Committee reports

Diagnostic Accreditation Program Committee

The Diagnostic Accreditation Program (DAP) has a mandate to assess the quality of diagnostic services in the province of British Columbia through accreditation activities.

The scope, mandate and authority of the DAP is derived from section 5-25 of the Bylaws made under the *Health Professions Act*, RSBC 1996, c.183.

ACCREDITATION

The DAP accredits eight diagnostic services that cover 36 distinct testing services or modalities in the following areas:

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

- anatomic pathology
- chemistry
- cytogenetics
- cytology
- hematology
- microbiology
- molecular diagnostics
- point-of-care testing
- transfusion medicine

Neurodiagnostic services

- electroencephalography
- evoked potentials
- electromyography and nerve conduction studies

Community neurodiagnostics

- electromyography and nerve conduction studies

Pulmonary function

- spirometry
- flow volume loops
- diffusing capacity
- lung volumes
- respiratory muscle testing
- conductance/resistance
- reactive airways (methacholine challenge testing)
- exercise-induced asthma testing
- cardiopulmonary exercise testing
- pulse oximetry/overnight oximetry
- exercise testing – duration test or six-minute walk test category

Community spirometry

- spirometry
- flow volume loops

Polysomnography

- polysomnography (level 1)

Home sleep apnea testing

- home sleep apnea testing (level 3)

HIGHLIGHTS IN 2022/23

The DAP conducted assessments of facilities in 2022/23 as follows:

- 294 assessments scheduled
    - laboratory medicine: 89
        - regional: 1
        - COVID-19 PCR sites: 8
        - sample collection sites: 36
        - laboratories: 44
    - diagnostic services: 205
        - diagnostic imaging: 71
        - neurodiagnostics: 5
        - community neurodiagnostics: 16
        - pulmonary function: 6
        - polysomnography: 6
        - home sleep apnea testing: 101
- 427 assessments completed
    - laboratory medicine: 200
        - regional: 1
        - COVID-19 PCR sites: 7
        - COVID-19 POCT and sample collection sites: 47
            - initial: 38
            - focused: 3
            - relocation: 6
        - sample collection sites: 61
            - on-site: 6
            - self-audit: 6
            - initial: 17
            - focused: 3
            - relocation: 5

- laboratories: 84
  - on-site: 32
  - mid-cycle: 12
  - initial: 11
  - focused: 29
- diagnostic services: 227
  - diagnostic imaging: 87
    - on-site: 59
    - initial: 21
    - focused: 3
    - relocation: 4
  - neurodiagnostics: 7
    - on-site: 6
    - focused: 1
  - community neurodiagnostics: 16
    - on-site: 14
    - relocation: 2
  - pulmonary function: 7
    - on-site: 5
    - initial: 1
    - relocation: 1
  - polysomnography: 6
  - home sleep apnea testing: 104
    - desktop: 78
    - on-site: 19
    - initial: 3
    - relocation: 4

COVID-19 TESTING

In response to the letter issued by Public Health Officer, Dr. Bonnie Henry on June 16, 2020, the DAP supported a total of 144 COVID-19 diagnostic facilities through the accreditation process, of which 140 gained provisional accreditation (specimen collection, POCT, PCR diagnostic services). As of November 2022, only 120 facilities continued to operate.

The provisional accreditation term is expected to end in 2023. The DAP Committee weighed the resource intensiveness of the full accreditation assessment process considering the changing federal testing border requirements, safety risks and expected facility attrition. The committee decided to extend the provisional term by 12 months and approved modification of accreditation activity so that COVID-19 specimen collection and POCT facilities will be assessed to the same standards as used initially, and not to the full set of lab standards. This will ensure ongoing oversight of the quality of service provided by COVID-19 facilities while reducing the scope of assessment activities and resources required.

ASIA PACIFIC ACCREDITATION COOPERATION (APAC) ACCREDITATION

APAC is the regional accreditation cooperation for the Asia Pacific region and is recognized by the International Accreditation Forum (IAF) and the International Laboratory Accreditation Cooperation (ILAC).

The DAP's laboratory medicine program achieved APAC accreditation in 2022, which means the DAP is an APAC mutual recognition agreement (MRA) signatory. As a signatory to the APAC MRA, laboratory testing services accredited by the DAP to the ISO 15189 standard are accepted internationally. MRA facilitates the acceptance of conformity assessment results (e.g. test reports, test certificates, inspection reports, and certification) across the region and with other regions around the world. This mutual recognition and acceptance of conformity assessment reduces the need to undertake duplicate testing, inspection or certification, thus saving time and money, increasing economic efficiency and facilitating international trade.

ISQUAEEA ACCREDITATION

The International Society for Quality in Health Care External Evaluation Association (ISQuaEEA) provides third-party external evaluation services to health and social care external evaluation organizations and standards developing bodies around the globe. The DAP's diagnostic imaging (DI) and laboratory medicine (LM) programs have been accredited by IEEA since 2010 to the Accreditation of Health and Social Care Standards. The DAP achieved re-accreditation of its standards (DI and LM) in 2022 and is currently pursuing its organizational re-accreditation and new assessor training accreditation (expected completion in 2023).

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 developed in 2022/23:

- Direct-to-consumer, self-administered COVID-19 testing
- Fetal anatomy ultrasound assessments
- Physicians performing x-rays

Policy changes

The following policies were updated in 2022/23:

- *DAP Committee Terms of Reference and Appeals policy*
- *DAP Assessment policy* (staff assessor credentials)

Accreditation standards

The following standards were updated in 2022/23:

- *Laboratory Medicine Accreditation Standards* version 1.6: Transfusion Medicine (TRM)
- *Laboratory Medicine Accreditation Standards* version 1.7: Organization (ORG), Quality Management Systems (QMS), Facility (FAC), Equipment, Reagents and Supplies (ERS), Informatics (IMI) Quality Assurance (QUA), Pre-Examination (PRE), Examination (EXA), Post-Examination (POS), and Sample Collection (SCT)
- *Diagnostic Imaging Accreditation Standards* version 1.8: Nuclear Medicine and Bone Densitometry (major revisions), and Computed Tomography (minor revisions)

DAP laboratory medicine accreditation scheme development

The committee endorsed a new DAP LM accreditation approach which includes four schemes, of which two are currently in practice (DAP ISO 15189 accreditation scheme and DAP core accreditation scheme). The two new schemes include DAP limited-service accreditation scheme and the DAP community point-of-care accreditation scheme.

Home sleep apnea testing quality control

In 2022/23, a new HSAT quality control program, which monitors facility performance between on-site assessments, was developed and reviewed by community stakeholders. The committee approved the launch of this program February 1, 2023, which is six months prior to the effective date.

Quality management system

The DAP continued the operation and continuous improvement of its quality management system, providing structures to support adjustments required through the continuing pandemic and operational requirements. The Quality Improvement Committee, which met nine times during the year, examined quality improvement opportunities such as external assessments and internal audits results, key performance measures, nonconforming event trending, complaints, and other quality improvement projects status.

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 over 16 stakeholder engagements during this past fiscal year, such as:

- 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
- publications in the *College Connector*

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

INFORMATION

For more information regarding this report, please contact:

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Deputy Registrar

S. Camano
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.

FINANCIAL RESULTS

The College finished its fiscal year on February 28, 2023 with a deficit of $223,000 (~$1M surplus from operations before a ~$1.2M unrealized loss on long-term investment accounts). Investment income was $589K vs. $1.1M budgeted and the weighted average annual return on investments was -1.3%. The current economic uncertainty continues to be challenging with regard to the revenue generated from investments, which helps to offset the annual fees charged to registrants and supports the ongoing operational expenditures of the College. The College remains in an excellent financial position and continues to maintain the second lowest annual registrant licence fee in Canada despite operating in one of Canada's most expensive cities.

COMMITTEE 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 at February 28, 2023 was $28,794,000 ($30,911,000 in 2021/22).

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, e.g. major IT projects.

The target allocation for long-term investments is 40% fixed (bonds and cash) and 60% equities (Canadian, US and international). The balance of investments in the long-term accounts at February 28, 2023 was $34,692,000 ($32,568,000 in 2021/22).

Investment income

- Investment income for the 2022/23 fiscal year before any gains, losses, or investment management fees was $1,250,000 ($773,000 in 2021/22)
- Realized losses in 2022/23 were $661,000 ($528,000 realized gains in 2021/22)
- Unrealized losses in 2022/23 were $1,272,000 ($196,000 unrealized gains in 2021/22)
- Investment management fees in 2022/23 were $95,000 ($89,000 in 2021/22)

PROPERTY

The College owns 59,295 square feet of office space at 669 Howe Street, Vancouver, BC and leases out approximately 2,300 square feet to one tenant. This lease ends in February 2024 with an option to renew for another one-year period. Another 5,500 square feet is currently being marketed for lease, however, downtown vacancy rates have increased significantly over the past year.

An evaluation of the College's overall office space requirements will be conducted in 2023/24 now that the College's hybrid work plan has been made permanent as it is effectively meeting regulatory and business needs while allowing better work/life flexibility for staff. This evaluation will help determine if any remaining unoccupied space could be leased out to other tenants until it is needed for future College use.

TECHNOLOGY

The College's electronic content management project called CEDAR (College Electronic Documents and Records), which started in 2019/20 is now complete. CEDAR has significantly improved the process for storage and retrieval of documents and records as well as maintaining retention schedules for archival purposes. It has also significantly reduced the need for paper files. The

total project cost was $3.74 million upon completion vs. $4 million originally budgeted by the Board.

The College also successfully implemented a new human resources information system (HRIS), which has improved the operational effectiveness of the human resources and finance (payroll) departments.

C.S. Leger, 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 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 registrant to practise safely and effectively. In such circumstances, if the registrant 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.

The Inquiry Committee is composed of 30 members (19 registrants and 11 public members) who participate in five specialized panels. Due to increased complexity and rising complaint volumes, 15 alternate members (12 registrants and 3 public members) were appointed to the Inquiry Committee last year. Almost all of the alternate members were called upon to provide expertise at some point during the past year. Concerns brought to the attention of the College are initially triaged and categorized as primarily matters of clinical performance, registrant 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 2022/23 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 regulatory criticism of the registrant. 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. resolution through correspondence, interviews, and/or educational activities
2. 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

Over the past year the number of new complaints received by the College decreased slightly; yet the total still exceeded the historical average. The Inquiry Committee opened 1,081 complaint files and an additional 80 own-motion practice investigations in 2022/23 (compared to 1,210 complaints and 76 practice investigations the year before). In addition, the committee concluded 1,281 cases (compared to 994 the previous year). The committee was critical of registrants' performance in 460 cases.

Many 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 2022/23. Five disciplinary matters were concluded. Summaries of discipline decisions are posted on the College website.

SIGNIFICANT EVENTS IN 2022/23

The College underwent a comprehensive review and update of its complaint categories with the engagement of both internal and external partners. These partners included other health-care regulators in BC, First Nations Health Authority and other provincial and state medical regulatory bodies. These new and updated categories have been utilized since March 2022 and are reflected in the concluded complaint statistics tabulated separately in this annual report.

The College had previously implemented a complaint navigator position to support both complainants and registrants through the investigative process. Due to the growing demand for this support, a second complaint navigator role was created this past year. This additional resource will build on the College's ability to engage with complaint parties at the beginning of the process to ensure barriers to submitting a complaint are removed and parties are provided with appropriate support on what to expect at the different stages of the investigation.

B.A. Priestman, MD, FRCPC
Chair, Inquiry Committee

INFORMATION

For more information regarding this report, please contact:

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Deputy Registrar

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 College strategic priorities, the Library Committee and library staff engaged in the following activities.

LIBRARY RESOURCES DEVELOPMENT

The core online and physical information resources provided to registrants in 2021/22 were maintained in 2022/23.

The library is a member of the Electronic Health Library of British Columbia (eHLbc), a consortial of BC clinical, research, and academic libraries in the health sector. Through this membership, the library expanded registrants' online access to high impact full text journals through EBSCO's MEDLINE Complete. This subscription added 800 new journal titles, such as JAMA and eight other journals from the American Medical Association, bringing the total to 7,000 titles that registrants can access through the library web pages.

Curated lists of point-of-care tools, e-journals, ebooks, guidelines, print books, and videos were created or updated for registrants' continuous learning on significant issues intersecting society and medicine including planetary health, race and health equity, sexual and gender diversity, and trauma-informed care. These lists were posted to the College website.

SERVICE DELIVERY

Library service to registrants was altered temporarily in March 2022 when the College was required to verify the COVID-19 vaccination status of every registrant by order of the Provincial Health Officer. To support this work, library services were suspended for three weeks so library staff could contribute to the verification duties. Later in the year, a new query ticketing system was implemented, during which library promotion to registrants was diminished to temporarily decrease workload and facilitate staff member training and practice. Both events contributed to a decline in usage for 2022/23.

For example:

- 1,423 registrants posed 9,009 requests (-22% and -9% of previous year, respectively)
- 10,888 articles were manually delivered to registrants and 42,897 articles were downloaded from e-journals from the library website by staff and registrants (-11% and -10% of previous year, respectively)
- 1,066 in-depth literature searches were delivered to registrants (-9% of previous year)

STRATEGIC ACTIONS

In response to strategic priorities set in 2021, the library completed the following initiatives:

- selected the Canadian Health Libraries Association Levels of Service as a library-relevant benchmarking model to guide future status assessments and quality improvement
- engaged with Doctors of BC Regional Advisors and Advocates and with Medical Staff Associations to promote library services to registrants
- drafted an action plan to implement reconciliation, following many of the recommendations of the Canadian Federation of Library Associations in response to the Truth and Reconciliation Commission report and in the Calls to Action
- implemented a ticketing system to replace legacy software with a library-specific system for expanded data analysis and patron-relations project management

OUTREACH AND TEACHING

Library staff engaged in 14 in-person or virtual activities such as conference sponsorships, one-on-one teaching with registrants, and workshops, reaching 259 registrants.

P.A. Glaze, MD
Chair, Library Committee

INFORMATION

For more information regarding this report, please contact:

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Deputy Registrar

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.

The Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) has a mandate to assess the quality of private surgical, procedural pain management and podiatric surgical facilities in the province of BC through accreditation activities. As a program of the College, the mandate and authority of the NHMSFAP is derived from section B of the College Bylaws made under the *Health Professions Act*.

The NHMSFAP accredits non-hospital medical surgical facilities, podiatric and procedural pain management facilities.

HIGHLIGHTS IN 2022/23

The NHMSFAP conducted assessments of facilities in 2022/23 as follows:

- 25 assessments scheduled
  - private medical surgical: 13
  - procedural pain management: 9
  - podiatric: 3
- 24 assessments completed
  - private medical surgical facilities: 14
    - planned: 12
    - focused: 2
  - procedural pain management: 7
  - podiatric: 3

Private medical/surgical facilities are required to provide statistical data on the number and types of procedures performed for the fiscal year. This data will be available later.

The NHMSFAP supported the following objectives through various projects and initiatives.

ISQuaEEA accreditation

The International Society for Quality in Health Care External Evaluation Association (ISQuaEEA) provides third-party external evaluation services to health and social care external evaluation organizations and standards developing bodies around the world. The NHMSFAP is planning for an assessment of its core standards and assessor training in 2023.

PROGRAMS AND OPERATIONS

Patient safety incidents

Facilities are required to report patient safety incidents (PSIs), which are subsequently reviewed by the NHMSFAP Patient Safety Incident Review Panel. A revised Canadian Patient Safety Incident Analysis Framework is used for the review. A total of 132 PSIs were reviewed by the panel.

The committee agreed to amend the 24-hour reporting requirement to include only: death which occurred during or within 28 days of a procedure at a facility; unexpected admission to hospital within 28 days after a procedure at a facility; cluster of infections (more than one occurring on the same day, consecutive surgical cases, consecutive surgical days, same type of surgery); surgery on the wrong body part or wrong patient or conducting the wrong surgery; and, loss or theft of a controlled drug or substance. All other patient safety events remain reportable within 30 days.

Procedural pain management (PPM)

The NHMSFAP continued with the implementation of a program for the accreditation of procedural pain management facilities. Accreditation of PPM facilities was implemented utilizing a phased approach. In June 2021, PPM facilities that met the minimum requirements for provisional accreditation were granted provisional accreditation until February 28, 2022. To maintain provisional accreditation until their on-site accreditation assessment can be conducted, the NHMSFAP Committee approved a one-year provisional accreditation extension certificate, to March 31, 2023 with a second year as required. An additional one-year extension to March 31, 2024 was provided to PPM facilities scheduled for an on-site assessment in the second year. Nine on-site accreditation assessments were planned for and completed in the 2022/23 year.

Podiatry

The NHMSFAP continued with the implementation of the accreditation of podiatric facilities. Four podiatric surgery facilities that had initially expressed intention to continue podiatric surgery in their facility were granted a transition period to evaluate their physical infrastructure and determine how they intend on meeting the CSA Z8000 physical design standards for a new facility. Subsequently, three of the four facilities confirmed they would continue in the accreditation process, and focused assessments (MDRD/emergency cart) were completed. Subsequently, two additional facilities decided to no longer perform podiatric surgery procedures at their facility and instead will perform those surgeries at an existing accredited non-hospital facility.

Standards and guidelines

NHMSFAP standards and guidelines are reviewed and updated on an ongoing basis to ensure they continue to reflect current legislation, standards, and best practices. Standards and guidelines that were revised or created this fiscal year include:

Revised

- *Class 1 General Anesthesia Facility Emergency Cart*
- *Class 3 Local Anesthesia Facility Emergency Cart*
- *Medical Records and Documentation*
- *Human Resources*
- *Immediately Sequential Bilateral Cataract and Immediately Sequential Bilateral Refractive Lens Exchange Surgery*
- *IV Procedural Sedation and Analgesia in Adults*
- *Ketamine and Lidocaine Infusions for the Treatment of Chronic Pain*
- *Procedural Pain Management* (core standards)

New

- *Facility Design Assessment*

Policies and position statements

NHMSFAP position statements express or clarify the College's intent on a matter by providing guidance where events are evolving or when the implementation of a guideline or standard may not be necessary. Several guidelines and position statements were revised or created in 2022/23:

Revised

- *Construction and/or Renovation Time Limit policy*
- *Hair Restoration Procedures* position statement
- *Patient Safety Incidents Reporting* policy

New

- *Laundry Standards* policy
- *Rocuronium on the Emergency Cart* policy

New construction and renovations

During the year, the NHMSFAP engaged with 25 facilities regarding new design or renovation as follows:

- 13 total open new facility applications files in 2022/23
  - 4 applications were closed for exceeding the construction time-limit policy and given the option to reapply—one facility reapplied
  - 4 new applications were received, including the one reapplication noted above
  - 1 application was closed by the applicant (joined another new facility application)
  - 1 application (PPM) completed construction and opened
  - 3 applications opened in previous fiscal year remained open
  - 7 applications remain open as of February 28, 2023
- 1 existing facility renovation file
  - application was closed for exceeding the construction time-limit policy and applicant was given the option to reapply, which they did not
- 1 existing facility relocation (new build)
  - facility is currently under construction
- 6 existing facilities changed ownership
  - 2 facilities plan to relocate (new build)
  - 1 plan to close in April 2023
  - 3 facilities plan to renovate their existing location
  - 1 facility is in the decision phase (renovate or new build)
- 1 existing PPM facility procedure room size remediation
  - facility resolved its procedure room size deficiency by moving its PPM procedures to a different (larger) room within the facility
- 3 existing podiatric surgery facilities
  - 1 facility decided to perform its surgical procedures at an existing accredited non-hospital facility effective February 28, 2023

Ownership changes and closures

Three facilities noted intent to change ownership, including two Vancouver Island facilities that transferred to Island Health control.

Two existing facilities changed ownership. One of these facilities was already in the process of relocating (new build).

Clinical trials

Four clinical trials were reviewed by the committee to ensure the clinical trials were being conducted under ethics board oversight and that procedures were appropriate for the non-hospital setting.

Medical staff appointments

In accordance with section 5-7(5) of the College Bylaws, the facility medical director is responsible for the selection, appointment, and reappointment of all medical staff. The committee acknowledged that 136 registrant applications were verified during the year.

Facility-specific advice and approvals

The NHMSFAP continued throughout the year to assist facilities in their role in credentialing and privileging, in meeting with medical directors to understand their responsibilities, in compliance with standards for new facility builds, renovations, clinical trials, and accreditation non-conformances.

Quality management system

The NHMSFAP continued the operation and continuous improvement of its quality management system, providing structures to support adjustments required through the continuing pandemic and operational requirements. The Quality Improvement Committee, which met nine times during the year, examined quality improvement opportunities such as external assessments and internal audits results, key performance measures, nonconforming event trending, complaints, and other quality improvement projects status.

Stakeholder engagement

The NHMSFAP engages in dialogue to better understand and respond to the needs of its accreditation stakeholders through several channels. The NHMSFAP participated in 11 stakeholder engagements during this past fiscal year, such as:

- advisory committee meetings
- external committee meetings
- Ministry of Health meetings (ad hoc)
- health authority meetings
- facilities and medical directors
- publications in the College Connector

W.D. Sanden, MD, FRCSC
Chair, Non-Hospital Medical and Surgical Facilities Accreditation Program Committee

INFORMATION

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Deputy Registrar

S. Camano
Director, Accreditation Programs

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 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 practice standards and standards of professional ethics in medical practice. The committee identifies opportunities for partner consultation and provides guidance throughout the revision process for practice standards and professional guidelines.

Consent to Treatment

A top priority of the committee over the year was the development of a new draft standard, *Consent to Treatment*. The committee reviewed the initial draft of the standard, which went out for consultation with registrants, the public and key health partners. After being presented with the results, the committee proposed that the College complete further engagement with select groups of providers who care for vulnerable patient populations to ensure the voices of those who may experience higher levels of health inequities are included. College staff held meetings with these providers and shared their findings with the committee. This resulted in several changes to the draft standard, as well as the development of an accompanying registrant resource. Throughout this process, the committee was presented with an in-depth engagement framework, which will be applied to future consultations on other practice standards to ensure a more robust process using an equity lens.

Advertising and Communication with the Public

The committee reviewed the *Advertising and Communication with the Public* practice standard after amendments to the College Bylaws prompted a change to the existing practice standard. The draft practice standard was shared for consultation with registrants, key health partners, and the public. A total of 128 respondents provided their feedback. This led the committee to incorporate several amendments to the practice standard and the development of a public and registrant resource to add further clarity on the practice standard's principles. The practice standard and accompanying resource were endorsed by the Executive Committee and published to the College website on October 21, 2022.

Disclosure of Adverse or Harmful Events

The committee reviewed results from a consultation on *Disclosure of Adverse or Harmful Events*, which was held with registrants, the public and key health partners. This consultation had 241 respondents. After reviewing the feedback, the committee endorsed several minor revisions to the practice standard. The practice standard was then endorsed by the Executive Committee and published to the College website on June 23, 2022.

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

INFORMATION

For more information regarding this report, please contact:

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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 six family practice practitioners, three specialists, two podiatric surgeons, and four public members. The panel provides oversight to the Physician Practice Enhancement Program (PPEP), which is responsible for assessing the professional performance of a registrant, office assessments, and Physician Office Medical Device Reprocessing Assessments (POMDRA), which reviews the reprocessing of reusable medical devices in community-based offices in accordance with criteria established by the Board.

REGISTRANT ASSESSMENTS

Assessments provide an external evaluation of clinical practice using multiple measures to assess performance, knowledge, and skills. The approach to assessments also provides educational support to ensure registrants 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.

In 2022/23, physician assessments continued to take place through a combination of remote and on-site assessments. While the program introduced the remote assessment approach in response to ongoing challenges in professional and personal lives, the flexibility of dedicating time to important collegial feedback sessions is a benefit to both registrants and physician assessors (Figure 1).

The program held its first in-person conference since the COVID-19 pandemic with 47 physician assessors and PPE panel members attending the 2022 Assessor Conference. It was also an opportunity to welcome 10 new family practice assessors. The conference continued the program's educational journey on addressing systemic racism and oppressive systems through a health-care lens. The program continued discussions around the role of quality improvement assessments to advance conversations about the *Indigenous Cultural Safety, Cultural Humility and Anti-racism* practice standard.

In 2022/23, a new family practice office assessment approach was piloted where registrants engaged with program staff to demonstrate compliance with College practice standards and guidance on program assessment standards. This new program was well received, and registrants felt more aware of College practice standards and supported in making changes. Office assessments continue to support registrants and clinic offices on meeting the College practice standard on *Care Coverage Outside Regular Office Hours* and *Primary Care Provision in Walk-in, Urgent Care and Multi-registrant Clinics*. (Figure 2).

In 2022/23, the program held nine family practice medical record keeping courses and one psychiatry medical record keeping course via an online webinar format. This online format is conducted with a smaller number of participants to ensure discussion and synchronous learning.

PHYSICIAN OFFICE MEDICAL DEVICE REPROCESSING ASSESSMENTS

Medical device reprocessing assessments are 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 registrants who practise in a community-based setting whether in a solo office or multi-physician clinic. The initiative does not apply to clinical offices or outpatient clinics affiliated with a health authority or hospital as these bodies have their own evaluation processes.

Medical device reprocessing assessments continued using a remote assessment format with photograph submissions as evidence of compliance with required standards. After the assessment, feedback sessions provide an opportunity to guide and educate registrants and clinic staff on reprocessing best practices. Results from the post-assessment participant survey indicate that the remote assessment process for medical device reprocessing assessments is comparable to on-site assessments (Figure 3).

In 2022/23, the program began second cycle assessments of community-based clinic offices previously assessed in 2019 or earlier. Since then, the program has improved

processes and developed additional resources and educational modules to support offices in meeting documentation requirements. Preliminary results indicate that community-based clinic offices were able to maintain changes in their medical device processing practices (Figure 4).

PROGRAM DEVELOPMENT AND EVALUATION

The program is responsible for developing assessment and educational tools to support registrants in providing safe patient care within a quality improvement framework. Ongoing program evaluation ensures that the program is committed to continuous improvement.

In 2022/23, the program developed a BC assessment tool for rheumatology and trained assessors for this new specialty quality improvement program. Program staff will review the results of the feedback surveys to ensure alignment with program philosophy and approach.

Program staff continued to monitor the results from several post-assessment surveys. The decrease in program satisfaction is likely a reflection of ongoing personal and professional challenges in clinical practice. The program will use these evaluation results along with analysis of aggregate program data to evaluate and modify our approach to physician selection and assessments. As part of a multi-year development project, the program will explore opportunities to develop more supportive quality improvement programs.

HIGHLIGHTS IN 2022/23

Number of community-based PPEP assessments	500
Assessed registrants responding to survey agreeing/strongly agreeing that assessment was a worthwhile experience	49%
Assessed registrants responding to survey agreeing/strongly agreeing that their practice changed as a result of the assessment	53%
Number of POMDRA assessments (remote and on-site)	226

J.J. Kingsley, MD, CCFP
Chair, Physician Practice Enhancement Panel

INFORMATION

For more information regarding this report, please contact:

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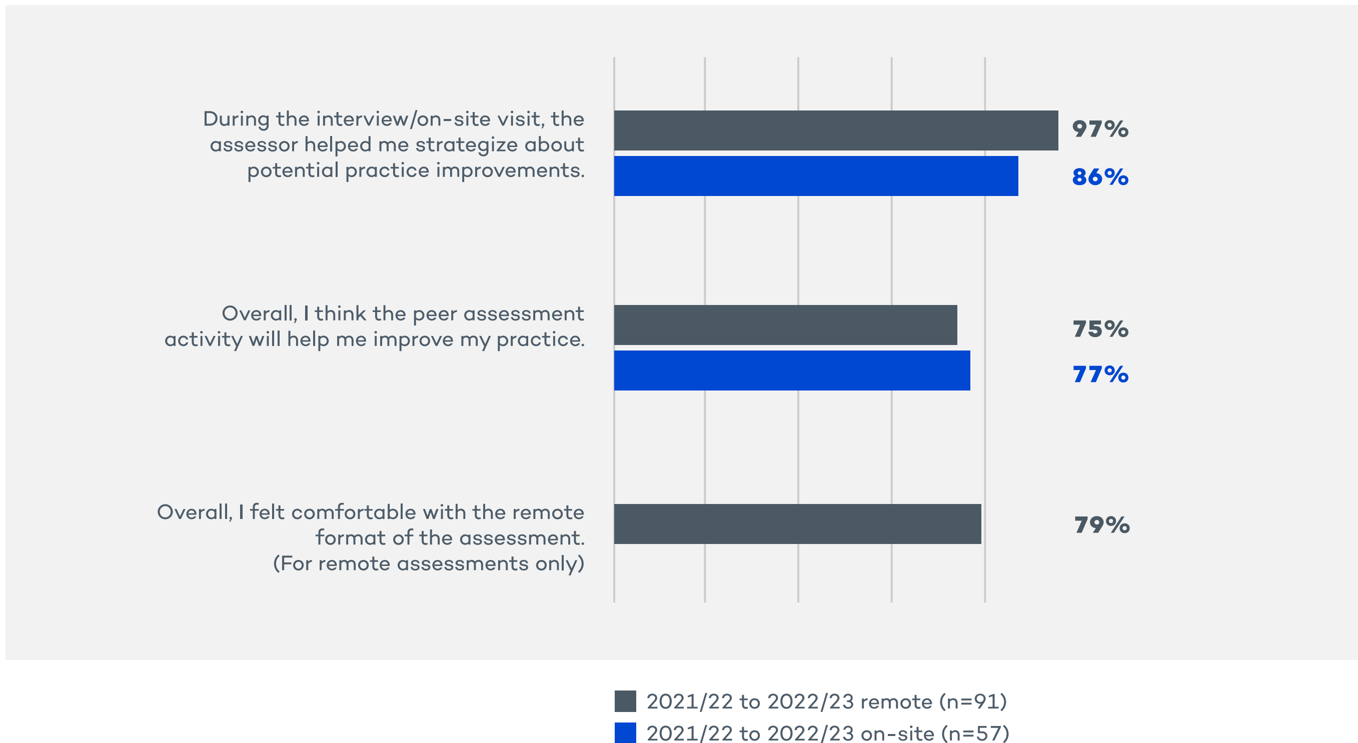
Deputy Registrar

N. Castro, MHA
Director, Physician Practice Enhancement Program

FIGURE 1

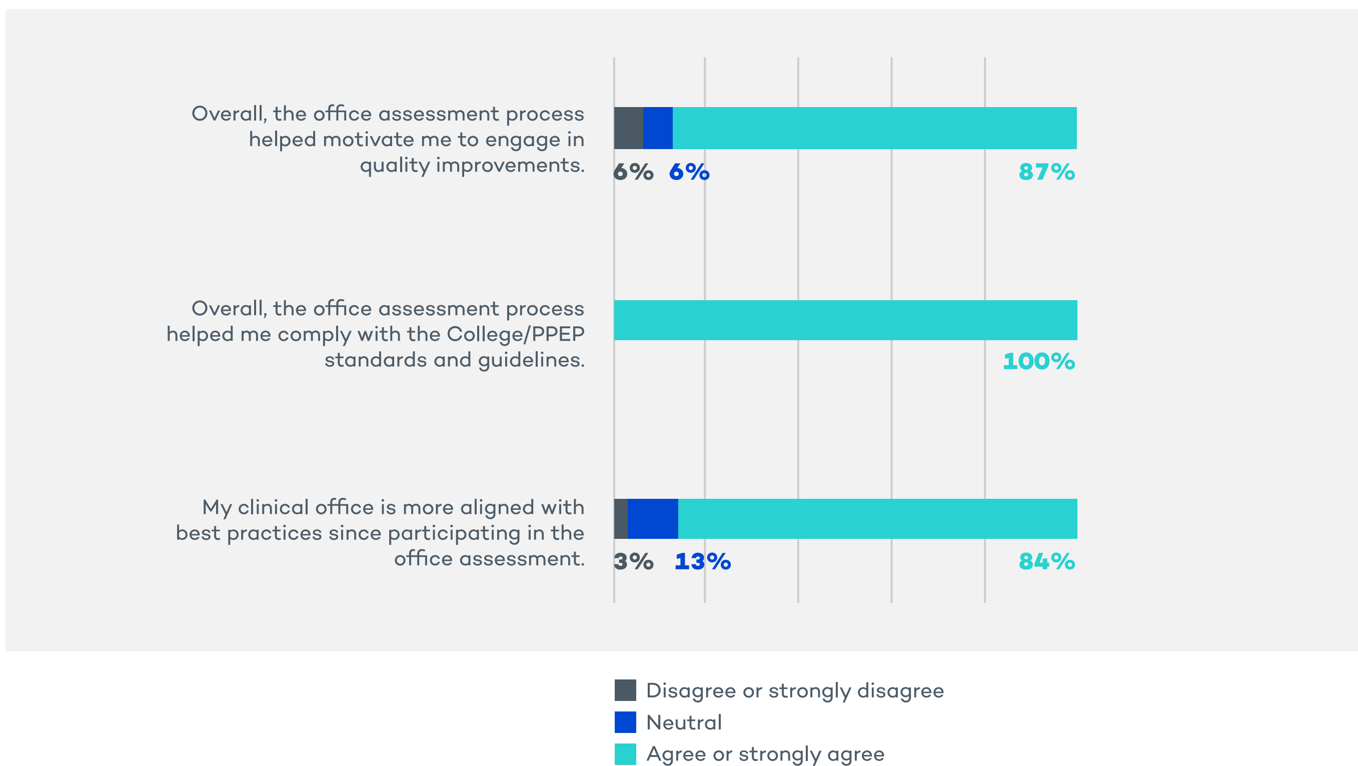
PPEP assessment survey | Agreed or strongly agreed with the following statements



2021/22 to 2022/23 remote (n=91)
2021/22 to 2022/23 on-site (n=57)

FIGURE 2

PPEP office assessments feedback survey | Level of agreement with the following statements



Disagree or strongly disagree
Neutral
Agree or strongly agree

FIGURE 3

POMDRA post-assessment survey | Agreed or strongly agreed with the following statements

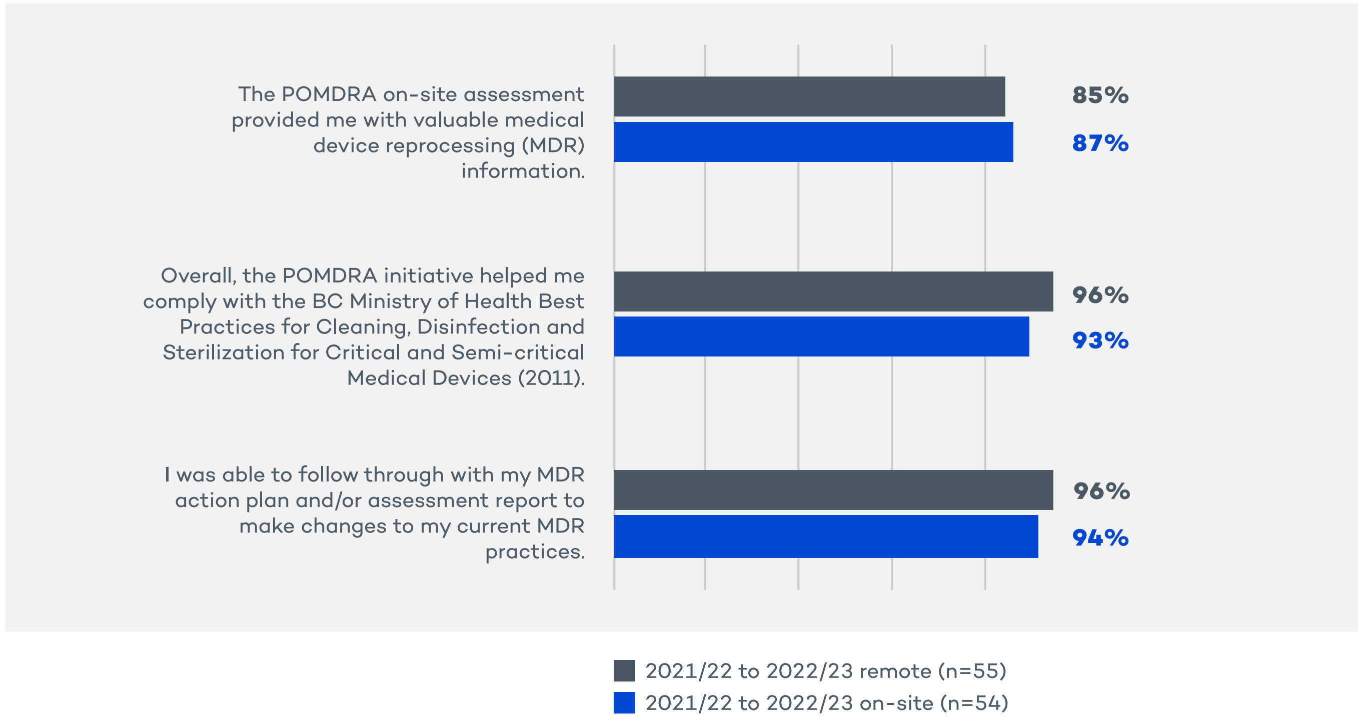
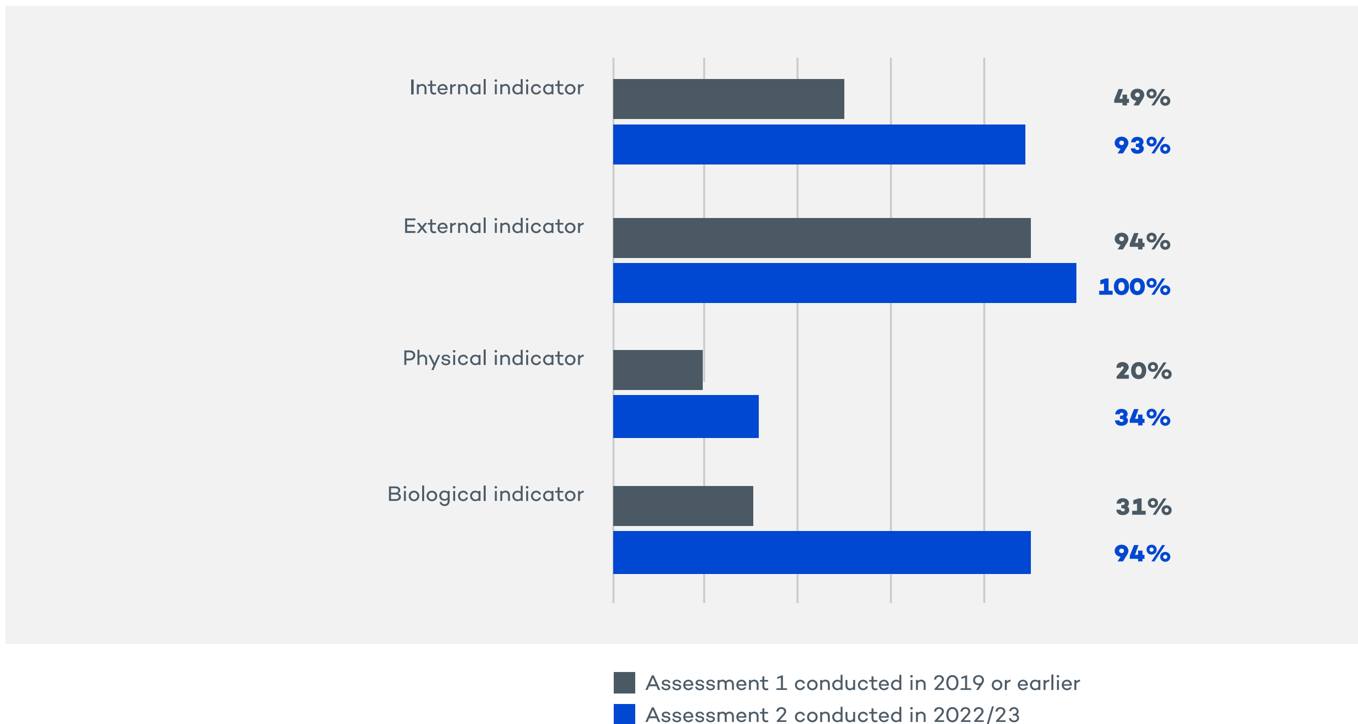


FIGURE 4

POMDRA assessment cycles | Compliance rates of community-based clinical offices



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
  - 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 during 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 contacted registrants find maintaining the status quo challenging and are grateful for the intervention. In keeping with the educational intent of the PRP, these activities qualify for Mainpro+ credits in the assessment category.

In addition to correspondence and self-reflection, the PRP recommends formal education and hosts the Prescribers Course twice a year and the annual Chronic Pain Management Conference in September. In 2022, the PRP was able to host both the Prescribers Course and the Chronic Pain Management conference virtually with record numbers of attendees and extremely positive feedback.

The PRP also vets and recommends various courses throughout the year. The courses assist registrants with strategies for managing complex chronic pain patients taking opioids and benzodiazepines. The Prescription Review Panel recommends attending these courses for registrants who struggle with safe prescribing despite the interventions of the PRP.

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

- 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 registrants 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.

In 2023/24, the program will point to antimicrobial stewardship as a key competency for registrants, as well as incorporating resources and guidance related to other safe prescribing issues including overprescribing, prescribing cascades and the off-label use of sedating medications.

HIGHLIGHTS IN 2022/23

Prescription Review Program

- 27 referrals received
  - 9 did not meet the criteria for enrollment and required no action
  - 2 referrals were channeled through the triage process and received correspondence from the medical consultant
- 16 files met the threshold for entry into our formal process
  - 74% had not had a previous engagement with the PRP
- 41 files closed
  - 78% closed for an improvement in prescribing
- 66 files currently open, in various stages
- 56 attendees at the Prescribers Course (over two courses)
- 100 attendees at the Chronic Pain Management Conference

Prescription Review Panel

- 17 matters (involving 13 registrants) were brought to the panel
    - 4 files were closed
    - 4 files were referred for a second interview with the senior medical consultant, deputy registrar and legal counsel
    - 4 files were referred to the Inquiry Committee
    - 5 files were brought forward to the panel for review at a later date

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

INFORMATION

For more information regarding this report, please contact:

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Deputy Registrar, Health Monitoring and Drug Programs

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) and family physicians who have successfully completed a recognized Practice Ready Assessment program as eligible for provisional registration. The College recognizes family practice IMGs who 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 ninth 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, University of British Columbia, College of Physicians and Surgeons of British Columbia, 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;
- a centralized orientation;
- a clinical field assessment; and
- an application for provisional registration and licensure from the College for successful program candidates.

During the clinical field assessment, candidates spend 12 weeks in a group family practice setting in a BC community, under the direct supervision of trained physician assessors. The first iteration of the PRA-BC program commenced in April 2015. To date, 188 candidates successfully completed the program and commenced independent practice of medicine as family practitioners. The PRA-BC program is funded to assess 32 physicians per year and is looking to expand this to assist with addressing health-care resourcing.

In 2022/23, the Registration Committee approved the following registration policy:

- *Royal College of Physicians and Surgeons of Canada (RCPSC) and the Practice Eligibility Route Subspecialty Examination Affiliate Program (PER-SEAP)*

In 2022/23, the registration department operationalized two new classes of licensure:

- Associate physician – acute care
- USA certified
  - For physicians who are not otherwise eligible for certification in the full specialty or provisional specialty class, and who hold the LMCC or have successfully completed the medical licensing examinations in the USA and who have completed three years of accredited postgraduate training in a training program accredited by the ACGME and achieved certification with one of the following American Board of Medical Specialities:
    - American Board of Pediatrics,
    - American Board of Internal Medicine, or
    - American Board of Emergency Medicine

In 2022/23, the registration department readied itself to operationalize one new class of licensure, pending Ministry of Health policy development to support this class of licensure:

- Associate physician – community primary care
  - For physicians who are not otherwise eligible for registration in the provisional or full class, who are practising under the direction and supervision of an attending physician. An associate physician may not be the most responsible physician.

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.

The College also 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 2022/2023

- 258 IMGs applied for registration in BC (based on preliminary completed date)—16% increase from 2021/22
    - This count includes 5 applicants under the associate physician class
- 77 PRA program-related applications for eligibility were reviewed by the committee—44% increase from 2021/22
- 171 IMGs previously on the provisional register were advanced to the full class
- 6 specialists completed an interim assessment and had their provisional licence moved to the full class—71% decrease from 2021/22

T. O'Grady
Chair, Registration Committee

INFORMATION

For more information regarding this report, please contact:

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