# EXECUTIVE SUMMARY:
# Ideas and Design Report

## Developing and Implementing

## a Modernized and Unified

## CHCPBC Quality Assurance Program

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### Note to readers

- This Executive Summary is an excerpt from the full report, available on the CHCPBC website.
- It includes most of the key outcomes and conclusions.
- Words in purple are found in the Glossary.
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- The references include all those cited in the full report.
- Questions are best directed to: QAPrograms@chcpbc.org

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# List of Acronyms

AI: artificial intelligence

AMEE: Association for Health Professions' Education

BEME: Best Evidence in Medical Education

CHCPBC: College of Health and Care Professionals of British Columbia

CPD: continuing professional development

CPE: continuing professional education

GPTs: generative pre-trained transformers

HPA: *Health Professions Act*

HPOA: *Health Professions and Occupations Act*

IS: information systems

IT: information technology

ML: machine learning

MSF: multisource feedback

NLPs: natural language processes

OSCE: Objective Structured Clinical Examination

PEMs: printed educational materials

QAP: quality assurance program

# Executive Summary

The *Ideas and Design Report* serves as a roadmap to inform the planning decisions of the College of Health and Care Professionals of British Columbia (CHCPBC)[1] for a modernized and unified quality assurance program (QAP) that innovatively aligns with the *Health Professions and Occupations Act* (HPOA, 2022), improves patient[2] outcomes, and supports licensees' learning and performance.

## A. Overview

This Executive Summary reviews the CHCPBC regulatory context and health professions' educational literature and practices related to QAPs, explains the methodology used by the consultants at SGT & Associates to prepare the report, and offers a summary and list of next steps.[3]

The purposes of the report are to

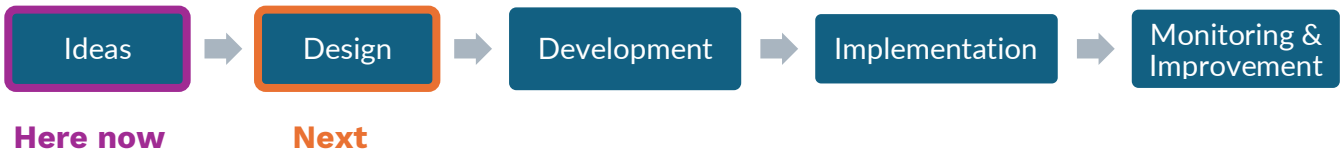
- Inform the strategic direction and planning decisions about CHCPBC's future QAP
- Be a resource for designing, developing, and implementing the QAP

The report includes

- An inventory of the current CHCPBC context and what information is still needed
- An explanation of the QAP's purpose and priority outcomes
- An analysis of the applicable educational and assessment[4] evidence relevant to QAPs
- A discussion of next steps, called "readiness activities," for moving forward to develop and implement the modernized, unified QAP

Figure 1 illustrates the multiple stages for implementing a QAP. The report begins at the ideas stage and moves to the design stage.

**Figure 1 QAP Development Stages—Ideas Stage**




[1] Spelled-out versions of acronyms are also given in the List of Acronyms after the Table of Contents.
[2] The HPOA uses "patients." CHCPBC health and care professionals variably use "patients" and "clients" in day-to-day practice, depending on the practice setting. This report uses "patients."
[3] The HPOA uses the language "quality assurance program." Ultimately, CHCPBC will have the opportunity to use that language or link the HPOA lexicon to organization-specific language. This report uses "quality assurance program."
[4] Words in purple are found in the Glossary and appear in purple only the first time they are used.

## 1) CHCPBC Background

CHCPBC was formed in June 2024 to amalgamate the regulation of a diverse group of health and care professionals: audiologists, dietitians, hearing instrument practitioners, occupational therapists, opticians, optometrists, physical therapists, psychologists, and speech-language pathologists.

At its core, CHCPBC is tasked with the critical mission of helping to safeguard public health by regulating these professionals to ensure that they have the competencies needed to practise and that they adhere to the standards needed for safe and ethical care.

## 2) Purpose of the QAP

With the amalgamation, CHCPBC has the novel opportunity to develop a modernized and unified QAP. This program will support the quality practice of almost 17,000 health and care professionals in the nine professions and be consistent with the HPOA when it is proclaimed.

> The College's QAP will improve patient outcomes and support licensees'[5] learning and professional performance.

Additionally, the modernized and unified QAP can advance CHCPBC's aims as follows:

- Centralize information: Serve as a single point of contact for information about the common quality assurance approach across the various health and care professions.
- Enhance public protection: Ensure a consistent approach to quality assurance across the various health and care professions, thereby augmenting public safety and trust.
- Boost efficiency and effectiveness: Provide greater access to resources and expertise while streamlining the regulatory process.

> Moving forward and building a new, unified QAP will require letting go of legacy QAPs and reimagining ways of thinking about quality assurance that reflect the CHCPBC and HPOA contexts.

The new approaches must be equitable, feasible, and sustainable, while prioritizing patient safety by addressing risks to patients and risks to competence. Designing the QAP offers a unique opportunity to innovate and bravely move forward with quality assurance assessments and quality assurance

[5] "Licensees" is used in the HPOA and this report rather than the terminology used in the *Health Professions Act* (HPA), "registrants."

activities suitable for all licensees, focused on patient health and care outcomes and licensees' performance. The QAP will include individual and collaborative care competencies that are central to safe care and improved outcomes. It will also include cultural safety and humility, health equity, and anti-discrimination initiatives and reflect these in its processes.

With consolidation from multiple systems, platforms, and approaches to a unified QAP, cost savings are expected.

## B. Methodology

From February to April 2025, the consultants employed the following research strategies to manage accuracy and ensure that sufficient information was included in the report:

1. Building on an available inventory[6] of research and resources, including using established terms and definitions
2. Identifying additional applicable information, resources, and research
3. Confirming transparency of literature search methods to ensure relevance within the regulatory context
4. Triangulating data and summaries through meetings with CHCPBC staff and consultations with invited health and care professional licensees
5. Undertaking iterative and structured analysis appropriate to the data collected

## C. Current CHCPBC Context

The contextual research for this report included looking at the nine legacy college's bylaws, website information, and QAPs, as well as profession-specific resources provided by legacy college staff that included QAP reports (25) and literature used to support their QAP or planned updates to the QAP (20).

The report also built on conceptualization of regulation as a system of assessments; factors affecting assessments; risk-based approaches for the QAP; the role of technology in the QAP; and strategies for facilitating change and implementation, internally and for licensee engagement.

## D. Inventory of Evidence

Identified evidence was explored and included key educational and assessment concepts that will influence the design of the QAP. While some concepts are familiar, others introduce approaches different from those used in legacy college programs.

[6] CHCPBC and SGT & Associates extend their gratitude to British Columbia College of Oral Health Professionals, who allowed the repurposing of the content and research from the following report: Glover Takahashi, S., & Clark, M. (2024, October). *Issues, options, and directions for the BCCOHP quality assurance program.* British Columbia College of Oral Health Professionals.

Quality assurance assessments and activities commonly found in regulatory programs were defined and analyzed, their features described, and key evidence systematically inventoried. These tools and materials can be categorized into two groups:

- Quality assurance assessment tools designed for competence assessment, as described in the educational literature, and selected and aligned with the HPOA term "performance"
- Quality assurance activities that serve as proxies for monitoring performance by regulators despite their limitations for regulatory purposes

In analyzing the inventory of many quality assurance assessments and activities found in the literature and in practice, the consultants screened a longer list of possibilities to arrive at a more focused selection suitable to the CHCPBC context.

Five types of assessments or activities are most promising for inclusion in the QAP:

- Shorter written quizzes
- Guided self-reports and self-inventories
- Continuing professional development (CPD) self-reports
- Dashboard for feedback
- Patient surveys

Four types of assessments and activities are possible in a focused, limited role (for example, for follow-up assessments, risk-based assessments, or remedial purposes):

- Case-based discussions
- Simulations
- Direct observation assessments
- Return-to-work self-reports

Five types of assessments and activities are not recommended for inclusion:

- Longer written tests
- Multisource feedback (MSF)
- Quantified continuing professional education (CPE)
- Currency and active practice hours requirements
- Reflective portfolios

## E. Summary and Next Steps

A unified design for a modernized QAP aimed at all CHCPBC licensees is necessary under the HPOA.

**WHY**: To improve patient health and care outcomes and support licensees' learning and professional performance.

**WHO**: For the almost 17,000 licensees of CHCPBC.

**WHAT**: The QAP will assess, monitor, and support licensees' individual and collaborative performance—which is central to the delivery of safe care and improved patient outcomes—including cultural safety and humility, health equity, and anti-discrimination initiatives.

**WHEN**: A staged process will move CHCPBC from the current legacy programs to the new, unified QAP. Considering time sensitivities and operational challenges, 2026 will likely be a transition year, with implementation of QAP Phase 1 in 2027 and QAP Phase 2 proposed for 2029.

**HOW**: The report inventories a topline list of key educational and assessment concepts and describes the design details including the following:

1. The design will support the performance and CPD activities of all licensees through regular (likely annual) common quality assurance activities and assessments. Only design features that are scalable for CHCPBC are recommended.

2. The QAP will recognize that most licensees have a low to moderate risk of patient harm and of dyscompetence. Licensees who have additional risks as defined in the HPOA (section 99 (1) (c)) may require additional specific quality assurance assessments and activities.

3. The QAP will support licensee learning and performance via assessment for learning, assess their performance via assessment of learning, and provide timely feedback on performance in both.

4. The QAP will focus on those elements of licensees' performance central to the delivery of safe care and improved health and care outcomes for patients and the public, including cultural safety and humility, health equity, and anti-discrimination initiatives.

5. The College's standards, once developed, will guide the content for the QAP and the expected performance level.

6. The design will reflect the fact that no single assessment tool is sufficient to assess licensee performance.

   The design will reflect the features of a program of assessment and include multiple assessment tools and methods. Some aspects could be common across all licensees and some required only for selected groups. The assessments and activities will be adaptable to the differences across licensee groups, including scope of practice, roles, practice settings, and team composition.

7. The design will attend to quality criteria including validity or coherence; reliability, reproducibility, or consistency; equivalence; feasibility; educational effect; catalytic effect; acceptability; coherent, continuous, comprehensive; purpose driven; and transparent and free from bias.

8. The design will use Miller's Pyramid and the Cambridge Model in selecting a variety of assessment tools to meet the program's purposes and outcomes.

9. Technology will enhance the integration of CHCPBC's system of competence, including the QAP delivery, monitoring, and feedback on quality assurance assessments and activities, as well as progress monitoring via a dashboard.

Next steps include establishing timelines and priorities; inventorying available and needed resources; designing prototypes of assessments and activities; and engaging and communicating with staff, licensees, and other affected parties.

The transition priorities include sunsetting the many legacy requirements and aligning staffing and operational systems for the new QAP, including strategies for development, engagement, and communication to facilitate the changes.

With the development of QAP Phase 1, CHCPBC sets the stage for a strong, unified program that aligns with the HPOA to improve health and care outcomes and support licensees' learning and continuing competence.

Time is of the essence

Given that the HPOA is to be proclaimed in 2025, CHCPBC does not have the luxury of a long design and development window.

Some of the current legacy programs do not meet HPOA expectations, so "lifting and shifting" all the programs from the HPA to the HPOA is not recommended.

The timely development of one modernized, unified QAP is both feasible and necessary.

# Glossary

**Amalgamated**
The outcome of merging seven colleges responsible for regulating nine health and care professions into CHCPBC.

**Artificial intelligence (AI)**
A concept, the most general of the terms, that spans any process that involves a machine acting "intelligent." Intelligence is most often defined as "human-like" in its ability to make decisions, learn from mistakes, generate insights, or understand language (Coppin, 2004, as cited in Gordon et al., 2024).

**Assessment**
"Any systematic process of obtaining information, used to draw inferences about characteristics of people, objects, or programs. In other words, a systematic process to measure or evaluate the characteristics or performance of individuals, programs, or other entities, for purposes of drawing inferences" (American Educational Research Association et al., 2014, p. 216).

**Assessment for learning**
Uses assessments as tools to support learning. Assessment for learning tools encourage reflection and provide the learner with feedback that enables them to understand where additional knowledge is needed and where options for learning exist (Schuwirth & van der Vleuten, 2020).

The assessment provides results and feedback in a fashion that motivates all affected parties to create, enhance, and support education; it drives future learning forward and improves overall program quality (Norcini et al., 2018). See also **formative assessment**.

**Assessment of learning**
Uses assessments for learners to demonstrate their competence. Assessment of learning is the more traditional way of thinking about assessment, where a learner must demonstrate competence such as the ability to apply knowledge or skills (Schuwirth & van der Vleuten, 2020). See also **summative assessment**.

**Assessors**
In the HPOA, referred to as "quality assurance assessors," with specific responsibilities differentiated from those of quality assurance officers. The assessors' responsibilities focus on conducting a quality assurance assessment. They are knowledgeable about programs of assessment, individual licensee performance, and group performance trends (HPOA, 2022).

**Blueprint**
A test or assessment blueprint outlines the specifications including

- The purpose of each assessment step
- The assessment content, format, and length
- The psychometric characteristics of the assessment items
- Overall assessment processes, delivery mode, administration, scoring, and score reporting (American Educational Research Association et al., 2014)

**Capability (aka capacity)**
Refers to the personal "raw materials," such as intellectual and cognitive functioning, physical ability, and psychological health (Wenghofer et al., 2009). This dimension can vary with time and circumstances. For example, a health professional might have a new progressive neurological condition, an acute depressive episode, a fractured hand, or a

substance abuse disorder that affects current performance or functionality or be fatigued due to prolonged service, with resulting impairment of decision-making or motor skills.

**Competence**
Competence means meeting or exceeding the standards required to perform as a health professional (Epstein & Hundert, 2002). It is a multi-dimensional and dynamic state that changes with time, experience, and context (Frank et al., 2010). Competence is developmental, impermanent, and context specific (Epstein & Hundert, 2002).

The elements of competence are the following:

1. Competencies (professional knowledge, skills, and abilities) (HPOA, 2022), which may also include integration of values and attitudes (Frank et al., 2010)
2. Context of practice (practice location, patient problems and cultures, scope of practice, and team and interprofessional networks and resources)
3. Continuum of practice (entry to practice, ongoing practice, specialized or focused practice, re-entry, approaching retirement, etc.) (Glover Takahashi et al., 2017; Wenghofer et al., 2009)
4. Capability, sometimes called "capacity," and reflected in the HPOA (2022) using the broader term "fit to practise"

*See* also **performance**.

**Competence assessment**[7]
In the HPOA, "an assessment of a [licensee's] competence [fitness to practise], conducted as part of an investigation and further to an order made under section 132." "Quality assurance assessment" means "an assessment of a licensee conducted for a purpose referred to in section 98 (1) *[purposes of quality assurance program]*" (2022, section 1).

**Competencies**
The observable abilities of health professionals (Epstein & Hundert, 2002). One example is the key competencies and enabling competencies in the CanMEDS Framework, which identify the knowledge, skills, and attitudes that physicians are required to have in order to perform competently (Frank et al., 2010).

**Context of practice**
Includes the types of patients and their problems; the location of work or practice (hospital, private practice, or community); and the infrastructure that does or does not protect competence (such as billing systems, staffing IS, electronic medical records, quality monitoring systems, and peer or mentor access or systems) (Wenghofer et al., 2009). The elements of an individual's context of practice are interrelated and have an impact on competence (Wenghofer et al., 2009).

**Continuing competence**
The ongoing competence of a health professional over time. It involves the habitual and judicious use of abilities in a certain context at a defined stage of practice for the benefit of the individual and the community being served (Epstein & Hundert, 2002; Frank et al., 2010). Continuing competence requires effort (to stay up to date, to adapt to contextual changes, to maintain wellness, etc.), including regular attention to and monitoring of risks and protective factors provided by people and systems.

**Continuing professional development (CPD)**

[7] The use of "competence assessment" is much broader in the health professions' educational literature and research. However, to prevent confusion regarding the assessment's purpose or intent, "competence assessment" is not being used when discussing possible directions for the QAP.

Engagement in the process of monitoring and reflecting on professional performance, identifying opportunities to close professional practice gaps, engaging in both formal and informal learning activities, and making changes in practice to reduce or eliminate gaps in performance (Samuel et al., 2021).

In the HPOA, “an activity or program undertaken for the purpose of ensuring that professional knowledge, skills and abilities remain current” (2022, section 1).

**Continuum of practice**
Refers to both the evolution of expertise (student, novice, competent, proficient, or expert) and the life cycle of the professional (student, field-based novice, independent professional, or retired) (Epstein & Hundert, 2002; Wenghofer et al., 2009).

**Dashboard**
“A way of displaying various types of visual data in one place. Usually, a dashboard is intended to convey different but related information in an easy-to-digest form” (Tableau, 2024). In QAPs, dashboards can be used to present completed activities and assessment results and show progress over time.

**Designation assessment**
In the HPOA (2022), an assessment to determine whether to designate a health profession or health occupation as a designated profession or occupation.

**Design thinking**
A problem-solving approach with a unique set of qualities: human centred, option focused, and iterative (Liedtka et al., 2017).

**Dyscompetence**
Means demonstrating less ability and failing to maintain acceptable performance in one or more standards due to challenges in one or more elements of competence (Federation of State Medical Boards of the United States House of Delegates, 1999; Frank et al., 2010).

It may reflect a temporary situation, such as severe fatigue when recovering from an illness or debilitating anxiety in anticipation of a stressful event (Glover Takahashi et al., 2017). It can also be due to a prolonged decline of knowledge and skills from injury, disease, or the aging process affecting a health professional, including their ability to meet standards. “Dyscompetence” is generally more accurate than “incompetence.”

**Ethics standards**
In the HPOA, “standards respecting the practice of a designated health profession in a manner that is ethical” (2022, section 7 (2)). Ethics may be a separate document from standards.

**Feedback**
“A process, an ongoing bidirectional discussion contextually situated within a safe environment to examine and understand past performance and to plan means of growth” (Dent et al., 2021).

**Fit for purpose**
Means assessments are “fit” for their intended purpose. The assessment should generate data that allows for effective judgments of the defined construct (such as competence) and directly informs decisions about the achievement of desired program outcomes (Holmboe & Iobst, 2020).

**Fit to practise**
In the HPOA, "a person is fit to practise a designated health profession if the person has the competence and capacity to practise the designated health profession" (2022, section 39 (1)).

**Formative assessment**
Assessment in which findings are accumulated from a variety of relevant assessments designed primarily for catalytic educational effects and personal improvement. Formative assessment is intended to provide specific, accurate assessment information and data to support constructive feedback and coaching to individual medical residents during their training (Holmboe & Iobst, 2020). See also **assessment for learning**.

**Generative pre-trained transformers (GPTs)**
"A type of large language model … and a prominent framework for generative artificial intelligence" ("Generative Pre-Trained Transformer," n.d.).

**Health hazard**
"(a) a condition, a thing or an activity that
(i) endangers, or is likely to endanger, public health, or
(ii) interferes, or is likely to interfere, with the suppression of infectious agents or hazardous agents, or
(b) a prescribed condition, thing or activity, including a prescribed condition, thing or activity that
(i) is associated with injury or illness, or
(ii) fails to meet a prescribed standard in relation to health, injury or illness" (Public Health Act, 2008, section 1).

**High stakes assessment**
A type of assessment of learning or summative assessment that provides "go/no-go" or "pass/fail" decisions (Holmboe & Iobst, 2020).

**Incompetence**
Means lacking the required abilities and qualities to perform effectively as a health professional in a certain context at a defined stage of education or practice (Federation of State Medical Boards of the United States House of Delegates, 1999; Frank et al., 2010).

Examples of incompetence include not keeping up to date with changes in standards, not maintaining acceptable performance, and committing serious professionalism breaches.

Factors that might impact competence, positively or negatively, fit into one or more of the four elements defined above. Identifying these factors (both hazardous ones, often called "risks," and protective ones, often called "supports") will allow CHCPBC to carefully select assessments that are fit for purpose.

By becoming aware of the risks and protections, a health professional can reduce their likelihood of dyscompetence (Glover Takahashi et al., 2017).

**Information systems (IS)**
"An integrated set of components for collecting, storing, and processing of data, and for providing information, knowledge and digital products" (Encyclopaedia Britannica, 2024).

**Information technology (IT)**
"The branch of technology concerned with the dissemination, processing, and storage of information, esp. by means of computers. Abbreviated *IT*" (Oxford University Press, 2023).

**Knowledge translation**
"A dynamic and iterative process that includes the synthesis, dissemination, exchange, and ethically sound application of knowledge to improve the health of [clients], provide more effective health services and products, and strengthen the healthcare system" (Canadian Institutes for Health Research, 2009).

**Legacy college**
One of the seven colleges amalgamated into CHCPBC. These colleges no longer exist or have any legislative responsibilities.

**Licensee**
"A person who holds a licence" as a designated health professional (HPOA, 2022, section 1).

**Machine learning (ML)**
"ML is a method and discipline. ML involves the specific mathematical and computational structures which produce computer programs/algorithms that can make decisions given input data. ML is most frequently [referred to as] the way in which we achieve (a semblance of) AI" (Gopinath & Churiwala, 2019, as cited in Gordon et al., 2024, p. 447).

**Medium stakes assessment**
A type of assessment of learning or summative assessment, such as follow-up or further assessment, that provides decisions that have some modest personal or professional implications to the participant. These decisions are not considered "go/no-go" or "pass/fail" and do not have the significant implications of a high stakes assessment.

**Natural language processes (NLPs)**
Any type of computational or mathematical approach that deals with natural human (written or spoken) language. NLP is almost always paired with other approaches, and it is often written with the other process divided by a slash (such as "NLP/ML"). ChatGPT, for example, is NLP/ML (specifically deep learning), because it is a deep machine-learning artificial neural network which processes natural language (Iroju and Olaleke, 2015, as cited in Gordon et al., 2024).

**Performance**
Is the product of competence where a licensee demonstrates that they do not meet, meet, or exceed standards (Rethans et al., 2002).

**Program of assessment**
Also referred to as "programmatic assessment" and defined as "the use of multiple assessment tools, often over a period to assess individuals holistically and meaningfully with rigorous attention to trustworthiness and credibility of the whole assessment process" (Schuwirth & van der Vleuten, 2019, p. 177).

**Protective factors to competence**
Means those factors or patterns known to support professionals in meeting or exceeding the standards (Glover Takahashi et al., 2017).

For each person, these factors are not causal, and they do not guarantee protection. However, they can support a professional's competence by helping to mitigate and manage a risk. If the health professional has protective factors, they are more likely to meet standards than if they do not have them. Taking stock of and enhancing or amplifying protective factors can help the professional meet or exceed standards.

**Quality assurance activities**
Refers to QAP requirements that are not assessments and that support the purposes of the HPOA.

**Quality assurance assessment**
In the HPOA, "an assessment of a licensee conducted for a purpose referred to in section 98 (1) *[purposes of quality assurance program]*" (2022, section 1). See **competence** for the four elements of competence, some or all of which may be assessed within a QAP.

**Quality assurance assessors**
See **assessors**.

**Quality assurance information**
Information that is considered as belonging to the quality assurance process (HPOA, 2022).

**Quality assurance officer**
A term used in the HPOA (2022) to describe a specific role with reporting responsibilities that are different than those of a quality assurance assessor.

**Reflection**
The process of analyzing, questioning, and reframing an experience to assess it for the purposes of learning and/or to improve practice (Aronson, 2011).

**Reliability/reproducibility**
When measurements (scores) are repeated and the new assessment results are consistent with the first scores for the same assessment tool on the same or similar individuals for the same competencies measured. Reliability essentially has three types:

- Consistency over assessors (inter-rater)
- Consistency over time (test-retest and intra-rater)
- Consistency over items (internal consistency, aka Cronbach's alpha) (Holmboe & Iobst, 2020)

**Remediation / remedial activities**
In the context of regulated health professionals, the process of addressing deficiencies in knowledge, skills, and attitudes to bring competence to the level where performance meets accepted standards through targeted educational interventions.

**Right-touch regulation**
A set of principles indicating that regulation should aim to be proportionate, consistent, targeted, transparent, accountable, and agile (Professional Standards Authority, 2015).

**Risk**
Is categorized into two types (Glover Takahashi et al., 2017; Kain et al., 2019; Wilson et al., 2015; Yen & Thakkar, 2019):

*1) Risks to Patients and the Public*
These are actions taken by a licensee that puts a specific patient at risk. Examples include

- Using inadequate infection prevention or control practices
- Engaging in fraudulent billing practices

*2) Risks to Health Professionals' Competence*
These are factors associated with an increased risk of dyscompetence. Examples include

- Using out-of-date clinical procedures

- Returning to practice after a significant absence

**Risk assessment**
In the HPOA, this is done as part of a designation assessment as outlined in section 21 (1). Section 22 outlines that risk assessment must entail at least the following matters:

(a) the types of health services provided by persons who practise the health profession or health occupation;
(b) the setting in which health services are ordinarily provided, including
  (i) the physical environment, and
  (ii) the nature and level of supervision or direction, if any, given by persons who practise the same or other health professions or health occupations;
(c) the extent to which practitioners are personally responsible for
  (i) determining the appropriate course of care for patients, and
  (ii) requesting or directing the provision of health services to patients by other persons;
(d) the knowledge, skills, ability and judgment required to practise the health profession or health occupation in a manner that protects the public from harm;
(e) the guidelines or codes, if any, that apply to the health profession or health occupation in relation to ethics and practice;
(f) taking into consideration the matters referred to in paragraphs (a) to (d), the likelihood and nature of any direct or indirect harm that may occur if health services are provided
  (i) in the usual course of health service delivery and, if applicable, according to the guidelines and codes referred to in paragraph (e), or
  (ii) by a person who does not have the knowledge, skills, ability and judgment referred to in paragraph (d) or, if applicable, does not comply with the guidelines or codes referred to in paragraph (e);
(g) the availability and quality of education and training programs in British Columbia or another jurisdiction with respect to the practice of the health profession or health occupation;
(h) any prescribed matter and any other matter that the minister directs.

**Risk-based approach**
Is an approach that identifies both risks and protective factors to support competence and an individual professional's or group of professionals' performance in meeting or exceeding standards.

**Risk-based assessment**
Is an approach to assessment that identifies both risks and protective factors that impact competence and the professional's performance in meeting or exceeding standards.

**Risk-based regulation**
A regulatory approach that assesses and addresses risks to public health, safety, and well-being and uses a data-informed approach to understanding risks and protective factors and the tailoring of regulatory interventions based on the level of identified risk (Organisation for Economic Co-operation and Development, 2021).

Risk-based regulation guides right-touch regulation (Professional Standards Authority, 2015), with its elements of
- Understanding the problem before jumping to the solution
- Selecting the level of regulation proportionate to the level of risk to the public
- Looking forward to anticipating change

See also **right-touch regulation**.

**Risk factors or risks to competence**
Means the patterns of risk that signal who is more likely to experience dyscompetence among health professionals (Glover Takahashi et al., 2017). For each professional, the risks they encounter vary as does the impact on their performance. If a health professional encounters multiple or significant risks, they are less likely to meet standards. Taking stock of and managing or mitigating risks can help the professional meet or exceed standards.

**Scoring rubrics**
"Specific criteria for evaluating [the participant's] performance and may vary in the degree of judgment entailed, the number of score levels employed and the ways in which criteria for each level are described. It is common practice to provide scorers with examples of performances at each of the score levels to help clarify the criteria" (American Educational Research Association et al., 2014, p. 79).

**Summative assessment**
Assessment in which findings and recommendations are designed to accumulate all relevant assessments for high stakes ("go/no-go" or "pass/fail") decisions. Of note, a clear distinction or dichotomy between formative and summative assessment is unhelpful. In reality, in programs of assessments, the assessments and judgments will exist across a spectrum of stakes depending on the assessment's purpose and the licensee's developmental stage (Holmboe & Iobst, 2020). See also **assessment of learning**.

**Technology-enhanced assessments**
Using technology to enhance students' learning and faculty's ability to support their learning to foster the achievement of specific learning outcomes (Fuller et al., 2022).

**Validity**
A process of accumulating evidence about how well an assessment is representing or predicting a participant's ability or behaviour. Validity refers to the specific measurements made with assessment tools in a specific situation with a specific group of individuals. The scores, not the type of assessment tool, are valid. Validity is best viewed as the ongoing reasoning and collection of evidence across multiple dimensions (Holmboe & Iobst, 2020).

# References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