



QUALITY ASSURANCE PROGRAM



**Developing the Continuing Competence Program for
the College of Occupational Therapists of British Columbia:**

From Ideas to Design

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Note to Reader

Words followed by a ^g are defined in the appendix.

1.0 Executive Summary

Having developed a Continuing Competence Program Framework in 2008, the College of Occupational Therapists of British Columbia (COTBC) is now moving forward from the ideas phase to the design phase. As with other aspects of the program, the Continuing Competence Committee (CCC) was charged with this responsibility by the COTBC Board. The COTBC Continuing Competence Program is an example of a quality assurance program which will be mandated under s. 16(2)(e) of the British Columbia *Health Professions Act*, RSBC 1996, c. 183 once the amendment to that provision enacted in 2008 (to include a requirement for a quality assurance program) is proclaimed in force.

The continuing competence program (CCP) needs to meet the expectations of multiple stakeholders, including the following four groups:

1. The public. To ensure public protection, the CCP needs to meet the public's expectations of rigour and attention to patient safety.
2. The COTBC Board. The CCP needs to look as if it monitors and enforces the continued safe, ethical, and effective practice of occupational therapists.
3. Employers. The CCP must be reasonable and consistent with important work activities.
4. Occupational therapists. The CCP needs to look like a viable approach to assessing—in a reasonably cost-efficient and feasible manner—day-to-day practice in a variety of contexts.⁶

The description of the CCP Framework comprises the authority and mandate; purpose, objective, and standard; guiding principles; and program elements.

The purpose of the chosen assessment⁶ tool is to provide evidence of the continued competence⁶ of registered occupational therapists. While an exhaustive range of tools for assessment was explored, a smaller subset was deemed the best match to the CCP's purpose, objective, standard, and guiding principles.

When selecting and developing a specific assessment tool, key measurement principles must be considered. Any tool designed to assess competence must have

- a systematic process (systematic administration and scoring, and knowledgeable developers and administrators);
- explicit criteria for what is being assessed, including a scoring rubric; and
- an explicit description of what is considered good enough (a passing score) and next steps for those candidates who are unsuccessful.

Assessments using multisource feedback (MSF) and a key features approach were explored in detail by the CCC to see if one was a better match for COTBC when looking at the following: face validity for the four stakeholder groups described above, the jurisprudence¹ content, and the college practice standards based on the *Essential Competencies of Practice for Occupational Therapists in Canada*.

In consideration of these three factors, the CCC unanimously recommends the use of a *case-based written examination with a key features approach* for the COTBC Competence Assessment Tool.

¹ Here *jurisprudence* refers to the knowledge and skills related to regulations and legislation. The term *regulatory topics* is used interchangeably with jurisprudence.

The draft blueprint for the CCP comprises three dimensions:

- Key regulatory topics to be assessed,
- Priority essential competencies to be assessed, and
- Core contexts of occupational therapy practice.

Further consultations about the dimensions—including the models for the context dimension and validation with registrants—will be completed before the blueprint is considered for approval by the Board.

Key next steps include the following:

- COTBC Board consideration of the CCC's recommendation to use a case-based written examination with a key features approach for the COTBC Competence Assessment Tool;
- Consultation and validation of the draft blueprint with registrants; and
- Development of a detailed implementation plan that outlines delivery options (e.g., computer based or paper based), timelines, and resource needs (e.g. staff, committees, infrastructure).

2.0 Project Background

The COTBC developed a CCP Framework in 2008 and now is moving this framework from the ideas phase to the design phase. The description of the framework includes the authority and mandate; purpose, objective, and standard; guiding principles; and program elements (see Section 3.0).

The CCP's transition from ideas to design involved the following objectives:

- To build on the implementation of the Competence Maintenance elements;
- To identify available Competence Assessment⁶ tools that reflect the approved framework and current best practices;
- To consider the implications, possible role, and impact of a case-based written examination with a key features approach;
- To consider the implications, possible role, and impact of the College of Occupational Therapists of Ontario's (COTO's) Multi-Source Feedback Tool;
- To select preferred assessment tool(s) for the program; and
- To develop the next steps for implementation of these tool(s).

2.1 Quality Assurance

Quality assurance is an important aspect of the COTBC's mandate because 3 of the 12 objects in Section 16 of the *Health Professions Act* amended in 2008² relate to monitoring of practice to ensure that standards and quality services are met. These objects include the following:

- to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants [16(2)d];
- to establish and maintain a quality assurance program to promote high practice standards amongst registrants [16(2)e]; and
- to establish, monitor and enforce standards of professional ethics amongst registrants [16(2)g].³

In the COTBC Bylaws, continuing competence falls under the Quality Assurance Committee, which "is responsible for making recommendations to the Board with respect to:

- (a) continuing competency requirements,
- (b) re-entry to the profession,
- (c) standards of practice,
- (d) professional ethics and
- (e) clinical practice guidelines."⁴

² Not yet proclaimed in force

³ Government of British Columbia, 2008

⁴ College of Occupational Therapists of British Columbia, 2001, Section 18(2), p. 9

3.0 The COTBC Continuing Competence Program Framework

This section describes the approved framework for the COTBC Continuing Competence Program. The description of the framework comprises the authority and mandate; purpose, objective, and standard; guiding principles; and program elements. Section 4.0 provides a description of the assessment tools.

3.1 Authority and Mandate

Protection of the public is a key objective of the COTBC, and programs that ensure the competence of occupational therapists and the quality of their services are one of the COTBC's core responsibilities as the regulatory body for occupational therapists. The COTBC Continuing Competence Program is an example of a quality assurance program which will be mandated under s. 16(2)(e) of the British Columbia *Health Professions Act*, RSBC 1996, c. 183 once the amendment to that provision enacted in 2008 (to include a requirement for a quality assurance program) is proclaimed in force.

3.2 Purpose, Objective, and Standard

Purpose

The most-often-noted purpose or goal of CCPs is “to ensure [that] health care is delivered in a consistent manner of high quality across all members of a professional group.”⁵

The purpose of this CCP is to support, monitor, and enforce the continued safe, ethical, and effective practice of occupational therapists in British Columbia.

Objective

COTBC will develop, implement, and maintain a recognized CCP that supports, monitors, and enforces the safe, ethical, and effective practice of occupational therapists in British Columbia.

Standard

The development and implementation of the CCP is based on the document *Essential Competencies of Practice for Occupational Therapists in Canada* (2nd Ed., ACOTRO, 2003). The program will focus on verifying that individual registrants demonstrate the essential competencies.

⁵ Bilawka & Craig, 2003, p. 161

3.3 Guiding Principles

These principles guide the development and implementation of the CCP.

1. *Public protection is the bottom line.*
 - When components of occupational therapy practice are identified as posing a high risk to the public, the CCP will focus attention and resources on these areas.
 - If any categories of practitioners are identified to be at a higher risk for competence gaps compared with the whole profession, the program will focus attention and resources on these practitioner categories.
2. *Maintaining and enhancing competence is the responsibility of the registrant.* The CCP will be designed to support registrants in understanding, applying, and demonstrating the essential competencies. The tools selected will help registrants identify ways in which they can demonstrate competence. The program will not be punitive and will provide feedback. This feedback will validate practice or provide guidance for improvement. When necessary, an appropriate amount of structure to support enhancement of practice will be provided.
3. *Competence is dynamic.* The program will require registrants to demonstrate that they understand and integrate the essential competencies into their practice using systematic reasoning and processes. It will focus on patterns of practice and decision-making rather than on a single clinical decision.
4. *Competence requirements apply to all registrants.* All occupational therapists registered in practising categories will be required to participate in the CCP.
5. *Competence varies with diversity in approaches to practice and in practice settings.* There's more than one right way to do things. It will be the individual registrant's responsibility to understand and apply the essential competencies and to demonstrate that he or she does so within his or her practice. The CCP, while based on common processes and tools, will have sufficient flexibility to accommodate a wide range of practice settings.
6. *The program design will reflect quality, balance, fiscal responsibility, and fairness.*
 - **Quality:** The program will be based on best practices in the field of CCPs. Validity and reliability of methods and tools will be considered. Since this is a developing field of knowledge, the program will be based on the best available information, and it will be evaluated and improved over time.
 - **Balance:** The program will balance the feasibility of registrant participation with the college's obligation to administer a CCP.
 - **Fiscal responsibility:** The program will balance the demands for public protection against the costs associated with implementing the best practice given the resources available.
 - **Fairness:** Competence Assessment and decision-making processes will be clearly defined and transparent. Registrants will be given reasonable opportunity to provide information before decisions related to their competence are made.

3.4 Program Elements

The program comprises three elements:

1. Competence Maintenance	2. Competence Assessment	3. Competence Improvement
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See Section 3.5 for a summary of these elements.

3.4.1 Competence Maintenance

This element, implemented in 2006, has three components:

1. Self-assessment tool,
2. Professional development plan, and
3. Continuing Competence Declaration form.

The self-assessment tool is a biennial self-administered report on the inventory of essential competencies: the knowledge, skills, and attitudes as found in the *Essential Competencies of Practice for Occupational Therapists in Canada*. This document is the approved standard for registered occupational therapists in British Columbia. With the inventory of competencies completed, the occupational therapist develops and annually updates his or her goals for professional development. Annually, the registrant submits a Continuing Competence Declaration form to certify that he or she has completed the self-assessment within the past two years and established and implemented an annual professional development plan.

3.4.2 Competence Assessment

The second element of the CCP is a regular, objective assessment of the occupational therapist's competence. The competence review and assessment includes a practice-based professional assessment.

The latter will be a structured, objective assessment. One sample of this that was explored is a key features approach which uses an assessment format based on occupational therapists' cases. Key features questions use a style of written assessment which focuses on the important aspects (key features) of safe, effective practice in a given scenario. The cases could be a combination of two scenario types: occupational-therapy-practice driven (practice context) and COTBC driven (strategic content choices). Strategic content choices refer to issues which are risk factors for competence problems, complaints, and ethical challenges. These issues include the following: client records, workload, professional autonomy, use of support personnel, understanding of standards, minimal practice requirements, professional autonomy, prioritization of client needs, documentation, information management, consent, duty to care, and conflict resolution.

3.4.3 Competence Improvement

Competence Improvement, the third element of the program, applies to those registrants who are not successful in demonstrating competence in the assessment element. While most registrants will successfully complete the Competence Assessment, the experience of similar programs suggests that from 5 to 15% of registrants will not be successful on their first attempt. If unsuccessful, registrants will have one opportunity to redo the Competence Assessment. If still unsuccessful,⁶ registrants will participate in the Competence Improvement element. Data from similar programs suggest that from 1 to 3% of all registrants will not be successful when they redo the Competence Assessment element.

The Competence Improvement element will have an occupational therapist experienced and trained in Competence Assessment and practice standards work with the registrant in the development of a customized competence improvement plan. The customized improvement plan will be based on a variety of information such as detailed analysis of exam results, one-on-one consultation, on-site visits, chart-stimulated recall, and professional development plans. The implementation and successful completion of the customized improvement plan will be overseen by the Registration Committee. The plan could include strategies such as targeted continuing education courses, mentorship plans, supervision plans, regular reporting, and follow-up on-site visits. The experience will involve education and mentoring, with the goal of assisting the registrant in improving his or her level of competence.

3.5 Summary Chart of Continuing Competence Program Processes and Tools

Features	Element		
	1. Competence Maintenance	2. Competence Assessment	3. Competence Improvement
Aim	Tell	Show	Help
Role of assessment	<ul style="list-style-type: none"> Support OT's self-regulation and OT's competence 	<ul style="list-style-type: none"> Support and monitor OT's competence Perform regular, objective assessment of OT's competence 	<ul style="list-style-type: none"> Where needed, improve OT's competence
Main accountability	Practitioner	Shared	Shared

⁶ If the registrant is close to the passing score on the second attempt, he or she may have an opportunity to do the exam a third time. Usually after two tries, the registrant will move to improvement activities.

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Features	Element		
	1. Competence Maintenance	2. Competence Assessment	3. Competency Improvement
Participant selection	All registrants	<ul style="list-style-type: none"> All registrants⁷ Reassess unsuccessful registrants (rough estimates indicate that 5–15% of registrants⁸ will retake the Competence Assessment) 	<ul style="list-style-type: none"> Rough estimates indicate that 1–2% of registrants will require Competence Improvement
Assessment tools	<ol style="list-style-type: none"> Self-assessment tool, Professional development plan, and Annual Continuing Competence Declaration form 	<p>Practice-based professional assessment. Content of assessment is</p> <ul style="list-style-type: none"> case based, occupational therapy driven (practice context), and college driven (relevant, strategic⁹). <p>Assessment approach will be case-based using key features and will include a written test using a variety of questions such as short answer, multiple choice, matching, and true–false.</p>	Customized competence improvement plan based on detailed analysis of assessment (exam) results, one-on-one consultation, on-site visits, chart-stimulated recall, and professional development plans
Frequency	<ul style="list-style-type: none"> Ongoing self-regulation Currently includes <ul style="list-style-type: none"> biennial self-assessment professional development plan annual declaration form 	<p><i>For example:</i></p> <ul style="list-style-type: none"> Once every 6 years for each registrant May assess half of the registrants every 3 years Can select earlier time frame 	<p><i>For example:</i></p> <ul style="list-style-type: none"> Targeted for registrants who were unable to fully demonstrate in the Competence Assessment that they meet practice standards As needed, customized focused approach for registrants identified in Competence Assessment
Implementation target	Currently in place	<p><i>For example:</i></p> <ul style="list-style-type: none"> Registrants informed: 2013 Registrants take exam: 2014 	2014

⁷ Modification of requirements for those that have *no* client care to be determined

⁸ These rough estimates are based on available information from established continuing competency assessment programs such as those for pharmacists in British Columbia and occupational therapists in Ontario.

⁹ Strategic topics are chosen from areas of practice which are risk factors for competence issues, complaints, and ethical challenges. The topics include client records, workload, professional autonomy, use of support personnel, the understanding of standards, minimal practice requirements, professional autonomy, prioritization of client needs, documentation, information management, consent, duty to care, and conflict resolution.

4.0 Assessment Tools

The purpose of the assessment tools is to provide evidence of competence. While an exhaustive range of tools for assessment was explored, a smaller subset was deemed the best match to the CCP's purpose, objective, standard, and guiding principles.

This section describes the principles of assessment and the smaller subset, and offers a brief commentary on the rationale for the subset's inclusion in the CCP.

4.1 Principles and Criteria for the Common Approach to Assessment

When developing an assessment system for occupational therapists, certain general principles and criteria need to be considered. The system should

- have transparent and clear assessment processes;
- be developed with the collaboration of all stakeholders;
- be flexible enough to address variations in jurisdictions and individual occupational therapists;
- be fairly and equitably implemented for all applicants;
- respect due process;
- use known standards (based on the required competencies and experience for safe and effective occupational therapy practice);
- be timely (have reasonable time frames);
- be as affordable as feasible;
- be economically sustainable;
- be acceptable in each jurisdiction, for the purpose of mobility; and
- be regularly updated to reflect improvements to assessments and changing practice standards.¹⁰

Each major revision or development of the common approach should include revisiting the above list to determine how the revision is measuring up.

4.2 Key Measurement Principles

When selecting and developing a specific assessment tool, several key measurement principles need to be considered. They are outlined below.

Face Validity

Face validity is a characteristic that describes how closely the tasks or actions required of the person being assessed match the actual competencies the tool is designed to assess. Tests of knowledge should appear on their "face" to be assessing knowledge, and tests of practice skills should appear to be assessing practice skills.

¹⁰ Glover Takahashi, Millette, & Eftekari, 2003

Reliability

Reliability means that the tools used in the continuing competence assessments can give reproducible results. In other words, the same conclusion would be drawn in different but parallel assessment conditions (e.g., different raters, different cases or items, different occasion of assessment).

Validity

Validity is a measurement concept related to the accuracy of the assessment inferences. For the purposes of the continuing competence assessment, validity means that those individuals who pass the assessments are in fact competent⁶ (i.e., capable of delivering safe, effective occupational therapy services in the context of the receiving jurisdiction). Additionally, it means that the tools used in the assessments can identify those occupational therapists not competent for practice in their jurisdiction.

Feasibility

This refers to the reasonableness of implementation given the resources (human, financial, infrastructural) to achieve the desired processes or outcomes.

Sustainability

It is important for a CCP to invest in its future. This can be done by ongoing research and periodic reviews of competencies and testing procedures. Professions and measurement practices change over time, and a licensure program must ensure that it remains current.

4.3 Overview of Tools

This section provides a brief overview of some tools used to assess the competence of occupational therapists, building upon information from several sources both within and outside occupational therapy. While a broad range of tools for assessment was seriously explored, a smaller subset was deemed to tie closely into the CCP's purpose, objective, standard, and guiding principles.

4.3.1 Tools Not Included

The current consensus is that the Objective Structured Clinical Examination and other standardized client-based assessment methodology will not be included due to the high costs of such assessments.

Another tool that is not included is continuing education credits. The literature suggests that although education is an important factor in attaining competence, its role in assuring continuing competence is uncertain, as mere attendance or participation assures neither learning nor learning in the areas of need.¹¹

¹¹ Health Regulatory Organizations of British Columbia, 2005; Hays et al., 2002; Barnhill, 2001

4.3.2 Competency-Based Assessment Tools

Competency-based assessment⁶ involves any approach to evaluation or assessment that measures what clinicians can do in controlled representations of professional practice.

Any tool used to assess competence must have

- a systematic process (systematic administration and scoring, and knowledgeable developers and administrators);
- well-developed, explicit criteria for what is being assessed, including a scoring rubric; and
- an explicit description about what is good enough (a passing score) and next steps for those candidates who are unsuccessful.

Written Examinations of Application of Clinical Knowledge

There are many types of written examination formats (e.g., multiple choice, short answer, long answer). Written examination formats can be oriented towards recall of factual knowledge, or they can assess clinical reasoning skills in a case-based situation.

The examination delivery mechanisms can be paper and pencil or computer. Written simulations (paper or computer based) fall here under the category of written examinations.

The more open ended the examination response format (e.g., essay), the more discriminating the test can be about the person's ability, but more time and effort are required to score the examination. The more closed ended the examination response format (e.g., true–false, multiple choice), the less discriminating the test can be about the person's ability, but less time and effort are required to score the examination.

Portfolio Assessments

Portfolios provide a flexible, multifaceted means of collecting evidence. Depending on the competencies being assessed and criteria for assessment, the evidence gathered by the registrant will differ. A portfolio might be the label applied to a number of documents and a variety of information that the occupational therapy regulator may ask the occupational therapist to gather. A logbook of clinical activities, a resumé, and documentation of professional development activities are examples of evidence that might be gathered for a portfolio. This portfolio may have some utility in the continuing competence assessment of occupational therapists.

Portfolios are excellent for providing formative assessment and facilitating dialogue with the occupational therapist but are onerous to score and difficult to use for summative assessment purposes. As with other open-ended written assessments that do not have one right answer, standard criteria and scoring systems are needed for a portfolio to be used for assessment of continuing competence.

Practice-Based Interview

During a structured interview, interviewees are required to describe practice experiences where they demonstrated specific competencies. This approach can be useful for clarifying or verifying competencies in areas such as attitudes, ethics, general approach towards clients, and decision-making and problem-solving

skills. A skilled interviewer, standard criteria, and scoring systems are needed to use this tool for assessment of continuing competence.

4.3.3 Performance-Based Assessment Tools

Performance-based assessment⁶ involves any approach to evaluation or assessment that measures what clinicians actually do in real-life professional practice. By virtue of being situated in actual clinical practice, performance-based tools demonstrate higher face validity than the tools described in the previous section. A limitation of the former is that they are less standardized than a controlled environment such as an Objective Structured Clinical Examination. Performance-based assessments are best used as part of a group of assessments. They require specific attention to criteria and scoring systems to control such potential differences as setting variation (e.g., acute management within a mental health setting, school-based prevention work with children) and the increased subjectivity of the raters when the test taker is assessed in the milieu in which he or she works.

Direct Observation of Practice

This refers to the ongoing observation, assessment, and documentation of actions taken by registrants in real clinical settings during their training period. The critical factor that distinguishes direct observation from other forms of assessment is that the occupational therapist is observed performing authentic actions that occur naturally as part of daily clinical experience.¹²

Assessment forms are completed by supervisors or observers at a prescribed frequency. Ideally, the assessment involves specific performance criteria, expectations for performance, and rater training. The clinical setting determines the extent of what can be demonstrated. Because clinical settings vary, it may be necessary to develop a menu of types of situations, clients, and interventions that need to be assessed. Preexisting tools, such as the Competency Based Fieldwork Evaluation for Occupational Therapists,¹³ would need to be carefully studied to establish their appropriateness for practising occupational therapists, as opposed to the students and entry-level occupational therapists for whom the Fieldwork Evaluation was developed.

Peer Assessment of Practice

Peer assessment on its own, or as part of a 360-degree or MSF assessment system, assesses what is done in the actual clinical setting, and therefore face validity is high. Feedback is typically provided through a questionnaire-based tool that is designed to assess clinical behaviours.

MSF can include input from people who do not normally have an organizational responsibility for providing feedback. These could include clients, colleagues, other professional groups, and administrative staff, who may have a different perspective on the occupational therapist's actual day-to-day performance. The number of required sources of feedback varies.

¹² Bandiera, Sherbino, & Frank, 2006

¹³ Bossers, Miller, Polatajko, & Hartley, 2007

Explicitly incorporating the input of peers into the assessment of occupational therapists may have the added benefit of additional opinions (raters) of performance, thereby decreasing bias associated with single-rater approaches.

One challenge to MSF is that the competencies assessed are limited to such areas as communication skills, interpersonal skills, collegiality, and professionalism. Hence, MSF appears to fall short in the assurances on the range of competencies expected by the public or the COTBC Board (e.g., regulatory topics, clinical reasoning, occupational processes). Additionally, the noted administrative challenges to implementing and maintaining an MSF system for a large number of people are considerable (i.e., distributing, tracking, collecting, and collating multiple documents for several registrants in a single workplace).

Chart Audit

This entails reviewing a sample of a registrant's charts (i.e., notes on client interactions) to glean information about competence. The tool can either be a checklist with standardized criteria, or global ratings of the therapist's competence on a number of predefined domains as assessed by the rater.

Chart-Stimulated Recall

This tool uses actual client charts as the basis for discussion of clinical reasoning and client management approaches. Chart-stimulated recall permits the emergence of client, environmental, system, and other factors that can influence clinical decisions. Whereas chart audits assess what clinicians wrote, chart-stimulated recall allows further probing, thereby perhaps decreasing the possibility that omissions in charting penalize the candidate. Rater differences can be tempered through the use of standardized scoring rubrics or multiple raters.

Practice Review

This is an intensive, often practice-based, review of all aspects of a registrant's practice. Tools incorporated into the review may include some combination of practice interview and review of learning portfolio, work samples, recent cases, or decisions made.

Practice review is comprehensive for both the reviewer and the person being reviewed. It is a lengthy, labour-intensive process used most often for those who have been flagged through screening assessments or for disciplinary cases. Rater agreement and reproducibility of assessment findings require standardized approaches, and scoring and performance assessment criteria.

4.4 Summary

There is no perfect assessment tool, which is why a variety of tools are often used in assessment programs. Many tools can be used to assess a number of different aspects of competence (competencies, context, capability⁶) as long as the tools are specifically developed with a stated purpose and validated for that purpose.

To understand the utility of a given tool or measure, the following questions need to be asked:

- What is the construct being measured?

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- What are the criteria by which to measure it?
- What is the process to ensure that the criteria are applied in a standardized fashion?
- How are the measurement principles and criteria being monitored (reviewed and revised) on a regular basis in order to ensure that they are consistently being met?

5.0 Choosing a Competence Assessment Tool

While there is no perfect assessment tool, the CCC recommends the use of a case-based written examination with a key features approach for the COTBC Competence Assessment Tool.

This unanimous recommendation follows extensive consideration of two different assessment tools: (a) the case-based key features approach and (b) MSF assessments. The recommendation is based on the greater consistency of the case-based written examination with the CCP guiding principles. (See Section 3.3).

5.1 First Things First

The approved CCP guiding principles were consulted during the process of selecting a competence assessment tool. More specifically, it was agreed that the competence assessment tool needs to meet the “common sense, first blush impressions” of or demonstrate face validity to the following four stakeholder groups:

1. The public. The tool must look like it ensures public protection.
2. The COTBC Board. The tool must look like it monitors and enforces the continued safe, ethical, and effective practice of occupational therapists.
3. Employers. The tool must appear reasonable and appropriate.
4. Occupational therapists. The tool must look like a viable approach to assess—in a reasonably cost-efficient and feasible manner—day-to-day practice in a variety of contexts.

In addition, the CCC looked closely at the framework previously developed to establish which of the two assessment tools would be more effective at assessing and monitoring the key jurisprudence content (e.g., boundaries, consent, client records, understanding of standards) and the key essential competencies for ensuring the continued competence of occupational therapists in British Columbia.¹⁴

5.2 Multisource Feedback

In programs that use MSF, such as the College of Occupational Therapists of Ontario,^{15,16} the registrant selects clients and coworkers to complete structured surveys, in addition to completing a self-assessment survey. Each registrant is expected to submit at least 12 client surveys, 10 coworker surveys, and the self-assessment survey. COTO indicates that it has a goal of having each occupational therapist participate in the competency review and assessment approximately once every five years, but the organization may require participation at any time.¹⁷

COTO’s 2007–2008 annual report indicates that 246 registrants (approx. 5.6% of 4369 registrants with a general certificate) completed the MSR, with 18 registrants (7.3% of the subgroup or 0.4% of all registrants)

¹⁴ Association of Canadian Occupational Therapy Regulatory Organizations, 2003

¹⁵ College of Occupational Therapists of Ontario, 2008a

¹⁶ College of Occupational Therapists of Ontario, 2008b

¹⁷ College of Occupational Therapists of Ontario, 2008a

subsequently involved in the peer review process.¹⁸ COTO expended considerable resources to complete the assessment of this 0.4% of registrants. This suggests that the assessment of 100% of COTBC registrants within a five-year window—assuming the tools were able to assess all the features of interest—would make such a system administratively onerous and possibly cost prohibitive.

In other systems that use MSF, such as the Alberta physician system,^{19,20} more surveys are required for acceptable performance assessment statistics (i.e., generalizability coefficient). Those systems require assessment by a minimum of 8 peer colleagues (medical colleagues), 8 coworkers, and 25 patients, as well as the registrant's self-assessment. This illustrates the volume of data required to collect meaningful and reliable information, underscoring the administrative burden in a system that captures only a portion of the information of interest.

5.3 Case-Based Written Examinations With a Key Features Approach

The key features approach to assessment of clinical decision-making was initially developed and described by Page and Bordage.²¹

Key features problems have face validity in that they assess the application of knowledge, in other words what clinicians do in real life. Additionally, the key features format assesses bottom-up thinking, from undifferentiated presentation to diagnosis and management. This approach appears more in keeping with what clinicians actually do in practice, and it is based on literature in cognitive psychology that seeks to understand clinical reasoning or problem-solving skills.²² The key features approach encourages assessment of the most important or critical elements of a scenario that must be considered in the process of decision-making in order to achieve the best solution. This leads to better sampling of cases and decreases content and context specificity, which in turn leads to increased inter-item reliability (i.e., internal consistency). Key features assessments have been shown to be better at identifying weaker candidates than are traditional written-item formats.

5.4 Coming to a Decision

In consideration of the face validity (for the public, the COTBC Board, employers, and registrants), the key jurisprudence content, and essential competencies for ensuring the continued competence of occupational therapists in British Columbia, the CCC unanimously recommends the use of a case-based written examination with a key features approach for the COTBC Competence Assessment Tool.

¹⁸ College of Occupational Therapists of Ontario, 2008b

¹⁹ Lockyer et al., 2006

²⁰ Violato, Lockyer, & Fidler, 2008

²¹ Page & Bordage, 1995

²² McIlroy & Glover Takahashi, 2009

6.0 Implications and Next Steps

With the selection of a recommended competence assessment tool comes the planning for implementation.

Key next steps include

- COTBC Board consideration of the CCC's recommendation to use a key features test for the competence assessment tool;
- consultation and validation of the draft blueprint with a sample of registrants; and
- completion of a detailed implementation plan that outlines delivery options (e.g., computer or paper based), timelines, and resource needs (e.g., staff, committees, infrastructure).

7.0 References

- Association of Occupational Therapy Regulatory Organizations. (2003). *Essential competencies of practice for occupational therapists in Canada* (2nd ed.). Toronto, ON: Author.
- Bandiera, G., Sherbino, J., & Frank, J. R. (Eds.). (2006). *The CanMEDS assessment tools handbook: An introductory guide to assessment methods for the CanMEDS competencies*. Ottawa, ON: The Royal College of Physicians and Surgeons of Canada.
- Barnhill, G. C. (2001, April). *Continuing competence developments*. Presentation to the Federation of State Boards of Physical Therapy Annual Meeting & Delegate Assembly.
- Bilawka, E., & Craig, B. (2003). Quality assurance and dental hygiene. *International Journal of Dental Hygiene*, 1, 218–222.
- Bossers, A., Miller, L. T., Polatajko, H. J., & Hartley, M. (2007). *Competency Based Fieldwork Evaluation for Occupational Therapy (CBFE-OT)* (2nd ed.). Toronto, ON: Thompson Learning.
- College of Occupational Therapists of British Columbia. (2001). *College of Occupational Therapists of British Columbia Bylaws*. Victoria, BC: Author. Retrieved from http://www.cotbc.org/PDFs/COTBC_Bylaws.aspx
- College of Occupational Therapists of Ontario. (2008a). *Competency review and evaluation guide: Step 1 guide 2008/2009*. Retrieved from http://www.coto.org/pdf/QA_Competency_Review_Guide_2008.pdf
- College of Occupational Therapists of Ontario. (2008b). *Supporting, guiding, managing change: 2008 annual report*. Retrieved from http://www.coto.org/pdf/publications/COTO_AR_2008.pdf
- Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *Journal of the American Medical Association*, 287, 226–235.
- Glover Takahashi, S., Millette, D., & Eftekari, T. (2003, June). *Exploring issues related to the qualification recognition of physical therapists*. Paper presented at the congress of the World Confederation for Physical Therapy, Barcelona, Spain.
- Government of British Columbia. (2008). *Health Professions Act*. Retrieved from http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96183_01
- Hays, R. B., Jolly, B. C., Caldon, L. J., McCrorie, P., McAvoy, P. A., McManus, I. C., & Rethans, J. J. (2002). Is insight important? Measuring capacity to change performance. *Medical Education*, 36, 965–971.
- Health Regulatory Organizations of British Columbia. (2005). *Quality assurance in the regulation of health professions in British Columbia*. Vancouver, BC: Author.

- Lockyer, J., Blackmore, D., Fidler, H., Crutcher, R., Salte, B., Shaw, K., ... & Wolfish, N. (2006). A study of a multi-source feedback system for international medical graduates holding defined licenses. *Medical Education, 40*, 340–347.
- McIlroy, J., & Glover Takahashi, S. (2009). *A manual to guide the development of key feature cases*. Unpublished manuscript.
- Page, G., & Bordage, G. (1995). The Medical Council of Canada's key features project: A more valid written examination of clinical decision-making skills. *Academic Medicine, 70*(2),104–110.
- Violato, C., Lockyer, J. L., & Fidler, H. (2008). Changes in performance: A 5-year longitudinal study of participants in a multi-source feedback programme. *Medical Education, 42*, 1007–1013.

Appendix: Glossary

Assessment

A structured and analytical review of an individual's knowledge, skills, attitudes, or competencies. Sometimes the words *assessment* and *evaluation* are used interchangeably. In this document, the word *assessment* pertains to the individual and *evaluation* applies to a review of a program or organization.

Capability

The physical, mental, and emotional potential and facility of an individual that enables that person to fulfill his or her professional role. Abilities include talent, aptitude, and adequacy.²³

Competence

An outcome of training to a specific standard or a level of performance. Competence in practice is “the habitual and judicious use of communication, knowledge, technical skills, professional reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served.”²⁴

Competence Assessment

An analytical form of assessment of the individual's capability to

- demonstrate the requisite knowledge, skills, and attitudes;
- demonstrate the required capability; and
- perform adequately in the necessary work context.

Competency

One competency is a unit of or component part of the whole (i.e., competence). A competency is an outcome statement that reflects the knowledge, skills, and attitudes needed to achieve a major part of a job (a role or responsibility). Each competency can be measured against well-accepted standards and can be improved via training and development.

Often, two levels of competencies are described, key competencies and enabling competencies:

- Key competencies are the important outcome objectives (what is to be achieved or performed). Central to the accuracy of the competencies is the action verb.
- Enabling competencies are the subobjectives or key ingredients to achieving the key competencies.

²³ Synonyms for *capability* that clarify the term include *talent*, *aptitude*, *adequacy*, *facility*, and *potential*.

²⁴ Epstein & Hundert, 2002, p. 226

Competency-Based Assessment

A criterion-based process of obtaining evidence about performance and making judgments on that evidence against prescribed standards of performance. Hays et al.²⁵ distinguish between “competency-based assessment” (which measures what clinicians can do in controlled representations of professional practice) and “performance-based assessment” (which measures what clinicians do in actual professional practice).

Competent

Being competent refers to the skill level of a practitioner, which meets or exceeds the minimum and ongoing performance expectations. Competent practice depends on three elements:

1. Context of practice;
2. Capability of practitioner (e.g., physical, cognitive, affective); and
3. Competencies demonstrated by practitioner.

Context of Practice

The environment where practice occurs. Context of practice describes the details about the practice milieu including the who (types of clients, groups, populations), what (areas of practice, types of service), where (practice settings), and how (professional roles, funding models) in which practitioners elect to practise. The areas describing the context of practice are interrelated and affect which essential competencies are needed for safe and effective practice.

Performance-Based Assessment

Assessment approaches or methodologies that measure what clinicians do in actual professional practice. This is in contrast with assessment approaches or methodologies that measure a clinician’s capability to perform in a simulated environment (e.g., written or live simulations).

²⁵ Hays et al., 2002