College of Dental Hygienists of Ontario

Quality Assurance Program

EVALUATION REPORT 2012

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This report provides the details of an outcome evaluation on a project undertaken by the Quality Assurance Committee of the College of Dental Hygienists of Ontario (CDHO). This report follows the format of the ***Checklist for Designing the Evaluation of Outcomes*** documented in the **CDHO Guidelines for Evaluating the Success of Projects, Programs and On-Going Activities.**

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STEP 1 – ASSESSMENT (Background and Baseline Information)

Objective of the Evaluation

Lisa Taylor, Deputy Registrar and Jane Keir, Manager, Quality Assurance Program have prepared this internal evaluation. The following report is for the consideration of the Quality Assurance Committee and the CDHO Council. The rationale for the evaluation was to ensure that the program continues to be consistent with the College mandate to regulate the practice of dental hygiene in the interest of the overall health and safety of the public of Ontario and to provide information that will aid the Quality Assurance Committee in future decisions. Chief considerations for this evaluation include:

1. Determining if changes should be made to the current Quality Assurance Program;
2. Ensuring that the Quality Assurance Program continues to align with the goals and objectives of the College;
3. Ensuring that the Quality Assurance Program continues to meet the requirements under the *Regulated Health Professions Act, 1991 (RHPA)*; and
4. Budgeting for the cost of administering the Quality Assurance Program.

Target Population

Members of the public are intended to be the ultimate beneficiaries of this evaluation, as information gained in completing the program evaluation will help to ensure that the College's mandate to regulate the practice of dental hygiene in the interest of the overall health and safety of the public is being met. The findings of the evaluation are intended to provide information and guidance to the Quality Assurance Committee to assist them in making recommendations to the Council regarding the future direction of the program. Input from other sources including registrants of the College, College data and documentation, Quality Assurance Assessors and the Committee itself will also be considered in making recommendations.

Background Information

History and Development of the Quality Assurance Program

With the proclamation of the *Regulated Health Professions Act, 1991 (RHPA)*, all health regulatory colleges were required to establish a Quality Assurance Committee which was responsible for the development of regulations prescribing a quality assurance program to assure the quality of practice of the profession and to promote the continuing competence of members.

Under the *RHPA*, all Colleges were required to establish:

- Standards of Practice outlining the knowledge, skills and judgment required to be a competent regulated health professional;
- A Quality Assurance Committee;
- Regulations prescribing a quality assurance program; and
- A prescribed process to define deficiencies.

At this time, the Ministry of Health delineated the following goals for the quality assurance programs:

- To maintain the quality of services provided by individual practitioners;
- To improve the quality of those services;
- To improve the health status of the public by improving the collective performance of the health profession.

As well, the Ministry of Health provided the health regulatory bodies with guidelines for the development of the quality assurance programs. The quality assurance program must have:

- A quality assurance component to identify and address the issue of registrants who are incompetent or unfit to practise or whose skills are deficient but can be improved through remedial activities;
- A continuing quality improvement component to ensure the maintenance and improvement of individual registrant's competence; and
- A total quality improvement component aimed at raising the collective bottom-line performance of the profession by focusing on patient outcomes.

The Ministry of Health suggested and supported innovation in the design of these quality assurance programs rather than adopting the existing mandatory continuing education approach.

College of Dental Hygienists of Ontario Quality Assurance Program

In the newly established College of Dental Hygienists of Ontario (CDHO), the Quality Assurance Committee(s) adopted a consultative approach over time in the ongoing development of the CDHO Quality Assurance Program. In the early stages of development, the Committee interviewed and worked with a number of consulting firms, consulted with the Ontario Dental Hygienists Association (ODHA) to establish consensus regarding the basic design of the Quality Assurance Program while incorporating the Ministry of Health's guidelines.

The College employed the services of PMJ Consultants. Dr. Patricia Johnson who worked with the Quality Assurance Committee to design and administer a Baseline Survey, Dental Hygiene Practice in Ontario, 1995. This survey was designed to describe and to determine quality dental hygiene practice prior to the establishment of the Quality Assurance Program. Eighty percent of the CDHO registrants responded to a twenty-page survey providing the Committee with baseline data. This data provided information essential for comparison and evaluative purposes over time and also influenced the ultimate design and components of the Quality Assurance Program.

Prior to the establishment of the Quality Assurance Program, a pilot project was conducted to test the design of the professional portfolio. The Committee incorporated the feedback from the pilot project participants into the final draft of the professional portfolio.

The Quality Assurance Regulation received ministerial approval in 1998 and was first implemented in 1999. Prior to the implementation of the Quality Assurance Program, the College conducted 35 Information Sessions across the province. As per the regulation, the Quality Assurance Program had 3 components: a Professional Portfolio/Practice Review; a Total Quality Improvement Review, which was to be administered every five to seven years; and a Continuing Quality Improvement Review. In 2003, all components were operational at full capacity. Originally, the Quality Assurance Committee was also responsible for remediation for remarks and behaviour of a sexual nature. This responsibility has since been passed to the Patient Relations Committee.

In 2010, a new Quality Assurance Regulation was put in place. While much of the regulation remained the same, significant changes to the regulation included the ability of the Quality Assurance Committee to set the criteria for selection for registrants' portfolio submissions and the removal of the CQI review and TQI review requirements.

Professional Portfolio/Practice Review

The professional portfolio is the primary instrument for both the former Continuing Quality Improvement Review and the Professional Portfolio/Practice Review.

Of the 12,180 registrants whose portfolio(s) has been requested

7663	have met the assessment guidelines
3998	are due to submit their portfolio by January 31, 2014
11	are still in the assessment process
88	are participating in directed learning/remediation
420	are no longer registered with the College.

The discrepancies in these numbers can be attributed to several factors:

- Some dental hygienists have participated in the review more than once due to being randomly selected multiple times
- Registrants who resign from the College are not required to submit their portfolio
- Some registrants have received deferrals or extensions from the Committee for various reasons

According to the Quality Assurance Regulation, each professional portfolio shall include at least,

a) a statement of the member's planned continuing quality improvement goals for each year and the relationship of each goal to the member's practice and the College's standards of practice and ethics;
b) a description of a typical day in each of the member's workplaces;
c) a description of the member's continuing quality improvement measures; and
d) an assessment of the implementation and outcome of the acquired knowledge, skills, judgment and attitudes in the member's dental hygiene practice for each continuing quality improvement measure.

In 2008 and 2009, registrants participated in a number of surveys and focus groups commissioned by the Quality Assurance Committee. The data obtained indicated that registrants were generally satisfied with the Quality Assurance Program. However, the registrants reported three common issues. First, they did not like the thirty-day notice they were given to produce their portfolios when selected through the stratified random selection. Secondly, they wanted to see more direction on the type and amount of learning required each year to meet the Quality Assurance Committee's expectations. Thirdly, a number of registrants suggested that limiting the assessment to a one-year period did not provide an adequate picture of their continuous quality improvement activities. More specifically, they felt that the one-year snapshot did not allow for high and low years of activity. In response to this information,

the Committee changed the notice period for those selected through the stratified random selection from thirty days to one year and are now requesting that registrants submit their learning goals and continuing quality improvement activities for the previous three years. Further to this, the Committee created The Guidelines for Continuing Competency for Ontario Dental Hygienists, which is found in **Section F** of the Quality Assurance Package.

In 2010, with the enactment of a new Quality Assurance Regulation, the QA Committee obtained the ability to set the selection criteria without the restrictions of the previous regulation which required that 10% of the membership be randomly selected. In response to input from various sources, the Committee determined that in 2012 and 2013, all eligible registrants who had not previously been selected would be required to submit their professional portfolios for assessment. Registrants who graduated prior to 2006 were requested to make their portfolio submission in 2013 and the remainder of eligible registrants has been requested to submit in 2014. By the end of 2014, 14,418 portfolios will have been requested and 12,180 registrants will have completed the quality assurance process.

Quality Assurance Assessors review registrants' submissions and evaluate portfolios according to a set of pre-determined assessment criteria. Portfolios are assigned an assessment status as described in **Table 1**.

Table 1: Assessment Status Definitions

Assessment Status	Definition
A1	Meets assessment criteria
A2	Additional information required
A3	Onsite review required
A4	Deficiencies identified

Registrants who are granted an A1 status receive a letter notifying them that their portfolio has met the assessment criteria and that their review is complete. In cases where the assessor is unable to determine that a registrant's practice meets the assessment criteria, a status of A2 will be temporarily assigned. These registrants will receive a phone call from their assessor to give them the opportunity to clarify or provide additional information that will allow the assessor to make the determination whether the portfolio should be given an A1 or an A3 status, indicating the need for an onsite practice review. The Continuing Quality Improvement (CQI)

goals and activities section of the portfolio is then reviewed to determine if the registrant has demonstrated sufficient quality learning to ensure the maintenance and improvement of individual registrant's competence. In cases where a registrant is not able to demonstrate continued competence, a status of A4 will be assigned.

The Quality Assurance Committee will then review the portfolio assessment status and may make one or more of the following determinations:

1. Grant the member an extension for a specified period of time to achieve specified continuing quality improvement goals.
2. Grant the member an exemption from some or all of the requirements for the year in question.
3. Direct the member to complete specified continuing education within a specified period of time.
4. Direct a peer assessment and practice review of the member's practice at his or her practice location.
5. Direct that no further action is required.

Table 2 below illustrates the number of portfolios requested and onsite reviews completed since the inception of the program.

Table 2: Portfolios Selected and Onsite Reviews Required from 1999–2012 Selection

Year	Portfolios Requested	Onsite Reviews Completed*	% of Total Registrants in Selection
1999	0	0	0
2000	157	3	2.5%
2001	300	2	5.0%
2002	476	3	7.5 %
2003	617	0	10%
2004	645	4	10%
2005	721	3	10%
2006	770	6	10%
2007	852	38	10%
2008	875	36	10%
2009	978	57	10%
2010	59*	102	0**
2011	1058	57	10%
2012	1253	38	10%
2013	1659	27	N/A***
2014	3998	–	N/A***

* *Includes 2nd onsite visits required following remediation programs ordered by the QA Committee.*

** *As a result of an increased notification period, there was no random selection in 2010. Portfolios requested in 2010 were those carried forward from a previous year and those submitted as part of a Registrar's referral.*

*** *Selection was not made as a percentage of membership but rather from registrants who had never previously been selected. Also included here are registrants who were requested to submit their portfolios as a result of their failure to assure the College that they had complied with the quality assurance requirements upon registration renewal as described below.*

Continuing Quality Improvement Review

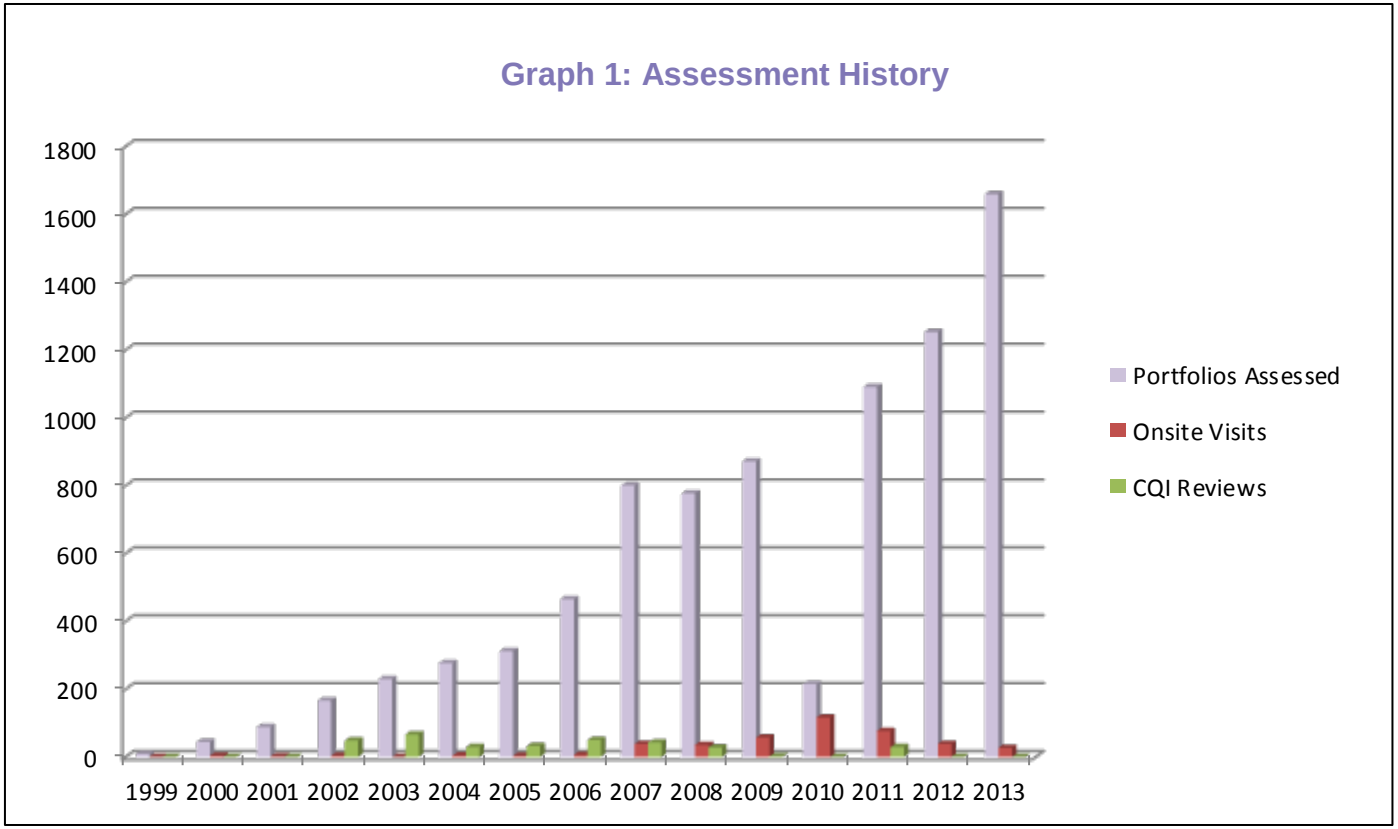
Each year, in accordance with the Quality Assurance Regulation, registrants are required to maintain a professional portfolio and participate in Continuing Quality Improvement (CQI) activities sufficient so as to have the knowledge, skills and judgment to practise in a manner consistent with the *CDHO Dental Hygiene Standards of Practice.* In the years 1999 to 2011, the Registrar referred registrants to the Quality Assurance Committee for failure to assure the College that they had complied with the quality assurance requirement when renewing their certificates of registration. Every dental hygienist must provide the College with sufficient evidence of her/his participation in CQI activities when renewing their general/specialty certificate of registration. The Committee had the option to appoint an assessor to assess the dental hygienist's CQI activities. **Table 3** shows the aggregate data for the CQI assessments performed from 1999 to 2011.

Table 3: Number of CQI Referrals from 1999–2011

Year	CQI reviews
1999	0
2000	0
2001	0
2002	50
2003	67
2004	32
2005	15
2006	24
2007	17
2008	2
2009	0
2010	0
2011	29

In 2010, with the adoption of the new Quality Assurance Regulation, the requirement for CQI reviews was removed and the Quality Assurance Committee acquired the ability to make a determination of the steps to be taken where registrants failed to assure the College that they had complied with the quality assurance requirements upon renewal of their certificate of registration. In 2012 and 2013, the Committee directed that these registrants should submit their full portfolio to the Committee for assessment in the same manner as those in the regular selection.

Graph 1 shows the aggregate data for the portfolio, onsite and CQI assessments performed since the inception of the program.



Total Quality Improvement Review

In addition to the initial baseline survey in 1995, Total Quality Improvement (TQI) Surveys were performed in 2002 and 2008. A comparative analysis of the 1995, 2002 and 2008 survey data was performed for the purpose of determining if change had occurred in the practice profile, to evaluate the Quality Assurance Program and to determine the need for revision to the CDHO Dental Hygiene Standards of Practice. The requirement to complete a TQI review has been removed from the new regulation; however, the Quality Assurance Committee has the discretion to complete these surveys if the need is identified.

During these surveys, a CQI (continuing quality improvement) Index was constructed to summarize the overall quality improvement activities and to examine possible associations with dental hygiene practice outcomes. The index was developed taking into account the number of activities pursued by a registrant, a summary of the intensity of reading of three key publications and a summary of the number of topics respondents pursued. CQI scores for the 2008 survey were, on the whole, higher than those in either of the two previous surveys. There was a big jump in the CQI scores between 1995 and 2002, and there was again a rise, although more modest, in 2008. The most important factor in contributing to this increase in overall score was the increase in the number of CQI activities completed by dental hygienists in the province. There was also evidence that there was a correlation between quality of practice and participation in client care activities. That these increases took place concurrently with the implementation of the CDHO Quality Assurance Program speaks well for the College's quality improvement initiatives.

Staffing Requirements

The Quality Assurance Committee meets approximately 8–10 times per year on an as-needed basis to provide specific instructions to college staff regarding registrant decisions. College staff performs the day-to-day administration of the program. This includes a full-time Quality Assurance Manager, previously known as the Quality Assurance Administrator dividing her time between the QA Program and her role as a practice advisor. There is also one full-time administrative assistant assigned exclusively to the QA Program.

Quality assurance assessors review the submitted professional portfolios and complete the onsite assessments, acting as fact finders for the Quality Assurance Committee. At the current time, there are 38 assessors on the roster, with contracts to assess until January 2014. Assessors are contacted each fall to determine their commitment to return to assess for the upcoming portfolio assessment period.

Training and calibration workshops are held each year prior to the commencement of the portfolio assessments. New assessors attend an initial training session separate from, and prior to, the calibration workshop attended by all assessors.

Technology Requirements

Full information and documentation required by registrants regarding the QA Program is available on the CDHO website and registrants' USB resource. Maintenance and updates to the website and updates to the USB resource are completed on an as-needed basis, as well as following the annual review by college staff including the Project Coordinator and the Information Technology Manager.

Registrant status in regards to their quality assurance assessments is retained and tracked in the college database. In keeping with the confidentiality requirements for the program, only college staff directly involved in the program has access to quality assurance information regarding each registrant.

The quality assurance assessors have access to scanned copies of registrant portfolios from the website using a secured portal and login that is accessible only by college staff and the assessors. Assessors complete the portfolio template and assessments are entered directly into the college database from the assessor site.

Quality Assurance Program Budget History

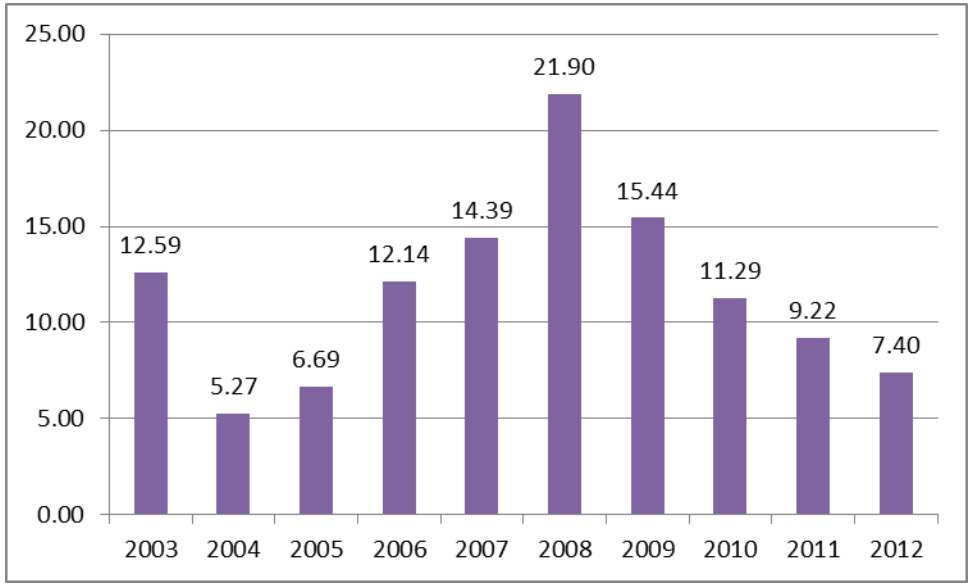
Costs varied by year according to the number of assessments completed, the need to complete a TQI Assessment, and research and development costs. Quality assurance assessors are hired on a contract basis and are paid for each portfolio assessment at a rate of $30 per portfolio assessment and for onsite visits and report writing at a rate of $350 per visit. Second visits to the same registrant in the same assessment period are paid at a rate of $250 per visit. **Table 4** below shows a breakdown of budget by category.

Table 4: Budget for 2009–2013

	2009	2010	2011	2012	2013
Assessor Workshop	6,625	13,250	13,250	10,600	13,250
Portfolio Review	27,000	36,000	36,000	36,900	48,900
Practice Review	35,000	70,000	70,000	24,500	24,500
Workshop Accommodation	6,250	12,500	12,500	10,000	12,500
Meals for Workshop	1,875	3,750	3,750	3,000	3,750
Guest Speaker for Workshop	500	500	500	–	–
Travel/Accommodation/ Meals for Practice Reviews	40,000	80,000	80,000	28,000	28,000
Phone and Couriers	1,250	7,000	7,000	2,450	2,450
TQI Report	25,000	–	–	–	–
Computer Support	–	10,000	10,000	–	–
Legal Counsel	–	2,000	2,000	2,000	2,000
Consulting	–	–	–	–	–
QA Tools Development	–	–	–	50,000	75,000
Research	–	–	25,000	25,000	25,000
Budget Estimate	**$143,500**	**$235,000**	**$260,000**	**$192,450**	**148,700**
Total Budget	**$144,000**	**$238,000**	**$261,000**	**$193,000**	**150,000**
Actual	**$175,672**	**$136,073**	**$117,277**	**$97,397**	**–**

Over the last 10 years, on average, the Quality Assurance Program has cost $11.63 per registrant to run. **Graph 2** shows the cost per registrant per year since 2003.

Graph 2: Annual Cost of QA Program per Registrant



Note: *Number of registrants in 2005 estimated due to error in annual report.*

A 2010 study was completed by the Health Professions Council in Great Britain looking at the quality assurance programs of Ontario Regulatory Health Colleges. The annual running costs for selected programs ranged from $31.63 to $174.75 per member per year. It should be noted that the program costs vary by the components of the program and the methods used to assess their registrants. The CDHO appears to be spending significantly less per member than other Colleges. **Table 5** shows the reported costs of quality assurance programs for various Colleges in Ontario.

Table 5: Annual Costs of QA Programs per Registrant Reported in 2010

Regulatory College	QA Running Costs (per member per year)	Percentage of Total College Budget Spent on QA (%)
Dental Hygienists	$11.29	2.72–3.07 (2011/2012)
Occupational Therapists	$31.63–$41.64	6.08 (2011)
Optometrists	Not available	3.83–4.90 (2011/2012)
Pharmacists	$31.85	4.40–4.49 (2011/2012)
Physicians and Surgeons	$174.75	Not available
Physiotherapists	$40.78–$56.63	4.40–6.78 (2012/2013)

QA Committee Strategic Planning

In 2011 and 2012, the Quality Assurance Committee held several strategic planning sessions to initiate the program evaluation. During these meetings, the Committee developed the following Mission and Vision Statements and identified key values for the program:

1. Mission Statement:

To fulfill the CDHO's legislative obligation to the public of Ontario and the Ministry of Health and Long-Term Care by facilitating dental hygienists as they measure and improve their level of performance and competence based on a quality improvement process of self-reflection consistent with the CDHO Standards of Practice, bylaws and regulations.

2. Vision Statement:

That the QA Program is embraced by dental hygienists who as self-regulated professionals value learning as they monitor, assess and improve their level of competence as primary providers of oral preventative health care to the public of Ontario.

A Successful QA Program Will:

- *Allow dental hygienists to position themselves as integral members of the inter-professional health care team.*
- *Be fair, consistent and transparent.*
- *Provide constructive feedback to assist registrants in improving their practice.*
- *Continually review its process with an aim to evaluate the effectiveness of the QA Program.*

3. Key Values:

Accountability, autonomy, critical thinking, transparency, fair and ethical practice, confidentiality.

In 2012, the Committee contracted an educational consultant specializing in assessment and evaluation to assist them in developing evaluation questions along with indicators and thresholds to be used in their evaluation of the program (Appendix 1).

CDHO's Strategic Critical Success Factors

The CDHO Council developed critical success factors and goals to assist in directing Council decision making. All College goals and activities are expected to contribute to the success of the College to regulate the profession. This Quality Assurance Program evaluation will be examined to determine if it meets this requirement. The program will be assessed against these factors following analysis and any resulting changes to the program.

Critical Success Factor # 1

The CDHO continues to thrive with independence to regulate the profession well into the future.

- **Goal # 1 –** Implement a plan that ensures that the College maintains autonomy in the regulation of dental hygiene.

Critical Success Factor # 2

The CDHO has ongoing effective regulation of the profession.

- **Goal # 2 –** The reputation and integrity of the College is maintained, ensuring confidence in the College's ability to govern its registrants.
- **Goal # 3 –** Resources are allocated for evaluating information that may affect the standards of practice, the Quality Assurance Program, the regulations, and related activities.
- **Goal # 4 –** An effective governance process is in place that supports Council members in fulfilling their obligations.

Critical Success Factor # 3

The CDHO maintains effective communications and relationships with stakeholders.

- **Goal # 5 –** The public is provided with information that enables them to make informed choices regarding oral health issues.
- **Goal # 6 –** Develop, maintain and enhance appropriate information channels with stakeholders.

People Involved in Conducting the Project

The administrative staff persons overseeing this project and evaluation were Lisa Taylor, Deputy Registrar and Jane Keir, Manager of the Quality Assurance Program. Kate Sutherland, Ledia Kurti and Terri-Lynn Macartney, Quality Assurance Coordinators, provided assistance and administrative support during the evaluation process.

STEP 2 – DIAGNOSIS (Problem / Need / Question)

What?

The rationale for the evaluation was to ensure that the program continues to be consistent with the College mandate to regulate the practice of dental hygiene in the interest of the overall health and safety of the public of Ontario, and to provide information that will aid the Quality Assurance Committee in reaching future decisions regarding:

1. Determining the effectiveness of the current program and if changes should be made to the current Quality Assurance Program
2. Ensuring that the Quality Assurance Program continues to align with the goals and objectives of the College
3. Ensuring that the Quality Assurance Program continues to meet the requirements under the *Regulated Health Professions Act, 1991 (RHPA)*
4. Budgeting for the cost of the Quality Assurance Program

Why?

As per Council directive, all programs must undergo periodic evaluation. It was determined that a full evaluation of the Quality Assurance Program has never been completed. The evaluation is intended to provide information that will aid the Council and Quality Assurance Committee in reaching future decisions regarding the Quality Assurance Program.

STEP 3 – PLANNING (Setting Goals and Methods)

Goal

To evaluate the current CDHO Quality Assurance Program to ensure the mandate of the College is being met.

Measurement of Success

Achievement of indicator thresholds as described in evaluation template (Appendix 1)

Methods of Collecting Information

Information will be collected from various sources including:

- Public opinion survey related to QA Program
- Registrant survey report
- Committee survey report
- Assessor tracking data and survey
- College database
- College documentation
- Staff reporting
- Past TQI reports

Evaluation Priorities

The evaluation will be completed in order to help Council/Committee make informed decisions regarding changes to the Quality Assurance Program to be implemented in January 2015. Cost of the project will be limited to those associated with the hiring of a consultant to help develop the evaluation template and registrant survey.

Process and Structure

Information gathered from the various sources was expected to provide valuable data to complete a comprehensive assessment of the Quality Assurance Program and to inform the Committee's recommendations to Council.

- The *Public Opinion Survey* commissioned by the Patient Relations Committee in 2011 was expected to provide valuable information to the Committee in regards to the expectations of the public of Ontario related to the Quality Assurance Program and the confidence in the quality of the treatment they expected to receive from registered dental hygienists in the province.
- The *Registrant Survey* was expected to provide experiential data from registrants' experiences with the Quality Assurance Program and critical input to assist in making decisions regarding future programming.
- The *Registrant Survey Report* was to be completed by an authority in program evaluation and was expected to provide an unbiased assessment of registrant responses.
- The *Committee Survey* was expected to assess the Committee's perceived knowledge about the entire QA process and the expectations and feasibility of the Committee's expected time commitment.
- The *Assessor Survey* and tracking data was expected to provide insight into the process from the perspective of those completing the actual assessment functions of the program.
- The College database was expected to provide valuable statistics and data to evaluate the effectiveness of the program.
- Review of College documentation was also expected to provide valuable statistics and data related to the program.

The Quality Assurance Manager was responsible for coordinating all aspects of the evaluation and providing the information to the Committee to assist in their decision making. College staff organized and extracted information collected from all sources. The statistics and information gained were used in compiling this comprehensive report of the current Quality Assurance Program.

Budget

$25,000 was included in the QA Budget for research for both 2012 and 2013.
$75,000 is budgeted for tools development for 2013, which has not yet been utilized.

STEP 4 – IMPLEMENTATION (Information Gathering)

Execution

Information was gathered from the following sources according to the evaluation plan:

- The *Public Opinion Survey* report was available for review.
- The *Registrant Survey* was sent to 12,700 registrants.
- Independent analysis of 4,725 full registrant responses to the survey.
- The *Committee Survey* (Appendix 5) was completed via Survey Monkey. 100% of current Committee members completed the survey and a report was generated.
- The *Assessor Tracking Data* was compiled and the *Assessor Survey* completed via Survey Monkey. A report of assessor responses to the survey was generated.
- Data and statistics were extracted from the College database as needed.
- Data was collected from College documentation and College staff as needed.

The Quality Assurance Manager was responsible for coordinating all aspects of the evaluation and providing the information to the Committee to assist in their decision making. College staff organized and extracted information collected from all sources. The statistics and information gained were used in compiling this comprehensive report of the current Quality Assurance Program.

Resources

Resources required for the completion of the evaluation were easily accessed and included the following:

- Public opinion survey results (Available in shared College documents)
- Access to Survey Monkey website (Available free of charge at surveymonkey.com)
- Assessor tracking data (Available in restricted quality assurance files)
- Access to College Quality Assurance database
- Resources required to administer the registrant survey were provided by the consultant and fees included those required to administer the survey via the Fluid Survey application. To date, $17,651.74 has been disbursed to the consultant.

STEP 5 – EVALUATION (Data Analysis and Conclusions)

The Quality Assurance Committee worked with Dr. Marla Nayer, a consultant in assessment and evaluation, to develop the criteria by which the QA Program would be evaluated. Indicators and Thresholds were set for each question where applicable. In keeping with the mandate of the College, the primary consideration of the Committee when developing the evaluation tool was ensuring the overall health and safety of the public. It has been determined that the program evaluation meets with the critical success factors and goals developed by Council as described on page 20 of this report.

Findings

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
1. Are the program goals well defined and available to registrants?	Documentation that clearly articulates the goals is available	Goals are published in documents available to registrants	College documentation	Documentation that articulates the goals of the program are published on the CDHO website and in Quality Assurance articles in *Milestones*	Goals of the program are well defined and readily available to registrants from various sources
2. Are Committee members aware of how assessing is completed?	Committee members are aware of the entire QA process	100% of Committee members have received an orientation to the QA process on joining the Committee	Committee survey	100% of current QA Committee members are aware of the entire QA process and 100% have received an orientation to the QA process on joining the Committee	Committee members are trained and aware of the QA process and how assessing is completed

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
3. Are registrants completing the portfolio documentation annually?	Registrants report they complete the portfolio documentation annually.	75% of registrants report they complete the portfolio documentation annually	Registrant survey Annual declaration	83.5% of registrants report that they complete the portfolio annually From 2003–2012, 0.26% of registrants have indicated that they have not maintained a portfolio resulting in a CQI review	Survey results and renewal files show that the majority of registrants are completing the portfolio documentation annually
4. Are registrants submitting their portfolios when selected?	% of registrants who submit the required portfolios as requested	90% of registrants submit the required reports by the deadline	Database	In 2012, 96.6% of registrants submitted their portfolio by the deadline. In 2013, 96.0% of registrants submitted their portfolio by the deadline. (These statistics do not include those registrants who received extensions or who were referred to the ICRC for non-compliance)	Data collected suggests that over 90% of registrants are submitting their portfolios by the deadline

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
5. Are registrants setting appropriate learning goals consistent with the Standards of Practice, guidelines and bylaws?	Registrants construct appropriate goals	30% of registrants submitting portfolios write appropriate goals	College documentation	In 2012, 98% of the portfolios received contained acceptable goals that related to program requirements In 2013, 98% of portfolios received contained acceptable goals	Based on the data collected from 2012 and 2013, registrants appear to be writing acceptable goals that are appropriate and related to the CDHO Standards of practice, guidelines and bylaws. Prior to 2012, this data was not specifically tracked

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
6. Do submissions include all required forms and documentation?	Submissions include all required documentation (e.g. following portfolio guidelines regarding forms and documentation)	90% include all appropriate forms and documentation (e.g. form 6, 7, etc.)	College documentation	In 2012, 96.5% of submissions included all required documentation. In 2012, 96.8% of submissions included all required documentation. (Assessment tracking)	Based on the data collected from 2012 and 2013, the majority of registrants is following the portfolio guidelines regarding forms and documentation and is submitting all required documentation. Prior to 2012, this data was not specifically tracked
7. Are registrants making changes in their practice based on their learning activities?	Learning activities result in changes in practice	80% of registrants report implementing changes based on their learning activities	Registrant survey	72% report making changes based on their learning within the past 3 years	Threshold was not met. 28% of registrants are not making changes to their practice based on their learning

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
8. Are learning goals met within one year?	Goals are met within one year	90% of goals are met within one year	Registrant survey	50% report achieving goals within 1 year	Threshold was not met
9. Is the portfolio feasible in terms of time commitment for registrants?	Hours spent reviewing College QA documents and requirements, and creating or updating a portfolio	Registrants spend approximately 30 hours creating their portfolio and 10 hours/year annually to maintain	Registrant survey	49.1% spent over 30 hours to create portfolio and 49.4% spend over 10 hours to maintain the portfolio	No threshold set. Data collected showed that approximately half of all registrants are spending time in excess of the QA Committee's expectations in creating and maintaining their portfolio. This suggests the portfolio may not be feasible in terms of time commitment for registrants

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
10. Is the portfolio relevant to all practice settings?	Registrants in all practice settings report they are able to create and maintain the portfolio	95% of registrants report they are able to create and maintain the portfolio	Registrant survey	55.7% of registrants who have submitted a portfolio have been able to demonstrate their practice using the portfolio forms. 36.0% indicated that they could not accurately portray their practice using the portfolio forms	Threshold not met
11. Does the portfolio process allow for an assessment of how the registrant is practising?	Assessor confidence in evaluation Onsite review results confirm accuracy of assessor identification of deficient practices	95% of assessors confident their decisions are appropriate 95% of onsite reviews accurately identify deficient practices	Assessor survey Database	In 2013, QA assessors report that they are confident that their decisions are appropriate in 96.4% of the portfolios assessed 2 of 376 (0.53%) of onsite practice evaluations did not reveal any deficiencies in practice	Data collected suggests that the process allows for an assessment of how the registrant is practising Assessor evaluations of deficient practices were accurate in 99.47% of cases

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
12. Is the portfolio relevant to inactive registrants?	Registrants who are inactive report that they are able to create and maintain the portfolio Registrants who are inactive report that the portfolio is relevant to them	50% of registrants report they are able to create and maintain the portfolio 30% of registrants report the portfolio is relevant to them	Registrant survey	78.5% of inactive registrants were able to create and maintain their portfolio 29% of respondents reported that completing the portfolio assists them in their learning processes 68.6% did not make changes to their practice within the past 3 years 11% did not complete the portfolio; 34% did not set goals	Data collected suggests that inactive registrants are able to maintain a portfolio 68.6% of inactive registrants were unable to make changes as they were not practising and less than 30% reported that the portfolio assisted them in their learning suggesting that the portfolio is not relevant to them

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
13. Do all registrants have access to acceptable CQI activities?	Registrants are all able to access CQI activities	80% of registrants report they are able to access CQI activities	Registrant survey	81.6% attended courses or workshops 73.7% read dental hygiene scientific journals 70.7% completed self-study using current dental, dental hygiene and/or medical peer-reviewed journals and textbooks 53.8% attended presentations, read publications or completed learning modules offered by the CDHO 15% indicated no barriers to participation. Major barriers reported are cost, time, and ability to travel	Registrants have access to acceptable CQI activities

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
14. Are registrants able to complete 75 hours of CQI activities over a 3.year period?	Portfolios include documentation of 75 hours of CQI activities over 3 years	90% of registrants complete 75 hours of activities over 3 years	Registrant survey College documentation	34.5% complete 50 or fewer hours In 2012, 90% of registrants who were assessed were found to have sufficient hours of CQI activities. In 2013, 91% of registrants who were assessed were found to have sufficient hours of CQI activities. These results are due in part to registrants not complying with the Continuing Competency guidelines requiring that at least 80% of their hours be obtained completing goal-related activities	While the registrant survey indicated that registrants were not completing the required hours, the assessment data from 2012 and 2013 portfolio assessments, suggests that this is not the case The data collected from the two sources suggests it is possible that registrants who have been selected ensure that they have sufficient hours to meet the requirements while those who have not been selected are not achieving the required hours

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
15. Are 80% of the CQI activities related to the learning goals and practice?	Portfolios include documentation that link the CQI activities to learning goals and practice	90% of registrants have linkages that indicate 80% of their CQI activities are related to their learning goals and practice	College documentation	In 2012 98% of portfolios met the requirement that 80% of their activities be related to their goals and practice In 2013, 98% of portfolios met the requirement that 80% of their activities be related to their goals and practice	The data collected suggests that assessments meet the threshold set by the Committee and registrants are linking their CQI activities to their learning goals and practice
16. Is the portfolio providing an educational experience?	Registrants report portfolio assists them in their learning	70% of registrants report portfolio assists them in their learning	Registrant survey	38.5% report that completing the portfolio assists them in their learning processes	Data collected suggests that the portfolio does not assist registrants in their learning processes

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
17. Are registrants satisfied with/see values in the portfolio?	Registrant opinions on the portfolio are positive	50% of registrants find creating a portfolio a positive learning experience	Registrant survey	Specific question not asked Survey indicated the 63.3% of selected registrants and 61.3% of never selected registrants are satisfied with the current program which includes the professional portfolio Individual comments submitted trended to the negative	N/A

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
18. Are the instructions for completing each of the nine portfolio forms clear?	Registrants report the instructions for completing the portfolio are clear	80% of registrants report the instructions for completing the portfolio are clear	Registrant survey	Respondents rating the forms as "Neutral", "Clear" or "Very Clear" (excluding those who reported not using the form) Form 1 – 95.0% Form 2 – 94.6% Form 3 – 91.8% Form 4 – 72.0% Form 5 – 87.0% Form 6 – 75.2% Form 7 – 74.4% Form 8 – 80.5% Form 9 – 83.1%	Data collected suggests that the instructions for completing forms 4, 6 and 7 are less clear than the other forms. Forms 4, 6 and 7 did not meet the threshold for clarity of instructions
		No threshold set for # of acceptable calls/emails regarding form instructions	College documentation of # of calls/emails to College asking for clarification of form instruction	Not currently tracked	N/A

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
19. Is the portfolio feasible in terms of time commitment (committee, assessor)?	Committee members and Assessors are able to complete their review of documents in a reasonable period of time.	Committee members spend no more than 15 hours reviewing documents for each Committee meeting; about 8 meetings a year, therefore ~120 hrs/yr in prep.	Committee survey	Committee members report spending an average of 12 hours preparing for each meeting	Data collected suggest that Committee members are spending less than 15 hours reviewing documents for each meeting therefore the portfolio is feasible in terms of time commitment
		Assessors spend 30 minutes on each review & report	Assessor tracking portfolio review time	Assessors report spending an average of 56 minutes on each portfolio review	Assessors are taking longer than expected to complete each portfolio review and report and the portfolio review is not feasible in terms of time commitment for the assessors

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
20. Do registrants conduct a self-assessment?	Registrants complete the Self-Assessment Tool Annually	25% of registrants complete the Self-Assessment Tool annually	Registrant survey	41.3% complete the tool annually	Met the threshold

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
21. How many registrants have been selected multiple times? How many have never been selected?	#/% of registrants assessed since inception in various categories	95% of registrants are assessed once over a 10-year period	Database/registrant survey	Program was selecting 10% of eligible registrants since 2003 but due to requirement for random selection, some registrants were selected multiple times while others were never selected. College documentation shows that 12,180 portfolios of registrants have been selected since the inception of the program including approximately 4000 registrants who were not previously selected, are due to submit their portfolios in 2014 and who would not yet have received their selection letter at the time of the registrant survey 2370 registrants have been selected multiple times 69.3% report having been selected while 30.4% report never having been selected	100% of eligible registrants will have been selected as of January 2014

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
22. Does the portfolio allow the registrant to demonstrate competence?	Registrant is confident that they are able to demonstrate competence	90% of registrants indicate they are able to demonstrate their competence through completion of the portfolio	Registrant survey	63% of registrants indicate they are able to demonstrate their competency	37% of registrants indicate they are unable to demonstrate competency with the portfolio
23. Are the assessor instructions regarding evaluating documents clear?	Assessors report instructions are clear	95% Assessors report instructions are clear	Assessor survey	100% of assessors report that instructions for evaluating portfolios during the initial training are clear. 95% of assessors report that the instructions for evaluating portfolios during the annual workshops are clear	Data collected suggests that assessors receive clear instructions for evaluating portfolios

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
24. Are assessors provided with sufficient training to carry out their tasks?	Assessors report workshop provides necessary information and skills Assessors report that updates provide appropriate information	80% of assessors report that they have the information needed to carry out assessment tasks 90% of assessors report that they have the information needed to carry out assessment tasks	Assessor survey	100% of assessors report that the initial training provided them with the information needed to carry out assessment tasks 95% of assessors reported that they have the information needed to carry out assessment tasks	Assessors are provided with sufficient training to carry out their tasks

Process Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings**	**Judgment**
25. How many registrants have had a portfolio assessment and then been identified for an onsite assessment?	% of registrants selected for portfolio review who are then identified for an onsite assessment	No more than 10% of registrants selected for portfolio are identified for onsite practice assessment	Database	Since 1999, 10,420 portfolios have been assessed and 376 onsites have taken place (3.6%). Some onsite assessments in the database are 2nd onsites to confirm implementation of remediation knowledge so actual percentage of registrants identified for an onsite assessment is actually lower than 3.6%	Data reveals that less than 3.6% of registrants submitting portfolios are identified for an onsite review
26. Is the onsite process feasible in terms of registrant time?	Registrants report the onsite session of 4-5 hours is acceptable	90% of registrants report 4-5 hours is acceptable	Registrant survey	Onsite visits: <2 hours 19.0% 2-4 hours 54.8% 4-6 hours 15.5% 6 hours + 10.7% Registrants not asked about acceptability of time taken for onsite	N/A

Process Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings**	**Judgment**
27. Are assessors current? (i.e. are they up on current standards?)	Assessor portfolios meet the requirements of the program	100% of assessor portfolios meet the requirements of the program	Database	100% of assessors have submitted their portfolio as part of their application and/or completed a portfolio review and/or onsite practice assessment and meet the program requirements	Assessment reports and 100% attendance at training and refresher workshops ensures that the assessors are in possession of current knowledge of dental hygiene practice and program expectations
	Assessors attend an annual refresher program	90% of assessors attend an annual refresher program	College documentation	All assessors must participate in the annual refresher program. Those assessors unable to attend the refresher are taken off of the roster for that assessment year	

Process Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings**	**Judgment**
28. Is the feedback from the onsite visit provided to the registrants timely and useful?	Registrants report feedback is provided in a timely manner Registrants report feedback is helpful to them in planning future learning	85% of registrants receive feedback within 2 months of assessment 75% of registrants report feedback is helpful in planning future learning	Registrant survey	Not assessed 72.6% of respondents indicated that the feedback provided in their onsite report was helpful to direct their future learning	N/A Although the threshold was not reached, data collected suggests that feedback provided to registrants is useful to them in planning their future learning
29. Is the program being implemented as planned?	Program runs within defined timelines	Variance from work plans nominal (mailings within 2 weeks of projections)	College documentation	In all years, portfolio results were mailed prior to advertised date	Mailings were sent within 2 weeks of projections and the program is being implemented as planned

Process Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings**	**Judgment**
30. Have adequate resources been allocated for timely and efficient implementation? Is there a match between the program elements and resources available? (e.g., staffing, funding, skills sets, IT technology)	Staff time Outside administrative time purchased IT barriers	Actual staffing resources can manage tasks within timelines without the need to purchase outside administrative time Technology meets needs of program	Staff reports	To date, the program has sent results in a timely manner. Program elements and resources are sufficient to administer the current program The current system meets the needs of the program at the current time. The IT manager has made numerous additions and modifications to improve the database and meet specific needs of the QA Program	Adequate resources been allocated for timely and efficient implementation of the program. In anticipation of the large number of portfolio submissions expected in 2014, back up staff will be available for assistance and adjustments have been made to the internal server and processes to accommodate the greater number of email submissions expected

Process Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings**	**Judgment**
31. Have adequate data collection systems been established? Is information available in a format that makes analysis as simple as possible (design of database)? Has the data necessary for evaluating the process been collected and entered appropriately?	Essential data collected; data entry reliable; database design facilitates analysis; allows evaluation questions and indicators to be answered	Provides usable data that makes analysis possible	Database and College documentation	QA database has been modified over the years of the program to facilitate collection of data. Some information is available but difficult to obtain	Data collection system has been established. Upon completion of evaluation, additions or modifications may be necessary to collect additional information for analysis and future evaluations

Process Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings**	**Judgment**
32. What are barriers to completing CQI activities?	Description of barriers	10% registrants selected identify the same issue	Registrant survey	66% report cost is a barrier 63% report time is a barrier 34% report ability to travel is a barrier 15% reported other barriers	Data collected suggest that cost, time and ability to travel are significant barriers to participating in CQI activities
33. Are registrants being informed about the findings, results and learning of the QA Program?	Publication of global results in College documents or separate mailing	Updates in college documents annually	College documentation	Results of the portfolio and onsite assessments are published three times/year in Committee reports to Council, in *Milestones* and in the Annual Report. Reports include statistics of number and outcomes of assessments as well as common deficiencies	Registrants are informed about the findings, results and learning of the QA Program

Process Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings**	**Judgment**
34. Have provisions been put in place to protect registrants with a legitimate reason to postpone involvement?	Policies and procedures documents Policies allow for deferrals and extensions Registrants are aware of the policies regarding deferrals or extensions	Policies and procedures documents are available 100% of registrants applying for deferrals or extensions are considered by Staff or the Committee; approval of deferrals and extensions in line with policy; policy revised when evidence suggests a need for change	College documentation	Policies and procedures are published online and in college documents 100% of registrant requests for deferrals or extensions and supporting documentation are taken to the QA Committee for consideration. The Committee looks at each case on an individual basis prior to reaching a decision	Provisions are in place for registrants with a legitimate reason to postpone involvement in a QA assessment

Combined Process/Outcome or Process/Content Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings**	**Judgment**
35. Is the program affordable and sustainable?	10% of registrants reviewed within approved annual budget of the QA Program	10% of registrants reviewed within approved annual College budget	Database/College Documentation	Between 2003 and 2012, 10% of registrants were selected each year to participate in the portfolio assessment process. Budget projections were based on the selection of 10% of the expected number of registrants for the selection year. The Quality Assurance Program has remained within the approved budget for the program each year since the establishment of the program	The current practice of reviewing 10% of the registrant population is affordable and sustainable

Combined Process/Outcome or Process/Content Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings**	**Judgment**
36. Are registrants complying with and participating in the program?	Total number of non-compliant over total registrants selected (non-compliant may include "difficult" registrants who fight the process)	100% of annual registrants selected (minus Committee approved extensions and deferrals) complete the process within specified timeframe	College documentation	Since 1999, 86 registrants have been referred to the Executive or Inquiries, Complaints and Reports Committee for non-compliance since the inception of the QA Program	99.99% of registrants selected to participate are compliant with the program

Combined Process/Outcome or Process/Content Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings**	**Judgment**
37. Is the format of the current program acceptable to the registrants (face validity)?	Registrants indicate the program is acceptable	80% of registrants selected indicate program acceptability 50% of registrants who have *not* been selected indicate program acceptability	Registrant survey	63.3% report "overall acceptable" 61.3% report "overall acceptable"	The majority of registrants who have previously been selected find the program to be acceptable; however, the target threshold set by the Committee was not met. The majority of registrants who have not previously been selected find the program to be acceptable; the target threshold set by the Committee was met

Outcome Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings** (Source of information)	**Judgment**
38. Are registrants falling below minimal competence identified?	# of registrants are identified as being near or below minimal competence	5%–10% of those assessed are found to need assistance to reach appropriate standards	Database	Less than 5% of those assessed have needed assistance to meet appropriate standards	Based on program statistics over 95% of registrants are practising above minimal competence standards
39. Has information from program evaluation been integrated into future programming?	Changes occurring in response to evaluation results	QA Committee considers recommendations and makes appropriate changes	College documentation TQI surveys Focus groups/past registrant surveys	The QA regulation was amended to allow for changes to the program (i.e. selection criteria) Program was set up based on the initial survey The Continuing Competency Guidelines were developed based on input from registrants during focus groups	The QA Committee reviews the findings of all evaluations in consideration of changes to the program

Outcome Questions					
Evaluation Question	**Indicator**	**Threshold**	**Information Required and Source(s) of Information**	**Findings** (Source of information)	**Judgment**
40. Can we identify the predictors of incompetence (e.g., solo practice, age, certification status [e.g., restorative])?	Collecting appropriate data; numbers large enough to allow for analysis	Analysis possible; data needs outlined elsewhere; ~500 registrants in appropriate database	Database Program research	Current program tracking contains data regarding deficiencies in practice and CQI activities for less than 500 registrants assessed with deficiencies. Preliminary predictors of incompetence have been identified	A more comprehensive database that tracks registrant assessment results as well as additional registrant history is required to identify the predictors of incompetence
41. Are courses relevant to all registrant remediation needs available to registrants?	Registrants are able to access appropriate courses	90% of registrants are able to access relevant courses	College documentation	All remediation courses must pass specific criteria prior to being approved. 100% of registrants requiring remediation are given a list of approved provider based on their specific remediation orders	All registrants who are required to complete remedial activities have been able to access appropriate and relevant courses

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
42. Are remediation activities implemented as planned?	Registrant is able to implement required activities	90% of registrants are able to implement remediation activities	Database	100% of registrants who were able to implement remediation programs following onsite visits have demonstrated that they have implemented their new learning into practice. Where required, registrants are monitored for compliance with requirements to complete remediation programs as well as implementation through chart audits, second onsite reviews or alternate activities. This does not include registrants who are still in process, who now hold a status of resigned, revoked or deceased or who have been referred to the ICRC for non-cooperation or non-compliance with the QA Program	Data collected suggests that in all cases, remediation activities are implemented as planned

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
43. Are registrants able to implement changes in practice to meet competence standards following onsite assessments? (e.g. spore testing)	Registrant is able to implement appropriate changes in practice setting	90% of registrants are able to implement changes in practice	Registrant survey Database	100% of registrants were able to implement changes even where barriers existed. The sample size from the survey was very small (n=5) therefore result may not be reliable or valid indicator of ability to implement change. Appropriate changes to practice following onsite assessments have been made in 100% of cases whose assessment is complete. This does not include registrants who are still in process, who now hold a status of resigned, revoked or deceased or who have been referred to the ICRC for non-cooperation or non-compliance with the QA Program.	Data collected from the registrant survey suggests that registrants are able to implement changes in their practice to meet competence standards Data collected suggests that registrants are able to implement changes in practice to meet competence standards

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
44. Were remediation activities effective at assisting registrants to improve their knowledge?	Types of activities and reports on effectiveness	50% of registrants improve their knowledge	Database	100% of registrants who have been required to complete remediation programs are either in progress or have demonstrated that they have achieved competency standards and therefore increased their knowledge with the exception of those registrants who were revoked, suspended, resigned, who have received an exemption from all or part of the program, who are no longer practising or who have been referred to the ICRC for non-cooperation or non-compliance with the QA Program	Data collected suggests that Remediation Programs were effective and that registrants improved their knowledge.

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
45. Does the Remediation Program assist registrants in achieving competency standards?	Registrants meet competence standards	100% of registrants remaining in practice meet competence standards	Database	100% of registrants who have been required to complete remediation programs are either in progress or have demonstrated that they have achieved competency standards with the exception of those registrants who were revoked, suspended, resigned, who have received an exemption from all or part of the program, who are no longer practising or who have been referred to the ICRC for non-cooperation or non-compliance with the QA Program	Data collected suggests that Remediation Programs assist registrants in achieving competency standards
46. Is the Remediation Program affordable for the Registrant?	Registrant report of cost	Costs 80% of registrants report costs are affordable	Registrant survey	Costs $300–$2000 Due to subjective nature of question, Committee decided not to expressly ask registrants if this was “affordable”	Registrant’s opinion on affordability of remediation programs was not obtained

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
47. Does the current Quality Assurance Program meet the minimum requirements as set out in the *RHPA, 1991*?	The program includes all of the following: a) continuing education or professional development designed to i) promote continuing competence and continuing quality improvement among the members, ii) address changes in practice environments and iii) incorporate standards of practice, advances in technology, changes made to entry-to-practice competencies and other relevant issues	100% of the requirements of the *RHPA, 1991* are met	College documentation Database	The program includes a) continuing education or professional development designed to i) promote continuing competence and continuing quality improvement among the members, ii) address changes in practice environments and iii) incorporate standards of practice, advances in technology, changes made to entry-to-practice competencies and other relevant issues b) self, peer and practice assessments; and c) a mechanism for the College to monitor members' participation in, and compliance with, the Quality Assurance Program	The program contains 100% of the minimum requirements for a Quality Assurance Program according to the *RHPA, 1991*

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
	b) self, peer and practice assessments; and c) a mechanism for the College to monitor members' participation in, and compliance with, the Quality Assurance Program		Registrant survey		
48. Does the current Quality Assurance Program comply with the CDHO Quality Assurance Regulation?	All QA policies and procedures comply with the QA Regulation	All QA policies and procedures comply with the QA Regulation	Review of current policies and procedures as they relate to the QA Regulation	All policies and procedures comply with the QA Regulation with the exception of the availability of an evaluation tool designed to help assess the member's knowledge, skills and judgment as described in Section 20 (4) 6.	The current program does not comply with the CDHO Quality Assurance Regulation. An additional tool needs to be developed to fully comply

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
49. Does the public of Ontario believe that dental hygienists should participate in ongoing training and education?	The public believes that dental hygienists should participate in ongoing training and education.	No threshold set	Public opinion survey	99% of respondents say it is important for dental hygienists to undertake ongoing training and education	The public places great importance on dental hygienists participating in ongoing training and education
50. Provided with the information that dental hygienists *are* required to undertake ongoing training and education, how many hours of education and training does the public believe should be completed by dental hygienists in one year?	The number of hours of training and education expected by members of the public surveyed	The average number of hours of ongoing training and education expected by the public	Public opinion survey	The average number provided by the public was 49 hours, while the median was 25 hours. The average was inflated by a small number of outlier responses and survey administrators suggested that the median is more representative of the public views	The public believes that dental hygienists should complete 25 hours of ongoing training and education per year

Evaluation Question	Indicator	Threshold	Information Required and Source(s) of Information	Findings	Judgment
51. Would members of the public be less inclined to visit a dental hygienist who did not complete ongoing training and education?	The percentage of the public who would be less inclined to visit a dental hygienist who does not undergo ongoing training and education	No threshold set	Public opinion survey	81% of the public would be less inclined to visit a dental hygienist who does not undergo ongoing training and education. 17% say ongoing training and education would have no impact on their decision and 2% said they would be more likely to visit a dental hygienist who does not undergo ongoing training and education	The public would be less inclined to visit a dental hygienist who does not undergo ongoing training and education

Conclusions

Overall, the evaluation revealed that the Quality Assurance Program is working. However, there is always room for improvement. It is important to note that for the purposes of this summary, we have chosen to highlight areas of the evaluation that suggested change would be beneficial. In comparing our predetermined indicators of success and the analysis of the data collected, a number of conclusions can be reached regarding the relationship of various factors to the Quality Assurance Program. These are outlined below.

Compliance with the RHPA, 1991 and Quality Assurance Regulation

1. The current program meets the requirements of the *Regulated Health Professions Act, 1991*. All policies and procedures comply with the QA Regulation with the exception of the availability of an evaluation tool designed to help assess the member's knowledge, skills and judgment as described in Section 20 (4) 6.

Public Interest

1. The public places considerable importance on their dental hygienist maintaining competency and would be less inclined to visit a dental hygienist who does not participate in ongoing training and education. The public believes that 25 hours/year is an appropriate amount of time to spend on Continuing Quality Improvement (CQI) activities.

Technology

1. Registrants report difficulty with completing the portfolio forms in their current format and are spending a significant amount of time creating and maintaining their portfolio (in addition to time spent completing CQI activities).

2. Current college tracking mechanisms do not provide the program with easy access to data that would be valuable in tracking registrants, determining predictors of competence/incompetence or extracting statistics. Currently, extraction of some statistics that would assist in the evaluation of the program is not possible or feasible.

Committee and Assessors

1. The current program is feasible in terms of Committee time commitment. New Committee members are invited to attend the assessor training and all members participate in an annual orientation session. The Committee receives all information required regarding the QA process to inform their decisions regarding registrant assessments. The Committee reviews all registrant requests for deferrals or extensions on an individual basis, in addition to all assessment reports.

2. The Quality Assurance Assessors receive initial and annual training that provides information and skills needed to complete a full assessment of registrants' competence. Assessors report that the training is valuable and communicate with one another regularly.

Process and Structure

1. The random selection of registrants required by the previous Regulation resulted in a large number of registrants not being given the opportunity to participate in the assessment process. This resulted in a number of registrants being selected multiple times while others were never selected. In order to ensure inclusion of all registrants, selection for 2013 and 2014 included all eligible registrants who had never been assessed. This has and will place an added burden on staff, assessors and College resources.

2. Although registrants have access to acceptable CQI activities as described in the Continuing Competency Guidelines, many are not aware of many of the resources available to assist them in completing the portfolio.

3. Registrants are spending a significant amount of time creating and maintaining their portfolios. They identify Form 4 as an area where instructions for completion are not clear. Further, they indicate they are unable to demonstrate their competency using the portfolio.

4. Registrants also identify Forms 6 and 7 as areas where instructions for completion are not clear. Further, they indicate the portfolio does not assist them in their learning.

Recommendations

Compliance with the RHPA, 1991 and Quality Assurance Regulation

1. Develop and implement the use of an evaluation tool designed to help assess the member's knowledge, skills and judgment as described in Section 20 (4) 6.

Public Interest

1. Continue to utilize the current Continuing Competency Guidelines in assessments including completing 75 hours of CQI activities in a 3-year period.

Technology

1. Research and implement an online portfolio system with a third-party provider that will guide registrants as they complete portfolio sections and reduce the time spent creating and maintaining their portfolio. Ensure online system is compatible with College database and secure assessor login area to permit the transfer of information when registrant makes their submissions.

2. Additions or modifications to the current College database as necessary to facilitate the collection of data and statistics regarding the QA Program for analysis, future evaluations and predictors of competence.

Committee and Assessors

1. Continue to provide training and orientation to Committee members on an annual basis. Ask Committee members to track preparation time for meetings and to complete an annual survey for use in future program evaluations.

2. Continue to provide Quality Assurance Assessors with mandatory initial and annual training that provide information and skills needed to complete a full assessment of registrant’s competence. Include tracking of specified information in assessor reporting for each registrant. Validate assessor reviews by conducting a study to determine inter-rater reliability.

Process and Structure

1. Implement a system in which all registrants will be selected once every 10 years.

2. Create and deliver an educational session in all districts to educate registrants regarding changes to the Quality Assurance Program, including a webinar that can be accessed by all registrants throughout the province. Require registrants to continue to follow the Continuing Competency Guidelines.

3. Modify Form 4 to remove the typical day reporting for those in clinical practice (i.e. general, perio, orthodontic, etc.) and replace with submission of 3 client charts and a copy of their infection control protocol including a signed declaration that the protocol is being followed. Continue use of the current Form 4 for educators and develop a Form 4 for use by those in non-traditional practices (i.e. administration, research, sales, continuing education providers, etc.). Modify the current assessment process by removing the telephone interview from the portfolio assessment. Replace the onsite review with a paper-based second stage of assessment where the registrant is required to submit further specified documentation related to their practice. This second stage would include an optional telephone interview for clarification as necessary. An onsite review would remain an option for monitoring clinical competency.

4. Investigate the use of an online portfolio system to assist registrants in self-assessing and in developing their learning goals.

Summary

The current Quality Assurance Program supports the current goals and objectives of the College and meets the College's mandate to protect the public interest. Committee members and assessors are satisfied with the current program; however, changes to the current program could improve the reporting ability of the program and reduce the burden on registrants, allowing them to more easily report on their practices and their Continuing Quality Improvement activities while still continuing to meet the legislative mandate.

Answering to the CDHO's Strategic Critical Success Factors

The recommendations made were assessed against the CDHO Council-developed critical success factors. It has been determined that all recommendations meet with the Council criteria.

Critical Success Factor # 1

The CDHO continues to thrive with independence to regulate the profession well into the future.

- **Goal # 1 –** Implement a plan that ensures that the College maintains autonomy in the regulation of dental hygiene. YES

Critical Success Factor # 2

The CDHO has ongoing effective regulation of the profession.

- **Goal # 2 –** The reputation and integrity of the College is maintained, ensuring confidence in the College's ability to govern its registrants. YES
- **Goal # 3 –** Resources are allocated for evaluating information that may affect the standards of practice, the Quality Assurance Program, the regulations, and related activities. YES
- **Goal # 4 –** An effective governance process is in place that supports Council members in fulfilling their obligations. YES

Critical Success Factor # 3

The CDHO maintains effective communications and relationships with stakeholders.

- **Goal # 5 –** The public is provided with information that enables them to make informed choices regarding oral health issues. YES
- **Goal # 6 –** Develop, maintain and enhance appropriate information channels with stakeholders. YES