December Council Meeting

Friday, December 13th, 2019 | 8:00 a.m. |

AMENDED AGENDA

Time		Item		Page Number
5 min	8:00 am	**1.**	Opening Remarks	-
0 min	8:05 am	**2.**	Agenda – Approval	-
		3.	Call for Conflict of Interest	
		4.	In Camera (if needed)	-
5 min	8:05 am	**5.**	Council Meeting Minutes – For Approval – i. September 13th, 2019 Council Minutes ii. September 27th, 2019 Electronic Council Minutes	**3**
60 min	8:10 am	**6.**	Report on Chief Medical Examiner's Referrals on Prescribing – Dr. Reinecke (For Information) **See Power Point Presentation – See Addendums at End of This Document – Page 89**	**9**
30 min	9:10 am	**7.**	Strategic Organizational Priorities Update (Includes Working Groups) (For Information)	**10**
30 min	9:40 am	**8.**	Governance Review Recommended Changes for Quick Fixes – For Approval	**12**
5 min	10:10 am	**9.**	Self-Evaluation of Councillors (For Information)	**16**
20 min	10:15 am	**10.**	--Break--	
10 min	10:35 am	**11.**	Standards of Practice and Practice Directions Ongoing Review – 4 Year Cycle (For Information)	**19**
30 min	10:45 am	**12.**	Continuity of Care (Ontario) – For Direction	**26**
15 min	11:15 am	**13.**	CEO/Registrar's Report	**39**
10 min	11:30 am	**14.**	Practicing Telemedicine in Nunavut – Memorandum of Understanding	**45**
5 min	11:40 am	**15.**	Modification to the Practice Direction – Manitoba Prescribing Practices Program Regarding who can Prescribe Drugs on the M3P Program Schedule – For Approval	**51**

			a. **Additional Modification to the Practice Direction Manitoba Prescribing Practices Program – M3P – See Addendums at End of This Document – Page 66**	
5 min	11:45 am	**16.**	Replacement of Deputy Registrar Term - For Approval	**56**
10 min	11:50 am	**17.**	Committee Reports (written, questions taken) – For Information i. Executive Committee ii. Audit & Risk Management Committee iii. Complaints Committee iv. Investigation Committee v. Program Review Committee vi. Quality Improvement Committee vii. Central Standards Committee **See Addendum at End of This Document ..Page 72**	**57**
		18.	**Accredited Facilities Bylaw Amendments – Handout at Meeting – See Addendums at End of This Document – Page 74**	
0 min	12:00 pm	**19.**	FMRAC Snapshot – Fall 2019 – For Information	**62**
15 min	12:00 pm	**20.**	Review of Self-Evaluation of Governance Process – In Camera	
4 hrs 15 min			Estimated time of sessions	

Meeting of Council, September 13, 2019

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on Friday, September 13, 2019 at the College offices, 1000-1661 Portage Avenue, Winnipeg, Manitoba.

1. CALL TO ORDER

The meeting was called to order at 8:00 a.m. by the Chair of the meeting, Dr. Ira Ripstein.

PRESENT:
Ms Leslie Agger, Public Councillor
Ms Dorothy Albrecht, Public Councillor
Dr. Kevin Convery, Morden
Dr. Heather Domke, Winnipeg
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor*
Dr. Ravi Kumbharathi, Winnipeg
Dr. Brent Kvern, Winnipeg
Dr. Daniel Lindsay, Selkirk
Dr. Deborah Mabin, The Pas
Dr. Matthew MacDowell, Assoc. Member
Ms Lynette Magnus, Public Councillor
Dr. Wayne Manishen, Winnipeg
Ms Marvelle McPherson, Public Councillor
Dr. Ira Ripstein, Winnipeg
Dr. Nader Shenouda, Oakbank
Dr. Eric Sigurdson, Winnipeg
Dr. Heather Smith, Winnipeg
Dr. Roger Suss, Winnipeg
Dr. Alewyn Vorster, Treherne
Dr. Anna Ziomek, Registrar

REGRETS:
Dr. Brian Blakley, Winnipeg
Dr. S. Jay Duncan, Brandon
Dr. Brian Postl, Winnipeg
Dr. Josef Silha, Winnipeg

STAFF:
Dr. Terry Babick, Deputy Registrar
Ms Kathy Kalinowsky, General Counsel
Ms Lynne Leah, Executive Assistant
Dr. Garth Campbell, Medical Consultant
Mr. Dave Rubel, Chief Operating Officer

* only attended part of the meeting

2. Dr. Ripstein welcomed the new Public Councillor, Ms. Leslie Agger.

3. ADOPTION OF AGENDA

IT WAS MOVED BY DR. ROGER SUSS, SECONDED BY MR. ALLAN FINEBLIT:
CARRIED

That the agenda be approved.

4. ADOPTION OF MINUTES OF JUNE 21, JULY 8 AND JULY 11, 2019

IT WAS MOVED BY DR. ERIC SIGURDSON, SECONDED BY DR. DEBORAH MABIN:
CARRIED

That the minutes of the June 21, July 8 and July 11, 2019 be accepted as presented.

CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

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

5. BOUNDARY VIOLATIONS - SEXUAL INVOLVEMENT WITH A PATIENT

At the June 2019 Council meeting, Council directed the Registrar to establish Working Group to review the law, policies, and procedures of the College for addressing matters of maintaining boundaries – sexual involvement with a patient. Mr. Allan Fineblit, Public Councillor, has agreed to Chair this Working Group. The College is currently reaching out to a diverse group of individuals and organizations to participate in this Working Group to ensure the public interest is fulfilled.

An amendment to each of the following Terms of Reference was considered.

IT WAS MOVED BY DR. HEATHER DOMKE, SECONDED BY MR. ALLAN FINEBLIT:
CARRIED

That the motions for the following Terms of Reference:

- Boundary Violations – Sexual Involvement with a Patient Working Group
- Standard of Practice for Prescribing Benzodiazepines Working Group
- Standard of Practice for Authorizing Marijuana Working Group
- Non-Hospital and Surgical Accredited Facilities Working Group

be amended to include the provision that the Chair of the Working Group, at their discretion, has the power to add any other representative to the working group.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY MS MARVELLE MCPHERSON:
CARRIED

That Council Approve the Terms of Reference for the Working Group on Maintaining Boundaries – Sexual Involvement with a Patient.

6. STANDARD OF PRACTICE FOR PRESCRIBING BENZODIAZEPINES

At the June 2019 Council meeting, Council directed that as part of a strategic organizational priority, a Standard of Practice for Prescribing Benzodiazepines be created and a Working Group be formed to develop a draft Standard for the review of Council. Dr. Ripstein will Chair the Working Group. Those invited to participate have agreed and value the patient safety of this work.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. NADER SHENOUDA:

CARRIED

That Council approve the Terms of Reference for the Standard of Practice for Prescribing Benzodiazepines Working Group.

7. STANDARD OF PRACTICE FOR AUTHORIZING MARIJUANA FOR MEDICAL PURPOSES

Council has approved a strategic organizational priority for reviewing the current Standard of Practice for Authorizing Medical Marijuana. A Working Group is being formed to develop a draft Standard for the review and subsequent consultation with the profession and stakeholders, prior to implementation. The public interest and patient safety will be paramount in developing an updated Standard of Practice. It was recommended that an Obstetrics & Gynecology Specialist and Physical Medicine and Rehabilitation Specialist be included in the Working Group.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. ROGER SUSS:
CARRIED

That Council approve the Terms of Reference for the Standard of Practice for Authorizing Marijuana for Medical Purposes Working Group.

8. NON-HOSPITAL MEDICAL OR SURGICAL FACILITIES ACCREDITATION CRITERIA

The College will undertake a new strategic organizational initiative to review Non-Hospital Medical or Surgical Facilities Accreditation Criteria. This would be to ensure the appropriate criteria captures those facilities which require accreditation in the public interest, due to the equipment they utilize, procedures undertaken, or the risks posed to patient safety. Dr. Wayne Manishen will Chair this Working Group.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. NADER SHENOUDA:
CARRIED

That Council approve adding the Review of Non-Hospital Medical or Surgical Facilities Accreditation Criteria as a Strategic Organizational Objective of the College.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. NADER SHENOUDA:
CARRIED

That Council approve the Terms of Reference for Non-Hospital Medical or Surgical Facilities Accreditation Criteria Working Group.

9. ORGANIZATION PRIORITIES

A progress and time chart was prepared and presented to Council to report on the accountability and delivery of the CPSM strategic organizational priorities.

10. GOVERNANCE REVIEW

Following the issuance of the Cayton Report into the BC College of Dental Surgeons, an in depth review was undertaken of this College's governance. It was determined that overall CPSM is performing very well in its governance, but there is opportunity to review and consider adopting some current best practices in governance for the public interest.

Material was presented to Council for information purposes and discussion as to how the governance will be enhanced in the future.

11. CEO REPORT

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

12. COMMITTEE REPORTS

The following Reports were presented to Council for information:

- Executive Committee
- Audit & Risk Management Committee
- Complaints Committee
- Investigation Committee
- Program Review Committee
- Quality Improvement Committee
- Standards Committee

13. MISSION STATEMENT OF CPSM FOR REVISION

After discussion, a review of the College's mandate is to be included in the Governance Review.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. DEBORAH MABIN:
WITHDRAWN

The current mandate of the College be replaced with the following:
"The College's mission statement is to protect the public as consumers of medical care and promote the safe and ethical delivery of quality medical care by medical practitioners in Manitoba."

14. PHARMACEUTICAL ACT AND REGULATIONS AMENDMENTS

The College of Pharmacists of Manitoba has made a proposal to Government to obtain the authority to prescribe certain medications, travel health prescribing, ordering of tests, and therapeutic substitutions of a prescription. CPSM provided a review and commentary on this proposal. A new CPhM document responded to the CPSM concerns. Council directed that the Registrar obtain clarification on the process for ordering and following up test results and communicate with CPhM to ensure patient safety.

15. IN CAMERA

Drs. Kvern and Sigurdson provided self-evaluation comments on process at this meeting. An updated and improved version of the self-evaluation form was requested.

There being no further business, the meeting ended at 12:15 p.m.

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Dr. I Ripstein, President

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Dr. A. Ziomek, Registrar

Electronic Council Meeting September 27, 2019

There being no other formal business, Council was asked to approve the following material via e-mail reply by noon Friday, September 27, 2019.

RESPONSES RECEIVED FROM:

Ms Leslie Agger, Public Councillor
Ms Dorothy Albrecht, Public Councillor
Dr. Kevin Convery, Morden
Dr. Heather Domke, Winnipeg
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor
Dr. Ravi Kumbharathi, Winnipeg
Dr. Brent Kvern, Winnipeg
Dr. Daniel Lindsay, Selkirk
Dr. Matthew MacDowell, Assoc. Member
Ms Lynette Magnus, Public Councillor
Dr. Wayne Manishen, Winnipeg
Ms Marvelle McPherson, Public Councillor
Dr. Brian Postl, Winnipeg
Dr. Nader Shenouda, Oakbank
Dr. Eric Sigurdson, Winnipeg
Dr. Heather Smith, Winnipeg
Dr. Roger Suss, Winnipeg
Dr. Alewyn Vorster, Treherne

RESPONSES NOT RECEIVED FROM:

Dr. Brian Blakley, Winnipeg
Dr. S. Jay Duncan, Brandon
Dr. Josef Silha, Winnipeg

RECUSED:

Dr. Ira Ripstein, Winnipeg

Council approved the following matters by majority vote:

SUBJECT:

Executive Committee Substitution

BACKGROUND:

A hearing has been scheduled for an Appeal of Interim Conditions on September 30th, 2019. One of the councillors scheduled to hear this is unable to now attend. At very short notice, Ms Lynette Magnus has agreed to be a substitute for that member of the Executive Committee for this hearing. To obtain quorum Council must appoint a substitute member to the Executive Committee for the purpose of hearing this one appeal.

RESOLUTION:

Council appoints Ms Lynette Magnus to the Executive Committee on an interim basis for the sole purpose of hearing the Appeal of Interim Conditions of Dr. L. scheduled for September 30th, 2019.

Dr. Ira Ripstein, President

COUNCIL MEETING – DECEMBER 13, 2019

PRESENTATION

SUBJECT:

Chief Medical Examiner's Referrals on Prescribing

DISCUSSION:

Dr. Marina Reinecke and Dr. Kernjeet (Keny) Sandhu will present a report of the Chief Medical Examiner's Referrals on Prescribing as a follow-up to an earlier report by Dr. Reinecke on the College's Prescribing Practices Program.

This will be presented at December's Council meeting and copies of the presentation will be available then.

COUNCIL MEETING – DECEMBER 13, 2019

BRIEFING NOTE

SUBJECT:
Strategic Organizational Priorities

DISCUSSION:
At the June Council Meeting the Strategic Organizational Priorities were approved. To provide Council with reporting on the development of these strategic organizational priorities, a Progress Tracking Chart was prepared and shared with Council in September. This Progress Tracking Chart is provided to Council to report on the priorities and provide continued updates and accountability on the delivery of these strategic organization priorities.

The one change that should be noted is the Accredited Facilities Working Group's progress was slightly delay. This was due to the challenge of obtaining input from so many different specialties and the apparent newness of the issue and the College's role in this issue to the many participants. The dates have been altered to accommodate this, recognizing the March 2020 target date to provide recommendations to Council is not achievable.

At the Council meeting the Chair of each Working Group will provide a brief oral synopsis of the progress made and preliminary issues identified by the Working Group.

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

The College has established, and Council has approved, strategic organizational priorities which reflect the mandate and duties of the College and that these are being preformed within the public interest by the self-regulating medical entity. All Working Groups are thoroughly aware that the recommendations to Council are to be made in the public interest.

CPSM
ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	FMRAC Working Group	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Benzodizaepine Prescribing Standard of Practice		Sep-19	Sep-20	Started Oct 2019	Mar-20	April May 2020	Jun-20	Sep-20	On Track	Three Meetings Held
Marijuana Authorization Standard of Practice		Sep-19	Sep-20	Started Nov 2019	Mar-20	April May 2020	Jun-20	Sep-20	On Track	Two Meetings Held
Streamlined Registration - Fast Track Application	FMRAC-Started								Not Started	
Streamlined Registration - Portable Licence	FMRAC-Started								Not Started	
Artificial Intelligence	FMRAC-Started								Not Started	
Telemedicine	FMRAC-Started								Not Started	
Extended/ After Hours Coverage		2015	Jun-19	Finished 2019	Mar-19	N/A	N/A	N/A	Achieved	Initiative paused for Healthcare system transformation
Maintaining Boundaries - Sexual Involvement with a Patient		Sep-19		Started Sept 2019	Jun-20	TBD	TBD	TBD	On Track	Three Meetings Held
Governance Review		Jun-19	Dec-19	Started Sept 2019	TBD	N/A		TBD	On Track	To be done by component part
Standards of Practice Ongoing Review - 4 Year Cycle		Jan-20	Dec-24						Not Started	
Accredited Facilities Criteria		Sep-19		Started Oct 2019	Jun-19	July Aug 20	Sep-20	Dec-19	Delayed	One Meeting Held, new dates posted for tracking

Last revised: November 29/2019

COUNCIL MEETING – DECEMBER 13, 2019

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Governance Review – Recommended Changes for Quick Fixes

BACKGROUND:

The Executive and Council have been apprised of the Cayton Report into the BC Dental College and the Governance Review of this College that would arise from it.

At its September meeting, Council provided positive reviews and feedback and the overall direction for how to proceed with the implementation of the recommendations for change. Accordingly, Council is being presented with the identified Quick Fixes in addition to other governance items.

QUICK FIXES

1. CALL FOR CONFLICT OF INTEREST AT MEETINGS

Cayton:

There should be a call for a declaration of conflict of interest at the commencement of all Council and Committee meetings. This should be a standing agenda item and publicly accessible register of interests.

Recommendation:

Institute a call for declaration of conflict of interest at the commencement of all Council and Committee meeting. This should be a standing agenda item.

Change:

Include a call for a declaration of conflict of interest in all agendas. This will be a practice to be implemented in a new Conflict of Interest Policy to be drafted. No changes to existing documents are required.

2. CONCURRENT REPRESENTATION ON COLLEGE COUNCIL/COMMITTEES AND DOCTORS MANITOBA BOARD/COMMITTEES

Cayton:

Councillors should not be concurrent members of both the Regulatory Authority and the professional association and must have a cooling off period both before and after serving as Board members of association and being on Council.

Recommendation:

No CPSM Councillor or Committee member should be a member of the Board of Directors or Committee member of Doctors Manitoba concurrently.

Change:

Amend the Affairs of the College Bylaw by adding the following:

PART B – ELECTIONS AND APPOINTMENTS

Councillors Eligibility and Electoral Districts

Eligibility requirements **for candidates**

1. To be eligible to be a candidate for election as a Councillor, a regulated member must meet all of the following requirements:
   a. be on the voters list for that electoral district;
   b. maintain his or her primary practice location in the electoral district in which he or she seeks to be a candidate up to the election date;
   c. be nominated as a candidate for election as set out in this Bylaw;
   d. meet the requirements of s. 14 of the RHPA.
   e. not be a current member of the Board of Directors or Committee Member of Doctors Manitoba.

Council members ceasing to hold office

36. An elected Councillor or a Councillor appointed by Council ceases to hold office if the Councillor:

   a. resigns by written notice delivered to the Registrar;
   b. ceases to be eligible for election or appointment to the Council, unless the Councillor loses eligibility only by reason of parental leave or illness;

c. is censured pursuant to section 102 of the RHPA or an Inquiry Panel makes a finding against the member pursuant to section 124 of the RHPA;
d. is absent, without cause, from three consecutive Council meetings, unless previously excused by the Council;
e. is removed from Council in accordance with s. 20(5) of the RHPA governing breach of the Oath of Office or is removed for breach of the Councillor and Committee Code of Conduct located in the Governance Policy;
f. dies; or
g. is determined to be permanently mentally incapacitated.
h. becomes a member of the Board of Directors or Committee of Doctors Manitoba.

3. PROCUREMENT POLICY

Cayton:

The Procurement Policy was not followed.

Recommendation:

Create a Procurement Policy within the Financial Management Policy. Include provisions for tendering or obtaining multiple quotes for significant expenditures. Include a minimum dollar value.

Change:

Draft Amendment to the Financial Management Policy. This will be reviewed with Audit and Risk Management Committee in February 2020.

4. ACTION ITEMS FOR COUNCIL AND COMMITTEES

Cayton:

The minutes do not indicate whether matters are followed up such as whether a Working Group is indeed working, do not record and track decisions unless voted on. Matters are changed after the meeting and do not reflect the decision at times.

Recommendation:

Ensure Council and Committees have Action Items list.

Change:

Create Action Item lists for Council and all Committees. This is a process change and does not require any change to existing governance documents.

5. VOTING TRANSPARENCY – NO SECRET BALLOTS FOR COUNCIL AND COMMITTEES

Cayton:

Voting should be open and transparent, secret ballots have no place in a public body. This is especially true for controversial items.

Recommendation:

There currently is a provision in the Bylaw for a secret ballot. It is recommended to eliminate the secret ballot for Council and Committees since it is contrary to transparency. If Councillors want their names recorded as voting against, then they may request this at the time and will be recorded as such.

Change:

Amend the Affairs of the College Bylaw by deleting and adding the following:

Voting at Council meetings

51. Each Councillor, except the Chair, is entitled to one vote on all matters. If there is an equality of votes on a matter the Chair has the deciding vote.

~~52. Any Councillor may request a vote by ballot.~~

52. All voting at Council and Committee meetings is open, with the exception of voting for the position of presidency, if requested by secret ballot by any Councillor.

53. A Councillor is not entitled to vote by proxy.

ADDITIONAL GOVERNANCE ITEMS (NOT STEMMING FROM CAYTON REPORT):

1. COUNCIL SELF EVALUATION UPDATE

Recommendation:

Update the current Council Self Evaluation Report which is based on the previous Carver governance model and structure. The Self Evaluations of Ontario, Saskatchewan, and BC Colleges were reviewed. This is to apply to both Council and non-disciplinary committees.

Change:

See Council Self Evaluation. No motion required.

2. CENTRAL STANDARDS COMMITTEE CHAIR TO SIT ON SOME SUBCOMMITTEES

Recommendation:

The Central Standards Committee passed a motion recommending that the Central Standards Chair be appointed to the Quality Improvement, Maternal and Perinatal, and Child Health Subcommittees of the Central Standards Committee.

Change:

Amend the Governance Policy Terms of Reference of the Quality Improvement, Maternal and Perinatal Health Standards, and Child Health Standards Subcommittees to include:

4.15. Subcommittees of the Central Standards Committee Terms of Reference

4.15.1 Maternal & Perinatal Health Standards Subcommittee

4.15.1.b Composition

4.15.1.b.i The Subcommittee shall consist of 10 members including the chair, with one subcommittee member nominated by Manitoba Health.

4.15.1.b.ii One of the subcommittee members will be the Chair of the Central Standards Committee as ex officio and non-voting member.

4.15.2 Child Health Standards Subcommittee

4.15.2.b Composition

4.15.2.b.i The Subcommittee shall consist of 8 members including the chair.

4.15.2.b.ii One of the subcommittee members will be the Chair of the Central Standards Committee as ex officio and non-voting member.

4.15.5 Quality Improvement Standards Subcommittee (QI Committee)

4.15.5.c Composition

4.15.5.c.i The subcommittee shall be composed of at least 6 individuals appointed by Council plus the non-voting, ex officio members:

4.15.5.c.i.1 A Chair who must be a regulated member who is a practicing physician, who need not be a Councillor.

4.15.5.c.i.2 The Vice Dean, Continuing Competence and Assessment, Rady Faculty of Health Sciences, or delegate, unless the University representative is the chairperson in which case any other regulated member who is a practicing physician may be appointed by Council.

4.15.5.c.i.3 A public representative who is a councillor.

4.15.5.c.i.4 Two regulated members who are practicing physicians.

4.15.5.c.i.5 One regulated member who is a practising physician representative from Doctors Manitoba.

4.15.5.c.i.6 The President and the President-Elect as ex officio, non-voting members.

4.15.5.c. i.7 The Chair of the Central Standards Committee as ex officio and non-voting member.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2019, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

i) Council Amend the Affairs of the College Bylaw by adding the following:

3. To be eligible to be a candidate for election as a Councillor, a regulated member must meet all of the following requirements:

e. not be a current member of the Board of Directors or Committee Member of Doctors Manitoba.

36. An elected Councillor or a Councillor appointed by Council ceases to hold office if the Councillor:

h. becomes a member of the Board of Directors or Committee of Doctors Manitoba.

ii) Council Amend the Affairs of the College Bylaw by deleting and adding the following:

~~52. Any Councillor may request a vote by ballot.~~

52. All voting at Council and Committee meeting is open, with the exception of voting for the position of presidency, if requested by secret ballot by any Councillor.

iii) Council Amend the Governance Policy Terms of Reference of the Quality Improvement, Maternal and Perinatal Health Standards, and Child Health Standards Subcommittees to include:

4.15.1.b.ii One of the subcommittee members will be the Chair of the Central Standards Committee as ex officio and non-voting member. (Maternal and Perinatal)

4.15.2.b.ii One of the subcommittee members will be the Chair of the Central Standards Committee as ex officio and non-voting member. (Child Health)

4.15.5.c. i.7 The Chair of the Central Standards Committee as ex officio and non-voting member. (QI)

COUNCIL MEETING – DECEMBER 13, 2019

BRIEFING NOTE

SUBJECT:
Self Evaluation of Councillors

DISCUSSION:
At its September meeting Council requested an updated Self Evaluation of Council form be developed. The evaluation forms of the Colleges in Ontario, BC, and Saskatchewan were reviewed, and a new form created which keeps a few of the current questions and add new questions to improve governance. Please see attached Self Evaluation of Council form.

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

One particular question addresses whether Council has fulfilled its mandate to serve and protect the public interest. Another question addresses whether the meeting agenda topics were appropriate and aligned with the mandate of the College and Council.

SELF-EVALUATION OF COUNCIL

The CPSM is interested in your feedback regarding your experience at the Council meeting. The results of this evaluation will be used to improve the experience of members and to inform the planning of future meetings.

	Strongly Disagree	Neutral	Strongly Agree	Comments
How well has Council done its job?				
1. The meeting agenda topics were appropriate and aligned with the mandate of the College and Council.	1	2	3	
2. I was satisfied with what Council accomplished during today's meeting.	1	2	3	
3. Council has fulfilled its mandate to serve and protect the public interest	1	2	3	
4. The background materials provided me with adequate information to prepare for the meeting and contribute to the discussions.	1	2	3	
How well has Council conducted itself?				
5. When I speak, I feel listened to and my comments are valued.	1	2	3	
6. Members treated each other with respect and courtesy.	1	2	3	
7. Members came to the meeting prepared to contribute to the discussions.	1	2	3	
8. We were proactive.	1	2	3	

Feedback to the President				
9. The President/Chair gained consensus in a respectful and engaging manner.	1	2	3	
10. The President/Chair ensured that all members had an opportunity to voice his/her opinions during the meeting.	1	2	3	
11. The President/Chair summarized discussion points in order to facilitate decision-making and the decision was clear.	1	2	3	
Feedback to CEO/Staff				
12. Council has provided appropriate and adequate feedback and information to the CEO	1	2	3	
My performance as an individual Councillor				
13. I read the minutes, reports and other materials in advance so that I am able to actively participate in discussion and decision-	1	2	3	
14. When I have a different opinion than the majority, I raise it.	1	2	3	
15. I support Council's decisions once they are made even if I do not agree with them.	1	2	3	
Other				
16. Things that I think Council should start doing during meetings:				
17. Things that I think Council should stop doing during meetings:				

COUNCIL MEETING – DECEMBER 13, 2019

BRIEFING NOTE

SUBJECT:
Standards of Practice and Practice Directions Ongoing Review - 4 Year Cycle

DISCUSSION:
At the June Council Meeting the Strategic Organizational Priorities were approved. One of the items included was the Standards of Practice Ongoing Review – 4 Year Cycle. Though approved by Council as required for the RHPA, the Standards of Practice have been in place for a number of years and have not been reviewed recently to determine ongoing relevance, best practices, and whether new standards are required to reflect changes in the practice of medicine and shifting societal norms.

This review will also encompass both Standards of Practice and the Practice Directions as the Practice Directions often further elaborate on the Standards of Practice.

The attached four-year cycle has been created to review the Standards of Practice and the Practice Directions. It is suggested this cycle be repeated thereafter, with any modifications required. A few of the items were chosen for the first year of review because there have been numerous questions and issues arising from the current Standards of Practice or Practice Direction. These include:

- Patient Records
- Medical Directors (in Practice Environment)
- Qualifications and Registrations – Practice Direction
- Medical Corporations – Practice Direction

The Qualifications and Registration Practice Direction was revised for the RHPA and with one full year of experience, several matters have arisen requiring modification. All items regarding prescribing have been clustered into one year to be reviewed concurrently. Items that have been recently drawn up such as Interprofessional Collaborative Care and Prescribing Opioids are placed into the final year of the four-year cycle.

Some of the items may require Working Groups to review, others can be done internally. Examples of these include Patient Records which requires a Working Group while Home Births likely does not require a full Working Group.

Any changes to the Standards of Practice require consultation with the members, Manitoba Health Minister, and other provincial health regulatory authorities, and any other individual or organization as Council considers appropriate. The Practice Directions do not require consultation, but Council can require consultation as it considers appropriate.

There was a former Guideline for Arrangements for Expected Death at Home which is out of date. Though the College does not publish Guidelines anymore, this is not fitting material for a Practice Direction nor a Standard of Practice. It is very important material and will be included on the College's new website following a comprehensive review with relevant stakeholders.

This 4 Year Review Cycle is being shared with Council for information, and no formal approval is required.

PUBLIC INTEREST RATIONALE

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

Council has approved Strategic Organizational Priorities which reflect the mandate and duties of the College and that these are being performed within the public interest by the self-regulating medical entity. One of these Organizational Priorities is the Standard of Practice and Practice Directions Ongoing Review – Four Year Cycle. Each Standard of Practice and Practice Direction will be reviewed to ensure the public interest is at the forefront.

STANDARDS OF PRACTICE
4-Year Review Cycle

Part/ Schedule	Title	Level of Review	2020	2021	2022	2023
1	Definitions	Small		X		
2	Good Medical Care	Large			X	
3	Practice Environment	Large	X			
4	Collaborative Care	Large		X		
5	Patient Records	Large	X			
6	Practice Management	Large			X	
7	Confidentiality and Privacy	Medium				X
8	Prescribing Requirements	Medium		X		
9	Duty to Assist in an Emergency	Small			X	
10	Conflict of Interest	Small		X		
11	Research	Small				X
12	Advertising	Medium	X			
13	Continuing Disclosure Requirements and Notices of Changes for Members Matters	Large			X	
14	Specific Subject Matters					
A	Female Genital Cutting/Mutilation	Small				X
B	Home Births	Small	X			
C	Seatbelt/Helmet Exceptions	Small	X			
D	Withholding & Withdrawing Life-Sustaining Treatment	Medium				X
E	Professional Responsibilities in Undergraduate and Postgraduate Medical Education	Medium		X		
F	Duty to Report Another Member	Medium	X			
G	Treating of Self and Family Members	Medium				X
H	Self-Reporting to the College	Medium		X		
I	Volume of Service	Medium			X	
J	Bloodborne Pathogens	Medium			X	
K	Virtual Medicine	Large		X		
L	Prescribing Opioids	Large				X
M	Medical Assistance in Dying (MAID)	Large				X

PRACTICE DIRECTIONS
4-Year Review Cycle

Part/ Schedule	Title	Level of Review	2020	2021	2022	2023
	Appeals Pursuant to Section 38 of the RHPA	Small			X	
	Cancellation of Registration or Certificate of Practice Pursuant to S48 of the RHPA	Small			X	
	Complaints Investigations Appeals	Small			X	
	Continuing Professional Development	Small				X
	Decisions Regarding Permits for Health Profession Corporations & Related Appeals	Medium			X	
	Dispensing Physicians	Small		X		
	EKG Interpretation and Billing Eligibility	Small	X			
	Electronic Transmission of Prescriptions	Small		X		
	Facsimile Transmission of Prescriptions	Small		X		
	Interprofessional Collaborative Care	Large				X
	Manitoba Practice Assessment Program Summative Assessment	Large				X
	Manitoba Prescribing Practices Program (M3P)	Medium		X		
	Medical Corporations	Large	X			
	Prescribing Methadone or Suboxone	Medium				X
	Prescribing Practices: Doctor/Pharmacist Relationships	Medium		X		
	Qualifications and Registration	Large	X			
	Reinstatement Application	Medium			X	
	Rural, Remote, and Underserved Populations: Access to Prescribed Drugs	Medium		X		
Additional Policy	Arrangements for Expected Death at Home	Medium	X			

COUNCIL MEETING – DECEMBER 13, 2019

BRIEFING NOTE

SUBJECT:
Continuity of Care Policies (Ontario)

DISCUSSION:
The following is taken from the College of Physicians and Surgeons of Ontario website:

> After an extended six-month consultation period, CPSO Council has approved four inter-related *Continuity of Care* policies. Continuity of care is an essential component of patient-centred care and an important contributor to patient safety. While the CPSO recognizes that physicians are not solely responsible for ensuring that continuity of care is achieved, as there are often health system level factors beyond their control that impede or facilitate continuity of care, physicians do have a role to play given the prominent and important role they hold in the health care system.
>
> The CPSO's approach has been to focus on those issues or elements of continuity of care that are within the control or influence of physicians. The policies set out expectations relating to a range of inter-related issues. They are:
>
> - Availability and Coverage
> - Managing Tests
> - Transitions in Care
> - Walk-in Clinics
>
> In addition to these policies, a companion *Advice to the Profession: Continuity of Care* document has been developed to help physicians interpret their obligations and provide guidance around how these obligations may be effectively discharged. It also provides some background information on the scope of these policies and the role of patients, technology, and the health care system in facilitating continuity of care.

At this point these four policies are being shared with Council for discussion purposes and whether these could be added to the list of Strategic Organizational Priorities.

The four CPSO policies are attached.

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

The four policies deal with issues that are fundamental to the provision of care by almost all physicians in the province. The College in Ontario put significant resources into developing these policies recognizing the importance to patient safety and the practices of physicians. In issuing

these policies, the College in Ontario believes it reached the appropriate degree to protect patient safety in these crucial areas to ensure patient centric medical care.

https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Continuity

AVAILABILITY AND COVERAGE

Approved by Council: September 2019

Companion Resource: Advice to the Profession

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Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Sustained physician-patient relationship: A physician-patient relationship where care is actively managed over multiple encounters.

Temporary leaves of absence: Vacations and leaves of absence (e.g., parental leave, educational leave),[1] as well as unplanned absences due to, for example, illness or family emergencies.

Policy

Being Available by Phone (or other means)

1. Physicians **must** have an office telephone that is answered and/or allows voicemails to be left during regular business hours.[2]
2. Physicians **must** ensure that the outgoing voicemail message is up to date and accurate, indicating, for example, office hours, any closures, and relevant information regarding coverage arrangements or access to appropriate care outside of regular office hours and during temporary absences from practice.
3. Physicians **must** ensure that voicemail messages are reviewed and responded to in a timely manner. What is timely will depend on, for example, when the message was left and the impact to patient safety that may be caused by a delay in responding.
    a. Physicians who offer electronic means of secure communication[3] **must** similarly ensure that messages are reviewed and responded to in a timely manner.

Communicating with Other Health-Care Providers

4. Physicians **must** respond in a timely manner when contacted by other physicians or health-care providers who want to communicate or request information about a patient. What is timely will depend on, for example, the impact to patient safety that may be caused by a delay in responding.
5. Physicians **must** include their professional contact information when ordering a test, writing a prescription, or making a referral[4] and **must** provide relevant coverage contact information directly to other health-care providers (e.g., laboratories, diagnostic facilities) where it is appropriate to do so.

Facilitating Access to Appointments

6. Physicians providing care as part of a sustained physician-patient relationship **must** structure their practice in a way that allows for timely access to appointments for urgent or time-sensitive issues.

Supporting Access to Appropriate After-hours Patient Care

7. Physicians providing care as part of a sustained physician-patient relationship **must** inform patients of when and where to access appropriate care outside of regular office hours (e.g., Telehealth, local walk-in clinics, emergency department, any coverage arrangements that have been made[5], etc.).[6]

Managing Care During Temporary Absences from Practice

8. Physicians who will be unavailable during temporary absences from practice **must** make specific coverage arrangements with another health-care provider(s) to:

   a. Receive, review, and provide or coordinate immediate care that is required during the temporary absence for all outstanding tests; and
   b. Receive, review, and provide or coordinate immediate care that is required during the temporary absence for outstanding consultation reports.
9. Physicians **must** also have a plan or coverage arrangement in place that allows other health-care providers to communicate or request information pertaining to patients under their care during temporary absences from practice.
10. Physicians providing care as part of a sustained physician-patient relationship **must** make reasonable efforts to arrange for another health-care provider(s) to provide care to patients during planned temporary absences from practice. What is reasonable will depend on, for example, the length of the absence, the needs of the physicians' patients, and the health-care provider and/or health system resources available in the community.
   a. If specific arrangements are made, physicians **must** inform patients seeking care during the temporary absence of these arrangements;[7] or
   b. If after reasonable efforts are made it is not possible to make specific arrangements, physicians **must** inform patients seeking care during the temporary absence about appropriate alternative access points of care (e.g., Telehealth, local walk-in clinics, emergency department, etc.).

Coordinating Coverage for Critical Test-Results

11. Physicians **must** ensure that *critical test results*[8] can be received and reviewed at all times, including outside of regular office hours and during temporary absences from practice, and that appropriate steps can be taken to notify patients if immediate emergency intervention is required.

Endnotes

[1.] This does not include suspensions of a physician's certificate of registration. For expectations relating to suspensions, please see the *Closing a Medical Practice* policy.

[2.] In a group practice, institutional, or departmental setting, there may be a common phone and voicemail system shared among a number of physicians.

[3.] For example, e-mail or a messaging portal. All communication must comply with privacy legislation, including, the *Personal Health Information Protection Act, 2004* S.O. 2004, c. 3 Sched. A. (hereinafter, *PHIPA*).

[4.] See the College's *Managing Tests*, *Prescribing Drugs*, and *Transitions in Care* policies for more information.

[5.] This would include any after-hours or weekend coverage arrangements that are made as part of contractual agreements with the Ministry of Health and Long-Term Care.

[6.] Provision 2 of this policy sets out expectations regarding the type of information that is appropriate to include on an outgoing voicemail message. Otherwise, the policy is not prescriptive about how physicians must inform patients and allows for flexibility.

[7.] Again, provision 2 of this policy sets out expectations regarding the type of information that is appropriate to include on an outgoing voicemail message. Otherwise, the policy is not prescriptive about how physicians must inform patients and allows for flexibility. For example, staff could notify patients upon calling the office or in some instances physicians may elect to proactively inform patients depending on, for example, the nature and length of their leave.

[8.] Critical test results are those that are of such a serious nature that immediate patient management decisions may be required. See the *Managing Tests* policy and the *Advice to the Profession* companion document for more information.

MANAGING TESTS

Approved by Council: September 2019

Companion Resource: Advice to the Profession

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Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Test Result: Includes results for tests performed at laboratories, diagnostic facilities (including imaging facilities), and in physicians' offices, and also includes pathology results.

Critical Test Result: Results of such a serious nature that immediate patient management decisions may be required.[1]

Clinically Significant Test Result: A test result determined by a physician to be one which requires follow-up in a timely fashion, urgently if necessary. Physicians determine the clinical significance of a test result using their clinical judgment and knowledge of the patient's symptoms, previous test results, and/or diagnosis.

Follow-up: Communication of the test result to the patient in an appropriate manner and taking appropriate clinical action in response to the test result.

Policy

Test Results Management System

1. In order to ensure appropriate follow-up on test results can occur, physicians **must** have an effective test results management system that enables them to:
    a. record all tests they order;
    b. record all test results received;
    c. record that all test results received by physicians have been reviewed;
    d. identify patients who have a high risk of receiving a clinically significant result, and critical and/or clinically significant test results; and
    e. record that a patient has been informed of any clinically significant test results and the details of the follow-up taken by the physician.
2. Physicians who are not responsible for choosing the test results management system **must** be satisfied that the system in place has the capabilities listed above.

Tracking Tests

3. For patients who have a high risk of receiving a clinically significant test result, physicians **must** track their test results when they are not received when expected.[2]
4. For patients who are not at high risk of receiving a clinically significant test result, physicians **must** use their professional judgment to determine whether to track a test result. In making this determination, physicians **must** consider the following factors:
    a. the nature of the test that was ordered,
    b. the patient's current health status,
    c. if the patient appears anxious or has expressed anxiety about the test, and
    d. the significance of the potential result.
5. Physicians **must** either personally track test results or assign[3] this task to others.

Follow-up

6. Ordering physicians **must** ensure that follow-up on test results received occurs in accordance with provisions 7 through 17.

a. In certain health-care environments, the ordering physician may not be the same physician who receives the test result (e.g., in an emergency department or a walk-in clinic). In these situations, ordering physicians **must** either delegate, assign[4] or otherwise ensure that there is another person that is responsible for coordinating the follow-up or that there is a system in place to do so.

Communication of Test Results

7. When in receipt of a clinically significant test result, physicians **must** always communicate the test result to their patient and **must** do so in a timely manner.
8. For test results that are not clinically significant, physicians **must** use their professional judgment to determine whether to communicate a test result, and if doing so, when to communicate the test result.
9. Physicians **must** use their professional judgment to determine how to best communicate a test result; for example, over the phone or, at the next appointment. In making this determination, physicians **must** consider a variety of factors, including,
    a. the nature of the test,
    b. the significance of the test result,
    c. the complexity and implications of the test result,
    d. the nature of the physician-patient relationship,
    e. patient preferences/needs, and
    f. whether the patient appears anxious or has expressed anxiety about the test.
10. Physicians **must** use their professional judgment to determine the circumstances where it makes sense for other health-care providers and/or non-medical staff to communicate test results. The factors physicians **must** consider include:
    a. the nature of the test,
    b. whether the patient appears anxious or has expressed anxiety about the test,
    c. the significance or implications of the test result, and
    d. whether communicating the test result would mean communicating a diagnosis.[5]
11. When relying on others to communicate test results, physicians **must** have a mechanism in place that enables them to respond to any follow-up questions that the patient may have.
12. Physicians **must** ensure that the communication of test results adheres to their legal[6] and professional obligations[7] to maintain patient confidentiality and privacy.
13. Physicians **must** ensure that all attempts made to either communicate the test result to the patient and/or to book a follow-up appointment to discuss a test result are documented in the medical record.[8]

‘No News is Good News’ Strategies

14. Physicians **must** only use a ‘no news is good news’ strategy for managing test results if they are confident that the test result management system in place is sufficiently robust to prevent test results from being missed and that no news really means good news.
15. Physicians **must** use their professional judgment to determine when a ‘no news is good news’ strategy is appropriate in each instance and **must** consider the following factors in making this determination:
    a. the nature of the test that was ordered,
    b. the patient’s current health status,
    c. if the patient appears anxious or has expressed anxiety about the test, and
    d. the significance or implications of the potential result.
16. Physicians **must** inform patients as to whether they are using a ‘no news is good news’ strategy and **must** tell patients that they have the option to personally contact the physician’s office or make an appointment to come into the office to hear their results.

Clinically Appropriate Action Following Receipt of Test Results

17. When physicians receive a critical and/or clinically significant test result for a test that they have ordered, they **must** take clinically appropriate action. The timeliness of these actions will depend on the significance of the test result. Physicians can take clinically appropriate actions personally or they can assign or delegate this task to others.[9]

Receiving Test Results in Error

18. Physicians who receive a critical or clinically significant test result in error (e.g., same or similar name or contact information) **must** inform the laboratory or diagnostic facility of the error.

Communication and Collaboration with other Health-Care Providers

19. Physicians in receipt of a test result **must** use their professional judgment to determine if it is necessary to share a patient’s test result with other relevant health-care providers whose ongoing care of the patient would benefit from that knowledge and, if sharing the test result, the

timeliness with which to share it.[10] The timeliness of the communication will depend on the degree to which the information may impact patient safety, including exposure to adverse clinical outcomes.

20. Physicians whose role is to interpret and report test results (e.g., a radiologist, pathologist, laboratory medicine physician) **must** contact the health-care provider who ordered the test when there is an unusual, unexpected or urgent finding to ensure that this information is communicated quickly and that it does not go astray.[11]

Patient Engagement

21. When ordering a test, physicians **must** inform patients of the significance of the test, the importance of getting the test done (in a timely manner, as appropriate), and the importance of complying with requisition form instructions.

Availability and Coverage

22. Physicians **must** comply with the expectations relating to availability and coverage for test results as set out in the *Availability and Coverage* policy.

Endnotes

1. See the *Advice to the Profession* document for more information.

2. Tracking could include following-up with a laboratory and/or diagnostic facility, or the patient to find out where the test result is.

3. If the task does not include a controlled act, the physician would be assigning the task to the other person.

4. If a task includes performance of a controlled act, then the physician may delegate it to another person. When delegating a controlled act, physicians must comply with the College's *Delegation of Controlled Acts* policy. One of the controlled acts under the *Regulated Health Professions Act, 1991* S.O. 1991, Chapter 18 (*RHPA*) is "communicating a diagnosis". Specifically, the wording in the *RHPA* states: "Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis". Please also see footnote 3.

5. Please see footnote 4.

6. The *Personal Health Information Privacy Act* S.O. 2004, Chapter 3 Schedule A (*PHIPA*) sets out requirements with respect to collecting, using and disclosing a patient's personal health information.

7. See the College's *Medical Records* and the *Confidentiality of Personal Health Information* policies for more information. The *Confidentiality of Personal Health Information* policy states that "the College advises physicians that messages left for patients on a voice mail that is not private or with a third party should not contain any personal health information of the patient, such as details about the patient's medical condition, test results or other personal matters".

8. Including those attempts made by staff on behalf of the physician.

9. Please see footnotes 3 and 4.

10. Under the *PHIPA* physicians can assume they have consent to share relevant test results with those in the patient's circle of care unless consent to do so has been expressly withdrawn by the patient.

11. For example, a physician interpreting a prenatal ultrasound where there is a risk to the fetus would phone the referring health-care provider in addition to generating a written report.

TRANSITIONS IN CARE

Approved by Council: September 2019

Companion Resource: Advice to the Profession

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Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Policy

Keeping Patients Informed About Who is Involved in Their Care

1. Within hospitals or health-care institutions where care is provided by a team of changing individuals, physicians **must** coordinate with others on the team to keep patients informed about who has primary responsibility for managing their care (i.e., their most responsible provider).[1]
2. Referring physicians **must** clearly communicate to patients what the physician's anticipated role will be in managing care during the referral process, including how patient care and follow-up may be managed and by whom, and keep patients informed about any changes that occur in their role.
3. Consultant physicians[2] **must** clearly communicate to patients the nature of their role, including which element(s) of care they are responsible for and the anticipated duration of care, and keep patients informed about any changes that occur in their role.
    a. When it is possible to do so, consultant physicians **must** also clearly communicate when the physician-patient relationship has reached its natural conclusion or when it is anticipated that it will reach its natural conclusion.[3]

Managing Patient Handovers in Hospitals and Health-Care Institutions

4. When handing over primary responsibility for patients to another health-care provider, physicians **must** facilitate a comprehensive and up to date exchange of information and allow for discussion to occur or questions to be asked by the health-care provider assuming responsibility.[4]

Discharging Patients from Hospital[5] to Home

5. Prior to discharging an inpatient from hospital to home,[6] physicians **must** ensure that they or a member of the health-care team has a discussion with the patient and/or substitute decision-maker about:
    a. Post treatment or hospitalization risks or potential complications;
    b. Signs and symptoms that need monitoring and when action is required;
    c. Whom to contact and where to go if complications arise;
    d. Instructions for managing post-discharge care, including medications (e.g., frequency, dosage, duration); and
    e. Information about any follow-up appointments or outpatient investigations that have been or are being scheduled or that they are responsible for arranging and a timeline for doing so.
6. Physicians **must** take reasonable steps to facilitate the involvement of the patient's family and/or caregivers in the discharge discussion where the patient or substitute decision-maker indicates an interest in having them involved and provides consent to share personal health information.
7. Physicians **must** use their professional judgment to determine whether to support this discussion with written reference materials, and if so, the specific nature of the materials. In making these determinations, physicians **must** consider a variety of factors including:
    a. the health status and needs of the patient;
    b. post treatment or hospitalization risks or potential complications;
    c. the need to monitor signs or symptoms;
    d. whether follow-up care is required;
    e. language and/or communication issues that may impact comprehension;
    f. whether those involved in the discussion are experiencing stress or anxiety which may impair their ability to recall and act on the information shared; and

g. where the patient is being discharged to.

Completing and Distributing Discharge Summaries

8. The most responsible physician **must** complete a discharge summary for all inpatients within 48 hours of discharge.[7]
9. The most responsible physician **must** include in the discharge summary the information necessary for the health-care provider(s) responsible for post-discharge care to understand the admission, the care provided, and the patient's post discharge health care needs. While physicians **must** use their professional judgment to determine what information to include in the discharge summary, it will typically include:
    a. Relevant patient and physician identifying information;
    b. Reason(s) for admission;
    c. Any diagnoses or differential diagnoses at discharge;
    d. A summary of how active medical problems were managed (including major investigations, treatments, or outcomes);
    e. Medication information, including any changes to ongoing medication and the rationale for these changes;
    f. Follow-up care needs or recommendations; and
    g. Appointments that have or need to be scheduled, any relevant and outstanding outpatient investigations, tests, or consultation reports.
10. The most responsible physician **must** use language that is understandable to the health-care providers who will receive the discharge summary.
11. The most responsible physician **must** direct that the discharge summary be distributed to the patient's primary care provider, if there is one, and/or another health-care provider who will be primarily responsible for post-discharge follow-up care.
12. If a delay in the completion or distribution of the discharge summary is anticipated, the most responsible physician **must** provide a brief summary of the hospitalization directly to the health-care provider responsible for follow-up care in a timely manner.
13. Where follow-up care is time-sensitive or the patient's condition requires close monitoring, the most responsible physician **must** also consider whether direct communication with the health-care provider assuming responsibility for follow-up care is warranted.

Making Referrals[8]

14. Referring physicians **must** have a mechanism in place to track referrals where urgent care is needed, in order to monitor whether referrals are being received and acknowledged.
    a. Referring physicians **must** engage patients in this process by, for example, informing them that they may contact the referring physician's office if they have not heard anything within a specific time-frame.
15. Referring physicians **must** make a referral request in writing and include the information necessary for the consultant health-care provider to understand the question(s) or issue(s) they are being asked to consult on. While physicians **must** use their professional judgment to determine what information to include in the referral request, typically this will include:
    a. Patient, referring physician, and, if different, primary care provider identifying information;
    b. Reason(s) for the consultation and any information being sought or questions being asked;
    c. The referring physician's sense of the urgency of the consultation; and
    d. Summary of the patient's relevant medical history, including medication information and the results of relevant tests and procedures.
16. If the patient's condition requires that a consultation be provided urgently, a verbal referral request may be appropriate, although the referring physician **must** follow-up with a written request.

Acknowledging Referrals

17. Consultant physicians **must** acknowledge referrals in a timely manner, urgently if necessary, but no later than 14 days from the date of receipt.[9]
18. When acknowledging the referral, consultant physicians **must** indicate to the referring health-care provider whether or not they are able to accept the referral.
    a. If they are, consultant physicians **must** provide an anticipated wait time or an appointment date and time to the referring health-care provider. When providing an anticipated wait time, consultant physicians **must** follow-up once an appointment has been set.
    b. If they are not, consultant physicians **must** communicate their reasons for declining the referral to the referring health-care provider.

Communicating Consultant Appointments with Patients

19. Consultant physicians **must** communicate the anticipated wait time or the appointment date and time to the patient, unless the referring physician has indicated that they intend to do so, and **must** allow patients to make changes to the appointment date and time directly with them. When providing an anticipated wait time, consultant physicians **must** follow-up once an appointment has been set.

Preparing and Distributing Consultation Reports

20. Following an assessment of the patient (which may take place over more than one visit), consultant physicians **must** prepare a consultation report that includes the information necessary for the health-care provider(s) involved in the patient's care to understand the patient's health

status and needs. While physicians **must** use their professional judgment to determine what information to include, this will typically include:

a. Relevant patient, consultant physician, and referring health-care provider identifying information;
b. The date(s) of the consultation;
c. The purpose of the referral;
d. A summary of the relevant information considered, including a review of systems, physical examinations and findings, and the purpose and results of tests or investigations;
e. A summary of the conclusions reached, including any diagnoses or differential diagnoses;
f. Treatments initiated or recommended, along with their rationale, including medications or changes in ongoing medications;
g. Outstanding investigations and referrals, along with their rationale;
h. Important advice given to the patient; and
i. Recommendations regarding follow-up and whether ongoing care from the consultant physicians is needed.

21. When consultant physicians are involved in the provision of ongoing care, they **must** prepare follow-up consultation reports when there are new finding or changes are made to the patient's care management plan. While physicians **must** use their professional judgment to determine what information to include, this will typically include:
    a. The original problem and any response to treatment;
    b. Subsequent physical examinations and their findings;
    c. The purpose and results of additional tests or investigations; and
    d. Conclusions, recommendations, and follow-up plan(s).
22. Consultant physicians **must** distribute consultation reports to the referring health-care provider and, if different, the patient's primary care provider.
23. Consultant physicians **must** distribute the consultation report and any subsequent follow-up reports in a timely manner, urgently if necessary, but no later than 30 days after an assessment or a new finding or change in the patient's care management plan. What is timely will depend on the nature of the patient's condition and any risk to the patient if there is a delay in sharing the report.
    a. If urgent, a verbal report may be appropriate, although the consultant physician **must** follow-up with a written consultation report.

Record Keeping of Referral Requests and Consultation Reports

24. Both referring and consultant physicians **must** keep a copy of the referral request and any consultation reports in their respective patient medical records. Where the referring and consultant physician have access to a common medical record, referral requests and consultation report may be contained in that common medical record.

Using Technology to Prepare and Distribute Referral Requests and Consultation Reports

25. Physicians who use technology to assist in the preparation and distribution of referral requests or consultation reports **must** ensure that they are accurate and follow-up with the receiving health-care provider if any errors are identified after the referral or consultation report has been sent.

Endnotes

[1.] Recognizing that the scopes of practice of other health-care providers are evolving and that other health-care providers may have overall responsibility for managing patient care, this section of the policy has adopted the term "most responsible provider" as opposed to "most responsible physician" (see the Canadian Medical Protective Association's "The most responsible physician: a key link in the coordination of care" for more information).

[2.] This policy uses the term "consultant physician" in order to capture any physician, including primary care physicians, who accept referrals.

[3.] See as well the College's *Ending the Physician-Patient Relationship* policy.

[4.] The information may be exchanged through a variety of methods including: in person, via e-communication, or static communication methods such as a patient information board within a hospital department. Similarly, any discussion that is required can be done in-person, or through the phone, text, or other methods of e-communication, so long as doing so is in compliance with physicians' obligations under *Personal Health Information Protection Act, 2004* S.O. 2004, c. 3 Sched. A. (hereinafter, *PHIPA*).

[5.] This includes people who have been admitted as inpatients to any type of hospital, including complex continuing care facilities and rehabilitation hospitals

[6.] Home is broadly defined as a person's usual place of residence and can include, for example, institutions such as a retirement home or long-term care.

7. Physicians are reminded that they must complete the discharge summary within 48 hours of discharge in order to bill the Ontario Health Insurance Plan for a patient visit on the day of discharge.

8. The expectations set out in this policy apply broadly to all referrals with the exception of effective referrals that are made when physicians choose to limit the services they provide for reasons of conscience or religion. Specific expectations for effective referrals are set out in the College's *Professional Obligations and Human Rights* and *Medical Assistance in Dying* policies.

9. The date of receipt would be the first day of practice for physicians returning from vacations or other temporary absences from practice (as defined in the *Availability and Coverage* policy).

WALK-IN CLINICS

Approved by Council: September 2019

Companion Resource: Advice to the Profession

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Walk-in Clinic: Medical practices that provide care to patients where there may be no existing association between the patient and the practice, where there may be no requirement to book appointments, and where the care provided is generally, although not always, episodic in nature. This includes urgent care centres, but does not include hospital-based emergency departments.

Policy

This policy does not provide an exhaustive catalogue of all physician expectations that apply in the walk-in clinic practice setting and other College policies set out expectations for physicians that apply in this setting as well.[1]

Supporting Patients

1. Physicians practising in a walk-in clinic **must** use their professional judgement to determine whether it would be appropriate to sensitively remind patients:
    a. That there are differences between episodic care and care that is provided as part of a sustained physician-patient relationship[2];
    b. About the benefits of seeing their primary care provider, if they have one, for care within their physician's scope of practice; and/or
    c. About the benefits of having a primary care provider and encouraging them to seek one out, if they don't already have one.
2. Physicians practising in a walk-in clinic who are asked for assistance in finding a primary care provider **must** be as helpful as possible in supporting the patient.[3]

Meeting the Standard of Practice

3. Physicians practising in a walk-in clinic **must** meet the standard of practice of the profession, which applies regardless of whether care is being provided in a sustained or episodic manner.
    a. For example, physicians practising in a walk-in clinic **must** conduct any assessments, tests, or investigations that are required in order for them to appropriately provide treatment and **must** provide or arrange for appropriate follow-up care.[4]
4. Physicians practising in a walk-in clinic who limit the care or services they provide due to the episodic nature of walk-in clinic care[5] **must:**
    a. Make decisions to limit the services they provide due to the episodic nature of walk-in clinic care in good faith;
    b. Communicate any limitations to patients in a clear and straightforward manner; and
    c. Communicate appropriate next steps to patients seeking care or services that are not provided, considering factors such as the urgency of the patient's needs and whether other health-care providers are involved in the patient's care.

Managing Tests and Referrals

5. Physicians practising within a walk-in clinic who order tests **must**:
    a. Comply with the expectations set out in the *Managing Tests* policy, including providing appropriate follow-up on test results; and
    b. Comply with relevant expectations set out in the *Availability and Coverage* policy, in particular those relating to coordinating coverage for *critical* test results.
6. Physicians practising in a walk-in clinic who make referrals **must** provide or arrange for the provision of necessary follow-up care, including reviewing consultation reports.
7. Physicians practising in a walk-in clinic **must not** rely on the patient's primary care provider or another health-care provider involved in the patient's care to provide or coordinate appropriate follow-up for tests they have ordered or referrals they have made, unless the other providers

have agreed to assume this responsibility.

Coordinating with Primary Care Providers

8. Physicians practising in a walk-in clinic **must** provide the patient's primary care provider (if there is one) with a record of the encounter[6] when:
    a. The patient makes a request to do so; or
    b. In their opinion, one is warranted from a patient safety perspective and the patient has provided consent to do so.
9. If it is not possible to send the record of the encounter directly to the patient's primary care provider (e.g., where there is uncertainty regarding their identity or incomplete contact information), physicians practising in a walk-in clinic **must** provide the patient with the record of the encounter and inform them of the importance of sharing it with their primary care provider.

Endnotes

1. For example: *Medical Records*, *Confidentiality of Personal Health Information*, *Professional Obligations and Human Rights*, etc.

2. As defined in the *Availability and Coverage* policy, a sustained physician-patient relationship is one where care is actively managed over multiple encounters.

3. Examples include directing patients to a colleague who is accepting new patients or to an organization that may be able to assist, such as a Community Health Centre, local hospital or emergency room, or other organization. The College's Physician and Public Advisory Service (PPAS) may also be able to provide some general tips and advice to patients seeking a new provider. PPAS can be reached toll free at 1-800-268-7096 ext. 603.

4. See, as well, provisions 5 through 7 in this policy.

5. Among other factors, a physician's practice environment may determine their scope of practice at a particular point in time. This is distinct from limitations that result from a moral or religious objection where specific expectations apply (see the College's *Professional Obligations and Human Rights* policy).

6. This may include, for example, a record of any tests ordered, diagnoses reached, any treatment and advice provided, any referrals that were made, and any follow-up care that was arranged or advised, etc.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – DECEMBER 13, 2019

ITEM FOR INFORMATION

SUBJECT:

CEO/Registrar's Report

1. **Media**

   There has been no media coverage of CPSM of note in the past four months.

2. **Staffing Matters**

   Dr. Ainslie Mihalchuk will replace Dr. Terry Babick upon his retirement on December 31, 2019. Dr. Babick has indicated he will attend at the College for a couple of weeks in the new year to assist in the transition. Dr. Mihalchuk has been the Acting Chief Medical Officer at the Winnipeg Regional Health Authority and maintains a family practice. Dr. Mihalchuk will be an Assistant Registrar at the College and not a Deputy Registrar as this is part of a flattening of the reporting structure. As part of the changing of reporting structures, Dr. Karen Bullock Pries has been named the Assistant Registrar, from the position of Director of Complaints and Investigations.

3. **Aesthetic Clinics and Dermatology Clinics**

   Several dermatologists have become increasingly concerned about the safety of Manitoba patients undergoing elective non-surgical aesthetic procedures in physician directed clinics. They indicated frequently they are seeing patients with harm done to them by practitioners lacking in knowledge, skill, and judgment required to administer safe care.

   At the meeting two issues arose:
   1 – the role of the Medical Director in physician directed clinics (absenteeism, lack of oversight, inducements, knowledge, etc.)
   2 – the competency of practitioners (both in CPSM and in CRNM and other unregulated practitioners). The College in Saskatchewan has established the competencies to change a scope of practice for medical aesthetics, which the dermatologists are requesting the College to adopt a similar approach.

   Further review of this matter is pending.

4. Report on FMRAC priorities

The following are the organizational priorities of FMRAC:

1. Telemedicine
2. The Impaired Physician
3. Streamlined Registration
4. Artificial Intelligence and the practice of medicine
5. Standardizing the Certificate of Professional Conduct
6. Prescription Opioids
7. Physician Competence

The College is awaiting further development on the telemedicine and streamlined registration at the FMRAC level prior to proceeding with these two strategic organizational priorities itself.

5. Medical Records

The College receives many inquiries regarding medical records – content, legibility, control, transfer to new offices or to new physicians, etc. The issues and difficulties of transferring Electronic Medical Records are becoming more prevalent. This topic will be reviewed in the first year of the ongoing cycle of Standard of Practice Review.

6. Update on Registration Renewals

This was the first year of the renewal under the RHPA and went as smooth as expected. There were new questions this year requesting the names of medical directors for those practising in non-institutional settings and inquiring on plans to store patient records following the end of their practice. This prompted numerous questions which were handled by staff. A further new question on renewal was to seek information on the physician office laboratories. There are currently 18 tests approved for physician office laboratories. Total renewals:

Completed Physician Renewals: 3261
Incomplete Physician Renewals: 22
Total: 3283

Completed Corporation Renewals: 1998
Incomplete Corporation Renewals: 62
Total: 2060

7. Website

The website is to be launched shortly, prior to the December 13 meeting of Council.

8. Meeting with the Minister

Drs. Ripstein, Ziomek, and Babick along with Ms. Kalinowsky met with the Minister of Health, Seniors, and Active Living, Mr. Friesen, in addition to the Deputy Minister, Ms. Herd. The Minister was interested in the four Strategic Organizational Priorities Working Groups and a lengthy discussion occurred. The College is still awaiting the appointment of public representatives and was advised these should be forthcoming.

9. Physician Health Program

The Physician Health Program of the College has experienced a recent increase in physicians involved in its program. Those working in this area have faced numerous challenges recently.

10. Shared Health Medical Advisory Council

Dr. Ziomek as Registrar has been asked to join the Shared Health Medical Advisory Council which advises Shared Health on issues of system-wide clinical governance across the province. This Council is to take a province-wide view of medical resources, expertise, and functions to assist in structural and organizational reform that is patient-focused, evidence-based, and clinically informed from the perspective of medicine. This Council is composed of the 13 clinical leads within the province in addition to other physicians occupying key administrative positions. With the 5 Year Clinical and Preventative Services Plan being implemented, the Shared Health Medical Advisory Council will advise Shared Health of implications, concerns, and issues with its roll-out.

11. Western Registrars Meeting

On November 18, Kathy Kalinowsky attended the biannual Western Registrars meeting in Saskatoon. Many of the items are very applicable to Manitoba; while some are not such as providing a safe supply of opioids directly to the public are not. Items discussed included Buprenorphine/Naloxone prescribing practices in Alberta, legislative changes in Alberta, regulation of clinical assistants and physician assistants, risk based regulation, telemedicine, a legal case on protected titles (Death Midwife case), MAID, and Ontario's use of Alternative Dispute Resolution in the complaints and investigations processes.

12. CMA Committee on Ethics

The CMA has created a Policy on Equity and Diversity in Medicine which has been circulated to the membership and stakeholders for consultation. Dr. Ziomek attends the national CMA Committee on Ethics to represent FMRAC. Another Policy on Organ and Tissue Donation and Transplantation is circulated for consultation.

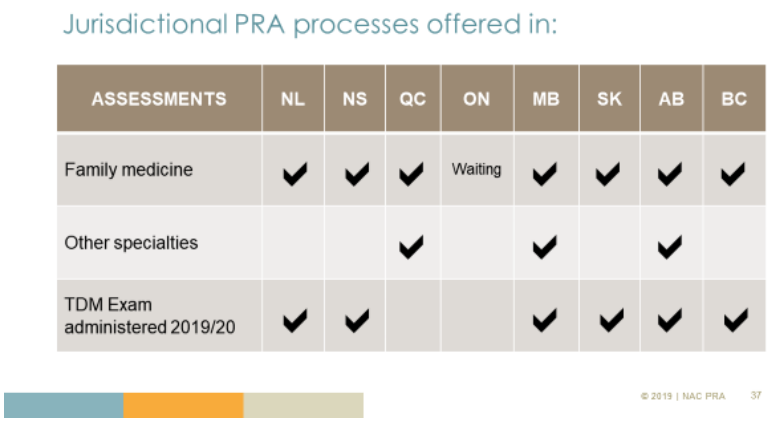
13. Rural and Remote and Underserved Population: Access to Prescribed Medications Practice Directions

An interdisciplinary team has been working on the issue of ensuring these populations can access prescribed medications when there is no access to either a physician or a nurse practitioner. The group includes pharmacy, registered nurses, psychiatric nurses, licensed practical nurses, Manitoba Health, First Nations Indian Health Branch, Northern Regional Health Authority, and Omgomiizwin at the University.

At issue is that a patient in a federal reserve nursing station need to be able to access an appropriate prescription by an authorized prescriber that is entered into DPIN. Given many factors, this has proven to be extremely challenging. A Practice Direction will be forthcoming next year to Council, in addition to the Colleges of Pharmacists and Registered Nurses.

14. National Assessment Collaboration Committee – Practice Ready Assessment

Dr. Ziomek recently attended a national meeting for assessment collaboration. The Practice Ready Assessment was created initially by Dr. Marilyn Singer when she was at the University of Manitoba. It has now been followed by all Canadian regulators (minus one). Manitoba remains at the forefront and is one of the few provinces that provides Practice Ready Assessments for specialists.



15. BC Regulatory Changes

In response to the Cayton Report on the College of Dental Surgeons, a government committee report (authored in part by the Health Minister) recommends streamlining the regulation of health professionals in B.C. by reducing the number of regulatory colleges, altering the makeup of college boards, and improving the transparency of the complaint system.

There are currently 20 health professions colleges in the province with more than 120,000 members. The province is proposing a system where there are five colleges. The College of Physicians and Surgeons of B.C., the College of Pharmacists of B.C. and the B.C. College of Nursing Professionals would remain, while the other colleges would be grouped into two other larger colleges – a College of Oral Health and a College of Health and Care Professions. The College of Podiatric Surgeons will merge with the Physicians and Surgeons.

Other recommended changes include:

- Smaller Boards have equal numbers of registrants and public members
- Create a new diagnostic and therapeutic regulated health profession to oversee respiratory therapists, radiation therapists, clinical perfusionists, and medical laboratory technologists
- Create subcommittees to ensure profession-specific clinical expertise
- Establish a new oversight body to "regulate the regulator"
- Create a new independent discipline process for a clear separation between the investigation and adjudication/discipline stages of complaints. A new adjudication body will be established separate from the colleges to make disciplinary decisions.
- All actions take to resolve accepted complaints be made public (including agreements such as completing additional training)6
- Permit colleges to provide limited public comments if a complaint under investigation becomes known to the public
- Establish timelines for stages of the complaints process

Feedback from the public and stakeholders is being sought prior to final recommendations to government.

16. Telemedicine

The College receives many inquiries from physicians seeking to practice telemedicine in Manitoba, whether to provide the occasional follow-up care or to engage in a more "entrepreneurial/corporate" practice of medicine. The CPSM General Regulation provides for a new restricted purpose class for telemedicine. This has never been used. Given the recent increase in telemedicine inquiries and the lengthy FMRAC efforts to

achieve national standards on telemedicine practices, it is the intention of this College to proceed with activating this restricted purpose class for telemedicine. It is intended to bring forward a Practice Direction on Restricted Purpose Class at the March Council meeting.

COUNCIL MEETING – DECEMBER 13, 2019

BRIEFING NOTE

SUBJECT:
Practicing Medicine in Nunavut – Memorandum of Understanding

DISCUSSION:

Many Manitoba physicians provide medical care to patients in Nunavut via telemedicine, frequently before and after in-person care. This in-person care may have occurred either in Nunavut or in Manitoba (usually at the tertiary hospitals). Sometimes, the medical care is provided remotely by video or telephone, and there may be no in-person care. Often, these are "one off" cases.

An issue arose recently with regard to Manitoba physicians treating patients in Nunavut via telemedicine. The Government of Nunavut and the College have acted quickly and put into place a Memorandum of Understanding respecting telemedicine services. Here are the salient points of the attached agreement:

- Manitoba physicians may provide medical care to patients in Nunavut via telemedicine without obtaining a Nunavut license.

- Nunavut agrees not to prosecute any Manitoba physician for providing medical care to patients in Nunavut via telemedicine without a license contrary to the *Medical Profession Act* where the Manitoba physician provides medical care to Nunavut residents via telemedicine.

- Manitoba physicians will be subject to the registration requirements of the College when providing medical care to patients in Nunavut via telemedicine.

- Manitoba physicians will be required to adhere to the College's Code of Ethics and Professionalism, Standards of Practice of Medicine, and Practice Directions when providing medical care to patients in Nunavut via telemedicine.

- The College maintains jurisdiction over the Manitoba physicians they register, regardless of the physical location of the physician if they provide medical care to patients in Nunavut via telemedicine.

- The College shall investigate and discipline Manitoba physicians respecting their provision of medical care to patients in Nunavut via telemedicine in substantially the same manner as in Manitoba.

PUBLIC INTEREST RATIONALE

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

Manitoba physicians can continue to provide immediate medical care to patients in Nunavut via telemedicine without needing to register in Nunavut. This reduction of the regulatory burden ensures that patients are cared for and that Manitoba physicians adhere to the same high standards of practice and duty of care whether treating Manitoba or Nunavut patients.

Memorandum of Understanding respecting Telemedicine Services

Between:

The Government of Nunavut as represented by the Minister of Health

("the GN")

And

The College of Physicians and Surgeons of Manitoba

("the College")

WHEREAS:

A. The GN is responsible for licensing and regulating medical practitioners in Nunavut pursuant to the *Medical Professions Act*;

B. The College is responsible for licensing and regulating medical physicians in Manitoba pursuant to the *Regulated Health Professions Act*;

C. Manitoba Physicians are full practicing class of regulated membership as defined in s. 2.3 of the *College of Physicians and Surgeons of Manitoba General Regulation; and*

D. Some Manitoba physicians provide telemedicine services to Nunavut residents;

THEREFORE, the Parties Agree:

1. All medical practitioners engaging in the practice of medicine in Nunavut must be licensed by the GN pursuant to the *Medical Profession Act* except in accordance with this agreement
2. Manitoba physicians in may provide medical care to patients in Nunavut via telemedicine without obtaining a Nunavut license.
3. Manitoba physicians will be subject to the registration requirements of the College when providing medical care to patients in Nunavut via telemedicine.
4. Manitoba physicians will be required to adhere to the College's Code of Ethics and Professionalism, Standards of Practice of Medicine, and Practice Directions when providing medical care to patients in Nunavut via telemedicine.
5. The College maintains jurisdiction over the Manitoba physicians they register, regardless of the physical location of the physician if they provide medical care to patients in Nunavut via telemedicine.
6. The College shall investigate and discipline Manitoba physicians for any matter included in s. 124(2) of the *Regulated Health Professions Act* respecting their

provision of medical care to patients in Nunavut via telemedicine in substantially the same manner as in Manitoba.

7. The College shall inform the Nunavut Registrar of Health Professions of any action referred to in section 6 that is taken by the College.
8. The Nunavut Registrar shall forward any complaints received with respect to Manitoba physicians referred to in section 6 to the College.
9. Investigations regarding the standard of care provided by a Manitoba physician via telemedicine will be informed by the minimum expectations set out in the Federation of Medical Regulatory Authorities of Canada's Framework on Telemedicine and the College's Standard of Practice of Medicine and Practice Directions.
10. The GN will assist the College in conducting its investigations in Nunavut upon request.
11. The GN agrees not to prosecute any Manitoba physician for providing medical care to patients in Nunavut via telemedicine without a license contrary to the *Medical Profession Act* where the Manitoba physician provides medical care to Nunavut residents via telemedicine in accordance with this Memorandum of Understanding.
12. Any notice required to be given herein or any other communication required by this Agreement shall be in writing and shall be addressed as follows:

    a) To the GN:
    Tom Sidebottom
    Assistant Deputy Minister of Programs and Standards
    Department of Health
    Government of Nunavut
    PO Box 1000 Stn. 1000
    Iqaluit NU X0A 0H0
    E-Mail Address: tsidebottom@gov.nu.ca

    b) To the College:

    Anna Ziomek MD
    Registrar
    The College of Physicians & Surgeons of Manitoba
    1000 – 1661 Portage Ave
    Winnipeg, MB R3J 3T7

13. This Agreement shall be effective from the 1st day of November 2019 and shall terminate on the 31st day of October, 2020.
14. This Agreement may be extended for an additional one-year term by the mutual consent of the Parties.

15. This Agreement is prepared in English by the mutual consent of the parties.

16. This Agreement may be signed in counterparts and each such counterpart shall constitute an original document and such counterparts, taken together, shall constitute one and the same instrument. Execution and delivery of this Agreement or a counterpart thereof by any party by fax or electronically shall constitute valid and effective execution and delivery, but each party shall retain an originally executed copy of the Agreement.

IN AGREEMENT WITH THE FOREGOING PROVISIONS the parties hereto set down their signatures, by hand or by facsimile, and together bind themselves to this Agreement as of the 24 day of OCTOBER, 2019.

FOR THE GOVERNMENT OF NUNAVUT:

Tom Sidebottom, Assistant Deputy Minister

FOR THE COLLEGE:

Anna Ziomek MD, Registrar

15. This Agreement is prepared in English by the mutual consent of the parties.

16. This Agreement may be signed in counterparts and each such counterpart shall constitute an original document and such counterparts, taken together, shall constitute one and the same instrument. Execution and delivery of this Agreement or a counterpart thereof by any party by fax or electronically shall constitute valid and effective execution and delivery, but each party shall retain an originally executed copy of the Agreement.

IN AGREEMENT WITH THE FOREGOING PROVISIONS the parties hereto set down their signatures, by hand or by facsimile, and together bind themselves to this Agreement as of the day of Oct. 23, 2019.

FOR THE GOVERNMENT OF NUNAVUT:

Tom Sidebottom, Assistant Deputy Minister

FOR THE COLLEGE:

Anna Ziomek MD, Registrar

COUNCIL MEETING – DECEMBER 13, 2019

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Modification to the Practice Direction – Manitoba Prescribing Practices Program

BACKGROUND:

Certain prescription drugs listed under the Manitoba Prescribing Practices Program (M3P) can only be prescribed on a prescription form approved by the College and are governed by more stringent prescribing and dispensing requirements. These drugs are listed on Schedule A to the Manitoba Prescribing Practices Program Practice Direction, which has been approved by Council. Changes to the M3P drug list must be approved by the Councils of the College of Physicians and Surgeons of Manitoba and the College of Pharmacists of Manitoba.

PUBLIC INTEREST:

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

Patient safety is extremely important for those drugs listed on this schedule and their prescribing is limited to those with the highest level of educational and professional achievement (full practicing members). Full practicing physicians must also apply to the Registrar for the privilege of prescribing drugs listed on the M3P. A check is done on the physician's prescribing practices prior to the issuance of any M3P pads. For outpatient prescriptions, clinical assistants, physician assistants, and medical residents are not permitted to prescribe M3P listed drugs as per the CPSM General Regulation.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2019, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

1. Council approve deleting "residents, physician assistants, and clinical assistants" from item #2 of the Manitoba Prescribing Practices Program (M3P) Practice Direction.

2. Council approve deleting #6.7 “for residents, physician assistants and clinical assistants, the prescriber’s supervising physician’s name from Item 6 of the Manitoba Prescribing Practices Program (M3P) Practice Direction.

PRACTICE DIRECTION

Manitoba Prescribing Practices Program (M3P)

Initial Approval: November 22, 2018

Effective Date: January 1, 2019

Reviewed with No Changes

Reviewed with Changes December 13, 2019

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

This Practice Direction is made under the authority of s. 85 of the RHPA with specific reference to s. 5.8 of the CPSM General Regulation and s. 59 of the CPSM Standards of Practice of Medicine.

1. In accordance with s. 5.8 of the CPSM General Regulation, a member who is authorized under the Controlled Drugs and Substances Act (Canada) is to prescribe the drugs listed on the M3P schedule in the manner prescribed in the Regulation and this Practice Direction.

2. Physicians~~, residents, physician assistants and clinical assistants~~ must prescribe the drugs listed in the attached Schedule only in the manner prescribed in this Practice Direction.

3. All prescription drugs in the attached Schedule shall be written on a prescription form as is approved by the College from time to time and made available only through the College of Pharmacists of Manitoba.

4. The prescription shall contain only one drug on each prescription form.

5. The prescription shall be valid for only three days after its issuance to the patient and the physician must so advise the patient.

6. The prescription must be legible and shall include:
   - 6.1. the date;
   - 6.2. the patient name and address;
   - 6.3. patient's date of birth;
   - 6.4. patient's Personal Health Information Number;
   - 6.5. the number of repeats, where applicable;
   - 6.6. the quantity and dose;
   - ~~6.7. for residents, physician assistants and clinical assistants, the prescriber's supervising physician's name; and~~
   - 6.8. signature of the physician.

7. This Practice Direction does not apply to:
   7.1. prescriptions for drugs administered in a personal care home as described under the *Manitoba Health Services Insurance Act,*
   7.2. prescriptions for drugs administered in a hospital,
   7.3. the direct administration of a designated drug to a patient by a prescriber.

8. Physicians wishing to prescribe methadone for opioid use disorder, for analgesia or for analgesia for palliative care must first obtain the approval of the Registrar.

9. Physicians wishing to prescribe Suboxone for opioid use disorder must first obtain the approval of the Registrar.

LIST OF DRUGS COVERED BY THE MANITOBA PRESCRIBING PRACTICES PROGRAM (M3P)

NOTE: All sales reportable narcotics and controlled drugs are included under the M3P Program.
WARNING: This is a reference list provided for convenience.
While all generic names appear, only sample brand names are provided. It should not be viewed as an all-inclusive listing of brand names included under the M3P program**.**

AMPHETAMINES & DERIVATIVES
- Adderall XR
- Dexedrine
- Dexedrine Spansule

ANILERIDINE

BUPRENORPHINE & NALOXONE
- Suboxone

NOTE: May be prescribed only by those prescribers approved by their regulatory authority.
- Butrans

BUTALBITAL WITH OR WITHOUT CODEINE
- Fiorinal
- Tecnal

BUTORPHANOL
- Apo - Butorphanol
- PMS - Butorphanol

COCAINE

CODEINE (either pure or those preparations with only 1 active ingredient other than codeine)
- Codeine Contin
- Ratio-Emtec
- Lenoltec #4
- Tylenol #4
- Tylenol with Codeine Elixir

DIACETYLMORPHINE
NOTE: May be prescribed only by those prescribers approved by their regulatory authority.

DIETHYLPROPION
- Tenuate

DIPHENOXYLATE
- Lomotil

FENTANYL/SUFENTANIL/ ALFENTANIL
- Fentanyl Patches
- Sufentanil injection
- Alfentanil injection

HYDROCODONE
- Ratio-Coristex DH
- Dimetane Expectorant DC
- Hycodan
- Novahistex DH & DH Expectorant
- Novahistine DH
- Triaminic Expectorant DH
- Tussionex

HYDROMORPHONE
- Dilaudid
- Dilaudid HP
- Dilaudid LA
- Dilaudid Powder
- Hydromorph Contin
- Hydromorph-IR

KETAMINE (Including compounded prescriptions containing ketamine)

MEPERIDINE (PETHIDINE)
- Demerol

METHAQUALONE

METHADONE
NOTE: May be prescribed only by those prescribers approved by their regulatory authority.

METHYLPHENIDATE
- Ritalin
- Foquest

MORPHINE
- Kadian

NOTE: If for opioid replacement therapy, may be prescribed only by those prescribers approved by their regulatory authority.
- M-Eslon
- Morphine
- MOS
- MS Contin
- MS-IR
- Statex

NABILONE
- Cesamet

NALBUPHINE
- Nubain

NORMETHADONE-p-HYDROXYEPHEDRINE
- Cophylac

OPIUM & BELLADONNA
- *SAB*-Opium & Belladonna suppositories

OXYCODONE
- Endocet
- Oxycodan
- Oxycocet
- OxyContin
- Oxy-IR
- Percocet
- Supeudol

PENTAZOCINE
- Talwin

PENTOBARBITAL
- Nembutal Sodium

PHENOBARBITAL WITH CODEINE

PHENTERMINE
- Ionamin

PROPOXYPHENE
- Darvon N

TAPENTADOL
- Nucynta CR

TETRAHYDROCANNABINOL (and all derivatives of Cannabis including synthetic preparations)
- Marinol
- Sativex

REVISION: October 2018

*Please note that lisdexamfetamine (Vyvanse®), methylphenidate OROS (Concerta®), and methylphenidate MLR (Biphentin®) are no longer on the M3P Drug List.

COUNCIL MEETING – DECEMBER 13, 2019

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Replacement of the Term "Deputy Registrar" with Assistant Registrar

BACKGROUND:

Following the retirement of Dr. Terry Babick as Deputy Registrar, there will no longer be a Deputy Registrar. Instead there will be two Assistant Registrars. Dr. Ainslie Mihalchuk will be one Assistant Registrar with responsibilities for Standards and the Physician Health Program. Dr. Karen Bullock Pries is the Assistant Registrar with responsibilities for Complaints and Investigation.

There are numerous instances throughout the Bylaws, Practice Directions, and Policies of Council that refer to the Deputy Registrar or the Director of Complaints and Investigations. It is necessary to change these references to Assistant Registrars.

It is proposed that this be done by one motion and not cite the numerous instances in which the changes of reference to Assistant Registrar are being made.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2019, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

The Terms "Deputy Registrar" and "Director of Complaints and Investigation" be replaced with Assistant Registrar in all Bylaws, Practice Directions, and Policies of Council.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – DECEMBER 13, 2019

ITEM FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met on October 16th and November 20th, 2019. Most of the matters dealt with by the Executive Committee end up on the agenda for this meeting of Council, so will not be reiterated.

Additionally, the Executive Committee on September 30, 2019 heard the matter of an appeal of an interim suspension of a matter. A decision is still pending on this matter.

AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

1. Independent Auditor's 2020 Audit Plan

- The independent auditing firm Deloitte presented their annual Audit Plan for the upcoming audit of the College Financial Statements for the fiscal year 2019-20.
- An Audit Report and the College Annual Financial Statements will be presented to Council at the AGM June 19, 2020.

2. October 31, 2018 Quarterly Financial Statements

- Management presented the October 31, 2019 quarterly financial statements of the College.

3. Investment portfolio update

- The Committee received an overview and update of the College investment portfolio.
- Letters of Compliance with the approved investment policies of the College were received by TD Wealth and CIBC Private Wealth Management regarding the College investment portfolio.

4. Cost recoveries from inquiry cases

- The Committee heard from legal counsel about the options available to the College to recover costs awarded by the Inquiry Committee against physicians.
- The Committee moved that the College take the necessary steps to recover the costs awarded from inquiry cases.

Respectfully submitted,
Dr. Jacobi Elliott
Chair, Audit & Risk Management Committee

COMPLAINTS COMMITTEE REPORT:

Complaints Received between
01-May-2019 and 27-Nov-2019

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Complaint Received	Total Cases
May/2019	17
June/2019	10
July/2019	11
August/2019	8
September/2019	3
October/2019	19
November/2019	8
Grand Total	76

Length of time required to acknowledge complaints received
between 01-May-2019 and 27-Nov-2019

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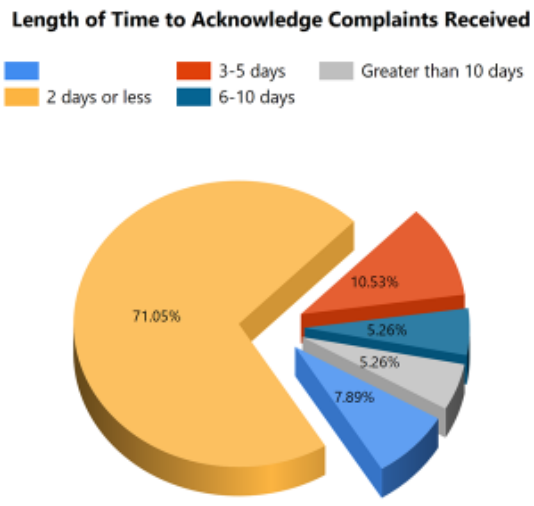
Complaints Acknowledge In	Total Cases
	6
2 days or less	54
3-5 days	8
6-10 days	4
Greater than 10 days	4
Total number of complaints cases in time period:	76



Length of time required to resolve complaints for cases closed between 01-May-2019 and 27-Nov-2019

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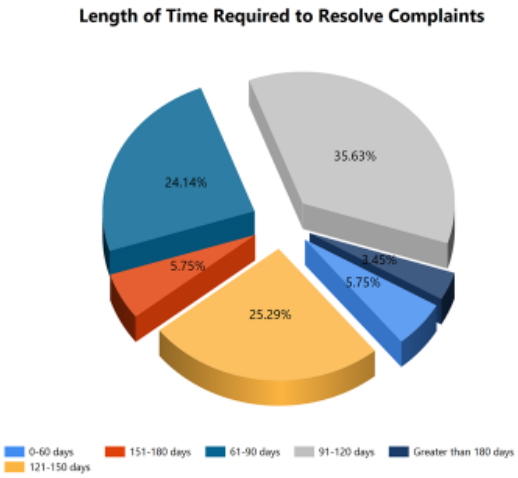
Complaints Cases with	Total
0-60 days	5
61-90 days	21
91-120 days	31
121-150 days	22
151-180 days	5
Greater than 180 days	3
	87



Respectfully submitted,
Dr. Heather Smith
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

The Investigation Committee has been very busy since Council last met in September 2019.

- Nineteen new investigation files have been opened.
- When the Investigation Committee met on October 2, 2019 it considered 20 cases.
- When the Investigation Committee met on November 6, 2019 it considered 9 cases.
- The Committee will be considering 6 cases when it next meets on December 11, 2019.
- Between September 1, 2019 and November 27, 2019, 24 cases were closed by the Investigation Committee.
- As of October 2, 2019, there were 2 open appeals from decisions of the Investigation Committee to the Appeal Committee. As of November 27, 2019, there is 1 outstanding appeal to be heard.

We are in the midst of a lengthy Inquiry hearing, and legal counsel have presented at two other hearings.

The department is trying to improve communication with the public. Information on the website is being revised and letters and forms are being rewritten to be more "user friendly".

The department is also attempting to improve our process around allegations of boundary violations. This includes an effort to provide more support to patients in this scenario. We have recently offered a limited amount of legal and/or counselling services to 2 patients who have come forward. Staff are also participating in the president's working group related to boundary violations.

Respectfully submitted,
Dr. Nader Shenouda
Chair, Investigations Committee

PROGRAM REVIEW COMMITTEE REPORT:

The committee has met twice since the summer, dealing with MANQAP reviews of labs and imaging facilities as per the CPSM service purchase agreement (SPA) with MB Health as well as non-hospital treatment facility accreditation as per the CPSM Accredited Facilities Bylaw (s183 of the RHPA). Discussion focused around lobbying Shared Health to acquire software to measure and flag cumulative patient radiation exposure from repeated CT scans. Concerns were also expressed about the upcoming December closure of twenty-four Dynacare satellite labs near MD offices in Winnipeg, with the creation of four larger regional lab sites (Unicity, St. Vital, Garden City, Seasons of Tuxedo), with potential impaired access for seniors with mobility challenges.

An additional issue is the on-going, prolonged negotiations with MB Health on the future location of MANQAP, dating back to a 2016 CPSM Council approved, divestment directive.

Respectfully submitted,
Dr. Wayne Manishen
Chair, Program Review Committee

QUALITY IMPROVEMENT COMMITTEE REPORT:

The Quality Improvement (QI) Committee convened on September 17, 2019. The committee was debriefed on any updates to the program activities. From the ongoing reviews from the first two intakes of the QI process, two files were brought forward for review and discussion. Both files were provided with recommendations for practice improvements, as well as a follow up chart audit in six months' time. The policy for retirement of a participant was brought forth and approved by the committee. The committee had discussions outlining the drafting of a policy, whereby the Consultant for Quality Improvement will be allowed the discretion to move a participant to another category of review, if deemed necessary.

The Quality Improvement Program launched two intakes, encompassing 199 family physicians in January and March of 2019. As of August 15, 2019, 173 participants have completed the process. A third intake was initiated on September 24, 2019, with another 95 participants entering the process.

The Quality Improvement Committee meeting scheduled for December 10, 2019 has been cancelled as there are no files to bring forward for review and discussion. The next meeting is scheduled for Thursday, February 13, 2020.

Respectfully submitted,
Dr. Christine Polimeni
Chair, Quality Improvement Committee

STANDARDS COMMITTEE REPORT:

The Standards Committee report will be forthcoming, via email, as the Committee meets on Friday, November 29, 2019. **See Addendum at end.**

Respectfully submitted,
Dr. Roger Suss
Chair, Central Standards Committee

SNAPSHOT – FALL 2019

Federation of Medical Regulatory Authorities of Canada

Fédération des ordres des médecins du Canada

Dr. Linda Inkpen
President

Ms. Fleur-Ange Lefebvre
Executive Director & CEO

Board of Directors

The Board met four times since the last issue of Snapshot: 7 June 2019 (in person in Whistler, BC), 20 August 2019 (teleconference), 18 September 2019 (teleconference) and 8 October 2019 (in person in Toronto, ON).

Key discussion areas

- Current organizational priorities
- Emerging and urgent issues
- Core organizational activities
- Outside organizations and representation, including working with the Federal Government
- Corporate activities

2019-2020 Organizational Priorities – selected on 8 October 2019

1. Ongoing
   - 1.1 Prescription opioids – it is expected that the FMRAC *Framework on a Regulatory Approach to Physicians Who Care for Patients with Acute or Chronic Pain and/or Opioid Use Disorders and Prescribe Opioids* will be approved by the Board in December 2019 or February 2020.
   - 1.2 Streamlined registration – focusing on the Pan-Canadian Licensure backgrounder and, eventually, on the License Portability Agreement.
   - 1.3 Artificial intelligence and the practice of medicine – examining the regulatory interface between physicians and medical devices that will have an impact on how they practise medicine.
   - 1.4 Physician competence – focusing on a comprehensive review of the 2016 *FMRAC Physician Practice Improvement* document (http://fmrac.ca/physician-practice-improvement/); for now, this is on temporary hiatus as various stakeholder organizations are referencing the current PPI document in their own work.
2. New
   - 2.1 The impaired physician from an occupational health perspective – FMRAC will strike a working group to develop a framework on a regulatory approach.
   - 2.2 Standardizing the Certificate of Professional Conduct across all MRAs – this will build on the work that led to the 2013 *FMRAC Policy on Disclosure of Professional Information* (http://fmrac.ca/policy-of-disclosure-of-professional-information/).

FMRAC Annual Meeting and Conference

8-10 June 2019, Whistler, BC

FMRAC recorded the highest number of registrants, including guests from several international medical regulatory authorities, at this meeting. The educational conference on *Physician Sexual Boundary Violations:*

Effective and Proactive Regulation for Public Protection was well received and resonated with most people in attendance. FMRAC thanks the CPSBC for its generous financial contributions and for their staff volunteers.

6-8 June 2020, Halifax, NS
The Board chose *Emerging Technologies and Physician Regulation* as the theme for its next educational conference. FMRAC looks forward to working with CPSNS staff to ensure yet another successful event.

Highlighting one Organizational Priority – *FMRAC INTEGRATED RISK MANAGEMENT SYSTEM or FIRMS*

FMRAC first launched FIRMS in December 2016. Key features are:

- it is a partnership with the Healthcare Insurance Reciprocal of Canada (HIROC);
- it provides a model and framework for ongoing integrated risk management and quality improvement;
- it was designed "for medical regulatory authorities, by medical regulatory authorities";
- FIRMS is a voluntary, continuous, systematic process to understand, manage and communicate risk within and among MRAs;
- it is intended to support strategic decision-making towards fulfilling the MRA's mandate.

Participation and engagement in FIRMS may reassure an MRA's council or board, registrar, staff and external stakeholders that their MRA meets its goals of integrated risk management and quality improvement.

FIRMS has recently undergone an in-depth review whereby the original 11 modules of standards were streamlined and converted to plain language. This involved the FMRAC Risk Management Committee, the FIRMS Users Group, 11 subcommittees of subject matter experts, as well as HIROC and FMRAC staff. The resulting changes significantly reduced the overall number of standards. Earlier this month, the Board approved the new modules shown in the framework below:

#	FIRMS Modules	# of standards
Overarching		
1	Governance	24 → 10
2	Leadership (new)	0 → 8
MRA Core Mandate		
3	Registration & Licensure	34 → 3
4	Complaints & Resolution	39 → 5
5	Quality Assurance (QA) of Medical Practice	28 → 6
6	Facility Accreditation/Quality Review Programs	44 → 4
Operations		
7	Integrated Risk Management (IRM)	24 → 7
8	Human Resource (HR)	35 → 10
9	Finance	31 → 11
10	Information Technology (IT) Records Management & Privacy	28 27 } 55 → 15
11	Security & Premises	23 → 5
	Total	**337→ 84**

These modules will be uploaded onto HIROC's Risk Assessment Checklist platform by 1 November 2019. This will provide MRAs the opportunity to continue or to initiate participation in FIRMS by 31 December 2019. Engagement by an MRA in this process results in a reduced HIROC premium. Once all participating MRAs are on board, the Risk Management Committee will review aggregate, de-identified data on a regular basis to identify areas of common need and further action.

MISSION

To advance medical regulation on behalf of the public through collaboration, common standards and best practices.

PILLARS

The following six pillars will enable FMRAC to achieve this mission as proactively and creatively as possible:	
P1	*establish mechanisms for the effective exchange of information, discussion and collaboration with its members and others, on issues that involve medical regulation*
P2	*develop policies, standards, statements and perspectives on aspects of medical regulation – either pan-Canadian or drafts that can be adapted by the members*
P3	*actively participate in the design and coordination of pan-Canadian health system changes*
P4	*be an effective voice to interact with and inform key stakeholders (including governments, the public and media) on medical regulatory matters of national or international importance*
P5	*develop and maintain programs, services and benefits for its members*
P6	*identify and mitigate risk to medical regulation in a timely manner*

CORE ACTIVITIES

C1	*advocacy and common voice – where FMRAC stands publicly and speaks on behalf of the medical regulatory authorities of Canada* ▪ *at the federal level* ▪ *with the members, the public and the media – promote pan-Canadian standards, even if they are aspirational, especially when members can use them in discussions with their own governments* ▪ *with other national organizations – promote the notion of public interest regulation*
C2	*surveillance of political developments and trends that may have an impact on the work of the Members in fulfilling their mandate*
C3	*the FMRAC Integrated Risk Management System (FIRMS)*
C4	*Model Standards for Medical Registration in Canada*

Addendums

COUNCIL MEETING – DECEMBER 13, 2019

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Addition and Removal of M3P Drugs, Practice Direction – Manitoba Prescribing Practices Program

BACKGROUND:

Certain prescription drugs listed under the Manitoba Prescribing Practices Program (M3P) can only be prescribed on a prescription form approved by the College and are governed by more stringent prescribing and dispensing requirements. These drugs are listed on Schedule A to the Manitoba Prescribing Practices Program Practice Direction, which has been approved by Council. Changes to the M3P drug list must be approved by the Councils of the College of Physicians and Surgeons of Manitoba and the College of Pharmacists of Manitoba.

At its meeting on December 2, 2019 the College of Pharmacists of Manitoba Council reviewed and approved Foquest (methylphenidate hydrochloride) controlled release capsules for **removal** from the M3P list.

The background for this is that the CPSM Registrar received the following request from a member.

> "I am writing to formally request that the medication Foquest be removed from the M3P medication list.
>
> By way of background, I am an Adult Psychiatrist that specializes in Mood Disorders, Anxiety Disorders, and ADHD in adults. I have been diagnosing and treating adults with ADHD for 14 years and have extensive experience in this area. I have also been prescribing long-acting stimulants for the same duration.
>
> As you are aware, Biphentin, Concerta, and Vyvanse were all removed from the M3P medication list in October 2018. …..
>
> Foquest Is a long-acting Methylphenidate product that was initially approved for use in adults for the treatment of ADHD and has since been approved for the treatment of ADHD in children and adolescents. Foquest is formulated with the same technology as Biphentin (which was removed from the M3P medication list in October 2018, thus no longer requiring a triplicate prescription), with the benefit of a significantly longer duration of action. Foquest is in the same class as the other long-acting stimulants, and as such needs to be removed from the M3P medication list.

> Unfortunately there has been much confusion for both physicians and pharmacists regarding the status of Foquest and the M3P medication list. It is not in fact listed as a medication requiring a triplicate prescription, but for some reason this requirement remains. Consequently it is not available to be prescribed electronically as the other long-acting stimulant can now be prescribed. In addition to confusion, this adds a significant level of inconvenience for many patients. For instance, many of my patients reside a fair distance from my office, and so they are required to make a trip (taking time off work) in order to obtain a new prescription.
>
> In discussing this with representatives of the College of Pharmacists of Manitoba, my understanding is that this was simply an oversight in October 2018 as Foquest had only been released in February 2018. Please consider this a formal request to correct this error and have Foquest removed from the triplicate prescription requirement."

When contacted, Dr. Jitender Sareen, Department Head of Psychiatry, University of Manitoba indicated he is in favour of Foquest being removed from the M3P list. Additionally, two psychiatrists at MATC were contacted and indicated their support as well. CPhM supported the removal of Foquest and with their Council meeting scheduled for December 2, 2019, coordinated with CPSM to seek their CPhM Council's approval for removal.

The following is an excerpt from the Briefing Note to Council in September 2018 seeking the removal of Concerta, Vyvanse, and Biphentin, which was approved:

> "Initially a request by a child psychiatrist, the Council of the College of Pharmacists of Manitoba approved the removal of Concerta, Vyvanse, and Biphentin from the M3P drug list at their last meeting on July 23, 2018. Adderall was also considered initially, but ultimately not recommended to their Council.
>
> The College of Pharmacists of Manitoba undertook a consultation amongst their members and found that the most common reasons provided from members that were in full support of removing the stimulants from the M3P program were the following:
>
> - M3P requirements hinder the filling of prescriptions and create challenges for the patient, pharmacist, and the prescriber;
> - Parents unknowingly present with an expired M3P form (especially difficult for divorced parents);
> - Relatively low concern for abuse/misuse/diversion on the basis of experience;
> - Remote locations make it especially challenging for accessing medications within a three day period. Remote locations have limited hours and are sometimes closed on weekends.
>
> Members that were against the removal of these stimulants from the M3P program provided the following reasons:
>
> - These medications still carry a risk for abuse and misuse. There are ways to extract the stimulant from the time release mechanism;
> - Pharmacies are open seven days a week, so a three day window should not pose a problem;

- Currently in the midst of an opioid use/abuse epidemic in North America;
- Families admitting to "drug sharing"; and
- Removal from the M3P is more about convenience than concern for patient safety.

Having reviewed literature evidence and feedback from the members, the College of Pharmacists of Manitoba indicated that the following conclusions can be drawn:

- Sufficient evidence exists to support that long-acting formulations have a lower abuse potential than short-acting formulations;
- Stimulant medication use was unlikely associated with an increased risk of developing substance use disorders;
- The risk of diversion in cases where individuals with ADHD were asked to sell or give away their medications was on average lower than 10%;
- Fourteen out of nineteen members that provided feedback *fully supported* the removal of the four long-acting stimulants from the M3P program.

The College of Pharmacists provided literature reviews on the potential abuse of stimulant medication and a jurisdictional scan on controlled prescription programs focussing on long-acting stimulants.

At its meeting on December 2, 2019 the College of Pharmacists of Manitoba Council reviewed and approved Xyrem (sodium oxybate) oral solution for **addition** to the M3P list.

Xyrem is listed in Schedule I to the *Controlled Drugs and Substances Act* and approved only for use in the treatment of cataplexy. Like other drugs in Schedule I of the CDSA, it has high abuse potential, Xyrem is known as a "date rape drug" and should be included in the M3P list. An issue brief on Xyrem that was presented to CPhM Council is attached.

CPSM and CPhM will prepare a joint notice to the profession to advise of these changes to the M3P list of drugs. Consultation with the registrants and stakeholders is not required to amend a Practice Direction.

PUBLIC INTEREST:

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

Patient safety is extremely important for those drugs listed on this schedule and their prescribing is limited to protect patients and others from the risks inherent in these drugs.

With the removal of Concerta and Vyvanse from the list of M3P drugs, there is no reason for the similar long acting stimulant of Foquest to be included on the M3P list of drugs. The rationale provided to Council previously for Concerta and Vyvanse are the same for Foquest.

Owing to Xyrem's restricted use, high abuse potential, and classification under the Controlled Drugs and Substances Act, Xyrem should be included on the M3P list for patient safety and the safety of others in society.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2019, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

Council approve amending Schedule A to the Manitoba Prescribing Practices Program Practice Direction by **removing** Foquest from and **adding** Xyrem to the list of drugs covered by the Manitoba Prescribing Practices Program.

College of Pharmacists of Manitoba

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APPENDIX A
Issue Brief: Adding Xyrem (sodium oxybate) to the M3P List

Situation

The College received an enquiry regarding the product Xyrem (sodium oxybate), in order to determine if it needs to be written on an M3P prescription form.

Xyrem (sodium oxybate) is not found under the NAPRA drug schedules and is not currently on the M3P list. Sodium oxybate is a gamma-hydroxybutyrate (GHB), which is listed in Schedule I to the Controlled Drugs and Substances Act (CDSA). It is approved by Health Canada only for treating cataplexy (loss of muscle tone) in narcolepsy patients. It has a strong abuse potential and is known as a "date rape drug."

Background

Xyrem (sodium oxybate) is an oral solution indicated for cataplexy in narcolepsy patients. Xyrem can only be prescribed by a physician who has experience in cataplexy treatment and has completed the Xyrem Physician Success Program, a risk management education program for physicians, pharmacists, and patients. The program also restricts distribution of Xyrem to one wholesaler that sends the drug directly to pharmacies in the program as needed. The program maintains a registry of physicians, pharmacies, and patients who have completed program training.

Sodium oxybate is a gamma-hydroxybutyrate (GHB), which is a CNS depressant approved by Health Canada (DIN 02268272). It is known as a drug of abuse, and has been known to cause death in abuse situations. Reports of respiratory depression occurred in clinical trials. It is also associated with confusion, neuropsychiatric events, depression, and suicide. There have been reports of developing dependence to sodium oxybate. The drug is a desirable choice for abuse due to its rapid sedation effects. GHB has been illicitly used socially by young adults.

For more information, see the Xyrem product monograph and Health Canada's Summary Basis of Decision for Xyrem.

Assessment

The Manitoba Prescribing Practices Program (M3P) is a risk management system to minimize drug diversion of narcotics and controlled substances. It would be beneficial to add sodium oxybate to this list, in light also of its abuse potential and severe adverse effects.

College of Pharmacists of Manitoba

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GHB and any of its salts are listed in Schedule I of the CDSA. This Schedule also includes the following drugs which are listed and, in fact, make up the majority of drugs in the M3P program: alfentanil, amphetamines, anileridine, buprenorphine, butorphanol, cocaine, codeine, diacetylmorphine, diphenoxylate, fentanyl, hydromorphone, ketamine, morphine, nalbuphine, naloxone, normethadone, opium, oxycodone, pentazocine, pethidine, sufentanil, and tapendatol. Like sodium oxybate, these are drugs of high abuse potential. It would be appropriate to include sodium oxybate alongside them on the M3P.

Recommendation

The College of Pharmacists of Manitoba therefore recommends that Council support the addition of Xyrem (sodium oxybate) to the Manitoba Prescribing Practice Program (M3P) list. Approval from the College of Physicians and Surgeons is also required for additions to the M3P list.

COUNCIL MEETING – DECEMBER 13, 2019

ITEM FOR INFORMATION

STANDARDS COMMITTEE REPORT:

Context

The council must establish a standards committee that is responsible for supervising the practice of medicine by members and may establish any subcommittees of the standards committee. (RHPA 182.1)

This includes medical audit or peer review and multidisciplinary care audits which are considered primarily educational in nature. (cpsm.mb.ca/standards/central-standards-committee)

Activities

The Central Standards Committee met in September and November.

Twelve elderly physician chart audits were reviewed. Seven were considered acceptable and will be re-audited in five years. Three were given feedback by the auditor and will have a repeat audit to ensure that the feedback is incorporated. Two were asked to participate in a medical record keeping course and will have a repeat audit thereafter.

Three death audits were performed based on referrals from the Chief Medical Examiner and a review of the case by a peer appointed by the College. In one case the care was considered acceptable. Two of the files are still open pending a second medical reviewer.

Review of Standards activities in other provinces showed that no other province has a Central Standards Committee or equivalent, and none have an equivalent of the Evidence Act which facilitates Standards activities.

Subcommittees

There are 2982 licenced medical practitioners in Manitoba. During the past year 433 charts were audited by subcommittees. Most of those come from a few active subcommittees. Of note WRHA Women's Health, VGH surgery, WRHA Family Medicine, Interlake Eastern, and St Claude/Emerson/ Treherne accounted for 421 of those 433.

Conclusions

Roughly 448 physicians out of 2982 licenced members ie 15% have had supervision by the Central Standards Committee and its subcommittees. The supervision is very unevenly distributed with most of this occurring in WHRA Women's Health, and a few rural hospitals.

Plans

1. Improve communication with subcommittees. Request specific data such as number of charts reviewed and actions taken.
2. Work with QI committee to increase number and targeting of chart audits done by Standards.
3. Refine chart audit techniques to improve validity, reliability, and efficiency.
4. Develop measurable outcomes of supervision to report to Council.
5. Direction from Council is welcome.

Respectfully submitted,
Dr. Roger Suss
Chair, Central Standards Committee

COUNCIL MEETING – DECEMBER 13, 2019

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Accredited Facilities Bylaw Amendments

BACKGROUND:

The Program Review Committee approves the accreditation of diagnostic facilities in which services are performed by registrants of the College. This includes diagnostic facilities that are under the jurisdiction of the Manitoba Government, including those belonging to hospitals, regional health authorities, Shared Health, and the former Diagnostic Service Manitoba, now operating under Shared Health. These are generally laboratories or diagnostic imaging facilities.

The College has entered into a Service Purchase Agreement with the Manitoba Government whereby the College receives funding to administer the Manitoba Quality Assurance Program to accredit these diagnostic facilities, including those that are owned and operated by and under the jurisdiction of the Manitoba Government.

There are several changes to the bylaw proposed.

1 – Cooperate with MANQAP Inspectors, s. 2.8

Amendments are proposed to specifically require, as part of the accreditation process, the facility director (physician) and personnel to cooperate fully with MANQAP, as per s. 2.8. This would permit access to inspect the premises and equipment, inspection of records, obtaining samples, and answering questions. Currently, the facilities have generally cooperated, but there have been instances of refusal to do so initially. This proposed section clearly will require such full cooperation.

2 – Accreditation Status Reviewed, s. 2.17

The current bylaw provides that accreditation status can be reviewed if the ownership or director changes. These are very limited grounds for review and would not include if there were safety concerns. The proposed change is to grant the power to review at the discretion of the Committee.

3 – Variance and Renewal of Accreditation, s. 4.2 and 5.2

The process for a variance or renewal is slightly different than for a new accreditation. For instance, if varying the accreditation for merely adding or deleting a procedure, then the process can be significantly abridged as compared to the initial accreditation.

4 – Qualifications and Competence of Laboratory/Radiology Technologists, s. 7.8.7, 7.8.8, and 7.8.9

The current bylaw provides that persons providing services must have appropriate qualifications but does not establish what those qualifications are. The Program Review Committee recently denied an application for accreditation on the basis that the person who would be performing the diagnostic laboratory tests was not appropriately qualified because they had not undertaken an accredited medical laboratory technician/assistant training program. The Program Review Committee placed great value in these educational programs to provide deeper context and understanding of the diagnostic tests being administered and considered this to be a significant factor in minimizing risk to patients, thereby enhancing patient safety.

5 - Other Minor Changes

There are other minor changes throughout the bylaw which are highlighted.

The Program Review Committee only met and reviewed these proposed amendments on September 4, 2019, after Council's agenda and materials were distributed on August 30, 2019. Accordingly, these could not be included in Council's materials at that time.

PUBLIC INTEREST RATIONALE:

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

Quality Assurance, and thereby patient safety, is the fundamental rationale for this accreditation program operated by MANQAP within the College. Each of these proposed amendments will enhance patient safety by improving the ability of MANQAP to perform its duties for accreditation and for the Program Review Committee to determine whether to accredit a diagnostic facility. Diagnostic testing must be carried out extremely carefully to ensure patient safety and these amendments should minimize risk of harm to the patient.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 13, 2019, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

The attached amendments to the Accredited Facilities Bylaw be approved as presented.

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

Accredited Facilities Bylaw

(Under Section 183 of The Regulated Health Professions Act)

The College of Physicians and Surgeons of Manitoba

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba on November 22, 2018 repealing and replacing Bylaw #3 and 3D under The Medical Act)

Effective Date January 1, 2019

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Preamble

Prior to making this Bylaw, the Minister must be provided with a copy of the proposed bylaw for review and Council must review and consider any comments made, pursuant to s. 183 of the RHPA.

PART A – DIAGNOSTIC FACILITIES

Application of this Part

Part A of this Bylaw applies as follows:

1. Pursuant to The Regulated Health Professions Act(RHPA), ss 183(1)[1], to all diagnostic facilities in Manitoba in which services are performed by members of the College, other than those under the jurisdiction of the provincial or municipal governments and those designated as hospitals under *The Health Services Insurance Act, and a facility or class of facilities exempted by Regulation from the application of s.183(1) of the RHPA*.

2. Pursuant to *s.183(15)[2] of the RHPA* and pursuant to the Service Purchase Agreement made between the College of Physicians and Surgeons of Manitoba and the Government of Manitoba governing diagnostic facilities, to those diagnostic facilities falling within the jurisdiction of the Government of Manitoba as specified in the Service Purchase Agreement.

Article 1 - Definitions

1.1. In Part A of this ~~b~~Bylaw:

1.1.1. "**accreditation**" means a review process conducted by the College to determine whether the facility being reviewed meets ~~or exceeds~~ the standards specified by the College.

[1] 183(1) This section applies to any facility in which a member performs or causes to be performed diagnostic or treatment services, such as a non-hospital medical or surgical facility or a nuclear medicine facility, other than
(a) a facility that is designated as a hospital under *The Health Services Insurance Act*;
(b) a hospital or health care facility operated by the government, the government of Canada or a municipal government; and
(c) a facility or class of facility exempted by regulation from the application of this section.

[2] 183(15) The council may enter into agreements with the government, the government of Canada or a municipal government to make this section applicable to any facility or any part of a facility that falls within that government's jurisdiction.

1.1.2. **“anatomic pathology ~~facility~~ laboratory”** means a place where human surgical tissue biopsies and specimens, cytologic**al** specimens and autopsies are examined for diagnostic purposes.

1.1.3. **"certificate of accreditation"** means a certificate issued under this ~~b~~**B**ylaw.

1.1.4. **“clinical pathology laboratory”** means a place where diagnostic testing is performed on human samples including the disciplines of chemistry, hematology, ~~blood banking~~ **transfusion medicine**, cytology, immunology, microbiology, virology, histology or pathology.

1.1.5. **“Committee”** means the Program Review Committee of the College.

1.1.6. **“diagnostic imaging facility”** means a place where imaging techniques are used for diagnostic purposes including radiography, ultrasound, computed tomography, magnetic resonance imaging, fluoroscopy**,** ~~**or**~~ mammography **or nuclear medicine** ~~but does not include a physician’s office where ultrasound is done by a physician or under a physician’s supervision for the diagnosis of the physician’s own patients~~.

1.1.7. **“facility”** means a place or a vehicle, whether privately owned or affiliated with or administered by a hospital or other health facility, which is principally equipped to perform a procedure normally performed in an anatomic pathology ~~facility~~ **laboratory**, a clinical pathology laboratory, a diagnostic imaging facility **or a patient service centre**~~, a nuclear medicine facility, or a short list laboratory~~. A clinical pathology laboratory facility may be comprised of a primary location, which is its laboratory, and one or more patient service centres.

1.1.8. **“facility director”** means a physician appointed as director of a facility in accordance with this bylaw and is synonymous with the term “medical director” used in section 183(3) of the RHPA.

~~1.1.9. **“nuclear medicine facility”** means a place where patients are imaged using radiopharmaceuticals or where patients are treated through the use of radiopharmaceuticals, or where radioimmunoassays are performed.~~

1.1.10. **“patient service centre”** means a location ~~operated by a clinical pathology laboratory~~ for the collection **and/or testing** of specimens of blood and of body fluids for the purpose of testing in an accredited laboratory.

1.1.11. **“physician office laboratory”** means a physician’s office where specimens are collected **and tested** by the physician or **a laboratory technician/assistant qualified by training from an accredited medical laboratory technician/assistant training program and is certified or eligible for**

certification with the Canadian Society of Medical Laboratory Science ~~an employee under the physician's supervision~~ for the diagnosis of the physician's own patients.

~~1.1.12. **"short list laboratory"** means a laboratory which limits its services to those tests listed in the Manitoba Health Physician's Manual as short list procedures.~~

1.1.13. **"standards"** means the standards ~~established~~ **approved** by Council for facilities.

1.1.14. **"vehicle"** means a device in, upon or by which diagnostic equipment is transported upon a roadway and which is:

1.1.14.a. used primarily for the purpose of offering diagnostic services; and

1.1.14.b. has the approval of the Government of Manitoba to offer diagnostic services in Manitoba but does not include an emergency vehicle as defined in *The Highway Traffic Act*.

1.1. In this ~~b~~**B**ylaw, words and phrases defined in *The RHPA* have the same meaning as in the *RHPA*.

Article 2 - Facility Accreditation

2.1. A facility is required to obtain accreditation before it offers any services to the public.

2.2. Accreditation of a facility must be:

2.2.1. except in the case of a vehicle, for a specific address or addresses.

2.2.2. for the fixed period of time determined by the Committee, to a maximum of 5 years.

2.2.3. for the procedures specified ~~in~~ **with** the certificate of accreditation.

~~2.3. Accreditation of a clinical pathology laboratory may be for its primary location and for some or all of its patient service centres. Accreditation may be granted to or withdrawn from any one or more of the primary locations and its patient service centres.~~

2.4. In the case of a vehicle, the facility must provide a current mailing address for the owner and the operator of the service.

2.5. Prerequisites to full accreditation of a facility pursuant to this By-law are:

2.5.1. compliance with the relevant standards; and

2.5.2. appointment of a facility director acceptable to the Committee.

2.6. The Committee must establish and make available on request:

2.6.1. standards for each type of facility.

2.6.2. the accreditation process for each type of facility~~., which may include but is not limited to:~~

~~2.6.2.a. completion of a pre-inspection questionnaire in a manner satisfactory to the Committee.~~

~~2.6.2.b. an on-site inspection by one or more health care professionals who have expertise in the appropriate area of practice and who are designated by the Committee to conduct the inspection.~~

~~2.6.2.c. review of the facility's compliance with the relevant standards.~~

2.6.3. the Committee's policies governing the accreditation process for each type of facility.

2.7. Applications for accreditation of a facility must be made to the Committee by the facility director, on the forms prescribed by the Committee, and must contain the information required by the Committee.

2.8. **A facility director and personnel who are subject to the accreditation process must cooperate fully which includes but is not limited to:**

2.7.1 permitting inspectors to enter the facility and inspect the premises and all diagnostic equipment located therein.

2.7.2 permitting inspectors to inspect all records pertaining to the provision of services and providing copies of the same if so requested.

2.7.3 providing requested samples or copies of any material, specimen, radiological image or product originating from the diagnostic service.

2.7.4 answering questions posed by the inspectors as to the procedures or standards of performance relating to examinations/procedures performed.

2.9. Where an inspection is conducted as part of the accreditation process, **and deficiencies are observed,** the Committee must issue a report of the inspection and must provide a copy of the report to the applicant.

Full Accreditation

2.10. Where a facility fully complies with the relevant standards, the Committee will grant full accreditation and will specify ~~in~~ **with** the certificate of accreditation the procedures for which the facility is accredited.

Accreditation Not Granted

2.11. Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to the Executive Committee.

Conditional Accreditation

2.12. Where a facility does not fully comply with the relevant standards, but the Committee is of the opinion that it is in the public interest to permit the facility to operate while it corrects specified deficiencies, the Committee may grant conditional accreditation.

2.13. Where conditional accreditation is granted, the Committee must:
- 2.13.1. provide written notice of its decision and the reasons therefor and **the** information on the right of appeal to the Executive Committee.
- 2.13.2. state in its decision a fixed deadline for the facility to comply with all relevant standards and for the facility director to provide written confirmation of compliance to the Committee.
- 2.13.3. state in its decision whether a follow-up inspection must occur before full accreditation may be granted.

2.14. The Committee may extend the deadline for compliance with standards fixed pursuant to Article 2.10 if, in its sole discretion, the Committee deems it appropriate to do so.

2.15. Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:
- 2.15.1. direct an inspection.
- 2.15.2. withdraw the conditional accreditation and if the facility is publicly owned, report the matter to government with the request that the government require the facility to cease operation.

2.16. If the Committee is of the opinion that it is unsafe for the facility to provide services, **it must** direct the Registrar to notify the public of the deficiencies and to require that physicians not use the diagnostic facility.

Accreditation Status Review

2.17. Accreditation status ~~will~~ **may** be reviewed **at the discretion of the Committee** ~~if the facility ownership changes or the facility director changes~~.

Temporary Accreditation

2.18. Temporary ~~approval~~ **accreditation** may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.

Article 3 – Maintenance of Accreditation

3.1. In order to maintain accreditation, a facility must:
- 3.1.1. comply with the relevant standards.
- 3.1.2. perform only the procedures permitted pursuant to the facility's certificate of accreditation.
- 3.1.3. at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect.
- 3.1.4. cooperate with and participate in the inspection process approved by the Committee for its type of facility.

3.2. ~~If d~~**D**uring the currency of a full or conditional accreditation, ~~the Committee is of the opinion that a facility may not meet the relevant standards of practice or is not in compliance with the requirements of the Act, the Regulations, this Bylaw or relevant Standards of Practice,~~ the Committee may direct an inspection for the purpose of monitoring compliance**, if the Committee is of the opinion that:**
- 3.2.1 a facility may not meet the relevant standards or practice.
- 3.2.2 an inspection would be in the public's best interest.

Article 4 – Variance of Accreditation

4.1. A facility may apply at any time to vary its accreditation.

~~4.2. The accreditation process on a request to vary is the same as the process for initial accreditation.~~

Article 5 – Renewal of Accreditation

5.1. In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation.

~~5.2. The accreditation process for a renewal is the same as the process for initial accreditation.~~

Article 6 – Cancellation of Accreditation

6.1. Where a facility is no longer providing patient services, the Committee may cancel the facility's accreditation.

6.2. Council may cancel accreditation in accordance with The Regulated Health Professions Act.

Article 7 – Facility Director

7.1. A facility must have a facility director.

7.2. A facility director must be a physician whose credentials are acceptable to the Committee.

7.3. The Committee must establish and make available on request the qualifications for facility directors in each type of facility.

7.4. The facility director is responsible for granting privileges to any physician who wishes to work for the facility and notifying the Committee of the physicians who are granted privileges. Before granting privileges to any physician a facility director must:

7.4.1. define in writing the qualifications and competencies required in order to obtain privileges in each field of practice.

7.4.2. obtain written confirmation that the applicant is registered and licensed to practice medicine in Manitoba.

7.4.3. obtain full particulars of the applicant's education, training, competencies and experience.

7.4.4. take reasonable steps to ensure that the applicant has the education, training competencies and experience required, and that the applicant is otherwise a suitable candidate for privileges.

7.5. Within one year of first granting privileges to a physician, the facility director must review that physician's privileges. Thereafter, privileges must be reviewed by the facility director at least every two years.

7.6. Before granting renewal of privileges or extending the existing privileges of any physician, the facility director must take reasonable steps to ensure that the physician has the education, training, competencies and experience required for each field of practice for which he or she is seeking privileges within the facility.

7.7. The facility director must have effective control of and be responsible for the safe operation and administration of the facility, the supervision of all professional, technical and administrative activities of the facility, and for compliance with this ~~b~~Bylaw and with the relevant standards established by the Committee.

7.8. Without limiting the generality of the foregoing, the facility director must:

7.8.1. have access to all records and documents relating to the operation of the facility and the procedures performed therein.

7.8.2. communicate with any facility under his/her direction a minimum of once per year.

7.8.3. ensure that quality management system requirements and improvement programs are in place.

7.8.4. ensure that the facility has current up to date policies and manuals as required by the standards for that facility.

7.8.5. ensure that complete and accurate patient records and documentation relating to the operation of the facility and procedures performed are kept.

7.8.6. ensure that no procedure is carried out in the facility unless it is permitted by the certificate of accreditation.

7.8.7. ensure that technologists have the qualifications as provided by training from an accredited:

7.8.7.a. medical laboratory training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.

7.8.7.b. medical radiology technology training program and are certified or eligible for certification with the Canadian Association of Medical Radiology Technologists.

7.8.8. ensure that medical laboratory technologists who are required to perform x-ray examinations and medical radiology technologists who are required to perform laboratory testing have graduated from a cross-training program.

7.8.9. Ensure that laboratory technicians/assistants have the qualifications as provided by training from an accredited medical laboratory technician/assistant training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.

7.8.10. ensure that persons who provide services to the facility ~~have appropriate qualifications and~~ maintain competence to perform the procedures for which the facility is accredited.

7.8.11. ensure that work referred out of the facility is performed by persons with appropriate qualifications and competence to perform the work.

7.8.12. promptly notify the College of any change in the ownership or directorship of the facility.

7.8.13. promptly notify the College if the facility is no longer providing patient services.

7.8.14. where applicable, be available for consultation with referring physicians.

7.8.15. promptly notify the Committee if there is a major change in the following:

7.8.15.a. equipment.

7.8.15.b. the accredited list of diagnostic imaging examinations, laboratory or transfusion medicine tests, or blood and blood products dispensed.

7.8.16. Ensure that the duties and responsibilities of all personnel are written and understood;

7.8.17. Ensure adequate quality assurance and improvement programs are in place

7.9. The facility director must submit to the College such ~~annual report forms~~ **information** as required by the Committee.

Article 8 - Appeal

8.1. The facility or a physician who has been adversely affected by a decision of the Committee may appeal the decision of the Committee**. The appeal must be made by filing a written notice of appeal with the Council within 30 days after the person receives notice of the decision. The notice of appeal must specify the reasons for the appeal** ~~by filing a Notice of Appeal in writing with the Registrar within thirty days of the decision, and the appeal process shall be in accordance with policies established by Council~~.

Article 9 - Fees

9.1. A privately-owned facility must pay all expenses, charges and fees incurred by the College in relation to the accreditation or inspection of that facility.

~~9.2. Each facility must pay any licence fees fixed by resolution of the Council of the College as payable by facilities for the purpose of recovering the cost of administering this bylaw.~~

Article 10 – Physician Office Laboratory

10.1. Physicians must not operate a physician office laboratory without first obtaining the written approval of the College.

~~10.2. A physician who operates a physician office laboratory with the approval of the College does not require accreditation of the facility where physician office laboratory procedures are performed.~~

10.3. The Committee may direct the inspection of any facility where physician office laboratory procedures are performed.

Article 11 – Standing

~~11.1. Upon the request of a facility, the Committee may issue a letter confirming the facility's standing.~~

Article 12 - Transition

12.1. A facility that holds accreditation at the time this ~~b~~Bylaw comes into force continues to hold that accreditation status under this ~~b~~Bylaw in accordance with the terms of that accreditation.

12.2. A facility which has not undergone the accreditation process will be notified in writing by the College that it is exempt from the requirement of accreditation set forth in this ~~b~~Bylaw until the inspection process for that facility is complete and a report is issued, but the facility must cooperate with the College for the timely completion of its accreditation process in accordance with this ~~b~~Bylaw.

12.3. A physician who holds a facility directorship at the time this bylaw comes into force continues to hold that status under this ~~b~~Bylaw.

~~12.4. A physician who holds privileges in a facility at the time this bylaw comes into force continues to hold those privileges until <<DATE>> or the date on which the facility director has met the requirements of Article 7 of this bylaw for privileging within the facility, whichever is earlier.~~

PART B – NON-HOSPITAL SURGICAL FACILITIES

Article 13 - Application of this Part

13.1 Subject to section 183 of the RHPA and Article 13.3 of this Bylaw, Part B of this Bylaw applies to all non-hospital medical/surgical facilities that carry out diagnostic and treatment procedures.

13.2 Subject to Article 13.3, Part B of this Bylaw applies to the following procedures:

13.2.1 Any procedure that is carried out with the concurrent use of:

13.2.1.1 procedural sedation, or

13.2.1.2 local, regional or general anesthesia,

provided that the standard of care requires monitoring of vital signs as a result of the administration of the drug to induce sedation or anesthesia;

13.2.2 Any procedure that the Committee directs must be performed in an approved non-hospital surgical/medical facility in order to meet the minimum acceptable standard of care for that procedure.

13.3 This Part of the Bylaw does not apply to any facility which is wholly owned and operated by a Regional Health Authority.

Chief Medical Examiners' Death Review

A component of the CPSM Prescribing Practices Program

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Kernjeet Sandhu MD, CCFP

CPSM Prescribing Practices Program

- **Chief Medical Examiners' Death Review**
- High Dose Opioid Prescribing Review
- CPSM Opioid Prescriber Profile
- Fentanyl Prescribing Review
- Generic Oxycontin Prescriber Education
- OAT Prescriber Training, Mentoring and Auditing
- Opioid Prescribing Standard and Resources
- Individual Informal Case Support/Mentoring

Learning Objectives

- **At the conclusion of this activity, participants will be able to:**
- Describe the history of the CPSM's involvement with the Chief Medical Examiners Office
- Describe the Chief Medical Examiners' Death Review Process
- Discuss important observations regarding recent changes in MB's death trends
- Propose how lessons learned from local, provincial death data should transform physician prescribing practices
- Propose how this data may inform regulatory approaches moving forward

Polling Questions:

1. Between 2013-2018 in Manitoba, which opioid is responsible for the largest number of overdose deaths, either as primary cause or as a major contributing factor?

a) Fentanyl
b) Carfentanyl
c) Codeine
d) Tramadol
e) Oxycodone

Polling Questions:

2. In 2018 in Manitoba, which benzodiazepine contributed to the largest number of overdose deaths?

a) Alprazolam
b) Diazepam
c) Temazepam
d) Bromazepam
e) Lorazepam

Polling Questions:

3. In Manitoba, most opioid overdose deaths can be attributed to:

a) A single prescribed opioid
b) Multiple prescribed opioids
c) A single illicit opioid
d) One or more opioids combined with multiple other drugs
e) Opioids in combination with alcohol

Polling Questions:

4. In Manitoba between 2014-2017, which two drug classes were the top contributors to opioid overdoses?

a) Alcohol and benzodiazepines
b) Antipsychotics and antidepressants
c) Benzodiazepines and antidepressants
d) Statins and antihypertensives
e) Benzodiazepines and Z-drugs

Polling Questions:

5. In Manitoba in 2018, which two over-the-counter ingredients contributed to the largest number of deaths?

a) Acetaminophen and ASA
b) Acetaminophen and pseudoephedrine
c) Diphenhydramine and dextromethorphan
d) Dextromethorphan and acetaminophen
e) Ibuprophen and desloratadine

Chief Medical Examiners' Death Review

A component of the CPSM Prescribing Practices Program

Chief Medical Examiners' Death Review

- Relationship initiated by the previous ME who was concerned regarding the number of prescription drug related deaths
- Reviewers: 4 medical consultants with extensive primary care experience in the management of pain, addiction and mental health concerns.
- **Adult Inquest Review Committee**
- All deaths involving prescription medications undergo detailed review
- No chart information unless we ask for it (high volume and educational process and meant to prompt self-reflection)
- Methadone; buprenorphine/naloxone deaths

Chief Medical Examiners' Death Review

- Prescribers receive standard cover letter plus relevant resources if needed
- Plus summary of the ME report highlighting the manner of death, cause of death, notable circumstances of death, toxicology findings and summary of relevant DPIN data
- Feedback to prescribers in 3 categories:
  - FYI
  - Rx'bing falls outside of guidelines (standardized evidence-based quality indicators, e.g. concomitant opioids and benzo's); includes resources
  - Significant concerns (rare)

Chief Medical Examiners' Death Review

- Once 3 letters to the same physician – individualized letter to ask for reflection, learning needs identified and plan established to address those learning needs
- May include feedback regarding unidentified learning needs
- Response back to Registrar
- Outcomes thus far - Referral to Standards (1 case)
  - Referral to Investigations (1 case)
  - OAT "for cause" Practice Audit (1 case in new year)
  - One case pending response from the physician

Discussion??

Caution: ++ labor intensive work

Glen

- 44 y/o male
- Working full time as a project manager for a construction company.
- History of hypertension, GERD, heavy smoking and prescription drug abuse in his 20's. He was successfully treated for Hepatitis C in his early 30's.
- Non drinker.
- Known to have had an argument with his common law partner the night before..
- Found unresponsive face up on his bed the following morning.
- No threats of suicide or suicide note

Case discussion - Glen

- DPIN:
- Tylenol #3 240 tabs q 60 days
- Alprazolam 1mg 180 tabs q 60 days
- Temazepam 30mgs 60 tabs q 60 days
- Cyclobenzaprine 10mgs 180 tabs q 60 days
- Quetiapine 200mgs 120 tabs q 60 days
- Enalapril, HCTz, esomeprazole and ferrous gluconate
- ……last delivered 9 days prior to death

ME's report:

- **COD:** Acute multidrug toxicity
- **Manner of death:** Undetermined
- **Toxicology:** codeine (free) 2310 ng/ml (10 - 100)
  morphine (free) 22 ng/ml
  temazepam 3180 ng/ml (600 - 900)
  ethanol 0 mg/dl
  cyclobenzaprine 510 ng/ml (3-23)
  norcyclobenzaprine 120 ng/ml

Discussion..

DPIN:

- Tylenol #3 240 tabs q 60 days
- Alprazolam 1mg 180 tabs q 60 days
- Temazepam 30mgs 60 tabs q 60 days
- Cyclobenzaprine 10mgs 180 tabs q 60 days
- Quetiapine 200mgs 120 tabs q 60 days
- Enalapril, HCTz, esomeprazole and ferrous gluconate
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Toxicology:

- codeine (free) 2310 ng/ml (10 - 100)
- morphine (free) 22 ng/ml
- temazepam 3180 ng/ml (600 - 900)
- ethanol 0 mg/dl
- cyclobenzaprine 510 ng/ml (3-23)
- norcyclobenzaprine 120 ng/ml

Bill

- 53 y/o male
- History of poorly controlled diabetes, for which he was hospitalized in Dec, 2017.
- A fall on Jan 14th, 2018 for which he was brought into hospital and found to only have a minor neck injury.
- A dental infection requiring antibiotic therapy.
- And remote surgeries to remove a portion of his pancreas and one kidney.
- Was complaining of not being able to ambulate the morning of his death
- Found dead in bed during the afternoon of January 25th, 2018.
- No threats of suicide or suicide note (per ME report)

Case discussion – Bill

DPIN :

Tylenol #3

- 180 tabs for 20 days Dispensed Jan 22, 2018 (Dr. A)
- 12 tabs for 4 days dispensed Jan 20, 2018 (Dr. B)
- 30 tabs for 7 days dispensed Jan 15, 2018 (Dr. C)
- 180 tabs for 30 days dispensed Dec 21, 2017 (Dr. A)
- 8 tabs for 2 days dispensed Dec 17, 2017 (Dr. D)
- 120 tabs for 30 days dispensed Dec 13, 2017 (Dr. E)
- 180 tabs for 30 days dispensed Nov 23, 2017 (Dr .A)
- 30 tabs for 28 days dispensed Nov 8, 2017 (Dr. F)

222 tablets dispensed within10 days of patient's death
Date of death: Jan 25, 2018

DPIN Overview continued

Tylenol #3

- 28 tabs for 14 days dispensed Oct 25, 2017 (Dr. G)
- 30 tabs for 28 days dispensed Oct 19, 2017 (Dr. F)
- 30 tabs for 7 days dispensed Oct 7, 2017 (Dr. H)
- 30 tabs for 3 days dispensed Sept 27, 2017 (Dr. H)
- 30 tabs for 5 days dispensed Sept 12, 2017 (Dr. I)
- 30 tabs for 3 days dispensed Aug 29, 2017 (Dr. C)
- 20 tabs for 4 days dispensed Aug 24, 2017 (Dr. B)

DPIN overview continued

Tylenol #3

- 30 tabs for 10 days dispensed Aug 20, 2017 (Dr. B)
- 40 tabs for 13 days dispensed Aug 9, 2017 (Dr. B)
- 20 tabs for 5 days dispensed Aug 3, 2017 (Dr. J)
- 28 tabs for 7 days dispensed July 26, 2017 (Dr. K)
- 30 tabs for 5 days dispensed July 16, 2017 (Dr. L)
- 30 tabs for 8 days dispensed July 10, 2017 (Dr. M)
- 15 tabs for 4 days dispensed July 4, 2017 (Dr. N)

DPIN overview continued

Other sedating medications:

- dimenhydrinate 50 mg 20 tabs for 5 days dispensed Jan 22, 2018 (Dr. A)
- Gabapentin 300 mg 60 tabs for 30 days dispensed Jan 22, 2018 (Dr. A)

- Zopiclone 7.5 mg 45 tabs for 30 days dispensed Jan 22, 2018 (Dr. A)
- Zopiclone 7.5 mg 30 tabs for 30 days dispensed Dec 17, 2017 (Dr. D)
- Zopiclone 7.5 mg 30 tabs for 30 days dispensed Dec 13, 2017 (Dr. E)
- Zopiclone 7.5 mg 45 tabs for 30 days dispensed Nov 23, 2017 (Dr. A)

105 zopiclone tablets dispensed in less than one month

- Cyclobenzaprine 10 mg 10 tabs for 5 days (Dr. C)

DPIN overview continued

Morphine SR 15 mg

- 45 tabs for 14 days dispensed Oct 13, 2017 (Dr. J)
- 45 tabs for 14 days dispensed Sept 29, 2017 (Dr. J)
- 45 tabs for 14 days dispensed Sept 16, 2017 (Dr. J)
- 45 tabs for 14 days dispensed Sept 3, 2017 (Dr. J)
- 45 tabs for 15 days dispensed Aug 19, 2017 (Dr. P)
- 45 tabs for 15 days dispensed Aug 5, 2017 (Dr. P)
- 45 tabs for 15 days dispensed July 22, 2017 (Dr. P)

ME's report

- COD: Bronchopneumonia and Mixed drug intoxication (significant contributor)
- Manner of death: Accidental
- Toxicology: all alcohols negative

  codeine (free) 690 ng/mL (10 -100)

  morphine (free) 12 ng/mL (10 - 80)

  hydrocodone 14 ng/mL (2-24)

  diphenhydramine 865 ng/mL (14-112)

  gabapentin 58 ug/mL (2-20)

  zopiclone 319 ng/mL (25-65)

  cyclobenzaprine and norcyclobenzaprine below limit of quantitation

  acetaminophen (presumptive)

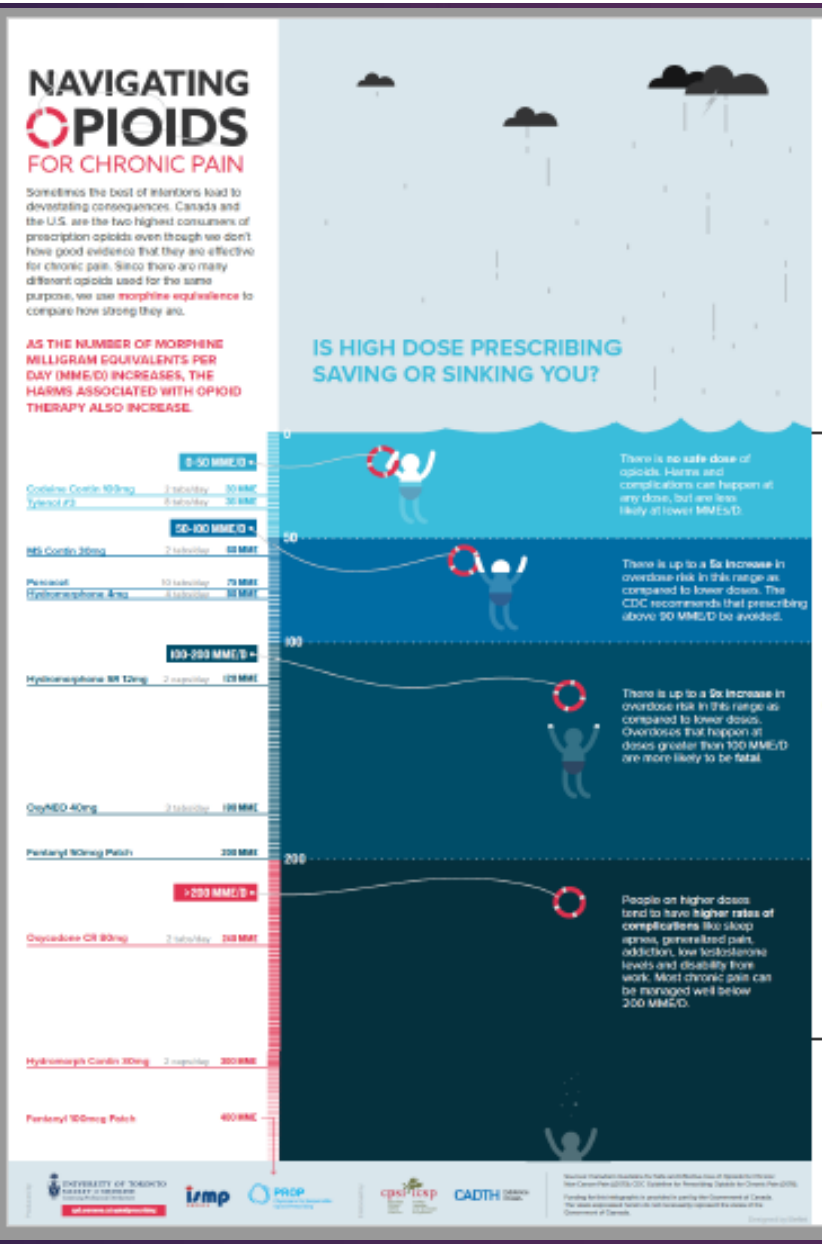
Discussion..

DPIN:

- **Tylenol #3** 222 tablets dispensed within10 days of patient's death
- **Dimenhydrinate** 50 mg 20 tabs for 5 days dispensed Jan 22, 2018
- **Gabapentin** 300 mg 60 tabs for 30 days dispensed Jan 22, 2018
- **Zopiclone** 105 tablets dispensed in less than one month starting Dec 13th, 2018
- **Cyclobenzaprine** 10 mg 10 tabs for 5 days

Toxicology:

- **codeine (free) 690 ng/mL (10 -100)**
- **morphine (free) 12 ng/mL (10 - 80)**
- **hydrocodone 14 ng/mL (2-24)**
- **diphenhydramine 865 ng/mL (14-112)**
- **gabapentin 58 ug/mL (2-20)**
- **zopiclone 319 ng/mL (25-65)**
- **cyclobenzaprine and**
- **norcyclobenzaprine below limit of quantitation**
- **acetaminophen (presumptive)**



Updated March 1, 2018

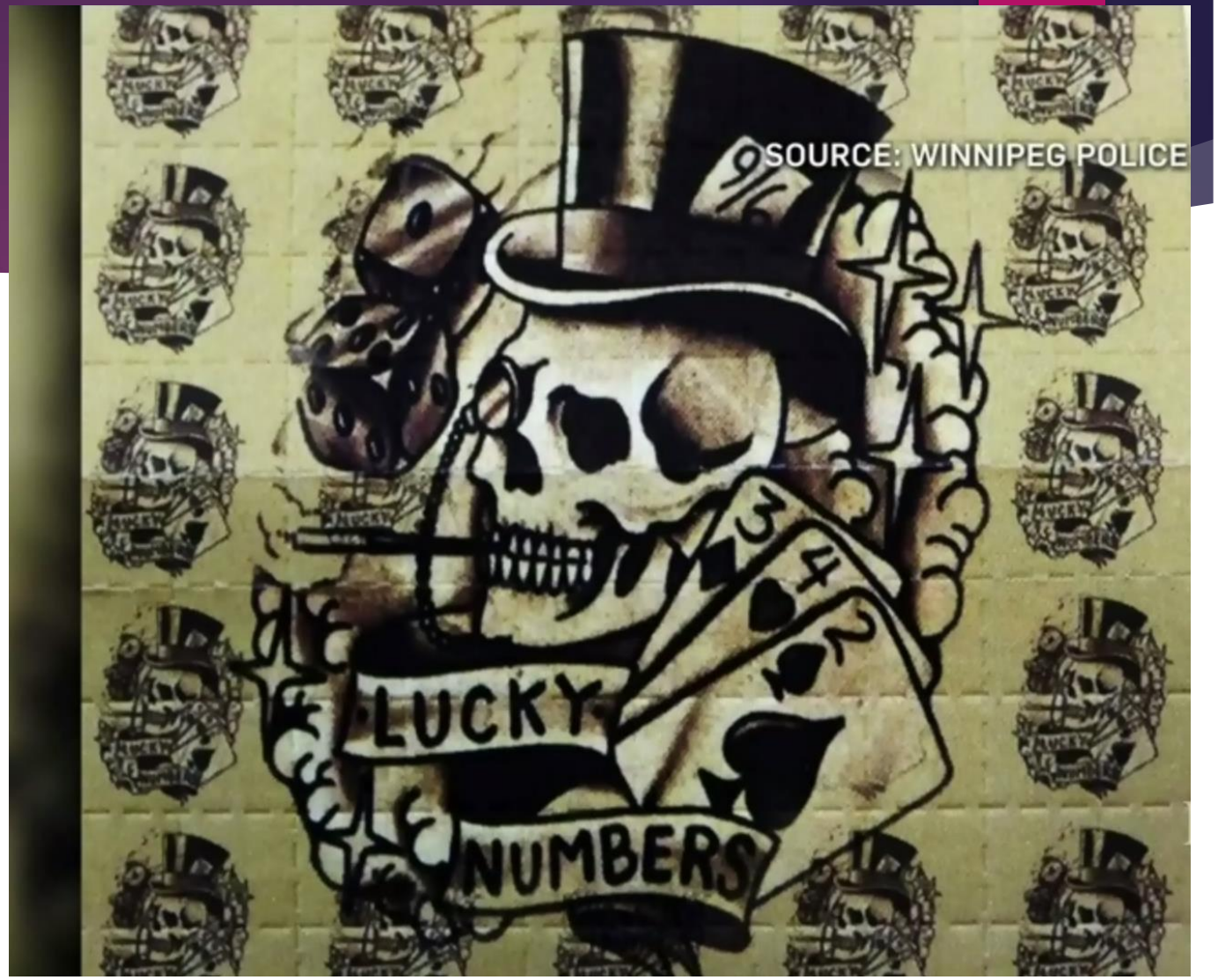
Number* of Unique Patients in Manitoba with "Average Morphine Equivalence Per Day"**

Ave. MME Per Day	Q4 2017: Oct. 1 2017 to Dec. 31, 2017 # Unique Patients	Q4 2017: Oct. 1 2017 to Dec. 31, 2017 Proportion of Unique Patients	% Var. # Unique Patients from Prev. Year	Q4 2016: Oct. 1 2016 to Dec. 31 2016 # Unique Patients	Q4 2016: Oct. 1 2016 to Dec. 31 2016 Proportion of Unique Patients
0 to 50	4,203	45.2%	↑ 1.8%	4,128	44.5%
50 to 90	2,365	25.5%	↑ 4.0%	2,273	24.5%
90 to 200	1,937	20.8%	↓ (0.7%)	1,951	21.0%
>200	787	8.5%	↓ (14.6%)	922	9.9%
	9,292	**100.0%**	**↓ (2.5%)**	**9,274**	**100.0%**

*Data source is DPIN, excludes Long Term Care & Palliative Care clients; does not include drugs dispensed in hospital. Includes fentanyl.
** MME Per Day Calculated by taking Total MME divided by Days Supply

Non prescription Fentanyl

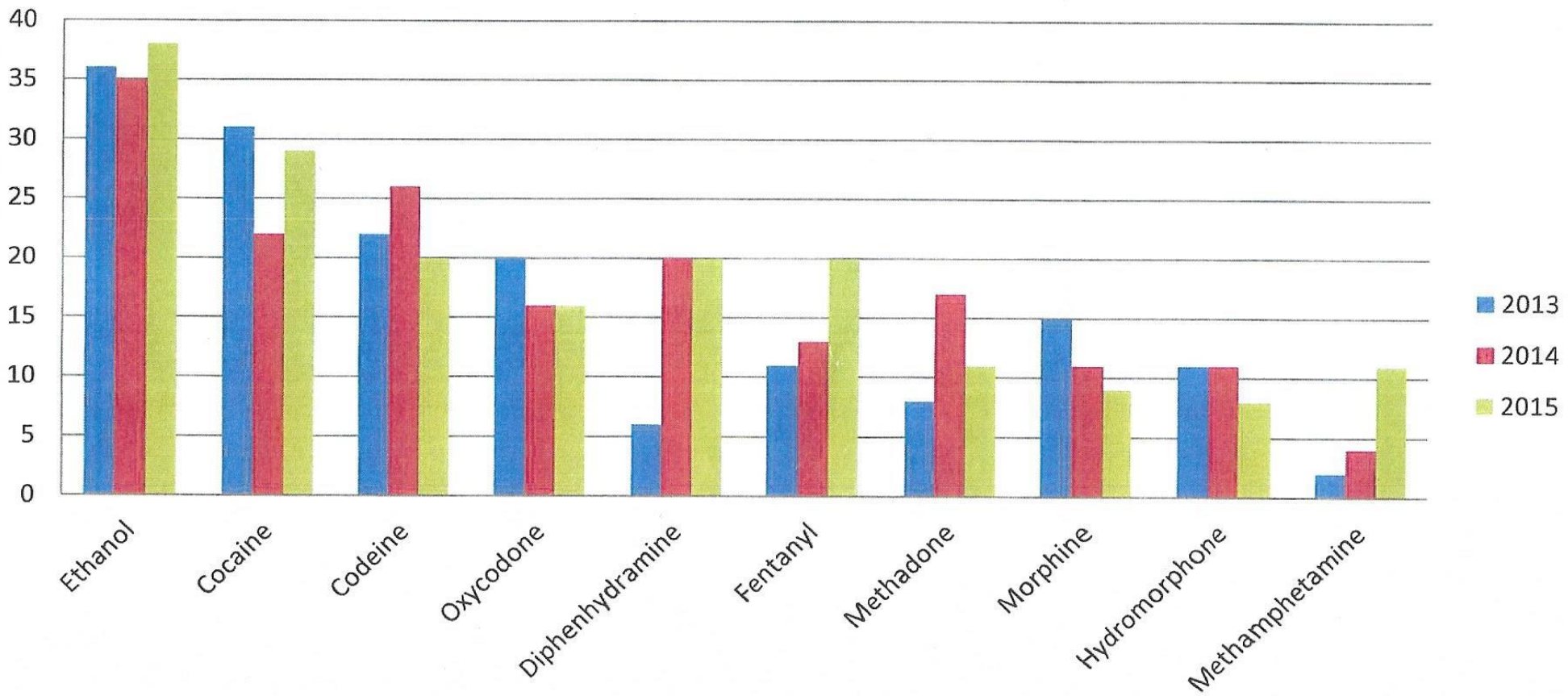
- Fentanyl smuggled in from China on west coast. Available through internet pharmacies
- Different formulations of fentanyl with varying strengths (carfentanil)
- Attainable from internet pharmacies – 1 kg goes a long way (100K street value)
- Adulterated into other drugs:
  - West coast heroin 70%
  - Local – adulterated into powdered cocaine, crystal meth, fake oxys.
  - Blotter tabs

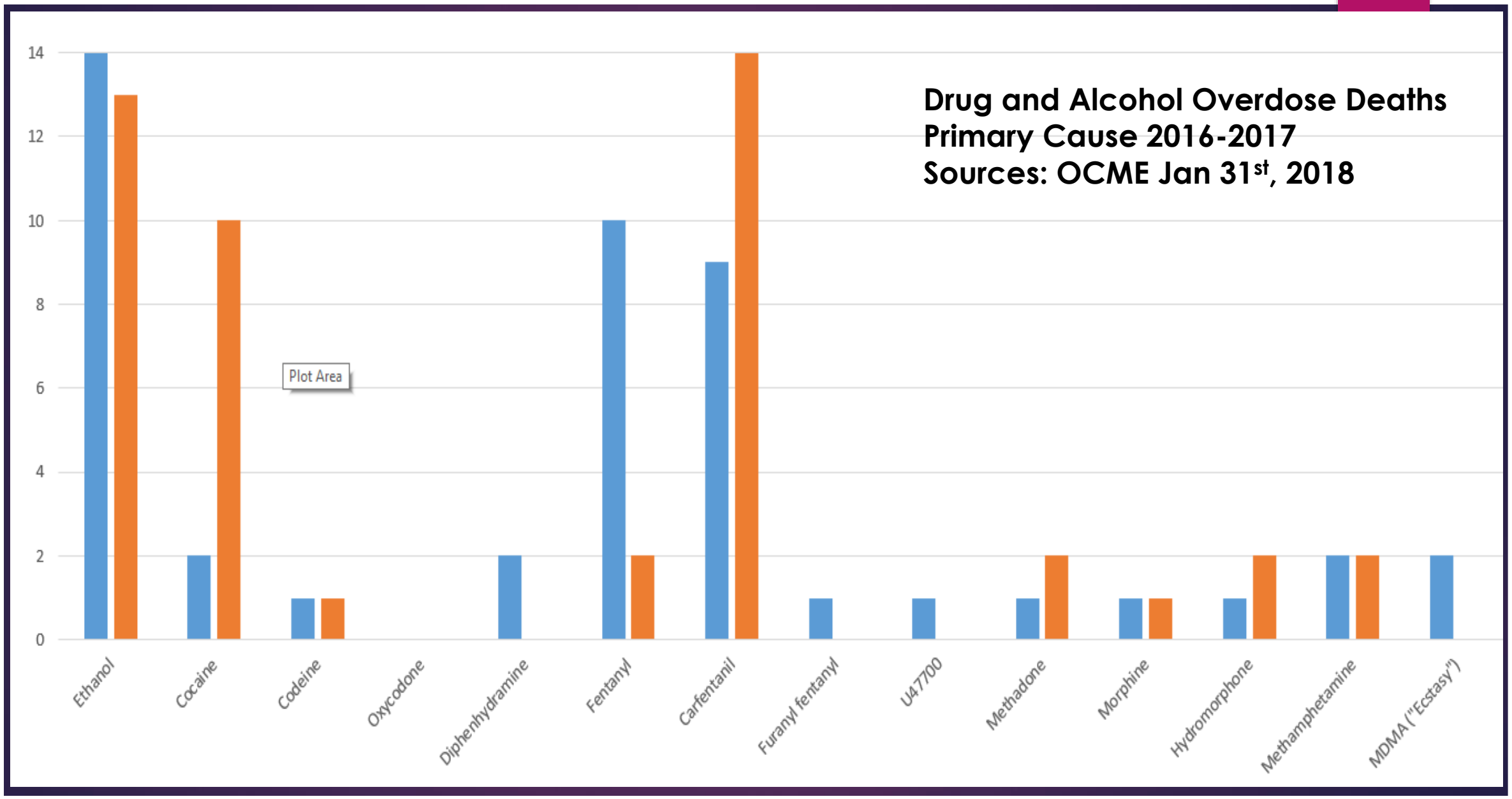


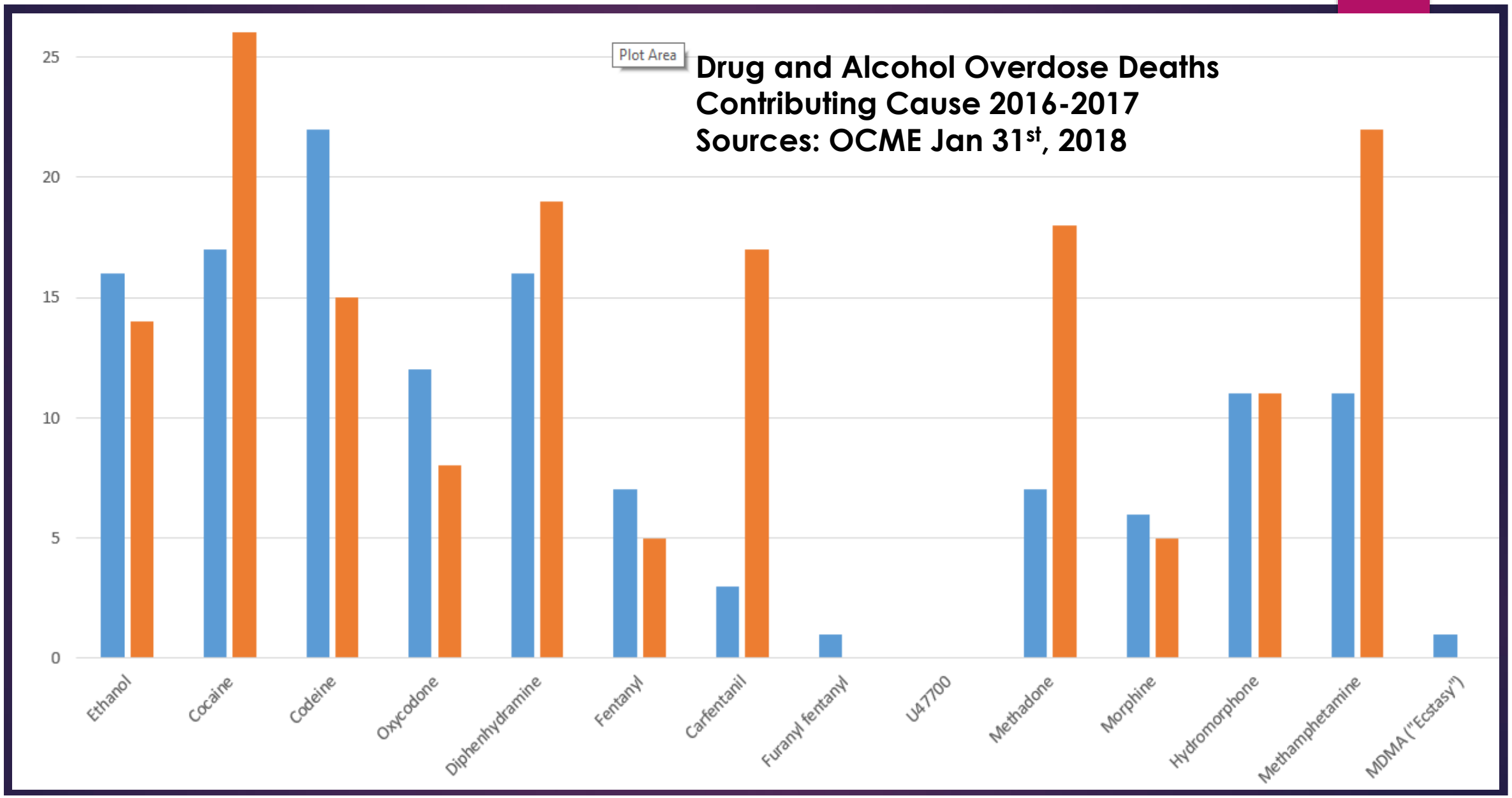
Illicit fentanyl and prescribed opioids -What's the connection?

- Jan 1st - April 4th, 2017: 20 deaths with positive screens for fentanyl analogs
- 75% positive for carfentanyl (15), Furanyl Fentanyl (2), U47700 (3), 2 unknown
- 60% of individuals who died during this period had a recent opioid prescription on DPIN
- Frequently negative toxicology for prescribed opioid in illicit opioid deaths

Drug and Alcohol Overdose Deaths (primary or contributing cause) 2013-2015 source: OCME Nov 3, 2016




Drug and Alcohol Overdose Deaths
Primary Cause 2016-2017
Sources: OCME Jan 31st, 2018
Plot Area
14
12
10
8
6
4
2
0
Ethanol
Cocaine
Codeine
Oxycodone
Diphenhydramine
Fentanyl
Carfentanil
Furanyl fentanyl
U47700
Methadone
Morphine
Hydromorphone
Methamphetamine
MDMA ("Ecstasy")


Plot Area
Drug and Alcohol Overdose Deaths
Contributing Cause 2016-2017
Sources: OCME Jan 31st, 2018
25
20
15
10
5
0
Ethanol
Cocaine
Codeine
Oxycodone
Diphenhydramine
Fentanyl
Carfentanil
Furanyl fentanyl
U47700
Methadone
Morphine
Hydromorphone
Methamphetamine
MDMA ("Ecstasy")

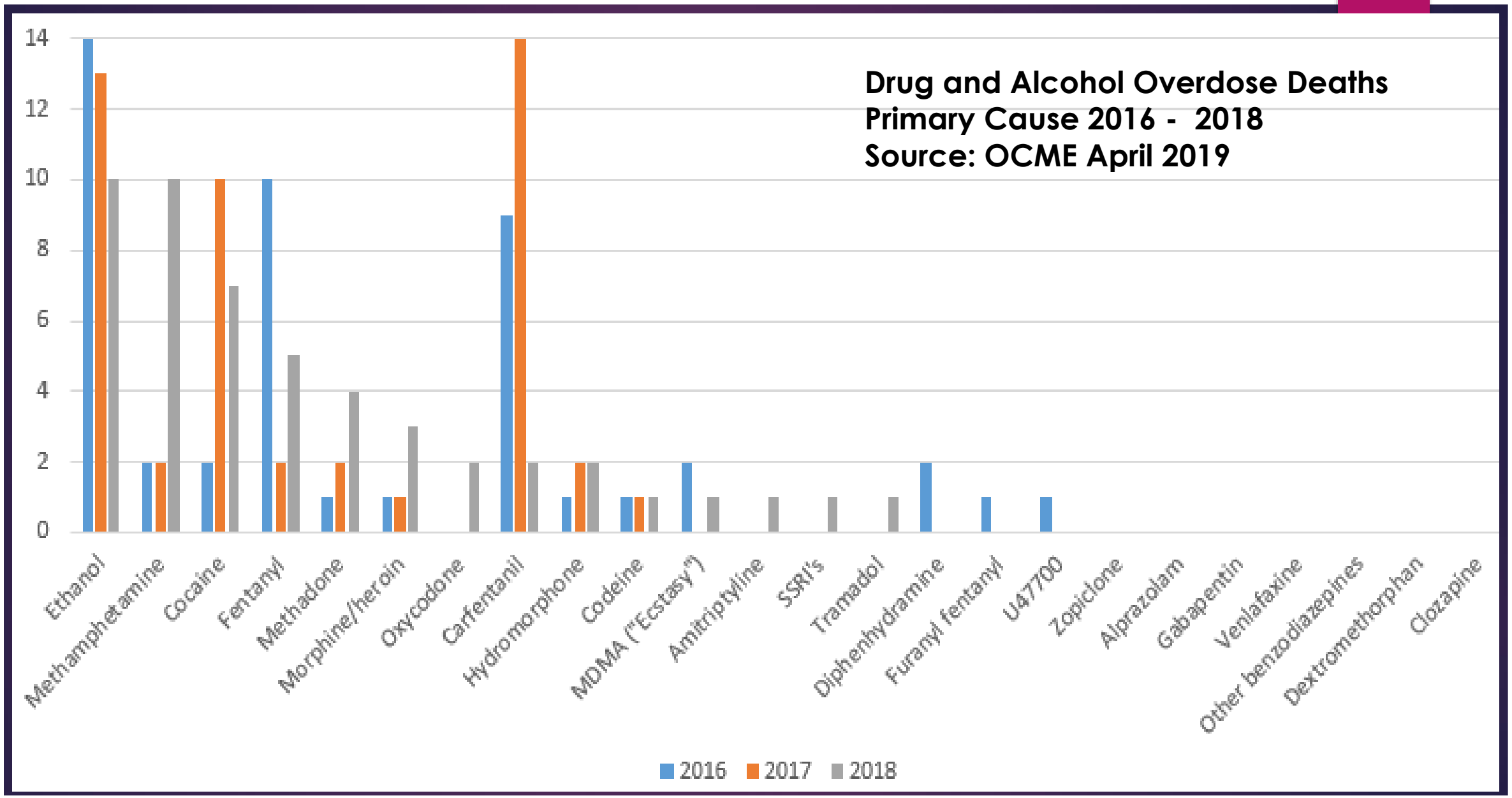
Effective February 1, 2016,
ALL CODEINE PRODUCTS
will require a prescription

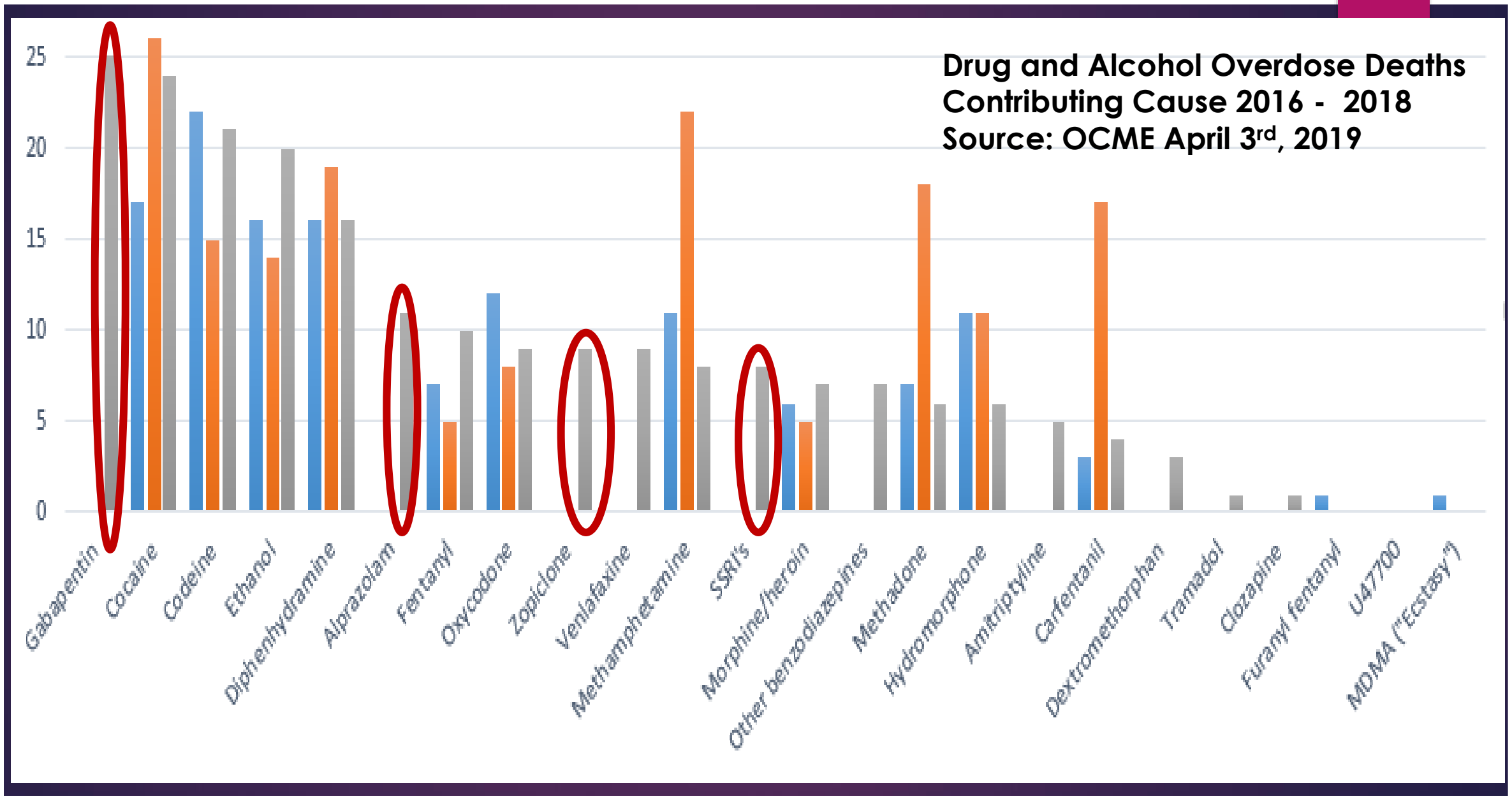
Ask your pharmacist
or another healthcare prescriber
about a prescription for
EXEMPTED CODEINE PRODUCTS...
It's all about your safety!

Patient safety is our priority

COLLEGE OF PHARMACISTS OF MANITOBA

LEARN MORE at www.cphm.ca


Drug and Alcohol Overdose Deaths
Primary Cause 2016 - 2018
Source: OCME April 2019
14
12
10
8
6
4
2
0
Ethanol
Methamphetamine
Cocaine
Fentanyl
Methadone
Morphine/heroin
Oxycodone
Carfentanil
Hydromorphone
Codeine
MDMA ("Ecstasy")
Amitriptyline
SSRI's
Tramadol
Diphenhydramine
Furanyl fentanyl
U47700
Zopiclone
Alprazolam
Gabapentin
Venlafaxine
Other benzodiazepines
Dextromethorphan
Clozapine
2016
2017
2018


Drug and Alcohol Overdose Deaths
Contributing Cause 2016 - 2018
Source: OCME April 3rd, 2019
25
20
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Gabapentin
Cocaine
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Furanyl fentanyl
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MDMA ("Ecstasy")

Important changes in 2018

- Opioid deaths have leveled off.
- **Stimulant-related deaths are climbing rapidly. Alprazolam** and **gabapentin**, as well as **diphenhydramine**, have become significant drugs of abuse.

- Note that more than one drug is often involved in a given death where a drug is given as a "contributing" cause.
- Overall, **138 drug-related deaths have been tabulated for 2018** so far. This does not include deaths where drug intoxication led to death by other means (MVAs, suicides, homicides, etc.), or where death occurred due to the effects of chronic drug use (cirrhosis, etc.).

CPSM CME Program Statistics

	16/17	17/18	18/19	19/20
Total Deaths From Overdose	73	128	95	38 (thus far)
Prescribing Deemed Appropriate	34	30	58	16
Prescribing Fall Outside Guidelines	79	95	67	15
Referred to Other Colleges	0	3	0	1

- *Numbers don't add up because in some cases letters to multiple physicians were generated from the same death

What can we learn from local CME data?

Three themes:

Largest category: Deaths involving sedating polypharmacy where all prescriptions were written by a single physician.

- Drug interactions
- Additive ADVERSE EFFECTS
- Often mimics symptoms of the condition being treated
- Memory impairment, falls, confusion, sedation and additive respiratory depression
- Often leads to high doses increases risk of DM, metabolic syndrome, cognitive impairment

- Incomplete tapers or switches
- Poor adherence (looks like partial response)
- No Longer clinically relevant
- No evidence that combining agents from same class increases efficacy (**benzodiazepines** hypnotics, SSRI's)
- Simplifying therapy without clinical deterioration is possible with medical supervision

An APPROACH to polypharmacy

- Set the stage
- Get a detailed history of every drug
- Reformulate list of active problems (acute or in remission)
- Discontinue what is not indicated, not being taken, diverted, or reduced dose if appropriate
- Taper what can't be discontinued abruptly

An APPROACH to polypharmacy

- One at a time (if feasible)
- More frequent visits; increased supports; frequent safety messaging; enlist loved ones
- Be patient but persistent
- **Listen to and actively collaborate with community/hospital pharmacist!**

The evidence: Opioids and benzodiazepines

Benzodiazepines increase opioid toxicity and risk of overdose.

- The **serum concentration of opioids is lower in mixed overdoses** than in pure overdoses, suggesting that other drugs significantly lower the lethal opioid dose (Cone 2004).

- Most **opioid overdoses involve multiple drugs in addition to opioids.** Overall, the top two other substances contributing to deaths between 2014 and 2017 were **benzodiazepines** and antidepressants.

Government of Manitoba, Manitoba Health, Seniors and Active Living, Epidemiology and Surveillance. (2018). Surveillance of Opioid Misuse and Overdose in Manitoba: October 1 – December 31, 2017.

The evidence: Opioids and benzodiazepines

There is evidence that benzodiazepines can be successfully tapered in a primary-care setting, with improved health outcomes.

- Several controlled trials have demonstrated that benzodiazepine tapering can be done in a primary-care setting.

- R06 For patients taking benzodiazepines, particularly for elderly patients, consider a trial of tapering (Grade B). If a trial of tapering is not indicated or is unsuccessful, opioids should be titrated more slowly and at lower doses. (Grade C).

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, NOUGG, April 3rd, 2010

Benzodiazepines in MB

- **Multiple benzodiazepines** prescribed concurrently is a **major concern** in the context of prescribing safety in Manitoba.
- **High doses** (single or combined benzo's) compounds the risks
- **No evidence** that combining these agents increases efficacy
- **Increased** confusion, falls, MVA, episodic memory impairment and abuse/addiction

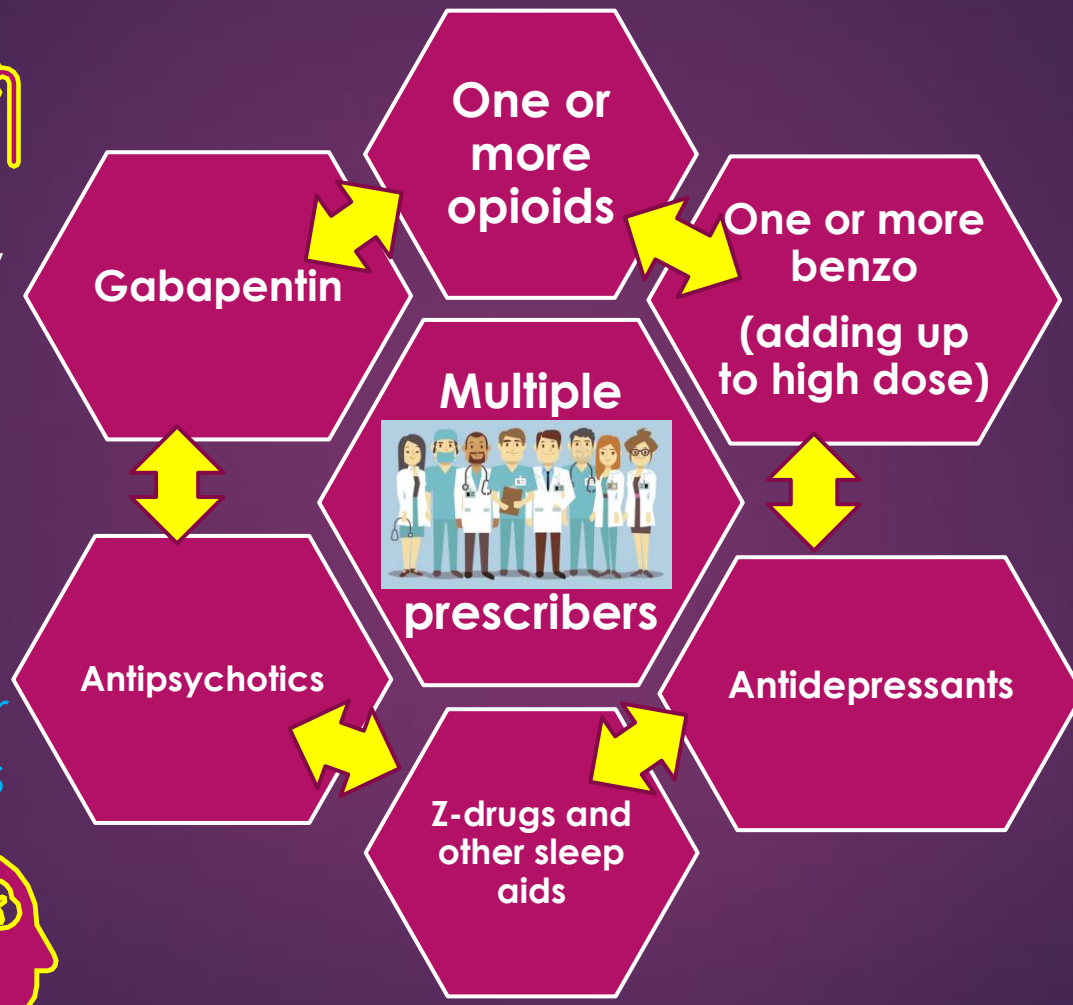
Key message

- Keep the overall picture in mind: The overall risk may outweigh the benefit from individual medications

What can we learn?

Deaths involving multiple sedating medications (often including an opioid and more than one benzodiazepine at a time) prescribed to the same patient by different physicians; filled at multiple different pharmacies.

- Frequently prescribers not aware of Rx history or each other?
- Increases risk of adverse events even further…
- CPSM Standard for prescribing opioids requires DPIN review



- Cross-over or consultative collaborative care?
- Who takes the lead on different aspects of care?
- DPIN not universally available
- e-Chart
- Collaboration with community pharmacist key!

Key messages

- All prescribers are encouraged to utilize DPIN or e-Chart (ungrouped) to improve patient safety.
- Clear treatment agreement and one primary responsible physician for monitored drugs may be helpful
- Listen to and actively collaborate with community/hospital pharmacist!

What can we learn?

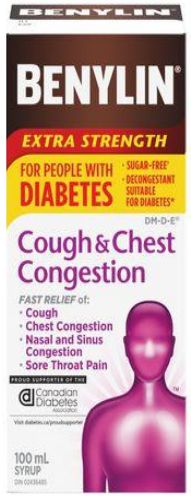
- OTC medications used in combined with prescribed medications can significantly contribute to overdose risk.
- Pharmacists can provide valuable collateral information – listen to and actively collaborate with community pharmacist!

Deadly OTC's in 2018

- **Diphenhydramine (contributed to 16 deaths in 2018)**
- **It is a first generation H_1-antihistamine and an anticholinergic**
- **Because of its sedative and anxiolytic properties, diphenhydramine is widely used in non-prescription sleep aids for insomnia.**
- **Diphenhydramine i**s the primary constituent of **dimenhydrinate** and dictates the primary effect. The main difference relative to pure diphenhydramine is a lower potency due to being combined with 8-chlorotheophylline

Others to watch…

- Dextromethorphan (contributed to 3 deaths in 2018)
- Dextromethorphan acts as a dissociative anesthetic in doses exceeding recommended ranges.
- DXM and its major metabolite, dextrorphan, also act as an NMDA receptor antagonist at high doses, which produces effects similar to, yet distinct from, the dissociative states created by other dissociative anesthetics such as ketamine and phencyclidine.



Increase screening!!!

- Ask your patient in a non-judgemental way!!
- Pay attention to collateral - "family" and pharmacists!!
- Educate!!
- Urine drug testing (UDT) may be useful if concerning report, appearance, function or collateral information.

  Comprehensive UDT preferred
- Policy?? More risky meds behind the counter or a Rx??

Types of Urine Drug Testing (UDT)

- **Point-of-care Testing**

For point-of-care (POC) testing: urine sample collected and test interpreted at the physician's office/clinic. POC test kits are available for purchase; Cups or dips; Results are immediate, but it tends to be less sensitive and specific than laboratory tests.

- **Laboratory Testing**

For laboratory testing: urine sample collected at physician's office/clinic and sent to a laboratory for testing.

Two types of laboratory tests: **immunoassay** and **chromatography**

Provincial health plans pays for immunoassays for **classes of drugs** (opioids, cocaine, benzodiazepines, cannabis), but **does not distinguish between different types of opioids** and often misses semi-synthetic or synthetic opioids such as oxycodone or meperidine.

Chromatography is more expensive and **requires specification of the drug(s) to be identified** e.g., oxycodone, morphine, codeine, hydromorphone (alternatively can indicate: "full screen" or "broad spectrum screen").

Key messages

- Smaller dispensed quantities
- Consider past hx of substance/medication abuse
- Ask re OTC meds and screen utilizing comprehensive UDS's if concerning appearance, function or collateral reports
- Listen to and actively collaborate with community pharmacist!

Regulatory approaches

- Interdisciplinary Education
- Death Review Process
- Standard of Practice for Opioid Prescribing
- Standard of Practice for Benzodiazepine Prescribing
- CPhM – Consultation regarding diphenhydramine - ?Rx and behind counter

References

I wish to recognize the following excellent sources:

- Government of Manitoba, Manitoba Health, Seniors and Active Living, Epidemiology and Surveillance. (2018). Surveillance of Opioid Misuse and Overdose in Manitoba: October 1 – December 31, 2017.
- Chateau D, Enns M, Ekuma O, Koseva I, McDougall C, Kulbaba C, Allegro E. Evaluation of the Manitoba IMPROVE Program Winnipeg, MB. Manitoba Centre for Health Policy, January 2015.
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- Clinical Guideline: Management of anxiety in adults. UK National Institute for Clinical Excellence. 2004;152. http://www.nice.org.uk/pdf/CG02 2niceguideline.pdf
- Barbone F, McMahon AD, et al. Association of road-traffic accidents with benzodiazepine use. Lancet. 1998;352:1331-1336.

THANK YOU