March 18, 2026 CPSM Council Meeting

REVISED AGENDA

CPSM Office – Brown Room 1000 – 1661 Portage Avenue

Time		Item		Action		Page #
5 min	8:00 am	1.	**Opening Remarks and Land Acknowledgment**		Dr. Penner	
0 min	8:05 am	2.	**Agenda – Approval**		Dr. Penner	
0 min	8:05 am	3.	**Call for Conflict of Interest**		Dr. Penner	3
5 min	8:05 am	4.	**Consent Agenda** i. **Council Meeting Minutes** • **December 10, 2025** • **February 10, 2025 (Electronic Vote)** ii. **New Policies and Other Changes to CPSM's Registration Requirements**	For Approval	Dr. Penner	4
5 min	8:10 am	5.	**Regulation Status Update** • **Reducing Barriers for Provisional Registration of Family Registrant Update** • **Regulatory Changes to Address Emergency Room Shortages Update**	For Information	Dr. Penner	87
20 min	8:15 am	6.	**Practice Ready Assessment for Emergency Doctors**	For Information	Dr. Penner/ Dr. Mihalchuk	90
40 min	8:35 am	7.	**Standard of Practice Collaborative Care Consultation**	For Approval	Dr. Penner/ Dr. Mihalchuk/ Dr. Süss/ Mr. Triggs	92
20 min	9:15 am	8.	**Request/Communication with Community Living Manitoba regarding Healthcare for Persons with Intellectual Disabilities and/or Persons with Autism**	For Discussion	Dr. Penner/ Dr. Mihalchuk/ Mr. Triggs	209
10 min	9:35 am	9.	**CPSM Support of proposed amendments to The Mental Health Act**	For Approval	Dr. Penner/ Dr. Mihalchuk/ Mr. Triggs	218
5 min	9:45 am	10.	**Prescribing Opioids and Prescribing Benodiazepines and Z-Drugs Working Group Update**	For Information	Dr. Penner/ Mr. Triggs	237
10 min	9:50 am	11.	**Elections Committee Update**	For Information	Dr. Convery	238
20 min	10:00 am	12.	**Consultation for New Standard of Practice - Entering a New Practice Setting**	For Approval	Dr. Shenouda/ Mr. de Jong	239
20 min	10:20 am		**------ BREAK ------**			

Time		Item		Action		Page #
20 min	10:40 am	13.	**2026-27 CPSM Budget & Certificate of Practice Fees** • **Financial Management Policy Amendments**	**For Approval**	**Dr. Convery/ Mr. Penner**	**254**
30 min	11:00 am	14.	**Registrar and CEO Report** • **Performance Metrics Update – Proposed 2026-2027 Metrics** • **Operational Reports** • **Trends/Topics in Regulation**	**For Information**	**Dr. Mihalchuk**	**281**
10 min	11:30 am	15.	**Council Committees Reports (questions taken)** • **Executive Committee** • **Board of Assessors** • **Complaints Committee** • **Central Standards Committee** • **Elections Committee** • **Finance, Audit & Risk Management Committee** • **Inquiry Committee** • **Investigations Committee** • **Program Review Committee** • **2026/2027 Council Dates**	**For Information**	**Dr. Mihalchuk**	**308**
20 min	11:40 am		------ LUNCH ------			
15 min	12:00 pm	16.	**Performance Metrics – IT**	**For Information**	**Mr. Penner**	**317**
5 min	12:15 pm	17.	**Council Training**	**For Information**	**Dr. Penner**	**321**
15 min	12:20 pm	18.	**In Camera**	**For Discussion**		
	12:35 pm	19.	**Review of Self-Evaluation of Governance Process-survey via email**		**Dr. Penner**	
4 hours, 35 minutes			**Estimated time of sessions**			

Regulated Health Professions Act

Duty to serve the public interest

s. 10(1) A college must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest.

CPSM Mandate

10(2) A college has the following mandate:
  (a)   to regulate the practice of the health profession and govern its members in accordance with this Act and the regulations and by-laws;
  (b)   to develop, establish and maintain standards of academic or technical achievement and qualification required for registration as a member and monitor compliance with and enforce those standards;
  (c)   to develop, establish and maintain standards of practice to enhance the quality of practice by members and monitor compliance with and enforce those standards;
  (d)   to develop, establish and maintain a continuing competency program for members to promote high standards of knowledge and skill;
  (e)   to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues;
  (f)   to work in consultation with the minister towards achieving access for the people of Manitoba to adequate numbers of qualified and competent members of the regulated health profession;
  (g)   to develop, establish and maintain programs that provide information about the health profession, and that assist persons in exercising their rights under this Act and the regulations, by-laws and code of ethics;
  (h)   to promote and enhance the college's relations with its members, other colleges, key stakeholders and the public;
  (i)   to promote inter-professional collaboration with other colleges;
  (j)   to administer the college's affairs and perform its duties and carry out its powers in accordance with this Act and the regulations and by-laws.

CPSM Governance Policy – Governing Style and Code of Conduct:

1.1 General

Council recognizes its accountability to the people of Manitoba to carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest. To that end, Council will govern with an emphasis on strategic leadership, including a commitment to obtaining public and membership input, encouragement of diverse viewpoints, and clear distinction of Council and staff roles.
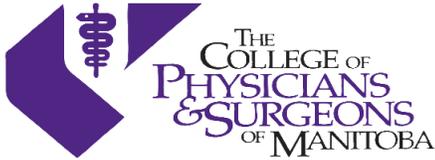
COUNCIL MEETING
MARCH 18, 2026
CONSENT AGENDA
NOTICE OF MOTION FOR APPROVAL

SUBJECT: Consent Agenda

BACKGROUND:

In order to make Council meetings more efficient and effective the consent agenda is being used. Routine and non-contentious business has been consolidated into a 'consent agenda'. Many organizations and their committees use consent agendas. Below is how the consent agenda works:

1. The President decides which items will be placed on the consent agenda. The consent agenda appears as part of the normal meeting agenda.

2. The President authorizes the consent agenda and associated documents distribution in time for members to read and review.

3. At the beginning of the meeting, the President asks members if any of the consent agenda items should be transferred to the regular discussion items.

4. If a member requests an item be transferred, it must be transferred. Any reason is sufficient to transfer an item. A member can transfer an item to discuss the item, to query the item, or to vote against it.

5. Once the item has been transferred, the President may decide to take up the matter immediately or transfer it to a discussion item.

6. When there are no items to be transferred or if all requested items have been transferred, the President notes the remaining consent items.

The President Elect can move to adopt the consent agenda, and a seconder is required. A vote will be called on approving the items in the consent agenda. There will be a single (en bloc) motion for all the items included in the consent agenda.

The following items are on this consent agenda for approval. See attached for details on each item.

i.   Council Meeting Minutes - December 10, 2025
ii.   Special Council Meeting Minutes - February 12, 2026 (electronic vote)
iii.   New Policies and Other Changes to CPSM's Registration Requirements:
    a. **Draft:** Council Policy - Registration in the Full (Practicing) and Full (Non-Practicing) Classes
    b. **Draft:** Council Policy - Registration in the Provisional (Academic - Post s. 181 Faculty) and the Provisional (Academic - Visting Professor) Classes
    c. **Draft:** Council Policy - Registration in the Provisional (Academic - Post Certification Trainee) Class

d. **Amendments:** Council Policy - English Language Proficiency
e. **Amendments:** Council Policy - Registration in the Provisional Family Practice - Limited, Assessment Candidate (Family Practice), and Provisional (Non-Practicing) Classes
f. **Amendments:** Council Policy - Registration of Clinical and Physician Assistant and Physician Assistant Students
g. **Amendments:** Council Policy - Supervision of Provisional Registrants
h. **Amendments:** Practice Direction - Practice and Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students

MOTION:
NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 18, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

All items on the consent agenda are approved as presented.

Notice of Motion for Approval Briefing Note Prepared by: Mr. Mike Triggs, General Counsel

MINUTES OF COUNCIL

Council of The College of Physicians and Surgeons of Manitoba met on December 10, 2025, at the CPSM Office with an option to join virtually via Zoom.

CALL TO ORDER

The meeting was called to order at 08:02 a.m. by the Chair of the meeting, Dr. Charles Penner.

COUNCILLORS:
Dr. Ganesan Abbu, Winkler **(V)**
Dr. Kevin Convery, Morden **(V)**
Dr. Caroline Corbett, Winnipeg
Mr. Allan Fineblit, Public Councillor
Dr. Wendy MacMillan-Wang, Associate Member
Ms. Lynette Magnus, Public Councillor
Dr. Rizwan Manji, Winnipeg
Dr. Jennifer McNaught, Winnipeg
Ms. Marvelle McPherson, Public Councillor
Dr. Lisa Monkman, Scanterbury **(V)**
Dr. Charles Penner, Brandon
Ms. Leanne Penny, Public Councillor
Dr. Nader Shenouda, Oakbank
Dr. Alewyn Vorster, Treherne **(V)**

STAFF:
Dr. Ainslie Mihalchuk, Registrar & CEO
Dr. Guillaume Poliquin, Assistant Registrar, C/I **(V)**
Mr. Mike Triggs, General Counsel
Mr. Paul Penner, Chief Financial Officer
Dr. Sonja Bruin, Assistant Registrar, Quality
Mr. Jeremy de Jong, Interim Director Registration **(V)**
Ms. Barbie Rodrigues, Senior Executive Assistant
Ms. Wendy Elias-Gagnon, Communications Officer
Ms. Helena Tessier, Executive Assistant
Ms. Stacey Carlson, Executive Assistant

REGISTRANTS:
Dr. Richard McCammon
Dr. Alexis Botkin **(V)**

REGRETS:
Mr. Neil Cohen, Public Councillor
Dr. Chaitasi Intwala, Winnipeg
Dr. Peter Nickerson, Winnipeg
ABSENT:
Ms. Lesile Agger, Public Councillor

1.   **OPENING REMARKS AND LAND ACKNOWLEDGEMENT**

     Dr. Penner conveyed the CPSM Land Acknowledgment.

     During opening remarks, Dr. Penner advised on the following items:
     - No further update on the New Emergency Medicine Classification – Regulatory changes would be provided as Manitoba Health has not furnished any status update.
     - A portion of Agenda 9.0 Standard of Practice – Collaborative Care Public Consultation will be motioned to move to In-Camera.
     -

- As previously communicated, the Governance training session was cancelled due to a last-minute scheduling issue.
- Further assessment of the March 2026 Council meeting duration is to be determined relating to the Cyber Security training for Council members.

2. ADOPTION OF AGENDA

IT WAS MOVED BY MS. McPHERSON AND ADPOTED BY CONSENSUS:
CARRIED:

That the agenda be approved as presented.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

Dr. Penner called for any conflicts of interest to be declared. There being none, the meeting proceeded. Similarly, there was no request for an in-camera session.

4. CONSENT AGENDA – FOR APPROVAL

Dr. Penner provided an overview of how the Consent Agenda is used. Dr. Penner asked if any Councillors wished to discuss any of the consent agenda items.

IT WAS MOVED BY DR. DR. CONVERY, SECONDED BY MS. PENNY:
CARRIED

That the following item on the consent agenda be approved as presented:
   i. Council Meeting Minutes - September 24, 2025

5. COUNCILLOR ELECTION PROCESS PUBLIC CONSULTATION UPDATE – AMENDMENTS TO THE AFFAIRS OF THE COLLEGE BYLAW & AMENDMENTS TO GOVERNANCE POLICY – FOR APPROVAL

At the September 24, 2025 Council meeting, Council approved consultation on proposed amendments to *The Affairs of the College Bylaw.* The agenda material, including a revised bylaw, an amended Governance Policy and a draft Council Profile were considered.

IT WAS MOVED BY DR. DR. CONVERY, SECONDED BY MS. McPHERSON THAT:
Council approves the:
   • amendments to *The Affairs of the College Bylaw* contained in 5.2, Appendix B
   • recommended amendments to the Governance Policy
   • Council Profile contained in 5.4, Appendix D
Subject to reference to the "Nomination Committee" being changed to the "Election Committee".

Council further appoints Dr. Kevin Convery, Mr. Neil Cohen, and Dr. Rizwan Manji to the

Election Committee and authorizes the Executive Committee to appoint a female member of Council to the Election Committee for one annual election cycle.

CARRIED - 12 in favour, 1 abstaining

6. REDUCING BARRIERS FOR PROVISIONAL REGISTRATION OF FAMILY REGISTRANTS – FOR APPROVAL

A second 30-day consultation on amendments to the *CPSM General Regulation 163/2018* ended on November 15, 2025, and Council considered the results received.

IT WAS MOVED BY DR. DR. CONVERY, SECONDED BY DR. MANJI:

Council approved the regulation amendments to the subclause 3.19 (1) (B) of The College of Physicians and Surgeons of Manitoba General Regulation 163/2018, to reduce barriers for Provisional Registration of Family Registrants as follows:

"a total of at least 960 hours of direct patient clinical practice experience in family medicine in the preceding 36 months, for recency of practice; and a total of 2 years of independent practice since post graduate training."

CARRIED

7. STANDARD OF PRACTICE – PRESCRIBING OPIOIDS AND PRESCRIBING BENZODIAZEPINES AND Z-DRUGS – FOR DISCUSSION

A working group chaired by Dr. Penner will review:
- Standard of Practice – Prescribing Opioids,
- Standard of Practice – Prescribing Benzodiazepines & Z-Drugs, and
- Practice Direction – Rural, Remote and Underserved Populations: Access to Prescribed.

The membership will be a combination of registrants and public representatives who have experience in emergency medicine, family medicine, geriatrics psychiatry, pharmacy, opioid agonist therapy, Indigenous health issues, rural and remote issues.

It is anticipated that the working group will require 6 meetings to complete its recommendations to Council.

8. STANDARD OF PRACTICE – SENSITIVE EXAMINATIONS (NEW) – FOR APPROVAL

Based on consultations with victims of Dr. Arcel Bissonnette's sexual assaults, Manitoba Prosecution Services advise CPSM to create educational resources to inform patients about the procedures and expectations during sensitive physical examinations. CPSM considered the recommendation and concluded a preferred means to address the issue would be to create a new Standard of Practice related to sensitive examinations.

IT WAS MOVED BY DR. DR. CONVERY, SECONDED BY MS. MAGNUS:

Council authorize CPSM to develop a new Standard of Practice – Sensitive Examinations for Council's consideration.

CARRIED

--------BREAK----------- **(10:20-10:50 AM)**

9. **STANDARD OF PRACTICE – COLLABORATIVE CARE FOR CONSULTATION – FOR APPROVAL**

Dr. Penner requested a motion for an in-camera discussion to occur at 9:15 am; it was moved by Dr. Shenouda, seconded by Ms. Magnus. *Carried*

The motion was made to move in-camera to receive information from Doctors Manitoba that was not to be made publicly available at this point.

Dr. Penner requested a motion for the in-camera discussion to end and moved back to regular discussion at 9:46 am, it was moved by Mr. Fineblit, seconded by Ms. Magnus. *Carried*

IT WAS MOVED BY DR. DR. CONVERY, SECONDED BY DR. MACMILLAN WANG:

Council authorized CPSM to seek input for 30 days from registrants, stakeholders, and the public on the 3 proposed Standards of Practice and the proposed Practice Direction – Interprofessional Health Care Delivery.

CARRIED - 12 members in favour, 1 member opposing*.*

10. **IMG/ITP WORKING GROUP UPDATE (SURVEY RESULTS AND ORIENTATION PROGRAM) – FOR INFORMATION**

Dr. Shenouda provided a verbal update, and Dr. Bruin and Mr. de Jong provided a presentation to Council on the survey results and next steps in developing an orientation program and new Standard of Practice.

11. **2026-27 CPSM BUDGET APPROVAL CHANGE – FOR APPROVAL**

The current budget process has budget development occurring from February /March to May with final approval coming at the June Council meeting. The timing of the budget approval occurs almost 2 months after the fiscal year begins (May 1). The consequence of the current approval timing is CPSM operates for two months of the year without formal budget/spending approval.

IT WAS MOVED BY DR. DR. CONVERY, SECONDED BY DR. SHENOUDA:

Starting this upcoming fiscal year and moving forward, Council will approve the annual operating budget during the March Council meeting as presented and will update the Fee Bylaw with the revised fees at the June Council meeting.

CARRIED

12. REGISTRAR & CEO REPORT – FOR INFORMATION

Dr. Mihalchuk provided the Registrar and CEO report to Council which included the revised Performance Metrics scorecard as well as the Operational Report.

13. COMMITTEE REPORTS – FOR INFORMATION

The following Reports were presented to Council for information:
- Executive Committee
- Board of Assessors
- Central Standards Committee
- Complaints Committee
- Finance, Audit & Risk Management Committee
- Inquiry Committee
- Investigation Committee
- Program Review Committee

Discussion occurred around Standards committee reporting; it was determined that subject would be added to the March Council meeting as a discussion item.

14. IN CAMERA SESSION

An in-camera session was held.

There being no further business, the meeting ended at 12:16 PM.

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Dr. C. Penner, President

_____
Dr. A. Mihalchuk, Registrar & CEO

SPECIAL MINUTES OF COUNCIL
FEBRUARY 10, 2026
ELECTRONIC VOTE

Council of The College of Physicians and Surgeons of Manitoba held a special meeting on February 10, 2026 via electronic vote.

On behalf of Dr. Penner, Mr. Triggs sent email correspondence to Council for approval via electronic means as is authorized by **section 55** of the *Affairs of the College Bylaw*.

Pursuant to **4.3.2** of the *Governance Policy*, Council appointed Dr. Abbu and Mr. Cohen as substitute members of the Executive Committee to sit on appeal scheduled for February 25, 2026.

Pursuant to **section 56** of the *Affairs of the College Bylaw* the motion was passed with a simple majority of Councillors voting in favour by the time specified by 4:00 pm, Thursday, February 12, 2026.

Electronic votes received were a total of 11 in favour, motion carried.

_____
Dr. C. Penner, President
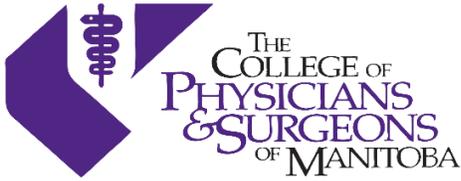
_____
Dr. A. Mihalchuk, Registrar & CEO

SUBJECT: New Policies and Other Changes to CPSM's Registration Requirements

BACKGROUND

We are seeking approval from the Council respecting the following new policies and changes to CPSM registration requirements. The Board of Assessors have endorsed these new policies and amendments to current requirements.

1. **Draft Council Policy – Registration in the Full (Practicing) & Full (Non-Practicing) Classes**

This is a newly drafted policy describing CPSM's requirements for registration in the full (practicing) and full (non-practicing) classes. No new changes to requirements are present, rather the intent is to bring all current requirements to one document to enhance accessibility.

The draft policy is attached as *Appendix A*.

2. **Draft Council Policy – Registration in the Provisional (Academic - s. 181 Faculty) Class and the Provisional (Academic – Visting Professor) Classes**

This is a newly drafted policy describing CPSM's requirements for registration in the provisional (academic – s. 181 faculty) class. No new changes to requirements are present, rather the intent is to bring all current requirements to one document to enhance accessibility.

The draft policy is attached as *Appendix B*.

3. **Draft Council Policy – Registration in the Provisional (Academic - Post-Certification Trainee) Class**

This is a newly drafted policy describing CPSM's requirements for registration in the provisional (academic – post-certification trainee) class. No new changes to requirements are present, rather the intent is to bring all current requirements to one document to enhance accessibility.

The draft policy is attached as *Appendix C*.

4. **Amendment to Council Policy for English Language Proficiency**

Amendments are proposed to *clause 1.1.1.* and footnote four to add clarification to our requirements, including that IELTS results from multiple sittings will be considered and ELP will not expire during the application period.

The Council Policy with tracked changes is attached as ==**Appendix D**==.
See tracked changes at *clause 1.1.1.* and footnote 4.

5. **Amendment to Council Policy for Registration in the Provisional Family Practice – Limited, Assessment Candidate (Family Practice-Limited) and Provisional (Non-Practicing) Classes**

Draft amendments to this policy include clarifying what constitutes satisfactory post-graduate training in family medicine, removing reference to the LMCC requirement, which was deleted from the *CPSM General Regulation*, and updating the process for applying to the PRA-FP.

In terms of post-graduate training requirements for provisional registration as a family physician, the most significant additions are:
- *"The training must be recognized in the jurisdiction where it took place as sufficient for certification or authorization to practice as a general practitioner or family physician."*
- *"CPSM may accept clinical rotations that take place as part of an internship program following undergraduate medical education."*

Clause 2.2. is updated to reflect that CPSM will be the front door for those who require referral to the PRA MB-FP.

The Council Policy with tracked changes is attached as ==**Appendix E.**==
See tracked changes at *clauses 1.3., 1.6.3., 1.7.2., 2.2.,* and *2.3.*

6. **Amendment to the Council Policy for Registration of Clinical and Physician Assistants and Physician Assistant Students**

Draft amendments at *clause 10.2.1.* are proposed because of **1)** the cancellation of the Clinical Assistant Assessment at the University of Manitoba and **2)** the MCCQE1 is the relevant part of the assessment (rather than holding the LMCC).

The Council Policy with tracked changes is attached as ==**Appendix F**==.
See tracked changes at *clause 10.2.1*.

7. **Amendment to the Council Policy for Supervision of Provisional Registrants**

Draft amendment to this policy to revise the minimum practice experience required for a

registrant to be approved as a Practice Supervisor for a provisional registrant, reducing it from two (2) years to one year of independent practice in Manitoba.
The Council Policy with tracked changes is attached as *Appendix G*.
See tracked changes at *clause 2.2.*

8. **Amendment to the Practice Direction for Practice and Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students**

Draft amendment to this Practice Direction to revise the minimum Manitoba practice experience required for a registrant to be approved as a supervisor for a Clinical or Physician Assistant, reducing it from two (2) years to one year of independent practice in Manitoba.

The Practice Direction with tracked changes is attached as *Appendix H*.
See footnote 9 on page 6.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 18, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

CPSM Council approve the following new policies and changes to CPSM registration requirements:

- Council Policy – Registration in the Full (Practicing) & Full (Non-Practicing) Classes
- Council Policy – Registration in the Provisional (Academic - s. 181 Faculty) Class
- Council Policy – Registration in the Provisional (Academic - Post-Certification Trainee) Class
- Amendment to Council Policy for English Language Proficiency
- Amendment to Council Policy for Registration in the Provisional (Family Practice-Limited) Class
- Amendment to the Council Policy for Registration of Clinical and Physician Assistants and Physician Assistant Students
- Amendment to the Council Policy for Supervision of Provisional Registrants
- Amendment to the Practice Direction for Practice and Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students

Notice for Motion for Approval Briefing Note prepared by: Mr. Jeremy de Jong, Director of Registration and Innovation.

<mark>DRAFT -</mark> COUNCIL POLICY

Registration in the Full (Practicing) and Full (Non-Practicing) Classes

Initial Approval:	Effective Date:
Reviewed with No Changes	Reviewed with Changes

Preamble:

This Policy relates to registration in the following classes:
- Full (Practicing) Class, and
- Full (Non-Practicing) Class.

Specific provisions of the *CPSM General Regulation* that apply to each of the above classes of registration are reproduced in this Policy for ease of reference. The purpose of this Policy is to set out additional registration requirements that have been approved by Council.

This Policy addresses what is required for a certificate of registration. It does not deal with the requirements for certificates of practice which are described at Part 4 of the *CPSM General Regulation*[1] and further in the Council Policy for Certificates of Practice.

1. **Full (practicing) class**

1.1. Purpose and overview

The Full (Practicing) Class allows for the unrestricted[2] and independent practice of medicine in Manitoba within an authorized field of practice. Applicants for registration in the Full (Practicing) Class must satisfy the following requirements from the *CPSM General Regulation*:[3, 4]
- the Common Requirements for all registrants of CPSM at s. 3.2,
- the Non-Exemptible Requirements for all Regulated Registrants at s. 3.7, and
- the Specific Requirements for this class at s. 3.8, including academic requirements.

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[1] Part 4 of the *CPSM General Regulation* establishes the requirements for issuing a certificate of practice. Of note, s. 4.1 states, "*A certificate of registration does not entitle a member to practise medicine. To do so, a member must also hold a certificate of practice. ...*"

[2] Subject to any terms and conditions deemed appropriate by the Registrar.

[3] RHPA at s. 32(1)

[4] Subsection 3.2(1) of the *CPSM General Regulation* at point 8.

1.2. Specific Requirements under the *CPSM General Regulation*

Specific requirements for registration in the Full (Practicing) Class are set out at section 3.8 of the *CPSM General Regulation*:

> *3.8 An applicant for registration as a full (practising) member must*
>   *(a) establish that he or she holds*
>   *(i) a medical degree granted from a nationally approved faculty of medicine[5], or*
>   *(ii) a Doctor of Osteopathic Medicine degree from a school in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation;*
>   *(b) establish that he or she meets one of the following criteria:*
>   *(i) he or she holds at least one of the following:*
>   *(A) certification from the CFPC,*
>   *(B) certification from the Royal College in a specialty field of practice,*
>   *(C) certification from the Collège des médecins du Québec,*
>   *(i.1) he or she*
>   *(A) holds affiliate status with the Royal College in a subspecialty,*
>   *(B) successfully completed a Royal College subspecialty examination through the Royal College — Subspecialist Examination Affiliate Program, and*
>   *(C) satisfactorily completed an approved period of supervised practice,[6]*
>   *(i.2) the applicant holds*
>   *(A) a licence issued by the medical board of a state of the United States to engage independently in the practice of medicine, and*
>   *(B) Member Board certification and has satisfactorily completed a post-graduate training program accredited by the Accreditation Council for Graduate Medical Education (USA),*
>   *(ii) he or she received*
>   *(A) the designation "successful" in the MPAP, or*

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[5] See the definition at s. 1.4 of the *CPSM General Regulation*.
[6] See the Council Policy for Supervision of Provisional Registrants for considerations as to whether supervision will be required.

Effective XX

> (B) the designation "partially successful" in the MPAP and the registrar has granted the request referred to in subsection 7.11(2),
>
> (iii) he or she graduated from the Manitoba faculty before January 1, 1994 and successfully completed the post-graduate training requirements set out in the Schedule,[7]
>
> (iv) he or she
>
>> (A) was previously registered as a full registrant in good standing on the Manitoba Medical Register under subsection 17(3) of the former regulation as it read on February 16, 2012 or under section 4 of the Registration of Medical Practitioners Regulation, Manitoba Regulation 9/94 as it read on the day before it was repealed, as the case may be, and
>>
>> (B) was engaged in professional practice in Manitoba while so registered;
>
> (c) if applicable, establish that he or she has engaged in the field or fields of practice that he or she intends to practise in Manitoba within the approved time period;[8] and
>
> (d) if applicable, provide a description of the continuing professional development activities that the applicant was required to complete as a condition of being authorized to practise medicine in any jurisdiction in Canada in the three years immediately before the application was submitted and indicate how he or she met those requirements.[9]

2. Full (non-practicing) class

2.1. Purpose and overview

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[7] Previous registration regulations have grand-parented physicians who trained and were registered at a time when the current post-graduate training requirements were not in effect. It is necessary to extend the grand parenting to include physicians who achieved full registration on the Manitoba Medical Register and engaged in the practice of medicine in Manitoba while so registered. By way of example, physicians who were conditionally registered in Manitoba were able to achieve full registration by five years of satisfactory practice and success in achieving the LMCC. These physicians may never have achieved certification but will continue to have full registration. In other words, prior full registration in good standing in Manitoba qualify a physician for full registration under the RHPA.

[8] Applicants must provide documented evidence of having been in discipline-specific formal training or discipline-specific independent practice within the last three years. See the Practice Direction for Professional Practice and Inactivity respecting inactivity in practice.

[9] These requirements are intended to limit the opportunities for a physician to move from one jurisdiction to another without meeting the currency requirements in Manitoba or despite not having met the CPD requirements in another jurisdiction.

The Full (Non-Practicing) Class is intended for those registrants who take a leave of absence from practice in Manitoba, but who intend to return to practice in Manitoba. It may also be used for those who no longer practice in Manitoba, but whose registration has not been cancelled or surrendered.

The Full (Non-Practicing) Class of registration is to be distinguished from the retired physician class, which is intended for those registrants who have retired from the practice of medicine.[10] Public registry requirements are lessened in respect to those in the retired class, which is the main difference between the two classes.[11]

2.2. Conversion to the full (non-practicing) class

To convert from the Full (Practicing) Class to the Full (Non-Practicing) Class, the registrant must establish that they were registered or qualified to be registered as a full practicing registrant in good standing immediately before applying for registration as a full non-practicing registrant. In most cases, in order to apply to convert to this class simple notice to CPSM is required as well as compliance with CPSM's Standard of Practice for Practice Management.

Requirements for the Full (Non-Practicing) Class are set out in section 3.9 of the *CPSM General Regulation*:

> *3.9 An applicant for registration as a full (non-practising) member must establish that [they were] registered or [were] qualified to be registered as a full (practising) member in good standing immediately before applying for full (non-practising) membership.*

As an exception to the usual requirement for an application to convert between classes of registration, section 3.79 of the *CPSM General Regulation* provides:

> *3.79 If a member fails to renew or voluntarily surrenders his or her certificate of practice, the registrar may change the member's registration to the applicable non-practising class.*

Conversion to the Full (Non-Practicing) Class will be the usual default for registrants who no longer hold a valid certificate of practice (e.g., if it was not renewed), have not expressly indicated an intention to retire, and have not otherwise had their registration cancelled.

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[10] See section 3.36 of the *CPSM General Regulation*.

[11] Per section 2.6, this will have implications on the public nature of registry information. For certain individuals, including retired members, such information must not be made available to the public if the registrar is satisfied that the member will not apply to change his or her membership class to one for which a certificate of practice may be issued.

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4.2 APPENDIX B

DRAFT - COUNCIL POLICY

Registration in the Provisional (Academic – s. 181 Faculty) and the Provisional (Academic – Visiting Professor) Classes

Initial Approval:	**Effective Date:**
Reviewed with No Changes	**Reviewed with Changes**

Preamble

This Policy relates to registration in the following classes:
- the Provisional (Academic – S. 181 Faculty) Class, and
- the Provisional (Academic – Visiting Professor) Class.

Specific provisions of the *CPSM General Regulation* that apply to each of the above classes of registration are reproduced in this Policy for ease of reference. The purpose of this Policy is to set out additional registration requirements that have been approved by Council.

This Policy addresses what is required for a certificate of registration. It does not deal with the requirements for certificates of practice which are described at Part 4 of the *CPSM General Regulation*[1] and further in the Council Policy for Certificates of Practice.

1. Provisional (academic – s. 181 faculty) class

1.1. Purpose and overview

This class is for physicians registered at the request of the Manitoba faculty pursuant to subsection 181(1)(a) of the RHPA[2]. Section 181:

> *181(1) The registrar must approve an application for registration*
> > *(a) as a regulated member, if the applicant*
> > > *(i) is granted a certificate by the university in accordance with subsection (2), and*
> > > *(ii) meets the requirements set out in clauses 32(1)(c) to (g);*
> > > *...*

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[1] Part 4 of the CPSM General Regulation establishes the requirements for issuing a certificate of practice. Of note, s. 4.1 states, "A certificate of registration does not entitle a member to practise medicine. To do so, a member must also hold a certificate of practice. ..."

[2] Previously section 64 under *The Medical Act*.

Effective XX

> *181(2) The university may grant a certificate under the academic seal of the university to an applicant who meets both of the following requirements:*
> > *(a) the applicant is a full-time member of the Faculty of Medicine;*
> > *(b) the applicant provides evidence to the university's satisfaction that [they have] passed any examinations required by the university and has met any other requirements of the university.*
>
> *181(3) A registration may be subject to any conditions that the registrar considers advisable.*

Applicants for registration in the provisional (academic – s. 181 faculty) class must satisfy the following requirements from the *CPSM General Regulation*:[3, 4]
- the Common Requirements for all registrants of CPSM at s. 3.2,
- the Non-Exemptible Requirements for all Regulated Registrants at s. 3.7, and
- the Specific Requirements for this class at s. 3.10.

However, they do not need to establish that they meet the academic or certification requirements for full registration. Instead, they are registered based on the Manitoba faculty providing a section 181 certificate.

1.2. Specific requirements under the *CPSM General Regulation*

Specific requirements for the Provisional (Academic – s. 181 Faculty) Class are set out at section 3.10 of the *CPSM General Regulation*:

> *3.10 An applicant for registration as a provisional (academic — s. 181 faculty) member must*
> > *(a) submit to the registrar a written request to approve the applicant's registration from the dean of the Manitoba faculty (or the dean's designate) that contains*
> > > *(i) a confirmation that the applicant is or will be legally entitled to work in Manitoba before engaging in his or her professional practice,*
> > > *(ii) a confirmation that the applicant meets the approved English language fluency criteria, and*
> > > *(iii) a description of the applicant's most recent professional practice and proposed professional practice; and*
> > *(b) establish that he or she has been granted a section 181 certificate.*

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[3] RHPA at s. 32(1)
[4] Subsection 3.2(1) of the *CPSM General Regulation* at point 8.

CPSM Council Policy - Registration in the Provisional (Academic – s. 181 Faculty) and the Provisional (Academic – Visiting Professor) Classes

1.3. Terms and conditions

The standard terms and conditions to be imposed on any section 181 registrant under the RHPA include that the registrants practice shall be restricted to the Manitoba faculty and in accordance with the section 181 certificate. Section 3.11 of the *CPSM General Regulation* further provides:

> *3.11(1) A person may be registered as a provisional (academic — s. 181 faculty) member for as long as he or she holds a section 181 certificate.*
>
> *3.11(2) As a condition of registration, a provisional (academic — s. 181 faculty) member must continue to hold a section 181 certificate.*

1.4. Cancellation

Section 3.81 of the *CPSM General Regulation* provides that, "*The registration of a provisional (academic — s. 181 faculty) member is cancelled if the member's section 181 certificate is revoked or lapses.*"

1.5. Conversion to another class

Physicians registered under section 181 of the RHPA may achieve full registration by applying, paying the applicable fees set out in a CPSM bylaw, and providing evidence that they have met the usual requirements for full registration. Sections 3.75 and 3.76 of the *CPSM General Regulation* provide:

> *3.75 Upon receiving a designation of "successful in the MPAP" or otherwise completing the requirements for full (practising) membership under section 3.8, a member's registration in*
>
> > *…*
> > *(d) the provisional (academic — s. 181 faculty) class;*
> *may be changed by the registrar to the full (practising) class.*
>
> *3.76 Upon receiving a designation of "partially successful in the MPAP", a member's registration in*
>
> > *….*
> > *(d) the provisional (academic — s. 181 faculty) class;*
> *may be changed by the registrar to the full (practising) class in accordance with section 7.11 (restricted professional practice).*

If a section 181 faculty member decides to take the MPAP route and is unsuccessful, they will be

restricted to applying in an educational class or clinical assistant class pursuant to section 7.13 of the *CPSM General Regulation*. They would not be able to register again in the provisional academic class.

2. Provisional (academic – visiting professor) class

2.1. Purpose and overview

The purpose of the Provisional (Academic – Visiting Professor) Class is to provide a means for an eligible physician to:
- attend to teach or to learn in a university-based setting for a term approved by the Registrar, and
- have, during that time, clinical contact with patients and provide limited medical services in circumstances approved by the Registrar.

Applicants for registration in the Provisional (Academic – Visiting Professor) Class must satisfy the following requirements from the *CPSM General Regulation*:[5, 6]
- the Common Requirements for all registrants of CPSM at s. 3.2,
- the Non-Exemptible Requirements for all Regulated Registrants at s. 3.7, and
- the Specific Requirements for this class at s. 3.12.

Given the nature of a visiting professor's professional practice and the fact that it will occur within a university setting, they do not need to establish that they meet the academic or certification requirements for full registration.

In each case, the requirement is for the dean of the Manitoba Faculty (or the dean's designate) to make the request and to have satisfied themself that the basic requirements have been met for the candidate to practice within the University setting.

2.2. Specific requirements under the *CPSM General Regulation*

Specific requirements for the Provisional (Academic – Visiting Professor) Class are set out at section 3.12 of the *CPSM General Regulation*:

> *3.12 An applicant for registration as a provisional (academic — visiting professor) member must*
>
> > *(a) establish that he or she holds*

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CPSM Council Policy - Registration in the Provisional (Academic – s. 181 Faculty) and the Provisional (Academic – Visiting Professor) Classes

(i) a medical degree granted from a nationally approved faculty of medicine, or
(ii) a Doctor of Osteopathic Medicine degree from a school in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation; and

(b) submit to the registrar a written request to approve the applicant's registration from the dean of the Manitoba faculty (or the dean's designate) that contains the following:
> *(i) a confirmation that the applicant is or will be legally entitled to work or study in Manitoba before engaging in his or her professional practice,*
> *(ii) a confirmation that the applicant meets the approved English language fluency criteria,*
> *(iii) a description of*
>> *(A) the applicant's most recent professional practice and proposed professional practice, or*
>> *(B) the specific medical procedures that the applicant will be performing,*
> *(iv) the name of the person and department that will be responsible for supervising the applicant,*
> *(v) the dates when and the location or locations where the applicant will be teaching or studying.*

2.3. Terms and conditions

The standard terms and conditions to be imposed on any Provisional (Academic – Visiting Professor) Class registrant include that the registrants practice shall be supervised and restricted to approved location(s) of practice and, if appropriate, to the procedure or teaching experience for which the registrant is attending. Other conditions may be imposed, depending upon the circumstances.

Registration is for a period of not more than 24 consecutive months, unless extended by the Registrar for up to 12 additional months. Section 3.13 of the CPSM General Regulation provides:

> *3.13 A person may be registered as a provisional (academic — visiting professor) member for a time period of not more than 24 consecutive months, which may be extended in accordance with sections 3.71 to 3.73.*

An extension may be granted only if:

- the registrant provides a written request from the dean of the Manitoba Faculty (or the dean's designate) for an extension before the initial registration expires and sets out the reasons for the extension request, and
- the Registrar determines that there are exceptional or extenuating circumstances that merit an extension.

Sections 3.72 and 3.73 CPSM of the *CPSM General Regulation* require that the Registrar provide written reasons for his or her approval or refusal of the extension and, if the Registrar does not grant an extension, the applicant has a right of appeal.

2.4. Cancellation

Section 3.82 of the *CPSM General Regulation* provides:

> *3.82 The registration of a provisional (academic — visiting professor) member is cancelled on the earliest occurrence of the following:*
> *(a) the specified or extended membership period ends;*
> *(b) the member completes his or her teaching or studying obligations;*
> *(c) the member ceases to be supervised by the person or the department referred to in subclause 3.12(b)(iv).*

DRAFT - COUNCIL POLICY

Registration in the Provisional (Academic – Post Certificate Trainee) Class

Initial Approval:	Effective Date:

Provisional (Academic – Post Certificate Trainee) Class

The Provisional (Academic – Post Certificate Trainee) Class is for the purpose of enabling an eligible post-medical degree trainee, who has successfully completed all the requirements that would allow them to practice as a specialist in their home country, to pursue further clinical or research training in their specialty in Manitoba. This class is intended to permit registration for fellowship work within the Manitoba faculty even when the requirements for full registration are not met.

Applicants must meet the common requirements for registration as a regulated registrant. Given the nature of the work of a post certification trainee and the fact that it will occur in the university setting, these applicants need not meet requirement for certification.

1. **Specific requirements under the CPSM General Regulation**

Specific requirements for the Provisional (Academic – Post Certificate Trainee) Class are set out at section 3.14 of the *CPSM General Regulation*:

> *3.14 An applicant for registration as a provisional (academic — post-certification trainee) member must*
> > *(a) establish that he or she holds*
> > > *(i) a medical degree granted from a nationally approved faculty of medicine, or*
> > > *(ii) a Doctor of Osteopathic Medicine degree from a school in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation; and*
> > *(b) submit to the registrar a written request to approve the applicant's registration signed by the applicant, the head of the division or department of the Manitoba faculty that will be responsible for supervising the applicant and the dean of the Manitoba faculty (or the dean's designate) that contains the following information:*

(i) a confirmation that the applicant
> *(A) has satisfactorily completed the educational requirements for Royal College specialist certification or is recognized as a medical or surgical specialist in the jurisdiction in which he or she last practised before applying for registration,*
> *(B) meets the approved English language fluency criteria, and*
> *(C) is or will be legally entitled to work or study in Manitoba before engaging in professional practice,*

(ii) a description of the applicant's most recent professional practice and proposed professional practice,

(iii) the division or department and the person who will be responsible for supervising the applicant,

(iv) a confirmation that the applicant possesses training that is acceptable to the dean of the Manitoba faculty (or the dean's designate) and that warrants admission to the post-graduate program of the Manitoba faculty.

2. Terms and conditions

The standard terms and conditions to be imposed on any Provisional (Academic – Post Certificate Trainee) Class registrant include that the registrants practice shall be restricted to approved location(s) of practice and, if appropriate, to the field of practice for which the registrant is attending. Supervision is also required. Other conditions may be imposed, depending upon the circumstances.

Registration is for a period of not more than 24 consecutive months, unless extended by the Registrar for up to 12 additional months. Section 3.15 of the *CPSM General Regulation* provides:

> *3.15 A person may be registered as a provisional (academic — post-certification trainee) member for a time period of not more than 24 consecutive months, which may be extended in accordance with sections 3.71 to 3.73.*

An extension may be granted only if:
- the registrant provides a written request from the dean of the Manitoba Faculty (or the dean's designate) for an extension before the initial registration expires and sets out the reasons for the extension request, and
- the Registrar determines that there are exceptional or extenuating circumstances that merit an extension.

Sections 3.72 and 3.73 CPSM of the *CPSM General Regulation* require that the Registrar provide written reasons for his or her approval or refusal of the extension and, if the Registrar does not grant an extension, the applicant has a right of appeal.

3. **Cancellation**

Section 3.83 of the *CPSM General Regulation* provides:

> *3.83 The registration of a provisional (academic — post-certification trainee) member is cancelled on the earliest occurrence of the following:*
> *(a) the specified or extended membership period ends;*
> *(b) the member completes the clinical or research training;*
> *(c) the member ceases to be supervised by the person, division or department referred to in subclause 3.14(b)(iii).*

COUNCIL POLICY

English Language Proficiency

Initial Approval: September 25, 2024	Effective Date: September 25, 2024
	Reviewed with changes: March 26, 2025

Preamble:

Registrants practicing medicine in Manitoba need to be able to communicate clearly with their patients and document their involvement in care in English. Consequently, non-exemptible requirements for registration with CPSM for all classes include that the applicant must establish that they meet English language fluency criteria approved by Council.[1, 2] This Policy establishes those criteria.

1. English language proficiency testing

   1.1. Unless exempt under paragraph 2 of this Policy, applicants for registration are required to complete one of the following English language proficiency tests[3, 4]:

   1.1.1. International English Language Testing System (IELTS), general or academic version, within the last twenty (24) months at the time of application and achieved a minimum score of 7.0 in each of the four components. This need not be in the same sitting.

   1.1.2. Occupational English Test - Medicine (OET-Medicine) within the last 24 months at the time of application, with a minimum grade of B in each of the four subsets in the same sitting.

   1.1.3. Canadian English Language Proficiency Index Program-General (CELPIP-General) test within the last 24 months at the time of application, with a minimum score of 9 in each of the four skills in the same sitting.

   1.2. Direct verification of test results may be waived for applicants who are currently in independent practice in a country where English is the first and/or native language,[5] and who were required to achieve English language proficiency prior to registration with the applicable regulatory body. Waiver under this paragraph requires the following information directly from the regulatory body:

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[1] See sections 3.7 and 3.37, as well as 3.10, 3.12, 3.14, 3.57, and 3.64 of the *CPSM General Regulation*.

[2] Issues such as language proficiency testing are permissive under the Canadian Free Trade Agreement (CFTA). English language proficiency testing is beneficial and preferable.

[3] This list is based on the FMRAC Model Standards for Medical Registration in Canada, as modified to comply with Manitoba's Language Proficiency Testing Regulation.

[4] Applicants who demonstrate language proficiency by way of language test results do not need to re-establish language proficiency, as long as the applicant's file with the CPSM remains active.

[5] See list at paragraph 3.

      1.2.1.   confirmation English language proficiency must be demonstrated to enter training or practice in the jurisdiction,

      1.2.2.   a description of the English language proficiency requirement (including the necessary scores on any required English language tests), and

      1.2.3.   a copy of the applicant's test results that were accepted when they entered training or practice in that jurisdiction.

2.   English languages proficiency testing exemptions

    2.1.   Labour mobility applicants:

      2.1.1.   The requirement to demonstrate proficiency in English is fulfilled if the applicant provides proof that they currently hold an equivalent medical license in any province or territory in Canada and demonstrates they practice primarily in English.[6]

    2.2.   Educational registrants:[7]

      2.2.1.   Medical students and physician assistant students are exempt from the English language testing requirement based on confirmation of their admission into the Manitoba Faculty.

      2.2.2.   Visiting elective trainees and applicants who are enrolled in a residency or fellowship program at the Manitoba Faculty are exempt from English language testing requirement for the first ninety (90) days of training. They will be fully exempt from English language testing if CPSM receives confirmation from the Associate Dean or Assistant Dean of the applicable program confirming the trainee has satisfied the Manitoba Faculty's English language fluency criteria.

    2.3.   Provisional academic registrants:[8]

      2.3.1.   Applicants for the provisional (academic — s. 181 faculty), provisional (academic — visiting professor), and provisional (academic — post-certification trainee) classes are exempt from English language testing requirements if CPSM receives confirmation from the Associate Dean or Assistant Dean of the applicable program confirming the applicant has satisfied the Manitoba Faculty's English language fluency criteria.

    2.4.   Additional exemptions:

      2.4.1.   Applicants may be exempted from English language proficiency testing if one of the following circumstances apply:

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[6] Satisfactory evidence may include verification from a director or supervisor at the practice setting.
[7] See sections 3.48, 3.50, 3.52, 3.54, and 3.57.
[8] See sections 3.10, 3.12, and 3.14 of the *CPSM General Regulation*.

2.4.1.a.   Their undergraduate or postgraduate medical education[9] was taken in English in one of the countries that have English as a first and/or native language.[10]

2.4.1.b.   They can provide evidence that is satisfactory to the Registrar of appropriate exposure to English language in training and/or practice. For example, evidence could be provided to support the following:

2.4.1.b.i.   that they have taken the majority (>50%) of their undergraduate or postgraduate medical education in English, and/or

2.4.1.b.ii.   the majority (>50%) of patient care provided by the applicant has been in English, and/or

2.4.1.b.iii.   other substantially equivalent evidence of English proficiency in training and practice (e.g., significant clinical teaching, research, and/or academic experience).

Commentary: When assessing English language proficiency under paragraph 2.4.1., evidence will be evaluated by the Registrar on a case-by-case basis. Examples of satisfactory evidence include:

- Inclusion of their UGME or PGME training program in the list of English programs in FAIMER's World Directory of Medical Schools (https://www.wdoms.org/).
- Completion of a fellowship of at least two years within a country where English in the first or native language, as verified by a director or supervisor at the location of the fellowship.
- For 2.4.1.b.ii., evidence the candidate has successfully completed an English language proficiency exam beyond the expiry period, but who has been working in an English-speaking environment, as verified by a director or supervisor at the practice setting.

3.   For the purposes of this Policy, the list of countries where English is a first and/or native language includes, but is not limited to: Australia, Bahamas, Bermuda, British Virgin Islands, Canada, Ireland, New Zealand, Nigeria, Singapore, South Africa, United Kingdom, United States of America, US Virgin Islands, and the Caribbean Islands of Anguilla, Antigua and Barbuda, Barbados, Dominica, Grenada, Grenadines, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent, Trinidad and Tobago.

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[9] This includes residency and medical fellowship training.
[10] See list at paragraph 3.

COUNCIL POLICY

Registration in the Provisional Family Practice-Limited, Assessment Candidate (Family Practice), and Provisional (Non-Practicing) Classes

Initial Approval: March 19, 2025	Effective Date: March 19, 2025
Reviewed with No Changes	Reviewed with Changes June 25, 2025

Contents

Preamble

This Policy relates to registration in the following classes:
- provisional (family practice-limited),
- assessment candidate (family practice), and
- provisional (non-practicing).

Specific provisions of the *CPSM General Regulation* that apply to each of the above classes of registration are reproduced in this Policy for ease of reference. The purpose of this Policy is to set out additional registration requirements that have been approved by Council.

This Policy addresses what is required for a certificate of registration. It does not deal with the requirements for certificates of practice, which are described at Part 4 of the *CPSM General Regulation*.[1]

1.   **Provisional (family practice-limited) class**

   1.1.   Purpose and overview

The provisional (family practice-limited) class allows for the registration of candidates who do not meet all Specific Requirements for full licensure (i.e., CCFP, successful completion of MPAP, CMQ certification, or registration under the CFTA). This applies to many internationally trained physicians, and Canadian trained physicians who have not obtained CCFP or CMQ certification.

Applicants for registration in the provisional (family practice-limited) class must satisfy the following requirements from the *CPSM General Regulation*:[2], [3]
- the **Common Requirements** for all registrants of CPSM at s. 3.2,
- the **Non-Exemptible Requirements** for all Regulated Registrants at s. 3.7, and
- the **Specific Requirements** for this class at s. 3.19, including academic requirements.

Applicants must commit to work toward achieving the requirements for full licensure within five (5) years of initial registration in the provisional class.[4] Additional requirements, including terms and conditions of registration and practice supervision, are imposed.

Unless exempt, applicants must have satisfactorily completed an Approved Assessment to be eligible for registration in the provisional (family practice-limited) class. Exemptions are described

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[1] Part 4 of the *CPSM General Regulation* establishes the requirements for issuing a certificate of practice. Of note, s. 4.1 states, "*A certificate of registration does not entitle a member to practise medicine. To do so, a member must also hold a certificate of practice. ...*"
[2] RHPA at s. 32(1).
[3] Subsection 3.2(1) of the *CPSM General Regulation* at point 8.
[4] CCFP or successful completion of MPAP.

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below. An Approved Assessment may be completed while registered in the assessment candidate (family practice) class (which is also described in this Policy).

    1.2.   Specific Requirements under the *CPSM General Regulation*

       1.2.1.   Specific Requirements for provisional (family practice-limited) class are set out at section 3.19 of the *CPSM General Regulation*:

3.19(1) An applicant for registration as a provisional (family practice-limited) member must

    (a) establish that he or she holds

        (i) a medical degree granted from a nationally approved faculty of medicine, or

        (ii) a Doctor of Osteopathic Medicine degree from a school in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation;

    (b) establish that he or she meets one of the following criteria:

        (i) he or she holds CFPC certification or is confirmed by the CFPC to be eligible for certification by the CFPC,

        (ii) he or she holds Member Board certification in family medicine or is confirmed by a Member Board to be eligible,

        (iii) he or she holds certification in family medicine from the Collège des médecins du Québec,

        (iv) he or she has satisfactorily completed two years of post-graduate clinical training in family medicine that

            (A) took place in one or more facilities that provide health care and are recognized by a national post-graduate training authority,

            (B) was accredited with a national post-graduate training authority at the time he or she took the training, and

            (C) is approved by the registrar,

        (v) he or she has satisfactorily completed at least one year of post-graduate clinical training in family medicine that meets the requirements of subclause (iv) and has had a total of at least three years practice experience in family medicine in the preceding five-year period;

    (c) establish that he or she holds a certificate issued by the minister stating that the applicant is required to provide medical services in a specified geographical area or practice setting;

    (d) if applicable, establish that he or she has engaged in the area of family practice that he or she intends to undertake in Manitoba within the approved time period;

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(e) provide a description of the continuing professional development activities that the applicant was required to complete as a condition of authorization to practise family medicine in any jurisdiction in Canada in the three years immediately preceding the application and indicate how he or she met those requirements;
(f) establish that he or she has entered into a satisfactory arrangement with a practice supervisor; and
(g) subject to subsection (2), establish that he or she has
> *(i) satisfactorily completed an approved family practice assessment, and*
> *(ii) entered into a satisfactory arrangement with a practice mentor;*
(h) [repealed] M.R. 171/2022.

1.3.   Satisfactory post-graduate clinical training in family medicine

   1.3.1.   In considering whether the family medicine clinical training requirements at subsections 3.19(1)(b)(iv) or (v) are met, the Registrar will compare the applicant's training experience against the Canadian standard as a reference.[5]

   1.3.2.   Training must have taken place in one or more facilities that
   - provide health care,
   - are recognized by a national post-graduate training authority,
   - was accredited with a national post-graduate training authority at the time of training, and
   - is approved by the registrar.

   1.3.1.   The training must be recognized in the jurisdiction where it took place as sufficient for certification or authorization to practice as a general practitioner or family physician.
   1.3.2.
   1.3.3.   At a minimum, training must include rotations of at least 8 weeks duration in medicine[6], obstetrics and gynecology and pediatrics[7], and at least 4 weeks in surgery (as needed for procedural skills).

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[5] Post-graduate medical education (PGME) in family medicine in Canada is designed to prepare residents to provide comprehensive, patient-centered primary care. The goal is to provisionally license family physicians that will be able to go to obtain certification from the CFPC.
[6] This is interpreted to include rotations in general medicine, medicine, or internal medicine. Up to 4 weeks of this period can be medicine related subspecialties, for example respirology, cardiology, hepatology, infectious disease, nephrology, etc.).
[7] This is interpreted to include pediatric emergency medicine.

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1.3.4. ~~1.3.4.~~ CPSM may accept clinical rotations that take place as part of an internship program following undergraduate medical education.

1.3.5.1.3.3. Rotations in areas including psychiatry, emergency medicine, and geriatrics are desirable, but do not substitute for the required rotations.

1.3.6.1.3.4. Only in-person, full-time training will qualify.

1.3.7.1.3.5. For the purposes of subsection 3.19(1)(b)(iv), successful completion of the twelve (12) month Manitoba Licensure Program for International Medical Graduates (MLPIMG) will count toward one year of clinical training experience.

1.4. Practice experience in family medicine (ss. 3.19(1)(b)(v))

1.4.1. For the purposes of subsection 3.19(1)(b)(v), practice experience in family medicine must be:
1.4.1.1. independent practice experience,
1.4.1.2. in general practice, family medicine, or primary care as a physician, and
1.4.1.3. equal to or greater than seventy (70) percent in-person care (a minority of practice may be virtual).

1.4.2. Postgraduate training (internship/residency) does not count towards the practice experience requirement and vice versa.

1.4.3. Independent practice requires a license to practice independently in the applicable jurisdiction and the authority to act as the most responsible physician for patient care.

1.5. Currency in practice requirement (ss. 3.16(d))

1.5.1. Applicants who do not meet the currency in practice requirement at subsection 3.19(d) of the *CPSM General Regulation* are not eligible for provisional (family practice-limited) class registration. They may be eligible for registration in the assessment candidate (re-entry to practice) class for the purpose of undergoing an assessment (see section 3.44 of the *CPSM General Regulation*).

1.5.1.1. The currency in practice requirement is further described in CPSM's Practice Direction for Professional Practice and Inactivity.[8]

1.5.1.2. This assessment candidate (re-entry to practice) class is further described in CPSM's Council Policy for the Assessment Candidate (Re-Entry to Practice) Class.[9]

1.6. Assessment requirement (ss. 3.19(1)(g)(i)) and exemptions

Approved Assessments

1.6.1. Subsection 3.19(1)(g)(i) of the *CPSM General Regulation* states that, subject to available exemptions (see below), applicants for registration in the provisional (family practice-limited) class are required to establish that they have satisfactorily completed an Approved Assessment in family medicine.

1.6.2. Assessments that have been approved by Council are as follows:[10]

1.6.2.1. Western Alliance for Assessment of International Physicians.

1.6.2.2. Practice Ready Assessment - Family Practice (PRA-FP), formerly known as the Assessment for Conditional Licensure for Family Medicine ("ACL"), excluding anaesthesia.

1.6.2.3. Family practice including anaesthesia:
1. PRA-FP; and
2. the anaesthesia assessment **annexed as Schedule A**.

1.6.2.4. The practice ready assessment for family medicine used by the College of Physicians and Surgeons of Alberta.

1.6.2.5. An assessment conducted elsewhere in Canada certified by the Dean of the Manitoba Faculty as equivalent to the competencies for family medicine/practice ready assessment.

1.6.2.6. Successful completion of the twelve (12) month Manitoba Licensure Program for International Medical Graduates (MLPIMG) will count as an approved assessment.

Exemptions to having to undergo an Approved Assessment

1.6.3. Subsection 3.19(2) provides exemptions to having to undergo and Approved Assessment:

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[8] https://cpsm.mb.ca/assets/Policies/Professional%20Practice%20and%20Inactivity.pdf

[9] If an applicant does not meet both the currency in practice requirement (ss. 3.19(1)(d)) and the approved assessment requirement (ss. 3.19(1)(g)(i)), then assessment candidate registration under section 3.38 and 3.44 may be blended if all other applicable registration requirements are met.

[10] In approving assessments, the main issue is ensuring confirmation of competency. A secondary goal is ensuring equivalency for what is required to obtain CFPC certification eligibility.

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3.19(2) An applicant is exempt from the requirement in clause (1)(g) (assessment and practice mentor) if the applicant establishes that one of the following criteria is met:

    (a) he or she

        (i) was not a member on the day he or she applies for registration in this class but

            (A) was previously registered as a provisional (family practice-limited) or provisional (academic — s. 181 faculty) member in good standing, or

            (B) was previously conditionally registered in the area of family practice under the former Act or was previously registered in the area of family practice under section 64 of that Act,

        (ii) has either satisfactorily completed an approved family practice assessment or was exempt under the former Act from such a requirement while he or she was previously registered under the former Act, and

        (iii) has the training and experience necessary to competently engage in family practice;

    (b) he or she holds CFPC certification or provides written confirmation from the CFPC that he or she is eligible for certification;

    (c) he or she holds Member Board certification in family medicine and has satisfactorily completed a post-graduate training program accredited by the Accreditation Council for Graduate Medical Education (USA);

    (d) he or she holds certification in family medicine from the Collège des médecins du Québec. …

Candidates who have not completed an Approved Assessment

1.6.4.   Candidates who do not establish that they have satisfactorily completed an Approved Assessment, or are not otherwise exempt from this requirement, are not eligible for provisional (family practice-limited) class registration. However, they may be eligible for registration in the assessment candidate (family practice) class for the purpose of undergoing an Approved Assessment (see section 3.41 of the *CPSM General Regulation*).

1.6.5.   For registration in the assessment candidate (family practice) class, applicants must meet all other requirements for registration in the provisional (family practice-limited) class, but for subsection 3.19(1)(g), and must establish that they:

    1.6.5.1. have been accepted into an Approved Assessment, and

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           1.6.5.2.   have an employment offer to engage in their professional practice in a specific geographical area or practice setting that is approved by the minister.

      1.6.6.   The assessment candidate (family practice) class is further described below.

1.7.   Terms and conditions

      1.7.1.   Provisional (family practice-limited) class registration is time limited and subject to restrictions imposed by the Minister's certificate. Section 3.20 of the *CPSM General Regulation* provides:

3.20(1) A person may be registered as a provisional (family practice-limited) member for a time period of not more than five years, which may be extended in accordance with sections 3.71 to 3.73.

3.20(2) A person may be registered as a provisional (family practice-limited) member to practise in a specific geographical area or practice setting as specified in the person's ministerial certificate.

      1.7.2.   Provisional (family practice-limited) class registrants must be supervised in respect to their professional practice and must work toward full registration:

3.21(1) As a condition of registration, a provisional (family practice-limited) member must be working towards meeting the requirements to be registered as a full (practising) member by either
          (a) obtaining ~~registration in the Canadian Medical Register as a holder of the LMCC and~~ CFPC certification; or
          (b) obtaining the designation of "successful in the MPAP" in the area in which he or she is assessed.

3.21(2) As a condition of registration, a provisional (family practice-limited) member must have a practice supervisor.

      1.7.3.   Practice supervision must accord with the requirements of the Council Policy for Supervision of Provisional Registrants.[11]

1.8.   Extension of provisional registration

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[11] http://cpsm.mb.ca/

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1.8.1. Under section 3.71 of the *CPSM General Regulation*, the Registrar may extend the usual maximum five (5) year period of registration for up to an additional twelve (12) months, subject to any conditions that the Registrar considers advisable. The registrant must apply in writing for an extension before their five (5) years expires and set out the reasons for the extension request.

1.8.2. In accordance with section 3.71 of the *CPSM General Regulation*, the extension may be granted if the Registrar determines that the registrant requires the extension due to an extended absence from professional practice due to a medical condition or for a statutory or approved leave. In any application for an extension, the onus is on the registrant to demonstrate that the extension should be granted, and the following conditions must be met:

1.8.2.1. The registrant must be eligible to receive a satisfactory certificate of good standing.

1.8.2.2. In applicable, the registrant must undertake to attend the earliest dates of the examination sittings and to cease registration if the physician is unsuccessful in the examinations.

1.8.3. Sections 3.72 and 3.73 CPSM of the *CPSM General Regulation* require that the Registrar provide written reasons for their approval or refusal of the extension and, if the Registrar does not grant an extension, the applicant has a right of appeal.

1.9. Conversion to another class

1.9.1. Registration in the provisional (family practice-limited) class is limited to a five (5) year period, plus any extension granted by the Registrar. By the end of that period, to maintain registration, the registrant must covert to another class for which they are eligible, for example the provisional (MPAP) class or the full (practicing) class. Members in the provisional (family practice-limited) class may also be converted to the provisional (non-practicing) class in certain specified circumstances. Conversion is governed by sections 3.74, 3.75, and 3.76 of the *CPSM General Regulation*, which provide:

> *3.74(1) If*
> > *…(b) a provisional (family practice-limited) member in good standing;*
> > *…*
> *ceases to have a practice supervisor, the registrar may change the member's registration to provisional (non-practising)*

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membership for a period of not more than 30 days from the date the member ceases to have a practice supervisor.

3.74(2) If the member enters into a subsequent satisfactory arrangement with a practice supervisor before the 30-day period expires, the registrar may change the member's registration to the applicable class listed in subsection (1).

3.75 Upon receiving a designation of "successful in the MPAP" or otherwise completing the requirements for full (practising) membership under section 3.8, a member's registration in

> *…*
> *(b) the provisional (family practice-limited) class;*
> *…*

may be changed by the registrar to the full (practising) class.

1.9.2.   If the 30-day period contemplated under section 3.74 of the *CPSM General Regulation* expires without the member identifying a new supervisor, then the member's registration is cancelled as they no longer meet registration requirements.

1.10. <u>Cancellation</u>

1.10.1.   Section 3.84 of the *CPSM General Regulation* provides as follows:

3.84(1) The registration of a … provisional (family practice-limited) member … is cancelled on the earliest occurrence of the following:
> *(a) the ministerial certificate is revoked or lapses;*
> *(b) the member is no longer eligible for the Medical Council of Canada examination for cause;*
> *(c) the member's certification by the Royal College, American Board of Medical Specialties, or CFPC, as the case may be, is revoked for cause;*
> *(d) the specified or extended membership period ends;*
> *(e) the member receives the designation of "unsuccessful in the MPAP";*
> *(f) the member ceases to practise in Manitoba.*

3.84(2) A person whose registration is cancelled under clause (1)(d) or (e) may apply for registration only as a regulated associate member in one of the following classes:
> *(a) educational (medical student);*
> *(b) educational (physician assistant);*
> *(c) educational (resident);*

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(d) clinical assistant (full)

3.84(3) To avoid doubt, a person whose registration is cancelled under clause (1)(d) or (e) is not permitted to apply for any class of regulated or regulated associate membership other than the ones listed in clauses (2)(a) to (d).

2. Assessment candidate (family practice) class

The assessment candidate (family practice) class is intended for candidates who do not meet all Specific Requirements for registration in the provisional (family practice-limited) class. It is to allow for the candidate to undergo an Approved Assessment.

To be considered for registration, applicants must establish they have accepted into an Approved Assessment and that they have an employment offer to engage in their professional practice in a specific geographical area or practice setting that is approved by the minister.

2.1. Specific requirements under the *CPSM General Regulation*

2.1.1. Specific requirements for the assessment candidate (family practice) class are set out at section 3.41 of the *CPSM General Regulation*:

3.41 The registrar may register an applicant in the assessment candidate (family practice) class if the applicant establishes that
(a) he or she meets the requirements for registration as a provisional (family practice-limited) member in subsection 3.19(1) other than the requirements to
(i) enter into a satisfactory arrangement with a practice supervisor under clause 3.19(1)(f), and
(ii) complete an approved family practice assessment and enter into a satisfactory arrangement with a practice mentor under clause 3.19(1)(g);
(b) he or she has been accepted into an approved family practice assessment; and
(c) he or she has an employment offer to engage in family practice in a specific geographical area, or practice setting, that is approved by the minister.

2.2. Accepted into an Approved Assessment

2.2.1. Council has approved the Practice Readiness Assessment - Family Practice ("PRA-FP") offered through the Manitoba Faculty's IMG Program.

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2.2.2.   CPSM ~~will not accept an application for registration in the assessment candidate (family practice) class unless it is supported by a letter of eligibility for the PRA-FP from the IMG Program.~~ will accept applications for the PRA-FP and will review the applicant's training and practice experience. Candidates who meet the eligibility requirements will be referred to the IMG Program for the next stage of the selection process.

2.3. ~~Employment offer~~

~~2.3.1.~~2.2.2.   ~~CPSM will not accept an application for registration in the assessment candidate (family practice) class unless it is supported by an employment offer to engage professional practice in a specific geographical area or practice setting that is approved by the minister.~~

~~2.4.~~2.3.   Time limited registration

~~2.4.1.~~2.3.1.   Registration in this class is time limited. Section 3.42 of the *CPSM General Regulation* provides:

> *3.42(1) A person may be registered as an assessment candidate (family practice) member for a period of up to three months, which may be extended in accordance with sections 3.71 to 3.73.*
>
> *3.42(2) The time period described in subsection (1) does not include the time period for the orientation program referred to in section 3.43.*

~~2.4.2.~~2.3.2.   Under section 3.71 of the *CPSM General Regulation*, the Registrar may extend the usual twelve (12) month period of registration for up to an additional twelve (12) months, subject to any conditions that the Registrar considers advisable. The registrant must apply in writing for an extension before their registration period expires and set out the reasons for the extension request.

~~2.4.3.~~2.3.3.   In accordance with section 3.71 of the *CPSM General Regulation*, the extension may be granted if the Registrar determines that the member requires the extension due to an extended absence from professional practice due to a medical condition or for a statutory or approved leave. In any application for an extension, the onus is on the registrant to demonstrate that the extension should be granted, and the following conditions must be met:

~~2.4.3.1.~~2.3.3.1. The registrant must be eligible to receive a satisfactory certificate of good standing.

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~~2.4.3.2.~~2.3.3.2. The registrant must undertake to complete the assessment promptly.

~~2.4.4.~~2.3.4. Sections 3.72 and 3.73 CPSM of the *CPSM General Regulation* require that the Registrar provide written reasons for their approval or refusal of the extension and, if the Registrar does not grant an extension, the applicant has a right of appeal.

~~2.5.~~2.4. Terms and conditions

~~2.5.1.~~2.4.1. Registration in this class is restricted to a specific practice setting and professional practice and may be subject to having to do orientation.[12] Subsections 3.42(3) and 3.43 of the *CPSM General Regulation* provide:

> *3.42(3) A person may be registered as an assessment candidate (family practice) member to practise in a specific geographical area or practice setting.*
>
> *Condition of registration*
> *3.43 As a condition of registration, the registrar may require that an assessment candidate (family practice) member complete an orientation program within a time period approved in accordance with a national standard.*

~~2.6.~~2.5. Conversion to provisional registration

~~2.6.1.~~2.5.1. Subsection 3.77(2) of the *CPSM General Regulation* provides:

> *3.77(2) Upon successful completion of the approved family practice assessment, the registration of an assessment candidate (family practice-limited) may be changed by the registrar to provisional (family practice-limited) membership.*

~~2.7.~~2.6. Cancellation

~~2.7.1.~~2.6.1. Assessment candidate (family practice) registration is cancelled in the following circumstances:

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[12] A candidate is not eligible for movement from the assessment class to registration in the family practice limited class until orientation, if required, has been completed.

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> *3.91 The registration of an assessment candidate (specialty practice) member or assessment candidate (family practice) member is cancelled on the earliest occurrence of the following:*
>> *(a) the specified or extended membership period ends;*
>> *(b) the member completes his or her assessment and the registrar receives the assessment results and changes his or her membership class as provided for in subsection 3.77(1) or (2);*
>> *(c) the member fails the assessment or fails to complete it.*

3. Provisional (non-practicing) class

3.1. The provisional (non-practising) class is intended for provisional registrants who take a leave of absence but intend to return to practice. For example, this may occur due to a gap in supervision, or a medical leave of absence.

3.2. To convert to the provisional (non-practising) class, the registrant must meet the specific requirements set out at subsection 3.34 of the *CPSM General Regulation*:

> *3.34(1) An applicant for registration as a provisional (non-practising) member must establish that he or she was registered in good standing in one of the following membership classes immediately before applying for non-practising membership:*
>> *(a) provisional (academic — s. 181 faculty);*
>> *(b) provisional (specialty practice-limited);*
>> *(c) provisional (family practice-limited);*
>> *(d) provisional (public health officer)*

3.3. As an exception to the usual requirement for an application to convert between classes of registration, section 3.79 of the *CPSM General Regulation provides*:

> *3.79 If a member fails to renew or voluntarily surrenders his or her certificate of practice, the registrar may change the member's registration to the applicable non-practising class.*

3.4. Conversion to the provisional (non-practising) class will be the usual default for registrants who no longer hold a valid certificate of practice (e.g., if it was not renewed or their Practice Supervisor resigns).

3.5. The maximum registration period for registrants who convert from provisional (gamily practice-limited) class to the provisional (non-practising) class is indicated at section 3.35 of the *CPSM General Regulation*:

> *The maximum time period for provisional (non-practising) membership for a member who was previously registered as a provisional (specialty*

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practice-limited) member or provisional (family practice-limited) member is the remaining time period that he or she had under subsection 3.17(1) or 3.20(1), as the case may be, with any extensions approved before he or she was registered under this section.

Schedule A – Anesthesia Assessment

Low Risk Anesthesia Assessment Program
Department of Anesthesia
University of Manitoba

PREAMBLE

The College of Physicians and Surgeons of Manitoba (CPSM) recognizes two levels of Anesthesia practice.

- Unlimited practice requires Royal College certification.
- Low-risk anesthesia requires either completion of a College of Family Physicians of Canada Certificate of Added Competence program, or an equivalent.

Candidates with the latter, whether from a Canadian non-standard program or from an International program, require an assessment in low-risk anesthesia. This Low-Risk Anesthesia Assessment (LRA) will be conducted within the Department of Anesthesia, under the governance of the Division of Continuing Professional Development in the Manitoba Faculty.

GOALS AND OBJECTIVES

The overall goals and objectives of this program are to assess the skills, knowledge, and ethical behaviour of candidates for licensure. This is not a training program, and there is no intention to provide for remediation of any discovered deficiencies within the limits of this assessment program. The clinical standard against which candidates shall be assessed is the same as that for trainees within our own program. The full standard is the same as that for Family Practice Anesthesia residents. They will therefore need to demonstrate proficiency in Pediatric, Obstetrical and adult anesthesia. Specific goals and objectives for each of these components are attached. Thus, for each section the minimum standard shall be to fulfill the PGY2 goals and objectives.

PROGRAM ADMINISTRATION

A designated supervisor shall be appointed for each component. A committee consisting of all three supervisors, and the Anesthesia Program Administrator and the Associate Head for Education in Anesthesia shall be the governing body for the LRA. This committee shall formulate the specific outline and requirements of the program, as well as collaborate on each final evaluation report. The Chair shall report to the Anesthesia Department Head, and to the Faculty LRA Coordinator.

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DURATION OF ASSESSMENT

The LRA in Anesthesia is organized into three rotations over two four-week periods. The minimum duration of the assessment will include one four-week period of adult anesthesia and a second four-week period comprising two weeks each of pediatric and obstetrical anesthesia. As outlined below, any individual rotation may be extended by 100 % if it is deemed that the candidate's performance is neither clearly acceptable nor unacceptable. This extension will not be used to remediate any deficiencies exposed during the first portion of the assessment.

EARLY TERMINATION OF ASSESSMENT

The LRA reserves the right to terminate an assessment after a period of one month if, in the opinion of the assessing department, the candidate is clearly unsuitable to continue the assessment period. The criteria for such unsuitability may include inadequate anesthesia skills or knowledge, the inability to work with colleagues, nursing and/or allied health professional staff, or any other pattern of behaviour that is felt to preclude competent practice. In the case of early termination, the LRA will have no further responsibility to the candidate or to the sponsoring institution.

FACULTY/SUPERVISION

For each component of the LRA within the department of anesthesia, there will be a supervisor assigned. This supervisor will have the responsibility of collecting the input from staff with whom the candidate works. This data will be used as the basis of the interim and final evaluations.

DAILY RESPONSIBILITIES

The candidate shall have a graduated increase in responsibility in each of the components of the program. On initial exposure, it will be necessary for the purposes of safety to regard the candidate as a PGY1 resident. It is anticipated that candidates qualifying for this program will in fact be functioning at a level above that. By the mid-rotation evaluation, they will be expected to function at the same level as a Family Practice Anesthetist. Candidates shall be assigned to daily slates in the same manner as FPA residents. In addition, they will be expected to do four calls per month, to allow assessment of emergency performance. These will be done according to the same rules established for residents on Scholarly activity, in the Anesthesia Postgraduate Program.

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EVALUATIONS AND FORMS

There will be an evaluation at the midpoint and the end of each of the components. At the midpoint evaluation, if possible, an indication will be made of the potential for extension. There may be formative feedback given in the process of this interim assessment, but this implies no commitment by the department to provide any necessary remediation. The assessment at the end of the component will serve as the final assessment for that component. The designated supervisor for the respective component shall perform these assessments. The evaluation forms used shall be the same as those used for the resident ITAR. Daily forms will not be required, as they are intended primarily for formative, as opposed to summative evaluation. The Anesthesia Associate Head for Education shall compile a summary of the individual component evaluations, which will then be discussed by the LRA committee to create an overall FITER for the LRA.

In addition to the clinical assessment, the LRA candidate shall complete the exam used by the department for family practice anesthesia. This is not required of full-program PGY2 residents because they will ultimately be assessed by the Royal College exam process. However, it is necessary in order to fulfill the first level of the assessment's goals, which is Family Practice Anesthesia equivalence.

REPORTING

Results of this assessment shall be reported to the Anesthesia Department Head and the LRA Coordinator for the Faculty of Medicine, as well as directly to the candidate. There will be no other report provided directly to any other party.

ACCESSING THE PROGRAM

The Faculty LRA Coordinator shall refer candidates to the Anesthesia LRA committee for consideration. Eligible candidates for the program must have:
- a provisional or assessment license from CPSM, and
- certification of non-specialist training from a program acceptable to the CPSM.

COUNCIL POLICY

Registration of
Clinical and Physician Assistants and
Physician Assistant Students

Initial Approval: March 20, 2024	Effective Date: March 20, 2024

PREAMBLE:

Clinical Assistants (ClAs), Physician Assistants (PAs), and Physician Assistant Students (PA Students) may be registered as Regulated Associate Members in one of the following classes:[1]
- Educational (Physician Assistant Student),
- Educational (External or Visiting Student),
- Educational (Non-Practicing),
- Physician Assistant (Full),
- Physician Assistant (Restricted Purpose),
- Physician Assistant (Academic – S. 181 Faculty),
- Physician Assistant (Non-Practicing),
- Clinical Assistant (Full),
- Clinical Assistant (Non-Practicing),
- Retired (Physician Assistant), and
- Retired (Clinical Assistant).

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[1] See s. 2.4 of the *CPSM General Regulation*.

ClA, PA, and PA Student applicants must satisfy the following registration requirements found in the *CPSM General Regulation:*[2]
- common requirements for all registrants of CPSM listed at s. 3.2,
- non-exemptible requirements for all Regulated Associate Members listed at s. 3.37, and
- specific provisions that apply to the class for which they are applying.[3, 4]

Specific provisions of the *CPSM General Regulation* that apply to ClA, PA and PA Student classes of registration are reproduced in this Policy for ease of reference. The purpose of this Policy is to set out additional registration requirements that have been approved by Council. This Policy only relates to the issuance of certificates of registration. It does not deal with the requirements for certificates of practice listed at Part 4 of the *CPSM General Regulation*.[5] Certificates of practice and other practice requirements for ClAs, PAs, and PA Student are also addressed in the 'Practice and Supervision Requirements for ClAs, PAs, and PA Students' Practice Direction and at Part 8 of the *CPSM General Regulation*.

1. **APPLICABLE PRACTICE LIMITATIONS**

1.1. Although not registration requirements, it is important to note that the ability of ClAs and PAs to engage in their professional practice is limited by the following CPSM regulations:
    1.1.1. Part 8 of the *CPSM General Regulation* concerning practice description and contract of supervision requirements for PAs and ClAs,[6]
    1.1.2. Part 6 of the *CPSM General Regulation* concerning title restrictions, and
    1.1.3. sections 4, 5 and 6 of the RHPA, section 6 of the *CPSM Practice of Medicine Regulation*, and Part 5 of the *CPSM General Regulation* respecting the performance and delegation of reserved acts.

1.2. PA Students do not require a practice description and contract of supervision. Their scope of practice is limited to practice under the supervision of the teaching staff in a particular department or departments of their educational program. Other conditions may be imposed, depending upon the circumstances. Sections 5.18, 5.19 and 5.20 of the *CPSM General Regulation* limit the performance of reserved acts by all students, including PA Students. Further information about the practice of PA Students is provided in the attached contextual information document.

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[2] The RHPA at s. 33 states, "*an application for registration as a regulated associate member must be considered and decided upon in accordance with the regulations.*"
[3] As an exception, an applicant for registration in the Physician Assistant (Academic — Section 181 Faculty) Class must provide satisfactory evidence that they meet the requirements at s. 181(1)(b) of the RHPA.
[4] See s. 3.2(1) of the *CPSM General Regulation* at point 9(b).
[5] Part 4 of the *CPSM General Regulation* establishes the requirements for issuing a certificate of practice. Of note, s. 4.1 states, "*A certificate of registration does not entitle a member to practise medicine. To do so, a member must also hold a certificate of practice. This Part adds to the requirements in the* [RHPA] *for a certificate of practice.*" Additional requirements for ClAs and PAs are set out at s. 4.5.
[6] See also the 'Practice Direction Practice and Supervision Requirements for ClAs, PAs, and PA Students'.

2. EDUCATIONAL (PHYSICIAN ASSISTANT STUDENT) CLASS

2.1. Specific requirements for registration:

2.1.1. This class is established for the registration of PA Students. The specific requirements for the Educational (Physician Assistant Student) Class are set out at section 3.50 of the *CPSM General Regulation*:

> *3.50 An applicant for registration as an educational (physician assistant student) member must establish that he or she is confirmed by the Manitoba faculty to be enrolled as a physician assistant student.*

2.2. Terms and Conditions on registration:

2.2.1. Section 3.51 of the *CPSM General Regulation* states:

> *3.51 As a condition of registration, a member must continue to be enrolled as a physician assistant student in the Physician Assistant Education Program at the University of Manitoba.*

2.3. Cancellation of Registration:

2.3.1. Pursuant to section 3.93 of the *CPSM General Regulation*, a PA Student's registration is cancelled if they cease to be enrolled as a PA Student with the Physician Assistant Education Program, or if their registration in the Physician Assistant (Full) Class is approved by the Registrar, in which case they are converted to that class.

3. EDUCATIONAL (EXTERNAL OR VISITING STUDENT) CLASS

3.1. Specific requirements for registration:

3.1.1. The Educational (External or Visiting Student) Class is intended for students or graduates of approved faculties of medicine (i.e., medical students) or physician assistant training programs (i.e., PA Students) outside Manitoba who are also enrolled in the Manitoba faculty for a limited period. Given the special nature of registration as an external or visiting student, the applicant must meet all the following requirements instead of other usual disclosure requirements (i.e., the common requirements for all registrants are reduced for this class):
3.1.1.1. submit a signed application in the approved form,
3.1.1.2. submit the fees provided for in the by-laws,
3.1.1.3. establish that they are a graduate or a student of an approved physician assistant training program outside Manitoba,

3.1.1.4. establish that they are in good standing with the regulatory authority in the jurisdiction in which they are currently authorized to practise medicine, and

3.1.1.5. the specific requirements at section 3.57 of the *CPSM General Regulation*.

3.1.2. The specific requirements for registration in the Educational (External or Visiting Student) Class are set out at section 3.57 of the *CPSM General Regulation*:

> *3.57 An applicant for registration as an educational (external or visiting student) member must*
>
> > *(a) establish that he or she is a graduate, or an undergraduate or post-graduate student in good standing, of either*
> >
> > > *(i) a nationally approved faculty of medicine located outside Manitoba, or*
> > > *(ii) an approved physician assistant training program located outside Manitoba;*
> >
> > *(b) if applicable, establish that he or she is in good standing with the regulatory authority in the jurisdiction in which he or she is currently authorized to practise medicine; and*
> > *(c) provide written confirmation from the dean of the Manitoba faculty (or the dean's designate) that*
> >
> > > *(i) he or she has been accepted by the Manitoba faculty as an external or visiting student in a specified department,*
> > > *(ii) he or she is legally entitled to study in Manitoba,*
> > > *(iii) he or she meets the approved English language fluency criteria,*
> > > *(iv) a specified regulated member from the department in which the external or visiting student will be studying has been designated to supervise the student, and*
> > > *(v) he or she has obtained a criminal record check from the jurisdiction in which the applicant is currently authorized to practise medicine, or is enrolled in the faculty or program, that is satisfactory to the Manitoba faculty.*

3.2. Approved PA training programs located outside of Manitoba:

3.2.1. For the purposes of subsection 3.57(a)(ii) of the *CPSM General Regulation* (see directly above), Council has approved the following physician assistant training programs located outside of Manitoba:

3.2.1.1. the Canadian Armed Forces,

3.2.1.2. University of Toronto,

3.2.1.3. McMaster University,

3.2.1.4. a university-affiliated program in Canada satisfactory to the Board of Assessors, and

3.2.1.5. a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States.

3.3. <u>Terms and conditions on registration:</u>

3.3.1. Section 3.58 of the *CPSM General Regulation* provides that "*A person may be registered as an educational (external or visiting student) member for a time period of not more than six consecutive months, which may be extended in accordance with sections 3.71 to 3.73.*"

3.3.1.1. The Registrar may extend registration for up to twelve (12) additional months. An extension can only occur if the student provides a written request from the dean of the Manitoba faculty, or the dean's designate, for an extension before the initial registration expires and sets out the reasons for the extension request. Written reasons must be given by the Registrar and the student has a right of appeal.

3.3.2. Section 3.59 of the *CPSM General Regulation* provides that "*As a condition of registration, an educational (external or visiting student) member must continue to be enrolled as an external or visiting student with the Manitoba faculty or the Physician Assistant Education Program at the University of Manitoba, as the case may be.*"

3.4. <u>Cancellation of registration:</u>

3.4.1. In accordance with section 3.93 of the *CPSM General Regulation*, an external or visiting PA Student's registration is cancelled if they cease to be enrolled with the Physician Assistant Education Program or the specified period for which the registration was issued expires.

4. **EDUCATIONAL (NON-PRACTICING) CLASS**

4.1. This class is for PA Students who are on leave of absence approved by the Manitoba faculty. Section 3.60 of the *CPSM General Regulation* provides:

> *An applicant for registration as an educational (non-practising) member must establish that*
> > *(a) he or she was registered or was qualified to be registered as an educational member in good standing immediately before applying for educational (non-practising) membership; and*

(b) his or her leave of absence has been approved by the Manitoba faculty.

5. PHYSICIAN ASSISTANT (FULL) CLASS

5.1. Specific requirements for registration:

5.1.1. The specific requirements for registration in the Physician Assistant (Full) Class are set out at section 3.61 of the *CPSM General Regulation*:

3.61 An applicant for registration as a physician assistant (full) member must

(a) establish that he or she has satisfactorily completed an approved clinical training program; and

(b) establish that he or she meets one of the following criteria:

(i) he or she is a graduate of the Physician Assistant Education Program at the Manitoba faculty,

(ii) he or she

(A) is a graduate of a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States,

(B) has passed the examination set by the NCCPA, and

(C) holds the designation "PA-C",[7] [or]

(iii) he or she is a graduate of another approved physician assistant training program.

5.2. Examinations required by Council:

5.2.1. In accordance with subsection 3.37(a) of the *CPSM General Regulation*, Council requires that the applicant must have passed one of the following examinations to be initially registered in the Physician Assistant (Full) Practicing Class:[8]

5.2.1.1. the Physician Assistant Entry to Practice Certification Examination ("PA Certification Examination")[9], or

5.2.1.2. the examination set by the NCCPA.

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[7] Per section 1.4 of the *CPSM General Regulation*, "PA-C" means the "Physician Assistant – Certified" designation granted by the NCCPA. "NCCPA" means the National Commission on Certification of Physician Assistants in the United States.

[8] Council does not expressly require PAs to hold the PA-C or CCPA designation to maintain registration. However, it is recognized this may be needed to meet CPSM's continuing competency requirements under Part 10 of the *CPSM General Regulation*.

[9] The Physician Assistant Certification Council of Canada ("PACCC") is a Council of the Canadian Association of Physician Assistants ("CAPA"). The Physician Assistant Entry to Practice Certification Examination (PA Certification Examination) is recognized by the PACCC. "CCPA" means Canadian Certified PA.

5.3. <u>PA training programs approved by Council:</u>

5.3.1.   In addition to the PA training programs identified at ss. 3.61(b) of the *CPSM General Regulation* (see directly above), the following training programs have been approved by Council for the purposes of ss. 3.61(b)(iii):
5.3.1.1.   the Canadian Armed Forces,
5.3.1.2.   University of Toronto,
5.3.1.3.   McMaster University, and
5.3.1.4.   a university-affiliated program in Canada satisfactory to the Board of Assessors.

6.   PHYSICIAN ASSISTANT (RESTRICTED PURPOSE) CLASS

6.1.   <u>Specific requirements for registration:</u>

6.1.1.   As with the restricted purpose class for Regulated Members, the Physician Assistant (Restricted Purpose) Class is for the purpose of enabling a PA to engage in practice in Manitoba for a restricted purpose approved by Council. Examples include a public emergency or military service.

6.1.2.   The specific requirements for registration in the Physician Assistant (Restricted Purpose) Class are set out at section 3.62 of the *CPSM General Regulation*:

> *3.62 An applicant for registration as a physician assistant (restricted purpose) member must*
> > *(a) establish that he or she is authorized to practise medicine as a physician assistant in another jurisdiction in Canada or elsewhere and is in good standing in that jurisdiction;*
> > *(b) submit to the registrar a signed declaration that he or she will engage in the practice of medicine only for one or more of the following purposes:*
> > > *(i) to provide medical services on a temporary basis at a specified location or facility,*
> > > *(ii) to conduct a training course or clinical presentation related to his or her professional practice,*
> > > *(iii) to conduct or engage in a research program related to his or her professional practice,*
> > > *(iv) to demonstrate equipment or techniques to be used in clinical care related to his or her professional practice,*
> > > *(v) to provide medical services during a public health emergency as authorized under subsection 56(1) of the Act,*
> > > *(vi) for any other approved purpose; and*

(c) establish that he or she has met any other approved requirements for physician assistant (restricted purpose) membership.

6.2.   Terms and conditions on registration:

6.2.1.   Section 3.63 of the *CPSM General Regulation* provides:

3.63 A person may be registered as a physician assistant (restricted purpose) member for a time period, geographical area or practice setting specified by the registrar.

6.3.   Cancellation of registration:

6.3.1.   Cancellation will occur on the earliest of:
6.3.1.1.   expiry of the specified period of registration,
6.3.1.2.   receipt by CPSM of written notice that the purpose or purposes for which the registration was granted have been fulfilled, or
6.3.1.3.   the registrant ceasing to be registered and in good standing as a PA in another jurisdiction in Canada or elsewhere.

7.   PHYSICIAN ASSISTANT (ACADEMIC – S. 181 FACULTY) CLASS

7.1.   Specific requirements for registration:

7.1.1.   Section 181 of the RHPA requires CPSM register PAs in the Physician Assistant (Academic – S. 181 Faculty) Class based on a certificate from the Manitoba Faculty when the requirements of that section are met.[10] Section 181 states:

181(1) The registrar must approve an application for registration
…
(b) as a regulated associate member, if the applicant
(i) is granted a certificate by the university in accordance with subsection (2), and
(ii) meets the requirements set out in the regulations.

181(2) The university may grant a certificate under the academic seal of the university to an applicant who meets both of the following requirements:
(a) the applicant is a full-time member of the Faculty of Medicine;

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[10] When registration occurs under this section, the usual common requirements, and non-exemptible requirements under *the CPSM General Regulation* are abrogated.

(b) the applicant provides evidence to the university's satisfaction that he or she has passed any examinations required by the university and has met any other requirements of the university.

181(3) A registration may be subject to any conditions that the registrar considers advisable.

7.1.2.   Section 3.64 of the *CPSM General Regulation* lists other specific requirements for registration in the Physician Assistant (Academic – S. 181 Faculty) Class:

3.64 An applicant for registration as a physician assistant (academic — s. 181 faculty) member must
   (a) submit to the registrar a written request to approve the applicant's registration from the dean of the Manitoba faculty (or the dean's designate) that contains the following:
      (i) a confirmation that the applicant is or will be legally entitled to work or study in Manitoba before engaging in his or her professional practice,
      (ii) a confirmation that the applicant meets the approved English language fluency criteria,
      (iii) a description of the applicant's most recent professional practice and proposed professional practice; and
   (b) establish that he or she has been granted a section 181 certificate.

7.2.   Terms and conditions:

7.2.1.   Section 3.65 of the *CPSM General Regulation* provides:

3.65(1) A person may be registered as a physician assistant (academic — s. 181 faculty) member for as long as he or she holds a section 181 certificate.
3.65(2) As a condition of registration, a physician assistant (academic — s. 181 faculty) member must continue to hold a section 181 certificate.

7.3.   Cancellation

7.3.1.   The Physician Assistant (academic – s. 181 faculty) Class registrant's membership is cancelled if the member's s. 181 certificate is revoked or lapses.

8.   PHYSICIAN ASSISTANT (NON-PRACTICING) CLASS

8.1. The Physician Assistant (Non-Practising) Class is intended for those registrants who take a leave of absence from practice in Manitoba but intend to return to practice in Manitoba. This may occur when a Contract of Supervision is terminated. This class may also be used for those who no longer practice in Manitoba but whose registration has not been cancelled or surrendered. PAs without an approved Contract of Supervision may be placed in this class at the time of initial registration pending authorization of a contract.

8.2. This non-practicing class of registration is to be distinguished from the Retired (Physician Assistant) Class, which is intended for those registrants who have retired from practice. Public registry requirements are lessened in respect to those in the retired class, which is the main difference between the two classes.

8.3. To convert to the Physician Assistant (Non-Practising) Class, the registrant must meet the specific requirements set out at subsection 3.66(1) of the *CPSM General Regulation*:

> *3.66(1) An applicant for registration as a physician assistant (non-practising) member must establish that he or she was registered or was qualified to be registered as a physician assistant (full) member in good standing immediately before applying for physician assistant (non-practising) membership.*

8.4. Council has extended subsection 3.66(1) to include those registered in the Physician Assistant (Academic – S. 181 Faculty) Class.

8.5. As an exception to the usual requirement for an application to convert between classes of registration, section 3.79 of the *CPSM General Regulation provides*:

> *3.79 If a member fails to renew or voluntarily surrenders his or her certificate of practice, the registrar may change the member's registration to the applicable non-practising class.*

8.6. Conversion to the Physician Assistant (Non-Practising) Class will be the usual default for registrants who no longer hold a valid certificate of practice (e.g., if it was not renewed or their Contract of Supervision is terminated), have not expressly indicated an intention to retire, and have not otherwise had their registration cancelled.

9.   RETIRED (PHYSICIAN ASSISTANT) CLASS

9.1. Section 3.69 of the *CPSM General Regulation* provides:

> *3.69 An applicant for registration as a retired (physician assistant) member must establish that he or she was registered in good standing in one of the following classes immediately before applying for retired membership:*
> > *(a) physician assistant (full);*
> > *(b) physician assistant (academic — s. 181 faculty);*
> > *(c) physician assistant (non-practising).*

10.   CLINICAL ASSISTANT (FULL) CLASS

10.1. Specific requirements for registration:

10.1.1. The specific requirements for registration in the Clinical Assistant (Full) Class are set out at section 3.67 of the *CPSM General Regulation*:

> *3.67 An applicant for registration as a clinical assistant (full) member must*
> > *(a) complete an approved assessment; and*
> > *(b) establish that he or she meets one of the following criteria:*
> > > *(i) he or she holds*
> > > > *(A) a degree in medicine granted from a nationally approved faculty of medicine, or*
> > > > *(B) a Doctor of Osteopathic Medicine degree from a school in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation,*
> > > *(ii) he or she is a graduate of an approved and accredited physician assistant or clinical assistant training program that is restricted to a field of practice,*
> > > *(iii) he or she is a member in good standing of a regulated health profession in Manitoba,* [or]
> > > *(iv) he or she is certified in the highest level of emergency medical attendant certification at the time of application.*

10.2. Approved Assessments for ClAs:

10.2.1. ClA assessments approved by Council for the purposes of ss. 3.67(a) of the *CPSM General Regulation* are as follows:

10.2.1.1.   For ClAs with no field of practice restriction on their registration:

   i. Registered Clinical Assistant Assessment offered by the Manitoba faculty.[11]

   ii. National Assessment Collaborative OSCE (NAC-OSCE).

   iii. ~~Hold the LMCC~~Successful completion of the MCCQE1.

  10.2.1.2. For ClAs with registration restricted to practice in a specific field of practice:

   i. Satisfactory completion of a program accredited by the Royal College of Physicians and Surgeons of Canada in a Canadian University teaching hospital in the applicant's intended field of practice.

11. CLINICAL ASSISTANT (NON-PRACTICING) CLASS

11.1. The Clinical Assistant (Non-Practising) Class is intended for those registrants who take a leave of absence from practice in Manitoba but intend to return to practice in Manitoba. This may occur when a Contract of Supervision is terminated. This class may also be used for those who no longer practice in Manitoba but whose registration has not been cancelled or surrendered. ClAs without an approved Contract of Supervision may be placed in this class at the time of initial registration pending authorization of a contract.

11.2. This non-practicing class of registration is to be distinguished from the Retired (Clinical Assistant) Class, which is intended for those registrants who have retired from practice. Of note, public registry requirements are lessened in respect to those in the retired class.

11.3. To convert to the Clinical Assistant (Non-Practising) Class, the registrant must meet the specific requirements set out at subsection 3.68(1) of the *CPSM General Regulation*:

> *3.68(1) An applicant for registration as a clinical assistant (non-practising) member must establish that he or she was registered or was qualified to be registered as a clinical assistant (full) member in good standing immediately before applying for clinical assistant (non-practising) membership.*

11.4. As an exception to the usual requirement for an application to convert between classes of registration, section 3.79 of the *CPSM General Regulation provides*:

> *3.79 If a member fails to renew or voluntarily surrenders his or her certificate of practice, the registrar may change the member's registration to the applicable non-practising class.*

11.5. Conversion to the Clinical Assistant (Non-Practising) Class will be the usual default for registrants who no longer hold a valid certificate of practice (e.g., if it was not renewed or

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[11] The Clinical Assistant Assessment is no longer being conducted by the Manitoba faculty, though candidates assessed under the program in the past will still be eligible for registration.

their contract of supervision is terminated), have not expressly indicated an intention to retire, and have not otherwise had their registration cancelled.

12. **RETIRED (CLINICAL ASSISTANT) CLASS**

12.1. Section 3.70 of the *CPSM General Regulation* provides:

> *3.70 An applicant for registration as a retired (clinical assistant) member must establish that he or she was registered in good standing in one of the following classes immediately before applying for retired membership:*
>   *(a) clinical assistant (full);*
>   *(b) clinical assistant (non-practising).*

COUNCIL POLICY

Supervision of Provisional Registrants

Initial Approval: September 27, 2023	Effective Date: September 27, 2023

Contents:

1.   Application of this policy:

1.1.   For most classes of provisional registration there is a condition that the registrant only engage in the practice of medicine under supervision or monitoring. This Council Policy sets out the approved supervision requirements for provisional registrants in the following classes:[1]

1.1.1.   Provisional (Speciality Practice-Limited), per subsections 3.16(1)(f) and 3.18(2) of the *CPSM General Regulation*,

1.1.2.   Provisional (Family Practice-Limited), per subsections 3.19(1)(f) and 3.21(2) of the *CPSM General Regulation*, and

1.1.3.   Provisional (MPAP), per section 3.23 of the *CPSM General Regulation*.

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[1] This policy does not apply to supervision or monitoring requirements for those provisionally registered in the Academic classes (s. 181 Faculty, Visiting Professor, or Post-Certification Trainee), or the Public Health Officer, Restricted Purpose, Temporary-Locum, Transitional, and Non-Practising classes.

1.2.   For the above listed classes of provisional registration, registrants must enter a satisfactory arrangement with a Practice Supervisor approved by the Registrar. The prescribed arrangements for supervision will be articulated in undertakings to CPSM to be signed by the Provisional Registrant and the Practice Supervisor.

2.   Approval criteria for practice supervisors:

2.1.   The Practice Supervisor must:

    2.1.1.   be approved by the Registrar, who may consider the proposed supervisor's professional conduct history in determining whether they are approved as a supervisor,

    2.1.2.   be a fully or provisionally registered physician, and

    2.1.3.   recognize the importance of their need to demonstrate effective communication and interpersonal skills and knowledge and understanding of cultural differences and values and beliefs that affect performance in a Canadian practice environment.

2.2.   The Practice Supervisor should:

    2.2.1.   have a similar scope of practice and be in a similar current practice situation and environment as that in which the Provisional Registrant will be practising, including the possibility of geographic isolation, and

    2.2.2.   be experienced in the system, with a minimum of ~~two (2) years of independent practice~~ one year of independent practice experience in Manitoba~~.~~

2.3.   Best practices for the Practice Supervisor include:

    2.3.1.   affiliation with the Manitoba Faculty,

    2.3.2.   affiliation with relevant health institutions in the community, and/or

    2.3.3.   demonstrated commitment to training and evaluation of the work they do as a Practice Supervisor.

2.4.   Prior to approval, the Practice Supervisor must have completed relevant, formal training satisfactory to the Registrar.[2]

2.5.   The Practice Supervisor will have a direct link to a CPSM staff member or an experienced practice supervisor in the field to discuss supervision practices and concerns.

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[2] The ordinary requirement is that proposed practice supervisors must have completed the Practice Supervisor Workshop organized by the Manitoba Faculty in association with CPSM.

3.   Practice supervisor's role and responsibilities:

3.1.   The Practice Supervisor is responsible for:

   3.1.1.   assisting with orientation as may be necessary,

   3.1.2.   reviewing the Provisional Registrant's professional practice at regular intervals, as prescribed by the Registrar,[3]

   3.1.3.   receiving and reviewing audit reports prepared in accordance with this policy,[4]

   3.1.4.   ascertaining whether the Provisional Registrant is practising safely, and meeting expected clinical standards of care,

   3.1.5.   meeting with the Provisional Registrant to discuss supervision, and

   3.1.6.   providing written Monitoring Reports to CPSM on a schedule prescribed by the Registrar.[5]

3.2.   In fulfilling their supervisory responsibilities, the Practice Supervisor must always act in good faith and must:

   3.2.1.   maintain appropriate boundaries with the Provisional Registrant respecting their role and responsibilities to CPSM,

   3.2.2.   be an unbiased reporter of the observations of the Provisional Registrant's practice,

   3.2.3.   provide written Monitoring Reports to CPSM, in a form satisfactory to CPSM, at the prescribed frequency, using the input of others, including other health professionals, in completing Monitoring Reports,

   3.2.4.   make recommendations to CPSM regarding supervision and the frequency of reporting based upon the performance of the Provisional Registrant, and

   3.2.5.   provide feedback to the Provisional Registrant in an unbiased and constructive manner.

3.3.   The Practice Supervisor should identify physician enhancement opportunities to the Provisional Registrant as well as assist in learning about community resources to help meet   patient   needs   and   promote   good   care.

3.4.   Provisionally registered physicians are usually linked to a separate mentor to assist with orientation, integration into the health care system and identification of professional development based upon need. If a separate mentor cannot be

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[3]This usually includes chart reviews at a frequency determined by CPSM. A schedule of chart reviews will be set out in applicable undertakings. This requirement will include discretion for the Registrar to require additional chart reviews if concerns are identified.

[4] To support supervision and monitoring, an auditor appointed by CPSM will conduct routine audits of the Provisional Registrant's practice and produce a report. The auditor's report will be made available to the Practice Supervisor. The schedule for audits will be described in applicable undertakings.

[5] The schedule for Monitoring Reports will be set out in applicable undertakings. This will include discretion for the Registrar to require additional Monitoring Reports if concerns are raised. The schedule for Monitoring Reports will generally align with the schedule for prescribed chart reviews.

obtained, the Practice Supervisor may also assume the mentorship role, as long as this does not interfere with the Practice Supervisor's primary role, including their CPSM reporting obligations.

3.5.   Supervision of the Provisional Registrant will be monitored by CPSM.[6]

4.   Degree of supervision:

4.1.   Supervision during provisional registration is one component of a progressive path to full registration. Some components of supervision of the Provisional Registrant remain in place until they receive full registration.

4.2.   Supervision is of a graduated nature; the level will be more intense at the onset and gradually reduced through the supervisory period, as appropriate. The components and frequency of reviews and Monitoring Reports for the duration of provisional registration are to be determined by the Registrar.[7] While under supervision, the intensity of supervision may be decreased or increased based on, but not limited to:

    4.2.1.   the Practice Supervisor's Monitoring Reports, which provide explicit indications as to whether the Provisional Registrant is meeting expected standards in prescribed areas,

    4.2.2.   recommendations by the Practice Supervisor,

    4.2.3.   other forms of feedback,

    4.2.4.   audit reports prepared in accordance with this policy,

    4.2.5.   professional conduct history (e.g., complaints), and

    4.2.6.   any issues addressed in the Quality Department.

4.3.   Supervision as required under this Practice Direction will be removed immediately if the Provisional Registrant achieves the minimum eligibility requirements for full registration and converts to that class.[8]

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[6] Monitoring is typically overseen by the Assistant Registrar in the Quality Department.

[7] This usually includes chart reviews followed by a Monitoring Report 1) monthly for the first three months of supervision, 2) at nine, eighteen, and twenty-four months, and 3) at any other time at the direction of the Registrar. Immediate reporting would be required where the Practice Supervisor, for whatever reason, is of the opinion that the Provisional Registrant is unable to practice medicine safely. CPSM's Duty to Report Standard of Practice otherwise applies in the usual way.

[8] For some registrants, a determination may be made that further audits or monitoring is indicated, even after conversion to full registration. When that is the case, this will typically be accomplished through referral to the Central Standards Committee.

5.   Orientation plan:

5.1. Provisional Registrants who have not practiced medicine in Manitoba may be required to complete an orientation plan to the satisfaction of the Registrar as part of their supervisory arrangements. This is mandatory for those who have not practiced in Canada for at least two (2) years. Orientation plans are individualized, but need to include one or more of the following components, as relevant to the Provisional Registrant's professional practice:[9, 10]

5.1.1. CPSM's regulatory scheme, including Standards of Practice and Practice Directions.

5.1.2. Fundamentals regarding the Manitoba Health Care system and the role of the physician in that system.

5.1.3. Cultural sensitivity and trauma informed practices in delivering good care,

5.1.4. Patient-centered approach to care.

5.1.5. Team-based practice environments.

5.1.6. Documentation and maintenance of patient records.

5.1.7. Business arrangements and practice management in non-institutional practice settings.

5.1.8. Continuing professional development expectations.

6.   Reporting mechanisms for practice supervisors:

6.1. Nature and content of Monitoring Reports:

6.1.1. Monitoring Reports must be provided by the Practice Supervisor to CPSM. Reports must provide evidence of the competence and quality of practice of the Provisional Registrant during the identified period of supervision.

6.1.2. The Provisional Registrant must be appraised on their performance on a regular basis by the Practice Supervisor and provided with opportunities for response. This includes discussion of Monitoring Reports.

6.2. Frequency of Monitoring Reports and management of the report information:

6.2.1. Monitoring Report frequency and reporting mechanisms will be clearly defined by the Registrar.

6.2.2. Scheduling of Monitoring Reports, including tapered frequency over time, will be reflective of the demonstration of practice competence through the period of supervised practice.

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[9] In all cases, Provisional Registrants are encouraged to seek out mentorship responsibilities and opportunities to orient themselves to their practice environment.

[10] The intended purpose of the orientation plan is to set the Provisional Registrant up for success. Aspects of a good plan will be case specific. Numerous components can be accomplished through online resources, such as CPSM's published materials and educational modules offered through the Medical Council of Canada (MCC), the Canadian Medical Protective Association (CMPA), and the Manitoba Faculty.

6.2.3. Monitoring Reports must be shared with the Provisional Registrant to enable them to identify personal areas for continuing professional development.

6.2.4. The Monitoring Report will form a part of the registration file held by CPSM.

6.3. The Practice Supervisor must immediately report any concerns regarding patient safety to CPSM.

7. Audits, reviews, and inspections by CPSM:

7.1. During the period of supervision, audits of the Provisional Registrant's practice will occur on a schedule determined by the Registrar. They are conducted by a CPSM appointed auditor. The Provisional Registrant must cooperate with and participate in audits as required. This may include chart or interactive audits, as appropriate in the circumstances. The Practice Supervisor is expected to assist with audits as necessary and is provided with the audit report as part of their supervision.[11]

7.2. Reviews or inspections of the Provisional Registrant's practice by a CPSM appointee, as part of monitoring and supervision, may occur as determined by the Registrar. The Provisional Registrant must cooperate with and participate in such reviews or inspections. The Practice Supervisor is expected to assist with reviews and inspections as necessary and will be provided with any report arising therefrom.[12]

8. Agreements and undertakings:

8.1. The Provisional Registrant will be required to enter a written undertaking to CPSM regarding arrangements for supervision.

8.2. There must be a written undertaking to CPSM from the Practice Supervisor, including an undertaking to commit to the responsibilities described in this policy. The undertaking should include details with respect to:

8.2.1. charts reviews, reporting requirements, and frequency determined by CPSM,

8.2.2. declaration of freedom of any real or perceived bias or conflict of interest,

8.2.3. fulfilling supervisory responsibilities notwithstanding any financial and remuneration arrangements between the Practice Supervisor and the Provisional Registrant,

8.2.4. confidentiality between the Provisional Registrant and the Practice Supervisor, and

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[11] This usually includes a chart audit after 6 months of practice, and at any other time at the direction of the Registrar.

[12] In the usual course, this is limited to a 360-degree multisource feedback review of the Provisional Registrant's practice. This is included in applicable undertakings.

8.2.5.   principles governing the relationship between the Practice Supervisor and the Provisional Registrant and the Practice Supervisor and CPSM, including issues relating to power imbalance and resolving disputes.

8.3.   The Provisional Registrant will be responsible for costs associated with arrangements for supervision.

9.   Provisional Registrants who have completed the Royal College Subspeciality Examination Affiliate Program (SEAP):

9.1.   For the purposes of subsection 3.8(b)(i.1)(C) of the *CPSM General Regulation*, the approved period of supervised practice for those seeking full registration based on successful completion of a Royal College SEAP is to be determined by the Registrar under the following framework:

9.1.1.   In situations where the candidate has successfully completed an accredited Canadian subspecialty training program in a Royal College recognized subspeciality discipline, the Registrar may deem them to have completed the approved period of supervised practice.

9.1.2.   If the candidate has no relevant training or experience in Canada, then supervision should be for a minimum of eighteen (18) months, plus any period required to complete additional orientation, reviews, audits, or Monitoring Reports prescribed by the Registrar in accordance with this policy, up to a maximum period of twenty-four (24) months.

9.1.3.   In all other situations, the required period of supervision shall be determined on a case-by-case basis by the Registrar, up to a maximum period of twenty-four (24) months.

9.1.4.   If the Registrar determines that the Provisional Registrant has not satisfactorily completed the approved period of supervised practice, then the candidate ceases to be eligible for full registration under subsection 3.8(b)(i.1) of the *CPSM General Regulation*. In this situation, they would need to pursue another path to full registration (i.e., MPAP or RC certification).

9.1.5.   In determining whether the Provisional Registrant has satisfactorily completed the approved period of supervised practice, the Registrar will consider relevant indicators of performance and competence, including reviews, audits, and Monitoring Reports prepared in accordance with this policy.

9.2.   For clarity, during the period of supervision, the Provisional Registrant will be registered in the Provisional (Speciality Practice-Limited) Class.

PRACTICE DIRECTION

Practice and Supervision Requirements for Clinical and Physician Assistants and Physician Assistant Students

Initial Approval: March 20, 2024	Effective Date: March 20, 2024

Practice Directions set out requirements related to specific aspects of the practice of medicine. Practice Directions are used to enhance, explain, or guide registrants with respect to the subject matter relevant to the practice of medicine. Practice Directions provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, Bylaws, and Standards of Practice issued by CPSM. All registrants <u>must</u> comply with Practice Directions, per s. 86 of *The Regulated Health Professions Act*.

This Practice Direction is made under the authority of s. 85 of the RHPA and represents requirements of CPSM registrants in so far as appropriate.

This Practice Direction sets out requirements that must be followed in practice by Clinical Assistants (ClAs), Physician Assistants (PAs), Physician Assistant Students (PA Students), as well as all supervising physicians. It also includes requirements for obtaining a certificate of practice and compliance with Part 8 of the *CPSM General Regulation.* Registration requirements and policies for ClAs, PAs, and PA Students may be found in the 'Council Policy – Registration of Clinical and Physician Assistants and PA Students'.

Please note that Contextual Information for this Practice Direction is under development. When added, notice will be provided through CPSM's Newsletter.

Contents:

1.   Certificates of practice:

1.1.   ClAs, PAs, and PA Students require a valid certificate of practice[1] issued by CPSM to engage in practice.[2, 3] Certificates of practices are issued in accordance with Part 4 of the *CPSM General Regulation*.[4] Pursuant to section 4.5 of the *CPSM General Regulation*, ClAs and PAs must have an approved practice description and contract of supervision[5] before they may be issued a certificate of practice:[6]

> *4.5(1) An applicant for a certificate of practice who is or will be registered as a physician assistant (full), (restricted purpose) or (academic — s. 181 faculty) or clinical assistant (full) must also submit a practice description and contract of supervision to the registrar for approval.*
>
> *4.5(2) For the purpose of clause 41(1)(f) of the* [RHPA]*, a certificate of practice may be issued only if the registrar approves the practice description and contract of supervision.*

2.   General requirements for practice descriptions and contracts of supervision:

2.1.   Part 8 of the *CPSM General Regulation* establishes the requirements for practice descriptions and contracts of supervision for ClAs and PAs. Sections 8.1 and 8.3 state:

> *8.1 A physician assistant or clinical assistant may practise only under a contract of supervision with a regulated member and a practice description approved by the registrar. …*
>
> *…*

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[1] A certificate of practice is a license to practice medicine. This differs from a certificate of registration, which provides membership with CPSM.

[2] See sections 4.1 and 4.2 of the *CPSM General Regulation*.

[3] Subsections 4.3(1)(d), (e) and (f) of the *CPSM General Regulation* include that certificates of practice may be issued to ClAs, PAs, and PA Students. This includes PAs in the restricted purpose and academic classes as well as visiting PA Students. Note that certificates of practice are not issued to registrants in a non-practicing class.

[4] Common requirements and non-exemptible requirements for all regulated registrants are found at section 4.4 of the *CPSM General Regulation*.

[5] In brief, a contract of supervision in an agreement entered by either a ClA or a PA with a Primary Supervision (physician), whereby the Primary Supervisor undertakes to supervise the medical services provided by the ClA or PA. CPSM requires that before beginning practice, ClAs and PAs must enter a contract of supervision, in addition to completing the usual requirements for registration. Read together with this Practice Direction and the ClA's or PA's Practice Description, the contract of supervision outlines the roles and responsibilities of supervisors and the ClA or PA and sets out the scope of practice and the medical duties that the ClA or PA is permitted to perform. The Practice Description provides specific details about the professional practice in which the ClA or PA will be engaged.

[6] This requirement does not apply to PA Students.

8.3(1) A physician assistant or clinical assistant may engage in his or her professional practice only if he or she has entered into a contract of supervision approved by the registrar.

8.3(2) A physician assistant or clinical assistant may engage in his or her professional practice only in accordance with a contract of supervision, and a practice description, approved by the registrar.

8.3(3) A physician assistant or clinical assistant may be supervised by a regulated member who has signed the assistant's contract of supervision and meets the requirement in section 8.7.

2.2. <u>Practice descriptions:</u>

    2.2.1.   Sections 8.4 and 8.5 of the *CPSM General Regulation* describe general requirements for practice descriptions:

> *8.4 A practice description must*
> *(a) be in writing;*
> *(b) describe the duties and the services that the physician assistant or clinical assistant will provide; and*
> *(c) be approved by the registrar.*

> *8.5 Before expanding the scope of his or her professional practice, the physician assistant or clinical assistant must first obtain the registrar's approval of a new practice description.*

2.3. <u>Contracts of supervision:</u>

    2.3.1.   Section 8.6 of the *CPSM General Regulation* describes general requirements for contracts of supervision, including that a Primary Supervisor must be designated:

> *8.6(1) A contract of supervision must*
> *(a) be in the approved form;*
> *(b) designate by name the regulated member who will supervise the applicant as the primary supervisor and indicate the primary supervisor's role and responsibilities;*
> *(c) designate by name one or more regulated members who will supervise the applicant as an alternate supervisor and indicate*
> > *(i) the period during which, or the circumstances under which, the alternate will assume the duties and responsibilities of the primary supervisor, and*

(ii) any substantive alteration in the physician assistant's or clinical assistant's duties or responsibilities while supervised by the alternate supervisor;

(d) include a term of the contract stating that each regulated member who signs the contract agrees to supervise the physician assistant   or   clinical   assistant; for performing the duties described in the practice description;

(f) be signed by

> *(i) the applicant for registration as a physician assistant or clinical assistant,*
> *(ii) the primary supervisor,*
> *(iii) each designated alternate supervisor, and*
> *(iv) in the case of a physician assistant or clinical assistant practising in a departmental or program setting, each additional regulated member who agrees to supervise the applicant; and*

(g) be approved by the registrar.

8.6(2) With prior approval of the registrar, a contract of supervision for a clinical assistant need not meet the requirement in clause (1)(c) if the contract states that the assistant may work only when the supervisor is also working.

2.4.   Section 8.14 of the *CPSM General Regulation* places limits on the number of contracts of supervision a regulated registrant may enter as the Primary Supervisor:

> *8.14(1) At any one time, a regulated member may not be the sole primary supervisor for more than three physician assistants and clinical assistants in total.*
>
> *8.14(2) As an exception to subsection (1), the registrar may permit a member to be the supervisor for more than three physician assistants and clinical assistants. The permission must be granted before the contracts of supervision are entered into.*

2.5.   Pursuant to section 8.15 of the *CPSM General Regulation*, ClAs and PAs may enter multiple contracts of supervision:

> *8.15(1) A physician assistant or clinical assistant may enter into a contract of supervision with two or more regulated members who are not associated in a group practice or department or program setting if each of them requires the services of the assistant on a part-time basis.*

8.15(2) Each regulated member under subsection (1) is a primary supervisor and must enter into a contract of supervision with the physician assistant or clinical assistant.

2.6.   Any addition of an Alternate Supervisor or Additional Supervisor to a contact of supervision must be approved by the Registrar. This can be done by the execution of a new contract or by way of an addendum in the approved form to the original contract of supervision.

3.   Supervision of ClAs and PAs:

3.1.   Interpretation:

3.1.1.   Three categories of supervisors are established under Part 8 of the *CPSM General Regulation,* Primary Supervisors, Alternate Supervisors, and Additional Supervisors. In summary:

3.1.1.1.   **Primary Supervisor**'s role and responsibilities:

i.   The **Primary Supervisor** has ultimate and overarching responsibility for directing and reviewing the ClA's or PA's professional practice under an approved practice description and contract of supervision.

ii.   The Primary Supervisor's role and responsibilities can be transferred to an **Alternate Supervisor** designated under the contract of supervision at times when the Primary Supervisor is unavailable or unable to act in this regard.

3.1.1.2.   Immediate supervision:

i.   The **Primary Supervisor** may assign, direct, and supervise the duties and services performed by the ClA or PA while actively engaged in their practice. This is referred to as '**immediate supervision**'. When acting, the **Alternate Supervisor** may also perform these general supervisory duties.

ii.   **Additional Supervisors** may be appointed under a contract of supervision in departmental or program settings to fulfill certain supervisory duties, particularly relating to the immediate supervision of the ClA or PA in delivering patient care.[7]

iii.   While they may assign, direct, and supervise the duties and services performed by the ClA or PA, **Additional Supervisors** cannot assume the Primary Supervisor's role and responsibilities. (see section 3.4)

3.1.1.3.   Primary Supervisors, Alternate Supervisors, and Additional Supervisors must comply with the general duties for all supervisors when acting in

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[7] For clarity, Additional Supervisors are intended to extend the supervisory capabilities of the Primary Supervisor or Alternate Supervisor. They do not assume ultimate responsibility for directing the professional practice of the ClA or PA or for providing regular reviews. See section 3.8.

these capacities. The role and responsibilities of the Primary Supervisor as well as the general duties for all supervisors of ClAs and PAs are further explained below.

3.1.2.   For the purposes of this Practice Direction, the supervisor immediately responsible for supervising the ClA or PA while actively engaged in their practice is referred to as the '**responsible supervising physician'**. The responsible supervising physician must remain readily available for consultation when the ClA or PA is engaged in practice under their supervision.

3.1.3.   The clinical activities and reserved acts that may be **assigned** to a ClA or PA are set out in their approved practice description.

3.2.   Requirements to be a supervisor:

3.2.1.   Section 8.7 states:

8.7 A regulated member who meets the approved criteria may be a supervisor for a physician assistant or clinical assistant if the member has signed a contract of supervision approved by the registrar.

3.2.2.   Approved criteria for supervisors include that they must:[8]
    3.2.2.1.   be a fully or provisionally registered physician who is experienced in the system,[9]
    3.2.2.2.   recognize the importance of their need to demonstrate effective communication and interpersonal skills and knowledge and understanding of cultural differences and values and beliefs that affect performance in a Canadian practice environment, and
    3.2.2.3.   be approved by the Registrar, who may consider:
        i.   the proposed supervisor's scope of practice,
        ii.   professional conduct history, and
        iii.   potential and actual conflicts of interest
        in determining whether they should be approved as a supervisor.

3.2.3.   Section 8.18 relates to a supervisor acting through a health profession corporation:

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[8] In accordance with section 8.7, the Registrar still has discretion to refuse to add a supervisor even when these criteria are met.

[9] The candidate should have a minimum of ~~two~~ one year ~~(2) years~~ of independent practice experience in Manitoba, particularly if they are fulfilling the role and responsibilities of the Primary Supervisor.

> *8.18 To avoid doubt, subsections 64(1) to (3) of the Act apply to a supervisor in respect of his or her duties and responsibilities under this Part even if the supervisor is practising through a health profession corporation.*

3.3. Supervision in departmental or program practice setting:

3.3.1. Section 8.8 of the *CPSM General Regulation* establishes supervision criteria that must be met before a ClA or PA is permitted to work in an institutional departmental or program setting[10]:

> *8.8 A physician assistant or clinical assistant may provide services within a department or program setting if each of the following requirements is met:*
> *(a) one regulated member who works in the setting*
> > *(i) signs the contract of supervision designating the member as the primary supervisor, and*
> > *(ii) agrees to be responsible for the physician assistant or clinical assistant even when the assistant is acting under the immediate supervision of any other regulated member in the setting who has signed the contract of supervision;*
> *(b) at least one of the regulated members who works in the setting signs the contract of supervision and agrees to act as an alternate supervisor;*
> *(c) every regulated member of the department or program who agrees to supervise the physician assistant or clinical assistant signs the contract of supervision.*

3.4. Primary Supervisor's role and responsibilities:

3.4.1. Section 8.9 of the *CPSM Geneal Regulation* states, *"A primary supervisor is responsible for giving direction and providing regular reviews concerning the performance of the physician assistant or clinical assistant while he or she engages in professional practice."*

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[10] *"Institutional setting"* has the same meaning as it does elsewhere in CPSM's Standards of Practice of Medicine, which is: *"(a) a facility that is designated as a hospital under The Health Services Insurance Act; or (b) a hospital or health care facility operated by the government, the government of Canada, a municipal government, a regional health authority or CancerCare Manitoba."*

3.4.2. The Primary supervisor has ultimate responsibility for the ClA or PA's practice under an approved practice description and contract of supervision. This includes supervising the ClA or PA in accordance with the terms and conditions of the contract of supervision and practice description, as well as all regulations, Standards of Practice, Practice Directions, and the Code of Ethics.

3.4.3. Except where arrangements are in place for supervision by an Alternate Supervisor[11], the Primary Supervisor shall:

     3.4.3.1. direct and review the work, records, and practice of the ClA or PA on a continuous basis to ensure appropriate and safe care is provided to each patient cared for by the ClA or PA;[12] and

     3.4.3.2. always be reasonably available to fulfil their supervisory role when the ClA or PA is practicing, even when the ClA or PA is practicing under the immediate supervision of an Additional Supervisor in a departmental or program setting.

3.4.4. The Primary Supervisor shall contact each Alternate Supervisor named in the contract of supervision to review performance and workload issues in accordance with the evaluation provisions set out in the practice description.

     3.4.4.1. This responsibility cannot be assigned or delegated.

3.4.5. In accordance with subsection 8.12 of the *CPSM General Regulation*, the Primary Supervisor must send periodic reports to CPSM that are satisfactory to the Registrar regarding the performance of the ClA or PA in accordance with the evaluation provisions set out in the practice description.[13]

     3.4.5.1. This responsibility cannot be assigned or delegated.

3.5. <u>General duties of all supervisors of ClAs and PAs:</u>

3.5.1. Section 8.10 of the *CPSM General Regulation* outlines requirements for on-site supervision by Primary Supervisors, Alternate Supervisors, and/or Additional Supervisors:[14]

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[11] See section 8.13 of the *CPSM General Regulation*.

[12] The degree of review and direction required is a matter of professional judgment and will be dependent on the nature of the practice setting and the relationship between the Primary Supervisor and the ClA or PA.

[13] CPSM reporting obligations are integrated into the Practice Description under the heading 'Evaluation and Assessment of Performance'. For the vast majority of ClAs and PAs, the Primary Supervisor will be required to send periodic reports to the Registrar that are satisfactory to the Registrar regarding the ClA or PA's performance. Absent exceptional circumstances, for example evidence that the ClA or PA has worked with the Primary Supervisor within the previous few months under a similar Practice Description, reporting will occur on the following schedule: once per month for the first three months, every three months for the following 9 months, and every 12 months thereafter.

[14] The usual requirement will be that the Primary Supervisor, an Alternate Supervisor, an Additional Supervisor, or any combination of the foregoing must provide on-site, personal supervision for a cumulative total of at least 8 hours per month, or the total time worked by the ClA or PA if it is less than 8 hours.

> *8.10(1) For a physician assistant, a supervisor must*
>> *(a) provide personal on-site supervision for at least the number of hours each month as specified in the contract of supervision;*
>> *(b) subject to subsection (2), be available to supervise the physician assistant for at least the number of hours each week as specified in the contract of supervision; and*
>> *(c) comply with any requirement set out in the practice description concerning the supervision of physician assistants.*
>
> *8.10(2) The supervisor is not required to be physically present for the weekly supervision if the physician assistant is engaged in his or her professional practice in a location separate from the supervisor's regular practice location.*
>
> *8.10(3) For a clinical assistant, a supervisor must*
>> *(a) provide personal on-site supervision in accordance with the contract of supervision; and*
>> *(b) comply with any requirement set out in the practice description concerning the supervision of clinical assistants*

3.5.2.   In supervising ClAs and PAs, Primary Supervisors, Alternate Supervisors, and/or Additional Supervisors must ensure that the ClA or PA does not practice beyond the safe limits of their skills, knowledge, and judgement, or their authorized scope of practice. Supervisors are expected to be aware of the ClA's or PA's Level of Competence, as described in their practice description, and related limits arising therefrom. Section 8.11 of the *CPSM General Regulation* states:

> *8.11(1) A supervisor must not permit a physician assistant or clinical assistant to engage in professional practice beyond the scope of the supervisor's professional practice.[15]*
>
> *8.11(2) The supervisor must not permit or require a physician assistant or clinical assistant to engage in professional practice, including the performance of a reserved act, if the supervisor determines that the physician assistant or clinical assistant is not competent to do so.*
>
> *8.11(3) The supervisor must not permit a physician assistant or clinical assistant to independently assume some or all of the supervisor's duties or responsibilities.*

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[15] In other words, the ClA or PA is limited by the scope of practice of the responsible supervising physician.

3.6.   The role and responsibilities of ClA's and PA's:

3.6.1.   ClAs and PAs are expected to faithfully, and to the best of their knowledge, skill, and judgment, assist the Primary Supervisor in their professional practice in accordance with their approved practice description and the terms and conditions of the contract of supervision.

3.6.2.   ClAs and PAs shall comply with all proper directions of the Primary Supervisor and perform only those duties and responsibilities that are assigned by the Primary Supervisor or an Alternate Supervisor (when acting) who has signed the contract of supervision and is acting in accordance with the contract of supervision.

3.6.3.   ClAs and PAs shall cooperate with performance evaluations in accordance with their practice description.

3.6.4.   In engaging in their professional practice pursuant to the contract of supervision, the ClA or PA shall:

3.6.4.1.   Solely practice under the supervision of the Primary Supervisor, or an Alternate Supervisor or Additional Supervisor designated in the contract of supervision.

3.6.4.2.   Limit their practice solely to what is described in the practice description, including,
i.   practicing only at practice settings named in the practice description, and
ii.   refraining from the performance of any reserved act that is not listed in the practice description.

3.6.4.3.   Never practice beyond the professional scope of the responsible supervising physician's professional scope of practice, including by not performing any reserved act which the responsible supervising physician is not competent to perform.

3.6.4.4.   Comply with all rules and regulations of CPSM governing ClAs and PAs, including the *CPSM General Regulation*, the Standards of Practice of Medicine, and the Code of Ethics.

3.6.4.5.   Refrain from engaging in professional practice pursuant to a contract of supervision when the Primary Supervisor is unavailable or unable to fully fulfil their supervisory role - unless an Alternate Supervisor has assumed Primary Supervisor's role and responsibilities under the contract of supervision.

3.6.5.   Section 8.17 of the *CPSM General Regulation* provides:

> *8.17(1) A physician assistant must clearly identify himself or herself as such when engaging in professional practice.*
>
> *8.17(2) A clinical assistant must clearly identify himself or herself as such when engaging in professional practice.*

3.6.6. An overriding principle in terms of documentation and communication is that everyone in the circle of care or multidisciplinary environment must understand the ClA or PA's class of registration. This is because they are not in independent practice and must be supervised by a responsible supervising physician. This circumstance must also be understood in the context of peer review, including by a health professional regulatory authority. Information about the ClA or PAs class of registration must be reasonably reflected in the patient record, prescriptions, orders, requisitions, etc. Content in these records must also accord with institutional documentation requirements and CPSM expectations, including requirements established under the *CPSM General Regulation*.

3.7. Alternate Supervisor's role and responsibilities:

3.7.1. The Primary Supervisor is expected to designate an Alternate Supervisor in accordance with section 8.6 of the *CPSM General Regulation* to assume their role and responsibilities during any period when the Primary Supervisor is unavailable or unable to fully fulfil the role of Primary Supervisor and the ClA or PA is practicing.[16] The role of the designated Alternate Supervisor is described at section 8.13 of the *CPSM General Regulation*:

> *8.13(1) The role of a designated alternate supervisor is to assume some or all of the duties and responsibilities of the primary supervisor under the contract when he or she is absent or otherwise unable to act.*
>
> *8.13(2) If an additional or substitute alternate supervisor in a department or program is proposed,*
> > *(a) the designation of that supervisor must be confirmed in writing by the additional or substitute alternate supervisor and by the physician assistant or clinical assistant by either adding the additional designation to the contract of supervision or entering into a new contract of supervision; and*
> > *(b) the amendment or the new contract approved by the registrar.*

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[16] The exception is that responsibility for evaluation of performance and related CPSM reporting obligations cannot be assigned or delegated by the Primary Supervisor.

> *8.13(3) If the primary supervisor is absent or unable to act for any reason, he or she must take reasonable steps to ensure that the designated alternate supervisor supervises the physician assistant or clinical assistant.*

3.7.2.   Only those individuals who have signed the contract of supervision as an Alternate Supervisor may act as an Alternate Supervisor for the ClA or PA.

3.7.3.   The role and responsibilities of the Primary Supervisor may not be held concurrently by Primary Supervisor and an Alternate Supervisor. Only one Alternate Supervisor may assume the role and responsibilities of Primary Supervisor at any time.

3.7.4.   Where the Primary Supervisor is unavailable or unable to fully fulfil their supervisory role and no alternate supervising physician is available and designated, the ClA or PA must cease practicing until either:
    3.7.4.1.   the Primary Supervisor can resume their supervisory role; or
    3.7.4.2.   an alternate supervising physician is designated in accordance with subsection 8.6 of the *CPSM General Regulation*.

3.7.5.   To be clear, where an Alternate Supervisor assumes the Primary Supervisor's role and responsibilities, they and the ClA or PA are bound by the same terms and conditions as would apply as between the Primary Supervisor and the ClA or PA, including that the Alternate Supervisor will:
    3.7.5.1.   direct and review the work, records, and practice of the ClA or PA on a continuous basis to ensure that appropriate and safe care is provided to each patient cared for by the ClA or PA,
    3.7.5.2.   always be reasonably available to fulfil their supervisory role when the ClA or PA is practicing.

3.7.6.   Where an alternate supervisor identifies any concerns about the competence or fitness to practice of the ClA or PA, they must bring them to the attention of Primary Supervisor.

3.7.7.   When not acting in their capacity as an Alternate Supervisor, any person who signs the contract of supervision as an Alternate Supervisor will also have authority to act as an Additional Supervisor in a departmental or program setting.

3.8.   <u>Additional Supervisor's role and responsibilities (departmental or program setting):</u>

3.8.1.   In accordance with subsection 8.8 of the *CPSM General Regulation*, the ClA or PA may provide services under the contract of supervision within an institutional

department or program setting if each of the following requirements are met:

    3.8.1.1.   the Primary Supervisor works in the setting,

    3.8.1.2.   at least one of the regulated members who works in the setting has signed the contract of supervision as an Alternate Supervisor, and

    3.8.1.3.   every regulated registrant in the department or program who agrees to supervise the ClA or PA has signed the contract of supervision as an Additional Supervisor.

3.8.2.   When working in an institutional departmental or program setting, the ClA or PA may be assigned certain medical duties or undertake medical responsibilities under the supervision of a regulated registrant who works in the setting and is named in the contract of supervision as an Additional Supervisor. When this occurs, the Additional Supervisor will supervise the ClA or PA in relation to the medical services they perform. In this context, the Additional Supervisor will be considered a responsible supervising physician in respect to the work they supervise. However, the Primary Supervisor, or Alternate Supervisor when designated, retains ultimate responsibility for the ClA's or PA's practice. Section 8.8. of the *CPSM General Regulation* provides that:

> *8.8 A physician assistant or clinical assistant may provide services within a department or program setting if each of the following requirements is met:*
>   *(a) one regulated member who works in the setting*
>   *(i) signs the contract of supervision designating the member as the **primary supervisor**, and*
>   *(ii) **agrees to be responsible for the physician assistant or clinical assistant even when the assistant is acting under the immediate supervision of any other regulated member** in the setting who has signed the contract of supervision".*
> *(emphasis added)*

3.8.3.   Ultimately responsibility, as referred to under section 8.8. of the *CPSM General Regulation,* concerns direction and oversight of the ClA or PA's practice and performance. Part of this responsibility requires that the Primary Supervisor, or a designated Alternate Supervisor reasonably satisfy themselves that the ClA or PA is appropriately taking direction and is being adequately observed in their professional practice in accordance with the approved practice description and contract of supervision.

3.8.4.   In accordance with the general duties of all supervisors, the ClA or PA may perform medical functions that are within the scope of their practice description and the scope of the Additional Supervisor's practice when acting under the supervision of the Additional Supervisor.

3.8.5.   Where an Additional Supervisor identifies any concerns about the competence or

fitness to practice of a ClA or PA, they must bring them to the attention of Primary Supervisor.

3.9. <u>Information sharing:</u>

3.9.1. Contracts of supervision are to include appropriate information and confidentiality provisions. This includes the following:

3.9.1.1. All supervisors named in a contract of supervision are expected to speak to each other freely and to exchange any information relevant to the ClA's or PA's work and in particular the Clinical Assistant's workload and ability to manage that workload. Any supervisor named in a contract of supervision would also be expected to communicate such information to the Medical Director or Chief Medical Officer of the Regional Health Authority where they work, if applicable.

3.9.1.2. ClAs and PA are expected to notify Primary Supervisors of any investigation or proceeding related to their conduct, competence, or fitness to practice that is initiated by CPSM or any other body with statutory authority to regulate a health profession in Manitoba or Canada or elsewhere. Notice must be provided within ten (10) days of the initiation of the investigation or proceeding.

3.9.1.3. Primary Supervisors and Alternate supervisors are expected to promptly notify CPSM if they are permanently unable to fulfil their supervisory role under a contract of supervision.

3.9.1.4. PAs and ClAs are expected to promptly notify CPSM if they cease to practice at a listed practice location.

3.10. <u>Termination of contract of supervision:</u>

3.10.1. Contracts of supervision may be terminated by either the Primary Supervisor or the ClA or PA by giving thirty (30) days' notice of the fact in writing to the other and to CPSM. Contracts of supervision can be otherwise cancelled in accordance with subsection 8.16(1) of the *CPSM General Regulation*. Upon termination of the contract of supervision, the Primary Supervisor and ClA or PA must advise CPSM of the circumstances which led to termination.

3.10.2. Those named in a contract of supervision as an Alternate Supervisor, or an Additional Supervisor may have their name removed by giving thirty (30) days' notice of the fact in writing to both the Primary Supervisor and to CPSM.

3.10.3.   Under subsection 8.16(1) of the *CPSM General Regulation*, a contract of supervision is automatically cancelled if the Primary Supervisor is unable to fulfil their role and responsibilities under the contract and none of the designated Alternate Supervisors can fulfil their responsibilities under the contract.

3.10.4.   The Registrar further has discretion to cancel a contract of supervision if one or more of its terms are breached.

3.10.5.   In the event a ClA or PA can no longer work at the practice location(s) listed in a contract of supervision, for example due to loss of employment, the Primary Supervisor or Alternate Supervisor would consequently no longer be able to fulfil their supervisory role at the listed practice location(s) and therefore the contract would be cancelled. Thus, employment issues can have implications respecting the ability of the parties to fulfil the terms of a contract of supervision.

3.11. <u>Breach of contract of supervision:</u>

3.11.1.   Breach of a contract of Supervision may result in the following:
       3.11.1.1.   the imposition of conditions on the ClA's or PA's certificate of practice by the Registrar,
       3.11.1.2.   removal of an Alternate Supervisor or Additional Supervisor from the contract of supervision, or
       3.11.1.3.   cancellation of the contract of supervision.

4.   Title restrictions:

4.1.   Part 6 of the *CPSM General Regulation* establishes title restrictions for registrants.

4.1.1.   For PAs, section 6.8. of the *CPSM General Regulation* provides:

> *6.8(1) A member who is registered in any physician assistant membership class (including the physician assistant (retired) class) is permitted to use the title "physician assistant" and the abbreviation "PA" or any variation of them or equivalent in another language.*
>
> *6.8(2) No person — other than a member described in subsection (1) — shall use the title or abbreviation described in that subsection or any variation of them or the equivalent in another language alone or in combination with other words in a manner that states or implies that the person is a physician assistant.*

4.1.2.   For ClAs, section 6.9. of the *CPSM General Regulation* provides:

6.9(1) A member who is registered in any clinical assistant membership class (including the clinical assistant (retired) class) is permitted to use the title "clinical assistant" and the abbreviation "Cl. A." or any variation of them or equivalent in another language.

6.9(2) No person — other than a member who is registered in a clinical assistant membership class — shall use any titles or abbreviations listed in subsection (1) or any variation of them or the equivalent in another language alone or in combination with other words in a manner that states or implies that the person is a clinical assistant.

5.   **Performance of reserved acts and delegation of reserved acts:**

5.1.   Reserved acts are listed at section 4 of the RHPA. Subsection 5.20(1) of the *CPSM General Regulation* restricts ClAs and PAs to performing only those reserved acts they are authorized to perform by their practice supervisor where the practice supervisor is legally permitted and competent to perform the reserved act.[17]

5.2.   Delegation:

     5.2.1.   Delegation by a regulated health professional allows the recipient of the delegation to perform a reserved act they would not otherwise be permitted to perform under the RHPA. Delegation is a regulated process under the RHPA and requires assessment and monitoring on the part of the delegator.[18] Pursuant to ss. 5.16(1) of the *CPSM General Regulation*, ClAs and PAs are not permitted to delegate reserved acts.

     5.2.2.   A PA may provide direct, onsite supervision for a PA student in accordance with section 5.19 of the *CPSM General Regulation* if they themselves are legally permitted and competent to perform the reserved act. This is not equivalent to delegation.

5.3.   Prescribing Drugs or Vaccines

     5.3.1.   When involved in prescribing, ClAs and PAs must comply with all relevant CPSM Standards of Practice and Practice descriptions as well as ss. 5.8(3) and ss. 5.12 of the *CPSM General Regulation*.

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[17] See s. 4, 5 and 6 of the RHPA and s. 6 of the *CPSM Practice of Medicine Regulation* which govern the performance of reserved acts and the delegation of the performance of reserved acts.

[18] Delegation differs from collaboration or authorization. For example, a ClA or PA can write an order to another health care professional requesting that person perform a reserved act. However, for the recipient of the order to perform that act, they would have to be entitled to do so in their own right under the RHPA. In this scenario, the recipient is being asked to do something they can do; it is not a delegation.

5.3.2.   Section 5.12 of the *CPSM General Regulation* provides for specific restrictions on prescribing a drug of vaccine by a ClA or PA:

> *5.12(1) A physician assistant or clinical assistant may prescribe a drug or vaccine only if*
> > *(a) his or her supervisor has determined that the assistant is qualified to prescribe that drug or vaccine; and*
> > *(b) the prescribing is done in accordance with the assistant's practice description.*
>
> *5.12(2) A prescription issued by a physician assistant or a clinical assistant must include*
> > *(a) his or her name and the designation "PA" or "Cl. A", as the case may be;*
> > *(b) the name of his or her supervising physician;[19]*
> > *(c) his or her telephone or paging number; and*
> > *(d) one or more of the following:*
> > > *(i) the patient's clinical indication,*
> > > *(ii) the patient's diagnosis,*
> > > *(iii) the treatment goal for the patient.*

5.3.3.   Prescribing M3P schedule drugs adds additional requirements. ClAs and PAs can only prescribe M3P drugs when they are both expressly authorized to do so by:
    5.3.3.1.   the Registrar as part of their Practice Description, and
    5.3.3.2.   in accordance with section 5.12 of the *CPSM General Regulation*.

5.3.4.   M3P prescription contents are strictly regulated, including in terms of required contents. Section 5.8 of the *CPSM General Regulation provides*:
> *5.8(1) A member who is authorized under the Controlled Drugs and Substances Act (Canada) to prescribe the drugs listed on the M3P schedule must*
> > *(a) use an approved form to issue the prescription; and*
> > *(b) prescribe only one drug on each form.*
>
> *5.8(2) The prescription must*
> > *(a) include the patient's name, address, date of birth and personal health information number on the approved form;*

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[19] Prescriptions prepared by ClAs or PAs must include the name of the responsible supervising physician respecting the care provided to the specific patient. It is noted that in some institutional scenarios, the 'responsible supervising physician' may not be the physician who is considered the 'most responsible physician' for that patient's care (e.g., the admitting physician/MRP).

(b) clearly and accurately set out the name and dosage form of the drug, the quantity to be dispensed, and the directions for use, including the intervals at which the drug is to be taken; and
(c) be dated and signed by the member.

5.8(3) Subject to the regulations under the Controlled Drugs and Substances Act (Canada) and section 5.12 of this regulation, physician assistants and clinical assistants are not authorized to prescribe drugs listed on the M3P schedule.

5.3.5.   The Registrar will only consider authorizing M3P prescribing by ClAs and PAs in departmental or program practice settings that are within an institutional practice setting.

6.   Collaborative care:

6.1.   Depending on the wording of the practice description, participating in team-based or collaborative care is generally acceptable and encouraged. The work in this sense would be considered collaborative rather than a supervisory relationship. It remains the case that the ClA or PA would be required to be under supervision by a responsible supervising physician in accordance with the terms of their contract of supervision while practicing.[20]

7.   Continuing professional development

7.1.   ClAs and PAs must remain current in their area of practice, including through compliance with:

7.1.1.   the performance and evaluation provisions of their practice description, and

7.1.2.   Part 10 of the *CPSM General Regulation* and the Continuing Professional Development Practice Direction.

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[20] For example, a PA working in a health care facility under the remote supervision of their Primary Supervisor can work with other physicians or allied health care providers in that setting in a collaborative way. Physicians who are not named as supervisors in the contract of supervision are not able to act as their "responsible supervising physician".

THE COLLEGE OF
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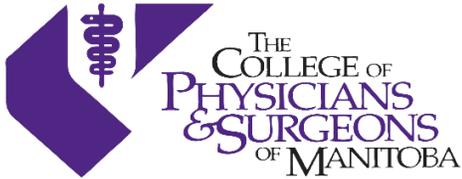
COUNCIL MEETING
MARCH 18, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Reducing Barriers for Provisional Registration of Family Registrants Update

BACKGROUND:

CPSM has consulted twice with registrants and the public regarding amending *CPSM General Regulation* related to the pathway to provisional registration for family medicine applicants.

The initial consultation took place in April of 2025. Following the consultation, the proposed amendment to *subclause 3.19(1)(b)* of the *CPSM General Regulation* (163/2018) was approved by Council with the addition of **"for recency of practice; and a total of 2 years of independent practice since post graduate training."** This wording was returned to government for assent.

In response, government felt that, due to the addition, another consultation was required. Minor wording changes were also recommended as follows:

> *… the member*
>
> > *…*
> > **(B)** *has had a total of at least 960 hours of practice experience in family medicine in the preceding 36 months, and*
> > **(C)** *has independently engaged in the practice of medicine for at least two years since completing post-graduate training …*

In November 2025, CPSM consulted on its decision to further modify the original proposed regulatory change. One registrant and two stakeholders provided comments. This second round of consultation resulted in a December 10, 2025, Council motion reaffirming the above wording.

The result of the December 10 motion was communicated to government. Unfortunately, government has indicated that since a final version of the regulation in the appropriate form was not subject to the November consultation it is considering whether it will require a third consultation on that basis. We have taken the position that further consultation is not necessary, and we are awaiting government's position on the matter.

For Information Briefing Note prepared by: Mr. Jeremy de Jong, Director of Registration and Innovation
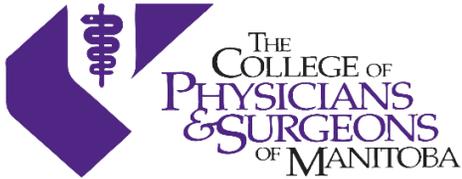
COUNCIL MEETING
MARCH 18, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Regulatory Changes to Address Emergency Room Shortages Update

ISSUE

There is an urgent need to address Emergency Room (ER) physician shortages—particularly in rural and Northern Manitoba—through regulatory amendments enabling a new class of registration for Internationally Trained Physicians (ITPs) with extensive Emergency Medicine (EM) experience, but who do not meet existing Royal College or CFPC pathways. Parallel to this, development of a Practice Ready Assessment for Emergency Medicine (PRA-EM) is underway to ensure competence and public safety.

BACKGROUND

1. Current Regulatory Constraints

Under the *CPSM General Regulation*, only two categories of registrants are presently recognized as qualified to practice in ER settings:
* Royal College–certified Emergency Medicine specialists, and
* Family physicians with Emergency Medicine training.

However, many internationally trained physicians (ITPs) have practiced exclusively in EM abroad without completing the broader training frameworks required for Canadian specialty certification. This creates a misalignment between existing regulatory categories and the competencies of available physicians, limiting CPSM's ability to respond to system needs.

2. Emerging Third Pathway

Collaboration among the Department of Emergency Medicine, the CPSM Registration Department, and Manitoba Health has resulted in a proposal for a third provisional class of registration for ITPs with satisfactory training and experience, which would capture EM-focused ITPs. This new class would include:
* distinct eligibility criteria – particularly focused on a blend of satisfactory training and practice experience,
* defined supervision and reporting requirements, and
* a mandatory practice ready assessment to verify competence (e.g., for EM).

The proposed class requires amendments to the *CPSM General Regulation* and would necessitate an accompanying Council Policy.

It is important to emphasize that while the new class could be used for any field of practice where there is an urgent need, the focus of the work to date has been on EM.

STATUS

The problem and rationale underlying this work was articulated in the September 2025 Council briefing, including through a presentation delivered by Dr. Paul Retana, Head of the Department of Emergency Medicine. Early consultation with the Manitoba Faculty and Emergency Medicine leadership has confirmed clinical feasibility and system need for EM.

1. Draft amendments to *CPSM General Regulation* 'Part 3 – Registration Classes' to add a new provisional urgent need class.

This process is very close to completion. Government, CPSM, and the Department of Emergency Medicine has endorsed the latest draft, which is with government for final formatting. We expect to hear back soon.

This work included the identification of required consequential amendments (e.g., scope of practice language, references to assessment requirements).

2. A PRA-EM framework is under development with the Department of Emergency Medicine. This is a collaborative effort with CPSM.

The Registration Department has been working closely with the Department of Emergency Medicine with reference to MCC guidance in order to develop a framework for the PRA-EM that meets the Canadian Standard. This complex work is also very close to fruition.

NEXT STEPS

1. Complete draft regulatory amendments for Executive Committee and then Council review. These will then need to be approved to be sent for public consultation and subsequent government assent.

2. Finalize the proposed framework for the PRA-EM in partnership with Emergency Medicine. The PRA-EM will then require Council approval as a new PRA program.

3. The Registration Department will need to prepare a new Council Policy to operationalize the new class of registration and PRA process.

> **For Information Briefing Note prepared by: Mr. Jeremy de Jong, Director of Registration and Innovation**
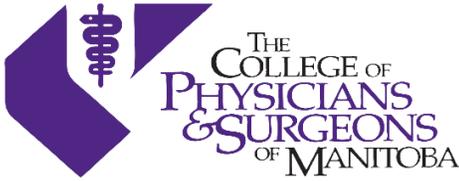
COUNCIL MEETING
MARCH 18, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Practice Ready Assessment for Emergency Doctors

Purpose: To provide an update to Council on the status of the Emergency Medicine Practice Readiness Assessment (PRA MB-EM), designed to assess candidates at the CCFP-EM/PGY3 level.

BACKGROUND:

Purpose of PRA MB-EM

The PRA MB-EM is being developed in parallel with work to establish a new class of provisional registration for ITPs based on training and experience (discussed in agenda item 5.0 ii).

The PRA MB-EM is designed to determine whether internationally trained physicians demonstrate the skills, knowledge, and judgment equivalent to a CCFP-EM/PGY3 trainee by the end of the assessment. It is not a training program, but an assessment for licensure eligibility.

Components of the PRA-EM under development

A. Governance: A governance model has been proposed including program directors, supervisors, and leadership. CPSM has identified measures needed to ensure independence and manage potential conflicts of interest. Strengthened CPSM oversight—potentially via the Board of Assessors—has been recommended.

B. Candidate Selection: Requirements include:
- Verified medical degree (World Directory);
- Relevant EM training and practice experience;
- English proficiency; and
- Credential review and pre-screening interviews.

C. Orientation: Orientation includes education on regulatory responsibilities, documentation, communication, and the Canadian healthcare system. Some expansion is recommended to fully meet CPSM expectations.

D. Structure of the PRA. Components include:
- Workplace-Based Assessment over approximately 12–16 weeks, with potential extension.
- Rotations across practice sites, tertiary centres, anesthesia, and pediatrics.
- Candidates must demonstrate PGY3-level functioning by completion.

- 16 shifts per 4-week block, covering days, evenings, nights, including weekends.

E. Assessment Tools: Daily structured feedback, rotation evaluations, and multisource feedback are used. CPSM has recommended adopting MCC-standard WBA tools and the MCC e-portfolio to strengthen standardization.

F. Program Outcomes & Licensing Pathway: Upon successful PRA completion:
1. Candidate receives a Provisional (Scope-of-Practice-Limited) licence under the new class;
2. Works independently with supervision for 2 years;
3. Undergoes a 4–6-month MPAP assessment;
4. Achieves full EM-type licence if successful.

Progress to Date

Draft regulation and requirements
- Full draft language for the new class has been completed and circulated for review among partners. With government for final development. Should be available imminently.
- For current purposes, the draft remains consistent with the intent to regulate a limited scope tailored to emergency medicine service needs.

PRA-EM Framework
- Comprehensive assessment framework drafted, including governance, rotations, assessment processes, and clinical expectations.
- Recent internal meetings have refined elements such as assessor roles, quality improvement structure, and minimum required competencies.
- Work continues to align PRA-EM with national assessment standards and CPSM guidance.

Next Steps
1. Finalize regulatory language for Council approval and consultation.
2. Finalize PRA MB-EM framework for Council approval.
3. Finalize bylaw amendments and Council policies to enable the new class of registration and PRA approval.

For Information Briefing Note prepared by: Mr. Jeremy de Jong, Director of Registration and Innovation
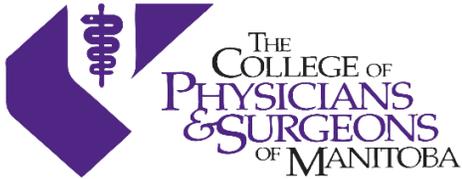
COUNCIL MEETING
MARCH 18, 2026
NOTICE OF MOTION FOR APPROVAL BRIEFING NOTE

SUBJECT: Standard of Practice – Collaborative Care Consultation

BACKGROUND:

At its December 10, 2025 meeting, Council authorized CPSM to seek input for 30 days from registrants, stakeholders, and the public on drafts of:

- Standard of Practice - Collaborative Care, *Appendix A*
- Standard of Practice - Non-Emergent Consultation Requests, *Appendix B*
- Standard of Practice - Emergent, Urgent, and Inpatient Requests, *Appendix C*
- Practice Direction - Interprofessional Health Care Delivery, *Appendix D*

The consultation period was from January 13, 2026 to February 13, 2026.

Attached as *Appendix E* is a memo to the Collaborative Care Working Group summarizing the feedback received. The Working Group met on February 24, 2026, and agreed that the attached memo accurately summarized the consultation feedback. The Working Group recommended minor amendments to the Standard of Practice – Non-Emergent Consultation Requests which are tracked changed in *Appendix B*.

Submitted as part of the consultation were Contextual Information – Collaborative Care *Appendix F*, Contextual Information – Non-Emergent Consultation Requests *Appendix G*, and Contextual Information – Emergent, Urgent, Inpatient Requests *Appendix H*. The Working Group provided feedback on suggested amendments to these documents. These amendments were not included in the attached documents because of the short turn around time from the Working Group meeting and the publication of these meeting materials. The Contextual Information documents do not require Council approval and are provided for information.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 18, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves, effective June 1, 2026, replacing the current Standard of Practice - Collaborative Care and the Practice Direction Interprofessional Collaborative Care with the attached
> - Standard of Practice - Collaborative Care

- Standard of Practice - Non-Emergent Consultation Requests
- Standard of Practice - Emergent, Urgent, and Inpatient Requests
- Practice Direction - Interprofessional Health Care Delivery

Notice of Motion for Approval Briefing Note prepared by Mr. Mike Triggs, General Counsel

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA	**Standard of Practice** **Collaborative Care**

Initial Approval: XXX, 2026	**Effective Date: XXX, 2026**

This Standard establishes how registrants must work with other health care providers when providing patient care.

Collaborative Care starts when a registrant and other health care providers begin to work together in the care of a patient and ends when the registrant's help is no longer needed.
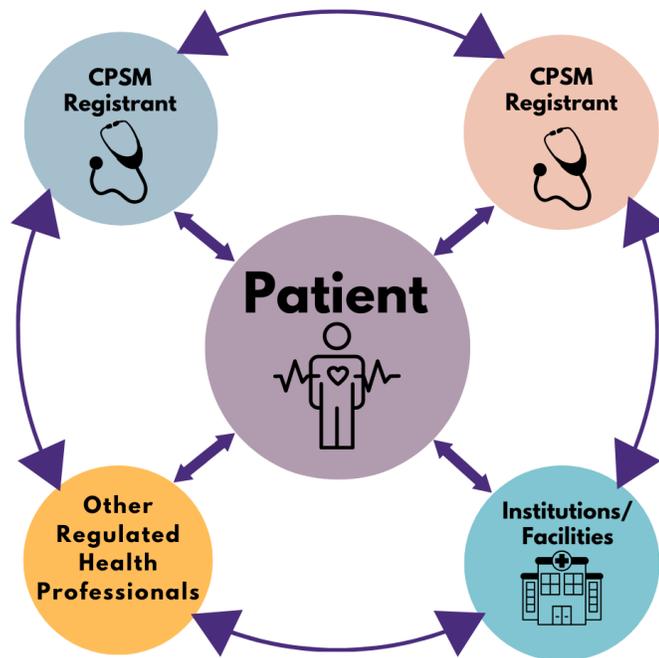
The most important goal:

Every action and decision must be based on ensuring the patient receives good medical care.

Guiding Principles from the Code of Ethics & Professionalism

Commitment to the well-being of the patient

• *Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient.*
• *Provide appropriate care and management across the care continuum.*
• *Take all reasonable steps to prevent or minimize harm to the patient; disclose to the patient if there is a risk of harm or if harm has occurred.*
• *Recognize the balance of potential benefits and harms associated with any medical act; act to bring about a positive balance of benefits over harm.*

Physicians and colleagues

• *Treat your colleagues with dignity and as persons worthy of respect. Colleagues include all learners, health care partners, and health care team members.*
• *Engage in respectful communications in all media.*
• *Take responsibility for promoting civility, and confronting incivility, within and beyond the profession. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.*
• *Assume responsibility for your personal actions and behaviours and espouse behaviours that contribute to a positive training and practice culture.*
• *Support interdisciplinary team-based practices; foster team collaboration and shared accountability for patient care.*

[Canadian Medical Association Code of Ethics and Professionalism](#)

Core Responsibilities for Effective Collaboration

Registrants must demonstrate the following when providing Collaborative Care:

1. Respond in a timely fashion.
2. Listen and consider the problem.
3. Provide care or offer professional advice.
4. Stay involved until your help is no longer needed.
5. Share enough information so others can understand the patient's situation.
6. Be professional and respectful at all times.
7. Respect the skills, expertise, scope of practice and resource settings of other collaborating health care providers.

Closed-Loop Communication

In order to share responsibility for the patient, health care providers need to acknowledge to one another when a message has been received. Closing the loop is an essential part of effective communication.

If the patient is better served by someone else, registrants help redirect the request and support the transition until complete.

Continuity of Care Responsibilities

To ensure smooth patient care transitions, registrants must:

Transfers of Care
• When transferring care, make sure the accepting registrant has all necessary clinical information (test results, active problems, treatment plan) to assume care.

Discharges and Follow-Up

• When discharging a patient from an institutional setting, (including an emergency department) who needs follow-up by another health care provider, prepare a clear summary of test results, active medical problems, and treatment plans for the follow-up appointment.

• If follow-up is needed within two weeks, contact the accepting health care provider directly to facilitate the follow-up care appointment and transfer the necessary medical information.

Delays Beyond Control

• You are not directly responsible for delays in communication caused by institutional systems issues that are outside your control.

Related Standards of Practice:
• Non-Emergent Consultation Requests
• Emergent/Urgent/In-Patient Consultation Requests

Related Resources:
• Contextual Information *****
• Practice Direction - Interprofessional Health Care Delivery

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the Regulated Health Professions Act, Regulations, and Bylaws. All registrants must comply with Standards of Practice of Medicine, per section 86 of the Regulated Health Professions Act.

This Standard of Practice of Medicine is made under the authority of section 82 of the Regulated Health Professions Act and section 15 of the CPSM Standards of Practice Regulation.

	Standard of Practice **Collaborative Care** **Non-Emergent Consultation Requests**
Initial Approval: XXX, 2026	**Effective Date: XXX, 2026**

This Standard address collaborative relationships when a registrant seeks the assistance of another registrant with specialized knowledge or experience for the care of their patient.

The most important goal is to ensure the patient receives good medical care.

Patient Rights in Referrals

A registrant seeking the assistance of another registrant for the care of a patient must:

- **Discuss the referral**: If a referral is suggested, explain to the patient why it's needed.
- **Respect patient choices**: If the patient disagrees with a referral, talk about the reasons and document the discussion. The registrant shall continue care within their abilities but never go beyond their expertise or do something they believe isn't in the patient's best interest.
- **Refuse of referral**: A registrant can refuse to make a referral if they believe it is unlikely to provide a clinical benefit to the patient.
- **Disclose uncovered fees upfront**: Tell the patient if they know of any fees not covered by Manitoba Health.
- **Choice of consultant**: If the patient wants a different consultant, try to accommodate their request.

Making and Handling Consultation Requests

- **Seeking help:** A registrant can ask another registrant with special expertise for help.
- **Shared responsibility**: Both referring and consulting registrants have a shared responsibility for providing good care. This shared responsibility begins when the consulting registrant receives a request for assistance. The nature and duration of the medical care provided by each will vary depending on individual circumstances.
- **Patient first**: As per the *Code of Ethics and Professionalism*, both registrants must "*consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient*".
- **Clear process**: Consulting registrants should clearly indicate how referrals should be submitted to them (phone, secure email, letter, fax, etc.) except in circumstances where consultations are assigned through a service that assigns the patient to a consultant.

The Referring Registrant's Responsibilities

When making a non-emergent consultation request, include:

- Patient's name, sex, age, Manitoba Health number, and contact information.
- The registrant's name and contact information (and the continuity of care provider's contact information if not the same person).
- Date of the request.
- Reason for the consultation (opinion or transfer of care).
- Whether this is a first referral or if there have been prior referrals for this consult.
- Relevant medical information (history, findings, test results, concerns regarding the issue).
- A clear, relevant clinical question to be answered or the reason for the consultation.
- Whether the consultation request is solely for a third party (ex., insurance company).

Triage Responsibilities of Registrant Receiving Requests to Help

- **Acknowledge receipt/triage a response**: Within 14 days[**] of receiving a consultation request, the consulting registrant, who has received a request for help, must inform the referring registrant:
  - Whether the referral can be processed in their routine sequencing and provide an estimated appointment date, so the referring physician can plan ongoing care. The exact appointment date can be communicated afterwards.
  - If an expedited assessment is needed, communicate the timeline in which the patient needs to be examined.
    - If unable to see the patient within the expedited timeline, help the patient/referring registrant find another qualified registrant, if any are available, who can see them within the timeline.
  - If the patient needs to be seen sooner than they can reasonably accommodate, assist in identifying a qualified registrant, if any are available, who can see them within the timeline.
  - If the consultation request cannot be processed because it lacks sufficient information to triage the request, the consulting registrant must advise what information is required.
  - If the consulting registrant does not provide the requested type of consultation, suggest other registrants who may be able to help, if possible.
  - Any other reason for not accepting the patient for consultation.
  - Any "red flags" of concern the patient should be aware of before seeing a consulting registrant.
  [**] If a consulting registrant is away from their practice, they must have an away-from-practice notification so that the referring registrant is aware that they will not receive a triage response within the 14-day timeframe. A standard out-of-office/away-from-practice message with a date of return is sufficient.
- If a consulting registrant arranges to see a patient without a referral, they must not insist on a formal request from the patient's primary care physician.

Pre & Post Appointment Requirements of Registrant Receiving Requests to Help

- **Scheduling**: Contact the patient directly to set up the appointment and inform the referring registrant. A copy of the appointment notice is sufficient to close the communication loop.
- **Consent**: Obtain informed consent directly from the patient for any procedure.

- **Pre-operation preparation**: The referring registrant may help with preparation but is not expected to assess fitness for procedures.
- **Investigations and follow-up**: Do not have the referring registrant arrange tests or follow-ups unless you both agree.

Reporting Requirements of Registrant Receiving Requests to Help

- **Timely reports**: After seeing the patient, send a detailed report to the referring registrant as soon as possible but generally within 14 days (and not more than 28 days).
- **Interim and final reports**: If more investigation or treatment is needed, send interim reports to the referring registrant and a final report at the end of the consultation.
- **Report contents** should include:
  - Consulting registrant's identity.
  - Patient's identity.
  - The referring registrant's identity (and primary care physician, if different).
  - Date of consultation.
  - Purpose of referral.
  - Information reviewed (history, findings, tests).
  - Diagnosis and treatment.
  - Recommendations for follow-up and ongoing care (for referring and consulting registrants as applicable).
  - Any referrals made to other consultants.
  - If the patient requests privacy, note information is withheld at patient's request.
  - Advice given to the patient.

Continuing and Discharge of Care

- **Clear agreements**: Registrants are to agree on ongoing or discharge care and communicate this to the patient.
- **Explain your role**: Registrants are to explain to the patient their role in ongoing care and any follow-up needed.
- **Return to referring registrant**: When the patient goes back to the referring registrant, provide written information promptly.
- **Continuing care agreements** must address, where applicable:
  - Medication and disease monitoring.
  - Post-operative care.
  - Follow-up requirements and reporting.
  - Informing about changes in care.
- **Discharge agreements** must address, where applicable:
  - Medication and disease monitoring.
  - Post-operative care.
  - When consulting registrant is no longer involved in care.
  - Criteria for re-referral to the consulting registrant.

Related Standards of Practice:
- Collaborative Care
- Emergent/Urgent/In-Patient Consultation Requests

Related Resources:
- Contextual Information *****
- Practice Direction - Interprofessional Health Care Delivery

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the Regulated Health Professions Act, Regulations, and Bylaws. All registrants <u>must</u> comply with Standards of Practice of Medicine, per section 86 of the Regulated Health Professions Act.

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7.1 APPENDIX C

	Standard of Practice
THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA	**Collaborative Care**
	Emergent, Urgent and Inpatient Requests

Initial Approval: XXX, 2026	Effective Date: XXX, 2026

This Standard establishes how registrants must work with other health care providers when responding to emergent, urgent, and inpatient care requests.

The most important goal is to ensure patient safety and timely care through collaboration.

When Collaborative Care Begins

Collaborative Care principles begin when a registrant, or other health care provider, contacts another registrant verbally or by secure text message regarding what they believe to be an emergent matter that, without immediate medical attention, places the patient's health in jeopardy.

Shared Responsibilities

- All registrants involved share responsibility for finding a safe solution for the patient.
- All registrants involved must support each other by sharing knowledge, expertise, and resources.
- All registrants involved must understand their role and responsibilities in collaborative care.

Initial Steps to Determine Care Actions

In determining the next steps of the patient's care, registrants must:

Determine if the patient can be safely and adequately treated at their present location given the resources available.

If yes - If the patient can be safely and adequately treated at their present location, develop a plan of action for their treatment.

If not - If the patient cannot be safely and adequately treated at their present location, the registrants must develop a plan of action to transfer the patient to a facility where they can be safely and adequately treated.

Responsibilities of Registrant Receiving Request to Help

Registrants receiving requests to help with emergent care:

- Should know and follow facility guidance materials for the best pathway to finding care for the patient.
- Are required to apply Collaborative Care principles to the request for assistance.

Examples of **unacceptable** behaviour/responses are:

- "It's not my problem."
- "I cannot work with you."
- "I cannot help you; my facility doesn't have beds."
- Providing negative feedback on the expected skills, resources, or scope of practice of the other registrant.

The Referring Registrant's Responsibilities

Registrants making a request for help with emergent care:

- Should articulate the reason why assistance is sought.
- Provide relevant medical information (history, findings, test results, concerns regarding the issue).
- Provide the registrant receiving the request to help with reasonable assistance within their knowledge, skill and judgement, and resources available to them.

Transfer of Patient

If the patient cannot safely and adequately be treated at their present location, registrants must:

- **Identify an appropriate facility**: Determine where the patient can be safely and adequately treated.
- **Coordinate the transfer**: Collaborate on arranging the transfer, involving all necessary resources and registrants (including those at multiple facilities, if required).
- **Share responsibility**: All registrants involved in developing the plan of action share responsibility for finding a safe solution for the patient.
- **Follow facility policies**: If the accepting service at the identified facility is unclear, the registrant at the receiving facility should follow their facility's policies.
- **Avoid unnecessary delays**: The transfer should not be delayed while seeking clarity about accepting service.

Interventions and Documentation

During the process of determining the next steps in the patient's care, interventions (tests, procedures, or treatments) may be required. Registrants must:

- Work together to decide how to perform necessary interventions (test, procedures, treatments).
- Not require the calling registrant to perform interventions beyond their ability.

If Transfer is Declined

If a transfer request is declined and the patient remains under the calling registrant's care, the consultant registrant should express willingness to accept follow-up calls if the patient's condition changes.

Applicability to All Health Care Professionals

Although these guidelines often describe two registrants working together, the same principles apply when working with other health care professionals.

Related Standards of Practice:
- Collaborative Care
- Non-Emergent Consultation Requests

Related Resources:
- Contextual Information *****
- Practice Direction - Interprofessional Health Care Delivery

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the Regulated Health Professions Act, Regulations, and Bylaws. All registrants <u>must</u> comply with Standards of Practice of Medicine, per section 86 of the Regulated Health Professions Act.

This Standard of Practice of Medicine is made under the authority of section 82 of the Regulated Health Professions Act and section 15 of the CPSM Standards of Practice Regulation.

PRACTICE DIRECTION

Interprofessional Health Care Delivery

Initial Approval:	**Effective Date:** XXXXX

Practice Directions set out requirements related to specific aspects of the practice of medicine. Practice Directions are used to enhance, explain, or guide registrants with respect to the subject matter relevant to the practice of medicine. Practice Directions provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, Bylaws, and Standards of Practice issued by CPSM. All registrants <u>must</u> comply with Practice Directions, per s. 86 of The Regulated Health Professions Act.

This Practice Direction is made under the authority of s 85 of the RHPA with specific reference to Part 10 of the CPSM General Regulation.

Introduction

The purpose of the Standards of Practice related to Collaborative Care is to provide guidance to registrants on how they deliver care with other health care providers. When the phrase "other health care providers" is used it may, depending on the circumstances, mean another registrant or another regulated health professional.

Essential Requirements of Successful Interprofessional Health Care Delivery

When registrants are providing collaborative care with other regulated health professionals they are working as a team. The elements of successful teamwork are:

Patient Centric
The most important goal of the Standard of Practice - Collaborative Care is:

> Every action or decision must be based on ensuring the patient receives good medical care.

Communication
While engaging in collaborative care, the registrant's behaviour with other health care providers must be in accordance with *The Code of Ethics and Professionalism*:

- *Treat your colleagues with dignity and as persons worthy of respect. Colleagues include all learners, health care partners, and health care team members.*

- *Engage in respectful communications in all media.*

- *Take responsibility for promoting civility, and confronting incivility, within and beyond the profession. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.*

- Assume responsibility for your personal actions and behaviours and espouse *behaviours that contribute to a positive training and practice culture.*

- *Support interdisciplinary team-based practices; foster team collaboration and shared accountability for patient care.*

Respect
Registrants must:

- maintain a consistently professional and respectful demeanour
- recognize and respect the skills, expertise, scope of practice, and resource setting of the other collaborating regulated health professionals involved in the care of the patient

Role Clarification
When registrants work collaboratively with other regulated health professionals, each party will have different roles and responsibilities for providing care to the patient based on their respective scopes of knowledge, skills, and abilities. Effective collaborative care is dependent on the parties knowing their role and competence in the delivery of care to the patient.

Registrants must:

- know their role and responsibilities in the delivery of care to the patient
- recognize their own limitations in skills, knowledge and abilities
- know the role of and use the full scope of knowledge, skills and abilities of other regulated health professionals to provide care that is safe, timely, efficient, effective and equitable

The parties must also have a clear understanding of the goal of collaborative care for the patient. Ensuring the other health care providers understand the goal will enable them to best apply their knowledge, skills and abilities to their role and responsibilities. How this is achieved will be depend on the circumstances of the collaborative care being provided but the registrant needs to ensure that understanding exists.

Leadership
In most situations the registrant will have a leadership role in the delivery of collaborative care. Effective leadership is crucial for guiding the team, facilitating communication, and resolving conflicts. As leaders, registrants must promote a culture of collaboration and respect.

However, depending on the situation and environment another health care professional may have the lead role. In these circumstances registrants must understand their role and be respectful of the other's lead role.

Shared Decision-Making:
Involving all relevant team members in care planning and decision-making promotes comprehensive and patient-centered care.

Including the patient as a part of the team is also very important.

MEMORANDUM

TO: Working Group – Collaborative Care

FROM: Mike Triggs, General Counsel

DATE: February 17, 2026

RE: Collaborative Care Consultation

Consultation Format

The consultation took the form of a survey. The questions varied slightly depending on how the person identified themselves (referring registrant, consulting registrant, referring & consulting registrant, or public). In total 193 commenced the questionnaire, 120 answered every question. The survey contained check box answers and free flow comments. All answers are attached as ==**Appendix A**==. Registrant Feedback begins on page 1 of the PDF document, Public Feedback begins on page 64, and written submissions from the CMPA begin on page 82, and Doctors Manitoba begin on page 86.

Each survey participant is assigned a number and is categorized as a referring registrant, consulting registrant, referring & consulting registrant or public. For each question, we have displayed the total numbers for each answer and how each participant answered. Where comments were provided, we identified the number assigned to the participant who provided the comment.

For example, Q4 asked:

How important is closed-loop communication (health care providers acknowledging receipt of communication) to the provision of good medical care?

31 referring registrants said it was very important and 9 said it was important. None answered – neutral, not that important, or not important at all.

Survey #90 (a referring registrant) said:

"it helps with admin burden - if i do not get an acknowledgement of receipt, my receptionist will follow up - and if a fax was dropped or lost - we can lose months of time thinking that the consult is actually in the works."

SURVEY RESULTS

The survey results were overwhelmingly positive, and the limited criticism was constructive.

That said, it is important to review the survey results and the comments. To aid in your review I have identified the following themes:

1.   Administrative challenges faced by consultants receiving an excessive number of referrals.

The survey divided the 14-day triage response into two parts (acknowledging receipt and responding with specific content). The majority of respondents were able to acknowledge receipt and respond with specific content 100% of the time or about 80% of the time within the 14-day period. However, approximately 35% of respondents identified that they would have difficulty meeting these timelines more than half of the time. The source of the difficulty is volume of referrals and resources to process them.

2.   Uncertainty about how communication is to take place.

Several registrants identified that the Standards did not specify how communication is to take place– faxes, emails, Tiger Connect, or phone.

3.   System/technical/VECTRS issues.

Several registrants identified that "system" issues related to lack of integration, communication and collaboration will make it difficult for compliance with the new standards unless there are changes within the system.

Survey #64 provided the following response to Q14 (If executed correctly, do you think these guidelines will enhance care for patients by improving communication and collaboration between physicians involved in their care?):

Survey #64: *Yes! However I think it would be great if other major players could co-release statements at the same time as the CPSM, acknowledging that they know about the changes, and whether or not they plan to comply. Eg. The department heads of individual diagnostic imaging departments should release a statement that they've reviewed the CPSM SOP, identified areas where they are part of the "system issues", and how they will endeavor to make improvements to comply with the SOP, as their employees are effectively entering a Collaborative Care arrangement by virtue of receiving and triaging the requests. Eg. VECTRS should release a statement that it's aware of the SOP, and has had a conversation w/ CPSM about how they may be facilitating (or impeding) complying with the standard.*

4.   Tweaks

Below are some of the improvements suggested:

Clinics should identify patient's communication modality for contacting them.

Statement that explains how registrants in institutions are to foster improvement in collaborative care. The current language allows them to use the "system" loophole for doing nothing.

CPSM should have a communication strategy with institutions, facilities, and RHAs for the rollout of the Standards.

Consultation requests should indicate whether this is the 1st or multiple consults for the patient.

Identify whether referring registrant is the primary care physician or walk-in physician.

Referring physician should identify when consultation referral is urgent, ex. suspected ectopic pregnancies.

More examples in Contextual Information, from simple scenarios to more ambiguous and debatable scenarios. Include a better explanation of what is relevant and not relevant information that is sent to a consultant as part of a referral request.

Clarity that these standards apply to Diagnostic Imaging.

Highlight points in the standards that have additional contextual information available.

SUMMARY of SURVEY RESULTS:

REGISTRANTS:

Q. 2 - 96.7% (119/123) either strongly agree or agree with the goal of the standard – Every action and decision must be based on ensuring the patient receives good medical care.

Q.3 - 96.7% (119/123) either strongly agree or agree with the stated 7 core responsibilities of effective collaboration.

Q. 4 – 91.9% (113/123) believe closed-loop communication is very important or important.

Q. 5 – 52.8% (65/123) feel more confident in their ability to meet the standard knowing that they will not be held responsible for delays in communication that are beyond their control.

Q.6 - 72.4% (89/123) believe the continuity of care responsibilities are extremely reasonable or very reasonable.

Q.7 – 93.5% (101/108) believe the referring registrant's responsibilities for making a non-emergent consultation request are clear.

Q.8 – 77.1% (27/35) of referring registrants believe a 14-day timeframe for a consulting registrant to acknowledge receipt of a consultation request is reasonable.

65.7% (48/73) of consulting and referring/consulting registrants believe it is feasible to meet the 14-

day timeframe to report after seeing a patient in 100% or 80% of the time.

Q.9 85.7% (30/35) of referring and referring/consulting registrants believe a 14-day timeframe for a consulting registrant to provide a triaged response is reasonable.

64.4% (47/73) of consulting and referring/consulting registrants believe it is feasible to meet the 14-day timeframe to report after seeing a patient in 100% or 80% of the time.

Q.10 (Q.11) 71.2% (26/35) of referring registrants believe a 14-day timeframe for a consulting registrant to provide a report after seeing the patient is reasonable.

71.2% (52/73) of consulting and referring/consulting registrants believe it is feasible to meet the 14-day timeframe to report after seeing a patient in 100% or 80% of the time.

Q.11 (Q.12) 80.0% (80/100) of registrants believe the role of registrants involved in the transfer of a patient in emergent situations is clearly defined.

Q.12 (Q.15) 93.9% (62/66) of registrants strongly agree or agree the role of registrants involved in collaborative emergent care is clearly defined.

<mark>PUBLIC:</mark>

Q.2 – 89.3% (25/28) either strongly agree or agree with the goal of the standard – Every action and decision must be based on ensuring the patient receives good medical care.

Q.3 - 100% (28/28) believe it is very important or important that doctors work together and share information about the patient's care.

Q.4 – 28.6% (8/28) believe a 14-day timeframe for a consulting registrant to acknowledge receipt of a consultation request is reasonable; 50.0% (14/28) believe less than 14 days is reasonable.

Q.5 – 89.3% (25/28) either strongly agree or agree that collaborative care leads to better health outcomes for patients.

Q.7 – 71.4% (20/28) do not have concerns about doctors who treat them sharing information with each other and work together as part of the patient's care.

Q.9 – 92.9% (26/28) are very supportive or somewhat supportive of a standard of practice that encourages collaborate care.

REGISTRANT SURVEY RESULTS

About the survey:

The survey was created on SurveyMonkey, and it launched on January 13.

The survey for collaborative care was designed in four different versions

1. Referring physician
2. Consulting physician
3. Both referring and consulting physicians
4. Public member (resident of Manitoba)

A total of **193** respondents opened the survey; **120** completed it in its entirety, and 73 began it but abandoned it, marking it incomplete. Although incomplete, SurveyMonkey includes the provided answers and is recorded in the results below.

Q1: Choose one of the following:

- I am a referring physician
- I am a consulting physician
- I am both a referring physician and consulting physician
- I am a member of the public (patient) residing in Manitoba

Category	Count
Referring physician	46
Consulting physician	30
Both referring and consulting physician	72
Member of the public	45
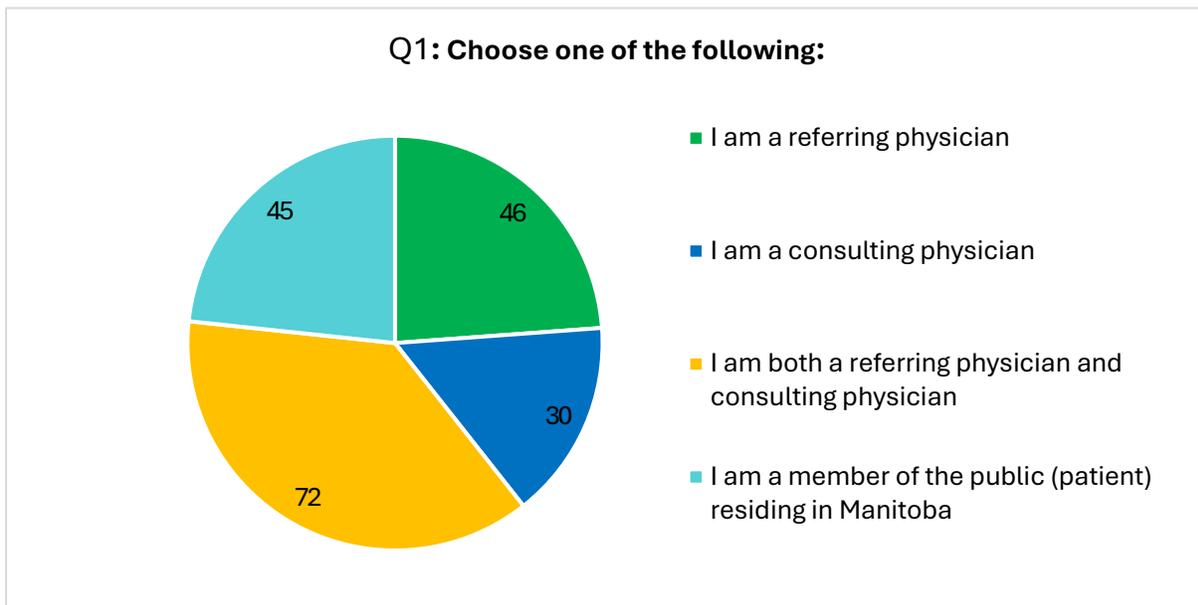
Survey participation overview categorized by version type and status

|														
*1 IN	2	3 IN	4	5	6	7	8	9	10	11	12	13 IN	14	15
*16 IN	17	18	19 IN	20	21 IN	22 IN	23 IN	24 IN	25 IN	26	27 IN	28 IN	29	30
31	32	33	34	35	36	37	38	39 IN	40	41 IN	42 IN	43	44	*45 IN
46	47 IN	48	49 IN	50	*51 IN	52	53 IN	54 IN	55 IN	56 IN	*57 IN	58 IN	59	60
61	62	63	64	65	66	67	68	69	70 IN	71 IN	72	73	*74 IN	75 IN
76	*77 IN	78	*79 IN	80	81	82	83	*84 IN	85	86	87	88 IN	89	90
*91 IN	*92 IN	93 IN	94	95	96 IN	97	98	99	100	101 IN	102	103 IN	104 IN	105
*106 IN	107 IN	108 IN	109	110	111	*112 IN	113	*114 IN	115	*116 IN	*117 IN	118	119	120
121	*122 IN	123	*124 IN	125	126	127	*128 IN	129 IN	130	*131 IN	132	133	134 IN	135 IN
136	137 IN	*138 IN	139 IN	140	141	142	143	*144 IN	*145 IN	146	*147 IN	148	149 IN	150
151	152	153	154	155	156	157	158	*159 IN	160	161	162 IN	163 IN	164	165
166	167	168 IN	169	170	171 IN	172 IN	173	174	175	*176 IN	177	178	179 IN	180
181	182	183 IN	184	185	186	187	188	189	190	191	192	193		

IN: incomplete survey.

*: didn't complete the survey in its entirety, however, provided some answers

🟩 : Referring physician

🟦 : Consulting physician

🟧 : Both referring and consulting physician

🟦 : Public member

Section 1 – Standard of Practice Collaborative Care

Q2: The goal of the standard is: **Every action and decision must be based on ensuring the patient receives good medical care.** On a scale from 1-5, how strongly do you agree (with 5 being strongly agree) or disagree (1 being strongly disagree) with the statement?

	Referring Physicians	Consulting Physicians	Referring and Consulting
■ Strongly Agree	32	18	40
■ Agree	7	5	17
■ Neutral	0	0	1
■ Disagree	1	0	0
■ Strongly Disagree	0	0	2
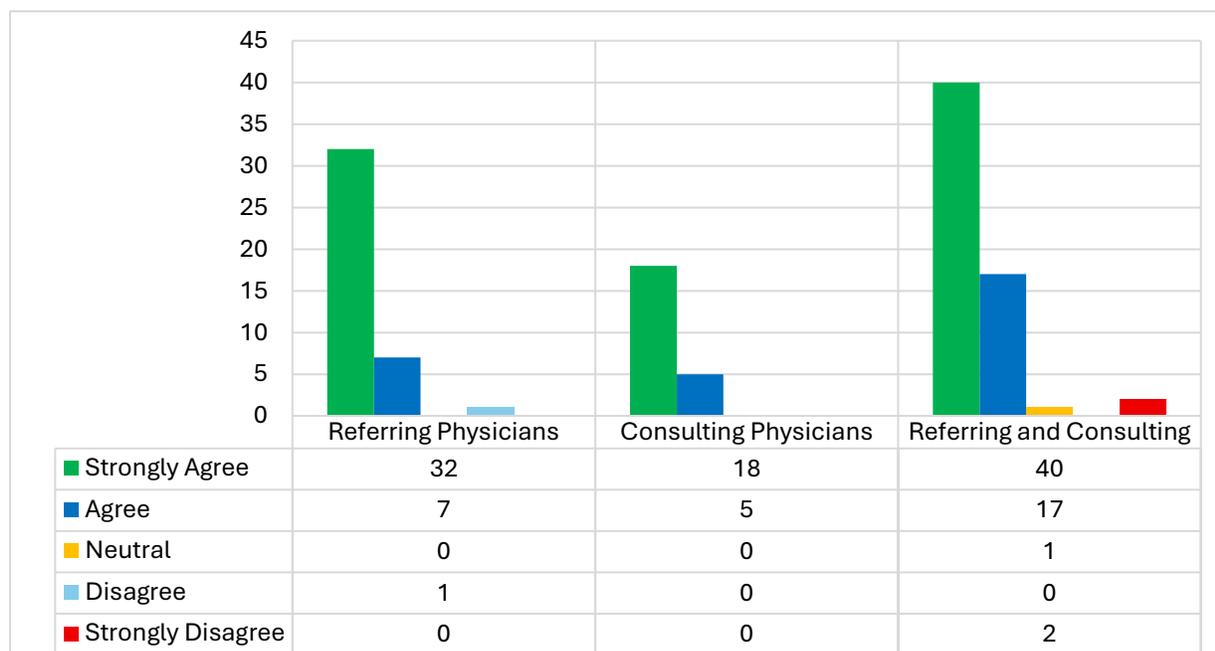
Referring Physicians	Consulting Physicians	Referring and Consulting
Survey #2: Strongly Agree	**Survey #4:** Agree	***Survey #1:** Agree
Survey #5: Strongly Agree	**Survey#66:** Strongly Agree	****Survey #7:** Strongly agree
Survey #6: Strongly Agree	**Survey #72:** Agree	**Survey #9:** Agree
**Survey #7: Strongly Agree	**Survey #74:** Strongly Agree	**Survey #10:** Agree
Survey #8: Agree	**Survey #78:** Strongly Agree	**Survey #12:** Agree
Survey #11: Strongly Agree	**Survey #79:** Strongly Agree	**Survey #15:** Strongly agree
Survey #38: Strongly Agree	**Survey #80:** Strongly Agree	***Survey #16:** Strongly agree
Survey #40: Strongly Agree	**Survey #82:** Strongly Agree	**Survey #17:** Strongly agree
*Survey #45: Strongly Agree	**Survey #84:** Agree	**Survey #18:** Strongly agree
Survey #46: Strongly Agree	**Survey #85:** Strongly Agree	**Survey #20:** Strongly agree
*Survey #57: Strongly Agree	**Survey #100:** Agree	**Survey #26:** Agree
Survey #61: Agree	**Survey #109:** Strongly Agree	**Survey #32:** Agree
Survey #63: Strongly Agree	**Survey #110:** Strongly Agree	**Survey #34:** Strongly agree
Survey # 89: Strongly Agree	**Survey #111:** Strongly Agree	**Survey #43:** Strongly agree
Survey # 90: Strongly Agree	***Survey #114:** Strongly Agree	**Survey #50:** Agree
*Survey #106: Agree	***Survey #117:** Strongly Agree	**Survey #51:** Strongly agree
*Survey #116: Agree	***Survey #124:** Strongly Agree	**Survey #59:** Strongly agree
Survey #120: Strongly Agree	***Survey #138:** Strongly Agree	**Survey #64:** Strongly agree
Survey #121: Strongly Agree	**Survey #141:** Strongly Agree	**Survey #65:** Strongly agree
Survey #123: Strongly Agree	**Survey #142:** Strongly Agree	**Survey #68:** Strongly agree
Survey #125: Disagree	**Survey #143:** Strongly Agree	**Survey #73:** Strongly disagree

Survey #130: Strongly Agree	**Survey #156:** Strongly Agree	**Survey #76:** Agree
***Survey #131:** Strongly Agree	**Survey # 165:** Agree	***Survey #77:** Strongly agree
Survey #136: Agree		**Survey #86:** Strongly agree
****Survey #145:** Strongly Agree		**Survey #87:** Agree
Survey #146: Strongly Agree		***Survey #91:** Strongly agree
Survey #150: Strongly Agree		***Survey #92:** Strongly disagree
Survey #153: Strongly Agree		**Survey #94:** Strongly agree
Survey #155: Strongly Agree		**Survey #98:** Agree
Survey #154: Strongly Agree		**Survey #99:** Neutral
Survey #158: Strongly Agree		***Survey #112:** Agree
Survey #164: Agree		**Survey #113:** Strongly agree
Survey #166: Strongly Agree		**Survey #115:** Strongly agree
Survey #174: Strongly Agree		**Survey #118:** Agree
Survey #175: Agree		**Survey #119:** Strongly agree
***Survey #176:** Strongly Agree		***Survey #122:** Strongly agree
Survey #182: Strongly Agree		**Survey #126:** Strongly agree
Survey #185: Strongly Agree		**Survey #127:** Strongly agree
Survey #190: Strongly Agree		***Survey #128:** Strongly agree
Survey #193: Strongly Agree		**Survey #133:** Agree
		***Survey #137:** Strongly agree
		Survey #140: Strongly agree
		***Survey #144:** Strongly agree
		****Survey #145:** Strongly agree
		***Survey #147:** Strongly agree
		Survey #148: Strongly agree
		Survey #151: Strongly agree
		Survey #152: Strongly agree
		Survey #154: Strongly agree
		***Survey #159** Strongly agree
		Survey #161: Strongly agree
		Survey #167: Agree
		Survey #169: Agree
		Survey #170: Agree
		Survey #180: Strongly agree
		Survey #181: Strongly agree
		Survey #184: Strongly agree
		Survey #186: Agree
		Survey #187: Strongly agree
		Survey #192: Strongly agree

*Incomplete survey (started, but abandoned), however, the feedback that was provided has been recorded
**The respondent provided feedback on both referring and referring/consulting versions of the survey

Q3: The core responsibilities for effective collaboration in the standard are:
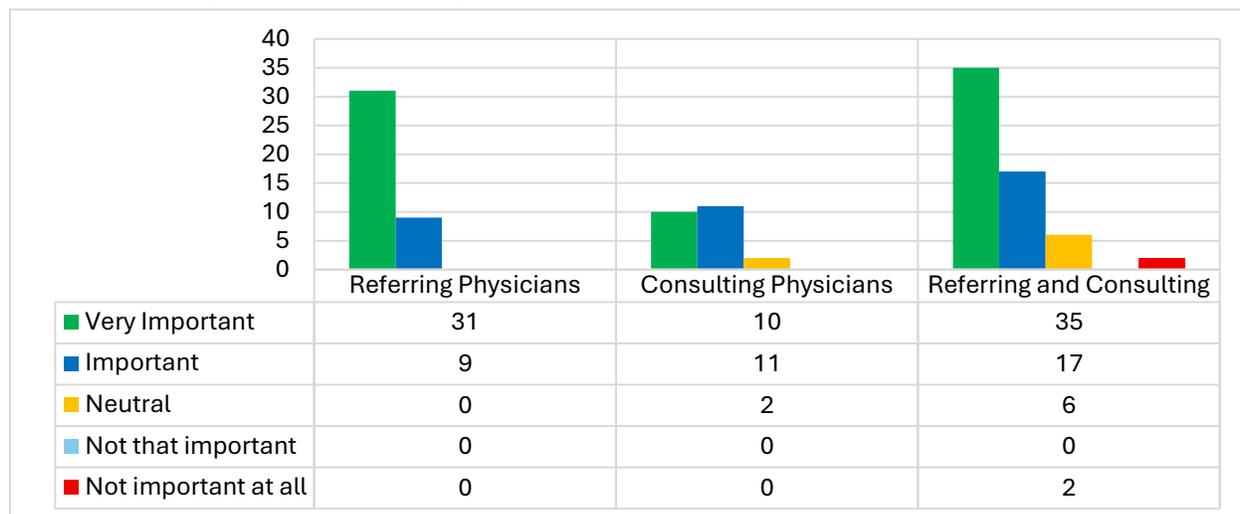
> **Core Responsibilities for Effective Collaboration** Registrants must demonstrate the following when providing Collaborative Care:
>
> 1. Respond in a timely fashion.
> 2. Listen and consider the problem.
> 3. Provide care or offer professional advice.
> 4. Stay involved until your help is no longer needed.
> 5. Share enough information so others can understand the patient's situation.
> 6. Be professional and respectful at all times.
> 7. Respect the skills, expertise, scope of practice and resource settings of other collaborating health care providers.

On a scale from 1-5, how strongly do you agree (with 5 being strongly agree) or disagree (1 being strongly disagree) with the core principles of the standard?

	Referring Physicians	Consulting Physicians	Referring and Consulting
Strongly Agree	31	18	39
Agree	8	4	19
Neutral	0	0	1
Disagree	0	1	0
Strongly Disagree	1	0	1

Referring Physicians	Consulting Physicians	Referring and Consulting
Survey #2: Strongly agree	**Survey #4:** Strongly agree	***Survey #1:** Agree
Survey #5: Strongly agree	**Survey# 66:** Strongly agree	****Survey #7:** Agree
Survey #6: Strongly agree	**Survey #72:** Agree	**Survey #9:** Agree
****Survey #7:** Agree	**Survey #74:** Strongly agree	**Survey #10:** Agree
Survey #8: Strongly agree	**Survey #78:** Strongly agree	**Survey #12:** Neutral
Survey #11: Strongly agree	**Survey #79:** Strongly agree	**Survey #15:** Agree
Survey #38: Strongly agree	**Survey #80:** Strongly agree	***Survey #16:** Strongly agree
Survey #40: Strongly agree	**Survey #82:** Strongly agree	**Survey #17:** Strongly agree
***Survey #45:** Strongly agree	***Survey #84:** Agree	**Survey #18:** Agree
Survey #46: Strongly agree	**Survey #85:** Disagree	**Survey #20:** Agree
***Survey #57:** Strongly agree	**Survey #100:** Strongly agree	**Survey #26:** Agree
Survey #61: Agree	**Survey #109:** Strongly agree	**Survey #32:** Strongly agree
Survey #63: Strongly agree	**Survey #110:** Strongly agree	**Survey #34:** Agree
Survey # 89: Strongly Agree	**Survey #111:** Strongly agree	**Survey #43:** Strongly agree
Survey # 90: Strongly Agree	***Survey #114:** Strongly agree	**Survey #50:** Strongly agree
***Survey #106:** Agree	***Survey #117:** Strongly agree	***Survey #51:** Strongly agree
***Survey #116:** Agree	***Survey #124:** Agree	**Survey #59:** Strongly agree
Survey #120: Strongly Agree	***Survey #138:** Strongly agree	**Survey #64:** Strongly agree

Survey #121: Strongly Agree	**Survey #141:** Strongly agree	**Survey #65:** Agree
Survey #123: Strongly Agree	**Survey #142:** Strongly agree	**Survey #68:** Agree
Survey #125: Strongly disagree	**Survey #143:** Agree	**Survey #73:** Strongly agree
Survey #130: Strongly Agree	**Survey #156:** Strongly agree	**Survey #76:** Strongly agree
***Survey #131:** Strongly Agree	**Survey #165:** Strongly Agree	***Survey #77:** Strongly agree
Survey #136: Agree		**Survey #86:** Strongly agree
****Survey #145:** Strongly Agree		**Survey #87:** Strongly agree
Survey #146: Strongly Agree		***Survey #91:** Strongly agree
Survey #150: Strongly Agree		***Survey #92:** Strongly disagree
Survey #153: Strongly Agree		**Survey #94:** Strongly agree
Survey #155: Strongly Agree		**Survey #98:** Agree
Survey #157: Strongly Agree		**Survey #99:** Agree
Survey #158: Agree		***Survey #112:** Strongly Agree
Survey #164: Agree		**Survey #113:** Strongly Agree
Survey #166: Strongly Agree		**Survey #115:** Strongly Agree
Survey #174: Strongly Agree		**Survey #118:** Agree
Survey #175: Agree		**Survey #119:** Agree
***Survey #176:** Strongly Agree		***Survey #122:** Strongly Agree
Survey #182: Strongly Agree		**Survey #126:** Agree
Survey #185: Strongly Agree		**Survey #127:** Strongly Agree
Survey #190: Strongly Agree		***Survey #128:** Strongly Agree
Survey #193: Strongly Agree		**Survey #133:** Agree
		***Survey #137:** Strongly Agree
		Survey #140: Strongly Agree
		Survey #144: Strongly Agree
		****Survey #145:** Strongly Agree
		***Survey #147:** Strongly Agree
		Survey #148: Strongly Agree
		Survey #151: Strongly Agree
		Survey #152: Strongly Agree
		Survey #154: Agree
		***Survey #159:** Strongly Agree
		Survey #161: Agree
		Survey #167: Strongly Agree
		Survey #169: Strongly Agree
		Survey #170: Strongly Agree
		Survey #180: Strongly Agree
		Survey #181: Strongly Agree
		Survey #184: Strongly Agree
		Survey #186: Strongly Agree
		Survey #187: Strongly Agree
		Survey #192: Strongly Agree

Q4: How important is closed-loop communication (health care providers acknowledging receipt of communication) to the provision of good medical care?

	Referring Physicians	Consulting Physicians	Referring and Consulting
■ Very Important	31	10	35
■ Important	9	11	17
■ Neutral	0	2	6
■ Not that important	0	0	0
■ Not important at all	0	0	2

Referring Physicians	Consulting Physicians	Referring and Consulting
Survey #2: Important	Survey #4: Very important	*Survey #1: Important
Survey #5: Very important	Survey# 66: Important	**Survey #7: Important
Survey #6: Very important	Survey #72: Important	Survey #9: Not important at all
**Survey #7: Important	Survey #74: Very important	Survey #10: Very important
Survey #8: Very important	Survey #78: Important	Survey #12: Very important
Survey #11: Important	Survey #79: Very important	Survey #15: Important
Survey #38: Very important	Survey #80: Very important	*Survey #16: Very important
Survey #40: Very important	Survey #82: Important	Survey #17: Very important
*Survey #45: Very important	*Survey #84: Important	Survey #18: Important
Survey #46: Very important	Survey #85: Neutral	Survey #20: Very important
*Survey #57: Very important	Survey #100: Important	Survey #26: Neutral
Survey #61: Important	Survey #109: Very important	Survey #32: Very important
Survey #63: Very important	Survey #110: Important	Survey #34: Very important
Survey # 89: Very important	Survey #111: Very important	Survey #43: Very important
Survey # 90: Very important	*Survey #114: Important	Survey #50: Very important
*Survey #106: Very important	*Survey #117: Very important	*Survey #51: Important
*Survey #116: Very important	*Survey #124: Important	Survey #59: Very important
Survey #120: Very important	*Survey #138: Very important	Survey #64: Very important
Survey #121: Very important	Survey #141: Very important	Survey #65: Important
Survey #123: Very important	Survey #142: Important	Survey #68: Neutral
Survey #125: Important	Survey #143: Important	Survey #73: Very important
Survey #130: Very important	Survey #156: Very important	Survey #76: Very important
*Survey #131: Very important	Survey #165: Neutral	*Survey #77: Very important
Survey #136: Very important		Survey #86: Important
**Survey #145: Very important		Survey #87: Neutral
Survey #146: Very important		*Survey #91: Very important
Survey #150: Very important		*Survey #92: Important
Survey #153: Very important		Survey #94: Very important
Survey #155: Important		Survey #98: Very important
Survey #157: Very important		Survey #99: Important
Survey #158: Very important		*Survey #112: Very important
Survey #164: Important		Survey #113: Important

Survey #166: Very important		**Survey #115:** Very important
Survey #174: Very important		**Survey #118:** Neutral
Survey #175: Important		**Survey #119:** Not important at all
***Survey #176:** Very important		***Survey #122:** Very important
Survey #182: Important		**Survey #126:** Very important
Survey #185: Very important		**Survey #127:** Important
Survey #190: Very important		***Survey #128:** Very important
Survey #193: Very important		**Survey #133:** Very important
		***Survey #137:** Very important
		Survey #140: Important
		Survey #144: Very important
		****Survey #145:** Very important
		***Survey #147:** Very important
		Survey #148: Important
		Survey #151: Very important
		Survey #152: Very important
		Survey #154: Neutral
		***Survey #159:** Very important
		Survey #161: Important
		Survey #167: Very important
		Survey #169: Very important
		Survey #170: Very important
		Survey #180: Neutral
		Survey #181: Very important
		Survey #184: Very important
		Survey #186: Important
		Survey #187: Important
		Survey #192: Important

COMMENTS:

Referring Physician

Survey #190: It helps to keep everyone informed.

Survey #182: However, this generates additional burden for both parties. The receiver in generating receipt and then the sender receiving this receipt. This is 2 additional documents generated. This can be easily improved by removing the need for fax communication and have alternative secure communication -one exists as of today in form of econsult.

Survey #176: provided we continue to fax things, there is no way to be sure that consults have been received without closed-loop communication. The patients get confused and sometimes multiple consults are sent. I've been scolded for sending multiple consults before.

Survey #157: This should also apply when a referral has been made to one consultant and that consultant refers the patient to another consultant. The receiving consultant when sending their report, should be expected to include the referring consultant along with the original referring physician, thereby closing the communication loop for all involved.

Survey #155: There is variability on who is responsible for notifying the patient of specialist appointment

Survey #131: ███████████ seem to be specifically trained to not communicate.

Survey #123: N/A

Survey #121: N/A

Survey #90: it helps with admin burden - if i do not get an acknowledgement of receipt, my receptionist will follow up - and if a fax was dropped or lost - we can lose months of time thinking that the consult is actually in the works.

Survey #89: We routinely do not hear back from faxed referrals regarding either wait times or when the appointment has been scheduled for. I had sent a referral to ███████████████ last Jan (2025) expecting a year's wait as that was what we had been previously told. This Jan (2026) we checked on it as the patient █████████████████████████████ had not heard from the ██████████ office. We were told that the patient missed his appointment in March 2025. Neither the patient nor I had ANY IDEA there was an appointment for him in March 2025. I spoke with the ██████████ office and they confirmed the above. I mentioned the CPSM standard and that it would be helpful for them to let us know about upcoming appointments because we could help our patient to not miss those appointments by making sure they know about them (which we routinely do) and for those patients that we know have trouble making appointments, we can, and do, set reminders and call them nearer the appointment to remind them. The receptionist basically said that the doctor hasn't told them to do that (let referring offices know), so they don't do it. I wonder if he has read CPSMs standard. I hope that you (CPSM) can be sure all consultants are aware of these standards of care! Thank you!

Survey #40: This is exceptionally important, and one of the largest time consumers in my clinic- patients not having heard, our clinic not having heard, having to verify fax received. Also puts patient care at risk bc sometimes you don't find out for months that a referral wasn't received

Survey #5: CRITICAL FOR PATIENT'S CARE

Consulting Physician

Survey #165: To some extent I feel like this is corporate jargon. We should make every attempt to avoid using what amounts to empty epithets to describe what we want in processes.

Survey #156: I work in clinics at ███████████ which are understaffed. We have no control over our staffing. If these standards are approved the college must address this issue with Shared health

Survey #124: Anticipate that time consumption will be a major limitation to this principle.

Survey #84: It is important but the timeline of 14 days to triage the referrals (to decide to accept or refuse a referral, never mind to give an exact appointment) is extremely short for those specialists who are bombarded by referrals. There is a big difference if a consulting specialist receives only a few referrals a month vs receiving 90-100 referrals monthly. The admin burden is obviously much more when the quantity of referrals are increasing. The standard of care has not provided any solution for the latter situation. Even any proposed solution will likely add more admin burden (eg send a default letter to say referral is received but not triaged, then another letter to inform if the referral is rejected or accepted and then a third letter when an appointment is given!) This simply makes the already troubled admin burden worse. The situation is even worse for community specialists who pay for the cost of their own staff and do not have the support of allied health care workers that provide assistance to hospital based doctors. I think the timeline should be changed to at the very least 30 days.

Referring/Consulting

Survey #186: I would like the standard to include an expectation for physicians to optimize their use of electronic communications. This is one way of improving all communication and also verifying closed-loop communication.

Survey #154: It's mostly an administrative advantage not to have to f/u - yes, it also would avoid delays for the patient which would be not the best care.

Survey #140: Not needed to acknowledge every letter sent from a consultant to referring MD. assume if consult requested that referring MD will review consultant reply. Too much paper work other wise

Survey #119: This creates extra administrative burden. The referring MD should periodically check on the status of a referral if they have not heard back.

Survey #118: Not to the extent that the physicians time is wasted with sending commuications

Survey #113: not always easy; ideal but do not think it needs to be the MD directly themselves when receiving a consultation

Survey #87: In the rare case that a fax or consult not delivered : the patient can alert referring dr to resend as heard nothing in reasonable time frame. Ie1-2 months. This is creating alot of extra paper that referring dr has to review. Consult recieved/ consult bookedand finally the only important communication- pt seen and helped(hopefully with learning points for referring dr.) Even if no letter back from consultant- patient can tell you what done ie if problem looked after. The only important thing is pt gets looked after. Lengthy or letters mean fewer pts get seen by consultants.

Survey #68: I worry about multiple communications that must be "reviewed by primary md" i.e notification of receipt of a consult is good to ensure a fax goes through but sometimes ends up with a system where a physician must acknowledge 10-20 consult receipts in their inbox everyday which is very hard to keep track of. If communication of consultation receipt was sent to patients then they are always part of the loop. If I am a primary care physician and do a non urgent consult as outpatient I could simply tell the patient if you haven't heard from the consultants office in 2-3 weeks please call our office and we will ensure the consult was received. With the volume of consult receipts I receive that aren't responses myself and my

clerical staff don't have a system of keeping track if consults were "received" then processed then seen or not.
Survey #65: I acknowledge that this is ideal but with the degree of volume we are receiving it is near impossible to respond to every consult to close the loop. We automatically triage all of them but to send letters back in a timely way is extremely time consuming for our office staff.
Survey #32: Communication is the most important factor in any standard of practice. A two-tier communication variable would be extremely beneficial
Survey #15: It can be difficult to know if a referral has been read and engaged with until some significant time has passed due to delays in processing of reply letters
Survey #12:I agree with all of the points above STRONGYLY, accept for #4. Given the extreme stress on my time, I cannot ethically be involved in ongoing patient care as a consultant in cases where I cannot provide meaningful help even if others desire it/feel it is necessary (I do feel it is appropriate to provide help until it is not needed, OR meaningful help cannot be provided). This will take time away for patients I can provide meaningful help to- and in my opinion is inappropriate and unethical in a resource limited environment.
Survey #10: As a family MD I often have no idea if a referral was received or not. Results in missed referrals and having my MOA call various offices to ensure referral received.
Survey #9: Could you expand a bit on the need to acknowledge when a message is received? This is very vague and seems that it may apply to email unless email is excluded. I have doctors emailing me about patients to my ▮▮▮ email and I'd prefer that they don't as I do not check it as frequently as might be needed to respond in a timely manner. My obligation is to monitor faxes and my TigerConnect and my office phone during office hours. I will comply if email is included but will prefer it to be explicit.
Survey #7: This isn't always easy for emergency physicians- but it is appreciated when we hear back from specialists to know what happened to our patients, if we were on the right track or totally wrong etc

Q5: The standard is clear that physicians are not responsible for delays in communication beyond their control (see below) due to system issues (i.e. institutional settings, hospitals, other government health systems).

Delays Beyond Control

- You are not directly responsible for delays in communication caused by institutional systems issues that are outside of your control.

Knowing that the standard acknowledges system limitations, do you feel more confident in your ability to work toward meeting the standard?

	Referring Physicians	Consulting Physicians	Referring and Consulting
🟩 Extremely confident	9	2	5
🟦 Very confident	16	9	24
🟨 Neutral	12	7	19
🟦 Moderately confident	3	1	5
🟥 Not at all confident	0	4	7
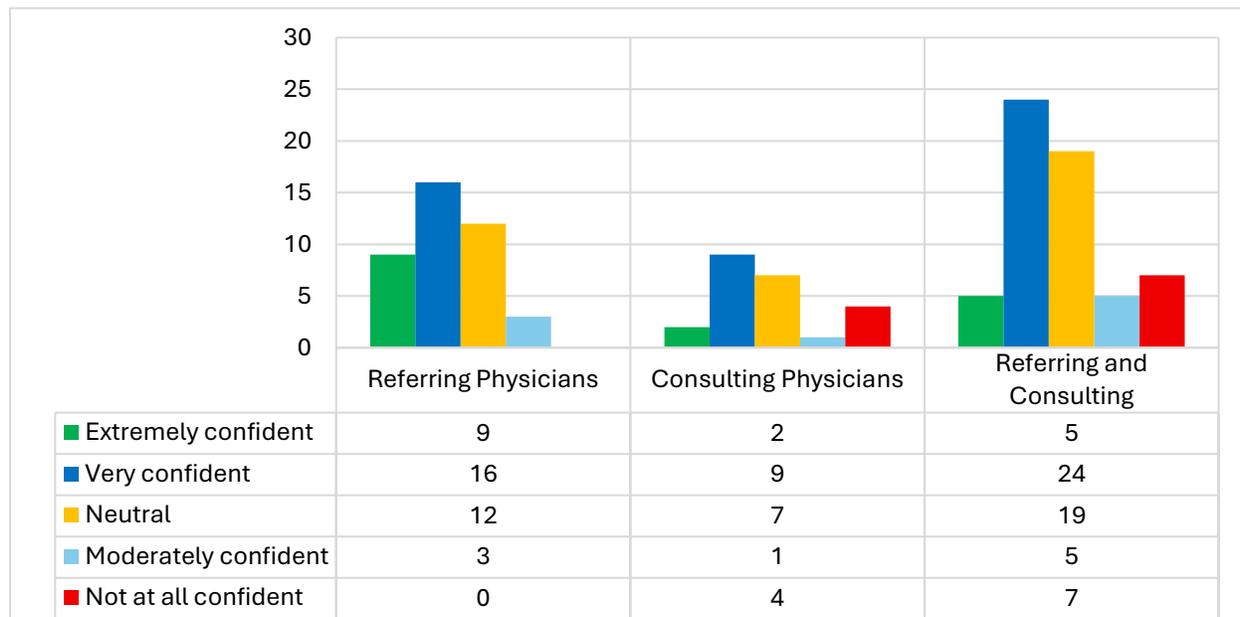
Referring Physicians	Consulting Physicians	Referring and Consulting
Survey #2: Very confident	Survey #4: Extremely confident	*Survey #1: Not at all confident
Survey #5: Extremely confident	Survey#66: Moderately confident	**Survey #7: Very confident
Survey #6: Neutral	Survey #72: Very confident	Survey #9: Neutral
**Survey #7: Very confident	Survey #74: Very confident	Survey#10: Moderately confident
Survey #8: Moderately confident	Survey #78: Neutral	Survey #12: Very confident
Survey #11: Neutral	Survey #79: Neutral	Survey #15: Very confident
Survey #38: Very confident	Survey #80: Neutral	*Survey #16: Very confident
Survey #40: Extremely confident	Survey #82: Very confident	Survey #17: Very confident
*Survey #45: Extremely confident	*Survey #84: Neutral	Survey #18: Extremely confident
Survey #46: Very confident	Survey #85: Not at all confident	Survey #20: Very confident
*Survey #57: Very confident	Survey #100: Not at all confident	Survey #26: Neutral
Survey #61: Neutral	Survey #109: Very confident	Survey #32: Very confident
Survey #63: Neutral	Survey #110: Very confident	Survey#34: Moderately confident
Survey #89: Neutral	Survey #111: Extremely confident	Survey #43: Very confident
Survey #90: Neutral	*Survey #114: Very confident	Survey #50: Very confident
*Survey #106: Very confident	*Survey #117: Neutral	*Survey #51: Extremely confident
*Survey #116: Very confident	*Survey #124: Neutral	Survey #59: Neutral
Survey #120: Very confident	*Survey #138: Very confident	Survey #64: Neutral
Survey #121: Extremely confident	Survey #141: Extremely confident	Survey #65: Not at all confident
Survey #123: Very confident	Survey #142: Very confident	Survey #68: Neutral
Survey #125: Neutral	Survey #143: Very confident	Survey #73: Extremely confident
Survey #130: Extremely confident	Survey #156: Not at all confident	Survey #76: Neutral
*Survey #131: Neutral	Survey #165: Neutral	*Survey #77: Very confident
Survey #136: Extremely confident		Survey #86: Very confident
**Survey #145: Very confident		Survey #87: Neutral
Survey #146: Extremely confident		*Survey #91: Extremely confident
Survey #150: Extremely confident		*Survey #92: Neutral
Survey #153: Neutral		Survey #94: Neutral

Survey #155: Neutral		**Survey #98:** Not at all confident
Survey #157: Very confident		**Survey #99:** Not at all confident
Survey #158: Very confident		***Survey #112:** Very confident
Survey #164: Very confident		**Survey #113:** Neutral
Survey #166: Extremely confident		**Survey #115:** Very confident
Survey #174: Very confident		**Survey #118:** Neutral
Survey #175: Moderately confident		**Survey #119:** Neutral
***Survey #176:** Moderately confident		***Survey #122:** Neutral
Survey #182: Neutral		**Survey #126:** Not at all confident
Survey #185: Neutral		**Survey #127:** Neutral
Survey #190: Very confident		***Survey #128:** Moderately confident
Survey #193: Very confident		**Survey #133:** Neutral
		***Survey #137:** Neutral
		Survey #140: Very confident
		Survey #144: Very confident
		****Survey #145:** Very confident
		***Survey #147:** Moderately confident
		Survey #148: Very confident
		Survey #151: Very confident
		Survey #152: Very confident
		Survey #154: Moderately confident
		***Survey #159:** Very confident
		Survey #161: Very confident
		Survey #167: Not at all confident
		Survey #169: Neutral
		Survey #170: Very confident
		Survey #180: Neutral
		Survey #181: Not at all confident
		Survey #184: Extremely confident
		Survey #186: Very confident
		Survey #187: Neutral
		Survey #192: Very confident

COMMENTS:
Referring Physician
Survey #175: I feel like even though it's written down, the college will enforce unobtainable goals anyways
Survey #123: N/A
Survey #121: N/A
Survey #89: It is good that the standard recognizes this. I don't get consults coming to me, so I don't think this applies to me.
Survey #61: There are many gaps in the system. One of the main ones is lacking information technology that provides universal access to information to all providers. I am a believer in having one EMR that all health care providers in MB use rather than the multiple systems that do not interface with each other. At the very least all health care providers should be on Tiger Connect
Survey #38: Timely is relative to availability of consultants. Referrals are poorly organized at present and all patients wait unreasonably long

Survey #8: There are many ways that consultations go awry, including technology that malfunctions, little oversight and quality control, no attempt to audit or assess how well systems are working, and no way to know if one's efforts have been successful in many cases without very time-consuming laborious individual checking of work (eg manually checking the fax butler report to see if a faxed consultation sent or failed to send) and responsibility is so diffuse that it is difficult to feel confident that the standard will be met.

Consulting Physician

Survey #165: As an operating surgeon, went on call, the most common reason for a delayed response from me would be that I'm already presently operating. This is a communication delay that has nothing to do with a system's problem. It is unavoidable at times. I feel like under this guideline, I'm now responsible for taking calls in the middle of critical procedures.

Survey #156: Shared Health consistently understaffs our clinics and is not interested in improving outpatient care. This standard should also apply to DIAGNOSTIC IMAGING for CT scans, echocardiograms and MRI. The DI requisition states it is for a diagnostic consultation and hence the above should apply to DI/echo

Survey #85: ▮▮▮▮ Clinic does not allow providers to mail out letters to patients, leading to geriatric patients without e-mail or text messaging services to get appointment notifications. Patients then blame the consulting physician for this. There should be a mandate for clinic owners to provide requested communication modality for their providers.

Survey #66: we must be able to have some say by which route this communication is to happen

Survey #4: This is a huge barrier to hospital based clinics for university (GFT) physicians.

Referring/Consulting

Survey #186: One issue regarding delays that should be included in the standard is being honest about the urgency for getting a test done or being seen by a collaborator. Physicians should not exaggerate urgency to shorten a wait time, even if they think it will improve "ensuring good medical care". The standard should address the issue that physicians should behave in a way that is fair for all patients, not just the one they are caring for.

Survey #181: This divides the physicians into 2 groups- those in private practice who are then obliged to follow the guidelines and those who are in hospitals who do not. As a physician practicing in both places, I am then subject to 2 different Standards. I have been involved in Standards for years and I am aware of Specialists who never review incoming consults, don't do dictations for months and then hide behind the institutional shortcomings. With computerizations and now the use of AI, there is no need for a double standard. I assume we physicians can all print or write and so a short written note- letter or email could easily be sent while the dictated one waits. This also puts an extra burden on those in private practice to pay more for an upgrade to fulfill the requirements. I believe that the standard is reasonable - 1 months- but I do not believe that it should be discriminative. The physician needs information within that time and the patient should not be negatively impacted because the hospital based specialist is not trying to send recommendations within an appropriate time framed. There have been documented CI's because of lack of communication from the. hospital. Even deaths.

Survey #169: I would like to see the standard better address physician and other resource shortages. I am a ▮▮▮▮▮▮▮▮▮▮▮▮ that is understaffed, making it sometimes impossible to provide consultations in a timely manner. What is my personal/my subspecialty's responsibility in this situation? The standard on "Emergent, Urgent, and Inpatient Requests" states that it is inappropriate for a physician who is receiving a consultation to say "I cannot help you; my facility doesn't have beds." It would be helpful to outline how physicians should respond to a request for transfer when there is no bed available.

Survey #154: From a patient's perspective it systemic delays remains to be blamed foremost on the messenger and creates unnecessary friction and repetitive, unnecessary encounters (f/u that there are no updates for example while having to manage the uncertainty and distress the patient has to endure).

Survey #140: 14 days from referral sent to acknowledging receipt of referral sent by fax to clinic is NOT long enough. If MD away or on busy rotation not practical to respond that quickly. If referal is urgent referring MD must contact directly ie phone.

Survey #122: What would classified as institutional limitations.

Survey #119: I am not certain what would be an administrative issue outside a consultants control. Th consultant needs to direct the process not hide behind it

Survey #118: Resource limitations and lack of resources should be made public and not "covered up". This is what most administrators do and the physicians bear the brunt of this

Survey #113: It is challenging to meet the timeline standard on response, when many aspects of a consult involve testing and work up that can take time;

Survey #99: The processes within our systems are slow and ineffective

Survey #98: Within the context of ER it is not possible to contact every family physician when discharging a patient that needs follow up within 2 weeks. During the evenings and nights most family physicians are not available. Even during daytime they may not be in clinic, may not take the phone call, may not have availability within 2 weeks. This additional time burden is impossible to reconcile with the needs of other ER patients waiting to be seen. Further, a discharge summary is sent to the family doctor at the end of every ER visit, I believe this should suffice as a request for <2 week follow up.

Survey #94: None of the hospitals have an EMR to easily send or communicate when sending a referral. Even at ▓▓▓▓▓▓▓▓▓▓ referrals are faxed and if more information is requested or the consultant declines the consult that paper response will sit in a mailbox perhaps for weeks if the referring physician works at multiple hospitals (which I do). It is critical to have access to sending electronic referrals and receiving communication electronically from the hospital for timely communication and for things not to be missed.

Survey #87: Systems can be inefficient with staff uploading and sorting documents, or residents not finishing letters in timely fashion for staff to send... a myriad of reasons that guideline and suggested standards can not be met. A gold standard to work toward however is acceptable

Survey #76: so many people involved in our process

Survey #68: Delays are often multifactorial and so how the standard would be applied is unclear.

Survey #65: Our private office is working with Telus to create a method in the system to send receipt of consult letters automatically but this will apparently take months to put together !!! For now we can send a template letter but still need to get the dr name and contact and manually enter after receiving the consult. This is too time consuming for office staff. They would rather be calling and actually booking the patients in their very limited free moments

Survey #64: As someone who receives referrals, I feel that I can find the tools (eg. staff training, EMR functions) to comply with the closed-loop communication requirements. I am only mildly concerned about institutional systems that will affect this. Conversely, I worry that this statement will abdicate "the systems" from improving. Eg. who is responsible for the terrible communication re: diagnostic imaging? There are many individuals who "touch" the request, but surely someone should be compelled to foster improvement. Who is that individual? Department heads? Shared Health? Perhaps this statement could include some examples, so that registrants don't always fall back on this loophole.

Survey #34: Will the CPSM be sending out tailored communication to facilities? (Follow facility policies: If the accepting service at the identified facility is unclear, the registrant at the receiving facility should follow their facility's policies. Avoid unnecessary delays: The transfer should not be delayed while seeking clarity about accepting service.) In my experience, many receiving hospitals have informal policies (eg, "no lateral transfers") which make it very difficult to get patients to a service that they need, especially if they've been admitted to a lower-level facility. Communicating this Standard may prompt RHAs and regional hospitals to put those informal policies through the appropriate critique and consultation to create a formal policy "on paper" that is defensible and patient-centred.
Survey #26: Being overworked will get in the way of being able to meet the standards for many people. Many of us have limited control over our schedules. I am in a consultative practice and I have templates that are frequently overridden because of urgency and acuity. It makes it so I cannot get charting done in a reasonable time. Charting and letters becomes challenging because you are assigned to the next clinic/consult before you have had time to do charting on the last one. Of course we should all aim to meet these standards. But most of the time they are not being met it is not because we are being lazy - it is because the demands being placed on us are impossible to attain. I have considered leaving the province because the demands placed on me make it impossible to maintain what I would consider to be good professional standards. For me it is unfair to many of us to set these standards if it is okay for institutions to continue to work us beyond what we are able to tolerate. For example, perhaps there should be an exemption from such standards for those of us who are expected to work beyond a 1.0 FTE or beyond 2+ weeks of call coverage a month due to circumstances beyond out control.
Survey #9: Please define what channels of communication are covered by this Standard.
Survey #7 : I think this gets abused. I see it a lot in emergency where "I couldn't get a hold of_____ so I'm sending them to ER" and later find out that no actual effort was made to contact the specialist etc.
Survey #1: Standards are nice but are not based in reality on the ground - for example, I as a physician in a community hospital cannot directly communicate with a specialist (e.g. cardiology) ███████████ - I have to go through VECTRS or straight up have cardiologists ██ ██ ████ refuse to take my calls because "it's outside of their responsibility".

Q6: The standard outlines continuity of care responsibilities (see below).

Continuity of Care Responsibilities

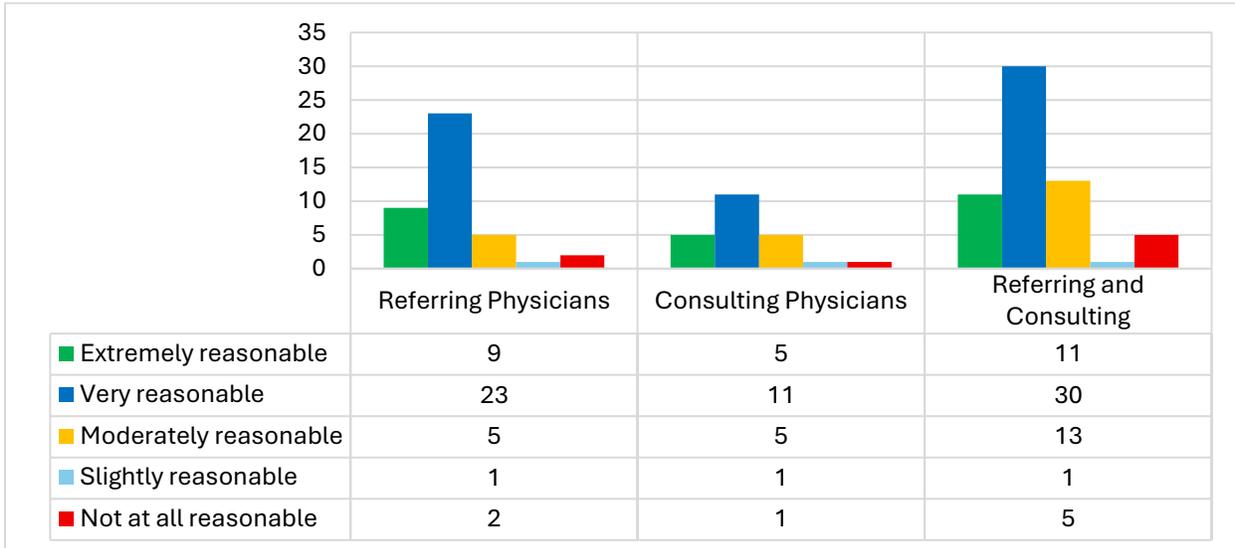To ensure smooth patient care transitions, registrants must:

Transfers of Care
• When transferring care, make sure the accepting registrant has all necessary clinical information (test results, active problems, treatment plan) to assume care.

Discharges and Follow-Up
• When discharging a patient from an institutional setting, (including an emergency department) who needs follow-up by another health care provider, prepare a clear summary of test results, active medical problems, and treatment plans for the follow-up appointment.

• If follow-up is critical within two weeks, contact the accepting health care provider directly to facilitate the follow-up care appointment and transfer the necessary medical information.

Consider the responsibilities listed, how reasonable do you find the continuity of care responsibilities within the limitations of your practice setting?

	Referring Physicians	Consulting Physicians	Referring and Consulting
■ Extremely reasonable	9	5	11
■ Very reasonable	23	11	30
■ Moderately reasonable	5	5	13
■ Slightly reasonable	1	1	1
■ Not at all reasonable	2	1	5

Referring Physicians	Consulting Physicians	Referring and Consulting
Survey #2: Very reasonable	**Survey #4:** Very reasonable	***Survey #1:** Moderately reasonable
Survey #5: Very reasonable	**Survey# 66:** Very reasonable	****Survey #7:** Not at all reasonable
Survey #6: Very reasonable	**Survey #72:** Very reasonable	**Survey #9:** Slightly reasonable
**Survey #7: Not at all reasonable	**Survey #74:** Not at all reasonable	**Survey#10:** Very reasonable
Survey #8: Very reasonable	**Survey #78:** Moderately reasonable	**Survey #12:** Moderately reasonable
Survey #11: Moderately reasonable	**Survey #79:** Extremely reasonable	**Survey #15:** Moderately reasonable
Survey #38: Moderately reasonable	**Survey #80:** Very reasonable	***Survey #16:** Very reasonable
Survey #40: Extremely reasonable	**Survey #82:** Very reasonable	**Survey #17:** Very reasonable
*Survey #45: Extremely reasonable	***Survey #84:** Very reasonable	**Survey #18:** Very reasonable
Survey #46: Very reasonable	**Survey #85:** Moderately reasonable	**Survey #20:** Extremely reasonable
*Survey #57: Moderately reasonable	**Survey #100:** Moderately reasonable	**Survey #26:** Moderately reasonable
Survey #61: Not at all reasonable	**Survey #109:** Very reasonable	**Survey #32:** Extremely reasonable
Survey #63: Very reasonable	**Survey #110:** Very reasonable	**Survey#34:** Very reasonable
Survey #89: Very reasonable	**Survey #111:** Extremely reasonable	**Survey #43:** Extremely reasonable

Survey #90: Very reasonable	***Survey #114:** Extremely reasonable	**Survey #50:** Moderately reasonable
***Survey #106:** Slightly reasonable	***Survey #117:** Very reasonable	***Survey #51:** Moderately reasonable
***Survey #116:** Very reasonable	***Survey #124:** Very reasonable	**Survey #59:** Moderately reasonable
Survey #120: Very reasonable	***Survey #138:** Slightly reasonable	**Survey #64:** Very reasonable
Survey #121: Very reasonable	**Survey #141:** Extremely reasonable	**Survey #65:** Moderately reasonable
Survey #123: Very reasonable	**Survey #142:** Very reasonable	**Survey #68:** Very reasonable
Survey #125: Very reasonable	**Survey #143:** Moderately reasonable	**Survey #73:** Extremely reasonable
Survey #130: Very reasonable	**Survey #156:** Extremely reasonable	**Survey #76:** Very reasonable
***Survey #131:** Very reasonable	**Survey #165:** Moderately reasonable	***Survey #77:** Very reasonable
Survey #136: Very reasonable		**Survey #86:** Very reasonable
****Survey #145:** Moderately reasonable		**Survey #87:** Very reasonable
Survey #146: Extremely reasonable		***Survey #91:** Extremely reasonable
Survey #150: Extremely reasonable		***Survey #92:** Extremely reasonable
Survey #153: Very reasonable		**Survey #94:** Moderately reasonable
Survey #155: Very reasonable		**Survey #98:** Not at all reasonable
Survey #157: Very reasonable		**Survey #99:** Moderately reasonable
Survey #158: Extremely reasonable		***Survey #112:** Very reasonable
Survey #164: Moderately reasonable		**Survey #113:** Not at all reasonable
Survey #166: Extremely reasonable		**Survey #115:** Very reasonable
Survey #174: Very reasonable		**Survey #118:** Very reasonable
Survey #175: Very reasonable		**Survey #119:** Extremely reasonable
***Survey #176:** Very reasonable		***Survey #122:** Very reasonable
Survey #182: Extremely reasonable		**Survey #126:** Not at all reasonable
Survey #185: Very reasonable		**Survey #127:** Very reasonable
Survey #190: Extremely reasonable		***Survey #128:** Very reasonable
Survey #193: Extremely reasonable		**Survey #133:** Not at all reasonable
		***Survey #137:** Moderately reasonable
		Survey #140: Very reasonable
		Survey #144: Very reasonable
		****Survey #145:** Very reasonable
		***Survey #147:** Very reasonable
		Survey #148: Very reasonable
		Survey #151: Extremely reasonable
		Survey #152: Very reasonable
		Survey #154: Moderately reasonable
		***Survey #159:** Very reasonable
		Survey #161: Very reasonable
		Survey #167: Very reasonable
		Survey #169: Moderately reasonable
		Survey #170: Very reasonable
		Survey #180: Very reasonable
		Survey #181: Extremely reasonable
		Survey #184: Very reasonable
		Survey #186: Very reasonable
		Survey #187: Extremely reasonable
		Survey #192: Extremely reasonable

SECTION 2 - Collaborative Care Non-Emergent Consultation Requests

Q7: The standard lists the requirements and responsibilities of referring physicians (see below).

The Referring Registrant's Responsibilities

When making a non-emergent consultation request, include:

- Patient's name, sex, age, Manitoba Health number, and contact information.
- The registrant's name and contact information.
- Date of the request.
- Reason for the consultation (opinion or transfer of care).
- Relevant medical information (history, findings, test results, concerns regarding the issue).
- A clear, relevant clinical question to be answered or the reason for the consultation.
- Whether the consultation request is solely for a third party (ex., insurance company).

Are the responsibilities of the referring registrant clear?
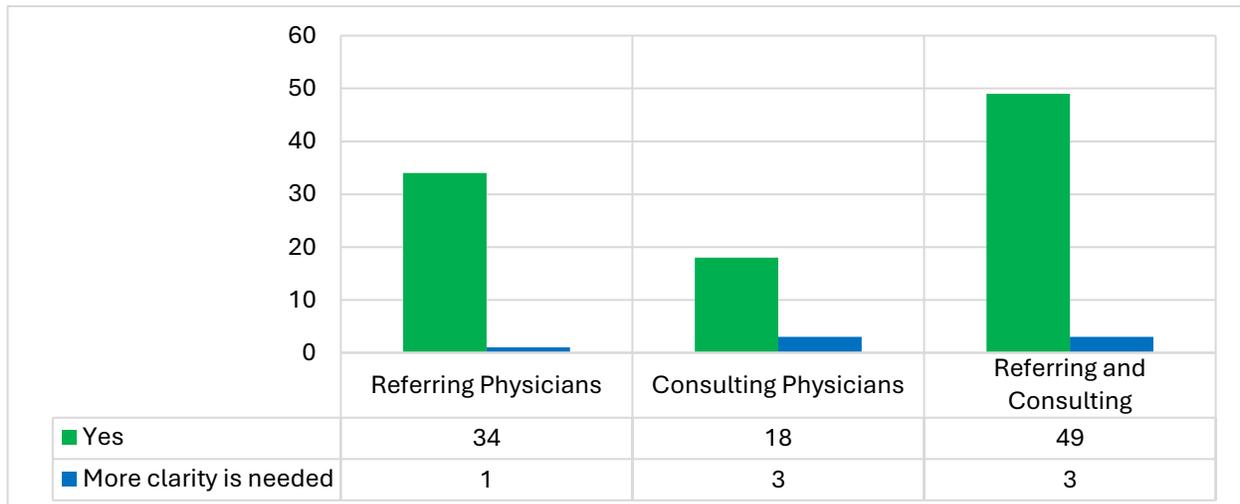
	Referring Physicians	Consulting Physicians	Referring and Consulting
Yes	34	18	49
More clarity is needed	1	3	3

Referring Physicians	Consulting Physicians	Referring and Consulting
Survey #2: Yes	Survey #4: More clarity is needed	*Survey #1: Yes
Survey #5: Yes	Survey# 66: Yes	Survey #9: More clarity is needed
Survey #6: Yes	Survey #72: Yes	Survey#10: Yes
Survey #7: Yes	Survey #78: Yes	Survey #12: Yes
Survey #8: Yes	Survey #79: More clarity is needed	Survey #15: Yes
Survey #11: Yes	Survey #80: Yes	*Survey #16: Yes
Survey #38: Yes	Survey #82: Yes	Survey #17: Yes
Survey #40: Yes	*Survey #84: Yes	Survey #18: Yes
Survey #46: Yes	Survey #85: Yes	Survey #20: Yes
Survey #61: Yes	Survey #100: More clarity is needed	Survey #26: Yes
Survey #63: Yes	Survey #109: Yes	Survey #32: Yes
Survey #89: Yes	Survey #110: Yes	Survey#34: Yes
Survey #90: Yes	Survey #111: Yes	Survey #43: Yes
Survey #120: Yes	*Survey #117: Yes	Survey #50: Yes
Survey #121: Yes	*Survey #124: Yes	*Survey #51: Yes

Survey #123: Yes	*Survey #138: Yes	Survey #59: Yes
Survey #125: More clarity is needed	Survey #141: Yes	Survey #64: Yes
Survey #130: Yes	Survey #142: Yes	Survey #65: Yes
*Survey #131: Yes	Survey #143: Yes	Survey #68: Yes
Survey #136: Yes	Survey #156: Yes	Survey #73: Yes
*Survey #145: Yes	Survey #165: Yes	Survey #76: Yes
Survey #146: Yes		*Survey #77: Yes
Survey #150: Yes		Survey #86: Yes
Survey #153: Yes		Survey #87: Yes
Survey #155: Yes		*Survey #91: Yes
Survey #157: Yes		*Survey #92: Yes
Survey #158: Yes		Survey #94: Yes
Survey #164: Yes		Survey #98: Yes
Survey #166: Yes		Survey #99: Yes
Survey #174: Yes		Survey #113: Yes
Survey #175: Yes		Survey #115: Yes
Survey #182: Yes		Survey #118: Yes
Survey #185: Yes		Survey #119: More clarity is needed
Survey #190: Yes		*Survey #122: Yes
Survey #193: Yes		Survey #126: More clarity is needed
		Survey #127: Yes
		Survey #133: Yes
		Survey #140: Yes
		Survey #148: Yes
		Survey #151: Yes
		Survey #152: Yes
		Survey #154: Yes
		*Survey #159: Yes
		Survey #161: Yes
		Survey #167: Yes
		Survey #169: Yes
		Survey #170: Yes
		Survey #180: Yes
		Survey #181: Yes
		Survey #184: Yes
		Survey #186: Yes
		Survey #187: Yes
		Survey #192: Yes

COMMENTS
Referring physician
Survey #193: No
Survey #175: When sending in lab results at a later date, need to send a document explaining which patient it goes with and why you're sending the investigation results
Survey #121: N/A
Survey #89: No. I hadn't thought about telling the consultant it is just for a third party. Good point. Not sure I do many of those types of referrals.
Survey #61: I believe this is clear and complete
Survey #38: Responsibility is often beyond reasonable, due to long waiting periods

Survey #8: If the referral is originating from an episodic care provider the name of the primary care provider should be included if there is one, and the referral letter should be cc'ed to the PCP.

Survey #5: NO

Consulting physician

Survey #165: I would just like to note that presently, critical information is missing from about 40% of the referrals that I receive electively. These are typically semi-urgent elective case cases. It's extremely common for a patient to be said to me for endoscopy with anemia, and no blood work will be sent with the referral. Another common referral will be a endoscopy or surgery for a critical finding on a CT scan, and the CT scan scan will not be sent with a referral. I'm hoping this guideline will address this.

Survey #156: Referral should include whether the patient has previously seen a different specialist for the same medical problem and should include that consultation response

Survey #100: Relevant medications. It should also be noted that attaching 53 pages of irrelevant labs is not helpful to the consulting physician. Included information should be carefully curated for relevance, and include ONLY relevant results, not merely all results for a certain time period.

Survey #4: If other specialists have been consulted for the same issue and if possible, including the other specialists assessment.

Referring/Consulting

Survey #186: Hopefully we will look back at this standard as necessary only because of inadequate electronic health information systems and their connectivity between systems. Much of the information in this list should be accessible online to the consultant and referring doctor.

Survey #181: it would be so nice if the above was included

Survey #169: A big issue for physicians is administrative burden. I think it would be very helpful to expand on what is required under "relevant medical information", as it can create unnecessary work for the referring and the consulting physician if too much information is provided (and also sometimes when not enough is required). When I review Central Intake consults for my specialty, some of them include up to 20+ pages of results, many of which are irrelevant to the consult.

Survey #119: Why would the physician act as th middle person for a third party? It is the third party responsibility to ask for the opinion. In the absence of this it is like a game of telephone

Survey #199: has the patient been made aware of the referral and are they willing to attend

Survey #68: Consults that are to an appropriate consultant and contain the relevant information should not be declined because the consult was not on the preferred consultant form for referrals.

Survey #65: Indicate if this is first time patient is being seeing or is doctor shopping for another opinion for a second consultant. I often see consults and the fdr never indicated that the pt was already seen for the issue. For example, they didn't have good rapport . They often have given sound advice. This is a waste of an appointment that I could have given to someone who has never seen anyone.

Survey #64: This list seems appropriate. However, there are some referrals that REQUIRE a specific form. For example, many GI referrals - organic, functional, or otherwise - get initiated with a Endoscopy Central Intake Form, which is mandated by Shared Health. The form is excellent for urgent and truly organic and pathological processes. However, there is very tiny print at the bottom, which no one reads/follows, listing conditions that are not appropriate for endo and should be seen in consultation first. When the system mandates standardized forms, a consulting registrant is engaged in this collaborative care relationship ("tapped in"), but referring registrant isn't compelled to include the information as listed.

Survey #34: Has the CPSM considered the use of "forms" in this process? Some consultants require that their specific form be used in order to arrange a consultation. This is likely borne out of their need to get appropriate information to triage, but it is very frustrating for the referring physician who has already composed a comprehensive referral letter containing all the needed information. Conversely, Shared Health has implemented some mandatory forms, such as the Centralized Endoscopy Referral Form, which has, in some cases, degraded the quality of information. Many referring practitioners are compelled to choose a check-box that over-emphasizes urgency, ignoring the very tiny print that explains conditions that require consultation rather than endoscopy.
Survey #15: Some language about PHIN equivalents from other provinces would be helpful, I'm concerned this standard will lead to Manitoba specialists refusing to see cross-border patients from Saskatchewan for example
Survey #9: The CPSM should require the referring Physician to indicate if they are the Primary Care Provider of the patient or whether their involvement is episodic/ walk-in. Often this is not included and even the patient may not know with clarity whether the referring Physician intends to continue other aspects of care for them that are not part of the reason for Consultation

Q8: The standard requires a triage response within 14 days of receipt of a consultation request. We are looking for feedback in two parts: a) acknowledgement of receipt and b) content of response (question 9).

Acknowledgment of receipt
The standard states, that within **14 days of receiving a consultation request**, the consulting physician must **acknowledge receipt of the request**.

Is 14 days a reasonable time for you to get confirmation that your consultation request has been received?
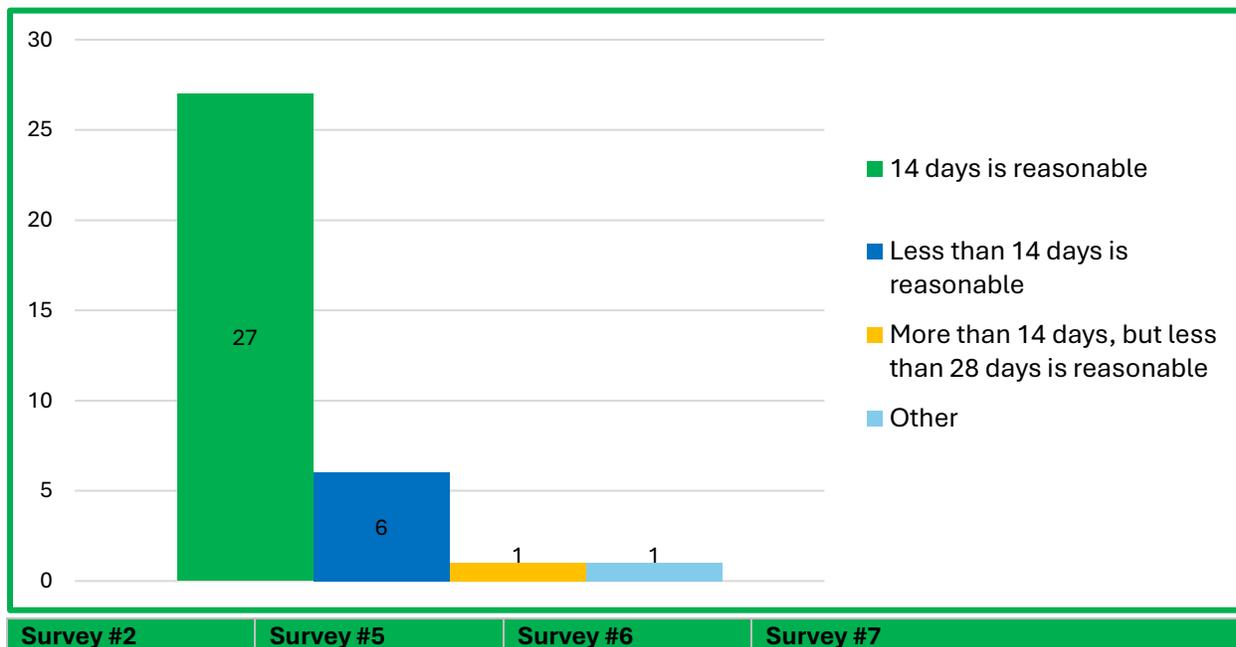
Survey #8	Survey #11	Survey #38	Survey #40	
Survey #46		Survey #61	Survey #63	Survey #89
Survey #90	Survey #120	Survey #121	Survey #123	
Survey #125	Survey #130	Survey #131	Survey #136	
*Survey #145		Survey #146	Survey #155	Survey #153
Survey #155	Survey #157	Survey #158	Survey #164	
Survey #166	Survey #174	Survey #175	Survey #182	
Survey #185	Survey #190	Survey #193		

COMMENTS
Survey #175: With the lack of EMR communication between different servers in Manitoba, I find this timeline unreasonable. Many clinics have information faxed to them, which needs to be manually uploaded to their own EMR before even having a chance to review it. This doesn't even take into account support staff going on vacation or time away. This is an unreasonable timeline. The original 30 day timeline should remain, but be overseen better.
Survey #155: With clarification of patient notification
Survey #121: N/A
Survey #90: up to 28 days is reasonable for a NON urgent request but it is difficult to ascertain the concern in the body of a letter so I think it is easier to have 14 days as the benchmark
Survey #89: As above, I hope that we see improvement in this.
Survey #61: The only institution that I receive this from now is CCMB and I really like it. Otherwise I have not received this from any other consultation source that I currently use. If I need a urgent consult, I use Tiger Connect and a follow up letter.
Survey #38: But that does not solve the referring doctor's problem. The appointment might be a year away

Consulting Physician version:

In your practice setting, how feasible is it for you to acknowledge receipt of a referral request within 14 days?

Legend:
- ■ I can meet the 14-day timeline all of the time (100%)
- ■ I can meet the timeline most of the time (about 80% of the time)
- ■ I can meet the timeline half of the time (about 50% of the time)
- ■ I can meet the timeline less than half of the time (under 50% of the time)

Bar values: 3, 13, 3, 2
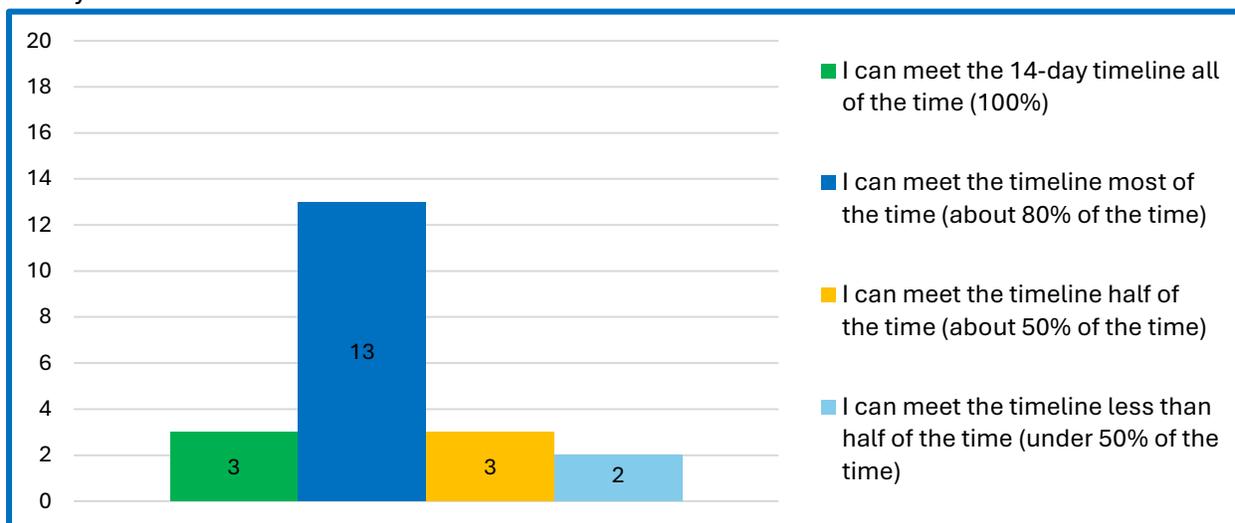
Survey #4	Survey #66	Survey #72	Survey #78
Survey #79	Survey #80	Survey #82	*Survey #84
Survey #85	Survey #100	Survey #109	Survey #110
Survey #111	*Survey #117	*Survey #124	*Survey #138

Survey #141	Survey #142	Survey #143	Survey #156
Survey #165			

COMMENTS
Survey #165: The structure of our particular surgical group is peculiar. I came into it as a young surgeon and it was already set up when I started practice. Basically the referrals are split between all the surgeons in the group. This means that my ancillary clinical staff are reviewing the referrals and assigning them to various surgeons. I broach the subject with my group of changing the processes so that the surgeons could be more directly involved in accepting the referrals. However, no one else in my group agrees with me that this would be beneficial. I will need to clarify with █ Clinic that we are sending out these notices in a prompt fashion. I actually have no idea at present if we're meeting the standard.
Survey #138: only when I am away or when we are short staffed it is hard to commit to meet the deadline
Survey #124: Time of receipt may be out of the clinician's control.
Survey #111: Mind you, it has been YEARS since patients were referred to me for a █████ consultation.
Survey #109: Has no referrals as working in NICU
Survey #100: This sort of automated acknowledgement of receipt comes from clinic practices I have no control over at ████ Clinic. The managers make the decisions about what/how the clerks respond, and I am not clear that they factor College regulations into this. Nor do I have any authority to force them to do so.
Survey #85: If this can be automated by office staff saying a referral has been received, that is fine. If every consultation document needs a physician to manually review, decide on an appointment date, then provide that date to both the patient and referring provider within 14 days, the this is unrealistic. Faxes can take several days to trickle through from a sending provider, to the receiving fax, then categorized manually into the EMR - in this setting, all it would take would be a week long vacation and the 14 days timeline would not be met.
Survey #84: I simply receive too many referrals. As I explained earlier, acknowledging receipt does not mean that I accept a referral (the most time taking step is reading over referrals and deciding whether it could be accepted or not). Sending a receipt-acknowledgment letter is not an issue but I think it is awkward to first send a default letter acknowledging the receipt of a referral and later when I have time to triage the referral sending another letter that the referral is not accepted. I personally receive several referrals that are not suitable for my clinical work.
Survey #66: this could be a challenge when we are away, as it is not just receipt, but reviewed and triaged that will be needed. our office staff can be tasked to send acknowledgement of receipt , but they cannot review for urgency or content

Both referring and consulting physician version:

Consider your consulting role: how feasible is it for you to acknowledge receipt of a referral request within 14 days?

Legend:
- ■ I can meet the 14-day timeline all of the time (100%)
- ■ I can meet the timeline most of the time (about 80% of the time)
- ■ I can meet the timeline half of the time (about 50% of the time)
- ■ I can meet the timeline less than half of the time (under 50% of the time)

Bar values: 15, 17, 9, 11

*Survey #1	Survey #9	Survey#10	Survey #12
Survey #15	*Survey #16	Survey #17	Survey #18
Survey #20	Survey #26	Survey #32	Survey#34
Survey #43	Survey #50	*Survey #51	Survey #59
Survey #64	Survey #65	Survey #68	Survey #73
Survey #76	*Survey#77	Survey #86	Survey#87
*Survey #92	Survey #94	Survey #98	Survey #99
Survey #113	Survey # 115	Survey #118	Survey #119
*Survey #122	Survey #126	Survey #127	Survey #133
Survey #140	Survey #148	Survey #151	Survey #152
Survey #154	*Survey #159	Survey #161	Survey #167
Survey #169	Survey #170	Survey #180	Survey #181
Survey #184	Survey #186	Survey #187	Survey #192

COMMENTS

Survey #186: 14 days seems unnecessarily long to me.

Survey #181: I hope this applies to ALL physicians regardless of of the site of practice I think 21 days is a bit more reasonable. If I do 2 weeks of call in a row, it is very difficult to keep up with this piece of practice when lab results and pharmacy requests and patient s=issues are more important

Survey #154: I believe to change the process to "acknowledge receipt" to make it close to 100% - but that will not answer the acceptance of the consult nor provide a date for an appointment; but will add an administrative task and cost for the clinic (until there would be a digital communication that could be used), which could limit that impact.

Survey #140: See above comment. Needs to be LONGER than 14days.

Survey #133: Working part-time, allowing for vacation absence, 14 days is too short

Survey #119: This is an unnecessary step. Does the consult requestor then acknowledge the acknowledgement and so on and so forth. If you send a consult request what prevents it from being received?

Survey #118: Clinicians are frequently on call and have to catch up with clinic related work after they come back from call. 14 -day is unreasonable

Survey #99: referrals often do not make it to me within this timeline and there is such a high volume with no assistance that it would be impossible to meet this standard current process
Survey #98: The only referrals I receive are to the urgent care, so I immediately accept or decline the referral by phone. There are still a number of physicians who do not contact the department before sending patients.
Survey #87: 1 month would be better
Survey #65: There are not enough hours in the day for our office staff to get these responses done in that degree of time. It is unrealistic and we have a huge backlog of letters.
Survey #50: not really relevant to emergency medical practice
Survey #34: As both a referring and receiving physician, I feel that the CPSM's expectations are very reasonable. However, I also acknowledge the administrative burden and expense of community-based physicians who must employ staff to help with this work.

Q9: **Content of response**

The standard states, that within **14 days of receiving a consultation request**, the consulting physician must provide a response about **whether the request can be accommodated in routine scheduling** and provide an estimate of the appointment date (exact appointment date can come at a later date)

OR
If expedited assessment is required, communicate the timeline for examination;
OR
Notification that the consultation request cannot be processed because it lacks sufficient information to triage the request and advise what is needed to process request;
OR
If the requested type of consultation is not provided;
OR
Any red flags of concern.

Referring Physician version:

Is 14 days a reasonable amount of time for you to receive communication that your consultation request was accepted or not?
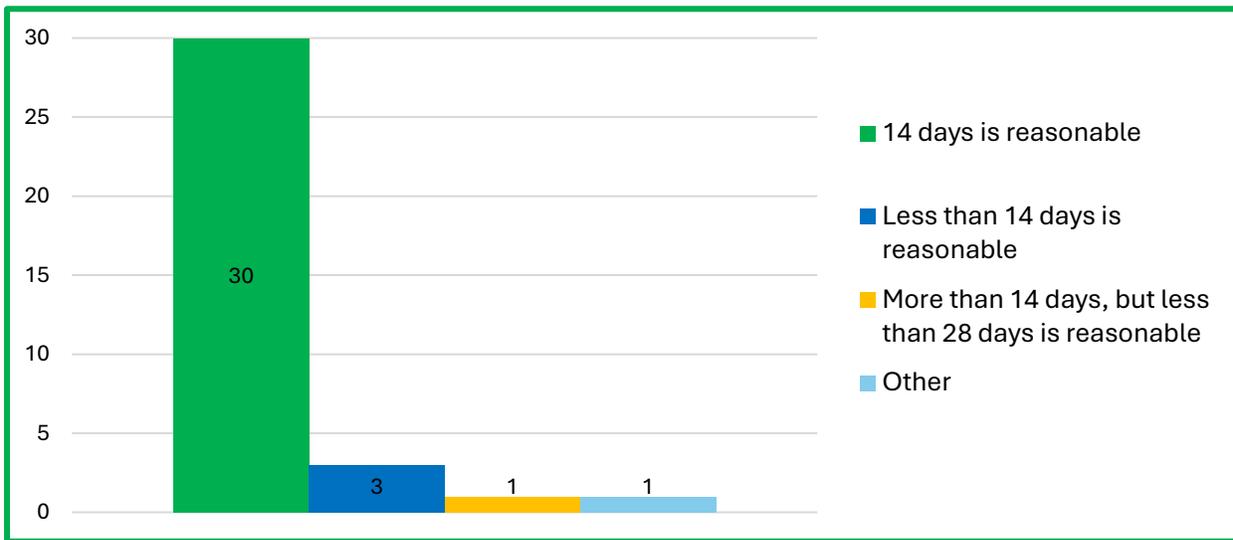
Legend:
- 14 days is reasonable
- Less than 14 days is reasonable
- More than 14 days, but less than 28 days is reasonable
- Other

Bar chart values: 30, 3, 1, 1

Survey #2	Survey #5	Survey #6	Survey #7
Survey #8	Survey #11	Survey #38	Survey #40
Survey #46	Survey #61	Survey #63	Survey #89
Survey #90	Survey #120	Survey #121	Survey #123
Survey #125	Survey #130	Survey #131	Survey #136
*Survey #145	Survey #146	Survey #150	Survey #153
Survey #155	Survey #157	Survey #158	Survey #164
Survey #166	Survey #174	Survey #175	Survey #182
Survey #185	Survey #190	Survey #193	

COMMENTS
Survey #175: Please see above comment.
Survey #121: N/A

| Survey #61: It is also important(maybe more important) to include diagnostic imaging in this guideline. After all, ordering an imaging assessment is consulting diagnostic imaging. |
| Survey #38: It adds a lot to our administration. Re-referral or change of management. This is only useful if we have a system where alternatives are known or suggested or better, if dealt with in a central , well managed referral system |

Consulting Physician version:

In your practice setting, how feasible is it for you to respond whether the referral can be accepted or not within 14 days?

Legend:
- I can meet the 14-day timeline all of the time (100%)
- I can meet the timeline most of the time (about 80% of the time)
- I can meet the timeline half of the time (about 50% of the time)
- I can meet the timeline less than half of the time (under 50% of the time)

Bar chart values: 3, 11, 4, 3
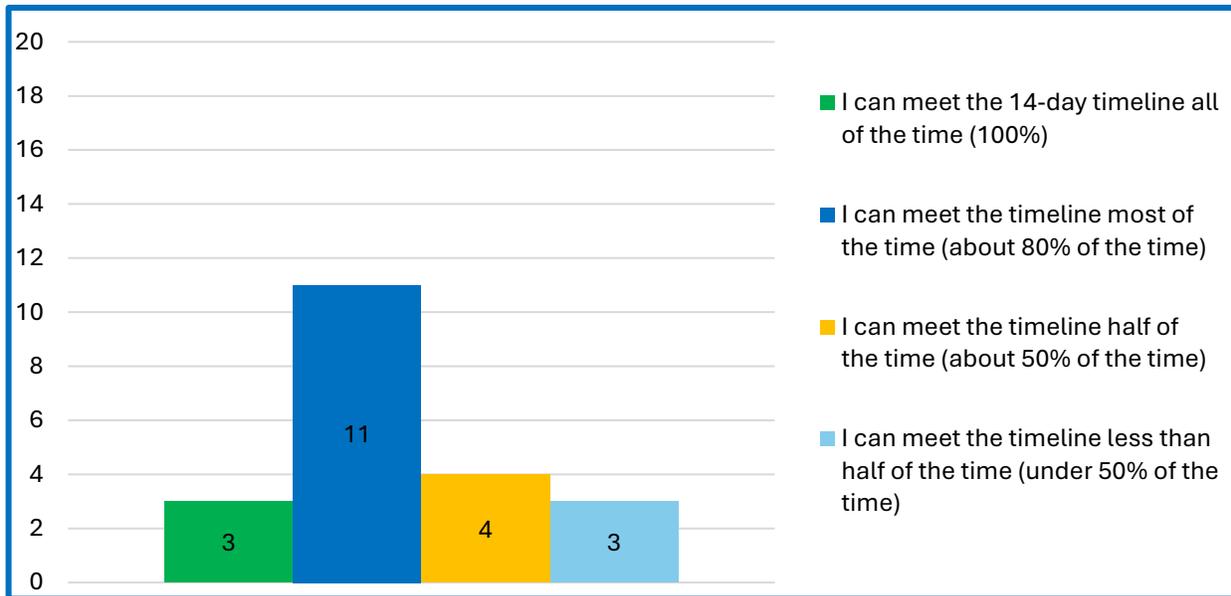
Survey #4	Survey# 66	Survey #72	Survey #78
Survey #79	Survey #80	Survey #82	Survey #84
Survey #85	Survey #100	Survey #109	Survey #110
Survey #111	*Survey #117	*Survey #124	*Survey #138
Survey #141	Survey #142	Survey #143	Survey #156
Survey #165			

COMMENTS

| Survey #165: See above |
| Survey #124: Test results requested in the context of the consultation may require more time than would be appropriate. Again, this may be out of the clinician's control. |
| Survey #111: At least many years ago when I welcomed referrals, which I no longer do. |
| Survey #109: Has no referrals as working in NICU |
| Survey #100: Many specialists do call in 2-week blocks, or may have call before or after vacation. To demand that urgent call-related care be postponed to accommodate responding to NON-urgent outpatient referrals, or to expect that a consulting physician stay even later into evenings or on weekends for uncompensated responses to NON-urgent outpatient referrals places a significant burden on those who juggle inpatient and outpatient responsibilities. Additionally, the options above do not list a commonly-used option in our specialty - an advice letter in lieu of an actual appointment. These take longer to generate as some chart review is involved, but is an |

important option when managing a new referral that is many months long. And many referring physicians are looking merely for advice and are happy to apply that advice to their ongoing care. Separating the acknowledgement from the response means that you are expecting every consult to receive 2 responses? One acknowledging receipt, and one with a plan for booking. I do not have time to recheck my current wait time before every consultation. And accurate information on this is not always available to me. An accurate estimate can therefore not be provided. A generic overestimate, e.g. up to 1 year, could be provided if that is sufficient. If the appointment is deemed urgent, we would send the actual appointment information to the patient, not an estimated timeframe to the referrer.

Survey #85: It is impossible to estimate the date oftentimes, as the appointment wait times can vary widely depending on the referral volume, evolution of the practice, wait times for diagnostic imaging, and even things like the season (less busy in the winter when out of towners dont want to come in and lots of cancellations happen). We used to try to estimate referral times on our forms for routine/urgent/emergency consults but after 6 months, they were wildly off. Creating a new unfunded burden for tracking and estimating wait times is not fair for receiving providers.

Survey #84: 30 days

Survey #78: I can indicate whether the consult is within my scope of practice or not easily, but not always how long it will take to see the patient.

Survey #66: see comment above

Survey #4: I have no idea as this is the responsibility of the hospital based staff and I have no say or control over when my mail is delivered or when consults are reviewed and communications are sent.

Both referring and consulting physician version:

Consider your consulting role: how feasible is it for you to respond whether the referral can be accepted or not within 14 days?

Legend:
- ■ I can meet the 14-day timeline all of the time (100% of the time)
- ■ I can meet the timeline most of the time (about 80% of the time)
- ■ I can meet the timeline half of the time (about 50% of the time)
- ■ I can meet the timeline less than half of the time (under 50% of the time)

Bar values: 10, 23, 7, 12

*Survey #1	Survey #9	Survey#10	Survey #12
Survey #15	*Survey #16	Survey #17	Survey #18
Survey #20	Survey #26	Survey #32	Survey#34
Survey #43	Survey #50	*Survey #51	Survey #59
Survey #64	Survey #65	Survey #68	Survey #73
Survey #76	*Survey #77	Survey #86	Survey #87
*Survey #92	Survey #94	Survey #98	Survey #99
Survey #113	Survey # 115	Survey #118	Survey #119
*Survey #122	Survey #126	Survey #127	Survey #133
Survey #140	Survey #148	Survey #151	Survey #152
Survey #154	*Survey #159	Survey #161	Survey #167
Survey #169	Survey #170	Survey #180	Survey #181
Survey #184	Survey #186	Survey #187	Survey #192

COMMENTS

Survey #181: The 2 are intertwined- as I review the consult the booking is immediately sent out

Survey #170: As a single mom physician, I do a consult practice and I work ▆▆▆▆▆ medicine. My consult practice does not pay my bills and so I only work once a week. If my child is sick, I am unable to. ▆ Clinic has repetitively been terrible at trying to look after my patients. It's been an ongoing struggle.

Survey #154: Estimated - this refers to having staff advised NOT to accept any referrals d/t lack of capacity. The remainder takes longer to arrange times to fit patients in.

Survey #140: See above. Sometimes need to see if others can accommodate referal. Thus can take time.

Survey #133: working part-time and allowing for vacation/absences 14 days is too short

Survey #122: I can see this being impacted by physicians vacations. Maybe extend to 21 or 28 days.

Survey #119: Any referrals that are not appropriate get a fax sent back the same day or a call to the referring MD. Those accepted are not needing a response

Survey #118: In a clinic, where wait times are > 6 months; referrals can be accepted; but no guarantee can be made regarding the booking date
Survey #94: Difficult to estimate an appointment date. The patient may need to be sooner than you can see but there is no one else who could see fast enough. Thus there will be a burden on the consultant physician they can't meet.
Survey #87: 1 month more reasonable for non urgent consults
Survey #65: I receive all consults and review and triage them within 7 days of receiving them. I have given them to my assistant and she books accordingly. Sending letters back to indicate response (even if it is one line statingconsult is received) takes time in the computer system. Our backlog is on that end. If I can not see I send letter back immediately within 1-2 weeks of receipt.
Survey #59: This is largely due to the administrative burden of the consults coming in. They tend to be batched when sent to me then I triage and send that back to admin to send out information based on the triage. This is going to add to the constant administrative burden
Survey #50: not really relevant to emergency medical practice

Consulting Physician version:

Q10*(this question was asked in section 2 of the survey within the consulting and referring/consulting version only)*

Taking time away from your practice is important for your health and well-being. Recognizing this, it is reasonable to expect that there will be situations when the timelines outlined in the standard cannot be met (see below).

> ** If a consulting registrant is away from their practice, they must have an away-from-practice notification so that the referring registrant is aware that they will not receive a triage response within the 14-day timeframe. A standard out-of-office/away-from-practice message with a date of return is sufficient.

Consider how you currently manage days off, vacation, or leave of absences; what mechanisms (if any) have you developed in your own practice to manage closed-loop communication during your absence?

COMMENTS

Survey #165: I typically log into my online clinic to manage critical results when I'm away. Sometimes this breaks down, for instance, with the birth of a new baby or critical illness and children. Normally, I'm able to act on critical results or at least direct people in the right direction to consultants who can cover for me when I'm away.

Survey #156: No

Survey #143: Other colleagues are informed that we are away and can address urgent requests

Survey #142: Group practice

Survey #138: We still continue to do it ourselves during vacation

Survey #124: disease site based shared care model of care

Survey #117: I am the pathologist and always try to clean up my cases before my leave

Survey #111: I am available by telephone, email and text 24/7 when I am travelling or on holiday.

Survey #109: Spend time with family Exercise Travel

Survey #100: We arrange coverage with colleagues to address urgent issues, or cover our own inboxes while away to address urgent issues. For absences > 2 weeks, no other standard out of office reply is given. For a large clinic where staff are shared between multiple providers, I am not sure it is feasible to expect clerks to be able to track exactly which days each physician is on holidays, and regardless, physicians have no say in clerk processes at ███ Clinic. Mechanisms are in place for longer leaves, eg. maternity leave.

Survey #85: None formal

Survey #82: Colleagues look at consults while I'm away and deal with urgent consults. I've never been away for more than 2 weeks.

Survey #79: None

Survey #78: None at present

Survey #66: we have coverage of urgent issues, but closed loop communication re triage of incoming consults would wait until the individual has returned. Extended leaves have a designated proxy

Survey #4: I have short leaves so haven't encountered this yet

Both referring and consulting physician version:

Q10(this question was asked in section 2 of the survey within the consulting and referring/consulting version only)

Taking time away from your practice is important for your health and well-being. Recognizing this, it is reasonable to expect that there will be situations when the timelines outlined in the standard cannot be met (see below).

> ** If a consulting registrant is away from their practice, they must have an away-from-practice notification so that the referring registrant is aware that they will not receive a triage response within the 14-day timeframe. A standard out-of-office/away-from-practice message with a date of return is sufficient.

<u>Consider your consulting role:</u> How you currently manage days off, vacation, or leave of absences? What mechanisms (if any) have you developed in your own practice to manage closed-loop communication during your absence?

COMMENTS
Survey #192: I, generally reply to any emergency request when away on holiday with in 2-4 weeks.
Survey #187: group practice = group triaging
Survey #186: Appropriate replies on phone, emails, or preferrably electronic communications in the electronic health record system should solve this problem.
Survey #181: I have someone triage the consults - all urgent ones generally are directed to the on call covering physician anyways
Survey #180: Covering for colleagues for urgent issues
Survey #170: There's no one to cover for me. My patients know that when I'm away, there's nobody else. They actually respect that because they respect me as a mom and a single parent ████████████████
Survey #169: We use a Central Intake, which means that there is always someone covering incoming consults.
Survey #167: group practice
Survey #159: Usually if I'm away, I'll either be managing my inbox or will arrange for a colleague to do so.
Survey #154: Staff is advised to inform any caller about communication delays during absence.
Survey #151: My time off has been capped at 2 weeks. Out-of-office notification was issued on as needed basis.
Survey #148: In group practice Reception know when I am back and relay to patient or offer consultation from one of my colleagues
Survey #140: Unfortunately, unless out of country and without emr access still have to do letters or review labs or other diagnotics. This needed to manage workload. Colleagues can deal with emergencies that arise but not regular work tasks.
Survey #133: This would require the entire office to agree upon and fund the office assistants to manage this. It cannot be "automatic" within most current EMR systems used in private clinics.
Survey #127: I travel with my laptop and check the office regularly
Survey #126: as above
Survey #122: Delighting staff to respond as needed, asking colleagues to cover.
Survey #119: Others cover. There is never a day without someone looking at all new consults before thy are put on wait list

Survey #118: I am more concerned about time doing call and other clinical commitments. Away notices are sent to clerks and managers

Survey #117: Automatic reply via email and/or Tiger connect communicating the return date and length of absence and who to be in touch with during that time.

Survey #113: Because I am part of a group practice, and all our intakes go through the group and are reviewed, this specific response would not be possible per MD... it is in my email and other forms of communication however

Survey #99: There is no process. I can be assigned 10 consults the day I leave for vacation and it is not as though the referral office with do anything even though I have an away from practice notification

Survey #98: The urgent care department is always covered when I am away

Survey #94: No one available to cover. Have to check on holidays.

Survey #92: administrative assistant advises consulting dr that I am out of town and to redirect to another dr if my colleagues will not see.

Survey #87: Partners that cover

Survey #86: answering machine message

Survey #77: I continue to check the EMR weekly and my assistant would continue to send out decline or appointment letters.

Survey #76: staff will inform referring physician of absences

Survey #68: Group practice with alternating physicians on Triage duty.

Survey #65: I have never been away more than 2 weeks. My assistant catches up on the backlog of consult receipt letters though. I have discovered that she is still sending letters for as far back as April 2025! (non urgent I said I'd see within a year)

Survey #64: I never take more than 2 weeks off, and I check messages while I'm away, so I don't anticipate an issue.

Survey #59: This ads to admin burden to send multiple replies now. Also L there may be less staff in office at times when MD away.

Survey #50: not really relevant to emergency medical practice

Survey #43: my assistant will communicate with the referring practioners that it will be dealt with on my return I also ask my assistant to book a pc withe patient as soon as possible

Survey #34: I am the only physician in my area with my scope of practice. If I am away, I continue to triage referrals and communicate with staff while I am away, as there is no one to delegate this task to.

Survey #32: I have a colleague that helps me out during my days off or time away from work, but in return, I do the same for my colleague

Survey #26: I am the only person in my specialty . I have been told I cannot take time off for this reason.

Survey #20: Front staff know when I'm away. Out of office email. Covering physician for emergencies.

Survey #18: If I am away, new consults go to my partner, so not an issue.

Survey #15: Tend to review incoming correspondence even on time off

Survey #12: Currently I take little vacation and review paperwork remotely. However colleagues could cover for me if I was out of country.

Survey #10: none

Survey #9: A fax could be easily sent back with an extended abscence.

Q10 (Q11): The standard outlines the requirements of a consulting physician for reporting back to the referring physician (see below).

Reporting Requirements of Registrant Receiving Requests to Help

- **Timely reports**: After seeing the patient, send a detailed report to the referring registrant as soon as possible but generally within 14 days (and not more than 28 days).
- **Interim and final reports**: If more investigation or treatment is needed, send interim reports to the referring registrant and a final report at the end of the consultation.
- **Report contents** should include:
  - Consulting registrant's identity.
  - Patient's identity.
  - The referring registrant's identity (and primary care physician, if different).
  - Date of consultation.
  - Purpose of referral.
  - Information reviewed (history, findings, tests).
  - Diagnosis and treatment.
  - Recommendations for follow-up and ongoing care (for referring and consulting registrants as applicable).
  - Any referrals made to other consultants.
  - If the patient requests privacy, note information is withheld at patient's request.
  - Advice given to the patient.

Referring Physician version:

Is 14 days a reasonable amount of time for the consulting physician to report back after the consultation has occurred?
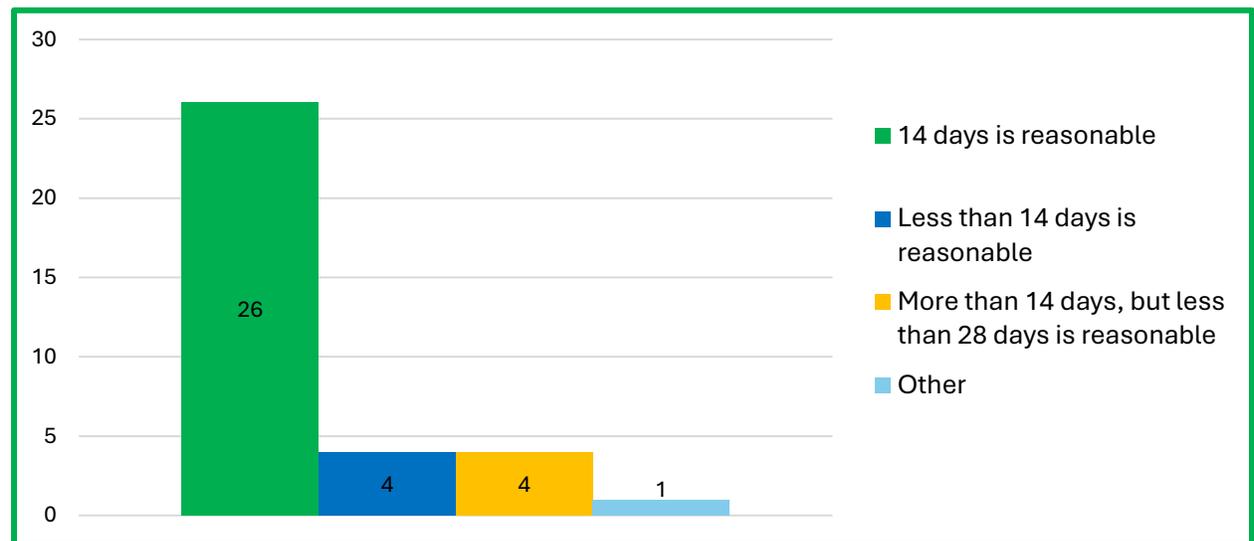
Survey #2	Survey #5	Survey #6	Survey #7
Survey #8	Survey #11	Survey #38	Survey #40
Survey #46	Survey #61	Survey #63	Survey #89
Survey #90	Survey #120	Survey #121	Survey #123
Survey #125	Survey #130	Survey #131	Survey #136
*Survey #145	Survey #146	Survey #150	Survey #153
Survey #155	Survey #157	Survey #158	Survey #164
Survey #166	Survey #174	Survey #175	Survey #182
Survey #185	Survey #190	Survey #193	

COMMENTS

Survey# 157: Within one week should be encouraged for greater accuracy regarding assessment and recommendations/next steps

Survey #131: The sooner the better of course. PCP f/up is usually at about the 14 day mark (sometimes the week after), so communication prior is important, if possible. Cleints are usually quite surprised and disappointed when they are not received even the next day.
Survey #121: N/A
Survey #89: many are faster than that, but there was one that we NEVER heard from, and a few that are more like a month and that is just too slow. Unless it is post op care and they need seen sooner than that. The communication needs to occur before the patient needs seen for follow up care. A phone call or text would even be ok in that instance.
Survey #40: 14 days seems reasonable- especially if there is anything for the referring doc to follow up on. At minimum 28 days if there is nothing for the referring doc to follow up on

Consulting Physician version:

In your practice setting, how feasible is it for you to meet the 14-day timeline for reporting back to the referring physician after a consultation?

Legend:
- 🟩 I can meet the 14-day timeline all of the time (100%)
- 🟦 I can meet the timeline most of the time (about 80% of the time)
- 🟧 I can meet the timeline half of the time (about 50% of the time)
- 🟦 I can meet the timeline less than half of the time (under 50% of the time)
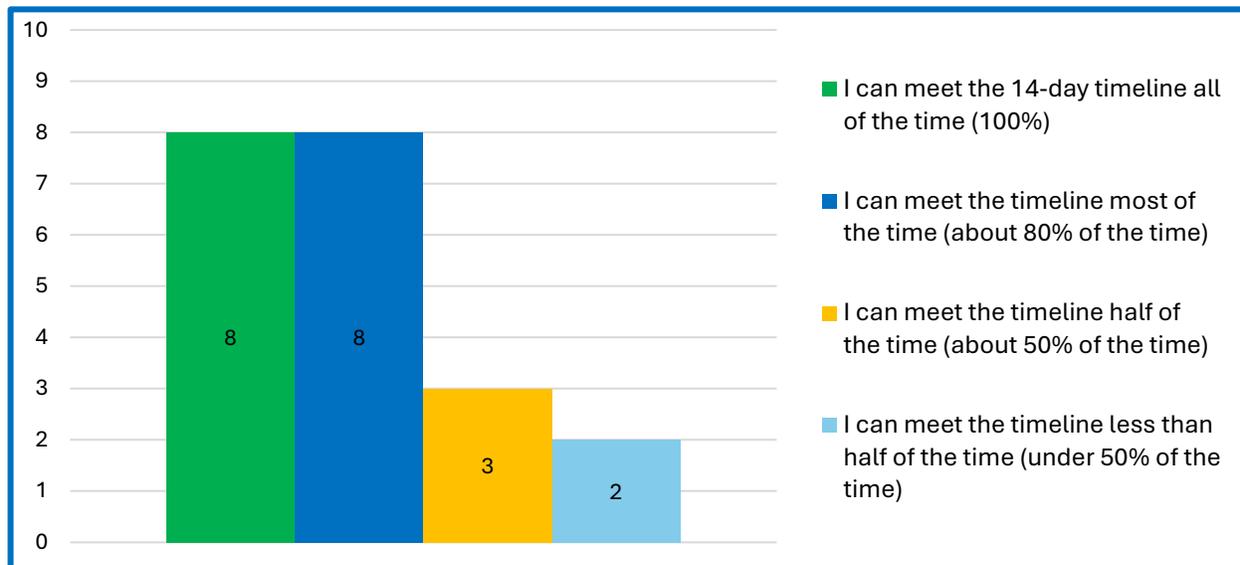
Survey #4	Survey #66	Survey #72	Survey #78
Survey #79	Survey #80	Survey #82	Survey #84
Survey #85	Survey #100	Survey #109	Survey #110
Survey #111	*Survey #117	*Survey #124	*Survey #138
Survey #141	Survey #142	Survey #143	Survey #156
Survey #165			

COMMENTS

Survey #165: I do all of my consult letters immediately

Survey #111: This is no longer relevant, as I am not longer accepting referrals, but when I did receive referrals my work schedule was flexible enough that I had no problem meeting the timeline 75-80 % of the time.

Survey #109: Has no referrals as working in NICU

Survey #100: Again, the major limitation here is inpatient call responsibilities. When on inpatient service, it is not always possible to send non-urgent reports back to referring physicians in a 14-day window.

Survey #78: The intial letter back is easy as my EMR converts my chart notes into a letter, it's the follow up information as more results come in that ends up being onerous.

Survey #66: i have concerns about the requirement to identify an alternate provider if I am unable to accomodate a referral in a timely fashion. the vast majority of declined consults are due to lack of capacity. There is no way that I will be able to predict someone else's capacity without centralized intake

Survey #4: I do a ███████████ clinic and the current outpatient dictation model I am forced to use doesn't work for this clinic. I have to dictate the letter and then it is typed in the system. I then need to correct the letter, cut and paste the letter into a word document and email to the 2 colleagues that do the clinic with me. They then add their information into the letter and email back to me. I then collate the letter and have to then paste it back into the provincial escription

system. I have asked multiple times and there is no other way to do this and I am not allowed to use any other system, including typing my own letters which would be faster. This contributes significantly to physician administration burden.

Both referring and consulting physician version:

Consider your consulting role: how feasible is it for you to meet the 14-day timeline for reporting back to the referring physician after a consultation?

Legend:
- **I can meet the 14-day timeline all of the time (100%)** (green)
- **I can meet the timeline most of the time (about 80% of the time)** (blue)
- **I can meet the timeline half of the time (about 50% of the time)** (yellow)
- **I can meet the timeline less than half of the time (under 50% of the time)** (light blue)

Bar values: 13, 23, 8, 8

*Survey #1	Survey #9	Survey#10	Survey #12
Survey #15	*Survey #16	Survey #17	Survey #18
Survey #20	Survey #26	Survey #32	Survey#34
Survey #43	Survey #50	*Survey #51	Survey #59
Survey #64	Survey #65	Survey #68	Survey #73
Survey #76	*Survey #77	Survey #86	Survey #87
*Survey #92	Survey #94	Survey #98	Survey #99
Survey #113	Survey # 115	Survey #118	Survey #119
*Survey #122	Survey #126	Survey #127	Survey #133
Survey #140	Survey #148	Survey #151	Survey #152
Survey #154	*Survey #159	Survey #161	Survey #167
Survey #169	Survey #170	Survey #180	Survey #181
Survey #184	Survey #186	Survey #187	Survey #192

COMMENTS

Survey #187: Meeting the 14 day cut off is very hard; the consultations on my patients include detailed histories (ie they are not the 3 liners that some specialties have). I work in an academic setting: resident sees patient > resident needs to complete full letter (resident can take days to do this - on call, post call, other academic / service demands > letter gets to me to review and then I having competing demands (eg. am on service, have urgent patients that have needs, providing service at a different site etc). This is all without taking personal time / vacation. It is not nearly as linear as it seems: 14 day is a very difficult standard to meet for all but simple consultations. 28 days is even hard.

Survey #186: Ideally, these communications and sharing of information should happen automatically through connected EHR systems.

Survey #181: I can send a note immediately with a general outline but cannot provide a detailed report as often complex investigations are required and they take time. often several notes are sent in sequence.

Survey #170: I think one month is more reasonable and that is currently what I do. I try to see my patients within three months, and I tried to get back to them and their provider within one month.
Survey #169: I am in the process of reducing patient volumes in order to be able to meet this standard, and I am improving.
Survey #140: Sometimes if waiting for investigtions letters take longer
Survey #113: 14 days is not realistic if the goal is to have a well formatted consult response that is mostly complete when the work up I often am doing takes 2 weeks minimum ~ clear definition of what an interim or primary fyi response would be should be clear from the colleges perspective for this reason; Further, my documents are used often in non-medical contexts, so the associated write ups take longer involving medical language translation etc. throughout ALSO; as I work with medical students and residents regularly, there is often a delay in getting their writeups for then editing and forwarding.
Survey #99: may be issues when on call particularly if a lot of information needs to be gathered from elsewhere (ie EPR, E chart)
Survey #98: We do not generally track who sent the patient in to the urgent care department. If it is not the family physician, they will not receive a report. Certainly at this time no system exists to get reports back to doctors who send patients in, it would be easy enough to add the sender to the distribution list, but I'm not sure any of the doctors, nurses or ward clerks have the time to ensure this task is completed every time, especially when the sender does not include a written referral with their contact info.
Survey #87: Residents slow process down but are an important part of the process
Survey #77: I dictate and transcription sometimes takes up to 30 days.
Survey #68: 14 days is very short turn around for non urgent general pediatrics consultations. For myself due to working in different locations delays with trainees and consultation note transcription and faxing, I would generally meet 28 days but not 14 and don't think this is reasonable for non urgent issues.
Survey #64: With today's technology, and multiple options to assist in documentation, there is absolutely no reason that these consultation letters can't be sent back immediately, or within 1-2 days. The only area I could see this being difficult to achieve is in discharge summaries. As a ▮▮ physician who cares for other physicians' patients in hospital, among my MANY other, often urgent and time-sensitive, responsibilities, combined with a disastrous chart management process at our hospital, discharge summaries are sometimes difficult to complete until a large block of dedicated uninterrupted time is available. I realize this isn't a referring-consulting relationship, but I would argue there's the same responsibility to follow the collaborative care standard.
Survey #59: May be time when waiting on information that delays
Survey #50: not really relevant to emergency medical practice
Survey #26: Please see previous comment. ▮▮▮▮▮▮▮▮▮▮▮▮▮ ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮ I provide 3+ weeks of call coverage per month. In addition, I am expected to work in a second speciality that is also poorly resourced. In my opinion there needs to be an exception to some of this stuff for people who have been told that they must work well above a regular FTE due to their specialty being under resourced. If someone is doing regular clinical duties plus being on call for more than 2+ weeks a month - I don't know how this person can be expected to keep up to the same standard as people who have not been told that they have to work that much.
Survey #18: I always review and edit my transcripted clinic letters before they can be mailed out and there are multiple steps before letters can be sent out. Therefore, there will be times when

disruptions related to transcription service, my office staff being away or me being away, will result in letters not being sent out in time. However, we do our best to clear things off before scheduled holidays.
Survey #15: If the consulting physician is engaging in ongoing care, is every interaction to be forwarded to the referring physician?
Survey #9: That is a very restrictive timeline for sending a response back of high quality.

SECTION 3 – Emergent, Urgent and Inpatient Requests

Q11(Q12): The standard outlines the responsibilities for physicians involved in the transfer of a patient (see below).

Transfer of Patient

If the patient cannot safely and adequately be treated at their present location, registrants must:

- **Identify an appropriate facility**: Determine where the patient can be safely and adequately treated.
- **Coordinate the transfer**: Collaborate on arranging the transfer, involving all necessary resources and registrants (including those at multiple facilities, if required).
- **Share responsibility**: All registrants involved in developing the plan of action share responsibility for finding a safe solution for the patient.
- **Follow facility policies**: If the accepting service at the identified facility is unclear, the registrant at the receiving facility should follow their facility's policies.
- **Avoid unnecessary delays**: The transfer should not be delayed while seeking clarity about accepting service.

Are the roles clearly defined?
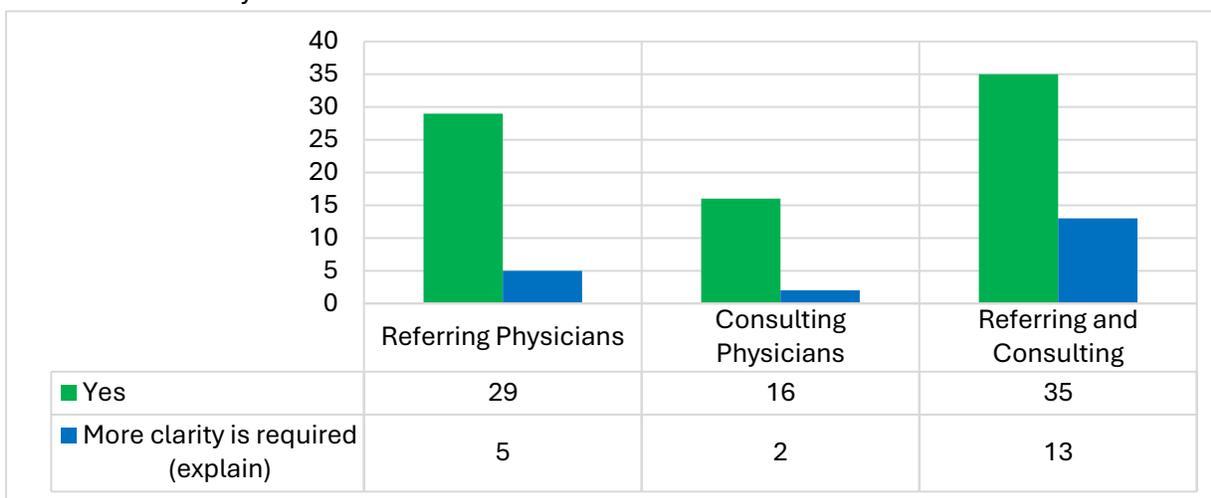
	Referring Physicians	Consulting Physicians	Referring and Consulting
■ Yes	29	16	35
■ More clarity is required (explain)	5	2	13

Referring physicians	Consulting physicians	Referring and consulting
Survey #2: Yes	**Survey #4:** Yes	***Survey #1:** Yes
Survey #5: Yes	**Survey #66:** Yes	**Survey #9:** Yes
Survey #6: Yes	**Survey #72:** Yes	**Survey#10:** Yes
Survey #7: Yes	**Survey #78:** Yes	**Survey #12:** Yes
Survey #8: Yes	**Survey #79:** Yes	**Survey #15:** More clarity is required
Survey #11: Yes	**Survey #80:** Yes	**Survey #17:** Yes
Survey #38: More clarity is required	**Survey #82:** Yes	**Survey #18:** Yes
Survey #40: Yes	**Survey #85:** Yes	**Survey #20:** Yes
Survey #46: Yes	**Survey #100:** More clarity is required	**Survey #26:** Yes
Survey #61: More clarity is required	**Survey #109:** Yes	**Survey #32:** Yes
Survey #63: Yes	**Survey #110:** Yes	**Survey#34:** Yes
Survey #89: Yes	**Survey #111:** Yes	**Survey #43:** More clarity is required
Survey #90: More clarity is required	***Survey #138:** Yes	**Survey #50:** More clarity is required
Survey #120: Yes	**Survey #141:** Yes	***Survey #51:** Yes

Survey #121: Yes	**Survey #142:** Yes	**Survey #59:** Yes
Survey #123: Yes	**Survey #143:** Yes	**Survey #64:** More clarity is required
Survey #125: Yes	**Survey #156:** Yes	**Survey #65:** Yes
Survey #130: Yes	**Survey #165:** More clarity is required	**Survey #68:** Yes
***Survey #131:** Yes		**Survey #73:** Yes
Survey #136: Yes		**Survey #76:** Yes
Survey #146: Yes		***Survey #77:** Yes
Survey #150: Yes		**Survey #86:** More clarity is required
Survey #153: More clarity is required		**Survey #87:** More clarity is required
Survey #155: Yes		**Survey #94:** Yes
Survey #157: Yes		**Survey #98:** More clarity is required
Survey #158: Yes		**Survey #99:** Yes
Survey #164: Yes		**Survey #113:** More clarity is required
Survey #166: Yes		**Survey #115:** Yes
Survey #174: Yes		**Survey #118:** Yes
Survey #175: More clarity is required		**Survey #119:** Yes
Survey #182: Yes		**Survey #126:** More clarity is required
Survey #185: Yes		**Survey #127:** Yes
Survey #190: Yes		**Survey #133:** Yes
Survey #193: Yes		**Survey #140:** Yes
		Survey #148: Yes
		Survey #151: Yes
		Survey #152: Yes
		Survey #154: Yes
		Survey #161: Yes
		Survey #167: More clarity is required
		Survey #169: More clarity is required
		Survey #170: Yes
		Survey #180: Yes
		Survey #181: Yes
		Survey #184: Yes
		Survey #186: More clarity is required
		Survey #186: More clarity is required
		Survey #192: Yes

COMMENTS
Referring physician
Survey #175: For the last point - what does that mean? Can you transfer a patient even if the other side doesn't agree?
Survey #153: There are frequent delays in the transfer of patients from outside/rural facilities to tertiary hospitals/emergency departments because often no physician/service is willing to accept the patient. i.e. the patient is "too sick" for Internal Medicine, but ICU doesn't have beds or won't accept the patient ("not sick enough"). In these cases, the sending physician is often left with inability to transfer until someone will accept. The Emergency Department physicians are instructed not to accept inpatients from other facilities unless they are accepted by an inpatient service at their site.

Survey #90: this is a little nebulous, WHO should coordinate the transfer - right now physicians are expected to be on the phone while actively dealing with a patient in very low resourced location- this is unacceptable.

Survey #61: Can you take a moment and imagine how difficult it might be when you have a very sick patient arriving at your office. You have a busy schedule and you find that this patient is requiring emergent care. You call the ER, they decline the consult and transfer because they are over capacity, you reach out to VECTRS and they are not able to provide a timely solution, so then you call 911, prepare the letter of referral, monitor the patient until they arrive and hope for the best.

Survey #38: How do the referring doctor know 1 who is available, 2 who is available the soonest possible

Consulting physician

Survey #165: The part where it says that we must collaborate on arranging the transfer is not clear. Typically an accepting physician at a tertiary centre would not be responsible for calling an ambulance, for ensuring that the patient gets on the ambulance, for ensuring that the patient is suitable and stable enough for transfer and has all the needed medical treatment while in transfer. The way this is worded the accepting physician shares this responsibility. I don't see how they can possibly be responsible for this given that they're not at the patient's bedside and they're not at the sending facility. It should be revisited.

Survey #100: Emergent, Urgent and Inpatient requests are all lumped together in this standard, but the transfers and processes seem only to apply to emergent requests.

Referring/consulting

Survey #187: I work in the pediatric setting that is more straightforward. I cannot comment on whether better roles need definition as I am sure I am missing something in the adult world (I would have skipped answering but the survey won't let me.

Survey #186: Sharing of responsibilities is good but things can fall through the cracks if one registrant does not have a leadership accountability.

Survey #169: Lack of beds is an ongoing problem, which I think needs to be addressed in the standard. What are physicians to do when they agree that a patient would benefit from transfer but there is no bed?

Survey #167: Transfer problems are often related to system issues. It is difficult to find administrators to actually take responsibility.

Survey #126: poorly available information on accepting physicians from referring hospitals for repatriations.

Survey #113: with vectrs and other systems involved, I think this needs more clarity

Survey #98: Often physicians will try to send an inappropriate patient to urgent care, for example: suspected appendicitis, suspected peritonsillar abscess, suspected myocardial infarction. If I as the physician receiving the call decline, am I responsible for helping get that patient to the appropriate hospital? "Avoid unnecessary delay while seeking accepting service", this is impossible. ER's will frequently decline to accept a transfer from urgent care before they have an accepting service. Contacting the accepting service can take hours, especially for surgical services

Survey #87: Roles aren't clear if no accepting service- who is responsible at recieving end- can it be left ER to ER

Survey #86: lack of an on lne bed registry and on call physician contact info can make transfer difficult

Survey #64: Follow facility policies - This would be a good place to reiterate that, even if a consultant cannot take a patient based on their facility policies, they have to stay involved in the case, as they are "tapped in". Avoid uneccessary delays - Transfers that are arranged by MTCC/VECTRS (ie: almost all of emergent transfers) cannot be initiated until we have an accepting service/physician. This is not a small proportion of cases. Collaboration with VECTRS/MTCC on this specific area would be beneficial prior to release of the new standard.
Survey #50: Share responsibility - the usual response is not my problem and these is no shared responsibility. The automatic response is who else can I punt this to?
Survey #43:THE CONSTANT DEFLCTION AND WAIT FOR A RESPONSEBY ER DEPTS AND DOCS IN PARTICULAR MAKE THE ABOVE EXTERMELY DIFFICULT
Survey #15: The sharing of responsibility if there are systemic barriers to transfer of care (no beds, for example) seems inappropriate for non-tertiary care centers

Q13 *(this question was asked in section 3 of the survey within the consulting and referring/consulting version only)*

If you practice in a hospital/institutional setting, what, if any, provisions in the standard would be difficult to comply with?

COMMENTS
Consulting physician
Survey #165: It would be very hard to ensure that the patient is transferred appropriately from other facilities to our site when we typically as an accepted physician, do not busy ourselves in the details of those transfers.
Survey #156: chronic lack of beds to admit patients referred from community hospitals
Survey #141: None
Survey #110: None
Survey #100: The transfer should not be delayed while seeking clarity about accepting service" implies that a facility can send the patient to a different institution without an accepting service. Or that emergency could send a patient to a unit or for a surgery without an accepting service.
Survey #82: N/a
Survey #79: Open beds
Survey #78: none
Survey #66: none
Referring/consulting
Survey #181: The support staff is not trained, often absent and no appropriate staff are available Dictation is slow- BUT I now type and send a note immediately . The process whereby consults are received is not secure (ie the issues at ███) and even when I have asked to have patients booked and the physician notified, the clerk ws "too busy" to do
Survey #180: wrong information provided
Survey #170: Most doctors have no control over this. It's the bed doctors in rural Manitoba.
Survey #169: See above
Survey #167: No beds, no staff
Survey #154: N/A
Survey #151: N/A
Survey #148: N/A
Survey #140: ?

Survey #119: None
Survey #115: Standard is clear and by extension includes the bed managers
Survey #113: ▮▮▮▮ regularly refers after hours to MD's for urgent follow ups without calls directly to the individuals (they have a certain number of spots reserved at these clinics for these patients)~ if this was approved as stands, this practice and likely many others with set pathways for outpatient follow up would not meet the criteria you are proposing
Survey #98: Contacting outpatient physician for < 2 week follow up Avoiding transfer delays Providing the physicians that refer patients into urgent care a discharge summary
Survey #94: ER being way over capacity with lack of treatment spaces can lead to difficulty to safely accept patients who need transfer.
Survey #86: see above
Survey #76: availability of resources in hospital
Survey #65: It can be difficult to get in touch with the referring physician. As on ObGyn we are often in OR or in delivery and can't take the transfer call immediately. This can delay transfer time.
Survey #64: The only area I could see this being difficult to achieve is in discharge summaries. As a ▮▮▮▮ physician who cares for other physicians' patients in hospital, among my MANY other, often urgent and time-sensitive, responsibilities, combined with a disastrous chart management process at our hospital, discharge summaries are sometimes difficult to complete until a large block of dedicated uninterrupted time is available. We do not have residents and PAs/CAs to assist with completing this work more quickly, as there would be in larger facilities. I realize this isn't a referring-consulting relationship, but I would argue there's the same responsibility to follow the collaborative care standard.
Survey #50: accepting service - accepting services in hospital very reluctant to accept inpatients from other facilities. It makes no sense for a patient on a ward in another hospital to start their patient care journey from scratch again in the ED. Should ALWAYS be coming direct to an accepting service, or preferably a ward directly. Also identifying appropriate facility. I work at ▮▮▮▮ ▮▮▮▮ in Winnipeg. The default is to send everything here, when their care needs can clearly be managed at another site. Community sites need to play a larger part in receiving referrals from elsewhere - for example, a paitent being referred by a PCP with abdominal pain does not need to come to HSC. This can be investigated and worked up at a community site and if a surgical issue is identified, then transferred. Meanwhile urgent cares will not see these patients creating unnecessary barriers for our patients that must come to tertiary care, and for them as well.
Survey #34: Arranging urgent consultations and procedures is difficult for a solo provider with no designated hospital-based administraitve staff. Eg. If a patient needs an urgent procedure, especially if <1 week, it is extremely time-consuming for the consultant to arrange - appropriate paperwork and forms completed, medication review, prep instructions relayed, finding other team members [anesthesia, nursing, etc]) eg. Some facilities require that specific (redundant) paperwork is completed before anything can proceed with booking. (eg. endo intake form, SWIM)
Survey #15: The sharing of responsibility if there are systemic barriers to transfer of care (no beds, for example) seems inappropriate for non-tertiary care centers
Survey #12: Rarely transfers from out clinic are needed to a hospital. Because we close at 6PM, I may not be available to answer a call to review a case from a accepting facility after a transfer has been intitiated.
Survey #9: Finding an accepting provider in a hospital that has capacity.

Q14 *(this question was asked in section 3 of the survey within the consulting and referring/consulting version only)*

If you practice in a hospital/institutional setting, what, if any, provisions in the standard are likely to create barriers to your patients receiving timely, safe care?

COMMENTS
Consulting physician
Survey #156: Lack of beds.
Survey #141: None
Survey #110: EPR
Survey #82: N/a
Survey #79: Delays in transport due to transport services. I had asked patients to drive themselves in some situations - that is frankly ridiculous that I have to ask that of them.
Survey #78: availability of transport
Survey #66: none in the standard. it will be bed availability, capacity of the system, etc
Referring/consulting
Survey #181: see above
Survey #180: resource limitation
Survey #170: Not having control over where patients are transferred. Often patients are transferred to a different community and then families are not able to get there. Either because they don't have transportation or they're elderly.
Survey #169: Nothing in the standard, but lack of resources (beds, nursing) is a barrier.
Survey #167: No beds, no staff
Survey #154: N/A
Survey #151: NA
Survey #148: N/A
Survey #140: System limitations
Survey #119: None. There is a bed manager who does this
Survey #115: None clearly emerge when I think of my work
Survey #113:"identify an appropriate facility" ~ this can be incredibly limiting when the hospitals are full and their is a patient at a Nursing station; they will never be in a situation where it is better for the patient to wait their while a location to longer term support the patient is found~ delays related to this have led to deaths in the community that could have been prevented
Survey #98: Requirement to spend time calling outpatient physicians to arrange follow up
Survey #94: Internal medicine often gets asked to accept patients admitted at community or rural hospitals who may not be sick enough for icu to want to accept them but are too sick for an internal medicine ward. These patients should be transferred to tertiary care but it is sometimes hard to find a safe way to do this. These patients cannot just be transferred to ER for assessment by ERP (which would be the safest for sicker patients especially at night). If they are admitted ER demands an accepting service. It is variable how much an ER physician may help for a sick patient who comes direct to internal medicine (often they don't assess the patient). This creates patient safety concerns for sick patients transferred direct to internal medicine.
Survey #86: lack of space at accepting facility
Survey #76: Hospital resources
Survey #64: Avoid uneccessary delays - Transfers that are arranged by MTCC/VECTRS (ie: almost all of emergent transfers) cannot be initiated until we have an accepting service/physician. This is

not a small proportion of cases. Collaboration with VECTRS/MTCC on this specific area would be beneficial prior to release of the new standard.
Survey#50: following facility policies regarding question 13
Survey #34: None. I already strive to meet the parameters outlined in the standard. The barriers I experience are already established, and not promoted/worsened by the standard.
Survey #15: Need to ensure that transportation system (VECTRS) is comfortable transferring a patient without a receiving physician if the need is emergent
Survey #1: Capacity is the biggest one, and consultants not accepting transfers due to "not being their responsibility" and having to jump through 10 hoops to get a patient out.

Conclusion

Q12(Q15): The standard specifies the roles of referring and consulting physicians. To what extent do you agree that the standard clearly defines the responsibilities of referring physicians and consulting physicians?

Referring physician

Survey #2:	Survey #5	Survey#6
Referring physicians: Agree	Referring physicians: Strongly Agree	Referring physicians: Agree
Consulting physicians: Agree	Consulting physicians: Strongly Agree	Consulting physicians: Agree
Survey #7	**Survey #8**	**Survey #11**
Referring physicians: Agree	Referring physicians: Agree	Referring physicians: Agree
Consulting physicians: Agree	Consulting physicians: Agree	Consulting physicians: Agree
Survey #38	**Survey #40**	**Survey #46**
Referring physicians: Agree	Referring physicians: Strongly Agree	Referring physicians: Agree
Consulting physicians: Agree	Consulting physicians: Strongly Agree	Consulting physicians: Agree
***Survey #61**	**Survey #63**	**Survey #89**
Referring physicians: Agree	Referring physicians: Agree	Referring physicians: Strongly Agree
Consulting physicians: Agree	Consulting physicians: Agree	Consulting physicians: Strongly Agree
Survey #90	**Survey #120**	**Survey #121**
Referring physicians: Agree	Referring physicians: Agree	Referring physicians: Agree
Consulting physicians: Agree	Consulting physicians: Agree	Consulting physicians: Agree
Survey #123	**Survey #125**	**Survey #130**
Referring physicians: Strongly Agree	Referring physicians: Disagree	Referring physicians: Strongly Agree
Consulting physicians: Strongly Agree	Consulting physicians: Disagree	Consulting physicians: Strongly Agree
Survey #136	**Survey #146**	**Survey #150**
Referring physicians: Strongly Agree	Referring physicians: Strongly Agree	Referring physicians: Strongly Agree
Consulting physicians: Strongly Agree	Consulting physicians: Strongly Agree	Consulting physicians: Strongly Agree
Survey #153	**Survey #155**	**Survey #157**
Referring physicians: Agree	Referring physicians: Agree	Referring physicians: Strongly Agree
Consulting physicians: Neutral	Consulting physicians: Agree	Consulting physicians: Strongly Agree
Survey # 158	**Survey #164**	**Survey #166**
Referring physicians: Strongly Agree	Referring physicians: Agree	Referring physicians: Strongly Agree
Consulting physicians: Strongly Agree	Consulting physicians: Agree	Consulting physicians: Strongly Agree
Survey #174	**Survey #175**	**Survey #182**
Referring physicians: Agree	Referring physicians: Agree	Referring physicians: Strongly Agree

Consulting physicians: Agree	Consulting physicians: Neutral	Consulting physicians: Strongly Agree
Survey #185 Referring physicians: Agree Consulting physicians: Agree	**Survey #190** Referring physicians: Strongly Agree Consulting physicians: Strongly Agree	**Survey #193** Referring physicians: Strongly Agree Consulting physicians: Strongly Agree

Consulting physician

Referring physicians: Strongly agree 3, Agree 11, Neutral 1, Disagree 1

Consulting physicians: Strongly agree 3, Agree 9, Neutral 2, Disagree 1, Strongly disagree 1

Legend: Strongly agree, Agree, Neutral, Disagree, Strongly disagree
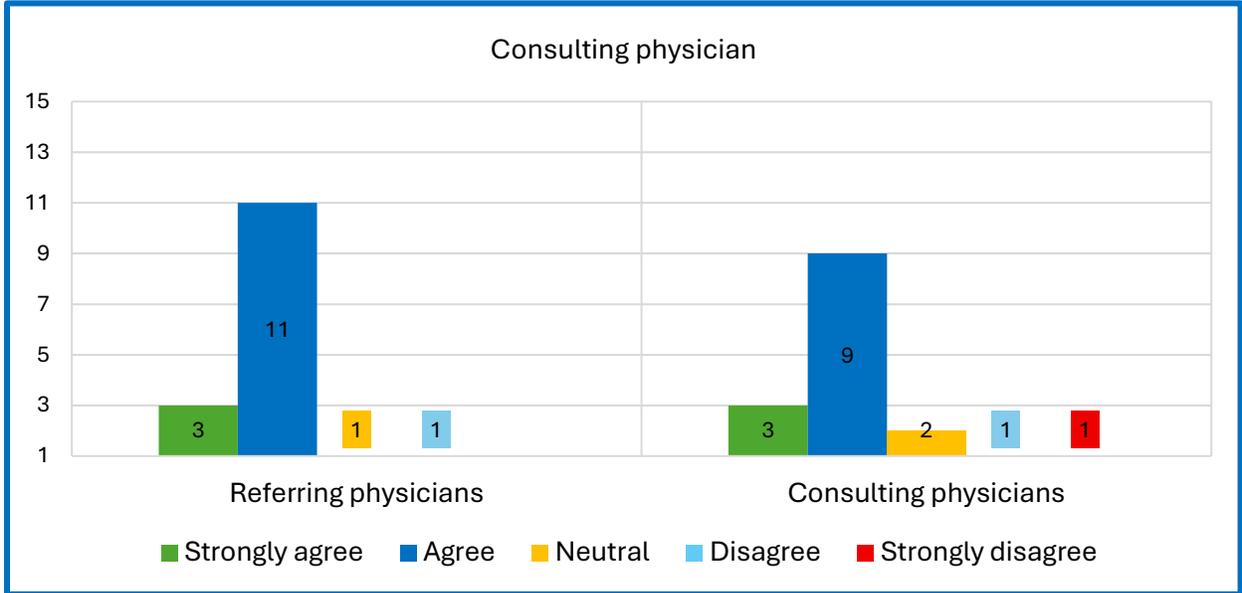
Survey #4: Referring physicians: Agree Consulting physicians: Agree	**Survey #66:** Referring physicians: Agree Consulting physicians: Agree	**Survey #72:** Referring physicians: Agree Consulting physicians: Agree
Survey #78: Referring physicians: Agree Consulting physicians: Agree	**Survey #80:** Referring physicians: Neutral Consulting physicians: Agree	**Survey #82:** Referring physicians: Agree Consulting physicians: Agree
Survey #85: Referring physicians: Agree Consulting physicians: Strongly disagree	**Survey #: 100** Referring physicians: Disagree Consulting physicians: Disagree	**Survey #: 109** Referring physicians: Agree Consulting physicians: Agree
Survey #110 Referring physicians: Agree Consulting physicians: Agree	**Survey #111** Referring physicians: Strongly agree Consulting physicians: Strongly agree	**Survey #141** Referring physicians: Strongly agree Consulting physicians: Strongly agree
Survey #142 Referring physicians: Agree Consulting physicians: Agree	**Survey #143** Referring physicians: Agree Consulting physicians: Agree	**Survey #156** Referring physicians: Strongly agree Consulting physicians: Strongly agree
Survey #165 Referring physicians: Agree Consulting physicians: Neutral		

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Referring/consulting physician

	Referring physicians	Consulting physicians
Strongly agree	14	9
Agree	26	29
Neutral	3	3
Disagree	2	2
Strongly disagree	0	0

Legend: ■ Strongly agree ■ Agree ■ Neutral ■ Disagree ■ Strongly disagree
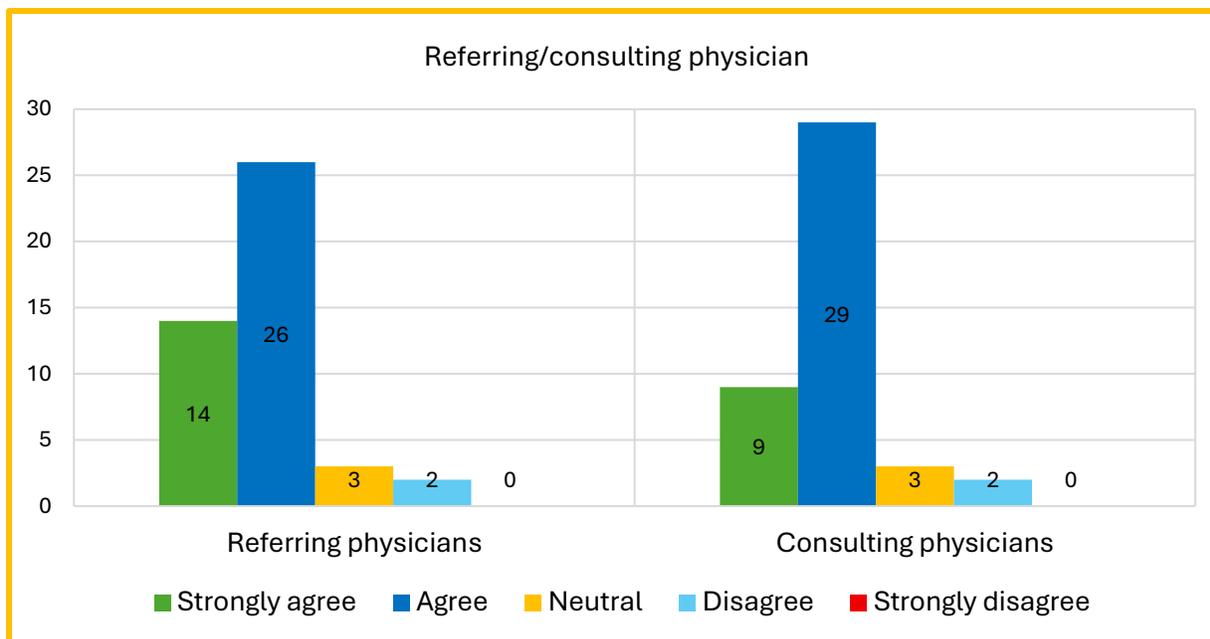
Survey #9 Referring physicians: Disagree Consulting physicians: Disagree	**Survey#10** Referring physicians: Agree Consulting physicians: Agree	**Survey #12:** Referring physicians: Agree Consulting physicians: Agree
Survey #15 Referring physicians: Agree Consulting physicians: Agree	**Survey #17** Referring physicians: Agree Consulting physicians: Agree	**Survey #18** Referring physicians: Strongly agree Consulting physicians: Agree
Survey #20 Referring physicians: Strongly agree Consulting physicians: Strongly agree	**Survey #26** Referring physicians: Agree Consulting physicians: Agree	**Survey #32** Referring physicians: Strongly agree Consulting physicians: Agree
*Survey #34 Referring physicians: Strongly agree Consulting physicians: Agree	***Survey #43** Referring physicians: Strongly agree Consulting physicians:	**Survey #50** Referring physicians: Agree Consulting physicians: Agree
Survey #59 Referring physicians: Agree Consulting physicians: Agree	**Survey #64** Referring physicians: Strongly agree Consulting physicians: Agree	**Survey #65** Referring physicians: Agree Consulting physicians: Agree
Survey #68 Referring physicians: Agree Consulting physicians: Agree	**Survey #73** Referring physicians: Strongly agree Consulting physicians: Strongly agree	**Survey #76** Referring physicians: Neutral Consulting physicians: Neutral
Survey #86 Referring physicians: Agree Consulting physicians: Agree	**Survey #87** Referring physicians: Agree Consulting physicians: Agree	**Survey #94** Referring physicians: Agree Consulting physicians:
Survey #98 Referring physicians: Agree Consulting physicians: Agree	**Survey #99** Referring physicians: Agree Consulting physicians: Agree	**Survey #113** Referring physicians: Strongly agree Consulting physicians: Strongly agree
Survey #115 Referring physicians: Strongly agree Consulting physicians: Strongly agree	**Survey #118** Referring physicians: Neutral Consulting physicians: Neutral	**Survey #119** Referring physicians: Neutral Consulting physicians: Neutral
Survey #126 Referring physicians: Disagree Consulting physicians: Disagree	**Survey #127** Referring physicians: Strongly agree Consulting physicians: Strongly agree	**Survey #133** Referring physicians: Agree Consulting physicians: Agree
Survey #140 Referring physicians: Agree Consulting physicians: Agree	**Survey #148** Referring physicians: Agree Consulting physicians: Agree	**Survey #151** Referring physicians: Strongly agree

		Consulting physicians: Strongly agree
Survey #152 Referring physicians: Agree Consulting physicians: Agree	**Survey #154** Referring physicians: Agree Consulting physicians: Agree	**Survey #161** Referring physicians: Agree Consulting physicians: Agree
Survey #167 Referring physicians: Agree Consulting physicians: Agree	**Survey #169** Referring physicians: Agree Consulting physicians: Agree	**Survey #170** Referring physicians: Agree Consulting physicians: Agree
Survey #180 Referring physicians: Agree Consulting physicians: Agree	**Survey #181** Referring physicians: Strongly agree Consulting physicians: Strongly agree	**Survey #184** Referring physicians: Strongly agree Consulting physicians: Strongly agree
Survey #186 Referring physicians: Agree Consulting physicians: Agree	**Survey #187** Referring physicians: Agree Consulting physicians: Agree	**Survey #192** Referring physicians: Strongly agree Consulting physicians: Strongly agree

Q13(Q16): With the goal of patient-centred care, which areas of the standard do you think can be improved?

COMMENTS
Referring physician
Survey #193: Consult report in a timely manner
Survey #190: Patient wait time
Survey #185: (improved) policing of new guidelines
Survey #182: There is over investigation as the patient has access to walkin clinics and subsequent duplication of investigation/treatment. I think the home clinics needs to be encouraged to provide more access to patient and at the same time, walkin clinics need to investigate for appropriate episode. This is a wide topic and scope of improvement is vast.
Survey #175: I agree having more closed loop communication is helpful; if gives more information to referring physicians about when their patient will be seen and also lets patients know. Referring physicians have to send informative consults. Otherwise everything gets delayed. The timeline is too tight - business days or all days? What if there are administrative delays in uploading documents?
Survey #157: Prompt communication back to the referring physician
Survey #130: The initial response sometimes be late than 14 days
Survey #123: N/A
Survey #121: n/A
Survey #90: i think ensuring that communication is sent out would be key, we often have to request information from consultants after they are seen
Survey #89: Patients expect that I have been in receipt of their walk in clinic notes either because they think our computers are connected or because the walk in clinic asked who their regular (family) doctor is and they told them and often asked them to send me the note. However, the walk in clinic doesn't send me anything until the patient tells me they went to the walk in clinic and I have the patient sign a release of information and fax that and a request for the note to the walk in clinic. This is a terrible fracture in care that needs addressed. Patients want me to know their information and they expect that I have it and they are routinely surprised when I tell them otherwise. If you can do ANYTHING to help this, I will kiss your feet! Thank you!
Survey #61: Universal EMR

Survey #38: Can only be effective if a central,accessible and Updated register of actively receiving consultants is available. Does not exist in Manitoba
Survey #8: Could there be a section to address when a patient requests a consultation that is deemed unnecessary?
Survey #7: I think a centralized intake for specialties would be so helpful. It would reduce the bounce back referrals (rejections), ensure that referral go to the correct person, and decrease time waiting for consultation
Survey #5: GOOD AS IT STANDS
Survey #2: Very reasonable standard so long as physicians comply
Consulting physician
Survey #165:I think there should be stronger emphasis on the responsibility of the transferring physician to arrange the transfer for a patient who needs to be sent to a facility with more capabilities.
Survey #156:I think the standards need to acknowledge the role that hospital staffing/resources play in patient care and that physicians have no ability to meaningfully improve patient care without the help of administration
Survey #142: Tapped in and Tapped out
Survey #111: The answer is clear: the medical system is under-staffed in every category of worker; the administrative burden and "red tape" consumes far too much time.
Survey #110: Team involvement
Survey #100: Unreasonable expectations on consulting physicians. There are also no directions for referring physicians to do some due diligence, basic exam/workup, apply basic medical knowledge, prior to sending a consult.
Survey #85: Eliminate fixed deadline for responding, eliminate having to provide an appointment estimate to the referring provider.
Survey #82: Response within 2weeks seems unreasonable for non urgent consults.
Survey #66: urgent consultations. emergent and intrafacility transfer is mostly discussed. There would be a benefit to exploring expectations for patients who need to be seen within days to 1-2 weeks. frequently I receive referrals for ectopic pregnancies or miscarriages that are sent to the office and end up in the queue of nonurgent consultations. Suggest in these cases the referring provider is expected to contact the consultant directly
Referring/consulting
Survey #192: Responding in 14 days. I will review my practice to improve and stick to standards more.
Survey #186: See my comments.
Survey #184: INVOLVED EMR PROVIDERS TO FIND A WAY TO AUTOMATE AND LESSEN EXTRA ADMINISTRATIVE BURDEN TO PROVIDERS AND STAFFS
Survey #180: work load
Survey #170: We need specific standards for kids. Currently kids are falling through the cracks. When they turn 18, they literally fall off a cliff. There's no handoff to an adult specialist. Families are really struggling and patients are deteriorating.
Survey #169: I appreciate that the standards outline inappropriate behaviour on the part of consultant physicians, as I know that some consultants are unprofessional/verbally abusive to the referring physicians. I would like to see the standard go farther in addressing this, including emphasizing the barrier to care that this creates. I would also like to see a formal (ideally anonymous) system for unprofessional/abusive consultants to be reported to the College, including a formal remediation process.

Survey #167: none
Survey #161: Effective communications and having a common portal where investigations and other documents can be seen - as obtaining appropriate work up and investigations performed sometimes takes a fair proportion of time before a patient consultation can be accepted or not.
Survey #154: No standard makes sense if it doesn't have the resources to be applied to.
Survey #151: NA
Survey #148: Waiting times must be improve
Survey #126: More primary care physicians. The current standards increase the burden on specialists who see patients who do not have a primary care physician to take over long term follow up
Survey #119: More access to a centralized resource such as the clinical EPR. If this were available to all MDs they can log in and check status. There are too many EMRs that are not accessible. We need to get into the 2010s and stop using clay tablets
Survey #118: Have expectations based on Physician strength. Making rules in a province, which is heavily deficient in GPs and specialists makes these goals intangible across preferentially impacted specialties
Survey #115: I would clarify how, if a consultant makes a new referral, the family physician, or initial referral registrant can be kept as part of the communication (i.e. avoid that the second consultant's response never gets back to the original referral registrant, FP referrs to general surgeon who refers to plastic surgeon who only responds to general surgeon leaving the FP out)
Survey #113: the time frame; clarity for what is included; and that larger centres need to accept patients from locations that do not have the staffing to ensure immediate medical safety
Survey #99: We cannot be patient centred if we have a process and system that do not work. Simply creating this standard without implementing real changes in workflow only increases burden on physicians. This is a fallacy of patient centered care. Of course we want what is best for patients but just using this terminology does nothing. Please read the book "Patients Come Second" .
Survey #86: The communication standard time limits should apply to diagnostic imaging requests as these are consideed consultations
Survey #76: quality of information given to us often erratic need to use more email virtual systems
Survey #68: Communication to patients of consultations
Survey #65: Delays in auxiliary staff in transfers. I have often accepted a patient for care from the other doctor at another site. In theory they should arrive from the other city hospital within minutes but it can take hours! It is shocking with stretcher services and other delays.
Survey #50: see my response to 13 and 14 the expectations are too vague
Survey #43: THE ERS ARE SO FULL AND STRESSED THE RELATIONASHIP BETWEEN OFICE BASED PACTICE AND ER PRACTICE IS FRACTURED AND STRESSED
Survey #32: The format presented with the new policy, if followed by physicians should improve the outcome thus affect the quality of patient care
Survey #20: With point #4 on Core responsibilities, does this cover discharging patients who are no longer showing up for treatment or not benefiting from your treatment? I'm thinking of patients who after many conversations, are not following treatment advice.
Survey #9: It should be specified what types of communication are covered by this standard of practice.

Q14(Q17): If executed correctly, do you think these guidelines will enhance care for patients by improving communication and collaboration between physicians involved in their care?

COMMENTS
Referring physician
Survey #193: Yes
Survey #190: Yes
Survey #185: absolutely!
Survey #182: yes, definitely
Survey #175: Probably not
Survey #174: Yes
Survey #158: If executed and *REVIEWED;* without external review and pressure, nothing will change. This may mean assistance provided by the College to help with streamlining processes, improved understanding of digital systems to automate parts of the communication, and ongoing advocacy for the profession to not be the "catch all" for every issue, including sick notes, private insurance requests, education forms....
Survey #157: Yes.
Survey #155: Y
Survey #136: Yes
Survey #130: Yes
Survey #123: Yes
Survey #121: Yes
Survey #90: I think it at least sets a benchmark -I think care is already pretty good, but this way there is a clear expectation
Survey #89: absolutely
Survey #61: yes, but only if uniform adoption
Survey #46: Yes
Survey #40: Yes
Survey #38: We are doing it mostly already
Survey #11: Yes
Survey #8: Yes
Survey #7: Communication and collaboration is key. However, none of our systems talk to one another. Our EPR is different from clinics EPR, from cancer care EPR etc. Half the time Winnipeg specialists can't see images from Brandon on their system. Makes for difficult transfer of care when communication in those ways faces its own barriers
Survey #5: YES
Survey #2: Only if executed correctly
Consulting physician
Survey #165: No, I think these guidelines are very unlikely to improve patient care. Most of the time when we introduced new things trying to make improvements. We actually make things worse. In this province. It's really quite amazing. I would give Vectors as an example. The goal of the system was to provide a single number so that physician is needing to call somebody could contact a person. In my experience instead of being able to call the person who I already know I need to call directly and now I have to call the second number and then occasionally wait up to eight hours ██ ████████████████████████████████████, before receiving a callback. So now

instead of waiting for one position to call me back, I need a second position to decide if I deserve the call back. It's really remarkable how bad the system is.
Survey #156: Yes
Survey #142: Yes
Survey #111: If these guidelines don't enhance care nothing will
Survey #110: Yes
Survey #100: I am not convinced these standards will change anything for the better.
Survey #85: No
Survey #82: Yes
Survey #78: unsure. It's not about agreeing with the standard - it's about the sheer number of referrals and patients already being seen on any given day.
Survey #66: yes
Referring/consulting
Survey #192: yes
Survey #186: Yes.
Survey #184: YES
Survey #181: only if applied equally to all
Survey #180: Yes, to a degree.
Survey #170: Somewhat
Survey #169: I hope so!
Survey #167: it is common sense and respectful
Survey #161: Yes.
Survey #154: If the resources are truly there.
Survey #151: Yes
Survey #148: yes
Survey #140: They may increase admin burden f draft timelines are imposed.
Survey #133: perhaps
Survey #127: Yes
Survey #119: No
Survey #118: In a specialty, which is even otherwise experiencing physician shortage, imposing these is going to worsen physician burnout
Survey #115: yes
Survey #113: overall yes
Survey #99: this is a leading question
Survey #98: Yes
Survey #94: If there were functional EMRs in hospitals yes, but this will be impossible with our current system. Outpatient clinics should be able to adhere to the standard however.
Survey #87: Too much extra paperwork for physicians to review . Consult recieved, consult booked. I only want consultant letter
Survey #86: It should help eliminate the outlying consultants who take a long time for responding to consultation requests
Survey #76: yes
Survey #68: maybe
Survey #65: I'm not sure how to fix the delays in transfer for the other reason listed above.
Survey #64: Yes! However I think it would be great if other major players could co-release statements at the same time as the CPSM, acknowledging that they know about the changes, and

whether or not they plan to comply. Eg. The department heads of individual diagnostic imaging departments should release a statement that they've reviewed the CPSM SOP, identified areas where they are part of the "system issues", and how they will endeavor to make improvements to comply with the SOP, as their employees are effectively entering a Collaborative Care arrangement by virtue of receiving and triaging the requests. Eg. VECTRS should release a statement that it's aware of the SOP, and has had a conversation w/ CPSM about how they may be facilitating (or impeding) complying with the standard.
Survey #50: no because they will not be followed or enforced
Survey #43: YES
Survey #34: Yes. It is clear that the CPSM has consulted broadly, as very specific scenarios are captured. As a ▮▮▮ physician, I appreciate the language around consultants who are "tapped in", even if they are not the final MRP - especially when it comes to lack of beds, and need to coordinate transfer to another facility.
Survey #32: If he's guidelines are followed, patient care will improve, because communication and collaboration is essential for any aspect of Being a physician
Survey #26: Personally - I don't have any more time in the day and I am already behind. Anything that adds to my workload is something that I won't be able to do
Survey #20: Yes. It's a problem when you send a referral and you have no idea if the program received it or not.
Survey #18: Yes
Survey #17: definitely
Survey #15: Yes
Survey #12: Yes
Survey #10: Yes
Survey #9: yes, the current acknowledgement of referrals by specialists I have consulted is only around 60% acknowledged in my practice currently. I personally acknowledge 100% that I receive now within 72 hours.

Q15(Q18): Do the FAQs in the Contextual Document help you understand and apply the standard in practice?

COMMENTS
Referring physician
Survey #193: Yes
Survey #190: Yes
Survey #185: I think so
Survey #182: yes
Survey #175: For some parts
Survey #158: Yes
Survey #157: Yes
Survey #155: Y
Survey #136: Yes
Survey #130: Yes
Survey #123: Yes
Survey #121: Yes
Survey #90: yes

Survey #89: yes, very much
Survey #46: Yes
Survey #40: Yes
Survey #38: Yes
Survey #8: Yes, though discussion of non-urgent, episodic care settings that make referrals could be included as they do not as closely follow the Standard for closed-loop communication.
Survey #7: I'm not sure
Survey #5: YES
Survey#2: Yes
Consulting physician
Survey #165: No
Survey #156: yes
Survey #142: Yes
Survey #111: perfectly
Survey #100: No
Survey #82: Yes
Survey #78: Sure
Survey #66: yes
Referring/consulting
Survey #192: yes indeed
Survey #184: YES
Survey #180: Yes
Survey #170: Yes
Survey #167: yes
Survey #154: Mostly.
Survey #151: Yes
Survey #148: Yes
Survey #140: ?
Survey #133: somewhat
Survey #127: Yes
Survey #119: Could you list them with this question or provide a link?
Survey #115: Yes
Survey #99: no
Survey #86: y
Survey #76: yes
Survey #65: I feel that Ob Gyn practice volume is at an all time high and the number of consults received is out of proportion to the reasonable time limit response expectations. Yes we are specialists, but we are also primary care providers in women's health as well so the degree of communication received from doctors in the community is higher than other practitioners. I read all consults within 2 weeks but don't have the office manpower to implement a fast response system. We are happy to accept help from CPSM or the province in automating the reply system in a user friendly way. Telus health doesn't allow this but says they are working on it.
Survey #64: Yes.
Survey #50: Yes
Survey #43: YES

Survey #34: Yes. I would support additional common examples being included, so that there is less room for disagreement and false interpretation.
Survey #32: For the most part yes however all of these small changes will take time to transform The collaboration and communication tool
Survey #15: Yes
Survey #12: yes
Survey #10: Yes
Survey #9: no

Q16(Q19): What, if anything, should be added to the Contextual Information documents to help you better understand and apply the standard in your practice?

COMMENTS
Referring physician
Survey #193: None
Survey #190: None
Survey #175: An example back and forth of process
Survey #158: The contextual information should be rolled into the standard to have one source of information and context, OR the standard should highlight areas that have additional context to review
Survey #157: No comment
Survey #136: No
Survey #123: N/A
Survey #121: N/A
Survey #89: the template referred to for consultants to use to respond should be linked in
Survey #8: Discussion of episodic non-urgent care presentations that deserve consultation - should they be done by the episodic care provider (eg walk-in clinic, minor injury clinic, extended hours primary care clinics physicians and NPs)? What is the patient does not have a PCP or their PCP is not available eg on sick leave?
Survey #5: I THINK IT IS COMPLETE
Survey #2: I believe the information documents are helpful in my standard of practice
Consulting physician
Survey #165: I think you could possibly outline in more detail how a transfer might be arranged. Key steps.
Survey #156: nil
Survey #111: All good
Survey #100: Practical advice when attempting to juggle many conflicting responsibilities
Referring/consulting
Survey #192: not sure there is more
Survey #184: WEBINAR MAYBE
Survey #180: Nothing much
Survey #170: Prediatric specific standards for collaborative care with complex kids
Survey #167: Nothing
Survey #154: Unsure.
Survey #151: NA

Survey #148: none
Survey #119: Provide a link with this question so I know what you are asking
Survey #115: They are clear
Survey #76: nothing
Survey #64: More examples! From simple (perhaps obvious) scenarios, to more ambiguous and debatable scenarios.
Survey #43: THE INABILTY OF ER DOCS /SATFF TO UNDERSTAND THAT WHEN WE SEND PATIENT TO THE ER WE ARE SUFFICENTLY WORRIED THAT WE WOULD LIKE THEM SEEN, WE DO NOT SEND PATIENTS WHO ARE NOT SEVERLY UNWELL OR IN DANGER OF LIFE AND LIMB
Survey #18: I recall the previous version required that consulting physicians include a copy of the letter to the PCP. I think that is very important. Also, while it may be clear, occasionally I do not get a copy of the letter when I send a referral, and it only goes to the PCP which is wrong. I think it should be clear that at least the 1st consultation letter go to both, and thereafter, there can be judgement whether the referring specialist still needs to be copied. For example, if as a specialist, I refer to another specialist for an incidental finding of diabetis on invesitations I order, I don't need to get copied on all the Endocrine visits beyond the first encounter. However, the PCP should be copied on all the Endocrine letters thereafter...Please comment on the consultants obligations for when a referred patient does not show up for the initial consultation or for follow up appointments. I will let the referring MD know if I was unable to see the patient for the initial consultation. However, I have not made it a practice to let the PCP know when the patient has been dropped from follow up due to non-attendance at follow up appointments.
Survey #9: When followup is needed within 2 weeks the referring provider is advised to contact the health care provider directly to facilitate followup. Is fax acceptable? Or is a phone call or TigerConnect what is meant by this? Please Clarify.

PUBLIC MEMBER SURVEY RESULTS

Q2: The goal of the standard is: **Every action and decision must be based on ensuring the patient receives good medical care.** On a scale from 1-5, how strongly do you agree (with 5 being strongly agree) or disagree (1 being strongly disagree) with the statement?
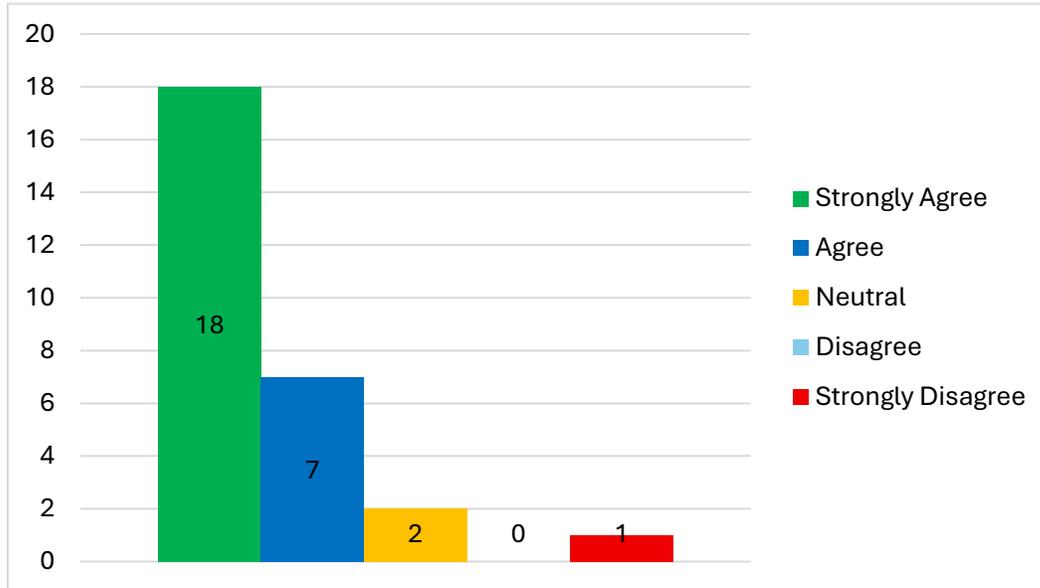
Survey #14: Strongly agree	Survey #29: Strongly agree	Survey #30: Strongly agree
Survey #31: Strongly agree	Survey #33: Strongly agree	Survey #35: Strongly agree
Survey #36: Strongly agree	Survey #37: Strongly agree	Survey #44: Strongly agree
Survey #48: Strongly agree	Survey #52: Neutral	Survey #60: Strongly agree
Survey #62: Strongly agree	Survey #67: Agree	Survey #69: Agree
Survey #81: Agree	Survey #95: Agree	Survey #97: Strongly disagree
Survey #102: Strongly agree	Survey #105: Strongly agree	Survey #132: Agree
Survey #160: Agree	Survey #173: Strongly agree	Survey #177: Agree
Survey #178: Strongly agree	Survey #188: Neutral	Survey #189: Strongly agree
Survey #191: Strongly agree		

Q3: How important is it to you that your doctors (family doctor, specialists, or emergency and urgent care doctors, and other healthcare providers) work together and share information about your care?
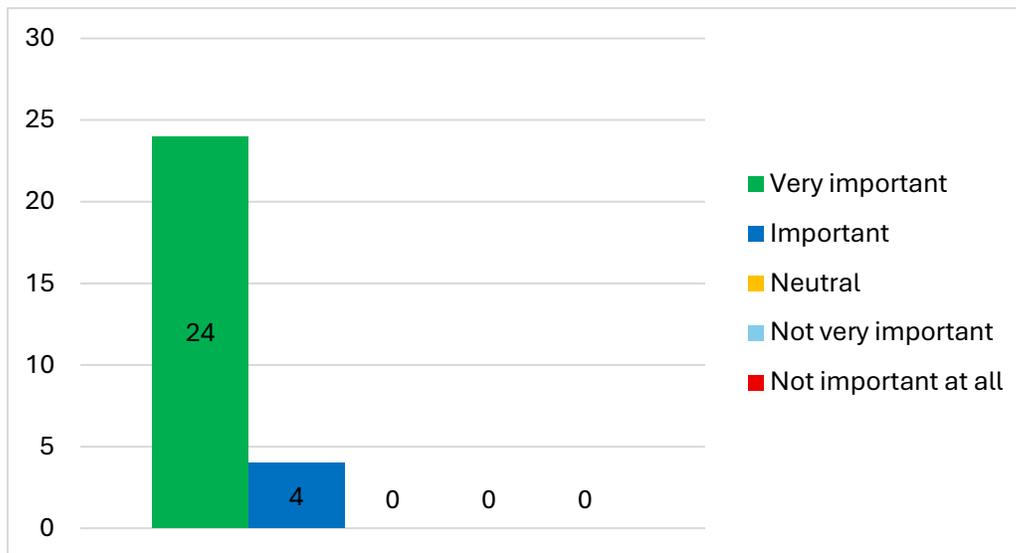
Survey #14: Very important	Survey #29: Very important	Survey #30: Very important
Survey #31: Very important	Survey #33: Very important	Survey #35: Very important
Survey #36: Very important	Survey #37: Very important	Survey #44: Very important
Survey #48: Very important	Survey #52: Very important	Survey #60: Very important
Survey #62: Important	Survey #67: Very important	Survey #69: Important
Survey #81: Very important	Survey #95: Important	Survey #97: Very important
Survey #102: Very important	Survey #105: Very important	Survey #132: Very important
Survey #160: Very important	Survey #173: Very important	Survey #177: Important
Survey #178: Very important	Survey #188: Very important	Survey #189: Very important
Survey #191: Very important		

COMMENTS
Survey #178: This is especially important when providing care to people with intellectual disabilities and autism.
Survey #95: Depends on the information. Lab, imaging results, medication history, vaccine history, yes. Biased opinions about me, no.
Survey #69: I think there needs to be strengthened protections for the patient and their information. Including control and governance over who has access to it, what it could be used for, and clear rules on the informations interpretation. To avoid bias, medical colonialism, safe and anti-oppressive care, to name a few reasons. Power should be restored to the person and their identified safe people.
Survey #67: team based care needs to be made easier
Survey #60: The medical system is riddled with red tape, ongoing errors and other mistakes, broken methods, poorly trained staff, often without knowledge of medical history and symptoms, too specialized to be competent, to general to be competent, unwillingness to follow their own codes and standards, unwillingness to follow local laws and regulations, incapable of managing proper spending, too reliant on technology to be called doctors, incapable to properly working with other departments or specialists, incapable of understanding medical and natural science,

incapable of owning their own mistakes as expected from a profession, incapable of transparency, incapable of medical judgement, incapable of recognizing the limits of their competence, incapable of recognizing that medical opinion when based on errors is not an opinion, incapable of consulting, incapable of duty to report, incapable of reporting and investigating critical incidents, incapable of providing patient records, incapable of documenting patient records, incapable of interpreting patient histories and records, incapable of updating patient charts, and this list can go on for pages upon pages.

Survey #37: This is very important however, the roles are unclear. A specialist or hospital doctordoes not know what the scope of a family doctor can actually do. Familydoctors cannot actuallydo things tat specialists expect. Information is made unclear. Medical plans are not followed through on because Noone wants the responsibility of care.

Survey #36: My care team relay on the patient to be the communication "middle man"

Survey #31: I find there is a huge disconnect between doctors. Very little ability to work together. Often the Er doctor or hospital doctor refers you to your family doctor to take care of something connected to the medical issue or encourages follow up from the family doctor but the family doctor it turns out is unable to do the follow up item. It's not in their scope of practice. The family doctor often does not get complete reports from hospital doctors after a stay. There seems to be many misunderstandings or disconnects as to what each doctor can or cannot do in the medical system. It is a huge challenge for those living with chronic conditions.

Survey #29: Currently navigating care from GP, Cardiologist, Specialist Cardiac Surgeon and Interventional Radiologist and there seems to be very little of any interaction between them! Very frustrating.

Q4: The standard states that the specialist must let you know within 14 days that they got your referral. Do you think 14 days is a reasonable amount of time for you and your doctor to get confirmation that the specialist received your request?

| 14 days is reasonable (green) |
| Less than 14 days is reasonable (dark blue) |
| More than 14 days, but less than 28 days, is reasonable (yellow) |
| Other (light blue) |
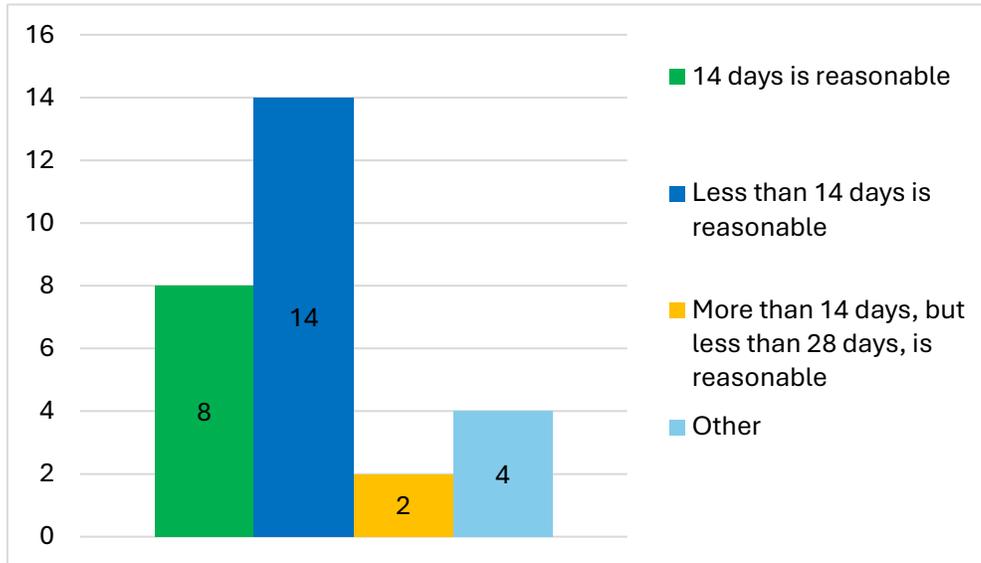
Survey #14	Survey #29	Survey #30
Survey #31	Survey #33	Survey #35
Survey #36	Survey #37	Survey #44
Survey #48	Survey #52	Survey #60
Survey #62	Survey #67	Survey #69
Survey #81	Survey #95	Survey #97
Survey #102	Survey #105	Survey #132
Survey #160	Survey #173	Survey #177
Survey #178	Survey #188	Survey #189
Survey #191		

COMMENTS
Survey #188: Depends on the situation. In some cases a referral is needed quickly as a positive outcome may be dependent on early diagnosis.
Survey #178: For those with intellectual disabilities and cannot communicate verbally or otherwise having the help of a specialist involved quickly could make the difference between good care and bad care. Even if someone with IDD can speak there may be difficulty in describing what is happening.
Survey #95: I have never gotten a confirmation this early, sometimes I never do. So yes 14 days is very reasonable.
Survey #81: Making it an absolute rule is not reasonable, what if they are away?
Survey #69: It depends on various factors that are patient specific and the response time needs to be contextualized based on the realities of the patient. This would likely influence what the patient feels is a reasonable time and should not be a one-size fits all approach.
Survey #67: acknowledgement of receipt of referral decreases anxiety. If we send things electronically, 7-10 days should be reasonable

Survey #62: Depending on the type &/or reason for referral .....14 days is too long in high risk situation!
Survey #60: Depends on the circumstance. If the patient is critical, in the emergency, or there has been a critical occurrence it be sooner!
Survey #37: -14 days is not really happening currently. Maybe a month and sometimes never. The specialist just does not respond at all after a referral
Survey #36: Because every day impacts the patient, if you're referrals is denied I'd want to start looking at other options. You'd also be concerned they didn't receive it or it was lost in piles and piles of referrals.
Survey #31: They do not let you know in 14 days.
Survey #30: When you are only focused on your health and the next steps, 14 days is too long
Survey #29: I've been waiting since the end of October for a referral (separate issue than stated above) and have received no communication from either the referring or referred physician. Time totally depends on the nature of the referral. Oncology? Cardiac? Very different than say Dermatology.
Survey #14: It should be 3 days

Q5: Do you feel that collaborative care (two or more doctors or healthcare providers working together) leads to better health outcomes for patients?
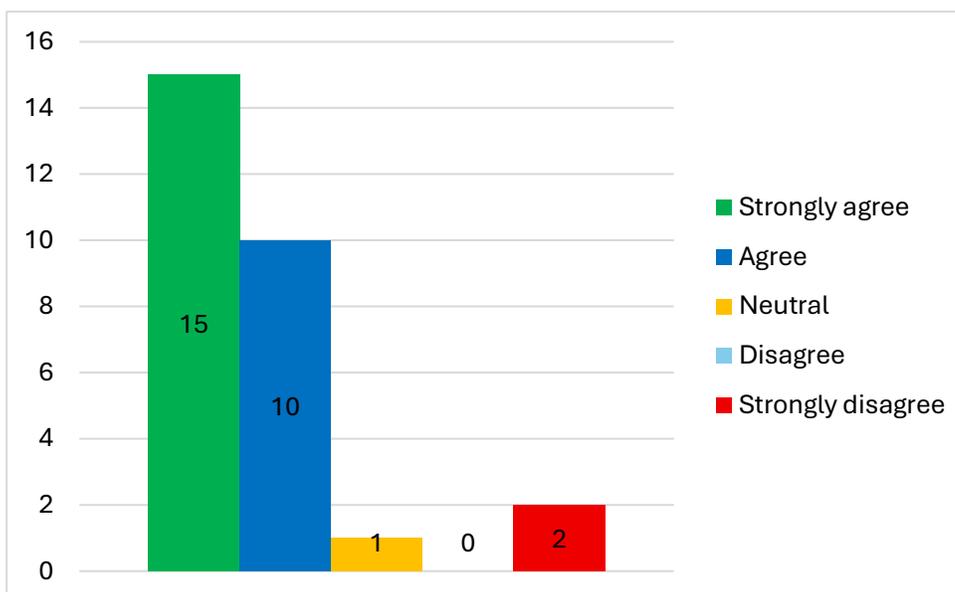
Survey #14: Strongly disagree	**Survey #29:** Strongly agree	**Survey #30:** Agree
Survey #31: Strongly agree	**Survey #33:** Agree	**Survey #35:** Strongly agree
Survey #36: Strongly agree	**Survey #37:** Strongly agree	**Survey #44:** Neutral
Survey #48: Strongly agree	**Survey #52:** Strongly agree	**Survey #60:** Strongly disagree
Survey #62: Agree	**Survey #67:** Strongly agree	**Survey #69:** Agree
Survey #81: Agree	**Survey #95:** Agree	**Survey #97:** Agree
Survey #102: Strongly agree	**Survey #105:** Strongly agree	**Survey #132:** Agree
Survey #160: Agree	**Survey #173:** Strongly agree	**Survey #177:** Agree
Survey #178: Strongly agree	**Survey #188:** Strongly agree	**Survey #189:** Strongly agree
Survey #191 : Strongly agree		

COMMENTS
Survey #188: I have experienced collaboration with multiple specialists and it made a big difference in getting me the treatment needed quickly.
Survey #178: This has been noted as the best method to care for persons with Intellectual disabilities and autism.
Survey #95: For patients who can't advocate for themselves and keep track. Elderly, and patients with complex health needs.
Survey #81: This sounds like a scheme engineered by Doctors MB so that doctors can charge more for referrals and consults. Doctor's should have enough training to make the determination/diagnosis themselves.
Survey #69: Actions must be in alignment with the notion that the most benefit must come from this approach. It should always be a choice and consented to by patients. If it adds burden, such as room for disconnect and understanding, and delays in plans and services, then no. Unless patients and identified safe individuals are a part of that collaborative care, then no. However, if dialogue and efforts to facilitate mutual understanding regarding roles, responsibilities, permissions, and ongoing communication pathways have taken place and the patient consents to collaborative care, then yes.
Survey #67: I don't always need to waste my docs time and other team members may be more suitable and be able to provide more time/more effective care
Survey #60: When the medical system is riddled with red tape, ongoing errors and other mistakes, broken methods, poorly trained staff, often without knowledge of medical history and symptoms, too specialized to be competent, to general to be competent, unwillingness to follow their own codes and standards, unwillingness to follow local laws and regulations, incapable of managing proper spending, too reliant on technology to be called doctors, incapable to properly working with other departments or specialists, incapable of understanding medical and natural science, incapable of owning their own mistakes as expected from a profession, incapable of transparency, incapable of medical judgement, incapable of recognizing the limits of their competence, incapable of recognizing that medical opinion when based on errors is not an opinion, incapable of consulting, incapable of duty to report, incapable of reporting and investigating critical incidents, incapable of providing patient records, incapable of documenting patient records, incapable of interpreting patient histories and records, incapable of updating patient charts, incapable of understanding conflicts of interest, and this list can go on for pages upon pages, as they continue to demonstrate in gross deficiency the answer is hell no!
Survey #44: If it was done in an effective, thorough, and well-connected way, yes, as it is done now, I question whether my health outcomes are improving with so many separate individual physicians participating. Luckily pharmacists are doing a great job otherwise I'd have some dangerous medication interactions thanks to this situation.
Survey #37: But this collaboration is not happening with complex cases. Notes to family doctors are unclear... GI refuses to connect with other specialists especially if there are multiple different system concerns.
Survey #36: If collaboration was used the connection it would take a lot of pressure off the patient in remembering everything. Having an actual point of care to look at the full case not just one single part would make a world of difference.
Survey #31: I feel collaborative care should be a focus for professional development and should be encouraged as it is important... but is not happening in Manitoba.

Survey #30: As long as their communication is seamless. Otherwise, too many hands in the pot aren't good unless they are working together	
Survey #29: Absolutely! How can it not!	

Q6: What are the main reasons you would support a standard that requires doctors providers to communicate and collaborate about your care? (Select all that apply)

Survey #14:	Survey #29:	Survey #30:
☑save time and reduce delays ☑encourages doctors involved in my care to be "on the same page"	☑avoid mistakes or missed information ☑makes me feel more confident in my care	☑avoid mistakes or missed information ☑save time and reduce delays ☑ makes me feel more confident in my care ☑encourages doctors involved in my care to be "on the same page"
Survey #31: ☑Other (please specify) Comment below	**Survey #33:** ☑avoid mistakes or missed information ☑save time and reduce delays ☑encourages doctors involved in my care to be "on the same page"	**Survey #35:** ☑avoid mistakes or missed information ☑save time and reduce delays ☑ makes me feel more confident in my care
Survey #36: ☑avoid mistakes or missed information ☑ makes me feel more confident in my care	**Survey #37:** ☑Other (please specify) Comment below	**Survey #44:** ☑avoid mistakes or missed information ☑save time and reduce delays ☑ makes me feel more confident in my care ☑encourages doctors involved in my care to be "on the same page" ☑Other (please specify) Comment below
Survey #48:☑ makes me feel more confident in my care	**Survey #52:** ☑Other (please specify)	**Survey #60:** ☑Other (please specify)

	Comment below	Comment below
Survey #62: ☑save time and reduce delays	**Survey #67:** ☑avoid mistakes or missed information ☑save time and reduce delays ☑encourages doctors involved in my care to be "on the same page"	**Survey #69:** ☑save time and reduce delays ☑encourages doctors involved in my care to be "on the same page" ☑Other (please specify) Comment below
Survey #81: ☑avoid mistakes or missed information	**Survey #95:** ☑avoid mistakes or missed information ☑save time and reduce delays ☑Other (please specify) Comment below	**Survey #97:** ☑avoid mistakes or missed information ☑ makes me feel more confident in my care ☑encourages doctors involved in my care to be "on the same page"
Survey #102: ☑avoid mistakes or missed information ☑save time and reduce delays ☑ makes me feel more confident in my care ☑encourages doctors involved in my care to be "on the same page"	**Survey #105:** ☑avoid mistakes or missed information ☑save time and reduce delays ☑encourages doctors involved in my care to be "on the same page"	**Survey #132:** ☑avoid mistakes or missed information ☑save time and reduce delays
Survey #160: ☑avoid mistakes or missed information ☑save time and reduce delays ☑ makes me feel more confident in my care ☑encourages doctors involved in my care to be "on the same page"	**Survey #173:** ☑avoid mistakes or missed information ☑save time and reduce delays ☑ makes me feel more confident in my care	**Survey #177:** ☑save time and reduce delays ☑encourages doctors involved in my care to be "on the same page"
Survey #178: ☑avoid mistakes or missed information ☑save time and reduce delays ☑ makes me feel more confident in my care ☑encourages doctors involved in my care to be "on the same page"	**Survey #188:** ☑avoid mistakes or missed information ☑encourages doctors involved in my care to be "on the same page	**Survey #189:** ☑avoid mistakes or missed information ☑save time and reduce delays ☑encourages doctors involved in my care to be "on the same page"
Survey #191: ☑avoid mistakes or missed information ☑save time and reduce delays ☑ makes me feel more confident in my care		

COMMENTS
Survey#95: Consolidate medications.
Survey #69: Less taxing on the labour to explain to each provider any updates and bear the burden of formulating plans with primary care leads based on information you remember during your most vulnerable time. It also allows for strengthened coordination of resources, to allow for various areas to support the patient to be addressed in a cohesive way.
Survey #60: When the medical system is riddled with red tape, ongoing errors and other mistakes, broken methods, poorly trained staff, often without knowledge of medical history and

symptoms, too specialized to be competent, to general to be competent, unwillingness to follow their own codes and standards, unwillingness to follow local laws and regulations, incapable of managing proper spending, too reliant on technology to be called doctors, incapable to properly working with other departments or specialists, incapable of understanding medical and natural science, incapable of owning their own mistakes as expected from a profession, incapable of transparency, incapable of medical judgement, incapable of recognizing the limits of their competence, incapable of recognizing that medical opinion when based on errors is not an opinion, incapable of consulting, incapable of duty to report, incapable of reporting and investigating critical incidents, incapable of providing patient records, incapable of documenting patient records, incapable of interpreting patient histories and records, incapable of updating patient charts, incapable of understanding conflicts of interest, and this list can go on for pages upon pages, as they continue to demonstrate in gross deficiency the answer is hell no!
Survey #52: If you mean Physicians then I think it's important because health care is multi disciplinary and a single physician can't provide complex care anymore. That ship sailed a long time ago and it's time for the physicians to realize this and catch up
Survey #44: I wouldn't have to relay information myself, which kind of speaks to the first choice in this question but also would reduce burden on patients and caregivers
Survey #37: Recognizing that these different health issues could be part of a bigger problem or diagnosis.
Survey #31: Body systems can be interconnected. It's important as it ensures nothing is missed and would be beneficial for chronic conditions.

Q7: Do you have any concerns about doctors who treat you sharing information with each other and working together as part of your care?
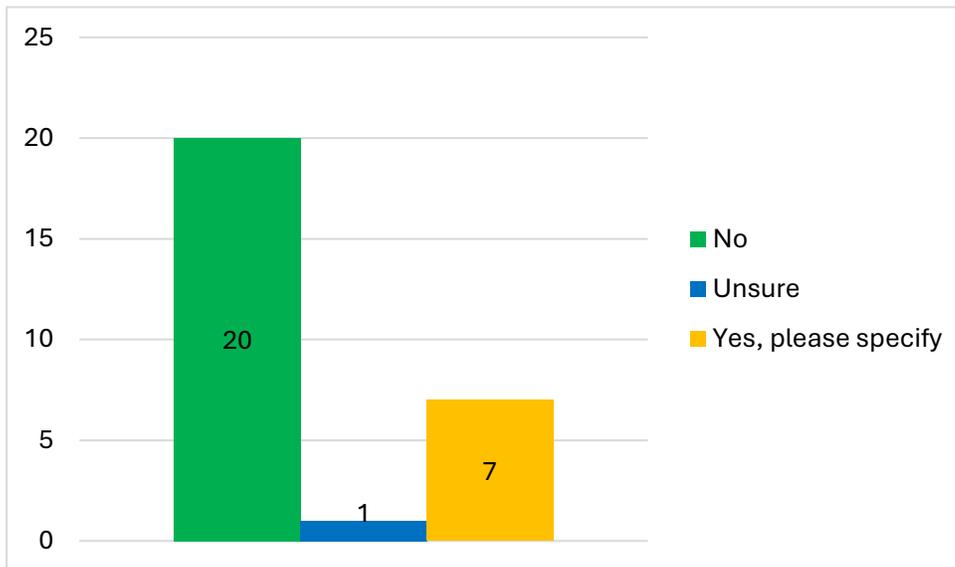
Survey #14: No	**Survey #29:** No	**Survey #30:** No
Survey #31: Yes, please specify	**Survey #33:** No	**Survey #35:** No
Survey #36: Yes, please specify	**Survey #37:** Yes, please specify	**Survey #44:** Yes, please specify
Survey #48: No	**Survey #52:** No	**Survey #60:** Yes, please specify
Survey #62: No	**Survey #67:** No	**Survey #69:** Yes, please specify
Survey #81: No	**Survey #95:** Yes, please specify	**Survey #97:** Unsure
Survey #102: No	**Survey #105:** No	**Survey #132:** No

Survey #160: No	**Survey #173:** No	**Survey #177:** No
Survey #178: No	**Survey #188:** No	**Survey #189:** No
Survey #191: No		

COMMENTS
Survey #95: I have experienced judgment and biases occasionally. If this is to happen it should be stating facts and diagnosis.
Survey #69: Ongoing consensual processes needs to occur, clear protections to patients, clear identification of communication pathways and paths to addressing concerns, including confidential and culturally safe avenues, clear accountability mechanisms and disciplinary action to those in positions of power and are responsible, and having all this backed in detailed policy.
Survey #60: When the medical system is riddled with red tape, ongoing errors and other mistakes, broken methods, poorly trained staff, often without knowledge of medical history and symptoms, too specialized to be competent, to general to be competent, unwillingness to follow their own codes and standards, unwillingness to follow local laws and regulations, incapable of managing proper spending, too reliant on technology to be called doctors, incapable to properly working with other departments or specialists, incapable of understanding medical and natural science, incapable of owning their own mistakes as expected from a profession, incapable of transparency, incapable of medical judgement, incapable of recognizing the limits of their competence, incapable of recognizing that medical opinion when based on errors is not an opinion, incapable of consulting, incapable of duty to report, incapable of reporting and investigating critical incidents, incapable of providing patient records, incapable of documenting patient records, incapable of interpreting patient histories and records, incapable of updating patient charts, incapable of understanding conflicts of interest, and this list can go on for pages upon pages, as they continue to demonstrate in gross deficiency the answer is hell no!
Survey #44: We need widespread support (resources, funding, and infrastructure) to support this, and it needs to be done in an effective and modern way. I.e. top-of-the-line systems and cybersecurity supports, and it needs to ALSO be accessible and useful to physicians AND patients. This is going to cost money, we need government to invest and get out of the way of healthcare providers who understand the nuances and day-to-day operations that will inform an effective, useful, and appropriate system.
Survey #37: They don't really work together especially with multisystem issues or health concerns. They refuse to explore the concern that all these health issues could be connected and be part of a diagnosis. Doctors treat individual symptoms but don't recognize patient as a whole.
Survey #36: They don't ever work together
Survey #31: Often the doctor is unavailable esoteric specialists. There is a Refusal to give a second opinion. When specialists have Difficulty getting answers as your medical condition is complex they give up and are difficult to get help from. With a complex medical condition the only answer is being constantly referred to the ER over and over again. There are littlw to no supports for people with chronic and complex medical issues especially if it affects more than 1 body system. Cardiologist doesn't connect with GI doctor or urologist....

Q8: As a patient, how has collaborative care (two of more doctors or healthcare providers working together), affected your care?

COMMENTS
Survey #199: Positive
Survey #188: Got me the treatment I needed quicker
Survey #178: For my sister with IDD more collaboration with other doctors/health care providers was more thorough.
Survey #177: Positively
Survey #173: It is important for being from the intellectual, developmental disability and Autism Sector, it is important to have doctors that have experience and education in disability. This document could use a disability lens.
Survey #160: Rarely occurs
Survey #105: Benefit
Survey #97: Often it is very difficult to get any collaborative care. If a referral is made, there are long waitlists and sometimes the referral is declined due to a long waitlist.
Survey #95: Specialist sent a report to my doctor. My doctor told me about the diagnosis. Decades later I got a copy of it and read it myself, it had a follow up recommendation written on it that my doctor never told me about nor followed up on. Patient should also be made privy to all that the doctors are sharing with each other.
Survey #81: no
Survey #69: I have not been in a situation where this has occured or offered as an option, without placing the burden on me to make that communication pathways. Instead of the providers.
Survey #67: improved my access allowed different perspectives makes me feel better cared for
Survey #62: As above. Same applied to the thoracic surgeon and radiation oncologist. We were also included in this communication, which is equally important.
Survey #60: When the medical system is riddled with red tape, ongoing errors and other mistakes, broken methods, poorly trained staff, often without knowledge of medical history and symptoms, too specialized to be competent, to general to be competent, unwillingness to follow their own codes and standards, unwillingness to follow local laws and regulations, incapable of managing proper spending, too reliant on technology to be called doctors, incapable to properly working with other departments or specialists, incapable of understanding medical and natural science, incapable of owning their own mistakes as expected from a profession, incapable of transparency, incapable of medical judgement, incapable of recognizing the limits of their competence, incapable of recognizing that medical opinion when based on errors is not an opinion, incapable of consulting, incapable of duty to report, incapable of reporting and investigating critical incidents, incapable of providing patient records, incapable of documenting patient records, incapable of interpreting patient histories and records, incapable of updating patient charts, incapable of understanding conflicts of interest, and this list can go on for pages upon pages, as they continue to demonstrate in gross deficiency the answer is hell no!
Survey #52: It's better and safer especially because non physician clinicians tend to take more time and care and I feel better taken care of
Survey #48: It worked very well for me when I needed a pacemaker and when i was diagnosed with Colon cancer.
Survey #44: It has created more burden for me in tracking my health outcomes and medications in particular, I have taken to spending hours of time collecting results and histories to create my own personal health record so I know what's going on. GPs are so rushed they don't have time to dedicate to patients to put together all the pieces and think carefully about it. Or they're taking too many patients. I don't know.

Survey #37: This has not happened in our experience. It is extremely rare. When it has happened it makes a massive difference in a positive way.
Survey #36: Hasn't because that doesn't really happen. When they had a collective meeting it was one doctor telling everyone what to do. They disagreed and now everyone does their own thing
Survey #31: When it happens (which is rare) it can be excellent... but doctors seem to work in their own bubbles. We really rarely see this collaborative care.
Survey #30: Currently, there are too many involved and not communicating properly. We also know that when one specialist only works 1 day a week (urologist in Brandon) it takes weeks to get any decisions made This delayed care, consumed valuable time in a hospital, disrupted routines, and caused such stress and additional care issues, we have a formal complaint forwarded to the province
Survey #29: I haven't experienced effective collaborative care at this point. It seems that I'm the one who is informing them of what is transpiring. It would be nice not to have to do that.
Survey #14: No effect Is much worse

Q9: Overall, how supportive are you of a standard of practice for doctors that encourages collaborative care in Manitoba?
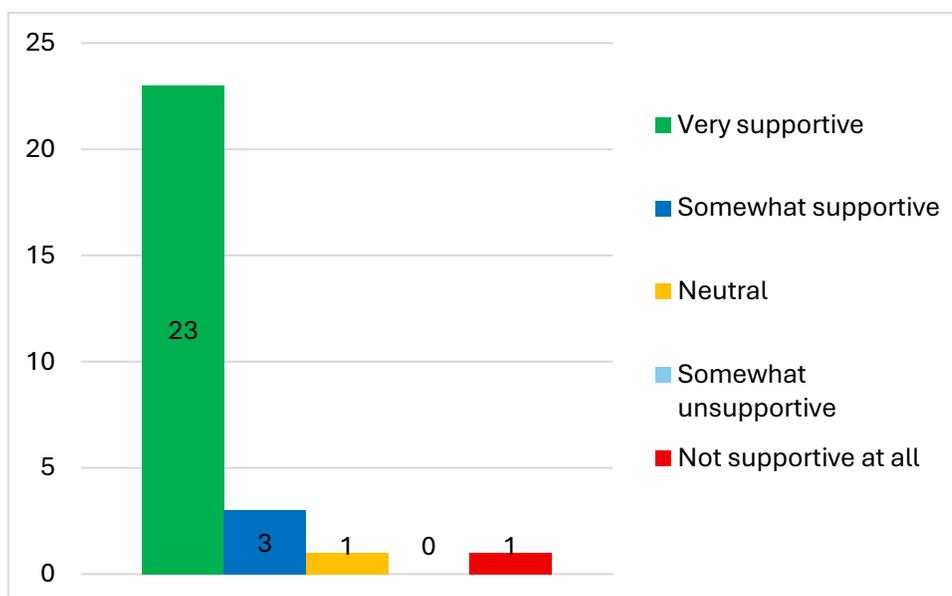
Survey #14: Very supportive	Survey #29: Very supportive	Survey #30: Very supportive
Survey #31: Very supportive	Survey #33: Very supportive	Survey #35: Very supportive
Survey #36: Very supportive	Survey #37: Very supportive	Survey #44: Very supportive
Survey #48: Very supportive	Survey #52: Very supportive	Survey #60: Not supportive at all
Survey #62: Very supportive	Survey #67: Very supportive	Survey #69: Somewhat supportive
Survey #81: Somewhat supportive	Survey #95: Neutral	Survey #97: Very supportive
Survey #102: Very supportive	Survey #105: Very supportive	Survey #132: Very supportive
Survey #160: Very supportive	Survey #173: Very supportive	Survey #177: Somewhat supportive
Survey #178: Very supportive	Survey #188: Very supportive	Survey #189: Very supportive
Survey #191: Very supportive		

Q10: Anything else you would like to share about your experience with collaborative care?

COMMENTS
Survey #178: There should be a Standard of Practise specifically designed to care for people with intellectual disability.
Survey #177: N/a
Survey #173: Would love to have a standard of care for providers that are working with persons with intellectual, developmental disability and Autism. It is important that all Manitobans have access to good health care, some of of might just need a little extra support when being examined and supported. Thank you for all the work you do to create a Manitoba where everyone has equal access to healthcare.
Survey #102: CPSM's characterization and definition of collaborative care is heavily siloed within the parameters of physician-to-physician collaboration, and physician-to-patient collaboration. While both of those interactions are indeed important to patient care, I recommend CPSM include more details re: collaborative care as a health care team, like our Collaborative Care practice direction. The document focus was on physician collaboration with other physicians and little mention of collaborative care with multiple health professionals working together to provide care. There was minimal discussion on role clarity, negotiation of care and team functioning. A huge gap missing in the document and a large part of collaboration is "shared decision-making". This was not mentioned as the document's focus was solely on physician communication, working relationships, patient referrals, and handoffs. • Specifically, the end of their definition of collaborative care "ends with the registrant's help is no longer needed" could be a great place for CPSM to further expand and clarify. While it is true that some care for a patient may extend to another health care provider (nurse, physio, specialist, etc.), it should be reiterated to physician that if they are the Most Responsible Provider, their care does not end when their help is no longer needed as they still have a duty to be informed and support the broader health care team for the provision of care for the patient, even if their expertise is no longer needed at the time. • It would be advantageous for CPSM to review the multi–College Practice Direction: Interprofessional Collaborative Care as it contains key elements that are not explicitly identified or described in CPSM's standards. This includes: o Relationship – Focused care (stress importance of the patient at the center of care - inclusion of the patient and their family/significant other) o Team communication (more than just respectful communication) o Collaborative leadership o Shared Decision Making - ensuring important decisions are made collectively when appropriate with inclusion of the patient/family (supporting team members' decision-making, integrating multiple clinical viewpoints to support safer, comprehensive, and holistic care) o Engage in reflective practice in partnership with the health care team and colleagues – this will support continuous learning and quality improvement which will ultimately strengthen health care team functioning and optimizing quality patient care.
Survey # 97: In my experience in the healthcare system, collaborative care is rare due to the lack of physicians and specialists with long waitlists. Having diagnostics ordered and completed are also difficult due to a lack of resources. Physicians hesitate to order them, and if they do the waiting time is unreasonable.
Survey #95: Please share it with the patient too, at no extra cost.
Survey #81: Cannot result in increased billing and hence costs.
Survey #69: Again, consent needs to be ascertained on an ongoing basis. And unless all issues with racism and oppressive practice is dealt with at the root and sustained, this could be perceived as another mechanism to hold power away from the patient. Furthering the distance

within the provider-patient relationship and resulting in poorer health outcomes. There is much work that needs to be committed to and sustained prior to this. Including ensuring adequate, sustainable and predictable funding to all program and service areas. Because this in itself supports prevention, preparedness, but more importantly less chance for disputes on jurisdiction and/or responsibilities.

Survey #60: When the medical system is riddled with red tape, ongoing errors and other mistakes, broken methods, poorly trained staff, often without knowledge of medical history and symptoms, too specialized to be competent, to general to be competent, unwillingness to follow their own codes and standards, unwillingness to follow local laws and regulations, incapable of managing proper spending, too reliant on technology to be called doctors, incapable to properly working with other departments or specialists, incapable of understanding medical and natural science, incapable of owning their own mistakes as expected from a profession, incapable of transparency, incapable of medical judgement, incapable of recognizing the limits of their competence, incapable of recognizing that medical opinion when based on errors is not an opinion, incapable of consulting, incapable of duty to report, incapable of reporting and investigating critical incidents, incapable of providing patient records, incapable of documenting patient records, incapable of interpreting patient histories and records, incapable of updating patient charts, incapable of understanding conflicts of interest, and this list can go on for pages upon pages, as they continue to demonstrate in gross deficiency the answer is hell no!

Survey #52: It's a non negotiable.

Survey #37: If it happens maybe we could get some quality care in Manitoba. Currently this is not happening. Living with chronic illness in Manitoba us a constant struggle. The system is failing people with chronic care and creating more medical issues, more visits to the ER and longer hospital stays.

Survey #36: It's a great thing to have, but unless in hospital you don't receive this.

Survey #31: It's really not happening. Maybe if you have a straight forward simple ailment but not when you have a complex issues. Which is truly when it should be happening

Survey #30: Please focus on the client and clients family as a whole. And increase all staff across the board. Advocate to increase the patient staff ratios for doctors, nurses and health care aides

Survey #14: I do not think the specialist ever sees the consult Someone in the office with no medical training does the filtering

Q11: Contact Information

PUBLIC CONSULTATION: Collaborative Care Feedback – Email Submissions
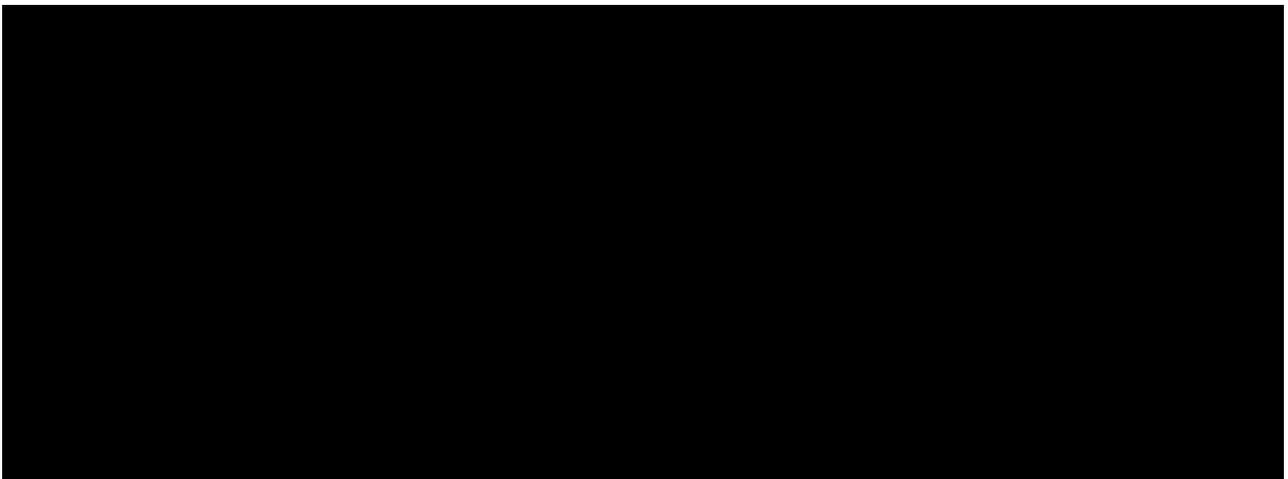
REGISTRANT FEEDBACK

Hello

Thank you for the opportunity to review the CPSM draft Standard of Practice regarding consultations / collaborative care. Notably, there is no reference to scenarios when a non-urgent consultation request is made via episodic care (as opposed to being made from a longitudinal care setting).

Non-urgent consultation requests from EHPCCs (Extended Hours Primary Care Clinics) ███ ███████████ present some challenges. In some ways we might prefer that they not take place at all, because of the lack of continuity of care, however realistically they may happen. And given that primary care is the mechanism for accessing consultations, this should probably be considered an agreed-upon component given the place that episodic care now occupies in overall provision of health care services.

I have provided some feedback via the survey in this regard, including that the PCP should be cc'ed or forwarded the original referral letter, and a reference made to the fact that the referral is not originating with the PCP but with an episodic provider, which I have noticed does not routinely happen.

If there is any need for additional discussion I would be willing to participate.

Regards,

████████

I am very pleased with the work you, CPSM, have done on the Collaborative Care Standard. I have filled out your survey. I have a couple more comments.

I very much agree about the consultant not asking the referring physician to do something beyond their ability and that the consultant should not comment negatively to the referring physician about this. I had this happen to me. I didn't realize that I would have had the backing of CPSM to respond to that surgeon. I waited and called another surgeon the next day (got different on call surgeon). This was about an auricular hematoma and I suspect, but don't know, as the patient doesn't come in much, that it didn't get treated in time to prevent cauliflower ear. However, the patient didn't initially present very timely either. Never-the-less, I was not comfortable trying to excise any hematoma there.

I also appreciate that you have stated that I can refuse to do a referral that will not clinically benefit a patient. I recently had to do this. I did not realize I would have had the support of CPSM to back me up.

Also, just this week, a consultant responded to my request with a letter telling me which tests to order. Tests that I do not know how to order or how to interpret. I was taught that I should not be ordering tests that I do not know how to interpret. I have reached out to that consultant by econsult for help with this. But I was really expecting the consultant to do that as that is why I was sending the patient to them. So, thank you for addressing this in the standard.

Also, just yesterday, I received an ER report on a patient that included the CT report and only in that did I see an incidental finding that the radiologist recommended follow up of. Thank you for addressing that incidental findings need to be communicated back to the referring physician so they can be followed up.

Best of luck getting all the physicians to adjust their ways. But you are doing a great job! Thank you!

Thanks for the reminder to have a good look at these documents.
(Just as proof I did, there is a typo on Page 2 of "Contextual Information – Emergent, Urgent, and Inpatient Requests," where the first of the three D's is "Dely." I think that should be Delay!)

Clearly a lot of work has been done on this. I appreciate much of the language.

Recently I have been involved in ▮▮▮▮▮▮ committees that are struggling with the words: "Referral" and "Consultation." Well, truthfully, they are not struggling so much as I am struggling, because I think they have got it wrong.

In the CPSM document I note terms like: "seeking a consultation" and "requesting a consultation." Those make sense to me.
In the CPSM document, there is also the word referral. That also makes sense to me.

The way I see it (based on my readings of dictionaries, paper and online), Registrant A sends a referral (or refers) to Registrant B for a consultation. That consultation might be a single event or may mean some ongoing care, or may even mean taking over care in certain circumstances.

My frustration has been with groups trying to suggest that referrals happen in hospital and consultations happen upon discharge!

I'm not sure that definitions would help. I do sense that the suggested CPSM document generally makes the issue clear, and the wording of administrations muddies things up.

Thanks for allowing review of the document by members.

▮▮▮▮▮▮▮

STAKEHOLDER FEEDBACK	
Name	**Comment**
Letter submission – Letter 1	
Letter submission – Letter 2	
Dear CPSM, Thank you for the opportunity to provide feedback as part of your Public Consultation: Collaborative Care. The College of Pharmacists of Manitoba (CPhM) has reviewed all the associated documents. We support the aims of these Standards of Practice, especially as they relate to interprofessional collaborative care. Pharmacy professionals, including pharmacists and pharmacy technicians, work collaboratively with physicians, physician assistants, clinical assistants, and residents in many settings across Manitoba. Connection to Joint Practice Direction: Interprofessional Collaborative Care. As you know, both CPSM and CPhM have collaborated on a Joint Practice Direction: Interprofessional Collaborative Care ("Joint Practice Direction"). Since CPSM's draft Standard of Practice - Collaborative Care touches on interprofessional care (e.g. in citing the Code of Ethics, "Support interdisciplinary team-based practices; foster team collaboration and shared accountability for patient care"),	

PUBLIC CONSULTATION: Collaborative Care Feedback – Email Submissions

CPhM is hoping to see reference or connection to the Joint Practice Direction, in order for CPSM registrants to understand how the Joint Practice Direction can fit with this new Standard of Practice. Linkages between these two documents can help provide clarity to registrants about their obligations to healthcare teams.

Institutional Systems Issues

In the draft Standard of Practice - Collaborative Care, there is a statement on Delays Beyond Control, stating, "You are not directly responsible for delays in communication caused by institutional systems issues that are outside your control." CPhM believes there is opportunity to further clarify the meaning of this type of statement. There are many institutional systems issues consistently at play in the delivery of healthcare services. These include administrative burden, workplace pressures on capacity, and a lack of seamless integration across medical records. Despite these, healthcare professionals can be expected to provide the best possible care, under the circumstances, to the patient's benefit. Systems issues can always be a contributory cause to delays in communication; however, it is important to create greater clarity about what a registrant's obligation, in the face of these issues, must be. CPhM recommends adding clarity about the obligations of CPSM registrants when faced with institutional systems issues. Modes of Communication Available in Emergency The draft Standard of Practice - Emergent Urgent and Inpatient Requests states, "Collaborative Care principles begin when a registrant, or other health care provider, contacts another registrant verbally or by secure text message regarding what they believe to be an emergent matter that, without immediate medical attention, places the patient's health in jeopardy. [emphasis added]" In many cases, pharmacists, who are not co-located or have access to a direct phone number for the physician, cannot reach a physician verbally. Pharmacists in community settings are also not generally linked to physicians via secure text messaging platforms (e.g. Tiger Connect). For emergent or urgent requests in these settings, it is still important for pharmacists and other healthcare professionals to be able to engage in collaborative care with CPSM registrants. CPhM recommends broadening the means of communication that engage "collaborative care" and this Standard of Practice.

Thank you again for the opportunity to provide feedback to this consultation. Should you have any clarifying questions about any of the above comments from CPhM, please do not hesitate to reach out.

■■■■

CMPA.ACPM

Empowering
better healthcare

Pour l'avancement
des soins de santé

February 12, 2026

Via email: CPSMconsultation@cpsm.mb.ca

Dr. Ainslie Mihalchuk
Registrar
The College of Physicians & Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg, MB R3J 3T7

Dear Ainslie:

Re: Consultation on Collaborative Care

The Canadian Medical Protective Association (CMPA) appreciates the opportunity to provide feedback on three draft Standards: *Collaborative Care*, *Emergent, Urgent, and Inpatient Requests*, and *Non-Emergent Consultation Request*.

As you know, the CMPA delivers efficient, high-quality physician-to-physician advice and assistance in medico-legal matters, including the provision of appropriate compensation to patients injured by negligent medical care. Our evidence-based products and services enhance the safety of medical care, reducing unnecessary harm and costs. As Canada's largest physician organization and with the support of our over 119,000 physician members, the CMPA collaborates, advocates and effects positive change on important healthcare and medico-legal issues.

The CMPA's comments focus on the following aspects of the draft Standards and contextual documents that may create medico-legal challenges for physicians:

- Tapping in
- Closed-loop communication
- Defining roles and responsibilities
- Reporting obligations
- Liability protection
- Documentation in the emergent and urgent care context
- Response time and managing results in the non-emergent care context

Collaborative Care

"Tapping in" and "tapping out"

To help physicians understand when they are "tapped in" and "tapped out" of a patient's care, we suggest providing practical examples. The College uses these terms to describe when a physician is or is no longer responsible for assisting in the care of another physician's patient

The Canadian Medical Protective Association | L'Association canadienne de protection médicale

P.O. Box 8225, Station T | C.P. 8225, Succursale T Ottawa ON K1G 3H7 | 613-725-2000, 1-800-267-6522 | 613-725-1300, 1-877-763-1300   **www.cmpa-acpm.ca**

but offers limited guidance in the draft contextual documents about when responsibility is initiated, allocated, or concluded.

Although the contextual documents suggest that a physician is tapped in when another provider seeks assistance, it is unclear whether, for example, a telephone call, voicemail, or hallway discussion is sufficient to consider a physician being tapped in. The current Standard requires requests be made in writing. Similarly, it is unclear whether a physician needs to take positive action to tap out of the patient's care, such as notifying the most responsible physician or documenting the end of their involvement, or whether they can assume they are tapped out when their input is no longer needed.

Clarification would also be helpful on whether tapping in and out apply when collaborating with non-physician providers.

Closed-loop communication

We recommend that the College clarify whether the closed-loop communication requirement also applies in urgent and emergent care, where interactions are more spontaneous and occur closer in time than in non-emergent care.

As drafted, the closed-loop communication requirement appears to address only the non-urgent context. If the College intends for providers in urgent and emergent settings to implement closed-loop communication, we suggest adding examples illustrating how the requirement would operate in those settings.

Defining roles and responsibilities

It would be helpful for the draft Standard to encourage physicians to ensure all members of the care team understand their roles and responsibilities, especially where team responsibilities may overlap. When each member understands their own role and those of other team members, accountability is clear and care can be shared appropriately.

Reporting obligations

We recommend providing clear thresholds, timelines, and expectations regarding physicians' obligations to report system issues.

The draft Standard would require physicians to notify appropriate decision-makers of any practice or system issues that impede them from meeting their responsibilities and, if such issues persist, to escalate the matter to the CPSM. Similarly, the draft *Collaborative Care* and the *Emergent, Urgent, and Inpatient Requests* contextual documents specify that registrants should report rude or obnoxious behaviour to the department lead or to the CPSM.

Without clear guidance and examples of situations that warrant a report, physicians may be unclear as to when their reporting obligation is triggered.

Liability protection

The CMPA consistently encourages physicians to make reasonable efforts to ensure all members of the healthcare team, including regulated and unregulated health professionals,

have their own adequate liability protection commensurate with the risks posed by their involvement in patient care. It would be helpful if the draft Standards did the same.

Sufficient and adequate liability protection for all healthcare team members is essential to ensure patients receive appropriate compensation where proven to have been injured as a result of negligent care. Liability protection also provides reassurance to the healthcare team because co-defendants are exposed to the concept of joint and several liability (i.e., when more than one party is responsible for having caused injury to the plaintiff, the plaintiff may recover full compensation from the defendant most able to pay, even though that recovery is out of proportion to that defendant's degree of liability).

Emergent, Urgent and Inpatient Requests

Documentation

We recommend the College provide additional guidance on appropriate documentation when collaborating with other healthcare providers.

Although the draft Standard contains a section on "Interventions and Documentation", it does not set out any documentation expectations. For example, it would be helpful to specify which physician is responsible for documenting the interaction when a most responsible physician consults another physician for advice or a transfer of care.

Non-Emergent Consultation Requests

Response time

It would be helpful if the College maintained a more flexible response time for consultation requests.

The draft Standard proposes reducing the response time for a consultation request from 30 days to 14 days. Given ongoing healthcare provider shortages and increased workloads, it would be reasonable to allow physicians more time to respond to consultation requests.

Managing results

It would be useful for the draft contextual document to clarify who is responsible for managing the results of additional tests ordered following a referral or request for consultation.

As drafted, the expectations may be unclear as to whether the referring or consulting physician is responsible for ensuring follow-up of these tests. We are aware the CPSO's *Advice to the Profession: Continuity of Care* states that, generally, any physician who determines that a test is needed is responsible for ordering that test, tracking the results, and managing any follow-up stemming from that test.

We trust the above comments will be of assistance to the College in finalizing the draft Standards: *Collaborative Care*, *Emergent, Urgent, and Inpatient Requests*, and *Non-Emergent Consultation Request*.

Yours sincerely,

Lisa Calder, MD, MSc, FRCPC
Chief Executive Officer

LAC/ml

cc.   Dr. B. Singh

VIA EMAIL

February 13, 2026

Dr. Ainslie Mihalchuk, Registrar & CEO
The College of Physicians & Surgeons of Manitoba
1000 – 1661 Portage Ave
Winnipeg, MB R3J 3T7
cpsmconsultation@cpsm.mb.ca

Dear Dr. Mihalchuk,

RE: CPSM Consultation on Collaborative Care

Thank you for the opportunity for Doctors Manitoba to comment on the proposed new Standards of Practice of Collaborative Care (which include the Standard of Practice Collaborative Care, Standard of Practice Collaborative Care Non-Emergent Consultation Requests, and Standard of Practice Collaborative Care Emergent, Urgent and In-Patient Consultation Requests).

Introduction

CPSM's work to develop new Standards of Practice on Collaborative Care is timely, and critical to improving patient care in Manitoba.

Doctors Manitoba appreciates CPSM's engagement and willingness to listen to physician concerns about collaborative care, and the efforts of the CPSM Working Group. Our partnership in holding the well-attended and successful Referral and Consultation Summit in October was an important signal to physicians, system leaders and government that improving collaborative care is a priority.

Our research finds that more than one million referrals and diagnostic imaging requests move through Manitoba's system every year. Most of these requests are faxed or mailed, with no reliable way to confirm receipt or track status. On the sending side, it can be difficult for physicians to determine which consultant is the right fit and what information they need. On the receiving end, referrals are sometimes misdirected or are missing needed information.

CPSM and Doctors Manitoba share a great deal of common ground on improving collaborative care. However, we know that real progress will require significant investment by government and health authorities. As we noted in our report from the Referral and Consultation Summit:

- **85%** of consultations are still sent by fax or mail.

- Only **19%** of physicians can share information electronically with colleagues.

- Physicians waste **30 – 40 hours per year each** navigating inefficient referral processes — adding up to **100,000+ hours annually**.

- **Patients** feel this too, with unnecessary delays adding to their wait times and having to spend time contacting your offices seeking updates.

Doctors Manitoba has presented a practical roadmap to modernize referrals and consultations. Our key recommendations include:

- **A provincial physician directory** to help referring physicians find the right specialist the first time for each patient.

- **Interoperable** eReferral tools integrated with EMRs to support closed-loop communication.

- **Clear guidance** on when physicians should use emergent, urgent, or routine consultation channels with integration to move requests between them as appropriate.

- **Properly resourced central or pooled intake models**, developed with physicians, not imposed on them.

- **Urgent fixes for diagnostic imaging backlogs**, alongside a move to digital eRequisitions with closed-loop tracking.

We do not believe the new Standards would create any inconsistencies or barriers in implementing these recommendations.

We are hopeful that government will make the necessary investments to make significant progress on all of these issues. The government's recent announcement respecting some of these issues give hope that there will be meaningful improvements.

What We Heard

All participants in the Referral and Consultation Summit were invited to provide us with their feedback. Further, Doctors Manitoba invited all other members to comment. We received feedback from many members which has been shared with CPSM.

As is our usual practice, we amplified the CPSM's Consultation through our e-newsletter, Vitals. We asked physicians to copy us with their submissions or, if they preferred, send their comments directly to us to inform our submission. Very few physicians have done so.

Based on the limited further involvement of physicians, we believe the views expressed during and after the Summit represent the prevailing position of physicians. We believe the feedback leads to three main themes:

1. Sending physicians (predominantly, but not entirely family physicians) want to ensure that receiving physicians comply with the time limits and other requirements in the proposed Standards, and that sending physicians are not burdened with further obligations;

2. Receiving physicians (predominantly, but not entirely specialists) want to ensure that the time limits and other requirements in the proposed Standards are applied by the CPSM in a reasonable way; and

3. All physicians want to improve the flow of requests for diagnostic tests.

There are some other minor themes we will also address briefly.

Moving Towards Compliance

A frequent issue raised in physician feedback, particularly from family physicians, is support for enforcing time limits for responding to consultation requests, and time limits for providing information about the consultation. It is not often that physicians call for *greater* scrutiny by the CPSM, but this seems to be a place where it would be welcomed.

Regular CPSM practice audits may identify concerns about a receiving physician's timeliness in replying to consultation requests and providing reports to the sending physician. However, we expect that most scrutiny will arise from complaints to the CPSM about the timeliness of the receiving physicians' communications.

Doctors Manitoba wishes to avoid members complaining about each others' practice. We will plan to educate our members about the new Standards and provide our members with our advice about addressing questions and concerns. A complaint with the CPSM should be a last resort. As the CPSM moves to more educative and restorative processes to address complaints, there should be opportunities for joint communications to have members comply with the new Standards without the need for punitive measures.

The efforts by the CPSM to promote civility among physicians on this and other issues is appreciated. Challenges with transferring the care of patients can lead to frustration and conflict. Doctors Manitoba looks forward to working with CPSM on this issue.

Compliance in a Challenged System

We have heard from physicians – generally those receiving requests – that current technological and system barriers make the time limits and some other requirements difficult, if not impossible, to meet.

As noted above, 85% of consultations are still sent by fax or mail – fax machines break down and run out of paper, mail gets lost or mislaid, and "out of office" notifications are not received by sending physicians. Fewer than one in five physicians can share information electronically with colleagues and many – particularly those practicing in hospitals and facilities – are still constrained by paper charts. Many specialists feel overworked and have expressed their concerns about having to take on an ever-increasing volume of work, with increasingly challenging and complex patients.

We appreciate the CPSM's express acknowledgement of these and other concerns. As we communicate with physicians, we will remind both sending and receiving physicians that the Standards must be applied

with these barriers in mind, and that perfection is not expected in an imperfect system. We will also continue to press government for appropriate investments to reduce or eliminate these barriers, and sufficient human resources to reduce the wait times for speciality areas with challenges.

Referrals for Diagnostic Tests

Physicians have overwhelmingly told us of their frustration in referring their patients for diagnostic imaging and other tests. The CPSM's goal of "closed-loop" communications - approved by Doctors Manitoba – appears to be a distant one. Physicians report great frustrations in having to pursue requests which disappear for weeks or months, or forever. Following up on missing requests means administrative burden for physicians, and responding to requests is a further draw on limited system resources. Most importantly, delays in diagnostic imaging and testing are worrying and potentially harmful for patients.

Government has promised movement on this issue. We will continue to press for details on timing and resources, and look forward to working with CPSM to call for investments to improve the flow of these requests.

Other Issues

An issue raised by some physicians, both from those sending and receiving consultations, is the responsibility for patient care after the receiving physician agrees to accept the consultation.

In some cases, the patient's wait for the first appointment might be many months, and the receiving physician might be able to provide valuable advice for the patient in the interim. Some sending physicians would welcome advice from the receiving physician to improve the care of patient in the meantime. At the same time, some sending physicians do not want to be burdened by ordering and reviewing a lengthy series of tests.

The Standard provides that the sending physician can be required to order tests or otherwise prepare a "workup" only if mutually agreed by the physicians. A lengthy wait for the patient to see the receiving physician may result in a deterioration in the patient's condition.

CMPA has issued guidance on wait times at https://www.cmpa-acpm.ca/en/education-events/good-practices/the-healthcare-system/wait-times-when-resources-are-limited as follows:
College policies generally require that specialists take a number of factors into account when deciding whether to accept the referral, including:

- *urgency and clinical need*

- *current wait times*

- *scope of practice and clinical competence*

If the referral is accepted, the consultant is generally in the best position to communicate the appointment time to the patient and the referring physician. To minimize the likelihood that a deteriorating

patient lingers on a wait list, it is important that consultants inform both the patient and the referring physician of the expected wait time and of the signs and symptoms of concern that should prompt a phone call or a re-evaluation of the patient's position on the list. In addition, it is helpful for patients to be notified of any consultant office administrative requirements (i.e. expectations around cancelling an appointment, costs for no shows, etc.) as well as any medical requirements prior to attending (e.g. bowel preparations, medication adjustments, etc.).

We believe that more work must be done in the future to clarify the responsibilities of the sending physician and the receiving physician, with a goal of better patient care. While that should not prevent the Standards from moving forward, we believe future work should set out preferred communications and allocation of responsibilities between physicians (and, with government, suitable remuneration for physicians taking on this work).

Our members have repeatedly told us about the value of a current and comprehensive Referral Directory. This would minimize the time needed for sending physicians to find the appropriate receiving physician - and could even allow real time updates of physician availability and wait times. This is a resource issue for government to address and would assist physicians in complying with the Standards.

A welcome development would be a convenient and timely way for receiving physicians to get information to the sending physicians. We envision a timely and effective way to send "fact sheets" to the sending physician – noting what issues should be monitored during the wait to see the receiving physician, when a follow up communication is warranted (i.e, if the patient's condition declines which could suggest greater priority to be seen) and possibly – with the caveat noted below – for tests to be ordered by the sending physician.

Ongoing communication between the sending and receiving physicians pending the consultation is important. It is unrecognized by Manitoba Health at present. Receiving physicians may be frustrated by a lack of information they believe would be important to the patient. Sending physicians may be frustrated if they are told to order tests which they may not request often in their practice and asked to review results they do not feel comfortable in interpreting.

There is value in ongoing collaboration between the time of the referral and the consultation actually taking place. This benefits patient care and mitigates physicians' liability where wait lists are lengthy. We believe Manitoba Health should recognize the value in ongoing communications between physicians and consider additional collaborative care tariffs to compensate both sending and receiving physicians for taking time to work together.

Conclusion

Doctors Manitoba believes these Standards are an important step forward in improving patient care in Manitoba. We appreciate the CPSM as a partner in working to improve collaborative care. We also appreciate CPSM's acknowledgement that significant technological and system barriers remain. Until these barriers are resolved, there will be challenges for physicians to comply with the letter of the

Standards. We look forward to working with CPSM to continue to address these issues and improve patient care in Manitoba.

Yours truly,

ANDREW SWAN
General Counsel

AS/cb

cc: M. Triggs

Contextual Information – Collaborative Care

The Standard of Practice – Collaborative Care establishes clear requirements for registrants to work collaboratively with other registrants and health care providers to deliver good medical care to patients. This standard must always be interpreted from the patient's perspective, with the primary focus on ensuring that the patient receives the best possible medical care. Every action and decision taken by the registrants involved should be guided by the intention to deliver good medical care to the patient.

Collaboration and Behavioural Expectations

Working alongside other registrants, health care providers, and institutions presents opportunities to significantly enhance the medical care provided to patients. At the same time, collaboration can sometimes be a source of frustration. However, each registrant is responsible for their own behaviour, and this Standard of Practice outlines the behavioural expectations for all registrants involved in patient care.

Benefits of Adopting Professional Behaviours

When all registrants adhere to the behaviours defined by the *Code of Ethics and Professionalism*, many of the frustrations associated with providing collaborative care are reduced. As a result, both patients and registrants benefit from improved collaboration and professionalism in the delivery of care.

Supporting Registrants

To further assist registrants in understanding the requirements of the Standard of Practice, a set of frequently asked questions (FAQs) has been provided.

Q. Why do I become responsible for another registrant's patient?

A. Another registrant needs help providing care to their patient which they may not be able to provide. When they seek your assistance, you are "tapped in". When you are "tapped in", you are expected to assist with the patient's care. The extent of your involvement depends on the specific circumstances. You may take over care of the patient, or it may be determined that there is little, if anything, that you can provide to the care. However, until you are "tapped out" you remain responsible for assisting the requesting registrant provide care.

Q. When I am "tapped in" does this mean that I am the Most Responsible Physician?

A. "Tapped in" means that you are responsible for assisting the requesting registrant provide care. What that assistance looks like will vary depending upon the circumstances. Eventually, you may become the Most Responsible Physician but that occurs when you accept that responsibility.

Q. How do I "tap out", and why should I be responsible for a patient's care just because someone has contacted to me?

A. Each situation will be unique but for the most part Collaborative Care can be divided into two main categories.

1. When a registrant seeks a non-emergent consultation, or
2. When a registrant seeks an emergent, urgent or inpatient assistance.

The Standards of Practices for Non-Emergent Consultation Requests and Emergent, Urgent, and Inpatient Requests provide detailed information on how to respond professionally to these two types of requests for assistance.

If you are contacted, it is because the referring registrant believes that you are the right person to help. If you are able to provide the needed assistance, you are responsible until the assistance is complete or it is agreed that your help is no longer needed.

If you are not the appropriate person to assist, your role will be minimal. However, in most cases you will probably have more familiarity with the subject matter than the referring registrant. Your responsibility is to determine how you can help the patient - every action or decision is to help the patient receive good medical care. You must determine, even if it is minimal, what can you do to help.

Q. I work in an institution, and I have no control over administrative staff who perform tasks associated with my provision of care to patients. How can I meet my professional obligations if I have no means of ensuring the tasks are performed.

A. The Standard of Practice specifically recognizes that system issues may prevent you from meeting certain obligations. You are not personally responsible for matters outside your control. That said, this does not absolve you from taking any steps.

If you identify a practice or system issue that prevents you from meeting your responsibilities; notify the relevant decision makers in the institution.

If the issues persist, escalate the matter by informing CPSM and request assistance in communicating these standards to the relevant decision makers.

Q. When transferring care, what information should I provide to the accepting registrant?

A. Remember, the accepting registrant may have little or no prior knowledge of the patient's condition or medical history. Whenever possible, communicate directly with the accepting registrant to share the information you have and determine what they need to know. If direct communication is not possible, exercise your professional judgment to determine and share the most relevant information. Do not send the patient's entire medical record unless specifically requested, and do not provide insufficient details. At a minimum, summarize key steps taken so far and explain why you are involving the accepting registrant.

Q. What is the importance of Communication Closing the Loop?

A. A common concern expressed by registrants and patients is that they do not know what is happening with a particular matter. For example, a request for a consultation was sent and there is no acknowledgement that it was received or that it will be acted upon. The concept of closing the loop communication is basic courtesy of acknowledging the request was received and providing a meaningful information.

The Standard of Practice – Non-Emergent Consultation Requests requires you must provide a triage response with specific information within 14 days of receiving the request. If you cannot provide all the required information within this period, acknowledge receipt and indicate when the information will be available.

If there is no response within 14 days, it signals a potential issue – such as the request not being received or a problem preventing a timely reply. This prompts the referring registrant to follow up and ensures patient care is not delayed.

Always acknowledge requests promptly and provide meaningful updates. This is basic courtesy and a professional obligation.

Q. What do I do when the registrant I am working with is behaving rudely and obnoxiously?

A. Disrespectful behaviour can be frustrating, especially when you are committed to professionalism. Some constructive steps to consider are:

- **Remain Professional**: Continue to act respectfully and avoid mirroring the rude behaviour. This helps protect your credibility and helps prevent escalation.
- **Address the Behaviour:** If you feel comfortable, remind the registrant of the Standard of Practice, emphasizing that all actions and decisions must be based on ensuring the patient receives good medical care.
- **Document Interactions:** Keep a record of incidents, including dates and details. This can be useful if the issue persists and needs escalation.
- **Escalate if Necessary:** If the behaviour persists or it compromises patient care, report it, where appropriate, to the department lead or to CPSM. CPSM's role is to encourage improvement, not to punish bad behaviour.

Contextual Information – Non-Emergent Consultation Requests

The Standard of Practice – Non-Emergent Consultation Requests establishes clear requirements for registrants to work collaboratively with other registrants when specialized knowledge or experience is sought in the treatment of a patient.

This standard must always be interpreted from the patient's perspective, with the primary focus on ensuring that the patient receives the best possible medical care. Every action and decision taken by the registrants involved should be guided by the intention to deliver good medical care to the patient.

Collaboration and Behavioural Expectations

Working alongside other registrants, health care providers, and institutions presents opportunities to significantly enhance the medical care provided to patients. At the same time, collaboration can sometimes be a source of frustration. However, each registrant is responsible for their own behaviour, and this Standard of Practice outlines the behavioural expectations for all registrants involved in patient care.

Benefits of Adopting Professional Behaviours

When all registrants adhere to the behaviours defined by the *Code of Ethics and Professionalism*, many of the frustrations associated with providing collaborative care are reduced. As a result, both patients and registrants benefit from improved collaboration and professionalism in the delivery of care.

Supporting Registrants

To further assist registrants in understanding the requirements of the Standard of Practice, a set of frequently asked questions (FAQs) has been provided.

Q. What is the importance of Communication Closing the Loop?

A. Effective communication is critical for good medical care. Lack of communication can negatively impact patient care.

A common concern expressed by registrants and patients is that they do not know what is happening with a particular matter. For example, a request for a consultation was sent and there is no acknowledgement that it was received or that it will be acted upon. The concept of closing the loop communication is basic courtesy of acknowledging the request was received and providing a meaningful information.

The Standard of Practice – Non-Emergent Consultation Requests requires a triage response with specific information within 14 days of receipt. In nearly all cases the registrant who is being asked

to help will be able to provide the specific information. However, in limited circumstances they will not be able to so. The appropriate response will be to acknowledge receipt of the request within the 14-day period and advise that required information will be provided by a specified date.

Establishing response timelines ensures that both the patient and the referring registrant are aware that a lack of response within 14 days indicates a potential issue requiring attention. The referring registrant will know that the consultation request was either not received or there is some issue that is prevented the triage response from being sent.

Q. When I am seeking a consultation for my patient what Information do I need to provide?

A. The registrant who you are asking to help care of your patient does not know your patient and does not know why you are sending the patient to them. If you want them to assist you, you need to assist them.

Be clear and concise. Let them know if you are seeking an opinion, transferring care or if there is some other reason for the consultation. Clearly state the relevant clinical question you want answered or why you want the consulting registrant to see the patient.

You also must provide the relevant medical information that you have gathered that has brought you to point where you have determined that you need assistance. It is not sufficient to refer a patient to an internal medicine specialist with a referral that merely states – "abdominal pain".

Do not send extraneous information. If your patient has a discrete medical issue do not send their entire 20-year medical history and expect the consulting registrant should look through it all to determine what is relevant. Use your knowledge, skill, and judgment to assess what you believe to be relevant and provide it in a clear easily understood format.

Q. I have received a referral, what am I supposed to do to triage and knowledge receipt?

A. An important purpose of the requirement to respond within 14 days after receiving the referral is to provide an acknowledgement that it has been received. Everyone is aware of the someone saying, "I never received the fax". The purpose of the requirement is to let the referring registrant know that the referral was received and reviewed.

Another important purpose of this requirement is to triage the referrals. This is just a preliminary assessment of the referral.

- Is this a subject matter you consult on?
    - If not, let them know.
- Is there enough information provided to enable a preliminary assessment?
    - If not, let them know what additional information you require.
- Is the referral clear?
    - If not, seek clarity on where the uncertainty exists.
- If this is a routine consultation let them know approximately when they can be seen. **You are not required to book an appointment date at this time**. You can, if you are able to, book the appointment, but it is not required. You are simply providing basic information

about when they can be expected to be seen. For example, if your wait list is currently 3 months long you can advise that they will most likely be seen within a specified range. This provides the patient and referring registrant with a reasonable expectation of a timeline so they can plan next steps.

- Upon reviewing the material, you may conclude that the patient needs an expedited assessment or they need to be seen before you can reasonably see them. In these circumstances you are responsible for advising them of the timeline they should be seen in. You should use reasonable efforts to assist in identifying a qualified registrant who can see them within that timeframe if you cannot.
- If you cannot accept the referral advise why you cannot and suggest other qualified registrants who may be able to accept the referral. The patient needs specialized medical care, and although you are not required to find an alternative registrant you are most likely more knowledgeable as to who may be able to assist than the referring registrant. As such, for the patient's benefit you are to suggest alternatives.

Q. Despite my best efforts it will be impossible for me to provide the required triage response within 14-days, what do I do?

A. Be respectful and reasonable. How would you like to be treated if you were the patient or referring registrant? Acknowledge that the referral was received and advise when you expect to have a triage response to them. You are not obligated to provide reasons for the delay but doing so can be beneficial.

Q. While I was away on a two-week vacation, I received a consultation request via fax which my out of office email response did not reply to. I cannot complete the required triage response within 14-days, what do I do?

A. Simply advise the referring registrant that you just returned to the office and are triaging several referral requests. Hopefully, you will have a response within 14 days but advise them if it may be slightly longer because of a backlog.

Q. I sent a consultation request over 14-days ago but have not received any response, what should I do?

A. The Standard requires a triaged response within 14-days; however, something may have occurred that prevented the response back in that timeframe. The first step is to confirm whether you sent the consultation request to the correct contact information. If you did, reach out to the registrant (or their office) to confirm the consultation request was received and when a triaged response may be provided.

As always be respectful and reasonable in your communication.

Q. I see that CPSM has a template Consultation Triage Response. Do I have to use it? Why is it necessary?

A. The Standard of Practice – Non-Emergent Consultation Requests has requirements on consulting registrants to triage and respond to the referring registrant within 14 days of receiving a consultation request. The template is provided as an example of what may be used to meet this requirement. Many consulting registrants have their own templates that provide this information to the referring registrant. The form is not as important as the communication.

The triage response is to close the loop on the communication that the referring registrant sent. The primary purpose of the triage response is to let the referring registrant know that you have received the request and whether you can see the patient.

If you cannot see the patient, the referring registrant needs to know this so that they consider an alternative plan for the patient. There can be many reasons for not seeing the patient, such as:

- You may not do that type of consultation
- You may have such a long wait list that it is not reasonable for them to wait that long to see you.

There have been situations where a referring registrant has waited more than 3 months to be told that the registrant who is asked for help replied that they do not do that sort of consultation. The patient is not receiving good medical care if they wait 3 months to be told that the registrant does not perform this type of consultation. 14 days is a reasonable time for the registrant to triage the request to determine whether it is something they do.

Q. I receive about 50 referral requests a day; I cannot possibly see patients and complete all these triage responses within 14 days. Is CPSM going to punish me because of I am unable to complete this imposed administrative burden?

A. Registrants are required to provide good medical care to patients. CPSM recognizes that registrants are feeling tremendous stress because of unrealistic expectations placed upon them due to physician shortages. CPSM also recognizes that registrants want to help patients and do not want to turn anyone away who they can help.

It is important for registrants to recognize their own personal capacity for volume of service. The Standard of Practice – Volume of Service states:

"Excessive workload volume may result from overly long work hours, insufficient time to provide an acceptable standard of care per unit of service or being on call most or all of the time. Each of these risk factors may in turn result in chronic fatigue and place patients at unnecessary risk."

You are not expected to be a Superhero. You are permitted to say to the referring registrant – "I do not have capacity to consider your consultation request."

The concept underlying Collaborative Care is that when you receive a request for help you have a degree of responsibility for that patient (you have been "tapped in"). Your initial responsibility to the patient is to determine within 14 days if you can or cannot provide medical care. If your workload

volume is so excessive that you cannot provide that response the answer is clear that you must not accept them as a patient.

Q. I often receive referral requests with incomplete information or uncertain requests. How can I possibly assess within 14 days whether I see the patient?

A. You can only triage a request based upon the information provided. There will be situations when you are provided with limited information that makes it difficult to triage or there is not a clear reason stated for the consultation. At this point the triaging ends and you simply reply that you cannot proceed further to consider the request without specific information. Your responsibility is to provide this response within 14 days and to specify what you require to complete the triage.

The 14-day clock will reset when you receive the information you requested.

Q. What is meant by advising the referring registrant of my normal sequencing of patient referrals?

A. The length of time it takes to see a patient after the request is received will vary from registrant to registrant, and it may also vary for a registrant from one year to the next. The referring registrant and patient do not know your wait times. All you are asked to do is advise them of the approximate time before you see the patient. This could be 3 weeks, 3 months or 3 years. You can even provide an approximate range.

Q. What do I do if I receive a call about transferring a patient and my program/facility doesn't have capacity to accept the patient?

A. You have a responsibility <u>to assist</u> the referring registrant with finding appropriate resources for their patient. You are not responsible for finding the appropriate resource, but you most likely have more knowledge about existing resources than the referring patient so provide them with what assistance you can.

Q. What is my responsibility when discharging a patient from my care back to their primary care provider?

A. You should ensure that information is provided in a timely manner to the primary care provider about the discharge, including medications, any investigations or monitoring required (and who will be responsible for this), and follow up required. In situations where the patient does not currently have a primary care provider and may have to attend a walk-in clinic for follow up, pertinent information should be provided to the patient.

Q. After receiving a referral letter/request, the registrant receiving the request deems more information or additional testing is required, prior to seeing the patient.

> **A. Who is responsible for requesting the tests?**

> **B. Who is responsible for managing the results?**

Answer A: If a registrant receiving a consultation request requires additional testing prior to triaging or seeing a patient, and it is within the scope of practice for the referring registrant, the referring registrant should proceed in requesting the test to expedite patient care. Should the referring registrant feel this is not in their scope of practice, it will be the consulting registrant's responsibility to request the test. Clear communication needs to occur between the referring and consulting registrants, making sure everyone knows their role.

Answer B: If a registrant receiving a consultation request asks a referring physician to perform additional testing, and the result is abnormal and pertaining to the reason the consult was made, it would be in the interest of the patient for the consulting registrant to see them in an expedited manner. If that is not possible, the consulting registrant could liaise with the referring registrant, and treatment or care could occur in the interim, if the referring registrant agrees. Should this be outside the scope of practice for the referring registrant, all effort should be made by the consulting registrant to provide care in an acceptable time frame.

Q. Consulted registrant saw my patient and advised that a test or diagnostic imaging is necessary in the future for monitoring the condition. Who is responsible for requesting that follow up test/imaging?

A. After a consulting registrant sees a patient and deems the patient stable, but in need of follow up testing at a future date, the consulting registrant could request the referring registrant to arrange this. However, this must be agreed upon by both referring and consulting registrant. There are instances where the patient may have been referred to a consulting registrant and the referring registrant is no longer in the circle of care. The responsibility for follow-up and repeat testing would fall onto the consulting physician.

Q. As the consulting registrant) requested a test and the results have a finding that is not within my scope of practice. Who needs to arrange appropriate care?

A. If an abnormality is found that is not within the scope of practice of the consulting registrant, it is reasonable for the consulting registrant to communicate this to the referring registrant and clearly state what part of the test result they will deal with and what part of the abnormal result they need to referring registrant to deal with. Clear communication and delineating expectations are key. Ignoring abnormal results or assuming the referring registrant would deal with the outstanding abnormality is not acceptable patient care.

Contextual Information – Emergent, Urgent, and Inpatient Requests

The Standard of Practice – Emergent, Urgent, and Inpatient Requests establishes clear requirements for registrants to work collaboratively with other registrants and health care providers to deliver good medical care to patients who have a condition that places their health in jeopardy if immediate medical attention is not provided.

This standard must always be interpreted from the patient's perspective, with the primary focus on ensuring that the patient receives the best possible medical care. Every action and decision taken by the registrants involved should be guided by the intention to deliver good medical care to the patient.

Collaboration and Behavioural Expectations

Working alongside other registrants, health care providers, and institutions presents opportunities to significantly enhance the medical care provided to patients. At the same time, collaboration can sometimes be a source of frustration. However, each registrant is responsible for their own behaviour, and this Standard of Practice outlines the behavioural expectations for all registrants involved in patient care.

Benefits of Adopting Professional Behaviours

When all registrants adhere to the behaviours defined by the *Code of Ethics and Professionalism*, many of the frustrations associated with providing collaborative care are reduced. As a result, both patients and registrants benefit from improved collaboration and professionalism in the delivery of care.

Supporting Registrants

To further assist registrants in understanding the requirements of the Standard of Practice, a set of frequently asked questions (FAQs) has been provided.

Q. What are my responsibilities when considering transfer of a patient?

A. Assess Local Treatment Options: First determine if the patient can be safely treated at their current location. Make sure you have reasonably explored all available local resources and treatment options before considering a transfer.

If Transfer is Necessary:

> **Communicate Clearly:** Contact the receiving registrant directly. Provide concise, relevant information about the patient's situation, including what care has already been provided and your reasons for recommending a transfer.

Collaborate: Work together with the receiving registrant to arrange the transfer and ensure a safe solution for the patient.

Perspective Matter – Here are differing perspectives on the same issue:

Q. I often receive request from rural or remote facilities seeking to transfer patients for matters that I do not have the expertise to deal with, what am I supposed to do when I am not the right person?

Q. When I try to transfer a patient in need of emergent care, I often feel that I am met with the 3 D's (Dely, Defect, Deny), how do I deal with this?

A. All registrants must start with the understanding that the most important goal is to ensure patient safety and timely care through collaboration. Every action and decision must be based on ensuring the patient receives good medical care.

Applying the 7 Core Responsibilities of Effective Collaboration to the context of ensuring patient safety and timely care will address the above concerns:

1. Respond in a timely fashion.
2. Listen and consider the problem.
3. Provide care or offer professional advice.
4. Stay involved until your help is no longer needed.
5. Share enough information so others can understand the patient's situation.
6. Be professional and respectful at all times.
7. Respect the skills, expertise, scope of practice and resource settings of other collaborating health care providers.

Q. When someone calls me about transferring a patient am I "tapped in" and become the Most Responsible Physician?

A. "Tapped in" means that you are responsible for <u>assisting</u> the requesting registrant provide care. What that assistance looks like will vary depending upon the circumstances. Eventually, you may become the Most Responsible Physician but that occurs when you accept that responsibility.

Q. What do I do when the registrant I am working with is behaving rudely and obnoxiously?

A. Disrespectful behaviour can be frustrating, especially when you are committed to professionalism. Some constructive steps to consider are:

- **Remain Professional**: Continue to act respectfully and avoid mirroring the rude behaviour. This helps protect your credibility and helps prevent escalation.
- **Address the Behaviour:** If you feel comfortable, remind the registrant of the Standard of Practice, emphasizing that all actions and decisions must be based on ensuring the patient receives good medical care.
- **Document Interactions:** Keep a record of incidents, including dates and details. This can be useful if the issue persists and needs escalation.

- **Escalate if Necessary:** If the behaviour persists or it compromises patient care, report it, where appropriate, to the department lead or to CPSM. CPSM's role is to encourage improvement, not to punish bad behaviour.

COUNCIL MEETING
MARCH 18, 2026
FOR DISCUSSION BRIEFING NOTE

SUBJECT: Request/Communication with Community Living Manitoba Regarding Healthcare for Persons with Intellectual Disabilities and/or Persons with Autism

BACKGROUND:

In November 2025, Community Living Manitoba, reached out to CPSM regarding the need for a Standard of Practice for healthcare for persons with intellectual and developmental disabilities and/or autism *(Appendices A and B)*. They are seeking an opportunity to meet with the CPSM to discuss how to work collaboratively to improve healthcare access, quality and outcomes for this patient population, citing these service standards will assist healthcare providers and patients understand what common issues to be aware of and what level of care is to be expected in every doctor visit.

Prior to meeting with Community Living Manitoba, CPSM wants to discuss with Council its perspectives on how to address this request.

For Discussion Briefing Note prepared by: Mr. Mike Triggs, General Counsel

Community Living Manitoba

6-120 Maryland Street
Winnipeg, Manitoba
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October 29, 2025

College of Physicians and Surgeons Manitoba
1000-1661 Portage Ave
Winnipeg, MB R3J 3T7

sent via email: cpsm@cpsm.mb.ca

Re: Request for Standard of Practice for Healthcare for persons with Intellectual Disabilities and/or Persons with Autism

Recent research shows that persons with intellectual and developmental disabilities (IDD) and/or persons with autism[1] are facing barriers in having their unique needs met within healthcare systems across Canada. Improving the delivery of primary care to persons with IDD would result in better access to preventive care and the timely treatment of chronic and acute conditions, ultimately leading to a higher quality of life for this group of patients as well as a more efficient and supportive healthcare system.

Community Living Manitoba was established by an Act of the Legislature in 1961. It was formed by parents to advocate for better education and social supports for their children with intellectual disabilities, and to drive change. We're a family-led movement dedicated to the full inclusion of persons of all ages who live with an intellectual disability. Today, we are a strong provincial network and the provincial arm of a national federation including 13 provincial-territorial associations and over 300 local associations across the country. Through our national organization, Inclusion Canada, our movement extends beyond our borders, as part of Inclusion International.

Our current goal is to work together with the College of Physicians and Surgeons of Manitoba to equip patients and doctors with tools to bridge the gap between the experience of patients with IDD and the high-quality care doctors aim to provide.

Community Living Manitoba is requesting a meeting with the College to discuss the co-development and implementation of:

- a standard of practice for treating patients with IDD, and
- comprehensive training on this standard of practice for all your members.

A standard of practice will give patients and doctors a clear metric and understanding of what appropriate care should look like for patients with IDD, including effective communication and adequate preventative care.

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[1] For purposes of this letter, we refer to persons with intellectual and developmental disabilities as "IDD", which we mean to include persons with intellectual and developmental disabilities as well as persons with autism.

Systemic Barriers in Healthcare Settings

In 2021, Community Living Manitoba published a research report which highlighted the healthcare experiences of people with IDD. This research found systemic barriers in accessing healthcare, and ultimately that current healthcare systems across Canada largely fail to adequately meet the unique needs of persons with IDD.[2]

Our study found that communication and time were prominent systemic barriers, specifically:

- The challenge of limited appointment times in a fast-paced medical system; and
- The lack of training or guidelines to communicate effectively with patients with IDD.

Effectively assessing and treating patients with IDD may be challenging as persons with IDD have higher healthcare needs and may require more time during appointments. The 15 minute typical appointment is often too short for a patient to feel comfortable and address potentially multiple and complex healthcare needs.

Communication barriers compound the barriers posed by fast-paced, short appointments. Doctors may not understand patients with IDD, know how a patient who is non-verbal communicates, or they may presume a patient cannot consent or understand.

These barriers mean patients are missing important preventative health care and health promotion treatments. Patients also experience diagnostic over-shadowing, resulting in higher levels of undiagnosed pain, over-medication and health conditions that go undiagnosed or are diagnosed later than other patients.

Other research across the country found patients with IDD fare worse in healthcare settings regardless of age, sex, or type of disability when compared to those without IDD. Specifically, persons with IDD are more likely to visit long-term care, require repeat emergency department visits, and ultimately experience premature mortality when compared to persons without IDD.[3]

With appointments that are structured to meet the needs of patients with IDD and training on how to treat and communicate with patients with IDD, access to preventative healthcare can be increased and hospitalization rates, continuing care/rehabilitation and medication costs could be reduced. Most importantly, persons with IDD can live longer lives.

Standard of Care - Appropriate levels of care that patients can point to

We are asking to work with the College to develop a standard of care for treating patients with IDD. Service standards will assist healthcare providers and patients understand what common issues to be aware of, and what level of care is to be expected in every doctor visit.

We were pleased to see the College address the needs of other marginalized communities in healthcare settings through the adoption of the College's *Practicing Medicine to Eliminate*

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[2] Community Living Manitoba (2021). *Exploring Healthcare Experiences of Persons with Intellectual Disabilities and/or Persons with Autism*, online.
[3] For more information, see Elizabeth Lin et al., "Addressing Gaps in the Health Care Services Used by Adults with Developmental Disabilities in Ontario" (February 2019), online.

Anti-Indigenous Racism practice standard, aimed at reducing healthcare inequalities for Indigenous Manitobans.[4]

We seek to work collaboratively to draw on the knowledge and experience of healthcare professionals and persons with IDD, their families and support networks to create guidelines and ongoing training to develop and implement these service standards. The groundwork for developing these service standards has already begun by The College of Family Physicians of Canada in their 2018 *Canadian Consensus Guidelines*.[5]

The creation of Manitoba specific service standards will address issues such as effective communication, capacity for decision-making and the role of families and caregivers. Although relevant for all patients these issues warrant particular emphasis because some patients with IDD are accustomed to agree with authority figures, others may face barriers in communicating their wishes, and still others lack the capacity to give informed consent or can do so only with support. Clear guidelines on how to account for and respect these differences will allow for more efficient and productive appointments, both for patients and healthcare professionals.

While the human dignity of patients with IDD is a driving factor in our advocacy and the College's mandate, increasing the quality of and access to preventative primary care can also reduce hospitalization and healthcare costs. Making these changes will not only improve access to healthcare for patients with IDD but can increase efficiency in a strained healthcare system.

To further assist patients and doctors in providing high quality healthcare, Community Living Manitoba is committed to assisting those within our network to utilize pre-screening and comprehensive health assessments.[6] These tools help identify health problems and their symptoms common in adults with IDD to facilitate diagnosis and disease management. These proactive tools can complement a standard of care by equipping patients to self-assess and be aware of their medical needs so appointments can be more efficient and informed. When doctors also implement this tool, and have a corresponding billing code, doctors can better detect new diseases and enhance regular health screening and promotion.

Conclusion

The goal of healthcare for patients with IDD is to improve their well-being, function, and participation in family and community. We seek to work with the College, disability community and patients so the healthcare system works for both patients and doctors by ensuring the safe and ethical delivery of quality medical care for persons with IDD. Through developing and implementing service standards, we believe we can achieve high-quality medical care for all.

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[4] See College of Physicians and Surgeons of Manitoba, "Standard of Practice: Practicing Medicine to Eliminate Anti-Indigenous Racism" (June 21, 2025) online.

[5] See Sullivan et al., "Primary care of adults with intellectual and developmental disabilities: 2018 Canadian consensus guidelines" (April 2018) 64 *Canadian Family Medicine,* 254, online.

[6] For examples, see IDD Health Check or Comprehensive Health Assessment Program.

We would like to schedule a meeting to discuss the development and implementation of a standard of practice to assure the provision of adequate and dignified care. Please contact me directly at 204-612-4806 to schedule a meeting.

Sincerely,

Debra Roach, Chair of the Human Rights Committee
Board of Directors
Community Living Manitoba

cc. The Honorable Nahanni Fontaine, Minister of Families, Accessibility and Gender Equality
The Honorable Uzoma Asagwara, Minister of Health, Seniors and Long-Term Care
Dr. Peter Nickerson, Dean, Max Rady College of Medicine, University of Manitoba
Public Interest Law Centre

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Responsive and informed healthcare required for individuals with intellectual and developmental disabilities.

Opinion Editorial

Ensuring appropriate access to health care professionals is essential for the maintenance of good health and well-being, and an important first step to preventing and minimizing illness over the course of a person's life. Community Living Manitoba is dedicated to the full inclusion of individuals with intellectual disabilities into all aspects of community life. We are concerned about people who live with intellectual disabilities and/or autism and the lack of reliable and accommodating access to health care in Manitoba.

We have heard examples of people with these disabilities being subject to procedures they do not require because they cannot communicate with their care team verbally. For example, a person with such disabilities was about to be taken for dialysis but were not able to communicate that they did not require dialysis. An advocate arrived in time to question the procedure, and it turned out that the health care professional was looking at another patient's chart. Fortunately, the patient was spared an unnecessary procedure.

In another case, a woman was in the hospital with her legal advocate. They were told that the patient was to be taken for x-rays, and the advocate stepped out while this was to take place. When the advocate returned, they learned that the breathing tube had been removed from the patient – a procedure that had been decided by the staff and not communicated to either the

patient or the advocate, resulting in significant trauma and breathing challenges. Thankfully, the breathing challenges have been reversed, but the trauma remains.

It is important to consider the whole person each and every time any patient comes into contact with someone in the health care system. This is especially true for persons with intellectual disabilities and/or autism. Health care professionals need to know relevant information about various disabling conditions and how they might affect the health of a person. On the other hand, care must be taken to ensure that a disability isn't used as the sole explanation for a potential health problem resulting in a failure to look for causes of discomfort or ill health, which can lead to no diagnosis, or a misdiagnosis and ultimately results in poorer health outcomes. This process is referred to as diagnostic overshadowing and is just one issue facing this patient population.

Access to good health care is a longstanding issue in a complex system. Building awareness among policy makers and health care practitioners about the situation of individuals with intellectual disabilities and/or autism is essential. Changing current practice in our health care system to become responsive and effective in caring for this group is our ultimate objective.

In a 2021 study conducted on behalf of Community Living Manitoba, researchers learned that many individuals with intellectual disabilities and/or autism are asked if they have a standing Do Not Resuscitate (DNR) order in place. This was the case not because they were ill, but because they lived with disabilities. This illustrates the concern of many citizens with disabilities that low or negative expectations of, and attitudes about them, may influence life or death decisions while receiving health care.

Practices such as this cannot stand. What steps might be taken in order to begin to make a difference? First, requiring pre- and in-service education for all health practitioners (physicians, nurses, and allied health care professionals) regarding the social situation of individuals with intellectual disabilities and/or autism. This must include consideration of the assumptions, consciously held or not, about this group and what their place is in society, and what they deserve as members of our society. Information on potential ways of providing effective care in response to specific conditions is also necessary.

While education is an important first step, it is not sufficient. As a second step, we must ensure hospitals, clinics, and physician offices are physically accessible. In some cases, individuals will be accompanied by a family member as well as assistants who provide needed support. Consulting rooms must be large enough to accommodate advocates, as well as wheelchairs or other mobility equipment. Examination tables must also be accessible for individuals with limited mobility. Fluorescent lights may trigger certain types of seizures or headaches for some people with sensory difficulties. These difficulties are at times common for, but not limited to, those with autism and make a visit to the doctor much more stressful for all concerned.

Finding ways to minimise wait times is an important third step that would help everyone experience the health care system more positively. This is especially true for individuals who may not understand why they don't feel well, and why they have to wait in an unfamiliar, uncomfortable, busy, and noisy place. Reduced and predictable wait times mean that some people will not be tired, hungry, and/or agitated when they get to see a health care professional.

Along with shorter wait times, health care professionals must have enough time with each person in order to make a proper diagnosis. A 15-minute appointment may be enough time for

routine consultations, but it is rarely enough time for individuals who have difficulty in communicating. The provincial billing system makes compensation for longer visits challenging. This impacts physicians' and nurses' ability to get the information they need and may result in patients and their caregivers not fully understanding what is happening and what they should be doing to protect their health.

In addition to ongoing care that will help individuals with intellectual and developmental disabilities to achieve and maintain their physical health, this group will also benefit from good psychological and psychiatric care. This means that they should have access to qualified personnel and specialists when needed, and that the practitioners have had relevant training to enable them to provide helpful and effective care.

Introducing clear standards of care and practice for all health care professionals regarding the treatment of individuals with intellectual disabilities and/or autism in Manitoba is essential. Community Living Manitoba invites all relevant parties to develop and adopt such standards immediately.
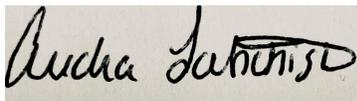
Audra Latschislaw
Executive Director
Community Living Manitoba
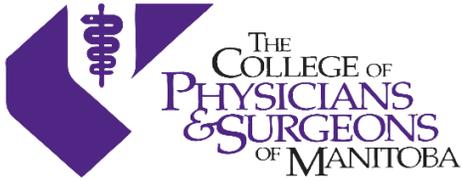
COUNCIL MEETING
MARCH 18, 2026
NOTICE OF MOTION FOR APPROVAL BRIEFING NOTE

SUBJECT: CPSM Support of proposed amendments to *The Mental Health Act*

BACKGROUND:

On July 25, 2025, the Department of Housing, Additions and Homelessness requested written response from CPSM regarding proposed amendment to *The Mental Health Act* to authorize Physician Assistant and Clinical Assistants to complete Form 4 Applications for Involuntary Psychiatric Assessment. *(Appendix A)*

On August 14, 2025, Dr. Ainslie Mihalchuk replied with CPSM's response supporting the proposed amendments *(Appendix B)*.

The Department followed up requesting whether Council also supported the proposed amendments.

This matter is being brought to Council to determine whether they support the Registrar's position.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 18, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

> CPSM Council supports CPSM's August 14, 2025 response to the proposed amendments to *The Mental Health Act.*

Notice of Motion for Approval Briefing Note prepared by: Mr. Mike Triggs, General Counsel

The Mental Health Act Review and Legislative Proposal

College of Physicians and Surgeons of Manitoba (CPSM) Presentation and Discussion

Department of Housing, Addictions, and Homelessness (HAH)

Mental Health and Addictions Treatment and Recovery (MHATR) Branch

July 31, 2025

Manitoba

The Mental Health Act (MHA) Review

- The Mental Health Act ("the MHA") provides the legislative authority governing psychiatric assessment, admission and treatment

- 25 years since the last comprehensive review with significant developments in mental health care and treatment options

- On October 1, 2024, a public commitment by the Minister of Housing Addictions and Homelessness (HAH) was made to conduct a review of the MHA.

The Mental Health Act (MHA) Review

- Concerns have been raised by the Chief Provincial Psychiatrist (CPP) and other community partners that highlight potential limitations and gaps in the legislation.

- On March 31, 2024, the Modernization of Manitoba's Mental Health Act: A Discussion Paper outlined preliminary findings and recommendations.

- Major recommendations included a broader public engagement to review the MHA and expediting amendments to ensure timely access to mental health treatment.

Legislative Proposal to Amend the MHA

- Under the MHA, an application for an involuntary psychiatric assessment may only be made by a physician, if due to a mental health disorder, an individual is at serious risk of harming themselves or others or at high risk of substantial mental or physical deterioration.

- A Form 4 authorizes a psychiatrist to complete a psychiatric assessment to determine if involuntary admission and treatment in a psychiatric facility is necessary.

Manitoba

Legislative Proposal to Amend the MHA

- In June 2025, Cabinet approved a legislative proposal (LP) to amend the MHA to authorize physician assistants (PAs) and clinical assistants (Cl. As) to complete medical examinations and Form 4 Applications for Involuntary Psychiatric Assessments (Form 4).

- Informed and guided by the recommendations of Chief Provincial Psychatrist (A/CPP) and psychiatric leadership in Shared Health (SH) to expand authority beyond physicians.

- Challenges: Serious shortage of physicians and an increase in high-acuity mental health presentations create a greater demand for mental health treatment.

Legislative Proposal to Amend the MHA

- Authorizing PAs and CI. As will improve access and alleviate delays in mental health care in emergency departments, crisis response, and rural mental health settings.

- Potential Outcome: Improve patient flow, public safety, and reduce emergency wait times.

- Nine other Canadian jurisdictions expanded authority in legislation to other qualified health professionals (e.g., nurses and nurse practitioners) to apply for psychiatric assessments.

Legislative Proposal to amend the MHA

- PAs and Cl. As are highly trained health care professionals who exercise medical skill, knowledge and judgement under a physician's supervision.

- CPP to work with SH to develop a pilot project with the Crisis Response Centre (CRC) to establish and evaluate processes.

- PAs and Cl. As working in mental health settings have training and experience to complete the Form 4 and would require minimal additional training.

Discussions with CPSM, SH and the CPP

- Preliminary discussions between the A/CPP, College of Physicians and Surgeons of Manitoba (CPSM) and SH indicate that there is potential support for these amendments.

- Under The Regulated Health Professions Act (RHPA) and regulations, CPSM authorizes their members' scope of practice in the public interest.

- Discussions with Health, Seniors and Long-Term Care (HSLTC) indicate that amendments to CPSM regulations may be required.

Discussions with CPSM, SH and CPP

- CPSM approval, along with the Minister of HSLTC is required to amend the RHPA regulations with consideration of the following:

  - Potential parameters for authorizing PAs and CI. As to complete Form 4 (e.g. when a physician is unavailable),

  - Standards of Practice, and/or

  - Training.

Next Steps

- The input and expertise of CPSM, in collaboration with CPP and SH is being requested in support of the legislative proposal and drafting.

- Please consider the following questions and provide a response.

- Additional written feedback is also requested by August 15, 2025.

- This feedback will be used to develop a draft bill with Legislative Counsel and a submission to seek Cabinet approval to introduce a bill into the Manitoba Legislative Assembly.

Questions for CPSM

1. Can CPSM please confirm if the CEO/Registrar and governing council are in support of amendments to the MHA to authorize PAs and CI. As to complete medical examinations and Form 4 Applications for Psychiatric Assessment?

2. Can CPSM advise if there are any potential parameters or conditions for authorizing PAs and CI. As to complete Form 4 Applications for Psychiatric Assessments?

Questions for CPSM

3. Can CPSM advise if there are any standard(s) of practice for CPSM to authorize PAs and CI. As to complete Form 4s?

4. Could CPSM please elaborate on any other considerations?

5. How would any additional training for PAs and CI. As differ for those with experience in mental health settings versus those with less or no experience?

Questions for CPSM, CPP and SH

6. How many PAs and CI. As are currently registered in Manitoba?

7. How many PAs and CI. As are currently working in mental health settings in Manitoba?

8. Can you please provide a firm estimate of PAs and CI. As that are currently competent (with any additional training) to complete this work within the scope of their practice?

Questions for CPSM, CPP and SH

9. How many PAs and Cl. As would need additional training?

10. How many PAs and Cl. As are involved in completing Form 4s under the supervision of a physician now?

11. Any other overall thoughts or feedback?

Any questions?

Thank you!!

. . . .

Department of Housing, Addictions, and Homelessness (HAH)

Mental Health and Addictions Treatment and Recovery (MHATR) Branch

July 31, 2025

Manitoba

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August 14, 2025   ***SENT VIA EMAIL:*** **Caithlin.McArton@gov.mb.ca**

Ms. Caithlin McArton
Senior Policy Analyst | Mental Health and Addictions Treatment and Recovery
Housing, Addictions and Homelessness
4116 – 300 Carlton Street
Winnipeg, Manitoba R3B 3M9

Dear Ms. McArton,

Re: Legislative Proposal to Amend *The Mental Health Act*

Further to the Consultation Guide for the Legislative Proposal to Amend *The Mental Health Act* (MHA) below is the College of Physicians & Surgeons of Manitoba (CPSM) response to the questions posed. If you require further clarification, please do not hesitate to contact me.

1. **Can CPSM please confirm if the CEO/Registrar and governing council are in support of amendments to the MHA to authorize PAs and Cl.As to complete medical examinations and Form 4 Applications for Psychiatric Assessment?**

The Registrar & CEO of CPSM supports the concept of the proposed amendments as outlined in the answer to these questions. CPSM Council has not been apprised of the proposed amendments. Council's next meeting in which the amendments could be discussed is September 24, 2025.

2. **Can CPSM please advise if there are any potential parameters or conditions for authorizing PAs and Cl.As to complete Form 4 Applications for Psychiatric Assessments?**

Two fundamental parameters/conditions required for a Physician Assistant or a Clinical Assistant to complete Form 4 for Psychiatric Assessments are:

1. The Physician Assistant or Clinical Assistant is acting in the capacity of an extension of their supervising physician and are bound by their practice description and contract of supervision requirements. The Physician Assistant or a Clinical Assistant is not acting independently from their supervising physician when they complete the Form 4.

2. The Physician Assistant or Clinical Assistant has the appropriate knowledge, skill, and

judgement to properly complete the Form 4.

3. **Can CPSM please advise if there are any standard(s) of practice for CPSM to authorize PAs and Cl. As to complete Form 4s?**

There are no Standards of Practice specific for Physician Assistants or Clinical Assistants to authorize them to complete the Form 4.

4. **Could CPSM please elaborate on any other considerations?**

An elaboration of the points raised in the answer to question #2 is that both requirements are necessary for a Physician Assistant or Clinical Assistant to complete the Form 4. If the supervising physician does not have the necessary training to apply the criteria set out in *The Mental Health Act* to complete the Form 4, the Physician Assistant or Clinical Assistant are not permitted to do so even if they were otherwise competent to do so.

5. **How would any additional training differ for the PAs and Cl.As with experience in mental health settings versus those with less or no experience?**

Whether an individual is competent to apply the criteria set out in *The Mental Health Act* for completing the Form 4 is a question of fact. The assumption is that since no Physician Assistant or Clinical Assistant is currently completing the Form 4 that none currently have the necessary knowledge, skill, and judgement to do so. How much additional training a particular Physician Assistant or Clinical Assistant will need is based on their individual experience with *The Mental Health Act* requirements. It is a reasonable assumption that an individual working in mental health settings would require less training than a person working in a surgical environment.

6. **How many PAs and Cl.As are currently registered in Manitoba?**

As of July 30, 2025, there are 411 Physician Assistant or Clinical Assistant registered with CPSM.

7. **How many PAs and Cl.As are currently working in mental health settings in Manitoba?**

As of July 30, 2025, there are 25 Physician Assistants/Clinical Assistants registered with CPSM working in mental health settings in Manitoba. 14 are Physician Assistants and 11 are

Clinical Assistants. 24 work in the WRHA and 1 Clinical Assistant works in the NRHA.

8. **Can you please provide a firm estimate of PAs and Cl.As that are currently competent (with any additional training) to complete this work within the scope of their practice?**

As stated above, the assumption is that since no Physician Assistant or Clinical Assistant is currently completing the Form 4 that none currently have the necessary knowledge, skill, and judgement to do so. How much additional training a particular Physician Assistant or Clinical Assistant will require to become competent is based upon the individual's experience.

9. **How many PAs and Cl.As would need additional training?**

All the current Physician Assistants and Clinical Assistants will require additional training. The nature and scope of the training is dependent upon the individual's knowledge and experience.

10. **How many PAs and Cl.As are involved in completing Form 4s under the supervision of a physician now?**

It is assumed that all the current 25 Physician Assistants/Clinical Assistants registered with CPSM working in mental health settings in Manitoba are currently involved in varying degrees in the completion of Form 4s.

11. **Any other overall thoughts or feedback?**

No further thoughts or feedback.

Sincerely,
COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA
Per:

Ainslie J. Mihalchuk, MD
Registrar & CEO

AM/br

COUNCIL MEETING
MARCH 18, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Standard of Practice – Prescribing Opioids and Prescribing Benzodiazepines and Z-Drugs Working Group Update

BACKGROUND:

The Working Group met February 3, 2026, and confirmed membership and roles, reviewed project scope, objectives, and timelines.

The Working Group received presentations on the 2026 Opioid Atlas and Benzodiazepines prescribing. A request was made to Manitoba Health to provide DPIN history for certain medications prescribed by Manitoba prescribers to Manitoba patients within certain parameters. Once the information is received it will be collated and presented to the Working Group.

A jurisdictional scan was undertaken to determine how the various Medical Regulatory Authorities address prescribing Opioids and Benzodiazepines.

The first decision for the Working Group will be whether a Standard of Practice is required, if so, how is the document(s) to be formatted, and finally the content of the Standard(s).

The Working Group is also reviewing the Practice Direction – Rural, Remote and Underserved Populations: Access to Prescribed Medications. This is a joint practice statement of the Manitoba colleges of Licensed Practical Nurses, Pharmacists, Registered Nurses and Psychiatric Nurses and CPSM. The Working Group (which is comprised of representatives from CPhM) will review of the Practice Direction to determine if a wider review with the other colleges is warranted.

The timeline is dependent upon how quickly data is provided and analysed; however, it is anticipated that a draft standard(s) will be presented at the September Council meeting for approval to circulate for consultation.

The Working Group will meet again Tuesday, March 3, 2026.

For Information Briefing Note prepared by: Mr. Mike Triggs, General Counsel
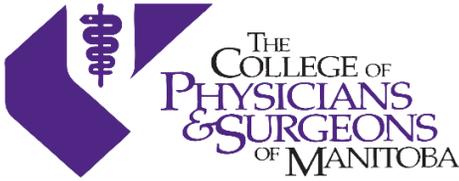
COUNCIL MEETING
MARCH 18, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Elections Committee Update

BACKGROUND:

On December 10, 2025, Council approved the appointment of Dr. Kevin Convery, Dr. Rizwan Manji and Mr. Neil Cohen to the Elections Committee for two annual election cycles. Council also directed the Executive Committee to add a female member to the Committee. On January 19, 2026, Executive Committee appointed Ms. Lynette Magnus to the Committee.

The Committee met January 28, 2026, and reviewed the Terms of Reference, the open Councillor positions, timelines and the required election materials. The Committee approved the *Call for Application; Application; Councillor Election Pamphlet; and the Call Letter* to be distributed to Registrants.

The Committee discussed its strategy for contacting organizations and key individuals to request names of potential candidates.

The next meeting is scheduled for March 12, 2026 to review and evaluate applicants. This work must be completed by March 24 to allow sufficient time for an appeal process prior to the Election Period beginning April 16.

The eligible positions on Council for election in 2026 are:

1 - Regulated Associate Registrant
2 -Rural Electoral District
1 - Winnipeg Electoral District

As of March 4 (12:20 PM), there are **16** Nominations received of the following:
7 - Regulated Associate Registrant
5 - Rural District
4 - Winnipeg District

For Information Briefing Note prepared by Mr. Mike Triggs, General Counsel

SUBJECT: Standard of Practice – Entering a New Practice Setting (IMG Working Group) Consultation

BACKGROUND

CPSM is recommending a new *Standard of Practice – Entering a New Practice Setting* be submitted for consultation.

Purpose of the Standard

The new *Standard of Practice – Entering a New Practice Setting* aims to ensure that registrants entering practice in Manitoba—whether newly licensed or transitioning from another jurisdiction—are effectively supported in their integration into the local clinical and community context.

The Standard seeks to:
- Promote safe, ethical, and effective medical practice during transitions into new practice settings.
- Clarify professional expectations for both *new* and *receiving* registrants.
- Reinforce the shared professional responsibility to create inclusive, respectful, and supportive practice environments that align with Manitoba's healthcare needs.
- Emphasize the profession's commitment to patient safety, cultural humility, inclusive professionalism, and ethical practice.

Rationale

Registrants entering practice in Manitoba bring diverse training, perspectives, and experience. Many also arrive with limited familiarity with local:
- systems of care
- clinical expectations
- community context
- administrative processes
- cultural norms and patient expectations

To ensure safe patient care and effective integration, CPSM recognizes the need for structured support, clear expectations, and shared accountability among all registrants, including those already established in Manitoba.

Reports from Internationally Trained Physicians (ITPs) highlight experiences of:
- professional bias or assumptions about competence

- systemic barriers
- conditional belonging
- reduced autonomy during provisional licensure

These findings reinforce the need for a Standard addressing inclusivity, cultural safety, mentorship, and system-level support.

Development of the Standard

The Standard was considered at multiple meetings of the IMG Working Group and was shaped by focus groups and a survey of the profession.

COMPONENTS OF THE STANDARD

1. Expectations for new registrants

The Standard clarifies responsibilities related to:
- Accountability within Manitoba's health system
- Communication expectations
- Professionalism, self-reflection, and openness to learning

2. Expectations for receiving (established) registrants

Receiving registrants are expected to:
- Provide structured orientation and mentorship
- Foster safe, inclusive, and supportive working environments
- Participate in maintaining professional standards
- Engage in collaborative, respectful team-based care
- Address discrimination, promote cultural humility, and confront incivility

3. Structured orientation & onboarding requirements

Practice settings must implement structured onboarding covering:
- Patient-centered care & cultural competence
- Indigenous health, anti-Indigenous racism, and trauma-informed practices-informed practices
- Team-based care expectations
- Local clinical systems, administrative processes, and documentation standards
- Communication norms and local medical colloquialisms
- Mentorship networks for new registrants adapting to the Manitoba context

4. Self-care & peer support

The Standard emphasizes:

- Shared responsibility for physician health and wellness
- Modelling healthy boundaries and promoting wellness resources
- Psychological safety and help-seeking behaviours

5. Equity, systemic safety & cultural humility

All registrants must:
- Treat colleagues with dignity and respect
- Call out discrimination
- Promote inclusion and belonging
- Understand and address systemic inequities experienced by ITPs and marginalized groups

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 18, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

Council authorized CPSM to seek input for 30 days from registrants, stakeholders, and the public on the draft Standard of Practice – Entering a New Practice.

Notice of Motion for Approval Briefing Note prepared by: Mr. Jeremy de Jong, Director of Registration and Innovation.

Standard of Practice
Entering Practice in Manitoba

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

Initial Approval:	Effective Date:

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the *Regulated Health Professions Act*, Regulations, and Bylaws. All members <u>must</u> comply with Standards of Practice of Medicine, per section 86 of the *Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of the *Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

This Standard outlines requirements for receiving registrants and incoming registrants who are transitioning into a new practice setting. It is intended to support patient safety and quality of care throughout the transition and to promote wellness and effective collaboration.

Please refer to the accompanying Contextual Information document for further guidance on interpreting this Standard.

Guiding Principles from the CMA Code of Ethics & Professionalism

- **Professional Excellence:** Contributing to knowledge, mentorship, teaching, system improvement.
- **Collegiality and Respect:** Cultivating respectful, collaborative relationships across the healthcare team.
- **Self-Care and Peer Support:** Fostering psychologically safe work environments and supporting colleagues in distress.
- **Physicians and Society:** Upholding system-wide efforts to improve access to equitable, culturally safe care.

Part 1: Building relationships when entering a new practice setting.

All registrants are expected to:

- Ensure a shared understanding of roles and responsibilities in the practice setting, including each health professional's scope of practice, limits, and accountabilities in delivering patient care;
- Foster mentorship, team collaboration and shared accountability for patient care,

recognizing that these are essential to safe patient care and professional growth;

- Promote a culture that is open and receptive to feedback, recognizing it is crucial that all registrants can speak up, seek help, and share concerns and advice with one another.

Receiving registrants are expected to:

- Support new colleagues by contributing to orientation, mentorship, and professional development activities that promote safe and competent practice;
- Be approachable and responsive and encourage registrants new to the practice setting to ask questions or request assistance;
- Only assign or expect colleagues to provide care or medical services that they are safe and competent to provide;
- Actively participate in maintaining the standards of the profession by ensuring that expectations are clearly communicated and modeled in practice.

A registrant entering a new practice must:

- Actively engage in orientation;
- Openly communicate with colleagues about training, experience, and any areas where extra support is needed;
- Work within limits and ask for help whenever unsure or facing a situation beyond the registrant's competence or privileges;
- Adapt practices to meet local standards as appropriate.

Part 2: Orientation is key to a safe landing in practice

Orientation to the practice setting is required:

- All practice settings are expected to develop structured onboarding and orientation programs for registrants new to the practice setting that is appropriate to the setting and the incoming registrant.
- Proportionate to their role and responsibilities, formal leaders in the practice setting who are registrants of CPSM are expected to take reasonable steps within their control to ensure this expectation is met.

Content of orientation:

- While appropriate domains of orientation will vary based on context, orientation should address:
  - **Patient-centred care and cultural competence.** This includes orientation about the local patient population and local culture, including Indigenous health needs,

rural populations, and patient expectations.

- o **Preventing anti-Indigenous racism.** This includes understanding the systemic racism experienced by Indigenous people and the concerted efforts required to create awareness and take meaningful steps to prevent anti-Indigenous racism.
- o **Workplace culture and team-based practice.** Registrants new to the practice setting may come from a system where things were done differently; so, adapting to a new reality may involve a learning curve. Orientation should consider differences in collaborative care requirements often exist between practice settings and jurisdictions.
- o **Communication.** Orientation should include topics of communication that emphasize local dialect, medical colloquialisms, and patient-centered dialogue.
- o **Practice administration.** Differences in administrative aspects of practice should be addressed, for example systems for maintaining patient records and billing.

Part 3: Commitment to self-care and peer support.

Registrant health and wellness.
- Registrant health and wellness is a shared responsibility that extends beyond the individual. Inclusion, cultural humility, and creating a psychologically safe space that supports wellness are important in practice, particularly during a stressful period of transitioning into a new practice setting, environment or community.
- In supporting registrants new to a practice setting, receiving registrants should model the commitment to self-care and peer support by respecting limits, encouraging healthy boundaries, and acknowledging – as applicable - the unique stressors that may accompany relocation, cultural adaptation, and entering a new practice.

As part of their professional obligations, all registrants are expected to:
- Demonstrate a commitment to personal health and wellness, recognizing that self-care and balance between personal and professional responsibilities are essential to sustainable practice.
- Value and promote a practice environment where all colleagues feel empowered to seek help and access support related to physical, mental, and social well-being.
- Encourage open dialogue, recognize signs of distress or burnout, normalize help-seeking behaviours, and engage with empathy and discretion when a colleague may be struggling.

Part 4: Workplace culture and professionalism

Commitment to professional excellence.

- A professional and collaborative workplace culture is crucial to maintaining ethical standards in practice. This enables registrants to enact core values such as respect, integrity, collaboration, and accountability, thereby fostering trust among colleagues and with patients and supporting the delivery of safe, quality care.

- Receiving registrants play a vital role in fostering a safe, inclusive, and supportive practice environment for registrants entering a new practice setting. Recognizing certain systemic biases that have existed in the medical profession, receiving registrants should take steps to promote inclusivity and belonging, including by involving new registrants in decision-making processes and leadership roles to foster a sense of professional integration.

All registrants must

- Treat their colleagues respectfully and with dignity and show cultural humility in interactions with colleagues;

- Call-out all forms of hostility and discrimination when observed in practice and take meaningful steps to address discriminatory acts and omissions;

- Support colleagues who have experienced harassment or discrimination from any source.

Related Standards of Practice:

- *Collaborative Care*
- *Non-Emergent Consultation Requests*
- *Emergent, Urgent and Inpatient Requests*

Related Resource:

- *Contextual Information – Entering a New Practice Setting.*

Contextual Information - Standard of Practice – Entering a New Practice Setting

Purpose and context for this Standard

Entering a new practice environment—whether as a newly licensed physician, an internationally trained physician (ITP/IMG), or a registrant transitioning between practice settings—creates significant shifts in clinical, cultural, administrative, and relational expectations. The Standard is intended to support safe integration, uphold patient safety, and foster professional success for both the new registrant and those already established in the practice setting.

The Standard is grounded in the recognition that new registrants often arrive with diverse training backgrounds and clinical strengths, but may have limited experience with the Manitoba or Canadian healthcare context, including differences in:
- systems of care,
- community expectations,
- documentation practices,
- communication norms,
- collaborative care models, and
- professional and cultural expectations.

Because of these differences, structured orientation, mentorship, and supportive workplace culture are critical components of safe and effective integration.

Relationship to the CMA Code of Ethics and Professionalism

This Standard is not a standalone document—it must be read in conjunction with the **CMA Code of Ethics and Professionalism**, which informs nearly every expectation.
Key ethical commitments relevant to entering a new practice setting include:
- Professional Excellence: contributing to knowledge, mentorship, teaching, system improvement.
- Collegiality and Respect: cultivating respectful, collaborative relationships across the healthcare team.
- Self-Care and Peer Support: fostering psychologically safe work environments and supporting colleagues in distress.
- Physicians and Society: upholding system-wide efforts to improve access to equitable, culturally safe care.

Additional interpretation for this Standard

- **Community of practice -** Means the collective professional environment in which registrants work together to deliver patient care. It includes formal structures (such as teams, clinics, and organizations) and informal professional relationships, and is characterized by shared accountability for patient safety, professional standards, learning, and mutual respect.

- **Cultural humility -** Is understood as an ongoing commitment to self-reflection, openness to learning, and recognition of the limits of one's own knowledge and experience. It includes respect for diverse cultural, educational, and professional backgrounds, and an awareness of systemic inequities that may affect colleagues and patients.

- **Inclusive professionalism -** Refers to professional behaviours that foster belonging, equity, and respect within the medical profession. This includes valuing diverse training pathways, addressing bias or discrimination, supporting psychological safety, and ensuring that all registrants can participate meaningfully in professional and clinical decision-making.

- **Shared responsibility -** Reflects the principle that successful integration into a new practice setting depends on both individual accountability and collective professional support. Registrants are expected to contribute, within their roles and influence, to environments that support learning, wellness, ethical practice, and continuous improvement.

Why orientation and onboarding are required

Information and data from surveys, focus groups, and the literature consistently show that the lack of structured orientation contributes to:
- patient safety risks,
- misunderstandings about roles and responsibilities,
- delayed integration into team-based practice,
- difficulty navigating local administrative processes,
- feelings of isolation, stigma, or exclusion among new registrants.

Orientation must therefore be:
- structured,
- proportionate to the setting and role,

- tailored to the individual's background and experience.

Key domains orientation should address include:
- patient-centred care and cultural competence,
- cultural safety and preventing anti-Indigenous racism,
- local patient population and community context,
- workplace culture and team-based practice expectations,
- communication norms, including colloquialisms and local dialect,
- EMR usage, documentation, billing, administrative workflows,
- understanding roles, limits of practice, and supervisory requirements.

Professional culture and expectations

Surveys of Manitoba registrants reveal that new physicians frequently encounter challenges such as:
- unclear role expectations,
- lack of mentorship and feedback,
- variability in team-based care norms,
- differing expectations around patient load, workflow, and interprofessional communication,
- cultural misunderstandings,
- difficulty accessing peer support.

These findings reinforce why the Standard emphasizes:
- building collaborative and respectful relationships,
- promoting a culture of constructive feedback and open communication,
- clarifying scopes of practice and responsibilities, and
- addressing discriminatory or exclusionary behaviours.

Receiving registrants have a duty to model professionalism and collegiality because new registrants often observe and absorb workplace culture through their interactions.

Cultural Safety and Equity

Evidence from working group consultations demonstrates that IMGs/ITPs frequently report:
- assumptions being made about their competence,
- exclusion from decision-making,
- a sense of conditional belonging when under provisional licenses, and
- exposure to bias or systemic inequities.

The Standard therefore calls for:
- cultural humility,
- inclusive decision-making,
- confronting incivility and discrimination,
- recognizing the impact of systemic bias, and
- integrating Indigenous-specific cultural safety principles into orientation.

Physician wellness and psychological safety

Transitions into new environments are periods of heightened stress.
The Standard emphasizes the shared responsibility of:
- modelling healthy boundaries,
- recognizing signs of distress or burnout,
- supporting colleagues in need,
- creating psychological safety for help-seeking.

How this Standard supports system-level goals

This Standard also aligns with system-wide objectives identified by CPSM's IMG Working Group, including:
- improving equitable access to care,
- strengthening physician retention,
- enhancing collaborative care,
- supporting the integration of internationally trained professionals,
- advancing reconciliation by addressing anti-Indigenous racism in care,
- promoting high-quality care across diverse settings.

Behaviours demonstrating meeting this Standard

Shared responsibility and community of practice
- Proactively welcoming a colleague who is new to the practice setting and ensuring they are introduced to team members, workflows, and informal norms of the workplace.
- Recognizing that supporting colleagues entering practice is a collective professional responsibility, not limited to formal supervisors or leaders.
- Participating constructively in team discussions that address integration, workload distribution, and patient safety during periods of transition.

Communication and role clarity
- Taking reasonable steps to communicate clearly about one's own scope of practice, training background, and limits, particularly when joining a new clinical team.
- Ensuring that roles and responsibilities within team-based care are discussed and understood, especially when working with colleagues from different jurisdictions or practice models.
- Seeking clarification when unfamiliar terminology, systems, or expectations arise, rather than making assumptions that could affect patient care.

Orientation, onboarding, and mentorship
- Participating in structured orientation or onboarding processes that address local clinical expectations, administrative systems, and community context.
- Supporting or contributing to mentorship, supervision, or peer-support arrangements that help new registrants integrate safely and effectively.
- Recognizing that orientation may be ongoing and engaging in continued learning about Manitoba's health system, patient populations, and professional norms.

Cultural humility and inclusive professionalism
- Demonstrating openness to learning from colleagues with different training pathways, cultural backgrounds, or professional experiences.
- Reflecting on one's own assumptions or biases and taking steps to ensure they do not affect collegial interactions or professional decision-making.
- Engaging colleagues entering practice in meaningful clinical, professional, or organizational discussions, rather than excluding them from decision-making processes.
- Many ITPs report experiencing professional bias or assumptions about their training or competence, which can often result in exclusion. They also report a sense of conditional belonging or lack of autonomy when under provisional licenses, which can affect morale. Following the above examples can mitigate this issue.

Respectful and psychologically safe practice environments
- Treating colleagues with dignity and respect, and addressing incivility or discriminatory behaviour when it arises, consistent with professional obligations.
- Fostering an environment in which colleagues feel safe to ask questions, raise concerns, or seek guidance without fear of reprisal or stigma.
- Responding to feedback—whether given or received—with openness, professionalism, and a commitment to learning.

Self-care and peer support
- Modelling healthy professional boundaries and acknowledging the personal and professional stressors that may accompany relocation or transition into a new practice setting.
- Encouraging colleagues to access available wellness, peer support, or professional resources when needed.
- Responding with empathy and discretion when a colleague appears to be experiencing distress or burnout, while recognizing shared responsibility for physician wellness.

Commitment to patient safety and quality of care
- Adjusting practice behaviours, supervision, or consultation patterns as needed during periods of transition to ensure patient safety is maintained.
- Participating in quality improvement, mentorship, or educational activities that support competence and confidence in new practice environments.
- Recognizing that safe integration of new registrants contributes to broader system sustainability and access to care.

Frequently asked questions

Q. As a new ITP, I'm sometimes unsure about local protocols or when to call for help. How should I handle this?

A. Always ask for help when you need it. Seeking guidance is a sign of responsibility. The Standard expects new registrants to recognize their limits and **speak up whenever patient care could be affected**. If you're unsure about a local procedure (for example, how to arrange an urgent referral or use a specific electronic tool) or you're facing a case beyond your comfort level, **proactively reach out** to a colleague. It's often best to ask early rather than struggle in silence – a quick question can prevent errors. To make this easier, many practices designate a mentor or "go-to" person; take advantage of that support. Also, prepare by learning the local protocols from orientation materials or manuals, but understand that it's normal to have questions even after reading them. Importantly, don't let fear of looking inexperienced stop you from voicing concerns. Your colleagues expect some questions and would much prefer you ask than make a harmful mistake. Over time, as you become familiar with the environment, you'll need less assistance. But even experienced registrants consult each other when in doubt – that's part of maintaining high-quality care.

Q. What if a new registrant's approach to care is different from our usual practices?

A. It's common for new colleagues to have different approaches, given their diverse training backgrounds. **Safety and quality come first**: if the new colleague's approach is clinically sound but just different, be open to it. Many variations (for example, a different medication choice that achieves the same result) can be accommodated in practice. In fact, you might learn something new or find a better way. However, if the approach conflicts with established local protocols or could pose a risk (perhaps due to resource differences or patient expectations), you should **discuss it openly**. Explain the local standard and the rationale behind it (e.g., "We do it this way here because our labs process tests differently" or "Our patients are used to this care pathway"). The new colleague should adapt to meet local standards, but the adaptation period is a two-way learning opportunity. Both parties should practice **cultural humility**: avoid dismissing something as "wrong" just because it's unfamiliar. Instead, evaluate whether it meets the patient's needs and fits the local context. Often, a hybrid approach or a small adjustment can incorporate the new idea without compromising care. The key is open communication—ensure the new registrant feels comfortable explaining their perspective, and likewise they should respect guidance from experienced colleagues. Over time, practice styles will harmonize as the new colleague gains understanding of local expectations and the team values the strengths their new colleague.

Q. How should I address disrespectful or biased behavior toward the new ITP in our team?

A. A respectful, inclusive workplace is essential. If you observe a colleague or staff member treating any team member in a disparaging or biased manner, it's important to act:

- **Address it early (if safe):** If someone makes an inappropriate remark about a colleague's background or abilities, speak up in a professional way. For example, a gentle correction like, "We don't judge skills by where someone trained; Dr. X is a valued member of our team," can set the tone.

- **Support colleagues:** Check in with your colleague privately afterward. Acknowledge what happened, reassure them of their value, and encourage them to report any future incidents. Knowing they have allies can make a big difference.

- **Document and report if needed:** If disrespect or harassment continues, document specific incidents (dates, what was said or done). Escalate as appropriate. CPSM can also provide guidance if the issue involves professional conduct. Remember that the standard – and the Code of Ethics – require confronting incivility and protecting colleagues from unfair treatment.

- **Model inclusive behavior:** Ensure **you** consistently treat the new registrant as an equal colleague. Involve them in discussions, introduce them to others, and give them credit

for their contributions. Often, setting a strong positive example will discourage others from acting negatively.

No one should be made to feel like a "second-class" team member. Disrespectful behaviour not only harms the registrant, it can also affect patient care by undermining team cohesion. By addressing issues promptly and decisively, you help create a culture where everyone can perform at their best.

Q. I'm new to practice and I feel overwhelmed by the workload and new environment. What should I do?

A. Feeling overwhelmed is not unusual during a big transition. The key is to recognize it and respond early:

- **Speak up:** Let colleagues know that you're struggling with the workload or certain tasks. This isn't complaining – it's about patient safety and your well-being. Together, you can find solutions, such as adjusting your schedule, getting more support for certain duties, or clarifying priorities.

- **Use available resources:** Tap into support systems. Many institutions have registrant wellness programs, mentorship groups, or even informal networks. Connecting with peers who have gone through similar transitions can provide practical tips and moral support. CPSM and other organizations can also direct you to resources for stress management or counseling if needed.

- **Set boundaries and self-care:** While you may be eager to prove yourself, remember that medicine is a team sport. Take breaks, ensure you're eating and resting, and don't hesitate to say "no" to additional non-mandatory responsibilities until you've found your footing. It's better to do a solid job with a slightly reduced load than to risk burnout by taking on too much.

- **Remember it gets better:** Almost every registrant has felt the steep learning curve of a new position. With each week, you will become more efficient and more comfortable in the system. If you've communicated openly and sought help, you'll find that colleagues will rally to assist you. Over time, as you gain confidence, the sense of overwhelm should lessen. However, if you continue to feel overburdened despite these steps, consider reaching out to CPSM or a professional support service for guidance – sometimes there may be systemic issues that need addressing in your practice setting.

Resource guide

[Under development with external partners]

COUNCIL MEETING
MARCH 18, 2026
NOTICE OF MOTION FOR APPROVAL BRIEFING NOTE

SUBJECT: 2026-2027 CPSM Budget & Certificate of Practice Fees

BACKGROUND:

The 2026-27 budget was presented to the Finance Audit and Risk Management Committee (FARMC) on February 25, 2026 for approval. Management recommended an increase to the fees described in the Fee Bylaw equal to the Manitoba consumer price index (cost of living -COLA) – which is currently estimated to be 2%. CPSM is projecting a surplus for the 2026-27 budget year of approximately **$550,000** (please see below for information that impacts the projected surplus). Key documents prepared for FARMC have been included in the Executive Committee package for your information.

- Operating Budget and Certificate of Practice Fees - 2026-27 *(13.0 Appendix A)*
- Program Growth - CPSM Staffing Review **(13.0 *Appendix B*)**

FAMRC is tasked as per their terms of reference to review the appropriateness of the rates and amounts of honoraria and stipends to be paid by CPSM. FARMC reviewed the background detail, which can be found in Appendix A, and approved the increase of honorariums from $150-$160, stipends to be increased by 5% and the inclusion of preparation time for the Investigation and Inquiry Committees (2 hours maximum). The budget presented to FARMC (*see 13.1 NOM BN*) did not take these impacts into account. An updated budget has been appended to this briefing note which indicates a revised anticipated surplus of **$484,000** for the 2026-27 fiscal year. The impacts related to these increases does not alter the recommendation to limit the fee increases to inflation.

Council approval is not required for the 2026-27 budget as the increase to the fees listed in the Fee Bylaw will be limited to the estimated Manitoba consumer price index. The revised Financial Management Policy (*see 13.1 Appendix A*) has been amended as per the direction of FARMC and does require approval from Council.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 18, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves the 2026/27 annual operating budget as presented.

2026-27 Budget

(Expenses by function)

College of Physicians & Surgeons of Manitoba
Budget Statement of Operations
FY's 2026-27 to 2028-29

	2026-27 Budget	2027-28 Estimate	2028-29 Estimate
Revenues			
Physician & Resident License Fees	9,573,730	9,897,883	10,392,541
Educational Register Fees	109,901	116,412	118,752
Clinical Assistant License Fees	181,382	178,224	204,071
Physician Assistant License Fees	88,508	87,284	89,122
Medical Corporation Fees	734,226	751,780	787,147
Other Fees and Income	854,621	854,621	854,621
Interest Income	135,376	134,177	141,262
Change In Market Value	204,777	204,777	204,777
	11,882,522	12,225,157	12,792,294
Expenses			
Governance	233,374	234,708	236,068
Registration	741,573	756,608	792,840
Complaints and Investigations	2,264,450	2,358,434	2,448,435
Quality	3,144,661	3,258,189	3,365,954
Operations and General Administration	3,893,419	4,000,006	4,077,553
IT	1,225,006	1,224,945	1,232,256
	11,502,484	11,832,889	12,153,105
Other Item			
Government Funded Programs	104,557	100,358	103,352
Excess (Deficiency) of Revenue Over Expenditures	484,595	492,626	742,541

(Expenses by nature)

College of Physicians & Surgeons of Manitoba
Budget Statement of Operations
FY's 2026-27 to 2028-29

	2026-27 Budget	2027-28 Estimate	2028-29 Estimate
Revenues			
Physician & Resident License Fees	9,573,730	9,897,883	10,392,541
Educational Register Fees	109,901	116,412	118,752
Clinical Assistant License Fees	181,382	178,224	204,071
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Medical Corporation Fees	734,226	751,780	787,147
Other Fees and Income	854,621	854,621	854,621
Interest Income	135,376	134,177	141,262
Change In Market Value	204,777	204,777	204,777
	11,882,522	**12,225,157**	**12,792,294**
Expenses			
Employee Costs	8,519,444	8,854,068	9,161,064
Staff Travel	191,228	190,354	194,161
Committee Meetings	372,334	372,969	373,616
Professional Fees	565,797	568,493	572,964
Service Fees	364,825	371,078	377,456
Building & Occupancy Costs	549,941	563,704	570,666
Office Expenses	757,212	757,197	775,138
Capital Assets	171,704	145,026	118,040
	11,502,484	**11,832,889**	**12,153,105**
Other Item			
Government Funded Programs	104,557	100,358	103,352
Excess (Deficiency) of Revenue Over Expenditures	484,595	492,626	742,541

Key parameters used in the 2026-27 Budget process:

Revenues

○ Inflationary increase of 2% for 2026-27 based on actual CPI statistics. Inflationary increase of 2% for 2027-28 and 2028-29 based on federal target.

○ Yearly net increase of 114 in MMR membership base according to the average growth in the last 3 years per the annual report.

○ Conservative expectation of 4% return on investments.

Expenses

○ Salaries
  ▪ 2% COLA in the next 3 years based on forecasted CPI statistics.
  ▪ Overall growth of 1.8 FTE in 2026-27 including 1.6 FTE in Manitoba Quality Assurance Program.

○ Staff Travel
  ▪ Restorative Practices Program to start operating fully next year as conceptualized after initially focusing on setting up the new program. Travel activities associated with its outreach program are expected to ramp up accordingly.

○ Committee Meetings
  ▪ Honoraria rates increased based on an hourly rate increase from $150 to $160.
  ▪ Accommodation of preparation time up to 2 hours for Investigation and Inquiry meetings.

○ Inquiry Costs
  ▪ Assumed as breakeven events with a contingency reserve of $288,000.

○ Other expenses such as Professional Fees, Building & Occupancy, and Office Expenses were generally kept at prior year levels, adjusted for inflation.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA
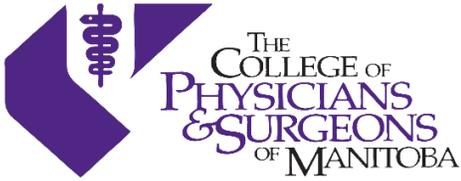
FINANCE AUDIT AND RISK MANAGEMENT
MEETING
FEBRUARY 25, 2026
BRIEFING NOTE – FOR DECISION

SUBJECT: Operating Budget and Certificate of Practice Fees - 2026-27

BACKGROUND

CPSM is projecting a surplus in the 2026-27 budget year of approximately $550,000. Below are the assumptions for the 2026-27 fiscal year.

- CPC fees will continue to be a source of revenue for 2026-27 - $120,000. This was previously thought to be discontinued in 2026-27.

- Bill payment option related to the payment of certificate of practice for 2026-27 is estimated to be around 10%, providing only minimal savings from credit card fees.

- Council, Committee and working groups costs are expected to increase by up to $60,000 in 2026-27. This includes adding all-day Council meetings, an increase in committees/working groups.

- Revenues are assuming an increase of 114 registrants in 2026-27

- CPSM will continue to treat inquiries as break-even events.

- Investments are conservatively estimated to provide a 4-6% return annually

The 2026-27 budget and projections to 2028-29 are included in **Appendix A** below.

Options
1. Apply cost of living increase to the certificate of practice fee (estimated to be 2%). This option would build CPSM's reserve to 100% in approximately 8 years.

2. Hold certificate of practice fees at 2025-26 rates. The impact of this option is the increased number of years estimated for CPSM to meet it's reserves target of 100% (13 years).

Full details of these options and impact on projected reserves can be found in Appendix C.

2026-27 Fee Recommendation
Management is recommending a cost of living increase (COLA) be applied to the certificate of practice fees effective November 1, 2026. The recommendation is assuming some or all of the budget items detailed in the "Additional Items for Consideration" are included in the 2026-27 expenses. Currently

13.0 Appendix A Operating Budget and Fees 2025-26

management is estimating COLA to be 2%. Based on the current Fee Bylaw, Council approval is not required to implement a fee increase limited to COLA.

CPSM will be able to meet its operating needs as well as continue to incrementally build it's reserves to the 100% target. The current estimate has CPSM reaching its reserve target by 2035-36.

A funding analysis summary for 2026-27 to 2028-29 (Appendix A), Certificate of Practice Fee comparisons (Appendix B) and CPSM Reserve estimates, Reserve Comparison to other MRA's (Appendix C) are shown in the appendices that follow the briefing note.

Additional Items for Consideration

Items for the Committee to consider that are not included in the 2026-27 budget are,
1. Increase in honorariums
2. Increase in Council position stipends
3. Council and Committee preparation time
4. Prescribing Practice Program Medical Consultant – 0.4 EFT

An analysis of each topic area and projected impacts is shown below.

Honorarium – Typically CPSM reviews and potentially adjusts honorarium rates every two years. The chart below details honorarium rates paid in the MRA's. For each $5 increase in the honorarium rate expenses increase by approximately **$20,000.** Currently CPSM is below the average by approximately $15.

		Average	Min	Max	Median
Honoraria	Hourly	$ 164.67	$ 100.00	$ 215.00	$ 160.00
	Full day	$1,203.17	$ 1,000.00	$1,500.00	$1,190.00
	Chair				

	Hourly	Daily Max	Chair
BC	$ 191.00	$1,339.00	NA
Alb	$ 160.00	$1,280.00	170/hour
Sask	$ 160.00	no max	NA
MB*	$ 150.00	$1,100.00	$70/meeting
ON	$ 196.00	no max	NA
Quebec	?	?	?
NB	$ 215.00	$1,500.00	$285/hour
NL	$ 100.00	$1,000.00	NA
NS	$ 185.00	no max	NA
PEI	$ 125.00	$1,000.00	NA

13.0 Appendix A Operating Budget and Fees 2025-26

Council Stipends

Similar to honorarium rates, CPSM reviews the stipends paid to Council members every two years. The rate paid to the President, President Elect and Investigations chair has not changed in a number of years (2019). The chart below details the stipend paid by each MRA for the Council President role. CPSM seems to be the only MRA will additional roles on Council receiving stipends.

Current Stipends

President -	$12,500
President Elect -	$5,000
Investigation Chair -	$10,000
Investigation Vic-Chair -	$6,000

In addition to the stipend, the positions are also provided with a zero charge for their annual certificate of practice fee which is equivalent to $2,480 for 2025-26.

MRA	President Stipend	Additional Information
CPSBC	$ 35,000	in addition to honoraria for regular scheduled meetings
CPSA	$ 24,480	in addition to honoraria for regular scheduled meetings
CPSS	$ 6,500	in addition to honoraria for regular scheduled meetings
CPSM	$ 12,500	in addition to honoraria for regular scheduled meetings + annual certificate of practice fee (total $14,980 excluding meeting honoraria)
CPSO	amount not provided	
CPSQue	amount not provided	
CPSNB	no stipend provided	
CPSNL	$ 5,000	in addition to honoraria for regular scheduled meetings
CPSNS	$ 20,000	in addition to honoraria for regular scheduled meetings
CPSNPEI	hourly rate while working on College matters (honorariam rate of $100/hour)	

Average	Min	Max	Median
$17,246.67	$5,000.00	$35,000.00	$16,250.00

Council & Committee Preparation Time

Two CPSM committees currently allow for preparation time; Complaints Committee (2 hours max per meeting), and Inquiry Committee (no maximum preparation time). With the dissolution of the Complaints Committee, the request to add 2 hours of preparation time to the Investigations Committee is under consideration. A comparison of to other MRA's are shown below.

Province	Preparation Time Details	Hourly Rate
Sask	Council meetings – 1 hour prep time for every meeting Exec Committee – max of 4 hours Quality of Care Advisory Cmttee - max of 10 hours combined for meeting time and prep time	$160/hour for physicians & $128 for public members (no max)
BC	no	$191/hour ($1,339 max day)

13.0 Appendix A Operating Budget and Fees 2025-26

Alberta	Not typical – allowed for in exceptional circumstances	$160/hour ($1,280 max/day)
MB	Complaints – max 2 hours Inquiry – no maximum	$150/hour ($1,100 max/day)
Ontario	Prep time is allowed, amount of prep time should not exceed 50% of the meeting time	$196 (no max)
NB	Hourly rate compensates for required prep time	All day meetings - $1,500
NL	Council meetings are 5 hours but paid @ 8 hours, Committee meetings are 2 hours and paid @ 4 hours	$100/hour ($1,000 max)
NS	Limited to Chairs of Council and Committees – max 2 hours per meeting	$185/hour (no max)
PEI	no	$125/hour ($1,000 max/day)

While no clear pattern exists when examining the preparation time landscape across the MRA's, the expansion of preparation time for other committees in conjunction with the potential increase in honorariums should be considered when examining the impact on expenditures. Adding preparation time to the existing Council and Committees at the existing honorarium rates is estimated at $50,000 for each hour of preparation time added (assuming the honorarium rate does not change). The analysis does not take into account working groups of the College.

Prescribing Practices Program

A temporary position (0.4 EFT) – medical consultant – was hired into the Prescribing Practices Program in January 2026 to focus on reviewing cases in the High-Dose Morphine Milligram Equivalent (MME) area. The position is scheduled to conclude April 30, 2026. Continuing the position into 2026-27 would impact the budget by approximately **$112,000**.

Impact Summary

Impact Area	Description	Budget Impact
Honorariums	$5 increase – $15 increase	$20,000 - $60,000
Council Stipends	5% Increase	$2,480
Preparation Time	1 hour	$50,000
Medical Consultant – PPP	0.4 EFT	$112,000
Total		**$184,480 - $224,480**

Prepared by: Paul Penner & Johnvee Calaguian

13.0 Appendix A Operating Budget and Fees 2025-26

13.0 Appendix A Operating Budget and Fees 2025-26

APPENDIX A – 2026-27 Budget with Projections to 2028-29
Function Summary

College of Physicians & Surgeons of Manitoba
Budget Statement of Operations
FY's 2026-27 to 2028-29

	2024-25 Actual	2025-26 Forecast	2026-27 Budget	Increase/ (Decrease)	%	2027-28 Estimate	%	2028-29 Estimate	%
Revenues									
Physician & Resident License Fees	8,088,036	8,944,251	9,573,730	629,479	7%	9,897,883	3%	10,392,541	5%
Educational Register Fees	103,476	104,439	109,901	5,462	5%	116,412	6%	118,752	2%
Clinical Assistant License Fees	105,085	146,261	181,382	35,121	19%	178,224	-2%	204,071	15%
Physician Assistant License Fees	74,597	78,797	88,508	9,711	11%	87,284	-1%	89,122	2%
Medical Corporation Fees	595,010	694,438	734,226	39,788	5%	751,780	2%	787,147	5%
Other Fees and Income	977,425	865,364	854,621	(10,744)	-1%	854,621	0%	854,621	0%
Interest Income	246,315	151,590	135,324	(16,266)	-12%	134,188	-1%	141,248	5%
Change In Market Value	212,325	396,769	204,777	(191,992)	-94%	204,777	0%	204,777	0%
	10,402,269	11,381,910	11,882,470	500,560	4.2%	12,225,169	2.9%	12,792,279	4.6%
Expenses									
Governance	143,475	139,522	222,849	83,327	37%	224,183	1%	225,543	1%
Registration	707,269	808,201	740,243	(67,957)	-9%	755,278	2%	791,510	5%
Complaints and Investigations	2,219,599	2,093,332	2,237,690	144,358	6%	2,331,674	4%	2,421,675	4%
Quality	2,208,141	2,735,122	3,124,528	389,406	12%	3,238,055	4%	3,345,820	3%
Operations and General Administration	3,322,854	3,530,559	3,887,841	357,283	9%	3,994,428	3%	4,071,976	2%
IT	1,145,546	1,268,144	1,225,006	(43,137)	-4%	1,224,945	0%	1,232,256	1%
	9,746,883	10,574,878	11,438,158	863,280	7.5%	11,768,563	2.9%	12,088,780	2.7%
Other Items									
Government Funded Programs	89,368	94,710	104,319	9,610	9.2%	100,226	-3.9%	103,220	3.0%
Inquiry - net	10,467	25,872	-	(25,872)		-		-	
	99,835	120,581	104,319	(16,262)	-15.6%	100,226	-3.9%	103,220	3.0%
Excess (Deficiency) of Revenue Over Expenditures	755,220	927,613	548,631	(378,982)	-69%	556,831	1%	806,720	45%

13.0 Appendix A Operating Budget and Fees 2025-26

Nature of Expense Summary

	College of Physicians & Surgeons of Manitoba								
	Budget Statement of Operations								
	FY's 2026-27 to 2028-29								
	2024-25	**2025-26**	**2026-27**	**Increase/**			**2027-28**		**2028-29**	
	Actual	**Forecast**	**Budget**	**(Decrease)**	**%**		**Estimate**	**%**	**Estimate**	**%**
Revenues										
Physician & Resident License Fees	8,088,036	8,944,251	9,573,730	629,479	7%		9,897,883	3%	10,392,541	5%
Educational Register Fees	103,476	104,439	109,901	5,462	5%		116,412	6%	118,752	2%
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Change In Market Value	212,325	396,769	204,777	(191,992)	-94%		204,777	0%	204,777	0%
	10,402,269	11,381,910	11,882,470	500,560	4.2%		12,225,169	2.9%	12,792,279	4.6%
Expenses										
Employee Costs	7,211,143	7,620,798	8,515,756	894,958	11%		8,850,380	4%	9,157,376	3%
Staff Travel	85,838	117,120	191,228	74,108	39%		190,354	0%	194,161	2%
Committee Meetings	249,571	266,145	328,131	61,986	19%		328,766	0%	329,413	0%
Professional Fees	494,625	731,461	549,362	(182,099)	-33%		552,058	0%	556,529	1%
Service Fees	281,238	378,492	364,825	(13,667)	-4%		371,078	2%	377,456	2%
Legal	21,448	5,575	10,000	4,425	44%		10,000	0%	10,000	0%
Building & Occupancy Costs	542,205	539,214	549,941	10,727	2%		563,704	3%	570,666	1%
Office Expenses	698,675	691,792	757,212	65,420	9%		757,197	0%	775,138	2%
Capital Assets	162,140	224,283	171,704	(52,579)	-31%		145,026	-16%	118,040	-19%
	9,746,883	10,574,878	11,438,158	863,280	7.5%		11,768,563	2.9%	12,088,780	2.7%
Other Items										
Government Funded Programs	89,368	94,710	104,319	9,610	9.2%		100,226	-3.9%	103,220	3.0%
Inquiry - net	10,467	25,872	-	(25,872)			-		-	
	99,835	120,581	104,319	(16,262)	-15.6%		100,226	-3.9%	103,220	3.0%
Excess (Deficiency) of Revenue										
Over Expenditures	755,220	927,613	548,631	(378,982)	-69%		556,831	1%	806,720	45%

13.0 Appendix A Operating Budget and Fees 2025-26

APPENDIX B – Annual Certificate of Practice Fee (Renewal)

Current

2025

Fee	Class	BC	Alb	Sask	MB*	ON	Quebec	NB	NL	PEI	NS
Annual Renewal "Fee"	Full Registrants (Physicians)	$ 1,900	$ 2,000	$ 2,170	$ 2,480	$ 1,725	$ 1,930	$ 2,300	$ 2,300	$ 2,300	$ 2,300
Annual Renewal "Fee"	Physician Assistants	$ 800	$ 500	$ 475	$ 483	$ 425	na	$ 400	na	$ 500	$ 400
Annual Renewal "Fee"	Medical Corporations	$ 135	$ 200	$ 250	$ 241	$ 175	$ 100	$ 300	$ 300	$ 250	$ 100

*indicates the rate of Nov 1, 2025 to Oct 31, 2026.

Class	Average	High	Low	Median
Full Registrants (Physicians)	$ 2,141	$ 2,480	$ 1,725	$ 2,235
Physician Assistants	$ 498	$ 800	$ 400	$ 479
Medical Corporations	$ 205	$ 300	$ 100	$ 221

2026

Fee	Class	BC	Alb	Sask	MB*	ON**	Quebec**	NB	NL	PEI	NS
Annual Renewal "Fee"	Full Registrants (Physicians)	$ 1,925	$ 2,000	$ 2,270	$ 2,530	$ 1,725	$ 1,930	$ 2,300	$ 2,300	$ 2,300	$ 2,300
	% Increase from 2025	1%	0%	5%	2%	0%	0%	0%	0%	0%	0%
	Physician Assistants	$ 800	$ 550	$ 475	$ 493	$ 425		$ 400	na	$ 500	$ 400
	% Increase from 2025	0%	10%	0%	2%	0%	na	0%		0%	0%
	Medical Corporations	$ 135	$ 200	$ 300	$ 246	$ 175	$ 100	$ 300	$ 300	$ 250	$ 100
	% Increase from 2025	0%	0%	20%	2%	0%	0%	0%	0%	0%	0%

*indicates the anticipated rate as of Nov 1, 2026 to Oct 31, 2027.

**Rates for Ontario and Quebec for 2026 not available- 2025 rates shown.

Class	Average	High	Low	Median
Full Registrants (Physicians)	$ 2,158	$ 2,530	$ 1,725	$ 2,285
Physician Assistants	$ 505	$ 800	$ 400	$ 484
Medical Corporations	$ 211	$ 300	$ 100	$ 223

13.0 Appendix A Operating Budget and Fees 2025-26

APPENDIX C – Reserve Comparison and CPSM Reserve Growth Projections

The chart below is the analysis of 6 MRA's and their current ratio of reserves to operating expenses and how this compares with CPSM's 2024-25 reserve to operating expense %. This also relates to investments and investment income generation.

MRA's
Reserves as percentage of annual opex
(Based on most recent AFS)

MRA	Reserves	Annual Opex	Reserves over Opex
		(In thousand)	
CPSM	7,141	9,803	73%
CPSS	12,743	9,118	140%
CPSNS	6,691	7,755	86%
CPSNL	6,102	3,945	155%
CPSA	49,002	37,427	131%
CPSBC	66,050	41,016	161%
CPSO	89,741	85,751	105%

13.0 Appendix A Operating Budget and Fees 2025-26

Inflation increase as mandated

FY	Status	Reserves	Core Expenses	Reserves as % of Expenses	Net Surplus	Growth in Core Exp.
2024-25	Actual	7,141,331	9,746,883	73%		
2025-26	Forecast	8,068,944	10,574,878	76%	927,613	827,995
2026-27	Budget	8,617,575	11,438,158	75%	548,631	863,280
2027-28	Estimate	9,174,406	11,768,563	78%	556,831	330,405
2028-29	Estimate	9,981,126	12,088,780	83%	806,720	320,216
Year 4		10,787,846	12,408,996	87%	806,720	320,216
Year 5		11,594,566	12,729,212	91%	806,720	320,216
Year 6		12,401,286	13,049,429	95%	806,720	320,216
Year 7		13,208,006	13,369,645	99%	806,720	320,216
Year 8		14,014,726	13,689,862	102%	806,720	320,216

Inflation increase waived in **2026-27** *(Note 1)*

FY	Status	Reserves	Core Expenses	Reserves as % of Expenses	Net Surplus	Growth in Core Exp.
2024-25	Actual	7,141,331	9,746,883	73%		
2025-26	Forecast	8,068,944	10,574,878	76%	927,613	827,995
2026-27	Budget	8,514,592	11,438,158	74%	445,648	863,280
2027-28	Estimate	8,864,203	11,768,563	75%	349,611	330,405
2028-29	Estimate	9,451,911	12,088,780	78%	587,708	320,216
Year 4		10,039,618	12,408,996	81%	587,708	320,216
Year 5		10,627,326	12,729,212	83%	587,708	320,216
Year 6		11,215,033	13,049,429	86%	587,708	320,216
Year 7		11,802,741	13,369,645	88%	587,708	320,216
Year 8		12,390,449	13,689,862	91%	587,708	320,216
Year 9		12,978,156	14,010,078	93%	587,708	320,216
Year 10		13,565,864	14,330,294	95%	587,708	320,216
Year 11		14,153,571	14,650,511	97%	587,708	320,216
Year 12		14,741,279	14,970,727	98%	587,708	320,216
Year 13		15,328,986	15,290,944	100%	587,708	320,216

FINANCE AUDIT AND RISK MANAGEMENT MEETING
FEBRUARY 25, 2026
BRIEFING NOTE – FOR INFORMATION

SUBJECT: CPSM EFT and Program Growth

BACKGROUND:

The information below highlights the staffing changes/investments CPSM has made as well as the planned staffing investments for 2026-27.

CPSM Staffing Changes

EFT* Breakdown by Cost Centre

Fiscal Years

Department	2020-21	2021-22	2022-23	2023-24	2024-25**	2025-26	2026-27	Change
Complaints	9.2	9.6	10.6	12.4	12.00	12.70	12.70	**0.00**
Corporate	8	8	7	8.6	9.6	10.6	10.6	**0.00**
Finance	2	2	2	2	2	2	2	**0.00**
IT	2.6	4	5	5	5	5	5	**0.00**
MANQAP	5	4	4	4.6	6.8	5.4	7	**1.60**
Quality	9.5	10.1	11.5	12.5	12.4	14.6	14.8	**0.20**
Registration	7	7	7	7	6	6	6	**0.00**
TOTAL	**43.3**	**46.3**	**47.1**	**52.1**	**53.8**	**56.30**	**58.1**	**1.8**

*Casual staff and short term contracts not included in the numbers above

**2024-25 - CPSM added 2.3 EFT to create the Restorative Practices Program

2025/26-2026/27

Quality	Medical Consultant (PPP)**	-0.4	(term position expires May 1, 2026)
	Medical Consultant (Quality)	0.6	Position split between QA/QI & Registration
	MANQAP	1.6	Assistant Inspector (.6 Eft is due to a return from LOA)
	Total	**1.8**	

The positions indicated in the Manitoba Quality Assurance Program (MANQAP) are all within the funding approval of the government funding CPSM receives annually to support accreditation services.

To provide additional context with respect to how CPSM compares to our medical regulatory counterparts, the chart below analyzes the ratio of staff to the number of full physician registrants. CPSM is highlighted in green. Not all medical regulatory authorities are reporting their numbers however there is a good comparison with respect to CPSSK and CPSNS due to their relative size and physician registration complement.

13.0 Appendix B FARMC For INFORMATION BN – CPSM EFT and Program Growth

Staffing to Physician Registrant Ratio

Year   2025

MRA	Full License	EFT	Registrants /EFT	
BC	16,900	220	76.82	(figures as of Feb 2026
AB	12,123	178.1	68.07	
SK	2,703	45.3	59.67	
MB*	**3,444**	**56.3**	**61.17**	
ON	not reporting			
QC	not reporting			
NB	2,281	56	40.73	
NS	3,081	47.9	64.32	
PEI		4	-	
NL	1,742	15	116.13	

*full license numbers from end of Jan 2026 - only physicians,
EFT includes individuals on Leaves of absence

CPSM compares well to MRA's of similar size. If physician assistants and clinical assistants are included, the ratio for CPSM increases to 68.31 registrants per EFT. With the addition of 1.8 EFT in staffing and an estimated increase of 114 physician registrants, CPSM would have a projected Registrant to EFT ratio of 61.24 or 68.16 if Physician Assistants and Clinical Assistants are included.

2026-27 Planned Program Changes:
The Quality department has observed an increase in new referred cases that require medical consultant engagement in addition to the increases of existing program work driven by increasing Registrant numbers. Many of these include complex cases that require extensive monitoring. Recent metrics from the Quality department indicate variances from the target that are attributable to these impacts. This is the core reason behind hiring increased medical consultant services in the Quality Department.

BUDGET CONSIDERATIONS:
Budget impacts associated with the annualizations of new staff added in 2026-27 are reflected in the proposed budget. The projected year end positive variance is expected to continue to incrementally improve CPSM's reserve position without requiring additional increases in Registrant fees beyond inflation impacts.

PREPARED BY: Paul Penner, CFO

SUBJECT: Annual Review of Financial Management Policy

BACKGROUND:

The Financial Management Policy must be reviewed annually by Council with recommendations from the Finance Audit and Risk Management Committee as per the Committee's terms of reference

> **4.9.3** *Responsibilities*
>> **4.9.3.a.i.V**. *Review the appropriateness of the rates and amounts of honoraria and stipends to be paid by CPSM.*

RECOMMENDATIONS:

The Finance Audit and Risk Management Committee (FARMC) is recommending increases to honorariums and Council stipends. In addition, FARMC is recommending the formal adoption of preparation time for two committees: Investigation Committee and Inquiry Committee. The recommendation with respect to preparation time is to allow for up to a maximum of 2 hours paid preparation time for these committees due to the significant length of the material and complex nature of these committees.

A) *2.8* - Honoraria and Stipends are recommended to increase. Honoraria would increase from $150/hour to $160/hour as well as a adjustment for the stipends provided to the President, President-Elect, the Investigation Chair and the Investigations Vice-Chair. Stipends have been held static since 2019.

Honoraria	Current	Proposed
Hourly	$150	$160
½ Day	$550	$600
Full-Day	$1,100	$1,200
Evening	$190	$200
Chair	$70	$80

Stipends	Current	Proposed (5% adjustment)
President	$12,500	$13,125
President-Elect	$5,000	$5,250
Investigation Chair	$10,000	$10,500
Investigations Vice-Chair	$6,000	$6,300

D) Include under *2.8* a section describing preparation time:

> **2.8.1.** Preparation Time
> Investigations Committee - eligible for $160/hour for up to a maximum of 2 hours of

preparation time per committee meeting

Inquiry Committee - eligible for $160/hour for up to a maximum of 2 hours of preparation time per inquiry meeting.

Preparation time beyond 2 hours must be pre-approved by the chair of the Committee and is only to be approved in exceptional circumstances.

The updated Financial Management Policy is found in ==*Appendix A*.== All proposed changes are tracked and shown in red.

BUDGET CONSIDERATION:
The total budget impact associated with the honoraria, stipends and preparation time is estimated to be $66,000 before factoring in Inquiry Committee meetings. At this point CPSM Management does not have an accurate estimate on the number of Inquiry Committee meetings expected to take place.

Budgetary impacts above have been accounted for and will not impact the certificate of practice fees increase beyond the automatic increase equal to the Manitoba Consumer Price index to cover inflationary costs (taken from the CPSM Fee Bylaw). The information below highlights the staffing changes/investments CPSM has made as well as the planned staffing investments for 2026-27.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 18, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves the recommended amendments to the Financial Management Policy.

Notice of Motion for Approval Briefing Note prepared by: Mr. Paul Penner, Chief Financial Officer

COUNCIL POLICY **Financial Management**	

Initial Approval: November 22, 2018	**Effective Date:** January 1, 2019
Reviewed with No Changes June 19, 2020	**Reviewed with Changes** June 21, 2019, December 8, 2021 June 22, 2022, June 28, 2023 June 26, 2024, June 25, 2025 September 24, 2025, May 1 ,2026

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FINANCIAL MATTERS

Auditor

1.1. At each annual meeting of the registrants, a registrant of, or a firm licensed by the Chartered Professional Accountants of Manitoba, must be appointed as auditor.

Office

1.2. The office of CPSM shall be at such place in Manitoba as the Council from time to time determines.

Fiscal year

1.3. The fiscal year of CPSM commences on May 1 and ends on April 30 of the following year.

Contracts

1.4. All deeds, contracts and agreements entered into on behalf of CPSM   shall be in form and content approved and signed by one of the President, President Elect or Past President and by one of the Registrar or an Assistant Registrar, except that the following may be approved and signed by the Registrar alone or in the Registrar's absence, an Assistant Registrar:
- 1.4.1. Employment contracts (other than the Registrar's contract which shall be approved and signed by the President);
- 1.4.2. Contracts or agreements for the provision of services by an individual or a medical corporation;
- 1.4.3. Contracts, agreements, memoranda with no financial commitment; and
- 1.4.4. Agreements or contracts, other than in (a) or (b) above, where the total financial commitment over the term of the agreement or contract is less than $75,000.

Cheques

1.5.   All cheques or other negotiable instruments to be sent out or requiring endorsement of CPSM require two signatures and
     1.5.1.   For transactions of $75,000 or less may be signed by any two of the President, President-Elect, Registrar, Assistant Registrar, or the Chief Operating Officer of CPSM; and
     1.5.2.   For transactions above $75,000 one of the signatures must be the President or President-Elect.

Banking

1.6.   The Council or, subject to any directions given by the Council, the Registrar, may establish and maintain such accounts with a chartered bank, trust company or credit union as Council determines necessary from time to time.

Investments

1.7.   The Audit and Risk Management Committee or, subject to any directions given by that committee, the Registrar, may invest funds of CPSM in accordance with Council's investment requirements set out in the Council Policy- **Investment Policy** (established June 2025).

Restricted Accounts in the Accumulated Surplus:

1.8.   In order to protect the fiscal soundness of future years and to build organizational capability sufficient to achieve ends in future years, the Registrar must maintain funds in the accumulated surplus of CPSM, as restricted accounts for the following specified purposes:
     1.8.1.   To cover the potential costs of Inquiry cases. The level of reserve shall be determined by considering important factors such as average cost per case, average case volume, and nature and complexity of cases based on recent history. This reserve shall be funded entirely from Inquiry case cost recoveries, accumulated surplus, special levy, or any combination thereof.
     1.8.2.   To maintain an operating reserve to cover unanticipated operating deficit not covered by the above Inquiry reserve. The operating reserve should be the equivalent of one month's worth of core expenditures.
     1.8.3.   To maintain $500,000 reserve every five years to cover periodic IT upgrades, including, but not limited to, the registrant database software upgrade.
     1.8.4.   To cover the potential wind-up costs should CPSM be required to cease operations. The fund level shall reflect the estimated costs of winding down operations in a period of six months.

1.9.   To allow the Registrar flexibility to react quickly to operational needs, the Registrar may

appropriate an amount of no more than $100,000 in a single year towards any discretionary program without requiring the approval of the President and President-Elect, or the Council.

1.10.   The Registrar shall:

   1.10.1.   Evaluate the adequacy and appropriateness of the reserves at the end of each year, and incorporate in the budget of the following year a plan that supports or enhances the prescribed reserves, subject to the approval of the Audit and Risk Management Committee.

   1.10.2.   Determine the need for a special levy in case of any deficiency to the above reserves, provided the Registrar explores all other options first subject to the debt guidelines set forth in 1.11 below and with the approval of the Council.

Restrictions on Registrar Discretion in Management of CPSM Funds

1.11.   The Registrar must not expend more funds than have been received in the fiscal year to date unless both CPSM debt guidelines are met:

   1.11.1.   Not borrow more than $125,000 in order to obtain a financial advantage superior to cashing in investments.

1.12.   The Registrar must:

   1.12.1.   settle CPSM payroll and debts in a timely manner.

   1.12.2.   aggressively pursue receivables after a reasonable grace period.

   1.12.3.   file all reports and make all payments required by government accurately and on time.

Requirements for Protection of CPSM Assets

1.13.   For the protection of CPSM assets, the Registrar must:

   1.13.1.   Require staff with access to material amounts of CPSM funds to be bonded.

   1.13.2.   Receive, process, or disburse funds under controls which meet the Council-appointed auditor's standards.

   1.13.3.   Give due consideration to quality, after-purchase service, value for dollar, and opportunity for fair competition when making purchases.

   1.13.4.   Have the approval in writing of the President or President-Elect for any purchase not contemplated in the budget for an amount in excess of $75,000.

1.14.   The Registrar is authorized to acquire, encumber or dispose of land or buildings ("property") subject to the following conditions:

   1.14.1.   Acquisition Conditions:

      1.14.1.a.   Needs Assessment: A thorough assessment of the CPSM's needs must be conducted to justify the acquisition of property. This includes evaluating the necessity, benefits, and alignment with strategic goals.

      1.14.1.b.   Due Diligence: Comprehensive due diligence must be performed, including legal, financial, and environmental assessments. This

ensures the property is free from encumbrances and suitable for the intended use.

1.14.1.c. Approval Process: All acquisitions must be approved by the Finance Audit and Risk Management Committee, and the Executive Committee and finally to a vote at Council.

1.14.1.d. Funding: The source of funds for the acquisition must be identified and approved. This includes ensuring that the acquisition does not adversely affect the organization's financial stability.

1.14.1.e. Ethical Considerations: The property must align with the organization's ethical standards and mission. Properties associated with industries or activities that conflict with the organization's values should be avoided.

1.14.1.f. The property is used directly for CPSM operations;

1.14.2. Disposition Conditions

1.14.2.a. Strategic Review: A strategic review must be conducted to determine the necessity and timing of the disposition. This includes evaluating the impact on the organization's operations and financial health.

1.14.2.b. Market Analysis: A market analysis should be performed to determine the fair market value of the property. This ensures the organization receives a fair price for the disposition.

1.14.2.c. Approval Process: All dispositions must be approved by Council.

1.14.2.d. Use of Proceeds: The use of proceeds from the disposition must be clearly defined and approved. This includes ensuring that the funds are used in a manner that supports the organization's mission and objectives.

1.14.2.e. Transparency: The disposition process must be transparent, with regular reporting to the Council and relevant stakeholders. This includes providing detailed information on the transaction and its impact on the organization.

1.14.3. Reporting & Documentation

1.14.3.a. Record Keeping: Detailed records of all property transactions must be maintained, including contracts, assessments, approvals, and financial statements.

1.14.3.b. Regular Reporting: The Finance, Audit and Risk Management Committee must receive regular reports on property transactions, including updates on acquisitions, dispositions, and their impact on the organization's financial health.

COUNCIL AND COMMITTEE REMUNERATION AND EXPENSES

Council and Committee Expenses

2.1.   The philosophy underlying honoraria and expenses recognizes the individual physician as a contributing registrant of the profession. Accordingly, honoraria and expense reimbursement are not intended as inducements. They are based on the wish of Council that there be no significant barriers to the participation of any registrant in the self-governing process.

Remuneration

2.2.   Councillors, officers, and committee members are entitled to:
   2.2.1.   be reimbursed by CPSM for reasonable expenses necessarily incurred in connection with the business of CPSM in accordance with Council policies governing reimbursement established from time to time; and
   2.2.2.   receive honoraria for attending meetings (whether attendance is in person or by electronic communication) in connection with the business of CPSM in accordance with Council policies governing honoraria established from time to time.
   2.2.3.   Notwithstanding clauses a. and b., members of a subcommittee of the Central Standards Committee, except for the Area Standards Committees, are not entitled to be reimbursed by CPSM or to receive honoraria by CPSM. Members of all other subcommittees of the Central Standards Committee may be entitled to honoraria pursuant to the policies of their "sponsor" organization.

2.3.   The members of Council, Council committees, designated subcommittees and the President's working groups are entitled to receive honoraria, travel time and reimbursement of expenses, all in accordance with the provisions of this section, at the rates determined annually by Council.

2.4.   Honoraria and Stipends
   2.4.1.   Honoraria are intended to replace time away from fee generating practice. A member may choose not to submit a claim for honorarium and instead submit only a claim for expenses.
   2.4.2.   The following policies govern the payment of honoraria:
      2.4.2.a.   In submitting claims, "Morning" is the period preceding 12:30 p.m., "Afternoon" is from 12:00 noon - 6:00 p.m., and "Evening" is any period after 4:00 p.m.
      2.4.2.b.   A member who leaves at noon for a meeting scheduled for the afternoon is entitled to claim for the ½ day session, regardless of the actual time taken in the meeting.
      2.4.2.c.   A member who attends any meeting scheduled for 4:00 p.m. or later is entitled to claim for the evening rate regardless of the actual time taken

in the meeting.

2.4.2.d. A member may claim an hourly rate up to the maximum of a half day or full day rate, with the exception of 2.4.2.c.

2.4.2.e. A member who attends meetings scheduled for 6 or more hours in one day is entitled to claim the full day rate.

2.4.2.f. The maximum that can be charged for a 24-hour period is the full day rate.

2.4.2.g. Full day Council meetings, regardless of the day of the week, will be compensated.

2.4.2.h. When a member participates in a meeting by telephone or in person, the member is considered to be in attendance and is entitled to full payment.

2.4.2.i. If a member is scheduled to attend a morning, afternoon or all day meeting, arrived late and/or left early, the member is not entitled to the full honoraria, but is entitled to be paid for the hours the member was present.

2.4.2.j. Canada Revenue Agency (CRA) regulations state that all honoraria payments are considered personal taxable income under the Income Tax Act of Canada and subject to withholding taxes and CPP deductions. A T4 slip will be issued for each calendar year. Council and Committee members may not bill honoraria through their corporations.

2.4.2.k. As the CRA permits individuals who are at least 65 years old but under 70 years old and who are receiving a Canada Pension Plan retirement pension to exercise an election to stop making CPP contributions by filing a CRA Form with CPSM and any other employer of that eligible individual. Members are advised to seek independent financial advice in this regard. Eligible members are responsible to file the completed CRA Form with CPSM if they do not wish to contribute to the CPP plan.

2.4.2.l. Annual stipends are paid in recognition of the formal administrative roles held by the President, the President-Elect, the Investigation Chair and Vice-Chair. The stipend is intended to recognize the extra administrative time spent in discussions with the Registrar and staff (other than attendance at Committee meetings or other formal CPSM meetings covered by the payment of honoraria) in addition to covering the other administrative functions required by the holders of these positions to conduct the business of CPSM.

2.5. Travel Time

2.5.1. Subject to the exclusions for travel time, an hourly rate is billable for travel time for members, subject to the following policies, which govern the payment of travel time to meetings in Winnipeg.

2.5.1.a. Members who reside in the City of Winnipeg are not compensated for travel time to meetings held within the city.

2.5.1.b. Members who reside outside of the City of Winnipeg and who commute to meetings in Winnipeg may claim for travel time where

the **total commute exceeds one hour from the Winnipeg perimeter or approximately 100 km's from the Winnipeg perimeter**. This claim is in addition to the claim for honoraria in relation to attendance at the meeting.

2.5.1.c.   Members who reside outside of Winnipeg and meet the criteria in 2.5.1.b above, may charge for:

2.5.1.c.i.   mileage for the round trip from the closest town or village to their residence to CPSM offices in Winnipeg provided they drive. The distance travelled will be calculated by CPSM staff using an internet satellite tracking system, selecting the "fastest time" calculation; and

2.5.1.c.ii.   travel time as calculated by CPSM staff using an internet satellite tracking system's fastest time calculation for the round trip rounded up to the nearest half hour unless the member flies to the meeting.

2.5.1.c.iii.   if the member flies to the meeting, the calculation of time will be based on the flight time estimate provided by the airline used for travel. Time would be rounded up to the nearest half hour. No mileage will be paid for the portion of travel by air.

2.5.1.c.iv.   Total expense for a member travelling will be set at a maximum of what is calculated in 2.5.1.c.iii. For example, if a Council member chooses to drive from their location, then the maximum expense allowable between, mileage + travel time is equal to or less than the flight time estimate and the cost of the flight. This only applies for travel where the option of a <u>regularly scheduled</u> commercial flight exists.

2.6.   Expenses

2.6.1.   CPSM will not reimburse any expense incurred unless the member provides the supporting receipt, with the sole exception of claims for parking at a meter. The following policies govern claims for reimbursement of expenses:

2.6.1.a.   CPSM must have a receipt documenting the GST in order to claim the GST input tax credit. Accordingly, credit card slips are not accepted in lieu of receipts. Members must submit the actual receipt. **Expenses will not be reimbursed if the member does not submit the actual receipt.**

2.6.1.b.   CPSM anticipates that members travelling on CPSM business may incur reasonable expenses for transportation, meals and accommodation. Any expense outside of these items would be regarded as unusual and must be specifically authorized by the Registrar. Expenses will be reimbursed in accordance with CPSM Expense Policy. **Expenses will be considered for members whose total commute exceeds one hour from the Winnipeg perimeter or approximately 100 km's from the Winnipeg perimeter.**

2.6.1.c. **Meals** - CPSM will reimburse expenses for meals on a per diem basis. Councillors and Committee members may claim the meal per diems only if the corresponding meal was not provided at the meeting/conference attended. Meals will be reimbursed at the following established per diem rates:
- Breakfast: $17
- Lunch: $27
- Dinner: $40
- Incidentals: $12 (for business travel the exceeds 24 hours)

Receipts are not required – only adherence to the per diem rates. Alcoholic beverages are not eligible for reimbursement.

2.6.1.d. **Mileage** – This covers the actual costs of transport to and from the meeting for those travelling from outside Winnipeg. For those who use their cars, the calculation must be shown on the claim form. For other forms of transport, attach a receipt. Airfare is paid at the scheduled economy rate. The reimbursement rate per kilometer will be consistent with the rate used by Shared Health. This is applicable to all reimbursable mileage claims (ie Area Standards, MANQAP, Council members, etc.)

2.7. Annual Review
   2.7.1. Annually, the Council must:
      2.7.1.a.   review the honoraria paid by CPSM,
      2.7.1.b.   review the stipend paid to the President, President-Elect, Investigation Chair and Investigation Vice-Chair,
      2.7.1.c.   review preparation time paid by CPSM,
                   2.7.1.b.
      2.7.1.d.   fix the honoraria and , stipends and preparation time for the next fiscal year. In setting honoraria and stipends and preparation time,
      2.7.1. .
   2.7.3.2.7.2.   Council must take into account:
      2.7.2.a.   the amount of the honoraria or stipends, and preparation time paid by other organizations of a like nature;
      2.7.2.b.   the philosophy set forth above; and
      2.7.2.c.   the Finance, Audit & Risk Management Committee recommendation to Council as to the appropriate level for honoraria and the ,stipends and preparation time.

2.8. Honoraria and Stipends
   2.8.1. Honoraria
      Hourly $150160
      Half Day $550 600 (where meetings exceed 3 hours follow the definition in 2.4.2.a.)

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Full Day $~~1,100~~1,200 (where meetings exceed 6 hours)

Evening $~~190~~ 200 (flat rate for meetings occurring after 4:00 pm)

Chair $80~~70~~   (per meeting)

2.8.2. Preparation Time

Investigations Committee – eligible for $160/hour for up to a maximum of 2 hours of preparation time per committee meeting

Inquiry Committee – eligible for $160/hour for up to a maximum of 2 hours of preparation time per inquiry meeting.

Preparation time beyond 2 hours must be pre-approved by the chair of the Committee and is only to be approved in exceptional circumstances.

~~2.8.2.~~2.8.3.   Stipends

President $~~12,500~~$13,125   plus annual Certificate of Practice fee

President-Elect $~~5,000~~$5,250   plus annual Certificate of Practice fee

Investigation Chair $~~10,000~~$10,500   plus annual Certificate of Practice fee

Investigation Vice-Chair $~~6,000~~$6,300   plus annual Certificate of Practice fee

2.9.   Remuneration for Area Standards Committee

2.9.1. Notwithstanding remunerations provisions for other Committee members, members of an Area Standards Committee shall be entitled to be:

2.9.1.a.   paid $~~150~~160.00 per hour of meeting time to a total provincial committee maximum of $84,000 per year (based upon 7 standards committees X 5 members x 16 hours x $~~150.00~~160 = $~~84,000~~89,600)

2.9.1.b.   reimbursed for mileage from their office to the meeting place provided that the member works outside of the municipality where the meeting is held. The reimbursement rate per kilometer will be consistent with the rate used by Shared Health.

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COUNCIL MEETING
MARCH 18, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT:　　　Registrar/CEO's Report

Internal - People and Culture

- A senior leadership retreat was held in early January to identify priority operational areas for 2026 and ensure alignment on CPSM's vision among the leadership team, including the Registrar, Assistant Registrar of Quality, Assistant Registrar of Complaints and Investigations, General Counsel, Chief Financial Officer, Executive Director of People and Culture, Communications Officer, and Director of Registration and Innovation. Conversations and planning based on the retreat discussion items are ongoing.

External Relations

- Met with Silvester Komlodi, Deputy Minister of Health, Seniors, and Long-Term Care and Michele Lane, provincial lead for the Health Care Retention and Recruitment Office.
- Participated in the Medical Council of Canada governance and nominating committee (January 26).
- Participated in the FMRAC Board meeting (January 30).
- Participated in the Medical Council of Canada governance and nominating committee (January 26).
- Gave a lecture to Med 1 students (health law section of Professionalism course) on self-regulation (February 4).
- Participated in the International Association of Medical Regulatory Authorities (IAMRA) Board meeting in the role of non-regional director (February 11).
- Sent a representative to attend the National Registry of Physicians Data Governance Committee meeting (February 25).
- Participated in the FMRAC Board Meeting / Registrars Forum (February 26).
- Participated in the FMRAC Governance Committee Meeting (February 27).
- Participated in the FMRAC Federated Model of Multijurisdictional Licensure (FMMJL) Working Group Meeting (March 2).

For Information Briefing Note prepared by: Dr. Ainslie Mihalchuk, Registrar & CEO
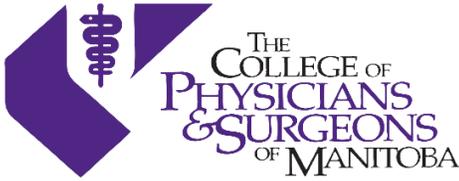
COUNCIL MEETING
MARCH 18, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Performance Metrics Update

BACKGROUND:

The 2025-2026 – 3rd quarter performance metrics reporting scorecard is attached *(Appendix A)* for Council's review. The report's first section summarizes each area and relative performance. The remaining sections of the scorecard highlight each area and use graphics to represent how the specific metric is performing.

The Complaints and Investigations Department is undergoing a revamp, in part driven by the changes to the Complaints Committee, which in turn is driving the requirement to redefine the metrics strategy.

The graphic on the attached scorecard highlights the following for each metric.
- a description of the performance indicator,
- the target(s) and where performance is not meeting the target,
- the variance explanation/course correction details.

For Information Briefing Note prepared by: Mr. Paul Penner, Chief Financial Officer

CPSM Performance Scorecard

2025-26 - 3rd Quarter

	Snapshot				
	Quality	CI	Registration	Support	Total
Meeting/Exceeding	7		3	7	17
Not Meeting	3			3	6
Lagging	1				1
Insufficient data	3	3		2	8
Total # of Performance Metrics	14	3	3	12	32

THE COLLEGE OF
PHYSICIANS
&SURGEONS
OF MANITOBA

QUALITY - Quality Assurance

NA

75
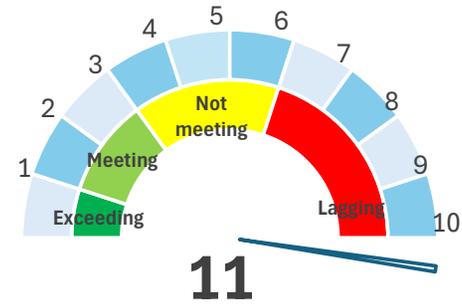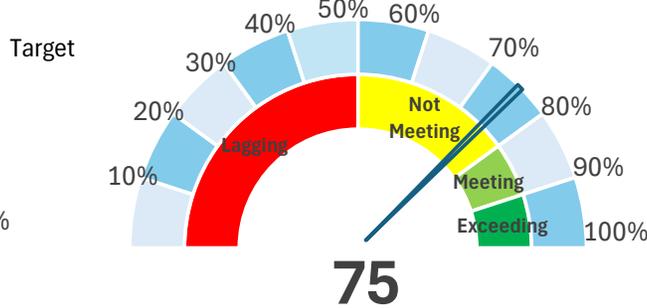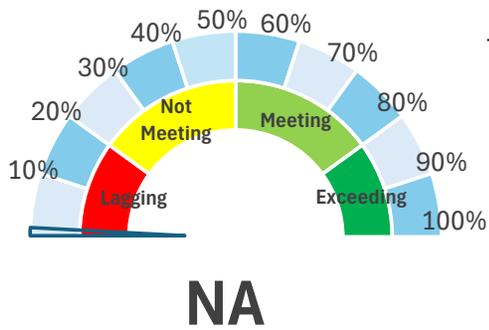
9/11 Audits in this quarter completed within 30 days (82%).

11

Performance Indicator	Registrants will demonstrate a measurable improvement on follow-up assessments	Audits will be performed in a timely and predictable manner	Provisional Registration chart audit reports will be sent to the physician in a timely and predictable manner
Targets	Target is 50%	Target is 80% within 30 days	Target is 3 days
Variance Explanation/Course Correction	CSC was not held in the third quarter	Target was not met due to temporary staffing issues	Number of chart reviews has doubled due to increase in registrants - reviewing workload and staffing

QUALITY - Physician Health Program

63

100
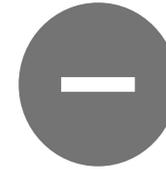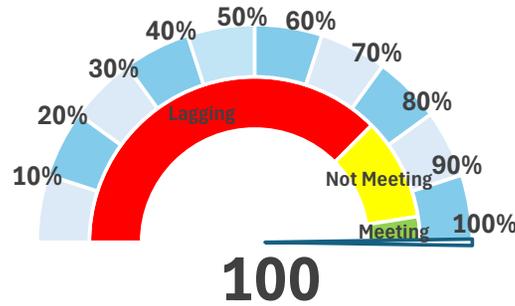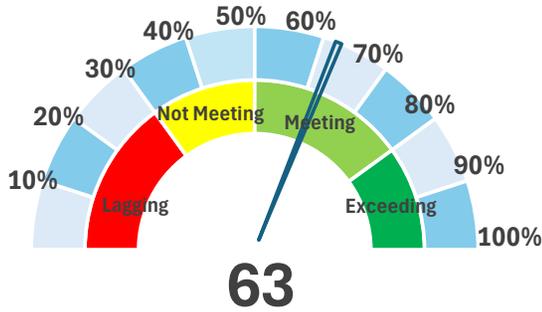
Performance Indicator	# of referrals coming from registrants about self/colleagues to the PHP	Implement the necessary monitoring/restrictions on identified high-risk registrants.	PHP will survey registrants and other PHP participants to ensure registrants are feeling supported by the PHP and possibly identify opportunities for program improvement.
Targets	50% generated from self referrals	100% of flagged registrants are monitored	80% of surveyed registrants indicate that they had a neutral, positive, supportive or very supportive interaction with the PHP.
Variance Explanation/Course Correction			Will report annually only

QUALITY - Quality Improvement
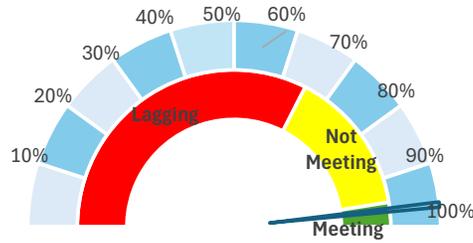
Quality Improvement is on track to "initiate" reviews with 100% eligible registrants by Dec 2025.

98

Category 1

Category 2

Category 3

Performance Indicator	CPSM will complete reviews of 95% of all eligible registrants by the end of the seven year cycle (December 2025)
Targets	Initiate remaining eligible registrants
Variance Explanation/Course Correction	

QI process will be completed within targeted timelines 90% of the time for Category 1 (30 days), 2 (110 days) and 3 (240 days)	
90% completion: Category 1 -30 days	
	Category 2 - 110 days
	Category 3 - 240 days
Category 1 - 95% - 58%	Category 2 Category 3 - 50%

QUALITY - Prescribing Practices Program

70
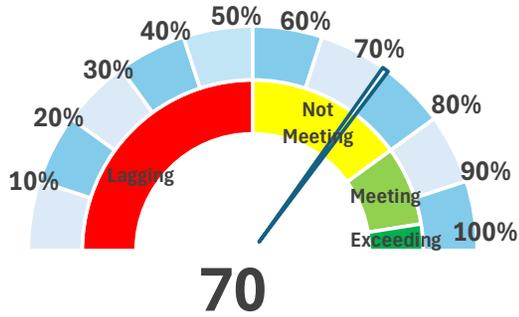
70% within 1 business day
77% within 2 business days

100

100% high risk within 1-2 business days
91% moderate risk within 1-2 weeks

39
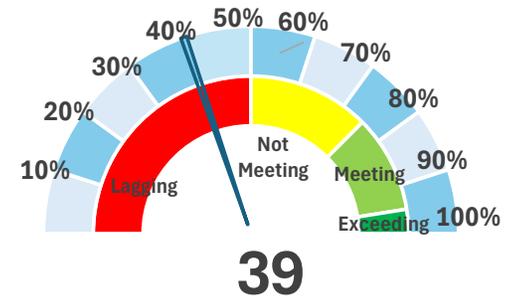
Performance Indicator	Will respond in a timely manner to general prescribing advice inquiries	PPP will provide timely intervention for general prescribing advice inquiries with significant risks identified	PPP will survey registrants who seek prescribing advice to identify opportunites for program changes/growth
Targets	80% - 1 business day 90% - 2 business days	80% of high risk cases responded to in 1-2 business days 90% of moderate risk in 1-2 weeks	98% of surveys will rate impact of interventions as neutral to positive
Variance Explanation/Course Correction	staffing issues have impacted program responsiveness however it is expected this will improve in the next quarter		Number of surveys collected in Q1-Q3 is too low to maintain anonymity or for significant data analysis. Plan is to re-evaluate in coming quarters.

QUALITY - Accreditation

66
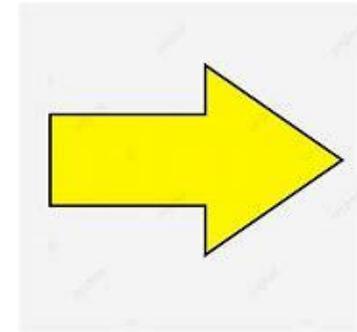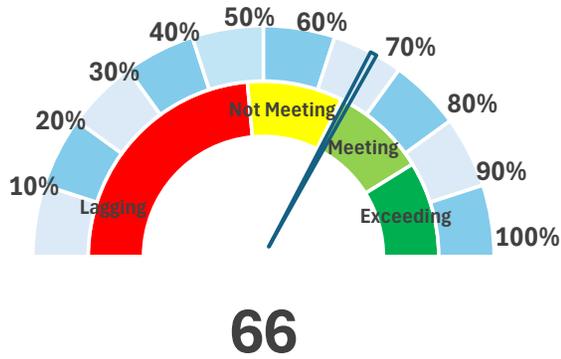
Performance Indicator	MANQAP will inspect the required number of facilities to be in compliance with the Manitoba Health contract and will ensure all required NHMS facilities are inspected	MANQAP completion of 7 temporary status site accreditations accumulated since Covid to meet compliance with the Continuing Service Agreement MB	Monitor and measure MANQAP implementation of the new WCAA Laboratory and Transfusion Medicine rollout.
Targets	90% of inspections completed	Complete by year-end	Inspect 10 sites in 2025-26
Variance Explanation/Course Correction	35 public inspections were planned for 2025-26, 23 have been completed as of Q3. On track for meeting target by year-end	6 sites have been completed - on track for year-end.	4 sites granted accreditation using the new standards. Target was adjusted from 40 to 10 sites to adjust for extension requests and reflect site using new standards.

COMPLAINTS & INVESTIGATIONS
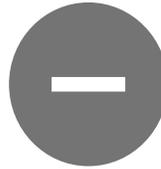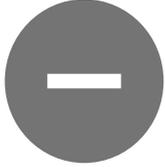
Performance Indicator	Response Time for Boundary Violations/Severe Care Issues
Targets	90% have plans in place in 5 days
Variance Explanation/Course Correction	

Performance Indicator	Responding to Complaints and Informal Resolution in a Timely Manner
Targets	80% of cases resolved in 180 days
Variance Explanation/Course Correction	New processes still in implementation phase. Continuing to revamp processes and the use of quality auditors to clear the backlog

REGISTRATION

Registration - Application Response times (in days)

	2025-26 3rd Qtr	2024-25 Baseline
Avg time to respond - initial	0.84	1.4
Avg time advise eligibility	7.74	9
Avg time Application is open	50.9	48
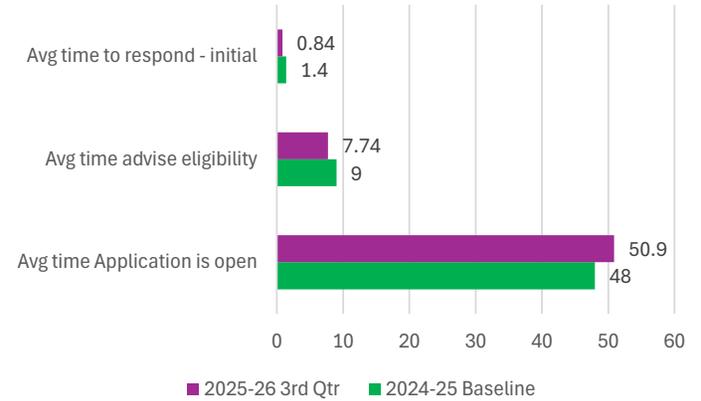
Performance Indicator	National Registry Project development and implementation	Compliance with Fair Registration Practices Office	Applications processed in a timely way.
Targets	Implementation of Phase 2	Ensure adoption/compliance and timely reporting	Baseline (green bar) is from 2024-25 and relfects response time for 1,415 applications received
Explanation/ Course Correction			Baseline is 2024-25 for three categories *Avg time to respond to applicant - initial *Avg time to advise re eligibility *Avg # of days applications are "open"

SUPPORT AREAS - Finance

77

CPSM on track for a balanced budget in 2025-26

Performance Indicator	CPSM will maintain adequate reserves	CPSM will achieve a balanced budget	CPSM implement an investment strategy that supports it's mandate
Targets	Debt to Equity ratio of 1.0 (reported annually). Reserves are maintained at a min 100% of operating expenses		Achieve a rate of return on investments of 8%
Variance Explanation/Course Correction	Debt to equity ratio - .99 Reserves at 77% of operating expenses excluding government programs	3rd quarter forecast indicates CPSM should end the year in a positive position	6.8% for the 9 months ending January 31, 2026

SUPPORT AREAS - Information Technology

57

99

94

Performance Indicator	CPSM's technology and information is protected from both external and internal loss/destruction	Information Systems are considered highly reliable and available	IT responsiveness
Targets	Centre for Internet score of 70-75%	Target is under development	Triage IT issues - 95% within 24 hours
Variance Explanation/Course Correction	Timing of the following implementations impacted the score Outstanding items: 1. Cyber Penetration Testing 2. Upgraded licensing 3. Disaster Table-top exercise - Cyber Breach. We expect to reach 65% by the fall of 2026		

SUPPORT AREAS - People & Culture

TBD
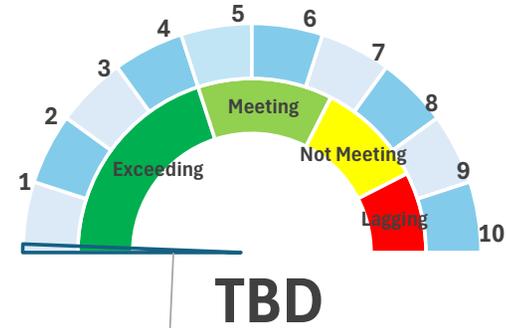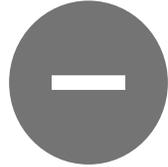
Performance Indicator	Employee satisfaction and engagement with CPSM priorities	Retention of staff	Employees are productive
Targets	Conduct staff Survey and report on findings	1. Average years of service 2. # of Employees resigning	
Variance Explanation/Course Correction	All departments have been re-engaged on survey results with discussion and development on future goals	Reported Annually	Metric is being reviewed

SUPPORT AREAS - Communications

Media Sentiment

Category	2025-26 3rd Qtr	Baseline
Neutral	22.4	88.1
Positive	71.6	3.8
Negative	6	8.1

■ 2025-26 3rd Qtr ■ Baseline
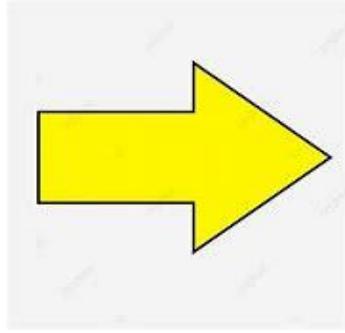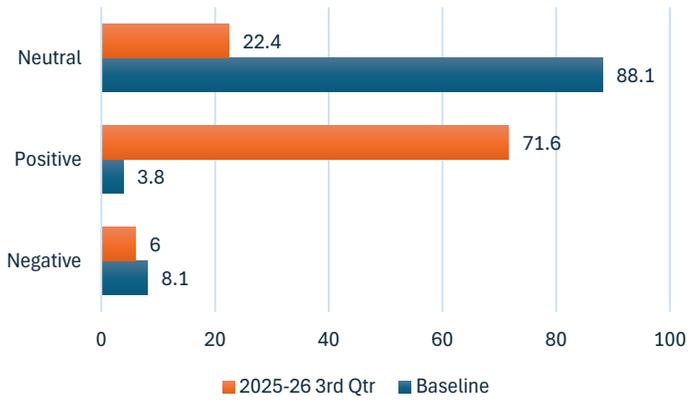
Performance Indicator	Increase positive sentiment score in media coverage	# of educational opportunities executed	# of engagement targets met
Targets	Improve sentiment by 20%	Educate the public on CPSM's role to protect the public and how that is accomplished through three core functions.	Boost engagement from the public & registrants

Variance Explanation/Course Correction

Communications supported public education in the following ways:

1) One public newsletter sent out during this period: Public consultation on Collaborative Care. Further support included designing the public survey

2) RPP support with public engagement materials for the Yellowquill career fair

1) Managed and hosted webinar Strength in Community (RPP) on Dec. 2

2) Created script and coordinated taping on Collaborative Care video to accompany the launch of the draft standard

3) Finalized and launched CPSM's What is Self-Regulation video

4) Supported the launch of Collaborative Care public consultation by sending out email communications. Further support included designing the registrant surveys and contextual documents.

5) Supported new election process by refining registrant election package and advising outgoing communications through the portal.

SUBJECT: Operational Reports

COMMUNICATIONS & MEDIA

The communications function oversees corporate communications, including email campaigns, registrant, public, and media communications, as well as the launch of new or updated Standards of Practice, public consultations, and the development of assets to support communications campaigns.

Highlights from this quarter include:
- Managing communications for the public consultation on the updated Standard of Practice for Collaborative Care.
- Supporting the IMG Working Group, including the development and launch of a survey. Supporting the Registrar's office with external and internal communications.
- Launched informational video for registrants on "Self-regulation of the medical profession - whose responsibility is it?" in the February newsletter.

Supporting the Restorative Practices Program

- Works closely with the Restorative Practices Program (RPP) team on communications and outreach to registrants and to the public to raise awareness about the RPP and related initiatives (Standard of Practice, and mandatory cultural safety and anti-Indigenous racism training). Completed this quarter:
  - Hosted a registrant webinar with the Restorative Practices Program team (December).
  - Developed collateral and supported the RPP team's attendance at the Yellow Quill College career fair (February).
- In development: assets to support the program, including working with a third party to:
  - develop a visual identity and visual assets for the program.
  - develop a video on the significance of addressing anti-Indigenous racism in medical care.

Media:

Responded to several media inquiries that aligned with regulatory matters. Notable coverage in this period included inquiries patient records retention and disposal of U.S. physicians relocating to Manitoba, addressing the backlog of complaints, and disciplinary publication of a registrants and the interim suspension of a registrant.

For Information BN Operational Reports

[Political 'instability' a factor in move to Manitoba, says 1 of 6 docs recruited from U.S.](#)
(*CBC News Winnipeg, October 23, 2025*)
[More than 30 U.S. doctors on path to Manitoba](#) (*Winnipeg Free Press, October 16, 2025*)
[Building a better complaints system for Manitobans](#) (*Winnipeg Free Press, October 4, 2025*)
[Rise in international trainees helps Manitoba add 164 net new doctors](#) (*Winnipeg Free Press, September 19, 2025*)

Registrant communication campaigns:

- Council Election Nomination Notice
- Feb 2026 newsletter
- Public Consultation on Collaborative Care
- December 2025 Council Update
- December 2025 newsletter

Submitted by:
Wendy Elias-Gagnon
Communications Officer

COMPLAINTS & INVESTIGATIONS DEPARTMENT

The transformation of C&I has continued as expected throughout the past quarter. Staffing of open positions is now fully complete. The Analytics Unit is up and running, allowing regular incoming complaints to be reviewed for triaging decisions on a weekly basis and high impact complaints to be reviewed within one business day.

Sunsetting of the Complaints Committee is nearly complete, with a meeting in March and likely one last meeting in April to resolve any outstanding cases. This will allow the staff supporting the Complaints Committee to redirect their efforts to other parts of C&I, including Analytics and Investigations.

Investigations Committee work continues to remain high, though a combination of procedural changes and onboarding of contract-based investigators has been helpful in increasing throughput.

In response to all the changes, a contract has recently been issued to an individual to review and update our procedures manual to reflect the new workflows. Once that work is complete, externally-facing documents and the CPSM website will be updated to ensure that they are easier to understand for members of the public and reflective of current procedures.

Submitted by:
Dr. Guillaume Poliquin
Assistant Registrar, Complaints & Investigations Department

FINANCE

2025-26 - 3rd Quarter Financial Results

CPSM posted a net surplus of $1,140,000 vis-à-vis budgeted surplus of $62,000, resulting in a $1,077,000 favorable variance. Favorable variances of $469,000 in revenues and $608,000 in expenditures both played significant roles in producing favorable operating results for the period. The majority of the variances are one-time in nature and are not expected to re-occur in 2026-27. CPSM predicts that the year will end with around $900,000 net surplus.

Investment Update

The Principal Protected Note (PPN) segment of the investment portfolio has performed very well in the first half of the year and was the main driver behind the 7% year-to-date return on investments with three months left in the year. In comparison, the return for the entire year prior was 4%.

By the end of the year, the equity segment of the investment portfolio (which includes the PPN's) will outweigh the fixed income segment—reflecting CPSM's adjusted risk tolerance for growth over the previous strategy of low-risk consistent, but limited, returns.

2026-27 Operating Budget

CPSM concluded its revised annual budget exercise by presenting the 2026-27 business plan to FARMC at the February 25, 2026 meeting. Beginning this year, CPSM altered the timing of the annual budget exercise in order to obtain Council's budget approval prior to the start of the new fiscal year as opposed to the previous budget approval which occurred at the end of June.

With FARMC's recommendation, CPSM is proposing a net surplus budget of $484,000 for the 2026-27 fiscal year.

Bill Payment Initiative

CPSM successfully introduced the bill payment option for payment of fees by the members during the recently concluded license fees renewal period. To encourage members to transition to the new payment feature, a modest discount of 1% on their fees was offered resulting in an 8% utilization rate. Moving forward, CPSM will aim to further educate members on the significant cost savings that can be gained by favoring bill payment over credit card payment. This will allow CPSM to redirect resources towards meaningful investments instead of servicing the credit card companies.

Submitted by:
Mr. Paul Penner
Chief Financial Officer

INFORMATION TECHNOLOGY

The IT team has several long-term projects currently in the queue which includes a complete revamp of how Registration uses iMIS and SharePoint, Phase 2 of the Quality Assurance project, and a conversion of Manitoba Quality Assurance database into the Portal. Below are some key deliverables the team has accomplished in the last quarter.

Registrant Voting System
The IT team utilizing the Portal developed a voting system for electing the CPSM council members. The first phase has been successfully released – nominations. Potential candidates can upload their candidate profiles for potential inclusion into the final voting phase. The creation of the voting system has saved CPSM $3,000 on an ongoing basis (formerly used a commercial product) as well as simplified the previous process.

Cybersecurity Tabletop Exercise
The IT team performed an incident response tabletop exercise. This readies the IT team for incidents involving a breach of CPSM's IT infrastructure. The exercise allows the team to practice responses in different situations. The Senior Leadership Team will undergo the same exercise in the near future.

Physician Dashboard
The IT Team is developing a custom physician dashboard for the Quality, Complaints and Investigation, Registration and Executive Office. The dashboard will highlight key information that each department requires at a quick glance with customized views for the user. The Team has completed the Quality Physician Dashboard portion and is moving to the other departments.

Submitted by:
Mr. Sam Lount
Manager, Information Technology

PEOPLE AND CULTURE

People and Culture is responsible for developing and executing human resource strategies in support of the overall operational plan and strategic direction of CPSM. This includes talent management, organizational and performance management, training and development, as well as total compensation. The position provides strategic leadership by articulating human resources needs and plans to the executive management team, strategic partners, and Council.

- Supported a Senior Leadership Team strategic retreat focusing on individual and team strengths, priorities for team building and communication
- Supported Department Organizational Design reviewing positions, competencies and human resources. Transitioning within CPSM are:

- o   Tara Myran - Program Director for Restorative Practices Program
- o   Jason Martin - Sr. Administrative Assistant Quality
- o   Kathy Osadczuk - Complaint Navigator
- o   Lauren Lederer - Compliance Monitor

- Joining CPSM
  - o   Meghan Cabel | Restorative Practices Coordinator – effective February 2
  - o   Callie Farthing | Assistant Inspector, MANQAP - effective February 2
  - o   Christopher Urrutia | Financial Accountant - 18-month Term effective February 17, 2026 - supporting a leave of absence

- Recruitment underway for:
  - o   Review Analyst Registration – Term from March 9 to July 31 – supporting a leave of absence
  - o   Program Clerk MANQAP – Term from March 2025 to January 2027- supporting a leave of absence

Submitted by:
Ms. Sherry Dupuis
Executive Director, People and Culture

QUALITY DEPARTMENT

Manitoba Quality Assurance Program (MANQAP)
- POL Scalability Proposal submitted to Manitoba Health - outcome pending
- Provincial 1st MDMA Non-Hospital accreditation process has started
- Provincial 1st Hyperbaric Non-Hospital accreditation process has started
- Manitoba Community Lab Medicine Governance Committee– 1st provincial visit Selkirk Access Centre January 16
- March 5 Thompson Hospital revisit- as requested by PRC
- Successfully recruited new 1.0 FTE Assistant Inspector MANQAP

Physician Health Program (PHP)
- Now fully implemented into the Portal; have a built-in case summary on those registrants with PHP profiles for easy access to case details
- Since the beginning of December, we've had 23 new referrals (for a total of 98 so far this fiscal year), with more than 2 months until end of year. Last fiscal year, we had 104 total.
- Our current caseload is 162 with 18 pending releases, after medical consultant review.

Prescribing Practices Program (PPP)

- **Registrant Advice & Support**: responded to **43 general prescribing advice** inquires Dec-Mar. KPI metrics: 63% responded to same day, 84% within 1 business day, and 88% within 2 business days. 25 GPA cases thus far in 2026 (234 cases in 2025).
- **Outcome Evaluation**: Presently 38% response rate for (anonymous) survey sent to registrants/other HCPs who seek prescribing advice, to evaluate the impact of PPP interventions. Number of surveys received is too low for significant data analysis (review at year end).
- **Prescribing Approvals**: Issued **6 Suboxone** & **1 methadone approval** for OAT Dec-Mar (current total 265 OAT prescribers). **1 pain/palliative methadone approval** Dec-Mar (current total 75 P&P prescribers).
- **Prescribing Rules**: Supporting SLT with implementation of changes as needed, and revision of SOPs for prescribing opioids and prescribing benzodiazepines/Z-drugs.
- **High Dose Morphine Milligram Equivalents (MME) Reviews**: Reviewing cases identified by MB Health DPIN dataset, involving high-dose opioid prescribing (≥ 900 MME per day). Risk stratification used to design intervention: 12 registrants completed HD MME process by Feb 2026 (2 with learning plan for 1y follow up). Case-based and audit/feedback style intervention used over several months, to promote quality assurance and safer prescribing practices.

Quality Assurance Program (QAP)

- Fully implemented in the CPSM Portal in December 2025

Quality Improvement Program (QIP)

- Second seven-year cycle began in January 2026 with first cohort to launch in spring 2026
- Two Auditor Refresher sessions held in February 2026

Restorative Practices Program (RPP)

- **Staff Updates:** Meaghan Cabel is the new Program Coordinator as of February 2026. Tara Myran's role updated to Program Director, in addition to Knowledge Translation & Mobilization Specialist. Dr. Jayson Stoffman's role updated to Medical Director.
- **Conferences:** Abstracts accepted for Society of Rural Physicians of Canada (SRPC) Rural and Remote Medicine Conference April 2026 and Canadian Association of Emergency Physicians (CAEP) Annual Conference on Emergency Medicine June 2026. Tara Myran and Jeremy de Jong presented on behalf of RPP at the First Nations Health and Social Secretariat of Manitoba (FNHSSM) Anti-Indigenous Racism Conference: Moving Beyond Land Acknowledgements in February 2026. Abstract submitted for RPP to present at The College of Family Physicians of Canada Family Medicine Forum in November 2026.
- **Awareness Campaign and Outreach:** January 2026: Met with the Mayor of Portage la Prairie, Mayor Knox, and connected with the Portage Clinic and Portage la Prairie Community Revitalization Corporation where RPP held in-person meetings in February 2026 to network and share. February 2026: RPP presented to the Assembly of Manitoba Chiefs First Nations Family Advocate Office, traveled to Sioux Valley Dakota Nation to present to the Director of Health and Council, and had a booth at the Career Day for Yellowquill University College. RPP shared information with over 80 students.

- **Cases & Process Development:** 32 Referrals as of December 31, 2025. Updates to processes continue for intake, triage, and forms to ensure consistency and relevance of data collected and trauma-informed language throughout RPP.
- **Logo and Branding:** The development of a dedicated logo and branding for RPP continues, which will assist with promotion of RPP, outreach and education activities.

Submitted by:
Dr. Sonja Bruin
Assistant Registrar, Quality Department

REGISTRATION DEPARTMENT

The Registration Department's primary role is to ensure that only qualified, competent, and ethical applicants are registered to practice in Manitoba. In recent years, the Department has been redefining its role to improve access to care, provide clear and accessible registration information, strengthen orientation and support for changing practice environments, and build strong relationships with registrants, other regulatory colleges, partners, and the public.

To support these objectives, the Registration Department is strengthening its performance and risk monitoring through the development of key indicators, a quality management system, and improved data and reporting infrastructure. This involves significant work with the IT Department as we review and improve data infrastructure and strategy.

Registration policies and practice directions have been reviewed and updated, with new policies in development to address identified gaps. Work is underway to consolidate these authorities into a single, clear reference.

The Registration section of the CPSM website continues to be updated to provide clear, step-by-step information for all registration classes, with further improvements planned to enhance accessibility. CPSM is also working with external partners to improve communication around complex registration pathways.

The Department remains engaged nationally and internationally to align with best practices, including work on regulatory updates, new pathways to registration, and the relaunch of PRA MB-FP. Staff participate in national working groups and committees and maintain a strong relationship with Manitoba's Fair Registration Practices Office.

The Department also supports national initiatives such as the National Registry of Physicians, IMG orientation development, and the ongoing work of the Board of Assessors.

Significant projects include:
- a review and revisions to CPSM's license renewal questions,
- a review of how we regulate medical corporations permits,
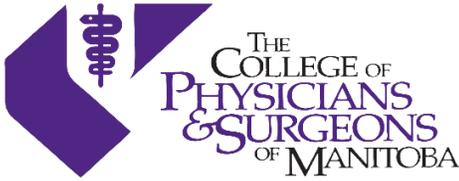- implementing improvements to the PRA process, and

- a review of how CPSM registers CAs and PAs and the process for approving contracts of supervision.

Submitted by:
Mr. Jeremy de Jong
Director, Registration Department and Innovation

COUNCIL MEETING
MARCH 18, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Trends/Topics in Regulation

PURPOSE:

To update the Council on issues CPSM is watching across the regulatory landscape. For this meeting, information regarding physician workforce shortages will be highlighted.

PHYSICIAN WORKFORCE:

This briefing note summarizes important regulatory trends and emerging issues that CPSM is monitoring across the international, national, and provincial landscape, with a focus on how physician workforce shortages are shaping licensure policy, mobility initiatives, and credential recognition. This note highlights current discussions and initiatives related to interjurisdictional portability, IMG assessment and integration, ethical international recruitment, and Manitoba-specific regulatory reforms—including ongoing work on jurisdictional recognition and expanded pathways that support timely access to qualified medical practitioners while maintaining public interest standards. The above issues are summarized below at the international, national, and the provincial level.

At the international level:

Workforce mobility, licensure portability and mutual recognition are among the most prominent international issues for medical regulators.

Specific initiatives:
- IAMRA has emphasized cross-border mobility as a global priority, especially for underserved regions.
- Australia's National Registration and Accreditation Scheme.
- FSMB's Interstate Medical Licensure Compact (IMLC).

Signicaint issues to contend with:
- Fairness, transparency, and consistency in ITP/IMG assessment.
- Language proficiency standards.
- Cultural safety, professionalism, and orientation requirements.
- Legal challenges around discriminatory or inconsistent pathways.
- Best practices for assessment of competency.
- Reliance on currency and recency in practice for new immigrants.
- Scope of practice issues.

The are also serious ethics issues relating to international recruiting that the World Health Organization (WHO) is grappling with. The WHO has published guidance and standards on ethical recruitment to be mindful of. This brings about a great deal of discussion around sharing information, including to avoid credential fraud, misrepresentation, and failures to disclose.

At the national level:

Physician workforce shortages and access to care is the loudest issue at the national level. Canada is experiencing shortages of family physicians and specialists, particularly in rural and underserviced communities, which drives regulatory and policy reforms focused on physician supply, retention, and practice models. Shortages are compounded by burnout and rising retirements.

- There are significant projects on going related to recognizing foreign credentials, easing administrative burden, improving team-based care models, and expanding medical education programs.
- With respect to interprovincial licensure and mobility, many believe Canada's provincially fragmented licensing system remains a barrier that should be addressed. Although the Atlantic provinces have multi-jurisdiction agreements (the Atlantic Registry), most physicians must re-license when moving between provinces, limiting workforce flexibility. This issue is being examined at the national level by MRAs via FMRAC.
- International Medical Graduates (IMGs) integration efforts are essential to address workforce issues. IMGs face lengthy, inconsistent credential recognition and licensure pathways across provinces despite meeting competency standards. This both worsens workforce shortages and raises equity concerns. Medical Regulatory Authorities (MRAs) are looking at standardizing and expediting licensure pathways and addressing language and cultural competency requirements. Means of ensure a soft-landing are also in focus, including examples like Nova Scotia's Physician Assessment Centre of Excellence (PACE) program.
- Canada's multijurisdictional licensure discussions are ongoing (FMRAC mediated). This is supported by ongoing work developing a National Registry of Physicians (Medical Council of Canada). The Atlantic Registry has been operating for over a year. The evaluation is here for reference: https://cpsns.ns.ca/news/college-radar/march-2025/radar-march-2025-atlantic-registry/

At the provincial level:

Manitoba continues to struggle with one of the lowest physicians-per-capita ratios in Canada, especially for family doctors and rural practitioners. Addressing shortages remains central to regulatory and health policy reforms. CPSM has established and is developed numerous proposals for regulatory changes to help address access to qualified medical practitioners.

- Manitoba has made significant regulatory changes to reduce barriers for IMGs, including removing certain exam requirements (such as the MCCQE1) and expanding practice-ready assessment pathways to accelerate licensure without compromising safety.
- The Registration Department is hard at work on exploring how we can expand our list of approved jurisdictions.
- Recent amendments now allow U.S.-trained physicians with accredited residencies and board certification to apply directly for full licensure in Manitoba — eliminating the prior requirement for provisional registration and supervision.
- The Manitoba faculty is steadily increasing enrolment in training programs for healthcare professions.
- CPSM launched a 2-day orientation program for physicians with limited Canadian practice experience to ensure a soft landing. We are working on new initiatives to expand mentorship and our process for arranging practice supervision for provisional registrants. A significant issue to contend with is ensuring the system can absorb physicians from varied training and experience backgrounds.

Jurisdictional recognition:

Canadian medical regulatory authorities are under sustained pressure to improve physician supply, mobility, and retention, while maintaining rigorous public-interest standards. One mechanism receiving a lot of attention is jurisdictional recognition—training and certification systems deemed substantially equivalent to Canadian standards—allowing eligible physicians to access direct or expedited licensure pathways without duplicative assessments or examinations. At the national level, this work aligns with long-standing efforts by medical regulatory authorities, the CFPC, the Royal College, and FMRAC to reduce unnecessary barriers while respecting provincial jurisdiction over licensure. Recent initiatives include:

- CPSM currently recognizes a defined set of Approved Jurisdictions for both family medicine and specialty practice, based on equivalence of postgraduate training, certification, and regulatory oversight. These routes permit eligible physicians to bypass practice-ready assessment or provisional registration requirements that would otherwise apply. Our pathways are primarily subject to what has already been approved or recognized by the CFPC and the Royal College, though CPSM has expressly recognized certain US physicians for full registration. CPSM is considering ways we can expand our own list of recognized jurisdictions.
- FMRAC is coordinating a national discussion on the evaluation of international jurisdictions, including training, certification and licensing processes, with a view to creating a rubric under which MRAs can recognize international qualifications. CPSM has representation on the FMRAC Jurisdictional Recognition Working Group (established January of 2026) and results are expected by summer 2026.
- The Royal College and the CFPC maintain a national framework identifying recognized or approved jurisdictions whose postgraduate programs are considered substantially equivalent to Canadian specialty training. This leads to eligibility for certification.

For Information BN Trends/Topics in Regulation

     Provincial regulators rely on this framework when determining eligibility for their regulated licensure pathways. CFPC is actively engaged in a project to expand their list of recognized jurisdictions (Jurisdictional Route to Family Medicine Steering Committee), with additions anticipated in the near term.

For Information Briefing Note Prepared by: Mr. Jeremy de Jong, Director of Registration and Innovation

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& SURGEONS
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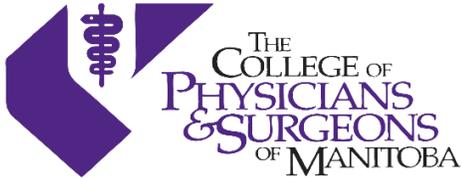
**COUNCIL MEETING
MARCH 18, 2026
COMMITTEE REPORTS
FOR INFORMATION BRIEFING NOTE**

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met on February 25, 2026. Most of the matters discussed are on the current Council meeting agenda; in addition, the Committee appointed 7 registrants to act as auditors for the Quality Improvement Program, and 2 registrants and 1 public representative to the Investigation Committee.

On January 19, 2026, the Executive Committee appointed, Ms. Magnus to the Elections Committee.

On February 25, 2026, a Panel of the Executive Committee heard an appeal of a Program Review Committee decision.

Respectfully submitted by
Dr. Charles Penner
President, CPSM and Chair of the Executive Committee

BOARD OF ASSESSORS REPORT:

Since December 2025, the Board of Assessors met once on February 12, 2026. The Board reviewed two new draft Council Policies and recommended amendments to five other registration policies. Two registration applications were considered and decided by the Board.

The Board continues to work through complex registration issues. Meetings bring together CPSM staff and public representatives to share perspectives and make well-informed, transparent decisions. These discussions also support the Registration Department's day-to-day work and help improve policies, ensuring decisions are fair and consistent.

Respectfully Submitted by
Dr. Alewyn Vorster
Chair, Board of Assessors

COMPLAINTS COMMITTEE REPORT:

The Panels of the Complaints Committee have met eight times since May 1, 2025:

- May 8, 2025
- June 5, 2025

- August 14, 2025
- September 25, 2025
- November 13, 2025
- December 11, 2025
- January 8, 2026
- February 5, 2026

During this period, 106 cases have been closed. Resolution of these cases is as follows, including a comparison to the 2024 – 2025 full year.

Resolution of cases closed	For the period May 1, 2025 to February 5, 2026		For the full year May 1, 2024 to April 30, 2025	
No further action	46	43%	80	50%
Advice	15	14%	33	21%
Criticism	13	12%	16	10%
Informal resolution	4	4%	6	4%
Referral to Investigations Committee	11	10%	16	10%
Cases withdrawn	0	-	1	1%
Dismissed	8	8%	-	-
Referred to Quality Program	2	2%		2%
Other: Inactive unable to reach complainant after 1 year	7	7%	4	2%
Total	106	100%	159	100%

A summary of total cases closed during the period, along with the number of outstanding cases is as follows. Results from the current 8-month period is compared with the previous 2024 – 2025 full year.

Cases closed during the period	For the period May 1, 2025 to February 5, 2026	For the full year May 1, 2024 to April 30,2025
Number of meetings	8	11
Outstanding cases, beginning of year	132	132
New complaints received during period	2	159
Total number of complaints	134	291
Total cases closed during the period	(106)	(159)
Outstanding cases, end of the period	28	132

Respectfully submitted by
Ms. Lynette Magnus
Chair, Complaints Committee

CENTRAL STANDARDS COMMITTEE REPORT:

CSC Activities for 2025

CSC met March 7, June 20, September 19, and November 21, 2025.

QUALITY ASSURANCE (QA) AGE-RELATED/REFERRED REVIEWS IN 2025

CSC reviewed:

- 35 New and Repeat QA Age-Related Reviews
- 58 New and Repeat QA Referred Reviews
  (Two cases with same physician resulted in one outcome – Interactive Audit)

The following outcomes were determined at CSC.

63	#1 Outcomes
14	#2 Outcomes
4	#3 Outcomes
5	#4 Outcomes
5	#5 Outcomes
*1	Other – Full Practice Audit, Interactive Audit and More Information Requested (two cases = one outcome, same registrant involved in two single case reviews)
91	Total outcomes

Standards Sub-Committee Reporting

CSC receives quarterly and annual reports from the various Standards Committees within the province. The following table represents the active committees by region and status.

Current active Committees by Region:

Committee	RHA	Chair	Last Report Received
Brandon Regional Health Centre ASC	Prairie Mountain	Dr. Brian Bookatz	16-Dec
Interlake-Eastern ASC	Interlake-Eastern	Dr. Habtu Demsas	14-Jan
Northern ASC	Northern	Dr. Shadi Mahmoud	14-Jan
Portage ASC	Southern	Dr. Jim Ross	05-Feb
Prairie Mountain Health ASC	Southern	Dr. Shannon Prud'homme	25-Apr

For Information BN Council Committees Reports

Southern ASC	Southern	Dr. Shayne Reitmeier	17-Feb
Boundary Trails Health Centre	Southern	Dr. Kevin Convery	23-Oct
Eden Mental Health Centre	Southern	Dr. William Miller	23-Dec
CancerCare	Provincial	Dr. Chantalle Menard	09-Sep
Endoscopy Provincial	Provincial	Dr. Gerard Coneys	19-Feb
Orthopedic Surgery Provincial	Provincial	Dr. Eric Bohm	04-Apr
Winnipeg Regional Health Standards Committee	WRHA	Dr. Elizabeth Salamon	29-Apr-2024

Cumulative Reporting by Area/Region

The following cumulative report includes total numbers from Quarter 3 reports received from all Provincial Standards Committees and Area Standards Committees for the months of December 2025 – February 2026.

	Cases Reviewed	Total	Suggested Change Outcomes		Required Change Outcomes		
			Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Plan	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
All Regional Area Standards Committees	Cases Reviewed due to an Adverse Patient Outcomes (APO)	24	23	1			
	Cases Referred because of a concern but not an APO	0					
	Non-APO cases – either routine or randomly selected	0					
	Practice Review or Interactive Review	0					
	Newsletter Item	0					
	Referral to Another Organization	0					
	Number of Meetings in 2025	26					

Respectfully submitted by
Dr. Roger Süss
Chair, Central Standards Committee

ELECTIONS COMMITTEE REPORT:

On December 10, 2025, Council approved the appointment of Dr. Kevin Convery, Dr. Rizwan Manji and Mr. Neil Cohen to the Elections Committee for two annual election cycles. Council also directed the

For Information BN Council Committees Reports

Executive Committee to add a female member to the Committee. On January 19, 2026, Executive Committee appointed Ms. Lynette Magnus to the Committee.

The Committee met January 28, 2026, and reviewed the Terms of Reference, the open Councillor positions, timelines and the required election materials. The Committee approved the *Call for Application; Application; Councillor Election Pamphlet; and the Call Letter* to be distributed to Registrants.

The Committee discussed its strategy for contacting organizations and key individuals to request names of potential candidates.

The next meeting is scheduled for March 12, 2026 to review and evaluate applicants. This work must be completed by March 24 to allow sufficient time for an appeal process prior to the Election Period beginning April 16th.

Respectfully submitted by
Dr. Kevin Convery
Chair, Elections Committee

FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

The Finance, Audit & Risk Management Committee met on February 25, 2026, the items below represents the summary of the meeting.

2025-26 3rd Quarter Update - Financial Results

CPSM has posted a net surplus of $1,140,000 vis-à-vis budget of $65,000 net deficit, resulting in $1,077,605 favorable variance. Favorable variances of $488,000 in Revenues and $581,000 in Expenditures both played significant roles in producing a solid operating results for the 3rd quarter. Management is forecasting a year-end surplus of $900,000.

Investment Update

Year to date investment returns is seeing an increase over the previous year and are tracking at a 6.8% return.

2025-26 Operating Budget

Management presented the 2026-27 budget as well the forecasted budgets to 2028-29. Management also provided background on human resources growth by program. Growth in staffing is primarily contained the Quality Department (net of 0.2 Eft increase) and the Manitoba Quality Assurance Program (1.0 EFT net increase). Management recommended that the certificate of practice fee be increased by the rate of inflation which is currently estimated to be 2%. The committee unanimously agreed to recommend to Council that the 2026-27 budget be approved.

Financial Management Policy

The committee reviewed detail as well as environmental scans related to honorariums, stipends and preparation time for committees. FARMC recommended the following changes effective May 1, 2026;

- Increase hourly honorariums from $150-$160, chair rates from $70-$80 and evening meetings from $190-$200. Honorarium were last increased in 2023.
- Increase Council stipends by 5%. Council stipends had been held static since 2019.
- Formally adopt preparation time for the Investigations Committee (2 hours maximum) as well as the Inquiry Committee (2 hours maximum) into the Financial Management Policy. Previously the Complaints Committee, which is being discontinued, and the Inquiry Committee received preparation time (2 hours for the Complaints Committee per meeting and no limit for preparation time for each Inquiry Committee meeting), however this was not documented in CPSM policy.

Bill Payment Initiative

CPSM successfully introduced the bill payment option for payment of fees by the members with a utilization rate of 8%. Utilization regarding incenting Registrants to increase the bill payment option, which decreases credit card fee, will be reviewed for the next membership year.

Respectfully submitted by
Dr. Kevin Convery
Chair, Finance, Audit & Risk Management Committee

INQUIRY COMMITTEE REPORT:

Dr. Nazmun Nahar Bhuiyan was summoned and appeared before an Inquiry Panel on November 20, 2025. Dr. Bhuiyan waived reading of the charges as set out in the Notice of Inquiry and entered a plea of guilty to all counts relating to all the charges set out in the Notice of Inquiry. The Panel accepted the guilty plea and determined that the Joint Recommendation as to disposition was appropriate in the circumstances. Dr. Bhuiyan was reprimanded by the Panel, will pay costs and her entitlement to practice medicine will be limited in accordance with the terms and conditions set out in the Agreement and Undertaking as well. This matter was published onto the CPSM website January 28, 2026.

At the September 24, 2025 Council meeting, Council appointed eight registrants to the Inquiry Committee and nominated to the Minister of Health, three appointments to the public roster. To date, we are awaiting on the approval of the Minister of Health.

An Inquiry Committee Orientation was held February 6th, 2026 lead by Ms. Lynda Troup, TDS. The orientation was well attended.

Respectfully submitted by
Dr. Nader Shenouda
Chair, Inquiry Committee

For Information BN Council Committees Reports

INVESTIGATION COMMITTEE REPORT:

Since the last reporting, the Investigation Committee met December 3, 2025, January 7 & February 11, 2026, with the February 11th meeting being chaired by Dr. Ganesan Abbu.

At the December 3, 2025 meeting, nine cases were reviewed with the following outcomes:
- Criticism – 1
- No Further Action – 6
- Undertaking – 2

At the January 7, 2026 meeting, twelve cases were reviewed with the following outcomes:
- Advice – 1
- Criticism – 1
- No Further Action – 7
- Refer to Inquiry – 1
- Undertaking – 2

At the February 11, 2026 meeting, eleven cases were reviewed with the following outcomes:
- Chart Audit – 1
- Criticism – 3
- Informal Resolution – 1
- No Further Action – 5
- Undertaking - 1

As of February 15, 2026, there are 272 open investigations.

As a result of the recent restructuring, the number of matters being referred to the Investigation Committee has increased. The Complaints and Investigations Department have expanded its staffing capacity and is now able to manage a higher volume of work, resulting in more cases being prepared for review by the Investigation Committee. To ensure timely review of these matters, increasing the frequency of Investigation Committee meetings would be beneficial. To support this, additional panel members are required to serve on the Investigation Committee to help facilitate an expedited review process.

Respectfully submitted by
Dr. Jennifer McNaught
Chair, Investigation Committee

PROGRAM REVIEW COMMITTEE REPORT:

Diagnostic Facilities:

In January 2026, the new Diagnostic Imaging Standards were officially rolled out. It is anticipated that the first accreditation inspections using the new standards will happen this spring.

Non-Hospital Medical Surgical Facilities (NHMSF):

The Committee continues to monitor and discuss trends as they appear in the Adverse Patient Outcome (APO) data. Discussion occurred around the expectations for NHMSFs to identify and manage patients who are at a higher risk of urinary retention / voiding prior to discharge.

In September 2024, the requirement was added to the Accredited Facility Bylaw that Registrants who perform anesthesia services in dental clinics report adverse patient outcomes to CPSM. In September 2025, a memorandum of understanding (MOU) was signed with the Manitoba Dental Association (MDA) to share information where there is crossover in Manitoba private clinics for dental procedures and anesthesia services. The Committee discussed their roles and responsibilities as it relates to the different facility types (dental clinic vs NHMSF) and services (dental procedure vs anesthesia).

Respectfully submitted by
Ms. Leanne Penny
Chair, Program Review Committee

COUNCIL MEETING
MARCH 18, 2026
FOR INFORMATION BRIEFING NOTE

**SUBJECT:**   2026-2027 CPSM Council Meeting Dates

BACKGROUND:

Please note the following dates have been selected for the 2026/27 calendar year for the CPSM Council meetings for the interim:

- September 23, 2026 *distribution of package required on September 9*
- December 9, 2026 *distribution of package required on November 25*
- March 17, 2027 *distribution of package required on March 3*
- June 16, 2027 *distribution of package required on June 2*

Final review for approval of those dates along with all CPSM Council Committees 2026/27 meeting dates will occur at the June 24, 2026 Council meeting.

For Information Briefing Note prepared by: Ms. Barbie Rodrigues, Senior Executive Assistant
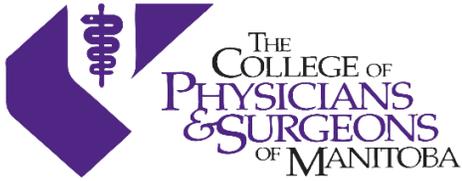
SUBJECT: Performance Metrics IT

As Organizations become more reliable on information technology, they also become more vulnerable to cyberthreats. Cyber-attacks are becoming more sophisticated and with the proliferation of AI, the tools cybercriminals have at their discretion has once again altered the playing field.

BACKGROUND:

Cybersecurity typically fails due to a lack of adequate controls. No organization is 100% secure, and organizations cannot control threats or bad actors. Organizations only control priorities and investments in security readiness.

CPSM is taking the following initiatives to improve our security posture.

1. **Multi-Factor Authentication** [MFA] in the CPSM Portal for all Registrants
   a. MFA is a "best practice" in any cybersecurity posture (CPSM staff already utilize MFA in the CPSM Portal)
   b. Planned Implementation
      i. Introduction on Spring, 2026
      ii. Allow those who log into the CPSM Portal to opt into using MFA.
      iii. Provide step-by-step instructions and a QR Code link to set up MFA using an Authenticator application on a cell phone.
      iv. After September 1, 2026, this will become mandatory
   c. MFA for staff when working in the domain
      i. Staff working at the CPSM offices have not had to use MFA to login to the system until now. This will prevent "bad actors" from using stolen credentials to access the system.

2. **Penetration Testing**

CPSM recently underwent penetration testing by an external vendor. The testing focused on the following areas; External, Internal, and Social Engineering.

External Access

Scorecard and Summary of Findings

The penetration test revealed a strong security posture with minimal vulnerabilities.

- CPSM received a grade of A due to the lack of exploitable vulnerabilities.
- There were 0 critical and high findings, 1 medium finding, and 2 low findings.
- The identified vulnerabilities posed a significantly smaller risk.

Internal Network

Scorecard and Summary of Findings

The penetration test revealed the existence of some issues that would allow for small scale compromise but an overall healthy security posture.

- CPSM received a grade of B.
- There were 0 critical and 2 high findings, 2 medium findings, and 2 low findings.
- SRG was able to compromise some user accounts and devices through the use of relaying and cracking. This represents the majority of the risk to the environment, but some other issues exist as well which allow for information disclosure, or which increases ransom potential.
- Overall, the issues identified are not pervasive and can be relatively easily remedied.

Social Engineering

This component evaluated the College of Physicians and Surgeons of Manitoba's employee resilience against phishing attacks through controlled social engineering assessments.

Executive Summary

- Two phishing campaigns were conducted: one focused on credential harvesting via a fake "Beta Portal" and the other using a charity-themed lure related to the United Way program.
- Both campaigns were executed in a controlled environment, ensuring no impact on production systems.
- A notable number of employees engaged with the phishing attempts, indicating vulnerability to both technical and socially themed attacks.

KEY FINDINGS:

- Engagement metrics showed that 32% of employees opened phishing emails, with 12% clicking links and 10% submitting credentials in the Beta Portal campaign.
- The United Way campaign had similar open rates, with 33% opening emails and 11% submitting credentials.
- Employees were more likely to provide sensitive information when presented with familiar, socially oriented themes, highlighting the effectiveness of such lures.

Recommendations

- Strengthening employee awareness and reinforcing reporting procedures are essential to mitigate risks associated with phishing attacks.
- Continued phishing simulations will help build long-term resilience against these threats.

Remediation

Most items identified by the external consultant have or are in the process of being implemented. Once complete, CPSM will engage with the external consultant to test the remediated systems.

Centre for Internet Security – Monitored Security Controls

CPSM has worked with our partner MSP Corp (formerly Broadview Networks) for several years in reviewing our systems, controls and policies. The latest scorecard on page 4 of this briefing note identifies CPSM's current score against 18 security controls. All items are continuously being worked on and updated to improve scoring. A low score with many controls implemented means that policies need to be written and adopted to improve scoring. CPSM scores in the **top 25 percentile** of organizations of similar size.

MSP Corp Executive Summary
The chart below shows CPSM's Centre for Internet Security score from February 2023 to October 2025. As CPSM continues to address cybersecurity issues, the progress from an overall scorecard perspective will slow.

For Information BN Performance Metrics IT

SCORE CARD					
	Feb 2023	Feb 2024	Nov 2024	Feb 2025	Oct 2025
CIS V.8	**24%**	**49%**	**53%**	**57%**	**59%**
1. Inventory and Control of Enterprise Assets	51%	53%	53%	66%	66%
2. Inventory and Control of Software Assets	32%	36%	36%	61%	61%
3. Data protection	35%	47%	47%	47%	47%
4. Secure Configuration of Enterprise Assets and Software	34%	61%	61%	61%	61%
5. Account Management	28%	39%	51%	51%	51%
6. Access Control Management	34%	47%	52%	52%	52%
7. Continuous Vulnerability Management	34%	35%	69%	69%	69%
8. Audit Log Management	Q1 2023	68%	69%	69%	69%
9. Email and Web Browser Protections	36%	63%	63%	63%	63%
10. Malware Defense	53%	69%	69%	69%	69%
11.Data Recovery	50%	54%	54%	54%	54%
12. Network Infrastructure Management	27%	42%	52%	53%	53%
13. Network Monitoring and Defense	Q1 2023	56%	58%	58%	58%
14. Security Awareness and Skills Training	Q1 2023	52%	52%	58%	58%
15. Service Provider Management	Q2 2023	47%	47%	54%	54%
16. Application Software Security	Q2 2023	34%	34%	34%	46%
17. Incident Response Management	Q3 2023	42%	42%	56%	56%
18. Penetration Testing	Q3 2023	33%	33%	38%	69%

Additional Initiatives – Winter 2025-26

- Tabletop Exercise for Disaster Recovery – December 2025
  - The IT team is tasked with a number of scenarios, technical in nature, which specifically delves into the technical response to a specific issue. In addition, the technical issue is later escalated and involves members of the senior leadership team. The goal is to stress test the critical incident command system from an internal perspective (technical and internal communications) to how CPSM would respond to the external partners public.
    - The IT Team is working through the recommendations from the tabletop sessions. The next step is to run a cyber security tabletop exercise at the SLT level.

- Sensitivity Labels implementation to better protect sensitive data.

For Information Briefing Note prepared by: Mr. Paul Penner, Chief Financial Officer

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA
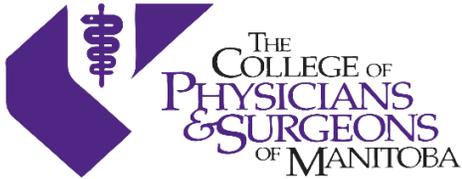
COUNCIL MEETING
MARCH 18, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Council Training
- Governance
- Integrated Risk Management and Cyber Security

BACKGROUND:

A highly functioning Council requires its members have a comprehensive understanding of the roles, responsibilities, and best practices for nonprofit regulatory councils. The training topics that have been agreed upon as being beneficial are Governance in Action, Integrated Risk Management, and Cyber Security.

Training Available June 24, 2026

1. Integrated Risk Management: (**45 Minutes**)
   a. Risk Management – What it means in terms of Governance
   b. FIRMS process and framework for Integrated Risk Management
   c. Top Risk Report (non-acute) and Environmental Scan
   d. Review of the 21 question IRM tool
   e. Cyber Governance and HIROC support
   f. Closing with a scenario that allows for the distinction between operations and governance

Presented by CPSM insurer - Healthcare Insurance Recipricoral of Canada (HIROC)

2. Cyber Security: (**15 Minutes**)
   a. Review of threats and mitigations that are integrated into CPSM's information technology service
   b. Rating and Evaluation

Training available September 23, 2026 (tentative date, approval at June 24 Council)

3. Governance In Action   (**3 hours**)
   a. Clarifying Oversight Roles for Councils and Executive Teams
   b. Governance Fundamentals: The Council's Legal and Fiduciary Duties
   c. Executive Roles & Council Support
   d. Shared Oversight Responsibilities & Decision-Making Protocols

Proposed Presenter Ms. Judy Murphy - Biography attached (**Appendix A**)   Cost $1850

For Information BN CPSM Council Training Governance and Cyber Security

Alternatives

Education available from the Council on Licensure, Enforcement and Regulation (CLEAR), Introduction to Regulatory Governance includes 5 topics of learning in 3 formats; online self-paced, on demand board hosted, or live hosted virtual offerings (next available dates noted below) with a recording available for 30 days.
[Board Member Training - Council on Licensure, Enforcement and Regulation](#)

1. Foundations of Occupational and Professional Regulation
   Content includes: the importance of regulatory boards; rationale for licensure; typical pro and con arguments; and an overview of trends in licensure.
   March 12, 1:00-2:00 PM Eastern

2. Roles and Responsibilities of a Board Member
   Content includes: board member responsibility; defining "the public interest"; requirements for service on regulatory boards; how a board member can participate effectively; the purpose of appointing public members; and ethical considerations.
   April 16, 1:00-2:00 PM Eastern

3. Administrative Rulemaking
   Content includes: what is a rule; kinds of rules; authority to issue rules; when is a rule needed; writing a good rule; avoiding problem areas; regular procedures for adopting rules; notice and publication; public comment and hearing process; and emergency rulemaking.
   May 21, 1:00-2:00 PM Eastern

4. Professional Discipline
   Content includes: steps in the enforcement process; characteristics of a strong enforcement process; receiving and sharing information; types of disciplinary sanctions; and practitioner impairment.
   June 18, 1:00-2:00 PM Eastern

5. Assessing Competence
   Content includes: the board's role in entry to practice assessments, continuing education programs and their applicability; and ways to evaluate continued competence.
   July 16, 1:00 - 2:00 PM Eastern

Costs for the program are:

Online self-paced – 1-year unlimited licences	**$1945 USD**
On Demand Board Hosted – the council views together	**$835 USD**
Limited to 1 board for 1 year	
Live Hosted Virtual with a recording available for 30 days	**$270 USD/registration**

For Information Briefing Note prepared by: Ms. Sherry Dupuis, Executive Director, People and Culture and Paul Penner, Chief Financial Officer

YOUR CONSULTANT

Murphy's Executive Leadership is dedicated to equipping you and your board or teams with the tools and skills you need so you can perform at your best, feel confident and maximize your individual and collective impact on the world. We accomplish that through supporting organizations in board governance, strategic planning and executive and team coaching.

Judy Murphy

Judy draws on her nearly three decades of on-the-ground experience gained from multiple perspectives: CEO, Board Director, Consultant and Coach.   Judy's clients include not-for-profit organizations, for-profit companies, Provincial Crowns and Agencies and post-secondary institutions.   Judy has also worked extensively with self-regulated bodies including CPA Manitoba and CPHR Manitoba both in board development and strategic planning.

She is the owner of Murphy's Executive Leadership. Previously, she was President & CEO of Safety Services Manitoba and Practice Leader for Strategy and Governance for MNP. She has held executive leadership positions in three other organizations. She also teaches Ethical Behaviour for the Certified Management Consultants of Canada. Judy taught Organizational Behaviour for the University of Winnipeg's PACE Programs for six years.

Boards
She is currently Chair of the St. Boniface Hospital and the Vice-Chair of the Reh-Fit Centre where in both organizations she previously chaired the Governance and Nominating Committee. She was also previously the external member for the Finance, Audit and Risk Committee of Doctors Manitoba. She has previously been the Chair of both the Manitoba and Winnipeg Chambers of Commerce, a Board Director and Finance and Audit Committee Chair for the Crown Corporations Council of Manitoba and for the Manitoba Centennial Centre Corporation. She was previously a member of the Premier's Economic Advisory Council where she chaired three task groups.

Judy brings expertise and depth of experience in:
- Board Governance
- Team Development (Insights Discovery and Myers Briggs);
- Strategic and Operational Planning; and
- Systemic Team Coaching and Executive Coaching.

Designations and Credentials
- Certified Management Consultant (CMC)
- FCPA, FCA (Institute of Chartered Accountants of Manitoba)
- ICD.D (Designated Corporate Director; Institute of Corporate Directors/Rotman School of Business – University of Toronto)
- BA (University of Manitoba)
- CPHR (Chartered Professional in Human Resources)
- Certified Executive Coach (Royal Roads University)
- Accredited Systemic Team Coach Practitioner (European Mentoring and Coaching Council)
- Accredited Executive Coach (International Coach Federation)
- Licensed Practitioner for Insights Discovery
- Certified in Enneagram Studies with Russ Hudson and Jessica Dibbs
- Certified Trainer in Resilience at Work for individuals, leaders and teams
- Certified practitioner in Myers Briggs Typology and Emotional Intelligence 2.0 Clients