CDSBC College of Dental Surgeons of British Columbia

Improved Quality Assurance Program

Approved by CDSBC Board in February 2021

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Submitted by the

Quality Assurance Program Working Group

Please note: *This program is not currently in effect. A number of significant developments have impacted B.C.'s oral healthcare sector which were not contemplated during creation of this program. These will be evaluated by a board-directed working group prior to rolling the program out to registrants. Visit www.cdsbc.org/quality-assurance to stay up to date on the implementation timelines.*

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INTRODUCTION AND BACKGROUND

CDSBC maintains a quality assurance (QA) program as required as part of its duties and objects in the *Health Professions Act* (HPA), S.16 (2) (e). It is the responsibility of the Quality Assurance Committee to administer and maintain the QA program in accordance with Part 9 of the CDSBC Bylaws.

In February 2015, the CDSBC Board charged the QA Committee to review and update the existing QA program (Appendix A). The Board asked the Committee to research and develop a comprehensive, mandatory quality assurance program that goes beyond reporting continuous education and practice hours and promotes career-long hands-on learning, encourages collaboration among colleagues, and produces improved patient outcomes. The improved program needed to be objective, credible, inclusive and administratively realistic.

The Quality Assurance Committee struck a Working Group (WG) and they drafted a proposal in accordance with the Board's direction and based on what was heard from the dental community. The draft program was approved for consultation by the Board February 2018 (Appendix B).

The WG is confident it has met its responsibility outlined in the terms of reference and guiding principles for the new program (Appendix C).

There is still much to do to implement the program but the primary task of researching, consulting and designing a revised program is complete.

The purpose of this report is to summarize the feedback that was received, reviewed and considered by the WG, describe the changes to the original proposal, and provide the rationale for those changes.

Once the draft proposal was approved and published on the CDSBC website, the WG continued its work and met every six to eight weeks to complete their task.
The WG began a consultation process in the March of 2018 by hosting in-person sessions throughout the province to hear from registrants, certified dental assistants and other stakeholders firsthand. Sessions were held in Vancouver, Victoria, Upper Island, Fairmont Hot Springs, Terrace and the Thompson-Okanagan with a total of 202 attendees participating.

CDSBC inaugurated an online consultation forum on the website and the program consultation period was held September through November 2018. The forum was open to registrants and stakeholders, 74 responses were received. During that period the working group reached out to the 20 limited volunteers for feedback specific to that category with 13 respondents.

In November 2019 the working group further reached out with a survey to all 6500 CDAs we regulate to hear their thoughts on Peer Collaboration with 350 respondents sharing their comments.

There were limitations in the consultation process. While there were many opportunities for input there was less-than-desired feedback. However, there was commonality, in the responses received.

ANALYSIS OF FEEDBACK AND RATIONALE FOR CHANGE

The WG recognized its responsibility to improve the program to reflect the overarching mandate of CDSBC, to protect the public. The improved program was designed to reflect the activities and behaviors of highly regarded oral healthcare providers. For a comparison of the existing program and improved program (see Appendix D).

It was understood by the WG that much of what makes up the components of a QA program is informed by the specific profession, its norms and culture. The WG also recognized that in exchange for being granted the privilege of practicing health care, society expects health care professionals to continually improve their quality of care and competence.

During their research, the WG found that there is a lack of high-level policy research into QA programs or continuous professional development (CPD), particularly in the field of dentistry. There is not enough research or work into evidence-based quality frameworks and measures specific to dentistry. Whilst much of the research has been in the medical field, there are some similarities that can be applied to dentistry. The WG developed a Logic Model (Appendix E) which helped to show there is good reason to think that aspects/rationale that work in medicine would also work in dentistry.

Although there is lack of evidence-based research, QA programs put into place to promote life-long learning and continuous improvement go a long way to increase public trust and confidence in their dental professionals.

The improved QA program is informed by evidence and input from the dental professionals. All of the feedback received through the consultation work described above was reviewed and considered by the working group. Themes in the feedback were identified (Appendix F) and considered.

The feedback reflected both positive attitudes, toward the new components in the program, and negative. There were some views expressed which were very supportive of the direction toward improving public trust and “upping our game”. There were others expressed which focused on the program being too onerous on registrants.

As was done during the research and planning of the program, the WG emphasized “quality improvement.” The working group’s intent was to improve what was currently in

place to support continuous improvement for registrants and the shared purpose to provide the best care and ideally improve outcomes for patients.

The improved program encourages active learning with purposeful interactions with peers and professionals, promotes critical thinking, and in-depth learning for lasting change. It allows for the recognition and ratification of higher-quality discussion and interaction that already exists between colleagues, and which reflects increasingly collaborative and multi-disciplinary dental care.

The improved program amplifies the qualities of what professionalism is today. It is multi-disciplinary based in expertise; shared decision making and does this through the encouragement of collaboration and engagement with colleagues.

COMPONENTS OF IMPROVED PROGRAM

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

Final Program: Proceed with CPD rather than CE terminology.

Feedback Received:

The WG group received comments asking for the rationale for changing of the terminology from Continuing Education (CE) to Continuing Professional Development (CPD).

These included: “changing continuing education to 'Continuing Professional Development' is unnecessary as the new term does not encourage a greater ownership of one's professional development and it actually weakens the link to life-long learning.”

“Continuing Education is succinct and sufficient whereas Continuing Professional Development is a vague bureaucratic term that is meaningless”

Rationale :

The decision to keep the change in the language was based on several factors. The term CPD is increasingly used around the world and in healthcare generally. Also, CPD includes components of CE but takes a more holistic view of learning to ensure that dental professionals remain competent in the modern dental care system.

The term continuing professional development speaks to registrants' ongoing professional responsibility to lifelong learning to maintain and improve their knowledge and skills rather than simply meeting an educational requirement. It is a broader term that encompasses activities beyond classroom learning. It positions registrants as professionals who are responsible for their own development.

PARTICIPATORY LEARNING

Final Program: No changes were made.

Feedback Received:

The feedback received about participatory learning was generally positive. Respondents agreed the study club experience is beneficial and should receive more credits. Some respondents commented that there should also be mixed dentist-CDA groups for the participatory learning.

Rationale:

This will encourage more participatory learning and purposeful interactions with peers. The increase in credits will provide incentive to engage with colleagues.

Note: this component will require a Bylaw change to define credit hours to increase the CPD credits from 1- 1.5.

CORE VS NON-CORE

Final Program:

The working group increased the number of activities directly related to the provision of patient care and treatment. Registrants must obtain a minimum of 75% of their CPD credits in "core" activities to improve their clinical knowledge and skill to better protect the public.

All other topics would be non-core. Non-Core category will cover non-clinical content including practitioner wellness and dental care administration.

Feedback Received:

The proposed relabeling of categories feedback was mostly positive. Respondents commented the existing categories of CE were confusing and difficult to determine which was most applicable.

Respondents also commented that practice management is essential skill for running a quality practice and that this subject should be a core credit. Additionally, practitioner wellness should be emphasized.

Rationale:

The WG wanted the emphasis of CPD to be on core activities that relate directly to patient care and clinical practice.

Final Program:

The WG decided to change the terminology: from “Practice Management” to “Dental Care Administration."

Rationale:

The change in terminology from Practice Management to Dental Care Administration acknowledges that courses can more broadly address dimensions of dental care quality through the administration of oral health care professionals, facilities or programs.

REQUIRED COMPETENCIES

Final Program: No changes were made.

Feedback Received:

Most respondents supported and some even suggested this requirement-specifically the courses included in this proposal. There was some feedback questioning whether a dentist who has never had a complaint needs to take an ethics course or, whether a dentist who teaches the subject matter needs to take these courses. Additionally, required competencies were seen as “annoying” if they must be repeated every two cycles.

Rationale:

The required competencies will keep registrants current in these critical subject areas.

SITUATIONAL JUDGMENT EXERCISES

Final Program: No changes were made.

Feedback Received:

It was expressed that CDSBC should consider other sources for these exercises rather than creating them as the concern about the costs, time and effort to set up the exercise along with the desired results in the behavior. Additionally, some requested evidenced-based research to speak to the benefits of the exercise.

Rationale:

Communication is a key component of patient care. These exercises will help registrants identify different strategies for speaking to patients, identify issues and solving common misconceptions /miscommunication that may take place within a dental office as such the working group did not make any changes to this component.

OBJECTIVE FEEDBACK

Final Program:

The WG revised and renamed the *Objective Feedback* component to *Peer Collaboration and Feedback* to better describe the purpose of the requirement, which is peer engagement and sharing to improve practice outcomes. All oral health care professionals have a responsibility to, and a role in, improving the quality of patient care. Additionally, the standards of practice apply to every dentist, dental therapist and CDA as such the WG determined CDAs would be required to participate.

Feedback Received:

Respondents said they wanted more clarity regarding the purpose of the Objective Feedback requirement. They wanted more choices for how to meet this requirement, and more details about the types of activities that would qualify under this banner.

Respondents voiced that existing study clubs and dental societies achieve most, if not all, of the goals of objective feedback. They also commented rather than

creating an onerous new system of collaborative peer groups, we should promote objective feedback in the Study Club/Dental Society framework.

Concern was expressed about the sort of documentation which would be acceptable as well as concern for those registrants in rural parts of the province.

Rationale:

The purpose of this component of the QA program is for registrants to learn from and collaborate with their peers. The working group felt this approach would be an opportunity to safely and openly discuss best practices, share advice, provide insight, offer constructive comments, and learn from one another outside of the direct provision of dental care.

Peer Collaboration and Feedback:

This revised component of the QA program offers a choice of more ways to meet this requirement. These include:

Study Clubs (with participation)
All participants would prepare and present learning material to the group, with the opportunity for direct feedback from their peers. The subject matter would be clinical content that relates to the provision of patient care and treatment (e.g. protocols, procedures, health technologies, materials, etc). A template would guide the format of the posting and supporting documentation and explain the requirements for the reporting for QA credit.

For CDAs who utilize this component as part of their dentist's study club they could present/discuss/ get feedback on services related to their role during procedures. For example: making impressions, taking radiographs, placing a dental dam etc.

Case Reviews
These center around a patient's condition and treatment, as managed by the presenter, with the opportunity for direct feedback from peers; they are like medical rounds but without the patient present. These could be about unique cases, complex cases, multidisciplinary cases, or cases involving areas that applied the most current research and evidence. They also

could be about cases where there were adverse events or operational issues.

For CDAs, this component focuses on a patient's condition and treatment, as managed by the CDA. Scenarios could be discussed along with outcomes; what was learned; what could be done differently. Examples of topic might include, managing an anxious patient, challenges in taking radiographs, infection control discussions, new products, services CDA can provide etc.

Online Forums

These are a contemporary and accessible venue to present learning material to a group of peers, with the opportunity for feedback from and interaction with other subscribers/participants. The subject matter would be clinical content that relates to the provision of patient care and treatment (e.g. protocols, procedures, health technologies, materials, etc.), or a case presentation of a patient's condition and treatment as managed by the poster.

PEER TO PEER VISITS

Final Program: The working group has delayed this component of the improved program for now.

Feedback Received:

Respondents provided a great deal of feedback on the Peer to Peer Visit component.

Comments during the engagement sessions and on the survey concluded that respondents were opposed to office visits/reviews. Comments heard ranged from "not wanting the College to come in and police them" to "forcing registrants to report on themselves will result in them telling CDSBC what we wanted to hear". Concerns were expressed about: training, standardization for peer evaluators, favoritism, how the CDSBC would oversee peer activities.

Rationale:

The decision to table the peer-to-peer (dentist-to-dentist) visits was the result of difficulty in specifying the objectives of the peer to peer visit. Since the CDSBC has identified creating and reorganizing the practice standards and guidance as a priority, a suitable visit framework and template was not feasible at this time. Other components of the improved program address the intent of the peer to

peer visits using engagement activities. This area of QA will be monitored by CDSBC staff and the committee as evidence becomes available from other regulatory bodies, in this area of research, and as the College undertakes more internal data input.

CONTINUOUS PRACTICE HOURS (CPH) REQUIREMENT

Final Program:

The WG recognized that continuing practice hours alone do not prove that a practitioner is competent, CP hours must be considered in the context of the QA program as a whole.

As such, the WG chose to leave this requirement generally unchanged on the basis that this requirement was not unreasonably difficult to attain; registrants in the limited volunteer and limited research categories will be required to obtain and report a minimum of 50 hours of practice within the previous three years. Additionally, the CPH requirement promotes the ongoing application of professional knowledge, judgement, and is an existing requirement for many other health regulators.

One addition was the definition of “Continuous Practice Hours”. These are defined as hours spent performing restricted activities as defined in the registrant’s scope of practice”.

The WG determined acceptable CPH include clinical teaching of a restricted activity. Didactic teaching (theory of a restricted activity) hours are recognised to the maximum of 100 hour/year or equals 300 hours/cycle for dentists, for CDAs 68 hours/ year or 200 hours per cycle. This maximum of 100/ 68 year of didactic portion of teaching will be carried throughout all other registration categories.

If teaching does not involve a restricted activity CPHs are not recognized.

Feedback Received:

Respondents raised concerns about the CPH requirement and whether the required hours prove that a practitioner is competent. Questions arose asking if CDSBC had data that correlates the continuous practice hours/cycle with favorable patient outcomes.

Concerns were expressed for those registrants who take time away from practice and the ability to meet the continuous practice hour requirement when they are ready to return.

Rationale:

The WG determined a definition of CPH would clarify acceptable practice hours are based on providing the restricted activities outlined in the Dentist's Regulation and CDSBC Bylaws. Requiring continual practice in these activities support currency, knowledge, and skill.

In cases where practitioners fail to meet the required number of hours, the WG considered that the program overall has been improved, providing more avenues for maintaining competence, and thus reduces the risk associated with a shortfall of hours. The WG further noted that in cases where individuals do not meet the QA requirements to renew registration or certification, the Bylaws allow for them to submit proposals for consideration that might be equivalent to the QA requirements. The Registration and CDA Certification committees have approved alternate paths back to practice.

CPH REQUIREMENTS FOR LIMITED CATEGORIES

Final Program:

Limited Education - 100 CP hours per year- can be all didactic teaching of a restricted activity. To transfer to a practicing full registrant, one must maintain another 600 (in the three (3) years) in clinical activity may include teaching-preclinical teaching.

Limited Volunteer - 50 CP hours per year that must be obtained working in BC serving the patients this category was created for. To transfer to a practicing full registrant, one must meet the QA requirements and would need to be approved by the Registration Committee.

Limited Research - 50 CP hours per year – to transfer to full registration, one must meet the QA requirements and would need to be approved by the Registration Committee.

Feedback Received:

While some feedback questioned the reason for this requirement, criticism of this component generally centered on the precise number of hours and not the requirement itself.

Rationale:

In the draft proposal, approved by the CDSBC Board, 100 CPH hours were suggested for the Limited Categories. The change in the requirements for the limited categories was based on supporting currency of practice along with

continued CPD for all categories of registration in the interest of protecting the public.

The WG noted dentists should be required to provide the same level of care to all patients, regardless of their registration category or the patients they may be treating.

Setting a minimum requirement of hours should allow these registrants the opportunity to practice and provide care within their unique category of registration. (See the QA Requirements By Registration Class, Appendix G)

Using a logic model of program analysis, improved patient outcomes can reasonably be expected from being an active practitioner. A reduction in the CP hours requirement for most practitioners cannot be reasonably justified either (nor can an increase). Some feedback cited the possible “poor quality” of some practice hours and therefore the WG clarified and improved the definition of qualifying hours.

The final CPH number was reduced in the limited research and volunteer categories. This change was made in consideration of the populations these registrants primarily serve. Feedback received from the dentists holding the limited volunteer class of registration, highlighted the limited hours that these dentists spend in the not-for-profit clinics. Their concern was that they would not be able to maintain this registration class if the CPH was increased to 100. The WG recognizes access to care is an important part of oral health care. The modification of CPH, in these limited categories facilitates this. To promote currency of practice the working group will require these groups to complete additional components of the improved program.

Please find attached, as Appendix H, the Final Draft of the Improved Quality Assurance Program.

EVALUATION

The Quality Assurance Committee will continually evaluate the improved program to ensure that it remains valid, reliable, feasible and acceptable.

Objectives will be developed to assist in the evaluation. Surveying registrants to get their feedback on how the changes are working or not working will be part of this process. This would also be accomplished by collecting data from the new QA program dashboard as it will assist in capturing the nature of CPD activities registrants are completing. Other measures will be considered to evaluate this improved program to determine if it has met the charge from the Board.

As part of the first step in evaluation, the WG developed a logic model (Appendix E) which outlines that by doing the activities of the improved QA program, a number of

improved outcomes will be realized. While we may not be able to quantify all aspects of this program, the WG is comfortable with the “if we do this, then that should happen” approach. We will measure and change the program once we have evaluated what works and what doesn’t and how we have changed.

NEXT STEPS

CDSBC’s registration and QA department staff are working on implementing the move to an audit process for the CE submissions. This is expected to be in place in September 2020. As this is an administrative component, the WG agreed that this could be implemented as a piece on its own and before the new program is in place.
Prior to implementation of the other components in the new program, work needs to be done on revising Part 9 of the CDSBC bylaws to allow for certain parts of the new program to be put into place.

Bylaw Changes Required

To change the credit allotment for participatory learning the definition of a credit hour requires a bylaw change. 9.01(1)

Additionally, the WG has stated the expectation is for all registrants to take CPD in all areas not just the areas they practice in most often, as such there is no need to have the specific requirement for specialists to do 50% of their CPD in their specialty. 9.03(2)

CONCLUSION

The Quality Assurance Working Group believes that it has fulfilled the charge from the Board to improve the current program with this proposal. The improved processes are well aligned with the CDSBC’s mandate and follows through with the requirements laid out in our legislation.

There is still much to do to implement the program but the primary task of researching, consulting and designing a revised program is complete. As such the working group asks that the Quality Assurance Committee consider and accept this proposal so it may be forwarded to the CDSBC Board for ratification.

With the Board’s support, along with the experience and confidence of the CDSBC staff, we are confident that we can implement this plan and deliver a leading quality assurance program.

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APPENDICES

Appendix A: Letter to the QA Committee from the Board (2015)

Appendix B: Draft QA Program submitted to the Board in February 2018

Appendix C: Terms of Reference – Quality Assurance Working Group

Appendix D: Comparison of the existing QA program to the new program

Appendix E: QA Program Logic Model

Appendix F: Themes of Feedback

Appendix G: QA Requirements by Registration Class

Appendix H: Final Draft of the Improved QA Program