

Peer & Practice Assessment Handbook

General Medicine

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The General Medicine Peer Assessment Handbook is made publicly available to support transparency in the Peer and Practice Assessment Program of the College of Physicians and Surgeons of Ontario (CPSO). It is freely available for research purposes, informal self-assessment, and for individual use in developing quality improvement plans.

The present materials were developed specifically for the Quality Assurance Program carried out by the CPSO under section 28. (1) of the Ontario Regulation 346/11 made under the Medicine Act, 1991. No part of these materials may be adopted as part of any formal quality assurance or assessment programs without express agreement from the CPSO.

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1. Introduction to Peer Assessment

1.1 Purpose of Peer Assessment

Peer 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 Peer Assessment is to:

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

Peer assessment is 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 assessment program has been operational since 1980 and thousands of physicians have been assessed. In 2012, the CPSO began an initiative to redesign its peer assessment program to better align the program 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 Peer Assessment Handbook.

The Peer Assessment Handbook was developed by the CPSO in collaboration with peer assessors. Assessors provided the content expertise for establishing the elements of quality and evaluation criteria found within this handbook.

The CPSO 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 Canada¹ 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.



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¹ 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.cpso.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.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Assessments>

2. Peer Assessment Process

Peer Assessments are conducted in a structured way, as 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 College Assessment Coordinator matches an assessor to the physician based on relevant practice details.

B. *Pre-visit Telephone Discussion*

- In advance of the site-visit, the assessor initiates a telephone discussion with the physician to be assessed.
- Relying on information from the Physician Questionnaire, the assessor may ask for further clarification about the physician's practice as well as respond to questions or concerns the physician may have.
- As part of the discussion, the assessor reviews the purpose and process of the on-site and/or virtual assessment and the physician's responsibility for preparing/selecting patient records that will be reviewed during the assessment.
- The time and date of the assessment visit is confirmed. 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 must be accessible at all times if questions arise**. The physician must also set aside time at the end of the visit for the post-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 **patient record selection protocol** (section 3.2).
- The assessor records notes for each record using the **patient record summary** (section 5.1).

E. Physician Discussion

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

Phase 3 - After the Assessment

F. Assessment Report

- The assessor reviews information collected through the patient record review and physician discussion to complete the **peer assessment report** (see section 5.2). This 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 narrative comments of the assessor are particularly important for providing the specific examples of care and documentation that supported their decision making and suggestions for improvement to assessed physicians.

The scoring rubrics 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](#).

3. Assessment Tools and Protocols

3.1 Patient Record Selection Protocol

A structured method is used for selecting and reviewing patient records. This method 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 General Practice:

Record Selection:

1. In advance of the assessment:

a. The physician to be assessed will:

§ Retrieve day sheets and corresponding patient records for three dates from within the last year and organize and pull those patient records so they are easily accessible for the assessor to review.

2. On the day of the assessment:

b. The **physician to be assessed** will:

§ Provide an overview of the patient record filing system to orient the assessor

§ Be prepared to retrieve additional patient records as needed

c. The **assessor** will:

§ Select a total of 15 patient records reflecting both consultations and follow-up assessments from the total number of patient records that have been pulled.

Record Review:

Patient Record Content	Review Process
Initial Consultations	<ul style="list-style-type: none">• Initial consultations• Ancillary documentation (e.g., referral information)
Assessments	<ul style="list-style-type: none">• Assessment• Corresponding initial consultation
Follow-up over multiple years	<ul style="list-style-type: none">• Initial consultation• Most recent visit• Intermediate visits that convey patient management

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 medication prescribing, 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 Assessor-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 provides the assessed physician with specific information about their practice from a peer. Assessors review areas of appropriate care, discuss any issues 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](#) section of the

CPSO's CPD webpages may also be shared for additional educational resources:
www.cpso.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.

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).

S _{ubjective}	O _{bjective}	A _{ssessment}	P _{lan}
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, 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 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: General Medicine

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 and a diverse range of medical specialties. It is acknowledged that not every element of quality will be relevant for every medical record or patient visit nor for every medicine specialty. 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 College policies (e.g., Medical Record Management, Prescribing Drugs, etc.). Relevant College 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 CPSO policy will 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 Documentation](#) [Protecting Personal Health Information](#)

ELEMENTS OF QUALITY

1) Demographic information was documented, including:

- a. Patient’s age/date of birth
- b. Patient’s gender
- c. Patient’s contact information (address, telephone number, etc.)
- d. Patient’s Health Card number (as applicable)
- e. Name and contact information of primary care physician and of any health professional who referred the patient

2) Reasons for assessment/consultation were documented, including **relevant details** of:

- a. Referral Information from the referring physician (e.g., history, physical exam, and presumptive diagnosis)
- b. Chief complaint(s)
- c. Source of history information (e.g., patient, interpreter, family member, etc.)

2) Presenting illness histories were documented, including **relevant details** of:

- a. Onset and evolution
- b. Symptom description, duration, aggravating and relieving factors
- c. Pertinent positives and negatives
- d. Targeted functional inquiry
- e. Functional status (activities of daily living)
- f. Source of history information (e.g., patient, interpreter, family member, etc.)

3) Review of systems was documented, as **relevant**

4) Medical histories were documented (including significant negative observations), including **relevant details** of:

- a. Past medical conditions/medical comorbidities (with reference to CPP, as appropriate)
- b. Past and ongoing medical treatment and surgeries
- c. Immunization records

- d. Allergies and sensitivities (medications, food, environment)
- e. Family medical histories

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. Alternative and complimentary medications and supplements
- d. Drug benefit coverage

6) Social histories were documented, including **relevant details** of:

- a. Education/Occupation
- b. Marital/relationship status
- c. Social support
- d. Lifestyle (smoking, exercise, use of recreational drugs/alcohol – including misuse of prescribed medications)
- e. Legal guardians (e.g., power of attorney), as pertinent

7) When relevant, reproductive and sexual histories were documented, including **relevant details** of:

- a. Current activity
- b. Past or current pregnancies (Gravida, Term, Preterm, Abortion, Living – (GTPAL))
- c. Past or current sexually transmitted infections (STIs)
- d. Sexual orientation

8) When relevant, mental health histories were documented (including significant negative observations), including **relevant details** of:

- a. Past and current psychiatric conditions
- b. Previous treatments and/or hospitalizations
- c. Family history of mental health issues
- d. Past or current family violence/abuse
- e. Assessment of family and community supports
- f. Impact of mental health on functioning (at home, work, school, community)
- g. Assessment of suicidality/homicidality

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor.</p> <ul style="list-style-type: none"> • Social histories were sometimes not included, where pertinent • Family histories relevant to presenting complaints were occasionally not documented
2	<p>Moderate improvement 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"> • Chief complaints were often not clearly stated • Functional enquiries for symptoms were often incomplete • Review of systems was often inadequately documented when appropriate • Pertinent positives and negatives were often not noted when appropriate • Family histories relevant to presenting complaints were often not documented • Chronic condition flow sheets were often not used to their full capacity • Pertinent immunization histories relevant to presenting complaints were often not documented (either in patient encounter record or in the CPP)
3	<p>Significant improvement 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"> • Presenting illness histories were often inadequately documented (e.g., presenting complaints lacked sufficient detail regarding onset, duration, associated signs and symptoms). Presenting illness histories were not sufficiently detailed to determine courses of action • Significant past medical histories relevant to presenting complaints were consistently not noted (either in patient encounter record or in the CPP) • Psychosocial histories were consistently not noted (either in patient encounter record or in the CPP) and assessments of homicidality/suicidality were not completed when relevant • Current medications were often not noted when appropriate (either in patient encounter record or in the CPP). Drug allergies were often not documented when appropriate (either in patient encounter record or in the CPP). • Developmental milestone histories in Well Child Care were often not documented clearly
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EXAMINATION:

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

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

ELEMENTS OF QUALITY

1) Physical examinations were completed based on presenting complaint, with **relevant documentation*** of:

- Pertinent positive and negative findings
- Physical measurements and vital signs, where appropriate (with abnormal vital signs highlighted where appropriate)
- Relevant descriptive information (e.g., dimensions indicating spread of cellulitis at presentation, quality of respiratory sounds, description of rash)
- Illustrations of conditions, where appropriate (e.g., location of rash, laceration, abdominal tenderness)
- Pertinent changes from previous examinations

2) Mental health examinations were completed **when indicated**, with **relevant documentation** of:

- Mental Status Examinations (MSEs) (e.g., mood and affect [including risk of harm to self/others, including suicidality and homicidality], appearance, attitude, behavior, speech, thought process, thought content, perception, cognition, insight and judgment)
- Interplay of psychological and physiological factors

3) Standardized Measures were completed **when indicated**, with **relevant documentation** of:

- Scoring flow sheets (e.g., PHQ-9, mini-mental state exam, pain scale)

*The constituent elements of examinations are determined by the needs of the patient and nature of care provided (e.g., initial consultation versus subsequent visit for established patients.)

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>Little to no improvement 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"> • Examinations sometimes included components not relevant to the presenting complaints • Mental status examinations were present but could be expanded upon
2	<p>Moderate improvement 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"> • Descriptions of general appearance, level of alertness, and comfort level were minimal when appropriate • Relevant physical measurements were not consistently present (e.g., height, weight, and BMI for preventive care and other assessments) • Physical examinations tended to lack focus on presenting complaints and relevant histories • Physical examinations were often not thorough enough to fully assess current presentations (e.g., repeated diabetic assessments with no evidence of a foot examination) • Important, relevant descriptive information (e.g., dimensions indicating spread of cellulitis at presentation) was often not included • Illustrated/described conditions (e.g., location of rash, laceration, abdominal tenderness) were often not included when appropriate • Observations tended to be poorly described • Key elements of examinations (e.g., pertinent positive and negative findings) were often not documented • Pertinent abnormal information from examinations was often not documented • Relevant changes from previous examinations were often not documented
3	<p>Significant improvement 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"> • Pertinent vital signs (e.g., temperature and weight in child with infectious complaint) were consistently not documented • Mental status examinations were often not included when relevant

INVESTIGATION:

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

Key [CPSO Policies](#) : [Medical Records Documentation](#) [Managing Tests](#)

ELEMENTS OF QUALITY:

1) Investigations were **selected** appropriately, as demonstrated by:

- a. Rationale (e.g., based on histories, examinations, presenting conditions and appropriate screenings)
- b. Consideration of differential diagnosis
- c. Review of previous investigations and findings, as relevant
- d. Urgency (e.g., life-threatening conditions prioritized)
- e. Use of decision support tools in decision making (e.g., CHADS₂ score*, NYHA classification**, CCS class***, etc.) // consideration of judicious use of resources (e.g., evidence to support clinical decision-making)

2) Investigations were **reviewed** appropriately, as demonstrated by:

- a. Accuracy of interpretations
- b. Pertinent normal and abnormal information noted for consideration in management plans

3) Patient Engagement regarding discussion of investigations risks and benefits were completed as relevant:

- a. Documentation demonstrated appropriate patient discussion of investigations such as: Integrated Prenatal Screening (IPS), Prostate Specific Antigen (PSA)

4) Effective test result management system(s) were implemented to ensure that all test orders, results, and interpretations were recorded, with high-risk patients and clinically significant test results identified.

*CHADS = Congestive heart failure, Hypertension, Age, Diabetes, Stroke/TIA [risk stratification schema for ischemic stroke]

**NYHA = New York Heart Association [functional classification schema for heart failure]

***CCS = Canadian Cardiovascular Society [functional classification schema for angina]

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>Little to no improvement 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"> Investigation benefits and risks, when indicated, were sometimes absent from documentation Investigations occasionally did not include “red flag” possibilities Rationale for the selection of investigations was sometimes unclear
2	<p>Moderate improvement 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"> Investigations were often not documented Some tests/procedures ordered were not appropriate for presenting complaints (or for ancillary/opportunistic conditions) – i.e., not clinically indicated Evidence-based/consensus guidelines were often not followed (e.g., Canadian Diabetes Association’s diabetes management guidelines; Canadian Hypertension Education Program’s blood pressure guidelines; Anti-Infective Review Panel’s Anti-infective Guidelines for Community-acquired Infections; Ottawa Ankle Rules; etc.) Overall there was a tendency to over-investigate (e.g., X-rays, blood work ordered when not clinically indicated)
3	<p>Significant improvement 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"> Appropriate tests/procedures based on histories and physical examinations were often not ordered/performed Investigations were often not reflective of differential diagnoses An effective test results management system was not in place (e.g., test/procedure results were often not reviewed and recorded and/or potentially clinically significant abnormal test/procedure results were not followed up)

DIAGNOSIS:

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

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

ELEMENTS OF QUALITY:

1) Diagnostic conclusions were appropriate, considering:

- Alignment with histories (medical, surgical, allergies, medications, family, risk factors), examinations, and investigations (including physiological and psychosocial issues)
- Consideration of most/least likely and other possible causes
- Consideration of comorbidities and presenting symptoms
- Noting acuity and/or severity, as relevant

2) Differential, working and/or final diagnoses were clearly stated, as appropriate.

Examples include, but are not limited to:

- a. **Final diagnoses** were clearly **documented, as appropriate.**
- b. **Differential diagnoses** were documented when final diagnoses were not yet determined (e.g., “chest pain – not yet diagnosed”) **or** when diagnoses were unlikely but still were to be considered if investigations or clinical course tended to rule out initial/working diagnosis **or** when potentially serious diagnoses were considered but were thought to be unlikely.
- c. **Diagnoses were qualified** (e.g., “controlled”, “not controlled”, “improving”, “worsening”), **as relevant.**
- d. **Recognition of family violence or abuse, as relevant.**
- e. **Diagnostic assessments/formulations and provisional diagnoses are consistent with current DSM* or ICD** criteria** (considering co-morbidities and differential diagnoses), as relevant for psychiatric or psychosocial care.

*DSM = Diagnostic and Statistical Manual of the American Psychiatric Association

ICD = International Classification of Diseases *confirm DSM and ICD acronyms***

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>Little to no improvement 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"> • Risk factors were occasionally not adequately considered in diagnostic methods • Diagnoses sometimes lacked specificity and/or clarity
2	<p>Moderate improvement 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"> • OHIP diagnostic codes were often used rather than more specific written diagnoses • Differential diagnoses were often not considered, not clear, or not documented, when appropriate • Patient risks were often not adequately considered in diagnoses (e.g., Framingham or other similar framework not considered for assessment of cardiovascular risk) • Chronic diseases and their role in presentations were often not adequately considered in diagnoses (e.g., diabetes with presentation of chest pain) • Psychosocial factors were often not taken into consideration in diagnoses, when appropriate
3	<p>Significant improvement 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"> • Final diagnoses or differential diagnoses were consistently not clearly documented/stated and needed to be inferred from plans or medications prescribed • Diagnoses or provisional diagnoses were often inappropriate based on histories, examinations, and investigations.

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 Documentation](#) [Consent to Treatment](#)

ELEMENTS OF QUALITY:

1) Management plans were developed appropriately, as demonstrated by:

- a. Treatment plans consistent with and appropriate given histories, examinations, and results of investigations
- b. Appropriate pre-treatment screening for contra-indications or cautions
- c. Consideration of co-morbidities in treatment plans
- d. Consideration of acuity of the patient's presenting complaint and accompanying safety issues
- e. Dealing with emergency/urgent problems quickly and aptly (including management of suicidality and homicidal risk)
- f. Relevance of ordered/conducted tests, procedures and referrals and reassessments
- g. Employment of patient safety and infection control measures, as warranted
- h. Consideration of judicious use of resources (e.g., referrals and requisitions)
- i. Use of clinical measurements as decision-making tools for investigations, treatment, and follow-up (e.g., risk scores, intensity or severity scores, etc.), as applicable and appropriate
- j. Consideration of patient circumstances and costs (e.g. coverage for medication, physiotherapy, etc.)
- k. Documentation of outstanding preventive health topics to be addressed at future appointments, as warranted

2) Management plans were implemented and recorded appropriately, with relevant details of:

- a. CPP updates regarding chronic, ongoing conditions, as applicable
- b. Purpose of treatment
- c. Indicators of treatment progress
- d. Treatment outcomes (e.g., patients' responses, good/bad effects, treatment errors, and suggestions for improvement)
- e. Discussions of patients' expectations and compliance related to treatment processes
- f. Explanations to patient/substitute decision maker regarding management plan (including pre-procedure, as applicable), treatment alternatives/options, risks/benefits and potential side effects to enable an informed consent
- g. Advice and education/resource material given to patients/family
- h. Prompt follow-up of critical investigations
- i. Prompt and appropriate management of high-risk situations before and during procedures (including responses to unexpected or adverse intra-procedural events and complications)
- j. Plan to deal with unexpected complications, outcomes, and/or long-term follow-up needs after an intervention (i.e., recording of how and who will be responsible)
- k. Follow-up plan, including recommendations for return appointments
- l. Referrals (including indications and choice of referral destination [such as local social services/agencies or support groups in reference to specific clinical situations], with all patients who need to be referred [particularly including high risk patients] having been referred)
- m. Periodic health assessments and age- or familial-related disease screening (e.g., mammography, cervical cancer screening, colorectal cancer screening, etc.), as applicable
- n. Periodic discussion of health maintenance (e.g., regarding smoking, alcohol consumption, obesity, lifestyle, etc.), as applicable

- o. Well baby visits (e.g., immunizations, growth monitoring, developmental milestones, etc.), as applicable
- p. Prenatal care, as indicated
- q. Adult immunizations, as indicated
- r. Counselling sessions (including start and stop times, patient's response, and future care plans), as indicated
- s. Psychotherapy sessions (e.g., start and stop times, documentation of critical interventions, the physician's input, the patient's response, future care plans, frequency of sessions, etc.), as indicated
- t. Doctor-patient relationships (e.g., boundaries, transference, counter-transference, etc.), as indicated
- u. Recognition of family violence or abuse, as indicated

v. Psychiatric forms (i.e., Form 1, etc.), as indicated w. Termination planning, as indicated x. Documentation of Advanced Care Directives or plan, as appropriate	
EVALUATION CRITERIA:	
Score	Opportunities for Improvement
1	<p>Little to no improvement 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"> • Written advice sheets were sometimes not provided to patients when indicated • Rationale for management plans was sometimes not clearly documented • Details of procedures sometimes lacked detail • Follow-up plans were sometimes not clearly stated • Documentation of Advanced Care Directives were sometimes not made when relevant
2	<p>Moderate improvement 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"> • Appropriate consultations for ongoing care or acute/chronic conditions were not considered and documented, as applicable • Appropriate reassessments of patients following treatments were often not considered and documented when appropriate • Rationale for management plans were often not documented when diagnoses not evident • Consent procedures/discussions were often not documented when appropriate (e.g., treatment for patients with dementia, treatment of minors) • Refusal of consent and the discussions that took place were often not documented • Discussions regarding patient non-compliance were often not noted • Resources were often not used judiciously • Relevant consultations were often not initiated or were considered too late during hospital stay
3	<p>Significant improvement 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"> • Appropriate procedures were often not performed when relevant • Management plans were often not appropriate for presenting complaints, patient conditions, and/or results of investigations • Management plans did not consistently take into consideration the acuity of the patients' presenting complaints (e.g., symptoms consistent with DVT or angina are not managed handled as emergency presentations) • Necessary reassessments were often not performed • Management plans often failed to address diagnostic conclusions or patients' presenting complaints • Management plans often did not account for comorbidities • High risk situations were often not managed appropriately before and/or during procedures • Complications were often not attended to promptly • Resources were often used inappropriately • Management advice given to patients/substitute decision-makers was often not completed and/or documented • Advice given to patients regarding the circumstances under which they should seek urgent/follow-up care and with whom was often not documented • Treatment information was often not provided to patients or substitute decision-makers • Patients' capability of consenting was often not determined/documented when appropriate • Patients were often not notified of treatment options based on clinically significant results of tests

	<ul style="list-style-type: none"> • Important preventive measures were not recommended to patients when appropriate
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MEDICATION:

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

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

ELEMENTS OF QUALITY:

1) Medications were selected appropriately considering:

- Diagnosis
- Patient characteristics (e.g., age, sex, sensitivity/allergy profile)
- Goals of pharmacological treatment

2) Prescriptions were comprehensively documented, including **relevant details** of:

- Name of medication
- Dosage
- Duration
- Quantity/repeats
- Route

3) Information provided to patients was appropriate, including **relevant details** of

- Material risks and benefits
- Side effects (nuisance and serious)
- Contraindications and precautions
- Indications for follow-up (e.g., what to do if side effects occur)

4) Medication monitoring was appropriate, as demonstrated by:

- CPP updates, as applicable
- Ongoing tests, examinations, and investigations (i.e., follow-up plan with time frame for re-evaluation)
- Medication list updated with changes and rationale for changes
- Medication side effects monitored at appropriate intervals
- Evidence of periodic review of chronic medications and discussions with patients regarding the pros and cons of medications as health and age change
- Responsible persons identified for monitoring medications, as appropriate
- Substance misuse issues (e.g., narcotic addiction screening, narcotic addiction monitoring, and medication diversion) are addressed, as appropriate
- Opioid narcotic contracts used when appropriate

5) When drug samples were provided:

- Documentation of drug samples given included:
 - Date provided
 - Name of the drug
 - Drug strength
 - Quantity or duration of therapy
- Samples given to patients have not passed their expiry dates

EVALUATION CRITERIA:

Score	Opportunities for Improvement
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1	<p>Little to no improvement 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"> • When drug samples were given, details of the drug and the need for follow-up were sometimes not documented • Rationale for the selection of medication was sometimes not clear from documentation • Discussions regarding potential side effects of medications were sometimes not documented
2	<p>Moderate improvement 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"> • Discussions with patients regarding potential risks, important side effects, indications for follow-up, etc., were often not documented • Monitoring of medications, side effects, and risks were often inappropriate • Continuation of medications and/or polypharmacy was often inappropriate given patients' conditions • Parameters for medication administration were often not communicated • Inappropriate medications were sometimes prescribed (e.g., antibiotics for viral infections, or narcotics for first line management of chronic non-cancer pain) without plausible rationale documented
3	<p>Significant improvement 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"> • Medications prescribed were often inappropriate given patients' conditions • Important medication information (e.g., medication name, quantity, dose, duration) was often not documented • Significant risks or contraindications were not considered when prescribing medications in one or more cases (e.g., interaction with anticoagulants) • Inappropriate or contraindicated medications, doses, or quantities of medication, which could result in harm, were given to one or more patients (e.g., amoxicillin prescribed when allergy to penicillin exists) • Appropriate medications were often not prescribed for clinical conditions in accordance with current, generally accepted clinical practice guidelines

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 Documentation](#), [Managing Tests](#)

ELEMENTS OF QUALITY:

1) Investigations and laboratory reports were followed up appropriately, as demonstrated by:

- Prompt follow-up of critical investigations and results
- Relevant ordering of follow-up tests
- Timely follow-up of abnormal results (including pathology reports)

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

- Documentation of the purpose of follow-up, any repeat investigations, and outcome targets
- A regularly updated Cumulative Patient Profile (CPP) or equivalent, as applicable
- Coordination with referring healthcare provider, as relevant
- Coordination of ongoing care between specialist and patient's family doctor/general practitioner, as relevant

- e. Interdisciplinary coordination of care between specialist and other healthcare professionals practising in same clinical setting (e.g., nurse practitioner, physician assistant, etc.)
- f. Prompt attention to emergency problems
- g. Effective treatment and monitoring of post-intervention complications, as applicable
- h. Documentation of patient's progress relative to goals
- i. Appropriate use of consultations and mechanism(s) to review of consultant reports
- j. Referrals to/recommendations for relevant community services (e.g., cardiac rehabilitation, cancer support groups, etc.)
- k. Action on hospital discharge recommendations and consultant reports, as applicable
- l. Growth charts, as applicable
- m. Antenatal charts (e.g., Ontario Antenatal Charts), as applicable
- n. Immunization records, as applicable
- o. Flow sheets for chronic conditions and health maintenance, as applicable

3) Linkage to next visit was appropriate, as demonstrated by documentation of:

- a. Expectation for patient follow-up (time, place, circumstances) for acute conditions, as appropriate
- b. Investigations, treatments and/or actions to be completed by patient prior to next appointment
- c. Possible complications and/or adverse events that would be expected to trigger an earlier assessment/appointment
- d. Summary of expected disease course/progression/resolution during time to next follow-up appointment

4) Documentation of chronic disease was appropriate, as demonstrated by documentation of relevant:

- a. Targets (met or unmet)
- b. Ongoing observation, assessment, and treatment of patient
- c. Flow sheets (or equivalent information readily accessible in the record) used and populated to demonstrate disease stability/progression over time
- d. Tests ordered and documented to ensure patient stability or recognize disease progression over time

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>Little to no improvement 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"> • Recommendations for follow-up appointments were occasionally not documented • Parameters for appropriate follow-up were sometimes unclear • Follow-up plans sometimes failed to address comorbid conditions, as applicable
2	<p>Moderate improvement 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"> • Patient monitoring was often insufficiently documented • Results of tests and investigations ordered (i.e., for ongoing investigations and therapies) were often not documented • Indeterminate test results (e.g., contaminated urine C&S specimen, indeterminate STI blood or urine test) were often not followed up on • Interdisciplinary coordination of care was not evident when appropriate • Appropriate urgent consultations/patient visits were arranged but documentation of reasons was often not clear or absent • Rationale for changes to patient treatments were often not documented • Flowcharts (or equivalent) for planned chronic disease management were often not being used proactively

3	<p>Significant improvement 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"> • Relevant <u>follow-up</u> tests were consistently not ordered • Investigations and laboratory reports were not followed up appropriately • Immediate consultations, referrals or transfers were not considered when appropriate • Treatment plans were often not modified according to test results (e.g., urinary culture growth resistant to prescribed antibiotic, warfarin dose adjustments due to abnormal INR, etc.) or referral specialist recommendations • Important patient indicators (e.g., vital signs, medications) were inappropriately monitored in one or more patient records • Hospital monitoring orders were often incomplete (e.g., accurate hourly fluid ins/outs were not done, as applicable) • Changes in patients' conditions were not appropriately followed up • Follow-up investigations were often not appropriately followed up
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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 Documentation](#)

ELEMENTS OF QUALITY:

1) Communication with referring healthcare providers was effective, as demonstrated by:

- Provision of copies of consultation records, assessments, and discharge summaries (and documentation of such)
- Provision of periodic progress reports on long-term therapy patients
- Identification of physicians responsible for patient monitoring and follow-up
- Prompt alerts regarding changes in diagnosis, health status, or therapeutic regimen

2) Communication as a referring source was effective, as demonstrated by:

- Clear and comprehensive articulation of medical consultation requests and referrals including details of:
 - Reason for referral with sufficient clinical detail to assess urgency of consultation
 - Results of investigations to date relevant to reason for referral
 - Results of treatments already/previously initiated
 - Patient history (past history, family history, medications and allergies)
- Appropriate and comprehensive referrals to community services/agencies

3) Communication with other treating professionals was effective, including details of:

- Change in patient condition
- Complications potentially requiring alternate approach
- New conditions
- Investigation results

4) Communication with other health care system partners was appropriate, as demonstrated by:

- Notification to Medical Officer of Health/Public Health Unit follows expectations of public health notification regulatory requirements and guidelines (e.g., Health Protection and Promotion Act list of Reportable Diseases – Ontario Regulation 559/91)
- Transfers to emergency department logged appropriately following clinic process

5) Transfer and/or discharge information was documented, including **relevant details** of:

- a. Purpose of consultations
- b. Diagnoses, including explanations of any inconsistencies between pre-procedural and post-procedural diagnoses
- c. Interventions/treatments proposed or performed
- d. Patient's status
- e. Post-procedural complications (e.g., infections, haemorrhage)
- f. Indication of the patient's comfort or concerns with transfer of care or termination
- g. Risks or concerns about the patient
- h. Recommendations for continued and future management
- i. New medications and/or medication changes
- j. New referrals

6) Hospital discharge summaries were appropriate, as demonstrated by:

- a. Timeliness of communication to family physicians/general practitioners
- b. Comprehensiveness of information about hospital stay
- c. Completion of discharge medication list with new or changed medications
- d. Complete recipient lists inclusive of primary care provider and other relevant health care providers

7) Documentation completed in accordance with the **CPSO Medical Records** policy:

- a. Information was legible, complete, accurate, and presented in a systematic and chronological manner (including date of each professional encounter with the patient)
- b. Patients' charts were filed by name; i.e., not by date of encounter
- c. The record system allows for ready retrieval of an individual patient file verbatim/literal from the Policy***
- d. Abbreviations were appropriate (i.e., no potential for confused interpretation by the range of health care providers who might need to access the record)
- e. Physician-patient encounters, including telephone contact, were documented and dated
- f. Assessments or procedures performed by delegated staff are documented (e.g., BP taken by nurse) and, in the case of shared records, it is clear who made the entry (including identification of each physician)
- g. Most responsible physician ensured trainee entries were accurate
- h. 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
- i. Templates were used appropriately, including pre-populated templates
- j. An effective system existed for recording and managing test findings and follow-up

8) Electronic medical records (EMRs) were appropriate, including:

The EMR system provided a visual display of the recorded information.

- a. The EMR system provided a means of access to the record of each patient by the patient's name and, if the patient had an Ontario health card number, by the health number.
- b. The EMR system is capable of printing the recorded information promptly.
- c. The EMR system is capable of visually displaying and printing the recorded information for each patient in chronological order.
- d. Confidentiality is maintained.

EVALUATION CRITERIA:	
Score	Opportunities for Improvement
1	<p>Little to no improvement 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"> • Medical records were mostly legible (some words were unreadable but charts could be understood by a clinician) • Abbreviations were sometimes inappropriate (i.e., potential for confusion by other healthcare providers) • Cumulative Patient Profiles could be more comprehensive, where applicable • Discharge summaries did not consistently include pertinent details of other health providers' assessments
2	<p>Moderate improvement 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"> • Medical records were somewhat illegible (many words were unreadable; meaning of charts was sometimes unclear) • Patient discharge instructions were often inadequately documented • Arrangements made with patients and families regarding ongoing monitoring and follow-up were not adequately documented • Public Health was sometimes not notified regarding suspected or confirmed reportable communicable diseases, food poisoning, and other mandatory notifiable conditions • Transfer of patients to hospital emergency departments was not consistently documented • Consultation requests to and from family/general practice office were not consistently documented • Physician-patient encounters, including telephone contact, were often not documented, not dated, and, in the case of shared records, it was not clear who made the entry • Information was not presented in a systematic and chronological manner • Templates (including pre-populated templates) were often used inappropriately or not completed in full • Communication to referring healthcare providers or communication as a referring source was often inadequately documented
3	<p>Significant improvement 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"> • Medical records were often illegible (most words unreadable; meaning of charts was generally unclear) • Discharge summaries often lacked important detail, were poorly organized, or were not completed • Discharge medication reconciliations were consistently not documented • Documentation to referring sources and/or other health professionals were often delayed, which could result in patient harm • Trainee entries were often not checked for accuracy • Cumulative Patient Profiles (or equivalent) were not used and/or not kept up to date, where applicable • Coordination of care between consultant/specialist and referring healthcare providers was not evident • Overall, the clinical notes did not tell the story of patients' health care conditions in a way that would allow other healthcare providers to understand them

Appendix A – 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	✓	✓	✓				
PEER ASSESSMENT COMPONENTS	Pre-visit Questionnaire*				✓		✓	✓
	Physician Discussion*				✓		✓	✓

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

CanMEDS and Continuing Professional Development

CanMEDS is widely incorporated into Continuing Professional Development (CPD) activities that are 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.