June 2022 Council Meeting

Wednesday, June 22, 2022 | 8:00 a.m. |

AGENDA

CPSM Office – Brown Room

1000 – 1661 Portage Avenue

	Time	Item		Action	Presenter	Page #
8:00 am	5 min	1.	Opening Remarks		Dr. Elliott	
8:05 am	0 min	2.	Agenda – Approval			
8:05 am	0 min	3.	Call for Conflict of Interest			
8:05 am	5 min	4.	Consent Agenda • Council Meeting Minutes March 23, 2022 • Reappointment of Ms Magnus • Financial Management Policy • Fee Bylaw	For Approval	Dr. Elliott	3
8:10 am	45 min	5.	Prescribing Practices Program Update - Presentation	For Information	Dr. Reinecke	31
8:55 am	45 min	6.	Strategic Organizational Priorities for 2022/23	For Direction	Dr. Elliott Ms Kalinowsky Dr. Ziomek	32
9:40 am	45 min	7.	Operating Budget & Fees 2022/23	For Approval	Dr. Shenouda Mr. Penner	78
10:25 am	20 min	8.	-- Break --			
10:45 am	30 min	9.	Standard of Practice - Episodic, House Calls, & Walk-in Primary Care	For Information	Ms Penny Mr. Barnes Ms Kalinowsky	112
11:15 am	5 min	10.	Appointments to Committees 2022/23	For Approval	Dr. Elliott	198
11:20	10 min	11.	Registrar's Report	For Information	Dr. Ziomek	205
11:30 am	0 min	12.	2022 – 2033 Meeting Dates	For Information	Dr. Elliott	208
11:30 am 12:00	30 min	13.	In-Camera Session: • With the Registrar in attendance • Without the Registrar • Review of Self-Evaluation of Governance Process			209
4 hours	0 min		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 – JUNE 22, 2022
CONSENT AGENDA
NOTICE OF MOTION FOR APPROVAL

SUBJECT: Consent Agenda

BACKGROUND:

Council used to utilize consent agendas to expedite its meetings and ensure the time spent at the meeting is productive, focussed on governance and fulfilling its mandate.

In order to make Council meetings more efficient and effective the consent agenda will be re-introduced. Routine and non-contentious business has been consolidated into a 'consent agenda'. Many organizations and their committees use consent agendas. Some Councillors may not have encountered a consent agenda previously. How the consent agenda works:

1. The President decides which items will be placed on the consent agenda. The consent agenda will appear 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 moved to the regular discussion items.
4. If a member requests an item be moved, it must be moved. Any reason is sufficient to move an item. A member can move an item to discuss the item, to query the item, or to vote against it.
5. Once the item has been moved, the President may decide to take up the matter immediately or move it to a discussion item.
6. When there are no items to be moved or if all requested items have been moved, 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.

Any item can be removed from the consent agenda if notice is provided to the President at least 24 hours prior to the meeting of Council.

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

i. Council Meeting Minutes – March 23, 2022

ii. Reappointment of Ms Magnus

iii. Financial Management Policy

iv. Fee Bylaw

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 22, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

All items on the consent agenda are approved as presented.

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MINUTES OF COUNCIL

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on March 23, 2022 in person.

1. CALL TO ORDER

The meeting was called to order at 08:00 a.m. by the Chair of the meeting, Dr. Jacobi Elliott.

COUNCILLORS:

Ms Leslie Agger, Public Councillor
Ms Dorothy Albrecht, Public Councillor
Mr. Chris Barnes, Associate Member
Dr. Kevin Convery, Morden
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor
Dr. Ravi Kumbharathi, Winnipeg
Ms Lynette Magnus, Public Councillor
Dr. Wayne Manishen, Winnipeg
Dr. Norman McLean, Winnipeg
Ms Marvelle McPherson, Public Councillor
Dr. Charles Penner, Brandon
Ms Leanne Penny, Public Councillor
Dr. Brian Postl, Winnipeg
Dr. Mary Jane Seager, Winnipeg (Virtually)
Dr. Nader Shenouda, Oakbank
Dr. Eric Sigurdson, Winnipeg (Virtually)
Dr. Heather Smith, Winnipeg
Dr. Brett Stacey, Flin Flon
Dr. Roger Süss, Winnipeg

GUEST: Dr. Lisa Monkman for Item #7

STAFF:

Dr. Anna Ziomek, Registrar
Dr. Ainslie Mihalchuk, Assistant Registrar
Dr. Karen Bullock Pries, Assistant Registrar
Ms Kathy Kalinowsky, General Counsel
Mr. Paul Penner, Chief Operating Officer
Ms Karen Sorenson, Executive Assistant
Dr. Marina Reinecke attended for Item 6

REGRETS:

Dr. Daniel Lindsay, Selkirk
Dr. Ira Ripstein, Winnipeg

2. ADOPTION OF AGENDA

IT WAS MOVED BY DR. ROGER SUSS, SECONDED BY DR. CHARLES PENNER:
CARRIED:

That the agenda be approved with the removal of Consent Agenda Item 4.iii Practice Direction – Appeals inclusion in PD CC/IC Resolving Conflict 7 CPSM's CC/ICC Process which was removed and placed at the end of the agenda.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

Dr. Elliott 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

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MS MARVELLE MCPHERSON:
CARRIED

- That the minutes of the December 8, 2021, and February 17, 2022, meetings be approved.
- That Nuclear Medicine be added to the Qualifications and Registration Practice Direction as a Specialist Field of Practice for Assessment for the purpose of CPSM General Regulation Section 3.38(b).

5. STANDARD OF PRACTICE EPISODIC, HOUSE CALLS, AND WALK-IN PRIMARY CARE

Ms Penny provided an overview and the reasoning for the need for this Standard of Practice and Mr. Barnes explained both the main components of the draft Standard of Practice and the approaches of the Working Group.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. ROGER SUSS:
CARRIED

That the draft Standard of Practice - Episodic, House Calls, and Walk-in Primary Care be distributed to the public, stakeholders, and membership for consultation.

6. M3P – ADDITION OF TRAMADOL AND TRAMACET

Dr. Marina Reinecke presented the rationales for the inclusion of Tramadol/Tramacet in the M3P Schedule. After some discussion regarding Tramadol/Tramacet, Council discussed whether Codeine should be added to the M3P Schedule.

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY MR. ALLAN FINEBLIT:
CARRIED

That direction be provided to work with the College of Pharmacists of Manitoba to consider adding Codeine containing preparations to the M3P Schedule as part of the Prescribing Rules Review.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. BRIAN POSTL:
CARRIED

That Tramadol Products and Preparations be included on the M3P Schedule.

Dr Reinecke withdrew from the meeting. The agenda order was revised due to time.

7. TRC ADVISORY CIRCLE UPDATE

Dr. Lisa Monkman, Chair of the TRC Advisory Circle to Eradicate Anti-Indigenous Racism in Medical Practice provided an update on the activity of the CPSM TRC Advisory Circle. Dr. Monkman shared personal experiences with racism in the health care system. Council viewed the film "The Unforgotten – A Five Part Film Exploring the Health and Well-Being of Indigenous Peoples Living in Canada" and further discussion followed.

Dr. Monkman withdrew from the meeting.

8. REFERENCE TO REGISTRANT IN CPSM MATERIALS

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MR. ALLAN FINEBLIT:
CARRIED

That the word "Registrant" be substituted for "Member" in the CPSM Bylaws, Standards of Practice, Practice Directions, and Policies unless it is a direct quote from the legislation.

9. PRACTICE DIRECTION APPEALS INCLUSION IN PD CC/IC RESOLVING CONFLICT & CPSM'S CC/IC PROCESS

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MS LEANNE PENNY:
CARRIED

That the Practice Direction – Appeals from Investigation Committee Decisions be approved as presented.

10. STRATEGIC ORGANIZATIONAL PRIORITIES UPDATE

Councillors were presented with the Progress Chart for the Strategic Organizational Priorities and progress.

11. COMMITTEE REPORTS

The following Reports were presented to Council for information:

- Executive Committee
- Audit & Risk Management Committee
- Complaints Committee

- Investigation Committee
- Program Review Committee
- Quality Improvement Committee
- Standards Committee

12. REGISTRAR/CEO'S REPORT

Dr. Ziomek provided Council with a written report for information outlining the matters currently being dealt with at CPSM. Dr. Ziomek spoke verbally to this report and answered the questions presented by the Councillors.

13. IN CAMERA SESSION

An in-camera session was held, and the President advised that the 2022/23 Deliverables of the Registrar were approved.

There being no further business, the meeting ended at 1:00 p.m.

_____

Dr. J. Elliott, President

_____

Dr. A. Ziomek, Registrar

COUNCIL MEETING - JUNE 22, 2022
CONSENT AGENDA ITEM

TITLE: **Re-Appointment of Lynette Magnus**

BACKGROUND

Lynette Magnus is a public representative on Council appointed by Council. Her four-year term expires in June 2022. The Executive Committee acting in its capacity to nominate councillors recommends the re-appointment of Ms. Magnus for a further four year term. Ms. Magnus has agreed to a re-appointment for a further four years should Council re-appoint her.

By way of background, Ms. Magnus is a Chartered Accountant. She sits on the Investigation Committee and the Finance Audit and Risk Management Committee. She has participated in many CPSM Working Groups to develop Standards of Practice. Ms. Magnus is the Vice-Chair of the Board of Governors of the University of Manitoba.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 22, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> Ms Lynette Magnus be re-appointed to Council for a four-year term commencing June 22, 2022.

COUNCIL MEETING –JUNE 22, 2022

CONSENT AGENDA ITEM

SUBJECT: Financial Management Policy

BACKGROUND:

There are three changes to the Financial Management Policy, as tracked in the attachment.

1 – Forecast of Inquiry Cases for Annual Operating Budget

> Rather than estimate the potential costs of inquiry case on a periodic basis, this estimate will be performed annually as part of the annual operating budget process.

2 – Clarification is provided for Travel Expenses.

3 – Mileage

> The mileage reimbursement rate is set to equal that used by Shared Health.

Annually the Council must review the honoraria and stipends paid by CPSM and fix them for the next fiscal year as per the Financial Management Policy. In setting the Honoria and stipends the Council must take into account the Finance Audit & Risk Management recommendations to Council as to the appropriate level for honoraria and stipends. No changes have been made to the honoraria and stipends.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 22, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> The Financial Management Policy be approved as attached.

THE COLLEGE OF PHYSICIANS & SURGEONS

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

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 $50,000.

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 $~~5~~60,000 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 $~~5~~60,000 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 this Policy.

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 extraordinary number of inquiry cases based on historical cost that management will analyze as part of the annual operating budget process~~on a periodic basis~~.

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 of CPSM of no less than $2,922,000 for the 2018-19 fiscal year, and thereafter adjusted annually for applicable inflationary and general salary increases.

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 6.2.1 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.
- 1.11.2. Incur debt in an amount greater than can be repaid by certain, otherwise unencumbered revenues within 60 days.

1.12. The Registrar must:
- 1.12.1. settle CPSM payroll and debts in a timely manner.
- 1.12.2. settle CPSM payroll and debts in a timely manner.
- 1.12.3. aggressively pursue receivables after a reasonable grace period.
- 1.12.4. 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 $50,000.

1.14. The Registrar must not acquire, encumber or dispose of land or buildings.

1.15. Registrar must not initiate legal action outside of the disciplinary process.

Investment Policies

1.16. CPSM investments must be managed in a way that preserves capital, provides necessary liquidity requirements, and adds value to the investments.

1.17. Speculation or leverage with CPSM investments is prohibited. This includes, but is not limited to, prohibition on equity investments, investments in options, futures and any type of derivative.

1.18. CPSM investments must be maintained in a conservative, low risk profile within the following parameters:

1.18.1. Short and medium term, cashable, fixed income obligations are permitted.

1.18.2. Permissible asset classes for CPSM investments are cash and money market securities and fixed income instruments, provided that each investment must have a minimum "A" or "R1" credit rating or equivalent as rated by a recognized rating service at the time of purchase.

1.18.3. Where liquidity is the primary concern, cash and money market securities are limited to treasury bills and other short-term government securities, bankers' acceptances, and guaranteed investment certificates with term to maturity of not more than 365 days.

1.18.4. Where long term growth is the primary concern, fixed income instruments are limited to federal and provincial bonds, municipal bonds, corporate bonds, and guaranteed investment certificates with a term to maturity of one to ten years.

1.18.5. Before making any investments, advice must be obtained from CPSM's professional portfolio advisor.

1.18.6. Performance of the investments must be reviewed at least semi-annually and reported to the Audit & Risk Management Committee and Council.

1.18.7. No investment may be made without taking into account the cash requirements for day-to-day operation of CPSM.

1.18.8. All parties involved in dealing with CPSM investments must disclose any conflict of interest.

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 the CPSM for reasonable expenses necessarily incurred in connection with the business of the 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 the 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 Quality Improvement Committee and Area Standards Committees, are not entitled to be reimbursed by the CPSM or to receive honoraria by the 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.

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 the 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 and the Investigation 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 set out in section 302, 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. 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 who travel more than one hour to attend meetings in Winnipeg, 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. 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.iii. 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.iv. 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.~~2.5.1.c.v. Total expense for a member travelling will be set at a maximum of what is calculated in 2.5.1.c.iv. 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 regularly scheduled 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, telephone call to home or office, 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 the CPSM Expense Policy.

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: $15~~0~~
- Lunch: $25~~0~~
- Dinner: $35~~0~~

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 and Investigation Chair,

2.7.1.c. fix the honoraria and stipends for the next fiscal year. In setting honoraria and stipends,

2.7.2. Council must take into account:

2.7.2.a. the amount of the honoraria or stipends 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.

2.8. Honoraria and Stipends

2.8.1. Honoraria

Hourly	$135
Half Day	$500
Full Day	$1000
Evening	$175

2.8.2. Stipends

President	$12,500
President-Elect	$5,000
Investigation Chair	$10,000

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 $135.00 per hour of meeting time to a committee maximum of $10,800 per year (based upon 5 members x 16 hours x $135.00 = $10,800)

2.9.1.b. reimbursed for mileage from their office to the meeting place ~~at .52 per kilometer~~ 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.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING - JUNE 22, 2022

CONSENT AGENDA ITEM

TITLE: **Fee Bylaw Amendments**

BACKGROUND

The Fee Bylaw contains both the rules or policies relating to fees and additionally a comprehensive schedule of fees charged by CPSM. The fees are grouped under the categories of registration, certificates of practice, medical corporations, non-hospital medical surgical facilities fees, and various sundry fees charged by CPSM. These sundry fees range from fees charged for photocopies, audits, Certificates of Professional Conduct, to late fees.

The Fee Bylaw contains the provision that the annual registration fee is to increase automatically every year by the rate of Manitoba Consumer Price Index. Other increases must be approved by Council.

The RHPA provides that Council may make a fee bylaw:

> "prescribing the fees payable by members and applicants for registration, and the fees payable for certificates of practice and health profession corporation permits, or the manner of determining those fees, which may be different for different classes of memberships."

The RHPA also provides that Council may make a fee bylaw:

> "respecting fees payable by applicants for accreditation and by accredited facilities."

In essence, the Fee Bylaw need only contain the four types of fees underlined above.

CPSM Staff is reviewing all fees payable to determine whether there is appropriate cost allocation – namely whether the fees charged for an activity or service are sufficient to cover all costs associated with the activity or service. This is to prevent cross subsidization. As an example the cost incurred by CPSM to register Clinical Assistants should be all paid by Clinical Assistants and not from the fees by other classes. Another example is the accreditation fees for accredited facilities should cover all costs incurred for the accreditation. The fees from registering physicians should not be used to cover the costs incurred during accreditation.

CPSM staff is also reviewing the costs of audits. A qualifications audit is listed at $300, an interactive audit at $600, but there is no fee listed for investigation audits or other quality audits. All audit costs will be reviewed and fees will be determined. Audit costs are highly variable depending upon the nature and extent of the audit. CPSM is considering charging hourly rates for some audits to ensure the costs are accurately covered.

In the meantime, the Fee Bylaw will be revised to only include those types of fees listed in the RHPA, namely, registration, certificates of practice, medical corporation permits, and accreditation/ accredited facilities. For accredited facilities the Fee Bylaw includes a $500 annual fee plus expenses. CPSM has built a charge model that covers expenses related to annual renewals and re-accreditation that occurs every five years. The charge model is tier based (small-medium-large) upon the procedures and their complexity. The charge is the expenses, which is not included in the bylaw. The charge will vary over time depending upon the expenses incurred. It is important that the expenses incurred for accreditation be paid by the facilities and not be subsidized by the annual registration fees paid by all registrants.

Charge Model - Expenses related to NHSF Accreditation

Charge Model	Size	# of Sites	Annual	Accreditation
Tier 1	Small	2	$ 750	$ 1,794
Tier 2	Medium	12	$ 5,200	$ 3,585
Tier 3	Large	6	$ 8,970	$ 7,732

Council will be required to approve only those fees in the Fee Bylaw. CPSM staff will set the other sundry fees, including audit fees. The fees set by CPSM management will be based insofar as possible on costs. These fees will be posted on the CPSM website. The fees in the schedule will be revised to reflect the decision of Council taken later in this meeting.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 22, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

The Fee Bylaw be approved as attached.

1000 – 1661 Portage Avenue
Winnipeg, Manitoba R3J 3T7
TEL: (204) 774-4344
FAX: (204) 774-0750
Website: www.cpsm.mb.ca

Fee Bylaw

The College of Physicians and Surgeons of Manitoba

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba on November 22, 2018 repealing and replacing Schedule E of Bylaw #1 under The Medical Act)

Effective Date January 1, 2019

Table of Contents

The following fees payable are set out in Schedule A to this Bylaw:

- Applicant's documentation and registration
- initial certificate of practice and for each renewal of a certificate of practice
- medical corporations for an initial permit and for each renewal of a permit
- late fees and daily assessments payable by a registrant who is in arrears of annual renewal of their certificate of practice
- fees payable by a registrant for an audit

FEES

Definition

1. **"certificate year"** means the time period for which a certificate of practice is issued for a particular class of registrants.

Fees Payable

2. Each registrant must pay the fees and levies applicable to the registrant as fixed by Council from time to time.

Increases in Fees

3. The fee for the annual certificate of practice shall automatically increase by an amount equal to the Manitoba Consumer Price index to cover inflationary costs.

4. Council may also increase the fee for the annual certificate of practice by an additional amount provided that management presents Council with a budget and a satisfactory rationale justifying an increase.

5. The council may issue a special assessment on some or all classes of registrants to cover unexpected expenses, which were not reasonably foreseeable at the time the budget was prepared.

Payment of Fees

6. Fees for all types of certificates of practice and permits are deemed to be a debt due to the College and must be paid in full on the due date stipulated in the renewal notice.

7. Notwithstanding section 6, classes of membership may pay their certificate of practice fee on a monthly basis in accordance with the fees set out in Schedule "A" to this Bylaw.

8. No renewal notice is sent to a certificate of practice paid on a monthly basis. Any registrant who wishes to continue to practise medicine in Manitoba after the expiry of his/her monthly certificate of practice must renew his/her certificate of practice and pay the certificate of practice fee before the effective date of the certificate of practice to be renewed.

9. A medical corporation permit is issued on an annual basis only and may not be obtained on a monthly basis.

Late Payment, Daily Assessments and Non-Renewal

10. Registrants must deliver a completed annual renewal of certificate of practice form and pay the annual certificate of practice fee to the College before November 1 each year. A registrant who does not meet this requirement is in arrears of annual renewal.

11. A registrant who is in arrears of annual renewal and who applies for renewal of his or her certificate of practice after November 1 and before November 30 or within such additional time as Council may allow, may apply to renew his or her certificate of practice, but must:
    a. pay the prescribed late fee; or
    b. if the Registrar exercises discretion to waive or lower the late payment fee, pay the reduced amount.

12. If a registrant fails to apply for renewal or to pay the late payment fees under section 11 before November 30, upon application for renewal by the registrant, the Registrar may renew the registrant's certificate of practice if the following conditions are met:
    a. the Registrar finds that exceptional circumstances exist warranting extension of the time for the registrant to apply for renewal; and
    b. the registrant pays the late payment fee and applicable daily assessment, unless the Registrar exercises discretion to waive or lower the late payment fee, the daily assessment, or both and the registrant pays the reduced amount.

13. Where the Registrar declines to extend the time for the registrant to apply for renewal, or the registrant fails to meet the conditions for renewal in section 12, the registrant must be notified of the right to appeal the Registrar's decision pursuant to s. 46 of the Act. Issuing a practice certificate effective a date other than the date the applicant applied for renewal is at the sole discretion of the Executive Committee. The appeal of the Registrar's decision must contain a complete written explanation of the circumstances that led to the failure to renew by the required renewal date.

14. Pending any appeal pursuant to section 46 of the Act, the registrant is not entitled to practice medicine unless and until the registrant is issued a certificate of practice.

Medical Corporation Late Payment and Non-Renewal

15. Section 10 to 14 apply to late applications or late payments for annual renewal of permits for medical corporations with all necessary modifications implied.

Administration Fees

16. The College may charge administration fees for services requested from the College in accordance with the administration fees approved by Council and set out on Schedule "A" to this Bylaw.

Fee Rebate

17. Where a registrant with an annual certificate of practice:
    a. has had a maternity or parental leave or has had an illness which required the registrant to take a leave of absence from the practice of medicine for a continuous period of at least two calendar months in any certificate year; and
    b. during the maternity or parental leave or leave of absence due to illness the registrant did not engage in the practice of medicine,

    the registrant may apply to the College for a rebate of fees.

18. Where a registrant with an annual certificate of practice dies, the legal representative of the estate may apply for a rebate of fees.

19. Fee rebates shall be calculated on a pro-rata basis, at the rate of one-twelfth of the certificate of practice fee for each full calendar month of the certificate year during which the registrant did not engage in the practice of medicine, but in all cases, there shall be a minimum certificate of practice fee equal to one-half of the amount of the applicable annual certificate of practice fee fixed for the certificate year for which the rebate is sought.

20. Applications for a fee rebate must be made to the College by November 30 of the certificate year immediately following the certificate year for which the rebate is sought. The applicant shall be solely responsible for providing such evidence as may be required by the Registrar in support of the application for fee rebate.

21. The Registrar is responsible to review and decide each application for fee rebate.

22. Where the Registrar does not approve the application for fee rebate, the registrant may appeal the decision to the Executive Committee.

23. Where an appellant has paid the prescribed fee to appeal a denial of registration, the fee shall be refunded if the appeal is successful.

Schedule A

	Applicant's Documentation Fee	Registration Fee	Certificate of Practice Fee	Late Payment Fee for Certificate of Practice (payment during first 30 days following due date)	Late Payment Fee for Certificate of Practice per day (after first 30 days)
REGULATED MEMBER - FULL					
Regulated Member – Full Practising	$210[1]	$300[2]	$1890 -per certificate of practice fee year $300 monthly $250 Resident per certificate of practice fee year $125 Resident reduced (8 months or less)	$200 $200 $50 $50	$50 $50 $10 $10
Non-Practising	---	---	$1890 required fee for those members who wish to maintain their medical corporation and require certificate of practice, otherwise $0.	---	---
Retired	---	---	---	---	---
REGULATED MEMBER – PROVISIONAL					
Academic Faculty S.181	$630	$300	$1890 per certificate of practice fee year $300 monthly	$200 $200	$50 $50
Academic Visiting Professor	$210	---	$100 per certificate of practice fee for the specified term	---	---
Academic Post Certification Trainees	$210	$300	$1890 per certificate of practice fee year $300 monthly $250 Resident per certificate of practice fee year $125 Resident reduced	$200 $200 $50 $50	$50 $50 $10 $10
Specialty Practice Limited	$210 Review of Qualifications $600[3][4]	$300[5]	$1890 per certificate of practice fee year[6] $300 monthly	$200 $200	$50 $50

[1] Excluding Manitoba Medical graduates
[2] Less any registration fee submitted as an Associate Member - Educational
[3] Less any documentation fee paid as an Assessment Candidate Specialty Practice Limited
[4] Less any fee paid for Review of Qualifications
[5] Less any registration fee paid as an Assessment Candidate Specialty Practice Limited
[6] Less any certificate of practice fee paid as an Assessment Candidate Specialty Practice Limited

	Applicant's Documentation Fee	Registration Fee	Certificate of Practice Fee	Late Payment Fee for Certificate of Practice (payment during first 30 days following due date)	Late Payment Fee for Certificate of Practice per day (after first 30 days)
Family Practice Limited	$210 Review of Qualifications $600[7] [8]	$300[9]	$1890 per certificate of practice fee year)[10] $300 monthly	$200 $200	$50 $50
MPAP	$600	---	---	---	---
Restricted Purpose	$210	$300	$100 per certificate of practice fee for the specified term	---	---
Temporary (locum)	$600	$300	$1890 per certificate of practice fee year $300 monthly	$200 $200	$50 $50
Public Health Officer	$600	$300	$1890 per certificate of practice fee year $300 monthly	$200 $200	$50 $50
Transitional	---	---	$1890 per certificate of practice fee year $300 monthly $250 Resident per certificate of practice fee year $125 Resident reduced	$200 $200 $50 $50	$50 $50 $10 $10
Non-Practising	---	---	$1890 required fee for those members who wish to maintain their medical corporation and require certificate of practice, otherwise $0	---	---
Retired Physician	---	---	---	---	---
REGULATED ASSOCIATE MEMBER					
(a)Assessment Candidate					
(i) Specialty Practice Limited	$600 (i)$210 Review of Qualifications (ii) $390 following ROQ	$300	$1890 per certificate of practice fee year $300 monthly	$200 $200	$50 $50

[7] Less any documentation fee paid as an Assessment Candidate Family Practice Limited
[8] Less any fee paid for Review of Qualifications
[9] Less any registration fee paid as an Assessment Candidate Family Practice Limited
[10] Less any certificate of practice fee paid as an Assessment Candidate Family Practice Limited

	Applicant's Documentation Fee	Registration Fee	Certificate of Practice Fee	Late Payment Fee for Certificate of Practice (payment during first 30 days following due date)	Late Payment Fee for Certificate of Practice per day (after first 30 days)
(ii) Family Practice Limited	$600 (i)$210 Review of Qualifications (ii) $390 following ROQ	$300	$1890 per certificate of practice fee year $300 monthly	$200 $200	$50 $50
(iii) Re-Entry	$210	$300	$1890 per certificate of practice fee year $300 monthly	$200 $200	$50 $50
(b)Educational					
(i) Undergraduate Manitoba Medical Student per certificate of practice year July 1-	---	$50	$75	$20	$5
(ii) Manitoba Physician Assistant Student	---	$50	$75	$20	$5
(iii) Resident	$330[11]	$50	$75	$20	$5
(iv) Resident Limited	---	$250	$250 per certificate of practice fee year $125 reduced (8 months or less)	$50 $50	$10 $10
(v)External/Visiting Student	---	$50	$25 (per 6 month period)	---	---
(vi)Non-practising	---	---	---	---	---
(c) Physician Assistant					
(i) Full Physician Assistant	$330[12]	$300[13]	$300 per certificate of practice fee year	$50	$10
(ii) Academic Faculty S.181	$630	$300	$300 per certificate of practice fee year	$50	$10
(iii) Restricted Purpose	$210	$300	$100 per certificate of practice fee for the specified term	---	---
(iv) Non-Practising or Retired	---	---	---	---	---
(d) Clinical Assistant					
(i) Clinical Assistant Full	$330	$300	$300 per certificate of practice fee year	$50	$10
(ii) Non-Practising or Retired	---	---	---	---	---

[11] Except Manitoba Medical Graduates
[12] Except Manitoba Physician Assistant Graduates
[13] Less any registration fee paid as an Associate Member - Educational

Other Fees

Medical Corporation Registration Fees	$350
Medical Corporation Fees (renewal)	$150
Medical Corporation Fees Late Payment on Renewal (Payment during the first 30 days following the due date)	$50
Medical Corporation Retroactive registration and licensure (Per calendar day thereafter)	$15
~~Qualifications Audit~~	~~$300~~
~~Standards Audit (if a re-audit is required within 5 years of initial audit)~~	~~$300 plus expenses~~
~~Interactive Audit~~	~~$600 plus expenses~~
~~NSF Cheque Administration Fee~~	~~$35~~
~~Use of College Seal~~	~~$25 plus GST~~
~~Refund and/or Rebate Administration Fee~~	~~$25~~
~~Copying documents from a physician's file~~	~~$25 plus $0.10 per page~~
~~Request for documents from Complaints Committee or Investigations file when a legal proceeding has been commenced against a physician~~	~~$500~~
~~Request for documents from a Complaints or Investigations file in other circumstances~~	~~$25 plus $0.10 per page~~
Non-Hospital Reviews	$500 plus costs
~~Hospital Reviews~~	~~$600 plus costs~~
~~Certificate of Professional Conduct~~	~~$100 plus GST~~
Specialist Registration of Credentials	$200
Specialist Register 2.9(2) Application	$600
Appeal of a Registrar's Denial of Registration	$2000

COUNCIL MEETING –JUNE 22, 2022

BRIEFING NOTE

SUBJECT: Prescribing Practices Program Update

BACKGROUND:

Dr. Marina Reinecke will provide a presentation to Council on updates to the Prescribing Practices Program. The presentation is not attached.

PUBLIC INTEREST RATIONALE:

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

The Prescribing Practices Program is an integral part of the Quality Department of CPSM and plays a pivotal role in patient safety.

For several years CPSM has been working on a number of quality improvement initiatives related to the prescribing of drugs with potential for abuse. Some of the most notable outcomes of this program includes the following components:

- Chief Medical Examiners` Death Review
- High Dose Opioid Prescribing Review
- CPSM Opioid Prescriber Profile
- Fentanyl Prescribing Review
- Generic Oxycontin Prescriber Education
- Opioid Agonist Treatment (methadone and buprenorphine/naloxone) Prescriber Training, Mentoring and Auditing
- Support around the implementation of the Opioid/Benzodiazepines/Cannabis Prescribing Standards through online resources and individual case support/mentoring

Through its multi-faceted approaches, the Prescribing Practices Program improves patient safety by increasing safe prescribing of certain drugs that can be abused. The education and feedback provided through this program also supports and builds capacity for individual practitioners who are struggling with safe prescribing and is an opportunity for registrant engagement and relationship building.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING –JUNE 22, 2022

BRIEFING NOTE

TITLE: **Strategic Organizational Priorities**

BACKGROUND

Council has adopted Strategic Organizational Priorities for CPSM. The idea behind identifying these Strategic Organizational Priorities is that by establishing organizational and operational priorities CPSM can successfully plan and utilize its resources for future initiatives in a disciplined manner and provide accountability for work undertaken through the quarterly review by Council of the Progress Tracking Table. Once a year, Council reviews the various proposed initiatives and then directs the CPSM Registrar to pursue these.

Council has continued to increase its attention in defining the strategic organizational priorities for CPSM. This follows from the Governance Session held in December with Mr. Chisholm in which Council indicated its desire to become a "More Strategic Council". This was reinforced in the first in camera meeting of Council in January and then again at the "Blue Sky" Meeting of Council in February 2022.

In the past few years since Council decided to create Strategic Organizational Priorities in 2019, Council has chosen these items to be the Strategic Organizational Priorities:

- ✓ Benzodiazepines Prescribing
- ✓ Medical Cannabis Authorizations
- ✓ Extended/After Hours Coverage
- ✓ Virtual Medicine
- ✓ Maintaining Boundaries – Sexual Involvement with a Patient
- ✓ Governance Review of Cayton Report
- ✓ Accredited Facilities Criteria
- ✓ Standard of Practice Ongoing Review – Four Year Cycle
- ✓ Patient Records – Maintenance of Records
- ✓ Patient Records – Documentation of Care
- ✓ Duty to Report
- ✓ Office Based Procedures
- ✓ Exercise Cardiac Stress Testing
- ✓ Episodic, House Calls, and Walk-In Primary Care
- Prescribing Rules Review
- Truth and Reconciliation – Addressing Anti-Indigenous Racism by Medical Practitioners

Almost all CPSM Strategic Organizational Priorities have been accomplished at a very quick and demanding pace, especially with the COVID-19 pandemic intervening. The exceptions have been the TRC – Anti Indigenous Racism and Prescribing Rules Review, both of which are more complex and multifaceted than the other Strategic Organizational Priorities and were anticipated to take a longer time. The Episodic, House Calls, and Walk-In Clinics Standard of Practice has received feedback through consultation which is being reviewed by the Working Group and should be finalized this year.

The Four-Year Review of all Standards and Practice Direction has proved to be too demanding to complete in four years. There are thirty Standards of Practice, twenty Practice Directions and eight Policies. The Prescribing Rules Review will review a couple of Standards of Practice and several Practice Directions. It is anticipated that a few of the Standards will be reviewed internally by CPSM staff without the need to convene a Working Group and fully revise the Standards. Any changes, of course, will require approval by Council.

FMRAC Organizational Priorities

A number of years ago CPSM included the national organizational priorities of FMRAC (Federation of Medical Regulatory Authorities of Canada) as CPSM Strategic Organizational Priorities if applicable to Manitoba. There are several FMRAC initiatives that are awaiting moving forward or have been altered. These include:

- Streamlined registration – Fast Track Application
- Portable license
- Artificial intelligence
- Telemedicine / Virtual Medicine

FMRAC has stated its organizational priorities for 2022/23 to be the following:

- Artificial Intelligence and the Practice of Medicine
- Virtual Care
- The Impaired Physician
- Physician Competency
- Physician Database / Registry
- Disclosure of Information on Physicians with Multiple Licenses in Canada

CPSM has already proceeded with its own Virtual Medicine Standard of Practice. It is recommended that none of the other FMRAC initiatives be considered to be adopted by CPSM until FMRAC proceeds much further with them. This is due to FMRAC not proceeding quickly on initiatives, not following some through to completion, not applicable to CPSM as a Council Strategic Organizational Priority, or simply not meeting the criteria or the “cut” to be a CPSM Strategic Organizational Priority given the many other competing and pressing priorities.

Recommendation of Executive Committee and Senior Staff

It is important to finish the outstanding Strategic Organizational Priorities chosen in 2021. These are the TRC Anti-Indigenous Racism and Prescribing Rules Review priorities and finalizing the Episodic, House Calls, and Walk-In Primary Care Standard of Practice. With the pandemic and finishing the previous Strategic Organizational Priorities, CPSM was late in starting the TRC and Prescribing priorities. The Prescribing Rules Review was further delayed again due to Omicron spiking again in this winter. The first meeting was held in April. The Prescribing Rules Review is very large – comprising the review of numerous regulations, statutory schemes, Standards of Practice, Practice Directions, and other items. This is a multi-year initiative.

The TRC Anti-Indigenous Racism priority is also a multi-year initiative as it aims to change a culture that is pervasive in Canada and mainstream Canada is only starting to come to terms with. The TRC Advisory Circle has met on six occasions and is close to making several recommendations to Council.

Staff have prepared a one-page snap-shot summary of the Blue Sky Council meeting held earlier in February. This was shared with the Executive Committee earlier, and instructions were provided to expand upon each of these items with a commentary as to how CPSM could achieve these items, if possible. This has been undertaken. Both documents are attached.

What is interesting are the repeated themes throughout the Blue Sky documents:

Quality

Relationships

Performance Metrics

These are marked in red in the expanded Blue Sky Summary document.

The Executive Committee and Senior Staff have discussed this and recommend that **performance metrics** be included as a Strategic Organizational Priority. CPSM needs to be seen by both Council and registrants as a performance minded organization that is fulfilling its mandate. The development of meaningful performance metrics across all core functions of CPSM will take time and effort to create, but will ultimately demonstrate not only where improvements are necessary but also where CPSM excels.

The other themes in the Blue Sky are **quality** and **relationships**. These themes can be linked. The Registrars have been unanimous in stating that for the registrants, the face of CPSM should be Quality with its educational approach rather than Complaints/Investigation with its punitive approach. We hear anecdotally that many registrants who are excellent medical practitioners are fearful of CPSM. In engaging with registrants, the relationship can be switched from one of a fear of the punitive arm of CPSM instead to a positive educational approach from quality

improvement. This change can be applied to not only registrants, but through other relationships with CPSM stakeholders.

The relationship building also fits in with the Registrar's Deliverables. There are opportunities to improve clarity, transparency, timely, communication with membership, along with the mandate of public protection. It is important that CPSM is respected by the registrants and that the registrants understand that the degree and scope of regulation is appropriate for patient safety and in the public interest. Relationships with stakeholders, and importantly the public, can always be improved upon.

This can be summarized under an overall Strategic Organizational Priority of Quality of Care as the Identity of CPSM.

Accordingly, the Executive Committee and CPSM Senior Staff recommends the following Strategic Organizational Priorities to Council for the upcoming year:

Prescribing Rules Review - Continue
TRC Anti-Indigenous Racism - Continue
Performance Metrics Creation – New
Quality of Care as the Identity of CPSM - New
Standard of Practice – Episodic, House Calls, and Walk-In Primary Care (almost completed)

It should be noted that the Prescribing Review will include a review of the Prescribing Standard of practice and several Practice Directions that are joint with the Colleges of Registered Nursing and Pharmacy.

It is also recommended that the other FMRAC led initiatives chosen in the past as CPSM Strategic Organizational Priorities be eliminated. These are:

- Streamlined registration – Fast Track Application
- Portable license
- Artificial intelligence
- Telemedicine / Virtual Medicine

Regulatory Impact Assessments

In making any decision, Council will be provided with Regulatory Impact Assessments and financial estimates to ensure there is capacity to pursue these initiatives. The Regulatory Impact Assessment tool will also assist in Council understanding the implications of their decisions on strategic organizational priorities.

Regulatory Impact Assessments are attached for the Quality of Care as the Identity of CPSM, TRC – Addressing Anti-Indigenous Racism in Medical Practice, and Prescribing Rules Review. The Regulatory Impact Assessment for the Standard of Practice - Episodic, House Calls, and Walk-in Primary Care was previously reviewed by Council earlier this year at its regular meeting in March and is also attached.

The Creation of Performance Metrics as a Strategic Organizational Priority is the development of measurement tools. The impact will come based upon the results of the measurements and what CPSM does with those results. Accordingly, the Creation of Performance Metrics does not lend itself well to a Regulatory Impact Assessment and thus one is not prepared.

Also attached is a diagram demonstrating how Council has become a "More Strategic Council" and how the strategic organizational priorities have their beginning in Blue Sky session and the financial implications of these choices.

As there is a financial impact to the Strategic Organizational Priorities, there is another document explaining how the budget process will incorporate these priorities, their cost, and the impact upon fees.

Operating Budget

Best practices require an integration of the operating budget to determine the selection of the Strategic Organizational Priorities. This is included in the next agenda item of this Council meeting.

POSSIBLE QUESTIONS FOR DISCUSSION

- Does CPSM have the correct resources and time to pursue these five Strategic Organizational Priorities?
- Will the public interests be served best through these strategic organizational priorities?
- The medical profession is exhausted after COVID and is under continuously greater stress due to health care transformation and resource constraints in the health care system. Do the registrants have the capacity to make the changes required by these strategic organizational priorities?
- Racism and prescribing are key priorities that need to be addressed sooner rather than later. Can anything be done to speed these priorities us?
- Are there any other alternatives?
- What about reviewing some of the current Standards of Practice that may require updating?

PUBLIC INTEREST RATIONALE

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

The public interest mandate can be served by each of the recommended Strategic Organizational Priorities.

TRC – Addressing Anti-Indigenous Racism in Medical Practice

Several high-profile cases have highlighted racism in medical practice and health care throughout Canada (Joyce Echaquan, Jordan's Principle, BC hospital ER staff betting on blood alcohol levels of Indigenous patients). The societal awareness of residential schools and their devastating impact upon Indigenous persons has also increase awareness of racism. All CPSM registrants are aware of the socio-economic determinants of health and the poor delivery and outcomes for Indigenous persons. FMRAC has adopted, as one of its ongoing priorities, Addressing Racism in Physician Practice. CPSM was an attendee at the two-day summit hosted by the federal government on "Addressing Anti-Indigenous Racism in Canada's Health Care Systems". At that summit, the federal government announced the National Consortium for Indigenous Medical Education and the commitment to the development of Indigenous health care legislation and a federal Indigenous health care authority. The University of Manitoba leads the country with an 80-hour requirement for teaching indigenous cultural competence in their undergraduate curriculum. Other organizations such as CFPC, Royal College, MCC and others have made commitments to address anti-Indigenous Racism in the health care system. Addressing Indigenous Racism in the medical practice is critical to fulfill the mandate of regulating the profession in the public interest.

Prescribing Rules Review

Prescribing can be difficult and dangerous yet can yield tremendous outcomes in health benefits. Any changes to prescribing must be done solely in the interest of the public and must adhere to the highest standards of both patient safety and societal safety. A risk assessment will be undertaken of each and every recommended change to ensure the patients remain safe, yet there is still access to drugs. The access may be eased or limited, depending upon both patient safety and societal safety. Many of the drugs may be abused, and so access to these drugs may differ due to the deleterious impact on society. Prescribing must be done by those with the appropriate knowledge, skill, and judgment. This will better allow for patient safety. A review of qualified prescribers will form part of the review as will the future use of M3P.

Quality of Care as the Identity of CPSM

As the regulator, we must hold our registrants accountable and deal with those individuals who have demonstrated egregious behavior or have caused harm in negligent ways. However, we

can still protect the public and leave registrants with a positive experience in the way we communicate with them, how we create transparency in process and reduce fear and use audit and feedback to build and enhance their proficiency and effectiveness as professionals. The public would be served in knowing the ways in which registrants practicing in Manitoba are held to our standards of practice and are supported to be the best practitioners possible. Rebranding itself as an organization built upon supporting and enhancing the quality of care in the medical profession is in the public interest and enhances patient safety.

Performance Metrics

How does the public, Council, registrants, or stakeholders know if CPSM is fulfilling its mandate to regulate in the public interest? One way is to create measurement tools for each of its core functions (Registration, Quality, and Complaints). Measurement tools in and of themselves will not enhance the public interest. However, the impact to patient safety and the public interest will come based upon the results of the measurements and what CPSM does with those results.

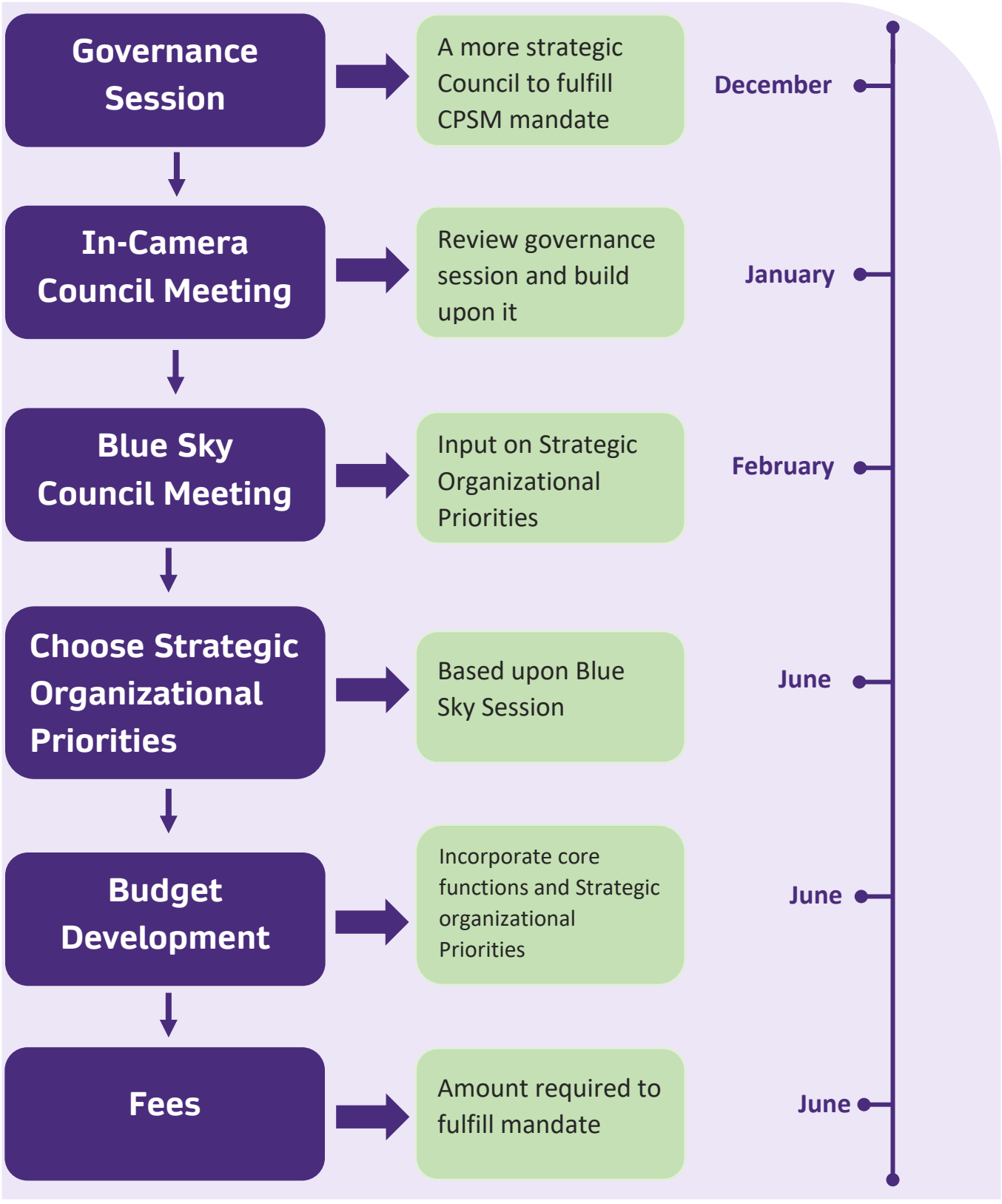
Episodic, House Calls, and Walk-In Primary Care Standard of Practice

This Standard is required to ensure the continuity of care in a fragmented primary care delivery environment. Critical to required good medical care is patient safety. The Standard requires that the medical care is provided in the patient's interest and recognizes the choice of patients in choosing the modality of care delivery. This Standard recognizes episodic, house calls, and walk-in clinic primary care plays an important role in the delivery of medical care, but additional guidance to the profession is required to ensure it is safe and good medical care providing for continuity.

The Standard recognizes the importance of episodic, house calls, and walk-in clinics in the delivery of primary care in many different circumstances throughout the province. The integration of that care with the primary care provider may be critical for good medical care.

CPSM COUNCIL'S

PATH TO MORE STRATEGIC GOVERNANCE



"BLUE SKY" STRATEGIC ORGANIZATIONAL PRIORITIES

GOVERNANCE MEETING OF COUNCIL-FEBRUARY 17, 2022
IDEAS SUBMITTEDBY COUNCILLORS

MANDATE	
Public interest (patient safety) is paramount	Requires clarification of mandate
CPSM is meeting its mandate in its core functions of registration, quality, and complaints	
Quality Department is great start	
Complaints/Investigations changes on the right track	
Standards of Practice for opioids, benzodiazepines, and virtual medicine are examples of what the regulator should be doing	
President can advocate	Advocacy role for health care system improvements to improve patient outcomes
Registrar can use position on key health committees to advocate	Focus discussion on what CPSM can do (ie. withdraw accreditation vs service decisions on closing Dynacare labs)

COUNCIL – GOVERNANCE	
Improve governance by considering following the Chisholm Report	
CPSM is meeting its mandate in its core functions of registration, quality, and complaints	
Require clarification of roles of Council oversight vs operations	Diversity on Council to be considered
Regulatory Impact Assessment tool helpful	Performance metrics required to assess whether mandate met
Relate the Strategic Organizational Priorities to the mandate	

RESOURCES	
Regulatory Impact Assessment tool helpful	Performance metrics required to assess whether mandate met
Charge fees required to ensure CPSM is meeting its statutory mandate	Adequate resources are required to fulfill mandate
Connect budget and resources to strategic plan	Consider alternative financial arrangements including sale of services

POSSIBLE STRATEGIC ORGANIZATIONAL PRIORITIES
Anti-Indigenous Racism as a key strategic organizational priority
Mobility of members across Canada
Virtual medicine is constrained by borders but should not be
Improve relationship with members –communication, transparency, satisfaction
Work on relationships with Shared Health, Health, and University
Medical error is third most common cause of death in hospital, so address proactively for physician error

MISCELLANEOUS
Standards Committees merged into Shared Health is problematic as work will not be continued
Amend the RHPA and regulations if required for improvements
Importance of all registrants, not just physicians, so value Clinical and Physician Assistants too
"CPSM is doing a really good job"

"BLUE SKY" STRATEGIC ORGANIZATIONAL PRIORITIES

GOVERNANCE MEETING OF COUNCIL-FEBRUARY 17, 2022
IDEAS SUBMITTEDBY COUNCILLORS

MANDATE

Public interest (patient safety) is paramount

- *Understood by all*

Requires clarification of mandate

- *Mandate from RHPA sections provided to all councillors in March 2022 Council package. As a self-regulatory professional body, in essence CPSM has three core responsibilities: 1 –ensure members are qualified for registration (or rules for admission to the profession)2 –set the rules and standards required for good practice and 3 –hold members accountable (through quality or discipline) to adhere to the rules and standards for good practice. All this must be done in the public interest. Performance metrics may be developed and used to ensure these three core responsibilities are being achieved. The perception and reputation of CPSM is to be altered from punitive to quality of medical care provided.*

CPSM is meeting its mandate in its core functions of registration, quality, and complaints

- *While Councillors believe this to be true, this will be demonstrated by the performance metrics to be created in 2022 for each area.*

Quality Department is great start

- *In 2022 Dr. Mihalchuk will present to Council the further development of the Quality Department and its performance metrics. It is important for registrants to see Quality and its educational approach as the face of the CPSM, and not the Complaints/Investigation punitive wing. This requires a relationship rebuilding.*

Complaints/Investigations changes on the right track

- *In 2022 CPSM will create performance metrics for complaints/investigations.*

Standards of Practice for opioids, benzodiazepines, and virtual medicine are examples of what the regulator should be doing

- *A Strategic Organizational Priority is to review the prescribing rules–regulations, Standards of Practice, and Practice Directions. The review is joint with the colleges of pharmacy and registered nursing. These all relate to the improved quality of practice of medicine.*

President can advocate

TBD

Advocacy role for health care system improvements to improve patient outcomes

TBD

Registrar can use position on key health committees to advocate

- *Registrar is a member of the Manitoba Clinical Leadership Council, meets with the CMOs at their monthly meetings, meets biweekly with Public Health and CMOs on the pandemic, is on key committees at the university and meets quarterly with the Deputy Minister of Health. Strong relationships are formed through these committees. The Registrar is on the hiring committee for the new Dean of Health Sciences and Medicine, so there will be a relationship with that key figure from the outset.*

Focus discussion on what CPSM can do (ie. withdraw accreditation vs service decisions on closing Dynacare labs)

- *Recognize through governance that CPSM does not play a role in health care system management nor transformation. Instead CPSM can concentrate on improving the competence and conduct and quality of CPSM members and their provision of good medical care within the system.*

COUNCIL – GOVERNANCE

Improve governance by considering following the Chisholm Report

- *Review the Chisholm Report and Address the recommendations and comments. Improve if required and keep doing what is praised.*

Require clarification of roles of Council oversight vs operations

- *Continue with governance education to ensure councillors understand their role vis-à-vis oversight (what Council does) compared to operations (what staff does). This is a common refrain in governance for most boards.*

Diversity on Council to be considered

- *Consider reviewing the diversity on council and if the distribution of elected members can be revised to promote equity, diversity, and inclusion, including a position on Council for an indigenous practicing physician. Revise the bylaws to capture the voices which should be heard on Council, rather than solely having elections on geographic practice locations. Considerations could be for voices from the North, Rural areas, Winnipeg, Indigenous, Gender, new to practice, international medical graduates, etc.*
- *Diversity on Council may also be addressed by the appointments to Council, both through Government and through Council. The skills and attributes matrix already developed may assist in this, however, should not be a substitute for seeking diversity from the physicians elected to Council.*
- *Current relationships with physicians of diverse backgrounds can be drawn upon to encourage them to run for positions on Council.*

Regulatory Impact Assessment tool helpful

- *This was developed following the initial governance session led by Bradley Chisholm. Council has indicated it is a helpful tool to ensure the implications of their regulatory decision has been considered and addressed. Often the Quality Department is called upon to provide support for the implementation of these initiatives, and they must have the capacity to do so.*

Performance metrics required to assess whether mandate met
Mentioned above under mandate too.

Relate the Strategic Organizational Priorities to the mandate

- *In choosing the Strategic Organizational Priorities, ensure these are indeed furthering the mandate of CPSM and are most important for the public interest.*

RESOURCES

Regulatory Impact Assessment tool helpful

- *This was developed following the initial governance session led by Bradley Chisholm. Council has indicated it is a helpful tool to ensure the implications of their regulatory decision has been considered and addressed. Often the Quality Department is called upon to provide support for the implementation of these initiatives, and they must have the capacity to do so.*

Performance metrics required to assess whether mandate met

- *These will be created in 2022 to demonstrate the mandate is being fulfilled in the core functions of CPSM*

Charge fees required to ensure CPSM is meeting its statutory mandate

- *The issue for fees is the amount of the annual registration fee is not to be set at a level to satisfy the membership, but instead fees set at an amount to ensure that CPSM can self-regulate the profession and fulfill its mandate to regulate in the public interest. This is non-negotiable.*

Adequate resources are required to fulfill mandate

- *See above*

Connect budget and resources to strategic plan

- *Agreed to the extent that there is a strategic plan, or at least strategic organizational priorities. This is on the plan for the upcoming year. The budget and resources will be linked to fulfillment of the mandate and obtaining adequate fees and resources to do so.*

Consider alternative financial arrangements including sale of services

- *TBD. Need to ensure that CPSM is first fulfilling its mandate and if there is any excess capacity for services, then the discussion can be entertained as to whether the excess services should be sold or the resources adapted or reallocated to fulfill the mandate.*

POSSIBLE STRATEGIC ORGANIZATIONAL PRIORITIES

Anti-Indigenous Racism as a key strategic organizational priority

- *This is a current Strategic Organizational Priority and is being led by Dr. Monkman through the TRC Advisory Circle. It is a multi-year initiative and requires a change in culture that is challenging at the personal level.*

Mobility of members across Canada

- *This is listed now as a FMRAC led Strategic Organizational Priority and CPSM was awaiting FMRAC proceeding. This initiative has been stalled at the FMRAC level and due to the provincial jurisdiction of health care and health care regulation, and not all jurisdictions deciding to pursue. There may be ways that CPSM can ease and streamline the regulatory processes to permit full practicing physicians in other Canadian jurisdictions to register in Manitoba so that more physicians are registered to practice in Manitoba. This will require an amendment to the regulations.*

Virtual medicine is constrained by borders but should not be

- *The virtual medicine Working Group is being re-convened with other leaders in the health profession to discuss how the Standard is impacting health care delivery.*

Improve relationship with members –communication, transparency, satisfaction

- *It is important that registrants see the Quality Department with its educational approach to improving the quality of the practice of medicine as the face of CPSM rather than the Complaints/Investigation which is the punitive approach. This in essence will be a re-branding of CPSM for the registrants.*

- *The relationship building also fits in with the Registrar's Deliverables. There are opportunities to improve clarity, transparency, timely, communication with membership, along with the mandate of public protection. It is important that CPSM is respected by the registrants and that the registrants understand that the degree and scope of regulation is appropriate for patient safety and in the public interest.*

Work on relationships with Shared Health, Health, and University

- *This is ongoing. The pandemic highlighted the critical role played by CPSM. CPSM could message all members on ongoing developments and CPSM could create and enforce minimum rules for physicians to follow in their practice at different stages of the pandemic. No other entity had such reach. In turn, the Registrar was asked to participate in the biweekly meetings with Public Health and the CMOs. CPSM is the only CDN regulator to participate in such meetings.*
- *Relationships with stakeholders, and importantly the public, can always be improved upon.*

Medical error is third most common cause of death in hospital, so address proactively for physician error

- *Patient safety is paramount. This strategic organizational priority should be considered for review insofar as the medical error relates to an error by a physician. It could be through Standards in the Quality Department or in Complaints Investigations. This warrants further discussion and consideration.*

MISCELLANEOUS

Standards Committees merged into Shared Health is problematic as work will not be continued

- *CPSM has advocated hard for this decision to be reversed, but has been unsuccessful. However, this decision by Shared Health may be delayed slightly. This is an integral part of the Quality Department and the Standards Committees for the improvement of the quality and competence of medical practice.*

Amend the RHPA and regulations if required for improvements

- *CPSM has already submitted specific recommendations to Government on four amendments to the RHPA and Regulations recently, and none have been pursued by Government:*
  - *Section 56 exemption to Controlled Drugs and Substances Act –permit electronic subscribing which was introduced in the beginning of the pandemic. MB is the only province that has not permitted this legislatively.*
  - *Recommend Government regulate risky medical aesthetic procedures offered by unregulated individuals.*
  - *Amend the RHPA to amalgamate the Complaints and investigation Committees into one Committee similar to the other professions in the RHPA.*
  - *Indigenous Physician Councillor –This was mentioned to the Deputy minister who expressed interest.*

Importance of all registrants, not just physicians, so value Clinical and Physician Assistants too

- *Agreed, CPSM must be more inclusive for all registrants.*

"CPSM is doing a really good job"

CPSM Regulatory Impact Assessment

Quality of Care as the Identity of CPSM

DATE: June 22, 2022

Background/Issue:

CPSM has for years been identifiable by registrants and the public as the entity responsible for disciplining doctors given this is often our most public-facing and publicized business. This has impacted the reputation of CPSM and has influenced the perception of CPSM as adversarial and an organization to be feared by registrants. In the eyes of the public, they may see discipline as CPSM's only function. Only a very small number of registrants who have been proven to demonstrate severe breaches of professional conduct face discipline relative to the entire registrant pool. Despite this, the pervasive and negative attitudes of registrants towards CPSM have overshadowed much of the routine business of CPSM which is supportive, focused on patient safety and quality improvement and articulating and enforcing the standards for medical practice in a collegial and non-adversarial manner.

CPSM has also not been proactive in promoting our educational, collaborative and quality improvement focus to contravene the common perspectives of our registrants and to shift the focus from being retroactive and punitive to proactive and improvement focused. Recent changes in internal operations of CPSM including the formation of the Quality Department, changes to Standards and Central Standards Committee operations as well as the focus of Complaints and Investigations on mediation and informal dispute resolution are all compelling reasons to act now to change the reputation and perception of CPSM both publicly and with our registrants.

Proposed Solution:

CPSM Council (Blue Sky conversation), Dr. Ziomek and staff agree that there is opportunity to rebrand CPSM with a focus on the organization's efforts to support and promote quality improvement and patient safety across the 3 core business functions (registration, quality, complaints/investigation). By shifting the spotlight to the tremendous amount of work that is done to ensure we register only those who meet criteria, support registrants in learning and growing from feedback (audits, standards, complaints, investigations) and promoting best practices and high-quality care we can improve our reputation and how we are perceived by our registrants and the public.

As the Regulator, we must hold our registrants accountable and deal with those individuals who have demonstrated egregious behavior or have caused harm in negligent ways. However, we can still protect the public and leave registrants with a positive experience in the way we communicate with them, how we create transparency in process and reduce fear and use audit and feedback to build and enhance their proficiency and effectiveness as professionals. The public would be served in knowing the ways in which registrants practicing in Manitoba are held to our standards of practice and are supported to be the best practitioners possible.
It is proposed that CPSM make active efforts to rebrand itself as an organization built upon **supporting and enhancing the quality of care in the medical profession** as the primary focus in all of our business functions.

Execution of this rebranding would be led by Dr. Ziomek and the Assistant Registrars and carried out at an operational level with the development of a formal plan. Some examples may include:

1) Using supportive and engaging language in all interactions with registrants emphasizing CPSM's role in collaboration, education and quality improvement in their practice of medicine
2) Review of letters and outgoing communication to registrants for tone, language
3) Utilizing our Communications Officer to intentionally message through:
    a. Public communication
    b. Registrant Communication
    c. Website
    d. Media
4) Webinars – registrants and/or public
5) Through routine consultations for standards of practice

Accountability:

Registrar and Assistant Registrars

Timeline:

Fixed Timeframe Not Applicable X
On-going
This would be ongoing work over the next 1-2 years

Alignment with Organizational Priorities:

There are synergies with three of the proposed organizational priorities for 2022-2023.

There is opportunity to improve the reputation and perception of CPSM with the public and registrants by emphasizing the focus of our work in **Indigenous Anti-Racism** to improve the quality of care for Indigenous patients and to address other forms of racism in our organizational processes and approaches.

The **Prescribing Rules Working Group** is focused on improving quality in prescribing and synergizes with existing work in the realm of Quality Improvement/Standards/Prescribing Practices Program to further improve safe prescribing through building educational and supportive relationships with registrants.

Becoming a more data informed, and performance minded organization through **Performance Metrics** will naturally create an organizational focus on quality and will demonstrate this to the public and registrants.

Patient Safety:

CPSM will improve patient safety by putting a greater emphasis on supporting and enhancing the quality of care in the medical profession and making it known to registrants and the public that this is core to all our business functions.

Risk Analysis:

Public Risk
Adopting a "Quality First" approach for our CPSM operations will decrease the risk to the public through what we hope is enhanced engagement and cooperation from registrants. Patients win when our focus is on the quality of medical care and registrants gain comfort and confidence to reach out to CPSM for assistance and support, rather than being fearful their interaction with CPSM will result in discipline.

Reputational Risk
Rebranding and focusing the attention of registrants and the public on supporting and enhancing the quality of care in the medical profession as core to all CPSM business functions will improve the reputation of CPSM by promoting our proactive efforts to improve care before there is harm and to build a culture within the profession of continuous quality improvement. There is a minor risk that by focusing on engaging our registrants we may be further perpetuating perception that we protect doctors from accountability. This risk could be

mitigated through careful messaging and strategic linkages to the mandate of CPSM to protect the public.

Regulatory Risk
Registrants are fearful of CPSM and this creates a regulatory environment which makes it difficult to engage registrants in many of our quality activities because they are afraid they will be disciplined. By creating a supportive and education-focused interaction with registrants there is a greater chance that engagement and outcomes for patient care will be positive.

Operational Risk
Changing the culture within CPSM will be necessary to support changes in communication and interactions with registrants. Effort and consistency will be needed to achieve the goal of rebranding. However, operational leadership is engaged and on board to support this important work. In the ways in which this change has already started, staff engagement and job satisfaction has improved since interactions with registrants are more positive, there is evidence of registrant engagement and a sense that CPSM's day to day work is helping to make care better for the public.

Regulatory Impact on Registrants:

This change should have a positive impact on registrants and support enhanced engagement and cooperation with the core functions of CPSM as they relate to ensuring quality of care and protecting the public.

Financial Impact:

This will be developed over the next 1-2 years. CPSM will be monitoring potential resource re-allocation from other areas where quality initiatives are reducing expenditures in those departments.

Financial:
TBD

Infrastructure: Not Applicable X
Click here to enter text.

Transition Budget: Not Applicable ☐
No additional investments have been requested to initiate this operational priority.

Alternatives or Status Quo:

The alternative here would be to do nothing and to leave the reputation and perception of CPSM as it is. Status Quo is an option requiring minimal effort however, the long-term consequences of continuing to represent CPSM as adversarial and 'to be feared' will be further disengagement of registrants and will misrepresent the large majority of the organization's work which is supportive, and improvement focused. It is highly likely that greater investments will be required in the complaints and investigations areas without rebranding and refocusing the organization's efforts on supporting and enhancing quality of care in the medical profession. That is, where registrants do not see our work as supportive, more resources are required to appropriately address concerns that have been raised.

Evaluation and Outcomes:

Operational leadership will need to further define success as they better understand what specific changes are needed to operations to adopt a Quality of Care focus in all business functions. However, these are some proposed outcomes and metrics that could be considered to demonstrate the desired outcomes:

1) Staff satisfaction related to positive interactions with the public and registrants.
2) Monitoring shifts in positive feedback from the public and registrants after interactions or through written correspondence.
3) Enhanced engagement with registrants through opportunities to work with CPSM (audits, standards of practice, committees, working groups, feedback on standards).
4) Monitoring events and trends that would benefit from broader quality initiatives and thereby reduce higher cost interventions.
5) More registrants approach CPSM to address issues at an earlier stage of the problem or accept supportive measures at an earlier stage in a review process.

Additional Information: Not Applicable X

Recommendation:
Approve Quality of Care as the Identity of CPSM and rebrand CPSM's focus for all core business to supporting and enhancing the quality of care within the medical profession as an organizational priority for 2022-23.

Submitted by:
Dr. Ziomek/Dr. Mihalchuk/Dr. BullockPries

CPSM Regulatory Impact Assessment

TRC-Addressing Indigenous Racism in Medical Practice

DATE: June 22, 2022

Background/Issue:

Several recent sad events in healthcare have launched the issue of Indigenous racism in healthcare to the forefront (Joyce Echaquan's death after being taunted by healthcare workers recorded on facebook, Jordan's Principle, BC ER staff betting on blood alcohol level of Indigenous patients). This is also accompanied by a slowly growing societal realization, understanding, and acknowledgment of the many harms caused to Indigenous persons by residential schools, displacement, and colonialism.

There are calls to action from the Truth and Reconciliation Commission and the Missing and Murdered Indigenous Women and Girls Inquiry which may place responsibilities on healthcare professional regulators. The BC Government launched an external investigation which released its report in November 2020, "In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in BC Health Care". Although the report is from British Columbia, much of that report may be applicable to Manitoba. The Manitoba 2008 death of Brian Sinclair exposed racism in the health care system and by healthcare providers. Manitoba Health, the RHAs, and the University have responded with various changes, yet anti-Indigenous racism still exists in healthcare.

All registrants are aware of the socio-economic determinants of health and the poor outcomes in healthcare experienced by Indigenous patients in the province. Many (or most) do not fully understand how Indigenous racism in their delivery of health care by both the system and importantly by themselves impacts upon the care they provide Indigenous patients.

Proposed Solution:

CPSM Council in 20221 chose TRC – Addressing Indigenous Racism in Medical Practice as a Strategic Organizational Priority. The purpose of the TRC - Addressing Indigenous Racism by Medical Practitioners Advisory Circle is to provide advice and recommendations to help CPSM reflect on its own processes and identify how it can and better guide the physicians and other CPSM members who provide medical care to Indigenous patients and to create better understanding and support of Indigenous patients. It is important to note that CPSM has jurisdiction to regulate the medical profession to ensure CPSM registrants have the knowledge,

skill, and judgment to practice medicine competently, ethically, professionally, and with honesty and integrity. CPSM does not have jurisdiction to change the healthcare system.

Accountability:

Registrar and Assistant Registrars

Timeline:

Fixed Timeframe Not Applicable X

On-going

Addressing racism in medical practice requires a shift in culture at the societal, professional, and individual level. This shift in culture takes much time and is longitudinal in nature.

The timeline would be ongoing work over the next several years. Expecting quick, easy solutions to longstanding, complex, deeply ingrained systemic problems of racism is unrealistic. However, delays, and small changes can be frustrating to those experiencing racism. Small steps that seem positive to the majority can be perceived as tokenism to Indigenous people living with racism in health care.

Alignment with Organizational Priorities:

This is already chosen to be a Strategic Organizational Priority. It is also a priority of FMRAC, Royal College, and College of Family Physicians, Canadian Medical Association, and many other organizations. The federal government has created several initiatives to start to address this.

Patient Safety:
Racism is a public health issue. Extensive literature and evidence-based studies strongly support the existence of structural racism in medicine and its adverse impact upon health. Many CPSM registrants and the medical profession in general requires greater knowledge and accountability as to how racism impacts patient care and outcomes.

Risk Analysis:
CPSM's mandate is to regulate the medical profession in the public interest.

Public Risk Not Applicable ☐

CPSM's mandate is to regulate the profession in the public interest. CPSM must be accountable to the public, particularly those most vulnerable including Indigenous patients. It is simply unacceptable that some Indigenous patients may not access medical care because they consider their medical treatment or their CPSM registrant to be racist.

Reputational Risk Not Applicable ☐

Indigenous peoples are underrepresented in the powerful medical institutions, including at CPSM. Indigenous voices are often not solicited nor heard and this undermines trust in the regulator. CPSM must maintain the public's confidence in its ability to regulate the profession in the public interest and in keeping with changing societal expectations. A changing societal demand is awareness of and addressing Indigenous racism.

Regulatory Risk Not Applicable ☐

Failure to fulfill the mandate to regulate the medical profession and keep abreast of societal expectations will negate CPSM's moral authority to continue to regulate.

Operational Risk Not Applicable ☐

Indigenous racism is a deeply ingrained feature in Manitobans, including most CPSM staff. CPSM must address this and not be seen to be offering token steps towards addressing this. CPSM staff have very limited knowledge and training in any anti-racist training or bias.

Regulatory Impact on Registrants:

To address something as ingrained as racism is longitudinal. Culture change is required and that is not quick. As mentioned about expecting quick, easy solutions to longstanding, complex, deeply ingrained systemic problems of racism is unrealistic. However, this needs to be addressed and registrants will be required to be motivated, aware, and exert effort to understand and address their Indigenous racism and bias. Some may be resistant, defensive, or will merely put in the minimal effort to "tick the boxes". Others may welcome this.

There will be high expectations on registrants to practice medicine without racism. Possible requirements include mandatory training and self-reflection, a new Standard of Practice with which they will have to comply, and recognition that their practice and how they treat Indigenous patients must change. These are complicated components.

Financial Impact:

There will be costs for this Strategic Organizational Priority.

Financial: Not Applicable ☐

As an initial item in the 2022/23 annual operating budget, an amount of $50,000 has been included. This will include tuition paid for councillor enrolled in The Path Indigenous Cultural Awareness, reimbursement for councillors to attend the FMRAC conference "Eradicating Indigenous-Specific and other forms of Racism and Discrimination", and honoraria for the members of the Advisory Circle. If there is a desire to include a Manitoba healthcare/medical care component into The Path, that will likely be a significant cost. Possibilities to share this cost with other regulators or regional health authorities is a possibility. There are a number of other items that are currently under discussion at the TRC Advisory Circle that this funding will support.

Infrastructure: Not Applicable X

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Transition Budget: Not Applicable ☐

CPSM has recommended budgeting $250,000 over the next 3 years to develop initiatives that will address this strategic priority.

Alternatives or Status Quo: Not Applicable ☐

The alternative here would be to do nothing and not address Indigenous Racism in the medical profession. As a leader in the medical community CPSM has a responsibility to have its registrants practice medicine without racial bias. Failure to do this violates the statutory mandate in the RHPA to regulate in the public interest.

Evaluation and Outcomes: Not Applicable ☐

This is under development.

Additional Information: Not Applicable X

Please see the attached article "The Role of Regulatory Boards in Combating Racism and Promoting Diversity" in the Journal of Medical Regulation.

Recommendation:

Continue to proceed with this Strategic Organizational Priority.

Submitted by:

Dr. Ziomek

Commentary

The Role of Regulatory Boards in Combating Racism and Promoting Diversity

Second in a JMR series on Diversity, Equity and Inclusion in Medical Regulation

Norman T. Reynolds, MD

ABSTRACT: In order to create a more just and equitable medical culture for racial and ethnic minorities, all stakeholders in the medical system must acknowledge and learn lessons from past and ongoing mistakes toward minorities. The Federation of State Medical Boards (FSMB), in its leadership position, can influence state medical boards to recognize systemic racism and take steps to combat racism and promote racial diversity. This article reviews current and historical examples of medical racism toward Black or African Americans that are largely invisible to the white community; offers ethical guidelines to ensure fairness; provides guidelines for medical boards to reduce implicit bias in disciplinary proceedings; and suggests educational approaches to increase understanding and empathy for the experience of Black physicians and Black patients in the medical system. Eight fundamental questions, outlined in this article, provide a road map for the FSMB and medical boards to increase racial diversity and reduce inequity

"Racism in all of its forms is a public health issue."[1]
Washington Medical Commission

Introduction

Racism is a deeply ingrained feature that impacts a wide range of American institutions, including those in the medical profession. In order for regulatory organizations to take meaningful action in addressing racial inequity, they must candidly assess the current environment within which health care is delivered in the United States. Addressing eight fundamental questions, outlined in this article, can provide a road map for medical boards to increase diversity and reduce inequity.

We, as a medical community, have a responsibility to work towards equitable care for all. Where better to start than with the things over which we have some control? How can we begin to make amends for the racial inequities in our society through our regulatory boards and systems? In order to create a more just and equitable medical culture for racial and ethnic minorities, all players in the medical system must acknowledge and learn lessons from past and ongoing mistakes toward minorities. The Federation of State Medical Boards (FSMB), in its leadership position, can influence state medical boards to recognize systemic racism and take steps to create systems that embrace racial diversity.

Creating diversity in the membership of regulatory bodies will be a step toward building trust among ethnic and racial minorities. State medical boards can take actions that will reduce bias in disciplinary proceedings. Educational programs can inform physicians and others in the medical system about the history of racism so that they understand and empathize with the experience of Black people in the United States and through self-reflection and self-analysis make changes that promote diversity, equity and inclusion.

What is Racism?

There are no uniformly agreed upon definitions of racism and related terms. According to the American Medical Association (AMA) Manual of Style Committee:[2]

> Terms and categories used to define and describe race and ethnicity have changed with time based on sociocultural shifts and greater awareness of the role of racism in society… Although race and ethnicity have no biological meaning, the terms have important, albeit contested, social meanings. Neglecting to report race and ethnicity in health and medical research [and health initiatives and policies] disregards the reality of social stratification, injustices, and inequities and implications for population health… Terminology, usage, and

word choice are critically important, especially when describing people and when discussing race and ethnicity.

The Committee accepts the definition of terms offered by the Centers for Disease Control and Prevention (CDC) as follows: [3]

- Racism is a "system of structuring opportunity and assigning value based on the social interpretation of how one looks…("race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of our whole society through the waste of human resources."

Three levels of racism are defined as follows:[4]

- Institutionalized racism (also referred to as systemic and structural racism): "Structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by 'race' (e.g., how major systems — the economy, politics, education, criminal justice, health, etc. — perpetuate unfair advantage)."
- Personally-mediated racism: "Prejudice and discrimination, where prejudice is differential assumptions about the abilities, motives, and intents of others by 'race,' and discrimination is deferential actions towards others by 'race.' These can be either intentional or unintentional." (Unintentional prejudice referred to as implicit bias is defined below in this article.)
- Internalized racism: The power of culture to affect attitudes should not be underestimated. The prejudiced attitude of the dominant white culture that views Black people as inferior can result in "Acceptance by members of the stigmatized 'races' [e.g., Black individuals] of negative messages about their own abilities and intrinsic worth."

White supremacy is at the root of racism. It is the belief and idea purporting natural superiority of the white race over other racial groups. Over the centuries, it has taken many forms and levels of acceptance within societal institutions — political, legal, scientific, medical, and religious. According to the Challenging White Supremacy Workshop Catalyst Project: "White Supremacy is an historically based, institutionally perpetuated system of exploitation and oppression of continents, nations, and people of color by white peoples and nations of the European continent, for the purpose of maintaining and defending a system of wealth, power and privilege."[5]

In her article "White Privilege: Unpacking the Invisible Knapsack,"[6] Peggy McIntosh discusses "whiteness" as a racial identity. She describes white privilege as "an invisible package of unearned assets"—culturally unacknowledged. White people enjoy unearned skin privilege and have been conditioned into oblivion about its existence. White people are culturally conditioned into a mindset that "their lives are morally neutral, normative, and average, and also ideal, so that when we work to benefit others, this is seen as work which will allow 'them' to be more like 'us.'"

According to McIntosh, racism is "invisible systems conferring dominance" to the white majority. It is a "myth that all democratic choice is equally available to all." She lists twenty-six examples of cultural advantages automatically conferred on her by virtue of being white. Concretizing how their privilege plays out in real life helps white people see it, and explicitly acknowledging it validates what Black people experience throughout their lives.

Is There Racism in the Medical Establishment?

Some physicians disavow the presence of racism in medicine and among physicians. A recent case in point is the controversial 2021 *Journal of the American Medical Association* (JAMA) podcast and tweet that stated, "No physician is racist, so how can there be structural racism in health care?"[7] However, extensive literature and evidence-based studies strongly support the existence of structural racism in medicine and its adverse impact on health. Prestigious medical organizations, including the AMA, admit to their own record of racism as well as to racism in the medical profession as a whole. The AMA, for example, has adopted a formal policy recognizing racism as a public health threat and committing to actively work on dismantling racist policies and practices across all of health care — making clear that "a proactive approach to prevent, or identify and eliminate racism is crucial…"[8] Following the 2021 *JAMA* podcast and tweet, the editor in chief of *JAMA* issued an apology and later

WE, AS A MEDICAL COMMUNITY, HAVE A RESPONSIBILITY TO WORK TOWARDS EQUITABLE CARE FOR ALL. WHERE BETTER TO START THAN WITH THE THINGS OVER WHICH WE HAVE SOME CONTROL?

resigned, and the AMA's CEO declared "we are deeply disturbed — and angered — by a recent JAMA podcast that questioned the existence of structural racism and the affiliated tweet…"[9]

The historical record, omitted in the education of physicians, includes abundant evidence of long-standing issues of medical racism. Although there are general themes and principles regarding disparities that apply to all minorities, this article focuses on Black or African Americans as a specific example — well documented by Harriet Washington in her 2008 book "Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present."[10]

Recently, racial disparities are evident in the high morbidity and mortality among minority groups from COVID-19. More generally, and historically, data show that Black patients receive less care than white patients regarding many medical conditions. According to CDC data,[11] compared to the white population, racial and ethnic minorities in the United States experience higher illness and death across a wide range of health conditions: diabetes, hypertension, obesity, asthma and heart disease. The United States has the highest maternal and infant mortality rates among comparable developed countries. African American women are dying from preventable pregnancy-related complications at three to four times the rate of non-Hispanic white women. The death rate for Black infants is twice that of infants born to non-Hispanic white mothers. The 2015 Kelly Report documents in great detail the health disparities in America,[12] and little, if anything, has changed over time.

RACIAL AND ETHNIC MINORITY INDIVIDUALS ARE TYPICALLY UNDERREPRESENTED IN THE POWER STRUCTURE OF MEDICAL ORGANIZATIONS, INCLUDING REGULATORY ORGANIZATIONS. THEIR VOICES ARE OFTEN NOT SOLICITED.

Systemic racism is also reflected in the fact that there are disproportionately fewer Black physicians than white physicians in the United States. Although more than 13% of the U.S. population self-identify as Black or African American,[13] only 5% of physicians so self-identify.[14] This disparity exists for a variety of reasons. On the supply side, for example, there is a long history of medical schools actively excluding and discriminating against Black students. In 2009, the Liaison Committee on Medical Education introduced pro-diversity accreditation guidelines. Data show that from 2002 to 2017 Black and other ethnic minority applicants and matriculants to medical schools of both sexes were underrepresented, with a significant trend toward decreased representation for Black female applicants from 2002 to 2012.[15] This decline in Black male medical school applicants and matriculants to medical schools occurred in spite of more Black men graduating from college. Without Black medical students, you can't have Black physicians.

In order to understand and empathize with the experience of Black physicians, it is important to hear their voices. Following medical school, Black physicians may experience job-related discrimination. Typically, systemic or institutional protections are lacking, and they may be left to endure humiliating, hurtful acts of discrimination on their own, without collegial or institutional support. Damon Tweedy, MD, in his book, "Black Man in a White Coat,"[16] relayed his experience as a Black physician, beginning with medical school, describing what it is like for Black patients to live in a medical system that only looks at them through a white lens — a lens of discrimination.

In an article published by the Association of American Medical Colleges, Kali Cyrus, a Black female academic physician, explained why "I gave up my dream of leading diversity efforts in medicine":[17]

"[Despite many accomplishments,] I often felt overwhelmed and unsupported…I felt terribly alone. So few of my colleagues shared my identites: I'm a Black, queer woman, and many of them were White men… As long as the culture discouraged asking for help, didn't fully value those who focus on innovative diversity education, and failed to provide sufficient support to minority faculty, I would never feel truly safe. I knew members of my medical community appreciated my work, but unless they intended to use their privilege to prevent Black and brown faculty from leaving, it was not worth it to stay… Meanwhile, I find myself hoping for progress in academic medicine, though I'm not completely optimistic. Senior physician-leaders of most academic communities continue to look the same, unlike the rest of the United States, which is becoming increasingly diverse… But, medical schools and teaching hospitals need to do much more to create a culture of inclusivity at every level across the entire institution."

What Relevance Does Racism Have to State Medical Boards and the FSMB?

Racial and ethnic minority individuals are typically underrepresented in the power structure of medical organizations, including regulatory organizations. Their voices are often not solicited. This absence of their voices undermines trust. Given the historical record of discrimination and even exploitation and abuse of Black people and the relative absence of Black people in the controlling organizations and power structures, can racial and ethnic minority physicians who are under investigation trust that they will be dealt with fairly? Also, can racial and minority complainants trust that investigation of their issues will acknowledge racism when it occurs? Even further, do racial and ethnic minority individuals avoid making complaints because of mistrust that their complaints will be dealt with fairly? Are topics of racial and ethnic bias adequately addressed in the medical education process, including continuing education? Is there bias against Black individuals in medical school admission, internship and residency processes? Is there bias in qualifying test instruments? Unless these types of issues are addressed and realistic data generated, important questions remain unanswered, and discrimination remains invisible and perpetuated.

EVEN THE MOST WELL-INTENTIONED INDIVIDUALS CAN HARBOR SUBCONSCIOUS NEGATIVE STEREOTYPES AND ASSUMPTIONS ABOUT RACE AND ETHNICITY.

What is Implicit Bias?

Bias represents a preferential, rather than neutral, attitude or belief toward a person or group of people. Although bias can be positive, bias typically implies a negative attitude or belief. It can manifest verbally or non-verbally through acts of commission or omission.

When bias is unconscious or outside of conscious awareness, it is referred to as "implicit bias." It affects communications and actions toward others. Even the most well-intentioned individuals can harbor subconscious negative stereotypes and assumptions about race and ethnicity.

Bias can be expressed by any of the stakeholders in the medical system, including providers and institutions — medical schools, postgraduate training programs, professional medical organizations, hospitals and other health care delivery organizations, insurers, accrediting bodies, medical boards, regulatory entities and legislators.

What Effect Does Bias Have on Patient Care?

For several decades, inequities in health for racial and ethnic minorities have been documented in great detail at the national level. Racial prejudice and discrimination, complexly caused and manifested at many levels, have resulted in inequities, and they continue to be barriers to implementing change. The following are a few examples of government sponsored reports documenting ethnic and racial disparities in health care:

In 1985, the U.S. Department of Health and Human Services Office of Minority Health released the Report of the Secretary's Task Force on Black and Minority Health (the Heckler Report).[18] The eight-volume report recommended a national agenda for improving minority health.

In 2003, the Institute of Medicine, mandated by Congress, published a report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care."[19] Its multidisciplinary panel of experts concluded that, even when access-to-care barriers are controlled for, racial and ethnic minorities received worse health care than non-minorities: "Stereotyping, biases [both explicit and implicit] and uncertainty on the part of healthcare providers can all contribute to unequal treatment." The report noted that white clinicians who did not believe they are prejudiced "typically demonstrate unconscious implicit negative racial attitudes and stereotypes." The report stirred controversy in the medical community and prompted additional research documenting disparities in health care.

In 2018, fifteen years after the Institute of Medicine study, the National Healthcare Quality and Disparities Report documented that Black and other racial and ethnic minorities continued to receive poorer care than white patients on 40% of the quality measures, with little to no improvement from decades past.[20]

Although racial and ethnic disparities in health care for many conditions have been well documented, uncovering the reasons for the disparities can be difficult. The reasons are complex and can relate to any of the following: evaluating individual patient-doctor relationships based on race concordance versus discordance because of the low percentage of Black physicians; Black patients' mistrust of the

medical establishment to safeguard their best interests and protect them from exploitation; and systemic issues, such as insufficient numbers of Black physicians and racism in the larger culture in which we live. Much needed research can be hampered and limited by these and other factors, such as the difficulty of finding funding resources, small sample-sizes that make it difficult to control for variables, and differences in research study designs and methodologies that make it difficult to compare findings and reach firm conclusions.

Despite these limitations, there are studies worthy of note that document the impact of both conscious and implicit bias on the care of ethnic and racial minorities.

The attitudes and behaviors of health care providers have been identified as two of many factors that contribute to health disparities. In a systematic review,[21] authors Chloë FitzGerald and Samia Hurst found that "Implicit biases have been identified as one possible factor in healthcare disparities and our review reveals that they are likely to have a negative impact on patients from stigmatized groups."

Implicit bias in pain assessment and management has been the subject of several studies. Racial minorities and women are less likely to receive accurate diagnoses and appropriate pain management, leading to worse clinical outcomes.[22] In a study by Hoffman et al.,[23] half of a sample of white medical students and residents endorsed false beliefs about biological differences based on race (Black compared to white). Participants who endorsed these beliefs rated the pain of Black patients as lower than white patients and made less accurate treatment recommendations. The authors cite other studies that show that "relative to white patients, black patients are less likely to be given pain medications, and, if given pain medications, they receive lower quantities."[24] Additional research to uncover the cause of racially based false beliefs could help point to remedies.

Another factor that affects disparities in health care is Black patient underutilization of medical services because of mistrust of the white medical establishment. The Conference on Addressing Medical Mistrust in Black Communities published an extensive bibliography of "Reviews, Definitions, and Context and Origins of General Medical Mistrust."[25] Mistrust has been fueled by a long history of neglect, exploitation, and abuse of Black people by the white medical establishment, which is discussed in Appendix I of this article. Mistrust of the medical profession is further reinforced when discrimination and abuses occur as part of American culture — in law enforcement practices, the criminal justice system and voter suppression.

Despite extensive published documentation of racial and ethnic disparities in health care, change has been slow in correcting racism in medicine. With recent heightened public awareness through the news media focused on police brutality, inequities in the criminal justice system and voter suppression, there is increased momentum to support positive change in all institutions of our society, including in medicine.

How Effective is Implicit Bias Training?

Bias, whether implicit or explicit, is a habit that can be overcome with motivation, awareness and effort. Because implicit bias is unconscious, individuals need to be trained to recognize it in themselves, and institutions need to be restructured to include minority individuals and their perspectives.

Implicit bias training is one type of cultural competency training. Implicit bias training includes experiential and educational components, helping participants identify their own biases and recognize the negative impact those biases can have on others. It is in the nature of human beings to develop biases. No one is immune to biases, even those who hold to egalitarian goals of fairness and equality. Stating this as part of training can help reduce defensiveness.

MISTRUST OF THE MEDICAL PROFESSION IS FURTHER REINFORCED WHEN DISCRIMINATION AND ABUSES OCCUR AS PART OF AMERICAN CULTURE — IN LAW ENFORCEMENT PRACTICES, THE CRIMINAL JUSTICE SYSTEM AND VOTER SUPPRESSION.

Effective training requires ongoing participation in training sessions, data collection and assessments to determine effectiveness. Many medical schools and hospitals have incorporated cultural competency into their training.

There are mixed opinions about the effectiveness of cultural competence programs. One systematic review of the literature[26] found that: "Cultural competence training is an effective intervention that

enables healthcare providers to give culturally competent care that increases satisfaction of patients from minority groups." Another systematic review, by Renzaho et al.,[27] concluded: "Although the programs may increase practitioner knowledge and awareness, there is no evidence that this translates to improved patient health." However, there is a problem in evaluating such contradictory conclusions due to the "lack of patient health outcome measures in the majority of studies."[28] The authors also found that participants undertaking training may have

REQUIRING ORGANIZATIONS TO SELF-EVALUATE BIAS AT AN INSTITUTIONAL LEVEL CAN HELP THEM APPLY THE BEST FINDINGS AND INTERVENTIONS TO CREATE INCLUSIVE CULTURES.

differing values and attitudes that affect their receptivity to learning and making changes. The spectrum can range from those who hold humanistic values and are receptive to learning to those who hold deeply ingrained white supremacist values. The authors acknowledged: "More research is, thus, required to properly examine the impact, if any, of CC [cultural competence] PCC [patient-centered care] models on health outcomes."[29] When devising and evaluating educational programs, there is likely no one-size-fits-all approach, given the range of receptivity versus resistance among participants.

A good example of positive results from implicit bias training comes from the experience of the Ohio State University College of Medicine (OSUCOM). The admissions committee members were aided in recognizing their implicit bias and that translated into acceptance of greater numbers of racial and ethnic minority students. Results from the Implicit Association Test (IAT) revealed that all groups within the admissions committee displayed significant levels of implicit white preference, with men and faculty having the largest bias and women and students less bias. Most survey respondents thought the IAT might be helpful in reducing bias. Approximately half were conscious of their individual bias results when interviewing candidates in the next admissions cycle, and approximately 20% reported that knowledge of their IAT results impacted their decisions in the subsequent admissions cycle. A summary of OSUCOM's IAT activity noted: "The class that matriculated following the IAT exercise was the most diverse in the OSUCOM's history."[30]

Requiring organizations to self-evaluate bias at an institutional level can help them apply the best findings and interventions to create inclusive cultures. This has been the experience of the Washington Medical Commission, a state medical board whose efforts are noted below. The American Surgical Association has published organizational survey and self-assessment tools that can be useful to any organization. (See details in Appendix II.)

What Steps are Regulatory Bodies Taking to Address Implicit Bias and Racism?

Increasingly, regulatory bodies are recognizing the need to proactively address racism in order to ensure adequate care to minorities. According to the Washington Medical Commission, key steps in addressing racism in regulatory organizations include the following:[31]

1. Accept that there is a problem.
2. Acknowledge our role in continuing the systems that produce these outcomes.
3. Use our position and privilege to change the systems to serve all people.
4. As with medical error, we should recognize and apologize when our efforts to effect positive change do not have the desired impacts.

In 2020, the Commission published a formal statement: "Racism in all of its forms is a public health issue."[32] The Commission acknowledged its own role in a system that has produced biased outcomes, and it committed to using its position of authority and privilege to change its system to serve all people. Dismantling racism requires remedies at all levels of the organization, which the Commission addressed through a series of action steps:

- All commissioners now receive implicit bias training.
- The Commission created a multidisciplinary Health Equity Advisory Committee comprised of clinicians, faculty, administrators, students, community and system leaders. This Committee is tasked with reviewing the Medical Commission's policies and procedures to ensure equity for all patients regardless of race, ethnicity, language, religion, age, spiritual practice, sexual orientation and gender identity.
- The principle of equity has also been applied to staff hiring processes.

- The Commission seeks to address systemic racism in the health care system, from medical school and residency to practice, including patient safety.
- The Commission established a Healthcare Disparities Workgroup with a specific focus on maternal mortality, breast cancer, heart disease, and pain assessment, noting that data show a disproportion of morbidity and mortality from these conditions among persons of color.
- To minimize the effect of implicit bias in disciplinary actions, the Commission has incorporated policies and methods to make its disciplinary proceedings fair and equitable — without bias toward individual physicians because of race and other demographics.
- The Commission has instituted practices that level the playing field in addressing complaints against practitioners. Complaint summary documents that come before the Commission no longer list the complainant's name, the name of the physician against whom the complaint is filed, or any other information that may introduce bias into the complaint review process.

With these actions, the Washington Medical Commission has not only acknowledged the need for decisions to be fair, based on merit and without bias, but it has also taken steps to ensure equity. The Commission's work is laudable and can serve as a role model for other regulatory bodies to make changes.

Examples of actions taken by other states include the following:

Michigan

Beginning in 2022, Michigan will require any new medical health care provider to undergo implicit bias training as a condition of medical licensure.[33]

ORGANIZATIONS — AND THEIR LEADERS — THAT HAVE THE MOST POWER AND INFLUENCE MUST LEAD BY EXAMPLE TO ROOT OUT NEGATIVE RACIAL BIASES; NOT ONLY 'DO AS I SAY,' BUT ALSO 'DO AS I DO.'

In Michigan, reported cases of COVID-19 have been three times higher among the Black population than among white people. Although 14% of Michigan's population is Black, 40% of confirmed deaths were among Black patients. The Michigan Coronavirus Task Force on Racial Disparities recognizes that "By providing awareness to health care workers on how to recognize and mitigate implicit bias, we can help them carry out their mission of providing the best health care to every patient they serve."[34]

California

California law stipulates that a physician "is required to demonstrate satisfaction of continuing education requirements, including cultural and linguistic competency in the practice of medicine." As of January 2022, the curriculum of all continuing medical education (CME) must include "specified instruction in the understanding of implicit bias in medical treatment."[35]

Oregon

Noting disparities in health care among population groups, the Oregon Medical Board published "Cultural Competency: A Practical Guide for Medical Professionals." The Board encourages physicians "to provide care that is increasingly culturally responsive."[36] Beginning in July 2021, cultural competency continuing education became a condition of re-licensure (Oregon HB 2011). Also, Oregon requires health professional regulatory boards to "establish programs to increase the representation of people of color and bilingual people on the boards in in the professions that they regulate…" [37]

By taking actions such as these, state boards are increasingly making explicit public demonstrations of their commitment to reducing inequity. Such actions can carry significant weight in helping raise awareness and can influence other organizations to take similar steps. Examples of public commitments by others, aimed at admitting to issues of racial inequity and improving conditions, are included in Appendix II.

What Can Regulatory Bodies Do to Promote Diversity Within Their Own Membership?

A concerted system-wide effort to combat racism and promote diversity is necessary in order to create a more just and equitable medical culture for minorities. Regulatory bodies, as one part of a larger medical system, need to embrace diversity in their power structures and in their dealings with racial and ethnic minority physicians and health care workers. Organizations — and their leaders — that have the most power and influence must lead by example to root out negative racial biases; i.e., not only "do as I say," but also "do as I do."

Eight Guiding Questions

The following eight questions are important for regulatory bodies, including the FSMB and medical boards, to address as they seek to embrace diversity and include racial and ethnic minority voices in their organizations:

1. Are members of racial and ethnic minority groups represented on the medical board?
2. Are members of racial and ethnic minority groups represented among staff and investigators of the medical board?
3. Does the board require ongoing training about diversity, cultural competence and implicit bias for board members, staff and investigators?
4. Does the board require ongoing training about diversity, cultural competence and implicit bias as a requirement for licensees?
5. Do the board's mission statement and website embrace fairness and justice toward ethnic and racial minorities and their issues?
6. Do the board's regulations, policies and procedures consider the needs of racial and ethnic minority groups?
7. Does the board influence lawmakers to enact legislation that addresses racial and ethnic minority needs?
8. Are there mechanisms in place to measure disciplinary disparity outcomes and the effectiveness of efforts to achieve fair outcomes?

What Role Can the FSMB Play in Influencing State Medical Boards to Embrace a Diversity Agenda?

The FSMB can play a leadership role, alone and in collaboration with other stakeholders, to influence state medical and osteopathic boards to promote diversity, equity and inclusion of Black physicians, physician assistants and other health providers in the medical profession. This is consistent with the FSMB's mission to lead, assist and support state boards in providing physicians and other health care professionals with continuing medical education activities that bear on medical regulation, licensure, discipline, advocacy and policy in order to promote public health, safety and welfare. It should be noted that the FSMB launched a new, formal Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care in 2021.

Examples of questions and issues that could be addressed as the medical regulatory community advances a diversity agenda include the following:

- What impediments exist that discourage Black individuals from applying to medical schools and entering the medical profession?
- What needs to occur so that Black physicians are respected and included as equal members of the profession, not marginalized or discouraged from meaningful participation? What can be done to protect them from acts of discrimination?
- What can be done to promote more Black physicians to positions of influence and authority in medical organizations and establishments?
- What policies and procedures can be developed so as not to discriminate against Black physicians in disciplinary proceedings?
- What can be done to ensure that Black patients are treated fairly and with respect and to protect them from exploitation?
- What are the best ways to help white physicians understand and empathize with the experiences of Black physicians and Black patients?
- What are the best ways to develop cultural competency? For example, how can programs such as implicit bias training programs most effectively address racism among physicians, taking into account the range of attitudes from overt prejudice to pro-diversity?
- What are the best ways to measure the effectiveness of such programs and to utilize results to improve program content and delivery?

What Ethical Principles Can Guide Corrective Practices?

Moving forward, important ethical principles can guide our system toward diversity, equity and inclusion for all persons regardless of race, ethnicity, religion, sex and other factors.

Living the age-old principle of the "Golden Rule"—treating all people the way you want to be treated, with dignity, kindness and fairness—is a good place for all of us to start.

We can empathize with situations faced by racial and ethnic minorities. One way to do so is by learning the history of racism and its impact on attitudes and values of both Black people and white people in the present. According to Thomas Jefferson, "No people who are ignorant [uninformed] can be truly free."

We can embrace diversity, thinking about how we all are different from each other in some ways. This

includes valuing our differences and accepting our shared humanity. In so many ways, we are the same. Inside, we all have feelings and basic survival needs.

We should all make an effort to practice democracy and its emphasis on liberty and justice for everyone. The society in which we live should ensure inclusion of all its members, not just in words but also in real actions.

At every turn, the effort must be made to include ethnic and racial minority voices. Understand racial and ethnic minority issues and needs from the viewpoint of minorities. Include the voices of racial and ethnic minority individuals at the decision-making table.

These guidelines are consistent with accepted medical sources and authorities. The Hippocratic Oath asks practitioners to never harm others because life is sacred, to soothe the pain of anyone who is in need and to never betray them or risk their well-being. The guidelines are consistent with Accreditation Council for Graduate Medical Education (ACGME) Core Competencies that expect physician residents to demonstrate patient care that is compassionate; effective interpersonal and communication skills with others across a broad range of socioeconomic and cultural backgrounds; professionalism in the form of compassion, integrity, and respect for others and sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion and other factors. Violation of these ethics is obvious when reviewing the history of racial relations in medicine.

SOME MEDICAL BOARDS THAT HAVE ALREADY BEGUN TO INSTITUTE CONSTRUCTIVE CHANGE CAN SERVE AS ROLE MODELS TO HELP OTHERS ENSURE FAIRNESS IN THEIR REGULATORY ACTIVITIES.

Living according to these virtues is easier said than done. Relinquishing the status quo in favor of diversity can be challenging for those already in positions of power. White supremacy is alive and well in many segments of American society, and it does not support application of these ethical principles to Black and other minority groups. Trust is easily broken and difficult to earn, especially when it has been repeatedly undermined since the founding of America. Gaining the trust of racial and ethnic minorities requires more than lip-service but real action that embraces these ethical guidelines and is sustained over time.

Summary and Conclusions

Racism is a deeply ingrained feature that impacts a wide range of American institutions, including the medical establishment. Corrective efforts need to address diversity, equity and inclusion for Black physicians and Black patients — both as individuals as well as communities. Eight questions are posed for the FSMB and medical board self-assessments to uncover racist practices and promote positive changes within their organizations. In addition, the FSMB can assist medical boards to create a medical culture that encourages Black individuals to enter the profession, rather than one that discriminates against them. The recent launch of the FSMB's Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care is an encouraging step towards promoting an agenda of racial and ethnic diversity.

Rooting out racism is the right thing to do. It is a call for action — now. Doing so is a matter of conscience. Although recognition of disparities in health care has been well documented, constructive change has been slow to occur. Some medical boards that have already begun to institute constructive change can serve as role models to help others ensure fairness in their regulatory activities. Positive steps are being taken, but there is much more work to be done.

On the one hand, expecting quick, easy solutions to longstanding, complex, deeply ingrained systemic problems is unrealistic. On the other hand, delays and small changes can be frustrating to those who bear the brunt of discrimination. Small steps that seem positive to the white majority can be experienced as token efforts to the Black community.

According to Ortega and Roby, "Ending structural racism and inequities in the U.S. health care system has proved to be a challenge. What has become clear is that there needs to be much more intensified and multifaceted approaches that by necessity will require a much larger and committed investment in research, training, clinic[al] practice, and community engagement."[38] ■

About the Author

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APPENDICES

Preface: Why is History Important?

Appendix I offers historical examples of racism in the medical profession, while Appendix II offers examples of efforts to *address* racism in the medical profession.

Knowledge of this history is essential for understanding and creating positive change. Otherwise, as noted by George Santayana, "Those who cannot remember the past are condemned to repeat it." Knowing one's heritage is part of one's identity. Knowing another person's heritage — family and racial identities — allows us to understand and empathize with them. Systems that minimize, distort and deny history undermine that process. Omitting factual history about racism makes it difficult for white people to understand their white privilege and the oppression of Black people as individuals and as a group. Without factual information, it is difficult for white people to empathize with the experiences of Black people — to appreciate that the Black voice is largely absent in the medical profession; to recognize exploitation of Black people in government-sponsored medical experiments; to appreciate Black people's distrust of the white medical establishment and the reasons for it. Omitting the historical record can result in Black people feeling ignored, discounted and unprotected from ongoing abuses.

The appendices included here are intended to provide some details about racism in the medical community and efforts to address that racism.

There is a need to include information about racial and ethnic racism and how bias can impact the medical education curriculum and continuing education processes used by medical boards. Because racial and ethnic minority group perspectives and needs have not traditionally been part of their education and training, health care professionals are relatively uninformed about those perspectives and needs. Those who are uninformed can develop biases that negatively affect patient care. Although some physicians may be influenced by humanistic concerns of fairness alone, they can be enlightened by knowing the history of Black/white race relations. The appendices provide examples of factual information that should be included in the educational curriculum in order to inform physicians about the nature and extent of medical racism.

Appendix I: Historical Examples of Racism in The Medical Profession

The following are just a few examples of discrimination and abuse of Black people by the medical profession.

- **Racial theories of disease**. In 1851 prior to the Civil War, Dr. Samuel Cartwright, under the aegis of the Medical Association of Louisiana, published his theories about diseases peculiar to the "negro race," both enslaved and free. His work reflects the deep-seated belief that Black people were, by nature, inferior and best kept in slavery — a culturally sanctioned viewpoint shared by many lay and well-educated whites, especially in the south. According to Cartwright, "drapetomania" was a mental disease that caused slaves to run away and become free; it manifested as "rascality," a disease that made slaves commit petty offenses. "Dysaesthesia aethiopica" made slaves "insensible and indifferent to punishment." In the case of slaves becoming "sulky and dissatisfied without cause"— a warning sign of imminent flight — Cartwright prescribed "whipping the devil out of them" as a "preventive measure." As a remedy for this mental disease, doctors made running away a physical impossibility by prescribing the removal of both big toes.[39]

  Cartwright's pseudoscience served as a foundation for scientific racism. The impact at the time and its subsequent legacy should not be underestimated. According to Nancy Krieger,[40] "Exemplifying the political salience of scientific racism was the inclusion of an essay by Cartwright in the first print edition of the infamous U.S. Supreme Court 1857 Dred Scott decision, which declared that Black Americans 'had no right which the white man was bound to respect…'" Over a half century later, the third edition (1914) of Thomas Lathrop Stedman's Practical Medical Dictionary defined "Vagabondage, dromomania; an uncontrollable or insane impulsion to wander."[41]

- **Tuskegee medical experiment.** The U.S. government-sponsored Tuskegee medical experiment (from 1932 to 1972) studied the natural course of untreated syphilis in poor Black males without informing them of their diagnosis and withholding treatments, including in the era of penicillin. Failure to treat them resulted in unnecessary suffering, premature death and unwittingly infecting others.[42] When questioned, the government officials and the physicians conducting the study attempted to cover over the abuses and rationalized the study. None of the physicians were ever disciplined or sanctioned for their involvement. This experiment significantly contributes to the distrust that Black people have of the medical profession and their reluctance to seek medical care. It is important to note the Tuskegee experiment on Black individuals is just one of many abuses of Black people in medicine. Harriet Washington references misuse of Black people for surgical experiments, plutonium radiation experiments of African Americans, research on Black prisoners and research targeting young African Americans.[43]

- **The eugenics movement**. The eugenics movement during the twentieth century fostered racist practices in the United States. Racial disparities in illnesses were considered to be due to the biological inferiority of the Black race, without consideration of sociocultural determinants that shape health and illness. Many prominent individuals endorsed the idea of improving the human population by selecting for those with "superior" traits and reducing the reproduction of those with "negative" traits.

  Influenced by eugenics ideas, the government (U.S. and state) sponsored involuntary medical sterilization of "undesirables," mainly involving persons of color. Thirty-two states passed eugenic-sterilization laws during the twentieth century, and between 60,000 and 70,000 people were sterilized under them.[44]

  Eugenics practices in the United States began prior to those of Nazi Germany, and they continued after the post-WWII Nuremberg Tribunal that condemned Nazi physician involvement in involuntary experimentation on human beings as crimes against humanity. The 1947 Nuremberg Code, spearheaded by the United Sates, was put forth as a standard to protect human subjects. The ethical principles about the use of humans in experiments that arose in the course of the Tribunal proceedings are laudable, but they have not been followed by the U.S. government in its treatment of Black and other racial and ethnic minority citizens in the United States. Racist eugenics policies and actions help explain why many Black patients mistrust a medical system dominated by whites.

- **The Flexner Report.** Standards set by the Flexner Report (1910) resulted in the closing of many medical training institutions for Black people.[45] In the latter part of the nineteenth century and early twentieth century, Black physicians helped to establish institutions where Black patients could obtain medical care and Black people could be trained to become physicians. The values expressed in the report were not only in line with the "separate but equal" 1896 decision of the Supreme Court (Plessy v. Ferguson) that legitimated segregation but also supported an elitist white superiority agenda consistent with mainstream values of the day, especially in the south. The Flexner Report recommendations were intended to elevate the medical profession by setting high-quality standards for the education and training of physicians. Meeting these standards required costly resources that most Black training facilities could not meet. The report proposed "development of the requisite number of properly supported institutions and the speedy demise of all others."[46] As a result, only Howard University College of Medicine and Meharry Medical College continued to exist. The other Black medical schools became defunct. Some white schools in the north admitted Black students but few in number, and Black students were denied admission to many other schools. Despite the establishment of two additional Black medical schools—Charles R. Drew Medical School (founded in 1966) and Moorehouse School of Medicine (founded in 1975)—the legacy of the Flexner Report continues up to the present with an underrepresentation of Black physicians in the medical profession and a too-common attitude of prejudice toward Black physicians who are in the profession.
- **AMA membership exclusions.** Through its policies and practices, the American Medical Association excluded Black physicians from its membership for many years. In 1895, Black physicians formed their own medical organization, the National Medical Association.

These are just a few examples of medical racism. Harriet Washington provides abundant examples in her book "Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present."[47]

Appendix II: Examples of Efforts to Address Racism in the Medical Profession

Credit is due to those entities that acknowledge their role in racism and offer to do better in the future. Some examples include the following:

- **Tuskegee apology**. In 1997, President Clinton issued a formal apology acknowledging the government's betrayal of the Black men who were subjects in the Tuskegee experiment. "The United States government did something that was wrong—deeply, profoundly, morally wrong," he said. President Clinton proposed measures to protect African Americans from future abuses.[48]
- **Reparations for sterilizations**. Some states passed legislation to pay reparations to victims of forced sterilizations. For example, North Carolina and Virginia paid monies to some of the surviving victims of eugenics sterilization programs.[49] In contrast, California has not offered reparations, despite approximately 20,000 sterilizations having been conducted in the state. In 2014, California banned coerced sterilizations as means of birth control in prisons.[50]
- **Cultural competency**. The U.S. Department of Health and Human Services has published core concepts and principles of cultural and linguistic competence in health care. "Think Cultural Health" is a program that provides information to health care professionals.[51] There is a separate program for behavioral health professionals.
- **National Institute on Minority Health and Health Disparities**. In 2010, the National Institute on Minority Health and Health Disparities (NCMHD) was designated as an institute of the National Institutes of Health (NIH) with a charge to eliminate inequities in health and health care.
- **AMA apology and new focus on equity**. In 2008, Dr. Ronald Davis, as President of the American Medical Association (AMA), formally apologized for more than a century of AMA policies that excluded African American physicians from the AMA. The AMA pledged to "do everything in our power to right the wrongs that were done by our organization to African-American physicians and their families and their patients."[52] The AMA pledged to make changes to include Black physicians as equals.

  The AMA House of Delegates has prioritized the elimination of racial and ethnic disparities as of top importance. Launched in 2019, the new AMA Center for Health Equity has a mandate to embed health equity across the organization so that equity becomes a part of the AMA's practice, process, action, innovation and organizational performance and outcomes.
- **AAMC and NMA partnership**. In August 2020, the Association of American Medical Colleges (AAMC) and the National Medical Association (NMA) announced a joint effort to convene an Action Collaborative that will address the lack of representation of African Americans in medicine.[53]
- **ACGME Equity Matters**. In 2021, the Accreditation Council for Graduate Medical Education (ACGME) announced "ACGME Equity Matters," a new initiative that introduces a framework for continuous learning and process improvement in the areas of diversity, equity and inclusion and anti-racism practices. The initiative aims to drive change within graduate medical education by increasing physician workforce diversity and building safe and inclusive learning environments, while promoting health equity by addressing racial disparities in health care and overall population health.[54]
- **Academic efforts**. Academic institutions, prestigious journals and professional associations have taken strong stands to promote diversity, equity and inclusion. For example, the American Surgical Association produced a handbook titled "Ensuring Equity, Diversity, and Inclusion in Academic Surgery."[55] The handbook "identifies issues and challenges and develops a set of solutions and benchmarks to aid the academic surgical community in achieving these goals." According to the Association, "Surgery must identify areas for improvement and work iteratively to address and correct past deficiencies. This requires honest and ongoing identification and correction of implicit and explicit biases. Increasing diversity in our departments, residencies, and universities will improve patient care, enhance productivity, augment community connections, and achieve our most fundamental ambition—doing good for our patients." The 77-page document includes useful resource-assessment tools in its appendices:

  — Employee/Faculty/Staff Survey to Evaluate Diversity

  — Organizational Diversity, Inclusion, and Equity—A Self-Assessment Tool

  — Tool for Recognizing Microaggressions and the Messages They Send

  — Negative Acts Questionnaire

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CPSM Regulatory Impact Assessment

Prescribing Rules Review

DATE: June 22, 2022

Background/Issue:

Prescribing has changed dramatically with COVID-19 pandemic rules, the introduction of virtual medicine, technology, and in general changing societal expectations around expected convenience of access to drugs. Changes that broadened the prescribing landscape by adding classes of registrants such as Clinical Assistants, Physician Assistants, and Residents have added complexity to the current prescribing environment. The current regulations constraining prescribing were written when both Clinical and Physician Assistants were a new class of registrant and their scope of practice and integration into the healthcare system was somewhat undetermined. The success of clinical assistants and physician assistants in the health care system is fully evident now and their prescribing powers likely need to be altered to better reflect the positive impacts these classes of health providers have had on the health system.

Proposed Solution:

Chosen by Council as one of the Strategic Organizational Priorities in June 2021, Prescribing Rules Review will be a **joint** review with the College of Pharmacy of many aspects of prescribing which is one of the core treatments performed by physicians and CPSM members.

The Prescribing Rules Review Working Group will review the following prescribing practices:

1. Possible elimination or reform of the M3P
2. Tramadol inclusion in M3P
3. Transmission of prescriptions: e-prescribing
4. Enhanced Prescribing Powers for Clinical and Physician Assistants and Residents
5. Review the Standard of Practice on Prescribing Requirements
6. Review of Practice Directions (or Joint Statements) regarding prescribing
    a. Dispensing Physicians
    b. Electronic Transmission of Prescriptions
    c. Facsimile Transmission of Prescriptions
    d. Manitoba Prescribing Practices Program (M3P)
    e. Prescribing Practices: Doctor/Pharmacist Relationship
    f. Rural Remote and Underserved populations: Access to Prescribed Medications
7. Review Regulations on Prescribing
8. Consider whether the prescribing rules are for just prescribing in the community and for outpatients or whether it also includes in-patients in the hospitals and personal care homes and other such residential health care facilities.
9. Exemption for Prescribers Prescribing and Pharmacists Providing Controlled Drugs and Substances Under s. 56. CDSA

10. Review other prescribing matters the Working Group considers appropriate for patient safety.

Accountability:

Registrar

Timeline:

Fixed Timeframe Not Applicable ☒

On-going
This is ongoing work over the next two years.

Alignment of Organizational Priorities:

Council has already chosen this as a Strategic Organizational Priority in June 2021. It certainly aligns with Rebranding Quality of Care as the Identity of CPSM since the focus will be quality prescribing. Creating Performance Metrics will also apply to Prescribing Practices Program at CPSM and maybe to other prescribing matters, depending upon what the Working Group chooses.

Patient Safety:

CPSM will further enhance patient safety by improving the rules and procedures for prescribing. Patient safety is paramount in any decisions made regarding prescribing.

Risk Analysis:

Public Risk
Improving the rules and procedures for prescribing is being done with the intent of diminishing public risk in prescribing, ensuring better access to care/prescribing, and facilitating prescribing where safe and appropriate. Recognizing that prescribing can contribute to significant adverse outcomes, the risk to the public and patient safety will be at the forefront of every conversation and decision, with an intent to minimize public risk.

Reputational Risk
Many of the prescribing rules and procedures are anachronistic – including faxing requirements or handing a paper prescription directly to a patient. This latter scenario did not work in the pandemic and inadvertently created a number of opportunities to change prescribing workflows.

These should be formalized and written in appropriate documentation – whether it is in regulations, Standards of Practice, or in Practice Directions. The public expects CPSM to ensure prescribing procedures and rules are up to date, relevant, and that the appropriate classes of registrant have proper authority to prescribe.

Regulatory Risk

CPSM's mandate is to regulate the medical profession in the public interest. This includes ensuring registrants have the knowledge, skill, and judgment and competence to prescribe. The Prescribing rules and procedures have to ensure access to prescriptions, but most importantly be safe for the public. Failure to obtain the optimal balance will place CPSM at significant regulatory risk.

Operational Risk

Making rules based on generalized principles is required – failure to do so will result in extraordinarily long documents that are inaccessible. However, it is recognized that one set of rules may not fit all circumstances, especially for those patients that are in distant rural or remote parts of the province with more limited access to medical care. Similarly, the rules have to take into account lack of connectivity to the internet in parts of the province, or some patient's preferences for different delivery of prescriptions. Some of these are the most vulnerable patients and the operational requirements must not be such as to limit their access to medical care and/or prescriptions. Failure by CPSM to achieve the appropriate balance in striking its prescribing rules will have very tough and completely unwarranted consequences on patients.

Regulatory Impact on Members:

One of the major decisions is whether to continue with the pandemic rules for M3P or not. These rules have been embraced by physicians and patients, albeit the work-arounds are rather unusual (ie, taping a M3P prescription to a piece of paper and faxing it – in 2022!). Moving back to in-person delivery of a written prescription to a patient in a world of virtual medicine would have an enormous negative impact on members – and on patients.

It is believed that both Clinical and Physician Assistants would welcome expanded prescribing abilities, if that is what is decided upon ultimately.

For the other decisions to be made, the regulatory impact will vary depending upon the decision made.

Financial Impact:

Human Resources:

Several individuals at CPSM will spend time participating in the Working Group, developing the new rules, and communicating to the registrants. With any change, there are inquiries to respond to, and it has yet to be determined who will answer these. CPSM will be dedicating internal resources to this priority.

Financial: Not Applicable ☐

The operating budget for 2022/23 fiscal year includes $50,000 for both Working Group work and the initiatives. A baseline of $50,000 annually for three years commencing 2022/23 is included in the operating budget.

Infrastructure: Not Applicable ☒

Transition Budget: Not Applicable ☒

Alternatives or Status Quo:

The alternative is to do nothing or even try to go back to pre-COVID rules. This does not reflect the changes made in the past two years which appear beneficial, changes in societal expectations, and changes in technology. The current COVID rules for delivery of prescriptions is lacking in legal authority and was written in the space of a few days in March 2020, the early days of the pandemic.

Evaluation and Outcomes: Not Applicable ☐

Due to the varied nature of this priority, the evaluation and outcomes will be dependent upon the choices made to revise the prescribing rules. The ultimate goal is safe prescribing, access to prescriptions, and most importantly patient safety.

Additional Information: Not Applicable ☒

Recommendation:

Continue with the Prescribing Rules Review as a Strategic Organizational Priority as was chosen in June 2021.

Submitted by:

Dr. Ziomek

CPSM Regulatory Impact Assessment

Standard of Practice – Episodic, House Calls, and Walk-in Primary Care

March 4, 2022

Background/Issue:

There is a need for CPSM to establish minimum practice requirements for those members providing care that is episodic, house calls, or in a walk-in primary care basis.

This an identified gap in the standard of care provided in a non-institutional environment. Fragmented care delivery often lacks the continuity of care required for the delivery of best medical care, yet there is a role for episodic, house calls, and walk-in care. This is especially because not all Manitobans have a family physician, the lack of availability of their family physician, inability to travel to the physician's office, travelling within the province or from another province, and convenience of hours amongst other factors.

This is a Strategic Organizational Priority for CPSM.

Proposed Solution:

Not Applicable ☐

There is a need for CPSM to have a Standard of Practice to establish minimum practice requirements for those members providing care that is episodic, house calls, or in a walk-in primary care basis.

Accountability:

Registrar

Timeline:

Fixed Timeframe

Not Applicable ☐

The Standard of Practice for Episodic, House Calls, and Walk In Primary Care is a Strategic Organizational Priority for 2021/22. If Council approves the draft recommended by the Working Group, then it will be in a consultation period in the spring. The Working Group will reconvene to review the feedback and will revise the document accordingly. The final Standard may be ready for Council to review at its September meeting, but if slightly delayed due to the summer holiday schedule, it will be ready for the December Council meeting.

On-going Not Applicable ☐

For the implementation of any Standard, there is a communication strategy prepared to ensure ease of implementation – both for the patients and for the profession. It is anticipated there will be numerous inquiries, both from patients and from the public as the new minimum requirements for care impact upon the delivery of care.

There will likely be several complaints filed as some of the profession may not adhere to the minimum care requirements.

Alignment of Organizational Priorities:

Not Applicable ☐

This is a Strategic Organizational Priority.

Patient Safety:

This Standard is required to ensure the continuity of care in a fragmented primary care delivery environment. Critical for required good medical care is patient safety. The Standard will ensure that the medical care is provided in the patient's interest. This Standard will recognize episodic, house calls, and walk-in clinic primary care plays an important role in the delivery of medical care, but additional guidance to the profession is required to ensure it is safe and good medical care providing for continuity. The Standard also requires the communication of this care with the family physician and has requirements for follow-up of care and tests. This communication between care providers is particularly important in the absence of a single electronic medical records system in the province.

Risk Analysis:

Public Risk Not Applicable ☐

The public expects good medical care to be delivered regardless of whether delivered by their family doctor, a house call, or a walk-in clinic or some other episodic care. Many patients do not understand the limitations of such care and may assume that there is continuity of care between their family doctor and the episodic primary care. Many patients do not realize that the care provided in a walk-in clinic is not full continuous primary care and may even consider that walk-in clinic their family doctor. CPSM must ensure registrants delivering this type of episodic primary care have responsibilities for communication with the family doctor and follow ups, and explain the limits of care to patients.

Reputational Risk Not Applicable ☐

Ensuring good medical care delivered by CPSM registrants is the core mandate of CPSM. Failure to meet the regulatory mandate could impact CPSM's reputation with the public, stakeholders, registrants, and government.

Regulatory Risk Not Applicable ☐

Similar to reputational risk, failing to meet the mandate of self-regulation in the public interest could place the privilege of self-regulation in jeopardy.

Operational Risk Not Applicable ☐

The operational risks are for those registrants with this type of primary practice, and not CPSM as an organization. The increased requirements for minimum care should cause some registrants to take longer in individual appointments and follow up communications and monitoring. There will be an administrative cost and time spent on sending information to the regular primary care provider. There is a remote possibility that the requirement may force some registrants who provide this type of care to only provide care for low complexity patients to avoid the responsibilities associated with patients requiring complex care.

Regulatory Impact on Members:

The impact will be greatest on those physicians who engage in primary care that is episodic, perform house calls, and work in walk-in clinics. If not already doing so, they will have to revise their practice to meet the standard of care that is the same across all delivery modes. They must conduct any assessments, tests, or investigations required for treatment and can only limit their care in good faith. There are also requirements for communication, supporting patients, and continuity of care and follow-ups.

These changes will provide improved care for Manitobans, and will require those delivering episodic care to deliver care at the same standard as others. This will likely take more time for each patient encounter.

Financial Impact:

Human Resources: Not Applicable ☐

Several physicians, legal counsel, and staff will likely respond to inquiries on this Standard if and when implemented. Those inquiries will come from both registrants and patients. It simply takes time to respond to each inquiry. With a Standard in place clearly outlining the minimum requirements for good medical care, if those standards are not met, then either the Quality or Complaints/Investigation Department will likely be required to address any allegations of deficiencies in care.

Financial: Not Applicable ☐

See above (in Human Resources).

Infrastructure: Not Applicable ☒

There may be some related IT infrastructure required from Digital Health to better track the care longitudinally even though the care is provided episodically (would help an Emergency physician when providing care if they knew what the patient went to a walk-in clinic for and what tests might have been ordered)

Transition Budget: Not Applicable ☒

Alternatives or Status Quo: Not Applicable ☐

If not implemented, then good medical care may be compromised with patient outcomes not being as good as they should be.

Evaluation and Outcomes: Not Applicable ☐

Improved patient care with enhanced communication with the regular primary care provider are desired outcomes. It will be difficult to evaluate this.

Additional Information: Not Applicable ☒

Recommendation:

Approve and implement the Standard of Practice for Episodic, House Calls, and Walk In Primary Care.

Submitted by:

Dr. Anna Ziomek
Kathy Kalinowsky

CPSM
STRATEGIC ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	FMRAC Working Group	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Prescribing Practices Review		21-Sep-21		Formed					**Delayed**	The Working Group met on April 26 and a meeting between the the Registrars of CPSM and CPhM is scheduled
Truth & Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners		21-Sep-21		Formed					On Track	The Advisory Circle has met 6 times to date. Next meeting is scheduled for June 14 2022
Episodic Care, House Calls, Walk-Iin Clinics - Standard of Practice		21-Sep-21	21-Jun-21	Formed	22-Mar-21	22-Apr-21	22-Jun-21	22-Jul-21	On Track	Feedback from consultation will be reviewed by Council in June 2022. The Working Group will convene to review feedback.
Streamlined Registration - Fast Track Application	FMRAC-Started								**Not Started**	
Streamlined Registration - Portable Licence	FMRAC-Started								**Not Started**	Amendments to Acts Required in many jurisdictions
Artificial Intelligence	FMRAC-Started								**Not Started**	

Last revised: May 19, 2022

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING –JUNE 22, 2022

NOTICE OF MOTION FOR APPROVAL

SUBJECT: Operating Budget and Fee Increase

BACKGROUND:

PART I – OPERATING BUDGET

The 2022-23 proposed operating budget (see Appendix **A** for details) accounts for resources added in the previous year, new resources related to meeting the requirements of the RHPA, both current and future strategic objectives and increased workload in the key areas of Quality, Prescribing Practices Program and Complaints and Investigations. CPSM has proposed a 3 year budget that will provide:

- Balanced budget by 2024-25,
- Adjusted fees on specific categories where revenues do not match workload/expenses at CPSM,
- Adjusted fee categories that have not previously been adjusted by the CPI,
- Address potential cross subsidization of the Physician certificate of practice fee to other fee categories,
- Utilize CPSM's unrestricted reserve to assist in minimizing fee increases.

The timing of a fee increase has in fact been delayed a number of years due to factors that have positively impacted expenses, not the least of which was COVID. CPSM ended the fiscal year with a modest deficit of approximately $50,000 while initially forecasting a deficit of $500,000. A number of factors contributed to the significant improvement that are not likely to reoccur.

- Recoveries due to investigations (registrant penalties and fines)
- Expenses delayed or muted due to COVID
    - Decrease in number of meetings as well as decrease in in-person committee meetings
- Timing delays (staff hired late in 2021-22) that were expected to be in place in early 2021

Furthermore, the decision was made by Council in June 2020 in the early stages of COVID to remove the automatic inflation increase for registration fees as a unique one-time event due to COVID-19. This decision to forego a 2% increase in 20/21 for one year has compounded and CPSM continues to operate without that inflationary increase even though most of its expenditures such as the lease and employee salaries increase by inflation.

Absence a fee increase or significant change in operations, CPSM would exhaust its unrestricted reserve in 2023-24 which would significantly impact operations beyond 2023-24. In order for CPSM to continue delivering on the strategic objectives of the Council, increased revenues will be required to achieve the desired results.

2018-2022 CPSM Resources

The following table and detail illustrate where CPSM has expanded its workforce. The program expansions target the key areas and deliverables of CPSM and are directly linked to increasing workload pressures CPSM is experiencing.

CPSM Staffing and associated workload

Equivalent Full-Time @ Fiscal Year-End							
Department	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**Change from 2019-20**	**2022-23 - Proposed**	**Change**
Complaints	6.8	6.4	9.2	9.6	3.2	9.6	0.0
Corporate	7.0	7.0	8.0	8.0	**1.0**	8.0	0.0
Finance	2.0	2.0	2.0	2.0	0.0	2.0	0.0
IT	2.0	1.6	2.6	3.6	**2.0**	3.6	0.0
MANQAP	5.0	5.0	5.0	5.0	0.0	5.0	0.0
Quality	5.9	6.5	9.5	10.1	**2.6**	11.7	**1.6**
Registration	7.0	7.0	7.0	7.0	**1.0**	7.0	0.0
TOTAL	**35.7**	**35.5**	**43.3**	**46.3**	**9.8**	**47.9**	**1.6**
Head count	**37**	**38**	**47**	**48**		**50**	

2021-22 EFT Changes- Detail

Complaints: 1.0 EFT Lawyer, 0.6 EFT Patient Advocate (Social Worker), 1.0 EFT Program Support, 0.6 EFT Medical consultant, temporary increase of 0.2 EFT for Assistant Registrar.

Corporate: 1.0 EFT Communications

IT: 1.0 EFT IT support related to SharePoint and other IT office support & 1.0 EFT charge to IT Reserve for CPSM Portal project work (this is an 18 month term and is not reflected in the numbers above) and 1.0 EFT to support the CPSM portal and development long-term (position approved in 2021-22 and started in May of 2022).

Quality: 1.0 EFT for Quality Department Admin Support, 0.9 EFT Occupational Health (PPP), 1.0 Pharmacist (PPP) to replace former medical consultant (other EFT changes account for the 0.4 difference)

Registration: 1.0 EFT was transferred to the Quality department as the major function of the individual dealt with audits. Due to the increasing numbers and complexity in Registration, the 1.0 EFT was backfilled.

Workload Trends

WORKLOAD TRENDS: Complaints and Investigations **67% increase in cases received** over 2020-21				
	2021-22*	**2020-21**	**2019-20**	**2018-19**
Outstanding Cases from previous year	117	112	104	128
Cases received during the year	360	215	194	243
Total	**477**	**327**	**298**	**371**
Cases outstanding as of year end	289	118	114	103
Total cases closed	188	206	184	268
# of Cases Dismissed**	9	na	na	na
Inquiries	3	2	1	
Matters Pending before Inquiry Committee	1	3	1	
*2021-22 is the first year the public could initiate complaints through a web interface **2021-22 is the first year that complaints have been dismissed				

WORKLOAD TRENDS: Quality			
Physician Health Program **100% increase** over 2019-20			
Referrals	**2021-22**	**2020-21**	**2019-20**
New Referrals	84	58	41
Quality Improvement Program More than a **doubling** of initiated and completed quality assurance reviews from the previous years.			
	2021-22	**2020-21**	**2019-20**
Initiated	481	223	291
Completed	337	159	192
The RHPA requires all physicians to participate in and their competence be assessed by the Quality Improvement Program over a 7 year cycle. The resources attached to this function is insufficient to meet that target.			
Prescribing Practices Program			
	2021-2	**2020-21**	**2019-20**
Total Number of Deaths Reviewed	71	39	54
Prescribing Deemed Appropriate	43	13	28
Prescribing Falls Outside Guideline	58	34	21
Referred to Other Colleges	10	6	5
Other: • OAT Workshops - 660 Attendees from 2018-22 (30 Workshops in total with 7 of these occurring in 2021-22). • Over 100 MDs added to the OAT Prescriber list over the last 7 years with significant growth year over year of general prescribing advice cases (<10 in 2019 to 60 in 2022).			

WORKLOAD TRENDS: Registration This area continues to see incremental growth in renewals, however 2021-22 experienced a significant increase in new applicants.			
	2021-22	**2020-21**	**2019-20**
Full Certificates (renewals)	3157	3083	3029
New Applications	619	462	479
% Change from Previous year	-	-	-
Full Certificates (renewals)	2.4%	1.8%	n/a
New Applications	34%	-3.5%	n/a

The Operating Budget for 2022/23 to 2024/25 is attached as Appendix A. Council is only being asked to approve the Operating Budget for 2022/23.

PART II - FEES

The following table illustrates the certificate of practice fees charged over the last 10 years (Quebec is not represented)

CPSM fees as compared to other Colleges of Physicians and Surgeons										
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
AB	$ 1,900	$ 1,960	$ 1,960	$ 1,960	$ 1,960	$,960	$ 1,960	$ 1,960	$ 2,150	$ 2,150
NS	$ 1,655	$ 1,555	$ 1,555	$ 1,555	$ 1,750	$ 1,750	$ 1,850	$ 1,950	$ 1,950	$ 1,950
MB	**$ 1,600**	**$ 1,650**	**$ 1,700**	**$ 1,700**	**$ 1,700**	**$ 1,780**	**$ 1,816**	**$ 1,870**	**$ 1,870**	**$ 1,890**
SK	$ 1,500	$ 1,600	$ 1,700	$ 1,800	$ 1,880	$ 1,880	$ 1,880	$ 1,880	$ 1,880	$ 1,880
NL	$ 1,650	$ 1,650	$ 1,750	$ 1,750	$ 1,750	$ 1,750	$ 1,850	$ 1,850	$ 1,850	$ 1,850
ON	$ 1,530	$ 1,550	$ 1,570	$ 1,570	$ 1,595	$ 1,625	$ 1,725	$ 1,725	$ 1,725	$ 1,725
BC	$ 1,400	$ 1,500	$ 1,540	$ 1,590	$ 1,625	$ 1,670	$ 1,685	$ 1,700	$ 1,700	$ 1,715

Based on the increases over time, Manitoba ranks 3rd lowest both on average amount of annual increase as well as % of annual increase over the 10-year period for the MRA's shown.

Appendix B and C show how CPSM's certificate of practice compares when factoring in average physician income by province (Appendix B) as well as how the % of fees when compared to income compares for other self-regulating professions in the Province of Manitoba (Appendix C)

Fee Bylaw

The Fee Bylaw sets out the following rules to be followed or fee increases.

Increases in Fees

3. The fee for the annual certificate of practice shall automatically increase by an amount equal to the Manitoba Consumer Price index to cover inflationary costs.
4. Council may also increase the fee for the annual certificate of practice by an additional amount provided that management presents Council with a budget and a satisfactory rationale justifying an increase.
5. The Council may issue a special assessment on some or all classes of members to cover unexpected expenses, which were not reasonably foreseeable at the time the budget was prepared.

Recommended Fee Increases

With the approval of Finance, Audit, and Risk Management Committee and the Executive Committee below are the details of the fee increase recommended for 2022-23 (effective November 2022)

1. **Physician annual certificate of practice fee** to be increased by 2% ($40) in 2022-23. Including the automatic inflation indexation of 6% ($120), this will result in the physician certificate of practice increasing by 8% from the current $1,890 to $2,050. In accordance with the Fee Bylaw the CPI inflation amount (6%) is automatically increased; whereas the additional increase (2%) must be approved by Council with a budget and satisfactory rationale justifying the increase.

2. **Clinical & Physician Assistants annual certificate of practice fees** to be increased by $100 from **$300 to $400** in 2022-23 (25% increase). This particular certificate of practice has been exempt in the past from CPI rate increases. This oversight will be remediated going forward effective 2023-24. In addition, the Registration Department reports significant workload associated with this category and therefore the fees are not sufficient to cover the expenses currently incurred at CPSM to register this class. In reviewing the existing rate and comparing to other provinces it appears that Manitoba is low in this fee assessment. When compared against a somewhat similar health professional, Nursing, the fee is appreciably lower for CA/PA's in comparison.

   CPSA -Alberta $537.50 (PA annual renewal)

   College of Registered Nurses Manitoba
   Nursing - $510.79
   Nurse Practitioner - $784.35

3. **Medical Corporation fee** to increase by $50 from $150 to $200 in 2022-23 (33% increase)
    a. Medical Corporation fees have been static for an appreciable period of time and have been previously exempted from the CPI.

PART III - RECOMMENDATION

The Finance, Audit and Risk Management Committee unanimously recommended to Council that:

A. Council approve the 2022-23 Annual Operating Budget as presented; and,

B. Council approve the following member fee increases for membership year 2022-23:
    b. For the annual certificate of practice of Full Practicing, Provisional, and Assessment Candidate Members, additional 2% increase of $40 for a final amount of $2,050;
    c. For the annual certificate of practice of Regulated Associate Member – Physician Assistant, an increase of $100 for a final amount of $400;
    d. For the annual certificate of practice of Regulated Associate Member – Clinical Assistant, an increase of $100 for a final amount of $400; and,
    e. For the annual Medical Corporation Fee, an increase of $50 for a final amount of $200.

After 2022-23, the expectation is there will be no need for an additional fee increase requested of Council for the proposed 3 year budget beyond the CPI. The automatic CPI inflation amount is expected to cover increases in costs.

The above funding options are expected to result in the following:

- Funding of baseline budget plus new initiatives (Truth & Reconciliation and Prescribing Rules Review)
- Regaining path to financial stability by achieving breakeven status in 3rd year
- Partial utilization of the free reserve to help absorb the financial stress on members

Revised MRA comparison using CPSM's 2022-23 (effective November 1, 2022) recommended certificate of practice fee. Due to the variable timing of approvals at the Colleges across the country, it is uncertain how the fees will be adjusted due to the very recent spike in inflation.

College	2022
AB*	$ 1,792
NS	$ 1,950
MB**	$ 2,050
SK	$ 1,880
NL	$ 1,850
ON	$ 1,725
BC	$ 1,725

*CPSA is providing a one-time rebate to registrants out of their building fund. The 2021 fees are $2150.
**CPSM rate reflects the 2021 fee of $1,890 + $120 related to CPI + $40 related to 2% general increase

POSSIBLE QUESTIONS FOR DISCUSSION

- The inflation rate has climbed extremely quickly to 6%. What happens to the budget if inflation continues to climb into double digits?
- Are there fees other than registration fees from which CPSM can better recover its costs?
- Are you confident in the forecast expenditures and revenues?
- Is there an opportunity to receive another SUAP-type grant from Government for expenses?
- What are the implications if Council does not approve the 2% registration fee increase?

PUBLIC INTEREST RATIONALE:

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

The operating budget provides the financial resources required to regulate the medical profession in the public interest and to fulfill the statutory requirements of the RHPA. Fees are set at the appropriate amount to provide these financial resources for self-regulation in the public interest, and not set at whatever amount that is acceptable to the registrants. Having said that, these fees are within reasonableness when compared to other colleges and regulatory bodies.

MOTION

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 22, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

1. Council approve the 2022/23 annual operating budget as presented.
2. Council approve the following registrant fee increases for membership year 2022-23:
    a. For the annual certificate of practice of Full Practicing, Provisional, and Assessment Candidate Registrants, additional 2% increase of $40 for a final amount of $2,050;
    b. For the annual certificate of practice of Regulated Associate Registrants – Physician Assistant, an increase of $100 for a final amount of $400;
    c. For the annual certificate of practice of Regulated Associate Registrants – Clinical Assistant, an increase of $100 for a final amount of $400; and,
    d. For the annual Medical Corporation Fee, an increase of $50 for a final amount of $200.

Appendix A – 2022-23 Budget

College of Physicians & Surgeons of Manitoba

Budget Statement of Operations

FY's 2022-23 to 2024-25

	2020-21 Actual	2021-22 Actual	2022-23 Budget	2023-24 Estimate	2024-25 Estimate
Revenues					
Physician & Resident License Fees	6,025,030	6,227,838	6,606,588	6,988,156	7,394,565
Educational Register Fees	82,100	84,300	83,794	83,912	83,925
Clinical Assistant License Fees	34,950	38,400	40,275	44,463	46,344
Physician Assistant License Fees	41,100	45,000	46,875	54,733	56,264
Medical Corporation Fees	376,975	387,625	440,050	503,149	524,560
Other Fees and Income	442,463	625,539	412,463	352,640	352,640
Interest Income	23,837	29,103	23,368	22,976	24,025
Change In Market Value	205,268	101,247	59,996	61,705	63,482
Government Funded Program Revenues	1,332,430	1,271,658	998,409	896,000	896,000
	8,564,153	**8,810,710**	**8,711,818**	**9,007,734**	**9,441,804**
Expenses					
Governance	138,677	161,279	190,542	240,887	241,239
Qualifications	885,559	721,502	745,151	777,420	811,839
Complaints and Discipline	1,509,985	1,805,860	1,811,997	1,866,275	1,922,347
Quality	998,626	1,221,931	1,702,666	1,927,723	1,986,801
Operations and General Administration	2,517,345	2,661,415	2,787,771	2,900,202	2,954,642
IT	906,385	1,048,197	1,118,055	911,751	864,505
Government Funded Program Expenses	1,281,632	1,245,010	1,116,702	814,706	814,727
	8,238,208	**8,865,193**	**9,472,884**	**9,438,965**	**9,596,100**
Excess (Deficiency) of Revenue Over Expenditures	**325,944**	**-54,483**	**-761,066**	**-431,231**	**-154,296**

College of Physicians & Surgeons of Manitoba

Budget Statement of Operations

FY's 2022-23 to 2024-25

	2020-21 Actual	2021-22 Actual	2022-23 Budget	2023-24 Estimate	2024-25 Estimate
Revenues					
Physician & Resident License Fees	6,025,030	6,227,838	6,606,588	6,988,156	7,394,565
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Clinical Assistant License Fees	34,950	38,400	40,275	44,463	46,344
Physician Assistant License Fees	41,100	45,000	46,875	54,733	56,264
Medical Corporation Fees	376,975	387,625	440,050	503,149	524,560
Other Fees and Income	442,463	625,539	412,463	352,640	352,640
Interest Income	23,837	29,103	23,368	22,976	24,025
Change In Market Value	205,268	101,247	59,996	61,705	63,482
Government Funded Program Revenues	1,332,430	1,271,658	998,409	896,000	896,000
	8,564,153	**8,810,710**	**8,711,818**	**9,007,734**	**9,441,804**
Expenses					
Employee Costs	5,925,684	6,212,701	6,755,301	6,932,315	7,133,219
Committee Meetings	223,420	340,850	420,240	472,114	474,845
Professional Fees	477,801	453,116	542,934	417,989	401,384
Service Fees	193,460	277,690	243,959	236,400	240,624
Legal	125,885	156,916	42,000	42,000	42,000
Building & Occupancy Costs	443,942	511,234	562,033	567,819	573,952
Office Expenses	613,660	606,691	608,615	589,311	604,972
Capital Assets	234,358	305,992	297,802	181,017	125,103
	8,238,208	**8,865,193**	**9,472,884**	**9,438,965**	**9,596,100**
Excess (Deficiency) of Revenue Over Expenditures	**325,944**	**-54,483**	**-761,066**	**-431,231**	**-154,296**

Note – see changes in Expense categorization compared to previous page

College of Physicians and Surgeons of Manitoba

Funding Analysis	20223-23 Budget	2023-24 Estimate	2024-25 Estimate	Cumulative
Deficit after applying fee increases	**- 761,066**	**- 431,231**	**- 154,296**	**1,346,593**
Funded by reserves:				
Depreciation	297,802	181,017	125,103	**603,922**
Inquiry	40,000	40,000	40,000	**120,000**
IT Project (Member Portal)	70,634	20,080		**90,714**
Unrestricted Reserve	352,630	190,134	- 10,807	**531,957**
Restated Deficit	-	-	-	-

Appendix B

Certificate of Practice Fees as a % of Income

MRA	*Full License Renewal – 2021*	*Physician Avg Salary* (2019-20)*	*Renewal as a % of fees*
British Columbia	$ 1,725	$ 389,716	0.44%
Alberta	$ 2,150	$ 448,098	0.48%
Saskatchewan	$ 1,880	$ 418,060	0.45%
Manitoba	**$ 1,890**	**$ 417,413**	**0.45%**
Ontario	$ 1,725	$ 356,508	0.48%
Quebec	$ 1,735	$ 415,071	0.42%
New Brunswick	$ 1,950	$ 403,677	0.48%
PEI	$ 2,125	$ 377,211	0.56%
Nova Scotia	$ 1,950	$ 357,318	0.55%
Newfoundland	$ 1,850	$ 355,523	0.52%
**CIHI data – full time equivalent physicians*			

With the proposed increase to $2,050 for CPSM, the % changes to **0.49%**

Appendix C

Certificate of Practice Fees compared to other self-regulated professions in Manitoba using the proposed certificate of practice fee

Professional Regulatory Body	Dues	Average Income	% of Avg Income
CPSM	$ 2,050	$ 417,071	0.49%
CRNM (RN)	$ 511	$ 84,530	0.60%
Physiotherapy	$ 775	$ 83,033	0.93%
Speech Language Pathologist	$ 921	$ 83,794	1.10%
CPA (Accountant)	$ 1,080	$ 110,560	0.98%
Law Society of MB (Lawyer)*	$ 2,987	$ 146,250	2.04%
College of Dentistry**	$ 3,750	$ 175,230	2.14%

*includes insurance of $1700.

**includes association fees

The College of Physicians & Surgeons of Manitoba

CPSM Proposed 2022-23
Budget & Fee Increase recommendation

Agenda

- 2021-22 Year-End Review
- Program Growth Review 2018-19 to 2022-23
- MRA Fees Comparison – 2012-2021
- 2022-23 Budget Development & Fee Recommendation
- Proposed Fee Increase
- Motion to Approve the 2022-23 Budget and Fee Increase

2021-22 Year-end review

CPSM originally was forecasting a significant deficit of approximately $500k. Due to some of the factors shown below, the actual deficit at year-end is approximately $50k.

- Recoveries due to investigations 7(registrant penalties and fines)
- Expenses delayed or muted due to COVID
- Timing delays (staff hired late in 2021-22) that were expected to be in place in early 2021

The above factors are not expected to reoccur for 2022-23

Program Growth at CPSM 2018-19 to 2021-22

EFT @ Fiscal Year-End							
	Fiscal Years						
Department	2018-19	2019-20	2020-21	2021-22	Change from 2019-20	2022-23 - Proposed	Change from 2021-22
Complaints	6.80	6.40	9.20	9.60	3.20	9.60	0.00
Corporate	7.00	7.00	8.00	8.00	1.00	8.00	0.00
Finance	2.00	2.00	2.00	2.00	0.00	2.00	0.00
IT	2.00	1.60	2.60	3.60	2.00	3.60	0.00
MANQAP	5.00	5.00	5.00	5.00	0.00	5.00	0.00
Quality	5.90	6.50	9.50	10.10	2.60	11.70	1.60
Registration	7.00	7.00	7.00	7.00	1.00	7.00	0.00
TOTAL	**35.70**	**35.50**	**43.30**	**46.30**	**9.80**	**47.90**	**1.60**
Head count	37	38	47	48		50	

Program Expansion – Details 2019-20 to 2021-22

- **Complaints**: 1.0 EFT Lawyer, 0.6 EFT Patient Advocate (Social Worker), 1.0 EFT Program Support, 0.6 EFT Medical consultant, increase of 0.2 EFT for Assistant Registrar.
- **Corporate**: 1.0 EFT Communications
- **IT**: 1.0 EFT IT support related to SharePoint and other IT office support & 1.0 EFT to support the CPSM portal and development long-term (position approved in 2021-22 and started in May of 2022). 1.0 EFT will be charged to IT Reserve for CPSM Portal project work (this is an 18-month term and is not reflected in the numbers on the table in the previous slide)
- **Quality**: 1.0 EFT for Quality Department Admin Support, 0.9 EFT Occupational Health (PPP), 1.0 Pharmacist (PPP) to replace former medical consultant (resulted in an increase in 0.4 EFT but an overall $ savings), deletion of 1.0 EFT vacant position.
- **Registration**: 1.0 EFT was transferred to the Quality department as the major function of the individual dealt with audits. Due to the steady increasing numbers and complexity in Registration, the 1.0 Eft was backfilled.

Program Expansion – Workload 2019-20 to 2021-22

Complaints: 67% increase in cases received 2021-22 vs 2020-21

Complaints and Investigations	2021-22*	2020-21	2019-20	2018-19
Outstanding Cases from previous Yr	117	112	104	128
Cases received during the year	360	215	194	243
Total	477	327	298	371
Cases outstanding as of YE	289	118	114	103
Total cases closed	188	206	184	268
# of Cases Dismissed**	9	na	na	na
Inquiries	3	2	1	
Matters Pending before the inquiry Cmtee	1	3	1	
*2021-22 is the first year the public could initiate complaints through a web interface				

Program Expansion – Workload 2019-20 to 2021-22

Quality: more than a doubling of initiated and completed quality assurance review from the previous years

Reviews	Initiated	Completed
2019-20	291	192
2020-21	223	159
2021-22	481	337

The RHPA requires all physicians to go through the Quality Improvement Program over a 7 year cycle. The resources attached to this function is insufficient to meet that target.

Physician Health referrals - doubling of referrals since 2019-20

Referrals	2021-22	2020-21	2019-20
New Referrals	84	58	41

10 year comparison - MRA fees

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
AB	$ 1,900	$ 1,960	$ 1,960	$ 1,960	$ 1,960	$ 1,960	$ 1,960	$ 1,960	$ 2,150	$ 2,150
NS	$ 1,655	$ 1,555	$ 1,555	$ 1,555	$ 1,750	$ 1,750	$ 1,850	$ 1,950	$ 1,950	$ 1,950
MB	$ 1,600	$ 1,650	$ 1,700	$ 1,700	$ 1,700	$ 1,780	$ 1,816	$ 1,870	$ 1,870	$ 1,890
SK	$ 1,500	$ 1,600	$ 1,700	$ 1,800	$ 1,880	$ 1,880	$ 1,880	$ 1,880	$ 1,880	$ 1,880
NL	$ 1,650	$ 1,650	$ 1,750	$ 1,750	$ 1,750	$ 1,750	$ 1,850	$ 1,850	$ 1,850	$ 1,850
ON	$ 1,530	$ 1,550	$ 1,570	$ 1,570	$ 1,595	$ 1,625	$ 1,725	$ 1,725	$ 1,725	$ 1,725
BC	$ 1,400	$ 1,500	$ 1,540	$ 1,590	$ 1,625	$ 1,670	$ 1,685	$ 1,700	$ 1,700	$ 1,715

❖Manitoba ranks 3rd **lowest** in the provinces shown above in both average annual fee increases and % of fee increases over the last 10 years (to 2021-22)

Budget development 2022-23 to 2024-25 Baseline Impacts

Starting with building the base budget to meet the requirement of the core mandate of CPSM

- Annualizing resource impacts that have occurred in 2021-22
- Adding in key resources to meet core mandates in 2022-23
- Prescribing Practices Program – building in baseline funding to offset loss of SUAP funding
- Adding in resources to support advancements in IT
- Building in assumptions for future years

Core Mandate performance metrics

Operations

HUMAN RESOURCES, INFORMATION TECHNOLOGY, COMMUNICATIONS & FINANCE*

*Supports the pillars and reporting requirements

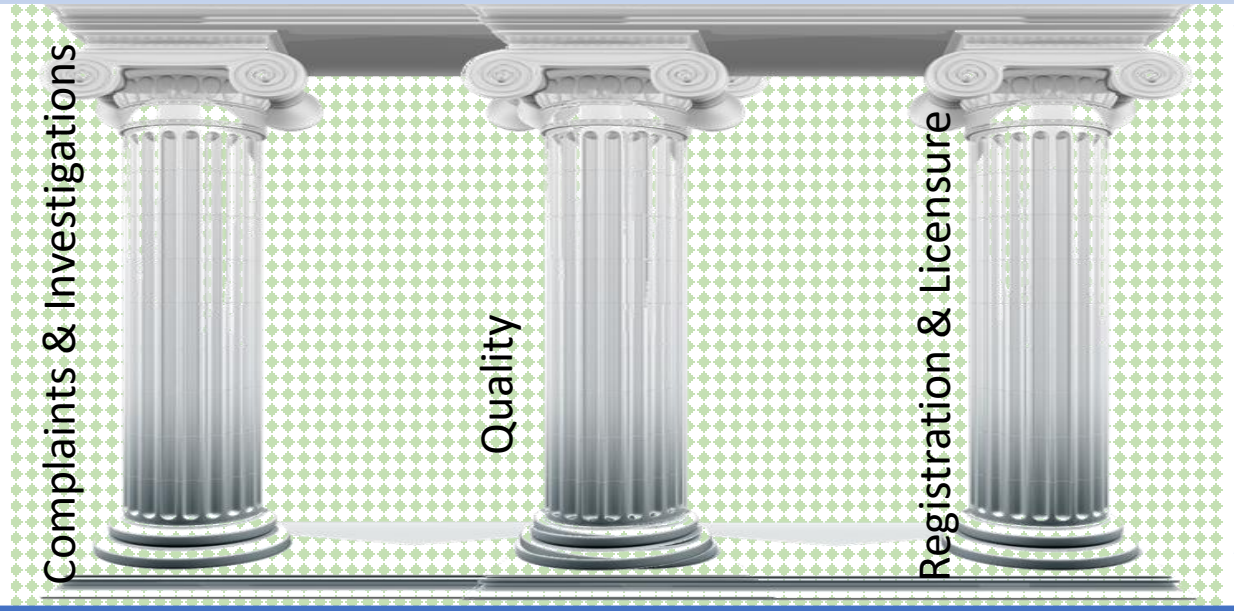
Budget development 2022-23 to 2024-25
New Initiatives

Key performance indicators
CSPM Scorecard

Strategic priorities established by the Council

1. Change the Registrants perception of CPSM to be on Quality Initiatives vs Investigations & Punishment
2. Implement Truth and Reconciliation recommendations across all CPSM core areas
3. Plan and implement a Prescribing Practices approach focused on patient safety and quality
   - A leading practice for all MRA's to emulate
4. Move CPSM towards being a High Performance Organization through performance metrics

New Initiative performance metrics



Operational & Tactical Plans
Focused on the strategic priorities

HUMAN RESOURCES, INFORMATION TECHNOLOGY, COMMUNICATIONS & FINANCE*

*Supports the pillars and reporting requirements

Budget development 2022-23 to 2024-25 New Initiatives

- Quality as the “face” of CPSM
  - Under development
- TRC Advisory Circle Recommendations
  - Anticipating $50,000 required in year 1 and an additional $50,000 in year 2 for the first phases
- Prescribing practices initiative
  - Anticipating $50,000/year for the next 3 years
- Metrics Development & Reporting framework
  - Internal resources
- CPSM Portal
  - Funded through the IT reserve

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  - Internal resources
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  - Funded through the IT reserve

The College of Physicians & Surgeons of Manitoba

Proposed Fee Increase

CPSM Fee Bylaw

Increases in Fees

3. The fee for the annual certificate of practice shall automatically increase by an amount equal to the Manitoba Consumer Price index to cover inflationary costs.

3. Council may also increase the fee for the annual certificate of practice by an additional amount provided that management presents Council with a budget and a satisfactory rationale justifying an increase.

3. The Council may issue a special assessment on some or all classes of members to cover unexpected expenses, which were not reasonably foreseeable at the time the budget was prepared.

2022-23 Proposed Impact on Fees

A revenue increase is required to meet the baseline budget, continue to meet increasing workload pressures, as well as cover the increased expenses associated with New Initiatives. CPSM is recommending the following as sources of revenue:

- **Source 1** – Registrants fees
  - Anticipating a 6% CPI ($120 per registrant)- this is assumed to be approved as per the Fee Bylaw
  - Additional Fee above the CPI (2% or $40 per registrant)
    - The above two increases are assumed to not be applied to “Educational” category
  - Certificate of Practice would increase from $1,890 to $2,050
- **Source 2** – Medical Corporation fees
  - Increase Medical Corporation fees by $50 (total of $200)
  - CPI would be applied in the years following 2022-23
    - Med Corp fees have been static for a considerable period of time
      - Previous CPI increase were not applied to Med Corp Fee

2022-23 Proposed Impact on Fees

Sources continued

- **Source 3** – Clinical Assistant/Physician Assistant fees
  - Increase CA & PA fees by $100 (CPI to be applied in 2023-24)
  - Current fees of $300 would move to $400
    - CA/PA fees have been static for a considerable period of time
    - Previous CPI increases were not applied to this category
    - Current registration fee is considerably below Alberta (currently $537.50) and comparison to a relatively similar health profession – Nursing ($510.79 & Nurse Practitioner @ $784.35)

2022-23 Proposed Impact on Fees

Sources continued

- **Source 4** – CPSM Unrestricted Reserve
  - Unrestricted Reserve currently has approximately $1.6 million
    - Recommending using up to $500,000 to offset operating costs over the next 3 years

CPSM anticipates to balance the budget by 2024-25

- 2023-24 & 2024-25 assumes a 3% and 2% CPI adjustment respectively

2022-23 Proposed Impact on Fees

Comparison of MRA fees for 2022 with proposed CPSM fee increase

	2022
AB*	$ 1,792
NS	$ 1,950
MB**	$ 2,050
SK	$ 1,880
NL	$ 1,850
ON	$ 1,725
BC	$ 1,725

*CPSA applied a rebate of $358 to registrants from their building fund for 2022-23

** CPSM rate reflects the increase of 6% related to CPI as well as an additional 2% increase

MRA Certificate of Practice Fees 2022-23

	2022
AB*	$ 1,792
NS	$ 1,950
MB**	$ 2,050
SK	$ 1,880
NL	$ 1,850
ON	$ 1,725
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Budget 2022-23 to 2024-25

College of Physicians & Surgeons of Manitoba
Budget Statement of Operations

FY's 2022-23 to 2024-25

	2020-21 Actual	2021-22 Actual	2022-23 Budget	2023-24 Estimate	2024-25 Estimate
Revenues					
Physician & Resident License Fees	6,025,030	6,227,838	6,606,588	6,988,156	7,394,565
Educational Register Fees	82,100	84,300	83,794	83,912	83,925
Clinical Assistant License Fees	34,950	38,400	40,275	44,463	46,344
Physician Assistant License Fees	41,100	45,000	46,875	54,733	56,264
Medical Corporation Fees	376,975	387,625	440,050	503,149	524,560
Other Fees and Income	442,463	625,539	412,463	352,640	352,640
Interest Income	23,837	29,103	23,368	22,976	24,025
Change In Market Value	205,268	101,247	59,996	61,705	63,482
Government Funded Program Revenues	1,332,430	1,271,658	998,409	896,000	896,000
	8,564,153	8,810,710	8,711,818	9,007,734	9,441,804
Expenses					
Governance	138,677	161,279	190,542	240,887	241,239
Qualifications	885,559	721,502	745,151	777,420	811,839
Complaints and Discipline	1,509,985	1,805,860	1,811,997	1,866,275	1,922,347
Quality	998,626	1,221,931	1,702,666	1,927,723	1,986,801
Operations and General Administration	2,517,345	2,661,415	2,787,771	2,900,202	2,954,642
IT	906,385	1,048,197	1,118,055	911,751	864,505
Government Funded Program Expenses	1,281,632	1,245,010	1,116,702	814,706	814,727
	8,238,208	8,865,193	9,472,884	9,438,965	9,596,100
Excess (Deficiency) of Revenue Over Expenditures	325,944	-54,483	-761,066	-431,231	-154,296

Budget 2022-23 to 2024-25

College of Physicians and Surgeons of Manitoba				
Funding Analysis	20223-23 Budget	2023-24 Estimate	2024-25 Estimate	Cumulative
Deficit after applying fee increases	- 761,066	- 431,231	- 154,296	- 1,346,593
Funded by reserves:				
Depreciation	297,802	181,017	125,103	603,922
Inquiry	40,000	40,000	40,000	120,000
IT Project (Member Portal)	70,634	20,080		90,714
Unrestricted Reserve	352,630	190,134	- 10,807	531,957
Restated Deficit	-	-	-	-

Motion to Council

1. Council approve the 2022/23 annual operating budget as presented

1. Council approve the following registrant fee increases for membership year 2022/23
    a) For the annual certificate of practice for Full Practicing, Provisional, and Assessment Candidate registrants, additional 2% increase equivalent to $40 for a total of $2,050.
    b) For the annual certificate of practice of Regulated Associate Registrant – Physician Assistant, and increase of $100 for a final amount of $400 and,
    c) For the annual certificate of practice of Regulated Associate Registrant – Clinical Assistant, and increase of $100 for a final amount of $400 and,
    d) For the annual Medical Corporation Fee, an increase of $50 for a final amount of $200.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
JUNE 22, 2022
BRIEFING NOTE

TITLE: **Episodic, House Calls, and Walk-In Primary Care Standard of Practice**

BACKGROUND

At its June 2021 meeting, Council established its upcoming Strategic Organizational Priorities. One of these is to develop a Standard of Practice for Episodic, House Calls, and Walk-In Clinics Primary Care. The Terms of Reference for the Working Group were approved by Council in September 2021. The draft Standard was reviewed by Council in March 2022 and was distributed for consultation feedback with the registrants, public, and stakeholders. Much of this background was provided to Council at an earlier meeting, so it may look familiar.

Continuity of primary care is fundamentally important for the delivery of good medical care. Much of the medical system requires each person having a family doctor to provide continuous medical care. Continuous medical care includes not only a longitudinal relationship between patient and physician, but also referrals to specialists, ordering of tests and follow-up, prescribing of long-term drugs, and at times, multiple attempts to treat medical conditions.

However, not all persons have family doctors – whether due to a shortage of family doctors in the community, the patient not trying to obtain a family doctor, or various other reasons. Some patients without family doctors seek medical care from alternative sources – walk-in clinics or other sources, including urgent care/emergency departments. Other patients may not be able to access their family doctor in a timely manner or at a time that is suitable for their schedule, so they resort to other alternative medical care delivery. This fragmented care can create challenges in providing good medical care.

Walk-In clinics fill the void for many patients, whether due to the availability of same day clinical encounters, convenient hours (open weekends and evenings), convenient locations (maybe close to work or home), etc. Walk-in clinics play an important role in providing same day medical care to those who require it. These also can play an important part in providing medical care for those who are travelling (for instance, the patient from The Pas who is in Winnipeg and requires medical care for strep throat).

Some practice groups offer medical care on a same day walk-in or appointment with one physician in the practice group. That physician providing the episodic care will have access to the patient's medical charts and will also be familiar with the style of the usual family doctor. In those cases, the usual family doctor may or may not be responsible for follow-up and referrals.

The traditional model of a doctor attending bedside in the patient's home to deliver medical care has almost disappeared. Some family physicians may still offer house calls for long-standing patients in their time of need. And physicians working in the WRHA Access Centres run a house call service for their patients unable to attend one of their physicians in the clinic. There are also limited house call services available in Winnipeg. While many patients use house calls because they are too ill to attend at a medical clinic, many resort to house calls because of mobility constraints – whether due to disability, socio-economic, or other. For instance, anecdotally, one of the higher users of house calls is the single mother of multiple children who can avoid taking the entire family on a bus for an appointment of one sick child.

Some have accused walk-in clinics of churning patients quickly for financial gain. Like any care provided, it depends upon the individual physician. To ensure good medical care in episodic, house calls, and walk-in clinics CPSM will develop a Standard of Care for this type of care. Many other medical regulatory colleges in Canada have established rules to guide members in treating patients in episodic and walk-in clinics. There are no special rules for house calls, though some of that will fall under episodic care.

FEEDBACK FROM CONSULTATION

The feedback can be broken down as follows:

CPSM registrants:	38 (including some clinics)
Other stakeholders	4
Public Survey	97

Themes from the Feedback of the Profession

The feedback was relatively robust from the profession and centred largely around four major themes:

- How necessary and valuable this type of care is for many who do not have family physicians, or whose family physicians do not treat patients beyond 9-5 M-F, or are vulnerable and socio-economically disadvantaged, or cannot travel to see a physician. Don't do anything to limit access to this care.

- Strong opposition to the absolute requirement to provide a copy of the medical record or summary of the clinical encounter to the primary care provider unless patient consent is not granted. Partnering with this theme is the corollary that the receiving physician would have to read all of the sent information. The criticism on both ends was that the administrative burden was high for very little benefit since much of the care was minor requiring no follow-up – including stitches, earwax removal, minor sprains, UTIs, etc.

- The Standard will require those providing episodic care to the profession will be required to follow up on chronic disease management. In essence, the continuity of care and/or follow

up care requirements mean that the walk-in doctor will be required to become the family doctor. This interpretation of the Standard was opposed.
- Specialized walk-in clinics such as sports medicine or Pan Am don't really fit this model and should be excluded.

There is an attached document on the Summary of Feedback Themes. Also attached are the full responses from the feedback, with the names removed unless it is from a stakeholder.

Themes from Public Survey

The data collection was useful to make an informed decision on the Standard.

- When asked as to why they visited a walk-in clinic, almost equal numbers responded
  - I needed immediate care
  - The wait to see my family doctor was too long
  - It was convenient due to time or availability
  - It was convenient due to location
  - I needed to see a doctor in person and my family doctor could not accommodate me

- More than half indicated their medical concern was resolved with their visit, but some required follow up tests or bloodwork

- When asked to rate the care received compared to their family doctor
  - 62% responded the same
  - 9% responded better
  - 18% responded not as good

- 85% of patients think they would benefit from increased communication between the episodic care and their family doctor

The survey results are attached.

Comments from Public Survey

Some to the comments included the following:
- I went to PanAm because it has the most expertise, I needed special sports medicine care
- It was the weekend and I needed to see a doctor, or the clinic was closed, my doctor was away
- I had a house call by my neurologist who needed to see me ASAP and I was home-bound due to disabilities and a broken leg
- I was offered a prescription for T3s every time I saw the walk-in which I declined
- Walk in docs just give you a prescription and move on so they can bill more
- I saw a physician who would not discuss my pain issue with me stating that he ran an acute care clinic only and my problem was a chronic one,

- Family docs and walk-in docs are the same. It is just that walk-in docs care a little bit less and take even less time with you.
- I love having both options for different scenarios
- Need for a province-wide electronic medical record system for communication
- Walk-In clinics fill the need between family doctors 9-5 M-F and Urgent Care/ERs
- Some walk-in clinics have sings on their doors saying that if you are in pain do not come in.
- My family doctor is part of a walk-in clinic. Having my medical history right there has continuity when my doctor is away.
- I have to wait 3-4 weeks for an in-person appointment to see my doctor even when I have an urgent need.
- Waiting over six months for a physical is unacceptable. I may be dead before I see the doctor.

NEXT STEPS

The Working Group has me once to review the feedback and incorporate changes where appropriate. The Working Group will meet again and will have recommendations for a revised Standard of Practice for Council to review at its September meeting. At this point we can advise that there will be changes to the Standard reflecting some of the feedback.

POSSIBLE QUESTIONS FOR DISCUSSION

- What is the benefit to the patient of having the medical information sent to their primary care provider vs the administrative burden on the episodic care provider?
- Should the medical information that is sent to the primary care provider be limited to the discretion of the treating physician as to what is reasonably required by the primary care provider for the ongoing care of the patient?
- Should sports medicine care be included in the Standard?
- If a patient is treated once for a chronic condition, what is the responsibility of the episodic care provider for the continuity of that care? What if that care is beyond their scope of practice? How does that work for locums? What about doctors that take relatively few shifts in walk-in clinics?
- How will patient concerns be addressed?
- Will this Standard limit access to care? Improve care?

PUBLIC INTEREST RATIONALE

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

This Standard is required to ensure the continuity of care in a fragmented primary care delivery environment. Critical to required good medical care is patient safety. The Standard requires that the

medical care is provided in the patient's interest and recognizes the choice of patients in choosing the modality of care delivery. This Standard recognizes episodic, house calls, and walk-in clinic primary care plays an important role in the delivery of medical care, but additional guidance to the profession is required to ensure it is safe and good medical care providing for continuity.

The Standard recognizes the importance of episodic, house calls, and walk-in clinics in the delivery of primary care in many different circumstances throughout the province. The integration of that care with the primary care provider may be critical for good medical care.

Standard of Practice

Episodic, House Calls, and Walk-in Primary Care DRAFT

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 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.

PREAMBLE

CPSM has responsibility to set standards and policies that result in high quality care for patients regardless of their point of contact with members in the health care system. For reasons of lack of access or convenience of hours, patients often turn to episodic services such as walk-in or ''no-appointment'' visits in clinics. Members are expected to manage these episodic encounters to provide optimal continuity of care for patient safety. CPSM recognizes that geographic impediments to accessing continuous primary care from members may exist for distant rural and remote and First Nations communities and that episodic and walk-in treatment may be the only medical care available.

The *Code of Ethics and Professionalism* provides the ethical basis for this Standard.

> *2. Having accepted professional responsibility for the patient, continue to provide services until these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient has been given reasonable notice that you intend to terminate the relationship.*

DEFINITIONS

Episodic Care refers to a single primary care medical encounter with a patient focussed on presenting concern(s), identified medical conditions(s), where neither the regulated member nor the patient have the expectation of an ongoing care relationship.

Walk-in Clinic refers to medical practices that provide care to patients where there may be no existing association between the patient and the practice, where there may be no requirement to book appointments, and where the care provided is generally, although not always, episodic in nature.

House Calls refers to a medical encounter performed by the member while visiting the patient's home (or property where residing including hotel, shelter, or temporary lodgings).

Part 1. APPLICATION

1.1 This Standard applies to primary medical care provided through episodic care, walk-in clinics, and house calls (including episodic care clinics such as PanAm Clinic, Minor Injury Clinics, Public Health Clinics including for Sexually Transmitted Infections, Contraceptive Clinic etc.).

1.2 This Standard does not apply to care provided in:

1.2.1. emergency and urgent care in hospital settings.
1.2.2. long-term care facilities such as personal care homes.
1.2.3. palliative and end-of-life care, including medical assistance in dying.
1.2.4. consultations with specialists. Standard of Practice Collaborative Care

Part 2. STANDARD OF CARE

2.1. Members must provide the same standard of care to patients irrespective of the practice setting in which such care is provided and irrespective whether the patient is, or is not, a regular patient of the clinic where the physician works.

2.2. Members must meet the standard of practice of the profession, which applies regardless of whether care is being provided in a sustained or episodic manner. For example, members practising in a walk-in clinic must conduct any assessments, tests, or investigations that are required for them to appropriately provide treatment. Members must also provide or arrange for appropriate follow-up care.

2.3. Members who limit the care or services they provide due to the episodic nature of their care must only do so in good faith.

2.4. Members must communicate any limitations to patients in a clear and straightforward manner; and communicate appropriate next steps to patients seeking care or services that are not provided, considering factors such as the urgency of the patient's needs and whether other health-care providers are involved in the patient's care.

Part 3. PRIMARY CARE PROVIDER

3.1. Patients must be asked if they have a primary care provider who they usually see for care and, if so, that name must be recorded on the patient's record.

3.2. The clinic must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider identified by the patient unless patient consent is not granted.

Part 4. SUPPORTING PATIENTS

4.1. If primary care providers are present in the community, members must use their professional judgment to determine whether it would be appropriate to advise patients:
  4.1.1. That there are differences between episodic care and care that is provided as part of a sustained primary care provider-patient relationship; and
  4.1.2. About the benefits of seeing their primary care provider for care or encouraging them to seek one out, if they don't already have one.

4.2. The patient's choice in obtaining episodic, house calls, or walk-in care must be respected.

Part 5. CONTINUITY OF CARE AND/OR FOLLOW-UP CARE

5.1. A member must continue to assume responsibility for medical care and provide medical follow-up to investigations, diagnosis, treatment, and test results (whether critical or other) for that encounter in accordance with the provisions in the *Standard of Practice for Good Medical Care*. The medical care and follow-up is required unless the member has ensured that another primary care provider has agreed to provide this.

5.2. A member providing care must not rely on the patient's primary care provider or another health-care provider involved in the patient's care to provide or coordinate appropriate follow-up for tests they have ordered or referrals they have made, unless the other has agreed to assume this responsibility.

Part 6. PRESCRIBING

6.1. To mitigate risk of harm the member must use reasonable efforts (recognizing there may not be internet connectivity throughout the province) to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN as appropriate.

6.2. Members prescribing opioids, benzodiazepines, and Z-drugs, and authorizing cannabis must comply with the relevant *Standard of Practice for Prescribing Opioids*, the *Standard of Practice for Prescribing Benzodiazepines and Z-Drugs*, and the *Standard of Practice for Authorizing Cannabis for Medical Purposes*.

Part 7. VIRTUAL EPISODIC AND "WALK-IN" CARE

7.1. The Standard of Practice for Virtual Medicine is applicable to virtual episodic and walk-in care, in so far as possible.

EPISODIC, HOUSE CALLS, AND WALK-IN CLINICS

STANDARD OF PRACTICE

SUMMARY OF FEEDBACK THEMES

FROM CONSULTATION WITH REGISTRANTS AND CLINICS

1. STRONG OPPOSITION TO ABSOLUTE REQUIREMENT TO PROVIDE A COPY OR SUMMARY OF THE CLINICAL ENCOUNTER TO THE PRIMARY CARE PROVIDER UNLESS PATIENT CONSENT IS NOT GRANTED

3.2 The clinic must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider identified by the patient unless patient consent is not granted.

- No medical benefit to communicate stand-alone one time treatments (UTI, earwax clearing, stitches, minor trauma, refills, rash, cold/flu, sprains, etc)
- Administrative burden for both the episodic care provider staff who has to send the information from the clinical encounter and the primary care physician who has to review the information which is often unimportant
- Patients reluctant to seek medical care if their primary care physician will be provided with information.
- 2SLGBTQ community may be reluctant to seek care for sexual health matters with friendly physicians due to this unsafe environment of sharing medical records
- Physicians will stop offering this type of care thereby limiting access to care due to this requirement
- Minimal benefit compared to maximum effort on both sending and receiving doctors
- There is no clarification on the requirements for the receiving doctor to review information. Fax flurry on Monday mornings from weekend visits.
- Sharing information is difficult absent a shared EMR. Share by fax? Email? Entire chart? Summary?
- This provision reveals a clear disconnect between the good intentions of the working group and the reality of what family physicians face on a grassroots level.

2. OTHER COMMENTS ON THE REQUIREMENT TO PROVIDE A COPY OR SUMMARY OF THE CLINCAL ENCOUNTER TO THE PRIMARY CARE PROVIDER

3.2 The clinic must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider identified by the patient unless patient consent is not granted.

- Recommendation of many is to have this requirement at the discretion of the physician using their clinical judgment if the nature of the clinical encounter requires follow-up by the primary care physician or is reasonably expected to be useful to the primary care physician

- Recommendation is to simply chart episodic care in eChart rather than pushing out all info to family doctors. This supports on-demand access when required instead of physcians spending their time reviewing records – much of which is inapplicable.
- Several family doctors liked the compulsory reporting – their patients can't recall the drugs or the diagnosis or tests and it is difficult to determine
- Direct communication with the primary care provider would be helpful as a collaborative approach
- Since the draft Standard was released some indicated they have received improved communication from walk-in clinics on important clinical encounters

3. EPISODIC CARE CAN LEAD TO FOLLOW UP ON CHRONIC ILLNESSES

5.1. A member must continue to assume responsibility for medical care and provide medical follow-up to investigations, diagnosis, treatment, and test results (whether critical or other) for that encounter in accordance with the provisions in the Standard of Practice for Good Medical Care. The medical care and follow-up is required unless the member has ensured that another primary care provider has agreed to provide this.

5.2. A member providing care must not rely on the patient's primary care provider or another health-care provider involved in the patient's care to provide or coordinate appropriate follow-up for tests they have ordered or referrals they have made, unless the other has agreed to assume this responsibility.

- There are many patients with chronic conditions without primary care providers who rely upon walk-ins for prescriptions. The Standard seems to imply that if a patient present to a walk-in for diabetes, COPD, CHT, etc., then that medical care and follow-up is the responsibility of the walk-in clinic physician until another physician has agreed to take over that care. There is often no such doctor to hand over care to. This is untenable for walk-in clinic doctors.
- The follow up of test results should not create an ongoing long-term physician-patient relationship since many of the visits are for exacerbations of chronic conditions.
- Will a sports medicine physician have to follow up on hypertension instead of using their special skills/offices/equipment for sports medicine?
- Episodic treatment cannot lead to requirement to treat patient outside of scope of practice.

4. CONTINUITY OF CARE AND/OR FOLLOW UP CARE MAY MEAN THAT WALK-IN DOCTOR IS FORCED TO BECOME THE FAMILY DOCTOR

4.1 A member must continue to assume responsibility for medical care and provide medical follow-up to investigations, diagnosis, treatment, and test results (whether critical or other) for that encounter in accordance with the provisions in the Standard of Practice for Good Medical Care. The medical care and follow-up is required unless the member has ensured that another primary care provider has agreed to provide this.

4.2 A member providing care must not rely on the patient's primary care provider or another health-care provider involved in the patient's care to provide or coordinate appropriate follow-up for tests they have ordered or referrals they have made, unless the other has agreed to assume this responsibility.

- The provision that physician must continue to assume responsibility for follow-up unless other care provider agrees to take the care over. What happens if someone else does not agree to take over the care?
- Why can the primary care provider decline to accept their patient back into care?
- Why have the episodic care provider continue to provide the care that they are not best suited to provide?
- Will this lead to walk-in clinics becoming family clinics? And therefore no access to walk-ins which fill a need for many patients.
- This will lead to less access to care.

5. REQUIREMENT TO REVIEW ECHART

6.1 To mitigate risk of harm the member must use reasonable efforts (recognizing there may not be internet connectivity throughout the province) to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN as appropriate.

- There is a requirement to review eChart or consult with a pharmacist as appropriate, but several did not read the "as appropriate" applying to the former also. (Note – this can be altered by slight re-wording).
- Further concerns with having to review eChart when there is a simple stand-alone issue such as stitches or earwax and there is no benefit to such a review.

6. IMPORTANCE OF THIS TYPE OF CARE FOR MARGINALIZED AND RACIALIZED PATIENTS

- Vulnerable patients are high users of this type of care, including for obs/gyn (STI, PAP smear, birth control) and these requirements may limit care provided.

7. REQUIREMENT TO LIMIT THE CARE OR SERVICES PROVIDED DUE TO THE EPISODIC NATURE OF THEIR CARE IN GOOD FAITH IS MISINTERPRETED

2.3 Members who limit the care or services they provide due to the episodic nature of their care must only do so in good faith.

- This is misinterpreted such that physicians in primary care cannot limit the scope of their practices or that physicians will be required to provide care that is beyond their usual scope of practice. (Note – the intent was to prevent some doctors from just treating the easy patients. It was not intended to make sports medicine doctors treat every type of patient beyond their scope).
- Several do not understand what this requires them to do.

8. VARIOUS ALLEGATIONS OF BAD CARE BY WALK-INS

- Several provided examples of what they considered bad care.

9. CERTAIN PRACTICE SETTINGS SHOULD BE EXCLUDED FROM THIS STANDARD

- University Health Service / Campus Care since it is a designated Home Clinic
- Pan Am Clinic
- Sports Medicine clinics
- NRHA which has a connected EMR and almost every physician practices within the NRHA system
- Remote Indigenous communities
- 2SLGBTQ+
- Travel medicine
- Family physicians providing non-specialist medical care such as vasectomies, certain skin or aesthetic procedures

10. CLARIFICATION THAT THIS DOES NOT APPLY WITHIN A TRUE GROUP PRACTICE SETTING

- This Standard should not apply to a physician taking same day or walk-in appointments in a group setting for another group physician who is not available.

11. PAN AM CLINIC

- PanAm Clinic provides musculoskeletal care which includes long-term care of MSK matters. Patients make appointments themselves, are referred by physicians, told by health care providers including ER to "go to PanAm". This is not episodic care.
- PanAm offers specialized care not provided by most family doctors, yet is primary care.
- PanAm is WRHA operated facility, so the administrative burden should be on the system to share documentation, and not the individual doctors who work shifts in this WRHA facility.
- Compliance with this draft Standard will necessitate a significant change in PanAm and will make this service much less accessible – and instead possibly by referral only.

12. GOOD FAITH / REASONABLE / APPROPRIATE

- Several suggested that these adjectives be defined. (Note these are terms used throughout all Standards of Practice and imply a threshold of good intention and what most peers would do in a similar situation).

13. ALLEGATION THAT THIS DRAFT STANDARD WILL DECREASE ACCESS TO CARE

- A common theme is this draft Standard will decrease access to care by requiring physicians to spend more time in administration, review charts when unnecessary, do all follow-up care, take on more general patients instead of providing limited walk-in care, and practice medicine outside their scope of practice.

PUBLIC CONSULTATION March 30 – April 30
Standard of Practice for Episodic, House Calls, and Walk-In Primary Care – Feedback from Registrants and Stakeholders

Comment
CPSM REGISTRANTS
I would like to mention some points as I am working mainly as walk in. 1. Many patients have no family doctors as their doctors closed their practices or left the province. 2. Many patients are not able to book an appointment with their family doctors on Urgent base . 3. Practice in walk in clinic put a huge pressure on the provider to obtain sufficient medical information related to the patient as its not available on EMR , for many reasons like using another EMR or no sufficient information on E chart . 4. Many patients seek walk in clinic for renew RX or referrals or to fill forms like driving medicals ..etc. For these points that mentioned above , it is inconvenient to put many and hard regulations on walk in practice or episode encounters as it will make many providers reluctant to offer walk in practice, as a result, patients will not be able to find at least the necessary medical care in case they are not able to have family doctor or need to address urgent care such as renew RX or fill forms. Kindly take these points into your account in finalizing the new standard.
I respectfully suggest explicitly referencing the “Standard of Practice Documentation in Patient Records” requirements in this Standard of Episodic care. My experience suggests the documentation post-visit to some walk-in facilities lacks details, such as physical exam findings, and referencing the Documentation Standard would be worthwhile. There are times when knowing injury Range of Motion, or if a rash has expanded, or even noted, would be of benefit.
Note: This email was responded to I have a question about if the draft standard, WALK-IN MEDICAL CARE, HOUSE CALLS AND OTHER EPISODIC CARE, applies to the clinical area I work in. I work at the Misericordia in their Eye Care Centre. We are open 24/7. No appointment is needed. We provide care for eye issues like vision loss, red eye, eye pain, etc. We are family physicians and emergency physicians. We provide urgent care for eye issues. If you google "Eye Emergency Winnipeg" you get many websites telling you to go the Misericordia. Health Links instructs people with urgent eye issues to come to Misericorida. The WRHA directs people with urgent eye issues to come to Misericorica (https://misericordia.mb.ca/files/2017-04-eye-emergency.pdf). Misericordia is designated as a hospital under the Hospitals Designations Regulation of the Health Services Insurance Act. Does the draft standard apply to the eye care clinic at Misericordia? My guess is that it doesn't because we provide urgent care in a hospital setting.

I have a few concerns with the proposed standards. For context I work both at a busy walk in clinic and an access centre.
Many patients do not know their primary care provider's name, and when asked will either not know or spend a long time trying to find it(either by Googling the clinic or calling someone who may know) When I have patients waiting and a limited time, waiting for them to find this out is frustrating. This is especially unnecessary when echart has a primary care provider tab. Instead, it should be the primary care provider who updates echart, much easier for them to do (can be done by their staff) and guaranteed to be correct (correct PCP spelling and clinic address/name).

Similarly, sending a letter to every PCP for every visit is unlikely to add a lot of value and is going to add a lot of time to the encounter and time after the encounter. It should be dependent on tbe issue. For example, episodic concerns such as URTIs or acute self limited low back pain events are unlikely to change the PCP's care plans, and are only going to add work for walk in physicians. I do agree with providing letters for things that it is reasonable to believe the PCP should be aware of, but not every visit.
On the flip side, on my work as a primary care provider, I already am inundated with documents for my patients, getting every single walk in visit for minor issues that do not add to my care of the patient will only result in further fatigue and eventual burnout.

This type of medicine has to stop
Know of 2 people both women who have Ovarian cancer Stage 3-4
They complained to their physician for 2 years during COVID and were treated virtually with guess what result.

Virtual care bears no resemblance to the practice of medicine
A computer would do a better job at NO cost .
Of course you will do nothing about this email or feedback as you have already decided on the standards

I am one of a couple physicians who share a weekly walk-in sexual health clinic for the 2SLGBTQIA+ community. Many of these patients come to the sexual helath clinic, held by Our Own Health Centre, only for sexual health screening, prevention and treatment because they are not comfortable discussing their sexual activities with their primary care provider. This policy seems like it would violate patient confidentiality and could impact access to proper sexual health for a marginalized patient population. Although the larger issue is how to help this population feel safe within the medical system, for now this policy could create an unsafe environment for potentially vulnerable patients.
I would suggest that perhaps sexual health-related visits be exempt from policy.

I suggest the following changes for part 3 in red font below:

Part 3. PRIMARY CARE PROVIDER
3.1. Patients must be asked if they have a primary care provider who they usually see for care and, if so, that name must be recorded on the patient's record.
3.2. In cases when a long term follow up is needed, The clinic must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider identified by the patient upon request from the primary care provider.

Rationale for this suggestion: 1. In many occasions the walk-in patients do mention a name of a primary care provider they have seen few years back under the assumption that they are still under the care of this provider. Sending medical records in this situation will creat confusion and unnecessary back and forth communication between health care provider. 2. Most walk-in visits doesn't require follow up from the primary care provider e.g. cold, UTI, minor trauma etc. Also the walk-in provider always offer availability for short term follow if needed. Sending such records will have no real value in patients' care but only add more paper work to already overloaded primary care providers.
Please find below my comments on the following point 3.2.: 3.2. The clinic must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider identified by the patient unless patient consent is not granted. This doesn't seem beneficial for the following reasons: - walk-in visit reason in 80 % at least of the time doesn't need a scheduled further follow up (cold., refills , uti , rash minor trauma) and the standard of medical care has been always to advice patients to return to clinic or follow up with their primary health care provider if the issue doesn't resolve or concerns.. patient should have the autonomy and responsibility to further follow up on their medical conditions !!! - in multiple cases patient doesn't recall the exact name of his pcp or not seen them for few years and not sure if they are still under their care … sending a copy to an incorrect health care provider will cause confusion on both sides and might be even harmful - copy of encounter and investigations should be sent to pcp upon their request .. And patient should be always advised to follow up with their pcp and documented ..
It seems the College is suggesting that the doc that sees a patient has an ongoing responsibility beyond the visit regarding follow up. That may make sense if tests are done and perhaps if a medication is prescribed but I don't think that should be the case generally in walk-in settings.
The goals stated are laudable and over due. My only comment is on the relatively short mention of episodic care and the Rx of cannabinoids. There seems to be a not so under ground industry in the prescribing of cannabinoids with no follow up whatso ever.
Great Job! I would prefer to have the information sent to the family doctor, unless consent is withdrawn to do so. In other words, individuals with a named family doctor would be advised that their doctor would receive copies of notes and tests ordered from the walk-in or episodic care provider, unless the individual specifically refused to have that information shared. I had a patient go elsewhere for treatment of a rohipnole (sp) assault, and was not happy when I received copies of the test results, as she wished to hide the event from me. That is one scenario.

Most patients already assume that I receive copies of their interaction with an episodic care provider, which is not true, so those individuals would be only too happy to have me receive information about their health.

The wording to have a patient opt out of shared medical information would be best stated, after being advised that information sharing is the usual, preferred, common-place health care process. Rather than having to approve the sharing of their health information with their family doctor, the patient should be given the option of denying their primary care provider as their right.

It would a fascinating study to see how often, and for which concerns the veto would be invoked. It does make it difficult for those patients who receive a Rx, as it would be visible on eHealth, at some point after the fact, for patients to completely hide their medical interactions with other physicians. I have no solution for that concern over privacy, as to my knowledge, there is no means of specifying selected information on e-Health that can be blocked. It is either accessible, or not, in its entirety.

The determination of which information is important enough to be sent to the primary care provider creates a nebulous vacuum that is neither helpful or useful to the patient. If the patient is not informed as to which information is being withheld and why, the physician remains remiss in providing episodic care and not providing information of the interaction to the primary care provider.

Is it more time consuming to inform the patient that the information of their interaction is not worthy of sending to their PCP and why, or simply CC to the PCP? Explaining each scenario makes more of a challenge that not.

Many medical conditions only become clear over time. A classic is Shingles. The first visit, localized pain with no physical findings would appear a non-disclosure type of visit. However the next visit, with a localized rash, brings the diagnosis into perspective. For an interval care provider to determine which visit is worthy of passing along is concerning. I would suggest consulting legal on this one, as it would appear to put a lot of pressure on the interval care provider to discern which set of symptoms could NEVER result in a serious condition, or which MIGHT at some future point in time be part of a pattern that makes a particular diagnosis more likely. I have either had or consulted on several cases over the years where knowledge is power. Particularly in medicolwegal cases, the sharing of information, or for that matter the purposeful withholding of information on the patient's part could play a significant role in assigning liability.

These are my first round responses.
As I review the document, I will forward other thoughts, if necessary.

I have reviewed the draft standard and have the following comments:
Part 3.2 - This will create additional administrative burden on physicians and their staff. This will be on the sending and receiving ends. Much of the care provided in walk-in is irrelevant to the family doctor, examples: ankle sprain, contact dermatitis, laceration, URTI. Under this system family doctors will have additional inbox items to review, their staff will have additional documents to scan in. In addition to the encounter notes the lab results present another challenge. A walk-in doctor could fill in the "cc" section of the requisition, but this requires knowing the phone and fax #'s of the family physician. Either the walk-in doctor would need to search these each time, or develop an

EMR address book of all family physicians in Manitoba. The other option is sending labs as they come in, this involves recalling it was a walk-in patient, finding the contact info for their family doctor, then faxing. If results are staggered, suppose a patient does bloodwork one day, x-ray the next, the walk-in doctor needs to perform the sending action twice. The receiving family doctor now has multiple documents to review that are likely to come at different times, if the walk-in doctor is responsible for following up on all the tests they order then copies to the family doctor won't change management. Further, if the family doctor really needs to know, they can log onto echart to get all lab and imaging results. All of these actions are small, but will be multiplied over thousands of visits across Manitoba every day, resulting in much wasted physician time in the context of a system that doesn't have enough family physician time to begin with which creates the need for walk-in clinics.

5.1 - There are many patients with chronic conditions without primary care providers who rely on walk-ins for prescriptions. This part seems to imply that if a patient presents to walk-in for diabetes, COPD, CHF, etc that medical care and follow up is the responsibility of the walk-in doctor until another doctor has agreed to take over. In many cases there is no other doctor to hand off to. This seems to me to give several untenable options to walk-in doctors: #1 - stop providing episodic care altogether and start a family practice, thus giving more comprehensive care to fewer patients, #2 - refuse to treat any chronic conditions and advise walk-in patients they must find a family doctor to deal with these conditions (impossible in many areas) #3 - provide indefinite follow up care of an ever increasing number of patients until they have no time left for episodic care, essentially resulting in option #1 over a fairly short span of time, #4 - generate huge numbers of specialist consults for follow up care, every diabetic gets referred to endocrinology, every COPD patient to respirology, etc. While it might be ideal if we had enough family doctors for every Manitoban, and that family doctors chose to hold clinics in the evenings and weekends, this is not our reality. Therefore walk-in clinics exist, this provision seems to make it impossible for walk-ins to serve patients with chronic conditions which if enacted and enforced would worsen our overall health care system.

In [redacted], where I work, we have thousands of patients without a family doctor. There are thousands more patients with a family doctor that is so overloaded with patients that the next available appointment is >3months away. Many of the family physicians have extensive hospital duties, such that they may only be in clinic 4-8 days per month. Each clinic has set up a walk-in clinic to deal with these issues, and to provide after-hours care to patients who cannot attend during business hours. If we are not able to staff the walk-in shifts because doctors find the administrative burden too much or they are unwilling to add new chronic disease patients to their already overloaded practice rosters, what will become of these thousands of unattached patients? Will their care be improved by the closure of walk-in clinics? The only recourse they would have at that point would be ER, which also would not be following their chronic diseases.
I suspect this doctor shortage situation is not unique to [redacted].

Respectfully, I think part 3.2 needs to be changed to allow physician discretion on what visits do not need to be sent. Perhaps sending is the default, and documented justification in the note is required if a copy is not sent. Part 5.1 needs clarification regarding chronic diseases and what responsibility the walk-in doctor has past the episodic visit. If the expectation is that the walk-in doctor provides medical care and follow-up until another primary care provider has agreed to do so when there are no available primary care providers to hand off to, the walk-in system becomes untenable.

I write to you today as a family physician who works in campus care at University Health Service (UHS) and as the medical director of said clinic. I do agree that while there should be a standard for episodic care that health care providers need to adhere to, I respectfully submit that campus care, and UHS specifically, should not be lumped in with clinics/providers who provide only episodic care. While we do provide episodic care to students at the University of Manitoba, we also provide continuous care for a significant proportion of students during their time at the University of Manitoba. Many of these students are from out of the city, out of the province or out of the country. We follow these students for the entire time they are registered at the university and for one year after they leave the university. If their medical condition is such that the physician feels the patient would benefit from long term continued care at UHS, the patient is invited to stay on long term. We also service a small proportion of staff at the clinic and are their continuous care providers. These staff can stay on after they retire. We have students who have family physicians within the city of Winnipeg but who do not feel comfortable using these physicians for care related to certain health concerns. For these patients, we provide ongoing care specific to their medical condition. It should be noted that University Health Service has been a designated Home Clinic since 2017. DUring UHS" application process, Manitoba Health determined that UHS does meet the criteria to become a Home Clinic as the clinic " is providing continuous care to the patients for the time they are attending the clinic". I ask that UHS and/or campus care be recognized as clinics providing a hybrid of care, both episodic and continuous. When providing episodic care, we would, of course, abide by the standards for episodic care. However, when providing continuous care, we would expect to be recognized as a patient's primary care provider and as such, be sent all appropriate medical information as it relates to Urgent care/Emergency visits, walk in visits etc.
I have many concerns re this new practice direction Much of the episodic care provided occurs in regular clinics that have walkin capacity, for overflow where the doctor cannot see any extra patients that day/or is away on holiday/illness etc these patients have a PHYSICIAN at the SAME clinic for followup. It should not be necessary to create and send copies of the patients visit or results to the regular physician, when that doctor accesses the patients' EMR, that includes the visit details and tests of the episode of care that occurred at the clinic It should be sufficient to let the physician know by internal email (tasks in the EMR) that the patient was seen and suggestions for followup

In addition, there should be some discretion in all patient visits(whether they are provided in the same clinic as the patients' doctor or a distinct walkin clinic) as to which NEED to be sent to the patients' doctor afterward

Many of these episodic visits are for stitch removal/syringing blocked ear canals/cystitis etc, there should be no need to send chart notes for simple matters that are unlikely to need folllowup

If a competent patient is told to followup with their identified primary care provider, and this is well documented in the chart, there should be no need to contact the patients physician for minor matters

Also with respect to obtaining DPIN records, this should only be a recommendation to do so where needed, don't need to do so for the simple visits referenced above especially where no Rx is necessary,, nor for children or for adults, on no meds,or who know what meds they are taking/have a list , certainly where there are narcotic/benzodiazepine concerns etc then DPIN review is prudent.

Many patients cannot find /nor desire a regular primary care physician. I inform them that the visit is for care relating to todays problem at that visit ,and that ongoing longterm can not be expected or provided.

with respect to followup of tests ordered, it is reasonable for the ordering physician be responsible to contact the patient re appropriate followup, needed. however it should be clear that the followup relating to the results should not create an ongoing physician patient relationship, as many of these visits are for exacerbations of chronic conditions.

This followup expectation should not be a way of creating an ongoing care obligation for an episodic care physician, many of these patients do not want to find a regular physician, preferring the convenience of episodic care, on weekends especially.

As for contacting the patients regular physician, this should only need be done when the episodic care physician believes prompt followup is necessary based on the patient's condition, there should be no need to contact when the condition needs nonurgent followup and the patient has been expressly told to followup with their regular practitioner within a specified time frame(and can contact the episodic care clinic if cant be seen by their physician within that time frame)

where does responsibility for care land when the episodic care physician calls the patients' primary care practitioner, and that physician declines to accept ongoing care for the problem, or the physician states the individual is not their patient anymore, or never was the patients' doctor

It cannot be expected by the College to expect an ongoing relationship with an episodic care physician, by the patient simply presenting with a medical condition of a chronic nature where ongoing care needed ie BP/Diabetes/COPD etc When is the encounter over, if the condition is chronic?, when the patient is back to baseline?

I look forward to modification of this standard, the current form is onerous , episodic care clinics provide patients an option other than clogging up the hospitals, creating even longer waits.

Having read the proposed document I would like to make the following comments.

1) The family doctor and other health care crises are the result of poor planning and management by governments, Regional Health Authorities, their civil service staff and others, including the various Colleges of, Physicans, and Surgeons, Nurses, etc..

It is also the result of "a pie in the sky " view of a health care system by politicians and others, who confuse Universal Access with Universal Availability.
For the poor and rich living next to a major hospital it is possible for all to have equal access and equal availability
For those living more remotely , they too have universal access, but, because of location and the obvious practicalities involved, they cannot have universal availability.
During all my years in Canada this has, never been addressed honestly, as a factor in the delivery of health care.
In not addressing this in an honest manner the politicians, administrators and regulators have created a dishonest system that was bound to, and is now failing.

2) Over regulation of health care professionals by proposing standards and legistation that are impossible to achieve in practice is not going to solve the problem.

The solution requires a pragmatic approach by all parties.
More doctors, nurses, students, educators, less burocracy and unecessary paper work, less centralisation, sensible realistic regulation is needed.

3) The basic principle of ANY contract is that BOTH parties have responsibilities (and duties) with regard to the service rendered.

4) This contract may be a formal written agreement with specific conditions or implied as is a visit to the doctor. Just to be clear I don't get written consent for a clinic visit, house call, hospital visit, etc..

My responsibility is to give my opinion, advice and recommendations. The the patient's responsibility is to accept or not accept that opinion, advice or recommendations. If they choose not to, the contract is void, if they accept the contract is valid.
Should any party not fulfil their side of that contract the contract is rendered void and the offending party assumes responsibility for any damages caused.
The proposed standard for episodic care, assumes that the patient carries no responsibility for their health care and that the doctor assumes all responsibility, clearly this is not reasonable.
Many of my Walk in Clinic consultations are for patients with family doctors who have prescribed medication for chronic conditions and have run out of medication. These patients have had ample time to make a follow up visit for a repeat of their medications, but just didn't bother(i.e. they have not taken responsibility).
A reasonable exam and short term script with the advice to see their family doctor is not unreasonable. It is not my duty to assume ongoing care patient's health or to run "routine tests" that are the responsibility of the family doctor caring for the patient.
Clearly this would result in excessive testing and would not be choosing wisely.

Practicing in a group practice rural Manitoba the drainage area is serviced by 2 clinics and approximately 40 doctors all of whom are, to the best of their ability, looking after the population of the area. I can say this with all honesty as I would trust my family to any of them.
Each clinic runs a Walk in Clinic during the week.
Patients are encouraged to only use one of the clinics as there scource of episodic care, in order to maintain continuity.
We also have an understaffed, inadequately sized Regional Hospital that can serve as a back up for any cases that may require attention other than can be offerred in the Walk in Clinic situation. A brief note and phone call accompanies the patient.
In order to cope with the demand on these \Walk in Clinics both clinics "double book" and limit the number of appointments so potentially 8 patients per hour could be seen, however in practical terms it is at best 6 patients per hour.
To now add to this burden by adding further burden, as required in the proposed standard, will only serve to increase the average time per appointment for each patient and will only reduce the services available to the patients in our area.
Carefull reconsideration is required by the College.
Has there been any consultation with other Professions providing Primary Care?

Specific comments on the regulations:

Part 1. Application
This requires no comment and is self explanatory.

Part 2. Standard of care
Paragraph 2.3
This is unclear.
As a physician who no longer has a family practice I do not understand what is meant by the phrase "in good faith."
Other paragraphs in this Part only serve to increase to the administrative burden, costs and/or time needed in providing care to the patient.
They could be covered by posting notices that are clearly visible.

Part 3. Primary Care Provider
Clearly this serves only to increase administrative burden, especially if applied to all encounters.
It is already occurring as I have received copies on encounters where the physician involved deemed it necessary.

Part 4. Supporting Patients
Evidence of the failing system.
No one is taking patients anyway. Doctor Finder is unable to help in the vast majority of cases.

Part 5. Continuity of Care
If I order tests (copy to the patient's provider) and refer the patient back to their Primary Care Provider or the patient does not go for tests, I should not be responsible .
What if I requested a copy of the result to go to the Primary Care Provider?

Paragraph 5.2 If I have provided the Primary Care Provider a copy of my notes and rationale for the tests or referral and the specialist has been informed who is Primary Care Provider, is it still my responsibility?

Part 6 Prescribing
Paragraph 6.1 Aah yes! My computer, the Government computer and intermediatary computer need to be able to talk to each other.. Funny how it does not work all the time! More, "pie in the sky.". It also increases the administrative burden and takes time, if it works.
Accessing eChart takes 3 minutes every time it is accessed. It automatically times out and then needs to be reaccessed
Paragraph 6.2
I have no problem with this at all!

Paragraph 7
I have no comment as I do not provide virtual care.

Re: Standard of Practice Episodic, House Calls, and Walk-in Primary Care DRAFT

Part 3. PRIMARY CARE PROVIDER
3.1. Patients must be asked if they have a primary care provider who they usually see for care and, if so, that name must be recorded on the patient's record.
3.2. The clinic must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider identified by the patient unless patient consent is not granted.

I agree with 3.1, but as a now-retired House Call Provider with Envoy for ~30 years, I think 3.2 should have the proviso "when appropriate". Many encounters are 1-time only, for a simple problem, & have nothing to do with the 1ary MD's ongoing care. As such, a summary would add extra time/work at both ends, and I can't see that it would be useful. However, if the House Call or Walk-In visit requires follow-up, or would be useful if documented in the 1ary chart, then this proviso makes sense.

In this day and age and for the sake of convenience, there is a need for the above forms of medical care . However, there is a constant lack of communication whereby I only find out from patient that he/she did require their use, and received certain medications - usually a very sketchy and quite often incorrect reporting. Sometimes eChart does help identify the medication, but the primary care physician is never in receipt of a resume of that interaction, with a possible diagnosis and their recommendations for follow up care - so very little continuity of care follows. These institutions should mandatorily provide the family physician a brief note or e-mail regarding that particular visit that will help him provide an appropriate continuity of care. Sometimes, patients do report that the Walk In physician " just told me to take some Tylenols and see your FP on Monday." We all have to work as a team to provide an uninterrupted and continuous flow of good medical care to our patients. Thank you

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The [redacted] clinic provides primary care access for patients with musculoskeletal problems/injuries, both acute and chronic. Our encounter records are shared with the primary care providers through distribution [redacted] health information services.
Many patients require follow-up related to their injuries/problems that are not available through their primary care providers, or prefer to attend Pan Am for our specific services/expertise. Understanding the importance of continuity of care, Communication, and collaboration, we are challenged with what

level of encounter communication is optimal to share with primary care providers. For example, a distal radius fracture that would require several visits for surveillance, cast changes, x-ray review, rehabilitation, and return to work planning. If the treatment plan is clearly stated in the original encounter note, would it be necessary to share every encounter note, or a summary once the patient is recovered (6-8 encounters)? There would be a significant administrative burden To [redacted], along with a substantial amount of communication to the primary care provider that does not provide any additional Important information for the record.

Additionally, patients often require investigations (imaging, lab work) that may or may not be relevant for the primary care provider. For example, serial x-rays of a fracture to monitor healing. Other imaging and lab work may be more relevant to the primary care provider. Will the primary care provider require copies of all investigations, or those deemed relevant by the treating physician at Pan Am?

We look forward to CPSM's Direction on the standard for episodic care, but have concerns about the details necessary for important communication to primary care providers. It will certainly cause an increased administrative burden to Pan Am and may lead to unimportant communication burden to primary care providers on the receiving end.

If any further discussion is required regarding the [redacted] clinic, I am pleased to communicate with the College as necessary. My role is confined to the [redacted] population. There is also a separate practice on the [redacted] side which may have some different perspectives and issues related to the pending standard.

I am a generalist Obs/Gyn practitioner based primarily out of Winnipeg. I have concerns about the proposed new standard for episodic care. I feel that it will negatively impact patient access to care, and physician retention in Manitoba.

1. Access to care. Our most vulnerable population is often dependent on episodic care. Sometimes that is how they engage in any kind of care at all. Accessing this care is often an oppertunity for them to receive preventative care (such as an oppertunistic pap smear, or STI treatment). This new regulation will make episodic care less available to these patients.

2. Physician retention. Manitoba already has one of the worst physician retention rates. The rate of physician burnout is at an all time high. The new standard will create increased administrative burnden and de-incentivize establishment of new practice in Manitoba. Although I do not work in episodic care, I empathize with my colleagues who do and would like for them to continue providing Manitobans with this much needed service.

I urge you to reconsider this proposal.

Please see my feedback for the DRAFT Standard of Practice for Episodic, House Calls and Walk-in Primary Care.

1. This standard is necessary to maintain high quality primary care focused on continuity of care. After reviewing the standard, I does a good job of setting reasonable expectations on the walk-in/episodic providers to ensure patients do not get harmed due to missing information. I would say this standard would be helpful for the vast majority of settings and would improve patient care and patient safety, and this it should be adopted.
2. The only comments I have are for point 3.2 proposed in the standard as follows: "

1. The clinic must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider identified by the patient unless patient consent is not granted."

My comments on the above are:

A. As a practitioner who works in NRHA, we have the unique advantage of owning a shared Electronic Medical Record that connects all the NRHA run clinics (and even some private clinics who have agreement with us) and this information is readily shared. Learning from our success, to improve sharing of documentation between providers when patient is seen at different clinics, there should be a provincial mandate to either adopt a provincial EMR or another solution to increase connectivity between different EMRs. Some of this work is done by Digital Health such as using eChart for uploading Home Clinic client summaries (Home Clinic Information Sharing- please see attached document). I suggest that the College consults this group from Digital Health to benefit from their expertise on the issue of information sharing between clinics, and potentially avoiding duplication of work as the Draft standard implies clinics themselves have to communicate the information to PCP's clinic. Some of this may be unnecessary if we leverage tools available to us using the Home Clinic Information Sharing.

B. To achieve the information sharing in the point A above, we should work together in asking all clinics in the province to adopt EMR systems for ease of information sharing, and move away from paper charting. This of course won't be possible in remote locations like fly-in Indigenous communities which don't have access to internet (I will provide further comments on these communities below).

C. One caution- if we do adopt a provincial EMR or a solution connecting EMRs, we do have to consider patient consent (which is addressed in 3.2) as some patients may not want information from their episodic care shared with their PCP, and they must have the right to do so. A mechanism must be developed to avoid sharing of information in these cases. I recommend making this a "withdrawal of consent" where patient is given choice to withdraw and if they don't specifically withdraw, information is shared by default.

D. Regarding remote Indigenous communities that are sometimes only fly-in, there are several issues for consideration which will make following the proposed standard in 3.2 challenging. First is that there is usually no solo physician who stays in community on a fixed schedule like 4-5 days a week to provide service. Most of the care provided by physicians is episodic and consultative (where the nursing staff have triaged patients and have specific questions for the physician) in nature. In many circumstances, the Nurse-in-Charge is acting as a default PCP for these patients and maintains the continuity of care, and coordinates and helps integrate the patient journey between visiting physicians. As the nurse is not a CPSM member, this standard won't apply to them. This is fine for most situations as the patient record is readily available in the Nursing Station patient chart between providers. Another point to note is that most of the times, the documentation is done in a paper chart as EMRs are not readily available due to lack of funding and/or bandwidth. Also, these patient charts are protected under stricter federal privacy regulations making information sharing even more challenging. Considering these circumstances, if a patient is from another community and received care in one of these remote communities, it will be extremely challenging for information to be shared as required in 3.2, so in most situations the standard will not be met. I wanted to point it out so this could be somehow mentioned in the standard, so it

doesn't cause confusion or distress for physicians providing services to these severely under-resourced communities under challenging conditions. Last thing we want is physicians refusing to provide coverage due to the fear of violating the standard, as this will cause severe harm to patients who are already getting bare-minimum service.

Please allow me to start off by thanking you for the excellent work done in drafting the Standard of Practice for Episodic, House Calls and Walk-In Primary Care. This Standard is long overdue and much appreciated. I have been an advocate for improving the Standard of care delivered through these settings for many years.

[redacted]

This presentation will focus on the standard of care which are provided to the walk-in patient. The discussion will include expectations as it relates to intra-professionalism as well as reputational risk to the family physician and the associated medical clinic.

Learning Objectives:

1. Recognizing the role of the family physician in meeting the standard of care provided in a walk-in setting.

2. Construct an easy-to-follow framework to assist in meeting standard of care expectations.

3. Solidify the walk-in clinic as a high standard, essential component in meeting primary care demands.

The reason for me including this information is to demonstrate to the working group that I am as committed and as enthusiastic as the College when it comes to the issue at hand.

Having said that, I have serious reservations about paragraph 3.2 of the proposed standard: "The clinic must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider identified by the patient unless patient consent is not granted."

The purpose of this paragraph is clear, easy to understand and excellent in its intent. This should indeed be the standard of care we aspire to provide. As technology evolves, we will hopefully reach the stage where all EMRs are interconnected, providing health care providers access to all aspects of a patient's care: chart notes, laboratory results, imaging reports, reports from allied health care professionals, etc.

Unfortunately, this technology is not yet available in Manitoba and all such communications between health care providers currently take place through a process of the physician reviewing a patient's chart and identifying the relevant information, followed by a staff member faxing the information to the identified recipient. At the other end of the communication, different staff receive faxed documentation and attach the information to a patient's chart, which then becomes part of the

physician's administrative duties to review at the end of his workday.

Paragraph 3.2 of the proposed standard will require this process to take place following each encounter with a patient who is under the care of a physician at a different medical clinic, regardless of the relevance of the encounter as it pertains to future medical care, unless the patient is asked and gives consent not to share information.

This is a standard [redacted] is unable to meet.

Our clinic consists of 10 family physicians with established practices. In spite of the established practices of each physician, the clinic is committed to providing same-day access to all patients in the [redacted] area who may be in need of urgent medical care. This is done in an effort to relieve the strain on [redacted].

Our clinic provides service from 6:30 am to accommodate patients prior to work until 6:00 pm to accommodate patients after work. We also provide care on Saturdays and Sundays.

Same-day access translates to 100 - 125 walk-in patients per weekday and 75 - 80 walk-in patients over weekends. We play an important role in timely access to care in the [redacted] area.

I will once again point out that this service is provided by the physicians out of a commitment to the community and is not an essential component of their practices since all the physicians have established family practices. I am sad to say this is a service my colleagues will be more than willing to forsake should circumstances justify their decision.

Paragraph 3.2 of the proposed standard will justify their decision to stop providing this service for the following reasons:

1) The additional work generated by gathering the contact information for each walk-in patient's primary physician and then faxing the medical information on 100 - 125 walk-in patients per day—while receiving medical information faxed back to our clinic as it pertains to patients belonging to our clinic but evaluated at a different clinic—will necessitate the hiring and training of an additional full-time staff member.

This is an expense our clinic is simply unable to afford. Even Pre-Covid 19 this would not have been possible. However, considering the loss of income as well as the astronomical increase in overhead expenses due to Covid 19, this is now simply an impossibility.

This recommendation reveals a clear disconnect between the good intentions of the working group and the reality of what family physicians face on a grassroots level. The timing is also poor and inconsiderate considering the challenges community-based physicians have faced over the last 2 years.

2) Next, the sheer volume of incoming and outgoing faxes will surpass the maximum number of faxes that are allowed by the EMR vendor, in this case, Input Health. Each additional incoming and outgoing fax is paid for separately, over and above the monthly cost charged by the EMR vendor. This additional cost is significant, cannot be recovered from Manitoba Health and is an additional expense the clinic is unable to afford.

3) Even if (1) and (2) were irrelevant, the fact of the matter is that [redacted] does not have the physical space available to accommodate an additional full-time staff member. We are literally unable to fit another body behind a desk or into a working space.

4) Support staff consists of a skeleton crew on Saturdays and Sundays. Staff will not be able to address the required communications over the weekend which means this volume of work will carry over until Monday. This volume of work—added onto the volume on a Monday, traditionally the busiest day of the week—will necessitate 2 additional staff members on a Monday, compounding the problems highlighted in (1), (2) and (3).

5) The additional administrative duties placed on an already burnt-out group of physicians following two years of Covid 19 (by adding hours to the end of their workday as they review additional incoming and outgoing communications) are unfair and not feasible.

In Summary:

[redacted] appreciates and supports the intent of paragraph 3.2 of the proposed standard. The realities of providing care in a community-based setting make paragraph 3.2 of the proposed standard impossible considering current limitations in technology, and, are compounded by the financial ramifications of the Covid 19 pandemic as well as the need for consideration of physician health and wellness as it pertains to physician burnout.

It has always been understood that not all medical services provided through a walk-in setting affect future medical care or are relevant to the continuity of care concept. Many simple, uncomplicated problems can be very effectively dealt with without the need for communication to the primary care provider.

Having said that, [redacted] supports the idea that services which affects future care and which are provided by a different care provider should be communicated to the primary health care professional. What is needed is an understanding that the walk-in physician has a responsibility to use his/her clinical judgement in deciding what medical information should be communicated to the primary health care provider, rather than a blanket directive to communicate all medical records, regardless of relevance to the primary care provider.

Once again, I appreciate the work of the working group on Standard of Practice for Episodic, House Calls and Walk-In Primary Care as well as the opportunity to comment on said document.

I am a physician practicing in the community of Winnipeg. I practice in the area of Sport Medicine and have provided medical care in Manitoba for 1 year.
I have serious concerns respecting the proposed Regulation on Record Keeping.
The regulation will negatively impact patient care by adding new administrative requirements into my practice.

The consultation documents claim that there will be “no additional administrative burden” on physicians, but this is simply not true. The Regulation will increase the administrative record-keeping burden in my practice without increasing or improving patient care. Instead, the increased administrative burden will reduce the number of patients I am able to see each day.

Physicians already follow very detailed and rigorous documentation requirements, both from our regulator CPSM, and under the Physician Manual from Manitoba Health. These requirements already provide the documentation necessary for patient care and to justify the claims I submit to Manitoba Health. As a physician, I take very seriously my obligations to maintain accurate patient records and to submit valid claims for remuneration. To be frank, it seems like the sole reason for these new regulations is to make the job easier for medical claims auditors when reviewing physician billings. From what I understand, the Auditor General reviewed physician billings recently and found that Manitoba Health has all of the necessary legal authority to review patient billings, and suggested improving the training for the auditors who often lack a background in health care or medicine. Rather than adding new regulations and red tape, I would suggest the government instead pursue better training for the auditors so they are able to understand the detailed and comprehensive documentation that already exists. If this feedback was reviewed, please reply with a succintly summarized response outlining how you deemed the feedback and plans to address such concerns. This proposed Regulation does not advance patient care and has the very real risk of resulting in less patient care being available. This comes at a time that physicians are trying to catch up on care that has been disrupted or put on hold during the pandemic. With this in mind, I respectfully request that Manitoba Health withdraw this regulation.
The draft regarding episodic, house calls, and walk-in Primary Care was read and reviewed. All points laid out make common sense and are reasonable guidelines to follow.
I feel that virtual medicine by phone is being abused by a few family physicians. Unnecessary calls are made to the patents almost every week without a valid reason. Follow up and complete physical exams are done over the phone without the patient being aware if it. I would recommend that consultation by phone should be limited to geriatric patients only. The physician should call patients only if there is a valid reason. Complete physical exams and unnecessary follow ups should be discouraged as these do not benefit the patient but only add to increased billing for the physician.
I am a physician practicing in the rural community of [redacted]. My practice encompasses both clinical and hospital-based duties. Currently, I have concerns respecting the *Walk-in Medical Care, House Calls, and other Episodic Care Standards of Practice*. Sexuality and Gender are areas of medicine I proudly maintain a special interest in. This is because the 2SLGBTQ+ community has unique healthcare needs that are often left unrealized by the general public. Although inclusive medicine has brought greater awareness to underrepresented groups, the 2SLGBTQ+ remain disadvantaged in seeking equitable and culturally competent services. I am concerned that the proposed standard will deter vulnerable patients from seeking care. Many of the patients I see at the Teen Clinic have their own family physician, yet they intentionally seek care elsewhere for sexual health and gender affirmation. This is because they do not feel

psychologically safe to discuss such vulnerabilities. Many doctors were not trained in an era where inclusive medicine was prioritized and unfortunately, stating that inclusive medicine is the standard sadly does not reflect the reality. I have patients that will explicitly ask who can see their medical record as they are concerned that their health provider may unintentionally disclose to other family members within their practice.

A potential solution would be to amend section 3.2 to limit the duty to provide a copy or summary to circumstances where it is reasonably expected to be useful to the primary care provider. This would allow those of us who work directly with vulnerable populations to exercise professional judgement on whether to disclose the information. It also opens the opportunity for discussion regarding their barriers to health services, and ensure a safe and sensitive approach is taken to providing care.

Although not addressed in the proposed standard, I want to take this opportunity to encourage the CPSM to implement gender affirming policies. I strongly deem gender affirmation to be a Standard of Care, however we currently do not have a policy to reflect this. For example, a patient who identifies as male, has the pronouns he/him, should not have to pick up a lab requisition that has their name/sex assigned at birth. There are other means to confirm patient identity (date of birth, PHIN) that would be paramount for the care of the 2SLGBTQ+ community. During previous attempts to have this addressed with other organizations, I have been told that the "EMR won't support it" or "it must be legally changed first." Yet, ample research shows that affirming one's identity is a part of social transitioning and is a pivotal step in supporting the well-being of our trans community. Gender recognition policies are a determinant of transgender health. I would encourage the CPSM to consider this in the near future and would be thrilled to assist the CPSM should a working group be developed.

As a community family md, I just wanted to weigh in with respect to this standard.

I agree with point 5.2 and say that this MUST be adhered to. I all too often am given a cc of a lab test and the patient was instructed to follow up with me re this with little/no point of reference.

However, a scenario may exist where COLLABORATION can occur - where the wi md call/discusses the issue (ie the er md informing me of his/her findings) and for me to now be up to date with the medical pathway and know what next steps are. There needs to be language in this to clearly state DIRECT COMMUNICATION - ie phone call or Cortext.

Thank you for the opportunity to review the draft and provide feedback on the proposed standard of practice for episodic, house calls, and walk-in primary care draft. I am writing to express my feedback on some of the stated proposed standards.

I am a Family Physician working at [redacted] since 1987. We have 21 Family Physicians, 2 Nurse Practioners and a My Health team. We do have a Walk In clinic operating Monday to Friday to serve patients who cannot see their own provider as there are no openings or they do not have a provider. Ideally patients would see their own Primary Care provider as I feel this provides better continuity of care but is not possible some of the time.

I am concerned about the effects that item 3.2 will have on provider workload/liability, panel size, and physician wellness. Item 3.2 states that "*The clinic must provide a copy or summary of the*

clinical encounter (including copies of ordered tests) to the primary care provider identified by the patient unless patient consent is not granted."

This will create a large amount of administrative work without necessarily benefiting patient care. First you will need to explain to patients of the requirement to send your note to their Primary care provider and get their consent to do so. The clinic will need to develop a process to send all these notes to different clinics and ensure consent has been provided. This will create an influx of items in physician's inboxes to sign off. Already the amount of time spent outside of direct patient care is staggering.

It is unclear to me if this standard would apply to a group setting. Would you need to forward every episodic care note to the patient's Primary care provider even if they are in the same clinic. This would increase Administrative burden.

I feel it should be at the discretion of the physician to send your clinic notes to the Primary care provider. I routinely forward notes, and results on patients where I think this will be relevant to ongoing care. Any imaging or labs you order will already be available on EChart to view. The Primary care provider can also request clinic notes if they feel it will be helpful to patient care.

The standard could say that it is at the discretion of the episodic provider to send notes if a concern is something that the primary care physician should be aware of. Minor concerns that are fully addressed by the episodic provider would not need to be shared but chronic or ongoing concerns would be sent to the primary care physician.

Another concern I have is item 6.1 - "*To mitigate risk of harm the member must use reasonable efforts (recognizing there may not be internet connectivity throughout the province) to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN as appropriate. "*

This to me implies you should look up the medication list on EChart for each patient you write a prescription. This again is an administrative burden that will limit the number of patients who can be seen. I feel it should be at the discretion of the episodic provider to look up medications if it is reasonable to the presenting complaint. I regularly look up information on EChart when I am doing a Walk in shift.

Unfortunately in our area there is a shortage of Family Physicians. There is a lot of immigration into the area and many people are registered on Family Doctor Finder , some for years without getting a primary care provider. This necessitates use of Walk in and episodic care for these patients. With these guidelines and the administrative burden, less patients will be able to seen and more will have their health issues not addressed and they may need to go to the ER department for more minor issues and further increase wait times in ER.

I am taking this opportunity to provide feedback in response to the CPSM's proposal on "Standard of Practice – Episodic, House Calls, and Walk-in Primary Care. By introduction, I am a physician who is currently providing focused care in a primary care sports medicine practice at the Pan Am Clinic in Winnipeg. My practice consists of approximately 75-80% episodic primary care and 25-20% collaborative or referral based care (as I believe would be defined by the CPSM). Upon reviewing

the draft statement, I note several areas of concern which I have outlined below for your consideration.

To begin, myself and many of my colleagues have taken exception to the fact that the Pan Am Clinic is specifically targeted in the proposed draft, as it is the only clinic mentioned by name (point 1.1). We are a practice that has been built with the specific intent of providing focused musculoskeletal care by leveraging: i) specialized infrastructure located at the clinic (including access to casting, Xray and MRI); ii) close working relationships / networks built with other specialist physicians (including Orthopedic surgery, Plastic Surgery, Physical Medicine, Rheumatology, etc..) iii) and finally leveraging the expertise of primary care physicians who have developed a deep knowledge of musculoskeletal and sports medicine. In short, I believe we are a clinic that provides a much-needed service in Manitoba through the provision of specialized MSK primary and referral-based care. It speaks volumes that the Pan Am Minor Injury Clinic (staffed by both focused Primary Care Sports Medicine Physicians and Emergency Medicine Physicians) is a part of the orthopedic referral algorithm for both the St Boniface Hospital Emergency Department and Victoria Hospital Urgent Care. I believe that we provide excellent care, but care that is intentionally focused because we've developed a deep expertise in the field and we have support and infrastructure that is not readily available elsewhere. Furthermore, I believe the Pan Am Clinic and our practice, in its current form, are a benefit to our healthcare system as a whole. In seeing large volumes of non-surgical orthopedic cases we relieve burden from an already strained orthopedic system, likely saving the system money in doing so, and provide an access point for patients to access orthopedic care on both a formal referral and self-referred basis. The proposed changes, while likely not intended to do so, may very well change part of the dynamics of the clinic that have made it both accessible for patients and cost efficient for the system as a whole.

In its current form, in my opinion, the statement is somewhat vague and I am concerned, may have some unintended consequences for access to patient care as I will outline below.
Point 2.3 – this point is unclear. This statement could be taken in such a way to insinuate two points: i) that physicians in primary care cannot limit the scope of their practices and ii) physicians will be required to try and provide care that is outside of the scope of their usual practice. For example, in the work up low back pain often blood pressure is taken – if the patient is found to be moderately hypertensive does that then mean the physician is now responsible for further investigation and management of such?

Point 2.4 – this point may have a similar interpretation to point 2.3 above requiring physicians to start practicing outside their usual scope of practice and, in the case of the Pan Am Clinic, requiring physicians to become de facto primary care providers for patients they see as a whole. The consequences of this specifically for our clinic would likely be two fold. Firstly, this will likely result in myself (and likely my colleagues) providing less episodic care through our Minor Injury Clinic and secondly as a result this will reduce the access of patients to the specialized care and infrastructure that the clinic provides. In short, if I have to start expanding my practice to more generalized areas I'll have less time to spend using my specific skill set. We are good (and efficient) at what we do because we run a focused practice and have the infrastructure to back us up. It doesn't make much sense (system and patient access wise) to me to require physicians with specialized skill sets and access to specialized infrastructure to provide routine primary care that can be accessed elsewhere. To be blunt, I can spend my time providing specialized MSK care with the facilities and expertise I have or I can provide routine primary care – but I can't do both.

Point 3.2 – This point is unclear as to what extent this is required. This could be interpreted as all notes from all primary care sports medicine physicians will be required to be sent to primary care providers. While this may be a good idea in theory it would likely result in a significant burden of paperwork for the primary care physicians involved. Point 5.2 – This point may lead to confusion for patients and practitioners. At what point would it be appropriate for a physician providing episodic care to complete a formal referral back to the patient's family physician for a further workup of a medical concern found incidentally that is outside of the physician's area of practice, or one that may require further follow up beyond that required for the primary presenting concern. For example – a patient presents for radicular low back pain and an MRI is performed. The MRI shows an incidental gynecological concern with suggestion for follow up imaging in 6-12 months. Once the radicular back pain has resolved, is there an appropriate time to send a written referral back to a patient's primary care provider to request further ongoing management as one would with a consultant? I am appreciative of the opportunity to provide feedback and would be happy to make myself available for further input / feedback if desired.
I'm a family physician. I do a mix of family practice and episodic care (walk-in). I have significant concerns about this guideline, largely the potential for large amounts of additional paperwork without a significant additional benefit. I worry this guideline will serve to further drive away family physicians from longitudinal outpatient/clinic based practice, as the burden of unrecompensed paperwork is already huge and this will only further add to this issue. If I genuinely thought it would add significant value I would agree with this drafted guideline, but the appearance of a forced requirement for family physicians to receive and review ALL episodic care notes for all their patients, is frustrating and will just cause further drowning in paperwork. Can the CPSM clarify the duty of the receiving physician? Am I required to add all of these summaries to my patient's file? Am I bound to review all of the summaries? Am I required to take positive action based on the summaries? If the walk-in physician's summary notes that the patient should come to see me, do I have an obligation to follow up? Whenever I am dealing with a more complex episodic care issue- like unexplained weight loss , new onset shortness of breath in a patient not ill with an acute URTI etc., I always ask about whether or not they have a family MD and whether or not I can loop in their family physician so they can know about our discussion, investigations etc.; and if they agree I send them my clinic notes and other investigations. I do not see much added value for patients coming into with uncomplicated issues (like a URTI, a UTI in a premenopausal non-pregnant female patient etc.), and I know I would not look forward to the significant added paperwork that will not help me manage my patient with any extra benefit. I worry that these guidelines are often not drafted with the average community family physician in mind. It seems to me there is an easy solution: limit the obligation to share the summary to visits where the walk-in physician reasonably believes it would be useful for me to know about the visit. What I really wish, would be for the province to work on creating a EMR that would allow access notes from other providers as needed instead of being forced to wade through them without a choice. I recognize that this is beyond the scope of the Standard, but it would greatly assist physicians and minimize obligations which do not add to patient care.
Overall looks great! I particularly like Part 3 - please keep both 3.1 and 3.2 in it!
[redacted]

First of all, thank you for putting the time, thoughtful consideration, and energy into creating what is a particularly complex Standard of Practice. I have long been concerned about the issue of continuity of care and I welcomed the news that a Working Group was addressing this issue in the service of writing a Standard of Practice. I recognize that there is much that I am not aware of that must play a part in the contents and writing of the subject Standard of Practice. More importantly, I am not a primary care provider so no matter that suggestions and ideas may sound wonderful, if they are not practicable they will not have utility. My suggestions are predicated on the belief that for a Standard of Practice to be effective, it must be expressed as clearly and specifically as is both

possible and reasonable. Lack of clarity and specificity potentially undermines the intention of the Standard to address the underlying concerns. Accordingly, as you will read, several of my suggestions relate to the way in which the Standard is expressed. I hope that you find at least some of my suggestions helpful in formulating and/or of some assistance in writing this Standard of Practice.

Part 2.2 is specific in referring to "a walk-in clinic" but does not include "Episodic Care" or "House Calls". If there is no particular rationale for excluding the latter, then rather than singularly noting walk-in clinic I suggest that all three settings be named.

I agree that members should provide or arrange appropriate follow-up care. But what does this actually mean? If this is the Standard of Practice, then it needs to be more specific. One member's "appropriate follow-up" is another member's "poor medical practice". Is it not important for a Standard of Practice to define more objectively those areas that can so easily vary in interpretation subjectively? I suggest that the Standard of Practice address this by listing some of the possibilities that this might include so that it could read: Members must also provide or arrange for appropriate follow-up care such as consultation with a specialist, a follow-up appointment with the member, a follow-up appointment with the primary care physician (where one exists), etc. It might also be worth including the suggestion that when a patient has a primary care provider that this information be included in the information provided to consultants so copies of reports automatically include the primary care providers.

Regarding 2.3, the phrase "in good faith" is confusing and vague. I genuinely do not have a clue what this means in this context nor even what the intention you are attempting to communicate is.

Regarding 2.4: When reading this Draft originally, it was at this point that I began to think that I was particularly obtuse because I could not understand whether you were saying that the patient was expected to take "the appropriate next steps" or whether this was all about doctors talking to their patients to communicate information but that it would be the doctors who would be acting to get the care or services for the patients. But then I showed it to two other people (one a physician and the other a very literate nonmedical person) and neither of them were sure either. So I still don't know, but that needs to be clearer. Either way I have concerns that need to be at least considered: I am going to assume that your intent was for this section to be about members informing patients about actions that the patients would then undertake. There are many groups of people who are particularly vulnerable. People with intellectual disabilities, immigrants who come from cultures that do not share our attitudes regarding the role of patients in their own care and/or in relation to their physicians, people who do not speak English or do not speak it fluently enough to understand and/or speak it fluently to others, people with all manner of mental illness, people who are in significant pain and therefore cannot concentrate, and people who have such high anxiety that they cannot think straight and therefore cannot absorb what is said to them (these groups and especially the last group, taken together, may constitute the majority of patients who are provided care in the subject settings/situations) are all very likely to fail to understand and/or remember much of what they are told. This doesn't even begin to take into account the many physicians who have difficulty with effective communication for one reason or another (and my impression is that they may be disproportionately represented in the subject settings). There are many other reasons that come to mind as to why 2.4 (assuming it means that the doctor is explaining to the patient what the patient needs to do) may sound good but, as written, is not going to work. It is not reasonable to expect the

patient to navigate a cumbersome, disorganized health care system – a system that I not infrequently struggle with in spite of my considerably greater resources – in the absence of the names of specific organizations preferably with the position/name of the individual(s) that they need to speak with and definitely with telephone numbers and hopefully websites or e-mail addresses etc. If it is a lengthy list then the member needs to indicate on the paper which of the many organizations are the relevant ones. I am not sure how this can be effectively communicated in a Standard of Practice but I am certain that it could be without losing its meaning and without such detail as to be inappropriate. If you want to discuss it further please call me because as it stands I do not think that it is generally comprehensible and for that reason and those described above may not useful.

I also do not know what is meant by "any limitations" or "services that are not provided" . I guess I am saying that the entire 2.4 needs to be rewritten for clarity and I hope you will take what I have said above into consideration.
Regarding 3.1, I suggest that "full name, address/approximate address, and phone number if available" be substituted for "name". Many people have phone numbers stored in phones and it could really expedite the process of contacting the provider for the treating member. Please consider adding "with the other identifying information" or "with the other personal information" at the end of the sentence in 3.1. Again, it is more likely to be done and will be easier to find.

Section 3.2 is inconsistent and, in fact, is in contradistinction to the PHIA Section 22(2) (a). The way 3.2 is written, it requires consent. The opposite is true in the PHIA ; the referenced section clearly states that relevant information can be shared between treating physicians unless expressly stated otherwise. There are excellent reasons for this and in a discussion with [redacted] (who was involved in the writing of the PHIA) he explained that this clause was deliberately included so that people "in the circle of care" (as he described it) were able to provide optimal treatment. At any rate, the CPSM and PHIA ought not to be at odds with eachother.

Regarding Part 4, perhaps the WRHA/CPSM might want to put a poster together on this subject (as has been done during flu season, for example) to be hung in offices of both primary care physicians and walk-in clinics and other episodic care settings.

Regarding 5.1 and 5.2: It needs to be specified that the communication that determines that "the other has agreed to assume this responsibility" needs to be between physicians and/or physician assistants and that it should be documented the same way other aspects of care are documented. (I have images of a receptionist copying it down for a family doctor in a note or, worse yet, simply saying that ofcourse they will look after it – the patient is theirs and that being accepted as sufficient "to assume this responsibility".

Finally, somewhere in the Standard it needs to be stated that if there is medical urgency the member must be in direct communication with the physician/physician assistant in an appropriately timely manner. It may already state this but if so, I have missed it.

Thanks again for what I know has been a lot of hard work.

I had the opportunity to review the CPSM April Newsletter and The Draft of the Standard of Practice for Episodic, House Calls, and Walk-in Primary Care. I would like to provide my feedback.

I have been practicing in a medical clinic providing continuity of care to my patients for many years. I personally do not see walk-in patients however we do leave open slots in the day-to-day schedule to accommodate my patients with urgent needs the same day or ASAP. This helps my patients avoid going to urgent care or a walk-in clinic. I also try to optimize continuity of care for my patients by making it easy for them to schedule appointments by having efficient front staff and extra phone lines.
Providing continuity of care to my patients over the many years, I noticed that at times I have to track down the results of tests when my patient is seen in a WIC. I feel it would be beneficial for the continuity of care of the patient if the walk-in-clinic practitioner could send or fax a copy of the visit with my patient (including test results, referrals if made, etc.) to my office. I hope this would also apply to visits of patients with Optometrists.

In addition, I find a slow transition from virtual care to seeing patients in person is beneficial for the outcomes of medical care, continuity of care, and maintaining a trustful patient-physician relationship.

Regarding virtual care, I find it is a very useful tool to support follow up visits (like follow up tests results, rather stable medical conditions, evaluation of treatment response for patients suffering with depression or severe anxiety in the patient's home environment).

For example, I have a 15-year-old patient suffering from severe depression and anxiety who refused to come into the office or see a psychiatrist or have any further mental health referral. She was being followed by virtual care from me, with the assistance of her mother present during each visit and monitoring her medications. I spent approximately a year of doing virtual visits with her and her mom, and she make substantial progress and was even able to finally come in person to the office.

Virtual care is useful as well. For instance, I find some common scheduling difficulties for patients are challenges in finding child care, having to take time off work, having to travel from outside Winnipeg, elderly who are stable but don't drive or don't have easy transportation to the office - especially in the winter time. Virtual care does help alleviate some of these mentioned issues patients may have, and helps to get them access to quicker, more accessible care.

Finally, regarding the issue of prescribing opioids to my patients - before I renew the opioid medication, I always contact the patient. I will have a discussion with them regarding any further need for refill or discuss possible side effects, dosage decrease, substitution medication options, or a time of discontinuation.
I would like to thank the CPSM for allowing me to represent my voice in the above matter.

Briefly, I will be very happy to have the local walk-in clinic start sending me notes on the patients of mine that they see when I am closed. The local ER does and I think the walk-in clinic should as well. Thank you.

I believe the document on episodic care is overkill.

For example, if I syringe a person's ears of earwax, does that necessitate a report to the patient's own physician? (This is an example of what I do now as a walk-in doctor, after 40+ years of general practice.)

Likewise, uncomplicated UTIs, URTIs, otitis media, renewals of prescriptions when the patients cannot reach their family MD (available on DPIN for the MD); drivers license medicals. Etc etc. I am not trying to build a practice and always tell the patient's to followup with their own MD. If they can't, our clinic is available, even if I am not working personally. I provide phone numbers for clinics for patients without doctors.

Not all clinics have EMRs… [redacted] , where I sometimes work, has paper records. Sending a report to every doctor after an interaction would seriously stymie the clinic 's ability to provide timely care, I believe.

Have you evidence that patients are being harmed by episodic care, or that reporting is so lacking that you need to come out with another document.?

If I have significant findings or concerns, I fax a report to the family MD. Believe me, I am happy to keep them informed and transfer care. As I said, I am not looking to build a practice. I try to treat people the way I'd like people to treat me.

Why not re-evaluate and revise your document to take some of these concerns into consideration?

I am [redacted]. I have been providing care in Manitoba for 22 years, of which 19 years have been at [redacted]

My practise consists :
80% of providing musculoskeletal care to patients at Sport Medicine Clinic that:
1) make appointments themselves out of their own choice for a MSK problem
2) are told by their Family Doctor to "go to Pan Am" for their MSK concern without sending any documentation, test results etc. (many of these were only consulted virtually the past 2 years by their Family Doctor who does not
want to see the patient themselves but expect Pan Am Physicians to see the patient in clinic)
3) are referred by Family Doctors and Specialists (with appropriate documentation, test results etc.)
4) follow up care to all above when needed
10% providing MSK care at Pan Am Minor Injury Clinic to patients that:
1) decide to come as walk-in patients for what should be MSK problems
2) are told by Family Medicine walk-in clinic or by own Family Physician to " go to Pan Am" without sending any documentation, test results etc
3) referrals from St Boniface ER or Victoria Urgent Care (2% of my patients)
10% proving follow up MSK care for patients seen at Pan Am Minor Injury Clinic

Commentary on the Draft:
1) Definition **Episodic Care:** In contradiction to this definition many patients seen at Pan Am have the expectation of ongoing care for their MSK problem as the care they need or expect can not be provided by their Family Doctor or other Orthopaedic services. Many of these patients will also return frequently for care of other MSK problems due to the same, namely that the care they need or expect can not be provided by their Family Doctor or other Orthopaedic services.

2) **Point 1.1:** Interesting that Pan Am Clinic is mentioned by name in the document when I get impression that the persons that created this Draft, have absolutely no idea on the kind of service that is provided at the Pan Am Primary Care Sport Medicine Clinic. Minor Injury Clinics are also mentioned by name when the service provided at Pan Am Minor Injury Clinic is totally different from other clinics like the Minor Illness and Injury Clinic.
For instance, Pan Am Minor Injury Clinic service is provided by physicians with extra training in Sport Medicine and follow up care is provided until the MSK problem has resolved. (in that sense not a true Walk-In Clinic).

At the Minor Illness and Injury Clinic for instance, service is provided by ER physicians and Family Doctors as a Walk- In Clinic and no follow up care. Many of these patients are referred to Pan Am for ongoing care (usually without Xray report or access to X-rays images which has to be repeated then)

3) **Point 1.2:** Interesting that the Standard does not apply to emergency and urgent care facilities when the Pan Am Minor Injury Clinic is part of the WRHA Emergency program, with the goal to provide this service to take MSK burden off the ER and urgent care facilities.

4) **Point 2.3:** I have no idea what this vague statement means and what is required of me.

5) **Point 3.2:** As stated earlier, I see patients at the Pan Am Sport Medicine Clinic (which is a private clinic) that make appointments themselves out of their own choice. As a rule these patients choose to come to Pan Am Clinic for the excellent focused and specialized MSK care they know they will get. This can most of the time not be provided by their Family Doctor, they are not satisfied with the Family Doctor's care, are not improving in spite of treatment already or does not have a primary care provider. I also see many patients that has already seen their own Family Doctor or at a Walk - In Clinic and was told "got to Pan Am" without providing documentation on test results already performed, consultation reports from specialists etc. Why can the Family Doctor do this and I am then required to provide documentation to him / her if they do not even have the decency to at least provide me with the patient documentation ? Why is this side of the problem not addressed in this Draft ?
The Pan Am Minor Injury Clinic is a WRHA clinic and I (and all the other physicians) work shifts there. The Pan Am Minor Injury Clinic administration should be responsible to provide the copies of the clinical encounter to he primary care provider, and not the physician.
All lab results, imaging results should be available to the patient's Family Doctor on e-chart and should not require the extra burden of sending it again.

The concerns are:
This will require an immense increase in the administrative burden on my practise. The only way to absorb this extra burden will be to change my practise to see patients only on a referral basis in future. This will force the Family Doctor / Walk - In Clinic to provide me with the appropriate referral letter and test results and not just tell the patient "go to Pan Am" . Patients will also not be able to make their own appointments as they have been doing for the past 25 years or more. This will in exchange require patients to see their Family Doctor or Walk-In Clinic just to get a referral with an extra burden and cost to the already overwhelmed system and will delay care of patients that may have more urgent MSK issues.

6) **Point 5.1, 5.2:** This is not clear as to the full extend of my responsibility. As Pan Am Clinic is a focused MSK clinic, the far majority of patients are seen for MSK problems and they are all followed up for the MSK problem until it is not needed anymore. Is it acceptable to only inform the patient to follow up with the primary care provider if a non urgent MSK problem is found ? In my opinion the primary care provider should accept the responsibility for any non MSK primary care problem and I would not be required to get the Family Doctor to agree on this.

In summary:
This document does not and will not improve patient care at Pan Am Clinic.
This will provide an extra administrative burden on my practise.
This will likely force me (and my colleagues at Pan Am Clinic) to change how we run the practise, resulting in less access for patients to MSK care and a further burden on the already overwhelmed Family Physicians.

I hope these points mentioned will be considered. I am available to for any discussion, questions if needed.

I am a physician practicing in Winnipeg, Manitoba. I practice in the area of Family Practice, Walk-in Clinic, and obstetrics, and have provided medical care in Manitoba for 2 years.

I have serious concerns respecting the proposed Regulation on Record Keeping. The regulation will negatively impact patient care by adding new administrative requirements into my practice.

The consultation documents claim there there will be “no additional administrative burden” on physicians, but this is simply not true. The Regulation will increase the administrative record-keeping burden in my practice without increasing or improving patient care. Instead, the increased administrative burden will reduce the number of patients I am able to see each day.

Physicians already follow very detailed and rigorous documentation requirements, both from our regulator CPSM, and under the Physician Manual from Manitoba Health. These requirements already provide the documentation necessary for patient care and to justify the claims I submit to Manitoba Health. As a physician, I take very seriously my obligations to maintain accurate patient records and to submit valid claims for remuneration.
To be honest, it seems like the sole reason for these new regulations is to make the job easier for medical claims auditors when reviewing physician billings.

From what I understand, the Auditor General reviewed physician billings recently and found that Manitoba Health has all of the necessary legal authority to review patient billings, and suggested improving the training for the auditors who often lack a background in health care or medicine. Rather than adding new regulations and red tape, I would suggest the government instead pursue better training for the auditors so they are able to understand the detailed and comprehensive documentation that already exists.

This proposed Regulation does not advance patient care and has the very real risk of resulting in less patient care being available. This comes at a time that physicians are trying to catch up on care that has been disrupted or put on hold during the pandemic.

With this in mind, I respectfully request that Manitoba Health withdraw this regulation.

The [redacted] consists of 19 practitioners working together to provide a comprehensive range of primary care, including walk-in. The proposed draft was reviewed at our last Department meeting and the following questions arose: Does 5.1 require a member to enroll an unattached patient into their practice if they see them in a walk-in? Please explain what 2.3 means. None of our Physicians were clear on this clause. With respect to the proposed 3.2 the Physicians recommend limiting the requirements to encounter forwarding to complex encounters only. There is concern that Physicians will be inundated with unnecessary reporting which will reduce their availability for patient care. As a My Health Team member we are active participants on the Steering Committee. A reoccurring topic at each meeting is the shortage of Family Physicians especially in the rural setting. The Family Doctor Finder program faces an impossible task of attaching patients to a Family Physician. Although the proposed Standard of Practice has good intentions of increasing the quality of care for patients it may have an unintended consequence of reducing access to care should Physicians eliminate walk-in services because their practices are already full. We look forward to learning more about the application of the proposed Standard specifically 2.3 and 5.1.
I have reviewed carefully summary provided of standard of practice for episodic, house calls and walk-in primary care. I also attended MCFP SCIENTIFIC ASSEMBLY on 28 and 29 April 2022. I agree and will support all the regulations that were summarized for walk-in clinics, episodic care and house calls. During pandemic my patients were frequently attending mostly walk-in clinics and sport injuries clinics.This was present when virtual medicine was at the beginning of pandemic the most common way of assessing patient's.During that time from my experience rarely I received any information and summary from these visits. Recently I have been receiving summary of visits and copies of investigations that were provided by the doctors working in walk-in clinics and periodic visits. I have not had any experience with housecalls visits. Since I have transitions to almost 90% of office visits, my patients have an accsess to schedule office visit.
The [redacted] is one of two larger Primary Care clinics located in [redacted] MB. Our group of primarily Family Physicians provides ongoing primary care, episodic primary care, in-patient care, low-risk obstetrics care and PCH coverage in the community. The majority of our care is providing ongoing comprehensive care and our current practice services over 23,000 patients.

We are writing to express our feedback regarding the proposed standard as stated above. We are concerned in regards to the increased workload for Physicians that this standard may impose and the negative impacts that may result. By the end of 2022, our clinic will lose three Family Physicians due to reasons that include COVID 19 and its mental health impacts, administrative requirements and the time commitment required to provide continuity of care for patients in a Primary Care setting. Our facility and our community is not alone in regards to struggling to keep Family Physicians who are the foundation of comprehensive care for patients.

This standard will require increased administrative requirements and what is being interpreted as a requirement for our Physicians to follow patients seen in our Walk-in clinic, thereby obligating them to increase their patient panels which in turn causes more delays for patients to be seen. This will ultimately create disruption in continuity of care, Physicians not willing to see patients who are not enrolled in their practice (risking the Clinic from continuing walk-in services) and ultimately increased Emergency Room visits which is neither effective nor efficient. Due to reduced numbers of Physicians across the province the need for walk-in services is required.

The administration burden of Part 3, 3.2 will be immense for staff and Physicians. The suggested standard infers that Physicians working walk-in will be required to send out all information pertaining to a visit and then receive all of that information when their patient is seen elsewhere. Administrative time and delays for timely care will be immense.

A suggestion would be to utilize eChart for pulling information regarding episodic care as opposed to pushing it out to Family Physicians. This supports an on-demand access when required as opposed to Physicians spending even more of their day reviewing paperwork than actually spending time listening to and hearing what their patients need. It is our concern that the costs of this change will far outweigh the potential benefits.

In a time when the Medical Community is only starting the work to recover from the pandemic, implementing new measures will only create more complexities in the patient/physician relationship, thereby increasing obstacles to providing good health care as opposed to clarifying them.

Thank you for inviting us to provide feedback. We would welcome a meeting to provide additional information and suggestions to assist in improving patient care.

STAKEHOLDERS

I reviewed the proposed standard of practice and really have little to add except 2.3 and 2.4 could be potentially combined.

Not really anything more insightful. CPS PEI

Thank you for the opportunity to provide feedback. The CRNM staff members who reviewed and are providing feedback include RN and other Professional Conduct Case managers with CRNM. Overall, we found the background/rationale document and Draft Standard of Practice understandable and clearly written. We appreciate that there is a benefit/need for this specific standard. Linking this Standard to other standards (e.g. good medical practice, virtual care etc) makes sense and appears to be done with congruence.

PUBLIC CONSULTATION March 30 – April 30

Standard of Practice for Episodic, House Calls, and Walk-In Primary Care – Feedback from Registrants and Stakeholders

The following feedback is intended to strengthen the implementation of this Standard, to support CPSM to meets its protection and service of the public. 2.3 Good faith: Because this is not defined within the standard, it would appear that a commonly accepted definition would apply, such as "honesty or sincerity of intention." While we can appreciate the benefit and need for good faith, it is not always possible to measure or determine ones intentions. As such, we suggest the wording be clarified to include the expected behaviours. 3.2 It makes a lot of sense for a copy/summary of the clinical encounter to be provided to the primary care provider, with the client's consent. It is not clear whether this standard expects the practitioner to seek consent as part of every clinical counter, in order to determine if the client provides informed consent. Added clarity on this expectation – as otherwise we see the opportunity for an assumption that the client did not consent, so the information cannot be shared. As well, it is suggested that this expectation include an expectation of timely sharing of the information with the primary care provider. 6.1 Reasonable efforts: It would help to have a definition of reasonable in terms of the behaviours expected. CRNM
Doctober Manitoba – See attached
The Canadian Medical Protective Association – See attached
College of Pharmacists of Manitoba – See attached

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April 29, 2022

Dr. Anna Ziomek, Registrar
The College of Physicians & Surgeons of Manitoba
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CPSMconsultation@cpsm.mb.ca

Dear Dr. Ziomek,

Doctors Manitoba appreciates the opportunity to comment on the proposed Standard of Practice on Episodic, House Calls, and Walk-in Primary Care (the "Standard").

The proposed Standard has generated a considerable amount of comment from our members, mostly from those members providing episodic care and whose patients may attend upon episodic care.

We have been copied with some of our member submissions sent to you, while some members have asked us to carry forward their concerns to you directly.

The CPSM may be surprised by the strongly held views being expressed by some members. This consultation on the Standard is taking place at the same time as Manitoba Health is consulting on proposed amendments to the Regulation respecting fee-for-service billing. These proposed changes to the Regulation would create new administrative burdens on many of the same members who will have increased obligations with the Standard. Some of our members have expressed frustration, anger, and/or disbelief that their regulator and their primary payor are imposing greater obligations at the same time, just as our members hope to emerge from the challenges of the pandemic. Those feelings have been expressed in some of the submissions our members have provided to you.

This is not stated to detract in any way from the importance of the Standard. Unlike the Manitoba Health Regulation, which appears to be a one-sided government initiative to create new or duplicate administrative burdens for the sole purpose of denying our members payment for medical services provided to Manitobans, Doctors Manitoba (and the great majority of our members) accept the importance of clarifying the duty of care in light of the reliance of Manitobans on episodic care. There is much common ground between the Standard and Doctors Manitoba's advocacy for our members, including our interactions with Manitoba Health and health authorities.

General Comments

It is the position of Doctors Manitoba that every Manitoban who wants a primary care physician should have one. We believe the values of continuity of care, the creation over time of a comprehensive record of a patient's care, and the strengthening of trust between patients and their "home" physician are understood by the CPSM and our members (if not Manitoba Health).

However, the reality is that episodic care is a necessary part of the delivery of health care services to Manitobans. Manitobans are "voting with their feet" (or their fingers, for virtual care) and making the choice to use episodic care.

As the CPSM acknowledges in the preamble to the Standard, there are many reasons patients attend upon physicians providing episodic care. For some it is a purely voluntary choice, for others there may be compelling reasons to do so.

Far too many Manitobans do not have a primary care physician. This may be for geographic reasons (as the CPSM acknowledges, including but not limited to patients in distant rural and remote communities), or cultural reasons. It may also be the case in underserved urban neighbourhoods and may also be connected to Manitobans' own personal issues and challenges. Many Manitobans may be unable to advocate for themselves to find a primary care physician while others, for one reason or another, may not appreciate the benefits of having a primary care physician.

Further, we are greatly concerned that the number of Manitobans without a primary care physician will increase. Practice data, media coverage, and anecdotal stories from our members tell us that many family physicians are considering retiring, moving away from Manitoba, or limiting their practice. This year's CaRMS match demonstrated a national shortfall in physicians wishing to pursue a residency in family medicine.

Manitobans with a primary care physician may also attend for episodic care. Although described as "reasons of lack of access or convenience of hours" in the Standard, it runs much deeper for both physicians and patients. Primary care physicians cannot be expected to serve 24/7 by attending to their patients in the evening and on weekends. Physicians may work less than five days a week for family responsibilities, or because they have other duties in a local hospital, teaching duties, involvement in their professional organizations, or are involvement in other health care settings. The "convenience" of episodic care may encompass a patient unable or unwilling to use limited paid sick leave in their employment or suffer a financial loss if they do not have paid sick leave. The "convenience" may be very real for a patient who cannot afford to pay parking costs downtown on a weekday, or even afford bus fare to see their doctor downtown or across town and need assistance from their friends or family which may be available after working hours.

Episodic care, as defined, also includes a patient who may choose to visit a physician at an access care or clinic other than their primary care provider, and outside of their home community, for valid personal reasons.

Episodic care also appears to include a patient who decides to visit a family physician with a particular interest, such as sports medicine or travel medicine.

Doctors Manitoba states emphatically that episodic care is not second-class care. Accordingly, Doctors Manitoba supports wholeheartedly the overriding standard of care in the Standard, stated in Article 2.1 as follows:

Members must provide the same standard of care to patients irrespective of the practice setting in which such care is provided and irrespective whether the patient is, or is not, a regular patient of the clinic where the physician works.

This is a clear and fundamental statement to all Manitobans, and any physician who chooses to provide episodic care. It is so clear, in fact, that we believe it makes some of the other provisions of the Standard unnecessary, as we will discuss below.

Comments on the Standards

We will provide our comments on the specific provisions of the Standard.

Our comments do not mean Doctors Manitoba necessarily "opposes" the provision. However, we believe that in some cases there is a need for greater clarity to give direction to our members or, in the alternative, we would ask for the CPSM's commitment to providing satisfactory education to members to ensure they are following the intent of the provision. In certain case, but there are considerations which must be taken into account when interpreting and applying the Standard in any particular situation. Where we can suggest wording to accomplish the intended goal, we will provide it.

Part 1. APPLICATION

Article 1.1 defines "episodic care" and "primary medical care". It appears this applies to a wide range of visits, outside of the exceptions for certain facilities in Article 1.2.

For example, Article 1.1 appears to include visits to a sports medicine clinic, which may include repeated visits to the same physician in the same clinic for treatment and follow up until the condition resolves. Is that considered "episodic care" or "ongoing care"? Is this intended by the CPSM to be covered by the Standard?

This would also appear to include a visit to a family physician with a travel medicine practice, where there may be one or more visits to receive a vaccine for international travel. Is this intended to be included by the CPSM in the Standard?

This would also appear to include visits to family physicians providing certain non-specialist medical services, such as certain skin or aesthetic procedures, vasectomies, or photo therapy. Are all of these considered "primary medical care" by the CPSM and included in the Standard?

Doctors Manitoba believes that the main intention of the Standard is ensuring an appropriate standard of care for visits to walk-in clinics. More clarity respecting these other situations would be helpful; we believe existing Standards already provide an appropriate standard or care.

Part 2. STANDARD OF CARE

As stated above, we believe the overriding standard of care expressed in Article 2.1 is a clear and comprehensive direction to all members who choose to provide episodic care.

Article 2.2 provides more detail about the required standard of care. We believe the obligation is somewhat self-limiting, as it applies to "assessments, tests, or investigations that are required for them to appropriately provide treatment". However, Article 2.2 also states that "members must also provide or arrange for appropriate follow-up care". This language (together with the wording in Part 5) has created considerable uncertainty and concern.

In many cases, the appropriate follow-up care is the patient seeing their primary care physician in a timely way. It appears that this advice to the patient, appropriately charted, should be sufficient to meet the Standard. If that is the CPSM's intention, it would be helpful to confirm this for members.

Appropriate advice to the patient in other situations might be to attend at an Emergency Department or Urgent Care should their symptoms worsen, or certain new symptoms develop. Again, if that is what the CPSM intends would meet the Standard, it would be helpful to spell this out.

Some patients seeking out episodic care, especially those who for one reason or another do not have a primary care physician, may be difficult to reach after the visit. They may have no fixed address, or their phone may be disconnected. They may be disinclined to accept advice or follow through with instructions. There may be linguistic, cultural or gender issues which add more challenges to "following up" on a visit. We presume it is the intention of the CPSM that the Standard only requires the member providing episodic care to provide appropriate advice and direction.

Article 2.3 states that members who limit the care or services they provide "must only do so in good faith". This wording has created confusion for our members, and we are unable to provide direction. It would be helpful for CPSM to provide some examples members could review and apply to their practice.

Article 2.4 appears to be tied to Article 2.3, by requiring the member to communicate the limitations of episodic care, presumably respecting the range of care that can be provided during the visit. Article 2.4 specifically appears to contemplate a patient being counselled to seek out care elsewhere. It appears to us that the member providing episodic care can satisfy this duty by communicating where and how the patient should attend for the care or services. If this is not the case, the CPSM should articulate more detail about this obligation.

Part 3. PRIMARY CARE PROVIDER

Part 3 has generated more comments and concerns than the rest of the Standard combined.

Article 3.1 requires every patient to be asked if they have a primary care provider. Our members report that many patients do not know if they have a primary care provider and, if they do, who that is. They may or may not know which clinic they go to. Some may not have attended on their primary care provider for years.

Our members advise us that this is not a rare occurrence. One member estimates that 80% of the patients visited on house calls cannot provide the name of their physician.

Physicians and their staff should not have to play "20 questions" to determine which of the more than 1400 family physicians in Manitoba provides primary care.

Accordingly, we propose Article 3.1 be redrafted as follows:

Patients must be asked if they have a primary care provider who they currently see for care and, if the patient is able to provide a name and clinic, that name and clinic must be recorded on the patient's record.

Article 3.2 obligates the member providing episodic care to provide a “copy or summary” of the clinical encounter, including copies of ordered tests, to be sent to the primary care provider.

This provision has provoked many comments to us, which we expect are reflected in the submissions to the CPSM. Many of the concerns are expressed by members providing episodic care, for a range of reasons. We have also heard from primary care physicians concerned about their obligations when receiving these copies or summaries for their patients.

The concerns raised by members providing episodic care can be grouped into two main areas: concern about the administrative burden if every patient’s summary must be sent, and concern that that some patients will be less likely to seek out care if they are worried their primary care physician will be provided with details of the visit (or even notice that the visit took place). These concerns relate directly to patient care.

We believe there can be adjustments to Article 3.2 which would not impact (and would in fact enhance) patient care.

The obligation to send a summary or copy for every visit every time a primary care physician is identified is a major administrative burden. Either there will be significant staffing costs, or the member practicing in a walk-in clinic will see fewer patients if they prepare and send the documents themselves. There may be direct costs in sending faxes using an EMR system; there will certainly be costs in copying documents if they are faxed manually. Some clinics may not have space to house required additional staff.

Patients attend for episodic care because they want access to medical services. Our members have told us in no uncertain terms that Article 3.2 will restrict the availability of episodic care. Fewer physicians will provide episodic care, and those who do will be able to see fewer patients.

Doctors Manitoba accepts and respects the CPSM’s role to protect patient care and safety. However, we submit that Article 3.2 as proposed adds a substantial burden which will affect access to medical services without enhancing patient care and safety. We believe this could result in delayed or missed care which will result in more serious conditions and greater interventions.

The primary care physician would likely gain little from receiving a summary for a patient attending upon episodic care for treatment for a sinus infection, bladder infection, or a rash. On the other hand, if a patient presents at episodic care for a sudden serious headache, and is directed to go to the Emergency Department, the primary care physician certainly would want to know this information.

Many episodic care providers will tell you that providing meaningful information to primary care physicians is already their usual practice. The obligation to report should be whenever it is reasonable for the member providing episodic care to believe the information would be helpful for the primary care physician receiving the summary.

At the same time, some of our members with busy primary care practices have expressed concern about the volume of episodic clinical encounter copies or summaries they will receive, and any imposed obligation to review and file anything received. One member described the prospect of a “fax flurry” every Monday as summaries of weekend walk-in clinic visits are received.

Even if it is not obligatory to review these records, many members will still take it upon themselves to do so. While some may, where appropriate, follow up with their patients by a virtual or in-person visit, others will simply review the material without any compensation at all.

We have reviewed the Standard of Practice on Good Medical Care, which reads in part as follows:

2. Follow-up to Diagnosis and Test Results

2.2. A registrant who orders a diagnostic test or makes a referral to another health care professional must have a system in place to review the test results and the results of referrals to other health care professionals and have reasonable arrangements in place to follow-up with the patient when necessary.

2.3. A registrant who orders a diagnostic test and directs a copy of the results to another registrant remains responsible for any follow-up care required, unless the registrant to whom a copy of the results is directed has agreed to accept responsibility for the patient's follow-up care.

Accordingly, unless the primary care physician agrees to accept responsibility for the patient's follow-up care, the member providing episodic care who orders the test has the responsibility to follow up. We presume that this Standard does not change this responsibility, but it would be helpful for primary care physicians for the CPSM to confirm this.

As well, defining the obligation to forward summaries to those which would be helpful for the primary care physician, as discussed above, would also be helpful.

Some members providing episodic care have also raised concerns about patients who may not want their primary care physician to know details about, or even the fact of, their visit to a different physician. A youth questioning their sexual or gender identity may be afraid to attend at a clinic serving the 2SLGBTQ+ community because they are concerned their family physician will receive information and share it with their parents. A patient may not want their visit to a clinic to discuss birth control to be known to their primary care physician. A woman seeking a therapeutic abortion may know her physician's beliefs and worry that it will impair their ongoing relationship. Some patients may want to receive a "second opinion" and be concerned it will be seen by their primary care physician as a lack of confidence or trust. In all of these circumstances, patients may delay care or not seek care at all.

We acknowledge that Article 3.2 says that consent to provide the summary to the primary care physician may not being granted. However, the wording seems to indicate that the patient must initiate the withholding of consent. How intentional can a physician or clinic be in making patients aware they can withhold consent? Can a physician or clinic post a sign or even address this on their website where patients may seek out information? Can the presumption of consent to have their visit summary be reversed?

Given all of this, we recommend that Article 3.2 be amended to read as follows:

"The clinic must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider if identified by the patient, where:

- *the patient consents, and*
- *it is reasonable to expect the information in the copy or summary will be useful to the primary care provider for the ongoing care of the patient."*

Part 4. SUPPORTING PATIENTS

We believe the intent to provide information to patients in Article 4.1 is appropriate. However, the wording is somewhat unclear and could be improved.

First, the episodic care physician's obligation to use their judgment to advise patients arises only "if primary care providers are present in the community." Does that mean available at usual office hours, or available at the time of the visit? What is the definition of the "community" – is it within a town or city? A patient in Winnipeg without access to a car or limitation issues may find it more difficult to travel to a primary care provider than another patient may find it to travel between cities. A patient outside of Winnipeg without access to a car or transit may have no means of attending a clinic they cannot walk to.

If it is "appropriate" to have the discussion, the CPSM should give more direction as to what this advice should be. If there are certain statements the CPSM believes should be made, this should be made clear.

Article 4.2 is presumed to apply to primary care physicians to respect their patients' choice to seek out episodic care.

Part 5. CONTINUITY OF CARE AND/OR FOLLOW-UP CARE

Part 5 has also generated many comments from members.

We believe the obligations in Article 5.1 are intended to be consistent with Part 2 of the Standard of Practice on Good Medical Care we have referred to above.

The challenge is understanding how long this obligation is intended to continue. For example, a patient with a chronic condition may attend at a walk-in clinic to deal with particular symptoms. The member providing episodic care may provide useful medical service, including providing treatment, ruling out diagnoses, or writing a prescription. Further, it is understood that if the member providing episodic care orders tests, the member must follow up.

But how much further does the obligation go? If a patient with a chronic condition seeks relief of their symptoms, why would the patient not be counselled in most cases to return to their primary care physician for follow up? Does a member providing episodic care have a presumed duty to see the patient again? Has the CPSM considered the views of Manitoba Health when it comes to chronic care tariffs which are claimed by the primary care physician providing care to the patient?

All of this would seem to be directly contradictory to the episodic care provider's duty to provide a summary to the primary care provider, and the duty to counsel each patient on the limitations of episodic care.

We understand there may be additional challenges for members providing house calls, based on the way Manitoba Health interprets the Rules of Application. The "Special Call" tariffs in the Physician's Manual require each visit to be patient generated and set out several conditions. Manitoba Health takes the position that a follow up visit to discuss test results is not claimable under the Special Call tariffs. If physicians are required to provide follow up care in the patient's home, only the regular visit tariffs (i.e. 8509/8529) are available to meet the Standard, and it is unlikely physicians will choose to provide this service. Again, patients requesting a house call are doing so because it may be the only care they believe they can access, short of being transported in an ambulance to an Emergency Department or Urgent Care. We are very concerned that the application of Part 5 will end the practice of house calls in Manitoba, which is a limited but part of access to health care for Manitobans.

As noted in the Standard, there is already a Standard of Practice for Good Medical Care. The current wording appears to create a conflict and add uncertainty to the Standard. Accordingly, we recommend that Part 5 be removed from the Standard. In the alternative, those relevant sections of the Standard of Practice for Good Medical Care could be set out in Part 5.

Part 6. PRESCRIBING

The risk of patients being overprescribed and potentially dangerous drugs making their way to the street is well understood, and Doctors Manitoba is generally in agreement with Article 6.

However, a concern has been raised that it will be effectively impossible for a physician making a house call to access DPIN or employ the other alternatives in Article 6.1. If the CPSM can provide more direction and advice on what would constitute "reasonable efforts" to review the patient's current and past medications it would be very helpful. These efforts should vary based on the practice situation given the benefit of care being provided to housebound patients or those in remote communities.

It is agreed that the provisions of Article 6.2 for the prescription of certain medications will always require a higher standard or care, whatever the practice setting.

Our members note that all prescriptions must be filled by pharmacists – the health care professionals who are in the best position to review patients' current and past medications based on DPIN (together with all of the monitoring available) and flag any potential concerns respecting potential drug interactions. As one member stated, "if the physician can't rely on the pharmacist to provide feedback when issues arise, then why not have pharmacy technicians run the pharmacies?"

Part 7. VIRTUAL EPISODIC AND "WALK-IN" CARE

Doctors Manitoba agrees that that the Standard of Practice for Virtual Medicine should apply to episodic care.

However, it is important to consider that the reasons why a patient would seek out virtual care are aligned with the reasons they would seek out episodic care – including issues of access through geography, mobility, or cost.

We would expect the CPSM to consider the circumstances of those patients who seek out virtual episodic care in determining the standard of care of the physician.

If a patient without a primary care physician determines they require virtual episodic care, they should have the opportunity to receive care. What is the alternative? Either the patient will go without care, or they will be more likely attend upon an emergency department or urgent care clinic.

Accordingly, we urge the CPSM to be very flexible in its interpretation of both this Standard and the Standard of Practice for Virtual Medicine, for those physicians who serve patients with challenges accessing in-person medical care.

Again, Doctors Manitoba takes the position that virtual medicine and episodic care are not “second class” options. Members providing care are bound to a high standard of care but must be allowed to use their professional judgment, especially when assisting individuals who have challenges accessing medical care.

Other Health Care Professionals

Episodic care can be provided by Nurse Practitioners working independently. We understand there are no similar obligations placed upon Nurse Practitioners. Why should Nurse Practitioners not provide similar counselling about the benefits of primary care, have the same duties of continuity of care and follow-up of care, and provide a summary of each visit to each patient’s primary care provider?

Episodic care can now also be provided by pharmacists for certain limited conditions. We understand there are no similar obligations placed upon pharmacists. Why should they not provide similar counselling about the benefits of primary care, have the same duties of continuity of care and follow up of care, and provide a summary of each visit to each patient’s primary care provider?

Has CPSM approached the respective colleges, to ensure there is at least an equivalent standard being met by these professionals? If other health care professionals have been entrusted with an expanded scope of practice, why should Manitoba patients not expect the same standards to apply to them?

Conclusion

In conclusion, Doctors Manitoba acknowledges the reliance of Manitobans on episodic care. We recognize the role of the CPSM in protecting the public and clarifying the duties of our members.

We believe the few changes we have proposed to the Standard are reasonable. These changes would spare our members substantial administrative burdens, and provide greater comfort to patients, without impairing patient safety.

We believe the other items we have raised can, and should, be addressed by the CPSM before the Standard comes into force, to provide greater clarity and more information to members.

We would be happy to discuss our submission with you at your convenience.

Sincerely,

Andrew Swan

ANDREW SWAN
General Counsel

AS/jb

cc: Ms. Theresa Oswald
Dr. Kristjan Thompson

CMPA.ACPM
Empowering better healthcare
Pour l'avancement des soins de santé

April 21, 2022

Via email to:
CPSMconsultation@cpsm.mb.ca

Dr. Anna M. Ziomek
Registrar/CEO
College of Physicians & Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg, MB R3J 3T7

Dear Dr. Ziomek:

Re: Draft Standard of Practice on Episodic, House Calls, & Walk-in Primary Care

Thank you for inviting the Canadian Medical Protective Association (CMPA) to provide feedback on the College's draft Standard of Practice on Episodic, House Calls, & Walk-in Primary Care.

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 105,000 physician members, the CMPA collaborates, advocates and effects positive change on important healthcare and medico-legal issues.

The CMPA appreciates the draft Standard is intended to address breakdowns in continuity of care. We have identified the following aspects of the draft Standard that could be improved. In particular, our comments will focus on:

- Clarifying the expectations for physicians who limit their care or services due to their episodic nature; and
- Encouraging the College to establish better primary care linkages.

Limiting Care or Services

It would be useful if the College provided further clarification – perhaps in the form of examples – in relation to the requirement in section 2.3 that "Members who limit the care or services they provide due to the episodic nature of their care must only do so in good faith."

In this regard, it may be helpful for the draft Standard to include a similar explanation to that found in the Background document for the draft Standard, which states that episodic care includes such services as sports and injury clinics, on-campus clinics, and public health clinics that offer medical care on a walk-in or appointment basis.

Primary Care Linkages

The College may wish to consider creating better primary care linkages to assist physicians in helping patients find primary care providers and promote continuity of care.

As the College has recognized, there are significant impediments for certain patient populations in accessing continuous primary care. Episodic care and walk-in clinics are therefore a reality of our healthcare system. Indeed, many patients rely upon walk-in clinics as their main source of primary care. It is for this reason that the CMPA published the article, *Walk-in clinics: Unique challenges to quality of care, medical-legal risk*, to alert physicians to the challenges and risks when working in these settings.

It would be helpful if the College provided some resources for physicians and patients to assist them in linking patients to primary care providers. For example, we are aware that the College of Physicians and Surgeons of Ontario's Physician and Public Advisory Services is available to provide some general tips and advice to patients seeking a primary care provider. With the Citizen Advisory Group, the CPSO has also co-published a *Guide for Patients and Caregivers on Continuity of Care*, which includes a section on walk-in clinics and provides recommendations to patients for finding a primary care provider.

We hope these comments will be helpful to the College in finalizing the draft Standard.

Yours sincerely,

Lisa Calder, MD, MSc, FRCPC
Chief Executive Officer

LAC/ml

cc. Dr. M. Cohen

College of Pharmacists of Manitoba

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April 29th, 2022

Dr. Anna M. Ziomek
Registrar/CEO
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1000 – 1661 Portage Avenue
Winnipeg MB R3J 3T7

Dear Dr. Ziomek,

Thank you for the opportunity to provide feedback on the draft CPSM Standard of Practice on Episodic, House Calls, and Walk-in Primary Care. The College of Pharmacists of Manitoba (CPhM) respectfully submits the following for your consideration.

Section 2.3 of the standard states "Members who limit the care or services they provide due to the episodic nature of their care must only do so in good faith". This may require more context or guidance. What sort of services would a prescriber for episodic care limit? Can they be limited in all circumstances (such as a clinic policy), or should the prescriber's professional judgment and the patient's situation be taken into consideration? The use of professional judgement and a wholistic consideration of patient needs are both important aspects of good care.

Section 6.1 of the Standard suggests consulting with a pharmacist to obtain DPIN as appropriate. When consulting with a pharmacist, CPhM suggests consulting with a pharmacist directly involved in the patient's care whenever possible. DPIN is not a complete and accurate source of information on patient history, especially if no internet access is available to the prescriber.

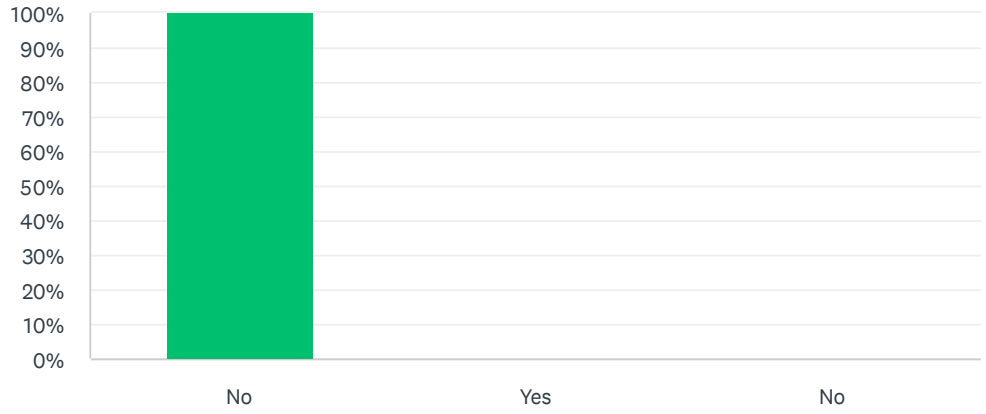
Part 7 of the standard states the Standard of Practice for Virtual Medicine is applicable to virtual episodic and walk-in care, "in so far as possible". Most instances of episodic care are only provided once. If this episodic care is provided virtually, would this contradict the Standard of Practice for Virtual Medicine? This section might benefit from more clarification on how the standard of virtual care can be met in a walk-in/episodic care setting to ensure providers of episodic care understand their obligations under both standards.

Kind regards on behalf of the College of Pharmacists of Manitoba,

Chris Louizos, Assistant Registrar-Field Operations
Kevin Chaboyer, Quality Assurance and Field Officer
Meret Shaker, Practice Consultant, Legislation and Policy

Q1 Are you a registrant (member) of The College of Physicians and Surgeons of Manitoba?

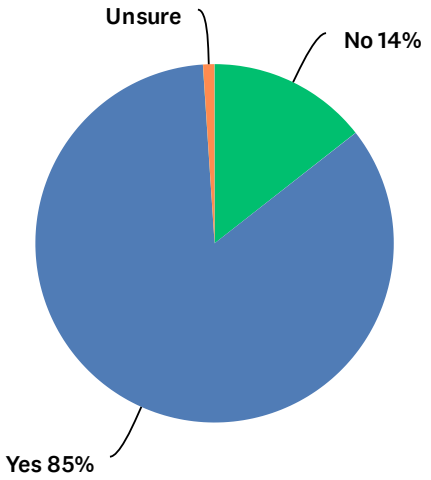
Answered: 97 Skipped: 0



ANSWER CHOICES	RESPONSES	
No	100.00%	97
Yes	0.00%	0
No	0.00%	0
TOTAL		97

Q2 In the past two years, have you, or a family member in your household, seen a doctor at a walk-in clinic, via an in-person house call, or another form of episodic care?

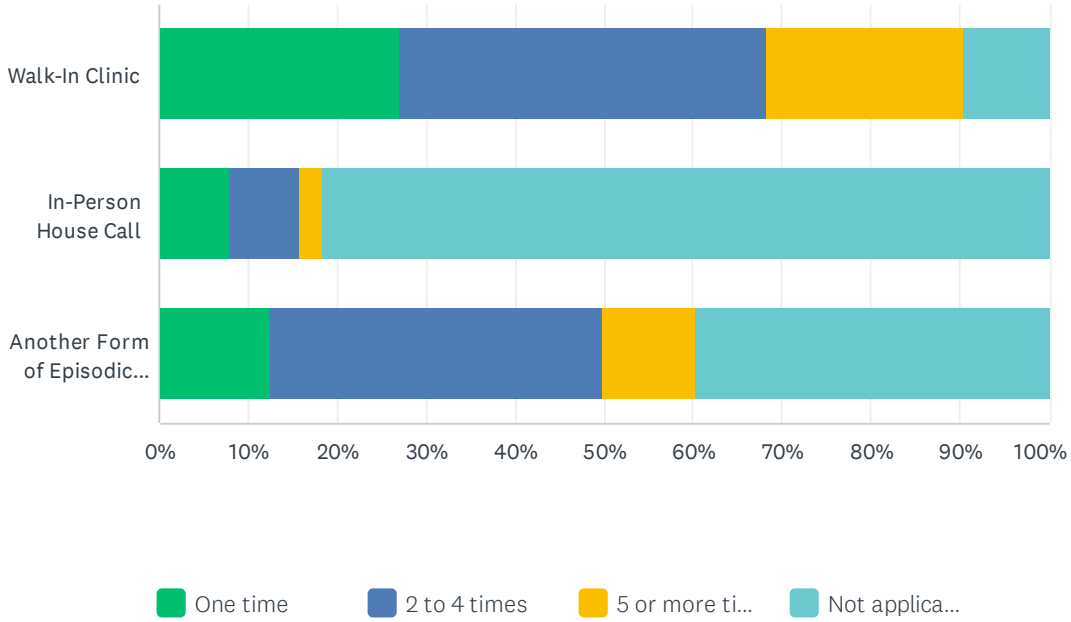
Answered: 97 Skipped: 0



ANSWER CHOICES	RESPONSES	
No 14%	14%	14
Yes 85%	85%	82
Yes, 2-4 times 1%	0%	0
Yes, 5 or more times	0%	0
Unsure	1%	1
TOTAL		97

Q3 In the past two years, how many times have you, or a family member in your household, accessed care at a walk-in clinic, house call, or another form of episodic care (including sports or illness clinics such as the Pan Am Clinic, Minor Illness and Injury Clinic, on-campus clinics, etc.)?

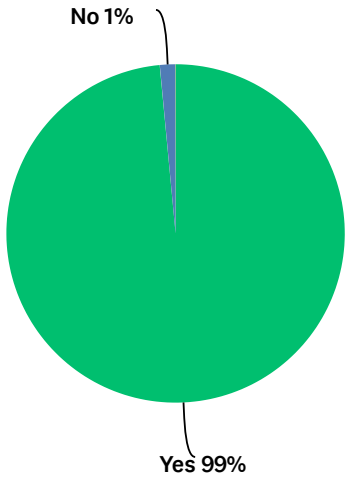
Answered: 67 Skipped: 30



	ONE TIME	2 TO 4 TIMES	5 OR MORE TIMES	NOT APPLICABLE	TOTAL
Walk-In Clinic	27% 17	41% 26	22% 14	10% 6	63
In-Person House Call	8% 3	8% 3	3% 1	82% 31	38
Another Form of Episodic Care	13% 6	38% 18	10% 5	40% 19	48

Q4 Do you have a family doctor?

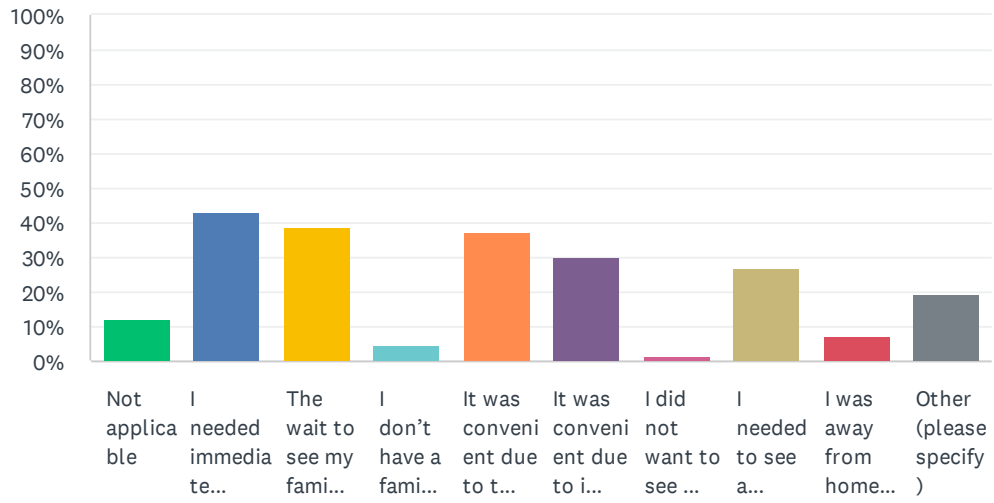
Answered: 67 Skipped: 30



ANSWER CHOICES	RESPONSES	
Yes 99%	99%	66
No 1%	1%	1
Unsure	0%	0
TOTAL		67

Q5 Why did you visit a walk-in clinic? Select all that apply.

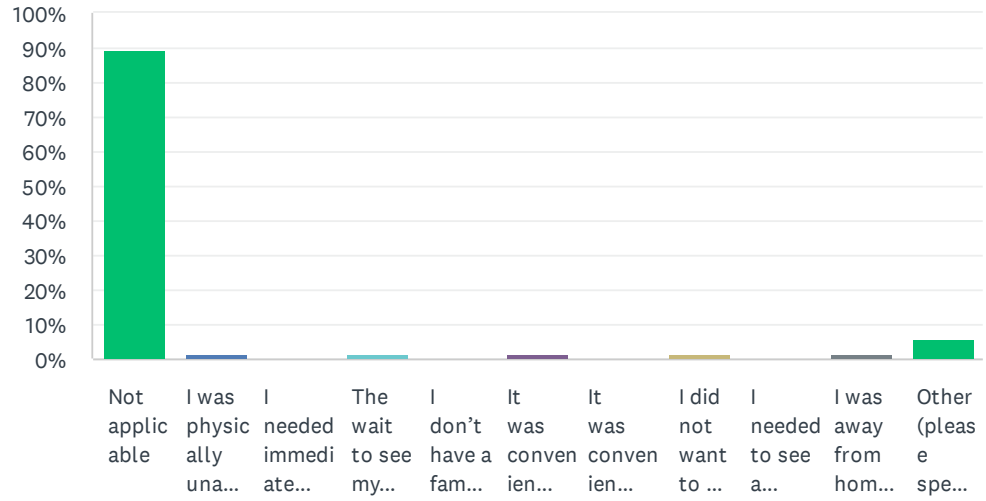
Answered: 67 Skipped: 30



ANSWER CHOICES	RESPONSES	
Not applicable	12%	8
I needed immediate medical care	43%	29
The wait to see my family doctor was too long	39%	26
I don't have a family doctor	4%	3
It was convenient due to time or availability	37%	25
It was convenient due to its location	30%	20
I did not want to see my family doctor about this concern	1%	1
I needed to see a doctor in person and my family doctor could not accommodate me	27%	18
I was away from home and needed to see a doctor	7%	5
Other (please specify)	19%	13
Total Respondents: 67		

Q6 Why did you seek a house call? Select all that apply.

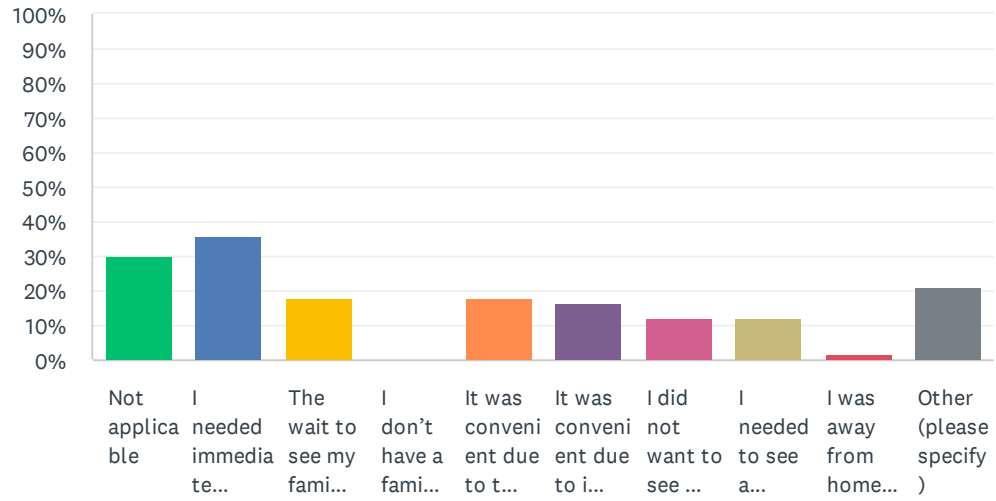
Answered: 67 Skipped: 30



ANSWER CHOICES	RESPONSES	
Not applicable	89.55%	60
I was physically unable to get to a clinc	1.49%	1
I needed immediate medical care	0.00%	0
The wait to see my family doctor was too long	1.49%	1
I don’t have a family doctor	0.00%	0
It was convenient due to time or availability	1.49%	1
It was convenient due to its location	0.00%	0
I did not want to see my family doctor about this concern	1.49%	1
I needed to see a doctor in person and my physician could not accommodate me	0.00%	0
I was away from home and needed to see a doctor	1.49%	1
Other (please specify)	5.97%	4
Total Respondents: 67		

Q7 Why did you seek another form of episodic care (including sports or illness clinics such as the Pan Am Clinic, Minor Illness and Injury Clinic, on-campus clinics)? Select all that apply.

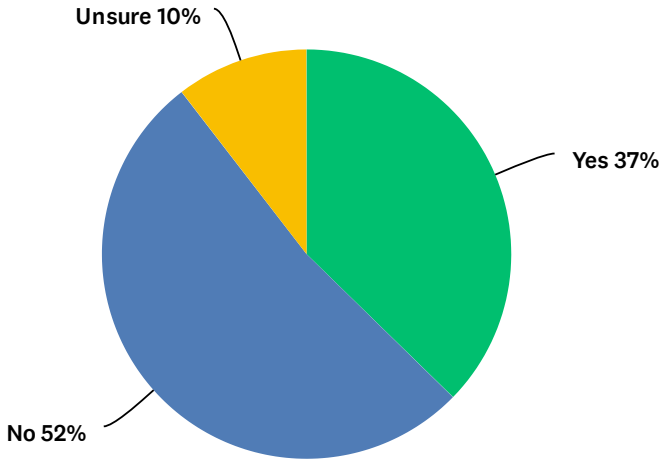
Answered: 67 Skipped: 30



ANSWER CHOICES	RESPONSES	
Not applicable	29.85%	20
I needed immediate medical care	35.82%	24
The wait to see my family doctor was too long	17.91%	12
I don't have a family doctor	0.00%	0
It was convenient due to time or availability	17.91%	12
It was convenient due to its location	16.42%	11
I did not want to see my family doctor about this concern	11.94%	8
I needed to see a doctor in person and my physician could not accommodate me	11.94%	8
I was away from home and needed to see a doctor	1.49%	1
Other (please specify)	20.90%	14
Total Respondents: 67		

Q8 Did the doctor at the walk-in or house call ask you about your family doctor? (If you had multiple visits, think of your most recent visit.)

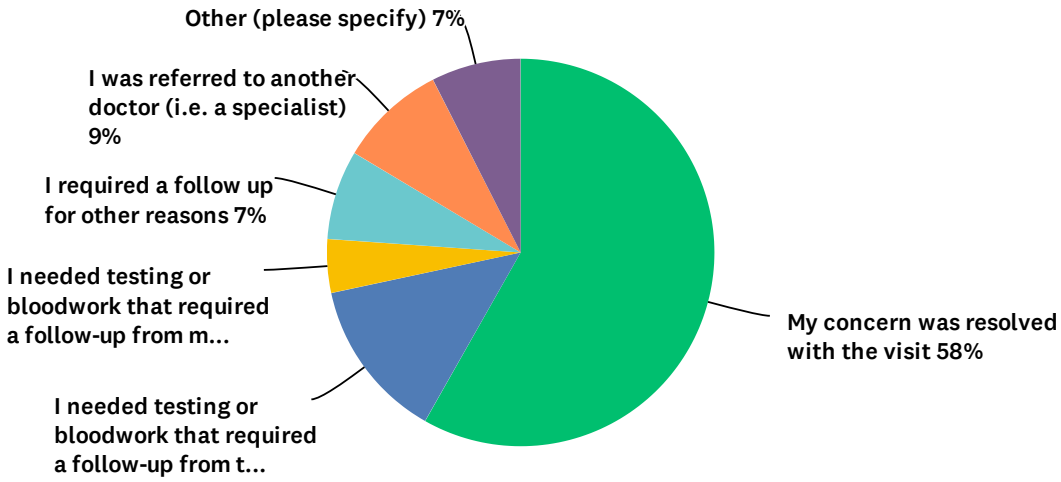
Answered: 67 Skipped: 30



ANSWER CHOICES	RESPONSES	
Yes 37%	37%	25
No 52%	52%	35
Unsure 10%	10%	7
TOTAL		67

Q9 What was the outcome of your visit? (If you had multiple visits, think of your most recent visit.)

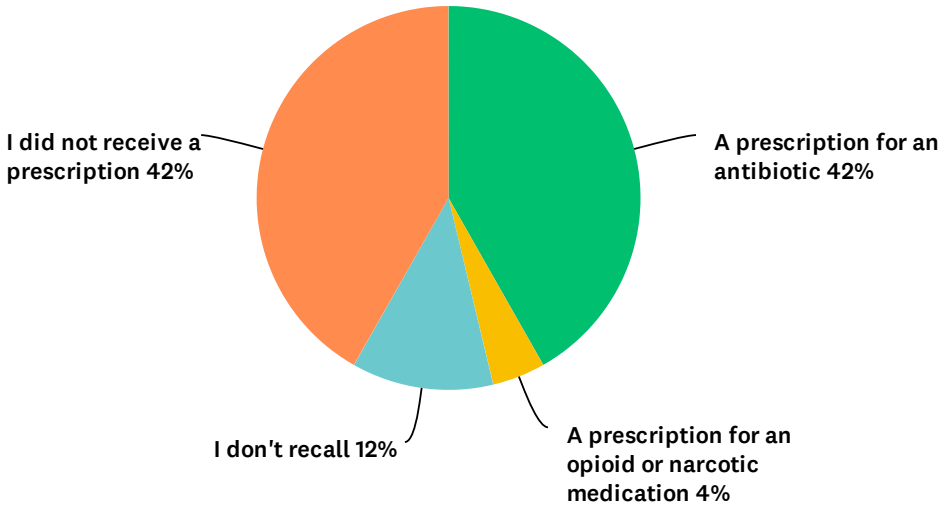
Answered: 67 Skipped: 30



ANSWER CHOICES	RESPONSES	
My concern was resolved with the visit 58%	58%	39
I needed testing or bloodwork that required a follow-up from the same clinic 13%	13%	9
I needed testing or bloodwork that required a follow-up from my family doctor 4%	4%	3
I required a follow up for other reasons 7%	7%	5
I was referred to another doctor (i.e. a specialist) 9%	9%	6
Other (please specify) 7%	7%	5
TOTAL		67

Q10 Did you receive any of the following:

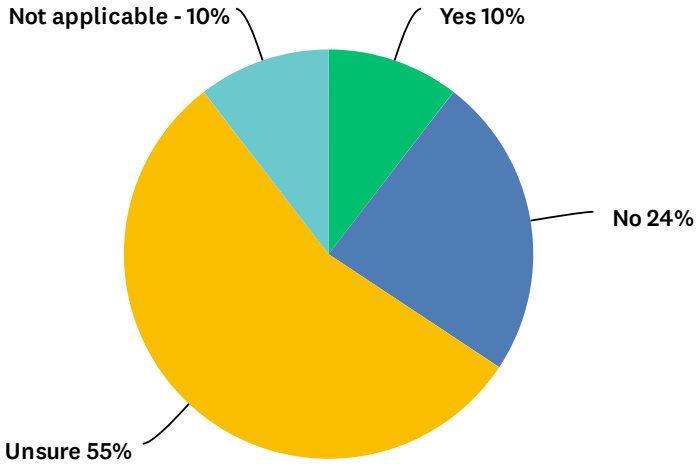
Answered: 67 Skipped: 30



ANSWER CHOICES	RESPONSES	
A prescription for an antibiotic 42%	42%	28
A prescription for a sedative medication to relax you	0%	0
A prescription for an opioid or narcotic medication 4%	4%	3
I don't recall 12%	12%	8
I did not receive a prescription 42%	42%	28
TOTAL		67

Q11 After your visit, did the walk-in or house call doctor communicate with your family doctor?

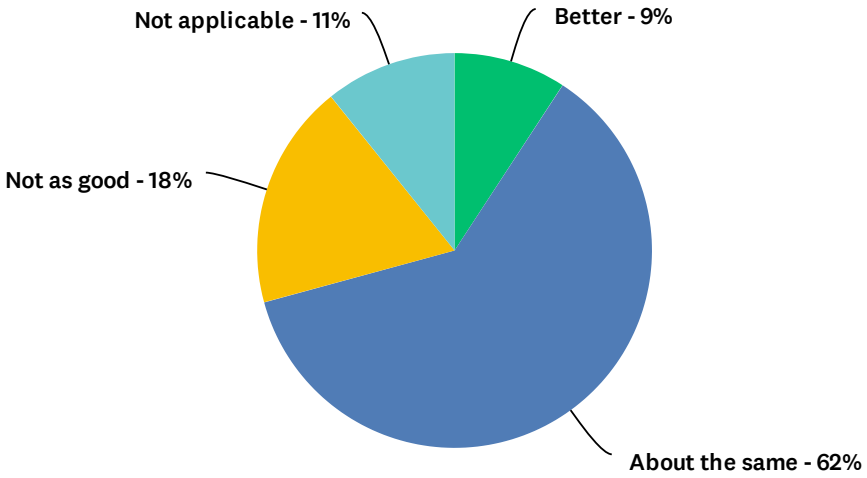
Answered: 67 Skipped: 30



ANSWER CHOICES	RESPONSES	
Yes 10%	10%	7
No 24%	24%	16
Unsure 55%	55%	37
Not applicable - 10%	10%	7
TOTAL		67

Q12 Compared to your family doctor, how would you rate the care you received from the walk-in, house call, or episodic care doctor?

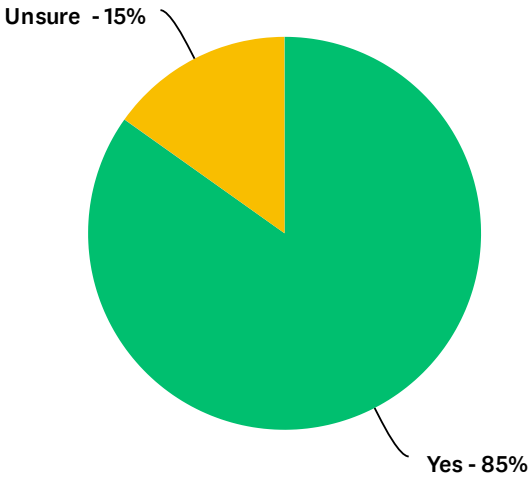
Answered: 65 Skipped: 32



ANSWER CHOICES	RESPONSES	
Better - 9%	9%	6
About the same - 62%	62%	40
Not as good - 18%	18%	12
Not applicable - 11%	11%	7
TOTAL		65

Q13 Do you believe patients would benefit from increased communication between their family doctor and walk-in, house call or episodic care doctor?

Answered: 66 Skipped: 31



ANSWER CHOICES	RESPONSES	
Yes - 85%	85%	56
No - 0%	0%	0
Unsure - 15%	15%	10
TOTAL		66

Individual Responses

Public Survey on Walk-In Medical Care, House Calls, and Episodic Care

Some of the questions from the online public survey included the opportunity to offer additional comments, or were optional, open-ended questions. These responses are included below:

Q. 5 - Why did you visit a walk-in clinic? Other (please specify)
My family physician's clinic did not offer COVID-19 testing so I went as a walk-in to the nearest clinic that did.
My husband is in assisted living and he was having issues with his feet. Blizzard was to arrive the nest day. I felt he needed to be seen by Dr. Or nurse practitioner.
It was the weekend
The doctor I was assigned from sitting on the wait list operates out of a walk-in. I might as well have not been assigned a “family doctor”
I believed Panama clinic offered the most expertise
minor illness and injury has appointments next day after business hours
My doctor retired and I did not get to meet and greet the new doctor after 6 months
My family physician's clinic did not offer COVID-19 testing so I went as a walk-in to the nearest clinic that did.
My husband is in assisted living and he was having issues with his feet. Blizzard was to arrive the nest day. I felt he needed to be seen by Dr. Or nurse practitioner.

Q. 6 - Why did you seek a house call? Other (please specify)
My neurologist needed to examine me ASAP, and I was home-bound due to disabilities and a broken leg at the time.
Clinic closed to public.
As my husband was in pain and the doctor I spoke to David take him to emergency he didn’t deal with this problem.
I never knew house calls existed.

Q. 7 - Why did you seek another form of episodic care (including sports or illness clinics such as the Pan Am Clinic, Minor Illness and Injury Clinic, on-campus clinics)? Other (please specify)
Needed hip surgery
Was not getting any help/further at walkin clinics
Family doctors don't know how to deal with sports injuries. They just order an x-ray and refer you to physio.
My doctor was away
I knew I had broken or torn something in my shoulder and I needed specialized care.
Preferred a doctor with an interest in sports medicine
I require monthly blood and urine testing for medication monitoring. Using Dynacare's home visit service is very convenient.
Believed pan am offered the expertise my dr would not have on a wrist injury and available immediate and convenient xray and treatment advise
Sports medicine Doctor at Pan Am
Previously seen by doctor who specializes in area of concern.
Specific back injury
I needed to see various specialists.
Virtual call about a specific problem
Pediatrician at Minor Illness

Q. 9 - What was the outcome of your visit? (If you had multiple visits, think of your most recent visit.) Other?
I went to Emergency in St. Pierre and followed-up with a local doctor (mine wasn't available)
My concern was resolved with the visit and then follow up with my regular doctor.
the last 4 apply
My concern was not resolved.

Q. 10 - Do you have any additional comments related to a prescription you received during your visit?
I was offered a prescription for Tylenol 3's every time I saw the walk-in which I declined each time.
Walk-in docs just give you a prescription and move on so they can bill more!
I saw a physician who would not discuss my pain issue with me stating that he ran an acute care clinic only and my problem was a chronic one. In reality the pain had been recent in the last two days.

I also asked my doctor about periodic male issues I had been experiencing. I was sent for blood work and a scrotal ultrasound, neither of which provided answers. I went to see Dr Mattialano, a urologist, and he blatantly told me there was nothing wrong with me and he couldn't help me. Prescribed Viagara after me adamantly saying I don't feel it's a long term solution.
The local drug store did not have my med and I went to another town's drug store and ordered it for the next day.
given a topical rub made with diclofenac
Altho dr asked about family dr name I I don't know why .He did not say the info would be forwarded to him or suggest I advise him myself of this visit or outcome or to explore followup
prescription for anti fungal ringworm cream
Sent me for an x-ray
The doctor did not seem well informed on the different medications
I received a prescription for a muscle relaxer
Prescription for a salve.

Q. 12 - Compared to your family doctor, how would you rate the care you received from the walk-in, house call, or episodic care doctor? *(Optional) What made your visit better, about the same, or not as good?)*

I was able to get an x-ray immediately
Family docs and walk-in docs are the same. It's just that walk-in docs care a little bit less and take even less time with you.
Person was not family Dr. But a nurse practitioner
I have an excellent family doctor but the walk in doctor's have been great too
None of the doctors I saw engaged me in an informed consent process. None of them made any attempt to communicate with me about the potential seriousness of my situation and what I should do if things got worse.
It was the same, because the walk in is literally the same as my family doctor. As assigned by the Province.
The emerg doctor was fine. The local follow-up doctor was all religion and home remedies (not my preferrence).
just not able to trust the understand the context as well as my doctor of twenty years can.
The dr had more expertise on the muscular wrist injury and X-rays were readily avail at Panam. It was convenient and I needed help immediately.
My family Doctor provided excellent care for 40 years
my medical concern was answered
My family doctor is aware of my medical history. I required a referral to a specialist, and other follow up. That, IMO, is best done by my family doctor.

I do not think of the care as better or worse than my GP. It was effective care when it was needed.
Just as bad.
Both family doctor and walk in doctor do not provide high quality medical care.
The dr. took the time to really listen. I had to have a look at my rash which was near my genital area and he had a woman come in the room the whole time. I appreciated that.
Visit better becuz wait time was reduced substantially.
Nurse practitioner. Thorough but I lacked confidence
I love having both options for different scenarios
Both doctors did their best but the family doctor knows the history unfortunately it takes two or three weeks to get an appointment which is good for regular visits but not good for necessary attention as the problem would only have got worse.
Other than long wait time at walk in
The doctor was very open about my condition and answered all my questions and didn't make me feel rushed.
My family doctor is excellent, but I had a broken arm and needed immediate care at Pan Am where they specialize in sports injury.
The walk-in was the same clinic as my family doctor, operating as a walk in on weekends. The doctor I saw was not my doctor.

Q. 13 - Do you believe patients would benefit from increased communication between their family doctor and walk-in, house call or episodic care doctor? (Optional) Why do you think patients would or would not benefit from more communication between both doctors?

Family doctor is aware if past issues if anything else arises from that illness seen by a Walk-in doctor.
In my case its been months of dealing with my issue. I have gone to many different places to get some answers and relief from my pain and have gotten nowhere. Better communication would be great so that the same things are not prescribed or same things to get same outcome, which has not solved my problems.
It's useless unless the patient encounter, diagnostics and prescriptions all get worked into the EMR. If the family doctor doesn't need to look at the information, it's also pointless. Continuity of care requires physicians to step up and provide care.
Yes, absolutely! Not all walk-in clinic doctors are poor communicators but many are because they don't know you and have no investment in your ongoing care.
Most of the time I would visit a walk in because my family doctors office is closed. In order not to visit and ER I feel it is better to go to a walk in but that means my family doctor does not necessarily know of the visit and therefore cannot follow up.
My family doctor is thorough but hard to see because she only works a couple days a week.

As my doctor is on the far side of the city and I have a clinic within a few minutes of walking, I would like to use it more, better communication would help my confidence with that.
Family doctors should be at the centre of a revamped health care system in Canada. They treat the whole person, and can find answers to specialist questions they don't know. The problem comes in when your familky doctor is constantly changed due to turnovers, retirements, etc. so their is no time to build a relationship.
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I think for continuity of care it is always important to have records sent to the primary care provider
I was started on a new medication by a walk in Doctor
would be helpful if both documented in the same electronic charting system to ensure primary care provider aware as they are the main coordinator of medical care
doctors need full information
I thought the file system is electronic and my family doctor is able to review all of the information. If not, the information should be communicated between the doctors.
Current health system should have shared information capabilities so that physicians/medical personnel can make better informed decisions
Patients should have all their medical records accessible for their own reviews, for information, and for corrections etc.
Then the family dr would have a more complete view of their patients and more medical information would be in one file / location.
It would be nice if all my medical problems would be recorded in one central spot.
There would be more accurate record of patient health issues.
Collaboration, two opinions, continuity of care
Family doc would have more, specific info
The walk in doctor was caring and conscientious but obviously didn't know the history. A group of doctors in an area would be a better solution where although you have one doctor named as 'yours' all doctors where considered as though they were yours and able to have an appointment in days instead of weeks.
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That way everyone is kept informed.
In Manitoba my doctor can access my records through the computer data base.

Q. 14 - Is there anything else you would like to add or share regarding your experience with walk-in visits, house calls or another form of episodic care in Manitoba?

I have learned to appreciate virtual appointments as somethings can be triaged that way.
I have always had good experiences with the walk-in clinics and the Minor Illness clinic's I have visited.
I wish my records were equally accessible anywhere in MB by any medical professional that I choose to see.
When an evident diagnosis is not evident, one basically has to plead to get answers. Its extremely frustrating and defeating. I often wish we had the option to pay for Healthcare because maybe then we could get some answers.
Ultimately I ended up seeing my family physician because the walk in physician referred me to a specialist and I regret going to the walk-in clinic to begin with (even though it was originally out of convenience that I went there)
Even with walk-ins, it's nearly impossible to find a physician open during evenings and weekends. If you need care at 9pm, you'll end up in the Urgent Care or ER just because it's the only place open.
Didn’t need to wait very long as it was getting late in the afternoon very few people in waiting room.
Brandon walk in clinics are excellent
I have had and continue to have excellent family physicians who could never get away with the lax standards of communication that many walk-in clinic physicians employ.
No
I didn't even know house calls were an option. Is that advertised to the public?
I think they are very necessary and more should be available. I am very fortunate to have a family physician, but all are not so lucky. This stops the visits to the ER and also makes a return visit for follow up much better
My phone appt's by my family doctor have occurred while I was at work and I could not speak privately which lead to an incorrect diagnosis and waste of money on a medication.
I used it for a suspected case of Shingles where immediate care can make a difference. To get that care without a day in an emergency room was great and it would have been hard to get into see my own doctor, at least on the weekend.
FOR A PERSON (SENIOR) LIKE ME WITH AN UNDIAGNOSED CHRONIC NEUROLOGICAL CONDITION REQUIRING CONSTANT MONITORING, HAVING ALTERNATIVES WHEN AN ISSUE SUDDENLY ARISES AND MY DOCTOR IS NOT AVAILABLE IS CRITICAL. I DO NOT LEAVE MY HOME EXCEPT FOR ESSENTIAL MEDICAL APPPOINTMENTS DUE TO COVID AND MY IMMUNOCOMPREOMISED STATUS.

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Minor Illness and Injury Clinic rocks my world. I can walk there from my house, get professional and thorough treatment and I can make an appointment online that I can go to after I'm done work or on the weekend. Things like ringworm from the rescue kitten really don't need missing work for. I also really really like walk in connected care, but I miss when it was quick care so you could book an appointment. The best part about wicc is that because I am a patient at an access centre they can look me up in accuro and have all my records. Between WICC and Minor Illness and Injury I will likely never go to a walk in again. I've found the care to be so much better at the above. Walk in clinics you are taking a gamble with your care.
Up until September 2021 I had no reason to visit a walk in clinic because my family Doctor of 40 years always was available for me
If communication was effective between PCP and episodic care, then the option of going to episodic care to address more urgent concerns/questions can be an asset to both PCP and the patient. I do not go to a walk-in if I can avoid it. The episodic care clinics offer quick access to some diagnostics e.g. xray, lab
My experience was Feb 2017, however, poor care led to life-threatening situation. I am concerned many people would not take steps I did to get care (I am a Registered Nurse). Please read synopsis. Feb 2017: gross rectal bleed; family MD away ill, no projected return date, office advised I attend walk-in clinic "right away" when I told them about rectal bleed Feb 2017: attended walk-in (Lakewood Clinic); MD said "you need a scope--see family MD." Explained situation; he ordered Esameprozole + return visit Returned 2 weeks later; and pain continued; still bleeding. Walk-in MD: "you need scope". Re-told him family MD away, no coverage for her, no return date predicted. He refused to order scope; was very clear I needed it ASAP March 2017: Went to SBH ED, knowing that was inappropriate, but seeing no other option. Explained situation to Resident, who brought Attending in to listen to my story; he directed Resident to place order for colonoscopy April 2017: colon cancer diagnosed May 2017: hemicolectomy performed I sincerely hope care is different now, however, perhaps this type of abdication of responsibility is contributing to ED crisis.

Yes. First: Some clinics have signs on their doors saying that if you are in pain do not come in. They assume everyone experiencing pain is an addict. There are many incurable chronic pain conditions (CRPS is the worst of many) and sudden flareups of pain need attention. Second: many clinic are not wheelchair accessible. And third point: some people live in communities where the only doctor is at a walk-in clinic. Because different doctors are there at different times, patients do not always see the same doctor. Prescriptions from the same clinic for the same patient have different doctor's names on them. Pharmacists assume that a patient is shopping around for doctors and refuse to fill prescriptions, and the innocent patient is blamed and accused.
My family doctor is also part of the walk-in clinic I attended. Having my file/medical history right there has continuity when my doctor is away.
Additional hours are necessary (evenings, weekends, holidays)
I believe that Manitoba health care should employ Physicians Assistants like they have in the United States. Our experience with Physicians Assistants in the US has been great. It alleviates wait time as well as provides assistance and more time for the physicians themselves. You really need to take a broader look at the current healthcare system as Band-Aid solutions are not working. Staff are overworked, underpaid and sometimes underappreciated. One does not need to create a new model, you can study those that are currently working in other countries and make changes/adaptations to their models so that it would work here. The Manitoba health care system really does need help.
I agree there are many gaps/issues/problems in Manitoba's medical system as a whole, in all levels of the system. Another thing we need to be cautious of - specialists can be too specialized which can hinder and miss the underlying issue the patient needs treated.
I have to wait 3-4 weeks for an in person appointment to see my doctor even when I have an urgent need to see her. Normal response from her office is to go to a walk-in. By following restrictions, haven't had the need to go to a walk-in. Don't have much confidence in walk-ins except for Minor Illness & Injury clinic which I have used in the past. Excellent care received there. I would certainly like to have an option for a house call when I am sick and can't drag myself to an appointment
No further comments.
It would be nice if doctors in this backwater were able and/or allowed to start practicing 21st century medicine. Limiting the influence of the U of M -- third tier med-school that it is -- would also be a good thing. Additionally, doctors should recognize that there are legitimate and proven alternatives to what they offer that are often complimentary and/or better than what they have to offer and they should willingly encourage them to be fully integrated into our health care system instead of constantly wanting to keep the whole pie to themselves. To a large extent our health care system has, in fact, become a sickness care system where doctors much prefer to provide "managed care" by spending as little time as possible with a patient and merely treating symptoms -- essentially becoming partners with Big Pharma -- rather than spending the time necessary to actually find and treat the cause of what's ailing a patient. Yes, that approach can be more expensive in the near term, but when looked at in the long term it's the cheaper route to pursue . . . and the patient -- the part of the equation that's supposed to be of greatest import -- will tend to be happier and healthier.

Seems like the best care for everyone would be with a family doctor but I hear so many people don't have one. The system needs to be updated. Kudos for doing this survey
Doctors need to improve their communication skills and listen to their patients. Patients concerns are often over looked and not heard by doctors. Canadian doctors have to do better for our population. Other medical professionals including doctors in other countries offer much better medical care and are paid more modestly.
My regular dr is retired 2 days ago and I was relieved he had a new dr take over his practise. I had my meet and greet and the new dr. told me his patients don't go to walk-in clinics so that sounds very positive to me.
I am very satisfied for the care I received.
Waiting over 6 months for a physical is unacceptable. I may be dead before I see the doctor
Wait time was extremely long
I attended Wpg Minor Illness clinic on Corydon on 2 occasions for ear infections. I was able to schedule appt at convenient time & received prompt service - no waiting.
We need more family docs
hire more nps
It's so comforting to a new parent to know they can access different options for different times AND avoid the ER. We have a fantastic family doc but he's not available every day and the minor illness clinic has a pediatrician. I also work for home care and the value of a house call doctor is immeasurable. I have dozens of clients who cannot leave their homes without a stretcher. We need all of these services and more!
House calls would be appreciated to couples like us who are nearly 80 and aging in place. I look after my husband who is hearing and sight impaired and is in chronic pain, had cancer radiation etc., but taking him to visits is getting really difficult some days as he's unsteady and I have to get a third person to help. Phone calls from doctors are a good idea but as my husband even with hearing aids doesn't quite hear, have you ever tried explaining some one else's headache to a doctor on the phone, I can only explain my pain!
Appreciate being able to interact with a health care provider via telephone.
In today's day and age I find it unbelievable the the various doctors and dentists treating a patient don't have a centralized database to access that patient's records. If need be, a consent form could be signed by the patient. This, in my opinion, would make it easier for different doctors to have the full picture as to what a patient's medical issues are and reduce the need for redundant records being kept.
I really liked the doctor at the walk-in and wished he could be my family physician.
Pan Am was fast and efficient for the initial treatment and every follow up. The only issue I had was getting documentation done in a timely manner for my short term disability claim for work. They simply don't have the time to do this. My wellbeing is still suffering impacts from this.

Individual Responses

Public Survey on Walk-In Medical Care, House Calls, and Episodic Care

Some of the questions from the online public survey included the opportunity to offer additional comments, or were optional, open-ended questions. These responses are included below:

Q. 5 - Why did you visit a walk-in clinic? Other (please specify)
My family physician's clinic did not offer COVID-19 testing so I went as a walk-in to the nearest clinic that did.
My husband is in assisted living and he was having issues with his feet. Blizzard was to arrive the nest day. I felt he needed to be seen by Dr. Or nurse practitioner.
It was the weekend
The doctor I was assigned from sitting on the wait list operates out of a walk-in. I might as well have not been assigned a “family doctor”
I believed Panama clinic offered the most expertise
minor illness and injury has appointments next day after business hours
My doctor retired and I did not get to meet and greet the new doctor after 6 months
My family physician's clinic did not offer COVID-19 testing so I went as a walk-in to the nearest clinic that did.

Q. 6 - Why did you seek a house call? Other (please specify)
My neurologist needed to examine me ASAP, and I was home-bound due to disabilities and a broken leg at the time.
Clinic closed to public.
As my husband was in pain and the doctor I spoke to David take him to emergency he didn’t deal with this problem.
I never knew house calls existed.

Q. 7 - Why did you seek another form of episodic care (including sports or illness clinics such as the Pan Am Clinic, Minor Illness and Injury Clinic, on-campus clinics)? Other (please specify)
Needed hip surgery
Was not getting any help/further at walkin clinics
Family doctors don't know how to deal with sports injuries. They just order an x-ray and refer you to physio.
My doctor was away
I knew I had broken or torn something in my shoulder and I needed specialized care.
Preferred a doctor with an interest in sports medicine
I require monthly blood and urine testing for medication monitoring. Using Dynacare's home visit service is very convenient.
Believed pan am offered the expertise my dr would not have on a wrist injury and available immediate and convenient xray and treatment advise
Sports medicine Doctor at Pan Am
Previously seen by doctor who specializes in area of concern.
Specific back injury
I needed to see various specialists.
Virtual call about a specific problem
Pediatrician at Minor Illness

Q. 9 - What was the outcome of your visit? (If you had multiple visits, think of your most recent visit.) Other?
I went to Emergency in St. Pierre and followed-up with a local doctor (mine wasn't available)
My concern was resolved with the visit and then follow up with my regular doctor.
the last 4 apply
My concern was not resolved.

Q. 10 - Do you have any additional comments related to a prescription you received during your visit?
I was offered a prescription for Tylenol 3's every time I saw the walk-in which I declined each time.
Walk-in docs just give you a prescription and move on so they can bill more!
I saw a physician who would not discuss my pain issue with me stating that he ran an acute care clinic only and my problem was a chronic one. In reality the pain had been recent in the last two days.

I also asked my doctor about periodic male issues I had been experiencing. I was sent for blood work and a scrotal ultrasound, neither of which provided answers. I went to see [redacted], a urologist, and he blatantly told me there was nothing wrong with me and he couldn't help me. Prescribed Viagara after me adamantly saying I don't feel it's a long term solution.
The local drug store did not have my med and I went to another town's drug store and ordered it for the next day.
given a topical rub made with diclofenac
Altho dr asked about family dr name I I don't know why .He did not say the info would be forwarded to him or suggest I advise him myself of this visit or outcome or to explore followup
prescription for anti fungal ringworm cream
Sent me for an x-ray
The doctor did not seem well informed on the different medications
I received a prescription for a muscle relaxer
Prescription for a salve.

Q. 12 - Compared to your family doctor, how would you rate the care you received from the walk-in, house call, or episodic care doctor? *(Optional) What made your visit better, about the same, or not as good?)*

I was able to get an x-ray immediately
Family docs and walk-in docs are the same. It's just that walk-in docs care a little bit less and take even less time with you.
Person was not family Dr. But a nurse practitioner
I have an excellent family doctor but the walk in doctor's have been great too
None of the doctors I saw engaged me in an informed consent process. None of them made any attempt to communicate with me about the potential seriousness of my situation and what I should do if things got worse.
It was the same, because the walk in is literally the same as my family doctor. As assigned by the Province.
The emerg doctor was fine. The local follow-up doctor was all religion and home remedies (not my preferrence).
just not able to trust the understand the context as well as my doctor of twenty years can.
The dr had more expertise on the muscular wrist injury and X-rays were readily avail at Panam. It was convenient and I needed help immediately.
My family Doctor provided excellent care for 40 years
my medical concern was answered
My family doctor is aware of my medical history. I required a referral to a specialist, and other follow up. That, IMO, is best done by my family doctor.

I do not think of the care as better or worse than my GP. It was effective care when it was needed.
Just as bad.
Both family doctor and walk in doctor do not provide high quality medical care.
The dr. took the time to really listen. I had to have a look at my rash which was near my genital area and he had a woman come in the room the whole time. I appreciated that.
Visit better becuz wait time was reduced substantially.
Nurse practitioner. Thorough but I lacked confidence
I love having both options for different scenarios
Both doctors did their best but the family doctor knows the history unfortunately it takes two or three weeks to get an appointment which is good for regular visits but not good for necessary attention as the problem would only have got worse.
Other than long wait time at walk in
The doctor was very open about my condition and answered all my questions and didn't make me feel rushed.
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Q. 13 - Do you believe patients would benefit from increased communication between their family doctor and walk-in, house call or episodic care doctor? (Optional) Why do you think patients would or would not benefit from more communication between both doctors?

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I believe that Manitoba health care should employ Physicians Assistants like they have in the United States. Our experience with Physicians Assistants in the US has been great. It alleviates wait time as well as provides assistance and more time for the physicians themselves. You really need to take a broader look at the current healthcare system as Band-Aid solutions are not working. Staff are overworked, underpaid and sometimes underappreciated. One does not need to create a new model, you can study those that are currently working in other countries and make changes/adaptations to their models so that it would work here. The Manitoba health care system really does need help.
I agree there are many gaps/issues/problems in Manitoba's medical system as a whole, in all levels of the system. Another thing we need to be cautious of - specialists can be too specialized which can hinder and miss the underlying issue the patient needs treated.
I have to wait 3-4 weeks for an in person appointment to see my doctor even when I have an urgent need to see her. Normal response from her office is to go to a walk-in. By following restrictions, haven't had the need to go to a walk-in. Don't have much confidence in walk-ins except for Minor Illness & Injury clinic which I have used in the past. Excellent care received there. I would certainly like to have an option for a house call when I am sick and can't drag myself to an appointment
No further comments.
It would be nice if doctors in this backwater were able and/or allowed to start practicing 21st century medicine. Limiting the influence of the U of M -- third tier med-school that it is -- would also be a good thing. Additionally, doctors should recognize that there are legitimate and proven alternatives to what they offer that are often complimentary and/or better than what they have to offer and they should willingly encourage them to be fully integrated into our health care system instead of constantly wanting to keep the whole pie to themselves. To a large extent our health care system has, in fact, become a sickness care system where doctors much prefer to provide "managed care" by spending as little time as possible with a patient and merely treating symptoms -- essentially becoming partners with Big Pharma -- rather than spending the time necessary to actually find and treat the cause of what's ailing a patient. Yes, that approach can be more expensive in the near term, but when looked at in the long term it's the cheaper route to pursue . . . and the patient -- the part of the equation that's supposed to be of greatest import -- will tend to be happier and healthier.

Seems like the best care for everyone would be with a family doctor but I hear so many people don't have one. The system needs to be updated. Kudos for doing this survey
Doctors need to improve their communication skills and listen to their patients. Patients concerns are often over looked and not heard by doctors. Canadian doctors have to do better for our population. Other medical professionals including doctors in other countries offer much better medical care and are paid more modestly.
My regular dr is retired 2 days ago and I was relieved he had a new dr take over his practise. I had my meet and greet and the new dr. told me his patients don't go to walk-in clinics so that sounds very positive to me.
I am very satisfied for the care I received.
Waiting over 6 months for a physical is unacceptable. I may be dead before I see the doctor
Wait time was extremely long
I attended Wpg Minor Illness clinic on Corydon on 2 occasions for ear infections. I was able to schedule appt at convenient time & received prompt service - no waiting.
We need more family docs
hire more nps
It's so comforting to a new parent to know they can access different options for different times AND avoid the ER. We have a fantastic family doc but he's not available every day and the minor illness clinic has a pediatrician. I also work for home care and the value of a house call doctor is immeasurable. I have dozens of clients who cannot leave their homes without a stretcher. We need all of these services and more!
House calls would be appreciated to couples like us who are nearly 80 and aging in place. I look after my husband who is hearing and sight impaired and is in chronic pain, had cancer radiation etc., but taking him to visits is getting really difficult some days as he's unsteady and I have to get a third person to help. Phone calls from doctors are a good idea but as my husband even with hearing aids doesn't quite hear, have you ever tried explaining some one else's headache to a doctor on the phone, I can only explain my pain!
Appreciate being able to interact with a health care provider via telephone.
In today's day and age I find it unbelievable the the various doctors and dentists treating a patient don't have a centralized database to access that patient's records. If need be, a consent form could be signed by the patient. This, in my opinion, would make it easier for different doctors to have the full picture as to what a patient's medical issues are and reduce the need for redundant records being kept.
I really liked the doctor at the walk-in and wished he could be my family physician.
Pan Am was fast and efficient for the initial treatment and every follow up. The only issue I had was getting documentation done in a timely manner for my short term disability claim for work. They simply don't have the time to do this. My wellbeing is still suffering impacts from this.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
JUNE 22, 2022
NOTICE OF MOTION

TITLE: **Committee Appointments for 2022/23**

BACKGROUND

With a smaller Council and term limits imposed under the RHPA, there are several councillors that are not returning, including Drs. Lindsay and Manishen. There are several other councillors not returning including Drs. Smith, Sigurdson, Kumbharathi, and Stacey. There is an annual election for the Associate member who is always placed on the Central Standards Committee and Mr. Barnes has been re-elected. Dr. Postl will continue on Council until the University appoints a new Dean and the University is currently interviewing for the position. There are several other vacancies.

This creates vacancies on Committees as follows:

- Executive (Dr. Postl)
- FARM (Dr. Postl)
- PRC Chair (Dr. Manishen)
- PRC (Dr. Lindsay)
- Complaints Chair (Dr. Smith)
- Complaints (Dr. Stacey)
- Standards (Dr. Sigurdson)
- Standards (Ms. Stansfield – retirement)
- Investigation (Dr. Kvern)

The Executive appoints members to Committees. These can be both Councillors and CPSM registrants. For those who are not councillors, an email was sent to them asking if they wish to continue being a member of their current Committee. This is a wide range of individuals and includes individuals who are there because of the position they hold. The letter was tailored to that specific individual given the nature of the position. Their responses were taken into account in making these recommendations. All councillors and others who are changing or new to committees have been approached and agreed to their appointments. An email was also sent to all Councillors seeking their preferences as to which Committees they wish to be appointed to.

Given Dr. Postl's short time to remain on Council, the Executive Committee recommends that this opportunity to sit on the Executive Committee should be offered to Dr. Penner given his broad experience as a specialist within the healthcare system, his experience in the University as Associate Dean of Distributed Learning, and his experience being a CMO and administrator within the healthcare system. Dr. Postl's experience and skills will be greatly missed, and it is opportune to

determine who has the skill set most closely aligned to his for consideration as a member of the Executive Committee. Dr. Penner is already appointed to the Finance, Audit, and Risk Management Committee.

There has been a dramatic increase in the number of Investigation matters recently. Given the increased number of cases, more frequent meetings, and IC will in the future have two separate panels to hear different cases. This creates significant demands on the individual IC members. IC will in the future sit in two separate panels. This will necessitate further individuals being appointed.

It is recommended that Dr. Convery continue as Chair of IC and that Dr Jawanda be re-appointed. Investigation is seeking to appoint two further physicians to the Investigation Committee. It is recommended that Dr Rafiq Andani and Dr Heather Smith be appointed. Dr. Andani was unsuccessful in the recent election in Winnipeg for the one position and has indicated his interest in other work at CPSM. He is known for his fine judgment, empathy, and high standard of care. He has had a very diverse practice including North, Rural family practice, ER, ICU, and Addictions. Dr. Heather Smith did not seek re-election to Council and has been the Chair of the Complaints Committee.

There is also a need to appoint several individuals to Investigations Committee, not only to address the departure of Dr. Kvern, but also to handle the dramatic increase in the number of investigations. Currently, Dr. Convery is the Chair of the Investigation Committee and is assisted by Dr. Penner from Council and Dr. Jawanda. Dr. Penner who was the interim CMO of Prairie Mountain RHA and is now acting interim CMO of Interlake very frequently experiences conflicts of interest and must regularly be recused from acting on the Investigation Committee. It is recommended that Dr. Penner not be reappointed, simply because of the frequent conflicts of interest, and not because of the quality of his work which has been excellent.

In the past few years the Complaints Committee has included members who have been excellent as associate members on Council, namely Drs. Boshra Hosseini and Shayne Reitmeier. It is recommended that Dr. McLean who is a current member become the Chair of the Complaints Committee. A member of Council must be the Chair as peer the RHPA. It is also recommended that Dr. Nicole Vosters be considered for the Complaints Committee. She is currently on the Truth and Reconciliation Advisory Circle and has made excellent contributions and shows very fine judgment and other skills.

There are two new Councillors: Dr. Monkman (North) and Dr. Carrie Corbett (Winnipeg). Dr. Monkman is currently the Chair of the CPSM TRC Advisory Circle and this is a very busy position so it is recommended that no further committee appointments be made for this new Councillor. It is recommended that Dr. Carrie Corbett be appointed to Central Standards. She is the current Chair of the WRHA Women's Health Standards Committee and has experience. There may be conflicts of interest that could arise from this area of practice, and she would have to recuse herself.

It is recommended that the Chair of PRC be Ms. Leanne Penny. To assist PRC staying within its jurisdiction, a public representative could be helpful in actively chairing PRC since they are not vested in the medical system. With her background in audit, risk management, and experience in chairing multiple boards, she could provide good chairing of PRC.

Dr. Polimeni has resigned from her position as Vice Dean, Continuing Competency and Assessment, Rady Faculty of Health Sciences. She serves on Central Standards Committee. She holds that position by virtue of the office and it will go to the next person occupying that position. Her successor has not yet been named. Similarly, Ms. Katherine Stansfield was appointed to the Central Standards Committee. The Governance Policy does not name the position, it is referred to as representatives of other health care professions. She is retiring this summer and her successor is Ms. Deb Elias, a Deputy Registrar at CRNM. It is recommended that Ms. Deb Elias be appointed to Central Standards Committee.

Attached you will find the Councillors Terms and the Appointments to Committees. Also attached is the membership of the Inquiry Committee. This is the Committee membership that the Executive Committee has nominated to Council for its approval.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 22, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Committee membership for the 2022/23 year be as per attached charts.

Committee Membership 2022 - 2023

Council Members	Executive	Finance, Audit & Risk Mgmt	Central Standards	Program Review	Complaints	Investigation	Inquiry
Agger, Ms Leslie				Pub Rep			
Albrecht, Ms Dorothy			Pub Rep				
Convery, Dr. Kevin						Chair	
Corbett, Dr. Carrie			Councillor				
Elliott, Dr. Jacobi (President)	Chair	Ex O-NV	Ex O-NV	Ex Officio			
Fineblit, Mr. Allan	Pub Rep						
Magnus, Ms Lynette		Pub Rep				Pub Rep	
McLean, Dr. Norman					Chair		
McPherson, Ms Marvelle	Pub Rep		Pub Rep				
*Monkman, Dr. Lisa							
Penner, Dr. Charles	Councillor	Councillor					
**Penny, Ms Leanne		Pub Rep		Chair	Pub Rep		
Postl, Dr. Brian							
Ripstein, Dr. Ira (Past-President)	Councillor		Councillor				Chair
Seager, Dr. Mary-Jane			Councillor				
Shenouda, Dr. Nader(President-Elect)	Councillor	Chair	Ex O-NV	Ex O-NV			
Suss, Dr. Roger			Chair				
Barnes, Mr. Christopher (Associate Member)			Councillor				
Ziomek, Dr. Anna (Registrar)	Ex O-NV	Ex O-NV	Ex O-NV	Ex O-NV			

External Members	Executive	Finance, Audit & Risk Mgmt	Central Standards	Program Review	Complaints	Investigation	Inquiry
Andani, Rafiq						Member Rep	
Arya, Dr. Virendra				Member Rep			
Cabel, Ms Jennifer				Gov Rep			
Hosseini, Dr. Boshra					Member Rep		
Jawanda, Dr. Gurswinder (Gary)						Member Rep	
Kabani, Dr. Amin				Member Rep			
Kirkpatrick, Dr. Iain				Member Rep			
Naidoo, Dr. Jenisa				Member Rep			
Pintin-Quezada, Dr. Julio				Member Rep			
***University CPD Representative			Member Rep				
Reitmeier, Dr. Shayne					Member Rep		
Smith, Dr. Heather						Member Rep	
Elias, Ms Deb			Pub Rep				
Vosters, Dr. Nicole					Member Rep		

Ex-officio | Chair | Councillor | Public Rep | Member Representative

**Term finishes in 2021

*** Formerly Dr. C. Polimeni - awaiting appointment

* Chair CPSM TRC Advisory Circle

Committee Membership 2022 - 2023

Public Representatives on Roster	Executive	Finance, Audit & Risk Mgmt	Central Standards	Program Review	Complaints	Investigation	Inquiry
Benavidez , Sandra							Pub Rep
Bjornson, David							Pub Rep
Gaudet, Ryan							Pub Rep
**Gelowitz, Eileen				Pub Rep			
**Magnus, Lynette		Pub Rep				Pub Rep	
Martin, Sandra							Pub Rep
Scramstad, Alan							Pub Rep
Smith, Nicole					Pub Rep		
**Strike, Raymond					Pub Rep		
Tutiah, Elizabeth						Pub Rep	
Yelland, Diana							Pub Rep

Ex-officio
Chair
Councillor
Public Rep
Member Representative

CPSM Members Appointed to the Inquiry Panel 2022-2023

Sal	Last Name	First Name	
Dr	Ahmed	Munir	
~~Dr~~	~~Andani~~	~~Rafiq~~	Appointed to Investigations Committee instead
Dr	Basta	Moheb Samir Samy	
Dr	Bello	Ahmed Babatunde	
Dr	Bernstein	Keevin Norman	
Dr	Bhangu	Manpreet Singh	
Dr	Buduhan	Gordon	
Dr	Butler	James Blake	
Dr	Campbell	Barry Innes	
Dr	Cham	Bonnie Paula	
~~Dr~~	~~Corbett~~	~~Caroline~~	Appointed to Central Standards Committee & is a Councillor
Dr	Derzko	Lydia Ann Lubomyra	
Dr	Dyck	Michael Paul	
Dr	Ghorpade	Nitin Namdeo	
Dr	Goldberg	Aviva	
Dr	Grocott	Hilary Peter Thomas	
Dr	Hanlon-Dearman	Ana Catarina de Bazenga	
Dr	Harris	Kristin Renee	
Dr	Henderson	Blair Timothy	
Dr	Herd	Anthony Michael	
Dr	Hynes	Adrian Francis Mary	
Dr	Jellicoe	Paul Arthur	
Dr	Jones	Jodi Lynn Plohman	
Dr	Kakumanu	Ankineedu Saranya	
Dr	Kean	Sarah Lynn	
Dr	Kettner	Joel David	
Dr	Knezic	Kathy Ann	
Dr	Lane	Eric Stener	
Dr	Leonhart	Michael Warren	
Dr	Manji	Rizwan Abdulmalik Samji	
Dr	Martens-Barnes	Carolyn	
Dr	McCammon	Richard James	
Dr	Nair	Unni Krishnan	
Dr	Nashed	Maged Shokry	
Dr	Peterson	John David	
Dr	Porhownik	Nancy Rose	

CPSM Members Appointed to the Inquiry Panel 2022-2023

Sal	Last Name	First Name	
Dr	Price	James Bryan	
Dr	Ross	Timothy K.	
Dr	Roux	Jan Gideon	
Dr	Samuels	Lewis	
Dr	Scott	Thomas Jason Paul	
Dr	Shah	Ashish Hirjibhai	
Dr	Simmonds	Reesa	
Dr	Singh	Harminder	
Dr	Sommer	Hillel Mordechai	
Dr	Spencer	Mandy Lee	
~~Dr~~	~~Stephensen~~	~~Michael~~	Now works as Consultant at CPSM in the Complaints Department
Dr	Swartz	Jo Stephanie	
Dr	Tagin	Mohamed Ali Mashhoot	
Dr	Taraska	Vincent Aloysius	
Dr	Thompson	Susan Bomany	
Dr	Van Dyk	Werner Willem Adriaan	
Dr	Weiss	Elise Collette	
Dr	Yaffe	Clifford Stephen	
	Public Reps		
Mr.	Bjornson	David	
Ms	Benavidez	Sandra	
Mr.	Gaudet	Ryan	
Ms	Martin	Sandra	
Mr.	Scramstad	Alan	
Ms	Yelland	Diana	

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING –JUNE 22, 2022

ITEM FOR INFORMATION

SUBJECT: Registrar/CEO's Report

COVID-19 Pandemic

All staff have returned to the office in person, though we continue to see absences for individuals who have tested positive for COVID. Numerous individuals have periodically been working at home during periods of testing, or with symptoms, or looking after children/family members with COVID. With the two years of on and off remote work, individuals are able to switch immediately to remote work. During a spring snowstorm staff took their computers home with them and worked for two days remotely. Prior to COVID, those days would have had limited or even no productivity from many employees.

Meetings with Public Health and other key stakeholders in the healthcare system relating to COVID, including vaccines, have ended.

CPSM will continue to monitor and adjust as COVID hopefully becomes more endemic than pandemic.

STAFF MATTERS

Ms. Jackie Tower joined CPSM as the Accreditation Coordinator and Inspector for the Manitoba Quality Assurance Program (MANQAP). Jackie has significant experience in the laboratory world with over 20 years working in labs across the country as a cytotechnologist. Jackie's most recent position was at Dynacare as the Charge Cytotechnologist.

All staff completed the Accessibility training module in compliance with the educational requirements of the new legislation, the Accessibility Act.

Following the move to the expanded 2nd floor for the Complaints and Investigations Department, various office relocations have occurred.

Since January 2021 when CPSM Staff completed The Path Cultural training we have hired 10 new staff members and they are now completing The Path Cultural training.

MEETINGS WITH GOVERNMENT OFFICIALS

Meeting regarding health care to be provided to Ukrainian Nationals arriving in Manitoba – April 27, 2022

MEETINGS ATTENDED OTHER ORGANIZATIONS

WRHA Medical Advisory Committee – March 24, 2022

CMA Committee on Ethics – April 1, 2022

Provincial Health Research Privacy Committee – April 6, 2022

Chief Medical Officers Meetings -April 7 & May 5, 2022

PGME Executive Committee – April 12, 2022

Medicine Subcommittee – April 20, 2022

Professionalism Subcommittee on Admissions – April 21, May 4, May 10 (Regrets), 2022

Federation of Medical Regulatory Authorities of Canada (FMRAC)

- Board Retreat – Vancouver, BC – March 27 & 28, 2022
- Board Meeting – April 27, 2022
- Educational Conference June 11-12, 2022, Topics was "Eradicating Indigenous-specific and other forms of Racism and Discrimination Creating a safe Regulatory Environment for Patients"
- AGM - June 10, 2022
- Board Meeting – June 13, 2022

Grand Rounds – Over Prescribing – Participated with Dr. Jamie Falk – April 27, 2022

Shared Health Medical Advisory Committee – April 28, 2022

Presidential Advisory Committee – Search for Dean, Rady Faculty of Health Sciences & Dean, Max Rady College of Medicine – May 2, 12, 13, 17, 2022 and three dates in June for public lectures.

Fellowship Committee – May 4, 2022

Medical Council of Canada/FMRAC Retreat – May 9 & 10, 2022 in Ottawa

Spring Convocation – May 19, 2022

MEDIA

Media Requests
CPSM received 13 inquiries related to complaints and investigations and disciplinary matters from local and national media outlets.

CPSM also received four requests for comments on various other tertiary matters.

FINANCE

Information was presented at AGM June 21, 2022

INFORMATION TECHNOLOGY

Information was presented at AGM June 21, 2022

QUALITY DEPARTMENT

Information for all areas was presented at AGM June 21, 2022

COMPLAINTS & INVESTIGATIONS DEPARTMENT

Information was presented at AGM June 21, 2022

REGISTRATION DEPARTMENT

Information was presented at AGM June 21, 2022

COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

2022-2023 MEETING DATES

MONTH	MEETING DATE			COMMITTEE	OTHER DATES
June 2022	Tue	7		Complaints Committee	
	Tue	21	5:00	AGM	
	Wed	22	08:00	Council	
July 2022	Wed	6	8:00	Executive Committee	1st : Canada Day - CPSM Closed
August 2022	Tue	23		Complaints Committee	1st : Civic Holiday - CPSM Closed
	Wed	24	8:00	Executive Committee	
September 2022	Wed	7	8:30	Program Review	5th : Labour Day - CPSM Closed
	Wed	7		Investigation Committee	
	Fri	9	8:30	Central Standards Committee	
	Thu	29	08:00	Council	
October 2022	Tue	4		Complaints Committee	10th : Thanksgiving Day - CPSM Closed
	Wed	5	8:00	Executive Committee	
	Wed	12		Investigation Committee	
November 2022	Tue	1		Complaints Committee	11th : Remembrance Day - CPSM Closed
	Wed	2	08:00	Executive Committee	
	Fri	4		Central Standards Committee	
	Wed	9		Investigation Committee	
	Mon	21	8:30	Audit & Risk Management	
	Wed	23	8:00	Executive Committee	
	Wed	30	8:30	Program Review	
December 2022	Tue	6		Complaints Committee	27th Dec - 30th Dec: CPSM Closed
	Wed	7		Investigation Committee	
	Wed	14	8:00	Council	
January 2023	Wed	4	8:00	Executive Committee	
	Tue	10		Complaints Committee	
	Wed	11		Investigation Committee	
	Fri	20	8:30	Central Standards Committee	
February 2023	Wed	1	8:00	Executive Committee	21st : Louis Riel Day - CPSM Closed
	Tue	7		Complaints Committee	
	Wed	15		Investigation Committee	
	Tue	21	8:30	Audit & Risk Management	
	Wed	22	8:00	Program Review	
March 2023	Wed	1	08:30	Executive Committee	22: Associate Member Nominations Out
	Tue	7		Complaints Committee	
	Wed	15		Investigation Committee	
	Fri	17	8:30	Central Standards Committee	
	Wed	22	08:00	Council	
April 2023	Tue	4		Complaints Committee	15th : Good Friday
	Wed	5	8:00	Executive Committee	
	Wed	12		Investigation Committee	12: Associate Member Nominations Closed
	Fri	28	8:30	Central Standards Committee	19:Associate Member Ballot ut
May 2023	Tue	2		Complaints Committee	03: Ballots In - Associate Member Election Day
	Wed	3	8:00	Executive Committee	23rd : Victoria Day - CPSM Closed
	Wed	17		Investigation Committee	
	Tue	30	8:30	Finance, Audit & Risk Mgmt	
June 2023	Tue	6		Complaints Committee	FMRAC: 10 - 14 (not confirmed)
	Wed	7	8:00	Executive Committee	
	Fri	16	8:30	Central Standards Committee	
	Wed	21		Investigation Committee	
	Tue	27	5:00	AGM	
	Wed	28	8:00	Council	

EVALUATION OF COUNCIL

The CPSM is interested in your feedback regarding your experience at the Council meeting. The results of this evaluation will be used to improve the experience of members and to inform the planning of future meetings.

	Strongly Disagree	Neutral	Strongly Agree	Comments
How well has Council done its job?				
1. The meeting agenda topics were appropriate and aligned with the mandate of the College and Council.	1	2	3	
2. I was satisfied with what Council accomplished during today's meeting.	1	2	3	
3. Council has fulfilled its mandate to serve and protect the public interest	1	2	3	
4. The background materials provided me with adequate information to prepare for the meeting and contribute to the discussions.	1	2	3	
How well has Council conducted itself?				
5. When I speak, I feel listened to and my comments are valued.	1	2	3	
6. Members treated each other with respect and courtesy.	1	2	3	
7. Members came to the meeting prepared to contribute to the discussions.	1	2	3	
8. We were proactive.	1	2	3	

Feedback to the President				
9. The President/Chair gained consensus in a respectful and engaging manner.	1	2	3	
10. The President/Chair ensured that all members had an opportunity to voice his/her opinions during the meeting.	1	2	3	
11. The President/Chair summarized discussion points in order to facilitate decision-making and the decision was clear.	1	2	3	
Feedback to CEO/Staff				
12. Council has provided appropriate and adequate feedback and information to the CEO	1	2	3	
My performance as an individual Councillor				
13. I read the minutes, reports and other materials in advance so that I am able to actively participate in discussion and decision-	1	2	3	
14. When I have a different opinion than the majority, I raise it.	1	2	3	
15. I support Council's decisions once they are made even if I do not agree with them.	1	2	3	
Other				
16. Things that I think Council should start doing during meetings:				
17. Things that I think Council should stop doing during meetings:				

Prescribing Practices Program

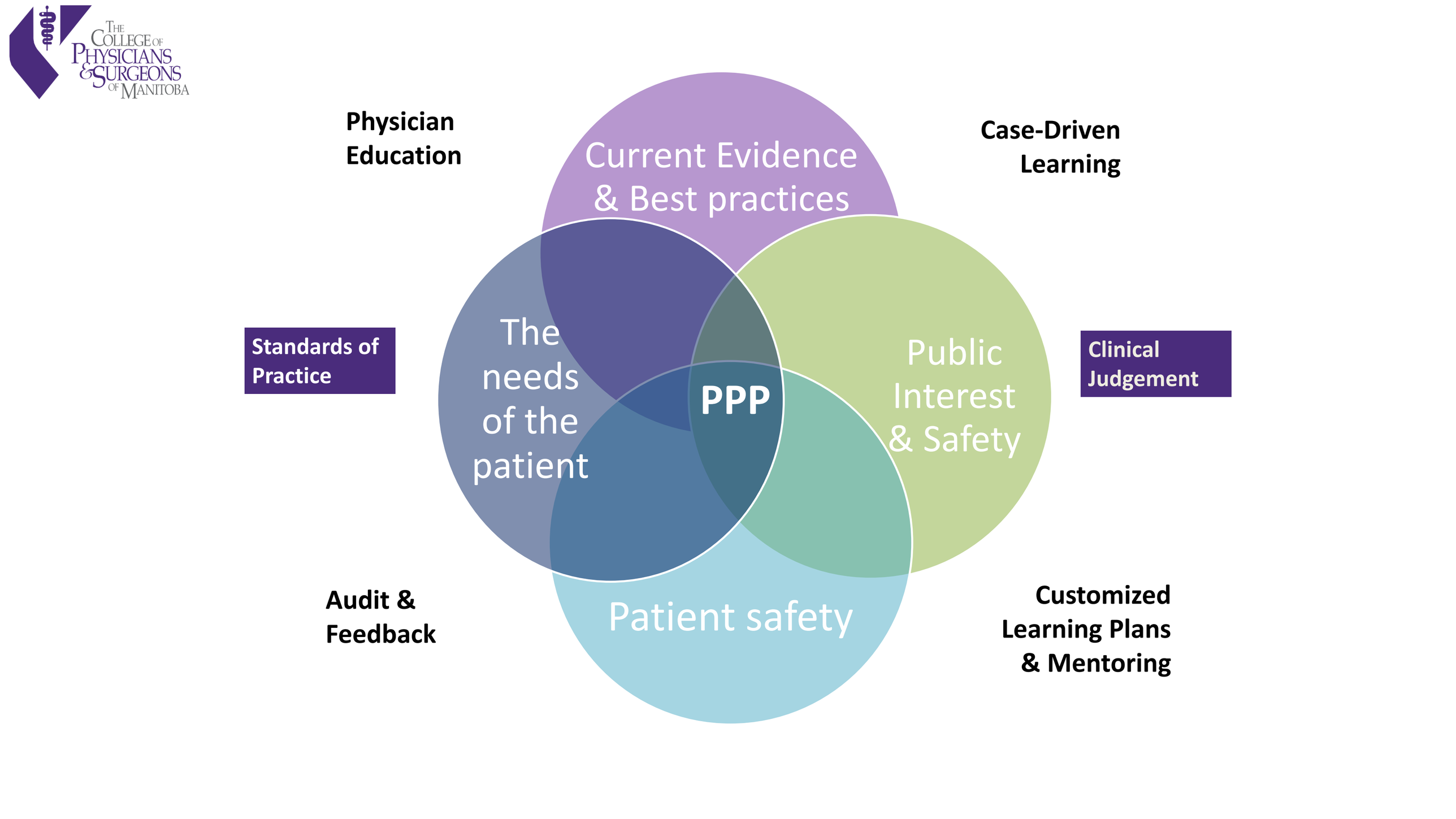
THE DATA STORY: MEETING OUR MANDATE

REINECKE CARTER WIEBE PPP 2022

PPP Mandate

*PPP utilizes a **quality improvement approach** to promote prescribing practices that are informed by current **evidence** and reflective **of best practices**.*

*Our **educational approach** balances patient safety with a registrant's duty to be a guardian for public safety.*


Physician Education
Case-Driven Learning
Current Evidence & Best practices
Standards of Practice
The needs of the patient
PPP
Public Interest & Safety
Clinical Judgement
Audit & Feedback
Patient safety
Customized Learning Plans & Mentoring

Right Touch Regulation:
Balancing Patient Safety
& Access to Care

Opioid Agonist Therapy Portfolio SUAP Grant related activities

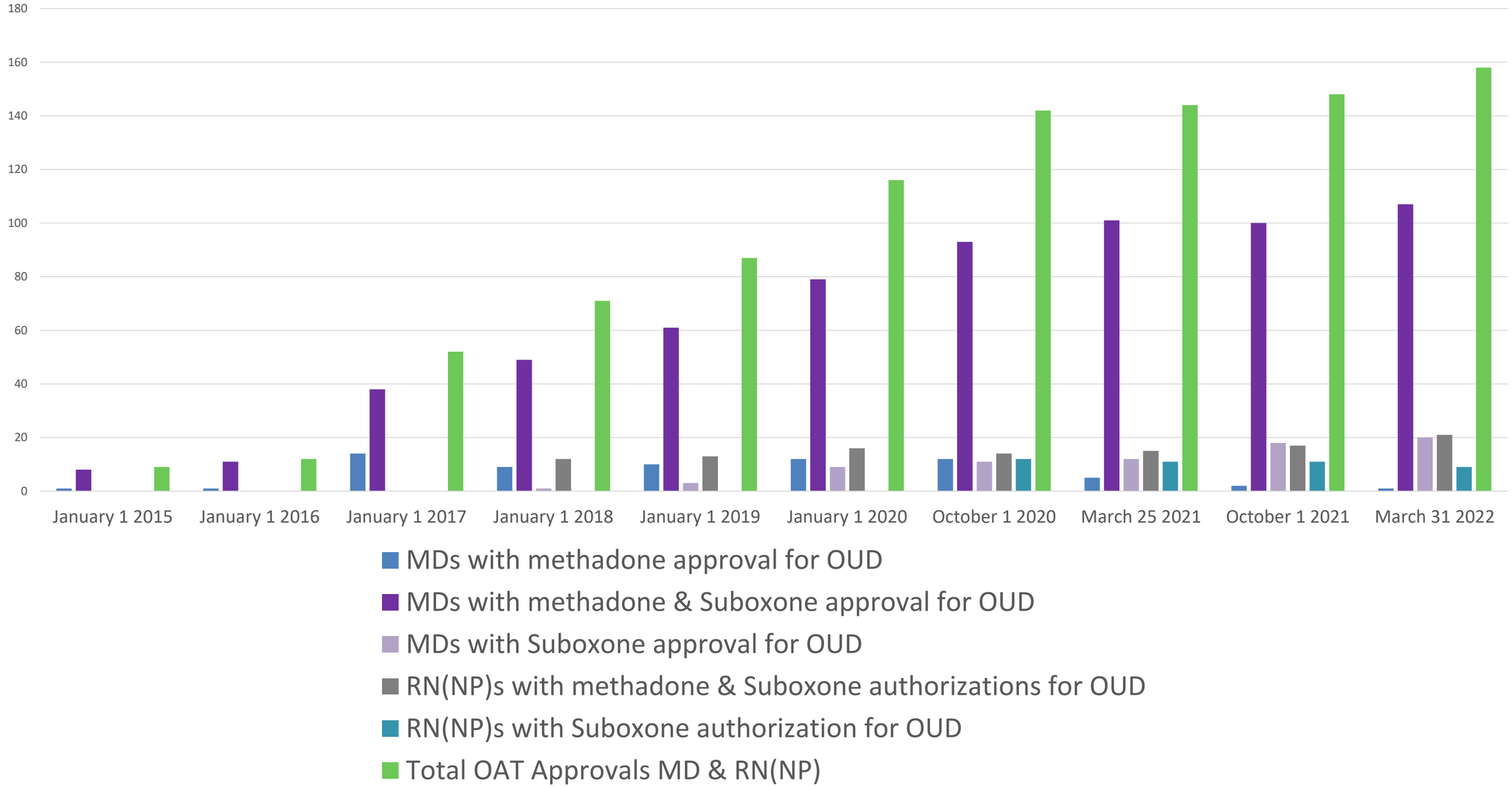
Drawing to a close…..

- OAT Audits
  - Quality improvement audits (new prescribers 1 year in practice)

- OAT Training: 2-Day Workshops – Now completed
  - 30 Workshops in total
  - 660 professionals attended since 2018!

- MB Buprenorphine Recommended Practice Guideline
  - 7 Chapters posted over past year (Working Group collaboration)

Manitoba OAT Prescribers 2015 - 2022

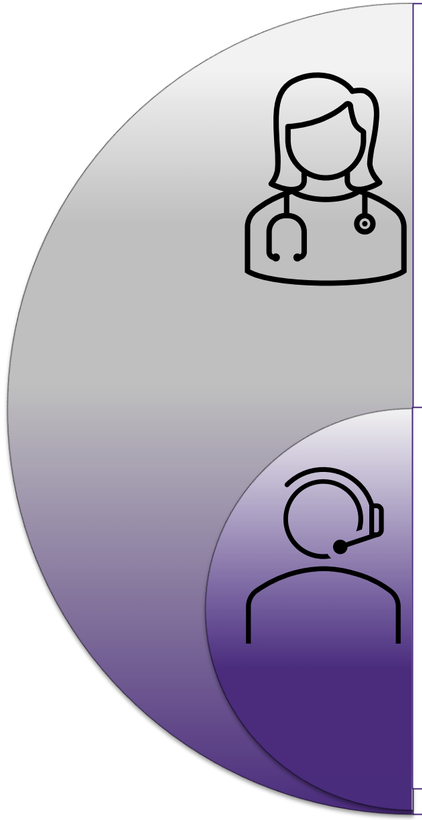


Ongoing Regulatory Functions:

OAT, Pain, Palliation

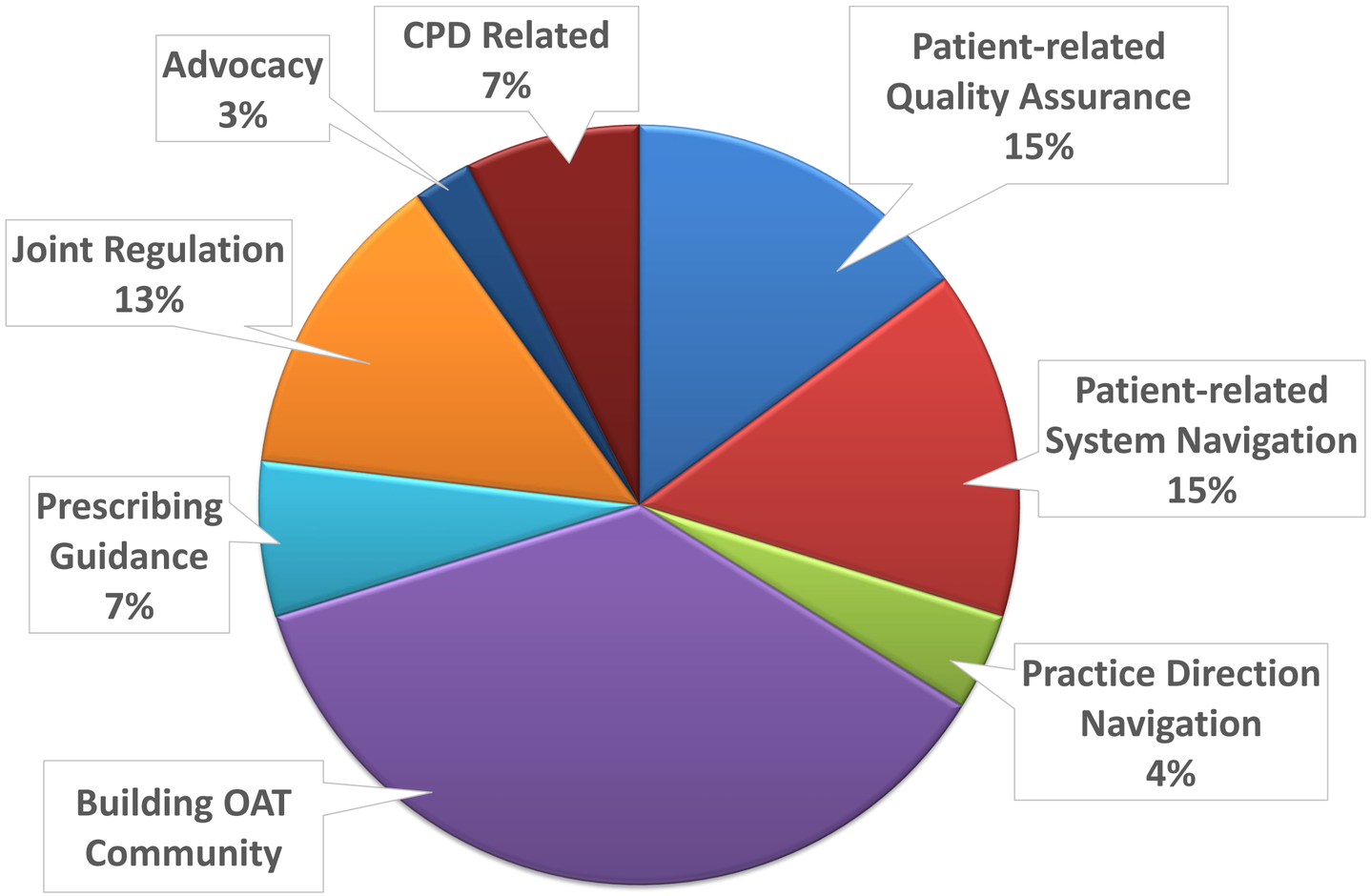
Prescribing Approvals & Inquiries/Mentoring

May 2021-April 2022



25 New MD OAT Approvals (2 Declined)	**New to PPP: Pain and Palliative portfolio** **55 Renewals in 2022; 5 Expired** **Update Practice Direction**
Inquiries/Requests for Support: ("Mentoring")	OAT Inquiries in 2021/2022: 121 Pain/Palliative: 2

OAT Mentoring Cases May 2021-April 2022



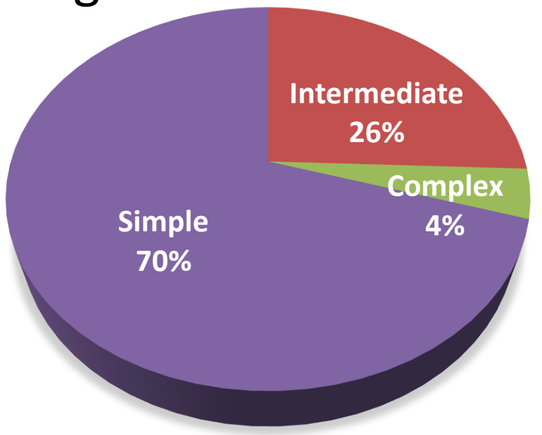
121

Mentoring Cases*

577

Total Contacts
(email & phone)

Degree of Intervention



* Support sought by registrants, pharmacists, nurses, allied health, CPSM staff & community members

General Prescribing Advice

Guidance & advice regarding…

- Interpretation of Standards of Practice/Practice Directions
- Prescription & dispensing requirements
- Complex clinical case management
- Issues around effective interprofessional communication

Approach is…

- Educational & supportive
- Collaborative with other regulators – promotes consistent messaging for interprofessionals teaming
- Connecting registrants to clinical & system resources, other subject matter experts, and/or specialist consultation

General Prescribing Advice

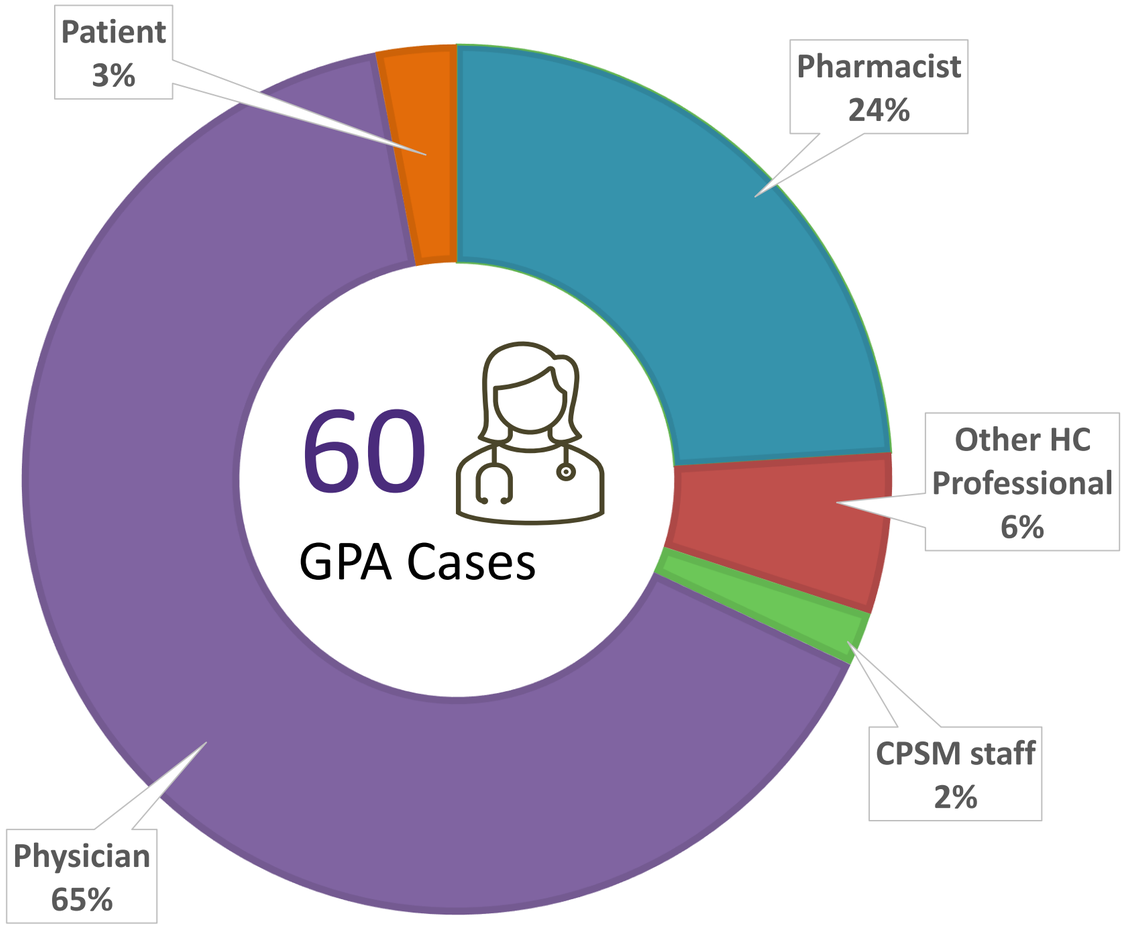
May 2021-April 2022

Based on the principle of **CAPACITY BUILDING**

- When a registrant develops proficiency in managing a complex clinical case, it allows them to manage other similar cases effectively, with increased confidence.
- And share their learning with colleagues in “hallway consultations” & other practice-based interactions

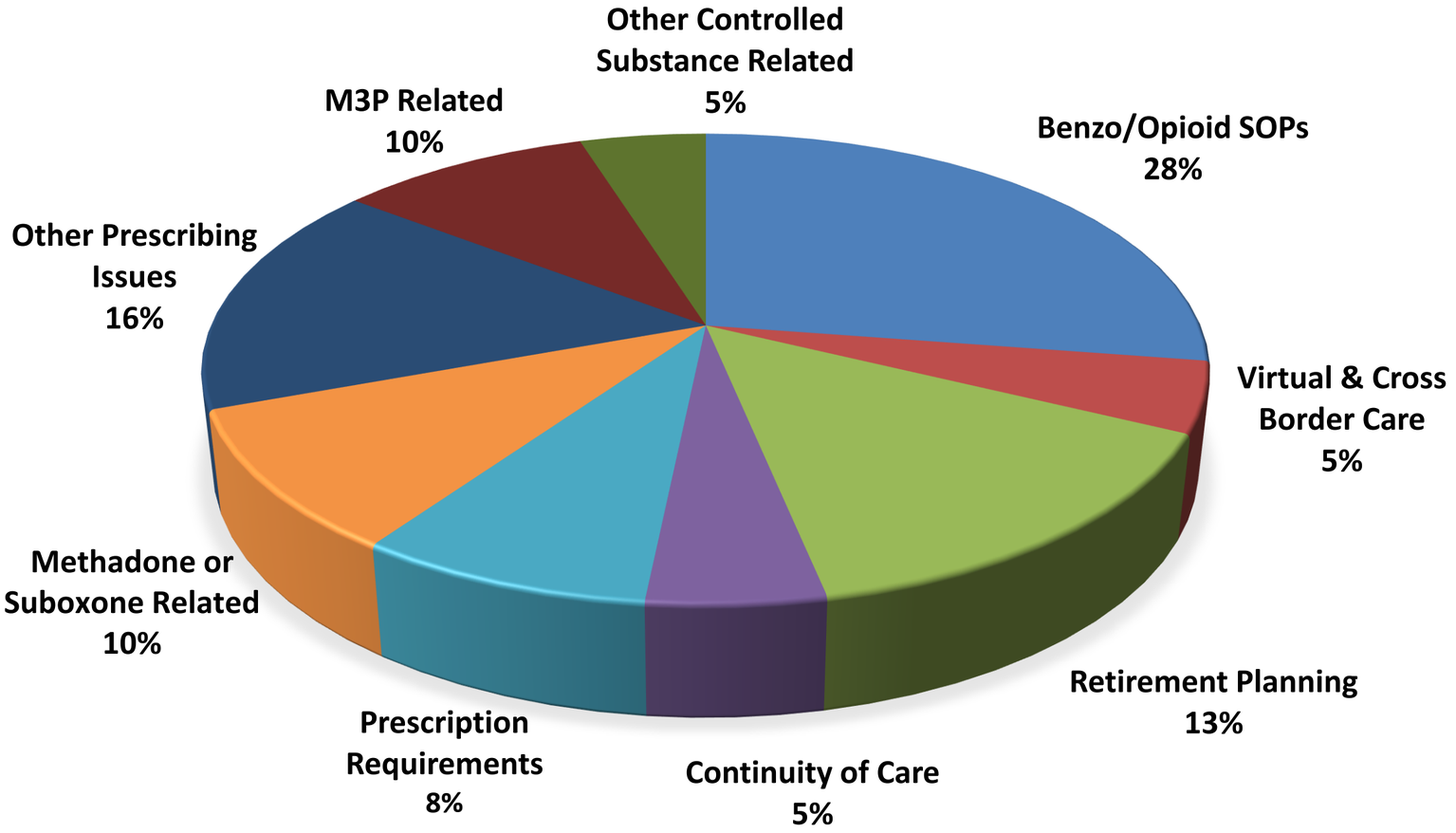
GPA is an alternate route to Complaints & Investigations

Source of Concern



General Prescribing Advice May 2021-April 2022

A broad spectrum of prescribing-related questions/concerns:

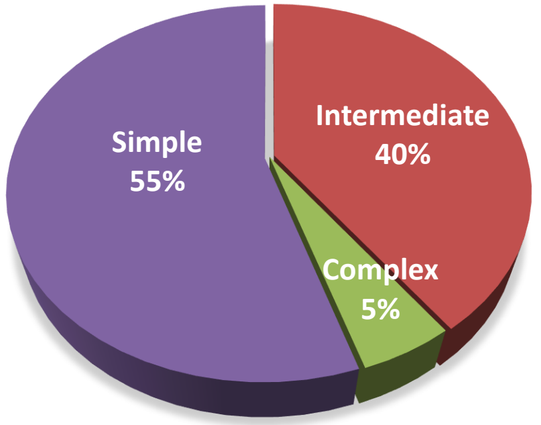


Case Complexity

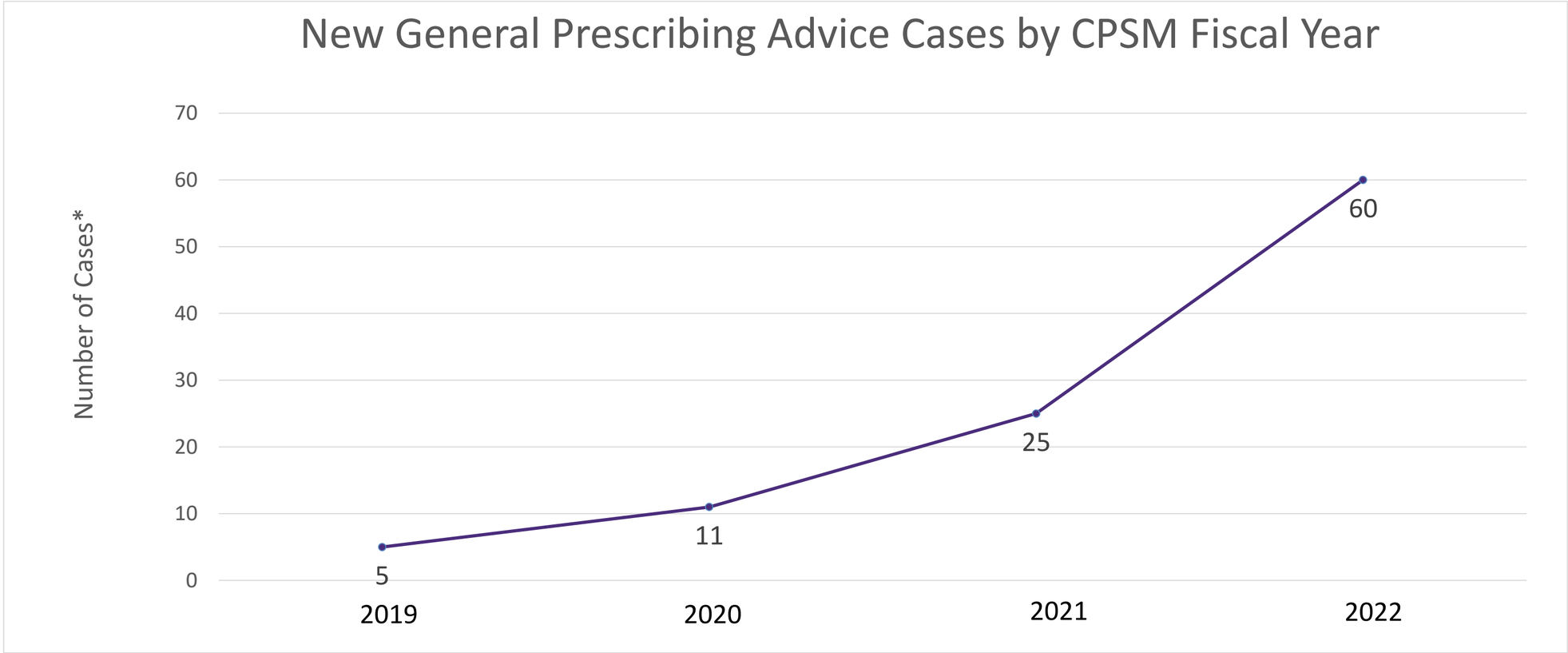
55% Simple (1h)

40% Intermediate (2-3h)

5% Complex (1d)

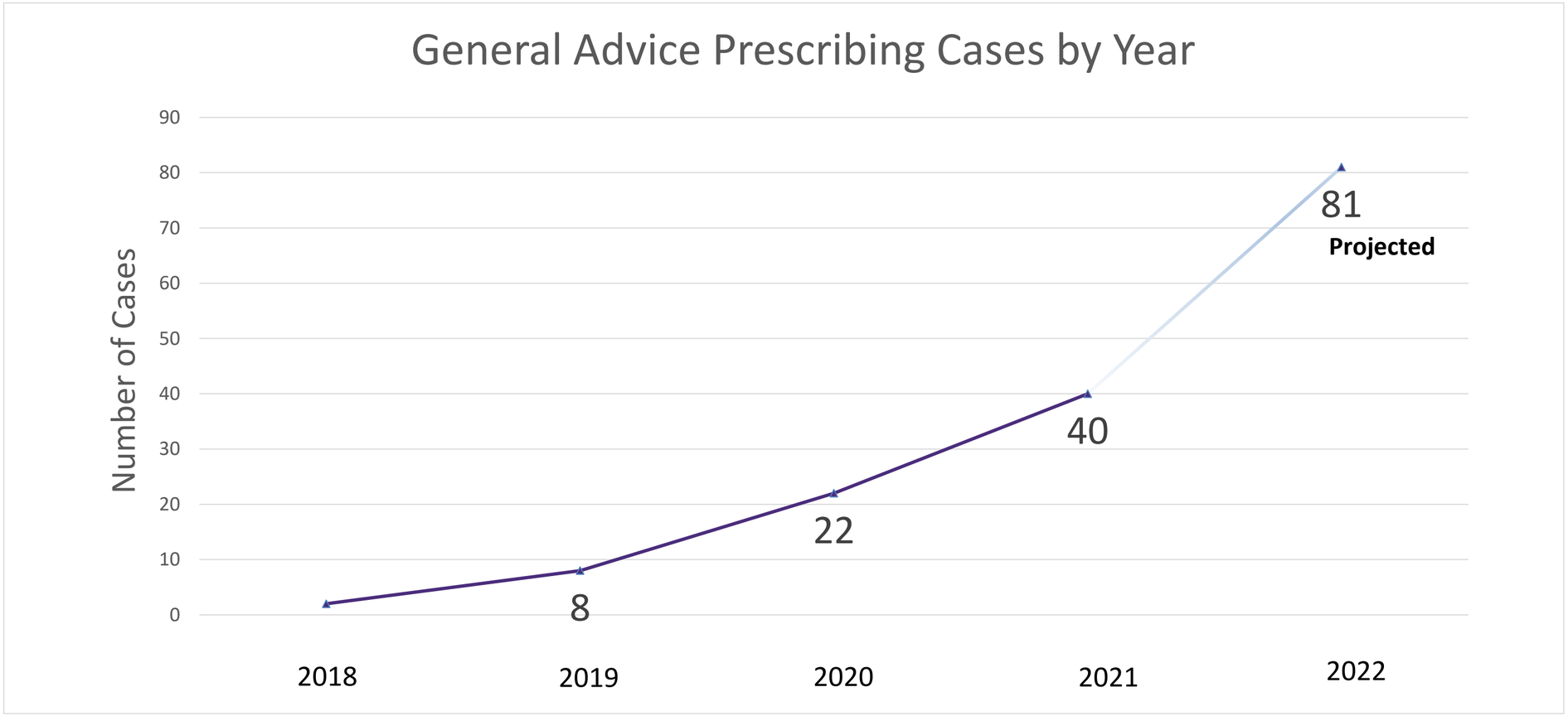


General Prescribing Advice



*Denotes the number of GPA cases opened by the end of the fiscal year indicated (2022 = May 1, 2021-April 30, 2022)

General Prescribing Advice



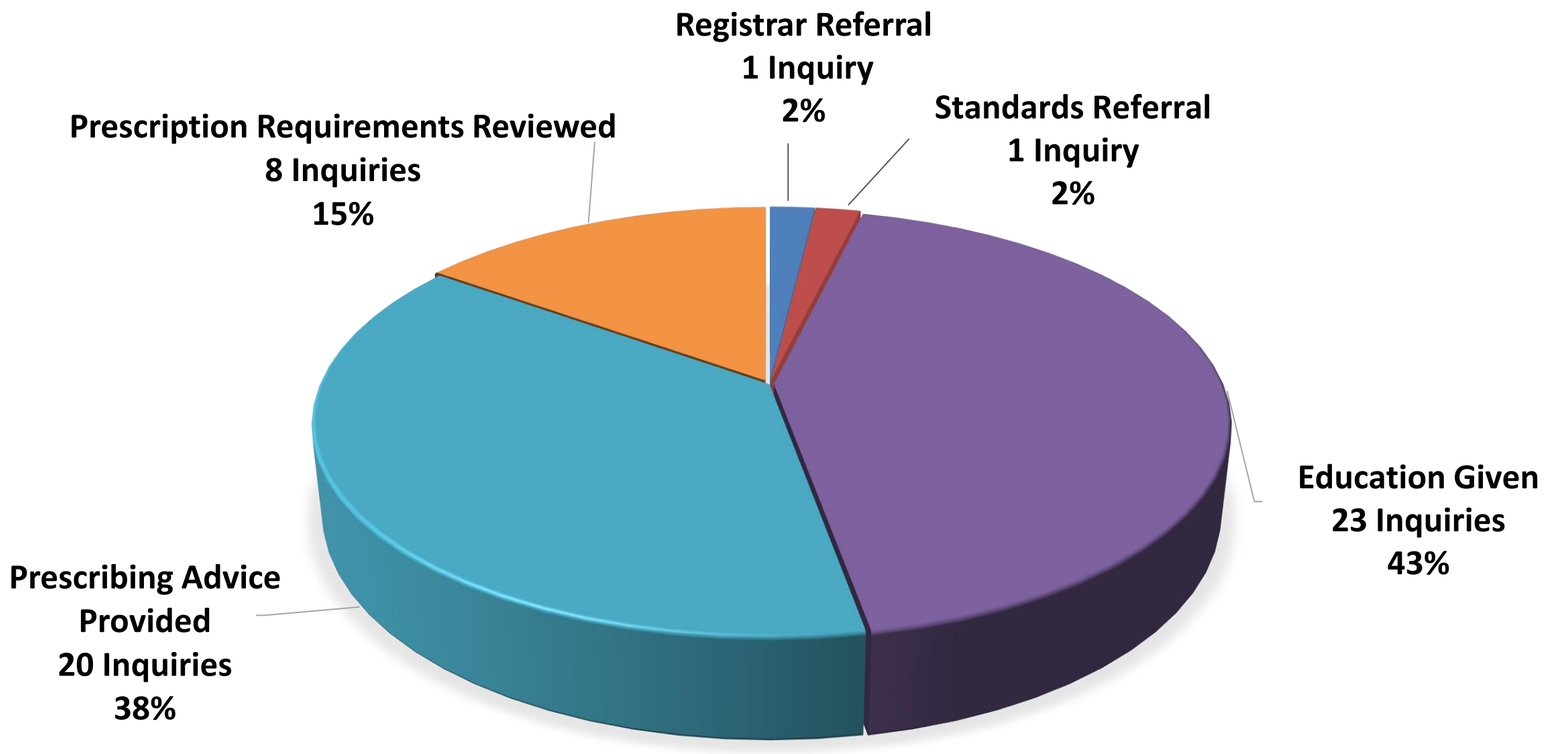
GPA cases by year shows exponential growth!

→ Supports & engages registrants as an avenue for case-specific support

Who would take these calls if not Prescribing Practices Program?

GPA Outcomes

May 2021-April 2022



- Supportive & educational intervention, gathering collateral, and clinical recommendations as needed for complex matters.
- Rare cases become more formalized for concerning matters → Registrar, Standards, CI Referrals
- **Every Inquiry or Concerns = Appropriate Level of Response**

GPA Complex Case Example

May 2021-April 2022

- Phone call to CPSM from a specialist physician, prescribing drug of abuse and aberrant patient behaviours → was directed to the PPP
- Concerns included termination of a physician-patient relationship, with “Mr S”
  - Mr S not able to receive care from another registrant due to the complexity of their condition and special prescribing authority needed
- PPP supported the physician to design a written treatment agreement & recommended additional safety measures/structure to incorporate into Mr S’s care
  - Physician advised not to terminate relationship without first setting boundaries & expectations with Mr S & treatment referral = +++ calls/e-mails
  - And contact CMPA
- Physician was very thankful for the professional support & guidance
  - This proactive regulatory involvement improves patient safety by guiding prescribing and preventing potential abandonment and crisis presentations
  - Supports registrant: mental health, capacity building, CI informed

GPA Complex Case Quote 2022

“I found all your feedback very informative.

It made me think in some more expansive ways about the case, the problem with addiction, and how it contributes to the total disease burden.

*This has been **a learning experience for me**.*

I appreciate all the help from the College. Thank you.”

– Specialist Physician

Used Prescribing Practices Program for assistance managing a complex clinical case

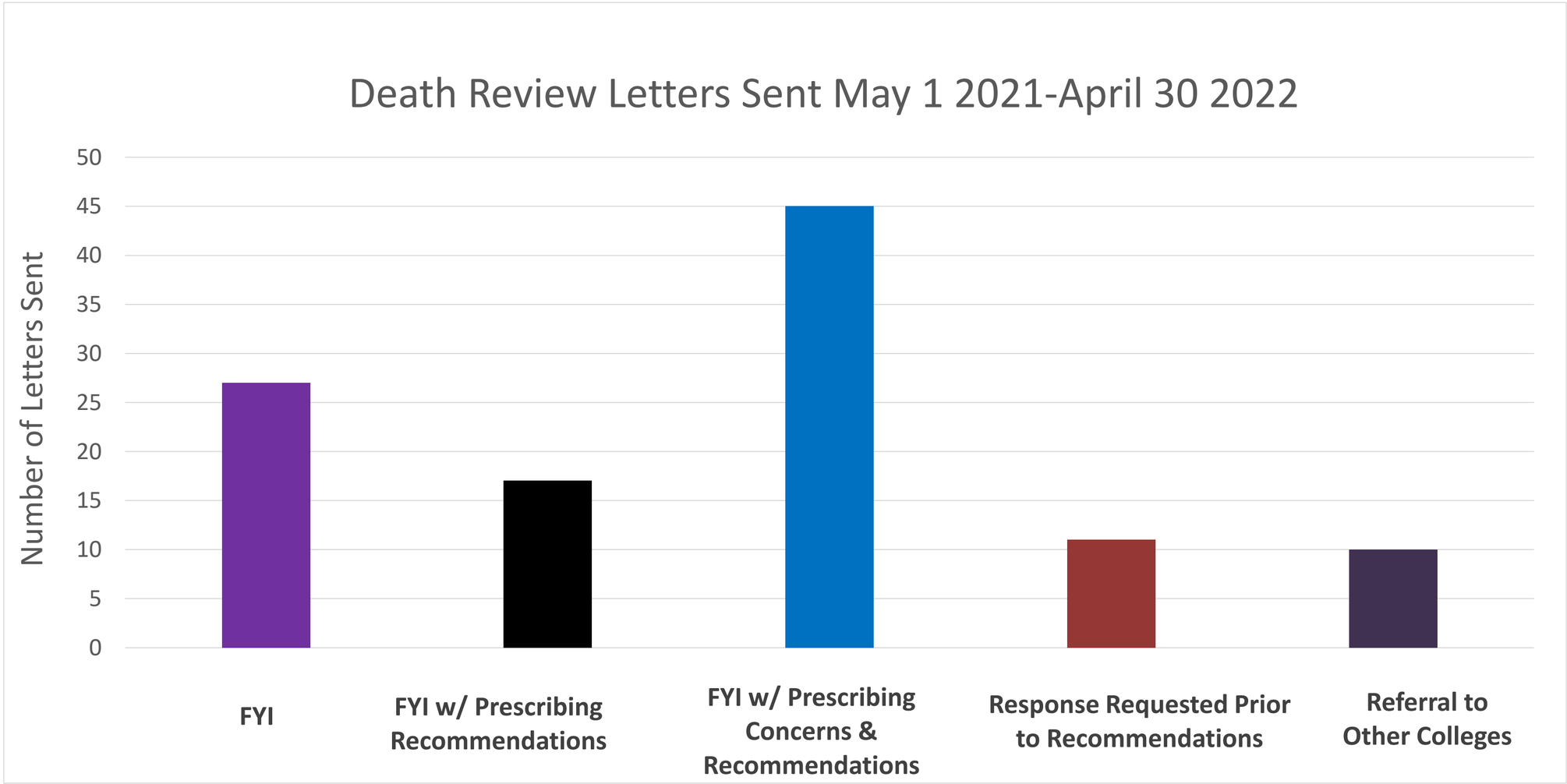
Chief Medical Examiner's Death Review (with CPhM)

- Review of deaths in adults ages 18-65 involving prescription & non-prescription medication
  - Focus on medications profiles that put patients at ↑ risk of serious harm, including meds with sedating/psychoactive properties, polypharmacy and OTC use (diphenhydramine)
- **Continue to review a significant number of accidental overdose deaths related to (usually multiple) medications prescribed by registrants (most often single prescriber)**
- All prescribers involved in the patient's care receive:
  - Standard cover letter
  - Summary of the ME report, DPIN, toxicology etc
  - Case-specific feedback utilizing standardized quality indicators

- **Letters are educational in nature, promote registrant reflection on prescribing practices**
- In ~ 10% of cases will write to registrants to clarify rationale for prescribing prior to feedback

CME Death Review Letters

May 2021-April 2022



The College of Physicians & Surgeons of Manitoba

CME Death Review

Annual Comparison

Deaths categorized into appropriate prescribing & prescribing that is outside of guidelines endorsed by CPSM

CPSM Year	17/18	18/19	19/20	20/21	21/22
Total Number of **Deaths Reviewed***	128	95	54	39	72
Prescribing **Deemed Appropriate**	30	58	28	13	44
Prescribing Falls **Outside Guidelines**	95	67	21	34	56
Referred to **Other Colleges**	3	0	5	6	10

*Total number of deaths ≠ sum of corresponding categories (letters often sent to multiple prescribers re: same death)

CMEO closed for part of 2020-2022 (COVID related) → stats 19/20 to 21/22 likely underrepresented

The College of Physicians & Surgeons of Manitoba

CME Death Review Outcomes May 2021-April 2022

- CME Death Review Program offers **high-impact regulation**
  - Informing physicians re: circumstances of death is relevant to ongoing practice → unique opportunity for **case-based education** & to **promote self-reflection**
  - Registrants encouraged to implement of universal precautions with high-risk medications
  - Case-based learning promotes ability to identify high-risk medication regimes & patient circumstances that may warrant a highly structured approach to care – in living patients!
- Aligns with CPSM mandate to **protect the public** & **promote quality medical care**

The College of Physicians & Surgeons of Manitoba

CME Deaths – Secondary Reviews

≥3  Triggers  Secondary Review

CME Death Review Letters can identify need for Secondary Reviews

Secondary Review may involve…

a) Written communication re reflection on risk management themes and current learning needs

b) In-person/self-directed educational support for prescribers

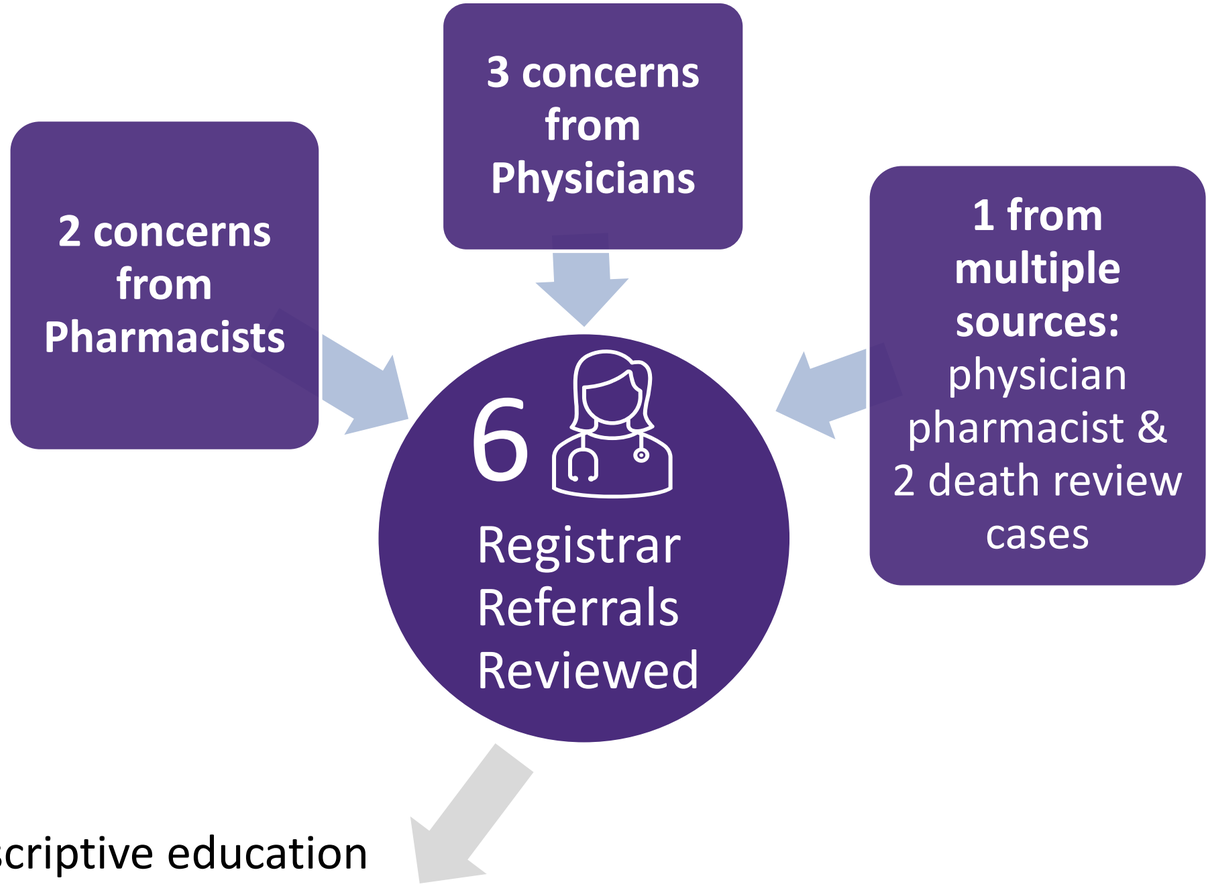
c) Referral to Standards or Complaints & Investigations (rare)

Registrar Referrals

May 2021-April 2022

A serious prescribing-related concern…

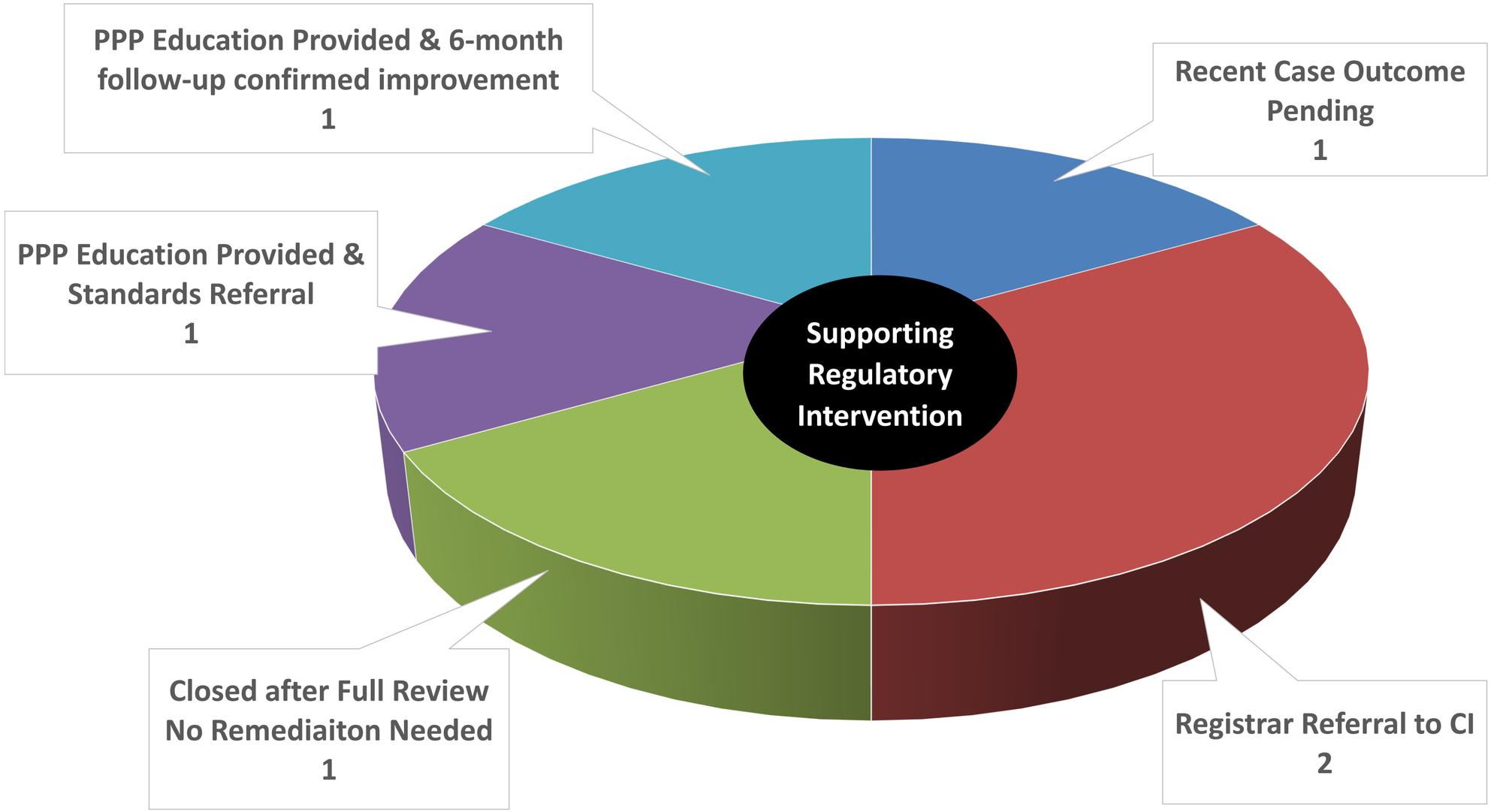
- From variable sources
- Presently does not warrant a higher level of regulatory involvement (CI referral) or unclear what to do.
- PPP reviews concerns, gathers collateral & provides written recommendations



Recommendations may include:

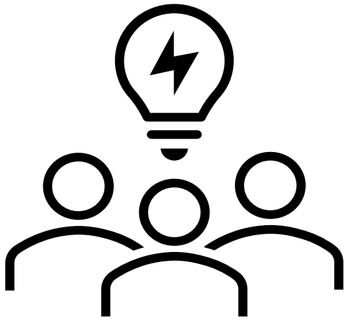
- Advice, mentoring/coaching, and/or prescriptive education
- Referral to Central Standards Committee, or at Registrar's discretion, to the Investigations Committee upon further review

Registrar Referral Outcomes May 2021-April 2022



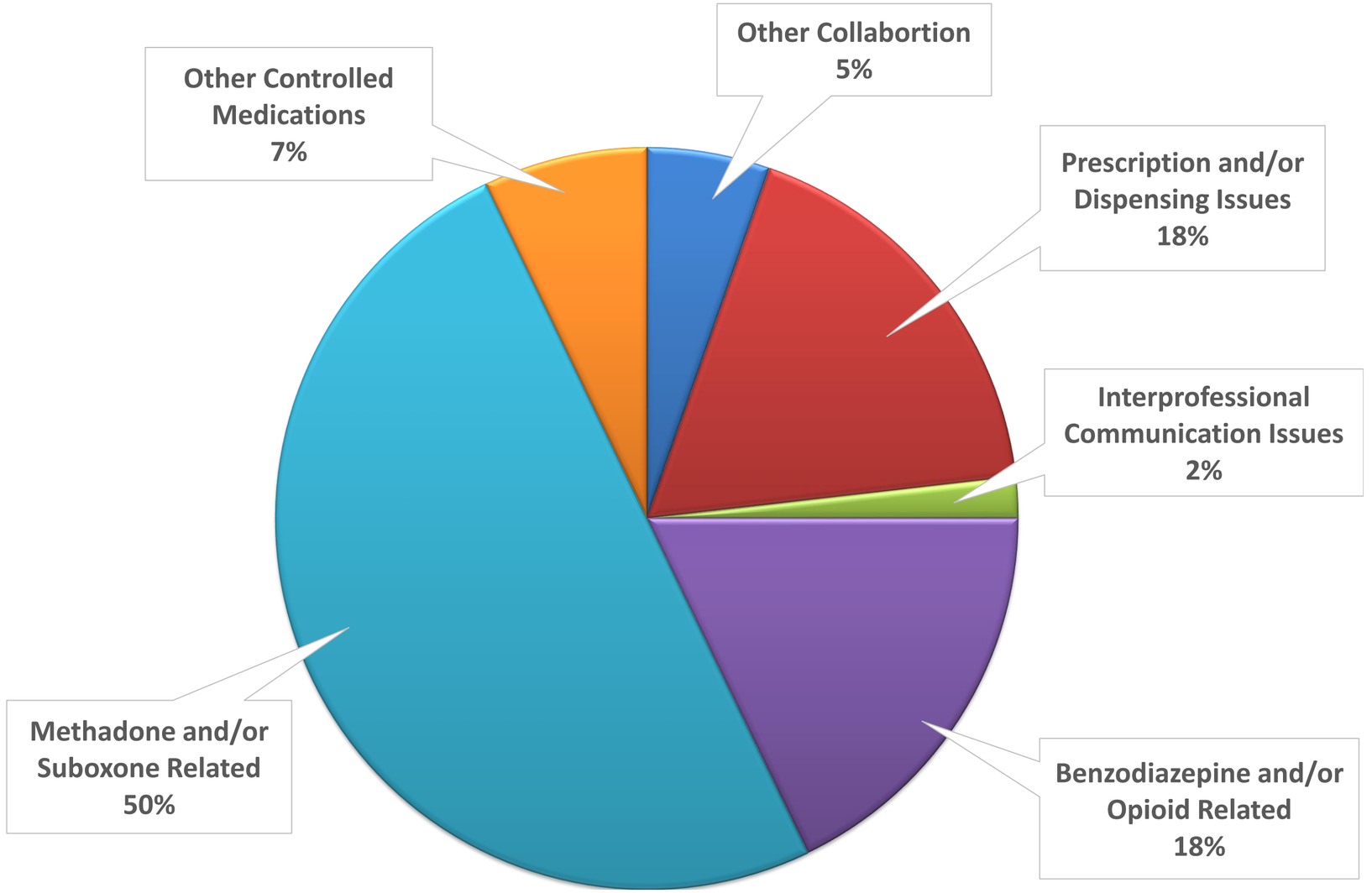
CPSM CPhM CRNM Collaborative Initiatives

- Interdisciplinary work with CPhM & CRNM counterparts, often overlaps with other portfolios (e.g., OAT & GPA):
  - Joint practice guidance
  - Regulatory standards and policies
  - Audits
  - Prescribing/dispensing advice
  - Facilitation of interprofessional communication to promote patient safety



- Roll-out of new Standards of Practice of prescribing impacts registrants from all 3 colleges → Pharmacists & NPs adapt alongside MDs
  - Work from the **Benzo & Z-drug SOP** highlights this real-life impact and collaboration
  - SOP effective November 1/20 → CPSM supported registrants as adapted to new standards in prescribing/dispensing well into this fiscal year

CPSM CPhM CRNM Collaborative Initiatives



56

Collaborative Cases*
May 2021-April 2022

- Inquires from regulators, government, physicians, pharmacists, & other community agencies, public members ⟹ stakeholder engagement

SOP for Prescribing Benzos & Z-Drugs

Total 27 Inquires related to SOP*

- **63%** required **Simple** intervention
  - Mostly clarifying interpretation of SOP
- **37%** required **Intermediate** (26%) to **Complex** (11%) intervention
  - Multiple calls, collecting collateral info, team discussion, correspondence, pharmacist & prescriber education
- **6 inquiries involved collaboration with CPhM**

Who's Calling?

- **63% Pharmacists** seeking guidance
- **15% Physician Registrants** seeking guidance
- 15% Patients/Community with questions
- 7% CPSM colleagues, in-house collaboration

*Data compiled from date SOP effective to September 15, 2021

Does not include complex cases requiring discussion & application of SOP captured in other data sets (e.g. CME Deaths, Registrar Referrals, General Prescribing Advice, OAT Mentorship)

Standard of Prescribing Benzodiazepines & Z-Drugs

effective November 1, 2020

Benzo & Z-Drug SOP FAQs

PPP developed for prescribers & patients to facilitate understanding, communication & patient care

posted February 2021

CPhM Companion Document to CPSM Opioid & Benzo/Z-drug SOPs **Joint collaboration**

April 2021

By fall 2021, overlapping work with registrants and Prescribing SOPs became more interwind

Now captured under General Prescribing Advice

28%

of 60 GPA Cases re:

Benzo/Opioid SOPs

May 2021-April 2022

SOP for Prescribing Benzos & Z-Drugs

Simple Intervention

- Pharmacist call re: Rx received for 6-mo dispense of moderate dose clonazepam – Pt is “snow bird” wanting travel supply
- Call & correspondence with Pharmacist to clarify 3-mo max dispense as per SOP, for exception of travel
- Call to Prescriber to advise of SOP existence, relevant restriction on dispensing, intent of SOP & requesting cooperation with consistent application to all benzo & Z-drug Rx’s

Intermediate Intervention

- Pt call triaged by IC – Request to PPP from IC for assistance as complex Pt Hx
- Call to Pt to collect Hx – Subsequent discussion internally via email & Pt has confirmed Dx warranting exception from SOP
- Further calls from PPP to Prescriber & Pt reveals relationship unfortunately adversely affected by MD refusal to provide low-dose clonazepam Rx *of any duration,* questioning legitimacy of Pt Hx → Prescriber provided education
- Used established connections in community to find Pt new primary care provider in her area

Complex Intervention

- CPhM requested assistance to further advise group of Regional Pharmacy Leads (RPLs) re: what they perceived as insurmountable practical challenges to implementing SOP in PCHs province wide (RPLs wanted exemption from SOP in PCHs)
- Virtual meeting with CPhM & RPLs to understand concerns/challenges with SOP
- Internal correspondence & discussion with SLT, time to reflect, & further discussion with CPhM
- Written response provided to RPLs that *no exemption* granted → Rationale explained & support offered re: practical solutions to challenges

CPSM→ PPP→ Physician Resources

October 2021
CPSM CPhM CRNM Joint Article

Considerations for Travellers or "Snowbirds": Opioids, Benzodiazepines/Z-Drugs, and Virtual Medicine Standards of Practice

The College of Physicians and Surgeons of Manitoba (CPSM) Standards for Prescribing Opioids and Benzodiazepines and Z-Drugs came into effect on September 30, 2018, and November 1, 2020, respectively. The College of Registered Nurses of Manitoba (CRNM) Practice Direction for RN(NP) Opioid Prescribing to Treat Non-Cancer Pain has been in effect since March 2020. On April 15, 2021, the College of Pharmacists of Manitoba (CPhM) Companion Document to the CPSM Standards of Practice was also approved.

Prescribing and Dispensing of Opioids and Benzodiazepines

On an exceptional basis, prescribers may only authorize a dispensing interval of up to three months for patients in remote communities or for travel, if the patient has been on a stable long-term prescription. **The exception should be noted on the prescription**. This limit also applies to those patients who may leave the country for longer than three months at a time, including "snowbirds".

Although patients may be approved by Manitoba Health and Seniors Care to receive six months' worth of medication for out-of-country travel, **prescribing or supplying more than three months of opioids, benzodiazepines, and/or Z-drugs is not acceptable**.

Travellers or "snowbirds" who will be away for longer than three months, and who will need a refill while away, are to see a practitioner in the country where they are travelling for proper assessment to receive a valid prescription. Seeing a provider is part of the cost of such extended international travel, including the health insurance needed for such travel.

Virtual Medicine Across Borders

The legal interpretation of the Regulated Health Professions Act, Regulations, and common law concludes that the location of medical care in Manitoba is the location of the patient. The CPSM Standard of Practice for Virtual Medicine, effective November 1, 2021, reinforces this. The CRNM also has resources for Telepractice and Guidance on Telepractice, developed with other Manitoba regulatory colleges.

The Prescribing Practices Program = High Impact Regulation

Moving forward, SUAP to make room for:

- **High dose MME review program**
- **Prescriber profile program**

The Prescribing Practices Program = High Impact Regulation

- **Meeting our mandate** & accountability regarding concerns/inquiries that come to CPSM

- **Patient safety** and individual needs balanced with **public safety**

- **Reputation:** OUR BRAND

  Positive member engagement

  “Value add” to routine regulatory functions

  Relationship building with registrants, our regulatory partners, governments, health authorities and the public

The Prescribing Practices Program = High Impact Regulation

- **Operationally:** Divert cases from CI….reduced adverse mental health impact for registrants and expert support

  Operational support and expertise that benefits the organization as a whole

- **Organizational risk management** with a **preventative and capacity building** component

- **Evaluation and outcome driven**

Questions?

Contact Information

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