

Peer & Practice Assessment Handbook

Hospitalists

Acknowledgments

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The Hospitalist Peer and Practice 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 formal quality assurance or assessment programs without express agreement from the CPSO.

For inquiries, please contact the CPSO Quality Department.

Peer Assessment Handbook: Hospitalists

Table of Contents

1. Introduction to Peer Assessment.....	4
1.1 Purpose of Peer 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 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	14
4.1 Peer Assessment Framework.....	14
4.2 Scoring Rubric	15
HISTORY	15
DIAGNOSIS	19
MANAGEMENT PLAN	20
FOLLOW-UP & MONITORING.....	22
DOCUMENTATION FOR CONTINUITY OF CARE.....	23
5. Assessment Templates.....	25
5.1 Patient Record Summary	25
5.2 Peer Assessment Report	27
Appendix A – Development and Evaluation Process	34
Appendix B – CanMEDS in Peer Assessment	37
Appendix C - Choosing Wisely Canada – Hospitalist Medicine.....	38

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 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 Assessment Handbook

The Handbook is designed to be a resource for both assessors and physicians undergoing assessment. It describes the peer assessment process and outlines 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 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 is available if questions arise**. The physician must also set aside time at the end of the visit for the assessment discussion. Some assessors prefer to conduct the record review in an interactive fashion with the physician throughout the duration of the visit; **this will be clearly communicated by the assessor to the physician prior to the assessment date**.

Phase 2 - During the Assessment

C. Initial Discussion

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

D. Patient Record Review

- The assessor reviews a sample of the physician's patient records that have been selected using a discipline-specific **patient record selection protocol** (section 3.2).
- The assessor records 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 (the **scoring rubrics** [section 4.2] can be used as informational tools during this time).
 - 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 assessor uses two main resources to guide decision-making and feedback during the record review:
 - The **scoring rubric** (see section 4.2) defines the elements of quality and evaluation criteria used during assessments. The scoring rubrics are intended to be broadly applicable across diverse patient care interactions and provide an extensive framework for evaluating care and documentation within a practice discipline.
- The assessor submits the assessment report and patient record summaries to the College for review.
- The College 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 College committee comprised primarily of physicians with additional public members from the CPSO Council. The committee reviews assessment reports and provides additional feedback to assessed physicians, either recommending no further action or directing appropriate follow-up to ensure physicians are meeting the standard of practice in Ontario.
- 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

- Ideally, peer assessments will provide feedback to physicians that prompts practice improvements.

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 Hospitalists:

1. In advance of the assessment:

- a. The **physician to be assessed** will:
 - Liaise with the Medical Records department to ensure that the assessor will have access to all necessary resources in order to review entire patient records (i.e., EMR, paper notes, summaries) on the day of the assessment (note: a temporary EMR password will need to be set up in advance)
 - Retrieve 25-30 patient records reflecting a variety of diagnoses and patient management scenarios (e.g., initial management, referrals from other services, discharge) representing the scope of practice, in which the physician to be assessed has been responsible for the majority of patient care (i.e., most responsible physician for at least 80% of care)
- b. The **assessor** will:
 - Liaise with the physician to be assessed **and** the relevant Medical Records personnel as necessary to ensure that all aspects of patient record selection process are prepared

2. On the day of the assessment:

- a. The **physician to be assessed** will:
 - Provide an overview of the patient record filing system to orient the assessor
 - Be prepared to assist in retrieving additional patient records as needed
- b. The **assessor** will:
 - Select 10-15 of the patient records assembled by the physician to be assessed
 - Review the following content areas, where possible:
 - Initial patient management (e.g., first 3-4 days)
 - Collaboration and coordination of patient care with medical colleagues and allied health professionals

- Cases outside of the assessed physician's area of expertise
- Interaction with families of patients, where indicated
- Discharge process including involvement with CCAC and the patient's primary care physician

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

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 issues and topics which cannot be determined from reviewing patient records. As well, the assessor may solicit information to clarify issues or questions which 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.

Discussion Themes for Hospitalists:

1. Transitions of care

- a. How do you minimize risks to patients during transitions of care (e.g., community to hospital, moves within hospital, changes of MRP, discharge to community)?
- b. How do you communicate during patient handover?
- c. How do you communicate with other disciplines?

2. System-level care

- a. What is your role in improving the care, efficiency and safety of patients within your hospital?
- b. What is your role in appropriate utilization of resources in the hospital?
- c. How do you facilitate the navigation of patients through the hospital?

3. Social aspects of care

- a. How do you incorporate patients' social histories and contexts into their care?
- b. How do you consider a patient's social context during discharge?

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 Rubric

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 (appropriate to the presenting condition) 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

Histories were **dictated/documented in a timely manner** (suggested within 24 hours from admission)

1) Reason for admission was documented, including **relevant details** of:

- a) Chief complaint(s)
- b) Source of history information (e.g., patient, interpreter, family member, Ambulance Call Report, long-term care staff)

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

- a) Onset and evolution
- b) Symptom description, duration, aggravating and relieving factors
- c) Nature, location, and duration of pain
- d) Presence of infectious symptoms
- e) Pertinent positives and negatives
- f) Targeted functional inquiry
- g) Functional status (activities of daily living)
- h) Falls (witnessed or un-witnessed)

3) Review of Systems was documented

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

- a) Past medical conditions / medical comorbidities
- 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/complimentary medications/supplements and (over the counter drugs)

d) Drug coverage	
6) When relevant, social histories were documented, including pertinent details of:	
a) Education/Occupation	
b) Marital/relationship status	
c) Social support	
d) Lifestyle (smoking, exercise, use of recreational drugs/alcohol)	
e) Legal guardians (e.g., power of attorney) as relevant	
f) Advanced directives	
7) When relevant, reproductive and sexual histories were documented, including pertinent 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 pertinent details of:	
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	<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"> • Social histories sometimes lacked pertinent details • Medication histories lacked appropriate inquiry (e.g., about NSAID use or factors that may influence INR (i.e., over the counter products that may prolong INR)) • Family histories were often not addressed
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"> • Presenting illness histories lacked sufficient detail to support conclusions (e.g., no clear link between cause and effect, lack of significant positives and negative features) • Review of systems was often incomplete • Social histories often lacked important details (e.g., alcohol and smoking) • Past medical histories were often too brief (e.g., “History of heart disease” documented with no useful detail) • Medication histories were often not complete (e.g., recent medication changes not explored; doses not listed)
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"> • Histories were consistently dictated in an untimely fashion (i.e., more than 24 hours from time of admission) • One or more records contained significant omissions in history (e.g., did not note conditions for which there were medications listed) • Records consistently showed an over-reliance on previously collected histories (e.g., emergency report or nursing home transfers of care) without appropriate revisions after admission • Presenting complaints often lacked sufficient detail and histories were generally disorganized with no logical sequence of events

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) Pertinent positive and negative findings
- b) Vital signs, with abnormal vital signs highlighted where appropriate
- c) Relevant descriptive information (e.g., "heart murmur" - where it is heard, systoli/diastoli, etc; dimensions indicating spread of cellulitis observed across multiple examination points)
- d) Illustrations of conditions, where appropriate (e.g., location of rash, tenderness, laceration)
- e) Description regarding general appearance, level of alertness, comfort level

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

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

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"> Physical examinations sometimes included components not pertinent to the presenting complaints or pre-existing or co-morbid conditions
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"> General appearance, level of alertness, and comfort level were often not documented Physical examinations were often not related to histories and presenting complaints Observations were often poorly described
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"> Key elements of the physical examinations were consistently not documented (i.e., pertinent positive and negative findings) In a number of records, examinations did not include attention to conditions/problems documented in nurses' notes

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) Rationale (e.g., based on histories, examinations and presenting conditions)
- b) Consideration of differential diagnosis
- c) Review of previous investigations and findings as relevant
- d) 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) Urgent situations were **responded** to appropriately, as demonstrated by:

- a) When presenting symptoms indicated major threat to life (e.g., acute neurological change, acute sepsis), there was sufficient documentation of pertinent investigation and relevant negatives as well as appropriate initiation of urgent speciality consults

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"> Inappropriate benign investigations (i.e., not relevant to treatment or monitoring of present conditions) were sometimes completed
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 comprehensive (i.e., not all relevant investigations were considered/completed)
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 investigations and relevant findings were not sufficiently documented in one or more records Specialty consults were not urgently initiated for unstable patients Relevant investigations/work-ups were consistently not ordered Investigations were often inappropriate for the patients' symptoms, histories, or comorbid conditions

DIAGNOSIS:

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

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

Elements of Quality

1) Diagnostic conclusions were appropriate, as demonstrated by:

- a) Alignment with histories, examinations, and investigations
- b) Consideration of most/least likely and other possible causes
- c) Consideration of comorbidities and presenting symptoms
- d) Noting acuity and/or severity as relevant

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

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"> Alternative diagnoses were often considered, as evidenced by treatment plans, but were not documented as clear differential diagnoses
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"> Differential diagnoses were often too narrow Diagnoses were often inferred but not explicitly documented Problem lists were often too brief to support an appropriate treatment plan
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"> Differential diagnoses were often not clearly defined Significant comorbidities were consistently not considered in diagnostic methods Differential diagnoses often did not align with results of investigations Primary diagnoses were often not documented

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, as **demonstrated by:**

- a) Alignment of treatment plans with results of investigations
- b) Appropriate pre-treatment screening for contra-indications or cautions
- c) Consideration of co-morbidities in treatment plans
- d) Relevance of ordered/conducted tests, procedures and referrals
- e) Employment of patient safety and infection control measures as warranted
- f) Judicious use of resources (e.g., referrals and requisitions)
- g) Use of evidence-based guidelines (e.g., anticoagulation)

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

- a) Purpose of treatment
- b) Goals and milestones of treatment, when relevant (e.g., extent of functional recovery after stroke)
- c) Treatment outcomes (e.g., patients' responses, positive or negative effects, treatment errors, and suggestions for improvement)
- d) Discussions of patients' expectations and compliance related to treatment processes
- e) Explanations to patients/families/power of attorneys regarding management plan, options, risks, benefits and potential side effects to enable an informed consent
- f) Advice and education material given to patients/family
- g) Advanced directives / AND (Allow Natural Death)
- h) Prompt follow-up of critical investigations
- i) Ongoing consultation with appropriate specialists and other health care professionals (e.g., OT, PT, SLP, SW, CCAC, dietician, RT)

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"> Documented discussions with patients and families could include more detail Allied health professionals were not always consulted when appropriate (e.g., occupational or physiotherapy)
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 consultations were often not initiated or considered too late in hospital stay New symptoms and/or changes in conditions were often not addressed 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"> Management plans were consistently not aligned with results of investigations (i.e., failed to address results of all investigations or included treatments for conditions with no record of investigations) Documentation of management plans often lacked important details (e.g., code status, discussion of management plan with next of kin or power of attorney (when relevant)) Relevant evidence-based guidelines were often not followed

	<ul style="list-style-type: none"> • Potential emergent conditions (e.g., blood on hold for transfusion) were not planned for • Discussions with patients regarding management plans, informed consent, and/or patients' statuses were often not documented • Appropriate specialists were often not consulted in the development of management plans
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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:

- Diagnosis
- Patient characteristics (e.g., narcotics, benzodiazepines, and antipsychotics were appropriate to patients' age and weight)
- Treatment goals (when relevant)
- Potential risks (e.g., VTE)

2) Medication orders were appropriate and comprehensively documented, including **relevant details** of:

- Type
- Dosage
- Quantity/repeats
- Route
- IV fluid type, composition and rate

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

- Material* risks and benefits (i.e., make clear without legalize)
- Side effects significant and serious) (e.g., anti-coagulants)
- Contraindications and precautions
- Indications for follow-up (e.g. what to do if side effects occur)

4) Medication monitoring was appropriate, as demonstrated by:

- Ongoing tests, examinations, and investigations
- Medication lists updated with changes and rationale for changes
- Medication side effects monitored at appropriate intervals
- Responsible persons identified for monitoring medications, as appropriate
- Substance misuse issues addressed, as appropriate

*Material risks are those that a reasonable person would find important to consider when making decisions regarding treatment options.

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"> • Rationale for selection of medications was often 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"> • Significant medication risks were often not discussed with patients or families

	<ul style="list-style-type: none"> Monitoring of medications, side effects and risks were often inappropriate Inappropriate continuations of medications were prescribed given patients' conditions Parameters for medication administration were often not given
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"> Inappropriate medications or doses of medications, which could result in harm, were prescribed/administered to patients IV fluids were not consistently managed and monitored Medications were often inconsistent with patient conditions and/or were not in accordance with current clinical practice guidelines Medication orders were often not reviewed after transfers from the emergency department Medications were often ordered without appropriate investigations Medical Reconciliation Summaries (MRSs) were often not completed Medication errors were not adequately documented Institute for Safe Medication Practices (ISMP) guidelines were not consistently adhered to Important preventive measures (e.g., VTE prophylaxis) were not taken when appropriate

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:

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

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

- Prompt attention to emergency problems
- Documentation of patient progress relative to goals
- Completion of ongoing assessments
- Patients with potentially infectious diseases isolated
- Implementation of appropriate preventive measures (for pressure sores, falls, line-associated infections)

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"> Follow-up plans sometimes failed to address comorbid conditions
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 orders were often not documented Discharge planning was often not considered early enough in 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"> • Important patient indicators (e.g., vital signs, medications) were inappropriately monitored in one or more patient records • Monitoring orders were often incomplete (e.g., accurate hourly fluids ins/outs were not done) • Immediate consultations or transfers were not considered when appropriate • Changes in patients' conditions were not appropriately monitored or followed-up on • Investigations were often not appropriately followed-up on • Patients with potentially infectious diseases were not isolated
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DOCUMENTATION FOR CONTINUITY OF CARE:

Documentation in the patient record, 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) Hospital discharge summaries were appropriate, as demonstrated by:

- Timeliness of dictation (suggested within 24-48 hours)
- Comprehensiveness of information about hospital stay, including:
 - Most responsible diagnosis
 - Course in hospital
 - Investigations/procedures in hospital
 - Follow-up plans
- Completion of discharge medication list with new or changed medications
- Relevant input from nurses and other healthcare professionals (e.g., PT, OT, social worker, CCAC, dietitian, SLP, RT)
- Documentation of outstanding tests and results
- Recipient lists inclusive of primary care providers and other relevant health care providers (e.g., CCAC)
- Provision of instructions for primary care provider(s) regarding follow up (e.g. details re: situations of medical risk or medication changes)
- Information provided to patients/families regarding conditions, prognoses, instructions for follow up
- Appropriate information provided supporting effective transfer of care

2) Death summaries followed a logical flow, and included **relevant details** of:

- Most probable cause of death
- Other contributing causes of death
- Co-morbid conditions, pre-admission and in hospital
- Course in hospital
- Investigations

3) Documentation adhered to the record keeping requirements specified by CPSO Policy:

- Information was legible, complete, accurate, and presented in a systematic and chronological manner
- Abbreviations were appropriate (i.e., no potential for confused interpretation by the range of health care providers who might need to access the record)
- Physician-patient encounters, including telephone contact, were documented, dated, and in the case of shared records, it is clear who made the entry
- Most responsible physician ensures medical trainee entries were accurate
- 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
- Templates were used appropriately, including pre-populated templates

g) An effective system exists for recording and managing test findings and follow up	
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"> Discharge summaries did not consistently list 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"> Patient death summaries often did not follow a logical flow Patient discharge instructions were often inadequately documented Discussions with patients and families regarding ongoing monitoring and follow-up were not adequately documented Discussions regarding dangers of driving were not documented, when relevant, in one or more patient records
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"> Discharge medication reconciliations were consistently not documented Discharge summaries often lacked important detail, were poorly organized, or were not completed Documentation to referring sources and/or other health professionals were often delayed, which could result in adverse patient outcomes

5. Assessment Templates

5.1 Patient Record Summary

The Patient Record Summaries are records of each chart reviewed during the assessment. The 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 will inform the Peer Assessment Report and be attached to the final report submitted to the College. This package will be reviewed by the Quality Assurance Committee and will be 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), you should clarify this 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:* The identifier can be patient initials or a chart number. Full patient names should not be used.
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 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 is for recording essential details from review of each patient record. 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):* Include a brief statement about whether or not concerns were found in the record. Exemplary documentation and care can be recognized here (as appropriate). When follow-up discussion with the physician clarifies issues or concerns noted in a patient record summary, relevant clarifying information should be added.

PATIENT RECORD SUMMARY TEMPLATE

Chart #1

Patient Identifier (Initials/Chart Number):

--

Date of Birth (dd/mm/yyyy):

Gender:

--	--

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

--

Presenting Problem of Patient/Clinical Issue:

--

Comments / Concerns / Recommendations:

--

Specific Concerns:

Clarification from physician discussion (if relevant):

--

5.2 Peer Assessment Report

The Peer Assessment Report provides an overall summary of the assessment. The report template guides the format of the report. The report will include relevant background information about the physician's practice, highlight areas of appropriate care, detail areas for improvement across the eight assessment domains, summarize pertinent information from the discussion, and provide 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 will then be provided to the assessed physician.

Instructions to Assessors for completing the Peer Assessment Report:

The Peer Assessment Report should be completed after all the patient records have been reviewed and the discussion with the assessed physician has taken place. The report should provide 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:* Insert the assessed physician's name, CPSO number and the scope of practice that was assessed. Insert the assessed physician's initials in the footer at the bottom left of the page (this will automatically be copied onto all subsequent pages).
2. *Assessment Information:* Insert your 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, insert the amount of time spent completing the patient record review and the amount of time spent discussing with the physician. Sign the form when completed.
3. *Relevant Background Information:* Provide 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 specific information that informed the assessment.
4. *Ratings & Comments:* For each assessment domain, provide a rating (1, 2, or 3) based on your overall assessment of the physician's practice. The scoring rubrics should be used to guide your decision making about ratings. Ratings should be 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:* Briefly summarize positive aspects of the physician's practice, as they relate to the elements of quality, in order to validate and encourage continued effort in these areas. Summarize optional suggestions for practice improvement and professional development.
 - ii. *Specific Concerns Requiring Attention and Recommendations for Practice Change:* Describe specific concerns that were identified during the assessment, including both the nature and extent of the concerns, as well as specific recommendations for improvement in this area. When relevant, refer to examples in specific patient record summaries. Clear and concise narrative details are vital for the Quality Assurance Committee's understanding of the issues and ability to make valid decisions and recommendations.
5. *Summative Comments:* Provide a brief summary of your overall assessment of the physician's practice across all eight domains including aspects of quality care and any areas of concern. 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:											
<p align="center">Ratings and Comments</p> <p>1 - Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor.</p> <p>2 - Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low.</p> <p>3 - Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected.</p>											
<p>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.</p> <table border="0"> <tr> <td>• Reason for admission</td> <td>• Medication histories</td> </tr> <tr> <td>• Presenting illness histories</td> <td>• Social histories</td> </tr> <tr> <td>• Review of systems</td> <td>• Reproductive and sexual histories</td> </tr> <tr> <td>• Medical histories</td> <td>• Mental health histories</td> </tr> </table>				• Reason for admission	• Medication histories	• Presenting illness histories	• Social histories	• Review of systems	• Reproductive and sexual histories	• Medical histories	• Mental health histories
• Reason for admission	• Medication histories										
• Presenting illness histories	• Social histories										
• Review of systems	• Reproductive and sexual histories										
• Medical histories	• Mental health histories										
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>Examination: Guided by the presenting problem, a systematic evaluation of the patient's physical and/or mental state.</p>											

<ul style="list-style-type: none"> • Physical Examinations • Psychological Examinations 			
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 • Urgent situations responded to 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 			
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
- Medication orders appropriate
- Information provided to patients appropriate
- 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 appropriately
- 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.

- Hospital discharge summaries appropriate
- Death summaries followed logical flow

- Documentation adhered to the record keeping requirements specified by CPSO Policy

Rating:

1 ☐

2 ☐

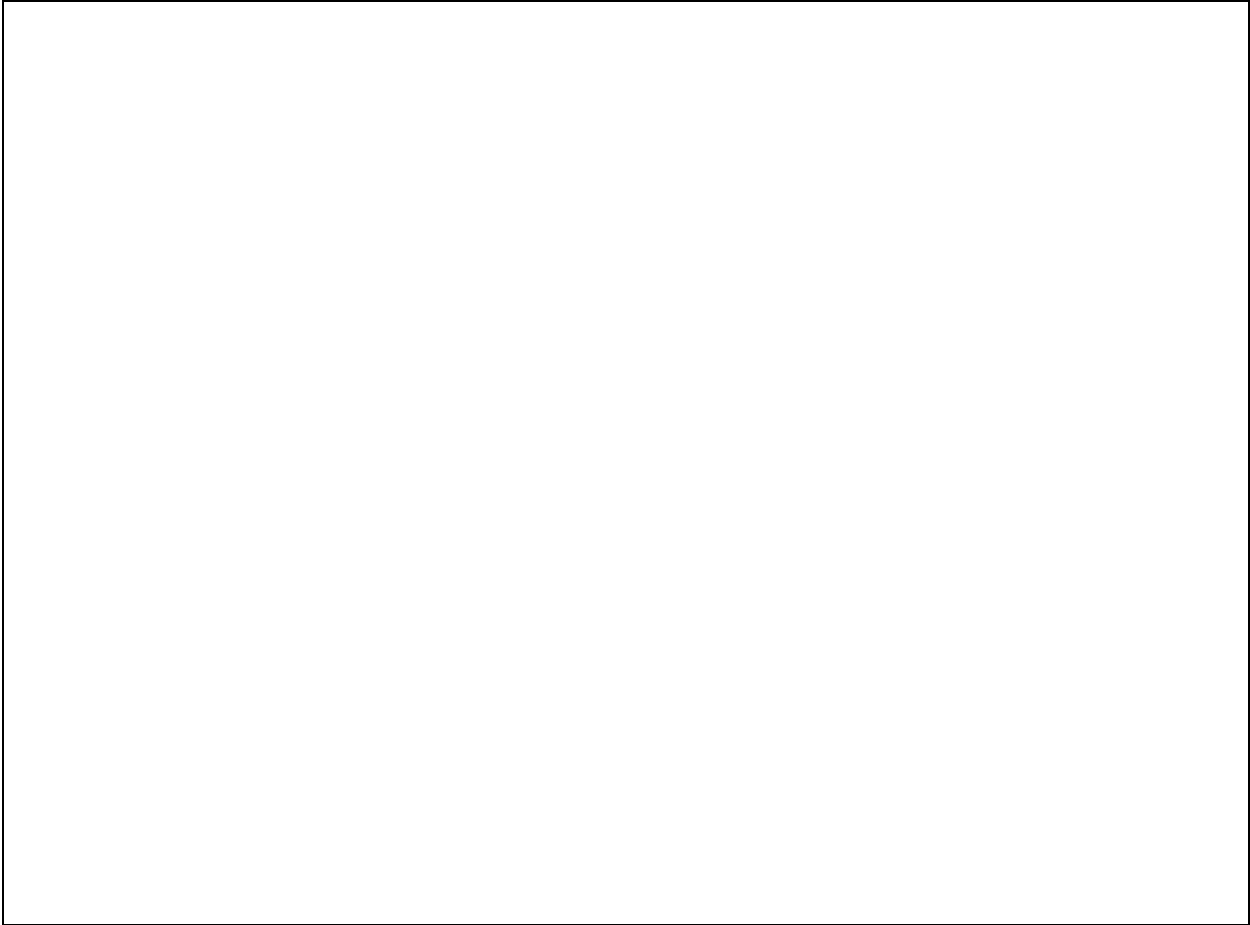
3 ☐

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 educational 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:

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 scale was developed for rating performance and assessors populated discipline-specific examples for each score to provide comprehensive scoring rubrics for assessor decision making. 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' decision making.

Using simulated records and the discipline-specific scoring rubrics, assessors would make ratings anonymously and then be presented with the ratings of all other assessors to see their consistency with each other. They would then discuss any disagreement by sharing their unique perspective on the case and each make a new rating until an acceptable level of agreement was met. Through this exercise, assessors would identify areas of potential inconsistency in their interpretations and actively work 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 physicians within a specific discipline (e.g., Hospitalists) 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 were contacted and asked 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 will be conducted to systematically collect data on the effectiveness of the program. The evaluation will consist of two arms: a *process evaluation* to monitor the implementation of the newly developed assessment tools and processes; and an *outcome evaluation* to examine the impact of the redesigned assessment program on assessed physicians.

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

6. Continuous Improvement

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

Reference:

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

Appendix B – CanMEDS in Peer Assessment

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

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

Appendix C - Choosing Wisely Canada – Hospitalist Medicine

- Choosing Wisely Canada // Canadian Society of Hospitalist Medicine
<http://www.choosingwiselycanada.org/recommendations/hospital-medicine/>
 1. Don't place or leave in place a urinary catheter without reassessment.
 2. Don't prescribe antibiotics for asymptomatic bacteriuria (ASB) in non-pregnant patients.
 3. Don't use benzodiazepines and other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.
 4. Don't routinely obtain neuro-imaging studies (CT, MRI scans, or carotid Doppler ultrasonography) in the evaluation of simple syncope in patients with a normal neurological examination.
 5. Don't routinely obtain head computed tomography (CT) scans, in hospitalized patients with delirium in the absence of risk factors.