Phase II
February 2014

Maintenance of Certification Program Evaluation

Executive Summary

Prepared for:

Dr. Craig Campbell
Director, Continuing Professional Development,
Specialty Education

Prepared by:

Dr. Tanya Horsley
Associate Director, Research and Principal Scientist
Research Unit, Health Systems Innovation and External Relations

In Collaboration with:

Dr. Katherine Moreau
Children's Hospital of
Eastern Ontario,
Research Institute

Dr. Jocelyn Lockyer
Continuing Medical Education
& Professional Development
University of Calgary

Ms. Jeanie Zeiter
Research Unit, Health Systems
Innovation and External Relations

Dr. Lara Varpio
Uniformed Services University of
the Health Sciences

ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL
DES MÉDECINS ET CHIRURGIENS DU CANADA

Background

In May 2011, based on feedback from Fellows and a review of the CPD research literature, the Royal College of Physicians and Surgeons of Canada launched a revised Maintenance of Certification (MOC) Program framework, credit system, and ePortfolio (MAINPORT). The new MOC Program framework was organized under three sections instead of the former six, in an attempt to better reflect how physicians learn and to facilitate an expansion of the number of learning activities that had been previously proposed by Fellows.

The new credit system was conceptually developed with the intent of providing greater incentives to participate in (some) self-learning and assessment activities. The revisions aspired to provide "a more streamlined and user-friendly experience for Fellows and Health Care Professionals."

The current program evaluation was thus intended to:

1) Describe how well the changes implemented to the re-designed MOC Program framework, credit system, and MAINPORT responded to the themes identified from previous phases of program evaluation (Phase I, 2008-9); and to

2) Examine the established purposes of the MOC Program and explore the impact of the MOC Program on lifelong learning and practice improvements through a critical and comprehensive evaluation. (Phase III)

This report summarizes data from open- and close-ended survey questions exploring MOC user's perceptions and experiences of the re-designed MOC Program. Survey questions were developed from overarching themes that emerged as priority areas by the Program Evaluation Steering Committee.

Program Evaluation Support & Approach

Early development of the program evaluation model was guided by members of the Professional Development Committee (PDC). Through discussions with the PDC, a two-phased approach was conceptualized to allow for both intermediate (1-year) and long-term evaluation. To support and guide the development of the project both a Program Evaluation Steering Committee and Communication Advisory Working Group were convened.

Methods

A web- and paper-based survey was developed using the evaluation questions developed in collaboration with the Program Evaluation Steering Committee. The MOC Program

evaluation (PE) survey included several questions included in the 2008 program evaluation survey for comparative purposes and additional questions unique to the current PE themes.

Using descriptive statistics, frequencies were generated for each relevant item using SPSS version 16.0. Results are presented in tabular format using absolute values and percentages. Means and standard deviations (M, SD) for each factor were also calculated and are reported when applicable. Absolute values and percentages were the preferred method of reporting given the problems inherent in 'grouping' categories or values ('e.g. strongly agree and agree) on a 5-point scale.

Demographic Characteristics of Respondents

Of all survey respondents (N=5259) a total of 34.1% were female and 65.9% were male. The top three represented countries from outside of Canada were the USA (174, 3.3), Saudi Arabia (24, .5), and Oman (8, .2). Age of respondents ranged from (min-max) 28 – 90 years old with a mean of 52.1 (SD 11.8). The most represented specialties were psychiatry (616, 11.7), followed by anesthesiology (502, 9.5), pediatrics (391, 7.4), diagnostic radiology (357, 6.8), obstetrics and gynecology (258, 4.9) and, general surgery (255, 4.8). The survey sample is similar to the proportions of females and males within the entire membership sample and thus deemed representative of the underlying population (34% female and 66% male; based on a total sample for those who submitted at least one activity Jan 1, 2012 to Dec 31, 2012, N=31,158).

Summary of Findings

Overall, positive findings included a perception that the new Program is less complex in its design, having reduced the number of categories from 6 to 3 (53.9%). Further, respondents indicated in large part, that the framework is successful at providing a mechanism for credit entry; however, data suggests that users' understanding of the framework and what *can* be documented remains a barrier to credit submission for some.

Changes to the new MOC Program have had a modest yet important impact on participants' willingness to increase the frequency of credit submission. While the MOC Program in some respects continues to be viewed as obligatory, 1/4 of respondents reported increasing their frequency of credit submissions as a result of the Program re-design (26.5%). The magnitude of change was unable to be determined from the data.

Two-thirds of survey respondents agreed with the draft purposes of the MOC Program. Nearly 1/3 of respondents, however, felt the purposes were appropriate as a guide for what the MOC Program should be, but remarked that the current system did not achieve them. Of

the minority that did not understand the stated purposes of the MOC Program, most described it as 'simply a documentation tool' or a 'waste of time'.

Among the survey findings was the phenomenon of 'disconnectedness' of the MOC Program from physician practice realities. Respondents described the Program as an 'add on' to what they already do and as having little impact on one's engagement in lifelong and continuing professional development.

Barriers to participation in MOC remain a contemporary concern. The number one expressed barrier was lack of time providing the impetus to continue to examine ways to increase efficiencies and foster a more seamless integration between the MOC Program and physician learning. Findings are consistent with those of the 2008 MOC program that included workload and lack of time as primary barriers.

Future Recommendations

The provision/development of self-assessment strategies received strong agreement amongst respondents; these findings echo those from the 2008 report. Continued efforts to include self-assessment programs developed outside of Canada should remain a high priority. There is limited agreement for other assessment domains despite a perceived lack of access to these types of assessment programs.

MOC Program users want credit for 'what they do' in practice. Findings remain stable from 2008 with regards to credits for engagement in preceptorships and teaching or supervising residents/students. Ensuring a clear understanding of the purpose of the MOC Program as more than 'getting credit for what you do' emerged as an important area of our own reflection and consideration.

Strategies to enable automatic transfer and enhance strategies to document outcomes of learning were identified as a high priority of respondents. Automation and seamless integration of learning activities into MAINPORT is a critical area of future development and investment.

One of the strongest and most consistent findings was for increased educational support about the MOC Program. Despite the investment in a National CPD Educator Program, a 20% increase (over 2008 data) was seen for providing tutorials related to MAINPORT and greater support from the Royal College Services Center. This is likely a result of the re-design; however, it will be important to monitor these data over time.

Conclusions

The program evaluation included both positive and negative findings. It is clear the MOC Program continues to elicit a wide range of opinions from its users, oft described as 'simpler', 'improved' and 'important' on the one hand and with 'complex', 'time consuming', 'confusing', and 'make work' on the other.

Given participation in the MOC Program is a requirement to maintain Fellowship, the finding that the Program is perceived as 'obligatory' is not entirely surprising. However, strategies to enhance the value or relevance of the MOC Program for its users remains a priority, particularly given the perceived 'disconnectedness' of the MOC Program from the realities of practice.

The MOC Program re-design has resulted in a reduction in the perceived complexity of the framework. What hasn't been resolved (yet) is the perception of the MOC Program as an add-on to one's work by necessitating the documentation of learning that already occurs. The perception that the Program is merely a documentation mechanism remains part of the common vernacular of many of the respondents; a cultural shift in thinking amongst users is still required.

Practically speaking, respondents desire greater automation and further simplification of MAINPORT. Future design and development considerations should be focused on automation, accessible educational supports and further simplification – particularly with regards to documenting credits.

While 'wins' can be gleaned from our findings regarding the MOC Program re-design, delivering on our declaration that 'MOC places learning at the centre of practice' to users will be paramount going forward.