WELCOME

All Program Directors & FM Site Directors Meeting

Friday, May 25, 2018
AGENDA

• Welcome
• Awards & Thanks
• PAAC Update
• Charles Mickle Fellowship Address
• Accreditation Standards
• CBD/CBME Updates with Q&A
• Board of Medical Assessors: UPDATE with Q&A
Exiting Residency Program Directors
(from July 2017)

- Michael Pollanen  Forensic Pathology
- Najma Ahmed  General Surgery
- Julia Keith  Neuropathology
- Adelle Atkinson  Pediatric Clinical Immunology & Allergy
- Ann Yeh  Pediatric Neurology
- Agostino Pierro  Pediatric Surgery
- Maurice Blitz  Surgery & Surgical Foundations

A special thank you to:
- Norman Rosenblum  Clinician Investigator Program
- Neal Sondheimer  Medical Genetics & Genomics
New Residency Program Directors (from July 2017)

- Jayantha Herath, Forensic Pathology
- Fred Brenneman, General Surgery
- Patrick Shannon, Neuropathology
- Vy Kim, Pediatric Clinical Immunology & Allergy
- Blathnайд McCoy, Pediatric Neurology
- Georges Azzie, Pediatric Surgery
- Mark Wheatcroft, Surgery & Surgical Foundations
Awards Acknowledgements
Previously Presented
2018 PGME Excellence Awards

Development and Innovation

Dr. Sandra de Montbrun, Surgery
Dr. Lynfa Stroud, Medicine
2018 PGME Excellence Awards

Teaching Performance, Mentorship and Advocacy

Dr. Abhaya Kulkarni, Surgery
Dr. David F. Tang-Wai, Geriatrics
Dr. John Thenganatt, Medicine
2018 Sarita Verma Award for Advocacy and Mentorship in Postgraduate Medicine

Dr. Janet Bodley
Obstetrics & Gynaecology
2018 Social Responsibility Award in Postgraduate Medical Education – Faculty

Dr. Meldon Kahan
Family Medicine
2018 Robert Sheppard Award – Faculty

Dr. Stephen Hwang
Medicine
2018 PARO Award Recipients

Excellence in Clinical Teaching
Dr. John Lee, Otolaryngology
Dr. Edward Margolin, Ophthalmology & Vision Sciences

Resident Teaching
Dr. Rajesh Bhayana, PGY4 Diagnostic Radiology
Dr. Cathrynn Sibbald, PGY5 Dermatology
2018 PARO Award Recipients

Citizenship Awards for Medical Students

Benjamin Fung, MD Candidate

Aatif Qureshi, MD Candidate
2018 Charles Mickle Fellowship

Awarded annually to a member of the medical profession anywhere in the world who has “..done the most within the preceding 10 years to advance and promote sound knowledge of a practical kind in medical art or science by careful and thorough work.”
2018 Charles Mickle Fellowship

Dr. Kevin Imrie, Medicine

- Physician-in-Chief of the Department of Medicine at Sunnybrook Health Sciences Centre and is a Professor of Medicine in the Faculty of Medicine at the University of Toronto.

- Vice-Chair of Education for the University of Toronto Department of Medicine and is a Clinical Hematologist at the Odette Cancer Centre at Sunnybrook Health Sciences Centre.

- Past president of the Royal College of Physicians and Surgeons of Canada.
AWARDS PRESENTATION
PGME Trainee Leadership Awards
2018 Recipients

Dr. Leora Branfield Day
Internal Medicine

Dr. Justin Chang
Surgery

Dr. Justin Hall
Emergency Medicine

Dr. Rachelle Krause
Cardiology

Dr. Alex Summers
Public Health and Preventive Medicine

Dr. Brie Yama
Paediatrics
PGME Trainee Leadership Awards
2018 Recipients

CONGRATULATIONS!
2018 Social Responsibility Award in Postgraduate Medical Education – Trainee

Dr. Amy Gajaria
Psychiatry
2018 Robert Sheppard Award – Trainee

Dr. Anna Dare
Surgery
All Program Directors & FM Site Directors Meeting

Friday, May 25, 2018
Postgraduate Administrators’ Advisory Committee (PAAC) - UPDATE

Bryan Abankwah
Chair, Postgraduate Administrators’ Advisory Committee
All Program Directors & FM Site Directors Meeting

Friday, May 25, 2018
2017 Charles Mickle Fellowship

Dr. Catharine Whiteside

- Professor of Medicine and Dean, Faculty of Medicine and Vice Provost, Relations with Health Care Institutions, University of Toronto, 2006-2014
- Member of the Order of Canada, 2016
- Executive Director of the Strategic Patient-Oriented Research Network in Diabetes and Related Complications
2017 Charles Mickle Fellowship Address

Creating a Learning Health System - Patients, Practice and Politics

Catharine Whiteside, CM MD PhD FRCPS(C) FCAHS

Executive Director, Diabetes Action Canada, CIHR SPOR Network
Emerita Professor and Former Dean of Medicine, University of Toronto
Mickle Fellowship Address

“Creating a Learning Health System - Patients, Practice and Politics”

Catharine Whiteside CM MD PhD
Executive Director, Diabetes Action Canada – SPOR Network

May 25, 2018
Objectives:

1. Context - What is a learning health system?
2. Learning from Patients – the real challenges
3. Collective Impact- changing practice
4. Politics of changing the health system
The Learning Health System Series
Continuous improvement and innovation in health and health care

Starting in 2007
The Learning Healthcare System
The Data Utility
Patients and the Public
Leadership

Care Complexity
Effectiveness Research
Value (in Health Care)
Core Metrics

and more

Consensus Reports: Best Care
Vital Signs
Access
“A Learning Health System is created when science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience.”
Learning Health Care System

Clinical care

Professional Development

Research

Engaged patients and decision makers

Electronic Medical Records

Learning Health care Networks

Evaluation infrastructure

Supportive regulatory agencies

Novel research designs

Health promotion, quality and security
Learning from and Building on Research Network Success

IMPORTANT SUCCESSES (acute care):

- **Canadian Stroke Network**: national quality indicators and standardized care
- **Canadian Cardiovascular Outcomes**: quality indicators for acute MI, CHF
- **Canadian Neonatal Network**: standardized quality care, improved outcomes
- **Canadian Critical Care Trials Group**: blood transfusions, ventilator care

Recent Investments – disease prevention and chronic conditions

**Federal**: e.g., Strategic Patient-Oriented Research Program (7 Networks), 4 health-related NCEs, Drug Safety

**Provincial**: e.g., Alberta – Strategic Clinical Networks
Improving health outcomes and care experience of persons with diabetes and related complications

80 Patient Partners  29 Partners  7 provinces  91 Researchers  10 Programs
Learning from Persons Living with Diabetes

What do Patients fear most?

• lower limb amputation (foot ulcer)
• loss of vision
• kidney failure requiring dialysis
• heart attack or stroke
• stigma

Patient Challenges with the Health System?

• **Access** – to primary and specialist care, affordable food and drugs, community services
• **Communication** - with health professionals and service providers
Diabetes in vulnerable populations

- Type 2 diabetes is 4 times more common in low income compared to high income bracket populations
- Ethnic groups (new immigrants) experience higher prevalence – Asian, South Asian, African descent
- Seniors (>65y) make up 50% of those diagnosed with diabetes
- Indigenous Peoples 3 to 5 times prevalence compared to non-Indigenous with poorer access to early diagnosis and prevention
- One-third of individuals with diabetes are uninsured for drug benefits

In Canada, diabetes is the leading cause of…….

- Lower limb amputation
- Blindness
- Kidney failure
Learning from Diabetes Complications Data

Lower Limb Amputations
- An amputation every four hours related to diabetic foot ulcers – 85% preventable
- Of $1.6 billion/yr direct cost on diabetes in Ontario, $400 million/yr related to diabetic foot ulcers and amputation
- Indigenous Peoples suffer 5X the rate of foot ulcers and amputation compared to the non-Indigenous population

Good News (2017)
- Ontario only province to provide off-loading foot devices ($150 - $600/device)
- Health Quality Ontario published standard measures for diabetic foot ulcer treatment and amputation prevention
Patient engagement – our core success factor

Francophone and New Immigrant

Indigenous Peoples

General Patient Council

Lines represent connections with larger communities of people affected by diabetes
Specific Goal-Directed Programs

1. **Retinopathy Screening to Prevent Blindness** – Michael Brent (UoT), David Maberley (UBC)
2. **Indigenous Peoples Health** – Jon McGavock (U Manitoba), Alex McComber (McGill)
3. **Aging, Community and Health Research Program** – Maureen Markle-Reid, Jenny Ploeg, Ruta Valaitis (McMaster U)
4. **Digital Health for Diabetes Research and Care** – Michelle Greiver, Joe Cafazzo (UoT)
5. **Innovations in Type 1 Diabetes (Clinical Trials)** – Bruce Perkins (UoT), Peter Senior (UoA)
6. **Foot Care to Prevent Amputations** – Mohammed Al-Omran, Thomas Forbes (UoT)

Enabling Programs

1. **Patient Engagement** – Holly Witteman, Joyce Dogba (U Laval)
2. **Knowledge Translation** – France Légaré, Sophie Desroches (U Laval)
3. **Training and Mentoring** – André Carpentier (U Sherbrooke), Mathieu Bélanger (UNB)
4. **Sex and Gender** – Paula Rochon, Robin Mason (UoT)
Screening and Treatment for Diabetic Retinopathy

Facts

• In Ontario over ~500,000 persons with diabetes are without a dilated eye exam in last 2 yr (9% will have sight-threatening disease)
• OHIP pays for retinal imaging (including by Optometry)
• Screening (telemedicine) associated with primary care communities including First Nations proven cost effective
• Retinal specialists organized across the province to respond to referrals

Barriers

• Tracking screening and primary care referrals
• Timely availability of screening for working individuals
• Education of patients and care providers about necessity of eye exams

How to achieve collective impact?
Collective Impact


“...we believe that there is no other way society will achieve large-scale progress against the urgent complex problems of our time, unless a collective impact approach becomes the accepted way of doing business.”

1. Common Agenda
   Keeps all parties moving towards the same goal

2. Common Progress Measures
   Measures that get to the TRUE outcome

3. Mutually Reinforcing Activities
   Each expertise is leveraged as part of the overall

4. Communications
   Enables a culture of collaboration

5. Backbone Organization
   Takes on the role of managing collaboration
Population management applied to Diabetic Retinopathy

**IDENTIFY**
Key clinical indicators used to identify at-risk individuals

**ENGAGE**
Individual engaged; care provider supports follow-up

**CARE INTERVENTION**
Individual has eyes screened; intervention as needed
- Screening results sent to care provider

**FOLLOW-UP**
Individual receives follow-up and ongoing diabetic care from appropriate care provider

**ONGOING MONITORING**
Data analyzed to continually improve or maintain health

Tele-ophthalmology screening & intervention
Enabling a new model of collaboration

Key Stakeholders Consulted

- Ontario Ministry of Health and Long-Term Care
- eHealth Ontario cyberSanté Ontario
- Ontario Health Quality Ontario Qualité des services de santé Ontario
- Diabetes Action Canada
- Otn.
- UHN Toronto General Toronto Western Princess Margaret Toronto Rehab
- Canada Cancer Care Ontario Action Cancer Ontario
- ICES
- Public Health Ontario Santé publique Ontario
- University of Toronto
- Ontario Toronto Central Local Health Integration Network
- BeACCoN
- WHV Women's College Hospital Institute for Health System Solutions and Virtual Care
Prevention of Diabetes in Indigenous Peoples

The Aboriginal Youth Mentorship Program (AYMP): a peer-led healthy living after school program for achieving a wellness lifestyle and creating mentorship skills among First Nations children living either in a northern isolated setting, or inner city.
Resilience-Informed Diabetes Prevention

Brokenleg, Brendtro Reclaiming Children and Youth 2005
Objectives:

1. Context - What is a learning health system?
2. Learning from Patients – the real challenges
3. Collective Impact- changing practice
4. Politics of changing the health system
Community Partnership Program
T2D ≥ 65 yr with more than 2 chronic conditions

- **Home Visits**
- **Monthly Group Sessions**
- **Monthly Nurse-led Case Conferences**
- **Nurse-led Care Coordination**

Source: CDC #14167

Source: CDC #13735
Creating a Learning Health System Requires:

1. Patients as Partners, engaged in co-designing solutions;
2. Healthcare practice fully integrated with communities;
3. Political commitment at all levels (federal, provincial, regional) to effectively address health determinants; and,
Thank You
Q&A – slido.com #3963

Creating a Learning Health System - Patients, Practice and Politics

Catharine Whiteside, CM MD PhD FRCPS(C) FCAHS

Executive Director, Diabetes Action Canada, CIHR SPOR Network
Emerita Professor and Former Dean of Medicine, University of Toronto
Accreditation Standards

Dr. Linda Probyn
Director, Admissions and Evaluation

Laura Leigh Murgaski
Program Manager, Accreditation & Education Quality Systems
WHAT’S NEW IN ACCREDITATION?

Building to Accreditation 2020
WHAT’S NEW IN ACCREDITATION

• New Accreditation Standards
• Accreditation Cycle
• Accreditation Management System (AMS)
• Preparing for New Accreditation Systems
• Accreditation Trivia
NEW ACCREDITATION STANDARDS

- Take effect July 1, 2019
- Institutional Standards
- Program Standards
**Accreditation Standards (New 2017)**

### Standards Organization Framework

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Domains were defined by the Future of Medical Education in Canada-Postgraduate (FMEC-PG) Accreditation Implementation Committee to introduce common organizational terminology, to increase alignment of accreditation standards across the medical education continuum.</td>
</tr>
<tr>
<td>Standard</td>
<td>The overarching outcome to be achieved through the fulfillment of the associated requirements.</td>
</tr>
<tr>
<td>Element</td>
<td>A category of the requirements associated with the overarching standard.</td>
</tr>
<tr>
<td>Requirement</td>
<td>A measurable component of a standard.</td>
</tr>
<tr>
<td>Mandatory &amp; Exemplary Indicators</td>
<td>A specific expectation used to evaluate compliance with a requirement (i.e. to demonstrate that the requirement is in place).</td>
</tr>
</tbody>
</table>

Mandatory indicators must be met to achieve full compliance with a requirement. Exemplary indicators provide improvement objectives beyond the mandatory expectations and may be used to introduce indicators that will become mandatory over time.

Indicators may have one or more sources of evidence, not all of which will be collected through the onsite accreditation visit (e.g. external data, documentation within the program portfolio, etc.).
EXAMPLE

**Standard 3:** Residents are prepared for independent practice

**Element 3.4:** There is an effective, organized system of resident assessment

**Requirement 3.4.1:** The residency program has a planned, defined and implemented system of assessment

**Indicator 4.1.3.2:** The system of assessment is based on residents’ attainment of experience specific competencies and/or objectives
EXAMPLE

**Standard 3:** Residents are prepared for independent practice

**Element 3.4:** There is an effective, organized system of resident assessment

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**Indicator 3.4.1.1:** The system of assessment is based on residents’ attainment of experience specific competencies and/or objectives
THE ACCREDITATION CYCLE

1. PGME Office Review  
   – Nov 7\textsuperscript{th} and 8\textsuperscript{th}

2. Accreditation prep

3. Onsite Survey  
   – Fall 2020
ACCREDITATION MANAGEMENT SYSTEM (AMS)

• Online information system for program reviews
• Pre-Survey Questionnaire (PSQ) questions online
• Being developed by CanRAC (Canadian Residency Accreditation Consortium)
• Used for all reviews starting July 1, 2019
• Used for on-site survey 2020
• Start populating Spring 2019
• PGME Workshops and Tip Sheet
PREPARING FOR THE NEW ACCREDITATION SYSTEMS

• Workshops
• Self Study of your program
• PGME identifying gaps between old and new standards – send to programs
• Work with programs on implementation
• AMS tip sheet
UPCOMING WORKSHOPS

• New Accreditation Standards – May 29, 2018
• New Accreditation Standards – Summer 2018
• Accreditation Management System – Spring 2019
ACCREDITATION TRIVIA
1. Which of these is no longer an accreditation standard?

A. The residency program encourages and recognizes resident leadership.
B. The Residency Program Committee must meet at least quarterly and keep meeting minutes.
C. Residents receive timely, in-person, meaningful, feedback on their performance.
D. Volume and variety of patients is sufficient to meet the educational needs of the residents.
1. Which of these is no longer an accreditation standard?

A. The residency program encourages and recognizes resident leadership.

B. The Residency Program Committee must meet at least quarterly and keep meeting minutes.

C. Residents receive timely, in-person, meaningful, feedback on their performance.

D. Volume and variety of patients is sufficient to meet the educational needs of the residents.
2. Which of these is no longer an accreditation standard?

A. There is a positive learning environment for all involved in the residency program.

B. Teachers reflect on the potential impacts of the hidden curriculum on the learning experience.

C. Residents are supported and encouraged to exercise discretion and judgment regarding their personal wellness.

D. The RPC must have an elected resident.
2. Which of these is no longer an accreditation standard?

A. There is a positive learning environment for all involved in the residency program.

B. Teachers reflect on the potential impacts of the hidden curriculum on the learning experience.

C. Residents are supported and encouraged to exercise discretion and judgment regarding their personal wellness.

D. The RPC must have an elected resident.
3. Which of these is a **new** accreditation standard?

A. The educational objectives must be reflected in the assessment of residents

B. Teaching must include issues of age, gender, culture, ethnicity, and end of life issues

C. The program director is accessible and responsive to the input, needs, and concerns of residents

D. Feedback sessions to residents must include face-to-face meetings
3. Which of these is a new accreditation standard?

A. The educational objectives must be reflected in the assessment of residents

B. Teaching must include issues of age, gender, culture, ethnicity, and end of life issues

C. The program director is accessible and responsive to the input, needs, and concerns of residents (1.1.1.2)

D. Feedback sessions to residents must include face-to-face meetings
4. Which of these is a new accreditation standard?

A. Administrative personnel receive feedback on their performance in a fair and transparent manner

B. Overall objectives of the program must be based on input from a wide range of stakeholders

C. Training encompasses reflective observation, theoretical concepts and practical experience

D. Trainees have a permanent mentor throughout their training
4. Which of these is a new accreditation standard?

A. Administrative personnel receive feedback on their performance in a fair and transparent manner (8.2.2.4)

B. Overall objectives of the program must be based on input from a wide range of stakeholders

C. Training encompasses reflective observation, theoretical concepts and practical experience

D. Trainees have a permeant mentor throughout their training
5. When is our next on-site survey (accreditation visit)?

A. Fall 2019
B. Spring 2020
C. Fall 2020
D. Winter 2021
5. When is our next on-site survey (accreditation visit)?

A. Fall 2019  
B. Spring 2020  
C. Fall 2020  
D. Winter 2021
Questions ?
All Program Directors & FM Site Directors Meeting

Friday, May 25, 2018
CBD/CBME Implementation Updates

Dr. Susan Glover Takahashi
Director, Education & Research, Postgraduate Medical Education
CBD UPDATE
@ University of Toronto

S. Glover Takahashi

All PDs & Family Medicine Site Directors Meeting
Friday, May 25, 2018
Overview

1. **Rationale** – what our CBME/CBD is focused on
2. **Progress to date** - cohorts & meantime work
3. **Structure in PGME to support success** – national & local
4. **Infrastructure @ UofT**
5. **Next steps**
RATIONALE

IMPROVEMENTS to PGME

1. More accurate, varied and focused assessments
2. Improved frequency, transparency, and quality of data for PD, faculty and residents, shared decision making
3. Improved engagement of trainees in learning activities, incl soliciting & incorporating feedback
4. More confident and knowledgeable trainees regarding their performance strengths and limitations
REFRESHER:
Key CBD differences

1. Developmental approach
2. TIME is not THE parameter for success but is part of the considerations
3. Assessment plan
   ▪ Focus on workplace assessments
   ▪ Instead of G & O, focus on what can ‘do’ (i.e. EPAs)
4. ‘Trust’ is explicitly assessed
5. Enhanced feedback & coaching
Principles Guiding CBME @ U of T

- Quality of patient care will not be adversely affected
- Health care team functioning should not be negatively impacted
- Implementation will build on the excellence in residency education programs and practices
CBD @ U of T is a **local** PARTNERSHIP

1. Residency Program
   – Director, Learners, Program Admin, Residency Program Committee, Site Directors

2. Department
   – Chairs, Vice Chair Education, Division Chair, Faculty Development Lead

3. PGME Office
   – PGME Assoc Dean, Lead & EIG Team, Post MD Dean, IT teams

4. Hospitals
   – Cross hospital needs, systems support
CBD @ U of T is a national PARTNERSHIP

• Specialty Committees & the Royal College
  → Program Directors

1) CBD Content
2) Faculty Development in CBD
3) Program Evaluation of CBD
BPEA Advisory Committee

- Subcommittee of PGMEAC
- Developed minimum standards for:
  1) Entrustment Scales
  2) ITER/ITAR tools
  3) Competence Committees
  4) Appropriate Disclosure of Learner Needs
  5) Timing of Workplace Assessments (i.e. EPAs)
  6) Who can be an Assessor
  7) Role of Self-Assessment & Self Report in CBME
July 2017 - 18 @ U of T

- 2 programs  
  Full RC national implementation
- 12 programs  
  Partial local launch at U of T using online tools
- 12+ programs  
  Meantime local activities
July 2018-19 @ U of T

- 2 programs/specialties:
  → → → Yr 1 & 2 - Full RC nat’l implementation

- 14 programs/6 specialties
  → → → Yr 1 - Full RC national implementation

- 10+ programs  Meantime local activities
Faculty Development

Assumptions

1. Every CBE interaction includes **FD** discussion
2. As little **FD** as necessary to support individual, program, system → for success
3. Imitation vs innovation
4. 1 size does not fit all (individual, program, system)
5. **FD** takes many times, many ways
Who receives CBME/CBD FD?
- Faculty
- Learners
- Educational leaders

What are hot, needed, not topics?
- **Hot**: assessment tools, online interface, what CBE means to THEM
- **Needed**: change, feedback, trust assessment, learner handover
- **Not (rarely)**: educational speak, models
- **How:**
  - Everything we do is, or includes, **FD**
  - E.g., emails, newsletters, workshops, coaching in meetings
  - 2-3 minute version, 15 minute version, 1 hour version, ongoing regular info, topic specific
  - **FD** uses targeted, strategic approach

- **Who involved in CBE **FD**
  - **FD** is a partnership
  - Builds on available resources, strengths, interests
  - Leaders guide/direct choices, timing
  - As identified initially OR via program evaluation
Faculty Development

- **Partnership:** with CFD, Depts, Divisions, Programs
- **Networks w CFD:** Faculty Developers, Competence Committee Special Interest Group
- **Resources:** [http://cbme.postmd.utoronto.ca](http://cbme.postmd.utoronto.ca)
New system: **Elentra**

- A CBME solution for *new* assessment tools and assessment practices
- **Customizable** to U of T’s needs:
  - User friendly and intuitive
  - Designed for a CBME model of assessment
  - Can add other features (e.g. rotation scheduling, teacher & rotation evaluations reporting and data visualization)
- **Confidential** assessment data resides on U of T servers
- Opportunity to collaborate via **consortium model**
Elentra @ U of T – ON BOARDING STRATEGY

July 2017 ---
• Launched Pilot with Orthopedic Surgery using version v.1.8

Nov 2017 to Apr 2018
• Building Entrada v. 1.12
• Uploading content, creating forms
• Tagging questions/items to EPAs, milestones and required experiences
• Development and User testing

April to June 2018
• User testing, report building, more development
• Faculty development, training materials for all users

July 2018
• Launch for all 15 programs onboarding for 2018/19
Elentra @ U of T
Elentra @ U of T - mobile device
Looking back at progress
...almost 3 years

• Awareness higher about CBME/CBD
• Many involved, many conversations
• How to build…more systemized nationally, at PGME, in departments
• Re-alignment of people, systems
Looking ahead...next 2-3 years

• Moving to almost full implementation
• **Program evaluation** increasingly important for refinement
• **Faculty development** increasingly important for success
Recap

1. **Rationale** – what our CBME/CBD is focused on
2. **Progress to date** - cohorts & meantime work
3. **Structure in PGME to support success** – national & local
4. **Infrastructure @ UofT**
5. **Next steps**
Questions & Discussion
All Program Directors & FM Site Directors Meeting

Friday, May 25, 2018
Board of Medical Assessors: UPDATE

Dr. Julie Maggi
Director, Resident Wellness
Postgraduate Medical Education

Dr. David Tannenbaum
Chair, Board of Medical Assessors (Postgraduate)
Postgraduate Board of Medical Assessors

*What the BMA Can Do for You and Your Residents*

*And*

*How to Refer*

David Tannenbaum MD, *Chair BMA*

Julie Maggi MD, *Director, Office of Resident Wellness*
Purpose of BMA:

- To consider and determine whether there is a medical condition that affects, or may affect, the ability of a trainee to participate, perform or continue in the training program.

- To make recommendations regarding such matters to the Dean.
  - Advisory role of the BMA.

- 2 sub-boards: UG and PG.
Membership and Meetings

- Broad representation from faculty
- Core and alternate members
- Monthly meetings of 1.5-2 hours
- Quorum = 5
  - Rep from specialty
    - Has not supervised trainee
  - Psychiatrist
  - Chair or Vice-Chair
  - Director of Resident Wellness (ex-officio; presents case and does not vote on outcome)
Referrals

- Programs, (with assistance of Director of Resident Wellness)
- Associate/Vice Dean
- Board of Examiners

- Details of referral process will be described by Dr. Maggi
Procedures:

- Relevant materials including reports from treating physicians are gathered - with resident consent

- Circulated confidentially in advance of meetings

- Case is discussed with specific attention to questions posed by referring source
Procedures (cont’d)

- Board will determine whether a medical condition is affecting ability to participate in the program, and decide on a recommendation,

Or,

- Board will determine that further assessment is required, and will discuss the resident again once reports are received.
Possible Outcomes:

a. Trainee is required to withdraw either permanently or until appropriate investigations have been completed and effective treatment is in place

b. Trainee continues in the program while investigations and/or treatments are initiated

c. Trainee continues in the program with specified modifications or accommodations

d. Trainee continues without modifications or accommodation
Themes Among Cases Reviewed

Clinical skills or professionalism concerns
  - In the context of medical or mental health issue
    - Is assessment complete, management optimized
    - Learning abilities

Accommodation questions
  - Extent required
  - Competency acquisition within accommodated program
  - Evaluation of the resident under accommodation
  - Patient safety

Role of Physician Health Program, OMA
  - Monitoring requirements
6 cases reviewed

In 3 cases, IME ordered

Referral sources: 5 from PD and one from Associate Dean

Timeline from referral to completion of process = 1 month to 6 months. (average 3.4 months)

Themes

- Trigger events/situations - Professionalism incident(s) or poor performance
- Questions asked of BMA - Is there an illness accounting for behaviours/poor performance? Is treatment optimized? Are accommodations necessary? What extent of accommodations is necessary? Is trainee able to return to training?
Resources for Assessment

- Personal physicians of the resident
- OMA Physician Health Program
- Independent medical examiners
- Allied health professionals
- CAMH Work, Stress and Health Program or equivalent
PROCESS OF A BMA REFERRAL

Julie Maggi
Director, Office of Resident Wellness
PD or Vice Dean contacts my office
- Is a BMA referral necessary?
- What are the issues that have led to the need for a referral?
- What are the exact questions you want the BMA to answer?

Referral received
- Consider BMA meeting dates - second Friday of the month

BMA-PG Chair made aware of referral through Faculty Affairs Officer
INFORMATION GATHERING PHASE

- **To consider**: what is your “script” to let resident know you are referring him/her?

- DRW meets with resident
  - Review BMA Terms of Reference
  - Collection of medical information-discussion and signing of consent
  - Reports sent to BMA members via Faculty Affairs Officer
POST MEETING PROCESS

- Board report sent to Vice Dean for approval then to referral source, resident, DRW
- DRW meets resident to discuss recommendations
- DRW arranges recommended assessments
- Assessment reports reviewed at next available BMA meeting
CHALLENGES AND RATE LIMITING STEPS

- Ensuring the referral clearly identifies the problems and poses the key questions for the BMA to answer

- Face to face meetings with resident pre and post

GETTING MEDICAL INFORMATION

- In a timely way
- That helps the BMA make recommendations

- Arranging the right assessments that move the process forward

- Getting reports in timely way
INDEPENDENT FROM BOE

BMA

Consider whether there is a medical condition that affects or may affect ability of trainee to perform in program

- doesn’t evaluate performance

- makes recommendations about continuation in program

BOE

Reviews cases of residents in academic difficulty and determines appropriate course(s) of action

Assesses resident’s performance (academic, professional…)

Makes recommendations on progression of resident through program.
**HOW YOU CAN HELP**

- Talk to DRW before making your referral  
  (If you are wondering if you need to make a referral, CALL to talk about it!)

- Gather your evidence, formulate your questions

- Explain to resident initial stage of process

- Patience....
HOW BMA HELPS YOU

- Offers independent evaluation of medical conditions possible affecting performance

- Support development of accommodated training schedules

- Allows PD to be the educator/administrator and not the physician
PGME Visiting Scholar: Roundtable Event
Jamiu Busari MD, MHPE, PhD

Teachable Moments in Leadership
Wednesday June 13, 2018
10:30am - 12:00pm
PGME Boardroom, 500 University Ave


Please join us in hosting our international colleague and visiting scholar, Dr. Jamiu Busari, for a presentation/discussion on longitudinal approaches to fostering leadership capabilities in our trainees.

• Dr. Busari is Associate Professor of Medical Education, Maastricht University, and Department Chair and Program Director of the specialist training program at the Department of Pediatrics, Zuyderland Medical Center, Netherlands. He is a Harvard Macy Scholar and Harvard Business School executive graduate in Managing Health Care Delivery.
THANK YOU FOR ATTENDING!

All Program Directors & FM Site Directors Meeting

Friday, May 25, 2018
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