Committee reports

Diagnostic Accreditation Program Committee

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

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

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

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

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

Diagnostic imaging

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

Laboratory medicine

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

Neurodiagnostic services

- electroencephalography
- evoked potentials
- electromyography and nerve conduction studies

Pulmonary function

- hospital-based services
- community-based services

Polysomnography

HIGHLIGHTS IN 2017/18

The DAP provides accreditation services to 675 diagnostic facilities throughout a four-year accreditation cycle.

	Public	Private	Total
Laboratory medicine	128	20	**148**
Laboratory sample collection sites (SCS)	33	121	**154**
Diagnostic imaging	135	66	**201**
Pulmonary function	58	22	**80**
Neurodiagnostics	25	42	**67**
Polysomnography	7	9	**16**
Total	**386**	**280**	**666**

INITIAL ASSESSMENTS

Facilities require provisional accreditation prior to opening and operating in British Columbia. No diagnostic facility may operate without an accreditation award. Provisional accreditation uses a focused standard set addressing patient and staff safety and facility equipment validation prior to opening for service. The provisional assessment is valid for up to one year during which time a full assessment will be scheduled to all applicable standards.

In addition to initial assessments, facilities may require additional assessments that were not identified as part of the annual accreditation cycle (e.g. relocation assessment). Collectively, these are referred to as unscheduled assessments.

Unscheduled assessments conducted between March 2017 and February 2018

Completed Assessments	DI	LM	N	NC	PF	P	Total
Initial	10	5	0	0	1	3	**19**
Relocation	2	4	0	0	2	2	**10**
Focused	0	0	0	0	0	0	**0**

PROFICIENCY TESTING AND QUALITY SYSTEMS

Laboratory medicine

The DAP, in consultation with DAP advisory committees, maintains a list of mandated measurands requiring participation in a commercially available proficiency testing (PT) program. Laboratories must notify the PT provider to release copies of the laboratory PT reports to the DAP. Mandated measurands are subject to the DAP reportable exceptions criteria. Laboratories are expected to submit PT investigation response forms to the DAP within eight weeks of identifying a DAP reportable exception in the PT provider report.

Proficiency Testing Summary

March 1, 2017–February 28, 2018	Total
# PT provider reports reviewed	**551***
# PT investigation responses reviewed	**428**
# PT investigation responses received and pending review	**117**

* PT providers submit reports to DAP in a variety of methods, some of which include multiple reports in one file. In these cases, the file is counted as one report in this data. Typically PT provider reports to DAP also include multiple facility reports.

Pulmonary function quality control monitoring

The DAP utilizes quality control performance to monitor pulmonary function laboratories' technical quality throughout the accreditation cycle. The DAP requires accredited pulmonary function laboratories to participate in a DAP-mandated quality control program to monitor all equipment within the pulmonary function lab, and to submit data twice annually to the DAP for assessment.

Pulmonary Function Facilities

March 1, 2017–February 28, 2018	Total
Number of facilities monitored March 1, 2017	**28**
Number of newly accredited	**0**
Number of voluntary withdrawal	**0**
Number suspended	**0**
Number revoked	**0**
Number transferred from spirometry quality control monitoring	**7***
Number of facilities monitored Feb 28, 2018	**35**

* These facilities offer spirometry and oximetry testing, which requires an on-site assessment by the DAP, so these were moved into the pulmonary function QC monitoring program.

DAP STANDARDS REVISIONS

The Laboratory Medicine Accreditation Standards were revised and released as version 1.3 in February 2017. The primary goal of this version release was to incorporate the ISO 15189 standards as part of the ISO compliance project. The ISO 15189 standards were cross-referenced to the DAP standards to ensure the international requirements were all successfully incorporated.

The community neurodiagnostics accreditation program was launched in 2017.

- Standards were approved by the committee on April 3, 2017
- Accreditation commenced September 2017

Note: This is entirely a new program and should be recognized as such.

Medical peer review standards for polysomnography, pulmonary function, and neurodiagnostics were revised and published. They became effective May 3, 2017.

- **Physicians credentials:** The DAP conducted a comprehensive review of the BC privileging dictionaries and revised the DAP standards accordingly.
- **Magnetic resonance imaging and radiation safety:** Changes to the DAP magnetic resonance imaging acceptance testing and quality control standards and the radiation safety standards were approved for incorporation into the Diagnostic Imaging Accreditation Standards.
- **Molecular genetics:** The College continues to engage discussions with the Ministry of Health regarding accreditation of genetic testing in laboratories within BC. The DAP completed an assessment and an initial assessment of two genomic/genetics facilities in 2017/18.

QUALITY MANAGEMENT SYSTEM

The DAP continued a number of initiatives to develop and refine processes to ensure that the quality management system is continuously improving and that the program is taking steps to comply with best practice ISO standards. Quality initiative training programs in 2017/18 included the following:

Quality Initiative Training Program	Participants
1. QMS orientation New employee orientation	**7**
2. Document control New employee orientation	**7**
3. Writing effective Pprocedures New employee orientation	**6**
4. Developing process maps – part 1 Training just-in-time	**3**
5. Developing process maps – part 2 Training just-in-time	**3**
6. LabQMS user training Software live 2017-03-10	**18**
7. LabQMS editor training Software live 2017-03-10	**18**
8. Introduction to nonconforming events 2017-04-10	**15**
9. NCE process training 2017-05-31	**18**

10.	Introduction to internal auditing 2018-08-01	**16**
11.	Continuous improvement process 2017-09-13	**14**
12.	Internal auditor training Training just-in-time	**5**

The DAP continues to work through the requirements of ISO 17011 to formalize policy and process in support of its bid for ISO accreditation.

BUSINESS PLAN 2018/19

The DAP was pleased to develop the DAP business 2018/19 plan, aligned with the College's three-year strategic plan.The DAP business plan has three objectives:

1. **Enhance communication and engagement with DAP stakeholders:** Building on the relationships developed through various issues (e.g. ISO accreditation, point-of-care testing), DAP staff held multiple meetings with key stakeholders (Ministry of Health, BC's Agency for Pathology and Laboratory Medicine, health authorities) to discuss operational and policy issues of mutual interest.
2. **Continuous quality improvement:** Staff continue to implement and refine the quality management system.
3. **Regulatory innovation**: The DAP is addressing emerging issues in areas of direct-to-consumer marketing of genetics/genomics, medical peer review in diagnostic services, point-of-care testing in non-accredited facilities, and unaccredited sleep clinics.

V.J. Astrope, MD, RCPSC
Chair, Diagnostic Accreditation Program Committee

INFORMATION

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Deputy Registrar

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

Committee reports

Finance and Audit Committee

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

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

PROPERTY

Subsequent to the fiscal year ended February 28, 2018, the College sold one of its strata units comprising 3,173 square feet. The College now owns 59,295 square feet of office space in the building and makes available approximately 7,700 square feet for lease to others until such time that this space is to be repurposed for College use.

COLLEGE INVESTMENTS

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

Short-term investment accounts

The primary goal of the short-term account portfolio is to preserve cash or cash equivalents to meet the annual financial obligations for operational expenses of the College, while optimizing investment returns. The allocation of operational funds is currently 100% fixed investments (short-term bonds, cash and/or term deposits). The balance of cash and short-term investments in the operating accounts at February 28, 2018 was $25,657,000 ($24,844,000 in 2017).

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.

The target allocation for long-term investments is 40% fixed (bonds and cash) and 60% equities (Canadian, US and international). The balance of cash and investments in the long-term accounts at February 28, 2018 was $16,543,000 ($13,652,000 in 2017).

Investment income

- Investment income for the 2017/18 fiscal year before any gains, losses, or investment management fees was $814,000 ($664,000 in 2016/17)
- Realized gains in 2017/18 were $78,000 ($288,000 realized gains in 2016/17)
- Unrealized losses in 2017/18 were $153,000 ($1,156,000 unrealized gains in 2016/17)
- Investment management fees in 2017/18 were $78,000 ($67,000 in 2016/17)

TECHNOLOGY

As part of the College's continuing commitment to enhance and improve its information technology systems, the Board approved an additional $1.8 million in the 2018/19 fiscal year budget for new and ongoing capital projects, which include, but are not limited to the following:

- upgrade to the College's database (iMIS)
- implementing iMIS in the drug programs and quality assurance (Physician Practice Enhancement Program) departments
- integration of the College's accounting systems (Microsoft NAV) with iMIS
- iMIS implementation for the Diagnostic Accreditation Program (DAP)
- iMIS implementation for the Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP)
- complaints new case management
- further enhancements to e-Accreditation and the College's intranet/website
- business analytics/advanced reporting

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

INFORMATION

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Chief Operating Officer

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

Committee reports

Inquiry Committee

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

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

1. investigation of complaints and reports concerning College registrants
2. practice investigations initiated by the Inquiry Committee on its own motion
3. oversight when a physical or mental health disorder may impair the ability of the physician to practise safely and effectively; in such circumstances, if the physician is appropriately engaged and compliant with treatment to the satisfaction of the health monitoring department, the Inquiry Committee is usually not required to take further action

Thirty-one Inquiry Committee members (20 physicians and 11 public members) are appointed amongst five specialized panels. The total number of complaints and reports received is remarkably constant—about 1,000 annually. Adding files opened for own-motion practice investigations, the Inquiry Committee opened 1,012 investigations in 2017/18 (compared to 979 the year before). Of 921 concluded, 371 (40%) were critical of some aspect of the conduct or clinical performance of the subject physician(s). All but three of those were resolved remedially with one or more of the options explained below.

Concerns brought to the attention of the College are initially triaged and categorized as primarily matters of clinical performance, physician conduct, boundary violations (which may include sexual misconduct or a variety of other breaches such as inappropriate business or financial entanglement, self-disclosure or dual relationships), and fitness to practise issues. Statistics for 2017/18 are tabulated in this report.

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

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

In 2017/18, disciplinary citations were authorized against five physicians.

The majority of complaints prompting the issuance of a citation are ultimately resolved through consent orders pursuant to section 37.1 of the *HPA*. If a consent resolution is not possible, the matter proceeds to a hearing before a panel of the Discipline Committee. There were no Discipline Committee hearings held in 2017/18. Five disciplinary matters were concluded. Summaries of discipline decisions are posted on the College website.

CONDUCT, ETHICS AND PROFESSIONALISM

Failure to respond to the College is a recurring conduct concern with potential to conclude with disciplinary consequences. The sole mandate of the College is public protection. That is not possible if physicians do not respond promptly to College investigations. Section 4-13 of the Bylaws made under the *HPA* obliges physicians to cooperate fully and respond promptly. In the past two years, two registrants have been disciplined for their failure to respond, both resulting in a suspension and a fine. Often in such cases the original complaint alleges failure to provide records or a report to inform an insurance claim or legal action.

As noted in previous reports, allegations of deficient clinical communication form a major part of work in the complaints and practice investigations department—a common theme that cuts across several areas of practice that may trigger complaints. The committee considered a number alleging sexual misconduct in 2017/18 that turned out to be misperceived but appropriate physical examinations. The standard *Physical Examinations and Procedures* was updated accordingly. Common themes include failure to adequately explain the purpose of the examination, failure to verbally confirm the patient's consent to each part of the examination, and inadequate explicit attention to modesty mostly through consistent and skilled use of gowning and draping. A review of online posts by medical trainees suggests that gowning and draping is a subject that is poorly taught and not well understood. The College intends to produce an educational video to help address knowledge gaps.

The committee investigated a number of complaints alleging discrimination on the basis of medical condition and complexity this past year. Examples included a patient new to a community already established on long-term opioids for chronic non-

cancer pain and patients initiating or in the midst of insurance or WorkSafeBC claims. The standard *Access to Medical Care* concisely but comprehensively addresses physician obligations in this regard. In many instances, the physician subjects of the complaints expressed surprise that their conduct was characterized as discrimination, responding that that had not been their intent. Allegations of discrimination my also lead to complaints to the BC Human Rights Tribunal. Physicians are encouraged to review the standard.

Altering patient records on receipt of a College complaint is serious misconduct. The committee reviewed the case of a middle-aged man who sought assessment at the walk-in clinic for new-onset right lower quadrant pain and tenderness. His usual physician was unavailable. The physician he saw apparently considered appendicitis as likely, but failed to pursue definitive action, leading to a delayed diagnosis. On receiving the complaint from the College, the physician realized that he had not documented physical examination findings at the time of the visit. He chose to alter the record by adding them, without documenting the late entry. In the age of electronic records, late additions are easy to detect and prove.

A finding of inadequate patient management will normally conclude with remedial activities. Altering a record may be considered unprofessional conduct and may attract serious consequences ranging from a published reprimand to discipline. In this instance, based on what it regarded as compelling mitigating circumstances, the committee directed staff to seek the physician's consent to an unpublished reprimand and a remedial interview. The committee also resolved to investigate the practice of the physician as a separate matter.

Another instance of altering patient records was concluded with disciplinary action.

CLINICAL PERFORMANCE

Concerns about safe prescribing of opioids and sedatives continue to account for a number of clinical complaints. Some allege excessive prescribing and others that physicians have refused to prescribe medications the complainant maintains they ought to receive. All are thoroughly investigated. The most compelling come from families who have lost a loved one after a long struggle with addiction, alleging that inappropriate use of opioid analgesics (too much for too long—usually for musculoskeletal complaints) triggered the illness and failure to recognize and treat the opioid use disorder (OUD) contributed to the tragic outcome. Recent news media reports have suggested that in the era of bootleg fentanyl poisoning, analgesic prescribing is no longer a significant factor in the ongoing opioid crisis. It is clear that most of those dying acquired their OUD years before. But the circumstances of first exposure and emergence of the addiction have not been systematically studied. The College's strong impression is that many OUDs begin with prescribing and that treating acute pain should be regarded as an opportunity for primary prevention.

The College invariably takes a remedial approach to poor prescribing, and has yet to come across a physician who does not aspire to prescribe safely. The College recommends adherence to practice standards, courses and the work of the Practice Support Program (PSP) of the General Practice Services Committee to physicians.

The College has long been concerned about risks associated with older family physicians closing their practices and remaining marginally clinically engaged seeing people they do not know in the course of occasional walk-in shifts. The committee was critical of a part-time walk-in clinic physician who attributed chest discomfort to a benign cause in circumstances highly suggestive of myocardial ischemia.

The literature suggests that, on average, older physicians are disproportionately challenged by novelty. While logistically difficult, the College believes it would be far better for older physicians to work through their pre-retirement trajectory in the familiar confines of the practice they have managed for many years, engaged in the care of patients they know well. That would require the recruitment of younger colleagues to share the work—something that can be very challenging in the current market place and system. But transitioning to the rapid-turnover environment of a walk-in clinic setting and assessing acute presentations afflicting unfamiliar patients is not ideal for the final chapter in an otherwise long and productive professional life.

In the context of the health-care team, making critical diagnoses is a primary role for physicians. Making the wrong diagnosis puts patients at risk. The College expects physicians to be just as competent on their last day in practice as they were on their first. It is a foundational aspect of the professional obligation to give primacy to the well-being of every patient.

In this instance, the committee directed that its investigation be concluded with an interview with the physician to reinforce its message, while this was an error any physician could have made, the literature tells us that the risk, on average, increases with practitioner age. Noting that its review of this matter raises questions about the competence of the registrant, the committee also resolved on its own motion to comprehensively investigate his practice as a separate matter.

BOUNDARY VIOLATIONS AND DISCIPLINARY MATTERS

The number of boundary complaints was unchanged (21 vs. 20 in 2016/17). There were 14 allegations of unwelcome physician contact. As noted above, following investigation, most of those were determined to have been misperceived examinations. There were no disciplinary orders for sexual misconduct in 2017/18.

Five disciplinary matters were concluded in 2017/18. Two were for improperly billing the Medical Services Plan of BC (MSP). One of those led to a criminal conviction for fraud. Billing fraud has the potential to lead to financial, regulatory and criminal penalties. One followed a disciplinary hearing for failure to

respond. One involved failure to maintain professional boundaries with a patient. Finally, as noted above, a registrant was disciplined largely for altering patient records.

SIGNIFICANT EVENTS IN 2016/17

The complaints and practice investigations department welcomed the appointment of Mr. Derek Martinig as director.

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

INFORMATION

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J.G. Wilson, MD, MSc, FCFP
Senior Deputy Registrar

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.

The Library Committee and library staff engaged in a triennial strategic planning process in May 2017. To support the library's mission, the strategic priorities for the coming three years were determined to be:

SERVICE DELIVERY

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

- Regarding document delivery, library subscriptions to over 6,000 electronic journals were the source of over 50,000 articles downloaded by staff and registrants. To optimize access for registrants, the e-journals are listed in an A-to-Z list on the library's website and are integrated into databases such as Medline and PsycINFO.
- Registrants posed 3% more in-depth literature search requests in 2017; a total of 1,445 requests were addressed by librarians.
- A broad scope of clinical information resources are accessible to registrants through the library's website including apps, audio lectures, Canadian and international drug information sources, over 600 current ebooks, key medical and specialty databases, and evidence-based point of care tools such as BMJ Best Practice.
- Librarians also interacted with registrants at events such as library workshops, medical conferences, and one-to-one literature search training sessions. The 36 events were 50% more than the previous year, attended by 347 registrants.

SERVICE TRANSFORMATION

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

- A plan to integrate clinically relevant library resources into physicians' electronic medical record systems was launched in 2017. A single sign-on technical solution was developed leveraging the College website's authentication system and a pilot project is anticipated in the coming year.
- Another initiative broke ground in 2017, the development of a library app, which will make mobile access to resources simpler and more direct. An app vendor with success in managing the unique authentication challenges of delivering subscription-based online resources was identified and preliminary consultations indicate a launch of the app to registrants is likely in mid-2018.

PROMOTION

The library has benefited from feedback from physicians who were identified by their colleagues as key knowledge leaders (KKLs). A suggestion from KKLs was to regularly inform them about library services.

- KKLs received "What I Need to Know" email messages in 2017 that invited them to utilize the library's literature search service to help answer their clinical questions. From the 1,845 invitations sent, 110 queries from key knowledge leaders were directed to the library, 45 of which were in-depth reference queries and 14 were made by physicians who were new to using library services.
- All KKLs also received email messages highlighting drug information, patient education, and clinical knowledge resources on the library's website.

LIBRARY'S IMPACT ON CLINICAL PRACTICE

Direct support of clinical practice is one of the most efficacious roles of the College library in protecting the public. The library's impact is reflected in a great deal of positive unsolicited feedback from registrants.

HIGHLIGHTS IN 2017/18 OF LIBRARY USAGE DATA

Individual physicians served (excluding self-serve through the website)	1,953
Total contacts between staff and registrants	11,517
Literature search requests	1,445
Articles delivered	52,008
Ebook chapters viewed	10,303

G. Parhar, MD, CCFP, CIME
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

Methadone Panel

The scope of the Methadone 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. **Note: These sections of the Bylaws were repealed on June 5, 2017.**

This report covers the period March 1, 2017 to June 3, 2017. On June 5, 2017, the Methadone Maintenance Program was transferred to the BC Centre on Substance Use (BCCSU).

The Methadone Panel met twice to assist physicians in prescribing methadone safely and effectively by developing guidelines, providing education and assessing methadone practice. Guidelines for prescribing methadone included the *Methadone and Buprenorphine: Clinical Practice Guideline for Opioid Use*. On June 5, 2017, the BCCSU released the new provincial *Guideline for the Clinical Management of Opioid Use Disorder*, and the College removed its set of guidelines. It also assumed responsibility for education of new prescribers. Regarding methadone for analgesia, the *Methadone for Analgesia Guidelines* were reviewed and updated in 2016. They are still available on the College website.

The BCCSU requirements to be a prescriber of methadone for opioid use disorder are available on their website. The College still operationalizes authorizations to prescribe methadone for analgesia, which simply involve required readings and a brief but thorough online course.

The panel reviewed new prescribers' practices after the first year and at regular intervals thereafter. In the time period specified in this report, 18 methadone practice assessments were performed: four on-site preceptorship assessments and 14 documentary assessments (via review of clinical charts and PharmaNet prescription profiles). The lack of opioid agonist treatment (OAT) prescribers in rural British Columbia concerns the College and the Ministry of Health. New prescribers from rural areas are therefore particularly encouraged to engage in addictions treatment. To remove a barrier to methadone prescribing, the College discontinued the requirement for registration of methadone patients in July 2016. The requirement for a methadone exemption in order to prescribe buprenorphine/naloxone was removed at that time as well.

A list of BC methadone clinics accepting new patients can be found on the BCCSU website.

HIGHLIGHTS IN 2017/18

From March 1 to June 3, 2017 unless otherwise specified:

Number of new physicians with opioid use disorder authorizations	51
Number of new physicians with analgesia authorizations	12
Number of new physicians with temporary authorizations	14
Number of new physicians with hospitalist authorizations	2
Total number of physicians with opioid use disorder authorizations	610
Total number of physicians with dual authorizations (opioid use disorder and analgesia)	324
Total number of physicians with analgesia authorizations (March 1, 2017–February 28, 2018)	846
Total number of physicians who underwent methadone practice assessments	18

WORKSHOPS IN 2017/18

In response to the opioid crisis, the College expanded the workshops outside the Lower Mainland in order to increase the number of methadone prescribers in these underserviced rural areas:

Vancouver – April 1, 2017	82 attendees
Prince George – June 3, 2017	23 attendees

D.J. Etches, MD, MClSc, CCFP, FCFP
Chair, Methadone Maintenance Committee

INFORMATION

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Deputy Registrar, Health Monitoring and Drug Programs

F.J. Bhimji, BSP
Manager, Drug Programs

Committee reports

Non-Hospital Medical and Surgical Facilities Accreditation Program Committee

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

As legislated by the Ministry of Health, the Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) currently accredits 57 private surgical facilities within BC. Program accreditation is recognized as a standard that demonstrates a facility's commitment to delivering safe quality healthcare.

PUBLIC TRUST

The committee's overriding interest is the protection and safety of the public through ensuring quality and safe patient care delivery in the non-hospital sector. The committee promotes excellence in medical and surgical services through establishing accreditation standards, evaluating performance and monitoring outcomes.

As part of the College's overarching objectives, the committee launched a three-year strategic plan on June 8, 2016. The committee continued its focus on the aims of the plan, namely quality assurance, enriched partnership with stakeholders, organizational efficiency and increasing public access to information.

Ensuring good governance is an integral component of the work of the committee and in 2017/18, the College Board set out a strategic direction for the revision of the program's section of the Bylaws. The revised Bylaws were posted on the College website for stakeholder feedback immediately prior to the last fiscal year in February 2017. In addition to implementing this revision of the Bylaws, the committee and program staff completed a number of important strategies objectives in 2017/18:

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

   The medical directors of non-hospital medical and surgical facilities have a responsibility for the overall quality of care provided in their facilities. Effective leadership, accountability and quality assurance are essential components of the work they do. The committee supported the work of medical directors through review and evaluation of medical directors' applications for appointment at facilities, ongoing communications on issues of clinical importance, and facility-specific advice and guidance.

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

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

   - review of patient safety incidents through renewed processes and procedures
   - annual evaluations were completed by the chair and committee members
   - ongoing development and review of standards related to interventional pain management, medication management, point-of-care testing, and specimen handling

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

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

   - participation in provincial-level working group on the development of revised recommendations for the reprocessing of endocavity ultrasound probes
   - analysis of accreditation processes and data systems to improve program efficiencies
   - implementation of an operational plan to ensure ongoing commitment for a cost neutral budget
   - ongoing development of a quality management system, including the implementation of an electronic document management system

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

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

   - external stakeholder consultation of the Heating, Ventilation and Air Conditioning Impact Assessment and Options Report and development of related policy for facilities
   - ongoing information sharing with stakeholders, including standards development, communiques, articles in the *College Connector* and the Annual Report

HIGHLIGHTS IN 2017/18

The NHMSFAP witnessed the following activity:

- 4 new private medical/surgical facilities opened
- 4 private medical/surgical facilities closed
- 57 private medical/surgical facilities were operating in BC
- 16 private medical/surgical facilities were accredited as part of their four-year accreditation cycle or focused visit, of which:
    - 14 were granted a four-year full accreditation, and
    - 2 were granted accreditation subject to a report

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

- 69,516 procedures were performed in private medical/surgical facilities across the province (including laser refractive procedures)
- 51% of procedures performed (excluding laser refractive procedures) were publicly funded cases (e.g. MSP or health authority)
- 6% of procedures (excluding laser refractive procedures) were contracted by a third party (e.g. WorkSafe BC, ICBC, federal government)
- 737 physicians were authorized by the College to provide medical services in one or more private medical/surgical facilities

S.G. Holland, MD, FRCPC
Chair, Non-Hospital Medical and Surgical Facilities Accreditation Program Committee

INFORMATION

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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 PRPSE Committee administers a patient relations program to prevent professional misconduct of a sexual nature, and to serve as a resource to the Board in matters pertaining to standards of practice, and standards of professional ethics in medical practice. The committee identifies opportunities to consult with stakeholders as draft standards and guidelines are developed.

PROFESSIONAL BOUNDARIES IN THE PATIENT-PHYSICIAN RELATIONSHIP

Following consultation with the profession and the public, the committee finalized two standards: *Boundary Violations in the Patient-Physician Relationship* and *Physical Examinations and Procedures*, as well as a companion patient education bulletin. The two standards and the patient bulletin were approved by the Board and published on the College website in June 2017.

WALK-IN CLINICS

Using an online engagement platform called PlaceSpeak, the committee consulted with the public on their general experiences related to the care they receive at walk-in clinics. The committee reviewed the results from the consultation and directed that more FAQs be added to the College website, and that a patient education bulletin be drafted about what patients should expect when they visit a walk-in clinic.

REFERRAL PROCESS ADVISORY GROUP

This year the committee invited two family practitioners and two specialists to participate in an advisory group to help guide the development of a revised guideline or standard on the referral/consultation process. The new document will be circulated to the profession for feedback and is expected to be finalized in fiscal 2018/19.

CONTINUITY OF CARE STANDARDS

With direction from the Board, the committee began a review of all of the existing standards and guidelines related to continuity of care, including: *Access to Medical Care; After-Hours Coverage; Ending the Patient-Physician Relationship;* and *Leaving Practice*. The newly drafted documents will be circulated to the profession and the public for feedback in fiscal 2018/19.

L.C. Jewett, MD, FRCSC
Chair, Patient Relations, Professional Standards and Ethics Committee

INFORMATION

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H.M. Oetter, MD
Registrar and CEO

Committee reports

Physician Practice Enhancement Panel

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

The Physician Practice Enhancement Panel is comprised of five general practice physicians, three specialist physicians, and four public members, and provides oversight to the Physician Practice Enhancement Program (PPEP) which assesses the professional performance of a registrant in accordance with criteria established by the Board.

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

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

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

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

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

STRATEGIC PLANNING

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

As the program shifts to an explicit quality-improvement orientation it continues to adopt new measures to support physician self-reflection and self-learning. Physician assessment reports, Performance Review and Action Plan, now include action plans as an added opportunity for feedback. While not all physicians are required to complete and submit an action plan, the framework allows physicians to reflect on their assessment feedback, evaluate their clinical practice, and plan for change.

PPEP also continues to increase the program's capacity to assess additional medical specialties and recruited four dermatologists to develop a dermatology peer assessment program. Assessor training for the new specialty assessments will begin in 2018.

PEER PRACTICE ASSESSMENTS

In 2017, the PPEP program assessed over 600 community-based physicians with the most common opportunity for improvement being record keeping. The panel refers to the requirements for medical records outlined in the College's professional standard, *Medical Records*, and the PPEP assessment standard *Unified Medical Record*. Physician records need to document an intellectual footprint to allow for continuity of care by other health professionals such as locums. This requirement forms part of the panel's mandate to ensure patient safety.

The majority of PPEP assessments completed were conducted in multi-physician clinics, including walk-in clinics, where the program continues to educate medical directors and clinic physicians on the requirements of appropriate longitudinal patient care for patients. The panel refers to the requirements directed under the College's *Walk-in, Urgent Care and Multi-physician Clinics* standard and the PPEP assessment standard *Medical Director/Solo-practice Physician*, which outlines the requirement for having a system in place to capture detailed recorded care, a cumulative patient profile, and an identified most responsible physician (MRP).

PHYSICIAN OFFICE MEDICAL DEVICE REPROCESSING ASSESSMENTS

Physician Office Medical Device Reprocessing Assessments (POMDRA) began within the office assessment component of

PPEP, where assessors raised concerns regarding the medical device reprocessing (MDR) practices of reusable semi-critical and/or critical medical devices in community-based physician offices. POMDRA was developed to proactively educate and support physicians in making the necessary changes to the reprocessing of their reusable medical devices and continue providing safe care to their patients.

This quality assurance program is based on the requirements of the Ministry of Health *Best Practices for Cleaning, Disinfection and Sterilization for Critical and Semi-Critical Medical Devices* (2011) and the Canadian Standards Association (CSA) for medical device reprocessing.

In 2017, more than 4,000 physicians identified on their Annual Licence Renewal Form that they reprocess semi-critical and/or critical reusable medical devices in their community-based clinical office. Given the number of physicians, POMDRA developed various resources to support physicians in meeting the required standards including a Physician Office Medical Device Reprocessing Assessment Tool for Steam Sterilization, which provides physicians an opportunity to self-identify deficiencies prior to participating in POMDRA. The assessment tool is also used during on-site assessments and contributes to the final report that is shared with physicians.

To date, the most common deficiencies of steam sterilization practices include: the lack of biological indicator and chemical indicator (internal/external) testing; incorrect cleaning product or detergent; no physical monitoring including the time, temperature, and pressure of the steam sterilizer; and no log book or record keeping.

HIGHLIGHTS IN 2017/18

Number of community-based PPEP assessments	601
Registrants agreeing/strongly agreeing that assessment was worthwhile experience	62%
Registrants agreeing/strongly agreeing that their practice changed as a result of the assessment	62%
Number of POMDRA on-site assessments	116
Number of POMDRA telephone assessments	156

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

INFORMATION

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Deputy Registrar

N. Castro, MHA
Director, Physician Practice Enhancement Program

Committee reports

Prescription Review Panel

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

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

- reviewing the prescribing of controlled medications with potential for misuse/abuse, such as opioids, benzodiazepines, sedative/hypnotics and stimulants
- providing guidance to registrants on the use of these drugs by:
    - corresponding with physicians
    - reviewing submitted patient records and providing advice
    - directing that physicians attend for interview
    - assigning readings
    - providing relevant courses

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

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

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

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

Since January 2017, a survey has been sent to each physician who has completed the PRP process. Based on feedback from the survey, the process was revamped and launched in July 2017.

HIGHLIGHTS IN 2017/18

- 247 referrals were received
- 130 new files were opened; 70% had not had a previous engagement with the PRP
- 219 files are currently open, in various stages
- 192 files were closed
    - Old process files
        - 0 files were closed in stage 1
        - 67% of files were closed in stage 2
        - 21% of files were closed in stage 3
        - 7% of files were closed in stage 4
        - 1% of files were closed in stage 5
        - 2% of files were closed in stage 6
        - 2% of files (five physicians) referred to the Inquiry Committee
    - New process files
        - 43% of files were closed in stage 2
        - 57% of files were closed in stage 3
        - No files have progressed to later stages
- 81% of files were closed for improvement in prescribing
- Average lifespan of a file was 26 months
- Sponsorship of the Foundation for Medical Excellence Chronic Pain Management Conference – held March 2 and 3, 2018
- Implementation of a physician feedback survey, to assist with continuous quality improvement of the PRP process
- Continued implementation and ongoing review of a new case management system based on adult learning methods

PRESCRIBER'S COURSE IN 2017/18

April 28, 2017	36 attendees
October 13, 2017	20 attendees*

* Course size and venue were changed to accommodate small-group learning.

The Prescribers Course assists physicians with strategies for managing complex chronic pain patients taking opioids. Half of the day is spent in practice interviews with standardized patients. With the advent of nurse practitioners prescribing controlled medications, the College has expanded attendance at the Prescribers Course to include nurse practitioners. Allied health professionals are also welcomed, if numbers permit. The course will also be held outside of the Lower Mainland once a year, to provide assistance to those practising in more remote areas.

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

INFORMATION

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Deputy Registrar, Health Monitoring and Drug Programs

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

British Columbia currently is in the fourth year of the Practice Ready Assessment – British Columbia (PRA-BC) program which is governed by a steering committee made up of representatives from the Physician Services Strategic Advisory Committee, the University of British Columbia, the College of Physicians and Surgeons of British Columbia, the BC Ministry of Health and its health authorities, the Doctors of BC, and Health Match BC. The PRA-BC program was developed between 2012 and 2014 to create an acceptable entry-to-practice competency assessment program for general practitioners wanting to practise in British Columbia. The program consists of four components: a screening and selection process; point-in-time orientation and examination phase; a clinical field assessment; and an application for provisional registration and licensure from the College for successful program candidates. The clinical field assessment is 12 weeks in duration in a group general/family practice setting in BC. The first iteration of the PRA-BC program commenced in April 2015. To date, 87 of 89 candidates are now engaged in the independent practice of medicine as family practitioners under sponsorship and supervision. In the next year, there will be 60 candidates that go through the PRA-BC program.

Work continues on updating and developing policies that support the implementation of College Bylaws made pursuant to the *Health Professions Act*. Policy development and implementation has focused on defining parameters around current registration and licensure requirements for the various classes of registration and reviewing and updating the current registration assessment program. Under the College Bylaws, certain registrants must meet criteria stipulated by the Registration Committee within a given time period (these are defined at the commencement of their practice in British Columbia). As part of this process, summative assessments are completed for those general/family practice registrants who were first registered under the provisions of the former *Medical Practitioners Act* (i.e. those registered prior to June 1, 2009) and who elect to undergo a summative practice assessment in lieu of obtaining their CCFP examinations. These are also completed for specialists trained in the United States of America who have registered under either the *Medical Practitioners Act* or the *Health Professions Act* and who have completed postgraduate training accredited by the Accreditation Council for Graduate Medical Education (ACGME) and who hold their American board specialty examinations. Those registrants with successful summative assessments are eligible to be granted registration and licensure in the full class in their primary specialty in lieu of obtaining Royal College of Physicians and Surgeons of Canada (RCPSC) certification.

NATIONALLY

At the national level, work continues on developing national registration standards for the full class of registration for all provinces and territories. Together with the Medical Council of Canada, the Federation of Medical Regulatory Authorities of Canada and its member colleges began developing the web-based electronic application process for physicians wanting to obtain full or provisional registration in any province or territory of Canada. The Medical Council of Canada launched a new system and candidate portal on May 23, 2013: the Application for Medical Registration in Canada (AMRC) at physiciansapply.ca. The College implemented the AMRC in September 2016.

HIGHLIGHTS IN 2017/18

- 237 IMGs applied for registration in BC
- 90 PRA program-related applications for eligibility were reviewed by the committee
- 98 IMGs previously on the provisional register were advanced to the full register

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

INFORMATION

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