



The Meantime Guide - You asked, we listened

As the Royal College's Competence by Design (CBD) initiative gains momentum, stakeholders are learning more and they're eager to participate. If you are not part of a discipline that is scheduled to implement CBD in the next two years, there are still meaningful opportunities for you to prepare your entire faculty or program. This Meantime Guide describes those opportunities in practical steps that you can take.

Editors Anna Oswald & Cynthia Abbott

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Getting started: What is CBD?

By: Anna Oswald and Cynthia Abbott

The Competence by Design (CBD) initiative is gaining momentum. Some disciplines are already actively engaged in CBD, and many other disciplines are scheduled to make the change in the next few years. People in these "later cohorts" tell us they are keen to get involved in CBD sooner rather than later. If you are part of a discipline that has not yet started the Royal College CBD transition workshops there are still meaningful opportunities to prepare yourself, your faculty and your program. The Meantime Guide describes these opportunities in a series of practical steps. You asked, we listened.



Using this guide

If you are a clinical supervisor, residency program committee member, program director or specialty committee member whose discipline has not yet officially started the CBD process, the Meantime Guide was written for you. It is meant to provide an initial introduction to the CBD process and to help you start thinking about and preparing for this change. Although you can read the guide from start to finish if you'd like, we know you're busy, so we've designed it to allow you to quickly scan the material and identify the content you need most.

All of the activities described in this guide are optional until your discipline starts the CBD transition workshops. The more you tackle now, though, the easier the CBD transition is likely to be down the line.

Where to find additional information

In this guide we introduce key concepts that will help get you started in CBD. You can find more information on the Royal College website (<http://www.royalcollege.ca>). Your specialty committee will also dive into much greater detail once your discipline starts to plan for its CBD workshops.

Competency-based medical education (CBME) and the Competence by Design (CBD) initiative

Competency-based medical education (CBME) is an outcomes-based approach to the design, implementation, assessment and evaluation of a medical education program using an organizing framework of competencies (e.g., CanMEDS 2015).

In a CBME system, a curriculum is organized around the outcomes expected of a resident, and that resident's advancement is dependent on having achieved those outcomes. In some cases, CBME is designed as a time-free system (i.e., residents progress from one stage of their training to the next as soon as they achieve a certain set of competencies).

Many people have trouble distinguishing between CBME and CBD. Many countries are implementing CBME, but each one is doing it somewhat differently. CBD is the Royal College's version of CBME.

In a nutshell, CBD has these characteristics:

- It focuses on expected outcomes.
 - Competencies required of a clinician are now the organizing principle of postgraduate curricula.
 - CBD moves away from the assumption that time is a surrogate for competency (competence is no longer assumed, and promotion is no longer guaranteed, on the basis of time spent).
 - Residents must now demonstrate competencies and abilities to progress through their training.
- It finds a balance between a fully time-dependent and a fully time-free mode of training.
 - As a hybrid model, CBD de-emphasizes time based training — time is instead used as a guideline and resource.
- It promotes greater accountability, flexibility and learner centredness.
 - Residents will play a greater role in planning their learning and tracking their progress, which will promote development of lifelong learning skills.
- It includes broader system-level changes in areas such as assessment and accreditation.

The Lingo

There are two key terms that will help you as you navigate this guide and the CBD process.

An EPA (Entrustable Professional Activity) is a task in the clinical or work setting that may be delegated to a resident by their supervisor once sufficient competence has been demonstrated. Typically, each EPA integrates multiple milestones.



A **milestone** is an observable marker of an individual's ability or competence along a developmental continuum, used for planning and teaching.

For example, you might think of the ability to safely drive a car in reverse as one of the milestones related to an EPA of parallel parking. Similarly, the ability to assess and protect the airway can be one of the milestones related to the EPA of running a code in medical practice.

EPAs are created for [stages of training](#).

Stages of training

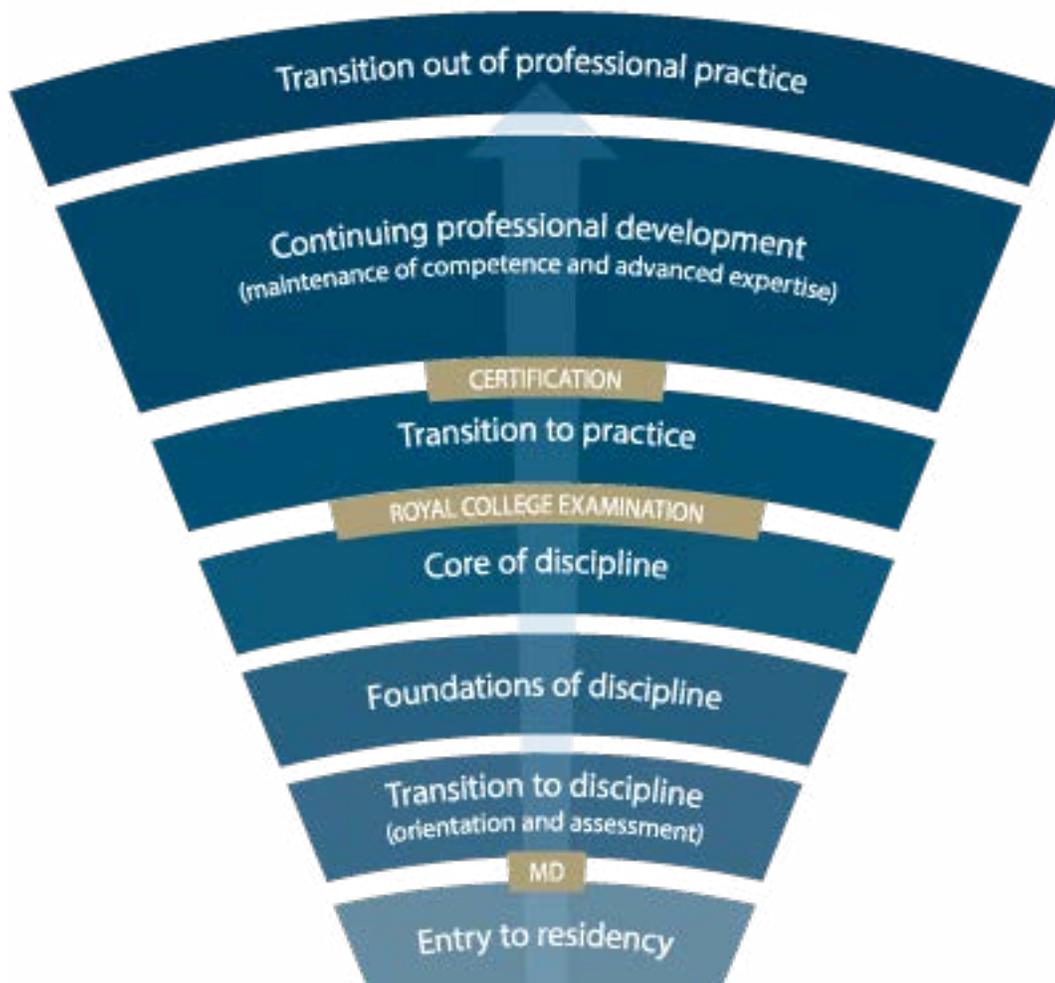
CBD organizes residency training into four developmental [stages](#) and clearly lays out markers for teaching and learning at each stage (see figure 1).

Each stage of training, and each learning experience, focuses on the identified outcomes for that stage.

- In CBD, the first stage in residency is known as Transition to Discipline. It emphasizes the orientation and assessment of new trainees.
- Foundations of Discipline, the second stage, covers broad-based competencies that every trainee must acquire before moving on to the third stage.
- The third stage, which is known as Core of Discipline, covers more advanced, discipline-specific competencies. As part of CBD, the Royal College is exploring moving the Royal College exam to the end of this stage
- The fourth and final stage of residency education is known as Transition to Practice. During this stage the trainee demonstrates readiness for autonomous practice.

Figure 1

Competence Continuum diagram



Prepare your program for change

By: Rhonda St. Croix

[The Competence by Design \(CBD\)](#) initiative is a multi-partner, [multi-phase](#), multi-project enterprise designed to improve residency education, the exam process, the accreditation system and continuing professional practice. Change on this scale does not happen one person at a time. Rather, it occurs as people who share a common purpose develop networks and then reach out to others to make the change together.



The path to a new way of doing things rarely follows a straight line and usually involves a “dip” that includes discomfort and setbacks. It’s natural for there to be tension as people adapt. Fortunately, there are a number of things you can do to moderate the dip. As you read through the list of practical suggestions in this section, keep in mind that one of the best ways to support change is to help people to engage in new ways of thinking and behaving.

Here are some things you can do now to help your program to prepare for the transition to CBD.

Improve your knowledge and skills so that you can become a local resource person, a role that we’re calling “CBD champion.”

- Review our [CBD rationale](#) materials: [video 1](#), [video 2](#), [2-pager](#)
- Consider a resident’s perspective on CBD.

Make CBD your own: prepare a “story” about how you relate to CBD as a program director, CBD or CBME lead, resident or teacher. If you present the case for change with a motivating story or cause that your listeners care about, they are more likely to respond positively than if you simply present them with numbers and statistics.

- As you prepare your story, consider these questions:
 - [Why are we changing?](#)
 - What’s our goal?
 - What’s changing and what’s not?
 - Why should others care about CBD?
- Demonstrate the gap between what is and what could be.
 - What could CBD fix?
 - Educational needs of learners
 - Care needs of patients
 - Accountability to the public
- Think about your key messages. How do you think CBD will most benefit your program? For example:
 - We want to design our program to meet patient care and societal needs.
 - We want to ensure that residents are safe, ready for practice and have the competencies they need.
 - We want to provide more timely coaching feedback to residents.
 - We want to identify struggling learners at an earlier stage, when interventions are more likely to be effective.
 - We want to chip away at the culture of “failure to fail.”
 - We want to support residents to take ownership of their own learning and to develop lifelong learning skills.
- Use your CBD story as a conversation starter in your community.

Show how CBD is relevant to your program’s success.

- You don’t always have to host special CBD meetings; sometimes it’s just about getting onto existing agendas and using existing communication channels.
- Host local conversations at your regular meetings (divisional business meetings, grand rounds, program retreats, etc.) to share your CBD story and ensure that your colleagues see CBD as being relevant to your program’s success.

Lead by example. Be a CBD resource or champion and inspire other people to become champions by modelling the change and making progress visible.

- Invite local CBD champions from other programs to talk with your program faculty and other stakeholders about why change is needed and why CBD is so important.
- Invite some of your colleagues to develop talking points about CBD and to engage in discussions about how CBD supports lifelong learning.

Share and make explicit the design of CBD, emphasizing key activities and language (e.g., direct observation, coaching feedback and documentation).

- Begin to explore what it might take to implement CBD in your program.
- Consider how to adapt the new behaviours and activities associated with CBD for your setting, then test them out on a small scale (e.g., try requiring a single documentation of observation and feedback per rotation in your program).
- Share and celebrate early successes.

Build broader ownership and commitment

- Think about how you will enlist your local stakeholders. What new or existing mechanisms can you use to build support for CBD (e.g., departmental meeting, postgraduate education committee, faculty retreat, grand rounds, resident meetings, regular emails and newsletters)?
- Facilitate peer-to-peer conversations about CBD and what it will mean for each person (e.g., how it will impact their role).
- [Engage your residents](#) and empower them to support this change.
- Gather feedback so that you and your colleagues can learn from each other. People support what they have helped to create and have actually tried.
- Tailor your methods: there is no-one-size-fits-all approach to change.

Ease the way for change.

- Review the concepts of CBD and make sure enablers are in place for your program (e.g., give your faculty information on how to provide coaching feedback to residents according to the principles of CBD, help support your program's new CBD competence committee).
- Consider which [elements of your program](#) will need to be reviewed when your program transitions to CBD (e.g., [policies](#), processes, systems, supports).

Other recommended resources

- [CBD early cohort materials](#) – videos, slide decks, handouts all designed to help build understanding around CBD among early cohort disciplines
- [CBD tools and resources](#)
 - [Switch by Heath Brothers \(resources\)](#)
 - [Switch by Dan Heath \(short videos\)](#)
 - [Viral Change by Leandro Herrero](#)
 - [Start with Why by Simon Sinek](#)
 - [Derek Sivers How to Start a Movement \(3 min video\)](#)
 - [Bronze Age Orientation Day \(funny change video\)](#)

Review the CanMEDS Special Addendum to the Objectives of Training Requirements (OTR)

By: Cynthia Abbott



Rationale

Implementation of the CanMEDS 2015 Framework will happen gradually as disciplines develop their new competency-based standards with the help of the Royal College. In the meantime, the Royal College has introduced a CanMEDS 2015 Special Addendum to the Objectives of Training Requirements (OTR) for any discipline that will transition to CBD after July 1, 2018. The purpose of the special addendum is to ensure that the new elements of CanMEDS 2015 are incorporated efficiently into training programs, without overburdening stakeholders who are also dealing with significant changes as their programs transition to CBD.

Here are some things you can do now to help your program to incorporate the CanMEDS 2015 changes.



Read about the changes to the CanMEDS Framework.

Download the [special addendum](#).

Familiarize yourself with the major NEW content areas that were added to CanMEDS 2015 (handover, patient safety, quality improvement, etc.).

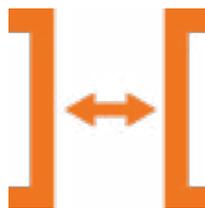


Check your curriculum plan against the CanMEDS 2015 requirements.

Obtain a copy of the CanMEDS 2015 Milestones Guide from [CanMEDS Interactive](#).

Cross-reference the list of new competencies against your own curriculum plan.

Identify any gaps.



Plan to address gaps.

Develop a plan for how you will incorporate the new competency(ies) into your program, consulting relevant resources like the [CanMEDS Teaching and Assessment Tools Guide](#).

Plan the specific changes needed to address any gaps you identified in Step 2.



Obtain feedback.

Share your plan with your program committee, faculty and/or other educators and get their input.

Incorporate their suggestions and revise your plan.

Other recommended resources

- [CanMEDS Interactive](#) allows you to manipulate the CanMEDS framework and milestones to generate a fully customized and exportable file; sort through Royal College generic milestones easily to find what you need, when you need it; and access practical tips and sample tools to help you to teach and assess the seven CanMEDS Roles.

Prepare clinical teachers to observe, coach and document

By: Denyse Richardson

Rationale

One of the changes that will be most notable for clinical teachers as they transition to Competence by Design (CBD) is the need for more frequent observation with coaching feedback and documentation. Coaching* is beneficial for anyone who is pursuing optimal performance. Simply defined, a coach is a person guiding another through a process, leading to performance enhancement¹. Coaches can help an individual to do some task better, develop a skill they don't yet possess or achieve a specific goal.

Athletes rely on their coaches to provide correction so that they can improve their performance. Coaches can't provide helpful critique if they haven't observed the athlete: they need to observe how the athlete executes the task(s), either in practice or on game day. Musicians and athletes can't imagine useful coaching that doesn't begin with detailed observation of their performance. But in medicine, observation remains limited, random, and unstructured. For medicine to embrace coaching as part of its learning culture, it must better embed observation in its daily routines and practices².

*Within education, coaching is defined as "a one-to-one conversation focused on the enhancement of learning and development through increasing self-awareness and a sense of personal responsibility, where the coach facilitates the self-directed learning of the coachee through questioning, active listening, and appropriate challenge in a supportive and encouraging climate.

In residency education, some clinical teachers are already using regular, direct observation of trainees as an effective tool to provide feedback to help learners improve (i.e., assessment for learning or formative assessment). In CBD, there is an increased emphasis on direct and indirect work-based observation to facilitate resident learning. The role of faculty must evolve from one of supervision to one that includes more observation of the work residents are doing day to day^{3,4,5}. Regular observation will equip faculty to coach (<http://www.royalcollege.ca/rcsite/cbd/implementation/wbas/coaching-wbas-e>) residents toward optimal performance, EPA after EPA and milestone after milestone.



Here are some things you can do now to help prepare your program’s clinical teachers to coach for excellence.

1. Build a coaching mindset.

Review the concept of coaching and think specifically about the skills needed to coach residents. [There are many resources for coaching](#) ^{6,7,8,9}. As you’re reading them, think about how to apply to residency training the skills and strategies the resources recommend.

Consider how coaching is different from supervising a resident’s work (which is what we mostly do now).

Consider attending a workshop that will allow you to practise the skills and strategies that you’ve been reading and thinking about.

2. Make a specific plan for observation in your practice setting(s).

- Identify opportunities in your clinical environment(s) that are conducive to resident observation. Remember that resident observation can be direct or indirect (indirect observation includes things like reviewing the results of a resident's completed work, such as completed sutures or their notes or dictations).
- As your program probably doesn't have entrustable professional activities (EPAs) yet, identify a couple of competencies within one or two CanMEDS Roles that you can readily observe in your practice setting(s). For example, you could watch a resident give handover (Collaborator) or obtain informed consent (Communicator). While physicians are more than the sum of a series of milestones or EPAs, focused coaching allows teachers to make concrete suggestions for improvement.
- Be realistic and practical about what you take on. Direct observation doesn't have to require a huge amount of your time: sometimes your observation can be based on a partial encounter (e.g., you might observe only the obstetrical history if that is the concern). Short, focused assessments are more likely to be completed and result in specific suggestions for improvement.

3. Set the stage for coaching^{10, 11, 12}.

- Think of yourself as a "learning for practice" coach: tell your learners explicitly that you are approaching your interaction with them with a coaching mindset so that you can help them to progress.
- Be intentional about creating a positive learning culture in your clinical setting(s). Figure out when and where you can explain to your residents that your role is not only to supervise patient care but also to act as a coach for them.
- Emphasize the benefits of observation and coaching for learning.
- At the beginning of a clinical experience, ask the resident about their personal learning objectives and goals. Eventually, these discussions will revolve around what milestones or EPAs the resident is working on. You might also discuss what stage the resident is at (i.e., past experience and achievement) and what they need to do to achieve a higher level of performance in a particular task.
- Encourage residents to regularly solicit suggestions for improvement from you and your colleagues. Help residents learn to treat constructive recommendations as a valued element of their ongoing development. Note that this will help your residents create habits for ongoing life-long learning.

4. Try it: observe, coach and document.

- Plan when and where you can observe a particular resident by matching the resident's learning objectives to the clinical opportunities for observation.
- Observe residents more often.
- Follow each observation with a timely, specific, constructive discussion — a coaching conversation, in other words — to facilitate the resident's development. Residents should start to see you as a coach whose job is to help them improve their "game."
- Help each resident build a portfolio of observations by taking a few minutes to document the key points of your feedback. If your program doesn't have encounter coaching/feedback forms, use a simple framework that identifies;
 - something the resident did well and should continue;
 - something you observed that needs correction, further development or improvement (be specific about the correction); and
 - a time to revisit the task requiring improvement.

5. Be realistic about the change: you won't adjust to the new aspects of your role as a coach overnight.

- Set realistic expectations for the frequency of observations. Depending on your program, observations may or may not be done every day
- Keep in mind that your observations will form part of a larger picture of resident performance that takes into account the input of many observers. Using a program of assessment (i.e., multiple assessors and multiple assessments over time) allows for all relevant domains to be assessed over the course of a training program. No one needs to observe everything, all the time — nor can they.

References

1. Van Nieuwerburgh C: Coaching in Education: Getting Better Results for Students, Educators and Parents. London, Karnac Books, 2012.
2. Watling, C., Driessen, E., van der Vleuten, C., Lingard, L. Learning culture and feedback: an international study of medical athletes and musicians *Medical Education* 2014; 48: 713–723
3. Voyer, S., et al. (2016). "Investigating conditions for meaningful feedback in the context of an evidence-based feedback programme." *Medical Education* 50(9): 943-954.
4. Pelgrim, E. A., et al. (2012). The process of feedback in workplace-based assessment: organisation, delivery, continuity. *Medical Education* 46(6): 604-612.
5. Watling, C J. Lingard, L. Toward meaningful evaluation of medical trainees: the influence of participants' perceptions of the process. *Adv in Health Sci Educ* (2012) 17:183–194
6. Van Nieuwerburgh C: Coaching in Education: Getting Better Results for Students, Educators and Parents. London, Karnac Books, 2012.
7. Deiorio, N. M., et al. (2016). Coaching: a new model for academic and career achievement. *Medical Education Online* 21: 33480.
8. Ross S, Huie M, Schipper S. Use words that count: A content analysis to identify words and phrases that commonly appear in effective formative feedback. *International Conference on Residency Education, October 22-24, 2015, Vancouver BC.*
9. Ross, S., Dudek, N., Halman, S., Humphrey- Murto, S. Context, time, and building relationships: bringing in situ feedback into the conversation. *Medical Education* 2016 50: 889–895 <http://www.businessballs.com/coaching.htm>
10. Pelgrim, E. A., et al. (2012). The process of feedback in workplace-based assessment: organisation, delivery, continuity. *Medical Education* 46(6): 604-612.
11. Telio, S., et al. (2016). Feedback and the educational alliance: examining credibility judgements and their consequences. *Medical Education* 50(9): 933-942.
12. Watling, C., Driessen, E., van der Vleuten, C., Lingard, L. Learning culture and feedback: an international study of medical athletes and musicians *Medical Education* 2014; 48: 713–723

Pilot an EPA

By: Anna Oswald

Rationale

As part of Competence by Design (CBD), your program will teach and assess residents on the basis of a set of standards that include [milestones](#) and entrustable professional activities ([EPAs](#)).

Eventually your specialty committee will create a suite of EPAs that will encompass all of the activities of your discipline. In the meantime, you may find it helpful to work with your colleagues to write and pilot a small number of EPAs so you can become more familiar with how to apply EPAs to your setting and test how they might work. It's generally most efficient to do this in collaboration with members of your specialty committee. If you have some experience with EPAs, we expect you will hit the ground running at your first Royal College CBD cohort transition workshop. Keep in mind that your pilot EPAs may be changed when your national group comes together.



Here are some things you can do now to help design and pilot an EPA.

1. Learn about EPAs and milestones.
Visit the Royal College website and review key resources.
Peruse some of the EPAs that other disciplines have developed.
2. Consider a key clinical activity that practitioners in your specialty/subspecialty need to be able to perform.
 - For example, what specific activities would a physician who has just completed residency be expected to do without supervision?
 - Consider what other activities may be entrusted to a learner at different stages in the continuum of training as they work toward being able to perform the key clinical activity independently.
3. In discussion with colleagues in your discipline, choose one of the activities that can be entrusted to learners as the focus of your pilot EPA. It is best to start with an activity that is not controversial and that practitioners and residents will encounter frequently.
4. Write a description of this activity in one sentence.
 - Consider whether it is necessary to specify context or complexity
 - Work to write the description at the right level of detail. Should you lump several professional tasks into this EPA? Or do some of the tasks you're thinking of including in your pilot EPA actually warrant being split off as separate EPAs?
 - Ensure that you could see yourself or your colleagues observing a resident doing this activity and giving feedback related to the learner's performance.
5. Ask your colleagues to try out your EPA by observing residents perform the EPA and giving the learners coaching feedback (see Prepare clinical teachers to observe, coach and document).
 - Ask them what went well and what challenges they faced.
 - Consider how you might revise your pilot EPA in light of this feedback.
6. Consider piloting another EPA. However, keep in mind that your full EPA suite will be created through the CBD cohort transition workshop process via national consensus with the specialty committee.

Other recommended resources

- Understanding Entrustable Professional Activities (EPAs) (video) — [watch it here](#).

Pilot a Modified Competence Committee

By: Anna Oswald

Rationale

The competence committee is an important element of Competence by Design (CBD). This committee uses data integrated from a variety of sources and observations to make informed and transparent decisions about a learner's performance and progression. In CBD, promotion decisions are made by the competence committee away from the individual teacher-learner interactions. Shifting broader promotion decisions to the competence committee frees teachers up to focus on giving coaching feedback for improved resident performance (i.e., assessment for learning).

The competence committee identifies patterns of performance revealing a broader picture of a resident's progression to support his/her learning over time. Competence committees will be able to identify residents who are not meeting their milestones. In these cases, the competence committee can help to arrange support and coaching for residents before they get too far off their trajectory (e.g., assigning special mentors, extra readings or modified rotations).



Your discipline's official transition to CBD may be years away, but in the interim your program is free to pilot a competence committee. This committee can meet to review collated resident assessment data and make recommendations to guide resident learning and development as a supplement to the discussions that happen at your existing progress decision meetings.

Some programs have asked for advice on setting up and running a competence committee. There isn't one "right" way to set up this committee: there are guidelines and sample terms of reference on the [Royal College website](#) that will help you to set up your committee in the way that will work best for your program.

Here are some things you can do now to pilot a competence committee.

1. Review the purpose and role of a competence committee.
 - Familiarize yourself and others with CBD, its scope, the new terminologies and the new assessment strategies.
 - Review the Royal College's sample guidelines and terms of reference documents for setting up a competence committee.
2. Consider how your competence committee might look.
 - Define your competence committee's terms of reference and procedures, including membership (e.g., voting vs. nonvoting members), frequency of meetings, plans for collating and presenting assessment data, and methods for decision making (e.g., majority, unanimous, consensus).
 - Identify the skill sets your committee members will need.
 - Recruit committee members. You may decide to recruit members from your current residency program committee or you may decide to choose other members, depending on the skills of your group.
3. Pilot your competence committee.
 - Consider engaging your residency program committee in piloting activities related to their coming competence committee.
 - Even if you don't yet have entrustable professional activities (EPAs) and/or other CBD specialty requirements for your discipline, you can identify current assessment inputs and outcomes that will inform promotion decisions.
 - Identify gaps in your program's assessment system: What data are you currently collecting? What are you missing?
 - Make plans to address gaps.
 - Meet regularly to systematically review individual residents' performance on the basis of collated assessment data and synthesize existing data on patterns of competence.
 - Plan how you will communicate this information back to your trainees to give them feedback and direction on their progress.

Recommended Resources

- [Link in new Competence Committee webpage on the Royal College's website](#)
- [CBD resources page](#)
- [Competence Committee sample terms of reference and guidelines documents](#)

Review what to expect during implementation

By: Adelle Atkinson

Rationale

Your program's transition to Competence by Design (CBD) will take time and effort, but the outcome will be worth it. You are not alone in this journey: there are teams of people across the country working to make the implementation of CBD as smooth as possible.

As you probably know, the Royal College has developed a series of interactive, in-person workshops to guide and support each discipline as it transitions to CBD. These CBD cohort transition workshops (CBD workshops) will help prepare you for the changes you will face as your cohort moves to CBD. They will also highlight work that will need to happen back at your local program.



What can you expect at the Royal College CBD workshops?

Each discipline will typically have three workshops (three days each) facilitated by a Royal College clinician educator.

Workshop 1

will start with an introduction to CBD. The facilitator(s) will then help you to review and/or reimagine the scope of your discipline, determine how the stages of training apply to your discipline, and draft entrustable professional activities (EPAs) for those stages. You may also start to consider the training experiences needed to achieve those EPAs.

Workshop 2

will focus on achieving consensus on the EPAs as developed by the specialty committee during and after workshop 1. It will also focus on developing assessment plans for the individual EPAs.

Workshop 3

will usually focus on finalizing the EPAs and assessment plans. EPAs will be examined individually and they will also be reviewed to ensure that they fit together as a group (i.e., to avoid gaps and/or redundancies). In addition, the specialty committee will work to validate milestones linked to the EPAs and finalize the full document suite. Throughout each of the workshops participants will discuss strategies to prepare for implementation. If you're invited, try to attend all three workshops as it will make it easier for you to understand, contribute to and implement these changes.

What "homework" can you expect?

Workshop 1

BEFORE: Participants will be asked to carefully consider the scope of their discipline (see specialty committee chapter 9 in this guide).

AFTER: Members will usually work on EPAs in small groups through teleconferences and/or electronic document sharing (e.g., Dropbox, Alfresco).

Workshop 2

AFTER: Members will usually work on EPAs in small groups through teleconferences and/or electronic document sharing (e.g., Dropbox, Alfresco).

Workshop 3

AFTER: Members will usually focus on finalizing all of the documents they've created and on preparing for implementation, which may include field tests and faculty development.

What will your program and faculty be responsible for doing at the local level?

- Local curriculum and assessment mapping, adjustment of curriculum and assessments to meet national standards, local communication, local faculty development and change management will largely happen at the school and program level.
- Consider brushing up on your curriculum mapping skills, as you will need to map your specialty's/subspecialty's national EPAs to your local training experiences and assessments.

- Start considering the strengths and weaknesses in your program when it comes to implementing CBD. Where do you anticipate changes may be needed? How might you address any gaps in curriculum or assessment?
- Think about the discussions you'll need to have with your colleagues and residents as your program moves to CBD. What can you do before and after the workshops to ease the transition process? For example, you might introduce the rationale for CBD and its concepts and terms at a local business meeting, you might introduce new assessment tools to document short observations with feedback, you might pilot a competence committee and you might consider how you will prepare residents for new expectations.
- Think about who can help you with these tasks. Many schools have assigned CBME leads, faculty development leads or communications teams who will help with local implementation. Find out if your school has people in these roles and reach out to them.
- Find colleagues from other disciplines who are further along in their transition. Connect with them and learn from them. Chat about the lessons they've learned.

Recommended Resources

- [CanMEDS 2015 Presentation: Including Summary of Changes](#)
- [CanMEDS 2015 Special OTR Addendum](#)
- [The CanMEDS Teaching and Assessment Tools Guide](#)
- [CanMEDS Interactive](#)
- [CanMEDS Summary Cards](#)

FOR SPECIALTY COMMITTEES

Review the composition of your specialty committee

By: Anna Oswald

Rationale

In Competence by Design (CBD), the specialty committee will have new roles in assessment as well as an expanded role in educational design. For this reason, you may want to revisit your committee's composition to make sure you have the right mix of skills.

Here are some things you can do now to review your committee's composition.



Review the changing role of the specialty committee.

Familiarize yourself and your committee members with [CBD](#), its scope, the cohort [rollout](#) plan for your disciplines and the [new terminologies](#), [assessment strategies](#), and so on, involved in CBD.

Review the Royal College's document on the terms of reference for specialty committees.



Identify gaps and redundancies in the skill sets of your committee members.

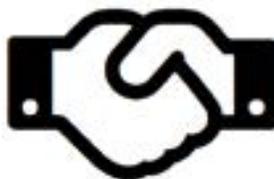
Identify the skill sets of your committee members and the perspective they bring to committee work.

Familiarize yourself with the major [new content areas that were added to CanMEDS 2015](#)([handover](#), [patient safety](#), [quality improvement](#), etc.).

Identify skill sets that will be needed but are currently missing from your group.

Identify skills sets that are overrepresented in the committee.

Identify timelines for committee renewal to address gaps and redundancies.



Recruit new members.

Engage the broader community to identify suitable candidates.

Use your CBD network (or build one) to tap into local talent.



Plan for faculty training.

Incorporate faculty development activities into your committee meetings.

Incorporate CPD thinking for the future into your committee meetings.



Obtain feedback.

Share your plan with others in your discipline.

Incorporate their feedback into your plan.

Share lessons learned with the Royal College so we can support others more effectively.

Recommended Resources

- [CanMEDS 2015 presentation: Including Summary of Changes](#)
- [CanMEDS 2015 Special OTR Addendum](#)
- [The CanMEDS Teaching and Assessment Tools Guide](#)
- [CanMEDS Interactive](#)
- [CanMEDS summary cards](#)

Review the scope of practice of your specialty / subspecialty.

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Rationale

Royal College specialties and subspecialties evolve over time as new treatments and technologies enter practice; as practice in the discipline moves into new locations or care settings; and/or as the patient population ages, becomes more complex and/or changes in other ways. An ongoing mandate of a specialty committee is to adapt its standards as the discipline transforms, but sometimes changes in standards lag behind changes in practice patterns.



Competency-based medical education is an outcomes-based approach to teaching, learning and assessment. This means that specialty committees start with the end in mind and design programs that will achieve that end goal. For individual specialties/subspecialties, program design requires a clear understanding of the societal need for, and expectations of, the discipline. Consider how you might answer the following questions:

- What is the role our specialty/subspecialty plays in the Canadian health care system?
- What services do the public expect from a graduate of our program?
- What effect does practice location have on the skills required of a graduate?

Questions like these will guide your early transition work, so start the discussion early with colleagues in your discipline. Give yourself time to consult widely before your first CBD cohort transformation workshop. This pre-work will make your workshops run more smoothly, and the consultations you do at this preliminary stage should help with engagement and uptake later on.

Here are some things you can do now to review your discipline's scope of practice.

1. Engage your specialty committee in a discussion about the scope of practice in your discipline.
 - Put this on the agenda for an upcoming committee meeting.
2. Gather information about practice patterns in your discipline.
 - Sources of information may include
 - the most recent Committee on Specialties review (done every six years),
 - data from your national specialty society and
 - recent publications in the field (e.g., epidemiological studies, reports on new technological advances).
3. Plan to address any gaps in that information.
 - Consider additional sources of information. For example, are there key billing codes used in your specialty that do not map to the described scope of practice?
 - Consider whether you need to survey current practitioners and recent graduates to gather more information.
 - Continue planning until all identified gaps have been addressed.
4. Obtain feedback.
 - Share your findings within your specialty committee, with your national specialty society and with other stakeholders.
5. Ensure your national standards documents are updated to reflect this review process.

If you identify an initiative that you believe will support CBD, please contact cbd@royalcollege.ca