CPSBC Bylaws Consultation – Group Three
The following table compares the draft bylaws under the Health Professions and Occupations Act (HPOA) and the existing bylaws under the Health Professions Act (HPA) and provides a high-level summary of the changes under Group Three. Regulatory colleges, such as CPSBC, are required to review and update their bylaws to reflect the provisions of the HPOA. This document highlights Doctors of BC's concerns related to the HPOA, as reflected in CPSBC's draft bylaws, as well as concerns related to CPSBC's interpretation of the HPOA. These concerns are distinct and described in our analysis as appropriate.

This document will be updated based on our ongoing review and analysis of CPSBC's draft bylaws and as new information becomes available.

Public Protection			
Bylaws under the HPOA	**Existing bylaws under the HPA**	**Summary of Changes**	**Key Concerns**
Division 1 - Discipline for administrative matters • The registrar may dispose of an administrative matter. When doing so, the registrar must deliver notice of the proposed disposition to the respondent and provide an opportunity to be heard, which may be in writing. • Alongside the registrar, the Investigation Committee is responsible for managing disciplinary orders related to administrative matters. The registrar is required to provide a copy of an order to investigation Committee with the reasons for the order, what information has been delivered to the respondent, and the respondent's disciplinary record and capacity summary, if applicable. • Respondents may request a review of a disciplinary order no more than 30 days following its receipt. This request must be sent to the Investigation Committee, who must provide the respondent with an opportunity to be heard. • After completing their review, the Investigation Committee must provide a copy of their assessment to the registrar. The review decision with reasons must then be shared by the registrar to the respondent. Division 2 – Discipline of health profession corporations • Notice of a proposed disciplinary action is provided by the Permit Committee to the registrar, who is then responsible for serving a written notice to the health profession corporation. • The Permit Committee is entitled to proceed with the hearing in the absence of a representative of the health profession corporation, upon proof that written notice was provided. • The respondent and CPSBC have the right to cross-examine witnesses and call evidence. • The Permit Committee must provide a copy of its decision on the disciplinary action to the registrar with directions, if any, regarding notice to the public as soon as practical. The registrar	Section A – Complaint Handling and Discipline • Investigations are handled by the inquiry committee and disciplinary committee. • The inquiry committee must carry out an investigation by directing the registrar to investigate a matter. • The registrar, or any other person designated to investigate a matter on the registrar's behalf, may meet with the complainant, the respondent and any other person the registrar considers necessary. • If a complainant and respondent agree, the inquiry committee may attempt to resolve a complaint or other matter under investigation through an alternative dispute resolution. Alternative dispute resolutions may include negotiation and mediation. • The terms of any agreement reached between the College and the respondent through alternative dispute resolution are subject to the approval of the inquiry committee. • Includes a provision on "undertaking and consent," which includes any consent to a reprimand or other action made by the respondent. • The registrar can issue citations for disciplinary hearings. The registrar may amend the citation after it's been issued but before a hearing is convened. At any time, a discipline committee panel may amend the citation. Respondents must be notified if an amendment is made. • A discipline committee panel may make an order that the public, in whole or in part, be excluded from the hearing or any part of it if the discipline committee panel is satisfied that such an order is appropriate in the circumstances, and, in determining whether such an order should be made, the discipline committee panel may, without limitation, consider ○ (a) whether avoiding public disclosure of personal, confidential, financial or other information outweighs adhering to the principle that hearings be open to the public, ○ (b) whether a person involved in a criminal proceeding may be prejudiced,	• CPSBC will continue to investigate and manage complaints filed against licensees. However, complaints where the Investigation Committee is requesting a citation from the director of discipline will be managed under the Office of the Superintendent of Health Profession and Occupation Oversight and its discipline tribunal. • The CPSBC's Investigation Committee is now responsible for managing the investigation of complaints as the inquiry and discipline committees no longer exist. • There are three different processes for managing complaints: ○ Administrative matters concluded by the registrar where the licensee is alleged to have breached an undertaking, a discipline order or a duty as defined in the HPOA. ○ The registrar has authority to conclude a complaint matter that does not meet the threshold of misconduct, lack of competence or lack of capacity with the consent of the licensee, which may include discipline without referral to the Investigation Committee. Complaint matters that do meet the threshold may be summarily disposed of by the registrar with discipline, with the consent of the licensee, without referral to the Investigation Committee. ○ Complaint matters can be referred to the Investigation Committee • CPSBC can initiate an investigation based on information from any source. • Complainants can apply for partial or full identity protection orders. The Investigation Committee can terminate an investigation if they determine that they cannot proceed with an identity protection order in place. • The Investigation Committee may take extraordinary action, now referred to as a "summary protection order," such as placing limits or conditions on a licensee's practice, to	• There are many terms used in the draft bylaws that are defined in the HPOA but not the bylaws themselves. This challenges the reader's understanding and interpretation of the bylaws if they have not carefully read the HPOA. • Under Division 2 of the draft bylaws, the Permit Committee is entitled to proceed with a hearing in the absence of a representative from the health profession corporation if they fail to appear or provide a written submission by the specified deadline. Unlike other provisions, this bylaw provision does not outline a specified number of days (e.g., 30 days), which could permit the setting of arbitrary deadlines for respondents. • Under Division 3, registrants may now be subject to participate in a CPSBC compliance program, which monitors licensees for contraventions of the HPOA. The concept of a compliance process seems to be included by CPSBC beyond what is required by the HPOA. For example, the HPOA speaks to an "oversight process" but does not go as far as the compliance program described in these bylaws. • Registrants may be required to participate in the compliance audit process. The compliance program assessor may specify the time periods within which the licensee must comply with the requirements of the compliance audit process, which could disrupt physicians' business/practice. • Under Division 4, the registrar can withhold all or some information with respect to a complaint against the respondent. Though the registrar must justify why sharing information may compromise the investigation, it could challenge a respondents' ability to adequately respond to the complaint and any claims made against them. • In the context of assessing a regulatory complaint, the registrar and Investigation Committee can review a respondent's disciplinary record and capacity summary. However, there is potential that this information could bias decision-making. • While the bylaws provide licensees the opportunity to challenge and respond to various orders and reports, further clarity is needed to confirm if the

must then deliver written notice of the disciplinary action decision with reasons to the respondent. Division 3 – Monitoring regulatory compliance • The CPSBC compliance program may engage in activities to monitor licensees for contraventions of the HPOA and the College bylaws, including practice and ethics standards. • The CPSBC compliance program's activities may include: ○ recommending materials for CPSBC publication, including materials to educate licensees about their requirements, ○ collaborating with other colleges, government agencies, public bodies, professional associations, and other organizations to share information and coordinate efforts to monitor licensees for contraventions, ○ periodically and selectively monitoring online platforms, social media, websites, and other public media or resources to identify potential contraventions by selected licensees or licensees generally, ○ periodically requiring licensees to provide self-assessment reports to confirm their awareness of the Act ○ determining criteria to select licensees for compliance audits of aspects of their practices, ○ determining criteria to defer or exempt selected licensees from compliance audits from time to time ○ determining the scope of, and performing, compliance audits, ○ appointing one or more CPSBC employees, contractors, or subject matter experts as assessors to conduct or participate in compliance audits, ○ seeking information from any source to determine if a licensee's practice contravenes the Act, ○ identifying potential contraventions by licensees, and providing such licensees an opportunity to respond, and ○ providing compliance and contravention reports to the registrar who may refer such matters to the quality assurance	○ (c) whether the safety of a person may be jeopardized, and ○ (d) whether matters involving public security may be disclosed. • A discipline committee panel may make such orders it considers necessary to prevent the public disclosure of matters disclosed at a hearing, including orders prohibiting publication or broadcasting of those matters. The public can also be excluded from a part of the hearing. • A discipline committee panel may make any orders it considers necessary to ensure that the proper respect is afforded to the hearing process by members of the public attending the hearing, and to reasonably limit the number of seats in the hearing room. • Where a discipline committee panel by a unanimous or majority report makes a finding, the discipline committee panel must consider the issue of punishment and costs after the respondent is given at least 14 days' notice of the time and place of the hearing. • During any period of suspension from practice, a registrant must: ○ (a) not engage in the practice of medicine in BC, ○ (b) not hold himself or herself out as being a registrant entitled to practise, ○ (c) not hold office in CPSBC, ○ (d) not make appointments for a patient or prospective patient, ○ (e) not contact or communicate with a patient or prospective patient, except ○ (f) remove his or her name and any sign relating to his or her practice of medicine from the medical premises and the building in which the medical premises are located unless exempted by the registrar, ○ (g) prominently display a notice of suspension, in a form and in an area approved by the registrar, and ○ (h) surrender any certificate of registration and licence to practise medicine issued by the College. • A registrant suspended from practice is not entitled to a refund of the annual fee for the portion of the suspension or of any special assessment that the registrant has paid.	protect the public while a complaint is being investigated. • A complaint that does not result in a discipline order is considered dismissed. This includes complaints where the allegations don't meet the threshold of misconduct, complaints where the respondent is not found to have committed misconduct, and those that conclude with advice or warning. • Complaint matters that are referred to the Investigation Committee may also be concluded with consent agreements of the respondent, disciplinary orders for a restorative process, or imposed orders for the respondent to undergo remediation, training or education. • In all cases where sexual abuse is alleged, the Investigation Committee may not dispose of the complaint without the approval of the director of discipline. • The Investigation Committee may order a competence assessment. • The board authorizes the registrar to administer a CPSBC compliance program[1]. This includes a "compliance audit process," which licensees must participate in and cooperate with.	right to be heard in advance applies across all situations, including before an identity protection order is made. • Under Division 6, only some of the investigative powers provided to the Investigation Committee are referenced in the bylaws. Others can be found under section 127 of the HPOA. Incomplete information in the bylaws on the powers of the different bodies could limit licensee's understanding on the bylaws, what powers can be used against them, as well as what they are entitled to. • One of the provisions is called "dispositions with or without consent" and describes what the Investigation Committee may consider when completing an assessment. However, consent is not actually mentioned in the text of the provision and further clarity may be needed. • Division 8 does not provide physicians the opportunity to be heard prior to a summary protection order, only once it has been delivered to the respondent as part of the reconsideration process. In addition, the bylaws don't state that reconsideration can be made more than once. However, the HPOA suggests that a respondent can challenge the decision multiple times. • Under Division 9, "The Investigation Committee may request a citation based on the public interest in disposing of a matter with a hearing despite a provisional assessment that CPSBC may not discharge the burden of proof." Adding this wording creates confusion on when a citation could be requested and how it is determined that requesting the citation (without being able to discharge the burden of proof) is in the public interest. • Both Division 3 (monitoring regulatory compliance) and Division 12 (unauthorized practice and title use) allow for the monitoring of online platforms, social media, websites and other resources to engage in surveillance of licensees. It is important to note, that online monitoring has been included at the discretion of the College and is not mentioned in the HPOA.

[1] The CPSBC compliance program may engage in activities to monitor licensees for contraventions of the Act, Regulations, and these Bylaws, including practice and ethics standards.

program or initiate a regulatory complaint. • A licensee who is subject to a compliance audit must participate in, and cooperate with, the compliance audit process. • Requirements to participate in the compliance audit process may include: ○ completing and submitting a compliance audit questionnaire, ○ responding to requests and answering all questions in a prompt and complete manner, ○ providing access to all requested information, files, and records in the licensee's possession or control, including but not limited to information, files, or records related to the licensee's compliance with the applicable requirements for licensure, quality assurance, and practice and ethics standards, ○ attending one or more interviews with the assessor, either in person or by electronic means as directed by the assessor, which interviews may be recorded by the assessor by audio and/or video, and ○ facilitating office and site visits, in person or by electronic means, by the assessor or any person designated by the assessor, including taking reasonable steps to arrange for office and site access. Division 4 – Complaints, reports, and initiating investigations • Outlines requirements for regulatory reports and regulatory complaints. • Upon making or receiving a regulatory complaint, the registrar must review the respondent's disciplinary record and capacity summary, if any. • After providing information regarding a regulatory complaint to the Investigation Committee, the registrar must deliver a copy of the regulatory complaint or a summary of it, and may deliver all or some of the information and records obtained with respect to the complaint, to the respondent as soon as practicable unless the registrar has reasonable grounds to believe that doing so at any time before completion of the investigation risks harm to any person, or a material loss of evidence. Division 5 – Identity protection			

• An application for reconsideration can be submitted in the specified form to the registrar no later than 30 days following receipt of the notice of intent to take action or a termination order.
Division 6 – Investigations of fitness and misconduct
• The Investigation Committee may establish and prioritize investigative goals.
• Investigators can order competence assessments for respondents to evaluate one or more of the following:
  ○ the respondent's clinical performance of the designated health profession,
  ○ the respondent's knowledge and understanding of the regulatory requirements applicable to the practice of the designated health profession, including practice and ethics standards, and anti-discrimination measures, and
  ○ any other aspect of the respondent's practice which will assist in assessing whether the respondent is competent to practice the designated health profession.
• Unless a regulatory complaint has been dismissed, an investigator must provide a copy of the final investigation report to the registrar and Investigation Committee.
• The registrar may provide a copy of all or part of the final investigation report to the complainant, if any, and must provide the final investigation report to the respondent for response before the Investigation Committee determines whether there are reasonable grounds to believe that the respondent lacks competence or has committed an act of misconduct.
Division 7 – Capacity evaluations
• The registrar is authorized to exercise the powers and perform the duties of a capacity officer. The Investigation Committee and licensees can also direct or conduct an assessment for a capacity evaluation.
• A licensee conducting an assessment for a capacity evaluation must submit a written report to the capacity officer identified by the registrar if the respondent, who is the subject of the assessment, fails to cooperate with all or any part of the assessment.
• Licensees can conduct assessment reports. A written assessment report should include:
  ○ a summary of the concerns that formed the basis for the assessment,			

○ a description of the respondent's practice context and the context in which the concerns arose, ○ a description of the assessment process, ○ a summary of the information obtained from interviews and other sources, ○ the licensee's professional opinion regarding whether the respondent's capacity is impaired by a health condition and, if so, whether the nature or extent of the impairment may present a current or imminent significant risk of harm, and any recommendations to mitigate that risk, ○ recommendations for treatment, education, reassessments, interventions such as training, coaching, or mentoring, or other steps to restore or ensure continued capacity, recommendations for ongoing monitoring to ensure continued capacity, ○ recommendations for limits or conditions on the respondent's licence to ensure public safety, and recommendations on what should be required to end monitoring. • If the capacity officer has reasonable grounds to believe that the respondent lacks capacity, they must provide written notice, which must include: ○ a summary of the professional opinions and recommendations contained in the assessment reports, ○ the reasons for considering making a continuing practice order or a revocation order, as applicable, ○ the time frame in which the respondent may provide additional information and records and/or request changes to the order being considered, and ○ notice that the continuing practice order or revocation order, as applicable, may be made if no further additional information or records are provided or no request is made to change the order being considered within the specified time frame. • Respondents subject to revocation orders can apply for reconsideration by the capacity officer no more than 30 days following receipt of the order. • The capacity officer must conduct a reconsideration upon receipt of a request and			

must provide the respondent an opportunity to be heard. Division 8 – Summary action or disposition during investigations • When considering whether to make a direction for a summary protection order based on a significant risk of harm, the Investigation Committee must consider whether there is a prima facie case for incompetence or misconduct or whether there is a significant and immediate risk of harm to any person. • The Investigation Committee may direct that the summary protection order contains one or more limits or conditions on a respondent's practice, such as: ○ a requirement that the respondent practice under supervision or under the direction of a practising licensee approved by CPSBC, ○ a requirement that the respondent practice only in the presence of a chaperone approved by CPSBC, ○ a restriction on how the respondent practises an aspect of their profession, including but not limited to a condition that a respondent practise only after disclosing specified information to patients and posting signage as directed by the registrar, ○ a restriction limiting the classes of patients to whom the respondent may provide health services ○ a restriction limiting the scope of health services the respondent may provide, ○ a requirement to comply with periodic and/or random practice audits on terms specified by CPSBC, and ○ such other limits or conditions the Investigation Committee considers necessary and appropriate to protect the public from a significant risk of harm. • The Investigation Committee may consider several regulatory goals when completing their assessment of a regulatory complaint, including: ○ denouncing misconduct, and harms caused by misconduct, ○ preventing and discouraging future misconduct or incompetence by rehabilitating the respondent through corrective measures, ○ preventing and discouraging future misconduct by other licensees,			

○ educating the respondent, licensees, and the public about standards and other requirements of licensees and maintaining public confidence in the professions governed by CPSBC. • The Investigation Committee can order a suspension of a respondent's practice, in which the respondent may elect to either arrange for another licensee to manage the practice (e.g., locum) or cease practice during the suspension period. During the suspension period, the respondent may not profit financially from their practice and must inform their patients, staff, and others specified in the order. • During a suspension period, the medical records of each patient must be transferred to an approved licensee, patients must have access to their own records, and the registrar must be notified of the location of the records. • Expenses related to an investigation can be ordered to be paid by the registrant. Division 9 – Request for citation • Outlines considerations for requesting a citation be issued by the director of discipline, including the nature and seriousness of the allegations, need to protect the public from harm and discrimination, and the respondent's disciplinary record and capacity summary, if any. • Provides considerations for when CPSBC would likely discharge the burden of proof at a discipline hearing. • The Investigation Committee may request a citation based on the public interest in disposing of a matter with a hearing despite a provisional assessment that CPSBC may not discharge the burden of proof. • The registrar is responsible for proposing the content of a citation in consultation with the Investigation Committee. Division 10 – Review of discipline tribunal orders • The registrar is responsible for determining whether to proceed with administrative and judicial reviews to the director of discipline. Division 11 – Enforcement of disciplinary orders • The registrar is responsible for establishing a process for the enforcement of disciplinary orders. The registrar may also recommend that the Licence Committee or Permit Committee attach limits or conditions to enforce an order. This may occur in lieu of enforcing a bylaw fine. Division 12 – Unauthorized practice and title use • The registrar can administer an unauthorized practice monitoring program. The program can			

exercise the same powers as CPSBC's compliance program. • The identity of individuals who make reports to the monitoring program will remain confidential unless disclosure is necessary to proceed further under the Act. Schedule X Outlines Investigations and disciplinary tariffs, including the rate of indemnity for each expense.			
CPSBC Administration			
Bylaws under the HPOA	**Existing bylaws under the HPA**	**Summary of Changes**	**Key Concerns**
In keeping with the HPOA: • The registrar may appoint an employee or contractor to assist CPSBC with initiatives relating to reconciliation with Indigenous Peoples. • The deputy register is authorized to perform all duties of the registrar without limitation if the registrar has a conflict of interest or is otherwise unable to act or provide direction. • The registrar may appoint additional deputies. • There are new provisions related to conflict of interest. Additional bylaw provisions developed by CPSBC: • Each fiscal year, the board must: ○ (b) set limits or conditions on the registrar's authority to make financial commitments on behalf of CPSBC, and ○ (c) approve a contingency reserve fund policy. • The registrar may raise money, guarantee or secure the payment of money, in the name of CPSBC. • An auditor must conduct an audit of CPSBC's financial statements no later than 60 days after the end of each fiscal year.	Section B – College Administration • Besides the additions noted left, the College's existing bylaws are like the proposed bylaws under the HPOA.	In keeping with the HPOA: • Reconciliation with Indigenous Peoples is a guiding principle of the HPOA and must be integrated in health profession oversight/governance. The registrar's authority to appoint an individual to assist with advancing cultural safety and eliminating anti-indigenous racism is specified. • Boards are required to make bylaws with respect to conflict of interest. These bylaws must be in relation to board members, officers, employees and the registrar of a regulatory college. Indigenous identity is not a presumptive source of conflict. CPSBC has revised several existing bylaws to specify the registrar and board's fiscal authorities and responsibilities, including: • The ability to set limits or conditions on how CPSBC operates each fiscal year. • More specificity to the auditing process. • Inclusion of a provision related to borrowing, which permits the registrar to raise money, guarantee, or secure the payment of money, based on board direction, and in the name of CPSBC.	• The draft bylaws may lead to an increase in costs for licensees, as it's unclear how funds will be raised in the name of CPSBC and could include an increase in fees for physicians.
General			
Bylaws under the HPOA	**Existing bylaws under the HPOA**	**Summary of Changes**	**Key Concerns**

• A board may make bylaws establishing special fees payable by licensees to enable CPSBC to:
  ○ Properly conduct governance activities
  ○ Make a commitment for or pay for an extraordinary expenditure.
• The board may not levy a special fee that will raise a total aggregate amount that is greater than needed.
• The board can levy a special fee on all or any class of licenses.
• CPSBC may charge fees for reconsideration and review applications.
	• Under Schedule "A," the board may establish special fees to be paid by a registrant, certified non-registrant, or an applicant for registration.	• CPSBC has authority to establish special fees and additional administrative fees.
		• More specificity is provided for when (in what circumstances) the board may establish special fees.
		  • Introduces a new fee for application reviews and reconsiderations.
			• Potential for additional special and administrative fees to be imposed on licensees. The reconsideration and review fee amount is not listed, while administrative fees will be $50.

Interpretation			
Bylaws under the HPOA	**Existing bylaws under the HPOA**	**Summary of Changes**	**Key Concerns**
• The draft bylaws provide new definitions that apply across all parts of the Bylaws. • The full list of definitions can be found here: Interpretation.	N/A	• While many of the concepts/definitions remain the same, several new definitions have been developed to reflect the provisions in the HPOA. • The College has developed separate definitions for actual, potential, and perceived conflict of interest. It is important to note that the definitions on conflict of interest do not apply to licensees. • "Good standing" is now defined with respect to licensees and health profession corporations. However, the HPOA only references good standing with respect to corporations. • "Private interest" is defined but only applies to "responsible persons" and not licensees – unless they are a member of a committee. Responsible persons refer to board members, committee members, or employee of CPSBC as applicable.	• The list of definitions is not exhaustive as it does not include all new concepts introduced across the bylaw groups to date.
Bylaws under the HPOA	**Existing bylaws under the HPA**	**Summary of Changes**	**Key Concerns**
Division 2 – NHMSFAP Committee • The language has been revised under the draft bylaws but there are no significant changes for the NHMSFAP Committee. As per the "Committee" bylaws released under Group 1: • The Non-hospital Medical and Surgical Facilities Accreditation Program Committee must consist of at least six persons appointed by the board, and must include: • an anesthesiologist, a surgeon and another licensee who performs invasive procedures, • a person recommended by one or more of the health authorities in British Columbia, and a person recommended by the Ministry of Health. • The number of public representatives on the Non-hospital Medical and Surgical Facilities	The responsibilities of the committee are: • to impose such administrative penalties, fines and costs as is appropriate for the breach of or failure to comply with the Bylaws or standards, • to receive patient safety incident reports from facilities and where necessary make recommendations or give direction to facilities, to assess and resolve all matters coming before it, or, where necessary, to refer to the board or its committees with any recommendations it sees fit, and • to keep records of the receipts and expenditures in a manner approved by the board.	• NHMSFAP is an existing committee. • As referenced in our analysis of Group 1, NHMSFAP is a Statutory Committee under the HPA but is now considered an Additional Regulatory Committee under HPOA. Such committees are not required under the HPOA but are established as the board sees fit. • There have been minor changes in committee responsibilities. This includes the information in column 2 under "existing bylaws under the HPA", which highlights the activities that have been removed from the new bylaws.	• N/A

Accreditation Program Committee must constitute at least one-third of the total number of persons on the committee.			
Division 3 - Provisional accreditation[2] • An applicant seeking provisional accreditation for a facility for more than one physical location must provide a completed application to the registrar for each proposed location. • An application for provisional accreditation for a new facility must be submitted to the registrar and include: • Information (including contact information) confirming the identity and legal name of the proposed medical director for the facility • Information on licensure status and regarding the ownership of the facility • information regarding any other physical location for which a certificate of provisional or full accreditation is held or will be sought, including ownership of the facility at such other location, information confirming the facility meets the requirements for provisional accreditation set out in these Bylaws and all patient safety accreditation standards and substantially meets all other requirements for accreditation set out in the accreditation standards, • consent to participate and cooperate with pre-accreditation inspections of the facility at the facility's cost during the application process. • Upon receiving a completed application for provisional accreditation, the NHMSFAP will schedule an inspection of the facility. NHMSFAP has the discretion to schedule a further inspection if the facility does not meet the requirements for provisional accreditation, including patient safety accreditation standards. • The certificate of provisional accreditation must state the term of provisional accreditation, which must not exceed two years, identify the physical location, list each procedure and technology authorized, and set out limits and conditions. • The term can be extended at the NHMSFAP's discretion for up to one year in extenuating circumstances.	Part 5, Section A • The medical director and owner of a new facility must apply to the NHMSFAP committee for accreditation. • The committee or persons appointed by the committee must carry out an on-site assessment and can grant the facility a provisional accreditation or deny accreditation. • Provisional accreditation can be granted to a diagnostic facility following an on-site inspection. • Applications are submitted to the NHMSFAP. • Inspections of facilities may be conducted at any time. • The NHMSFAP Accreditation Manual provides more information on accreditation, including provisional accreditation. • NHMSFAP accreditation involves a formal assessment against all appropriate NHMSFAP accreditation standards once every 46 to 48 months. The outcome of the assessment is reviewed with the NHMSFAP Committee ("the committee"), who then decides on the accreditation award.	• There are now separate processes for applying for provisional versus full accreditation. • Provides greater detail regarding inspections. For example, the NHMSFAP must schedule a pre-accreditation inspection of the facility at a time agreed upon with the applicant and additional inspections may be conducted at NHMSFAP's discretion. Under the previous guidance, the inspection would occur once the facility was ready to open. • The NHMSFAP is now required to provide the proposed medical director with a report for response, following an inspection. • Allow for the term of accreditation to be extended up to one year in extenuating circumstances.	• Additional requirements for applications seeking provisional accreditation have been introduced, but it is unclear to what extent they will impact the application process. • While there is a definition for "equity interests" under Division 1, this term is not used elsewhere in the bylaws. More clarity is needed regarding what information must be provided with respect to owners of independent facilities and "their respective interests" and if this includes what falls under "equity interests." • Requiring a medical director to provide a response to the inspection report could create additional work.
Division 4 – Full accreditation • A facility must hold a certificate of provisional accreditation in good standing for a period of at	Part 5, Section A 5-3 • The medical director and owner must of a new facility must apply in writing to NHMSFAP for accreditation of the facility.	• Amendment to terms of accreditation processes are now outlined in separate divisions. • Subject to NHMSFAP's discretion, a facility with provisional accreditation in good standing must	• Placing a six month wait period is likely to delay the full accreditation of a facility. This is also subject to NHMSFAP's discretion, which could permit an eligibility period of longer than six months.

[2] "**Provisional accreditation**" means accreditation that is only provided for a new facility up to one year to be determined by the committee with the requirement that the facility be subject to a further on-site assessment prior to full accreditation.

least six months before it is eligible to apply for full accreditation. • The medical director for the facility must cooperate with an inspection, promptly answer questions and provide information and records requested by the NHMSFAP or the appointed inspector(s). They must also ensure that the facility is available for on-site inspection at any time during regular business hours. • The term can be extended at the NHMSFAP's discretion for up to one year in extenuating circumstances.	• After receipt of an application, NHMSFAP must carry out an on-site assessment. Full accreditation can be granted following the completion of the further on-site assessment for a period of 5 years, with or without the requirement for a further assessment during the term. • OR NHMSFAP can grant the facility an accreditation subject to a report and may include conditions on the accreditation to allow the facility to comply with any outstanding requirements for full accreditation. • NHMSFAP may extend the term of the certificate of accreditation for an additional 5 years following review for reaccreditation. • The NHMSFAP Accreditation Manual provides more information on accreditation, including for full accreditation. • NHMSFAP accreditation involves a formal assessment against all appropriate NHMSFAP accreditation standards once every 46 to 48 months. The outcome of the assessment is reviewed with the NHMSFAP Committee ("the committee"), who then decides on the accreditation award.	wait at least six months before they are eligible to apply for a certificate of full accreditation. This waiting period and the ability for NHMSFAP to exercise discretion are not mentioned in the existing bylaws. • The NHMSFAP is now required to provide the proposed medical director with a report for response, following an inspection. • Allow for the term of accreditation to be extended up to one year in extenuating circumstances. • New inclusion of site -specific accreditation.	• Rather than the 'facility' more broadly, an application for full accreditation must be submitted by the medical director, which imposes additional requirements on physicians occupying that role.
Division 5 – Requirement for and responsibilities of medical director • Medical director must be licensee in good standing with CPSBC with the education, • credentials, qualifications, and experience required under the Medical Director Standard. • Immediate suspension of accreditation if the facility ceases to have a medical director. The facility's owner must cease operations until a new medical director is appointed. General responsibilities include: • ensuring only authorized procedures are performed by medical staff privileged at the facility. • Ensuring unregulated health service providers at the facility do not perform restricted activities. • ensuring the NHMSFAP Committee has access to all records relating to the operation of the facility and the procedures performed there, • conducting reappointments of all medical staff at the facility at least every two years and regularly documenting their performance at the facility, • ensuring proper supervision of licensed medical students, residents, or fellows at the facility by a qualified preceptor who holds privileges at the facility,	• The responsibilities of a medical director under the HPA are not substantially different from what is outlined in the draft bylaws, beyond what is mentioned under general responsibilities in the first column.	• Immediate suspension of accreditation if the facility ceases to have a medical director. • Expanded scope of responsibilities for medical directors managing under NHMSFAP.	• Meeting the Medical Director Standard may be challenging with limited resources. In addition, the expanded responsibilities could discourage physicians from taking on the role of medical director. • The immediate suspension of a facility in the absence of a medical director will have significant impacts on physicians, other staff, and patients.

• ensuring temporary medical staff are properly privileged before providing and/or receiving education at the facility, • reporting to the NHMSFAP Committee, in the specified form, at least annually or on request: information concerning the ownership of the facility, including any changes to ownership, including the name(s) of each owner and their respective legal and/or beneficial interest in the facility, and such other information and records as the NHMSFAP Committee may direct. • The medical director's responsibilities apply regardless of whether the medical director is also a member of the medical staff who performs procedures.			
Division 6: Continuity of Care • All medical staff practicing in a facility must ensure continuity of care for their patients. • Licensees are expected to admit and manage the patient as appropriate to the patient's condition.	Part 5, Section A 5-16 • Requirements for continuity of care remain unchanged between bylaws.	• There are no changes between the existing and draft bylaws.	• There are no changes between the bylaws; however, physicians should be aware that there are additional requirements related to continuity of care that are outlined in a separate policy document on the College's NHMSFAP webpage.
Division 7 – Inspections and Audits • NHMSFAP will schedule an inspection no less than every four years and prior to considering an application for a certificate of full accreditation. • Inspections can be at different levels of frequency for different classes of accredited facilities. • Medical directors must participate and be provided with an inspection or audit report.	Part 5, Section A 5-19 • Inspections may be conducted at any time and the facility must be available and open for inspection during normal business hours.	• NHSMFAP inspections must take place every four years.	• Given that the current bylaws don't outline how frequent facilities should be/ae inspected, it is unclear if this will greatly impact medical directors.
Division 8 – Renewal of certificate of full accreditation • The registrar must provide written notice to the medical director for the facility of the renewal process and the consequences of failing to renew at least six months' notice before the expiration of a certificate of full accreditation, including the requirement for pre-renewal inspection and access to the renewal application. • NHMSFAP may renew the certificate for the full accreditation period for up to five years. • If the renewal application is not submitted within 60 days of the expiration date, complete the renewal process and pay any applicable fees. • If within 60 days the medical director fails to complete process/pay late fees: certificate of full accreditation will expire, and the facility must immediately cease providing procedures. However, NHMSFAP can extend the term for up to one year to allow the medical director to	Part 5, Section A, 5-4 • College will deliver reaccreditation package prior to expiry of certificate (no timeline, clarity as to whether the package includes consequences of failure). • Term of accreditation can be extended pending decision on renewal up to five years, with or without requirement for further on-site assessment for the term of accreditation. • Committee can grant the facility accreditation subject to a report and can include limits/conditions or can deny accreditation.	Under draft bylaws: • 'Renewal' replaces 'reaccreditation'. • More clarity around process and timelines to inform medical director of renewal requirements. • Renewal to be submitted within 60 days of certificate expiry or be subject to fees. No timeline was previously provided in the bylaws. • No longer an option for committee to extend term of certificate pending decision (however can extend term of existing certificate by up to a year in extenuating circumstances to allow medical director to complete application – see Division 4). • New bylaws outlined that the term of a certificate of full accreditation can be extended up to one year. Failure to meet the requirements within 60 days will limit the facility to seeking provisional accreditation.	• The bylaws remove the option for NHMSFAP to grant facilities renewed accreditation subject to a report and limits/conditions to allow it to comply with any outstanding requirements. Under new bylaws, NHMSFAP can either only grant or deny accreditation, which may challenge the ability of some facilities to remain open, operate, and provide services to patients. • There is a lack of clarity on the process of when the NHMSFAP will respond to applications. There is no service standard/timeline mentioned in the draft bylaws, which could allow NHMSFAP long periods to respond prior to granting accreditation, requiring some facilities to potentially shut down.

complete the renewal process if extenuating circumstances apply. If they fail to meet the requirements, they must apply for a new certificate of provisional accreditation.			
Division 9 – Mandatory Notice Requirements • Medical directors must provide notice to the registrar within 14 days of any changes in information regarding the facility. • Medical director must provide prior written notice to registrar before appointment of new medical staff, or if any licensee, regulated health practitioner, regulated health service provider, or staff resigns, is terminated while under investigation, or has privileges restricted. • An accredited facility must obtain written authorization from the NHMSFAP before making a proposed change. • NHMSFAP cannot approve a proposed change to a procedure or technology that does not fall within the scope of the facility's certificate. • Medical director must report proposed construction/ renovation within 180 days in advance. • Must provide written notice at least 90 days before changes in ownership or location. • Medical director must provide written notice of patient safety incidents in accordance with Patient Safety Incident Reporting Standard, and give written notice within 48 hours of facility events that give risk to patient, staff or public safety (e.g., fire, flood) and immediately cease operations at facility until risk abated, passed inspection, registrar has provided written authorization to medical director that facility may resume operations.	Part 5, Section A 5-8 • The medical director must notify NHMSFAP if the facility intends to enter into a contract with a health authority or other this party regarding new or expanded medical procedures and programs. • The facility cannot enter a contract with a health authority or third party until NHMSFAP is satisfied. 5-9 • Major renovation plans must be reported in writing to the NHMSFAP at least 90 days in advance. • Medical director must report all patient safety incidents, including duty to report any death that has occurred within 28 days of a procedure in the facility. 5-10 • Medical director must notify the committee prior to any change in ownership.	• Removes the provisions related to health authority and third party contracting. • The draft bylaws now reference the Patient Safety Incident Reporting Standard, requiring medical directors to comply with its requirements. Of note, while the draft bylaw refers to this document as a "standard" it is currently published on CPSBC's website as a "policy." • Draft bylaws add in requirement for written notifications for any change in information within 14 days. Currently bylaws only require notice to be given of 'significant' changes. As well as, 90 days' notice of proposed change in ownership or location; 30 days' notice of closure; and within 48 hours of any event posing risk to patients, staff, or public. • New bylaws specify that operations must cease when there is any safety risk until inspection passed and written authorization of resumption received from registrar. Draft bylaws introduce time periods for written notice for change in ownership/location. • Draft bylaws provide additional details regarding applications for new or revised programs, procedures, or technology, and include provision to include expanding satellite services from existing physical location.	• Draft bylaws risk additional administrative burdens for medical directors to provide written notice within 14 days of what could be minor changes and for any changes in staff. • Draft bylaws do not include requirements for NHMSFAP to note receipt of such written notices, risking future bureaucratic and record discrepancies. • The requirement to report the intention to enter a contract with a health authority or other third party or to enter into an agreement which would increase the number of procedures performed at the facility has been removed. Since there is now no reference to this in the draft bylaws, it is unclear whether medical directors are still permitted to enter into a contract from a third party or if this is no longer possible. • The need for medical directors to report any changes in information could result in administrative burdens for what may be minor changes. • Clarity is needed on whether the "Patient Safety Incident Standard" has now become a standard or if it continues to stand as a "policy." This is important as accreditation standards are legally binding and it is unclear whether other documents (such as policies, guidelines, etc.) listed on the College's website are legally binding like a standard.
Division 10 – Application to amend certificate of accreditation. • A medical director can amend the terms of a certificate of provisional or full accreditation. • NHMSFAP may direct an audit or inspection at the facility's cost as part of the application. • Medical directors seeking to provide procedures/tech that are outside of the scope of their certificate must submit a new application for provisional accreditation.	• *Current bylaws do not include a dedicated provision related to amending a certificate of accreditation.*	• 5-6 of the current bylaws speaks to "revocation, suspension or change to the level of accreditation." However, this section does not mention amendments to terms of accreditation by the medical director, which is now introduced in the draft bylaws.	• N/A
Division 11- Clinical Trials • A medical director must provide written notice to NHMSFAP at least 90 days before permitting facility to conduct a clinical trial with records to show under research ethics board, information verifying procedure/technology falls within scope of certificate, information that confirms the	Part 5, Section A 5-17 • Clinical trials may be conducted at a facility if the investigative procedure is conducted under a properly constituted clinical trial with ethical oversight, there is no opportunity for the clinical trial to be conducted in an accredited hospital, and the committee has approved the procedure to be performed in the facility under the clinical trial.	• A medical director must now provide at least 90 days' notice to NHMSFAP prior to permitting a facility to conduct a clinical trial, alongside information that verifies that a clinical trial will be taking place. • NHMSFAP may in its discretion, issue a notice prohibiting a facility from conducting a clinical trial.	• The new requirement specifying the clinical trial process may lead to increased burdens for medical directors who may have to follow additional steps and may result in fewer facilities conducting clinical trials. • The draft bylaws indicate enhanced oversight related to the clinical trial process by NHMSFAP.

medical director has approved privileges of licensees, any additional information requested. • NHMSFAP can prohibit facility from conducting trial if the written notice/supporting records do not comply with requirements above.			
Division 12 – Imposition of limits, conditions, suspension, or revocation • NHMSFAP can amend, impose limits and conditions, or suspend or revoke a certificate of accreditation at any time based on reasonable groups, such as failing to comply with the certificate of provisional or full accreditation. • NHMSFAP must provide written notice to the medical director with the notice of proposed action and hearing. • The medical director can respond within 30 days following receipt of the written notice to provide written submissions or request an oral hearing. • If the medical director requests an oral hearing: the medical director and CPSBC may appear as parties with legal counsel, testimony of witnesses on oath, solemn affirmation, or culturally appropriate form of affirmation, and both parties have right to cross examine and call evidence. • If the medical director does not attend the oral hearing or fails to provide a written submission, NHMSFAP may proceed with a hearing on proof that written notice provided.	Part 5, Section A 5-6 • NHMSFAP can revoke, suspend, or change the terms of accreditation at any time if it is of the opinion that the facility did not comply with bylaws/standards; there are one or unacceptable patient outcomes; or a risk to patient care or safety. • Upon receipt of written notice, medical director can file a written request for review of decision by the board.	• Draft bylaws outline when limits and conditions may be imposed on a certificate or suspend or revoke a certificate. • New bylaws provide further information and details about medical director's options to challenge decisions.	• NHMSFAP can impose limits and conditions based on "one or more unacceptable patient outcomes at the facility," however this is not defined. While this language mirrors what is outlined in the bylaws under the HPA, there may be new implications for physicians given their lack of right to appeal.
Division 13 - Extraordinary Action (EA) • If registrar considers EA necessary to protect the public, they can impose limits/conditions or suspend a certificate. • Reasons must be provided to the medical director and the right to review. • The registrar's decision is not effective until the earlier of the time the medical director receives the decision, AND three days after the decision is mailed to the medical director at the facility address. • The medical director can request review of decision within 30 days at which time NHMSFAP will provide the medical director an opportunity to be heard. • After review, NHMSFAP may affirm the registrar's decision, vary the decision, or set aside the decision, and deliver the decision as soon as practical to the medical director.	Section A 5-6 (3) • If the registrar believes immediate action is required to protect the public, the registrar can impose limits or conditions on the procedures performed at the facility or suspend its accreditation. The decision must be delivered to the medical director in writing. Registrar can cancel limits or suspension if no longer believed to be necessary. • Medical director can request NHMSFAP review of decision within 30 days.	• Clarifies that written decision must include reasons provided to the medical director in writing. • If medical director requests review of decision, the committee must provide them with an opportunity to be heard, which may be in writing providing more transparency to extraordinary action decisions.	• The bylaws don't define extraordinary action. Without a clear definition, licensees could be subject to limits and conditions on their certificates without full understanding what could prompt an extraordinary action – a concept that is not mentioned or defined in the current bylaws as well.
Division 14 – Reconsideration of adverse decisions • A medical director or proposed medical director can request that the NHMSFAP reconsider adverse decisions. Following the reconsideration, the NHMSFAP can affirm, vary,	Section A 5-5 • A medical director may request a review on the record by the board of a final decision of the NHMSFAP.	• Draft bylaws remove opportunity to seek additional review by board of an adverse decision.	• The medical director is no longer able to seek recourse from the board, limiting their ability to challenge an adverse accreditation decision.

or set aside the adverse accreditation decision, and must deliver a written decision to the medical director.			
Division 15 – Change of ownership of facility • When NHMSFAP receives notice of proposed change of ownership, it can direct the medical director to provide additional information or records concerning the proposed change. If it determines that the proposed change in ownership requires an amendment to the certificate of provisional or full accreditation, it will provide notice to medical director. • If a medical director fails to submit an application for amendment or new certificate, NHMSFAP will provide notice of proposed action. Despite this, NHMSFAP may grant an exemption to the owner of the facility accredited on or before December 31, 2017, based on extenuating grounds.	Section A 5-10 • Change of ownership of a facility can terminate accreditation, requiring the facility to apply for new certificate (which will be treated as application for new facility)	• Draft bylaws allow option for NHMSFAP to decide to retain current accreditation despite change in ownership. Removing the automatic requirement for termination or application for new accreditation under new ownership could reduce administrative tasks for medical directors. • Introduction of allowance for facilities accredited prior to 2018. Unclear why this date has been specified.	• N/A
Division 16 – Accreditation Standards • Facilities need to comply with 62 accreditation standards relating to facility and clinical operations.	• Current accreditation standards, policies and position statements are listed on NHMSFAP web pages	• Continuity of care and patient safety incident reporting requirements are now specified in an accreditation standard.	• Without physician input, it is unclear if the addition of the two practice standards are reasonable or if they could contribute to operational strains.
Diagnostic Accreditation Program (DAP)			
Bylaws under the HPOA	**Existing bylaws under the HPA**	**Summary of Changes**	**Key Concerns**
Part 3 - Section 3-2.8 • DAP must consist of at least six persons appointed by the board, and must include (a) a pathologist, a medical imaging specialist and another licensee who performs diagnostic services, (b) a person recommended by one or more of the health authorities in British Columbia, and (c) a person recommended by the Ministry of Health. • (2) The number of public representatives must constitute at least one-third of the total number of persons on the committee. • (3) The function of the DAP is to assess, accredit and monitor accredited diagnostic facilities.	Section B- Diagnostic Accreditation Program • DAP has at least six board-appointed members, the majority of whom must be registrants and include at least one board member. • DAP must include a pathologist, medical imaging specialist, of whom one must be the chairperson, and one the vice-chairperson. Must also include a registrant who does not practice in a diagnostic facility, and a person recommended by the health authorities of the province. • Responsibilities include establishing performance standards to ensure the delivery of high quality and safe diagnostic services, monitor external proficiency testing programs, and to keep records of receipts and expenditures. • CPSBC publishes its DAP governance policy online.	• Registrant who does not practise in a diagnostic facility has been replaced with "licensee who performs diagnostic services." • Change of a language related to DAP composition from "a person recommended by all Health Authorities" to "a person recommended by one of more health authorities." • Addition of a person recommended by the Ministry of Health. • Requirement of Chair and Vice-Chair positions to be filled by pathologist and medical imaging specialist is removed. • The requirements to monitor external proficiency testing programs, and to keep records of receipts and expenditures have been removed from the draft bylaws.	• Addition of a DAP member recommended by the Ministry of Health is concerning regarding politicisation of decisions and the addition of another non-physician on the committee. • Since the requirement for the vice-chair to be a physician has been removed, both the chair and vice-chair could be non-physicians, limiting physician influence over DAP. • Removal of requirement for at least half the committee members to be licensees could result in a DAP monopolized by public representatives.
Division 18 – Provisional Accreditation • *Same summary of changes as outlined under Division 3. Criteria are the same for both DAP and NHMSFAP.*	Section B – Diagnostic Accreditation Program 5-26 • The current bylaws do not delineate between provisional and full accreditation. • The medical director must apply to the DAP for an initial assessment of the diagnostic facility or new diagnostic service within an existing or new accredited facility. • On-site inspection must be performed by one or more representatives of DAP and must ensure compliance with performance standards.	In addition to the changes outlined under Division 3: • The term 'medical director' replaced with 'applicant' (for provisional accreditations only), and as inspections are underway 'proposed medical director'. • Applications to go to registrar instead of DAP. • DAP has discretion to perform follow-up inspection if not all requirements met initially. • New requirement for applicants to be provided with inspection report for response.	In addition to the key concerns outlined under Division 3: • The existing bylaws and the information on DAP on the CPSBC website are misaligned. CPSBC should update its webpages to reflect any new guidance.

	• After on-site inspection, facility will be granted provisional accreditation for a period determined by the committee or denied accreditation.	• Certificates of provisional accreditation can have limits or conditions. • Draft bylaws impose limit of two years on certificate of provisional accreditation (current bylaws allow timeframe to be determined by committee, although website states two years validity).	
Division 19 – Full accreditation • *Same summary of changes as outlined under Division 4. Criteria are the same for both DAP and NHMSFAP.*	Section B – Diagnostic Accreditation Program • Before expiration of provisional accreditation, the facility must: ○ Provide any requested information to the committee and demonstrate it has performed enough procedures to permit a full on-site accreditation inspection. ○ Complete an on-site inspection. ○ If granted, full accreditation will be for three years, or such time as determined by DAP. ○ Facilities can be granted conditional accreditation for a period determined by DAP to allow it to comply with any outstanding mandatory requirements. ○ Accreditation is limited to a specific address or addresses. Where a diagnostic facility operates from more than one address, the application must include information about each address and the inter-relationship thereof.	• Full accreditation must be applied for by the 'medical director' (replaces 'facility') • Subject to DAP's discretion, a facility with provisional accreditation in good standing must wait at least six months before they are eligible to apply for a certificate of full accreditation. This waiting period and the ability for DAP to exercise discretion are not mentioned in the existing bylaws. • New requirement for inspector to provide report to medical director for response. • Reference to 'conditional accreditation' has been removed. • Term of full accreditation can be up to five years instead of three years. • Introduction of extension of accreditation for up to one year where there are extenuating circumstances. • Application and certificate limited to one "physical location" (replaces "specific address or addresses"). As such, a medical director seeking full accreditation for a facility for more than one physical location must provide a completed application to the registrar for each proposed location.	In addition to the key concerns outlined under Division 4: • The existing bylaws are misaligned with CPSBC's website under DAP, which states that 'accreditation awards' will be valid for five years, and subject to a four-year cycle of continuous assessment. • Requirement for applying for full accreditation now solely falls on the medical director, which could create additional work.
Division 20 – Requirement for and responsibilities of medical director • *Same summary of changes as outlined under Division 5. Criteria are the same for both DAP and NHMSFAP.*	• *The responsibilities of a medical director under the HPA are not substantially different from what is outlined in the draft bylaws. However, the bylaws under the HPA allow for an alternate medical director for DAP facilities.*	In addition to the changes outlined in Division 5: • Removal of requirement for alternate medical director.	In addition to the key concerns outlined under Division 5: • Without an alternate medical director, there are major risks to the operation of diagnostic facilities during personnel changes, which will have major disruptions for staff (including physicians) and patients with existing appointments.
Division 21 – Inspections and audits of accredited facilities • *Same summary of changes as outlined under Division 7. Criteria are the same for both DAP and NHMSFAP.*	Part 5, Section A 5-33 Inspections may be conducted at any time and the facility must be available and open for inspection during normal business hours.	• DAP inspections must take place to every four years.	• Given that the current bylaws don't outline how frequent facilities should be/ae inspected, it is unclear if this will greatly impact medical directors.
Division 22 – Renewal of certificate of full accreditation • *Same summary of changes as outlined under Division 8. Criteria are the same for both DAP and NHMSFAP.*	Part 5, Section A, 5-4 • College will deliver reaccreditation package prior to expiry of certificate (no timeline, clarity as to whether the package includes consequences of failure). • Term of accreditation can be extended pending decision on renewal up to five years, with or without requirement for further on-site assessment for the term of accreditation.	• *Same as outlined under Division 8.*	• The bylaws remove the option for DAP to grant facilities renewed accreditation subject to a report and limits/conditions to allow it to comply with any outstanding requirements. Under new bylaws, DAP can either only grant or deny accreditation, which may challenge the ability of some facilities to open and operate.

	• Committee can grant the facility accreditation subject to a report and can include limits/conditions or can deny accreditation.		
Division 23. Mandatory notice requirements In addition to the information outlined under Division 9: • The medical director must provide written notice to the registrar prior to: (c) expanding satellite services at the same physical location. • The medical director must provide written notice of patient safety incidents which occur in an independent facility to the registrar in accordance with the Patient Safety Incident Reporting Standard.	Section B – Diagnostic Accreditation Program Part 5, Section A 5-8 • The medical director must notify NHMSFAP if the facility intends to enter into a contract with a health authority or other this party regarding new or expanded medical procedures and programs. • The facility cannot enter a contract with a health authority or third party until NHMSFAP is satisfied. 5-9 • Major renovation plans must be reported in writing to the NHMSFAP at least 90 days in advance. • Medical director must report all patient safety incidents, including duty to report any death that has occurred within 28 days of a procedure in the facility. 5-10 • Medical director must notify the committee prior to any change in ownership	In addition to the changes outlined under Division 9: • Draft bylaws increase period of written notice prior to construction/renovation from 90 days to 180 days. Facilities are required to report to the DAP a proposed construction or renovation in advance of commencement of construction or renovation, and this may require submission of an application for a certificate of provisional accreditation.	In addition to the key concerns outlined under Division 9: • Requirement of a certificate of provisional accreditation when undertaking renovations could delay the construction and access to patient care.
Division 24. Application to amend certificate of accreditation • *Same summary of changes as outlined under Division 10. Criteria are the same for both DAP and NHMSFAP.*	*Current bylaws do not include a dedicated provision related to amending a certificate of accreditation.*	• *Same changes as outlined under Division 10.*	• *Same key concerns as outlined under Division 10.*
Division 25 Clinical trials In addition to what is outlined under Division 11: • A medical director of an independent facility must provide written notice to the DAP Committee at least 90 days prior to permitting an independent facility to conduct or participate in a clinical trial together with: (a) records that verify the clinical trial will be conducted under the oversight of a research ethics board acceptable to the DAP Committee, • (b) information that verifies the procedure or technology in the clinical trial falls within the scope of procedures or technology authorized by the facility's certificate of provisional or full accreditation, as applicable, • (c) information that confirms the medical director has approved the privileges of the licensee(s) who will perform or participate in the clinical trial, and • (d) such additional information or records the medical director is requested to provide.	Section B – Diagnostic Accreditation Program • DAP bylaws include no reference to clinical trials.	• There were previously no bylaws under DAP related to clinical trials.	• N/A

• Subsection (1) does not apply to: the provision of tests or procedures that are standard of care, or the provision of testing or procedures for patients involved in clinical trials that originate outside of the independent facility.			
Division 26 – Imposition of limits, conditions, suspension or revocation • *Same summary of changes as outlined under Division 12. Criteria are the same for both DAP and NHMSFAP.*	Section B – Diagnostic Accreditation Program • Accreditation of a diagnostic facility is limited to specific address or addresses, • DAP may revoke or change the terms of accreditation at any time during the period specified in the certificate of accreditation if it is their opinion that the change is warranted.	• *Same changes as outlined under Division 12.*	• *Same key concerns that are outlined under Division 12.*
Division 27 – Extraordinary action • *Same summary of changes as outlined under Division 13. Criteria are the same for both DAP and NHMSFAP.*	Section B – Diagnostic Accreditation Program • *Concept of extraordinary action is not referenced in current bylaws.*	• *Same changes as outlined under Division 13.*	• *Same key concerns that are outlined under Division 13.*
Division 28 – Reconsideration of adverse decisions. • *Same summary of changes as outlined under Division 14. Criteria are the same for both DAP and NHMSFAP.*	• A medical director may request that the committee review any decision denying accreditation to a facility or changing the terms of accreditation, by filing a written request for review with the registrar within 30 days after the date of the committee's decision. • A medical director may request a review on the record by the board of a final decision of the committee, by filing a written request with the registrar within 30 days after the date of the committee's final decision, but the decision of the committee will continue to be effective pending the review by the board.	• *Same changes as outlined under Division 14.*	• *Same key concerns that are outlined under Division 14.*
Division 29 – Change of ownership of independent facility • *Besides the addition of "independent" facility, the same summary of changes as outlined under Division 15. Criteria are the same for both DAP and NHMSFAP.*	Section B – Diagnostic Accreditation Program 5-23(c) • The medical director must promptly notify DAP of any change of ownership.	• *Same changes as outlined under Division 15.*	• *Same key concerns that are outlined under Division 15.*
Division 30 – Accreditation standards • All accredited facilities must comply with 17 accreditation standards.	Section B – Diagnostic Accreditation Program • To be granted accreditation, a diagnostic facility must meet the requirements as defined by the accreditation standards (not specified in current bylaws). • There are 6 categories of standards associated with DAP.	• The College has established new accreditation standards to capture the different certificate types (i.e., provisional vs. full).	• N/A
Bylaws applicable to NHMSFAP and DAP			
Bylaws under the HPOA	**Existing bylaws under the HPA**	**Summary of Changes**	**Key Concerns**

Division 31 – General • The medical director must pay non-refundable fees for applications for a certificate of provisional or full accreditation, related amendments, and an annual program fee. • Failure to pay an annual program fee within 30 days of the due date will result in the suspension or revocation of the certificate of provisional or full accreditation, as applicable. • The medical director is responsible for costs related to facility inspections, audits, assessments, clinical trial applications, and other fees.	• Applicants must pay annual dues and assessment fees that are set by DAP and approved by the board (similar for both programs). • NHMSFAP (not DAP) includes an option for facility to submit a written request for review of imposition of an administrative penalty and costs by the committee within 30 days of imposition. • Failure to pay NHMSFAP and DAP fees, administrative penalties and/or costs may result in revocation of accreditation.	• Draft bylaws add explicit statement that costs of facility inspections and assessments are borne by the facility. • Fees paid are explicitly non-refundable.	• Fees (and schedule in which they appear) are not yet set. We do not know if this will be substantially different from current fees and dues. • Draft bylaws remove option for facility to request review of NHMSFAP administrative penalty and costs. • Draft bylaws impose revocation or suspension if fees/administrative penalties/costs are not paid within 30 days of due date, changing from the potential revocation.
Division 32 - Disclosure of information • Where the registrar considers disclosure to be in the public interest in relation to any accredited facility, the registrar may, subject to the Act, these Bylaws and FIPPA, disclose any information about the medical director, medical staff, former medical director, former medical staff, the facility, or any other facility owned in whole or in part, by the facility owners, including but not limited to accreditation applications, accreditation decisions, and inspection reports, to the public. • Where the registrar considers disclosure to be necessary or advisable, the registrar may disclose any information about the medical director, medical staff, former medical director, former medical staff, the facility, or any other facility owned in whole or in part, by the facility owners, including but not limited to accreditation applications, accreditation decisions, and inspection reports, to: (a) one or more facility owners, health authorities, colleges and other regulators of health practitioners and health services providers in and outside of British Columbia, and (c) the Ministry of Health.	Disclosure of information subject to HPA and FIPPA • Disclosure of information clauses only within NHMSFAP (not DAP)	• Disclosure of information added to draft bylaws for DAP. • Change referenced from HPA to HPOA in draft bylaws.	• The NHMSFAP has authority to disclose information that is in the public interest, necessary or advisable in relation to any accredited facility, including information about the medical director, medical staff, former medical director, former medical staff and the facility, including but not limited to accreditation applications, accreditation decisions, and inspection reports. • While the bylaws outline that the information that can be shared is related to accredited facilities (e.g., applications, inspections, etc.), the language also states "including but not limited to" the above mentioned. As a result, it is unclear what information can be disclosed and, in this context, what would be considered "to be in the public interest."
Division 33 – Transitional provision • A certificate of provisional or full accreditation issued to a facility before the date of the coming into force of these Bylaws continues to be valid until it expires or is suspended, amended, or revoked in accordance with these Bylaws.	• An accreditation of a facility granted before the date of coming into force of the amended Part 5 Section A – Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) of the Bylaws continues to be valid until the accreditation expires or is revoked, suspended or changed by the committee.	• Traditional provision now applies to both Programs.	• N/A

Schedule X • Includes new definitions: "simple procedure" and "superficial procedure" to be performed in accredited facilities. • Table 1 outlines the procedures that may be performed in an accredited NHMSFAP facility. *Note: There is no Schedule XX* Schedule XXX • List of procedures that must only be performed in an accredited diagnostic procedure. Schedule XXXX • List of fees and other charges for NHMSFAP and DAP (no fees set).	• These schedules are not part of the current bylaws – limited information on procedures occurs within definitions for each program. • Schedule A: Fees; Schedule B: Costs; schedule C: Administrative penalties and costs	• Procedures restricted to an accredited facility are now specified in schedules.	• Fees not yet set, so not known how this will affect facilities going forward.