College Performance Measurement Framework (CPMF) Reporting Tool

Submitted by the College of Midwives of Ontario

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College of **Midwives** of Ontario | Ordre des **sages-femmes** de l'Ontario

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December 2020

INTRODUCTION

THE COLLEGE PERFORMANCE MEASUREMENT FRAMEWORK (CPMF)

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

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

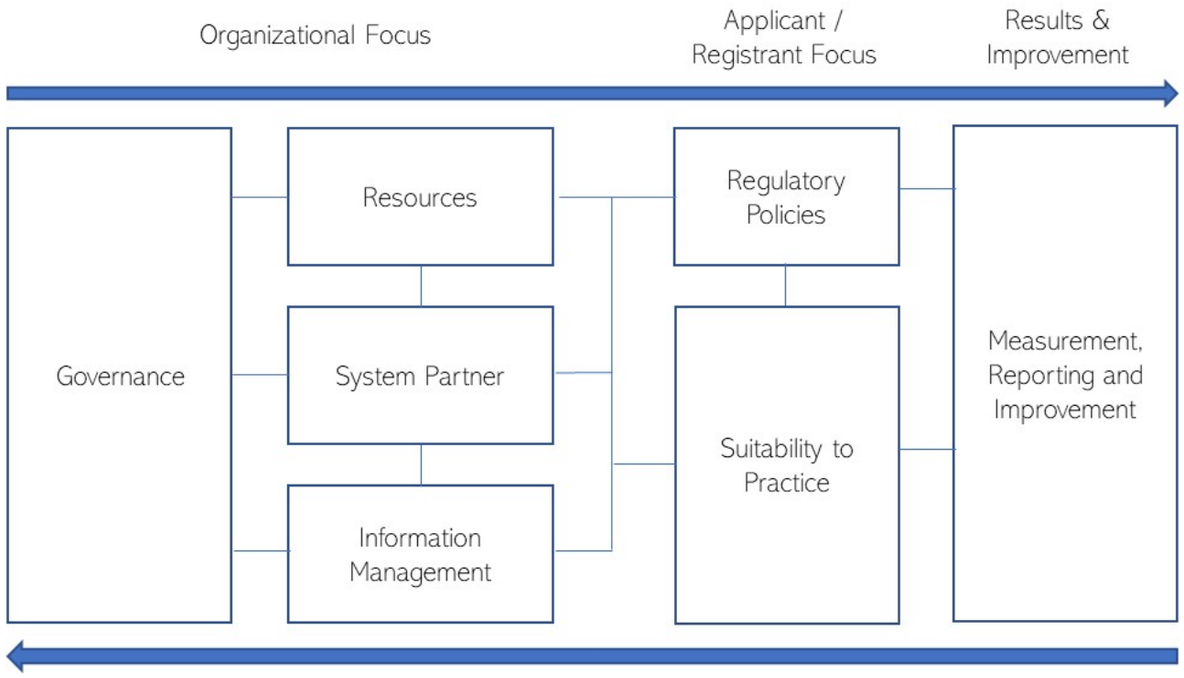
a) Components of the CPMF:

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

b) Measurement domains:

The proposed CPMF has seven measurement domains. These domains were identified as the most critical attributes that contribute to a College effectively serving and protecting the public interest (Figure 1). The measurement domains relate to Ontario's health regulatory Colleges' key statutory functions and key organizational aspects, identified through discussions with the Colleges and experts, that enable a College to carry out its functions well.

Figure 1: CPMF Model for measuring regulatory excellence



The seven domains are interdependent and together lead to the outcomes that a College is expected to achieve as an excellent regulator. Table 1 describes what is being measured by each domain.

Table 1: Overview of what the Framework is measuring

	Domain	Areas of focus
1	**Governance**	• The efforts a College undertakes to ensure that Council and Statutory Committees have the required knowledge and skills to warrant good governance. • Integrity in Council decision making. • The efforts a College undertakes in disclosing decisions made or is planning to make and actions taken, that are communicated in ways that are accessible to, timely and useful for relevant audiences.
2	**Resources**	• The College's ability to have the financial and human resources to meet its statutory objects and regulatory mandate, now and in the future.
3	**System Partner**	• The extent to which a College is working with other Colleges and system partners, where appropriate, to help execute its mandate in a more effective, efficient and/or coordinated manner and to ensure it is responsive to changing public expectation.
4	**Information Management**	• The efforts a College undertakes to ensure that the confidential information it deals with is retained securely and used appropriately in the course of administering its regulatory activities and legislative duties and objects.
5	**Regulatory Policies**	• The College's policies, standards of practice, and practice guidelines are based on the best available evidence, reflect current best practices, are aligned with changing publications and where appropriate aligned with other Colleges.
6	**Suitability to Practice**	• The efforts a College undertakes to ensure that only those individuals who are qualified, skilled and competent are registered, and only those registrants who remain competent, safe and ethical continue to practice the profession.
7	**Measurement, Reporting and Improvement**	• The College continuously assesses risks, and measures, evaluates, and improves its performance. • The College is transparent about its performance and improvement activities.

c) Standards, Measures, Evidence, and Improvement:

The CPMF is primarily organized around five components: **domains**, **standards**, **measures**, **evidence** and **improvement**, as noted on page 3. The following example demonstrates the type of information provided under each component and how the information is presented within the Reporting Tool.

Example:

Domain 1: Governance			
Standard →	**Measure** →	**Evidence** →	**Improvement**
1. Council and Statutory Committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.	1. Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. Meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	• The College is planning a project to develop required competencies for Council and Committees and will develop screening criteria. By-laws will be updated to reflect the screening criteria as a component of the election process to determine professional registrant eligibility to run for a Council position.
		b. Statutory Committee candidates have: i. met pre-defined competency / suitability criteria, and ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	• The College is planning a project to develop required competencies for Council and Committees and will develop screening criteria.
		c. Prior to attending their first meeting, public appointments to Council undertake a rigorous orientation training course about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	Nil
	2. Council and Statutory Committees regularly assess their effectiveness and address identified opportunities for improvement through ongoing education.	a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; ii. Council	Nil
		b. The framework includes a third-party assessment of Council effectiveness at minimum every three years.	Nil

THE CPMF REPORTING TOOL

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

1. meet with the ministry to discuss the system partner domain;
2. complete the self-assessment;
3. post the Council approved completed CPMF Report on its website; and
4. submit the CPMF Report to the ministry.

The ministry will not assess whether a College meets or does not meet the Standards. The purpose of the first iteration of the CPMF is to provide the public, the ministry and other stakeholders with baseline information respecting a College's activities and processes regarding best practices of regulatory excellence and, where relevant, the College's performance improvement commitments. Furthermore, the reported results will help to lay a foundation upon which expectations and benchmarks for regulatory excellence can be refined and improved. Finally, the results of the first iteration may stimulate discussions about regulatory excellence and performance improvement among Council members and senior staff within a College, as well as between Colleges, the public, the ministry, registrants and other stakeholders.

The information reported through the completed CPMF Reporting Tools will be used by the ministry to strengthen its oversight role of Ontario's 26 health regulatory Colleges and may help to identify areas of concern that warrant closer attention and potential follow-up.

Furthermore, the ministry will develop a Summary Report highlighting key findings regarding the best practices Colleges already have in place, areas for improvement and the various commitments Colleges have made to improve their performance in serving and protecting the public. The focus of the Summary Report will be on the performance of the regulatory system (as opposed to the performance of each individual College), what initiatives health regulatory Colleges are undertaking to improve regulatory excellence and areas where opportunities exist for colleges to learn from each other. The ministry's Summary Report will be posted publicly.

As this will be the first time that Colleges will report on their performance against the proposed CPMF standards, it is recognized that the initial results will require comprehensive responses to obtain the required baseline information. It is envisioned that subsequent reporting iterations will be less intensive and ask Colleges only to report on:

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

[1] Informed by the results from the first reporting iteration, the standards, measures and evidence will be evaluated and where appropriate further refined before the next reporting iteration.

Completing the CPMF Reporting Tool

Colleges will be asked to provide information in the right-hand column of each table indicating the degree to which they fulfill the "required Evidence" set out in column two.

Furthermore,

- where a College fulfills the "required evidence" it will have to:
  - provide link(s) to relevant background materials, policies and processes ***OR*** provide a concise overview of this information.
- where a College responds that it "partially" meets required evidence, the following information is required:
  - clarification of which component of the evidence the College meets and the component that the College does not meet;
  - for the component the College meets, provide link(s) to relevant background material, policies and processes ***OR*** provide a concise overview of this information; and
  - for the component the College does not meet, whether it is currently engaged in, or planning to implement the missing component over the next reporting period.
- where a College does not fulfill the required evidence, it will have to:
  - indicate whether it is currently engaged in or planning to implement the standard over the next reporting period.

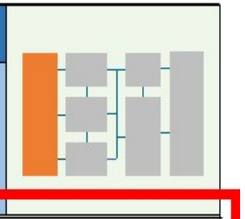
Furthermore, there may be instances where a College responds that it meets required evidence but, in the spirit of continuous improvement, plans to improve its activities or processes related to the respective Measure. A College is encouraged to highlight these planned improvement activities.

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

The areas outlined in red in the example below are what Colleges will be asked to complete.

Example:

DOMAIN 1: GOVERNANCE



Standard 1

Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.

Measure	Required evidence	College response
1. Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. Meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement: Yes ☐ Partially ☐ No ☐ • The competency/suitability criteria are public: Yes ☐ No ☐ *If yes, please insert link to where they can be found, if not please list criteria:* • Duration of orientation training: • Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): • Insert a link to website if training topics are public ***OR*** list orientation training topics: *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional):*

PART 1: MEASUREMENT DOMAINS

The following tables outline the information that Colleges are being asked to report on for each of the Standards. Colleges are asked to provide **evidence** of decisions, activities, processes, and verifiable results that demonstrate the achievement of relevant standards and encourages Colleges to not only to identify whether they are working on, or are planning to implement, the missing component if the response is "No", but also to provide information on improvement plans or improvement activities underway if the response is "Yes" or "Partially".

DOMAIN 1: GOVERNANCE		
Standard 1 **Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.**		
Measure	**Required evidence**	**College response**
1.1 Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • The competency/suitability criteria are public: Yes X No ☐ *If yes, please insert link to where they can be found, if not please list criteria:* Eligibility (or suitability) criteria for election are set out in s 5.08 of the College's General by-law, which Is available on the website here: https://www.cmo.on.ca/wp-content/uploads/2018/10/General-Bylaw-December-2020-FINAL.pdf The competency criterion (paragraph z) requires that all midwives successfully complete the College's training program relating to the duties, obligations and expectations of Council and Committee members prior to the date of nomination. • **Duration of orientation training and format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end):** Currently all candidates running for election must complete the College's governance education modules, including completion quizzes. Evidence of completion is obtained once final quizzes are successfully completed and automatically submitted to the College. As part of their election nomination form, all candidates are required to complete Confirmation of Eligibility that includes a signed declaration that they

		have satisfactorily completed the governance education modules. The form can be found here: https://www.cmo.on.ca/wp-content/uploads/2020/06/Nomination-Forms-COI-Final.pdf There are three modules that each have their own learning themes. The first module focuses on the legislation and regulations that provide the governance framework for regulating midwifery as a profession, the second module focuses on the College as a regulatory institution, and the last module focuses on the role of the College Council and its Committees. The Governance Manual accompanies the modules and is provided to all candidates. This manual provides an overview of governance, its meaning and purpose as it applies to the regulation of midwifery by the College of Midwives of Ontario. It also provides detailed information relating to the duties, obligations and expectations of Council and committee members, including time commitment expectations. The Governance Manual is available here: https://www.cmo.on.ca/wp-content/uploads/2019/03/GOVERNANCE-MANUAL-2021-Revisions-1.pdf • **Insert a link to website if training topics are public *OR* list orientation training topics:** The governance education modules and completion quizzes can be found here: https://www.cmo.on.ca/resources/governance-education
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional):
	b. Statutory Committee candidates have: i. met pre-defined competency / suitability criteria, and ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	The College fulfills this requirement: Yes ☐ Partially X No ☐ • **The competency / suitability criteria are public: Yes X (suitability criteria) No ☐** *If yes, please insert link to where they can be found, if not please list criteria:* The suitability criteria for statutory committee candidates are set out in College by-law. See ss 6.10-6.12: https://www.cmo.on.ca/wp-content/uploads/2018/10/General-Bylaw-December-2020-FINAL.pdf • **Duration of each Statutory Committee orientation training:** Half day or full day orientation sessions are provided to all statutory committees. Members who join Council /committees mid-year receive separate orientation.

		• Format of each orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): In 2020 all orientation trainings were provided virtually. Registration, ICRC, Discipline/Fitness to Practise committee trainings involved external speakers. There is no knowledge testing built into these sessions. • **Insert link to website if training topics are public *OR* list orientation training topics for Statutory Committee:** Orientation sessions are all specific to the role of each committee and generally include the following components: - Mandate under the RHPA - Relevant legislation and regulations - The concept of procedural fairness - College obligations under the fairness legislation and labour mobility legislation - The concepts of reasonableness and reasonableness review - Confidentiality and conflicts of interest - Appeals process - Sexual abuse prevention program - Discipline and fitness to practise training - Finance training and introduction to the various tools used by the Executive Committee (audit review tools, Registrar review tools, evaluation tools, etc.) - Chair training
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes □ *No* X
		Additional comments for clarification (optional): The College does not currently have pre-defined competency criteria. Given the governance model set out in the RHPA, which is not based on competencies, the College's focus is on developing the necessary competencies once Council members join Council by providing proper orientation and ongoing training based on the identified needs.
		The College fulfills this requirement: Yes X Partially ☐ No ☐

	c. Prior to attending their first meeting, public appointments to Council undertake an orientation training course about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	• **Duration of orientation training:** 1 full day in person orientation training for both professional and public members, and an individualized orientation session is provided to public members who join mid-year. • **Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end):** Generally, a comprehensive Council orientation session is delivered in-person before the first meeting of Council (generally held in October). Both professional and public members are required to attend. In addition, public members who join Council mid-year, receive an individualized orientation by Council chair and Registrar/CEO. In 2020, due to the COVID-19 pandemic, the orientation session was held remotely. External speakers are generally invited to speak. There is no knowledge testing built into these sessions. • **Insert link to website if training topics are public OR list orientation training topics:** A full day training session was held in October 2020 and included introduction on Council roles and responsibilities, fiduciary duties, the legislative framework that exists in Ontario and the regulatory framework specific to the midwifery profession as well as introduction to the concepts of professionalism and competence and how the College should ensure those. In addition, two individualized orientation sessions were held on June 17th and September 25th for four new members (two attended each session), in advance of their first Council meeting. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional):*
1.2 Council regularly assesses its effectiveness and addresses identified opportunities for improvement through ongoing education.	a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; ii. Council	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Year when Framework was developed *OR* last updated:** The framework was developed in 2015. It was last reviewed and revised in 2020. Council performance is evaluated in four different ways: **Council Performance Evaluation Survey:** Anonymous online survey is conducted in October. It requires Council members to focus on and assess key areas that affect the Council's performance as a whole and its key responsibilities for governance of the College. The following areas are assessed: 1. Strategic Governance 2. Operational Oversight 3. Council-Registrar/CEO Relationship

		4. Council Governance Processes 5. Council Engagement and Interpersonal Skills 6. Chairing Skills 7. Chair Evaluation 8. General Strengths and Improvement Needs The results are reviewed by Executive in November and presented to Council in December. **Peer Review:** This survey is conducted to assess individual member's effectiveness, help them develop and bring value to their roles. The survey is sent out by Chair to all Council members who receives responses on a confidential basis. Thematic analysis is presented to Executive in November. Chair emails "unfiltered" responses to individual Council members and holds one-on-one teleconference meetings with Council members to discuss feedback provided by peers. The responses to this questionnaire and subsequent discussions with the Chair are held in complete confidence. **Council member competencies:** Council members are asked to review the list of essential competencies and personal attributes and skills (approved by Council) and indicate their level of competence in accordance with the provided competency level descriptions. The results of evaluation are used to create a competency matrix unique for the College's current Council. **Post-Council Meeting and Training Day Evaluations:** An online survey is conducted online after each Council meeting to evaluate effectiveness of Council meetings and trainings and identify any gaps that must be addressed. This survey is conducted online. • **Insert a link to Framework OR link to Council meeting materials where (updated) Framework is found and was approved: <*insert link*>** The Executive Committee (as the College's governance committee) revises and approves the framework. A report was presented to Council in June 2020 (under the Chair's report). See the summary of discussion noted in the June Council minutes (agenda item 5): https://www.cmo.on.ca/wp-content/uploads/2020/09/4.0-Approved-Council-Meeting-Minutes-June-24-2020.pdf • **Evaluation and assessment results are discussed at public Council meeting:** Yes X No □ • **If yes, insert link to last Council meeting where the most recent evaluation results have been presented and discussed:** The results of the 2020 evaluations were presented and discussed at the December 2020 Council meeting (agenda item 6: Council Annual Evaluation Presentation): https://www.cmo.on.ca/wp-content/uploads/2020/11/meeting-book-council-meeting-3.pdf

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
	b. The framework includes a third-party assessment of Council effectiveness at a minimum every three years.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• **A third party has been engaged by the College for evaluation of Council effectiveness: Yes x No ☐** In accordance with the Council Evaluation Policy (GP10), a third party assessment of Council's effectiveness must be conducted at least once every 3 years. Please see here: https://www.cmo.on.ca/wp-content/uploads/2015/06/Governance-Policies-APPROVED-December-9-2020.pdf The first third-party assessment of Council effectiveness is scheduled for the fall of 2021 • **Year of last third-party evaluation** This process was developed in 2020 and will be implemented in 2021.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
	c. Ongoing training provided to Council has been informed by: i. the outcome of relevant evaluation(s), and/or ii. the needs identified by Council members.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• **Insert a link to documents outlining how outcome evaluations and/or needs identified by members have informed Council training;** The results from the Council evaluations are used by the Executive Committee to develop an annual training plan. Trainings are provided four times a year (in person or virtually). The survey results are also used to make changes to College governance policies and processes as needed. *Note: in 2020, three training days were initially scheduled because of the Strategic Planning Day scheduled for December.* • **Insert a link to Council meeting materials where this information is found *OR d*escribe briefly how this has been done for the training provided over the last year.** Annual training plans are approved by the Executive committee as described above. Due to the pandemic, the proposed training for 2020 was slightly modified to be able to deliver it remotely. The March 2020 training day was cancelled. The training sessions provided to Council in 2020 included:

		- Finance training - Discipline Training - The Concept of Competence and Regulated Professionals - Governance 101 - Governance training (organized by HPRO)
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional):

Standard 2 **Council decisions are made in the public interest.**		
Measure	**Required evidence**	**College response**
2.1 All decisions related to a Council's strategic objectives, regulatory processes, and activities are impartial, evidence-informed, and advance the public interest.	a. The College Council has a Code of Conduct and 'Conflict of Interest' policy that is accessible to the public.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Year when Council Code of Conduct and 'Conflict of Interest' Policy was implemented OR last evaluated/updated:** The College has a conflict-of-interest by-law (Article 8) and a code of conduct by-law (Article 9 – Duties of Council and Committee members) that set out expectations in the performance of Council and Committee duties. These provisions were last reviewed and revised in 2018. The by-law also includes a provision on how these requirements will be enforced and the potential outcomes for breaching these provisions (ss. 9.03-9.14). In addition, the College's Council and Committee Member's Role and Code of Conduct Policy sets out further expectations relating to their role on College Council or committees and includes the Code of Conduct Acknowledgement for Council and Committee Members and Disclosure of Conflict of Interest form that must be signed by all Council and Committee members on an annual basis. Finally, the College's Confidentiality and Disclosure of College Information Policy sets out the confidentiality requirements that all Council and Committee members must adhere to. A Statement of Confidentiality is signed by all Council and Committee members on an annual basis. • **Insert a link to Council Code of Conduct and 'Conflict or Interest' Policy OR Council meeting materials where the policy is found and was discussed and approved:**

		The General By-law can be found here: https://www.cmo.on.ca/wp-content/uploads/2018/10/General-Bylaw-December-2020-FINAL.pdf The governance policies and the forms mentioned above can be found here: https://www.cmo.on.ca/wp-content/uploads/2015/06/Governance-Policies-APPROVED-December-9-2020.pdf
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes □ No □
		Additional comments for clarification (optional)
	b. The College enforces cooling off periods[2].	The College fulfills this requirement: Yes X No ☐
		• **Cooling off period is enforced through:** Conflict of interest policy □ By-law X Competency/Suitability criteria □ Other <*please specify*> • **The year that the cooling off period policy was developed *OR* last evaluated/updated:** These provisions of the General bylaw were last reviewed in 2018. The Non-Council Committee Appointments Policy was last reviewed and revised in June 2020. • **How does the college define the cooling off period?** Systems are in place to ensure that Council and its statutory committees are structurally separated from inappropriate influence to support regulatory integrity and to protect independence of Council and committee decision makers from any interests other than the public interest. For example, the College's current by-law (ss. 5.06 and 6.12) stipulates that a midwife may be eligible for election to Council or appointment to a Committee if they: 1. have not been a director, board member, officer or employee of a Professional Association in the previous 12 months 2. have not been a director, board member or owner of a midwifery educational institution in the previous 12 months 3. have not been disqualified from Council within the preceding three years

[2] Cooling off period refers to the time required before an individual can be elected to Council where an individual holds a position that could create an actual or perceived conflict of interest with respect to his or her role and responsibility at the college.

		4. have not been an employee of the College during the previous two years. In terms of non-Council public Committee appointments, the College has a policy that stipulates that the criteria outlined in the by-law (provided above) must be met by all non-Council candidates (including members of the public) who want to apply to sit on College statutory committees. • **Insert a link to policy / document specifying the cooling off period, including circumstances where it is enforced;** See ss. 5.06 and 6.12 that enforce "cooling off" requirements as outlined above: https://www.cmo.on.ca/wp-content/uploads/2018/10/General-Bylaw-December-2020-FINAL.pdf See Policy GP14 Non-Council Committee Members Appointments here: https://www.cmo.on.ca/wp-content/uploads/2015/06/Governance-Policies-APPROVED-December-9-2020.pdf • **insert a link to Council meeting where cooling off period has been discussed and decided upon; *OR* where not publicly available, please describe briefly cooling off policy:** Please see links to the bylaw and the policy above.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes □ No □
		Additional comments for clarification (optional)
		The College fulfills this requirement: Yes X Partially ☐ No ☐

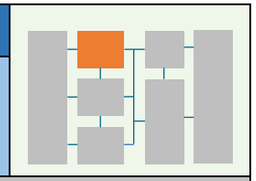
	c. The College has a conflict of interest questionnaire that all Council members must complete annually. Additionally: i. the completed questionnaires are included as an appendix to each Council meeting package; ii. questionnaires include definitions of conflict of interest; iii. questionnaires include questions based on areas of risk for conflict of interest identified by Council that are specific to the profession and/or College; and iv. at the beginning of each Council meeting, members must declare any updates to their responses and any conflict of interest specific to the meeting agenda.	• **The year when conflict of interest the questionnaire was implemented *OR* last evaluated/updated** The conflict of interest questionnaire was last reviewed in June 2020. • **Member(s) update his or her questionnaire at each Council meeting based on Council agenda items:** Always X Often □ Sometimes □ Never □ • **Insert a link to most recent Council meeting materials that includes the questionnaire:** All Council and committee members are required to complete a conflict-of-interest questionnaire on an annual basis. They also declare any conflicts as they arise in between the meetings and before each Council meeting. https://www.cmo.on.ca/wp-content/uploads/2020/11/meeting-book-council-meeting-3.pdf *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes □ No □* *Additional comments for clarification (optional)*
	d. Meeting materials for Council enable the public to clearly identify the public interest rationale (See Appendix A) and the evidence supporting a decision related to the College's strategic direction or regulatory processes and actions (e.g. the minutes include a link to a publicly available briefing note).	The College fulfills this requirement: Yes x Partially ☐ No ☐ • **Describe how the College makes public interest rationale for Council decisions accessible for the public:** All materials provided to Council identify the public interest rationale and the evidence supporting a decision for any issue brought to Council for review, discussion or approval. In addition, all regulatory proposals must be accompanied by a regulatory impact assessment that is designed in a way that allows for risk identification and assessment of impacts and regulatory options considered to mitigate the identified risks. Council materials are available online to ensure that regulatory policy decision-making is open and transparent (in addition to meeting the legislative requirements set out in the Code). • **Insert a link to meeting materials that include an example of how the College references a public interest rationale:**

		An example of how the College references a public interest rationale in its documents can be found here (agenda item 11: Registration Regulation – Clinical Currency Recommendations): https://www.cmo.on.ca/wp-content/uploads/2020/11/meeting-book-council-meeting-3.pdf
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed)
Standard 3 **The College acts to foster public trust through transparency about decisions made and actions taken.**		
Measure	**Required evidence**	**College response**
3.1 Council decisions are transparent.	a. Council minutes (once approved) are clearly posted on the College's website. Attached to the minutes is a status update on implementation of Council decisions to date (e.g. indicate whether decisions have been implemented, and if not, the status of the implementation).	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• **Insert link to webpage where Council minutes are posted:** https://www.cmo.on.ca/about-the-college/governance/councilmeetings/ A status update on implementation of Council decisions is provided through Registrar's quarterly report, provided to Council at each Council meeting. The College also provides an update on important Council decisions (with a link to meeting materials) in its quarterly newsletters. An example can be viewed here: https://www.cmo.on.ca/wp-content/uploads/2020/11/2020-11-ON-CALL-FINAL.pdf
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
		The College fulfills this requirement: Yes X Partially ☐ No ☐

	b. The following information about Executive Committee meetings is clearly posted on the College's website (alternatively the College can post the approved minutes if it includes the following information). i. the meeting date; ii. the rationale for the meeting; iii. a report on discussions and decisions when Executive Committee acts as Council or discusses/deliberates on matters or materials that will be brought forward to or affect Council; and iv. if decisions will be ratified by Council.	• **Insert a link to webpage where Executive Committee minutes / meeting information are posted:** Executive Committee reports are provided at every Council meeting, including the meeting date, issues discussed, decisions made (including decisions made on behalf of Council) and recommendation brought to Council for review and approval. The Executive's report provided to Council in December 2020 can be viewed here (p. 34): https://www.cmo.on.ca/wp-content/uploads/2020/11/meeting-book-council-meeting-3.pdf *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional)*
	c. Colleges that have a strategic plan and/or strategic objectives post them clearly on the College's website (where a College does not have a strategic plan, the activities or programs it plans to undertake).	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Insert a link to the College's latest strategic plan and/or strategic objectives:** Strategic Plan 2021-2026: https://www.cmo.on.ca/wp-content/uploads/2021/03/Strategic-Plan-2021-2026-Web.pdf Strategic Plan 2017-2020: https://www.cmo.on.ca/wp-content/uploads/2017/03/strategic-plan-2.pdf *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional)*
3.2 Information provided by the College is accessible and timely.	a. Notice of Council meeting and relevant materials are posted at least one week in advance.	The College fulfills this requirement: Yes X Partially ☐ No ☐ *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional)*
		The College fulfills this requirement: Yes X Partially ☐ No ☐

	b. Notice of Discipline Hearings are posted at least one week in advance and materials are posted (e.g. allegations referred)	*If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional)*

DOMAIN 2: RESOURCES



Standard 4

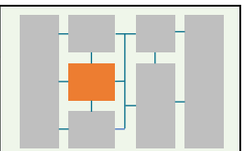
The College is a responsible steward of its (financial and human) resources.

Measure	Required evidence	College response
4.1 The College demonstrates responsible stewardship of its financial and human resources in achieving its statutory objectives and regulatory mandate.	a. The College's strategic plan (or, where a College does not have a strategic plan, the activities or programs it plans to undertake) has been costed and resources have been allocated accordingly. Further clarification: A College's strategic plan and budget should be designed to complement and support each other. To that end, budget allocation should depend on the activities or programs a College undertakes or identifies to achieve its goals. To do this, a College should have estimated the costs of each activity or program and the budget should be allocated accordingly.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Insert a link to Council meeting materials that include approved budget *OR* link to most recent approved budget:** The College has developed a Costed Strategic Plan 2021-2026 which details the planned initiatives that will contribute to the delivery of each of the College's three strategic priorities (identified in the 2021-2026 Strategic Plan) as well as provides the forecasted costs of each strategic priority. In addition, the College's 2021/2022 Budget includes strategic costs allocated for 2021/2022 (Y1 of the Strategic Plan). These costs are broken down into budget area (e.g., expert, database etc.) for inclusion in the budget. Both the costed strategic plan and the 2021/2022 budget can be found in the March council materials: Agenda item 7 (costed strategic plan) and item 8 (budget): https://www.cmo.on.ca/wp-content/uploads/2021/03/FULL-MEETING-BOOK-COUNCIL-March-24-2021.pdf *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐*

		Additional comments for clarification (optional)
	b. The College: i. has a "financial reserve policy" that sets out the level of reserves the College needs to build and maintain in order to meet its legislative requirements in case there are unexpected expenses and/or a reduction in revenue and furthermore, sets out the criteria for using the reserves; ii. possesses the level of reserve set out in its "financial reserve policy".	The College fulfills this requirement: Yes X Partially ☐ No ☐
		If applicable: • **Insert a link to "financial reserve policy" *OR* Council meeting materials where financial reserve policy has been discussed and approved:** The December Council materials (the briefing note and draft policy) can be found under agenda item 6: https://www.cmo.on.ca/wp-content/uploads/2020/11/meeting-book-council-meeting-3.pdf • **Insert most recent date when "financial reserve policy" has been developed *OR* reviewed/updated:** 2020 • **Has the financial reserve policy been validated by a financial auditor?** Yes X No □
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes □ No □
		Additional comments for clarification (if needed)
	c. Council is accountable for the success and sustainability of the organization it governs. This includes ensuring that the organization has the workforce it needs to be successful now and, in the future (e.g. processes and procedures for succession planning, as well as current staffing levels to support College operations).	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• **Insert a date and link to Council meeting materials where the College's Human Resource plan, as it relates to the Operational and Financial plan, was discussed.** In accordance with the Financial Planning and Budgeting policy (RE2), the Registrar must: - Allocate sufficient resources, both human and financial, to satisfy Council's intended outcomes - Appropriately balance resources, both human and financial, between the budget and Council's intended outcomes. The College assesses its human resource on a regular basis as part of annual budgeting to determine if:

		- staff are compensated at market value to ensure quality recruitment, retention, stability and efficiency - the College has internal capacity, skills and knowledge to meet the demands of an increasing membership volume - staff are capable of navigating the complexity of work while satisfying the public safety mandate Based on this analysis relevant recommendations are brought to Council for review and approval. In 2020, it was determined that the College achieves efficiency and effectiveness with its current staff complement relying more on the expertise and flexibility of staff and less on external consultants. The College entered 2020-21 with a hiring freeze and no additional positions were anticipated. The 2020-2021 Budget (as it relates to human resource projections) can be accessed here (at p. 116) – it was approved by Council in March 2020: https://www.cmo.on.ca/wp-content/uploads/2020/03/meeting-book-council-meeting-March-25-2020-for-website2.pdf The College assesses its salaries externally with the assistance of an expert consultant every few years to ensure its market competitiveness. The most recent analysis was completed in 2018. All staff are currently placed, based on the expert assessment, within a salary band and should progress through their band in a set amount of time.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)

DOMAIN 3: SYSTEM PARTNER



Standard 5

The College actively engages with other health regulatory Colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.

Standard 6

The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public expectations.

Standard 7 **The College responds in a timely and effective manner to changing public expectations.**	
Measure / Required evidence: N/A	**College response**
	Colleges are requested to provide a narrative that highlights their organization's best practices for each of the following three standards. An exhaustive list of interactions with every system partner the College engages is not required. ***Colleges may wish to provide Information that includes their key activities and outcomes for each best practice discussed with the ministry, or examples of system partnership that, while not specifically discussed, a College may wish to highlight as a result of that dialogue. For the initial reporting cycle, information may be from the recent past, the reporting period, or is related to an ongoing activity (e.g., planned outcomes).***
The three standards under this domain are not assessed based on measures and evidence like other domains, as there is no 'best practice' regarding the execution of these three standards. Instead, Colleges will report on key activities, outcomes, and next steps that have emerged through a dialogue with the Ministry of Health. Beyond discussing what Colleges have done, the dialogue might also identify other potential areas for alignment with other Colleges and system partners. **In preparation for their meetings with the ministry, Colleges have been asked to submit the following information:** • **Colleges should consider the questions pertaining to each standard and identify**	**Standard 5: The College actively engages with other health regulatory colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.** **Recognizing that a College determines entry to practice for the profession it governs, and that it sets ongoing standards of practice within a health system where the profession it regulates has multiple layers of oversight (e.g. by employers, different legislation, etc.), Standard 5 captures how the College works with other health regulatory colleges and other system partners to support and strengthen alignment of practice expectations, discipline processes, and quality improvement across all parts of the health system where the profession practices. In particular, a College is asked to report on:** • ***How it has engaged other health regulatory Colleges and other system partners to strengthen the execution of its oversight mandate and aligned practice expectations? Please provide details of initiatives undertaken, how engagement has shaped the outcome of the policy/program and identify the specific changes implemented at the College (e.g. joint standards of practice, common expectations in workplace settings, communications, policies, guidance, website etc.).*** The College engages with other health regulatory colleges and other system partners, or stakeholders, in a meaningful way and on a regular basis. We recognize that we cannot effectively fulfill our mandate of regulating in the public interest without thoughtful engagement with system partners. We believe that we do better working with others, and that maintaining quality relationships with our system partners will enable us to achieve better regulatory outcomes. We recognize the limits of our own statutory powers and responsibilities. Our focus is always on the needs of the clients and the public and by building a comprehensive stakeholder engagement we will ensure that issues are dealt with by the most appropriate organization rather than simply falling outside our remit. More information on our Stakeholder Engagement Strategy can be found here: https://www.cmo.on.ca/wp-content/uploads/2018/12/Stakeholder-Engagment-Strategy.pdf Below are highlights of some of the relationships that we believe to be best practices in this area.

examples of initiatives and projects undertaken during the reporting period that demonstrate the three standards, and the dates on which these initiatives were undertaken.	**Canadian Midwifery Regulators Council** The College engages regularly with all midwifery regulators in Canada, a total of nine provinces and three territories (only PEI remains unregulated) through its membership with the Canadian Midwifery Regulators Council (CMRC). Its mission is "to encourage excellence among Canadian midwifery regulatory authorities through collaboration, harmonization and best practice". It achieves this by maintaining and administering the national Canadian Midwifery Registration Examination (CMRE), participating in the accreditation process of Canadian Baccalaureate Midwifery Education Programs, setting Canadian competencies for midwives, and developing consistent registration and professional practice standards and/or procedures which is the focus of its standing committees. The College's Registrar is an active Director and elected Treasurer of the CMRC and recently led a governance review to establish clear governance policies and practices that have led to more transparent decision making, improved collaboration, and achievement of strategic goals. College staff and Council Chair participate in several committees and working groups, including Executive, Registration Affairs, Professional Practice, and Equity, Diversity and Inclusion. Some significant achievements this past year included the substantial review and revision of the Canadian Competencies for Midwives which outline the knowledge, skills and abilities expected of entry-level midwives in Canada. The foundational national competencies were established nearly two decades ago and, with its revised governance and organizational structure, the CMRC was able to undertake this necessary work again. College staff participated on the advisory committee and were responsible for working closely with Yardstick Assessment Strategies in its drafting and validation. The Competencies are expected to be approved in December and a project to revise the blueprint for the CMRE will then be undertaken and completed in 2021. The CMRE Committee worked on behalf of the CMRC to manage the challenges that were faced due to COVID-19. The committee, on which the Registrar is an active member, made the necessary decision to postpone the in-person writing of the national exam that was set to be delivered in May 2020. This decision was well-coordinated with all provincial/territorial regulatory bodies as each were impacted differently due to their specific legislation, regulations or bylaws that governed the exam requirement for applicants. The committee continued to meet regularly throughout the year to determine if the exam could be delivered online and remotely and yet still be valid and secure. Messaging to all regulators and exam candidates was consistent and frequent. In the end, the committee made the decision to increase the number of locations the exam was to be delivered (to minimize large gatherings) and, in some locations, administered the exam in private hotel rooms to ensure safety of candidates. The exam was successfully delivered on October 29th across Canada. The committee continues to explore its options for online exams, which has been a proposed project for several years but is waiting for federal funding to assist with implementation. Another noteworthy accomplishment is the working relationship the CMRC has with the Canadian Association of Midwifery Education (CAMEd). The Accreditation Council of CAMEd is responsible for accrediting Midwifery Education Programs in Canada, a newly established process. The College Registrar is the individual appointed to represent the CMRC on that Council. Two Ontario universities have successfully achieved accreditation and the third program is undergoing its assessment now. College staff participated in two onsite visits and one that was delivered remotely to ensure regulatory expectations were met and to assure the CMRC that the process is fair, impartial, objective and transparent. Once all Midwifery Education Programs have had the opportunity to be assessed, the CMRC will recognize those that achieved accreditation, allowing provincial and territorial regulators to rely on this process for their own jurisdictional recognition processes. This process results in achieving consistent program standards and a fair and transparent system for recognition. **Collaboration with the Ontario Midwifery Sector**

	The College meets regularly with stakeholders in the midwifery sector, including the Association of Ontario Midwives and its Director of Indigenous Midwifery, the Ontario Midwifery Education Programs, representatives from the Provincial Council of Maternal and Child Health, the Ministry's Ontario Midwifery Program, and representatives from the Ministry of Colleges and Universities. Data reports and other important news is shared between organizations at those meetings to allow for all midwifery organizations to be well informed of any recent or planned changes that could affect the sector. In particular, the College benefits from consulting with the AOM as they provide midwives' perspectives on College activities such as regulation changes, by-laws, policies, and standards. In order to regulate effectively, we have to know that our high standards are achievable and our consultation with the AOM can help us with this. For example, as part of our recent standards review, the College proposed to rescind a "cornerstone" standard and instead develop a Scope of Practice guide for midwives. This decision was informed by our risk-based regulatory framework where regulatory tools are used only when risks cannot be mitigated by other means. The Association provided meaningful feedback which will strengthen the final guide and make it more useful to our registrants as well as their health professional colleagues who may have questions about the legislative framework that affects midwifery practice. Additional and more frequent midwifery stakeholder meetings took place throughout the year to address the pandemic and to ensure all parties were aware of risks that impacted the sector. In particular, the College and the Association quickly established a close communications relationship to ensure that our messages did not conflict. The College participated on an AOM-led province-wide webinar in the early days of the pandemic to help answer questions and demonstrate our cooperation and consistent messaging to our shared members/registrants. **Independent Health Facilities (IHF) and Public Health Ontario (PHO)** In accordance with the Independent Health Facilities Act (IHFA), and at the request of the Director of the Independent Health Facilities Branch of the Ministry of Health, the College conducts general and emergent assessments of the two Ontario Midwife-Led Birth Centres (MLBC). The College conducts assessments to evaluate compliance with the College approved Facility Standards and Clinical Practice Parameters (FS & CPP). The FS & CPP set minimum standards for all MLBCs and serves as the basis for College assessments, including standards related to Infection Prevention and Control (IPAC). MLBCs are held to the standards established by the Provincial Infectious Diseases Advisory Committee (PIDAC) to ensure appropriate infection prevention and control in the facility and in the reprocessing of equipment (where applicable). The College was responsible for training its assessors and needed to ensure they had sufficient expertise in IPAC assessment. As a result, the College required each assessor to undertake the online IPAC certification program delivered by Public Health Ontario prior to delivering an assessment. In addition, the College requested the presence of a PHO representative to advise the assessors if they had questions during the onsite assessment. The College assessors, the PHO representative, and the Birth Centre recognized the importance of this collaboration as it led to capacity building and trust building between all parties. **Health Profession Regulators of Ontario (HPRO)** HPRO's primary purpose is to advance excellence in public safety through collaboration. The Registrar and College staff participate on several HPRO committees and working groups, including HPRO Management Committee, Anti-BIPOC Racism Working Group, and Communications Committee. The College participates in many HPRO-led initiatives, including sending Council, committees, and staff to discipline training, governance training, and communications workshops. Our staff, Council and committee members benefit from this training as it results in greater consistency of practices among Colleges and their decision-makers.

	Ontario Regulators for Access Consortium (ORAC) ORAC's purpose is to encourage the collective collaboration of regulators of self-regulated professions in Ontario on matters related to the access of internationally trained individuals to practice in Ontario. Our Registration Manager serves as the co-Chair of ORAC along with a representative of the Human Resources Professionals Association. **Working groups and discussion groups** Additionally, staff participate in working groups and discussion groups, such as Deputy Registrars, Corporate Services, Practice Advisors, and Quality Assurance. Informal collaboration between College staff and/or Council members has resulted in finding appropriate consultant expertise for specific work projects, providing consistency with respect to how Registrars are evaluated, improving efficiency and consistency with Alternative Dispute Resolution programs, and participating in a project to establish fair and competitive salary ranges for staff. The College of Midwives has enthusiastically responded to requests to share the governance education modules and quizzes that we developed as an onboarding educational tool for public Council members and an eligibility requirement for elected Council and appointed (public and professional) non-Council committee members. Our commitment to share our work with other Colleges has resulted in many others building similar programs to assist with Council and committee member competencies. The Registrar and other staff have recently collaborated with 9 other Colleges to consider ways in which we can more formally work together to improve efficiencies or effectiveness. Some of the projects relate to sharing physical space, collective vendor requests, HR policies and trainings, and data analysis. The broader regulatory sector is actively considering how it upholds the principles of diversity, equity and inclusion and how it can actively address anti-black and anti-indigenous racism. The Registrar is working with other College representatives through a newly formed HPRO working group to build a framework/toolkit for health regulators to address equity, diversity and inclusion in regulatory policy, governance policy, human resource policy, and to assist with building capacity among staff with expert support.

	Standard 6: The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public/societal expectations. The intent of standard 6 is to demonstrate that a College has formed the necessary relationships with system partners to ensure that it receives and contributes information about relevant changes to public expectations. This could include both relationships where the College is "pushed" information by system partners, or where the College proactively seeks information in a timely manner. • *Please provide some examples of partners the College regularly interacts with including patients/public and how the College leverages those relationships to ensure it can respond to changing public/societal expectations.* • *In addition to the partners it regularly interacts with, the College is asked to include information about how it identifies relevant system partners, maintains relationships so that the College is able access relevant information from partners in a timely manner, and leverages the information obtained to respond (specific examples of when and how a College responded is requested in standard 7).*	**Standard 7: The College responds in a timely and effective manner to changing public expectations.** Standard 7 highlights successful achievements of when a College leveraged the system partner relationships outlined in Standard 6 to implement changes to College policies, programs, standards etc., demonstrating how the College responded to changing public expectations in a timely manner. • *How has the College responded to changing public expectations over the reporting period and how has this shaped the outcome of a College policy/program? How did the College engage the public/patients to inform changes to the relevant policy/program? (e.g. Instances where the College has taken the lead in strengthening interprofessional collaboration to improve patient experience, examples of how the College has signaled professional obligations and/or learning opportunities with respect to the treatment of opioid addictions, etc.).* • *The College is asked to provide an example(s) of key successes and achievements from the reporting year*.

Standards 6 and 7

The analysis of our internal data (through our complaints survey and practice advice data) and literature review have demonstrated that the public expect increased access to information to better understand midwifery practice and the College's public protection role, and to be able to better navigate our complex regulatory system. To this end, we have completed or undertook to complete the following work to respond to changing public expectations:

Internal review of our regulatory performance

In 2020, we piloted and successfully completed the first internal review with the aim of assessing its regulatory performance. The framework was developed to assess how the College meets the outcomes it is expected to achieve in four broad domains: Regulatory Policy; Suitability to Practise; Openness and Accountability; Good Governance. It comprises a number of performance standards that form the basis of the performance measurement framework. The framework as approved by Council in June 2019 can be found here: https://www.cmo.on.ca/wp-content/uploads/2019/06/meeting-book-council-meeting-2019.pdf (p. 116). The framework was piloted in 2019/2020 fiscal year; starting from 2020, the College will use the framework to conduct regular annual performance reviews and will publicly report on its performance. The College will compare the results of each year's review with the results from previous years in order to determine how its performance has improved or worsened over time. While the framework can be used for various purposes (including to improve internal processes and procedures), its intended audience is the public.

Direct engagement with midwifery clients and the public

Our new Strategic Plan identified managing increased expectations of information (both about midwifery practice and College procedures), openness in decision-making and demonstrating our value as the regulator as one of the priorities in the College's new Strategic Plan. As part of this priority the following initiatives will be completed. We will be able to report on their progress as early as 2021.

1. We will conduct a series of qualitative surveys with midwifery clients to gain a better understanding of clients' personal experiences, needs and expectations across the range of settings in which midwifery care is provided and to identify emerging policy issues that may be of relevance to us. Using the findings, we will engage constructively with the profession to address clients' expectations and find solutions to the issues which might have led to dissatisfaction (or complaints) by setting new standards or providing regulatory guidance (e.g. regular webinars, practice advisories and practice guidelines).

2. We will conduct a series of qualitative surveys with midwifery clients and the broader public who went through our complaints process (including in-depth interviews with people who participated in the survey) to assess their perceptions of the College so we can better understand the impact of our work and how we can support, provide guidance, and communicate more effectively with the public. Using the findings, we will address clients/public's legitimate expectations and find solutions to the issues which might have led to dissatisfaction with or confusion about our processes.

Diversity, Equity and Inclusion

In response to the Black Lives Matters social movement that was escalated in 2020, the College addressed anti-BIPOC Racism in letters from the Chair and Registrar in the Summer and Autumn 2020 On-Call Newsletters and committed to taking action and reporting on it. See the newsletters here: https://www.cmo.on.ca/wp-content/uploads/2020/08/2020-06-ON-CALL-Final..pdf and here https://www.cmo.on.ca/wp-content/uploads/2020/11/2020-11-ON-CALL-FINAL.pdf.

The Registrar is an active member of HPRO's Anti-BIPOC Racism Committee. The committee met regularly throughout 2020 and recently hired Dr. Javeed Sukhera, psychiatrist and expert in equity, diversity, inclusion and belonging to assist in meeting the committee's objectives. A summary of the committee's important work to date can be reviewed in the March 24, 2021 Council package under agenda item 7, Registrar's report : https://www.cmo.on.ca/wp-content/uploads/2021/03/FULL-MEETING-BOOK-COUNCIL-March-24-2021.pdf

In October 2020, after Joyce Echaquan died in hospital after she filmed staff making racist comments about her, Federal Ministers held an emergency meeting with provinces and health leaders to hear lived experiences of anti-Indigenous racism in healthcare. In January 2021, Federal Ministers and staff, First Nations, Metis and Inuit leaders, and a variety of health leaders throughout the country, including those from the regulatory sector, took part in a two-day follow up meeting to discuss possible initiatives to eliminate anti-Indigenous racism in the healthcare system. The College Registrar attended these meetings as a representative from the Canadian Midwifery Regulators Council. A final report is expected soon.

The College incorporated the principles of equity, diversity and inclusion in its 2021-2026 Strategic Framework: https://www.cmo.on.ca/wp-content/uploads/2021/03/Strategic-Framework.pdf

Appointment of non-Council public members to serve on our statutory committees

In our Public Engagement Strategy (https://www.cmo.on.ca/wp-content/uploads/2018/01/Public-Engagement-Strategy.pdf) that sets out the principles and the model we adopted to directly engage with the public, direct collaboration with the public is identified as one of its components. Since 2018, non-Council public members have served on College committees bringing their knowledge and expertise to the decision-making process and regulatory work. Candidates can submit their application to the College throughout the year. All Committee appointments are made in the fall. More information can be found here: https://www.cmo.on.ca/about-the-college/governance/elections/public-non-council-member/

Information and support during the COVID-19 pandemic

We created a COVID-19 webpage for the public to provide first-hand information (by way of frequently asked questions) about how the COVID-19 pandemic has changed the way midwifery care is being provided, and to assure the midwifery clients that we continue to ensure that their safety is prioritized. More information can be found here: https://www.cmo.on.ca/covid-19/

What to Expect from Your Midwife brochure

Our What to Expect from Your Midwife brochure outlines the role of the College in regulating midwifery in the public interest, as well as what clients can expect from their midwives throughout their pregnancy and for the first six weeks postpartum. The brochure was initially developed in 2019. The French version of the brochure can be found here: https://www.cmo.on.ca/wp-content/uploads/2019/09/What-to-Expect-French-web.pdf. The College sends brochures (in both English and French) to all Midwifery Practice Groups across the province for client distribution. The brochure order form can be found here: https://www.cmo.on.ca/resources/publications-presentations/what-to-expect-from-your-midwife-brochure-order/

HPRO's communications committee

Our Communications Officer is an active member of the HPRO's communications committee. The committee meets throughout the year to create and execute public campaigns on behalf of all regulated health colleges in Ontario. Examples of work accomplished in 2020 include:

1. Monthly Articles for Zoomer Magazine: On a monthly basis, the HPRO committee drafts articles that are published online for Zoomer magazine. The topics of these articles are timely and relate to what the public needs to know about regulated health professions. For example, an article was written about eight things you are entitled to at your health care appointments, in the spring the committee pivoted their communication when the COVID-19 pandemic hit and instead published articles about how health regulators were keeping clients and patients safe when they were able to reopen, and how to make the most of their health care visit (virtual or in person).
2. Online Survey on Public Perception of Regulated Health Professionals: The committee created an online survey on the public's perception of regulated health professionals. The survey was sent through Zoomer media and it asked participants if certain health professions were regulated. If the participants answered incorrectly, they were given the correct information and a link to the profession that is regulated. If participants answered correctly, they were told so and also provided with a link to that regulated profession. For example, a question asked whether or not doulas were regulated. When the participant chose their answer, they were told that doulas were not regulated but midwives were, and they were directed to the College of Midwives of Ontario to learn more.

DOMAIN 4: INFORMATION MANAGEMENT

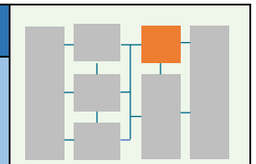
Standard 8

Information collected by the College is protected from unauthorized disclosure.

Measure	Required evidence	College response
		The College fulfills this requirement: Yes X Partially ☐ No ☐

8.1 The College demonstrates how it protects against unauthorized disclosure of information.	a. The College has and uses policies and processes to govern the collection, use, disclosure, and protection of information that is of a personal (both health and non-health) or sensitive nature that it holds	• Insert a link to policies and processes ***OR*** provide brief description of the respective policies and processes. The Privacy Code, which is available on College website (see the below links), describes how the College manages personal information and other sensitive information that it collects in the course of fulfilling its regulatory obligations and activities. It was last reviewed and revised in 2020. https://www.cmo.on.ca/privacy/ https://www.cmo.on.ca/wp-content/uploads/2021/03/Privacy-Code-FINAL.pdf
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes □ No □
		Additional comments for clarification (optional)

DOMAIN 5: REGULATORY POLICIES



Standard 9

Policies, standards of practice, and practice guidelines are based in the best available evidence, reflect current best practices, are aligned with changing public expectations, and where appropriate aligned with other Colleges.

Measure	Required evidence	College response
9.1 All policies, standards of practice, and practice guidelines are up to date and relevant to the current practice environment (e.g. where appropriate, reflective of changing population health needs, public/societal expectations, models of care, clinical evidence, advances in technology).	a. The College has processes in place for evaluating its policies, standards of practice, and practice guidelines to determine whether they are appropriate, or require revisions, or if new direction or guidance is required based on the current practice environment.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Insert a link to document(s) that outline how the College evaluates its policies, standards of practice, and practice guidelines to ensure they are up to date and relevant to the current practice environment OR describe in a few words the College's evaluation process (e.g. what triggers an evaluation, what steps are being taken, which stakeholders are being engaged in the evaluation and how).** The College adheres to a rigorous approach to policy development to ensure that its policy decisions are based on a proper evaluation of risk, a solid evidence and a thorough analysis of options and impacts. This process is in place to ensure that regulatory tools are not adopted as the default solution but rather introduced to mitigate risk when other non-regulatory options are unable to deliver the desired results. Our policy development process is based on the principles of good regulation and ensures that: 1. Regulation is proportionate to the risk of harm being managed 2. Regulation is evidence-based and reflects current best practice 3. Regular and purposeful engagement is undertaken with partner organizations, midwives, and the public throughout the policy making process. All College documents, including bylaws, policies, standards of practice and other guiding documents that are approved by Council or a committee must be formally reviewed within a period not to exceed four years from the date of first issue or the date of the last review. The formal review of a policy may result in no change to the policy, rescinding the policy or revisions to the policy. All revisions must follow a consistent process that includes first determining if the problem is about risk of harm, and then ensuring that recommended revisions are based in evidence and reflect the current practice. More information about our policy development process, including how revisions are made, can be found here: https://www.cmo.on.ca/wp-content/uploads/2021/03/Policy-Development-Process-updated-2020.pdf

		The revision schedule can be found here: https://www.cmo.on.ca/wp-content/uploads/2021/03/Policy-review-schedule.pdf Every policy proposal designed to introduce a regulatory tool must be accompanied by a regulatory impact assessment (RIA) statement. This tool is designed to encourage rigour and better policy outcomes. It can be viewed on our website here: https://www.cmo.on.ca/wp-content/uploads/2017/08/Regulatory-Impact-Assessment-Statement-for-web.pdf
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
	b. Provide information on when policies, standards, and practice guidelines have been newly developed or updated, and demonstrate how the College took into account the following components: i. evidence and data, ii. the risk posed to patients / the public, iii. the current practice environment, iv. alignment with other health regulatory Colleges (where appropriate, for example where practice matters overlap) v. expectations of the public, and vi. stakeholder views and feedback.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **For two recent new policies or amendments, either insert a link to document(s) that demonstrate how those components were taken into account in developing or amending the respective policy, standard or practice guideline (including with whom it engaged and how) OR describe it in a few words.** In 2016, the College adopted a principles-based approach to the development of the standards of practice; an approach that relies on broad principles, rather than rigid rules that midwives must follow. Adopting a principles-based approach required a review of all of the College's existing standards in order to revise or rescind those with prescriptive rules that limited midwives' ability to exercise clinical and professional judgment in their midwifery practice. The first part of this review, completed in June 2018, resulted in rescinding a number of standards of practice and the implementation of the Professional Standards for Midwives was implemented. The second phase of the standards review involved developing The Midwifery Scope of Practice so the CTCS could be rescinded and revising the Professional Standards for Midwives and the Guideline on Ending the Midwife Client Relationship to allow for the rescinding of the standards When a Client Chooses Care Outside Midwifery Standards of Practice and Delegation, Orders and Directives. For more information about our rationale for making these change The development of these documents was informed by a variety of sources including identification and risk assessment, literature review (including on what the public expects of healthcare providers), internal data (e.g., professional conduct and professional practice data), and multiple consultations with the public, midwives and College stakeholders.

		The below show that the first phase of the standards review took into account the components noted under 9.1b: 1. Regulatory Impact Assessment statement included in Council materials (agenda item 6): https://www.cmo.on.ca/wp-content/uploads/2015/07/For-Web-meeting-book-council-meeting-june-28-2017-2.pdf 2. Briefing materials included in the March 2018 Council package when the proposals were approved (agenda item 7): https://www.cmo.on.ca/wp-content/uploads/2018/03/Council-Meeting-Agenda_March-21-2018.pdf 3. Consultation paper: https://www.cmo.on.ca/wp-content/uploads/2017/07/Consultation-Paper-standards.pdf 4. The College's response on the first consultation that reports on the feedback we received and set out our response to all the issues raised in the first consultation, including how the feedback was incorporated : https://www.cmo.on.ca/wp-content/uploads/2017/10/Response-to-Consultation.pdf The below show that the second phase of the standards review took into account the components noted under 9.1b: 1. Briefing materials included in the March 2020 Council package when the proposals were approved for consultation (agenda item 7): https://www.cmo.on.ca/wp-content/uploads/2020/03/meeting-book-council-meeting-March-25-2020-for-website2.pdf 2. Briefing materials included in the December 2020 Council package when the proposals were approved (agenda item 10): https://www.cmo.on.ca/wp-content/uploads/2020/11/meeting-book-council-meeting-3.pdf 3. Consultation paper: https://www.cmo.on.ca/wp-content/uploads/2020/08/Consultation-Paper-Phase-2-Final-.pdf 4. Public consultation: https://www.cmo.on.ca/about-the-college/consultations/professional-standards-phase-ii-consultation/ 5. The College's response that reports on the feedback and provides a response to consultation, including how the feedback was incorporated into final proposals: https://www.cmo.on.ca/wp-content/uploads/2021/02/Response-to-consultation_Feb-2021.pdf
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes □ *No* □

		Additional comments for clarification (optional)

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 10

The College has processes and procedures in place to assess the competency, safety, and ethics of the people it registers.

Measure	Required evidence	College response
10.1 Applicants meet all College requirements before they are able to practice.	a. Processes are in place to ensure that only those who meet the registration requirements receive a certificate to practice (e.g., how it operationalizes the registration of members, including the review and validation of submitted documentation to detect fraudulent documents, confirmation of information from supervisors, etc.)[3].	The College fulfills this requirement: Yes x Partially ☐ No ☐ • **Insert a link that outlines the policies or processes in place to ensure the documentation provided by candidates meets registration requirements *OR* describe in a few words the processes and checks that are carried out:** Full information is provided on the College's website about College registration requirements: In addition, the Registration Application handbook provides further information about what supporting documentation must be submitted to the College for verification. This information can be found here: https://www.cmo.on.ca/applicants/application/ A file is created in the system for the applicant when an application form is received by the Registrar. A requirements checklist is used by staff to keep track of all documents received or outstanding as an application is not complete unless all required pieces of information are included. Once the application is complete, a registration staff member reviews application against the list of registration requirements. If requirements have been met and no issues are noted, the manager then does final approval and sign-off. Applicants who meet all College requirements are notified through a formal notice that they have been registered. Applicants who do not meet the requirements for registration in the General class, Supervised

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

		Practice class or the Transitional Class, are referred to a panel of the Registration Committee in accordance with section 15 of the Health Professions Procedural Code. • **Insert a link *OR* provide an overview of the process undertaken to review how a college operationalizes its registration processes to ensure documentation provided by candidates meets registration requirements (e.g., communication with other regulators in other jurisdictions to secure records of good conduct, confirmation of information from supervisors, educators, etc.):** The College ensures authenticity of documents by requiring that documents come from an official source The Registration Application handbook outlines which documents must be submitted by the applicant and which ones must come from an official source. The handbook can be accessed here: https://www.cmo.on.ca/applicants/application/ Staff carefully verifies that documents come from official sources. If necessary, clarification is sought from the applicant or an institution (e.g., an educational institution or another regulator) that provided the documentation to the College.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
	b. The College periodically reviews its criteria and processes for determining whether an applicant meets its registration requirements, against best practices (e.g. how a College determines language proficiency).	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• **Insert a link that outlines the policies or processes in place for identifying best practices to assess whether an applicant meets registration requirements (e.g. how to assess English proficiency, suitability to practice etc.), link to Council meeting materials where these have been discussed and decided upon *OR* describe in a few words the process and checks that are carried out.** The College is committed to continuous improvement of its regulatory systems to ensure they are effective and efficient. This includes regular review of its registration procedures and processes. A few examples of changes that have been made recently are provided below: 1. In 2019, the College implemented a Criminal Record Screening Policy that allows for the College to require that each applicant produce the results of a vulnerable sector screening. This policy was developed to better evaluate applicants' character in accordance with the good character provisions under the Registration Regulation. The policy can be accessed here: https://www.cmo.on.ca/wp-content/uploads/2018/11/Criminal-Record-Screening-Policy-Updated-

		January-2020.pdf In addition, the College developed a Good Character Guide explaining how the College and assessed good character at entry to practice and how a positive finding on a vulnerable sector screening report would be evaluated. The guide can be accessed here: https://www.cmo.on.ca/wp-content/uploads/2018/11/Good-Character-Guide-Final-.pdf 2. In 2019, the College completed a 3-year Risk Assessment Checklist Program developed by HIROC (Healthcare Insurance Reciprocal of Canada). It is a web- based, self-assessment program that aims to improve College's internal processes and systems. The program consists of checklists, or risk modules, for each of the high-cost/high-frequency risks identified from HIROC's extensive claims database. Each risk module is comprised of the most impactful, evidence-based mitigation strategies the colleges should implement to effectively address the respective risk. The registration related program (Failure to Register and License in a Fair and/or Consistent Manner) focused specifically on registration practices related to registering and licensing in a fair and consistent manner. The completion of the registration HIROC checklist included a detailed review of all internal registration procedures and information to help with implementing efficient registration practices, which also align with the OFC's fair registration practices. 3. The College is in the process of developing an online portal for applicants which will contribute to the overall efficiency of the program. • **Provide the date when the criteria to assess registration requirements was last reviewed and updated.** As noted above, the HIROC Risk Assessment Checklists program that included a review of all registration procedures and processes was completed in 2019.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ *No* ☐
		Additional comments for clarification (optional)
10.2 Registrants continuously demonstrate they are competent and practice safely and ethically.		The College fulfills this requirement: Yes X Partially ☐ No ☐
		• **Insert a link to the regulation and/or internal policy document outlining how checks are carried out and what the currency and other requirements include, link to Council meeting materials where documents are found and have been discussed and decided upon *OR* provide a brief overview:**

	a. Checks are carried out to ensure that currency[4] and other ongoing requirements are continually met (e.g., good character, etc.).	Clinical currency (known as active practice requirements) and other ongoing registration requirements are set out in the Registration Regulation made under the Midwifery Act, 1991. College documents that outline the requirements and how checks are carried out to ensure that the requirements are met are provided below: 1. Active practice requirements (APR), including how the College monitors that midwives meet these requirements is outlined in the following document: https://www.cmo.on.ca/wp-content/uploads/2018/11/APR-Information-November-1-2018_Formatted_UpdateAUG1-2019.pdf 2. Good character: The College relies on self-declarations in determining if a midwife continues to meet ongoing requirements relating to character. All midwives are required to make disclosures to the College at annual renewal (and throughout the year if there is a change of information) in accordance with the Health Professional Procedural Code, the Registration Regulation and College bylaws. The Registrar reviews all disclosures and assesses the impact of the disclosed conduct on the midwife's suitability to practise midwifery ethically and safely. If the Registrar has concerns about a midwife's conduct, the Registrar can appoint an investigator to investigate the midwife's conduct or can make inquiries and on the basis of such inquiries, can decide whether to appoint an investigator. The results of the investigation will be reported to the ICRC. The College's Good Character Guide provides more information on how midwife's suitability to practise is assessed and what action is taken when risks are identified: https://www.cmo.on.ca/wp-content/uploads/2018/11/Good-Character-Guide-Final-.pdf 3. All practising midwives must maintain current training in neonatal resuscitation (NRP), cardiopulmonary resuscitation (CPR) and emergency skills (ES). To do this, the Regulation requires that midwives provide proof of continuing competence, as satisfactory to the College, every year in NRP and every two years in ES and CPR. To facilitate this process, all practising must provide the College with proof of successful completion of training in the above-mentioned areas by the registration renewal deadline of October 1 each year. More information on what constitutes satisfactory evidence for the purpose of meeting these requirements can be found here: https://www.cmo.on.ca/wp-content/uploads/2019/06/Continuing-Competency-Requirements-and-Approved-Courses-January-2021-V2-1.pdf • **List the experts / stakeholders who were consulted on currency:** Please see below under *Identify the date when currency requirements were last reviewed and updated*

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

- **Identify the date when currency requirements were last reviewed and updated:**

Work to review and revise the Registration Regulation, including clinical currency requirements, has been underway for some time. The Registration Committee has already done a significant amount work around clinical currency, which included literature review and jurisdictional analysis, numerous consultations with partner organizations and direct engagement with midwives. Preliminary policy recommendations made by the Registration Committee were discussed at the December 2020 Council and can be viewed here (pp. 164-174): https://www.cmo.on.ca/wp-content/uploads/2020/11/meeting-book-council-meeting-3.pdf. The College will continue its work in 2021 with the aim of formally submitting the proposed changes to the Registration Regulation to the Ministry of Health in the spring of 2022.

- **Describe how the College monitors that registrants meet currency requirements (e.g. self-declaration, audits, random audit etc.) and how frequently this is done.**

As noted above, under the current Registration Regulation, midwives are required to actively practise the profession to maintain currency and ability to practise in all birth settings. These requirements are outlined below.

Active Practice Requirements (APR)	1-year	2-year	5-year
Primary out-of-hospital births	5	10	25
Primary hospital births	5	10	25
Total births	20	40	100

Members are required to report their active practice birth numbers annually by October 1 each year through the online Member Portal. Members report each year based on the births they attended in the reporting period of July 1 – June 30. 2 or 5-year APR due dates are communicated to members in the APR tab in the Member Portal. The first APR due date is the 2-year APR due date, which is two years from the date a member is registered with the College, adjusted to coincide with the October 1 reporting period. Subsequently, a 5-year APR due date applies. When a member has met their APR requirement and/or their due date is adjusted, a member will be notified. Post October 1 annually, all members who were due to have met their active practice requirement are identified, 2-year or 5-year, as of October 1. Each member's active practice report as submitted via the Member Portal are reviewed. Members in the General class who met their APR will be notified and their subsequent APR due date will be available in the Member Portal. If after a review it is determined that a member has an APR shortfall, they are referred to a panel of the Registration Committee in accordance with section 12 the Registration Regulation.

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐ *Additional comments for clarification (optional)*
10.3 Registration practices are transparent, objective, impartial, and fair.	a. The College addressed all recommendations, actions for improvement and next steps from its most recent Audit by the Office of the Fairness Commissioner (OFC).	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Insert a link to the most recent assessment report by the OFC *OR* provide summary of outcome assessment report:** The most recent assessment by the OFC was completed in 2018 for the 2016-2018 assessment period. The OFC did not make any recommendations for this assessment period. The report also noted that the previous assessment conducted in 2014 did not identify any recommendation or opportunities for improvement and so no action place was issued. The full report for the 2016-2018 assessment can be found on the College's website at: https://www.cmo.on.ca/wp-content/uploads/2018/08/Registration-Practices-Assessment-Report-OFC-2016-2018.pdf • Where an action plan was issued, is it: Completed ☐ In Progress ☐ Not Started ☐ No Action Plan Issued X *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (if needed)*
Standard 11 **The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.**		
Measure	**Required evidence**	**College response**
		The College fulfills this requirement: Yes X Partially ☐ No ☐

11.1The College supports registrants in applying the (new/revised) standards of practice and practice guidelines applicable to their practice.	a. Provide examples of how the College assists registrants in implementing required changes to standards of practice or practice guidelines (beyond communicating the existence of new standard, FAQs, or supporting documents).	- **Provide a brief description of a recent example of how the College has assisted its registrants in the uptake of a new or amended standard:** ○ **Name of Standard** ○ **Duration of period that support was provided** ○ **Activities undertaken to support registrants** ○ **% of registrants reached/participated by each activity** ○ **Evaluation conducted on effectiveness of support provided** There is a growing body of evidence that shows that regulated professionals are more likely to comply with standards when they understand why those standards exist and believe such standards are legitimately improving their practice. This is why the College's consultation process is designed to not only seek input on our policy proposals but to engage in discussions with midwives to ensure midwives understand what is expected of them before, during, and after implementation and how the standards apply to their practice. As noted above, the College most recent standards review consisted of 2 phases. The activities undertaken to support midwives throughout the process where multiple standards were created, revised and rescinded included: Phase 1 (2016-2018) included the implementation of the Professional Standards for Midwives and the rescinding of 25 college standards: - Circulation of consultation paper to educate midwives about the College's new approach to regulation and standards development: https://www.cmo.on.ca/wp-content/uploads/2017/07/Consultation-Paper-standards.pdf - Paper to set out our response to all the issues raised by midwives in the first consultation and explains how the proposed changes will affect midwifery practice: https://www.cmo.on.ca/wp-content/uploads/2017/10/Response-to-Consultation.pdf - Member Education day held during the second consultation period (in person and via a live webcast). Two keynote speakers were invited to present on professionalism and competence to set the stage for the discussion about new standards: https://www.cmo.on.ca/member-education-day-2017/ - Presentations to senior midwifery students - Mass communication through website/ availability of practice advice - Multiple articles in College publications

		Phase 2 (2018-2020) included the implementation of the Midwifery Scope of Practice, revisions to the Professional Standards for Midwives and rescinding 3 College standards. The changes will come into effect on June 1, 2021: - Consultation paper (including providing findings from the first consultation): https://www.cmo.on.ca/wp-content/uploads/2020/08/Consultation-Paper-Phase-2-Final-.pdf - Response to consultation, including how the proposed changes will affect midwifery practice: https://www.cmo.on.ca/wp-content/uploads/2021/02/Response-to-consultation_Feb-2021.pdf - Meeting with midwifery students - Mass communication through website/ practice advice - Webinars scheduled for the spring of 2021 with midwives and senior midwifery students Does the College always provide this level of support: Yes X No □ *If not, please provide a brief explanation:* *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes □ No □* *Additional comments for clarification (optional)*
11.2 The College effectively administers the assessment component(s) of its QA Program in a manner that is aligned with right touch regulation[5].	a. The College has processes and policies in place outlining: i. how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice; ii. details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity (and	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **List the College's priority areas of focus for QA assessment and briefly describe how they have been identified *OR* link to website where this information can be found:** The College's new peer and practice assessment program implemented in January 2020 is grounded in the assumption that midwives are practising competently while recognizing that the changing dynamic of practice environments and best practices create the need for continued leaning and development. This approach emphasizes the non-punitive nature of the quality assurance program in line with the clear intent of the legislation. The evaluations are completed in a fair and consistent manner and are based on the College's competency framework that addresses the full spectrum of midwifery professional practice including non-technical competencies such as communication and interprofessional care. Owing to its broad competencies the CanMEDS framework was adapted, with permission, and validated by midwives during 2

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

	which type if multiple assessment activities); and iii. criteria that will inform the remediation activities a registrant must undergo based on the QA assessment, where necessary.	focus groups in May, 2018. The competency domains were identified as Expert, Communicator, Collaborator, Leader and Scholar. This framework was used as the foundation for tool development (see below). • **Is the process taken above for identifying priority areas codified in a policy: Yes** X **No** □ The framework used for the College's assessment program can be accessed here: https://www.cmo.on.ca/wp-content/uploads/2019/12/11.3-Competencies-October-2019.pdf • **Insert a link to document(s) outlining details of right touch approach and evidence used (e.g. data, literature, expert panel) to inform assessment approach *OR* describe right touch approach and evidence used:** The College's new assessment program uses objective and valid tools and is laddered or tiered meaning that it uses longer follow-up assessments only where risks are identified after a short distance assessment. These criteria are aligned with the principles of right-touch regulation (i.e., the regulation should aim to be proportionate, consistent, targeted, transparent, accountable, and agile) as demonstrated below. Each year, 10% of practising midwives are randomly selected to participate in a peer and practice assessment. There are two components to the assessment process; distance and in-person. Depending on the outcome of the distance assessment, participation in an in-person assessment may not be required. A distance assessment is conducted virtually between the assessor and the member being assessed and takes approximately an hour to complete. The assessment consists of short scenario-based questions that allow members to demonstrate their knowledge of midwifery practice, professional standards and the regulations that govern the profession. Midwives who indicate scores of 75% or above in the distance assessment are streamed out of the process and not required to participate in an in-person assessment. These members are also removed from the selection pool for a period of five years In-person assessments take place at the member's place of practice. They involve a review of a small selection of the member's charts as well as an interview about the care that was provided. The goal of the assessment is to identify possible areas for practise improvement. These assessments will take approximately three to four hours to complete. and. Assessors use the information gathered during the assessment process to summarize the member's knowledge and their application of midwifery legislation, standards and best practices in the provision of client care. All information is submitted to the Quality Assurance Committee (QAC) for review and determination of outcomes. The details of the College's peer and practice assessment program can be found here: https://www.cmo.on.ca/wp-content/uploads/2019/12/Peer-and-Practice-Assessment-Guide-Final-2019.pdf

		An example of the distance assessment tool can be found here: https://www.cmo.on.ca/wp-content/uploads/2019/12/11.4-Distance-Assessment-Sample-Scenario-.pdf The In-person Assessment Chart tool used during the in-person assessment is available on the website: https://www.cmo.on.ca/wp-content/uploads/2020/02/Chart-Tool-for-website-final.pdf • **Provide the year the right touch approach was implemented *OR* when it was evaluated/updated (if applicable):** ***If evaluated/updated, did the college engage the following stakeholders in the evaluation:*** – ***Public*** ***Yes*** □ ***No*** **x (only what we know from research)** – ***Employers*** ***Yes*** **x** ***No*** □ – ***Registrants*** ***Yes*** **x** ***No*** □ – ***other stakeholders*** ***Yes*** **x** ***No*** □ As noted above the new peer and practice assessment program was implemented in January 2020. For background information on how the program was developed, see pp. 107-111 of the December 11, 2019 Council package here: https://www.cmo.on.ca/wp-content/uploads/2019/11/meeting-book-council-meeting-15-.pdf • **Insert link to document that outlines criteria to inform remediation activities *OR* list criteria:** When a matter (either non-compliance with the quality assurance program requirements or unsatisfactory completion of an assessment program) brought to Quality Assurance Committee, panel members assess risk by applying a risk assessment tool to determine if a matter has no or minimal, low, moderate or high risk. In each situation there can be aggravating factors and mitigating factors, which will be considered by the panel. Depending on the level of risk, a recommended outcome will inform the panel's decision making. The Committee's risk assessment tool can be found here: https://www.cmo.on.ca/wp-content/uploads/2018/01/QAC_decision-tool_Final.May_.2018.pdf Assessment panels follow the same risk assessment process. Panel outcomes and risk factors that are taken into account when making a decision are outlined in a college document here: https://www.cmo.on.ca/wp-content/uploads/2019/12/Peer-and-Practice-Assessment-Guide-Final-2019.pdf It should be noted that formal regulatory action (e.g., SCERP or imposing a term, condition or limitation on a midwife's certificate of registration) taken by the Quality Assurance Committee is rare and is required only when a midwife refuses to cooperate with the College or has an extensive history of non-compliance or other College history. This is in line with the non-punitive nature of the quality assurance program.

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐ *Additional comments for clarification (optional)* One of the strategic priorities in the College's new 2021-2026 strategic plan is Effective Use of Data to Identify and Act on Existing and Emerging Risks. We are planning to enhance our data capabilities so that we better understand the emerging risks to safe and ethical practice. This work will allow us to conduct criteria-based assessments where a subset of midwives will be selected for an assessment based on pre-specified criteria based on areas of risk.
11.3 The College effectively remediates and monitors registrants who demonstrate unsatisfactory knowledge, skills, and judgment.	a. The College tracks the results of remediation activities a registrant is directed to undertake as part of its QA Program and assesses whether the registrant subsequently demonstrates the required knowledge, skill and judgement while practising.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Insert a link to the College's process for monitoring whether registrant's complete remediation activities *OR* describe the process:** Staff monitors completion of any remedial activities ordered by the Quality Assurance Committee. • **Insert a link to the College's process for determining whether a registrant has demonstrated the knowledge, skills and judgement following remediation *OR* describe the process:** Some remediation activities may include a follow up component, for example a chart review conducted after a midwife who was directed to complete a remediation activity has completed the activities ordered by the QAC. When this happens, a College assessor will conduct a chart interview with the midwife to look at their care management, decision-making and knowledge-base or non-technical competencies with a focus on areas where gaps were identified during the assessment. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (if needed)*
Standard 12 **The complaints process is accessible and supportive.**		
Measure	**Required evidence**	**College response**

12.1The College enables and supports anyone who raises a concern about a registrant.	a. The different stages of the complaints process and all relevant supports available to complainants are clearly communicated and set out on the College's website and are communicated directly to complainants who are engaged in the complaints process, including what a complainant can expect at each stage and the supports available to them (e.g. funding for sexual abuse therapy).	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Insert a link to the College's website that describes in an accessible manner for the public the College's complaints process including, options to resolve a complaint and the potential outcomes associated with the respective options and supports available to the complainant:** Information: The complaints process is transparent with information provided to the public on the College website, including flow charts https://www.cmo.on.ca/public/inquiries-reports-and-complaints/#fileclickto and numerous guiding documents. The College has a Guide to Filing a Complaint that can be found on the website: https://www.cmo.on.ca/wp-content/uploads/2018/06/Guide-to-Filing-a-Complaint-March-2020.pdf. This document provides guidance and helps complainants understand how to make a complaint, what the complaints process entails and possible outcomes. Additional information is provided to clients who make a complaint to the College about sexual abuse or are the subject of a registrar's investigation involving allegations of sexual abuse, at the time the allegation of sexual abuse is made. The Guide on Funding and Therapy (https://www.cmo.on.ca/wp-content/uploads/2018/05/Guide-on-Funding-for-Therapy-Counselling-final-May-2018-.pdf) sets out information on the process for obtaining funding for therapy and counselling for individuals who were, or may have been, sexually abused by a midwife while they were a client. Additional resources are available to for individuals who are applying for funding and therapy: https://www.cmo.on.ca/public/preventing-sexual-abuse/funding/ Furthermore, information is provided to complainants on the process in an acknowledgement of complaint package. Support: Relevant contact information is provided on the website, in the guide and in the acknowledgment sent to the complainant. All complainants are contacted by College staff within 2 days of receiving a complaint. Usually College staff will arrange a phone call to explain the complaints process and to confirm the issues of the complaint. Staff is available to respond to any further inquiries throughout the process. College has a policy (included in the Operations Manual) that require staff to acknowledge all inquiries within two business days and to provide a timeline in which the inquiry can be addressed if it cannot be addressed within that time. All staff of the College are responsible for abiding by this policy and identifying when the standard cannot be met to management. The generic email address: conduct@cmo.on.ca that is used in all formal documents for inquiries relating to complaints, reports, or unauthorized practice and general information about the complaints, discipline or ADR process have an automatic response programmed that indicate the inquiry is received and give the established timeline of 2 business days for a response. In addition, the College will translate documents as requested and will provide assistance with identifying a midwife. Finally, the College offers a practice advisory service at intake and throughout the process if complainants need advice on clinical, ethical or regulatory issues.

		Accessibility: The College's website meets the accessibility requirements under AODA. In addition, the content on the website is monitored and updated as needed to ensure that the information is presented in a format that is accessible and allows the public to understand how our complaints and discipline processes work, and how we make decisions that affect them. The changes are often informed by results from the complaints survey that is provided to the complainants (and midwives) following receipt of the panel's decision on the complaint matter. Complainants can file a complaint by mail, email or through an online form here: https://www.cmo.on.ca/public/inquiries-reports-and-complaints/submit-your-complaint/ Accessibility requests made by complainants (e.g., help needed to file a complaint) are accommodated by College staff. • **Does the College have policies and procedures in place to ensure that all relevant information is received during intake and at each stage of the complaints process:** Yes X No □ • **Does the College evaluate whether the information provided is clear and useful:** Yes X No □
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes □ No □
		Additional comments for clarification (optional)
	b. The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Insert rate (see Companion Document: Technical Specifications for Quantitative CPMF Measures) 100%
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes □ No □
		Additional comments for clarification (optional) As noted above, all inquiries are followed up on within two business days.
	c. Examples of the activities the College has undertaken in supporting the public during the complaints process.	• **List all the support available for public during complaints process:** Please see above (12.1.a) under *Support* • **Most frequently provided supports in CY 2020:** Responding to email and phone inquiries about the complaints process and providing updates on the status of the file.

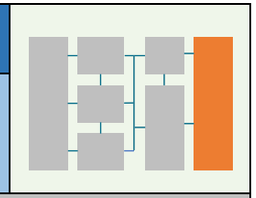
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐ *Additional comments for clarification (optional)*
12.2 All parties to a complaint and discipline process are kept up to date on the progress of their case, and complainants are supported to participate effectively in the process.	a. Provide details about how the College ensures that all parties are regularly updated on the progress of their complaint or discipline case and are supported to participate in the process.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Insert a link to document(s) outlining how all parties will be kept up to date and support available at the various stages of the process *OR* provide a brief description:** As noted above and in College guiding documents, the complainant and the midwife are provided with a written notice of complaint, that acknowledges the receipt of their complaint or informs a midwife that a complaint was filed against them and advises them of the next steps, including timelines and possible outcomes. All parties are regularly updated on the status of their file and College staff (including professional conduct staff and a practice advisor) is available to respond to any inquiries about the process or provide an update on the status of the case. Once investigation process reaches 150 days since the complaint was received, delay letters are sent to the complainant and a midwife. Subsequent letters are sent at 210 days (including to HPARB) and then every 30 days until the matter is disposed of. If the complaint is referred to discipline, relevant information is available on the website, including the process flow chart: https://www.cmo.on.ca/public/discipline-2/#flowclickto and College staff is available to respond to further inquiries about or provide information about the discipline process. The Discipline Rules of Procedures is available on the website: https://www.cmo.on.ca/wp-content/uploads/2015/07/Discipline-Rules-of-Procedure_30Nov18.pdf *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional)* The College's new strategic plan 2021-2026 identified *Building Engagement and Fostering Trust with the Public and the Profession* as a strategic priority. One of the initiatives undertaken to meet this priority is the development of an online portal to provide complainants and midwives with access to key information about the complaints process and to the status of their specific case at each step.
Standard 13 **All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.**		

Measure	Required evidence	College response
13.1 The College addresses complaints in a right touch manner.	a. The College has accessible, up-to-date, documented guidance setting out the framework for assessing risk and acting on complaints, including the prioritization of investigations, complaints, and reports (e.g. risk matrix, decision matrix/tree, triage protocol).	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Insert a link to guidance document *OR* describe briefly the framework and how it is being applied:** Once a complaint has been received in an appropriate form, it is immediately assessed for any risks to the public that need to be acted upon expeditiously by making an interim order and as to whether it could be referred to the College's Alternative Dispute Resolution (ADR) process. The criteria for identifying cases that warrant an interim order at intake and throughout the investigative process are set out in the College's ICRC Procedures Manual. The eligibility criteria for ADR are set out in the Alternative Dispute Resolution Eligibility Policy: https://www.cmo.on.ca/wp-content/uploads/2019/03/ADR-Eligibility-Policy_12DEC18.pdf Risk assessment is designed into our complaints and reports processes. Staff take risk into account in every decision, and every new piece of information triggers a risk assessment and consideration of whether action is necessary in response. This might be to prioritize the case, seek legal /expert advice, to interview a new witness, or to consider making an interim order. When a matter is brought to the Inquiries, Complaints and Reports Committee, they also assess risk by applying a risk assessment tool to determine if a matter has no or minimal, low, moderate or high risk. In each situation there can be aggravating factors and mitigating factors, which will be considered by the panel. Depending on the level of risk, a recommended outcome will inform the panel's decision making. The ICRC risk assessment tool is available on the College's website: https://www.cmo.on.ca/wp-content/uploads/2017/11/Revised-Categories-ICRC-Risk-Assessment-Framework-Updated-04JUN18.pdf **Provide the year when it was implemented *OR* evaluated/updated (if applicable):** In 2019, the College successfully completed a 3-year Risk Assessment Checklist Program developed by HIROC (Healthcare Insurance Reciprocal of Canada) which focused specifically on management of reports (the College completed two risk assessment checklists: Mismanagement of Complaints about Members from the Public and Mismanagement of Practitioner-Member Complaints). The completion of these checklists included a detailed review of all internal procedures and information to help with implementing efficient practices, including conducting a comprehensive file review which was completed in 2018. Conducting reviews of complaints/reports records is now part of the department work plan and is conducted periodically to ensure adherence to internal complaint/report management processes. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐*

		Additional comments for clarification (optional)
Standard 14 **The College complaints process is coordinated and integrated.**		
Measure	**Required evidence**	**College response**
14.1The College demonstrates that it shares concerns about a registrant with other relevant regulators and external system partners (e.g. law enforcement, government, etc.).	a. The College's policy outlining consistent criteria for disclosure and examples of the general circumstances and type of information that has been shared between the College and other relevant system partners, within the legal framework, about concerns with individuals and any results.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Insert a link to policy *OR* describe briefly the policy:** The College's internal disclosure policies and procedures are in line with the requirements set out in the RHPA and other provincial legislation. In addition, the College proactively discloses concerns about midwives in the following circumstances: <u>Disclosures to a body to a body that governs a profession inside or outside of Ontario</u> A Letter of Standing and Professional conduct that discloses professional conduct information is provided in situations where a midwife applies for a midwifery certificate of registration in another jurisdiction (other midwifery jurisdictions in Canada and internationally). These letters were developed in collaboration with other Canadian midwifery regulators through the Canadian Midwifery Regulators Council. <u>Disclosures to hospitals, midwifery practice groups and other health facilities</u> Upon request, the College discloses professional conduct information to hospitals and other facilities (such as birth centres) as well as midwifery practice groups. A letter of professional conduct is required by Ontario hospitals and other health facilities reviewing a midwife's application for hospital privileges or by midwifery practice groups for employment. <u>Disclosures under 36(1)g of the RHPA</u> Disclosures under 36(1)g (i.e., ongoing investigations) are made only when there is compelling public interest in disclosing such information. Such disclosures are considered on a case-by-case basis and must be authorized by Manager who would consider the seriousness of the alleged conduct and the countervailing privacy rights of the midwife. Further details about the above-mentioned letters, including what information is disclosed, can be found here: https://www.cmo.on.ca/applicants/registration-policies/

		Provide an overview of whom the College has shared information over the past year and purpose of sharing that information (i.e., general sectors of system partner, such as 'hospital', or 'long-term care home'). As noted above, the information is proactively shared with Ontario hospitals and other health facilities where a midwife holds privileges, midwifery practice groups as well as other regulators inside or outside of Ontario. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (if needed)*

DOMAIN 7: MEASUREMENT, REPORTING, AND IMPROVEMENT



Standard 15

The College monitors, reports on, and improves its performance.

Measure	Required evidence	College response
15.1 Council uses Key Performance Indicators (KPIs) in tracking and reviewing the College's performance and regularly reviews internal and external risks that could impact the College's performance.	a. Outline the College's KPI's, including a clear rationale for why each is important.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • **Insert a link to document that list College's KPIs with an explanation for why these KPIs have been selected (including what the results the respective KPIs tells, and how it relates to the College meeting its strategic objectives and is therefore relevant to track), link to Council meeting materials where this information is included *OR* list KPIs and rationale for selection:** The College assesses its performance in three different ways: 1. Measures regulatory performance against the standards of good regulation set by Council 2. Assesses risks to its regulatory outcomes set by Council (in 2017 and revised in 2020) 3. Reports on progress of the strategic priorities against success measures set by the College's Council

		Regulatory performance measurement The College's regulatory performance measurement framework was approved in June 2019 and piloted in 2019/2020 fiscal year. This framework provides the College with a way to review, evaluate and report on its performance using a set of standards based on its legislative mandate and expected outcomes. The framework describes the outcomes the College is expected to achieve in four broad domains: Regulatory Policy; Suitability to Practise; Openness and Accountability; Good Governance. It comprises a number of performance standards that form the basis of the performance measurement framework. A performance standard is a minimum level of performance for the College to achieve while fulfilling its regulatory functions. Some of the standards must be met as they are required under legislation and regulations. Other standards are voluntary which means that the College will strive to meet them as part of its commitment to regulatory excellence. All standards are based on the principles of good regulation and were developed based on the work done by the Organization for Economic Co-operation and Development (OECD) and the European Commission, the Professional Standards Authority and other professional authorities in the UK and Australia. In developing the performance standards, the College sought to give a balanced overall picture of what the organization is required to do, covering all functional areas of the College such as regulatory policy, registration, investigations and complaints, and quality assurance. Operational questions, such as budgeting and human resources, are beyond the scope of this framework. Qualitative and quantitative data are used to demonstrate that the College has met each standard. Qualitative data include descriptions of requirements as well as systems and procedures the College has in place. Quantitative data is based on what data is available and feasible to collect given the College's size and resources. The College underwent organizational re-structuring in 2019 to enable a member of the senior management team to conduct annual internal reviews. **Assessment of risks to our regulatory outcomes** In 2017, implementation of risk-based regulation was made a strategic priority in the College's 2017-2020 Strategic Plan. As part of this work, the College developed a list of regulatory outcomes. These outcomes are compatible with the duty and the objectives of the College as set out in the *Regulated Health Professions Act, 1991,* and specify the desired results that we intend to achieve in fulfilling our public protection mandate. The outcomes were reviewed and revised in 2020 as part of our new strategic plan and can be viewed here: https://www.cmo.on.ca/wp-content/uploads/2021/03/Strategic-Framework.pdf The College also created a Risk Register in order to ensure consistency in the way in which risks are identified and to have a comprehensive picture of our risk exposures across all core areas of regulatory activity that may pose a risk to our regulatory outcomes.

		Risks are assessed regularly - the College's Risk Register is a living document that evolves as new risks emerge and as the regulatory/operating environment changes. However, a comprehensive risk assessment is conducted as part of the College's strategic planning process (every 3-5 years) to ensure that the College's strategic goals are guided by focusing activity and attention on issues that were identified as high priority risks for the organization. The College assesses its risks by using a risk assessment matrix, which is an important part of the College's risk management decision-making process. The goal is to rank the risks to determine priority. Assessment is about two things: the likelihood that the event will happen and how severe is the outcome of the event. Likelihood and impact both receive a score using a similar scale. The risk level is then calculated from the two scores. For example, a risk with high likelihood and high impact will rank higher than a risk with low likelihood and medium impact. This exercise leads to a list of risks ranked according to their combined score of likelihood and impact which then leads to identifying mitigating strategies and deciding what action to take. It is the risk tolerance of the organization that will ultimately determine the type and extent of action taken. The Risk Matrix (including the Risk Register) can be viewed here: https://www.cmo.on.ca/wp-content/uploads/2021/03/Risk-Matrix-2020.pdf Risk assessment scale can be viewed here: https://www.cmo.on.ca/wp-content/uploads/2021/03/Risk-Assessment-Scales.pdf **Performance as it relates to meeting the strategic priorities set by the College's Council** The College's strategic plan consists of strategic priorities (identified through risk assessment as described above), the outcomes the College is expected to achieve as well as success measures identified to demonstrate that success in achieving these priorities. The College's operational plan, that outlines in great detail areas of work for the year, is approved by Council at its March meeting and a progress report is provided to Council again at the end of the fiscal year.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed)
		The College fulfills this requirement: Yes ☐ Partially ☐ No ☐

	b. Council uses performance and risk information to regularly assess the College's progress against stated strategic objectives and regulatory outcomes.	• **Insert a link to last year's Council meetings materials where Council discussed the College's progress against stated strategic objectives, regulatory outcomes and risks that may impact the College's ability to meet its objectives and the corresponding meeting minutes:** • June 2020 Council meeting where the results of the College's performance evaluation (pilot review) were presented to Council. The 2020/2021 internal review will be conducted in April 2021 and the report will be presented to Council in June 2021 and posted publicly on College website. Council meeting materials (agenda item 11): https://www.cmo.on.ca/wp-content/uploads/2020/06/meeting-book-council-meeting-7.pdf Minutes: https://www.cmo.on.ca/wp-content/uploads/2020/09/4.0-Approved-Council-Meeting-Minutes-June-24-2020.pdf • December 2020 Council meeting to review the strategic priorities for the 2021-2026 Strategic proposed by the Strategic Planning Working Group, which included a review of the Risk Assessment Matrix (a full day Strategic Planning Retreat was held in December): https://www.cmo.on.ca/wp-content/uploads/2020/11/meeting-book-council-meeting-3.pdf (the minutes from the December Council will be approved at the March Council meeting) • March 2020 Council meeting to approve the Operational Plan for 2020 (provided under Registrar's report): https://www.cmo.on.ca/wp-content/uploads/2020/03/meeting-book-council-meeting-March-25-2020-for-website2.pdf (progress report on the 2020 operational plan will be provided to Council in March 2021) • Minutes from the March 2020 meeting can be found here: https://www.cmo.on.ca/wp-content/uploads/2020/06/FINAL-Council-Meeting-Minutes-March-25-2020.pdf *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (if needed)*
		The College fulfills this requirement: Yes X Partially ☐ No ☐

<table>
<tr>
<td>15.2 Council directs action in response to College performance on its KPIs and risk reviews.</td>
<td>a. Where relevant, demonstrate how performance and risk review findings have translated into improvement activities.</td>
<td>

• **Insert a link to Council meeting materials where relevant changes were discussed and decided upon:**

As noted above, as a risk-based regulator, the College ensures that its regulatory activities remain focused on risks to the public. The College's conducts risk assessment as part of its strategic planning to proactively reduce the risks posed to its regulatory outcomes by targeting its strategic priorities at the greatest areas of need. Such risk assessment was last conducted in 2020 as part of a year-long strategic planning process where the following risks were identified as high priority through this exercise.

<table>
<tr><th>#</th><th>High Priority Risks</th><th>Level</th></tr>
<tr><td>1</td><td>Risks arising from changes in the midwifery environment that may affect midwifery practice.</td><td></td></tr>
<tr><td>2</td><td>Risks arising from a lack of adequate training, including bridging and remedial opportunities for midwives with identified gaps and deficiencies in professional knowledge.</td><td></td></tr>
<tr><td>3</td><td>Risk that a midwife does not maintain the knowledge and clinical skills necessary to provide safe and effective care to clients</td><td></td></tr>
<tr><td>4</td><td>Risk that a midwife fails to meet legislative or regulatory requirements</td><td></td></tr>
<tr><td>5</td><td>Risk that the College grants eligibility to (re)enter practice to an individual who does not have the knowledge & skills to practice safely, ethically and competently</td><td></td></tr>
<tr><td>6</td><td>Risk arising from a lack of data and records mismanagement</td><td></td></tr>
<tr><td>7.</td><td>Risk arising from increased expectations of information, openness in decision-making and demonstrating our value as the regulator</td><td></td></tr>
</table>

To learn more about how the College assesses the likelihood of a risk even occurring and the severity of outcome see the risk assessment scale here: https://www.cmo.on.ca/wp-content/uploads/2021/03/Risk-Assessment-Scales.pdf

Based on the above, the following priorities were approved by Council for the College's Strategic Plan 2021-2026

Strategic Priority 1: Regulation that enables the midwifery profession to evolve (to mitigate risks 1-5)
Strategic Priority 2: Effective use of data to identify and act on existing and emerging risks (to mitigate risk 6)
</td>
</tr>
</table>

		Strategic Priority 3: Building engagement and fostering trust with the public and the profession (to mitigate risks 7) Council meeting materials where relevant changes were discussed and decided upon can be found here: December 2020 Council meeting: https://www.cmo.on.ca/wp-content/uploads/2020/11/meeting-book-council-meeting-3.pdf
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed)
15.3 The College regularly reports publicly on its performance.	a. Performance results related to a College's strategic objectives and regulatory activities are made public on the College's website.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Insert a link to College's dashboard or relevant section of the College's website: Please see our response and links provided above under 15.1a Starting from 2020, the College will use its regulatory performance measurement framework to conduct regular annual performance reviews. The College will compare the results of each year's review with the results from previous years in order to determine how its performance has improved or worsened over time. Where differences are noted, an explanation will be provided. The results of the performance review will be presented to Council every year at its June meeting and will be posted to the website. The first public report will be made available on the website in the summer of 2021.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed)

PART 2: CONTEXT MEASURES

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

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

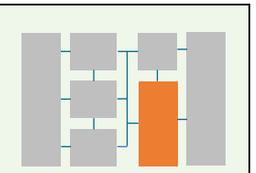
In those instances where a College does not have the data or the ability to calculate the context measure at this point in time it should state: 'Nil' and indicate any plans to collect the data in the future.

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

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.



Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended □ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)

CM 1. Type and distribution of QA/QI activities and assessments used in CY 2020*

Type of QA/QI activity or assessment	#
i. Annual Continuing Education and Professional Development	821
ii. Annual peer and practice assessments	79
iii. *<Insert QA activity or assessment>*	
iv. *<Insert QA activity or assessment>*	
v. *<Insert QA activity or assessment>*	
vi. *<Insert QA activity or assessment>*	
vii. *<Insert QA activity or assessment>*	
viii. *<Insert QA activity or assessment>*	
ix. *<Insert QA activity or assessment>*	
x. *<Insert QA activity or assessment>*	

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

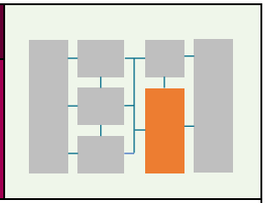
***NR** = Non-reportable: results are not shown due to < 5 cases*

What does this information tell us? *Quality assurance (QA) and Quality Improvement (QI) are critical components in ensuring that professionals provide care that is safe, effective, patient centred and ethical. In addition, health care professionals face a number of ongoing changes that might impact how they practice (e.g. changing roles and responsibilities, changing public expectations, legislative changes).*

The information provided here illustrates the diversity of QA activities the College undertook in assessing the competency of its registrants and the QA and QI activities its registrants undertook to maintain competency in CY 2020. The diversity of QA/QI activities and assessments is reflective of a College's risk-based approach in executing its QA program, whereby the frequency of assessment and activities to maintain competency are informed by the risk of a registrant not acting competently. Details of how the College determined the appropriateness of its assessment component of its QA program are described or referenced by the College in Measure 13(a) of Standard 11.

Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care

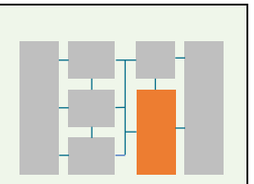
Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended □ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
	#	%	***What does this information tell us?*** *If a registrant's knowledge, skills and judgement to practice safely, effectively and ethically have been assessed or reassessed and found to be unsatisfactory or a registrant is non-compliant with a College's QA Program, the College may refer him or her to the College's QA Committee.* *The information provided here shows how many registrants who underwent an activity or assessment in CY 2020 as part of the QA program where the QA Committee deemed that their practice is unsatisfactory and as a result have been directed to participate in specified continuing education or remediation program.*
CM 2. Total number of registrants who participated in the QA Program CY 2020	1. 72 assessed 2. 802 compliant	1. 9% 2. 98%	
CM 3. Rate of registrants who were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undertake remediation. *	NR	NR	

Additional comments for clarification (optional)
* *NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)*

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.

Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended □ College methodology

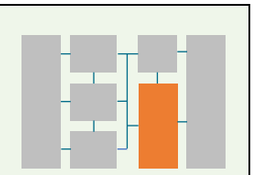
If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
CM 4. Outcome of remedial activities in CY 2020*:	#	%	***What does this information tell us?*** *This information provides insight into the outcome of the College's remedial activities directed by the QA Committee and may help a College evaluate the effectiveness of its "QA remediation activities". Without additional context no conclusions can be drawn on how successful the QA remediation activities are, as many factors may influence the practice and behaviour registrants (continue to) display.*
I. Registrants who demonstrated required knowledge, skills, and judgment following remediation**	NR		
II. Registrants still undertaking remediation (i.e. remediation in progress)	NR		

Additional comments for clarification (if needed)

** NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)*
*** This measure may include registrants who were directed to undertake remediation in the previous year and completed reassessment in CY2020.*

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended □ College methodology

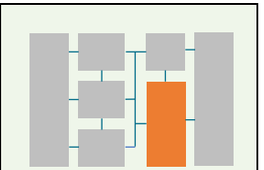
If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)

CM 5. Distribution of formal complaints* and Registrar's Investigations by theme in CY 2020	Formal Complaints received‡		Registrar Investigations initiated‡		
Themes:	#	%	#	%	
I. Advertising	NR	NR	0	0	***What does this information tell us?*** *This information facilitates transparency to the public, registrants and the ministry regarding the most prevalent themes identified in formal complaints received and Registrar's Investigations undertaken by a College.*
II. Billing and Fees	0	0	0	0	
III. Communication	30	57%	0	0	
IV. Competence / Patient Care	23	43%	NR	NR	
V. Fraud	0	0	0	0	
VI. Professional Conduct & Behaviour	0	0	NR	NR	
VII. Record keeping	0	0	0	0	
VIII. Sexual Abuse / Harassment / Boundary Violations	0	0	0	0	
IX. Unauthorized Practice	0	0	0	0	
X. Other <*Issues related to Practice Management*>	NR	NR	NR	NR	

Total number of formal complaints and Registrar's Investigations**	**46**	**100%**	**9**	**100%**	
* ***Formal Complaint**: A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquires and other interactions with the College that do not result in a formally submitted complaint.* ***Registrar's Investigation**: Where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.* ǂ ***NR** = Non-reportable: results are not shown due to < 5 cases (for both # and %)* ** *The requested statistical information (number and distribution by theme) recognizes that formal complaints and registrar's investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar's investigations.*					
The College received new 30 complaints, which resulted in complaints being filed about 46 Registrants. Under NR, the College received 1 complaint about advertising, and 4 complaints about Registrant's practice management. There was a total of 58 issues. The College commenced 9 Registrar's Investigations, 1 related to Practice management, 7 related to Professional Conduct & Behaviour, and 3 related to Competence/Patient Care.					

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: □ Recommended □ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
CM 6. Total number of formal complaints that were brought forward to the ICRC in CY 2020	69		
CM 7. Total number of ICRC matters brought forward as a result of a Registrars Investigation in CY 2020	16		
CM 8. Total number of requests or notifications for appointment of an investigator through a Registrar's Investigation brought forward to the ICRC that were approved in CY 2020	9		
CM 9. Of the formal complaints* received in CY 2020**:	#	%	***What does this information tell us?*** *The information helps the public better understand how formal complaints filed with the College and Registrar's Investigations are disposed of or resolved. Furthermore, it provides transparency on key sources of concern that are being brought forward to the College's committee that investigates concerns about its registrants.*
I. Formal complaints that proceeded to Alternative Dispute Resolution (ADR)ǂ	NR	NR	
II. Formal complaints that were resolved through ADR	NR	NR	
III. Formal complaints that were disposed** of by ICRC	35	51%	
IV. Formal complaints that proceeded to ICRC and are still pending	33	49%	
V. Formal complaints withdrawn by Registrar at the request of a complainant D	NR	NR	
VI. Formal complaints that are disposed of by the ICRC as frivolous and vexatious	0	0	

VII. Formal complaints and Registrars Investigations that are disposed of by the ICRC as a referral to the Discipline Committee	NR	NR	

** ***Disposal:*** *The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*

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

ǂ ***ADR****: Means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute.*

D The Registrar may withdraw a formal complaint prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest.

 # May relate to Registrars Investigations that were brought to ICRC in the previous year.

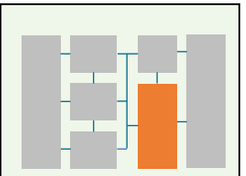
** *The total number of formal complaints received may not equal the numbers from 9(i) to (vi) as complaints that proceed to ADR and are not resolved will be reviewed at ICRC, and complaints that the ICRC disposes of as frivolous and vexatious and a referral to the Discipline Committee will also be counted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

ƒ ***Registrar's Investigation:*** *Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.*

NR *= Non-reportable: results are not shown due to < 5 cases (for both # and %)*

The College had 4 complaints that proceeded to ADR, 3 of which were resolved through ADR. The College has 1 complaint that was withdrawn by the Registrar at the request of a Complainant. The ICRC referred 1 matter to Discipline. These numbers are recorded as non-reportable in the chart above based on criteria set out.

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended □ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)							
CM 10. Total number of ICRC decisions in 2020							
Distribution of ICRC decisions by theme in 2020*	# of ICRC Decisions‡						
Nature of issue	Take no action	Proves advice or recommendations	Issues an oral caution	Orders a specified continuing education or remediation program	Agrees to undertaking	Refers specified allegations to the Discipline Committee	Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations or by-laws.
I. Advertising	0	0	0	0	0	0	0
II. Billing and Fees	0	0	0	0	0	0	0
III. Communication	8	NR	0	0	0	0	0
IV. Competence / Patient Care	18	5	NR	NR	NR	NR	0
V. Fraud	0	0	0	0	0	0	0
VI. Professional Conduct & Behaviour	NR	NR	0	NR	0	0	0
VII. Record keeping	0	0	0	0	0	0	0
VIII. Sexual Abuse / Harassment / Boundary	0	0	0	0	0	0	0
IX. Unauthorized Practice	0	0	0	0	0	0	0

X. Other <*Practice Management*>	NR	NR	0	NR	0	0	0

** Number of decisions are corrected for formal complaints ICRC deemed frivolous and vexatious AND decisions can be regarding formal complaints and registrar's investigations brought forward prior to 2020.*

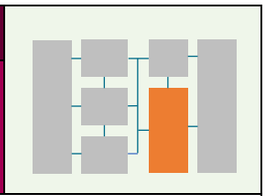
*ǂ **NR** = Non-reportable: results are not shown due to < 5 cases.*

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

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

Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended □ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

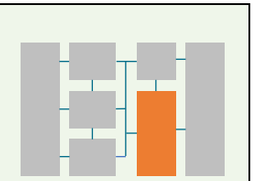
Context Measure (CM)		
CM 11. 90th Percentile disposal* of:	Days	***What does this information tell us?*** *This information illustrates the maximum length of time in which 9 out of 10 formal complaints or Registrar's investigations are being disposed by the College.* *The information enhances transparency about the timeliness with which a College disposes of formal complaints or Registrar's investigations. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the disposal of a formal complaint filed with, or Registrar's investigation undertaken by, the College.*
I. A formal complaint in working days in CY 2020	772	
II. A Registrar's investigation in working days in CY 2020	NR	

* ***Disposal Complaint:*** *The day where a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*
* ***Disposal Registrar's Investigation:*** *The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*
Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended □ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
CM 12.	90th Percentile disposal* of:	Days	***What does this information tell us?*** *This information illustrates the maximum length of time in which 9 out of 10 uncontested discipline hearings and 9 out of 10 contested discipline hearings are being disposed. ** *The information enhances transparency about the timeliness with which a discipline hearing undertaken by a College is concluded. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the resolution of a discipline proceeding undertaken by the College.*
I.	An uncontested^ discipline hearing in working days in CY 2020	NR	
II.	A contested# discipline hearing in working days in CY 2020	0	

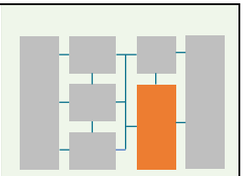
* ***Disposal:*** *Day where all relevant decisions were provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant, including both liability and penalty decisions, where relevant).*

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

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

The College held no contested hearings in 2020.
The College held one uncontested hearing and the actual working days from time of receipt to disposal was 291 days.

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: □ Recommended □ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)

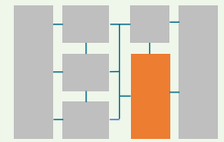
CM 13. Distribution of Discipline finding by type*

Type		#
I.	Sexual abuse	0
II.	Incompetence	0
III.	Fail to maintain Standard	NR
IV.	Improper use of a controlled act	0
V.	Conduct unbecoming	NR
VI.	Dishonourable, disgraceful, unprofessional	NR
VII.	Offence conviction	0
VIII.	Contravene certificate restrictions	0
IX.	Findings in another jurisdiction	0
X.	Breach of orders and/or undertaking	0
XI.	Falsifying records	0
XII.	False or misleading document	0
XIII.	Contravene relevant Acts	0

What does this information tell us? *This information facilitates transparency to the public, registrants and the ministry regarding the most prevalent discipline findings where a formal complaint or Registrar's Investigation is referred to the Discipline Committee by the ICRC.*

* *The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the number of findings may not equal the total number of discipline cases.* ***NR** = Non-reportable: results are not shown due to < 5 cases.*
This data is relevant to the one completed case. The Discipline Panel found the Member to be unprofessional and did not make findings with respect to dishonourable and disgraceful.

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended □ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)

CM 14. Distribution of Discipline orders by type*

Type	#
I. Revocation+	0
II. Suspension$	0
III. Terms, Conditions and Limitations on a Certificate of Registration**	NR
IV. Reprimand^ and an Undertaking#	0
V. Reprimand^	NR

What does this information tell us? *This information will help strengthen transparency on the type of actions taken to protect the public through decisions rendered by the Discipline Committee. It is important to note that no conclusions can be drawn on the appropriateness of the discipline decisions without knowing intimate details of each case including the rationale behind the decision.*

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

\+ *Revocation of a registrant's certificate of registration occurs where the discipline or fitness to practice committee of a health regulatory college makes an order to "revoke" the certificate which terminates the registrant's registration with the college and therefore his/her ability to practice the profession.*

$ *A suspension of a registrant's certificate of registration occurs for a set period of time during which the registrant is not permitted to:*

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

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

^ *A reprimand is where a registrant is required to attend publicly before a discipline panel of the College to hear the concerns that the panel has with his or her practice*

\# *An undertaking is a written promise from a registrant that he/she will carry out certain activities or meet specified conditions requested by the College committee.*

***NR** = Non-reportable: results are not shown due to < 5 cases*
Actual data is relative to 1 case. There was 1 reprimand issued and TCLs were placed on one certificate of Registration

For questions and/or comments, or to request permission to use, adapt or reproduce the information in the CPMF please contact:

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Appendix A: Public Interest

When contemplating public interest for the purposes of the CPMF, Colleges may wish to consider the following (please note that the ministry does not intend for this to define public interest with respect to College operations):