CPSO

Peer & Practice Assessment Handbook

Family Medicine/General Practice

December 2022

Acknowledgments

Development of the Family Medicine / General Practice Peer Assessment Handbook was only made possible through the contributions of CPSO Peer Assessors. In particular, we would like to recognize the dedication and many months of work contributed by Family Medicine / General Practice Peer Assessor Working Group, including Dr. Michel De Grace who passed away in 2015.

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Peer Assessment Handbook:
Family Medicine / General Practice

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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

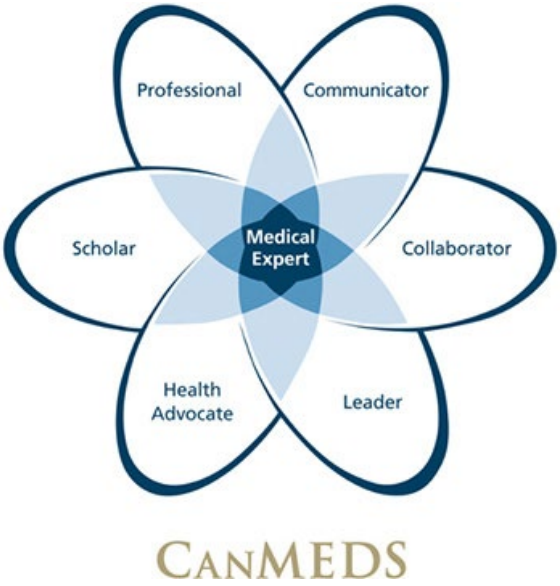
The Peer and Practice Assessment program has been operational since 1980 and thousands of physicians have been assessed. In 2012, the CPSO began an initiative to redesign the program to better align it with its primary purpose of encouraging continuous quality improvement for all physicians. Particular 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 handbook.

The Peer and Practice 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

eCanMEDS 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 Canada[1] 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. The College of Family Physicians of Canada (CFPC) has created an adapted version of CanMEDS known as CanMEDS-FM.



[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 C**.

[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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1.4 How to use the Peer Assessment Handbook

This handbook is designed to be a resource for both assessors and physicians undergoing a peer assessment. It describes the assessment process and 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 by trained assessors who are physicians practicing in the same scope as the assessed physician. Assessments take place at the assessed physician's workplace and involve a review of patient records and a discussion with the physician. The assessor completes a report about the assessed physician's practice that is then submitted to the CPSO and reviewed by a committee. The assessed physician receives a copy of the report and a letter outlining any potential follow up. Details of each step in this process are 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 CPSO Assessment Coordinator matches an assessor to the physician based on relevant practice details.

B. Pre-visit Telephone Discussion

- In advance of the assessment, the assessor initiates a telephone discussion with the physician to be assessed.
- During this discussion, the assessor reviews the assessment process and outlines the physician's responsibility for preparing patient records that will be reviewed during the assessment. The assessor may also ask for further clarification about the physician's practice and respond to questions or concerns the physician may have. The assessor and physician will then set a date for the assessment.
- 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 with the physician. 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 <u>each record</u> using the **patient record summary** (section 5.1).

E. Physician Discussion

- In addition to reviewing patient records, the assessor discusses 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 and highlight opportunities for practice improvement including Continuing Professional Development (CPD) activities.

B. The **scoring rubrics** (section 4.2) can be used as informational tools during this time.

Phase 3 - After the Assessment

F. *Assessment Report*

- The assessor completes a **peer assessment report** (see section 5.2) based on the information collected through the patient record review and physician discussion.
- This report 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 assessor uses two main resources to guide this process:
    - The **scoring rubric** (see section 4.2) defines the elements of quality and evaluation criteria used during assessments within a given specialty or discipline. The scoring rubrics are intended to be broadly applicable across diverse patient

care interactions and provide an extensive framework for evaluating care and documentation.

- The assessor submits the assessment report and the patient record summaries to the CPSO for review.
- The CPSO 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 CPSO committee comprised of physicians and elected public members. The QAC reviews assessment reports and provides additional feedback to assessed physicians, either recommending no further action or directing follow-up to ensure physicians are meeting the standard of practice in Ontario.
- Whereas the assessor is responsible for collecting information during the on-site assessment and providing immediate feedback to assessed physicians, the QAC is responsible for reviewing assessment reports and deciding the outcome of the assessment.
- If potential concerns are identified, the assessed physician is provided an opportunity to address those concerns prior to any further action being taken by the QAC (e.g. reassessment).
- 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

- As part of the effort to continuously improve the Peer Assessment program, feedback is sought from assessed physicians about the impact of the assessments on their practices.

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 Family Medicine / General Practice:

Patient Record Selection

Number of records: In total, the assessor will review approximately 15 patient records.

Timeframe: All patient records should be for index visits dating at least 3 months prior to the notification of assessment date[3]. An index visit is the date of a patient's visit as recorded on the clinic's day sheet. It represents the entry point in the patient record where the assessor begins their review (which may extend forwards or backwards in time to other appointments, as required, to collect an informed impression of patient care and documentation).

Selection Process:

- Prior to the assessment, the physician to be assessed will retrieve day sheets with 3 dates from within the time described above. Appointment schedules should minimally specify patient name, date of index visit, and diagnosis/presenting complaint for that index visit. The assessed physician will select 15 patient records that are representative of his/her practice (see **Types of Records** list below).

Types of Records: The 15 records reviewed by the assessor should include the following index visits, when possible:

- Preventive Care[4] (e.g., cancer screening, immunization, etc.) (minimum 1 male, 1 female)

[3] The notification of assessment date is the date on the "notification of peer assessment" letter sent from the CPSO to the physician to be assessed and the date in the engagement letter sent from the CPSO to the assessor.
[4] The incorporation of preventive care into regular appointments with patients is replacing the former practice of dedicated periodic health assessments.

- Prenatal care (minimum 1)
- Well baby check (minimum 1, including an 18 month check if possible)
- Chronic health conditions (minimum 1 hypertension, minimum 2 diabetes, minimum 1 complex care case (i.e., patient with multiple co-morbidities))
- Psychosocial/mental health (minimum 1 depression or anxiety, and minimum 1 other which may include domestic violence or non-prescription substance abuse)
- Chronic non-cancer pain management with or without opioids (minimum 1)
- Acute care management (minimum 2, including at least 1 respiratory tract infection)

Patient Record Review

The assessor will review patient records in sufficient detail, forwards and backwards in time from the date of selected index encounter, to evaluate:

- The care and documentation provided for the presenting condition on the index date
- Management of chronic, ongoing medical conditions over time
- Cumulative Patient Profile
- Comprehensiveness of family/general practice and continuity of care (e.g., immunizations, screenings, blood pressure monitoring, blood glucose monitoring, etc.)
- Completeness of the "narrative of the patient" (from CPP, patient encounter notes, etc.)
- Physician-initiated "Opportunistic Care" (e.g., preventive healthcare interventions, etc.)

When relevant, the assessor will review the following Electronic Medical Record components/screens (or hard copy equivalents) to ensure the entire patient record has been reviewed:

- Preventive Care (immunizations, cancer screening, etc.)
- Medications
- Allergies
- Medical History / Risk Factors
- Social History
- Family History
- Physicals
- Lab work
- Referrals
- Reminders
- Chronic Disease Flowsheets

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 prenatal care, chronic condition management, 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. If required to accommodate this added focus in the reassessment, the assessor may adjust the "Types of Records" listed above to ensure they have sufficient information to address any issue or area of concern (e.g., if prenatal care was a concern in the previous assessment, the assessor will use their judgement to decide if extra prenatal care records must be reviewed in order to provide an informed impression in the reassessment report).

Timeframe for records selected during reassessment: Index visits may be chosen during any point between the previous 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 prenatal care identified in the previous assessment were ameliorated").

3.2 Physician Discussion Guide

Purpose

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 allows the assessed physician to receive specific information about their practice from a peer. Assessors will review areas of appropriate care, discuss any issues that were 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. A listing of Global Resources for Family Medicine can found in Appendix B.

The CPD/Practice Improvement Resources section of the CPSO's CPD webpages may also be shared for additional educational resources:

https://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 context and circumstances of the assessed physician.

Discussion Themes for Family Medicine/General Practice:

A. "What is your approach to management of common family practice issues such as diabetes, hypertension, coronary heart disease, preventive care (e.g., screening and immunizations), and depression?"

(Probes)

1) Draw on the patient record review to focus this discussion in area where the assessor has identified practice improvement opportunities.
2) "How do you problem solve when faced with clinical situations or questions that you cannot immediately address?"
3) Enquire on and discuss patient resources utilized by the physician (e.g., handout sheets/pamphlets, recommended links on practice website)?

B. "What practice management areas do you think need improvement in your practice?"

(Probes)

1) Patient call-backs?
2) Use of technology for patient communication (e.g., phone, email, fax, etc.)?
3) Requests for same day appointments?
4) Requests for Rx renewals?
5) Management of abnormal lab results?
6) Management of lab work such as INRs?

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 C**.

Subjective	Objective	Assessment	Plan
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) support 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 evaluation criteria and sought feedback from practicing physicians and selected physician organizations to ensure their relevance and appropriateness. The criteria in the rubrics are periodically reviewed to ensure they are up-to-date.

Assessors use the scoring rubrics 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 Rubrics: Family Medicine/General Practice

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 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

1) Demographic information was documented, including:

a. Age/date of birth
b. Gender information
c. Patient contact information

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

a. Onset and evolution
b. Symptom description, duration, aggravating and relieving factors
c. Pertinent positives and negatives
d. Targeted functional inquiry
e. Functional status (activities of daily living)

3) Review of systems was documented, **as relevant**

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

a. Past medical conditions/medical comorbidities (with reference to CPP, as appropriate)
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 and complimentary medications and supplements
d. Drug benefit coverage

6) Social histories were documented, including **relevant details** of:

a. Education/Occupation

b. Marital/relationship status
c. Social support
d. Lifestyle (smoking, exercise, use of recreational drugs/alcohol – including misuse of prescribed medications)
e. Legal guardians (e.g., power of attorney), as relevant

7) When relevant, reproductive and sexual histories were documented, including **relevant 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 **relevant details** of:

a. Past and current psychiatric conditions
b. Previous treatments and/or hospitalizations
c. Family history of mental health issues
d. Past or current family violence/abuse
e. Assessment of family and community supports
f. Impact of mental health on functioning (at home, work, school, community)
g. Assessment of suicidality/homicidality

EVALUATION CRITERIA:

Score	Opportunities for Improvement
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. Examples include: • Review of systems was often inadequately documented when appropriate • Pertinent positives and negatives were often not noted when appropriate • Pertinent family histories relevant to presenting complaints were often not documented • Chronic condition flow sheets were often not used to their full capacity • Pertinent immunization histories relevant to presenting complaints were often not documented (either in patient encounter record or in the CPP)
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Presenting illness histories were often inadequately documented (e.g., presenting complaints lacked sufficient detail regarding onset, duration, associated signs and symptoms) • Significant past medical histories relevant to presenting complaints were consistently not noted (either in patient encounter record or in the CPP) • Psychosocial histories were consistently not noted (either in patient encounter record or in the CPP) and assessments of homicidality/suicidality were not completed when relevant • Current medications were often not noted when appropriate (either in patient encounter record or in the CPP) • Drug allergies were often not documented when appropriate (either in patient encounter record or in the CPP) • Developmental milestone histories in Well Child Care were often not documented clearly

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. Physical measurements and vital signs, where appropriate
c. Relevant descriptive information (e.g., dimensions indicating spread of cellulitis at presentation, quality of respiratory sounds, description of rash)
d. Illustrations of conditions, where appropriate (e.g., location of rash, laceration, abdominal tenderness)

2) Mental health 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

3) Standardized Measures were completed **when indicated**, with **relevant documentation** of:

a. Scoring flow sheets (e.g., PHQ-9, mini-mental state exam, pain scale)

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**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: • Examinations sometimes included components not relevant to the presenting complaints • Mental status examinations were present but could be expanded upon
2	**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: • Descriptions of general appearance, level of alertness, and comfort level were minimal when appropriate • Relevant physical measurements were not consistently present (e.g., height, weight, and BMI for preventive care and other assessments) • Physical examinations tended to lack focus on presenting complaints and relevant histories • Physical examinations were often not thorough enough to fully assess current presentations (e.g., repeated diabetic assessments with no evidence of a foot examination) • Important, relevant descriptive information (e.g., dimensions indicating spread of cellulitis at presentation) was often not included • Illustrated/described conditions (e.g., location of rash, laceration, abdominal tenderness) were often not included when appropriate • Observations tended to be poorly described • Key elements of examinations (e.g., pertinent positive and negative findings) were often not documented
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Pertinent vital signs (e.g., temperature and weight in child with infectious complaint) were consistently not documented • Mental status examinations were often not included when relevant

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, presenting conditions and appropriate screenings)
b. Consideration of differential diagnosis
c. Review of previous investigations and findings, as relevant
d. Urgency (e.g., life-threatening conditions prioritized)
e. Consideration of judicious use of resources (e.g., evidence to support clinical decision-making)

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) Patient Engagement regarding discussion of investigations risks and benefits were completed as relevant:

a. Documentation demonstrated appropriate patient discussion of investigations such as: Integrated Prenatal Screening (IPS), Prostate Specific Antigen (PSA)

4) Effective test result management system(s) were implemented to ensure that all test orders, results, and interpretations were recorded, with high risk patients and clinically significant test results identified.

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**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: • Investigation benefits and risks, when indicated, were sometimes absent from documentation • Investigations occasionally did not include "red flag" possibilities
2	**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: • Investigations were often not documented • Some tests ordered were not appropriate for presenting complaints (or for ancillary/opportunistic conditions) • Evidence-based/consensus guidelines were often not followed (e.g., Canadian Diabetes Association's diabetes management guidelines; Canadian Hypertension Education Program's blood pressure guidelines; Anti-Infective Review Panel's Anti-infective Guidelines for Community-acquired Infections; Ottawa Ankle Rules) • Overall there was a tendency to over-investigate (e.g., X-rays, blood work ordered when not clinically indicated)
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Appropriate tests based on histories and physical examinations were often not ordered/performed • Investigations were often not reflective of differential diagnoses • An effective test results management system was not in place (e.g., test results were often not reviewed and recorded and/or potentially clinically significant abnormal test results were not followed up on)

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, considering:

a. Alignment with histories (medical, surgical, allergies, medications, family, risk factors), examinations, and investigations (including physiological and psychosocial issues)
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**.

Examples include, but are not limited to:

a. **Final diagnoses** were clearly **documented, as appropriate.**
b. **Differential diagnoses** were documented when final diagnoses were not yet determined (e.g., "chest pain – not yet diagnosed") **or** when diagnoses were unlikely but still were to be considered if investigations or clinical course tended to rule out initial/working diagnosis **or** when potentially serious diagnoses were considered but were thought to be unlikely.
c. **Diagnoses were qualified** (e.g., "controlled", "not controlled", "improving", "worsening"), **as relevant.**

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**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: • Risk factors were occasionally not adequately considered in diagnostic methods
2	**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: • OHIP diagnostic codes were often used rather than more specific written diagnoses • Differential diagnoses were often not considered when appropriate • Patient risks were often not adequately considered in diagnoses (e.g., Framingham or other similar framework not considered for assessment of cardiovascular risk) • Chronic diseases and their role in presentations were often not adequately considered in diagnoses (e.g., diabetes with presentation of chest pain) • Psychosocial factors were often not taken into consideration in diagnoses
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Final diagnoses or differential diagnoses were consistently not clearly stated and needed to be inferred from plans or medications prescribed • Diagnoses were often inappropriate based on documented assessments

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. Treatment plans consistent with and appropriate given histories, examinations, and results of investigations
b. Appropriate pre-treatment screening for contra-indications or cautions
c. Consideration of co-morbidities in treatment plans
d. Consideration of acuity of the patient's presenting complaint and accompanying safety issues
e. Relevance of ordered/conducted tests, procedures and referrals and reassessments
f. Employment of patient safety and infection control measures, as warranted
g. Consideration of judicious use of resources (e.g., referrals and requisitions)
h. Consideration of patient circumstances and costs (e.g. coverage for medication; physiotherapy)
i. Documentation of outstanding preventive health topics to be addressed at future appointments

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

a. CPP updated regarding chronic, ongoing conditions
b. Purpose of treatment
c. Indicators of treatment progress
d. Treatment outcomes (e.g., patients' responses, good/bad effects, treatment errors, and suggestions for improvement)
e. Discussions of patients' expectations and compliance related to treatment processes
f. Explanations to patients regarding management plan, options, risks/benefits and potential side effects to enable an informed consent
g. Advice and education material given to patients/family
h. Prompt and appropriate responses to unexpected or adverse intra-procedural events and complications
i. Follow-up plan, including recommendations for return appointments
j. Documentation of Advanced Care Directives or plan, as appropriate

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**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: • Written advice sheets were sometimes not provided to patients when indicated • Follow-up plans were sometimes not clearly stated • Documentation of Advanced Care Directives were sometimes not made when relevant
2	**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: • Appropriate consultations for ongoing care or acute/chronic conditions were not considered and documented • Appropriate reassessments of patients following treatments were often not considered and documented when appropriate • Rationale for management plans were often not documented when diagnoses not evident • Consent procedures/discussions were often not documented when appropriate (e.g., treatment for patients with dementia, treatment of minors)

	• Refusal of consent and the discussions that took place were often not documented • Discussions regarding patient non-compliance were often not noted
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Appropriate procedures were often not performed when relevant • Management plans were often not appropriate for the presenting complaints • Management plans did not consistently take into consideration the acuity of the patients' presenting complaints (e.g., symptoms consistent with DVT or angina are not managed handled as emergency presentations) • Necessary reassessments were often not performed • Management plans often failed to address diagnostic conclusions or patients' presenting complaints • Management advice given to patients/substitute decision-makers was often not completed and/or documented • Advice given to patients regarding the circumstances under which they should seek urgent/follow-up care and with whom was often not documented • Treatment information was often not provided to patients or substitute decision-makers • Patients' capability of consenting was often not determined/documented when appropriate • Patients were often not notified of treatment options based on clinically significant results of tests

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:

a. Diagnosis
b. Patient characteristics (e.g., age, sex, sensitivity/allergy profile)
c. Goals of pharmacological treatment

2) Prescriptions were comprehensively documented, including **relevant details** of:

a. Name of the drug
b. Dosage
c. Quantity/repeats
d. Route

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

a. Material risks and benefits
b. Side effects (nuisance and serious)
c. Contraindications and precautions
d. Indications for follow-up (e.g. what to do if side effects occur)

4) Medication monitoring was appropriate, as demonstrated by**:**

a. CPP updates
b. Ongoing tests, examinations, and investigations (i.e., follow-up plan with time frame for re-evaluation)
c. Medication list updated with changes and rationale for changes
d. Medication side effects monitored at appropriate intervals
e. Evidence of annual review of chronic medications and discussions with patients regarding the pros and cons of medications as health and age change
f. Responsible persons identified for monitoring medications, as appropriate
g. Substance misuse issues addressed, as appropriate
h. Opioid narcotic contracts used when appropriate (see Chronic Non-Cancer Pain Management QI resource in section 6)

5) When drug samples were provided:

a. Documentation of drug samples given included:
    I. Date provided
    II. Name of the drug
    III. Drug strength
    IV. Quantity or duration of therapy
b. Samples given to patients have not passed their expiry dates

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**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: • When drug samples were given, details of the drug and the need for follow-up were sometimes not documented • Rationale for the selection of medication was sometimes not clear from documentation • Discussions regarding potential side effects of medications were sometimes not documented

2	**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: • Relevant discussions with patients (e.g., regarding side effects, indications for follow-up) were often not documented • Continuation of medications and/or polypharmacy was often inappropriate given patient conditions • Inappropriate medications were often prescribed (e.g., antibiotics for viral infections, or narcotics for first line management of chronic non-cancer pain), without plausible rationale documented (e.g., rapid strep test negative but clinical presentation suggestive of strep throat)
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Relevant medication information (e.g., medication name, quantity, dose, duration) was consistently not documented • Inappropriate or contraindicated medications, doses, or quantities of medication, which could result in harm, were given to one or more patients (e.g., amoxicillin prescribed when allergy to penicillin noted in the CPP) • Appropriate medications were often not prescribed for clinical conditions in accordance with current, generally accepted clinical practice guidelines

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:

a. Prompt follow-up of critical investigations and results
b. Relevant ordering of follow-up tests
c. Timely follow-up of abnormal results

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

a. A regularly updated Cumulative Patient Profile (CPP)
b. Coordination of ongoing care between family doctor/general practitioner and specialist
c. Interdisciplinary coordination of care between family doctor/general practitioner and other healthcare professionals practising in same clinical setting (e.g., nurse practitioner, physician assistant, etc.)
d. Prompt attention to emergency problems
e. Documentation of patient progress relative to goals

3) Linkage to next visit was appropriate, as demonstrated by documentation of:

a. Expectation for patient follow-up (time, place)
b. Investigations, treatments and/or actions to be completed by patient prior to next appointment
c. Possible complications and/or adverse events that would be expected to trigger an earlier assessment/appointment
d. Summary of expected disease course/progression/resolution during time to next follow-up appointment

4) Documentation of chronic disease was appropriate, as demonstrated by documentation of relevant:

a. Targets (met or unmet)
b. Flow sheets (or equivalent information readily accessible in the record) used and populated to demonstrate disease stability/progression over time
c. Tests ordered and documented to ensure patient stability or recognize disease progression over time

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**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: • Recommendations for follow-up appointments were occasionally not documented • Parameters for appropriate follow-up were sometimes unclear
2	**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: • Indeterminate test results (e.g., urine C&S specimen contaminated, indeterminate STI blood or urine test) were often not followed up on • Interdisciplinary coordination of care was not evident when appropriate • Appropriate urgent consultations/patient visits were arranged but documentation of reasons was often not clear or absent • Rationale for changes to patient treatments were often not documented • Flowcharts (or equivalent) for planned chronic disease management were often not being used proactively

3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Relevant follow-up tests were consistently not ordered • Investigations and laboratory reports were not followed up appropriately • Immediate consultations, referrals or transfers were not considered when appropriate • Treatment plans were often not modified according to test results (e.g., urinary culture growth resistant to prescribed antibiotic, warfarin dose adjustments due to abnormal INR) or specialist recommendations

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.

Key CPSO Policies: Medical Records

ELEMENTS OF QUALITY:

1) Communication as a referring source was effective, as demonstrated by:

a. Clear and comprehensive articulation of consultation requests and referrals including details of:
   I. Reason for referral with sufficient clinical detail to assess urgency of consultation
   II. Results of investigations to date relevant to reason for referral
   III. Results of treatments already/previously initiated
   IV. Patient history (past history, family history, medications and allergies)

2) Communication with other treating professionals was effective, including details of:

a. Change in patient condition
b. Complications potentially requiring alternate approach
c. New conditions
d. Investigation results

3) Communication with other health care system partners was appropriate as demonstrated by:

a. Notification to Medical Officer of Health/Public Health Unit follows expectations of public health notification regulatory requirements and guidelines (e.g., Health Protection and Promotion Act list of Reportable Diseases – Ontario Regulation 559/91)
b. Transfers to emergency department logged appropriately following clinic process

4) Documentation completed in accordance with the **CPSO Medical Records** policy**:**

a. Information was legible, complete, accurate, and presented in a systematic and chronological manner
b. Patients charts filed by name; i.e., not by date of encounter
c. Abbreviations were appropriate (i.e., no potential for confused interpretation by the range of health care providers who might need to access the record)
d. Physician-patient encounters, including telephone contact, were documented and dated
e. In the case of shared records, it is clear who made the entry
f. Most responsible physician ensures trainee entries were accurate
g. 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
h. Templates were used appropriately, including pre-populated templates

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	**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: • Medical records were mostly legible (some words were unreadable but charts could be understood by a clinician) • Abbreviations were sometimes inappropriate (i.e., potential for confusion by other healthcare providers) • Cumulative Patient Profiles could be more comprehensive
2	**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: • Medical records were somewhat illegible (many words were unreadable; meaning of charts was sometimes unclear)

	• Public Health was sometimes not notified regarding suspected or confirmed reportable communicable diseases, food poisoning, dog bites, and other mandatory notifiable conditions • Transfer of patients to hospital emergency departments was not consistently documented • Consultation requests to and from family/general practice office were not consistently documented • Physician-patient encounters, including telephone contact, were often not documented, not dated, and, in the case of shared records, it was not clear who made the entry • Information was not presented in a systematic and chronological manner • Templates (including pre-populated templates) were often used inappropriately or not completed in full • Communication to consultants was often inadequately documented
3	**Significant improvement** is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include: • Medical records were often illegible (most words unreadable; meaning of charts was generally unclear) • Trainee entries were often not checked for accuracy • Cumulative Patient Profiles were not used and/or not kept up to date • Coordination of care between referring physician and consultant/specialist was not evident • Overall, the clinical notes did not tell the story of patients' health care conditions in a way that would allow other healthcare providers to understand them

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.

<u>How to complete the summaries</u>

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 (Index) Visit / Date Range of Record Reviewed*: The range of dates that were reviewed within the chart. If only one specific visit was reviewed, that date is entered.
4. *Record selected to demonstrate care in*: The reason for the patient's visit, if applicable. See list of Types of Records in section 3.2: Patient Record Selection Protocol.
5. Evidence of "opportunistic care": Note if patient needs beyond the presenting complaint were addressed. Such "opportunistic care" may include addressing of psychosocial issues, exploration of prescription or non-prescription substance use, initiation of preventive medicine interventions such as cancer screening or immunizations, etc.
6. *Comments/Concerns/Recommendations*: This section, which is divided into the eight assessment domains, is where pertinent information about the record should be recorded. Comments do not need to be made for every assessment domain; only relevant details regarding quality of care and record keeping need to be included. If concerns are noted, the nature and the extent of the concern should be clearly articulated.

7. *Key Positives/Concerns and Clarification from Discussion with Physician (if relevant)*: 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.

FAMILY MEDICINE/GENERAL PRACTICE PATIENT RECORD SUMMARY TEMPLATE

Chart #1

Selector of patient record ❑ Assessed Physician ❑ Assessor

Patient Identifier (Initials/Chart Number):

Date of Birth (dd/mm/yyyy):

Date of index visit (dd/mm/yyyy):

Date range of record reviewed, as determined by assessor (dd/mm/yyyy – dd/mm/yyyy):

Record selected to demonstrate care in (drop-down menu from record-selection protocol):

Evidence of "opportunistic care"; i.e., instance(s) in which physician seizes opportunities to explore issues beyond the patient's presenting complaint(s).

Comments - Concerns - Recommendations Regarding Patient Care:

History
Examination
Investigation
Diagnosis
Management Plan
Medication
Follow-Up & Monitoring
Documentation for Continuity of Care
Follow-up from physician discussion (if relevant)

5.2 Peer Assessment Report

The *Peer Assessment Report* provides an overall summary of the assessment. This report template guides the format of the report, which includes relevant background information about the physician's practice, areas of appropriate care, areas for improvement, and 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 is then provided to the assessed physician.

Instructions to Assessors for completing the Peer Assessment Report:

The Peer Assessment Report is completed after all the patient records have been reviewed and the discussion with the assessed physician has taken place. The report provides 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:* The assessed physician's name, CPSO number, and scope of practice that was assessed. The assessed physician's initials are inserted in the footer at the bottom left of the page (this will automatically be copied onto all subsequent pages).
2. *Assessment Information:* The assessor's 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, the amount of time spent completing the patient record review and the amount of time spent in discussion with the physician. The assessor signs the form when completed.
3. *Relevant Background Information*: 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 and planned changes to practice). Information already included in Physician Questionnaire need not be repeated unless it provides context for the assessment findings.
4. *Ratings & Comments*: For each assessment domain, a rating (1, 2, or 3) is given based on the assessor's overall assessment of the physician's practice. The scoring rubrics guide assessors' decisions about ratings. Ratings are 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*: A brief summary of the positive aspects of the physician's practice, as they relate to the elements of quality in the scoring rubrics, in order to validate and encourage continued effort in these areas. Optional suggestions for practice improvement (where the base provision of care and documentation are appropriate) or suggestions for professional development can be included.

ii. *Specific Concerns Requiring Attention and Recommendations for Practice Change*: If a score of "2" (moderate improvement needed) or "3" (significant improvement needed) is assigned, the specific concerns that resulted in that score should be described here. When outlining concerns, include both the nature and extent of the concerns, as well as specific recommendations for improvement in this area. When relevant, reference should be made to instances of the concern found in specific patient record summaries. Clear and concise narrative details regarding a concern assist the Quality Assurance Committee in understanding the issues in order to make valid decisions and recommendations.

5. *Summative Comments*: A brief summary of the assessor's overall assessment of the physician's practice across all eight domains including aspects of quality care and any areas of concern. Assessors will 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:

Ratings and Comments

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.

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.

- **Demographic information**
- **Presenting illness histories**
- **Review of systems**
- **Medical histories**
- **Medication histories**
- **Social histories**
- **Reproductive and Sexual histories**
- **Mental Health histories**

Rating:	**1** ❑	**2** ❑	**3** ❑

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns Requiring Attention and Recommendations for Remediation:

Examination: Guided by the presenting problem, a systematic evaluation of the patient's physical and/or mental state.

- **Physical Examinations**
- **Psychological Examinations**
- **Standardized Measures**

Rating:	**1** ❑	**2** ❑	**3** ❑

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns Requiring Attention and Recommendations for Remediation:

Investigation: Procedures or tests performed to detect, diagnose, or monitor disease processes and determine a course of treatment.

- **Investigations selected appropriately**
- **Investigations reviewed appropriately**
- **Patient engagement in investigations**

Rating:	**1** ❑	**2** ❑	**3** ❑

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns Requiring Attention and Recommendations for Remediation:

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

- **Diagnostic conclusions**
- **Differential, working and/or final diagnoses**
- **Diagnoses were qualified**

Rating:	**1** ❑	**2** ❑	**3** ❑

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns Requiring Attention and Recommendations for Remediation:

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 Requiring Attention and Recommendations for Remediation:

Medication: The prescribing, titrating and tapering of drugs to reach intended drug therapy goals.

- **Medications selected appropriately**
- **Prescriptions comprehensively documented**
- **Medication monitoring appropriate**
- **Information provided to patients appropriate**
- **Appropriate providing of drug samples**

Rating:	**1** ❑	**2** ❑	**3** ❑

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns Requiring Attention and Recommendations for Remediation:

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**
- **Patient monitoring and follow-up**
- **Linkage to next visit was appropriate**
- **Documentation of chronic disease was appropriate**

Rating:	**1** ❑	**2** ❑	**3** ❑

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns Requiring Attention and Recommendations for Remediation:

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.

- **Communication as a referring source**
- **Communication with other treating professionals**
- **Communication with other health care system partners**
- **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 Requiring Attention and Recommendations for Remediation:

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 rigourous and educationally valuable 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, described below:

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

Using simulated records and the discipline-specific scoring rubrics, assessors made ratings anonymously and then were presented with the ratings of all other assessors to view their consistency with each other. They then discussed any disagreement by sharing their unique perspective on the case and each made a new rating until an acceptable level of agreement was met. Through this exercise, assessors identified areas of penitential inconsistency in their interpretations and actively worked 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 Ontario physicians within the discipline (i.e., Family Medicine/General Practice) 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 (e.g., the Ontario College of Family Physicians) were contacted and invited 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 is being conducted to systematically collect data on the effectiveness of the program. The evaluation consists 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 physicians using Kane's validity framework. *Canadian Medical Education Journal*, *9*(3), e14–e24.

Appendix B – Global Family Medicine Guidelines/Resources

- Levitt C, Hilts L. *Quality* Book of Tools. Hamilton: McMaster Innovation Press; 2010. [*Quality* in Family Practice Book of Tools: A comprehensive set of quality performance indicators for family practices] https://qualitybookoftools.ca/wp-content/uploads/2013/07/QBT-Book.2013-Lightning.4.pdf

- Quality Book of Tools Resources Database, McMaster University, 2010, Links in book updated in June, 2011. http://quality.resourcedb.machealth.ca/navigator/view

- Choosing Wisely Canada // CMA's Forum on General and Family Practice and College of Family Physicians of Canada, 2014. www.choosingwiselycanada.org/recommendations/family-medicine/

- Choosing Wisely Canada // Physician Recommendations. Last accessed: July 12, 2016. www.choosingwiselycanada.org/recommendations/

Appendix C – 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 that are 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.