

Peer & Practice Assessment Handbook

Endocrinology

Acknowledgments

Development of the Endocrinology Peer Assessment Handbook was only made possible with ongoing contributions of Ontario physicians whom serve as Peer Assessors with the CPSO. In particular, we would like to recognize the dedication and many months of work contributed by the Endocrinology Peer Assessor Working Group.

Working Group Members:

Merrill Edmonds, MD, FRCP

Catherine Kelly, MD, FRCP

Anne Kenshole, MD, FRCP

Aliya Khan, MD, FRCP

W. John Langlois, MD, FRCP

Reservation of Rights

The Endocrinology Peer Assessment Handbook is made publicly available to support transparency in the Peer and Practice Assessment Program of the College of Physicians and Surgeons of Ontario (CPSO). It is freely available for research purposes, informal self-assessment, and for individual use in developing quality improvement plans.

The present materials were developed specifically for the Quality Assurance Program carried out by the CPSO under section 28. (1) of the Ontario Regulation 346/11 made under the Medicine Act, 1991. No part of these materials may be adopted as part of any formal quality assurance or assessment programs without express agreement from the CPSO.

For inquiries, please contact the CPSO Quality Management Division.

Copyright © 2019 College of Physicians and Surgeons of Ontario

Peer Assessment Handbook: Endocrinology

Table of Contents

1. Introduction to Peer Assessment.....	4
1.1 Purpose of Peer Assessment.....	4
1.2 Development and Maintenance of Peer Assessment Tools	4
1.3 CanMEDS in Peer Assessment	5
1.4 How to use the Peer Assessment Handbook.....	6
2. Peer Assessment Process.....	7
3. Assessment Tools and Protocols.....	9
3.1 Patient Record Selection Protocol	9
3.2 Physician Discussion Guide	12
4. Assessment Framework and Scoring Rubric.....	13
4.1 Peer Assessment Framework.....	13
4.2 Scoring Rubric: Endocrinology	14
HISTORY	14
INVESTIGATION	17
DIAGNOSIS	18
MANAGEMENT PLAN	19
FOLLOW UP & MONITORING	21
DOCUMENTATION FOR CONTINUITY OF CARE.....	22
5. Assessment Templates.....	24
5.1 Patient Record Summary	24
5.2 Peer Assessment Report	26
Appendix A – Development and Evaluation Process	32
Appendix B – CanMEDS in Peer Assessment	35

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 assessment program has been operational since 1980 and thousands of physicians have been assessed. In 2012, the CPSO began an initiative to redesign its peer assessment program to better align the program 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 Peer Assessment Handbook.

The Peer 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

[CanMEDS](#) 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 Canada¹ 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.



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 B**.

¹ Adapted from the CanMEDS Physician Competency Framework with permission of the Royal College of Physicians and Surgeons of Canada. Copyright © 2015

² Copyright © 2015 The Royal College of Physicians and Surgeons of Canada.

<http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e>. Reproduced with permission.

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.cpsso.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.cpsso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Assessments>

2. Peer Assessment Process

Peer Assessments are conducted in a structured way, as 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 College Assessment Coordinator matches an assessor to the physician based on relevant practice details.

B. Pre-visit Telephone Discussion

- In advance of the site-visit, the assessor initiates a telephone discussion with the physician to be assessed.
- Relying on information from the Physician Questionnaire, the assessor may ask for further clarification about the physician's practice as well as respond to questions or concerns the physician may have.
- As part of the discussion, the assessor reviews the purpose and process of the on-site assessment and the physician's responsibility for preparing/selecting patient records that will be reviewed during the assessment.
- The time and date of the assessment visit is confirmed. 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 must be available if questions arise**. The physician must also set aside time at the end of the visit for the assessment discussion. 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 each record using the **patient record summary** (section 5.1).

E. Physician Discussion

- In addition to reviewing patient records, the assessor has a discussion 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 (the **scoring rubrics** [section 4.2] can be used as informational tools during this time).
 - Highlight opportunities for practice improvement including Continuing Professional Development.

Phase 3 - After the Assessment

F. Assessment Report

- The assessor reviews information collected through the patient record review and physician discussion to complete the **peer assessment report** (see section 5.2). This 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 narrative comments of the assessor are particularly important for providing the specific examples of care and documentation that supported their decision making and suggestions for improvement to assessed physicians.
- The assessor uses two main resources to guide decision-making and feedback during the record review:

- The **scoring rubric** (see section 4.2) defines the elements of quality and evaluation criteria used during assessments. The scoring rubrics are intended to be broadly applicable across diverse patient care interactions and provide an extensive framework for evaluating care and documentation within a practice discipline.
- The assessor submits the assessment report and patient record summaries to the College for review.
- The College 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 College committee comprised primarily of physicians with additional public members from the CPSO Council. The committee reviews assessment reports and provides additional feedback to assessed physicians, either recommending no further action or directing appropriate follow-up to ensure physicians are meeting the standard of practice in Ontario.
- 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

- Ideally, peer assessments will provide feedback to physicians that prompts practice improvements.

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 Endocrinology:

1. In advance of the assessment

The **physician to be assessed** will:

Retrieve day sheets and corresponding patient records for three dates from within the last year and organize and pull those patient records so they are easily accessible for the assessor to review.

2. On the day of the assessment

a. The **physician to be assessed** will:

- Be prepared to provide an overview of the organization of the patient records (EMR and/or paper charts) to assist the assessor
- Retrieve additional patient records as needed

b. The **assessor** will:

- Select and review 15 patient records from these days, reflecting a mix of new patients and follow-ups
- Review the selected charts sufficiently to evaluate the continuity and quality of patient care, including attention to
 - Initial consultations
 - Follow ups
 - Laboratory investigations and imaging results

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 record selection to ensure they have sufficient information to address any issue or area of concern (e.g., if there was concern specific to one area of practice, such as prescribing for a particular condition, the assessor will use their judgement to decide if extra records of that type must be reviewed in order to provide an informed impression in the reassessment report).

Timeframe for records selected during 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 patient care identified in the previous assessment were ameliorated”).

3.2 Physician Discussion Guide

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 provides the assessed physician with specific information about their practice from a peer. Assessors review areas of appropriate care, discuss any issues 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. The [CPD/Practice Improvement Resources](#) section of the CPSO's CPD webpages may also be shared for additional educational resources:

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 circumstances of the assessed physician.

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 B**.

S _{ubjective}	O _{bjective}	A _{ssessment}	P _{lan}
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 criteria and sought feedback from practising physicians and specified physician specialty organizations to ensure the relevance and appropriateness of the tools. The criteria in the rubric are periodically reviewed to ensure they are up-to-date.

Assessors use the scoring rubric 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 Rubric: Endocrinology

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) Reason for assessment/consultation was documented, including **relevant details** of:

- a. Referral information
- b. Chief complaint(s)

3) 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)
- f. Source of history information (e.g., patient, interpreter, family member)

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

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

- a. Past medical conditions / medical comorbidities (documented in Problem List with date of onset or diagnosis for each problem)
- b. Past and ongoing medical treatment and surgeries
- c. Immunization records
- d. Allergies and sensitivities (medications, food, environment), recorded at initial consultation and kept up-to-date and visible if paper chart
- e. Relevant family medical histories (history (e.g. family history of premature vascular disease, osteoporosis, familial cancers, components of MEN [Multiple Endocrine Neoplasia], etc.)

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

- a. Current and past medications
- b. Recent changes in medication (recent starts, discontinuations, dose changes)

- c. Pharmacological and non-pharmacological substance use and misuse (including herbal substance use as relevant)

7) When relevant, social histories were documented, including **pertinent details** of:

- a. Education/Occupation
- b. Marital/relationship status
- c. Social support
- d. Lifestyle (smoking, exercise, use of recreational drugs/alcohol)

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

- a. Current activity
- b. Menstrual history
- c. Past or current pregnancies (Gravida, Term, Preterm, Abortion, Living – (GTPAL))
- d. Past or current sexually transmitted infections (STIs)
- e. Sexual orientation

9) When relevant, mental health histories were documented, including **relevant details** of:

- a. Past and current psychiatric conditions
- b. Previous treatments and/or hospitalizations
- c. Past or current family violence/abuse
- d. 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	<p>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:</p> <ul style="list-style-type: none"> • Problem lists were often incomplete (e.g., medications for which there was no obvious problem were listed, dates of onset or diagnosis were not included) • Medication histories were often incomplete or inaccurate • Family histories often did not include important negatives or positives (e.g., no mention of family history of thyroid disease in person with thyroid nodule, family history of vascular disease in diabetic patient) • Source and reliability of information was questionable and not appropriately followed-up • Changes in medication were often not clearly indicated during consultations
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> • Problem lists (active and inactive) were consistently missing from records • Medication lists were often not completed • Allergies were often not mentioned • Family histories were often not included in records • Social histories, including alcohol and smoking, were often not mentioned • Date of birth or age were often not recorded in follow up

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. Vital signs (e.g., weight, height, BMI/waist circumference, pulse, BP), with abnormal vital signs highlighted where appropriate
- c. Relevant descriptive information
- d. Illustrations of conditions, where appropriate
- e. Condition-specific physical assessments performed, when relevant (e.g. weight for thyroid disease, foot examination for patients with diabetes, BP for hypertension[postural, when relevant])

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>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:</p> <ul style="list-style-type: none"> Blood pressure levels were sometimes not reassessed when initial levels not at target
2	<p>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:</p> <ul style="list-style-type: none"> Pertinent negative findings often not recorded Descriptions of physical findings related to referring problems were often inadequate
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> Vitals signs were consistently not documented Physical findings related to the referring problem were consistently not documented

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 and presenting conditions)
- b. Consideration of differential diagnosis
- c. Review of previous investigations and findings as relevant
- d. Urgency (e.g., life-threatening conditions prioritized)
- e. Judicious use of resources

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) Investigations were shared with other health professionals, 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.
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: <ul style="list-style-type: none">• Questionable tests were sometimes ordered with inadequate explanations for orders made
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: <ul style="list-style-type: none">• Inappropriate tests were consistently ordered with no explanations for orders made• Analysis of test results were incomplete or inaccurate with potential for serious patient harm

DIAGNOSIS:

The identification of possible diseases, disorders, or injuries in a patient.

Key [CPSO Policies](#): [Medical Records](#)

ELEMENTS OF QUALITY

1) Diagnostic conclusions were appropriate, as demonstrated by:

- a. Alignment with histories, examinations, and investigations
- 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**

3) Diagnoses are **ranked in order of severity**, if multiple endocrine diagnoses present

- a. Ideally, diagnoses organized based on conditions being treated by the endocrinologist versus diagnoses being treated by other health care providers

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: <ul style="list-style-type: none"> • Differential diagnoses were typically incomplete, but most likely diagnoses were usually mentioned
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: <ul style="list-style-type: none"> • Failure to recognize the diagnoses and the severity of the condition(s) • Important possible diagnoses were often not mentioned in records • Differential diagnoses were often disjointed/disorganized • Diagnoses often did not consider other possible contributing factors (i.e., comorbid problems, current medications)

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. Alignment of treatment plans with 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. Relevance of ordered/conducted tests, procedures and referrals (e.g. Diabetes Education Centre, smoking cessation, weight loss, cardiology, neurosurgery)
- e. Judicious use of resources (e.g., referrals and requisitions)
- f. Consideration of patient circumstances and costs (e.g. coverage for medication; physiotherapy)
- g. Legal guardians (e.g., power of attorney) documented as relevant

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

- a. As appropriate, initiation and maintenance of Cumulative Patient Profile (CPP) and/or patient flow-sheet(s)
- b. Documentation of procedures performed in office
- c. Purpose, goals and milestones of treatment
- 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 follow-up of critical investigations
- i. Prompt and appropriate responses to unexpected or adverse intra-procedural events and complications

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>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:</p> <ul style="list-style-type: none"> Respective roles of endocrinologist and primary care providers, re: follow up, were often not clearly specified CPPs and/or flow-sheets were often missing
2	<p>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:</p> <ul style="list-style-type: none"> Referrals were often incomplete and/or not documented appropriately CPPs and/or flow-sheets were initiated but often incomplete
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> Referrals were not initiated or documented when appropriate (i.e., smoking cessation, diabetes education, surgical procedures) Failure to take appropriate action based on any report received Informed consent for procedures performed were often not mentioned in records CPPs and/or flow-sheets were consistently not included in records

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. Treatment goals (i.e. Hemoglobin A1C or blood pressure control explicitly stated)
- d. Recommendations for changes in medications and/or doses

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

- a. Name of drug
- b. Dosage
- c. Quantity/repeats
- d. Route
- e. Retaining copies of prescriptions is recommended

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. Ongoing tests, examinations, and investigations
- b. Medication list updated with changes and rationale for changes
- c. Medication side effects monitored at appropriate intervals
- d. Responsible persons identified for monitoring medications, as appropriate

EVALUATION CRITERIA:

Score	Opportunities for Improvement
1	<p>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:</p> <ul style="list-style-type: none"> Copies of prescriptions were sometimes not retained
2	<p>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:</p> <ul style="list-style-type: none"> Questionable medications or doses were often prescribed Changes in medications were often not clearly noted on the Medication List
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> Inappropriate medications or doses were prescribed in one or more records Recommended changes in medications were not clearly explained and/or documented Discussions regarding medication side effects were not recorded when relevant Medication targets (e.g., A1c, LDL, TSH) were often not documented

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. Relevant follow-up tests ordered and patients instructed to complete investigations at the appropriate time
- b. Abnormal results followed-up in a timely fashion

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

- a. Brief interval history of the condition(s) was/were obtained
- b. Review of recent medical history
- c. A regularly updated Cumulative Patient Profile (CPP)
- d. Notation about any significant inter-current illness that could result in change in therapeutic targets and/or regimen.
- e. Assessment of compliance with drug therapy and reasons for not taking as advised
- f. Appropriate follow-up physical examination performed
- g. Updated investigations and results documented
- h. Appropriate follow-up of abnormal test results not related to reason for referral (e.g. investigation of anemia or lung lesion identified by endocrinologist)
- i. Instructions to patients regarding should specific problems emerge
- j. Specification of return visit date
- k. Consideration of referring stable patients back to primary care physicians with explicit instruction for appropriate monitoring and follow-up (e.g., re-referral when 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.
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: <ul style="list-style-type: none"> • Follow-up histories were often incomplete • Physical findings were often inadequately indicated in records • Inadequate or illogical justification for tests ordered
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: <ul style="list-style-type: none"> • Appropriate follow-up tests were often not ordered • Abnormal test results were not followed up on in one or more records • Records often did not indicate what patients should do if further problems experienced • Return visit dates were often not specified in records • Physical findings were consistently not indicated in records • Ongoing follow-up was evident for patients that should have been referred back to primary care physicians • Suggestions about monitoring were not given to primary care physicians when patients were referred back

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 with referring sources was effective, as demonstrated by:

- a. Provision of copies of assessments and discharge summaries
- b. Provision of periodic progress reports of long term therapy patients
- c. Identification of physicians responsible for specific aspects of patient monitoring and follow-up (i.e. appropriate timing of subsequent investigations)
- d. Clear specification about whether the endocrinologist is taking on the responsibility only for the condition for which the patient was referred (the exclusive approach) or whether he or she plans to manage all identified endocrine conditions (the inclusive approach)
- e. Prompt alerts regarding changes in diagnosis, health status or therapeutic regimen

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

- a. Clear and comprehensive articulation of consultations and referrals

3) Transfer and discharge information was documented, including **relevant details** of:

- a. Diagnosis
- b. Treatments already provided
- c. Recommendations for continued and future management
- d. Indication of the patients' comfort or concerns with transfer of care or termination
- e. Risks or concerns about the patient
- f. New medications and/or medication changes
- g. New referrals

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. Abbreviations were appropriate (i.e., no potential for confused interpretation by the range of health care providers who might need to access the record)
- c. Physician-patient encounters, including telephone contact, were documented and dated
- d. In the case of shared records, it is clear who made the entry
- e. Most responsible physician ensures trainee entries were accurate
- f. 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
- g. Templates were used appropriately, including pre-populated templates
- h. An effective system exists for recording and managing test findings and follow-up

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	<p>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:</p> <ul style="list-style-type: none"> • Patient records were often difficult to understand and/or disorganized • Communication with referring sources regarding pertinent care issues and/or changes was inadequate • Instructions given to referring sources regarding ongoing care were often incomplete • Physicians responsible for managing other endocrine problems for which the patient was not referred were not identified in records
3	<p>Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected. Examples include:</p> <ul style="list-style-type: none"> • Patient records were impossible to decipher or significantly incomplete • Inadequate written communication with the referring physicians regarding pertinent care issues • Instructions were not provided to referring sources regarding ongoing care in one or more cases

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 interview. 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.

How to complete the summaries

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 Visit / Date Range of Record Reviewed:* The range of dates that were reviewed within the chart. If only a specific visit was reviewed, that date should be entered.
4. *Presenting Problem of Patient/Clinical Issue:* The reason for the patient's visit.
5. *Comments/Concerns/Recommendations:* This section, which is divided into the eight assessment domains, is where pertinent information about the chart 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.
6. *Key Positives/Concerns and Clarification from Discussion with Physician (if relevant):* Include 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.

PATIENT RECORD SUMMARY TEMPLATE
(placeholder – 1 page in pdf)

Chart #1

Patient Identifier (Initials/Chart Number):

--

Date of Birth (dd/mm/yyyy):

--

Date of Visit (dd/mm/yyyy):

--

Presenting Problem of Patient/Clinical Issue:

--

Comments - Concerns - Recommendations Regarding Patient Care:

History

Examination

Investigation

Diagnosis

Management Plan

Medication

Follow-Up & Monitoring

Documentation for Continuity of Care

<u>Specific Concerns & clarification from Physician Discussion (if relevant):</u>

5.2 Peer Assessment Report

The Peer Assessment Report provides an overall summary of the assessment. The report template guides the format of the report. The report will include relevant background information about the physician's practice, highlight areas of appropriate care, detail areas for improvement across the eight assessment domains, summarize pertinent information from the discussion, and provide 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 will then be provided to the assessed physician.

Instructions to Assessors for completing the Peer Assessment Report:

The Peer Assessment Report should be completed after all the patient records have been reviewed and the discussion with the assessed physician has taken place. The report should provide 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:* Insert the assessed physician's name, CPSO number and the scope of practice that was assessed. Insert the assessed physician's initials in the footer at the bottom left of the page (this will automatically be copied onto all subsequent pages).
2. *Assessment Information:* Insert your 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, insert the amount of time spent completing the patient record review and the amount of time spent in discussion with the physician. Sign the form when completed.
3. *Relevant Background Information:* Provide 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 planned changes to practice). Information already included in Physician Questionnaire need not be repeated unless it provides specific information that informed the assessment.
4. *Ratings & Comments:* For each assessment domain, provide a rating (1, 2, or 3) based on your overall assessment of the physician's practice. The scoring rubrics should be used

to guide your decision making about ratings. Ratings should be 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:* Briefly summarize positive aspects of the physician's practice, as they relate to the elements of quality, in order to validate and encourage continued effort in these areas. Summarize optional suggestions for practice improvement and professional development.
 - ii. *Specific Concerns Requiring Attention and Recommendations for Practice Change:* Describe specific concerns that were identified during the assessment, including both the nature and extent of the concerns, as well as specific recommendations for improvement in this area. When relevant, refer to examples in specific patient record summaries. Clear and concise narrative details are vital for the Quality Assurance Committee's understanding of the issues and ability to make valid decisions and recommendations.
5. *Summative Comments:* Provide a brief summary of your overall assessment of the physician's practice across all eight domains including aspects of quality care and any areas of concern. 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					
<p>1 - Little to no improvement is needed when the trend shows that most elements of quality were evident and deficiencies, if any, were minor.</p> <p>2 - Moderate improvement is needed when the trend shows some elements of quality were lacking, but the likelihood of adverse patient outcomes was low.</p> <p>3 - Significant improvement is needed when the trend shows many elements of quality were lacking, or when patient outcomes could be adversely affected.</p>					
<p>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.</p> <table border="0"><tr><td><ul style="list-style-type: none">• Demographic information• Reason for assessment/consultation• Presenting illness histories• Review of systems• Medical histories</td><td><ul style="list-style-type: none">• Medication histories• Social histories• Reproductive and sexual histories• Mental health histories</td></tr></table>				<ul style="list-style-type: none">• Demographic information• Reason for assessment/consultation• Presenting illness histories• Review of systems• Medical histories	<ul style="list-style-type: none">• Medication histories• Social histories• Reproductive and sexual histories• Mental health histories
<ul style="list-style-type: none">• Demographic information• Reason for assessment/consultation• Presenting illness histories• Review of systems• Medical histories	<ul style="list-style-type: none">• Medication histories• Social histories• Reproductive and sexual histories• Mental health histories				
Rating:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		
Areas of Quality Care and Suggestions for Quality Improvement:					
Specific Concerns and Recommendations Requiring Attention:					
Examination: Guided by the presenting problem, a systematic evaluation of the patient's physical and/or mental state.					

<ul style="list-style-type: none"> Physical Examinations 			
Rating:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<p>Areas of Quality Care and Suggestions for Quality Improvement:</p> <p>Specific Concerns and Recommendations Requiring Attention:</p>			
<p>Investigation: Procedures or tests performed to detect, diagnose, or monitor disease processes and determine a course of treatment.</p> <ul style="list-style-type: none"> Investigations selected appropriately Investigations reviewed appropriately 			
Rating:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<p>Areas of Quality Care and Suggestions for Quality Improvement:</p> <p>Specific Concerns and Recommendations Requiring Attention:</p>			
<p>Diagnosis: The identification of a possible disease, disorder, or injury in a patient.</p> <ul style="list-style-type: none"> Diagnostic conclusions appropriate Differential, working and/or final diagnoses stated 			
Rating:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

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 and Recommendations Requiring Attention:

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

- Medications selected appropriately
- Information provided to patients appropriate
- Prescriptions comprehensively documented
- Medication monitoring appropriate

Rating:

1 ☐

2 ☐

3 ☐

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

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 followed up appropriately**
- **Patient monitoring and follow-up appropriate**

Rating:

1 ☐

2 ☐

3 ☐

Areas of Quality Care and Suggestions for Quality Improvement:

Specific Concerns and Recommendations Requiring Attention:

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 with referring sources**
- **Communication as a referring source**
- **Transfer and discharge information**
- **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 and Recommendations Requiring Attention:

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 rigorous and educational 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:

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

Using simulated records and the discipline-specific scoring rubrics, assessors would make ratings anonymously and then be presented with the ratings of all other assessors to see their consistency with each other. They would then discuss any disagreement by sharing their unique perspective on the case and each make a new rating until an acceptable level of agreement was met. Through this exercise, assessors would identify areas of penitential inconsistency in their interpretations and actively work 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 physicians within a specific discipline (e.g., Endocrinology) 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 Canadian Society of Endocrinology and Metabolism) were contacted and asked 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 will be conducted to systematically collect data on the effectiveness of the program. The evaluation will consist 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 – 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 COMPONENT	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 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.