Resource Stewardship Committee Meeting Minutes November 4th, 2014

Attending: Anne Matlow, Rory McQuillan, Mathew Cesari, Julie Maggi, Gareth Seaward, Lisa Bevacqua

Regrets:

---

1. Business arising from previous minutes:

i) Update on meeting with committee residents:

Anne met with Amy Chen, Ben Fine and Amol Verma re: grassroots perspectives on promoting RS.

a) RS considered a soft skill; would get better traction if framed within the 'expert' CanMEDS role.

b) CW focus is mainly ambulatory; can still learn principles from how initiatives were chosen.

c) Need role models, faculty, CRs – Dante Morra and Alan Detsky came to mind as speakers.

d) Capitalize on an existing venue to promote RS rather than starting a new one

Ideas (not mutually exclusive) including discussion from the RSC:

ii) Devote 1 week/ month of a weekly round to RS: key is that all faculty be there as a way to start embedding RS into 'usual business' as opposed to the Academic Half Day where there are limited faculty.

That said, GIM plans to introduce into academic ½ days by linking faculty people who teach the academic half-day to faculty who are involved in RS, thus seamlessly embedding RS into all academic 1/2-days by incorporating into 'expert' CanMEDS role.

iii) Identify a faculty member / division (possible also per hospital) who could partner with at least one resident (perhaps the Chief Resident + another to make a dyad or triad) to lead this initiative eg by presenting a relevant case-based scenario at rounds, perhaps using elements adapted from ACPs framework:

Step 1: What are/ were the benefits, harms, and relative costs of the interventions ordered/ done

Step 2: What interventions/orders offered no benefit and/or may have been be harmful

Step 3: What interventions/ care settings would maximize benefits, minimize harms, and reduce costs? Use comparative effectiveness/cost effectiveness data if available

Step 4: Did or how could the team customize a care plan with the patient to incorporate the patient's values and addresses patient and family concerns

Step 5: What system level opportunities are/were there to improve outcomes, minimize harms, and reduce healthcare waste

iv) Could consider every resident required to work up/ present a RS case as part of rotation

v) Critical success factors:

a) templated approach to evaluating RS in scenario

b) branded slide deck

c) opportunity for interested individuals to self identify

d) PD support

vi) Could do at a local hospital division/ department level, or at a city-wide level : probably should start locally to garner interest and make it happen.

vii) Interdisciplinary/specialty rounds will enforce the value of incorporating RS.

viii) Medicine is ahead of all other depts. To increase capacity at a faculty level, consider

1. a didactic "catch-up" session for others, perhaps using undergrad videos (Rory) or Wendy Levinson presenting at GR or elsewhere

2. Fac Devt ½ day: Rory and Brian could do

3. Could start with grand rounds to introduce the concept of RS and then have it embedded into the individual specialty's rounds.

**Key is to have someone in every department or hospital to serve as a catalyst for RS. Note that one size will not fit all –need a "menu" of how to introduce RS across PGME, ideally a 2 pronged approach, both local hospital and city wide department level.

Action: Anne will connect w Geoff Anderson to see if we can access the undergrad videos

2. Response regarding Education Deans Fund resources

No special RFP as they recently funded an RS related initiative.

2.New Business

i. **Review Brian Wong and Wendy Levinson's ICRE Presentation**: deferred

---

ii) Review of proposed competencies for PGME

General comments: ACP website – an amazing resource – 6 modules with PP presentations, template teaching tools, videos that can be accessed. Free, need to register; likely the best resource currently online. https://hvc.acponline.org/curriculum.htm

5 step framework discussed: see 1d-iii above. Probably a better resource for faculty > learner. Can be incorporated into bedside rounds. Lends itself to a templated approach, even an acronym or "jingle". Again, will need contextual adaptation.

Review of the RS Draft Competencies document – see attached document :

NB: CanMEDS has RS at a very high-level but does not get into the "nitty gritty"

Precirculated document that was a consolidation of input from committee members discussed and amended as per revised document attached

The "trick" will now be to turn these comp. into milestones for each level of learner.

iii) Consolidation of objectives and timelines.

- By next meeting, we will have met with PGMEAC and we will need to develop a strategy to roll out competencies across the PG landscape, embedding them into current training.
- Work with PDs .
- Get endorsement from PGMEAC to get into POWER. Most programs have transitioned to very specific ITERS – can there be a RS targeted competency on the ITER? Turning the comp. that is worded appropriately with examples.
- How to get into PGY1-entry level programs? Provide a workshop at All PDs (June or January) for PDs as well as curriculum leads for each program. Guest speaker? Eg Alan Detsky? Start with educating the faculty.
- Consider a PG Quality/ RS day such as Brian has for interested faculty in Medicine? Speakers, workshop, posters and presentations and prizes. Find out what venues are available hospital-based for their faculty development across disciplines.

Next Meeting:

Tuesday, December 16 – 10:00 am to 11:30 am