1.0 PURPOSE

The Policy on CPD Educational Planning exists to provide guidance for staff, faculty, planning committee members, and co-developing organizations on the approach used in the development of CPD educational programs.

2.0 BACKGROUND

To guide its educational processes, the CPD Medicine Program has an instructional design component, a programming component, and the foundation. The instructional design model outlined by Morrison, Ross, and Kemp (2007) is incorporated into the CPD model to guide staff, faculty, planning committee members, and others in all phases of curriculum and program development. For simplicity, the nine main elements (i.e., instructional problem, learner characteristics, task analysis, instructional objectives, content sequencing, instructional strategies, designing the message, development of instruction, and evaluation) of Morrison et al.’s model are visually represented by five main stages that together are frequently referred to as the ADDIE Model: an acronym referring to the major stages in the generic instructional systems development process: Analysis, Design, Development, Implementation, and Evaluation. The foundation for the CPD Model is a novice to expert continuum grounded in lifelong learning, the CanMEDS/CanMEDS FM roles and competencies, and research.

3.0 POLICY

The CPD Instructional Design Model shall inform the design, development, implementation and evaluation of CPD programming.

3.1 ADDIE Model

3.1.1 Analysis: Identifying Educational & Learner Needs

The CPD educational planning process links identified educational needs regarding knowledge, competence, and performance with a desired result. The need for each CPD activity must be substantiated through identification and assessment of professional practice gaps of the target audience. These gaps may come from any number of sources and documentation is required for each accredited educational event. Examples of sources include:
**Perceived needs** which may be derived from the following:

- Evaluation results from previous CME/CPD activities
- Formal surveys of potential participants (mail and Internet-based)
- Informal comments from individuals or groups (participants, course directors, potential faculty, planning committee members, experts in the field, hospital administrators, researchers, patients)
- Patient problem inventories compiled by potential participants
- Consensus of faculty members within a department or service area
- Availability of new method(s) of diagnosis or treatment
- Availability of new medication(s) or indication(s)
- Development of new technology
- Legislative, regulatory, or organizational changes effecting patient care

**Unperceived needs** which are based on objective external data sources. These needs may be derived from the following:

- Epidemiological data
- Quality assurance/audit data
- Morbidity/Mortality
- Critical incidence reviews, college complaints
- Statistics, infection control data
- Surgical procedures statistics
- Professional society requirements and guidelines
- Peer Reviewed Literature
- Government/Ministry of Health reports
- Results of self-assessment tests
- Direct observation of practice performance

Multiple sources of information must be considered when determining needs and should include both perceived and unperceived needs. Additionally, the process may include identification of the learner characteristics and an analysis of tasks.

### 3.1.2 Design: Creating Learning Objectives & Selecting Educational Strategies

**a) Creating Learning Objectives**

Objectives should be derived from the needs assessment, and learning objectives should relate to the intended audience’s scope of practice and explain what specific actions/knowledge learners will be able to apply to their practice after participating in this educational activity. Objectives should be an expression of the expected change, in terms of physician competence or performance. The learning objectives should complete this statement: “At the conclusion of this educational activity, the participant should be able to:”

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Every CPD activity must state the learning objectives in the printed brochure or other promotional material, and in the syllabus or handout materials in order to provide a benchmark for the evaluation of the activity, and assist participants in deciding whether or not to attend the activity.

Additionally, all faculty members and planners complete the learning objectives during the planning stages in order to assist them in preparing presentations that fit with the overall objectives.

b) Selecting Educational Strategies

The choice of educational format must be based on the needs, the type of professionals attending the program and their learning preferences, and other logistical and financial considerations.

Educational activities should ensure that a minimum of 25 percent of time involves interactive learning as it has been shown that active participation engages the learner and helps the facilitator to better judge the audience level of comprehension for the concepts or problems presented. Educational strategies to promote interactive learning include: pre-tests, post-tests, questions, voting cards/pads, buzz groups, progressive problems, discussion, debates, patient-related interventions, video-tape triggers, and simulation.

3.1.3 Develop

In the Development stage, information gathered through the analysis and design stages is used to develop instructional materials.

Presenters, speakers and/or facilitators will be selected by members of planning committee and will receive specific instructions regarding their involvement, including descriptions of the program format, the target audience and the nature of the evaluation to be completed by participants.

Presentations should be amplified by good use of audio-visual materials, appropriate handout materials, and interactive sessions whenever possible.

3.1.4 Implement

In this fourth stage, the educational program or session is delivered or implemented. Efforts must be made to ensure an optimal learning environment for participants.

3.1.5 Evaluation

All activities must include an evaluation component. Evaluation methods should be determined during the program’s planning stage and be linked to the established needs and stated learning objectives.

Evaluation methods should allow learners to judge whether educational objectives were met and judge the likelihood of improvement in the quality, effectiveness, or efficiency of the attendee’s professional activities. The methods should allow learners to judge the quality of the instructional process and provide feedback to faculty who teach.

The evaluation may be in the form of a questionnaire; a pretest and/or post-test; a follow-up survey by mail or phone to learn if course content changed professional activities or methods of practice; a medical audit; systematic interviews with all or a sampling of persons who participated in a program; gathering of various
statistical data that may provide some sense of the success of the program or a critique by program planners. There may be other means of evaluation appropriate to the particular activity.

A participant does not necessarily need to evaluate the activity to receive educational credit. Separate methods may be used for documenting attendance and evaluating the activity.

Ideally, when feasible, attempts will be made to link outcomes data and demonstrated needs to improved patient care.

Evaluations are used to assess education needs of the physician; they are summarized and assessed after each activity and will be retained by the Division of CPD for no less than one (1) year after the event. The evaluation results should be shared with faculty who teach at the event and planning committees. The information is also used to provide information that will help planners improve their future activities and as part of the ongoing assessment of the Division of CPD’s processes.

### 3.2 Foundational elements

The foundation for the CPD Model is a novice to expert continuum grounded in lifelong learning, the CanMEDS/CanMEDS FM roles and competencies, and research.

#### 3.3.1 Novice to Expert

Physicians and health professionals continually move along the novice to expert continuum based on their current role, knowledge level, and advances in healthcare research and technology. Continuing Professional Developments aims to assist its participants in progressing along this continuum.

#### 3.3.2 Lifelong Learning

All physicians and health professionals need to commit to lifelong learning in order to maintain their clinical and professional competence. The CPD Medicine Program will assist physicians and health professionals in acquiring the knowledge, skills, and attitudes necessary to maintain their own competence.

#### 3.3.3 CanMEDS/CanMEDS FM

Originally developed by the RCPSC, and modified by the CFPC is well established in both undergraduate and postgraduate medical education programs. The CanMEDS/CanMEDS FM framework reflects all aspects of physician professional life (expert, communicator, collaborator, leader, health advocate, scholar, and professional). It will be used to guide the development of programming that will ensure comprehensive professional development.

#### 3.3.4 Research

The CPD Medicine Program shall ensure that best practices are being incorporated into all aspects of programming. In addition, it will engage in a program of educational research and share research findings through conference presentations and publications to add to the growing body of CPD knowledge for physicians and health professionals.
References


APPROVALS:
CPD Advisory Committee: April 6 2016