Evolution of Competence by Design (CBD)
Call to Action – Options for Change PROPOSAL

DRAFT 1 November 20, 2023

Dear medical education partners,

Clear signals about the benefits and challenges of the Competence by Design (CBD) model have emerged from both formal program evaluation and feedback from our invested partner groups, and it is apparent and fully acknowledged that the introduction of CBD across Canada has had both positive effects and several unintended negative impacts.

While there are many benefits, the challenges include:

- the burden of using entrustable professional activities (EPAs) observations to both frame regular feedback to residents and to assemble data points for resident assessment;
- time and resources required to implement all aspects of CBD as designed;
- deploying an electronic learner portfolio; and
- associated impacts of CBD-related changes on resident and faculty wellness.

While the Royal College remains confident in the merits of competency-based medical education (CBME) as a framework for residency training, we recognize that a "one size fits all" approach does not adequately account for unique obstacles and opportunities within each local institution, discipline, and program. We also recognize that part of the solution involves addressing barriers to CBD implementation that are at the systems level, outside of the control of individual programs.

Multiple invested groups have called for increased flexibility of implementation, along with enhanced opportunities for local institutional education leaders to deliver CBD in more efficient ways that match the desired intent of CBD principles with the clinical workflow processes and local context and culture. We acknowledge that, in addition to reduced specificity of expectations and increased program-level flexibility, formal design adaptations in the CBD model may be required to achieve the intended impacts of competency-based medical education, improve the training experience, and address the impact on faculty and residents.

The Royal College has committed to a collaborative process with its invested partner groups to reimagine how CBD can enhance residency training across Canada, including the relative importance of national harmonization balanced against room for local innovation and contextually relevant implementation. The following preliminary proposal is one of the outputs of that process. It outlines early ideas for potential changes to CBD that emerged from the discussions with a diverse group of medical education partners representing various constituent groups at the first two national CBD summits held in June and September 2023.

We welcome your feedback and critical review of this first draft proposal. Please share it widely with your colleagues and submit a collated version from your invested group by December 22, 2023 to cbdsecretariat@royalcollege.ca

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Feedback will be collated and synthesized to contribute to a refined proposal for further feedback and consideration in early 2024 – see here for further details about next steps.

A sincere thank you to the many groups who contributed their time, expertise, and guidance in the collaborative development of this proposal. We remain committed to the ongoing improvement of the residency training experience for all.

Sincerely,

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Executive Summary

[To be added to later draft]

The path to change

Clear signals about the benefits and challenges of the Competence by Design (CBD) model for residency training have emerged from both formal program evaluation and feedback from invested partner groups. Important challenges described to date include the burden of using Entrustable Professional Activities (EPAs) observations to both frame regular feedback to residents and to assemble data points for resident assessment, the time and resources required to implement all aspects of CBD as designed, deploying an electronic learner portfolio, and associated impacts of CBD-related changes on resident and faculty wellness.

In response to these concerns, Royal College leadership issued the *Commitment to Action* in May 2023, the first step in a 12-month collaborative process to reimagine the evolution of CBD and continue towards the goal of enhancing residency training across Canada.

Image 1. Process toward CBD evolution

For more information about the process toward CBD evolution so far, and the outcomes of CBD Summits 1 and 2, please see the Appendix.

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Strategic approach to CBD 2.0

Preserve national standard setting - The role of the Royal College is to set standards for specialty medical education in Canada. While preserving the responsibility for national standard setting, there is also recognition of unique obstacles and opportunities within each institution, discipline and program that require a degree of flexibility that leverages what we have learned about CBD implementation since 2017.

Simplify and optimize what's working today - We remain confident in the merits of CBD for learners, faculty and patients, and recognize that the implementation must be simplified, and the burden of assessment decreased for residents and frontline faculty. We must also reinforce and optimize what is working within the existing CBD model. This includes stages of training, EPAs used as tools for curricular planning and as an important part of a wider program of assessment, decisions about resident progression made by competence committees, and new opportunities for feedback and coaching moments. It is also important to acknowledge that teaching takes place within the context of the finite capacity of our current health care system which is under significant stress (e.g., health human resources crisis, health care worker fatigue and wellness, increasing complexity of healthcare needs, volume and acuity of patient care demands).

Add value for learners - The intention of the CBD model is to provide additional value to residency education through system design features that include enhanced feedback and coaching opportunities, clear articulation of the expectations of training and tasks of the discipline, multiple low-stakes assessment moments, evidence-based promotion decisions via competence committees, tailored training experiences, increased direct supervision, and overall, an optimized training experience. It is apparent there has been a mixed experience across disciplines in deriving this value from CBD. Going forward, additional flexibility and modifications within the CBD model with further supports in implementation must occur to realize the intended value of CBD.

Align with accreditation - Programs and institutions are accountable through accreditation processes to ensure national standards are being upheld in residency training. All adaptations, flexibility, and change introduced in the CBD 2.0 Summit process will accordingly be integrated as appropriate into the discipline-specific national standards that guide accreditation activities. This will be well communicated to all invested groups with respect to clear expectations and timelines for implementation as they apply to accreditation activities.

The outcome of this process is a multi-modal approach to the evolution of CBD that will leverage multiple interventions. Once these recommendations are reviewed, discussed and approved through the co-development process, a proposal will be submitted to relevant Royal College standing committees and eventually Council for final approval.

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Goals for CBD 2.0

- Increase flexibility for programs and PGME offices to implement CBD components while maintaining accountability for specialty-specific standards;
- Decrease the assessment burden for residents and frontline faculty, by using more strategic sampling processes to increase the focus on quality of assessments and decrease overall observation numbers;
- Enhance in-the-moment and longitudinal feedback and coaching to provide value for learners;
- Decrease the performance orientation culture to create space for desired feedback and coaching opportunities; and intentionally nurture a growth mindset in our learners, ourselves and our systems;
- Continue to ensure resident progress and promotion remains based on evidence-informed decision making.

In building toward these goals, summit participants also considered the resource implications and constraints of the system, the shared, system-wide responsibility for solutions, and the recognition that there will not be a 'one-size-fits-all' approach to implementing the basic design principles of a national specialty education framework: CBD. In response to the input from the experts across multiple invested groups (see full list of partners here), the CBD Steering Group has gathered the following recommendations and plan for action for national review and input.

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CBD 2.0- Suggested Plan for Action – Potential Interventions for Consideration

Please note: *The following recommendations and interventions have been developed by the CBD Steering Group based on the discussions at CBD Summits 1 and 2 and are intended to be widely circulated for feedback before final recommendations for change are adopted during future revision and feedback cycles. We appreciate your feedback on these points and welcome additional suggestions for interventions, follow-up metrics, and responsible groups not listed here.*

Recommendation 1. Improve communication and understanding of the foundational elements of the CBD model that will continue: 1) the four-stage model of residency training (Transition to Discipline, Foundations, Core, and Transition to Practice), 2) the use of EPAs as tools to promote clear articulation of the tasks of a discipline and to stimulate observation with focussed coaching and feedback, 3) programmatic assessment principles, 4) competence committees to facilitate evidence-informed promotion decisions, and 5) enhanced feedback and coaching moments.

Responsibility

- Royal College
- Institutions (postgraduate medical education [PGME] offices, competency-based medical education [CBME] Leads)
- Resident organizations

Intervention

Royal College

1.1 Develop supporting documents to accompany this document (*Call to Action - Options for Change Proposal*) that outline the evolution of CBD over the last 10 years (from conception to the desired state of CBD 2.0).

1.2 Review and revise (as necessary) existing CBD resources provided by the Royal College for clarity and alignment with CBD 2.0.

1.3 With input from key partners re-visit mix of Forums/Workshops/Clinician Educator outreach faculty development and program support.

Royal College and institutions

1.4 Collaborate with PGME offices and resident representatives to share resources in the evolution of CBD 2.0.

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Royal College and resident organizations

1.5 Collaborate with resident organizations to share resources widely across their networks.

Follow-up metric(s)

- Dissemination of CBD communications documents to all invested groups with shared resources to be made available at institutions / PGME offices / programs and specialty committees

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Recommendation 2. Reduce formal assessment requirements to enhance opportunities for safe spaces for feedback and coaching.

Responsibility

- Local programs
- Institutions (PGME offices, CBME Leads)
- Royal College, in collaboration with specialty committees
- Royal College, in collaboration with resident organizations

Intervention

Local programs

2.1 Promote a culture that fosters safe formative developmental feedback.
2.2 Reinforce the use of narrative-only EPA observations forms as part of program of assessment.
2.3 Provide ongoing faculty development aimed at improving feedback culture and encouraging effective coaching-in-the-moment.
2.4 Provide longitudinal coaching supports to residents.

Institutions

2.5 Provide resources and best practices for disciplines and programs to support faculty development aimed at improving feedback culture and encouraging effective coaching-in-the-moment.
2.6 Reinforce the use of narrative-only EPA observations forms as part of program of assessment.

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Royal College, in collaboration with specialty committees

2.7 Revise EPA-observation requirements and processes at the specialty and program level to systematically encourage and reward assessment *for* learning (coaching in the moment).
2.8 Reinforce the use of narrative-only EPA observations forms as part of program of assessment.
2.9 With input from key partners re-visit mix of Forums/Workshops/Clinician Educator outreach faculty development and program support.

Royal College, in collaboration with resident organizations

2.10 Collaborate with resident organizations to develop a strategy to encourage feedback literacy among residents including national level webinars, and resources for local program delivery.
2.11 Collaborate on opportunities for further program evaluation work related to feedback and coaching.

Follow-up metric(s)

- Document/evaluate/and share "desired vs expected vs opportunistic vs realized" feedback and coaching moments (documented and undocumented) across a variety of specialty-specific contexts
- Royal College to integrate program evaluation questions and/or project(s) that examine the impact on feedback and coaching experienced by residents and frontline faculty

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Recommendation 3. Re-envision and promote EPAs as tools for curricular design, feedback and coaching, and as one component of resident workplace-based assessment.

Responsibility

- Royal College, in collaboration with specialty committees
- Local programs
- Institutions (PGME offices, CBME Leads)

Intervention

Royal College, in collaboration with specialty committees

3.1 Revise discipline-specific CBD documents to identify opportunities for EPAs being used to design curricula and provide opportunity for feedback and coaching.

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3.2 Ensure programs have a robust program of assessment that is intentionally designed and includes EPA work-placed based assessments, in addition to a variety of other modalities.
3.3 Highlight best practices of EPA mapping to curriculum, feedback and coaching moments, and assessment, and utilize CBD resources provided by the Royal College.
3.4 With input from key partners re-visit mix of Forums/Workshops/Clinician Educator outreach faculty development and program support.

Local programs

3.5 Revisit curricular mapping practices (related to EPAs) within rotations and other required training experiences.
3.6 Decrease EPA-focused assessment practices to allow for EPA-focused observation with associated feedback and coaching opportunities that are formative rather than summative.
3.7 Work with institutional PGME offices and local CBME Leads to maximize faculty development opportunities.

Institutions

3.8 Work with programs and share resources related to curricular mapping and resident engagement in their processes.

Follow-up metric(s)

- Shared resources from clinician educators provided through the facilitation of specialty committee revision processes – with wide dissemination to local programs, institutional PGME offices and CBME Leads.

Recommendation 4. Optimize programmatic assessment to better reflect the value of multiple types of assessment and to discourage an over-reliance on EPA observations.

Responsibility

- Royal College, in collaboration with specialty committees
- Local programs
- Institutions (PGME offices, CBME Leads)

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Intervention

Royal College, in collaboration with specialty committees

4.1 Work with specialty committees within the standards development/revision process to better customize assessment and RTE plans.
4.2 Guide discussions at the specialty committee level to enhance existing best practices within each specialty committee.
4.3 Encourage specialty committees to create/share/optimize resources for faculty, competence committee chair/members and resident development (online and other) to avoid duplication of effort at the program level.
4.4 Consider renaming/changing the language of assessment tools to better reflect the workplace-based observation, assessment and reflective practice elements.
4.5 Continue to support program directors with resources for faculty development, best practice guidelines, and assessment tool options.
4.6 With input from key partners re-visit mix of Forums/Workshops/Clinician Educator outreach faculty development and program support.

Local programs

4.7 Customize assessment plans within local contexts/culture to optimize the possibilities and resources for comprehensive modes of assessment.
4.8 Continue to provide faculty development and leverage CBD champions to lead this work.
4.9 Support RPC and competence committee structures to strengthen CQI processes regarding programmatic assessment.

Institutions

4.10 PGME level faculty development for program directors and other program leaders (program administrators, Competence Committee Chairs, CBD champions, etc.) to assist with best-practice implementation of CBD guidelines, assessment tool options, and support for IT platform functionality.

Follow-up metric(s)

- Evidence of CQI monitoring of specialty specific components of CBD implementation
- Pulse Check analysis
- Royal College comprehensive program evaluation plan exploring programmatic assessment data capture (see Recommendation 7 below)

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Recommendation 5. Promote competence committee processes that support flexibility, local variation of assessment models, and opportunities for comprehensive assessment with multiple inputs.

Responsibility

- Institutions (PGME offices, CBME Leads)
- Local programs
- Royal College

Intervention

Institutions

5.1 Implement and oversee competence committee continuous quality improvement (CQI) processes and faculty and resident development.
5.2 Continue to optimize IT platforms to address barriers in the end user experience (e.g., timely updates of discipline standards, improved functionality, and support for local program customizations, etc.).
5.3 Ensure regular communication regarding competence committee processes and expectations to residents, competence committees and program leaders.

Local programs

5.4 Address faculty accountability re: assessment form completion.
5.5 Clarify faculty expectations re: specific EPAs/tool orientation (specificity rather than general expectation for all).
5.6 Ensure longitudinal coaching models/supports.
5.7 Strengthen resident communication processes between residency program committee, competence committees, and residents.
5.8 Support ongoing competence committee processes with a CQI lens.

Royal College

5.9 Continue to provide clear guidelines to competence committees around standard process expectations and opportunities for flexibility that encourage the use of comprehensive and broad assessment modalities as part of a program's overall program of assessment.
5.10 Develop strategy to disseminate competence committee guidelines and Spring 2023 accreditation doc to clarify to local programs and institutions the flexibility for their competence committee to make decisions locally.
5.11 With input from key partners re-visit mix of Forums/Workshops/Clinician Educator outreach faculty development and program support.

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Follow-up metric(s)

- Institutions to collect data/metrics to provide evidence of CC oversight (e.g., monitoring CC meeting frequency, CC meeting documentation, ensuring communication between CCs, RPCs and residents.

Recommendation 6. Provide targeted support to specialty committees as they respond to their discipline's CBD experiences by helping committees develop or revise their national standards and workflows in a manner that better reflects their unique specialty practices and learning environments.

Responsibility

- Royal College, in collaboration with specialty committees

Interventions

Royal College, in collaboration with specialty committees

6.1 Redesign, enhance and streamline the processes to revise national specialty standards within the current revision cycle.
6.2 Enhance the CBD implementation and program evaluation data provided to specialty committees to better support evidence informed decision making.
6.3 Enhance the supports to the dedicated team of trained Standards Unit specialists and Clinician Educators who are available to facilitate specialty committees as they interpret CBD implementation data and make evidence-informed decisions about their standards.
6.4 Develop a comprehensive template/checklist for specialty committees that clarifies the flexibility and possible adaptations in the CBD 2.0 model. This CBD standards aid will facilitate specialty committees to customize revisions to their document suites (RTEs, assessment plans, EPA suite, etc.). It can also be used to socialize programs to the changes and ensure standardization across the country for each specialty.
6.5 Develop shared toolkits widely available across all specialty committees that can be used "off the shelf" for programs to orient their constituents to any changes (e.g., resident and faculty orientation packages, assessment tool templates, feedback and coaching templates, resident and faculty development modules/toolkits). Toolkits can also be "pushed" at appropriate times to specialty committee members, including program directors, such that they have what they need when they need it.
6.6 Ensure resident input and previous program evaluation signals are incorporated in this process of designing enhanced specialty support.

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Follow-up metric(s)

- Royal College Clinician Educators matched to all specialty committees during development/revision process
- Royal College map of key indicators and data collection for successful revision process
- Royal College report on status of specialty committee revisions on an annual basis

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Recommendation 7. Enhance the comprehensive CBD program evaluation strategy to monitor the impact of changes in the CBD model on the experience and value of CBD for all partners and measure the outcomes of CBD implementation, including unintended negative consequences.

Responsibility

- Royal College
- Institutions (PGME offices, CBME Leads)
- Local programs

Intervention

Royal College

7.1 Develop a new multi-year practical evaluation plan, grounded in evaluation theory, with specific prioritized program evaluation goals, and including a strategy for operational support and funding.

7.2 Continue fostering the development of a community of practice relating to CBD program evaluation, and increase collaboration with invested partners, including protected grant allocations, shared work with specialty committees and partnering institutions, and engagement with education scholars across the country.

7.3 Integrate elements of the new program evaluation strategy into the specialty committee document suite revision processes.

7.4 Share the evaluation plan widely with PGME Deans and CBME Leads to identify areas for further program evaluation projects that align with the national strategy.

7.5 Encourage local programs to participate in smaller, manageable program evaluation efforts which support local implementation adaptation and enhance the perceived value of CBD.

7.6 Provide funding opportunities for Program Evaluation (PE) work across the country (CBD medical education grants).

7.7 With input from key partners re-visit mix of Forums/Workshops/Clinician Educator outreach faculty development and program support.

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Institutions

7.8 Partner with local programs to communicate/disseminate the Royal College program evaluation plan to encourage opportunities for joining the PE community of practice and explore PE project opportunities locally and/or nationally.

7.9 When possible, provide local funding opportunities for medical education projects related to CBD program evaluation work.

Local programs

7.10 Support frontline faculty in continuous quality improvement based on evolving best evidence

Follow-up metric(s)

- Program Evaluation Operations team (Royal College) to design implementation of new projects in line with revised program evaluation strategy (value, outcomes, implementation & evolution)
- Participant evaluations of annual PE Summit and concurrent semi-annual virtual program evaluation forums focused as venues for updates, sharing of findings and best practices, and opportunities for partnership/co-development

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Links to accreditation

As described in the Commitment to Action, PGME accreditation is a holistic evaluation of a program. It is not an evaluation of CBD implementation in isolation, and does not, for example, evaluate the number of EPA observations conducted. Rather, accreditation seeks to verify that residents have a safe learning environment with appropriate supervision, feedback and coaching, that there is a continuous quality improvement process in place and functioning, that programs are appropriately resourced, and that there are effective leadership and communication processes. The standards and evaluation process focus on the principles of sound educational design. Those involved in the accreditation review and decision-making (surveyors, specialty committees, accreditation committees) seek to verify that the essential requirements for CBD implementation, as outlined above and detailed in the general and specialty-specific standards of accreditation, are in place.

The Royal College is committed to ensuring that both volunteers and staff involved in the accreditation process have a clear and renewed understanding of the level of focus and the type and amount of information reviewed during accreditation, including any new considerations with proposed changes to CBD as described in this proposal.

Next Steps

This document represents the first draft of a proposal for consideration by invested partners, and we welcome your feedback and that of your colleagues on this draft **by December 22, 2023**.

The CBD Steering Group will engage in a series of consultation and revisions of the proposal over the next five months:

- **January 2024**: CBD Steering Group will incorporate feedback into a second draft proposal.
- **Late January 2024**.: Second draft proposal will be circulated to invested groups for feedback.
- **Late February – early March 2024**: CBD Steering Group will incorporate feedback into a third draft proposal.
- **March 20, 2024**: Participants will discuss the third draft proposal at CBD Summit #3, with a goal to progress towards to a near-final draft.
- **Early April 2024**: Fourth draft proposal will be circulated to Chairs of invested groups for final comments and refinements.
- **May 2024**: Final draft proposal will be presented to the Committee on Specialty Education for decision.

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Appendix A – Summary of CBD Summits 1 and 2

CBD Summit 1 – June 2023

Working in breakout groups facilitated by the Clinician Educator members of the CBD Steering Group, participants discussed and worked towards building consensus on proposed design adaptations in the CBD model such as:

- Improved resident and faculty experience of CBD;
- Increased flexibility in the system while maintaining accountability;
- A reduction in the burden of assessment;
- Better facilitated coaching (in-the-moment & over time);
- Approval for program and/or discipline-specific innovation and customization with oversight of the local PGME office; and
- Closer monitoring of the evolution of CBD through enhanced/renewed program evaluation processes.

In breakout groups and plenary discussions, the majority of the day was focused on generating, prioritizing, and considering the implications and opportunities of proposed adaptations to CBD. This work was summarized in a table that was shared with participant groups following the summit for their feedback.

CBD Summit 2 – September 2023

Summit 2 brought together the Royal College's CBD Steering Group with representative leads from system partner groups for 'deeper dive' discussions on potential adaptations to CBD identified during Summit 1. Participants also considered the resource implications and constraints of the system, the shared, system-wide responsibility for solutions, and the recognition that there will not be a 'one-size-fits-all' approach to CBD.

Following two days of deep and thoughtful discussion, four key themes emerged:

1) EPAs as tools, and their respective work-placed based assessments (WBAs) have been used for both formative and summative assessment, which has led to unintended consequences. In CBD 2.0, work needs to be done to better position EPAs as tools for curricular design, teaching moments, and programmatic assessment. EPAs observed "in the moment" are currently trying to serve multiple purposes including coaching and feedback triggers as well as summative assessment tools. While intended to contribute to enhanced feedback and coaching opportunities, the lived experience of "EPAs as assessment tools" for many has taken precedence, creating stress and burden that had not been anticipated in the launch of the CBD model.

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2) There is a desire to have protected opportunities for feedback and coaching that is not tied to summative assessment, and to increase the focus on narrative and longitudinal assessment. The emphasis of EPAs solely existing to generate WBAs for summative assessment purposes has reduced the focus on feedback and coaching, resulting in the loss of those opportunities for residents. Further culture change is needed across the system to increase focus on formative feedback and coaching and alleviate concerns of repercussions in providing honest feedback for both learners and faculty.

3) Different types of multi-modal assessment need to be leveraged to reduce the focus on workplace-based assessment of EPAs alone and provide competence committees with a more comprehensive and diverse picture of resident progress.

4) All partners represented at the Summits have a shared responsibility to immediately leverage the current flexibility of CBD elaborated in the Commitment to Action to reduce the assessment burden being experienced. A single approach to implementation will not fit all disciplines, programs, and institutions. A few interventions and multi-modal support are needed at all levels to customize and evolve the CBD model to optimize improvements.

The CBD Steering Group has focused on these themes as the basis for the proposed recommendations.

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Appendix B- List of partners/partner organizations engaged in CBD evolution process

CBD National Advisory Board

Collège des médecins du Québec (CMQ)

Competency-based Medical Education (CBME) Leads

Fédération des médecins résidents du Québec (FMRQ)

Postgraduate Medical Education (PGME) Deans

Program Directors

Residency Accreditation Committee

Resident Doctors of Canada (RDoC)

Scholars/Researchers

Specialty committee Chairs

Other institutional education leaders (e.g., Department Chairs & Vice-Chairs Education)

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Summary of recommended interventions

[To be completed as part of later draft]

Responsibility	Short-term	Medium-term	Long-term
Royal College			
Specialty committees			
Programs			
Institutions			

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