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June 2017 **COMPETENCE BY DESIGN (CBD) NEWSLETTER** **Issue 3**

To: Residents, College of Medicine staff, faculty, program directors, program administrative assistants, Ministry of Health, SMA, CPSS, PAIRS, RHA CEO & CMO, U of S Provost

From: Anurag Saxena, MD, M.Ed., MBA, FRCPC. Associate Dean, Postgraduate Medical Education, College of Medicine, University of Saskatchewan

This is the third in the series of organization-wide Competence By Design (CBD) newsletters. From July 01, 2017 one of our programs, Anesthesiology, will go live with CBD under the leadership of Dr. Mateen Raazi and Dr. Ian Jorgensen. In this communique there are articles by Dr. Cathy McLean, Dr. Sharon Card and Dr. Betty Rohr regarding some key aspects of CBD and its implementation. Please direct any questions or comments to cbe@usask.ca

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Contents:

Update from the Royal College

If you are familiar to the Royal College website, then you may have noticed it is changing. The intention is to make it easier to find the information that you are looking for. Especially in regards to the Royal College's Competence By Design (CBD) initiative, they have relaunched CBD webpages (http://www.royalcollege.ca/rcsite/cbd/competence-by-design-cbd-e) to improve navigating to the information you need. Explore the Resource Directory that will further assist you to finding the tools and resources you are interested in.

Update on Local Implementation in Saskatchewan

The countdown is less than 30 days and Anesthesiology will be our first discipline to launch their residency training with the new CBD competency-based approach.

We are committed to using the Royal College Mainport Resident ePortfolio electronic system to track the learning and assessment activities for the CBD cohort. As a quick overview, the system is explicitly designed to meet the principles of CBME and CBD including pre-loaded milestones and EPAs, enable competence committees decision-making and facilitate credentialing and exam registration for residents.

Unpacking EPAs – Decoding TLAs (Three Letter Acronyms) by Dr. Sharon Card

The journey through residency enables the acquisition of skills that residents need to perform in their future career. In essence they are acquiring skills needed to move from the residency home to an independent living situation.

In Competence by Design those skills are termed – "**EPAs or Entrustable Professional Activities.**" The Royal College of Physicians has a robust section on this on their website if you want to read more:

http://www.royalcollege.ca/rcsite/cbd/implementation/cbd-milestones-epas-e

Essential Facts about EPAs:

WHAT is an EPA?

- A clinical task of the discipline.

Think of a graduate moving out of the residency home – what skills do they need to live independently?

HOW is an EPA Picked?

- National Specialty Committees design EPAs based on the clinical tasks of the discipline.
- They are standardized across Canada for individual disciplines through the RCPSC.

HOW is an EPA Assessed?

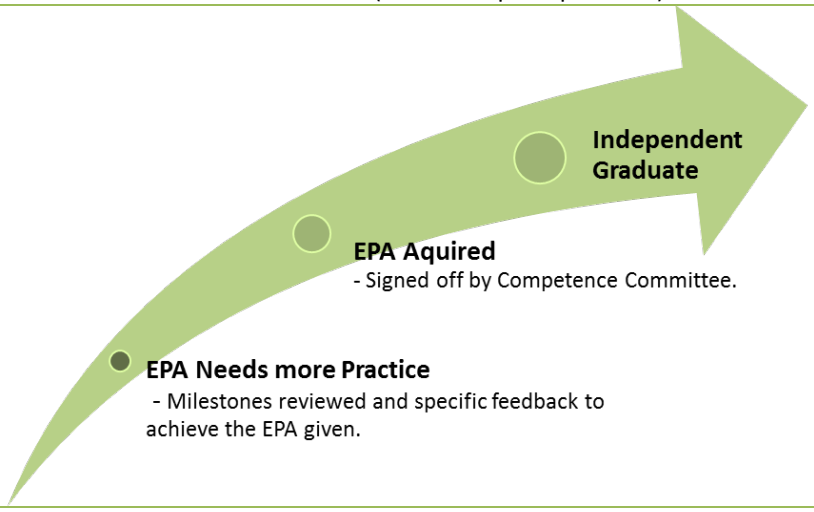
- Assessment of EPAs is based on entrustment scales – clinical faculty innately know when to "trust" a resident to perform a task independently.
- Attaining successful completion of an EPA ensures a graduate can perform a needed skill of the discipline. It is therefore, anticipated that this should take more than one – maybe multiple attempts with continuous feedback to achieve success.
- Overall assessment of EPAs is collated through the Competence Committees to allow for a holistic view of performance across contexts, and case characteristics.
- Individual observation of EPAs by clinical faculty is geared towards coaching and continuous improvement and NOT pass/fail.

WHAT are milestones?

- Milestones are an individual's abilities.
- EPAs are made up of multiple milestones across many CanMEDs roles.
- If a resident has not yet achieved an EPA, then milestones can be used to isolate a component of that EPA the learner needs more practice and feedback on.

WHY change?

- There is good evidence that the EPAs (although the term is awkward!!) resonate well with both learners and front line clinical faculty in practice.
- Allows valuable clinical faculty and learner's time to be focused on the end goal – direct observation and feedback is geared to tasks with the highest yield for future benefit to the learner (and subsequent patients!).



Lifelong Learning

FACULTY DEVELOPMENT

CBD Resources

Family Medicine Triple C competency based curriculum information is available at this site including introductory information on competency based medical information:

http://www.cfpc.ca/TripleCToolkit/

Royal College resources on Competency By Design can be found at:

http://www.royalcollege.ca/rcsite/cbd/competence-by-design-cbd-e

Videos

Tools

Articles

Texts

Contact the office of Faculty Development if you would like a workshop or session on competency based medical education. We are happy to help!

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CBD/CBME Mythbusters 101 By Dr. Betty Rohr

MYTH	FACT
Myth #1 ITERS will disappear	**Fact: In building a common national assessment tools, the In-Training Evaluation Report (ITER) is not part of the assessment tools planned. The national tools should be viewed as the minimal requirements, with each university and program deciding locally what is needed and necessary to support effective residency education. PGME at the University of Saskatchewan recommends that when programs rollout CBD, they may elect to continue with ITERs where its role is not the focus but part of a collection of information within a programmatic assessment approach.**
Myth #2: CBD means that residents will be done residency 'early'	**Fact: Within CBD, time is framed as a resource – not a restriction. CBD programs will estimate the 'usual' time period for completion of the RC-EPAs and the Specialty Training Requirements. It is anticipated that most residents will finish in the usual time period with a small number needing more time to master the outcomes – which is similar to the current situation. It is anticipated that a small number of residents will master the outcomes more quickly than usual which will allow for further development through elective experiences.**
Myth #3 There is only one way to structure and run a competence committee	**Fact: There will be guidelines offered from RC and PGME University of Saskatchewan; however, programs will work within guidelines to tailor needs unique to their situations.**
Myth #4 Competence Committee will replace the Residency Program Committee	**Fact: The two committees have different mandates. The Competence Committee will be focused on reviewing resident assessment data to make progression decisions whereas the Residency Program Committee has a broader mandate in the resident review.**
Myth #5 There will be an overload of assessments to do in an already busy clinical practice	**Fact: CBD assessments are being designed to be feasible to do within the busy clinical program. In CBD, clinical oversight activity is used to engage in work-based assessment of resident performance. With EPAs and milestones, the assessment criteria is intended to be more focused and explicit than before.**

Single Point of Contact for all CBME inquiries

We will keep you informed of the developments and progress. In the meantime,
if you have any questions, please do not hesitate to connect with us: cbe@usask.ca

This newsletter is the third in the communication series from the PGME office to provide information on ongoing change efforts to implement competency-based medical education (CBME) in the specialty programs. The Competence by Design (CBD) initiative is the Royal College of Physicians and Surgeons of Canada (RCPSC) version for specialty programs and is a hybrid of CBME and time as a resource. Triple C Competency-based curriculum is the CFPC's version for family medicine residents and is already implemented in Family Medicine and continues to get refined.