Council Meeting
September 3 & 4, 2015

Agenda

A meeting of the Council of the College of Physicians & Surgeons of Alberta will be held in the Council Chamber at 2700, 10020 100 Street, Edmonton, commencing at 1:00 p.m. on Thursday, September 3, 2015, reconvening at 8:00 a.m. on the 4th.

Thursday, September 3

1:00 p.m. 1. Overview of Meeting, Conflict of Interest Declarations, Approval of Business and Consent Agendas Action Required: Resolution

2. Approval of Minutes, May 28 & 29, 2015 (circulated previously) Action Required: Resolution

3. President’s Report

4. Registrar’s Report .................................................................

1:45 p.m. 5. Appoint Election Officers (T. Theman) ..........................................................5 mins Action Required: Resolution

1:50 p.m. 6. 2017 Council Meeting Schedule (T. Theman)..........................................................5 mins .......................

Action Required: Approval

2:00 p.m. 7. Executive Search Committee Terms of Reference .................................................15 mins .................

(J. Stone, M. Munsch)

Action Required: Resolution

2:15 p.m. 8. Governance

8.1. 2016 Strategic Plan Review Request for Proposal ..................10 mins .................

(T. Theman)

Action Required: Resolution

... /
8.2. Triennial Review of Bylaws...... 20 mins .................24
(J. Stone)
Action Required: Resolution

**2:30 p.m.** Comfort Break

**2:45 p.m.** 9. Strategic Plan Targets & Measures ....... 10 mins .................50
(T. Theman)
Action Required: None. For information

**3:00 p.m.** 10. Finance & Audit Committee
(C. MacDonald, O. Heisler)

10.1. Update ........................................ 30 mins .................90

10.1.1. University Requests
Action Required: For information

10.1.2. Building Fund
Action Required: For information

10.2. 2016 Business Plan .................... 30 mins .................... 94
Action Required: Discussion

10.3. Budget ........................................ 30 mins .................. 109
Action Required: Resolution

**4:15 p.m.** 11. Provisional Register Conditional Practice
Amended Registration Requirements ...... 5 mins ................. 120
(K. Reed)
Action Required: Resolution

**4:20 p.m.** In-Camera w/the Registrar

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**Friday, September 4**

**8:00 a.m.** 12. Standards of Practice
(O. Heisler, S. Thomas)

12.1. Call to Action ............................... 5 mins
*Collaboration in Patient Care; Referral Consultation Process; Transfer of Care*
Action Required: None. For information

12.2. Pre-consultation .......................... 90 mins ................. 122
*Assessing Mental Capacity; Informed Consent; Moral or Religious Beliefs*
Action Required: Direction

... /
12.2.1. Advice to the Profession: Informed Consent
Action Required: For information

12.2.2. Advice to the Profession: Legislated Reporting & Release of Medical Information
Action Required: For information

12.3. Post-Consultation
Action Required: For information

12.3.1. Advice to the Profession: Advertising
Action Required: For information

**Councillor Education**

**11:30 a.m.** 13. About the Registration Department ....... 30 mins
(K. Reed)

******

Noon Lunch

**1:00 p.m.** 14. Rural Physician Action Plan ............... 30 mins
(D. Kay, Executive Director, RPAP)
Action Required: None. For information

**1:30 p.m.** 15. Competence Committee ...................... 45 mins
(A. Crabtree, K. Mazurek)

15.1. Activity Report ........................................  .................... 173
Action Required: None. For information

15.2. Rules for Member Participation ..............  .................... 175
Action Required: Resolution

a. Continuous Professional Development .......... 183
b. Physician Achievement Review Program .......... 186
d. Competence Assessment  .................... 189

**2:15 p.m.** 16. Registration Criteria for ..................... 30 mins .......... 192
Physician Assistants
(K. Reed)
Action Required: Resolutions (3)

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| 3:00 p.m.| 17. Liability Insurance ........................................... 15 mins .......................... 199  
(K. Reed)  
Action Required: Resolution |
| 3:15 p.m.| 18. Legislation Committee ........................................... 20 mins .......................... 201  
(M. O’Beirne)  
Action Required: Discussion |
| 3:35 p.m.| 19. In-camera w/the Registrar                                      |

**Consent Agenda**

(approval is automatic upon resolution)
(unanimous consent needed to move an item to the Business Agenda)

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<td>3:35 p.m.</td>
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Registrar’s Report to Executive and Council: August/September 2015

Follow-up from May Council

A number of items from the May Council meeting are scheduled for discussion and decision at the September meeting including the governance review, the request for funding by the CPD departments of the Faculties of Medicine (in the FAC report) and physician-assisted death (PAD). Dr. Gibson’s request to have Choosing Wisely on the agenda has been tentatively scheduled for December to accommodate the presenters.

As usual, summer is quieter than the rest of the year but staff (those not on holiday!) have been busy planning and preparing business plans and budgets for FAC and Council. Staff is also taking on a complete review and overhaul of the Registration Information Form (RIF) to be complete for 2017 annual renewal, removing redundancies and duplication, eliminating non-essential information and improving the readability and formatting.

Our two major “public” issues this summer continue to be physician-assisted death (PAD) and sponsorship (for the Provisional Register – Conditional Practice, or PRCP).

Physician-Assisted Death (PAD)

Staff, primarily Sarah Thomas, Owen Heisler and Barb Krahn, has been working over the summer both to meet with interested parties and groups and to prepare an advice document for the profession to be made public this fall. We expect this document will generate discussion within the profession and public that will inform both this document and future revisions to specific Standards of Practice relevant to PAD (such as consent, medical records and reporting, determining competency).

The advisory panel appointed by the federal government has assumed a mode of “passive consultation” until after the federal election. Recently the P/T governments agreed to create their own advisory panel under the leadership of the Ontario Ministry of Health and Long Term Care (MOHLTC). The co-chairs are Dr. Jennifer Gibson, Director of the U of T Joint Center for Bioethics and Maureen Taylor, a Physician Assistant and medical journalist. I’m honored to have been appointed to this panel as the sole medical regulator and as the nominee of Alberta Health.

The issue of physician autonomy in refusing any participation in actions that are objected to on the grounds of moral or religious beliefs is gaining prominence and will almost certainly be topics of debate at both the CMA and CMPA annual meetings in Halifax in August.

Sponsorship (for Applicants to the Provisional Register-Conditional Practice)

The dust seems to be settling on the sponsorship issue as potential applicants who’ve been waiting to learn if they’ll be sponsored have received direction to apply to the physician job listing site of Alberta Health Services, and as applicants who have a non-AHS sponsor (and their sponsors) are being contacted directly by AHS and learning whether support for the applicant is forthcoming or not.

By the time this is read College staff will have participated in a status review of this file with staff from AHS and Alberta Health.
Continuity of Care

We are proceeding with our communication and implementation plan for this newly revised Standard of Practice. Questions and calls from members are now around mechanics – *how can I meet the expectations of the standard in my circumstances?* Our messaging has been consistent: the decision to approve the revised standard has been made after fulsome consultation and the College is serious about ensuring adherence to the standard. Success will require some time for adaptation and creation of call groups, for example, and persistence by the CPSA.

FMRAC

The FMRAC annual general meeting and educational session took place shortly after Council. The topics addressed in the educational sessions were those of *transparency* (half a day) and *continuity of care* (full day). While undoubtedly biased in my perspective I believe the CPSA is performing well in both of these areas. Specifically, we are quite open about the information we make publicly available about our members and we are very transparent about the work of the College itself – posting agenda materials, making processes and policies public, providing email addresses and phone numbers for staff, etc. While we all have a long way to go to ensure continuity of care for patients, Council’s approval of the Standard of Practice on Continuity of Care and the related consultation have highlighted this issue in Alberta relative to some other jurisdictions in Canada (see comments above).

Liaison and other matters

We understand that Alberta Health is hopeful that the HPA and HIA amendments will, after much delay, be introduced in the fall sitting of the legislature. Included in the package (we hope) will be amendments to the College’s regulations to allow for the regulation of Physician Assistants. You will see on Council’s agenda proposed registration categories and a fee for the registration and annual renewal for Physician Assistants.

Mike Caffaro and I met with Deb Prowse, Alberta’s Patient Advocate, to introduce Dr. Caffaro as our new Complaints Director and to discuss some common concerns. The Patient Advocate’s office has been given more resources under the new government and intends to expand its staff and services. From my perspective there remains a need to revise the regulations of the Alberta Health Act to clarify the role of the Patient Advocate’s office with respect to complaint handling.

I continue to participate as the CPSA representative at the Alberta Advisory Committee on Health Technologies (AACHT), our rep to the community partners group of the Health Research and Innovation Collaboratory (HRIC), the oversight committee on health research ethics for Alberta Innovates-Health Solutions (AIHS) and to the Health Quality Network.

At a couple of these forums I’ve advocated for the need for a clear vision for our health system, consistent with goal 2 of the College’s strategic plan; the response has been mixed. While there is some agreement about the need for a clear vision, other perspectives are that we know where we’re going and our failure is around execution rather than vision; and we just need to do some things to prove we can – we can work out the big picture later. I’ve not yet had the chance to meet with Carl Amrhein in his
new role as Deputy Minister or with the new Minister of Health, Sarah Hoffman, to speak about these and other issues.

Recently I met with a representative of the Auditor General of Alberta. The AG plans to conduct a review of Alberta’s health system focused on two specific areas – integration (or not) of the health system and physician engagement.

Finally, at the end of June we said goodbye to Ken Gardener in his role as Assistant Registrar for Accreditation and Competency Enhancement. Staff recognized Ken at our annual staff appreciation lunch. Following that event we hosted an informal reception for Ken. About a hundred people attended including Dr. Stone who offered words of appreciation on behalf of Council. While retired as Assistant Registrar, Ken continues to support our competence program on a limited basis.

Trevor Theman
2017

New Councillor Orientation
Thursday, February 2, - 9:00 to 4:30
Location: Jasper Room, CPSA
(new councillors, president, secretariat)

Retreat
Friday, February 3 – Meeting
Saturday, February 4 – Meeting until Noon
Location TBA

Council Meetings
@CPSA
March 2 & 3    May 25 & 26
March (act dates TBA 2016)    President & Registrar
Saturday, February 4 – Meeting until Noon
Location TBA

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March (act dates TBA 2016)    President & Registrar

May 25 & 26    November 30, December 1

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<td>US Fed, Omni Fort Worth</td>
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<td>June 9-12</td>
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<td>August 20-23</td>
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<td>September 7 &amp; 8</td>
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<td>September 24-26</td>
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The College of Physicians and Surgeons of Alberta

Registrar Search & Selection Committee
Terms of Reference

Purpose

The College of Physicians and Surgeons of Alberta (CPSA), is undertaking a search for a new Registrar to be in place for July 1, 2017.

A Search and Selection Committee will be established by, and accountable to, the CPSA Council for leading the search & selection process. The Committee will remain in place until a successful candidate is secured.

Principles

The objective of the Search and Selection process is to secure the best candidate for the Registrar role. The following principles will guide the process:

- Search will be international in scope.
- A fair and transparent process will be used.
- Input from the relevant stakeholders will be secured, including the CPSA Council and staff.
- Deliberations of the committee and all matters pertaining to its proceedings will be strictly confidential.
- All candidates, internal and external, will follow the same selection process.

Committee Composition

The Search & Selection Committee will be comprised of 5 Members of CPSA Council, recommended by the Nominating Committee of Council and ratified by Council. Council will appoint the Committee Chair. Committee members will include:

- President of CPSA Council
- 4 Members of College Council, with a minimum of 1 Public Member

The Nominating Committee of Council will recommend Committee Members based on interest, availability and experience. Experience in executive search will be a valuable asset.

In the event a vacancy occurs on the Committee during the course of the search, the Committee Chair, in consultation with the Committee, will make a final determination on whether or not it is in the best interests of the search process to fill the vacancy.
Mandate/Deliverables

The Search & Selection Committee will:

- Develop a budget for the search and selection process.
- Develop a position profile that aligns with the CPSA’s vision, mission, values, and strategic priorities. The profile will be shared with CPSA Council to secure input and support.
- Hire an Executive Search Company through a Request for Proposal process to assist the Committee in conducting an International Search.
- Develop an agreed upon comprehensive search and selection process.
- Establish selection criteria including appropriate weighting of qualifications for the position when determining a short list of candidates.
- Participate in all personal interviews with short listed candidates.
- Strive for consensus on a recommended candidate. However, a majority vote will prevail, and the top candidate will be presented to CPSA Council.
- Recommend to CPSA Council a candidate for the role of Registrar.

The Chair of the Committee will:

- Work with the President of Council and the Chair of Finance & Audit Committee to establish the parameters of the compensation package for the new Registrar, ensuring it aligns with the College’s compensation framework.
- Work with the Search Firm to negotiate the employment contract with the final candidate.
- Work with the President of Council and Legal to draft the new employment contract.

Individual Role and Responsibilities of Committee Members

The Chair of the Search & Selection Committee will call meetings. Every consideration will be made to accommodate members’ schedules, but attendance at all scheduled Committee meetings is mandatory. At the discretion of the Chair meetings may be held by teleconference.

For a successful process, it is important that all Committee Members:

- Commit to attending all scheduled Committee meetings and interviews with candidates and to remain on the Committee until its work is fully completed.
- Respect the process and maintain focus on the goal of the Committee.
- Ensure the best possible candidate is recommended to CPSA Council.
- Bring his/her career and personal experience to the candidate evaluation process. While the position profile and selection criteria will serve as a benchmark on which all potential candidates are evaluated, intuition and a sense of candidate fit are important in any selection process and the goal is to
use all information, both subjective and objective, in the evaluation of potential candidates.

- Maintain strict confidentiality in all matters related to the search. All enquiries must be taken to the Chair of the Search & Selection Committee.
- Fully engage in respectful, open, thoughtful discussion, ensuring breadth of opinion and thought.
- Declare a conflict of interest with any potential candidate and discuss strategies to address.

Communication

The Committee, prior to beginning the search and selection process, will draft a communication to all employees and stakeholders outlining the goals and timelines for the process.

The Chair will communicate regularly with CPSA Council on the progress of the Committee. The Chair is the official and only spokesperson for the Committee.

CPSA Council and Committee Members will direct any questions from interested candidates for the position to the Chair of the Search & Selection Committee or the Executive Search Consultant engaged to lead the search.

The Committee will develop a Communication strategy to announce the successful candidate.

Timeline for Search & Selection Process

Outlined below is a timeline to guide the process to ensure a candidate for the Registrar’s role is selected and in place for July 1, 2017. Consideration has been given that the successful candidate may need to provide ample notice (i.e. 6 months) to his/her current employer.

**January 1, 2016**
Committee is established with committee members selected and ready to commence the process.

**January – March 2016**
Committee will:
- Develop a position profile for the Registrar Role.
- Develop a budget for the process.
- Develop a Request for Proposal (RFP) to secure a Search Firm to work with the Committee.

**April – May, 2016**
Committee will:
Select the Search Company to work with the Committee.
Provide the Search Company with the necessary information required to commence and International Search.

**June – August 2016**
- Search Company will conduct their search, identifying candidates for the Search & Selection Committee to interview.
- Committee responsibilities over this period will likely be minimal with the exception of the Chair being available to respond and follow up with the Search firm.

**September – November 2016**
- Interview process underway.

**December 2016**
- Candidate recommended to CPSA Council for approval.

**December 2016 – January 2017**
- Offer/negotiation with successful candidate.

**July 1, 2017**
- New Registrar commences.
Request for Proposal

Facilitating Review of the CPSA’s Strategic Plan

College of Physicians & Surgeons of Alberta

September 2015
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Purpose

The College of Physicians & Surgeons of Alberta (“the College”) is seeking proposals for a review of our Strategic Plan approved in 2011.

College of Physicians & Surgeons of Alberta

Our Organization

The College is responsible for the regulation of the medical profession in Alberta. The main lines of business include:

- Registering physicians
- Investigating and resolving physician-related complaints
- Providing clinical review
- Accrediting health facilities
- Guiding professional conduct and ethical behavior
- Contributing to public policy affecting health care delivery

The College currently operates under the authority of the Health Professions Act and applicable regulations and bylaws.

The College’s governing Council includes physician members, public members and representatives from Alberta's medical schools. Physician members are elected annually by Alberta doctors, while public members and medical school representatives are appointed. College staff, all located in Edmonton, number approximately 110. The Chief Executive Officer, who carries the title Registrar, is Dr. Trevor Themian.

Our Vision

Albertans are healthier because the College of Physicians & Surgeons of Alberta:
- ensures that physicians are competent throughout their careers;
- supports physicians in providing compassionate, caring and ethical services to the people of Alberta;
- fosters quality health care for all Albertans through innovation, collaboration and cooperation with other key stakeholders; and
- advocates for public policy that contributes to the health of Albertans.

Our Mission

Serving the public by guiding the medical profession.
Project Definition

Introduction

The College of Physicians & Surgeons of Alberta completed a strategic planning exercise in 2011. A copy is attached as an Appendix. The plan is reviewed annually by Council however a more in depth strategic planning exercise is needed to ensure that the College remains relevant in today’s health care environment. College Council determined that a formal review of the strategic plan be conducted in 2016.

Deliverables:

Key deliverables of the project will include:

- Review of the current strategic plan focusing on a ten year horizon
- Engagement of regulated members, key interest groups and the public
- A facilitated process to engage Council and the College’s management team in developing and supporting an updated strategic plan
- An updated public document, written in plain language, outlining the Strategic Directions of Council, and internal work plans to build upon them
- Coordination with the College’s communications staff, to derive maximum benefit from this exercise

Governance

A three-person Strategic Planning Review Committee, working with the Registrar and/or his designate will provide direction and oversight to the consultant.

Major Activities

Updated Environment Scan

A comprehensive environmental scan was conducted in 2011. The major activities that are required to update this environment scan include:

- Focus on external environment, in particular:
  - Medical regulation in Canada and internationally
  - The medico-political environment in Alberta and Canada
- Report to the steering committee and Council

Review of Plan and Setting Directions

The major activities that are required to design and implement a process for a review of the Plan include taking actions to:
• Determine, with the review committee, time available from Council and the College’s management team to conduct these activities. Two full-day meeting dates have been budgeted for the Council to align with the current Council schedule. Four ½ day steering committee meetings have been planned in 2016.
• Schedule those activities in a cost-effective way
• Design an agenda to ensure appropriate engagement of Council and the College’s management team
• Interpret the environment scan, determine the key issues and concerns as well as strengths and weaknesses that must be addressed in the next ten years
• Facilitate discussions/workshops for Council and the College’s management team regarding review of a vision, mission and mandate for Council; (including some key indicators of performance)
• Develop and produce materials (visuals, pre-reading, activities, etc.) to conduct the meetings/workshops
• Analyze the information and use the results of the analysis to write in plain language a draft strategic plan document outlining the strategic directions of Council for public consumption

Validation Phase

The major activities that are required to communicate and validate the draft document for strategic directions of Council include:

• Confirm, with the review committee, what set of activities should be conducted
• Establish a work plan and process to implement the validation activities across Alberta
• Organize and conduct activities
• Process information and prepare a report to Council

Communications

A fundamental element of success for this project is a clear communications strategy and plan to ensure the Project is perceived by all internal and external participants in the most positive light. The College’s communications staff will plan and conduct this communications, but will require the consultant to coordinate closely with them.
Proposals

To be considered, each proposal must contain:

- A business plan outlining in sufficient detail the methodologies to be considered for completion of each phase of work. Ideally, a range of methodologies, with pros and cons, will be identified
- An estimate (or range) of the costs associated with each phase of the work

Work on the project will start early January 2016. The chosen consultant will work closely with the Registrar and the steering committee to choose the specific elements and processes within each phase.

Success will be a plan that:

- lays the groundwork for the College’s work over the next decade
- is understood and endorsed by key partners in Alberta’s health system
- identifies key measurable outcomes that will achieve the College’s mandate

The budget for this project is $200,000, which must include all professional fees, subcontract fees (if applicable), expenses and taxes. This budget excludes any Council or steering committee expenses. Completion must be no later than March 31, 2017.
**Required Bidder Information**

The following information should be included in your (your firm’s) proposal to the College:

**Firm Expertise**

Describe the firm’s expertise, qualifications and experience with respect to each aspect of the activities described in the project definition. Alternatively, describe the process by which you propose to select suitable individuals/firms to which you would subcontract such activities.

**Firm Resources**

Describe the expertise, qualifications and experience of each person who would be providing services to the College, including the proposed role of each individual. Please include the biographies of individuals who will be assigned to work on the project.

Describe any project management or administrative support that would be part of the firm’s services to the College. If any portion of the project is to be done by subcontractors, please include in the pricing information.

**General Firm Information**

Please provide:

- Firm name and contact information
- Description of the firm’s size and structure and the general services it provides
- Names and contact information for the key personnel who would serve as the primary contacts for the College

**Pricing Information**

Proposals must include a detailed description of the basis for charging of fees and expenses associated with this project.

**Conflicts of Interest**

Proposals must identify any potential conflicts of interest known to the firm that may affect the provision of services to the College.

**References**

Please include three references. References for similar projects and/or organizations similar to the College are preferred.
Proposal Process

Schedule

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<tr>
<td>October 26, 2015</td>
<td>RFP will be made available to invited firms.</td>
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<tr>
<td>November 13, 2015</td>
<td>All proposals must be submitted to the College by noon of this day.</td>
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<tr>
<td>November 16 - 30, 2015</td>
<td>Internal screening of proposals. The College will develop a short list of at least two firms whose references will then be contacted.</td>
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<tr>
<td>December 7, 2015</td>
<td>Selection of the successful firm will be made and negotiation of terms of engagement undertaken. Other short listed firms will be notified.</td>
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<tr>
<td>January 4, 2016</td>
<td>The successful firm will start the project.</td>
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Proposal Requirements

Proposals must not exceed 15 pages in length, including all attachments and appendices.

Proposals are to be submitted directly to the College via email, addressed to Dr. Trevor Theman, Registrar at trevor.theman@cpsa.ab.ca.

Selection Criteria

Proposals will be evaluated against the following criteria:

- Demonstrated expertise, qualifications and experience to meet the requirements set out in the project definition.
- Demonstrated understanding of the issues facing the College and the environment in which it operates.
- Demonstrated ability of the consultant to work cooperatively with diverse groups and individuals.

The College will not necessarily select the lowest cost proposal.

Proposal Conditions

Contingencies

This Request for Proposals (RFP) does not commit the College to award a contract. The College reserves the right to accept or reject any or all proposals or waive irregularities if the College determines it is in the best interest of the College to do so.
Acceptance or Rejection of Proposals
Proposals shall remain open, valid and subject to acceptance anytime up to three months after the proposal opening date and time. The College realizes that conditions other than lowest cost are important and will award contract(s) based on the proposal(s) that best meet the needs of the College.

Modifications
The College reserves the right to issue addenda or amendments to this RFP.

Proposal Submission
To be considered, all proposals must be submitted in the manner set forth in this proposal. It is the Proposer’s responsibility to ensure that its proposal arrives on or before the specified time.

Incurred costs
This RFP does not commit the College to pay any costs incurred in the preparation of a proposal in response to this request and Proposer agrees that all costs incurred in developing its proposal are the Proposer’s responsibility.

Negotiations
The College may require the firms selected to participate in negotiations, and to submit cost, technical, or other revisions of their proposals as may result from negotiations.

Final Authority
The final authority to award contracts as a result of this RFP rests solely with the College.

Contact Information
All inquiries should be directed to the following individual:
Dr. Karen Mazurek, Deputy Registrar
karen.mazurek@cpsa.ab.ca
780-969-4957

College of Physicians & Surgeons of Alberta
2700, 10120 – 100 St NW
Edmonton, AB
T5J 0N3
Appendix

CPSA 2011 Strategic Plan

CPSA 2014 Annual Report
# Bylaws of the College of Physicians & Surgeons of Alberta

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Bylaws of the College of Physicians & Surgeons of Alberta
Issued January 1, 2015

1 In These Bylaws

(1) “Act” means the Health Professions Act;
(2) “College” mean the College of Physicians & Surgeons of Alberta;
(3) “Council” means the Council of the College;
(4) “Electronic signature” means electronic information that a person creates or adopts in order to sign a record and that is in, attached to or associated with the record;
(5) “Election Officer” means a member of the College appointed under these bylaws;
(6) “President” means the President of Council as appointed by Council;
(7) “Registrar” means the Registrar of the College;
(8) “Regulations” means regulations relating to the College made under the Act;
(9) “Vice-President” means the Vice President of Council;
(10) Terms that are defined in the Act and the regulations have the same meaning in these bylaws.

2 Council

(1) The voting members of Council shall consist of:

(a) Eleven (11) regulated members elected by the regulated members of the College,
(b) Four (4) public members appointed by the Lieutenant Governor in Council, and
(c) The Dean of the Faculty of Medicine (or designate), on an alternating basis, from the University of Alberta and the University of Calgary.

3 Annual Elections

(1) There shall be an election for any regulated member vacancy on Council each year on a date set by the Registrar.
(2) Council may establish rules for the conduct of an election, including campaigning and the resolution of disputes arising from the election.
(3) Regulated members on Council are elected from one electoral district, being the entire Province of Alberta.
(4) The Registrar shall, at least sixty (60) days before the date on which the election is to be held, forward to each regulated member entitled to vote:
(i) the nomination form; and

(ii) a notice stating the date of election.

(5) The information to be provided under subsections (4) and (10) shall be sent electronically, unless a regulated member has requested that the information be sent to that regulated member by mail.

(6) A regulated member of Council may serve a maximum of two (2) consecutive terms (totaling 6 years).

(7) A regulated member may return as an acclaimed or elected member of Council after at least three hundred and sixty-five (365) days have passed since the regulated member’s previous term on Council.

(8) A nomination form will be valid if it is signed by three (3) other regulated members eligible to vote and by the nominee indicating acceptance of the nomination.

(9) The Registrar shall not accept any nomination that is not received at least thirty-five (35) calendar days before the date fixed for the election.

(10) If more than one nomination is received for a vacancy, the Registrar, no less than 28 calendar days before the date fixed for the election, shall send to each regulated member eligible to vote:

(a) a copy of the instructions to voters, and

(b) a ballot listing the names of persons nominated for the election.

(11) A regulated member on the General Register, the Provisional Register (Conditional Practice) or the Limited Practice Register, who is in good standing, may stand for nomination, be a nominator, and vote in an election.

(12) Prior to the election, the Council shall appoint three (3) members of the College to act as Election Officers for the election.

(13) The Election Officers shall be responsible for:

(a) determining, by majority decision of the Election Officers, whether a ballot is spoiled, and

(b) completing a report in the form set by Council regarding the election results.

(14) A nominated regulated member may withdraw from the election at any time prior to seven (7) days before the election by notifying the Registrar in writing.

(15) If the number of nominations received is equal to or less than the number of vacancies on Council, then each nominee shall be elected by acclamation.

(16) If the number of nominations received is greater than the number of vacancies on Council, then the election will proceed by counting of ballots to determine the successful candidates to fill the vacancies on Council.
A vote by a regulated member may be cast in person at the offices of the College on the day of the election, by mail-in ballot received before the stated deadline or electronic ballot received before the stated deadline, provided the electronic ballot is secure and confidential, as determined by the Election Officers.

A regulated member entitled to vote shall have one vote for each vacancy on Council.

Ballots will be counted on the first business day following the day of the election.

The counting of ballots shall be carried out by appointees of the College under the supervision of the Election Officers.

The candidate or candidates with the largest number of votes shall be declared elected by the Registrar.

If there are an equal number of votes for two or more candidates competing for a vacancy on Council, the ballots will be counted two (2) more times.

If there are an equal number of votes for two or more candidates after recounting the ballots in accordance with these bylaws, the Registrar shall, within a reasonable period of time, hold a by-election for the candidates with the equal number of votes.

The Registrar shall notify the candidates of the results of the election.

An unsuccessful candidate with less than one hundred (100) votes fewer than the successful candidate with the least number of votes may request a recount of the ballots by submitting a written request to the Registrar within seven (7) days of receiving notification of the results.

The Registrar may publish the results of the election once the time period to request a recount has passed or upon the completion of a recount under these bylaws.

Subject to subsection (28), the Registrar shall destroy all ballots fifteen (15) days after the publication of the election results.

When a recount has been requested within the time prescribed in these bylaws, the Registrar shall destroy all ballots fifteen (15) days after the recount.

If, at any time, there is a vacancy of a position on Council to be held by a regulated member, the Council may, in its discretion:

(a) invite the first runner-up from the most recent election for Council to assume the vacant position on Council;

(b) conduct a by-election in the same manner as an annual election, all necessary modifications implied; or

(c) elect to leave the position vacant until the next scheduled election for Council members, if the remaining term is less than 12 months.
In the event a vacancy of a position on Council is filled by appointment or by-election, the term of that position will be the remaining portion of the term of the member who vacated.

The term of office for an elected member of Council shall be a period of three (3) years commencing on the first day of January of the year following the election in which that member was elected.

An elected member of Council may be removed by a two-thirds (2/3) majority vote at a meeting of Council.

Before a vote under subsection (31) may be held, the President of Council shall give the members of Council seven (7) days written notice of the date on which the vote is to be held and the member facing the vote for removal the opportunity to make submissions to Council before the vote is held.

4 Officers

(1) Council shall elect a President and Vice President from among the members of Council.

(2) The President shall preside in Council.

(3) The President is an ex-officio member of all committees appointed by Council unless excluded by the Act.

(4) In the absence of the President, the Vice President shall preside in Council.

(5) In the absence of the President, the Vice President shall have the powers and duties of the President.

5 Meetings

(1) There shall be at least four (4) regular meetings of the Council during the calendar year.

(2) All members of Council shall receive at least fifteen (15) days notice of regular meetings.

(3) The agenda and order of business at a meeting of the Council will be determined by Council, and may be amended at Council’s discretion.

(4) A special meeting of the Council may be held at the call of the President.

(5) All members of Council shall receive at least seven (7) days notice of a special meeting.

(6) The President may call an emergency meeting of the Council.

(7) A member of Council may call an emergency meeting of Council with the agreement of two-thirds (2/3) of the members of Council.

(8) All members of Council shall receive at least twenty-four (24) hours notice of an emergency meeting.

(9) A record of a Council meeting will be maintained in the form of minutes.
Council may make the minutes publicly available in a form determined by Council.

Council may determine procedures to be used at any meeting.

If Council has not determined a procedure to be used at a meeting, Roberts Rules of Order shall apply.

A meeting of Council shall be open to the public except when Council moves in camera.

Quorum shall be fifty (50) percent of Council.

A decision of Council may be made by consensus or motion.

Council may meet in person, by teleconference or by any other communications technology that permits all persons participating in the meeting to communicate with each other.

Unless otherwise required by these bylaws, a majority vote of Council members present at a meeting decides any vote.

The President does not vote unless there is a tied vote, in which case the President’s vote decides the matter.

Subject to section 78 of the Act, Council may determine to conduct any portion of a meeting in-camera.

6 Committees

Subject to the Act, Council may appoint standing committees to assist Council in carrying out its duties and responsibilities.

Council shall approve terms of reference for all standing committees.

All standing committees shall meet at least annually.

Council shall appoint a chair for each standing committee.

Council shall appoint members for each standing committee, and the membership list for complaint review committees and hearing tribunals, subject to the following:

(a) an appointment shall be for a term not to exceed three (3) years,

(b) there shall be an optional further appointment of an additional three (3) year term for a total of six (6) years,

(c) there shall be a minimum period of one (1) year off the membership list for complaint review committees and hearing tribunals or a standing committee prior to an additional re-appointment to the list or the same standing committee,
(d) despite subsections (b) and (c), the Council may, in its sole discretion, extend the member’s appointment on the membership list for complaint review committees and hearing tribunals or a standing committee for a period of time, and

(e) a person who is not a member of the College may be appointed by Council to sit on a standing committee.

(6) A vacancy on the membership list for complaint review committees and hearing tribunals or on a standing committee shall be filled at the next meeting of Council subject to the following:

(a) should a member be unable to complete his term of appointment, a new member will be appointed to complete the unexpired term,

(b) further appointment at the end of this term shall be in accordance with subsection (5).

(7) A member of a standing committee may be removed on a two-thirds (2/3) majority vote of the Council members participating and eligible to vote at a meeting of Council.

(8) Before a vote under subsection (7) may be held, the President of Council shall give the members of Council seven (7) days written notice of the date on which the vote is to be held and the member facing the vote for removal the opportunity to make submissions to Council before the vote is held.

(9) Standing committees shall include, but are not limited to:

(a) Executive Committee,

(b) Nominating Committee,

(c) Finance and Audit Committee, and

(d) Appeals Committee.

(10) Subject to sections 19 and 20 of the Act, Council or a standing committee may at its discretion appoint a sub-committee.

(11) Subject to the Act, the Council may appoint an ad hoc committee as necessary to perform specific functions.

(12) Where Council has delegated a power or duty to a person or committee, that person or committee may not delegate that power or duty to any other person or committee unless expressly authorized to do so.

(13) Subsection (12) does not apply to delegation to the Registrar.

7 Awards

(1) Certificates of Merit may be awarded by Council to individuals who have provided outstanding service to the profession, the community or both.
8  **Bylaws**

(1) A bylaw, or an amendment to a bylaw, under section 132(1) of the Act may be passed at any meeting of the Council provided:

(a) A notice of motion has been:

   (i) given at a previous meeting; or

   (ii) sent to all members of Council at least fourteen (14) days prior to the meeting.

(2) A notice of motion may be waived by a unanimous vote of the Council.

(3) Despite section 5(17), a bylaw or an amendment of a bylaw requires a two-thirds (2/3) majority vote of the Council members participating and eligible to vote at a meeting of Council.

(4) Whenever an amendment is made to the bylaws, any consequential editorial changes to the bylaws as required are implied.

9  **Code of Ethics and Standards of Practice**

(1) At least sixty (60) days before Council considers a motion to adopt or amend a code of ethics or a standard of practice, the Registrar shall provide, for review and comment, a copy of the proposed code of ethics or standard of practice in accordance with section 133(2) of the Act.

(2) A person receiving notice under subsection (1) may make submissions in writing to the Registrar within the time period stipulated by the Registrar.

(3) Council shall review and consider any submissions made under subsection (2).

(4) Despite section 8(3), Council may, on a two-thirds (2/3) majority vote of members of Council present at a meeting, adopt or amend the code of ethics and, on a majority vote of members of Council present at a meeting, adopt or amend standards of practice.

(5) Whenever amendments are made to the code of ethics or standards of practice, any consequential editorial changes as required are implied.

10  **Expenses and Remuneration**

(1) Members of Council and members of committees when attending or conducting business on behalf of the College may claim expenses and per diem amounts as determined by resolution of Council.

11  **Head Office**

(1) The head office of the College is located in Edmonton, Alberta or at such other location as may be determined by the Council.

12  **Seal**

(1) The Registrar shall:
have custody of the seal of the College; and
(b) affix the seal to all documents requiring the seal.

(2) Council may amend the design of the seal.

13 Fiscal Year
(1) The fiscal year of the College commences January 1 and ends the following December 31.

14 Auditors
(1) Council shall appoint one or more chartered accountants registered in the Province of Alberta as auditor for the College.
(2) The Auditor shall, at least once each year, examine the accounts, books, and securities of the College, and provide a written report to the Council.
(3) The Registrar shall publish annually a copy of the audited financial statements.

15 Money on Deposits
(1) All funds of the College shall be deposited in the banking institution designated by the Registrar.
(2) The Registrar shall designate the individuals authorized to withdraw and pay out the funds of the College.

16 Investments
(1) Investments made by the College shall be made in the name of the College of Physicians & Surgeons of Alberta.
(2) Council shall establish an investment policy and amend it from time to time.

17 Documents, Records and Forms
(1) The Registrar is authorized to determine such forms, certificates, permits or other documents that may be required for the purposes of the Act, the Regulations and the bylaws.
(2) All deeds, mortgages, securities, documents or other papers not in current use in the Registrar's office shall be retained in safe keeping as determined by the Registrar.
(3) Subject to any enactment of Alberta or Canada, the Registrar is authorized to prescribe the record retention period for all records, provided all legal requirements are met.
(4) For the purpose of subsection (3), “records” shall mean the physical representation or recording of any information, data or other thing that is capable of being represented or reproduced visually or by sound, or by both.

18 Grants
(1) The Council may make grants as it determines from time to time.
19 Notices

(1) Unless otherwise required under an enactment of Alberta or Canada, any notice or document that may be given or required to be given under the Act or these bylaws may be given by:

(a) mail;
(b) electronic mail;
(c) fax;
(d) posting on the website of the College; or
(e) any other means that may be available for transmission provided such means is as reliable as any of the other means set out in this bylaw.

20 Use of Electronic Documentation

(1) Unless otherwise specified, a requirement for a signature in these bylaws may be satisfied by an electronic signature that reliably identifies the person signing.

(2) Unless otherwise specified, a requirement for “writing” or “written” in these bylaws may be satisfied by electronic form of such requirement.

(3) A reference in these bylaws to an item being made available to a person, in addition to being made available in paper format, includes availability by way of:

(a) the website of the College;
(b) an electronic interface hosted by the College or an agent of the College; or
(c) electronic mail.

21 Registrar

(1) Council shall appoint a Registrar.

(2) The Registrar shall perform all duties required of, and exercise the powers provided to, the Registrar in the Act, the Regulations and these bylaws.

(3) Subject to section 19 of the Act, Council may delegate any of its duties or powers to the Registrar.

(4) Council may impose conditions upon any delegation made under subsection (3).

(5) Subject to section 20 of the Act, the Registrar may delegate any of the powers or duties of the Registrar to any other member of the College staff or to a committee or working group appointed under subsection (6).

(6) The Registrar may appoint such committees and working groups as the Registrar considers necessary to assist in performing the duties or exercising the powers of the Registrar.

22 Acting Registrar

(1) If the office of the Registrar becomes vacant or the Registrar otherwise becomes incapable of acting for any reason, Council may appoint an Acting Registrar,
who shall have all the powers and duties of the Registrar under the Act, the Regulations and these bylaws.

(2) The Acting Registrar holds office until:
(a) The Registrar again becomes capable of acting;
(b) Council appoints a new Registrar; or
(c) Council terminates the appointment of the Acting Registrar.

23 Fees, Charges and Levies
(1) The fees, charges and levies of the College shall be determined by resolution of Council.

24 Non Regulated Members
(1) The Retired Member Register includes the names of those former regulated members who:
(a) have retired from the practice of medicine; and
(b) were in good standing with the College on the date of retirement.

(2) Each applicant for registration as a retired member must:
(a) notify the College in writing of the effective date of retirement; and
(b) submit the annual fee.

(3) A retired member shall not practise medicine in Alberta.

(4) The Physician Assistant register includes the names of non-regulated members who are:
(a) A graduate of a Physician Assistant training program meeting one of the following criteria:
   (i) provided through the Canadian Forces Medical Services School,
   (ii) accredited by the Canadian Medical Association Conjoint Accreditation Process in Canada, or
   (iii) accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States of America, and
(b) A certified Physician Assistant with one of the following credentials:
   (i) Canadian Certified Physician Assistant (CCPA), granted by the Physician Assistants Certification Council of the Canadian Association of Physician Assistants, or
(ii) Physician Assistant – Certified (PA-C), granted by the National Commission on Certification of Physician Assistants in the United States of America.

(5) Each applicant for registration as a Physician Assistant must:
(a) complete the application form to the satisfaction of the Registrar, and
(b) submit the registration fee.

(6) A Physician Assistant shall only work under the supervision of a regulated member on the General Register or the Provisional Register Conditional Practice, and that regulated member will take responsibility for the clinical performance of the Physician Assistant.

(7) If the Registrar determines that a Physician Assistant has not paid the registration fee or an annual fee, has not worked only under the supervision of a regulated member, has provided incomplete or inaccurate information to the Registrar or no longer qualifies for registration as a Physician Assistant, the Registrar may cancel the registration of the Physician Assistant.

(8) If the Registrar cancels the registration of a Physician Assistant under subsection (7), the Registrar may publish the information as the Registrar determines is required in the circumstances.

25 Practice Permits

(1) The Registrar shall determine any decision on issuance or renewal of a practice permit.

(2) A practice permit:
(a) is effective on January 1 or on the actual date that it is issued, whichever is later, and
(b) expires on December 31 following the date of issue of the practice permit.

(3) A regulated member shall submit to the Registrar a completed annual form for the renewal of a practice permit along with the required annual renewal fee by December 31 in the year in which the practice permit expires.

(4) A regulated member whose registration or practice permit has been suspended or cancelled for a reason other than under Part 4 of the Act, may apply in writing for the practice permit to be issued or the registration to be reinstated in accordance with these bylaws.

(5) An application under subsection (4) shall be in the form determined by the Registrar along with the required fee, any outstanding fees, charges or levies, and any other information required by the Registrar.

(6) The Registrar shall, within a reasonable period of time, consider a completed application under subsection (4) in accordance with section 30 or section 40 of the Act, as the case may be.
Limited Liability Partnership

(1) Regulated members or professional corporations are not permitted to enter into a limited liability partnership for the practice of medicine or osteopathy.

Professional Corporation Application

(1) An applicant for approval under section 108 of the Act shall provide to the Registrar:
   (a) an application in the form determined by the Registrar,
   (b) a copy of the articles of incorporation; and
   (c) payment of the required fee.

Professional Corporation Annual Permit

(1) Subject to sections 108 and 109 of the Act, a professional corporation annual permit:
   (a) is effective on January 1 or on the actual date that it is issued, whichever is later, and
   (b) expires on December 31 following the date of issue of the annual permit.

Renewal of Professional Corporation Annual Permit

(1) The Registrar shall, on or before November 1 in each year, mail to each professional corporation then holding an annual permit, a written notice respecting the renewal of its permit.

(2) Every professional corporation that wishes to have its annual permit renewed for the following calendar year shall provide to the Registrar on or before November 30 in each year:
   (a) a statement of particulars in the form determined by the Registrar; and
   (b) the required fee.

(3) When a professional corporation has provided the material under subsection (2) and has paid the required renewal fee, the Registrar shall, if he is satisfied with respect to the matters described in section 109 of the Act, issue a renewal of the annual permit to the professional corporation in the form determined by the Registrar.

Records

(1) In addition to the requirements of section 113 of the Act, the Registrar shall keep and maintain a register of professional corporations containing the following information:
   (a) name of all shareholders,
   (b) the number and type of shares held by a shareholder, and
   (c) the name of the directors.
(2) The Registrar shall:

(a) enter on the appropriate register a memorandum with respect to the name of a professional corporation whose permit has expired; and

(b) notify the professional corporation and regulated member concerned and all other parties considered necessary by the Registrar that the permit of the professional corporation has expired.

(3) The Registrar shall determine the notification form for the purpose of section 112 of the Act.

(4) The Registrar may provide to the registrar of corporations, pursuant to section 115(3) of the Act, any other information that the Registrar, in his sole discretion deems relevant.

31 Names

(1) Subject to section 10 of the Business Corporations Act and approval by the Registrar, the name of a professional corporation shall contain only the surname, or the surname and any combination of the given names or initials, of one or more regulated members of the College who are shareholders of the corporation followed by "Professional" and “Corporation” and an appropriate descriptive term such as “medical” or “surgical”.

(2) Except as provided in subsection (3), a professional corporation shall carry on the practice of medicine under its corporate name.

(3) A professional corporation may carry on the practice of medicine in partnership under a firm name that does not contain its full corporate name, if the firm name is in accordance with the code of ethics and standards of practice established by the Council.

(4) The full corporate name of each professional corporation that is a member of a partnership for the practice of medicine shall be shown on the letterhead and any advertisement used by that partnership.

32 Reissue after Revocation

(1) An annual permit of a professional corporation that has been cancelled by the Registrar may be reissued if the Registrar is satisfied that the applicant has complied with sections 108 and 109 of the Act.

33 Removal of Information

(1) Subject to the Act, the Registrar, in his sole discretion, may amend or delete any information on any register or record of the College which is irrelevant, inaccurate or outdated.

34 Publication of Ratified Settlement

(1) For the purpose of section 60 of the Act, and subject to the terms of a ratified settlement, the Registrar may publish information regarding the ratified settlement.
35 **Publication**

(1) The Registrar may publish or distribute information regarding:

(a) Part 2 or Part 4 of the Act,

(b) any condition imposed on a regulated member’s practice permit under Part 2 or Part 4 of the Act,

(c) any direction made pursuant to section 118(4) of the Act,

(d) any order or direction made under Part 4, Division 4 and Division 5 of the Act, including the reasons and the testimony given before the hearing, except the part of the testimony that was given while the hearing was held in private, at the expiry of the appeal period.

(2) For the purpose of section 119(1)(f) of the Act, the Registrar may omit from publication or distribution any individually identifying information about any person identified in an order made by a hearing tribunal or the Council under Part 4 of the Act.

(3) The Registrar shall consider the following factors in any decision regarding publication of information described section 119(1) of the Act:

(a) the public interest, including transparency of the College’s discipline process,

(b) the education of regulated members, and

(c) any other factors that the Registrar considers relevant to the matter.

36 **Accreditation of Medical Facilities**

(1) The Council does hereby constitute a standing committee to be known as the Medical Facility Accreditation Committee.

(2) For the purposes of this section, the definitions set out in section 8 of Schedule 21 of the Act shall apply.

(3) For the purpose of the Health Care Protection Act, major surgical services are those that, in the opinion of the Council, may be performed only in a public hospital because there is a significant risk inherent in the procedure or by reason of the pre-operative condition of the patient.

(4) For the purpose of the Health Care Protection Act, specific surgical services which may be performed only in a public hospital and which shall not be conducted in a medical facility include:

(a) procedures under general anesthetic on patients less than eighteen months of age;

(b) procedures on the contents of the retroperitoneal space;

(c) procedures on the contents of the cranium;

(d) procedures on the contents of the thorax; and
For the purpose of the Health Care Protection Act, minor surgical procedures are those which may be performed in a physician’s general office.

In this section and for the purposes of Section 8(g) of Schedule 21 of the Act "prescribed health services" include:

(a) diagnostic imaging services;
(b) medical laboratory services, except for unaccredited point-of-care testing on a physician’s own patient;
(c) pulmonary function testing, except for unaccredited peak flow measurement or vitalometry on a physician’s own patient;
(d) neurophysiologic diagnostic services;
(e) sleep medicine diagnostic services;
(f) vestibular diagnostic testing;
(g) the use of drugs which are intended or which may induce general anaesthesia or sedation requiring the monitoring of vital signs, including all uses of intravenously administered sedatives or narcotics, except in emergency circumstances;
(h) the use of drugs by injection which are intended or may induce a major nerve block, or spinal, epidural, or intravenous regional block;
(i) surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal organs and other life-threatening complications or requiring sterile precautions to prevent blood-borne, deep, closed cavity or implant-related infections;
(j) Hyperbaric oxygen therapy.
(k) Cardiac exercise stress testing,
(l) Hemodialysis, and
(m) the following surgical and endoscopic procedures:
   i) DERMATOLOGIC
      • Liposuction to a maximum of five (5) litres total aspirate
      • Lipolysis by percutaneous application of any form of energy
      • Mohs micrographic surgery
   ii) GENERAL SURGICAL
      • Upper gastrointestinal endoscopy with or without biopsy
      • Colonoscopy with or without biopsy or minor polypectomy
      • Simple mastectomy
      • Segmental resection of breast and sentinel node biopsy
• Resection of large or deep soft tissue lesions
• Deep lymph node biopsies – up to but not including full axillary dissection
• Inguinal hernia repair, including femoral
• Minor abdominal wall hernia repair, including umbilical hernia repair
• Varicose vein ligation and stripping
• Hemorrhoidectomy beyond simple single excision
• Trans-anal excision of rectal polyps
• Laparoscopic procedures
  - Diagnostic
  - Biopsies – peritoneal
  - Laparoscopic Adjustable Gastric Band procedures
• Endovenous ablation (including, but not limited to, laser ablation, radio frequency ablation, mechano-chemical ablation)

iii) **GYNECOLOGIC**

• Perineoplasty not requiring extensive dissection
• Marsupialization of Bartholin cysts
• Cervical, vaginal and vulvar polypectomy and biopsy with risk of bleeding requiring surgical control
• Dilatation and curettage of uterus
• Trans-cervical global endometrial ablation procedures except those performed by resection or by electrocautery that does not have impedance regulation
• Cystoscopy
• Minimally invasive incontinence procedures: injectables, percutaneous slings
• Laparoscopy with minor surgical interventions:
  - Diagnostic
  - Tubal sterilization
  - Aspiration of cysts
  - Minor adhesiolysis
  - Diathermy for endometriosis (AFS Stages I and II)
• Abortions – as per the general Non-hospital Surgical Facilities Standards and Guidelines and the Supplementary Standards for the Termination of Pregnancy
• Oocyte retrieval
• Tumescent anterior and posterior vaginal repair
• Hysteroscopic tubal sterilization

iv) **OPHTHALMOLOGIC**

• Intra-ocular surgery requiring dissection of the tissues of the globe including procedures on:
- the cornea (including ring segment implants, keratotomies, LASIK and corneal transplant)
- the lens and implants
- the iris
- the sclera
- the vitreous

• Eyelid procedures requiring implants or dissection of the orbital septum or beyond
• Lacrimal procedures requiring incision into the nasal passages.
• Orbital and socket procedures not associated with risk of intracranial or neurovascular complications, including:
  - orbital tumor excision
  - insertion of an implant
  - enucleation/evisceration with or without implant
  - socket reconstruction requiring implant, transplant or exposure of bone
  [Note: Minor anterior orbital procedures are considered office procedures.]
• Strabismus procedures
• Rheopheresis for patients enrolled in a research study approved by a research ethics review body acceptable to the College

v) ORTHOPEDIC

• ARTHROSCOPY
  - diagnostic
  - repair and reconstruction of ligaments
  - meniscectomy, meniscal repair and arthroplasty
  - excision meniscal cysts, loose bodies and foreign bodies

• AMPUTATION
  - finger through MCP or IP joints, hand
  - toe – through TP or IP joints foot
  - single ray amputation hand or foot

• ARTHRODESIS
  - hand and wrist
  - foot and ankle

• ARTHROPLASTIES
  - acromio-clavicular and sterno-clavicular joints
  - radial head arthroplasty
  - wrist and hand joints
  - foot

• OSTEOTOMIES
  - hand/wrist/foot/ankle

• LIGAMENT REPAIR
  - shoulder
  - elbow
- wrist
- hand
- knee
- ankle and foot

- **TENDON OR MUSCLE REPAIR OR TRANSPLANT OR TRANSFER**
  - transfers repairs and transplants at or distal to elbow or knee
  - decompression/repair rotator cuff at shoulder

- **FASCIA OR TENDON SHEATH**
  - plantar fasciotomy or fasciectomy of hand or foot
  - release or excision Dupuytren’s contracture
  - excision of minor hand tumors including ganglions
  - carpal tunnel release
  - excision tendon sheaths: wrist, forearm or hand

- **ARTHROTOMY OR SYNOVECTOMY**
  - shoulder
  - elbow
  - wrist and hand
  - knee
  - ankle and foot
  - excision Baker’s cyst

- **EXCISION OF BURSA OR GANGLIA**

- **MUSCULOSKELETAL TUMORS**
  - biopsy of peripheral tumors
  - needle biopsy only of tumors of the spine
  - excision of minor tumors

- **DISLOCATIONS**
  - open reduction acromio-clavicular joint
  - closed or open reduction of joints of upper extremity
  - closed reduction of dislocated total hip
  - closed or open reduction of patello-femoral joint
  - closed or open reduction of ankle, hindfoot, midfoot or forefoot

- **FRACTURES**
  - closed and open reduction clavicle, humerus, radius/ulna, wrist and hand
  - closed reduction of scapula
  - closed and open reduction of patella, fibula, ankle and foot
  - closed reduction of tibia

- **OTHERS**
  - single level lumbar discectomy and/or decompression – uncomplicated
  - procedures listed under podiatric surgery
- removal of hardware including plates, pins, screws, nails and wires
- peripheral nerve surgery – repairs, decompression or grafts
- saucerization
- sequestrectomy
- joint manipulation under general anesthesia or intravenous sedation
- harvesting of bone graft
- Microdiscectomy
- Minimally invasive lateral recess and central decompression – 3 levels or less
- Minimally invasive lumbar foraminotomy (with or without central stenosis)
- Posterior minimally invasive foraminotomy (or laminoforaminotomy)
- Posterior minimally invasive laminotomy for decompression of focal cervical canal stenosis – 2 levels or less

- PROCEDURES LIMITED TO FACILITIES APPROVED FOR EXTENDED STAY
  - hip arthroscopy and primary arthroplasty (including total joint replacement)
  - conversion of partial hip arthroplasty to total hip arthroplasty
  - knee arthroscopy and primary arthroplasty – (including total joint replacement)
  - tibial osteotomy
  - shoulder arthroscopy and primary arthroplasty – (including total joint replacement)
  - lumbar posterior spinal fusion – not exceeding two disc-space levels
  - lumbar spinal laminectomy – not exceeding two disc-space levels
  - ankle arthroscopy and primary arthroplasty (including total joint replacement)
  - below knee amputation

vi) OTOLARYNGOLOGIC

- Deep* biopsy of the nasopharynx
- Deep excision of intraoral papilloma

*The terms “deep”, “major”, and “complicated” refer to procedures that may require more resources than are commonly available in a medical office. Surgeons should make decisions as to the appropriate location for these surgical procedures in accordance with the resources necessary for unexpected complications and with generally accepted standards of care in Alberta.
- Major* excision of lip, nasal, ear or neck lesions
- Lip shave procedures
- Major partial glossectomy limited to anterior 2/3 of tongue
- Adenoidectomy
- Rigid laryngoscopy
- Rigid trans-oral nasopharyngoscopy
- Complete esophagoscopy – flexible only
- Complete bronchoscopy – flexible only
- Caldwell Luc procedure
- Intranasal antrostomy
- Intranasal complete ethmoidectomy
- Turbinate resection
- Sphenoidotomy
- Nasal septum reconstruction
- Nasal septum submucous resection
- Nasal polypectomy in conjunction with complete ethmoidectomy
- Rhinoplasty
- Complicated* nasal fractures
- Biopsies of the parotid beyond needle aspiration or sampling the tail of the gland
- Excision of submandibular gland
- Excision of sublingual gland
- Otoplasty
- Complicated myringoplasty
- Dissection of neck beyond the platysma muscle
- Deep cervical node biopsy
- Endoscopic soft-tissue surgery

vii) PLASTIC
- SKIN AND SUBCUTANEOUS
  - Excision of deep tumors outside a body cavity requiring exposure of bone or isolation of vascular or nerve supply
  - Grafts, flaps, and tissue expansion where there is a minimal risk of major bleeding or third space fluid loss that may require replacement fluids
  - Liposuction to a maximum of 5 litres total aspirate.
  - Lipolysis by percutaneous application of any form of energy

*The terms “deep”, “major”, and “complicated” refer to procedures that may require more resources than are commonly available in a medical office. Surgeons should make decisions as to the appropriate location for these surgical procedures in accordance with the resources necessary for unexpected complications and with generally accepted standards of care in Alberta.
- Lipectomy
- Brachioplasty
- Facial implants
- Fat grafting
- Thigh lift
- Buttocks (Gluteoplasty) lift

**HEAD AND NECK**
- Grafts and flaps as above except where there is a significant risk of airway compromise requiring post-operative or overnight monitoring.
- Eyelids (blepharoplasty, ptosis repair, tarsorrhaphy, canthopexy, canthoplasty)
- Browlift, facelift (rhytidectomy), necklift
- Nose (SMR, rhinoplasty, turbinectomy, reduction of fractures)
- Ears (otoplasty)
- Genioplasty

**BREAST**
- Reduction mammoplasty
- Augmentation mammoplasty
- Mastopexy
- Mastectomy without chest wall, muscle or axillary node dissection
- Capsulotomy and capsulectomy
- Gynecomastia surgery
- Reconstruction of breast or nipple

**ABDOMEN**
- Repair of abdominal wall hernia
- Abdominoplasty not requiring overnight monitoring of blood or third space fluid loss

**OTHERS**
- Tendon – repairs, transfers or grafts
- Peripheral nerve – repairs, decompression or grafts
- Muscle – flaps or repairs.
- Fascia – flaps, decompression or excision
- Bone – biopsies, fusions, removal of hardware, excision of exostoses, amputations of digits or rays, open and closed reduction of hand fractures
- Joints – arthrotomy, arthroscopy, arthrodesis, and reductions of hands, wrists, feet and TMJ
- Minor treatment of surgical complications such as hematoma or wound separation

viii) **PODIATRIC**

- Amputation
- single ray of the foot only
- Arthrodesis of joints of the foot and ankle
  - Lisfranc’s joint procedures
- Arthroplasty of joints of the foot and ankle
  - foot procedures requiring significant exposure of the joint
  - ankle procedures which do not require tibial or fibular osteotomy for exposure
- Arthroscopy
  - ankle/subtalar joint/mid-tarsal joint
- Fractures and dislocations
  - uncomplicated closed fractures and dislocations of the foot
- Incision/excision/transfer/repair of tendons and ligaments
  - tendons and ligaments proximal to Lisfranc’s joint but not of the rear-foot/leg via the interosseous route
- Neoplasms
  - benign neoplasms of the cuneiforms
  - benign neoplasms of soft tissues below deep fascia
- Neurolysis/neurectomy
  - deep nerves including and distal to the tarsal tunnel and proximal to Lisfranc’s joint
- Osteotomy of bones of the foot
  - osteotomy of the calcaneus, mid-tarsus and cuneiforms

ix) UROLOGIC
- Inguinal canal surgery
- Open procedures on scrotal contents
- Penile procedures up to but not including implants
- Minor urethral reconstruction, urethral fistula repair and distal hypospadius repair
- Minimally invasive incontinence procedures, including injectables and percutaneous slings
- Cystoscopy and ureteroscopy with or without biopsy or minor manipulation of stones or obstruction.

(7) In addition to subsection (5), “prescribed health service” shall mean only those procedures which will safely allow the discharge of a patient from medical care in the accredited medical facility within 12 hours of completion of the surgical procedure by a regulated member unless the accredited medical facility is approved for extended stays.

(8) An accredited medical facility shall have a designated medical director who is a regulated member in good standing with the College and with qualifications as set out in the accreditation standards.
Notwithstanding subsection (8), a medical laboratory that is operated by a health authority in Alberta may designate a certified clinical laboratory doctoral scientist with qualifications as set out in the accreditation standards.

For the purposes of this section, the term “medical director” includes an acceptable clinical laboratory doctoral scientist under subsection (9).

Upon application by a medical director of a medical facility, the registrar may, subject to the accreditation standards, provide interim approval for the performance of any prescribed health service until the determination of the request by the accreditation committee.

The medical director of a medical facility shall pay or cause to be paid to the College those fees and expenses determined by the accreditation committee, which shall include:

(a) an initial registration fee set by Council
(b) an annual renewal of registration fee set by Council; and
(c) the actual cost of any initial or subsequent inspection of the medical facility, including all expenses incurred by the accreditation committee or its sub-committee for any assessment, inspection, or both.

Any accreditation granted by the accreditation committee under Section 8.3(2) of Schedule 21 of the Act shall expire effective 12:01 a.m. on February 1 following the date of accreditation unless the accreditation has been renewed in accordance with these bylaws.

The accreditation committee shall be composed of not more than nine (9) members all of whom shall be appointed by the Council.

The accreditation committee shall report to the Council on its activities and programs of assessment at such times and in such manner as the Council may from time to time direct.

The accreditation committee may, from time to time, appoint one or more of its members, consultants or both as a sub-committee with particular expertise in the services provided in a medical facility and delegate to that sub-committee the authority to conduct an assessment of an application for accreditation or renewal of accreditation of a medical facility or to conduct an inspection of a medical facility, or both and report thereafter to the accreditation committee.

There shall be paid to members of the accreditation committee, a sub-committee and any consultants retained by them such fees for attendance and such reasonable traveling expenses as may be fixed by Council.

The accreditation committee shall:

(a) develop and direct regular reviews of the ownership and operation of any medical facility and the financial arrangements pertaining thereto;
ensure that the operation of a medical facility is in accordance with the accreditation standards;

confirm that the practice of medicine conducted in a medical facility and the financial arrangements pertaining thereto are in accordance with the Code of Ethics and Standards of Practice approved by the Council;

assess the educational background, qualifications and ongoing experience of regulated members and non-medical personnel assisting a regulated member in the provision of medical services, including prescribed health services, in the medical facility;

assess the adequacy of the design of the medical facility and the equipment utilized therein along with the standards of operation of the medical facility in providing medical services, including prescribed health services, to the public; and

assess the business and professional relationships between regulated members conducting the practice of medicine and the owners of the medical facility.

The accreditation committee shall determine the specific provisions of the accreditation standards which apply to a specific medical facility or class of medical facility.

As part of an assessment of an application for accreditation, an application for renewal of accreditation or ensuring the continuing compliance of a medical facility with existing accreditation, the accreditation committee shall determine whether the skill, knowledge and training of a specified regulated member is sufficient for that regulated member to perform a prescribed health service in the medical facility.

Responsibilities of a Medical Director of a Medical Facility

Subject to section 8.4 of Schedule 21 of the Act, the medical director of a medical facility which is the subject of an assessment or inspection by the accreditation committee shall co-operate fully, which shall include:

(a) permitting assessors to enter the medical facility and inspect the premises and all diagnostic equipment located therein;

(b) permitting the assessors to inspect all records pertaining to the provision of medical services, including prescribed health services, and providing copies of the same if so requested;

(c) providing to the assessors information requested by them in respect of the provision of medical services, including prescribed health services, in the medical facility;

(d) providing the information described in clause (c) in the form requested by the assessors;
(e) providing requested samples or copies of any material, specimen, radiological image or product originating from the medical services, including prescribed health services, provided by the medical facility;

(f) answering questions posed by the assessors as to procedures or standards of performance and if requested providing copies of records relating to procedures followed and standards of performance applied in the medical facility;

(g) providing requested copies of all documents and information relating to business arrangements involving the practice of medicine conducted in the medical facility, which shall include lease arrangements, management agreements, records of advertising and agreements for the provision of medical services, including prescribed health services.

(2) The accreditation committee may, with or without notice, suspend the accreditation or impose conditions on the accreditations of a medical facility if the medical director fails to co-operate fully with an assessment or inspection by the accreditation committee or its sub-committee appointed under section 36(16).

(3) Any suspension or conditions imposed under section 37, subsection (2) shall be cancelled once the accreditation committee is satisfied that medical director has co-operated fully pursuant to section 37, subsection (1).

38 Accreditation Standards

(1) Despite sections 8 and 9 of these bylaws, the accreditation standards for accreditation of all medical facilities required under this section and section 8.1(1) of Schedule 21 of the Act are determined, and amended from time to time, by simple majority resolution of Council.

39 Bylaws Under The Medical Profession Act

(1) The Bylaws of the College under the Medical Profession Act are hereby repealed.
## Key Performance Indicator (KPI) Reporting

**GOAL 1:** The public receives safe and effective medical care from competent physicians.

**PERFORMANCE INDICATORS:** Physician compliance with Standards of Practice and Code of Ethics; physician demonstration of desired competencies.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>2017 TARGET</th>
<th>2015 TARGET</th>
<th>2015 MID-YEAR RESULT</th>
<th>DEPENDENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians demonstrate compliance with standards of practice</td>
<td>80% of members reviewed apply CPSA standards of practice</td>
<td>Complete pilot project</td>
<td>Requires revision to target description: &quot;SOP audit tool developed - 2015&quot;, and &quot;SOP audit tool pilot complete - 2016&quot;. This revision is necessary to align with an operational decision to break up the practice review pilots into Phase 1 and Phase 2. Phase 1 involves: a) development of Family Medicine (FM) pilots (2015) and b) implementation and evaluation of FM pilots (2016). Phase 2 involves: a) development of Specialist pilots (2017) and b) implementation and evaluation of Specialist pilots (2018). ON SCHEDULE IN KEEPING WITH REVISED TIMELINES. Will be ready to pilot the audit tool in time for implementation of the FM pilots and the Spec pilots.</td>
<td>Communications: PAR-C, PD, Competence Committee Council</td>
</tr>
<tr>
<td>Physicians demonstrate desired competencies</td>
<td>80% physicians reviewed in competence activities</td>
<td>Define basic competencies</td>
<td>Completed. Definition of the competent physician created by the Competence Committee and approved by Council in June. Next step: begin to incorporate this definition into the various programs.</td>
<td></td>
</tr>
<tr>
<td>Practice improvements following competence activities</td>
<td>60% physicians make a practice change as a result of a screening (level one) competence review</td>
<td>50%</td>
<td>58% of PAR physicians reporting making at least 1 practice change as a result of participation in PAR (Jan - Jun 2015)</td>
<td></td>
</tr>
<tr>
<td>Practice improvements following competence activities</td>
<td>90% of physicians make a practice change as a result of a targeted (level two or three) competence intervention</td>
<td>85%</td>
<td>Target revision needs to a more achievable number for 2015 (70%), increasing to 80% over time in recognition that not all physicians are amenable (willingness or capacity) to remediation resulting in practice improvement. Jan - June 2015, physicians referred from PAR and undergoing a practice visit have self-reported that 10/12 (83%) did make at least 1 change in practice as a result of the practice visit. The competence team feels this is exceptional, despite it being below the 2015 target. Over the next 6 months, all competence programs will begin to measure this for physicians with whom they have intervened, for reporting in 2016.</td>
<td>X</td>
</tr>
<tr>
<td>Practice improvements following complaint interventions</td>
<td>60% of physicians make a practice change as a result of a complaint intervention</td>
<td>60%</td>
<td>Target revised to reflect expectations based on processes used and results from previous year. January to June (2015) results reflect 57% based on 150 responses</td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**
- Exceeding/Meeting target
- Below target at this time; plan to be on target by end of year
- Significant delay

Page 1 of 3
### PERFORMANCE INDICATORS: Health care policy considers/reflects CPSA positions and perspectives; impact of CPSA on quality of health care system.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>2017 TARGET</th>
<th>2015 TARGET</th>
<th>2015 MID-YEAR RESULT</th>
<th>Comm</th>
<th>IT</th>
<th>PHQ</th>
<th>Dept</th>
<th>Ext</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 &amp; 3</td>
<td>HPA amendments reflect CPSA recommendations</td>
<td>Complete</td>
<td>HPA recommendations submitted by CPSA are still awaiting government review/approval. May be brought forward during the fall 2015 sitting of the legislature.</td>
<td></td>
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<tr>
<td>2 &amp; 3</td>
<td>Data sharing agreement finalized</td>
<td>Complete</td>
<td>Complete</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2 &amp; 3</td>
<td>Health Canada’s Marijuana for Medical Purposes regulations reflect CPSA recommendations</td>
<td>Complete</td>
<td>The CPSA’s recommendations are still under consideration with the federal government. There have been minor changes in the legislation that reflect input provided by CPSA. The term “Marihuana for medical purposes” - a term the CPSA uses in all its material, seems to be more prevalent in federal language.</td>
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<tr>
<td>2 &amp; 3</td>
<td>Accreditation contract with AHS finalized</td>
<td>Complete</td>
<td>Contract signed in December 2015 for 2 years, with option for 1 year extension. Ongoing discussion with AHS re: external participants in assessments</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>2 &amp; 3</td>
<td>Appropriate funding secured to add benzodiazepines and codeine containing medications to TPP</td>
<td>Complete</td>
<td>Funding for Codeine is secured for incorporation in early 2016</td>
<td></td>
<td></td>
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<td>X</td>
<td></td>
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<tr>
<td>2 &amp; 3</td>
<td>Secure a 3 year TPP funding framework with AHS to monitor medications set up by the TPP steering committee</td>
<td>Complete</td>
<td>Funding model finalized and ongoing for three years concluding in March 2017</td>
<td></td>
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<tr>
<td>2 &amp; 3</td>
<td>Reduce # of Alberta public over the age of 65 who are on two or more benzodiazepines by 20%</td>
<td>Reduce by 5%</td>
<td>Monitoring of benzodiazepines beginning in Q3 and interventions not to occur until late Q3 2015. Measurement of effectiveness of intervention not likely available until very early 2016.</td>
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<tr>
<td>2 &amp; 3</td>
<td>Reduce # of Alberta public who are on a daily narcotic dosage greater than 600 Oral Morphine Equivalents (OME) by 20%</td>
<td>Reduce by 5%</td>
<td>Reduction of 2.75%; over past year (1,713 patients down to 1,666 patients).</td>
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</tbody>
</table>
### GOAL 4: The College is a trusted resource to Albertans (public and others) when they have questions or concerns about medical practice.

**PERFORMANCE INDICATORS:** Satisfaction of public and physicians with CPSA communications and interactions; employee engagement; effectiveness of core operational processes; achievement of Council-approved budget.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>2017 TARGET</th>
<th>2015 TARGET</th>
<th>2015 MID-YEAR RESULT</th>
<th>Comm</th>
<th>IT</th>
<th>PHO</th>
<th>Dept</th>
<th>Ext</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public complainants' satisfaction with CPSA services</strong></td>
<td>4</td>
<td>90% of complainants satisfied with CPSA interactions</td>
<td>90%</td>
<td>January to June reporting 88% with 78 responses.</td>
<td></td>
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<td></td>
<td>4</td>
<td>60% of patients with complaints who say the CPSA resolved their complaint in a fair and thorough manner</td>
<td>55%</td>
<td>January to June reporting 55% with 78 responses.</td>
<td></td>
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<tr>
<td><strong>Physician satisfaction with CPSA interactions</strong></td>
<td>4</td>
<td>90% of physicians with complaints satisfied with CPSA complaint interactions</td>
<td>90%</td>
<td>January to June reporting 96% with 150 responses</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>4</td>
<td>90% physicians who say CPSA resolved the complaint about them in a fair and thorough manner</td>
<td>90%</td>
<td>January to June reporting 92% with 150 responses</td>
<td></td>
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</tr>
<tr>
<td><strong>Physician satisfaction with CPSA communications</strong></td>
<td>4</td>
<td>90% physicians who agree CPSA does a good job of communicating with them</td>
<td>90%</td>
<td>We do not have a physician survey schedule for 2015 (every two years only). Next survey will take place in Spring of 2016.</td>
<td></td>
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<tr>
<td><strong>Employee engagement score per Best Small &amp; Medium Employer</strong></td>
<td>4</td>
<td>85% employees engaged</td>
<td>82%</td>
<td>No survey conducted in 2015; Survey conducted every 3 years, next survey 2016.</td>
<td></td>
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</tr>
<tr>
<td><strong>Absenteeism rate per full-time employee</strong></td>
<td>4</td>
<td>Average number of work days missed due to illness per employee per year = 3.75</td>
<td>4.25%</td>
<td>Jan - June 2015 = 2.74 days</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Expense variance budget to actuals</strong></td>
<td>4</td>
<td>10% expense variance budget to actuals</td>
<td>10%</td>
<td>Jan - June 2015 Gross expenses = -6.5% variance to budget.</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Deficit/surplus variance budget to actuals</strong></td>
<td>4</td>
<td>10% deficit/surplus variance budget to actuals</td>
<td>10%</td>
<td>Jan - June 2015 Income from operations $1.2M, budget $435k = +181% variance to budget.</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Legend: 
- Exceeding/Meeting target
- Below target at this time; plan to be on target by end of year
- Significant delay

---

We do not have a physician survey schedule for 2015 (every two years only). Next survey will take place in Spring of 2016.
Accreditation

The work of the Accreditation programs support goal #2 and #3 of the strategic plan, that of being a trusted contributor to public policy affecting health care and engaging as an essential partner in a patient-centered health care system. This is accomplished through our review of physician credentials and training for approvals and privileges, working with other provincial MRAs to implement consistent accreditation standards in the western provinces and by enhancing the quality and safety of medical diagnostic and non-hospital surgical services by measuring services provided against a set of best practice standards.

Highlights:

- **Accreditation Evaluation Surveys:** We now have electronic survey results for a full year. The survey is sent to facilities that have undergone a four-year accreditation assessment shortly following their receipt of the advisory committee-approved report. Completion of these surveys has increased significantly: in the period January – June 2015, a total of 56 responses were received from facilities. There were no responses from assessors; this is due to the timing of assessments and surveys sent out, as well as repeat assessments for some assessors. The facility survey has a total of 17 questions broken down into “Pre-Assessment Phase,” “Accreditation Assessment Evaluation,” and “Post Assessment Phase.” The assessor survey contains 11 questions regarding the interaction and relationship of the College and accreditation staff in their experiences preparing for and conducting the assessments. Rating categories are “Strongly Agree,” “Agree,” “Disagree,” “Strongly Disagree,” and “N/A.” We gather our satisfaction data based on the “Strongly Agree” and “Agree” categories. This graph provides results from January – June 2015:
• **Medical Facility Accreditation Committee:** The Medical Facility Accreditation Committee (MFAC) is appointed by Council to oversee the work of the accreditation programs. There were two meetings of the MFAC from January 1 – June 30, 2015. The following are outcomes of interest arising from MFAC consideration and decisions:

  o **Laboratory Medicine Standards (annual revisions)** – Revisions were submitted for review and approval. Revisions are now done only on an annual basis driven by three primary factors: altered wording to facilitate use by other provincial MRA jurisdictions, changes to referenced national and international standards, and requests from users.

  o **Diagnostic Imaging Standards – Echocardiography** – A request had come forward to revise the College training requirements for approval to interpret echocardiography studies to align with requirements identified by a joint task force of the Canadian Society of Echocardiography and the Canadian Cardiovascular Society; this included a request from the division of perioperative echocardiography for anesthesiologists. Draft standards were developed by College staff and the Advisory Committee on Diagnostic Imaging (ACDI) and sent out for province-wide consultation to appropriate stakeholder groups. Results of feedback were vetted through the ACDI, and proposed standards were recommended for submission to MFAC. Representatives from the Alberta Society of Radiologists (ASR) presented their views to MFAC on February 4th. There was little concern of the training requirements proposed; the concern was primarily around the availability of training. Upon discussion, MFAC unanimously agreed that with slight rewording, the revisions be sent to Council for approval. Council approved these standards in March 2015.

One of the functions of the MFAC members is to audit the accreditation advisory committee meetings through review of the minutes of past meetings or attending meetings in person. Feedback was received from committee members on the perceived value of reviewing minutes versus attending meetings. Many more positive comments were received on the value of attending meetings and observing the proceedings/process of the meetings. A decision was made that going forward, MFAC members will participate in one face-to-face audit of an advisory committee meeting for 2015 and onward.

  o **ECG Exam** - Results of March 10th ECG Interpretation examination: six candidates wrote the exam, and two passed. The next exam is scheduled for Edmonton on September 15th, 2015.

All other accreditation program Advisory Committees met on a regular basis to ensure the business of facility/program accreditation moved forward. The number of facilities achieving full accreditation status from January 1st to June 30th, 2015 is listed in the table below. This is not reflective of the volume of facilities undergoing the assessment process, as full accreditation may take several months to achieve.
All accreditation programs - Facilities that Achieved Full Accreditation Status – comparison to 2014 results

- **Standards Revisions**: The plan is to ultimately revise all accreditation standards to current best practice/process-based standards similar to the Laboratory Medicine Standards. The Diagnostic Imaging standards are currently being rewritten with our commitment to Alberta Health Services (publicly-owned imaging facilities) to implement the new standards in early 2017. Other standards currently under revision are the Non-Hospital Surgical Facility (NHSF) and Sleep Standards. We will be working with the IPAC program to ensure the NHSF infection prevention standards are aligned.

- **Western Canadian Diagnostic Accreditation Alliance**: Feedback was received from CPSS and CPSM accreditation programs on CPSA’s Memorandum of Agreement on use of our Laboratory Medicine Standards, sharing of resources, etc. CPSBC indicated that they will not joining the WCDAA at this time. CPSS signed the MOA in late May 2015 and is working with us in implementation. CPSM is eager and intends to sign the MOA; however, they are awaiting a decision from their Ministry before formally joining.

**Challenges & Issues:**

- Obtaining/recruiting external laboratory experts (technical and clinical) from outside Alberta to meet the required 50% of the assessment teams for AHS facilities.

- Continue to work with CPSS and CPSM accreditation programs in the implementation of the CPSA Laboratory Medicine standards/processes. One of the positive spin-offs we are hoping for is increased access to assessors from other provinces on a larger scale than previously required.
• In the process of significant revisions/rewriting of standards in several programs while still ensuring day to day needs of the program and stakeholders are met. These projects are proceeding as human resources permit. Most accreditation programs have grown in the past several years with little growth in our staffing model. The increase in privately-owned Pulmonary Function Testing and Diagnostic Imaging Facilities has been significant with resulting work load issues on current staff. This will be reviewed over the upcoming quarter.

• On June 30th, 2015, Dr. Ken Gardener, Assistant Registrar, retired from the College. We welcome Dr. Owen Heisler as our new Assistant Registrar for Accreditation.
Communications & Government Relations

Department staff members shape the organization’s reputation by developing and implementing communications/GR strategies using various tools and tactics to help the College achieve its business objectives. Tools include the CPSA website, annual report, Messenger newsletter, promotional/educational material, speeches, presentations, internal communications, and providing advice/support to internal clients.

Highlights:

- **Continuing Competence Program communications plan:** We are building a comprehensive communications strategy and supporting tools/tactics that will capture stakeholder input and build understanding and support for the goals/objectives of the program. This will include focus groups, surveys, presentations, articles, media and promotional material.

- **Researched and responded to more than 90 media inquiries**, with topics including Physician-Assisted Death (PAD), various disciplinary hearings, Continuity of Care standard of practice, marihuana for medical purposes, prescription drug abuse/PPP program.

- **Released the 2014 CPSA Annual Report.** This report highlights CPSA programs, services and statistics in a storytelling format. The research, interviews, writing, editing, project management and layout and design for the report were all done in-house by CPSA communications staff. We created a hard copy and electronic version with distribution taking place in July 2015.

- **CPSA website redevelopment project:** after nearly two years of stakeholder research, content review/revision and extensive consultation, we are on track to launch a completely redeveloped website in September 2015.

- **Supported Council’s decision to stream sponsorship through AHS.** The May 2015 decision by Council received unexpected stakeholder feedback, requiring the development of various tools/tactics to strengthen our relationship with AHS and address questions/concerns from various audiences.

- **Continued to expand the College’s social media presence.** We now have over 1,500 Twitter followers and more than 600 Facebook friends. We monitor hundreds of social media threads around the clock, contributing to conversations and responding to questions or comments about the College.

- **Public Policy Research:** we are working with an Ottawa-based firm (Summa Strategies) to research, test and present the CPSA with potential public policy issues. This includes data collection on issues that resonate with key CPSA stakeholders. The public survey (1,000 Albertans) was conducted in June 2015, and we are developing an action plan to address the results.

- **Supported consultation process and rollout for various standards of practice.** We provided writing/editing support for proposed standards; promoted the consultation process to various audiences; monitored website feedback on draft standards for Advertising, Conflict of Interest, and Health Human Research; and implemented communications plans on approved standards including Continuity of Care, Episodic Care, and Establishing the Physician-Patient Relationship.
• **Completely revamped the TPP annual report.** We researched, wrote content, designed and distributed a user-friendly and visually engaging report for the government-required TPP report.

• **Organized Regional Tour visits to St. Albert, High Level and Peace River.** Through face-to-face meetings with physicians, the public, and community leaders, we identify local issues affecting good medical practice and confirm the College is continuing to deliver relevant programs and services to Alberta physicians and their patients. In November, the Regional Tour will visit the communities of Innisfail, Rocky Mountain House and Red Deer.

• **Generative work on issue of Physician-Assisted Dying:** the Government Relations shop invited Alberta Health (AH) to work collaboratively with the CPSA on the PAD provincial framework, setting an agreeable first meeting agenda and encouraging an open exchange of background information and working documents. AH and CPSA are now working together, informed of each other's positions and required outcomes. This level of collaboration on such difficult issues is unique between our organizations.

• **Continued our Community Relations work:**
  - Communications staff attended various events with medical students and residents, building relationships with future generations of physicians in ways unconnected to our regulatory/disciplinary role.
  - The CPSA sponsored the Alberta Medical Student Conference and Retreat (AMSCAR). We provided a speaker (Dr. Owen Heisler spoke on professionalism) and hosted a booth – two great opportunities to connect with students at the beginning of their medical career.
  - We co-hosted the North/South Doctors’ Golf Tournament with the AMA and CMF, raising more than $50,000 for medical student bursaries.

• **Launched IPAC on-line educational tool.** Working with the Infection Prevention and Control (IPAC) program and IT department, we developed an online course to educate physicians on OHS best practices for reprocessing in physician offices. Since the online course launched in the Spring of 2015, 79% of those who completed the evaluation said they would make a change to their practice as a result of taking the course.

• **Support the CPSA Service Excellence initiative:** we provide extensive communications support to various projects, including improving clarity of stakeholder communications – both online and in print – and by highlighting staff achievements on our intranet, bulletin boards and at CPSA staff meetings.

• **Ongoing work:**
  - CPSA website – day to day writing, editing, layout/design and content management
  - Messenger newsletter – writing, editing, layout/design, distribution
  - Internal communications – ensuring staff are aware of organizational decisions/changes (e.g. staff meetings, bulletin boards, CPSA intranet)
  - Responding to info@cpsa.ab.ca inquiries
  - Support for CPSA departments – includes communications strategies, tools and tactics for various initiatives including survey development, writing/editing expertise, development of promotional material, newsletters, etc.
Challenges & Issues:

- The website redevelopment project has required more time/resources than initially anticipated, causing capacity issues and stress for department staff. Once the site is launched September 1st, we should be back to more balanced workloads/expectations.
Continuing Competence Department

The Continuing Competence Department at the College of Physicians & Surgeons of Alberta was established to oversee programs that assist the College to “Ensure physicians remain competent throughout their careers.”1 The College wishes to accomplish this in a manner that maximizes efficiencies and effectiveness of assessment interventions (programs) and also reduces the burden to physicians. It also wishes to operate its various competence programs in a supportive and educational environment that operates outside of the disciplinary arm of the College. Strict thresholds have been established around the referral of physicians out of the Continuing Competence Department to Professional Conduct as identified in the Health Professions Act of Alberta2.

PRACTICE READINESS ASSESSMENT PROGRAM

Highlights:

- Activity has been stable with a slight increase in the total number of assessments for the first half of 2015 (102) compared to 2014 (98), representing a 4% increase. The total number of 6-month assessments continued to increase by an additional 11% from the first six months of 2014.

- The program operated with an overall pass rate of 95% in the first six months of 2015 as compared to a 100% pass rate in the first six months of 2014.

- Council approved a new sponsorship model on May 29, 2015 limiting sponsorship to only Alberta Health Services (AHS) for all applicants who did not already have a sponsorship letter on file. In time this will lead to a reduction in the number of private sponsorships of specialists and non-specialists into walk-in clinics in the urban areas. This reduction is not expected to be fully realized until 2016.

- Engaged in a formal research study with the Medical Council of Canada designed to evaluate the effectiveness of formalized multi-source feedback (MSF) within the preliminary clinical assessment. The MSF data collection for this study will conclude in August followed by collection of feedback from assessors on the value of formal MSF in their assessment decisions. No further collection of formal MSF will proceed until the research is complete and we understand the value and appropriateness of formal MSF in a preliminary clinical assessment.

- A workshop for Provincial Physician Assessment Program (PPAP) assessors has been scheduled for this fall as part of our commitment to continued professional development.

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1 College of Physicians & Surgeons Strategic Plan (2011); Goals
2 HPA Protection Section 52(1)
Challenges & Issues:

- There is a significant backlog of 65 applicants currently waiting for assessments. The majority of applicants in the backlog are waiting for walk-in clinics in either Edmonton or Calgary of which are a total of 45 family medicine and five specialist assessments; the remaining 15 hold AHS sponsorship.

- AHS will be developing ‘sponsorship’ criteria they will apply to all recruitment requests from private clinics. This criteria and the new process they will engage in their role as sole Sponsor in Alberta will be forthcoming over the later part of 2015.

CHANGE IN SCOPE ASSESSMENTS
Highlights:

- Received three new referrals and conducted two assessments, one of which was for the previous reporting period. Both were completed successfully and the requested changes approved.

FITNESS TO PRACTICE ASSESSMENTS
Highlights:

- No referrals or assessments completed during this reporting period.

RETURN TO PRACTICE ASSESSMENTS
Highlights:

- Received one new referral and conducted two assessments for referrals from previous reporting period. Both assessments resulted in a full return to practice.

PHYSICIAN ACHIEVEMENT REVIEW PROGRAM
Highlights:

- In keeping with Council direction, Pivotal will cease to initiate physicians in the Physician Achievement Review (PAR) cycle as of July 1st, 2015 until June 30th, 2016. All physicians who are already underway in PAR as of June 30th will continue through to completion of their report and be referred for further follow-up as indicated.

- In the first six months of 2015, a total of 632 reports were completed and sent to physicians, confirming 50% of our annual target has been met and indicating a slight increase from 591 reports completed for the same time period in 2014.

- A total of 134 of these physicians were referred to the Survey Subcommittee (SSC) for follow-up, representing 21% of all reviewed physicians and consistent with the first six months of 2014.
these, a total of 23 physicians (17%) were referred to SSC for stress, representing an increase from 17 physicians referred for stress January – June 2014.

- Upon physician contact and review of each case by the SSC, a total of 14 physicians were further referred on to Assessment Subcommittee (ASC) for follow-up. This referral rate represents 10.4% of all reviewed physicians, which is a decrease from 19.5% for the same period last year.

- SSC reported a number of flagged physicians have experienced a significant ‘negative’ reaction to receipt of their PAR report containing T-Scores. PAR-C is aware of the concerns, and has requested SSC to monitor this on a monthly basis for volume and severity.

- Between January – June 2015, 138 Physicians responded to the PAR feedback survey, representing a 49% response rate. Approximately 58% of these respondents report making at least one change in their practice because of their PAR results.

- Engaged in two studies that will impact the quality of the PAR report to physicians:
  - *Narrative Comments* study: all data has been collected and is currently being evaluated by Drs. Lockyer and Sargent. Results are expected by the end of the year.
  - *Displaying data to better engage physicians in practice improvement*: study was delayed and only started in April 2015; however, all research participation requests were distributed in mass batches to support the study prior to the scheduled decrease in PAR initiations. It is expected that this study will be conducted over the period of slow down so that results will be known prior to restarting full activity in the summer of 2016.

- The Anesthesia Instrument redevelopment concluded and was accepted by PAR-C in early 2015 for use upon resumption of PAR initiations in 2016. Manitoba will begin using the new instrument immediately and will share information with Alberta about any physician impact involving the new questions and asymmetric scale prior to it being used in Alberta.

- A consultant has been hired by the Medical Council of Canada (MCC) to develop a project scope and work plan to support a transition of the PAR instruments and research. Progress has been slower than anticipated. Alberta will most likely stop charging a user-fee at the end of 2015, pending transition of research to the MCC.

**PHYSICIAN PRESCRIBING PRACTICES**

Physician Prescribing Practices (PPP) offers physicians educational materials, peer support and practice tools to improve the overall quality of prescribing in Alberta. The program emphasizes a quality improvement approach to prescribing that includes collaboration between physicians, College staff and others with expertise in prescribing practices.
PPP Regular Work:
- Prescribing Interventions:
  o 36 opened
    ▪ 1 from DOME 5000
    ▪ 14 from Demerol Project
    ▪ 19 from FNIHB Project
    ▪ 2 Prescribing Concerns
  o 10 closed
  o 42 ongoing interventions

- Compliance with Undertakings, Order of Councils or Agreements:
  o 2 opened
  o 4 closed
  o 23 ongoing

- 1 article written for the Prescribing Corner (June)

High-Risk Patient Identification (HRPI) Project:
Triplicate Prescription Program (TPP) data identified potentially high-risk patients on oral morphine equivalent doses of > 600 mg daily and seeing > two physicians and attending > two pharmacies in a three-month period of time.
- Started August 2013 - Collaborative project with ACP to provide this information to the physicians and pharmacists providing care to these patients:
  o Physicians were notified that this is a potential high-risk patient.
  o Review HRPI patients quarterly, and if physician continues to prescribe for a potential high-risk patient, PPP will open an intervention to work with physicians with an educational approach.

- 2015 Running Totals
  o 22 physicians received a patient alert letter in 2015
  o 2/22 (9%) physicians continue to prescribing for the same patient.

DOME 5000 Project
- August 2014 - Targeted intervention to physicians with patients receiving ≥ 5000mg OME/day

- Letters and questionnaires were sent to the 14 physicians prescribing for the 12 patients (two patients have two physicians) on daily OME>5000mg in September 2014.
  o Questionnaires were received for 13/14 physicians so far:
- One physician on medical leave until the Spring 2015
- 6/14 (42%) physicians are interested in working with a chronic pain expert for educational intervention
  - 6/14 (42%) declined
    - Two physicians were covering for another physician while on holiday
  - 1/14 (7%) retired

- Mentors began working with interested physicians in Q1 of 2015.
- All files of physicians not interested in mentorship have been assigned to a Senior Medical Advisor for follow-up

- 2015 Review:
  - Two new physicians
  - Five dropped off list
  - Nine ongoing

- Physicians working with mentors seem to be benefitting from the relationship and mentoring; prescribing is showing changes. Due for review in August, 2015.

- Feedback from two physician mentors is positive

**Meperidine Intervention:**

- Targeted intervention to provide feedback to physicians with patients on > 600 mg meperidine daily in a quarter. Initial patient cohort from 2011

- February 2014 review of 2011 cohort of 43 patients:
  - Two deceased
  - 33/41 (80%) patients off meperidine or dose significantly reduced
  - Two patients prescribing supported by chronic pain specialists
  - 6/41 (15%) patients no change in dose or ↑
    - Two new physicians were contacted with patient advisory letter
    - Four physicians previously identified, initial positive changes had reverted to previous prescribing. Request for clinical information to support prescribing via questionnaire.

- August 2014 Review
  - 9/13 (69%) physician contacted in Feb 2014 stopped prescribing Demerol
  - 3/13 (23%) physicians showed no change in dose
  - 1/13 (7%) physician reduced the dose significantly
  - 5 new physicians were contacted with patient advisory letter
June 2015 Review
  - 4/9 (44%) physician contacted in August 2014 stopped prescribing Demerol
  - 5/9 (55%) physicians showed no change in dose
  - 14 new physician were contacted with patient advisory letter

CAMH Opioid Dependence Treatment Core Course (Alberta Version) Completed:
Online course developed in collaboration with the Centre for Addiction and Mental Health (CAMH) and the University of Calgary. The CAMH ODT Core Course was modified to reflect Alberta content and MMT standards. The course includes a facilitated online webinar using virtual patients to support case based discussions.

- In June, the course was piloted with two groups to validate the course and train the facilitators.
- Course offered September 24, 2014 (registration was full) and now is being offered by the University of Calgary.
- Six physicians Completed the April 8-June 8, 2015 course

Methadone Exemption Stats:
- 87 Dependence (general)
- 13 Dependence (patient-specific)
- 242 Analgesia (general)
- 234 Analgesia (patient-specific)

Suboxone Authorizations Stats:
- 136 physicians authorized

Marihuana for Medical Purposes (MMP) Standard of Practice:
This new standard was issued April 3, 2014 and posted with a companion document “Advice to the Profession” on the website.

- Council made the decision to add MMP to the Triplicate Prescription Program.
- MMP Stats, effective July 20, 2015:
  - 128 registered physician authors
  - 2,257 patients (five physicians responsible for 1,697 patients)
Optimized Prescribing with Seniors (OPS): The CPSA and AMA have collaborated to develop a practice support tool for Alberta physicians focused on prescribing issues in senior patients. OPS is published bimonthly in electronic format in the Messenger and MD Scope

- Dr. Jim Silvius (Provincial Medical Director, Seniors Health; Provincial Medical Director, Pharmacy Services) is the coordinator.
- Publication began in March 2014, and three articles have been published in 2015.

Benzodiazepine Reports
A series of three reports were completed in order to provide a descriptive analysis of benzodiazepine medication utilization in Alberta. These reports support planning for the inclusion of benzodiazepines as part of the TPP and PPP programs.

- Analysis used 2013 dispense data from Alberta’s Pharmaceutical Information Network (PIN).
- The first report focused on utilization in all patients 16 years of age and above.
- The second report refined its focus on use in patients 65 years of age and above.
- The final report looked at the use of benzodiazepine-related medications that are used primarily as sedative-hypnotics.

The Physician Prescribing Practices Committee utilized these reports to help determine the measures and thresholds to be used for four benzodiazepine intervention strategies. Monitoring of Benzodiazepines and Benzodiazepines-related medications to begin on July 1st, 2015.

PRACTICE VISIT PROGRAM
Highlights:

- This new program involves the amalgamation of the PAR practice visitor program and the Peer Review program. The intention of the new program is to provide a consistent, high-quality approach when intervening with physicians referred to the Continuing Competence Department.
- A team of Senior Medical Advisors (SMAs) are now reviewing all program referrals to determine the type and format of the intervention based on evaluation of multiple competence-based data sources, including PAR, Prescribing, Alberta Health Care billing data, etc.
Following recruitment of additional physician resources to the department, a total of 41 outstanding referrals involving the PAR Program have been closed. Only nine files from 2012/2013 remain open, but active, as they involve physicians who are currently participating in other competence programs, or who are having their PAR surveys repeated. It is anticipated that these referrals should be closed or in progress by the end of 2015.

The Program has received a total of 17 new referrals from January – June 2015 and has conducted a total of 25 practice visits.

Those physicians who underwent a practice visit following referral from the PAR Program received a follow-up survey to evaluate the effectiveness of this intervention. To date, 10/12 physicians have reported making a change to their practice as a result of the visit. Further, these physicians rated the effectiveness of the intervention in the following manner:

- Not informative or worthwhile: two physicians
- Somewhat informative and worthwhile: five physicians
- Very informative and worthwhile: five physicians

All physicians who have been referred to the Continuing Competence department and have undergone an intervention will receive a similar survey beginning in 2016.

A practice visitor workshop was held in Calgary in May 2015 as part of our commitment to continued professional development.

Challenges & Issues:

- Taking the best from both programs and making our approach consistent is challenging logistically, and to some extent, legally. The current PAR rules do hinder some of this work, so they will be revised over the summer and taken to Council for approval in the fall. We are working through the opportunities to enhance the effectiveness of this Program.

INFECTION PREVENTION & CONTROL PROGRAM

Highlights:

- Completed 27 medical device reprocessing (MDR) assessments and 32 pilot assessments of general infection prevention & control; three MDR assessments met the criteria of a public health threat reportable to the Medical Officer of Health, and those clinics are under review by the Alberta Health Services Risk Assessment Panel.

- Completed development of an online course that addresses risks and employer obligations for offices that perform MDR using the Alberta Jobs, Skills, Training, and Labour OHS Grant (2013-15). To date, 85 participants have accessed content, and 25 have completed the full course.
- **New Alberta Jobs, Skills, Training, and Labour OHS Grant** (2015-17) approved: joint grant proposal with 11 other health-regulatory colleges – preventing and managing blood and body fluid exposures in community health care. The Project Steering Committee is recruiting a Project Manager with activity anticipated to begin in late 2015.

- Standards development: draft for General Infection Prevention & Control sent out for stakeholder consultation and is undergoing piloting and revision.

- Guideline development with College & Association of Registered Nurses of Alberta (CARNA) and the Alberta College of Pharmacists (ACP): document for Hand Hygiene was approved; document for Medications, Vaccines, and Injection Safety was drafted.

- Converting assessment tools (e.g. forms) from paper-based to electronic to allow future collection and reporting of statistical and outcome-based assessment information (e.g. office types, compliance rates).

**Challenges & Issues:**

- Current office identification system (physician billing records) is inefficient and imperfect. The program may not be capturing all unaccredited facilities that fall under regulation by CPSA.

- Alignment of IPAC standards in all CPSA program areas and facility types (accredited vs unaccredited).

- Capacity to conduct IPAC assessments – recruitment of assessors in different geographic zones has been initiated.

**COMPETENCY ENHANCEMENT PROGRAM Highlights:**

- The Department of Family Medicine (University of Alberta) is hosting the physician communication course this September to accommodate referrals from the College. The University of Calgary is now offering a similar program for all physicians, on a trial basis, and if successful will make available for College referrals who may find Calgary more amenable than Edmonton based on their practice location.

- The College continues to work with the University of Calgary departments of CME-CPD and Family Medicine to develop a Memorandum of Understanding that will support College referrals of practicing physicians with competence concerns for assessment and remediation (where appropriate). A draft agreement has been completed and is now sitting with the university lawyer for review.
PRACTICE REVIEW PILOT
Highlights:

- PAR-C established a working group, the Pilot Development Team (PDT), to assist College staff with development and evaluation of the pilots. This team met at the end of June to discuss the work involved in the practice review pilot, including how to best engage with our members through this process. The PDT supported the use of a survey to engage with members about Council’s direction on aligning existing programs, improving PAR and changing the way in which the review is administered. Stakeholder engagement will unfold over summer 2015, concurrent to development of the pilot.

STANDARDS OF PRACTICE PROGRAM
Highlights:

- Council provided direction that members be required to demonstrate knowledge of, understanding of and compliance with the SOPs as a continuing competence requirement and that assessment of those requirements include the following:
  - Confirmation of knowledge and understanding of the SOPs at initial registration and annually upon renewal of a practice permit.
  - Assessment of compliance with SOPs either on a regular basis or targeted toward members who may be at greater risk.

- Efforts are underway to develop the following tools to support achieving these goals and objectives:
  - Collaborating with Registration to develop an opportunity to engage with new registrants to Alberta.
  - Introducing several questions on 2017 RIF for the purposes of gauging and enhancing awareness of our standards with practicing physicians (on a regular basis).
  - Collaborating with our Practice Auditors and our SMA – Research and Evaluation to develop a SOP screening tool and a full SOP audit tool for use during a practice visit (on a targeted basis). The nurses are working through the document to confirm what items are measurable and to develop those tools that will help them measure adherence such as questionnaires and interviews. An evaluation framework will be developed concurrently so the effectiveness of this program can be evaluated through the ‘pilot’ phase. It is intended that this new program be piloted during the Practice Review pilot scheduled in 2016.
Information Technology

Information Technology provides services around all hardware, software, and electronic equipment. This includes computers, servers, phones, printers and the access card system.

Highlights:

- A Security Audit was completed by Telus in March 2015 that performed an assessment of the resiliency to common security weaknesses and provided recommendations regarding any issues uncovered. The process involved an assessment of administrative security measures and technical controls. The results of the audit were positive for the College.

There were two administrative controls wherein there were suggestions for new practices or major adjustments – both involved arranging more formal governance processes; we are in the process of organizing a more robust governance structure that will be presented to FAC in the near future. On the technical side, eight of twenty identified controls were recommended for modification. Of these recommendations, three were based on Telus not understanding that we already had processes in place that dealt with these issues, and one that we were already in the process of implementing.

There was only one vulnerability from the outside world, and that was a recently-identified issue with the video conferencing system (limited impact), which was addressed as soon as it was identified.

The areas of internal focus revolved around limiting CPSA staff ability to make changes to local machines, monitoring the installation of non-approved software, and improving documentation and enhancing the governance structure around risk. The College was already in the process of working on many of the issues identified in the report and will use the feedback to further enhance our governance and technical controls.

- With the increased usage of our document management system (QUEST), we have had to work hard to make the application scalable and improve performance. A lot of work has gone into enhancing the system to increase its performance; this has been accomplished with great success.

- Our server and network people have been working hard to have a VDE (Virtual Desktop Environment) up and running that allows users to login from anywhere in the world securely and have a high-performing virtual desktop on which to work. We now have the ability between document management, Voice over Internet Protocol phones, and a virtual environment to have many users in the office work remotely and efficiently.

Challenges & Issues:

- Our only real challenge is ensuring that requests are triaged, prioritized and tracked consistently. Priorities from the executive are reviewed and reported on a regular basis to ensure there is a high-level of transparency in all projects.
Operations

The Operations Department consists of the Accounting, Administration, and Human Resource functions at the College.

Highlights:

**Accounting**

- **Grant Reporting** - The Accounting Team has assisted departments with the financial summaries for grant requests and/or grant reporting in the following areas:
  - **Triplicate Prescription Program**
    - Final report on the 2014 – 2015 funding of $515,000 was submitted.
    - Grant request submitted for the 2nd year (April 1, 2015 to March 31, 2016) of a three-year term. $655,800 in grant funding was requested.
  - **IPAC**
    - Final report on the March 1, 2013 to April 30, 2015 funding of $15,000 was submitted.

- **Business Planning/Budgeting** – The Management Team prepared three-year objectives for 2016 and presented them to Council for their input at their March meeting. These priorities were the basis for preparing the College draft budget for 2016.

- **Electronic Work Flows** – The Accounting Team completed the roll-out of the second phase of our electronic work flows and document storage solution in June 2015. The new software routes all scanned vendor invoices electronically to department coders and approvers. Comments and account codes can be added, and then the invoice is routed back to accounting for payment. The electronic work flows are tied into our accounting software and financial reporting software.

- **Financial Results – 2015** – The Directors have completed their financial variances to the end of June 2015. Projections have also been made for financial results to the end of the year. We anticipate ending the year in the black.

- **Finance & Audit Committee (FAC) highlights include:**
  - Approved the College and Pension Fund audited financial statements for the year ended December 31, 2014.
  - Heard a report from our Investment Managers on the investment portfolio performance for 2014.
  - Approved an update to the Statement of Investment Policies and Procedures for the College’s registered pension plan.
  - Approved an update to the College’s Investment Policy.
  - Approved an update to the College’s Due Diligence and Financial Controls policy.
  - Heard a presentation from PwC about the benefits of a whistleblower policy.
  - Heard a presentation from a consultant regarding options for future office space and the forecast of the Edmonton real estate market.
  - Reviewed and recommended to Council a change in the College’s Surplus Policy.
• Reviewed the 2016 College draft budget for Council’s approval at its September meeting.

• **Building Fund Update**
  o In September 2011, Council approved a $150 addition to the annual fee for the purpose of creating a Building Reserve Fund. Our current lease in Telus House (south tower) at ATB Place expires in February, 2019.
  o Including the 2015 annual billing, we are 4 years into this collection cycle and have accumulated $5.7 million.

• **Ongoing Activities:** Provided assistance for members, professional corporations, and facilities for collection of receivables.

**Challenges & Issues:**

• The FAC will continue to review the College’s pension plan in detail to ensure our benefit arrangements are cost-effective and in-line with our people strategy to attract and retain staff.

• The new Alberta Pension legislation regulations were effective September 1, 2014, which will allow additional registered pension options for the College. The FAC will be reviewing the options available in 2016.

• The new pension regulations also require additional policies be in place by the end of 2015. The FAC will be reviewing a new pension Governance Policy and Funding Policy in the second half of 2015.

**Administration**

Summary of Documents scanned & uploaded by Records Admin to SharePoint

<table>
<thead>
<tr>
<th></th>
<th>2015 (Jan - 1 – June 30)</th>
<th>2014 (Jan 1 - Dec. 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scanned, faxed, emailed &amp; manually uploaded</td>
<td>18,579</td>
<td>27,524</td>
</tr>
<tr>
<td>Conversion documents</td>
<td>2,016</td>
<td>1,289</td>
</tr>
<tr>
<td>Total</td>
<td>20,595</td>
<td>28,813</td>
</tr>
</tbody>
</table>

The Admin Records Team has assisted with document naming for the Professional Conduct (formerly Complaints) Department. The uploading of complaint documents is anticipated to start in the second half of 2015.

Starting in June 2015, the Admin Records Team begun scanning accounting invoice documents. These totals are not included in the above chart.
• **Office Reconfiguration** – With the realignment of executive portfolios and the establishment of the Continuing Competence Department, our Operations Coordinator worked with the Management Team and an interior designer to redesign our modular furniture to best meet the needs of our staff. During February – April, the office moves were accomplished. The Registration, Accreditation, IT, and Continuing Competence staff were involved in the moves.

• **Ongoing Activities**: contract maintenance & insurance renewal.

**Challenges & Issues:**
- The Admin Records Team will continue with revising our records management policies and procedures in 2015.

**Human Resources**
The College strives to hire and retain the best staff in an effort to achieve employee excellence and engagement. Our People Strategy is based on four main strategies:

- **Employee Attraction**
  - Recruiting: 8 positions (three new permanent positions, one maternity contract position, one short-term contract for staff leave, two replacements)
  - Total Full Time Equivalent (FTE) count:
    - June 2015 = 107.4
    - December 2014 = 101.3

- **Employee Development**

<table>
<thead>
<tr>
<th>Learning &amp; Development Metrics</th>
<th>2015 (6 months)</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of dollars invested in learning and development per FTE.</td>
<td>$1,036</td>
<td>$1,730</td>
</tr>
<tr>
<td>The total costs of learning and development as a percentage of the total labour costs.</td>
<td>1.5%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

- **Employee Assessment**
  - Mid-year reviews for staff were conducted.
### Employee Retention

<table>
<thead>
<tr>
<th>Retention Metrics</th>
<th>2015 (6 months)</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turnover</td>
<td>1.8%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

#### Employee Engagement (BSME survey)

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of College employees rated as “engaged”</td>
<td>n/a</td>
<td>82%</td>
</tr>
<tr>
<td>Average of “engaged” employees for all organizations in the BSME survey</td>
<td>n/a</td>
<td>71%</td>
</tr>
</tbody>
</table>

The survey on employee engagement using the Best Small & Medium Employers in Canada Survey (BSME) was not conducted in 2014 & 2015. The next survey is scheduled for 2016.

### Compensation Metrics

<table>
<thead>
<tr>
<th>Compensation Metrics</th>
<th>2014 (6 months)</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour Cost Expense Percent</td>
<td>56.4%</td>
<td>56.3%</td>
</tr>
<tr>
<td>Benefits as Percentage of Total Compensation</td>
<td>23.4%</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

### Productivity Metrics

<table>
<thead>
<tr>
<th>Productivity Metrics</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Absenteeism Rate per Full-Time Equivalent (FTE)</td>
<td>2.74</td>
<td>3.61</td>
</tr>
</tbody>
</table>

### Workforce Demographics

<table>
<thead>
<tr>
<th>Workforce Demographics</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>45.6</td>
<td>44.8</td>
</tr>
<tr>
<td>Average Length of Service</td>
<td>7.4</td>
<td>7.9</td>
</tr>
</tbody>
</table>

- In May, the College celebrated its long-service employees:
  - 5 year award - 9 employees
  - 10 year award - 1 employee
  - 15 year award – 1 employees

- In June, the College recognized the retirement of Dr. Ken Gardener as Assistant Registrar.

### Challenges & Issues:

- As the average age of the employee group continues to increase, we must ensure we have appropriate succession plans in place to manage our people.
Physician Wellness

The Physician Wellness Department manages all health-related concerns that could impact a physician’s practice. These conditions come to the attention of the College through a variety of ways, including self-report through registration application, annual renewal or at the time the condition occurs. Reports can also be received from colleagues, Alberta Health Services or universities. The department assesses the nature of the illness, risks to practice, impact on practice, and determines if further investigation or assessment is required. The department also monitors physicians with health conditions and liaises with the Physician and Family Support Program (PFSP) of the AMA and other professionals involved with our members to ensure they remain fit to practice.

Highlights:

- The number of physicians who either self-report or are reported by colleagues continues to grow, and in the first six months, there were 60 new reports to the program. We see this as a very positive indicator of success.

- We are reviewing and documenting all of our processes to better streamline the work we do. The process reviews will inform:
  - The Wellness Program transition into QUEST
  - Review of the resources allocated to the work we do
  - Create data about our processes and the program to improve transparency
  - Review of the management of confidential physician health information

- Blood-borne viral infection reporting has been reviewed by both the Expert Review Panel and the Physician Health Monitoring Program Advisory Committee, and it was recommended physicians should only be required to report their viral status to the College if they perform exposure-prone procedures as part of their practice.

- The RIF 2016 questions will be modified and internal processes adapted to reflect the modifications to the reporting requirement.

- Work continues with the AMA and the PFSP to address the recommendations in the Health Law Institute report. Collaborative work will continue in 2015 to establish education and to proceed with an evaluation of the Physician Health Program in Alberta in 2016.

- The Physician Health Special Interest Group of FMRAC met on June 5, 2015. The intent of this meeting is to share best practices and develop national approaches to specific issues (i.e. blood-borne viral infections, health information reported on CPCs, biologic monitoring processes).

- Practice conditions are all being monitored to ensure compliance.

- Risks for drug misuse in anesthesia: work with the multi-stakeholder group has continued. The framework is being finalized, and implementation of the recommendations will be planned by the end of 2015.
Challenges & Issues:

- The number of physicians reporting medical issues that could negatively affect practice continues to grow, resulting in an increased work load for the department.

- The department is reviewing our processes to improve efficiencies and to convert to an electronic file format.

Charts & Graphs:

### Physicians Monitored

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>Percentage Working</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>67</td>
<td>0</td>
<td>67</td>
<td>79%</td>
</tr>
<tr>
<td>2008</td>
<td>91</td>
<td>0</td>
<td>91</td>
<td>71% working</td>
</tr>
<tr>
<td>2009</td>
<td>103</td>
<td>0</td>
<td>103</td>
<td>100%</td>
</tr>
<tr>
<td>2010</td>
<td>149</td>
<td>0</td>
<td>149</td>
<td>88%, 2% retired</td>
</tr>
<tr>
<td>2011</td>
<td>167</td>
<td>0</td>
<td>167</td>
<td>85% working, 5% retired</td>
</tr>
<tr>
<td>2012</td>
<td>180</td>
<td>0</td>
<td>180</td>
<td>91%</td>
</tr>
<tr>
<td>2013</td>
<td>220</td>
<td>0</td>
<td>220</td>
<td>93%</td>
</tr>
<tr>
<td>2014</td>
<td>244</td>
<td>0</td>
<td>244</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>256</td>
<td>0</td>
<td>256</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Numbers are not exact as, on occasion, physicians have multiple conditions and may be counted twice.
Condition Monitored by Geography

- **Blood Borne Infection**
  - Non-Specialist Rural: 7
  - Non-Specialist Edmonton: 6
  - Non-Specialist Calgary: 7
  - Specialist Rural: 11
  - Specialist Edmonton: 1
  - Specialist Calgary: 0

- **Professionalism Concerns**
  - Non-Specialist Rural: 5
  - Non-Specialist Edmonton: 2
  - Non-Specialist Calgary: 5
  - Specialist Rural: 3
  - Specialist Edmonton: 0
  - Specialist Calgary: 0

- **Boundary**
  - Non-Specialist Rural: 6
  - Non-Specialist Edmonton: 5
  - Non-Specialist Calgary: 6
  - Specialist Rural: 3
  - Specialist Edmonton: 4
  - Specialist Calgary: 0

- **Substance Use/Addiction**
  - Non-Specialist Rural: 13
  - Non-Specialist Edmonton: 13
  - Non-Specialist Calgary: 12
  - Specialist Rural: 12
  - Specialist Edmonton: 13
  - Specialist Calgary: 13

- **Disruptive Behavior**
  - Non-Specialist Rural: 1
  - Non-Specialist Edmonton: 1
  - Non-Specialist Calgary: 1
  - Specialist Rural: 1
  - Specialist Edmonton: 2
  - Specialist Calgary: 1

- **Medical**
  - Non-Specialist Rural: 13
  - Non-Specialist Edmonton: 13
  - Non-Specialist Calgary: 13
  - Specialist Rural: 8
  - Specialist Edmonton: 7
  - Specialist Calgary: 23

- **Psychiatric**
  - Non-Specialist Rural: 13
  - Non-Specialist Edmonton: 13
  - Non-Specialist Calgary: 9
  - Specialist Rural: 9
  - Specialist Edmonton: 10
2015 January - June Admissions and Discharges:

- 60 new cases
  - 12 are Residents
  - 2 are Medical Students
- 86 files were closed
- 2 deceased

2015 Monitored Physicians:

- Independent Practice (2.0% of Registrants)
- Residents (2.1% of Residents)
- Medical Students (1.9% of Medical Students)
Practice Condition Monitoring

When the College underwent the transition to the HPA, practice conditions became part of the public record and were included on practice permits. At this time, we became aware of circumstances where physicians had not been compliant with their conditions. We therefore developed a process to track and monitor all practice conditions.

Since January 2012, the College has verified compliance of physicians with practice, procedure and/or geography-related conditions on their practice permits. Compliance is verified through billing information from Alberta Health, Blue Cross, WCB, a physician’s employer and, at times, through direct communication between the Assistant Registrar and the physician.

NB: Conditions related to triplicate prescribing or physician wellness issues are monitored by the Physician Wellness Department. Physicians monitored for a health condition may also have a practice condition. Conditions related to practice readiness assessments are monitored by the ACE Department.

Highlights:

- The CPSA IT department developed a monitoring database to track physicians with conditions on their practice permits.
- Changes were made to the CPSA database allowing for staff to be notified immediately of any changes/deletions/additions to physicians with conditions on a Practice Permit, ensuring consistent and timely action.
- Reprocessing conditions will be removed for all but two physicians. The remaining physicians are monitored on a yearly basis through review of Alberta Health billing data.
- 100% of currently-monitored physicians are compliant.

Challenges & Issues:

- Continued challenges with the quality of Alberta Blue Cross and Alberta Health databases; further clarification is required at times.
Charts & Graphs:

- Active physicians with conditions: 122

- Source of Condition:
  - Registration Department: 39
  - Professional Conduct Department: 33
  - Physician Wellness: 51
  - Peer Review: 1
  - Assessment & Competency: 1

- Types of Conditions (*note: some physicians have multiple conditions*):
  - Procedures/Practice Restrictions:
    - Group Practice: 18
    - Maximum Amount of Hours/Week or Maximum Amount of Patients: 25
    - Approved Clinical Setting: 3
    - Types of Procedures: 1
    - Types of Practice: 58*
    - Geographic Location: 5
    - Chaperone Requirement: 19
    - Type of Patients: 6
    - Practice Monitor Required: 3
    - Restricted to Providing Medical Service to British and Canadian Military Members: 1
    - Communication Mode: 1
  - Prescribing Restrictions: 18*
  - Supervision Requirement: 3
  - Administrative Medicine Restriction: 4
  - Restricted to Teaching: 2
  - Restricted from Providing Patient Care: 3
  - Suspended or Inactive: 34*
  - Not in Current Practice: 4
Professional Conduct

The Professional Conduct Department administers those processes which fall directly under the purview of the Complaints Director as declared in Part 4 of the Health Professions Act, RSA 2000, c H-7. This includes all aspects of the complaints and discipline processes. Our goal is to provide fair, effective and open complaints and discipline processes. We achieve this by approaching complaints as opportunities to enhance quality of care by understanding:

- the situation and circumstances surrounding the complaint issue from both the physician’s perspective and the complainant’s perspective,
- that complaints can be a useful tool in identifying areas for improving a physician’s clinical practice and/or professional interactions through education and/or remedial activities; and
- that discipline, although not preferred, may be necessary in order to ensure public safety.

At the time of complaint intake, staff collaboratively and thoroughly reviews the complaint in considering the most appropriate process to address and/or resolve the matter. For those matters not dismissed due to insufficient evidence, this includes both informal resolution processes and formal investigations.

Highlights:

- Dr. Michael Caffaro joined our team in April and was appointed Complaints Director effective July 1, 2015.
- Early indicators of the Satisfaction Survey suggest the strategies deployed in 2014 to improve the satisfaction of complainants who experience the processes of 1) investigation and dismiss and 2) dismiss with no further action beyond review of complaint are starting to show some improvement. These are only small numbers at this time, and we will report the full results in at the end of the year.

  - Strategies being used (since 2014) to improve satisfaction include:
    - Preparing letters of dismissal with more acknowledgement and explanation around complaint issues.
    - Ensuring we answer any specific questions asked by complainant when preparing the decision letter.
    - Increasing contact with complainants by investigators.
    - Patient Advocates working to understand the deeper interests of the complainant in order to inform the decision letter.
Challenges & Issues:

- We have more contested hearings scheduled for this year than in previous years. This will impact our budget with an increase in cost beyond what was budgeted. Budgeting for hearings continues to be challenging; this activity is dependent on variables beyond our control and difficult to predict with accuracy (examples include: level of co-operation by physician, complexity of cases; possible criminal charges against the physician, physician’s health, etc).
- Work in building electronic work flow processes and moving paper records to electronic records for complaints is moving slower than anticipated due to available resources and fluctuations in work load.

Productivity Chart:

<table>
<thead>
<tr>
<th>Status</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31-Mar</td>
<td>30-Jun</td>
</tr>
<tr>
<td>Direct Resolve</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Resolve with Consent</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>Inquiry</td>
<td>56</td>
<td>52</td>
</tr>
<tr>
<td>Investigation</td>
<td>93</td>
<td>95</td>
</tr>
<tr>
<td>Expert Opinion</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Resolution</td>
<td>28</td>
<td>42</td>
</tr>
<tr>
<td>Hearing</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Total files open</td>
<td>201</td>
<td>243</td>
</tr>
</tbody>
</table>

Flow

<table>
<thead>
<tr>
<th>Status</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Complaints Received</td>
<td>170</td>
<td>179</td>
</tr>
<tr>
<td>Complaints Closed</td>
<td>175</td>
<td>142</td>
</tr>
<tr>
<td>Total files open</td>
<td>-5</td>
<td>37</td>
</tr>
</tbody>
</table>
Registration

The Registration Department processes all applications for medical practice permits in Alberta and registers medical professional corporations. The department also establishes and maintains members’ profiles in the college database, administers annual renewal of physician practice permits and corporation registrations, and issues Certificates of Professional Conduct. These tasks are divided between two divisions within the Registration Department: Registration Administrators and Member Services Agents. The department is led by Dr. Kate Reed, Assistant Registrar, and Mr. Bruce Leisen, Director.

Highlights:

- Continue to work closely with the Medical Council of Canada and other medical regulators across Canada to advance and improve the national online Application for Medical Registration.

- Professional Corporations profile sites are now developed in QUEST. This is the next step in integrating all Professional Corporation electronic workflow processes into QUEST.

- Processing of most work of the department is begun within two days of being received.

- The Registration Department relocation to the 28th floor provided a further opportunity for us to redesign how we work. We now have five generic work stations shared by the nine Registration Administrators who work from home up to 50% of the time. This has decreased the footprint within the College for the Registration Department.

- Dr. Reed, Mr. Leisen, and two Registration Administrators again attended the Registration Interest Group meeting at the June FMRAC meeting. The CPSA continues to be seen as a leader in many registration practices, and we were called upon numerous times to answer the question “How does the CPSA do ...?” Having two staff members attend was a very valuable experience for them, as they were able to experience first-hand how highly the innovations they help create are viewed by their colleagues across the country.

Challenges & Issues:

- New work:
  - Updating the Professional Corporation application process to the College online standard.
  - Transferring Professional Corporation files into QUEST.

- Competing priorities within the College limit our ability to ensure all electronic process and software improvements can be updated as soon as Registration would like.
Charts & Data:

Qualification Reviews for Independent Practice, with percent change from first half of 2014:

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine, General Practice</td>
<td>486 (+10.9%)</td>
</tr>
<tr>
<td>Specialty Discipline</td>
<td>424 (-7.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>910 (+1.2%)</td>
</tr>
</tbody>
</table>

![Qualification Review Running Monthly Total Chart]

<table>
<thead>
<tr>
<th>Year</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>73</td>
<td>154</td>
<td>299</td>
<td>429</td>
<td>575</td>
<td>680</td>
<td>752</td>
<td>839</td>
<td>903</td>
<td>983</td>
<td>1048</td>
<td>1120</td>
</tr>
<tr>
<td>2011</td>
<td>95</td>
<td>161</td>
<td>270</td>
<td>363</td>
<td>541</td>
<td>652</td>
<td>746</td>
<td>838</td>
<td>929</td>
<td>983</td>
<td>1036</td>
<td>1114</td>
</tr>
<tr>
<td>2012</td>
<td>87</td>
<td>182</td>
<td>330</td>
<td>468</td>
<td>630</td>
<td>751</td>
<td>896</td>
<td>985</td>
<td>1084</td>
<td>1176</td>
<td>1252</td>
<td>1326</td>
</tr>
<tr>
<td>2013</td>
<td>97</td>
<td>189</td>
<td>345</td>
<td>472</td>
<td>611</td>
<td>713</td>
<td>852</td>
<td>912</td>
<td>993</td>
<td>1065</td>
<td>1161</td>
<td>1246</td>
</tr>
<tr>
<td>2014</td>
<td>119</td>
<td>235</td>
<td>411</td>
<td>586</td>
<td>737</td>
<td>899</td>
<td>1033</td>
<td>1130</td>
<td>1205</td>
<td>1300</td>
<td>1415</td>
<td>1513</td>
</tr>
<tr>
<td>2015</td>
<td>105</td>
<td>234</td>
<td>426</td>
<td>570</td>
<td>750</td>
<td>909</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. New Registrations, with percent change from first half of 2014:

<table>
<thead>
<tr>
<th>Independent Practice</th>
<th>Other Registers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GR</td>
<td>PRPC</td>
<td></td>
</tr>
<tr>
<td>309</td>
<td>109</td>
<td>869</td>
</tr>
<tr>
<td>-1%</td>
<td>+9.0%</td>
<td>-4.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRPC</th>
<th>Assess</th>
<th>PGT</th>
<th>PGT-PE</th>
<th>UGrad</th>
<th>LPR</th>
<th>CR</th>
<th>TM</th>
<th>PRPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>81</td>
<td>215</td>
<td>60</td>
<td>0</td>
<td>46</td>
<td>6</td>
<td></td>
<td></td>
<td>43</td>
</tr>
<tr>
<td>+26.6%</td>
<td>-17.9%</td>
<td>-24.0%</td>
<td></td>
<td>+17.9%</td>
<td>-60%</td>
<td></td>
<td></td>
<td>+13%</td>
</tr>
</tbody>
</table>

GR: General Register, PRPC: Provisional Register Conditional Practice, PGT: Postgraduates, PGT-PE: Physician Extenders, UGrad: Undergraduates, LPR: Clinical, Surgical, and Medical Research Assistants, CR: Courtesy Register, TM: Telemedicine, PRPP: Provisional Register, Pre-Post Grad Training Assessment.

**Explanations:**
- 0 Undergrad registrations is to be expected in the first half of the year since first year medical school starts in late summer, and applications from incoming students have not yet been received.
- 0 Telemedicine registrations in the first half of the year is a reflection of the very low number of these registrations we typically receive through the course of the full year.
- % change in LPR registrations: the number of candidates in this category is typically very small and totally dependent upon whether Alberta Health Services is hiring new Clinical and/or Surgical Assistants, and if so, how many.

2. New Professional Corporations Registered:
- 318, up 25% from first half of 2014.

3. Certificates of Professional Conduct Issued:
- 1002*, up 21.7% from first half of 2014.
  - *Number does not include duplicate CPC’s sent at same time to different locations.

4. Communications with Outside Parties by Member Services Agents (non-registration issues), with percent change from first half of 2013:

<table>
<thead>
<tr>
<th>Contact</th>
<th>Phone</th>
<th>Email</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>3418(+2.5%)</td>
<td>3773(-4.2%)</td>
<td>7191(-1.15%)</td>
</tr>
<tr>
<td>Public</td>
<td>2383(-13.8%)</td>
<td>547(+41.3%)</td>
<td>2930(-7.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>5801(-4.9%)</td>
<td>4320(-0.2%)</td>
<td>10121(-2.05%)</td>
</tr>
</tbody>
</table>

**Explanations** for decrease in public contacts:
- Better information and technical tools available to staff means most issues can be resolved during the initial contact, with fewer return calls required.
- More information is now available on the CPSA website, decreasing the need for physician and the public to call or email.
CPSA Standards of Practice & Internal Policy

The College’s strategic plan identifies the CPSA Standards of Practice (SOP) as a major component of our core business. The standards identify the minimum expectations for professional conduct by Alberta’s physicians, confirm professional vigilance to self-regulation and reflect the intent and direction of Council. The standards are also an important tool for fulfilling the College’s mandate of ensuring the public receives safe and effective medical care from competent physicians. The purpose of SOP & Internal Policy (IP) is to ensure standards of practice and other policy documents continually evolve and align with current medical practice and quality patient care.

Highlights:

- Developed and amended internal CPSA policy informed by Council direction, including:
  - Continuity of Care standard of practice
  - Episodic Care standard of practice
  - Establishing the Physician-Patient Relationship standard of practice
  - Advice to the Profession: Continuity of Care
  - Advice to the Profession: Legislated Reporting & Release of Medical Information
  - Supported Council to host current Consultation 009

- Provided leadership and direction for implementing Council-approved standards with a particular focus on Continuity of Care, including conducting a mini survey that resulted in:
  - A response rate of over 900 physician members with well over 2/3 reporting compliance with the standard;
  - Direct contact with and support to all 28 of our members who requested CPSA assistance through the survey; and
  - Identification of almost 70 physician members willing to share their process with other physicians.

- Hosted two public consultations on Council’s behalf (007 & 008) reviewing six amended standards.

- Incorporated stakeholder engagement in the SOP renewal process strategic review phase, which now includes an annual meeting with Alberta College of Pharmacists, College & Association of Registered Nurses of Alberta, and Alberta Dental Association + College.

- Steered Council through a strategic review of SOP renewal timeline resulting in a re-established priority list for SOP renewal and the development of advice to the profession.

- Conducted annual Council evaluation of SOP renewal process that indicated strong support for and confidence in the process (Figures 1 & 2).

- Responded to four external stakeholder requests for feedback and completed consultation on the Yukon Medical Council standards.

- Governance review complete. Council has received the report and recommendations. A governance committee task force will present its work to Council in September.
Challenges & Issues:

Internal

- SOP implementation to support physician member awareness of SOP requires clarification of a lead and additional resources. The SOP Renewal Team and Communications have been filling this gap to the best of our abilities. Filling this gap puts a strain on the SOP Renewal Team resources.

External

- The Supreme Court of Canada Judgment *Carter v. Canada (Attorney General)*. Physician Assisted Death (PAD) continues to require CPSA vigilance.

- The Health Quality Council of Alberta *Continuity of Patient Care Study* recommends amending the standards of practice related to coordination and provision of services. The *Referral Consultation Process* standard is prioritized for review.

- The CPSA Competence Committee highlights the importance of ensuring our members are knowledgeable about, understand and follow *CPSA Standards of Practice*.

- Through discussion papers, CPSA has identified a vision for eHealth, parts of which are addressed through proposed amendments to the *Patient Records* standard which is currently out for consultation and will be brought back to Council in December 2015.

- The management of abandoned records is addressed through proposed amendments to the *Patient Records* standard.

- The pending regulation of physician assistants (PA) requires standards of practice to align with PA scope of practice; particularly relevant is the *Supervision of Restricted Activities* standard.

- Ongoing environmental scanning will identify opportunities to refine and enhance the *CPSA Standards of Practice*.

Figures 1 & 2: Council Evaluation of SOP Renewal Process
Triplicate Prescription Program

The Triplicate Prescription Program (TPP) was established in 1986 through a partnership of physicians, pharmacists and dentists to monitor the use of certain drugs prone to misuse and abuse for non-medical purposes. CPSA administers the Triplicate Prescription Program on behalf of its partners and funders.

Highlights:

- PIN Transition projects were completed, which allowed TPP to utilize PIN data effective January 1st, 2013.
- PIN does not include prescriptions for veterinarians, out-of-province patients or out-of-province physicians, so this data entry will continue to be manually entered.
- Methadone and all other TPP medications that are compounded will continue to be manually entered until the quality of the PIN compound data is of a satisfactory quality, ideally by the end of 2015.
- Benzodiazepine daily dispense data is now being received by the program and monitoring will begin July 1st, 2015.
- Preparatory work is underway to allow for the incorporation and monitoring of Codeine in 2016.
- Marihuana for Medical Purposes (MMP) is now included as a product on the Triplicate List. This allows the College to track patients who are receiving MMP, and notes can be included on a patient’s TPP profile as information to physicians.
- Alberta Health agreed to a three-year grant model that will ensure stable funding for TPP until April 2017:
  - 2014-15: $515,000
  - 2015-16: $655,800
  - 2016-17: $659,600

Challenges & Issues:

- Alberta Health continues to challenge the value of the program, but does not provide clear expectations of what the program could do differently to demonstrate value.
- Significant funding increases are required in order to build a true pharmacovigilance system.
- Data quality issues still plague the Pharmaceutical Information Network that require significant time to report and resolve.
### TPP Prescriptions Entered 2008-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profiles Request</td>
<td>463,014</td>
<td>474,340</td>
<td>70,145</td>
<td>107,029</td>
<td>40,801</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>% change over previous year</td>
<td>-18.5%</td>
<td>-29.5%</td>
<td>-33.7%</td>
<td>+16.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Double Doctoring Letters</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta Physicians</td>
<td>5,801</td>
<td>2922</td>
<td>2084</td>
<td>1222</td>
</tr>
<tr>
<td>Yukon Physicians</td>
<td>113</td>
<td>11</td>
<td>24</td>
<td>4</td>
</tr>
</tbody>
</table>
The Finance and Audit Committee (FAC) met on June 23 and August 5, 2015 and dealt with the following issues:

1. **Pension Fund Audited Financial Statements for 2014**

   The pension fund financial statements were prepared as a requirement of the Alberta Employment Pension Plans Act and reflect the assets of the College’s registered pension plan. Pricewaterhouse Coopers’ (PwC) Final Report for the year ended December 31, 2014 was presented to and considered by FAC.

   The total net assets in the pension fund at the end of December are $22.7 million, up from $19.5 million at the end of 2013.

   FAC approved the pension fund audited financial statements. The financial statements have been filed with Alberta Finance.

2. **2016 Business Plan and Budget**

   The FAC reviewed in detail the draft 2016 Business Plan and Operating Budget for the College. Refer to separate memos and recommendations.

3. **Building Fund**

   Council approved a plan for a regular contribution to a Building Reserve Fund at its September 2011 meeting for five years. The last contribution to this fund will be in the 2016 year. The intention of accumulating these monies was with a view to put the College in a position to consider buying or building office space at the conclusion of our present lease.

   The College’s current office lease expires in February 2019. In February 2015, FAC agreed to hire an external consultant to provide a cost/benefit analysis of various potential real estate occupancy scenarios in Edmonton.
In May, the FAC heard a presentation from Altus Group on scenarios to buy, build or lease space in suburban and downtown Edmonton. The analysis included an overview of real estate availability and estimated office space vacancies in 2019. Detailed financial scenarios, including analysis of costs, mortgages and the net present value, were reviewed, including comparison of economic conditions in 2011 when the building fund contributions started to the forecasted economic conditions for 2019.

The committee also discussed and considered other non-financial factors to be considered for the College office space.

In March 2010, the FAC’s analysis of the market at that time showed a favourable position for the College to own its office space. Based on the 2015 market research, the market conditions in Edmonton have changed significantly. The commercial vacancy rate in downtown Edmonton is forecast to be high in 2019 when our current lease expires. In addition, other factors, such as the not-yet completed LRT lines which may open up opportunity in the future, led the committee to recommend that now is not the time to build. The committee did recognize there may be opportunities to buy that become available during the projected economic uncertainty in 2019, necessitating diligence in being available should such opportunities present themselves.

The Building Fund levy for 2012 - 2016 was set at $150 per physician. The following amounts have been or are expected to be collected, inclusive of the accumulated interest.

<table>
<thead>
<tr>
<th>Year</th>
<th>Building Fund Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$1,309,000</td>
</tr>
<tr>
<td>2013</td>
<td>$1,449,000</td>
</tr>
<tr>
<td>2014</td>
<td>$1,542,000</td>
</tr>
<tr>
<td>2015</td>
<td>$1,535,000 estimated</td>
</tr>
<tr>
<td>2016</td>
<td>$1,677,000 estimated</td>
</tr>
<tr>
<td>Total</td>
<td>$7,512,000</td>
</tr>
</tbody>
</table>

In light of the lack of suitable buildings to buy at this time, the committee recommends Council:

a. Plan to lease in downtown Edmonton at the expiry of the current lease in February 2019.
b. Retain the building fund monies for the future when the decision to own a building will be more favourable. Be available and strategic to purchase on a go-forward basis.
c. Retain the accumulated interest on the Building Fund monies with the Building Fund monies collected.

4. Funding Proposals from University of Calgary and University of Alberta

In follow-up to the May Council meeting, the Office of Continuing Medical Education and Professional Development from the University of Calgary and the Faculty of Medicine and Dentistry from the University of Alberta each submitted a proposal seeking financial support for their programs. The FAC reviewed each proposal in detail.
FAC is seeking further details from the University of Calgary to be more explicit as to what value is being added to the College as a result of any funding that may be provided. The further details are requested for FAC’s November 2015 meeting. At this point, a contingency was placed in the budget pending this further information.

After reviewing the University of Alberta proposal, the FAC is recommending declining the request to fund the program for 2016.

5. **Pension Governance & Funding Policies**

Alberta Finance updated pension regulations effective September 1, 2014. As part of these new regulations for defined benefit pension plans, the College is required to develop a pension governance policy and a funding policy to be in place by December 31, 2015.

Draft policies were created with the assistance of Mercer and presented to FAC. The new policies capture in writing the practices that have been in place at the College.

The Governance Policy contains prescribed content, including setting out governance structures, processes and participants; establishing performance measures; establishing a code of conduct and conflict of interest procedures; establishing education and skill requirements; identifying material risks; and dispute resolution.

The Funding policy similarly contains prescribed content, including setting funding objectives; identifying material risks; setting expectations for funded ratio, solvency ratio and amortization of deficiencies; and establishing actuarial valuation frequency.

The Governance and Funding policies were reviewed and approved.

6. **Q2 2015 Variance Report and Forecast**

The FAC discussed a report from management regarding budget variances in the first half of 2015. In the first six months, the College showed actual income from operations of $1,223,000 compared to a budgeted income of $435,000, a positive variance of $788,000.

The additional net income is comprised of a 4% positive variance for revenues of $430,000 and a 3.5% positive variance of net expenses of $358,000.

The current forecast for the year ended December 31, 2015 projects an income from operations of $1,653,000 compared to a budgeted income from operations of $800,000, a positive variance of $853,000.

FAC reviewed the management analysis of the major variances for the first quarter, including the past and ongoing assumptions behind the budgeted numbers. Timing and reduced spending compared to projected amounts were significant factors behind many of the operating variances. As it relates to revenues, significant fines were recognized in this period. Governance and accreditation reflected positive variations projected to timing. As it relates to expenses, while there were some
departments that spent above projected, overall there was reduced spending; filling staffing needs was a factor for several programs.

The FAC approved a request from management to spend $125,000 for the Physician Prescribing Practices Department to move forward with already approved enhancement of the PERFORxM application that will allow the College staff to generate batch form letters for groups of Alberta physicians. This work, originally scheduled for 2016, will be carried out in the fall of 2015 and completed by the end of the year; the opportunity to complete the work now will assist in coordination of efforts to advance the program.
MEMORANDUM

To: Council
From: Finance and Audit Committee
Date: August 17, 2015
Subject: Business Plan

Issue:
Council must approve a 2016 Business Plan.

Background:
Council reaffirmed its Strategic Plan at its September 2014 meeting. In March 2015, Council identified a number of three-year objectives for 2016 to 2018. These objectives, along with the annual strategies that support them, are included in the 2016 to 2018 business plan. The costs associated with the annual strategies to support the planned activities arising from the business plan for 2016 have been included in the 2016 budget. The 2016 budget also reflects funding required for continuation of existing College programs, which support core work and/or are required by legislation.

Developing a business plan and budget is a significant and vital project for any organization. The process that has been followed to develop the business plan for 2016 to 2018 and the budget proposed for 2016 is outlined in Appendix A. Beginning with Council reaffirming the Strategic Plan in Sept 2014, then providing input and feedback into the 2016 to 2018 objectives in March 2015, an iterative process sought to balance between:

a) ongoing business needs and new priorities;
b) competing priorities;
c) the desire to keep fees low with the desire to maximize quality outputs; and
d) activities for the present and security for the future.
In any healthy organization, a positive dynamic tension will always exist between these (and other) factors, as all individuals involved in the oversight, planning and delivery aspects of the organization bring unique and valuable perspectives and criteria on how best to define and achieve overall success.

Two appendices complement this document:

1) **Appendix A: Business Planning Process** – a summary of the business planning and budget preparation process.

2) **Appendix B: Draft 2016 to 2018 Business Plan** - a summary of Council’s goals, strategic direction, desired outcomes and three-year objectives, and the operational strategies proposed by staff to meet Council’s objectives

**Recommendation:**

**Business Plan**

*Recommendation: That the activity listed in Appendix B, CPSA – 2016 to 2018 Business Plan, be approved.*
# Planning and Budget Process

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council reaffirms the Strategic Plan</td>
<td>September 2014</td>
</tr>
<tr>
<td>Council approves 3-year objectives</td>
<td>March 2015</td>
</tr>
<tr>
<td>Input from Finance and Audit Committee</td>
<td>April 2015</td>
</tr>
<tr>
<td>CPSA senior staff develop draft plan &amp; budget</td>
<td>March - May 2015</td>
</tr>
<tr>
<td>Finance and Audit Committee provides feedback on draft</td>
<td>June 2015</td>
</tr>
<tr>
<td>CPSA senior staff reviews feedback and creates final draft</td>
<td>June - July 2015</td>
</tr>
<tr>
<td>Draft 2016 Business Plan and Budget presented to Council</td>
<td>September 2015</td>
</tr>
</tbody>
</table>
Core work continues

CPSA core business remains a priority. Core business includes the legislated regulatory and support functions including: Licensing and Registration; Complaint Resolution; Accreditation; Standards of Practice; Continuing Competence; Physician Health Monitoring Program; Methadone Program; and departments that support this work (Communications, Operations and IT). Core business is reported to Council semi-annually through activity reports and key performance indicators (KPI).

Goal #1: The public receives safe and effective medical care from competent physicians

**Strategic Direction:** Ensure that physicians are competent throughout their careers

### Outcomes

- Member driven demand for competence
- Physician practices are reliably assessed and at-risk practices are readily identified and remediated
- Outcome data available for all members compared to norm
- All physicians receive meaningful feedback on their practices
- CPSA, Faculties of Medicine, Alberta Health Services (AHS) and others collaborate in Physician Practice Improvement as per Federation of Medial Regulatory Authority of Canada (FMRAC) model

### Core work continues

<table>
<thead>
<tr>
<th>Goal #1</th>
<th>3- Year Objectives</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Year 2016</td>
</tr>
<tr>
<td>Adopt CPSA definition of physician competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-informed tools, processes, and assessors utilized. Stratification Tool is identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competence processes are evaluated to ensure effectiveness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopt CPSA definition of physician competence</td>
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</tr>
<tr>
<td>Evidence-informed tools, processes, and assessors utilized. Stratification Tool is identified</td>
<td></td>
</tr>
<tr>
<td>Competence processes are evaluated to ensure effectiveness</td>
<td></td>
</tr>
</tbody>
</table>

- Integrate physician factors into risk stratification tool.
- Refine and expand stakeholder communications and engagement as required.
- Pilot physician factor stratification process.
- Build and test stratification tool.
- Implement risk stratification process.
- Incorporate ongoing evaluation into risk stratification process.
- Refine and expand stakeholder communications and engagement as required.
- Build evaluation for existing competence programs.
- Examine findings of evaluation results and incorporate into.
- Continue to integrate evaluation into operations.
## Goal #1

### 3-Year Objectives

<table>
<thead>
<tr>
<th>Physicians engage in regular structured performance assessment/review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete pilot project, and if needed, revise the model for adoption into a new competence program</td>
</tr>
<tr>
<td>Roll out new office based competence program based on pilot results</td>
</tr>
<tr>
<td>Transition PAR instrument and report ownership, R&amp;D and ongoing maintenance to Medical Council of Canada (MCC)</td>
</tr>
<tr>
<td>Provide feedback to physicians on their prescribing practice using a standardized template</td>
</tr>
<tr>
<td>Portal analysis and design.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2016</strong></td>
</tr>
<tr>
<td><strong>Year 2017</strong></td>
</tr>
<tr>
<td><strong>Year 2018</strong></td>
</tr>
<tr>
<td><strong>Design of competence programs.</strong></td>
</tr>
<tr>
<td><strong>Adopt and promote a risk assessment tool for community offices to use for self-assessment purposes</strong></td>
</tr>
<tr>
<td><strong>Roll out complete and new process operating</strong></td>
</tr>
<tr>
<td><strong>Develop an educational strategy and reference material for distribution during office visits</strong></td>
</tr>
<tr>
<td><strong>Continue roll out and refine office based competence program</strong></td>
</tr>
<tr>
<td><strong>Provide feedback to physicians on their prescribing practice through remote personal access to their own comparative data</strong></td>
</tr>
</tbody>
</table>

| Ongoing communications plan to support new competence program |

<table>
<thead>
<tr>
<th>Standards of Practice (SOP):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify gaps in SOP renewal process</td>
</tr>
<tr>
<td>Develop formal linkages between</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorporate feedback from competence program into SOP renewal process</td>
</tr>
<tr>
<td>Goal #1</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>3- Year Objectives</td>
</tr>
<tr>
<td>In depth assessment occurs when necessary</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Goal #1</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Specific enhancement activities including remediation are available for physicians with identified learning needs</td>
</tr>
<tr>
<td>Registration Information Form is revised to reflect information needs and is user friendly.</td>
</tr>
</tbody>
</table>

**Goal #2:** CPSA is a trusted contributor to public policy affecting health care.

**Goal #3:** CPSA is an essential partner in a patient-centered health care system.

**Strategic Direction:** Contribute to a high-level health system view and to leadership in designing and implementing new models of care. Ensure there is a deep and mutual understanding among all the players in health care of the CPSA’s role and capacity. Participate with partner organizations in using evidence to bring about a culture change.

**Outcomes**
- CPSA perspectives and positions are reflected in government and health system policy
- CPSA is systematically engaged by government and health system partners in the development of health policy and discussion of relevant issues, challenges and opportunities
- Effective governance structure in place for community based care
- Alberta has a commonly understood “preferred future” for health care supported by a plan of action
- Physicians’ practices are aligned with the needs of the health care system

**Core work continues**

CPSA core business remains a priority. Core business includes the legislated regulatory and support functions including: Licensing and Registration; Complaint Resolution; Accreditation; Standards of Practice; Continuing Competence; Physician Health Monitoring Program; Methadone Program; and departments that support this work (Communications, Operations and IT). Core business is reported to Council semi-annually through activity reports and key performance indicators (KPI).
<table>
<thead>
<tr>
<th>Goals #2 &amp; #3 3- Year Objectives</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| CPSA is purposefully and proactively articulating its positions on priority health care/system issues and needs | **Year 2016**  
- Review identified issues, add new ones, and reprioritize.  
- Advance priority issues – identify research requirements, develop appropriate position papers, GR and communications plans  
- By September 2016, build formal processes and capacity to support issues management and research. Strategic planning review (scheduled for 2016) will inform work in this area. Continue to actively seek support of public policy issue with key influencers (GR/Registrar’s office)  
- Measure effectiveness of processes introduced in 2015/16.  
- Review identified issues, add new ones, and reprioritize.  
- Advance priority issues – identify research requirements, develop appropriate position papers, GR and communications plans  
- Ongoing environmental scanning and validation of positions and priorities  
- Build processes and capacity to support issues management and research  
- Roll out new strategic plan  
- Measure whether our policy issue is gaining traction with key influencers  
- Review our existing processes  
- Implement changes identified through measurement.  
| **Year 2017**  
- Implement strategic plan supported by comprehensive communications plan  
- Council evaluation Continue regular Council education, engagement and communication in support of their roles as ambassadors  
| **Year 2018**  
- Ongoing education/awareness for Council members is in place.  
| CPSA governance is high functioning and shaped and structured to achieve its goals and strategic directions | **Year 2016**  
- Enhance and expand Councilors’ roles as ambassadors, i.e., better orientation and timely briefings (Registrar’s office and Council President)  
- Institute ongoing Council education on issues, skills  
- Review our existing processes  
- Implement changes identified through measurement.  
| **Year 2017**  
- Ongoing education/awareness for Council members is in place.  
| **Year 2018**  
- Ongoing education/awareness for Council members is in place.  

<table>
<thead>
<tr>
<th>Goals #2 &amp; #3 3- Year Objectives</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2016</strong></td>
<td><strong>Year 2017</strong></td>
</tr>
</tbody>
</table>
| and matters important to the effective governance of CPSA (Council executive)  
▪ Continue implementation of governance review recommendations  
▪ Review Strategic Plan (Council/Executive) | ▪ Host stakeholder discussions to communicate the importance of and support for sound primary care oversight.  
▪ Continue to highlight need and advance solutions | |
| Sound oversight of all physicians is in place to ensure quality care and patient safety  
All physicians contribute to overall system goals  
CPSA will focus on aspects of practice that lack AHS oversight (i.e. primary care). | ▪ Host stakeholder discussions to communicate the importance of and support for sound primary care oversight.  
▪ Continue to highlight need and advance solutions | |
| There is an agreed-on data set to measure our member’s contributions to health system effectiveness | ▪ Build the measurement tools.  
▪ Start measuring  
▪ Review results and identify CPSA-specific measures. | ▪ Reconvne with AMA, AHS, AH and HQCA to evaluate process and plan future strategies. |
| Collaborative regulatory processes and tools are in place & operating | ▪ Continue rollout of programs developed in 2015.  
▪ Assuming grant funding, | ▪ Measure change in behavior  
▪ Assuming grant funding complete work on an educational program for health care providers re: blood and |
<table>
<thead>
<tr>
<th>Goals #2 &amp; #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3- Year Objectives</td>
</tr>
<tr>
<td>Strategies</td>
</tr>
<tr>
<td>Year 2016</td>
</tr>
<tr>
<td>continue work on an educational program for health care providers re: blood and body fluid exposure (BBFE).</td>
</tr>
<tr>
<td>Collaborate with ACP on intervention strategies for prescribers and dispensers of triplicate medications</td>
</tr>
<tr>
<td>By end of 2016, look at intervention strategies for other identified high-risk populations.</td>
</tr>
<tr>
<td>By fall 2016, generate a report on codeine-containing medication use and develop an intervention strategy.</td>
</tr>
<tr>
<td>▪ WCDAA further development/review/revision of diagnostic imaging (DI) standards for common use across jurisdictions</td>
</tr>
<tr>
<td>▪ Adoption of DI standards across Western Canada</td>
</tr>
<tr>
<td>Physician Wellness</td>
</tr>
<tr>
<td>▪ Evaluation of Physician health Program is complete.</td>
</tr>
<tr>
<td>▪ Measure effectiveness of action plan.</td>
</tr>
<tr>
<td>Goals #2 &amp; #3 3- Year Objectives</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>▪ Develop action plan to address results. Begin implementation by end of 2016. ▪ Implement anesthesia strategy. ▪ Adopt fatigue management toolkit for physicians developed by CMA and roll out in collaboration with AMA/PFSP/Universities.</td>
</tr>
<tr>
<td>▪ Hosting the FMRAC AGM in 2016.</td>
</tr>
<tr>
<td>CPSA stakeholders and partners support the work of CPSA and its role in the health care system</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>CPSA programs contribute to quality and safety of Alberta’s healthcare system</td>
</tr>
</tbody>
</table>
Goal #4: The College is a trusted resource to Albertans (public and others) when they have questions or concerns about medical practice

Strategic Direction: Maintain a healthy organization and effective processes to support our legislated mandate and the other strategies identified

Outcomes

- Open and transparent relationships with employees, stakeholders and the public
- CPSA Council and employees are confident in the processes and supports in place to serve physicians, stakeholders and Albertans

Core work continues

CPSA core business remains a priority. Core business includes the legislated regulatory and support functions including: Licensing and Registration; Complaint Resolution; Accreditation; Standards of Practice; Continuing Competence; Physician Health Monitoring Program; Methadone Program; and departments that support this work (Communications, Operations and IT). Core business is reported to Council semi-annually through activity reports and key performance indicators (KPI).

<table>
<thead>
<tr>
<th>Goal #4 3-Year Objectives</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 2016</td>
</tr>
<tr>
<td>Physicians, Albertans and stakeholders who interact with CPSA are highly satisfied with how they are served and treated</td>
<td>Communicate plan for service excellence</td>
</tr>
<tr>
<td></td>
<td>Continue rollout of service excellence plan:</td>
</tr>
<tr>
<td></td>
<td>- Based on physician feedback, add two additional business functions to the physician portal.</td>
</tr>
<tr>
<td></td>
<td>- Develop on-line service excellence training modules (new staff and refresher training for staff)</td>
</tr>
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<td>- Develop and document consistent policies and</td>
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<tr>
<td>Goal #4 3-Year Objectives</td>
<td>Strategies</td>
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<tr>
<td></td>
<td>procedures</td>
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<tr>
<td></td>
<td>- Establish baseline and</td>
</tr>
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<td></td>
<td>targets for measuring</td>
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<tr>
<td></td>
<td>customer satisfaction.</td>
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<td></td>
<td>- Continue revising CPSA</td>
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<td></td>
<td>website as per</td>
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<td></td>
<td>stakeholder feedback</td>
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<tr>
<td>Registration</td>
<td>Implement tools and</td>
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<td></td>
<td>processes for better</td>
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<td></td>
<td>information flow to new</td>
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<tr>
<td></td>
<td>candidates/registrants.</td>
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<tr>
<td>Communication</td>
<td>Conduct physician survey</td>
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<tr>
<td></td>
<td>Develop and begin</td>
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<tr>
<td></td>
<td>implementation of action</td>
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<tr>
<td></td>
<td>plans to address</td>
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<td></td>
<td>deficiencies raised in</td>
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<td>the survey.</td>
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<tr>
<td>Highly engaged staff who</td>
<td>Implement rewards and</td>
</tr>
<tr>
<td>understand how they</td>
<td>recognition program.</td>
</tr>
<tr>
<td>contribute to work of</td>
<td>Survey employees on line-of-</td>
</tr>
<tr>
<td>the CPSA</td>
<td>sight between what each</td>
</tr>
<tr>
<td></td>
<td>person does and the vision,</td>
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<td></td>
<td>goals and directions of</td>
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<tr>
<td></td>
<td>CPSA</td>
</tr>
<tr>
<td></td>
<td>Formal review of corporate</td>
</tr>
<tr>
<td></td>
<td>Prepare analysis on employee</td>
</tr>
<tr>
<td></td>
<td>SharePoint site</td>
</tr>
<tr>
<td></td>
<td>Implement rewards and</td>
</tr>
<tr>
<td></td>
<td>recognition program.</td>
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<tr>
<td></td>
<td>Evaluate and make any</td>
</tr>
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<td>necessary changes to the</td>
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<td>method(s) used for</td>
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<td>clarifying lines of sight</td>
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<tr>
<td></td>
<td>for staff and</td>
</tr>
<tr>
<td></td>
<td>Formal review of corporate</td>
</tr>
<tr>
<td></td>
<td>Evaluate rewards and</td>
</tr>
<tr>
<td></td>
<td>recognition program.</td>
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</tbody>
</table>

Registration
- Implement tools and processes for better information flow to new candidates/registrants.
- Continue action plans resulting from physician survey
- Conduct physician survey
- Develop and begin implementation of action plans to address deficiencies raised in the survey.
- Prepare analysis on employee SharePoint site
- Implement rewards and recognition program.
- Evaluate and make any necessary changes to the method(s) used for clarifying lines of sight for staff and
- Evaluate rewards and recognition program.
<table>
<thead>
<tr>
<th>Goal #4 3-Year Objectives</th>
<th>Strategies</th>
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<tbody>
<tr>
<td></td>
<td>Year 2016</td>
</tr>
<tr>
<td></td>
<td>values</td>
</tr>
<tr>
<td>▪ Conduct Search and Select Process for new Registrar</td>
<td>▪ Negotiate contract for new Registrar.</td>
</tr>
<tr>
<td>CPSA risk management processes are developed and compliant with FMRAC Integrated Risk Management System (FIRMS)</td>
<td>▪ Develop CPSA Risk management plans developed in other program areas (see below)</td>
</tr>
<tr>
<td>■ Continue development of Business Continuity Plan</td>
<td></td>
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<tr>
<td>■ Implement records management policies and procedures.</td>
<td>▪ Implement records management</td>
</tr>
<tr>
<td>■ Communicate plan to staff.</td>
<td>▪ Develop an audit schedule.</td>
</tr>
<tr>
<td>■ Train staff.</td>
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<tr>
<td>■ Identify records to be disposed to be in compliance with policy.</td>
<td></td>
</tr>
<tr>
<td>▪ Implement privacy policies and procedures.</td>
<td>▪ Implement training program</td>
</tr>
<tr>
<td>▪ Communicate to staff</td>
<td>▪ Implement audit schedule</td>
</tr>
<tr>
<td>▪ Develop training program for staff, include arrival/departure</td>
<td></td>
</tr>
<tr>
<td>▪ Develop audit schedule</td>
<td></td>
</tr>
<tr>
<td>▪ Implement IT security policies</td>
<td></td>
</tr>
<tr>
<td>Goal #4 3-Year Objectives</td>
<td>Strategies</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------</td>
</tr>
<tr>
<td></td>
<td>Year 2016</td>
</tr>
</tbody>
</table>
|                           | **and procedures.**  
|                           | • Conduct external security audit (last done December 2014) |  | (every 2 years) |
| Registration              |  |  |  |
|                           | • Start to implement strategies surrounding candidates/sponsors for whom we are unable to verify documents |  |  |
| Accounting                |  |  |  |
|                           | • Review Council direction for publishing expense reports on the CPSA web site. Implement as applicable. |  |  |
|                           | • Evaluate and implement decision regarding building/relocation. |  |  |
| Fiscal responsibility is maintained | • Continue roll out of three year planning.  
|                           | • Evaluate options for employee pension plan in light of HR people strategy and fiscal responsibility. |  |  |
|                           | • Decide on pension plan option and begin implementation. |  |  |
|                           | • Continue implementation of pension plan option. |  |  |
MEMORANDUM

To: Council

From: Finance and Audit Committee

Date: August 17, 2015

Subject: Budget 2016

Issue:
Council must approve a 2016 Budget.

Background:
The 2016 Budget reflects a continuation of existing College programs which support the College’s Strategic Plan and/or required by legislation plus implementation of the three-year objectives outlined in the 2016 – 2018 Business Plan.

Three appendices complement this document:

1. Appendix A: 2016 Budget Discussion and Analysis – a summary document outlining the assumptions behind the budget, potential uncertainties that could affect our financial results and 2016 budget highlights.

2. Appendix B: Budget spreadsheet – itemizes revenues and expenses by program areas, including the upcoming year, actuals for recent past and projections for the next two years.

3. Appendix C: FMRAC College Facts 2015 – a summary of comparative College statistics prepared by each of the medical regulatory authorities.
Recommendations:

Activities and Expenditures

Recommendation 1: That the honorarium rates for 2016 be approved as follows:

There is no change in the honorariums from 2015.

   The per diem rates are:
   Councilors                      $950/ day
   Committee Chairs                $950/ day
   Committee Members               $850/ day

   The annual honorarium:
   President of Council            $17,100
   Director – ALQEP \(^1\)          $14,600
   Consultant – ALQEP category I   $6,500
   Consultant – ALQEP category II  $11,650

\(^1\): ALQEP = Alberta Laboratory Quality Enhancement Program

Recommendation 2: That the mileage rate be reimbursed at $.54/km and the overnight expenses maximum be $260 for 2016.

There is no change in the mileage or overnight expenses from 2015.

Recommendation 3: That all activities listed in Appendix B in the “2016 Budget Full” column be approved for 2016.

This would bring the total planned expenditure for 2016 to:

<table>
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<tr>
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<tbody>
<tr>
<td>Ongoing Business (no new initiatives)</td>
<td>20,294,000</td>
</tr>
<tr>
<td>Priority A activities</td>
<td>1,698,000</td>
</tr>
<tr>
<td>Priority B activities</td>
<td>150,000</td>
</tr>
<tr>
<td>Priority B activities - allocation to be determined *</td>
<td>100,000</td>
</tr>
<tr>
<td>Total Expenditures Proposed</td>
<td>22,242,000</td>
</tr>
</tbody>
</table>

*FAC is requesting funding of $100,000 be included in the 2016 budget. The recommended allocation of this funding will be brought back to Council at the December 2015 meeting.
The changes in the budget will see an increase in the FTE from the 109.63 budgeted in 2015 (actual 107.38 at the end of quarter 2) to a forecast of 118.25 FTE at the end of 2016. The increased FTE are:

- Continuing Competence – 3
- Professional Conduct – 1
- Government Relations – 1
- Physician Wellness – 1
- Registration - 1

**Physician Annual Fee**

**Recommendation 4:**

- *That there is no change to the physician annual fee for 2016. The annual fee will remain at $1,960.*
- *That the Building Fund contribution remains at $150 for 2016.*

<table>
<thead>
<tr>
<th>2016 Operating Budget:</th>
<th></th>
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<tbody>
<tr>
<td>Revenue</td>
<td>$22,325,000</td>
</tr>
<tr>
<td>Expenses (net of program activity revenues)</td>
<td>$22,242,000</td>
</tr>
<tr>
<td>Net Income</td>
<td>$83,000</td>
</tr>
<tr>
<td>Resulting Unrestricted Surplus as % of Gross Expenses</td>
<td>57%</td>
</tr>
</tbody>
</table>

**Physician Assistants Fees**

It is anticipated that necessary changes in the *Health Professions Act* and the *Physician, Surgeons, and Osteopaths Profession Regulation* will be in place such that CPSA will start regulating Physician Assistants as early as July 1, 2016. In preparation, fees need to be determined for regulated Physician Assistants.

**Recommendation 5:**

1. That the initial registration fees for regulated Physician Assistants to be the following:
   a. Physician Assistant General Register: same as Physician General Register registration fee.
   b. Physician Assistant Provisional Register: same as Physician Provisional Register Conditional Practice registration fee.
   c. Physician Assistant Courtesy Register: same as Physician Courtesy Register registration fee.
d. Student Physician Assistant Register: same as the Physician Student Register registration fee.

2. That the **annual fee** for Physician Assistants to be the following:
   a. Physician Assistant General Register: 80% of Physician General Register annual fee
   b. Physician Assistant Provisional Register: 80% of Physician Provisional Register Conditional Practice annual fee
   c. Physician Assistant Courtesy Register: same as for Physician Courtesy Register annual fee
   d. Student Physician Assistant Register: same as the Student Register for Physicians.
Assumptions and Risks that Impact the CPSA’s Business and Financial Performance

Major Assumptions Made in Business Planning

Every business operates in environments of low, moderate and high certainty. Assumptions help us successfully manage uncertainty. This section outlines the informed assumptions made by Management in the preparation of the 2016 Business Plan.

One area of low certainty for the CPSA is the political climate. Government positions and policies can affect:

- the number of physicians entering and leaving the province, which has a direct impact on our member revenue and PPAP program;
- funding for our TPP program; and
- our PPP program, as we not only rely on TPP revenue, but also rely heavily on the data from TPP to run our PPP program. If we were to lose access to the data, we would be unable to run that program as well.

An area of moderate certainty is AHS. Our accreditation programs rely on AHS funding. AHS’s decisions about accreditation of public facilities will impact our accreditation program.

While we make these assumptions using all available information, it is important to recognize the uncertainty associated with the assumptions when preparing the annual budget. The following assumptions are integral to this budget:

1. **Annual fees** – The number of physicians registered at the College and paying annual registration fees will increase by 3.5% in 2016.

   Using trends over the past several years, we project growth of 3.5%. Over several years, the annual growth of physicians has been approximately 3.5% per year. The last few years have been unusual with higher physician growth than projected; however, this past year we are seeing slower growth and anticipate that growth will continue closer to historical levels. The PPAP assumption also influences this assumption, as variance in the number being assessed can impact registrants.

2. **Provincial Physician Assessment Program (PPAP) fees** – The number of physicians requiring a PPAP assessment will be lower in 2016 with approximately 116 physicians requiring an assessment. With the recent decision of Council to limit the practice readiness assessments to AHS sponsors, we are planning for fewer assessments in 2016.
3. **Accreditation funding** – The accreditation contract with AHS was renewed in 2015 for a two-year term with an option to renew for one additional year. With the new provincial government in place in Alberta, we are moderately optimistic this contract will continue for the full term and not be terminated early.

4. **Professional corporations** – Professional corporation fee projections are based on a 5% increase in the number of professional corporations. This estimate is based on historical figures.

5. **Grant funding** – The College will receive TPP grant funding in 2016 in the amount of $633,945, which will result in the TPP program breaking even.

6. **PAR program** – The College will transition the PAR program to the Medical Council of Canada, an external provider. The College will no longer collect license fees from other provinces. Rather we will pay a license fee of $30,000 to participate in the program.

7. **Program areas** – Work in the program areas will proceed as projected, all falling within the three-year objectives and the 2016 strategies outlined in the 2016 Business Plan.

**Uncertainties, Scenario Planning and Risk Mitigation**

Our business is affected by the needs and demands of the public and government. A crisis in health care confidence or a change in how health services are delivered in Alberta can impact the number of physicians who practice in Alberta and the type and volume of services provided. Predicting the future climate of health care delivery in Alberta with certainty will present a challenge. Shifts in care delivery will impact our lines of business and bring with it both challenges and opportunities. The following is a list of potential risks:

1. **Annual fees** - Physician growth is not as expected. If it is lower, we will experience reduced operating income that may result in a deficit. If the actual growth is higher than 3.5%, the additional income generated will continue to build the College’s accumulated surplus or could be used toward other opportunities, such as the Building Fund.

2. **Accreditation contract** – The College’s current contract with AHS for accreditation of lab, DI and clinical services in AHS facilities expires in December 2016. There is an option to extend the contract for one year. There is also an option to terminate the contract with 180 days’ notice. Since a percentage of this revenue supports fixed costs, termination of the contract early would require a re-balancing of the budget to cover fixed costs in the short-term and a review of programming in the long term.

CPSA is working with the other western regulators to continue the Western Canadian Diagnostic Accreditation Alliance (WCDAA), which strengthens our accreditation program by establishing consistent accreditation standards for western Canada by dealing with conflict of interest issues and identifying efficiency issues. Our accreditation program is investing in e-accreditation software which will improve our product for our users. We estimate the likelihood of AHS terminating the contract early is low.
3. **PPAP fees** – The College may be pressured to overturn Council’s decision to only accept AHS sponsored physicians for practice readiness assessments. More IMGs could be recruited to non-AHS practices than predicted, resulting in a greater need for PPAP assessments. The fixed costs in the PPAP program are small; however, an increase in the number of assessments would result in greater admin fee revenue.

With the assumption we proceed with the current policy, if the number of assessments initiated at the request of AHS is more than projected, there would be higher consulting expenses incurred; this should be offset by fees recovered from the sponsors. Alternatively, should AHS sponsor considerably fewer physicians than predicted, this would result in lower admin fee revenue and result in a deficit for the PPAP program.

4. **TPP grant** – TPP grant funding will not be renewed. AH is currently reviewing our grant request for the period April 1, 2015 to March 31, 2016. College staff continues to enhance relationships with AH and promote the benefits of the TPP program.

5. **PAR program** – The Medical Council of Canada may decide not to accept transfer of the program.

6. **External providers terminate their contracts** – The College relies on an external provider for development and support of its TPP, PPP and planned data analytics portal. We have had a good relationship with the vendor for over ten years. Should the vendor decide to terminate the relationship, considerable time would be required for our internal IT department to assume the technical support and programming. The College does not have absolute certainty of access to the source code for the programming should the relationship with the vendor cease.

7. **Physician recruitment for CPSA key staff positions, committees and contracts** – CPSA will not be able to hire/recruit the physician resources needed to carry out our business plan because:
   a. High demand on physician services will continue in 2016;
   b. Our honoraria rates do not provide comprehensive remuneration for their time;
   c. For key staff positions, compensation may not be comparable to compensation in clinical practice; or
   d. Assistant Registrar positions require physicians to commit to full-time, and concurrent clinical practice is not permitted. This may deter some suitable candidates from applying.

We anticipate we will be successful in our recruitments. A longer than expected time frame for recruiting may result in variances from budget.
## College of Physicians & Surgeons of Alberta

### Income Statement

#### Three Year Financial Budget

#### 2016-2018 Budget

<table>
<thead>
<tr>
<th>Period</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Fees</td>
<td>(17,217,151.45)</td>
<td>(18,025,587.74)</td>
<td>(18,462,000.00)</td>
</tr>
<tr>
<td>Levy for TPP</td>
<td>126,795.00</td>
<td>131,985.00</td>
<td>136,600.00</td>
</tr>
<tr>
<td>Registration</td>
<td>(630,149.32)</td>
<td>(920,930.63)</td>
<td>(1,053,640.95)</td>
</tr>
<tr>
<td>Professional Corporation Fees</td>
<td>(1,135,350.00)</td>
<td>(1,173,850.00)</td>
<td>(1,282,523.76)</td>
</tr>
<tr>
<td>Certificates and Data Extracts</td>
<td>(90,874.51)</td>
<td>(90,876.75)</td>
<td>(82,500.00)</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>(171,776.01)</td>
<td>(237,174.93)</td>
<td>(155,800.00)</td>
</tr>
<tr>
<td>Rental Income</td>
<td>(91,282.92)</td>
<td>(96,874.46)</td>
<td>(99,764.00)</td>
</tr>
<tr>
<td>Professional Corporation Fees</td>
<td>(1,135,350.00)</td>
<td>(1,173,850.00)</td>
<td>(1,282,523.76)</td>
</tr>
<tr>
<td>Certification and Data Extracts</td>
<td>(90,874.51)</td>
<td>(90,876.75)</td>
<td>(82,500.00)</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>(171,776.01)</td>
<td>(237,174.93)</td>
<td>(155,800.00)</td>
</tr>
<tr>
<td>Rental Income</td>
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<td>(99,764.00)</td>
</tr>
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<td>Professional Corporation Fees</td>
<td>(1,135,350.00)</td>
<td>(1,173,850.00)</td>
<td>(1,282,523.76)</td>
</tr>
<tr>
<td>Certification and Data Extracts</td>
<td>(90,874.51)</td>
<td>(90,876.75)</td>
<td>(82,500.00)</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>(171,776.01)</td>
<td>(237,174.93)</td>
<td>(155,800.00)</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>(19,859,209.79)</td>
<td>(21,012,334.50)</td>
<td>(21,119,864.00)</td>
</tr>
</tbody>
</table>

| **Expenditures Schedule** |      |      |      |
| Administration | 5,040,397.16 | 3,996,019.14 | 4,746,666.00 |
| Information Technology | 2,265,810.27 | 2,240,559.66 | 2,252,350.00 |
| Governance | 1,011,155.25 | 1,112,853.22 | 1,305,301.00 |
| Office of the Registrar | 1,133,688.51 | 1,241,550.51 | 1,205,612.00 |
| Communications | 1,017,330.56 | 1,038,532.37 | 1,269,450.00 |
| College Activities | 7,203,339.26 | 7,738,037.38 | 9,540,288.00 |
| Total Expenditures | 17,671,701.35 | 17,367,552.28 | 20,319,667.00 |

| **Income From Operations** |      |      |      |
| (2,187,508.44) | (3,644,782.22) | (800,197.00) |
| (3,483,833.25) | (2,242,168.88) | 16,982,226.60 |
| (83,236.14) | 1,698,226.60 | 250,000.00 |
| (83,236.14) | 1,698,226.60 | 250,000.00 |
| (83,236.14) | 1,698,226.60 | 250,000.00 |

| **Annual Fee for Building Fund** | (1,389,862.50) | (1,464,075.00) | 0.00 |
| **Investment Income/Loss from change in market** | (380,109.19) | (362,529.40) | 0.00 |
| **Investment Income Building Fund** | (59,452.97) | (77,634.01) | 0.00 |
| **<NET INCOME> LOSS** | (4,016,933.10) | (5,549,020.63) | (800,197.00) |
| **<NET INCOME> LOSS** | (4,016,933.10) | (5,549,020.63) | (800,197.00) |

<table>
<thead>
<tr>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tbody>
<tr>
<td><strong>Priority A</strong></td>
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<tr>
<td><strong>Priority B</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>No New Initiatives</strong></td>
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<tr>
<td><strong>2017 Budget Full</strong></td>
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<tr>
<td><strong>2018 Budget Full</strong></td>
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<table>
<thead>
<tr>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tbody>
<tr>
<td><strong>Priority A</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Priority B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No New Initiatives</strong></td>
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<td></td>
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<tr>
<td><strong>2017 Budget Full</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2018 Budget Full</strong></td>
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</table>
## College of Physicians & Surgeons of Alberta
### College Activities
#### Three Year Financial Budget
##### 2016-2018 Budget

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<tr>
<td></td>
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<td>Actual</td>
<td>Full</td>
<td>Full</td>
<td></td>
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<td>Priority B</td>
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<td>CPSA Activities</td>
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<td>Register Physicians</td>
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<td>2,045,899.89</td>
<td>2,207,976.72</td>
<td>2,219,016.67</td>
</tr>
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</table>

| Investigate Complaints |
| Professional Conduct | 2,790,420.92 | 2,866,390.25 | 3,378,385.00 | 3,364,782.83 | 3,238,232.30 | 0.00 | 0.00 | 3,238,232.30 | 3,170,811.12 | 3,288,766.43 |

| Provide Clinical Review |
| Continuing Competence |
| Physician Practice | 295,615.94 | 232,018.31 | 761,230.00 | 599,183.57 | 2,042,187.91 | 593,982.09 | 0.00 | 1,448,205.82 | 2,205,217.61 | 2,348,197.43 |
| Physician Achievement Review (PAR) | 858,063.07 | 943,180.36 | 1,022,740.00 | 1,075,160.08 | 533,831.72 | 0.00 | 0.00 | 533,831.72 | 835,660.44 | 863,404.15 |
| Infection Prevention & Control (IPAC) | 202,646.87 | 313,535.75 | 335,793.00 | 348,718.94 | 390,983.16 | 28,875.00 | 0.00 | 362,108.16 | 400,092.51 | 412,427.76 |
| Physician Prescribing Practices | 818,844.96 | 850,663.18 | 1,015,455.00 | 795,281.25 | 1,193,176.46 | 142,176.46 | 0.00 | 801,002.85 | 1,610,443.52 | 1,052,226.73 |
| Sub-total Continuing Competence | 2,175,170.84 | 2,339,397.60 | 3,135,218.00 | 2,818,343.84 | 4,160,179.25 | 765,300.70 | 250,000.00 | 3,145,148.55 | 5,051,414.08 | 4,676,256.07 |
| Triplicate Prescription Program | 60.00 | (0.00) | 107,913.00 | 42,904.03 | (0.00) | 0.00 | 0.00 | (0.00) | (0.00) | 12,235.84 |
| Physician Wellness | 685,085.73 | 824,179.50 | 872,828.00 | 877,822.85 | 1,080,797.40 | 81,796.98 | 0.00 | 999,000.42 | 1,173,742.79 | 1,298,932.11 |
| Practice Conditions Monitoring | 50,716.96 | 51,114.04 | 44,850.00 | 21,675.16 | 83,597.19 | 0.00 | 0.00 | 83,597.19 | 86,717.63 | 89,670.44 |
| Total | 2,911,573.53 | 3,214,691.14 | 4,160,809.00 | 3,760,745.88 | 5,324,573.84 | 846,827.68 | 250,000.00 | 4,227,746.16 | 6,311,874.50 | 6,077,094.46 |

| Accred Health Facilities |
| Accreditation Programs | (596,156.56) | (431,360.60) | (138,262.00) | (367,182.53) | (278,284.14) | 0.00 | 0.00 | (278,284.14) | (350,624.58) | (468,404.98) |
| Radiation Equipment | 0.00 | (0.00) | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | (120.00) | (120.00) |
| E-Accreditation Project | 0.00 | 52,432.45 | 0.00 | 48,389.98 | 48,400.00 | 0.00 | 0.00 | 48,400.00 | 4,400.00 | 4,400.00 |
| Total | (596,156.56) | (378,928.15) | (138,262.00) | (318,792.55) | (229,884.14) | 0.00 | 0.00 | (229,884.14) | (346,344.58) | (464,124.98) |

| College Activities |
| 7,203,339.26 | 7,738,037.38 | 9,540,288.00 | 8,958,395.68 | 10,461,541.31 | 929,547.10 | 250,000.00 | 9,281,994.21 | 11,344,317.76 | 11,120,752.58 |
QUICK COLLEGE FACTS 2015

AT A GLANCE

Licensed Physicians in Canada /
Médecins ayant un permis d’exercice au Canada

<table>
<thead>
<tr>
<th>Prov/Terr</th>
<th>Graduates of Canadian Medical Schools / Diplômés des facultés de médecine canadiennes</th>
<th>International Medical Graduates / Diplômés hors-Canada</th>
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<td>Provisional / Provisoire</td>
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<td>7,934</td>
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<td>356</td>
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<tr>
<td>Total</td>
<td>66,100</td>
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(a) These data combine the graduates of Canadian medical schools and the international medical graduates.

Ces données regroupent les diplômés des facultés de médecine canadiennes et les diplômés hors-Canada.

N.B.: The detailed Quick College Facts reports from each jurisdiction can be found on the FMRAC website and on the flash drive.
# Licensure / Renewal Fees

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<tr>
<td>CPSA</td>
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<td>1,960(^{(a)})</td>
<td>1,960(^{(a)})</td>
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<td>Nunavut</td>
<td>200</td>
<td>200</td>
<td>200</td>
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</table>

\(^{(a)}\) Includes a $150 fee for a building fund  
\(^{(b)}\) Effective 1 September
To: Council
From: Dr. Kate Reed, Assistant Registrar
Date: 03 September 2015
Subject: Amendment of the Criteria for the Provisional Register Conditional Practice

Issue: In follow up to the May 2015 motion of Council that made Alberta Health Services the only acceptable sponsor for applicants to the Provisional Register Conditional Practice, an amendment to the criteria for registration on this register is required.

Background: At the May 2015 meeting of Council, Dr. Gardener provided background on the work he had been doing in conjunction with representatives from Alberta Health Services (AHS) and Alberta Health (AH) over the previous 15 months. This work focussed on making changes to the sponsorship model that would be acceptable to all three parties, be similar to other jurisdictions in Canada, and would be similar to the process that was in place for the Special Register Part 5 under the Medical Professions Act.

The need for this change to the sponsorship model was identified as a means to address the dramatic increase in applicants eligible for the Provisional Register Conditional Practice (PRCP) with the accompanying increased demand to provide the required assessments. Dr. Gardener expressed his growing concern that the quality of such a high volume of assessments could not be assured.

Part of the discussions amongst AHS, AH, and the CPSA included that the CPSA would require AHS sponsorship to be one of the criteria for the PRCP, not simply for the assessment. With this change:

- Registration on the PRCP will be more closely aligned with provincial physician resource needs (through all disciplines of practice and throughout the province),
- AHS will have much better return on the resources spent on recruitment and assessment as the member will be required to remain in an AHS sponsored post until they are transferred to the General Register,
- Practice permit renewal will require that the member continues to occupy a sponsored position and that their performance/practice is satisfactory. This will allow the CPSA to be compliant with the national registration standards that require provisional registrants to be under supervision of the regulator.

There will be no changes to the requirements for members on the PRCP to transfer to the General Register.
**Recommendation:** That Council add, “sponsorship by Alberta Health Services” to the registration criteria for the Provisional Register Conditional General Practice and Provisional Register Conditional Specialty Discipline Practice, as highlighted:

Provisional Register - Conditional General Practice
1. Standard Route
   a. primary medical degree,
   b. English language proficiency, and
   c. one of:
      i. successful completion of a postgraduate program of family medicine training in Canada, one of the LMCC or CCFP, and sponsorship by Alberta Health Services,
      ii. successful completion of a postgraduate program of medical training of at least 24 months duration outside of Canada containing 4 months of community-based primary care; a minimum of eight weeks each of three of the following: Paediatrics, Obstetrics and Gynaecology, Surgery, and Internal Medicine; passed the Medical Council of Canada Evaluating Examination; sponsorship by Alberta Health Services, and a practice-based assessment satisfactory to the Registrar, or
      iii. satisfactory completion of a postgraduate training programme recognized by the College of Family Physicians of Canada, passed the Medical Council of Canada Evaluating Examination, sponsorship by Alberta Health Services, and a practice-based assessment satisfactory to the Registrar.

Provisional Register - Conditional Specialty Discipline Practice
1. Standard route:
   a. primary medical degree,
   b. English language proficiency, and
   c. one of
      i. Successful completion of postgraduate specialty training in Canada, one of LMCC or specialty certification from the Royal College of Physicians and Surgeons of Canada or the College des medecins du Quebec, sponsorship by Alberta Health Services, and a practice-based assessment satisfactory to the Registrar, or
      ii. At least 48 months postgraduate specialty training obtained outside of Canada, specialty certification and recognition in the discipline of training by another medical regulatory authority, passed the Medical Council of Canada Evaluating Examination, sponsorship by Alberta Health Services, and successful completion of a practice-based assessment satisfactory to the Registrar, or
      iii. At least 36 months postgraduate specialty training obtained outside Canada, specialty certification and recognition in the discipline of training by another medical regulatory authority, passed the Medical Council of Canada Evaluating Examination, sponsorship by Alberta Health Services, and successful completion of a practice-based assessment satisfactory to the Registrar (may not be eligible for specialty recognition in Alberta).
For Direction

Assessing Mental Capacity of a Patient

Standards of Practice of the College of Physicians & Surgeons of Alberta (“the College”) are the minimum standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) A physician conducting an assessment of a patient’s mental capacity must:

(a) attempt to obtain the patient’s agreement to participate,

(b) assess the patient’s capacity to understand information relevant to the topic at hand,

(c) assess the patient’s capacity to understand the decisions to be made,

(d) assess the patient’s capacity to understand the risks and benefits of actions that may be undertaken,

(e) assess the patient’s ability to justify his or her choices, and

(f) use accepted clinical means to determine mental capacity.
For Direction

Informed Consent

The Standards of Practice of the College of Physicians & Surgeons of Alberta ("the College") are the minimum standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

1. A physician is responsible for ensuring that consent, which may be implied or may be expressed orally or in writing, is obtained from a patient before performing an examination or treatment or before disclosing the patient’s personal health information, except where permitted by law to act without consent. A physician must:
   
   a. be aware of authoritative advice on informed consent, such as that of the Canadian Medical Protective Association, before establishing a policy on consent procedures in his or her medical practice,
   
   b. consider the risks to the patient, the potential for pain and discomfort, and the invasiveness of the procedure when deciding on the type of consent required,
   
   c. if relying on implied consent, be certain that the actions of the patient would be interpreted by others as having implied permission for the physician’s actions,
   
   d. ensure that written consent is obtained before performing a surgical operation, and
   
   e. consider the knowledge and expertise of trainees and staff if delegating the consent procedure.

2. A physician must determine a patient’s capacity to give consent in accordance with Assessing the Mental Capacity of a Patient, Standard 9.

3. A physician who obtains consent from a substitute decision maker on behalf of a patient must comply with applicable laws.

4. A physician must respect the right of a patient to withdraw consent at any time.

5. In obtaining full and informed consent for disclosure of personal health information or for procedures of higher risk of harm for the patient, a physician must discuss, at a minimum:
(a) the exact nature and the anticipated benefits of the proposed examination, treatment or release of personal health information,

(b) reasonable and accepted alternative examinations or treatments that are generally available

(c) the natural history of the medical condition at issue,

(d) consequences of not undertaking the examination or treatment or disclosing personal health information,

(e) the common and significant risks of the examination or treatment or disclosure and alternatives,

(f) serious risks, even if unlikely,

(g) special risks, that although uncommon, may have particular relevance to the patient, and

(h) any questions the patient may have.

(6) A physician who obtains consent from a patient for participation in research must also comply with direction and advice from an approved research ethics board.
For Direction

Moral or Religious Beliefs Affecting Medical Care

**Standards of Practice** of the College of Physicians & Surgeons of Alberta (“the College”) are the minimum standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the *Health Professions Act* and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

1. A physician must communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs.

2. A physician must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their moral or religious beliefs.

3. A physician must not promote their own moral or religious beliefs when interacting with patients.

4. When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician must ensure that the patient who seeks such advice or medical care is offered timely access to another physician or resource that will provide accurate information about all available medical options.
Legislated Reporting & Release of Medical Information

Related Standards of Practice:  Informed Consent, Assessing the Mental Capacity of a Patient

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the CPSA Standards of Practice. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

Contents

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Discretionary Release of Medical Information ............................................................................................................... 4
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Disclaimer

This document is provided as a convenient summary to guide physicians and should not be taken as an exhaustive compilation of every statutory provision in Alberta. The focus is on the obligations of the individual practitioner; other provisions not listed in this document apply specifically to institutions. Further, a physician acting as an employer has additional obligations outlined in the Alberta Occupational Health and Safety Act, Regulation and Code, for example reporting of occupational blood borne disease, injuries and so forth.
Legislated Reporting Requirements

By law, a physician is required to report:

a) specified communicable diseases (Public Health Act)
b) suspected child abuse (Child, Youth and Family Enhancement Act)
c) suspected abuse of a “person in care” (Protection for Persons in Care Act)
d) animal bites (if rabies is reasonably suspected) (Public Health Act)
e) deaths under certain conditions (Fatality Inquiries Act; Mental Health Act)
f) work-related injuries (Workers’ Compensation Act)
g) results of blood alcohol testing, when blood has been drawn for that purpose at the request of a Peace Officer (Criminal Code)
h) medical conditions of flight crews, air traffic controllers and others, where the physician believes that the medical condition is likely to constitute a hazard to aviation safety (Federal Aeronautics Act)
i) medical conditions that could be a threat to safe railway operations, for railway workers occupying a safety critical position (Railway Safety Act)
j) patients affected with or suffering from a “notifiable disease”, by notifying a Director of Medical Services in writing of the name, address and place of employment of that patient and the specific notifiable disease, within 7 days of making the diagnosis (Occupational Health and Safety Regulation)

See Appendices A and B.

Discretionary Reporting

A physician may choose to report:

a) a patient who is medically unfit to drive (see Reporting Unfit Drivers)
b) a patient who, the physician has reason to believe, presents a clear and present danger to society
c) a patient who has been treated for a mental illness associated with violence, or has threatened or attempted violence against any person

See Appendix A.
Reporting of Suspected Criminal Activity

A physician is **not required** to report:

a) injuries or conditions that may be related to criminal activity, for example:
   - gunshot wound
   - stabbing
   - admitted use of illegal drugs

**Note:** There is a common misconception of the law in this area. Currently such reporting is not required, although legislation is being advocated. A physician **should not** provide **any** information to a police officer, even to confirm the physician has treated a certain named person, except through a judicially authorized search warrant.

See Appendix A.

Mandatory Release of Medical Information

A physician is required to release medical information upon the request of:

a) a patient
b) a Court Order
c) a Medical Officer of Health, under Section 19(1) of the *Public Health Act*
d) a third party (including physicians not involved in the patient’s care), when accompanied by authorization to release
e) a patient’s legal guardian, with documentation
f) a patient’s parent, when the patient is younger than the age of consent
g) a patient’s separated/divorced parent, when the parent has legal custody and the patient is younger than the age of consent
h) the Executor of an estate, when the patient is deceased
i) the College of Physicians & Surgeons of Alberta, pursuant to an investigation under the *Health Professions Act*
j) the Workers’ Compensation Board, pursuant to the *Workers Compensation Act*
k) an Order of a Statutory Board

l) the Therapeutic Products Directorate, Health Canada, relating to narcotic drugs

m) an agent of the federal Minister of Health, pursuant to an investigation under Section 55 of the *Controlled Drugs and Substances Regulations* (information relating to narcotic prescriptions only)

n) a radiation medical officer, relating to the radiation health or safety of workers and the public

o) a Director under the *Child, Youth and Family Enhancement Act* who has exclusive custody of a child, when the guardian of the child is unable or unavailable to consent

(In this situation, the Director may authorize the provision of essential medical, surgical, dental or other remedial treatment for the child that is recommended by a physician or a dentist. This authorization extends to when a child in need of intervention has a guardian refusing consent only when the Director has obtained an Order of the Court to apprehend the child. If a child who is the subject of a temporary Guardianship Order, permanent Guardianship Agreement or permanent Guardianship Order refuses to consent to essential, medical, surgical, dental or other remedial treatment recommended by physician or dentist, the Director must apply to the Court for an Order authorizing the treatment.)

p) other individuals in circumstances defined under Section 17 of the *Mental Health Act* and Section 24 of the *Hospitals Act*

See Appendix A for detailed references and comments.

**Discretionary Release of Medical Information**

A physician may release:

a) individually identifying diagnostic treatment and care information without consent under circumstances outlined in the *Health Information Act* (HIA), as a custodian under that Act (see Appendix C)

b) information relating to a person receiving diagnostic and treatment services in a centre designated in the *Mental Health Act*, under circumstances outlined in that Act (see Appendix D)
Appendix A: Detailed References and Comments

<table>
<thead>
<tr>
<th>Legislated Reporting Requirements</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Specified communicable diseases</td>
<td>Public Health Act; see Appendix B.</td>
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</tbody>
</table>
| b) Suspected child abuse | The Child, Youth and Family Enhancement Act in Section 4(1) reads: “Any person who has reasonable and probable grounds to believe that a child is in need of intervention shall forthwith report the matter to a Director.” ‘Child’ is defined in 1(1)(d) as a person under the age of eighteen years and includes a youth unless specifically stated otherwise. ‘Youth’ is defined in 1(1)(cc) as a child who is sixteen years of age or older. Section 1(2) states: ‘For the purposes of this Act, a child is in need of intervention if there are reasonable and probably grounds to believe that the survival, security or development of the child is endangered because of any of the following:

  a) the child has been abandoned or lost;
  b) the guardian of the child is dead and the child has no other guardian;
  c) the child is neglected by the guardian;
  d) the child has been or there is substantial risk that the child will be physically injured or sexually abused by the guardian of the child;
  e) the guardian of the child is unable or unwilling to protect the child from physical injury or sexual abuse;
  f) the child has been emotionally injured by the guardian of the child;
  g) the guardian of the child is unable or unwilling to protect the child from emotional injury;
  h) the guardian of the child has subjected the child to or is unable or unwilling to protect the child... |
from cruel and unusual treatment or punishment.'

Section 1(2.1) reads: ‘For the purposes of subsection 2(c), a child is neglected if the guardian:

a) is unable or unwilling to provide the child with the necessities of life;

b) is unable or unwilling to obtain for the child, or to permit the child to receive, essential medical, surgical or other remedial treatment that is necessary for the health or well-being of the child, or

c) is unable or unwilling to provide the child with adequate care or supervision.’

Section 1(3) reads: ‘For the purposes of this Act, a child is emotionally injured

a) if there is impairment of the child’s mental or emotional functioning or development, and

   (i) if there are reasonable and probable grounds to believe that the emotional injury is the result of:

      (A) rejection,

      (A.1) emotional, social, cognitive or physiological neglect,

      (B) deprivation of affection or cognitive stimulation,

      (C) exposure to domestic violence or severe domestic disharmony,

      (D) inappropriate criticism, threats, humiliation, accusations or expectations of or toward the child,

      (E) the mental or emotional condition of the guardian of the child or of anyone living in the same residence as the child;
(F) chronic alcohol or drug abuse by the guardian or by anyone living in the same residence as the child,

b) a child is physically injured if there is substantial and observable injury to any part of the child’s body as a result of the non-accidental application of force or an agent to the child’s body that is evidenced by a laceration, a contusion, an abrasion, a scar, a fracture or other bony injury, a dislocation, a sprain, hemorrhaging, the rupture of viscus, a burn, a scald, frostbite, the loss or alteration of consciousness or physiological functioning or the loss of hair or teeth;

c) a child is sexually abused if the child is inappropriately exposed or subjected to sexual contact, activity or behavior including prostitution related activities.’

c) Suspected abuse of a "person in care"

Section 7(1) of the Protection for Persons in Care Act reads:” every individual who has reasonable grounds to believe that there is or has been abuse involving a client shall report that abuse within the time period referred to in section 8(1) (a) to a complaints officer, (b) to a police service, or (c) to a committee, body or person authorized under another enactment to investigate such abuse.” Section 7(2) states this applies “notwithstanding that the information on which the belief is founded is confidential and its disclosure is prohibited under any other Act.”

The definition of abuse is quite broad defining first what is meant and then outlining exceptions. Section 1(2) defines ‘abuse’ as “an act or an omission with respect to a client receiving care or support services from a service provider that (a) causes serious bodily harm, (b) causes serious emotional harm, (c) results in the administration, withholding or prescribing of medication for an inappropriate purpose, resulting in serious bodily harm, (d) subjects an individual to non-
consensual sexual contact, activity or behaviour, (e) involves misappropriating or improperly or illegally converting a significant amount of money or other valuable possessions, or (f) results in failing to provide adequate nutrition, adequate medical attention or another necessity of life without a valid consent, resulting in serious bodily harm.”

Section 1(3) notes however that “Notwithstanding subsection (2), an act or omission does not constitute abuse (a) if a service provider carries out the service provider’s duties in accordance with professional standards or practices or any standards established by or adopted pursuant to another enactment, (b) if the care or support services provided by the service provider are reasonably necessary in the circumstances, (c) where the act or omission is the result of, or is attributable to, a client’s refusing care or support services, (d) when the act or omission is based on a decision made on behalf of a client (i) by a co-decision-maker or a specific decision maker under the Adult Guardianship and Trusteeship Act, (i.1) by an agent under the Personal Directives Act, or (ii) by an attorney under the Powers of Attorney Act, or (e) in the circumstances prescribed in the regulations.”

The Act applies to service providers and via Section 1(1)(m) includes “(i) a lodge accommodation as defined in the Alberta Housing Act, (ii) an approved hospital as defined in the Hospitals Act, (iii) a facility designated under the Mental Health Act, (iv) a nursing home as defined in the Nursing Homes Act, (v) a hostel or other establishment operated to provide accommodation and maintenance for unemployed or indigent persons, (vi) a facility as defined in the Social Care Facilities Review Committee Act, or (vii) any person designated by the regulations as a service provider.” A physician attending upon a patient in one of those setting would be obliged to report suspected abuse. A physician may also be charged with an obligation to report suspected abuse if a patient came to the physician and reported being subjected to “abuse” while a “client” at one of
the designated locations.

d) Animal bites (if rabies is reasonably suspected);

Required under the Public Health Act. See Appendix B.

e) Deaths under certain conditions;

Under the Fatality Inquiries Act, physicians have an obligation to report:

1) unexplained deaths; 2) unexpected deaths when the deceased was in apparent good health; 3) deaths as a result of violence, accident or suicide; 4) maternal deaths during or following pregnancy and that might reasonably be related to pregnancy; 5) deaths that may have occurred as a result of improper or negligent treatment by any person; 6) deaths that occur within 10 days of an operative procedure or while under or during recovery from anesthesia; 7) deaths that result from poisoning; 8) death of a person not under the care of a physician; 9) death of a young person under Child Welfare custody; 10) deaths resulting from any disease, ill health, injury, or toxic substance arising from a person’s employment, or occupation now or in the past; 11) if a person dies in custody, or is a formal patient of any facility under the Mental Health Act, the death must be notified whether or not he or she is on the premises at the time. (Sections 11 and 12 of the Fatality Inquiries Act).

f) Work-related injuries

Workers’ Compensation Act. Section 34(1) says “A physician who attends an injured worker shall (a) forward a report to the Board (i) within 2 days after the date of the physician’s first attendance on the worker if the physician considers that the injury to the worker will or is likely to disable the worker for more than the day of the accident or that it may cause complications that may contribute to disablement in the future, and (ii) at any time when requested by the Board to do so, (b) advise the Board when, in the physician’s opinion, the worker will be or was able to return to work, either in the physician’s report referred to in clause (a)(i) or in

Revised July 2015
Published July 2005
a separate report forwarded to the Board not later than 3 days after the worker was, in the physician’s opinion, so able, and (c) without charge to the worker, give all reasonable and necessary information, advice and assistance to the worker and the worker’s dependents in making a claim for compensation and in furnishing any certificates and proofs that are required in connection with the claim."

The report must only contain information relating to the work related injury and relevant prior medical history. The physician has a duty to review the patient’s chart to determine what information is and is not relevant to the work related history.

The physician must also advise the Board when, in the physician’s opinion, a worker will be or was able to return to work. This can be either in the initial report to the WCB or in a separate report to the WCB forwarded no later than three days after the date when the worker was fit to return to work.

If the physician is uncertain as to whether or not prior medical history is relevant to a work related injury, it is recommended that the physician seek the advice of a medical specialist with expertise relevant to the circumstances. The physician must not disclose the previous medical history of the worker to the WCB, without the worker’s consent, unless it is relevant to the work related injury or the worker’s ability to return to work.

Further information is also available from the Workers Compensation Board including information on the need for workers to submit consent when they file a claim and a fact sheet that includes the FOIP Act as it relates to this topic.
Results of blood alcohol testing, when blood has been drawn for that purpose at the request of a Peace Officer;

Blood for such testing can only be drawn with the consent of the patient or upon production of a warrant under the Criminal Code for a blood sample.

Medical conditions of flight crews, air traffic controllers and others, where the physician believes that the medical condition is likely to constitute a hazard to aviation safety;

Required under the Federal Aeronautics Act. Section 6.5 says “(1) Where a physician or an optometrist believes on reasonable grounds that a patient is a flight crew member, an air traffic controller or other holder of a Canadian aviation document that imposes standards of medical or optometric fitness, the physician or optometrist shall, if in his opinion the patient has a medical or optometric condition that is likely to constitute a hazard to aviation safety, inform a medical adviser designated by the Minister forthwith of that opinion and the reasons therefore.” It is further noted in 6.5(4) that “No legal, disciplinary or other proceedings lie against a physician or optometrist for anything done by him in good faith in compliance with this section.”

Of interest the Act also places responsibility on the patient to both notify the physician and provide consent in that 6.5(2) says “The holder of a Canadian aviation document that imposes standards of medical or optometric fitness shall, prior to any medical or optometric examination of his person by a physician or optometrist, advise the physician or optometrist that he is the holder of such a document.” And Section 6.5(6) says “The holder of a Canadian aviation document that imposes standards of medical or optometric fitness shall be deemed, for the purposes of this section, to have consented to the giving of information to a medical adviser designated by the Minister under subsection (1) in the circumstances referred to in that subsection.”
i) Medical conditions that could be a threat to safe railway operations, for railway workers occupying a safety critical position; and

Section 35 of the federal Railway Safety Act requires notification of the railway company’s Chief Medical Officer, with a copy to the patient. It is the patient’s responsibility to inform the physician that he/she holds a designated safety critical position at the time of the examination.

j) Patients affected with or suffering from a “notifiable disease”, by notifying a Director of Medical Services in writing of the name, address and place of employment of that patient and the specific notifiable disease, within 7 days of making the diagnosis.

Section 6 of the Occupational Health and Safety Regulation has been amended so that the list of notifiable diseases is now as follows:

(i) asbestosis;
(ii) mesothelioma;
(iii) asbestos – induced lung, laryngeal cancer or gastrointestinal cancer;
(iv) coal worker’s pneumoconiosis;
(v) silicosis;
(vi) lead poisoning;
(vii) noise – induced hearing loss.

Section 23 of the Occupational Health and Safety Act requires a physician, who is performing or supervising a medical examination of a worker on the request of the Director of Medical Services, shall furnish any medical reports that the Director may require. The contact information is:

Director of Medical Services
Workplace Health and Safety
9th Floor, Labor Building, 10808 – 98 Avenue
Edmonton, AB T5K 0G5

Phone: (780) 415-0607
(If calling from outside Edmonton, use the Government's RITE line first: 310-0000.).
Mandatory Release of Medical Information upon request of:

a) Patient

Supreme Court of Canada decision June 12, 1992.

b) Court Order

Supreme Court of Canada decision June 12, 1992; also, Alberta Rules of Court.

c) Medical Officer of Health

Section 19(1) of the Public Health Act says “Where a medical officer of health knows or has reason to believe (a) that a person suffering from a communicable disease is or may be in or has frequented or may have frequented a public place, or (b) that a public place may be contaminated with a communicable disease, the medical officer of health may by notice in writing to the person in charge of the public place require that person to provide to the medical officer of health within the time specified in the notice any information relating to public place, the person and the communicable disease that is specified in the notice.”

d) Third party (including physicians not involved in the patient’s care), when accompanied by authorization to release

In part, this is an extension of the law declared by the Supreme Court of Canada (see above, regarding a patient). An agreement by the patient for the release of information to third parties must be honored by the physician, just as the physician must honor such a request by the patient.

e) Patient’s legal guardian, with documentation

By Order of the Court for the appointment of a guardian or committee of a mentally disabled person.

f) Patient’s parent, when patient is less than the age of consent

Note that age of consent (though not identified), rather than age of majority, is the operative phrase.

g) Patient’s separated/divorced parent, when the parent has legal custody and the patient is less than the age of consent

By Order of the Court either through consent or after contest by trial. As well, on the basis of a Settlement Agreement between the parties duly completed.
h) Executor of the estate, for a deceased patient

The executor of the estate, rather than next-of-kin, legally represents the deceased. If there is no executor of the estate, (which normally occurs only if the estate is less than $25,000), then the physician can release medical information to:

a. FIRST choice would be the spouse.

b. If the spouse is no longer alive, then the SECOND choice would be to release the information to the children. However, if there is more than one child, ALL children must agree to the release of information.

The only other option would be for the family to speak with a lawyer and appoint either an Administrator or Executor of the estate.

The Health Information Act, in Section 35(1)(d) and (d.1) indicates physicians may release limited information to the family or close friends of the deceased under certain conditions.

i) College of Physicians & Surgeons of Alberta pursuant to an investigation under the Health Professions Act

The Health Professions Act, Section 63(1) An investigator (a) may, at any reasonable time, (i) require any person to answer any relevant questions and direct the person to answer the questions under oath, and (ii) require any person to give to the investigator any document, substance or thing relevant to the investigation that the person possesses or that is under the control of the person, (b) may require any person to give up possession of any document described in clause (a) to allow the investigator to take it away to copy it, in which case the investigator must return it within a reasonable time of being given it but must return it no later than after a hearing is completed, (c) may require any person to give up possession of any substance and thing described in clause (a) to allow the investigator to take it away to examine it and perform tests on it, in which case the investigator must return it, if appropriate and possible, within a reasonable time of being given it but must return it, if appropriate and possible, no later than after a hearing is completed, and (d) subject to subsection (8), at
any reasonable time enter and inspect any building where a regulated member provides professional services, but if the building contains a private dwelling place may not enter any part of the building designed to be used as and is being used as a permanent or temporary private dwelling place.

Section 63(3) (3) The complaints director, on the request of an investigator or without a request if the complaints director is the investigator, may apply to the Court of Queen’s Bench for (a) an order directing any person (i) to produce to the investigator any documents, substances or things relevant to the investigation in the person’s possession or under the person’s control, (ii) to give up possession of any document described in sub clause (i) to allow the investigator to take it away to copy it, in which case the investigator must return it within a reasonable time after receiving it but return it no later than after a hearing is completed, or (iii) to give up possession of any substance or thing described in sub clause (i) to allow the investigator to take it away, examine it and perform tests on it, in which case the investigator must return it, if possible, within a reasonable time of being given it but return it, if possible, no later than after a hearing is completed; (b) an order directing any person to attend before the investigator to answer any relevant questions the investigator may have relating to the investigation.

j) Workers’ Compensation Board pursuant to the Workers’ Compensation Act

Section 17(5) The Board has the same powers as the Court of Queen’s Bench for compelling the attendance of witnesses and of examining them under oath and compelling the production and inspection of books, papers, documents and things.

k) Order of a Statutory Board

Any Board or Tribunal, empowered by statute to issue a subpoena to compel the attendance of witnesses and the production of documents may order a physician to produce relevant medical records. By way of example, an order from the Attendance Board, established under the School Act, issued to a physician to attend as a witness with medical records of a student, who is the subject of the hearing. The Attendance Board deals with
truanty by school aged children.

l) Therapeutic Products Directorate, Health Canada re: narcotic drugs

m) Agent of the Federal Minister of Health, who is undertaking an investigation under Section 55 of the Controlled Drugs and Substances Regulations (information relating to narcotic prescriptions only)

n) Radiation medical officer, relating to the radiation health or safety of workers and the public

o) Director under the Child, Youth and Family Enhancement Act who has exclusive custody of a child, when the guardian of the child is unable or unavailable to consent; or when a child in need of intervention has a guardian refusing consent and the Director has obtained an Order of the Court.

See Federal Controlled Drugs and Substances Regulations.

Described by the Federal Controlled Drugs and Substances Regulations. The agent must be specifically identified with documentation as conducting an investigation under Section 55 of those Regulations.

See the Radiation Protection Act, Section 15. The Act simply states that a doctor may release the information upon a request of the radiation medical officer, however should the doctor refuse to release the information, the radiation medical officer may obtain a Court Order restraining the doctor from interfering with the radiation medical officer in obtaining access and making copies of the medical records. Failure to comply with the Court Order, may result in the doctor being subject to civil contempt proceedings.

Section 22.1 of the Child, Youth and Family Enhancement Act says

“(1) If the guardian of a child who has been apprehended is unable or unavailable to consent to the provision of essential medical, surgical, dental or other remedial treatment for the child that is recommended by a physician or dentist, a director may authorize the provision of any recommended treatment for the child. (2) If the guardian of a child who has been apprehended refuses to consent to essential medical, surgical, dental or other remedial treatment for the child that is recommended by a physician or dentist, the director must apply to the Court for an order authorizing the treatment. (3) Despite section 23(4), notice of the date, time and place at which an application under subsection
(2) is to be heard must be served not less than one day before the date fixed for the hearing. (4) A director may make an application by telephone or other means of telecommunication to a judge of the Court in accordance with section 19(5) to (10), in which case section 19(11) applies to the order. (5) If it is satisfied that the treatment is in the best interests of the child, the Court may authorize the treatment notwithstanding that the guardian of the child refuses to consent to the treatment. (6) If the Court authorizes treatment under this section, the authorization extends to the conclusion of the course of treatment unless the Court orders otherwise, even if a director ceases to have custody or guardianship of the child. (7) If a child is treated pursuant to an order under this section, no liability attaches to the person treating the child by reason only that the guardian of the child did not consent to the treatment.”

Section 22.2 of the Child, Youth and Family Enhancement Act says “(1) If a child who is the subject of a temporary guardianship order or a permanent guardianship agreement or order refuses to consent to essential medical, surgical, dental or other remedial treatment that is recommended by a physician or dentist, the director must apply to the Court for an order authorizing the treatment. (2) Despite section 23(4), notice of the date, time and place at which an application under subsection (1) is to be heard must be served not less than one day before the date fixed for the hearing. (3) If the Court authorizes treatment under this section, the authorization extends to the conclusion of the course of treatment unless the Court orders otherwise, even if a director ceases to have guardianship of the child. (4) If a child is treated pursuant to an order under this section, no liability attaches to the person treating the child by reason only that the child did not consent to the treatment.”

Section 17 of the Mental Health Act (Appendix D) and Section 24 of the Hospitals Act sets out a list of persons...
to whom the health facility or staff can release patient information.

Explanatory Note: these statutory provisions set out to whom and what type of information can be released. These provisions refer to disclosure requirements in other statues which are noted in this Guide.

**Discretionary Reporting**

**a) Patient medically unfit to drive**

The physician is protected from liability if he/she reports medical conditions which might adversely affect the ability of a person to operate a motor vehicle. Physicians are not required to do so, but are protected if they choose to report. The Traffic Safety Act, Section 60 says “No liability accrues to a physician, optometrist or other health care provider by reason only that the physician, optometrist or other health care provider provides to the Registrar under this Act information respecting a person’s medical condition that may impair that person’s ability to operate a motor vehicle in a safe manner.” Further Section 60.1 says “If information is provided to the Registrar in good faith that a person (a) is not competent to safely operate a motor vehicle, (b) is not qualified or does not have the ability to operate a motor vehicle safely, or (c) may have a medical or physical condition that impairs his or her ability to safely operate a motor vehicle, no person shall release the identity of the person providing the information, or release any information provided by that person that could reasonably be expected to reveal that person’s identity, unless the person providing the information authorizes the release of that identifying information in writing.” See also Reporting Unfit Drivers

**b) Patient who, the physician has reason to believe, presents a clear and present danger to society**

This is a provision established by Common Law through decisions of the Courts. The test is whether or not there is a perceived threat to the public which outweighs the duty of confidentiality to the patient.
We are unaware of any judgments in Canada against physicians who have disclosed confidential medical information on the basis of a perceived real threat to the public. See also *Health Information Act*, Section 35(1)(m) – see Appendix C.

Section 55 of the federal *Firearms Act* may require an applicant for a firearms permit or authorization (i.e., the patient) to submit information relevant for determining eligibility. Section 55(2) provides the chief firearms officer with broad investigatory powers in making that determination.

In response to such a request, physicians should obtain written authorization from their patient prior to releasing such information. There is no express duty to provide a prediction of patients’ potential for causing harm.

**Comments**

This section says that a physician may disclose information to the persons or organizations identified, but does not require that disclosure.

Should the physician decline to provide information, the person or organization may seek a Court Order directing disclosure. Failure to comply with such a Court Order may result in the doctor being subject to civil proceedings and assignment of associated legal and court costs.

*Health Information Act*, see Sections 27 and 35 attached as Appendix C. Completion of reporting forms for the AMA Committee on Reproductive Care is also covered under these provisions.
# Appendix B: Public Health Act Excerpts

Communicable Diseases Regulation AR 238/85

## Schedule 1

(Notifiable Communicable Diseases)

(Section 6(1) of this Regulation; sections 20(1) and 22(1) of the Act)

<table>
<thead>
<tr>
<th>Acquired Immunodeficiency Syndrome (AIDS)</th>
<th>Kawasaki Disease</th>
<th>Reye Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amebiasis</td>
<td>Lassa Fever</td>
<td>Rickettsial Infections</td>
</tr>
<tr>
<td>Anthrax</td>
<td>Legionella Infections</td>
<td>Rocky Mountain Spotted Fever</td>
</tr>
<tr>
<td>Arboviral Infections (including Dengue)</td>
<td>Leprosy</td>
<td>Rubella (including Congenital Rubella)</td>
</tr>
<tr>
<td>Botulism</td>
<td>Leptospirosis</td>
<td>Rubeola</td>
</tr>
<tr>
<td>Brucellosis</td>
<td>Listeriosis</td>
<td>Salmonella Infections</td>
</tr>
<tr>
<td>Campylobacter</td>
<td>Malaria</td>
<td>Severe Acute Respiratory Syndrome (SARS)</td>
</tr>
<tr>
<td>Cerebrospinal fluid isolates</td>
<td>Measles</td>
<td>Shigella Infections</td>
</tr>
<tr>
<td>Chickenpox</td>
<td>Meningitis (all causes)</td>
<td>Smallpox</td>
</tr>
<tr>
<td>Cholera</td>
<td>Meningococcal Infections</td>
<td>Stool Pathogens, all types. See note below.</td>
</tr>
<tr>
<td>Congenital Infections (includes Cytomegalovirus, Hepatitis B, Herpes simplex, Rubella, Toxoplasmosis, Varicella-zoster)</td>
<td>Mumps</td>
<td>Tetanus</td>
</tr>
<tr>
<td>Dengue</td>
<td>Neonatal Herpes</td>
<td>Toxic Shock Syndrome</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>Nosocomial Infections</td>
<td>Trichinosis</td>
</tr>
<tr>
<td>Encephalitis, specified or unspecified</td>
<td>Ophthalmia Neonatorum (all causes)</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Enteric Pathogens. See note below.</td>
<td>Paratyphoid</td>
<td>Tularemia</td>
</tr>
<tr>
<td>Foodborne Illness. See note below.</td>
<td>Pandemic Influenza</td>
<td>Typhoid</td>
</tr>
<tr>
<td>Gastroenteritis, epidemic. See note below.</td>
<td>Pertussis</td>
<td>Typhus</td>
</tr>
<tr>
<td>Giardiasis</td>
<td>Plague</td>
<td>Varicella</td>
</tr>
<tr>
<td><em>Haemophilus influenzae</em></td>
<td>Poliomyelitis</td>
<td>Viral Hemorrhagic Fevers</td>
</tr>
<tr>
<td>Infections (invasive)</td>
<td>(including Marburg, Ebola, Lassa, Argentinian, African Hemorrhagic Fevers)</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Hemolytic Uremic Syndrome</td>
<td>Psittacosis</td>
<td>Waterborne Illness (all causes). See note below.</td>
</tr>
<tr>
<td>Hepatitis A, B, Non-A, Non-B</td>
<td>Q-fever</td>
<td>West Nile Infection</td>
</tr>
<tr>
<td>Human Immunodeficiency Virus Infections</td>
<td>Rabies</td>
<td>Yellow Fever</td>
</tr>
</tbody>
</table>

**Note:** Enteric Pathogens, Foodborne Illness, Gastroenteritis, epidemic and Waterborne Illness include the following and any other identified or unidentified cause: *Aeromonas; Bacillus cereus; Campylobacter; Clostridium botulinum and C. perfringens; E.coli* (enteropathogenic serotypes); *Salmonella; Shigella; Staphylococcus; Viruses such a Norwalk and Rotavirus, Yersinia*. 

AR 238/85 Sched.1;357/88;37/88;96/2005;58/2006
Schedule 2

(Notifiable Sexually Transmitted Communicable Diseases)

(Section 6(2) of this Regulation; Section 20(2) of the Act)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Disease</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chancroid</td>
<td><em>Lymphogranuloma venereum</em></td>
<td>Syphilis</td>
</tr>
<tr>
<td><em>Chlamydia trachomatis</em> Infections (genito-urinary)</td>
<td>Muco-purulent Cervicitis</td>
<td></td>
</tr>
<tr>
<td>Gonococcal Infections</td>
<td>Non-gonococcal Urethritis</td>
<td></td>
</tr>
</tbody>
</table>

AR 238/85 Sched.2;357/88;96/2005

Schedule 3

(Diseases for which a Certificate, Isolation Order or Warrant for Examination May be Issued)

(Section 6(3) of this Regulation; Sections 39(1), 44(1) and 47(1) of the Act)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Disease</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired Immunodeficiency Syndrome (AIDS)</td>
<td>Gonococcal Infections</td>
<td>Plague</td>
</tr>
<tr>
<td>Anthrax</td>
<td>Human Immunodeficiency Virus Infections</td>
<td>Severe Acute Respiratory Syndrome (SARS)</td>
</tr>
<tr>
<td>Cholera</td>
<td>Lassa Fever</td>
<td>Smallpox</td>
</tr>
<tr>
<td>Chancroid</td>
<td>Leprosy</td>
<td>Syphilis</td>
</tr>
<tr>
<td><em>Chlamydia trachomatis</em> Infections (genitor-urinary)</td>
<td><em>Lymphogranuloma venereum</em></td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>Pandemic Influenza</td>
<td>Viral Hemorrhagic Fevers</td>
</tr>
</tbody>
</table>

AR 238/85 Sched.3;357/88;96/2005;58/2006
Schedule 4

1 For the purposes of section 29(2) of the Act, a medical officer of health shall, unless this Schedule provides to the contrary, take all reasonable steps to ensure that the provisions of this Schedule respecting Investigation of Contacts and Source of Infection, Isolation Procedures, Quarantine and Special Measures are complied with.

This Schedule is 44 pages long and too comprehensive to include in this document.

Appendix C: Health Information Act Excerpts
(Chapter H-4.8; Section 27 and 35 of the Act)

Use of individually identifying health information

27(1) A custodian may use individually identifying health information in its custody or under its control for the following purposes:

a) providing health services;
b) determining or verifying the eligibility of an individual to receive a health service;
c) conducting investigations, discipline proceedings, practice reviews or inspections relating to the members of a health profession or health discipline;
d) conducting research
   i) if the custodian has submitted a proposal to an ethics committee in accordance with section 49,
   ii) if the ethics committee is satisfied as to the matters referred to in section 50(1)(b),
   iii) if the custodian has complied with or undertaken to comply with the conditions, if any, suggested by the ethics committee, and
   iv) where the ethics committee recommends that consents should be obtained from the individuals who are the subjects of the health information to be used in the research, if those consents have been obtained;
e) providing for health services provider education;
f) carrying out any purpose authorized by an enactment of Alberta or Canada;
g) for internal management purposes, including planning, resource allocation, policy development, quality improvement, monitoring, audit, evaluation, reporting, obtaining or processing payment for health services and human resource management.

(2) A custodian referred to in section 1(1) (f) (iii), (iv), (vii), (xii) or (xiii) may, in addition, use individually identifying health information in its custody or under its control to carry out the following functions within
the geographic area in which the custodian has jurisdiction to promote the objectives for which the custodian is responsible:

a) planning and resource allocation;
b) health system management;
c) public health surveillance;
d) health policy development.

Disclosure of diagnostic, treatment and care information

35(1) A custodian may disclose individually identifying diagnostic, treatment and care information without the consent of the individual who is the subject of the information:

a) to another custodian for any or all of the purposes listed in section 27(1) or (2), as the case may be,
b) to a person who is responsible for providing continuing treatment and care to the individual,
c) to family members of the individual or to another person with whom the individual is believed to have a close personal relationship, if the information is given in general terms and concerns the presence, location, condition, diagnosis, progress and prognosis of the individual on the day on which the information is disclosed and the disclosure is not contrary to the express request of the individual,
d) where an individual is injured, ill or deceased, so that family members of the individual or another person with whom the individual is believed to have a close personal relationship or a friend of the individual can be contacted, if the disclosure is not contrary to the express request of the individual,
   i. where an individual is deceased, to family members of the individual or to another person with whom the individual is believed to have had a close personal relationship, if the information relates to circumstances surrounding the death of the individual or to health services recently received by the individual and the disclosure is not contrary to the express request of the individual,
e) to an official of a penal or other custodial institution in which the individual is being lawfully detained if the purpose of the disclosure is to allow the provision of health services to the individual,
f) to a person authorized to conduct an audit of the information if the person agrees in writing,
   i. to destroy the information at the earliest opportunity after the audit is concluded, and
   ii. not to disclose the information to any other person, except as required to accomplish the audit or to report unlawful or improper conduct by the custodian or a health services provider,
g) to a committee that has as its primary purpose the carrying out of quality assurance activities within the meaning of section 9 of the Alberta Evidence Act.
h) for the purpose of a court proceeding or a proceeding before a quasi-judicial body to which the custodian is a party,
for the purpose of complying with a subpoena, warrant or order issued or made by a court, person or body having jurisdiction to compel the production of information or with a rule of court that relates to the production of information,

to a municipal or provincial police service for the purpose of investigating an offence involving a life-threatening personal injury to the individual, if the disclosure is not contrary to the express request of the individual,

to another custodian where the custodian disclosing the information has a reasonable expectation that disclosure will detect or prevent fraud, limit abuse in the use of health services or prevent the commission of an offence under an enactment of Alberta or Canada,

to an officer of the Legislature if the information is necessary for the performance of the officer’s duties,

to any person if the custodian believes, on reasonable grounds, that the disclosure will avert or minimize an imminent danger to the health or safety of any person,

if that individual lacks the mental capacity to provide a consent and, in the opinion of the custodian, disclosure is in the best interests of the individual,

to a descendant of a deceased individual, a person referred to in section 104(1) (c) to (i) who is acting on behalf of the descendant or a person who is providing health services to the descendant if, in the custodian’s opinion,
   i. the disclosure is necessary to provide health services to the descendant, and
   ii. the disclosure is restricted sufficiently to protect the privacy of the deceased individual,

if the disclosure is authorized or required by an enactment of Alberta or Canada, or

to its successor where,
   i. the custodian is transferring its records to the successor as a result of the custodian ceasing to be a custodian, and
   ii. the successor is a custodian.

(2) A committee to which health information is disclosed pursuant to subsection (1) (g) must not disclose the information to any other person except in accordance with subsection (3).

(3) A committee referred to in subsection (2) may disclose non-identifying health information to another committee that has as its primary purpose the carrying out of quality assurance activities within the meaning of section 9 of the Alberta Evidence Act.

(4) A custodian may disclose individually identifying diagnostic, treatment and care information to a health professional body for the purpose of an investigation, a discipline proceeding, a practice review or an inspection if:

   a) the custodian has complied with any other enactment authorizing or requiring the custodian to disclose that information for that purpose, and

   b) the health professional body agrees in writing,
i. not to disclose the information to any other person except as authorized by or under the Act governing the health professional body, and

ii. to destroy the information,

A. at the earliest opportunity if the investigation, discipline proceeding, practice review or inspection is abandoned, or

B. at the earliest opportunity after a final decision has been made relating to the investigation, discipline proceeding, practice review or inspection, including any decision made by a body authorized to hear appeals.

Appendix D: Mental Health Act Excerpts

17(7) The Minister, a person authorized by the Minister, a board, an employee of a board or a physician may disclose any health information relating to a person receiving diagnostic and treatment services in a centre:

(a) – (c) repealed RSA 2000 cH-5 s119;

(d) to the Public Guardian if the health information is, in the opinion of the person making the disclosure, relevant to the making of a guardianship order under the Dependent Adults Act in respect of the person to whom the health information relates;

(e) to the Public Trustee if the health information is, in the opinion of the person making the disclosure, relevant to the making of a trusteeship order under the Dependent Adults Act in respect of the person to whom the diagnosis, record or information relates;

(f) to a review panel that is to hear or is hearing an application from the person to whom the health information relates, or to the Court of Queen’s Bench for the purposes of an appeal under section 43;

(g) repealed RSA 2000 cH-5 s114;

(h) to a Director of Medical Services under the Occupational Health and Safety Act when the health information relates to an accident that occurred in respect of the person’s occupation or one or more of the person’s former occupations, or to a disease that is related to the person’s occupation or one or more of the person’s former occupations;

(i) to The Workers’ Compensation Board, the Provincial Health Authorities of Alberta or a provincial hospital insurance authority if the information is required in order to establish responsibility for payment;

(j) to the Department of Health (Canada) for purposes in connection with the Canada Health Act (Canada);

(k) repealed RSA 2000 cH-5 s119;
(l) to a Review Board appointed pursuant to the Criminal Code (Canada) that is to review the case of the person to whom the health information relates;

(m) to the council of the College of Physicians and Surgeons of the Province of Alberta or an investigating committee under the Medical Profession Act or the Professional Conduct Committee or the Appeals Committee under the Nursing Profession Act, if:

(i) an officer of the College or the Alberta Association of Registered Nurses, as the case may be, makes a written request for the health information and the disclosure is consented to by the person to whom the health information relates or the person’s legal representative, or

(ii) the disclosure is made in compliance with a notice under section 59 of the Medical Profession Act or section 72 of the Nursing Profession Act to attend as a witness or to produce documents;

(n) to a person conducting an investigation, a hearing tribunal or the council of the dental profession under the Health Professions Act if:

(i) an officer of The Alberta Dental Association and College makes a written request for it and the disclosure is consented to by the patient or the patient’s legal representative, or

(ii) the disclosure is made in compliance with a notice under sections 73 and 74 of the Health Professions Act to attend as a witness or to produce documents;

(o) repealed RSA 2000 cH-5 s119;

(o.1) to a hearing director of a college under the Health Professions Act, if the disclosure is made in compliance with a notice under section 73 or 74 of the Health Professions Act;

(p) to the Health Disciplines Board or:

(i) to the Committee of a designated health discipline governed by a Committee, or

(ii) in the case of a designated health discipline governed by a health discipline association, to the conduct and competency committee established by the health discipline association, if the disclosure is made in compliance with a notice under section 38(1) of the Health Disciplines Act;

(q) to a person conducting a preliminary investigation or the Discipline Committee under the Psychology Profession Act if:

(i) an officer of The College of Alberta Psychologists makes a written request for it and the disclosure is consented to by the patient or the patient’s legal representative, or

(ii) the disclosure is made in compliance with a notice under section 44 of the Psychology Profession Act to attend as a witness or to produce documents.
MEMORANDUM

To: Council  
From: Owen Heisler and Sarah Thomas  
Date: September 2015  
Subject: Standards of Practice: 008 for Resolution

Issue

Draft amendments to the following standards are pending Council’s resolution:

- Advertising by Regulated Members
- Conflict of Interest Involving Financial or Personal Gain by Physicians
- Health Human Research Ethics Review

Each appendix includes both the draft amendment (a) and current standard (b).

Council provided direction to inform these amendments in December 2014. At the following meeting in March 2014, Council approved draft amendments for consultation. Consultation took place March 23, 2015 through May 21, 2015. Based on feedback received during the consultation process, several further edits are proposed in this memo for Council’s consideration.

Council’s review process for standards of practice honors the CPSA’s values of responsibility and openness to new ideas and fulfills the College’s mandate of ensuring the public receives safe and effective medical care from competent physicians.

Advertising

Response Statistics

Regulated Members 35
Organizations (database) 6
  Alberta College and Association of Chiropractors
  Alberta College of Pharmacists
  Alberta Health
  College & Association of Registered Nurses of Alberta
  College of Physicians & Surgeons of Ontario
  College of Physicians & Surgeons of Saskatchewan
Organizations (other) 0
Other Healthcare Professions 2
  Alberta Society of Dermatology
  Canadian Academy of Facial Plastic and Reconstructive Surgery
Member of the Public 0
Summary of Feedback

The amended Advertising standard received 43 consultation responses. The majority of responses indicate overall support for the standard with some challenges identified. A number of themes emerge from the feedback, as well as areas where further amendments and additional clarity are recommended.

Discussion

Themes:

a. Consistent application of the standard is important (6) and includes:
   o All physicians, regardless of specialty;
   o Business entities that encompass physicians; and
   o A common understanding of testimonials.

b. Some exceptions for identifying practice interests should be allowed going forward (5), specifically (3)(b) iii) – limiting the use of Schedule 21 titles:
   o Facial Plastic Surgery in Otolaryngology; and
   o Oculoplastic Surgeon in Ophthalmology.

c. Scope of the standard goes:
   o Not far enough and should further restrict, such as how credentials are listed (3).
   o Too far, relating to only “symptom complex,” for example, and should allow more freedom (3).

d. Challenges with enforcement (3), including:
   o Whether the standard would stand up to a charter challenge;
   o Whether the Registrar has the authority to require the discontinuation of advertisements; and
   o Support for the standard to be better enforced.

e. Identified practice interests should be supported by full disclosure of certification including the awarding jurisdiction/institution (1).

Comments Seeking Clarity:

a. Word choice and definitions. Examples include “testimonial,” “disparage,” and “donated.”

b. Identify whenever an advertisement is for an uninsured service.

Recommended Amendments:

1. Clause 1: delete “associated with” and replace “responsible for.” Amended to align with the Direction and Control standard of practice.
2. Clause 1(d): delete “only.” Amended to acknowledge advertisements may include information in addition to the practice discipline.

3. Clause 1(h) & 2(c): delete “product.” Products are addressed in *Sale of Products by Physicians* standard.

4. Clause 3: delete “comparative.” Alberta Health identified clause 3(c) is not limited by a comparative qualifier. Negative or unsubstantiated comparatives are addressed in clause 1(a) & (b).

5. Clause 4(b): delete. Certain circumstances would be reasonable to identify a procedure.

6. Clause 6: reword. The obligation of action should be on the regulated member.

7. The remaining amendments recommended are to improve clarity or better addressed in an *Advice to the Profession: Advertising*.

8. Support *Advertising* standard of practice with an *Advice to the Profession: Advertising*.

**Conflict of Interest**

**Response Statistics**

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Summary of Feedback

Conflict of Interest standard received 45 consultation responses. The majority of responses indicated strong overall support for the standard. A number of themes and requests for clarity emerged from the feedback and are summarized. Minor amendments are recommended.

Discussion

Themes
a. Gaps in the standard (17), including conflicts of interest associated with:
   i. Sale of products, include examples (7)
   ii. Other roles, examples include participation on boards, investigator, and researcher (5)
   iii. Self-referral, including ordering additional tests (4)

b. Request for examples and case studies (6).

c. Concerns about how the standard will be enforced (2).

d. Unintended consequences, such as barriers to physicians participating in (2):
   i. Research
   ii. Medical director oversight

Comments Seeking Clarity
a. Disclosure expectations when a physician is in a reported conflict of interest (2).

b. How to determine proportionate financial contribution.

c. Definitions for the following (5): direct/indirect financial interest, conflict of interest, personal gain, benefit.

Recommendations:
a. Clause (2): remove “to the patient.” Identify that conflicts can exist beyond the physician-patient relationship.

b. Clause (2): clarify. Disclosure of conflict must still occur for any conflict of interest that has been approved and substantiated as per clause (4).

Health Human Research Ethics Review

Response Statistics
Regulated Members 21
Organizations (database) 6
- Alberta College and Association of Chiropractors
- Alberta College of Pharmacists
- Alberta Health
- College & Association of Registered Nurses of Alberta
- College of Physicians & Surgeons of Ontario
- College of Physicians & Surgeons of Saskatchewan
Organizations (other) 0
Other Healthcare Professions 0
Member of the Public 0

Summary of Feedback
The amended Health Human Research standard received 27 consultation responses. The standard is supported. Distinguishing quality improvement initiatives from research is important.

Discussion
Themes
a. Quality improvement initiatives do not require the same process rigour as research. Additional resources from Alberta Innovates Health Solutions may be helpful in distinguishing between the two (6).

b. More support for cultivating new researchers (1).

Comments and Seeking Clarity
a. Define the spectrum of activities that constitute “human health research.” Consider a definition from the Tri-Council Policy Statement.

b. Clarify the broader expectations of Health Information Act compliance.

c. Clarify the threshold between quality improvement and research and identifying the requirements that need to be met for research.

Recommendations:
 a. Clarify application of the standard.

b. Clause (1): clarify. Regulated members must comply with the Health Information Act.
c. Clause (3): addition. Regulated members must disclose to the patient the study has been reviewed by an ethics research committee along with any relevant conditions imposed by the committee.

d. Include the link to Alberta Innovates Health Solution resources on the Standards page.

Recommendation to Council

- Accept the *Advertising* standard as amended.

- Accept the *Conflict of Interest* standard as amended.

- Accept the *Health Human Research* standard as amended.
Appendix 1a: Advertising – draft amendments clean

The Standards of Practice of the College of Physicians & Surgeons of Alberta (“the College”) are the minimum standard of professional behaviour and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) A regulated member who is responsible for an advertisement must ensure the information provided:

(a) conforms to the Code of Ethics;

(b) contains factual and relevant information about the nature of the practice;

(c) includes the practice discipline as identified on the member’s practice permit issued by this College;

(d) is accurate, clear and explicitly states all pertinent details of an offer, with disclaimers as prominent as other aspects of the message;

(e) is supported by evidence that is readily available to the public;

(f) is compatible with the best interests of the public and upholds the reputation of the medical profession;

(g) is not false, incomplete, misleading or deceptive;

(h) does not include claims, representations, endorsements or testimonials regarding the service or business;

(i) does not create unreasonable expectations of beneficial treatment such as guarantees or warranties about results; and

(j) does not encourage the indiscriminate or unnecessary use of health services.

(2) A regulated member must promptly comply with direction from the Registrar to:

(a) substantiate any advertising claim or representation;

(b) confirm whether a specific advertisement is made by or on behalf of the regulated member; or

(c) change or stop using any advertising message(s) that the Registrar deems in violation of any part of this standard or the Code of Ethics.

1“Advertisement” is any message (spoken, text or image-based), in any medium, about a regulated member and/or a clinic, group, product or service with which a regulated member is associated, the content of which is controlled directly or indirectly by a regulated member.
(3) A regulated member must not directly or indirectly participate in advertising that:

(a) discredits, disparages or attacks another product, service, facility, clinic, provider or group;

(b) promises or offers more effective services or better results than those available from another provider unless substantiated to the satisfaction of the Registrar based on publically available information; or

(c) offers any inducement to provide a medical service to a patient, including but not limited to:

   i) time-limited prices for a service;

   ii) discount coupons, gift certificates, or prizes for a service;

   iii) communal gatherings (“parties”) where consultation or medical services are offered;

   iv) a service in conjunction with “makeovers” created for entertainment or promotional purposes; or

   v) events including “education sessions” where registration fees are donated.

(4) A regulated member must not:

(a) disclose the name or identifying features of a patient unless the regulated member has obtained the patient’s prior written consent to use the information for advertising purposes; or

(b) use a protected title listed in Schedule 21 of the Health Professions Act (HPA) alone or in combination with other descriptors to imply specialization in an area or branch of medicine unless recognized by the College or authorized by the Registrar to use that title.

(5) Notwithstanding 3(b), a regulated member may use a protected title as authorized by the Department of National Defence.

(6) A regulated member may indicate a practice interest only if the:

(a) area of interest falls within the context of the member’s practice discipline;

(b) area of interest is a demonstrated, significant focus of the member’s practice; and

(c) regulated member pursues continuing medical education related to the area of interest.
Appendix 1b: Advertising – draft amendments tracked

The Standards of Practice of the College of Physicians & Surgeons of Alberta ("the College") are the minimum standard of professional behaviour and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) A regulated member who is associated with responsible for an advertisement must ensure the information provided:

(a) conforms to the Code of Ethics;

(b) contains factual and relevant information about the nature of the practice;

(c) includes only the practice discipline as identified on the member’s practice permit issued by this College;

(d) is accurate, clear and explicitly states all pertinent details of an offer, with disclaimers as prominent as other aspects of the message;

(e) is supported by evidence that is readily available to the public;

(f) is compatible with the best interests of the public and upholds the reputation of the medical profession;

(g) is not false, incomplete, misleading or deceptive;

(h) does not include claims, representations, endorsements or testimonials regarding the service, or business or product;

(i) does not create unreasonable expectations of beneficial treatment such as guarantees or warranties about results; and

(j) does not encourage the indiscriminate or unnecessary use of health services.

(2) A regulated member must promptly comply with direction from the Registrar to:

(a) substantiate any advertising claim or representation;

(b) confirm whether a specific advertisement is made by or on behalf of the regulated member; or

(c) change or stop using any advertising message(s) that the Registrar deems in violation of any part of this standard or the Code of Ethics.

1"Advertisement" is any message (spoken, text or image-based), in any medium, about a regulated member and/or a clinic, group, product or service with which a regulated member is associated, the content of which is controlled directly or indirectly by a regulated member.
A regulated member must not directly or indirectly participate in comparative advertising that:

(a) discredits, disparages or attacks another product, service, facility, clinic, provider or group;

(b) promises or offers more effective services or better results than those available from another provider unless substantiated to the satisfaction of the Registrar based on publicly available information; or

(c) offers any inducement to provide a medical service or product to a patient, including but not limited to:

i) time-limited prices for a product or service;

ii) discount coupons, gift certificates, or prizes for a product or service;

iii) communal gatherings (“parties”) where consultation or medical services are offered;

iv) a product or service in conjunction with “makeovers” created for entertainment or promotional purposes; or

v) events including “education sessions” where registration fees are donated.

A regulated member who is associated with responsible for an advertisement must not:

(a) disclose the name or identifying features of a patient unless the regulated member has obtained the patient’s prior written consent to use the information for advertising purposes; or

(b) use a protected title listed in Schedule 21 of the Health Professions Act (HPA) alone or in combination with other descriptors to imply specialization in an area or branch of medicine unless recognized by the College or authorized by the Registrar to use that title.

Notwithstanding 3(b), a regulated member may use a protected title as authorized by the Department of National Defence. Unless the regulated member:

(c) falsely imply specialization in an area or branch of medicine as determined by the Registrar.

   i) unless the regulated member is recognized by the College or the Department of National Defence as authorized to use that title;

   ii) is recognized by the Department of National Defence as authorized to use that title; or

   iii) uses the title in a manner that does not falsely imply specialization in an area or branch of medicine with the approval of the Registrar.

A regulated member may indicate a practice interest only if the:

(a) area of interest falls within the context of the member’s practice discipline;

area of interest relates to a symptom complex and not a specific treatment or procedure;

(b) area of interest is a demonstrated, significant focus of the member’s practice; and

(c) regulated member pursues continuing medical education related to the area of interest.
(5) A regulated member may:

(a) remind a person of an upcoming appointment with the regulated member;

(b) offer a reduced fee or charge to a specific patient on compassionate grounds;

(c) offer a reduced fee or charge to an established patient for a service provided within a training context;

(d) inform patients that prices are subject to change without notice; and

(e) provide free consultations for the purpose of informing and assessing the eligibility of a patient for an uninsured product or service.

(6) The Registrar, to: at his or her sole discretion, may direct a regulated member to promptly:

(a) substantiate any advertising claim or representation;

(b) confirm whether a specific advertisement is made by or on behalf of the regulated member; or

(c) change or stop using any advertising message(s) that the Registrar deems in violation of any part of this standard or the Code of Ethics.

Link to the current version of Advertising by Regulated Members
Appendix 2a: Conflict of Interest – draft amendments clean

Administration of Practice

Conflict of Interest
Draft Amendments for Resolution

The Standards of Practice of the College of Physicians & Surgeons of Alberta ("the College") are the minimum standard of professional behaviour and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) A regulated member must resolve any real, potential or perceived conflicts of interest in the best interest of the patient.

(2) A regulated member must make full, frank and timely disclosure of any conflict of interest, and comply with clause (1) regardless of whether the regulated member has obtained consent to remain in the conflict of interest.

(3) A regulated member must not:

(a) seek or accept any benefit for a referral, service or product provided by another regulated professional to a patient, other than for services provided by a partner, associate, employee or locum of the regulated member;

(b) offer an inducement to another regulated professional conditional on providing a referral, service or product to a patient, whether or not such referral, service or product is medically appropriate; or

(c) encourage another person to offer or accept an inducement conditional on providing a referral, service or product to a patient, whether or not such referral, service or product is medically appropriate.

(4) A regulated member must not refer a patient to any facility or healthcare business separate and apart from the regulated member’s medical practice in which the regulated member has a direct or indirect financial interest unless the regulated member has the prior approval of the Registrar, and is able to substantiate compliance with the following on request:

(a) any interest or benefit the regulated member receives is directly attributable to the regulated member’s proportionate financial contribution or effort provided to that facility;

(b) there are no terms or conditions that relate any benefit to the regulated member to past or expected volume of patient referrals or other business from the regulated member to the facility; and

(c) there are no terms or conditions that require the regulated member to make referrals to the facility or otherwise generate business for the facility.
(1) A regulated member must resolve any real, potential or perceived conflicts of interest in the best interest of the patient.

(2) A regulated member must make full, frank and timely disclosure of any conflict of interest, to the patient, and comply with clause (1) regardless of whether the patient has obtained consent to the regulated member remaining in the conflict of interest.

(3) A regulated member must not:

(a) seek or accept any benefit for a referral, service or product provided by another regulated professional to a patient, other than for services provided by a partner, associate, employee or locum of the regulated member;

(b) offer an inducement to another regulated professional conditional on providing a referral, service or product to a patient, whether or not such referral, service or product is medically appropriate; or

(c) encourage another person to offer or accept an inducement conditional on providing a referral, service or product to a patient, whether or not such referral, service or product is medically appropriate.

(4) A regulated member must not refer a patient to any facility or healthcare business separate and apart from the regulated member’s medical practice in which the regulated member has a direct or indirect financial interest unless the regulated member has the prior approval of the Registrar, and is able to substantiate compliance with the following on request:

(a) any interest or benefit the regulated member receives is directly attributable to the regulated member’s proportionate financial contribution or effort provided to that facility;

(b) there are no terms or conditions that relate any benefit to the regulated member to past or expected volume of patient referrals or other business from the regulated member to the facility; and

(c) there are no terms or conditions that require the regulated member to make referrals to the facility or otherwise generate business for the facility.
Appendix 3a: Health Human Research – draft amendments clean

Human Health Research

Draft Amendments for Resolution

The Standards of Practice of the College of Physicians & Surgeons of Alberta (“the College”) are the minimum standard of professional behaviour and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) This standard applies to any regulated member involved in human health research as defined by the Tri-Council Policy Statement on the Ethical Conduct for Research Involving Humans; this may include quality review activities.

(2) A regulated member who intends to conduct human health research must comply with the Health Information Act including to submit a proposal for review by a research ethics board in the Province of Alberta. Such boards include:

(a) Health Research Ethics Board of Alberta (HREBA)

(b) Conjoint Health Research Ethics Board (CHREB), University of Calgary

(c) Health Research Ethics Board (HREB), University of Alberta

(3) A regulated member must have approval from a research ethics board before commencing human health research.

(4) A regulated member participating in human health research must:

(a) ensure the welfare of any patient involved in the research study is the primary concern throughout the duration of the study;

(b) disclose to patients that the study has been reviewed by an ethics board and relevant conditions imposed;

(c) comply with the requirements of the research ethics board as it relates to initial and ongoing review of the research study; and

(d) disclose any potential or actual conflicts of interest to the research ethics board.

Terms used in the Standards of Practice:
- *Must* refers to a mandatory requirement.
- *May* means that the physician may exercise reasonable discretion.
- *Patient* includes, where applicable, the patient’s legal guardian or substitute decision maker.
Appendix 3b: Health Human Research – draft version tracked

Draft Amendments for Resolution

The Standards of Practice of the College of Physicians & Surgeons of Alberta ("the College") are the minimum standard of professional behaviour and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides Advice to the Profession to support the implementation of the Standards of Practice.

(1) This standard applies to a regulated member who intends to participate in human health research, including quality review activities that meet the requirements for research as defined by the Tri-Council Policy Statement on the Ethical Conduct for Research Involving Humans; this may include quality review activities.

Policy on the Ethical Conduct for Research involving Humans, a regulated member must ensure that the requirements of this standard are met.

(1)(2) A regulated member who intends to conduct human health research must comply with the Health Information Act including to submit a proposal for review by a research ethics board in the Province of Alberta, as outlined in the Health Information Act. Such boards include:

(a) Health Research Ethics Board of Alberta (HREBA)
(b) Conjoint Health Research Ethics Board (CHREB), University of Calgary
(c) Health Research Ethics Board (HREB), University of Alberta

(2)(3) A regulated member must have approval from a research ethics board before commencing human health research.

(3)(4) A regulated member participating in human health research must:

(a) ensure the welfare of any patient involved in the research study is the primary concern throughout the duration of the study;

(b) disclose to patients that the study has been reviewed by an ethics board and relevant conditions imposed;

(c) comply with the requirements of the research ethics board as it relates to initial and ongoing review of the research study; and

(d) disclose any potential or actual conflicts of interest to the research ethics board, to disclose that the study has been reviewed by an ethics board and relevant conditions imposed;

disclose any potential or actual conflicts of interest to the research ethics board; and ensure the welfare of any patient involved in the research study is the primary concern throughout the duration of the study.
A regulated member may participate in quality review activities including review of health information providing such activities are not “research” as defined in the Tri-Council Policy Statement on the Ethical Conduct for Research Involving Humans.

Terms used in the Standards of Practice:
- **Must** refers to a mandatory requirement.
- **May** means that the physician may exercise reasonable discretion.
- **Patient** includes, where applicable, the patient’s legal guardian or substitute decision maker.

Link to the current version of *Health Human Research Ethics Review*
Appendix 4: Advice to the Profession: Advertising

Advertising

Related Standard of Practice: Advertising

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the CPSA Standards of Practice. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

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General

Advertising by a physician must first and foremost adhere to the Code of Ethics, which identifies the following responsibilities to the patient and to the profession:

- resist any influence or interference that could undermine your professional integrity (Precept 7)
- make every reasonable effort to communicate with your patients in such a way that information exchanged is understood (Precept 22)
- protect the personal health information of your patients (Precepts 31 and 33)
- recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege and to support its institutions (Precept 46)
- avoid impugning the reputation of colleagues for personal motives (Precept 47)
- avoid promoting, as a member of the medical profession, any service (except your own) or product for personal gain (Precept 50)
- treat your colleagues with dignity and as persons worthy of respect (Precept 52)
The College’s Advertising standard defines an advertisement as “any message (spoken, text or image-based), in any medium, about a regulated member and/or a clinic, group, product or service with which a regulated member is associated, the content of which is controlled directly or indirectly by a regulated member.”

The bold words relate directly to the Direction and Control of a Medical Practice standard, in which responsibility for advertising is part of a regulated member’s duty to maintain direction and control of his/her practice, including when the advertising is coordinated by a person/s working under the member’s direction, control or supervision.

Because advertising is so ubiquitous, the College acts mostly on concerns brought to our attention rather than monitoring proactively. Our approach is to manage these concerns collaboratively with the physician to develop a shared understanding. Inevitably innovative schemes arise that require specific guidance, but these should be the exception.

The College appreciates and understands that other providers outside our jurisdiction, particularly those providing uninsured services, may have greater latitude in advertising. While not allowing comparable latitude for physicians might seem unfair and restrictive, the College believes the right to use the protected titles “physician” and “medical doctor” and enjoy the public trust implicit in those titles more than makes up for any suggested disadvantage, providing our professional standards remain high and respected.

**Advertising Practice Information**

Advertising includes providing information about the regulated member’s qualifications and availability. This information might be provided on a business card, a notice about a practice opening or a sign posted at the practice location. The intent is to inform patients and potential referring physicians about the physician’s scope of practice and any specific practice interests.

The following are examples of acceptable advertisements in the general provision of care:

- reminder to a patient of an upcoming appointment
- offer to reduce a fee or charge to a specific patient on compassionate grounds
- offer to reduce a fee or charge to an established patient for a service provided within a training context
- notice to patients that prices for uninsured services are subject to change without notice
- offer for free consultation to inform and assess the eligibility of a patient for an uninsured product or service

In such advertising, a regulated member must include the practice discipline identified on the member’s practice permit, and may use any protected titles for which he/she has been recognized by this College as per Schedule 21(2) of the Health Professions Act. Specialty designations are usually indicative of certification by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada. For example, the title “dermatologist” usually indicates the member has a Fellowship in Dermatology with the RCPSC.

Full disclosure to the public about one’s training and credentials is essential, and most contentious in the provision of cosmetic surgical services. A patient seeking a rhinoplasty, for example, should know whether the surgeon offering the service is a plastic surgeon or an otorhinolaryngologist, and the patient seeking liposuction should know whether the physician offering the service is a dermatologist, a family physician or a plastic
surgeon. Knowing the medical background, training and credentials of the service provider is imperative to making a well-informed decision.

**Advertising Practice Interests**

Physicians often develop skills and expertise as subsets of the practice discipline recognized on their practice permit.

Members are allowed to advertise information about practice areas and interests for which they are duly qualified, to assist both patients and colleagues in prudently accessing services and expertise.

For example, a family physician with an interest in the management of skin disorders who has completed meaningful training in this area (e.g., several-month course) may advertise a practice interest in skin diseases or dermatology, provided the physician also indicates at the same time his/her core training is in family medicine. At no time can the family physician use the protected title “dermatologist” unless recognized as such by this College, usually on the basis of certification by the RCPSC.

In short, for a regulated member to include a practice interest in advertising, it must be:

- within the context of the regulated member’s expertise
- a focus of his/her practice
- supported by regular continuing medical education

When a concern about practice interest advertising by a regulated member is brought to the attention of the College, the regulated member is expected to produce evidence of this commitment.

**Publication by the College**

In conjunction with its 2015 review of the Advertising standard of practice, the College reconsidered publication on the CPSA website of regulated members’ “Practice Interests” (self-described, no review/approval process) and “Special Interests” (College-approved based on education/training review). To mitigate possible confusion by the public regarding the differences between these categories and avoid any perception the College is advertising on behalf of its members, the College will no longer publish this information on the CPSA website.

The two categories are being merged into “Practice Interests” as described above and terminology is being standardized. Regulated members will be asked to update Practice Interests at least annually during practice permit renewal, but this information will not appear on the College website.
Comparative Advertising

Comparative advertising characterizes a physician’s own services, outcomes or processes in relation to another provider. A regulated member may publish comparative information that is factually correct and supported by solid methodology to assist the public and profession in making informed choices, and to support opportunities for all members to aspire to excellence.

Three examples:

- A regulated member contracts a company to survey current patients about their satisfaction with reception staff and finds a high proportion are very satisfied; this information can be advertised.
- A regulated member obtains data from a properly conducted study that his/her risk stratified outcome is above average. The member’s outcome and the average data can be shared, but not the individual outcomes of other providers.
- A regulated member self-identifies as “one of the best”. This claim is acceptable only if the member can support it with objective evidence that is publicly available.

Professionalism demands that comparative advertising focus on output and performance and not personal attack. The word “disparage” is used intentionally in clause 3 of the standard to prohibit activities and comments that denigrate the services provided by colleagues. If a regulated member truly has concerns with a colleague’s practice, Precept 48 of the Code of Ethics applies: “Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.” The College’s Duty to Report a Colleague standard expands on this obligation.

Testimonials

A testimonial is a published endorsement by an individual patient about the skills and qualities of a regulated member. While typically positive, a testimonial can also be negative.

Testimonials are a problem for several reasons, most notably because patient privacy is compromised and selection bias may lead to misconceptions by the public. While publication by an independent party of all feedback (good and bad) collected in a transparent and fair manner may be acceptable, publication of selected testimonials might not fairly reflect most patients’ experience with the physician’s practice. Accordingly, the College does not allow testimonials.
The Competence Committee met on August 19, 2015 and dealt with the following issues:

1. **2016 Business Plan and Budget related to competence activities**

   The Competence committee reviewed the 2016 Business Plan and the new initiatives included in the 2016 Budget to support the competence activities. The committee supported the initiatives and provided feedback to the chair that the plan and initiatives are consistent with the discussions and recommendations of the committee.

2. **Continuing Competence Program Rules**

   The committee discussed on a draft set of rules to be presented to Council for approval in September (separate agenda item)

3. **Terms of Reference**

   In order to accomplish the changes requested by Council and those contemplated in the draft rules, the Terms of Reference for the Continuing Competence committee and its subcommittees (particularly PAR-C) require revision.

   Under Council direction, the Competence Committee is working with staff to align the College’s competence programs to improve efficiency and effectiveness while trying to minimize disruption to member’s practices.

   A significant part of that alignment is to combine two separate and distinct programs that currently organize practice visits for physicians who require a more detailed assessment of their practices (Physician Achievement Review Program and Assessment and Competence Enhancement Program) into a single Practice Visit Program. All these programs operate under the Part 3 of the Health Professions Act and are part of the continuing competence programs of the College.
Mr. Craig Boyer, legal counsel for the College, has recommended that the Competence Committee change its Terms of Reference to more clearly establish its relationship to the program areas and subcommittees. The purpose of this suggestion is to better define the delegation of authority from the Competence Committee to subcommittees and to staff who work directly with members.

Committee members commented that this presents an opportunity to review all the program areas and subcommittees. It is recognized that the subcommittees are committees originally struck under the Medical Profession Act and that the roles and responsibilities are changing with the continuous competence program evolution under HPA.

Revised Terms of Reference for the Competence Committee and its sub committees will be brought forward to Council in December 2015.

4. **Practice Review Program – Pilot Update**

The activities to engage the profession in a new practice review program have begun. An initial survey was sent to the profession on July 29, 2015; deadline for feedback is August 21, 2015. Response to the survey has been very good and results will be shared with the Pilot Development Team (PDT) and Competence Committee in September. A stakeholder consultation process is underway this fall to help inform the review process for primary care practices. Work is underway on practice assessment/feedback tools including prescribing report templates and a standard of practice audit process. Staff received interest and recommendations regarding potential clinics for the initial pilot; the PDT will meet in the fall and select clinics for the pilot which is on track to begin in early 2016.
MEMORANDUM

To: Council

From: Competence Committee

Date: August 19, 2015

Subject: Continuing Competence Program - Rules

Issue:

Update Competence Program Rules to be consistent with changes in the delivery of College’s continuing competence program.

Background:

Council directed the Competence Committee to align its competence programs. Program Rules must now be revised to reflect the alignment.

The authority to operate a continuing competence program is established in Part 3 of the Health Professions Act (HPA) and this authority rests with the Competence Committee. Practically, specific competence activities related to PAR, IPAC, PHM and PPP are delegated directly by the Competence committee to its subcommittees and staff (as allowed in Section 20 of the HPA). Revisions to the PAR, PPP and Competence Assessment rules are needed to clarify that the authority rests with competence committee which ensures that this delegation is legal.

The Physicians, Surgeons and Osteopath Profession Regulation (the regulations), describes three major components of the CPSA continuing competence program:

- Section 22 – General assessment (PAR surveys, all members must participate every 5 years);
- Section 23 – CPD (defer to MAINPRO and MOC); and
- Section 24 – Competence assessment (practice visits, IPAC, prescribing).

The rules need to be brought together under these three sections of the regulations.

The following draft rules are attached for Council’s review:

1. Rules for Member Participation in PAR Program
2. Rules for Members Undergoing Assessment
The draft changes to the rules noted above address four issues:

- Alignment of the programs
- Consolidation of the rules to align with the regulations
- Clarity that all competence activities arise from the authority of the Competence committee to ensure compliance with the HPA.
- Change of terminology from “physician” to “regulated member” to accommodate the addition of physician assistants to the CPSA

**Recommendation:**

1. The Competence Committee requests Council approve the changes to following rules and make them available to the profession for review as per Section 25(3) of the regulations:

(a) Rules for Member Participation in PAR Program
(b) Rules for Members Undergoing Assessment
(c) Rules of Member Participation - PPP
(d) Rules for Member Participation – CPD

All comments received within 30 days must be reviewed by Council, and, if needed, Council can amend the rules in December 2015. If no comments are received within 30 days of the consultation date, the rules are approved and can be implemented.

The draft rules, if approved would replace the current rules which can be found on the College’s website:

- Continuous Professional Development: [http://www.cpsa.ab.ca/Libraries/Pro/Continuous_Professional_Development_-_Rules_for_Member_Participation.pdf](http://www.cpsa.ab.ca/Libraries/Pro/Continuous_Professional_Development_-_Rules_for_Member_Participation.pdf)
- Assessment and Competence Enhancement: [http://www.cpsa.ab.ca/Libraries/Pro_ACE/Assessment_Competency_Enhancement_Program_Rules.pdf](http://www.cpsa.ab.ca/Libraries/Pro_ACE/Assessment_Competency_Enhancement_Program_Rules.pdf)
Attachments:

(a) DRAFT Rules for Member Participation in Physician Achievement Review
(b) DRAFT Rules for Member Undergoing Assessment (Physician Competence Assessment)
(c) DRAFT Rules for Member Participation (Physician Prescribing Practices Program)
(d) DRAFT Rules for Member Participation (Continuous Profession Development)
(e) Health Professions Act Physicians, Surgeons and Osteopaths Profession Regulation
(2) A regulated member who performs a restricted activity must do so in accordance with the standards of practice.

Non-regulated persons, supervision

20(1) A person who is not described in section 4(1)(a) of Schedule 7.1 to the *Government Organization Act* is permitted to perform a restricted activity described in section 17 only if that person

(a) has the consent of, and is being supervised in accordance with subsection (2) by, a regulated member while performing a restricted activity, and

(b) is engaged in providing health services to another person.

(2) When a regulated member supervises a person referred to in subsection (1) performing a restricted activity, the regulated member must

(a) not be a regulated member registered on the students register,

(b) be authorized to perform the restricted activity being performed,

(c) if the person being supervised is a regulated member of another college, be satisfied the other college is aware that the person is performing the restricted activity under supervision,

(d) supervise the person who is performing the restricted activity by being readily available for consultation by the person who is under supervision, and

(e) comply with the standards of practice governing the provision of supervision by regulated members of persons performing restricted activities pursuant to section 4(1)(b) of Schedule 7.1 to the *Government Organization Act*.

Continuing Competence

Continuing competence program

21 The continuing competence program of the College comprises

(a) general assessment,

(b) continuing professional development, and

(c) competence assessment.
General assessment

22(1) A regulated member registered on the general register must, in accordance with the rules established under section 25, submit to a general assessment by the Competence Committee once every 5 years.

(2) A regulated member registered on the provisional register may, in accordance with the rules established under section 25, be required to submit to a general assessment by the Competence Committee once every 5 years.

(3) A general assessment referred to in subsections (1) and (2) consists of a physician achievement review survey or other tool approved by the Competence Committee to assess a regulated member’s

(a) professional knowledge and skills,

(b) communication skills,

(c) practice management, and

(d) professional ethics.

Continuing professional development

23(1) Every regulated member registered on the general register must undertake continuing professional development by

(a) participating in a professional development program approved by the Council in accordance with the rules established under section 25,

(b) keeping records, in a form satisfactory to the Registrar, of any activities undertaken for the purpose of continuing professional development, and

(c) on the request of, and in accordance with the directions of, the Registrar, providing copies of the records referred to in clause (b).

(2) Regulated members registered on the provisional register, limited practice register or telemedicine register may be required by the Registrar or Competence Committee to fulfill the requirements of subsection (1) and when so required, must comply with all the requirements of subsection (1).

Competence assessment

24(1) The Competence Committee may, in accordance with the rules established under section 25, require a regulated member registered on the general register or provisional register to undergo
an assessment for the purpose of evaluating the regulated member's competence.

(2) For the purpose of an assessment under subsection (1), the Competence Committee may use one or more of the following processes:

(a) practice visits;

(b) examinations;

(c) individualized assessments of professional competence that may include, but are not limited to, assessments of
   (i) professional knowledge or skills,
   (ii) communication skills,
   (iii) mental and physical health,
   (iv) professional ethics, or
   (v) practice management;

(d) interviews;

(e) any other type of evaluation required by the Competence Committee.

Continuing competence program rules

25(1) The Council may establish rules governing

(a) how assessments under sections 22 and 24 are to be conducted,

(b) the professional development programs that may be approved for the purpose of section 23,

(c) the assessment and approval of programs as substantially equivalent to the professional development programs approved by the Council,

(d) the type of professional development activities that a regulated member may undertake for the purpose of section 23,

(e) the records referred to in section 23(1)(b) and the provision of those records in accordance with the directions of the Registrar;
(f) audits of a regulated member’s records under section 23(1)(b), or

(g) the requirements or circumstances when regulated members registered on the provisional register, limited practice register or telemedicine register may be required to participate in a professional development program under section 23(1)(a).

(2) The Registrar and the Competence Committee may recommend rules or amendments to the rules to the Council.

(3) Before the Council establishes any rules or amendments to the rules, the rules or the amendments to the rules must be made available to all regulated members for their review.

(4) The Council may establish the rules or amendments to the rules 30 or more days after they are made available under subsection (3) and after having considered any comments received on the proposed rules or proposed amendments to the rules.

Rule distribution

26 The rules and any amendments to the rules established under section 25(4) must be made available by the College to all regulated members and, in printed form, on request to the Minister, regional health authorities and any person who requests them.

Actions to be taken

27 If the results of a general assessment under section 22 or of a competence assessment under section 24 are unsatisfactory, the Competence Committee or Registrar may require a regulated member to undertake remedial action, including, but not limited to, the following:

(a) successful completion of continuing competence program requirements or professional development activities;

(b) successful completion of any examinations, testing, assessment, training, education or treatment to enhance competence in specified areas;

(c) to practise under the supervision of another regulated member;

(d) limitation of practice to specified procedures or practice settings;

(e) to report to the Competence Committee or Registrar on specified matters on specified dates;
(f) correction of any problems identified in the practice visit;

(g) demonstration of competence gained in a specific area.

Members responsible for costs

28 Any action that a regulated member must undertake in response to a direction by the Competence Committee or Registrar under section 27 is undertaken at the cost of the regulated member.

Practice Permit

Applying for renewal

29 Regulated members applying for renewal of their practice permit must

(a) continue to meet the requirements set out in sections 12 to 15, and

(b) meet the requirements of the continuing competence program.

Practice permit conditions

30 The Registrar may impose conditions on a practice permit, which may include, but are not limited to, the following:

(a) completing any examinations, testing, assessment, counselling, training or education as considered necessary by the Registrar or the Competence Committee;

(b) limiting a member’s practice to specified professional services, restricted activities or practice settings;

(c) limiting a practice permit to a specified purpose and time;

(d) practicing under the supervision of another regulated member for the period of time considered necessary by the Registrar;

(e) reporting to the Registrar on specified matters on specified dates.

Alternative Complaint Resolution

Process conductor

31 When a complainant and an investigated person have agreed to enter into an alternative complaint resolution process, the
Continuous Professional Development

DRAFT Rules for Member Participation

Issued: August XX, 2015

Rules for the College Programs are required under the Health Professions Act Regulations for Physicians, Surgeons and Osteopaths Profession. Rules address various parameters for a program including requirements for member participation.

(1) A regulated member on the General Register, Provisional Register, Telemedicine Register, Physician Assistant General Register, Physician Assistant Provisional Register of the College with an active practice permit must be continuously enrolled and in good standing with the MAINPRO program of the College of Family Physicians of Canada, the MOC/CPD program of the Royal College of Physicians & Surgeons of Canada, or the continuing professional development program established or approved by the Canadian Association of Physician Assistants, as the case may be.

(2) A regulated member must, when requested by the Registrar from time-to-time, provide evidence satisfactory to the Registrar that the regulated member is compliant with Rule 1.

(3) If a regulated member is non-compliant with Rule 1, the regulated member must, within thirty days of the regulated member first becoming non-compliant with Rule 1, make application to the Registrar for an exemption to or deferral of the application of Rule 1 to the regulated member.

(4) A regulated member must provide evidence satisfactory to the Registrar to support an exemption to or deferral of the application of Rule 1 to the regulated member.

(5) If the Registrar requires further evidence from a regulated member regarding an application under Rule 3, the regulated member must provide that further evidence by the deadline set by the Registrar.

(6) The Registrar must advise a regulated member in writing as to whether the exemption or deferral requested by the regulated member has been granted, with or without conditions as determined by the Registrar.

(7) A decision of the Registrar regarding an application under Rule 3 may, upon further application by the regulated member, be reviewed by Council.

(8) An application under Rule 7 must be submitted in writing to the Registrar within 30 days of the date of the Registrar’s decision under Rule 6, accompanied by the review fee, by the regulated member along with reasons for the application for review by Council.

Terms Used:
- Regulated member means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- Must refers to a mandatory requirement.
- May means that the physician may exercise reasonable discretion.
- Patient includes, where applicable, the patient’s legal guardian or substitute decision maker.
(9) The Registrar may grant an exemption to or deferral of Rule 1 in the following circumstances where a regulated member’s practice is limited to:

(a) supervised practice such as:

   (i) a regulated member exclusively in a training program; or

   (ii) a physician extender;

(b) surgical assisting (with no issuing or renewing of prescriptions and no writing of post-operative orders);

(c) an administrative position with no clinical duties and no provision of advice on diagnosis or treatment of patients;

1 A member must submit a copy of the Certificate of Completion of a CPD cycle upon request of the CPSA.

Terms Used:
- Regulated member means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- Must refers to a mandatory requirement.
- May means that the physician may exercise reasonable discretion.
- Patient includes, where applicable, the patient’s legal guardian or substitute decision maker.
(d) providing medico/legal advice based on a review of records and involving no examination of an individual;

(e) not resident in Alberta with no clinical duties in Canada; and

(f) practising in Alberta for less than three months each year and in full-time practice outside of Canada for the remainder of the year.

**Terms Used:**
- *Regulated member* means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- *Must* refers to a mandatory requirement.
- *May* means that the physician may exercise reasonable discretion.
- *Patient* includes, where applicable, the patient’s legal guardian or substitute decision maker.
DRAFT Rules for Member Participation in PAR Program

The Physician Achievement Review (PAR) Program has been in operation in Alberta since 1999, when it was established under the Medical Profession Act. As of December 16, 2009, the College came under the Health Professions Act (the “HPA”) and the Medical Profession Act was repealed. The PAR Program continues under the HPA and is operated by the Competence Committee as part of the continuing competence program of the College. The PAR program is a general assessment program under Section 22 of the Physicians, Surgeons and Osteopaths Profession Regulation (the “Regulations”) under the HPA.

Regulated members are required to participate in a general assessment under the PAR Program every five years. The general assessment is based on survey instruments established by the Competence Committee. All participating regulated members receive feedback from patients and others about their performance in practice. Some regulated members, based on the general assessment results, are also interviewed. If the results of the general assessment and the interview with the regulated member are unsatisfactory, the regulated member then undergoes a practice visit. After the practice visit, there may be a more detailed assessment. The nature and scope of such further assessment is set out in section 24 of the Regulations. The regulated member may also be required to undertake remediation which can include conditions on practice being imposed, be it temporary or permanent.

Pursuant to section 52 of the HPA, information from a regulated member’s participation in the College’s competence program is kept confidential by the Competence Committee. In limited circumstances, as set out in section 51.1 of the HPA, information about the regulated member can be given to the Complaints Director of the College if the Competence Committee believes there is a lack of competence that cannot be remedied, incapacity or unprofessional conduct. A failure or refusal to comply with the PAR program requirements is considered unprofessional conduct under the HPA.

1. All regulated members on the general and provisional registers of the College must fully participate in the general assessment under the PAR Program at least once every five years, unless granted a partial or full exemption as determined by the Competence Committee.

2. A regulated member must respond to communication from the Competence Committee or its delegate, be it received by mail, facsimile, email or telephone, in a timely manner and no later than 7 days after communication is received by mail, facsimile, email or telephone, unless the regulated member is granted an extension of that deadline as determined by the Competence Committee or its delegate.

3. A regulated member must make him or herself available within 30 days of request for an interview by the Competence Committee or its delegate, unless granted an extension of that deadline as determined by the Competence Committee or its delegate.

Approved by College Council in XX 2015
DRAFT Rules for Member Participation

Rules for the College Programs are required under the *Health Professions Act Regulations for Physicians, Surgeons and Osteopaths Profession*. Rules address various parameters for a program including requirements for member participation.

The College is obligated under the *Health Professions Act* (HPA) to establish and operate a competence program. The three broad components of the competence program are outlined in section 21 of the *Physicians, Surgeons and Osteopaths Profession Regulation* (Regulations) under the HPA. The Competence Committee is responsible for the operation of the College’s competence program. The competence program is intended to identify regulated members whose competence may require further assessment and possibly improvement through further education. The Physician Prescribing Practices (PPP) program is operated by the Competence Committee to monitor the prescribing practices of regulated members for certain drugs identified by Council as being included on the Type 1 and Type 2 Triplicate Prescription Monitored Medication lists. Any regulated member who prescribes triplicate prescription monitored medication must comply with the rules of that program.

The Competence Committee establishes at risk prescribing parameters and regulated members whose prescribing is identified from the TPP database as at risk are provided an educational intervention. Those regulated members who do not demonstrate satisfactory improvement following the intervention receive remediation as directed under Section 27 of the Regulations.

Pursuant to section 52 of the HPA, information from a regulated member’s participation in the College’s competence program is kept confidential by the Competence Committee. In limited circumstances, as set out in section 51.1 of the HPA, information about the regulated member can be given to the Complaints Director of the College if the Competence Committee believes there is a lack of competence that cannot be remedied, incapacity or unprofessional conduct. A failure or refusal to comply with the PPP program requirements is considered unprofessional conduct under the HPA.

The rules for regulated members participating in the PPP program are:

(1) A regulated member is responsible for the triplicate prescription forms issued to the member by the PPP Program.

(2) A regulated member must ensure that all blank triplicate prescription forms are kept secure at all times.

(3) A regulated member must use a triplicate prescription form only when prescribing a pharmaceutical product on the Type 1 Triplicate Prescription Program Monitored Medication list.

(4) A regulated member must maintain triplicate prescription information as part of the patient record for ten (10) years by:

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**Terms Used:**

- *Regulated member* means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- *Must* refers to a mandatory requirement.
- *May* means that the physician may exercise reasonable discretion.
- *Patient* includes, where applicable, the patient’s legal guardian or substitute decision maker.
(a) keeping the physician’s copy of the issued triplicate prescription forms in an accessible, secure location, or

(b) attaching the physician’s copy of the triplicate prescription form to the patient record, or

(c) making a notation on the patient’s chart with details of the triplicate prescription, including the triplicate prescription number, or

(d) in the case of electronic medical records, inserting either:
   (i) a clear, scanned version of the physician copy of the triplicate prescription form, or
   (ii) a notation with details of the triplicate prescription, including the triplicate prescription number.

(5) A regulated member must promptly report to the PPP program any lost, missing or stolen triplicate prescription forms issued to the member.

Terms Used:

- **Regulated member** means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- **Must** refers to a mandatory requirement.
- **May** means that the physician may exercise reasonable discretion.
- **Patient** includes, where applicable, the patient’s legal guardian or substitute decision maker.
Physician Competence Assessment

DRAFT Rules for Member Undergoing Assessment

Issued: August XX, 2015

Rules for the College Programs are required under the Health Professions Act Regulations for Physicians, Surgeons and Osteopaths Profession. Rules address various parameters for a program including requirements for member participation.

The College is obligated under the Health Professions Act (HPA) to establish and operate a competence program. The three broad components of the competence program are outlined in section 21 of the Physicians, Surgeons and Osteopaths Profession Regulation (Regulations) under the HPA. The Competence Committee is responsible for the operation of the College’s competence program. The competence program is intended to identify regulated members whose competence may require further assessment and possibly improvement through further education. Section 24 of the Regulations sets out a broad range of tools available to the Competence Committee to assess competence, and include practice visits, interviews, examinations of skill, knowledge and physical and mental health.

Pursuant to section 52 of the HPA, information from a regulated member’s participation in the College’s competence program is kept confidential by the Competence Committee. In limited circumstances, as set out in section 51.1 of the HPA, information about the regulated member can be given to the Complaints Director of the College if the Competence Committee believes there is a lack of competence that cannot be remedied, incapacity or unprofessional conduct. A failure or refusal to comply with the competence program requirements is considered unprofessional conduct under the HPA.

Council can establish rules under Section 25 of the Regulations as to how assessments are to be conducted. The rules for a regulated member undergoing an assessment under section 24 of the Regulations are:

(1) A regulated member who is directed by the Competence Committee or its delegate to participate in an assessment under section 24 of the Regulations shall cooperate with the requirements for the assessment within a reasonable timeframe provided by the Competence Committee or its delegate.

(2) Without limitation to the duties of a regulated member set out in the HPA, the co-operation required of a regulated member directed to participate in an assessment under section 24 of the Regulations will include:

(a) permitting the Competence Committee or its delegate to enter and inspect the premises where the regulated member engages in the practice of medicine, subject to the limitation set out in section 51(4) of the Act regarding private dwellings and publicly funded facilities,

(b) permitting the Competence Committee or its delegate to inspect the regulated member’s records of the care of patients,

Terms Used:
- Regulated member means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- Must refers to a mandatory requirement.
- May means that the physician may exercise reasonable discretion.
- Patient includes, where applicable, the patient’s legal guardian or substitute decision maker.
(c) providing to the Competence Committee or its delegate the information requested in respect of the practice of medicine conducted by the regulated member,

(d) providing the information in subsection (c) in the form requested by the Competence Committee or its delegate,

(e) answering questions posed by the Competence Committee or its delegate on matters going to medical competence and performance,

(f) conferring on the contents of a draft report of the assessment,

(g) meeting with the Competence Committee or its delegate and discussing final recommendations for practice changes or improvements, and

(h) demonstrating the adoption of recommendations or improvements.

(3) A regulated member who is directed by the Competence Committee or its delegate to participate in an interview for follow-up of an assessment shall make him or herself available within 30 days for the interview unless an extension is granted.

(4) A regulated member who is directed by the Competence Committee or its delegate to undertake a more detailed assessment of clinical knowledge and skills shall cooperate with the requirements for that assessment within a reasonable timeframe provided.

(5) The co-operation required of a regulated member in regard to a more detailed assessment may include, but not limited to, travel and attendance at a competence assessment program acceptable to the Competence Committee or its delegate and payment of the associated costs.

(6) Assessments of professional competence under subsection (5) may include medical knowledge and skills, communication skills, and fitness for practice.

(7) In the event of an unsatisfactory assessment, the Competence Committee or its delegate may direct a regulated member to undertake one or more remedial actions in accordance with section 27 of the Regulations which may include participation in the College’s practice visit program for a more detailed assessment.

(8) A regulated member who is directed to restrict, modify, or improve their practice shall comply with that direction to the extent that, at a minimum, the Competence Committee or its delegate is satisfied that the regulated member’s practice does not constitute an unreasonable risk of harm to patients.

(9) The Competence Committee or its delegate shall refer a matter to the Complaints Director if the Competence Committee or its delegate has reasonable grounds to believe that a regulated member:

(a) may be guilty of criminal conduct or unprofessional conduct, whether in a professional capacity or otherwise,

(b) may be incapacitated,

(c) displays a lack of skill or judgment in carrying out the professional practice that has not been remedied by participation in the Physician Prescribing Practices Program, or

Terms Used:
- **Regulated member** means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- **Must** refers to a mandatory requirement.
- **May** means that the physician may exercise reasonable discretion.
- **Patient** includes, where applicable, the patient’s legal guardian or substitute decision maker.
(d) has refused or failed to comply with a direction of the Competence Committee or delegate or these rules.

(15) The Competence Committee’s delegate will report to the Competence Committee on request and at least yearly all activity which has been delegated by the Competence Committee to the delegate including referrals to the Complaints Director and actions taken with members.

Terms Used:
- *Regulated member* means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- *Must* refers to a mandatory requirement.
- *May* means that the physician may exercise reasonable discretion.
- *Patient* includes, where applicable, the patient’s legal guardian or substitute decision maker.
Briefing Note

To: Council

From: Dr. Kate Reed, Assistant Registrar

Date: 4 September 2015

Subject: Regulation of Physician Assistants

Issue:
Council needs to determine the criteria for registration on the various registers for physician assistants, repeal the sections of Bylaw 24 that permit registration of physician assistants as non-regulated members, and establish the liability protection requirement once physician assistants become regulated members of the College of Physicians and Surgeons of Alberta.

Background:
The Government of Alberta plans to name physician assistants as regulated health professionals whose regulatory authority will be the College of Physicians and Surgeons of Alberta. It is anticipated that the necessary amendments to the Health Professions Act and the Physician, Surgeons, and Osteopaths Profession Regulation will be in place such that the CPSA will start regulating physician assistants beginning 01 July 2016. As regulated members who must always work under the supervision of a regulated physician or osteopath, physician assistants will be subject to the same Standards of Practice that apply to the supervising member(s). The only modification required to the current Standards of Practice is to alter the language to make them inclusive of all regulated members. This process is underway.

Subsections 4 - 8 of Bylaw 24 were created to enable the CPSA to register physician assistants as non-regulated members. Once physician assistants are regulated, the criteria for registration as non-regulated members will be redundant. See Attachment 1, Non-Regulated Members.

The criteria for the physician assistant regulated member registers need to be established. The proposed criteria are presented in Attachment 2, Physician Assistant Registers.

The Health Professions Act 28(1)(c) states that an application for registration as a regulated member includes “evidence of having the amount and type of professional liability insurance, if required by the regulations.” The Regulations (13.1) state that a regulated member must have the amount of professional liability insurance required by the Council. Council needs to establish the liability protection required of regulated physician assistants. See Attachment 3, Physician Assistant Liability Protection.
Recommendations:

1. That Council repeal subsections (4) - (8) of Bylaw 24 as of the date the regulation creating the registration categories for physician assistants becomes effective. Subsections (1) - (3) of Bylaw 24 will remain in force. See Attachment 1, *Non-Regulated Members*.

2. That Council approve the criteria for the Physician Assistant regulated member registers as detailed in Attachment 2, *Physician Assistant Registers*.

3. That Council approve the liability protection requirement as detailed in Attachment 3, *Physician Assistant Liability Protection*. 
(1) The Retired Member Register includes \textit{the names of those former regulated members} who:
   
   (a) have retired from the practice of medicine; and  
   (b) were in good standing with the College on the date of retirement.

(2) Each applicant for registration as a retired member must:
   
   (a) notify the College in writing of the effective date of retirement; and  
   (b) submit the annual fee.

(3) A retired member shall not practise medicine in Alberta.

(4) The Physician Assistant register includes the names of non-regulated members who are:
   
   (a) A graduate of a Physician Assistant training program meeting one of the following criteria:
      
      (i) provided through the Canadian Forces Medical Services School,  
      (ii) accredited by the Canadian Medical Association Conjoint Accreditation Process in Canada, or  
      (iii) accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States of America, and  
   
   (b) A certified Physician Assistant with one of the following credentials:
      
      (i) Canadian Certified Physician Assistant (CCPA), granted by the Physician Assistants Certification Council of the Canadian Association of Physician Assistants, or  
      (ii) Physician Assistant – Certified (PA-C), granted by the National Commission on Certification of Physician Assistants in the United States of America.

(5) Each applicant for registration as a Physician Assistant must:
   
   (a) complete the application form to the satisfaction of the Registrar, and  
   (b) submit the registration fee.

(6) A Physician Assistant shall only work under the supervision of a regulated member on the General Register or the Provisional Register Conditional Practice, and that regulated member will take responsibility for the clinical performance of the Physician Assistant.

(7) If the Registrar determines that a Physician Assistant has not paid the registration fee or an annual fee, has not worked only under the supervision of a regulated member, has provided incomplete or inaccurate information to the Registrar or no longer qualifies for registration as a Physician Assistant, the Registrar may cancel the registration of the Physician Assistant.

(8) If the Registrar cancels the registration of a Physician Assistant under subsection (7), the Registrar may publish the information as the Registrar determines is required in the circumstances.
Physician Assistant General Register

Definition:
This register permits physician assistants to participate in practice that may include remote supervision. Remote supervision is defined as supervision by a regulated physician at a distance from which urgent attendance to the patient is not possible within a reasonable amount of time.

Criteria for registration:
1. Standard Route:
   a. Successful completion of a physician assistant training program meeting one of the following criteria:
      i. provided through the Canadian Forces Medical Services School,
      ii. accredited by the Canadian Medical Association Conjoint Accreditation Process in Canada, or
      iii. Accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States of America, and
   b. One of the following physician assistant certifications:
      i. Canadian Certified Physician Assistant (CCPA), granted by the Physician Assistants Certification Council of Canada, or
      ii. Physician Assistant – Certified (PA-C), granted by the National Commission on Certification of Physician Assistants in the United States of America.
   c. English language proficiency
   d. Offer of employment as a physician assistant in Alberta that is satisfactory to the Registrar
2. Equivalent Jurisdiction Route (AIT):
   a. Regulated by, and on the Physician Assistant General Register equivalent of a medical regulatory authority in another Canadian jurisdiction,
   b. In good standing, and
   c. Offer of employment as a physician assistant in Alberta that is satisfactory to the Registrar which indicates the primary supervising physician
3. Substantial Equivalency Route:
   a. On the Physician Assistant Provisional Register of the College of Physicians and Surgeons of Alberta,
   b. Good standing, and
   c. One of the following
      i. Canadian Certified Physician Assistant (CCPA), granted by the Physician Assistants Certification Council of Canada, or
      ii. Physician Assistant – Certified (PA-C), granted by the National Commission on Certification of Physician Assistants in the United States of America,

Conditions related to registration:
- Must, at all times, work under the primary supervision of the regulated physician member identified in the offer of employment. (For information, not to be included in the motion: The name of the supervising physician will appear on the practice permit.)
This register is for those who do not satisfy the criteria for the Physician Assistants General Register, but who have the training and competencies to practice as a physician assistant. This form of registration is valid for two years and permits the physician assistant to practice under direct supervision only. Direct supervision is defined as supervision by a regulated physician who is immediately available to attend the patient(s) cared for by the physician assistant. Successful adherence to all of the conditions of this register will allow the candidate to be transferred to the Physician Assistant General Register via the Substantial Equivalency Route.

Criteria for registration:
1. One of:
   a. Successful completion of a physician assistant training program provided through the Canadian Forces Medical Services School, a programme accredited by the Canadian Medical Association Conjoint Accreditation Process in Canada, or a programme accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States of America, or
   b. Successful completion of a physician assistant training program outside Canada or the United States of America that was based on the medical model, at least two years in duration, and was accredited by the Canadian Medical Association Conjoint Accreditation Services, and

2. One of:
   a. National physician assistant certification in the country where the training was undertaken,
   b. If no national certification available, evidence of past or current registration or licensure as a physician assistant in the country in which the training was completed, or
   c. One of the following
      i. Canadian Certified Physician Assistant (CCPA), granted by the Physician Assistants Certification Council of Canada, or
      ii. Physician Assistant – Certified (PA-C), granted by the National Commission on Certification of Physician Assistants in the United States of America.

3. English language proficiency,
4. Offer of employment as a physician assistant in Alberta that is satisfactory to the Registrar, and
5. Successful completion of a practice-based assessment satisfactory to the Registrar

Conditions related to registration:
- Must, at all times, work under the direct supervision of the regulated physician member identified in the offer of employment. *(For information, not to be included in the motion: The name of the supervising physician will appear on the practice permit.)*
- May only work in an Alberta Health Services facility under the direct supervision of the supervising regulated physician.
- Must qualify for the General Register within two years of the date of entry on this register

**Physician Assistant Courtesy Register**

**Definition:**
This register is for physician assistants whose practice of medicine is restricted to providing physician assistant instruction or participating in a physician assistant learning activity
Criteria for registration

1. Successful completion of an accredited physician assistant training programme in Canada, the United States of America, or an international programme accredited by the Canadian Medical Association Conjoint Accreditation process,
2. Physician assistant licence/registration in good standing in the home jurisdiction,
3. Application is supported by a regulated physician member registered for independent practice in Alberta, and
4. The courtesy activity contemplated is satisfactory to the Registrar. (*For information, not part of the motion: The supporting physician member must provide direct supervision of the Physician Assistant during this activity.*)

Conditions related to registration:
- At all times, must be under the direct supervision of the regulated physician member who supported the Physician Assistant’s participation in the Courtesy activity. (*For information, not part of the motion: The name of the supervising physician will appear on the practice permit.*)

Physician Assistant Student Register

Definition:
This register is for all those students enrolled in a physician assistant educational programme at a university in Alberta, the Canadian Forces Medical Services School, or at an accredited programme of physician assistant education at another institution in Canada or the United States of America, who are participating in a period of education in Alberta.

Criteria for registration:
One of
1. Accepted into a physician assistant degree programme in the Canadian Armed Forces or at a university in Alberta, or
2. All of the following:
   a. Proof of enrolment in an accredited physician assistant training programme at an institution in Canada or the United States of America,
   b. Letter of acknowledgement from the home programme confirming that participation in a period of training in Alberta will satisfy part of the educational requirements, (*for information, not for the motion: this will include confirmation of the duration, including specific dates*), and
   c. Confirmation by the lead training preceptor, who is a regulated physician member, that the student is participating in an educational activity in Alberta.

Conditions related to registration:
- Must, at all times, work under the primary supervision of regulated physician member or a regulated physician assistant member while participating in activities related to a physician assistant training programme in Alberta.
Attachment 3

Physician Assistant Liability Protection Requirement

Physician Assistants must have professional liability protection through one of the following:

- Participation in the liability protection programme offered to members of the Canadian Association of Physician Assistants,
- A policy of professional liability insurance that provides coverage of at least $10 million issued by a company licensed to carry on business in the province of Alberta, or
- Through the employer (the physician assistant attests to being an employed physician assistant who provides services only to other employees and the employer carries liability protection that extends to the physician assistant’s professional services)
Briefing Note

To: Council

From: Dr. Kate Reed, Assistant Registrar

Date: 4 September 2015

Subject: Liability Protection

Issue: Should Council amend the amount of professional liability protection required of regulated physician members who are not members of the Canadian Medical Protective Association?

Background: Council Motion 39-07 added liability coverage to the Medical Profession Act Bylaws Part B and established that members must have coverage of at least $10,000,000. Under the Health Professions Act, the Regulations address the issue of liability coverage. The Physicians, Surgeons, and Osteopaths Profession Regulation Section 13(1) states that a regulated member must provide evidence of having the type and amount of professional liability insurance required by the Council. The Regulation further states that membership in the Canadian Medical Protective Association is considered to meet the requirement to have professional liability insurance. Physician members have the following options available for liability protection:

1. Professional liability protection through Membership in the Canadian Medical Protective Association,
2. Professional liability protection through a policy of professional liability insurance that provides coverage of at least $10 million issued by a company licensed to carry on business in the province of Alberta, or
3. Employed physician who provides medical services only to other employees and whose employer carries liability protection that extends to the member’s professional services

The following table shows the members’ annual renewal form responses regarding liability protection for the last five years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>7737</td>
<td>163</td>
<td>109</td>
</tr>
<tr>
<td>2012</td>
<td>8230</td>
<td>164</td>
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<td>2013</td>
<td>8583</td>
<td>156</td>
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<td>2014</td>
<td>9051</td>
<td>175</td>
<td>147</td>
</tr>
<tr>
<td>2015</td>
<td>9390</td>
<td>223</td>
<td>202</td>
</tr>
</tbody>
</table>

Information from CMPA legal counsel includes:

- $10,000,000 would be adequate coverage for 90 – 95% of cases settled through CMPA
• There have been several awards in the last few years in which the settlement has been for much more than $10,000,000, with some reaching into the low 20+ million range.
• Theoretically, a member would be personally liable for any amount awarded that is greater than the limit of the liability protection in place.
• $10 million may have been reasonable coverage at the time of motion 39-07 in 2007, but may not be now.

**Recommendation:**

That the minimum liability protection a member must have, if not covered through the Canadian Medical Protective Association, is at least [amount to be advised by the CMPA*].

*Advice pending at time of submission of document to the dossier.*
The Legislation Committee met on Monday June 22, 2015. Minutes are attached.

The Committee reviewed the submission to Alberta Health regarding Health Professions ACT (HPA) amendments that were approved by the Legislation Committee in 2014. The members of the Committee felt that additional changes are needed particularly as it relates to the power of the Minister or Cabinet to act in place of a College.

The Alberta Fatality Inquiries Act was discussed in relation to Physician Assisted Death (PAD). The Committee believes that changes to the AFIA are needed regarding the manner of death and the reporting expectations.

The Committee makes the following recommendations to Council:

1. That Council should advocate for removal of language in the Health Professions Act (HPA) that allows the Minister or Cabinet to either replace the functions of a College or direct a College to adopt bylaws, regulations or standards (see historic [Bill 41] Health Professions Statutes Amendment Act, 2007 and August 2007 Messenger).

2. That Council should identify preferred reporting expectations for PAD and advocate for legislative changes to address manner of death identifications in the AFIA.
Legislation Committee Monday, June 22, 4:00 p.m. – 5:00 p.m.

Attending: Maeve O’Beirne, Graham Campbell, Pauline Alakija, Jim Stone, Karen Mazurek, Marian Stuffco, Sarah Thomas

Regrets: Trevor Theman

| 1. Welcome | MO | • Round table introduction |
| 2. Review TOR & Group Expectations | MO | • Group shared perspectives on the roles and responsibilities of the committee including: a need to meet more frequently, roles identified in the TOR |

**Outcome**
- LC to meet quarterly as discussion items require.
- LC to review TOR scope during a future meeting.

| 3. (a) Pending Amendments HPA & HIA | KM | • Karen gave a brief overview of the submissions. The following sections were highlighted by committee members for discussion:  
• HPA Submission entry 5 – Entry into facilities for practice visits, inspections and investigations.  
• HPA Submission entry 10 – Supervision of physicians.  
• HPA Submission entry 11 - Enforcement of mandatory registration |

**Outcome**
- Recommend to Council to advocate for removal of language in the Health Professions Act (HPA) that allows the Minister or Cabinet to either replace the functions of a college or direct a college to adopt bylaws, regulations or standards (see historic [Bill 41] Health Professions Statutes Amendment Act, 2007 and August 2007 Messenger).

Moved by Pauline  
Second by Graham  
All in favour

**Next Step**
- Identified opportunity to reference HPA recommendation 10 when reviewing *Direction and Control* in the SOP renewal
process and the providing input into the work of the accreditation department.

<table>
<thead>
<tr>
<th>3. Albert Fatal Inquiries Act (AFIA)</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reporting of physician-assisted dying (PAD) is unclear under the AFIA.</td>
<td></td>
</tr>
<tr>
<td>• AFIA identifies expectations for deaths that require notification and reporting the manner of death.</td>
<td></td>
</tr>
</tbody>
</table>

**Outcome**

Recommend to Council to:
- identify preferred reporting expectations for PAD
- advocate for legislative changes to address PAD manner of death identification in the AFIA.

Moved by Pauline
Second by Graham
All in favour

**Next step**
LC committee to develop a brief backgrounder on this topic.

<table>
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<tr>
<th>4. Other topics</th>
<th>None.</th>
</tr>
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<tr>
<th>5. Next Meeting</th>
<th>• The committee expressed a desire to meet quarterly.</th>
</tr>
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<tbody>
<tr>
<td><strong>Next steps</strong></td>
<td>Identify staff support for the committee.</td>
</tr>
</tbody>
</table>
MEMORANDUM

To: Council

From: Dr. Susan Ulan

Date: August 20, 2015

Subject: Monitoring of Long-Acting Methylphenidate

Background:

Methylphenidate is considered to be one of the most efficacious choices in treating Attention Deficit Hyperactivity Disorder (ADHD), with long-acting formulations as first line agents, according to the Canadian ADHD Resource Alliance practice guidelines. One long-acting methylphenidate formulation, Concerta®, has been exempted from the Triplicate Prescription Program (TPP) list of monitored medications because it is accepted that this formulation has reduced abuse potential. The generic version of Concerta® currently requires a triplicate prescription.

In 2009, the AMA Section of Child and Adolescent Psychiatry requested that the TPP Steering Committee consider a more consistent approach to monitoring stimulants given that long-acting stimulant preparations are less likely to be abused to achieve a “high” compared to the short-acting preparations and improved compliance with once daily dosing. The decision was made at that time that once PIN data could support the TPP, the requirement to use a triplicate prescription for long-acting stimulants with tamper-resistant properties would be reviewed.

The Alberta Paediatric Society (APS) has been in regular contact with the TPP Steering Committee to request that another long-acting methylphenidate preparation, Biphentin®, be exempt from the requirement to use a triplicate prescription. The APS feels that the inclusion of Biphentin® in the TPP is an unnecessary barrier to effective treatment given the lack of evidence that Biphentin® has any increased risk of misuse or abuse compared to Concerta® or any other long acting stimulant.

After significant discussion and review of available literature the TPP Steering Committee passed a motion at the May 21, 2015 meeting that all long-acting methylphenidate medications
be considered Type 2 TPP monitored medications and will not require that prescribers use a triplicate prescription. All short-acting methylphenidate preparations such as Ritalin® will continue to be considered Type 1 TPP medications and require that prescribers use a triplicate prescription. All methylphenidate products will continue to be monitored by the TPP.

**Action:**

Final approval to move long-acting methylphenidate medications to the Type 2 TPP medication list requires approval of the College of Physicians & Surgeons of Alberta Council. The TPP Steering Committee requests the endorsement of Council to monitor all long-acting methylphenidate preparations as Type 2 medications on the Triplicate list and **not** require these products to be written on triplicate pads.