CDSBC | College of Dental Surgeons of British Columbia

Quality Assurance Program Appendices

Submitted by the

Quality Assurance Program Working Group

APPENDICES

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Appendix A

TO: CDSBC Quality Assurance Committee

FROM: Dr. David Tobias, President
Dr. Erik Hutton, Vice-President
Dr. Kerim Özcan, Treasurer

DATE: April 16, 2015

SUBJECT: **CDSBC Quality Assurance Program**

This message is a follow-up to the quality assurance workshop that was held on February 21, 2015, and the direction that the Board provided shortly thereafter. The Board Officers are providing it for the benefit of the Quality Assurance Committee members who were unable to attend the workshop.

As discussed at the workshop, and as the Board and Committee members are well aware, public expectations of health professions colleges are higher than ever before. This includes the expectation that colleges will develop and administer a robust quality assurance program.

Quality assurance of health professionals in British Columbia is also a priority of the provincial government. The Ministry of Health has signaled its intentions through the enactment of section 26.1 of the *Health Professions Act*. While it is not clear when this section will be put in to force, the language clearly contemplates that health professions colleges will one day be required to administer some type of audit process. Informal discussions with the Ministry indicate that section 26.1 is a response to the perceived inadequacy of some of the quality assurance programs presently in force.

Beyond external expectations, the Board is aware that the present quality assurance program is not sufficient. The Board has long believed that pro-active development of the quality assurance program is necessary, and that belief was reinforced by the presentations at the workshop. The result was a direction from the Board to begin work on a revised quality assurance program.

The Board does not necessarily envisage any particular program – and there are many different models – but aspires to develop a program that promotes career-long hands-on learning, encourages collaboration among colleagues, and produces improved patient outcomes.

The Board is therefore tasking the Quality Assurance Committee as follows: Research and develop a comprehensive mandatory quality assurance program that goes beyond reporting educational or practice hours. The program should be objective, credible, inclusive, and administratively realistic.

This will be a challenging project, worthy of the Quality Assurance Committee's collective talent and dedication. The result will benefit all British Columbians.

Dr. David Tobias, President

Dr. Erik Hutton, Vice-President

Dr. Kerim Özcan, Treasurer

CDSBC College of Dental Surgeons of British Columbia

Appendix B

Proposed Quality Assurance Program

February 2018

Submitted by the

Quality Assurance Program Working Group

Note:

This report was approved by the Board at the 24 February board meeting.

The report outlines the draft program proposed by the QA working group. Please note that the program is still being revised and changed. Since the Board approved this document, there have been some minor changes made to the proposal. Those changes are ***not*** reflected in this report.

TABLE OF CONTENTS

INTRODUCTION AND BACKGROUND

Quality assurance (QA) programs are developed and maintained by health professional regulatory bodies to help ensure the public is well-served by competent health professionals.

The *Health Professions Act* (HPA) stipulates that these health profession colleges maintain a QA program for their registrants. These programs are put in place to promote life-long learning and continuous improvement necessary for registrants to stay current in a changing health care environment and provide the best possible level of care for their patients in their chosen area of practice.

The current QA program is aligned with the College's strategic plan goals in that: it aims to be fair and transparent; it improves professionalism and practice standards; it promotes professional collaboration; and is committed to organizational excellence demonstrated by its pursuit of continuous improvement for both the registrants and the program. CDSBC has had a QA program in place for approximately 40 years. The program has evolved over the years to what it is today.

The College has recently developed a new policy development process to review and develop its various policies and standards. This new process enhances ongoing communication and consultation with registrants through each stage of the process. This QA program review was the first to implement the new policy process (Appendix 2).

As part of good governance practice, in February 2015, the CDSBC Board charged the QA Committee (the "committee") to review and update the existing QA program (Appendix 1). 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 program should be objective, credible, inclusive and administratively realistic.

To this end, the QA Committee formed a working group (WG) comprised of three dentists, one certified dental assistant (CDA), two public members and three staff.

The Pacific Northwest has a long and illustrious tradition of study clubs and peer collaboration, CDSBC was one of the forerunners in continuing education. The WG wanted to ensure that we continue to be leaders and to build on this historic tradition.

This report will outline the findings taken from the various sources of research performed and reviewed by the WG, much of which confirmed that the direction they were given from the Board and the program principles that they outlined from the early stages was echoed by many registrants, regulators and subject-matter experts.

It has been a long journey and much hard work was done by the WG members over the past two years. There is still a ways to go but the first difficult task of researching and designing a framework for a revised program is near completion and the working group is confident they will get there to fulfil their charge from the Board.

RESEARCH METHODOLOGY

Based on direction from the Board to research and develop a comprehensive mandatory QA program that goes beyond the current program, the WG has met every four to eight weeks to accomplish this task.

The first task completed by the WG was the creation of the terms of reference and a list of guiding principles for the new program (Appendix 3). The following is a description of the research and work done by the WG over the past two years.

Expert research

The WG sought articles written by subject matter experts on quality assurance: maintaining competence and self-assessment. A literature review was compiled to assist in demonstrating the findings taken from these articles. (Appendix 8)

Other regulators

The WG wanted to find out if they could learn any best practices or borrow ideas from other regulators. They researched the information available on other regulators' websites as well as contacted some regulators to obtain further information. The research was compiled. (Appendix 7)

Stakeholder feedback

The WG wanted to hear from those who would ultimately be affected by program changes. The goal was to hear registrants' thoughts on the current program. The WG wanted to learn what was working, what wasn't and how the current program could be improved. Expressing that the ultimate goal of an improved program would promote ownership of professionalism, engagement with other professionals and the shared purpose to provide the best care to patients, which would ideally improve outcomes for patients.

To begin this process, the WG met with the member services organizations (BCDA and CDABC) to share their perspectives. It was a valuable conversation. These two groups shared their views on the current program and challenges they hear about from their members.

Engagement with registrants

An engagement consultant was retained to assist the WG with developing an engagement strategy, a timeline for the group, and some tools to assist in the conversations they were planning to have. (Appendix 4) The consultant would also assist in facilitating sessions when needed.

With a strategy in place, the WG was ready to go out into the dental community to listen to the registrants. The last part of 2016 and most of 2017 was spent consulting with stakeholder groups. This was accomplished through: making a survey available to registrants at the CDSBC booth at the 2017 Pacific Dental Conference; participating in five listening sessions across the province; hosting three webinars; and holding three focus groups to target specific registrant groups. This feedback was captured on an initial consultation report. (Appendix 5)

Engagement with the public

The WG wanted to obtain feedback from members of the public about how they know that their dental professional is providing safe and quality care. A survey was sent to members of the public (via patient network groups) in December 2017. A report of the survey results to date is enclosed (Appendix 6).

Based on the findings from their research, the WG felt it had enough information to proceed and work toward establishing recommendations for an improved program.

FINDINGS & ANALYSIS

Research on other regulators and from subject matter experts showed that there is no one answer to QA for professionals. It found that best practices have not yet been determined. The WG also learned that many other regulators are working developing new QA programs of their own. It is understood and was determined by the WG that much of what makes up the components of a QA program may be informed by the specific profession, its practices and culture.

During the initial consultation with stakeholders, some general themes emerged:

- desire for different options for proving competency;
- individuals have different learning methods;
- individuals have different circumstances that contribute to how they collect their continuing education credits; and
- quality, accessibility, and availability of courses.

It was expressed by some registrants that the program should not limit practitioners with too many rules and regulations that may impede good practitioners from returning to work. The principles of the new program reflect that the program needs to be manageable, fair, and feasible for registrants.

The WG acknowledges that minor changes to the relevant CDSBC Bylaws may be required to accommodate the improved program requirements. Some of the changes relate to the registrant categories and as such will be reviewed and if necessary revised during the process of the Bylaw revisions.

Based on the feedback and the research that the WG completed over the past 2 years, highlights of the findings are listed below.

Continuous Practice Hours (CPH) Requirement

Concerns were raised about the CPH requirement and whether or not the required hours actually prove that a practitioner is competent. The hours may just prove that the practitioner is current in that skill. Quantity may not mean quality.

Research has shown that several other health regulators have a similar minimum CPH requirement in their QA program for their registrants.

Self-Assessments

There were many opinions on the ability of registrants to self-assess. Commenters suggested that self-assessments are too variable; that individuals might be too critical on themselves; and that individuals may be too generous on their evaluations.

The WG was impressed with the concept of a situational judgment exercise (SJE) that is used to determine the communication skills of a registrant. The premise is that if a registrant was a good communicator then, generally speaking, they are more likely to be competent. The exercise will consist of different scenarios involving communications in the context of patient care, such as informed consent. The SJE is meant to assist the participant to assess themselves - their problem solving skills - and reflect based on the outcomes of the communication exercise. By formulating questions in specific areas that could have more than

one correct answer may help the registrant to determine if/when more education may be needed. This exercise is used by other regulators in many professions and is considered to be a good tool for self-reflection.

Peer review

Peer review was considered by many of our registrants as a collaborative way to get feedback from colleagues. It is seen as an interactive way to learn and stay engaged with the professional community. We heard that there is a benefit to asking your peers "how could I have done this better?"

Several other health regulators have this type of component in their QA program and confirm it works for their registrants.

The review of available literature on the subject also showed that the programs that were the most effective were those that nurtured the concept of learning in a "safe" environment, and that involved "hands on" learning and "peer group" interaction.

Practice visits

Registrants had varying opinions on this topic. Comments during the listening sessions and on the survey concluded that registrants were not opposed to office visits/reviews, as they thought it is in the interest of the public. Those opposed did not want the College to come in and police them. After much discussion and research into what other regulators are doing, it was determined that practice visits could be a valuable tool if done in a collegial, collaborative way. The WG determined that registrants may be comfortable if the office visit was done by a peer and assisted with some tools to use to conduct the visit.

Examinations

Registrants were asked if they felt an examination process could determine currency and competency. Survey results from the 2017 PDC indicated 50% of the 76 people polled would support an examination process while 31% were opposed. From those that were opposed, the comments indicated that examinations do not ensure currency and competency in practice. Respondents also identified financial implications, as it is expensive to create and secure a test.

A major goal of the improved program is that it will encourage collaboration and engagement with other professionals to promote better patient outcomes. Examinations do not fit within the goals of the improved program.

Mandatory courses

Almost every registrant mentioned this should be a requirement - specifically the courses included in this proposal.

Engagement/participatory Learning

Many registrants currently participate in group learning through study clubs and have expressed this is a valuable way to learn and share knowledge with peers.

Participatory learning encourages active rather than passive learning. Evidence shows that active learning with purposeful interactions with peers promotes critical thinking, in-depth learning and lasting change. This is accomplished through hands on courses and study clubs, not just lectures, and peer-to-peer engagement either in person or virtually.

CPD Audits

The working group's research shows that other regulators are auditing their registrants' QA submissions. Registrants' comments regarding audits were minimal, other than some felt it was a process already in place. This change would allow submissions to be reported on an honour system but will be verified during the audit.

PROPOSED QUALITY ASSURANCE PROGRAM

During the research and planning of the program, the WG intentionally placed emphasis on "quality improvement." Quality improvement is a continuous process. It is proactive and helps to find ways to make improvements in practice. The working group's intent is to improve the program in place to support continuous improvement for registrants.

Evidence shows that active learning with purposeful interactions with peers and the profession promotes critical thinking, in-depth learning and lasting change.

This improved program encourages collaboration and engagement with colleagues. Participatory learning - learning that is active rather than passive - is also a key focus.

The following principles guide the development and implementation of the QA program.

Principles for CDSBC QA Program

The CDSBC QA Program should:

1. Be in the public interest – aligned with the HPA and CDSBC mandate
2. Improve registrants' dental knowledge, competency and skills
3. Encourage career-long learning
4. Encourage accountability and professionalism of registrants
5. Include and encourage opportunities for professional engagement and collaboration
6. Promote improved patient outcomes
7. Be objective, credible and manageable
8. Be inclusive and fairly applied to all registrants
9. Be evidence-based
10. Be feasible and cost effective for both registrants & CDSBC

RECOMMENDATIONS

The WG have come up with the following recommendations for the Quality Assurance Program based on the findings noted above. The rationale for each recommendation and its connection to the specific program principle have been included.

1. Continuing Professional Development		
Recommendation	**Rationale**	**Principles**
Terminology The terminology will change to "continuing professional development" from "continuing education."	▪ The term continuing professional development (CPD) speaks to registrants' ongoing professional responsibility 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.	▪ In the public interest ▪ Career-long learning ▪ Accountability ▪ Professional engagement and collaboration
Cycle and credits The current three-year cycle and total number of credits required will stay the same. Dentist = 90 credits CDAs = 36 credits Dental therapists = 75 credits	▪ The total number of requirements and the three-year cycle currently work well for registrants. ▪ Having some consistency from the old program to the new will reduce confusion for registrants when the new program is implemented. ▪ These requirements are similar to the QA requirements of other professional regulators.	▪ Objective, credible and manageable ▪ Accountability
Participatory Learning The program will give registrants enhanced credits for participatory learning.	▪ This program encourages active rather than passive learning. Evidence shows that active learning with purposeful interactions with peers and the profession promotes critical thinking, in-depth learning and lasting change. ▪ Engagement offers a form of ongoing feedback of one's competency and skills.	▪ Improves competency and skill ▪ Objective, credible and manageable ▪ Career-long learning ▪ Evidence-based

	▪ The enhanced credits will give registrants incentive to participate in a broader scope of activities that provide more beneficial learning opportunities.	▪ Promotes improved patient outcomes ▪ Professional engagement and collaboration
Re-labelling of CPD categories CPD will be broken down into two main categories: “Core” and “Non-core”. Core activities are clinically relevant and relate to the provision of patient care and treatment. Includes base competencies, patient safety, and teaching. Non-core activities cover non-clinical topics such as practitioner health, practice management and volunteering.	▪ “Core” and “non-core” activities will help ensure that registrants are taking a minimum number of courses that will improve their clinical knowledge and skill to better protect the public. ▪ This will increase the number of activities directly related to the provision of patient care and treatment.	▪ In the public interest ▪ Improves competency and skill ▪ Objective, credible and manageable ▪ Promotes improved patient outcomes ▪ Accountability ▪ Professional engagement and collaboration
Record retention and audit Registrants will still be required to keep their documents of each activity submitted as they may be audited. When a registrant is audited, they must submit documentation from each activity claimed. Each year, the College will do a random audit of the registrant accounts for those whose CPD cycle is ending.	▪ With the current QA program, College staff review all CE submissions as they are submitted. An audit should reduce the amount of administrative work required by staff. ▪ An audit will increase accountability. Registrants will be more motivated to complete substantial and worthwhile CPD activities. ▪ Audits will give the College a better understanding of how complete registrants’ CPD is and the types of activities that are being submitted.	▪ Objective, credible and manageable ▪ Accountability

Dashboard There will be a dashboard in the registrants' accounts to graphically demonstrate how much of the registrant's CPD requirements are met, as well as the range of topics they have focused their activities on in comparison to their colleagues (other registrants).	▪ This will be a form of objective and passive feedback. ▪ The dashboard gives registrants insight into what their colleagues are doing and could motivate them to take different types of CPD activities that they may not usually participate in. ▪ It allows self-reflection through comparison.	▪ Improves competency and skill ▪ Objective, credible and manageable ▪ Professional engagement and collaboration ▪ Accountability
2. Base Competencies		
Recommendation	**Rationale**	**Principles**
Base competencies The WG have determined that there are four areas of competency that the public should expect every dental professional to be current in. Every CPD cycle, registrants will be required to complete two of four base competency activities. The base competencies are: 1. Recordkeeping 2. Infection control 3. Ethics 4. Situational judgment Exercise Competencies 1-3 can be completed by taking a course on the subject matter. Competency 4 will be completed by completing an exercise online. The base competencies will count for CPD credits. Registrants will have two CPD cycles to complete all of the base competency activities.	▪ During the initial consultation many registrants shared an interest in having mandatory courses for recordkeeping, ethics and infection control. ▪ These activities are relevant to all registrants and every dental practice. ▪ The recordkeeping, ethics and situational judgment activities will cover topics that are often the subject of complaints to the College or that arise during inquiries/investigations. ▪ This time frame will provide registrants plenty of time to meet this requirement.	▪ In the public interest ▪ Improves competency and skill ▪ Objective, credible and manageable ▪ Career-long learning ▪ Evidence-based ▪ Promotes improved patient outcomes ▪ Inclusive and fairly applied to all registrants

Base Competencies - Courses Competencies 1-3 can be completed by taking a course. CDSBC's recordkeeping course will be acceptable for this requirement. It will be reviewed and updated as needed to meet this requirement. CDSBC will work with course developers to create courses for infection control and ethics. The working group will find equivalent courses to be used while the CDSBC courses are being developed. With each course, registrants can choose to bypass the course content and challenge the knowledge check questions.	▪ During the initial consultation many registrants shared an interest in having mandatory courses for recordkeeping, ethics and infection control ▪ The courses will help registrants stay competent in these subjects. New information will be communicated and taught to registrants through updates in the courses. For example, if the infection control guidelines change, the course will educate registrants who may not have been aware of these changes.	▪ Improves competency and skill ▪ In the public interest ▪ Career-long learning
Situational Judgment Exercise (SJE) One of the base competencies will be a situational judgment exercise that assesses registrants' communication and problem solving skills. The exercise will consist of different scenarios involving patient care and communications, such as informed consent.	▪ Communication is a key component of patient care. The SJE will assess registrants' communication and problem-solving skills. This exercise will help registrants reflect on strengths and weaknesses in their communication skills. ▪ The exercise will help registrants learn different strategies for speaking to patients, identifying issues and solving common misconceptions /miscommunication that may take place within a dental office.	▪ Improves competency and skill ▪ In the public interest ▪ Career-long learning
Mandatory CPR course Registrants are required to maintain a valid CPR (Healthcare Provider) certificate. They must submit their CPR course and the date their license expires in order to meet this requirement.	▪ The majority of our registrants have reported that they have CPR training. For best practices the working group determined that all registrants should be required to have this training.	▪ In the public interest ▪ Improves competency and skill ▪ Career-long learning

3. Objective Assessments

Recommendation	Rationale	Principles
Objective assessments Registrants will be required to complete at least one objective assessment per CPD cycle. An objective assessment is done through an evaluation and feedback of a registrant's work by a colleague or group of colleagues, eg. through a case study. Two types of objective assessments will be developed and provided as options to satisfy this component of the QA program: • Collaborative Peer Groups • Peer Office Visits (dentists only)	▪ To provide registrants with clear, credible, objective feedback on their professional practice. ▪ There is evidence that social engagement is a beneficial way for individuals to learn. ▪ Dental professionals respect the advice of their colleagues and can learn from one another. ▪ Peer collaboration demonstrates the profession is engaged in evaluating itself and remediating where necessary.	▪ In the public interest ▪ Improves competency and skill ▪ Objective, credible and manageable ▪ Career-long learning ▪ Evidence-based ▪ Professional engagement and collaboration ▪ Promotes improved patient outcomes ▪ Accountability
Collaborative peer groups Small groups of peers (e.g. dentists with dentists, CDAs with CDAs, etc.) meet in person to discuss selected cases. Each member of the group must present a case in order to meet their "objective assessment" requirement. The group will provide objective feedback on their peers' cases. This may require separate meetings to go through each case.	▪ Purposeful interaction with peers is considered a higher form of learning – particularly when coupled with objective assessments. ▪ In this process, registrants are expected to share selected cases with their colleagues. These personal examples will provide relatable and realistic scenarios that will enhance dialogue and learning.	

The College will develop criteria and a template for collaborative peer groups. These can be done in-person or virtually.		
Peer office visits (dentists only) This will involve collaborating with another dentist. Each dentist will visit the other's office to discuss their practices and procedures. It will be a structured interview with their colleague at their dental practice (physically or virtually). The College will provide a template for the interview. The College will develop guidelines for peer office visits that will provide resources for dentists completing an office visit.	▪ This is another form of peer-assessment and engagement that instils professionalism, transparency and collegiality within the profession. ▪ It is meant to be a comfortable and safe environment for dentists to review each other's dental practice. Dentists will have the opportunity to learn from their peers. ▪ This is an enhancement tool that takes place between colleagues and is not performed by the college. ▪ This will facilitate engagement within practitioners' offices and could potentially create better practices and increase patient safety. ▪ By sharing best practices, dentists may provide new solutions for their colleague, or they may identify and solve issues that their colleague may not have known existed. Should a dentist find a concern during a peer visit, they should have the opportunity to help their college remedy the situation. There will also be an avenue for registrants to get assistance without having to file a formal complaint.	

4. Continuous Practice Hours		
Recommendation	**Rationale**	**Principles**
Continuous Practice Hours The program will continue to have continuous practice hours. Continuous practice hours are defined as hours spent performing restricted activities	▪ There is evidence that experience and continual practice support currency of knowledge and skills. ▪ The current hour requirement is not onerous and can be met by practising one day a week. ▪ Research found that many other health professionals are required to	▪ In the public interest ▪ Objective, credible and manageable ▪ Career-long learning

as defined in registrants' scope of practice. Dentist = 900 hours CDAs = 600 hours Dental therapists = 900 hours	obtain a minimum number of continuous practice hours.	▪ Evidence-based ▪ Promotes improved patient outcomes ▪ Accountability
CP requirements for limited dentist categories Continuous practice hours will be required for dentists in some of the limited categories. For clarification, the following Limited categories will have CP requirements: **Armed Services or Government** ▪ 900 hours **Education** ▪ 100 CP hours per year ▪ 3-year time limit to return to full practice (must maintain CP hours) **Volunteer** ▪ 100 volunteer hours (in B.C.) per year ▪ 3-year time limit to return to full practice (must maintain standard CP hours)	▪ **Armed Services or Government** – Currently these registrants do report their CE and CP hours. They are working to the same standard as a Full Registrant and so should have the same QA requirements. ▪ **Limited education and limited volunteer** ○ There are currently no CP requirements for dentists in the education and volunteer categories. They do have CE requirements. ○ A dentist should be required to provide the same level of care to all patients, regardless of the dentist's registration category or the patients they may be treating. ○ The reality is that their situations are unique. Volunteers are providing care to patients who may not otherwise be able to access dental care. Educators are only teaching and working within the confines of their educational institution. Both categories work a lower number of hours each year than the typical registrant. ○ Setting a minimum requirement of hours should allow these registrants the opportunity to practice and provide care within their unique category of registration. ○ These categories were originally created for dentists in the	▪ In the public interest ▪ Promotes improved patient outcomes

	“sunset” of their careers who were moving towards retirement. In this case, these registrants can maintain the minimum of 100 hours per year for as long as they wish to work as a volunteer or educator. However if they choose to return to full practice at any point, they will have to keep in mind that they will be required to meet the full requirement of 900 CP hours before transferring categories.	

PROGRAM

There are 4 parts to the recommended Quality Assurance Program:

1. Continuing professional development
2. Mandatory base competencies
3. Objective assessments
4. Continuous practice hours

1. Continuing Professional Development (CPD)

CPD cycle

Registrants will acquire credits in three-year cycles with each new cycle starting 1 January of the calendar year following the year of registration or certification with CDSBC.

CPD credits

Dentists – 90 credits
CDAs – 36 credits
Dental therapists – 75 credits

One hour = 1 credit

Participatory learning

Registrants could receive "enhanced" credits for CPD activities that are considered to be a type of participatory learning. These could include those that involve hands-on learning, peer-to-peer engagement, collaboration or assessment.

One hour of participatory learning = 1.5 credit

Core and non-core activities

Registrants will be required to obtain a minimum of two-thirds of their CPD credits in "core" activities. Core activities are clinically relevant and increase patient safety. Registrants can get a maximum of one-third of their CPD credits in non-core activities.

Core activities *(minimum 2/3)*
The topics in this category should be clinically relevant and may include: courses that relate to the provision of patient care; base competencies; and teaching* or mentoring.
Non-core activities *(maximum 1/3)*
This category will cover non-clinical content including: practitioner health; practice management; and volunteering.

**If a registrant collects 2/3 of their CPD from teaching, they must get the rest of their requirement from the core category.*

Record Retention and Audit

Registrants must keep documentation from all the CPD activities they participate in. They will have the option to submit their documents when they submit their credits or to hold onto their documentation in case of an audit. The College will do a random audit of registrants whose CPD cycle is ending.

In July of each year, staff will begin the audit process and notify those registrants who are selected for an audit. Those registrants will be instructed to submit their documentation by 31 December of that year. They can submit proof of completion online or mail it directly to the College. Registrants will not be able to renew if they do not satisfy these requirements

During the review of registrants' submissions, the College staff may request additional information or proof of completion.

Registrants who don't pass the audit will be notified as soon as possible and will be required to submit their missing information before the end of renewal. Registrants who are not able to meet their requirements due to exceptional circumstances may submit a proposal to be reviewed by the Registration Committee.

Dashboard

A dashboard will be displayed in each registrant's online account which will graphically demonstrate where that registrant is in their completion of their CPD requirements as well as the range of topics they have focused their activities on in comparison to their colleagues (other registrants).

2. Mandatory Base Competencies

Base competencies

Every CPD cycle, registrants will be required to complete two of the four base competency activities. The four base competencies are:

1. Recordkeeping
2. Infection Control
3. Ethics
4. Situational Judgment Exercise (Communications + Patient Safety)

CPR Certification

Registrants will be required to maintain a valid CPR (HCP) certificate.

3. Objective Assessments

Registrants will be required to complete at least one objective assessment per CPD cycle. Objective assessments will count for 1.5 CPD credits per hour.

Collaborative peer groups

Small groups of 3-5 peers (e.g. dentists with dentists) meet in person to discuss selected cases.

Each member of the group must present a case in order to meet their "objective assessment" requirement.

The group will provide objective feedback on their peers' cases. This may require separate meetings to go through each case.

The College will develop criteria and a template for collaborative peer groups.

Peer office visits

This will involve collaborating with another dentist. Each will visit the other's office to discuss their practices and procedures.

It will be a structured interview with their colleague at their dental practice (physically or virtually).

The College will provide a template for the interview.

The College will develop guidelines for peer office visits that will provide resources for dentists completing an office visit.

4. Continuous Practice Hours

Continuous practice hours are defined as hours spent performing restricted activities as defined in the registrant's scope of practice.

Dentist = 900 hours
CDAs = 600 hours
Dental therapists = 900 hours

There will now be continuous practice hours required for dentists in some of the limited categories.

EVALUATION

The Quality Assurance Committee will be required to evaluate the improved program to ensure that it remains valid, reliable, feasible and acceptable. Additionally, we are looking to improve accountability by embarking on the quality improvement path and evaluation of the program should confirm this.

Objectives will be developed to assist in the evaluation. Reaching out to registrants to get their feedback on how the changes are working or not working will be part of this process. Input from the public will also assist with the evaluation.

Below are some things that can be measured/evaluated to include in the process:

- Professional engagement: Is there more purposeful interaction of registrants with their peers?
- Are registrants satisfied – do they consider the programs to be fair and useful?
- Accountability: We are improving accountability. What should that look like?
- Accountability: Are the processes transparent?
- Competency & skill: Does the program assist registrants to become competent and stay current in their practice?
- Patient outcomes: Is there evidence that they improve professional practice patterns – and that there are improvements for those receiving care?
- Public trust: Is the public aware of the college's regulatory responsibilities?
- Public trust- Is the patient/client/public satisfied with the quality of care registrants provide?

CONCLUSION

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

As such the working group asks that the Board consider and accept the recommendations put forward in this proposal.

With the Board's permission and acceptance, along with the experience and confidence of the CDSBC staff, we are confident that we can implement this plan and deliver a more effective and well-rounded quality assurance program.

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See Appendix 8 for the working group's literature review.

APPENDICES

Appendix 1. Letter to the QA Committee from the Board (2015)

Appendix 2. CDSBC's Policy Development Process

Appendix 3. Terms of Reference: Quality Assurance Program Working Group (2015)

Appendix 4. QAP Review: Engagement Strategy – Susanna Haas Lyons (2016)

Appendix 5. Initial Consultation Feedback (2017)

1. Pacific Dental Conference
2. Listening Sessions
3. Webinars
4. Focus Groups

Appendix 6. Patient Survey (2018)

Appendix 7. Review of other health regulators' programs

Appendix 8. Literature Review

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CDSBC | College of Dental Surgeons of British Columbia

Appendix C

Terms of Reference:
Quality Assurance Program Working Group

Established: June 5, 2015

Members to Include:
At least 5 members of the Quality Assurance Committee, including: at least three dentists; one certified dental assistant; and one public member.

Members:

1. Dr. Alexander Hird
2. Paul Durose
3. Dr. Andrea Esteves
4. Shelley Melissa, CDA (until Sept 30, 2018)
5. Dr. Ashok Varma
6. Dr. David Vogt

Staff:
1. Róisín O'Neill, Director of Registration & HR
2. Leslie Riva, Senior Manager: CDA Certification and Quality Assurance

Mandate:
To research and develop a comprehensive and mandatory program that goes beyond basic reporting of continuous practice hours and continuing education. The program should promote career-long hands-on learning, professional collaboration and promotes improved patient outcomes. To be successful, the program must be objective, credible, inclusive, and administratively realistic.

Tasks:

1) Communicate rationale of this initiative
2) Research and analyze QA Programs of other similar health regulators
3) Liaise and engage with the BCHR QAP Working Group; assist and align with recommendations if feasible
4) Engage stakeholders (such as component societies, the BCDA, and registrants) at large as appropriate to obtain input and foster collaboration and support. This will tie in with the critical aspect of communicating with our registrants in a continuous manner as we develop our program
5) Establish a program that will withstand scrutiny when measured against the College's and the Committee's mandate and objectives and be accepted by the profession
6) Ideally the program should be quantifiable (measurably improved competencies and patient outcomes)
7) In all tasks, emphasize the concept of lifelong learning and the importance of continuing competence
8) Communicate with the Minister of Health prior to filing QA related Bylaws
9) Communicate and educate to registrants (continuous)

10) Recommend ideas to the QA Committee then to the Board

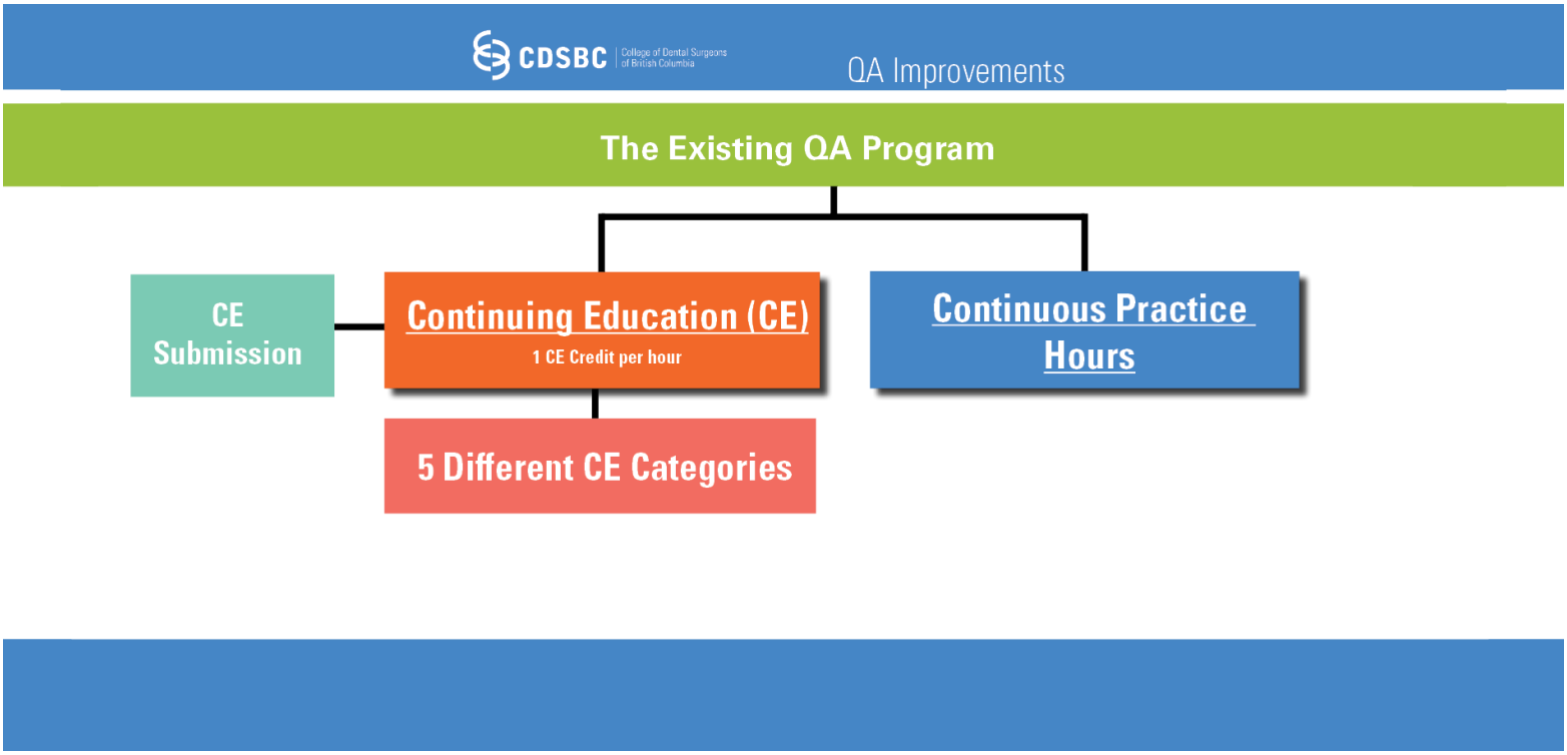
Meetings will occur every 4-6 weeks by Skype or in-person

Note: The Quality Assurance Committee will review the mandate and tasks assigned to this working group annually.

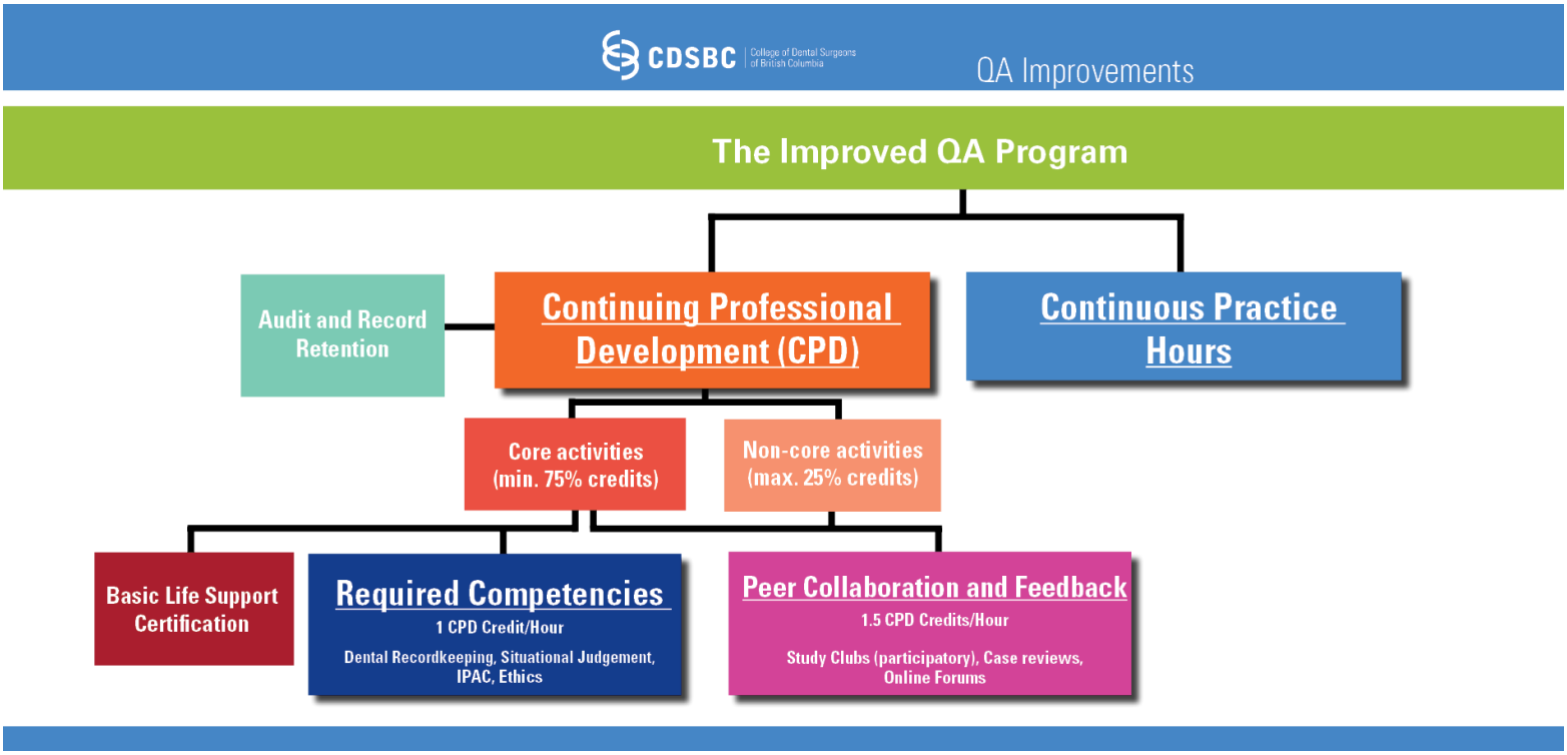
Appendix D

The QA Program: Before and After

Existing



Improved



CDSBC College of Dental Surgeons of British Columbia

Appendix E

IMPROVED QUALITY ASSURANCE PROGRAM
LOGIC MODEL

ACTIVITIES

REGISTRANTS
- complete and report on required QA activities per 3 year cycle:
  - CPD - obtain required credits
  - Required Competencies - complete a minimum of 2 of 4 required activities
  - Objective Feedback - complete one option
  - Continuous Practice Hours - obtain required number of hours

CDSBC
- establish QA requirements
- create a personal dashboard for registrants to monitor their progress
- conduct random audits of registrant submissions
- promote QA program to registrants and the general public

OUTPUTS

REGISTRANTS
- % of registrants engaged in QA activities by type
- % registrants choosing new and/or participatory learning options
- % of registrants indicating satisfaction with the new QA Program
-

CDSBC
- % of registrants completing requirements within 3 year deadline
- rates of registrant progress at years 1 and 2
- % of registrants who exceed the minimum requirements
- % of registrants checking their personal dashboard and frequency
- % of submissions audited
- % of submissions found to be accurate

OUTCOMES

SHORT-TERM

REGISTRANTS
- Improved and more current clinical knowledge and skills
- More registrants stay current in common complaint areas (record keeping, ethics, IPAC, communication and problem-solving)
- More registrants engaged in participatory learning and purposeful interactions with peers
- Greater sharing, learning, and objective feedback between peers
- Increased critical thinking

CDSBC
- Increased registrant awareness and participation in new QA program

INTERMEDIATE

REGISTRANTS
- More sustained learning and improvement among registrants
- More communication and collegial interaction among registrants
- All registrants have CPR training
- Decrease in common complaint areas

CDSBC
- More staff time spent on supporting registrants vs. supervising or policing
- Increased registrant trust in the QA program
- Increased registrant understanding of the CDSBC
- Increased recognition from the Ministry of Health and other regulators
- Increased public awareness of new QA program

LONG-TERM

CDSBC
- Increased public safety
- Increased public trust
- Improved health outcomes for public

Version 2019-04-19

Appendix F

Themes on Feedback Heard from Registrants

Feedback about evidence

What were the criteria through which the current QA program was evaluated and determined to be inadequate?

Does CDSBC have data that correlates continuous practice hours/cycle with favorable patient outcomes? Does CDSBC have data that correlates 90 CE credits/cycle with favorable patient outcomes?

Which stakeholders were contacted and which ones weren't? What sort of research was done and what sources are cited to justify changes?

How are we measuring improved treatment outcomes for patients, where the baseline is today?

If the public has lost trust in our profession, it is the 5% of bad apples that make us look bad for everyone else. We will be generating huge expenses for training that is needed by the 5% that maybe minimally getting their credits. The College knows who these individuals are, as I am sure they are repeat offenders. Can you not focus on these individuals without dragging the passionate dentists in?

Feedback on Continuing Professional Development

On CPD

Changing continuing education to 'Continuing Professional Development' is unnecessary, as the new term does not encourage a greater ownership of one's professional development. 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.

Core versus Non-core

Practice management improvement can greatly help an office, the ability of an office provide patient care and treatment in a timely manner, and in a way that helps maintain personal dignity for the patient. There is a real argument for practice management as part of the core. For example, you get a newer grad that has bought their first office and has no idea of how to manage the staff or office protocols.

Practitioner wellness. Given the high rates of stress, burnout, and suicide, and the effects this has on patient care, staff, and families, Dentists should be encouraged to take courses for self-care and overall health.

Feedback on Required Competencies

Situational Judgement Exercise (SJE)

CDSBC should consider other sources for these exercises rather than enjoying a monopoly. I cannot imagine the amount of time, money, and effort that setting up SJE will require.

Not confident such an investment by the CDSBC will have the desired results in the behavior of BC dentists. If the CDSBC has evidenced-based research that proves this not to be the case then I respectfully request the opportunity to review such research.

CPR

Is ACLS enough, or does the dentist have to take a CPR course on top of ACLS?

Feedback on Peer Collaboration and Feedback

Participatory Learning

Participatory learning is generally agreed upon to be a good thing.

People may not be paying attention in courses, so active participatory learning is good. The study club experience has been beneficial to many, so they should receive more credits.

Study clubs should be further supposed, as it is an ideal vehicle for peer participation

Should be mixed dentist-CDA groups when it comes to participatory learning.

Instead of putting the onus on registrants to prove that their course is participatory, the college should screen the courses first to see if they're participatory or lecture-based

Objective feedback and Peer Collaboration

In-person peer collaboration and feedback may prove difficult for CDAs who already spending the little time they have with patients, and may be working part time.

While not possible to mandate participation, study group members meet on a regular basis, and tend to build familiarity and share more comfortably. Diversity of the dentist composition is more likely to be achieved.

Similar questions arise over forced participation in study clubs or hands on courses, and while these are beneficial to the individual, there is a limit to what we can force people to do. People who don't want to do something will find a way to do the absolute minimum to get the requirement, to get their rubber stamp. Can't force people to learn, to be interested, and to be keep up with things in this way.

With all due respect, as much as "objective feedback" is an appealing catchphrase, I haven't seen any concrete evidence that it is going to improve public safety and public trust in our profession in a cost-effective manner. I do mourn the erosion of public trust in our profession through the quarter century of my career as you do. However, I suspect it has more to do with our behaviours that demonstrate self-interest (lack of professionalism and collegiality) over the publics in these competitive business climates. Consumers are smart, and they know how to "go public". Let's hope the College spends its energy wisely.

Feedback on Peer Collaboration and Feedback (continued)

Dentist to Dentist Visits

Through which criteria will "peers" be vetted as competent evaluators?

Will peer-evaluators receive training and be standardized? Which statistics will be used to ensure standardized peer-evaluation? How will bias be controlled?

What happens in corporate offices? Are they inspecting themselves?

Will friends and colleagues even give adequate feedback for fear of offending?

If a visiting dentist finds a practice that falls below standards, or is illegal, they would be placed in a difficult ethical position of either reporting their colleague, confronting their colleague, or do nothing, knowing that poor patient care will continue.

A hosting dentist may be self-conscious of the above, and make efforts to conceal the true operation of parts of their practice.

Both of these factors lead to an "inspection" type of atmosphere which hurts instead of fostering collegiality.

Will dentists obtain practice information that will help their practice from a business idea that the original dentist has used to make their practice successful?

Dentists in rural communities may be hesitant to invite "the competition" into their office and showing them their operation techniques.

Wouldn't two dentists who are friends simply get together for a drink, then report that they have done their peer reviews in each other's offices?

Feedback on Continuous Practice Hours

Does CDSBC have data that correlates ≥ 900 continuous practice hours/cycle with favorable patient outcomes? As compared to < 900 hours and unfavorable patient outcomes?

I would propose a 50 hour/ year requirement to keep a volunteer license active.
Also, volunteer dentists with that status should be able to volunteer one or two full days a month in a NFP clinic and fulfill the Continuous Practice Requirement.

Feedback on Audit and Evaluation

Audit

In order to receive CE credit we must submit to the CDSBC for approval. Is the CDSBC not checking submissions? I do not understand the need for a double check due.

Currently, we are able to submit our courses online and be done with it. This is a good system.

Having a reporting system that reflects the lack of trust from the profession to the individual dentist is not a way to promote public trust.

If audits are to be done in a random way, how will you proceed in such a way that all members feel confident that this was done in a completely unbiased manner?

Evaluation

Will the new QA be evaluated by the same criteria that deemed the current QA inadequate?

How will the administrator be trained to oversee the acceptance or failure of QA?

Will there be records of how the complaints increase or decrease after implementation of the new QA?

Appendix G

Draft Improved Quality Assurance Program: Requirements per Registration Category

Registration Category	Continuing Professional Development	Continuous Practice Hours (CPH)	Required Competencies	Peer Collaboration and Feedback
Full Registration (General Dentist)	90 credits within 3-year cycle 75 % Core minimum	900 CP hours in the last three calendar years Teaching – maximum of 100/year didactic	Two of four per cycle	One of three required per cycle
Certified Specialist	90 credits within 3-year cycle 75 % Core minimum	900 CP hours in the last three calendar years Teaching – maximum of 100/year didactic	Two of four per cycle	One of three required per cycle
Restricted to Specialty	90 credits within 3-year cycle 75 % Core minimum	900 CP hours in the last three calendar years Teaching – maximum of 100/year didactic	Two of four per cycle	One of three required per cycle
Academic-Academic grandparent	90 credits within 3-year cycle 75 % Core minimum	900 CP hours in the last three calendar years Teaching – maximum of 100/year didactic	Two of four per cycle	One of three required per cycle
Limited (Education)	90 credits within 3-year cycle 75 % Core minimum	• 100 hours/year (equal to 300/cycle) • Can be all didactic teaching (theory of restricted activities)	Two of four per cycle	One of three required per cycle

Registration Category	Continuing Professional Development	Continuous Practice Hours (CPH)	Required Competencies	Peer Collaboration and Feedback
		• If they transfer from Full and plan to return to Full practice, they must maintain another 600 hours in clinical activity (may include teaching, pre-clinical teaching)		
Limited (Research)	90 credits within 3-year cycle 75 % Core minimum	50 CP hours per year Teaching – maximum of 100/year didactic To transfer back to full registration, they are required to meet the QA requirements and must be reviewed by registration/certification committees to determine eligibility to do so.	One per year required	One of three required **per year**
Limited (Volunteer)	90 credits within 3 year cycle 75 % Core minimum	50 CP hours per year To transfer back to full registration, they are required to meet the QA requirements and must be reviewed by registration/certification committees to determine eligibility to do so.	One per year required	One of three required **per year**
Limited (Armed Services or Government)	90 credits within 3 year cycle 75 % Core minimum	900 CP hours in the last three calendar years	Two of four per cycle	One of three required per cycle

Registration Category	Continuing Professional Development	Continuous Practice Hours (CPH)	Required Competencies	Peer Collaboration and Feedback
Limited (Post-graduate)	N/A	N/A	N/A	N/A
Limited (Student Practitioner)	N/A	N/A	N/A	N/A
Temporary	N/A	N/A	N/A	N/A
Non-practicing	N/A	N/A	N/A	N/A
Dental Therapist	75 credits	900 CP hours in the last three calendar years	Two of four per cycle	One of three required per cycle
Practicing CDA	36 credits 75 % Core minimum	600 CP hours in the last three calendar years	Two of four per cycle	One of three required per cycle
Temporary CDA	N/A	N/A	N/A	N/A
Limited CDA	N/A	N/A	N/A	N/A
Non-practicing CDA	N/A	N/A	N/A	N/A

Appendix H

1. Continuing Professional Development

Registrants will acquire credits in three-year cycles with each new cycle starting 1 January of the calendar year following the year of registration or certification with CDSBC.

CPD credits: 1 credit/hour[1]

Dentists – 90 credits
CDAs – 36 credits
Dental therapists – 75 credits

Rationale: *The current system works well.*

Participatory learning -1.5 credits/hour[1]

Registrants will receive "enhanced" credits for CPD activities that are a type of participatory learning. These could include those that involve hands-on learning, and peer collaboration and feedback activities.

Rationale: *This will encourage more participatory learning and purposeful interactions with peers. Increase in credits provides incentive to engage with colleagues.*

Core and non-core activities

Core Activities (minimum 75%)			
Class	Dentists	Dental therapists	CDAs
CPD Credits	68	57	27
Activities The topics in this category include courses that relate to the provision of patient care; base competencies; and teaching[2] or mentoring.	**Study clubs**: Lectures - 1 credit/hour; Hands-on sessions 1.5 credits/hour		
	Teaching, mentoring or presenting: maximum of 2/3 per cycle[2] ► Theory - 1 credit/hour ► Clinical supervision - 1 credit/3 hours		
	First aid (max. 24 credits), **BLS**[3] (max. 12 credits), **ACLS** (max. 12 credits), **management of dental emergencies**[4]		
	CDA Modules (incl. sedation courses): maximum of 24 credits per module		
	Publication authorship: into an independent forum with peer review- maximum 15 credits per publication		
	Advanced study: studies related to dentistry post-grad, dental hygiene		

Rationale: *Core activities are clinically relevant and increase patient safety.*

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1 Needs a bylaw change to define credit hours.
2 If a registrant collects 2/3 of their CDP from teaching, they must get the rest of their requirement from the core category.
3 Registrants will be required to maintain a valid BLS certificate.
4 ***Rationale:*** *Best practice*

CPD, continued

Non-core Activities (maximum 25%)			
Class	Dentists	Dental therapists	CDAs
CPD Credits	22	18	9
Activities	Practitioner wellness		
	Dental care administration (Relates directly to the operation and management of a dental practice-required to be within CDSBC's standards guidance and ethics): 15 hours maximum per cycle.		
	Participation in organized dentistry (service on boards, committees, working groups): 15 hours/cycle maximum*		
	Attendance at a conference/convention: 1 credit/hour to a maximum of five hours per conference		

**Rationale:* *Promotes and facilitates engagement. Advances the profession as well as professionalism.*

2. Required Competencies

Every CPD cycle, registrants will be required to complete two of the four required competency activities. They are eligible for CPD credits.

1. **Dental Recordkeeping**
2. **Infection Prevention and Control**
3. **Ethics**
4. **Situational Judgment Exercise (SJE)**

Rationale: *The required competencies will keep registrants current in these subject areas.*

3. Peer Collaboration and Feedback

Registrants will be required to participate at least one PCF per CPD cycle and one is needed to meet the participatory requirement. These activities will count for 1.5 CPD credits per hour.

The purpose of this component of the QA program is for registrants to learn from and collaborate with their peers. This is 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.

Ways to meet this requirement include:

Case Reviews

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 in evolving 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 centers around 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.

A template would guide the format of the presentation and supporting documentation, and explain the requirements for the reporting for QA credit.

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).

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.

A template would guide the format of the presentation and supporting documentation, and explain the requirements for the reporting for QA credit.

PCF, continued

Ways to meet the requirement, continued:

Online Forum

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.

A template would guide the format of the posting and supporting documentation and explain the requirements for the reporting for QA credit.

Rationale: *Feedback and engagement are known to provide deeper learning and more sustained improvement. This requirement could assist in building support networks, reduce isolation, and increase communication within the profession.*

4. Continuous Practice Hours

Dentists, dental therapists and CDAs must achieve the following minimum number of practice hours in the preceding three years in order to renew their registration/certification.

Dentists and dental therapists – 900 hours
CDAs – 600 hours

Continuous practice hours are defined as hours spent performing restricted activities as defined in the registrant's scope of practice.

- Clinical teaching of a restricted activity CP Hours recognized
- Didactic teaching-100 hour/year CPH teaching (theory of restricted activity) equals 300 hours/cycle for dentists, for CDAs 68 hours per year 200 hour per cycle for CDAs
- This maximum of 100/68 year of didactic portion of teaching will be carried throughout all other registration categories. (Specialty)

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

Continuous practice hours requirement for Limited Categories:

Limited education and limited volunteer categories do not currently have CPH requirements. The following requirements are being considered for these categories:

- Limited Education - 100 CP hours per year
  - Can be all didactic teaching of a restricted activity.
  - To transfer to FP, they must maintain another 600 in clinical activity. It may include teaching and preclinical teaching.
- Limited Research - 50 CP hours per year
  - To transfer to FP. they must meet the QA requirements and then eligibility to be approved by the Registration committee.
- Limited Volunteer - 50 CP hours per year in BC
  - To transfer to FP must meet the QA requirements and then eligibility to be approved by the Registration committee.

Rationale: *Continual practice helps supports currency of knowledge and skills.*

Record Retention and Audit

Registrants will be required to keep all documentation from all the CPD activities they participate in.

When a registrant submits a course to their transcript, the system will indicate the submission has been accepted. Daily/weekly, the system will pull a random list of individual CE submissions to be audited. Registrants who are selected will be flagged and that submission reviewed. Staff may request supporting documentation or additional information to determine eligibly. If the submission is determined to be not eligible for credits, the registrant will be notified and will be required attend another CE session to in order to meet their CPD requirement to renew their registration.

Rationale: *Audits will increase accountability and will give CDSBC a better understanding of the types of activities being submitted. Assists with evaluation of the program. Reduces administrative work.*

Dashboard

A dashboard will be displayed in each registrant's online account which will graphically demonstrate where that registrant is in their completion of their CPD requirements as well as the range of topics they have focused their activities on in comparison to their colleagues (other registrants).