COLLEGE OF PHYSIOTHERAPISTS of ONTARIO | ORDRE DES PHYSIOTHÉRAPEUTES de l'ONTARIO

MEETING OF THE COUNCIL OF THE COLLEGE OF PHYSIOTHERAPISTS OF ONTARIO

AGENDA

March 21 and 22, 2019
At
The College Board Room
375 University Avenue, Suite 800, Toronto

Council Member Networking Breakfast 8:30am – 9:00am

9:00 AM		**Welcome**
	1 **Motion**	**Approval of the Agenda** For Decision
	2 **Motion**	**Approval of the Council Meeting Minutes of December 17-18, 2018** For Decision
	3	**Executive Committee Election** Election of the President, Vice President and Executive Committee members at large. *Note: the election will use electronic voting*
	4	**Registrar's Report** For Information Includes a brief status report on the College's technology infrastructure renewal project.
	5	**Q3 Financial Report** For Information Year to date spending, including notes about variance between budget and actual spending, are provided for review and discussion.
	6 **Motion**	**Proposal for Entry to Practice Program Review** For Decision The College entry to practice program is complex and intersects with multiple agencies, other regulators, government and other stakeholders. The College program has also been in place for more than 25 years without a detailed review or evaluation.

This is a proposal that funds be allocated in the budget so the College can engage an expert to plan a thorough review of its entry program.

7 **Approval of 2019-2020 Budget**
Motion For Decision

The Operating and Capital Budgets for 2019/2020 are provided to Council for approval.

12:00 PM	**Adjournment**
9:00 AM	**March 22, 2019**

8 **Quality Assurance Program Review**

8.1 **Part One: Project Update**
For Information

Council is receiving an update on the Quality Assurance Program Review project.

8.2 **Part Two: Program Policies**
Motion For Decision

Staff have completed a review of the Quality Assurance Program Policies to identify required updates to correspond to changes to the program. Council will be asked to approve four new policies and one updated policy.

8.3 **Part Three: Program Evaluation Plan**
Motion For Decision

As part of the Quality Assurance Program review, a program evaluation plan has been created to enable the College to systematically collect and analyze information for ongoing program improvement. Council is asked to approve the proposed program evaluation plan.

9 **Non-Council Appointment Process and Recruitment**
Motion For Decision

The Executive Committee recommends that Council approve the non-council appointment process and develop a pool of six non-council committee members for future consideration.

10 **Auditor Evaluation Tool**
Motion For Decision

A tool to evaluate the performance of the auditor is being proposed by both the Finance and Executive Committee for approval by Council.

11 Report – Annual Outreach Activities

Presentation by Fiona Campbell, Senior Physiotherapist Advisor

12 President's Report
For Information

- Q3 Committee Activity Summary
- Q3 Executive Committee Report to Council
- Other updates

13 Members' Motion/s

Adjournment

Future Council Meeting Dates:

- June 24 and 25, 2019
- September 26 and 27, 2019
- December 16 and 17, 2019

COLLEGE OF PHYSIOTHERAPISTS of ONTARIO | ORDRE DES PHYSIOTHÉRAPEUTES de l'ONTARIO

Motion No.: 1.0

Council Meeting
March 21-22, 2019

Agenda #1.0: Approval of the agenda

It is moved by

_____,

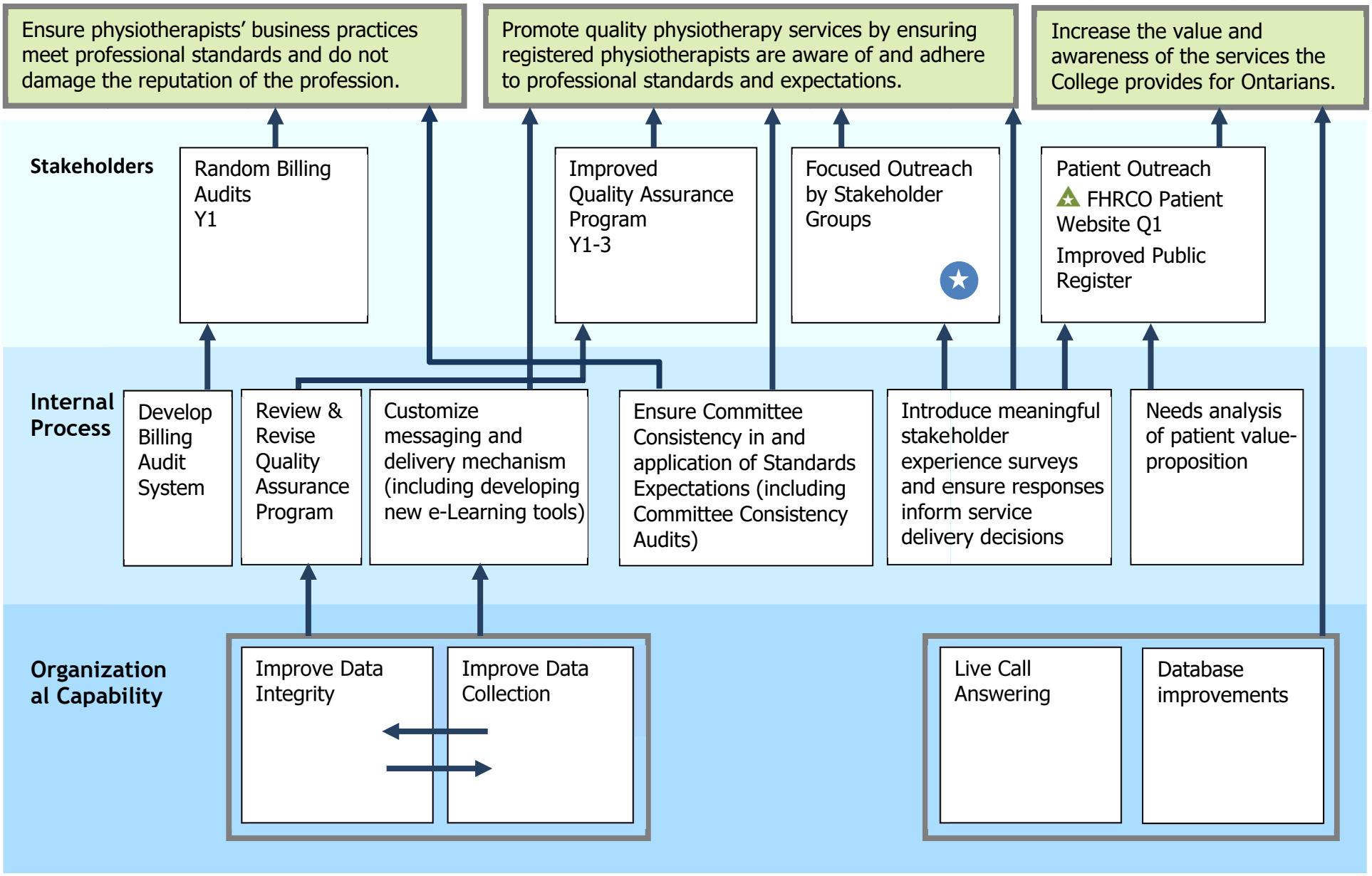
and seconded by

_____,

that:

the agenda be accepted with the possibility for changes to the order of items to address time constraints.

Strategy Map 2017–2020



Ongoing/External

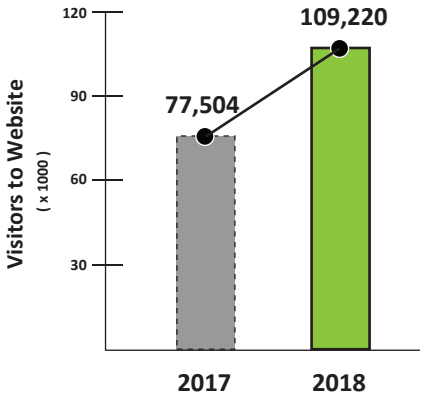
Y1: Supervisors, Students, Educators
Y2-3: Internationally Educated PTs, Employers, Insurers and Registration Ceremony for new graduates

College Dashboard

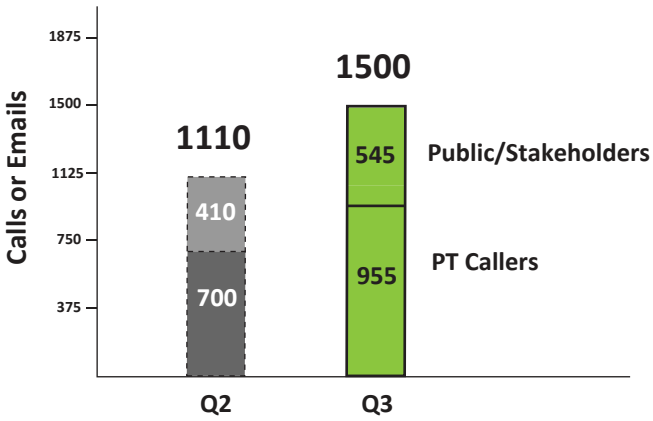
(Q3) OCTOBER—DECEMBER 2018

Strategic

Stakeholder Awareness Q3



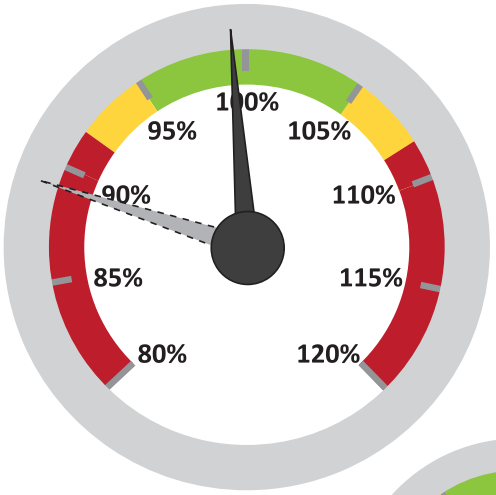
Practice Advice

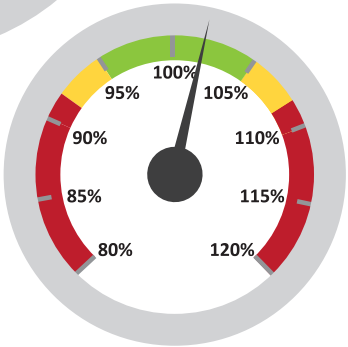


Operational

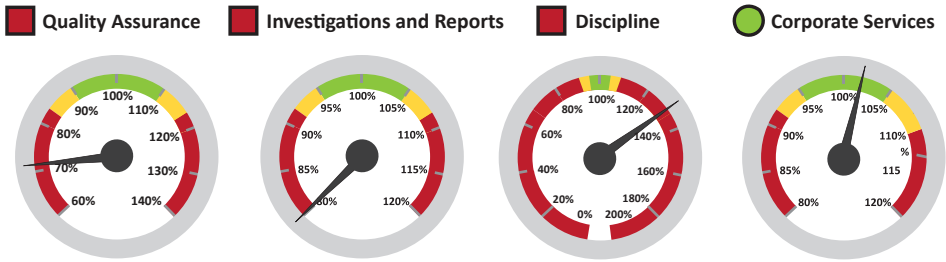
Financial Accountability

Overall 99% Q3





All Committees



	Target	Q3
Human Resource Excellence		
Absenteeism	< 1.7 days per employee	
Turnover	Green ≤ 3 Amber > 3 ≤ 5	
Stat Program Performance		
ICRC	Met all Statutory timelines	
Quality Assurance	Met all Statutory timelines	
Registration	Met all Statutory timelines	

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Dashboard Explanatory Notes, Q3 2018-2019

OPERATIONAL INDICATORS

What We Measure	What this Demonstrates and How	Quarterly Results
Financial Accountability Ratio of actual spending to budgeted spending	To demonstrate sound financial management by monitoring what was spent compared to what was budgeted. Target = Within 95% each quarter	Detailed explanation in the statement of operations.
Human Resource Excellence Composite measure of absenteeism and turnover rates	To provide an indication of overall organizational health. Absenteeism and turnover rates serve as proxies for good recruiting and performance management policies. Target = Absenteeism and turnover rates that are within industry standard based on the Conference Board of Canada	Absenteeism: on target. Turnover: In the past 12 month's four employees left. Two to pursue other opportunities and two were involuntary.
Meeting Statutory Obligations: Composite measure of the statutory obligations of all three committees	To monitor performance of core statutory duties. Specifically, whether each committee meets the specific timeline and notice requirements of the RHPA. Target: **QA** % PTs provided an opportunity to make a submission **Reg** % applicants provided 30 days to make a submission % individuals requiring notice of right to appeal were notified **ICRC** % complaints closed within 150 days or with notice of delay % complaints and reports given 14-day notice	Quality Assurance: on target. Registration: on target. Inquiries, Complaints and Reports Committee: This measure requires 100% compliance. In this quarter, two 14-day notice letters were sent late. This was because the complaint confirmation was received during the holiday office closure.

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Dashboard Explanatory Notes, Q3 2018-2019

STRATEGIC INDICATORS

What We Measure	What this Demonstrates and How	Quarterly Results
Stakeholder Awareness Hits to College Resources	To monitor whether our communications efforts effectively bring people to our resources. We assume that if there are more visits to our resources, we can improve awareness of standards and other requirements. Target = Increase in the number of times College resources are accessed year over year	Hits to College Resources: 29% increase The College changed websites and introduced new metrics to assess the number of hits it receives. Now that one year has passed, this is the first quarter where the new metrics can be compared. Increase in hits to College resources likely related to the following activities that were completed over the past year: • Increased Search Engine Optimization of the collegept.org • Ran digital advertising campaigns (both organic and paid) • Focused on different stakeholder groups than in the past (patients, employers, insurers) • Open and click through rates for Perspectives are up slightly over the past year which increases website traffic.
Practice Advice Increased number of calls over time to demonstrate improved stakeholder value	We assume that calls to practice advice reflect access to a valued service. Accordingly, increased call volume should indicate increase value to stakeholders. Target = increase from previous quarter	PT Callers: 36% increase Public/Stakeholders: 33% increase Total calls have increased by 35% Increase in calls likely related to the following three activities:

Dashboard Explanatory Notes, Q3 2018-2019

		• Targeted outreach to students, patients and employers, resulting in more calls from targeted demographics. • Improved technology has increased live call answering to 90% of all calls received • Various communication activities designed to drive stakeholders to College resources which includes practice advice. Q3 practice advice call trends: privacy, boundaries and billing.

COLLEGE OF PHYSIOTHERAPISTS of ONTARIO | ORDRE DES PHYSIOTHÉRAPEUTES de l'ONTARIO

Motion No.: 2.0

Council Meeting
March 21-22, 2019

Agenda #2.0: Approval of the Council Meeting Minutes of December 17-18, 2018

It is moved by

_____,

and seconded by

_____,

that:

the Council meeting minutes of December 17-18 2018, be approved.

COLLEGE OF PHYSIOTHERAPISTS of ONTARIO | ORDRE DES PHYSIOTHÉRAPEUTES de l'ONTARIO

MEETING OF THE COUNCIL OF THE COLLEGE OF PHYSIOTHERAPISTS OF ONTARIO

MINUTES

December 17-18, 2018
At
The College Board Room
375 University Avenue, Suite 800, Toronto
Council Member Networking Breakfast 8:30am – 9:00am

Attendees:		**Staff:**
Mr. Gary Rehan (President)	Ms. Janet Law	Mr. Rod Hamilton
Mr. Darryn Mandel	Mr. James Lee	Ms. Anita Ashton
Mr. Ron Bourret (teleconference)	Ms. Nicole Graham	Ms. Lisa Pretty
Ms. Jane Darville	Ms. Sharee Mandel	Ms. Fiona Campbell
Mr. Martin Bilodeau	Mr. Tyrone Skanes	Ms. Joyce Huang
Ms. Theresa Stevens	Ms. Lisa Tichband	Ms. Téjia Bain
Mr. Mark Ruggiero	Ms. Jennifer Dolling	Ms. Olivia Kisil
Mr. Ken Moreau	Ms. Kathleen Norman	Ms. Taylor Turner

Recorder: Ms. Elicia Persaud

9:00 AM **<u>Welcome</u>**

1.0 Approval of the Agenda

Motion 1.0

It was moved by Mr. Tyrone Skanes and seconded by Mr. Ken Moreau that:

the agenda be accepted with the possibility for changes to the order of items to address time constraints. **CARRIED.**

2.0 Approval of the Council Meeting Minutes of September 24 and 25, 2018 and October 14, 2018

Motion 2.0

It was moved by Mr. James Lee and seconded by Mr. Tyrone Skanes that:

the Council meeting minutes of September 24-25, 2018 and October 12, 2018, including the *in camera* minutes of October 12, be approved. **CARRIED.**

3.0 Quality Assurance Program Review – Project Update

Joyce Huang, Strategic Projects Manager provided Council with an update on the work of the Quality Assurance Working Group and requested the following approvals by Council.

Motion 3.0

It was moved by Mr. Tyrone Skanes and seconded by Ms. Sharee Mandel that:

Council approves the QAWG's recommendation to include a chart review component in the remote assessment process. The inclusion of this component will be re-evaluated based on the results of the pilot test assessments. **CARRIED.**

As part of the discussion Council concluded that they are in support of considering the development of a potential QA assessment for non-clinical physiotherapists.

Motion 3.1

It was moved by Ms. Nicole Graham and seconded by Ms. Janet Law that:

Council approve the QAWG's recommendation to defer the development consideration of a non-clinical QA assessment for two years. **CARRIED.**

Motion 3.2

It was moved by Mr. Ken Moreau and seconded by Mr. James Lee that:

Council approve the QAWG's recommendation that the QA program selects 9.1% of eligible members for assessment in the year 2019-20. **CARRIED.**

Motion 3.3

It was moved by Mr. Tyrone Skanes and seconded by Ms. Sharee Mandel that:

Council approve the following recommendations related to QA program policies:

1. Updated timelines for the remote and on-site assessment processes.
2. Members who are subject to an active professional conduct matter should not be exempted from selection automatically; they can ask for a deferral, which will be assessed on a case-by-case basis based on the QA Program's deferral policy.
3. Members who express their intent to retiring will not automatically receive a deferral.
4. The current policy on deferrals can stay largely the same, with two minor changes: educational programs should be specifically defined as full-time programs; and the member being the subject of an active PC matter should be added as a criterion in the policy.
5. The QA program should continue to accept volunteers; however, there should be criteria defined for who can volunteer only if the member has never been assessed before and meets the inclusion criteria for selection.

CARRIED.

Ms. Janet Law left the Council chambers at 11: 24 a.m.

4.0 Interim Registrar's Report

Mr. Rod Hamilton, Interim Registrar, provided an update on the following items:

- Councillor orientation
- Fairness commissioner activities
- Public appointments
- Governance trends
- College outreach
- Database project

Mr. Ron Bourret left the meeting at 1:58 p.m.

5.0 Reprioritization of Strategic Tactics

Motion 5.0

It was moved by Ms. Jane Darville and seconded by Mr. Tyrone Skanes that:

the Council approves the extension of the current strategic plan cycle until March 2021 and reset the timing of the tactics work as recommended by staff. **CARRIED.**

6.0 By-Laws and Governance Policies Plan

Motion 6.0

It was moved by Mr. Ken Moreau and seconded by Ms. Jennifer Dolling that:

Council approve the proposal that the College's Executive Committee act as a working group to review concerns and issues about the College's By-laws and governance policies and bring proposed changes forward to Council for consideration. **CARRIED.**

7.0 Review of the Advertising Standard

Council reviewed the proposed Advertising Standard in detail and provided direction for additional clarity around the responsibility of physiotherapists.

Motion 7.0

It was moved by Ms. Sharee Mandel and seconded by Mr. Martin Bilodeau that:

Council approve the recommended changes to the Advertising Standard with an effective date of February 1, 2019. **CARRIED.**

8.0 Case Studies and Decision Making

This item was deferred to a future Council meeting.

Day one of Council adjourned at 4:15 p.m.

9:00 AM **December 18, 2018**

9.0 Motion to go *in camera* pursuant to section 7(2)(d) of the Health Professions Procedural Code

It was moved by Mr. James Lee and seconded by Mr. Tyrone Skanes that:

The council move in camera pursuant to section 7(2)(d) of the health professions procedural code.

10.0 Announcement- Appointment of the new Registrar

Mr. Rehan, President, announced that Council has appointed Mr. Rod Hamilton as the new Registrar effective December 18, 2018. Mr. Hamilton provided an address to Council and staff.

11.0 Q2 Financial Report

The Q2 Financial report was reviewed with a few questions on the Colleges long-term investment strategy.

12.0 Pre- Registration Jurisprudence Exam

Council revaluated the pros and cons to administering the jurisprudence exam as a requirement for registration and determined that the there is no risk to the public to rescind their original decision.

Motion 12.0
It was moved by Ms. Jane Darville and seconded by Ms. Theresa Stevens that:

Council rescinds their decision to make completion of the Jurisprudence exam a requirement for registration. **CARRIED.**

Motion 12.1
It was moved by Ms. Theresa Stevens and seconded by Ms. Kathleen Norman that:

Council directs staff to review mechanisms of ensuring knowledge of jurisprudence in applicants and members. **CARRIED.**

13.0 Conference Attendance: Reporting Key Learnings to Council
Motion 13.0
It was moved by Mr. Tyrone Skanes and seconded by Mr. Ken Moreau that:

Council approves the use of a template for councilors to report their key learnings from conferences to Council. **CARRIED.**

14.0 Review of Expense Rule for Accommodations

Mr. Ken Moreau and Ms. Kathleen Norman withdrew the motion to remove the kilometer radius requirement for accommodation eligibility and the corresponding changes to expense rules section 10 (b)(c) and 11 (c)(d) of Policy 5.1 – Honoraria and Expenses, effective April 1, 2018.

The rules for accommodation will remain unchanged and staff will increase the hotel accommodation budget by 10% if a hotel contract is not secured.

15.0 Vestibular Therapy: Notice of Motion

Motion 15.0

It was moved by Mr. Ken Moreau and seconded by Ms. Kathleen Norman that:

Council has concluded that performance of vestibular therapy should not be a rostered College activity. **CARRIED.**

Mr. James Lee left the Council chambers at 12:15 p.m. and returned at 1:35 p.m.

16.0 President's Report

The President provided an update on the following items:

- Q2 Committee Activity Summary
- Q2 Executive Committee Report to Council
- Councillor Operations evaluation

17.0 Member's Motion/s

Adjournment

It was moved Mr. Tyrone Skanes by that the meeting be adjourned.

The meeting was adjourned at 2:00 p.m. **CARRIED.**

Agenda #3.0

Executive Committee Election

Election will take place on the day of Council via electronic voting

Meeting Date:	March 21-22, 2019
Agenda Item #:	4.0
Issue:	Registrar's Report
Submitted by:	Rod Hamilton, Registrar

Below, some highlights (in no particular order) from the past quarter.

New Health Legislation

On Tuesday, February 26, 2019, the Ontario Government announced plans to implement a significant restructuring of the provision of health care services in Ontario. The move was billed as a centralization of 20 agencies into one body called Ontario Health that will include the 14 LHINs, and:

- Cancer Care Ontario.
- eHealth Ontario.
- Trillium Gift of Life Network.
- Health Shared Services.
- Health Quality Ontario.
- HealthForce Ontario Marketing and Recruitment Agency.

However, the plan also envisions decentralization in the form of 30-50 provider groups each providing coordinated care to about 300,000 persons each on average. The government is anticipating health care providers (likely anchored by at least one hospital) will make proposals that will be accepted by the government.

The impact on RHPA Colleges is unclear at this time.

For more information you can view the following:

1. Two detailed summaries in the Toronto Star: https://www.thestar.com/politics/provincial/2019/02/26/massive-health-care-overhaul-called-biggest-change-since-medicare.html and https://www.thestar.com/politics/provincial/2019/02/25/new-ontario-health-agency-would-overhaul-disconnected-medical-system-minister-says.html
2. A summary on CBC: https://www.cbc.ca/news/canada/toronto/doug-ford-ontario-health-super-agency-lhin-cancer-care-1.5032830

3. The Ontario Government Newsroom release: https://news.ontario.ca/mohltc/en/2019/02/ontarios-government-for-the-people-to-break-down-barriers-to-better-patient-care.html?utm_source=ondemand&utm_medium=email&utm_campaign=p

4. The enabling legislation: https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2019/2019-02/b074_e.pdf. (See also https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-74#Sched18 for page where link to pdf is located.)

Governance discussions at Colleges

- As you may remember, the College of Nurses has proposed to government that it make changes to their governing statute to reduce the size of their board, require competency-based board appointment, separate of board and committee membership.
- The CNO has asked other Colleges to support its request.
- At the most recent FHRCO meeting other colleges indicates that most of them were still discussing governance at the Board level and had made no decisions as to whether to support the CNO. Many also indicated that they had invited CNO to their Council to provide information on the model.
- CPSO indicated that it had submitted its own model of revised governance to the government, which was similar but not identical to the model proposed by the nurses.
- Rumours continue to circulate that the government is going to makes changes to the way health professions are governed but so far, no real information has been made available.

Public Appointments

- Tyrone has been reappointed.
- Government is making short term appointments to health regulatory colleges' councils – generally not more than a year.
- This is a common problem, at a recent FHRCO meeting at least 3 colleges were currently unconstituted.
- Other government parties are beginning to take an interest in these problems as we were contacted by a researcher from the NDP to determine if we were are constituted.

Election For Councillors

- Saturday is the last day to withdraw.
- Voting opened March 15 and runs until April 17.
- Individuals are running from District 1 – 7 and District 2 – 9.
- I did contact two of the candidates to makes changes to their candidate statements to be more in keeping with Council's policies on campaigning.

College News

Staffing

I wanted to let you know of a couple of staffing changes:

- Barbara Hou, our Corporate Services Associated who is replacing Subbu will be moving over to our QA group starting April 1
- Subbu will also be returning on April 1
- We are hiring new investigator and a Director of investigations.

Tactics

- I would normally bring an update on progress toward the strategic tactics however as you will recall, Council directed that tactic work be temporarily deferred to allow for more concentrated activity on the database and the QA Program review

Annual Renewal

- Annual renewal is going smoothly.
- We did have a couple of small glitches which were quickly addressed.
- As of March 5 more than 2500 members have renewed, which is on target for this time of the process.

College Outreach Activities

- Fiona will be providing a more detailed update later in the meeting.
- Our Outreach events continue to focus on boundaries and sexual abuse, providing and refusing care, standards and general promotion of practice advice service available to all.
- In the last few months we have held events in Mississauga and Don mills with more than 50 people showing up to each of them. I attended both and I am happy to say that people really seemed enjoy themselves and asked lots of questions.
- We have one more in-person outreach event left in Richmond Hill (March 13) and a webinar on the same topic on March 19.

Perspectives

We plan to begin announcing new members names in Perspectives as a way of encouraging members to read it and to give people credit for joining the College.

Database Update

Joyce will be providing a more detailed update as well as a demonstration of what the product looks like.

- Work is proceeding on the database and we are getting back on track with the assistance of our program manager.
- The QA application is in testing and we plan on launching April 1.
- We are working on detailed functional design documents (FDDs) that outline our specific requirements in a number of program areas. We are planning on completing these by March 30. We have completed FDDs for:
  - Professional health corporations
  - Practice Advice

We are still working on:

- Professional conduct
- Committees
- Compliance Monitoring

Having all the FDDs done will allow the development of a detailed project plan for the completion of these components. This plan should be complete at the end of April.

CIHI Report

On February 26 CIHI approved the report we submitted.

This is a significant success because we had to do a lot of work to clean up the data after the problems with last years renewal, but we were able to do this successfully and next year will be far easier, with the assistance of the new database.

The report for the HDB is the next report that we have to submit.

Fairness Commission

We have submitted our annual report to the Ontario Fairness Commissioner – side note they are looking to revisit their audit process in the near future. There is a meeting in the spring to provide us with the updates

HPARB

Anita and I met with the Registrar from HPARB as part of their periodic outreach to Colleges.

- The are also having problems getting appointees.
- They were happy with the way we were meeting their timelines.
- They listened to our concerns about reviewing matters with new evidence in mind and would consider their options including returning the matter to the College for reconsideration if new evidence was provided.

Use of Scent in the Office

We are planning to transition to a scent-restricted office in April.

- There are staff who are sensitive to strongly scented perfumes, colognes and lotions so we will be asking people to avoid using them while in the office

Web and Social Media Usage

Website:

Audience:

27,719 users ↑ 70.9% new users ↓

105,158 pageviews ↑

44,570 sessions ↑

2:18 average session duration ↑ 2.36 pages per session ↑

Pages:

1. Homepage – 17,607 pageviews
2. Government-funded Physio – 9,020 pageviews, more than 3 minutes on page, high bounce & exit rate. Significant increase in traffic to this page due to social media campaign.
3. Public Register – 5,838 pageviews, less than a minute on page, very, very low bounce and exit rate
4. Rules and Resources – 4,385 pageviews, less than a minute on page, low bounce and exit rate
5. Members – 2,436 pageviews, more than 1 minute on page, average bounce and exit rate
6. Applicants – 2,073 pageviews, 1 minute on page, relatively low bounce and exit rate
7. Upcoming Hearings – 1,848 pageviews, more than 2 minutes on page, average bounce rate, low exit rate
8. Myth v Fact – 1,756 pageviews, almost 2 minutes on page, average bounce and exit rate
9. Consent – 1,601 pageviews, more than 2 minutes on page, average bounce and low exit rate
10. Practice Advice – 1,390 pageviews, almost 1.5 minutes on page, average bounce and exit rate

*changes to top 10 from last month are in blue
*High placement for Public Register!
*Myth v Fact likely due to successful Facebook post
*Practice Advice in top 10 – wonder if Fiona's team had a big month for calls emails? Would be interesting to see if there's a connection there.
*Good pick up for Consent from January Perspectives

Social Media (stats to date)

Facebook:

1,318 likes (+52)
1,382 followers (+55)

Twitter:

1,627 followers (+26)
25.7 k impressions, on par with December (more profile visits and mentions in January

OPA Strategic planning

The OPA is holding a forum on April 5th to consider the future of physiotherapy in Ontario in the context of their new strategic goal 'that all Ontarians have access to physiotherapy as an essential element of optimal health'.

Meeting Date:	March 21-22, 2019
Agenda Item #:	5.0
Issue:	Q3 Financial Report
Submitted by:	Fazal Raza, Accounting Coordinator & Rod Hamilton, Registrar

Issue:

The Q3 Statement of Operation with variance analysis are attached for review.

Background

The College uses zero-based budgeting process which means that our spending is planned on the real predicted costs we think we will incur.

We report on our performance on budgeting and spending through variances, which are the differences between the amount that we planned to spend and the amount that we actually did spend.

The third quarter continues to show some variance in individual accounts although the larger categories of income versus expense are closer to the budgeted projections.

For income, we are now at 100.15% of budget

For spending, we have also moved much closer to budget as we are now at 99.72% of the budget. However, while the global spending is close to budget, this is a result of some significant variances in individual accounts which should be considered below.

Key Variances

With respect to variance, you will recall that if we have spent more than 5% over or under the budget, you will find an explanation for the difference in the Variance Report, at Appendix A.

Income

The Income section of the report has much more detail than we have tracked before. We have segregated the administrative fees (i.e. for costs of printing wall certificates and similar things) from the registration fees and have identified specific types of administrative fees. From an oversight perspective, this may be more detail than you need, but we find it helpful in terms of predicting future income in this budget line.

The long-term value of tracking this data will provide a better understanding of where our membership is spending their money with the College, which will, in turn allow us to plan better for servicing their needs.

You will see that we have some large percentage variances in this area. However, many of the large percentage variance appear for fees and services which are relatively small in actual numbers so we anticipate that over time, more experience will help us become more accurate in these areas.

Expenses

As noted above, expenses are close to budget when looking at the total expenses. However, there are significant percentage variance in individual accounts. There is also a very significant actual variance arising in line 5901, Salaries. This actual large variance is due to settlement costs associated with staffing decisions. In keeping with rules associated with the accrual basis of accounting, such costs are recognized in the period in which they were incurred even if the payments occur in a future period.

2019 Forecast

We have not included a spending forecast in this report due to the fact that we are still in the process of hiring a comptroller to provide the highly specific expertise required for this exercise.

However, we do not anticipate any exceptional costs other than those which have been previously mentioned in prior reports. These include:

- Professional Conduct Accrual Expense – required "book" increase of $50,000, as recommended by the auditor.
- Amortization - this budget line will increase by $35,395 as a result of a recommendation by our auditor to change the way we record information. Note that while this is a technical accounting change and is offset by a reduction in our rent payments, it does have an impact on our bottom line.
- Additional IT expenses – an increase of at least $40,000 is known at this time for the cost of the QA Assessment Tool as the cost was unknown at the time of budget preparation, nor were we certain we would get to it in the current Fiscal year.

Individual budget items where spending has not met the target (within 5%):

The items are numbered in accordance with the Statement of Operations for ease of cross reference.

Income

4019 131.77% There were more applications for new Professional Health Corporations than anticipated.

4018 88% - This is the first time that we have separated our administrative fees into separate categories. Our ability to predict actual costs was impaired by two things: the rules for administrative fees are relatively new so demand for the specific services are unknown and we have no historical data upon which to make clear predictions.

4017 196.81% - This is the first time that we have separated our administrative fees into separate categories. Our ability to predict actual costs was impaired by two things: the rules for administrative fees are relatively new so demand for the specific services are unknown and we have no historical data upon which to make clear predictions.

4016 108.55% - This is the first time that we have separated our administrative fees into separate categories. Our ability to predict actual costs was impaired by two things: the rules for administrative fees are relatively new so demand for the specific services are unknown and we have no historical data upon which to make clear predictions.

4015 107.54% - This is the first time that we have separated our administrative fees into separate categories. Our ability to predict actual costs was impaired by two things: the rules for administrative fees are relatively new so demand for the specific services are unknown and we have no historical data upon which to make clear predictions. We underestimated administrative income

4007 122.41% - Lower than anticipated resignations for Q3

4004 252.74% - More cost orders have been recovered in Q3 than anticipated

4003 58.14% - The requirement for College supported practice coaching programs was less than anticipated.

4021 We have not previously captured registration fees to this level of detail and the actual income has been lower than anticipated in some categories.

4020 We have not previously captured registration fees to this level of detail and the actual income has been lower than anticipated in some categories.

4013 87.19%We have not previously captured registration fees to this level of detail and the actual income has been lower than anticipated in some categories.

4012 65.05% - We have not previously captured registration fees to this level of detail and the actual income has been lower than anticipated in some categories.

4010 This includes payment that the College received for having two students conduct their clinical placements at the College and a re-payment by a PT to the College for funding for therapy and counseling

Expense

5002 92.36% - We have one less professional member on the committee this year

5003 117.10% - Overage resulted from an additional one-day Council meeting that was unbudgeted.

5005 50.41% - A number of hearings were started in Q4 but will resume in Q4 / Q1 next year.

5006 50.49% - Underspending resulted from deferral of scheduled President governance work to Q4, change from a one-day in person Executive meeting to a one-hour teleconference meeting. Have not received any claims from one council member (although some of these claims have been anticipated).

5010 6.99% - There have been less applications for funding than anticipated. As such the PRC has not been required to meet.

5011 82.65% - QAC meeting via teleconference was cancelled because there were no cases to discuss.

5012 76.05% - Committee members are not incurring as much prep time as anticipated

5017 119.57% - The one hour teleconference became a two hour teleconference due to the volume of material to be discussed

5052 74.73% - There was a delay of the appointment of a non council committee appointee (2 meetings) and overall travel expenses have been lower.

5053 121.4% - Overage resulted from an unbudgeted one-day Council meeting and unbudgeted legal fees.

5055 45.79% - A number of hearings were started in Q3 and will resume in Q4 and Q1.

5062 63.38% - One member was unable to attend the QAC meeting in June

5063 109.10% - Committee member expense slightly higher than anticipated.

5300 63.63% - Less then anticipated networking and conference attendance due to staff changes.

5413 842.29% - To write off from our Accounts Receivable, a court ordered cost order that we are not able to collect.

5503 89.83% - Budgeted Council In-service education did not proceed as budgeted and not all claims received.

5505 52.10% - Working groups were not required to assist with the development of two standards as anticipated. Anticipated legal costs for a regulation change were not incurred because this work was determined not to be needed

5605 46.91% - Translation requests lower than anticipated

5620 10.03% - Projects deferred to Q4

5621 78.56% - Projects deferred to Q4

5622 85.83% - Outreach will wrap up in Q4 and is anticipated to come in on budget.

5702 21.33% - A number of hearings were started in Q3 and will resume in Q4/Q1.

5704 52.74% - External investigative support not required as anticipated

5710 Additional support required due to the ongoing database development and implementation

5752 Registration Committee required legal advice this year

5760 132.43% - A number of hearings were started in Q3 and will resume in Q4/Q1.

5761 60.54% - A number of hearings were started in Q3 and will resume in Q4/Q1.

5762 67.90% - A number of hearings were started in Q3 and will resume in Q4/Q1.

5763 56.36% - Two matters pending will not be addressed until Q4 - the Colleges insurer will cover the legal fees

5755 185.14% - HR related legal advice not anticipated

5811 50.28% - Meetings with the subject-matter experts were held by webinar as opposed to in person

5823 10.23% - The training scheduled for Q3 were moved to Q4 when Council moved the project timelines forward by one quarter.

5824 59.31% - No assessments were conducted in Q3; one assessment was budgeted for Q3.

5802 124.53% - The budgeted amount did not include the HST and the College has purchased a bank of exam questions to avoid future development costs which would have been incurred in 2019

5871 116.50% - More coaching programs required than anticipated.

5880 50.05% - ICRC ordered fewer SCERPS which included practice coaching than anticipated.

5890 22.93% - Number of applications for funding for therapy and counseling has been less than anticipated

5901 110.91% - Salary costs include expenses related to staffing changes

5903 86.83 - Scheduled RRSP contributions will occur in Q4 and bring this line closer to projections.

5904 65.35% - Project in Communications to complete in Q4.

5905 45.30% - No attendance at an international conference. Due to changes in staff, timing and shifts in priorities, courses originally identified were not taken as planned.

5906 149.65% - Cost of recruitment was more than anticipated.

5907 114.01% - Long-term staff service award program costs were greater than anticipated.

5911 106.35% - Under budgeted based on previous government rates

5913 118.41% - Under budgeted based on previous government rates

We are happy to discuss and answer any questions you may have regarding these statements.

Balance Sheet

We have provided you with comparative balance sheets for the end of Q3 2017 and the end of the 2017-18 as comparators for the end of Q3 2018 statement.

Decision Sought

No decision, for information only.

Attachment

- Appendix A – Statement of Operations (with variance analysis)
- Appendix B – Balance Sheet

Appendix A

College of Physiotherapists of Ontario
Statement of Operations - Budget vs. Actual
April 2018 through March 2019

	Q3 YTD			Full Year		
	Apr - Dec 18	Budget	% of Budget	Budget	% of Budget	Notes for Council
Ordinary Income/Expense						
Income						
4008 · Admin Fees						
4019 · Prof Corp Application $700	22,400.00	17,000.00	131.77%	21,000.00	106.67%	There were more applications for new Professional Health Corporations than anticipated.
4018 · Late Fees $225	4,950.00	5,625.00	88.00%	5,625.00	88.00%	This is the first time that we have separated our administration fees into separate categories, Our ability to predict actual costs was impaired by two things: the rules for administrative fees are relatively new so demand for the services are unknown and we have no historical data upon which to make clear predictions.
4017 · Wall Certificates $25	2,775.00	1,410.00	196.81%	1,880.00	147.61%	
4016 · Letter of Prof Stand / NSF $50	8,250.00	7,600.00	108.55%	10,100.00	81.68%	
4015 · Application Fees $100	84,200.00	78,300.00	107.54%	110,300.00	76.34%	
Total 4008 · Admin Fees	122,575.00	109,935.00	111.50%	148,905.00	82.32%	
4007 · Registration fee credits	-43,852.87	-35,823.79	122.41%	-35,823.79	122.41%	Lower number of resignations for Q3.
4004 · Cost recovery from cost orders	43,597.20	17,250.00	252.74%	23,000.00	189.55%	More cost orders have been recovered than anticipated.
4003 · Remediation Chargeback	4,691.86	8,070.00	58.14%	10,760.00	43.61%	The requirement for College supported practice coaching programs was less than anticipated.
4001 · Registration Fees						
4021 · Cross Border Fee $100	0.00	600.00	0.00%	800.00	0.00%	We have not previously captured registration fees to this level of detail and the actual income has been lower than anticipated in some categories.
4020 · Courtesy Registration Fee $100	0.00	900.00	0.00%	1,200.00	0.00%	
4014 · Provisional Practice Fees $75	30,300.00	30,000.00	101.00%	34,875.00	86.88%	
4013 · Prof Corp Fees $250	61,250.00	70,250.00	87.19%	88,250.00	69.41%	
4012 · Independent Practice - ProRated	85,989.49	132,187.50	65.05%	146,531.50	58.68%	
4011 · Independent Practice - $595	4,094,899.45	4,056,412.50	100.95%	5,408,550.00	75.71%	
Total 4001 · Registration Fees	4,272,438.94	4,290,350.00	99.58%	5,680,206.50	75.22%	
4002 · Interest Income	84,463.04	88,000.00	95.98%	112,000.00	75.41%	
4010 · Miscellaneous Income	785.00	0.00	100.00%	0.00	100.00%	This includes payment that the College received for having two students conduct their clinical placements at the College and a re-payment by a PT to the College for funding for therapy and counseling.
Total Income	4,484,698.17	4,477,781.21	100.15%	5,939,047.71	75.51%	
Gross Profit	4,484,698.17	4,477,781.21	100.15%	5,939,047.71	75.51%	
Expense						
5000 · Committee Per Diem						
5002 · ICRC - per diem	14,867.00	16,097.40	92.36%	21,463.20	69.27%	We have one less professional member on the committee this year
5003 · Council - per diem	38,143.25	32,572.00	117.10%	43,216.00	88.26%	Overage resulted from an additional one-day Council meeting that was unbudgeted.
5005 · Discipline Committee - per diem	12,282.00	24,365.00	50.41%	27,385.00	44.85%	A number of hearings were started in Q4 but will resume in Q4/Q1 next year.

Appendix A

College of Physiotherapists of Ontario
Statement of Operations - Budget vs. Actual
April 2018 through March 2019

	Q3 YTD			Full Year		
	Apr - Dec 18	Budget	% of Budget	Budget	% of Budget	Notes for Council
5006 · Executive - per diem	10,415.00	20,626.50	50.49%	26,389.50	39.47%	Underspending resulted from deferral of scheduled President governance work to Q4, change from a one-day in person Executive meeting to a one-hour teleconference meeting. Have not received any claims from one council member (although some of these claims have been anticipated).
5010 · Patient Relations - per diem	63.00	900.96	6.99%	1,126.20	5.59%	There have been less applications for funding than anticipated. As such the PRC has not been required to meet.
5011 · QA Committee - per diem	3,157.00	3,819.93	82.65%	4,208.24	75.02%	QAC meeting via teleconference was cancelled because there were no cases to discuss.
5012 · Registration Com. - per diem	2,849.00	3,746.00	76.05%	4,680.00	60.88%	Committee members are not incurring as much prep time as anticipated.
5017 · Finance Committee - per diem	1,955.00	1,635.00	119.57%	3,485.00	56.10%	The one hour teleconference became a two hour teleconference due to the volume of material to be discussed.
Total 5000 · Committee Per Diem	83,731.25	103,762.79	80.70%	131,953.14	63.46%	
5050 · Committee Reimbursed Expenses						
5052 · ICRC - expenses	17,062.23	22,831.44	74.73%	30,441.92	56.05%	There was a delay of the appointment of a non-council committee appointee (2 meetings) and overall travel expenses have been lower.
5053 · Council - expenses	73,385.08	60,451.59	121.40%	74,559.19	98.43%	Overage resulted from an unbudgeted one-day Council meeting and unbudgeted legal fees.
5055 · Discipline Committee - expenses	12,914.43	28,206.96	45.79%	32,172.24	40.14%	A number of hearings were started in Q3 and will resume in Q4 and Q1.
5056 · Executive Committee - expenses	7,741.11	8,048.40	96.18%	10,731.20	72.14%	
5062 · QA Committee - expenses	1,711.33	2,700.00	63.38%	2,700.00	63.38%	One member was unable to attend the QAC meeting in June.
5063 · Registration Comm. - expenses	1,854.71	1,700.00	109.10%	1,700.00	109.10%	Committee member expense slightly higher than anticipated.
5075 · Finance Committee - expenses	0.00	0.00	0.00%	3,220.00	0.00%	
Total 5050 · Committee Reimbursed Expenses	114,668.89	123,938.39	92.52%	155,524.55	73.73%	
5100 · Information Management						
5101 · IT Hardware	27,921.79	27,970.00	99.83%	37,620.00	74.22%	
5102 · Software	9,407.04	9,439.74	99.65%	16,586.32	56.72%	
5103 · IT Maintenance	67,226.33	67,123.50	100.15%	90,108.00	74.61%	
5104 · IT Database	187,070.10	183,500.00	101.95%	319,810.00	58.49%	
Total 5100 · Information Management	291,625.26	288,033.24	101.25%	464,124.32	62.83%	
5200 · Insurance	7,320.51	7,306.59	100.19%	9,742.12	75.14%	
5300 · Networking, Conf. & Travel	20,962.92	32,943.30	63.63%	34,108.30	61.46%	Less then anticipated networking and conference attendence due to staff changes.
5400 · Office and General						
5402 · Bank & service charges	31,501.69	31,000.00	101.62%	123,130.00	25.58%	
5403 · Maintenance & repairs	2,231.85	2,210.00	100.99%	3,100.00	72.00%	
5405 · Memberships & publications	168,523.58	161,600.00	104.28%	213,252.41	79.03%	
5407 · Office & kitchen supplies	14,927.24	14,325.00	104.20%	22,100.00	67.54%	
5408 · Postage & courier	4,313.09	4,200.00	102.69%	6,300.00	68.46%	
5409 · Rent	369,044.85	369,300.00	99.93%	492,400.00	74.95%	
5411 · Printing, Filing & Stationery	5,730.49	5,475.00	104.67%	9,700.00	59.08%	

Appendix A

College of Physiotherapists of Ontario
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April 2018 through March 2019

	Q3 YTD			Full Year		
	Apr - Dec 18	Budget	% of Budget	Budget	% of Budget	Notes for Council
5412 · Telephone & Internet	26,644.48	26,300.00	101.31%	35,785.88	74.46%	
5413 · Bad Debt	37,903.02	4,500.00	842.29%	6,000.00	631.72%	To write off from our Accounts Receivable, a court ordered cost order that we are not able to collect.
Total 5400 · Office and General	660,820.29	618,910.00	106.77%	911,768.29	72.48%	
5500 · Regulatory Effectiveness						
5503 · Council Education	39,821.63	44,330.00	89.83%	44,915.00	88.66%	Budgeted Council In-service education did not proceed as budgeted and not all claims received.
5504 · Elections	3,500.00	3,600.00	97.22%	3,600.00	97.22%	
5505 · Policy Development	16,505.64	31,679.53	52.10%	35,679.53	46.26%	Working groups were not required to assist with the development of two standards as anticipated. Anticipated legal costs for a regulation change were not incurred because this change was determined not to be needed.
Total 5500 · Regulatory Effectiveness	59,827.27	79,609.53	75.15%	84,194.53	71.06%	
5600 · Communications						
5605 · French Language Services	3,518.53	7,500.00	46.91%	10,000.00	35.19%	Translation requests lower than anticipated.
5620 · Print Communication	1,393.67	13,900.00	10.03%	14,200.00	9.82%	Projects deferred to Q4.
5621 · Online Communication	39,042.77	49,700.00	78.56%	77,400.00	50.44%	Projects deferred to Q4.
5622 · In-Person Communication	17,852.62	20,800.00	85.83%	26,900.00	66.37%	Outreach will wrap up in Q4 and is anticipated to come in on budget.
Total 5600 · Communications	61,807.59	91,900.00	67.26%	128,500.00	48.10%	
5700 · Professional fees						
5701 · Audit	25,990.00	25,000.00	103.96%	25,000.00	103.96%	
5702 · Hearing Expenses	2,044.35	9,585.00	21.33%	10,463.00	19.54%	A number of hearings were started in Q3 and will resume in Q4/Q1.
5704 · Investigations	23,891.39	45,300.00	52.74%	55,400.00	43.13%	External investigative support not required as anticipated.
5710 · Temporary staff	31,649.65	0.00	100.00%	0.00	100.00%	Additional support required due to the ongoing database development and implementation.
5750 · Legal						
5752 · Legal - Registration	6,953.46	0.00	100.00%	0.00	100.00%	Registration Committee required legal advice this year.
5753 · Legal - Professional Conduct						
5760 · General Counsel	31,782.63	24,000.00	132.43%	32,000.00	99.32%	
5761 · Independent Legal Advice	37,495.46	61,935.30	60.54%	68,817.00	54.49%	A number of hearings started in Q3 and will resume in Q4 and Q1.
5762 · Hearing Counsel	56,720.07	83,529.60	67.90%	93,654.40	60.56%	
5763 · Court Proceedings & Appeals	16,908.63	30,000.00	56.36%	30,000.00	56.36%	Two matters pending will not be addressed until Q4, the College's insurer will cover the legal fees.
Total 5753 · Legal - Professional Conduct	142,906.79	199,464.90	71.65%	224,471.40	63.66%	
5755 · General Legal	27,771.41	15,000.00	185.14%	20,000.00	138.86%	HR related legal advice not anticipated.
Total 5750 · Legal	177,631.66	214,464.90	82.83%	244,471.40	72.66%	
Total 5700 · Professional fees	261,207.05	294,349.90	88.74%	335,334.40	77.89%	
5800 · Programs						
5810 · Quality Program						
5811 · QA Program Development & Eval.	42,826.62	85,180.00	50.28%	106,095.00	40.37%	Meetings with the subject matter experts were held by webinar as opposed to in-person.
5821 · Assessor Travel	6,200.44	6,322.00	98.08%	6,322.00	98.08%	

Appendix A

College of Physiotherapists of Ontario
Statement of Operations - Budget vs. Actual
April 2018 through March 2019

	Q3 YTD			Full Year		
	Apr - Dec 18	Budget	% of Budget	Budget	% of Budget	Notes for Council
5823 · Assessor Training	1,717.27	16,785.00	10.23%	79,916.00	2.15%	The training scheduled for Q3 were moved to Q4 when Council moved the project timelines forward by one quarter.
5824 · Assessor Onsite Assessment Fee	6,370.00	10,740.00	59.31%	10,740.00	59.31%	No assessments were conducted in Q3; one assessment was budgeted for Q3.
Total 5810 · Quality Program	57,114.33	119,027.00	47.98%	203,073.00	28.13%	
5802 · Jurisprudence	14,437.50	11,594.00	124.53%	11,891.00	121.42%	The budgeted amount did not include the HST and the College has purchased a bank of exam questions to avoid future development costs which would have been incurred in 2019.
5870 · Practice Enhancement - QA						
5871 · QA Practice Enhancement fees	3,262.10	2,800.00	116.50%	2,800.00	116.50%	More coaching programs required than anticipated.
Total 5870 · Practice Enhancement - QA	3,262.10	2,800.00	116.50%	2,800.00	116.50%	
5880 · Remediation - PC	4,038.64	8,070.00	50.05%	10,760.00	37.53%	ICRC ordered fewer SCERPS which included practice coaching than anticipated.
5890 · Sexual Abuse Therapy	8,706.00	37,972.50	22.93%	53,430.00	16.29%	Number of people accessing funding has been less than anticipated.
Total 5800 · Programs	87,558.57	179,463.50	48.79%	281,954.00	31.05%	
5900 · Staffing						
5914 · Vacation Pay Adjustment	0.00	0.00	0.00%	5,000.00	0.00%	
5901 · Salaries	2,494,051.98	2,248,823.14	110.91%	2,977,391.31	83.77%	Salary costs include expenses related to staffing changes.
5902 · Employer Benefits	78,037.21	78,358.67	99.59%	109,559.95	71.23%	
5903 · Employer RRSP Contribution	82,301.31	94,783.33	86.83%	133,656.69	61.58%	Scheduled RRSP contributions will occur in Q4 and bring this line closer to projections.
5904 · Consultant fees	50,991.19	78,032.00	65.35%	105,398.00	48.38%	Project in Communications to complete in Q4.
5905 · Staff Development	50,685.74	111,893.27	45.30%	127,604.90	39.72%	No attendance at an international conference. Due to changes in staff, timing and shifts in priorities, courses originally identified were not taken as planned.
5906 · Recruitment	2,319.55	1,550.00	149.65%	1,950.00	118.95%	Cost of recruitment was more than anticipated.
5907 · Staff Recognition	12,295.67	10,785.00	114.01%	13,360.00	92.03%	Long-term staff service award program costs were greater than anticipated.
5911 · CPP - Canadian Pension Plan	53,079.21	49,910.79	106.35%	76,991.56	68.94%	
5912 · EI - Employment Insurance	22,609.52	21,905.28	103.22%	34,538.93	65.46%	Under budgeted based on previous government rates.
5913 · EHT - Employer Health Tax	49,166.25	41,523.40	118.41%	47,769.16	102.93%	
Total 5900 · Staffing	2,895,537.63	2,737,564.88	105.77%	3,633,220.50	79.70%	
Total Expense	4,545,067.23	4,557,782.12	99.72%	6,170,424.15	73.66%	
Net Ordinary Income	-60,369.06	-80,000.91	75.46%	-231,376.44	26.09%	
Other Income/Expense						
Other Income						
6001 · Amortization	-86,625.00	-86,625.00	100.00%	-115,500.00	75.00%	
Total Other Income	-86,625.00	-86,625.00	100.00%	-115,500.00	75.00%	
Net Other Income	-86,625.00	-86,625.00	100.00%	-115,500.00	75.00%	
Net Income	**-146,994.06**	**-166,625.91**	**88.22%**	**-346,876.44**	**42.38%**	

	31 Dec 18	31 Dec 17	31 Mar 18
ASSETS			
Current Assets			
Chequing/Savings			
1000 · Cash on Hand			
1001 · Petty Cash	250.00	250.00	250.00
1002 · Petty Cash (USD)	0.00	0.00	0.00
1003 · CC Clearing - RBC - 100-999-2	977.96	7,780.61	473,239.79
1005 · Operating - RBC - 102-953-7	63,383.70	65,535.59	107,687.06
1000 · Cash on Hand - Other	0.00	195.16	0.00
Total 1000 · Cash on Hand	64,611.66	73,761.36	581,176.85
1100 · Investments			
1104 · Investments - Long Term	3,637,498.58	3,547,068.40	3,637,498.58
1102 · Investments - Short Term	1,216,653.45	1,208,803.26	1,185,153.45
1103 · Savings - RBC - 100-663-4	3,083,775.72	2,829,237.56	5,537,882.68
Total 1100 · Investments	7,937,927.75	7,585,109.22	10,360,534.71
Total Chequing/Savings	8,002,539.41	7,658,870.58	10,941,711.56
Accounts Receivable			
1200 · Accounts Receivable	86,216.01	257,397.18	258,119.57
Total Accounts Receivable	86,216.01	257,397.18	258,119.57
Other Current Assets			
1201 · Allowance for Doubtful Accounts	-78,226.51	-242,631.40	-241,232.74
1400 · Prepaid Expenses			
1411 · Prepaid Rent	41,598.78	22,712.72	40,712.37
1401 · Prepaid Software	2,777.19	3,298.83	2,290.47
1403 · Prepaid IT services	23,473.39	10,861.29	27,654.90
1405 · Prepaid Insurance	4,842.45	1,855.17	2,156.76
1406 · Prepaid Membership	10,050.14	2,441.95	154,485.14
1408 · Prepaid staff development	3,126.66	5,390.42	2,565.10
1410 · Prepaid meetings	980.53	1,155.00	14,027.50
Total 1400 · Prepaid Expenses	86,849.14	47,715.38	243,892.24
Total Other Current Assets	8,622.63	-194,916.02	2,659.50
Total Current Assets	8,097,378.05	7,721,351.74	11,202,490.63
Fixed Assets			
1301 · Computer equipment	83,402.04	295,527.04	83,402.04
1302 · Computer Software	7,940.84	7,940.84	7,940.84
1305 · Computer equipment - Acc dep	-67,425.07	-284,449.90	-67,425.07
1306 · Computer Software - Acc Dep	-7,940.84	-7,940.84	-7,940.84
1310 · Furniture and Equipment	345,102.55	279,376.00	343,109.00
1312 · Furniture & Equipment -Acc Dep	-169,225.09	-13,968.80	-82,600.09
1320 · Leasehold Improvements	758,628.70	512,990.35	758,628.70
1322 · Leasehold Improvments -Acc dep	-69,540.96	-12,869.25	-69,540.96
1325 · Construction Work In Progress	0.00	-593.25	0.00
Total Fixed Assets	880,942.17	776,012.19	965,573.62
TOTAL ASSETS	**8,978,320.22**	**8,497,363.93**	**12,168,064.25**

	31 Dec 18	31 Dec 17	31 Mar 18
LIABILITIES & EQUITY			
Liabilities			
Current Liabilities			
Accounts Payable			
2000 · Accounts Payable	99,634.71	163,655.04	160,790.04
Total Accounts Payable	99,634.71	163,655.04	160,790.04
Other Current Liabilities			
2011 · Vacation Accrual	113,523.91	85,384.91	113,523.91
2010 · Accrued Liabilities	779,881.42	292,831.32	325,072.72
2100 · Deferred Revenue			
2101 · Deferred Registration Fees	0.00	0.00	0.00
2103 · Pro-Rated Fee Revenue	43,382.99	0.00	0.00
2102 · Deferred Full Fee Revenue	1,323,072.91	1,285,795.02	4,833,780.00
Total 2101 · Deferred Registration Fees	1,366,455.90	1,285,795.02	4,833,780.00
2110 · Banked refunds	41,806.71	29,335.28	28,971.20
Total 2100 · Deferred Revenue	1,408,262.61	1,315,130.30	4,862,751.20
2150 · Other Payables			
2154 · Citizen's Advisory Group	20,624.18	13,770.34	11,556.19
2152 · Due to London Life (RRSP)	25,000.00	15,153.12	15,982.74
Total 2150 · Other Payables	45,624.18	28,923.46	27,538.93
Total Other Current Liabilities	2,347,292.12	1,722,269.99	5,328,886.76
Total Current Liabilities	2,446,926.83	1,885,925.03	5,489,676.80
Long Term Liabilities			
2125 · Deferred Rent - Tenant Incentiv	246,225.04	0.00	246,225.04
Total Long Term Liabilities	246,225.04	0.00	246,225.04
Total Liabilities	2,693,151.87	1,885,925.03	5,735,901.84
Equity			
3000 · Unrestricted Net Assets	3,862,812.95	303,936.00	3,862,812.95
3001 · Invested in Capital Assets	719,348.58	180,073.00	719,348.58
3010 · Restricted Reserves			
3011 · Professional Conduct Expense / Contingency / PT Health Fund	1,000,000.00	6,078,725.00	1,000,000.00
3012 · Sexual Abuse Therapy	100,000.00	327,865.00	100,000.00
3013 - Strategic Initiatives	500,000.00	0.00	500,000.00
3014 - IT Improvements	250,000.00	0.00	250,000.00
Total 3010 · Restricted Reserves	1,850,000.00	6,406,590.00	1,850,000.00
3900 · Retained Earnings	0.88	0.88	0.88
Net Income	-146,994.06	-279,160.98	0.00
Total Equity	6,285,168.35	6,611,438.90	6,432,162.41
TOTAL LIABILITIES & EQUITY	**8,978,320.22**	**8,497,363.93**	**12,168,064.25**

COLLEGE OF PHYSIOTHERAPISTS of ONTARIO | ORDRE DES PHYSIOTHÉRAPEUTES de l'ONTARIO

Motion No.: 6.0

Council Meeting
March 21-22, 2019

Agenda #6.0: Program Review: Entry to Practice

It is moved by

_____,

and seconded by

_____,

that:

Council approves the $75,000 budgeted in line 5904– Consultant Fees, to complete a preliminary review of the Entry to Practice Program as outlined as phase one.

Meeting Date:	March 21-22, 2019
Agenda Item #:	6.0
Issue:	Proposal for Entry to Practice Program Review
Submitted by:	Gary Rehan, President

Issue

The College entry to practice program is complex and intersects with multiple agencies, other regulators, government and other stakeholders. The College program has also been in place for more than 25 years without a detailed review or evaluation.

Among all programs offered by the College, both professional conduct and entry to practice have the most direct impact on patients, and our mandate of public protection. Since the program has not been reviewed in the past 25 years, I believe that it is in the public interest for Council to pursue this evaluation.

With this in mind, I discussed this item with the Registrar, Deputy Registrar and Vice President, who in principle support the need for this review.

I then proposed to both the Finance and Executive Committees that funds be allocated in the budget to enable the College in engaging an expert to plan a review of our entry to practice program. Both Finance committee and Executive committee are in support of this review, and have recommended to Council to allocate funds for this purpose.

Purpose of the review

The ultimate purpose of the review would be to ensure that the complete College entry program is:

- Effective in protecting the public,
- Most efficient,
- Meets our organizational needs,
- Takes into account current best practices related to entry, and
- Is fair to all College applicants.

However, the agreement to conduct the full review would be the second phase. This first phase is a planning review to ensure that the College fully understands the scope of the second phase before it commits to it.

I have proposed that a maximum of $75,000 be allocated to this first phase to be spent over the 2019-2020 budget year.

The Finance committee and Executive Committee has considered this proposal and recommends that Council allocate money in it is budget for this purpose.

Scope of the review

Here is a high-level review of the objectives of phase one:

- To contract an external consultant who will undertake:
    - An environmental assessment of best practices in Entry to Practice programs in other jurisdictions and health professions, including identifying any work that may have already been conducted about best practices, and to establish the need for further research in this area
    - A review of the pros and cons of each entry to practice approach
    - A preliminary gap analysis to determine if our Entry to Practice program meets our organizational needs, statutory requirements and best practices
    - A proposal detailing the process for how the College should pursue a detailed review of its Entry to Practice program if needed.

To ensure neutrality the target consultant will be someone who is not involved in Canadian health regulation or physiotherapy entry-to-practice programs. This phase is intended to provide Council with the information it needs to determine the next steps in the review. It is anticipated that this work will take one year to be completed.

Decision sought

Council is being asked to approve the $75,000 budgeted in line 5904– Consultant Fees, to complete a preliminary review of the Entry to Practice Program as outlined as phase one.

COLLEGE OF PHYSIOTHERAPISTS of ONTARIO | ORDRE DES PHYSIOTHÉRAPEUTES de l'ONTARIO

Motion No.: 7.0

Council Meeting
March 21-22, 2019

Agenda #7.0: Approval of 2019-2020 Budget

It is moved by

_____,

and seconded by

_____,

that:

Council approves the Operating and Capital Budgets for the 2019-2020 Fiscal Year.

Meeting Date:	March 21-22, 2019
Agenda Item #:	7.0
Issue:	Approval of the 2019-2020 Budget
Submitted by:	Rod Hamilton, Registrar

Issue

The Finance and Executive Committee are recommending that Council approves the Operating and Capital Budgets for the 2019/2020 fiscal year.

Differences from Budget Presented to Finance Committee

At the time of the budget discussion with the Finance Committee, two small changes were noted that would affect two line items. In the process of making these changes staff identified three additional changes that have affected three additional line items.

As such, in the budget you are reviewing, the following changes have been made:

Two changes as directed by the Finance Committee:

- Council Education – budget line 5503 reduced by $7766; Canadian Physiotherapy Association (CPA) Congress occurs every two years and will not be taking place during this fiscal and was removed from the budget.
- Council Expenses – budget line 5053 changed from $10,452.50 to $7,400; originally budgeted for all Councillors and their spouse to attend the Presidents dinner (includes their meal costs only), at the direction of the President, was changed to include all expenses for three departed Councillors (with a plus one) and the President's wife.

Three additional changes were made by staff:

- Council Education – budget line 5503 reduced by $19,036. Conference costs for Q3 were duplicated in error for Q4 which should have $0 in costs; this is now corrected.
- Networking, Conference and Travel – budget line 5300 was increased by $1,500. In keeping with the Colleges second strategic goal, staff have budgeted to attend the Canadian, Life and Health Insurance Association (CLHIA) Conference. After submitting the original budget, the College has partnered with the College of Massage Therapists of Ontario (CMTO) to have a booth at the conference in order to build a stronger and mutually beneficial relationship with insurers. The cost of the booth is $3,000 which has been split with the CMTO, the addition of the$1500 is to cover the cost of the College's portion of the booth.
- Memberships and Subscriptions – budget line 5405 was increased by $250. An annual subscription of the Harvard Business Review was missed in error and has now been included.

The Amortization schedule was also updated: the cost of AODA doors was adjusted from $25,000 in the original budget to $10,961 in the current capital budget. Also these doors were originally amortized at 10 years, however this was changed to 8 years to reflect the remaining years left in the office lease. The lower capital cost and the change in the amortization time resulted in a lower overall depreciation cost for the door which resulted in am adjustment to the budget by a further $1,129.87.

As a result of all these changes, the deficit budget has been decreased by $29,234. 37.

	Budget Presented to Finance Committee	New Budget with Changes
Total Estimated Revenue	-6,534,874.98	-6,536,874.98
Total Estimated Expenses	6,876,539.90	6,849,305.53
Total Estimated Overage (Deficit)	**$341,664.92**	**$312,430.55**

Background

The College uses zero-based budgeting to build both the Operating and the Capital Budgets. This involves preparing a new budget every year where each expense is justified on an annual basis. Every line item of the budget is approved by Council.

The proposed budgets reflect the anticipated income, expenses and capital expenditures to support the College's ongoing operations and initiatives in support of its mission.

The information is presented in the following way:

- Operating Budget
- Capital Budget and Annual Amortization Schedule

<u>Finance Committee and Executive Committee Review of the Budget</u>

The Finance Committee met in-person in late January and conducted an in-depth review of the budget including a line by line review of each item. At the conclusion of the meeting, the Finance Committee was satisfied with the proposed budget and recommended that the Executive Committee and Council approve the proposed budget.

The Executive Committee met in-person in early March and reviewed the proposed budget including the changes above and endorsed Finance Committee's recommendation that Council approve the 2019-2020 fiscal budget.

Decision

Council is asked to approve the Operating and Capital Budgets for the 2019-2020 fiscal year, as recommended by the Finance and Executive Committees.

Attachments

- Attachment 1 - Proposed General Budget for 2019-2020
- Attachment 2 - Proposed Capital Budget for 2019-2020

Attachment 1 - Proposed General Budget for 2019-2020

Budget Account Numbers	Sum of Q1	Sum of Q2	Sum of Q3	Sum of Q4	Sum of Total
4001 · Registration Fees	-71,728.90	-133,008.75	-51,499.80	-5,898,824.00	-6,155,061.45
4002 · Interest Income	-45,900.00	-45,900.00	-45,900.00	-45,900.00	-183,600.00
4003 · Remediation chargebacks	-3,729.00	-5,446.00	-6,124.00	-7,458.00	-22,757.00
4004 · Cost recovery from cost orders	-3,000.00	-8,000.00	-12,500.00	-25,000.00	-48,500.00
4007 · Registration fee credits	1,357.28	686.86	374.33	-1,500.00	918.47
4008 · Admin Fees	-35,575.00	-29,900.00	-29,950.00	-30,200.00	-125,625.00
4010 · Miscellaneous Income	-250.00	0.00	0.00	0.00	-250.00
4022 · Recovery of Therapy Costs	-500.00	-500.00	-500.00	-500.00	-2,000.00
5001 · Chair's - per diem	0.00	4,389.00	0.00	0.00	4,389.00
5002 · ICRC - per diem	6,318.00	5,331.00	4,212.00	4,212.00	20,073.00
5003 · Council Per Diem	17,727.00	11,592.00	11,592.00	11,592.00	52,503.00
5005 · Discipline Committee - per diem	11,223.04	3,366.91	13,105.15	10,100.74	37,795.84
5006 · Executive Committee Per Diem	4,863.00	4,863.00	5,964.00	4,863.00	20,553.00
5010 · Patient Relations - per diem	423.94	282.62	282.62	282.62	1,271.81
5011 · QA Committee - per diem	3,436.00	3,436.00	3,436.00	3,436.00	13,744.00
5012 · Registration Com. - per diem	846.00	1,707.00	846.00	846.00	4,245.00
5017 · Finance Committee - per diem	752.00	3,376.00	376.00	3,376.00	7,880.00
5051 · Chair's - expenses	0.00	8,415.00	0.00	0.00	8,415.00
5052 · ICRC - expenses	6,090.00	7,988.70	6,090.00	6,090.00	26,258.70
5053 · Council Expenses	23,450.00	12,715.00	13,388.00	12,715.00	62,268.00
5055 · Discipline Committee - expenses	24,450.00	7,335.00	29,670.00	22,005.00	83,460.00
5056 · Executive Committee Expenses	5,338.00	5,031.00	5,031.00	5,031.00	20,431.00
5062 · QA Committee - expenses	3,125.80	3,125.80	3,125.80	3,125.80	12,503.20
5063 · Registration Comm. - expenses	0.00	1,255.00	0.00	0.00	1,255.00
5075 · Finance Committee - expenses	0.00	2,000.00	0.00	2,000.00	4,000.00
5101 · IT Hardware	6,475.00	6,475.00	6,475.00	6,475.00	25,900.00
5102 · Software	12,175.00	18,425.00	12,175.00	7,425.00	50,200.00
5103 · IT Maintenance	26,267.50	19,267.50	19,267.50	19,267.50	84,070.00
5104 · IT Database	50,000.00	148,310.00	50,000.00	50,000.00	298,310.00
5200 · Insurance	2,700.00	2,700.00	2,700.00	2,700.00	10,800.00
5300 · Networking, Conf. & Travel	20,753.00	10,702.00	2,759.00	2,108.50	36,322.50
5402 · Bank & service charges	39,888.00	39,038.00	39,038.00	39,038.00	157,002.00
5403 · Maintenance & repairs	11,450.00	1,350.00	4,750.00	1,350.00	18,900.00
5405 · Memberships & publications	5,565.00	3,412.41	9,000.00	4,375.00	22,352.41
5406 · Alliance Registration Levy	0.00	0.00	0.00	198,799.44	198,799.44
5407 · Office & kitchen supplies	4,198.25	3,898.25	3,898.25	3,898.25	15,893.00
5408 · Postage & courier	1,850.00	1,250.00	1,850.00	1,250.00	6,200.00
5409 · Rent	121,923.18	121,923.18	121,923.18	121,923.18	487,692.70
5411 · Printing, Filing	2,040.00	2,260.00	1,800.00	1,800.00	7,900.00
5412 · Telephone & Internet	11,223.00	8,520.00	8,520.00	8,520.00	36,783.00
5413 · Bad Debt	650.00	650.00	650.00	650.00	2,600.00
5502 · Strategic Operations	0.00	87,575.00	0.00	0.00	87,575.00
5503 · Council Education	25,800.00	9,219.00	11,855.00	585.00	47,459.00
5504 · Elections	0.00	0.00	3,600.00	0.00	3,600.00
5505 · Policy Development	8,114.00	15,356.00	14,856.00	500.00	38,826.00
5605 · Translation Services	4,000.00	2,500.00	2,500.00	2,500.00	11,500.00
5620 · Print Communications	7,225.00	5,325.00	5,325.00	2,325.00	20,200.00
5621 · Online Communications	14,475.00	11,745.00	17,825.00	11,620.00	55,665.00
5622 · In-Person Communications	1,500.00	4,100.00	10,600.00	9,000.00	25,200.00
5701 · Audit	28,100.00	0.00	0.00	0.00	28,100.00
5702 · Hearing Expenses	2,094.00	1,057.00	3,111.00	4,507.00	10,769.00
5704 · Investigations	12,500.00	2,500.00	2,500.00	2,500.00	20,000.00
5751 · QA Legal	500.00	500.00	500.00	500.00	2,000.00
5752 · Registration - Legal	1,250.00	5,250.00	1,250.00	1,250.00	9,000.00

Attachment 1 - Proposed General Budget for 2019-2020

Budget Account Numbers	Sum of Q1	Sum of Q2	Sum of Q3	Sum of Q4	Sum of Total
5754 · Council Legal	1,250.00	1,250.00	1,250.00	1,250.00	5,000.00
5755 · HR Legal	500.00	500.00	500.00	500.00	2,000.00
5756 · Executive Office - Legal	2,000.00	2,000.00	2,000.00	2,000.00	8,000.00
5760 · General Counsel for PC	8,000.00	11,791.15	8,000.00	8,000.00	35,791.15
5761 · Independent Legal Advice	45,823.16	4,401.93	38,477.27	34,617.37	123,319.73
5762 · Hearing Counsel	69,186.04	14,825.58	24,709.30	44,476.74	153,197.66
5802 · Jurisprudence	13,680.00	0.00	0.00	0.00	13,680.00
5811 · QA Program Development & Eval.	50,791.50	29,357.00	6,137.00	0.00	86,285.50
5821 · Assessor Travel	0.00	6,900.00	5,750.00	5,520.00	18,170.00
5823 · Assessor Training	6,110.00	6,110.00	3,055.00	6,110.00	21,385.00
5824 · Assessor Assessment Fee	42,330.00	44,440.00	42,190.00	41,570.00	170,530.00
5871 · QA Practice Enhancement fees and travel	475.00	950.00	475.00	0.00	1,900.00
5880 · Remediation - CM	1,017.00	2,056.00	2,056.00	1,356.00	6,485.00
5880 · Remediation - PC	2,712.00	3,390.00	4,068.00	6,102.00	16,272.00
5890 · Sexual Abuse Therapy	5,200.00	6,250.00	7,300.00	8,350.00	27,100.00
5901 · Salaries	700,656.31	701,478.34	692,534.98	697,305.01	2,791,974.64
5902 · Employer Benefits	33,826.56	34,478.22	44,821.69	44,821.69	157,948.16
5903 · Employer RRSP Contribution	34,577.11	36,661.92	37,253.01	40,236.30	148,728.35
5904 · Consultant Fees	112,925.98	128,320.48	104,821.48	94,821.48	440,889.42
5905 · Staff Development	13,250.00	21,750.00	13,250.00	13,250.00	61,500.00
5906 · Recruitment	400.00	400.00	400.00	400.00	1,600.00
5907 · Staff Recognition	2,237.50	2,237.50	6,537.50	2,417.50	13,430.00
5911 · CPP - Canadian Pension Plan	29,125.46	14,040.92	3,767.90	37,541.08	84,475.35
5912 · EI - Employment Insurance	11,885.35	5,731.90	1,566.74	15,748.60	34,932.58
5913 · EHT - Employer Health Tax	14,460.68	14,476.71	14,302.31	4,336.57	47,576.27
5914 · Vacation Pay Adjustment	0.00	0.00	0.00	15,000.00	15,000.00
6001 · Amortization	40,367.53	40,367.53	40,367.53	40,367.53	161,470.13
Grand Total	1,614,220.26	1,531,614.66	1,415,337.74	-4,248,742.10	312,430.55

College of Physiotherapists of Ontario

Capital Budget and Amortization Schedule

	Asset Class	Amount	Amortization Expense	Useful Life
New Acquisitions:				
Microphones for Boardoom	Furniture and Equipment	25,000.00	5,000.00	5
AODA Auto Door Staff Entrance	Leaseholds	10,961.00	1,370.13	8
Purchase of NAS (Network Attached Storage)	Computer Equipment	65,000.00	13,000.00	5
Total New		**100,961.00**	**19,370.13**	
Existing Assets:				
Furniture & Equipment		318,500.00	63,700.00	5
Leaseholds		784,000.00	78,400.00	10
Total Existing		**1,102,500.00**	**142,100.00**	
Total Assets		**1,203,461.00**		
Total Amortization Expense for 2019/20			**161,470.13**	

Meeting Date:	March 21-22, 2019
Agenda Item #:	8.1
Issue:	Quality Assurance Program Review – Project Update
Submitted by:	Joyce Huang, Strategic Projects Manager

Issue:

This is an update on the Quality Assurance Program Review project. This briefing also includes two items considered at the QA Working Group that are being brought to Council for information.

Background:

Council established the Quality Assurance Working Group (QAWG) to conduct a review of the Quality Assurance Program with the goal of identifying what changes, if any, could increase the program's impact on practice without necessarily increasing cost. At the December 2017 meeting, Council considered the changes recommended by the QAWG, and they approved the framework for a new program in principle for the purpose of consultation. At the March 2018 meeting, Council considered the feedback received from the broad consultation on the proposed new program, and formally approved the new program for development.

Council assigned to the Quality Assurance Working Group the role of providing policy direction regarding the review and development of the Quality Assurance Program. A project plan was established for the development of new components and revisions to existing components of the QA program with the goal of implementing the new program on April 1, 2019.

Since the beginning of this project, as the Working Group conducted the detailed work of the program review, Council received updates about this work at each meeting, and where required, provided direction and made decisions.

Below is a history of Council direction and decision-making since the beginning of the review.

Date	Council Direction and Decisions
September 2017	• Provided direction that the primary objective of the Quality Assurance Program should be to ensure that all members meet pre-determined minimum standards for competency and/or quality
December 2017	• Considered the changes to the QA program recommended by the QAWG • Approved the framework for a new program in principle for the purpose of consultation
March 2018	• Considered the feedback received from the broad consultation on the proposed new program

Date	Council Direction and Decisions
	• Formally approved the new program for development, with the goal of launching the new program in April 2019 • Assigned to the Quality Assurance Working Group the role of providing policy direction regarding the review and development of the program, and approved a Terms of Reference document
October 2018	• Approved the recommendation by the WG to remove the additional random selection of physiotherapists who are "above threshold" after the remote assessment to do an on-site assessment • Deferred the consideration of whether non-clinical PTs should engage in practice assessments in the new QA Program, and directed staff to collect additional information • Provided direction that PTs should be asked to declare whether they have the applicable written policies in place in the pre-assessment questionnaire, and for PTs who are required to do an on-site assessment, they will be asked to submit copies of the policies for review • Provided direction that the on-site assessment should include a component where the assessor provides some feedback and engages in discussion with the member
December 2018	• Approved the WG's recommendation to include a chart review component in the remote assessment process. The inclusion of this component will be re-evaluated based on the results of the pilot test assessments • Approved the WG's recommendation to defer the consideration of a non-clinical QA assessment for two years • Approved the WG's recommendation that the QA program selects 9.1% of eligible members for assessment in the year 2019-20 • Approved the WG's recommendations related to QA program policies, with some amendments: 1. Updated timelines for the remote and on-site assessment processes. 2. Members who are subject of an active professional conduct matter should not be exempted from selection automatically; they can ask for a deferral, which will be assessed on a case-by-case basis based on the QA Program's deferral policy. 3. Members who indicate they plan to retire should not automatically receive a deferral, instead, those requests will be considered on a case-by-case basis. 4. The current policy on deferrals and exemptions can stay largely the same, with two minor changes: educational programs should be specifically defined as full-time programs; and the member being the subject of an active PC matter should be added as a criterion in the policy. 5. The QA program should continue to accept volunteers; however, there should be criteria defined for who can volunteer: only if the member has never been assessed before and meets the inclusion criteria for selection.

Project Update:

Below is an update on the status of the QA program review project since the last Council meeting.

Change in Working Group composition

- Working Group member James Lee's public member appointment expired on December 31, 2018, and therefore is no longer able to serve in this role.
- Staff sought direction from the Executive Committee in January 2019 regarding this vacancy, and the Committee appointed Jane Darville to the Working Group.
- The updated QA Working Group Terms of Reference document reflecting this change is attached in Appendix 1.

Draft assessment tools

- In February 2019, the draft remote and on-site assessment tools were pre-tested with a small group of PT volunteers.
- The purpose of the pre-test was to confirm the reliability of the questions, test inter-rater reliability, and identify required changes to the language in the questions to improve clarity.
- The WG reviewed the results of the pre-test and provided direction regarding changes to the tools.
- The WG also provided additional feedback on the draft pre-assessment questionnaire.
- Staff are in the process of developing the required checklists to assist assessors with the document review component; the WG is reviewing the checklists over two meetings.
- Detailed information about the draft tools is included in the section below.

Database functionality and Mobile Assessment Tool

- Initial development of database functionality and a technology tool to facilitate the assessments has been completed.
- The Mobile Assessment Tool platform is in place, and additional changes to the content will be made based on the most recent revisions to the assessment tools prior to program launch.
- Staff completed two rounds of testing of new database functionality and identified defects and other required changes to those tools. The vendor has implemented the required fixes and changes. Staff are in the process of conducting a final round of testing prior to program launch.

Upcoming work

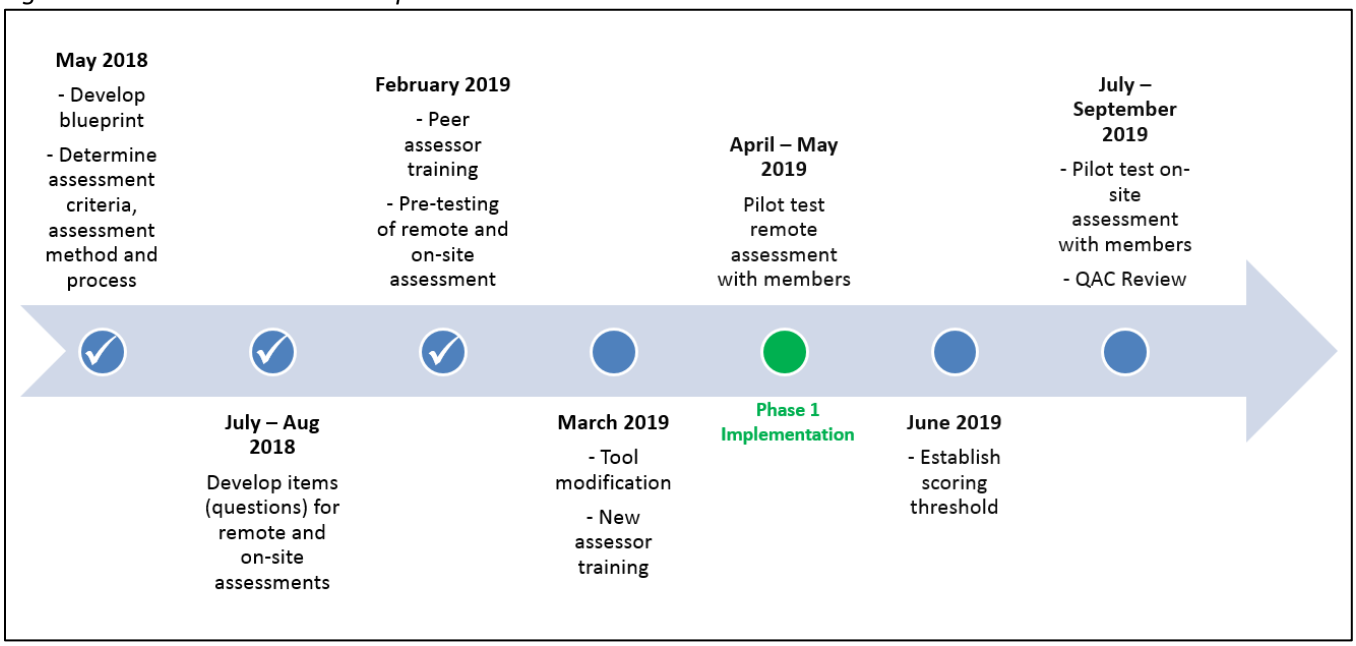
- Staff are working the development of tools and resources to help members and assessors prepare for remote assessments and on-site assessment. Member resources will be published on the College website.
- The second assessor training session will occur at the end of March, 47 assessors will be attending this session.
- The assessment consultant will assist with identifying a sample of eligible members to participate in the pilot test.
- Staff will complete the development of the written policy checklists for WG review at their next meeting.
- Staff will continue to update QA Program Policies as decisions are made about the new program in the coming months.

An updated project plan and timeline with current statuses is included in Appendix 2.

Assessment Tool Development:

The consultant who is supporting the College in the development and revision of the assessment tools is using an approach for the development of the assessment tools that is iterative and includes multiple stages of testing and validation of the tools (see Figure 1 below).

Figure 1: Assessment Tool Development Process and Timeline



The Working Group has had multiple opportunities to provide input and direction on a draft assessment blueprint, draft behaviour-based interview questions, and a draft pre-assessment questionnaire.

On February 2nd and 3rd, 2019, a group of 19 Assessors were trained and engaged in a pre-test of the remote and on-site behaviour-based interview (BBI) tools with 8 volunteer members. The pre-testing was conducted by assigning two or three Assessors to each volunteer member, with one assessor designated as the lead assessor, and the others assigned the tasks of recording data, scoring and tracking required changes. All Assessors had an opportunity to pose questions if unable to score. The Assessors used the Mobile Assessment Tool to record and upload the assessment data in a centralized database. The purpose of the pre-testing was multi-faceted:

a) To conduct an inter-rater reliability study
b) To evaluate the construct of interview questions; and
c) To obtain feedback on the BBI process.

At the February 2019 meeting, the WG received a report about the results of the assessment tools pre-test activity in early February, and provided direction regarding additional changes to the remote and on-site assessment tools based on those results.

The pre-test data showed that the most of the behaviour-based interview questions had high inter-rater agreement. Overall, the Assessors and members spoke very positively about the new process and welcomed the use of the behaviour-based interview methodology. The group agreed that the new assessment tools are objective and support efficiency. The Assessors recognized that the new tool would provide a consistent and valid assessment approach. The members stated the process was educational in nature and allowed them to self-reflect on their own practice during the assessment.

Two main issues were identified during the pre-testing of the draft behaviour-based interview (BBI) tools for the remote and on-site assessments that required further consideration:

1. The remote interview took 1.5 hours to complete during the pre-testing. The goal is to keep the remote interview within a one (1) hour limit.
2. Four questions presented a challenge during the pre-testing for both the assessors and the interviewees (members):
    - Remote BBI Question #5: Managing ethical dilemmas
    - Remote BBI Question #7: Collaboration or referral
    - On-site BBI Question #10: Addressing discrepancies between employer expectations and professional standards
    - On-site BBI Question #13: Confidentiality and privacy

Regarding the timing issue, the WG considered all of the questions that were developed for the draft remote assessment behaviour-based interview tool, and did not believe that any question should be taken out from the remote assessment. Instead, the WG suggested the following changes that would reduce the length of time required for the remote assessment:

- Change the question about collaboration and referral to be about professional support (seeking external feedback from the member's network of colleagues and peers)
- Incorporate the performance indicators related to collaboration and referral into the question about patient assessment
- Incorporate performance indicators related to patient safety into the question about performing rostered activities, and making those two questions interchangeable (meaning the member would only get one of the two questions, but not both)

With these changes, it is still possible that some members could take slightly more than one hour to go through all of the questions, but no more than 1 hour 15 minutes. The WG recommended that for the purpose of the pilot test, to use the updated set of questions, and re-visit the questions after the pilot test so that their decision about potential changes to the tool can be informed by the results data. The WG directed staff to communicate to members who are participating in the pilot test to ensure that they are aware that the remote assessment could take more than one hour.

Regarding the four questions that presented a challenge to participants in the pre-test, the WG recommended some changes to the way that the questions are posed and suggested adding specific

scoring cues. The assessment consultant will incorporate these recommended changes prior to the March assessor training so that they can be tested with that group of assessors and observe how the revised questions perform.

An updated draft assessment blueprint that reflects the most recent direction from the WG is included in Appendix 3. A copy of the draft pre-assessment questionnaire and behaviour-based interview tools will be provided during the meeting.

Items Considered at the Working Group:

Part of the QAWG's responsibilities is to identify items that are discussed at the QAWG that should be brought forward to Council for direction or decision-making. The QAWG identified a number of items for which they are seeking decisions from Council. Other items considered by the QAWG for which they provided direction are also brought forward to Council for their information. The for-information items are included below. The for-decision items are included in the next two briefings.

Draft Checklists for Document Review Component of the Assessment

In the new QA practice assessment process, assessors will be asked to review a number of documents that members will submit. In order to provide guidance and structure for this review, a number of checklists need to be developed based on the relevant criteria in College Standards.

In total, six checklists need to be developed for this purpose:

1. Record keeping review (for both remote and on-site assessments)
2. Written process for routine review of fees, billing and accounts
3. Written communication protocol when working with PTAs
4. Written instructions for how to manage adverse events when performing rostered activities
5. Written protocol for infection prevention and control
6. Written process for routine review of equipment maintenance and safety

In January 2019, the Working Group provided direction to staff that the checklists to be developed should capture the minimum requirements for these written policies and carefully balance the need to provide enough useful detail while being general enough to be applicable in a variety of practice situations. The WG also suggested that once content for the checklists are developed, where they are more detailed than the requirements articulated in the Standards and existing resources, then the information should also be provided to members as a resource so that they are clear about the expectations.

Staff are developing the checklists in two groups based on the amount of research and subject-matter expert input that is required. The first group of checklists can be developed with minimal research and subject-matter expert input because the Standards include detailed requirements and/or the College has already developed detailed guidance. They include the checklists for:

1. Record keeping review
2. Written process for routine review of fees, billing and accounts
3. Written communication protocol when working with PTAs

Staff undertook the following steps to develop this set of draft checklists:

- Compiled requirements in College Standards and resources
- Asked the College's Practice Advisors to review and provide input on the criteria
- Asked the assessment consultant to review the draft content to ensure usability as an assessment tool.

At their February 2019 meeting, the WG considered and provided feedback on these three draft checklists. A copy of these checklists with the WG's suggested changes will be provided during the meeting.

Staff are in the process of developing the remaining three checklists, and it is expected that the WG will consider and provide feedback on those in April. With the exception of the record keeping checklist, the first time the assessors will be using these checklists is expected to be in July for the pilot test on-site assessments.

More detailed background about this item is included in Appendix 4.

Providing Information to Members about the Assessment

In the previous QA program, the College made available the full assessment questionnaire to members as a resource to help them prepare for their assessments. The previous assessment questionnaire included open-ended core questions and some follow-up questions, but did not list specific performance indicators or scoring cues.

During earlier discussions at the WG and at Council, two questions were raised related to sharing information with members about the new assessments which required further consideration:

- How much information should we provide to members to allow them to properly prepare for the assessment?
- How can we ensure members would not be able to prepare artificial responses designed to "pass" the assessment?

The assessment consultant put forward recommendations regarding both of these issues.

To help members prepare for their assessments, which are based on behaviour-based interview questions, it is recommended that the College should provide:

1. A sample behaviour-based interview question, including the core question and probing questions, and a typical response (SAR/PAR – situation/problem, actions and results)
2. A descriptor of how the assessment tool aligns with the essential competencies and standards of practice.

3. A list of relevant Practice Standards and a link to the Essential Competencies Profile.
4. A list of categories that are asked during the assessment. These categories represent each question topic (e.g. managing confidential information, performing a rostered activity, working with PTAs).

Providing information with this level of detail will allow members to:

- Get a sense of the type of questions that will be asked;
- Obtain direction on providing an acceptable response;
- Gain an understanding of the competencies that are being assessed;
- Help them anticipate what topics will be asked; and
- Encourage members to identify a recent event for each of the topics.

The assessment consultant also indicated that it is unlikely that members would be able to come prepared with artificial responses because:

- Members are not likely to recall questions on the assessment in enough detail to help others craft artificial answers to all probing questions
- Questions assess member's actions in real-life situations, which are difficult to respond to with the required depth and breadth using a made-up scenario

The Working Group is in general agreement with the proposed approach, and identified other resources that the College could provide to members (e.g. a video of a sample behaviour-based interview question).

More detailed information about this item is included in Appendix 5.

Decision Sought:

None, this item is for information.

Attachments:

- Appendix 1: Updated QA Working Group Terms of Reference
- Appendix 2: Quality Assurance Program Review Project Plan and Timeline
- Appendix 3: Draft Assessment Blueprint (as of March 2019)
- Appendix 4: Detailed Background on Draft Checklists for Document Review Component of the Assessment
- Appendix 5: Detailed Background on Making information about the assessment available to members

Appendix 1:

Quality Assurance Working Group

Terms of Reference

Date: Approved by Council on March 20, 2018; Updated in January 2019

Role

The role of the Quality Assurance Working Group (the Working Group) is to provide policy direction regarding the review and development of the Quality Assurance Program.

Accountability

Council

Responsibilities

1. To identify questions and concerns for staff to consider and research.
2. Upon considering the research, to make recommendations about elements of the program (for example, the selection process, who will be selected, how many will be selected).
3. To identify items that should be brought forward to Council for decision-making.
4. To consider policy issues related to program operation as brought forward by staff and to provide advice and feedback (for example, program evaluation plan).
5. To select the appropriate external consultant for tools development based on project requirements and the proposals.

Staff Responsibilities

1. To bring forward outstanding policy questions to the Working Group for consideration and direction.
2. To bring items identified by the Working Group to Council for decision-making.
3. To schedule meetings as required.
4. To provide materials to the Working Group in advance of meetings.
5. To manage the agenda and discussion at meetings.

Term

The program review and development work is expected to take place from January 2018 to March 2019. The Working Group will continue until the expected completion of the program review and development work in March 2019, or as otherwise directed by Council.

Frequency of Meetings

Working Group meetings will be scheduled as required based on the progress of the work. It is expected that the activity of the Working Group will be more intense in the first half of its term.

Composition

- Jill Adolphe – Patient/Public
- Jatinder Bains - QAC
- Jane Darville - Councillor
- Darryn Mandel - Councillor
- Shelley Martin – QA Manager
- Kathleen Norman – Academic Councillor
- Gary Rehan - Councillor
- Theresa Stevens - QAC

Appendix 2 – Updated Project Timeline for the Quality Assurance Program Review

Timeline	New Tool Development Activity	Program Review Activity
March 2018 (after Council Meeting)	*Completed* - WG meeting to review the proposals from prospective assessment consultants and select the successful candidate; and to consider outstanding questions regarding program and tool design.	
April 2018	*Completed* - Hire the consultant, who will assist with the development of assessment tools.	*Completed* - Provide a report with data and research relevant to the current on-site assessment tool to the consultant, which will provide an evidence base on which they can make recommendations about revisions to the on-site assessment tool.
April 2018	*Completed* - WG meeting to resolve outstanding questions regarding tool design (if necessary).	
April – May 2018	*Completed* - Hold meetings with a group of subject matter experts (SMEs) to develop the blueprint for the remote assessment tool. Seek input from SME group on on-site assessment tool as required.	*Completed* - Review the existing pool of assessors to map their skills and to evaluate their past performance. Compare with desired competencies for assessors in the new program to identify suitable assessors.
June 2018	*Completed* - WG meeting to provide direction on outstanding policy questions, which may include: • the selection process for assessments • size and composition of assessor pool • appropriate remuneration for assessors • any questions or issues raised by the consultant	*Completed* - Contact current assessors who have the desired competencies to confirm their ongoing interest and ability to be assessors in the new program.
June – July 2018		*Completed* - Prepare for recruitment of new assessors: • Determine compensation model • Update recruiting tool based on the required key competencies and work experience
June – September 2018	*Completed* - Work with consultant to develop the remote and on-site assessment tools based on the blueprint and content developed by SME group.	*In Progress* - Revise internal program policies and procedures, and communications materials, to correspond to changes to the program. Revise QAC policies and procedures.
September – November 2018	*Completed* - Development of questions for the remote assessment tool question bank (if required).	
August – October 2018	*Completed* - Development of database functionalities for the Quality Assurance Program.	

Timeline	New Tool Development Activity	Program Review Activity
September 2018	*Completed* - Seek direction from WG on any outstanding policy considerations (if necessary).	
September – November 2018	*Completed* - Programming of online versions of the remote and on-site assessment tools.	
September – December 2018		*Completed* - Recruit and hire assessors.
October – December 2018	*Completed* - Plan post-implementation program evaluation with assistance from the consultant.	*In Progress* - Develop training and evaluation plans for assessors.
December 2018	*Completed* - Seek direction from WG on any outstanding policy considerations (if necessary).	
December 2018 – January 2019		*In Progress* - Create a decision-making aid for QAC based on the revised on-site assessment tool/process. *(To be finalized with QAC feedback at Sept 2019 meeting)*
January – February 2019	*In Progress* - Select a small group of PTs who will participate in the pilot test assessments (i.e. Phase 1 Implementation). Prepare/update related communication materials (e.g. notification letter, member resources).	
February 2019	*Completed* -1 of 2 assessor training sessions on using the new assessment tools. Pre-test the assessment tools with seven to eight volunteer PTs.	
March 2019	2 of 2 assessor training sessions on using the new assessment tools.	
April 2019	***Phase 1 Implementation***	
April 2019	Notify members who have been selected for the pilot test assessments (i.e. Phase 1 Implementation).	
April – May 2019	Conduct pilot test of the remote assessment. Conduct scoring calibration sessions with assessors. Collect feedback from members and assessors about the tool.	
June 2019	Conduct cut score study to establish threshold for those require further assessment. QAWG approves scoring threshold. Notify members who are required to do an on-site assessment. Make necessary changes to tool and processes based on feedback.	
July – August 2019		Conduct pilot test of the on-site assessment. Conduct scoring calibration sessions with assessors. Collect feedback from members and assessors about the tool. Make necessary changes to tool and processes based on feedback.
August 2019	Evaluate performance of assessors based on the pilot test assessments, provide feedback, and identify additional training needs.	

Timeline	New Tool Development Activity	Program Review Activity
September 2019	Hold QAC meeting to review the assessment reports and make individual member case decisions, evaluate the usefulness of the information in the reports and the decision-making aid, and identify necessary improvements.	
September 2019	***Completion of program review and development.***	

Appendix 3 – Draft Assessment Blueprint (as of March 2019)

This is a working draft. The assessment blueprint will be continually refined and updated as the tool development proceeds.

Remote Assessment

All members selected for a Practice Assessment will engage in step 1 which includes the following three components:

1. Pre-assessment questionnaire
2. Chart review
3. Behaviour-based Interview

Pre-assessment questionnaire

All members engaged in the Practice Assessment process will complete an online pre-assessment questionnaire. The primary purpose of the pre-assessment questionnaire is to obtain information about a member's practice to provide the assessors and the QA Committee with context of practice. The pre-assessment questionnaire also informs the matching of the member's practice with an appropriate assessor's professional experience. Portions of the pre-assessment questionnaire will be pre-populated with member specific data generated from the College's database (Atlas).

It has been identified that "jurisprudence-like" questions will provide formative information to determine if further assessment or remediation is required. Question topics include:

- Confirmation that required written policies are in place:
    1) Written policy for routinely reviewing fees, billing and accounts
    2) Written instructions on how to manage adverse events when performing a controlled act
    3) Written communication plan when working with PTAs
    4) Written protocols for infection prevention and control
    5) Written process for routinely reviewing he maintenance and safety of equipment
- Knowledge of the role and responsibilities of the Health Information Custodian (HICs)
- Patient record retention period
- Fee schedule and how patients are informed of the fee for service (if applicable)
- Infection control practices

Behaviour-based Interview

The behaviour-based interview is conducted by telephone or video teleconference, as chosen by the member. The interview will be approximately 1-hour in length and will include the following topics:

Core (relevant to all members)

1. Informed consent process
2. Patient assessment (including collaboration and referral)
3. Professional boundaries
4. Managing ethical dilemmas

5. Adapting communications
6. Professional support (seeking external feedback from member's network of colleagues and peers)

Practice-specific (based on pre-assessment questionnaire responses)

7. Patient safety (if the member does not perform rostered activities); *or* Performing rostered activities (including patient safety)
8. Working with PTAs

On-site Assessment

A scoring threshold will be established for the remote assessment, members whose score is below the threshold will be required to engage in an On-site Assessment. The On-site Assessment will be conducted in-person, at the member's place of employment. The assessment will not exceed 4-hours in length. The On-site Assessment includes four components:

1. Patient Record Review
2. Case-base questions
3. Situation-based questions
4. Feedback and discussion

Patient Record Review

A Patient Record Review is a review of the member's documentation habits for select patient records against a checklist that is aligned to the Record Keeping Standard. The member makes available during the on-site assessment 10 patient records of their choosing. The assessor selects 5 out of the 10 patient records for the review. The assessor and member collaboratively complete the checklist for three patient records. If, however, inconsistent scoring is noted amongst the three records, the assessor selects another record until a pattern of charting behaviour is identified or a total of five records are audited. The Patient Record Audit will take approximately an hour to complete.

Case-specific questions

The assessor selects one of the patient records reviewed during the Patient Record Audit and focuses the behaviour-based interview questions specific to that patient. The assessor may select additional records, from the group of 5 reviewed records to frame the member's actions in performing rostered activities.

The topics for discussion include:

1. Accepting the patient (assess personal knowledge and appropriateness for physiotherapy)
2. Informed consent
3. Assessment, clinical impression and referral to others
4. Treatment plan, assigning to PTAs
5. Develop goals, patient collaboration
6. Monitor, reassess and modify plan, self-management
7. Discharge planning or transitioning care

8. Performing rostered activities and maintaining competence (for all of the member's rostered activities)

Situation-based questions

The third component of the assessment includes a discussion with the member about recent past situations when they demonstrated the required actions associated with the following topics:

9. Patient safety
10. Addressing discrepancies between employer expectations and professional standards
11. Continuing professional development
12. Conflict resolution
13. Confidentiality and privacy
14. Infection control and prevention

Feedback and discussion

Following the final behaviour-based interview question, the assessor will "close" the assessment portion of on-site visit. The assessor will then, direct the member to specific College resources based on the assessor's preliminary scoring; and answer practice-related questions.

Appendix 4 – Detailed Background about Draft Checklists for Document Review Component of the Assessment

Issue:

As part of the new practice assessment process, there is a need to develop several checklists to assist assessors with the review of documents that members will submit. Staff are developing these checklists in two groups. Three of the checklists are being brought forward to the Working Group for review at this meeting. The remaining checklists will be brought forward to the Working Group at a future meeting.

Background:

The new practice assessment process involves the review of various documents about the member's practice by an assessor. In both the remote and on-site assessments, the assessor will be reviewing the member's charting. Members who are asked to participate in an on-site assessment will also be required to submit copies of applicable written policies and processes for review, including:

- Written process for routinely reviewing fees, billings and accounts
- Written communication protocol when working with PTAs
- Written instructions on how to manage adverse events when performing a rostered activity
- Written protocols for infection prevention and control
- Written process for routinely reviewing the maintenance and safety of equipment

In order to provide guidance and structure to assessors for this document review, there is a need to develop checklists with criteria based on College Standards.

The College already has a Record Keeping Checklist based on the Record Keeping Standard that could be adapted to use as an assessment checklist. The checklists for the review of written policies have to be developed. In January 2019, the Working Group provided direction to staff that the checklists being developed should capture the minimum requirements for these written policies and carefully balance the need to provide enough useful detail while being general enough to be applicable in a variety of practice situations.

Staff are developing the checklists in two groups, based on the work that is required:

- **Group 1:** Checklists that can be developed with minimal research and subject-matter expert input because the Standards include detailed requirements and/or the College has already developed detailed guidance. This group includes the checklists for record keeping; written communication protocol when working with PTAs; and written process for routine review of fees, billing and accounts. These three draft checklists are being brought forward for the Working Group's review and feedback at this meeting.

- **Group 2:** Checklists that require additional research and input from subject-matter experts because the Standards do not include specific requirements and the College has not provided detailed guidance. This group includes the checklists for written instructions on how to manage

adverse events when performing a rostered activity; written protocols for infection prevention and control; and written process for routinely reviewing the maintenance and safety of equipment. These checklists will be brought to the Working Group for review and feedback at a future meeting.

Record Keeping Checklist

The College has an existing Record Keeping Checklist which mirrors the expectations in the Record Keeping Standard. The assessment consultant, Ms. Leanne Worsfold, assisted with the adaptation of the existing checklist into a checklist that can be used by assessors for the chart review.

Checklist for Written Communication Protocol when Working with Physiotherapist Assistants

When developing this checklist, staff first considered the criteria for the written communication protocol described in the Working with Physiotherapist Assistants Standard. The Standard requires that:

> *The physiotherapist must have a written communication protocol that states:*
>
> - *how and when they will discuss patient care with the PTA*
> - *how to contact the physiotherapist*
> - *how to contact the alternate supervisor if the physiotherapist cannot be reached*

To complement the Standard and to assist members in meeting this expectation, the College also provides several sample communication protocols on the College website. These sample protocols were also considered during the development of the checklist.

Staff also obtained feedback from the Practice Advisors on what should be included in the checklist, keeping in mind that the checklist would be used by assessors when determining if a member has met the minimum expectations of the Standard.

After a draft checklist was developed by staff, it was reviewed by Ms. Worsfold to ensure the content is appropriate as an assessment tool for the assessors to use for the review.

Checklist for Written Process for Routine Review of Fees, Billings and Accounts

Similar to the approach for the communication protocol checklist, staff first reviewed the relevant expectations in the Fees, Billings and Accounts Standard to develop the checklist for the written process for routinely reviewing fees, billings and accounts. The Standard states that:

> *Physiotherapists must have a written process for routinely reviewing their fees, billings or accounts. This review process must ensure that:*
>
> - *Any fees charged are accurate and reasonable*

- *Billings or accounts are accurate*

Physiotherapists must be able to demonstrate that they did the review.

If the physiotherapist discovers inaccuracies or errors, they must:

- *take reasonable steps to correct the inaccuracies or errors, and*
- *document the finding, what action was taken, and the outcome.*

The College also provides guidance to members on creating a written process for reviewing billings on the College website. This information was developed internally and is also complemented by a sample billing review process document.

The Practice Advisors also provided feedback on the criteria in the checklist, and Ms. Worsfold reviewed the content to ensure it is appropriate to use as an assessment tool.

Appendix 5 – Detailed Background on Making Information about the Assessment Available to Members

Issue:

The assessment consultant has put forward recommendations regarding how to make information available to members to allow them to prepare for the assessments while not compromising the integrity of the assessment.

Background:

In the previous Quality Assurance Program, the College posts the full peer assessment form on the College's website. The previous peer assessment form includes the core questions and probing questions but does not include the assessment criteria or scoring cues. Therefore, all members have access to all assessment questions prior to engaging in the peer assessment.

The revised remote and on-site assessment tools include four levels of content: the core questions, the probing questions, the performance indicators and the scoring cues. All content is closely aligned with the essential competencies and standards of practice.

If the College shares the assessment tools in full in advance of the assessment, there is a risk that members may craft artificial responses to the listed questions in order to "pass" the assessment, instead of considering real situations that elicit the level of details needed to demonstrate competence during the assessment. So, disclosing the tools in full will compromise the integrity to the assessment.

The College's assessment consultant has worked with a number of other regulators to implement a behaviour-based assessment similar to the one this College is about to implement.[1] In their experience, the other regulators do not share the assessment tools with their members or publicly on the College's website. Instead, they provide a guide which describes the behaviour-based interview process and presents a list of topics for discussion during the interview.

To support the members in preparing for the assessment while maintaining the integrity of the assessment, the assessment consultant recommends that the following details are provided to members prior to the assessment:

1. A sample behaviour-based interview question, including the core question and probing questions, and a typical response (SAR/PAR – situation/problem, actions and results).
2. A descriptor of how the assessment tool aligns with the essential competencies and standards of practice.
3. A list of relevant Practice Standards and a link to the *Essential Competencies Profile*.

[1] Including the College of Occupational Therapists of Ontario, College of Kinesiologists of Ontario, College of Opticians of Ontario, College of Psychotherapists of Ontario, College of Nurses of Ontario, College of Registered Nurses of Manitoba and the College of Dieticians of Ontario.

4. A list of categories that are asked during the assessment. These categories represent each question topic (e.g. managing confidential information, performing a rostered activity, working with PTAs).

This level of detail will allow the member to:

- get a sense of the likely questions that will be asked;
- obtain direction on providing an acceptable response;
- gain an understanding of the competencies that are being assessed;
- help them anticipate what questions will be asked; and
- encourage members to identify a recent event for each of the topics.

This detail allows members to consider topics for discussion, encourage members to review relevant standards and competencies and supports personal learning prior to the assessment, while maintaining the integrity of the assessment and reliability of the scoring inference.

During the Council discussions in October 2018, a question was also raised about whether, over time, as members share with each other what they were asked during their assessments, there is a risk that members might be able to come up with artificial responses ahead of time. In theory this could happen even if the College does not publish the probing questions and scoring cues.

Research related to multiple choice questions has shown that people do not accurately recall the details of the test questions after they sit for the test. As for the behaviour-based interview assessment format, people are asked to recall a real-life personal experience at an in-depth level, or describe a hypothetical situation which assesses the member's critical thinking and decision-making skills in that situation. If someone is asked to describe a real-situation they experienced and provide a made-up situation, they would likely struggle with this level of detail. When a member is asked to provide a hypothetical situation, the question is structured in such a way that the member is asked to critically think through the situation at that time.

So, the impact of members sharing with each other the assessment questions is two-fold:

1) It is highly unlikely that members who have participated in an assessment will recall the required details at the depth and breadth required to answer the probing questions. Further to this, it is recommended that the College share the topics for discussion with the member in advance of the assessment. So, people would be sharing details that are already provided by the College.

2) The members are assessed on their actions in a real-life situation, or for some questions a hypothetical situation. So, it is highly unlikely the member will discuss someone else's scenario, or be able to provide the depth and breadth of the response to score a correct answer using a made-up scenario. During the on-site assessment, the main discussion is grounded in one of the member's cases. So, both the assessor and the member can use the case to support the recall and accuracy of the response.

COLLEGE OF PHYSIOTHERAPISTS of ONTARIO | ORDRE DES PHYSIOTHÉRAPEUTES de l'ONTARIO

Motion No.: 8.2

Council Meeting
March 21-22, 2019

Agenda #8.2: Quality Assurance Program Review – Program Policies

It is moved by

_____,

and seconded by

_____,

that:

Council approve the following draft QA program policies:

1. Eligibility and Selection Criteria for Practice Assessments,
2. Pre-Assessment Questionnaire,
3. Remote Assessment,
4. On-Site Assessment, and
5. Deferral and Extension.

Meeting Date:	March 21-22, 2019
Agenda Item #:	8.2
Issue:	Quality Assurance Program Review – Program Policies
Submitted by:	Joyce Huang, Strategic Projects Manager

Issue

Staff have completed a comprehensive review of policies related to the Quality Assurance Program in order to identify necessary changes to align with the revised program. Council is asked to approve five draft policies at this meeting.

Background

In previous years, Committees had a role in creating policies that related to the program area for which the Committee was responsible. The program policies in place today were reviewed and approved by a Committee in the past.

Several years ago, Council reviewed and revised the terms of reference for College Committees including a change where Committees will not have an active role in policy development. The review of the Quality Assurance Program is the first time that program policies are being reviewed and updated after this change, and are coming forward to Council for consideration and approval.

It should be noted that in December 2018, Council directed staff to undertake a comprehensive review of the College's by-laws and governance policies. In the initial stages of planning for this work, staff identified an opportunity to also review the College's program policies for currency and consistency. Therefore it is expected that Council will have an opportunity to review all program policies, including the revised Quality Assurance Program policies, as part of that comprehensive review.

In the meantime, as part of the QA program review, staff completed a comprehensive review of policies related to the Quality Assurance Program in order to identify necessary changes to align with the revised program. At the December 2018 meeting, Council considered and provided direction on five issues related to this policy review. Those issues are captured in the five draft policies that Council is asked to approve at this meeting.

In addition, staff have proposed other necessary changes and actions to update the program policies, including:

1. Quality Assurance Program Policies to be Rescinded
2. Quality Assurance Program Policies that require minimal change
3. Quality Assurance policies for future review

Policy Review Process

Over the course of the previous six meetings, the Quality Assurance Working Group (the WG) has made decisions about the new Quality Assurance Program. These decisions will be captured in the Quality Assurance Program policies. Existing policies of the 'old' QA program also need consideration.

The purpose of the policy review was to:

- Identify new policies to be considered by the WG based on the design of the new program and the WG's earlier decisions;
- Seek the WG's approval on new program policies that are not operational;
- Identify current policies that require the WG's input before making revisions;
- Find policies that are no longer required; and
- Give the WG a summary of new or existing operational policies that do not require their decision but are relevant to the operation of the Quality Assurance Program.

The following resources were consulted as part of this comprehensive review process:

- Existing and applicable legislation, regulations, by-laws, governance policies, QA Program policies
- Earlier Quality Assurance Committee decisions and relevant Council minutes
- QA Working Group minutes and meeting materials
- Previously obtained legal advice
- Operational policies related to the program and assessors
- Relevant College staff (policy team, Human Resources and Records Management Specialist & Privacy Officer, communications team, previous QA team members and the project team);
- Other regulators;
- iComp Consulting; and
- Relevant literature

A list of the policies reviewed by staff are included in **Appendix 1**.

On November 30, 2018, the Quality Assurance Working Group met and discussed several items related to Quality Assurance Program policies. Subsequently, Council had further discussion about these items at their December 2018 Council Meeting.

The following decisions were made by Council in December 2018 based on the Working Group's recommendations:

- Approve the revised remote and on-site assessment timelines as proposed by staff.
- Members who are the subject of an active professional conduct matter will not be automatically exempted from practice assessments but can ask for a deferral.
- Members who express their intent to retire will not automatically receive a deferral.
- Re-affirm the current policy regarding deferral and extension requests, with two minor changes to the criteria regarding members who are in a full-time educational program and who are the subject of an active Professional Conduct matter.

- The program should continue to allow volunteers if they meet the eligibility criteria for selection and have never been assessed before.

The sections below include proposed changes to existing policies that have been reviewed by the Working Group, as well as new draft policies that have been drafted and reviewed by the Working Group for which staff is seeking Council approval.

SECTION 1 – POLICIES TO BE RESCINDED

During the comprehensive review of Quality Assurance Program policies, four policies were identified to be rescinded. The table in **Appendix 2** provides the name of the policy, the reasons why the policy is no longer required and a copy of each original policy.

The policies in the table will be removed for the following reasons:

- The policies are now covered in other program policies
- The policies are not currently relevant to the new Quality Assurance Program
- The documents are covered in the College's operational or human resource policies
- Features and functions built into the new database

Working Group Feedback:

The WG was generally in agreement with the list of policies to be rescinded. Some WG members noted that there may be an opportunity to do a more comprehensive review of the policies to identify additional changes to simplify and streamline the policies. It was noted that this type of review might be done as part of the broader by-law and governance review that the College is about to undertake.

Attachments:
Appendix 2 – A summary table of policies to be rescinded followed by each policy.

SECTION 2 – POLICIES THAT DO NOT REQUIRE SUBSTANTIVE CHANGE

When College staff reviewed quality assurance related policies, some were identified as not requiring substantive change. **Appendix 3** includes a list of the documents included in this category, along with a description of the resource and additional comments about minor changes that are required to ensure currency.
In the case of the legislation, regulations, and by-laws, the revisions to the Quality Assurance Program were proposed and developed based on the current legislative framework. Therefore no changes are suggested or necessary.

Governance Policy 3.6, Terms of Reference for the Quality Management Committee, requires a simple language change to remove references to "Quality Management Committee" and "Quality Management Program" and replace with "Quality Assurance Committee" and "Quality Assurance Program." The change in language aligns with the change in terminology that the College has used for the last few

years. Additionally, the use of the terms 'quality assurance' aligns with the terminology in the *Regulated Health Professions Act* and the *Health Professions Procedural Code*. Changes to the Governance Policies will be brought to Council for approval.

In the case of the Quality Assurance Program policies, the policy statements remain relevant to the program because the policies are based on legislation, by-laws and previously obtained legal advice. In some cases, procedures were added to the policy to ensure College staff knows how to implement and follow the policy in their day to day work.

Appendix 4 includes a copy of the original policy along with a draft version of the revised policy. Please note, that the revised draft policies will be reviewed by College staff to ensure appropriate legislative and policy references, policy numbers, titles, and language.

Working Group Feedback:

The WG was generally in agreement with the list of policies that do not require substantive changes. The WG suggested that with regards to the policy about having an observer present during an assessment, that it would also be beneficial to prohibit members from recording the assessment to protect the integrity of the assessment questions. The Working Group decided not to address this issue within the policy about having an observer present, and directed staff to implement this by adding a declaration statement in the assessment process and including it in the assessor's opening script.

Attachments:

- Appendix 3 – table of policies that do not require substantive change
- Appendix 4 – original and revised versions of the policies listed in Appendix 3

SECTION 3 – POLICIES FOR FUTURE REVIEW

While completing the review of the existing policies, College staff identified several policies that need to be developed or revised and updated to reflect the new quality assurance program. A table in **Appendix 5** provides the WG with information about documents that will need to return in the future for review and decision.

A brief description of the policy and the required updates have been provided along with the estimated timeframe that the policy will return to the WG for review or decision.

Attachment:

- Appendix 5 – Policies & timelines for future review

SECTION 4 – DRAFT POLICIES FOR COUNCIL APPROVAL

Several new QA Program policies have been drafted and were brought forward to the Working Group for review. Staff are now seeking Council approval of these draft policies.

The policies in the table below capture decisions previously made by the Working Group and Council. The draft policies are included in the following pages.

Policy Name	Description	New or Revised
Eligibility and Selection Criteria for Practice Assessments	A document that identifies who is eligible for a practice assessment and how members are selected.	New
Pre-Assessment Questionnaire	A description of the pre-assessment questionnaire, including the reason it is used.	New
Remote Assessment	High level description of the remote assessment and the associated processes including a list of circumstances that would cause the PT to enter the process	New
On-Site Assessment	Description of the on-site assessment and the associated processes including a list of circumstances that would cause the PT to enter the process	New
Deferral and Extension	Description of circumstances that would allow Members to delay or put their practice assessment process 'on hold' or to request additional time to complete the process	Revised

Working Group Feedback:

The Working Group reviewed five draft policies and recommended minor changes to four of the policies. Minor re-wording was suggested in three policies to add clarity. One bullet point was moved in the On-site Assessment Policy for improved understanding. Finally, the WG revised the policy statement in the Remote Assessment Policy to clearly indicate that the Quality Assurance Committee will review and recommend changes to the cut-score but Council is required to confirm any proposed changes.

Decision Sought:

That Council approve the following draft QA program policies:

1. Eligibility and Selection Criteria for Practice Assessments,
2. Pre-Assessment Questionnaire,
3. Remote Assessment,
4. On-Site Assessment, and
5. Deferral and Extension.

Section: Quality Assurance Program
Title: Eligibility and Selection Criteria for Practice Assessments

Applicable to: XX
Date approved: XX
Date Revised: XX

Legislative References/ By-law Reference

XX

Related Policies

TBD

Policy

The Regulated Health Professions Act requires Colleges to have a quality assurance program. Colleges are given the flexibility to determine who is eligible for practice assessments, how they are selected and the frequency of participation.

Members are eligible for selection if they:

- Have an active Independent Practice registration
- Registered in Independent Practice for more than two years, and
- Are currently providing patient care

Eligible members will be selected based on who has been in practice the longest without having been assessed, with those who have not participated in a practice assessment before being selected first.

Procedure

1. Each year, the Quality Assurance Team will be required to forecast the number of members who will be eligible for a practice assessment in the following year. This forecast will assist in decision making about the percentage of members to be selected for assessment each year.
2. The percentage of members to be selected for assessment each year will be determined by Council.
3. The percentage, based on a forecast, will define a set number of members for selection.
4. Once this number is determined, it will be divided over each month of the year resulting in monthly selections for assessment.
5. Each month, QA staff will monitor the number of deferrals and extensions that are issued to ensure that the target percentage of members are assessed each year. When deferrals or extensions are issued, this may result in changes in subsequent monthly selections.

Section: Quality Assurance Program
Title: Pre-Assessment Questionnaire Policy

Applicable to: XX
Date approved: XX
Date Revised: XX

Legislative References/ By-law Reference

N/A

Related Policies

• Remote Assessment

• On-site Assessment

• Program Evaluation (TBD)

Policy

The Pre-Assessment Questionnaire is the first step in the practice assessment process once a member has been selected for a practice assessment according to the Eligibility and Selection Criteria for Practice Assessments Policy. The purpose of this questionnaire is:

- To ensure the College's database has the most accurate information about the member's employment and contact information
- To identify the site where the member spends the most time delivering patient care
- To provide the assessor with a general understanding of the member's practice
- To evaluate the member's knowledge of rules and Standards in select areas prior to the remote assessment

Procedure

1. After being selected for a practice assessment, a member will have two weeks to complete a Pre-Assessment Questionnaire. This questionnaire will be available to the member when they log on to the College's member portal.
2. Once completed, the member submits the questionnaire and the responses to each question cannot be modified.
3. The questionnaire will be available to the matched assessor for review prior to the remote assessment and the on-site assessment, where applicable.

4. Results of the knowledge-based questions will be included in the final report for the remote assessment.

5. If a member is identified to participate in an on-site assessment, he or she will be required to review their employment information or site where they deliver the most patient care. This information is necessary to help staff match the member with an appropriate assessor and determine where the assessor will conduct the on-site assessment as per the On-site Assessment Policy 6. Questions in the Pre-Assessment Questionnaire will be reviewed and updated according to the Program Evaluation Policy.

Section: Quality Assurance
Title: Remote Assessment Policy

Applicable to: Quality Assurance Committee, Quality Assurance Staff, Assessors and Members
Date approved: XX
Date Revised: XX

Legislative References/ By-law Reference

Regulated Health Professions Act, Health Professions Procedure Code, Sections 79.1 to 83.1

Physiotherapy Act, General Regulation 532/98, Part I Quality Assurance, sections 1 to 5

Related Policies

- Deferral and Extension
- Conflict of Interest
- Program Evaluation (TBD) (include cut-score in this)
- Quality Assurance Committee Decisions (TBD)
- On-site Assessment

Policy

The remote assessment is one component of the practice assessment process. A remote assessment is a one-hour practice assessment that takes place over the telephone or via video conference. Remote assessments are carried out by an assessor appointed by the Quality Assurance Committee.

The purpose of the remote assessment is to collect information about members' practice to help the College identify members who may need more in-depth assessment (the on-site assessment).

The remote assessment has a cut score, which is recommended by the Quality Assurance Committee and approved by Council. The cut-score is determined according to the Program Evaluation Policy.

Members who fall below the cut score will be required to participate in the on-site assessment.

Procedure

1. Quality Assurance Staff members will run a selection tool on a monthly basis to identify participants for a practice assessment.
2. Members will be required to complete a remote assessment when one or more of the following circumstances apply:
    a. A monthly selection is performed, and the member is selected for a practice assessment;

b. The member was previously granted a deferral, and the deferral expired;

c. The member was referred by the Registrar; or

d. The member volunteers[1] for a practice assessment

3. Members are permitted to request a deferral or extension to the remote assessment, according to the Deferral and Extension Policy.
4. The remote assessment must be completed within nine weeks from the initiation of the practice assessment process.
5. Prior to conducting the remote assessment, the member must complete the pre-assessment questionnaire.
6. Once the questionnaire has been submitted, the member will be matched with an assessor.
7. The member and the assessor must confirm there is no conflict of interest.
8. Once both the member and assessor confirm that there is no conflict of interest, they will schedule the date for the remote assessment
9. The Member and the Assessor will determine the method to carry out the remote assessment (telephone or video conference), and the following expectations should be met:

    a. The Member and the Assessor should not have anyone else present during their remote interview.

    b. The Member and Assessor will schedule a full hour to be available for the interview.

10. The Member is required to submit one patient record for review by the assessor. The record must be submitted by the member no later than one week prior to the remote assessment. The assessor will use a checklist to score the Member's record keeping, and the result will be included in the final report of the Member's remote assessment.[2]
11. The Assessor will submit the completed assessment report within 2 days of completing the remote assessment.
12. The remote assessment report will be reviewed by the Manager of Quality Assurance within two weeks of receiving the assessor's report. The Manager will ensure the report is complete, identify any questions that require follow up with the assessor and identify items that require follow up with the Member.
13. Once reviewed, the Quality Assurance Manager will accept the submission of the Assessor's report and the Member will be able to access their assessment report.

[1] Members are permitted to volunteer for a practice assessment if they meet the selection criteria and they have not already completed a remote or an on-site assessment before.

[2] Council will re-evaluate the inclusion of the record keeping review following the pilot test.

14. Feedback about the remote assessments will be collected and reviewed to evaluate the program on an ongoing basis according to the Program Evaluation Policy.
15. Members who do not meet the defined cut-score will be required to complete an on-site assessment. The process for determining the cut-score is described in the Program Evaluation Policy.
16. Members that do not require an on-site assessment will have their quality assurance file closed according to the Quality Assurance Committee Decisions Policy[3]
17. The required timeline for the remote assessment process is defined in Appendix A.

[3] The Quality Assurance Committee Decisions Policy will not be developed until the Pilot and cut-score study is completed.

Appendix A –Timelines for Practice Assessment Process; Approved by Council in December 2018

REMOTE ASSESSMENT		
Component of QA Program	**Deadline** (Where initiation of the practice assessment process = Day 0)	**Duration**
Pre-assessment questionnaire	Day 0 + 2 weeks	2 weeks
COI declaration	Day 0 + 3 weeks	1 weeks
Scheduling of the remote assessment	Day 0 + 5 weeks	2 weeks
Upload 1 patient record	Date of remote assessment – 1 week	1 week
Remote assessment	Day 0 + 9 weeks	4 weeks
Complete survey to provide feedback	Date of remote assessment + 3 weeks	3 weeks
Assessor submits assessment report	Date of remote assessment + 2 days	2 days
Review the remote assessment report & release to member (QA Manager)	Date of remote assessment report submission + 2 weeks	2 weeks
Total time to complete remote assessment, submit report and QA Manager review		11 weeks, 2 days
ON-SITE ASSESSMENT		
Component of QA Program	**Deadline** (Where initiation of the on-site assessment process = Day 0)	**Duration**
Review and update information submitted in the pre-assessment questionnaire	Day 0 + 1 week	1 week
Matching of PT and assessor assessment	Day 0 + 3 weeks	2 weeks
COI declaration	Day 0 + 4 weeks	1 week
Scheduling of the assessment	Day 0 + 6 weeks	2 weeks
Upload written policies	Date of assessment – 1 week	1 week
On-site assessment	Day 0 + 10 weeks	4 weeks
Complete survey to provide feedback	Date of assessment + 3 weeks	3 weeks

Assessor submits assessment report	Date of the assessment + 1 week	1 week
Review the on-site assessment report & release to member (QA Manager)	Date of on-site assessment report submission + 2 weeks	2 weeks
Total time to complete on-site assessment, submit report and QA Manager review		13 weeks
QUALITY ASSURANCE COMMITTEE REVIEW		
QA Committee review required	1 – 3 months	4 – 12 weeks
Maximum total time – remote and on-site assessments + QAC review		**28-36 weeks**

Section: Quality Assurance Program
Title: On-site Assessment Policy
Applicable to: Members, Quality Assurance Staff, Quality Assurance Committee
Date approved: XXX
Date Revised: XXX

Legislative References/ By-law Reference
Regulated Health Professions Act, Health Professions Procedure Code, Sections 79.1 to 83.1
Physiotherapy Act, General Regulation 532/98, Part I Quality Assurance, sections 1 to 5
Related Policies:

- Deferral and Extension
- Conflict of Interest
- Program Evaluation (TBD) (include cut-score in this)
- Quality Assurance Committee Decisions (TBD)
- Remote Assessment

Policy:
The on-site assessment is one component of the practice assessment process. An on-site assessment is a four-hour practice assessment that takes place at the site where the member spends the most time delivering patient care. On-site assessments are carried out by an assessor appointed by the Quality Assurance Committee.
The purpose of the on-site assessment is to collect information about the members' practice to help identify potential gaps in the member's knowledge, skill or judgment, and determine what follow-up action is required.
Procedure:

1. Members selected to participate in the practice assessment process will be required to complete an on-site assessment in the following circumstances[4]:
    a. After completing a remote assessment, through selection or volunteering, the remote assessment report indicates the member has not met the pre-determined cut score (see Program Evaluation Policy - TBD);
    b. Members who were previously granted a deferral and the deferral expired;
    c. Members who have been directed to complete a second on-site assessment by the Quality Assurance Committee;
2. Members are permitted to request a deferral or extension to the on-site assessment, according to the Deferral and Extension Policy.

[4] The Working Group and Quality Assurance Committee will be deciding upon a decision-making framework that could determine other triggers for the on-site assessment

3. The on-site assessment must be completed within ten weeks from the initiation of the on-site assessment process.
4. The member must review and confirm their employment and practice information.
5. Once the member has reviewed and updated their employment and practice information, the member will be matched with an assessor.
6. The member and the assessor must confirm there is no conflict of interest.
7. Once the member and assessor confirm that there is no conflict of interest, they will have two weeks to arrange a mutually convenient time to conduct the on-site assessment at the site where the member spends the most time delivering patient care, as indicated by the member.
8. The member will be asked to submit a copy of the following documents, if applicable to their practice, by no later than one week prior to the on-site assessment:
    a. For members who are on a roster to perform a controlled act, written instructions that tell them how to manage adverse outcomes that can be reasonably foreseen as per the Controlled Acts and Restricted Activities Standard.
    b. A written process for monitoring fees, billings and accounts as per the requirements of the Fees, Billings and Accounts Standard.
    c. A written process for infection prevention and control protocols in their practice as noted in the Infection Control and Equipment Maintenance Standard
    d. A written process for routinely reviewing the maintenance and safety of the equipment they use as per the Infection Control and Equipment Maintenance Standard
    e. For members who work with physiotherapist assistants, a written communication protocol as per the Working with Physiotherapist Assistants Standard
9. The assessor will review the submitted documents using checklists. The outcome of this policy review will be included in the assessor's final report following the on-site assessment.
10. The assessor will submit a completed report within one week of completing the on-site assessment.
11. The on-site assessment report will be reviewed by the Manager of Quality Assurance within two weeks of receiving the assessor's report. The Manager of Quality Assurance will ensure the report is complete, identify any questions that require follow up with the assessor or member, and identify items related to patient safety that require immediate review by the Quality Assurance Committee.
12. Once reviewed, the Quality Assurance Manager will accept the submission of the Assessor's report and the Member will be able to access their assessment report.

13. If the member's report requires a review by the Quality Assurance Committee[5], the member will be invited to make a submission within 30 days of receiving their report.
14. Feedback about the on-site assessments will be collected and reviewed to evaluate the program on an ongoing basis according to the Program Evaluation Policy.
15. All required timelines are defined in Appendix A.

[5] The Quality Assurance Committee Decisions Policy will not be developed until the pilot is complete. In some cases, the Committee may decide to defer certain types of reports and decisions to be carried out by the Quality Assurance Manager.

Appendix A –Timelines for Practice Assessment Process; Approved by Council in December 2018

REMOTE ASSESSMENT		
Component of QA Program	**Deadline** (Where initiation of remote assessment process = Day 0)	**Duration**
Pre-assessment questionnaire	Day 0 + 2 weeks	2 weeks
COI declaration	Day 0 + 3 weeks	1 weeks
Scheduling of the remote assessment	Day 0 + 5 weeks	2 weeks
Upload 1 patient record	Date of remote assessment – 1 week	1 week
Remote assessment	Day 0 + 9 weeks	4 weeks
Complete survey to provide feedback	Date of remote assessment + 3 weeks	3 weeks
Assessor submits assessment report	Date of remote assessment + 2 days	2 days
Review the remote assessment report & release to member (QA Manager)	Date of remote assessment report submission + 2 weeks	2 weeks
Total time to complete remote assessment, submit report and QA Manager review		11 weeks, 2 days
ON-SITE ASSESSMENT		
Component of QA Program	**Deadline** (Where initiation of the on-site assessment process = Day 0)	**Duration**
Review and update information submitted in the pre-assessment questionnaire	Day 0 + 1 week	1 week
Matching of PT and assessor assessment	Day 0 + 3 weeks	2 weeks
COI declaration	Day 0 + 4 weeks	1 week
Scheduling of the assessment	Day 0 + 6 weeks	2 weeks
Upload written policies	Date of assessment – 1 week	1 week
On-site assessment	Day 0 + 10 weeks	4 weeks
Complete survey to provide feedback	Date of assessment + 3 weeks	3 weeks
Assessor submits assessment report	Date of the assessment + 1 week	1 week
Review the on-site assessment report & release to member (QA Manager)	Date of on-site assessment report submission + 2 weeks	2 weeks
Total time to complete on-site assessment, submit report and QA Manager review		13 weeks
QUALITY ASSURANCE COMMITTEE REVIEW		
QA Committee review required	1 – 3 months	4 – 12 weeks
Maximum total time – remote and on-site assessments + QAC review		**28-36 weeks**

Section: Quality Assurance Program
Title: Deferral & Extension Policy
Applicable to: Members, Quality Assurance Staff, Quality Assurance Committee

Date approved: XX
Date Revised: XX

Legislative References/ By-law Reference: N/A

Related Policies:

- Remote Assessment Policy
- On-Site Assessment Policy

Policy

Deferrals or extensions may be granted by staff on a case-by-case basis for the following reasons:

- Personal injury or illness of the member;
- Injury or illness of a family member and the member is the primary caregiver;
- Extenuating personal circumstances;
- Not currently in practice due to parental leave or enrollment in a full-time education program; and
- Members who are the subject of an active professional conduct matter with the College

A deferral means the Member is unable to participate in the practice assessment and requires a lengthy delay in starting the process or an interruption in continuing the process. Deferrals are granted for up to one year.

Extensions are requested when the Member can continue the practice assessment process, however, they need additional time to complete the process. Extensions are granted for up to three months.

Requests for deferrals or extensions for reasons other than those described above will be reviewed by the Quality Assurance Committee.

Procedure

1. A member who requires a deferral or extension of their remote assessment or on-site assessment must send a written request to College Staff as soon as possible once the member recognizes the need for a deferral or an extension.
2. Staff has the authority to grant up to two deferrals for a maximum of one year in total based on the criteria defined in this policy. In the case of extensions, staff can grant up to two extensions

up for a maximum of six months in total. Any further requests for deferrals and extensions will be reviewed by the Quality Assurance Committee.

3. The Committee has the authority to determine additional reasons for granting deferrals or extensions as situations arise. The Committee may consider:

    a. Requesting additional written documentation to support the request for a deferral or extension (e.g., letter from health care provider)

    b. Past College history (registration and complaints) if relevant to making a decision

4. The member will receive a written response about their request for a deferral or an extension.

Appendix 1 – List of the policies reviewed by staff

The following table lists all of the quality assurance related policies that were reviewed by College staff.

Policies were selected for review if they related to the Quality Assurance Program, directly or indirectly. The intent of the review was to identify gaps and redundancies in current Quality Assurance Program policies including policies that relate to assessors.

Source Document	Sections
Regulated Health Professions Act – Schedule 2, Health Professions Procedural Code	Sections: 3, 10, 80 – 83.1, 95 • Section 3 – College Objects: includes references to the elements of a quality assurance program required by the College • Section 10 – Identifies the requirements to have a Quality Assurance Committee • Sections 80 – 83.1 – Describes the powers of the Quality Assurance Committee, confidentiality associated with the program • Section 95 – Identifies that the Council can make regulations and subsection (r) and (r.1) refer to the quality assurance program
Physiotherapy Act, O.Reg 532/98, General Regulation	Part I Quality Assurance, sections 1 – 5 • Defines each element of the Quality Assurance Program and process of the Quality Assurance Committee
Physiotherapy Act, O.Reg 388/08 Professional Misconduct	This document describes what constitutes professional misconduct. • Certain subsections could relate to a member who is selected to participate in the quality assurance program (e.g., subsections 11, 12, 13, 14)
By-Laws	Part 5 – Conduct of Councillors and Committee Members: Sections 5.1 Conflict of Interest – Council and Committee Members • Covers conflict of interest when performing Council and committee responsibilities Part 7 – Statutory and Non-statutory Committees • Describes the composition of all the committees, including the Quality Assurance Committee Part 8 – Members' Obligations: Sections 8.6: Fees - General

Source Document	Sections
	• Describes costs involved for an on-site assessment (if not part of the selection process) and practice enhancement costs beyond the 10 hours permitted to members participating in practice enhancement
Governance Manual 2018	Section 3.0 Terms of Reference • This describes the terms of reference for each Committee at the College Policy 3.6 Quality Management Committee • The role and responsibilities of the Quality Assurance Committee Policy 4.1 Confidentiality – General • All Council members, committee members (statutory & non-statutory), task forces, advisory groups, staff and agents of the College are required to sign a confidentiality undertaking when performing work on behalf of the college Policy 5.1 Honoraria and Expenses • Expenses that apply to all Council members, Committee members, staff and assessors Policy 6.2 College Policy Review Schedule • Describes the policy review schedule for official documents of the College Policy 6.3 Approval of Official Documents • Describes the approval process for official documents of the College
QM Program Policies Overview	1.1 The Quality Management Program • A general overview of the 'old' quality assurance program 1.2 Conflict of Interest (Rescinded 2011) 1.3 Communication • A description of the method of communication between committee, staff, assessors, and members 1.4 File Storage

Source Document	Sections
	• A policy describing the record retention schedule of quality assurance related material
QM Program Policies Practice Reflection	2.1 Professional Portfolio • Identifies the requirements of the mandatory portfolio of the 'old' program
QM Program Policies Practice Assessment	3.1 Practice Assessment • The policy covers selection process, items related to deferrals, ratings of reports • All related to the previous on-site assessment process 3.2 Deferrals • Describes the deferral process in addition to what is noted in policy 3.1 3.3 Exemptions • Describes policy for granting exemptions to members 3.4 Refusing to Participate in the Quality Management Program • A description of the QA Committee's options when a member refuses to participate in an on-site assessment 3.5 Assessor Selection and Utilization • A statement indicating that the QA Committee will appoint assessors based on staff recommendations • Additional information is found in policy 3.1 3.6 Observers Present at the Practice Assessment • This policy indicates that members cannot have observers present unless it is their lawyer 3.8 Accommodation of Special Needs (Rescinded 2011)
QM Program Policies Practice Enhancement	4.1 Process • A description of the practice enhancement process once ordered by the Quality Assurance Committee 4.2 Costs and Fees

Source Document	Sections
	• This policy supplements By-Law 8.6 related to fees • Members who require practice enhancement are provided 10 hours of coaching at no cost. Any additional coaching is the member's responsibility 4.3 Registrants who are Unwilling or Unable to Participate in Practice Enhancement • Similar to policy 3.4; this policy describes the QA Committee's options when the member refuses to participate in a practice enhancement 4.4 Deferring a Practice Enhancement • Similar to policy 3.2; description of the policy related to granting deferrals during a practice enhancement process 4.5 Selection of a Practice Enhancement Coach • The policy indicates that coaches assigned to members for a practice enhancement process are trained assessors
Human Resources Policies/ Operations	GL – 2.1 Accessibility – AODA • This operational policy is about ensuring that all persons who interact with the College can obtain, use and benefit from the College's programs and resources (e.g., QA assessment tools) HR – 1.00 Policy & Procedure Development and Maintenance • An operational policy to ensure a consistent, effective and established process for the development and maintenance of the College's operational policies and procedures HR – 1.02 Recruitment and Selection Policy, SOP Recruitment, and Selection • An operational policy for hiring at the College HR – 1.05 Confidentiality Policy, Appendix A – Confidentiality Provisions, Regulated Health Professions Act, Appendix B – Confidentiality Provisions, Health Professions Procedural Code • Describes the requirements for signing confidentiality agreements

Source Document	Sections
	• The appendices include relevant parts of the Regulated Health Professions Act, Health Professions Procedural Code and the agreement that is to be signed HR – 1.09 Conflicts of Interest • An operational policy that describes situations that constitute a conflict of interest for staff and how the conflict of interest should be avoided HR – 3.01 Workplace Harassment, Incident Report Form – Harassment and Violence in the Workplace • This policy provides employees, Council and committee members, contractors, and agents of the College with expectations and processes related to harassment in the work environment Record Retention Schedule, July 2018 • A document that describes the retention requirements for all types of documents across the College including meeting minutes, decisions, and QA files, etc.

Appendix 2 – Policies to be Rescinded

The following policies can be rescinded. The policies can be removed because they are now or will be captured in other program policies, the policies are no longer relevant to the program, or the items have been captured in operational or human resources policies.

Document	Reasons for Removal
QM Program Policy 1.4 File Storage	• The College is in the process of developing a Records and Information Management Program, and a record retention schedule has already been defined and implemented for all areas of the College, including Quality Assurance. This means the need for a separate policy in the Quality Assurance Program is no longer necessary. • This item has been reviewed and discussed with the policy team and the Human Resources and Records Management Specialist & Privacy Officer.
QM Program Policy 2.1 Practice Reflection: Professional Portfolio	• In March 2018, Council approved the new Quality Assurance Program plan, and this decision included removing the requirement to have a documented Portfolio that included evidence of learning. This means this policy is no longer required. The decision to rescind the formal portfolio did not mean that members were no longer required to participate in learning. • This policy also required evidence that the Professional Issues Self-Assessment (PISA) was completed. Several years ago, an operational decision was made to discontinue this requirement because the software used to deliver the PISA included the ability to track members who did not complete it. When this requirement was removed, it was communicated through the quality assurance section of the website and directly to the assessors • Because the College is tracking and following up on PISA compliance through the software and database, the inclusion of this item in a portfolio is unnecessary.
QM Program Policy 3.1 Onsite Assessment – Selection and Procedure	• The process and procedure for members to be selected for an on-site assessment has significantly changed • The current policy includes procedures that relate to other policies and programs. These procedures will be moved to their associated policies and programs to remove duplication

Document	Reasons for Removal
	• This policy will be replaced by separate policies to describe the pre-assessment questionnaire, remote assessment, and on-site assessment
QM Program Policy 3.3 Practice Assessments - Exemptions	• In the previous program, requests for exemptions were often related to incorrect information in a member's profile resulting in the member being selected incorrectly. Additionally, the earlier database did not allow records to be closes administratively once employment records were updated. The new database will allow for information to be corrected and files closed if the member was selected incorrectly. This means, an exemption is not required. • With the new database, the inclusion and exclusion criteria were set by the Working Group and approved by Council. Only members who have met the criteria will be selected • Requests for deferral will address any reasons a member will need to delay their participation in the Quality Assurance Program going forward. If a member does not require a remote assessment, they will be filtered through the exclusion criteria. In the last six years approximately, 17 exemptions were given per year. In some cases, we know that members who were given an exemption returned to clinical care and they were never selected again to complete an assessment. If a deferral had been provided, this situation would be avoided • Since July 2016, QA staff stopped using the exemption classification and used the deferral category instead. This ensured that if a member renewed their registration or returned to clinical practice once the deferral was over, they would be picked up in the selection process again. • Overall improvements to the database and the features built into the QA section will eliminate the need to formally exempt members from participating in the Quality Assurance Program

QM PROGRAM POLICIES

Policy Area	Quality Management
Policy Name	File Storage
Policy Number	1.4
Responsibility	QM Associate
Date of Approval	December 2011, May 2011, October 2009, January 2005, May 2001
Date Last Amended	July 2008
Advised Date of Next Review	One year post-approval
Related Policies	Confidentiality of Registrant Information

POLICY

The College has implemented a records management system to ensure consistent retention of its hard and electronic files for legal and archival purposes. The system is utilized by all programs of the College with oversight provided by Corporate Services.

Files of all Registrants who are assessed through the QM program will be retained for a period of ten (10) years and they are secured separately from other registrant files or information. Files will be retained and destroyed as per the College policy.

The Quality Management staff will adhere to the policies and procedure outlined in the College Policy: (Document Retention S2. 2.5) and Retention Schedule (July 2010).

The main record series for Quality Management are:

- Committee Materials,
- Policies,
- Member files and reports,
- and Studies

QM PROGRAM POLICIES

Policy Area	Quality Management
Policy Name	Practice Reflection: Professional Portfolio
Policy Number	2.1
Responsibility	QM Director
Date of Approval	May 2011, December 2009, July 2008, January 2005, December 2003
Date Last Amended	July 2008
Advised Date of Next Review	One year post-approval
Related Policies	The Quality Management Program

POLICY

Registrants of the College are required to maintain a Professional Portfolio. Portfolios are reviewed upon selection by the Quality Management Program. The mandatory components of the Professional Portfolio are:

- ◊ Evidence of completion of the Professional Issues Self-Assessment
- ◊ Evidence of learning activities

Professional Portfolios will also be audited when a Registrant is selected or referred for a Practice Assessment. Formative feedback will be provided to the registrant on their Professional Portfolio.

In addition:

1) Each Registrant will confirm, through a declaration on the annual registration form, that he or she is maintaining a Professional Portfolio and has completed the PISA.
2) In order to encourage physiotherapists to plan and track professional growth and development over one's career, Registrants are instructed to document professional development activities and demonstrate reflection on their practice. Registrants are advised to keep their Professional Portfolio updated throughout their career.

QM PROGRAM POLICIES

Policy Area	Quality Management
Policy Name	Practice Assessment: Onsite Assessment – Selection and Procedure
Policy Number	3.1
Responsibility	QM Director, Associate
Date of Approval	October 2013May 2011, October 2010, January 2010, December 2009, July 2008, February 2007, August 2006, February 2006, January 2005, December 2003
Date Last Amended	July 2014
Advised Date of Next Review	One year post-approval
Related Policies	The Quality Management Program

POLICY

The Practice Assessment component of the Quality Management program consists of a practice assessment process which assesses a selection of registrants annually as per the target set by Council.

1. Registrants will be required to participate in the Practice Assessment annually, including:
    a. Registrants randomly selected from the register each month or selected by other criteria set by Council.
    b. Registrants who were previously granted a deferral; and,
    c. Registrants selected for a reassessment.
    d. Referrals from the Registrar[1].

2. Registrants may volunteer to participate in the Practice Assessment.

3. Registrants who have passed the national competency examination in the last three years will be excluded from the Practice Assessment.

4. Registrants who have been reviewed through Practice Assessment will be excluded from the random selection pool for a minimum of five years (based upon the selection targets as set by Council). *Please see Appendix 1 for additional details of the pilot evaluation of the QA Roster Assessment Model, approved at Council, December 2012, implemented April 1 2013. This will potentially run for two 3 year cycles beginning April 2013.*

5. Registrants are given three months from the date of selection to complete the Practice Assessment.

6. If a deferral, extension or exemption is requested the Registrant is expected to submit the request, in writing, to the College within a reasonable timeframe from receiving the selection letter, specifying the timing requested, and provide appropriate supporting documentation.

7. Decisions regarding extensions, deferrals, and exemptions are made on an individual basis.

8. Staff has the authority of granting extensions, which can not be longer than three months, and deferrals as defined by the QM Committee (see policy 3.2). Requests of a different nature to those set previously by the Committee (no precedent) will be taken to the Committee for a decision.

1 *Some of the more common circumstances for Registrar referral include unsuccessful completion of the jurisprudence module; insufficient practice hours; lack of completion of the Physiotherapy Competency Examination (PCE); concerns raised in provisional practice monitoring reports; and other matters relating to current knowledge, skill and judgment as they arise*.

9. The Quality Management (QM) Committee selects and trains Assessors to perform an onsite practice review. The Practice Assessment is designed to provide evidence related to a physiotherapist's practice competence. The Committee relies upon the standardized assessment report. The Committee authorizes the Director, QM to confirm a satisfactory practice review with a registrant if the review of the assessment report demonstrates that either of the following criteria is met:

    a) All indicators provide evidence of 'Satisfactory Practices' or 'Rating 1',

    Or

    b) One or at most two 'Ratings of 2' have been indicated, there is no risk identified to public safety and the registrant has provided evidence of the ability to apply all relevant standards.

10. The Committee authorizes the Director of QM to confirm satisfactory practice reviews with Registrants. Decisions of the Director may be audited, from time to time, by the Committee to ensure decision consistency and accuracy. In cases where all ratings meet the criteria set by the QM Committee (all domains receive a Rating 1), the Director, Quality Management will direct that the Registrant receive a letter that indicates they have successfully completed their Practice Assessment.

    The Director may determine that the practice meets standards and direct that the Registrant receive a letter indicating they have successfully completed their Practice Assessment (with or without recommendations in cases where

    (i) all ratings meet (all domains receive a Rating 1), or

    (ii) the ratings do not meet all criteria (but limited to reports with either 1 or 2 Ratings of 2) and there is sufficient and reasonable evidence in the report and/or registrant's submission that the registrant has knowledge, intent and ability to meet standards.

The Director may also direct that the practice does not meet standards, that the registrant will receive a 30-day review letter and that their report will be brought forward for Committee review/decision. All report decisions of this nature will be audited by the QM Committee.

In cases where ratings fall below standard (domains receive Rating 3, 4, or more than 3 Rating 2) reports will be brought forward to the QM Committee for decision.

11. In cases where ratings meet (all domains receive a Rating 1) the criteria, and the Professional Portfolio or Professional Issues Self-Assessment are indicated as 'Not Evident', staff will send the registrant a 30-day review letter, offering them the opportunity to provide a submission. After this 30-day period, the file will be forwarded to the Committee for decision.

12. If there are concerns arising from the assessment, they will be dealt with in accordance with Policy 4.1.

College Review Program

13. For the purposes of Registration Referrals, the *College Review Program* (as mentioned in the Registration Regulation) consists of using the Practice Assessment tool.

14. The College Review Program follows, with necessary modifications, the same procedures as for the QM Practice Assessment.

    a. The disposition options will be described in a manner consistent with those permitted under the Registration Regulation (successful completion of the CRP [with or without recommendations] and unsuccessful completion that can be remediated to the point of successful completion or not).

    b. Registrants undergoing the College Review Program are generally not eligible for deferrals or exemptions.

    c. For Registrants undergoing the College Review Program, the Registrar will be notified of the outcome of this process. Registrants undergoing the College Review Program will reimburse the College for this assessment as per College By-law 43(2)
    The QM Committee shall act under the authority of the Registration Regulation for the review of Registrant reports and shall not assume remedial jurisdiction or impose terms, conditions and limitations that are only available under the QM Program.

QM PROGRAM POLICIES

Policy Area	Quality Management
Policy Name	Practice Assessments – Exemptions
Policy Number	3.3
Responsibility	QM Associate, QM Director
Date of Approval	May 2011, December 2009, March 2005, November 2004, December 2003
Date Last Amended	May 2011
Advised Date of Next Review	One year post-approval
Related Policies	Practice Assessment: – Selection and Procedure

POLICY

Staff has the authority to grant exemptions within criteria as previously defined by the Committee, including such reasons as: personal injury or illness of the Registrant, not in clinical practice and not planning on returning to clinical practice within one year, or employment outside of the province or country.

If the Registrant's status changes after the exemption is granted, the QM Committee can withdraw the exemption. If the exemption is withdrawn, the Registrant is notified and will either undergo assessment immediately or is placed back in the selection pool. If a Registrant resigns before completing a Practice Assessment or Practice Enhancement, but major concerns are identified that appear to constitute professional misconduct, incompetence or incapacity, the Committee may report the name of the member and the allegations to the Inquiries, Complaints and Reports Committee pursuant to 80.2(1).4 of the *Health Professions Procedural Code*.

Appendix 3 – Policies that do not require substantive change

The following legislation, regulations, by-laws, governance policies and program policies were identified as not requiring substantive changes in the policy content.

In the case of the legislation and regulations, the revisions to the College's Quality Assurance Program were approved under this existing framework. Therefore, no changes are necessary.

Governance policies are reviewed regularly and reported to Council.

In the case of the Quality Assurance Program policies, the policy remains relevant to the program because the policies are based on legislation, governance policies and legal advice. In some cases, procedures were added to the policy to assist staff in carrying out the intent of the policy.

Type of Document	Summary of current resources	Comments
Legislation, Regulations, By-laws		
Regulation Health Professions Act – Schedule 2 – Health Professions Procedural Code Sections: 10, 11, 79 – 83.1	Describes the quality assurance program • powers of the Quality Assurance Committee; • role of assessors; and quality assurance information and disclosure	No change
Legislation/ Regulation Physiotherapy Act Sections 1 – 5; Part I – Quality Assurance	Describes the elements of the QA Program: • self-assessment; • continuing education and continuing professional development; and peer and practice assessments	No change
By-laws Part 7 – Statutory and Non-Statutory Committees 7.1 (6) The Quality Assurance Committee	Describes the composition of the Quality Assurance Committee	No change
Governance Manual		

Type of Document	Summary of current resources	Comments
Governance Section 3 – Terms of Reference Policy #3.6	Review the duties of the Committee to ensure they align with current College practices	No substantive changes Suggest: • Update program language for consistency with the College's communications and the Regulated Health Professions Act
Governance Section 4 – Confidentiality Policy #4.1 Confidentiality – General	A confidentiality policy that applies to Council, committees, task forces, advisory groups and agents of the College	No change
Quality Assurance Program Policies		
Program Policy 1.3 Communication	• Describes communication between members, assessors, the Committee and Staff • Based on the College's by-law on conflict of interest.	No substantive changes to the policy • Update language, format and policy number • Add operational procedures to help guide the work of staff
Program Policy 3.5 Practice Assessment: Onsite Assessment – Assessor Selection and Utilization	• This policy indicates that the Quality Assurance Committee shall appoint assessors based on staff recommendations • This policy is based on the Health Professions Procedural Code (HPPC), section 81 that indicates that the Committee may appoint assessors • Legal advice obtained by Richard Steinecke in 2006 suggested that legal requirements would be met if assessors are selected by staff according to some criteria and then appointed by Committee.	No substantive changes to the policy • Operational procedures have been added to this document to help guide staff in this activity. Procedures did not exist in the original policy • Update language and policy number • Change the name of the policy to "Assessor Selection."

Type of Document	Summary of current resources	Comments
Program Policy 3.4 Refusing to Participate in the Quality Management Program	• It is the Committee's responsibility to decide how to manage members who refuse to participate in the quality assurance program. • The Health Professions Procedural Code (HPPC) requires members to comply with the Committee and the assessor.	No substantive changes to the policy • Update language and policy number • Add a reference to the remote assessment and on-site assessment for clarity • Change the name of the policy to "Refusing to Participate in the Quality Assurance Program." • Operational procedures have been added to this document to help guide staff in this activity. Operational procedures did not exist in the original policy
Program Policy 3.6 Practice Assessment: Onsite Assessment – Observers present at the On-site Assessment	• This policy indicates that observers are not permitted during the practice assessment except for legal Council. • This policy was based on earlier legal advice obtained from Richard Steinecke (2005).	No substantive changes • Update language and policy number • Add a reference to the remote assessment and on-site assessment for clarity • Change the name of the policy to "Observers Present at Practice Assessments." • Add operational procedures to help guide staff in the implementation of this policy

Appendix 4 – Original and revised versions of the policies listed in Appendix 3

ORIGINAL

QM PROGRAM POLICIES

Policy Area	Quality Management
Policy Name	Communication
Policy Number	1.3
Responsibility	QM Director
Date of Approval	December 2011, May 2011, October 2009, January 2005, August 2001
Date Last Amended	July 2008
Advised Date of Next Review	One year post-approval
Related Policies	Confidentiality of Registrant Information /Conflict of Interest

POLICY

All communications between the QM Committee or Assessor/Practice Enhancement Coach/Preceptor and the Registrant are to be conducted through a staff person. Similarly all communications between the QM Committee and an Assessor/Practice Enhancement Coach/Preceptor are to be conducted through a staff person. The only exception would be communications between the Registrant and an Assessor/Practice Enhancement Coach/Preceptor when the latter is actually scheduling or performing his or her Practice Assessment, Practice Enhancement or Preceptorship.

QM Committee members should be very careful if a Registrant involved in the program or his or her representative approaches the Committee member directly. The Committee member should terminate the conversation immediately, make a written note of what occurred and report the matter to a Quality Management staff person.

Any correspondence sent directly to a QM Committee member/Assessor /Practice Enhancement Coach should be forwarded to a staff person for reply.

Section: Quality Assurance

Title: Communication - **REVISED**

Applicable to: Quality Assurance Committee, Quality Assurance Staff, Assessors

Date approved: **TBD**

Date revised: **TBD**

Legislative References/ By-law Reference

Official By-Laws – Part 5, Conduct of Councillors and Committee Members, Conflict of Interest – Council and Committee Members

Related Policies:

- Remote Assessment
- On-Site Assessment

Policy:

When a member has concerns or questions about an active practice assessment, he or she should contact a College staff member directly. College staff have access to the member's quality assurance record, including assessment reports and other relevant information to assist the member. Assessors or QA Committee members should direct members to College staff if they are contacted directly by the member about an active practice assessment.

The QA Committee members should speak with College staff if they have concerns or questions about an assessor's report. College staff will relay questions or concerns and provide feedback to the assessors, as directed by the Committee.

The only exception to this policy would be communications between the member and an assessor when the latter is scheduling or performing his or her remote assessment or on-site assessment.

Procedure:

1. If a member contacts or sends correspondence to a member of the QA Committee, the communication should end or the communication should be forwarded to College staff.
2. The Committee member should make a written note of what occurred and report the matter to College staff.
3. If a member contacts an assessor, after the remote or on-site assessment has been completed, the member should be directed to College staff for assistance.

ORIGINAL

QM PROGRAM POLICIES

Policy Area	Quality Management
Policy Name	Practice Assessment: Onsite Assessment – Assessor Selection and Utilization
Policy Number	3.5
Responsibility	QM Director, Associate
Date of Approval	May 2011, December 2009, July 2008, January 2004
Date Last Amended	December 2009
Advised Date of Next Review	One year post-approval
Related Policies	Practice Assessment: Onsite Assessment – Selection and Procedure

POLICY

The Committee shall appoint assessors based on Staff recommendation who will conduct the Practice Assessments 5 (4) QA Reg.

The College will maintain a roster of qualified Assessors able to conduct assessments within the Practice Assessment component of the Quality Management Program.

Section: Quality Assurance Program

Title: Assessor Selection - **REVISED**

Applicable to: Quality Assurance Manager, Quality Assurance Associate

Date approved: May 2011, December 2009, July 2008, January 2004

Date Revised: **TBD**

Legislative References/ By-law Reference

Regulated Health Professions Act, Health Professions Procedural Code, Section 81: Assessors

81 *The Quality Assurance Committee may appoint assessors for the purposes of a quality assurance program. 1991, c. 18, Sched. 2, s. 81.*

Related Policies

- Remote Assessment
- On-site Assessment

Policy

The Quality Assurance Committee shall appoint assessors based on staff recommendation. Assessors will be hired and trained to conduct the remote assessments and on-site assessments.

Procedure

1. Staff will review the roster of assessors each year to determine the number of assessors required to carry out the defined volume of remote assessments and on-site assessments.
2. The pool of assessors will be composed of members from different areas of practice, practice settings, and patient populations.
3. Assessors who conduct remote assessments and on-site assessments must:
    a. Be registered with the College of Physiotherapists of Ontario
    b. Have worked as a physiotherapist for the past five years
    c. Have successfully completed a practice assessment
    d. Not be involved with the College in any other paid positions
    e. Not be the subject of a complaint or investigation that has resulted in a Caution, Acknowledgment and Undertaking, Specified Continuing Education and Remediation Program (SCERP), Discipline or Fitness to Practice Hearing
4. Staff will undertake a robust hiring process to ensure appropriate candidates are recommended to the Committee. This process will include, at a minimum:

a. Review of resumes and cover letters

b. Interviews

c. Completion of a quality assurance assessment, if the applicant has not yet done so.

d. Other activities, according to the identified needs of the quality assurance program (e.g., confirming the assessor can effectively use assessment technology required to conduct the assessments)

5. The Committee shall appoint the assessors based on staff recommendations following successful completion of the assessor hiring and training process.

ORIGINAL

QM PROGRAM POLICIES

Policy Area	Quality Management
Policy Name	Refusing to Participate in the Quality Management Program
Policy Number	3.4
Responsibility	QM Director
Date of Approval	May 2011, December 2009, July 2008, December 2003
Date Last Amended	July 2008
Advised Date of Next Review	One year post-approval
Related Policies	The Quality Management Program/Practice Assessment: Onsite Assessment – Selection and Procedure

POLICY

If a Registrant refuses to participate in the Practice Assessment, the QM Committee will select an appropriate action. Options include (but are not limited to) conducting an assessment that may include a review of records, interview(s) of Staff and colleagues or an observation of practice or referral to the Inquiries, Complaints and Reports Committee for further action and recommendations.

Section: Quality Assurance Program - **REVISED**

Title: Refusing to Participate in the Quality Assurance Program

Applicable to: Quality Assurance Committee, Quality Assurance Manager

Date approved: May 2011, December 2009, July 2008, December 2003

Date Revised: TBD

Legislative References/ By-law Reference

Health Professions Procedural Code, sections 79.1 - 83

Ontario Regulation 388/08 Professional Misconduct

Related Policies

- Quality Assurance Committee Decisions

Policy

If a member refuses to participate in any element of the Quality Assurance Program, the Quality Assurance Committee will select an appropriate action.

Procedure

1. Members who refuse to participate in the Quality Assurance Program will be identified by a Quality Assurance staff member.

2. Quality Assurance staff members will provide the Quality Assurance Committee information about the refusal to help inform the Committee's course of action.

3. The Committee will consider the information gathered by Quality Assurance staff and consider options that could include (but are not limited to):
    a. Conducting an assessment that may include a review of records
    b. Interview(s) of staff or colleagues
    c. Observation of practice
    d. Referral to the Inquiries, Complaints and Reports Committee

4. The member will be informed of the Committee's decision within two weeks once a decision is made.

ORIGINAL

QM PROGRAM POLICIES

Policy Area	Quality Management
Policy Name	Practice Assessment: Onsite Assessment – Observers present at the Onsite Assessment
Policy Number	3.6
Responsibility	QM Director
Date of Approval	May 2011, December 2009, July 2008, December 2003, March 2001, August 2001
Date Last Amended	July 2008
Advised Date of Next Review	One year post-approval
Related Policies	Practice Assessment: Onsite Assessment – Selection and Procedure

POLICY

A Registrant may not bring an observer to accompany him or her to the Practice Assessment but may have legal counsel present.

Section: Quality Assurance Program

Title: Observers at Practice Assessments - **REVISED**

Applicable to:

Date approved: May 2011, December 2009, July 2008, December 2003, March 2001, August 2001

Date Revised: TBD

Legislative References/ By-law Reference

N/A

Related Policies

- Refusing to Participate in the Quality Assurance Program
- Remote Assessment
- Onsite Assessment

Policy

A member may not bring an observer to accompany him or her during the remote assessment or the on-site assessment. A member may have legal counsel present.

Procedure

1. If a member brings an observer to the remote assessment or on-site assessment, the assessor will remind the member that observers are not permitted. The member will be asked if they agree to proceed without the observer.
2. If a member refuses to proceed without the presence of an observer, the assessor will attempt to contact College staff for advice. College staff will advise the member that refusing to proceed may cause the Quality Assurance Committee to take another course of action as noted in the policy *Refusing to Participate in the Quality Assurance Program.*
3. The assessor may withdraw from the assessment if he or she is not able to contact appropriate College staff and the member refuses to participate without an observer.
4. When a member chooses to have legal counsel present, this information should be provided to College staff, in advance.
5. If a member's legal counsel is present, but the member has not given College staff advance notice, the assessor should contact College staff. In the event the assessor is not able to reach an appropriate staff member, the assessor should withdraw from the assessment on that day in order to obtain advice from College staff.

Appendix 5 – List of Policies For Future Consideration

Document	Summary of Policy & Required Updates	Date of Review
By-laws Part 8 – Members' Obligations 8.6 (2) (ii) – the cost of the assessment $500 8.6 (2) (iii) – the cost of remediation 8.6 (2) (iv) – costs of programs provided by the College 8.6 (2) (v) – costs of SCERP 8.6 (2) (vi) – costs associated with an Acknowledgement & Undertaking	• This section of the College's by-laws describes the costs attached to assessments and remediation • Language for Quality Assurance Program has changed (e.g., the current by-law references a random selection process) • The new program is a multi-step process, and this by-law references a single step process	TBD – to be included with Council's broad review of by-laws
Quality Assurance QA Operational Policy – Conflict of Interest: assessors and members	• Conflict of interest is defined for Committee members in the Governance Manual • Conflict of interest has been previously defined for members and assessors in a letter template that they receive after being matched. • A new policy is being created to formally define what conflict of interest means between an assessor and a member for the purposes of matching and conducting an assessment	June 2019, for information only

Document	Summary of Policy & Required Updates	Date of Review
	• The content will be based on the College's governance policy, Standard of Practice – Conflict of Interest and the letter template that has been used for many years.	
Quality Assurance Program – Program evaluation	• A new policy that describes the requirements for ongoing program review and evaluation • This will include information about the cut score review, use of surveys	June 2019, *for decision*
Quality Assurance Program Policy – 3.7 Decisions and Reasons of the Quality Assurance Committee	• Staff will develop a proposed decision-making framework for the Working Groups consideration and feedback in March 2019 • The assessment consultant recommends that the draft decision-making framework is tested when the QA Committee reviews the assessment reports from the pilot test assessments, and adjust as directed by the Committee • An updated policy related to the Quality Assurance Committee's decisions and reasons will be created once this process is complete	*TBD – fall 2019*

Quality Assurance Program Policy – 1.1 Overview	• This policy provides a program overview of the previous version of the QA Program
	• This document needs to be updated to reflect the new format
	• Because the Working Group continues to make decisions about the how this program will be designed and delivered, this program overview will be finalized after the pilot test
	• This document will include the following elements:
	  ○ An overview of the legislative requirements
	  ○ A brief summary of each piece of the Quality Assurance Program along with a process diagram
		TBD – fall 2019

Quality Assurance Program Policy –	• This policy describes the requirements for members to participate in practice enhancements according to the Health Professions Procedural Code	*TBD – fall 2019*

Document	Summary of Policy & Required Updates	Date of Review
4.1 Practice Enhancement	• The document requires updates for current language • No substantive changes have been identified for the update	
Quality Assurance Program – 4.2 Practice Enhancement & Practice Assessment Cost & Fees	• The document outlines the fees and costs of a practice enhancement program, based on the current by-laws • This document will require revision according to any changes made to Part 8 of the by-laws • Update language, as needed	*TBD – fall 2019*
Quality Assurance Program – 4.3 Registrants who are unwilling, unable or fail to participate in practice enhancement	• Identifies what the QA Committee can do when a member does not participate in practice enhancement • No substantive changes required • Update language	*TBD – fall 2019*
Quality Assurance Program – 4.5 Practice Enhancement – Selection of Practice Enhancement Coach	• Description of who will fulfill coaching responsibilities for Committee ordered practice enhancements	*TBD – fall 2019*

COLLEGE OF PHYSIOTHERAPISTS of ONTARIO | ORDRE DES PHYSIOTHÉRAPEUTES de l'ONTARIO

Motion No.: 8.3

Council Meeting
March 21-22, 2019

Agenda #8.3: Quality Assurance Program Review – Program Evaluation Plan

It is moved by

_____,

and seconded by

_____,

that:

Council approve the QA program evaluation plan.

Meeting Date:	March 21-22, 2019
Agenda Item #:	8.3
Issue:	Quality Assurance Program Review – Program Evaluation Plan
Submitted by:	Joyce Huang, Strategic Projects Manager

Issue

As part of the Quality Assurance Program Review project, the College is developing a plan to evaluate the program after implementation. Council is asked to consider and approve the QA Program Evaluation Plan.

Background

As part of the Quality Assurance Program Review project, the College is developing a plan to evaluate the program after implementation. The program evaluation plan will enable the College to systematically collect and analyze information that will allow us to evaluate and improve our tools and processes.

A draft evaluation plan has been developed through collaboration between College staff, the lead assessment consultant Ms. Leanne Worsfold, and two academics with research experience. The draft evaluation plan was developed after two discussions in May and November 2018 which considered relevant evaluation and research questions, methodology for data collection and analysis, and dissemination or potential publication of the findings.

Working Group Feedback

The WG considered the draft program evaluation plan in February 2019. The WG made recommendations regarding the frequency of the review of the score threshold, test reliability, and currency of the assessment tools, and approved the plan with those changes. The WG also suggested that the plan should include Council's review of the annual target assessment volume and the eligibility and selection criteria. These recommended changes have been incorporated into the QA program evaluation plan attached.

In addition, staff also asked the WG to consider potential future research needs for the College and the potential opportunity to collect additional research data through the QA process. The WG recommended that this item be brought forward to the June 2019 Council meeting for consideration.

Decision Sought

That Council approve the QA program evaluation plan.

Attachments

- Appendix 1: Quality Assurance Program Evaluation Plan

Appendix 1:

Quality Assurance Program Evaluation Plan

Purpose

This plan lays out how the College will evaluate the Quality Assurance Program after implementation. The program evaluation plan will enable the College to systematically collect and analyze information that will allow us to evaluate and improve our tools and processes.

The evaluation of the Quality Assurance Program has several goals:

- In the short-term, at the pre-test and pilot test stage, the College needs to evaluate the assessment tools to ensure that they are valid and reliable, and they are working as intended.
- On an ongoing basis, the College needs to periodically re-calibrate the remote assessment scoring threshold and ensure the assessment tools remain valid and reliable as they are reviewed and updated over time.
- In the long-term, the College needs to evaluate the impact of the program on members' practice and to identify future improvements to the program.

The sections below outline the recommended strategy and methodology for meeting the above evaluation goals.

Evaluating the Assessment Tools for Validity and Reliability

Part of the QA program development is to pre-test and pilot test the remote and on-site assessment tools to confirm the test reliability and inter-rater reliability, and to use the remote assessment data to establish the remote assessment score threshold. Confirming these characteristics would involve psychometric analysis of the assessment results data.

Remote Assessment Pilot Test

College staff provided statistics about our members to the assessment consultant to allow them to do the calculations required to determine the appropriate sampling method and sample size. The data included statistics for the population as a whole, and the subset of members who are eligible for selection. For the purpose of this calculation only, a member was deemed to be eligible for selection if they have never done a QA assessment before; are currently in clinical practice; and completed the PCE more than three years ago. The statistics provided a breakdown of the membership by several criteria of

interest, such as rostered activities; practice setting; area of practice; whether the member is a clinic owner; and whether the member works with PTAs.

Charles Mayenga Ph.D., a psychometrician who works with iComp Consulting Inc., performed an analysis of the membership data and calculations to come up with recommendations for sampling method and sample size.

The recommended approach for selecting the pilot test sample group is to use the Practice Settings, in such way that each of practice setting will have at least 10 members represented in the sample. From the eligible PTs (n=3738), this could be attained with confidence interval of 6 at 95% confidence level. For the pilot test, it is recommended that the College select a random sample of 250 PTs from the pool of PTs who are eligible for selection, and then assess the sample selected against categories such as practice setting, rostered activities and working with PTAs. A confidence interval of 7.5 at 95% confidence level is acceptable if the practice settings are grouped by commonality to support a higher percentage within a category.

For the purpose of confirming inter-rater reliability, 120 of the 250 pilot test remote assessments will be conducted with pairs of assessors.

On-site Assessment Pilot Test

The sample size for the on-site assessment pilot test would be based on the remote assessment score threshold, with no fewer than 30 assessments, and they will be conducted with pairs of assessors to confirm inter-rater reliability.

Reviewing the Remote Assessment Score Threshold

The score threshold will be established using the results data from the pilot test assessments and in consultation with a cut score study group. A future review of the remote assessment score threshold would involve psychometric analysis of the assessment results data. The assessment consultant indicated that typically 50 assessments is the minimum number to allow for a review of the score threshold. However, given the relatively large number of remote assessments the College will conduct, it would not be practical to conduct this analysis for every 50 remote assessments.

The recommendation is that the Quality Assurance Committee will consider the score threshold each year, and if they believe that there is a need to adjust the score threshold or to perform a cut score study, the Committee will make that recommendation to Council.

Reviewing the Assessment Tools for Test Reliability

The assessment consultant indicated that typically 50 assessments is the minimum number to allow for an analysis to confirm test reliability and to identify interview questions that require modification. However, given the relatively large number of remote assessments the College will conduct, it would not be practical to conduct this analysis for every 50 assessments.

The recommendation is that the Quality Assurance Committee will consider the assessment results data each year, and if they believe that there is a need to conduct an analysis and review of test reliability, the Committee will make that recommendation to Council.

Reviewing the Assessment Tools for Currency

The assessment tools may need to be reviewed and updated over time to reflect changes in standards and expectations in the profession.

The recommendation is that the assessment tools are reviewed when there are changes to the relevant College Standards, the *Essential Competency Profile* (approximately every five years), or legislation, and no less than once every two years.

Reviewing the Eligibility and Selection Criteria and Annual Assessment Volume

As part of the QA Program Review, the QA Working Group made recommendations regarding the eligibility and selection criteria for selecting members for practice assessments, and the target volume of members to select each year, and Council approved those recommendations.

After the program is implemented, it is recommended that Council will review the target selection volume each year and determine when the eligibility and selection criteria should be reviewed.

Evaluation Questions to Inform Ongoing Program Improvement

For the purpose of informing ongoing program improvements, the evaluation questions would consider whether the program is achieving the intended goal of ensuring that all members are meeting minimum standards for competency and quality, and whether our processes are appropriate to support the program.

The following table summarizes the relevant evaluation questions, and the recommended methodology for collecting and analyzing evaluation data.

Evaluation Question	Recommended Evaluation Methodology
Does the remote assessment tool accurately identify members who performed below expectations during the on-site assessment?[1]	Method for collecting data: • Collated assessment results from the remote and the on-site assessments • Collated assessment results from members who fell below the score threshold after the remote assessment

[1] Where relevant, the analysis will take into account the fact that some members may self-remediate after the remote assessment and before the on-site assessment.

Evaluation Question	Recommended Evaluation Methodology
	• Identify members who took action to self-remediate after the remote assessment and prior to the on-site assessment via a member survey Method for data analysis: • Compare total score results of the remote assessment and the total score results of the on-site assessment. • Compare related competency scores between assessments. • Identify the number of members who fell below the score threshold after the remote assessment and engaged in self-remediation.
What is the sensitivity of the remote assessment tool in identifying members who perform below expectations?	Method for collecting data: • Collated assessment results from the remote and the on-site assessments Method for data analysis: • Conduct an item analysis and note item discrimination • Conduct descriptive statistics
Do the remote and on-site assessment tools accurately or reliably or consistently identify members who required remediation (self and directed)? [1]	Method for data collection: • Combine the remote assessment and the on-site assessment results from members who fell below the score threshold after the remote interview • Identify members who took action to self-remediate after the remote assessment and prior to the on-site assessment via a member survey • Track QA Committee decisions after the remote and on-site assessments Method for data analysis: • Identify the correlation of the assessment scores and competency gaps related to self- and directed-remediation. • Identify the descriptive statistics (threshold) for those members who engaged in self- or directed remediation. (For example, effect size statistics – Cohen's d[2])

[2] Cohen's D is one of the ways to measure effect size. An effect size is how large an effect of something is.

Evaluation Question	Recommended Evaluation Methodology
Does the remote assessment tool add value to the assessment process?[1] "Add value" could refer to: **a. Supporting QAC decision-making** **b. Supporting member self-remediation and influence change in members' practice** **c. Collecting data that would not have been collected during the on-site assessment** **d. Having the remote assessment effectively reduce the overall time of the assessment**	Method for data collection: • Conduct a survey with all participating members after the remote and on-site assessments, QAC members and assessors Method for data analysis: • Collated data from the survey results. Compare like questions amongst the three survey populations (members, assessors, and QAC members) • Compare the descriptive statistics; assess differences using effect size (Cohen's d)
What are the perceived benefits and feedback on the new format of the revised assessment tools from the assessors' perspective?	Method for data collection: • Conduct a survey with assessors after the pilot test Method for data analysis: • Collate and summarize survey results by comparing the descriptive statistics; assess differences using effect size (Cohen's d)
What is the perceived value or role of the assessment process from the members' perspective? **Do members perceive the assessment process to be fair?**	Method for data collection: • Conduct a survey with members who fell above the score threshold after the remote assessment, and with members who fell below requirements after the on-site assessment Data analysis: • Collate and summarize survey results by comparing the descriptive statistics; assess differences using effect size (Cohen's d)
What changes were implemented in practice by members after they were assessed? **What changes did the members plan to implement after they were assessed?**	Method for data collection: • Conduct a survey with all members after they received their remote assessment report, and with members who participated in the on-site assessment after they receive their on-site assessment report • Track members' outcomes where the QAC directed remediation Method for data analysis:

Evaluation Question	Recommended Evaluation Methodology
	• Collate and report on data by comparing the descriptive statistics; assess differences using effect size (Cohen's d)
What is the overall effectiveness of ongoing training and on-boarding of assessors?	Method for data collection: • Conduct a post-training evaluation with assessors • Include in the members' surveys (after remote and on-site assessments) questions related to assessors' skills and behaviour during the assessment Data analysis: • Collate survey results by comparing the descriptive statistics; assess differences using effect size (Cohen's d)

Dissemination of Evaluation Information

One of the required components of the Quality Assurance Program defined in regulation is the "Collection, analysis and dissemination of information." The College currently provides high-level aggregate data about the program in its annual report. If in the future, the College wishes to publish evaluation findings based on data collected through the Quality Assurance Program in a peer-reviewed publication, the College can seek a formal ethics review at that time.

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Motion No.: 9.0

Council Meeting
March 21-22, 2019

Agenda #9.0: Non-Council Appointment Process and Recruitment

It is moved by

_____,

and seconded by

_____,

that:

Council approves the non-council appointment process and directs staff to recruit a pool of six non-council committee members.

Meeting Date:	March 21-22, 2019
Agenda Item #:	9.0
Issue:	Non-Council Appointment Process and Recruitment
Submitted by:	Elicia Persaud, Executive Assistant

Issue

Staff are seeking Council's approval of the recruitment of six non-council committee members.

Background

On January 8, 2019 the Executive Committee met to discuss changes to the committee slate following the public appointment expiry of Mr. James Lee. Following the committee slate discussion, a concern was raised around inconsistencies with the non-council committee appointment process and as a result, potential gaps in committee specific knowledge.

Part One: Recruitment Process

Recruitment process prior to 2016

Prior to 2016, the recruitment process for non-council committee members were based on previous relationships with the College. In some instances, councillors and/or committee Chairs would refer colleagues, or past councillors identified their interest in continuing to serve the college as a non-council committee member. During this time, there was no formal process in place as it was difficult to retain qualified candidates.

Current recruitment process

In 2016 Council adopted a formalized recruitment process for non-council committee members. Essentially the process would be to treat committee appointment similar to a job recruitment. When committee members are needed the College would issue a call for applicants detailing the specifics of the role including:

- Which committee appointments were being recruited for
- What competencies were required by potential candidates
- The time commitment required
- How the role was remunerated
- The application process (i.e. submission of C.V. and expression of interest)

After a group of interested members are identified, they would be screened in a way similar to a normal staff recruitment. This would involve a pre-screening of C.V.s by the human resources professional at the College to identify candidates qualified for a further paper review by the program managers. Once

prospective candidates are identified this would lead to an interview with staff. All candidates are also reviewed for prior history with the College.

Once this process is completed, the recommendations of the program manager are fed into the committee slate development. It should be noted that the committee slate developed at the staff level is subject to review by the College's Executive Committee and final approval by Council, so no commitment could be made to potential applicants until the decision on committee memberships was approved by Council. The official appointment of non-council committee members occurs when Council approves the committee slate. Non-council committee members are then notified by staff that they have been appointed to the committee for a one-year renewable appointment.

Reappointment Process

After the initial appointment by Council, non-council committee members who have been selected are no longer required to go through the initial appointment process as they are now part of the pool of potential non-council committee members. They are provided with a committee interest form and are asked to submit their interest using the same process as Council members. Once all committee interest forms are received, staff review a number of factors including a committee workload assessment, committee experience summary, and assessments from the committee chairs and managers. Based on the outcomes of the committee slate development process staff bring forward a proposed committee slate to the Executive Committee and then Council for their approval.

Feedback from Council

Based on feedback from Council at its October meeting, there was a desire to add an additional step to the screening the candidates to increase transparency. In keeping with this, below is the new recruitment process:

1. Call for applicants detailing the specifics of the role
2. Candidates CVs are pre-screened by HR and top candidates are identified
3. Program managers review identified candidates and select candidates for interview
4. Selected candidates are interviewed, and staff recommendations are made
5. Staff bring forward all candidates interviewed, along with their recommendation to Executive Committee
6. Executive Committee reviews staff recommendation of the shortlisted group of candidates, and makes a recommendation to Council
7. Council reviews Executives recommendation as part of the committee slate approval
8. Candidates are approved with the approval of the committee slate

Part Two: Non-council Committee Term Limits

Non-council committee members are appointed for one-year renewable appointments (or terms) in June.

According to By-law 7.7:

(7) A Non-Council Committee Member is eligible for re-appointment to a Committee, except that a Non-Council Committee Member may not serve for more than nine consecutive years.

The College currently has ten non-council committee members. Five were appointed through the old process, that is appointed through word-of-mouth, and five were appointed using the approved recruitment process from 2016. As you will see in chart 1, there is one non-council committee member who has reached their ninth year ending in June 2019. This member has been notified that their term limit has come to an end and that they will no longer be eligible for reappointment.

Chart 1: Non-Council Committee Member Appointment Details and Years Left

Process	Name	Year Appointed	Term (years) Left	Last Eligible Appointment Year	Current Committee
Old Process	Jatinder Bains	June 2010	0	2018-2019	Quality Assurance Patient Relations
	Sheila Cameron	June 2011	1	2019-2020	Discipline and Fitness to Practise
	Lori Neill	June 2015	5	2023-2024	Discipline and Fitness to Practise
	Marcia Dunn	June 2015	5	2023-2024	Registration
	Vinh Lu	June 2015	5	2023-2024	Quality Assurance
New Process	James (Jim) Wernham	June 2017	7	2025-2026	Discipline and Fitness to Practise
	Daniel Negro	June 2017	7	2025-2026	Discipline and Fitness to Practise
	Monica Clarke	October 2018	8	2026-2027	Inquiries, Complaints and Reports
	Sue Grebe	October 2018	8	2026-2027	Discipline and Fitness to Practise
	Heather Anders	October 2018	8	2026-2027	Discipline and Fitness to Practise

Recommendation for this year's non-council committee appointments

Given that there will be a call for interest to replace the one non-council committee member who is no longer eligible for reappointment, staff have requested at least one additional non-council committee member be recruited for the Discipline and Fitness to Practise Committees.

In order to ensure there are no gaps in knowledge and equality amongst all non-council committee members the Executive Committee is proposing that staff go through the process of developing a pool of six candidates to fill the vacant seats in June. Those non-council committee members who were initially appointed through the old process will be asked to follow the new process to ensure uniformity.

This process will be adapted for all future non-council committee appointments.

Once the candidates have been selected and appointed by Council through the committee slate approval, they will be included in the pool of non-council committee members and will be reappointed on the basis of the usual reappointment process.

To ensure timelines are met, this recruitment will begin in early April.

As a reminder the committee composition requires the following number of non-council committee members:

- Registration Committee – 1
- Patient Relations Committee – 1
- Quality Assurance Committee – 2
- Inquires, Complaints and Reports Committee – 1
- Discipline and Fitness to Practise Committees – 1

Decision Sought:

Council is asked to approve the recruitment of a pool of six non-council committee members.

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Motion No.: 10.0

Council Meeting
March 21-22, 2019

Agenda #10.0: Approval of Auditor Tool

It is moved by

_____,

and seconded by

_____,

that:

Council approves the auditor evaluation tool.

Meeting Date:	March 21-22, 2019
Agenda Item #:	10.0
Issue:	Auditor Evaluation Tool
Submitted by:	Rod Hamilton, Registrar

Issue

A tool to evaluate the performance of the auditor is being proposed by both the Finance and Executive Committee for approval by Council.

Background

A key duty of the College's Finance Committee is to annually evaluate the performance of the auditor and recommend to Council the appointment or changes to the appointment of a firm of chartered accountants as the College's auditors.

However, currently the College has no process for undertaking this work. In order to remedy this situation, staff were asked to bring a tool to the committee for consideration.

There are many such tools available however most of them are based on the requirements for U.S. organizations.

The one that is most appropriate for Canadian usage is that developed and published by Chartered Professional Accountants Canada, "Annual assessment of the external auditors: Tools for audit committees".

The following information is based on this document which is available at: www.cpacanada.ca.

Because this guidance is intended to assist any organization conducting audits (large and small, profit and not-for-profit) some question are not relevant for the College.

Auditor Assessment

The annual assessment of the auditor is intended to identify three key factors of audit quality for the Finance Committee to consider and assess:

1. *Independence, objectivity and professional skepticism* — Do the auditors approach their work with objectivity to ensure they appropriately question and challenge management's assertions in preparing the financial statements?

2. *Quality of the engagement team* — Do the auditors put forward team members with the appropriate industry and technical skills to carry out an effective audit?

3. *Quality of communications and interactions with the auditor* — Are the communications with the auditor (written and oral) clear, concise and free of boilerplate language? Is the auditor open and frank, particularly in areas of significant judgments and estimates or when initial views differ from management?

Annual Assessment of the Auditor

Within each of these three factors, there are a number of sub-questions that can serve as useful indicators of audit quality.

According to most guides on the use of audit assessment, the tool does not require committees to come to an overall measure of audit quality. Rather, audit assessment is intended to help committees identify potential areas for improvement for the audit firm (and for the committee's own processes) and reach a final conclusion on whether the auditor should be reappointed or the audit should be put out for tender.

The questions presented are intended to be adapted to meet an organization's specific circumstances.

Use of the annual assessment tool

The recommended way to use the tool is to:

1. *Determine the scope, timing and process*

The committee chair, perhaps in conjunction with other committee members, determines the scope, timing and process of the annual assessment. This includes determining what information the committee requires from College staff about the auditor.

It also includes determining what questions the committee needs to consider in conducting the assessment. The tool can be amended by the committee chair to reflect these needs.

2. *Obtain input from College staff*

College staff, such as the registrar, and financial staff complete the tool's 'Obtain input from staff' section and return it to the committee.

3. *Assess areas for the committee to consider*

The committee chair distributes the results of the prior-year annual assessment (if there is one), the tool's 'Assess areas for the committee to consider' section, and the input received from staff.

Committee members complete this section of the tool.

At a meeting of the committee, members discuss each area of the assessment tool, comparing their views with those of staff and the results of the prior-year annual assessment.

4. *Conclude the annual assessment, and communicate the results*

Following this discussion, the committee reaches a conclusion on whether to recommend the auditor to the Council for reappointment and identifies matters that should be reviewed with the auditors to improve their future performance and effectiveness.

The committee records and communicates the results of the annual assessment. Keeping a record assists the committee to perform a subsequent annual assessment of the auditor.

Finance Committee Decision

The Finance Committee reviewed and identified the questions that are particularly relevant to the College. This included the addition of one section: Additional Information from the Auditor. This was added to allow the auditor to provide feedback or an explanation, to assist the committee with their evaluation of the audit.

Proposed Timeline

If Council approves this tool the Finance Committee will use it in May 2019 to evaluate the 2018-2019 audit. The committee will then meet in September 2019 to review the tool and make any required modifications to the tool and/or questions.

If changes are made it will be brought back to Council for approval.

Decision Required

Council is being asked to approve the auditor evaluation tool.

Attachment:

- Appendix 1: Audit Evaluation Tool

Appendix One: Audit Evaluation Tool

Proposed list of questions for Finance Committee to consider asking in the Auditor Assessment

This tool is to be used if the committees wants to do a annual review of the auditor.

The motion is for the tool to be approved for the annual audit.

Timeline:
March: initial tool approved. Tools approved for use for 2018-2019. If concerns are identified, then additional consideration needed to decide what to do.

June: Typically, auditor would be reappointed for one year. If Council decides not to reappoint, then the more comprehensive tool can be used in the fall if needed.

Part 1 – Determine the Scope, Timing, and Process and Audit Quality Indicators

Completed by: Chair/Committee or staff

Consider the scope, timing and process for the annual assessment. Some or all of the following questions may be relevant in the circumstances of the entity and the audit:

1. Have there been significant changes that require changes to the assessment process this year?
2. What is the appropriate timing of the annual assessment in relation to the committee's planned meeting agendas?
3. Do the results of the prior-year assessments indicate areas that should be given particular focus this year?
4. What additional information from the College is needed to help the committee conduct the assessment?
5. What information, if any, from the audit team is needed to help the committee conduct the assessment
6. What changes need to be made to other sections of this tool to reflect the approach to this year's annual assessment?

Audit Quality Indicators (AQI)

AQIs can provide useful quantitative and qualitative information for the purpose of external auditor evaluation. The following table illustrates how AQIs can be used for your annual assessment of the external auditor.

1. ***Independence, objectivity and professional skepticism***	• Do the auditors approach their work with objectivity to ensure they question appropriately, and challenge management's assertions made when preparing the financial statements? • The time spent by auditors on significant risk areas can help committees and management better understand the amount of effort spent in certain areas of the audit. This information can help determine whether a sufficient amount of time was allocated for the auditor to work objectively and challenge management's assertions. • A common way of assessing the auditor's independence is to report on independence breaches.
2. ***Quality of the engagement team***	• Does the audit firm put forward team members with the appropriate industry and technical skills to carry out an effective audit? • A common way to help assess the quality of the auditors is to understand the industry experience and client knowledge of individual team members. This can be measured by obtaining information about the number of years spent auditing the entity and/or companies in the same industry by each engagement team member. • Depending on the complexity of the audit, certain specialists / subject-matter experts may be required to complement the team. Where and how much (measured in hours) these specialists / subject-matter experts are used in the audit can be useful information for assessing the quality of the overall engagement team.
3. ***Quality of communications and interactions with the external auditor***	• Are the communications with the auditor (written and oral) clear, concise and free of boilerplate language? Is the auditor open and frank, particularly in areas of significant judgments and estimates or when initial views differ from those of management? • Consideration of the timing, format and content of communication from the auditor related specifically to the audit and/or wider issues of importance can help assess the effectiveness of the interactions with the auditor. Consider assigning a rating to the quality and timeliness of each communication. • Reports on the timeliness of meeting audit milestones during the engagement can provide committees and management with better insight into the progress of the audit and any issues identified.

Audit Quality Factor Example AQIs

It is important to note that AQIs on their own are not a complete measure of quality. This is because they will not necessarily convey the whole story since certain elements of audit quality such as the auditor's professional skepticism cannot be easily quantified.

AQIs are meant to be used as a tool to facilitate a more informed and meaningful conversation about audit quality among the committee, management and the auditor.

Once AQIs have been selected, the committee chair will request the auditor to report on them. The results can then be circulated to staff and the rest of the committee members as supplemental useful information for completing their respective sections of the assessment
tool.

Committees and management should also consider the results of AQIs used in overseeing the work of the auditor, such as the review of the audit plan and monitoring the audit progress as additional information to help in their assessment.

Part 2 – Obtain Input from Staff

Completed by: Internal Staff

This section of the tool includes a number of questions the committee may want to ask College staff.

The committee needs to determine from whom input is required, specific questions to be addressed, and whether to obtain input in writing or through discussions.

Registrar and/or designated staff - *Audit Quality Considerations*

Points to Consider Observations

1. Provide input on the **independence, objectivity and professional skepticism** of the external auditor. Some or all of the following questions may be relevant:

a. How does the auditor demonstrate integrity, objectivity and professional skepticism, for example, by maintaining a respectful but questioning approach throughout the audit?

b. How does the auditor demonstrate independence, for example, by proactively discussing independence matters and reporting exceptions to its compliance with independence requirements?

c. How forthright is the auditor in dealing with difficult situations, for example, by proactively identifying, communicating and resolving technical issues?

d. To what extent do you have concerns about the relationship between the auditor and staff that might affect the auditor's independence, objectivity or professional skepticism?

2. Provide input on the **quality of the audit team** provided to conduct the audit. Some or all of the following questions may be relevant:

a. How would you assess the technical competence and ability of the auditor to translate knowledge into practice, for example, by using technical knowledge and independent judgment to provide realistic analysis of issues and by providing appropriate levels of competence across the team?

b. How would you assess the auditor's understanding of our business and industry, for example, by demonstrating an understanding of our specific business risks, processes, systems and operations?

c. How sufficient are resources assigned by the auditor to complete work in a timely manner, for example, by providing access to specialized expertise during the audit and assigning additional resources to the audit as necessary to complete work in a timely manner?

d. To what extent has the audit team consulted and used specialists on complex technical matters?

e. To what extent has the auditor maintained quality control over the work?

3. Provide input on the **communication and interaction with the auditor**. Some or all of the following questions may be relevant:

a. How candid and complete was the dialogue between the auditors and management? How well did the auditors explain accounting and auditing issues?

b. How effectively does the auditor provide timely and informative communications about accounting and other relevant developments?

c. How does the auditor communicate about matters affecting the firm or its reputation, for example, by advising management on significant matters pertaining to the firm while respecting the confidentiality of other clients' information and by complying with professional standards and legal requirements?

Quality-of-Service Considerations

Provide input on the **quality of service** provided by the auditor. Some or all of the following questions may be relevant:

1. To what extent is the auditor effective in completing the audit on a timely basis?

2. To what extent does the auditor keep management informed about the progress of the audit and difficulties encountered?

3. To what extent have the auditors maintained a respectful and professional attitude during the audit?

4. To what extent is the auditor proactive in identifying information requirements and timely in requesting information from management?

Other Input Requested from Staff by the Committee

Does the Committee have any other information requirements about the auditors from staff?

1.

2.

3.

Part 3 – Additional Information from the Auditor

Completed by: Auditor (optional)

This section of the tool includes a few general questions that the committee may want to ask the auditor. If the auditor includes feedback it would be voluntary.

1. What is your audit firm doing to assess our risk management processes that could affect financial reporting?

2. During the audit was the assistance provided by staff sufficient?

3. Do the results of the prior-year's assessment indicate areas that should be given particular focus this year?

4. Do you have any general feedback for the committee as they consider the evaluation of the audit?

Part 4 – Assessment Areas for the Audit Committee to Consider

Completed by: Audit Committee

This section of the tool sets out the audit quality and quality of service considerations addressed in an annual assessment. It incorporates specific questions for committees to consider in addressing each area.

Audit Quality Considerations

1. Assess the auditor's **independence, objectivity and professional skepticism**. Some or all of the following questions may be relevant:

a. How does the auditor inform the committee about matters that might reasonably be thought to bear on the firm's independence?

b. In obtaining the committee's pre-approval for non-audit services, what safeguards were in place to protect the auditor's independence?

c. How did the auditor adjust the audit plan to respond to changing risks and circumstances?

d. What steps do the auditors take to ensure that they exhibit the values, ethics and attitudes necessary to support a quality audit?

e. How were significant differences in views, if any, between management and the auditor resolved?

f. What evidence is there that the auditor challenges significant judgments made by management in preparing the financial statements?

g. How has the auditor addressed potential risks of fraud (for example, incorporating an element of unpredictability into audit procedures during the period)?

h. How have the auditors responded to indicators, if any, of possible management bias in the preparation of the financial statements (for example, to achieve performance-based or incentive remuneration)?

i. How would you assess the quality of the significant professional judgments made by the auditors?

j. Which of the College's accounting policies or disclosures, if any, have been questioned by regulators, giving rise to questions about the auditor's independence, professional skepticism or judgment?

k. Are the audit fees appropriate in relation to costs incurred to enable the performance of a quality audit?

2. Assess the **quality of the audit team** provided by the external auditor. Some or all of the following questions may be relevant:

a. How did the auditors ensure that the necessary knowledge and skills (entity-specific, industry, accounting, auditing) were dedicated to the audit?

b. What evidence was there that the auditors devoted sufficient attention and leadership to the audit?

3. Assess the **communication and interaction with the auditor**. Some or all of the following questions may be relevant:

a. How candid and complete was the dialogue between the auditors, the committee and the committee chair? How well did the auditors explain accounting and auditing issues? How effective was the resolution of issues?

b. How would you assess the auditor's discussion about the quality of the College's financial reporting, including the reasonableness of accounting estimates and judgments, appropriateness of the accounting policies and adequacy of the disclosures?

c. During in camera sessions, what is your assessment of how the auditor discussed sensitive issues (for example, were concerns about management's reporting processes, internal control over financial reporting or the quality of the College's financial management team discussed in a timely, candid and professional manner)?

d. How promptly did the auditor alert the committee if they did not receive sufficient cooperation?

e. How well did the auditor inform the committee of current developments in accounting and auditing standards relevant to the College's financial statements and their potential impact on the audit?

Quality-of-Service Considerations

4. Assess the **quality of service** provided by the auditor. Some or all of the following questions may be relevant:

a. During the audit, how well did the auditor meet the agreed-upon performance criteria, such as the engagement letter and audit scope? How well did the auditor meet its commitments, for example, by meeting agreed-upon performance delivery dates and multiple reporting deadlines and by being available and accessible to management and the committee?

b. How would you assess the professionalism of the auditors?

c. How responsive and communicative is the auditor, for example, in soliciting input relative to business risks or issues that might impact the audit plan?

d. How proactive is the auditor in identifying opportunities and risks, for example, by anticipating and providing insights and approaches for potential business issues and improving internal controls?

e. How would you assess the value for money delivered by the audit; for example, do the audit fees fairly reflect the cost of the services provided given the size, complexity and risks of the entity and a cost-effective quality audit?

f. How would you assess the reasonableness of the explanations for any changes to fees (for example, change in scope of work) communicated to the committee?

Canadian Public Accountability Board (CPAB) Inspection Findings

5. If relevant, assess the implications of CPAB inspection findings on the audit's quality.
Some or all of the following questions may be relevant:

a. If CPAB performed an inspection of the College's audit, were there significant inspection findings?

b. If so, how has the auditor responded? Has there been an appropriate response to address the key issues in the current year?

c. Has the auditor changed the future audit approach to improve the audit in future years?

Are there further items that the committee needs to consider?

1.

2.

3.

Part 5– Conclude the Annual Assessment and Communicate the Results to Council

Completed by: Audit Committee

This section of the tool sets out considerations about the committee's conclusions from the annual assessment and how the committee will record and communicate the results.

This part is intended to help the committee conclude the results of the annual assessment and recommend to the Council whether to reappoint the auditor for a further year. It is also intended to help the committee consider how the results will be recorded and communicated.

Consider the following questions:

1. Has sufficient information been obtained to reach a conclusion?

2. What implications, if any, are there for the next review of the auditor?

3. How should the committee communicate the results to the Council — in written or oral form?

4. How are the results to be recorded for future?

Items to be raised with the auditor for follow-up or future changes (Should include Person Responsible for Follow-up)

1.

2.

3.

Potential future changes to the annual assessment or other committee process (Should include Person Responsible for Follow-up)

1.

2.

3.

Recommendation to Council:

Agenda #11.0

Report – Annual Outreach Activities

Presentation by Fiona Campbell, Senior Physiotherapist Advisor

REPORT TO COUNCIL- COMMITTEE ACTIVITY SUMMARY
(Q3) October, November, December

	# of Meetings		# of Cases Considered	# of Appeal Decisions Received (HPARB or Divisional Court)	Type of Outcomes		Q3 2018/19
	F2F	Tel					
Registration	1	0	2	0	Certificate Granted (with or without terms, conditions and limitations)		0
					Certificate Denied		1
ICRC	3	1	29	3	Direction provided to staff (case ongoing)		5
					Investigator appointed		5
					Referral to Discipline		4
					Incapacity Inquiry or Referral to Fitness to Practice		0
					Other decision		15
Quality Management	0	0	0	0	Practice Assessment	Successfully Completed (with or without recommendations)	0
						Practice Enhancement Required	0
					Practice Enhancement	Successfully Completed	0
						Second Practice Enhancement or Reassessment Required	0
						Practice Enhancement Rescinded after Submission	0
					Other Decision		0
					Requests for Deferral or Exemption	Granted	0
						Denied	0
Discipline ** deliberation days not included**	2	3	5	0	**Hearings Pending**		11
					Hearing Outcomes	Revoked	0
						Suspended (with or without terms, conditions and limitations)	2
						Terms, Conditions and Limitations only	0
						Other Adjourned indefinitely In progress	3
Fitness to Practice	0	0	0	0	**Hearings Pending**		0
					Hearing Outcomes	Revoked	0
						Suspended	0
						Terms, Conditions and Limitations	0
Patient Relations	0	0	0	0	**Request for Funding**	Granted	0
						Denied	0

REPORT TO COUNCIL- COMMITTEE ACTIVITY SUMMARY
(Q3) October, November, December

ISSUES AND TRENDS

Registration – Nothing to report

ICRC – Nothing to report

Quality Assurance – The Committee did not meet in Q3 because there were no cases to consider from the earlier program.

Discipline and Fitness to Practice – Nothing to report

Patient Relations – Nothing to report

COLLEGE OF PHYSIOTHERAPISTS of ONTARIO | ORDRE DES PHYSIOTHÉRAPEUTES de l'ONTARIO

EXECUTIVE COMMITTEE MEETINGS

REPORT TO COUNCIL

Date: March 22, 2019

Committee Chair: Mr. Gary Rehan, President

Committee Members: Mr. Darryn Mandel
Ms. Theresa Stevens
Mr. Tyrone Skanes
Ms. Sharee Mandel

Support Staff: Mr. Rod Hamilton
Ms. Elicia Persaud

Meetings:

Meetings held since last report:

- January 2, 2019 – *teleconference*
- March 1, 2019

Planned upcoming meetings:

- June 4, 2019

JANUARY 2, 2019 EXECUTIVE COMMITTEE TELECONFERENCE MEETING

1. **Committee Slate Amendments**

   The Executive Committee recommended that Council make the following amendments to the committee slate:

   - Discipline and Fitness to Practise Committees –appoint Ken Moreau and Jennifer Dolling in place of James Lee and Zita Devan
   - Quality Assurance Committee – appoint Ken Moreau in place of James Lee
   - Quality Assurance Working Group – appoint Jane Darville in place of James Lee
   - Finance Committee – appoint Ken Moreau in place of James Lee, and appoint Gary Rehan as Chair
   - Inquiries, Complaints, and Reports Committee – Remove Ken Moreau

MARCH 1, 2019 EXECUTIVE COMMITTEE MEETING

1. **By-laws and Governance Policies Review**

   The Executive Committee directed staff to bring forward a list of recommended priorities for the review at their next meeting.

2. Council Education Practices

The Executive Committee directed staff to explore alternative approaches to council education practices and bring forward recommendations at the June Executive Committee meeting. The committee also directed staff to add a "Respect in the workplace" training session to the March Council meeting.

3. Conference Attendance 2019-2020

The Executive Committee approved the attendance of the following councillors at the educational conferences listed below:

- Ontario Physiotherapy Association (OPA) Conference: Lisa Tichband
- American Physical Therapy Association: NEXT Conference: Theresa Stevens
- Council on Licensure Enforcement and Regulation (CLEAR) International Congress: Nicole Graham
- Council on Licensure Enforcement and Regulation (CLEAR) Annual Education Conference: Gary Rehan
- Canadian Network of Associations of Regulators (CNAR) Conference: Ken Moreau and Janet Law
- Federation of State Board Physical Therapists (FSBPT): Tyrone Skanes
- Society of Adjudicators and Regulators (SOAR): Ron Bourret

4. Program Review – Entry to Practice

The Executive Committee recommended that Council approve the addition of $75,000 to budget line 5904– Consultant Fees, to do a preliminary review of the Entry to Practice Program.

5. Budget 2019-2020

The Executive Committee recommended that Council approve the General and Capital Budget for 2019-2020.

6. Auditor Evaluation Tool

The Executive Committee supported the Finance Committee recommendation and recommended that Council approve the auditor evaluation tool.

7. Non-Council Appointment Process/Term Limits and Vacancy

The Executive Committee recommended that Council approve the non-council appointment process and develop a pool of six non-council committee members for future consideration.

Agenda #13.0

Member's Motion/s