Ideas and Design Report

Developing and Implementing

a Modernized and Unified

CHCPBC Quality Assurance Program

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List of Acronyms and Hints to Readers

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

Hints to Readers

- This is a very dense, technical report. Its aim is to act as both the rationale for the ideas and design of a new direction and program and serve as an ongoing resource for the organization. Much effort will be required to unpack the content for use by and communication to various audiences, including staff, committees, licensees, and the public.
- The Executive Summary has most of the key outcomes and conclusions and is a good place to start.
- In the report, important points are found in text boxes: *Key message*
- At the end of most sections, a ***Summary*** of take-away points is provided.
- Words found in the Glossary are highlighted in purple the first time they are mentioned.

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

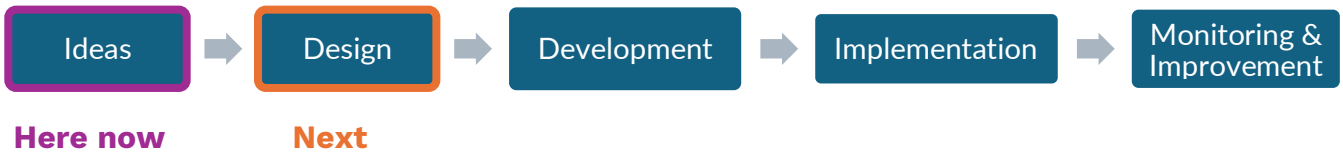
- Inform the strategic direction and planning decisions about CHCPBC's future QAP
- Be a resource for designing, developing, and implementing the QAP

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.

1. About This Report

A. Purpose of This Report

This report reviews the CHCPBC regulatory context and health professions' educational literature and practices related to QAPs.

The College's QAP must be consistent with the HPOA. Given that the HPOA will likely be proclaimed in 2025, CHCPBC does not have the luxury of a long design and development window.

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

This report includes

- An inventory of the 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 evidence relevant to QAPs
- A discussion of issues impacting CHCPBC's decisions when moving from the ideas to the design stage, including what additional evidence might be necessary for decision-making and options for those decisions

Figure 2 illustrates the stages for implementing a QAP. With sufficient information now gathered, analyzed, and documented in the ideas stage, this report makes recommendations for moving to the next stages of design, development, and implementation.

Figure 2 QAP Development Stages—Ideas Stage

B. Purpose of the Modernized and Unified Quality Assurance Program

The new, unified QAP is needed due to the amalgamation of seven legacy colleges. Additionally, as discussed in more detail in the report below, the expectations of the HPOA for QAPs are different from the expectations of the HPA.

In June 2024, CHCPBC was established as the single regulatory organization for nine groups of professionals: audiologists, dietitians, hearing instrument practitioners, occupational therapists, opticians, optometrists, physical therapists, psychologists, and speech-language pathologists. The amalgamation of regulatory bodies into a singular entity is rooted in the principles of public protection, education, and connection. Amalgamation represents a commitment to excellence, efficiency, and inclusivity in processes such as public complaints, registration, and licensee quality practice.

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.

With the amalgamation and the HPOA legislation, 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' learning and performance.

Each of the legacy colleges had their own QAP. These legacy programs have continued, with the individual licensees expected to meet profession-specific requirements. The new QAP must align with CHCPBC's current and future vision as a single regulatory body for nine professions while supporting the shift in mindset and practice for the health and care professionals who are continuing to meet their specific legacy college requirements.

Building a new QAP that serves patients and the public will require letting go of legacy QAPs and reimagining new ways of thinking about quality assurance that reflect the current and future 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 will require bravely moving forward with quality assurance assessments and activities suitable for all licensees, focused on health and care outcomes and licensees' continuing competence. The QAP will focus on individual and team competencies central to the delivery of safe care and improved health and care outcomes for patients and the public. It will also include cultural safety and humility, health equity, and anti-discrimination initiatives.

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

C. Scope and Content of Report

This report presents a broad yet comprehensive and targeted look at the available evidence about QAPs, drawing from the educational and assessment literature. Focused conversations with key experts across the nine health and care professions were conducted, and an inventory of the nine legacy programs was completed.

In this report, key terminology has been reconciled with the HPOA context, which sometimes meant finding a different yet still appropriate term. For example, the HPOA places "competence assessment" within the context of conduct, while in the educational literature, that same term is used to describe the measurement of a professional's performance. As such, this report uses the term "quality assurance assessment" for those assessments of performance specific to quality assurance.

The CHCPBC language needs to be updated to be consistent with the HPOA language and educational and assessment literature terminology.

Programs of assessment, assessment for learning, risk-based assessment, design thinking, and factors facilitating a culture of patient safety are some of the contemporary approaches explored in this report. A wide range of both quality assurance activities and assessments were reviewed, such as quantified continuing professional education, active practice hours, self-reports, and peer assessments.

With objectives similar to knowledge translation initiatives that are designed to provide more effective health services and strengthen the health care system, this report adopts an iterative approach, where available evidence was gathered and synthesized to provide clarity on issues and options related to current quality assurance practices.

Summary

1. The purpose of this report is to inform the design of CHCPBC's future QAP.

2. The QAP will improve health and care outcomes and support licensees' learning and performance.

3. Building a new QAP that serves patients and the public will require letting go of legacy QAPs and reimagining ways of thinking about quality assurance that reflect the current and future CHCPBC and HPOA contexts.

4. The CHCPBC language needs to be updated to be consistent with HPOA language and educational and assessment literature terminology.

5. Programs of assessment, assessment for learning, risk-based assessment, design thinking, and factors facilitating a culture of patient safety are some of the contemporary approaches explored in this report. A wide range of both quality assurance activities and assessments, such as quantified continuing professional education, active practice hours, self-reports, and peer assessments, were reviewed to determine which are best suited for a modernized and unified QAP within the HPOA.

2. Methodology

To prepare this report, from February to April 2025, the consultants employed the following research strategies to manage accuracy and ensure that sufficient information was included:

1. Building on an available inventory 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 professional licensees
5. Undertaking iterative and structured analysis appropriate to the data collected

A. Use of Available Inventory of Research and Resources

SGT & Associates are experts in the health professions education and assessment field. Over the last two decades, their team members have designed several QAPs and programs of assessment for provincial health professional regulators and led the design of numerous assessment and credentialling programs.

In 2024, in preparation for the proclamation of the HPOA, SGT & Associates led a comprehensive research project for the British Columbia College of Oral Health Practitioners to design their QAP. The resulting report, *Issues, Options, and Directions for the BCCOHP Quality Assurance Program*, was completed late in 2024 and was shared with CHCPBC, allowing SGT & Associates to fast-track this work.

1) Using Established Terms and Definitions

Commonly used definitions related to competence, quality assurance, and assessment were gleaned from a review of the most recent versions of textbooks used in post-graduate courses for health professionals (Bastable et al., 2019; Dent et al., 2021) and the 2020 Accreditation Council for Graduate Medical Education *Assessment Guidebook* (Holmboe & Iobst, 2020).

The consultants leaned on the Association for Health Professions' Education (AMEE) *AMEE Guide No. 156* (Tolsgaard et al., 2023) and the scoping review described in the Best Evidence in Medical Education (BEME) *BEME Guide No. 84* related to artificial intelligence (AI) in medical education (Gordon et al., 2024), as well as consensus statements related to assessment (Fuller et al., 2022; Heeneman et al., 2021; Norcini et al., 2011; Norcini et al., 2018). Additionally, the consultants looked at the HPOA's (2022) draft version for terms, definitions, and descriptions.

B. Identification of Additional Applicable Information, Resources, and Research

CHCPBC leadership, the team members involved in the legacy QAPs, and professional practice advisors were invited to send the consulting team seminal articles or resources that are relevant to their profession and could inform a modernized, unified QAP under the HPOA. Team members in most of the professions sent articles and/or resources that were inventoried and considered for review.

C. Transparency of Literature Search Methods

As experts in this area, the consultants agree that seminal articles related to competence, quality assurance, and assessment are widely considered reliable references. Publication alerts from *Academic Medicine*, *BMJ Open*, *Curriculum*, *Medical Education*, *Medical Teacher*, and other journals that publish peer reviewed papers were combed regularly for relevant articles. Only literature and grey literature published in English was included for review.

In total, 133 sources were included for review, as outlined in Table 1 below. The majority were published in the past 15 years. Older articles were included to help explain the history or evolution of an assessment or the construct of competence.

Table 1 Summary of Sources Reviewed

Source	No.	Years
Peer reviewed papers	81	1979–2024
Reports and briefing notes	11	1999–2024
Guides	10	2007–2024
Reviews (literature, scoping, and systematic)	10	2009–2021
Books, including book chapters	6	1996–2021
Internet sources (dictionaries and encyclopedias)	6	2020–2024
Peer reviewed consensus statements	4	2011–2022
Legislation	2	2022
Theses (master's and PhD)	2	1998–2003
Testing standards	1	2014

Research in this area is dominated by medicine, as reflected in the References. Articles from other health professions were included whenever relevant.

Searches on Google Scholar and PubMed were conducted to augment evidence from other professions, including for the nine health and care professions regulated by CHCPBC, including evidence for best practices in change management. The consultants studied some QAPs with more rigour than others,

and where the evidence is not yet available, outstanding questions remain regarding these mechanisms or emerging mechanisms.

The consultants' current database related to assessments in education and quality assurance holds over 2000 peer reviewed journal articles and 100 reports, such as evaluation reports, discussion papers, and guides. CHCPBC staff provided 20 peer reviewed articles and commission reports and 25 reports from legacy colleges. Twelve articles were retrieved from reviewing the references within reports sent, largely those related to pilot testing of updated QAPs. From these, literature that provided the most robust evidence (for example, randomized controlled trials and grounded theory approaches rather than single-case studies or program evaluations) was selected.

To prevent outdated information and bias, the consultants conducted hand searches of reference lists from the sources outlined above under Using Established Terms and Definitions, such as the consensus statements on assessment. Reference lists from grey literature published in the past five to eight years by regulatory organizations and more recently published articles were also reviewed. Searches confirmed that most sources were already included, but over 20 additional resources were identified.

Systematic reviews and papers included in these reviews carried more weight for inclusion. Where systematic reviews presented differing conclusions, the Cochrane Systematic Reviews were considered most robust, given their very rigorous quality protocols. When a Cochrane Systematic Review had been repeated and corrected for bias, these findings held added strength. In the case where findings had been replicated more recently, only the most current papers were cited except for seminal and historically significant articles.

D. Triangulation of Data Sources

In addition to the evidence selected from peer reviewed journals, data from two sources was triangulated to help ensure accuracy of the information collected and present a fuller picture:

- Most often, the evidence examined about QAPs was the grey literature of available documents from organizational websites, as well as some follow-up semi-structured conversations with organizations outside of CHCPBC. These outside sources help illuminate the contextual evidence: the landscape of why, where, and how different educational and assessment approaches are used in QAPs for regulation of health and care professionals.
- Semi-structured conversations with CHCPBC staff provided experiential evidence. These were guided by pre-circulated agendas and focused on developing an understanding of the organizational context and the design and current approaches used by the legacy QAPs. Regular meetings with CHCPBC leaders were structured to elicit feedback on areas where additional evidence may be needed and further clarity was required in the draft report. See

Appendix 1 for a list staff of members, licensees, and others who were consulted for input and feedback about the report.

E. Iterative and Structured Analysis

Analysis was used iteratively to inventory and summarize what was known, clarify what was not clear, and identify areas that needed further study or additional consideration.

To organize the large amounts of gathered evidence, a preliminary outline of the report was established to provide structure to the reported information. Once assembled, the outline was refined to reflect the analysis and highlight the most robust evidence.

Summary

1. The report's methodology was thorough and based on best practices for qualitative, multi-method projects.

2. The consultants completed focused literature searches and summaries. Triangulation and iterative structured analysis were used to monitor project content and process, to meet CHCPBC's needs.

3. Input from CHCPBC on early versions of the report was gathered to ensure clarity, relevance, and completeness.

4. CHCPBC should have a high degree of confidence in using this report to design and develop a QAP.

3. CHCPBC Context

Context matters. Context is essential when designing assessments and programs of assessment (Eva et al., 2016). When a QAP is being built or rebuilt, having an accurate understanding of the explicit and implicit structures and systems in place is necessary so that the QAP's new purposes and outcomes can be achieved.

This section explores the structures and systems affecting the selection of assessment tools and looks at other QAPs.

A. CHCPBC Purpose

CHCPBC unites the regulation of nine health and care professions in British Columbia. This integration ensures that these health and care professionals possess the competencies to deliver safe, ethical, and high quality care.

> CHCPBC is committed to the regulation of health and care professionals whose professions improve physical and mental health and well-being.

CHCPBC's aims include the following:

- 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 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.

B. CHCPBC Regulatory Approach

The CHCPBC Regulatory Approach aligns with statutory requirements and commitments, as well as consideration of modern approaches to regulation and health care.

The CHCPBC Statutory Authority and other regulatory guidance includes

- HPA (and forthcoming HPOA; see HPOA analysis in the next section)
- Human Rights Act
- Declaration on the Rights of Indigenous Peoples Act
- United Nations Declaration on the Rights of Indigenous Peoples Act

Key regulatory resources to inform the CHCPBC approach include

- Right-Touch Regulation
- Modernization of Health Professions in BC
- In Plain Sight Report
    - In Plain Sight Summary Report
- Truth and Reconciliation Commission of Canada
- United Nations Declaration on the Rights of Indigenous Peoples

As a new organization, CHCPBC needs to use the evolving clarity on their strategic directions to ensure that the approaches included in the modernized, unified QAP are aligned.

C. Health Professions and Occupations Act

Division 8 of the HPOA as drafted outlines requirements for QAPs. Division 2 of the HPOA includes the following guiding principles that apply to QAPs:[7]

14 (2) In exercising powers and performing duties under this Act, a person must act in accordance with the following principles:

(a) to protect the public from harm and discrimination;

(b) to support and promote awareness of all of the following, as they relate to the oversight and review of regulators, the governance of designated professions and occupations and the provision of health services:

(i) reconciliation with Indigenous peoples;

(ii) the United Nations Declaration on the Rights of Indigenous Peoples;

(iii) the need to address racism and anti-racism issues that are specific to Indigenous peoples, including acknowledging the rights, interests, priorities and concerns that are specific to First Nations peoples, Métis peoples and Inuit peoples, based on distinctions among them;

(c) without limiting paragraphs (a) and (b), to take and promote anti-discrimination measures;

(d) to act in a fair manner, including by demonstrating respect for the principles of procedural fairness;

(e) to act in a manner that is respectful of the privacy of persons who participate in regulatory processes.

(3) Unless it would conflict with a principle under subsection (2), in exercising powers and performing duties under this Act, a person must act in accordance with the following principles:

(a) to promote a holistic health care system that encourages collaboration between regulators and between persons who provide different types of health services;

[7] HPOA Guiding Principles

(b) to identify and remove barriers to the practice of a designated profession or occupation, in British Columbia, by extra-jurisdictional practitioners;
(c) to act in a manner that is transparent, including by providing opportunities for meaningful public engagement.

The HPOA guiding principles, with their commitments to anti-racism, reconciliation, and recognition of Indigenous rights, can be used with intentionality in the development, implementation, and evaluation of the QAP, including how tools are developed, how assessments are framed, how assessors are trained, and how progress is measured.

The Act is to be proclaimed in 2025. When approved, the content of the HPOA is not expected to have significant changes. However, the final version will need careful review once in force for impact on the QAP design.

One key difference between the HPOA and the HPA is the new and specific expectation of quality assurance assessments that are focused on assessing licensees' performance.

Additionally, CPD, where included in the QAP, is expected to be focused for the purposes outlined in section 98 (1):

(a) to assist individual licensees to improve their own professional performance;
(b) to identify issues of professional performance found across multiple licensees or within a class of licensees and recommend measures that may be taken to remedy those issues.

The consultants looked at the available HPOA documentation to inform the design of CHCPBC's program given that the Act is the organizing framework for QAPs. Table 2 provides a section-by-section commentary on the possible educational and assessment implications of Division 8 to the College's QAP based on the available text for that division. Table 3 includes definitions of key terms for QAPs in the HPOA.

Both tables were reviewed from a legal perspective by Angela Westmacott, legal counsel for CHCPBC.

Table 2 HPOA Division 8 and Educational and Assessment Implications for the College's QAP

Division 8 (as drafted)	**Educational and assessment implications**
Bylaws **97** A board must make bylaws respecting the establishment and administration of a quality assurance program, including respecting all of the following: (a) the qualifications of quality assurance assessors; (b) the conduct of quality assurance assessments; (c) the policies and procedures to be used to ensure minimal disruption to the ordinary course of providing health services when quality assurance assessments are conducted; (d) the means used to improve individual performance and to remedy issues of professional performance found across multiple licensees or within a class of licensees.	The QAP must have ● A process for ensuring that quality assurance assessors are knowledgeable about programs of assessment, individual licensee performance, and group performance trends ● Reliable methods for monitoring, reporting, and recommending measures for remediation ● Bylaws and policies requiring licensees to participate in assessments by a quality assurance assessor in compliance with the requirements of the program CHCPBC legal counsel confirmed that the HPOA requires bylaws to establish and administer the QAP but that it can largely be operationalized through a formal policy referenced in the bylaws. For CHCPBC, all registrants from the legacy colleges are expected to be classified as "licensees" under the HPOA. A unified approach to a new QAP depends on their future designation as licensees because QAP requirements will not apply to non-licensees.
Purposes of quality assurance program **98** (1) A regulatory college must establish and administer a quality assurance program for the following purposes: (a) to assist individual licensees to improve their own professional performance; (b) to identify issues of professional performance found across multiple licensees or within a class of licensees and recommend measures that may be taken to remedy those issues.	CHCPBC must have a QAP. The QAP must be consistent with the purposes set out in section 98 (1) and can assist licensees to improve their performance by ● Including data-gathering and analysis as part of monitoring issues in performance trends across licensees ● Identifying and recommending effective measures for improving recognized performance issues (education, policies, related practice resources, standards, etc.)
(2) A regulatory college must not conduct a quality assurance program (a) for the purposes of an investigation or disciplinary proceeding, or (b) solely as a type of continuing professional development or a similar type of program.	The QAP must not ● Be used for investigation or as part of a disciplinary proceeding or process ● Provide CPD unrelated to the purposes outlined in section 98 (1)
Conduct of quality assurance assessment **99** (1) A quality assurance assessment of a licensee may be conducted by a quality assurance assessor (a) on request of the licensee, (b) by random selection of the licensee, (c) based on an assessment of the risk presented by a class of licensees, by types of health services provided by licensees or	The QAP will need purposeful and defensible selection processes and criteria for assessments related to any risk presented by a class or group of licensees. The options for selection are request by a licensee, random selection of the licensee, selection where risk is based on an assessment of risk presented by

Division 8 (as drafted)	**Educational and assessment implications**
by a class established on any other basis, or (d) in any circumstance provided for under the bylaws.	a group of licensees, or other established rationale set out in the bylaws. A risk-based selection will be most consistent with the planned right-touch regulation and modernized approach for CHCPBC. The basis for conducting quality assurance assessments may be expanded as set out in the CHCPBC Bylaws.
(2) For the purposes of conducting a quality assurance assessment of a licensee, a quality assurance assessor may do one or more of the following: (a) require the licensee to complete a self-assessment; (b) observe the licensee practising the licensee's designated health profession, and give directions for this purpose; (c) inspect relevant records of the licensee, including records containing the personal information or other types of confidential information of patients; (d) take other actions as authorized under the regulations or bylaws.	The QAP can include the assessments outlined in section 99 (2) or as authorized under the regulations or bylaws. Examples include practice-based assessments; clinical records reviews, including confidential review and summary of patient records; and other practice documentation reviews. Self-assessment, if included by CHCPBC, will require a definition consistent with the modernized approach and the educational literature. Self-assessment for the QAP should be called "guided self-assessment," "self-report," or another similar, evidence-informed term. Such a term will help prevent misinterpretation, distance itself from the well-documented drawbacks of self-assessment, and accurately reflect the assessment's application of current educational and assessment literature for health professions.
If individual performance matter identified **100** (1) If, based on a quality assurance assessment, a quality assurance assessor is of the opinion that a licensee's professional performance could be improved, the assessor may give notice to the licensee, in writing, and do one or more of the following in the notice: (a) give advice to the licensee; (b) recommend that the licensee (i) undergo clinical or other evaluations, (ii) undertake further education, training or other remedial activities, or (iii) take one or more anti-discrimination measures; (c) recommend actions to prevent potential harm or discrimination while the deficiency is being remedied.	Where QAP assessments suggest that performance could be improved, the quality assurance assessor may give written notice to the licensee and can provide advice to the licensee; recommend that the licensee pursue education, undergo further clinical or other assessments, or take anti-discrimination measures; and recommend actions to prevent potential harm or discrimination while the deficiency is being remedied. Assessors will need training in the assessment of discrimination and licensee performance of discrimination and in mitigation measures to prevent potential harm or discrimination while the licensee deficiency is being remedied.

Division 8 (as drafted)	**Educational and assessment implications**
(2) A licensee's failure to comply with advice or a recommendation given under this section is not misconduct or sufficient cause to begin an investigation or disciplinary proceeding.	Note the following: ● Assessments are called "evaluations" in section 100 (1) (b) (i) ● Proposed remediation of licensee performance deficiencies is achieved through giving advice under section 100 (1) (a) or making recommendations to the licensee under sections 100 (1) (b) or (c) ● Licensee failure to comply with advice or recommendations is not to be viewed as misconduct, nor can refusal initiate investigation or disciplinary actions ● If so stated, CHCPBC bylaws can contemplate licensee non-compliance with a QAP assessment as a ground for directing additional and/or different assessments
If general issue of professional performance identified **101** (1) If, based on one or more quality assurance assessments, a quality assurance assessor is of the opinion that there are issues of professional performance across multiple licensees or within a class of licensees, the assessor may make a report that includes recommendations respecting one or more of the following: (a) further education, training or other remedial activities that licensees should undertake; (b) types of anti-discrimination measures that licensees should take; (c) actions to prevent potential harm or discrimination while the issues are being remedied; (d) prescribed matters. (2) A report under subsection (1) must be made in writing to the board or to a person or body identified for this purpose under the bylaws.	The quality assurance assessors should ● Monitor and report on common licensee performance issues ● Identify group performance issues, including those that may be prevalent in particular practice settings regardless of the type of licensee ● Provide written recommendations to remedy identified performance issues (education, policies, related practice resources, standards, etc.), anti-discrimination measures that licensees should take, and mitigation measures to prevent potential harm or discrimination while the licensee group's deficiency is being remedied Note the following: ● Recommendations for remediation of licensee group performance deficiencies are included in section 101 (1) (c) ● CHCPBC legal counsel advised that sections 100 (1) (a) and 100 (1) (b) can also be considered remediation measures ● The report must be submitted to the Board unless the CHCPBC Bylaws stipulate that the written report be made to another person or body identified for this purpose (for example, a QAP Oversight Group, Quality Assurance Committee, or designate of the Registrar)
Protecting confidentiality **102** (1) All of the following is quality assurance information for the purposes of this Act: (a) the personal information of a patient or a person who sought health services from a licensee; (b) information or records prepared or obtained by any person or body for the	This section details the wide range of patient health information that can be accessed and must be protected as quality assurance information. The exceptions to the blanket requirement of confidentiality are set out in section 102 (2) as confirmed by legal counsel. Disclosure of information is permitted to

Division 8 (as drafted)	**Educational and assessment implications**
purposes of a quality assurance assessment; (c) information or records that identify or may identify, directly or indirectly, a person or body who gave information or records to a quality assurance assessor for the purposes of a quality assurance assessment. (2) A quality assurance officer must not disclose quality assurance information except as follows: (a) to other quality assurance officers for the purposes of a quality assurance program; (b) as provided for under this Division. (3) Subsection (2) applies despite (a) section 490 (2) and (3) *[compellability of information]* of this Act, and (b) the *Freedom of Information and Protection of Privacy Act*, other than section 44 (2) or (3) of that Act.	• Other quality assurance officers for the purposes of the QAP • The Registrar under section 103 (2) regarding discipline for administrative matters for licensees not cooperating with the quality assurance assessment • The Registrar under section 104 (1) where there are reasonable grounds to believe that the licensee is not fit to practise or the licensee has committed an act of misconduct and giving notice is necessary to protect the public from harm • The public health officer or a medical health officer if the circumstances in section 105 (1) exist and discourse is necessary to comply with a request under section 11 (e) of the *Public Health Act* Note: Quality assurance information is not disclosable under the *Freedom of Information and Protection of Privacy Act* and is not compellable for proceedings of a judicial nature under section 490 of the HPOA except 1) where it is compelled for a discipline hearing or other type of hearing under the HPOA or for a criminal prosecution under federal legislation; or 2) the College Board is of the opinion it would be in the public interest to disclose information or a record to a court or a tribunal conducting judicial proceedings.
Failure to cooperate **103** (1) A quality assurance officer may give written notice to the registrar that a licensee has contravened section 75 *[duty to cooperate]* if the officer is of the opinion that the licensee is interfering with the conduct of a quality assurance assessment, which may include the opinion that the licensee (a) is not participating adequately, or (b) has lied or given false information to, or is refusing to comply with a direction given by, a quality assurance assessor for the purposes of the assessment. (2) A quality assurance officer may disclose quality assurance information to the registrar as necessary for the purposes of taking an action under Division 9 *[Discipline for Administrative Matters]* of this Part with respect to the matters referred to in the notice given under subsection (1) of this section. (3) Quality assurance information that a	This section authorizes the quality assurance officer to give written notice to the Registrar when they are of the opinion that the licensee has failed to cooperate or has interfered with a quality assurance assessment. The quality assurance officer may disclose to the registrar only quality assurance information that is necessary to take action under Division 9 (*Discipline for Administrative Matters*), and information provided by a licensee cannot be tendered into evidence in a proceeding under the HPOA or in a civil proceeding except for the purpose referred to in subsection (2) of this section. This means that licensee information can be used for the purposes of taking action under Division 9 for failing to cooperate. Policies will be needed to outline what information can be shared with the Registrar under sections 103 (1) and (2) of the HPOA and when it can be shared.

Division 8 (as drafted)	**Educational and assessment implications**
licensee provides under a quality assurance program, including a self-assessment prepared by a licensee, must not be received as evidence in a proceeding under this Act or in a civil proceeding, or used against the licensee, except for the purpose referred to in subsection (2) of this section.	
Protecting the public **104** (1) A quality assurance officer may give written notice to the registrar if the officer has reasonable grounds to believe that (a) the licensee is not fit to practise, or (b) the licensee has committed an act of misconduct and giving the notice is necessary to protect the public from harm. (2) A registrar who receives a notice under subsection (1) of this section may, based on the notice, make a regulatory complaint under section 119 *[regulatory complaints by registrar]*. (3) A quality assurance officer may disclose quality assurance information in a notice given under this section as necessary for the purposes of an investigation, disciplinary action or disciplinary proceeding conducted as a result of the notice.	This section details that • The quality assurance officer may disclose quality assurance information in a notice to the Registrar under section 104 • The Registrar who receives notice under section 104 (1) may address this as an administrative matter under section 107 (b) or make a regulatory complaint under section 119
Notice of health hazard **105** (1) A quality assurance officer may give written notice to the provincial health officer or a medical health officer if the quality assurance officer has reasonable grounds to believe that (a) a health hazard within the meaning of the *Public Health Act* exists or may exist, and (b) there is a risk of significant harm to the public or a group of people. (2) A quality assurance officer who gives a notice under subsection (1) (a) must provide the information referred to in section 11 of the *Public Health Act* as if the notice were a report made under that section, and (b) may disclose quality assurance information, if necessary to comply with a request made under section 11 (e) of that Act.	This section details that • The quality assurance officer may give written notice of a health hazard to the provincial health officer or medical health officer if the quality assurance officer has reasonable grounds to believe that a health hazard as defined exists or may exist and that there is a risk of significant harm to the public or a group of people • The quality assurance officer may disclose quality assurance information in a notice of health hazard under section 105 only if necessary to comply with a request made under section 11 (e) of the *Public Health Act*

Table 3 HPOA Division 8 Definitions of Key Terms and Educational and Assessment Implications for the College's QAP

Term and definitions in Division 8 (as drafted)	**Educational and assessment implications**
"Capacity" means "capacity to be fit to practise a designated health profession, as described in section 39 (3) *[fit to practise]*" (section 1).	Refers to 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 practitioner 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" means competence to be fit to practise a designated health profession, as described in section 39 (2): "A person has the competence to practise a designated health profession if the person has the knowledge, skills, ability and judgment necessary to practise the designated health profession ethically, safely and in accordance with all applicable ethics standards and practice standards" (section 39 (2)).	The definition of "competence" is in keeping with current literature. The QAP should include an assessment of licensees' performance regarding standards. There must be bylaws establishing ethics and practice standards, or they must be identified in the bylaws. See also "performance."
"Competence assessment" refers to "an assessment of a respondent's competence [fitness to practise], conducted as part of an investigation and further to an order made under section 132 *[competence assessments]*" (section 1).	This differs from a quality assurance assessment (see below). Alignment of terminology across CHCPBC between the HPOA and the QAP is necessary.
"Continuing professional development" refers to "an activity or program undertaken for the purpose of ensuring that professional knowledge, skills and abilities remain current" (section 1).	The definition is sufficiently close to that of current literature and broad enough to not impede QAP design or content.
"Ethics standards" refers to "standards respecting the practice of a designated health profession in a manner that is ethical" (section 7 (2)).	The QAP should include an assessment of licensees' performance vis-à-vis standards. There must be bylaws establishing ethics and practice standards, or they must be identified in the bylaws.
"Fit to practise": "A person is fit to practise a designated health profession if the person has the competence and capacity to practise the designated health profession" (section 39 (1)).	"Fit to practise" is broadly used in the HPOA to encompass both competence and capacity.
A "licensee" is "a person who holds a licence" as a designated health professional (section 1).	This report uses the term "licensees," as regulated by CHCPBC.
Performance	"Performance" is not defined but is used in the CHCPBC context to mean a product of

Term and definitions in Division 8 (as drafted)	**Educational and assessment implications**
	competence where a licensee demonstrates whether they do not meet, meet, or exceed standards of practice (Rethans et al., 2002).
"Practice standards" refers to "standards respecting the practice of a designated profession or occupation" (section 7 (2)).	The QAP should include an assessment of licensees' performance regarding standards. There must be bylaws establishing ethics and practice standards, or they must be identified in the bylaws.
A "quality assurance assessment" is "an assessment of a licensee conducted for a purpose referred to in section 98 (1) *[purposes of quality assurance program]*" (section 1).	This differs from a competence assessment (see above). Alignment of terminology across CHCPBC between the HPOA and the QAP is required.
"Quality assurance information" enumerates the types of information that constituted quality assurance information gathered during the quality assurance process.	Quality assurance information is also subject to stringent confidentiality requirements. (See the section on protecting confidentiality in Table 2.)
Remedial activities	"Remedial activities" are not defined but are used in the context of further education or training that may be needed in the case of individual or general performance issues.
Risk assessment must be done as part of a designation assessment as outlined in section 21 (1). Section 22 indicates that the superintendent "must consider 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	Although situated within the designation assessment section, section 22 indicates the government's view of risk. This information should be aligned with CHCPBC's data collection to inform and guide the QAP.

Term and definitions in **Division 8** (as drafted)	**Educational and assessment implications**
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.	

Summary

1. The HPOA requires the establishment of a QAP with specific expectations related to quality assurance assessments of licensee performance.

2. Any QAP must comply with the HPOA. As the QAP is developed, the CHCPBC language, HPOA language, and terminology in the educational and assessment literature will need to be consistent.

3. The Bylaws will need to be updated to provide clarity on the QAP processes (for example, qualifications, roles, and responsibilities of assessors for discrimination assessments; risk-based assessments; and selection processes for assessment).

4. The risk factors identified in the HPOA should be included and aligned with the data collected by CHCPBC to inform and guide the QAP.

5. Assessors will require specialized training.

6. Policies will need to be developed to be consistent with the HPOA in matters such as privacy and disclosure of QAP data, failure to participate, and remediation.

D. CHCPBC Legacy Quality Assurance Programs

After a thorough review of the nine legacy colleges' bylaws, website information, and profession-specific resources, the wide variation across the QAP

requirements became apparent.

Examples of variations are numerous:

- Annual quality assurance reporting is a requirement for five of the professions (dietitians, occupational therapists, optometrists, physical therapists, and psychologists).
- Some programs have multiple layers and tools required annually (for example, optometrists and psychologists), while others have fewer annual requirements (for example, occupational therapists and physical therapists).
- Completion of education credit hours is a requirement for five professions (audiologists, hearing instrument practitioners, optometrists, psychologists, and speech-language pathologists).
- Continuous practice hours are reported every three years by audiologists, hearing instrument practitioners, occupational therapists, and speech-language pathologists but every five years by physical therapists.
- A three-year reporting cycle is used for four professions, though different approaches are taken:
    - Audiologists, hearing instrument practitioners, and speech-language pathologists use a common three-year cycle for all licensees (for example, 2022–2024 and 2025–2027).
    - One profession (opticians) has about one-third of licensees report each year, with each licensee reporting every three years based on initial registration date.
- Sometimes, quality assurance is linked to disciplinary conduct (for example, prior to reinstatement following a disciplinary action, opticians and optometrists are required to complete all outstanding quality assurance requirements.)
- Completion of quality assurance requirements is mandatory for non-practising licensees in four professions (audiologists, hearing instrument practitioners, opticians, and speech-language pathologists).
- In some cases, making up missed quality assurance requirements is linked to re-entry to practice:
    - Sometimes, the missed period is set at three years (such as for dietitians, occupational therapists, and opticians).
    - At other times, the period is six years (such as for optometrists and psychologists).
- Some professions have multiple certifications, where certified licensees have additional quality assurance requirements (for example, audiologists, hearing instrument practitioners, opticians, and speech-language pathologists), while other professions do not use certifications for comparable variations in scope of practice or competence.
- Sometimes, both paper-based and online options are provided for reporting completion of quality assurance requirements (for example, optometrists).
- Sometimes, unique, profession-specific requirements are defined in the bylaws (for example, CPR recertification every three years for optometrists and a jurisprudence examination every five years for dietitians).

The review to date highlights differences in how legacy QAPs explicitly used

educational evidence to guide initial QAP design, development, and implementation, as well as how the QAPs were refined over time. Even common approaches across the legacy colleges appear to be leaning on different theoretical frameworks. Furthermore, across legacy colleges, the terminology "right touch," "risk-based," and "assessment" is interpreted and applied unevenly.

Notably, several legacy colleges (audiologists, dietitians, occupational therapists, physical therapists, and speech-language pathologists) had planned QAP updates that, due to amalgamation, were neither completed nor implemented.

1) Priority Sunsetting Is Beneficial to New QAP

The current wide variation in QAPs illustrates that some CHCPBC licensees have many more requirements than others. Some of the legacy QAP requirements could be considered barriers to meeting staffing shortages for health and care professionals. Many of the legacy QAP requirements (for example, mandatory credits or hours) have financial implications for the licensees, CHCPBC, employers, and the health care system.

A strong case exists for pausing or stopping many aspects of the legacy QAPs as soon as feasible.

QAP mechanisms with insufficient validity evidence or those that are inconsistent with a modernized, unified approach aligned with the HPOA should be discontinued as soon as feasible. The time gained can be repurposed to processes that track improvement in licensees' competence and patient outcomes.

Many elements of the legacy QAPs that were feasible for smaller colleges or within the HPA framework will need to be set aside, given the concepts of right-touch, risk-based, programmatic assessments in the HPOA context.

Designing, developing, and implementing a new QAP while continuing with the legacy QAPs is likely not feasible—financially or administratively.

Current legacy requirements—some of which are found in the QAPs and others in registration requirements—that should be prioritized for sunsetting as soon as feasible include

- Reporting currency hours
- Undertaking quantified CPE
- Auditing currency hours and quantified educational credits
- Attesting during renewal of registration that required continuous practice hours have been completed

- Having unique requirements for a specific profession (for example, CPR recertification, jurisprudence examination, or paper-based documentation)
- Completing outstanding quality assurance requirements prior to re-entry
- Completing prescribed additional learning

Stopping current legacy requirements would not necessarily result in a gap in expectations for licensees.

A phased approach to implementation of a modernized, unified QAP, where Phase 1 is a transition period, will allow for earlier movement to more equitable requirements for all nine professions.

Summary

1. Wide variations are apparent in how legacy QAPs explicitly used educational evidence in their programs. Some CHCPBC licensees have many more requirements than others. Some of the legacy QAP requirements could be considered barriers to meeting staffing shortages for health and care professionals.

2. Across the legacy colleges, terminology was used inconsistently, which will necessitate the development of a common lexicon in the modernized, unified QAP.

3. Many of the legacy QAP requirements (for example, mandatory credits or hours) have financial implications for licensees, CHCPBC, employers, and the health care system.

4. A strong case exists for pausing or stopping many aspects of the legacy QAPs, including certification, as soon as feasible. The time gained can be repurposed to processes that track improvement in licensees' performance and patient outcomes.

   Designing, developing, and implementing a new QAP while continuing with the legacy QAPs is likely not feasible—financially or administratively.

5. A phased approach to implementation of a modernized, unified QAP, where Phase 1 is a transition period, will allow for earlier movement to more equitable requirements for all nine professions.

E. Thinking of Regulation as a System of Assessments

Regulation comprises various elements, all of which should be considered measures of and included in a program of assessment: initial licensure requirements, complaints and disciplinary matters, and annual re-licensure requirements.

Regulation is a program of licensee assessment

Regulation's core purpose is assessment to ensure quality care and prevent harm. All components of regulation should be designed as integrated, aligned elements of a program of assessment.

Assessment is an ongoing process that begins at registration and continues throughout an individual's licensure, with additional assessments conducted as needed for complaints and disciplinary matters.

Initial registration of an applicant to a health professional regulatory organization includes the requirement to demonstrate readiness for regulation by providing evidence in areas such as foundational knowledge, skills, judgment, and past behaviour. The required evidence often includes examinations that demonstrate minimal competence at the entry-to-practice level. Historically, registration committees had discretion, if an applicant (for example, a visiting professor or emergency care provider) was missing a key element of the usual inventory of requirements, and other measures of substantial equivalence were considered. Likewise, when considering regulation as a system of assessments, and a key component of competence cannot be demonstrated or performed in an ongoing matter, the authorizing body might reasonably establish conditions or limits to practice.

Complaints and disciplinary matters are those serious, usually infrequent occurrences when an identified person's performance is investigated (assessed) and sometimes determined as not meeting the standards. In these matters, the person's performance is assessed using the relevant standards, and an assessment decision determines whether they meet those standards or whether a gap exists. When a matter is egregious, the licensee's practice may be revoked for a specified period of time or permanently. More often, remedial activities are selected to be completed by the licensee either while they maintain their registration status or their registration is suspended until these are completed.

Between entry to practice and the atypical occurrence of complaints and disciplinary matters, most professionals complete the requirements for ongoing licensure.

A modernized, unified QAP that prioritizes risks and integrates assessment processes can both prevent and respond to risks related to patient harm and

dyscompetence. The QAP also spotlights assessment processes to encourage an individual's professional performance and the profession's growth, with the ultimate goal of improved patient outcomes.

All components of regulation should be designed as integrated, aligned elements of a program of assessment:

- Initial registration requirements should be explicitly linked to competence or their utility reconsidered. All registration requirements should work together to enable the applicant's evidence to demonstrate their fitness to practise (including competence and capacity) at the health profession's entry-to-practice level.
- Complaints and disciplinary matters deal with complex fitness to practise issues (competence and capacity), and investigations and assessments enable the regulatory organization to determine whether the licensee is meeting the standards.
- All requirements that are expected of licensees, annually or intermittently for renewal of registration, should be considered as part of an integrated, aligned QAP that is focused on supporting performance and safe patient outcomes.

Summary

1. All elements of regulation should be considered measures of competence and designed as integrated, aligned components of a program of assessment, including initial licensure, a QAP, and complaints and discipline matters.

2. All requirements that are expected of licensees, annually or intermittently, for renewal of registration should be part of an integrated, aligned QAP that is focused on supporting performance and safe patient outcomes.

F. Standards Framework

A regulatory organization should consistently use their standards (ethics standards and practice standards) as the content of licensee assessment. The standards tell the licensee "what is good enough" for their performance to meet acceptable patient health and care outcomes.

Assessment is the *how* of regulation.

Standards are the '*what*' of regulation, including what is good enough, or minimal expectations.

Currently, CHCPBC is using the multiple legacy standards that were available at the time of merging seven organizations encompassing nine health and care professions. A top priority for 2025, started in April, is to align standards across

CHCPBC to enable a smooth transition to the HPOA's requirements and to the development of the new QAP.

All nine health and care professions have adopted a common Indigenous Cultural Safety, Cultural Humility and Anti-Racism Practice Standard.[8]

Summary

1. A top priority for 2025, started in April, is to align standards across CHCPBC to enable a smooth transition to the requirements of the HPOA and the development of the new QAP.

2. All nine health and care professions have adopted a common Indigenous Cultural Safety, Cultural Humility and Anti-Racism Practice Standard with profession-specific requirements.

3. The modernized, unified QAP will use the standards as they are developed and available to build out the program's content. The Indigenous Cultural Safety, Cultural Humility and Anti-Racism Practice Standard can serve as a starting point.

4. The standards will inform and guide the performance of licensees and the assessments used in initial registration, the QAP, and complaints and discipline matters.

5. As it is developed, the QAP will need to establish what knowledge translation resources are needed to support licensees.

G. Factors Impacting Assessments for Quality Assurance Program

Quality assurance assessments must be central to the QAP, based on the requirements outlined in the HPOA. Competence, performance, continuing competence, dyscompetence, and incompetence are important factors that affect quality assurance assessments. This section defines these concepts in preparation for the discussion about them later in the report.

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:

[8] A side by side comparison of the Cultural Safety, Cultural Humility and Anti-Racism Practice Standard across the nine health and care professions was not completed. The consultants were told that some minor editorial refinements had been done before amalgamation, so it will be important to verify consistency for all nine professions as part of the alignment of CHCPBC standards.

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"

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

Continuing competence means 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, adapt to contextual changes, maintain wellness, etc.), including regular attention to and monitoring of risks and mitigating supports provided by people and systems. Given the need for the habit of continuing competence, annual attention to competence is best practice.

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). Dyscompetence 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."

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, health professionals can reduce their likelihood of dyscompetence (Glover Takahashi et al., 2017).

Summary

1. Clarity of definitions and descriptions is central to the QAP's design. The Glossary of current definitions is found in Section 7.

2. Definitions relevant to CHCPBC and consistent with the HPOA will need updating as the QAP is developed.

3. Linking CHCPBC-specific definitions to HPOA definitions is essential.

H. Overview of Risk-Based Approaches for Quality Assurance Program

This section defines key terms related to risk and discusses how risk-based approaches are included within a modernized QAP.

Risk-based regulation uses data to identify risk and protective factors that impact competence and the professional's performance in meeting or exceeding standards.

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

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 help mitigate and manage a risk to support a professional's competence. 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.

When applied to the QAP, risk assessment will inform the design and development related to which specific quality assurance assessments licensees need and when (for example, annually related to changes in standards or after an absence from active practice).

The types of risks that the HPOA expects CHCPBC to monitor include types of care and services; clinical practice and other work settings; and the knowledge, skills, and abilities of individuals providing care and services.

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 put 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

Risks to competence are considered a group-level risk. A health professional with the risk factors may or may not be impacted. Risk are not indicators; they reflect only an estimate or probability across a group. A day-to-day example is that prolonged sitting is a risk for back pain. That does not indicate that all people who sit for prolonged periods will suffer from back pain. Rather, the group-level risk says that those who sit for prolonged periods are more likely to have back pain. By studying a group of health professionals' risks for dyscompetence, regulators can calculate the relative importance of different risk factors for licensee dyscompetence.

Protective factors to competence are also considered at the group level. The competence of a health professional with protective factors may or may not be impacted. Protective factors are not guarantees that the individual will not be impacted by the risk; they reflect a protective factor estimate across a group. A day-to-day example is that hourly stretching is a protective factor to prevent back pain. That does not indicate that all people who stretch hourly will not suffer from back pain. Rather, those who stretch hourly are less likely to have back pain. By studying a group of health professionals' protective factors, regulators can calculate the relative importance of different factors to competence. The more protective factors and the more powerful those protective factors, the lower the likelihood of the risk's impact.

See Table 4 and Table 5 for commonly cited risks and protections to licensees' performance. These lists of examples are not comprehensive, nor is the relative impact on performance noted. These lists are for illustration purposes.

Table 4 Examples of Risks Common Across Many Health Professionals

Category	Description	Assessments and examples
Adequacy of practice or education	Dyscompetence or differences in performance associated with a previous educational program that, due to brevity or low quality, did not adequately prepare learners with particular skills or specific knowledge	Lack of adequate coverage in entry-level training; practising professionals who lack training on newer protocols
Age	Dyscompetence or differences in performance associated with the person's age, including youth	Lower measures of competence with older practitioners close to retirement or younger professionals

Category	Description	Assessments and examples
	and older age	with little experience
Area of specialty or certification	Specialty- or certification-based variations in dyscompetence. "Certification" and "specialty" are often used interchangeably.	Comparing skills and abilities between professionals of different specialties
Gender	Based on the research with self-identified gender, dyscompetence or differences in performance between those who identify as men versus as women. In the literature, those who identify as men commonly have a higher risk of dyscompetence regardless of whether they are the larger or smaller group in a health profession.	Assessments of knowledge, attitudes, or clinical performance; risks or predictors for burnout or depression; adherence to guidelines; rate of complaints; predictors for disciplinary action
International graduate	Dyscompetence or differences in performance associated with health professionals who were educated in a different country than the location where the health professional is currently working	Comparing the risk of disciplinary action for locally educated medical graduates versus internationally educated medical graduates; comparing exam scores or certification results for locally educated versus internationally educated practitioners
Lack of clinical exposure or experience	Dyscompetence or differences in performance associated with knowledge or competence gaps in certain clinical areas arising from insufficient volume of procedures and of patients with a particular condition to attain or maintain competence	Lack of sufficient volume of experience within a certain topic area to attain and maintain competence (HIV, obstetrics, etc.).
No certification	Dyscompetence or differences in performance based on whether the practitioner holds a certification in a specific area of practice or specialization	Examining the impact of certification on performance; examining the associations between certification status and QAP results, risks for disciplinary action, rate of complaints, or medical errors
Practice features	Dyscompetence or differences in performance associated with the practice's geographical or office features	How the location of practice (rural versus urban, etc.), professional isolation, or size of practice affects competence
Previous disciplinary activity	Impact on dyscompetence of previous complaint or disciplinary matter investigated by a regulatory authority, specialty organization, or health facility	Association between current rates of disciplinary actions, formal complaints, or legal malpractice activities and previous complaints or disciplinary actions for the same individual
Resources	Dyscompetence or differences in performance associated with resources, including people, money, and time	Impact on competence of insufficient administrative support; restricted access to library resources; high workload (as a systemic issue, such as the facility or hospital not hiring sufficient quantity or quality of staff); or inadequate infrastructure (access to or quality of equipment or medications)

Category	Description	Assessments and examples
Transitions	Dyscompetence or differences in performance associated with changes in work or professional status, changes in focus of practice, or as experienced by new graduates	Transitioning back into clinical practice after time away (due to child rearing, health issues, etc.); retraining for a different specialty (most often from a current specialty to family medicine); or transitioning from learner to independent practitioner
Wellness	Dyscompetence or differences in performance associated with physical or mental health issues	Effects on competence of fatigue, stress, burnout, substance abuse, physical health issues, or other mental health issues
Other	Differences related to risks to competence not included in high volume topics	Studies considering how practitioner language or ethnic background affects performance

Note. Adapted from Glover Takahashi et al., 2017.

Table 5 Examples of Protective Factors Common Across Many Health Professionals

Category	Description	Assessments and examples
Assessments and feedback tools	Approaches that employ a specific tool to measure professional competencies to determine the adequacy of performance or provide information and motivation for improvement	Exploring the value of an information management system to collect data on competencies and provide feedback to residents (chart entries for preventive health measures, etc.); MSF assessments with reports back to the practitioner; or knowledge tests that are associated with an education module and provide feedback to the learner
Clinical exposure or experience	Time spent in specific rotations or at specific clinical sites with a particular patient population	Sufficient experience (such as with specific surgical and obstetrics procedures) or volume of patients with a certain condition
Continuing education	Involvement in an educational activity, such as a course, workshop, or conference, during the practice life cycle (post-specialty or program-specific training)	Any form of continuing education participation
Educational program features	Actions or interventions included in a pre-existing educational program that are designed to improve the learning, knowledge translation, and application of the material	Any activity designed to enhance the learning and application of material, such as quizzes with feedback, readings, online modules, interactive activities, or small group work with follow-up. May also include new components brought into a program such as the reintroduction of ophthalmic training into the medical school curriculum.

Category	Description	Assessments and examples
Performance review	A formal or structured work-based process whereby a practitioner is provided with information on the adequacy of performance or with general supportive information and motivation for improvement	Annual on-the-job evaluation of performance
Personal support and feedback	Mentorship and feedback provided or available to individuals to inform or improve clinical skills or knowledge	Mentoring, teaching, or coaching others (such as students or colleagues) to improve their performance
Professional organization participation and systems	Mandatory participation in formal professional activities to develop or maintain competence as established through regulatory, association, or specialization requirements	Participation in the Royal College of Physicians and Surgeons of Canada Maintenance of Certification Program, College of Family Physicians of Canada Mainpro, or American Board of Internal Medicine Maintenance of Certification Exam
Quality assurance participation	Formal activities within a structured organizational QAP in the workplace	Participation in chart audits or in programs identifying the reasons behind a lack of adherence to guidelines
Reflection and self-assessment	Approaches to developing or maintaining competence that include introspection, personal analysis, and consideration of adequacy of competence or demonstration of competence	Discussing the use of portfolios and the overall utility of reflective activities
Support through structure or organization	Employer- or site-specific structures or processes that develop or maintain professional competence	Reporting on the practice support needs of health professionals through some type of needs assessment (including community health promotion, federal regulation updates, and technical assistance); or providing time off, compensation, or other institutional supports (such as online library access) to health professionals for continuing education
Technology	Mechanical or electronic means to develop or maintain competence via simulation, eLearning opportunities, and electronic decision-support rules	Examining whether simulation training results in short- or long-term improvement in the management of clinical events or whether online learning activities enhance learning compared with other educational activities
Other	Approaches to developing or maintaining competence not included in high volume topics	Geographical location of education, institution, or patient care; accreditation standards for educational programs; definitions of core competencies; or self-directed learning activities

Note. Adapted from Glover Takahashi et al., 2017.

Summary

1. The QAP needs to consider two distinct aspects of risk in regulation:
    a. Risk of harm to the patient by the licensee's performance

   b. Risks to performance leading to a licensee's dyscompetence or incompetence that in turn harms the patient

2. A full understanding of demonstrated and potential risks needs to be data driven through exploration of licensee group–specific historical and prospective data.

3. CHCPBC-specific data will confirm which risks and protective factors are common in each of the nine health and care professions and the relative impact of the risks and protective factors on licensee group dyscompetence and patient outcomes.

I. Role of Technology in Quality Assurance Program

Technology is an important resource, and it can enhance the integration of CHCPBC's systems of assessment. However, care must be taken to avoid or minimize problems relating to the use of technology. Considerations include the following:

1. Definitions of terminology related to technology and its component parts will be beneficial for common use across CHCPBC.

2. The extent to which data will drive or inform QAP development is a decision that needs to be made early. The HPOA describes risk information that should be tracked. Additionally, the scope and role of data need to be established.

3. The extent to which CHCPBC is ready for technological changes concurrent with the QAP's design and development needs to be determined. If a priority or staged sequence for technological changes exists, that sequence will be beneficial to the QAP's development.
4. CHCPBC will need to determine the role of technology in the QAP, including information technology (IT) and information systems (IS). Current CHCPBC technology initiatives may need to be evaluated for applicability to QAP purposes.

5. Year-over-year information and progress tracking should be available in plain sight for licensees. At a systems level, real-time scoring or reporting with feedback, answers, and explanations is an important resource that can support licensee competence and performance.

6. Methods need to be in place to support licensees' readiness and engagement with technology or changes in existing platforms from legacy colleges.

7. Another topic that needs exploration is AI and how generative AI can be harnessed for QAPs. AI, in its various forms of natural language processes (NLPs), machine learning (ML), and generative pre-trained transformers (GPTs), has the potential to transform educational content and processes

(Gordon et al., 2024).

Understanding the limitations, accuracy, and reliability of AI models and predictions will be critical, with the increased use of AI for supporting learning and clinical performance (Tolsgaard et al., 2023). NLPs used for text analysis in medical education may also generalize to QAPs depending on the program of assessment and the mechanism. Tolsgaard et al. (2023) cited emerging empirical studies related to scoring written exams, assessment of narrative feedback quality, early identification of learners (licensees) in need of remediation, and automated generation of test item distractors.

The BEME Guide on AI (Gordon et al., 2024) identified emerging contributions in the literature. Those related to assessment included 50 publications focused on assessment for, of, and as learning, and 191 describing uses such as the following: performance analytics (assessing knowledge, skills, abilities, etc.); sentiment analysis and bias evaluation (such as determining emotional tone from text); virtual patient simulators for clinical reasoning practice; personalized learning platforms; decision support tools; procedural guidance for trainees; chatbots; labelling and sorting; content generation (producing educational materials, etc.); and summative assessment completion (model performance on exams, etc.).

Many of the challenges and hazardous factors identified—such as privacy issues, lack of meaningful output, and authenticity of responses—will call for an integration of learning sciences with clinical science and data science when developing new AI systems. This integration aims to prevent an overreliance on AI systems while also reaping the benefits of access to expert-level automated guidance and feedback (Tolsgaard et al., 2023).

Technology has the potential to support implementation, provided that risks are managed. The Ottawa consensus statement and recommendations on technology-enhanced assessment provide a framework that describes three stages: (1) readiness of technology; (2) its application to the assessment life cycle; and (3) processes of evaluation (Fuller et al., 2022).

Summary

1. Technology can enhance the integration of CHCPBC's modernized, unified QAP.

2. CHCPBC will need to determine the role of technology, including IT and IS, as well any planned staging in timing relevant to QAP design.

3. Using technology in the QAP will require efforts to support licensee readiness for and engagement with technological approaches.

4. An important QAP resource will be the development of a QAP dashboard to support licensee performance, including prompt feedback, year-over-year information, and progress tracking.

5. Given the rapidly emerging uses of AI, CHCPBC will need to explore when, why, and for whom AI is best used to advance the QAP's goals and enhance the benefits of the program of assessment as designed.

J. Strategies Facilitating Change

Part of the QAP context is the readiness of people and systems for change. Interestingly, even when a current system is viewed as needing some improvements, resistance to new ways often occurs (Westley et al., 2009).

An added dimension for CHCPBC is that several legacy programs were already at various stages of QAP redesign and development, but due to timing, including the anticipated amalgamation, implementation was not completed. With the changing regulations (the HPOA), the diversity of CHCPBC's health and care professions, and the College's size, the past plans cannot be incorporated into the new QAP. For some licensees, it will be difficult, yet necessary, to set aside the time, resources, and emotional energy invested in the anticipated legacy plans. However, the lived experiences can inform creative innovations.

A recent scoping review studying organization-wide culture change programs identified 10 factors that assist a workforce to embed safe, quality care in health care (Wilson et al., 2025). They are applicable to a QAP focused on improving patient health and care outcomes and supporting licensees' learning and performance:

1. Leadership
2. Education and training
3. Process and structures
4. Measurement, monitoring, and feedback of outcomes
5. Resources to support the change
6. Alignment with organizational culture
7. Shared and defined accountability
8. Adaptable change programs
9. Engaged key parties
10. Alignment with the external environment

Below is a description of each of the ten factors, with examples of past or potential actions to manage this factor and facilitate change.

1) Leadership

Leadership that is shared, consistent, and supportive is a key success factor (Wilson et al., 2025). The support is pivotal at the beginning of the process, when resistance to change is high (Torre et al., 2022).

CHCPBC leadership gathered legacy QAP staff and professional practice advisors in October 2024 for a full-day workshop, *Imagineering Integrated Pathways for*

Quality Practice, less than six months after amalgamation. Shared leadership was demonstrated, by involving not only all of the quality practice team but also other senior leadership. Shared leadership will be instrumental in the change to the new QAP.

2) Education and Training

People involved in the change will need education and training throughout the various stages of development (pre-design, design, delivery and implementation, and post-implementation) (Wilson et al., 2025). Those involved in the change include governance groups and working groups, if used. Education will involve challenging assumptions and unlearning ways of approaching assessment to develop new ways of thinking about and assessing professional performance.

New staff should have traits that predict innovation, including conscientiousness and active volunteering with professional organizations (Hewko, 2022). Onboarding new staff will mean that education and training for a modernized and unified approach is ongoing.

Licensees will also need encouragement to learn new habits that monitor and advance their performance.

3) Process and Structures

Although, in almost all studies, Wilson et al. (2025) found that aligning the change with current processes and structures supports change, processes and structures at CHCPBC are still being developed, given that amalgamation occurred in only July 2024. However, operationalizing nine different legacy programs is not sustainable.

Involving operational leaders and staff early in the change process can help ensure that the infrastructure is in place for a cost-effective program equipped with qualified people and supported by technology. For example, several software platforms are in use for the various QAPs. Likely, only one or two will be needed. Integration of CHCPBC-wide data systems will be beneficial to a unified QAP.

Some licensees will need to adapt to new timing for completing their requirements. For example, legacy colleges that had three-year cycles or where licensees had to complete activities in alternate years will have more timing adjustments compared with licensees who had annual requirements.

Using established channels of communication, including the identification of primary informants (for example, manager-level staff), will ensure that information affecting each group is accurate, complete, consistent, and communicated as early as possible and that the messaging delivered by CHCPBC's key spokesperson is clear.

4) Measurement, Monitoring, and Feedback of Outcomes

The Wilson et al. (2025) scoping review found that all studies reported these three factors as important strategies for embedding change.

QAP evaluation will include monitoring ongoing progress on the system, structure, and people development. Giving timely feedback about small gains on outcomes is advantageous because it builds ownership and pride.

5) Resources to Support the Change

Staffing, dedicated funding, and infrastructure were resources most frequently cited in most of the studies reviewed by Wilson et al. (2025). The risk of burnout with major change is real, especially if development and implementation are added on top of existing responsibilities. Additional resources are needed to mitigate this risk.

Fortunately, the CHCPBC business structure includes a Department of Communications, Change Management and Organizational Development. Including organizational development with communications and change management recognizes that a new QAP creates a situation where systems, structures, and people need to be supported in their development. CHCPBC also has dedicated funding for transformation advisors, who can help develop structures that a QAP will depend on, such as new standards.

6) Alignment With Organizational Culture

Wilson et al. (2025) found that most studies identified that if organizational cultural characteristics were aligned, change was more easily embedded.

Fortunately, many of the legacy programs have common values. Working together to understand the design or benefits of a modernized and unified approach can foster collaboration and innovation. Development of a new strategic plan will also facilitate alignment.

Identifying and celebrating improvements will keep the program focused on its purpose and enhance the culture. For example, staff may express relief when a process is streamlined. A broader example is the positive recognition in annual reports if program evaluation reflects that assessment for learning is viewed by licensees as supportive, with evidence of performance improvement and demonstrated lowering of risk to patient harm.

7) Shared and Defined Accountability

Clear expectations regarding roles and responsibilities which are embedded in policies and procedures were considered essential in many of the studies in the scoping review (Wilson et al., 2025).

The QAP depends on and is connected to other organizational activities. QAP requirements can have a cascading effect on other departments and activities, and a coordinated effort will facilitate development and implementation.

8) Adaptable Change Programs

According to Wilson et al. (2025), several studies identified that initiatives that fit into services were successful, and four studies found that the ability to "course correct" was a key success strategy.

Despite best efforts, not everything can be predicted and planned for. Therefore, planning for a new QAP needs to be agile; change is not likely to be linear or fully anticipated. Making space for mistakes is part of the supportive approach to change at CHCPBC. Course correction will be necessary as feedback on early changes is received, new evidence arises, or new dependencies are identified.

9) Engaged Key Impacted Parties (Affected Groups)

Several studies in Wilson et al. (2025) identified engagement with key groups as an important factor. Affected parties included staff, licensees, patients, and the community across all phases of design, development, implementation, and evaluation.

In work with affected parties, often the focus is on the degree of power and level of interest of affected groups, with insufficient attention paid to the purpose of the engagement. Kujala et al. (2022) studied engagement and identified three components, each of which have specific purposes: principled, strategic, and pragmatic. Communication for engagement is considered strategic in their framework. Opportunities to engage staff and licensees regarding branding of the new approaches to assessment and the QAP can inspire and build ownership.

These authors also described the "dark side" of engaging affected parties, considering whether the impact or approach was negative intentionally or unintentionally. Appendix 2 offers details and sample activities to consider.

Inventories can be helpful to both anticipate and devise plans to overcome resistance by affected groups or individuals. Satel (2024) suggests identifying the cause for resistance or potential for it and then building strategies around five categories of resistance:

- Lack of trust (usually in leadership or management)
- Change fatigue (due to unnecessary change)
- Competing commitments (usually of time)
- Switching costs (with so much already invested, affected parties find the cost to change again is overwhelming)
- Identity, dignity, and sense of self (individual's investment in current state)

A key change management challenge is the need to refocus affected groups (licensees, staff, and committees) away from tools that are familiar and towards

feedback and a culture of learning from assessment (Harrison et al., 2017; Torre et al., 2022; Watling & Ginsburg, 2019).

Finally, Van der Vleuten et al. (2015) found success in communicating with affected parties and practising the new approaches to assessment.

Several legacy colleges made concerted efforts to engage licensees in the development or updating of their QAPs using a variety of methods, resulting in response rates ranging from 1% to close to 100%.

Most recently, the legacy colleges completed licensee surveys on the new Indigenous Cultural Safety, Cultural Humility and Anti-Racism Standard, demonstrating the organizations' commitment to seeking feedback to gather data on the needs licensees may have for both understanding and implementing a new standard. Applying this standard in the development of the QAP will confirm CHCPBC's commitment to reconciliation. The Strategy Governance and Social Accountability Group is an important resource for consultation throughout the QAP stages.

10) Alignment With the External Environment

Several of the Wilson et al. (2025) studies identified alignment with national structures as important to facilitating change. Applied to the CHCPBC context, the most obvious drivers of QAP change stem from the provincial government and include amalgamation and the pending HPOA.

Additionally, some professions may have national regulatory alliances which also aim to unify practices, particularly if they facilitate interprovincial and interterritorial mobility of health and care professionals. Identifying congruencies and opportunities for alignment can advance the enthusiasm for a new program.

Summary

1. Strategies for facilitating change include the recruitment of innovative-minded staff and development of both people and structures for a new and modernized QAP.

2. Several of these strategies have begun to be implemented and should continue to be integrated and happen throughout all stages of moving to the new QAP.

3. Processes and timing must allow for engagement and consultation activities to happen concurrently with the QAP stages.

4. Focused Review of Key Assessment Design Literature

This section explores key literature and concepts that will inform the QAP's design and development. Some of these concepts are familiar, while others are different from those used by legacy college programs. The content of the literature and concepts can also facilitate a common understanding and eventual use of agreed-upon definitions.

A. Assessing the Complexity of Competence

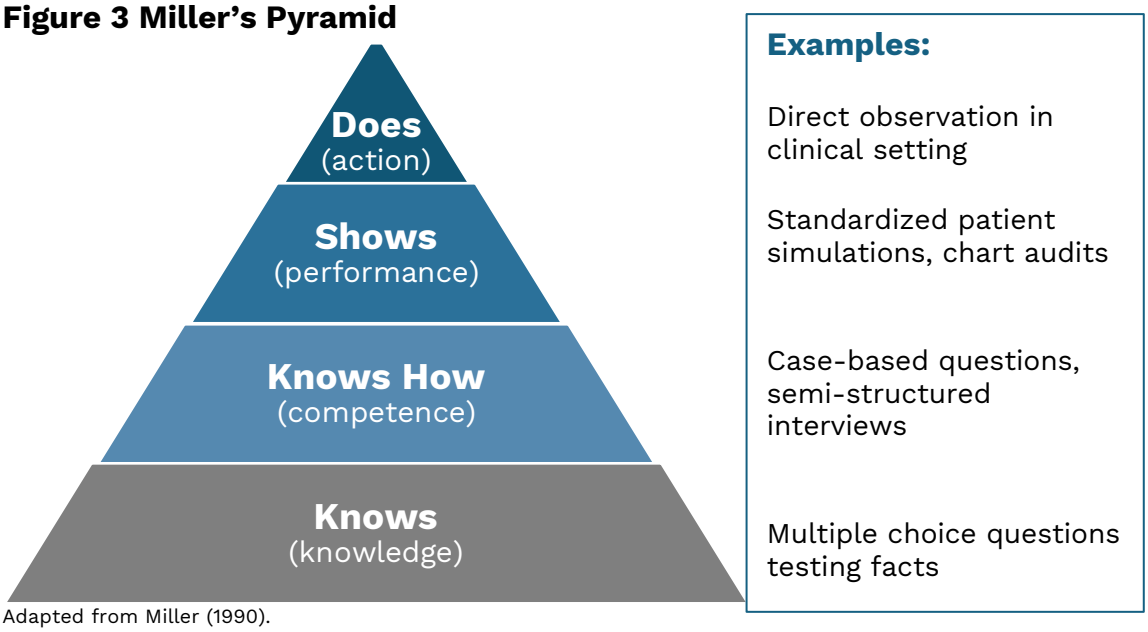
The challenge of defining the complex construct of competence has a spillover effect on describing assessment of competence and performance.

Miller's Assessment Pyramid (Miller, 1990) is a useful tool to help track the inventory of assessments. It aids decision-making regarding where, how, and how frequently the assessments should occur. Figure 3 shows Miller's Pyramid and provides examples of how it can be used to inform a program of assessment design, which is discussed later in this section.

The tool has stood the test of time and is one of the most broadly used assessment outcome frameworks to guide the selection and development of tools for assessing health professionals. Miller's framework can also be used to determine where a health professional's performance lies on the continuum and where efforts to improve their performance should be focused, as well as to inform content and question development in assessment design (Williams et al., 2016).

Yet its suitability for assessment of performance based on a licensee's continued competence rather than entry to practice is somewhat imperfect.

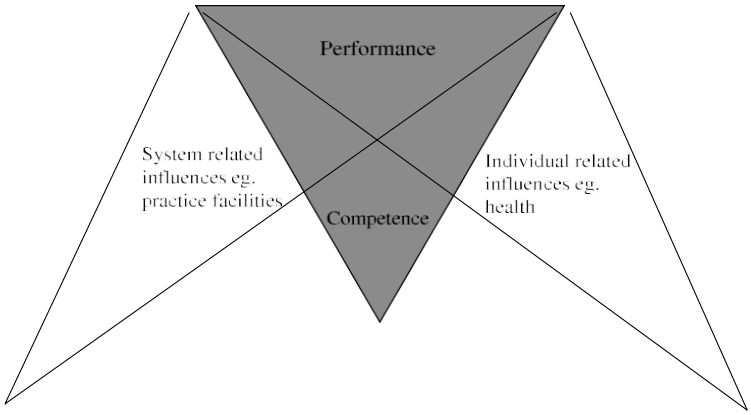
Figure 3 Miller's Pyramid



Adapted from Miller (1990).

The Cambridge Model for Delineating Performance and Competence (Figure 4) inverts the pyramid and proposes that if competence is a prerequisite to performance, then other factors impacting competence must also be considered when supporting learning and performance. These include system-related influences and individual-related influences. Although labelled differently, these are strikingly similar to the concepts found in the literature and discussed in Table 4 regarding the risks to health professionals' competence.

Figure 4 Cambridge Model for Delineating Performance and Competence



Rethans et al., 2002.

Summary

1. Miller's Pyramid is an important tool that will be helpful in designing the QAP's program of assessment and selecting various assessment tools.

2. The Cambridge Model unpacks competence and performance and reinforces the importance of including contextual influences, as well as licensee risks and protective factors in the design of the assessments.

B. Processes of Assessment *for* and Assessment *of* Learning

Well-documented evidence shows that assessment drives learning (Schuwirth & van der Vleuten, 2020) in that it tells the people taking the assessment what is important and what success looks like. Assessment can motivate and have a powerful steering effect on those being assessed to learn the content that is in the assessment. Results can also trigger those being assessed and others who provide CPD to enhance further learning opportunities. Assessment processes encourage both the individual's performance and the profession's growth, with the ultimate goal of improved patient outcomes.

The educational literature has explored and labelled the purposes of assessment as assessment for learning and assessment of learning (Gibbs et al., 2006; Institute of Medicine, 2014; Schuwirth & van der Vleuten, 2011). The QAP should explicitly include both purposes in its assessments:

- Assessment for learning will use assessments as tools to support learning and development of licensees' competence and performance. The tools will guide reflection and provide licensees with feedback to identify when additional knowledge for improved performance is needed and where resources for learning exist.

- Assessment of learning will use assessment tools where the licensees can demonstrate their performance. Assessment of learning is the more traditional way of thinking about assessment, where the assessment tools ask licensees to apply their knowledge or skills in practice.

Summary

1. The purpose of assessments in the QAP will be to support licensees' learning and performance.

2. The QAP will include both
   a. Assessments for learning, where performance is supported through facilitating guided reflection, identifying gaps in performance, providing feedback, and suggesting learning resources for CPD
   b. Assessments of learning, where licensees demonstrate performance in meeting or exceeding the standards and receive feedback

C. Programs of Assessment

No single assessment tool is sufficient to assess licensees' performance, given the variety of practice settings, variations in risks to patients, and variations in risks to competence. The challenge is to develop a program of assessment (Eva et al., 2016) that has coherence in design features and a selection of complementary and effective quality assurance assessments and activities.

A program of assessment is a systematic approach designed to assess and support the continuing competence of professionals in a given field (van der Vleuten et al., 2012).

A program of assessment approach for the future QAP will be valuable to CHCPBC for multiple reasons, including the following:

- Ensures consistency with CHCPBC's approach to regulation
- Enables a focus on improved health and care outcomes for patients and the public
- Ensures clarity about acting in the public's interest
- Offers a cohesive, integrated approach across the single regulatory organization rather than the wide variations currently found across the legacy colleges' QAPs
- Allows a comprehensive approach to licensees' competence while enabling the College to administer assessments of performance using a risk-based approach that prioritizes risks
- Supports licensees in their delivery of safe care and their maintenance of competence while providing additional needed assessments for some

licensees based on risks to patients and risks to health and care professionals' competence

For CHCPBC, a program of assessment will integrate and align multiple quality assurance assessments and activities that prioritize risk to assess the most important aspects of licensees' competence. Some aspects could be common across all licensees, while others could be specific to selected groups. Assessments that support continuing competence (assessment for learning) and those that support learning and performance (assessment of learning) must include timely and detailed feedback.

Features of a program of assessment include the following:

1. Multiple quality assurance assessments or activities: These are selected based on the competencies of interest or standards. Each assessment tool is mapped to specific competencies or standards. As a whole, the program of assessment provides a holistic view of the practitioner's competence (Norcini & Burch, 2007).

2. Variety of assessments for different purposes: A program of assessment includes low stakes assessments with assessments for learning (such as guided self-assessments); medium stakes assessments comprising assessments for learning and assessments of learning (such as an open-book, online knowledge application quiz); and high stakes assessments focused on assessments of learning (such as an onsite visit for remedial assessment purposes). Each assessment aims to determine the practitioner's professional performance—that is, their ability to meet specific standards.

3. Regular, integrated assessments: Assessments are conducted regularly to ensure CPD and promptly identify areas of deficiency. For QAPs, annual learning and monitoring for all health professionals is best practice because it supports the habit of ongoing learning and continuing competence.

4. Effective feedback mechanisms: Timely, focused, actionable feedback is crucial to helping practitioners understand their performance and identifying areas for improvement. For example, in an online quiz, personalized answers, explanations, and resources can be promptly provided when answers are submitted, which supports the professional by confirming what is known and identifying gaps in knowledge or knowledge application.

5. Ongoing CPD: Based on personal interest and professional needs identified through assessment, practitioners are encouraged and supported to take responsibility for their learning and competence maintenance and enhancement efforts.

Summary

1. No single assessment tool will be sufficient to assess licensees' performance, given the variety of practice settings, variations in risks to patients, and variations in risks to competence.

2. CHCPBC needs to develop a program of assessment that integrates and aligns multiple tools that prioritize risk to assess important aspects of licensee performance. Some aspects could be common across all licensees, while others could be specific to selected groups.

3. For both assessments to support licensees' continuing competence (assessment for learning) and performance (assessment of learning), the QAP will need to include timely and detailed feedback on performance.

4. Features of a program of assessment include multiple quality assurance assessments or activities; a variety of assessments for different purposes; regular, integrated assessments; effective feedback mechanisms; and CPD.

D. Factors Impacting the Effectiveness of a Program of Assessment

The effectiveness of an assessment tool or program can be determined by how well the tool or overall system achieves the attributes outlined in the *Consensus Framework for Good Assessment* (Norcini et al., 2018) and principles of the *Consensus Statement for Programmatic Assessment* (Heeneman et al., 2021).

These frameworks provide criteria that are internationally recognized and widely referenced in assessment literature. Some of these can be seen in the principles for QAP developed by the BC Health Regulators' working group. The frameworks can be used to evaluate the legacy colleges' current and previously piloted assessments and mechanisms. Comparing these to the evaluations completed by Holmboe and Iobst in the *Assessment Guidebook* (2020) would help to discern whether the limitations and strengths of the assessments and mechanisms were related to the original design of the tool or to its application and adaptation to a regulatory QAP.

The attributes of good single assessments and good programs of assessment are listed in Table 6 below, with examples of actions that can be taken to increase their effectiveness.

Table 6 Frameworks for Good Single Assessments and Programs of Assessment Including Implications for QAP

Single assessments	Programs of assessment	Implications for QAP
Validity or coherence. The results of an assessment are appropriate for a particular purpose as demonstrated by a coherent body of evidence.		Collect and document validity evidence throughout the development processes and annual updates as well as continue to monitor any outside evidence in scholarly or grey literature
Reliability, reproducibility, or consistency. The results of the assessment would be the same if repeated under similar circumstances.		Assessments will require both statistical and qualitative analysis to ensure consistency in decision-making and build trust that the results discriminate among those who require more support to fill competence gaps, overcome dyscompetence, and improve professional performance.
Equivalence. The same assessment yields equivalent scores or decisions when administered across different institutions or cycles of testing.		To help achieve equivalency, develop scoring rubrics using established methods and train assessors
Feasibility. The assessment is practical, realistic, and sensible given the circumstances and context.	Feasible. The system of assessment (including volume, type, and components) is practical, realistic, efficient, and sensible given the purposes, parties, and context.	Single assessments: Feasibility will be important to both those involved in administering the assessments, including IT and administrative support staff, and those who are assessed. Finding the right touch, based on probability and degree of harm both to patient outcomes and licensees' competence, will be important. Programs of assessment: As above for single assessments. Workplace assessments should be planned to avoid disrupting patient health and care and with no risk to the quality of care delivered during the assessment.
Educational effect. The assessment motivates those who take it to prepare in a fashion that has educational benefit.		The assessment content should be readily available long before the assessment will occur. How the content is presented, the methods chosen, and design of materials can promote agency and be relevant to licensees, as opposed to being a task licensees complete only to renew their registration.
Catalytic effect. The assessment provides results and feedback in a fashion that motivates all partners to create, enhance, and support education; it drives licensee and organizational outcomes forward.		Results and feedback can be provided for individuals, teams, and groups of licensees to inspire and open opportunities for CPD and the construction of new knowledge that advances the professions and improves patient outcomes.
Acceptability. Partners find the assessment process and results credible.		The process must make sense to licensees, the government, patients, and the public. Not all licensees will need to do the same assessments. For instance, licensees who perform higher risk activities in practice may require more frequent assessments. Those in areas where technology is changing rapidly may also need more frequent check-ins.
	Coherent. The assessment system is	Licensees and partners should be able to connect the dots among the pieces of the

Single assessments	Programs of assessment	Implications for QAP
	composed of multiple, coordinated individual assessments and independent performances that are orderly and aligned around the same purposes.	program of assessment and see the potential positive impact on licensees' professional performance and patient outcomes.
	Continuous. The assessment system is ongoing, and individual results contribute cumulatively to the system purposes.	Licensees should be able to monitor and track the impact of the assessments on their performance and patient outcomes, as well as look for any patterns or trends that should be continued or discontinued. Different assessments may be needed at different times in a health and care professional's career. One-time assessments are discouraged because they fail to recognize that competence is developmental, impermanent, and context specific (Epstein & Hundert, 2002).
	Comprehensive. The assessment system is inclusive and effective, consisting of components that are formative, diagnostic, and/or summative as appropriate to its purposes. Some or all components are authentic and integrative.	Both assessment for learning (to identify gaps and resources to fill these) and assessment of learning (to confirm professional performance) will be needed.
Purpose driven. The assessment tools and system support the purposes for which they were created.		All assessments in the program should work together towards a common purpose. They should focus explicitly on licensees' performance and patient outcomes and consider the risk of licensee groups and classes.
Transparent and free from bias. Partners understand the workings of the system, and its unintended consequences are minimized. Decisions are fair and equitable.		Transparent and ongoing communication regarding what is to be assessed, how, and when can provide licensees and their communities with opportunities to give input that can uncover unconscious biases and prevent unintended harm.

Summary

1. The attributes for single assessments and programs of assessment that need attention are validity or coherence; reproducibility, reliability, or consistency; equivalence; feasibility; educational effect; catalytic effect; acceptability; coherent, continuous, comprehensive; purpose driven; and transparent and free from bias.

5. Focused Review of Quality Assurance Assessments and Activities

This section inventories quality assurance assessments and activities commonly seen in regulatory programs. Each assessment and each activity is defined, its features described, and key evidence inventoried. A summary of applicability and utility for the QAP is provided in consideration of the CHCPBC context, the HPOA, evidence-informed assessment practices, and program of assessment design features.

This section aims to critically appraise the common quality assurance assessments and activities to identify those suitable for the CHCPBC context. As noted, multiple assessment tools will be needed to assess the professional performance of licensees. In addition to a common approach across most or all licensees, quality assurance assessments and activities will also be needed for specific assessments, follow-up assessments, and, as appropriate, remedial education.

The quality assurance assessments and activities can be thought of as the tools and materials used by the consultants to complete the new structure that meets the purposes of the QAP.

The tools and materials explored in this report are divided into two parts:

- Quality assurance assessments are those tools designed for assessment of competence as described in the educational literature
- Quality assurance activities are proxies of performance and have been used by regulators as a form of performance monitoring, though their use and utility have been shown to be problematic

If CHCPBC wishes to build a program of assessment in an evidence-informed manner, assessing professional performance using solely quality assurance activities would be unwise.

A. Quality Assurance Assessments

This section describes evidence obtained regarding a variety of formal assessments most relevant to regulatory organizations such as CHCPBC.

To begin, a large body of research has repeatedly confirmed that accurate, robust assessment is essential for effective feedback, coaching, self-regulated learning, and professional growth (Holmboe & Iobst, 2020).

In addition, the American Educational Research Association, American Psychological Association, and National Council on Measurement in Education publication *Standards for Educational and Psychological Testing* (American Educational Research Association et al., 2014) is a central resource used as the

gold standard for performance assessments in health professions education and regulation. It is an important resource in the design and development of assessment tools and systems, regardless of the assessments selected.

1) Case-Based Discussions, Chart-Stimulated Recall, Records Reviews, and Semi-Structured Clinical Interviews

Related assessments and terms:
- Low fidelity simulations
- Structured/semi-structured interviews
- Peer assessments

Features

These tools provide a structure to critique clinical practice, procedures, or records, thereby monitoring practice and improving quality of care. The content can include any element of clinical practice (assessment, treatment planning, interventions, patient education, discharge, or documentation) or standards.

The tools can be used as a primary or follow-up assessment for a more focused look at a licensee's performance. Tools can be done as homework or pre-work that is then discussed and the discussion and homework scored.

The assessment can be done in person, via phone, or asynchronously. With a common scoring rubric and assessor training, consistency across multiple assessors is sufficient for competence assessments by regulators (Miller et al., 2010).

Longitudinal progress can be tracked by repeating assessments over time where ongoing monitoring is needed.

Case-Based Discussions and Chart-Stimulated Recall

Case-based discussions are structured or semi-structured interviews where health professionals discuss aspects of a case in which they have been involved to explore their underlying reasoning, decision-making, and ethical understanding (Dent et al., 2021). In medicine, a case-based discussion will usually take around 15 to 20 minutes for presentation and discussion, with 5 to 10 minutes afterwards for feedback (Davies et al., 2009). Repeated interviews are required to obtain a valid picture of a practitioner's level of development (Dent et al., 2021).

Chart-stimulated recall is an assessment tool that complements chart audit by combining a records review of a patient encounter with a structured oral examination. An assessor uses predetermined questions to probe the health professional's thought processes. Reflective questioning and prompted self-assessment can also assess some aspects of professionalism. These reviews can take anywhere from 30 to 60 minutes (Holmboe & Iobst, 2020).

Records Reviews

When patient records are the content source for review, they can provide

- An archive of important patient information for use by other team members and patients
- A source of data to assess performance in practice for specific acute and chronic health care conditions and for patient preventative care or education
- A way of monitoring of patient safety and complications
- Documentation of diagnostic and therapeutic decisions (Holmboe & Iobst, 2020)

Details and Evidence

1. These tools have a long history of use in regulatory and educational settings (Albino et al., 2008; Logan & Gardner, 1988; Miller & Archer, 2010; Salvatori et al., 2000).
2. The tools' validity and reliability were established in 1982 for emergency medicine (Holmboe & Iobst, 2020).
3. Flexibility of design makes these tools applicable for small and larger groups, including team-based or clinical site assessments. However, in the case of team-based charting, individual practitioner contribution to records may be difficult to isolate (Griscti & Jacono, 2006).
4. Effective scoring rubrics and assessor training for calibration are key to validity and reliability (Miller et al., 2010; Raj & Thorn, 2014).
5. These tools can be designed for use in assessment for learning, such as an initial assessment followed by others administered over a period of time to provide feedback and assess practice change and impact on patient outcomes (Williamson & Osborne, 2012).
6. These tools are not recommended as an assessment of learning if delivered on its own or as a single, summative assessment in high stakes contexts (Reddy et al., 2015).
7. When only records reviews are used, important aspects of quality of care are missed (Goulet et al., 2007). If a records review is combined with chart-stimulated recall, the health professional can show how they competently meet the standards through examples from their practice.
8. Physicians were found to accept feedback if the quantitative and qualitative data was consistent. They dismissed feedback if coming from only one source and if they did not view the source as sufficiently knowledgeable. They were also more likely to complete an action plan if they had a peer assessor who helped them interpret the feedback and co-created the plan (Roy at al., 2023).

Summary

1. Case-based discussions can be designed for use in assessment for learning and assessment of learning.

2. Case-based discussions are adaptable to the various CHCPBC professions.

3. Keys to establishing validity and reliability include creating a blueprint, creating a checklist of questions with a corresponding rubric for decision-making consistency, training assessors such as peers, and having health professionals engage in pre-work.

4. Case-based discussions, records reviews, and related tools are feasible types of tools as focused assessments or follow-up assessments that can be based on risks to patients or selected risks for licensee dyscompetence.

2) Simulations, Standardized Simulated Patients, and Objective Structured Clinical Examinations

Related assessments and terms:
- High fidelity simulations

Features

Simulations used for assessment of clinical performance closely resemble reality and attempt to imitate but not duplicate real clinical problems.

These assessment tools are used widely in entry-to-practice education (Harden & Gleeson, 1979; Hodges, 2003; McWilliam & Botwinski, 2010; Newble, 2004). Their validity and reliability are well established for educational and regulatory assessments (Munoz et al., 2005; Varkey et al., 2008).

Simulations have several key attributes:
- They incorporate a wide array of options resembling reality
- They allow health professionals to reason through a clinical problem with little or no cueing
- They permit health professionals to make life-threatening errors without hurting a real patient
- They provide instant feedback so that health professionals can correct a mistaken action
- They rate a health professional's performance on clinical problems that are difficult or impossible to evaluate effectively in other circumstances (Holmboe & Iobst, 2020)

Standardized Simulated Patients

Direct observation that occurs via simulation of a patient by lay individuals ("actors") uses what are known as "standardized" or "simulated" patients (Holmboe & Iobst, 2020). Test takers spend short amounts of time at each station and undertake part-tasks rather than complete clinical encounters (Dent et al., 2021).

Objective Structured Clinical Examinations

An Objective Structured Clinical Examination (OSCE) consists of a series of structured stations or cases that a candidate moves through in sequence. OSCEs replaced long case and short case examinations previously used for assessment of performance (Khan et al., 2013).

At each station, specific tasks have to be performed. Different degrees of simulation may be used to test a wide range of knowledge, psychomotor skills, attitudes or communication skills, or collaboration or professionalism skills (Dent et al., 2021; Meskell et al., 2015). An OSCE uses simulated patients, charts, and results and resuscitation manikins or computer-based simulations. Each station has a time limit, and the marking scheme is structured and determined in advance (Dent et al., 2021).

Advances in Simulation Tools

The last 10 years have seen an increase in the development of high fidelity simulation technology for use in medical education. This permits reproduction of complex conditions at any time. Global rating scales are increasingly being developed, which take a more holistic approach to scoring and allow for variation in practice and style, in particular increasing levels of expertise (Dent et al., 2021).

Details and Evidence

1. OSCE is a widely used assessment tool for educational and regulatory assessments because of its ability to assess performance, albeit in a simulated environment (Kaczmarek, 2011; Khan et al., 2013; Meskell et al., 2015; Puryer, 2016).
2. Simulation tools allow test takers to “show” rather than “know” or “know how,” per Miller’s Pyramid (Miller, 1990), for greater confidence in the professional’s competence in actual practice.
3. Simulation tools are mostly used for assessment of learning and high stakes assessment decisions, given the logistical complexity to administer, including high cost. Because of their focus on high stakes, OSCE tools should be combined with other assessments (Khan et al., 2013).
4. Simulation tools overcome the impact of the patient’s performance and examiner’s bias on the test candidate’s performance and the risk of disruption to the ordinary course of providing health care services. Validity and reliability depend on design features; the tools require experts in simulation to develop assessment cases, organize and train staff and assessors, and develop scoring systems (Khan et al., 2013; Pell et al., 2010).

Summary

1. High fidelity simulations, including OSCEs, are not likely feasible assessments for broad use across all or most licensees, although they may be suitable for

follow-up assessments based on risks to patients or risks to licensee dyscompetence.

2. High fidelity simulations might have limited use in remediation for discipline or complaints matters. In such cases, connecting to available and established entry-level educational program OSCEs could be considered.

3) Written Tests

Related assessments and terms:
- **Exams, examinations**
- **Quizzes**

Features

Written tests include a series of questions (items) requiring responses (answers) from a participant. Written tests can be basic, casual, and low stakes, such as questions in a magazine about fitness habits or at the end of a book chapter, where the reader can do them (or not) with no consequences for not completing the questions.

Other times, a written test has medium stakes, where expectation exists that the questions are answered but no follow-up occurs unless the individual does not participate or gets a terribly low score.

Often when people think of written tests, their memories go to high stakes tests where the outcome was a grade or a pass that affected whether an individual could proceed, such as moving to the next grade or applying for registration with a licensing board. Many remember having to complete a longer, large-scale written examination that took multiple hours (or days) for entry-level registration to practice. Such experiences can negatively affect learning (La Chimea et al., 2020) and, in the regulatory context, decrease the acceptability of a written test in a QAP, regardless of whether the assessment is formative—that is, designed for learning (van der Vleuten & Schuwirth, 2005; Wiese et al., 2021).

Depending on the number of questions or items, a long test will offer information on the participant's performance on sections or topics, with scores for the sections in addition to the overall score.

Written tests of knowledge and knowledge application have an extensive research base that demonstrates that when well developed, including with attention to scoring, reporting, and interpretation (meeting the Standards for Educational and Psychological Testing), they are a very useful measure of competence. The evidence is very strong that high or low performance on required entry-level written tests is correlated to long-term competence or dyscompetence in practice and shows corresponding impacts on patient outcomes (Norcini et al., 2024; Tamblyn et al., 2007; Wenghofer et al., 2009).

Written tests come in many formats, including open text, multiple choice questions with single correct answers, multiple choice questions with multiple correct answers, matching, fill in the blank, sequence, and true or false.

The key features approach to written questions consists of short, clearly described cases or problems with a limited number of questions asking for essential decisions or key features (Farmer & Page, 2005; Nayer et al., 2018; Page et al., 1995). Key feature cases are more likely than other forms of assessment to discriminate among stronger or weaker candidates in the area of clinical reasoning (Nayer et al., 2018; Schuwirth et al., 2001) and have been used in several QAPs with success.

Written tests are often combined with assessments where the participant can demonstrate application or implementation of knowledge. This reflects similar approaches of moving away from one-time assessments or exams and adopting an assessment for learning and a more formative approach.

In QAPs, written tests are often shorter (less than 1 hour) and open book to reflect real-world practice, where references are available to inform practice decisions.

Details and Evidence

1. No matter which question format is used, the quality of the test is always related to the quality of the individual questions (Dent et al., 2021).
2. Designing tests includes practices, such as establishing an examination blueprint and key validation and setting standards, that contribute to reliability and validity. These practices need to be well documented (American Educational Research Association et al., 2014).
3. Shorter tests (30–60 minutes) or progress tests promote the establishment of regular feedback, supporting the development of a program of assessment (Alavarce et al., 2024).
4. Tests may consist of many different short cases, enabling broad sampling of the domain and thus reliable results per hour of testing time (Schuwirth, 1998). They have also been demonstrated to be valid for the assessment of medical decision-making or problem-solving (Dent et al., 2021).
5. Written tests done for entry-to-practice do not have a direct link to patient safety or better patient care. Yet correlations exist between those examination scores, patient care outcomes, and incidence of disciplinary action in later professional life, which some researchers indicate is sufficient evidence that these examinations directly lead to better care (Bartman et al., 2024; Tamblyn et al., 2007; Wenghofer et al., 2009).
6. Some competencies that are needed for practice are difficult or impossible to assess in a written test and thus often not included in the blueprint (Harden, 2009).
7. In the regulatory context, the content for written tests attracts much attention, with resistance towards those that appear not to reflect or support day-to-day practice. Constructing clinically relevant content that

reflects a wide variety of practitioner contexts is challenging, though acceptability is negatively affected without it (Clark et al., 2021; Eva et al., 2016; Sandilands, 2016).

8. Assessment experts do not fully agree about the strengths and challenges of licensing examinations. A balance needs to be achieved between assessing a breadth of skills and the capacity for such skills in practice. Focusing less on reproducibility and more on relevance and practicality may be beneficial (Archer et al., 2017).

Summary

1. Long written examinations (more than 1 hour) are not recommended for inclusion in the QAP design for use across all or most licensees. Acceptability and feasibility are two reasons. Additionally, the efforts to create a valid and reliable long written examination are considerable, often affecting the development of other mechanisms in a program of assessment.

2. Shorter (30–45 minutes), open-book written tests or quizzes are a feasible type of assessment tool for CHCPBC to consider using across all or most licensees to assess understanding and application of standards within an online educational module.

   Short, open-book written tests can yield valid information about licensee performance competence and can be cost efficient.

   Shorter tests can include an assessment for learning approach where health professionals are provided with the answers and explanations if they choose the wrong answer.

3. Constructing quality written test items (scenarios, questions, answer options, and explanations) and maintaining a high performing question bank requires licensees from each specific profession who are skilled in item development and psychometric checks and balances to work as consultants. Attention to test security is also essential.

4) Direct Observation Assessments

Features

Direct observation is considered a work-based assessment that allows the health professional to be observed in an authentic clinical environment. It captures how the health professional performs and what they actually do in practice. It may involve a team to assess teamwork and the clinical reasoning in relation to their team.

Direct observation has been a preferred tool for assessing competencies related to patient care and interpersonal communication rather than decision-making

processes, particularly when a clear right or wrong answer does not exist (Holmboe & Iobst, 2020).

Details and Evidence

1. This tool offers strong content validity because the health professional is observed within a practice setting and with real or simulated patients (Fromme et al., 2009).
2. The research notes a "Hawthorne effect," where the performance level may be negatively affected by being observed or where the health professional is on "best behaviour" and not reflecting usual practice (Jouriles et al., 2002; Kane, 1992).
3. Validity, including reliability or consistency of decision-making, depends on design features, and it benefits from structured observation that requires observation experts, training of staff and assessors, and development of scoring systems (Kogan et al., 2009).
4. The number and duration of observations needed to reflect competence requires consideration (Fromme et al., 2009; Mills et al., 2011).
5. Assessment of procedural skills requires several assessments by multiple observers to ensure reliability (Kogan et al., 2009).
6. This tool can be designed for use in assessment for learning and assessment of learning.
7. The tool is generally used for higher stakes assessment decisions in regulatory contexts, given the logistical complexity to administer, including impact on patients and other team members and high cost.

Summary

1. Direct observation assessments are complex, very expensive, and thus not feasible assessments for CHCPBC to consider as a core approach across all or most licensees.

2. Direct observation assessments could be useful for focused or follow-up assessments where a detailed understanding of performance warrants needed resources, such as part of an investigation for discipline or complaints matters, or for licensees who have higher or the highest risks (risk of demonstrated harm to patients, risk of potential harm to patients, history of dyscompetence, or potential for high risk of dyscompetence).

5) Multisource Feedback

Related assessments and terms:
- Assessments by peer via survey
- Patient experience surveys
- 360-degree feedback

Features

MSF consists of measurement tools completed by multiple people who interact and work with a licensee. In traditional MSF, the health professional selects informants to complete surveys, creating bias and conflict of interest concurrently.

Most MSF approaches use a survey, rating scale, or questionnaire to gather information about an individual's performance. Comprehensive MSF usually includes surveys completed by patients and their families. Having the licensee complete the same MSF form (as a type of guided self-assessment) provides insight into their perception of themselves compared with others using the same tool (Holmboe & Iobst, 2020). The power of MSF is the opportunity to gather assessments on key competencies (teamwork, communication, management skills, decision-making, etc.) from multiple perspectives (Holmboe & Iobst, 2020).

Details and Evidence

1. MSF has advantages when assessing professionalism, interpersonal and communication skills (especially an interprofessional team's knowledge, skills, and attitudes), and systems-based practice (Holmboe & Iobst, 2020).
2. Research has shown relationships between MSF and fewer malpractice claims (Lagoo et al., 2019).
3. Patient experience surveys can go beyond satisfaction ratings and focus on aspects of care that are more actionable and can affect satisfaction. These surveys are effective in assessing person or patient centredness (Price et al., 2014).
4. Selecting patients can present challenges (who does the selecting, what language barriers may arise, etc.) (J. Lockyer, personal communication, July 29, 2024).
5. Patient survey length needs careful consideration. Patients probably do not want to spend time answering 25 questions (D. Faulkner, personal communication, July 12, 2024).
6. Scalability is an important feasibility consideration (A. Wainwright, personal communication, July 17, 2024).
7. Licensees may choose individuals that are likely to be lenient in their feedback and apply a global assessment across all domains. If licensees receive nothing but positive feedback, they may feel no need to change (Ng et al., 2011).
8. Somewhere between 8 and 15 peer assessments are required for an acceptable level of generalizability regarding accuracy of results (Lockyer, 2013).
9. Careful design is required to ensure that feedback is related to the competencies under review (Stevens et al., 2018) and that it is helpful (Dent et al., 2021).
10. MSF may have unintentional consequences on individuals and teams (Stevens et al., 2018).

11. Standardizing completion of feedback surveys is difficult (Stevens et al., 2018).
12. Difficulties encountered with patient surveys include
    a. Dealing with language and literacy problems
    b. Obtaining enough per-licensee surveys to provide reproducible results
    c. Finding the resources required to collect, aggregate, and report survey responses
    d. Assessing the licensee's contribution, separate from that of the health care team, to a patient's care (Holmboe & Iobst, 2020)
13. Research supports MSF's use as formative (assessment for learning) and not summative (assessment of learning) because not all feedback sources have the knowledge to adequately assess all the competencies (Sargeant et al., 2011).
14. Licensees in isolated clinical or geographical areas may have difficulty identifying sufficient people for feedback (Graham & Beuthin, 2018).

Summary

1. Traditional MSF is not feasible for CHCPBC's use.

2. The use of a patient survey to assess patient outcomes, such as patient centredness, is a promising idea if CHCPBC designs specific questions that explore aspects of practice that are of most interest to patients (such as effective communication skills and a respectful, culturally sensitive approach).

3. The focus of a patient survey would not be related to assessing clinical elements of competence. As such, the survey would need to be part of a program of assessment.

B. Quality Assurance Activities

This section outlines quality assurance activities used in regulatory QAPs.

1) Guided Self-Assessments

Related activities and terms:

- **Self-reports**
- **Self-assessments**
- **Self-directed assessments**
- **Self-inventories**
- **Self-reflections**

Features

Guided self-assessment can be used for a variety of purposes such as

- Identifying performance gaps
- Informing a CPD plan

- Addressing knowledge, skill, or ability gaps
- Building a collection of information to document performance, completion of professional expectations, or meeting standards
- Serving as one source in an MSF process (described in Subsection A of Section 5)

The use of "self-assessment" in education and regulation has been much studied over the past 25 years. The consensus is that while health professionals may be able to self-monitor their knowledge, skills, and performance in the moment, they cannot reasonably be expected to generate accurate global judgments that identify strengths and weaknesses (Marceau et al., 2024). In health professions education and practice, refinements have been identified that have led to some general agreement on where and when self-assessment should be used in medical education (Eva & Regehr, 2005; Sargeant, 2008).

Details and Evidence

1. Evidence supports the use of self-assessment for low stakes assessment, formative assessment, or assessment for learning when combined with structured guidance from a knowledgeable person (teacher, peer, coach, or coworker) who can provide informed feedback and promote reflection (Sargeant et al., 2008). As such, best practice is to qualify or describe this activity as "guided self-assessment," "self-inventory," or "self-report."
2. Guided self-assessment, self-inventory, or self-report should include close-ended questions with examples. Feedback should follow such an activity, whenever possible.
3. Self-assessment can be useful to identify an individual's motivation related to their values and beliefs (Konzelmann Ziv, 2011).
4. Humans are not effective at self-assessment (Kruger & Dunning, 1999), especially when no guidance is provided. The Dunning–Kruger effect is a cognitive bias in which people with limited competence in a particular domain overestimate their abilities. This lack of accuracy is not influenced by the intellect or education of the person conducting the self-assessment.
5. Long-standing and substantial literature supports the idea that health professionals are very poor at self-assessing at both ends of the scale, with some health professionals underestimating and others overestimating competence or performance (Colthart et al., 2008; Davis et al., 2006; Eva & Regehr, 2005; Eva & Regehr, 2007).
6. Even in situations where health professionals identify a higher level of skills at self-assessment, that assessment does not correlate with other measures:
   - Improved performance (Andersen et al., 2015)
   - Insight (Ehrlinger et al., 2008)
   - Learning (Colthart et al., 2008)
   - Patient outcomes (Al-Kadri et al., 2012)
7. Self-assessment should never be used on its own. It should be triangulated with assessments that are not self-directed (van der Vleuten et al., 2012).

Summary

1. Self-assessment is included within the HPOA but not defined. For CHCPBC, the best approach is to use guided self-inventory or self-report, as appropriate, depending on the activity.

2. A guided self-inventory could be useful as an activity to inform self-knowledge or self-reflection for focused, structured situations to gain information about the licensee's current circumstances or intended plans.

3. A guided self-inventory could be considered part of an assessment for learning if informed feedback and guided reflection are provided or if the tool is used in combination with a trained coach or assessor.

4. A guided self-report about CPD could use an assessment for learning approach, reinforcing the value of ongoing learning to support competence.

2) Continuing Professional Development

Related activities and terms:

- CPE
- Continuing competence activities
- Learning activities, formal or informal

Features

Regulators expect health professionals to participate in CPD to keep current and informed about changes to practice that may require updated knowledge and skills for delivery of safe and effective care to patients.

Regulators often require submitting a CPD plan that could include

- Stating specific learning objectives and activities to meet these
- Mapping CPD to standards or competency profiles
- Undertaking an annual or semi-annual attestation tied to a registration renewal requirement
- Auditing by the regulator
- Completing mandatory courses containing specific content

Common CPD activities include taking continuing education courses at colleges and universities, teaching, lecturing and presenting, attending seminars at professional conferences, attending online courses, publishing, giving scholarly poster or research presentations, and undertaking independent study (Institute for Credentialing Excellence Research and Development Committee, 2013).

Licensees are often encouraged to reflect on their practice to identify their own developmental needs; carry out the appropriate CPD activities to meet these identified needs; and reflect on how the learnings can be applied in practice, while identifying any further developmental needs (Main & Anderson, 2023).

Details and Evidence

1. CPD is "a process where a [licensee] monitors and reflects on professional performance, identifies opportunities to improve professional practice gaps, engages in both formal and informal learning activities and makes changes in practice to reduce or eliminate gaps in performance" (Campbell et al., 2010 as cited in Samuel et al., 2021, pp. 919–920).
2. Supporting licensees to engage in CPD is important.
3. Research into CPD is difficult due to the variety of CPD activities—the differences in both design and content and the various outcome measures chosen—and the lack of rigour or lower quality of primary studies (Samuel et al., 2021).
4. CPD costs can be a barrier, especially when acceptable or approved CPD requires formal education or courses. The costs and benefits as an outcome measure of formal CPD are seldom considered (Samuel et al., 2021).
5. Health professionals often seek out CPD that enhances competence to build expertise in areas of interest rather than activities that address gaps in competence (ten Cate et al., 2024).
6. Due to the flaws of self-assessment (as described above), the choices that health professionals select for CPD may not address gaps in competence.
7. There is no evidence as to whether CPD is more effective if it is carried out in smaller amounts, more frequently, or via formal education or courses (Mann et al., 2023).
8. Good evidence suggests that the retention of knowledge and skills varies with the task, such that it would be beneficial for skills to be refreshed more frequently for more complex technical skills or procedures that are practised infrequently (Mann et al., 2023).
9. CPD leads to greater improvement in performance and patient outcomes if it is more interactive, uses a variety of methods (such as case-based learning, demonstrations, feedback, lectures, problem-based learning, point-of-care techniques, role play, and patient simulations), is delivered in a sequence to the learner involving multiple exposures over a longer period of time, and is focused on outcomes that are considered important by practitioners (Mann et al., 2023).
10. eLearning is as effective as face-to-face CPD for changes in behaviour or patient outcomes (Mann et al., 2023; Samuel et al., 2021).
11. Learners respond well to interprofessional coaching, their attitudes and perceptions of one another improve, and they report increases in collaborative knowledge and skills (Mann et al., 2023).
12. CPD should be free of conflicts of interest (Mann et al., 2023).

Summary

1. Health professionals need to keep up to date with changes in practice.

2. Participation in CPD is a protective factor in preventing the risk of dyscompetence.

3. CPD is a supportive activity. When based on structured, guided reflection or

prioritized risks to competence, CPD is an important inclusion in a modernized QAP.

4. The literature identifies important features of in-person and online CPD that lead to greater improvement in patient outcomes and licensee performance (interactivity, sequencing, feedback, assessments, problem- and case-based content, and spaced repetition).

5. Requiring focused, directed, remedial CPD likely has utility for those individuals for whom competence gaps have been identified based on an assessment.

3) Quantified Continuing Professional Education

Related activities and terms:
- CPD credits
- Continuing education credits
- Mandatory continuing education

Features

Regulators set the amount of CPE within a specific time frame. This set amount may be a requirement for annual registration renewal or part of a QAP cycle that can be several years but generally no more than five.

CPE requirements are not an assessment. CPE is a quality assurance activity based on the view that participating in mandatory CPE results in ongoing competence for the professional and improved patient outcomes.

It is important to disentangle the value of CPE or CPD and the often-used regulatory requirement of quantified CPE within a QAP. CPE or CPD is required to stay up to date as practice evolves, new evidence emerges, and patient needs change. It is needed to ensure that the licensee's performance continues to meet standards over their career. As such, CPE requirements such as number of hours or credits have been commonly used by regulators to encourage health professionals to stay up to date.

However, there is a wide variation in CPE numbers, definitions, and descriptions; how CPE is reported and tracked; and the limits of the systems for licensees to document requirements. Generally, documentation is done by self-report without much oversight or verification. Selected numbers found in the literature are not defensible, and the literature is not helpful about whether any specific number has merit. More broadly, CPE varies in the need for pre-approval, for documentation of educational design, and for guidance to professionals or educational providers.

Additionally, the burden of quantified CPE is high, both administratively and

financially. Quantified CPE is costly (in terms of both time and money) to licensees, regulators, employers, and the health care system, even with technology that improves reporting processes.

The literature is clear that mandatory continuing education will not lead to change. As outlined below, a large amount of high quality evidence from the past 25 years demonstrates the very limited effectiveness of CPE on competence or patient outcomes. The enthusiasm for its inclusion in QAPs is both surprising and problematic.

Details and Evidence

1. Excluding specific time requirements for CPE did not negatively affect selecting appropriate learning activities and change implementation (Asadoorian, 2003).
2. Interpretation is difficult due to the vast variety of educational activities and methods used in CPE (Forsetlund et al., 2021).
3. Several systematic reviews indicate that CPD didactic programs may increase knowledge but have very little impact on clinical performance and patient outcomes. On the other hand, interactive approaches, using a variety of methods and sequencing over time, do have an impact (Forsetlund et al., 2021; Main & Anderson, 2023).
4. Cochrane Systematic Reviews provide evidence of the impact of some learning activities. In the updated reviews, authors have included statements regarding bias in response to earlier criticism by Marinopoulos et al. (2007, as cited in Forsetlund et al., 2021). These reviews focus on randomized controlled trials, which are given the highest level of evidence because they are designed to be unbiased and have less risk of systematic errors.
    a) Forsetlund et al. (2021) compared no intervention with educational meetings as the single intervention and found the following:
        i. The meetings probably slightly improved professional practice and, to a lesser extent, patient outcomes
        ii. Participation may improve compliance with desired practice to a greater extent than other kinds of behavioural change interventions, such as text messages, fees, or office systems
        iii. Multi-strategy approaches (such as goal-setting, provision of feedback, provision for social comparison, and provision for social support) sometimes positively influence the effects of educational meetings
    b) Ivers et al. (2012) reviewed the effects of audit and feedback on the practice of health professionals and patient outcomes and examined factors that may explain variation in the effectiveness of audit and feedback. Only randomized controlled trials of audit and feedback (defined as a summary of clinical performance over a specified period of time) that reported objectively measured health professional practice or patient outcomes were included. When the trials involved multi-faceted interventions, audit and feedback had to be the core aspect of at least one intervention arm. The results were as follows:

i. Audit and feedback generally led to small but potentially important improvements in professional practice. The evidence for change in patient outcomes was limited.
ii. Effectiveness of audit and feedback seems to depend on baseline performance and how the feedback is provided.
iii. Feedback may be more effective when baseline performance is low, the source is a supervisor or colleague, feedback is provided more than once, it is delivered in both verbal and written formats, and it includes both explicit targets and an action plan.

c) Giguère et al. (2020) reviewed the effect of printed educational materials (PEMs) on the practice of health professionals and patient health outcomes and explored the outcome effect of some characteristics of PEMs (source, content, format, etc.). The results were as follows:
i. When used alone and compared with no intervention, PEMs may slightly improve health professionals' practice outcomes and patient health outcomes. The effectiveness of PEMs compared with other interventions, or of PEMs as part of a multi-faceted intervention, is uncertain.

5. Although these reviews suggest some improvements in professional practice and patient outcomes, the enduring impact is unclear. Self-reports of participation in CPE as an indicator of competence fail to acknowledge the complexity of outcome evaluation.
a) The impact should be measured more than 6 months after the original baseline data, to determine whether a change has really taken place (Abruzzese, 1996).
b) Davis et al. (1999) found that negative findings were more likely to appear at 12 or 18 months.
c) CPD requires knowledge of how to establish baseline data, expertise to develop measurement and data collection strategies, time to conduct the evaluation, and the ability to collect reliable and valid data for comparative purposes after the learning experience has occurred (Abruzzese, 1996).
d) In self-reports, licensees report attendance, which may not actually indicate that they have acquired the competencies to make the practice change and positively influence patient outcomes.
e) Although improvement and retention of content knowledge can occur if the pre-identified learning need is matched to education with complementary learning objectives, the impact on patient outcomes (did the health professional’s practice change?) would require direct observation during patient care (Abruzzese, 1996).
f) Fairness and acceptability to the licensee require reasonable expectations for time and cost to satisfy regulatory requirements and availability of opportunities to complete specific CPE (Institute for Credentialing Excellence Research and Development Committee, 2013).
g) There is no evidence to suggest any benefits or disadvantages of requiring CPE over a specified time period (for example, a 5-year cycle) or to show that CPE in smaller amounts and more frequently is more effective (Main & Anderson, 2023).

h) Evidence shows that retention of knowledge and skills varies with the task, so some skills should be refreshed more frequently—for example, complex technical skills such as surgical or resuscitation procedures (Main & Anderson, 2023).
i) Several studies reveal that mandatory CPE increases a health professional's motivation to complete activities (Main & Anderson, 2023), yet completion of CPE does not guarantee a change in professional practice or improved patient outcomes.

6. While health practitioners like this quality assurance activity and regulators frequently use it, the evidence does not support its link to improved performance or patient health and care outcomes.

Summary

1. The use of quantified CPE for all licensees for quality assurance or re-licensure purposes should be set aside, given its limited links to improved performance or patient outcomes.

2. CHCPBC will need to be explicit about the ongoing importance of CPE for licensees separately from the plans to stop collecting and reporting quantified CPE.

4) Currency and Active Practice Hours Requirements

Related assessments and terms:

- **Continuous practice requirements**
- **Currency hours**
- **Recency of practice**

Features

Regulators set the number of hours that a licensee must engage in practice within a specific time frame. This set number may be a requirement for annual renewal or be part of a QAP cycle that can be several years but generally no more than five.

Documentation of active practice hours is not an assessment. It is a quality assurance activity based on the premise that practitioners will have a greater chance of maintaining competence if they work within their current scope of practice for a set number of hours.

Across the legacy colleges and across other health professions who use this activity, wide variations exist in the number of hours and definitions. Generally, active practice hours are communicated by self-report without much oversight or verification. Selected numbers found in the literature offer no defensibility.

Additionally, the approaches to requirements for returning to work after an absence from practice are subject to wide variations in expectations and processes across licensees and other health professions more broadly.

The variation in active practice hours numbers, definitions, administrative systems, and return-to-work requirements across all professions arises from each group making independent decisions based on their profession's circumstances and available information.

Details and Evidence

1. Practice hours provide some information about licensees who may be at risk of knowledge decay or disuse due to inactivity (Glover Takahashi et al., 2016).
2. Practice hours of doctors and other health professionals is not a subject that has been extensively researched. In the wider literature, though, substantial evidence demonstrates that time out of practice does have an impact on an individual's skills. Skills have been shown to decline over periods ranging from 6 to 18 months (General Medical Council UK, 2014).
3. Some components or facets of competence in a profession may be more susceptible to effects of disuse than others (Hambrick, 2021).
4. Some people are more susceptible to dyscompetence than others due to individual differences or characteristics (such as number of years of experience) (Hambrick, 2021).
5. Lack of clinical (practice) exposure or experience can reduce both competence and confidence (Alexander, 2021; Clark, 2018; Dodds & Herkt, 2013; Glover Takahashi et al., 2017; Hambrick, 2021; Mark & Gupta, 2002; Wenghofer et al., 2009).
6. Risk to competence may increase if the practice context or area is known to require frequent updates to knowledge and skills due to technological advances or patient presentation (Main & Anderson, 2023).
7. Active practice hours are a complex issue given that the evidence indicates that competence decays after an absence from work and also that the impact of the absence varies across practitioners and depends on previous practice, currently planned practice, and related activities during absence that could have prevented the competence decay. As such, the impact is highly variable, and none of the selected numbers of "currency" hours are defensible. The administrative monitoring of currency hours and auditing of self-reports are also of variable quality.

Summary

1. The use of practice hours for quality assurance or re-licensure purposes should be set aside.

2. CHCPBC should consider developing processes that reflect the assessment literature such as

a. Encouraging the effective return to work of former licensees via resources such as a guide to planning to return to work after an absence, which could inform licensee and employer plans.
b. Requiring online guided self-reporting after a modest period of time away, including directing licensees to outline their return-to-work plans.
c. Having licensees who are returning to work after a modest or prolonged period complete a risk-based, follow-up assessment. Clarity on definitions will need to be part of the QAP development.

5) Reflective Portfolios

Related activities and terms:

- Portfolios

Features

Reflective portfolios were originally defined as a "system [that] operates ... through the interaction of a learner and supervisor using the material as a catalyst to guide [discussion and] further learning" (Snadden et al., 1996, p. 148). A reflective portfolio can be considered an aggregation method, in that it can sample performance across a longer time period or even continuously (van der Vleuten et al., 2010).

In post-graduate health care education, reflective portfolios are used to support reflective practice, deliver summative assessment, and aid knowledge management processes (Tochel et al., 2009).

Comprehensive portfolios may contain reflections, but their content is much more diverse than that of the original reflective portfolios described above (Driessen, 2017). They frequently include self-assessments and professional development plans. Currently, comprehensive portfolios are more common in educational settings than regulatory assessment schemas. However, reflective portfolios may support the licensee's CPD and provide the regulator with evidence of actions the licensee has taken to maintain or improve their competence, including the ways in which these actions have improved patient health and care.

Here, a collection of activities is not considered to be a reflective portfolio but rather a record of learning activities and results of assessments over time.

Details and Evidence

1. Reflective portfolios have been effective and practical for educational settings, including in increasing personal responsibility for learning and supporting professional development processes, although the applicability for interprofessional settings is not known (Tochel et al., 2009).

2. The time and effort to maintain a portfolio is perceived as burdensome by many health professionals (Driessen, 2017; Tochel et al., 2009).
3. Because health professionals gather the majority of the content themselves, the relevance to their daily practice provides strong evidence of content validity (Campbell et al., 2014; Tochel et al., 2009). Those not inclined to regularly gather content end up pulling content together close to submission deadlines, limiting the portfolio's validity and usefulness for reflections on competence.
4. The learner's written reflection is often one criterion assessed in comprehensive portfolios. However, without learner education on how to reflect and express these reflections in writing, scores on portfolios as summative assessments are negatively affected (Gadbury-Amyot & Overman, 2018).
5. Portfolios that include reflection activities may fall under assessment for learning but not without additional conditions, most importantly a supervisor or guide. These conditions include mentoring, an open structure, a supportive learning environment, and a direct learning gain for users (Gadbury-Amyot & Overman, 2018; Tochel et al., 2009). Driessen et al. (2005) suggest that these conditions are almost impossible to satisfy in educational environments, given the intensity of supervision or staff support needed to achieve these required design features.
6. The assessment methods and tools for the reflection aspect of a portfolio need to adopt a holistic approach, accommodating the diversity of individuals and allowing a fair amount of adaptation (Gathu, 2022).
7. Because of this, assessment of reflection often comes down to checking whether certain rules are followed, and although clear assessment guidelines for reflection intend to counter problems of arbitrariness and bias, such assessment instigates behaviour to correctly follow the recipe and pass the assessment (Schaepkens & Lijster, 2023).
8. Accommodating diversity may be appropriate when competence gaps relate to the licensee's beliefs, attitudes, and values rather than knowledge or skills (Donyai et al., 2010).
9. Unfortunately, portfolios that include self-assessment to inform the CPD plan and activities rely on the belief that health professionals accurately self-assess their learning needs. Limitations of self-assessment are outlined in a previous subsection.
10. Inter-rater reliability for summative assessment of portfolio data is varied, so triangulation with other assessment methods is recommended (Tochel et al., 2009).
11. Many regulatory bodies require portfolios that include annual evidence of CPD, which is informed by reflective practices and guided by learning plans. Outcomes apart from submission of reflective evidence have not been measured, and health professionals' feedback has indicated mixed opinions of the portfolios' utility (Zaccagnini & Miller, 2022).

Summary

1. Reflective portfolios are not feasible for the QAP, given their logistical and educational design features and limitations.

2. Portfolios designed to address specific competence gaps or performance issues may be feasible for smaller groups of licensees where oversight, coaching, and compliance are likely to be well structured and resourced.

3. For CHCPBC, a well-designed electronic report portal in a program of assessment that is sometimes called a "portfolio" will be called a "dashboard." A dashboard can answer some of the same purposes as a portfolio, such as supporting the learning process by creating an aggregate of information and a summary of the licensee's performance over time, including feedback and assessment results. A dashboard could include automatic populating of results that are mapped to CPD plans with progress noted based on year-over-year activities and assessment results.

C. Selecting Quality Assurance Assessments and Activities

This section summarizes the suitability of the aforementioned quality assurance assessments and activities in an effort to move from a longer list of possible ideas to a more focused inventory consistent with the QAP's purposes.

Table 7 provides a high level overview of the assessments and activities, with colour coding corresponding to their suitability for the QAP.

Table 7 Possible Quality Assurance Assessments and Activities for the QAP

Legend

1. Most promising. Might work in main QAP, for all licensees. Strong positive evidence for QAP use.
2. Possible. More useful in focused or follow-up assessments than in main QAP. Strong positive evidence for QAP use.
3. Not recommended for inclusion. Not suitable for QAP.

Name	Assessment or activity	Features
Case-based discussions, chart-stimulated recall, records reviews, and semi-structured clinical interviews	assessment	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement
Simulations, standardized simulated patients, and OSCE	assessment	• Useful for team and clinical assessments • Complex logistics and costly
Long written tests, longer than 1 hour, periodic, high stakes	assessment	• Flexible across licensees, settings, work, contexts, and teams • Complex to develop and implement effectively across health professions

Name	Assessment or activity	Features
Short written tests or quizzes, shorter (30–60 mins), based on Standards Framework, online modules, and assessment for learning	assessment	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Scalable
Direct observation assessments	assessment	• Useful for team and clinical assessments • Complex logistics and costly
MSF	assessment	• Complex logistics and costly
Patient surveys per MSF literature	assessment	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Scalable • Could also be used for individual or team assessment
Guided self-assessments and self-reports	activity	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Scalable
CPD annual self-reports	activity	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Scalable
Quantified CPE	activity	• Lack of evidence to support the idea that a select number of CPE hours will maintain or improve competence
Currency and active practice hours requirements	activity	• Lack of evidence to support the idea that a select number of hours will maintain competence
Return-to-work guided self-reports	activity	• Used when away from practice for moderate or prolonged period
Reflective portfolios	activity	• Complex logistics and costly
Dashboard feedback about quality assurance activities and assessments	activity	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Scalable • Meaningful information that provides licensees agency for continuing competence

Summary

1. The comprehensive application of the literature about the appropriateness of different quality assurance assessment tools for the current CHCPBC context has yielded a more focused inventory of five that are most promising, four that are possible, and five that are not recommended.

2. While the College is completing the design of the QAP and moving to the development of prototypes of quality assurance assessments and activities for pretesting, a fuller description of the QAP will emerge and further refinement of the selection of assessments and activities will occur.

6. Directions and Next Steps

Thus far, this report has gathered and summarized the available relevant evidence to enable CHCPBC to move forward with the development and implementation of a modernized, unified QAP.

> The timely development of a modernized, unified QAP that innovatively aligns with the HPOA, improves patient outcomes, and supports licensees' learning and performance is both feasible and necessary.

The consultants gathered the many ideas in this report to review key findings and identify issues that will affect CHCPBC decision-making as it moves from the ideas stage to the design stage and then to the development stage. The QAP has now moved past the ideas stage and on to the design stage, as illustrated in Figure 5.

Figure 5 QAP Development Stages—Design Stage

Here now

This section summarizes

- The QAP's directions
- Its design features
- Assessments and activities suitable for the QAP
- Readiness activities relevant to completing the design and development
- Final notes

A. Directions

This report has examined the regulatory context for CHCPBC, including the legacy QAPs and the HPOA. These documents inform the context of the QAP and its WHY, WHO, WHAT, WHEN, and HOW of regulation and quality assurance.

As noted, all elements of regulation should be considered measures of licensee competence and be designed as integrated, aligned elements of a program of assessment: initial registration, the QAP, and complaints and discipline matters. Additionally, the requirements of licensees expected annually or intermittently for renewal of registration should be considered as part of an integrated, unified QAP.

The Standards Framework will guide the expectations for all licensees. The QAP content will be based on the standards, once developed.

A unified design for a modernized QAP aimed at all CHCPBC licensees is an important transformation 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 are 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.

B. Design Features

This section clarifies HOW the QAP will be designed. A topline list of key educational and assessment concepts is followed by design details.

Key educational and assessment concepts that underpin the QAP's design include the following:

- Programmatic assessment
- Risk-based assessment
- Miller's Pyramid and the Cambridge Model for selecting quality assurance assessments and activities to meet the program's purposes and outcomes
- Validity and reliability requirements for design, development, implementation, and improvement
- Program monitoring, evaluation, and improvement framework and tools
- Design thinking
- Change management strategies that are integrated and concurrent in all stages from design to evaluation
- Focus on competence, including engagement in ongoing learning, connections to supports, and management and mitigation of risks to competence

The design details are based on the concepts above:

1. The design will support the performance and continuing professional activities of almost 17,000 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 standards will be the content for the QAP and the benchmark for the expected performance level.

6. The design will reflect 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.

C. Suitable Assessments and Activities

In analyzing the inventory of many quality assurance assessments and activities found in the literature and in practice, the consultants moved from a longer list of possible assessments and activities to a more focused one, suitable to the CHCPBC context.
The key to selecting suitable assessments and activities is verifying that they have moderate to strong evidence of positive impact on patient outcomes or health professional learning. As noted, all licensees will do some quality assurance

assessments and activities, while some licensees, selected based on risk, may need specific or follow-up assessments or activities.

Based on the fuller understanding of the rationale for the recommendation of each quality assurance assessment and activity (found in Section 5), and in consideration of the CHCPBC context, the consultants have selected five types of assessments or activities that are most promising for inclusion in the QAP prototype. Table 8 outlines these assessments and activities.

Table 9 outlines those assessments and activities that might have a useful, though more focused and limited role (such as in remedial, follow-up, or risk-based assessments). Table 10 outlines those assessments and activities that are not recommended.

The selection and prototype development of assessments and activities will be confirmed, depending on the availability of additional information and resources as outlined in the next section, on Readiness Activities.

Table 8 Most Promising Quality Assurance Assessments and Activities

Name	Type	Potential uses	Features
Short written tests or quizzes (30–60 mins) based on standards, online modules, and assessment for learning	assessment	May work in main QAP, for all licensees, in QAP Phase 1	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Scalable • Strong positive evidence for QAP use
Guided self-reports and self-inventories	activity	May work in main QAP, for all licensees, in QAP Phase 1	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Scalable • Strong positive evidence for QAP use
CPD self-reports	activity	May work in main QAP, for all licensees, in QAP Phase 1	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Scalable • Strong positive evidence for QAP use
Dashboard feedback about quality assurance activities and assessments	activity	May work in main QAP, for all licensees, in QAP Phase 2	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Scalable • Strong positive evidence for QAP use • Meaningful information provides licensees agency for continuing competence
Patient surveys per MSF literature	assessment	May work in main QAP, for all licensees, or as focused assessment based on risk in QAP Phase 2 Could be used for individual or team assessment	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Scalable • Strong positive evidence for QAP use

Table 9 Possible Quality Assurance Assessments and Activities

Name	Type	Potential uses	Features
Case-based discussions, chart-stimulated recall, records reviews, and semi-structured clinical interviews	assessment	Best used as follow-up or focused assessments in QAP Phase 2	• Flexible across licensees, settings, work, contexts, and teams • Feasible to develop and implement • Strong positive evidence for QAP use
Simulations, standardized simulated patients, and OSCEs	assessment	Best used as follow-up or focused assessments in QAP Phase 2	• Useful for team and clinical assessments • Complex logistics and costly • Strong positive evidence for QAP use
Direct observation assessments	assessment	Best used as follow-up or focused assessments in QAP Phase 2	• Useful for team and clinical assessments • Complex logistics and costly • Strong positive evidence for QAP use
Return-to-work self-reports	activity	Best used when away from practice for moderate or prolonged period in QAP Phase 2	• Strong positive evidence for QAP use

Table 10 Not Recommended as Quality Assurance Assessments and Activities

Name	Type	Potential uses	Features
Long written tests, longer than 1 hour, periodic, high stakes	assessment	None	• Flexible across licensees, settings, work, contexts, and teams • Complex to develop and implement effectively across multiple health professions
MSF	assessment	None	• Complex logistics and costly
Quantified CPE	activity	None	• Lack of evidence to support the idea that a select number of CPE hours will maintain or improve competence
Currency and active practice hours requirements	activity	None	• Lack of evidence to support the idea that a select number of hours will maintain competence
Reflective portfolios	activity	None	• Complex logistics and costly

D. Readiness Activities for Design and Development

Many next steps, or readiness activities, were identified. Readiness activities are requisite steps to advancing the QAP design and development. For example, one of the readiness activities is to gather and analyze risk data for the QAP. Defining risk for the QAP will be necessary to know which groups of licensees will require specific or additional quality assurance assessments or activities.

E. Final Notes

In this report, the project has moved from gathering information to completing the ideas stage and making progress on the design stage by clarifying many of the big elements of design: purpose (why), context (where), outcomes (what), key design features (how), reasonable quality assurance assessments and activities (what) for the CHCPBC context, and available evidence that applies to QAPs.

A few questions may remain.

Is enough information available to start to design and develop the QAP?
Yes.

While researchers are always interested in more investigation and more information, sufficient high quality evidence, including contextual factors, is available to inform CHCPBC's decisions of the WHY, WHO, WHEN, HOW, and WHAT.

In preparing this report, and through the many consultations and conversations, the consultants focused on the completeness and interpretation of the currently available and relevant research and information. Using this research, the consultants worked to recommend the QAP design features appropriate for the HPOA and the College's Regulatory Approach, which focuses on serving patients' needs.

What's next?
First, confirm that this report should be used to complete the design of and develop the College's QAP.

Next, take stock of the readiness activities and the resources needed to start the development phase. These include establishing timelines and priorities, inventorying available and needed resources, designing prototypes of assessments and activities, and engaging and communicating with licensees and other affected parties. The transition priorities should include sunsetting the many legacy requirements and aligning staffing and operational systems for the new QAP.

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.

When will the building of the QAP be "done"?
Design thinking suggests that the first iteration should be a start that informs the next that informs the next. Each subsequent iteration involves improvements and refinements to better achieve the program's purpose.

With the building of QAP Phase 1, CHCPBC will be well on its way to establishing a strong, unified program that aligns with the HPOA and the Regulatory Approach, while improving patient health and care outcomes and supporting licensees' learning and performance.

7. 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[9]
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)

[9] 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).

8. Appendices

Appendix 1: Key Informants for Consultations

Multiple consultations were held by the consultant in April and May to gather input and suggestions for refinement on the draft Ideas and Design Report.

1. CHCPBC Senior Leadership

Two meetings were held to accommodate attendance by 11 senior staff:

- Dianne Millette, CEO, Registrar
- Cameron Cowper, Chief Regulatory Officer & Deputy Registrar
- Kathy Davidson, Executive Director, Strategy, Governance & Social Accountability
- Michelle Da Roza, Executive Director, Communications, Change Management & Organizational Development
- Chris Smerdon, Director, Licensure
- Lisa Bannerman, Director, Quality Practice
- Melanie Journoud, Director, Investigations, Discipline & Monitoring
- Lainie Shore, Regulatory Transformation Advisor, Investigations, Discipline & Monitoring
- Susan Paul, Regulatory Transformation Advisor, Quality Practice
- Cathy Silversides, Manager, Quality Assurance & Professional Practice
- Christopher Dodge, Lead Opticians Quality Assurance

2. CHCPBC Lead, Indigenous Cultural Safety and Humility

- Amy Poirier, Indigenous Cultural Safety and Humility

3. External Legal Counsel

- Angela R. Westmacott, K.C.
  Lovett Westmacott, Barristers & Solicitors

4. CHCPBC Health Professional invitees including staff, volunteers, registrants

Participants were invited to attend two, 1.5 hour consultation sessions and completed a confidential survey.

Name	Attended April 22	Attended May 6	Staff	Profession
Nick Grundmann	Yes	No	Yes	Audiologist
Christiane Basilo	Yes	Yes	No	Audiologist/Hearing Practitioner
Rachel Jordan	Yes	Yes	No	Audiologist/Hearing Practitioner
Shally Yuan	Yes	Yes	No	Audiologist/Hearing Practitioner
Alysone Martel	Yes	Yes	No	Dietitian
Cindy Huang	Yes	Yes	Yes	Dietitian
Elaine van Oosten	Yes	Yes	Yes	Dietitian
Sian Hoe	Yes	Yes	No	Dietitian
Eric Lipschultz	Yes	Yes	No	Hearing Practitioner

Name	Attended April 22	Attended May 6	Staff	Profession
Sabreena Sunner	Yes	Yes	Yes	Hearing Practitioner
Alyson Clark	Yes	Yes	Yes	Occupational Therapist
Kathy Williams	Yes	Yes	No	Occupational Therapist
Kelly Peyton	Yes	Yes	No	Occupational Therapist
Teresa Green	Yes	Yes	No	Occupational Therapist
Avin Kishore	No	Yes	Yes	Optician
Clara Tam	Yes	Yes	No	Optician
Crystal Pollard	Yes	Yes	No	Optician
Karl Chua	Yes	Yes	No	Optician
Marty Semaniuk	Yes	Yes	No	Optician
Brad Generoux	Yes	Yes	No	Optometrist
Ivan Prpic	Yes	Yes	No	Optometrist
Jessica Ng	Yes	Yes	No	Optometrist
Mark Boudreau	Yes	Yes	Yes	Optometrist
Evan Wilton	Yes	Yes	No	Physical Therapist
Jeannette Lim	Yes	Yes	Yes	Physical Therapist
Jodie Pulsifer	Yes	Yes	No	Physical Therapist
Sue Murphy	Yes	Yes	Yes	Physical Therapist
Jason Grief	Yes	Yes	No	Psychologist
Lindsey Jack	Yes	Yes	No	Psychologist
Maureen Olley	Yes	Yes	No	Psychologist
Melanie Badali	Yes	Yes	No	Psychologist
Spencer Wade	Yes	Yes	No	Psychologist
Tigerson Young	Yes	Yes	Yes	Psychologist
AJ Hildebrand	Yes	Yes	Yes	Speech Language Pathologist
Gail Gumprich	Yes	Yes	No	Speech Language Pathologist
Wendy Duke	Yes	Yes	No	Speech Language Pathologist

Staff Observers

- Cathy Silversides
- Dianne Millette
- Lainie Shore
- Lisa Bannerman
- Michelle Da Roza
- Susan Paul

Appendix 2: Impacted Parties Engagement Components

Engagement Components

Components	Aims	Sample Activities	Impacts
Principled "the right thing to do"	· Build trust, legitimacy, and fairness	· Empowerment · Democratic activities (e.g., people vote on best choice)	· Enhanced social and ecological well-being · Giving voice to parties in their full complexity
	· Fulfill regulator responsibility and sustainability		
	· Advance inclusion and organization accountability		
Strategic use of analysis of critical factors to meet longer-term goals	· Improve financial performance	· One-way and two-way communication · Co-creation · Supportive organizational structures	· Enhancing relational culture · Including marginalized partners and rights holders
	· Manage risk		
	· Create value		
	· Create knowledge and foster learning		
	· Build reputation		
Pragmatic sensible, realistic, practical	· Consider the context when problem-solving and making decisions	· Collaborative with opportunities for dialogue · Cultivating relationships	· In depth understanding the parties' practice in different contexts · Iterative and ongoing process of engagement
	· Develop the organization and/or the health professionals		

Adapted from source: Kujala, J., Sachs, S., Leinonen, H., Heikkinen, A., & Laude, D. (2022).

Dark Side of Engagement

Unintentional Drift of Parties to the Dark Side

Origins	Leads to	Engagement Activities
● Mistakes ● Misalignment	● Interest conflicts ● Incongruent values	● Conflict resolution ● Mutual learning

Intentional (purposeful) Actions of Parties to the Dark Side

Origins	Leads to	Engagement Activities
● False claims ● Destruction of commitment and cooperation	● Misuse of individual interests or values ● Hyper self-interest	● Mitigate harmful strategies ● Uncover misleading and destructive behaviour

Adapted from source: Kujala, J., Sachs, S., Leinonen, H., Heikkinen, A., & Laude, D. (2022).

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