CPSO

Serving the people of Ontario through effective regulation of medical doctors

College Performance Measurement Framework (CPMF) Reporting Tool

March 30, 2022

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Introduction

The College Performance Measurement Framework (CPMF)

The CPMF has been developed by the Ontario Ministry of Health (the Ministry) in close collaboration with Ontario's health regulatory Colleges (Colleges), subject matter experts and the public with the aim of answering the question "how well are Colleges executing their mandate which is to act in the public interest?" This information will:

1. strengthen accountability and oversight of Ontario's health regulatory Colleges; and
2. help Colleges improve their performance.

Each College will report on seven Domains with the support of six components, as illustrated in Table 1.

Table 1: CPMF Measurement Domains and Components

1	**Measurement domains**	→	Critical attributes of an excellent health regulator in Ontario that should be measured for the purpose of the CPMF.
2	**Standards**	→	Performance-based activities that a College is expected to achieve and against which a College will be measured.
3	**Measures**	→	More specific requirements to demonstrate and enable the assessment of how a College achieves a Standard.
4	**Evidence**	→	Decisions, activities, processes, or the quantifiable results that are being used to demonstrate and assess a College's achievement of a standard.
5	**Context measures**	→	Statistical data Colleges report that will provide helpful context about a College's performance related to a standard.
6	**Planned improvement actions**	→	Initiatives a College commits to implement over the next reporting period to improve its performance on one or more standards, where appropriate.

CPMF Model

The seven measurement domains shown in Figure 1 are the critical attributes that contribute to a College effectively serving and protecting the public interest. They relate to key statutory functions and organizational aspects that enable a College to carry out its functions well. The seven domains are interdependent and together lead to the outcomes that a College is expected to achieve as an excellent regulator.

Figure 1: CPMF Model for Measuring Regulatory Excellence

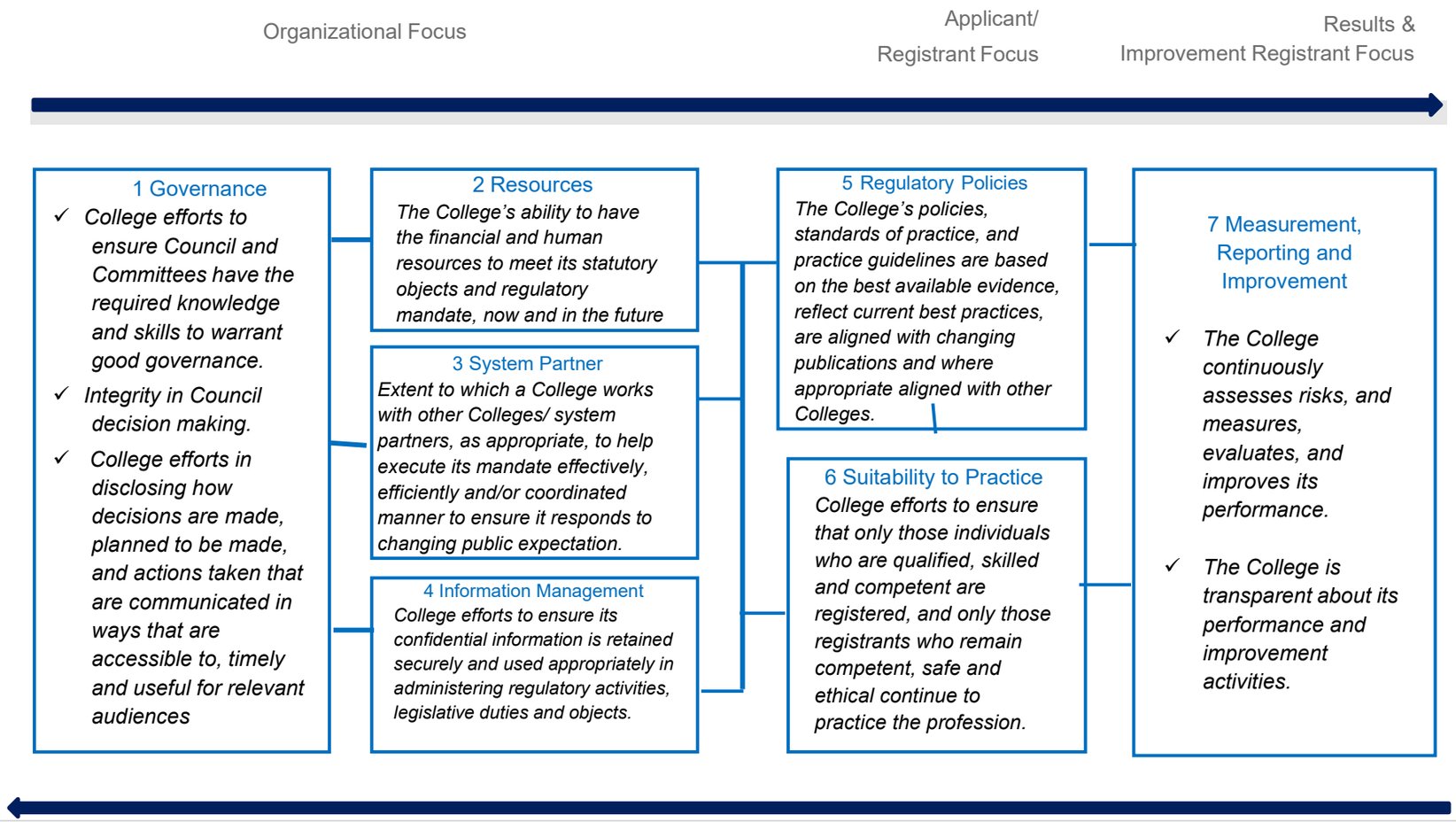


Figure 2: CPMF Domains and Standards

Domains	Standards
Governance	1. Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.
	2. Council decisions are made in the public interest.
	3. The College acts to foster public trust through transparency about decisions made and actions taken.
Resources	4. The College is a responsible steward of its (financial and human) resources.
System Partner	5. The College actively engages with other health regulatory Colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.
	6. The College maintains cooperative and collaborative relationships responds in a timely and effective manner to changing public expectations.
Information Management	7. Information collected by the College is protected from unauthorized disclosure.
Regulatory Policies	8. Policies, standards of practice, and practice guidelines are based in the best available evidence, reflect current best practices, are aligned with changing public expectations, and where appropriate aligned with other Colleges.
Suitability to Practice	9. The College has processes and procedures in place to assess the competency, safety, and ethics of the people it registers.
	10. The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.
	11. The complaints process is accessible and supportive.
	12. All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public
	13. The College complaints process is coordinated and integrated.
Measurement, Reporting and Improvement	14. The College monitors, reports on, and improves its performance.

The CPMF Reporting Tool

The second iteration of the CPMF Reporting Tool (along with the companion Technical Specifications for Quantitative CPMF Measures document) will continue to provide comprehensive and consistent information to the public, the ministry and other stakeholders by each of Ontario's health regulatory Colleges (Colleges). In providing this information each College will:

1. meet with the ministry to discuss the system partner domain and their progress on improvement commitments identified in the 2020 CPMF Report;
2. complete the self-assessment;
3. post the completed CPMF Report on its website; and
4. submit the CPMF Report to the ministry.

The purpose of the first and second iterations of the CPMF is to provide the public, the ministry and other stakeholders with baseline information respecting a College's activities and processes regarding best practices of regulatory excellence and, where relevant, the College's performance improvement commitments. At this time, the ministry will not assess whether a Collegemeets or does not meet the Standards.

The information reported through the completed CPMF Reporting Tools may help to identify areas of improvement that warrant closer attention and potential follow-up. Furthermore, the reported results will help to lay a foundation upon which expectations and benchmarks for regulatory excellence can be refined and improved. Finally, the results of the first and second iterations may stimulate discussions about regulatory excellence and performance improvement among Council members and staff within a College, as well as between Colleges, the public, the ministry, college registrants/members, and other stakeholders.

Additionally, in 2021 the ministry developed a Summary Report highlighting key findings regarding the commendable practices Colleges already have in place, collective strengths, areas for improvement and the various commitments Colleges have made to improve their performance in serving and protecting the public as per their 2020 CPMF Reports. The focus of the Summary Report is on the performance of the regulatory system (as opposed to the performance of each individual College) and on areas where opportunities exist for colleges to learn from each other.

The ministry's Summary Report is available:
In English: health.gov.on.ca/en/pro/programs/hwrob/regulated_professions.aspx, and
In French: health.gov.on.ca/fr/pro/programs/hwrob/regulated_professions.aspx

As this will be the second time that Colleges will be reporting on their performance against the CPMF standards, the Colleges will be asked to report on:

- Improvements a College committed to
- undertake in the previous CPMF Report;
- Changes in comparison to baseline reporting from the 2020 CPMF Report; and
- Changes resulting from new or refined standards, measures, and evidence.[1]

Completing the CPMF Reporting Tool

While the CPMF Reporting Tool seeks to clarify the information requested, it is not intended to direct College activities and processes or restrict the way a College fulfills its fiduciary duties. Where a term or concept is not explicitly defined in the CPMF Reporting Tool, the ministry relies on individual Colleges, as subject matter experts, to determine how a term should be appropriately interpreted given the uniqueness of the profession each College oversees.

In the spirit of continuous improvement, if the College plans to improve its activities or processes related to the respective Measure or Evidence, it is encouraged to highlight these planned improvement activities.

What has changed in 2021?

Based on feedback from the Colleges, the ministry made improvements to the current CPMF Reporting Tool, making it easier to complete.

- In Part 1 - These changes include drop-down menus, bookmarks to Measures, and additional information for clarification. Where a question remained unchanged from the 2020 CPMF reporting tool and a College fully met the Standard or Evidence, a College may opt to respond with 'Meets Standard' to illustrate that the current response is consistent with last year's response for the same Evidence. However, if there were changes between 2020 and 2021, the College is required to provide this updated information, including supporting information (i.e. provision of relevant links). Please note that this option is limited to only certain Evidence and is not available for all Evidence. Colleges will be asked to provide information in the right-hand column of each table indicating the degree to which they fulfill the "required Evidence" set out in Column Two.

- In Part 2 - Colleges are requested to refer to the Technical Specifications Document for detailed guidance on how to complete the section on Context Measures. Additionally, the ministry has also applied a drop-down menu where appropriate and has hyperlinked the definitions to a glossary of terms for easier navigation.

[1] Informed by the results from the first reporting iteration, the standards, measures, and evidence were evaluated by a second CPMF Working Group and where appropriate were further refined for the second reporting cycle. Additionally, Colleges will also be asked to report on Measures where it was identified that further information is required to establish baseline information relevant to the intent of the requested Evidence.

Part 1: Measurement Domains

	Measure **1.1 Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.**	
DOMAIN 1: GOVERNANCE STANDARD 1	**Required Evidence**	**College Response**
	a. Professional members areeligible to stand for election to Council only after: i. meeting pre-defined competency and suitability criteria; and	The College fulfills this requirement: Yes • The competency and suitability criteria are public: Yes *If yes, please insert a link to where they can be found, if not please list criteria.* CPSO outlines both minimum eligibility requirements to determine the suitability of professional members of Council, as well as desired competencies that are highlighted as part of any call for nominations. Minimum eligibility requirements (or exclusion criteria) are set out in s. 13(1) of CPSO's General By-law. These set out foundational criteria to assess suitability and include requirements that potential members not be the subject of any disciplinary or incapacity proceeding; that they not, and have not been within one year before the date of the election, a director or officer of any major stakeholder organization (e.g. the Ontario Medical Association); that they are not, and have not been within five years before the date of the election, an employee of the College; and so on. Provided a professional member candidate meets the minimum eligibility requirements for Council, he or she is then assessed in accordance with CPSO's competency framework. In 2020, a Council Profile was developed and approved by Council, including diversity attributes, technical skills and behavioural competencies that Council members should possess to ensure that Council can carry out its strategic objectives. Since CPSO submitted its last CPMF to the Ministry of Health in 2020, the Council Profile was shared with the Public Appointments Secretariat and the Minister's Office to inform the process of selecting public members for appointment to CPSO's Council. As part of the election process to Council, professional members are asked to highlight in their nomination statement the skills and experience they bring as they relate to the Council Profile. Link: https://www.cpso.on.ca/en/About/Council/Council-Elections *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* Choose an item *Additional comments for clarification (optional):*

		ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement:	Yes
			• Duration of orientation training. • Please briefly describe the format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end). • Please insert a link to the website if training topics are public ***OR*** list orientation training topics. All professional members who wish to stand for election must complete CPSO's Governance Orientation eLearning Program, approximately 1-1.5 hours in duration. The online program can be completed at the professional member's desired pace and includes a combination of presented information, case studies, and quizzes to provide opportunities to demonstrate the knowledge gained. Staff are also available to connect with professional members to answer questions or clarify any information provided in the Governance Orientation eLearning Program. The list of training modules for professional members include: Introduction to the College; By-Laws, Legislation and Regulation; Fiduciary Duty and Serving the Public; Confidentiality and Communications; A Day at Council; and Council Election Process.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional):	
		b. Statutory Committee candidates have: i. Met pre-defined competency and suitability criteria; and	The College fulfills this requirement:	Yes
			• The competency and suitability criteria are public: Yes • *If yes, please insert a link to where they can be found, if not please list criteria.* Click here to view the skills and qualifications that are expected of all Committee members. Statutory committees are comprised of Council members as well as non-Council members. As for professional members of Council (outlined above in 1.1.a.i.), CPSO outlines both minimum eligibility requirements to determine the suitability of professional members of committee, as well as desired competencies that are highlighted as part of any call for applications. Minimum eligibility requirements (or exclusion criteria) are set out in s. 35(1) of CPSO's General By-law. These set out foundational criteria to assess an individual's suitability to sit on committee and include requirements that potential members not be the subject of any disciplinary or incapacity proceeding; that their certificate of registration not have been revoked or suspended in the six years preceding the date of the appointment; and so on. In addition, s. 36(1) of the By-law sets out separate grounds that would disqualify a professional committee member from sitting on committee. Provided a candidate meets the minimum eligibility requirements, he or she is then evaluated against the competency framework and specific needs identified by the particular committee. When appointing a Council member to statutory committees, the Governance Committee considers the member's skills, experience and commitment and makes appointments based on the competencies required for the statutory committee. The Governance Committee recruits non-Council members to	

			statutory committees using competencies, qualifications, and suitability criteria that the particular committee requires, which are publicly available on CPSO's website when committee vacancies are posted. Using the Council Profile as a model, CPSO continues to develop and refine the skills, competencies and diversity attributes for each statutory committee to better inform the recruitment and appointment process. For example, the recruitment of new members of the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT, the CPSO's Discipline Committee) underwent some significant changes in 2021. In 2021, the College recruited five new experienced adjudicators to the OPSDT. They were appointed following a competitive process. Among the required qualifications was at least five years of part-time or full-time experience as an adjudicator. The job posting specifically invited applications from members of equity-seeking groups and was sent to associations of lawyers and physicians representing members of such groups. In addition to a rigorous skills-based interview, the candidates were also required to write a decision. Staff prepared a mock Notice of Hearing and Agreed Statement of Facts. Lawyers made legal arguments on the appropriate penalty as if it were a real case. Staff recorded the arguments, the candidates watched the video and had two weeks to write a decision, which was then scored anonymously.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item *Additional comments for clarification (optional):*
		ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	The College fulfills this requirement: — Yes • Duration of each Statutory Committee orientation training. • Please briefly describe the format of each orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end). • Please insert a link to the website if training topics are public ***OR*** list orientation training topics for Statutory Committee. All new committee members must complete CPSO's Governance Orientation eLearning Program prior to beginning their committee work. The online program provides a robust orientation to CPSO, its governance structure and the role of a committee member. The program is approximately 1-1.5 hours in duration and can be completed in one sitting or at the member's desired pace. The program includes a combination of presented information, case studies and quizzes to provide opportunities to apply the knowledge gained. Staff are also available to connect with members to answer any questions or clarify any information provided in the Governance Orientation eLearning Program. For non-Council committee members, the list of training modules include: Introduction to the College; By-Laws, Legislation and Regulation; Fiduciary Duty and Serving the Public; Confidentiality and Communications; Council Overview; and A Day at Committee. (The training modules for publicly-appointed Council members, who are cross-appointed to various statutory committees, are covered below in 1.1.c.) Depending on the committee, there may be additional training provided to committee members to support their work. The committee specific orientation topics are listed below: **Ontario Physicians and Surgeons Discipline Tribunal (Discipline Committee) and Fitness to Practise Committee**: For new physician and public members, staff conduct a virtual one-day session including an introduction to discipline principles and process, jurisdiction and procedural fairness, rules of evidence, a presentation on myths and stereotypes in sexual misconduct cases, and an introduction to inclusive and accessible adjudication. Members also watch at least one hearing before sitting. For new experienced adjudicator members, staff conduct one full-day and two half-day virtual sessions. Topics include an introduction to College complaints and

investigations, common allegations of professional misconduct, incompetence and Fitness to Practise cases, considerations on penalty, and an advanced reason-writing workshop. The sessions also include discussion of professional discipline values, rules of evidence, joint submissions, the reason writing and review process, reprimands, reinstatements, vulnerable witnesses, a presentation of myths and stereotypes in sexual misconduct cases, and victim impact statements.

Executive Committee: Informal onboarding for new Executive Committee members is provided by senior staff and the topics vary according to the issues before the Committee at any given time. These can include the Strategic Plan and Key Performance Indicators, the CPSO Leadership Team, Legislative and Regulatory Framework, Government Relations Initiatives, and Governance Modernization.

Inquiries, Complaints and Reports Committee: Topics for orientation include a welcome and introduction to ICRC outlining basic responsibilities of ICRC and introducing the Investigations and Resolutions area, Meeting Logistics, the Pre/Post/During ICRC Panel overview, Administrative Law Part I, Role of the RHPA, Role of ICRC and their focus of analysis in Decision Making, Administrative Law Part II, Deliberative Privilege, Legal Counsel Advice, Basic framework re sexual abuse and ICRC relationship with the Ontario Physicians and Surgeons Discipline Tribunal

- Duration of training: 2 half-day sessions on the above topics. In addition, new members observe several panels (3-4 types), after which, based on their comfort level, they are assigned as an active member to a panel. New members also have mentors assigned to them. For their first panel as a participant, the mentor also attends and is available to assist as needed.
- Format: virtual. Staff from I&R leadership, Legal, and committee support are in attendance.

Patient Relations Committee: Topics for orientation include the Committee Terms of Reference, Funding for Therapy and Counselling, Benchmarks, Privacy/Confidentiality, Webmail, Legal Opinions, Decision Components, Application Package, Legislation, Annual Report

- Duration of training: a 1.5 hour session.
- Format: virtual. New members are also provided with a committee-specific orientation manual that they are asked to read in advance of the training.

Quality Assurance Committee: Topics for orientation include a Committee Primer and Competency Framework, Policy Minutes, QAC Regulations, QAC Meeting resource material, Remuneration, Sample Peer Report, Orientation to CPSO Technology, Privacy and Confidentiality. New members also receive an orientation package including the following material:

- Welcome letter
- Staff Contact List
- QAC Members List and 2022 meeting dates
- QAC Primer & Competency Framework
- Sample of Policy Minutes (from the last meeting)
- QAC Regulation
- QAC Meeting Material Resources
- Sample Statement of Services Rendered (reimbursement claim form)
- Sample Peer Assessment report (redacted)
- Privacy & Confidentiality
- Acronyms
- Instructions for Solis (CPSO's member database) and Finance & Operations Quick Reference Guides [in development]

- Duration of training: 2 hour session

			• Format of training: virtual. New members also attend member-specific issue (MSI) meetings as an observer to see how they are conducted and are paired with a mentor who they can reach out to at anytime to discuss cases if needed. Once a member is comfortable with the MSI process and how decisions are made, they commence presenting their assigned cases. Generally new members observe 2-3 MSI meetings first before they start presenting. **Registration Committee**: Topics for orientation include CPSO registration policies, CPSO Practice Guide, CPSO Best Practices – Privacy & Confidentiality (internal), CPSO CPD website (internal, contains resources assisting Committee and staff when making education-related decisions), information and background on the Registration Regulation, information on the practice of medicine (for public members), conflict of interest and bias, and SOLIS (CPSO's member database). The application questions are also reviewed with new committee members. • Duration of training: The hands on-orientation is roughly a 2-3 hour session. Material, links and a PowerPoint presentation are provided in advance so new members have time to review in advance of the meeting, and they also have access to this material afterward. There is also an informal mentoring program, which connects each new member with an existing member, and lasts for about a year. Newest members sit as observers without voting ability at several meetings (3 to 6) in order to understand the process and nuances, and to gain a robust understanding of CPSO policies and Regulation. • Format: The hands on-orientation portion is currently virtual.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (optional):
		c. Prior to attending their first meeting, public appointments to Council undertake an orientation training course provided by the College about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	The College fulfills this requirement: — Yes met in 2020, continues to meet in 2021
			• Duration of orientation training. • Please briefly describe the format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end). • Please insert a link to the website if training topics are public ***OR*** list orientation training topics. Public members who are appointed to the CPSO Council by the Lieutenant Governor-In-Council are required to complete the following programs as part of their orientation to Council: the Council on Licensure and Enforcement and Regulation (CLEAR)'s Introduction to Regulatory Governance course (3-4 hours online) and CPSO's Governance Orientation eLearning Program (1-1.5 hours online). The CPSO's Governance Orientation eLearning Program provides a robust orientation to CPSO, its governance structure and the role of a committee member. The program is approximately 1-1.5 hours in duration and can be completed in one sitting or at the member's desired pace. The program includes a combination of presented information, case studies, and quizzes to provide opportunities to apply the knowledge gained. Staff are also available to connect with members to answer any questions or clarify any information provided in the Governance Orientation eLearning Program. The list of training modules for public appointments to Council include: Introduction to the College; By-Laws, Legislation and Regulation; Fiduciary Duty and Protecting the Public; Confidentiality and Communications; A Day at Council; A Day at Committee; and Remuneration. Within each of these categories are various topics which include references to CPSO by-laws and the documents contained in the Declaration of Adherence package. The Governance Orientation eLearning Program also provides helpful resources to support public members in learning more about equity, diversity and inclusion in the context of health care.

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional):	
		Measure **1.2 Council regularly assesses its effectiveness and addresses identified opportunities for improvement through ongoing education.**		
		Required Evidence	**College Response**	
		a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; and ii. Council.	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
			• Please provide the year when Framework was developed ***OR*** last updated. • Please insert a link to Framework ***OR*** link to Council meeting materials where (updated) Framework is found and was approved. • Evaluation and assessment results are discussed at public Council meeting: Choose an item • *If yes, please insert a link to the last Council meeting where the most recent evaluation results have been presented and discussed.*	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	

		b. The framework includes a third-party assessment of Council effectiveness at a minimum every three years.	The College fulfills this requirement:	Yes
			• A third party has been engaged by the College for evaluation of Council effectiveness: Yes • *If yes, how often over the last five years? Once* • Year of last third-party evaluation. 2020 Over the last 5 years, CPSO has engaged a third party to conduct a targeted evaluation of Council's effectiveness once, in 2020. In addition, Council conducts an annual assessment using a tool developed by a third party to evaluate its effectiveness and benchmark with other not-for-profit health care boards. Information about CPSO Council's assessment tool can be found here. CPSO made some minor updates to the tool in 2021 to better tailor it to the needs of Council. Council is also provided education about what makes an effective board member, so that when they conduct the annual assessment they have an educated place from which to do so.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	
		c. Ongoing training provided to Council and Committee members has been informed by: i. the outcome of relevant evaluation(s); ii. the needs identified by Council and Committee members; and/or	The College fulfills this requirement:	Yes
			• Please insert a link to documents outlining how outcome evaluations have informed Council and Committee training. • Please insert a link to Council meeting materials where this information is found ***OR*** • Please briefly describe how this has been done for the training provided over the last year. Each Council meeting concludes with an in-camera Meeting Reflection Session so that Council members may share observations about the effectiveness of the meeting and the engagement of members. Certain CPSO committees (e.g. Governance Committee) conclude in the same fashion. In addition, Council members are requested to complete an anonymous survey following each Council meeting to assess the appropriateness of the meeting agenda, the effectiveness of the conduct of the meeting, the adequacy of background materials, and the level of support provided by Council support staff. Members are also specifically prompted to provide information about areas they feel Council should focus on in the future. Results from these surveys are collected by senior CPSO staff to develop and enhance subsequent Council agenda topics relating to education and training. In 2020, the Governance Committee initiated education on equity, diversity, and inclusion issues for its Committee. With the creation of an EDI role and strategy within CPSO, a broader education and training program for all committees and Council was initiated. The new Governance Orientation eLearning Program, described above in 1.1., was designed so that all new Council and committee members receive the necessary resources and training to embed EDI into the work they do. Over the course of 2021, external guests held a number of virtual sessions for Council and committees, sharing their expertise and lived experience of topics including unconscious bias, anti-Indigenous racism, privilege and allyship, and how we can embed an equity analysis into our work. These 1.5-2 hour sessions were extremely well-received by attendees. • Dr Lisa Richardson: Wise Practices for Reconciliation in Health Care (Council), March 2021	

			• Dr Javeed Sukhera: Understanding Equity, Diversity, Inclusion, and Belonging in a Regulatory Context (Council and Committee), April 2021 • Dr Lisa Richardson: We Are All Treaty People: Reconciliation in Health Care (Committee), May 2021 • Anna Dewar-Gully, Tidal Equality: Equity Sequence (Council), September 2021 • Drs Stephanie Nixon and Ed Connors: Toward Peacemaking, Part 1: An Introduction to the Coin Model of Privilege and Critical Allyship (Committee), October 2021 • Drs Stephanie Nixon and Ed Connors: Toward Peacemaking, Part 2: Embracing Alternatives to a Colonial Mindset (Committee), November 2021 Relevant feedback from the Council EDI education sessions in March, April, and September 2021 helped inform the development of the November 2021 session, as well as the CPSO's 2022 EDI plan. Topics slated for 2022 include anti-Black racism and LGBTQ2S+ issues as they relate to health care. In the spirit of collaboration, CPSO has provided ongoing updates and suggestions to other health regulatory colleges regarding its EDI work. Some colleges have engaged the above-noted speakers to initiate conversations within their Councils and staff, and HPRO also invited our EDI Lead to present our EDI work and discuss with them how they could move forward with EDI work within their Colleges. Our EDI Lead has also been invited to give presentations at a number of other external organisations, including hospitals and faculties of medicine. Finally, in September 2021 Council members received an education session relating to Governance Best Practices, which had been identified as an area of interest for more learning by Council.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (optional):
		iii. evolving public expectations including risk management and Diversity, Equity, and Inclusion. <u>Further clarification:</u> Colleges are encouraged to define public expectations based on input from the public, their members and stakeholders. Risk management is essential to effective oversight since internal and external risks may impact the ability of Council to fulfill its mandate.	The College fulfills this requirement: — Yes
			• Please insert a link to documents outlining how evolving public expectations have informed Council and Committee training. • Please insert a link to Council meeting materials where this information is found ***OR*** • Please briefly describe how this has been done for the training provided <u>over the last year</u>. Although CPSO's work on this topic had already begun, EDI became a clear focus for us following the death of George Floyd in May 2020 and the release of the report *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* in November 2020. Both of these events occurring within a short time of each other, and the resulting, notable cultural shift among the public and CPSO members, helped CPSO to translate some of these important issues into education opportunities. As noted above, in 2021 Council received a series of well-received education sessions on topics including unconscious bias, anti-Indigenous racism, privilege and allyship, and how we can embed an equity analysis into our work. Video from these sessions have been archived on the CPSO's internal website for access by staff, Council members, and committee members. Education on these topics was also provided to all committee members via mandatory education sessions. The Inquiries, Complaints and Reports Committee (ICRC) also received two additional sessions on best practices for managing complaints of discrimination. These were case-based discussions led by our EDI Lead and Senior Legal Counsel. CPSO's EDI work will continue into 2022 with a focus on Anti-Black Racism and LGBTQ2S+ Health. Feedback from Council and committees has been

			incorporated into the planning of these 2022 sessions, including more opportunities for small group discussion as well as a case-based approach. More information about our overall EDI Strategy and work in 2021 can be found here. In addition to other ways that CPSO gathers insights from the public to inform its work, CPSO relies on its government-appointed public members to provide insights into how expectations among Ontarians more broadly are evolving. Public members have an opportunity to suggest topics for discussion and/or further training and education at Council as well as within committees. As part of CPSO's efforts to ensure that we are responding to evolving public expectations, staff and the Governance Committee review the Council and committee training and education annually to ensure it reflects new and/or emerging priorities as they relate to our mandate to serve in the public interest. Finally, in September 2021 Council members received an education session relating to Governance Best Practices in order to learn about effectively managing internal and external risk and addressing organizational challenges. This training covered best practices, the need for and value of competencies, the need to understand board composition in terms of key skills, and the importance of viewing the board as composed of members each contributing different skills and assets (and understanding that no member is expected to be an expert in every domain).
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (optional):
DOMAIN 1: GOVERNANCE	STANDARD 2	**Measure** **2.1 All decisions related to a Council's strategic objectives, regulatory processes, and activities are impartial, evidence-informed, and advance the public interest.**	
		Required Evidence	**College Response**
		a. The College Council has a Code of Conduct and 'Conflict of Interest' policy that is: i. reviewed at least every three years to ensure it reflects current legislation, practices, public expectations, issues, and emerging initiatives (e.g. Diversity, Equity and Inclusion); and <u>Further clarification:</u> Colleges are best placed to determine the public expectations, issues and emerging initiatives based on input	The College fulfills this requirement: — Yes
			• Please provide the year when Council Code of Conduct and 'Conflict of Interest' Policy was last evaluated/updated. • Please briefly describe any changes made to the Council Code of Conduct and 'Conflict of Interest Policy' resulting from the review. Both the Council Code of Conduct and the Conflict of Interest Policy were updated and approved by Council in December 2021. The Code of Conduct was revised to reflect evolving expectations pertaining to email and technology use as a result of the virtual work environment. The Conflict of Interest Policy was revised to require Council members to affirm that they do not have a conflict of interest to declare (previously Council members could leave the response blank if there were no conflicts – providing confirmation creates a clearer process for reporting conflicts).
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (optional)

		from their members, stakeholdersand the public. While there will be similarities across Colleges such as Diversity, Equity and Inclusion, this is also an opportunity to reflect additional issues, expectations and emerging initiatives unique to a College or profession.	
		ii. accessible to the public.	The College fulfills this requirement: Yes • Please insert a link to the Council Code of Conduct and 'Conflict or Interest' Policy ***OR*** Council meeting materials where the policy is found and was discussed and approved. Council discussed and approved the Code of Conduct and Conflict of Interest policy in December 2021. The link to the materials is here: https://www.cpso.on.ca/admin/CPSO/media/Documents/about-us/council/council-meetings/council-materials-2021dec.pdf (pages 108-122) The final documents can be accessed here: https://www.cpso.on.ca/Admin/CPSO/media/Documents/about-us/council/elections/declaration-of-adherence-documents.pdf (p. 7 for the Code of Conduct and p. 17 for the Conflict of Interest policy). *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* Choose an item *Additional comments for clarification (optional)*

		b. The College enforces a minimum time before an individual can be elected to Council after holding a position that could create an actual or perceived conflict of interest with respect their Council duties (i.e. cooling off periods).
		
		<u>Further clarification:</u>
		Colleges may provide additional methods not listed here by which they meet the evidence.
			The College fulfills this requirement: Yes met in 2020, continues to meet in 2021
			• Cooling off period is enforced through:
			• Please provide the year that the cooling off period policy was developed ***OR*** last evaluated/updated.
			  • Please provide the length of the cooling off period.
			• How does the college define the cooling off period?
			  – Insert a link to policy / document specifying the cooling off period, including circumstances where it is enforced;
			  – Insert a link to Council meeting where cooling of period has been discussed and decided upon; ***OR***
			  – Where not publicly available, please describe briefly cooling off policy.

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	
		c. The College has a conflict of interest questionnaire that all Council members must complete annually. Additionally: i. the completed questionnaires are included as an appendix to each Council meeting package; ii. questionnaires include definitions of conflict of interest; iii. questionnaires include questions based on areas of risk for conflict of interest identified by Council that are specific to the profession and/or College; and iv. at the beginning of each Council meeting, members must declare any updates to their responses and any conflict of interest specific to the meeting agenda.	The College fulfills this requirement:	Yes
			• Please provide the year when conflict of interest the questionnaire was implemented ***OR*** last evaluated/updated. • Member(s) note whether their questionnaire requires amendments at each Council meeting and whether they have any conflicts of interest based on Council agenda items: Yes • Please insert a link to the most recent Council meeting materials that includes the questionnaire. CPSO has a Declaration of Adherence that all Council members are asked to review and complete on an annual basis. The Declaration of Adherence is reviewed annually to ensure it reflects leading governance best practices (the document can be accessed here at p. 4). Included among the Declaration of Adherence material is a Conflict of Interest form that requires members to identify any potential conflicts of interest. Council members are reminded at each meeting of the potential for conflicts of interest and are prompted to identify any existing or new conflicts of interest that relate to the agenda items being discussed. Staff proactively monitor and work with the President to proactively identify any potential conflicts of interest and work with Council Members as needed.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	

		d. Meeting materials for Council enable the public to clearly identify the public interest rationale and the evidence supporting a decision related to the College's strategic direction or regulatory processes and actions (e.g. the minutes include a link to a publicly available briefing note).	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
			• Please briefly describe how the College makes public interest rationale for Council decisions accessible for the public. • Please insert a link to Council meeting materials that include an example of how the College references a public interest rationale.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (if needed)	
		e. The College has and regularly reviews a formal approach to identify, assess and manage internal and external risks. This approach is integrated into the College's strategic planning and operations.	The College fulfills this requirement:	Yes
		<u>Further clarification:</u> Formal approach refers to the documented method or which a College undertakes to identify, assess and manage risk. This method or process should be regularly reviewed and appropriate. Risk management planning activities should be tied to strategic objectives of Council since internal and external risks may impact the ability of Council to fulfill its mandate, especially in the absence of mitigations. Internal risks are related to operations of the College and may impact its	• Please provide the year the formal approach was last reviewed. At least annually. • Please insert a link to the internal and external risks identified by the College ***OR*** Council meeting materials where the risks were discussed and integrated into the College's strategic planning activities. See below. The CPSO actively participates in activities relating to the Federation of Medical Regulatory Authorities of Canada (FMRAC) Integrated Risk Management System (FIRMS), a risk management tool used by Canadian medical regulatory authorities (MRAs), with valuable contributions from the Healthcare Insurance Reciprocal of Canada (HIROC). FIRMS provides a model and framework for ongoing integrated risk management and quality improvement; its standards address, among other things, governance and the core mandate of MRAs (registration, complaints, QA of medical practice, and facilities review /accreditation). FIRMS works to reassure an MRA's Council, Registrar, staff, and external stakeholders that their MRA meets, as best it is able, its goals of integrated risk management and quality improvement. FIRMS is a voluntary, continuous, systematic process to understand, manage and communicate risk within the CPSO and among MRAs. The framework supports strategic decision making to fulfill the organizational mandate. To help ensure integrated risk management and due diligence, CPSO has incorporated FIRMS into day-to-day operational decisions. In addition, through HIROC, there is a review of CPSO cybersecurity and facilities with FM Global.	

		ability to meet its strategic objectives. External risks are economic, political and/or natural factors that happen outside of the organization.	The results from FIRMS are reviewed **annually** and the tool is updated every year, if not sooner as in the case of changing/pending/threatening risks (e.g. COVID, cybersecurity risks). As an example of risk being discussed and addressed by CPSO Council, at the end of 2020 the CEO/Registrar and Council identified that there was cybersecurity risk posed by CPSO's financial system after hospitals and other regulatory bodies were breached. There was direction to staff to transform the system and move it to the cloud, which was completed and reported on at the December 2021 Council meeting (materials can be accessed here). Moreover, the CPSO's new Enterprise Management System, for which rollout began in 2020 and will conclude in 2022, consolidates and shores up multiple databases/systems to support data integration across the organization. This includes the implementation of Solis (CPSO's member database), Vault (CPSO's document management system), and the new Finance and Operations (F&O) system. In moving all CPSO data to the cloud, it also minimizes cybersecurity risk and duplication, supports improved data quality (consistency across systems), supports improved registrant and case management, and enables a single source of information.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (if needed)
	STANDARD 3	**Measure** **3.1 Council decisions are transparent.**	
		Required Evidence	**College Response**
		a. Council minutes (once approved) and status updates on the implementation of Council decisions to date are accessible on the College's website, or a process for requesting materials is clearly outlined.	The College fulfills this requirement: — Yes met in 2020, continues to meet in 2021
			• Please insert a link to the webpage where Council minutes are posted. • Please insert a link to where the status updates on implementation of Council decisions to date are posted ***OR*** where the process for requesting these materials is posted.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (optional)

		b. The following information about Executive Committee meetings is clearly posted on the College's website (alternatively the College can post the approved minutes if it includes the following information). i. the meeting date; ii. the rationale for the meeting; iii. a report on discussions and decisions when Executive Committee acts as Councilor discusses/deliberates on matters or materials that will be brought forward to or affect Council; and iv. if decisions will be ratified by Council.	The College fulfills this requirement:	Yes
			• Please insert a link to the webpage where Executive Committee minutes / meeting information are posted. Click here to see the Terms of Reference for the Executive Committee as well as the meetings that have been scheduled for the year. From time to time there may be ad hoc meetings to address time sensitive matters, for example timely committee appointments to statutory committees so that they can carry out their work effectively. As outlined in our General By-Law, section 29(4), decisions that will be ratified by Council are generally required to be discussed with the Executive Committee first: The council shall, and may only, consider,(a) at a special meeting, the matter for decision at the meeting contained in the requisition deposited with the registrar; (b) at a regular meeting, a motion made and seconded in writing, (i) on behalf of the executive committee; (ii) in a report by a committee which has received prior review by the executive committee; (iii) of which a notice of motion was given by a councillor at the preceding council meeting; or 17 (iv) which the councillors agree to consider by a two-thirds vote of those in attendance; and (c) at any meeting, routine and procedural motions in accordance with the rules of order. Thus, when matters such as policy reviews come to Council, they have been reviewed first by the Executive Committee. In situations where the Executive Committee has acted on behalf of Council, those decisions are communicated to Council members by email after the Executive Committee meeting. The Executive Committee's decisions are made available again to Council and to the public in the Executive Report that is included in subsequent Council meeting materials. Click here to see an example of the Executive Committee Report (p. 29)	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	
		Measure **3.2 Information provided by the College is accessible and timely.**		
		Required Evidence	**College Response**	
		a. With respect to Council meetings: i. Notice of Council meeting and relevant materials are posted at least one week in advance; and ii. Council meeting materials remain accessible on the College's website for a minimum of 3 years, or a	The College fulfills this requirement:	Yes
			Please insert a link to where past Council meeting materials can be accessed ***OR*** where the process for requesting these materials is clearly posted. i. Notice of Council meetings and materials are posted 2.5 weeks in advance ii. Council meeting materials are accessible on the CPSO website going back at least five years https://www.cpso.on.ca/en/About/Council/Council-Meetings	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item

		process for requesting materials is clearly outlined.	*Additional comments for clarification (optional)*
		b. Notice of Discipline Hearings are posted at least one month in advance and include a link to allegations posted on the public register.	The College fulfills this requirement: Yes • Please insert a link to the College's Notice of Discipline Hearings. Link to Upcoming Hearings on the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) website: https://opsdt.ca/hearings/upcoming-hearings The hearings listed take place in the next 60 days.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Choose an item *Additional comments for clarification (optional)*
		Measure **3.3 The College has a Diversity, Equity and Inclusion (DEI) Plan.**	
		Required Evidence	**College Response**
		a. The DEI plan is reflected in the Council's strategic planning activities and appropriately resourced within the organization to support relevant operational initiatives (e.g. DEI training for staff).	The College fulfills this requirement: Yes • Please insert a link to the College's DEI plan. • Please insert a link to the Council meeting minutes where DEI was discussed as part of strategic planning and appropriate resources were approved. The CPSO's EDI Lead, Dr. Saroo Sharda, was announced in January 2021 and a comprehensive, cross-organisational strategy was planned, with the focus for 2021 being implicit/unconscious bias and anti-Indigenous racism. The results of that work, which can be accessed here, were presented in the end of year EDI Report at the December 2021 Council meeting, along with the EDI plan for 2022. (The EDI program was included in CPSO's 2022 Budget, which was also presented and approved at the December 2021 Council meeting – see December Council meeting materials beginning at p. 123.) CPSO's EDI plan is grounded in the principles of CPSO's Strategic Plan, including meaningful engagement, quality care, continuous improvement. These core priorities are supported by our EDI work from an engagement, process/program, and quality perspective. Through 2021, specific education and training opportunities were also offered to staff in divisions across CSPO. Overwhelmingly, the response was positive and staff reported that they would use these learnings in their everyday work. Specific education and training opportunities included: • Over 200 College staff completed the multi-hour, facilitated San'yas anti-racism Indigenous cultural safety training program. • Multiple departments completed the Tidal Equality, equity sequence training that provided concrete tools of how to embed an equity analysis into our work. Following this training, a review of CPSO's recruitment and onboarding practices was undertaken and staff engaged in a review and update of existing Human Resources policies, as well as the development of new and current policies and events through an equity lens. • The College's EDI Lead engaged with key College departments to share information on our EDI activities, seek feedback and answer questions. • An "EDI Corner" was created on the intranet and featured articles, interviews, resources, and highlighted recent developments in EDI and healthcare. Staff are encouraged to submit their own ideas for EDI corner to the EDI Lead.

			• Further training opportunities are planned for 2022, to align with the 2022 areas of focus of anti-Black racism and LGBTQ2S+ Health.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (optional)
		b. The College conducts EquityImpact Assessments to ensure that decisions are fair and that a policy, or program, or process is not discriminatory. <u>Further clarification:</u> Colleges are best placed to determine how best to report on an Evidence. There are several Equity Impact Assessments from which a College may draw upon. The ministry encourages Colleges to use the tool best suited to its situation based on the profession, stakeholders and patients it serves.	The College fulfills this requirement: — Yes • Please insert a link to the Equity Impact Assessments conducted by the College ***OR*** please briefly describe how the College conducts Equity Impact Assessments. • If the Equity Impact Assessments are not publicly accessible, please provide examples of the circumstances (e.g., applied to a policy, program or process) in which Equity Impact Assessments were conducted. While CPSO does not have a formal Equity Impact Assessment tool, we are actively building equity into our policies, processes, and decision-making. Several examples follow and additional details can also be found within our 2021 EDI Report. **Citizen's Advisory Group** The Citizen Advisory Group (CAG) helps to bring the patient voice and perspective to healthcare regulation in Ontario. The CAG is made up of patients and caregivers from across the province and provides essential feedback on important regulatory issues such as standards of practice, professional rules, policies, strategic priorities, and communications directed at the public. CPSO Chairs the Citizen Advisory Group on behalf of a partnership of 21 health regulatory colleges. In 2021, consistent and determined efforts were made to diversify the group and recruiting focused on adding members from equity seeking and underrepresented groups. As described more fully below in Measures 5, 6, and 8, an EDI lens is being built into the CAG in order to reflect changing public attitudes and expectations. This work will continue into 2022 and beyond. Policy staff and the EDI lead also worked with Nishnawbe Aski Nation during the review of the Complementary and Alternative Medicine policy. As a result of this consultation, Indigenous (and other) traditional medicines and traditional healing are now specifically mentioned in the policy. **New Land Acknowledgment** A new land acknowledgment was developed and presented to Council that recognized the role that health regulators may play in perpetuating colonization and racism and the work needed to action reconciliation. The land acknowledgement was supported by Council and well received by the broader community. An archived video of the land acknowledgement from December 2021 can be viewed here: https://www.youtube.com/watch?v=5x8mo6C3f28 . **Patient and Public Help Centre** With the support of an audio interpretation service, patients calling CPSO can now connect with an interpreter in one of 240 languages, including the three most commonly spoken Indigenous languages in Ontario. The interpreter can facilitate communication, and ensure any questions or concerns are accurately presented. These languages were added to help support the public and communities and to address the impact of inequity.

			CPSO Pay Equity Analysis In 2021 CPSO retained Korn Ferry, in collaboration with the Human Resources Department, to conduct a pay equity analysis to ensure our compensation structure and new salary administration plan, introduced in 2020, was gender-neutral and compliant with pay equity legislation. The analysis identified and adjusted the compensation of underpaid female job classes so that they are paid at least as much as an equal or comparable male job class or classes. The results of the analysis were posted for staff review. **Complaints Involving Discrimination** Our EDI Lead worked with leadership in Investigations and Resolutions and Senior Legal Counsel to develop training and resources for investigators and ICRC members to assist with managing complaints of discrimination. The ICRC has been provided with the relevant tools, information, and training to assist members in examining complaints of discrimination through the appropriate lens (e.g. anti-racism lens). As part of this process an EDI library of up-to-date, credible resources was created by the EDI Lead and our CPSO librarian. These resources are provided by the investigator to the subject physician and the ICRC to allow both parties to have appropriate and relevant information regarding EDI. Decision administrators have developed tools to support the committee to ensure appropriate language and context are employed in the writing of the decision. This is aligned with expectations from bodies such as Health Professions Appeal and Review Board and FMRAC regarding the management of complaints of racism or other forms of discrimination.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (optional)

	Measure **4.1 The College demonstrates responsible stewardship of its financial and human resources in achieving its statutory objectives and regulatory mandate.**		
DOMAIN 2: RESOURCES	STANDARD 4	**Required Evidence**	**College Response**
		a. The College identifies activities and/or projects that support its strategic plan including how resources have been allocated. Further clarification: A College's strategic plan and budget should be designed to complement and support each other. To that end, budget allocation should depend on the activities or programs a College undertakes or identifies to achieve its goals. To do this, a College should have estimated the costs of each activity or program and the budget should be allocated accordingly.	The College fulfills this requirement: Yes • Please insert a link to Council meeting materials that include discussions about activities or projects to support the strategic plan ***AND*** a link to most recent approved budget. • Please briefly describe how resources were allocated to activities/projects in support of the strategic plan. The strategic plan and the associated resources were discussed at two meetings of the Finance and Audit Committee and presented to Council along with any new requirements. The 2022 CPSO budget outlines the associated costs of each of the College's activities with the resources needed to support the College's strategic plan. The budget, approved by Council in December 2021, can be found in these materials beginning at p. 123. For example, Council was fully informed of the recent changes in our Enterprise Management System. This consisted of updates to Solis (CPSO's member database), Vault (CPSO's document management system), and Finance and Operations (F&O) systems. These upgrades to our systems were identified in our strategic plan as a Continuous Improvement measure and the Registrar gave an update at each 2021 Council session as to the progress of the Solis, Vault and F&O systems. In addition, as part of our best practices, a reserve fund was set up to support Continuous Improvement to our systems.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Choose an item
			Additional comments for clarification (optional)

		b. The College: i. has a "financial reserve policy" that sets out the level of reserves the College needs to build and maintain in order to meet its legislative requirements in case there are unexpected expenses and/or a reduction in revenue and ii. possesses the level of reserve set out in its "financial reserve policy".	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
			• Please insert a link to the "financial reserve policy" ***OR*** Council meeting materials where financial reserve policy has been discussed and approved. • Please insert the most recent date when the "financial reserve policy" has been developed ***OR*** reviewed/updated. • Has the financial reserve policy been validated by a financial auditor? Choose an item	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (if needed)	

		c. Council is accountable for the success and sustainability of the organization it governs. This includes: i. regularly reviewing and updating written operational policies to ensure that the organization has the staffing complement it needs to be successful now and, in the future (e.g. processes and procedures for succession planning for Senior Leadership and ensuring an organizational culture that attracts and retains key talent, through elements such as training and engagement).	The College fulfills this requirement:	Yes
			• Please insert a link to the College's written operational policies which address staffing complement to address current and future needs. • Please insert a link to Council meeting materials where the operational policy was last reviewed. **Note:** Colleges are encouraged to add examples of written operational policies that they identify as enabling a sustainable human resource complement to ensure organizational success. Operational policies, being operational in nature, are not generally issues for Council decision-making. With that said, CPSO has a recruitment policy to address current and future staffing needs, posted internally. In addition, CPSO ensures organizational success with a sustainable human resource complement through a number of processes and tools, including position management practices within the Human Resources department and the annual budget planning process. The latter is designed to ensure that managers and directors plan staffing requirements for the following year, taking to account new and upcoming vacancies and departmental budgets. Every year, as part of Budget process, current and projected staffing needs are identified and assessed by the Finance and Audit Committee. Decisions of the Committee relating to staffing are then presented to Council for approval. (The 2022 budget, approved by Council in December 2021, can be found in these materials beginning at p. 123.) In addition, during the CEO/Registrar's annual performance review, the Executive Committee and Council see the balanced scorecard, a strategy performance management tool that includes a review of the Key Performance Indicators and feedback from stakeholders, Council surveys and assessments, and staff engagement surveys. In that review, Council has opportunity to discuss any succession planning, HR, and resources concerns it may have. Succession planning will be a focus of CPSO for 2022 now that most of the work on internal enterprise system (described above in 4.1.a.) is concluding. Finally, many operational policies are included in the Declaration of Adherence package, with which all Council members are required to comply each year.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	

		ii. regularly reviewing and updating the College's data and technology plan to reflect how it adapts its use of technology to improve College processes in order to meet its mandate (e.g., digitization of processes such as registration, updated cyber security technology, searchable databases).	The College fulfills this requirement:	Yes
			• Please insert a link to the College's data and technology plan which speaks to improving College processes ***OR*** please briefly describe the plan. All CPSO electronic data is either in progress or has been migrated from on premises servers to the cloud, which started in 2019 and completed by early 2022. Moving to the cloud has enabled the CPSO to manage data and access through various governance models and protect with multiple layers of security. All member data that has been migrated to the cloud has also received an updated security model that does not allow devices that no longer meet the security requirements to access the system. All CPSO users are required to use CPSO managed and issued devices to work on the internal CPSO systems or technology that meet our security standards. All CPSO users also use Multi-Factor Authentication for additional security. All Council and Committee members are required to adhere to the CPSO's technology policies as outlined in the Declaration of Adherence that they are required to sign on an annual basis. These were last updated in December 2021 (relevant Council materials can be found here beginning at p. 117).	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	

DOMAIN 3: SYSTEM PARTNER

STANDARD 5 and STANDARD 6

Measure / Required evidence: N/A	College response ***Colleges are requested to provide a narrative that highlights their organization's best practices for the following two standards. An exhaustive list of interactions with every system partner that the College engaged with is not required.*** ***Colleges may wish to provide information that includes their key activities and outcomes for each best practice discussed with the ministry, or examples of system partnership that, while not specifically discussed, a College may wish to highlight as a result of dialogue.***
The two standards under this domain are not assessed based on measures and evidence like other domains, as there is no 'best practice' regarding the execution of these two standards. Instead, Colleges will report on key activities, outcomes, and next steps that have emerged through a dialogue with the Ministry of Health. Beyond discussing what Colleges have done, the dialogue might also identify other potential areas for alignment with other Colleges and system partners.	**Standard 5: The College actively engages with other health regulatory colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.** Recognizing that a College determines entry to practice for the profession it governs, and that it sets ongoing standards of practice for the profession it regulates and that the profession has multiple layers of oversight (e.g. by employers, different legislation, etc.), Standard 5 captures how the College works with other health regulatory colleges and other system partners to support and strengthen alignment of practice expectations, discipline processes, and quality improvement across all parts of the health system where the profession practices. In particular, a College is asked to report on: • *How it has engaged other health regulatory Colleges and other system partners to strengthen the execution of its oversight mandate and aligned practice expectations? Please provide details of initiatives undertaken, how engagement has shaped the outcome of the policy/program and identify the specific changes implemented at the College (e.g., joint standards of practice, common expectations in workplace settings, communications, policies, guidance, website, etc.).* System Collaboration is one of the five elements of CPSO's Strategic Plan. To achieve system collaboration, CPSO will continue to develop open and collaborative relationships that support a connected health system and promote interprofessional collaboration and share best practices. **Health Profession Regulators of Ontario**: CPSO frequently collaborates with other health regulatory Colleges through the Health Profession Regulators of Ontario (HPRO). CPSO attends and participates in regular board meetings and biweekly information-sharing sessions to share resources, practices, and learnings. Where possible, we seek and maximize opportunities to achieve consistency across our regulatory functions. CPSO also participates in **HPRO's Practice Advisors network**, designed for practice advisors across the different Ontario health regulatory bodies to share experiences, learnings, and issues across the colleges. For example, a college may be developing or implementing a new internal policy/protocol or external policy, and they may ask other colleges for feedback on their implementation process or policy. This work directly contributes to and promotes alignment between colleges on key practice issues.

	All policy reviews include a jurisdictional scan looking at alignment with other health/medical regulatory authorities as appropriate, and this can involve outreach to and collaboration with other health regulatory colleges on specific issues and files. For example, in the context of the Dispensing Drugs policy review, CPSO worked closely with the **Ontario College of Pharmacists** to ensure alignment of expectations for pharmacists and physicians. In addition, the Delegation of Controlled Acts policy review included particular efforts to work with the **College of Nurses of Ontario** to align our understanding and implementation of concepts of delegation. This review also closely considered the HPRO's *Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario* to ensure alignment across the sector. CPSO conducts regular meetings with the **Ontario Medical Association** and the **Ontario College of Family Physicians**. These meetings allow CPSO to share updates and perspectives on emerging or developing policy and practice issues. Over the last two years, it has also allowed CPSO to develop and promote consistent messaging to help physicians understand practice expectations and respond in a pandemic environment. Through late 2020 and early 2021, CPSO worked closely with key stakeholders including the **Professional Association of Residents of Ontario** and the **Medical Council of Canada** to enable residents to safely transition to independent practice following challenges experienced during the pandemic with the Medical Council of Canada Qualifying Examination (MCCQE) Part II. In early 2021, CPSO worked quickly to create an immediate path for licensure for residents who had not completed the MCCQE Part II (found here starting at p. 89), and in the fall of 2021, created a policy solution for residents (found here at p. 187) to enable a path for licensure following the discontinuation of the MCCQE Part II in June 2021. (The current policy is found here.) This work, which also included additional supporting guidance and information for physicians, was completed in close consultation with other colleges, PARO, and the MCC. In June 2021, CPSO participated in a two-day **Think Tank for the Advisory Group for Regulatory Excellence (AGRE)** organized by the College of Nurses of Ontario. The objective was to generate common guiding principles and/or draft competencies related to digital compassion. The Think Tank resulted in a report outlining guiding principles and competencies that were then considered as part of the research undertaken for CPSO's Telemedicine policy review. CPSO collaborated with Ontario's **Chief Medical Officer of Health** to help communicate to and support physicians in understanding pandemic-related issues, including the restrictions and resumption of services at various points in the pandemic, the balance between in-person and virtual care, and the scope of appropriate medical exemptions for the COVID-19 vaccine. This work includes but is not limited developing a COVID-19 FAQ for Physicians and a communication to physicians in eDialogue, which began in the summer of 2021 and is still ongoing. In the fall of 2021, CPSO worked with the **Federation of Medical Regulatory Authorities of Canada** on a Statement on Indigenous-specific Racism in recognition of the inaugural National Day for Truth and Reconciliation. CPSO Medical Advisor and Equity, Diversity, and Inclusion (EDI) Lead Dr. Saroo Sharda is a member of the national working group (the FMRAC Working Group on Anti-Racism) leading this work. The CPSO EDI Lead also represented the CPSO at Federal meetings on anti-Indigenous racism in 2021. Key themes from those meetings were brought back to inform CPSO EDI work. Finally, CPSO administers and Chairs the **Citizen Advisory Group (CAG)**, a partnership of over 20 health colleges that serves as a forum to consult with patients and the public, and facilitates collaboration between the colleges on a variety of issues of policy and practice. Through 2021, CPSO has worked with the CAG partnership to mature the CAG, including by implementing member Terms of References and a Code of Conduct. This content is being co-developed with CAG members and demonstrates an effort to use member engagement to improve the quality of that engagement.

	Standard 6: The College maintains cooperative and collaborative relationships and responds in a timely and effective manner to changing public/societal expectations. The intent of Standard 6 is to demonstrate that a College has formed the necessary relationships with system partners to ensure that it receives and contributes information about relevant changes to public expectations. This could include both relationships where the College is asked to provide information by system partners, or where the College proactively seeks information in a timely manner. *Please provide examples of key successes and achievements from the reporting year where the College engaged with partners, including patients/public to ensure it can respond to changing public/societal expectations (e.g., COVID-19 Pandemic). Please also describe the matters that were discussed with each of these partners andhow the information that the College obtained/provided was used to ensure the College could respond to a public/societal expectation.* *In addition to the partners it regularly interacts with, the College is asked to include information about how it identifies relevant system partners, maintains relationships so that the College is able access relevant information from partners in a timely manner, and leverages the information obtained to respond (specific examples of when and how a College responded is requested in Standard 7).* All of the CPSO's collaborative work highlighted above in Standard 5 also apply to Standard 6 as examples of our efforts to serve the people of Ontario through effective medical regulation, demonstrating our commitment to being accountable and responsive to the public. CPSO also regularly engages with health system stakeholders specifically to respond to changing public/societal expectations. While not an exhaustive list, a few different examples are included to highlight the breadth of partners, including patients/the public, with whom CPSO engages. Following initial discussions to identify concrete opportunities to better serve patients living in Indigenous communities, CPSO is in the process of engaging in a relationship accord with the **Nishnawbe Aski Nation (NAN)** to guide the partnership between NAN and CPSO as NAN proceeds with their Health Transformation process. This allows both parties to develop mutually supported initiatives to enable the NAN territory to build capacity and transform the experiences for the First Nations people within the health system. CPSO's EDI Lead has had multiple meetings with NAN, and we expect to finalize and sign this accord in 2022. Policy staff and the CPSO EDI lead also worked with Nishnawbe Aski Nation during the Complementary and Alternative Medicine policy review. As a result of this consultation, Indigenous (and other) traditional medicines and traditional healing are now specifically mentioned in the policy, and a companion resource outlines how the policy applies in these contexts. Our EDI Lead also collaborated with multiple other stakeholders and partners in 2021 and was invited to speak at multiple events. A list of these stakeholders and events can be found on pages 18 and 19 of the 2021 EDI Report. CPSO and the **Office of the Patient Ombudsman** share a common mandate in serving the public interest. We continued discussions through 2021 to explore opportunities to collaborate where appropriate. During the Covid-19 response, CPSO worked closely with government to provide and clarify information to assist with the province's response to the pandemic. CPSO was a critical source of information for physicians and many patients who were looking for guidance around what to expect regarding their care, and developed COVID-19 FAQ documents for both physicians and patients. CPSO continuously adapted to public expectations and provided the most current information to patients through the website. In addition, CPSO administers and Chairs the **Citizen Advisory Group (CAG)**, a partnership among over 20 colleges and serves as a forum to consult with patients and public

	about various issues that the colleges are facing. The CAG is consulted frequently on a variety of issues where the public voice adds tremendous value. As an example, in February 2021 members of the CAG reviewed CPSO's Alternative Dispute Resolution (ADR) webpage to provide feedback on the public information available regarding the early resolution process, including whether CPSO's ADR processes are clear, whether the information is accessible, and whether having ADR available demonstrates CPSO's commitment to being responsive and taking complainants seriously. In the last year, efforts have been made to augment our public engagement efforts for policy consultations to seek feedback from equity-seeking groups and providers serving these communities. Specifically, as part of the review for the Medical Assistance in Dying and Professional Obligations and Human Rights policies, **stakeholder summits** were convened to seek feedback from stakeholders and enable open dialogue. These meetings had a diversity of participants including those representing disabled, Indigenous, LGBTQ2S+, elderly, and substance-using communities. Faith-based groups and those delivering mental health and addictions services, people living with obesity, sexual health services, and groups providing care for inner city health populations were also represented. The feedback received directly influenced the work to review and update these CPSO policies. Finally, CPSO regularly uses **surveying and public polling** to inform policy and practice changes in response to public expectations. In 2021, CPSO engaged in four rounds of polling: • Regular surveying to understand awareness and understanding of CPSO along with public support for self-regulation in general, as well as how it relates to CPSO and other health care professionals – this is part of CPSO's routine reputation monitoring efforts (winter 2021). • Polling on issues relating to human rights in the practice of medicine, including the importance of addressing issues of equity and exploring attitudes regarding issues of conscientious objection – these results were used as part of ongoing policy reviews (spring 2021). • Polling to understand public expectations regarding physician behaviour on social media – these results were used as part of a policy review to explore public attitudes (spring 2021). • Polling on issues relating to end-of-life care and in particular attitudes relating to the provision of CPR and writing of no-CPR orders – these will be used as part of a policy review to understand public expectations (ongoing).

		Measure 7.1 The College demonstrates how it protects against and addresses unauthorized disclosure of information.	
DOMAIN 4: INFORMATION MANAGEMENT	STANDARD 7	**Required Evidence**	**College Response**
		a. The College demonstrates how it: i. uses policies and processes to govern the disclosure of, and requests for information;	The College fulfills this requirement: Yes • Please insert a link to policies and processes OR please briefly describe the respective policies and processes that addresses disclosure and requests for information. In September 2014, Council approved a strategy for data sharing that includes a governance structure, vision, and decision-making tool. Underpinning the vision are principles that provide a foundation for sound decision-making. The decision tool and governance structure enhance both the consistency and timeliness of responses to data-sharing requests. CPSO's data sharing was further updated in fall 2020 to a streamlined, timely, resource-efficient process to manage and provide information to health care stakeholders. The details of the policy and decision-making tool that governs the disclosure of information can be found on our website. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* Choose an item *Additional comments for clarification (optional)*
		ii. uses cybersecurity measures to protect against unauthorized disclosure of information; and iii. uses policies, practices and processes to address accidental or unauthorized disclosure of information.	The College fulfills this requirement: Yes • Please insert a link to policies and processes ***OR*** please briefly describe the respective policies and processes to address cybersecurity and accidental or unauthorized disclosure of information. CPSO has implemented an Information Breach Protocol that, in addition to reiterating the importance of confidentiality (also addressed in the CPSO Confidentiality Policy), sets out the process for addressing the loss or theft of confidential information and the unauthorized access, use or disclosure of confidential information. The process requires information breaches to be reported to the CPSO Privacy Officer, and provides for containment, assessment, mitigation, notification and prevention steps to be taken as deemed appropriate by the Privacy Officer and the incident response team for each information breach. The Information Breach Protocol also specifically addresses reporting and investigating information breaches caused by or involving cybersecurity incidents or technology system malfunction or misuse. Reported information breaches are tracked and recorded by the Privacy Officer. CPSO has also implemented a Protocol for Access to CPSO Information for Monitoring and Review that provides a process and oversight for monitoring or reviewing the use of CPSO technology by CPSO personnel and the CPSO information generated or stored by CPSO personnel on CPSO technology when deemed necessary. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* Choose an item *Additional comments for clarification (optional)*

	Measure **8.1 All policies, standards of practice, and practice guidelines are up to date and relevant to the current practice environment (e.g. where appropriate, reflective of changing population health needs, public/societal expectations, models of care, clinical evidence, advances in technology).**		
DOMAIN 5: REGULATORY POLICIES STANDARD 8	**Required Evidence**	**College Response**	
	a. The College regularly evaluates its policies, standards of practice, and practice guidelines to determine whether they are appropriate, or require revisions, or if new direction or guidance is required based on the current practice environment.	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
		• Please insert a link to document(s) that outline how the College evaluates its policies, standards of practice, and practice guidelines to ensure they are up to date and relevant to the current practice environment ***OR*** please briefly describe the College's evaluation process (e.g., what triggers an evaluation, how often are evaluations conducted, what steps are being taken, which stakeholders are being engaged in the evaluation and how are they involved).	
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
		Additional comments for clarification (optional)	

		b. Provide information on how the College takes into account the following components when developing or amending policies, standards and practice guidelines: i. evidence and data; ii. the risk posed to patients / the public; iii. the current practice environment; iv. alignment with other health regulatory Colleges (where appropriate, for example where practice matters overlap); v. expectations of the public; and vi. stakeholder views and feedback.	The College fulfills this requirement:	Yes
			• Please insert a link to document(s) that outline how the College develops or amends its policies, standards of practice, and practice guidelines to ensure they address the listed components ***OR*** please briefly describe the College's development and amendment process. The policy review process is multi-staged. Once a policy review is launched, the following steps are undertaken: • An analysis of any available CPSO data regarding complaints, investigations, or discipline findings • A review of any information provided by staff from the CPSO's Physician Advisory Service and the Public Help Centre • A comprehensive literature review of available data, evidence, and academic literature on the topic • A jurisdictional scan of other Canadian medical regulatory authorities and other Ontario health colleges, where relevant • An external consultation seeking feedback from all stakeholders, physicians, and members of the public (typically 60 days, but extended in some cases). The consultation process involves broad and targeted announcements and direct invitations to participate via an internal database of interested parties. • Facilitation of patient engagement activities, including the involvement of the Citizen Advisory Group, public polling, and/or stakeholder summits where appropriate. All of the above research and feedback (from the public, physicians, and stakeholder organizations) inform the development of a draft policy, which is also examined through the lens of implementing right-touch regulation and ensuring CPSO's public mandate is being fulfilled. The draft policy is then circulated for external consultation again. Revisions are then made in response to additional feedback from these same groups before receiving final approval from CPSO Council. All of this work is undertaken with the assistance of a Policy Review Working Group comprised of a diverse group of physicians and public members of Council and CPSO staff. Council must approve all CPSO draft policies prior to external consultation, and all revised policies must again be approved by Council before becoming a policy of CPSO. Each decision point is supported by the development of a comprehensive briefing note highlighting the various factors considered for the key policy changes being proposed (see e.g. Council materials regarding the Virtual Care draft policy (p. 123); Social Media draft policy (p. 196)). Outside of the normal policy review cycle, CPSO regularly monitors the external environment to determine whether new policy expectations or revised expectations are necessary. This includes keeping apprised of relevant legislative and regulatory developments, court cases, government announcements, revisions to guidance provided by other health Colleges, and changes in physician practice. For example, CPSO is exploring an update to our approach to regulating social media use by physicians by transitioning from a statement outlining general principles to a new policy setting out specific expectations (p. 123). In addition, the review of the current Telemedicine policy was expedited in light of learnings about how the provision of virtual care arose in a transformative way as a result of the pandemic. These examples demonstrate how the external environment triggered either a change in approach or an accelerated approach in the policy development process outside the normal review cycle.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	

		c. The College's policies, guidelines, standards and Code of Ethics should promote Diversity, Equity and Inclusion (DEI) so that these principles and values are reflected in the care provided by the registrants of the College.	The College fulfills this requirement:	Yes
			• Please briefly describe how the College reviews its policies, guidelines, standards and Code of Ethics to ensure that they promote Diversity, Equity and Inclusion. • Please highlight some examples of policies, guidelines, standards or the Code of Ethics where Diversity, Equity and Inclusion are reflected. To ensure that that CPSO policies promote and reflect EDI principles and values, in 2021 all CPSO policy staff received specific education and training opportunities, including the Indigenous cultural safety training program and Tidal Equality (equity sequence training that provided concrete tools of how to embed an equity analysis into CPSO's work). In addition, over the course of 2021, external guests held eight sessions for Council and committees, sharing their expertise and lived experience of topics including unconscious bias, anti-Indigenous racism, and privilege and allyship. This work has helped to support training, education, and adoption of these principles at the decision-making stage of the policy process. Moreover, the College's EDI Lead Dr. Saroo Sharda supports the Policy Review Working Group in its review of certain CPSO policies, including the Professional Obligations and Human Rights and the Social Media policies in 2021. In addition, the new Professional Responsibilities in Medical Education policy, which was approved in early 2021, was revised to include expectations around the prevention of violence, harassment, and forms of discrimination (Council materials here at p. 105). These revised expectations were developed in light of feedback from medical students, including a survey of students conducted by the University of Toronto; CPSO was aware of this survey through the Professionalism and Ethics Committee for the undergraduate medicine program at UofT, on which the CPSO Director of Policy sits. More generally, the CPSO policy process includes inviting key stakeholders representing EDI perspectives and marginalized populations to participate in our policy consultation process. In addition, and as noted above in Standard 5, as part of the review for the Professional Obligations and Human Rights (POHR) and Medical Assistance in Dying policies, stakeholder summits were convened to seek feedback from stakeholders and enable open dialogue. These meetings had a diversity of participants including those representing disabled, Indigenous, LGBTQ2S+, elderly, and substance-using communities. Faith-based groups and those delivering mental health and addictions services, people living with obesity, sexual health services, and groups providing care for inner city health populations were also represented. As part of the POHR review, CPSO also conducted public polling human rights and discrimination issues to learn the public's expectations around addressing these issues in medicine. All this feedback is directly influencing the work to review and update these CPSO policies. Finally, CPSO has worked with members of the Citizen Advisory Group to co-design Terms of References for their involvement in the group, including setting out member term limits and a Code of Conduct. These changes are being made in an effort to support good governance changes and to bring more diversity and representation into the CAG membership so that different perspectives are informing CPSO consultations. The co-design process is an example of how CPSO is attempting to build equity into the process of making the CAG itself more equitable.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	

	Measure **9.1 Applicants meet all College requirements before they are able to practice.**		
DOMAIN 6: SUITABILITY TO PRACTICE STANDARD 9	**Required Evidence**	**College Response**	
	a. Processes are in place to ensure that those who meet the registration requirements receive a certificate to practice (e.g., how it operationalizes the registration of members, including the review and validation of submitted documentation to detect fraudulent documents, confirmation of information from supervisors, etc.)[2].	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
		• Please insert a link that outlines the policies or processes in place to ensure the documentation provided by candidates meets registration requirements ***OR*** please briefly describe in a few words the processes and checks that are carried out. • Please insert a link ***OR*** please briefly describe an overview of the process undertaken to review how a College operationalizes its registration processes to ensure documentation provided by candidates meets registration requirements (e.g., communication with other regulators in other jurisdictions to secure records of good conduct, confirmation of information from supervisors, educators, etc.).	

[2] This measure is intended to demonstrate how a College ensures an applicant meets every registration requirement set out in its registration regulation prior to engaging in the full scope of practice allowed under any certificate of registration, including whether an applicant is eligible to be granted an exemption from a particular requirement.

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	
		b. The College periodically reviews its criteria and processes for determining whether an applicant meets its registration requirements, against best practices (e.g. how a College determines language proficiency, how Colleges detect fraudulent applications or documents including applicant use of third parties, how Colleges confirm registration status in other jurisdictions or professions where relevant etc.).	The College fulfills this requirement:	Yes
			• Please insert a link that outlines the policies or processes in place for identifying best practices to assess whether an applicant meets registration requirements (e.g. how to assess English proficiency, suitability to practice etc.), a link to Council meeting materials where these have been discussed and decided upon ***OR*** please briefly describe the process and checks that are carried out. • Please provide the date when the criteria to assess registration requirements was last reviewed and updated. We continue to evaluate our registration requirements on a regular basis. We have numerous policies that enable us to register qualified candidates outside of the requirements prescribed in the Regulation. We engage in dialogue with the other Canadian medical regulators (FMRAC), the certifying Colleges (Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada) and the Ontario medical schools. We routinely review our requirements and policies, and in 2021 saw revisions to the existing policies for Academic Registration and Alternative Pathways to Registration. Additionally, this year saw the approval of two new Registration Pathways. In view of the postponement and eventual cessation of the Part 2 of the Medical Council of Canada Qualifying Examination (MCCQE2), which is a requirement prescribed in the Regulation for the issuance of an Independent Practice Certificate, CPSO approved two policies: Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption (beginning at p. 90) and Licentiate of the Medical Council of Canada (LMCC) Policy. In terms of credentialing, CPSO does not utilize third parties to assess or analyze credentials. All document credentialing/source verification is completed in-house. Every application is supported by source documents, including Certificates of Professional Conduct (Certificates of Standing) from every jurisdiction where an individual has practiced medicine/been registered, confirmation of training and certification from the appropriate bodies, letters of reference, etc. Across Canada we are leaders in source verification and complex credentialing and have a vast repository of up-to-date resources to confirm authenticity of documentation. Further, we complete periodic quality assurance checks with the source bodies to ensure accuracy. As opposed to simple source verification which confirms the document is where it says it is from, CPSO conducts complex credentialing to piece together practice history and satisfy the conduct/character and suitability to practice requirement. We receive documentation electronically via password-protected document sent from an institutional email address for which we have a Memorandum of Agreement or sent from a verifiable organizational email address/server, clearly identifying sender's name and position/title. We may also receive source documentation via mail/courier in official sealed and stamped envelope from the source organization. Additionally, we verify the sender's address via the organization's website.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item

			Additional comments for clarification (optional)
		Measure **9.2 Registrants continuously demonstrate they are competent and practice safely and ethically.**	
		c. A risk-based approach is used to ensure that currency[3] and other competency requirements are monitored and regularly validated (e.g., procedures are in place to verify good character, continuing education, practice hours requirements etc.).	The College fulfills this requirement: Yes • Please briefly describe the currency and competency requirements registrants are required to meet. • Please briefly describe how the College identified currency and competency requirements. • Please provide the date when currency and competency requirements were last reviewed and updated. • Please briefly describe how the College monitors that registrants meet currency and competency requirements (e.g. self-declaration, audits, random audit etc.) and how frequently this is done. Physicians must remain qualified, competent and fit to practise medicine within their scope of practice at all times. There are several factors to consistently maintain the necessary knowledge, skills and experience to practise medicine safely and ethically. The Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice policy was last reviewed and updated in February 2018. This policy revision involved a thorough review of the literature, an environmental scan looking to other Canadian and US Regulators, and best practices. In terms of ongoing education, the Quality Assurance Regulation of the College requires members to be registered with and meet the Continuing Professional Development (CPD) requirements of one of the following 3 bodies: the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada (RCPSC) or the Medical Psychotherapy Association of Canada (MPAC). Every year on the Annual Membership Renewal, members are asked to attest that they are enrolled with one of the aforementioned bodies, and are compliant with their respective CPD requirements. In addition, CPSO's suite of Quality Improvement programs are built to ensure Ontario's physicians are engaging in self-reflection, self-improvement and meeting their quality requirements in five-year cycles. These programs take a strategic, data-driven approach to assessing physicians and ensuring they are delivering the best possible care to Ontario patients. This process will connect with more physicians more regularly to create the most favourable conditions to ensure their success at all stages of their careers. CPSO's Quality Improvement (QI) Program for individual physicians builds on the principles of right-touch regulation and our commitment to fulfilling our mandate ensuring quality care for patients in Ontario. The QI Program is proactive, self-directed, and encourages physicians to reflect on their own delivery of health care without a large time commitment. The QI for individuals program is comprised of a QI survey, The Practice Profile, The Self-Guided Chart Review, The Data-Driven Quality Improvement Tool, The Practice Improvement Plan and One-on-One Coaching. In terms of conduct/character requirements, all applicants must satisfy the non-exemptible requirement for registration: **2. (1)** It is a non-exemptible standard and qualification for a certificate of registration that the applicant's past and present conduct afford reasonable grounds for belief that the applicant,

			(a) is mentally competent to practise medicine; (b) will practise medicine with decency, integrity and honesty and in accordance with the law; (c) has sufficient knowledge, skill and judgment to engage in the kind of medical practice authorized by the certificate; and (d) can communicate effectively and will display an appropriately professional attitude. O. Reg. 865/93, s. 2 (1). Applicants are asked a series of questions on the application form designed to elicit responses to assess their conduct and character requirements. As part of the credentialing process, all applicants must submit a criminal record check conducted within the previous 6 months. In addition to this, all applicants are required to disclose any professional misconduct, remediation or adverse action against them. Applications are referred to the College's Registration Committee to determine whether an applicant would qualify for a certificate of registration to practise medicine in Ontario. On an annual basis through the membership renewal process, members are asked to provide updates on a variety of questions, including whether they have been subject to any disciplinary action, privilege changes, criminal charges, etc. since the previous renewal.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	

[3] A 'currency requirement' is a requirement for recent experience that demonstrates that a member's skills or related work experience is up-to-date. In the context of this measure, only those currency requirements assessed as part of registration processes are included (e.g. during renewal of a certificate of registration, or at any other time).

		Measure **9.3 Registration practices are transparent, objective, impartial, and fair.**		
		a. The College addressed all recommendations, actions for improvement and next steps from its most recent Audit by the Office of the Fairness Commissioner (OFC).	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
			• Please insert a link to the most recent assessment report by the OFC ***OR*** please provide a summary of outcome assessment report. • Where an action plan was issued, is it: Choose an Item	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (if needed)	
DOMAIN 6: SUITABILITY TO PRACTICE	STANDARD 10	**Measure** **10.1 The College supports registrants in applying the (new/revised) standards of practice and practice guidelines applicable to their practice.**		
		Required Evidence	**College Response**	
		a. Provide examples of how the College assists registrants in implementing required changes to standards of practice or practiceguidelines (beyond communicating the existence of new standard, FAQs, or supporting documents). <u>Further clarification:</u> Colleges are encouraged to support registrants when implementing changes to	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
			• Please briefly describe a recent example of how the College has assisted its registrants in the uptake of a new or amended standard: – Name of Standard – Duration of period that support was provided – Activities undertaken to support registrants – % of registrants reached/participated by each activity – Evaluation conducted on effectiveness of support provided • Does the College always provide this level of support: Choose an item *If not, please provide a brief explanation:*	

		standards of practice or guidelines. Such activities could include carrying out a follow-up survey on how registrants are adopting updated standards of practice and addressing identifiable gaps.	*If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?*	Choose an item
			Additional comments for clarification (optional)	
		Measure: **10.2 The College effectively administers the assessment component(s) of its QA Program in a manner that is aligned with right touch regulation[4].**		
		a. The College has processes and policies in place outlining: i. how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice;	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
			• Please list the College's priority areas of focus for QA assessment and briefly describe how they have been identified ***OR*** please insert a link to the website where this information can be found. • Is the process taken above for identifying priority areas codified in a policy: Choose an item *If yes, please insert link to policy:*	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	

[4] "Right touch" regulation is an approach to regulatory oversight that applies the minimal amount of regulatory force required to achieve a desired outcome. (Professional Standards Authority. Right Touch Regulation. https://www.professionalstandards.org.uk/publications/right-touch-regulation).

		ii. details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity (and which type of multiple assessment activities); and	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
			• Please insert a link to document(s) outlining details of right touch approach and evidence used (e.g. data, literature, expert panel) to inform assessment approach ***OR*** please briefly describe right touch approach and evidence used. • Please provide the year the right touch approach was implemented ***OR*** when it was evaluated/updated (if applicable). *If evaluated/updated, did the college engage the following stakeholders in the evaluation:* – *Public* Choose an item – *Employers* Choose an item – *Registrants* Choose an item – *other stakeholders* Choose an item	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	
		iii. criteria that will inform the remediation activities a registrant must undergo based on the QA assessment, where necessary.	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
			• Please insert a link to the document that outlines criteria to inform remediation activities ***OR*** list criteria.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	
		Measure: **10.3 The College effectively remediates and monitors registrants who demonstrate unsatisfactory knowledge, skills, and judgment.**		
		a. The College tracks the results of	The College fulfills this requirement:	Yes

		remediation activities a registrant is directed to undertake as part of any College committee and assesses whether the registrant subsequently demonstrates the required knowledge, skill and judgement while practising.	• Please insert a link to the College's process for monitoring whether registrant's complete remediation activities ***OR*** please briefly describe the process. • Please insert a link to the College's process for determining whether a registrant has demonstrated the knowledge, skills and judgement following remediation ***OR*** please briefly describe the process. The Quality Assurance Committee can request the member undergo a peer and practice reassessment that focuses on the areas of concern to ensure that the member has fulfilled the requirements. This is based on their response to the Opportunity to Address (OTA) avenues described above. These peer and practice reassessments happen within 12 months following the QAC decision. If there are clinical concerns identified following the OTA process and/or the physician has no insight into the deficiencies the QAC has the power under section 80.2 to resolve the matter via SCERP (Specified Continuous Educational Remediation Program). The SCERP is monitored by the College's Compliance Monitoring and Supervision area. Compliance will notify the QAC when the SCERP elements have been successfully completed and returns the matter to the QAC for a reassessment to ensure that the remediation plan has been successful. If the member wishes to resolve the matter by way of an Educational Undertaking, this undertaking is also monitored by the College's Compliance Monitoring and Supervision Department. The Individual Education Plan is developed in consultation with the QAC, which is attached as part of the Undertaking. In these situations, the reassessment is completed by the Compliance Monitoring and Supervision department. Outcomes of the reassessment are not conveyed to the QAC as these matters remain outside of the QAC "black box" of information. https://www.cpso.on.ca/en/Physicians/Your-Practice/Quality-Management/Assessments/Peer-Assessment SCERP and Educational Undertakings are public information and placed on the CPSO website, under the physician's name. These are updated once a member has successfully completed their SCERP and the Educational Undertaking.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE	STANDARD 11	Measure 11.1 The College enables and supports anyone who raises a concern about a registrant.	
		Required Evidence	**College Response**
		a. The different stages of the complaints process and all relevant supports available to complainants are: i. supported by formal policies and procedures to ensure all relevant information is received during intake at each stage, including next steps for follow up; ii. clearly communicated directly to complainants who are engaged in the complaints process, including what a complainant can expect at each stage and the supports available to them (e.g. funding for sexual abuse therapy); and	The College fulfills this requirement: Yes • Please insert a link to the College's website that clearly describes the College's complaints process including, options to resolve a complaint, the potential outcomes associated with the respective options and supports available to the complainant. • Please insert a link to the polices/procedures for ensuring all relevant information is received during intake ***OR*** please briefly describe the policies and procedures if the documents are not publicly accessible. Investigations uses the following to ensure all relevant information is received during all stages of an investigation: • Process guides for ○ Alternate Dispute Resolution (ADR) ○ Assessing Intake file information ○ Assessor interviews ○ Complaints made in bad faith ○ Consent for personal health information ○ Disclosure during an investigation ○ Early resolution process ○ Investigations with EDI concerns ○ Guide to investigative planning ○ Investigative report writing ○ OHIP & Narcotics Monitoring System guide • Complainant is engaged throughout the investigative process ○ Complainants are typically contacted within two business days to confirm their concerns ○ Complainants are provided with information, both verbal and written, on the investigative process, along with Frequently Asked Questions ○ Information about the investigative process can be found on the CPSO website ○ Complainants who have complaints about sexual abuse are connected with a Witness Support Coordinator who provides information on funding for therapy • The website is reviewed regularly and updated as required; resources and process guides are reviewed annually. In addition, as explained in further detail above in 3.3.b., the CPSO EDI lead worked with leadership in Investigations and Resolutions and Senior Legal Counsel to develop a new process for managing complaints of discrimination. The ICRC has been provided with the relevant tools, information, and training to assist members in examining complaints of discrimination through the appropriate lens (e.g. anti-racism lens). The EDI Lead is also available to support the committee at the panel discussion and decision administrators have developed tools to support the committee to ensure appropriate language and context are employed in the writing of the decision.

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	
		iii. evaluated by the College to ensure the information provided to complainants is clear and useful.	The College fulfills this requirement:	Yes
			• Please provide details of how the College evaluates whether the information provided to complainants is clear and useful. See response to 11.1.a. above.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	
		b. The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary.	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
			Please insert rate (see Companion Document: Technical Specifications for Quantitative CPMF Measures). 99.8 calls responded to within 5 business days	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	

		c. Demonstrate how the College supports the public during the complaints process to ensure that the process is inclusive and transparent (e.g. translation services are available, use of technology, access outside regular business hours, transparency in decision-making to make sure the public understand how the College makes decisions that affect them etc.).	The College fulfills this requirement:	Yes
			• Please list supports available for public during complaints process. • Please briefly describe at what points during the complaints process that complainants are made aware of supports available. Support available to the public during the complaints process includes: • Access to an assigned mediator or investigator throughout the entire process; able to communicate via email, telephone or Canada Post • Details of the complaints process on the CPSO website, including how to make a complaint, what to expect, consent and common Q&A • Concerns of the complainant are discussed and confirmed by the mediator/investigator at the initiation of the mediation/investigation • Language translation services are available; either in the moment through a translation service or by sending documents out for translation. With the support of an audio interpretation service, patients calling CPSO can now connect with an interpreter in one of 240 languages, including the three most commonly-spoken Indigenous languages in Ontario. The interpreter can facilitate communication, and ensure any questions or concerns are accurately presented. These languages were added to help support the public and communities and to address the impact of inequity • Complainants contacted within 2 business days • The Ontario Physicians and Surgeons Discipline Tribunal website (opsdt.ca) includes plain-language guides to the process and for witnesses. It has an extensive FAQ and a glossary of terms used in the Tribunal process.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	
		Measure **11.2 All parties to a complaint and discipline process are kept up to date on the progress of their case, and complainants are supported to participate effectively in the process.**		
		a. Provide details about how the	The College fulfills this requirement:	Yes

		College ensures that all parties are regularly updated on the progress of their complaint or discipline case, including how complainants can contact the College for information (e.g., availability and accessibility to relevant information, translation services etc.).	• Please insert a link to document(s) outlining how complainants can contact the College during the complaints process ***OR*** please provide a brief description. • Please insert a link to document(s) outlining how complainants are supported to participate in the complaints process ***OR*** please provide a brief description. An intake investigator contacts the complainant within 2 business days of receiving a public complaint. The intake investigator assesses the complaint for risk, reviews the complaints process with the complainant, explores the intention of their complaint and confirms their concerns. The intake investigator will identify cases appropriate for Alternative Dispute Resolution; these cases are streamed to a mediator. Within a week, the case is assigned to either a mediator or investigator who will contact the complainant to review the details of the complaint and to ensure all appropriate consents are on file. During an investigation, the complainant is kept up to date by the investigator every 3-4 weeks on the status of their complaint. The complainant is contacted when the investigation has been listed for ICRC review. The complainant is sent a copy of the ICRC decision immediately upon release, which is usually within 10 weeks. Once a matter is referred to the Ontario Physicians and Surgeons Discipline Tribunal, the Witness Support Coordinator establishes and maintains regular contact with witnesses to assists in the coordination of scheduling witnesses for hearings and to provide direct support to those testifying at a hearing. The Witness Support Coordinator will follow up with witnesses regarding the outcome and decisions of the OPSDT, provide updates and involve witnesses in penalty hearings, and provide some guidance and structure for witness impact statements if required. As noted above in 11.1.c., language translation services are available, either in the moment through a translation service or by sending documents out for translation.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (optional)	
	STANDARD 12	**Measure** **12.1 The College addresses complaints in a right touch manner.**		
		a. The College has accessible, up-to-date, documented	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021

		guidance setting out the framework for assessing risk and acting on complaints, including the prioritization of investigations, complaints, and reports (e.g. risk matrix, decision matrix/tree, triage protocol).	• Please insert a link to guidance document ***OR*** please briefly describe the framework and how it is being applied. • Please provide the year when it was implemented ***OR*** evaluated/updated (if applicable). Intake investigators assess each public complaint for risk by considering the following (the guide document is in the form a decision tree and a step-by-step process): • Patient safety/public interest • Physician's history with the CPSO, including registration status, previous investigations & outcomes • Isolated report vs. multiple sources with similar information • Another trusted organization is already investigating • Requirements of a public complaint met (e.g. concerns are regarding a physician) • Direction provided to investigations regarding decision-making supports • Checks & balances in place when closing a file without an investigation (investigator à manager à registrar/delegate) Triage team assesses all incoming reports for risk and appropriate action, using the principles of right touch regulation. The decision tree guide document for assessing a public complaint was reviewed in February 2021 and the guide for risk assessment of reports used by the triage team was reviewed in March 2021.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (optional)
	STANDARD 13	**Measure** **13.1 The College demonstrates that it shares concerns about a registrant with other relevant regulators and external system partners (e.g. law enforcement, government, etc.).**	
		a. The College's policy outlining consistent criteria for disclosure and examples of the general circumstances and type of information that has been shared between the College and other relevant system partners, within the legal framework, about concerns with individuals and any results.	The College fulfills this requirement: — Yes met in 2020, continues to meet in 2021
			• Please insert a link to the policy ***OR*** please briefly describe the policy. • Please provide an overview of whom the College has shared information over the past year and purpose of sharing that information (i.e. general sectors of system partner, such as 'hospital', or 'long-term care home').
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item
			Additional comments for clarification (if needed)

DOMAIN 7: MEASUREMENT, REPORTING AND IMPROVEMENT	STANDARD 14	**Measure** **14.1 Council uses Key Performance Indicators (KPIs) in tracking and reviewing the College's performance and regularly reviews internal and external risks that could impact the College's performance.**	
		Required Evidence	**College Response**
		a. Outline the College's KPI's, including a clear rationale for why each is important.	The College fulfills this requirement: Yes met in 2020, continues to meet in 2021
			• Please insert a link to a document that list College's KPIs with an explanation for why these KPIs have been selected (including what the results the respective KPIs tells, and how it relates to the College meeting its strategic objectives and is therefore relevant to track), a link to Council meeting materials where this information is included ***OR*** list KPIs and rationale for selection. CPSO's set of Key Performance Indicators for 2021 were discussed and approved by Council in December 2020 to accompany its Strategic Plan for 2020-2025. The Key Performance Indicators were selected based on how meaningful and relevant they were to the strategic plan and leveraging information that can be collected and monitored in a feasible and timely manner. CPSO successfully met its targets in 2021 and Council discussed and approved a new set of Key Performance Indicators for 2022. Click here to view the relevant Council Materials at pg. 221.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Choose an item
			Additional comments for clarification (if needed)
		b. The College regularly reports to Council on its performance and risk review against: i. stated strategic objectives (i.e. the objectives set out in a College's strategic plan); ii. regulatory outcomes (i.e.	The College fulfills this requirement: Yes
			• Please insert a link to Council meetings materials where the College reported to Council on its progress against stated strategic objectives, regulatory outcomes and risks that may impact the College's ability to meet its objectives and the corresponding meeting minutes. Progress on CPSO's Key Performance Indicators (KPIs) are data-driven indicators measured weekly and reported by management in huddle, shared at every Executive Committee meeting, and rolled up to a quarterly dashboard which is presented to Council and the public via live stream by the Registrar/CEO. The KPIs are aligned with the 2020-2025 Strategic Plan and designed to demonstrate progress against the following strategic priorities: Right-Touch Regulation; Quality Care; System Collaboration; Meaningful Engagement; and Continuous Improvement. The KPIs give Council and the organization a regular update on whether CPSO is at risk organizationally of not meeting its objectives. At the final Council meeting of every year, a working discussion occurs between the board and the CEO around

		operational indicators/targets with reference to the goals we are expected to achieve under the RHPA); and iii. its risk management approach.	planning for the subsequent year's strategic goals and operational targets as it aligns to the College's mandate. Highlights of the March, June, September, and December 2021 meetings of Council are posted online, including an infographic relating to notable KPIs as presented by the CEO/Registrar. The Lean approach to operationalize the delivery of core business has been flexible during the pandemic, allowing for virtual meetings of committees, staff support from the patient support queue, and assessments of physicians in practice. The risk of CPSO shutting down during the pandemic was mitigated by moving the organization to a cloud-based platform and Office 365. Council, committees, assessors, and staff were able to continue working in this new environment on laptops, soft phones, skype and then Microsoft Teams. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item *Additional comments for clarification (if needed)*
		Measure **14.2 Council directs action in response to College performance on its KPIs and risk reviews.**	
		a. Council uses performance and risk review findings to identify where improvement activities are needed.	The College fulfills this requirement: — Yes • Please insert a link to Council meeting materials where the Council used performance and risk review findings to identify where the College needs to implement improvement activities. As a result of emerging cybersecurity threats, Council has received information on increased organizational cybersecurity risks from both a data management and insurance perspective, and updates have been made to the operational policy regarding the use of CPSO technology (described above in 7.1.a.ii. and iii.). This work has also informed revisions to CPSO's Declaration of Adherence and Council and Committee Code of Conduct package to, among other things, align with language in the updated CPSO Use of Technology policy. A link to the Council material on this topic from December 2021 can be found here (p. 108). In addition, at the end of 2020, the CEO/Registrar and Council identified that there was risk posed by CPSO's financial system, after hospitals and other regulatory bodies were breached. There was direction to staff to transform the system and move it to the cloud, which was completed and reported on at the December 2021 Council meeting. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item *Additional comments for clarification (if needed)*

		Measure **14.3 The College regularly reports publicly on its performance.**		
		a. Performance results related to a College's strategic objectives and regulatory outcomes are made public on the College's website.	The College fulfills this requirement:	Yes met in 2020, continues to meet in 2021
			• Please insert a link to the College's dashboard or relevant section of the College's website.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item
			Additional comments for clarification (if needed)	

Part 2: Context Measures

The following tables require Colleges to provide **statistical data** that will provide helpful context about a College's performance related to the standards. The context measures are non-directional, which means no conclusions can be drawn from the results in terms of whether they are 'good' or 'bad' without having a more in-depth understanding of what specifically drives those results.

In order to facilitate consistency in reporting, a recommended method to calculate the information is provided in the companion document "Technical Specifications for Quantitative College Performance Measurement Framework Measures." However, recognizing that at this point in time, the data may not be readily available for each College to calculate the context measure in the recommended manner (e.g. due to differences in definitions), a College can report the information in a manner that is conducive to its data infrastructure and availability.

In those instances where a College does not have the data or the ability to calculate the context measure at this point in time it should state: 'Nil' and indicate any plans to collect the data in the future.

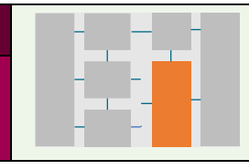
Where deemed appropriate, Colleges are encouraged to provide additional information to ensure the context measure is properly contextualized to its unique situation. Finally, where a College chooses to report a context measure using a method other than the recommended method outlined in the following Technical Document, the College is asked to provide the method in order to understand how the information provided was calculated.

The ministry has also included hyperlinks of the definitions to a glossary of terms for easier navigation.

Table 1 – Context Measure 1

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 11



Statistical data collected in accordance with the recommended method or the College's own method: Recommended

If a College method is used, please specify the rationale for its use:

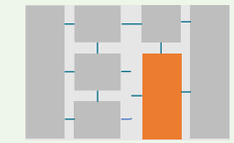
Context Measure (CM)		
CM 1. Type and distribution of QA/QI activities and assessments used in CY 2021*		
Type of QA/QI activity or assessment:	#	
i. QI: Practice Improvement Plan submitted	2553	*What does this information tell us? Quality assurance (QA) and Quality Improvement (QI) are critical components in ensuring that professionals provide care that is safe, effective, patient centred and ethical. In addition, health care professionals face a number of ongoing changes that might impact how they practice (e.g. changing roles and responsibilities, changing public expectations, legislative changes).* *The information provided here illustrates the diversity of QA activities the College undertook in assessing the competency of its registrants and the QA and QIactivities its registrants undertook to maintain competency in CY 2021. The diversityof QA/QI activities and assessments is reflective of a College's risk-based approach in executing its QA program, whereby the frequency of assessment and activities to maintain competency are informed by the risk of a registrant not acting competently. Details of how the College determined the appropriateness of its assessment component of its QA program are described or referenced by the College in Measure 13.1(a) of Standard 11.*
ii. QI: Hospital Partnership Participation	174	
iii. QI: Coaching	323	
iv. QA: Peer Assessment	673	
v. QA: Out of Hospital Premises Inspection	130	
vi. QA: Completion of a self assessment questionnaire	9824	

** Registrants may be undergoing multiple QA activities over the course of the reporting period. While future iterations of the CPMF may evolve to capture the different permutations of pathways registrants may undergo as part of a College's QA Program, the requested statistical information recognizes the current limitations in data availability today and is therefore limited to type and distribution of QA/QI activities or assessments used in the reporting period.* *NR*	
Additional comments for clarification (if needed)	

Table 2 – Context Measures 2 and 3

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 11



Statistical data collected in accordance with the recommended method or the College own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)			
	#	%	*What does this information tell us? If a registrant's knowledge, skills and judgement to practice safely, effectively and ethically have been assessed or reassessed and found to be unsatisfactory or a registrant is non-compliant with a College's QA Program, the College may refer them to the College's QA Committee.*
CM 2. Total number of registrants who participated in the QA Program CY 2021	673		*The information provided here shows how many registrants who underwent an activity or assessment as part of the QA program where the QA Committee deemed that their practice is unsatisfactory and as a result have been directed to participate in specified continuing education or remediation program as of the start of CY 2021, understanding that some cases may carry over.*
CM 3. Rate of registrants who were referred to the QA Committee as part of the QA Program where the QA Committee directed the registrant to undertake remediation as of the start of CY2021.	66	9.8	

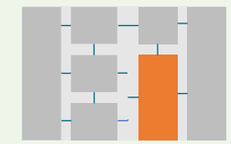
NR

Additional comments for clarification (if needed)

Table 3 – Context Measure 4

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 11



Statistical data collected in accordance with the recommended method or the College's own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)				
CM 4.	Outcome of remedial activities as at the end of CY 2021:**	#	%	*What does this information tell us? This information provides insight into the outcome of the College's remedial activities directed by the QA Committee and may help a College evaluate the effectiveness of its "QA remediation activities". Without additional context no conclusions can be drawn on how successful the QA remediation activities are, as many factors may influence the practice and behaviour registrants (continue to) display.*
I.	Registrants who demonstrated required knowledge, skills, and judgment following remediation*	37	56.1	
II.	Registrants still undertaking remediation (i.e. remediation in progress)	29	43.9	

NR

** This measure may include registrants who were directed to undertake remediation in the previous year and completed reassessment in CY2021.*

***This number may include any outcomes from the previous year that were carried over into CY 2021.*

Additional comments for clarification (if needed)

Table 4 – Context Measure 5

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

Statistical data is collected in accordance with the recommended method or the College's own method: Choose an item

If a College method is used, please specify the rationale for its use: The CPSO codes investigations upon closure of the file. The issues identified in an investigation is not available for ongoing cases.

Context Measure (CM)					
CM 5. Distribution of formal complaints and Registrar's Investigations by theme in CY 2021		Formal Complaints received		Registrar Investigations initiated	
Themes:		#	%	#	%
I.	Advertising				
II.	Billing and Fees				
III.	Communication				
IV.	Competence / Patient Care				
V.	Intent to Mislead including Fraud				
VI.	Professional Conduct & Behaviour				
VII.	Record keeping				
VIII.	Sexual Abuse				
IX.	Harassment / Boundary Violations				
X.	Unauthorized Practice				
XI.	Other <*please specify*>				
Total number of formal complaints and Registrar's Investigations**			**100%**		**100%**

What does this information tell us? This information facilitates transparency to the public, registrants and the ministry regarding the most prevalent themes identified in formal complaints received and Registrar's Investigations undertaken by a College.

Formal Complaints NR Registrar's Investigation ** *The requested statistical information (number and distribution by theme) recognizes that formal complaints and Registrar's Investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or Registrar's Investigations.*	
Additional comments for clarification (if needed)	

Table 5 – Context Measures 6, 7, 8 and 9

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

Statistical data collected in accordance with the recommended method or the College's own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)			
CM 6. Total number of formal complaints that were brought forward to the ICRC in CY 2021	1751		*What does this information tell us? The information helps the public better understand how formal complaints filed with the College and Registrar's Investigations are disposed of or resolved. Furthermore, it provides transparency on key sources of concern that are being brought forward to the College's committee.*
CM 7. Total number of ICRC matters brought forward as a result of a Registrar's Investigation in CY 2021	169		
CM 8. Total number of requests or notifications for appointment of an investigator through a Registrar's Investigation brought forward to the ICRC that were approved in CY 2021	105		
CM 9. Of the formal complaints and Registrar's Investigations received in CY 2021**:	#	%	
I. Formal complaints that proceeded to Alternative Dispute Resolution (ADR)	116	6.6	
II. Formal complaints that were resolved through ADR	112	6.4	
III. Formal complaints that were disposed of by ICRC	1289		
IV. Formal complaints that proceeded to ICRC and are still pending	420	24.0	
V. Formal complaints withdrawn by Registrar at the request of a complainant	252		
VI. Formal complaints that are disposed of by the ICRC as frivolous and vexatious	64	3.7	

VII. Formal complaints and Registrar's Investigations that are disposed of by the ICRC as a referral to the Discipline Committee	38	2.2	

ADR
Disposal
Formal Complaints
Formal Complaints withdrawn by Registrar at the request of a complainant
NR
Registrar's Investigation

 # May relate to Registrar's Investigations that were brought to the ICRC in the previous year.

*** The total number of formal complaints received may not equal the numbers from 9(i) to (vi) as complaints that proceed to ADR and are not resolved will be reviewed at the ICRC, and complaints that the ICRC disposes of as frivolous and vexatious and a referral to the Discipline Committee will also be counted in total number of complaints disposed of by the ICRC.*

Additional comments for clarification (if needed)

Table 6 – Context Measure 10

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

Statistical data collected in accordance with the recommended method or the College's own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)							
CM 10. Total number of ICRC decisions in 2021							
Distribution of ICRC decisions by theme in 2021*	# of ICRC Decisions++						
Nature of Decision	Take no action	Proves advice or recommendations	Issues a caution (oral or written)	Orders a specified continuing education or remediation program	Agrees to undertaking	Refers specified allegations to the Discipline Committee	Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations or by-laws.
I. Advertising	NR	NR	0	0	NR	0	
II. Billing and Fees	12	10	1	NR	3	5	
III. Communication	181	22	4	12	8	7	
IV. Competence / Patient Care	631	167	11	85	54	15	
V. Intent to Mislead Including Fraud	0	0	0	0	0	NR	
VI. Professional Conduct & Behaviour	302	56	9	19	25	32	
VII. Record Keeping	61	68	4	34	32	4	
VIII. Sexual Abuse/ Harassment / Boundary Violations	20	NR	NR	NR	6	14	

IX.	Unauthorized Practice	NR	0	0	0	0	0	
X.	Other Accepting New patients/Practice Mgmt.	56	14	2	6	5	2	

** Number of decisions are corrected for formal complaints ICRC deemed frivolous and vexatious AND decisions can be regarding formal complaints and registrar's investigations brought forward prior to 2021.*

++ The requested statistical information (number and distribution by theme) recognizes that formal complaints and Registrar's Investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar's investigations, or decisions.

NR

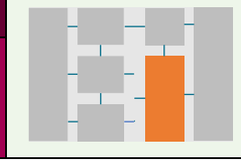
What does this information tell us? This information will help increase transparency on the type of decisions rendered by ICRC for different themes of formal complaints and Registrar's Investigation and the actions taken to protect the public. In addition, the information may assist in further informing the public regarding what the consequences for a registrant can be associated with a particular theme of complaint or Registrar investigation and could facilitate a dialogue with the public about the appropriateness of an outcome related to a particular formal complaint.

Additional comments for clarification (if needed)

Table 7 – Context Measure 11

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13



Statistical data collected in accordance with the recommended method or the College own method: Recommended

If College method is used, please specify the rationale for its use:

Context Measure (CM)		
CM 11. 90th Percentile disposal of:	Days	*What does this information tell us? This information illustrates the maximum length of time in which 9 out of 10 formal complaints or Registrar's investigations are being disposed by the College.* *The information enhances transparency about the timeliness with which a College disposes of formal complaints or Registrar's investigations. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the disposal of a formal complaint filed with, or Registrar's investigation undertaken by, the College.*
I. A formal complaint in working days in CY 2021	212	
II. A Registrar's investigation in working days in CY 2021	766	

Disposal

Additional comments for clarification (if needed)

Table 8 – Context Measure 12

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

Statistical data collected in accordance with the recommended method or the College's own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)		
CM 12. 90th Percentile disposal of:	Days	*What does this information tell us? This information illustrates the maximum length of time in which 9 out of 10 uncontested discipline hearings and 9 out of 10 contested discipline hearings are being disposed.* *The information enhances transparency about the timeliness with which a discipline hearing undertaken by a College is concluded. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the resolution of a discipline proceeding undertaken by the College.*
I. An uncontested discipline hearing in working days in CY 2021	471	
II. A contested discipline hearing in working days in CY 2021	557	

Disposal
Uncontested Discipline Hearing
Contested Discipline Hearing

Additional comments for clarification (if needed)

Table 9 – Context Measure 13

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

Statistical data collected in accordance with the recommended method or the College's own method: Recommended

If College method is used, please specify the rationale for its use:

Context Measure (CM)		
CM 13. Distribution of Discipline finding by type*		*What does this information tell us? This information facilitates transparency to the public, registrants and the ministry regarding the most prevalent discipline findings where a formal complaint or Registrar's Investigation is referred to the Discipline Committee by the ICRC.*
Type	#	
I. Sexual abuse	NR	
II. Incompetence	NR	
III. Fail to maintain Standard	11	
IV. Improper use of a controlled act	NR	
V. Conduct unbecoming	NR	
VI. Dishonourable, disgraceful, unprofessional	23	
VII. Offence conviction	NR	
VIII. Contravene certificate restrictions	NR	
IX. Findings in another jurisdiction	NR	
X. Breach of orders and/or undertaking		
XI. Falsifying records		
XII. False or misleading document		
XIII. Contravene relevant Acts		

** The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the number of findings may not equal the total number of discipline cases.* *NR*
Additional comments for clarification (if needed)

Table 10 – Context Measure 14

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

Statistical data collected in accordance with the recommended method or the College own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)		
CM 14. Distribution of Discipline orders by type*		*What does this information tell us? This information will help strengthen transparency on the type of actions taken to protect the public through decisions rendered by the Discipline Committee. It is important to note that no conclusions can be drawn on the appropriateness of the discipline decisions without knowing intimate details of each case including the rationale behind the decision.*
Type	#	
I. Revocation	NR	
II. Suspension	18	
III. Terms, Conditions and Limitations on a Certificate of Registration	19	
IV. Reprimand	26	
V. Undertaking	NR	

** The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the numbers set out for findings and orders may may not equal the total number of discipline cases.*

Revocation
Suspension
Terms, Conditions and Limitations
Reprimand
Undertaking
NR

Additional comments for clarification (if needed)

Glossary

Alternative Dispute Resolution (ADR): Means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute.

Return to:-Table 5

Contested Discipline Hearing: In a contested hearing, the College and registrant disagree on some or all of the allegations, penalty and/or costs.

Return to: Table 8

Disposal: The day upon which all relevant decisions were provided to the registrant by the College (i.e., the date the reasons are released and sent to the registrant and complainant, including both liability and penalty decisions, where relevant).

Return to: Table 5, Table 7, Table 8

Formal Complaint: A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint.

Return to: Table 4, Table 5

Formal Complaints withdrawn by Registrar at the request of a complainant: Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest.

Return to: Table 5

NR: Non-reportable: Results are not shown due to < 5 cases (for both # and %). This may include 0 reported cases.

Return to: Table 1, Table 2, Table 3, Table 4, Table 5, Table 6, Table 9, Table 10

Registrar's Investigation: Under s.75(1)(a) of the *Regulated Health Professionals Act, 1991* (RHPA) where a Registrar believes, on reasonable and probable grounds, that a registranthas committed an act of professional misconduct or is incompetent he/she can appoint an investigator which must be approved by the Inquiries, Complaints and Reports Committee (ICRC). Section 75(1)(b) of the RHPA, where the ICRC receives information about a member from the Quality Assurance Committee, it may request the Registrar to conduct an investigation. In situations where the Registrar determines that the registrant exposes, or is likely to expose, their patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.

Return to: Table 4, Table 5

Revocation: Of a member or registrant's Certificate of Registration occurs where the discipline or fitness to practice committee of a health regulatory College makes an order to "revoke" the certificate which terminates the registrant's registration with the College and therefore their ability to practice the profession.

Return to: Table 10

Suspension: A suspension of a registrant's Certificate of Registration occurs for a set period of time during which the registrant is not permitted to:

- Hold themselves out as a person qualified to practice the profession in Ontario, including using restricted titles (e.g. doctor, nurse),
- Practice the profession in Ontario, or
- Perform controlled acts restricted to the profession under the Regulated Health Professions Act, 1991.

Return to: Table 10

Reprimand: A reprimand is where a registrant is required to attend publicly before a discipline panel of the College to hear the concerns that the panel has with their practice.

Return to: Table 10

Terms, Conditions and Limitations: On a Certificate of Registration are restrictions placed on a registrant's practice and are part of the Public Register posted on a health regulatory College's website.

Return to: Table 10

Uncontested Discipline Hearing: In an uncontested hearing, the College reads a statement of facts into the record which is either agreed to or uncontested by the Respondent. Subsequently, the College and the respondent may make a joint submission on penalty and costs or the College may make submissions which are uncontested by the Respondent.

Return to: Table 8

Undertaking: Is a written promise from a registrant that they will carry out certain activities or meet specified conditions requested by the College committee.

Return to: Table 10