Impact of College-Administered Quality Practice Assessments: A Longitudinal Evaluation of Repeat Peer Assessments of Continuing Competence in Physiotherapists

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ABSTRACT

Purpose: The College of Physiotherapists of Ontario (CPO) developed its peer practice assessment (PA) process under statutory requirements for quality assurance. Each year, a small percentage of physiotherapists, most selected at random, undergo PA. To shed light on continuing competence, we report outcomes from physiotherapists who have had two PAs. **Methods:** Records were extracted for physiotherapists with two unrelated PAs. Demographic features, peer assessors' scores, and consequent outcome decisions were examined. Outcomes were examined cross-sectionally (vs. other PAs in the same time period) and longitudinally (within cohort). **Results:** Between 2004 and 2012, 117 Ontario physiotherapists underwent two unrelated PAs, typically 5–7 years apart. This cohort was representative of Ontario physiotherapists in terms of sex ratios, education, and years in practice. At the first PA (PA1), this cohort's outcomes were similar to those of other physiotherapists; at the second PA (PA2), they were better than others undergoing PA1 in the same period ($p = 0.02$). The cohort's outcomes were better at PA2 than at PA1 ($p < 0.001$). **Conclusions:** Physiotherapists are likely to meet professional standards in a repeat PA 5–7 years after an initial one. Additional research is required to identify risk factors for not meeting standards. The findings provide empirical evidence to guide ongoing development of the CPO's quality management program.

Key Words: clinical competence; peer review; program evaluation; quality improvement.

RÉSUMÉ

Objet: L'Ordre des physiothérapeutes de l'Ontario (OPO) a élaboré son processus d'évaluation de la pratique par les pairs en vertu d'exigences réglementaires relatives à l'assurance de la qualité. Chaque année, un petit pourcentage de physiothérapeutes, pour la plupart sélectionnés au hasard, font l'objet d'une évaluation de la pratique. Afin de jeter la lumière sur le maintien des compétences, nous rendons compte des résultats des physiothérapeutes qui ont subi deux évaluations de la pratique. **Méthodes:** On a extrait les dossiers des physiothérapeutes ayant subi deux évaluations de la pratique non connexes. On a ensuite examiné les caractéristiques démographiques, les notes des pairs-évaluateurs et les décisions qui en ont découlé. Les résultats ont fait l'objet d'un examen transversal (comparaison avec d'autres évaluations de la pratique effectuées au cours de la même période) et d'un examen longitudinal (dans la cohorte). **Résultats:** Entre 2004 et 2012, 117 physiothérapeutes de l'Ontario ont subi deux évaluations de la pratique non connexes, habituellement à un intervalle de 5 à 7 ans. Cette cohorte était représentative des physiothérapeutes de l'Ontario pour ce qui est des rapports de masculinité, des études et des années de pratique. À la première évaluation de la pratique, les résultats de cette cohorte étaient semblables à ceux des autres physiothérapeutes; à la deuxième évaluation, ils étaient meilleurs que les résultats des autres physiothérapeutes ayant subi une première évaluation de la pratique au cours de la même période ($p = 0,02$). Les résultats de la cohorte étaient meilleurs à la deuxième évaluation de la pratique qu'à la première ($p < 0,001$). **Conclusions:** Les physiothérapeutes sont susceptibles de répondre aux normes professionnelles à l'occasion d'une deuxième évaluation de la pratique effectuée 5 à 7 ans après la première évaluation. Des recherches supplémentaires s'imposent pour cerner les facteurs de risque de ne pas répondre aux normes. Les constatations donnent des preuves empiriques qui permettront d'orienter l'élaboration en cours du programme de gestion de la qualité de l'OPO.

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Regulatory bodies for health professions are mandated to ensure competence at entry to professional practice; indeed, historically, this was often their primary purpose.^{1,2} Rigorous attention to processes for ensuring continuing competence is a more recent development, arising from evidence that continuing education is insufficient to ensure continuing competence^{3,4} and from an understanding that competence is situational rather than an unchanging attribute of an individual established at entry to practice.⁵ The very factors that make continuing competence different from entry-level competence, however, make it challenging to assess, which creates a need for methods specific to a practitioner's current practice. Practitioners may not need to maintain ongoing competence in all the competencies demanded at entry level, but they must maintain professional standards in all respects necessary for their current practice area and setting.^{5,6} Approaches to continuing competence assessment by health professional regulatory bodies may include written tests or clinical examinations, portfolio reviews, peer assessments, or others, potentially in combination.^{3,5–11} To our knowledge, few health professional regulatory bodies have published evidence from longitudinal evaluation of the assessments of their members' continuing competence.^{7–11}

Physiotherapists across Canada participate in different processes to ensure continuing competence, depending on the jurisdiction in which they practise.^{12–21} Different jurisdictions may take different approaches, influenced by statutory requirements, regulatory bodies' resources and judgment, and the underlying concept of continuing competence as defined by the regulatory body. At the time of this writing, Ontario appears to be the only province whose physiotherapy regulatory body has a well-developed on-site assessment program as part of its continuing competence initiatives,¹⁶ although at least three others appear to be considering such programs, based on information posted to their Web sites.^{13,15,19} Many Canadian physiotherapy regulatory bodies require annual self-reporting, using mechanisms such as hours in practice^{14–16,18} or maintaining a professional portfolio.^{13–16,18–20} Some also require periodic assessment of jurisprudence knowledge.^{12–14,16} All of these regulatory bodies may also use strategies to ensure continuing competence that are not immediately evident on their public Web sites.

The College of Physiotherapists of Ontario (CPO), the regulatory authority for physiotherapists who practise in this province, defines professional competence as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection on daily practice for the benefit of the individual and community being served."^{22(p.226)},²³ By statutory authority, the CPO is required to have a quality assurance program that includes self-, peer, and practice assessments (PAs).^{24(s.80.1b)} The purpose of this program is to ensure quality practice and competence in physio-

therapists.²⁵ The CPO's quality assurance program focuses mainly on knowledge, self-reflection, and meeting quality standards in its assessment of physiotherapist competence in practice. The CPO on-site PA includes review of the physiotherapist's portfolio, a review of the work environment, and chart-stimulated recall (CSR).²⁵ The peer assessor considers whether the physiotherapist is meeting professional standards in five areas: practice issues, business practices, recordkeeping, CSR of decision making in patient care, and evidence of ongoing learning. The inter-rater reliability of the CPO's PA process conducted by peer assessors was found to be adequate.²⁵ To safeguard the validity of PA outcomes, the process is overseen by the CPO's Quality Management Committee (QMC); any suboptimal outcomes for the assessed physiotherapists receive particular scrutiny by the QMC, which also regularly audits assessment decisions against criteria the QMC developed and reviews on a regular basis.

Throughout the period studied (2004–2012), approximately 5% of physiotherapists were randomly selected for PA every year. All physiotherapists are eligible to be randomly selected for a PA after 5 years in practice. In addition, physiotherapists can undergo a PA through self-referral or College Review Program (CRP) referral; the latter arise from referrals by the CPO Registrar or when a registrant does not meet the required minimal practice hours on registration. After completing a full PA process, a physiotherapist becomes ineligible for random draw for 5 years, although he or she could still undergo another PA through self- or other referral. In 2004, approximately 6,100 physiotherapists were registered in Ontario; by 2012, approximately 7,500 were registered. With such large numbers, it was statistically likely that within a short period after the point at which physiotherapists assessed in 2004 began to re-enter the random draw pool, some would be randomly selected a second time; and, indeed, by 2012 a substantial number of physiotherapists had had two PAs, most approximately 5–7 years apart. Notwithstanding the ongoing review of PA program processes by the CPO's QMC, the program overall remained largely unchanged throughout this period, which provided an opportunity to carry out a longitudinal evaluation of the PA process and to examine long-term outcomes of PA among physiotherapists.

The purpose of our study was to describe outcomes for Ontario physiotherapists who underwent two PAs in 2004–2012, both by comparing first- and second-time outcomes and by comparing these outcomes with those of all physiotherapists who underwent PAs in the same time frame. This program evaluation project is intended to provide evidence to help the CPO understand whether it is achieving its quality assurance aims. As a regulatory body, the CPO must fulfill its primary mandate of protecting the public interest while also being a responsible steward of its resources. When the CPO's PA program

Box 1 Rating Systems and Scoring

Areas scored by assessor	Past systems of rating descriptors	Latest rating descriptors	Score
Summary report, practice issues, business practices, recordkeeping, chart-stimulated recall*	Not applicable, not available, or missing data†		0
	Meets standards / Satisfactory practices	Rating 1	1
	Just below standards / Needs minor improvement	Rating 2	2
	Somewhat below standards / Needs major improvement	Rating 3	3
	Well below standards / Unsatisfactory practices	Rating 4	4
PISA, professional development	Not applicable, not available, or missing data		0
	Present	Evident	1
	Not present	Not evident	2

*For each area, the assessor writes narrative responses to multiple questions and provides a single score, with the exception of chart-stimulated recall, which is repeated four to eight times and assigned a score for each repetition (see text).

†Common reasons for missing data were that business practices questions were not applicable to most physiotherapists employed in hospitals or other public sector sites or that fewer than the maximum of eight possible chart-stimulated recall scores were assigned.

PISA = professional issues self-assessment.

was designed, the principle that physiotherapists could be reassessed after 5 years (or less, in cases of non-random referral) was based on the assumptions that (1) a physiotherapist may diminish in competence over time and (2) all physiotherapists engaged in direct patient care should be eligible for assessment if they have not recently been assessed. These assumptions were grounded in the best available evidence at the time of the program's creation;²⁵ when any quality assurance program can assess only a subset of its members in any given year, however, all stakeholders have an ongoing interest in examining and justifying how often, and under what criteria, any member is eligible for reassessment. Therefore, in the interests of striving for evidence-based practice in physiotherapy regulatory matters, the CPO recognized that the accumulation of a relatively high number of cases of repeat assessments allowed examination of whether physiotherapists maintain competence over time with respect to their regulatory body's published standards. Our findings may inform the CPO's ongoing evaluation of how its statutory obligation to quality assurance is achieved and influence key policy decisions. The findings may also be applicable to physiotherapists and their regulatory bodies in other jurisdictions.

METHODS

Practice assessment process and determination of outcomes

The PA process is described in the CPO's Quality Management Framework²³ and in a publication about its psychometric properties.²⁵ The PA process was largely stable from 2004 through 2012. After a physiotherapist is selected for a PA, his or her eligibility is confirmed: physiotherapists are exempted if their current practice does not involve direct patient care or are granted temporary deferral in the case of extenuating personal circumstances.

The peer assessors for PAs are themselves physiotherapists who have undergone not only the PA process but also training by the CPO. The training program begins

with a lecture and case reviews; trainee peer assessors then observe another assessor conducting an assessment and, finally, are observed themselves. Assessment reports prepared independently by the trainee and the experienced peer assessor are then examined for consistency; trainees receive feedback at each stage of the training from the experienced peer assessor and the CPO's director of quality management.

After selection for PA, a physiotherapist has as long as 3 months to prepare before the assessment date. Preparation details are not monitored, but post-PA questionnaire responses suggest that physiotherapists use the preparation time to update their portfolios and review the CPO's published Standards of Practice.²⁶ Assignment of peer assessors takes into account both travel requirements and achieving the best possible match between assessor and physiotherapist with respect to areas of practice.

On the day of the assessment, the assessor visits the physiotherapist at the physiotherapist's practice site. The assessor reviews documents provided by the physiotherapist, including patient charts, and interviews the physiotherapist using a standardized questionnaire that addresses the physiotherapist's assessments, goals, treatment decisions, and clinical reasoning for each patient chart examined. A standardized assessment tool, consisting of scores and narrative description in specified areas, is used to collect information and develop a report to the CPO's QMC. Box 1 shows the areas assessed; the descriptors for score levels changed during the study period, but the intended meaning of each score level remained constant, in that the assessor rated and described whether the physiotherapist met all applicable CPO-established standards of practice and, if not, the extent to which the physiotherapist's practice was below the expected standard.

The CPO's quality management (QM) staff reviewed the assessor's PA report, tabulating all rating scores and examining the documents for any potential concerns

Box 2 Decisions and Outcomes

Study code	Description	Communicated to member	Outcome reported in College's annual report
A	All scores provided by assessor were optimal (i.e., 1 or 0). No concerns arose during staff review of all documents. QMC approved results of staff review; PA deemed complete.	Completed successfully	Completed successfully (staff reviewed)
B	One or more scores were suboptimal. Member invited to make a submission before QMC review. QMC reviewed all documents and deemed the PA to be complete.	Completed successfully	Completed successfully (QMC reviewed)
C	One or more scores were suboptimal. Member invited to make a submission before QMC review. QMC reviewed all documents and made specific recommendations to be communicated to member. Risks to patients were deemed minimal, and the member was not required to submit further documentation to QMC. QMC deemed the PA to be complete.	Completed with recommendations	Completed with recommendations
D	One or more scores was suboptimal: multiple scores at Level 2, at least one score at Level 3 or 4, or both. Member invited to make a submission before QMC review. QMC reviewed all documents and concluded that the member was not adequately meeting standards in at least one area. Risks to patients were identified, and QMC required follow-up.	QMC's requirements specific to the member's case for remediation, practice enhancement, or reassessment	Remediations, practice enhancements, and reassessments*

*The terms and processes used for addressing suboptimal outcomes evolved over the study period. For the purposes of this study, because the number of such cases was low, they were combined into one category, D.

QMC = Quality Management Committee; PA = practice assessment.

about the content or completeness of the assessor's report. If all rating scores were optimal and the report was considered complete, QM staff deemed the PA successfully completed; for this study, we term this *Outcome A*. If the CPO's QM staff were unable to confirm successful completion at this stage, they provided a copy of the assessor's written report, including scores, to the physiotherapist and invited him or her to submit any communication he or she deemed pertinent for the QMC to consider alongside its review of the assessor's report. The QMC then reviewed all documents and came to one of the following conclusions about the PA: successfully completed (termed *Outcome B*); completed with recommendations (termed *Outcome C*); or requirement for remediation, practice enhancement, or reassessment within a few months. Remediation and practice enhancement could take many forms—for example, self-directed or QMC directed, with or without a coach. Because outcomes other than “successfully completed” and “completed with recommendations” were very rare, we grouped them together as *Outcome D* for the present analysis. See Box 2 for further information about criteria to determine outcomes.

Data selected for inclusion in analysis

We examined the CPO's QM database to extract records for all physiotherapists selected to undergo PA more than once within the study period (2004–2012). Records were retained for inclusion in the analysis cohort if the selection date for the first PA (PA1) was April 2004 or later; the second PA (PA2) assessment report and QMC decision were known by December 2012; and PA2 was

an independent process initiated multiple years after PA1 and not a reassessment arising from an unclear or problematic outcome at PA1. Records were excluded if, because of an exemption or deferral at the time of selection for PA1 or PA2, two assessments were not completed.

For physiotherapists whose PA records qualified for inclusion, the CPO staff supplied information from the physiotherapist's entry in the registrant database: sex, location of entry-to-profession education, and years since completing entry-to-profession education. To reduce the risk of accidental breach of anonymity, location of education was collapsed into three categories: in Ontario, outside Ontario but in Canada, and outside Canada. The CPO staff also supplied information on the general rate of self-referral to PA by physiotherapists in 2004–2012.

Data analysis procedures

Scores and outcomes were tabulated for all extracted PA records. We obtained summary information about PA outcomes for the CPO's QM program as a whole from the CPO's published annual reports.^{27–32} These values allowed us to compare the study cohort's outcomes at PA1 and PA2 with those of all other physiotherapists who completed PAs in comparable time periods. The CPO's annual reports also provided demographic information about all Ontario physiotherapists, which enabled us to assess how representative the study cohort was of the population of physiotherapists in Ontario. The rate of self-referral to PA in the cohort was compared with that of all Ontario physiotherapists using Fisher's exact test.

Within the study cohort, we used the non-parametric sign test to compare whether outcomes of physiotherapists' PA2 differed from their PA1. To compare whether outcomes were different for physiotherapists in the study cohort than for other physiotherapists undergoing a PA in the same time periods, we dichotomized PA outcomes to A or not-A and compared them using Fisher's exact test. Dichotomized outcomes and Fisher's exact test were also used for two other comparisons: first, whether PA outcomes of non-cohort members in 2004–2007 were different from PA outcomes of non-cohort members in 2009–2012 and, second, whether outcomes for cohort physiotherapists who self-referred to PA were different from those of cohort physiotherapists who did not self-refer.

Ethical considerations

The data we used for our study were gathered as part of the CPO's quality assurance activities, which are exempt from Research Ethics Board review under Article 2.5 of the Tri-Council Policy Statement for Ethical Conduct for Research Involving Humans.³³ The current analysis represents a secondary use of de-identified data. Care was taken to ensure that linkages among data sources did not inadvertently reveal the identities of physiotherapists whose PA records we reviewed.

RESULTS

The CPO's QM staff identified 145 physiotherapists who had two or more PA entries in the QM database for 2004–2012. Of these, 117 had data for two distinct PA processes. In about half of all cases (59/117), the outcome was coded A for both PA1 and PA2; Outcomes B, C and D occurred more rarely. See Figure 1 for a flow-chart of cases and outcomes.

Of our study cohort of 117 physiotherapists, 79.5% were female and 20.5% were male; approximately 69% had received their entry-to-practice education in Ontario, 13% had studied elsewhere in Canada, and 18% were internationally educated. Mean time from graduation to PA1 was 16 (SD 9) years. These values were all similar to those reported annually by the CPO throughout the study period; this is unsurprising because most PA records were for physiotherapists selected at random for PA.

Among all PAs conducted by the CPO, outcomes were more likely to be in the top category in 2009–2012 than in 2004–2007: 415 PAs (54%) resulted in Outcome A in 2004–2007 versus 769 (78%) in 2009–2012 ($p < 0.001$; see Figure 2, left column, and Table 1).

The proportions of Outcomes A, B, C, and D at PA1 for the study cohort were similar to outcomes for all physiotherapists selected for PA in approximately the same period. We found no significant difference in the proportions of A versus not-A outcomes at PA1 between the records in our cohort and the remainder of the CPO's 2004–2007 data ($p = 0.32$; see Figure 2, top row, and

upper half of Table 2). In contrast, the proportions of Outcomes A, B, C, and D at PA2 in the study cohort were different than those among all physiotherapists selected for their first PA in approximately the same period. Specifically, we found a significant difference in the proportions of A versus not-A outcomes between our study cohort at PA2 and the remainder of the CPO's 2009–2012 PA data ($p = 0.012$; see Figure 2, bottom row, and lower half of Table 2). In addition, outcomes at PA2 for the 117 records in our cohort were better than at PA1 (non-parametric sign test, $z = 4.41$, $p < 0.001$; see Figure 2, middle column, and Table 3). Of 68 physiotherapists who had Outcome A at PA1, only 9 had a suboptimal outcome at PA2; of the 49 who had a suboptimal outcome at PA1, only 6 had a suboptimal outcome at PA2 (see Figure 1).

Of our 117 cases, 82 were randomly drawn for PA on both occasions, 10 self-referred for PA on both occasions, and 21 self-referred for one PA and were randomly drawn for the other. The other 4 cases were referred to PA through the CRP on both occasions ($n = 1$) or were referred through the CRP on one occasion and selected at random on the other ($n = 3$). At PA1, the percentage of self-referrals in the cohort (23%) was significantly higher than that for other physiotherapists assessed in 2004–2007 (13%, $p = 0.006$). At PA2, the percentage of self-referrals in the cohort (12%) was also significantly higher than that among the other physiotherapists assessed in 2009–2012 (3%, $p < 0.001$). Within the cohort, however, we found no systematic pattern of differences in scores or outcomes related to self-referral or random draw (see Table 4). For all five PAs associated with CRP referral, the outcome was A.

DISCUSSION

Our results indicate that most Ontario physiotherapists who participated twice in peer PA achieved a successful outcome on both occasions or achieved a better outcome on the second occasion than on the first. The cohort we studied was broadly representative of Ontario physiotherapists with respect to sex, education, and years of practice. Considered as a group, the physiotherapists who underwent a second PA not only had significantly better outcomes than on their first PA but also achieved significantly better outcomes than physiotherapists undertaking a first PA in the same time frame. Moreover, outcomes of explicitly needing recommendations or practice enhancement (Outcomes C and D) occurred on the second PA in only 5 of 117 cases.

Ontario physiotherapists may undergo a PA as a result of random selection, referral from another department of the CPO, or self-referral. The most common reason for a CPO referral (i.e., CRP) is that a physiotherapist's successive annual reporting of practice hours has fallen below the threshold of 1,200 hours over the previous 5 years. The requirement for a PA in this situation arises not

Figure 1 Flowchart of data sources and outcomes

Flowchart to illustrate the inclusion of records in the study and the outcomes at the first and second practice assessments (PA1 and PA2, respectively). Rounded rectangles indicate outcome at PA1. Diamonds indicate outcome at PA2. See Box 2 for explanations of Outcomes A, B, C and D.

from a presumption of not having maintained competence but merely a heightened risk. CRP referral to PA was so rare in our cohort that detailed analysis was not warranted. We considered CRP referral cases to be similar to those drawn randomly, that is, approximately equally as likely to maintain competence and not expressly wishing to undergo a PA. In contrast, those who self-referred to PA expressly wished to undergo a PA. On the basis of anecdotal personal communications, com-

mon reasons for a physiotherapist to self-refer to PA are that he or she wishes to become a peer assessor—for which having undergone a PA is a prerequisite—or that a colleague has been randomly drawn and they can thus prepare together and both be removed from the random draw pool for 5 years. The reduction in the percentage of self-referrals is related to the declining need for the CPO to train new peer assessors during the later part of the study period. It is not surprising that our cohort had a

Figure 2 Outcomes of study cohort relative to those of other physiotherapists

Outcomes from 2004 to 2007 (upper panels) and 2009–2012 (lower panels) are shown. Data from the study cohort (middle column of panels) were subtracted from all of the CPO's PA outcomes (left column) for statistical comparisons. See Box 2 for explanations of Outcomes A, B, C and D.

* $p < 0.001$ (see Table 1).

†Not significant (see Table 2).

‡ $p = 0.012$ (see Table 3).

§ $p < 0.001$ (see Table 4).

PT = physiotherapist; CPO = College of Physiotherapists of Ontario; PA = practice assessment.

Table 1 Comparison of Outcomes of All Practice Assessments Conducted by the College of Physiotherapists of Ontario in Early and Late Part of Study Period

	No. (%)			p for 2-tailed Fisher's exact test
	Outcome A*	Outcome B, C, or D*	Total	
2004–2007	415 (53.7)	358 (46.3)	773 (100.0)	<0.001
2009–2012	769 (78.1)	216 (21.9)	985 (100.0)	
Total	1,184	574	1,758	

*See also Box 2.

higher proportion of self-referred physiotherapists than the CPO data as a whole, given that a physiotherapist is assessed more frequently if he or she does not wait to be randomly drawn. However, our results do not support the assumption that self-referred physiotherapists are any more likely to succeed than other physiotherapists, at least in the time period under study.

The CPO's mission is "to protect and serve the public interest by promoting collaboration and accountability for self regulation and enabling a culture of continuous improvement to ensure that physiotherapists provide

Table 2 Comparison of Cohort's PA Outcomes with All Other PA Outcomes

	No. (%)			<i>p</i> for 2-tailed Fisher exact test
	Outcome A	Outcome B, C, or D	Total	
Cohort's PA1 outcomes vs. all other physiotherapists' PA outcomes, 2004–2007*				
Other physiotherapists	347 (52.9)	309 (47.1)	656 (100)	0.32
Cohort's PA1	68 (58.1)	49 (41.9)	117 (100)	
Total	415	358	773	
Cohort's PA2 outcomes vs. all other physiotherapists' PA outcomes, 2009–2012*				
Other physiotherapists' PA1	667 (76.8)	201 (23.2)	868 (100)	0.012
Cohort's PA2	102 (87.2)	15 (12.8)	117 (100)	
Total	769	216	985	

*See Figure 2.

PA = practice assessment.

Table 3 Comparison of Cohort's PA Outcomes at Two Time Points

At PA2	Outcome at PA1, No. (%)				Total, No. (%)	<i>p</i> for sign test
	A	B	C	D		
A	59 (50.4)	19 (16.2)	17 (14.5)	7 (6.0)	102 (87.2)	<0.001
B	8 (6.8)	1 (0.9)	1 (0.9)	0 (0.0)	10 (8.5)	
C	1 (0.9)	1 (0.9)	1 (0.9)	1 (0.9)	4 (3.4)	
D	0 (0.0)	0 (0.0)	1 (0.9)	0 (0.0)	1 (0.9)	
Total	68 (58.1)	21 (17.9)	20 (17.1)	8 (6.8)	117 (100)	

PA = practice assessment.

Table 4 Comparison of PA Outcomes with Respect to Self-Referral

	No. (%)			<i>p</i> for 2-tailed Fisher exact test
	Outcome A	Outcome B, C, or D	Total	
Outcomes from physiotherapists who self-referred to PA1 vs outcomes for all other physiotherapists in the cohort				
Self-referral	18 (66.7)	9 (33.3)	27 (100)	0.38
Not self-referral	50 (55.6)	40 (44.4)	90 (100)	
Total	68	49	117	
Outcomes from physiotherapists who self-referred to PA2 vs outcomes for all other physiotherapists in the cohort				
Self-referral	14 (100)	0 (0.0)	14 (100)	0.21
Not self-referral	88 (85.4)	15 (14.6)	103 (100)	
Total	102	15	117	

PA = practice assessment.

competent and ethical services.”^{31(p.5)} Its QM program is a component of enacting that mission, and its use of peer PAs fulfills part of its statutory requirement for a quality assurance program. Theoretically, if the CPO's resources were infinite, it would best serve public protection by continuous, detailed assessment of all members. The reality of finite resources, however, means that decisions must be made as to what proportion of members are assessed each year and how often members are eligible to be assessed.

Our findings imply that physiotherapists' competence at meeting the standards assessed in the PA process

is typically maintained for as long as 7 years after completing a previous PA process. From the perspective of practising physiotherapists, re-selection for PA may be considered an unfair burden when other Ontario physiotherapists have never been selected. Nevertheless, it was not universally true that physiotherapists had optimal outcomes on a second PA. Moreover, the CPO is required by statute to prioritize the public interest in all its decisions. To base its decisions about sampling for quality assurance process on empirical evidence, the CPO commissioned the present program evaluation research.

It would be interesting to know why a physiotherapist might achieve a sub-optimal outcome on the second PA. To that end, we are concurrently analyzing the sub-optimal score areas and de-identified narrative comments found in assessment reports and correspondence and intend to report those findings in a separate publication. Preliminary analysis thus far indicates that standards related to keeping thorough records of patient care are the most frequent reason for suboptimal scores and PA outcomes. Consistent with findings reported for both pharmacists and physicians,^{7–11} we are considering both individual demographic factors and practice environment factors as possibly being associated with a higher risk of not fully meeting standards in a peer assessment process.

We are unable to compare our findings with those of any other regulatory body for physiotherapists. To our knowledge, this is the first peer-reviewed publication of longitudinal assessment of continuing competence by a physiotherapy regulatory body. Literature searches in PubMed and CINAHL using search terms such as *professional competence*, *quality assurance*, *professional regulation*, and related terms had extremely low results when crossed with *physiotherapy* or related terms, and no sources provided directly comparative data. Although the professions of medicine and nursing have a more extensive literature on continuing competence, even recent reviews have concluded that there is little consensus on best practices or outcome comparisons for continuing competence, or re-validation, as it is sometimes called.^{5,6,34}

LIMITATIONS

The cohort studied had, by definition, approximately 5–7 years more experience at the time of their PA2 than at their PA1. It is possible that greater experience contributes to greater likelihood of meeting all professional standards; however, a high number of years since graduation has been linked to lower scores on re-assessments of competence among pharmacists.^{7–9} Therefore, we do not have grounds to suggest that experience is linearly and positively associated with competence.

It would have been of interest to examine practice environment factors for the cohort members, both to add to our judgment of the cohort's representativeness with respect to all CPO members and to examine whether these factors are associated with different probabilities of successful PA outcomes. However, these data were not available in any form that could be submitted to statistical analysis.

Finally, the cohort was relatively small from the perspective of statistical analysis. Nevertheless, it bears emphasizing that it is not a sample; rather, it is the entire population of physiotherapists in one regulatory body's jurisdiction who underwent two PAs in the specified time period.

CONCLUSION

It appears that Ontario physiotherapists undergoing a second peer assessment 5–7 years after a first one were very likely to meet all professional standards—indeed, more likely than physiotherapists undergoing a first assessment in the same time frame. The findings are expected to inform the CPO's considerations of how much time should elapse after one peer assessment before a physiotherapist becomes eligible for re-assessment. We acknowledge, however, that these findings may not be generalizable beyond the time frame examined in this cohort because any future substantial shifts in physiotherapists' practice environments or in the standards to which physiotherapists are held in QM assessment may alter the rate of optimal outcomes.

KEY MESSAGES

What is already known on this topic

The CPO has a peer PA process as part of fulfilling its statutory obligations for a quality assurance program. Other regulatory bodies have reported a link between a high number of years since graduation and lower scores on re-assessments of competence.

What this study adds

Ontario's physiotherapists are highly likely to meet all assessed standards in a second PA, more likely than their peers in a first PA. For those whose first PA outcome was suboptimal, the PA process may have had a positive impact that was sustained over time. The findings may inform physiotherapy regulatory bodies in determining frequency of re-assessment eligibility in quality assurance programs.

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