Committee reports

Finance and Audit Committee

The scope of the Finance and Audit Committee is set out in section 1-14 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

The Finance and Audit Committee helps the Board fulfill its mandate by developing the College's budget, regularly reviewing operational and capital expenditures, governing the annual external audit and regularly reviewing the College's systems of financial control.

PROPERTY

During the fiscal year ended February 28, 2019, the College sold one of its strata units comprising 3,173 square feet. The College now owns 59,295 square feet of office space and leases out approximately 5,500 square feet until such time that this space is to be repurposed for College use.

COLLEGE INVESTMENTS

The College's investments are maintained within two types of accounts as follows:

Short-term investment accounts

The primary goal of the short-term account portfolio is to preserve cash or cash equivalents to meet the annual financial obligations for operational expenses of the College, while optimizing investment returns. The allocation of operational funds is currently 100% fixed investments (short-term bonds, cash and/or term deposits). The balance of cash and short-term investments in the operating accounts at February 28, 2019 was $24,082,000 ($24,860,000 in 2017/18).

Long-term investment accounts

The primary goal of the long-term investment portfolio is to preserve capital. The secondary goal is to provide reasonable growth while minimizing risk to meet the long-term financial obligations of the College and to fund major capital projects approved by the Board.

The target allocation for long-term investments is 40% fixed (bonds and cash) and 60% equities (Canadian, US and international). The balance of cash and investments in the long-term accounts at February 28, 2019 was $22,275,000 ($16,543,000 in 2017/18).

Investment income

- Investment income for the 2018/19 fiscal year before any gains, losses, or investment management fees was $1,031,000 ($814,000 in 2017/18)
- Unrealized gains in 2018/19 were $388,000 ($152,000 unrealized losses in 2017/18)
- Realized losses in 2018/19 were $23,000 ($78,000 realized gains in 2017/18)
- Investment management fees in 2018/19 were $81,000 ($78,000 in 2017/18)

TECHNOLOGY

- During the fiscal year 2018/19, the Board internally restricted $4 million to fund an Electronic Document Records Management System (EDRMS), which will be implemented over a four-year period. The EDRMS will improve the processing, storing and retrieval of records as well as maintain retention schedules for archival purposes while reducing the need to store paper files.

S.G. Holland, MD, FRCPC
Chair, Finance and Audit Committee

INFORMATION

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Director, Finance and Corporate Services

Committee reports

Registration Committee

The scope of the Registration Committee is set out in section 1-15 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

PROVINCIALLY

The College Bylaws recognize general/family practice international medical graduates (IMGs) who have not completed jurisdictionally approved and accredited postgraduate training as recognized by the College of Family Physicians of Canada (currently only those IMGs from the United States of America, United Kingdom, Ireland and Australia are so reciprocally recognized), as eligible for provisional registration if they have undergone an assessment of competency (practice ready assessment or PRA) in a Canadian jurisdiction acceptable to the Registration Committee.

British Columbia currently is in the fifth year of the Practice Ready Assessment-British Columbia (PRA-BC) program which is governed by a steering committee made up of representatives from the Physician Services Strategic Advisory Committee, the University of British Columbia, the College of Physicians and Surgeons of British Columbia, the BC Ministry of Health and its health authorities, Doctors of BC, and Health Match BC. The PRA-BC program was developed between 2012 and 2014 to create an acceptable entry-to-practice competency assessment program for general practitioners wanting to practise in British Columbia. The program consists of four components: a screening and selection process; point-in-time orientation and examination phase; a clinical field assessment; and an application for provisional registration and licensure from the College for successful program candidates. The clinical field assessment is 12 weeks in duration in a group general/family practice setting in BC. The first iteration of the PRA-BC program commenced in April 2015. To date, 112 of 115 candidates are now engaged in the independent practice of medicine as family practitioners under sponsorship and supervision. In the next year, there will be 60 candidates that go through the PRA-BC program.

Work continues on updating and developing policies that support the implementation of College Bylaws made pursuant to the *Health Professions Act*. Policy development and implementation has focused on defining parameters around current registration and licensure requirements for the various classes of registration and reviewing and updating the current registration assessment program. Additionally, all current policies will be published on the College website in 2019/20.

NATIONALLY

The College continues to work with the Federation of Medical Regulatory Authorities of Canada (FMRAC) to align registration policies and procedures with other colleges throughout Canada. As part of this work the College is working with several other Canadian jurisdictions on telemedicine, pan-Canadian licensure and portability of a licence for those physicians that meet specific criteria agreed upon by participating jurisdictions.

The College continues to work with the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada and the Medical Council of Canada to ensure current policies, procedures and bylaws of all parties are in alignment.

HIGHLIGHTS IN 2018/19

- 246 IMGs applied for registration in BC
- 26 PRA program-related applications for eligibility were reviewed by the committee
- 137 IMGs previously on the provisional register were advanced to the full class
- 7 GPs completed a registration assessment and were moved to the full class

M.D. Carter, MD, FRCSC
Chair, Registration Committee

INFORMATION

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Executive Director, Registration

T. O'Brien, MBA
Manager, Registration

Committee reports

Inquiry Committee

The scope of the Inquiry Committee is set out in section 1-16 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183 and the *HPA* itself.

The Inquiry Committee performs three regulatory functions central to the mandate of the College:

1. Investigation of complaints and reports concerning College registrants, received from a variety of sources.
2. Practice investigations initiated by the Inquiry Committee on its own motion.
3. Oversight when a physical or mental health disorder may impair the ability of the physician to practice safely and effectively. In such circumstances, if the physician is appropriately engaged and compliant with treatment to the satisfaction of the health monitoring department, the Inquiry Committee is not required to take further action.

This past year, 28 Inquiry Committee members (17 physicians and 11 public members) were divided amongst five specialized panels. The total number of complaints and reports received is remarkably constant in proportion to the number of registrants—roughly one per 12 actively practising physicians. The net number of practitioners is increasing; so too is the number of complaints. Including files for own-motion practice investigations, the Inquiry Committee opened 1068 investigations in 2018/19 (compared to 1012 the year before). Of 860 concluded, for 322 (37%) the Inquiry Committee was critical of some aspect of the conduct or clinical performance of the subject physician(s). All but five of those were resolved remedially with one or more of the options described below.

Concerns brought to the attention of the College are initially triaged and categorized as primarily matters of clinical performance, physician conduct, boundary violations (which may include sexual misconduct or a variety of other breaches such as inappropriate business or financial entanglement, self-disclosure or dual relationships), and fitness to practise issues. Statistics for 2018/19 are tabulated in this report.

The Inquiry Committee is specifically tasked in the *HPA* with establishing review procedures that are transparent, objective, impartial, and fair. Following a thorough investigation, the Inquiry Committee must determine whether the available evidence forms an adequate basis for criticism of the registrant. Given that most complainants are not medically trained, sometimes the investigation identifies unacceptable conduct or deficient clinical performance that the complainant was unaware of or unable to recognize or articulate. When the Inquiry Committee concludes a review with criticism, the *HPA* provides three options for resolution, depending on the seriousness of the concern. In ascending order of seriousness:

- informal resolution through correspondence, interviews, and/or educational activities
- formal consequences, short of discipline, including reprimands, fines and practice limitations entered into voluntarily
- referral to the registrar with direction to issue a citation and commence disciplinary proceedings

In 2018/19, new disciplinary citations were authorized against three physicians and five matters were concluded with disciplinary outcomes. All disciplinary decisions are published and may be found on the College website.

The majority of complaints prompting the issuance of a citation are ultimately resolved through consent orders pursuant to section 37.1 of the *HPA*. If a consent resolution is not possible, the matter proceeds to a hearing before a panel of the Discipline Committee. There were no Discipline Committee hearings held in 2018/19. Five disciplinary matters were concluded. Summaries of discipline decisions are posted on the College website.

CONDUCT, ETHICS AND PROFESSIONALISM

Timely provision of third-party reports and failure to respond to the College continue to account for a large number of College complaints. Consequences for patients can be dire when their physicians fail to provide the documentation required to access income during periods of disability. Similarly, the College cannot effectively fulfill its public protection mandate when registrants do not fully cooperate with its investigations. Remedies follow a trajectory of progressive discipline—warnings for a first offence to discipline if an earlier investigation for similar conduct has concluded with a formal undertaking committing to future compliance. In 2018/19, three of five disciplinary outcomes were for tardy provision of records, reports and responses.

Physicians must complete College application and renewal forms accurately. A physician who omitted licensure and cancellation in another jurisdiction was subject to a published reprimand, fine and other disciplinary consequences.

Deficiencies in the conduct of physical examinations may cause patients to feel inadequately respected, sometimes triggering a sense of having been abused by the doctor. The College has posted an animated video setting out expectations when patients are required to disrobe for examinations, to supplement the *Physical Examinations and Procedures* practice standard. The video has been positively received by educators and other regulators. In the event of a complaint alleging misconduct associated with examination technique, the Inquiry Committee considers the process outlined in the video to be the expected

standard. Physicians, medical trainees and members of the public are encouraged to view it.

Criminal code amendments permitting medical assistance in dying (MAiD) made Canada one of a very small number of jurisdictions in the world permitting patients control over the timing and manner of their dying in specified circumstances. College registrants have responded to patient requests within the legal framework and College standard very well. Complaints have largely been limited to deficiencies in the provision of documentation and, occasionally, expressed annoyance when responding to requests for clarification from the Provincial MAiD Oversight Unit. The Inquiry Committee recognizes that physicians are challenged by the large number of forms and reports required of them, but reminds registrants that MAiD is unique among clinical activities for being governed by provisions in the Criminal Code. MAiD forms must be completed in strict accordance with protocols and queries from MAiD Oversight Unit staff addressed promptly and respectfully.

Expressed anger in the course of medical practice may be considered unprofessional conduct. The Inquiry Committee receives complaints from pharmacists, nurses, staff of health authority and Ministry of Health programs, physicians, office staff and others alleging verbal abuse by College registrants. Remedial interviews, educational interventions focusing on professionalism and communication, and formal reprimands are typical outcomes.

Finally, the Inquiry Committee continues to receive complaints about breaches in the *Telemedicine* standard. In 2018/19, the most common was from other jurisdictions in circumstances where BC physicians have provided telemedicine services to patients located outside the province in contravention of rules that apply where the patient is located. The legal framework for telemedicine varies widely. The College expects registrants to be familiar and comply with laws in effect where their patients reside and will investigate on receipt of complaints from other regulators.

CLINICAL PERFORMANCE

Public protection is the sole mandate of the College. Accordingly, safe prescribing of opioids and sedatives remains an abiding concern. The practice standard *Safe Prescribing of Opioids and Sedatives* has been regularly updated and revised. Physicians are encouraged to review it. Emerging themes in complaints include access to care for unattached patients already receiving long-term opioids (expectations are summarized in this article in the *College Connector*), approaching desirable dose reductions in a process of shared decision-making with patients, recognizing the emergence of opioid-use disorders affecting chronic pain patients and referring proactively (a missed OUD diagnosis can be fatal), and ensuring that long-term opioid patients are not abandoned when the physician retires or leaves practice for other reasons. The Inquiry Committee receives many prescribing complaints, alleging practices that are too liberal or too restrictive in roughly equal numbers. As in other areas of practice, whether the investigation concludes with criticism of the physician will depend on whether the patient record contains a well-documented, defensible rationale for the care provided.

The Inquiry Committee recognizes prescribing of potentially addictive medications as one of the most challenging aspects of clinical practice. Accordingly, the approach to deficient performance is invariably remedial. The College has not disciplined a physician for prescribing unsafely in over 25 years. The expectation is engagement in practice improvement. Physicians want to prescribe safely and work hard to improve their practices when the Inquiry Committee becomes involved.

Failure to perform and document clinically-indicated physical examinations and/or investigations in circumstances that mandate them are common sources of complaints. This past year the Inquiry Committee has been critical of physicians for not performing breast examinations when patients reported palpable lumps and vaginal examinations for bleeding and other symptoms. A complaint of rectal bleeding or hematuria requires investigation in every instance—failure to do so will trigger College intervention, usually including an investigation of competence.

Finally, documenting an adequate consent discussion prior to procedures that mandate explicit consent is a recurring point of criticism. Physicians are encouraged to review the best practice advice of the CMPA on documenting consent. A general statement to the effect that "risks, benefits and alternatives were discussed" is inadequate. Specified material risks must be disclosed to the patient and listed in the record.

BOUNDARY VIOLATIONS AND DISCIPLINARY MATTERS

Again in 2018/19, most sexual boundary complaints reviewed by the Inquiry Committee were determined to have been misperceived examinations and addressed with physician education and remediation. There were no disciplinary orders for sexual misconduct.

The College continues to offer a highly-rated workshop addressing the spectrum of professional boundary conduct concerns.

SIGNIFICANT EVENTS IN 2018/19

Mr. Harry Cayton's report *An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* presented to the Minister of Health in December 2018 gave considerable emphasis to opportunities to rationalize and streamline complaint investigation processes, including an explicit focus on patient safety. The Inquiry Committee looks forward to contributing to and operationalizing reforms that it hopes and anticipates Mr. Cayton's recommendations will inspire.

P.D. Rowe, MD, CCFP (EM), FCFP
Chair, Inquiry Committee

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Committee reports

Patient Relations, Professional Standards and Ethics Committee

The scope of the Patient Relations, Professional Standards and Ethics (PRPSE) Committee is set out in section 1-18 of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183. The PRPSE Committee reports directly to the Board.

The PRPSE Committee administers a patient relations program to prevent professional misconduct of a sexual nature and to serve as a resource to the Board in matters pertaining to standards of practice and standards of professional ethics in medical practice. The committee identifies opportunities for stakeholder consultation and provides guidance throughout the revision process for practice standards and professional guidelines.

SAFE PRESCRIBING OF OPIOIDS AND SEDATIVES

The PRPSE Committee gathered feedback from over 180 participants in a second consultation held to assess the *Safe Prescribing of Opioids and Sedatives* practice standard. Using the input received as guidance, several minor revisions were made by the committee and the revised standard was published to the College website. The committee offered support in the creation of an informative video, which was published alongside the practice standard to help communicate the College's position on key principles.

STANDARDS RELATED TO CONTINUITY OF CARE

The committee consulted the public and the profession on three different standards related to continuity of care: *Leaving Practice, Ending the Patient-Physician Relationship*, and *Care Coverage Outside Regular Office Hours*. Roughly 300 participants offered their feedback, resulting in several revisions to the practice standards. In addition to reviewing these standards, the committee identified the need to communicate continuity of care practice expectations to the public, particularly in the walk-in clinic setting. A supporting public resource outlining walk-in clinic care expectations was created.

ADDRESSING SEXUAL MISCONDUCT

The committee directed that staff do an environmental scan of how other comparable jurisdictions deal with complaints of professional misconduct of a sexual nature to determine if changes should be considered as to how the College deals with such complaints. This resulted in identifying the need to educate the public on appropriate physician behavior in conducting physical examinations. The committee provided direction in the creation of an informative video, which has helped communicate clear expectations on appropriate techniques for the gowning and draping of patients.

REFERRAL-CONSULTATION PROCESS

The *Referral-Consultation Process* professional guideline underwent two separate consultations. During the first consultation, the committee gathered feedback from over 1,200 participants, including self-nominated specialist and family practitioner representatives who were invited to attend the committee meeting. Due to the vast amount of feedback received, complexity of the issue, and the substantial changes made to the guideline, the committee identified the need to hold a second consultation on this guideline before reaching consensus on a final version. Roughly 250 participants took part in the second consultation on the revised *Referral-Consultation Process* guideline, and after reviewing the consultation feedback and making a few further revisions, a final version of the guideline was published.

STANDARDS AND GUIDELINES RELATED TO MEDICINE AND COMMERCE

With direction from the Board, the committee began a review of all practice standards and professional guidelines related to commerce and medicine.

The first pair of standards up for review were the previously titled S*ale and Dispensing of Drugs by Physicians and Promotion* and *Sale of Products*. The committee initiated a consultation which gathered feedback from 145 participants. Following this consultation, the committee revised the *Promotion and Sale of Products* standard and republished it with the title *Promotion and Sale of Medical Supplies and Devices*. The committee identified the need for further consultation on the *Sale and Dispensing of Drugs by Physicians* standard and will publish in the following fiscal year.

The committee reviewed the *Conflict of Interest* practice standard, revised it to include principles from the existing *Conflict of Interest Arising from Clinical Research* professional guideline, and incorporated new sections outlining conflict of interest as it relates to a physician's relationship with industry and education. The committee consulted with 163 stakeholders, and used the feedback received to guide multiple major revisions to the standard. The committee indicated the need to spend more time assessing the revisions to the *Conflict of Interest* practice standard and will publish in the following fiscal year.

S. Ross
Chair, Patient Relations, Professional Standards and Ethics Committee

INFORMATION

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S. Prins, MEd
Director, Communications and Public Affairs

Committee reports

Physician Practice Enhancement Panel

The scope of the Physician Practice Enhancement Panel of the Quality Assurance Committee is set out in section 9-1 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

The Physician Practice Enhancement Panel is comprised of five family medicine physicians, three specialty physicians, and five public members, and provides oversight to the Physician Practice Enhancement Program (PPEP), which assesses the professional performance of a registrant, and the Physician Office Medical Device Reprocessing Assessments (POMDRA) program, which assesses the reprocessing of reusable medical devices in accordance with criteria established by the Board.

PPEP OVERVIEW

Under the College Bylaws, an assessment of professional performance may include any of the following:

- a review of specified or random patient records
- an on-site peer assessment of the registrant's practice
- permitting assessors appointed by the committee to assess the premises where the registrant engages in the practice of medicine
- the collection of information from a registrant's peers, co-workers, or patients for the purposes of obtaining feedback about the registrant's professional performance
- a review of the patterns of prescribing, referral, and ordering diagnostic tests by the registrants
- any other method of quality assurance approved by the Board for the purposes of this part

During a PPEP assessment, a physician may be required to participate in five assessment components:

- peer practice assessment of recorded care
- multi-source feedback assessment
- review of their PharmaNet prescribing profile
- office assessment
- physician interview with feedback and coaching

PPEP assessments provide external evaluation using multiple measures to assess performance, knowledge and skills, as well as educational support to ensure physicians meet appropriate and current standards of practice throughout their professional lives. The goal of the program is to promote quality improvement in community-based medical practice by encouraging physicians to take a more proactive role in their own continued professional development, all with the ultimate goal of improving patient care.

POMDRA OVERVIEW

This College initiative proactively assesses the reprocessing of reusable semi-critical and/or critical medical devices in community-based physician offices and provides support and education to physicians and office staff so they can continue to provide safe care to their patients. This program is based on the requirements outlined in the Ministry of Health *Best Practices for Cleaning, Disinfection and Sterilization for Critical and Semi-Critical Medical Devices* (2011) and the Canadian Standards Association (CSA) medical device reprocessing standard. POMDRA applies to physicians who practice in a community-based office setting whether in a solo office or multi-physician clinic. The program does not apply to clinical offices or outpatient clinics affiliated with a health authority or hospital as these bodies have their own evaluation process.

PROGRAM DEVELOPMENT

PPEP continues to actively assess physicians, prioritizing the assessment of physicians aged 70 and above and those who are practising in solo and unsupported environments. It is the intent of the program that all community-based physicians have a periodic assessment, with those requiring ongoing remediation assessed on a more frequent basis. Where possible, physicians working in walk-in clinics and group medical practices are assessed simultaneously to recognize and address systemic issues and practices that may need to be brought to the attention of the medical director of the clinic.

In 2018, PPEP adapted the College of Physicians and Surgeons of Ontario (CPSO) Peer and Practice Assessment Program's redesigned assessment tools for family medicine and psychiatry assessments. These CPSO assessment tools were developed in association with the principles of the Royal College of Physicians and Surgeons of Canada (RCPSC) CanMEDS and the College of Family Physicians of Canada's (CFPC) CanMEDS family medicine framework. These new assessment tools, revised for BC family medicine and psychiatry assessments, include eight assessment domains and define high-quality care within each domain. The new tools also outline specific assessment criteria to guide external and internal evaluation and to continue the program's transition to a quality improvement orientation.

POMDRA continues to assess community-based physician offices and provide support to physicians and office staff on medical device reprocessing (MDR) practices. As part of ongoing program

improvements, POMDRA streamlined the assessment process to enable MDR assessors to conduct on-site assessments earlier with more custom feedback.

ASSESSMENTS

In 2018, the PPEP program assessed 600 community-based physicians, with the most common opportunity for improvement being record keeping. The requirement for medical record documentation is outlined in the College's *Medical Records* practice standard; part 3, section B of the College Bylaws; and the PPEP assessment standard *Unified Medical Record* for family physicians. A medical record needs to document an intellectual footprint to allow for continuity of care by other health professionals, including locums. For physicians practising in a multi-physician clinic, including walk-in clinics, the medical record includes requirements directed under the College's *Walk-in, Urgent Care and Multi-physician Clinics* practice standard and the PPEP assessment standard *Medical Director/Solo-practice Physician*. Multi-physician clinics are also required to have a system in place to capture detailed recorded care, a cumulative patient profile, and an identified most responsible physician.

In 2018, more than 2,500 physicians identified on their Annual Licence Renewal Form that they reprocess semi-critical and/or critical reusable medical devices in their community-based clinical office. Of the identified physicians, POMDRA communicated and supported 1,126 physicians in 289 clinics with their medical device reprocessing practices. POMDRA assessed 225 of those identified physician offices. In the two years since the program was launched, POMDRA assessors have marked the improvement in community-based physician offices using quality assurance parameters in steam sterilization, particularly the use of biological indicator and chemical indicator (internal/external) testing. Common deficiencies in steam sterilization practices include: the lack of biological indicator and chemical indicator (internal/external) testing; packaging of medical devices in preparation for sterilization; incorrect cleaning product or detergent; no documentation of physical monitoring including the time, temperature, and pressure of the steam sterilizer; and no logbook or record keeping.

HIGHLIGHTS IN 2018/19

Number of community-based PPEP assessments	601
Registrants agreeing/strongly agreeing that assessment was worthwhile experience	57%
Registrants agreeing/strongly agreeing that their practice changed as a result of the assessment	56%
Number of POMDRA on-site assessments	225

B.A. Priestman, MD, FRCPC
Chair, Physician Practice Enhancement Panel

INFORMATION

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Committee reports

Prescription Review Panel

The scope of the Prescription Review Panel of the Quality Assurance Committee is set out in section 9-2 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

The Prescription Review Panel gives oversight to the Prescription Review Program (PRP). Under the College Bylaws, its main responsibilities include:

- reviewing the prescribing of controlled medications with potential for harm, such as opioids, benzodiazepines, sedatives/hypnotics and stimulants
- providing guidance to registrants on the use of these drugs by:
    - corresponding with physicians
    - facilitating self-reflection on prescribing practices through an examination of select patient records
    - holding face-to-face or phone interviews with registrants
    - assigning readings
    - providing relevant educational offerings

The PRP is a quality assurance program, informed by the PharmaNet database. Its approach to prescribing issues is collegial and emphasizes an educational focus. When the College contacts physicians who appear to be experiencing challenges with safe prescribing, it is an offer to be helpful. Most find maintaining the status quo challenging, and are grateful for the intervention. In keeping with the educational spirit of these endeavors, these activities qualify for Mainpro-M1 credits in the practice audit category.

In addition to correspondence and self-reflection, the PRP recommends formal education in the form of the Prescribers Course. The Prescribers Course assists physicians with strategies for managing complex chronic pain patients taking opioids. Half of the day is spent in practice interviews with standardized patients. The Prescription Review Panel continues to recommend attending this course for registrants that struggle with safe prescribing despite the interventions of the PRP.

A survey is sent to each physician who has completed any stage of the PRP process. The process and the proceedings of the Prescription Review Panel have evolved continuously based on this feedback.

The panel is motivated by the public health crisis associated with the dramatic increase in long-term opioid prescribing in the past decade. Prescription opioid misuse is a contributor to the development of the opioid crisis. Accordingly, the panel gives emphasis to promoting primary prevention through:

- Careful patient selection—a history of addiction and/or mental illness is a strong relative contraindication to long term opioid prescribing.
- An approach that includes firmly declining to prescribe new combinations of opioids with benzodiazepines and/or sedative hypnotics. There is an expectation that physicians advise their patients of the dangers of combining these medications. Efforts are then needed to address the associated health risks.
- Engaging patients in long-term solutions for their health concerns rather than simply refusing to treat them or abruptly stopping pharmacotherapy.

There has been a natural trend in BC towards better prescribing. Now, though, with a heightened focus on addiction medicine and opioid agonist treatment, the panel anticipates that irregular or problematic prescribing in this realm will be an upcoming challenge that will need to be addressed by both the PRP and the Prescription Review Panel.

HIGHLIGHTS IN 2018/19

Prescription Review Program

- 264 referrals received and processed
    - 53 referrals resulted in a program medical consultant writing a letter, email or scheduling a phone call with physician
    - 61 files were entered into the formal process: 80% had not had a previous engagement with the PRP
- 136 files closed; 86% closed for an improvement in prescribing
- Average lifespan of a file was 22 months (down from 26 months in previous year)
- 137 files currently open, in various stages
- Well-attended educational offerings:
    - Sponsorship of the Foundation for Medical Excellence Chronic Pain Management Conference – March 1 to 2, 2019
    - Prescribers Course offered on-site in May and September with 18 and 34 participants respectively

Prescription Review Panel

- 33 files were brought to panel in 2018/19
- Outcomes from panel:
    - 7 files were referred to the Inquiry Committee
    - 7 files were referred for a first interview (physician and medical consultant), two for a second interview (physician with legal counsel present)
    - 6 files were referred to an educational course
    - 2 files were requested to submit an action plan
    - 7 files were closed
    - 4 files were brought forward to the next meeting for further review

B.A. Fleming, MD, FRCPC
Chair, Prescription Review Panel

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M. Horton, MPH
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Committee reports

Non-Hospital Medical and Surgical Facilities Accreditation Program Committee

The scope of the Non-Hospital Medical and Surgical Facilities Accreditation Program Committee is set out in section 5-1 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

As legislated by the Ministry of Health, the Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) currently accredits 53 private surgical facilities within BC. Program accreditation is recognized as a standard that demonstrates a facility's commitment to delivering safe, quality health care.

The committee's overriding interest is the protection and safety of the public through ensuring quality and safe patient care delivery in the non-hospital sector. The committee promotes excellence in medical and surgical services through establishing accreditation standards, evaluating performance and monitoring outcomes. As part of the College's overarching objectives, the committee annually reviews and updates its three-year strategic plan (current version 2017–2020). The committee continued to support the College's strategic plan though its three strategies of strengthening the roles of the medical director, the committee, and the program as well as enhancing communication and engagement with key stakeholders.

1. **Strengthening the role of the medical director**

   The medical directors of non-hospital medical and surgical facilities have a responsibility for the overall quality of care provided in their facilities. Effective leadership, accountability and quality assurance are essential components of the work they do. The committee supported the work of medical directors through

   - the review and evaluation of medical directors' applications for appointment at facilities,
   - the review of patient safety incidents and recommendations to the medical director for improvements within their facility,
   - ongoing communication on issues of clinical importance,
   - interviews with all new medical directors to ensure an understanding of their roles and responsibilities, and
   - facility-specific advice and guidance.

2. **Strengthening the role of the committee**

   The College carries out its regulatory functions through its committees comprised of clinical experts and public members. To ensure the committee is able to carry out its mandate, it must understand its role and function, have the necessary information, and actively participate in decision-making. The role of the committee was strengthened through

   - support for patient safety incidents review—the committee reviews approximately 250 patient safety incidents annually, supported by input from clinical staff,
   - annual evaluations of committee performance to ensure adequate support, management, and effectiveness, and
   - ongoing development and review of standards related to Interventional pain management, including the launch of a public consultation process.

3. **Strengthening the role of the program**

   Regulatory excellence requires high-functioning supports in human resources, business processes and information technology. The role of the program was strengthened through

   - analysis of accreditation processes and data systems in collaboration with the College's Diagnostic Accreditation Program,
   - review of program fees to ensure ongoing commitment for a cost neutral budget, and
   - ongoing development and implementation of a quality management system.

4. **Enhancing communication and engagement with key stakeholders**

   Effective, collaborative relationships with stakeholders are critical in establishing and upholding standards for the delivery of safe patient care in non-hospital medical and surgical facilities. Communication and engagement with key stakeholders was enhanced through

   - planned consultations and feedback provided to facilities pre- and post-accreditation assessment, and
   - ad hoc meetings with the Ministry of Health on various issues of policy.

HIGHLIGHTS IN 2018/19

The NHMSFAP witnessed the following activity:

- 1 new private medical/surgical facilities opened
- 5 private medical/surgical facilities closed
- 53 private medical/surgical facilities were operating in BC
- 13 private medical/surgical facilities were accredited as part of their four-year accreditation cycle or focused visit, of which:
    - 9 were granted a four-year full accreditation
    - 4 were granted accreditation subject to a report

With respect to procedures performed by facilities, the NHMSFAP reports the following:

- 70,831 procedures were performed in private medical/surgical facilities across the province (including laser refractive procedures)
- 43% of procedures performed (excluding laser refractive procedures) were publicly funded cases (e.g. MSP or health authority)
- 4% of procedures (excluding laser refractive procedures) were contracted by a third party (e.g. WorkSafe BC, ICBC, federal government)
- 696 physicians were authorized by the College to provide medical services in one or more private medical/surgical facilities

B.C. Bell
Chair, Non-Hospital Medical and Surgical Facilities Accreditation Program Committee

INFORMATION

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Committee reports

Diagnostic Accreditation Program Committee

The scope of the Diagnostic Accreditation Program Committee is set out in section 5-25 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

The Diagnostic Accreditation Program (DAP) has a mandate to assess the quality of diagnostic services in the province of British Columbia through accreditation activities. As a program of the College, the mandate and authority of the DAP is derived from section B of the Bylaws of the College made under the *Health Professions Act*.

ACCREDITATION

The DAP is committed to promoting excellence in diagnostic health care through the following activities:

- establishing performance standards that are consistent with professional knowledge to ensure the delivery of safe, high-quality diagnostic services
- evaluating a diagnostic service's level of actual performance to achieving the performance standards
- monitoring the performance of organizations through the establishment of external proficiency testing programs and other robust quality indicators of performance

The DAP currently has 24 accreditation programs covering the following diagnostic services:

Diagnostic imaging

- diagnostic radiology
- diagnostic mammography
- diagnostic ultrasound
- diagnostic echocardiography
- diagnostic computed tomography
- diagnostic magnetic resonance imaging
- diagnostic nuclear medicine
- diagnostic bone densitometry

Laboratory medicine

- sample collection, transport, accessioning and storage
- hematology
- chemistry
- transfusion medicine
- microbiology
- anatomic pathology
- point of care testing
- cytology
- cytogenetics
- molecular genetics

Neurodiagnostic services

- electroencephalography
- evoked potentials
- electromyography and nerve conduction studies

Pulmonary function

- hospital-based services
- community-based services

Polysomnography

- adult and pediatric polysomnography

HIGHLIGHTS IN 2018/19

Public and private accreditations

The DAP provides accreditation for 684 diagnostic services of which are 398 are public and 286 are private.

	Public	Private	Total
Laboratory medicine	165	157	**322**
Sample collection sites	34	135	**169**
Laboratories	131	22	**153**
Diagnostic imaging	144	62	**206**
Pulmonary function	58	17	**75**
Neurodiagnostics	24	39	**63**
Polysomnography	7	11	**18**
Total	**398**	**286**	**684**

Number of facilities surveyed

Laboratory medicine	82 on-site surveys (38 laboratories and 44 sample collection sites)
	17 sample collection sites self-audits that assessed 1 service
	1 regional assessment that assessed 8 services
	10 relocation assessments that assessed 2 services
Diagnostic imaging	60 on-site surveys that assessed 215 services
	3 relocation assessment that assessed 5 services

Pulmonary function	4 on-site surveys that assessed 22 services
Neurodiagnostics	29 on-site surveys that assessed 18 services
Polysomnography	6 on-site surveys that assessed 6 services
Total	**212 surveys**

Initial assessments for new facilities

Diagnostic imaging	15 that assessed 16 services
Laboratory medicine	2 that assessed 4 services
Total	**17 surveys**

PROGRAMS AND OPERATIONS

DAP standards

The laboratory medicine accreditation standards were revised and released as version 1.4 in August 2018, with an effective date of implementation of February 2019. The primary goal of this version release was to fulfill the continuous quality improvement process of review, revise and release current and relevant standards.

Position statements

DAP position statements are the result of analysis of currently available information and research, stakeholder review including the BC Ministry of Health as necessary, and DAP Committee review. Position statements on the following issues were approved by the DAP Committee in 2018/19:

- DAP Accreditation of Genetic Testing Laboratories and Direct-to-Consumer Testing
- Diagnostic Polysomnography Home Sleep Testing
- Handling Information Related to Peer Review in Diagnostic Facilities
- Credentialing Requirements for Pulmonary Function Testing
- Accreditation Requirements for Community Based Non-Laboratory Facilities
- Accreditation Requirement for Mobile Phlebotomy Services

Quality management system

The DAP continued the implementation and refinement of a robust quality management system. New in the 2018/19 fiscal year were improvements to the new employee orientation, training, and competency process; assessor training enhancement; development of commonly used and approved terms and definitions document to promote consistency in language; revised procedures to ensure the security of physician credentialing records; and formalization of the dispute resolution process.

Stakeholder engagement

The DAP engages in dialogue to better understand and respond to the needs of our accreditation stakeholders through a number of opportunities. The DAP participated in 37 stakeholder engagements during this past fiscal year, including:

- Advisory committee meetings
- External committee meetings (e.g. Lab Agency, Medical Imaging Advisory Committee, etc.)
- Ministry of Health meetings (ad hoc)
- Health authority meetings
- Diagnostic facilities and medical directors

Assessments of the DAP

The DAP is assessed for the work it does and some of the standards used through the International Society of Quality in Health Care (ISQua). The DAP has held this accreditation since 2011. The DAP has recently had both its diagnostic imaging and laboratory medicine standards assessed by ISQua. At the request of the International Society for Quality in HealthCare, the DAP reviewed and provided feedback on the ISQua organizational standards (2015) that will go into effect in 2019.

The DAP committed in 2017 to submit the application for a peer evaluation to ISO 17011:2017 and the opportunity to become part of the Mutual Recognition Arrangement (MRA) with other international accreditation bodies. In pursuit of that designation, the DAP secured an ISO 17011 consultant to provide a mock pre-peer evaluation of the DAP's readiness for an external evaluation. The DAP completed the Asia Pacific Laboratory Accreditation Cooperative (APLAC) self-assessment in May 2018 and was evaluated by Ned Gravel June 26 to 28, 2018. The closing statement on the report's executive summary was:

> *"The evaluation team was impressed with the expertise of staff; the rigor of the overall approach to accreditation and knowledge of and adherence to procedures aimed at patient safety and care."*

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Chair, Diagnostic Accreditation Program Committee

INFORMATION

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Committee reports

Library Committee

The mission of the library is to provide physicians in British Columbia with easily accessible, high-quality, reliable, and current clinical information to protect the public.

In support of the library's mission and 2017–2020 strategic priorities, the Library Committee and library staff were engaged in the following activities:

SERVICE DELIVERY

Article delivery, literature searches, teaching, provision of electronic resources, and outreach are the core activities of the library.

- Regarding provision of published documents, over 50,000 articles were downloaded by staff and registrants. A key source of these articles were the library's subscriptions to over 6000 e-journals. Licensing for e-journal access was arranged either directly between the library and the journal vendors or through the library's membership with the Electronic Health Library of BC library consortium.
- Registrants posed 1,267 requests for literature searches in 2018/19. College librarians searched Medline and other health databases dependent upon the nature of each query. An internal peer review process is used to ensure best practices in literature search strategy development.
- The library offers online resources relevant to a wide breadth of medical specialties. DynaMed Plus was a significant new acquisition, a point of care tool reported to be equivalent in quality to UpToDate and BMJ Best Practice. The library's electronic book collection continued to grow and showed a 2.5-fold increase in usage compared to 2017. An example of current, timely ebook content was the 2019 edition of Decker: Pain Management, available through the online catalogue.
- Librarians contacted 237 registrants at 23 outreach events in the form of College-organized courses, medical conferences, and one-to-one literature search training. This was fewer than 2017 due to several factors including a temporary hiatus for the Finding Medical Evidence workshop that was revamped in 2018 to include reflective learning components and to offer more CPD credits. The new course, FAST EVIDENCE, will launch in 2019.

SERVICE TRANSFORMATION

Providing ease of access to high-quality electronic information resources is a high priority.

- A technical solution has been developed to integrate library resources into electronic medical record (EMR) systems with a simplified approach to single sign-on authentication. Discussions with a selected EMR provider launched with a review of the single sign-on prototype.
- An app developer was engaged to create an app to make mobile access to library resources simpler and more direct. After considerable effort, a serviceable app could not be delivered due to the unique resources in the library's electronic collection. Other opportunities to develop an app will be investigated.

PROMOTION

- A pilot project concluded in mid-2018 designed to engage key knowledge leaders (physicians identified by other physicians as influential) with the library's literature search service. Emailed invitations to submit literature search requests resulted in one registrant replying with search requests for every 40 invitations to the key knowledge leaders. The project then expanded to all registrants beginning in late 2018, starting with 1000 physicians per month being invited to submit a literature search request. This resulted in approximately one in 63 registrants replying to each emailed invitation. This promotion plan will continue on a monthly basis such that all registrants will be contacted once per year.
- An email-based promotion of web resources to all registrants highlighted specialty-specific library online content. Use of selected resources identified in the emails (drug information, patient education, and clinical knowledge resources on the library's website) increased by 14 per cent in the month following the delivery of the emails.

HIGHLIGHTS IN 2018/19

Individual physicians served (excluding self-serve through the website)	1,865
Total contacts between staff and registrants	11,373
Literature search requests	1,267
Articles delivered	51,906
Ebook chapters viewed	25,988

B. Penner, QC
Chair, Library Committee

INFORMATION

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