

The Future of Medical Education in Canada (FMEC) Continuing Professional Development (CPD)

A Strategy for the Development of a Pan-Canadian FMEC CPD Consortium



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Introduction

A comprehensive review of the continuum of medical education for Canadian physicians began with the inception of the Future of Medical Education of Canada (FMEC) project in 2007. The FMEC MD project was funded by Health Canada to determine the types of physicians Canadians need, now and in the future. The FMEC MD recommendations were launched in 2010 and are being implemented in Canadian medical schools. The FMEC Postgraduate (PG) project followed with recommendations and action items launched in 2012. Implementation of these transformative activities is ongoing and focused on responding to society's evolving needs. Building on the success of the FMEC MD and PG projects, FMEC CPD will complete the comprehensive FMEC overview of the entire continuum of medical education, from medical student, through residency, and into practice.

Currently, undergraduate and postgraduate medical education are delivered through structured academic programs set in faculties of medicine, in which the faculties are responsible for ensuring that the education delivered meets acceptable standards. Despite the existence of accreditation standards across the medical education continuum, in CPD there are accreditation standards applicable to a limited number of CPD provider organizations and standards for a wide variety of learning activities (conferences, self-assessment programs, simulation) included within the CPD frameworks of the certifying colleges. These accreditation standards do not currently apply to self-directed learning activities. Unaccredited learning activities are provided in many areas for a variety of reasons, including direct industry marketing programs.

Given the transition from supervised learner to member of a self-regulated profession, the constant evolution of the practice of medicine, changes in the focus of a physician's practice over time, and the high-stakes decisions that physicians make in practice on a daily basis, continuing professional development is a critically important phase of medical education. Through CPD we must be role models in lifelong learning for learners across the continuum and for other health professionals.

Rationale

Continuing professional development refers to physicians' professional obligation to engage in learning activities that address their identified needs, enhance knowledge, skills, and competencies across all dimensions of professional practice, and continuously improve their performance and healthcare outcomes within their scope of practice. Three foci for this lifelong learning include continuing health professions education, faculty development and quality improvement.

1. Continuing health professions education focuses on lifelong learning in all CANMeds/CANMeds-FM competencies.
2. Faculty Development focuses on lifelong learning for physicians with roles in teaching/ education, leadership/ administration and research/scholarship.
3. Quality Improvement focuses on lifelong learning that maintains and promotes patient safety and quality in health systems to achieve excellence in patient care.¹

Although in Canada MD education and postgraduate education occur only within the structure of faculties of medicine and are funded by provincial ministries of health and education, accredited CPD is offered by a variety of providers that include but is not limited to faculties of medicine, colleges, associations, regulators, specialty societies and a variety of unaccredited activities are offered to physicians by pharmaceutical and devices companies.

This complex environment has some safeguards such as licensing, regulating, accrediting, and certifying bodies that require a certain level of accountability of maintenance of competence. The current environment is also one with competing influences from CPD providers that receive financial benefit from programs and organizations and gain financially for accrediting such programs. Pharmaceutical and medical device companies have also had significant influence historically on physicians by extensive funding of events that support their products and the physicians who have spoken on their behalf. Although this blatant conflict of interest has been addressed to a certain degree by the development of codes of ethic and policies, the community has not yet fully managed these and related issues.

¹ Yvonne Steinert, Constance LeBlanc, Craig Campbell

The current CPD accreditation systems do provide a structure and a process that sets and monitors the quality and delivery of some components of CPD (e.g., group learning and self-assessment programs) resulting in mutual accountability, in particular for provider organizations. What is still missing is the monitoring of performance and the regular provision of assessment data and feedback to either individual physicians, groups of physicians or inter-professional health teams.

Physicians should have comparative outcome data available to them regarding care provided to their patients. This data should drive the CPD activities accessed by physicians and reported to their college and regulating body and should also provide evidence of CPD effectiveness. Required activities should vary based on scopes of practice, and improvement of patient outcomes should be tracked and reported. These activities should be work and skill based and available in the practice setting when appropriate. They must also evolve over time to reflect a physician's practice.

The profession's social accountability commitment dictates that Canadians receive care from physicians who are competent within their scopes of practice, and for their entire careers. This is the CPD community's responsibility and the focus of the FMEC CPD Consortium.

A Brief History

Significant accomplishments have been made in the last forty years to advance CPD in Canada.² Some of these accomplishments have been the individual work of the eight partner organizations, while others have been facilitated by the bringing together of organizations such as happened at the Aylmer Conferences and in the ongoing efforts of the *Conseil québécois de DPC des médecins*, in Québec. The creation of an accreditation system for CPD provider organizations and for the accreditation of CPD activities has been achieved through the work of several partners. A broad consultation on the development of a Physician Performance Enhancement System Framework is in progress.

The FMEC CPD process began in December 2012 and has been progressing steadily. This proposed strategy is the result of several key activities over this time period.

December 2012	The Canadian Medical Association (CMA) sponsored an environmental scan and a national consultation on the "Future of Medical Education in Canada: Continuing Professional Development – Potential Scope, Feasibility, and Funding." Almost 100 stakeholders attended this full day event at which the CPD community spoke candidly about the need and desire to conceptualize an FMEC CPD project. A small taskforce was struck to construct a proposal.
Spring 2013	A proposal for funding of an FMEC CPD project was sent to Health Canada on two occasions but these efforts were unsuccessful in securing funding.
Fall 2013	Key stakeholders started discussions on raising funds to advance a FMEC CPD project. Eight partner organizations provided start-up funding: <ul style="list-style-type: none"> - Association of Faculties of Medicine of Canada (AFMC) - College of Family Physicians of Canada (CFPC) - Canadian Medical Association (CMA) - Canadian Medical Protective Association (CMPA) - Collège des médecins du Québec (CMQ) - Federation of Medical Regulatory Authorities of Canada (FMRAC) - Medical Council of Canada (MCC) - Royal College of Physicians and Surgeons (RCPS)
January 2014	Development of a governance structure, i.e., (i) Oversight Committee of CEOs representing the eight partner organizations in the project and (ii) a Steering Committee with representation of the eight partners as well.

² A brief history titled "Perspectives on the History of Continuing Professional Development in Canada" is provided in Attachment C.

Initial engagement of CEOs

Sharing of draft FMRAC document: The Physician Performance Enhancement System (Attachment D).

- February 2014: The CEO Oversight Committee requested the creation of a paper on “Perspectives of the History of CPD in Canada” and approved a budget that included funds for: (i) a national Invitational Summit, (ii) a consultant to design and facilitate the Summit and work with the Steering Committee to develop a proposed FMEC CPD strategy, and (iii) support for a secretariat for six months.
- March 2014 The Steering Committee, consultant, and AFMC staff developed the Invitational Summit.
- April 25, 2014: The Summit consultation was held with over 90 stakeholders representing a broad range of groups within the Canadian CPD community. Ten issues were identified through a pre-consultation survey and then discussed at the meeting in terms of their definition, scope and relevance to FMEC CPD. Information obtained during the consultation is a significant contributor to the overall CPD strategy.
- May 20, 2014: Distribution of (i) a communiqué to Invitational Summit participants, and (ii) a full Summit report to the project Steering Committee.
- June/August 2014: Creation of a draft proposed strategy, business case and budget for the development of the FMEC CPD project. A collaborative approach, including feedback from Steering Committee members indicates that the FMEC CPD part of a physician’s continuum of medical education should proceed differently than the FMEC MD and PG processes, i.e., not to produce a report and recommendations, but to take action on identified strategic issues (identified initially at the Summit) through collaboration among CPD stakeholder organizations.

Invitational Summit on the Future of Continuing Professional Development in Canada

This national consultation was a key event in furthering the understanding of CPD community expectations related to CPD in Canada.

The Association of Faculties of Medicine of Canada (AFMC), in collaboration with its partners – the Canadian Medical Association (CMA), the Canadian Medical Protective Association (CMPA), Collège des médecins du Québec (CMQ), the College of Family Physicians of Canada (CFPC), the Federation of Medical Regulatory Authorities of Canada (FMRAC), the Medical Council of Canada (MCC), and the Royal College of Physicians and Surgeons of Canada (RCPSC) – held this national event on the Future of Continuing Professional Development (CPD) in Canada at the Ottawa Convention Centre on Friday April 25, 2014.

Summit Objectives ³

The Summit supported the partnership’s goal of working as a collective to coordinate, advocate for, and support the Future of Medical Education in Canada strategy on Continuing Professional Development (FMEC – CPD). Summit objectives were to:

1. Update participants on the history and context of CPD in Canada;
2. Share current leading practices for CPD in Canada and internationally;
3. Consult with participants on a pan-Canadian strategy for CPD 2015 – 2018, including identification and description of issues, opportunities and challenges, and future research;

³ See Attachment B for a more fulsome report on the Summit.

4. Continue to build a dynamic and collaborative CPD community across the country.

Feedback from participants indicated that the Summit was an essential event in laying the groundwork for the development of a way forward for FMEC CPD.

Summit Overview

Approximately 90 participants took part in this event, representing CPD leaders, educators, regulators and researchers as well as key organizations and institutions across Canada. Patients were not represented and this was felt to be a significant omission at the summit. Throughout the Summit there was strong commitment to collaboration in building on what has been developed to date, attention to social accountability, evidence of improved patient care, and research in CPD. The tone of this meeting was constructive, thoughtful, and enthusiastic, and resulted in concrete suggestions for advancing the CPD agenda in nine strategic issue areas identified in a pre-meeting survey:

Clinical workplace education	Patient outcomes / quality
Conflicts of interest	Proven effectiveness
Funding model	Use of technology
Governance	Workplace assessment and skills-based assessment
Interprofessional education / teams	

For each of these areas participants described the main challenge, the important aspects of the issue, and the “most important thing to address at the outset”. This input will form the basis for considering next steps in each of these identified gaps/strategic issues.

Two additional theme areas at the Summit resulted in specific outputs. One was the development of a proposed definition of CPD as follows.

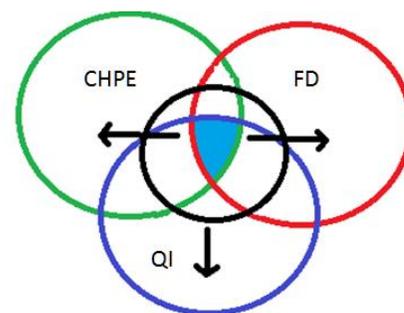
DRAFT definition of CPD proposed during summit: *A lifelong personal and professional obligation of all health care professionals to engage in learning activities that address their identified needs, enhance knowledge, skill, and competencies across all dimensions of professional practice, and continuously improve their performance and healthcare outcomes within their scope of practice.* - Dr. Craig Campbell and Dr. Constance LeBlanc

Continuing Professional Development Schematic

This draft schematic definition depicts the overlap of CPD with Continuing Health Professional Education (CHPE), Faculty Development (FD) (including research and administration) and Quality Improvement (QI) (including patient safety) and its potential for expansion into these areas. Participants also recognized that:

- It will be challenging to integrate the importance of health outcomes;
- We need to consider a systems approach because many of us wear multiple “hats”, e.g. clinicians, researchers, administrators, educators etc. Improving our abilities in even a few of these areas will impact the others;
- It will be very important that the grass roots medical community be part of this discussion;
- We need an iterative definition that will evolve over time.

A second theme area resulted in a proposed future research agenda for FMEC CPD which will inform an evidence-based approach to CPD.⁴



⁴ See Attachment B for additional information.

FMEC CPD: A Pan-Canadian Consortium

The FMEC MD and PG projects each resulted in a consensus-based report outlining a collective national vision and recommendations for specific issue areas. Given the greater complexity of the CPD environment (in comparison to the MD and PG initiatives), and the work already in progress by various partners who have commitments to continuing medical education, FMEC CPD will take a different approach to improving the quality of patient care.

The FMEC CPD vision is for a pan-Canadian consortium based on shared expertise, leadership and accountability among consortium partners. Rather than developing recommendations for the future, the consortium partners will take a real-time approach to ongoing physician learning and related action. The primary outcome is collective action and ongoing, results-focused updates among consortium partners on strategic issues.⁵

Goal

The goal of the FMEC CPD consortium is to contribute to the best health and healthcare of Canadians by enhancing evidence-informed opportunities for the Continuing Professional Development of physicians through collective action focused on maximum system benefit.

The partners in FMEC CPD are already committed to, and engaged in activities to enhance CPD for physicians in Canada. Being part of the FMEC CPD consortium will facilitate collaboration in a number of areas, enable better information sharing, enhance strategic systems thinking and capacity for change, and reduce duplication. This alignment and resulting synergies will increase the capacity for progress in CPD and result in the work of the consortium being more than the sum of its parts.

Key Features

- This consortium would take an evolutionary, stepwise approach to complex, large-scale system change, mobilizing the partnership leaders, organizations and stakeholders toward actions that will achieve advances for CPD in Canada beyond what could have been accomplished by individual organizations alone.
- Consortium partners would take an evidence-informed approach to setting out clearly the areas within the CPD environment in which change may or may not be necessary, building on the initial issues identified through the April 2014 Summit process.
- To be successful the consortium must demonstrate measurable benefits to healthcare systems and stakeholders and offer clear value-add to partners, practicing physicians, and patients.
- The partners would ensure that patients are at the centre of changes related to CPD and would develop a process for monitoring the outcomes achieved in each issue area.
- The anticipated initial commitment for the consortium is from 2014 to 2015 after which, if successful, will form the initial phase of a longer term commitment.
- The consortium is designed to be structured yet flexible, evolving in response to needs identified by the partners.

Advantages of a consortium include:

- Partner organizations would identify existing challenges and collaboratively develop practical solutions;
- Organizations would be better aligned towards common goals and activities;
- Unnecessary redundancy in CPD efforts (e.g., scrutinize using an evidence-informed approach) would be reduced;

⁵ See page 4 for an overview of strategic issues discussed at the FMEC CPD Summit in April 2014.

- Care would be optimized, easier to evaluate through the consortium and enable documented impacts on quality and safety with respect to clinical outcomes; and
- A coordinated approach on shared strategic issues promises to be more cost effective (e.g., targeted, issues-based environmental scans and collaborative change management strategies).

As stated by the NHS Institute for Innovation and Improvement, “[b]ecause of the complexity involved, the consortium process is emergent, i.e., the planning, design and related action will evolve based on monitoring progress and adapting as required.⁶ Flexibility, adaptability, and engagement of others are the keys to success.”⁷

Long-term Outcomes

Establishment of an FMEC CPD consortium could define or lead to:

- a. A culture shift that, through a collaborative effort, would take a strong system to the best system in the world.
- b. A governance model for CPD in Canada including the specific roles and responsibilities for medical regulatory authorities, Colleges, CPD Provider organizations, health care institutions, among others.
- c. Enhanced efforts in scholarly work on CPD.
- d. Increased support for physicians to access appropriate CPD opportunities;
- e. The expectations and requirements for licensed physicians to engage in continuing professional development that will sustain and enhance their competence and performance in their practice.
- f. Reporting requirements for users of the national CPD system.
- g. Resources and tools required to ensure access to performance data.
- h. The funding model(s) (including financial support from industry) needed to support and sustain CPD.
- i. The monitoring requirements (including scholarship initiatives) of the national CPD system to measure its impact on individual learners, CPD providers, MRAs, the health system (including quality and safety of care) and patient outcomes.
- j. The specific requirements for the accreditation of provider organizations and individual CPD programs/activities.

⁶ Leading Large Scale Change: NHS Institute for Innovation and Improvement, 2011, p28 adapted.

⁷ “There is a gap between what we know and what we do. Thus the focus of the consortium is to provide a venue where partners can share information, learn together, and support one another in developing, acting on, and monitoring dynamic change strategies in CPD throughout Canada.”
 Institute for Healthcare Improvement *The Breakthrough Series: IHI’s Collaborative Model for Achieving Breakthrough Improvement*. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003, adapted. (Available at www.IHI.org)

Key Terms

The terms used to describe CPD and its activities have different meanings to different people and organizations (e.g. difference between training, development, and education; assessment, feedback, and evaluation, etc). Wherever possible, shared terminology will be used. In circumstances where a term may have different meanings to different organizations, it will be noted that said term is defined differently (with explanation) by each organization.

Initial Meetings of the Consortium

Following is a proposal for next steps based on meetings of the consortium partners.

1. August-November 2014

Review the proposed high level strategy – a pan-Canadian consortium – and make a decision about a commitment to the approach at a strategic level.

Review the current structure (Committee of CEOs and Steering Committee) and decide on a governance structure and guiding principles to support the approach over the first 18 months. In addition to current partners, additional stakeholders proposed include:

- Health Canada
- Provincial governments
- Provincial Medical Associations
- Medical Associations and Specialty Societies
- Hospitals and departments
- Other health professional regulators, associations and societies
- Other institutions and groups (e.g., Canadian Patient Safety Institute)

Critical success factors at this point include:

- Commitment by all partners' boards/councils and leadership to the project
- A solid governance model that enables collaboration
- Appropriate financial support by partners and potentially Health Canada
- A strong, experienced secretariat
- Regular communication among partners and with all stakeholders
- Frequent feedback from partner organizations

Deliverables

A high level strategy, enabling governance structure, guiding principles and a draft Terms of Reference for the Consortium.

Identification of initial strategic issues that are a priority for the partners and can provide a successful start for the consortium.

2. November – March 2015

Develop co-leadership for the initial issues. Identify the key questions related to each issue. Bring together existing research, and practices related to CPD for each issue, developing a synthesis of what is known and where the gaps are. Explore how each organization is capitalizing on successes and addressing / planning to address issues; strategize on where efforts could be combined to improve consistency and create efficiencies; consider what can be done collectively to address gaps.

Deliverables

For each strategic issue and related initiatives:

- The specific question(s) or purpose the proposed initiatives will address

- The key target audiences and organizations
- The organizations that will develop the initiative including which FMEC-CPD partner organizations are the co-leads
- The current state of knowledge and practice about this topic area in Canada and internationally
- The most important anticipated areas of CPD knowledge and practice that this initiative will help to illuminate
- Evaluation strategies
- Time frames
- How the work will be funded.

3. April – May 2015

Based on the synthesis of evidence, the Summit conclusions about strategic issues, partner areas of emphasis, as well as the key questions and answers, successes and gaps: identify and describe priority initiatives for each issue. Include approaches related to “all levels of the CPD system”.

Deliverables

For each strategic issue: an operational plan based on priority initiatives that align relevant partners in collaborating on next steps.

4. May 2015 and ongoing

Implement the operational plan for each priority issue, including considerations related to knowledge translation and exchange. The consortium structure provides oversight, ensuring that the implementation process aligns with the collective vision, avoids unnecessary redundancy, builds on complementarity among the consortium partners, includes a practical change management strategy, etc.

Monitor progress and document results.

Deliverables

For each strategic issue: the implementation / change management process is documented and reported to consortium partners. Lessons learned through evaluation (including interprofessional / team-based learning and assessment) are noted to inform how to approach the next issues to be addressed.

5. Broad Consultation: ongoing as appropriate

For each strategic issue and related initiatives, determine the most appropriate consultations and how and when they should happen, e.g., (alphabetical order)

- Broad public consultation (e.g., Patients Canada and other groups) and including a potential Blue Ribbon panel of informed lay public
- FMEC MD and PG groups and Strategic Implementation Group (SIG) regarding insights related to their FMED
- Grassroots (internal) Deanery (UGME, PGME, CPD, Deans) with RCPSC (Regional Advisory Committees) and CFPC panels, CMPA, regulators, CMA, CMQ, MCC
- Industry
- International colleagues
- Interprofessional colleagues
- KT community

These consultations will take place through a variety of approaches and at various times and places (including opportunistic sessions in already scheduled meetings) and depending on challenges such as availability and cost efficiency, e.g., focus groups, webinars, town hall meetings, surveys, national forums, etc.

Deliverables

For each consultation: prepare a report that is distributed to those consulted and to consortium partners.

Include a synthesized list of observations and conclusions, paying attention to how the consultation results have the potential to impact related strategic issues and the FMEC CPD project as whole.

6. Taking the Pulse of the Consortium: November-December 2015

Review progress to date. Solicit input on the next key issues to be addressed.

Deliverables

Provide updates on progress to date for the consortium as a whole and for each issue area. Include direct references to the guiding principles for the consortium and how action taken on issues addressed to date have adhered to those principles.

Develop a KT strategy for communicating with the CPD community regarding successes and remaining gaps and how the consortium will address them.

Review and affirm the consortium structure and approach, refining specific aspects as required to ensure that the issues and actions taken continue to knit up into a coherent, pan-Canadian whole. Use the lessons learned and results of the established initiatives to strengthen and the consortium, moving forward collectively to develop and deliver CPD that best serves the needs of the Canadian health system.

Identify and describe new priority issues. Decide how to approach these new issues based on lessons learned.

Financial Considerations

Feedback on the initial draft of this strategy indicated that the first priority should be to get commitment to an overall approach (e.g., a pan-Canadian consortium) prior to getting into too much detail around cost estimates and specific budgets.

In that vein, current project coordination for FMEC CPD will continue to support the active engagement of partners and steering committee members of the project until October 2014. Once a governance structure, key deliverables and approximate timelines have been agreed upon by the partners, a budget and workplan can be created in line with the agreed scope of work and timelines.

Some preliminary financial considerations are emerging as vital elements to include in a FMEC CPD consortium budget:

- Meetings of consortium partners, key stakeholders (in-person)
- Modest secretariat support to facilitate communication and enable collaboration
- Broad consultations as appropriate
- Quality evaluation to ensure that questions of importance to FMEC CPD are addressed

Three levels of funding will support the Consortium: in-kind contributions from each partner organization; base funding to support the consortium arrangement; and, external funds (e.g. Health Canada; CIHR meeting grants, etc) for targeted activities. Additionally, each strategic issue and related initiatives will be designed to be of interest and benefit to specific collaborators, and as such will be funded “in-kind” through organizational resources made accessible by each collaborator. The overall cost for the consortium would be divided among the partners and could be significantly offset by obtaining a matching grant or funds for targeted activities from Health Canada. Some partners raised concerns about dependency on matching funds. Funds leftover from the current phase of work will reduce the overall ask of each partner.

Ultimately, the intention is to have the FMEC CPD consortium be self-sustaining after the initial funding is used, or at least affordable and low-cost to run.

Initial commitments from each partner under this funding model are:

PARTNER	IN-KIND CONTRIBUTIONS	CONSORTIUM SUPPORT	ACTIVITIES
AFMC	Yes	Amount to be confirmed	As appropriate
CFPC	Yes	Amount to be confirmed	As appropriate
CMA	Yes	Up to \$60k	As appropriate
CMPA	Yes	Amount to be confirmed	As appropriate
CMQ	Yes	No	As appropriate
FMRAC	Yes	Amount to be confirmed	As appropriate
MCC	Yes	Amount to be confirmed	As appropriate
RCPSC	Yes	Amount to be confirmed	As appropriate

Appendix A: Questions to Shape Implementation

Several Steering Committee members suggested seminal questions for consideration by stakeholders when developing an implementation path for the consortium. These are listed verbatim in alphabetical order, recognizing that they can provide a starting point for discussion and that they require further editing, potential alignment with the Summit themes, and grouping into prioritized sub topics if they are to steer implementation and provide a focus for funding. Responses to these questions will result in a variety of outcomes such as guiding principles, areas of emphasis, and action steps.

1. At what point do/should clinical work and learning intersect within the work-place?
2. Canadians must receive care from competent physicians. How do we identify and establish CPD requirements with the appropriate focus on increasing quality and safety in a supportive way for the general membership of the profession, those in higher risk clinical specialties and the “high needs” individual physicians fairly identified as representing greater risk for patients than their peers in the same type of practice?
3. Do we need a global definition of what a competent physician is that we can all agree on - CanMeds, CanMeds FM and the MCC blueprint (it all seems a bit confusing)?
4. Do we need to talk about how much a physician needs to work to stay competent - what is the minimum? How long can one be away from practice and still be competent?
5. How can physicians and healthcare teams access data and receive feedback on their individual or collective performance?
6. How can we improve funding for CPD for organizations and individual physicians?
7. How do we create a supporting legal and policy structure to provide a “safe haven” for learning that appropriately addresses privacy and confidentiality of patients’ personal health information and appropriately protects performance data of providers, and also addresses disclosure of harm to patients and families.
8. How do we address with appropriate training the needs of IMGs?
9. How do we align our CPD efforts where appropriate with other health professionals and groups?
10. How do we best align the MCC Blueprint, CanMEDS 15 and CanMEDS-FM appropriately to the continuum of training and CPD?
11. How do we better coordinate and build on the existing CPD infrastructure, including facilitate access by practicing physicians to simulation centers?
12. How do we contribute to faculty development in academic centers?
13. How do we further improve the use of appropriate Clinical Practice Guidelines and reduce unwarranted variations in care?
14. How do we maintain accreditation standards, and establish and facilitate the provision of credits?
15. How do we measure the outcome of CPD programs in the future as part of the continuous improvement *and what is the role of the physician?*
16. How do we promote further research in CPD and what topics would be of broad interest and need investigation?
17. How do we support practice measurement and provide point-of-care tools? What are appropriate measures and audit tools related to clinical outcomes?

18. How is adequate learning documented (knowledge gain? intent to change practice? documented practice change)?
19. How is inadequate physician knowledge discerned, documented and dealt with (remediation; restricted practice; loss of license) and by what organizations?
20. How should development and delivery of CPD programs or resources be paid for?
21. How should the trend toward team-based care be reflected in the future model of CPD?
22. How to build on existing leadership training?
23. How will learning and practice/behavior change be demonstrated?
24. How will the system ensure that adequate remedial/educational opportunities exist for physicians to retrain if they have been away from practice, have narrowed and are now expanding practice, or feel unprepared (e.g. are going to work in a rural area with little back up)?
25. What are reasonable costs (time/money) of a CPD accreditation system for CPD provider organizations?
26. What are the implications for the development of a competency-based model for CPD on individual learners, CPD provider organizations, medical regulatory authorities and educational organizations?
27. What methods will be used to establish an appropriate learning plan for an individual physician?
28. What remediation strategies will be used to identify and resolve concerns related to physician knowledge, competence or performance?
29. What role will assessment play in sustaining a physician's competence and performance?
30. What role(s) should patients have in setting CPD directions and priorities?
31. Who can sponsor an educational event and under what regulations, set by/endorsed by what organizations?
32. Who decides on what learning options (face to face; online; work place learning) should be available to learners and how is a quality experience assured?
33. Who decides what practitioners need to learn?
34. Who will establish the accreditation standards and processes for CPD provider organizations, individual CPD activities, assessment activities?
35. Will assessment become mandatory and summative as a requirement for licensure, credentialing or other privileges to practice?