

Peer & Practice Assessment Handbook

Rheumatology

Acknowledgments

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Peer Assessment Handbook: Rheumatology

Table of Contents

1. Introduction to Peer and Practice Assessment.....	4
1.1 Purpose of Peer and Practice Assessment.....	4
1.2 Development and Maintenance of Peer Assessment Tools	4
1.3 CanMEDS in Peer Assessment	5
1.4 How to use the Peer and Practice Assessment Handbook	6
2. Peer Assessment Process.....	7
3. Assessment Tools and Protocols.....	10
3.1 Patient Record Selection Protocol	10
3.2 Physician Discussion Guide	12
4. Assessment Framework and Scoring Rubric	13
4.1 Peer Assessment Framework.....	13
4.2 Scoring Rubrics: Rheumatology	14
HISTORY	14
EXAMINATION.....	16
DIAGNOSIS	18
MANAGEMENT PLAN	19
FOLLOW-UP & MONITORING.....	21
DOCUMENTATION FOR CONTINUITY OF CARE.....	22
5. Assessment Templates.....	24
5.1 Patient Record Summary	24
5.2 Peer Assessment Report	26
Appendix A – Development and Evaluation Process	32
Appendix B – CanMEDS in Peer Assessment	35

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 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.



2

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**.

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.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 must be available if questions arise**. The physician must also set aside time at the end of the visit for the assessment physician 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 notes for each record using the **patient record summary** (section 5.1).

E. *Physician Discussion*

- In addition to reviewing patient records, the assessor has a discussion 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.
 - 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 two main resources to guide this process:
 - The **scoring rubric** (see section 4.2) defines the elements of quality and evaluation criteria used during assessments within a given specialty or discipline. 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 **quality improvement resources** (see section 6) provide more granular information about specific conditions, procedures, or patient populations.
- 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.
- All assessed physicians are asked to complete a Post-Assessment Questionnaire, which is provided by the assessor following the assessment.
- Physicians may also be asked to provide further feedback via follow-up surveys or telephone discussion conducted by the CPSO's Research and Evaluation Department to contribute to the ongoing evaluation of the peer assessment program.

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 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 Rheumatology:

Number of records: In total, the assessor will review approximately 15 - 20 patient records.

Timeframe:

Physician selected: Any time period

Assessor selected: Index dates of at least 2-3 months prior to the date of assessment

Selection Process:

- Prior to the assessment, the physician to be assessed will select 10 patient records that represent his/her scope of practice, including both new and long-term patients. He/she will also retrieve appointment schedules (day sheets or equivalent) corresponding to approximately 50 different patient visits from at least 2-3 months prior to the date of the assessment. Appointment schedules should minimally specify patient name, date of index visit, and diagnosis/presenting complaint for that index visit.
- On the day of the assessment, the physician to be assessed will be prepared to provide an overview of how patient records are organized (EMR and/or paper) to orient the assessor and be available to retrieve additional patient records, as requested. The assessor will review 5 of the 10 records pre-selected by the assessed physician and will randomly select an additional 10 – 15 records from the 50 visits provided on the appointment schedules.

Types of Records: Inclusion of both new and long-term patients

Patient Record Review

The assessor will review patient records in sufficient detail to evaluate the quality of patient care across visits.

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 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). Details of how these domains align with the CanMEDS framework can be found in **Appendix B**.

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) supports 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 criteria and sought feedback from practicing physicians and specified physician specialty organizations to ensure the relevance and appropriateness of the tools. The criteria in the rubric are periodically reviewed to ensure they are up-to-date.

Assessors use the scoring rubric 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: Rheumatology

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 College policies (e.g., Medical Records, 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](#) [Confidentiality of Personal Health Information](#)

ELEMENTS OF QUALITY:

The CPP is highly recommended for specialists’ patient records, especially those specialists who see patients on an ongoing basis. Initial consultation histories can form the basis of the Cumulative Patient Profile (CPP). Subsequent histories can be taken with reference to the existing and evolving CPP.

1) Demographic information was documented, including:

- a) Age/date of birth
- b) Gender information
- c) Patient contact information

2) Reason for assessment/consultation was documented, including **relevant details** of:

- a) Referral information
- b) Chief complaint(s)
- c) 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) Pertinent positives and negatives
- d) Targeted functional inquiry
- e) Functional status (activities of daily living)
- f) Extra-articular manifestations and other associated symptoms
- g) Management history (previous investigations and treatment) of presenting illness

4) Review of systems was documented

5) Medical histories were documented, including **relevant details** of:

- a) Past medical conditions/medical comorbidities
- b) Past and ongoing medical treatment and surgeries
- c) Immunization history, where relevant
- d) Allergies and sensitivities (medications, food, environment)

e) Family medical histories 6) Medication histories were documented, including relevant details of: <ul style="list-style-type: none"> 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 herbal substance use as relevant) d) Drug coverage 7) Social histories were documented, including relevant details of: <ul style="list-style-type: none"> a) Education/Occupation b) Marital/relationship status c) Social support d) Religious practice, as relevant e) Lifestyle (smoking, exercise, use of recreational drugs/alcohol) f) Legal guardians (e.g., power of attorney), as relevant <p><i>Specific cases may require additional history documentation, as appropriate, relating to:</i></p> 8) Reproductive and sexual histories were documented, including relevant details of: <ul style="list-style-type: none"> 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 9) Mental Health histories were documented, including relevant details of: <ul style="list-style-type: none"> a) Past and current psychiatric conditions b) Previous treatments and/or hospitalizations c) Past or current family violence/abuse d) Assessment of suicidality / homicidality 	
EVALUATION CRITERIA:	
Score	Opportunities for Improvement
1	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: <ul style="list-style-type: none"> Family histories were sometimes missing Information regarding drug coverage was sometimes not included
2	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: <ul style="list-style-type: none"> Functional status was often not included Medication histories were often not complete
3	Significant improvement 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"> Presenting illness histories consistently lacked sufficient detail (e.g., extra-articular manifestations, positive/negative features, aggravating/relieving factors)

EXAMINATION:

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

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

ELEMENTS OF QUALITY:

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

- a) Vital signs and weight, with abnormalities highlighted, where appropriate
- b) Pertinent positive and negative findings
- c) Findings of active inflammation and damage
- d) Evidence for consideration of potential complications of disease (e.g. edema in nephritis)
- e) Evidence for consideration of potential complications of treatment (e.g. BP in patients on NSAID or steroid)
- f) Relevant descriptive information (e.g., deformity)
- g) Illustrations of conditions, where appropriate (e.g., location of rash, tenderness)

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"> Vital signs were occasionally missing
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"> Physical examinations were not consistently and/or sufficiently recorded (e.g., joint counts, screening for extra-articular manifestations or comorbidities)
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"> Examinations were consistently not thorough enough to allow for diagnoses or to justify significant changes in management

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

- a) Reason for investigation (e.g., based on histories, examinations and presenting conditions)
- b) Clear establishment of patient baseline functions (e.g. creatinine and liver function test and diabetic status)
- c) Consideration of differential diagnosis
- d) Review of previous investigations and findings, as relevant
- e) Urgency (e.g., life-threatening conditions prioritized)
- f) Judicious use of resources

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) 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.

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"> Potential over-use of tests (e.g., related to Choosing Wisely recommendations)
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"> Rationale for tests/investigations was often unclear (i.e., some tests were conducted without obvious reason) Analyses of test results were often incomplete Follow-up of abnormal test results was often delayed
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"> Analyses of test results were often incorrect and/or significant investigative abnormalities not noted or followed-up Invasive testing was conducted without appropriate indication

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, considering:

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

2) Working and/or final diagnoses were **clearly stated with, as appropriate, differential diagnosis**

- a) Description of supporting evidence for differential diagnosis

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"> No discussion of differential diagnosis in straight-forward cases
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"> Relevant differential diagnoses were often not recorded
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"> Diagnoses were often inappropriate given the available information

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 appropriately, with **relevant details** of:

- a) Treatment plans consistent with and appropriate given results of investigations
- b) Appropriate referrals
- c) Appropriate pre-treatment screening for contra-indications or cautions
- d) Consideration of co-morbidities or cautions in treatment plans (e.g. biologic check-list)
- e) Relevance of ordered/conducted tests, procedures and referrals
- f) Employment of patient safety and infection control measures as warranted (e.g., vaccinations)
- g) Judicious use of resources (e.g., referrals, requisitions, and use of community resources)
- h) Consideration of patient circumstances and costs (e.g., coverage for medication, physiotherapy)
- i) Special considerations: deliberation of treatment rationale with consideration of alternatives

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

- a) Purpose of treatment
- b) Goals and milestones of treatment
- c) Treatment outcomes (e.g., patients' responses, good/bad effects, treatment errors, and suggestions for improvement)
- d) Discussions of patients' expectations and compliance related to treatment processes
- e) Explanations to patients regarding management plan, options, risks, benefits and potential side effects to enable an informed consent
- f) Advice and/or education material given to patients/family
- g) Prompt follow-up of critical investigations
- h) Prompt and appropriate responses to unexpected or adverse intra-procedural events and complications

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 alert bracelets were not discussed with patients when appropriate
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"> Significant co-morbidities were often not considered in management plans
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"> Complications of the rheumatic disease or treatment were often not managed or documented One or more patients were dismissed without appropriate redirection (e.g., patients presenting with conditions not within bounds of specialty were discharged without proposing possible alternative care)

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

1) Medications were selected appropriately considering:

- a) Diagnosis
- b) Patient characteristics (e.g., age, sex, sensitivity/allergy profile)
- c) Treatment goals

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

- a) Name of the drug
- b) Dosage
- c) Quantity/duration/repeats
- d) Instructions for use/route

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

- a) Material risk/benefits
- b) Side effects (nuisance and serious)
- c) Contraindications and precautions (e.g. discussions regarding safety of medications for pregnant or nursing patients; expiration date for drug samples)
- d) Indications for follow-up (e.g. what to watch for and what to do if side effects occur)

4) Medication monitoring was appropriate, as demonstrated by:

- a) Ongoing tests, examinations, and investigations (e.g., laboratory, x-ray)
- b) Medication list updated with changes and rationale for changes
- c) Medication side effects monitored at appropriate intervals, with serious adverse events documented
- d) Responsible persons identified for monitoring medications, as appropriate
- e) Substance misuse issues addressed, as appropriate

EVALUATION CRITERIA:

Score	Opportunities for Improvement
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. Examples include: <ul style="list-style-type: none"> • Medications not adjusted appropriately following potential ill-effect or lack of effect • The rationale for or dose of medication was often unclear or undocumented • Inadequate monitoring for potential side-effects • Complete medication lists were often not adequately maintained
3	Significant improvement 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"> • Medication prescriptions and follow-up were inappropriate based on patients' conditions • Allergies, co-morbidities and/or adverse events were often not sufficiently considered when prescribing medications • Inadequate monitoring of opioid prescriptions (e.g., exact dates and quantities of opioids prescribed not recorded) • Appropriate pre-treatment screenings for contraindications or cautions were consistently not conducted

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

- a) Relevant follow-up tests ordered
- b) Abnormal results followed-up in a timely fashion

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

- a) Prompt attention to emergency problems
- b) Documentation of patient progress relative to goals
- c) Completion of ongoing assessments
- d) Appropriate monitoring for effects and side-effects of treatment and disease
- e) Follow-up visits include review of interval changes in patient condition and medications, and assessment of patient adherence
- f) Use of regularly updated Cumulative Patient Profiles (highly recommended for specialists), as appropriate, including: disease evolution, allergies, medication list, serious adverse events, medical, surgical and traumatic history

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"> • Age-specific screenings (e.g. bone densitometry) were sometimes not completed or not commented on yearly
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 sometimes inadequate (e.g., failure to monitor BP, blood sugar, or bone density for patients on steroids) • Follow-up for disease/treatment complications was sometimes insufficient
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"> • Responsibilities for patient monitoring were often unclear • Follow-up examination were often not conducted when appropriate • Abnormal test results (including those not related to the specialty) were often not followed up

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) Communication with referring sources was effective, as demonstrated by:

- a) Provision of copies of assessments and discharge summaries
- b) Provision of periodic progress reports of long term therapy patients (i.e., with primary care-giver - at least every 6 months or after major event/change)
- 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) Transfer and discharge information was documented, including **relevant details** of:

- a) Diagnosis
- b) Treatments already provided
- c) Recommendations for continued and future management
- d) Indication of the patients' comfort or concerns with transfer of care or termination
- e) Risks or concerns about the patient
- f) New medications and/or medication changes
- g) New referrals

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

- a) Information was legible, complete, accurate, and presented in a systematic and chronological manner
- b) Patients charts filed by name; i.e., not by date of encounter
- c) Abbreviations were appropriate (i.e., no potential for confused interpretation by the range of health care providers who might need to access the record)
- d) Physician-patient encounters, including telephone contact, were documented and dated
- e) In the case of shared records, it is clear who made the entry
- f) Most responsible physician ensures trainee entries were accurate
- g) 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
- h) When templates are employed, they are used appropriately, including pre-populated templates

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor. <ul style="list-style-type: none">• Occasional failure to copy results to relevant referring/treating/primary care physicians• Medical records were mostly legible (some words were unreadable but records could be understood by a clinician)
2	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: <ul style="list-style-type: none">• Majority of patient records were disorganized• Delegated acts/care were often not counter-signed when appropriate• Patient records were not maintained in a timely manner (i.e., reporting was often delayed)• Medical records were somewhat illegible (many words were unreadable; meaning of records was sometimes unclear)
3	Significant improvement 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"> • Communication with primary care providers was consistently inadequate (e.g., frequency, clarity, quality) • Referrals were often not made when appropriate or were inappropriate to the clinical situation • Medical records were often illegible (most words unreadable; meaning of charts was generally unclear)
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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

Selector of patient record ☐ Assessed Physician ☐ Assessor

Patient Identifier (Initials/Chart Number):

--

Date of Birth (dd/mm/yyyy):

Gender:

--	--

Date range of record reviewed (dd/mm/yyyy - dd/mm/yyyy):

--

Presenting Problem of Patient/Clinical Issue:

--

Comments / Concerns / Recommendations:

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 in discussion 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"> • Demographic information • Reason for assessment/consultation • Presenting illness histories • Review of systems • Medical histories | <ul style="list-style-type: none"> • Medication histories • Social histories • Reproductive and sexual histories • Mental health histories |
|---|--|

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

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.

- Investigations and laboratory reports followed up appropriated
- 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.

- Communication with referring sources
- 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, 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., rheumatology) 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., Ontario Rheumatology Association) were contacted and invited to provide feedback about the scoring rubrics and quality improvement resources. 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 physicians 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	✓	✓	✓				
PEER ASSESSMENT COMPONENTS	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.