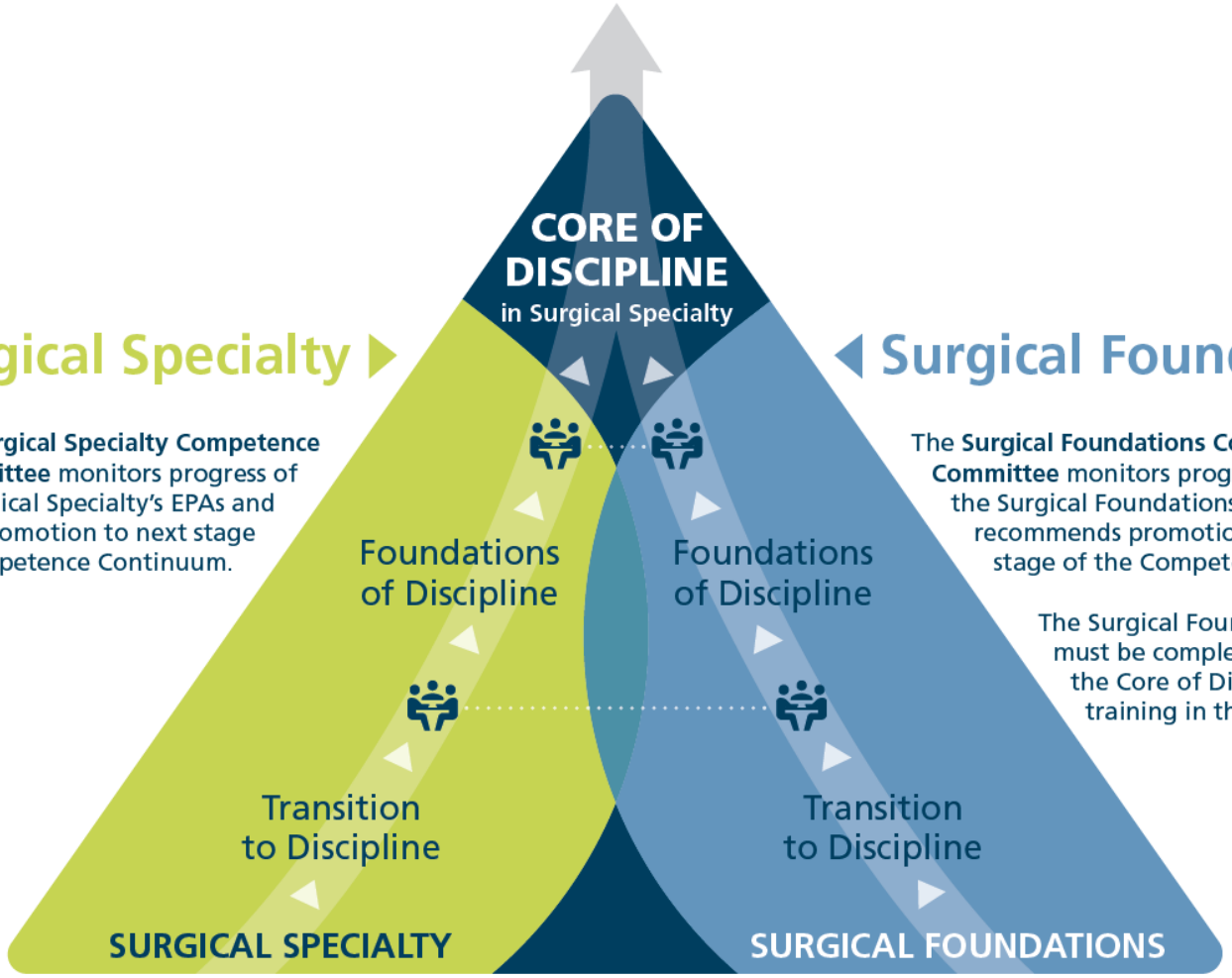
COL 2.1 Respond to requests and feedback in a respectful and timely manner

COL 2.1 Show respect for the diversity of perspectives and expertise among health care professionals

Entrustment



Surgical Foundations in CBD



Your **Surgical Specialty Competence Committee** monitors progress of the Surgical Specialty's EPAs and recommends promotion to next stage of the Competence Continuum.

The **Surgical Foundations Competence Committee** monitors progress of the Surgical Foundations EPAs and recommends promotion to next stage of the Competence Continuum.

The Surgical Foundations EPAs must be completed to enter the Core of Discipline stage of training in the Surgical Specialty.

Residents complete the Surgical Specialty and Surgical Foundations training simultaneously.

A resident may be eligible to write the Surgical Foundations exam 12-15 months into residency; eligibility for the exam does not require that the Surgical Foundations EPAs are complete.

The Surgical Foundations exam does not have to be successfully passed to enter the Core of Discipline stage of training, but must be passed in order to be eligible for the Surgical Specialty examination.

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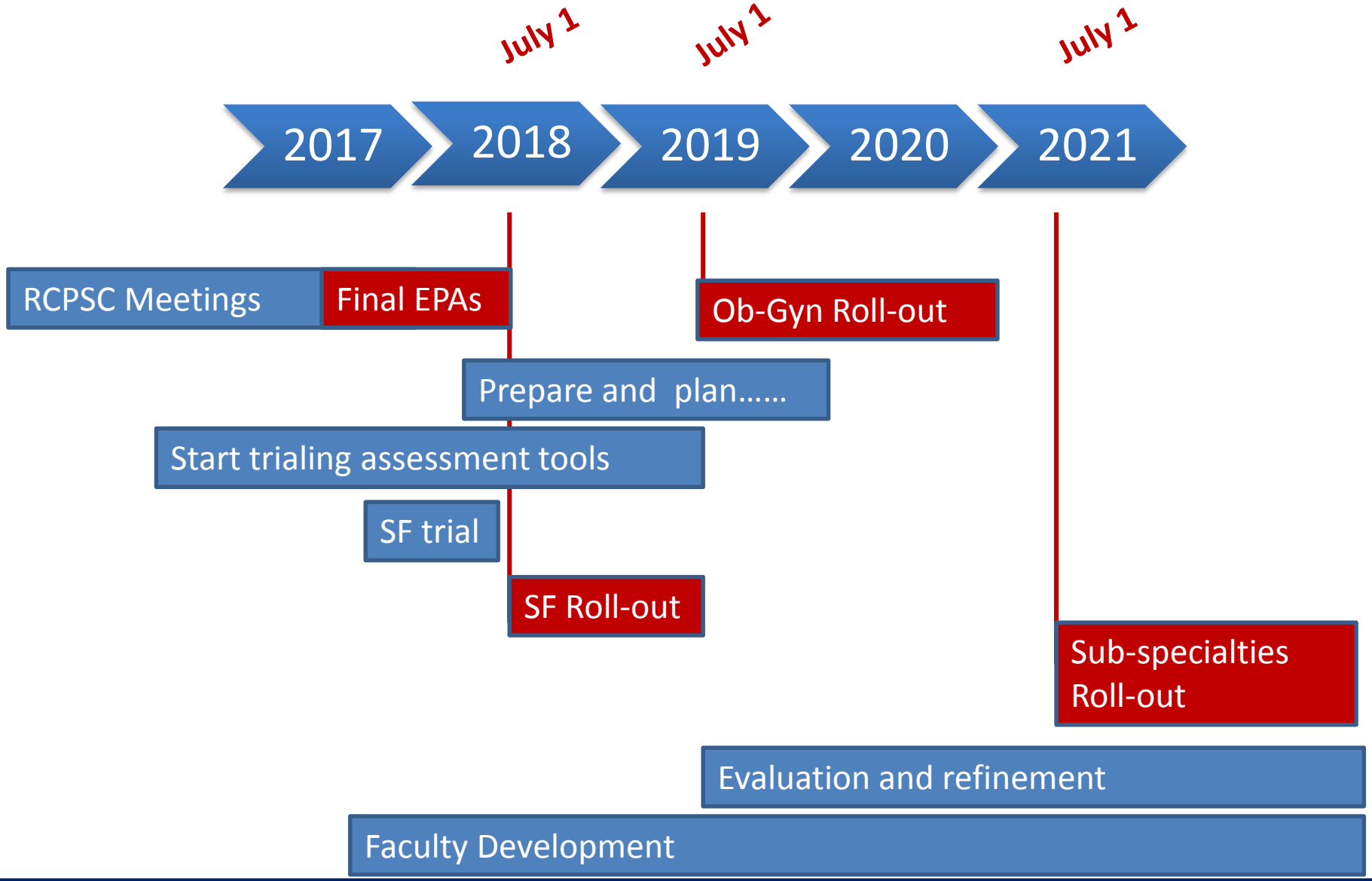
Surgical Foundations has its own….

- Specialty committee at the RCPSC
- U of T program director (not me!)
- Curriculum, including skills sessions, lectures and projects
- Competence Committee
- Assessment tools
  - 16 EPA's
- RCPSC exam

  -written in fall of PGY-2

  -MUST be passed before progressing to PGY-4


July 1
July 1
July 1
2017
2018
2019
2020
2021
RCPSC Meetings
Final EPAs
Ob-Gyn Roll-out
Prepare and plan……
Start trialing assessment tools
SF trial
SF Roll-out
Sub-specialties Roll-out
Evaluation and refinement
Faculty Development

July 1, 2019

Impact on current PGY 2 residents

- Have been doing CBD for Surgical Foundations
  - SF Exam in September 2019
- Will trial Obstetrics & Gynaecology Foundations of Discipline (FOD) EPAs
- Held to 2016 Royal College standards
  - No changes to rotation schedules
- Will benefit by more systematic review by Competence Committee

Impact on PGY3-5 residents

- Held to 2016 or 2013 Royal College standards depending on entry year
  - No rotation schedule changes
  - No EPA completion requirement

- Will benefit from increased direct observation and improved feedback
  - Improved tools: DEEF and O-Scores

- More systematic review by Competence Committee
- Can contribute to EPA assessment for juniors

Impact on New PGY1 residents

- Surgical Foundations: CBD
- Obstetrics & Gynaecology: CBD
- Will be held to 2019 Royal College Standards
- Rotation schedule changes planned

PGY1 -2 Rotation Schedule for CBD Cohort

1	2	3	4	5	6	7	8	9	10	11	12	13
Transition to Discipline (TTD)			Foundations of Discipline (FOD)									
Transition to Residency (TTR)	OB GYN	Community OBGYN	US	ICU	ER	Gen Surg	Family Planning	GynOnc	Community OBGYN	OBGYN	OBGYN	OBGYN

All residents start in Ob/Gyn

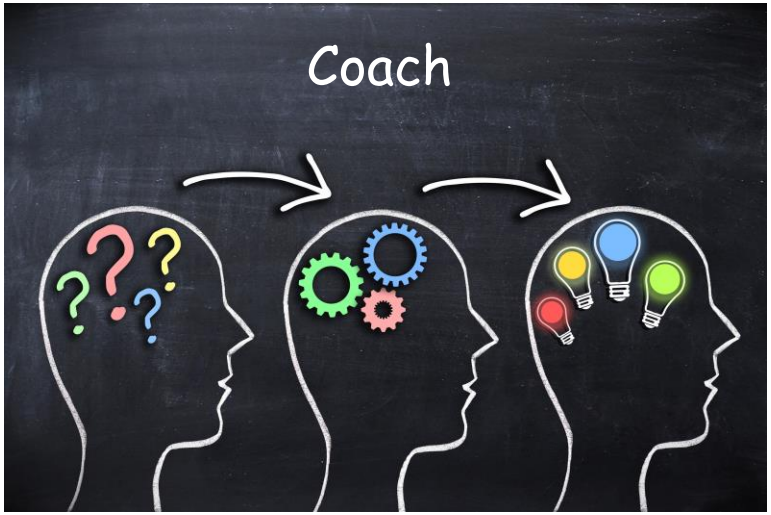
3 residents will start CORE at END of PGY1

1	2	3	4	5	6	7	8	9	10	11	12	13
Foundations of Discipline (FOD)												
Med Inpatient	Med Outpatient	Ambulatory Selective	OBGYN	OBGYN	OBGYN	OBGYN	OBGYN	NICU/ Clinics	OBGYN	OBGYN	OBGYN	OBGYN

3 residents will be off service at start of PGY2

NICU moves to PGY2 as a 2 week rotation

What can I do?



What does this mean for you?

- Day to day no change
- Continue to teach and coach
- Increase your direct observation to inform your feedback
- Provide formative feedback as a coach (document it using the beautiful easy to use electronic platform)
- Leave it to the competence committee to make judgements

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Thank-you!