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 BC 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*.

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 2019/20

The DAP conducted assessments of facilities in 2019/20 as follows:

- 188 reassessments scheduled
- 185 reassessments completed
- 98% reassessments complete
- 0 reassessments deferred/revised award
- 486 services assessed on-site

PROGRAMS AND OPERATIONS

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 released in 2019/20:

- Accreditation of Overnight Oximetry in Community Spirometry
- Mobile Community Spirometry
- Point-of-care Diagnostic Tests Exempt from DAP Accreditation

Quality management system

The DAP continued the implementation and refinement of its quality management system. The Quality Improvement Committee, which met nine times during the year to review opportunities for improvement, examined the results of external assessments and internal audits, key performance measures, nonconforming event trending, complaints, and improvement project status. Thirty-two participants engaged in 11 different quality training programs, and the DAP offered assessor training to 33 assessors.

Stakeholder engagement

The DAP engages in dialogue to better understand and respond to the needs of its accreditation stakeholders through several channels. The DAP participated in 59 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 submits both its diagnostic imaging (DI) and laboratory medicine (LM) standards for assessment by ISQua. The ISQua organizational assessment, which is an on-site assessment conducted every four years by an international assessment team, occurred on-site at the DAP from April 23 to 26, 2019. The DAP submitted a 90-page self-assessment and more than 200 pieces of evidence to ISQua. The assessment team awarded the DAP organizational accreditation and noted several areas where the DAP demonstrated exceptional performance.

The Asia Pacific Accreditation Cooperative (APAC) evaluates accreditation bodies in the Asia Pacific economies for their compliance to ISO/IEC 17011 General requirements for accreditation bodies accrediting conformity assessment bodies. Those accreditation organizations that successfully meet the standard are invited to sign on to the APAC Mutual Recognition Arrangement (MRA). As a signatory to the APAC MRA, laboratory testing services accredited by the DAP to the ISO 15189 standard are accepted internationally. The DAP intends to make application to APAC in 2020/21 for evaluation by APAC peer evaluators with the goal of becoming an APAC MRA signatory.

Dr. R.C. Reyes, MD
Chair, Diagnostic Accreditation Program Committee

INFORMATION

For more information regarding this report, please contact:

M.J. Murray, MD, CCFP(EM), MHSc, CHE
Deputy Registrar

J.D. Agnew, PhD, MBA
Director, Accreditation Programs

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

The College owns 59,295 square feet of office space at 669 Howe Street, Vancouver, BC and currently leases out approximately 5,500 square feet to two tenants. Subsequent to the fiscal year ended February 29, 2020, one of the tenants issued a lease termination notice effective September 30, 2020. The lease agreement with the other tenant ends in June 2022 with an option to renew for another three-year period. Prior to expiry of this lease, an evaluation will be conducted for future space requirements to determine what portion of this space, if any, can continue to be leased and what portion may need to be repurposed for future 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 29, 2020 was $23,733,000 ($24,082,000 in 2018/19).

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 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 29, 2020 was $25,375,000 ($22,275,000 in 2018/19).

Investment income

- Investment income for 2019/20 before any gains, losses, or investment management fees was $1,093,000 (1,031,000 in 2018/19)
- Realized gains in 2019/20 were $447,000 ($23,000 realized losses in 2018/19)
- Unrealized gains in 2019/20 were $270,000 ($388,000 unrealized gains in 2018/19)
- Investment management fees in 2019/20 were $70,000 ($81,000 in 2018/19)

TECHNOLOGY

In the prior fiscal year, the College Board internally restricted $4 million to fund an enterprise content management (ECM) system (formerly referred to as an electronic document and records management system), which will be implemented over a three-year period. The ECM will improve the processing, storing and retrieval of documents and records as well as maintain retention schedules for archival purposes, while reducing the need to store paper files.

During the 2019/20 fiscal year, the College spent $166,000 on the ECM project and expects the initial implementation and use of the system to occur in 2020. Further development of the ECM system will occur over the next two fiscal years.

SUBSEQUENT EVENT

Subsequent to February 29, 2020, the COVID-19 outbreak was declared a pandemic by the World Health Organization (WHO). This situation presents uncertainty over the College's future cash flows and may affect the College's future operations. Potential impacts on the College's operations could include future decreases in investment income and valuation of investments. As this situation is dynamic and the ultimate duration and magnitude of the impact on the economy are not known, an estimate of the financial effect on the College is not practicable at this time.

B.A. Priestman, MD, FRCPC
Chair, Finance and Audit Committee

INFORMATION

For more information regarding this report, please contact:

M. Epp, MBA
Chief Operating Officer

J. Pesklevits, CMA (IMA)
Director, Finance and Corporate Services

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 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 practise safely and effectively. In such circumstances, if the physician is appropriately engaged and compliant with treatment to the satisfaction of the confidential College health monitoring program, the Inquiry Committee is not required to take further action. The College explicitly treats health matters therapeutically.

This past year 27 Inquiry Committee members (16 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 to 13 registrants actively practising. The past year there was a modest decline in the number of new complaints. Including files for own-motion practice investigations, the Inquiry Committee opened 993 investigations in 2019/20 (compared to 1,068 the year before). Of 1,074 concluded, for 438 (41%) the committee was critical of some aspect of the conduct or clinical performance of the subject registrant(s). All but two 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 2019/20 are tabulated separately in this report.

The committee is specifically tasked in the *HPA* with establishing review procedures that are transparent, objective, impartial, and fair. Following a thorough investigation, the 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 deficient clinical performance that the complainant was unaware of or unable to recognize or articulate. When the 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:

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

In 2019/20, new disciplinary citations were authorized against two physicians.

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 2019/20. Six disciplinary matters were concluded. Summaries of discipline decisions are posted on the College website.

To give a sense of the work of the Inquiry Committee, illustrative examples of complaints concluded in 2019/20 with criticism and remedial dispositions are outlined in Inquiry Committee Case Studies.

SIGNIFICANT EVENTS IN 2019/20

This marks the final year of Dr. J. Galt Wilson's supporting role as senior deputy registrar for the Inquiry Committee, after more than a decade. The committee wishes Dr. Wilson well in his retirement and looks forward to the leadership of his successor, Dr. Derek Puddester.

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

INFORMATION

For more information regarding this report, please contact:

D. Martinig, MHA, RTNM, BSc
Director, Complaints and Practice Investigations

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 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 63,000 articles were downloaded by staff and registrants—an increase of 21% from the previous year. A key source of these articles were the library's subscriptions to 6,300 e-journals. Access licences are negotiated directly with publishers and, wherever possible, the library benefits from its membership with the Electronic Health Library of BC library consortium, which subscribes to large journal packages more affordably.
- Registrants posed 1,464 requests for literature searches in 2019/20—an increase of 16% from the previous year. Queries from registrants are diverse, covering specific clinical, administrative, research and medical-legal questions in practically all specialties. Search requests arose most frequently from practitioners in family practice, psychiatry, internal medicine, anesthesiology, community medicine, physical medicine and rehabilitation, and general surgery.
- The library offers generalists and specialists a robust suite of online resources. Two point-of-care tools, BMJ Best Practice and DynaMed, are available to registrants in both browser and app-based formats. Both resources are highly ranked for editorial quality, evidence-based methodology, and volume of content. Almost 700 electronic books are available 24/7 through the library catalogue. Librarians curated a list of medical podcasts from noted publishers and scholars, which is posted on the College website. Key podcast aspects are provided such as cost (most are free) and continuing professional development credit.
- Librarians contacted 375 registrants at 32 outreach events in the form of College-organized courses, medical conferences, one-to-one literature search training, and the interactive group workshop FAST EVIDENCE. FAST EVIDENCE includes post-workshop reflective learning components designed to help learners integrate evidence-based tools and literature resources into clinical practice.

SERVICE TRANSFORMATION

Measures to improve ease of access to high-quality electronic information resources have been a focus for the library.

- College IT experts designed a single sign-on application for a client-based electronic medical record (EMR) system. The library continues to work with an EMR vendor to pilot the application in their software.

PROMOTION

Conferences, workshops, and one-to-one teaching are some of the modes used by library staff to engage registrants with library services and resources.

- A promotional email initiative designed to encourage registrants to have their clinical questions addressed by librarians with literature searches reached 64% of registrants. The initiative correlated with a 16% increase in literature search queries compared to 2018/19.
- 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 123% (range: -19% to 800%) in the month following the delivery of the emails.

HIGHLIGHTS IN 2019/20

Individual physicians served (excluding self-serve through the website)	1,944
Total contacts between staff and registrants	11,284
Literature search requests	1,464
Articles delivered	63,000
Ebook chapters viewed	16,800

B. Penner, QC
Chair, Library Committee

INFORMATION

For more information regarding this report, please contact:

K. MacDonell, PhD
Director, Library Services

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 55 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 2019–2022). The committee continued to support the College's strategic plan though the five objectives and related projects outlined in its 2019/20 business plan:

- strengthening the role of the medical director
- enhancing communication and engagement with key partners
- strengthening the role of the committee
- strengthening the role of the program
- enhancing quality in the NHSMFAP through accreditation of the program

HIGHLIGHTS IN 2019/20

The NHMSFAP supported these objectives through various projects and initiatives:

1. **Interventional pain management**

   Developed interventional pain management standards and communications plan for the eventual oversight of facilities.

2. **Medical director education session**

   Hosted a day-long session for facility medical directors and their key staff covering the credentialing and privileging process, performance appraisals, NHMSFAP bylaws and expectations of medical directors, quality management systems, patient safety, and common accreditation deficiencies.

3. **Data collection**

   Streamlined the facility data submission and collection process for improved reporting to the committee.

4. **Support for medical directors**

   As in previous years, staff and the committee continued their review and evaluation of medical directors' applications for appointment at facilities, the review of patient safety incidents (via the NHMSFAP Patient Safety Incident Review Panel), and ongoing communication on issues of clinical importance.

5. **Standards development**

   NHMSFAP standards and guidelines are reviewed and updated on an ongoing basis to ensure that they continue to reflect current legislation, standards and best practices. Twenty-one standards were reviewed and updated in 2019/20, including those on human resources, routine practices, waste management and IV procedural sedation and analgesia for adults.

6. **New and updated policies and position statements**

   NHMSFAP position statements express or clarify the College's intent on a particular matter by providing guidance where events are evolving or when the implementation of a guideline or standard may not be necessary. Six new guidelines/position statements were developed in 2019/20, including those on major renovations for reasons of maintenance or restoration, renovations and new construction to a facility, change of ownership transition and hair restoration procedures.

7. **Facility-specific advice and approvals**

   Continued to assist facilities in meeting standards for new facility builds, clinical trials, renovations, and outstanding mandatory requirements.

ACCREDITATION ACTIVITY

In 2019/20, thirteen facilities were due for re-accreditation and were subject to accreditation site visits. In addition, focused assessments for four facilities were held.

Due to the COVID-19 pandemic, private medical/surgical facilities were unable to provide statistical data for the 2019/20 fiscal year on the number and types of procedures performed. This data will be reported at a later date.

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

INFORMATION

For more information regarding this report, please contact:

M.J. Murray, MD, CCFP(EM), MHSc, CHE
Deputy Registrar

J.D. Agnew, PhD, MBA
Director, Accreditation Programs

Committee reports

Patient Relations, Professional Standards and Ethics Committee

The scope of the Patient Relations, Professional Standards and Ethics 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 Patient Relations, Professional Standards and Ethics (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.

PRIMARY CARE PROVISION IN WALK-IN, URGENT CARE AND MULTI-PHYSICIAN CLINICS

The committee shared the revised *Primary Care Provision in Walk-in, Urgent Care and Multi-physician Clinics* practice standard with registrants, gathering feedback from 426 survey participants. After reviewing the comments received, the committee approved several revisions, including reframing the content of the standard so that it speaks more directly to primary care while clearly listing the specific settings to which the standard applies. Along with the revised practice standard, the committee asked that a new patient resource be published to help inform patients about what they can expect when receiving care at a walk-in clinic.

CHARGING FOR UNINSURED SERVICES

The committee gathered feedback from 312 registrants on the revised *Charging for Uninsured Services* practice standard and heard from 44 members of the public who shared their related experiences and expectations. Following this, the committee directed that the standard outline principles on charging a fee for service, charging a block fee, setting reasonable fees, communicating fees, combining uninsured and insured services, and charging for missed or cancelled appointments. The committee proposed that a resource also be published for patients to provide a summary of what to expect if they are charged for an uninsured service. The revised practice standard replaces both the *Annual Fees* and *Missed Appointments* standards, which have now been archived.

ADVERTISING AND COMMUNICATION WITH THE PUBLIC

Input was gathered from 313 registrants on key principles related to advertising and public safety while 20 members of the public shared their experiences and expectations regarding physicians' advertising conduct. This led to the development of a more robust set of principles, and insight into what the public expects of registrants who choose to advertise their services. The committee identified the need to clarify that registrants must only advertise under their proper name, describe their practice credentials and specialties appropriately, specify clearly which services being offered are not covered by the Medical Services Plan, and not describe their services in comparison to the services of others or imply any superiority over any other regulated health-care professional.

MEDICAL RECORDS, DATA STEWARDSHIP AND CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

The committee revised the *Medical Records, Data Stewardship and Confidentiality of Personal Health Information* practice standard to include new sections which outline expectations related to technology and transferring a copy of the medical record. Following the publication of the revised standard, the *Emailing Patient Information* professional guideline and *Data Stewardship Framework* guidance document were archived. As revisions to the practice standard were based largely on legal requirements set out in applicable legislation, a consultation was done retrospectively and focused on evaluating the standard's clarity. The committee reviewed the feedback gathered from the 109 registrants who participated in the consultation and, based on the comments received, deemed that no further revisions to the practice standard were necessary.

INDEPENDENT MEDICAL EXAMINATIONS

The *Independent Medical Examinations* practice standard underwent a consultation to gather feedback from both registrants and the public. Input from 107 registrants and 21 members of the public assisted the committee in making several key revisions, such as changing the guideline to a standard, revising the term "patient" to "examinee" throughout, simplifying the key principles, and adding new sections to outline expectations on providing access to independent medical examination (IME) findings and retention of the IME records. Stakeholder input also prompted the committee to recommend and review a supplementary public resource to assist examinees in understanding what they can expect of the physician conducting an IME.

ADDRESSING SEXUAL MISCONDUCT

The committee continues to review the College's policies, processes and patient resources related to sexual misconduct. Over this past year, the committee directed that staff engage key public advocacy groups for their feedback on appropriate ways to communicate and engage with the public on this topic. Additionally, the committee drafted two new practice standards: *Sexual Misconduct*; and *Non-sexual Boundary Violations*. These new standards will replace the current *Boundary Violations in the Patient-physician Relationship* practice standard. The draft standards will be shared for consultation during the upcoming fiscal year.

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

INFORMATION

For more information regarding this report, please contact:

H.M. Oetter, MD
Registrar and CEO

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 registrants, three specialty registrants, and five public members, and provides oversight to the Physician Practice Enhancement Program, which assesses the professional performance of a registrant, and the Physician Office Medical Device Reprocessing Assessments initiative, which assesses the reprocessing of reusable medical devices in accordance with criteria established by the Board.

PHYSICIAN PRACTICE ENHANCEMENT PROGRAM

The Physician Practice Enhancement Program (PPEP) actively assesses physicians, prioritizing the assessment of registrants 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 registrants have a periodic assessment, with those requiring ongoing remediation assessed on a more frequent basis. Where possible, registrants 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.

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 registrant
- any other method of quality assurance approved by the Board for the purposes of this part

During a PPEP assessment, a registrant 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 registrants to take a more proactive role in their own continued professional development, all with the goal of improving patient care.

PHYSICIAN OFFICE MEDICAL DEVICE REPROCESSING ASSESSMENTS

The Physician Office Medical Device Reprocessing Assessments (POMDRA) 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's *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 practise in a community-based 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

In 2019/20, PPEP continued to transition to the College of Physicians and Surgeons of Ontario (CPSO) Peer and Practice Assessment Program's redesigned assessment tools for the pediatrics, internal medicine, and dermatology assessment programs. Like the family practice and psychiatry assessment tools, the new specialty practice assessment tools include eight assessment domains and outline criteria to guide peer assessment.

Following a successful pilot of the Medical Council of Canada (MCC) multi-source feedback tool (MCC 360), the program will transition from the Physician Achievement Review multi-source feedback instruments previously administered by Pivotal Research Inc., to the MCC 360 program administered through

the MCC. The new tool will focus on the CanMEDS competencies of communication, professionalism, and collaboration by continuing to survey physician co-workers, non-physician colleagues, and patients.

POMDRA continued to assess community-based registrant offices and support registrants and office staff on medical device reprocessing (MDR) practices. Based on our MDR assessment feedback, POMDRA developed several online resources for policy and procedure development including steam sterilization failure and recall policy and checklist samples, and an instructional video on proper biological testing.

ASSESSMENTS

In 2019/20, PPEP assessed 650 community-based registrants with the most common opportunity for improvement being record keeping. A medical record needs to document an intellectual footprint to allow for continuity of care by other health professionals, including locums, and registrants providing peripatetic care. To support registrants in maintaining appropriate medical record documentation, the program held five Medical Record Keeping for Physicians sessions and introduced a new Medical Record Keeping for Physicians (Psychiatry) course. Information covered during these sessions is based on the requirement for medical record documentation outlined in the College's *Medical Records, Data Stewardship and Confidentiality of Personal Health Information* practice standard; part 3, section B of the College Bylaws; and the PPEP assessment standard *Unified Medical Record* for family practitioners.

For registrants practising in a multi-physician clinic, including walk-in clinics, the medical record includes requirements directed under the College's *Primary Care Provision in 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 2019/20, POMDRA focused on supporting offices where ultrasounds were used for semi-critical procedures and to ensure the proper packaging of medical devices in preparation for steam sterilization. Community-based offices where high-level disinfection (HLD) on critical and semi-critical medical devices was performed continued to be assessed. Since inception, the program has marked an improvement in physician offices using quality assurance parameters in steam sterilization, particularly the use of biological indicator and chemical indicator (internal/external) testing.

HIGHLIGHTS IN 2019/20

Number of community-based PPEP assessments (includes MCC 360 pilot assessments)	650
Assessed physicians responding to survey agreeing/strongly agreeing that assessment was a worthwhile experience	56%
Assessed physicians responding to survey agreeing/strongly agreeing that their practice changed as a result of the assessment	57%
Number of POMDRA on-site assessments	225

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

INFORMATION

For more information regarding this report, please contact:

M.J. Murray, MD, CCFP(EM), MHSc, CHE
Deputy Registrar

N. Castro, MHA
Director, Physician Practice Enhancement Program

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). In accordance with the College Bylaws, the main responsibilities of the PRP 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 registrants
    - 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

Registrants participating in this practice improvement intervention are protected by provisions in the *Health Professions Act* giving privileged status to documents generated in the course of quality assurance activities.

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 registrants 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+ credits in the assessment category.

In addition to correspondence and self-reflection, the PRP recommends formal education in the form of the twice-yearly Prescribers Course and the annual Chronic Pain Management Conference in March. The courses assist registrants with strategies for managing complex chronic pain patients taking opioids and benzodiazepines. In the Prescribers Course, half of the day is spent in practice interviews with standardized patients. The Prescription Review Panel continues to recommend attending these courses for registrants that struggle with safe prescribing despite the interventions of the PRP.

A survey is sent to each registrant who has completed any stage of the PRP process. The PRP process and the proceedings of the Prescription Review Panel have evolved continuously based on this feedback. In 2020/21, the program plans to implement an intake survey for all new PRP files. The intention of this survey is twofold: to set a collegial tone at the outset by outlining how the College's drug programs department can act as resource; and to provide upfront, practice-specific, demographic information to medical consultants.

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; however, with a heightened focus on addiction medicine and opioid agonist treatment (OAT), 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 panel. In response, a new OAT prescriber review has been implemented, where all new OAT prescribers in the province will be reviewed one year after completing the Provincial Opioid Addiction Treatment Support Program.

In anticipation of upcoming trends, there are plans to conduct an environmental scan examining antibiotic stewardship in other regions with an eye to implementing antibiotic stewardship oversight in the near future.

HIGHLIGHTS IN 2019/20

Prescription Review Program

- 115 referrals received and processed
    - 19 referrals resulted in a program medical consultant writing a letter, email or scheduling a phone call with a physician
    - 78 files were entered into the formal process
        - 72% had not had a previous engagement with the PRP
- 97 files closed
    - 77% closed for an improvement in prescribing
- Average lifespan of a file was 20 months (down from 22 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 held March 1 and 2, 2019
    - Prescribers Course offered on-site in May and October 2019 with 25 and 26 participants respectively

Prescription Review Panel

- 38 files were brought to panel in 2019/20 (up from 33 the previous year)
- Outcomes from panel:
    - 13 files were referred to the Inquiry Committee
    - 10 files were referred for a first interview
    - 6 files were referred for a second interview
    - 7 files were brought forward to panel for review at a later date
    - 2 files were closed

J.W.E. Dyson
Chair, Prescription Review Panel

INFORMATION

For more information regarding this report, please contact:

D.A. Unger, MSc, MD, CCFP, FCFP
Deputy Registrar

M. Horton, MPH
Manager, Drug Programs

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 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 sixth 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 family 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 family practice setting in BC. The first iteration of the PRA-BC program commenced in April 2015. To date, 117 of 122 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.

Amendments to the College Bylaws came into effect on May 3, 2019. These amendments clarified current application and registration processes and deleted outdated language.

Registration policies have been reviewed and updated and will be published on the College website in 2020/21.

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, expedited 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 2019/20

- 251 IMGs applied for registration in BC
- 32 PRA program-related applications for eligibility were reviewed by the committee
- 133 IMGs previously on the provisional register were advanced to the full class
- 7 family practitioners completed a registration assessment and were moved to the full class
- 1 specialist completed a registration assessment and moved to the full class
- 4 specialists completed an interim registration assessment

O.G. Casiro, MD, FRCSC
Chair, Registration Committee

INFORMATION

For more information regarding this report, please contact:

C. de Bruin, LLB, CAE
Executive Director, Registration