COMPETENCY BY DESIGN HANDBOOK

UNIVERSITY OF TORONTO
DEPARTMENT OF PSYCHIATRY

Prepared By: Pier Bryden, Sumeeta Chatterjee, Deanna Chaukos, Sarah Colman, Mark Fefergrad, Mara Goldstein and John Teshima
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HANDBOOK PURPOSE

The Competency 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 ‘Competency by Design’ (CBD) model used by the Royal College of Physicians and Surgeon 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 please contact Kristen Sharpe at kristen.sharpe@utoronto.ca or get in touch through the CBD e-mailbox at 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: Competency 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. |
| Competency Committee | The committee that considers if residents move on to the next stage of training based on assessments completed. |
| EPA: Entrustable Professional Activity | An essential task of a "discipline" that an individual can be trusted to perform independently in a given context: Used for assessment Encompasses multiple milestones “What can I safely delegate?” E.g. Develop and implement a management in a patient with a common mental health concern. |
| Milestones | Observable markers of an individual’s ability. E.g. Develop a formulation OR Develop a differential diagnosis OR Implement a biological treatment plan (these milestones are some of the components of the above EPA) |
| TTD: Transition to Discipline | The first stage of the new model for training (for U of T psychiatry, the first month of PGY1, springboard) |
| FOD: Foundations of Discipline | The second stage (for U of T psychiatry, the rest of PGY1 and 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 12 months) |
WHAT IS CBD?

Competency 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.

This graphic illustrates the stages of training under CBD as developed by the Royal College.
RATIONALE FOR TRANSITION TO CBD

The following is the rational 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”*

WHAT IS AN EPA?

In Competency 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, will provide a comprehensive image of their competence and inform promotion decisions.” For example – “develop and implement a management plan in a patient with a common mental health concern.”

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 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.”

Background information on EPAs and the details of each EPA and its milestones appear in Appendix A.
OUR EPAs THUS FAR...

Currently EPAs have been developed for the Transition to Discipline (TTD) and the Foundations of Discipline competencies. All EPAs and Milestones appear in Appendix A.

TRANSITION TO DISCIPLINE (TTD) (Springboard - July PGY1)

<table>
<thead>
<tr>
<th>EPA #</th>
<th>EPA Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTD-1</td>
<td>Obtain a history from a patient presenting with a common mental health concern</td>
</tr>
<tr>
<td>TTD-2</td>
<td>Complete documentation and orders associated with a clinical encounter</td>
</tr>
</tbody>
</table>

FOUNDATIONS OF DISCIPLINE (FOD) (August PGY1 to June PGY2)

<table>
<thead>
<tr>
<th>EPA #</th>
<th>EPA Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOD-1</td>
<td>Perform a Psychiatric Assessment with a common presentation</td>
</tr>
<tr>
<td>FOD-2</td>
<td>Develop and implement a management plan based on a bio-psycho-social-cultural formulation in a patient with a common mental health concern</td>
</tr>
<tr>
<td>FOD-3</td>
<td>Perform a Risk Assessment</td>
</tr>
<tr>
<td>FOD-4</td>
<td>Apply relevant legislation to patient care</td>
</tr>
<tr>
<td>FOD-5</td>
<td>Evaluate the medical stability of a patient with a mental health concern</td>
</tr>
<tr>
<td>FOD-6</td>
<td>Assess and manage agitation and aggression</td>
</tr>
<tr>
<td>FOD-7</td>
<td>Engages in the provision of a short-term, evidence based psychotherapy</td>
</tr>
<tr>
<td>FOD-8</td>
<td>Provide effective feedback to a variety of stakeholders in the health care system</td>
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EPA Matrix – When in the Continuum?

The following graphic illustrates when, in the continuum of residency, the mandatory observed EPAs must occur. These are essential assessments and contribute to determining the overall competency of the resident.

<table>
<thead>
<tr>
<th>Competency Level</th>
<th>PG Residency Timeline</th>
<th># of Psych Rotations</th>
<th>Length of Rotation</th>
<th># of EPAs to Observe per Rotation</th>
<th>Total # of EPAs to Observe during Rotations</th>
<th># of EPAs to Observe during LAE</th>
<th>Total # of Observed EPAs</th>
</tr>
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<tbody>
<tr>
<td>Transition to Discipline</td>
<td>Month 1</td>
<td>1</td>
<td>1 month</td>
<td>2</td>
<td>1x2 = 2</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Foundations of Discipline</td>
<td>Months 2 - 12</td>
<td>4</td>
<td>1 month</td>
<td>3</td>
<td>4x3 = 12</td>
<td>20</td>
<td>12+20 = 32</td>
</tr>
<tr>
<td></td>
<td>Months 13 - 24</td>
<td>3</td>
<td>4 months</td>
<td>10</td>
<td>3x10 = 30</td>
<td>20</td>
<td>30+20 = 50</td>
</tr>
</tbody>
</table>

What you need to know:

- EPAs must be observed on all **psychiatry** rotations:
  - In month 1, that includes 2 EPAs observed during the Springboard block. Each of the Transition to Discipline EPAs will be observed once.
  - In months 2 - 12, that includes: underserved community selective, emergency room psychiatry (x2 - CAMH and/or home base), and consultation liaison psychiatry. It is expected that 3 EPAs are observed during each of the 4 rotations or 12 total observed EPAs.
  - In months 13 - 24, that includes inpatient, child, and geriatric. Each rotation is 4 months long and we are expecting 10 EPAs to be observed in each of the 3 rotations or 30 observed EPAs.

- This works out to each resident undertaking approximately one EPA per week (taking post call and vacation days into consideration).

- During the LAE, 20 EPAs must be observed across the ~ 46 weeks in both PG months 2 – 12 and PG months 13 – 24.

**By the end of 24 months of PG residency, we expect that each resident will be entrusted with each FOD EPA 3 times or 24 out of the total 82 observed EPAs.**
PROPOSED CLINICAL ROTATION STRUCTURE

Rotations moving forward with the implementation of CBD will be structured as follows (these are also the rotations that will be taken by our CBD pilot residents):

Details, regarding the changes in the rotational structure, appear in Appendix E.
As discussed, an EPA is a task of the psychiatry specialty that is used for assessing residents’ competency. We have created an online tool for documenting the observation of EPAs. All CBD based residents receive a username and password for the tool, and a link to the www.psychrocks.ca website where the EPA tool is accessed.

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.) The resident logs on to www.psychrocks.ca using the resident’s phone, a computer or tablet.

5.) The resident **completes the demographic information** and then hands the tool to the supervisor.

6.) The supervisor **completes** the milestones if necessary, and then the overall entrustment scale and narrative feedback. Instead of using two thumbs, try clicking the microphone icon in the textboxes and dictating the feedback. The **narrative feedback is often the most important and meaningful part.** Be specific and constructive.

7.) The supervisor only needs to fill out the entrustment scale at the bottom. 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.
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.
- The creation a training log, akin to what medical students have, to ensure that residents are exposed to what we think is an essential part of training, even if they are not assessed per se. Examples include attending/leading a CCB hearing, starting clozapine, identifying NMS. These are things that may not be observed by a supervisor multiple times during a residency program, but we want to ensure our residents get exposure.
OTHER CHANGES TO THE PROGRAM (AND WHY)

Didactic Curriculum Overhaul

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 PGY1 during Springboard (July) and then likely as short intensives prior to starting clinical rotations. 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, the LAE will be a full day per week with increasing independence deemed appropriate for the individual resident. In more senior years, the residents’ LAE can be tailored to their 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 our transition to CBD be informed by multiple stakeholders. 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 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 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.
4) The 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 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 consists of various stakeholders including learners, physicians-in-chief, divisional leads, health systems experts and educational scientists. They meet 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 serves to provide another mechanism of feedback from relevant groups (e.g physicians-in-chief).
The Memberships of the CBD Subcommittees appear in Appendix F.
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: Is the EPA e-tool live now?
A: Yes, the EPA e-tool is live and ready for use! Residents have been trained and know how to access it and complete it.

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 competency committee.

Q: Are there still rotation specific objectives in CBD?
A: Yes, please review the rotation specific objectives at the beginning of the rotations.

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 non consistently had opportunities to complete these EPAs. So...not to worry...these EPAs can be carried forward and be completed through the Fall either during call or during an ER rotation. We will monitor progress and communicate if any further changes need to be made.

Q: Will staff have their own accounts in the EPA tool?

A: No – the EPA tool is resident driven and the residents use their own accounts.

Q: Can nursing and allied health team members complete the EPAs for the residents?

A: For now, it’s just the physician faculty who can complete the resident’s EPAs but we are working towards a more balanced and open process. We hope in the future that allied health can complete the EPA tool but we are awaiting direction from central postgrad before implementing.

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

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

Q: Why don’t we have an app for the EPA tool?

A: This is because apps need updating for all platforms (e.g. IOS, Android, etc.) with each new change and we anticipate needing to change this tool as
we learn what works and what does not. Also, we will be receiving a fancy and shiny tool from central PostMD at the University of Toronto in a few years, and this tool is only being used in the meantime.

Q: What is the purpose or goal of the homeroom experience?
A: Homeroom is designed to:

- Create an opportunity for residents to get together, even when on disparate services.
- Create a space to talk about professional identity development.
- Highlight the intersections between medical and mental health.

There is a consistent curriculum across hospital sites but the sites are welcome to showcase local talent and/or issues.

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. The basic unit of EPA assessment is that of entrustment. 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.

The Psychiatry Specialty Committee of the Royal College will ultimately determine EPAs nationally. In the interim, the University of Toronto, through extensive consultation, has created a series of EPAs. They 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.

The U of T EPAs are specifically designed to be easy to use and observe in common clinical settings. As a result, there are relatively few in number with only a small number of milestones. 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 Competency Committee reviews all EPA observations and provides feedback with respect to progress or opportunities to improve.
TRANSITION TO DISCIPLINE #1: OBTAIN A HISTORY FROM A PATIENT PRESENTING WITH A COMMON MENTAL HEALTH CONCERN

Short Description:
Obtain a relevant and accurate history of the present illness from a patient who presents with a single prominent mental health concern.

Assessment Plan Summary:
- Direct Observation (mobile assessments, encounter cards in clinical situations and seminars)
- OSCE

Milestones:

**Performs an interview that covers pertinent data on the presenting complaint or problem**
1. Addresses pertinent diagnostic criteria for presenting complaint and other regularly comorbid illnesses
2. Elicits stressors related to presenting illness
3. Screens for mood symptoms
4. Screens for anxiety symptoms
5. Screens for psychotic symptoms
6. Screens for substance use

**Presents the history of the present illness**
1. Presents case in an orderly, concise, systematic manner that is sufficiently detailed
2. Addresses pertinent positives, negatives and items that were missed while obtaining a history

**Be aware of major diagnostic categories in the DSM**
1. Bipolar and related disorders
2. Depressive disorders
3. Schizophrenia spectrum and other psychotic disorders
4. Anxiety disorders
5. Substance related and addictive disorders
6. Personality disorders
7. Obsessive compulsive and related disorders
8. Trauma and stressor related disorders

**Communicates effectively and interacts in a respectful and professional manner**
1. Introduces self
2. Explains interview
3. Remains respectful and nonjudgmental
4. Genuine interest displayed by verbal and non-verbal responses
5. Acknowledges patient’s distress with empathic responses
6. Interrupts or redirects politely when required
7. Facilitates organization of disorganized patients
8. Engages patient in a culturally appropriate manner

**Scope:** Adult in a clinical or educational setting
TRANSITION TO DISCIPLINE #2: COMPLETE DOCUMENTATION AND ORDERS ASSOCIATED WITH A CLINICAL ENCOUNTER

Short Description:
Write relevant documentation and orders for a patient who presents with a mental health concern

Assessment Plan:
● Direct Observation/Review of Document
● Written Exam

Milestones:

**Write a clinical note**
The note should be an accurate portrayal of the clinical encounter, including pertinent positives and negatives. There should be a clear diagnosis and management plan. The expectation is that the learner be able to document the history taken, but will require assistance in completing the remaining portions of the diagnosis and management plan.

**Write a mental status exam**
The Mental Status Examination should cover all major domains of a standard MSE.

**Write appropriate orders**
A learner should be able to complete a standard set of orders using an acceptable format. Medication orders should include route of administration, dosage, generic medication name and timing of administration, with appropriate abbreviations. PRN medications should include indication and maximum daily dosage. These orders should be placed in relevant medical record format for the setting (i.e. electronic records).

**Note is legible and content is clear**
This speaks to the utility of the note and whether it can be understood by other health care providers.

Scope: Adult in clinical setting
FOUNDATIONS OF DISCIPLINE #1: PERFORM A PSYCHIATRIC ASSESSMENT WITH A COMMON PRESENTATION

Short Description:
Learner should be able to perform a basic psychiatric assessment with a patient presenting with common mental health concerns such as psychosis, mood, substance, anxiety and personality disorders. Learner should be able to differentiate a primary and initial diagnosis to inform the initial management plan.

Assessment Plan Summary:
- All Psychiatry rotations in PGY1 and PGY2 - must pass at least one through direct observation with all milestones met (must be once /month).

Milestones:

Establishes and maintains rapport and effective therapeutic alliance
Communicates with empathic non-judgemental responsiveness to patients

History gathering is appropriately comprehensive to establish a diagnosis and inform a management plan
Gathers an appropriate history regarding risk (self and others)

Adjusts interview content and style to the patient’s presentation
1. Adapts the interview based on patient’s acuity, level of distress and cognitive abilities
2. Adapts language to patient

Obtains and integrates collateral information, medical investigations and other data needed to construct a comprehensive formulation

Scope: Any patient in a clinical setting
FOUNDATIONS OF DISCIPLINE #2: DEVELOP AND IMPLEMENT A MANAGEMENT PLAN BASED ON A BIO-PSYCHO-SOCIAL-CULTURAL FORMULATION IN A PATIENT WITH A COMMON MENTAL HEALTH CONCERN

Short Description: The Learner should demonstrate competence in formulating patients and developing, implementing, and monitoring a management plan in a variety of psychiatric settings for patients with common mental health concerns.

Assessment Plan Summary:
- General, Child and Geri STACERs
- Psychodynamic Case Report

Milestones:

Develop and document a bio-psycho-social-cultural formulation
1. Formulation should be specific to the patient
2. Formulation should include an appropriate organizational structure (grounded in a patient’s predisposing, precipitating, perpetuating and protective bio-psycho-social-cultural factors)

Develop a differential diagnosis and justify the preferred diagnosis
1. List at least 3-4 reasonable diagnoses
2. Provide a rationale for your preferred diagnosis and exclusion of others.

Develop a treatment plan that incorporates biological, psychological, social and cultural considerations
1. Obtain informed consent
2. Order investigations required to start a specific medication
3. Initiate and titrate an evidence-informed pharmacological intervention
4. Monitor for common and serious side effects and response to medication
5. Initiate and monitor side effects and response to ECT and/or rTMS
6. Identify and manage barriers to compliance
7. Consider potential drug interactions and medical comorbidities
8. Be aware of, and access as indicated, institutional, municipal, provincial and other appropriate resources
9. Suggests care that incorporates psychotherapeutic skills
10. Considers patient’s social supports with resources and care as indicated

Conveys the formulation, diagnosis and plan accurately and clearly
1. Uses a bio-psycho-social-cultural framework
2. Identifies short, medium and long term management goals
3. Links the formulation to the management plan
4. Communicates effectively

Scope: Any age group in a clinical or educational setting
FOUNDATIONS OF DISCIPLINE #3: PERFORM A RISK ASSESSMENT

Short Description:
Assess a patient with respect to risk. The focus of this EPA is on suicidality, though the learner should be able to perform a basic inquiry into other relevant areas of risk as described in the fourth milestone.

Assessment Plan Summary:
- Any psychiatry rotation

Milestones:

**Elicit a suicide risk history**
1. Elicits details of the events leading up to the ideation and/or attempt
2. Elicits details of the attempt itself if relevant
3. Demonstrate knowledge of risk factors for suicide and risk stratification in multiple patient populations
4. Recognize and appreciate the implications of various diagnoses related to suicidal ideation and attempts
5. Comprehensively document and communicate their risk assessment

**Elicit and identify pertinent protective factors**
1. Asks about supports and important relationships
2. Asks about patient’s reasons to continue living
3. Assesses future orientation

**Determine intent and assess potential lethality after a suicide attempt**
1. Elicits details of how the patient behaved after the suicide attempt in an attempt to determine risk
2. Identify and utilize important sources of collateral information
3. Demonstrate understanding of self harm versus suicidal ideation

**Assess non-suicidal risk**
1. Assesses risk to minors
2. Assesses homicidal ideation
3. Assesses risk of driving
4. Aware of duty to warn
5. Self-care and physical impairment risk

Scope: Any patient in any clinical setting with suicidal ideation or an attempt e.g. ER, outpatient, inpatient
FOUNDATIONS OF DISCIPLINE #4: APPLY RELEVANT LEGISLATION TO PATIENT CARE

Short Description:
Apply major healthcare legislation in a way that is consistent with the meaning and spirit of the relevant acts and aims to balance the complicated tensions between individual and societal rights.

Assessment Plan Summary:
• Any psychiatry rotation

Milestones:

Completes the appropriate Mental Health Act form or Health Care Consent Act for the clinical situation
1. Demonstrate understanding of criteria for one of the following: Form 1, 3, 4 or capacity, or community treatment order
2. Assess the validity for one of a Form 1, 3, 4, 33 completed by another physician
3. Accurately complete one of: Form 1, 3, 4, 33, CTO documentation
4. If applicable, differentiates between the criteria for box A and B

Provide the patient with the relevant notification under the Mental Health Act
1. Deliver a Form 30, 33, 42, CTP and other relevant CTO forms to a patient and explain the implications
2. Accurately complete one of a Form 30, 33, 42 or CTO documentation

Documents in the chart all relevant information related to the completion of Mental Health Act Form
1. Comprehensively document the clinical encounter
2. Document the application for rights advice where relevant
3. Document the review and filing with the officer in charge where relevant

Communicates the meaning of the Form to the patient being detained, including their right to appeal
1. Provides the form in a timely manner
2. Communicates empathically regarding the patient’s rights
3. Pays attention to the impact on the doctor-patient relationship

Scope: Patient in a clinical or educational setting
FOUNDATIONS OF DISCIPLINE #5: EVALUATE THE MEDICAL STABILITY OF A PATIENT WITH A MENTAL HEALTH CONCERN

Short Description:
Be aware of, and take steps to manage, important medical co-morbidities in an inpatient or emergency room setting.

Assessment Plan Summary:
• In ER, on Unit, standardized cases or simulation

Milestones:

Collaborate with health care providers for consultation requests
1. Obtain medical history from referral source
2. Review physical findings including vital signs
3. Recognize urgent and emergent medical issues

Assess medical contributors to psychiatric presentations
1. Recognize psychiatric symptoms manifesting from medical illnesses
2. Refer to medical and/or surgical specialty services when indicated

Recognize toxidromes or acute medical illnesses in the psychiatric emergency environment
1. Use toxicology screening tests and other investigations to ascertain medical causes of illness
2. Recognize patients risk of acute medical deterioration
3. Utilize CIWA protocol appropriately
4. Recognize and differentiate states of intoxication and withdrawal

Understand the principles of psychopharmacology in the medically compromised
1. Understand the use of psychotropic medications in patients with prolonged QTc
2. Understand the use of psychotropic medications in patients with renal or hepatic impairment
3. Understand the use of psychotropic medications in patients with metabolic co-morbidities

Scope: Patient in the ER or inpatient setting
FOUNDATIONS OF DISCIPLINE #6: ASSESS AND MANAGE AGITATION AND AGGRESSION

Short Description:
The Learner is able to assess and manage acute agitation and aggression in a psychiatric setting.

Assessment Plan Summary:
- The Learner should gain competence in the identification, assessment, and management of acute aggression, both individually and in a team setting, incorporating the local mechanisms to address safety issues.

Milestones:

Assess an agitated patient and construct a broad differential diagnosis, including psychiatric and non-psychiatric causes.
1. Construct a differential diagnosis
2. Identify salient risk factors for aggression
3. Link mental status findings to risk of aggression
4. Recognize and investigate toxidromes and medical causes of agitation
5. Interpret laboratory and radiographic results

Create a safe environment for the patient, self, and team
1. Be aware of positioning in the room
2. Bring appropriate support
3. Maintain easy access to means of egress
4. Be aware of local mechanisms to summon help when required
5. Be aware of sharps and other items that could be used as weapons
6. Use de-escalation and other non-pharmacological strategies to promote safety
7. Recognize the impact of the interventions on the patient

Implement a comprehensive pharmacologic management plan for agitation and aggression
1. Select appropriate acute pharmacological interventions and route of administration
2. Write orders for chemical and mechanical restraints and associated monitoring protocols
3. Recognize and manage side effects

Collaborate with an interprofessional health care team to manage agitation (e.g. code white)
1. Explain and use local safety mechanisms
2. Communicate clearly with security team
3. Participate in running a Code White with an awareness of the roles of all team members
4. Participate in a team debrief

**Scope:** Adult in simulation, emergency department, or inpatient unit
FOUNDATIONS OF DISCIPLINE #7: ENGAGES IN THE PROVISION OF A SHORT-TERM, EVIDENCE BASED PSYCHOTHERAPY

Short Description:
Learner should be able to assess a patient for suitability or interpret an existing assessment through that frame. Learner should be aware of the fundamental common factors that hold across multiple psychotherapeutic modalities. Establish a therapeutic frame and manage boundaries and countertransference that are integral to this process.

Assessment Plan Summary:
- Psychotherapy Case Supervision

Milestones:

**Establish a therapeutic frame**
1. Establish a regular schedule
2. Establish other norms around the meeting including appropriate language, location etc.
3. Establish and communicate rules around lateness and absences

**Set boundaries and be aware of crossings**
1. Be aware of boundary crossings by the patient
2. Be aware of learner’s boundary crossings
3. Manage simple crossings like small gifts and changes to frame
4. Devise an approach to communication by phone and electronic means

**Manage reactions to patients**
1. Articulate reactions in supervision
2. Use reactions therapeutically

**Differentiate between objective and subjective countertransference**
1. Use objective countertransference therapeutically
2. Devise an approach to manage and self-regulate affect

Scope: Ongoing therapeutic relationship with a patient
Short Description:
Providing feedback to patients, colleagues and supervisors is an essential skill in a complex system. Incorporating both supportive and critical comments in a way that is descriptive and actionable, can help stakeholders to reflect on their role in the provision of health care and education.

Assessment Plan Summary:
- During supervision, team meetings, family meetings

Milestones:

**Provide specific feedback to a patient, their family, a learner or health professional colleague about an element of their behaviour that you appreciate.**
1. Use clear descriptive language
2. Use examples

**Provide constructive, specific feedback to a patient, their family, a learner or health professional colleague about an element of their behaviour that you believe could be optimized to improve an outcome.**
1. Use clear descriptive language
2. Use examples
3. Describe the desired outcome

**Adjusts and responds to the comments and affect of the recipient of the feedback**
1. Pays attention to non-verbal cues
2. Adjusts language and tone as necessary
3. Act in a respectful and professional way

**Solicit feedback on your feedback from the relevant stakeholder**
1. Ask for feedback on the safety of the environment you created
2. Ask for the recipient’s reaction to the feedback
3. Demonstrate active empathic listening

**Scope:** Any relevant clinical encounter or educational feedback session
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…”


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
  - 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
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:
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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.
Stage 4. Coach for performance change

Goal: for the resident to identify areas for change and develop an achievable learning/change plans.

Stage 4 Strategies and sample phrases

Before developing a learning/change plan, residents need to understand and accept the content of their assessment.

Consider coaching as:

- guiding the development of goals and activities to achieve them
- supporting self-directed learning
- the "skill of offering solutions."
- ensuring a concrete plan is developed

- "What do you see as the priority/s for your improvement?"
- "What would you like to achieve for your next rotation?"
- "What 1-2 things would you target for immediate action?"
- "What would be your goal for this?"
- "What actions will you have to take?"
- "Who/what might help you with this change?"
- "What might get in the way?"
- "What else might you do to progress to the next level?"
- "Do you think you can achieve it?"


Evidence-Informed Feedback Research Team:
- Dalhousie University
  - Joan Sargeant (PI)
  - Karen Mann
  - Andrew Warren
  - Michelle Boudreau
  - Tanya MacLeod
- University of Toronto
  - Ivan Silver
  - Sophie Soklaridis
- University of Alberta
  - Heather Armson
  - Jocelyn Lockyer
- Rutgers University Medical School
  - Marygrace Zetkolic
- Maastricht University
  - Erik Driessen
  - Karen Konings
- American Board of Internal Medicine
  - Lorna Lynn
  - Kathryn Ross
- Accreditation Council for Graduate Medical Education
  - Eric Holmboe
- College of Physicians and Surgeons Nova Scotia
  - Mary Power
- College of Physicians and Surgeons Ontario
  - Wendy Yen

For information on the R2C2 model, please contact:
- Joan Sargeant PhD
  - Dalhousie University, Halifax, NS, CA
  - joan.sargeant@dal.ca
APPENDIX D: GUIDING PRINCIPLES

Coming Soon!
APPENDIX E: 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 sub-specialty rotations (child and geriatrics) earlier into training so that there is a more developmental approach to mental illness and to allow residents interested in applying for the sub-specialties 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 selective and inpatient rotations at later stages of training

2) Increasing the overall amount of time in the ER

3) Development of a 5-year Longitudinal Ambulatory Experience

4) Increased time with underserved and addictions populations

5) 3 new months of elective time in PGY3 and 4 new months of elective time in PGY4
APPENDIX F: CBD SUBCOMMITTEES AND MEMBERSHIP

CBD EXECUTIVE ADVISORY SUBCOMMITTEE

CHAIR:

- Sarah Colman
- Mark Fefergrad

MEMBERSHIP:

- Pier Bryden
- Tara Burra
- Carole Cohen
- Kenneth Fung
- Ben Goldstein
- Mara Goldstein
- Rida Hashmi (resident)
- Raed Hawa
- Jonathan Hsu (resident)
- Paul Kurdyak
- Naomi Mudachi (resident)
- Maria Mylopoulos
- Sanjeev Sockalingam
- Glendon Tait
- Adrienne Tan
- John Teshima
- Lesley Wiesenfeld
CBD OPERATIONS SUBCOMMITTEE

CHAIR:

- Sarah Colamn
- Mark Fefergrad

MEMBERSHIP:

- Pier Bryden
- Sumeeta Chatterjee
- Deanna Chaukos
- Mara Goldstein
- Sarah Levitt (resident)
- John Teshima
CBD CURRICULUM SUBCOMMITTEE

CHAIR

- Sarah Colman

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- Elia Abi-Jaoude
- Prakash Babani
- Kaitlin Baenziger (resident)
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- Amy Cheung
- Lucy Costa
- Shaheen Darani
- Mara Goldstein
- Daniel Gorman
- Cindy Grief
- Mark Halman
- Tamara Hoppe
- Donna Kim
- Wiplov Lamba
- Yona Lunsky
- Josee Lynch
- Rob Madan
- Joey Martinovic
- Lindsey MacGillivray
- Diane Meshino
- Alpna Munshi
- Jared Peck
- Aviva Rosatas
- Ben Rosen
- Karen Shin
- Ivan Silver
- Albert Wong
- Nikki Woods
CBD Competency Subcommittee

Chair:
- Sumeeta Chatterjee

Membership:
- Matt Boyle
- Sarah Colman
- Mark Fefergrad
- Mark Hanson
- Donna Kim
- Ilana Shawn
- Walter Tavares

CBD Faculty Development Subcommittee

Coming Soon!
CBD LEARNER EXPERIENCE SUBCOMMITTEE

CHAIR

• Deanna Chaukos
• Sarah Levitt (resident)

MEMBERSHIP

• John Aoun - PGY1 SHSC
• Phoebe Bao - PGY3 HRH
• Rachel Carr - PGY2 SHSC
• Tanner Isinger - PGY1 SHSC
• Candice Kung - PGY4 UHN
• Geoff Leblond - PGY1 SMH
• David Lee - PGY1 SMH
• Justan Lougheed - PGY1 SHSC
• Anthony Maher - PGY1 MSH
• John Perdue - PGY1 SMH
• Houman Rashidian - PGY1 UHN
• Hamza Riaz - PGY1 UHN
• Riley Rose - PGY3 MSH
• Rafae Wathra - PGY1 SMH
• Siqi Xue - PGY2 CBD Pilot
CBD PROGRAM EVALUATION SUBCOMMITTEE

CHAIR:

- Pier Bryden

MEMBERSHIP:

- Zenita Alidina (resident)
- Sarah Colman
- Bruce Fage (resident)
- Mark Fefergrad
- Susan Glove Takahashi
- Mara Goldstein
- Anthony Levitt
- Susan Lieff
- Betty Lin
- Bob Maunder
- Kathryn Parker
- Sophie Soklaridis
- Rosalie Steinberg