THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

PRE-SURVEY QUESTIONNAIRE

RESIDENCY TRAINING PROGRAMS IN ENHANCED SKILLS FOR FAMILY PRACTICE

February 2015

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INTRODUCTION

The application for approval of a residency training program in enhanced skills is intended to collect the necessary pre-survey documentation that the accreditation team of the College of Family Physicians of Canada will require in order to adequately prepare for the accreditation visit. The Accreditation Committee of the College asks that, in completing the application form, the program understands that this documentation must be such that it is easy to read and understand in a relatively short time. It should be possible for a surveyor to go through the material in no more than two hours and have a good general overview of the content and structure of the program.

As you review the following questions you will find that some of them refer specifically to certain sections of the "Red Book", *Residency Program Accreditation and Certification.* In answering these questions you are asked to carefully review the relevant sections of the Red Book before completing the form.

You are asked to provide an overall list of faculty and to indicate for each faculty member whether they are full or part-time teachers and to provide information on their status with the College of Family Physicians of Canada. You are reminded that all family physicians faculty **must** be members of the College of Family Physicians of Canada and all full-time family physician teachers **must** be certificants of the College. Furthermore it is a requirement that the program director of the enhanced skills program be a certificant of the College of Family Physicians. In the case of family medicine/emergency medicine it is a requirement that the program director be a certificant of the College of Family Physicians and hold a certificate of special competence in Emergency Medicine.

If you have any questions regarding the content of the questionnaire or the nature of the response required by the survey team, please do not hesitate to contact the Department of Education at the College.

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The term “Program Director” is used throughout this document to refer to the Program Coordinator/Director who is appointed by the Department of Family Medicine and chairs the Program committee for their respective, individual Enhanced Skills Training Program (e.g. Family Medicine-Emergency Medicine). The term Residency Training Committee may be used interchangeably with Residency Program Committee, in reference to the individual Enhanced Skills Program Committees (e.g. CCFP-EM Residency Training Committee).

AHS	Alberta Health Services
AM	Addiction Medicine
CCFP-EM	College of Family Physicians of Canada-Emergency Medicine
CME	Continuing Medical Education
CoE	Care of the Elderly
CSM	Cumming School of Medicine
DFM	Department of Family Medicine
DYO	Design Your Own
ES	Enhanced Skills
FP-A	Family Practice-Anaesthesia
GH	Global Health
PARA	Professional Association of Resident Physicians of Alberta
PD	Program Director
PGME	Postgraduate Medical Education
RPC/RTC	Residency Program Committee/Residency Training Committee
S/R	Scholarship/Research
SEM	Sport and Exercise Medicine
U of C	University of Calgary

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ENHANCED SKILLS FOR FAMILY PRACTICE

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1. Date of this application:
Tuesday, February 24, 2015 to Wednesday, February 25, 2015

2. Name of University:
University of Calgary

3. Name of the Chair of the Department of Family Medicine:
Dr. Charles Leduc, MD, MSc, FCFP

4. Name of the Family Medicine Postgraduate Director:
Dr. Keith Wycliffe-Jones, MBChB BSc (Med Sci) DRCOG DOccMed FRCGP CCFP

5. Name of the Enhanced Skills Program Director:
Dr. Lara Nixon, BSc BEd MD FCFP

6. A) Category 1 Programs

Please list the program name, program coordinator and the number of Residents registered in the program for each Category 1 program active at the time of the accreditation visit. Category 1 programs are those for which there are national accreditation standards published by the CFPC. These currently include Family Medicine-Emergency Medicine, Care of the Elderly and Family Practice-Anesthesia, and the Clinician Scholar Program.**

Program	**Program Director**	**# of Residents**
Care of the Elderly	Dr. Vivian Ewa MBBS, MRCP (UK), CCFP, CoE CoE Program Director	2
Family Practice Anaesthesia	Dr. Dan Wood BSc, MD, CCFP, FCFP, FRCPC (Anesthesia) FP-A Program Director	2
Family Medicine - Emergency Medicine	Dr. Todd Peterson BSc, BA, MD, CCFP-EM CCFP-EM Co-Program Director Dr. Margriet Greidanus BSc, MD, CCFP-EM, Dip Med. Ed. CCFP-EM Co-Program Director	8

Note 1: Palliative Medicine (PM)

The Palliative Medicine Program will be reviewed conjointly by the CFPC and RCPC, on the basis of the RCPC PSQ documentation, prepared by the Program Coordinator, Dr. Sara Pawlik MD CCFP (submitted separately).

6. B) Category 2 Programs

Please list the Category 2 programs that will be active at the time of the accreditation visit listing the type of training (I.e., maternity care, aboriginal health, surgery etc.) and the number of Residents involved in each program. Please list only those programs that are 6 months or longer in duration. Category 2 programs include defined programs such as Women's Health or Aboriginal Health that may have defined curriculum but for which no national accreditation standards currently exist. Also include extended enhanced skills programs that may have been designed to meet the individual needs of the trainees that are 6 months or longer in duration.

Program	Program Director	# of Residents	Residents	Program Duration
Sport and Exercise Medicine	Dr. Preston Wiley MPE, MD, CCFP, FCFP, Dip Sport Med SEM Program Director	1	Kathleen MacGregor	13 blocks
Design Your Own (changing to Maternal & Newborn Care, July 2015)	Dr. Lara Nixon BSc BEd MD FCFP Director, Enhanced Skills	3[1]	Beatrice du Prey Kathleen Hicks Christina Disipio Carmen Fong Katrina Low Nureen Sumar	13 blocks 3 blocks 11 blocks 3 blocks 3 blocks 7 blocks
Global Health	Dr. Bonnie Larson MD MA CCFP DTM&H GH Program Director	1	Nathaniel Winata	13 blocks

[1] Three DYO Residents in a Program six months or longer.

6. C) Other Programs

Please list other programs that are administered under the Enhanced Skills Program that may not currently be active but for which the Department of Family Medicine has a defined curriculum and the Program Coordinator if one has been appointed.

Program	Coordinator	# of Residents
Addiction Medicine	Dr. Ron Lim FASAM ABAM CCSAM AM Program Director	0
Scholarship/ Research	Dr. Turin Chowdhury MBBS, Ms, PhD S/R Program Director	0

7. A) Include an organizational chart for the program demonstrating the Enhanced Skills program's relationship with the Department of Family Medicine. Include membership for each committee designated in the organizational chart and job descriptions for the individuals identified. Lines of authority and responsibility must be clear to the surveyors.

- **ORGANIZATION**

The Enhanced Skills Program sits within the postgraduate education mandate of the Department of Family Medicine (DFM). The Enhanced Skills Director has overall responsibility and leadership for all of the enhanced skills programs operations and reports to the Postgraduate Family Medicine Director.

The following documents are provided at the end of this document:

- Postgraduate Department Organizational Chart (Appendix A)
- Postgraduate Department Staff Organizational Chart (Appendix B)
- PG FM & ES Committees Organizational Chart (Appendix C)

- **COMMITTEES**

Faculty & Program-wide Committees

In order to represent and advocate on behalf of the Enhanced Skills Programs, the DFM Enhanced Skills Director is a **full voting member** of the following committees, regularly submitting written or verbal reports or formal issues for discussion:

- Postgraduate Medical Education Committee
  - See Appendix D - PGME ToR
  - Responsible for:
    - strategic leadership and development and ratification of policies and procedures for all UofC residency programs
    - promoting and ensuring resident wellness and a safe learning environment
    - ensuring appropriate support and resource distribution for effective residency education

- Postgraduate Executive Committee
  - See Appendix E - FM PGEC ToR
  - Responsible for:
    - development and ratification of policies and procedures that cross all FM postgraduate Programs (Urban, Rural, ES)
    - Development of Resident assessment programs
    - Strategic direction for all FM postgraduate Programs
- Resident Progress Sub-Committee
  - See Appendix F - RPS ToR
  - Responsible for:
    - Review cases of Residents in difficulty, if the individual ES RPC requests
    - Review completion of program requirements and provide sign-off (exception: Palliative Medicine)
    - Hearing Resident appeals of assessments, as per the PGME Resident Appeals Policy

FM Residency Program Committees

To keep abreast of the policies, procedures, and operations of the 2-year PG FM programs, the Enhanced Skills Director is a **communicating member** on the:

- Urban FM Residency Program Committee
- Rural FM Residency Program Committee

ES Residency Program Committees

Each of the individual ES Programs has its own Residency Program/Training Committee (RPC/RTC.

- Care of the Elderly
  - Drs. Vivian Ewa, Paddy Quail, Darren Burback, Suparna Madan, Karen Fruetel, Paula Pearce, Diana Turner, Maureen Murray, Rachel deFina, Joel Weaver, Lara Nixon, Ahmad Zabal, Philip Chan, and Jeanine Robinson and Susheel Clair
- Family Medicine-Emergency Medicine
  - Drs. Bryan Young, Sarah McPherson, Margriet Greidanus, Todd Peterson, Aaron Johnston, Lisa Campfens, Jason Fedwick, Geoff Lampard, Patricia Lee, Matthew Petzold, Chris Hall, Jennifer Puddy, Matt Erskine, Hussain Unwalla, Paul Tourigny, Adam Oster, Kathryn Crowder, Lindsay McCormick, Eddy Lang, Keith Wycliff-Jones, Lara Nixon
- Family Practice-Anaesthesia
  - Drs. M. Austad, G. Bishop, M. Chong, J. Davies, K. Duttchen, R. Eng, A. Ewen, K. Gregg, J. Haber, M. Kapusta, M. Kostash, U. Larsen, C. Noss, C. Pearce, P. Samuels, K. Shinkaruk, J. Thompson, D. Wood, R. Chun, J. Demarty, M. Hayter, K. Illing, L. McMillan, L. Nixon, K. Rogan, M. Setiawan, D. Teoh, K. Torsher, B. Wilson, T. Yang, and C. Camac
- Addiction Medicine (inactive)
- Design Your Own
  - Although there is no formal RPC for the Design Your Own Program, the ES PD, Dr. L. Nixon, and Susheel Clair maintain regular contact with Residents in this program to ensure adequate support and completion of their proposed Program.
- Global Health
  - Drs. Christine Gibson, Steve Mintsioulis, Roger Thomas, Heather Baxter, Bonnie Larson, Martin Labrie, Janette Hurley, Annalee Coakley, Rod Crutcher, Amy Gausvik, Vivian Skovsbo, Lee Coackley, Van Nguyen, Susan Khun, Andrea Hull, Maeve

O'Brien, Jacqueline Lewis, Lara Nixon, Michael Aucoin, Raphael Nepomuceno, Rachel Talavlikar, Justin Urness, Leah Genge, Gwynn Curran-Sills, and Jeanine Robinson and Susheel Clair

- Scholarship and Research (inactive)
- Sport and Exercise Medicine
  - Drs. Preston Wiley, Victor Lun, Lara Nixon, Trevor Trinh, Marcus Robinson, Kathleen MacGregor, and Jeanine Robinson and Susheel Clair

To keep abreast of policies, procedures, and operations, as well as to facilitate a centralized approach to the planning and organization of all enhanced skills educational activities, the Enhanced Skills Director is a **communicating member** on each of the individual ES RTC's including:

- Category 1 Enhanced Skills Program committees
  - FM Emergency Medicine Residency Training Committee (CCFP-EM RTC)
  - Family Practice Anesthesia Residency Training Committee (FP-A RTC)
  - Care of the Elderly Residency Program Committee (CoE RPC)
- Category 2 Enhanced Skills Program committees
  - Global Health Residency Program Committee (GH RPC)
  - Sport & Exercise Medicine Residency Program Committee (SEM RPC)

The ES Director is also **voting member and chair** of the ES "Design Your Own" Residency Program Committee (DYO RPC).

➢ **JOB DESCRIPTIONS**

The following job descriptions are provided at the end of this document:

- Job description – Enhanced Skills Director (Appendix G)
- Job description – Category 1 Enhanced Skills Program Director, sample (Appendix H)
- Job description – Category 2 Enhanced Skills Program Director, sample (Appendix I)
- Job description – Enhanced Skills Program Administrator (Appendix J)

All ES Program Directors hold certification in Family Medicine. Each of the Directors also holds academic appointments within the DFM, and some are cross-appointed with other Departments within the Cumming School of Medicine.

B) Is there a residency training committee for Enhanced Skills? If yes, please provide the terms of reference.

- Enhanced Skills Residency Program Committee (ES RPC)
  - See Appendix K - ToR ES RPC
  - Responsible for:
    - providing a forum for discussion, support, and oversight of the Category 1 and 2 ES Programs
    - ensuring the ES Program meets the accreditations standards for FM residency training
    - support implementation of ES curriculum and ensure Program assessment and evaluation
    - policy and procedure development
    - oversight of all individual ES Residency Training/Program Committees
    - determine the distribution of PGME allocated positions for ES training, authority for which has been delegated by PGME Committee

- Membership is comprised of:
  - ES Chief Resident
  - ES Program leaders including all ES Program Directors
  - ES Program staff
- The ES Residency Program Committee (ES RPC) meets quarterly (or more frequently as required) and is advisory to the ES Director

The DFM Postgraduate Director is a member of the CCFP-EM Program RPC/RTC and the CCFP-EM co-directors are communicating, non-voting members of the DFM Urban RPC. The CCFP-EM co-directors are also voting rotating members of the Postgraduate Medical Education Committee from September 2015 to June 2017.

C) Describe how Residents are involved in the governance of the program.

Residents are members of both the ES Residency Program Committee and individual ES RPC/RTC's. Membership responsibilities are stated in the applicable Terms of Reference.

- Job description – ES Chief Resident (Appendix L)
  - elected by their peers, chosen by acclimation for the 2014-2015 academic year
  - represent ES Residents on the Enhanced Skills RPC
  - Enhance communication between the Program and ES Residents
- All ES Residents
  - Are communicating members of their Enhanced Skills Residency Program Committee and voting members unless in a Program
    - where there are three or more Residents, one is elected as a representative
    - where there are fewer than three Residents, both are members of the RPC/RTC
  - Can raise issues for discussion at the ES RPC through their representative, their Program Director, the DFM ES Director, or the DFM Postgraduate Director
  - Are welcome to attend committee meetings or may ask to be invited to speak to issues of special interest to them

8. Describe the adequacy of financial and administrative resources available to support the Enhanced Skills program.

➢ **ES PROGRAM FUNDING – LEADERSHIP**

The Program Directors (PD) are paid an honorarium in accordance with the rate guideline provided by Postgraduate Medical Education (PGME). This guideline recommends honoraria rates based on the number of Residents in the Program.

Enhanced Skill Program Director Payment Scale			
Number of Residents	0	1-4	5-9
Amount Paid	$6,750	$20,250	$27,000

PGME funds 25% of this payment. The remaining 75% is funded as follows:

- FM Emergency Medicine – paid by Emergency Medicine
- All other ES Programs – paid by Department of Family Medicine. ES PD's who are full-time academics (FTA) do not receive PD honoraria, as their administrative time is funded through Academic Alternate Remuneration Plans (AARP's).

- **ES PROGRAM FUNDING – EDUCATION ENHANCEMENT**

  PGME provides additional Program funding as "Education Enhancement" funds. These funds are used by Programs for e.g. purchase of equipment, education space, library resources, research support, software, teaching resources, education events, or conference attendance.

- **DFM FUNDING – CPD FOR FACULTY AND RESIDENTS**

  The Department's Faculty Development needs were formally assessed on five different occasions between 2009 and 2012. Most recently, our Continuing Professional Development (CPD) Director conducted a series of needs assessment interviews in August 2014.

  The Department dedicates a 0.2 FTE CPD Director, 0.3 FTE Administrator and a portion of the Education Manager role to support CPD.

  The Department uses multiple delivery methods, locations, times, and activities to provide varied content to our Preceptors:

  - CPD Events such as Grand Rounds, Conferences, Workshops
  - Courses
  - Podcasts

  In addition, the Department encourages and supports members to benefit from Faculty Development provided by the following external resources:

  - University of Calgary Teaching and Learning Centre http://tlc.ucalgary.ca/
  - Faculty of Medicine Office of Faculty Development http://www.ucalgary.ca/ofd/
  - Faculty of Medicine Continuing Medical Education and Professional Development http://medicine.ucalgary.ca/physicians/cme/
  - Canadian Leadership Institute for Medical Education (CLIME) http://www.came-acem.ca/mededconferences_clime_en.php
  - Scholarship and Innovation in Medical Education (SIME) offered at Canadian Conference on Medical Education (CCME) http://www.came-acem.ca/mededconferences_sime_en.php
  - External conferences:
    - Annual Scientific Assembly (ACFP)
    - Association for Medical Education in Europe (AMEE)
    - Association of American Medical Colleges Annual Meeting (AAMC)
    - Canadian Conference on Medical Education (CCME)
    - Family Medicine Forum (FMF)
    - International Conference on Residency Education (ICRE)
    - North American Primary Care Research Group (NAPCRG)
    - Ottawa Conference
    - Society of Teachers In Family Medicine (STFM)
    - World Organization of Family Doctors (WONCA)

- **DFM FUNDING – RESOURCES FOR RESEARCH AND SCHOLARLY ACTIVITY**

  The DFM operates a Research "Hub" that is accessible by all Faculty and Residents who may require support for their scholarly work. The Research Director, Dr. Tanvir Turin Chowdhury, and Research Manager, Ms. Agnes Dallison, facilitate access to Hub resources including: a staff epidemiologist, a biostatistician and academic specialists in knowledge translation, budget development, U of C research proposal processes and literature searches. If a specific resource does not exist within the Hub, the Hub staff can connect individuals with DFM fulltime academic

faculty (FTA's) with special interests and advanced degrees in ethics, psychology, basic sciences, epidemiology, biostatistics and informatics, as well as Cumming School of Medicine and U of C research resources.

- **DFM RESOURCES DEVOTED TO ES PROGRAM**

Administrative Staff

In addition to financial and Research Hub support, the following DFM positions form the 'umbrella' administration support staff for the overall Enhanced Skills Program.

- Enhanced Skills Program Administrator – ~0.6 FTE
  - Provides administrative support to the Enhanced Skills Director as well as to the Care of the Elderly and all Category 2 Program Directors (CCFP-EM, FM-A, and PM each have their own administrative support provided by their individual Departments)
    - e.g. meeting coordination and support, website maintenance, Resident selection, Resident assessment, archiving Resident files
- DFM Education Manager - ~0.25 FTE
  - Provides management support, policy development, budgeting, supervision of staff, continuity with core two year Program and connection with FM Undergraduate programming
- Financial Administrator - ~0.25 FTE
  - Provides financial support to the ES Program including – Program Director contracts, processing all Program Director stipends, providing teaching honoraria to Preceptors and processing Education Enhancement expenses

Administrative Processes

The DFM ES Program – through the Program Director, Education Manager, Program Administrator, and Financial Administrator – provide administrative support to all Category 2 Programs and to the Care of the Elderly Program. Some of these administrative processes are also accessed by our Category 1 Programs. Examples include:

- Search and selection procedures and tools
- Resident welcome and orientation
- Policies and procedures – e.g. Attendance and Absence, Resident Assessment, Resident Safety, Resident Electives, Out-of-Province procedures, Resident scheduling, Program Evaluation, etc.
- Program completion
- Financial management

To maintain and support the administrative processes, the ES Program leaders and staff meet weekly as an "ES Program Operations Group" (ES POG). These meetings involve the ES Program Administrator, DFM Education Manager, and the ES Program Director. The DFM Postgraduate Director attends monthly, or more frequently, as needed.

9. Describe the ways in which the program promotes a collegial environment and supports Resident health and well being.

- **ES PROGRAM STRATEGIES TO PROMOTE A COLLEGIAL ENVIRONMENT**
  - ES Program Orientation for all incoming Category 1 and 2 ES Residents to provide an opportunity to meet fellow Residents and ES Program staff and Faculty, as well as to orient Residents to ES policies, procedures, and resources.
  - Several ES Programs involve past ES graduates to participate as members of RTCs/RPCs, as mentors, and/or in their Search & Selection Process.
  - Since 2009, Calgary Urban Residency Program PGY1 and PGY2 Residents attend the annual Enhanced Skills Wine and Cheese Information Evening, and meet with the Enhanced Skills staff, Program Director, and DFM Postgraduate Director. This informal gathering is an opportunity for the ES Residents to share information about the Enhanced Skills Programs, and assist their colleagues' career planning in a relaxed atmosphere.
  - Some Enhanced Skills Residents, including graduates from the Programs, and ES Program Directors, participate in the undergraduate Obs Skills Day and Family Medicine Interest Group Enhanced Skills night to provide opportunities for undergraduate medical students to learn about ES Programs.
  - Some Enhanced Skills Residents participate as facilitators or case developers in the undergraduate Family Medicine Interest Group Resident Teaching Nights.
  - ES Residents are all offered the opportunity to remain involved with generalist Family Medicine clinical work during their Enhanced Skills Program.
  - ES Residents are invited to attend the annual DFM Resident-developed Fall and Spring Conferences.
  - All ES Residents are included in communication from the Department of Family Medicine Postgraduate and University of Calgary PGME offices relating to educational and social events.
  - The ES Residents are also invited to:
    - the annual Department of Family Medicine Welcome and Stampede B-B-Q
    - the annual Department of Family Medicine Christmas Party
    - the annual Department of Family Medicine Residency graduation celebration and dance
  - The weekly Resident Newsletter includes ES news and views. (Appendix M)
  - ES Residents are given clinical teaching opportunities in acute care, community-based settings, as well as classroom settings, involving undergraduate learners and 2-year Program FM Residents. Enhanced Skills Residents and graduates have also been involved in teaching during the Family Medicine Interest Group Medical School Urban Skills Day.
  - ES Residents are invited to participate in CaRMS and have been involved as physician interviewers.
  - ES Residents have been involved in Program Search and Selection Committees.
  - The ES Program Directors have a collegial and respectful attitude towards each other's' area of Enhanced Skills and interests, demonstrated in many ways. At the ES RPC meetings or through e-mail discussions, there is an easy sharing of ideas around resources and program development. For example, their individual understanding and application of PGME policies and procedures often informs discussion around ES Program needs such as those related to moonlighting, re-entry, search and selection, and assessment strategies.

➢ ES PROGRAM STRATEGIES TO PROMOTE RESIDENT HEALTH AND WELL BEING

Relevant policies

- Faculty Adviser Policy – Appendix N
- Resident Safety Policy – Appendix O
- Resident Supervision Policy – Appendix P
- Resident Wellness policy – Appendix Q

Resident well-being is an important consideration in each individual ES Program. All ES Program Directors (PD's) meet regularly with their ES Residents. ES Residents are made aware of the sources of available support for them by their individual ES Program Director(s).

- CCFP-EM and FP-A programs include inquiry into wellness, stressors, intimidation, abuse and discrimination at their quarterly Resident-PD meetings.
- CoE PD and Resident(s) do this monthly.
- GH PD has frequent contact by email and Skype (less frequently in- person) regarding Resident progress and Resident concerns.
- SEM PD plans to meet with Residents every three months.

However, a possible barrier to accessing needed help is perceived by the Enhanced Skills Program in the mixed support/assessor role of the individual ES Program Directors. In addition to their Program Directors, ES Residents are aware that they can approach the DFM ES Director, or the DFM Postgraduate Director directly should they have any concerns about their own well-being.

Some ES Programs have strategies in place or planned for Resident support, which are discrete and separate from the Program Director assessment role.

- FM-EM assigns a longitudinal Preceptor to each Resident.
- GH Residents are each assigned a mentor with whom they communicate regularly.

A Faculty Advisor Policy (Appendix N), is under development in Postgraduate Family Medicine, with ES program input, to provide guidance to individual ES programs in providing mentorship and support to ES Residents. This policy requires that all ES Residents have an identified faculty advisor and includes provision for Residents to request an alternate to their Program Director. Other policies developed by the postgraduate family medicine program to support ES programs and promote ES Resident wellness include: the PG FM Safety Policy, Supervision Policy, and the Wellness Policy (Appendices O, P, and Q)

As well, ES Residents were alerted to additional available supports and resources (and how to reach them) at the ES Orientation session in July 2014. These include:

- Alberta Medical Association's Physician and Family Support Program
- the Alberta Health Services Employee & Family Assistance Program
- the DFM Ombudsperson
- the Cumming School of Medicine Office of Equity and Professionalism
- the U of C Student Ombuds Office

Contact information for all of these programs is also listed on the DFM ES Program website (https://www.ucalgary.ca/familymedicine/residency-preceptors/information-enhanced-skills-Residents).

10. What formal procedures exist to identify Resident intimidation or harassment? How are such problems dealt with once they are identified?

Relevant policies

- Resident Safety Policy – Appendix O
- Resident Wellness policy – Appendix Q
- Faculty Adviser Policy – Appendix N

University of Calgary Relevant Policies

- University of Calgary Guidelines for Administrators Acting on Concerns About Conduct http://www.ucalgary.ca/hr/about_hr/policies_procedures/guidelines_for_administrators_when_acting_on_concerns_about_conduct
- Professional Standards For Faculty Members And Learners in the Faculty of Medicine at the University of Calgary http://cumming.ucalgary.ca/files/med/Professional%20Standards.pdf
- University of Calgary Code of Professional Ethics http://www.ucalgary.ca/policies/files/policies/Code%20of%20Ethics.pdf
- Statement on Principles of Conduct http://www.ucalgary.ca/hr/about_hr/policies_procedures/statement_on_principles_of_conduct?ticket=ST-34572-BCiD28DS0oesCLBJb0lF

Feedback regarding learning environment and treatment by Preceptors is invited on all Preceptor Evaluations in all ES programs. Residents may also raise any issues relating to intimidation, discrimination or harassment with any of: ES Program Director, ES Director, or the Post-Graduate Director or Ombudsperson within the Department of Family Medicine. ES Residents are also alerted to several external supports during their ES Orientation, including the Cumming School of Medicine Office of Equity and Professionalism, U of C Student Ombuds Office, AHS Employee & Family Assistance Program, and the AMA's Physician and Family Support Program.

Where there is a concern about a Preceptor, the ES Program Director, ES Director, and/or Post-Graduate Director will carry out an exploration and investigation in line with University of Calgary policies, and often in discussion with the U of C Office of Equity & Professionalism.

Category 1 Program

Please complete a form for each Category 1 program.

PROGRAM NAME: Family Medicine – Emergency Medicine

GENERAL STANDARDS

A) PRINCIPLES AND OBJECTIVES

As part of the questionnaire, please append one copy of the goals and educational objectives of the training program plus any mission statement that the program may have.

CCFP-EM Goals and Objectives – CCFP-EM Appendix A
CCFP-EM Residents Orientation Package – CCFP-EM Appendix B
CCFP-EM Mission Statement – CCFP-EM Appendix C

CCFP-EM 11 Describe the mechanisms by which the goals and educational objectives of the training program are distributed to Residents and faculty and indicate the date at which they were last reviewed by the program.

- The goals and educational objectives of the training program (CCFP-EM Appendix A) are included in the CCFP-EM Residents Orientation Package (CCFP-EM Appendix B). This is emailed to the Residents prior to their start date. The Residents Orientation Package is discussed extensively at their orientation session. The goals and objectives are also available online on the Calgary EM website.
- The goals and objectives are distributed to each respective faculty at each of the hospital site representatives on the RTC. All faculty also have access to the Calgary EM website.
- Rotation specific goals and objectives are reviewed on a rotating schedule at RTC. The overall program goals and objectives for adult emergency medicine are reviewed every year. The other rotations are evaluated and reviewed at least every 2 years. (CCFP-EM Appendix G, specific review dates are noted on each rotation form)

CCFP-EM 12 Describe the mechanism by which the educational objectives are discussed with the Residents.

- Residents are emailed out the educational objectives prior to their start date. During their orientation day the rotational objectives are referred to and the overall program goals and objectives are reviewed in more detail. In addition, the RTC meets monthly to discuss issues raised by Residents and faculty.
- The entire Residency Program (FRCPC and CCFP-EM) is reviewed every January at the Emergency Medicine Residency Program Retreat. At the retreat, Residents and faculty meet and discuss their educational objectives for the program in its entirety as well as the rotation specific objectives. The minutes of these meetings are presented at the next RTC.

CCFP-EM 13 Describe the structures and ways in which the program's goals and objectives are communicated to the specialty faculty responsible for teaching family medicine Residents.

The Residents are expected to access the rotation specific objectives prior to the start of a new rotation. The Residents are then asked to provide the specialty faculty with a copy of the rotation specific objectives so that the faculty are aware of the Resident goals for the rotation. Additionally, the EM faculty are aware of, and have access to, the EM website which outlines, in detail, specific objectives for that rotation.

B) EVALUATION

I. Program Evaluation

CCFP-EM 14 Describe the process by which the program evaluates all educational experiences of the curriculum. Include a description of how Residents are involved in this process.

- Residents are asked to complete a rotation assessment online for each educational experience. The online Resident assessment system also has a section for the Resident to evaluate the Preceptors and the rotation just completed. The Residents must complete their evaluation of the rotation and preceptor before they will receive their personal ITERS (In Training Evaluation Reports). (https://calgary.one45.com/)
- Quarterly review meetings with the CCFP-EM co-Program Directors and the longitudinal Preceptors also provide a forum to discuss any issues or concerns raised by the Residents.
- At the Annual Emergency Medicine Residency Program Retreat in January, each of the rotations is discussed. The Residents are asked to identify strengths and weaknesses of each rotation as well as suggestions for improvements. The Residents also provide feedback for their academic day, journal club, SIM Sessions (Human Simulation), and the scholarly activity. The major goals of the Annual Emergency Medicine Residency Program Retreat are program development and optimizing each learning experience. This meeting also brings together the CFPC (EM) and FRCP Emergency faculty and Residents from Edmonton and Calgary to share and compare ideas.

CCFP-EM 15 Describe the internal review process used by which faculty members within the department of family medicine program between accreditation visits.

The Office of Postgraduate Medical Education at the University of Calgary organizes the internal review. It is a comprehensive review by two program directors from other University departments and a Resident representative. It follows the same format as the external review for accreditation purposes. Our last internal review was January 29, 2013.

II. Faculty Evaluation

CCFP-EM 16 Describe the policies and procedures by which faculty members within the department of family medicine are evaluated for their teaching skills. Append any evaluation forms and/or policy statements.

- Following each clinical shift, Residents are expected to provide specific feedback and suggestions for improvement to their emergency medicine Preceptors. Each staff emergency physician has been briefed on the feedback processes post-shift, and in turn this time post-shift has become a valued and protected time for the staff and Resident to discuss the feedback from the shift.
- Residents also fill out a faculty evaluation form online before they can receive their own evaluation for each rotation. Specific feedback is also sought from the Residents at the Annual Emergency Medicine Residency Program Retreat, during their quarterly reviews and at their exit interview in June. Pooled anonymous feedback is given to faculty on an annual basis (CCFP-EM Appendix D). Any concerns or issues are addressed with faculty as soon as they are identified.
- Faculty are evaluated following their Grand Rounds and Academic day presentations.
- Residents choose a Preceptor annually to be the recipient of the Preceptor of the Year Award.
- Each year the Residents (FRCP and CCFP-EM) jointly review each of the teaching faculty and comment on their teaching skills. This is also included in the anonymous pooled feedback given to the faculty.
- For off-service rotations, Residents are asked to complete a rotation evaluation online for each educational experience. The online Resident assessment system also has a section for the Resident to evaluate the Preceptors. These Resident evaluation forms are pooled for feedback and distributed to each off-service Preceptor by their respective service educational administrators.
- Towards the end of the academic year, the Residents nominate outstanding Preceptors from off-service rotations and send out thank you letters to acknowledge excellent teaching from top Preceptors.

III. Resident Evaluation

For this section, provide appendices of any forms used to collect data in any of the areas specified by questions below.

CCFP-EM 17 Describe how the program coordinates Resident evaluations. In answering this question, please identify any individuals within the program with specific responsibility for evaluation or any committee structure that oversees the process. Append any policy statements or documents.

- The following components contribute to Resident assessment:
  - Daily Encounter ITERS during Emergency Medicine rotations (CCFP- EM Appendix E)
  - In Training Evaluation Reports for Clinical rotations (CCFP-EM Appendix F)
  - Quarterly oral exams (examiner feedback is sought, collated and provided to the Residents) (See Resident Files)
  - Bi-annual written exams

    - Quarterly meetings (see Resident Files) with Residents and their horizontal Preceptors
    - Informal Horizontal Preceptor/mentor feedback
    - Resident Research day presentations or feedback on their scholarly project
    - Yearly Oral Presentation feedback for Grand Rounds and Lab/X-ray round presentations (See Resident files)
    - Feedback for AHD rounds and journal club presentations
    - Tintinalli Round Exams
- Daily encounter ITERs are collated by one of our Program Assistants and then disseminated to the Program Directors and to the respective Residents. A copy is kept in their files. All assessments are signed off and dated once reviewed by the Program Directors. We are currently in the process of going to online daily assessments through one45. This will hopefully free up some administration time. Rotation ITERs for off service assessments are completed via one45 and collated by our Program Assistant. They are then signed off and dated once reviewed by the Program Directors. The Program Directors reviews all other assessments such as written exam scores, oral exam feedback, presentation feedback, as it is collected by the Program Assistant.

CCFP-EM 18 Describe the policies and procedures for the evaluation and supervision of Resident performance in the context of the family medicine settings.

Although there are not any required rotations in family medicine settings, those Residents who wish to do half-day weekly Family Medicine Call-back clinics are supported in this and would be supervised in keeping with the Supervision Policy (Appendix P), directly observed regularly, and assessed using field notes.

CCFP-EM 19 Describe the policies and procedures for Resident evaluation and supervision on specialty rotations.

- Our emergency departments are staffed so that Residents are not required for service. There is always one-to-one supervision; assessments are completed on Residents based on direct observation. The CCFP-EM co-Program Directors provide guidance to the faculty regarding the appropriate level of supervision (Appendix P).
- Residents work with a variety of Preceptors and are also scheduled for several shifts per block with their longitudinal preceptor. This system encourages the development of a teacher-learner relationship. It also allows graded progression of responsibility while allowing Residents to see a variety of practice patterns. There is a strong emphasis on providing quality feedback to Residents. We have recently changed our ITERS to emphasize and stimulate formal feedback to our Residents as well as for our Preceptors. This allows both parties to focus on areas for improvement.
- ICU utilizes its own ITER for assessment. The rotation is very good at interim assessment and has a reputation for being thorough, specific and forthright. Each Resident has an exit interview at the end of their rotation where their assessment is to be discussed in detail. Clinical supervision in the ICU is extremely close, including on-call shifts. There is almost always an in-house ICU fellow available to the Residents.
- CCU utilizes the ITER developed by the CCFP-EM RTC to reflect the CCU goals and objectives. In-house Cardiology Fellows and staff cardiologists supervise Residents.
- Anesthesia uses daily assessment forms and an ITER that has been developed to reflect the Anaesthesia goals and objectives. Residents are directly supervised by attending staff.

- Pediatric emergency medicine uses daily assessments and HPS (Human Patient Simulation) sessions to evaluate CCFP-EM Residents. One physician compiles all feedback. The clinical supervision is the same as in the adult ED. There is no service expectation. Residents are directly supervised by attending staff.
- The rural rotation in Banff utilizes the adult emergency medicine assessment form. Most Preceptors in Banff will allow the Residents to be in charge of the department if patient volume and acuity allows this to be done safely. Faculty are always in-house and immediately available to review patients.
- The rural/community rotation (Yellowknife, Red Deer, or Lethbridge) uses daily assessment forms developed by the CCFP-EM RTC. At the end of the rotation the Resident site lead completes a summative assessment on one45 and has a sit-down session with the Resident. Residents are directly supervised by attending staff.
- The Toxicology rotation uses an assessment form developed in conjunction with the CCFP-EM Program Directors to reflect the goals and objectives. The Residents are supervised directly by toxicology staff.
- Ophthalmology utilizes its own ITER for assessment. There is a summative assessment. The attending staff directly supervises our Residents.

C) FACULTY DEVELOPMENT

CCFP-EM 20 Describe how the faculty development needs are assessed and describe the faculty development program offered to department members. Comment specifically on the resources within the department to support faculty development.

- Our department has several positions that have been created in the past few years including Senior and Junior Research positions, HPS coordinator, Ultrasound Training Coordinator, and an overall Continuing Medical Education Director for the department. The latter position has yet to be filled.
- The development and implantation of a formal faculty development program in the department has recently been targeted by the RTC. There have been several initiatives undertaken by the CCFP-EM co-Program Directors to strengthen the relationship between the teaching programs and the faculty. In the spring of 2013, we hosted an educator's retreat for all Calgary Emergency physicians. The goal of this retreat was to provide faculty development in the areas of supervision, teaching, and assessment of our Residents. We will be hosting another educator's retreat in the spring of 2015.
- One opportunity for CME developed by our department for our staff involves human patient simulation sessions. A needs assessment was done prior to developing these sessions. These sessions run weekly in one of the resuscitations bays at one of the three hospital sites and involves our ER nursing and RT staff. Two physicians can participate each week. There is a debriefing session after each simulation scenario where feedback is provided. As of December 2013, 83 of our staff physicians (CCFP-EM and FRCP) have completed 152 sessions.
- Other opportunities for our staff include:
    - The Department of Family Medicine hosts a yearly Educators Day; "Fall Together". This conference information is disseminated to all of our teaching staff.
    - The Cumming School of Medicine offers many faculty development opportunities/courses each year. This information is disseminated to staff regularly.

    - Weekly departmental Grand Round presentations. These are also podcasted so that if any Faculty are unable to attend, the lectures can be accessed via the Physician Learning Program website. Attendance at these rounds is excellent. Staff physicians giving these rounds are provided with feedback and suggested areas of improvement.
    - Monthly Journal Club hosted by a staff physician at their home. Summaries of journal club articles are emailed out to all attending staff following the journal club evening.
    - The Poison and Drug Information Service in Calgary hosts a yearly conference targeting Emergency Medicine providers and toxicologists.
- The Department also stipulates that its members adhere to the CME programs required by each physician's respective certifying body: the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons, or the American Board of Emergency Medicine. Most members will attend conferences on Emergency Medicine to meet their CME requirements.
- Faculty are given feedback on teaching skills. Opportunities exist to improve their skills by attending the Cumming School of Medicine Office of Faculty Development sponsored programs.

CCFP-EM 21 Describe how the faculty members, both those within the family medicine department and those with appointments in other disciplines, are evaluated for their teaching skills and how faculty development needs are determined.

- Residents are asked to provide feedback on the bedside teaching skills of their Preceptors after every shift. This is collated along with feedback from undergraduate students and off service Residents and provided to faculty on an annual basis. (CCFP-EM Appendix D)
- Specific feedback for all faculty is also sought from the Residents at the Annual Resident Retreat, during their quarterly reviews, and at their exit interview in June. This feedback is collated with the formal feedback collected throughout the year.
- Residents choose a preceptor annually to be the recipient of the Preceptor of the Year Award.
- There is a process within the department to address negative Preceptor feedback. If a Preceptor is provided with a negative evaluation they are sent a letter to inform them of the feedback. They have an opportunity to review the evaluation with the Coordinator of Undergraduate and Off Service Resident Education who is responsible for distributing collated Preceptor feedback. If the same Preceptor receives a second negative evaluation the evaluations are then brought to the attention of the CCFP-EM Program Directors as well as the Department Head. The Department Head will meet with that Preceptor to develop a remediation plan to improve their teaching skills.
- For off-service rotations, Residents must fill out a faculty evaluation form online before they can receive their own evaluation for the rotation.

D) SCHOLARLY ACTIVITY

CCFP-EM 22 Does the program offer support to the Residents for scholarly activity or research.

Over the past few years, our research department has grown and developed further. We have hired Senior and Junior researchers, a Research Director as well as prominent researchers from across Canada that include both CCFP-EM and FRCP Emergency physicians. At the beginning of the year, our Residents meet with the Senior Researcher to provide the Residents with ideas and opportunities available to them. Typically, our Residents find a faculty member with whom they will be completing their project. The researchers then provide ongoing support for the scholarly activity. At the quarterly reviews we review the progress each Resident has made as well as discuss the goals for the next quarter. The research department is very keen and willing to engage our Residents in scholarly and research activity. It is expected that the Residents will present, with support from staff, at the yearly research day in April.

CCFP-EM 23 What do you perceive to be the major strengths of your program?

- People
  - The combined CCFP-EM and FRCPC Resident group of 26-30 people is strong clinically, academically and interpersonally. Although the mix of personalities varies from year to year, the commonalities among Residents attracted to Emergency Medicine usually ensures a collegial group. Together they have sufficient numbers to create a rich learning environment with varied perspectives and levels of expertise. They are an effective first line of support for each other in times of stress.
  - The popularity of Calgary as a place to live and practice Emergency Medicine has allowed us to attract and retain some of the best physicians graduating from Residency Programs across the country. As a result, our staff physicians are young, keen, well qualified and committed to providing a high standard of patient care and teaching. The learning and working environment created by these people is enthusiastic, high energy and generally characterized by acceptance and mutual respect. The past few years have seen an increase in the number of physicians volunteering to help with the education of CCFP-EM Residents and we are now routinely over-subscribed for faculty examiners for our quarterly exams and our academic day teaching. There is an unspoken competition among faculty to preceptor our Residents with staff being motivated to improve their teaching skills.
- Infrastructure
  - Regionalization of hospital services in the city over the past decade has created an excellent opportunity for Resident exposure to high acuity Emergency Medicine in Calgary. Our Emergency Departments now have an Information Management System, QI and Research Divisions, and ¼ million patients per year and some of the highest acuity in the country. Specific strengths in this system are:
    - Alberta Children's Hospital
    - Foothills Medical Centre
    - Poison & Drug Information Services (PADIS)
    - Pre-Hospital Care (Calgary EMS & STARS)
    - Human Patient Simulator Program
    - Four complementary and inter-dependent adult hospitals

- Learning resources
    - The emphasis on evidence-based medicine and lifelong learning are integral parts of the Program that aid in our goal of producing Residents who are both clinically competent and contributors to their profession and community.
    - We provide $500/year for Residents to buy textbooks, subscriptions or educational aids of their choice.
    - There are yearly subscriptions paid for by the Program to two educational resources, Emergency Medicine: Review and Perspectives (EMRAP) podcasts and Emergency Medicine reports.
    - Emergency Medicine textbooks and journals are routinely purchased for use in the EM Resident's room on the second floor of Foothills Hospital
    - Information resources are increasingly acquired in electronic format. Electronic resources include books (e.g. Books@Ovid, MDConsult, AccessMedicine, STAT!Ref), journals, major bibliographic databases (including MEDLINE, EMBASE, PsycINFO, Cochrane Database of Systematic Reviews, ACP Journal Club) of care clinical support tools (e.g. e-Therapeutics+, Dynamed, Clinical Evidence, Lexi-Comp online). These electronic services are web-based and are accessible via the university network on campus and at hospitals, clinics, laboratories, offices, and from home.
    - Access to UpToDate, the popular database of clinical practice information summaries, has been licensed throughout the hospitals and through the University of Calgary library.

CCFP-EM 24 What do you perceive to be the major weaknesses of your program?

- Faculty development and evaluation
    - There are faculty development courses offered by the university that are available to our teaching staff, and we have endeavoured to create our own CME effort around teaching skills, but no formal Emergency Medicine specific faculty development program currently exists. Our Department has also created a Continuing Professional Development position but despite significant recruitment efforts, that position still remains empty. To minimize this deficit we have run an "Educator's day", a full day of CME centred on teaching, feedback and evaluation. We plan to host another Educator's day in the spring of 2015. To determine the areas of weakness for our faculty, a needs assessment should be distributed to determine what faculty development would be most beneficial.
- Administrative support
    - In May 2012, the primary program administrator took an unexpected leave of absence. At that time, we were assigned a new administrative assistant, Ms. Stacey Dickinson. She was assigned a full 1.0 FTE to manage the CCFP-EM and the FRCPC Emergency Medicine Program. As a part of the administration team, there are also two other assistants who have been designated 0.5 FTE each to help, but they are also tasked with numerous duties unrelated to both education programs. Ms. Dickinson has had difficulty managing the workload and the tasks assigned. Given the large number of tasks to complete and despite the extra administrative assistance, the program could use increased administrative support.
- Ultrasound scanning practice
    - We encourage the Residents to become IP (Independent Practitioner) certified through the CEUS at the end of the year. With the short year, academic and clinical expectations, it is difficult for the Residents to obtain this certification. We are

trying to fit in dedicated US time for the Residents to finish their 200 required scans and find willing staff to proctor the exams.

- Learner volume
    - With the large volume of learners on shift at any one time, it is difficult for our Residents to get regular procedures and manage the sickest patients due to a dilution effect. There is pressure for our program and the FRCPC program to grow. We worry about outstripping our resources should this happen. In the same context, we have had difficulty booking rooms for academic full day large enough to accommodate the CCFP-EM/FRCPC Residents and additional visiting clerks and Residents. Often Residents are squeezed into rooms too small and there have been times when Residents have had to sit on the floor or stand.
- Involving new staff
    - We have had some difficulty recruiting new staff to Calgary into academic roles and encouraging new staff to simply be involved with teaching. Initiatives have been implemented to encourage new staff of the importance of their involvement. The Departmental 24 hours of service initiative requires all staff to contribute 24 hours of extracurricular time. As Program Directors, we encourage the new staff to provide this time to the Residency Program and offer ways to involve them with our Residents.
- EM Website
    - A major, and on-going, weakness is the lack of a formal EM website. Currently, we use an older and somewhat outdated website to disseminate information about rotations, scheduling, and academics but have had ongoing difficulties with this website. There is currently a Department of Emergency Medicine website in the very early stages of development. We are in need of a cohesive and comprehensive website to promote our program and keep staff and Residents up to date.
- Resident Feedback from Academic Full Day
    - Our Program has been inconsistent with providing the CCFP-EM Residents with constructive feedback on individual presentations and sessions. This has been done through a "survey-monkey" format, however feedback has been not completed or missed. This was addressed at the October 2014 RTC meeting and a standardized method of hand-written feedback has been instituted.
- Daily Assessments
    - During the Resident's Emergency Medicine blocks, the daily assessment used by the Resident and staff is handwritten. Collating this feedback is a significant burden to our administrative staff. We are in the process of developing a daily online (one45) assessment form to address this.
- Keeping the faculty aware of academic/Resident change
    - Our Program has been inconsistent with up-dating the faculty on changes to the Residency Program. We need to develop a formalized method for keeping the staff apprised of new Resident developments. One solution to disseminate the information more effectively is to include this information in our monthly newsletter the "Democrat".

CCFP-EM 25 Can you identify issues you hope the survey team might be able to help to address?

- Dissemination of information: keeping the faculty aware of the changes occurring in the Residency Program has presented some difficulty. Despite having site reps for each of the hospitals and the Calgary EM website, we struggle to ensure timely dissemination of

information related to the residency program.

- Vacation Requests: We have had difficulty with ICU and CCU rotations giving our Residents (and others) reasonable vacation time during these rotations. Often, vacation time, if given at all, is received late for the Resident. We have tried to address this with program staff but this has been met with resistance. Because these rotations offer excellent learning opportunities, we want to continue to schedule the Residents for these rotations. This issue is currently being addressed at the PGME Committee level
- CCU rotation: The Residents find that there is a lot of value while doing call on CCU. However, the rotation is quite fellow-dependent in terms of the learning opportunities. During the day, the Residents often feel that they are not given responsibility for their patients, as the fellow will often change the care plan without involving them. They often state that they are sitting around during the day without any organized teaching sessions or learning opportunities. To make the learning experience more consistent, we are looking at novel ways to enhance the CCU rotation by scheduling the Residents in subspecialty clinics during the day. (Heart Failure clinic, Atrial fibrillation clinic, Electrophysiology clinic etc.)

CCFP-EM 26 Describe future plans for the program in terms of curriculum or resource changes.

- There have been changes to the clinical rotations that were introduced in July 2011 and July 2012. In July 2011, we introduced a two-week Toxicology rotation and a two-week Neuro-Trauma ICU rotation. This results in a total of six weeks of ICU for our Residents. In July 2012, a one-week Ophthalmology rotation was added in response to the difficulty in the past of the Residents securing electives in Ophthalmology. For the 2013/2014 academic year, three weeks of elective rotations were changed to a three-week rural emergency rotation. Residents choose their rural location for that rotation; to date these have included Lethbridge, Yellowknife, Whitehorse and Red Deer. This has been funded through the Distributed Learning Rural Initiative program (DLRI).
- We are currently in discussion with the CCU program director. We have had repeated negative feedback regarding the CCU rotation. Call is felt to be a strength but our Residents would like more teaching during the day while covering CCU. A variety of options are being considered for the 2015-2016 academic year including working at various cardiology related clinics (i.e. Congestive Heart Failure clinic, Atrial fibrillation clinic, etc.).
- The academic day curriculum has undergone major changes in the past few years. In 2013/2014 academic year the academic half-day was increased to a full day. This has allowed for added teaching opportunities including monthly EKG rounds and monthly Tintinalli rounds. The Tintinalli rounds include a didactic session as well as an exam. The Education Coordinator has developed four MSK/Radiology small group modules that include over 100 x-rays each. There has also been recent development of other x-ray workshops coordinated by a Radiologist and Emergency Medicine Resident. In response to feedback that the burden of preparing rounds was too onerous, the faculty now give over 50% of all academic day lectures.
- The number of sessions of Human Patient Simulator (HPS) has increased since July 2012. There are sessions for the Residents every month. These sessions occur in real time in the Emergency Department with participation of ancillary staff including RNs and respiratory therapists. The staff co-ordinating the simulation program has completely re-vamped the curriculum so that in addition to medical knowledge, our Residents also learn crisis resource management skills. To introduce our Residents to simulation learning we have

developed a “Simulation Bootcamp”. This is a full day of simulation of Emergency Medicine cases offered at the beginning of the year to introduce the Residents to simulation and to principles of crisis resource management.

E) CURRICULUM

CCFP-EM 27 List the rotations with the duration and training sites involved.

Rotation	Duration	Training Sites
Adult Emergency Medicine	4 Blocks	FMC / PLC / RGH / SHC
Pediatric Emergency Medicine	2 Blocks	ACH
Rural Emergency Medicine	1 Block	Banff
Rural Emergency Medicine	3 Weeks	Rural Site of choice
ICU	1.5 Blocks	FMC / PLC
CCU	1 Block	FMC / PLC
Anaesthesia	1 Block	FMC / PLC / RGH
Toxicology	0.5 Block	FMC
Elective	1 Block	Various
Ophthalmology	1 Week	RGH

CCFP-EM 28 Provide a narrative description of each rotation (both core and elective) outlining its strengths and weaknesses.

- **Adult Emergency Medicine**
  - Excluding Banff (4 weeks), there are four rotations in Adult Emergency Medicine, and one three-week experience in a community setting (Yellowknife, Red Deer, or Lethbridge). Each Adult Emergency Medicine rotation consists of a total of 16 shifts spread over the four adult Emergency Departments within the Calgary Health Region. Half of these shifts take place at Foothills Medical Centre, Southern Alberta’s Level 1 Trauma Centre. Foothills Medical Centre also serves as the referral centre for interventional cardiology, cardio-thoracic surgery, stroke care, neurosurgery, transplant medicine, and is home to the Tom Baker Cancer Centre. The remaining half of the shifts in the rotation are divided between the Peter Lougheed Centre, the Rockyview General Hospital, and the recently opened South Health Campus. These are secondary centres within a regionalized health care system. The Peter Lougheed Centre is the referral centre for forensic psychiatry and vascular surgery, as well as having a busy in-patient pediatric service. The Rockyview Hospital is the referral centre for ophthalmology and urology. The South Health Campus is the referral centre for neurology.
  - Each rotation is Preceptor based, and every effort is made to schedule Residents with recurrent Preceptors throughout the block in order to maximize opportunities for longitudinal observation, feedback, and graded escalation of responsibility.
  - Each site brings specific strengths to the Program. The Foothills site provides exposure to a high volume of trauma, stroke and acute cardiac emergencies, as well as a limited number of shifts devoted to minor emergency treatment. The Peter Lougheed Centre provides exposure to a high volume of medical and surgical patients, with a unique exposure to immigrant populations, and a large pediatric census. The Rockyview site provides a similarly broad experience, but with a

greater emphasis on the care of geriatric patients. South Health Campus sees a diversity of patients with a heavy pediatric base. Acuity is universally high within these regional centres. All are receiving hospitals for our EMS service, and attending physicians usually work at more than one centre. Admission rates vary from ~18% at the Peter Lougheed site to ~27% at the Foothills site.

- Strengths
  - Exceptionally high volume of sick patients.
  - Preceptor-based rotations.
  - Strong core of Preceptors. Residents work predominantly with a core of 12-15 key CCFP-EM Preceptors who are committed to teaching, and the educational experience of the Residents. In addition, Residents work with FRCP trained physicians who have shown excellence in teaching and are involved in the Residency Programs. Specific strengths of the Preceptor group include the presence of certified toxicologists, and the medical directors of Calgary EMS and STARS air ambulance service.
  - Absence of service component. Departmental staffing is unrelated to Resident scheduling, so Residents are there to learn, not provide service.
  - Protected academic day on Thursdays. As of 2013-2014 the U of C has moved to an academic full day. This has allowed for increased learning opportunities as previously mentioned including EKG rounds and Tintinalli rounds.
- Weaknesses
  - The fee for service work environment does not reward time spent on teaching.
  - The high level of acuity continuously tugs the Preceptor between patient care and teaching. Residents with low self-confidence can become overwhelmed by the acuity, especially at Foothills Medical Centre.
  - Gridlock can occasionally result in insufficient numbers of patients to be seen.
  - Our current "waiting room care" initiatives force the Residents to work in suboptimal conditions, an increasing reality of Emergency Department work in Canada.

- **Pediatric Emergency Medicine**
  - Residents are scheduled for two four-week blocks of pediatric emergency medicine at the Alberta Children's Hospital. These are intentionally scheduled apart, with one occurring in the first half of the year, and the other in the second half. ACH is the pediatric referral centre for all of southern Alberta and south eastern BC. The emergency department sees 50,000 patients annually, including 100 major trauma cases.
    - Strengths
      - Preceptor-based teaching with excellent Preceptors. Residents consistently comment on the high quality of clinical teaching they receive at the ACH. Several emergency physicians at this hospital work under an Alternate Funding Program.
      - Brand new state of the art hospital with adequate resources (infrastructure and staff) to look after the sickest children in Southern Alberta.

        - The concentration of sick children at ACH ensures that Residents become comfortable with procedures, resuscitations and working with families.
        - Dedicated didactic teaching and Human Patient Simulator (HPS) sessions are held every Thursday morning for Residents rotating through the ACH ER. The HPS is located in the Emergency Department.
        - Despite the high number of learners rotating through pediatric emergency medicine at ACH (Family Medicine, Pediatrics, FRCP-EM, Peds EM Fellows and CCFP-EM), a concerted effort is made to schedule the EM Residents so that they are the most senior Residents. This will allow the Residents to see the most interesting and/or acutely ill patients.
    - Weaknesses
        - ACH emergency department has a high volume of low acuity patients. Occasionally, a Resident can have insufficient contact with high acuity patients.
- **Regional Emergency Medicine – Banff**
    - The Residents are scheduled for a four-week rotation at Banff Mineral Springs Hospital (MSH). This is a well-established rotation and routinely regarded by the Residents as one of their best rotations. Due to the location on the Trans-Canada highway and in close proximity to several ski hills, it is a rotation with a heavy emphasis on trauma and orthopaedics. MSH sees 15,000 patients per year. Residents work with a dedicated group of mostly CFPC-EM Preceptors, with limited clinical backup by other specialists. There are also FRCP(C) qualified Preceptors as well as family physicians whose work includes a community based family practice. The rotation is scheduled preferentially during ski season in order to maximize the exposure to orthopaedic trauma.
        - Strengths
            - Excellent exposure to orthopaedics with a mix of other typical emergency medicine problems.
            - Exposure to the practice of emergency medicine in a regional setting. This includes experience with making transfer decisions, arranging imaging with scarce resources, and admitting one's own patients
            - Experience with managing the overall flow of an Emergency Department. Given that the adult Emergency Departments in Calgary have in recent years become impossible for one physician to manage, Banff gives our Residents a chance to practice making decisions about how to manage an entire department.
        - Weaknesses
            - Due to the increased number of Residents in the program, the Residents are sometimes scheduled to begin the rotation in November. If there is a lack of snow at the beginning of the ski season, patient volumes can be low.
            - The site is remote from Calgary and Residents can find it difficult due to personal reasons to spend a month in Banff.
- **Intensive Care (ICU)**
    - Our Residents are scheduled for two weeks of Neuro/Trauma ICU at Foothills Medical Centre Intensive Care Unit. The other four weeks are scheduled either at the Foothills Medical Centre or the Peter Lougheed Centre in a mixed medical/surgical ICU. The six weeks exposes the Residents to a large number of

trauma and neurosurgical cases in addition to the usual cross-section of medical and surgical ICU patients. ICU fellows generally stay in house while on call, providing excellent support to the Residents as well as after-hours bedside teaching. This rotation provides many opportunities for procedures.

- Strengths
  - Structured, dedicated teaching time every week, including a one-day "Crash Course" at the start of every rotation.
  - Consistently excellent bedside teaching from ICU staff and ICU fellows.
  - Strong sense of collegiality with other rotating Residents.
  - Extensive procedural experience.
- Weaknesses
  - Stressful, high acuity learning environment with high expectations of Residents. Can be a difficult rotation for Residents with lower degrees of self-confidence
  - Lack of ICU rotations in FM training leaves many Residents unprepared for the expectations that are sometimes placed upon them as PGY-3's in the ICU.

- **Cardiology / CCU**
  - Residents are scheduled for four weeks of CCU at the Foothills Medical Centre. All Residents are based on the CCU, but also cover cardiology wards when on call. The Foothills CCU is one of the busiest, highest acuity coronary care units in Canada. A highly aggressive approach to cardiac care in Calgary has resulted in 24 hour angioplasty services, and on-call Residents are responsible for the care of these patients immediately post-procedure. CCU Residents will be expected to manage acutely ill patients with acute coronary syndromes, CHF, arrhythmias and syncope among other issues. When on-call, Residents are responsible for all ED and ward consults.
    - Strengths
      - High volume and acuity while on call.
      - Dedicated lunchtime teaching sessions once or twice a week.
      - A recent emphasis on improving response time for emergency department consults has led to an increased presence of staff cardiologists in the ED, lessening the burden of service in this rotation.
      - Excellent teaching from Cardiology Fellows.
    - Weaknesses
      - Very busy rotation with large service component, which sometimes overshadow opportunities for bedside and didactic teaching.
- **Anaesthesia**
  - Residents are scheduled four weeks of anaesthesia at Rockyview Hospital, or two weeks at Rockyview Hospital and two weeks at the Alberta Children's hospital. The rotation is intended to focus on airway management and the pharmacology of anaesthesia. In order to achieve this goal, Residents are generally scheduled in rooms with a high volume of cases.
    - Strengths
      - Good exposure to pediatric airways.
      - Highly accommodating site chiefs for anaesthesia at both Rockyview and Alberta Children's Hospitals who try to schedule our Residents for high turnover rooms.
    - Weaknesses

        - Occasional inflexibility by Preceptors with regard to facilitating Resident exposure to varied or advanced airway management techniques.

- **Toxicology**
    - Residents are scheduled for a two-week rotation with PADIS, the Poison and Drug Information Service, the referral poisons centre for Western Canada. Most of the time is spent in the PADIS office, as well as doing formal toxicology consults in local hospitals.
        - Strengths
            - Exposure to attending toxicologists with exceptional levels of expertise.
            - Protected time to read around cases.
            - Excellent didactic teaching sessions.
            - Recent emphasis on increasing the number of bedside consultations by PADIS consultants. The new medical director of PADIS has committed to increasing the presence of the Residents in the ED by including them on the "on-call list", and appealing to staff ED physicians to consult PADIS for educational purposes. This new initiative started on March 1, 2010.
        - Weaknesses
            - Short duration of rotation can result in "hit or miss" experience.
            - Many of the cases the Residents become involved in are not physically located in Calgary, therefore limiting the Resident's ability to assess the actual patient.
            - Limited referrals to PADIS by emergency physicians in the Calgary Health Region
- **Elective**
    - Each Resident has one four-week block of elective time. The Residents are encouraged to construct their own elective to best suit their needs either by combining the best educational opportunities from several different specialties or spending a whole month focusing on one interest. A common choice is to do one of ENT, a few days of Acute Stroke service and a few extra shifts in the emergency department. There are many opportunities available including ENT, ophthalmology, stroke, respirology, pre-hospital care, sport medicine, family medicine, plastic surgery, and rural or regional emergency medicine.
        - Strengths
            - Offers excellent opportunities to diverse electives
        - Weaknesses
            - In 2011 elective time was decreased from eight weeks to four weeks to increase exposure to rural medicine departments (three weeks) and ophthalmology (one week). Some Residents have felt this has diminished their opportunities to explore areas of interest, however, these mandatory rotations were added in response to previous feedback regarding the CCFP-EM Program.
- **Community Emergency**
    - Residents are scheduled for a mandatory three-week community emergency medicine rotation with options to visit Lethbridge, Red Deer, or Yellowknife. These locations offer an excellent window into community practice with high volume and acuity. The rotation, although in its infancy, has been given great reviews.
        - Strengths:

- Good acuity and volume, dedicated Preceptors, good balance of pediatric and adult cases, good understanding of working in cities with less back up than Calgary, great orthopaedic volume.

  - Weaknesses:
    - Acuity in these rural centres can be low.

- **Ophthalmology**
  - The Rockyview Hospital serves at the dedicated site for Residents scheduled for a one-week rotation in the urgent eye clinic. In this clinic the Resident works with ophthalmology Residents and dedicated staff. Urgent eye cases are assessed after being referred from Emergency.
    - Strengths
      - Dedicated ophthalmology staff running the clinic.
      - Excellent applicability to emergency practice.
      - Great teaching-particularly through specialty Residents.
    - Weaknesses
      - Occasionally, the ophthalmology staff asks the patients go to his/her own clinic rather than the Urgent Eye Clinic. The clinic may not be set up with as many slit lamps or as much space as the Eye clinic. We have contacted the administrator responsible for the Resident scheduling to ask that the Residents be scheduled with a preceptor that refers patients to the Eye Clinic.

CCFP-EM 29 Describe any horizontal experiences that complement the rotations noted above including half-day continuity of care clinics, etc.

- Half-day call back clinics in Family Medicine
  - Available upon request. This opportunity is presented to the Residents during their orientation session.
- Longitudinal Preceptorship
  - This program has been in place for about ten years. Every Resident is assigned a CCFP-EM horizontal preceptor. The intent is to schedule the Resident to work a minimum of 2-3 shifts with this preceptor during each block of EM. The Resident is also encouraged to pick up one or two shifts with their horizontal preceptor when off service on rotations with minimal or no call requirement. This facilitates the development of a mentoring relationship with an experienced staff physician. It is also expected that the horizontal preceptor directly observe the Resident for four sessions while the Resident provides patient care. These encounters include history taking, physical exam, presentation and management. In addition to working shifts with their preceptor the direct observation sessions allow their preceptor to observe their longitudinal development and provide meaningful feedback. The horizontal preceptor attends quarterly reviews when available. The preceptor would also collaborate with the program directors should remediation be necessary. Meetings between the Resident and preceptor outside of the clinical environment allow for a variety of discussion including work-life balance, future goals, and stress management.
- Scholarly Activity
  - Each Resident is required to complete a scholarly project over the course of the year. Although mandatory, we do not wish this project to overshadow the task of learning clinical emergency medicine. The scholarly activity can be any of the following:

- A critical review of a topic, using specific guidelines for assessing the current literature, usually at the request of a journal editor
- A freestanding QI project or participation in an ongoing departmental QI project
- A freestanding research project or participation in an ongoing departmental project

CCFP-EM 30 Provide a sample Resident schedule.

Block 1 (July1-July28, 2013)	Emerg	
Block 2 (July 29-Aug 25)	Emerg	
Block 3 (Aug 26-Sept 22)	Anes (RGH)	Anes (ACH)
Block 4 (Sept 23-Oct 20)	ICU (PLC)	
Block 5 (Oct 21-Sept 17)	Tox	ICU-FM (NT)
Block 6 (Nov 18-Dec 15)	Peds	
Block 7 (Dec 16-Jan 12, 2014)	CCU	
Block 8 (Jan 13-Feb 9)	Emerg	
Block 9 (Feb 10-March 9)	Banff	
Block 10 (March 10-April 6)	Elective	
Block 11 (April 7-May 4)	Peds	
Block 12 (May 5-June 1)	Opthal x 1	Rural Emerg x 3
Block 13 (June 2-June 30)	Emerg	

CCFP-EM 31 Describe how Residents are taught to apply the principles of evidence-based practice in the context of this program.

- Critical appraisal sessions have been developed specifically to teach the principles of evidence based practice. These six sessions are incorporated into the academic day and each are scheduled for 90 minutes.
- Clinical supervisors model the application of evidence derived from the medical literature as appropriate on a case-by-case basis in the Emergency Department. Residents are expected to base a progressively larger amount of their clinical decision-making on their interpretation of the literature as they progress through their training. Attending staff routinely probe Residents' knowledge in this area.
- The principles of biostatistics are covered in didactic sessions conducted as part of the formal academic day curriculum
- Monthly journal club sessions overseen by members of the research division provide an opportunity for practical application of the critical appraisal skills taught during didactic sessions.
- Finally, the biostatistics workshops coordinated through Cumming School of Medicine CME Office are available to all Residents.

CCFP-EM 32 Describe the teaching of bioethics in medical-legal aspects of practice in the program.

- Ethical and legal issues feature prominently in the teaching sessions focusing on psychiatry, public health, and abuse.
- In addition to the above, the University of Calgary PGME Office puts on two annual events of relevance. The first is an annual Ethics Day for all Residents new to the U of C. Any CCFP-EM Resident who has not attended as a FM Resident is excused from clinical and academic duties to attend. The second is a medical legal series put on in conjunction with the Faculty of Law which spans two days and involves a mock deposition/testimony. This event is optional, but Residents are excused from their duties if they choose to attend.
- PGME also offers a Conflict and Communication Workshop and a Patient Safety Workshop that are made available to all Residents.
- All new Residents and faculty are provided with the document 'Professional Standards for faculty members and learners in the Faculty of Medicine at the University of Calgary'.

CCFP-EM 33 Outline the program of seminars and didactic sessions that comprise the academic component of this program.

The academic curriculum consists of several discrete elements as follows:

- **Core Didactic Curriculum**
  - The core didactic curriculum takes place on Thursday afternoons, from 1:00-5:00 pm. This is protected academic time and Residents are expected to attend. In the past year we have begun to podcast our AHD rounds so that Residents who are unable to attend still have access to the rounds presentations.
  - Rounds are a joint presentation by a Resident and a faculty member. The Resident and faculty collaborate on the content of the presentation, the Resident does the bulk of the oral presentation, and the faculty member is there to help with clinical questions. These rounds are often a joint presentation between the two Emergency Medicine programs (FRCP and CCFP-EM), with the expectation that all Residents, regardless of program participate equally. The collegial relationship between the two groups of Residents is regarded as a major strength of the program.
  - The FRCP Resident rounds schedule follows a two-year cycle. Our requirement of teaching all major topics in one year results in the CCFP-EM Residents holding separate rounds many times during the year. We take advantage of the times when the FRCP Residents are covering advanced administrative roles, less mainstream toxicology topics, and other non-core subjects to cover the remainder of our core topics. Teaching faculty deliver these topics to the CCFP-EM Residents alone. (CCFP-EM Appendix G)
  - Since the implementation of the full academic day, there are teaching sessions in the morning. This includes both ECG rounds and Tintinalli rounds. These each are held once a month. ECG rounds covers basic to advanced ECG reading over the course of the year. Tintinalli rounds cover key concepts from each chapter. This, in addition to the afternoon curriculum ensures that all key concepts in emergency medicine are covered.
- **Regional Department of Emergency Medicine Grand Rounds**
  - These grand rounds take place from 9-10 am every Thursday. The lectures rotate between Grand Rounds Presentation by a faculty member, Pediatric Grand Rounds,

and Resident Grand Rounds Oral Presentations (see below). All Residents on an Emergency Medicine rotation are expected to attend. During the summer, the Residents typically give the grand rounds presentations. These will be brief topic reviews and usually there are two presentations. The topics include EKG's, Lab, X-Ray, or Case Presentation. Most of the grand rounds are podcast via the Physician Learning Program (PLP), which the Residents and staff can access.

- **Oral Presentations**
  - Once per year, each Resident is required to present departmental Grand Rounds. This is expected to be a state-of-the-art level academic presentation on a topic of relevance to Emergency Medicine.
- **Journal Round**
  - Journal Club takes place monthly on a Thursday evening. There is no industry sponsorship. The journal club is hosted at the home of one of the faculty members. Food is paid for by the RTC. Two articles are reviewed, the first typically is a sentinel article in the practice of Emergency Medicine, and the second article is generally a recent article of interest. Each Resident is responsible for one Journal Club per year. Often the Residents are paired to organize journal club. Our researchers will be assigned to help the Residents to choose the articles and help with critical appraisal. Following each journal club the presenting Residents summarize each articles and the summary is sent out to all the attending emergency physician staff.
- **Research Day**
  - Research Day takes place yearly. It is a half day or full day event in which the Residents are expected to present the results of their scholarly activity. Prizes are awarded by a panel of judges and supplied by the RTC. CCFP-EM Residents are frequently recognized in this way.
- **Human Patient Simulator (HPS) Sessions**
  - We have recently expanded our HPS training to monthly sessions, coordinated by Dr. Stuart Rose. These highly regarded educational opportunities utilize high fidelity simulation equipment and take place in the simulation labs at FMC or in the Emergency departments with ancillary staff.
  - HPS topics that have been presented in this academic year include:
    - Inferior MI with RV involvement - bradycardic arrest
    - Ant MI with V-fib arrest
    - Poly trauma pt (CHI/ pelvic smash)
    - Hyperkalemia / Digoxin toxicity
    - Status asthmaticus
    - Necrotizing Fasciitis / Septic shock
    - B-Blocker overdose
    - Respiratory Failure secondary to pneumonia
    - Aortic Dissection
    - Acute Anaphylaxis
    - Massive PE with obstructive shock
    - Status epilepticus / septic shock
    - Acute pulmonary edema
    - Bradycardia arrest / pacemaker insertion

PROGRAM SPECIFIC QUESTIONS

CCFP-EM 34 Describe the means by which Residents are taught the principles of quality assurance and quality management in the context of emergency care.

- Scholarly activity: several Residents chose to undertake or contribute to a QI project for their scholarly activity.
- Quarterly Grand Rounds given by the lead physician from the Safety Committee: these involve reviews of cases brought to the attention of the Safety Committee.
- Several Residents sit in on QI initiatives/reviews to gain more exposure to the health advocate role.

CCFP-EM 35 If there is no specific pre-hospital care rotation, describe how the Residents earn the necessary knowledge and skills in this area.

- Residents have the opportunity to learn this skill via several methods. They can listen in on RAPID calls (the referral service for Alberta) with their staff physician. If appropriate, the staff will let the Resident provide closely supervised advice during the referral process from outside physicians.
- Residents can also apply for a STARS pre-hospital elective or EMS ride along(s). They are provided with the EMS contact at the start of their year. One current Resident completed a 2 weeks EMS elective this year.
- There is also didactic teaching on pre-hospital care during their academic day.

CCFP-EM 36 Describe the means by which Residents learn the administrative skills necessary to serve as an effective resource to a hospital emergency department.

- Teaching of administration occurs through:
    - Weekly department grand rounds (issues of departmental interest are often discussed)
    - Resident Training Committee
    - Informal discussion during the annual retreat. We discuss issues of department administration as it pertains to education with the Residents
    - Resident participation in administrative meetings in the last few months of their residency. Residents choose between Site Operations Committees, Patient Safety Committee and Physicians Executive Committee. Our Deputy Regional Department Head, QI lead, Information technology director and two of the adult hospital Site Chiefs are key CFPC-EM faculty members. They provide specific instruction in a debriefing session after the meeting and act as administrative role models for the Residents.

CCFP-EM 37 If there is a rural emergency rotation as part of the program please describe it for the survey team or indicate how Resident learn the context of rurally based emergency physicians.

- The one-month rotation in Banff is a rural Emergency Medicine rotation. The rotation is highly regarded for its volume of orthopaedic trauma from the ski resorts and the Trans-Canada Highway. There is specialist back up in the disciplines of general surgery, plastic surgery and orthopaedic surgery. There is limited imaging and no CT scanner. The

Residents get a lot of experience in referring to a tertiary care centre and learning how to manage patients with somewhat limited resources.

- As of the 2012/2013 academic year, the Residents have been scheduled in a community hospital or rural emergency department. These sites include Lethbridge, Red Deer and Yellowknife. These rotations have been very popular with the Residents. Although our Residents have usually already completed rural FM rotations in their Family Medicine programs we find that this rotation solidifies their skills and knowledge regarding the realities of rural Emergency Medicine practice.

Category 1 Program

Please complete a form for each Category 1 program.

PROGRAM NAME: Family Practice-Anaesthesia

GENERAL STANDARDS

A) PRINCIPLES AND OBJECTIVES

As part of the questionnaire, please append one copy of the goals and educational objectives of the training program plus any mission statement that the program may have.

FP-A Appendix A: Goals and Objectives
FP-A Appendix B: Curriculum

FP-A 11 Describe the mechanisms by which the goals and educational objectives of the training program are distributed to Residents and faculty and indicate the date at which they were last reviewed by the program.

- The Goals and Objectives for FP-A as well as the Curriculum are given directly to the Residents at the start of the Residency. These are also available to Faculty to review at any time on the Department website, and the Daily Assessment form is structured to reflect the curriculum in order to assess attainment of educational goals, therefore faculty and Residents review them on a daily basis.
- The Goals and Objectives were last reviewed in June 2014 by the FP-A Residency Training Committee and the FP-A Program Director.

FP-A Appendix A: Goals and Objectives
FP-A Appendix B: Curriculum

FP-A 12 Describe the mechanism by which the educational objectives are discussed with the Residents.

There is an initial review of all goals and objectives with the Resident at the beginning of the year. Reassessment of attainment of goals and objectives are conducted on a daily basis by the Resident and Preceptors. The goals are reviewed in the daily assessment, and the objectives are reviewed primarily by the Resident in maintaining a logbook-journal of achieved objectives. This confirms that Residents have achieved of all curriculum objectives specific to the FP-Anesthesia Program.

FP-A 13 Describe the structures and ways in which the program's goals and objectives are communicated to the specialty faculty responsible for teaching family medicine Residents.

The Program's goals and objectives are communicated to the specialty faculty responsible for teaching Family Medicine Residents through the Fellowship and Family Practice Residency Training Committee. Specialty faculty are fully aware of the Program's current goals and objectives, as the Residents have a logbook based on objectives that they review with faculty to whom they are clinically assigned daily, and the daily assessments measure attainment of the program goals. In

addition, rounds include discussion of FP-Anesthesia training and review of unique features of the FP-Anesthesia training to ensure that involved Royal College specialist Preceptors are aware of the specific training objectives.

FP-A Appendix D: Daily Resident Evaluation
FP-A Appendix C: FP-Anesthesia Resident Logbook

B) EVALUATION

I. Program Evaluation

FP-A 14 Describe the process by which the program evaluates all educational experiences of the curriculum. Include a description of how Residents are involved in this process.

The FP-A Residency Training Committee, which includes Resident representatives, requests feedback from the Residents regarding the wide variety of educational structures including core program evaluations, evaluations of conferences and visiting professors. A reflective CanMeds-FM exercise is also reviewed at least once per year (FP-A Appendix N).

The Residents also evaluate faculty on a daily basis (as outlined below and FP-A Appendix D) to give rapid and detailed feedback on clinical teaching.

FP-A 15 Describe the internal review process used by the Faculty of Medicine to evaluate the family medicine program between accreditation visits.

Every three years, or more frequently, faculty-wide internal reviews are conducted by the PGME office. Every Program is reviewed by a team consisting of a primary and a faculty reviewer (each of whom are Program Directors), a member of the PGME office (the Associate Dean or delegate), and a Resident reviewer.

II. Faculty Evaluation

FP-A 16 Describe the policies and procedures by which faculty members within the department of family medicine are evaluated for their teaching skills. Append any evaluation forms and/or policy statements.

Residents complete a daily evaluation of any faculty they work with. These evaluations are accessible by the RTC and the Program Director for review. Feedback on performance is given to each faculty member including a summary of the faculty member's evaluations relative to other faculty members.

Each clinical rotation is similarly evaluated on an aggregate basis, and teaching Core Program sessions are likewise evaluated specific to the faculty member involved.

In order to protect Resident anonymity within such a small program, all faculty feedback is combined with the Royal College Residents' faculty feedback for an aggregate yearly report.

FP-A Appendix F: Faculty Evaluation by Resident

III. Resident Evaluation

For this section, provide appendices of any forms used to collect data in any of the areas specified by questions below.

FP-A 17 Describe how the program coordinates Resident evaluation. In answering this question, please identify any individuals within the program with specific responsibility for evaluation or any committee structure that oversees the process. Append any policy statements or documents.

Daily assessment forms are completed by faculty at each hospital site. These assessments are then reviewed by the Hospital Site Coordinator for each clinical rotation and a monthly assessment is compiled. The site coordinators for the rotations are Dr. Graeme Bishop, Dr. Stephen Phillips, Dr. Kim Illing, Dr. Ruth Connors, and Dr. Bev Wilson. The monthly assessments are all reviewed by the FP-Anesthesia Program Director, Dr. Dan Wood. If there are any concerns or unsatisfactory assessments, the Resident is reviewed in depth by the Fellowship and Family Practice Anesthesia Residency Training Committee.

The current FP-A Director, Dr. Dan Wood, is a member of the Departments of Family Medicine and Anesthesia, University of Calgary, a currently certified CCFP Family Physician and FCFP Fellow, both with the College of Family Physicians of Canada, as well as a specialty Royal College Fellowship Anesthesiologist. Dr. Wood is responsible for assessment of Residents in the FP-A program and reports to the Enhanced Skills Program Training Committee in the Department of Family Medicine.

FP-A Appendix D: Daily Resident Evaluation Form
FP-A Appendix E: Monthly In Training Evaluation Form
FP-A Appendix G: Fellowship and Family Practice Anesthesia RTC Membership

FP-A 18 Describe the policies and procedures for the evaluation and supervision of Resident performance in the context of the family medicine settings.

Due to the focused nature of FP-A training, out of one year, one mandatory month is spent with exposure to FP-Anesthesia physicians in a rural setting in Yellowknife, NWT. During that month, the daily assessment system is used as described under question 17. Supervision of Residents is addressed within the program manual.

FP-A Appendix D: Daily Resident Evaluation Form
FP-A Appendix H: Resident Supervision Policy
Appendix P: PG FM Resident Supervision Policy

FP-A 19 Describe the policies and procedures for Resident evaluations and supervision on specialty rotations.

Eleven out of twelve months are primarily supervised by specialist Anesthesiologists. Daily assessments are completed by specialists, using the FP-Anesthesia goals and objectives based daily assessments. Supervision of Residents clinically adheres to program policy.

FP-A Appendix D: Daily Resident Evaluation Form
FP-A Appendix H: Resident Supervision Policy
Appendix P: PG FM Resident Supervision Policy

C) FACULTY DEVELOPMENT

FP-A 20 Describe how faculty development needs are assessed and describe the faculty development program offered to department members. Comment specifically on the resources within the department to support faculty development.

All faculty are Fellows of the Royal College except for the Family Physician-Anesthetist who coordinates the rural Rotation in Yellowknife. The Royal College Faculty maintain fellowship/membership by meeting Continuing Medical Education requirements. The academic opportunities are extensive for faculty as well as Residents. Academic events include weekly grand rounds, journal club meetings usually 5-6 times per year, a formal visiting professor program coordinated and supported by the Anesthesia Department 2-4 times per year and extensive involvement in academics related to teaching Residents in the form of preparation for mock oral exams, didactic teaching, simulator sessions and weekly teaching rounds. Rounds specific to FP-Anesthesia issues have also been presented, and faculty are appraised of FP-Anesthesia specific goals and concerns via Residency Training Committee communication.

Conferences include a yearly FP-Anesthesia conference that many local faculty attend and also teach at. Faculty attending this conference also obtain direct feedback from other practicing Family Physician-Anesthetists about important and key teaching topics for Residents.

FP-A 21 Describe the process by which faculty members, both those within the family medicine department and those with appointments in other disciplines, are evaluated for their teaching skills and how faculty development needs are determined.

Faculty members are evaluated for their teaching skills with daily teaching evaluations completed by Residents. Faculty also receive a formal evaluation, at minimum on a yearly basis, demonstrating the faculty member's performance in evaluations by Residents related to all other faculty peers. FP-A Residents participate in yearly voting for awards for the best clinical teachers. FP-A Resident teaching issues and reviews of FP-Anesthesia training issues have also been conducted at grand rounds and on an informal basis with faculty.

FP-A Appendix F: Teaching Faculty Evaluation

D) SCHOLARLY ACTIVITY

FP-A 22 Does the program offer support to the Residents for scholarly activity or research?

The program supports scholarly activity on several levels. There is the requirement that Residents are involved in teaching of their peers, including Royal College Anesthesia Residents. The teaching occurs at formalized teaching sessions and rounds preparation and presentations. Scholarly activity is promoted for each Resident to research and review relevant patient cases that the Resident has been involved with. Participation in the plethora of academic activities outlined (Q33) allows for significant scholarly activity.

In addition, FP-Anesthesia Residents have access to the expertise and assistance of the Research Co-ordinator and a Quality Assurance Co-ordinator within the Department of Anesthesia if the Resident wishes to pursue a particular quality assurance, practice audit or research project.

FP-A 23 What do you perceive to be the major strengths of your program?

The Program boasts focused training on core Anesthesia, clinical excellence, and extensive clinical and academic opportunities. This gives our trainees ample opportunity to experience the breadth of anesthetic practise and complications in the general adult, pediatric, trauma and emergency, and obstetrical populations.

The Program has a very strong focus on individualized education. Day to day Anesthesia teaching is delivered with a one-on-one faculty to Resident ratio. Extensive opportunities exist for didactic teaching, journal club involvement and focussed conference and a yearly FP-Anesthesia Resident retreat.

The structure of the Program is a strength with the Program Director holding both CCFP certification/membership and RCPC (Anesthesiology) fellowship. Involvement in the Anesthesia Residency Training Committee and academic cross appointments to the Departments of Anesthesia and Family Medicine ensures a Family Medicine training aspect to the necessarily focused Anesthesia training.

FP-A 24 What do you perceive to be the major weakness of your program?

The stability of the FP-Anesthesia rotation in Yellowknife is dependent on several logistic, funding, staffing issues and support of a remote clinical department. It is an excellent rotation for the Residents, but if difficulty maintaining it occurred in future then alternative arrangements with another rural community would need to be made.

The learner centred approach to achieving curriculum goals and objectives has the potential to also be a weakness if program follow up and feedback is not adequate, as the Program depends on a number of different academic avenues for a learner to achieve all learning objectives.
The curriculum and logbook journaling of goals and objectives achievement allows for ready assessment of individual Resident learning needs and helps identify to the Resident, faculty and Program Director what topics (if any) require extra learning.

We have not, however, identified specific examples of weakness in this learner-centred approach with a variety of high quality teaching avenues available, based on Resident feedback, exit interviews and attainment of goals with previous trainees.

FP-A 25 Can you identify issues you hope the survey team might be able to help to address?

The lack of a national certifying exam may involve some inconsistency amongst programs in Canada. The Calgary program has made strong efforts to integrate the Departments of Anesthesia and Family Medicine, as well as developing goals and objectives that follow the CFPC “Red Book” guidelines in an attempt to achieve a consistent and high quality educational program. However, there is no national examination supported by the CFPC, which is suboptimal.

As well, feedback on the larger issue of evolving to a competency based framework for Residency training and how our program’s use of a journal logbook approach to document goals and learning achievements may fit in to this structural change in Resident education would be helpful.

Substantial consideration and debate around adding another rural FP-Anesthesia rotation has previously occurred within the Program. Feedback has been considered from Residents completing the year and that feedback has repeatedly advised that the single month in Yellowknife fulfils our Resident needs, but more time in a rural location may give them more time in a more similar environment to where they may practice. The challenge is that many rural sites do not have the volume of patient cases in the Operating Room to allow Residents to maximize their time learning critical patient care skills. The rural Yellowknife FP-Anesthesia rotation fills the role of our Residents being Preceptored in a setting that models their practice setting post-graduation, with adequate volume. Any advice comparative to how other programs are structured nationwide would be appreciated as we consider the drawbacks and advantages of adding more rural rotations in the future.

FP-A 26 Describe future plans for the program in terms of curriculum resource changes.

The Program is aware of significant formative changes at the College of Family Physicians level, and will plan to integrate recommended curricula updates e.g. to a more competency based assessment process, once we have clear direction on this. As noted above (Q25) consideration to adding another rural rotation is also an ongoing consideration.

There are no changes anticipated in terms of resources or general program structure.

E) CURRICULUM

FP-A 27 List the rotations with the duration and training sites involved.

Each "block" is a four week duration, and is scheduled as below:

Rotation	Duration	Training Sites
General Adult Anesthesia	7 blocks	Calgary sites: Peter Lougheed Centre, Foothills Medical Centre and Rockyview General Hospital
Pediatric Anesthesia	3 blocks	Calgary site: Alberta Children's Hospital
Obstetric Anesthesia	2 blocks	Calgary sites: Peter Lougheed Centre and Foothills Medical Centre
Rural FP Anesthesia	1 block	Yellowknife hospital: Stanton Hospital
Vacation	1 block is taken total during the above rotations	
Elective	1 block is optional and dependent on Resident application. This would take the place of one of the General Adult Anesthesia blocks	

FP-A 28 Provide a narrative description of each rotation (both core and elective) outlining its strengths and weaknesses.

- **General Adult Anesthesia: 7 blocks**
  - Rotations done in Calgary at the Peter Lougheed Hospital, Foothills Hospital and the Rockyview Hospital. All sites include primary, secondary, and tertiary care and all have cases that would be similar to the work done in rural settings. There is a variety of

experience including Code team and Trauma team involvement at the Foothills Hospital. Daily one-on-one clinical involvement with a specialist Anesthesiologist is the primary strength of the training program.

- Strengths
  - Include intensive exposure to provision of anesthesia in a range of patients. The exposure to emergency and critically ill patients increases the range of experience of the Residents in being involved with complications and situations that they may manage infrequently in community practice but must have an approach, skills and framework to manage critical situations.
- Weaknesses
  - May include occasional clinical placement in cases that are more advanced than a FP-Anesthetist would be managing independently, but there is flexibility in the scheduling and this does not happen frequently.

- **Pediatric Anesthesia : 3 blocks**
  - Rotations at the Alberta Children's Hospital, daily clinical anesthesia with children and infants.
    - Strengths
      - Tertiary and community type care is provided.
    - Weaknesses
      - May include limited training slots for Residents and pressure for clinical placement by other learners. This can at times limit which clinical operating rooms/cases are available.
- **Obstetric Anesthesia : 2 blocks**
  - Generally each block at 2 different sites: Rockyview, PLC, or Foothills doing community and tertiary care Obstetric Anesthesia for labour and delivery. Obstetric anesthesia training is quite strong and includes both exposure to the expected healthy parturient requiring analgesia, exposure to emergency situations and exposure to tertiary level disease and complications. This is important in teaching Residents about cases that they may not see in a shorter low volume and acuity rotation.
- **Rural FP Anesthesia : 1 block**
  - Yellowknife Hospital – we have developed a formal link to the FP-Anesthesia department and rotation to include working primarily with FP-Anesthetists in a rural community setting.
    - Strengths
      - Family Physician Preceptors, exposure to rural issues, a broad variety of clinically challenging cases and the fact that Residents are exposed to this environment after the majority of their training base has been completed are strengths of this rotation. This rotation has historically been extremely well reviewed by FP-A Residents.
    - Weaknesses
      - Include the potential that logistics and funding support may become more challenging in the future, but are secure at present.

FP-A 29 Describe any horizontal experiences that complement the rotations noted above including half-day continuity of care clinics, etc.

Residents have the option and are encouraged to attend preoperative assessment clinics particularly in the latter stages of the Program. They have the ability to anesthetize patients seen in the clinic by choosing that patient's operating room on their day of surgery.

Residents are encouraged to continue engaging in Family Practice during their Residency. Most Residents practice independently during the Residency year, often completing Family Medicine locums during time not scheduled for Anesthesia training. The option to coordinate supervised Family Practice exposure for any Residents who prefer is also available.

FP-A Appendix I: Family Medicine Practice Policy

FP-A 30 Provide a sample Resident schedule.

Block	Resident schedule
1 (July 1-27, 2014)	Anna-Kristen Siy: Adult Anesthesia, Peter Lougheed Centre Mike Kapusta: Adult Anesthesia, Peter Lougheed Centre
2 (July 28-Aug 24)	Anna-Kristen Siy: Adult Anesthesia, Rockyview General Hospital Mike Kapusta: Obstetric Anesthesia, Peter Lougheed Centre
3 (Aug 25-Sept 21)	Anna-Kristen Siy: Obstetric Anesthesia, Rockyview General Hospital Mike Kapusta: Adult Anesthesia, Rockyview General Hospital
4 (Sept 22-Oct 19)	Anna-Kristen Siy: Adult Anesthesia, Foothills Medical Centre Mike Kapusta: Adult Anesthesia, Foothills Medical Centre
5 (Oct 20-Nov 16)	Anna-Kristen Siy: Adult Anesthesia, Foothills Medical Centre Mike Kapusta: Adult Anesthesia, Foothills Medical Centre
6 (Nov 17-Dec14)	Anna-Kristen Siy: Obstetric Anesthesia, Peter Lougheed Centre Mike Kapusta: Obstetric Anesthesia, Rockyview General Hospital
7 (Dec 15, 2014-Jan 11, 2015)	Anna-Kristen Siy: Adult Anesthesia, Foothills Medical Centre Mike Kapusta: Adult Anesthesia, Foothills Medical Centre
8 (Jan 12-Feb 8)	Anna-Kristen Siy: Pediatric Anesthesia, Alberta Children's Hospital Mike Kapusta: Pediatric Anesthesia, Alberta Children's Hospital
9 (Feb 9-March 8)	Anna-Kristen Siy: Pediatric Anesthesia, Alberta Children's Hospital Mike Kapusta: Pediatric Anesthesia, Alberta Children's Hospital
10 (March 9-April 5)	Anna-Kristen Siy: Pediatric Anesthesia, Alberta Children's Hospital Mike Kapusta: Pediatric Anesthesia, Alberta Children's Hospital
11 (April 6-May 3)	Anna-Kristen Siy: Rural FP-Anesthesia, Yellowknife NWT Mike Kapusta: Adult Anesthesia, Peter Lougheed Centre
12 (May 4-May 31)	Anna-Kristen Siy: Adult Anesthesia, Peter Lougheed Centre Mike Kapusta: Rural FP-Anesthesia, Yellowknife NWT
13 (June 1-June 30)	Anna-Kristen Siy: Adult Anesthesia, Peter Lougheed Centre Mike Kapusta: Adult Anesthesia, Peter Lougheed Centre

FP-A 31 Describe how the Residents are taught to apply the principles of evidence-based practice in the context of this program.

Many didactic core sessions include components of evidence-based practice. Clinical teaching, often daily, by Anesthesia faculty includes discussion and application of evidence-based measures. In addition, teaching rounds, weekly grand rounds and visiting professor programs include significant review of evidence based clinical practices.

FP-A 32 Describe the teaching of bioethics and medical-legal aspects of practice in the program.

There is a full day workshop on ethics that is provided by the Postgraduate Medical Education office that is mandatory for all Residents. There is also an opportunity to participate in an annual Medico-Legal Day, dealing with mock court medical issues in combination with the Law Faculty.
Daily teaching and mentoring is undertaken by faculty as these issues relate to clinical management of patients.

FP-A 33 Outline the program of seminars and didactic sessions that comprise the academic component of the program.

The FP-Anesthesia Program curriculum is structured to align with the Goals and Objectives as well as the Logbook which serves to document achieved Curriculum goals. The teaching that enables this is very broad and encompasses many different learning opportunities.

FP-A Appendix O: Seminars and didactic sessions

Category 1 Program

Please complete a form for each Category 1 program.

PROGRAM NAME: Family Medicine – Care of the Elderly

GENERAL STANDARDS

A) PRINCIPLES AND OBJECTIVES

CoE 11 Describe the mechanisms by which the goals and educational objectives of the training program are distributed to Residents and faculty and indicate the date at which they were last reviewed by the program.

Prior to starting the CoE Program Residents are given an electronic and hard copy of the Care of the Elderly Residency Training Manual (CoE Appendix A) which contains the overall goals and objectives of the Care of the Elderly Training Program in addition to rotation specific goals and objectives. Residents are encouraged to review these goals and objectives prior to staring the program and each rotation.

The goals and educational objectives and changes that have been approved by the Residency Program Committee are circulated electronically to the entire faculty. Residents are given the goals and objectives at the time of orientation at the beginning of the rotation. The goals and educational objectives were last reviewed by the program in June 2014

CoE 12 Describe the mechanism by which the educational objectives are discussed with the Residents.

Upon enrolment into the CoE Program, the Resident has an orientation meeting with the CoE Program Director (immediately prior to or on the first day the Resident begins) in order to review the educational objectives. Thereafter, educational objectives are reviewed formally during the monthly meeting with the CoE Program Director. Residents are encouraged to review the rotation specific goals and objectives of each rotation prior to the start date. This assists the Resident in writing up their own learning goals which they can expect to achieve during the rotation.

CoE 13 Describe the structures and ways in which the program's goals and objectives are communicated to the specialty faculty responsible for teaching family medicine Residents.

Each specialty faculty member receives an email and a hard copy of the Care of the Elderly Residency Training Manual (CoE Appendix A), which includes the overall goals and educational objectives of the program, as well as rotation-specific objectives. At the start of the rotation, faculty members are also emailed a copy of the rotation specific objectives for quick reference.

B) EVALUATION

I. Program Evaluation

CoE 14 Describe the process by which the program evaluates all educational experiences of the curriculum. Include a description of how Residents are involved in this process.

The Resident has the opportunity of formally evaluating each rotation by completing an end-of-rotation evaluation of block/longitudinal rotation (CoE Appendix A, pgs 204-206 and 208-211) as well as a final program evaluation (CoE Appendix A, pgs 217-219). These are discussed at the CoE RPC meetings. Academic half days are evaluated by Residents to provide information on the relevance of the topic to training as well as the teaching methods used by the various presenters. Preceptor evaluation is also completed on the online "one 45" evaluation system and a composite report sent to Preceptors and presenters to encourage further development in their teaching.

Feedback from faculty is also sought and they are encouraged to provide feedback on the educational experiences of the Resident as well as how the program can improve the learning experience of the Residents. This process has informed a lot of changes in the Program especially the recent move to adopt a 1 year Program for recent graduates from family medicine training programs with expanded elective options and core rotations such as Geriatric Psychiatry.

The Residency Training Committee has a Resident member and program evaluation is discussed at RTC meetings. Resident evaluations and suggestions for improvements from both Residents and faculty are discussed at these meetings. When changes are being contemplated, the Resident member is invited to comment upon these changes and time is given to communicate these changes to the other Residents prior to implementing these changes.

CoE 15 Describe the internal review process used by the Faculty of Medicine to evaluate the family medicine program between accreditation visits.

Every three years faculty-wide internal reviews are conducted by the PGME office. Every program is reviewed by a team consisting of a primary and a faculty reviewer (each of whom are program directors), a member of the PGME office (the associate dean or the director), and a Resident reviewer. Each Program Director is responsible for conducting 1-2 reviews of other programs.

II. Faculty Evaluation

CoE 16 Describe the policies and procedures by which faculty members within the department of family medicine are evaluated for their teaching skills. Append any evaluation forms and/or policy statements.

The Resident completes a Preceptor evaluation on the "One45" software and anonymity is maintained as a composite report is sent to the Preceptor at the end of the year. Feedback to each Preceptor is provided once a year (CoE Appendix A, pgs 204-206). If more serious teaching problems occur they will be dealt with in a timely manner on an individual basis by a meeting with the CoE Program Director, Division Head and the Faculty member in question.

III. Resident Evaluation

For this section, provide appendices of any forms used to collect data in any of the areas specified by questions below.

CoE 17 Describe how the program coordinates Resident evaluation. In answering this question, please identify any individuals within the program with specific responsibility for evaluation or any committee structure that oversees the process. Append any policy statements or documents.

- In-training Evaluation Reports (ITERs)
  - The Resident is given both verbal and written feedback at the end of each rotation.
  - Rotations of up to 4 weeks have written mid (MRITER) and overall (MRITER) ITERs done via the One45 assessment and evaluation system (CoE Appendix A, pgs 156-159).
  - The Enhanced Skills Program Administrator sends ITERs to the Preceptors at the midpoint (MRITER) and end of the rotation (ORITER) and ensures these are completed in a timely manner. The CoE Program Director can then view completed ITERs via one45.
  - ITERs are discussed face to face by the Preceptor with the Resident at the time of completion.
- Monthly Progress Review Meetings
  - All assessments are discussed with the CoE Resident by the CoE Program Director during their monthly Resident-Program Director meeting. A Resident Progress Review sheet is completed at the end of these meetings (CoE Appendix B). Any problems around identified Resident academic performance are discussed at these meetings.
- Cases of poor performance
  - The primary assessment tool in CoE is the ITER, completed in "one45" at the end of all rotations. All ITERs are reviewed with the Resident at the monthly Progress Review meetings with the Program Director.
  - Any ITER with "red flags" or indicating rotation failure are immediately followed up by the CoE Program Director.
  - Any issues relating to Resident poor-performance are discussed at the Residency Program Committee meetings, and appropriate action recommended. This may be remediation and/or repeating the rotation.
  - Please refer to PGME Resident policies on Resident assessment in CoE training manual (CoE Appendix A, pgs 16-22).
- Longitudinal rotations (e.g. LTC and the geriatric OPD clinic)
  - Assessed with a mid-rotation ITERs which is completed at the end of 3 months, 6 months, and 9 months.
  - Preceptors and Residents are encouraged to use the formative electronic and hard copy assessment tools regularly to assess the Resident. The assessment tools inform completion of the ITERs at the 3 month intervals and ensures the Resident receives formal structured feedback at regular intervals.

CoE 18 Describe the policies and procedures for the evaluation and supervision of Resident performance in the context of the family medicine settings.

The Resident and Preceptor have copies of the overall and rotation specific objectives of the CoE Program. At the start of the rotation the Preceptor and Resident review these objectives and discuss this in line with the learning objectives of the Resident for the rotation. There is mid rotation review of the objectives to ensure that the Resident learning objectives of the rotation are

being met and the Resident is achieving the level of competency that is acceptable. The objectives of the rotation, which includes the expected competencies, forms the basis of the assessment of the Resident on the web based "One 45" that is completed at the midpoint and end of the rotation.

There are also other formative assessment tools that are used on a regular basis to assess the Residents' ongoing performance such as Mini CEX (Mini Structure Clinical Exam), direct observation, team STACER (Structured Assessment of Clinical Encounter), and self-assessment tools (CoE Appendix A, pgs 220-222 and 236-239).

The CoE Program Director also goes over learning objectives with the Resident to ensure that they are being met and in line with the stated program goals and objectives. The Resident is encouraged to participate in self-assessment and actively seek feedback from Preceptors on a regular basis. (A summary of the overall assessment framework, all assessment tools, and the Resident Assessment policy is provided in the CoE Residency Training Manual. This acts as a road map for CoE Resident assessment (CoE Appendix A, pgs 156-158).

Residents receive direct supervision of performance by a family physician in the context of any family medicine settings. Supervision is by direct contact and by phone, email, or fax (during on call times or when Residents are engaged in routine self-follow up of patients). Residents also have direct interactions with members of the multidisciplinary team and collaborative care is central to the health care of the Elderly patient. Members of the team are sometimes called upon to participate in the final rotation assessment of the Resident. This is done using the Multi Source Feedback Form (MSF) and incorporated into the completion of the ITERs (CoE Appendix C).

CoE 19 Describe the policies and procedures for Resident evaluations and supervision on specialty rotations.

The Resident and Preceptor have copies of the overall and rotation specific goals and objectives for the ES Resident in Care of the Elderly Medicine Program, which incorporate the CANMEDS-FM roles and are centred in family medicine. At the start of the rotation the Preceptor and Resident go over personal learning objectives of the Resident in line with the stated program objectives for the rotation. There is mid-rotation review of the objectives to ensure that the Resident learning objectives of the rotation are being met and the Resident is achieving the expected competencies. The objectives of the rotation, which includes the expected competencies, form the basis of the assessment of the Resident on the web based "One 45" that is completed at the midpoint and end of the rotation.

The CoE Program Director also goes over these objectives with the Resident to ensure that they are being met and in line with the stated program goals and objectives.

Residents receive direct supervision of performance by a specialty physician during the following:

- Acute care Inpatient Geriatric consult rotation
- Geriatric Psychiatry outpatient clinic
- Specialized Geriatric outpatient clinic

Supervision is by direct contact and communication by phone, email, or fax (during on call times or when Residents are engaged in routine self-follow up of patients).

Formative assessment tools are used in addition to completion of ITERs and include:

- Mini CEX
- Direct observation
- Team STACER
- CanMEDs letter review

Residents also have direct interactions with members of the multidisciplinary team and collaborative care is central to the health Care of the Elderly patient. Members of the team are sometimes called upon to participate in the final rotation assessment of the Resident using Multi Source Feedback Form (MSF) (CoE Appendix C).

C) FACULTY DEVELOPMENT

CoE 20 Describe how faculty development needs are assessed and describe the faculty development program offered to department members. Comment specifically on the resources within the department to support faculty development.

The Care of the Elderly Program Director is a member of the ES RPC. Faculty development needs across the ES training programs are discussed at committee meetings and educational events are developed to address these needs.

Several faculty development programs are open to all faculty members. The CoE PD routinely sends out this information to faculty involved in the CoE Program, as a reminder to take advantage of these teaching sessions provided locally by:

- Postgraduate Medical Education (PGME)
- Office of Faculty Development, Cumming School of Medicine
- Department of Family Medicine: annual faculty development conference, "Fall Together", open to all teaching faculty and overseen by the DFM CPD Director

A yearly educational retreat in the winter is organized by the CoE Program to address specific needs that have been identified from review of Preceptor and Resident assessment and assessments. Attendees include Preceptors in the program and alumni of the CoE program. Valuable feedback on future topics informs the design of the next session. In the past these sessions have included:

- Teaching CanMEDs-FM roles
- Curriculum review and development of LTC curriculum
- The use of various formative assessment tools (e.g. the Mini CEX)

CoE 21 Describe the process by which faculty members, both those within the family medicine department and those with appointments in other disciplines, are evaluated for their teaching skills and how faculty development needs are determined.

- Preceptor evaluation & Rotation Evaluations:
  - Completed by Residents at the end of each block via the "One45" system
  - Resident anonymity is maintained
  - Results are compiled and discussed at the CoE RTC
  - Common themes inform faculty development planning, including the annual educational retreat for CoE faculty

- Specific concerns raised about faculty members outside of the DFM, are relayed by the CoE PD to the division head/ rotation co-coordinator

D) SCHOLARLY ACTIVITY

CoE 22 Does the program offer support to the Residents for scholarly activity or research?

- Six-month program:
  - Residents complete a written critical appraisal of the literature on a CoE topic of their choice and present this orally
  - A quality assurance or improvement project can also be done during the six month program
- One-year program
  - Residents develop and complete a research project around a topic relevant to the health care of the elderly
  - Written and oral presentations of research findings are presented at the annual CoE education retreat; Residents are also encouraged to present their work at the annual
    - Family Medicine Forum
    - the Canadian Geriatric Society meeting
    - Geriatrics subspecialty training program Residents' Research Day
- DFM supports for Residents' Scholarly work:
  - CoE PD discusses Residents' research interests within the first few days of the program
  - DFM Research Director & members of the research hub, with expertise in both qualitative and quantitative research methods, meet with the COE PD & Resident in the first week of program to discuss research needs and resources, providing guidance as required on:
    - developing the research question
    - research methods and design
    - ethics application
- The Research Director from the Geriatric Medicine Program is also an identified resource for Residents to complete a research or QI project. She is available to meet with the Residents within the first few days of the CoE Program. Research supervisors are identified based on the research interest and the research topic the Resident selects.
- Health Sciences Library U of C
  - Provides 1:1 or group sessions on literature search reviews and appropriate citing of references in scholarly and research projects
  - Information regarding library support is provided to the Residents during the Enhanced Skills Resident Orientation in July and the CoE Program Orientation that occurs at the beginning of the Program
- The Resident is expected to participate in and present a current article in the monthly Geriatric Journal Club and bimonthly Frail Journal Club. The presentation of articles in the Geriatric Journal Club is based on published criteria for the critical appraisal of clinical journals and is designed to promote evidence-based practice. Resident presentations are assessed and feedback provided to the Resident. Monthly JAPES (Journals, Aging, Presentation, and Ethics) academic ½ day, which is a program that runs in collaboration with the Residents from the Geriatric Internal Medicine Training Program, incorporates critical appraisal skills by having Residents review landmark journal articles in geriatrics (CoE Appendix D).

- There are also monthly Resident presentations organised by the Division of Geriatric Medicine on the second Wednesday of every month. The Care of the Elderly Resident is expected to attend and participate in presentations at these rounds.
- The Care of the Elderly Resident also participates in Teaching of the R1/R2 Family Medicine Residents on topics related to the Health Care of the Elderly. Resident involvement in Course V, aging and neurosciences, for the medical students is also encouraged to develop skills in small group teaching methods.
- Academic half days occur on Thursday afternoons. Residents are expected to participate actively in presentations with appropriate faculty supervision. Topics for academic half days are selected from the CoE Program learning goals and objectives. Resident input into the topics for presentation is solicited at the start of the program. (CoE Appendix A, pgs 150-154).

CoE 23 What do you perceive to be the major strengths of your program?

- The commitment of the faculty members (Preceptors) required to meet the learning objectives for the Care of the Elderly Program
- The support of the Department of Family Medicine and the Associate Dean, Postgraduate Medical Education
- Funding for Residents at an Enhanced Skills level
- Adequate resources for CoE Program delivery
- The ability of the Resident to contribute to his or her own learning experience with expanded elective options in addition to scheduled core rotations
- A strong core of family physicians to act as Preceptors and mentors for the Resident
- The longitudinal rotation in specialized Geriatric outpatient weekly clinics, which is Resident-run with faculty supervision, ensuring continuity of care that is comprehensive and community based
- The long term care longitudinal rotation within the CoE Program with support and input from the LTC medical directors in Calgary
- The support of the Department of Family Medicine and the College of Family Physicians of Canada for Enhanced Skills Programs.
- A collegial, interactive and mutually beneficial relationship with the Division of Geriatric Medicine and Geriatric Psychiatry at the University of Calgary
- Strong Support from the COE program alumni and past Program Director

CoE 24 What do you perceive to be the major weakness of your program?

Previously identified weaknesses in the CoE Program have been addressed with the current structure of the 1 year program. There is now expanded elective time and learning opportunities in community based geriatric and psychiatry programs. The home based geriatric consult team is now an established program providing learning opportunities for Residents. There is still room to expand on available community resources such as the primary care network geriatric assessment programs.

CoE 25 Can you identify issues you hope the survey team might be able to help to address?

None identified at this time.

CoE 26 Describe future plans for the program in terms of curriculum resource changes.

Incorporating blended learning approaches such as moderated online learning activities incorporating use of online discussion boards. The new "Desire2learn" learning management system in the University of Calgary will be explored to achieve this goal.

Development of blended learning approaches will complement expansion of the six month program for return from practice family physicians wishing to enhance their skills in care of the elderly as they can be in different training sites while participating in core curricular content.

E) CURRICULUM

CoE 27 List the rotations with the duration and training sites involved.

One year rotation:

Rotation	Duration	Site	Rotation Coordinator
Acute Care Geriatric Consultation Service	8 Weeks	FMC and RGH	Dr. Darren Burback Clinical Associate Professor and Geriatrician Division of Geriatric Medicine
Inpatient Geriatric Assessment and Rehabilitation	8 Weeks	RGH	Dr. Maureen Murray Family Physician Department of Family Medicine
Geriatric Psychiatry	8 Weeks	RGH/ Community	Dr. Suparna Madan Clinical Assistant Professor and Geriatric Psychiatrist Department of Geriatric Psychiatry
Community Geriatrics	8 Weeks	C3 Sarcee/ Day hospital South/ High Risk Foot and Wound Clinic	Dr. Diana Turner Clinical Lecturer and Care of the Elderly Physician, Department of Family Medicine
Rural Geriatrics program	4 Weeks	Community	Dr. Joel Weaver Care of the Elderly Physician Department of Family Medicine, University of Alberta
Electives	8 Weeks	Various sites. See elective options (CoE Appendix A, pg 6)	Dr. Vivian Ewa Clinical Assistant Professor and Program Director, Care of the Elderly Residency Program, Department of Family Medicine
Research	8 Weeks		Dr. Chowdhury Research Director and Assistant Professor Department of Family Medicine
Longitudinal Long term Care	1year/ 1 half day per week	Intercare/ Carewest Continuing Care Facilities	Dr. Paddy Quail Clinical Assistant Professor, Department of Family Medicine
Longitudinal OPD Specialized Geriatric Clinic	1year/ 1 half day per week	Bridgeland Seniors Health Clinic	Dr. Paula Pearce Clinical Lecturer and Program Director Geriatric Internal Medicine Training Program

Six month rotation:

Rotation	Duration	Site	Rotation Coordinator
Acute Care Geriatric Consultation service	1 month	FMC and RGH	Dr. Darren Burback Clinical Associate Professor and Geriatrician Division of Geriatric Medicine
Inpatient Geriatric Assessment and Rehabilitation	1 month	RGH	Dr. Maureen Murray Family Physician Department of Family Medicine
Geriatric Psychiatry	1 month	RGH/ Community	Dr. Suparna Madan Clinical Assistant Professor and Geriatric Psychiatrist Department of Geriatric Psychiatry
Community Geriatrics	1 month	C3 Sarcee/ Day Hospital South/ High Risk Foot and Wound Clinic	Dr. Diana Turner Clinical Lecturer and Care of the Elderly Physician, Department of Family Medicine
Electives	1 month	Various sites. See elective options (CoE Appendix A, pg 6)	Dr. Vivian Ewa Clinical Assistant Professor and Program Director, Care of the Elderly Residency Program, Department of Family Medicine
Audit/ Literature Review/ research	1 month		Dr. Chowdhury Research Director and Assistant Professor Department of Family Medicine
Longitudinal Long term Care	6 months/ 1 half day per week	Intercare/Carewest Continuing Care Facilities	Dr. Paddy Quail Clinical Assistant Professor, Department of Family Medicine
Longitudinal OPD Specialized Geriatric Clinic	6 months/ 1 half day per week	Bridgeland Seniors Health Clinic	Dr. Paula Pearce Clinical Lecturer Division of Geriatric Medicine

CoE 28 Provide a narrative description of each rotation (both core and elective) outlining its strengths and weaknesses.

- **Inpatient Geriatric Assessment and Rehabilitation Program (GARP)**
  - The GARP unit is a 60-bed in patient geriatric assessment and rehabilitation program at the Rockyview General Hospital. The program is staffed by family physicians with a special interest and enhanced clinical skills in care of the elderly. Occupancy rates in this Program are usually above 98%. The Program accepts patients with multiple comorbidities who reside in the Alberta Health Services Calgary Zone. Focus of care is on interdisciplinary assessments and rehabilitation services to maximize functional independence and facilitate discharge plans. The Program also offers a full range of acute care services to assist in the medical management of patients with multiple comorbidities.

- Strengths
  - Family physician Preceptors and mentors who are highly skilled in the care of the elderly
  - Interaction with an interdisciplinary team, including weekly case management conferences with the entire team and the consulting Internal medicine-Geriatrician. Routine patient-family-team conferences.
  - A broad range of diagnostic and rehabilitation challenges that will result in development of enhanced clinical and case management skill in the care of the elderly.
  - An opportunity for acute care experience in management of the elderly patient.
  - The Resident also has the opportunity of teaching clinical clerks, R1/R2 Residents rotating through the unit.
  - Weekly didactic teachings with the other learners on the rotation.
- Weaknesses
  - Multiple leaners may be present during certain blocks. In this situation, the ES Resident acts as the senior Resident on the unit.

- **Acute Care Geriatric Consultation Services**
  - The inpatient Geriatric Consultation Service provides consultations for the frail older adult on the acute care units. These patients have complex biomedical, psychosocial, cognitive and functional problems, and have been admitted with acute exacerbations of chronic problems, acute onset of new problems and/or acute conditions superimposed on chronic medical problems. These frail individuals require the expertise of health care workers specializing in the care of the elderly. The team is made up of a Geriatrician and clinical nurse specialist. An average of 10 to 12 referrals from acute medical, surgical and orthopaedic units are seen in a week. Referrals range from Comprehensive geriatric assessment, Cognitive assessment, Capacity assessment, Delirium management and assist in discharge planning. Post-operative Delirium and need for rehabilitation post prolonged Hospitalisation also constitutes a bulk of the consults. Learning experiences in care of the hospitalized elderly patient, complex medical management, addressing therapeutic competition and end of life care are obtained during this rotation. Daily sign in rounds are held by the clinical team to review new consults and follow up patients. These rounds provide excellent teaching and opportunity to review evidence based care in the hospitalized elderly patient.
  - Lunch time teaching rounds occur at the Foothills medical centre on Friday afternoons. The Resident spends 4 weeks at the FMC site and 4 weeks at the RGH site. These two sites vary in the types of referrals that are received so exposure to both sites provides an increased opportunity for exposure to a wide range of complex medical and rehabilitation referrals
    - Strengths
      - Opportunity to develop skills in the management of the Hospitalized elderly patient.
      - Development of skills in recognizing and managing post op delirium
      - Wide variety of clinical cases and an opportunity to advocate for care appropriate for the elderly patient in hospital.
      - Collaborative care with a multidisciplinary team and attending team with regards to management of medical conditions and appropriate discharge planning process.
      - Opportunity to identify patients requiring ongoing assessment following the acute inpatient stay, with the capacity for the Resident to follow up

their own patients within the structure of the Longitudinal Clinic (CoE Appendix E).
        - Opportunity to develop supervisory skills of clinical clerks and junior Residents.
        - Opportunity to develop consultative skills in the assessment of complex older hospitalized patients.
    - Weaknesses
        - When the service is busy there may not be enough opportunities for teaching. To offset this dedicated teaching now held on Friday afternoons at the FMC site.
        - Multiple Preceptors may be involved in the training of the Resident.

- **Specialized Geriatric Outpatient Clinics**
    - The outpatient Specialized Geriatric outpatient clinics provide comprehensive assessment services to frail elderly individuals with complex medical, cognitive and functional concerns. Referrals are from hospital and community based Physicians, Community outreach workers and Home Care case managers. The clinic is staffed by Care of the Elderly Physicians, Geriatricians, Pharmacist, Nurse Practitioner, Dietician, Occupational therapists, Physiotherapists, and social workers.
    - The Resident has the opportunity of working one on one with a preceptor for two months prior to joining the Resident Run Clinic which takes place on Friday with faculty supervision. This gives the Resident the opportunity for graded professional responsibility to independent practice. Faculty supervision is dependent on the acquired level of competency of the Resident.
    - The fall prevention clinic is located at the Bridgeland site and has a special focus on elderly patients with recurrent falls who require a focused assessment on falls risk and interventions to reduce risk of falls. Home visits are a major part of this program. The Residents have various opportunities to participate in this program as an elective and during the acute care geriatrics rotation.
        - Strengths
            - Comprehensive, community based program providing continuity of care to the elderly patient.
            - A wide range of experience for common geriatric problems
            - Graded professional responsibility that prepares the Resident for independent practice in community based outpatient assessment of complex elderly patients.
            - Both family physician and IM-geriatrician Preceptors, who are highly skilled.
            - Involvement with multidisciplinary/ inter-professional teams. Collaboration with team members in developing management plans.
            - Enhanced knowledge of community based resources and how to access them.
            - Opportunity to learn from peers who are also running their own clinics at the same time.
            - Weekly staff-led “Case of the Week” discussions
            - Opportunity for direct observation of clinical skills decision making and communication skills.
        - Weaknesses
            - Longitudinal nature of the rotation may disrupt some of the other rotations.

- Multiple Preceptors as faculty members take turns in providing supervision to the clinic. This however allows for multiple observations of performance of the Resident.

- **Geriatric Psychiatry (Community and Hospital based)**
  - The Geriatric Psychiatry rotation is an 8 week block in which 4 weeks is spent in the community and the other 4 weeks is spent in the acute care hospital. In the hospital-based experience the learner has the opportunity to see referrals from acute medical and surgical inpatient units, liaise with mental health outreach teams (including accompanying outreach clinicians on home visits), geriatric rehabilitation units, geriatric psychiatry units, transitional units, and a shared care unit. Referrals range from agitated delirium, mood disorders (anxiety and depression), and difficult behaviours associated with dementia, review of Psychotropic medications, psychiatric complications of medical conditions and treatments and capacity assessments. The inpatient psychiatry unit enables Residents to participate in follow-up up of patients and work as part of a multi-disciplinary team. The Psychiatry Recovery and Rehabilitation program is a sub-acute program which operates under a shared care model between psychiatry and family medicine and has an interdisciplinary team. The focus is on mood disorders and opportunities to learn an approach to cognitive behavioural therapy exist.
  - The community based program provides learning opportunity in managing complex psychiatric issues in the elderly patient residing in continuing care facilities such as long term care and assisted living facilities as well as patients residing in their own homes. New consults are reviewed in conjunction with the geriatric psychiatrist. The Resident also has the opportunity of performing assessments with a clinical geriatric nurse specialist at these facilities. There is also an outpatient clinic at the Sheldon Chumir Health Centre and the Westbrook PCN clinic where referrals from community based family physicians are assessed.
    - Strengths
      - A wide range of experience for geriatric psychiatry problems in community and acute care sites.
      - A strong community experience and connection with the patient's primary care physician.
      - An opportunity to liaise with other community agencies.
      - Collaboration with multidisciplinary mental health teams, geriatric psychiatrists and family medicine Preceptors.
      - Excellent Preceptors who have a strong understanding of primary mental health care.
    - Weaknesses
      - Given the large geographical region of Calgary, there can be long travelling times between sites during the community rotation.
      - Longitudinal portions of the overall training program can sometimes interfere with the continuity of the rotation.
      - Limited didactic teaching in geriatric psychiatry, however this will be addressed in the future once Geriatric Psychiatry Residency Training Program in Calgary is running and formal lectures become available.

- **Community Geriatrics Program: C3/Day hospital/Geriatric High Risk Foot & Wound Clinic/ Home based Geriatric consult team**
  - **The Comprehensive Community Care for the Frail Elderly (C3):** This program provides care to frail community-dwelling seniors in a multidisciplinary team setting, with the goal of maintaining frail seniors in their home indefinitely. There are currently 2 sites

in the Calgary area though most of the training for the ES Residents occurs at the Sarcee Centre. The C3 rotation provides most of the community based geriatric experience and the Resident spends 4 half days there. Referrals can come from multiple sources which includes, home care, community and hospital based health care providers. Referrals are triaged and if the patient meets the inclusion criteria they are offered a 5-day trial admission. During the trial admission the patient meets and is reviewed by each member of the multidisciplinary team. If all parties are in agreement, the patient is formally admitted, with transfer of primary medical care to the programs family physician. Patients attend the program usually 2-3 days per week to engage in social activities, medical monitoring, and medication review, rehabilitation therapy and social work support services. Home care service is provided through the program, along with a telehealth monitoring service, transportation, on-site mobile lab service, and a 24-hour on call service to a program nurse and physician. There are five treatment and/or respite beds which are used for much needed respite to caregivers, early discharges from hospital, or to prevent hospital admission. Daily team meetings address patient care concerns, administrative and management issues, and promote optimal team functioning. The Resident is involved in the assessment of new patients as well as providing primary care patients already in the program. Comprehensive community based medical care that is centred in family medicine is provided. There is an opportunity for continuity of care as the Resident sees the patients over the 8 weeks rotation. The Preceptors in this rotation are family physicians with enhanced skills/ interest in health care of the elderly.

- **Day Hospital:** Provides comprehensive sub-acute rehabilitation from a multidisciplinary team to frail elderly individuals who are living in the community and are experiencing difficulties related to health and functional issues. The majority of referrals come from Home Care, specialized geriatric clinic physicians and from family physicians. Referrals are triaged through one line seniors' referral. This program differs significantly from the C3 program in that patients are enrolled only for an average of 3 months and the program's family physician acts only as a consultant and not as the primary care physician. The program prepares patients to return to the community, with supports at a level below that required by patients in continuing care or C3. In addition, for clients with dementia and their caregivers, a service focussed on their unique needs is offered one day per week. The Resident participates in comprehensive assessment of new patients and works collaboratively within the multidisciplinary team to develop care plans for patients admitted into the program.
- **The Geriatric and High Risk Foot and Wound Clinic:** provides a multidisciplinary team approach to foot and wound care. The team provides comprehensive wound care assessment and management in consultation with the patient's family physician. The Resident attends one half day a week and is supervised by a family physician with enhanced skills in the healthcare of the elderly and wound care management.
- **Home based Geriatric consult team: t**his is offered as part of the community geriatrics rotation as well as an elective option for the Resident interest in pursuing future practice in home based geriatric assessment and care of the elderly patient. The team is multidisciplinary with 2 family physicians trained in care of the elderly, a nurse practitioner, registered nurses, occupational therapists, physiotherapists and a pharmacist. Referrals are accepted from home care case managers and community family physicians. Referrals are broad and range from complex medical, cognitive, neuropsychiatric, medication review and disposition planning around transitions of care. The patients are mainly home bound with significant functional restriction requiring a home visit to assess their medical needs. Home visits are done by inter-

professional team members and the Resident has the opportunity to participate in these in home comprehensive geriatric assessments. Team rounds are held once a week on Wednesday afternoon. The Resident participates in these rounds where cases are discussed and a management plan is agreed upon. A letter is sent back to the referring physician with the agreed management plan.

- Strengths
  - The ability to follow frail community dwelling seniors as the primary care physician in the C3 program.
  - Through the Day Hospital and C3 program an opportunity to assess and manage patients with dementia and provide support and education to their caregivers.
  - C3 and Day Hospital provide community-based rehabilitation specifically to seniors.
  - Opportunity for in home assessment of the complex frail elderly patient with multi morbidity and functional limitation.
  - Very resourceful rotation with dedicated family physician Preceptors.
  - The Geriatric/ High Risk Foot and Wound Clinic is an important, first time, learning experience for the Residents on wound care. All Residents to date have remarked on this.
  - Collaboration with an inter-disciplinary community team based program.
  - Comprehensive community based program which enhances the knowledge and skill of the Resident for future community based geriatric practice including home based geriatric care.
  - Enhanced knowledge and skill in identifying and accessing community based resources.
- Weaknesses
  - The Geriatric and High Risk Foot and Wound Clinic is mainly observational.
  - The three community settings are located throughout the region and thus require significant travel for the Resident.
  - The home based geriatric program involves attendance at Wednesday rounds and home visits which makes for a very busy block. Residents are encouraged to pursue this as an elective experience.

- **Long Term Care Medicine**
  - During this rotation the Resident has the opportunity of following 8 to 12 patients for the duration of the program. It is longitudinal and involves weekly visits to the long term care facility. The Intercare Continuing Care Facilities and the Carewest Continuing Care Facilities have a core group of physicians that provide comprehensive Primary care mostly to the elderly population in these facilities. A multi-disciplinary team that includes the nurse, pharmacist, dietician and rehabilitation staff including recreation therapist are involved in the care of the patients. A comprehensive Geriatric assessment is done on new patients to the facility. In order to avoid acute care hospitalisation, attendance on site is desired in cases where there is acute deterioration in clinical status. Intake and annual care conferences are held on each patient. Three monthly medication reviews with the pharmacist are conducted on every patient. There are also teaching opportunities for the nursing and allied staff at the care centre. The Intercare group of physicians have a bi monthly journal club that the Resident attends and is required to present at least once during the year.
    - Strengths
      - Continuity of care.

- Comprehensive community based care to the elderly population in a facility.
- Development of skills in End of life care of the frail elderly patient.
- Working with and managing families, their expectations and needs.
- Opportunity for advocacy for the frail elderly population.
- Development of leadership skills as the leader of the team.
- Management of complex chronic medical conditions in the frail elderly.
- Ethical issues in Dementia and end stage chronic medical disorders are faced a lot and skills in addressing these are developed.
- Development of excellent communication skills with the patient, family, multi-disciplinary team and facility managers.
- Better understanding of the health care systems and transitions of care.
- Highly committed and skilled Preceptors who are family physicians skilled in care of the elderly Medicine
- Development of competencies in manager role including time management and use of scarce resources.

▪ Weaknesses
- The Resident has to make time to attend care conferences which may not necessarily coincide with their usual rounding times.
- Need to build more exposure to the role of the medical leader in this setting specifically medical staff oversight, quality and performance measurement.

- **Rural based Geriatric Program**
  - This 4 weeks rotation occurs in Lethbridge. It involves inpatient acute care geriatric assessments, outpatient and in-patient rehabilitation programs as well as outpatient clinic learning experience. The Resident also has the opportunity to participate in geriatric outreach programs that involves in home geriatric assessment of complex patients with functional limitations. The Resident works within a multidisciplinary team that involves a care of the elderly physician and other inter-professional health workers involved in health care of the elderly. There are numerous teaching opportunities for teaching and presentation at rounds. An outreach program involves visiting smaller rural communities and participating in geriatric assessment and provision of primary geriatric care.
    ▪ Strengths
    - Community based program involving comprehensive care.
    - Inter-professional learning and development of skills in working within a multidisciplinary setting.
    - Experience in rural based community geriatric care and resources available within the community.
    - Ability to appreciate and distinguish between services available in larger centres compared to the rural settings.
    - Better understanding of resource allocation.
    - Availability of funding for the rural based program.
    - Exposure of the Resident to rural communities and hence increasing the likelihood of practice in these communities

    ▪ Weaknesses
    - Being an out of town block Residents are unable to participate in academic half days and longitudinal rotations. Podcasting of academic half days is being explored to address this weakness.

- **Research/Scholar Project**
    - This block provides the Resident with the opportunity to develop on their research/ Literature review /QI Project. Time is spent on reviewing selected literature, data collection and analysis and writing up their report. Time is spent with the research Preceptor to assist in completing the project prior to the end of the program.
        - Strengths
            - Dedicated time for literature search, data collection and analysis and well as writing up the project.
            - Still have time for longitudinal rotations hence continuity of care is maintained.
            - Self-directed and hence requires motivation and commitment by Resident.
        - Weaknesses
            - None identified.
- **Electives**
    - The one-month elective may include one or more of the following: LTC medical administration, rehabilitation medicine, palliative care, and the home based geriatric consult team. Other areas related to seniors' health care can also be pursued as electives. The elective block provides the Resident an opportunity to individualize their learning experience according to their interests, however, it is structured so as to ensure program and personal learning objectives are met. The Resident may also choose to extend one of their core rotations during their elective time.
- **Palliative Care**
    - The regional Palliative Care Program provides inpatient and outpatient consultations. End of life palliative care is provided within five hospice centres. Alternatively, a Home Care or Long Term Care program exists to provide end of life palliative care within the patient's home or long term care facility. The Home Care program allows for the family physician to remain as the primary care physician or primary care can be transferred to the palliative care physician.
        - Strengths
            - Provision of comprehensive Palliative care services within the region.
            - Home based Palliative care program.
            - Development of skills in end of life care.
            -
        - Weaknesses
            - Multiple Preceptors at multiple sites.
            - May lack continuity of care as community programs mainly consultative.
- **Calgary West Central Senior's Health Clinic**
    - Primary care network geriatric assessment clinic. Multidisciplinary and designed for seniors with functional and cognitive decline in the community who require a comprehensive assessment and home visits to optimise medical status care in the community. More complex patients are referred to the specialized Geriatric clinics. The clinic is staffed by Family Physicians, Geriatric clinical nurse specialist and allied health personnel. A geriatrician geriatric psychiatrist are available for consultation on complex cases.
        - Strengths
            - Community based.
            - Family Physician as Preceptors.
            - Work with an interdisciplinary team.

        - Consultation model allows the Resident to develop skills in assessing complex older patients.
    - Weaknesses
        - Being a consultative model there is no continuity of care as patients are assessed and go back to their primary care physicians

- **Calgary Foothills Primary Care Network Navigation Team**
    - Focus is on Dementia, cognitive impairment coping with transitions, medication management and falls prevention. Referrals are from primary care physicians in the foothills primary care network. Goal is to support member physicians in the care of senior's with complex care needs. The team is made up of a social worker, clinical nurse specialist Geriatrics, social worker, pharmacist and occupational therapist.
        - Strengths
            - Community based involving in home assessments.
            - Multidisciplinary team.
            - Opportunity for leadership development in working with care teams.
            - Inter-professional learning
        - Weaknesses
            - Minimal physician involvement in assessments and care plan development.
            - No physician lead in these teams.
- **Rehabilitation Medicine**
    - This elective provides both inpatient and outpatient experience. There are four in-patient programs which include spine, brain injury, stroke, and general rehabilitation. In-patient consultations are assigned to one of these four services based on the nature of the presenting problem. There are five outpatient programs, which include the MS Clinic, Amputee Clinic, EMG/Nerve Conduction Clinic, Musculoskeletal Injury Unit, and Neurorehabilitation Unit.
        - Strengths
            - The Division of Rehabilitation Medicine has expanded physician numbers and services in Calgary Zone of the Alberta Health Services, which will improve the Residents' experience.
        - Weaknesses
            - Not specific to Care of the Elderly.
- **Movement Disorder Clinic**
    - This is a Specialty clinic involved in diagnosis and management of movement disorders. Referrals are received from community physicians and acute care Hospitals. Main reason for referrals is diagnosis and management of Parkinson's disease.
        - Strengths
            - Improved knowledge and skill in diagnosis and treatment of Parkinson's disease.
            - Improvement in knowledge of resources for persons with Parkinson's disease.
        - Weaknesses
            - No continuity of care.
            - High demand elective and so Residents have to book months in advance and may only get a couple of days.

CoE 29 Describe any horizontal experiences that complement the rotations noted above including half-day continuity of care clinics, etc.

In the Long Term Care rotation, the Resident acts as the primary care physician for 8-12 LTC patients as a horizontal component of the program. The Resident has one half day a week to see their patients and discuss them with their family physician Preceptor. This allows the Resident to develop the special clinical skill set required of medical staff that provides care in continuing care settings. In this capacity the Resident is expected to provide care to their designated patients according to the guidelines set out in the document "The Medical Service to Continuing Care – A Standard for Physician Practice" as set by Alberta Health Services (a copy of which the Resident has access to).

The Resident provides comprehensive care that is community based and centred in family medicine.

In the Specialized geriatrics outpatient clinic the Resident works with a preceptor in the clinic one half day a week for the first 2 months of the year. Subsequently the Resident is involved in the Resident run Friday clinic in which there is faculty supervision. The Resident is the primary physician performing the assessment of the patient and development of a management plan in collaboration with the other team members involved in the care of the patient. The case is then reviewed by the faculty supervisor at the end of the clinic. There is graded professional responsibility with faculty supervision dependent on the level of attained competence of the Resident. It is expected that the Resident progresses to independent practice in the course of the year. Residents see their patients in follow up and this provides an excellent opportunity for continuity of care. Additionally Residents have the opportunity to follow up patients identified during their acute inpatient rotations. This rotation provides the Resident an opportunity to enhance their clinical skills in the evaluation of elderly patients seen in outpatient assessment clinics. The longitudinal experience provides opportunity for learners to solve real life problems and learn from the consequences of various decisions that they do or do not make. Lifelong learning skills such as self-assessment and reflective practice are learnt during this and other longitudinal blocks.

There is also an opportunity for Residents if they desire to return to a half day continuing of care clinic in a primary care office.

Residents also attend weekly academic half days, LTC rounds, Family Medicine rounds, Geriatric Medicine divisional rounds & geriatric internal medicine journal club.

CoE 30 Provide a sample Resident schedule.

CoE Appendix A
CoE Appendix F

CoE 31 Describe how the Residents are taught to apply the principles of evidence-based practice in the context of this program.

During the academic half days there are sessions devoted to teaching evidence based medicine, critical appraisal skills, research topics, and writing and knowledge translation. The University of

Calgary library services also offers one on one session with Residents on systematic search of literature.

The Resident is expected to participate in and present a current article in the monthly Geriatric Journal Club. The presentation of articles in the Geriatric Journal Club is based on published criteria for the critical appraisal of clinical journals and is designed to promote evidence-based practice. Constructive feedback is provided by faculty members to the Resident at the end of the presentation to improve future performance. There is also an identified faculty member in the department of Family Medicine and the Division of Geriatrics that provides support and acts as a resource on how to apply evidence-based medicine to practice.

In the one-year program the Resident develops and completes a research project that involves developing a research question, performing a literature review using critical appraisal skills and designing the research using appropriate methods to answer the research question. The Resident meets with the research director and his team to discuss their ideas for research support is provided for the design and methods and ethics approval. Literature search is available on a one on one basis at the university of Calgary medical sciences library. A written and oral presentation of the research project is expected at the end of the program as well as presentation at scientific meetings of the Canadian Geriatric society and the family medicine forum.

In the six-month program the Resident does a critical appraisal of the literature to improve knowledge of the Care of the Elderly. This includes a written and oral presentation, and may include a quality assurance/improvement project in a senior care facility within the Calgary Zone.

CoE 32 Describe the teaching of bioethics and medical-legal aspects of practice in the program.

This is done through didactic teaching sessions and seminars during academic half days. Opportunities exist during the long term care rotations and Inpatient Geriatric consult service rotation for formal teaching of goals of care designation and advance care directives. The Alberta Adult Guardianship and Trusteeship Act, which covers the definition of capacity and when and who can perform a capacity assessment as well as the required forms for doing this, is covered in an academic half day teaching session. During the Geriatric psychiatry rotation capacity assessment is done routinely and teaching around this topic is also done.

Part of the academic half day program is a monthly session called JAPES which involves reviewing a Landmark Journal, aging and a system, an ethical issue and problem based learning. The ethical issue involves discussing an ethical issue that has had significant press attention or resulted in policy change in. This is discussed and debated by the Residents with faculty supervision (CoE Appendix D).

CoE 33 Outline the program of seminars and didactic sessions that comprise the academic component of the program.

CoE Appendix A, pgs 150-154

- Weekly academic half days (Thursday afternoons):
  - Core topics in Geriatric medicine to cover core components of the curriculum which are linked to the CanMEDS-FM roles.

    - Joint academic half day program with the Geriatric Residency training program from July to September; allows both programs to maximise available teaching resources.
    - Sept-June, the ES CoE Residents have their own academic half day program:
        - Self-directed learning modules through the American Geriatric society geriatric syllabus
    - Resident presentation at academic half days is encouraged, with facilitation by faculty members.
    - Invited speakers sometimes present seminars on topics such as advance care planning, guardianship and trusteeship, capacity assessment and transitions of care.
- Weekly didactic teaching and bedside teaching sessions:
    - Organized during the Acute Care Inpatient Geriatric rotation on Friday afternoons.
    - Staff-led case-based discussions are planned prior to each Longitudinal Clinic session. The Resident identifies their own learning point from the prior week's clinic and completes a brief literature search to inform discussion with staff and peers.
    - Didactic teaching sessions also occur during the Geriatric Psychiatric and the Inpatient Geriatric assessment and rehabilitation rotation.
- Monthly Rounds, Journal Club, & JAPES Academic ½ Day:
    - CoE Resident-led "meet the professor rounds" where Residents select topics that they can research and present to a faculty member. These are usually CoE specific topics and centred in family medicine.
    - JAPES (Journals, Aging, Presentation, and Ethics) academic ½ day which covers a landmark journal in geriatric medicine, an ethical issue, aging-related changes and problem based learning is done by both ES CoE Residents and the Geriatric Internal Medicine trainees on a monthly basis.
    - Geriatric Resident rounds presentations occur on the third Wednesday of the month. Constructive feedback is provided by faculty and peers at the end of the presentation.
    - Division of Geriatric Medicine Journal club occurs on the second Wednesday of the month. Both faculty and Residents have opportunities to present a recent journal article in geriatrics. Faculty and peer feedback is provided to the presenter. Residents are expected to present at least once during their Program.
    - Department of Geriatric Psychiatry also has journal club rounds in which the Resident is expected to present at least once during their 1 month rotation on Geriatric Psychiatry.
    - Division of Geriatric Medicine rounds occurs on the last Wednesday of the month. Case presentation varies between faculty and Residents. Topics are usually around a topical geriatric issue. Guest lecture presentation from Geriatric Psychiatry, Palliative care, Neurology and other visiting specialist sometimes occurs.
- The Resident also participates in the Frail Elderly Journal Club, which occurs every 2 months on a Thursday morning. Journals articles specific to long term care medicine are reviewed at these rounds. The Resident has an opportunity to present at these rounds.

PROGRAM SPECIFIC QUESTIONS

CoE 38 Outline how the program addresses the goal of preparing the Resident to provide community leadership in the area of geriatric services.

The longitudinal component of the Long Term Care Rotation provides an opportunity for leadership development as the Resident is the leader of the health care team for the patients assigned to

him/her. There are opportunities for health care decision making and education of the health care team. There is supervision by the Preceptor, however the Resident has the opportunity to influence care plans of the assigned patients. The Resident chairs the initial and annual multidisciplinary care conferences for their assigned patients, which enable them to develop their skills in team management, conflict resolution and managing difficult psychosocial/ family dynamics.

A number of CoE graduates have become medical directors of continuing care centres. This influence is largely due to the fact that the faculty members for the long term rotation are themselves program leaders and medical directors and provide role modelling which facilitates experiential learning opportunities in leadership for the CoE Residents.

There are elective opportunities in a number of innovative leadership programs in the Calgary Zone – Alberta Health Services that the Resident is encouraged to participate in. The CoE Resident is also a member of the CoE RPC and therefore has an opportunity to influence program development and policies. Involvement in quality improvement projects and elder friendly hospital initiatives is also encouraged to enable Residents to become more involved in program development.

Residents are enrolled in a self-directed leadership on line training program offered by the Canadian Medical Association. The program director facilitates this learning by moderating discussion groups amongst Residents around key points learned on line. These skills prepare the Resident for further leadership in the community.

CoE 39 Outline the program of seminars and didactic sessions that comprise the academic component of the care of the elderly curriculum.

Please see Question 33 and CoE Appendix G.

Category 2 Program

Please complete a form for each Category 2 program that is of 6 months duration or longer.

PROGRAM NAME: Family Medicine – Global Health

GH 1 If there is a common curriculum for all Residents, please provide this. Or, if the program is highly individualized, please provide a copy of the learning contract for each Resident.

There is no common curriculum for Global Health, but there are competencies formatted in the CanMEDS-FM roles (GH Appendix A). Please also see the learning proposals for the current Global Health Resident (GH Appendix B). Work on a more structured curriculum is currently underway.

GH 2 List the rotation with duration and training sites involved.

See below for examples of rotations that have been completed over the past 5 years:

Core and Elective Rotations	Duration	Training Sites
Arizona (pre-GH)	3 weeks	University of Arizona
Aboriginal Health	3-8 weeks	Elbow River Healing Lodge, Siksika Reserve, other sites globally
Immigrant and Refugee Health	3-8 weeks	Margaret Chisholm Center, CUPS, other sites globally
Inner City and Vulnerable Populations	3-8 weeks	CUPS Clinic, Drop-In Center, Dental Care, Pathways to Housing, Addiction Med consults, ODP, Alpha House Detox, Drumheller Institution (Prison Med)
Teaching and Learning	Ongoing	Undergraduate Medical School, Global Health Academic H-Day
Infectious Disease	2 weeks- 3 months	TB Clinic, Southern Alberta Clinic (HIV), Hep C Clinic, STI Clinic, Travel Med Tropical or Post-Travel Clinics, St. Paul's ID ward (Vancouver). DTM&H (London, UK or East Africa) or Gorgas Course (Peru)
Fieldwork or Research	3-9 months	Varies, anywhere across Canada or internationally

The current Global Health Resident's rotation schedule is provided in GH Appendix C.

Each Resident's course of study is tailored to their individual learning needs and interests, with an emphasis on clinical work locally or internationally. Some choose to focus on significant scholarly work, as well as coursework related to working in underserved settings or with specific marginalized populations, although time in non-clinical rotations and out-of-Province clinical rotations has recently become more constrained by recommendations developed by Joint Consultation Committee (AHS, PARA, and U of C).

GH 3 Provide a narrative description for each rotation.

Arizona Global Health Course: The University of Arizona Global health course, begun in 1982 and revised annually, is a multidisciplinary, case-based, problem-solving course preparing clinical students and Residents for health care experiences in developing countries.

This is a full-time (80 class hours), interactive course, with an optional medical/cultural weekend field trip, and a final grade based on examination and participation.
Aboriginal Health: This involves clinical and scholarly experiences around Aboriginal Medicine. Rotations take place in dedicated Aboriginal environments, typically community-based clinics that focus exclusively on this population. Residents can choose to work solely in the inner city clinic, head east to Siksika, or go to more remote reserves across Canada. One further option is to include exposure to Inuit populations in the North.

Immigrant and Refugee Health: Residents spend time at the Margaret Chisholm Immigrant and Resettlement Centre in Calgary, both primary care and specialty programs (Hepatitis C, Pediatrics, and Obstetrics available). Immigrant Centres exist in most urban settings in Canada, and students may choose to spend time at any of them. They can also go to refugee camps anywhere in the world, and complete online learning around any of these topics.

Inner City and Vulnerable Populations: There are multiple sites for training with marginalized patients (see table in Question 2). Residents choose those that fit their individualized learning objectives for the year, and the duration that it takes to fulfil those.

Infectious Disease: There are many options for training in infectious disease, including many within Calgary and others outside of Alberta and Canada (see table in Question 2). Formal training at a tropical medicine school has been pursued by students in the past, completing a 2-3 month Diploma, while others have chosen to spend less time than a full Diploma, achieving their objectives at infectious disease clinics and tropical disease clinics in Toronto, Montreal, or elsewhere in the world.

Teaching and Learning: Residents are encouraged to teach short courses (U of C's Undergraduate Medical Education course on Global Health) and support other academic informational events (Global Health Interest Group). They teach students and other Residents while on team rotations and in the field, and assemble teaching files as part of their portfolio.

Fieldwork or Research: This is the most flexible component of the curriculum, where the Resident determines (before or during the first half of the year) personal objectives and a training site for a prolonged stay. Often, this is an international clinical or research experience, but it can take place at an Aboriginal or Inner City clinic. Residents are able to fulfil Global Health objectives entirely within North America, should they choose to do so.

When they travel abroad, Residents must complete background reading on the country, demonstrate an understanding of the culture, and complete pre-departure training through the Global Health Office and International Partnerships at U of C, as well as register with U of C's Risk Management Office and the Government of Canada (GH Appendix D).

Residents must have a designated Preceptor, be appropriately licensed by local authorities, and have liability insurance to ensure they are adequately supervised and positioned to participate actively in all learning experiences.

Learning occurs through interaction and assembly of a portfolio for assessment. Residents take time to engage in this activity: write up reflective pieces or learning cycles, gather formative feedback from Preceptors and the Program Director, and ensure that all learning objectives are demonstrated as achieved through this medium. Some learning objectives that are quite individualized include language training, online education, or involvement with specific ethnic groups.

- Integrated theme 1: Ethics
- Integrated theme 2: Determinants of health
- Integrated theme 3: Cultural humility, competence, and safety.

GH 4 List of Residents doing category 2 programs less than 6 months in duration.

NA.

Please answer the following questions for Category 2 programs listed in the application. You are asked to provide a general description of the policies in place for Category 2 programs overall. It is not necessary to provide a separate set of answers for each program.

GENERAL STANDARDS

A) PRINCIPLES AND OBJECTIVES

As part of the questionnaire, please append one copy of the goals and educational objectives of the training program plus any mission statement that the program may have.

GH 5 Describe the mechanisms by which the goals and educational objectives of the training program are distributed to Residents and faculty and indicate the date at which they were last reviewed by the program.

The Global Health CanMEDS-FM competencies (GH Appendix A) and Program mandate (GH Appendix E) are available to potential applicants and GH Residents in a shared Dropbox.

The GH Residency Program Committee, including current and past Residents, reviews the GH CanMEDS-FM competencies annually. The original competencies were developed as part of the then GH Program Director's Master's thesis and underwent expert analysis and feedback through interviews, focus groups, and a survey.

Individual Resident learning objectives (GH Appendix N) are developed in consultation with the GH Program Director and all educational experiences are mapped/blueprinted (GH Appendix F) to these and the GH CanMEDS-FM competencies. Students iteratively review and refine their learning objectives and learning experience blueprint in collaboration with their Preceptors, mentors, and the GH Program Director.

Much of the teaching Faculty in Global Health have become formal mentors for the Residents, which means they have undergone extra training in reflective practice and writing, the learning objectives, and the use of portfolios for assessment. (GH Appendix G)

GH 6 Describe the mechanism by which the educational objectives are discussed with the Residents.

Educational objectives are discussed at the beginning of the Global Health Residency Training Program and throughout the year, but Residents are looking at them constantly. Their assessment process involves the Residents demonstrating achievement of each learning objective in a structured portfolio (GH Appendix H). Thus, they must be very familiar with these objectives, and figuring out how to

accomplish all of them during this period. They are discussed with Preceptors and mentors during the completion of assessment tools such as reflective learning cycles, case studies, and clinical evaluation exercises.

GH 7 Describe the structures and ways in which the program's goals and objectives are communicated to the specialty faculty responsible for teach family medicine Residents.

Almost all of the Faculty involved in teaching the Global Health Residents are Family Physicians who have a practice with a special population. Their innate practice pattern allows the Residents to have exposure to these groups. In terms of specific objectives, including public health perspective, cultural communication, and scholarly activity, Residents are responsible for discussing which objectives they hope to fulfil during their rotation and to contract on how to accomplish this with their Preceptor.

Preceptors are emailed a hand out describing the Program's mandate (GH Appendix E), the goals of the Residents and their educational position (so they are not left unsupervised). Many of them are invited to be part of the assessment of their reflective exercises for the portfolio, whether formative or summative, and also to contribute to the GH RPC meeting discussions.

B) EVALUATION

I. Program Evaluation

GH 8 Describe the process by which the program evaluates all educational experiences of the curriculum. Include a description of how Residents are involved in this process.

GH Residents regularly provide both informal and formal feedback about their rotations to the GH Program Director. Residents are encouraged to evaluate each educational experience for content and teaching and this feedback is used to improve the quality of all educational experiences. The Program is inherently reflective in that the portfolio assessment process includes the Residents' thoughts on each educational experience.

After each rotation in Canada, Residents are sent "one 45 WebEval" forms to evaluate their Preceptors (GH Appendix I). At the end of each international experience, Residents complete a six-page International Elective Evaluation Form (GH Appendix K). At the end of the year, they complete a formal Exit Interview to discuss the challenges and opportunities they experienced as Residents in the Program.

GH 9 Describe the internal review process used by the Faculty of Medicine to evaluate the family medicine program between accreditation visits.

The PGME Office at the U of C organizes the internal review. It is a comprehensive review that follows the same format as the external review for accreditation purposes, and is conducted by two Program Directors from other University departments and a Resident representative. Our last internal review was January 2013.

II. Faculty Evaluation

GH 10 Describe the policies and procedures by which faculty members within the department of family medicine are evaluated for their teaching skills. Append any evaluation forms and/or policy statements.

An annual evaluation of all Faculty is conducted by the GH Program Director. During this Faculty review, an inventory of contributions to teaching by the Faculty is reviewed and each Faculty member is provided with anonymous feedback from the completed Resident Preceptor evaluations (GH Appendix I). The confidentiality of learners is maintained at all times. The Resident evaluations are a compilation of the evaluations which are submitted by the Residents via the "one45 WebEval" system. In addition, the Head of the Department conducts an annual review of all Faculty contributions to the Department, which go beyond Postgraduate training activities.

III. Resident Evaluation

For this section, provide appendices of any forms used to collect data in any of the areas specified by the questions below.

GH 11 Describe how the program coordinates Resident evaluation. In answering this question, please identify any individuals within the program with specific responsibility for evaluation or any committee structure that oversees the process. Append any policy statements or documents.

Residents in the GH ES Residency Training Program are assessed on the basis of several formative and summative tools, all of which are compiled into a structured learning portfolio (GH Appendix H). The portfolio is reviewed regularly by the Resident with their mentor(s), and the GH Program Director and is presented by the Resident as summative evidence of achievement of the GH CanMEDS-FM competencies and their individual learning objectives.

All learning experiences are blueprinted to the GH CanMEDS competencies and these provide scaffolding for the learning portfolio, along with the individual learning objectives (GH Appendix F). Residents are responsible for identifying appropriate assessment strategies for each of their learning experiences, with guidance from the GH Program Director and faculty mentors. Assessment tools include daily observations completed by Preceptors (Clinical Evaluation Exercises), reflective writing exercises (including guided Case-based Discussions), 360/multisource feedback (Team-assessment of Behaviours) (GH Appendix L), and In-training Evaluation Reports (ITERs) (GH Appendix M). Summative ITERs are required for all rotations that are longer than 1 week. Residents are encouraged to maintain a procedural skills log.

Residents are provided with protected time throughout the year to build their portfolio, encouraging ongoing reflection and review of learning experiences and objectives. The portfolio is used as a means to both promote and document learning in all domains: cognitive, skills-based, and affective.

Residents present their portfolios for summative assessment to members of the GH Residency Program Committee, who together have expertise in various fields within Global Health. This group determines by consensus whether the Resident portfolio adequately demonstrates achievement of all GH CanMEDS-FM competencies and the Resident's individual learning objectives. The Resident submits the portfolio in both bound and email formats for review in advance of the year-end review meeting, in which the Resident presents their portfolio and year's work in a formal setting to

demonstrate how they have achieved their overall competencies. A Q & A format is used, which is interactive and educational for all those attending.

GH 12 Describe the policies and procedures for the evaluation and supervision of Resident performance in the context of the family medicine settings.

Formative assessment and feedback is given to Residents on a daily basis by Preceptors and summative assessment occurs in writing at the end of each rotation. These include but are not limited to case discussions, chart reviews, and direct observation.

The Department of Family Medicine adheres to the Postgraduate Medical Education policy on the supervision of Residents. Preceptor supervisors have a responsibility to provide appropriate supervision for Residents at all times (Appendix 0). Supervisors are made aware of the following requirements via direct communication or letter: supervisors must inform their patients that Residents may be involved in his/her care; they must discuss each case and perform a chart review with the Resident following each Resident-patient encounter; and they must be available at all times either in person or via telecommunication.

GH 13 Describe the policies and procedures for Resident evaluation and supervision on specialty rotations.

The same policies & procedures, as well as expectations of supervision listed above for Family Medicine-based rotations, apply to specialty rotations. (Appendix 0)

Ongoing formative feedback and end of rotation summative assessments are performed by Preceptors during each specialty rotation (GH Appendices I and J). A meeting with the supervisor is expected to occur so that the Resident may receive feedback and discuss the educational experience of the rotation. Residents are encouraged to play an active part in scheduling face-to-face feedback sessions.

C) FACULTY DEVELOPMENT

GH 14 Are there faculty development needs that are specific to this program. If so, how have they been met? If not, how is this assessed? Are there resources available to support faculty development needs?

Faculty development needs specific to Global Health are often addressed in the overall Departmental processes. There are a multitude of opportunities for Faculty Development available to community Faculty, including programs, conferences, and workshops. If further needs are identified, the office of Faculty Development is able to tailor programs on areas such as cultural competency and guiding self-directed learning. The Global Health Program has access to Dr. Juan-Antonio Garcia, who as CPD Director, is responsible for designing faculty development programs within the department of Family Medicine.

Drs. Bonnie Larson and Leah Genge organized Global Health Grand Rounds, as well as partnered with Tropical Medicine Rounds in 2013-14. They are also working with the Office of Global Health and International Partnerships to develop a CME day entitled “Conversations in Global Health”. These

events are meant to provide networking and learning opportunities to the Global Health Program mentors and a broader audience.

Many of the Global Health teachers function as mentors for the Residents. Mentors have opportunities to interact with the Residents on a number of levels: clinical teaching; suggesting, facilitating and discussing learning modules; career planning; research advice; reflection review; moral support; and portfolio assessment. Mentors are given additional information about the Program, the objectives, the intent of reflective writing exercises, and the use of portfolios for and of learning. Mentors are also invited to attend and participate in the annual GH New Resident Orientation, which provides all attendees with opportunities to discuss and learn about current global health issues, work/life balance in global health careers, travel medicine, and an opportunity to connect with all program Residents and other faculty working in the area of global health.

GH 15 Describe how faculty are evaluated.

See Question 10.

D) SCHOLARLY ACTIVITY

GH 16 Describe scholarly activity amongst faculty that is specifically relevant to this program.

Dr. Bonnie Larson, the current interim Global Health Program Director, who was also a Resident at the inception of the GH program, has published, along with some of our Preceptors at Elbow River Healing Lodge:

> Larson, B., Herx, L, Williamson, T, and Crowshoe, L. Beyond the barriers: family medicine Residents' attitudes towards providing Aboriginal health care. Medical Education 2011 (45): 400 – 406.

Dr Larson is also the Principal investigator on a longitudinal study in progress characterizing and following participants in an undergraduate MD Global Health Concentration Program.

The former Global Health Program Director, Dr. Christine Gibson, has completed a Masters in Medical Education, developing and evaluating the GH Residency Training Program.

Dr. Andrea Hull, a Global Health program mentor and alumnus, now co-leads the MD Program's Global Health course as well as developing research studies characterizing Hepatitis B and treatment of latent TB infection in Canada's refugee population.

Dr. Leah Genge, also a mentor and recent graduate of the Program, leads the Addictions and Homelessness section of the undergraduate medical education's Population Health course as well as precepting their Global Health course small groups. Additionally, Dr Genge has recently taken on the role of Domain Lead in the 2 year Residency program for Vulnerable and Underserved Populations.

Dr. Genge's research includes:

- Study design & Principal Investigator: "Task shifting for primary care in rural Tanzania: Determining knowledge and resources gaps at three district hospitals" (Update: on hold until local leadership in place - it is listed as a potential project for MPH students in Mwanza to take on.)

- Study design & co-investigator: "Defining global health: a survey of R3 enhanced skills programs in Canada" (in progress)
- Literature review: Primary care screening for adverse experiences and historical trauma among Aboriginal Canadians.
- Health systems strengthening project. Global health aid: the impact on public health care systems.
- Literature review: Illicit drug use in sub-Saharan Africa
- Peer reviewer for Open Medicine Journal

Dr. Michael Aucoin, mentor and graduate, is an author on: Parasitic stool testing in newly arrived refugees in Calgary, Canada. This poster was presented at Family Medicine Forum 2014 in Quebec.

Other FM Faculty, who serve as Preceptors and mentors, have presented and published related work (Drs. Roger Thomas, Jacqui Lewis, Rod Crutcher, and Lara Nixon).

GH 17 Describe how the program fosters Resident research and scholarly activity.

Residents in Global Health produce scholarly material throughout their year, as the portfolio includes much written work. Students must construct reflective writing pieces, literature reviews during learning cycles, and teaching material where they have to research a topic.

Residents engage in conferences and courses that assist in meeting their learning objectives. Residents also ensure their fieldwork is aligned with these objectives. The fieldwork assessment takes place through the completion of a project that can include research. Residents are given adequate time both to learn research methods and to analyse their experiences.

Recent publications by GH Residents;

Aucoin, M., Weaver, R., Jones, L., and Thomas, R. Vitamin D status of refugees arriving in Canada. Canadian Family Physician 2013 (59): e188-e194.

du Prey, B., Talavlikar, R., Mangat, R., Freiheit E., Drummond N. Induced abortion and contraception use among immigrant and Canadian-born women in Calgary, Alta. Canadian Family Physician September 2014 vol. 60 no. 9 e455-e463

2014 graduate Dr. Gwynn Curran-Sills has three research projects, worked on during his ES year, which focused on disaster relief. With faculty collaboration, he has presently submitted for publication:

1. An epidemiological description of the search and rescue incidents documented by the Alpine Club of Canada from January 1970 - June 2005
2. Outcomes and Characteristics of Non-immobilized, Spine-Injured Trauma Patients: A Systematic Review and Meta-Analysis of Pre-hospital Selective-Immobilization Protocols
3. Speed and accuracy of triage for simulated disaster patients in an emergency department setting: Comparison of the Canadian Triage acuity Scale (CTAS) and Simple Triage and Rapid Treatment (START) methods

Residents who undertake the LSHTM Diploma of Tropical Medicine and Hygiene on East African campus do research during field study visits. This short project, often a community health or needs assessment, also becomes part of their portfolio.

In the 2012-13 academic year, Dr. Leah Genge negotiated objectives for a research project with partners at CUHAS University in Mwanza, Tanzania. She has mentorship from, among others, Calgary DFM Faculty; Drs. Maeve O'Beirne and Dr Murray Lee. Dr. Genge will be returning to Tanzania to perform pilot studies in District Hospitals to examine the competencies and any gaps in skill or comfort in the health care workers.

There is also a new mentorship program within Global Health, where a variety (more than ten) Faculty train in processes around learning and assessment. The intent is that ,experienced mentorship can then increase the robustness of any research and stimulate learning through access to additional resources. (GH Appendix O & P)

Global Health Residents traditionally participate in teaching in the UME Program. They are invited to Precept small group sessions in the Global Health course as well as present during the UME Global Health symposium. This connection was initiated by the first GH Residents and has continued annually since 2008.

Category 2 Program

Please complete a form for each Category 2 program that is of 6 months duration or longer.

PROGRAM NAME: Family Medicine – Sport and Exercise Medicine

SEM 1 If there is a common curriculum for all Residents, please provide this. Or, if the program is highly individualized, please provide a copy of the learning contract for each Resident.

- Common curriculum (See Question 2 below)
- SEM Appendix A – Canadian Academy of Sport and Exercise Medicine Core Competencies for Enhanced Skilled Learners
- SEM Appendix B – Sport Medicine Competencies mapped to Family Medicine and Can MEDS-FM

SEM 2 List the rotation with duration and training sites involved.

Rotation	Duration	Training Sites
Mandatory Rotations		
Cardiac Rehab	4 weeks	Talisman Centre
Orthopedics	4 weeks	UC SMC
PMR	2 weeks	
Radiology	2 weeks	Community
Rheumatology	2 weeks	FMC
Sport Medicine	24 weeks	UC SMC Winsport/CSI
Women's Health	2 weeks	
Elective Rotations		
Cardiology	TBD	FMC
Respirology	TBD	RVH
Banff Sport Medicine	TBD	Banff

Vacation: 4 weeks (2 weeks to be taken during Sports Med rotation)
(Does not include PARA Break at Christmas/New Year's)

The current Sport and Exercise Medicine Resident's rotation schedule is provided in SEM Appendix C.

SEM 3 Provide a narrative description for each rotation.

The Program for the Sport and Exercise Medicine Resident starts with 4 months of Sport Medicine. This is followed by 27 weeks of rotations as noted in Question 2 (including elective time) and ending with a further 2 months of Sport Medicine. When the Resident is not on a Sport Medicine Rotation and there is no call, the Resident continues with Varsity and National Team game coverage.

Radiology – training in MSK imaging interpretation, predominately MRI but also bone scan, x-ray and CT. Experiences can be completed in both hospital and private radiology facilities.

Exercise Medicine – minimum 2 weeks training in post-MI care at a level II Cardiac Care facility. Experiences include stress testing, exercise prescription and diet and lifestyle counselling. Other

exercise medicine experience in chronic disease may be selected from the 'Thrive' centre (exercise prescription for cancer survivors), the 'Living Well Program' (A Program offered by Alberta Health Services that includes exercise prescription, behaviour therapy, nutrition counselling to those with chronic diseases such as COPD, organ transplant, osteoarthritis) or the 'Joint Effort Program' (A Program for those with knee and hip osteoarthritis that includes weight loss, behaviour therapy and exercise prescription). Other options are considered on an individual basis. As well during the sport medicine rotation, Dr. Kelly Brett is a certified Personal Fitness Trainer and discusses the role of exercise prescription in medicine. Drs. Preston Wiley and Willem Meeuwisse have Masters degrees in Exercise Physiology.

Rheumatology – experience in a referral based rheumatology clinic, which only sees inflammatory arthritides.

Female athlete – experiences in a Female Infertility Clinic, Eating Disorders Clinic and an Osteoporosis Clinic.

Orthopedics – office and operative experience with sport medicine orthopaedic surgeon(s) specializing in knee, shoulder, hip, and soft tissue surgeries.

Sport Medicine – experience in a predominately referral based Sport and Exercise Medicine Clinic. The referral pattern is mostly that of MSK injury (acute, overuse or degenerative) but includes exercise related medical problems. The Resident participates in specialty clinics in concussion, knee osteoarthritis and acute knee injury.

Additionally, the clinic provides care to Varsity and National team athletes. For these groups, the Resident participates in pre-participation physical examinations and screening, on-going medical care and event/game coverage.

The Resident also gains experiences in the clinic's nutrition program, in the physiotherapy program and from the consulting orthotist (to become familiar with standard bracing techniques).

Experiences are primarily at the University of Calgary Sport Medicine Centre, but may include other facilities such as WinSport (Canadian Sport Institute)

SEM 4 List of Residents doing category 2 programs less than 6 months in duration.

NA.

Please answer the following questions for Category 2 programs listed in the application. You are asked to provide a general description of the policies in place for Category 2 programs overall. It is not necessary to provide a separate set of answers for each program.

GENERAL STANDARDS

A) PRINCIPLES AND OBJECTIVES

As part of the questionnaire, please append one copy of the goals and educational objectives of the training program plus any mission statement that the program may have.

SEM 5 Describe the mechanisms by which the goals and educational objectives of the training program are distributed to Residents and faculty and indicate the date at which they were last reviewed by the program.

SEM Appendix A
SEM Appendix B

The competencies are a modification of the University of Western Ontario's list that has been previously approved and from the Canadian Academy of Sport and Exercise Medicine (core competencies developed by a committee of sport physicians). Work is underway to map SEM objectives to learning experiences, to facilitate the creation of rotation-specific objectives and ITERs.

The College of Family Practice of Canada (CFPC) and the Canadian Academy of Sport and Exercise Medicine along with the Royal College of Physicians and Surgeons of Canada are currently working conjointly on creating objectives/competencies in parallel as SEM moves to Category 1 status within the CFPC and Diploma status within the Royal College. This is expected to occur in 2015. Because of this national competency work in SEM, any more advanced work on competency development locally is on hold.

SEM 6 Describe the mechanism by which the educational objectives are discussed with the Residents.

As noted above, the SEM Program Director meets at the start of the Program with the Resident to discuss educational objectives. On-going review of these objectives/competencies occurs before each rotation as well as at the mid-point in the Program.

SEM 7 Describe the structures and ways in which the program's goals and objectives are communicated to the specialty faculty responsible for teach family medicine Residents.

As noted above, after review of the objectives/competencies before off-service rotations, the Resident reviews the objectives with the rotation Preceptor(s). Objectives are sent to each Preceptor before the start of the rotation.

B) EVALUATION

I. Program Evaluation

SEM 8 Describe the process by which the program evaluates all educational experiences of the curriculum. Include a description of how Residents are involved in this process.

SEM Residents fill out a "one WebEval" rotation evaluation at the end of each clinical experience. Strategies to correct any issues identified are discussed with the Resident. Items of concern are also reviewed by the SEM Residency Program Committee

During the SEM Director and Resident exit interview, a frank discussion about the Resident's experiences in the Program is also undertaken. The Exit Interview Template may be used. Pertinent pros and cons of the Program and rotations are discussed and compiled for review by the SEM RPC.

Program and rotation changes are assessed and implemented yearly unless immediate intervention is required to maintain Program or rotation quality for rotating Residents.

The SEM Program Director also has an open door policy for discussing any Resident concerns.

Major issues that arise are discussed by the SEM Program Director, Enhanced Skills Director, and the Post-Graduate Director, where appropriate.

SEM 9 Describe the internal review process used by the Faculty of Medicine to evaluate the family medicine program between accreditation visits.

The PGME Office at the U of C organizes the internal review. It is a comprehensive review that follows the same format as the external review for accreditation purposes, and is conducted by two Program Directors from other University departments and a Resident representative. Our last internal review was January 2013.

II. Faculty Evaluation

SEM 10 Describe the policies and procedures by which faculty members within the department of family medicine are evaluated for their teaching skills. Append any evaluation forms and/or policy statements.

Residents fill out a Preceptor Evaluation Forms at the end of each rotation via "one WebEval". (SEM Appendix D) Items of concern are reviewed by the SEM Program Director and by the SEM RPC. If appropriate, the SEM Program Director will share concerns with the Enhanced Skills Director and the FM Post-Graduate Director.

III. Resident Evaluation

For this section, provide appendices of any forms used to collect data in any of the areas specified by the questions below.

SEM 11 Describe how the program coordinates Resident evaluation. In answering this question, please identify any individuals within the program with specific responsibility for evaluation or any committee structure that oversees the process. Append any policy statements or documents.

Commonly an ITER is used during each clinical rotation. Preceptors are expected to monitor the progress of competencies gained during the rotation with the Resident. In some cases, log books are also used to identify experiences.

Preceptors are expected to provide "one45 WebEval"-based mid-rotation and summative assessment along with verbal discussion of the written feedback, wherever possible. (SEM Appendices E & F)

The SEM Program Director sits down with the Resident every three months to review completed ITERs and the log-book, where appropriate. Where there are concerns, the SEM Program Director discusses progress directly with the appropriate Preceptors and the SEM RPC. (SEM Appendix G)

Preceptors are also aware that there is an 'open-door' policy with the SEM Program Director to share concerns about Residents as needed.

Any remediation required is coordinated by the SEM Program Director in direct conversation with the Resident. PGME policies and procedures on assessment, remediation and probation apply. (SEM Appendix H).

SEM 12 Describe the policies and procedures for the evaluation and supervision of Resident performance in the context of the family medicine settings.

Formative assessment and feedback is given to Residents on a daily basis by Preceptors. Assessment and feedback occurs with case discussions, chart reviews, and following direct observation.

The Department of Family Medicine adheres to the Postgraduate Medical Education policy on the supervision of Residents and the DFM Supervision of Residents Policy (Appendix P). Preceptor supervisors have a responsibility to provide appropriate supervision for Residents at all times. Supervisors must inform their patients that Residents may be involved in his/her care, they must discuss each case and perform a chart review with the Resident following each Resident-patient encounter, and they must be available at all times either in person or via telecommunication.

SEM 13 Describe the policies and procedures for Resident evaluation and supervision on specialty rotations.

See Questions 8 and 10 above.

C) FACULTY DEVELOPMENT

SEM 14 Are there faculty development needs that are specific to this program. If so, how have they been met? If not, how is this assessed? Are there resources available to support faculty development needs?

Sport and Exercise Medicine Physicians at the University of Calgary Sport Medicine Centre attend appropriate conferences and meet the standards set out by the College of Family Physicians (accumulation of Mainpro M1 and M2 credits). Additionally, they are sought out as instructors of local and national CPD events.

The Cumming School of Medicine also provides numerous Faculty Development events through its Office of Faculty Development and the Department of Family Medicine organises a large Faculty development conference ("Fall Together") each year in the Fall to which the SEM Program Director is invited. This invitation can be disseminated to the SEM RPC and other SEM Preceptors.

SEM 15 Describe how faculty are evaluated.

See Question 10.

D) SCHOLARLY ACTIVITY

SEM 16 Describe scholarly activity amongst faculty that is specifically relevant to this program.

Dr. Willem Meeuwisse MD, PhD. Sport Medicine Physician, Professor Faculty of Kinesiology and Community Health Sciences – Epidemiologist, research area sport injury prevention. Co-Director of the Sport Injury Prevention Research Group. On-going active research program in sport injury epidemiology. Past Editor Clinical Journal of Sport Medicine.

Dr. Preston Wiley MPE, MD. Sport Medicine Physician, Associate Professor Faculty of Kinesiology and Department of Family Medicine – research area degenerative and overuse injury. Director University of Calgary Sport Medicine Centre. Ongoing active research in knee osteoarthritis and tendinopathy.

Dr. Nicholas Mohtadi MSc, MD, FRCS(C). Clinical Professor Section of Orthopedics – Sport Medicine Orthopedic Surgeon at the University of Calgary Sport Medicine Centre. Research areas include development of Quality of Life assessment tools, orthopaedic clinical trials and innovative ways of delivering health care. Ongoing active research in knee injury clinical trials, hip arthroscopy and medical education.

Dr. Caroline Emery BScPT, PhD. Physiotherapist, Associate Professor Faculty of Kinesiology and Community Health Sciences. Epidemiologist. Co-Director of the Sport Injury Prevention Research Group. Research area sport injury prevention as it applies to the pediatric population. Active research program in many areas.

Dr. Victor Lun MSc, MD. Sport Medicine Physician. Research area of interest is degenerative joint disease.

Dr. Brian Benson MD, PhD – Sport Medicine Physician, Epidemiologist; research area concussion. Ongoing active research program. Involved in International concussion committees and has an active concussion research program. He is based out of WinSport/Canadian Sport Institute

In addition, all Enhanced Skills Sport Residents and Program Directors have access to Department of Family Medicine scholarly medicine resources which include a staff epidemiologist, statistician, academic specialists in knowledge translation, budget development, U of C research proposal processes, and literature searches.

SEM 17 Describe how the program fosters Resident research and scholarly activity.

Required attendance at monthly:

- Clinical Rounds – presentation on numerous clinical topics by local experts in their field
- Research Rounds – presentations by undergraduate and graduate students as well as faculty on local research projects. If there is a visiting researcher, they would present at these rounds
- Shoulder Rounds – case presentations by staff and Residents. Attended by physiotherapists, athletic therapists, graduate students, sport medicine physicians and orthopaedic surgeons.
- Required lecturing (1 lectures) in Kinesiology 'Topics in Sport Medicine Class' run by Dr. Preston Wiley. Presentations are about an hour long on an assigned topic not commonly

seen in clinics. The Resident is assisted in developing the presentation and then critiqued after class by Dr. Wiley.

- Completed project (usually either a review paper on a specific topic or integration into one of the on-going research projects at the Sport Medicine Centre).
- ES SEM Residents expected to provide “Master Class Workshops” for DFM Resident Spring Conference as requested by the Program Planning Committee.

Category 2 Program

Please complete a form for each Category 2 program that is of 6 months duration or longer.

Design-your-Own (DYO) programs are typically less than 6 months duration and in the 2014-15 academic year, three ES Residents are expected to have completed 3-month Programs in Low Risk Maternal and Newborn Care. An additional three ES Residents are enrolled in 7, 11, and 13-block programs respectively in this academic year, all with a focus on women's health. Historically, this has been an internal program and only available for University of Calgary DFM R2's and for community physicians in Alberta who plan to continue working in Alberta.

PROGRAM NAME: Family Medicine – Design Your Own

DYO 1 If there is a common curriculum for all Residents, please provide this. Or, if the program is highly individualized, please provide a copy of the learning contract for each Resident.

There is no common curriculum. Each Resident is required to write a detailed proposal before his/her application is accepted. This proposal forms their learning contract and includes:

- objectives written in a competency-based format using Kern's guidance
- assessment strategies
- self-assessment tools
- resources, including sites and timelines extra education resources – planned rounds, journal club, conferences, internet learning modules, special certificates
- Resident interest in a scholarly project
- Resident interest in longitudinal continued practice in a general family medicine clinical setting. A Program goal for this continued time is skill development as an educator. Hence, the Program places such Residents with family practice teachers who can mentor the Enhanced Skills Residents as a teacher of clerks and more junior Residents.

The Proposal Guideline documents are given to all DYO applicants (DYO Appendices A & B). Common features include:

- DYO Program governed by PGME, DFM PG FM, DFM ES Program, and PARA policies and procedures.
- The application process and deadline is set for all Category 2 programs (typically early November). A draft proposal must accompany the application.
- If needed, proposal revisions will be made by the Resident with the support of the identified Lead DYO Preceptor; however, final decision regarding the adequacy of the proposal remains with the DYO Program Director (ES Director) and acceptance is contingent on an adequate proposal.

The development of individual proposals is onerous and Residents demonstrated variable skills in self-assessment regarding needs, objective development, and assessment strategies. Considerable resources have been invested in recent years to support R2's expressing interest (during the early part of their second year) in pursuing additional training in several areas under the DYO Program. By the end of their 2-year FM Residency, a high proportion of these applicants feel they no longer need the additional training. For this reason, further DYO programming has been suspended as of July 2015.

In collaboration with local Low Risk Maternity Care Family Physicians, Obstetricians, and Lactation Consultants in 2010, the ES Program developed educational modules on Low Risk Obstetrics and Lactation and Newborn Feeding (DYO Appendices C & D) which will be further reviewed and incorporated into a new 4-month Enhanced Skills in Maternal and Newborn Care (MNBC) Program. Four applicants have accepted positions in the new ES-MNBC Program for the 2015-2016 academic year.

Until now, assessment of DYO rotations has used an undifferentiated ITER based on the Four Principles (DYO Appendix E). Assessment tools specific to Enhanced Skills MNBC are under development.

DYO 2 List the rotation with duration and training sites involved.

Resident determined, unique to each Resident.

DYO 3 Provide a narrative description for each rotation.

NA.

DYO 4 List of Residents doing category 2 programs less than 6 months in duration.

Kathleen Hicks – 3 blocks
Carmen Fong – 3 blocks
Katrina Low – 3 blocks

Please answer the following questions for Category 2 programs listed in the application. You are asked to provide a general description of the policies in place for Category 2 programs overall. It is not necessary to provide a separate set of answers for each program.

GENERAL STANDARDS

A) PRINCIPLES AND OBJECTIVES

As part of the questionnaire, please append one copy of the goals and educational objectives of the training program plus any mission statement that the program may have.

DYO 5 Describe the mechanisms by which the goals and educational objectives of the training program are distributed to Residents and faculty and indicate the date at which they were last reviewed by the program.

As above, goals and objectives are developed by the Resident and reviewed, revised, and accepted prior to entry into the Program.

DYO 6 Describe the mechanism by which the educational objectives are discussed with the Residents.

As above, goals and objectives are developed by the Resident and reviewed, revised, and accepted prior to entry into the Program.

DYO 7 Describe the structures and ways in which the program's goals and objectives are communicated to the specialty faculty responsible for teach family medicine Residents.

Goals and objectives are shared with all Preceptors through the processes of requesting and securing educational rotations. This is primarily done by the Resident directly, but where rotations are scheduled through Program Administrators or Learner Schedulers, this can be shared by these staff.

B) EVALUATION

I. Program Evaluation

DYO 8 Describe the process by which the program evaluates all educational experiences of the curriculum. Include a description of how Residents are involved in this process.

At the end of each rotation, Residents complete an Evaluation of the Rotation.

In the event there are any "red flags" on these evaluations, the evaluation is forwarded directly to the Program Director (ES Director) for review. As required, the Program Director follows up directly with the Resident, Rotation Lead, and/or named Preceptor. In the event there are no "red flags" these evaluations are compiled and reviewed at the end of the year.

DYO 9 Describe the internal review process used by the Faculty of Medicine to evaluate the family medicine program between accreditation visits.

The PGME Office at the U of C organizes the internal review. It is a comprehensive review that follows the same format as the external review for accreditation purposes, and is conducted by two Program Directors from other University departments and a Resident representative. Our last internal review was January 2013.

II. Faculty Evaluation

DYO 10 Describe the policies and procedures by which faculty members within the department of family medicine are evaluated for their teaching skills. Append any evaluation forms and/or policy statements.

At the end of each rotation, Residents complete an Evaluation of the Preceptor.

In the event there are any "red flags" on these evaluations, the evaluation is forwarded directly to the Program Director (ES Director) for review. As required, the Program Director follows up directly with the Resident, Rotation Lead, and/or named Preceptor. In the event there are no "red flags" these evaluations are compiled and reviewed at the end of the year.

III. Resident Evaluation (Assessment)

For this section, provide appendices of any forms used to collect data in any of the areas specified by the questions below.

DYO 11 Describe how the program coordinates Resident evaluation. In answering this question, please identify any individuals within the program with specific responsibility for evaluation or any committee structure that oversees the process. Append any policy statements or documents.

Formative assessment and feedback is given to Residents during their clinical experiences. These may be in the form of Field Notes, case discussions, or chart reviews. Formative mid-term assessment may also be provided. Summative assessment is completed by the Preceptor at the end of each rotation using an online one45 In Training Evaluation Report (ITER).

Resident ITERs are reviewed by the Program Director at the completion of each rotation. In the event that a Preceptor identifies specific difficulties experienced by the Resident, the Program Director follows up with the Resident. The Program Director may bring concerns to the Resident Progress Sub-Committee of Postgraduate Family Medicine for consultation regarding remediation strategies.

The Family Medicine Assessment Director provides leadership of assessment in the Program.

The Program Director is responsible for determining if a Resident has met graduation requirements at the end of his/her program.

DYO 12 Describe the policies and procedures for the evaluation and supervision of Resident performance in the context of the family medicine settings.

See DYO 11 above.

DYO 13 Describe the policies and procedures for Resident evaluation and supervision on specialty rotations.

See DYO 11 above.

C) FACULTY DEVELOPMENT

DYO 14 Are there faculty development needs that are specific to this program. If so, how have they been met? If not, how is this assessed? Are there resources available to support faculty development needs?

In the current format of the DYO Program, there are not specific faculty development needs. This may become more apparent as the Program is replaced by the Maternal and Newborn Care Program beginning in July 2015. At that time, faculty development needs will be determined in collaboration with the core Urban Program as the preceptors are common to both Programs.

Faculty Development is provided for FM Preceptors centrally by the Department of Family Medicine. The Department utilizes a number of delivery methods, location, times and activities to provided varied content to our Preceptors. Resources include seminars, websites, podcasts, workshops, conferences. Global needs assessments have been undertaken on multiple occasions since 2009.

DYO 15 Describe how faculty are evaluated.

See DYO 10 above.

D) SCHOLARLY ACTIVITY

DYO 16 Describe scholarly activity amongst faculty that is specifically relevant to this program.

None specifically relevant.

DYO 17 Describe how the program fosters Resident research and scholarly activity.

In the DYO Program, Resident scholarly activity goals and support needs are determined at the time of the proposal. These are negotiated between the Resident and the Program Director. All Residents have access to the Department of Family Medicine Research Hub and the personnel and resources available there. The Program Director can facilitate access to these resources as needed.