British Columbia Ministry of Health – Provincial Review of Licensure, Credentialing, Privileging, Monitoring and Enhancement of Performance

FINAL REPORT
October 2012
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The information in this document is based on the scope of the review and the limitations set out herein.
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# Glossary of Abbreviations

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<tr>
<td>ABMS</td>
<td>American Board of Medical Specialties</td>
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<td>Alberta Health Services</td>
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<td>AIT</td>
<td>Agreement on Internal Trade</td>
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<tr>
<td>BC/the Province</td>
<td>The Province of British Columbia</td>
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<td>BCLP</td>
<td>British Columbia Locum Program</td>
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<td>BCMA</td>
<td>British Columbia Medical Association</td>
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<td>CFPC</td>
<td>College of Family Physicians of Canada</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>CMPA</td>
<td>Canadian Medical Protective Association</td>
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<td>CPC</td>
<td>Certificate of Professional Conduct</td>
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<td>College</td>
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<td>DAP</td>
<td>Diagnostic Accreditation Program</td>
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<td>DF</td>
<td>Denominational Facility</td>
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<td>FHA</td>
<td>Fraser Health Authority</td>
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<td>GMC</td>
<td>General Medical Council (UK)</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HA</td>
<td>Health Authority</td>
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<td>HIPDB</td>
<td>Healthcare Integrity and Protection Databank</td>
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<td>Health Professions Act</td>
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<td>HR</td>
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<td>Interior Health Authority</td>
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<td>IMG</td>
<td>International Medical Graduate</td>
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<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations (US)</td>
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<td>Medical Affairs Office</td>
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<td>Medical Services Plan</td>
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<td>University of British Columbia</td>
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<td>VCHA</td>
<td>Vancouver Coastal Health Authority</td>
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<td>Vancouver Island Health Authority</td>
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<td>VP Med</td>
<td>Vice President Medicine</td>
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Glossary of Key Terms

To provide a greater understanding of the meaning of the key terms used for this engagement, the following definitions were generated and approved by the Ministry:

- **Licensing**: The process whereby an authorized regulatory body issues a permit to practice medicine.

- **Credentialing**: An approach to obtaining, verifying and assessing against consistent criteria the qualifications of a physician for the purposes of licensing and/or privileging.

- **Privileging**: The process whereby an authorized body permits a specific scope and content of patient care services to a health care practitioner based upon:
  - A standardized evaluation, typically beyond that required for licensure purposes, of a practitioner’s training, experience and competence related to the delivery of specific services; and
  - A defined practice setting with its associated service needs, support infrastructure, patient mix, etc.

- **Performance management**: An ongoing evaluation, including formative and summative assessments, of a physician’s quality of care, conduct, clinical competencies, compliance with regulations, by-laws, rules and standards, and individual practice performance improvement.

- **Stewardship**: The role of government in formulating strategic policy directions, generating intelligence, exerting influence through regulation and ensuring accountability1.

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Chapter 1: Executive Summary

Background

In late 2010 and early 2011, problems were identified with the quality of radiology image interpretations within three Health Authorities (HAs) in British Columbia (BC/the Province). Dr. Doug Cochrane, Provincial Patient Safety and Quality Officer and Chair of the BC Patient Safety & Quality Council, conducted a review of these incidents and reported a number of issues and gaps in oversight and performance management of radiologists. As part of its response to Dr. Cochrane’s report, the Ministry of Health (the Ministry) engaged KPMG LLP (KPMG) to conduct a review of systems and processes for the licensing, credentialing, privileging and performance management of all physicians across the Province.

Scope

We agreed the following scope of the review:

1. The systems and processes of the College of Physicians and Surgeons of British Columbia (the College) in licensing physicians to practice medicine in British Columbia, including procedures and policies for special categories of licensure;

2. The systems and processes of the HAs in credentialing, privileging and monitoring the performance of physicians. This included a review of HA bylaws, rules and policies as well as a review of processes and procedures in a sample of facilities from across the Province in metro, urban and rural settings;

3. The regulatory framework for ensuring the quality and competence of physicians including, but not limited to, a review of the Health Professionals Act; and

4. The effectiveness of BC’s approach to licensing, credentialing, privileging, monitoring and enhancing performance for physicians compared to other Canadian jurisdictions and against evidence-based best practices.

KPMG sub-contracted with the law firm Osborne Margo to complete the legal and regulatory review in conjunction with our work. That report summarizes the legal framework for physician regulation in BC and identifies key issues regarding BC’s current regulatory framework. The report also includes a summary of the physician regulatory frameworks in Alberta, Saskatchewan and Ontario. While we quote the Osborne Margo report in the context of our findings, their report has been submitted as a stand-alone document.

As an extension to the original scope, the Ministry requested that KPMG provide commentary on all the initiatives underway and link progress with our suggestions for improvement.
**Approach**

We agreed the following key deliverables in our approach with the Ministry to frame the work we would undertake to review existing processes for licensing, credentialing, privileging, physician performance monitoring and peer review in BC at the College, the Ministry, HAs and hospitals:

- Development of a project charter and work plan;
- Development of a Review Assessment Framework (RAF);
- Final report with summary of findings and advice; and
- Final report presentation to the Ministry Action Team.

Given the time and resources available for this review, we agreed with the Ministry that we would focus our attention on the acute care sector and, in a more limited way, private Non-Hospital Medical Surgical Facilities (NHMSFs) in the Province. Specifically we agreed that we would not examine practices within other areas of the health care system such as community provision, mental health services or long-term care.

**Understanding this report**

The purpose of this report is to outline certain matters that came to our attention during our work and to offer our comments and suggestions for improvement for the Ministry’s consideration. These comments, by their nature, are critical, as they relate solely to opportunities for enhancement and do not address the many positive features of the Ministry’s current activities and undertakings.

Our procedures consisted of inquiry, surveying, and analysis of information provided by the Ministry, the College and HAs. The Ministry approved the interview list and the extent of the other materials provided by project participants. Such work does not constitute an audit. Accordingly, we express no opinion on processes, other information or internal controls.

The evidence that supports our suggestions for improvement has been gathered through completed questionnaires, interview feedback and other comments, explanations and information received during our work. We are not responsible for this evidence; the sole responsibility lying with those who provided us with information and those we interviewed or otherwise interacted with during this review.

Our findings arise from our enquiries, although we can provide no assurance as to the day-to-day operation of either those procedures reviewed or issues relating to physician licensing, credentialing, privileging and performance management in general. KPMG assumes no responsibility for our findings and we have not attempted to establish whether the issues raised in the report are pervasive, commonplace or rare; the issues raised are merely those that occurred during the course of our interviews and other work. All procedures covered in this report are dependent for their effectiveness on the diligence and propriety of those responsible for operating them and are capable of being overridden by persons holding positions of authority and trust.
We have not graded our suggestions for improvement and have not sought to emphasize their importance in any way. Our report has been factually checked by the Ministry and senior clinicians, as well as all members of the Ministry Action Team and VP Medicines, or equivalent, at all HAs.

The Ministry is responsible for the decisions to implement any recommendations and for considering their impact. Implementation of these opportunities will require the Ministry to plan and test any changes to ensure that the Ministry will realize satisfactory results.

**Key observations**

**Licensing**

The Provincial Physician Registry project being undertaken by the Ministry Action Team will assist in helping structure information on licensing and will make it easier for information on restrictions on physician licenses to be made more readily available across the healthcare system.

We make the following key observations in respect of licensing:

- The College has a robust and sound system for processing applications to be licensed in BC;
- The Federation of State Medical Boards in the US has a universal database that contains information on any disciplinary procedure across the US since the 1960s. BC would benefit from a similar system across Canada that incorporates standardization of aspects of the Agreement on Internal Trade; and
- The UK system of revalidation requires all doctors to demonstrate their licenses are up to date and their ongoing fitness to practice through five years of appraisal data, continuing professional development and multisource feedback. A similar system would reduce risk in BC.
Credentialing and Privileging

The replacement of the current paper-based system for reappointment of privileges through the Provincial Physician Registry system will address many of the identified issues and gaps identified. It will also assist in better structuring information on privileging, along with the Provincial Core Data Set project. The Provincial Credentialing and Privileging project will be key to advancing the debate on the establishment of Province-wide standards and the creation of definitions for use in privileging across the Province.

We make the following key observations in respect of credentialing and privileging:

- The current BC Locum Program registry has potential to be used inappropriately as some physicians could view it as a license to practice without formally obtaining privileges
- The College currently plays a statutory role in reviewing credentials for physicians seeking privileges for restricted activities. Most stakeholders agreed this was not an appropriate role for the College given the amount of due diligence already conducted by the HAs, although it will require a change in statute to correct;
- There is no common definition for ‘credentialing’ and ‘privileging’ within the system and they are used interchangeably, creating confusion;
- There are no independent checks that privileging processes are being followed in HAs;
- Few HAs have Board approved minimum standards that contain definitions for expectations of the minimum number of years experience/number of procedures regularly performed and any standards that are defined are not standardized across the Province;
- Duties need to be better segregated, especially within smaller facilities;
- The structure for regular physician reviews is inconsistent across and within HAs;
- The time taken to formally approve privileges is sometimes too long and results in significant use of the granting of temporary privileges; and
- Local processes could be streamlined to reduce the number of steps in the credentialing and privileging process.

Our work also identified the following leading practices in credentialing and privileging in BC:

- Independent Director participation in the Credentials Committee and Health Authority Medical Advisory Committee (HAMAC) at Vancouver island health Authority (VIHA);
- Department Heads meet with all physicians at Vancouver Coastal Health Authority (VCHA) and Provincial Health Services Authority (PHSA) during the re-appointment process; and
- PHSA uses an online re-appointment system that streamlines physician submissions.
Performance Management

The Provincial Performance Assessment Review project due to be undertaken by the Ministry will provide the opportunity for the system to address the issues raised in our report and will provide the platform for feedback and wider rollout of the Radiology Peer Review and Support project and the Accountability for Denominational Facilities (DFs) project.

We make the following key observations in respect of performance management:

- Stakeholders interviewed stated they would like the Ministry to prioritize performance metrics and provide standardized performance measurement tools;
- Our review identified a consistent theme that the College is perceived to have an advocacy role for physicians although our investigations showed this not to be the case. Any perception was refuted by College Board members;
- Our review found that clinical leadership needs to be addressed across the system, especially the role and function of the Chief of Staff;
- Communication gaps exist across the system, resulting in inconsistent or poor information flows;
- Stakeholders across the Province acknowledged that the collaborative approach demonstrated by the Registrar and her colleagues over the last year have improved their impressions of the College as a partner in strengthening the system;
- The value and importance of good performance management was a common theme in our interviews and stakeholders stated that the focus of performance and peer reviews needs to be aligned to improvement agenda and not viewed as confrontational;
- The College and HAs could share more performance information and participate in a more structured system-wide discussion of performance issues; and
- The Physician Achievement Review in Alberta and the Revalidation process in the UK allow for regular (typically 5 year) reviews of all physicians and 360 degree surveys that assist in the monitoring and focus of physician performance have been adopted in the US.

Our work also identified the following leading practices in performance management of physicians in BC:

- PHSA has adopted a pilot program to assist in training and supporting Department Heads; and
- Staff at PHSA have a mandatory 360 degree review every three years.
Suggestions for Improvement

Our findings indicate that there are a number of areas that need to be improved. When considering our suggestions for improvement we found that a number were relevant to more than one of the three key areas of licensing, credentialing and privileging and performance management. Accordingly we have grouped our suggestions for improvement under three headings:

- Accountability;
- Role of the College and HAs; and
- Clinical leadership.

Our suggestions for improvement need to be put in context of the current workload of the Ministry and its perception of both the need and the extent for change.

Accountability

Aligning performance to contracts

- The system of contracting with physicians within BC should be compared to other jurisdictions so that the pros and cons of changing the system could be assessed within the context of making physicians more accountable for their performance and encouraging greater levels of self- and peer-assessment. Any changes should be addressed through medical by-laws or other mechanisms as appropriate. Options could include:
  - Mandate that annual appraisals form an integral part of the Medical Services Plan (MSP) process, potentially with physicians asking to self-certify and the Ministry then performing central checks to ensure compliance, installing powers to suspend registration if physicians do not comply;
  - Introducing an element of performance-related bonus to award good quality, and alternatively a withdrawal of an element of pay for poor performance;
  - Consider mandating HAs to hold MSP contracts for all procedures performed in their HA, thereby providing the opportunity for local input and performance management into those areas that HAs consider most productive and effective; and
  - Mandate physicians move to central contracts with HAs and put in place appropriate support and Human Resources (HR) processes similar to other professional staff groups.

Stewardship and management of HA Boards

- The Ministry should review its wider role and define the extent to which it provides effective stewardship to the system by studying models from other jurisdictions. Depending on the outcome of that review, the Ministry should assess the short-term and longer-term changes required so that a framework for holding HA and DF Boards accountable for the implementation of policy directives and for physician governance and management in particular can be developed, along with the associated reporting mechanisms.
Executive accountability on HA Boards

- The Ministry should review governance models in other jurisdictions to establish whether a case could or should be made for a different model of governance within healthcare to reflect commercial leading practice and allow greater levels of direct accountability for Executive management. This may be necessary especially if contractual accountability changes;
- All HAs should establish an audit process through internal audit or another independent body to regularly review appointment and re-appointment processes and compliance (we consider that clinical audit is not capable of performing such a review as they are not necessarily experts in process). The Ministry should mandate HAs to perform this function and self-certify that they have complied with that mandate; and
- Where HA Boards have identified clinical challenge as a weakness, they should be encouraged to consider how to augment their ability to challenge clinically, potentially seeking to appoint an independent Medical Adviser mandated to specifically assist them gain comfort on the adoption of processes and the performance management of physicians generally.

Province-wide reporting protocol

- The College, HAs and DFs should share information to establish agreed definitions for the sort of issues or problems that indicate where physicians may present a risk. Once defined, the size of the population of those physicians should be determined and used to establish the urgency of the timetable for establishing a Province-wide performance management framework;
- The Ministry should oversee the establishment of a Province-wide reporting protocol which should be agreed by the College, each HA and all DFs. The protocol should outline what information related to performance should be provided, how it is to be provided, and when it should be provided. Moreover, each layer of the system (Ministry, HAs, DFs, College) should define what data it requires and why, to establish robust information and systems required for managing physician performance. Datasets from these deliberations can then be used to inform the development of the provincial information system. This reporting protocol should also be incorporated into the model staff by-laws which are currently being developed;
- The Ministry should consider whether the by-laws of the College need to be amended to reflect the need for certain performance information to be shared with HAs to mirror the by-laws of Saskatchewan. This is critical to enable the system to respond to potential areas of public concern, especially regarding the safety of patients;
- The Ministry’s Legislation and Professional Regulation Branch should review the legislative amendments being proposed in Ontario to establish whether the recommendations made by the College could be applicable in addressing the gaps identified in BC; and
- The College should review the Pulse Program in more depth to ascertain how the processes contained within it could be brought into assisting with the monitoring and processing of performance management concerns and the College’s own processes within BC.

Medical school participation in any new performance management framework

- The Terms of Reference for each Joint Advisory Committee between the HAs and the University of British Columbia (UBC) should be amended to include issues of performance management and remediation, including:
  - Discussing performance issues of residents in the HA; and
  - Discussing remediation opportunities for individual physicians, as well as broader systemic remediation program requirements.
HA systems for granting privileges

- While a number of the initiatives launched by the Ministry in response to Dr. Cochrane’s report address some of the inefficiencies identified above, the Ministry should mandate that HAs implement and effectively use the new systems being developed to minimize the risk of different levels of uptake in different HAs;
- Some of the recommendations may be processed by updating the medical staff by-laws within HAs. Any changes to the by-laws should be reviewed by the Ministry’s Legislation and Professional Regulation Branch prior to HAs seeking to obtain Physician Services Strategic Advisory Committee (PSSAC) or other approval so that the Ministry has the opportunity to consider the recommendations and has made decisions on the broader systemic issues;
- The Ministry should provide structure to confirm that the new Physician Registry and Peer Review software systems are set up correctly from the beginning, establishing:
  - The datasets required by all parties;
  - The right levels of functionality and reporting for all parties;
  - The ownership of the system and maintenance arrangements, with suitable methods of cross-charging for cost established; and
  - Governance arrangements, especially in relation to privacy of information, etc; and
- The Physician Registry should have the datasets available to all stakeholders so that compliance with privileging and performance management processes can be audited and levered so that the Ministry retains the right to withhold or suspend MSP status until and unless issues can be satisfactorily resolved.

Systems for Provisional Registrants

- The College and the Ministry should work together to review whether the system for continual review of Provisional Registrants should be adopted for performance managing physicians identified as posing a risk.

BC Locum Program

- The Physician Registry currently being developed should have the capability of identifying and tracking locums, and the Ministry’s registry through the BC Locum Program should be discontinued once the new system is in place and working correctly.

Role of the College and HAs

Stronger role for the College

- The Ministry should work with the College to agree the financial and organizational impact of any realignment of role. While some of that impact may be derived from contributions to the College, other aspects may need to be agreed centrally.
Enhancing the role of the College (1) – Provincial Performance Management Framework

- The College should be an integral part of the new performance management framework. As this involves all organizations across the system and the Ministry, we have included recommendations in the Accountability section above.

Enhancing the role of the College (2) – New technology and procedures

- The College should be accountable for publishing, on a timely (perhaps annual) basis, a list of new technology and procedures with guidance on training, standards and testing to inform the privileging process for those new developments. This work should be done in collaboration with the HAs and aligned with the mandate and activities of the new Health Technology Assessment Committee being set up by the Ministry; and
- The Tariff Committee rules should be amended to align with the process established by the College such that no fee, whether temporary, permanent or otherwise, is granted until the appropriate supporting resources (i.e.: space, nursing staff, etc.) as well as minimum competency standards are established.

Enhancing the role of the College (3) – Providing Minimum Standards for Credentialing

- The College should be mandated to manage the current procurement for a Provincial Credentialing & Privileging technology solution and should take responsibility for expediting the project completion timeline. A revised structure and timeline should be agreed with the Ministry and robustly performance managed;
- On an ongoing basis, the College (as the body that is consistent and is the most established and credible in terms of peer review and assessment) in collaboration with the VP Meds of the HAs, should be mandated to be responsible for establishing and agreeing minimum credentialing standards for all disciplines and report back progress to the Ministry and HA Boards as appropriate;
- The College should report to the Ministry on how to best to engage the debate on standardizing credentialing and privileging definitions across Canada. It is important that an action plan for that debate is constructed, including stakeholder maps and an analysis of the timeline (with associated local performance management goals). Once systems are in place in BC, the College (with support from the Ministry) should seek to establish minimum standards with other Colleges across Canada so that the system can have confidence in the work performed in other jurisdictions for doctors moving to BC; and
- The Ministry should consider engaging the public in a structured debate on standards across the Province to assess what services are acceptable to the public and where the boundaries of the postal code medicine\(^2\) debate should be drawn. Before the question can be answered, the Ministry could assess firstly whether the public should or could be consulted on acceptability of service, either in market research groups or more widely, and then work to define acceptability to inform definitions of minimum standards (potentially by geography).

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\(^2\) Refers to the debate of which services are provided in which communities based on geography and proximity to major centres.
Enhancing the role of the College (4) – Revalidation

- The College should expedite its efforts in implementing a process for physician revalidation. The Ministry should consider timelines for the introduction of revalidation, how to effectively performance manage the College if this task is mandated and establish an accountability framework for delivery and rollout of the revalidation program.

Redefining the College’s stewardship of quality

- The College needs to consider how it can engage with the system, especially the HAs, consulting with stakeholders and seeking to consolidate its mandate and build greater awareness of the function of the College, its commitment to quality and to build the relationships and understanding that will underpin the development of a performance management framework.

Realignment of the role of the College - Credentialing and privileging

- Responsibility for credentialing for diagnostic imaging and non-hospital surgical medical facilities should be transferred to another organization. For this to occur:
  - The Ministry needs to confirm that the entity that undertakes this responsibility are also signatories to the performance management framework (see below) so that they have the ability to communicate and share concerns for NHMSFs across the system; and
  - All MSP-related activity for restricted activities should be performed through existing mechanisms;
- The Ministry and College should work together to review whether the amendments being proposed in the Out-of-Hospital Premises Inspection Program in Ontario could be applicable in addressing the gaps in NHMSFs in BC; and
- The Ministry should consider the support the College requires to enable all of the above changes to take place. This would include providing independent support to the Board as required and in establishing a plan for managing change.

Clinical leadership

- The role of clinical leaders and their recruitment needs to be reviewed so that their role can be defined and standardized across the Province. The review needs to consider how to make these roles attractive to the right leaders through a combination of various levers including remuneration, the bestowing of real authority and the ability to contribute to the wider change agenda.
- The Ministry should work with all HAs to agree clinical leadership models that can be installed across the Province, with physicians taking far greater responsibility for the management of services and the modernization agenda generally. These models should then be linked to broader accountability frameworks so that real local accountability and performance management structures can be agreed across the system, with escalation policies in place that inform Boards and provide impetus to the service improvement agenda of all HAs.
Future State

Centralization and standardization of structure
We were asked to consider whether a single, centralized process for licensing, credentialing, privileging and managing performance of physicians would be beneficial and have concluded that the case for having a central organization manage the process has not been made, although our suggestions for improvement identify where activities can be better aligned.

Continuum of future system improvement
Based on our analysis of the current system, our suggestions for improvement, learning from other jurisdictions and input from stakeholders throughout this process, we have suggested a future-state view of how the system could be designed. This future state will be characterized by:

- The Ministry performing a stronger stewardship role, with HA Boards and Executive Teams having greater accountability for physician performance management and links made between physician payment and outcomes;
- A stronger and more integrated role for the College, taking an enhanced leadership role in setting minimum standards for all physicians in BC and realigning certain identified other responsibilities with HAs; and
- Improved clinical leadership with clinical leaders being better supported in order to fulfill their role in managing the day-to-day activities of physicians.

We appreciate that reaching this end state vision will take time and will be informed by the work already underway through the eight projects being undertaken by the Ministry Action Team, the suggestions for improvement in this report and the Osborne Margo review.

Acknowledgement
KPMG has appreciated:

- The opportunity to serve the Ministry;
- The excellent level of cooperation from the Ministry, the College and other stakeholders for pulling together background materials and their participation in our interview and survey process; and
- The frank and open input received from interviewees.
Chapter 2: Report structure and background

Understanding this report

The purpose of this report is to outline certain matters that came to our attention during our work and to offer our comments and suggestions for improvement for the Ministry’s consideration. These comments, by their nature, are critical, as they relate solely to opportunities for enhancement and do not address the many positive features of the Ministry’s current activities and undertakings.

Our procedures consisted of inquiry, surveying, and analysis of information provided by the Ministry, the College and HAs. The Ministry approved the interview list and the extent of the other materials provided by project participants. Such work does not constitute an audit. Accordingly, we express no opinion on processes, other information or internal controls.

The evidence that supports our suggestions for improvement has been gathered through completed questionnaires, interview feedback and other comments, explanations and information received during our work. We are not responsible for this evidence; the sole responsibility lying with those who provided us with information and those we interviewed or otherwise interacted with during this review.

Our findings arise from our enquiries, although we can provide no assurance as to the day-to-day operation of either those procedures reviewed or issues relating to physician licensing, credentialing, privileging and performance management in general. KPMG assumes no responsibility for our findings and we have not attempted to establish whether the issues raised in the report are pervasive, commonplace or rare; the issues raised are merely those that occurred during the course of our interviews and other work. All procedures covered in this report are dependent for their effectiveness on the diligence and propriety of those responsible for operating them and are capable of being overridden by persons holding positions of authority and trust.

We have not graded our suggestions for improvement and have not sought to emphasize their importance in any way. Our report has been factually checked by the Ministry and senior clinicians, as well as all members of the Ministry Action Team and VP Medicines (VP Meds), or equivalent, at all HAs.

The Ministry is responsible for the decisions to implement any recommendations and for considering their impact. Implementation of these opportunities will require the Ministry to plan and test any changes to ensure that the Ministry will realize satisfactory results.
Report structure

This Chapter provides context for the reader on the background of this review, our mandate and approach to completing the work.

Chapter 3 provides the reader with an understanding of the roles and responsibilities of all organizations which informs our analysis in subsequent Chapters. It also includes an analysis of progress on the eight initiatives put in place to address the Ministry’s response to Dr Cochrane’s report.

Chapter 4 details the Ministry’s response to Dr. Cochrane’s report and sets out commentary on the eight initiatives being managed by the Ministry Action Team as part of that response.

Chapters 5, 6 and 7 outline our findings related to physician licensing, credentialing and privileging and performance management respectively, under seven headings:

- Key observations
- Role of organizations;
- Communication;
- Governance and accountability;
- Process;
- Technology; and
- Learning from other jurisdictions;

Chapter 8 details our suggestions for improvement and sets out a suggested future state for managing licensing, credentialing and privileging and performance management in BC.

Appendix A is an overview of current licensing, credentialing, privileging and performance management processes, including process maps that illustrate the processes and systems in place by the College, the HAs and healthcare providers. Appendix A is informed by Appendices B and C that set out process maps in more detail for initial privileging and ongoing privileging re-appointments.

Appendix D details credentialing standards used at all HAs that informs our analysis of credentialing in Chapter 6.

Appendix E sets out an overview of the US Data Bank and Appendix F sets out different Board directives for peer review, both informing our analysis of performance management in Chapter 7.

Finally, Appendices G to I detail the Review Assessment Framework discussed further in this Chapter.
Background for the review

In late 2010 and early 2011, problems were identified with the quality of radiology image interpretations within Fraser Health Authority (FHA), VCHA and VIHA. Upon investigation, the HAs found that there were deficiencies in the experience and performance of the identified radiologists. Third party reviews were commissioned to assess the situation and determine whether patient care was adversely affected. In all cases, the privileges of these radiologists were suspended.3

As the deficiencies did not involve a single isolated event, rather were driven by identified, systemic concerns in a number of different parts of the Province, the Honourable Colin Hansen, then Minister of Health Services, commissioned an independent review by Dr. Doug Cochrane, Provincial Patient Safety and Quality Officer and Chair of the BC Patient Safety & Quality Council.

Dr. Cochrane’s review was split into two phases. Phase 1 reviewed the credentials of all radiologists in the Province to determine if all were qualified to review radiology images. The report concluded that as of February 2011 there were 287 practitioners licensed (at the time) to provide diagnostic imaging services. He concluded that all met the criteria required by the College for licensure and that all were providing services within the scope defined by their license.4

Phase 2 provided “a description of the [four] incidents, an analysis of causes, the response by the HA to the event and the role of the College.”5 The report, along with the Ministry’s response, was released on September 27, 2011 when the new Minister of Health, the Honourable Mike de Jong, confirmed that the Ministry had accepted Dr. Cochrane’s 35 recommendations and had created an action plan to implement his advice.6

Given that Dr. Cochrane’s review focused on radiology, and to a certain extent focused on the three HAs involved in the initial incidents, the Ministry commissioned this review for the whole Province in November 2011.

Terms of our engagement

KPMG was contracted to conduct a review of the existing College, Ministry, HA and hospital processes/systems for: licensure, credentialing, privileging, physician performance monitoring and peer review in BC, and relevant legislation pertaining to the previously mentioned items. This included the identification of suggestions for improvement and a suggested quality improvement strategy. Key deliverables included:

- Development of a project charter and work plan;
- Development of an assessment framework;
- Final report with summary of findings and advice; and
- Final report presentation to the Ministry Action Team.

As an extension to the original scope, the Ministry requested that KPMG provide commentary on all the initiatives underway and link progress with our suggestions for improvement.

Out of scope

Given the time and resources available for this review, we agreed with the Ministry that we would focus our attention on the acute care sector and, in a more limited way, private Non-Hospital Medical Surgical Facilities in the Province. This review did not examine practices within other areas of the health care system such as community provision, mental health services or long-term care.

KPMG sub-contracted with the law firm Osborne Margo to complete the legal and regulatory review. While we quote their report in our findings, their report has been submitted as a stand-alone document.

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7 These private facilities were involved in an online survey and covered through our interviews with leaders from the College, however, we did not conduct on-site visits or follow up with telephone interviews.
Our workplan for completing this review

Our approach to completing this review, including the key activities, is illustrated below (Figure 2-1).

**Figure 1-1. Our Approach**

- **Project Initiation**
- **Legal & Regulatory Review**
- **Health Facility Survey**
- **Stakeholder Meetings**
- **Canadian College Comparisons**
- **Assessment Framework Development and Validation**
- **Review of the Ministry**
- **Review of the DisC College**
- **Review of the Health Authorities**
- **Review of Health Facilities**
- **Analysis & Reporting**

**January**  |  **February**  |  **March**

**Project initiation**

The project began with a working session with the Action Team during the first week of January and the Project Charter was approved by the Project Sponsor on January 10, 2012. The key elements of the Project Charter included:

- Project objectives;
- Key messages to be used with stakeholders;
- An evaluation framework which outlined how the success of this engagement would be measured;
- Project management methods including roles and responsibilities, weekly status reports and the approach to raising and addressing issues and challenges;
- Project risks and mitigation strategies; and
- Detailed workplan on each project activity.

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8 This group is mandated with overseeing the implementation of the Physician Quality Assurance Portfolio which was created based on the recommendations in the review completed by Dr. Cochrane. Membership includes representatives from the Ministry, College and HAs, as well as other consultants who act as advisers to the group.
Development of the Review Assessment Framework

Upon confirming our mandate, we developed the RAF which outlined the data we would require and areas of inquiry we would pursue with every entity being reviewed. The RAF was approved by the Action Team on January 31, 2012 and is attached at Appendix G.

To inform the development of this framework, we completed the following activities:

- Stakeholder meetings with officials from the Ministry, the College and the UBC Faculty of Medicine. We also met with Dr. Doug Cochrane;
- Meetings with the Royal College of Physicians and Surgeons of Canada (Royal College), the College of Family Physicians of Canada (CFPC), the Medical Council of Canada (MCC) and senior leaders within the Colleges of Physicians and Surgeons in Ontario, Saskatchewan and Alberta;
- An online survey of all acute care hospitals in BC (attached at Appendix H); and
- An online survey of selected, agreed private NHMSFs (attached at Appendix I).

Legal & Regulatory Review

A legal and regulatory review was completed by the law firm Osborne Margo. That report summarizes the legal framework for physician regulation in BC and identifies key issues regarding BC’s current regulatory framework. The report also includes a summary of the physician regulatory frameworks in Alberta, Saskatchewan and Ontario. The Osborne Margo report should be read in conjunction with this report.
Review

Using the agreed RAF we held a series of meetings and interviews with leaders within four groups of organizations:

- **The Ministry**: including fifteen staff from the HAs and Medical Services Divisions;
- **The College**: including two half-day sessions, one with the Registrar and Deputy Registrar (Registration) and another with the Senior Deputy Registrar. We also interviewed six members of the College Board;
- **Every HA**: three separate interviews were held at each of the six HAs: one with the VP Med and staff responsible for credentialing (which in some cases also included the Chair of the Credentials Committee), one with the VP Med and Chief executive Officer (CEO), and one with either the Board’s Quality Committee and/or Board Chair. In the case of the PHSA, an interview was held with the VP of Physician Compensation, and
- **A sample of hospitals in BC**: eight facilities with interviews involving the Chief of Staff or Chair of the local Credentials Committee and staff from the Medical Affairs Office (MAO), as agreed with the Ministry, who also approved the following list of hospitals reviewed:
  - BC Children’s Hospital;
  - Cowichan District Hospital;
  - Peace Arch General Hospital;
  - South Okanagan General Hospital;
  - Squamish General Hospital;
  - St. John Hospital (Vanderhoof);
  - St. Joseph’s General Hospital (Comox); and
  - University Hospital of Northern British Columbia.

Reporting

The key themes and data emerging from the review are analyzed and presented in this report.

Project management

A number of project management methods were used throughout the engagement to assist in meeting project milestones. Specific activities included:

- Developing a detailed project charter which outlined key activities and milestones;
- Providing weekly status reports, including highlighting of weekly activities as well as risks and challenges; and
- Participating in briefings and seeking approval of key activities and deliverables with the Ministry and key stakeholders.
Chapter 3: Roles of Key Organizations in Physician Licensing, Credentialing, Privileging and Performance Management

This Chapter introduces the key organizations involved in physician licensing, credentialing, privileging and performance management within BC and the current role that they serve, dealing in turn with the Ministry, the College, HAs and DFs and medical education bodies.

The Ministry of Health

The Ministry has a narrow, but important, role in relation to the practice of physicians in BC. The Minister of Health (Minister) has overarching responsibility for public safety and health service quality and as such has specific and final authority for regulation under the Health Authorities Act, Hospital Act, and Health Professions Act (HPA). The Minister can appoint a person to inquire into aspects of the operation of the College or the state of practice of the profession. They also approve College and HA by-laws which include physician privileging and performance management governance.

The Minister enters into accountability and performance agreements (called Government Letters of Expectation) with HAs on an annual basis that define the expectations and performance obligations of each HA. The role that the Ministry undertakes in regulating the system is set out in more detail in the legal and regulatory review completed by Osborne Margo.

Through our review meetings with the Ministry, we identified several functions and initiatives which relate to physician management:

- **Assistance with work permits**: Providing ‘Confirmation Letters of Need’ to support an application for a work permit in Canada.
- **Funding post-graduate placements**: Setting out the number of placements that will be funded for post-graduate residents.
- **BC Locum\(^9\) Program**: Refers to a registry of physicians who are available to provide locum services. Locum positions can be posted through this registry, yet the physician will apply directly to the facility and/or HA to provide the service.
- **Model medical staff by-laws**: Work has been initiated to look at model medical staff by-laws. Over time, it is anticipated that each HA and DF would amend their by-laws to conform with a Provincial standard.

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\(^9\) A locum is a physician who temporarily fulfills the role and responsibilities of another physician.
The College of Physicians and Surgeons of British Columbia

The College is the licensing and regulatory body governing physicians in British Columbia. It is responsible for physician registration and licensure, complaints, investigations and discipline, as well as a variety of quality assurance (QA) programs and related matters. The College website states that “The College’s overriding interest is the protection and safety of patients, and the quality of care they receive from licensed physicians in BC.”

The role of the College includes:

- Establishing standards that must be met by physicians in order to get a license to practice medicine in BC;
- Ensuring physicians meet high standards of practice and conduct;
- Addressing and dealing with complaints about physicians; and where necessary, disciplining physicians;
- Ensuring that medical facilities such as private surgical clinics, labs and diagnostic imaging centres meet established standards through a formal accreditation process; and
- Working collaboratively with government, universities, hospitals and other organizations to address issues such as improving access to health care services and improving the quality of care patients receive.”

Through this mandate, the College has taken responsibility for two statutory accreditation programs:

- The Diagnostic Accreditation Program (DAP); and
- The Non-Hospital Medical Surgical Facility Program.

The College is governed by a 15-person Board of Directors which includes ten physicians elected by College registrants, and five public members who are appointed by the Provincial government.
Health Authorities and Denominational Facilities

HAs have primary responsibility for the quality of care and services within their respective regions. Part of this role includes owning and managing publicly owned hospitals and facilities within their territory as well as contracting with and performance managing other health care providers. Five of the six HAs in BC have regional mandates (FHA, Interior Health Authority (IHA), Northern Health Authority (NHA), VCHA and VIHA) with one, PHSA, having a Province-wide mandate for selected services. Through the *Hospitals Act*, the Boards of the HAs are responsible for granting physician privileges. Within their mandate of providing quality of care and services, HAs have a role in monitoring physician performance.

Each HA has a Board of Directors, accountable to the Minister of Health. Within the HA structure, there are a number of committees and individuals involved in physician credentialing, privileging and performance management:

- **HAMAC**: An advisory committee to the Board and the CEO, the Committee makes recommendations to the Board on physician privileges as well as have some oversight responsibility for performance management.
- **Chief Executive Officer**: Along with regular management duties, the CEO has the authority to grant temporary privileges subject to Board approval.
- **Vice President, Medicine**: Also referred to as the Chief Medical Officer (CMO), they act as a key resource and point of contact for the Board and Senior Medical Directors. They also play a role at a Provincial level in coordinating initiatives related to physician credentialing, privileging and performance management. In some HAs, the CEO has delegated the authority to grant temporary privileges to the VP Med.
- **Regional Medical Advisory Committee (MAC)**: Some Authorities have Regional MACs which review applications for privileges after they have been reviewed by the Credentials Committee but before going to HAMAC.
- **HA Credentials Committee (HACC)**: This body reviews applications for privileges before they are sent to HAMAC.
- **Senior Medical Directors**: Some HAs have adopted a regional approach to managing physician privileges and performance. The Senior Medical Director has a role in oversight and ensuring compliance of procedures at a local level. This person is often involved in reviewing applications and managing performance issues before they reach the VP Med/CEO and/or Credentials Committee levels.
- **Local Credentials Committees and Medical Advisory Committees**: These Committees (if they exist) function at an individual hospital or facility and review applications for privileges before they are sent through the approval process.
- **Department/Division Heads and Chiefs of Staff**: At the hospital-level, these individuals have a role in physician recruitment, reviewing and recommending applications for privileges as well as fulfilling performance management duties in their area.
- **Medical Affairs Office**: Administrative staff within the HA as well as each hospital who manage administrative functions. This includes reviewing applications to confirm that they are complete, flagging any concerns for further review, and coordinating the distribution of documents through the process.

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14 Committee and position titles vary from HA to HA. This list is intended to provide an overall representation of the roles and responsibilities.
In addition to the HAs, there are hospitals in BC which are owned by faith-based organizations. These DFs are subject to the same legislation regarding physician governance as the hospitals that are owned by HAs. These facilities have accountability agreements with the Ministry, but also enter into Affiliation Agreements with their respective HAs to provide a framework for a co-operative working relationship between the two entities.

**Medical education bodies**

There are four entities that are relevant to medical education in BC. Successful completion of their programs and examinations are relevant to licensure by the College.

The MCC is responsible for the development and provision of the examinations for all who want to practice medicine in Canada. Successful completion of all MCC Qualifying Examinations leads to recognition as a Licentiate of the MCC. This recognition is required to practice and is one of the requirements to be licensed as a physician without restriction\(^\text{15}\).

Physicians in Canada also need to be certified by either the Royal College or the CFPC, depending on what type of medicine they intend to practice; general practitioners (GPs) require CFPC certification while medical and surgical specialists require Royal College certification.

UBC is the sole provider of medical education in BC. It also provides training and limited individualized remediation programs for physicians. Joint Advisory Committees have been established between UBC and each HA with the mandate of discussing mutual areas of interest related to education, research and the medical community. We have been advised that these Committees have little involvement in discussing issues of credentialing, privileging or performance management.

\(^{15}\) Some applicants for licensure can be granted provisional registration subject to successful completion of some MCC exams.
Chapter 4: The Ministry’s response to Dr. Cochrane’s report

Following the release of Dr. Cochrane’s Phase 2 report, the Ministry has worked with the College and the HAs to produce the Ministry Action Plan that addresses the issues raised in the report and as a result eight initiatives have been launched to create a provincial framework which establishes consistent criteria and processes for credentialing, privileging and managing performance. These eight initiatives are commonly referred to within the Ministry as the Physician Quality Assurance Portfolio. A ‘Logic Model’ was developed to illustrate the ideal state of physician oversight and management; an end state which the eight projects will help to achieve. The Logic Model is subject to intellectual property rights and has not been reproduced in this report.

The eight initiatives are:

1. **Review of provincial system**: This review and report;

2. **Provincial Physician Registry**: This will be a Province-wide software tool which will link the College and HAs to maintain current information about licensing, credentials, and privileges;

3. **Provincial Credentialing and Privileging project**: A group has been established to set Province-wide standards and definitions of credentials required to privilege each type of physician and activity;

4. **Provincial Core Data Set**: In support of the Physician Registry and Provincial Credentialing and Privileging project, a group has been working to establish a common Province-wide form which will be used when applying and re-applying for privileges;

5. **Provincial Performance Assessment Review**: This will involve the development of a provincially consistent, but regionally administered, framework for active performance assessment of medical staff;

6. **Radiology Peer Review and Support**: With the intent of establishing a Province-wide system, VIHA is currently launching a pilot project for radiology peer review;

7. **Accountability for Denominational Facilities**: The Ministry is leading a discussion to strengthen accountability between the Ministry, HAs and Denominational Facilities (DFs) to clarify roles and authority in terms of quality and patient safety matters; and

8. **Adverse Event Protocol**: The Ministry is strengthening the protocol which sets out when and how the HAs must inform the Ministry of an adverse event.
These eight initiatives are mainly systemic in nature and their successful implementation will be critical to addressing some of the issues and gaps identified in this review. Broadly, projects 2, 3 and 4 relate to systems and processes for licensing, privileging and credentialing, with projects 5, 6, 7 and 8 concentrating predominantly on performance management, concentrating on accountability. Each of the initiatives are addressed in turn below.

**Review of the provincial system**

This report addresses this initiative.

**Provincial Physician Registry**

In January 2012, a rfp was issued to procure a common physician registry which all of the HAs would use. The rfp documentation\(^\text{16}\) states that “it is envisioned that the following modules will be part of a provincial medical affairs performance management system:

- Credentialing & Privileging;
- Peer and In-depth Review;
- Performance Management;
- Scheduling and Related Compensation;
- Sessional Compensation; and
- Contract Management”

To address the systemic gaps identified in this report (mainly variances in processes and standards as well as breakdowns in communication), interviewees felt it imperative that:

- This be a single, Province-wide solution;
- The procurement includes the participation of the College; and
- The procurement ensures that the system is scalable and capable of including physicians working throughout the Province, whether at facilities run by HAs or other bodies, including denominational and private facilities.

Discussions are underway to address issues related to governance, who will own the single license and how it will be paid for. In addition, some of the datasets required by the different users of the system (Ministry, HAs and College) have yet to be finally agreed. If the system is to be used for different uses including performance management, these datasets may need to be further discussed and agreed prior to any further decisions being made on the procurement.

\(^\text{16}\) Health Shared Services BC. *Request for Proposal for practitioner credentials and performance management.* RFP# HSSBC-00529, issued on December 14, 2011. Received electronically by the Ministry of Health.
**Provincial Credentialing & Privileging Project**

The end-state goal for this project is to have Province-wide credentialing standards for each specialty in the Province. As a starting point, the group is currently working to establish standard definitions and from there will set the credentialing standards. While they are currently focused on radiology, they will expand to all other types of medicine as the project progresses.

All HAs, as well as the College, are participating in the initiative. It is expected to take approximately three years to complete the work.

**Provincial Core Data Set**

To support the development of the credentialing and privileging process, this project involves identifying the minimum data set required for applications to medical staff in a HA. Based on that minimum data set, they will standardize the application forms across the Province.

While we have not reviewed the final product, the project lead has reported that this work has been completed.

**Provincial Performance Assessment Review**

The Provincial Performance Assessment Review will be informed by this review and launched after the publication of this report.

**Radiology Peer Review**

A software tool is currently being piloted by VIHA to facilitate peer review within radiology. The software will provide a central repository where radiology reports can be stored and reviewed by peers. It will also track statistics and information about when a second or third reader disagrees with the interpretation. If there are issues with a particular radiologist, a report can be flagged for the Medical Director.

It is important to note that this software will only provide a mechanism to support peer review within radiology and is not suited to facilitate peer reviews in other areas of medicine.

Phase 1 of the pilot will involve radiologists within VIHA, but it is intended that the software will be adopted by all HAs and DFs. Private facilities will not be included in the system.

The project team identified a number of challenges in connecting all HAs into the single system:

- Each HA has its own unique Picture Archiving and Communication system with distinct workflows;
- Each HA has its own IM&IT platform with different privacy issues;
- There are information sharing and privacy issues that need to be resolved across HAs; and
- There is still some resistance within the radiologist community about participating in peer review.
We have been advised that the Ministry is currently working on a Province-wide information sharing agreement which would address some of these challenges. Many of the challenges are due to the different platforms used across the system and a more detailed action planning process will be required to ensure the project plan is complete and properly assesses the timetable for implementation across the wider system.

**Accountability for DFs**

The goal of this project is to improve accountability of hospitals which are not owned-and-operated by HAs, and to ensure that HAs have the tools required to effectively oversee quality of health care services delivered within their region.

The project team is currently working to identify required system-level changes. Both HAs and DFs have been consulted and the project team has identified a number of leading practices that can be used to strengthen governance within current legislation and the Master Agreement. This work is ongoing.

**Adverse Event Protocol**

This project updated the provincial protocol for adverse event management to include disclosure guidelines. It includes a matrix which establishes when notification is required based on the number of individuals impacted and the severity of the event. It then outlines what type of reporting is required based on the assessment of the event and how it maps to the matrix.

In the past, notification was voluntary. The revised protocol makes notification of more serious events mandatory.

The updated protocol was finalized and went into effect on April 2, 2012.
Chapter 5: Our Findings – Licensing

Key observations

The Provincial Physician Registry project being undertaken by the Ministry Action Team will assist in helping structure information on licensing and will make it easier for information on restrictions on physician licenses to be made more readily available across the healthcare system.

In addition, the following key observations are covered in this Chapter:

- The College has a robust and sound system for processing applications to be licensed in BC;
- The Federation of State Medical Boards in the US has a universal database that contains information on any disciplinary procedure across the US since the 1960s. BC would benefit from a similar system across Canada that incorporates standardization of aspects of the Agreement on Internal Trade; and
- The UK system of revalidation requires all doctors to demonstrate their licenses are up to date and their ongoing fitness to practice through five years of appraisal data, continuing professional development and multisource feedback. A similar system would reduce risk in BC.

Role of the key organizations

The College has absolute authority under the HPA to grant physician licenses. Hence, there are no findings which point to a conflict between the roles of different organizations within the system.

Communication

The College issues Certificates of Professional Conduct (CPCs) which outline any restrictions on a physician’s license. CPCs are provided to the HA or denominational facility when a physician first applies for privileges. However, since CPCs are not required to support the annual application to renew privileges, HAs felt that the College was selective in the information provided when a restriction is placed on a physician’s license. For example, in communicating a restriction on a physician’s license to a HA, the HA will only be informed about that specific constraint without disclosing any additional limits placed on the license. While the College has acknowledged that it could improve its communication, it was noted that restrictions are due to privacy reasons.

All parties need to agree a way forward if information on restrictions can be made more readily available in the future and tracked through the Physician Registry System that is currently being procured as part of the Ministry’s response to Dr. Cochrane’s report.
Governance & Accountability

Within BC, a license issued by the College gives a physician the right to practice medicine. The license indicates the broad area of medicine for which they are qualified (i.e.: general – family, full – specialty), but the HA through the privileging process is tasked with making a determination of what specific areas of medicine they can practice.

While privileges are intended to restrict a physician’s scope of practice to the areas for which they have competence, there is a level of flexibility that has been built into the system based on the geography of the Province and the need to provide services in remote areas. From the patient and Chief of Staff perspective this is a conundrum. As a Chief of Staff, do you have a greater proportion of ‘generalists’ in remote areas, physicians who are adept at stabilizing and treating that know how to perform different surgical procedures and do so on a regular basis to save lives, or do you insist on patients receiving care from specialists that perform procedures regularly enough to be considered technically competent? As a patient, you want access to care as close to home as possible. Therefore, the system has to allow for flexibility while maintaining sufficient mechanisms to monitor physician activity. This is particularly challenging in remote areas.

During the course of our review we were advised of the following issues that are good examples that the procedures for licensing need to be tightened:

- Physicians often rely on nursing staff to raise red flags or file a complaint if a physician is performing outside their approved scope of practice;
- Physician leaders may not know what is happening in other, nearby facilities;
- Extra attention is being paid by HAs to applications re-appointments and performance-related issues for regional territories as there is little management confidence that processes are being followed at the local level; and
- One instance was identified where equipment existed that no one was privileged to use.

Process

As a whole, the College has a robust and sound system for processing applications to be licensed in BC. This is especially true for the management and continual review of Provisional Registrants, including geographic and service constraints.

As with other professions, the College relies heavily on physicians being forthright and honest on their applications. Also, if an application appears to be concern-free (a determination which is made by staff), the physician’s license is considered renewed with no further checks being made unless a complaint or issue is raised by another party. In cases where an issue is raised on the renewal form, the physician's license is still considered to be renewed until the matter is investigated and dispensed with.
Technology

The College’s annual licensure renewal process is completed online, and connects directly with their electronic registry. This allows the College to run variance reports to identify discrepancies on what is being reported with what is known about the physician from previous filings already described. The College’s initial application process is still paper-based, yet we have learned through our interviews with the College that they are working to bring this process online as well in the next few years.

Learning from other jurisdictions

The review did not uncover any significant learning from the licensing processes in other Canadian jurisdictions, although we highlight issues on the Agreement on Internal Trade (AIT) on other aspects of licensing nationally. The international jurisdictions reviewed yielded more insight into how British Columbia could improve its licensing processes and are covered below.

United States

Physician licensing is managed by each State’s medical board and like BC it is a license to practice medicine and does not indicate or certify competence in a sub-specialty. The American Board of Medical Specialties (ABMS) is the US body which is akin to the Royal College in Canada and provides examinations and training to certify that a physician is qualified to perform a specialty area of medicine. ABMS certification is, like a Royal College certification, required to be granted privileges in a specialty.

Each State medical board is a member of the Federation of State Medical Boards. One of the notable activities of this organization is their management of the Federation Physician Data Centre which is a database that includes information on any disciplinary action taken by any State medical board on a physician since the 1960s. Hence, if a physician has applied for a license in one State, that State medical board can query the database to see if there have been any disciplinary issues in another State. The database will also notify any hospital or managed care organizations if one of their physicians has recently been disciplined anywhere in the United States. There is a public component to this database which allows anyone, for a fee, to access information about a physician’s education, medical specialty, licensure history and locations and information on disciplinary sanctions.\(^\text{21}\)

United Kingdom

The General Medical Council (GMC) is the regulator of doctors in the UK and was established under the Medical Act of 1858. Its statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. It is a registered charity and its governance is overseen by a Council. The Council currently has 24 members of which 12 are doctors and 12 are lay members, and all were appointed by the Appointments Commission which is independent of the GMC and of government.

The GMC’s statutory responsibilities are22:

- Keeping up-to-date registers of qualified doctors;
- Fostering good medical practice;
- Promoting high standards of medical education and training; and
- Dealing firmly and fairly with doctors whose fitness to practice is in doubt.

All doctors who wish to practice in the UK must be registered with the GMC and hold a license to practice (issued by the GMC). Licensing of doctors was introduced in the UK by the GMC in November 2009. Prior to that time, doctors needed only to be registered with the GMC in order to practice.

The GMC publishes its register of doctors on-line via its List of Registered Medical Practitioners. In addition, a doctor who is qualified to practice as a GP or as a Specialist may be included on the GP Register or Specialist Register, as appropriate.

Concerns have arisen, to a large extent as a consequence of several high profile fitness-to-practice cases and a number of public inquiries involving doctors and poor medical practice, that a doctor should be required to prove to the GMC his/her competence and fitness to practice on a regular basis. In response to this situation, “Revalidation” is a new process by which such ongoing competence will be checked. It is due to be introduced, via new legislation, in December 2012 across the whole of the UK and will affect all doctors regardless of whether they practice in the NHS or in the private healthcare sector.

Revalidation builds upon the process of appraisal. Specifically, it will require doctors to demonstrate, typically in a five year cycle (similar to the time period adopted in Alberta – see Chapter 7) that they are up to date and fit to practice, through the collation and consideration of five years of appraisal data and supporting information (including complaints, continuing professional development and multisource feedback).

The detail of how revalidation will operate, including how the GMC will receive and process the recommendation to revalidate from a doctor’s employer, are still being finalized in time for the introduction of revalidation later this year. It is expected that the date on which a doctor is revalidated will be published as part of the List of Registered Medical Practitioners which the GMC holds.

22 General Medical Council (UK), 2012. The role of the GMC. Available at: http://www.gmc-uk.org/about/role.asp. [Accessed on March 14, 2012]
Other Canadian Provinces

The AIT was raised as an issue for licensing.\textsuperscript{23} It was noted during the interviews with the College that licensing standards may not be as rigorously applied in some Provinces as they are in BC\textsuperscript{24}. This could result in the College providing a license to a physician in BC when they might not otherwise have done so.

Through our conversations with the Colleges of Physicians & Surgeons in Alberta, Ontario and Saskatchewan, we also learned that the definitions of a ‘restriction’ on a license differ across Provinces. For example, the College in Quebec may place a geographic restriction on a physician’s license because of a performance concern. The challenge for another Provincial College in this example is to ascertain whether the geographic restriction (rather than a specific restriction on the scope of practice) in question is grounds for not granting a license under AIT.

We learned through our interviews that there is an active discussion among the Registrars across Canada to address this challenge and to standardize definitions. And while there is a desire to resolve these issues quickly, the mechanisms that are required to implement any agreed standards are more complex in some Provinces than others. For instance, some Provinces require a legislative amendment – something that could take years to accomplish. Others can simply amend their by-laws to adopt the new standards. Hence, adopting and implementing a Canada-wide solution may take years to accomplish and in the meantime, there could be a risk to patient safety.

\textsuperscript{23} The AIT was amended in January 2009 to require licensing bodies to grant a license to a worker in their jurisdiction if they have a license with no restrictions in another Province.

\textsuperscript{24} Our review did not seek to confirm or refute this statement made by the College, nor did we seek evidence to compare the standards for licensure in other Provinces or territories.
Key observations

The replacement of the current paper-based system for reappointment of privileges through the Provincial Physician Registry system will address many of the identified issues and gaps identified. It will also assist in better structuring information on privileging, along with the Provincial Core Data Set project. The Provincial Credentialing and Privileging project will be key to advancing the debate on the establishment of Province-wide standards and the creation of definitions for use in privileging across the Province.

In addition, the following key observations are covered in this Chapter:

- The current BC Locum Program registry has potential to be used inappropriately as some physicians could view it as a license to practice without formally obtaining privileges;
- The College currently plays a statutory role in reviewing credentials for physicians seeking privileges for restricted activities. Most stakeholders agreed this was not an appropriate role for the College given the amount of due diligence already conducted by the HAs, although it will require a change in statute to correct;
- There is no common definition for ‘credentialing’ and ‘privileging’ within the system and they are used interchangeably, creating confusion;
- There are no independent checks that privileging processes are being followed in HAs;
- Few HAs have Board approved minimum standards that contain definitions for expectations of the minimum number of years experience/number of procedures regularly performed and any standards that are defined are not standardized across the Province;
- Duties need to be better segregated, especially within smaller facilities;
- The structure for regular physician reviews is inconsistent across and within HAs;
- The time taken to formally approve privileges is sometimes too long and results in significant use of the granting of temporary privileges; and
- Local processes could be streamlined to reduce the number of steps in the credentialing and privileging process.

Our work also identified the following leading practices in credentialing and privileging in BC:

- Independent Director participation in the Credentials Committee and HAMAC at VIHA;
- Department Heads meet with all physicians at VCHA and PHSA during the re-appointment process; and
- PHSA uses an online re-appointment system that streamlines physician submissions.
Role of organizations

It is widely understood by all stakeholders we met with during this review, that those who own a public hospital (HAs and DF) have responsibility for granting physician privileges. However, there are two areas where the Ministry and the College are involved in programs that create exceptions to the current processes for privileging and credentialing:

BC Locum Program

Some managers within HAs raised a concern that some physicians may view their inclusion on the BC Locum Program (BCLP) registry as legitimacy to practice as a locum without having to formally apply for privileges. The current system may have potential to be used inappropriately and the Ministry cannot easily check the credentials of those registered.

The College’s role in credentialing diagnostic imaging restricted activities for the purposes of billing

As discussed in Chapter 3, the College currently plays a statutory role in reviewing credentials of physicians seeking privileges for restricted activities in diagnostic imaging within a HA-governed facility. This is solely for the purposes of the physician gaining approval to bill the MSP, and the College expects that the HA is performing its due diligence in granting privileges and monitoring performance.

There are two challenges with this role:

- The College’s by-laws do not enumerate this role and consequently the Senior Deputy Registrar (who at present manages this process) may be operating outside his approved mandate; and
- There was no strong justification provided to substantiate why the College would approve credentials for the purpose of accessing the MSP, when the HA is reviewing credentials to approve privileges anyway.

Most stakeholders agreed that this was not an appropriate role for the College, although it would require a change in statute if the role were to be performed by another body/other bodies (i.e. the HAs).

Communication

Through this review we found that the terms ‘Credentialing’ and ‘Privileging’ were used interchangeably, particularly in using the term credentials to refer to the privileges that a physician has within a practice setting. We identified that this was a contributory factor in perpetuating communication differences and confusion both between and within organizations.

Communication issues as they relate to credentialing and privileging are primarily associated with performance management information being shared across the system to inform privileging decisions. These issues are discussed at greater length in the performance management section below.
Governance & Accountability

Board-level concerns with the privileging process

Through the *Hospital Act*, the Board of Directors of each HA and DF is ultimately responsible for approving physician privileges. Although Boards receive reports and approve privileges (usually through summary reports detailing physician name, facility, category and privileges sought, etc.), most Board Directors noted that they had to have a high level of trust that the processes within the HA were being followed. Usually the VP Medicine or the Chair of the HAMAC is asked to confirm that processes have been followed, but there is little evidence, by way of audit or similar routine checks, to give Boards comfort that these processes have been followed.

Within VCHA an internal audit review has been commissioned with the overall objective to review due diligence for the appointment and re-appointment of physicians at VCH. Specific audit objectives include:

- Determine whether appointment and reappointment processes are in compliance with the Medical Staff By-laws and Medical Staff Rules for VCHA;
- Determine whether privileges are granted in compliance with Medical Staff By-laws and Medical Staff Rules for VCHA; and
- Review with management areas of any weaknesses and provide recommendations for improvement (if any).

Varying credentialing standards

To check whether there was variability in the credentialing standards set across the Province, we asked each HA to provide the credentials required to privilege nine types of physicians:

- General Practitioner;
- Obstetrics/Gynae;
- General Surgeon;
- Orthopedic Surgeon;
- Anesthetist;
- Radiologist;
- Pathologist;
- Cardiologist; and
- Emergency Physician.

Leading practices

In an effort to learn more about the activities undertaken to scrutinize applications and to provide himself with additional assurance on the processes followed, the Chair of the Board Health Quality Committee at VIHA has decided to attend meetings of the Credentials Committee and HAMAC. The direct witnessing of the deliberations in Committee will provide assurance, or the information required to challenge whether sufficient assurance is being obtained. This will provide the Board member, and subsequently the Board, with additional comfort that it may require, so we recommend this practice to other HAs.

Another leading practice in which Board members showed interest was having an internal auditor review the credentialing files in order to confirm that the process was followed. This currently takes places in VCHA and FHA.
Appendix D provides the responses provided by the HAs.

In reviewing their responses, we made two key observations:

- Very few HAs have Board-approved minimum standards; and
- The common standard set was certification by the Royal College in the appropriate sub-specialty or the CFPC for GPs. Very few of the HA standards contain definitions for expectations of minimum standards such as a minimum number of years experience or the number of procedures regularly performed.

In addition, the lack of standardization of minimum standards across the province presents a systemic risk as they could be vastly different. The Provincial Credentialing & Privileging project which is currently underway to set Province-wide credentialing standards should address this risk. However, to successfully address the gap in the longer term this project will need to be institutionalized to confirm that standards are being used, updated and refined as required.

At present the HAs are responsible individually for keeping credentialing standards up-to-date and consistent with technology advances, although the College appears to have the greatest dedicated clinical resources and is potentially uniquely placed to provide oversight across the system.

**Staying on top of technological changes**

As breakthroughs in technology and research emerge, there are often physicians who seek to remain on the cutting edge. Interviewees expressed a need to have a better system in place to set standards across the Province when new technologies and procedures emerge.

Through our interviews, we found that local Department Heads or Chiefs of Staff consult with their colleagues to determine whether one of their physicians could expand into new territory. We learned that if it was within their existing privileges (given that they are approved in general categories by the HA), the Department Head sets an expectation for education and training. If the request was outside of their scope of privileges, the physician would have to apply and the HA would be involved.

We have also learned that whilst it does consider competency requirements, the Tariff Committee is approving temporary billing numbers and fees for new procedures before the system has had a chance to confirm the minimum competency requirements and a full application can be vetted.

There is also the assumption that the HA and hospital are ensuring that the appropriate approvals have been granted before allowing a physician to undertake new procedures; while processes need to be flexible enough to allow for innovation, there is a concern that approval of a fee by the Tariff Committee acts as de facto approval that a physician can undertake a new procedure without regard for HA or hospital privileging processes. Accordingly, the processes need to be aligned.
The Health Technology Assessment Committee has been created to review all non-drug health technologies that meet a cost threshold of $25,000 per patient or $1 million across the Province. While the Committee’s Terms of Reference are still being developed, we have been advised that the Committee will provide advice and recommendations to Leadership Council on proposed technologies in the context of existing clinical practice, taking into account economic, human resource, regulatory, and ethical considerations. However, it is yet to be determined how this Committee’s work will be aligned with processes at the Tariff Committee for approving billing codes and HAs as it relates to privileging.

**Conflict of interest in smaller facilities**

The risk of conflicts of interest are greater within small hospitals where the same group of physicians act on the local Credentials Committee, the local MAC and the body which deals with performance related issues. Our interviews highlighted organizations where these conflicts are both actual and/or perceived.

While HAs have largely regionalized the privileging process, our interviews found that these systems rely both on information from the local level (which may not be forthcoming from small centres) and segregation of duties (that may not exist in whole or part). Wider networks may be required to ensure such segregation.

**Process**

The legal and regulatory review found that there is a lack of consistent Province-wide standards on the level of rigor required during the reappointment process. During our discussions, however, HA leaders noted that it was expected that the Department Head meet with each physician upon re-appointment before approving an application to discuss any performance issues, plans for the year, etc. While this expectation exists, especially among Board members, it is widely acknowledged that these review meetings are not occurring in some or many cases, depending on the organizations concerned. Some of the reasons offered include:

- Some departments are very large and a Department Head could not be expected to meet with hundreds of physicians;
- Department Heads are not given the tools or support to conduct the reviews effectively; and
- There is a general view that the annual re-appointment process is not the most appropriate time to deal with performance issues.

We found that in most cases the Department Heads review the files, check to see if any physicians were changing the privileges requested, and then approve the application. In one hospital, we actually found that the Department Heads receive a summary of the applications rather than the actual forms for approval.

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30 Email correspondence received from Ministry of Health Stakeholder Relations and Transformation Branch of the Planning and Innovation Division. Received April 3, 2012.

Those interviewed felt that it is important that some level of due diligence be completed during the annual re-appointment process, especially as a number of senior clinical leaders acknowledged during the interviews that some physicians are likely not telling the truth or disclosing performance or personal problems on their forms. Along with interviews with Department Heads, having physicians apply online through a shared system could highlight discrepancies on a physician’s file.

Once a physician’s application for privileges is submitted and deemed to be complete, the HA has 120 days to obtain Board approval. This extensive period of time results in the temporary approval of privileges being granted by the CEO or their designate subject to the Board’s approval. While the role of HAMAC and the Board is set out in legislation, our interviews identified opportunities to streamline the process.

It is noteworthy that the reappointment process in Alberta (see Learning from other jurisdictions below) only involves two steps between the Zone Department Head and the Alberta Health Services (AHS) Board. In BC, there can be as many as five steps (local credentials committee, the local MAC, the HA credentials committee, the regional MAC and then the HA MAC). Further work is required to assess the most appropriate balance of risk and process within BC.

**Technology**

With the exception of PHSA where re-appointment and in-depth performance review processes are done online, most of the systems and processes we reviewed are still administered on paper. HAs are using IT platforms to manage physician biographical and privileging information, however, the application documentation is not digitized. While staff within the various MAOs across the Province work hard to accurately manage paper, it is inherently prone to error and/or omission.

We learned of one example where the Chief of Staff receives a listing of the physicians who are privileged in the hospital on an annual basis. The Chief of Staff noted that the most recent report included errors in the listing of privileges associated with some physicians and also included physicians who have since retired or resigned years before. The Chief of Staff stated that “even if the paperwork is wrong, they [physicians] will still just do what they have been doing before”. To correct the report, this Chief of Staff would need to hand-write corrections and send them to the HA. We were also advised of a physician who received a letter from a HA inquiring about whether they would like to re-apply for privileges even though that physician had resigned from the HA three years before.

Those interviewed agreed that the current paper based system needs to be replaced by a digital system that can be easily maintained and shared across all organizations, with data for reporting easily manipulated by everybody and all organizations being provided with the relevant datasets.

Successful implementation of the Provincial Physician Registry should address many of these issues and gaps.

**Leading practice**

PHSA uses an online reappointment system that guides the physicians through the steps of updating their profile, completing certifications and disclosures, and submitting their reappointment applications. The snapshots provided to the review team indicate that the system is easy to navigate and attempts to capture the complex clinicians’ appointments that include university appointments, positions at other hospitals/agencies and committee memberships.

The application allows attachment of files that could include items such as CVs, proof of licensure, renewed work permits, etc. There is a Quality Review checklist that prompts Department Heads to notify the authority if a clinician had any performance issues during the previous year that were addressed. This web-based system has been in place for three years.
Learning from other jurisdictions

Other Canadian Provinces

Based on the interviews with the Colleges in Alberta, Saskatchewan and Ontario we found that there were only a few ‘operational’ leading practices in other Provinces. This view is supported by a literature review conducted by a member of the Ministry Action Team which states that “the literature review found virtually nothing addressing leading practice per se although there is a substantial body of American literature focusing on credentialing and related processes as impacted by Joint Commission on Accreditation of Healthcare Organizations standards.” The review concluded that “In summary, no perfect process in terms of form and content emerges from the literature, from standards or from the experience of organizations outside BC. Processes remain subject to design failure (i.e., applicant selected referees) and execution failure (i.e., references not checked) although, theoretically, these should be easily avoided or remedied.”

AHS is the sole HA in the Province and has responsibility for the provision of publicly-funded health care services, including hospitals. As a result, the Board of AHS is ultimately responsible for granting and revoking privileges. The AHS by-laws provide an overview of the process for granting privileges in Alberta, a process which is similar to the one conducted in BC.

In summary, the steps include:

- The physician completes the AHS application form and provides all necessary documentation. Once completed, the application goes to the AHS Medical Affairs Office (MAO);
- The MAO confirms that the application is complete and sends it to the Primary Zone Clinical Department Head for approval. If a physician applies for privileges in multiple zones, other Zone Clinical Department Heads must also give their approval. Once approved, the application is returned to the MAO;
- The MAO sends the application to the Zone Application Review Committee for approval;
- If approved, the application is sent to the CMO for their approval;
- If the CMO approves the application, a letter is sent to the physician with the terms of their appointment; and
- The list is sent to the Board for ratification.

As noted earlier, our review did not involve discussions with hospitals or AHS and hence we cannot verify whether and to what extent this process is followed.

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34 This review did not include discussions with the AHS, nor were their by-laws reviewed by Osborne Margo as part of the legal review. Hence, our referencing the by-laws is for the purposes of delineating the process as described. We have not verified whether this process is in practice.
35 Alberta Health Services is split into five administrative zones.
Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in the United States

The JCAHO is a US based not-for-profit organization which accredits over 19,000 healthcare organizations and programs in the US. JCAHO standards are seen, by many, to be the benchmark for credentialing and related processes\textsuperscript{36}.

The JCAHO publishes detailed standards regarding credentialing. These act as a guide for hospitals and organizations when they review credentials for the purposes of granting privileges.

\textsuperscript{36} Murtagh, J., 2011. Physician Credentialing & Privileging, Literature Review & Environmental Scan. December 2011. [Received electronically from Ministry of Health] Page 3.
Chapter 7: Our Findings – Performance Management

Key observations

The Provincial Performance Assessment Review project due to be undertaken by the Ministry will provide the opportunity for the system to address the issues raised in our report and will provide the platform for feedback and wider rollout of the Radiology Peer Review and Support project and the Accountability for Denominational Facilities project.

The following key observations are covered in this Chapter:

- Stakeholders interviewed stated they would like the Ministry to prioritize performance metrics and provide standardized performance measurement tools;
- Our review identified a consistent theme that the College is perceived to have an advocacy role for physicians although our investigations showed this not to be the case. Any perception was refuted by College Board members;
- Our review found that clinical leadership needs to be addressed across the system, especially the role and function of the Chief of Staff;
- Communication gaps exist across the system, resulting in inconsistent or poor information flows;
- Stakeholders across the Province acknowledged that the collaborative approach demonstrated by the Registrar and her colleagues over the last year have improved their impressions of the College as a partner in strengthening the system;
- The value and importance of good performance management was a common theme in our interviews and stakeholders stated that the focus of performance and peer reviews needs to be aligned to improvement agenda and not viewed as confrontational;
- The College and HAs could share more performance information and participate in a more structured system-wide discussion of performance issues; and
- The Physician Achievement Review in Alberta and the Revalidation process in the UK (see Chapter 5) allow for regular (typically 5 year) reviews of all physicians and 360 degree surveys that assist in the monitoring and focus of physician performance have been adopted in the US.

Our work also identified the following leading practices in performance management of physicians in BC:

- PHSA has adopted a pilot program to assist in training and supporting Department Heads; and
- Staff at PHSA have a mandatory 360 degree review every three years.
Role of organizations

Ministry of Health

The Ministry has established the overarching framework for physician quality assurance in the Health Professions Act, the Health Authorities Act and the Hospital Act. These together define the complementary roles of the College and the HA Boards in overseeing the quality of physician care in the Province and a full review can be found in the legal and regulatory review completed by Osborne Margo. The Ministry has also provided tools to the HAs in the form of templates for physician by-laws.

When non-Ministry stakeholders were asked what role, if any, the Ministry should perform in relation to licensing, credentialing, privileging and performance management there was broad consensus in one area: the Ministry needs to take a stronger role in stewardship of broader systemic and cultural issues such as physician management and accountability.

Our interviews reflect the delicate balance between policy development/implementation and management/delivery. Stakeholders suggested that:

- The Ministry advise organizations what to achieve, with the organizations themselves being allowed to conceive and implement the necessary governance processes and delivery mechanisms;
- The Ministry provide organizations with performance management frameworks and reporting mechanisms (so that there is collective understanding of what needs to be implemented and in what priority); and
- Stakeholders account to the Ministry for performance.

The College as the organization of last resort for performance management

The role of the College as the authority on licensure has the effect that it is perceived to be the organization of last resort by HAs in dealing with performance issues. It appears that the College is often brought in too late in a process, for example, just before a public disclosure. This situation has resulted in greater internal management and far less communication than many stakeholders believe constructive, with local managers seeking to find local solutions to problems and not sharing issues to ‘protect’ the physicians involved.

The lack of communication appears to have resulted in the introduction of a number of formal and informal processes and controls that have been put in place more to manage the system, not to manage physicians. Over time this appears to have confused the respective roles of all parties and through our interviews, a common theme emerged - a perception that the College has an advocacy role for physicians. This perception may have arisen because the role of the College in performance management is not particularly well understood within the system. However, on further investigation we can confirm that nothing published by the College reflects an advocacy role and that College Board members robustly refuted any suggestion that the College undertook any such activity. However, perceptions will need to be altered if the College is to be completely integrated into a system-wide performance management framework.
Clinical leadership in HA and other healthcare providers

Like many professions, physicians are keenly aware if a colleague is not performing to standard. We learned through the interviews that instead of reporting them, physicians may choose not to refer their patients to a poor-performing physician. It is difficult to define the cause for this finding. There are many reasons why a lack of challenge could exist, including payment mechanisms, mutual trust and empathy. Whatever the reason, our interviews found that doctors may be less likely to whistleblow and many clinical leaders, themselves doctors, do not feel that it is their place or role to judge a colleague, let alone actively manage poor performance.

This situation is magnified in organizations where clinical leadership roles are filled on a rotational basis, that is to say where a leader is chosen not through ability but because it ‘is their turn’.

In these cases, management can be seen to be a burden, a task that administrators may deem necessary but certainly one that does not motivate the clinical leader to perform anything other than a preemptory function.

Our interviews found that clinical leaders are seldom provided with the necessary training or support to fulfill these roles effectively.

Issues around clinical leadership are further compounded by the professional barrier that sometimes exists between physicians and management, where the feedback from administrators was that they understand that they are not necessarily equipped to challenge doctors professionally and/or clinically and look to clinicians to self-regulate and manage themselves more effectively.

During our interviews we were advised many times that one of the main difficulties is that the Chief of Staff role is often either not recognized by some local physicians or perceived to be valued by HAs themselves as an integral part of the management of physicians within the system. This observation appears to go further than simply a request for greater remuneration, more that those interviewed believe that the clinical leadership role needs to be better understood and reviewed by the system.

Who the clinical leaders are is usually clear; the fact that they are not motivated to lead is due to a combination of lack of remuneration, status, levers to create change and management support.

As many physicians are exclusively contracted to perform services through the MSP system rather than having contracts of employment, it may not be in the interests of the physician to disclose relevant information. A combination of regulation and this inherent conflict in the system has potential to form a major barrier to open and honest dialogue on performance issues that is not present in other jurisdictions such as the UK where physicians have contracts with the hospitals in which they work. That system may have greater potential to develop dialogue, because, as employees, doctors may be far less at risk of losing their livelihoods. Employers also may have a greater duty of care, and provide structured assistance programs to support individuals through any personal and professional difficulties and performance issues.

Leading practice

In response to this challenge of supporting clinical leadership, PHSA has developed a pilot program to train and support Department Heads. The approach will include:

- Clarifying the role, the requirements, and the expectations from a Department Head.
- Developing and implementing an orientation program.
- Developing and implementing a professional development program for medical administrators.
- Remunerating the position considering its importance in managing and directing medical staff and the impact that this has on the quality and safety for patients.
**Communication**

Issues around communication throughout the system were brought up in almost every conversation in this review. We learned of numerous examples of times when one organization did not share information with another, most frequently a member of HA staff complaining that the College had not provided information, most often about details of physician performance. This may be for privacy reasons as discussed in previous chapters.

Those interviewed acknowledged that the system needs to further review these issues and agree to a structure and communication framework across all organizations, particularly where they relate to a physician’s performance or where there were delays in Certificates of Professional Conduct.

In turn, the College is concerned about information sharing and the timeliness in which HAs provide information, especially on performance related matters.

Stakeholders across the Province acknowledged that the collaborative approach demonstrated by the Registrar and her colleagues over the last year have improved their impressions of the College as a partner in strengthening the system.

In looking at the whole system, communication operates on a “pull” rather than a “push” system. Unless someone asks, they will not find information. This has been highlighted through our interviews especially regarding prior performance concerns for new hires.

Leaders within hospitals and the HAs acknowledge the need to maintain some confidentiality in performance related matters, especially those that have been corrected. However, while they were not looking for all details of the performance issue to be divulged, most stated that they would like to see a flag on a record that requires further investigation during interviews, etc.

**Improved links with medical educators**

A study recently published in the *New England Journal of Medicine* stated that “unprofessional behavior as a student was by far the strongest predictor of disciplinary action [as a physician]”\(^\text{41}\). The study found that “physicians who were disciplined by state medical-licensing boards were three times as likely to have displayed unprofessional behavior in medical school than were control students”\(^\text{42}\).

While UBC was not a subject of this review, we did consult with representatives from the Faculty of Medicine during the initial stages as we developed the RAF. During the discussion we learned that the linkages among UBC, the College and the HAs are informal when in fact there could be benefit to stronger communication to identify issues or patterns of behavior earlier.

While there are Joint Advisory Committees between UBC and each HA, agendas are often focused on placements of Residents. We also learned of informal conversations between hospital officials and the Faculty of Medicine to establish a program for physicians who need to upgrade skills. Finally, we learned about breakdowns in communication with the College in that there have been instances where the Faculty of Medicine learns that a Resident has been suspended through a College publication.


Governance & Accountability

Some clinical leaders we interviewed through this review acknowledged that they were not entirely sure how to deal with a performance management issue, to whom they should report an issue (whether to the College, HA or both) and how they should make a report. The links of how any performance management issue would be reported up to the Ministry are even less clear.

In the case of Boards, a number of models exist in other jurisdictions where Executives are directly accountable to a Ministry or regulator for performance management per se. In the UK, Boards are comprised of both Non-Executive (Independent) Directors and Executive Directors, with the balance of power being held by the Independent Directors. In Ontario, Presidents/CEOs have a seat at the Board through separate contracts with Cabinet that allow direct accountability. We understand that it may be difficult to change the governance model in BC per se, however stakeholders confirmed that it would be worth exploring a different model in healthcare.

In the case of individual HAs or other provider organizations, the myriad stakeholders involved with performance management (i.e.: the College, HAs, DF, Medical Directors in private facilities, clinical leaders within hospitals, Senior Medical Directors in regionalized HA models, etc) increase the risk of breakdowns in governance and accountability, even without the evidenced communication difficulties. There is significant risk that performance issues fall through gaps in the process without an agreed, standardized performance management process.
Process

In discussing performance management during the interviews, we made three observations:

- There is a general view that the annual re-appointment process is not the time to deal with performance issues;
- While medical staff by-laws and rules require that in-depth performance reviews be completed, we found that these were largely not being done for physicians contracted under MSP. The only time when some form of performance review is being completed is when a physician is applying to move from ‘provisional’ to ‘active’ status; and
- Where physicians were contracted directly to a health body, peer review and performance management processes were greatly improved.

While the value and importance of performance management was a common theme in many of our interviews, the mechanisms for managing performance often centre on the formal processes of critical incident reviews and mortality and morbidity rounds which tend to be conducted within the protections of Section 51 of the Evidence Act. A number of interviewees from the HAs spoke aspirationally about the need for developing a robust peer review system, and while we learned that some HA Boards have directed their MAC to implement peer review\(^{43}\), the speed of implementation varied across HAs.

One of the reasons provided to explain why roll-out of peer review has been slow was that there is a residual concern that peer review is a confrontational process rather than one seeking improvement. Some physicians also expressed discomfort in having to be critical of their colleagues at one moment and then requesting their assistance on a case in another moment.

We understand that the College is actively pursuing a system of peer review similar to the Physician Achievement Review (PAR) program in Alberta. Proposals include a random selection of individuals who would submit information to a review, unlike Alberta where the physician has input on who is included. This peer review process could be linked to revalidation, although the College confirmed that there are no immediate plans to introduce revalidation in BC.

Our interviews confirmed that there is a need to change the tone and culture around peer review, and performance management more broadly. It needs to be positioned as an opportunity to learn and improve one’s skills and performance.

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\(^{43}\) The Board directives issued by HA are listed at Appendix F.
Technology

Technology can play a significant role in collecting, storing and sharing information related to physician performance. The software platforms currently being developed for Radiology Peer Review and the Provincial Physician Registry may, in the longer-term, address some of the communication and process gaps identified in this section.

Learning from other jurisdictions

Peer review processes in Alberta

The College of Physicians & Surgeons in Alberta has implemented a Physician Achievement Review (PAR) program whereby each physician must be reviewed every five years. This program is mandatory and is funded by fees paid by the physician. The review is conducted by a third party through an online questionnaire which is completed by twenty-five patients, eight physician colleagues and eight non-physician healthcare co-workers. The questionnaire covers five attributes of a physician’s practice:

- Clinical knowledge and skills;
- Communication skills;
- Psychosocial management;
- Office management; and
- Collegiality.

The third party which administers the survey provides a detailed summary of the results as well as comparative statistics on how other physicians with similar practices perform.

The College’s website[^44] states that the outcome of the review is for educational purposes only and cannot be used in any disciplinary processes. The information collected is protected under the Alberta Evidence Act. If the review identifies a need for further education, a database of courses and programs is made available. The College has partnered with the University of Calgary and the University of Alberta to provide many of these programs.

Legislative changes to enhance communication in Ontario

To ensure more effective communication between the College and hospitals in Ontario, the College has proposed amendments to the *Regulated Health Professions Act* (RHPA) and the *Public Hospitals Act* (PHA). Three of the nine changes proposed\(^{45}\) are relevant to this review:

- Eliminating loopholes in the RHPA to clarify mandatory reporting requirements from hospitals to the College, with a proposal that mandatory reporting be extended to issues related to quality of care and conduct;
- Adding the PHA to the list of statutory exceptions in the confidentiality section of the RHPA in order to allow the College greater flexibility in sharing information with hospitals; and
- Adding the *Health Promotion and Protection Act* (HPPA) to the list of statutory exceptions in the confidentiality section of the RHPA to allow the College to share information with the Chief Medical Officer of Health of Ontario.

The legal and regulatory review conducted by Osborne Margo also found similar gaps in British Columbia’s *Hospital Act, Health Professions Act* and *Health Authorities Act*.\(^{46}\)

By-law provisions which provide greater flexibility to communicate in Saskatchewan

Goodwill has been generated by the College’s willingness and capability through its by-laws to be slightly more open in communicating about systemic issues resulting from a physician complaint. Osborne Margo found that “under s. 6(1)(d) of the Saskatchewan College’s By-laws, the Practice Enhancement Committee (PEC) is authorized to report concerns of a systemic nature to individuals or organizations that in the Committee’s opinion have the responsibility to remedy the concerns. The PEC has the ability to meet with the physician or other individuals, prepare recommendations to address the concerns, and arrange for a review at a later date to determine whether the concerns have been rectified. These provisions are unique in explicitly allowing a way of addressing physician performance concerns that have a broader systemic aspect to them. The by-laws of the BC College do not contain a similar provision.”\(^{47}\)

The Data Bank in the United States

The Department of Health and Human Services in the United States maintains two databases (which together are referred to as the ‘Data Bank’): the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB).

Appendix E contains a table that provides an overview of these two databases that provide access of information to multiple stakeholders with a view to allowing organizations to research prior performance issues.

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\(^{45}\) College of Physicians and Surgeons of Ontario. *Letter to Minister of Health & Long-Term Care, the Honourable Deb Matthews, Re: Request for Legislative Amendments.* January 17, 2012.


Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in the United States

As well as detailing standards on credentialing (see Chapter 6) JCAHO standards also require that an evaluation of a physician’s practice be completed if they are new to a member-facility, are requesting changes to their privileges or if there are concerns about their performance.

Pulse Program in the United States

The Pulse Program is a physician development program based in Florida. It utilizes a formal and informal 360-degree survey for an individual Physician, Group, Department, or an entire Facility. Feedback reports are provided confidentially and exclusively to the individual physician. Physician coaching is available for those who are identified as needing support.
Chapter 8: Suggestions for Improvement and suggested Future State

Suggestions for Improvement

Our findings indicate that there are a number of areas that need to be improved. When considering our suggestions for improvement we found that a number were relevant to more than one of the three key areas of licensing, credentialing and privileging and performance management. Accordingly we have grouped our suggestions for improvement under three headings:

- Accountability;
- Role of the College and HAs; and
- Clinical leadership.

Our suggestions for improvement need to be put in context of the current workload of the Ministry and its perception of both the need and the extent for change.

The Ministry should continue with the existing eight initiatives within the Physician Quality Assurance Portfolio (addressing the issues in the Ministry’s Action Plan and response to Dr. Cochrane’s report) as their implementation along with the suggestions for improvement below will enable the Ministry to demonstrate that the issues raised by Dr. Cochrane are being better managed.

Accountability

Aligning performance to contracts

The Ministry’s primary link to physicians is through payments. However, contracts are not currently being utilized to align or manage performance nor are outcomes linked to payments. The most impactful lever that the Ministry currently possesses that could be used to assist change is the MSP registration and payment process for clinicians as the MSP process positions physicians as providers of care, not part of the care system itself.

Our interviews have shown that some physicians may not be willing to challenge practices; in some systems there is little appetite for whistleblowing and little sense that physicians are able or willing to hold colleagues to account, unless in the most dire circumstance. This may mean that the whole system of MSP needs to be reviewed or central contracts considered as part of the establishment of a performance culture based on rewarding quality service and providing the opportunity for any remedial action to be promoted and encouraged.
Suggestion for Improvement #1: The system of contracting with physicians within BC should be compared to other jurisdictions so that the pros and cons of changing the system could be assessed within the context of making physicians more accountable for their performance and encouraging greater levels of self- and peer-assessment. Any changes should be addressed through medical by-laws or other mechanisms as appropriate. Options could include:

- Mandate that annual appraisals form an integral part of the MSP process, potentially with physicians asking to self-certify and the Ministry then performing central checks to ensure compliance, installing powers to suspend registration if physicians do not comply;
- Introducing an element of performance-related bonus to award good quality, and alternatively a withdrawal of an element of pay for poor performance;
- Consider mandating HAs to hold MSP contracts for all procedures performed in their HA, thereby providing the opportunity for local input and performance management into those areas that HAs consider most productive and effective; and
- Mandate physicians move to central contracts with HAs and put in place appropriate support and HR processes similar to other professional staff groups.

Stewardship and management of HA Boards

Stakeholders were clear that they wanted a strong Ministry who advised organizations what to achieve, provided performance management frameworks and accountability frameworks, with the organizations themselves allowed to conceive and implement the necessary governance processes and delivery mechanisms.

Currently stakeholders assessed that the Ministry falls short of this strong stewardship role. This appears to be because the Ministry is the organization held responsible for delivery, although the system has yet to properly define specific accountability for the various aspects of clinical management and performance.

Suggestion for Improvement #2: The Ministry should review its wider role and define the extent to which it provides effective stewardship to the system by studying models from other jurisdictions. Depending on the outcome of that review, the Ministry should assess the short-term and longer-term changes required so that a framework for holding HA and DF Boards accountable for the implementation of policy directives and for physician governance and management in particular can be developed, along with the associated reporting mechanisms.
Executive accountability on HA Boards

The current system holds Boards accountable for physician performance and the systems for managing credentialing and privileging, however there is little direct Executive accountability to the Ministry. If the system for contracting with physicians is to have greater HA involvement, direct Executive accountability needs to be established.

Any change in accountability may require a review of the overall model of governance. This may be complicated as the governance model in BC has been established for some years and there appears to be little appetite for change per se.

**Suggestion for Improvement #3**: The Ministry should review governance models in other jurisdictions to establish whether a case could or should be made for a different model of governance within healthcare to reflect commercial leading practice and allow greater levels of direct accountability for Executive management. This may be necessary especially if contractual accountability changes.

Our review has found that Boards find it difficult to obtain independent confirmation that the processes for managing physician credentials and privileges within each HA is working and to obtain a view on overall risk, relying (sometimes exclusively) on the Executive team to confirm that the correct management processes and controls have been followed. Few crosschecks currently exist to assist Boards in obtaining independent confirmation.

Accordingly we suggest a number of improvements that can be made in the short-term to strengthen the Board’s ability to fulfill their mandate and fiduciary and other duties.

**Suggestion for Improvement #4**: All HAs should establish an audit process through internal audit or another independent body to regularly review appointment and re-appointment processes and compliance (we consider that clinical audit is not capable of performing such a review as they are not necessarily experts in process). The Ministry should mandate HAs to perform this function and self-certify that they have complied with that mandate.

**Suggestion for Improvement #5**: Where HA Boards have identified clinical challenge as a weakness, they should be encouraged to consider how to augment their ability to challenge clinically, potentially seeking to appoint an independent Medical Adviser mandated to specifically assist them gain comfort on the adoption of processes and the performance management of physicians generally.
Province-wide reporting protocol

Performance management of physicians is extremely difficult in the current system as there are insufficient levers to drive change and not enough clinical leaders within the system are motivated or trained to manage performance effectively.

The current system for assessing and enhancing the performance of physicians has been described as fragmented and unstructured. Currently organizations do not share information and the system does not share collective responsibility for performance management, indeed it has been impossible during our work to find out how many physicians that may present a risk (to patients, themselves or the organizations in which they work) currently trade within the Province. This is partly because no agreed definitions exist and partly because information is not shared between organizations.

Accordingly, a Province-wide reporting protocol is required to provide structure so that all bodies can establish what information they require and what information is needed by other organizations so that systems for proper performance management can be established.

The key to introducing a robust performance management framework is to have all organizations working together to enhance patient safety. While the new IT system may be a key enabler, all organizations will need to work hard to establish the right protocols to structure a system capable of working, and the lines of communication so that it gets established and has the desired impact in the system.

Suggestion for Improvement #6: The College, HAs and DFs should share information to establish agreed definitions for the sort of issues or problems that indicate where physicians may present a risk. Once defined, the size of the population of those physicians should be determined and used to establish the urgency of the timetable for establishing a Province-wide performance management framework.

Suggestion for Improvement #7: The Ministry should oversee the establishment of a Province-wide reporting protocol which should be agreed by the College, each HA and all DFs. The protocol should outline what information related to performance should be provided, how it is to be provided, and when it should be provided. Moreover, each layer of the system (Ministry, HAs, DFs, College) should define what data it requires and why, to establish robust information and systems required for managing physician performance. Datasets from these deliberations can then be used to inform the development of the provincial information system. This reporting protocol should also be incorporated into the model staff by-laws which are currently being developed.

Suggestion for Improvement #8: The Ministry should consider whether the by-laws of the College need to be amended to reflect the need for certain performance information to be shared with HAs to mirror the by-laws of Saskatchewan. This is critical to enable the system to respond to potential areas of public concern, especially regarding the safety of patients.

Suggestion for Improvement #9: The Ministry’s Legislation and Professional Regulation Branch should review the legislative amendments being proposed in Ontario to establish whether the recommendations made by the College could be applicable in addressing the gaps identified in BC.

Suggestion for Improvement #10: The College should review the Pulse Program in more depth to ascertain how the processes contained within it could be brought into assisting with the monitoring and processing of performance management concerns and the College’s own processes within BC.
Medical school participation in any new performance management framework

The Papadakis Article evidences that behavior in medical school is strongly linked with behavior as a physician. While it is difficult to suggest the level at which information should be shared, in a closed system where BC trained doctors are likely to work and practice in BC, the links cannot be ignored. UBC, as the only medical school in the Province, should be brought into the discussion to assess whether a system could be developed to provide early warnings for HAs and other prospective employers.

Suggestion for Improvement #11: The Terms of Reference for each Joint Advisory Committee between the HAs and UBC should be amended to include issues of performance management and remediation, including:

- Discussing performance issues of residents in the HA; and
- Discussing remediation opportunities for individual physicians, as well as broader systemic remediation program requirements.

HA systems for granting privileges

Our review uncovered a number of inefficiencies in the process that HAs use to grant privileges. While the process for granting privileges needs to be rigorous, the current process is cumbersome and causing some within the system to overlook certain steps. Opportunities to improve the process uncovered through this review include:

- Reviewing the role of either the local credentials committee and local medical advisory committee in reviewing and approving applications;
- Completing the digitization of the process and have all application forms completed online;
- Processes need to take into account standardizing processes for physicians with privileges in multiple HAs48;
- Moving from an annual to bi-annual appointment timeframe and stagger the re-appointments. FHA is currently adopting this approach so that it reduces the number of applications being considered at any given time, thus spreading out the work to allow Regional Department Heads to do their due diligence on the application; and
- One HA CEO also thought that going to staggered multi-year appointments might also provide the opportunity to create greater linkages with peer review processes.

Suggestion for Improvement #12: While a number of the initiatives launched by the Ministry in response to Dr. Cochrane’s report address some of the inefficiencies identified above, the Ministry should mandate that HAs implement and effectively use the new systems being developed to minimize the risk of different levels of uptake in different HAs.

48 We acknowledge that one of the Ministry’s initiatives in the Physician Quality Assurance Portfolio has recently developed a standard form which can be used across the HAs.
Suggestion for Improvement #13: Some of the recommendations may be processed by updating the medical staff by-laws within HAs. Any changes to the by-laws should be reviewed by the Ministry’s Legislation and Professional Regulation Branch prior to HAs seeking to obtain PSSAC or other approval so that the Ministry has the opportunity to consider the recommendations and has made decisions on the broader systemic issues.

Many of the systems and processes being used to manage licensing, privileging, credentialing and performance management are still paper-based. This is inefficient and prone to error. In responding to this challenge, a number of software solutions are currently being procured to provide a Province-wide platform for collecting, storing and sharing information about physicians. As these systems are being developed, there are a number of recommendations that the Ministry should consider:

Suggestion for Improvement #14: The Ministry should provide structure to confirm that the new Physician Registry and Peer Review software systems are set up correctly from the beginning, establishing:

- The datasets required by all parties;
- The right levels of functionality and reporting for all parties;
- The ownership of the system and maintenance arrangements, with suitable methods of cross-charging for cost established; and
- Governance arrangements, especially in relation to privacy of information, etc.

Suggestion for Improvement #15: The Physician Registry should have the datasets available to all stakeholders so that compliance with privileging and performance management processes can be audited and levered so that the Ministry retains the right to withhold or suspend MSP status until and unless issues can be satisfactorily resolved.

Systems for Provisional Registrants

Provisional Registrants controls are more advanced than for other groups of physicians. The College has a sound system in place for the management and continual review of Provisional Registrants (including geographic and service constraints) that could be expanded for use in monitoring physicians with performance and other issues.

Suggestion for Improvement #16: The College and the Ministry should work together to review whether the system for continual review of Provisional Registrants should be adopted for performance managing physicians identified as posing a risk.

BC Locum Program

The Ministry currently maintains a registry of physicians available as locums through the BC Locum Program, a role which blurs the line between oversight and delivery. While the Ministry does not review nor make judgment on a physician’s ability to act as a locum, a concern was raised that physicians may believe that their inclusion on the list is sufficient and an application for privileges as a locum is therefore not necessary.

Suggestion for Improvement #17: The Physician Registry currently being developed should have the capability of identifying and tracking locums, and the Ministry’s registry through the BC Locum Program should be discontinued once the new system is in place and working correctly.
Role of the College and HAs

Stronger role for the College

Our review has ascertained that there is confusion and ambiguity about the College’s role and a reluctance to involve them fully, partly due to the perception by some that the College has a role in advocacy of physicians rather than their accountability and management. This is strongly denied by the College and their role and function is clearly defined on their website. However, while confusion exists the College finds it difficult to assert their role.

The management team of the College is widely held in high regard, and this aspect should be built on when redefining and enhancing the College’s role which should concentrate on quality and its stewardship.

Our recommendations fall into two categories:

1. Those where roles should be realigned with HAs, where the system can be streamlined to use resources, information and skills to best effect; and
2. Recommendations that enhance the role of the College and position it to lead initiatives as and wherever appropriate.

We understand that the recommendations below address historic and systemic issues whereby the College has taken on a number of roles in the absence of other leadership and that there may be a cost associated with the transfer of any functions both to and from the College. However, our recommendations seek to address closing gaps in the system, rather than the cost of providing support in different areas.

Suggestion for Improvement #18: The Ministry should work with the College to agree the financial and organizational impact of any realignment of role. While some of that impact may be derived from contributions to the College, other aspects may need to be agreed centrally.

Enhancing the role of the College (1) – Provincial Performance Management Framework

The College should be an integral part of the new performance management framework. As this involves all organizations across the system and the Ministry, we have included recommendations in the Accountability section above.
Enhancing the role of the College (2) – New technology and procedures

Our review has highlighted the fact that new technologies and procedures are not considered in a structured way across the system in that:

- HAs are often not considering what training and other testing and resourcing requirements should be considered prior to allowing physicians to utilize new tools or to undertake new procedures; and
- The Tariff Committee is approving temporary fees for new procedures without training and minimum competency standards being finalized.

This needs to be structured so the College, in collaboration with the HAs, sets standards so that all new technology, whether it be new procedures or new machinery, can be appropriately monitored and managed by HAs. There also needs to be a central reporting mechanism so that the costs of bringing the new technology or procedure into service can be considered as part of the performance management process for the investment (especially if it relates to a large capital investment).

**Suggestion for Improvement #19:** The College should be accountable for publishing, on a timely (perhaps annual) basis, a list of new technology and procedures with guidance on training, standards and testing to inform the privileging process for those new developments. This work should be done in collaboration with the HAs and aligned with the mandate and activities of the new Health Technology Assessment Committee being set up by the Ministry.

**Suggestion for Improvement #20:** The Tariff Committee rules should be amended to align with the process established by the College such that no fee, whether temporary, permanent or otherwise, is granted until the appropriate supporting resources (i.e.: space, nursing staff, etc.) as well as minimum competency standards are established.

Enhancing the role of the College (3) – Providing Minimum Standards for Credentialing

The system currently does not have common minimum standards that can be applied to all specialties for credentialing and privileging purposes. This allows different HAs and facilities to take different views on the experience required for certain privileges to be granted and means that the definitions of experience needed in one part of the Province to be allowed to practice within any given specialty is different to another part of the Province.

If minimum standards are to be established for credentialing, the standards need to take into account the different levels of care provided in the Province. It simply is not possible to provide the same service in rural areas as services by necessity operate on a hub and spoke model that requires population density to underpin services.

There may be at least two, possibly up to four, population/service zones in BC based on geography; certainly the difference between ‘urban’ and ‘rural’ services should be defined and considered, with potentially ‘city’ and ‘remote’ definitions also being explored. However, it may be difficult to pursue different minimum standards unless the public are engaged in the debate.

**Suggestion for Improvement #21:** The College should be mandated to manage the current procurement for a Provincial Credentialing & Privileging technology solution and should take responsibility for expediting the project completion timeline. A revised structure and timeline should be agreed with the Ministry and robustly performance managed.

Ministry of Health
Provincial Review of Physician Licensing, Credentialing, Privileging & Performance Management
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**Suggestion for Improvement #22**: On an ongoing basis, the College (as the body that is consistent and is the most established and credible in terms of peer review and assessment) in collaboration with the VP Meds of the HAs, should be mandated to be responsible for establishing and agreeing minimum credentialing standards for all disciplines and report back progress to the Ministry and HA Boards as appropriate.

**Suggestion for Improvement #23**: The College should report to the Ministry on how to best to engage the debate on standardizing credentialing and privileging definitions across Canada. It is important that an action plan for that debate is constructed, including stakeholder maps and an analysis of the timeline (with associated local performance management goals). Once systems are in place in BC, the College (with support from the Ministry) should seek to establish minimum standards with other Colleges across Canada so that the system can have confidence in the work performed in other jurisdictions for doctors moving to BC.

**Suggestion for Improvement #24**: The Ministry should consider engaging the public in a structured debate on standards across the Province to assess what services are acceptable to the public and where the boundaries of the postal code medicine⁴⁹ debate should be drawn. Before the question can be answered, the Ministry could assess firstly whether the public should or could be consulted on acceptability of service, either in market research groups or more widely, and then work to define acceptability to inform definitions of minimum standards (potentially by geography).

**Enhancing the role of the College (4) – Revalidation**

Evidence from other systems indicates that it is leading practice to formally revalidate physicians at least every five years based on a robust appraisal system. Currently, leading practice in the Province is that adopted by PHSA whereby physicians have 360 degree reviews every three years, however this falls short of complete revalidation.

Statements made by College Board members during the interviews in support of implementing physician revalidation are encouraging. The adoption of some of the recommendations above may make a new process of revalidation easier, however it will not be possible unless physicians engage and agree that it is necessary.

**Suggestion for Improvement #25**: The College should expedite its efforts in implementing a process for physician revalidation. The Ministry should consider timelines for the introduction of revalidation, how to effectively performance manage the College if this task is mandated and establish an accountability framework for delivery and rollout of the revalidation program.

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⁴⁹ Refers to the debate of which services are provided in which communities based on geography and proximity to major centres.
Redefining the College’s stewardship of quality

The College needs to address the perceptions held within the system of it being an advocate for physicians if it is to properly integrate into the system and lead where appropriate. The perceptions start at the Board of the College, where there is a two-thirds majority of physicians on the Board rather than public members (10 physicians and 5 public members). While members of the College Board were adamant that their governance model was effective, other stakeholders interviewed felt that the perceptions held across the system were too prevalent to be ignored.

Suggestion for Improvement #26: The College needs to consider how it can engage with the system, especially the HAs, consulting with stakeholders and seeking to consolidate its mandate and build greater awareness of the function of the College, its commitment to quality and to build the relationships and understanding that will underpin the development of a performance management framework.

Realignment of the role of the College - Credentialing and privileging

The College currently has a role in credentialing and privileging for diagnostic imaging and NHMSFs, yet our review uncovered a number of concerns related to the College’s oversight of NHMSFs. While the accreditation process (currently completed every 4 years) is intended to confirm that privilege re-appointment and performance management processes are being followed, the HAs perform due diligence on the majority of physicians anyway and we have been made aware of instances where issues may not have been suitably addressed, mainly because of the communication difficulties we have observed across the system. The legal and regulatory review also uncovered gaps in NHMSF physician reporting requirements with the College.

Suggestion for Improvement #27: Responsibility for credentialing for diagnostic imaging and non-hospital surgical medical facilities should be transferred to another organization. For this to occur:

- The Ministry needs to confirm that the entity that undertakes this responsibility are also signatories to the performance management framework (see below) so that they have the ability to communicate and share concerns for NHMSFs across the system; and
- All MSP-related activity for restricted activities should be performed through existing mechanisms.

Suggestion for Improvement #28: The Ministry and College should work together to review whether the amendments being proposed in the Out-of-Hospital Premises Inspection Program in Ontario could be applicable in addressing the gaps in NHMSFs in BC.

Suggestion for Improvement #29: The Ministry should consider the support the College requires to enable all of the above changes to take place. This would include providing independent support to the Board as required and in establishing a plan for managing change.
Clinical leadership

Clinical leadership is one of the central components of driving systemic change and one that needs extensive consideration. Clinical leaders need to have the tools to manage appropriately and the standing with colleagues to make hard decisions and contribute to the development and redesign of services, where a culture of self-management, appropriate challenge and considered improvement is much easier to install and maintain if dynamic clinical leadership is present.

Our review ascertained that the role of clinical leaders within hospitals is underdeveloped. Clinical leadership roles, be that Chief of Staff or Department Head are undervalued especially by the physician community and duties are often seen as a chore. In this environment the risk of regular controls and procedures not being followed is higher than where roles are valued and respected.

Feedback was often that the roles were under-resourced and carried little or no remuneration for additional duties. However, we do not consider this an issue of remuneration exclusively, more an indication that the system needs to consider how it invests in clinical leaders generally and the training and other resource requirements that need to be put in place to enhance the role and standing of clinical leaders.

While there may be different ways of implementing changes and enhancements to clinical leadership locally, the case for mandating system-wide improvements may remove any local doubts on implementation. Any recommendations therefore could be linked to and driven by the Innovation and Change Agenda at the Ministry.

It is encouraging that clinical leaders are being installed at the top of organizations. What the system needs to tackle is how leadership roles attract the right people for both a clinical and managerial perspective and that those leaders, the change champions, can be empowered to make a real difference in the quality and effectiveness of service delivery and performance management of peers.

**Suggestion for Improvement #30**: The role of clinical leaders and their recruitment needs to be reviewed so that their role can be defined and standardized across the Province. The review needs to consider how to make these roles attractive to the right leaders through a combination of various levers including remuneration, the bestowing of real authority and the ability to contribute to the wider change agenda.

**Suggestion for Improvement #31**: The Ministry should work with all HAs to agree clinical leadership models that can be installed across the Province, with physicians taking far greater responsibility for the management of services and the modernization agenda generally. These models should then be linked to broader accountability frameworks so that real local accountability and performance management structures can be agreed across the system, with escalation policies in place that inform Boards and provide impetus to the service improvement agenda of all HAs.
Future State

Centralization & Standardization of Structure

Through this review, we were asked to consider whether a single, centralized process for licensing, credentialing, privileging and managing performance of physicians would be beneficial. Centralization, in this context, can be viewed two ways:

- Having a single, central organization that manages the process; and
- Having a standard process that is used across the Province, yet managed regionally.

While we did not make this distinction in the interviews, two opposing arguments were made throughout the discussions:

- There is a need to centralize processes and standards to reduce the variability in the system and to maintain a high standard of quality; and
- Organizations within the system need to be given the flexibility to implement the processes and standards that work best for their constituencies.

In considering the views expressed through the review, and our analysis of the issues and gaps, we consider that this is not a binary question. Those interviewed agreed there is a need for the HAs to have sufficient flexibility to address the local needs of their population, resources and circumstances and to reduce the variability in how performance management is executed, establishing minimum standards that are applied to granting privileges and ensuring that those standards are applied rigorously across the Province.

The case for having a central organization manage the process has therefore not been made, although our suggestions for improvement identify where activities can be better aligned. In relation to the structure of the future state we conclude for each of the aspects of our review:

- **Licensing**: no one but the College can perform this role as the existing system broadly works with our suggested improvements helping refine systems and processes;
- **Credentialing and Privileging**: the variability across the different HAs indicates that there is a necessary role for the College in establishing minimum standards across the system, the systems and processes within HAs need to be improved and the College is not the most appropriate organization to be managing privileges for private facilities; and
- **Performance management**: needs both a central and local component to be effective as neither in itself would provide sufficient overview of performance, especially in the absence of centrally held contracts that encompass performance, and the College needs to be better integrated into the performance management structure.

Continuum of future system improvement

Based on our analysis of the current system, learning from other jurisdictions and input from stakeholders throughout this process, we suggest below a Continuum of Improvement (Figure 3-1) that sets out a structured, streamlined future state capable of providing better oversight and performance management that minimizes duplication and maximizes the opportunity for information to be shared across all relevant organizations. Where possible, our suggestions for improvement are linked to the greatest current state challenges under the three generic headings used above.
This future state will be characterized by:

- The Ministry performing a stronger stewardship role, with HA Boards and Executive Teams having greater accountability for physician performance management and links made between physician payment and outcomes;
- A stronger and more integrated role for the College, taking an enhanced leadership role in setting minimum standards for all physicians in BC and realigning certain identified other responsibilities with HAs; and
- Improved clinical leadership with clinical leaders being better supported in order to fulfill their role in managing the day-to-day activities of physicians.

*Figure 2-1. Continuum of Improvement*

We appreciate that reaching this future state vision will take time and will be informed by the work already underway through the eight projects being undertaken by the Ministry Action Team, the suggestions for improvement in this report and the Osborne Margo review.
Appendix A: Overview of Licensing, Credentialing, Privileging and Performance Management Processes

This Appendix sets out how a physician is licensed in BC, including the approach taken with International Medical Graduates (IMGs), how credentialing works and how physicians receive privileges. The organizational diagrams have been compiled with the assistance of staff working in the constituent organizations and checked for factual accuracy by the Ministry and senior clinicians. Lastly, the Appendix details the performance management tools and techniques that we uncovered through this review.

Licensing

The College is the licensing and regulatory body governing physicians in BC. The College’s Registration Committee is responsible for granting registration to a physician as a member of the College, including initial registration, annual renewal and reinstatement of registration.

Initial registration

In order to be granted a full, unrestricted license (referred to as a ‘registrant’) in BC, a physician must have earned a medical degree at an accredited institution, passed the Medical Council of Canada Qualifying Examinations, become a Licentiate of the MCC and passed (or been exempted from) the exams of either the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada.

While there are eighteen classes of registration\(^{50}\) in BC, all applicants go through the same five-step process. The process, as described in the College’s Registration Manual\(^{51}\), includes:

**Step 1 – Initial contact with the applicant and eligibility review.** Prospective applicants must request an application form from the College. All requests are screened to determine whether there is a reasonable chance that the prospective applicant may be eligible for one of the eighteen classes of registration. If it is determined that they would likely be eligible, application forms are provided.

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\(^{50}\) The 18 classes as noted in the College by-laws are: full – general/family; full – specialty; special; osteopathic; provisional; academic; administrative; conditional – practice limitations; conditional – practice setting; conditional – disciplined; educational – medical student; educational – postgraduate; educational – clinical trainee; visitor; emergency; restricted; retired – life; retired – associate.

Step 2 – Receipt of the application. Once an application is received, College staff review it to confirm that all of the required information and documents have been provided. The applicant must provide evidence of Canadian residency status, academic qualifications, professional conduct, health status and English language proficiency. Applications that are incomplete or indicate a potential concern about education or previous performance are investigated by the Manager of the Registration Department before moving forward to the next step.

Step 3 – Processing the application. The Registration Department reviews the application to confirm that all required information and documentation are contained in the applicant’s file and verifies that registration requirements stipulated in the by-laws have been met.

Step 4 – Verification and registration. Once the application is verified, the applicant must attend an in-person interview at the College. The interview is either conducted by the Deputy Registrar or the full Registration Committee. When the applicant arrives for the interview, staff verify their identity and confirm that all required documentation has been provided in original form, with no photocopies allowed. Registration cannot occur until original copies of documents are provided. The interview also involves an orientation to practicing medicine in British Columbia.

Upon completion of the interview, and subject to the terms of any restrictions or waivers that the interviewer(s) may apply, the applicant can:

- Be granted registration without limits;
- Be granted registration with specified limits, conditions and/or undertakings with respect to scope of practice and/or specified activities;
- Have registration deferred pending the receipt of missing documents or the completion of specified activities; or
- Be denied registration.

Step 5 – Monitoring of the registrant. Registrations that are granted with restrictions are monitored and brought forward for review at prescribed intervals, until the restrictions are removed. Follow-up on restricted applications is performed by the Registration Committee, the Deputy Registrar, the staff, or other College Committees, dependent on the nature of the restriction.

Annual license renewal

On an annual basis, physicians are required to apply to the College to renew their license. This process is completed online. When a physician’s information is received in the system, staff will review it. If there are no issues or concerns with the application, it is considered to be accepted and no further approvals are required by the Registrar or a Board Committee.

Any issues on the form which are not already on the physician’s file are noted and sent to the appropriate department for further review (i.e.: if applicant discloses a legal matter, it would be sent to the College’s legal department. If they disclose a series of complaints, it would be sent to the department that handles complaints). If an application is referred for further review, the physician’s license is assumed to be renewed until the matter is resolved.
The College relies on their registrants to disclose all salient details, especially regarding any issues or concerns. One of the only mechanisms that the College has to check that the information provided is correct is through variance reports produced by the College’s database. This database holds information provided by each registrant in previous applications and declarations. The variance reports highlight any differences between the information that the physician has recently reported with information contained in the College database.

**International Medical Graduates**

Physicians who received their medical training outside of Canada are first licensed as a “Provisional Registrant”. The College’s Registration Procedures Manual notes that the bulk of the work and analysis for processing this type of application is done at step 1 (pre-screening) of the licensing process. In reviewing a physician’s education and background, the College provides an assessment and recommendations on what steps are required to be considered for licensure in British Columbia. Once they are invited to complete an application form to be licensed, steps 2 through 4 of the process outlined earlier in this Appendix are the same for IMGs.

As a Provisional Registrant, the College places limits on scope of practice. A supervisor and sponsor are also assigned to each physician who are responsible for monitoring their performance. The supervisor is contacted by the College at intervals of 3-months and one year after provisional registration for a written performance assessment.

A Provisional Registrant can be considered for full licensure between one and five years after their initial provisional registration.

**Agreement on Internal Trade**

With the goal of breaking down inter-provincial boundaries in recognizing the credentials of all types of workers, the AIT was amended in January 2009 to require licensing bodies to grant a license to a worker in their jurisdiction if they have a license with no restrictions in another Province. For example, a physician licensed in Newfoundland must be provided with a license in BC provided they meet language proficiency standards and there are no restrictions on their original Newfoundland license.
Credentialing and privileging

The role of the College

While HAs have primary responsibility for privileging within hospitals, the College currently fulfills the following roles in reviewing credentials and approving privileges for:

- **Private NHMS and diagnostic facilities.** This is done in conjunction with the role of accrediting these two types of facilities (overseen by the NHMS Committee and the Diagnostic Accreditation Program respectively).

- **Physicians seeking privileges for restricted activities** in diagnostic imaging within a HA-governed facility. This is required so that the physician can gain approval to bill the MSP. The College assumes and expects that each HA is performing its own due diligence in granting other privileges and monitoring overall performance.

**Process within private facilities**

The College’s role in reviewing credentials and privileges is a one-time event with annual re-appointment and performance management falling to the facility’s Medical Director. The process the College undertakes is the same for reviewing credentials and granting privileges in both a private NHMSF and a diagnostic facility.

Figure 3-1 illustrates this process.

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52 Restricted activities are diagnostic imaging activities which require credentialing by the College of Physicians & Surgeons. The activities include: magnetic resonance imaging (MRI); ultrasound (obstetrical/gynecological, transthoracic echocardiography, transesophageal echocardiography); nuclear medicine; nuclear cardiology; electroencephalography; electromyography; polysomnography; pulmonary function testing; nuchal translucency interpretation; CT colonography.

53 The Medical Director and an alternate must be registrants of the College and they must receive approval from the College before entering the role.

The College advised that the amount of extra due diligence it completes on an application depends on whether any concerns have been noted by staff in reviewing the documentation. Some of these concerns could include restrictions that have been placed on an applicant’s license, the number and nature of complaints on record or any deficiencies in experience or training. In cases where there are concerns, the Senior Deputy Registrar reviews the package in detail and checks references. If the application appears to be concern-free, staff sends the application to the Senior Deputy Registrar for approval.

Physicians within these facilities must apply for re-appointment annually using a standard form provided by the College. This form, and its subsequent approval or rejection, is handled by the Medical Director at the facility. Medical Directors are required to keep a record of the re-appointment form on file which is subject to a compliance review during the facility’s re-accreditation process (at present every four years for NHMSF and every three years for diagnostic facilities).
Process for restricted activities in HA governed facilities

Figure 3-2 illustrates the College’s process for reviewing credentials when a physician is seeking privileges for a restricted activity in a public diagnostic facility. This process is a one-time event with annual re-appointment being managed by the HA. This review of credentials is solely for the purpose of gaining approval to bill the MSP and the College expects that the HA or DF, where appropriate, review credentials for the purposes of granting privileges.

Figure 3-2. Process for reviewing credentials for restricted activities in public diagnostic facilities

 Credentialing and privileging within HAs

This review focused on two types of privileging applications within the system:

- Initial application when a physician is new to the HA, DF or private facility; and
- Application for re-appointment which occurs annually.

Appendix B outlines the processes for initially granting privileges and Appendix C shows processes for reviewing credentials and granting privileges within each HA as well as Providence Health Care (Providence).
Initial application

In many cases, before submitting an application for privileges, a physician’s credentials (including experience, references, confirmation of licensure) will have been reviewed and vetted extensively during a recruitment and selection process. Some exceptions which we learned of include:

- A GP already operating in the area is requesting privileges at a local hospital;
- A physician from outside the HA wants to perform duties as a locum; and
- A physician already has privileges within a HA, but is seeking a change.

For illustrative purposes, Figure 3-3 illustrates the process for reviewing an application for privileges at NHA and Providence.
Figure 3-3. Application Process at Northern Health Authority & Providence Health Care.
While both of these process maps identify a different approach to reviewing applications, there are some common traits and steps that all HAs and DF share. The process often involves the following steps:

1. The MAO sends an application to the physician who completes it and provides the following documents:
   - Completed application form;
   - Copy of applicant’s degree and license;
   - Three references. There is often a requirement for one of the references to be from the Chief of Staff of the most recent hospital where they worked;
   - Specialist qualification certificates as applicable; and
   - Evidence of current Canadian Medical Protective Association (CMPA) coverage.

   The application is returned to the MAO.

2. The MAO staff review the package to confirm that it is complete, and includes the following documents:
   - Physician impact analysis, which is completed by the Department Head or Chief of Staff and identifies what space, staff, equipment or other resources are required to support the physician’s intended activities;
   - Letter of offer submitted by the Department/Division Head (or equivalent); and
   - Certificate of professional conduct from the College.

3. The complete package is reviewed and approved at the hospital level by either the Department Head, Division Head or Chief of Staff. Often at least one reference is contacted. If they exist, the Local [facility] Credentials Committee and then MAC reviews and approves the full application package.

4. The approved application is then sent to the regional level, either to the Regional Department Head or Senior Medical Director who reviews the full application package and in cases where there is a concern, either interviews the physician or checks references.

5. The HACC then reviews the full application package. In cases where there is a concern (such as if the applicant has received numerous complaints, if their CV appears to be missing information) Committee Chairs stated that they call the Department Head or Regional Official to discuss an individual case, occasionally contacting and checking references themselves.

6. Once approved by the Credentials Committee, the MAO prepares a summary list of names and the privileges requested is then sent to the HAMAC and then the Board for final approval. Some HAs have a Board Quality-related Committee which reviews the request from the HAMAC and makes recommendations to the Board.

7. Upon being approved by the Board, a letter is sent from the MAO confirming the applicant’s appointment.
We noted that the privileges being granted by the Board fall into high-level categories. For example, a physician may be privileged for “Internal Medicine”, “General Practice” or “Surgery”. In some cases, upon being approved by the Board, it is the responsibility of the Department Head, Chief of Staff or Local Credentials Committee to further define the privileges granted to each individual clinician.

**Temporary privileges**

Given that it can take three to four months for an application to reach the Board, it is very common for the CEO or their designate\(^55\) to provide temporary approval of privileges subject to the Board’s approval. This is often done once the application is completed and has been approved by the Department Head or Chief of Staff.

The CEO or designate granting temporary approval of privileges is also responsible for dealing with emergency or last minute requests. Individuals we interviewed insisted that such approval is only granted once the application is completed. KPMG did not review a sample of these files nor follow them through the control system to either confirm or refute those claims. Often the CEO confirmed that they would also consult with the Department Head and in some cases call at least one reference before giving their approval.

**Re-appointment**

On an annual basis, or in the case of the FHA on a bi-annual basis, HAs are required to review and approve physician privileges. HA by-laws typically provide that the review will include an assessment of:

- Compliance with the HA’s by-laws, rules, policies and procedures;
- Satisfactory chart completion;
- Evidence of medical liability insurance (such as membership in CMPA);
- Evidence of renewal of licensure;
- Information on any actions taken by a disciplinary committee of the applicable regulatory College;
- Professional conduct; and
- Presence or absence of complaints.

The HA by-laws generally require that physician reviews are conducted by the Department Heads (or the HA’s equivalent), who then provides a recommendation on reappointment.

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\(^55\) Often the Vice President Medicine, or in the case of Fraser Health, the Regional Department Head.
Figure 3-4 illustrates the typical re-appointment process.
The process involves the following steps:

1. The MAO sends the re-appointment form directly to each physician.

2. The physician completes the application and provides the following documents:
   - Copy of BC license;
   - Proof of liability insurance; and
   - Continuing Medical Education (CME) list (only in some HAs as it is assumed that the College is confirming CME participation as part of the annual license renewal process).

   The completed application is sent back to the MAO.

3. The MAO checks to see that the application is complete and sends it to the Department Head for review and approval.

4. The Department Head reviews the application and gives approval. In a limited number of facilities, the Department Head meets with each physician to discuss performance and privileges being requested. The involvement and due diligence of the Department Head at this stage is a major gap which is discussed in Chapter 6.

5. Depending on how a hospital and/or HA have established their control environment and governance arrangements, a Division Head, Chief of Staff, Senior Medical Director or Local Credentials Committee reviews the applications.

6. The applications are reviewed by the HACC. At this stage, we found that most HACCs only review in more detail those applications that have a concern or 'red flag' attached from earlier reviews in steps 4 and 5. IHA does not have an HACC. Their applications go directly from the Local MAC to a Regional MAC and then to HAMAC.

7. MAO staff prepare a summary of the re-appointments (often the names, department, status and privileges requested) which is then sent to the HAMAC and then the Board for approval.
Performance management

BC physicians are subject to multiple layers of regulation and oversight. While the College has primary responsibility for licensing, and the HA has primary responsibility for credentialing and privileging, both are responsible for performance management.

College performance management

The College’s complaints, investigations, inquiries and discipline processes form a central part of the College’s public protection function, and play an important role in physician performance management. There are a number of bodies within the College which play a role in quality assurance and performance management issues:

- **Inquiry Committee:** This Committee has primary responsibility under the *Health Professions Act* (HPA) to investigate complaints that are filed by the public, another physician or health care professional. The Committee also has the power to launch investigations in specified circumstances such as evidence of professional misconduct, competence to practice, physical or mental ailment. The College attempts to resolve most complaints in a remedial manner. Most complaints are addressed and resolved informally by the College's staff through review of relevant records, and discussion or correspondence with the complainant(s) and the physician(s) involved. However, the Inquiry Committee is authorized, where it considers the action necessary to protect the public during an investigation or pending a hearing of the Discipline Committee, to impose limits or conditions on a physician’s practice or suspend the physician pending a Discipline Committee hearing.

- **Discipline Committee:** This Committee conducts hearings on matters related to physician performance and have the power to:
  - Reprimand a physician;
  - Fine the clinician;
  - Impose limits or conditions on a physician’s practice;
  - Suspend a physician’s registration;
  - Impose limits or conditions on the management of the physician’s practice during any suspension (subject to the By-laws); or
  - Cancel the physician’s registration with the College.

A physician has the right to appeal a decision of the Discipline Committee to the Supreme Court of British Columbia.
• **QA Committee:** This Committee focuses primarily on proactively improving or remediating concerns or deficiencies, through retraining and other activities. Provisions in the HPA and by-laws protect the confidentiality of QA information so that the activities of the Committee are “fire-walled” from the College’s other regulatory functions\(^56\) (for example, from the Registration and Discipline Committees), subject to limited exceptions applicable to serious circumstances\(^57\) that are specified in the HPA. The following five College Committees report to the QA Committee:

- Medical Practice Assessment Committee;
- Prescription Review Committee;
- Methadone Maintenance Committee;
- Ethics Committee; and
- Blood Borne Communicable Diseases Committee.

The QA Committee’s responsibilities, as outlined in section 1-20(2) of the College’s by-laws\(^58\), are:

- “To review standards of practice, to enhance the quality of practice, and to reduce incompetent, impaired or unethical practice by registrants;
- To administer the quality assurance programs of the College to promote high standards of practice among registrants;
- To assess the professional performance of registrants; and
- To recommend to the board mandatory continuing professional development requirements and any other requirements for revalidation of licensure.”

The College has a Clinical Competence Program which “is designed to give physicians detailed feedback on their knowledge base, history taking ability, physical exam skills, doctor-patient communication skills, problem solving ability and management skills”\(^59\). Approximately twenty doctors are included in the program every year at the request of the College. The program often involves physicians who have been absent from practice for a period of time and wish to return to work or physicians who have undergone a peer review and require additional assistance. Given the resources available for the program, the College focuses on physicians in community practices as they are not overseen through other mechanisms and controls operating within larger facilities within each HA.

The College co-funds, along with the Ministry and the British Columbia medical Association (BCMA), the Physician Health Program\(^60\). The program is designed to assist physicians with behavioural competence concerns as well as helps with problems such as substance abuse disorders, mental health issues and financial issues. The program provides help, confidential support and counseling.

\(^{56}\) The term “fire-walled” is used in a description of the QA Committee contained in the CPSBC Annual Report, 2010.

\(^{57}\) Includes acts of professional misconduct or incompetence, is deemed to pose a threat to the public, or has a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs their ability to practise the designated health profession.


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**Ministry of Health**

Provincial Review of Physician Licensing, Credentialing, Privileging & Performance Management

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HA performance management

Our interviews with each HA, hospital and Providence sought to identify the performance management tools and techniques in place. We ascertained the following formal and informal mechanisms:

**Formal**

- **Critical Incident Reviews** which are completed if a patient dies or is severely injured. Typically, these are undertaken by a Quality Assurance Committee on behalf of the Board and any information generated in completing a critical incident review will be protected under section 51 of the *Evidence Act*.
- **Morbidity & Mortality Rounds** involve a review of patient files to identify medical errors and discuss strategies to prevent further errors.
- **Patient surveys** conducted by the HA (currently being done at Interior).
- **Peer Review/In-Depth Performance Review**. Most HA medical staff by-laws and rules require that performance reviews be completed.
- **Scorecards** which provide a quantitative benchmark of a physician’s activities and patient outcomes.
- **National Surgical Quality Improvement Program (NSQIP)**. A surgical database and quality improvement program that provides data and information to improve quality and patient outcomes.

**Informal**

- Monthly team lunches where physicians can discuss a case and obtain informal advice [from colleagues and peers] on how to proceed with or resolve any identified concern.
- Department Head or Chief of Staff approaches a physician directly to discuss a complaint.
- Chief of Staff meets informally with local pharmacists to get feedback on physician prescribing habits.
- Chief of Staff audits patient files to check that they are complete and that there were no underlying performance concerns.
Appendix B: Process Maps for Initial Privileging Appointments
### Northern Health Authority

#### Physicians / Chief of Staff

- **START**
  - Physician is reviewed
  - (document identified)
  - Unsolicited request for privileging/review, manpower plan and impact analysis reviewed.

- Physician requests package from MAC.
- Physician returns complete package to MAC.
- MAC reviews the package for completeness, requests CPG and 2 confidential references, sends to hospital Chief of Staff.
- Local MAC reviews application.
- Chief of Staff, Chair of Medical Staff, Director reviews application, checks references.
- MAC sends letter to physician.

#### Medical Affairs Office (MAO)

- MAO sends package to the applicant.
- VP Medicine reviews the application to confirm completeness.

#### Credentials Committee, COC NACCC Board

- Request could be made to COC for non-temporary privileges.
- Credentials Committee reviews file and makes recommendations.
- Yes/No: IMAC reviews the files and makes recommendations to the board.
- Board reviews recommendation and makes decision.

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Ministry of Health

Provincial Review of Physician Licensing, Credentialing, Privileging & Performance Management

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Appendix C: Process Maps for Privileging Re-Appointments

Provincial Health Services Authority

**Applicant/Department Head**
- Applicant submits application.
- Application reviewed by Department Head.
- Department Head approves or declines appointment.

**Medical Staff Office (MSO)**
- MSO sends appointment to online renewal form.
- MSO confirms applications are complete.
- MSO ensures reviewers are in order, prepares renewal forms for Credentials Committee, provides reports, sends to Committee.
- Committee reviews applications and makes decisions.
- Committee recommends appointment, notifies MSO.
- MSO notifies Applicant and Department Head of Board decision (revokes, approves).

**Credentials Committee, HAMAC Board**
- Credentials Committee reviews and makes decisions.
- HAMAC reviews appointment, makes decision.
- Board reviews HAMAC recommendations and makes decision, notifies MSO.
**Interior Health Authority**

**Medical Affairs Office, VP Medics**

1. **START**
   - MAO sends the reappointment forms to all physicians

2. Physician completes the forms, returns to MAO

3. MAO circulates forms to appropriate Chief of Staff or Department Head for review

**Credentials Committee/HMAC, Board**

4. Local Credentials Committee and/or MAC reviews applications, makes decision

5. Regional MAC reviews the list of reappointments, makes recommendations to HMAC

6. HMAC reviews the list of reappointments, makes recommendations to the Board

7. Board reviews the recommendations and makes decision

8. Yes/No

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Appendix D: Credentialing Standards

The following table outlines the minimum HA-wide standards to be granted privileges for nine classifications of fully licensed physicians (standards may be different for physicians with a provisional license). In providing this information, most Vice President Medicines noted that each facility has the right to require additional education and/or experience in order to be granted privileges.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Fraser</th>
<th>Vancouver Coastal</th>
<th>Vancouver Island</th>
<th>Interior</th>
<th>Northern</th>
<th>PHSA**</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner</td>
<td>CFPC Certification</td>
<td>CFPC Certification</td>
<td>CFPC Certification</td>
<td>CFPC is preferred</td>
<td>CFPC Certification</td>
<td>CFPC Certification</td>
</tr>
<tr>
<td>OBGYN</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification, fellowship in pediatric and adolescent gynecology</td>
<td></td>
</tr>
<tr>
<td>General Surgeon</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification, ATLS, 2 year subspecialty residency training in pediatric surgery</td>
<td></td>
</tr>
<tr>
<td>Orthopedic Surgeon</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification, 5-year residency followed by a pediatric orthopedic fellowship</td>
<td></td>
</tr>
<tr>
<td>Anesthetist</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification, ACLS/PALS, 1 year minimum pediatric anesthesia fellowship training, 6-month minimum pediatric cardiac anaesthesia fellowship, 1 year minimum pediatric anesthesia fellowship</td>
<td></td>
</tr>
<tr>
<td>Radiologist</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification, certifications and fellowships in pediatric radiology</td>
<td></td>
</tr>
<tr>
<td>Pathologist</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification, fellowship in specific sub-specialty of pathology plus 1-2 year fellowship in pediatric pathology</td>
<td></td>
</tr>
<tr>
<td>Emergency Physician</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification, training in pediatric emergency medicine</td>
<td></td>
</tr>
<tr>
<td>Cardiologist</td>
<td>Royal College certification</td>
<td>Royal College certification</td>
<td>Royal College certification, experience with 50 cardiology patients in last 12 months</td>
<td>Royal College certification</td>
<td>Royal College certification, fellowship in pediatric cardiology and 3 core years of sub-specialty training</td>
<td></td>
</tr>
</tbody>
</table>

**PHSA hospitals provide highly specialized services; hence, for the purposes of this analysis we requested the credentialing standards for BC Children’s Hospital.

**Legend**

**61** All GPs at BCCH are visiting physicians and do not admit patients.
(B) = Board approved standard
CFPC = College of Family Physicians of Canada
# Appendix E: US Data Bank details

The following table provides an overview of the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank in the US (see Chapter 7).

<table>
<thead>
<tr>
<th>Database</th>
<th>National Practitioner Data Bank</th>
<th>Healthcare Integrity and Protection Data Bank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>NPDB is an information clearing house to collect and release all licensure actions taken against all health care practitioners and health care entities, as well as any negative actions or findings taken against health care practitioners or organizations by Peer Review Organizations and Private Accreditation Organizations.</td>
<td>HIPDB was implemented to combat fraud and abuse in health insurance and health care delivery and to promote quality care. HIPDB alerts users that a more comprehensive review of past actions by a practitioner, provider or supplier may be prudent.</td>
</tr>
<tr>
<td><strong>Reporting Organizations</strong></td>
<td>Medical malpractice payers &lt;br&gt; State health care practitioner licensing and certification authorities (including medical and dental boards) &lt;br&gt; Hospitals &lt;br&gt; Other health care entities with formal peer review (HMOs, group practices, managed care organizations) &lt;br&gt; Professional societies with formal peer review &lt;br&gt; State entity licensing and certification authorities &lt;br&gt; Peer review organizations &lt;br&gt; Private accreditation organizations</td>
<td>Federal and State Government agencies &lt;br&gt; Health plans</td>
</tr>
<tr>
<td><strong>Information Available</strong></td>
<td>Medical malpractice payments (all health care practitioners) &lt;br&gt; Any adverse licensure actions (all practitioners or entities) &lt;br&gt; Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction &lt;br&gt; Any other loss of license &lt;br&gt; Adverse clinical privileging actions &lt;br&gt; Adverse professional society membership actions &lt;br&gt; Any negative action or finding by a State licensing or certification authority &lt;br&gt; Peer review organization negative actions or finding against a health care practitioner or entity &lt;br&gt; Private accreditation organization negative actions or findings against a health care practitioner or entity</td>
<td>Licensing and certification actions &lt;br&gt; Revocation, suspension, censure, reprimand, probation &lt;br&gt; Any other loss of license - or right to apply for or renew - a license of the provider, supplier, or practitioner, whether by voluntary surrender, non-renewal, or otherwise &lt;br&gt; Any negative action or finding by a Federal or State licensing and certification agency that is publicly available information &lt;br&gt; Civil judgments (health care-related) &lt;br&gt; Criminal convictions (health care-related) &lt;br&gt; Exclusions from Federal or State health care programs &lt;br&gt; Other adjudicated actions or decisions (formal or official actions, availability of due process mechanism and based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service)</td>
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<td>Who has access</td>
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<td>• Other health care entities, with formal peer review</td>
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<td>• Health care practitioners/providers/suppliers (self-query)</td>
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<td>• State health care practitioner licensing and certification authorities</td>
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<td>• State entity licensing and certification authorities*</td>
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### Appendix F: Board Directives on Peer Review

| Organization       | Board Directive Motion                                                                                                                                                                                                                     | Date of Board Motion | Activities Undertaken by Staff                                                                                                                                                                                                 |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
| Fraser HA          | 1. Ensure all regional departments develop a process of clinical audit by peer review that is appropriate to the clinical function of the department and ensures continuing improvement in the quality of medical care in the department.  
                      2. Ensure all members of the medical staff participate in regular clinical audit of their clinical practice by peer review both within the process developed by regional departments and as required by relevant accreditation processes, with a report of that participation made available to the Board in the quarterly reporting by HAMAC.  
                      3. Ensure all regional departments develop a statement of expectations that represent the criteria for membership of the department and seek to promote continuous quality improvement in the department.  
                      4. As the HA develops the process for regular in-depth performance review, required by the Medical Staff By-laws, all members of the medical staff participate in the review and a summary report of such participation be provided to the Board in the quarterly reporting by HAMAC. | March 2011           | Update Received from Peter Owen: “Peter Doris (Chair of HAMAC) reported to the Board in February 2012 on the activities to date and will do so on a quarterly basis. We’re still in the early stages of building infrastructure in the Regional Depts. to support any serious QI/PS activity. Some Depts. have a few commendable processes underway. We have re-engaged the consultant who reviewed the state of affairs in the Depts. last year to work with the Dept Heads going forward in the development of their processes.” |
| Vancouver Coastal HA | 1. Ensure all departments develop a process of clinical audit by peer review that is appropriate to the clinical function of the department and ensures continuing improvement in the quality of medical care in the department.  
                      2. Ensure all members of the medical staff participate in regular clinical audit of their clinical practice by peer review both within the process developed by departments and as required by relevant accreditation processes, with a report of that participation made available to the Board in the quarterly reporting by HAMAC.  
                      3. Ensure all departments develop a statement of expectations that represent the criteria for membership of the department and seek to promote continuous quality improvement in the department.  
                      4. As the HA develops the process for regular in-depth performance review, required by the Medical Staff By-laws, all members of the medical staff participate in the review and a summary report of such participation be provided to the Board in the quarterly reporting by HAMAC. | March 2011           | Update Received from Dr. O’Connor: “VCH will be working toward an assessment that includes a scorecard for clinical audit. We will, as a first mission, be collating the responses and developing a template scorecard. Simultaneously after that we will seek physician, Department and Division Heads and HAMAC feedback, as well as assessment of costs (Decision Support) to actually collect the data on an individual physician basis. This may involve a potential sampling methodology (vs. every chart)” |
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<th>Organization</th>
<th>Board Directive Motion</th>
<th>Date of Board Motion</th>
<th>Activities Undertaken by Staff</th>
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| Vancouver Island HA                | It was MOVED, SECONDED and CARRIED THAT a recommendation be made to the Board to instruct the HA Medical Advisory Committee to implement clinical audits and peer review programs more broadly in VIHA, within existing resources. | March 2011           | Update Received from Dr. Crow:  
  - We have formed a VIHA Medical Staff Performance Review Task Group which has developed Terms of Reference for the group and is currently meeting.  
  - Prior to forming the Task Group our Acting Chair for the HA Medical Advisory Committee went to most VIHA Local Medical Advisory Committee and presented to the MACs on Peer Review and obtained feedback from them.  
  - Our Medical Staff Information System Foundation initiative has been expanded in scope to incorporate support for peer review – we have modified the project charter and the Project Manager has assisted with the Task Group and is a member of it.  
  - The Performance Review Task Group links with the Medical Planning and Credentials Committee and reports information to it.  
  - We are also actively participating on the provincial committees dealing with Credentialing/Privileging/Physician Performance. Our Chair of the Medical Staff Performance Review Task Group will sit on the provincial Performance Assessment Review Systems Committee once it is struck by the provincial Action Committee.  
  - No specific deadlines have been given by our Board, especially given the provincial activities that are underway and our wish to link with them. Our Task Group, however, is proceeding while awaiting the provincial committee to be struck. |
| Interior HA                        | Passed a motion that a letter would be sent to the Chairs of the Medical Advisory Committee of each PHSA Agency directing Medical Staff comply with Dr. Cochrane’s recommendation #4, which read: “It is recommended that HA boards instruct their Medical Advisory Committees or equivalent to implement clinical audit and peer review programs for all medical staff members, including regular in-depth performance reviews as described in their medical staff rules. The results of these reviews should be reported as part of the regular appointment and reappointment process or as necessary when performance concerns and remedial actions are necessary. Medical staff member participation in these reviews should be reported to the Board quarterly.” | June 22, 2011        | Update received from Georgene Miller:  
  - In accordance with the PHSA Medical Staff Rules, as you know, the in-depth review process is followed for Active Medical Staff every 3 years as well as Medical Staff moving from Provisional to Active Staff.  
  - Department Heads at Children’s and Women’s Hospital have begun to select 1/3 of their Active Medical Staff to undergo in-depth reviews. BC Cancer Agency and the Forensic Hospital will also be following the same approach.  
  - All Departments have been asked to provide to PHSA Medical Affairs, the Clinical Audit processes they are currently following.  
  - PHSA is developing a clinical audit framework incorporating these processes and coordinating the standards, reviews and indicators that are used to assess performance of Medical Staff across departments and Agencies. |
| Northern HA                        | The Board has not passed a motion instructing staff to implement peer review.             | June 22, 2011        | Update received from Georgene Miller:  
  - In accordance with the PHSA Medical Staff Rules, as you know, the in-depth review process is followed for Active Medical Staff every 3 years as well as Medical Staff moving from Provisional to Active Staff.  
  - Department Heads at Children’s and Women’s Hospital have begun to select 1/3 of their Active Medical Staff to undergo in-depth reviews. BC Cancer Agency and the Forensic Hospital will also be following the same approach.  
  - All Departments have been asked to provide to PHSA Medical Affairs, the Clinical Audit processes they are currently following.  
  - PHSA is developing a clinical audit framework incorporating these processes and coordinating the standards, reviews and indicators that are used to assess performance of Medical Staff across departments and Agencies. |

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**Ministry of Health**  
Provincial Review of Physician Licensing, Credentialing, Privileging & Performance Management  
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Appendix G: Review Assessment Framework

Note: ‘LCPPM’ refers to licensing, credentialing, privileging and performance management.

Introduction

This assessment framework will be our guide in conducting the review of systems and processes throughout British Columbia. It outlines our objectives and areas of inquiry for each entity to be reviewed (Ministry, College, HAs and hospitals). The information collected through the assessment framework will be combined with the legal and regulatory review, the hospital and private clinic surveys, and the Canadian College comparisons to complete our analysis.

After reviewing all of the information gathered through this assessment framework, we intend on having:

- A map of the processes involved with LCPPM both at a Province-wide level and within each HA
- An understanding of the accountability frameworks within the system to ensure that they are clear and effective, this includes governance as well as clarifying roles and responsibilities
- A clear picture of where there are gaps between written rules/policy and actual practice
- An understanding of the variability in standards and processes across the Province

Ministry of Health

Meeting Participants: The Ministry has identified 14 individuals that have responsibility for some aspects of LCPPM and/or have accountability for facility performance and reporting.

Areas of Inquiry in all meetings:

- An understanding of their initiatives around LCPPM (both current and pending), along with discussions of their effectiveness, the linkages with other areas of the system (ex: capital planning), areas for improvement and how they fit within the broader system.
  - Throughout the discussions, we will seek to develop an understanding of who is ultimately responsible within the Ministry for each aspect of LCPPM?

- Their interactions with the College and HAs?
  - Source of positive or negative interactions? Examples?
  - Challenges and areas for improvement? Examples?

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As it relates to physicians in acute care hospitals, locums, private diagnostic facilities and NHMS facilities

Ministry of Health

Provincial Review of Physician Licensing, Credentialing, Privileging & Performance Management
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**Additional Areas of Inquiry for meeting with Health Human Resources:**

- Should there be a Province-wide standard for the credentials required to privilege each type of physician activity and/or procedure?
  - If no, why?
  - If yes, who should set the standard?
    - What role would the College have?
    - What role would the HAs have?
- Discussion of the Agreement on Internal Trade and how that is impacting physician quality
- International Medical Graduate programming and standards

**Additional Areas of Inquiry for meetings with those responsible for accountability agreements with the HAs and DF:**

- Discussion of the current frameworks, how they are working and where there are areas for improvement.

**Additional Areas of Inquiry for meeting with Legal & Regulatory Branch:**

- What challenges and barriers exist within BC’s legal and regulatory framework?

**College of Physicians & Surgeons**

**Meeting Participants:** Meetings have been scheduled with Dr. Heidi Oetter (Registrar), Dr. Bob Vroom (Senior Deputy Registrar) and Dr. Jack Burak (Deputy Registrar).

**Areas of Inquiry:**

- Generate a process map for physician licensing in British Columbia, with specific probes for:
  - An understanding of roles and responsibilities, handoffs from one step to the other, time to complete a task, wait times between tasks, feedback loops.
  - Provide examples of issues or challenges they have faced
  - How the process differs for Provisional Registrants/IMGs
  - How the Agreement on Internal Trade impacts this process
  - How complaints and/or performance management issues impact licensing
  - What due diligence is completed on an annual basis when re-licensing physicians
  - Are there areas for improvement?
Generate a process map for credentialing and privileging physicians in non-hospital medical surgical facilities, with specific probes for:

- An understanding of roles and responsibilities, handoffs from one step to the other, time to complete a task, wait times between tasks, feedback loops.
- Provide examples of issues or challenges they have faced.
- How the process differs for Provisional Registrants/IMGs
- How the Agreement on Internal Trade impacts this process
- Performance management, the role of the Medical Director and what information is shared with the College and other public facilities that these physicians may be operating within
- The connections between the College’s role in credentialing and privileging and their role in accrediting these facilities

Generate a process map for credentialing and privileging physicians in diagnostic imaging departments within HA regulated hospitals, with specific probes for:

- An understanding of roles and responsibilities, handoffs from one step to the other, time to complete a task, wait times between tasks, feedback loops.
- Provide examples of issues or challenges they have faced.
- Should the College perform this task? If not, who?
- How the process differs for Provisional Registrants/IMGs
- How the Agreement on Internal Trade impacts this process
- Performance management and what information is shared with the College

Their interactions with the Ministry and HAs?
- Source of positive or negative interactions? Examples?
- Challenges and areas for improvement? Examples?

Their views on the College’s role in privileging for the purposes of billing the public system.

Do they have an induction program for new registrants, including Provisional Registrants/IMGs, and what does it entail?

Should there be a Province-wide standard for the credentials required to privilege each type of physician activity and/or procedure?
- If no, why?
- If yes, who should set the standard?
  - What role would the Ministry have?
  - What role would the College have?
  - What role would the HAs have?
Meeting Participants: Vice President Medicine (or their equivalent) along with anyone else the VP identifies & Chair of the Board Credentials Committee (or its equivalent)

Areas of Inquiry for VP Medicine & HA Staff:
- Generate a process map for credentialing, privileging and performance management for physicians, with specific probes for:
  - An understanding of roles and responsibilities, handoffs from one step to the other, time to complete a task, wait times between tasks, feedback loops.
  - The IT infrastructure and staff resources do they have to manage the LCPPM process
  - Provide examples of issues or challenges they have faced
  - How does the process differs for Provisional Registrants/IMGs?
  - How does the process differs for locums?
  - How do they accommodate urgent requests?
  - Do they have an induction program for new physicians in their HA, and what does it entail? Does it differ for IMGs/Provisional Registrants?
  - What information is gathered and shared with the HA Board?
  - What information is gathered and shared with the College?
  - What information is gathered and shared with other HAs?
  - What information is gathered and shared with hospitals?
  - Performance management systems, feedback and remediation mechanism
  - What due diligence is completed during the annual revalidation of privileges process?
- Their interactions with the Ministry and College?
  - Source of positive or negative interactions? Examples?
  - Challenges and areas for improvement? Examples?
- The effectiveness of the UBC/HA Joint Advisory Council system. Recommendations for improvement?
- Should there be a Province-wide standard for the credentials required to privilege each type of physician activity and/or procedure?
  - If no, why?
  - If yes, who should set the standard?
    - What role would the Ministry have?
    - What role would the College have?
    - What role would the HAs have?
• How does the HA currently determine what credentials they require to privilege each type of physician activity and/or procedure?
• Each HA will be asked to provide the list of credentials required to be privileged as a:
  • General Practitioner
  • OBGYN
  • General Surgeon
  • Orthopedic Surgeon
  • Anesthetist
  • Radiologist
  • Pathologist
  • Emergency Physician
  • Cardiologist
  • Locum

Areas of Inquiry for Chair of the Board Credentials Committee:
• How does the Committee operate and do they feel that they have sufficient information to fulfill their oversight function?

• Should there be a Province-wide standard for the credentials required to privilege each type of physician activity and/or procedure?
  • If no, why?
  • If yes, who should set the standard?
    • What role would the Ministry have?
    • What role would the College have?
    • What role would the HAs have?

• Where, as a whole, are there areas for improvement in the system?
Hospitals

Meeting Participants: Hospital Chief of Staff and any individuals they recommend be involved

Areas of Inquiry

- Generate a process map for privileges and performance management in their hospital, with specific probes for:
  - An understanding of roles and responsibilities, handoffs from one step to the other, time to complete a task, wait times between tasks, feedback loops.
  - What IT infrastructure and staff resources do they have to manage the process?
  - Provide examples of issues or challenges they have faced
  - How the process differs for Provisional Registrants/IMGs?
  - How the process differs for locums?
  - Do they have an orientation program for new physicians in their hospital, and what does it entail? Does it differ for IMGs/Provisional Registrants?
  - What information is gathered and shared with the HA?
  - Performance management systems, feedback and remediation mechanism
  - How do they accommodate urgent requests?
  - What due diligence is completed during the annual revalidation of privileges process?
Appendix H: Hospital Online Survey & Summary of Results

Sample size for this survey was 50. Not all respondents answered all questions. The following is an abridged version of the results which are on file and available upon request.

Physician Privileging

1. Who is responsible for physician privileging in your hospital?

For the majority of hospitals, a privileging committee is responsible for physician privileging. For example, Fort St. John Hospital has the Fort St. John Privileges Committee for new physicians and locums. It is also the case that a credentialing committee is generally responsible for physician credentialing.

Another common theme is the Chief of Staff is responsible for physician privileging. In a few cases the Medical Director, Department Head, or VP is responsible.

2. Please describe the process within your hospital for physician privileging?

There are a variety of responses to this question and some processes are quite extensive:

- For new hires, the physician could work regionally with the HA to gain privileges. Privileges are renewed each year when physicians renew their contract.
- Application to a credentialing committee. For example, the NH Credentials Committee for all sites in NHA.
- “Annual review at our MAC of all physicians. 360 degree assessment of new physicians prior to moving from associate to active staff.”

3. Do you have a separate process for privileging locums? If so, please describe this process.

In the majority of cases the process is the same as described in question two. 4/49 respondents indicated the process is different.

Some rural sites participate in the BC Locum Program (BCLP). This requires GPs to apply to their program; they collect credentials, College, insurance and reference information. The BCLP then shares this information with the facility in which the locum is applying.

In another case, at the time of application for privileging the Chief of Staff may have a verbal discussion with the Chief of Staff at the last location where the physician was privileged.
In another response, it was indicated that for a locum physician, application & references are reviewed by the Chief of Staff. Administrative Assistant is responsible for ensuring all information is complete for the review of credentials & privilege process. This includes collecting CMPA, license, Certificate of Professional Conduct, etc.

4. How frequently does your hospital review physician privileges? As a part of these reviews, do you re-assess credentials?

Almost all hospitals review physician privileges on an annual basis. However, there is variation in credentials being re-assessed. In some cases credentials are also re-assessed on this yearly basis (i.e.: Lillooet District Hospital). There are a limited number of instances where credentials are not re-assessed.

5. When was the last time that you conducted a hospital-wide review of physician privileges? Note: If a hospital-wide review is not completed, please indicate when each Department/Area conducted a review.

Most hospitals have an annual hospital-wide review of physician privileges. Dates of these reviews ranged from April 2011 to as recent as January 2012.

There are cases where a hospital-wide review has never been done (i.e.: Fort St. John).

6. Do you have any special processes for processing privileges of Provisional Registrants/International Medical Graduates? If so, please describe them.

Responses to this question are mixed. Approximately 20/50 responses indicate the process is no different for provisional registrants/IMGs compared to Canadian grads.

Approximately 13/50 responses stated that the Chief of Staff is involved in the process for privileging of provisional registrants/IMGs.

7. How do clinical audits inform privileging rights within your hospital?

Greater than 50% of responses indicate that clinical audits are not used or are rarely used to inform privileging rights within the hospital. Only one hospital explicitly stated that clinical audits have resulted in a change in privileges.

VIHA (10 hospital responses) stated: “Clinical audits are the responsibility of the Department/Division or Site Chief. If changes are to be made to a member’s privileges, the information is provided to the Site Chief and the Administrative Assistant’s office. After recommendation for approval through Executive Approval, the report is reviewed by MPCC, HAMAC and the Board. Once privilege recommendation occurs, information systems are updated. “

8. How do you manage the files and administrative work around physician privileging (i.e.: software, excel spreadsheet, database, paper

Most hospitals manage the files around physician privileging with paper files. Other mediums include Microsoft Access Databases and Microsoft Excel Spreadsheets.

After a July 2010 project, VIHA stated: “Everything from an access database in Nanaimo, a fox-pro database in South Island, excel spreadsheets, paper files, paper lists on bulletin boards and rolodexes were being used to manage information about medical staff privileges.”
To address these problems, planning was in place to centralize the processes around privileging and credentialing to three service centres, one in the South Island (already in existence), one in the Central Island and one in the North Island. Additionally, centralization of the information, as well as the processes was considered paramount.

Centralization of all of VIHA’s privileging and credentialing processes and information management is underway. In the past 6 months a credentialing sharepoint site has been created. All facilities have access to this sharepoint and keep their own facility’s information updated there. At this time, all information is kept on a facility-specific excel documents within the sharepoint site. The excel documents are password protected.

Centralization of the privileging processes in the central island is also underway. In February 2012 privileging and credentialing processes and information management for the West Coast General Hospital will move to Nanaimo.

Centralization of processes and information will poise VIHA for a smooth transition to a provincial credentialing system, a recommendation of Dr. Cochrane’s report.

9. What is your process for responding to requests for privileging information from other hospitals?

There is collaboration amongst hospitals to provide privileging information when requested to do so from another hospital. In many cases, the Chief of Staff or Medical Director provides information. Consent is gained from the physician in question.

10. What, if any information related to physician privileging, do you report to your HA?

For almost all hospitals, all information is passed to the HA.

11. Are there any instances where information related to physician privileging would be reported to BCs Ministry of Health? If yes, please describe them.

Almost all hospitals responded stating there are no instances where information related to physician privileging would be reported to the Ministry. A few hospitals may report this information in situations where patient care failures are in the system, there are large-scale issues affecting patient/public safety, or if there is a reason for loss of licensing.

12. Are there any instances where information related to physician privileging would be reported to the BC College of Physicians and Surgeons? If yes, please describe them.

Almost all hospitals describe instances where this information would be reported to the College. Situations where there is suspension of privileges, cancellation of appointment, knowledge of illness, unsafe physician practices, or if any criminal information is discovered would all be reported.
Performance Management

1. Do you have a process within your hospital for physician performance management?

20/48 hospitals have a process for physician performance management.

2. Who is responsible for performance management in your hospital? If this is completed by each Department, please also identify who within the hospital is accountable for all performance management activities.

In most cases the Chief of Staff, Medical Director, or Department Head is responsible. Other responses included a credentialing committee.

3. Is your performance management process guided by an evidence-based model such as a Balanced Scorecard? If so, please provide a brief description of the model.

The majority of hospitals do not have an evidence-based-model in place for performance management.

However, the Emergency Medicine department at NRGH provides each physician with a “6 monthly report card of various indicators such as hours worked, patients seen, pts/HR, admission rate...” and compares to colleagues while maintaining anonymity.

Other tools used include individual medical staff scorecards and 360 reviews.

5. How frequently does your hospital conduct physician performance reviews?

Almost 50% of hospitals conduct physician performance reviews annually. Approximately 25% stated this is never done and there is no formal process in place. Responses to this question range from never, quarterly, to annually.

6. When was the last time that you conducted a hospital-wide review of physician performance? Note: If a hospital-wide review is not completed, please indicate

Approximately 50% of respondents indicated a hospital-wide review has never been done. A few hospitals perform a review annually.

Overall, responses to this question ranged from never to annually. The oldest date for a hospital-wide review to be completed was January 2011. Some hospitals indicated there is currently a review occurring.

7. Do you have any special performance management processes for Provisional Registrants/International Medical Graduates? If so, please describe them.

There are no special performance management processes for Provisional Registrants/International Medical Graduates.
A few responses indicated a different process:

- At Providence, provisional staff must participate in CMEs and IMGs are registered through the IMG program.
- At RIH a 360 review is used.
- VIHA Physician Recruitment manages this process for their hospital sites.

8. **How do you manage the files and administrative work around physician performance (i.e.: software, excel spreadsheet, database, paper files)?**

Most hospitals manage the files around physician privileging with paper files. Many responses indicated to refer to question 8 from section one, since the process is the same.

9. **What, if any information related to physician performance, do you report to your HA?**

In some cases no information related to physician performance is reported to the respective HA. When information is reported, it includes:

- Any issues that arise, even if dealt with at a local level.
- Annual Reviews and 360 reviews.
- Outcomes of reviews of specific clinical cases.
- Compliance with clinical audit.

10. **Are there any instances where information related to physician performance would be reported to BCs Ministry of Health? If yes, please describe them.**

Greater than half of the responses indicate there are no instances where information related to physician performance would be reported to the Ministry. However, some sites stated they would report:

- Health provider performance undermined by health.
- Illegal actions/serious breaches of professionalism.
11. Are there any instances where information related to physician performance would be reported to the BC College of Physicians and Surgeons? If yes, please describe them.

Almost all hospitals responded that there are instances where information related to physician performance would be reported to the College. These include instances:

- There is serious misconduct or risk to patient safety.
- Unethical or persistent unacceptable behavior is identified.
- If privileges are suspended/revoked.
Appendix I: Private Facility Online Survey & Summary of Results

Physician Privileging

1. When was the last time that you conducted a facility-wide review of physician privileges? Note: If a facility-wide review is not completed, please indicate when each Department/Area conducted a review.

The majority of respondents indicated that a facility-wide review is conducted annually, usually in the winter months. The remaining respondents do not conduct a facility-wide review since there may be only one doctor working at the facility.

2. How do you manage the files and administrative work around physician privileging (i.e.: software, excel spreadsheet, database, paper files)?

36/53 respondents stated that paper files are used. The second most common response was using a software such as an excel spreadsheet to manage the files.

3. Are there any instances where information related to physician privileging would be reported to BCs Ministry of Health? If yes, please describe them.

46/48 respondents stated there are no instances where this information would be reported to the Ministry. If there were any instances to be reported, ex. misconduct, they would be reported to the College.

4. Are there any instances where information related to physician privileging would be reported to the BC College of Physician and Surgeons? If yes, please describe them.

Yes. The majority of respondents indicated there are instances where this information would be reported to the College. They include:

- Altered scope of practice;
- Any activity deemed a criminal offence or malpractice;
- Complaint or concern;
- If any changes to applicants surgical privileges or practice by a hospital or medical surgical facility;
- Any disciplinary action;
- Has any blood borne communicable disease;
- Any factors that may limit suitability to work at facility; and,
- Relinquished hosp/anaesth privileges.
Many facilities report this information to the College as part of an annual application for renewing privileges.

5. Are there any instances where information related to physician privileging would be reported to other private facilities? If yes, please describe them.

Almost all respondents stated they would not report this information to other facilities. The response was that the College should be involved in this process, not the individual private facility.

The response from the CPSBC states they would report this information. They provided an example: “If a physician’s privileges have been suspended at a hospital and the circumstances were relevant to the NH setting and in light of patient safety the College would as appropriate suspend privileges at any non-hospital where the physician worked.”

Performance Management

1. Do you have a process within your facility for physician performance management?

35/55 respondents stated “yes”.

2. Who is responsible for performance management in your facility? If this is completed by each Department, please also identify who within the facility is accountable for all performance management activities.

The Medical Director is responsible for performance management in almost all facilities. This aligns with the response from the College.

In a few cases the Director of Anesthesiology, Nursing Manager, or Surgical Director are responsible for performance management in their respective departments.

3. Is your performance management process guided by an evidence-based model such as a Balanced Score card? If so, please provide a brief description of the model.

Almost all facilities indicated “no”. However, some facilities indicated that they use:

- Reviewing outcomes – these include pregnancy rates related to treatments, treatment and outcome complications, and incidents. We also survey patients for feedback on their experience at the facility.
- Outcome Analysis. At one clinic, a proprietary Outcome Analysis software is used where every patient’s pre-operative data, surgical refractive treatment and post-operative outcome are analyzed per software. Any unexpected outcomes are then automatically flagged and brought to the Medical Director’s attention and dealt with.
4. Please describe the process within your facility for physician performance management. In your answer, please consider the following:

- Physician performance criteria
- Method for establishing a monitoring plan specific to the requested privilege
- Method for determining the duration of performance monitoring
- Circumstances under which monitoring by an external source is required
- Measures employed to resolve performance issues

Approximately 50% of the responding private facilities have a process in place for performance management. The remainder responded as “N/A” or “No”.

Since many of the private facilities only have 1-5 physicians working, they do not feel there is a need for a formalized process of performance management. Therefore, it is managed on an ongoing basis when there is a need for it.

Responses from the facilities which do have some type of a performance management process indicated that they use:

- Treatment outcomes (Infections, morbidity, mortality tracked through the year);
- Annual audit for physician performance by Medical Director;
- Patient complaints;
- Peer review; and,
- Chart review.

In some cases physician performance criteria is established by medical director.

5. How frequently does your facility conduct physician performance reviews?

The College recommends annually. Approximately 50% of respondents stated they conduct physician performance reviews annually. A few smaller facilities do not conduct these reviews.

Most of the remaining facilities conduct the reviews quarterly or bi-annually.

6. When was the last time that you conducted a facility-wide review of physician performance? Note: If a facility-wide review is not completed, please indicate when each Department/Area conducted a review.

17/39 facilities responded as “N/A” or “Never”. There was a large variability in responses to this question. A few facilities conduct the reviews annually.
7. Do you have any special performance management processes for Provisional Registrants/International Medical Graduates? If so, please describe them.

Over 90% of facilities stated “No” or “N/A”.

Some facilities described special processes. For example, one indicated that they:

- Monitor statistics on procedures performed;
- Chart review on IMG physician patients to confirm that clinical assessments and decisions are reasonable; and,
- Assessment from Departmental Managers to confirm he is functioning well between departments.

8. How do you manage the files and administrative work around physician performance (i.e.: software, excel spreadsheet, database, paper files)?

Almost all facilities utilize paper files. Excel spreadsheets and administrative software is also used.

9. Are there any instances where information related to physician performance would be reported to BCs Ministry of Health? If yes, please describe them.

All facilities responded “No”.

10. Are there any instances where information related to physician performance would be reported to the BC College of Physician and Surgeons? If yes, please describe them.

Most facilities indicated they would report certain instances related to physician performance to the College. They include:

- Professional misconduct;
- Compromising patient safety;
- Incompetence; and,
- Impairment.

11. Are there any instances where information related to physician performance would be reported to other private facilities? If yes, please describe them.

Almost all facilities responded as “No”. One facility stated they would report “Issues of impairment.”