COMPETENCY BY DESIGN HANDBOOK

UNIVERSITY OF TORONTO
DEPARTMENT OF PSYCHIATRY

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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 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.
# Glossary of Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBME: Competency Based Medical Education</td>
<td>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)</td>
</tr>
<tr>
<td>CBD: Competency by Design</td>
<td>The Royal College branding of CBME.</td>
</tr>
<tr>
<td>Competencies</td>
<td>Observable, can be measured and assessed to ensure their acquisition, and integrate, knowledge, skills, values and attitudes.</td>
</tr>
<tr>
<td>Competency Committee</td>
<td>The committee that considers if residents move on to the next stage of training based on assessments completed.</td>
</tr>
</tbody>
</table>
| EPA: Entrustable Professional Activity | An essential task of a "discipline" that an individual can be trusted to perform independently and safely in a given context.  
  - Used for assessment  
  - Encompasses multiple milestones  
  - "What can I safely delegate?"  
  E.g. Perform a Psychiatric Assessment in a patient with a common presentation. |
| 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 PGY1-2s as well as our PGY3 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 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 the final 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 measurable 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.
Who decides if the resident “passes” from one stage to the next?

All assessments (EPAs, STACERs, tests/exams, etc.) are reviewed by the Psychiatry Competency 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 elective 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, Competency 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.
RATIONAL 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, provide a comprehensive image of their competence and inform promotion decisions.” For example – “Develop and implement a management plan based on a bio-psycho-social-cultural formulation 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 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.”

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 the PsychRocks tool, which will usually be provided to you by the resident on their phone. More information can be found in the EPA Tool section in this Handbook. It can also be accessed [here](#) on your own device (please have the resident login instead of you). You will rate the resident’s overall performance of the EPA, using this scale:

<table>
<thead>
<tr>
<th>Entrustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
</tr>
<tr>
<td>Required the supervisor to do</td>
</tr>
<tr>
<td>Direction</td>
</tr>
<tr>
<td>Required supervisor direction</td>
</tr>
<tr>
<td>Guidance</td>
</tr>
<tr>
<td>Required guidance</td>
</tr>
<tr>
<td>Autonomy</td>
</tr>
<tr>
<td>Supervisor needed to be available, just in case</td>
</tr>
<tr>
<td>Excellence</td>
</tr>
<tr>
<td>Supervisor didn’t need to be there</td>
</tr>
</tbody>
</table>

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?

Except for TTD EPAs (which only need to be completed once), residents are expected to become “entrustable” in each EPA at least 3 times each training stage (see table below). 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.

- **2 Transition to Discipline (TTD) EPAs**
  - First 3 months of PGY-1

- **6 Foundations of Discipline (FOD) EPAs**
  - PGY-1 through PGY-2

- **10 Core of Discipline (COD) EPAs**
  - PGY-3 through PGY-4
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) (~months 1 - 3)**

<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) (~months 2 – 24)**

<table>
<thead>
<tr>
<th>EPA #</th>
<th>EPA Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOD-1</td>
<td>Perform a Psychiatric Assessment in a patient 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>Perform critical appraisal and present psychiatric literature</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>EPA #</th>
<th>EPA Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>COD-1</td>
<td>Perform a Psychiatric Assessment for a patient presenting with complex mental health concerns</td>
</tr>
<tr>
<td>COD-2</td>
<td>Develop a comprehensive bio-psycho-social-cultural formulation during an assessment</td>
</tr>
<tr>
<td>COD-3</td>
<td>Develop and deliver (as appropriate) a management plan</td>
</tr>
<tr>
<td>COD-4</td>
<td>Manage urgent/emergent medical psychiatric conditions (NMS, Acute Dystonia)</td>
</tr>
<tr>
<td><strong>COD-5</strong></td>
<td>Communicate information to families or caregivers</td>
</tr>
<tr>
<td><strong>COD-6</strong></td>
<td>Assess and manage agitation and aggression</td>
</tr>
<tr>
<td><strong>COD-7</strong></td>
<td>Initiate and manage patient care using neurostimulation across the lifespan</td>
</tr>
<tr>
<td><strong>COD-8</strong></td>
<td>Integrate the principles and skills of psychopharmacology</td>
</tr>
<tr>
<td><strong>COD-9</strong></td>
<td>Teach students, residents, the public and other healthcare professionals</td>
</tr>
<tr>
<td><strong>COD-10</strong></td>
<td>Engage in the provision of psychotherapy modalities</td>
</tr>
</tbody>
</table>
EPA Tool – How & When to Use It…

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 http://psychrocks.psychiatry.utoronto.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 http://psychrocks.psychiatry.utoronto.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 dictate 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.
EPA TOOL 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, ITERs, and other outstanding performance items/issues. Please make sure that two of these check-in meeting take place in the few weeks prior to the bi-annual Psychiatry Competence Subcommittee meetings (i.e. November and April).

Each CBD Coach has their own PsychRocks 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 PsychRocks?**

1) You can assess PsychRocks by visiting:  
   [https://psychrocks.psychiatry.utoronto.ca](https://psychrocks.psychiatry.utoronto.ca)

2) You will see a menu close to the top of your browser beside the Psychiatry logo. Select “Coaches View”

Select the resident you are coaching.

![Search by Resident](image)

![Select EPAs](image)

Submit

Note: you should only be able to see the data for residents who you are coaching. Please let us know if you are seeing information for residents you are not coaching or cannot access your own residents.

a. To view EPAs completed by a particular resident, select the EPA category (TTD, COD, FOD) e.g. I want to see all of the submitted
Transition to Discipline (TTD) for the resident. See below for an example.

b. you should also be able to view all EPAs completed by a resident regardless of EPA category e.g. I want to see TTDs, CODs, and FODs at the same time.
   - in the pulldown menu select the resident and click Submit

If your resident has a variety of EPAs completed you should see a list like the one below:
c. To view specific EPAs completed by a particular resident, you select the EPA category i.e. Transition to Discipline (TTD), Foundations of Discipline (FOD), Core of Discipline (COD).
   ➢ This will trigger a dropdown menu with a list of all available EPAs in that category. Select the EPA you are looking for.

   e.g. I want to see all COD1s submitted for a resident:

   Search by Resident

   Select EPAs
   COD

   CODs
   COD1: Perform a psychiatric assessment for a patient presenting with complex mental health concerns

   If you want to see the entire COD entries, leave drop down BLANK and submit

   Submit
FAQ:

1) I am a new user and/or I don’t think I have an account. Please connect with Tammy (tammy.mok@utoronto.ca) for assistance.

2) I don’t remember my login information (username/password). Please connect with Tammy (tammy.mok@utoronto.ca) for assistance.

3) I can see other residents that I am not coaching. Please connect with Tammy (tammy.mok@utoronto.ca).

4) I am both the LAE supervisor and CBD Coach for a resident. Is this a conflict? No. This is currently one of the coaching models we are using. If you are completing EPAs for your resident during LAE, you should be using the resident’s account to complete the EPA. If you are reviewing progress with your resident in your capacity as a CBD Coach, you may use your account to do so.
Residents should be getting 1 EPA assessed per week when on psychiatry rotations, one every 2 weeks on LAE. If they have fewer EPAs than that, troubleshoot how to get more with the resident.

5) **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. Agitation and aggression in the ER).

6) **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.

7) **Should I still be reviewing ITERs with the coachee?**
   Yes, review ITERs (resident can provide these for your review) for any themes/patterns of growth/concern.

8) **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).

9) **Can I see all of the EPAs completed by my resident, regardless of stage of training?**
   Yes, you can see all EPAs submitted in a resident’s profile by going to Coaches View, filter by resident but do not make a selection under the “Select EPAs” menu, hit submit and you will see all of their EPAs.
Rotations moving forward with the implementation of CBD will be structured as follows:

<table>
<thead>
<tr>
<th>Blocks</th>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
<th>PGY4</th>
<th>PGY5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Transition to Discipline (1 month)</td>
<td>1 month Underser’d Comm Selective</td>
<td>4 months Child Psychiatry</td>
<td>3 months Inpatient</td>
<td>Academic</td>
</tr>
<tr>
<td>2</td>
<td>2 months Emergency Room Psychiatry</td>
<td>1 month C/L Psychiatry</td>
<td>3 months Severe Persistent Mental Illness</td>
<td>3 months C/L Psychiatry</td>
<td>Academic</td>
</tr>
<tr>
<td>3</td>
<td>1 month PLEX*</td>
<td>2 month Addictions/ 2 months PLEX*</td>
<td>2 months Emergency Room Psychiatry</td>
<td>2 months Addictions</td>
<td>Academic</td>
</tr>
<tr>
<td>4</td>
<td>7 months Psychiatric Medicine</td>
<td>4 months Inpatient</td>
<td>2 months Underserved Community</td>
<td>4 months PLEX*</td>
<td>PLEX = Personalized Learning Experience</td>
</tr>
<tr>
<td>5</td>
<td>Longitudinal Ambulatory Experience</td>
<td>Academic</td>
<td>Academic</td>
<td>Integrated Mental Health Care</td>
<td>Academic</td>
</tr>
<tr>
<td>6</td>
<td>Core of Discipline (24 months)</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
</tr>
<tr>
<td>7</td>
<td>4 months Geriatric</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
</tr>
<tr>
<td>8</td>
<td>Longitudinal Ambulatory Experience</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
</tr>
<tr>
<td>9</td>
<td>Transition to Practice (12 months)</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
</tr>
<tr>
<td>10</td>
<td>12 months Transition to Practice PLEX*</td>
<td>Academic</td>
<td>Academic</td>
<td>Integrated Mental Health Care</td>
<td>Academic</td>
</tr>
<tr>
<td>11</td>
<td>Academic</td>
<td>Integrated Mental Health Care</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
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<tr>
<td>12</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
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<tr>
<td>13</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
<td>Academic</td>
</tr>
</tbody>
</table>

*PLEX = Personalized Learning Experience
EPA Attempts & Achievement: When in the Continuum?

The graphic below illustrates the target EPA attempts for PGY1, PGY2, and PGY3:

**Foundations of Discipline**

EPA Target Attempts

<table>
<thead>
<tr>
<th>PGY1</th>
<th>PGY2</th>
<th>PGY3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psych ER (CAMH) 3 Observed</td>
<td>Psych ER (Base) 3 Observed</td>
<td>ER 6 Observed</td>
</tr>
<tr>
<td>3 Observed</td>
<td>3 Observed</td>
<td>6 Observed</td>
</tr>
<tr>
<td>C/L 3 Observed</td>
<td>Addiction/Selective 10 Observed</td>
<td>Addiction 6 Observed</td>
</tr>
<tr>
<td>3 Observed</td>
<td>10 Observed</td>
<td>6 Observed</td>
</tr>
<tr>
<td>LAE 20 Observed</td>
<td>LAE 20 Observed</td>
<td>LAE 20 Observed</td>
</tr>
</tbody>
</table>

= 29 EPA Attempts

= 50 EPA Attempts

= 54 EPA Attempts

By the end of PGY2, 3 of each FOD EPA should be entrustable = 21 of the 79 Attempts

**Core of Discipline**

EPA Target Attempts

Note: we are expecting that each COD EPA should be entrustable 3 times by the end of PGY4. We will delineate recommended attempt numbers for PGY4 in the coming year.

In months 2-12 of residency training (PGY1), the EPAs should be observed during the Emergency Room Psychiatry rotations (Base ad CAMH) and Consultation Liaison Psychiatry rotation. 3 EPAs should be observed during each of the rotations or 9 total observed EPAs. The EPAs can be attempted as often as a resident wishes - more is always better. Residents are not required to complete EPAs when off-service.

In months 13-24 (PGY2) the EPAs should be observed during all rotations including: Inpatient, Child, Addictions and Selectives. In each 4-month rotation (child and inpatient), 10 EPAs should be observed. In each 2-month rotation (addictions/selectives) 5 EPAs should be observed. This totals 30 EPAs across all PGY2 rotations.

During the LAE (for both PGY1s and PGY2s), 20 EPAs must be observed across the ~46 weeks of 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. By the end of the first 24 months of PG training, it is expected that each
resident is entrusted with each FOD EPA 3 times or 24 times out of the total 79 observed.
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.
**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 PGY1 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, 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 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
feedback from relevant groups (e.g. physicians-in-chief). The CBD Executive Advisory Subcommittee no longer exists as of July 2019.

The Memberships of the CBD Subcommittees appear in Appendix E.
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 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 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 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 a resident complete and EPA on another resident?
A: Yes! You need at least 50% of your EPAs to be completed by faculty, but the other 50% can be completed by residents. 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 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: Am I correct that supervisors still complete POWER evals in addition to signing off on EPAs for PGY1s? Is there a way to integrate both somehow or streamline?
A: You are correct. Ultimately, the ITER will be transformed into an ITAR. They are not summative evals 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). We need to establish that the EPAs are being done and actually represent something “real” before we make that switch. We’re essentially keeping the ITERs as a backup for the moment (to determine pass/fail) in case there are EPA problems. I would anticipate that the ITARs will start to roll out July 2019 and it will take a year or two to convert them all... it’s coming!
Q: What are coaches meant to do during the coaching sessions?

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

Q: Are the Wednesday Academic 1/2 days being cancelled for all years next year (2019/20 academic year)?

Not cancelled but adjusted. PGY1 will still have the Wednesday 1/2 day. PGY2 will not. PGY2 will have 2-3 days of didactic teaching at the start of each rotation, then an additional day of didactic teaching at the end of the second month and the end of the third month of the rotation. PGY3s will similarly have didactic teaching embedded in the clinical rotations – some of these details are still being worked out.

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 Options:
● Direct observation in clinical situations or educational seminar
● OSCE (if applicable station)

Scope:
● Adult in a clinical or educational setting

Possible Clinical Settings:
● Any psychiatry rotation

Milestones:

Performs an interview that covers pertinent data on the presenting complaint or problem
● Addresses pertinent diagnostic criteria for presenting complaint and other common comorbid illnesses
● Elicits stressors related to presenting illness
● Screens for mood symptoms
● Screens for anxiety symptoms
● Screens for psychotic symptoms
● Screens for substance use
● Screens for trauma

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

Be aware of major diagnostic categories in the DSM
● Bipolar and related disorders
● Depressive disorders
● Schizophrenia spectrum and other psychotic disorders
● Anxiety disorders
● Substance related and addictive disorders
● Personality disorders
● Obsessive compulsive and related disorders
• Trauma and stressor related disorders

**Communicates effectively and interacts in a respectful and professional manner**

- Introduces self
- Explains interview
- Remains respectful and nonjudgmental
- Genuine interest displayed by verbal and non-verbal responses
- Acknowledges patient’s distress with empathic responses
- Interrupts or redirects politely when required
- Facilitates organization of disorganized patients
- Engages patient in a culturally appropriate manner
- Engages patient in a trauma-informed manner
TRANSITION TO DISCIPLINE #2: COMPLETE DOCUMENTATION AND ORDERS ASSOCIATED WITH A CLINICAL ENCOUNTER

Short Description:
Write relevant documentation of history and orders/prescription, if applicable, for a patient who presents with a mental health concern.

Assessment Options:
● Direct observation
● Review of documentation
● Written exam
● OSCE (if applicable station)

Scope:
● Adult in clinical or educational setting

Possible Clinical Settings:
● Any psychiatry rotation

Milestones:

Write a clinical note
The note should be an accurate portrayal of the clinical encounter, including pertinent positives and negatives. 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 or prescription 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.
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 Options:
● Direct observation
● Mock STACER
● STACER

Scope:
● Any patient in a clinical or educational setting

Possible Clinical Settings:
● Any psychiatry rotation

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
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 Options:
- Direct observation
- Psychodynamic case report
- Mock STACER
- STACER

Scope:
- Any patient in a clinical or educational setting

Possible Clinical Settings:
- Any psychiatry rotation

Milestones:

Develop a comprehensive formulation that takes into account biological, psychological, social, cultural including developmental and spiritual factors (i.e. the bio-psycho-social model) and history of trauma
- Formulation should be specific to the patient and take into account whole person experience
- Formulation should include an appropriate organizational structure (for example: grounded in a patient’s predisposing, precipitating, perpetuating and protective bio-psycho-social-cultural factors)

Develop a differential diagnosis and justify the preferred diagnosis
- Differential list is appropriate size (neither to narrow nor too broad)
- Diagnoses make sense based on the history obtained

Develop a treatment plan that incorporates biological, psychological, social, cultural, developmental and spiritual considerations, as well as history of trauma, which could include items such as:
- Obtain informed consent
- Order investigations required to start a specific medication
- Initiate and titrate an evidence-informed pharmacological intervention
- Monitor for common and serious side effects and response to medication
- Initiate and monitor side effects and response to ECT and/or rTMS
- Identify and manage barriers to compliance
- Consider potential drug interactions and medical comorbidities
● Be aware of, and access as indicated, institutional, municipal, provincial and other appropriate resources
Suggests care that incorporates psychotherapeutic skills
Considers patient’s social supports with resources and care as indicated

Conveys the formulation, diagnosis and plan accurately and clearly
● Uses a bio-psycho-social-cultural framework
● Identifies short, medium and long term management goals
● Links the formulation to the management plan
● Communicates effectively, in writing or orally
-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 Options:
● Direct observation

Scope:
● Any patient in any clinical setting with suicidal ideation or an attempt

Possible Settings
● Any psychiatry rotation

Milestones:

Elicit a suicide risk history
● Elicits details of the events leading up to the ideation and/or attempt
● Elicits details of the attempt itself, if relevant
● If applicable, determines intent and assesses potential lethality after a suicide attempt
● Identifies and utilizes important sources of collateral information

Elicit and identify pertinent protective and aggravating factors
● Elicits supports and important relationships
● Elicits patient’s reasons to continue living
● Assesses future orientation
● Demonstrates knowledge of risk factors for suicide and risk stratification
● Recognizes and appreciates the implications of various diagnoses or symptoms (e.g. anxious distress, psychosis, command hallucinations, delusions of control) related to suicidal ideation and attempts

Assess safety
● Assesses risk to minors
● Assesses homicidal ideation
● Assesses risk of driving
● Awareness of duty to warn
● Self-care and physical impairment risk
● Demonstrates understanding of non-suicidal self injury (self harm) versus suicidal ideation
Comprehensively document and communicate the risk assessment

- Effectively communicates orally to patients/family/supervisor.
- Documents in appropriate medico-legal fashion in patient chart and highlights modifiable and static risk factors, chronicity, etc.
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 Options:
● Direct observation
● Review of documentation/forms as detailed below

Scope:
● Any patient in a clinical setting

Possible Clinical Settings:
● Any psychiatry rotation

Milestones:

Completes the appropriate Mental Health Act form or appropriately references the Health Care Consent Act for the clinical situation (ex. Form 1, 3, 4 or capacity, or community treatment order)
● Demonstrates understanding of criteria for the Form
● Accurately completes one of: Form 1, 3, 4, 33, CTO documentation
● If applicable, assesses the validity of the Form completed by another physician

Provide the patient with the relevant notification under the Mental Health Act (ex. Form 30, 33, 42 or community treatment plan)
● Delivers Form to a patient or police and explains the implications

Documents in the chart all relevant information related to the completion of Mental Health Act Form
● Comprehensively documents the clinical encounter
● Documents the application for rights advice where relevant
● Documents 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
● Provides the form in a timely manner
● Communicates empathically regarding the patient’s rights
● Pays attention to the impact on the doctor-patient relationship
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 comorbidities.

Assessment Options:
● Direct observation
● Indirect observation
● Simulation

Scope:
● Any patient in a clinical or educational setting

Possible Clinical Settings:
● Inpatient Unit
● Emergency Room
● C/L

Milestones:

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

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

Recognize toidromes or acute medical illnesses
● Use toxicology screening tests and other investigations to ascertain medical causes of illness
  ● Recognize patient’s risk of acute medical deterioration
  ● If applicable, utilize appropriate withdrawal protocols (e.g. CIWA, COWS)
  ● Recognize and differentiate states of intoxication and withdrawal

Demonstrate awareness of common medically compromised populations and medication considerations
Possible scenarios include:
● Understand the use of psychotropic medications in patients with prolonged QTc
● Understand the use of psychotropic medications in patients with renal or hepatic impairment
- Understand the use of psychotropic medications in patients with metabolic comorbidities
FOUNDATIONS OF DISCIPLINE #6: PERFORMING CRITICAL APPRAISAL AND PRESENTING PSYCHIATRIC LITERATURE

Short Description:
This EPA focuses on the ability to critically appraise the 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 at a group setting.

Assessment Options:
- Direct observation by supervisor of presentation with input from the audience of the presentation in a group setting

Possible Settings:
- Presentation in a group setting such as grand rounds, journal club, case conference, M&M rounds, QI rounds, etc.

Milestones:
- Recognize uncertainty and knowledge gaps in clinical and other professional encounters relevant to their discipline (FOD6M1)
- Interpret study findings, including a critique of their relevance to their practice (FOD6M2)
- Assess the validity and risk of bias in a source of evidence (FOD6M3)
- Describe how various sources contribute to the evidence base of medical practice
  - including studies, expert option, and practice audits (FOD6M4)
- Discuss and provide examples of ethical principles
  - applicable to research and scholarly inquiry relevant to psychiatry (FOD6M5)
- Describe and compare the common methodologies used for scholarly inquiry in their discipline (FOD6M6)
Summarize and communicate the findings of applicable research and scholarship

- including to colleagues, the public, or other interested parties
CORE OF DISCIPLINE #1: PERFORM A PSYCHIATRIC ASSESSMENT FOR A PATIENT PRESENTING WITH COMPLEX MENTAL HEALTH CONCERNS

Short Description:
The learner should be able to perform a psychiatric assessment for a patient of higher complexity, where there is a high burden of symptoms and significant comorbidity. For example, a patient who has mood/anxiety/psychosis AND substance use/ eating disorder/ personality disorder/ intellectual disability/ neurocognitive disorder/ medical complexity. The learner should be able to provide a pertinent differential diagnosis, as well as highlight the most likely diagnosis (or diagnoses), which can inform their management plan.

Assessment Options:
● Direct observation
● Mock STACER
● STACER

Scope:
● Any patient in a clinical or educational setting

Possible Clinical Settings:
● Any psychiatry rotation

Milestones:

Establishes and maintains rapport and effective therapeutic alliance
● Communicates with empathic non-judgemental responsiveness to patient
● Uses multiplicity of validation techniques to build rapport (is interested, accurate reflection, validates unverbalized behaviour/feeling, links behaviour/feeling to person’s past history, normalizes behaviour/feeling)
● For example, uses “here and now” techniques to deepen the alliance

History gathering is appropriately comprehensive to establish a pertinent differential diagnosis, most likely diagnosis (or diagnoses) and to inform a management plan
● Is aware of differential and appropriately screens for comorbidities
● Gathers information about symptoms appropriately, given potential interplay between comorbidities
● Is able to be comprehensive with a multiplicity of symptoms, even if time is limited
● Gathers an appropriate history regarding risk (self and others)
Adjusts interview content and style to the patient’s presentation
- Adapts the interview based on patient’s acuity, level of distress and cognitive abilities
- Adapts language to patient

As indicated, integrates collateral information, medical investigations and other data needed to construct a comprehensive formulation
CORE OF DISCIPLINE #2: DEVELOP A COMPREHENSIVE BIOPSYCHOSOCIAL FORMULATION DURING AN ASSESSMENT

Short Description:
Learner will demonstrate mastery on the biopsychosocial formulation of presenting difficulties. The learner will conduct a comprehensive assessment based on this formulation for a variety of patients across the lifespan and in varying degrees of complexity.

Assessment Options:
● Direct observation
● Psychodynamic case report
● Mock STACER
● STACER

Scope:
● Any patient in a clinical or educational setting
● Must include one geriatric assessment and one child assessment

Possible Clinical Settings:
● Any clinical rotation

Milestones:

Demonstrates mastery of the generic structure of the biopsychosocial formulation and demonstrates excellence in developing a patient-specific formulation
● May demonstrate knowledge of generic structure of the formulation by teaching it to a junior learner or interdisciplinary learner (e.g. Social work student)
● Is able to discuss the role of a formulation, either with the patient or with staff
● Makes reference to predisposing, precipitating, perpetuating and protective factors, without necessarily having to rely on a table or a grid
● Draws on multiple sources and methods for obtaining information for the assessment
● Demonstrates flexibility in adapting and revising a formulation as further information emerges, and upon feedback from both patient and/or supervisor
Thoroughly assesses biological factors contributing to presenting difficulty
- Able to draw on varying biological hypotheses and known mechanism of action of presenting illness
- Is able to cite epidemiological and demographic data of the presenting difficulty, as well as the usual course of the condition
- Able to identify a wide biological differential and medical conditions mimicking this presenting difficulty, as it pertains to the patient
- Is able to comment on the complex interplay between ongoing comorbidities and presenting illness as it pertains to the patient (e.g. substance use contributing to ongoing symptoms)
- Is able to draw on standardized tools and measurement based care (e.g. PHQ9) to assess a degree of difficulty when appropriate

Thoroughly assess psychological factors contributing to presenting difficulty
- Able to draw on background knowledge including theory from different schools of thought
- Caters the formulation to a patient-appropriate psychological model (e.g. cognitive behavioural model)
- Is able to test these psychological theories out during the assessment of the patient
- Considers patient’s views, attitudes, and personal circumstances in ability to appreciate presenting difficulty (e.g. readiness to accept the information, level of insight)
- Explores patient’s identity and takes into account whole person experience
- Identifies patient’s coping style
- Explores meanings of symptoms/illness/suffering and experience of pathways to care
- Demonstrates the intricate relationship of socio-cultural factors of the individual with the presenting difficulty, and its psychological manifestation (e.g. social stigma leading to low self-worth)

Thoroughly assesses social factors contributing to presenting difficulty
- Appreciates the multiple contexts which the patient is part of in their everyday life, and how this has changed with their presenting difficulty (e.g. family system, school, employment, community setting, professional network, culture, religion)
- Identifies significant relationships and their dynamic influence on the presenting difficulty
- Identifies history of trauma
- Identifies developmental factors
- Awareness of how a patient’s environment or cultural setting may inform their attitude towards their healthcare provider
Clearly identifies social determinants of health as it relates to this patient
- Identifies gaps in available care as it relates to the patient
- Identifies ways in which a clinician can advocate for the patient

Communicates the formulation in an effective manner
- Presents management plan to colleagues in written or oral form
- Communicates formulation to patient in language that is appropriate and validating.
CORE OF DISCIPLINE #3: DEVELOP AND DELIVER (AS APPROPRIATE) A MANAGEMENT PLAN.

Short Description:
Develop and, where appropriate, implement or communicate management plans for patients with acute and chronic presentations, with a focus on patient populations with higher acuity and complexity. Management plans should be informed by a biopsychosocial framework.

Assessment Options:
- Direct observation
- Indirect observation - review of documentation

Scope:
- Any patient across the lifespan, in any clinical setting
- “Over time”

Possible Settings:
- Any psychiatry rotation

Milestones:

**Recommend appropriate pharmacologic, neurostimulation or psychotherapeutic treatments**
- *Example:* Initiate or recommend an appropriate trial of psychiatric medication, including titration schedule, length of treatment, as well as target/maximum dosages
- *Example:* Initiate or recommend an appropriate trial of neurostimulation, including modality, frequency, and other relevant treatment variables
- *Example:* Refer the patient to an appropriate therapist or clinic providing an evidence-based psychotherapy
- Apply treatment guidelines and relevant research literature
- Consider barriers to access, patient preference, and cost of treatment
- Plan appropriately for treatment intolerance or lack of effect

**Recommend appropriate lifestyle and social interventions**
- Apply treatment guidelines and relevant research literature
- *Consider:* Use appropriate aids such as pamphlets, apps, or online resources to bolster communication and improve adherence

**Anticipate, monitor and manage adverse effects**
- Integrate appropriate laboratory investigations for baseline and longitudinal monitoring
Integrate appropriate physical examinations for baseline and longitudinal monitoring

- *Example:* Initiate a pharmacologic agent for management of emergent adverse effects
- *Example:* Adjust medication dose to manage emergent adverse effects

**Recommend appropriate follow-up planning**
- Identify responsible follow-up clinician(s), frequency, and care setting
- Follow-up plan should allow for adequate monitoring of treatment response and tolerability
- Indicate potential conditions for follow-up or re-consultation if returning care to primary care provider
- Indicate, if present, further referrals or self-referral suggestions
- Integrate existing formal and informal supports
- Consider systemic barriers, wait times, and resource allocation

**Clearly communicate plan in oral and/or written forms**
- Communicate treatment plan and rationale to patient/family and team
- Collaborate with patient and with the care team where applicable on determining goals, tasks, and process of treatment plan, including psychotherapeutic components
- Obtain informed consent to implement plan
- List plan components using a simple, yet comprehensive structure
- Written plans should be easily legible, and components should be in a logical order
- *Consider:* Use a numbered list, with plan components organized in rough chronological order
- *Consider:* Separate the plan into headings, grouped by problem or issue
Core of Discipline #4: Manage Urgent/Emergent Medical Psychiatric Conditions (NMS, Acute Dystonia)

Short Description:
Be aware of and take steps to manage medical psychiatric emergencies (i.e. hypo/hyperactive delirium, NMS, SS, TCA toxicity, Li toxicity, acute dystonia, alcohol withdrawal, etc.) in an inpatient or emergency room setting.

Assessment Options:
- Direct or indirect observation of clinical interaction or simulation

Scope:
- Patient in the ER, inpatient or outpatient setting

Milestones:

Assess current medical status and recognize medical instability
- Obtain relevant HPI, including appropriate collateral
- Perform appropriate MSE/physical exam
- Order appropriate investigations

Recognize medical complications with high mortality
- Synthesize information from history and physical exam findings
- Develop appropriate differential diagnosis and identify primary provisional diagnosis
- Be aware of etiology, pathophysiology, risk factors, clinical course and prognosis

Initiate appropriate acute management
- Collaborate with interdisciplinary team
- Consult medical colleagues and/or poison control appropriately
- Initiate supportive management, as appropriate, including cessation of causative agents if applicable
- Determine appropriate disposition (i.e. ICU, medicine ward) and collaborate to facilitate transfer when necessary
- Provide psychoeducation to patient and family
- Be aware of considerations for capacity and consent, including Emergency Provisions Act

Consider plan for follow up and monitoring as part of longer term management
- Consider prognosis and impact on treatment plan and course
- Develop plan for monitoring - including medication monitoring, safety planning, use of monitoring scales as appropriate
• Liaise and collaborate with outpatient healthcare providers and make referrals as appropriate
CORE OF DISCIPLINE #5: COMMUNICATE INFORMATION TO FAMILIES OR CAREGIVERS

Short Description:
Working with families and caregivers is an essential skill in psychiatric practice. Effective communication with these key stakeholders about the patient’s diagnosis, prognosis and treatment recommendations needs to be clear, helpful and empathically delivered.

Assessment Options:
● Direct observation

Scope:
● Meeting with a family member or caregiver (or SDM) of a psychiatric patient where the patient’s diagnosis, prognosis and treatment are discussed
● Can be in a context where a patient is incapable or is a child, though not always

Possible Settings:
● Any psychiatry rotation
● Often during family meetings

Milestones:

- Provides information about the patient’s diagnosis, prognosis and treatment recommendations (or options) to the family member, caregiver or SDM
  ● This information must all be accurate and complete
  ● Where the patient is capable, learner will have ensured that the patient has given consent to discuss this information prior to proceeding.

- Is able to answer the family member, caregiver or SDM’s questions accurately
  ● This information must be accurate
  ● If information is not known, demonstrates willingness to get information at a later date

- Communicates information effectively and empathically
  ● Applies psychotherapeutic skills, relationship-centred and trauma-informed care principles
  ● Explains information in a manner that is at an appropriate level to the listener and checks to make sure they have accurately understood the information conveyed
● Pieces out information appropriately to ensure the listener is not overwhelmed by too much information
● Demonstrates empathy, especially when giving difficult news (for example, about diagnosis/prognosis)
● Also tries to impart hope and communicates using recovery-oriented language and principles

**Attends to safety planning. Actively enlists family member or caregiver into circle of support for patient.**

- Discusses options family member or caregiver has if patient decompensates or there are safety concerns (e.g. Form 2 protocol)
- Appropriately follows up on any further safety concerns brought up by the family member or caregiver during this discussion
CORE OF DISCIPLINE #6: ASSESS AND MANAGE AGITATION AND AGGRESSION

Short Description:
The learner should gain competence in the identification, assessment, and management of acute aggression, individually or in a team setting, incorporating the local mechanisms to address safety issues.

Assessment Options:
- Direct observation
- Simulation

Scope:
- Adult in clinical setting or simulated setting

Possible Clinical Settings:
- Emergency Room
- Inpatient Unit

Milestones:

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

Create a safe environment for the patient, self, and team
- Be aware of positioning in the room
- Bring appropriate support
- Maintain easy access to means of exit
- Be aware of local mechanisms to summon help when required
- Be aware of sharps and other items that could be used as weapons
- Use de-escalation and other non-pharmacological strategies to promote safety
- Recognize the impact of the interventions on the patient and apply trauma-informed approach

Implement a comprehensive pharmacologic management plan for agitation and aggression
- Select appropriate acute pharmacological interventions and route of administration
● Write orders for chemical and mechanical restraints and associated monitoring protocols
● Recognize and be aware of risk factors that increase the risk of side effects

**Collaborate with an interprofessional healthcare team to manage agitation (e.g. code white)**

- Explain and use local safety mechanisms
- Communicate clearly with security team
- Participate in running a Code White with an awareness of the roles of all team members
- Participate in a team debrief
Short Description:
Neurostimulation treatments (e.g., electroconvulsive therapy, transcranial magnetic stimulation) are effective yet often underutilized tools for the management of psychiatric illness. In the course of training, residents will gain familiarity with the pre-initiation, initiation, monitoring, and termination phases of at least one modality of neurostimulation treatment.

Assessment Options:
● Direct observation
● Indirect observation

Scope:
● Any relevant clinical encounter or educational session with a supervisor or other health care professional
● At least 5 observations should be done with the resident actually performing the procedure.

Possible Clinical Setting:
● Any psychiatry rotation
● ECT clinic - performing ECT

Milestones:

**Assess and manage the patient in the pre-initiation phase**
● Obtain informed consent from the patient or substitute decision maker (SDM) for neurostimulation treatment
● Order appropriate diagnostic and laboratory testing
● Order appropriate pre-initiation consultations
● Adjust or discontinue contraindicated medications

**Initiate a course of neurostimulation treatment**
● Determine appropriate setting of treatment (inpatient vs outpatient)
● Determine relevant treatment parameters (e.g. frequency, pulse parameters, electrode placement)
● Initiate appropriate diet, activity and medication orders for the immediate pre-treatment state

**Monitor and manage clinical effect during a course of neurostimulation treatment**
● Utilize appropriate clinical rating scales
● Document relevant subjective and objective clinical findings
- Manage treatment parameters appropriately to optimize treatment effect (e.g. adjusting electrode placement, frequency of treatment)

**Monitor and manage adverse effects during a course of neurostimulation treatment**
- Document adverse effects, course thereof and any relevant relationships to treatment timing/parameters
- Initiate appropriate management such as ancillary (PRN) treatments or modifications to treatment parameters (e.g. adjusting electrode placement, frequency of treatment)

**Plan for and manage treatment termination**
- Determine appropriate timing for a taper or termination of treatment
- Manage changes in treatment setting relevant to treatment taper or termination (e.g., transition from inpatient to outpatient setting)
- Initiate appropriate treatments in the context of treatment termination (e.g., restarting contraindicated medications, initiating appropriate maintenance treatments).
CORE OF DISCIPLINE #8: INTEGRATING THE PRINCIPLES AND SKILLS OF PSYCHOPHARMACOLOGY INTO PATIENT CARE

Short Description:
This EPA focuses on the pharmacological management of patients and the prescription and monitoring of medications for adult patients of all complexities as well as for children, adolescents, and elderly patients.

This EPA includes obtaining informed consent and providing education as appropriate for medication across the lifespan, including in pregnancy, in children, adolescents, and in the elderly population (with varying levels of capacity).

This EPA includes advocating for access to appropriate medication.

Assessment Options:
- Direct and indirect observation by psychiatrist supervisor, TTP resident, or subspecialty resident

Scope:
- Any patient in a clinical setting
- Must include one child, one adolescent, one adult and one geriatric patient

Possible Clinical Settings:
- Any clinical rotation

Milestones:
- COD8M1: Apply knowledge of changes in pharmacodynamics and pharmacokinetics
- COD8M2: Adapt care as the complexity, uncertainty, and ambiguity of the patient’s clinical situation evolves ensuring plan is safe and patient-centred
- COD8M3: Assess and monitor patient adherence and response to therapy
Assess potential harmful or beneficial drug-drug interactions

Describe the indications, contraindications, risks, and alternatives for a given procedure or therapy to the patient and family

Use shared decision-making in the informed consent process, taking risk and uncertainty into consideration

Establish plans for ongoing care, taking into consideration the patient’s clinical state, circumstances, preferences, and actions, as well as available resources, best practices, and research evidence

Document prescriptions accurately in the patient’s medical record, including the rationale for decisions

Negotiate overlapping and shared care responsibilities with physicians and other colleagues in the health care professions in episodic and ongoing care

Apply evidence and management processes to achieve cost-appropriate care

Facilitate patient access to appropriate medications

Recognize and manage conflicts of interest in independent practice
Short Description: This EPA focuses on the development of clinical teaching skills, including diverse audiences (patients, families, junior and senior learners, and other health professionals).

Assessment Options:
● Direct observation
● Indirect observation

Scope:
● Any clinical setting

Possible Settings:
● Teaching in team meetings
● Bedside teaching
● On-call
● Teaching rounds
● Patient education

Milestones:

COD9M1 Apply a broad base and depth of knowledge in biopsychosocial sciences

COD9M2 Select patient education resources related to their discipline

COD9M3 Identify the learning needs of learners

COD9M4 Ensure a safe learning environment for all learners

COD9M5 Ensure patient safety is maintained when learners are involved
Plan and deliver a learning activity

Provide effective feedback to a junior learner
• incorporate both supportive and critical comments in a way that is descriptive and actionable

Work with learner to develop plan for improvement

Appropriately assess junior learners

Teach other healthcare stakeholders

Exhibit appropriate professional behaviours and relationships in all aspects of practice
• demonstrating honesty, integrity, humility, commitment, compassion, respect, altruism, respect for diversity, and maintenance of confidentiality
CORE OF DISCIPLINE #10: ENGAGES IN THE PROVISION OF PSYCHOTHERAPY MODALITIES

Short Description:
Learner should be able to formulate a comprehensive understanding of the patient, his/her presenting issues, and previous trauma, integrating biological, psychological, social, cultural, spiritual, and developmental factors as well as applicable psychotherapeutic models. Learners should be able to utilize both common and specific factors to facilitate patient recovery, including maintaining an effective therapeutic alliance and providing appropriate evidence-based psychotherapies.

Assessment Options:
- Direct observation
- Indirect observation (audio or videotaped recordings of psychotherapy sessions)

Scope:
- Any patient in a clinical setting

Possible Clinical Settings:
- Psychotherapy case supervision

Milestones:

Establish and maintain therapeutic alliance and frame
- Establish an agreement on goals, tasks, roles, and processes in therapy
- Establish norms, expectations, and boundaries of therapy (e.g., missed sessions, total number of sessions, gifts, etc.)
- Express warmth, genuineness, positive regard, and empathy
- Identify and repair tensions and ruptures in therapeutic alliance (e.g., empathic failure, transference and countertransference issues, cultural issues, external factors, etc.)
- Recognize countertransference; regulate own affect; and utilize countertransference according to the specific therapeutic model

Conduct specific psychotherapy modalities (e.g., psychodynamic, CBT, IPT, Group Therapy, Family Therapy, DBT, MI, MBSR) with fidelity
- Provide orientation and psychoeducation to the specific therapy model
● Engage the patient in basic tasks of the specific therapy, applying suitable techniques and tools (e.g., thought records, interpersonal inventory, free association, etc.)
● Facilitate the patient to overcome therapeutic barriers (e.g., not completing homework, addressing resistance, low motivation, limited insight, etc.)
● Facilitate therapeutic termination, including reviewing therapeutic journey and gains; addressing thoughts and feelings regarding termination; and developing strategies for relapse prevention

Collect patient feedback and measure progress
● Collect patient feedback
● Monitor safety concerns
● Use validated scales to track progress (e.g., PHQ9, EPDS, WAI, GAD7, WHO-DAS, etc.)
● Seek consultation if patient is not improving

Tailor psychotherapy to the patient, while being adherent to the model
● Assess suitability of specific psychotherapy models for the patient
● Facilitate patient to identify and prioritize needs, maintain focus, and obtain appropriate help for issues outside the scope of therapy after termination (e.g., long-term dynamic therapy, couples therapy, interpersonal group therapy, etc.)
● Attend to patient’s in-session emotional cues and needs, and demonstrate empathy and flexibility in focus and techniques, including cultural adaptation
● Facilitate the patient to deal with external factors that may interfere with progress (e.g., family issues, discrimination, acculturation, job demands, etc.)
● Utilize patient’s unique strengths and coping skills to promote empowerment and self-efficacy
● Pay attention to individual and cultural considerations and trauma history
● Solicit and utilize patient’s and supervisor’s feedback non-defensively to refine therapeutic formulation, approaches, and techniques
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
  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.)
  o 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:
- 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.
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?”


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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 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 E: CBD SUBCOMMITTEES AND MEMBERSHIP

CBD OPERATIONS SUBCOMMITTEE

CHAIR:
- Sarah Colman
- Mark Fefergrad

MEMBERSHIP:
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- Inbal Gafni
- Sarah Levitt (resident)
- Mary Preisman
- Hamza Riaz (resident)
- John Teshima

CBD CURRICULUM SUBCOMMITTEE

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MEMBERSHIP
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- Ruxandra Colibasanu
- Sarah Colman
- Amy Gajaria
- Angela Golas
- Laura Kennedy
- Wiplov Lamba
- Robert Madan
- Robert McMaster
- Alpna Munshi
- Ronald Leung
- Tamir Streiner
- Chris Willer
- Gwyneth Zai
CBD Competency Subcommittee

Chair:

- Inbal Gafni

Membership:

- Amina Ali
- Shari Bai
- Neely Bakshi
- Matt Boyle
- Sumeeta Chatterjee
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- Sarah Colman
- Mark Fefergrad
- Amy Gajaria
- Mark Hanson
- Claire Harrington
- Donna Kim
- Susan Lieff
- Greg Lodenquai
- Michael Neszt
- Mary Preisman
- Kevin Rohani
- Ilana Shawn
- Adrienne Tan
- Adam Tasca
- Carmen Wiebe

CBD Learner Experience Subcommittee

Chair

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- Sarah Levitt, PGY5
- Hamza Riaz, PGY2

Membership

- John Aoun - PGY2 SHSC
- Vanessa Aversa PGY2 SHSC
- Sheiry Dhillon PGY1 SMH
- Tanner Isinger - PGY2 SHSC
- Bushra Khan PGY2 UHN
- Diana Kljenak – UHN Psychiatrist
- Geoff Leblond - PGY2 SMH
- David Lee - PGY2 SMH
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CHAIR:

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MEMBERSHIP:

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- Evan Baker (resident)
- Johny Bozdarov (resident)
- Amy Cheung
- Sarah Colman
- Bruce Fage (resident)
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