Committee reports

Diagnostic Accreditation Program Committee

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

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

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

Community spirometry

- spirometry
- flow volume loops

Polysomnography

- polysomnography (level 1)

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

Home sleep apnea testing (HSAT)

- home sleep apnea testing (level 3)

HIGHLIGHTS

The DAP conducted assessments of facilities as follows:

- 377 scheduled assessments
    - 152 laboratory medicine
        - 4 regional
        - 7 COVID-19 PCR sites
        - 41 COVID-19 POCT/SCS
        - 40 sample collection sites
        - 60 laboratories
    - 225 diagnostic services
        - 78 diagnostic imaging
        - 10 diagnostic imaging regional

        - 9 polysomnography
        - 101 HSAT
        - 10 pulmonary function
        - 10 neurodiagnostics
        - 7 community neurodiagnostics
- 452 completed assessments
    - 186 laboratory medicine
        - 4 regional
        - 1 COVID-19 PCR sites (6 withdrawn)
        - 3 COVID POCT/SCS (38 withdrawn)
        - 40 sample collection sites
            - 28 on-site
            - 12 self-audits
        - 138 laboratories
            - 44 on-site (2 withdrawn)
            - 12 mid-cycle (2 withdrawn)
            - 17 initial
            - 9 relocation
            - 56 focused
    - 266 diagnostic services
        - 96 diagnostic imaging
            - 75 on-site
            - 10 initial
            - 4 relocation
            - 7 focused
        - 13 diagnostic imaging regional (started regional for private facilities)
        - 11 polysomnography
            - 8 on-site
            - 3 initial
        - 114 HSAT
            - 47 on-site
            - 59 desktop
            - 4 initial
            - 4 relocation
        - 10 pulmonary function (on-site)
        - 10 neurodiagnostics (on-site)
        - 12 community neurodiagnostics
            - 10 on-site
            - 2 initial

COVID 19 TESTING

In response to the letter issued by Dr. Bonnie Henry and the Public Health Office on June 16, 2020, the DAP supported a total of 144 COVID-19 diagnostic facilities through the accreditation process. 140 of those facilities gained provisional accreditation (specimen collection, POCT, PCR diagnostic services).

As of February 29, 2024, five facilities continued to operate. In 2023, the committee decided to extend the provisional term by 12 months. The committee also 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 laboratory 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. The DAP will continue to accredit these facilities until a new letter of direction is issued.

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 (laboratory medicine) achieved APAC accreditation in 2022, which means that the DAP is an APAC mutual recognition agreement (MRA) signatory. As a signatory to the MRA, laboratory testing services accredited by the DAP to the ISO 15189 standard are accepted internationally. The 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 results reduces the need to undertake duplicate testing, inspection, or certification, thus saving time and money, increasing economic efficiency, and facilitating international trade. The DAP continues to ensure compliance with APAC (ISO 17011) requirements in preparation for the next assessment in 2025.

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 DAP (diagnostic imaging and

laboratory medicine) has been accredited by IEEA since 2010 to the Accreditation of Health and Social Care Standards. The DAP achieved reaccreditation of its standards (diagnostic imaging in 2022, and laboratory medicine in 2023), organizational reaccreditation (2023), and achieved a new accreditation for its assessor training program in conjunction with the College's Non-Hospital Medical and Surgical Facilities Accreditation Program (2023).

PROGRAMS AND OPERATIONS

Position statements

DAP position statements are the result of analysis of currently available information and research, committee review, and stakeholder review, including the BC Ministry of Health as necessary. Position statements on the following issues were developed or revised:

New

- Direct to Consumer Screening Testing – Diagnostic Imaging
- Introducing New Technology and Artificial Intelligence
- Point of Care Ultrasound
- The Use of Mobile X-ray Units as a Stationary X-ray Unit

Revised

- Credentialing Requirements for Spirometry Testing

Policy

New

- DAP New Technology Policy

Accreditation standards

The following standards were developed or updated:

New

- Indigenous Cultural Safety, Cultural Humility, and Anti-Racism

Revised

- Diagnostic Imaging Accreditation Standards Version 1.8
- Laboratory Medicine Accreditation Standards Version 1.6
- Laboratory Medicine Accreditation Standards Version 1.7

DAP laboratory medicine accreditation scheme development

The committee accepted 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. The new schemes are expected to be operationalized in 2024 to align with the implementation of the new accreditation programs software system.

Home sleep apnea testing (HSAT)

August 2023 saw the launch of the DAP HSAT quality control (QC) program. Between August 2023 and February 2024, the HSAT QC program evaluated technical and medical performance of 14 HSAT organizations. This encompassed 82 facilities with 348 cases from 24 interpreting physicians. Reviews for 8 of 14 organizations have been completed, which resulted in requesting evidence of corrective action from 11 of the 24 interpreters to address nonconformance to the DAP HSAT standards for reporting HSAT studies. Additionally, the Ministry of Health and the College HSAT were acknowledged as finalists in the innovation category of the 2023 Premier's Awards.

Quality management system

The DAP continued the operation and continuous improvement of its quality management system, providing structures to support adjustments required to meet and enhance operational requirements. The Quality Improvement Committee, which met ten 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.

New accreditation software

The DAP and the College's Non-Hospital Medical and Surgical Facilities Accreditation Program are working towards the implementation of new accreditation software, which is expected to improve efficiency for stakeholders. The software is expected to be implemented in 2024.

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 25 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.

FINANCIAL RESULTS

The College ended its fiscal year on February 29, 2024, with an $854,000 surplus from operations before a $4.4M unrealized gain on investments. The prior year ended with a deficit of $233,000. Investment income was $2.5M ($589,000 in 2022/23) and the weighted average annual return on investments was 12.1% (-1.3% in 2022/23). Investment income contributes to the ongoing operational expenditures of the College while helping to offset the annual fees charged to registrants and the facilities accredited by the College. The College is in a strong financial position and continues to maintain the second lowest annual registrant licence fee in Canada ($1,875 versus $2,118 Canadian average).

INVESTMENTS

Investments are kept within two types of accounts as follows.

Short-term investment accounts

The primary objective of the short-term account portfolio is to maintain cash or cash equivalents, ensuring they are available to cover the College's annual operational expenses. Simultaneously, the portfolio aims to optimize investment returns. Currently, all operational funds are allocated to fixed investments, including cash and term deposits. As of February 29, 2024, the total balance of cash and short-term investments stands at $31,552,000 ($28,794,000 in 2022/23).

Long-term investment accounts

The primary goal of the long-term investment portfolio is capital preservation. The secondary objective is to achieve reasonable growth while minimizing risk. These goals serve to meet the long-term financial obligations of the College and fund Board-approved capital projects, including major information technology initiatives.

The long-term investment allocation consists of 40% fixed assets (including bonds and cash) and 60% equities (comprising Canadian, US, and international stocks). As of February 29, 2024, the total balance in the long-term accounts stands at $39,870,000 (compared to $34,692,000 in 2022/23).

Investment income in 2023/24 fiscal year

- Investment income before any realized gains, losses, or investment management fees was $1,992,000 ($1,250,000 in 2022/23)
- Realized gains were $529,000 ($661,000 realized losses in 2022/23)
- Unrealized gains were $4,421,000 ($1,272,000 unrealized losses in 2022/23)
- Investment management fees were $104,000 ($95,000 in 2022/23)

PROPERTY

The College owns 59,295 square feet of office space located at 669 Howe Street in Vancouver, BC. Approximately 2,300 square feet of this space is currently leased to a single tenant, with the lease set to expire in February 2026. An additional 6,700 square feet is available for lease, although the downtown Vancouver office market remains highly competitive with commercial Class A vacancy rates exceeding 13%.

The College continually assesses its overall office space requirements and hybrid work strategy. If suitable, any unoccupied space may be leased out to other tenants until it is required for future College purposes.

AUDITED FINANCIAL STATEMENTS

The complete audited financial statements with notes can be found on the College website.

C.S. Leger, MD, FRCPC
Chair, Finance and Audit Committee

INFORMATION

For more information regarding this report, please contact:

M. Epp, BA (Econ), BComm (Hons), 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, the committee is not required to take further action if the registrant is appropriately engaged and compliant with treatment to the satisfaction of the confidential health monitoring program. The College explicitly treats health matters therapeutically.

The Inquiry Committee is composed of 33 members (21 registrants and 12 public members) who participate in five specialized panels. Due to increased complexity and rising complaint volumes, eight alternate members (six registrants and two public members) were appointed to the Inquiry Committee last year. Almost all 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 2023/24 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

Since 2020, the number of new complaints received at the College has steadily increased by approximately 10% each year. Over the past year, the number of new complaints received by the College increased by 13%, resulting in a combined increase of 36% over three years' time. This additional volume has been successfully managed through the recruitment of new staff resources, additional contractors, process adjustments and more committee meetings. Even when faced with sustained growth in complaint numbers, the complaints and practice investigations department continued to improve on its key performance measures of concluding files within a timely manner (an improvement of 13%) and concluded the second highest annual total of complaints.

The committee opened 1,216 complaint files and an additional 75 own-motion practice investigations in 2023/24 (compared to 1,081 complaints and 80 practice investigations the year before). In addition, the committee concluded 1,145 cases (compared to 1,281 the previous year). The committee was critical of registrants' performance in 470 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 was one Discipline Committee hearing held in 2023/24. One disciplinary matter was concluded. Summaries of discipline decisions are posted on the College website.

SIGNIFICANT EVENTS IN 2023/24

The College underwent a comprehensive review by the Castlemain Group, an organization that specializes in research, engagement and collaboration with Indigenous people, communities, and organizations. The focus of the review was to identify opportunities to make the College's complaint process safer and more accessible to Indigenous Peoples. The review identified several key themes including accessibility, cultural safety, communication, resolution and accountability, self-identification, and data collection. The report was presented to, and endorsed by, the College Board in May 2023 and published on the College website.

The College has committed to reviewing and implementing the recommendations of the report and providing reports on the progress of this work.

Several important changes made over the past year in response to the department's commitment to providing a culturally safe complaint process, include:

- The collection of complainant and patient cultural identity starting in January 2024. This information is voluntarily provided on the complaint form and is maintained confidentially in the complaint file.
- The committee and department have incorporated the College's new territorial acknowledgement, upholding the inherent rights and title of First Nations in relation to their traditional and ancestral lands.
- The College has recruited an Indigenous pathways development lead to guide further work on the implementation of the Castlemain report recommendations, in addition to the recommendations noted in the *In Plain Sight* report and Health Quality BC's *Sharing Concerns: Principles to Guide the Development of an Indigenous Patient Feedback Process*.

Further to the ongoing work in cultural safety and humility, the department continues to look for ways to humanize the process for all parties. In the spring of last year, case managers began phoning complainants following the review and intake of their complaint. The purpose of the call is to confirm the complainant's information, introduce the case manager and answer any questions about the process. In the fall, the process of conducting acknowledgement phones calls was extended to subject registrants. These calls served a similar function: to introduce the case manager, confirm how best to provide the complaint, explain the support available to the registrant, and answer any questions about the process. The feedback received thus far has been largely positive from both complainants and registrants.

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

CLOSURE OF THE LIBRARY

The College library permanently closed on March 15, 2024. This difficult decision was made after careful consideration of data showing a significant and ongoing decrease in the use of the library. Library use has consistently declined over the last several years with many registrants changing the way they access clinical resources due to the number of self-serve digital alternatives available to them. As such, this is the final Library Committee chair's report to the Board.

ACKNOWLEDGMENT OF SERVICE

The library duly assisted the College's registrants with their needs for six decades. For that, the College would like to acknowledge and recognize the exemplary dedication and service of the library staff throughout the years.

P.A. Glaze, MD
Chair, Library Committee

INFORMATION

For more information regarding this report, please contact:

D.G. Puddester, MA, MD, Med, FRCPC, PCC
Deputy Registrar

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) accredits non-hospital medical surgical facilities including procedural pain management (PPM) facilities. It 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. The mandate and authority of the NHMSFAP is derived from section B of the College Bylaws made under the *Health Professions Act*.

HIGHLIGHTS

The NHMSFAP conducted assessments of facilities as follows:

- 24 scheduled assessments
    - 12 private medical/surgical
    - 10 procedural pain management
    - 2 podiatric
- 20 completed assessments
    - 12 private medical/surgical
        - 10 planned
        - 2 focused
    - 8 procedural pain management
        - 6 planned
        - 2 focused
    - 0 podiatric (facilities closure)

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

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 achieved accreditation for assessor training (2023) and is planning for an assessment of the NHMSFAP standards in 2024.

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 116 PSIs were reviewed by the panel.

Procedural pain management (PPM)

The NHMSFAP continued the implementation of the accreditation program for PPM facilities. Accreditation of PPM facilities was implemented utilizing a phased approach. Seven PPM facilities were granted a third year of PPM provisional accreditation. One facility closed, two facilities were granted an initial provisional accreditation and will require a second year of accreditation. Another PPM facility relocated and was granted permission to open. As this facility had recently undergone a full reaccreditation, they were permitted to port their accreditation to the new facility, with the condition that a focused assessment within six to twelve months is conducted for a new imaging modality (i.e. C-arm).

Podiatry

The NHMSFAP continued with the implementation of the accreditation of podiatric facilities; however, one facility changed ownership to a health authority and the remaining facilities closed. Podiatry services are no longer provided in single-service private facilities, and several podiatrists moved their surgical services into an existing accredited non-hospital facility.

Standards and guidelines

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. Standards and guidelines that were revised or created this fiscal year included:

New

- AP Cultural Safety, Cultural Humility and Anti-Racism
- Environmental Cleaning of Pre- and Post-Anesthesia Care Areas
- Environmental Cleaning of the Medical Device Reprocessing Department
- Environmental Cleaning Program and Non-Clinical Areas
- Infection, Prevention and Control Program
- Obesity and In Vitro Fertilization Procedures
- Quality Performance
- Surgical Site Infection Surveillance

Revised

- Class 1 General Anesthesia Facility Emergency Cart
- Environmental Cleaning of Operating/Procedure Rooms and Sterile Core
- Gender, sex and sexual orientation-related revisions:
    - Admission and Pre-procedure Care
    - Medical Records and Documentation
    - Pre-admission Evaluation and Selection
    - Specimen Handling
- Governance and Leadership
- Immediately Sequential Bilateral Cataract and Immediately Sequential Bilateral Refractive Lens Exchange Surgery
- Medical Director

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. The following policies were created:

- Rocuronium on the Emergency Cart
- Laparoscopic Cholecystectomy in Non-Hospital Facilities

New construction and renovations

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

- 8 open new facility applications files
    - 1 new application was received
    - 7 applications opened in previous fiscal year(s) remained open
    - 1 application was subsequently closed for exceeding the construction time-limit policy and given the option to reapply
    - 2 applications were subsequently closed by the applicant
    - 1 application was subsequently closed for inactivity
    - 4 applications remain open as of February 29, 2024
- 1 existing facility relocation (new build)
    - 1 relocation application opened in previous fiscal year(s) remained open; this facility completed construction and was granted provisional accreditation
- 5 existing facilities change of ownership files
    - 0 new change of ownership notifications received
    - 5 change of ownership files from previous fiscal year(s) remained open
    - 1 facility is building new premises
    - 1 facility decided to close
    - 2 facilities have been granted an extended transition period, to either renovate or build new, due to their highly specialized scope of service
    - 1 facility plans to renovate their existing location
    - 4 change of ownership files remain open as of February 29, 2024

Ownership changes and closures

One facility changed ownership to Vancouver Coastal Health. This facility met the condition to notify the committee of its decision to either renovate and/or build new, and was granted an extension to complete renovations in accordance with the change of ownership transition period.

Clinical trials

One clinical trial was 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 119 physician 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, meeting with medical directors to understand their responsibilities, being compliant with standards for new facility builds, renovations, clinical trials, and accreditation nonconformances.

Expert group on IVF facilities

The NHMSFAP Committee was advised that in BC, fertility services are only available in a private non-hospital setting and that the Canadian Standards Association (CSA) Z8000 standards do not adequately address procedure room sizes, corridor, and door widths for these facility types.

At the direction of the committee, the NHMSFAP convened an expert panel including a CSA representative, an architect, and an infection control practitioner to develop recommendations to address these issues. The committee accepted the recommendations on procedure room sizes, corridor, and door widths, which were also provided to the CSA standards group for consideration in its next edition.

Should CSA Z8000 include specific design parameters for in vitro fertilization (IVF) facilities in the future which are different than the design parameters approved by the committee, the committee will uphold the design parameter for IVF facilities as per CSA Z8000. The committee also resolved that existing IVF facilities which have changed ownership be granted a five-year extension to meet the CSA Z8000 standards with the option to request an additional extension of up to five years now or at any time in the initial five years. This would mean a maximum extension of 10 years with specified limits and conditions.

Quality management system

The NHMSFAP continued the operation and continuous improvement of its quality management system, providing structures to support adjustments required to meet and enhance operational requirements. The Quality Improvement Committee, which met ten 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 over 15 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*

R. Preston
Chair, Non-Hospital Medical and Surgical Facilities 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

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.

INDIGENOUS CULTURAL SAFETY, CULTURAL HUMILITY, AND ANTI-RACISM

A top priority of the committee over the year was the evaluation of the *Indigenous Cultural Safety, Cultural Humility, and Anti-racism* practice standard. The committee was informed of the evaluation plan, including a registrant survey, interviews, and focus groups, to assess registrant awareness of the practice standard. The committee reviewed the results of the registrant survey, which received 532 responses. College staff engaged an external consultant to conduct one-on-one interviews and focus groups with select Indigenous and non-Indigenous registrants to gauge awareness of the standard and identify opportunities to enhance education and awareness.

MEDICAL ASSISTANCE IN DYING

Throughout the year, the committee was updated on the College's progress of revising the *Medical Assistance in Dying* (MAiD) practice standard in relation to the pending Criminal Code amendment allowing MAiD-MD-SUMC (MAiD where a mental disorder is the sole underlying medical condition). The revisions were withdrawn following the federal government's decision to delay the amendment.

CHARGING FOR UNINSURED SERVICES

The committee reviewed the *Charging for Uninsured Services* practice standard following concerns about the misuse of block fees by registrants. A consultation on the use of block fees was conducted and received 206 responses. Results reviewed by the committee indicated that most respondents were not concerned or aware of the misuse of block fees. The committee agreed that concerns regarding block fees fall outside the scope of the College and no changes were made to the standard.

CARE COVERAGE OUTSIDE REGULAR OFFICE HOURS

The committee reviewed a revised draft of the *Care Coverage Outside Regular Office Hours* practice standard and agreed that it was ready to be distributed for consultation. The committee was presented with the results of the consultation and further revisions to the standard. After thoughtful discussion with the committee, College staff will further refine the standard following a more comprehensive review.

ACCESS TO MEDICAL CARE

The committee was informed of the review of the *Access to Medical Care Without Discrimination* practice standard. College staff have developed an equity, diversity, and inclusion framework that is being applied to the practice standard. The committee has been informed of next steps in the process, which include engaging with key health partners and registrants, making proposed edits to the practice standard, and drafting supporting resources such as an equity toolkit.

ARTIFICIAL INTELLIGENCE

The use of artificial intelligence (AI) in medical practice was a standing item this year for the committee. The committee engaged in many thoughtful discussions on the rapidly evolving use of AI in medicine, and related emerging issues. The committee reviewed and endorsed interim guidance on the use of AI in medicine.

REFERRAL-CONSULTATION PROCESS

The committee engaged in discussions throughout the year on the *Referral-Consultation Process* professional guideline. College staff conducted a comprehensive review of the professional guideline, identifying several areas for improvement, and proposed edits to the committee, including elevating it to a practice standard. The committee agreed that College staff should continue to engage further with key health partners.

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

INFORMATION

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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 physicians, 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 registrants, 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.

PEER 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.

The PPEP began its transition towards compliance with the *Health Professions and Occupations Act (HPOA),* recognizing this forthcoming legislation as an opportunity to launch new opportunities that would allow registrants more flexibility and agency to reflect on their clinical practice and customize their continued professional development to best suit their professional goals.

Educational support and remediation are the cornerstones of peer assessments, and the program has focused efforts to create educational material to support standards in medical documentation. Medical Record Keeping 101 for Family Physicians is the first in a series of online modules providing registrants guidance on the professional and legal obligations in medical records documentation. Future courses will include guidance to ensure encounter notes contain essential, appropriate, and relevant information about the patient visit. The goal of these modules is to promote quality of documentation to allow any registrant to review the chart and continue to provide care for a given patient. In 2023/24, the program held ten Medical Record Keeping for Family Physicians webinars and one Medical Record Keeping for Psychiatrists via an online webinar format. This online format is conducted with a smaller number of participants to ensure discussion and synchronous learning.

In 2023/24, peer assessments continued to be conducted for community-based registrants and podiatric surgeons with positive feedback from participants on both in-person and remote assessment options (figure 1). The 2023 Assessor Conference included six new physician assessors and focused on new health technology platforms available to assist registrants improve workflow and efficiency while preserving quality care.

OFFICE ASSESSMENTS

Family physician office assessments support registrants and clinic offices in 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*. While most satisfy College practice standards, the program continues to collaborate with clinic offices that may require additional guidance, mainly around the *Care Coverage Outside Regular Office Hours* practice standard. While a number of clinic offices required adjustments to their practice or operations, the majority successfully met the requirements outlined in the practice standard. Only a minimal percentage of the assessed offices faced challenges in meeting these standards. Feedback from clinic offices that participated in the program has been favourable (figure 2).

PHYSICIAN OFFICE MEDICAL DEVICE REPROCESSING ASSESSMENTS

Medical device reprocessing (MDR) 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.

In 2023/24, the program completed 48 remote and 147 on-site assessments with registrant feedback strongly favourable, particularly in the support and guidance provided on the MDR action plan process (figure 3).

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 2023/24, program staff completed a review of program evaluation results along with analysis of aggregate program data to develop an innovative approach to quality improvement assessments. This proposed new approach to physician assessments has received positive reviews from experts in medical education and will align with the *HPOA*.

HIGHLIGHTS IN 2023/24

Number of peer assessments conducted	366
Assessed registrants agreeing/strongly agreeing that their assessment was a worthwhile experience	59%
Assessed registrants agreeing/strongly agreeing that their practice changed as a result of the assessment	50%
Assessed registrants agreeing/strongly agreeing that they were able to maintain changes implemented after their assessment one year later	84%
Number of MDR site assessments conducted (remote and on-site)	196
Number of office assessments conducted	315

J.J. Kingsley, MD, CCFP, FCFP
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

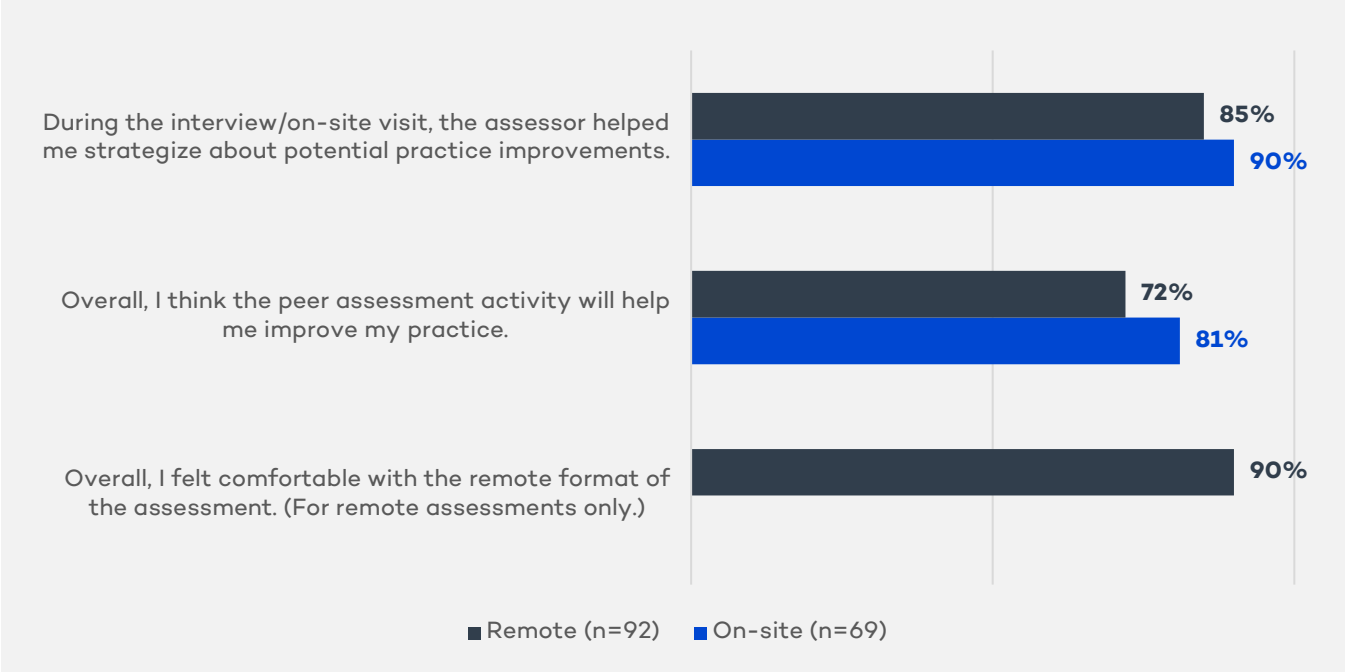


FIGURE 2

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

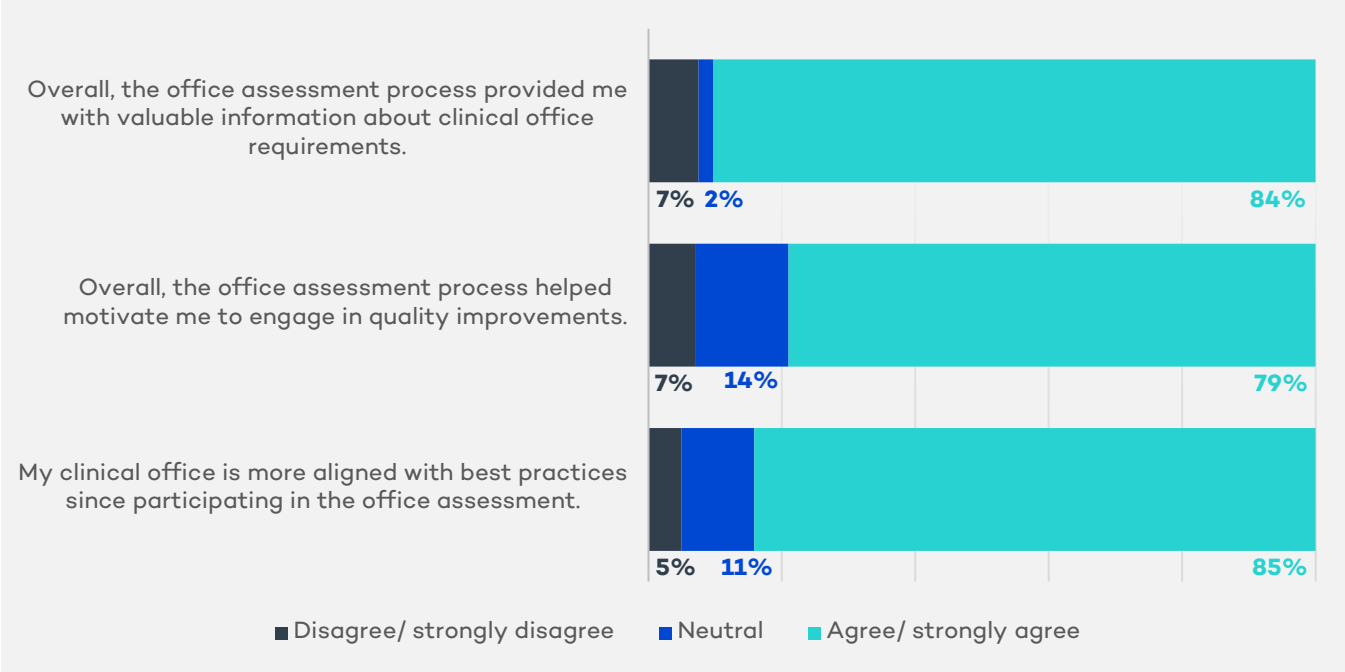
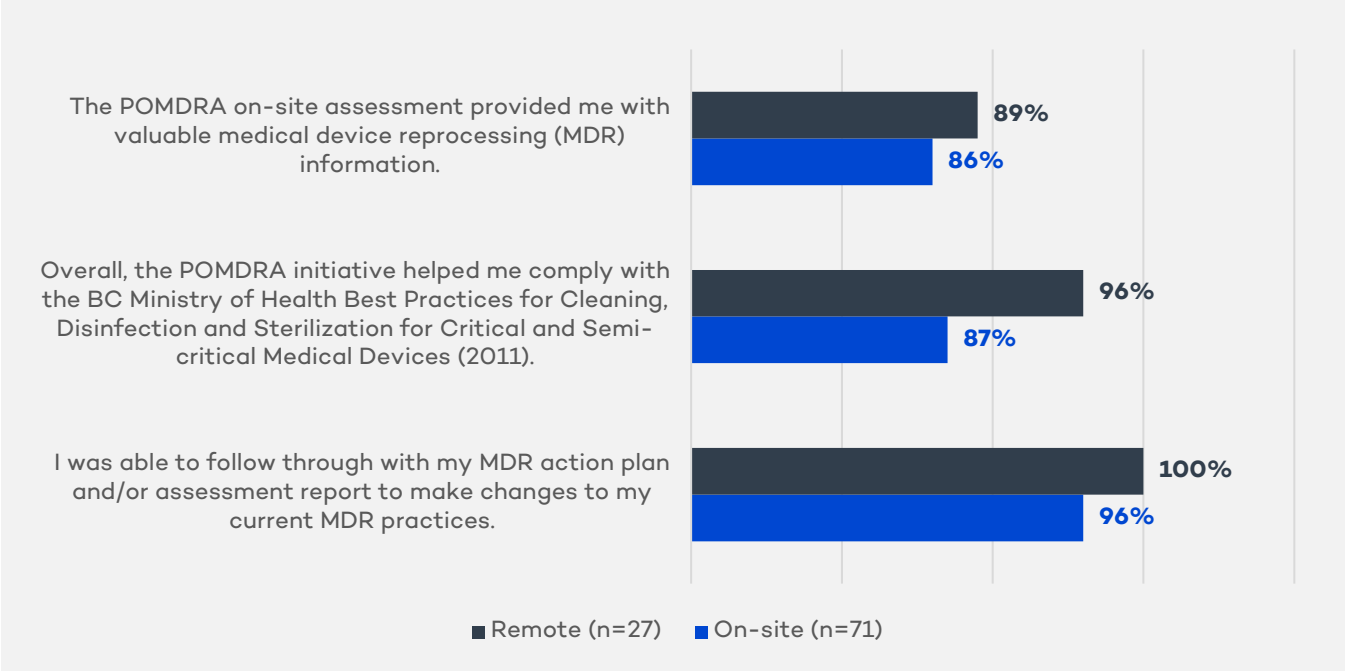


FIGURE 3

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



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. The College's intent is to be helpful when it contacts registrants who appear to be experiencing challenges with safe prescribing. 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 and the annual Chronic Pain Management Conference in September. In 2023, 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 patients with complex care issues, particularly those taking opioids and benzodiazepines. The Prescription Review Panel recommends these courses for registrants who struggle with safe prescribing despite the interventions of the PRP. On-demand, online educational modules are also in the final stages of development for registrants to complete as required.

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

- Careful medication 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 pointed to antimicrobial stewardship as a key competency for registrants and published updated web content including resources and guidance for prescribers. The program also designed and implemented a voluntary report that would allow registrants to compare their antimicrobial prescribing to a comparator group.

In the coming year, the program will continue to expand its scope related to other safe prescribing issues including polypharmacy, prescribing cascades, and stimulant prescribing.

HIGHLIGHTS IN 2023/24

Prescription Review Program

- 48 referrals received
    - 14 did not meet the criteria for enrollment and required no action
    - 18 referrals were channeled through the triage process and received correspondence from the medical consultant
- 22 files met the threshold for entry into our formal process

    - 56% had not had a previous engagement with the PRP
- 43 files closed
    - 81% closed for an improvement in prescribing
- 51 files currently open, in various stages
- 44 advice calls provided by program staff
- 23% of advice calls involved prescribing hesitancy
- 78% of PRP participants agreed that their participation in the program led to positive changes in their practice
- 30 attendees at the Prescribers Course (May 2023)
- 75 attendees at the Chronic Pain Management Conference (September 2023)

Prescription Review Panel

17 matters involving 12 registrants were brought to the panel

- 6 files were closed
- 4 files were referred for a second interview with the senior medical consultant, deputy registrar and legal counsel
- 3 files were referred to the Inquiry Committee
- 2 files were directed to arrange a phone call with the senior medical consultant

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

INFORMATION

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Deputy Registrar, Health Monitoring and Drug Programs

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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 as well as those family physicians that successfully complete a recognized Practice Ready Assessment program. 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 tenth 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 who want 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, 243 candidates successfully completed the program and commenced independent practice as family physicians. The Ministry of Health, as outlined in its 2022 Health Human Resource Plan, pledged to increase the capacity of the PRA-BC program from 32 to 96 assessments by March 2024. The program has since grown to accommodate the demand for family physicians, with funding allocated to assess 96 physicians annually.

In the 2023/24 fiscal year, the registration department licensed and registered the following:

- 28 associate physicians
  - 27 acute care
  - 1 community
- 9 USA certified
  - 2 American Board of Pediatrics
  - 5 American Board of Internal Medicine
  - 2 American Board of Emergency Medicine

The registration department also operationalized a pilot associate physician – community care licence for an urgent and primary care centre in Prince George. One person has been licensed under this pilot program.

In October 2023, new College Bylaws came into effect that affected those in the provisional class of registration and licensure. They provided provisional registrants with alternative options other than obtaining the Royal College of Physicians and Surgeons (RCPSC) certification by examination or certificate with the College of Family Physicians of Canada (CFPC).

These options now include:

1. Undergoing a summative assessment, at the registrant's cost, after two years of practice in BC. If satisfactory to the Registration Committee, and if the registrant meets all other requirements, they would be eligible to move to the full class.
2. After five years of practice in BC, the Registration Committee may find the registrant eligible to be granted registration in the restricted class. Registration in the restricted class requires ongoing sponsorship from a health authority; however, this removes the requirement for supervision.

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 across Canada.

The College also continues to work with the RCPSC, the CFPC and the Medical Council of Canada to ensure current policies, procedures and bylaws are aligned.

HIGHLIGHTS IN 2023/24

- 353 IMGs applied for registration in BC (based on preliminary completed date; 37% increase from 2022/23)
    - This count includes 58 applicants under the associate physician class
- 82 PRA program-related applications for eligibility were reviewed by the committee (6% increase from 2022/23)
- 174 IMGs previously on the provisional register were advanced to the full class (36% decrease from 2022/23)
- 6 specialists completed a registration assessment and had their provisional licence moved to the full class (same as 2022/23)

T. O'Grady
Chair, Registration Committee

INFORMATION

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