WELCOME

All Program Directors & FM Site Directors Meeting

Friday, May 25, 2018

Post MD Education
UNIVERSITY OF TORONTO

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

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Exiting Residency Program Directors
(from July 2017)

• Michael Pollanen	Forensic Pathlology
• 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

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New Residency Program Directors (from July 2017)

- Jayantha Herath — Forensic Pathology
- Fred Brenneman — General Surgery
- Patrick Shannon — Neuropathology
- Vy Kim — Pediatric Clinical Immunology & Allergy
- Blathnaid McCoy — Pediatric Neurology
- Georges Azzie — Pediatric Surgery
- Mark Wheatcroft — Surgery & Surgical Foundations

Awards Acknowledgements

Previously Presented

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2018 PGME Excellence Awards

Development and Innovation

Dr. Sandra de Montbrun, Surgery

Dr. Lynfa Stroud, Medicine

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2018 PGME Excellence Awards

Teaching Performance, Mentorship and Advocacy

Dr. Abhaya Kulkarni, Surgery

Dr. David F. Tang-Wai, Geriatrics

Dr. John Thenganatt, Medicine

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2018 Sarita Verma Award for Advocacy and Mentorship in Postgraduate Medicine

Dr. Janet Bodley

Obstetrics & Gynaecology

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2018 Social Responsibility Award in Postgraduate Medical Education – Faculty

Dr. Meldon Kahan

Family Medicine

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2018 Robert Sheppard Award – Faculty

Dr. Stephen Hwang

Medicine

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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. Cathryn Sibbald, PGY5 Dermatology

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2018 PARO Award Recipients

Citizenship Awards for Medical Students

Benjamin Fung, MD Candidate

Aatif Qureshi, MD Candidate

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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."

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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.

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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

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PGME Trainee Leadership Awards
2018 Recipients

CONGRATULATIONS!

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2018 Social Responsibility Award in Postgraduate Medical Education – Trainee

Dr. Amy Gajaria

Psychiatry

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2018 Robert Sheppard Award – Trainee

Dr. Anna Dare

Surgery

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Postgraduate Administrators' Advisory Committee (PAAC) - UPDATE

Bryan Abankwah

Chair, Postgraduate Administrators' Advisory Committee

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Friday, May 25, 2018

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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

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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

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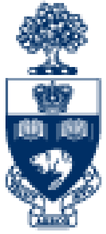

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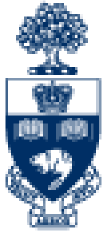
Mickle Fellowship Address

"Creating a Learning Health System - Patients, Practice and Politics"

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

May 25, 2018



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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

NAM Leadership Consortium for
Value & Science-Driven Health Care

NATIONAL ACADEMY OF MEDICINE

Leadership • Innovation • Impact | for a healthier future

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

NAM Leadership Consortium for
Value & Science-Driven Health Care

NATIONAL ACADEMY OF MEDICINE

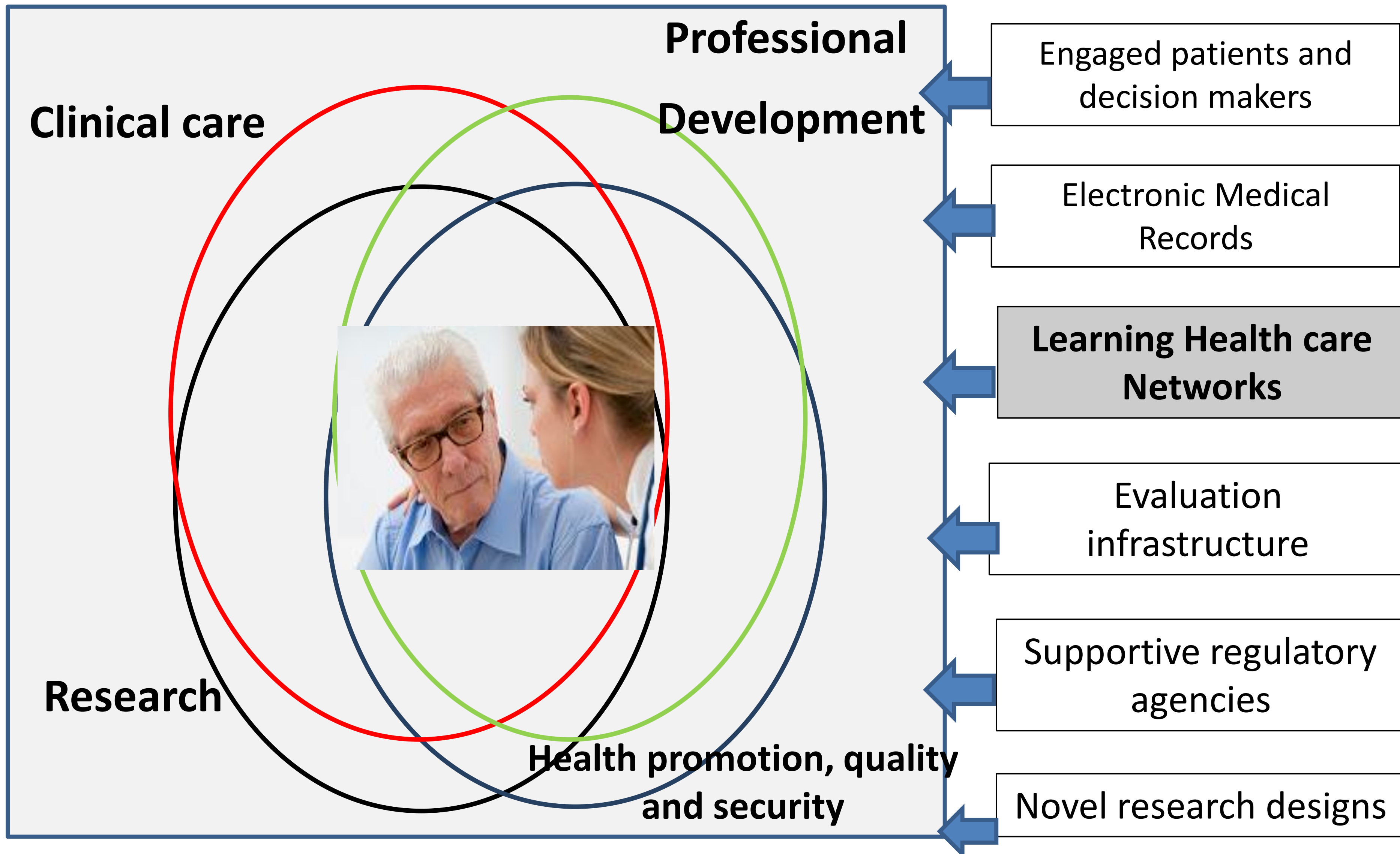
Leadership • Innovation • Impact | for a healthier future

The Learning Health System Series

Continuous improvement and innovation in health and health care

"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



……*in Canada*

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

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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

Diabetes Action Canada

Preventing complications. Transforming lives.

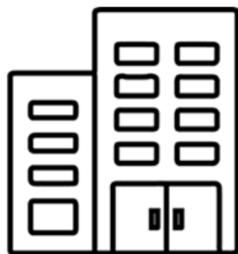
Strategy for Patient-Oriented Research

SPOR

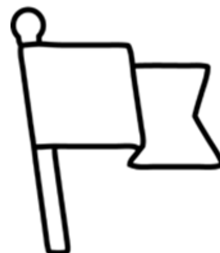
Putting Patients First

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

Learning from Diabetes Population Data

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

Kania & Kramer – *Stanford Social Innovation Review* 2011

"…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

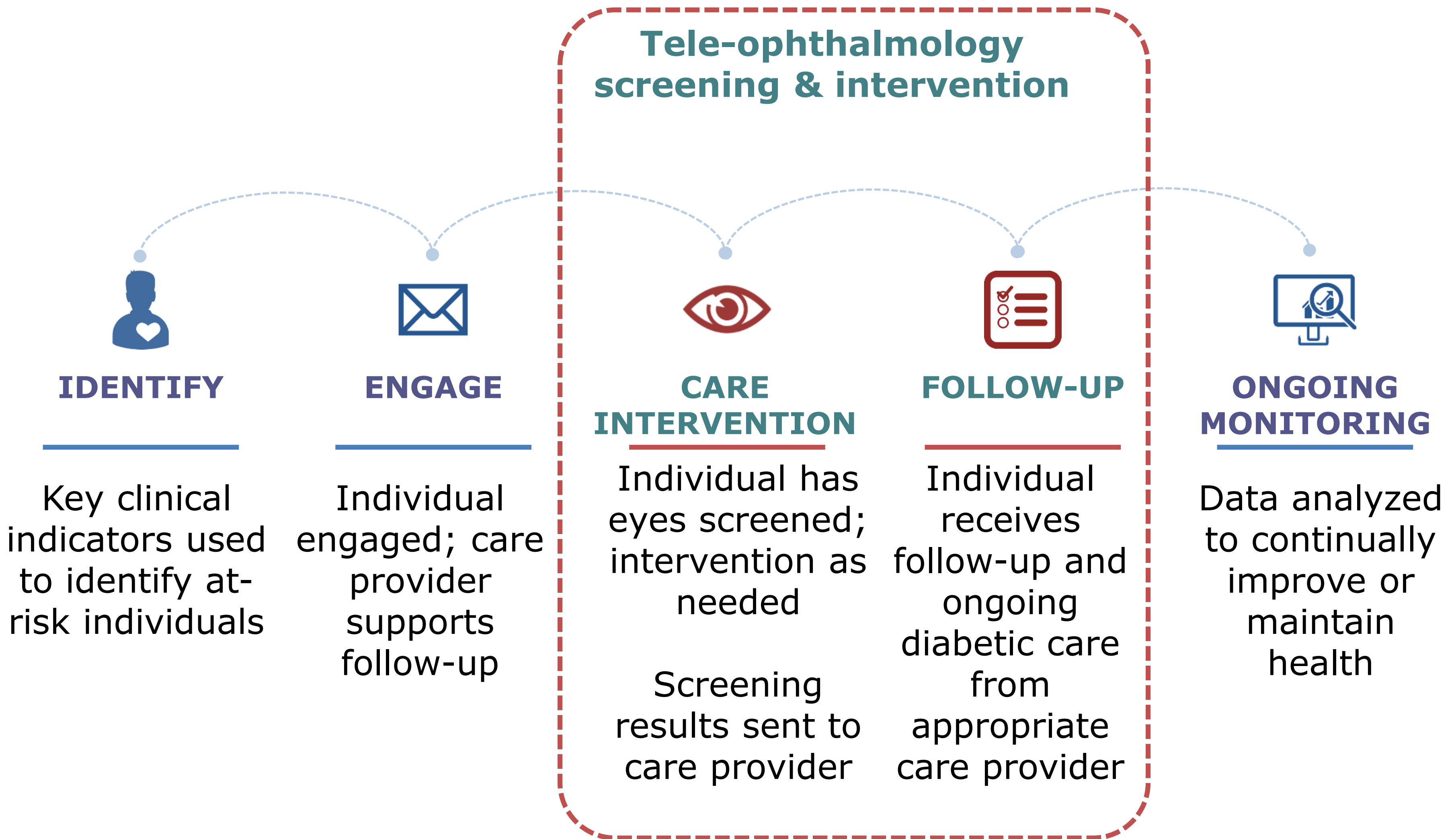
4. Communications

Enables a culture of collaboration

5. Backbone Organization

Takes on the role of managing collaboration

Population management applied to Diabetic Retinopathy

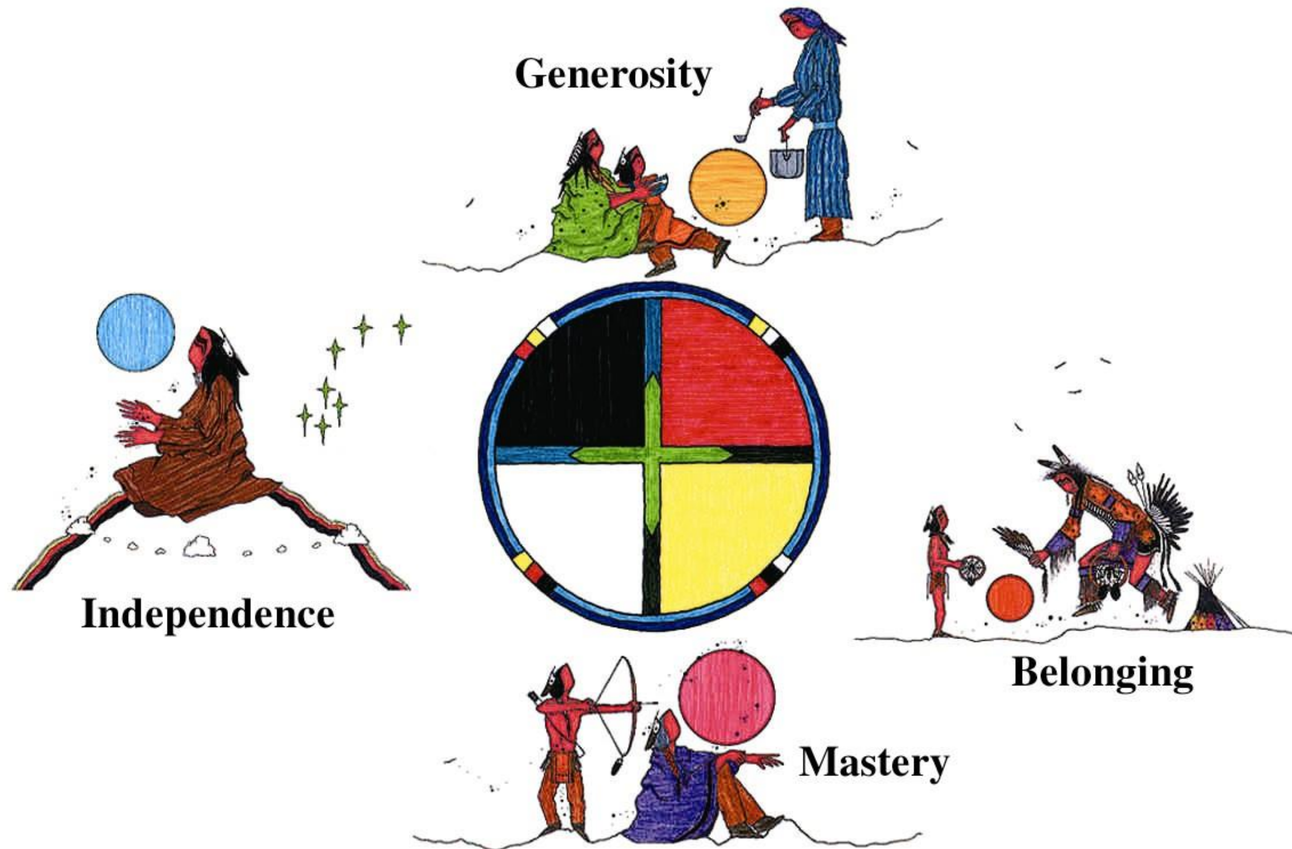


Enabling a new model of collaboration
Key Stakeholders Consulted

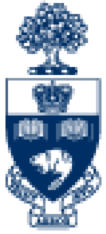
Prevention of Diabetes in Indigenous Peoples

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



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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

McMaster University

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,
4. Effective strategies for collective impact.

Diabetes Action Canada

Preventing complications. Transforming lives.

Strategy for Patient-Oriented Research

SPOR

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

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Accreditation Standards

Dr. Linda Probyn

Director, Admissions and Evaluation

Laura Leigh Murgaski

Program Manager, Accreditation & Education Quality Systems

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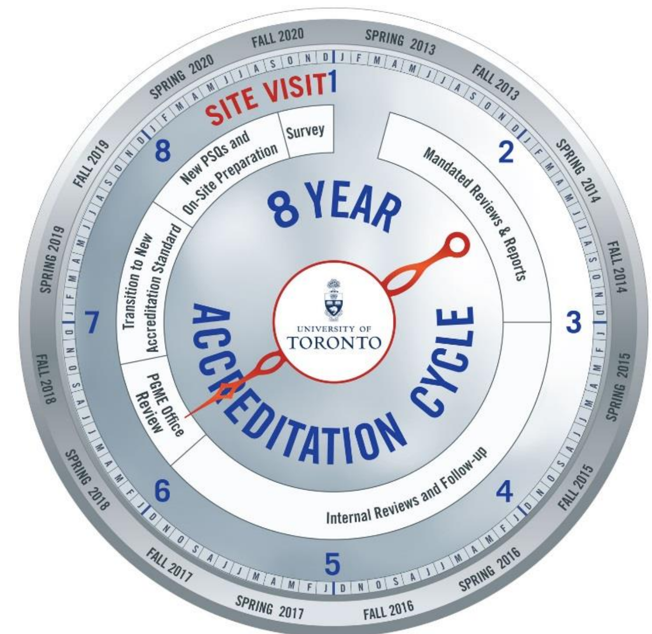
WHAT'S NEW IN ACCREDITATION?

Building to Accreditation 2020



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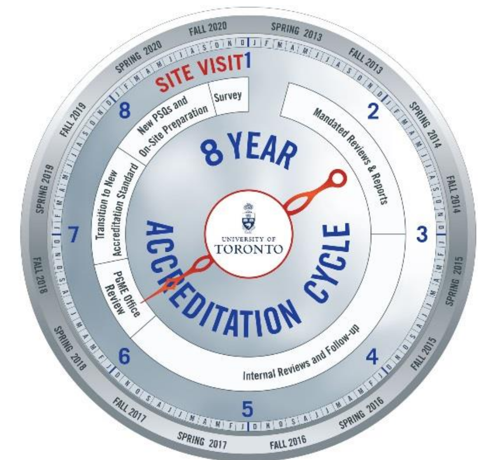
WHAT'S NEW IN ACCREDITATION

- 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

General Standards of Accreditation for Residency Programs

Version 1.1

General Standards of Accreditation for Institutions with Residency Programs

Version 1.1

Accreditation Standards
(New 2017)

STANDARDS ORGANIZATION FRAMEWORK

LEVEL	DESCRIPTION
Domain	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.
Standard	The overarching outcome to be achieved through the fulfillment of the associated requirements.
Element	A category of the requirements associated with the overarching standard.
Requirement	A measurable component of a standard.
Mandatory & Exemplary Indicators	A specific expectation used to evaluate compliance with a requirement (i.e. to demonstrate that the requirement is in place). 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

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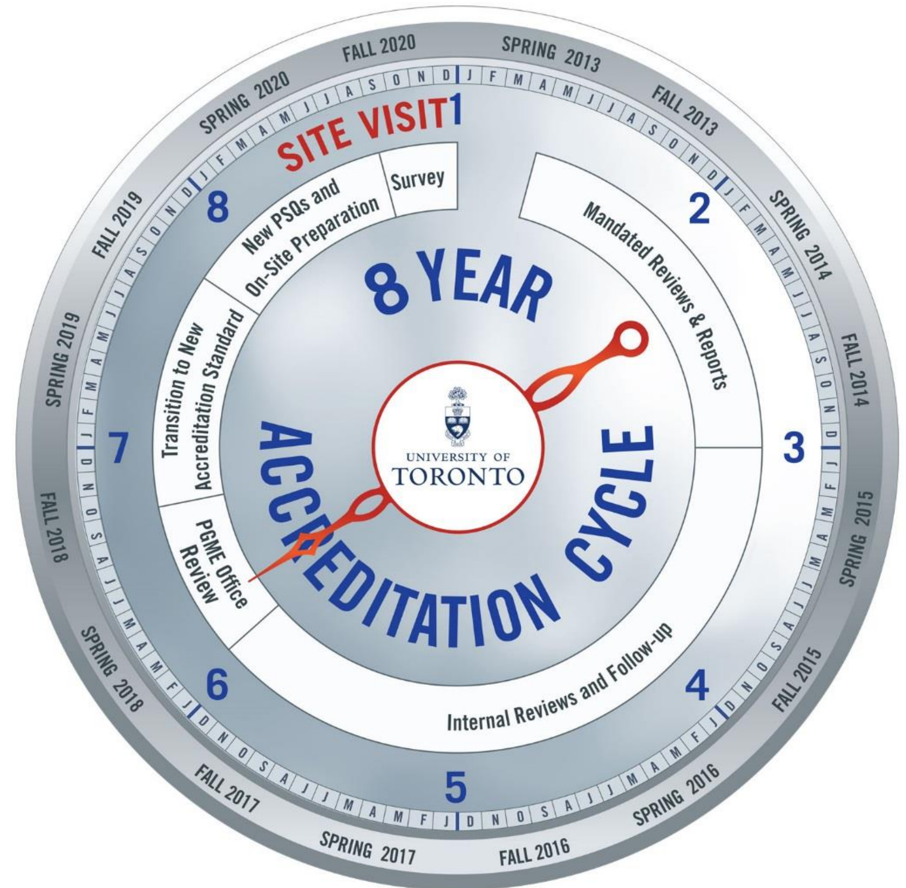
THE ACCREDITATION CYCLE

1. PGME Office Review
   – Nov 7th and 8th
2. Accreditation prep
3. Onsite Survey
   – Fall 2020



ACCREDITATION MANAGEMENT SYSTEM (AMS)

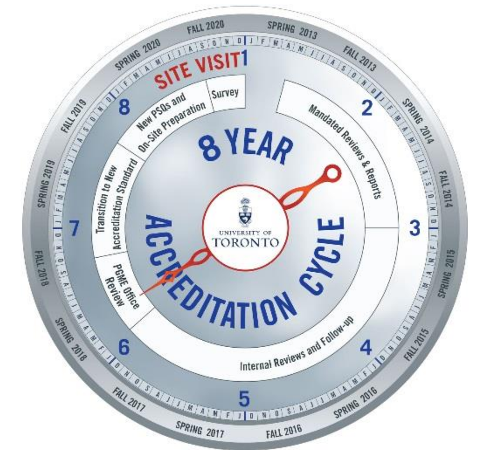
- Online information system for program reviews
- Pre-Survey Questionnaire (PSQ) questions online
- Being developed by CanRAC (Canadian Residency Accreditation Consortium)
- Used for all reviews starting July 1, 2019
- Used for on-site survey 2020
- Start populating Spring 2019
- PGME Workshops and Tip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

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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

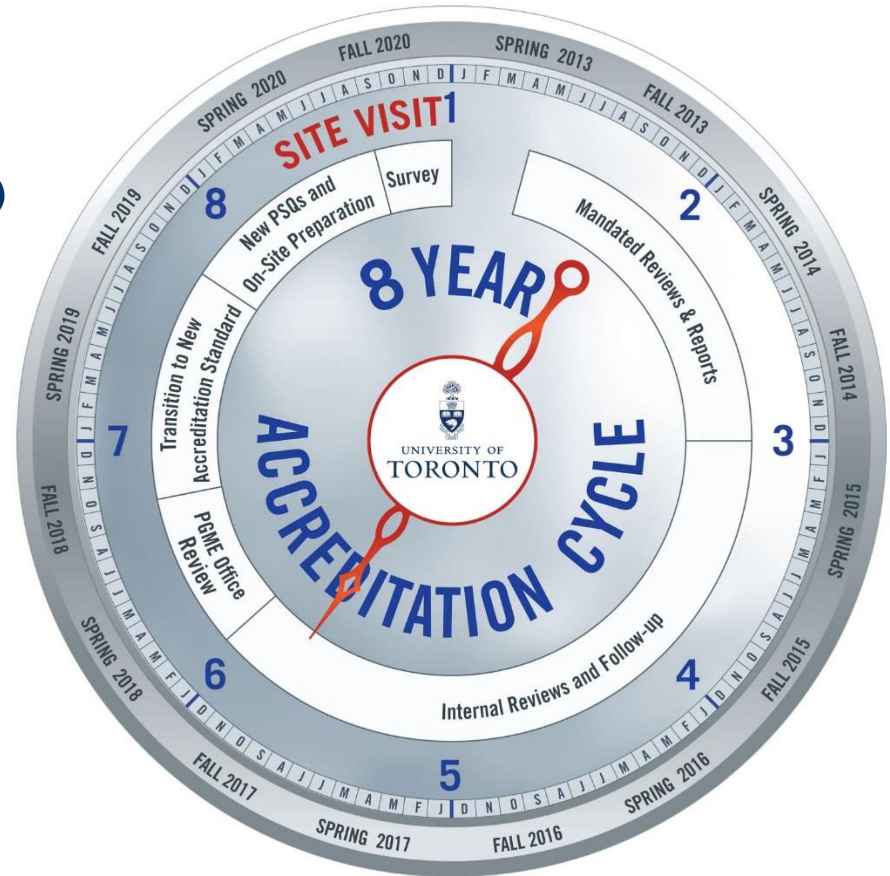
5. When is our next on-site survey (accreditation visit)?

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

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CBD/CBME Implementation Updates

Dr. Susan Glover Takahashi

Director, Education & Research, Postgraduate Medical Education

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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**

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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

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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**

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UT CBME / CBD

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

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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

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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

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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

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UT CBME / CBD

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

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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

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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

@UofTPGME CBD News

An occasional newsletter for Program Directors and PGME leaders and administrators

lay 2018

PGME CBME Newsletters

U of T CBME Faculty & Resident Resources

U of T CBME Curriculum & Implementation Resources

External Links

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***

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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

HOME | START ASSESSMENT | TASK & RESULTS DASHBOARD | PROFILE

OTOL: OTOLORYNGOLOGY

All

OBGYN

Stages | Assessments | Pins

Transition to Discipline

Sample Transition to Discipline Resource Link

D1 Assessing patients with Otolaryngology-Head and Neck Surgery presentations

3 Initial Assessment and Management

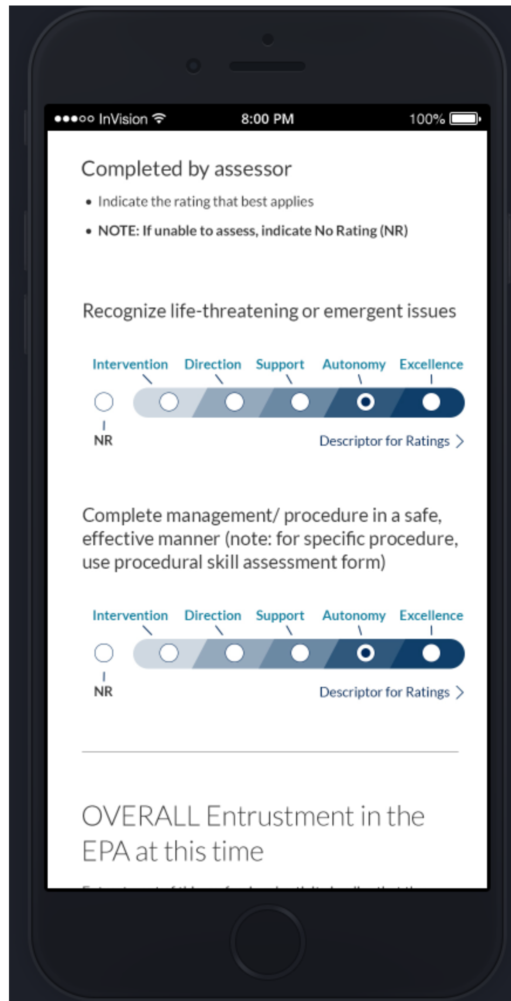
3 Assessments

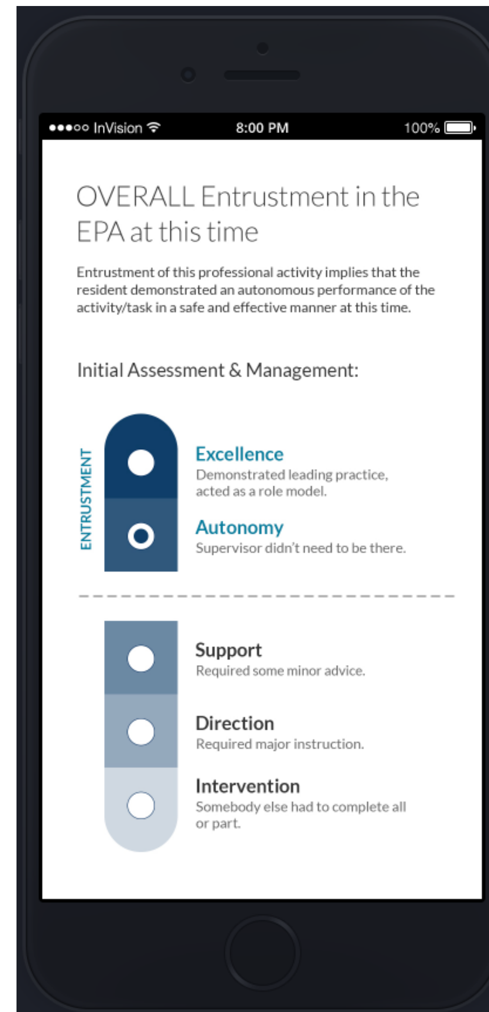
0 0 1

ENTRUSTMENT

2 0

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**

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Questions & Discussion

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All Program Directors & FM Site Directors Meeting

Friday, May 25, 2018

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Board of Medical Assessors: UPDATE

Dr. Julie Maggi

Director, Resident Wellness

Postgraduate Medical Education

Dr. David Tannenbaum

Chair, Board of Medical Assessors (Postgraduate)

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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*

Terms of Reference -1

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

Terms of Reference -2

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)

Terms of Reference -3

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

Terms of Reference -4

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

Terms of Reference -5

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

Terms of Reference -6

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

July 2017-May 2018

- 6 cases reviewed
- In 3 cased 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

REFERRAL FROM RTC, BOE, VICE DEAN

- 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

Negotiation. Communication. Emotional intelligence. Leadership.

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.*

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THANK YOU FOR ATTENDING!

All Program Directors & FM Site Directors Meeting

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