THE 6 MAINPRO+ QUALITY CRITERIA

NOTE: UBC CPD is limited to certifying activities at the 1 credit per hour level only unless they are internally developed by UBC CPD (for which each level must meet previous levels’ requirements as well).

QUALITY CRITERION 1:

Needs Assessments (NA) and Practice Relevance

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<tr>
<th>Credit Per Hour</th>
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| 1 credit per hour | • An indirect NA of target audience is used to guide program development and  
|                 |   o Determine prior knowledge and practice experience  
|                 |   o Identify both perceived and unperceived needs  
|                 | • Learning objectives are ties to NA results  
|                 | • NA addresses physician competency through CanMEDS-FM role(s)  
|                 |   o FM expert, professional, communicator, collaborator, manager, health advocate, scholar |
| 2 credits per hour | • NA sample is representative of the intended target audience  
|                 | • NA identifies gaps in physician competence in at least one CanMEDS-FM competency area |
| 3 credits per hour | • NA is performed on actual participants  
|                 | • Includes measures of gaps in knowledge, competence, or performance based on data from practice  
|                 | • Identifies gaps in physician competence in multiple CanMEDS-FM competency areas beyond FM Expert role |

Notes:
• Demonstrate a valid professional practice gap from which the educational needs are identified.
• Surveys indicating physicians are interested in improving care or enhancing knowledge, skills, performance with respect to a given disease or course of treatment do not demonstrate a valid professional practice gap.
• Establish the learning gap has been used as the basis of the program through the development of learning objectives that clearly define how the program will improve physician competence/performance/patient outcomes.
• All programs must be relevant to the overall practice of family medicine:
  o Fosters improved patient care  
  o Addresses at least one of the four principles of family medicine. 1) The family physician is a skilled clinician, 2) family medicine is a community-based discipline, 3) the family physician is a resource to a defined practice population, 4) the patient-physician relationship is central to the role of the family physician.  
  o Within the scope of practice for family physicians  
  o Has content and concepts that are evidence-based and/or generally accepted by the Canadian medical community.
The most useful NAs are those where multiple methods are utilized to identify educational needs linked to improved patient care.

Different types of learning needs:
- Self-recognized or perceived: *I know what I want and need to know*
- Unknown to the learner or unperceived: *I don’t know what I don’t know*
- Miscalculated or misperceived: *I think I know something I don’t*
- Emergent needs: *I have new info, I want or need to learn something else instead of, or in addition to what I am learning now*

Perceived needs strategies
- Survey, interview, focus group interview, key informant, representative planning committee, meetings with colleagues, evaluation of previous CPD activity

Unperceived needs strategies
- Knowledge test, chart audit, critical incident reports, duplicate prescription/health care diary, expert advisory group, patient feedback, direct observation of practice performance

The planning committee should be asked the following questions:
- How common is the need among the target audience?
- How many different assessment sources indicate this need?
- How significantly will the unfulfilled learning need hinder health care delivery?
- How directly is the need related to actual physician performance?
- How likely is it that a CPD activity will improve practice behaviour?
- Are sufficient resources available to effectively address this topic?
- How receptive will the target audience be to a session on this topic?

### EXAMPLES
- Literature search
- Evaluation feedback
- Survey
- EMR data
- Incident reports
- Referral patterns
- Interview
- Knowledge test

### QUALITY CRITERION 2: Interactivity and Engagement

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<td>1 credit per hour</td>
<td>At least 25% of the program is conducted in an interactive manner</td>
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<td>2 credits per hour</td>
<td>Learner engagement goes beyond Q &amp; A</td>
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<td>Include opportunities to engage with each other, facilitators, and material</td>
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<td>Component of the activity is based on small groups or workshops</td>
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<td>Self-Learning: requires engagement with facilitators and materials only</td>
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<td>3 credits per hour</td>
<td>Must be based on (ie. nearly all) small group learning</td>
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<td></td>
<td>Self-Learning: case-based learning component instead of small-group</td>
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<td>Program includes activities that can be applied to participants’ practices</td>
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QUALITY CRITERION 3:

Incorporation of Evidence

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| 1 credit per hour | • Provide an outline of evidence used to create content and include references in materials (authors, article title, journal, year, volume, and page numbers)  
  o Evidence should come from systematic review/meta-analyses of studies or single, moderate-sized, well designed RCTs or well-designed, consistent, controlled but not randomized trials or large cohort studies  
  o Lack of evidence for assertions or recommendations must be acknowledged  
  o If a single study is the focus or select studies are omitted, rationale to support the decision must be provided  
  o Graphs or charts cannot be altered to highlight one treatment or product  
  o Both potential harms and benefits should be discussed; an efficient way to present this to clinicians is through number needed to treat (NNT) and number needed to harm (NNH), as well as absolute and relative risk reductions |
| 2 credits per hour | • Reflect patient-oriented outcomes (outcomes a patient can feel and experience) and avoid surrogate outcomes (lab values serving as reliable substitute eg. blood sugar reduction for diabetes therapy efficacy)  
  • Include Canadian-based evidence where it exists |
| 3 credits per hour | • Include opportunity for participants to seek, appraise, and apply best available evidence  
  o Eg. Research component for participants, assigned readings with discussion of evidence presented, and participant-driven literature reviews |

Notes:
• Clinical component of the program is valid and represents best available and most up-to-date evidence  
• Must include references

QUALITY CRITERION 4:

Addressing Barriers to Change
## Credit Per Hour | Certification Requirements
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1 credit per hour | • Educational design includes discussion of commonly encountered barriers to practice change
2 credits per hour | • Educational design includes discussion on approaches to overcoming these barriers
3 credits per hour | • Asks actual participants to identify barriers to change
• Discusses barriers and approaches to overcoming barriers

### Notes:
- Understanding of barriers- real and perceived- to practice change
- i.e. negative personal and professional beliefs, financial disincentives, or lack of institutional support
- Identification of barriers can take a number of forms
  - Learn from key individuals with the knowledge, authority, and skills to speak to implementation of the innovation
  - Observe individuals in practice, especially for routine behaviours
  - Use a questionnaire to explore the individuals' knowledge, beliefs, attitudes and behaviour
  - Brainstorm informally in small groups to explore solutions to a problem
  - Conduct a focus group to evaluate the current practice and explore new ways of working
- Common barriers to physician change
  - Knowledge: lack of awareness or lack of familiarity with the content of guidelines or recommendations; lack of awareness of recent finding, evidence, techniques
  - Attitude: disagreement with new recommendations or guidelines; lack of outcome expectancy; lack of motivation to change; lack of belief in one’s ability to perform a behaviour
  - Behavioural: difficulty in recalling proposed intervention when needed; no place established for learning in usual routine of care; little to no opportunity to use new intervention, due to patient profile caseload
  - Organizational: process-relation barriers within health care system; financial constraints on implementing change; lack of time or opportunity to implement recommendations
- Interventions
  - Educational outreach
  - Academic detailing
  - Reminder systems (chart reminders, follow-up communication, feedback requests)
  - Audit and feedback
  - Patient-mediated interventions
  - Practice tools
  - Timed follow-up
  - Informal consultations

### QUALITY CRITERION 5:

**Evaluation and Outcome Assessment**
### Credit Per Hour Certification Requirements

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<td>1 credit per hour</td>
<td>• Measures are included to assess self-reported learning or change in what participants know or know how to do as a result of the CPD program. (See Evaluation questions)</td>
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| 2 credits per hour | • Includes an objective measurement of change in knowledge for the learner  
• Provides opportunity for participants to evaluate change in CanMEDs-FM competencies |
| 3 credits per hour | • Includes an objective measurement of change in performance for the learner  
• Opportunity to evaluate change in all CanMEDs-FM competencies identified in the learning objectives |

**Notes:**

- Change that occurs as a result of an educational intervention, particularly performance, patient health, and community health is a more valuable measure of program success
- Change as a direct result of an educational intervention can be very difficult to assess. Outcome assessment framework beyond declarative or procedural knowledge
  - Competence: observation of performance in the educational setting, commitment to change report
  - Performance: review of patient charts, observation in a simulated clinical setting, self-report of performance
  - Patient health: changes in health status of patients as recorded in charts or as self-reported by patients
  - Community health: data gleaned via epidemiology reports/studies or via self-reports by communities

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**QUALITY CRITERION 6:**

**Reinforcement of Learning**

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<tr>
<td>1 credit per hour</td>
<td>• Not required</td>
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<tr>
<td>2 credits per hour</td>
<td>• Incorporates one or more validated strategies to reinforce and/or facilitate continued learning</td>
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<tr>
<td>3 credits per hour</td>
<td>• Incorporates two or more validated strategies; ideally administered at staggered time intervals (e.g. 6 AND 12 weeks)</td>
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**Notes:**

- Educational interventions provide greater impact for learners when learning occurs over a continuum of time versus during a single, finite period or session
- Reinforce and facilitate continued learning because:
  - Encourage participants to reflect upon what they have gained from completing the educational intervention and how it might affect, or has affected their practice
  - Provide opportunities for participants to continue a dialogue with colleagues and/or faculty after having had the opportunity to apply new knowledge skill, or attitudes in practice
Help with recall and retention- both of which can be challenging given the workload of the average family physician

For three credits per hour, participants must not receive documentation of program completion, such as a certificate, until the reinforcement-type activity or activities have been completed and returned

EXAMPLES of post-program and learning reinforcement activities:

- Post-program teleconference
- Open-ended questionnaire
- Commitment to change contract with follow up
- Chart audit and feedback
- Performance or knowledge test
- Post-reflective exercise