

# Peer & Practice Assessment Handbook

## Medical Psychotherapy

## **Acknowledgments**

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# Peer Assessor Handbook: Medical Psychotherapy

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# 1. Introduction to Peer and Practice Assessment

## 1.1 Purpose of Peer and Practice Assessment

Peer and Practice Assessments are conducted by the College of Physicians and Surgeons of Ontario (CPSO) as part of its mandate under the Regulated Health Professions Act (RHPA) (Schedule 2, Section 80). The purpose of the Peer Assessment program is to:

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

Peer Assessments are based on the premise that all practices have room for improvement and is therefore intended to encourage continuous quality improvement for all physicians.

## 1.2 Development and Maintenance of Peer Assessment Tools

The Peer and Practice Assessment program has been operational since 1980 and thousands of physicians have been assessed. In 2012, the CPSO began an initiative to redesign the program to better align it with its primary purpose of encouraging continuous quality improvement for all physicians. Particular focus was given to supporting physicians in moving their practice from “good” to “excellent”. This initiative led to the creation of the tools found in this handbook.

The Peer and Practice Assessment Handbook was developed by the CPSO in collaboration with peer assessors. Assessors provided the discipline-specific content expertise for establishing the elements of quality and evaluation criteria found within this handbook. External consultations by practising physicians and physician bodies were conducted to validate the content with respect to how quality is defined, how it should be evaluated, and how it might be improved. A brief overview of the development process and milestones for the Peer Redesign Initiative (including the external review process) can be found in **Appendix A**.

The CPSO’s Research and Evaluation Department provided measurement expertise and established a rigorous validity framework for the peer assessment program. Specifically, attention was paid to optimizing the validity, reliability, acceptability, and educational impact of the program. In order to continue to improve the effectiveness of the peer assessment program, these tools and procedures are periodically reviewed and updated to ensure their validity and relevance.

### 1.3 CanMEDS in Peer Assessment

[CanMEDS](#) is a national competency-based framework for medical education that describes the abilities physicians require to effectively meet the needs of the people they serve. It was developed by the Royal College of Physicians and Surgeons of Canada<sup>1</sup> in the 1990s and organizes physician abilities thematically under seven roles: Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional. It was updated most recently in 2015 and now includes key milestones to describe the development of physician abilities across the continuum of their career starting at entry to residency, following them throughout practice, and finally into the transition out of professional practice.



The latest edition of CanMEDS, often referred to as CanMEDS 2015, was developed collaboratively by 13 Canadian medical education organizations. In May 2015, the CPSO formally adopted it as an organizing framework for physician education and assessment. From a regulatory perspective, CanMEDS complements much of the work of the CPSO, particularly with respect to [The Practice Guide](#) and [CPSO policy](#). Furthermore, a key competency of the Professional Role identifies the responsibility of physicians to participate in physician-led regulation. For more information about how CanMEDS relates to Peer Assessment, please see **Appendix B**.

<sup>1</sup> Adapted from the CanMEDS Physician Competency Framework with permission of the Royal College of Physicians and Surgeons of Canada. Copyright © 2015

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<http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e..> Reproduced with permission.

## **1.4 How to use the Peer and Practice Assessment Handbook**

This handbook is designed to be a resource for both assessors and physicians undergoing a peer assessment. It describes the assessment process and evaluation criteria in order to guide assessors in consistently delivering structured peer assessments and to inform physicians who are anticipating a peer assessment about what to expect and how to prepare.

An electronic copy of this handbook, and the handbooks of other disciplines, can be found listed under “Scope Specific Assessment Tools” at:

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

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

<https://www.cpsso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Assessments>

## 2. Peer Assessment Process

Peer Assessments are conducted by trained assessors who are physicians practicing in the same scope as the assessed physician. Assessments take place at the assessed physician's workplace and involve a review of patient records and a discussion with the physician. The assessor completes a report about the assessed physician's practice that is then submitted to the CPSO and reviewed by a committee. The assessed physician receives a copy of the report and a letter outlining any potential follow up. Details of each step in this process are described below.

### Phase 1 - Before the Assessment

#### *A. Physician and Assessor Selection*

- A physician is selected for assessment and his/her eligibility is confirmed. Physicians can be selected based on specific criteria (e.g., at 70 years of age).
- All physicians to be assessed complete a general Physician Questionnaire to provide details about his/her practice. This information is shared with the assessor to aid in providing a context for the assessment.
- A CPSO Assessment Coordinator matches an assessor to the physician based on relevant practice details.

#### *B. Pre-visit Telephone Discussion*

- In advance of the assessment, the assessor initiates a telephone discussion with the physician to be assessed.
- During this discussion, the assessor reviews the assessment process and outlines the physician's responsibility for preparing patient records that will be reviewed during the assessment. The assessor may also ask for further clarification about the physician's practice and respond to questions or concerns the physician may have. The assessor and physician will then set a date for the assessment.
- After discussing the planned assessment process, it should be clear when the physician is expected to be available on the day of the assessment. The physician can choose to see patients during the assessment record review **but is available if questions arise**. The physician must also set aside time at the end of the visit for the assessment discussion. Some assessors prefer to conduct the record review in an interactive fashion with the physician throughout the duration of the visit; **this will be clearly communicated by the assessor to the physician prior to the assessment date**.

## Phase 2 - During the Assessment

### C. *Initial Discussion*

- The assessment site visit begins with a discussion between the assessor and physician to review the assessment process, orient the assessor to the practice, and familiarize the assessor with the patient records.
- The initial discussion and orientation may include a review of the EMR and how to access all elements of the patient record.

### D. *Patient Record Review*

- The assessor reviews a sample of the physician's patient records that have been selected using a discipline-specific **patient record selection protocol** (section 3.2).
- The assessor records their notes for each record using the **patient record summary** (section 5.1).

### E. *Physician Discussion*

- In addition to reviewing patient records, the assessor discussion takes place with the physician in order to:
  - Clarify issues which may have arisen during the record review.
  - Gather further information which cannot be accessed through the record review.
  - Provide feedback to validate appropriate care.
  - Discuss opportunities for practice improvement and highlight opportunities for practice improvement including Continuing Professional Development (CPD) activities.
- B. The **scoring rubrics** (section 4.2) can be used as informational tools during this time.

## Phase 3 - After the Assessment

### F. *Assessment Report*

- The assessor completes a **peer assessment report** (see section 5.2) based on the information collected through the patient record review and physician discussion.
- This report is comprised of a brief description of the background of the physician's practice, overall ratings and narrative comments for each of the assessment domains, as well as an overall narrative summary.
- The assessor uses the **scoring rubrics** (see section 4.2) to guide this process. The scoring rubrics define the elements of quality and evaluation criteria used during assessments within a given specialty or discipline. They are intended to be broadly applicable across diverse patient care interactions and provide an extensive framework for evaluating care and documentation.



- The assessor submits the assessment report and the patient record summaries to the CPSO for review.
- The CPSO sends a copy of the assessment report and patient record summaries to the assessed physician, along with a letter outlining the Quality Assurance Committee's decision.

***G. Role of the Quality Assurance Committee (QAC)***

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

***H. Evaluating the Impact of Peer Assessments***

- As part of the effort to continuously improve the Peer Assessment program, feedback is sought from assessed physicians about the impact of the assessments on their practices.

## 3. Assessment Tools and Protocols

### 3.1 Patient Record Selection Protocol

A structured, discipline-specific method is used for selecting and reviewing patient records. This *Patient Record Selection Protocol* ensures that a representative sample of records is chosen (i.e., selection includes a variety of conditions over a sufficient time period), and that records are reviewed systematically (i.e., specific sections of the records are examined).

#### ***Patient Record Selection Protocol for Medical Psychotherapy:***

##### **1. In advance of the assessment:**

- a. The **physician to be assessed** will:
  - Select a minimum of 10 representative patient records which are active (i.e., include therapeutic notes from within the last six months)
  - Include records of at least one new and one long term patient(s)
  - Include records reflecting collaborative care involving other health care providers or agencies, when possible
  - Include at least one record representing a challenging case or patient encounter

##### **2. On the day of the assessment:**

- a. The **physician to be assessed** will:
  - Provide an overview of how the patient record is organized
  - Be prepared to retrieve additional patient records as needed by the assessor
- b. The **assessor** will:
  - Review the records presented by the assessed physician, requesting additional records as necessary, to sufficiently understand the continuity of patient care

## **Patient Record Selection and Review for Reassessments**

The CPSO Quality Assurance Committee may require a reassessment of a practice after completion of the initial assessment to assess whether recommended practice changes have been implemented. Reassessments follow the same broad and comprehensive assessment process as outlined in this handbook; however, specific patient care or documentation issues will be identified from the initial assessment by way of the assessment report and/or decision letter (e.g., improvement is needed regarding patient monitoring, clarity of documentation, etc.,).

During the reassessment, the assessor will pay particular attention to the issues identified in the previous assessment in order to provide an informed impression of whether those concerns were ameliorated. The assessor will use their professional judgement to determine if specific types of records should be included during the reassessment to address any issue or area of concern (e.g., if there was a concern regarding presentation “X” in the previous assessment, the assessor will use their judgement to decide if extra records of that type must be reviewed in order to provide an informed impression in the reassessment report).

Timeframe for records selected during reassessment: Records of care may be chosen during any point between the initial assessment and reassessment. Overall, records should be reviewed across a timeframe that allows the assessor to assess improvements in practice since the previous assessment.

Reassessment reporting: As with initial assessments, the assessor provides their impression in the assessment report regarding the quality of care and documentation observed during the reassessment. The assessor should also make a succinct statement in the reassessment report, as required, to make clear whether the standard of practice appears to be met for issues/concerns identified in the initial assessment (e.g., “The concerns related to “X” identified in the previous assessment were ameliorated”).

## 3.2 Physician Discussion Guide

### ***Purpose***

The *Physician Discussion* fulfills two essential components of the peer assessment:

#### *1. Gathering of information about the physician's practice*

As an information gathering technique, the Physician Discussion allows the assessor to explore topics which cannot be determined from reviewing patient records or to clarify issues that arose during the patient record review. This exchange is critical as the physician may provide an explanation which helps the assessor reach conclusions, particularly around determining where quality improvement may be required, e.g., "Is the problem one of inadequate record-keeping or is there an area where the process of care should be improved?"

#### *2. Provision of feedback to the physician to validate appropriate care and discuss opportunities for improvement*

As a feedback technique, the Physician Discussion allows the assessed physician to receive specific information about their practice from a peer. Assessors will review areas of appropriate care, discuss any issues that were identified through the record review, and provide specific recommendations for improvement. Assessors may provide educational materials or quality improvement strategies to address identified issues and may recommend relevant Continuing Professional Development (CPD) opportunities. The [CPD/Practice Improvement Resources](http://www.cpsso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Continuing-Professional-Development/) section of the CPSO's CPD webpages may also be shared for additional educational resources: [www.cpsso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Continuing-Professional-Development/](http://www.cpsso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Continuing-Professional-Development/).

Continuing Professional Development (CPD) is a [requirement](#) for all physicians. Prior to the assessment, the physician completes a questionnaire that provides the assessor with information about how the physician identifies and meets ongoing CPD needs. This topic may be further explored in the Physician discussion with respect to issues identified in the assessment. The assessor may also assist the physician in developing a self-directed CPD or quality improvement plan that is stimulated by feedback from the peer assessment.

**Structure:** Although information gathering starts from the first telephone call between the assessor and the physician, the Physician Discussion refers specifically to the discussion conducted during the last approximately 60 to 90 minutes of the peer visit. Depending on assessor preference, there may be other one-on-one time requested (e.g., after the first few patient records are reviewed to address any questions about navigating the record or to provide clarification). The physician discussion is semi-structured; some discussion themes are routinely explored and others develop naturally given the particular circumstances of the assessed physician.

***Discussion Themes for Medical Psychotherapy:***

1. What is your approach for addressing patient safety issues?
2. How do you handle patients who are suicidal (chronically or acutely)?
3. How do you assess and monitor depression and anxiety?
4. How do you manage resistance and deal with boundary issues?
5. How do you maintain a healthy work-life balance? What would you do if you found yourself overwhelmed by work demands?
6. How and when do you communicate with family doctors?
7. Is there an area of your practice that you find challenging? Do you have any patients that are particularly challenging?

## 4. Assessment Framework and Scoring Rubric

### 4.1 Peer Assessment Framework

The *Peer Assessment Framework* provides a structure for the assessment report and evaluation criteria. The framework consists of eight assessment domains organized into four broad categories borrowed from the “SOAP” format (see table below). Details of how these domains align with the CanMEDS framework can be found in **Appendix B**.

S <sub>ubjective</sub>	O <sub>bjective</sub>	A <sub>ssessment</sub>	P <sub>lan</sub>
1. History	2. Examination 3. Investigation	4. Diagnosis	5. Management Plan 6. Medication 7. Follow-up & Monitoring 8. Documentation for Continuity of Care

The *Scoring Rubrics* (listed in section 4.2) support consistency, discipline-specificity, and transparency in the assessment process. For each domain, high quality care is defined and specific evaluation criteria are provided to guide assessor evaluation. A working group of peer assessors developed the evaluation criteria and sought feedback from practicing physicians and selected physician organizations to ensure their relevance and appropriateness. The criteria in the rubrics are periodically reviewed to ensure they are up-to-date.

Assessors use the scoring rubrics to assist in their decision making when completing the assessment report. The rubrics are NOT intended to be used in “scoring” individual patient records, but rather to describe the overall trend in care, considering all information gathered during the patient records review and the physician discussion. The *global rating scores* for each of the 8 domains are expressed with a 3-point scale (see below). Narrative detail provided in the assessment report for each of the domains provides the critical information regarding validation of appropriate care and opportunities for improvement.

#### *Global Rating Scores:*

- 1 — Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor
- 2 — Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low
- 3 — Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected

## 4.2 Scoring Rubrics: Medical Psychotherapy

**IMPORTANT NOTE:** The elements of quality listed below are intended to be extensive in order to apply to a diverse range of possible patient presentations. It is acknowledged that not every element of quality will be relevant for every medical record or patient visit. By following the caveat statements (“including relevant details of”, “as required”, etc.), the assessor will use medical expertise and professional judgement to determine which elements of quality are relevant for a given patient interaction.

**CPSO POLICIES:** Many elements of quality are linked to specific CPSO policies (e.g., Medical Records, Prescribing Drugs, etc.). Key policies can be opened by clicking links in the header of each rubric. Where a perceived difference exists between the present content and CPSO policy, the relevant policy will always take precedent.

### HISTORY:

A record of information gathered through questioning the patient or others (e.g., family members, substitute decision-maker) and reviewing pertinent documents to determine the next steps in care.

Key [CPSO Policies](#): [Medical Records](#) [Confidentiality of Personal Health Information](#)

### ELEMENTS OF QUALITY

**NOTE:** History taking may occur over multiple patient visits

- 1) **Demographic information** was documented, including:
  - a. Age / date of birth
  - b. Gender
  - c. Patient contact information
- 2) **Reason for assessment/consultation** was documented, including **relevant details** of:
  - a. Referral information
  - b. Chief complaint(s)
  - c. Patient’s goals for therapy
  - d. Source of history information (e.g., patient, interpreter, family member)
- 3) **Presenting illness histories** were documented, including **relevant details** of:
  - a. Onset and evolution
  - b. Symptom description, duration, aggravating and relieving factors
  - c. Targeted functional inquiry
  - d. Functional status (activities of daily living)
  - e. Source of history information (e.g., patient, interpreter, family member)
- 4) **Medical histories** were documented, including **relevant details** of:
  - a. Past medical conditions / medical comorbidities
  - b. Past and ongoing medical treatment and surgeries
  - c. Allergies and sensitivities (medications, food, environment)
  - d. Family history (psychiatric and other relevant information)
- 5) **Medication histories** were documented, including **relevant details** of:
  - a. Current and past medications
  - b. Recent changes in medication (recent starts, discontinuations, dose changes)

c. Pharmacological and non-pharmacological substance use and misuse (including alternative and complimentary medications and supplements use as relevant)	
<b>6) Social histories</b> were documented, including <b>relevant details</b> of: <ul style="list-style-type: none"> <li>a. Education / occupation</li> <li>b. Marital / relationship status</li> <li>c. Sexual orientation</li> <li>d. Social support (family and friends)</li> <li>e. Lifestyle (smoking, exercise, use of recreational drugs/alcohol)</li> <li>f. Sexual/physical abuse or trauma</li> </ul>	
<b>7) Mental health histories</b> were documented, including <b>relevant details</b> of: <ul style="list-style-type: none"> <li>a. Past and current psychiatric conditions</li> <li>b. Past and current family psychiatric histories</li> <li>c. Previous treatments and/or hospitalizations</li> <li>d. Past or current family violence/abuse</li> <li>e. Assessment of suicidality / homicidality</li> </ul>	
<b>EVALUATION CRITERIA:</b>	
<b>Score</b>	<b>Opportunities for Improvement</b>
1	<b>Little to no improvement</b> is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: <ul style="list-style-type: none"> <li>• Histories were sometimes disorganized</li> <li>• Histories occasionally omitted pertinent information</li> </ul>
2	<b>Moderate improvement</b> is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: <ul style="list-style-type: none"> <li>• Histories were often not clearly relevant to the reason for patients' attendance</li> <li>• Historical information sometimes did not support a clinical impression</li> </ul>
3	<b>Significant improvement</b> is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: <ul style="list-style-type: none"> <li>• Reasons for attendance were often not clearly stated or explained</li> <li>• Historical elements were often unclear, confusing, or contradictory</li> </ul>

<b>EXAMINATION:</b>	
Guided by the presenting problem, a systematic evaluation of the patient's physical and/or mental state.	
Key <a href="#">CPSO Policies</a> : <a href="#">Medical Records</a>	
<b>ELEMENTS OF QUALITY:</b>	
<b>1) Mental Status Examinations (MSE)</b> were completed during initial visits, <b>as appropriate</b> , with positive/negative findings consistently documented, and may include <b>relevant details</b> of: <ul style="list-style-type: none"> <li>a. Appearance, behaviour and speech</li> <li>b. Affect/mood</li> <li>c. Assessment of risk as appropriate (may include risk of: suicide, harm to others, self-harm, postpartum harm to baby, driving, neglect of self-care or neglect of care to dependents (including postpartum))</li> <li>d. Content and form of thought (e.g., illusions/delusions, depersonalization/derealisation)</li> <li>e. Attention/concentration</li> <li>f. Memory</li> </ul>	



g. Cognitive deficiencies - orientation (person, place, time) h. Insight i. Judgement <b>2) There is evidence of ongoing MSEs</b> , as appropriate (e.g., reassessments associated with significant changes in patient status or course of treatment) <b>3) Questionnaires, if used</b> , were used appropriately to assess mood and anxiety disorders	
<b>EVALUATION CRITERIA:</b>	
<b>Score</b>	<b>Opportunities for Improvement</b>
1	<p><b>Little to no improvement</b> is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include:</p> <ul style="list-style-type: none"> <li>• More than 50% of components of the MSE were documented in the majority of initial visits, when relevant</li> <li>• Use of questionnaires or mood assessment tools was inconsistent with clinical diagnoses</li> </ul>
2	<p><b>Moderate improvement</b> is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include:</p> <ul style="list-style-type: none"> <li>• Less than 50% of components of the MSE were documented in the majority of initial visits, when relevant</li> <li>• MSEs during initial visits were often not thorough enough (i.e., important components were not addressed)</li> <li>• MSEs were often inadequately documented (e.g., suicidal thoughts were documented but suicidal plans were not)</li> </ul>
3	<p><b>Significant improvement</b> is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> <li>• MSEs were not documented when relevant and necessary</li> <li>• Significant changes in components of MSEs were not addressed in subsequent visits</li> <li>• Risk assessments were consistently not documented</li> <li>• Affect/mood were often not mentioned</li> </ul>

**INVESTIGATION:**

Procedures or tests performed to detect, diagnose, or monitor disease processes and determine a course of treatment.

Key CPSO Policies: [Medical Records](#) [Test Results Management](#)

**ELEMENTS OF QUALITY:**

- 1) **When relevant, investigations** were **selected** appropriately, as demonstrated by:
  - a. Rationale (e.g., based on histories, examinations and presenting conditions)
  - b. Consideration of differential diagnosis
  - c. Review of previous investigations and findings as relevant
  - d. Responsible parties for ordering tests and following up were specified
- 2) **When relevant, investigations** were **reviewed** appropriately, as demonstrated by:
  - a. Accuracy of interpretations
  - b. Pertinent normal and abnormal information noted for consideration in management plans

**EVALUATION CRITERIA:**

Score	Opportunities for Improvement
1	<b>Little to no improvement</b> is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor.
2	<b>Moderate improvement</b> is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: <ul style="list-style-type: none"> <li>• Therapeutic drug level monitoring was not consistently ordered when appropriate</li> <li>• Physicians responsible for ordering and following up on investigations (i.e., laboratory tests, psychological tests, imaging) were not consistently identified</li> <li>• Instructions for follow-up regarding abnormalities in laboratory testing/imaging were often not clearly documented</li> <li>• Laboratory tests were not reviewed by the physician and/or communicated with the patient when necessary</li> </ul>
3	<b>Significant improvement</b> is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: <ul style="list-style-type: none"> <li>• Therapeutic drug level monitoring was consistently not ordered when appropriate and/or physicians responsible for monitoring the investigations were not identified</li> <li>• Pertinent investigations (i.e., laboratory tests, psychological tests, imaging) were often not considered when relevant</li> <li>• Results of investigations (i.e., abnormal findings) were consistently not noted for consideration in management plans</li> </ul>

## DIAGNOSIS:

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

Key [CPSO Policies](#): [Medical Records](#)

## ELEMENTS OF QUALITY:

- 1) **Diagnostic conclusions** were appropriate, as demonstrated by:
  - a. Alignment with histories, examinations, and investigations
  - b. Consideration of comorbidities and presenting symptoms
  - c. Consistency with current standard of care and scientific acceptance
  - d. The diagnostic system used is understandable by other relevant healthcare providers
- 2) **When relevant, differential, working and/or final diagnoses** were **clearly stated** (when diagnoses or provisional diagnoses were not documented, information explaining omission was included)
- 3) **Formulations** were **documented when diagnoses were not relevant** (descriptions of patients' psychological states, with or without descriptions of etiologies and contributing factors)

## EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<b>Little to no improvement</b> is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: <ul style="list-style-type: none"><li>Comorbidities were considered in assessment and treatment but were often not clearly documented</li></ul>
2	<b>Moderate improvement</b> is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: <ul style="list-style-type: none"><li>Evidence of screening for comorbidities was often not clearly identified</li></ul>
3	<b>Significant improvement</b> is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: <ul style="list-style-type: none"><li>Working diagnoses were often not clearly defined</li><li>Significant comorbidities were often omitted</li></ul>

## MANAGEMENT PLAN:

A plan of care tailored to the patient's needs that includes objectives, interventions, time frame for accomplishment and evaluation.

Key CPSO Policies: [Medical Records](#) [Consent to Treatment](#)

## ELEMENTS OF QUALITY:

- 1) **Management plans** were **developed, implemented and recorded appropriately**, with **relevant details** of:
  - a. Purpose of treatment
  - b. Goals and milestones of treatment, as relevant to the psychotherapy modality
  - c. Therapeutic interventions
  - d. Treatment outcomes (e.g., patients' responses, good/bad effects, treatment errors, and suggestions for improvement)
  - e. Discussions of patient's expectations and compliance related to treatment processes
  - f. Employment of patient safety and infection control measures as warranted
  - g. Prompt and appropriate responses to unexpected or adverse events and complications
  - h. Referrals to appropriate resource (e.g., another health care professional, OPD psychiatric facility, 12 step program)
- 2) **Discussions with patients** (and significant others as appropriate) regarding management plans were appropriate, including:
  - a. Explanations to patients regarding management plan, options, risks (including talk therapies), benefits and potential side effects to enable an informed consent
  - b. Advice and education material given to patients/family
  - c. Discussion with patient on issues related to confidentiality
- 3) **Management plans** were **re-evaluated and updated** throughout the course of therapy, as needed

## EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<b>Little to no improvement</b> is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: <ul style="list-style-type: none"><li>• Discussions with patients regarding management plans could be documented in more detail (e.g., psychotherapy, medications, referral resource, etc.)</li><li>• Discussions regarding consent to treatment could be documented in more detail (e.g., ensuring that implied consent or verbal consent was clearly demonstrated in the records without an official written consent)</li></ul>
2	<b>Moderate improvement</b> is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: <ul style="list-style-type: none"><li>• Management plans were often not adequately discussed with patients or substitute decision makers (e.g., regarding treatment options (psychotherapy, medication, crises intervention), treatment information, and risks of treatment or non-treatment)</li><li>• Confidentiality issues were often not discussed</li><li>• Refusal of consent was often not noted or explained</li></ul>
3	<b>Significant improvement</b> is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: <ul style="list-style-type: none"><li>• Risk of harm to self or others was not considered in management plans, when relevant (e.g., referrals to appropriate resources were not made)</li><li>• Appropriate agencies were not reported to, when mandated</li></ul>

## MEDICATION:

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

Key [CPSO Policies](#): [Medical Records](#) [Prescribing Drugs](#) [Consent to Treatment](#)

## ELEMENTS OF QUALITY:

**NOTE: Only relevant when the Medical Psychotherapist is responsible for prescribing medications**

- 1) **Medications** were selected appropriately considering:
  - a. Diagnosis
  - b. Patient characteristics (e.g., age, sex, sensitivity/allergy profile)
  - c. Treatment goals
- 2) **Prescriptions** by Medical Psychotherapist were comprehensively documented, including **relevant details** of:
  - a. Name of medication
  - b. Dosage
  - c. Quantity/repeats
  - d. Route
- 3) **Information provided to patients** was appropriate, including **relevant details** of
  - a. Material risk and benefits
  - b. Side effects (nuisance and serious)
  - c. Contraindications and precautions
  - d. Indications for follow-up (e.g., what to do if side effects occur)
- 4) **Monitoring of medications** prescribed by the Medical Psychotherapist was appropriate, as demonstrated by:
  - a. Ongoing tests, examinations, and investigations
  - b. Medication list updated with changes and rationale for changes
  - c. Medication side effects monitored at appropriate intervals
  - d. Responsible persons identified for monitoring medications, as appropriate
  - e. Substance misuse issues addressed, as appropriate

## EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<b>Little to no improvement</b> is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: <ul style="list-style-type: none"><li>• Rationale for prescriptions were not always clearly documented</li></ul>
2	<b>Moderate improvement</b> is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: <ul style="list-style-type: none"><li>• Monitoring of medications, side effects, and risks were sometimes inadequate</li><li>• Medication side effects and risks were often not discussed</li><li>• Parameters for medication administration were often unclear</li></ul>
3	<b>Significant improvement</b> is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: <ul style="list-style-type: none"><li>• Inappropriate medications or dosages, which could result in patient harm, were prescribed in one or more records</li><li>• Medications were often not documented</li><li>• Medications were often not adequately and consistently monitored</li><li>• Medications were ordered without appropriate histories and/or investigations, when relevant</li><li>• Potential side effects and interactions were clearly not understood by the prescriber</li></ul>

## FOLLOW UP & MONITORING:

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

Key [CPSO Policies](#): [Medical Records](#) [Test Results Management](#)

## ELEMENTS OF QUALITY:

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

- a. If employed, Cumulative Patient Profiles regularly updated
- b. Periodic progress review summaries were regularly completed (frequency: (i) every six months; (ii) if there is a significant change; (iii) more frequently, as required), including:
  - I. Outline of current symptoms
  - II. Current medications and side effects
  - III. Social relationships and circumstances
  - IV. Substance abuse issues
  - V. Updates diagnosis (e.g., improvement, remissions, worsening)
- c. Critical changes were acted on appropriately with referrals as necessary (e.g., patient becomes suicidal or homicidal)
- d. Appropriate laboratory tests and/or physical examinations were conducted or requested; results obtained and followed up as required
- e. Progress reports were included relative to goals of treatment
- f. Continuity of chart notes (i.e., linkage in session notes to previous concerns)
- g. Continuous monitoring for risk of harm, when relevant (e.g., self-harm, violence to others, suicide)
- h. In cases of immediate risk, one or more of the following types of interventions were undertaken:
  - I. Psycho-educational;
  - II. Psychological;
  - III. Psychosocial;
  - IV. Pharmacological;
  - V. Admission to appropriate psychiatric facility (voluntary, involuntary)

## EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<b>Little to no improvement</b> is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include: <ul style="list-style-type: none"><li>• Periodic progress review summaries were often not completed</li></ul>
2	<b>Moderate improvement</b> is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include: <ul style="list-style-type: none"><li>• Previously identified issues/problems and referrals were often not adequately followed up</li><li>• Potential substance abuse issues were not identified or addressed</li></ul>
3	<b>Significant improvement</b> is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: <ul style="list-style-type: none"><li>• Changes in patient conditions across visits were often not documented</li><li>• Suicidality/homicidality was not addressed when relevant</li><li>• Serious illnesses were not recognized and treated, despite documented presence of symptoms</li><li>• Appropriate referrals (i.e., to specialists or to hospital) were often not made</li><li>• Mental Status Examinations were often not documented at subsequent visits</li></ul>

## DOCUMENTATION FOR CONTINUITY OF CARE:

Documentation in the patient record/chart as well as other written communications, intended to share information with care providers or referring sources to ensure effective continuity of care.

Key [CPSO Policies](#): [Medical Records](#)

## ELEMENTS OF QUALITY:

- 1) **Documentation for referring sources** was effective, **if applicable**, as demonstrated by:
  - a. Provision of copies of assessments and discharge summaries
  - b. Provision of periodic progress reports of long term therapy patients
  - c. Identification of physicians responsible for specific aspects of patient monitoring and follow-up
  - d. Prompt alerts regarding changes in diagnosis, health status or therapeutic regimen
- 2) **Denial of consent** was documented, **when relevant**
- 3) **Referral documentation** was effective, as demonstrated by:
  - a. Clear and comprehensive articulation of consultations and referrals
- 4) **Transfer and discharge information** was documented, **when applicable**, including **relevant details** of:
  - a. Diagnosis
  - b. Treatments already provided
  - c. Recommendations for continued and future management
  - d. Indication of the patient's comfort or concerns with transfer of care or termination
  - e. Risks or concerns about the patient
  - f. Follow-up self-discontinued therapy in instances when specific patient safety concerns present
  - g. New medications and/or medication changes
- 5) **Documentation** completed in accordance with the **CPSO Medical Records** policy:
  - a. Information was legible
  - b. Abbreviations were appropriate (i.e., no potential for confused interpretation by the range of health care providers who might need to access the record)
  - c. Physician-patient encounters, including telephone contact, were documented, dated, and in the case of shared records, it is clear who made the entry
  - d. Information was presented in a systematic and chronological manner
  - e. Most responsible physician ensures trainee entries were accurate
  - f. Clinical notes told the story of the patient's health care conditions and allowed other healthcare providers to read and understand the patient's health concerns or problems
  - g. Templates, when employed, were used appropriately, including pre-populated templates
  - h. An effective system exists for recording and managing test findings and follow-up

## EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p><b>Little to no improvement</b> is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. Examples include:</p> <ul style="list-style-type: none"><li>• Contact information of family doctors was sometimes not included in charts</li><li>• Consult notes to family doctors were sometimes not included in charts</li><li>• Documentation of discussions with patients or other health providers sometimes lacked sufficient detail</li><li>• Documentation of transitions or termination of care sometimes lacked detail</li><li>• Some pages of charts were missing names or start/end times of sessions</li><li>• When multiple physicians were involved in care, some entries were not signed</li><li>• Documentation was sometimes brief and/or not up-to-date</li></ul>

	<ul style="list-style-type: none"> <li>• In some cases, there was reliance on patients to communicate info back to family doctors</li> </ul>
2	<p><b>Moderate improvement</b> is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low. Examples include:</p> <ul style="list-style-type: none"> <li>• Referrals to community agencies were often not completed/documented when appropriate</li> <li>• Discussions regarding consent were inconsistently documented</li> <li>• Prescriptions were often not documented sufficiently</li> <li>• Significant changes in patient lives were often not recorded</li> </ul>
3	<p><b>Significant improvement</b> is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> <li>• Notes were mostly illegible</li> <li>• Notes were consistently not dated</li> <li>• Patient names were often omitted on chart notes</li> <li>• Family doctors were not contacted regarding serious deterioration of patients' status in one or more records</li> <li>• Discussions with patients or family members were consistently not documented</li> <li>• Transitions of care to other health providers were not documented when appropriate</li> </ul>



## 5. Assessment Templates

### 5.1 Patient Record Summary

The *Patient Record Summaries* are records of each patient chart reviewed during the assessment. These templates provide a structure for the assessor's "field notes" so that pertinent issues can be noted and referred to during the physician discussion. When the physician provides additional information about issues discussed, the assessor will note this in the summary. Patient record summaries inform the Peer Assessment Report and are attached to the final report submitted to the CPSO. This package is reviewed by the Quality Assurance Committee and is provided to the assessed physician.

#### Instructions to Assessors for completing the Patient Record Summaries:

The Patient Record Summaries are completed during the record review and updated, if necessary, after the physician discussion. One summary should be completed for each chart reviewed. **Note:** If issues are identified early in the patient record review (i.e., documentation appears to be missing), this should be clarified with the physician before proceeding to ensure that pertinent information is not stored in a different section of the chart / EMR.

#### How to complete the summaries

1. *Patient Identifier:* Patient initials or record number. Do not use full patient names.
2. *Date of Birth:* Patient's date of birth.
3. *Date of Visit / Date Range of Record Reviewed:* The range of dates that were reviewed within the chart. If only a specific visit/interaction was reviewed, that date should be entered.
4. *Presenting Problem of Patient/Clinical Issue:* The reason for the patient's visit.
5. *Comments/Concerns/Recommendations:* This section, which is divided into the eight assessment domains, is where pertinent information about the chart should be recorded. Comments do not need to be made for every assessment domain; only relevant details regarding quality of care and record keeping need to be included. If concerns are noted, the nature and the extent of the concern should be clearly articulated.
6. *Key Positives/Concerns and Clarification from Discussion with Physician (if relevant):* A brief statement about whether or not concerns were found in the record. Exemplary documentation and care can be recognized here (as appropriate). When follow-up discussion with the physician clarifies issues or concerns noted in a patient record summary, relevant clarifying information should be added.

## PATIENT RECORD SUMMARY TEMPLATE

### Chart #1

Patient Identifier (Initials/Chart Number):

--

Date of Birth (dd/mm/yyyy):

--

Date of Visit (dd/mm/yyyy):

--

Presenting Problem of Patient/Clinical Issue:

--

Comments - Concerns - Recommendations Regarding Patient Care:

History

Examination

Investigation

Diagnosis

Management Plan

Medication

Follow-Up & Monitoring

Documentation for Continuity of Care

Specific Concerns:

Clarification from physician discussion (if relevant):

--

## 5.2 Peer Assessment Report

The *Peer Assessment Report* provides an overall summary of the assessment. This report template guides the format of the report, which includes relevant background information about the physician's practice, areas of appropriate care, areas for improvement, and overall comments. The completed Peer Assessment Report (including the accompanying Patient Record Summaries) will be submitted to the CPSO. The report will be reviewed by the Quality Assurance Committee, who will use it to make a decision regarding the assessment; the Committee's decision along with the report is then provided to the assessed physician.

### Instructions to Assessors for completing the Peer Assessment Report:

The Peer Assessment Report is completed after all the patient records have been reviewed and the discussion with the assessed physician has taken place. The report provides a global summary of the assessed physician's practice taking into account all sources of information (i.e., the patient records and physician discussion).

#### How to complete the report

1. *Physician Demographic & Practice Information:* The assessed physician's name, CPSO number, and scope of practice that was assessed. The assessed physician's initials are inserted in the footer at the bottom left of the page (this will automatically be copied onto all subsequent pages).
2. *Assessment Information:* The assessor's name, the date of the assessment, and the address of the assessment (where the visit took place). In the boxes at the bottom right corner, the amount of time spent completing the patient record review and the amount of time spent discussing with the physician. The assessor signs the form when completed.
3. *Relevant Background Information:* A brief description of pertinent contextual information about the physician's practice (e.g., clinical environment, relevant training and experience, type and scope of practice, key patient population characteristics, recent and/or planned changes to practice). Information already included in Physician Questionnaire need not be repeated unless it provides context for the assessment findings.
4. *Ratings & Comments:* For each assessment domain, a rating (1, 2, or 3) is given based on the assessor's overall assessment of the physician's practice. The scoring rubrics guide assessors' decisions about ratings. Ratings are supported by narrative comments and specific examples. The space for narrative detail for each assessment domain is divided into two sections:

- i. *Areas of Quality Care and Suggestions for Quality Improvement:* A brief summary of the positive aspects of the physician's practice, as they relate to the elements of quality in the scoring rubrics, in order to validate and encourage continued effort in these areas. Optional suggestions for practice improvement and professional development are also included.
  - ii. *Specific Concerns Requiring Attention and Recommendations for Practice Change:* If a score of "2" (moderate improvement needed) or "3" (significant improvement needed) is assigned, the specific concerns that resulted in that score should be described here. When outlining concerns, include both the nature and extent of the concerns, as well as specific recommendations for improvement in this area. When relevant, reference should be made to instances of the concern found in specific patient record summaries. Clear and concise narrative details regarding a concern assist the Quality Assurance Committee in understanding the issues in order to make valid decisions and recommendations.
5. *Summative Comments:* A brief summary of the assessor's overall assessment of the physician's practice across all eight domains including aspects of quality care and any areas of concern. Assessors will provide a summary of all recommendations requiring attention. General comments about the assessment, the physician discussion, or perceptions regarding the physician's responsiveness to feedback and potential for self-directed improvement should be included here. If pervasive record keeping issues was a hindrance to evaluating quality of care, this can be noted here.

## PEER ASSESSMENT REPORT TEMPLATE

### Relevant Background Information:

### Ratings and Comments

**1 - Little to no improvement** is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor.

**2 - Moderate improvement** is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low.

**3 - Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected.

**History:** A record of information gathered through questioning the patient or others (e.g., family members, substitute decision-maker) and reviewing pertinent documents to determine the next steps in care.

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Demographic information</li> <li>• Reason for assessment/consultation</li> <li>• Presenting illness histories</li> <li>• Medical histories</li> </ul> | <ul style="list-style-type: none"> <li>• Medication histories</li> <li>• Social histories</li> <li>• Mental health histories</li> </ul> |
|--|---|

**Rating:**      **1** ☐

**2** ☐

**3** ☐

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

**Examination:** Guided by the presenting problem, a systematic evaluation of the patient's physical and/or mental state.

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Mental Status Examinations</li> </ul> | <ul style="list-style-type: none"> <li>• Questionnaires</li> </ul> |
|--|--|

<b>Rating:</b>	<b>1</b> <input type="checkbox"/>	<b>2</b> <input type="checkbox"/>	<b>3</b> <input type="checkbox"/>
<p>Areas of Quality Care and Suggestions for Quality Improvement:</p>    <p>Specific Concerns and Recommendations Requiring Attention:</p>    			
<p><b>Investigation:</b> Procedures or tests performed to detect, diagnose, or monitor disease processes and determine a course of treatment.</p> <ul style="list-style-type: none"> <li>• <b>Investigations selected appropriately</b></li> <li>• <b>Investigations reviewed appropriately</b></li> </ul>			
<b>Rating:</b>	<b>1</b> <input type="checkbox"/>	<b>2</b> <input type="checkbox"/>	<b>3</b> <input type="checkbox"/>
<p>Areas of Quality Care and Suggestions for Quality Improvement:</p>    <p>Specific Concerns and Recommendations Requiring Attention:</p>    			
<p><b>Diagnosis:</b> The identification of a possible disease, disorder, or injury in a patient.</p> <ul style="list-style-type: none"> <li>• <b>Diagnostic conclusions appropriate</b></li> <li>• <b>Differential, working and/or final diagnoses</b></li> <li>• <b>Formulations documented</b></li> </ul>			
<b>Rating:</b>	<b>1</b> <input type="checkbox"/>	<b>2</b> <input type="checkbox"/>	<b>3</b> <input type="checkbox"/>

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

**Management Plan:** A plan of care tailored to the patient's needs that includes objectives, interventions, time frame for accomplishment and evaluation.

- Management plans were developed and implemented appropriately
- Discussions with patients appropriate

Rating:

1 ☐

2 ☐

3 ☐

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

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

- Medications selected appropriately
- Information provided to patients appropriate
- Prescriptions comprehensively documented
- Medication monitoring appropriate

Rating:

1 ☐

2 ☐

3 ☐

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

**Follow-Up & Monitoring:** The ongoing observation and assessment of the patient's progress to assess treatment efficacy and need for treatment change or termination.

- Patient monitoring and follow-up appropriate

Rating:

1 ☐

2 ☐

3 ☐

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

**Documentation for Continuity of Care:** Documentation in the patient record/chart as well as other written communications, intended to share information with care providers or referring sources to ensure effective continuity of care.

- Documentation for referring sources
- Referral documentation effective
- Transfer and discharge information documented
- Documentation adhered to the record keeping requirements specified by CPSO Policy

Rating:

1 ☐

2 ☐

3 ☐

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

### Summative Comments

Provide a brief summary of your overall assessment of the physician's practice including aspects of quality care and any areas of concern. Provide a summary of all recommendations requiring attention and include your perceptions regarding the physician's responsiveness to feedback and potential for self-directed improvement.



# Appendix A – Development and Evaluation Process

## **Background**

In 2012, an initiative was undertaken at the CPSO to redevelop the peer assessment program. The goals of “Peer Assessment Redesign” were to create an assessment program that is speciality-specific, transparent, consistent, and aligned with its primary purpose to:

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

## **Development Process**

The Peer Redesign initiative was led by the CPSO Research and Evaluation Department. Best practices in program development and evaluation, contemporary validity theory, and established criteria for high quality assessments were utilized to ensure the program was rigorous and educationally valuable for physicians. A collaborative approach was taken with experienced peer assessors from a cross section of medical disciplines throughout the development process so that the program would be rooted in realistic, accurate and fair expectations of quality care.

Development progressed through five stages, described below:

### **1. Tool Development**

Specialty-specific working groups of assessors drafted the assessment tools through iterative, consensus-building meetings. They first established an assessment framework (the assessment domains), then defined high quality care for their specialty for each domain. A three-point rating scale was developed and assessors populated discipline-specific examples for each score to provide comprehensive scoring rubrics for assessing performance. In addition to the scoring rubrics, assessors developed criteria for selecting patient records, and discussion themes for the physician discussion.

### **2. Assessor Orientation and Feedback**

All assessors within a specialty were then provided with an orientation to their discipline’s assessment handbook. Assessors were given the opportunity to review the materials in detail and provide feedback via an online survey. All the feedback was consolidated, reviewed and implemented as appropriate.

### **3. Assessor Training and Consensus Building**

Once all assessors had the opportunity to provide feedback about their specialty's handbook, they were brought together to test the tools in a simulated environment. The focus of these sessions was: 1) to train assessors in how to use the new tools (i.e., how to apply the scoring rubrics during an assessment), and 2) to build consensus in assessors' judgement.

Using simulated records and the discipline-specific scoring rubrics, assessors made ratings anonymously and then were presented with the ratings of all other assessors to view their consistency with each other. They then discussed any disagreement by sharing their unique perspective on the case and each made a new rating until an acceptable level of agreement was met. Through this exercise, assessors identified areas of penitential inconsistency in their interpretations and actively worked together to reach collective agreement. If it was found that aspects of the scoring rubrics were unclear or unhelpful for guiding decision making, refinements were made to the tools to enhance their utility.

Consensus-building training was also provided to the Quality Assurance Committee (QAC) to support consistency in their processes and application of evaluation criteria.

### **4. Internal and External Review**

Each handbook then went through an extensive review process. Internally, the handbooks were reviewed by staff across the CPSO to ensure appropriate alignment with CPSO Policies and other initiatives. An external review was then carried out in two parts. First, all Ontario physicians within the discipline (i.e., medical psychotherapy) were contacted by e-mail with a link to an online survey. The survey explained what the peer assessment program is, how and why it was redesigned, and the way quality care has been defined for their specialty via the scoring rubrics. Feedback was sought about whether or not the definitions of quality care were clear and appropriate for driving quality improvement; space was provided for narrative comments about suggestions for changes. Second, relevant physician organizations for that specialty (e.g., the Medical Psychotherapy Association of Canada) were contacted and invited to provide feedback about the scoring rubrics. The feedback collected from both of the external review streams were collated and thematically analyzed. The tools were revised as needed to address the feedback received.

### **5. Implementation and Evaluation**

As the new tools and processes are implemented into live assessments, a formal evaluation is being conducted to systematically collect data on the effectiveness of the program. The evaluation consists of two arms: a *process evaluation* to monitor the implementation of the

newly developed assessment tools and processes; and an *outcome evaluation* to examine the impact of the redesigned assessment program on assessed physicians.

The process evaluation will ensure that the new tools are being used as intended and that the processes operate efficiently. Data for this will be collected from assessors, CPSO staff, and QAC members. The outcome evaluation will focus on examining the effects of the peer assessment program on assessed physicians. Data for this will be collected from assessed physicians three months after the completion of their assessment through a survey and/or a key informant interview. These complementary evaluations will inform further development and improvement of the program.

## **6. Continuous Improvement**

The program will undergo continuous quality improvement will ensure that the processes are feasible and that the tools remain useful and relevant. For example, assessors will be convened at appropriate intervals (e.g., every three years) to review currency and relevance of the handbook. Regular feedback will also be systematically collected from staff and QAC members about the utility, feasibility, and acceptability of the program.

### **Reference:**

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

## Appendix B – CanMEDS in Peer Assessment

The *Peer Assessment* addresses a range of CanMEDS roles across the eight domains and other assessment components as outlined in the table below.

		CanMEDS ROLES						
		Medical Expert	Communicator	Collaborator	Leader	Health Advocate	Scholar	Professional
PEER ASSESSMENT DOMAINS	1. History	✓	✓					
	2. Examination	✓	✓					
	3. Investigation	✓	✓	✓	✓			
	4. Diagnosis	✓	✓	✓				
	5. Management Plan	✓	✓	✓	✓	✓		
	6. Medication	✓	✓					
	7. Follow-up & Monitoring	✓	✓	✓		✓		
	8. Continuity of Care	✓	✓	✓				
Other Data	Pre-visit Questionnaire*				✓		✓	✓
	Discussion*				✓		✓	✓

\* Leader, Scholar and Professional are addressed to varying degrees in the Pre-visit Questionnaire and Discussion.

**CanMEDS and Continuing Professional Development:** CanMEDS is widely incorporated into Continuing Professional Development (CPD) activities accredited by the Royal College of Physicians and Surgeons of Canada and the CFPC. CanMEDS 2015 also includes a [Competence Continuum](#) that describes the development of physician abilities across the continuum of their career, including CPD (maintenance of competence and advanced expertise).

Furthermore, Key Competency 1 of the Scholar Role is fundamental in espousing the principles of lifelong learning and engagement that motivated the CPSO to make participation in CPD a [regulatory requirement](#) for physicians in Ontario: “Physicians are able to engage in the continuous enhancement of their professional activities through ongoing learning.” CPSO members are required to participate in CPD that meets the requirements set by the RCPSC, the CFPC, or an approved third pathway. The peer assessor may explore CPD with the physician, asking about the physician’s current CPD needs and provide specific recommendations about CPD or quality improvement initiatives that relate to the assessment findings.