AGENDA

Council Meeting
College of Homeopaths of Ontario

Thursday, June 12, 2025 10:00 a.m. – 12:10 p.m.
by teleconference

		ITEM	ACTION	MATERIAL	WHO	START TIME	DURATION
1		**Call to Order**	**Information**		**B Sharma**	**10:00**	**2 min**
2		**Welcome to Guests and New Council Members**	**Information**		**B Sharma**	**10:02**	**10 min**
3		**Agenda**					
	3.1	Consent Agenda* and Committee Reports 3.1.1 Update on Action Items 3.1.2 Membership Scorecard 3.1.3 ICRC Report 3.1.4 Registration Cttee Report 3.1.5 2024 CPMF 3.1.6 2024 OFC Report 3.1.7 SML Grey Areas	**Information**	3.1.1 3.1.2 3.1.3 3.1.4 3.1.5 3.1.6 3.1.7	**B Ziv**	**10:12**	**5 min**
	3.2	Adoption of Agenda	**Decision**	**3.2**	**B Sharma**	**10:17**	**3 min**
4		**Declaration of Conflict of Interest**	**Decision**	**4.1**	**B Sharma**	**10:20**	**3 min**
5		**Approval of minutes February 20, 2025**	**Decision**	**5.1**	**B Sharma**	**10:23**	**5 min**
6		**Election of Executive Committee**	**Decision**	**6.1**	**B Ziv**	**10:28**	**50 min**
BREAK						**11:18**	**8 min**

	ITEM	ACTION	MATERIAL	WHO	START TIME	DURATION
IN CAMERA						

As permitted by the Regulated Health Professions Act, 1991*, Schedule 2, section 7.2, there are times when it is appropriate for Council to discuss matters* in camera*. These include issues of public security; financial or personal or other matters of such a nature that it is desirable to avoid public disclosure; information related to a person involved in a criminal proceeding or civil suit; personnel matters or property acquisition; or instructions to be given to or opinions received from legal counsel. A meeting or any portion of a conference held* in-camera *is not open to the public.*

7		**Approval of *in camera* minutes– February 20, 2025**	**Decision**	**7.1**	**Chair**	**11:26**	**5 min**
8		**Statement of Operations**	**Decision**	**8.1**	**B Ziv**	**11:31**	**10 min**
9		**Council Self-Assessment and Third-Party Evaluation**	**Discussion**		**K Harvey**	**11:41**	**10 min**
10		**Committee Assignments**	**Decision**	**10.1**	**K Harvey**	**11:51**	**5 min**
11		**Other Business and Action Items Arising**	**Discussion**		**Chair**	**11:56**	**5 min**
12		**2025-2026 Meeting Dates**	**Information**		**K Harvey**	**12:01**	**5 min**
13		**HBS – Preparation Time**	**Information**		**Chair**	**12:06**	**2 min**
14		**Adjournment**	**Decision**		**Chair**	**12:08**	**2 min**

* A consent agenda is a bundle of items that is voted on, without discussion, as a package. It differentiates between routine matters not needing explanation and more complex issues needing examination. The Chair will ask if anyone wishes to remove an item from the consent agenda. Any Council member may request an item be removed so it can be discussed. To test whether an item should be included in the consent agenda, ask:

Is this item self-explanatory and uncontroversial? Or does it contain an issue that warrants Council discussion? Is this item for information only? Or is it needed for another meeting agenda issue?

NOTE: Please be reminded that all meeting materials, discussions, and decisions are confidential to the College and cannot be copied or shared until they are made public.

Log-in Information

Join Zoom Meeting

https://us02web.zoom.us/j/87062522929

Meeting ID: 870 6252 2929

Passcode: 582475

1 647 374 4685

College of Homeopaths of Ontario

Council Member Declarations

re: Conflict of Interest as of June 2025

Statement

Annually, CHO Council members complete a written declaration of Conflict of Interest which acknowledges and agrees to the premise that an actual or perceived conflict of interest can undermine confidence in the College and its ability to fulfill its public interest mandate. Council members review the College's Bylaws and conflict of interest policies and agree to take all reasonable steps to avoid any actual or perceived conflict of interest from arising and. If one cannot be avoided, Council members are required, in advance and at each meeting, to declare any real, perceived or potential conflict of interest and to remove him- or herself from any consideration of the matter in issue.

Council Member	Form Signed and Returned	Affiliations Identified	Conflict Identified
Akhlaq Ahmad	✓	Ontario Homeopathic Medical Association, Director 2017-2021 (resigned upon assuming seat on Council)	None
Sajeev Ampadi			None
Ayinde Azeez	✓	Licensed Financial Advisor	None
Heather Broadhead	✓	Rotary Club of London, member, ongoing Institute of Corp. Directors, member, ongoing Vimy Ridge Legion, member, ongoing	None
Kerri Flood	✓	CCHM, contract teacher, 2020-2021	None
Tyler Groen			None

Council Member	Form Signed and Returned	Affiliations Identified	Conflict Identified
Catherine Kerr	✓	None	None
Kamika McLean	✓	None	None
Sanjeev Nayyar	✓	Member, Ontario Homeopathic Medical Association	None
Bhupinder Sharma	✓	LIGA Homeopathica Medicorum Internalis, NVP Canada, 2009-present Ontario Homeopathic Medical Association, member, 2017-present Canadian Homeopathic Medical College, Dean, teaching homeopathy, 2016-present Past affiliations: Community Advisory Council, William Osler Health, Brampton General Hospital, member, 2009-2019 Community Care Access Centre, board member, 2009-2017 Homeopathic Medical Educational Center of Canada, teacher, 2006-2008	None
Yen Tran	✓	None	None
Paridhi Wasal	✓	Board of Directors, Ontario Homeopathic Medical Association, 2022-2024 (resigned upon election to Council)	None

DRAFT

Council Meeting
College of Homeopaths of Ontario (CHO)
Minutes

Thursday, February 20, 2025
by telephone and video conference

Present

Council

Bhupinder Sharma	Professional (Chair)
Akhlaq Ahmad	Professional
Ayinde Azeez	Public
Heather Broadhead	Public
Kerri Flood	Professional
Gifty Jassal	Professional
Catherine Kerr	Public
Kamika Mclean	Public
Sanjeev Nayyar	Professional
Angela Vani	Professional
Paridhi Wasal	Professional

Regrets

Yen Tran	Public

Staff

Kathryn Harvey	Deputy Registrar (recorder)
Basil Ziv	Registrar and CEO

Guests

Sarah Kibaalya	Health Workforce Regulatory Oversight Branch, Ministry of Health

1 Call to Order

The President called the meeting to order at 10:02 a.m. and conducted a roll call.

2 Welcome to New Council Members

The Chair welcomed Sarah Kibaalya from the Ministry of Health.

3 Agenda

3.1 Consent Agenda and Committee Reports

3.1.1 Update on Action Items
3.1.2 Membership Scorecard
3.1.3 Governance Panel Report
3.1.4 Executive Committee Report
3.1.5 Correspondence with Health Canada re: Importation of Remedies
3.1.6 SML Grey Areas

The Chair indicated that item 3.1.1 Update on Action Items would be raised in Other Business.

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Motion # 1: To adopt the consent agenda as amended
Moved by H. Broadhead, seconded by K. Flood

That Council adopt the consent agenda as amended.
CARRIED

3.2 Adoption of Agenda
(Appendix 3.2 Council Agenda)

Motion # 2: To adopt the agenda
Moved by H. Broadhead, seconded by K. Flood

That Council adopt the agenda.
CARRIED

4 Declaration of Conflict of Interest
(Appendix 4.1 Council Member Declarations re: Conflict of Interest)

None declared.

5 Approval of Minutes

5.1 September 26, 2024
(Appendix 5.1 Minutes, September 26, 2024 Council meeting)

Motion # 3: To approve the minutes of September 26, 2024
Moved by A. Ahmad, seconded by P. Wasal

That Council approve the minutes of its September 26, 2024 meeting.
CARRIED

6 Operational Goals and Objectives
(Appendix 6.1 2025-2026 OPGO)

6.1 2025-2026 OPGO
Staff reviewed the updated OPGO, noting that there had been few changes from the previous version in keeping with an earlier motion to maintain the same direction into the 2025 period. Updates were provided on deliverables.

Motion # 4: To approve the 2025-2026 OPGO
Moved by H. Broadhead, seconded by G. Jassal

That Council approve the 2025-2026 Operating Goals and Objectives as presented.
CARRIED

6.2 Update on Triad
Staff provided a history of the triad and described the current status of the College's relationship with its stakeholder partners.

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7 Council Evaluation Activities

7.1 2023-2024 Council Self-Assessment

(Appendix 7.1 Council Self-Assessment Report, 2023-2024)

Staff provided a brief overview of the results of the 2023-2024 Council Self-Assessment and indicated that Council member input will be sought on ways to make the process more useful.

7.2 Council Competency Framework as a Self-Assessment Tool

(Appendix 7.2 CHO Council Competency Framework 2024)

Deferred.

8 Rebranding/Engagement Strategies Update

8.1 Scope of Practice Project

Staff reported that this project would ramp up over the summer.

8.2 Communications Strategy

Staff briefly described communications issues in light of environmental changes related to provincial election and changes in the system partner landscape.

9 Health Professions Discipline Tribunals

The Registrar provided an overview of the tribunal structure, noting that while it had been effective thus far for a number of Colleges with significant complaint volumes, it might be too big an investment given the CHO's relatively small number of discipline cases. Staff will continue to monitor opportunities and will seek information from another small college that recently signed on to the HPDT.

Secretary's note:

As permitted by the Regulated Health Professions Act, 1991*, Schedule 2, section 7.2 there are times when it is appropriate for Council to discuss matters* in camera*. These include matters of public security; financial or personal or other matters of such a nature that it is desirable to avoid public disclosure; information related to a person involved in a criminal proceeding or civil suit; personnel matters or property acquisition; or instructions to be given to or opinions received from legal counsel. A meeting or any portion of a meeting held* in camera *is not open to the public.*

Motion # 5: To move *in camera*
Moved by H. Broadhead, seconded by G. Jassal

That Council move *in camera* at 11:36 a.m.
CARRIED

13 Other Business and Action Items Arising

Council discussed a request from a triad partner for a list of registrant names.

14 HBS Preparation Time

Half day preparation, half day meeting
Start time: 10:02 a.m.
End time: 12:28 p.m.

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15 Adjournment

Motion # 11: To adjourn
Moved by H. Broadhead, seconded by P. Wasal

That Council adjourn at 12:28 p.m.
CARRIED

The Chair agrees these minutes are an accurate reflection of the meeting.

Chair **Date**

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Disposition of Action Items

February 2025 to June 2025

Between February 20 and June 5, 2025, staff have been focused on a number of major annual obligations, including:

- **2025 Renewal Period**
- **Submission of Fair Registration Practices Report to the Office of the Fairness Commissioner**
- **Submission of College Performance Measurement Framework to the Ministry of Health**
- **Submission of Health Professions Database Report to the Ministry of Health**
- **Election of Council Members in the Ontario and Southwest Districts**

Updates on Previous Action Items

1. Engage a third party to assess Council effectiveness. [to take place at fall meeting of Council]
2. Schedule Governance Panel to meet again in the summer to outline specific information to request from the third-party evaluator. [in progress]
3. Proceed with the planning phase of the scope change project related to laboratory tests. [to ramp up in July]

4. Explore and expand the potential to engage registrants in achieving rebranding and policy goals. [July and August]

5. Continue exploration of the role of homeopaths in the broader health-care system. [ongoing]

6. Complete annual performance evaluation of Registrar. [completed, next evaluation in progress]

7. Explore Health Profession Discipline Tribunal as a means to deal with complaints. [decided against for now]

8. Move forward with quality assurance activities. [ongoing]

9. Schedule one committee meeting per month. [ongoing]

10. Prepare a report on the competency self-assessment initiative for Council. [completed, may be considered as part of third-party assessment of Council]

11. Look into Google Drive, Board Effects, and SharePoint as potential platforms for organizing and sharing council documents. [in progress, summer project]

12. Implement a process of resending meeting materials a couple of days before each meeting. [in place]

13. Executive Committee to develop plan for improving council member engagement and understanding of college operations. [in progress, to be on next Executive agenda]

14. Executive Committee to review and clarify college's relationship with professional associations. [in progress, see agenda item 6.2]

15. Review and update the Operational Plan, Goals and Objectives.Guided by the OPGO, Basil to define goals for 2025-2026, taking into account current staffing and budget constraints. [completed]

Operational Goals and Objectives 2025/2026 Membership Scorecard

Actual at March 31, 2024		2025-2026 Fiscal Year-End (PLAN)	Projected	At May 26/25
Line 1 Members in Good Standing at March 31, 2024	**440**	Line 1 Members in Good Standing at March 31/2025		**437**
Adjustments		**Adjustments**		
Line 2 Less Admin Suspension (Current Year)	-7	Line 2 Less Admin Suspension (Current Year)		0
Line 3 Less Suspension pending	0	Line 3 Less Suspension pending (notice of suspension sent)		0
Line 4 Less Members with Outstanding Payment or Form	0	Line 4 Less Members with Outstanding Payment or Form		-25
Line 5 Less Resignations	-17	Line 5 Less Resignations		-11
Line 6 Less Disciplinary Revocations	0	Line 6 Less Disciplinary Revocations		0
Line 7 Full Class Members 386		Line 7 Full Class Members 375		
Line 8 Inactive Class Members 30		Line 8 Inactive Class Members 26		
Line 9 2024-2025 Renewing Member (Line 7 + 8)	416	Line 9 2025-2026 Renewing Members (Line 7 + 8)		401
Line 10 New Members – Full Class	+20	Line 10 New Members – Full Class		+4
Line 11 Reinstated Members	0	Line 11 Reinstated Members		0
Line 12 Return to Good Standing from admin suspension prior to 2023-2024 fiscal year	+1	Line 12 Return to Good Standing from Admin Suspension issued prior to 2025-2026 fiscal year		0
Fiscal Year-End		**Ongoing Tally**		
Line 13 Members in Good Standing at March 31, 2025 (Line 9 + 10)	**437**	Line 13 Members in good standing at May 26, 2025		**405**

Comments:
The activities of administrative suspension, expiry and revocation are in accordance with the College's Registration Regulation O.Reg.18/14 and/or the Regulated Health Professions Act, Schedule 2, section 15.

CONSENT AGENDA ITEM # 3.1.3

College of Homeopaths of Ontario
Report Form / Briefing Notes

Meeting/Date:	Council – June 12, 2025	**DECISION**	□
Date:	June 5, 2025	**DISCUSSION**	□
Item Name:	**Committee Report – Inquiries, Complaints and Reports Committee (ICRC)**	**INFORMATION**	**X**
Initiated By:	K Flood, B Ziv		

Objective of this Report (relevance to the business of Council, potential impact/outcome of decision):

To provide an update on the activities of the ICRC from February to June 2025.

Strategic Directions: This initiative fits with the strategic direction of the College's 2024/2025 Operating Plan, Goals and Objectives in the Key Result Area or other requirement by:

- **x Delivering on legislative & legal mandate**
- **x Practicing good governance**
- **□ Achieving growth**
- **x Fulfilling RHPA objects**
- **x Meeting a legislative/regulatory or bylaw requirement**
- **x Meeting a requirement of the College Performance Measurement Framework**
- **□ Other, specify:** _____

Guiding Legislation/Bylaw/Policy:

Regulated Health Professions Act, 1991 (RHPA)

Protecting the Public: Provide a brief summary and rationale for any proposed decision and how it may impact and advance public interest and protection. i.e. How action taken or proposed demonstrates and advances public interest and protection, increases public trust and transparency, reduces risk to patients/public, and/or addresses changing public expectations.

The Inquires, Complaints, and Reports Committee (ICRC) is a Statutory Committee as defined in the Health Professions Procedural Code (Schedule 2 of the RHPA, 1991). ICRC investigates allegations of registrant-specific concerns which the College receives through reports to determine whether there is any evidence of professional misconduct, incompetence, or incapacity. The College's may receive this information from various sources, such as formal complaints, mandatory reports and information brought to the attention of the Registrar.

A panel[1] of the ICR Committee, after investigating a formal complaint or a Registrar's report, may do any one or more of the following, based on its assessment of risk:

- Take no action if the registrant's conduct and/or actions meet reasonable and acceptable standards of practice, or if there is insufficient information for the Committee to take action.
- Provide advice and recommendations to the registrant – this may be provided in writing.
- Ask the registrant to enter into an agreement with the College to complete upgrading.
- Require the registrant to complete a specified continuing education or remediation program (SCERP).
- Require the registrant to appear before a panel to be cautioned about his/her practice or conduct.
- Refer the matter to the Discipline Committee to hear specified allegations of professional misconduct or incompetence.
- Refer the registrant to another panel of the ICR Committee for investigation of possible mental or physical health concerns that might interfere with the registrant's ability to practise.

The College also has the option to use an alternative dispute resolution (ADR) program, as permitted by the RHPA to assist the registrant and complainant in coming to a mutual agreement, provided that the matter of the complaint is not one of sexual abuse. Any resolutions reached through the ADR program are ratified by a panel of the ICR Committee.

Link to Current/Future Operational Structure

The ICRC panel, supported by the Registrar and the Deputy Registrar, included:

- Kerri Flood (Professional, Chair)
- Catherine Kerr (Public)
- Paul Joseph (Professional, non-Council)

Panel Report

During the reporting period, a panel of the ICRC met once and successfully resolved the complaint before it. This resolution followed considerable investigation and deliberation at earlier meetings and incorporated legal advice as needed.

Action Items

Staff to notify relevant parties about the outcome of the complaint. [COMPLETED]

[1] In accordance with the Health Professions Procedural Code, the Chair may appoint a panel of three members of the committee to review a matter before the Committee pertaining to an inquiry, complaint, mandatory report, or an Registrar's report.

CONSENT AGENDA ITEM # 3.1.4

College of Homeopaths of Ontario
Report Form / Briefing Notes

Meeting/Date:	Council – June 12, 2025	**DECISION**	□
Date:	June 5, 2025	**DISCUSSION**	□
Item Name:	**Committee Report – Registration Committee**	**INFORMATION**	**X**
Initiated By:	B Ziv		

Objective of this Report (relevance to the business of Council, potential impact/outcome of decision):

To provide an update on the activities of the Registration Committee from February to June 2025.

Strategic Directions: This initiative fits with the strategic direction of the College's 2024/2025 Operating Plan, Goals and Objectives in the Key Result Area or other requirement by:

- □ **Delivering on legislative & legal mandate**
- □ **Practicing good governance**
- □ **Achieving growth**
- **x Fulfilling RHPA objects**
- **x Meeting a legislative/regulatory or bylaw requirement**
- □ **Meeting a requirement of the College Performance Measurement Framework**
- □ **Other, specify:** _____

Guiding Legislation/Bylaw/Policy:

Regulated Health Professions Act, 1991 (RHPA)
Homeopathy Act, 2007, Registration Regulation

Protecting the Public: Provide a brief summary and rationale for any proposed decision and how it may impact and advance public interest and protection. i.e. How action taken or proposed demonstrates and advances public interest and protection, increases public trust and transparency, reduces risk to patients/public, and/or addresses changing public expectations.

The CPMF measures and reports in a standardized manner how each College is acting in the public interest. It gathers information on how well Colleges have met a set of best practices (standards) related to their key statutory functions and key organizational aspects.

In addition, the CPMF will provide benchmark information and best practices that will help Colleges improve their performance and ensure that public confidence in the professions is maintained[1].

The Ministry is committed to building a connected and sustainable health care system centered around the needs of patients. One key component of this journey is to continue strengthening transparency and accountability of regulated health professions to engender trust between Ontario's Colleges and the public. The CPMF will assist the ministry in achieving these goals.

Measuring college performance will strengthen accountability by linking college activities to outcomes and providing consistent and aligned information across all Colleges. In addition, performance measurement strengthens transparency about the role of the Colleges (e.g., how decisions are made, the impact of those decisions and activities in advancing the public interest, etc.) helping to foster trust in the ability of the health professions to regulate themselves in the interest of the public.

Finally, this work places a focus on areas of improvement (e.g., better support for changing public expectations, patient needs, and delivery of care models); makes it easier for patients, their families and employers to navigate the regulatory system; and through highlighting best practices, reduces variation in the efficiency and effectiveness with which Colleges carry out their functions. [2]

Link to Current/Future Operational Structure

During the reporting period the Registration Committee, supported by the Registrar, Registration Manager and Deputy Registrar, met once. Members of the Committee included:

- Catherine Kerr (Public)
- Sanjeev Nayyar (Professional)
- Yen Tran (Public)
- Angela Vani (Professional)
- Bhupinder Sharma (*ex officio,* non-voting)
- Paridhi Wasal (Professional) - absent

Panel Report

The Registration Committee met on May 28, 2025.

The primary purpose of the meeting was to consider the administration of the Individual Assessment program. The program and assessment tool were developed in consultation with Human Resource Systems Group Ltd. (HRSG) prior to the College being proclaimed, and HRSG has continued to administer it since then. The tool is well established and the role of HRSG has been limited to administration for approximately ten years. Trained assessors (homeopaths) conduct the evaluation for each applicant. HSRG has managed the receipt and anonymization of applications – approximately 20 per year -- and distribution of those applications to assessors. That is, the company is not involved in assessment, just administration.

[1] MOH College Performance Measurement Framework FAQs Question and answer 1. Page 5. December 2020.
[2] Ibid.

Recently, HRSG notified the College that it would be changing its business focus and would no longer be able to continue to administer the CHO program. After much consideration and consultation with relevant parties, staff concluded that the administration of the program could be completed in house, specifically by the Registration Manager, given that the tool and procedures are proven entities, annual numbers are small, and HRSG has expressed a commitment to support the transition to whatever extent is required. The portion of applicant fees not used to pay assessors – formerly paid to HRSG -- will accrue to the College and will be available to support additional help should it be required if, for example, there were to be a significant increase in applicant numbers.

After thoughtful discussion, the Registration Committee approved a motion supporting the move in house of the administrative component of the Individual Assessment program. Evaluation of the move will be ongoing.

Action Items

- Staff to consult with legal counsel. [COMPLETED, NO LEGAL CONCERNS IDENTIFIED]

College Performance Measurement Framework (CPMF) Reporting Tool

Reporting Year: January 2024 – December 2024

College of Homeopaths of Ontario

Submitted March 31, 2025

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Introduction

The College Performance Measurement Framework (CPMF)

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

1. Strengthens accountability and oversight of Ontario's health regulatory Colleges; and
2. Supports Colleges in improving their performance.

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

Table 1: CPMF Measurement Domains and Components

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

CPMF Model

The seven measurement domains shown in Figure 1 are critical attributes that contribute to a College effectively serving and protecting the public interest. They relate to statutory obligations and organizational processes that enable a College to carry out its functions well. The seven domains are interdependent and together lead to outcomes that a College is expected to achieve as an excellent regulator. The fourteen Standards within the seven measurement domains are listed in Figure 2.

Figure 1: CPMF Model for Measuring Regulatory Excellence

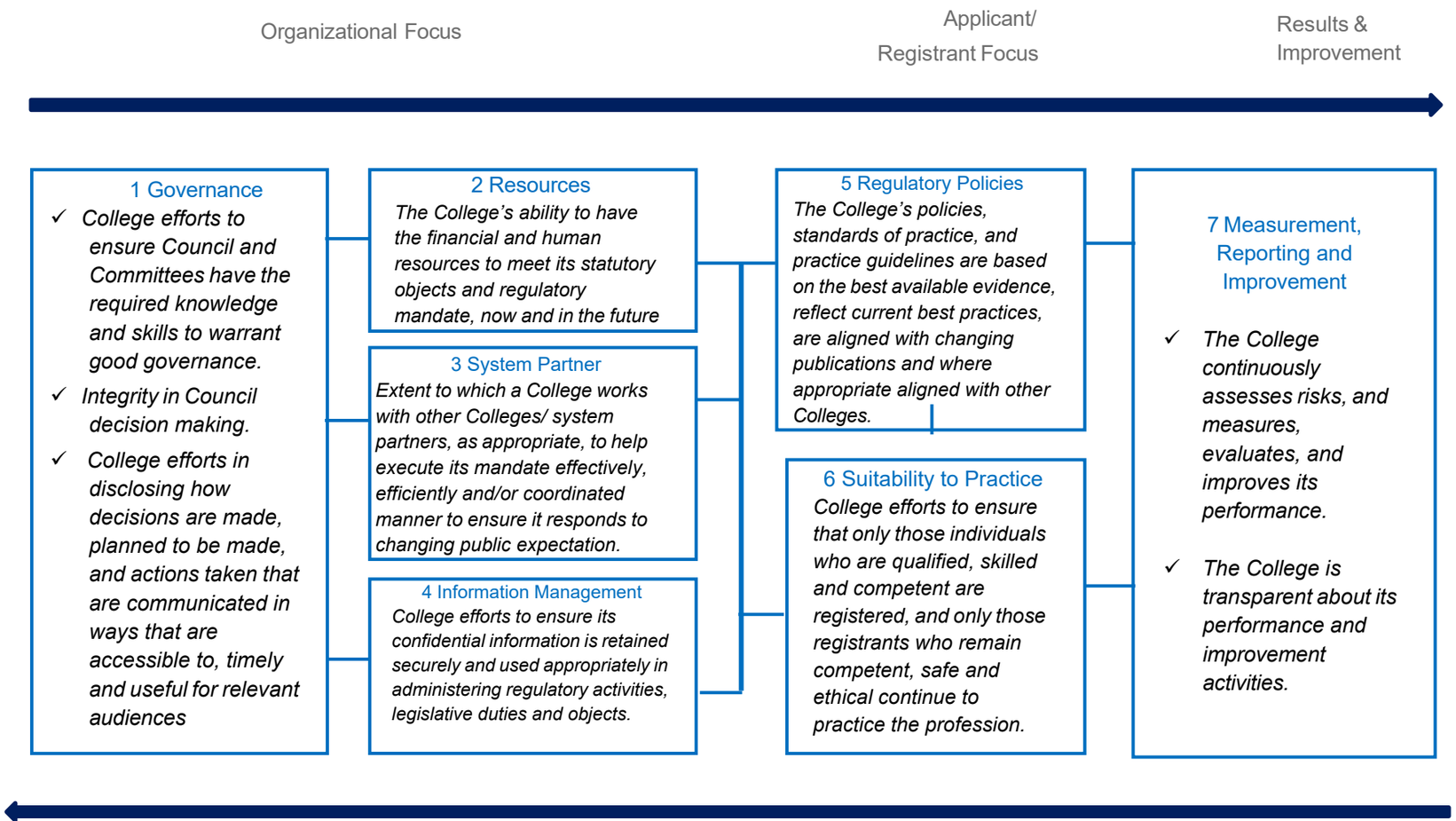


Figure 2: CPMF Domains and Standards

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

The CPMF Reporting Tool

The College Performance Measurement Framework (CPMF) remains a cornerstone of regulatory transparency and excellence in Ontario. Through this fifth iteration, the CPMF will continue to provide the public, the Ministry of Health, and other stakeholders with critical insights into the activities and processes of health regulatory Colleges during 2024.

The information gathered through the CPMF Reporting Tool is intended to spotlight areas for enhancement, prompting closer attention and potential follow-up actions. As in the past, the Ministry will not assess whether Colleges meet or do not meet the Standards in the CPMF. The outcomes of the reporting will continue to facilitate meaningful dialogue on performance improvement among College staff and Council members and between Colleges and their broader communities, including the public, the Ministry, members, and other stakeholders.

Completing the CPMF Reporting Tool

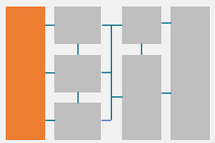
While the CPMF Reporting Tool seeks to clarify the information requested, it is not intended to direct College activities and processes or restrict the way a College fulfills its fiduciary duties. Where a term or concept is not explicitly defined in the CPMF Reporting Tool, the ministry relies on individual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

In the spirit of continuous improvement, if the College plans to improve its actions or processes related to a respective Measure or Evidence, it is encouraged to highlight these planned activities and progress made on commitments from previous years.

There are eight pieces of Evidence highlighted within Part 1 of the Reporting Tool as 'Benchmarked Evidence'. These pieces of evidence were identified as attributes of an excellent regulator, and Colleges should meet, or work towards meeting these benchmarks. If a College does not meet, or partially meets expectations on a benchmark, it is asked to provide an improvement plan that includes the steps it will follow, timelines and any barriers to implementing that benchmark.

Where a College fully met Evidence in 2023 and 2024, the College may opt to respond with 'Met in 2023 and Continues to Meet in 2024'. In the instances where this is appropriate, this option appears in the dropdown menu. If that option is not there, Colleges are asked to fully respond to the Evidence or Standard. Colleges are also asked to provide additional detail (e.g., page numbers), when linking to or referencing College documents.

Part 1: Measurement Domains



Measure:
1.1 Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.

DOMAIN 1: GOVERNANCE

STANDARD 1

Required Evidence	College Response	
a. Professional members are eligible to stand for election to Council only after:	The College fulfills this requirement:	Partially
i. meeting pre-defined competency and suitability criteria; and	• The competency and suitability criteria are public: Yes *If yes, please insert a link and indicate the page number where they can be found; if not, please list criteria.*	
Benchmarked Evidence	Professional members are eligible to stand for election to Council only after: i. Meeting pre-defined suitability criteria defined in the College's Bylaws, (see below, bylaw 10.04) ii. Reviewing the elections manual which details pre-defined competency criteria, and iii. Attending an interactive online orientation training about the College's mandate and expectations pertaining to the individual's roles and responsibilities as a Council member. (This training is a requirement as detailed in the College's Bylaws). **Suitability Criteria as per Bylaw 10.04 - Eligibility for Election** A Registrant is eligible for election to Council if the Registrant has been nominated in accordance with the bylaws, has completed and returned the conflict of interest questionnaire and if, on the deadline for the receipt of nominations and up to and including the date of the election, (i) the Registrant holds a certificate of registration; (ii) the Registrant is principally engaged in the practice of the profession in the electoral district for which he or she is nominated or, if the Registrant is not engaged in the practice of the profession, the Registrant principally resides in the electoral district for which he or she is nominated; (iii) the Registrant is not in default of payment of any fees to the College; (iv) the Registrant is not the subject of any disciplinary or incapacity proceeding; (v) the Registrant has not been the subject of any professional misconduct, incompetence or incapacity finding in the preceding three (3) years; (vi) the Registrant's certificate of registration has not been revoked or suspended in the preceding six (6) years for any reason; (vii) the Registrant's certificate of registration is not subject to a term, condition, or limitation imposed by the Discipline Committee or the Fitness to Practice Committee; (viii) the Registrant has agreed to resign and does, before taking office, any position such as director, owner, board member, officer or Employee that the Registrant holds with a Professional Association relating to homeopathy; (ix) the Registrant has not been disqualified from Council or a Committee within the preceding three (3) years; (x) the Registrant is not a member of a council of any other college regulated under the RHPA; (xi) the Registrant is not currently and has not been for the previous two years an Employee of the College;	

(xii) the Registrant does not have a conflict of interest to serve as a member of Council or has agreed to remove any such conflict of interest before taking office;
(xiii) the Registrant has substantially complied with the Election Guidelines of the College;
(xiv) the Registrant is not in any default of returning any required form or information to the College; and
(xv) the Registrant provides acceptable evidence of successful completion of the Council-approved training program relating to the duties, obligations and expectations of Council and Committee members.

The following pre-defined competencies for Council members are identified in the elections manual (page 6).

Effective Council members should also demonstrate the following general competencies:

1. **Continuous Learning** - Takes actions to improve personal capability and has the ability to quickly understand and apply information, concepts, and strategies. Demonstrates an interest in continuous personal learning.
2. **Creativity** - Generates new solutions, develops creative approaches and implements new approaches that lead to improved performance. Anticipates and leads change that contributes to organizational success.
3. **Effective Communication** - Is willing and able to see things from other perspectives. Demonstrates accurate insight into the behaviour and motivations of other individuals and groups and responds appropriately. Accurately listens, understands, and responds effectively with individuals and groups.
4. **Leadership** - Creates strong morale and spirit in his/her team. Shares wins and successes. Demonstrates integrity, a positive attitude, energy, resilience, stamina and the courage to take risks.
5. **Planning & Initiative** - Recognizes and acts upon opportunities or addresses problems. Displays effective use of time-management skills. and ability to plan and organize workflow and meetings in an efficient manner to address the opportunity or problem.
6. **Relationship-Building** - Works to build and maintain ethical relationships and networks of contacts with people who are important to achieving College-related goals and the Council mission.
7. **Results-Oriented** - Makes specific changes in own work methods or systems to improve performance beyond agreed standards (i.e., does something faster, at lower cost, more efficiently; improves quality, stakeholder satisfaction, revenues, etc.).
8. **Stakeholder-Focused** - Desires to help or serve others, meets the organization's goals and objectives. Focuses efforts on building relationships keeping the College's mandate in mind and discovering and meeting stakeholders' needs in the context of that mandate. Recognizes that partnerships among internal colleagues within the Council are essential to meet external stakeholder's needs.
9. **Strategic Thinking** - Understands the implications of decisions and strives to improve organizational performance. Has an awareness of organizational issues, policy, procedures, and outcomes as they impact key stakeholders and the organization's strategic direction.
10. **Teamwork** - Demonstrates cooperation within and beyond the Council. Is actively involved and “rolls up sleeves.” Supports group decisions, even when different from one's own point of view. Is a good team player and does his/her share of work. Compromises and applies rules flexibly and fairly and adapts tactics to situations or to others' responses. Accepts setbacks and changes own behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

Council members are not measured on these competencies.

			If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation. Following a comprehensive review of tools utilized by other RHPA colleges, the CHO has reviewed and revised its Council member competency profile to ensure that it fits the current needs of the College. Council, in conjunction with the Governance Panel, developed a comprehensive competency framework (item 7.1, pages 18-37) which received final approval in February 2024. In addition to this framework, the College will develop suitable mechanisms to measure and monitor competence. Additionally, staff have completed and are working to adopt, with minor modification, existing approaches to measuring and monitoring used by other RHPA Colleges.

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		ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement:	Yes
			• Duration of orientation training. • Please briefly describe the format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end). • Please insert a link and indicate the page number if training topics are public ***OR*** list orientation training topics. CHO has developed the following levels of Council training: • Pre-election – two-hour online overview of introduction to Council. No knowledge test. • Post-election – three to six hours - In the past, this has been via video-conference with a staff member; however, starting in 2024 this moved to online video on demand. No knowledge test. • Additionally, CHO has a pre-Executive training session – one-hour online, pre-recorded video. No knowledge test. (Bylaw) o CHO Bylaws further require that a Council member must be on Council at least one year prior to sitting on Executive Committee, plus an additional year on Executive Committee prior to standing for President or Vice President. o Prior to putting one's name forward as a nominee for President or Vice President the individual must take a 70-minute online, pre-recorded video introduction to the roles and expectations of the position. No knowledge test. o Following election to the position of President or Vice President the individual is provided with an estimated additional 5-hours of training. Length of training may vary depending on competencies and experience. No knowledge test. **Topics:** **Pre-Election:** o understanding relevant legislation and the purpose of RHPA, overview of Schedule 2 o other legislation and regulations governing the profession o role of RHPA Colleges - including regulating in the public interest, defining public interest, key differences between a regulatory college and an association, college mandate and RHPA objects, the role and responsibilities of Council and committee members o governing documents including regulations, bylaws, professional practice standards and guidelines and policies governing the work of the College o accountability o transparency o Governance overview, policies and principles **Council Member Orientation** (post-election for professional members, post-appointment for public appointees) o Policies and principles for internal processes	

			o What to expect at a Council meeting o Council member conduct and rules including conflict of interest, confidentiality, dealing with bias, procedural fairness o In-depth introduction to committees and panels o Introduction to CHO operations, information management and access to resources o Understanding reporting tools **Executive Committee** (See below) **Pre-election: President and Vice President** o Overview of Roles o Time commitments o Eligibility requirements and term o In-depth review of roles, specific duties, internal/external accountability, leadership and collaboration o President / Registrar Working Relationship o Regulatory Framework and Guiding Tools **Post-election President and Vice President** o Chairing skills in a regulatory environment including agenda development, rules of order, motion development, parliamentary processes, etc. o Enforcing Council member Code of Conduct, addressing conflict of interest o Signing authority policies and processes o Planning and oversight responsibilities including strategic planning and operational plans overview o Human resources matters - processes for handling non-registrant complaints, in-depth understanding of election process and terms, registrar/CEO annual review process and contract renewal, awareness of employee manual and policies, and Council/Council member evaluation.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item.
			Additional comments for clarification (optional):

		b. Statutory Committee candidates have: i. Met pre-defined competency and suitability criteria; and *Benchmarked Evidence*	The College fulfills this requirement:	Partially
			• The competency and suitability criteria are public: Yes • *If yes, please insert a link and indicate the page number where they can be found; if not, please list criteria.* CHO has suitability/eligibility criteria detailed in its bylaws. While the general competencies outlined above for Council apply, committee-specific competencies have yet to be assigned. **Bylaw 13.13 - Eligibility for Committee Appointment** A Registrant is eligible for appointment to a Committee if, on the date of the appointment, (i) the Registrant holds a certificate of registration; (ii) the Registrant is not in default of payment of any fees prescribed to the College; (iii) the Registrant is not the subject of any disciplinary or incapacity proceeding; (iv) the Registrant has not been the subject of any professional misconduct, incompetence or incapacity finding in the preceding three (3) years; (v) the Registrant's certificate of registration has not been revoked or suspended in the preceding six (6) years for any reason; (vi) the Registrant's certificate of registration is not subject to a term, condition, or limitation imposed by the Discipline Committee or the Fitness to Practice Committee; (vii) the Registrant has agreed to and does resign, before taking office, any position such as director, owner, board member, officer or Employee that the Registrant holds with a Professional Association relating to homeopathy; (viii) the Registrant has not been disqualified from Council or a Committee within the preceding three (3) years; (ix) the Registrant is not a member of a council of any other college regulated under the RHPA; (x) the Registrant is not currently and has not been for the previous two years an Employee of the College; (xi) the Registrant is not in any default of returning any required form or information to the College; and (xii) the Registrant does not have a conflict of interest to serve as a committee member or has agreed to remove any such conflict of interest before sitting on the committee or panel.	

			If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation. Following a comprehensive review of tools utilized by other RHPA colleges, the CHO has reviewed and revised its Council member competency profile to ensure that it fits the current needs of the College. Council, in conjunction with the Governance Panel, developed a comprehensive competency framework (item 7.1, pages 18-37) which received final approval in February 2024. In addition to this framework, the College will develop suitable mechanisms to measure and monitor competence. Staff have completed and are working to adopt, with minor modification, existing approaches to measuring and monitoring used by other RHPA Colleges The competency framework will be incorporated into the committee selection process in 2025, and will also be used as a tool in ongoing Council self-assessment initiatives.	
		ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	The College fulfills this requirement:	Yes
			• Duration of each Statutory Committee orientation training. • Please briefly describe the format of each orientation training (e.g., in-person, online, with facilitator, testing knowledge at the end). • Please insert a link and indicate the page number if training topics are public ***OR*** list orientation training topics for Statutory Committee. **Committee: Duration, Format and Orientation Training Topics** **Discipline Committee**: 1/2 day online, pre-recorded webinar presented by Independent Legal Counsel. This resource is always available to committee members. As this College has a limited number of hearing dates in any given year, panel members are asked to re-review all or parts of the webinar to refresh their learning prior to each hearing they participate in. The training broadly covers authority, legal framework, principles of administrative law, hearing process, responsibilities of panel members, evidence, deliberations, credibility and writing reasons. The pre-recorded webinar covers nine topics and each segment of the webinar is between 10 and 32 minutes in length. Segment titles include: 1. Path to Discipline; 2. Before the Doors Open; 3. Who is Who; 4. About the Hearing; 5. Evidence; 6. Deliberations; 7. Credibility; 8. Practical Issues; and 9. Writing Reasons. Additionally, the chair receives supplementary training to assist them in their specific role. **Inquiries, Complaints and Reports Committee**: 3 hours, live webinar Role and statutory mandate, confidentiality, conflict of interest, powers of the committee, what a panel can and cannot do, providing reasons, sexual abuse, appeals/reviews, case scenarios, procedural fairness. **Patient Relations Committee**: 1.5 hours, live webinar Role and statutory mandate of the committee, the College's sexual abuse prevention plan, what is sexual abuse, professional boundaries, patient relations and patient access to Funding for Therapy and Counselling. **Quality Assurance Committee**: 1.5 hours, live webinar	

			Role and statutory mandate, confidentiality, the Quality Assurance Program, possible decisions, suitable remedies and continuing education activities, suitable demonstration of remedy, and available resources. **Registration Committee**: 6 hours, live webinar Role of the College, legislation and regulations, by-laws, policies, types of certificates of registration, entry-to-practice requirements, role of Registration Committee, appeals/reviews, types of commonly reviewed applications and potential outcomes, role of the Office of the Fairness Commissioner, unconscious bias, fair access, procedural fairness, assessments of qualifications processes, process of approved programs, refresher programs, and Ontario Human Rights. **Executive Committee**: 1.5 hours, live webinar Statutory powers of Executive Committee between Council meetings and duty to report to Council; understanding the statutory roles and responsibilities of college committees and rights and limitations of Council/EC over the authority of committee/panel decisions; planning and oversight responsibilities; budgeting, financial reporting, procurement process and annual financial audit process; deep dive on the bylaws, policies, and regulatory requirements; Registrar/CEO annual review process. **Fitness to Practice Committee**: 1.5 hours, live webinar Role and statutory mandate of the committee, rules of procedure. The Council also serves as the Fitness to Practice Committee. As of the end of the reporting period there had not been a need to strike a panel of the Fitness to Practice Committee for the purpose of holding a hearing. Training/orientation will be provided in the event that the committee is required to hold a hearing. The topics to be covered: Role and statutory mandate, confidentiality, conflict of interest, powers of the committee, what a panel can and cannot do, role of experts and reports, procedural fairness, rules of the FTP committee.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional):	

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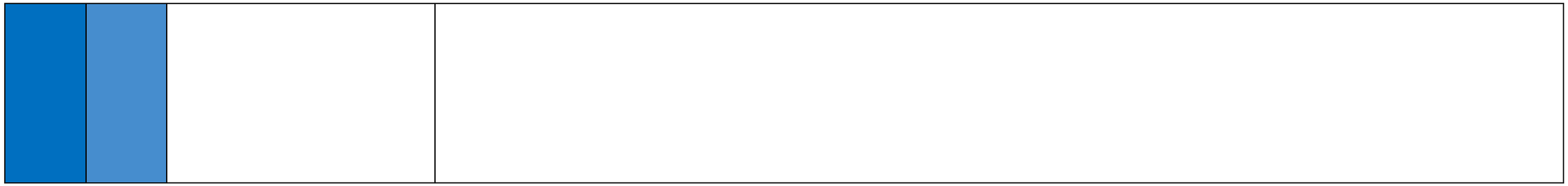
		c. Prior to attending their first meeting, public appointments to Council undertake an orientation training course provided by the College about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	The College fulfills this requirement: • Duration of orientation training. • Please briefly describe the format of orientation training (e.g., in-person, online, with facilitator, testing knowledge at the end). • Please insert a link and indicate the page number if training topics are public ***OR*** list orientation training topics. Council Training Report CHO staff conduct a three- to six-hour online video-conference introduction to Council (professional and public appointees). No knowledge test. **Topics**: o introduction to the College o duties and mandate of the College o fiduciary duties of Council and committee members o understanding Health Profession Legislation and the purpose of RHPA, overview of Schedule 2 The Code o other legislation and regulations governing the profession o role of RHPA Colleges - including regulating in the public interest, defining public interest, key differences between a regulatory college and an association, college mandate and RHPA objects, the role and responsibilities of Council and committee members o governing documents including the role of regulations, bylaws, professional practice standards and guidelines and policies in governing the work of the College o accountability o importance of transparency o governance overview, policies and principles including confidentiality, conflict of interest and corporate solidarity o overview of the homeopathy profession **Council Member Orientation** (post-election for professional members, post-appointment for public appointees) o Policies and principles for internal processes o What to expect at a Council meeting o Council member conduct and rules including conflict of interest, confidentiality, dealing with bias, procedural fairness o In-depth introduction to committees and panels o Introduction to CHO operations, information management and access to resources o Understanding reporting tools At the request of Council, as a result of its annual self-assessment exercise in 2022, a broad list of training topics and requirements was developed (item 3.1.3, page 6) and Council identified the highest priority items for training and education. Many of these topics have since been incorporated into the pre-election and post-election/appointment educational programs. Staff are currently working on expanding available online resources on the following topics: ○ Understanding the Principles of Public Protection and the Regulatory Framework ○ Understanding the roles and responsibilities of the College's statutory committees (See CPTO videos)	Met in 2023, continues to meet in 2024

			○ Procedural fairness, objective and impartial decision-making ○ Governance Policies - Deeper Dive ○ Introduction to CHO Annual Operations Cycle including planning/budgeting processes. Also covers financial management and fiduciary requirements. ○ Overview of CHO regulations ○ In-depth on CHO Bylaws ○ Chairperson training ○ Understanding professional standards, guidelines, and code of ethics ○ Complaints and discipline 101: Complaints, ICRC, fitness-to-practice, incompetency, incapacity, discipline processes and appeals ○ Homeopathy 101: overview of how Homeopathy works; what ailments do patients seek help from a homeopath; what does 'treatment' look like; brief history and status of homeopathy in Canada	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional):	

		Measure: **1.2 Council regularly assesses its effectiveness and addresses identified opportunities for improvement through ongoing education.**	
		Required Evidence	**College Response**
		a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; and ii. Council.	The College fulfills this requirement: — Met in 2023, continues to meet in 2024 • Please provide the year when Framework was developed ***OR*** last updated. 2021 • Please insert a link to Framework ***OR*** link to Council meeting materials and indicate the page number where the Framework is found and was approved. • Evaluation and assessment results are discussed at public Council meeting: Yes • *If yes, please insert a link to the last Council meeting and indicate the page number where the most recent evaluation results have been presented and discussed.* Council Meeting Effectiveness Following each Council meeting, Council members are asked to complete a meeting evaluation form: Evaluation Form The online evaluation covers the issues of: General satisfaction with the meeting, satisfaction with how Council accomplished its agenda items, the way in which Council members worked together and the chair's skills to facilitate discussion. Additionally, the evaluation covers time/timeliness and adequacy of background materials to help Council members prepare. Questions designed to ascertain the major strengths of the meeting, how the meeting could have been improved and if there was anything about the meeting that hindered the Council's work. If concerns are raised, Council members are invited to identify themselves for personal follow-up. Should issues arise from this survey, they would be discussed at the next Council meeting. Thus far, this has not been required. Council Effectiveness Each year, Council members are asked to complete a Council self-evaluation. The most recent of these was distributed in March 2024 and discussed at the December meeting of the Governance Panel prior to inclusion on the agenda of the February 2025 Council meeting. (see item 7, page 16 of Council package) *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item.



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		b. The framework includes a third-party assessment of Council effectiveness at a minimum every three years.	The College fulfills this requirement:	Partially
			• Has a third party been engaged by the College for evaluation of Council effectiveness? Yes • *If yes, how often do they occur?* • Please indicate the year of last third-party evaluation. Third-party evaluator has been engaged. Preparation in progress for third-party evaluation to take place in 2025.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			The CHO has engaged a consultant to meet this requirement in 2025 and will follow a similar approach used by other small Colleges. This process will enable CHO to undertake this measure within budgetary constraints while substantially meeting the Ministry's guidelines.	

		c. Ongoing training provided to Council and Committee members has been informed by: i. the outcome of relevant evaluation(s); ii. the needs identified by Council and Committee members; and/or	The College fulfills this requirement:	Partially
			• Please insert a link to documents outlining how outcome evaluations have informed Council and Committee training and indicate the page numbers. • Please insert a link to Council meeting materials and indicate the page number where this information is found ***OR*** • Please briefly describe how this has been done for the training provided over the last calendar year. Following development by the Governance Panel, a self-evaluation survey was approved by Council in March 2021. It was distributed for the third time in March 2024 with results reported at the December meeting of the Governance Panel and the next Council meeting, held in February 2025. Based on the items deemed to be the highest priority for training and education, staff have created a development schedule for online education focused on the following topics: ○ Understanding the Principles of Public Protection and the Regulatory Framework ○ Understanding the roles and responsibilities of the College's statutory committees (See CPTO videos) ○ Procedural fairness, objective and impartial decision-making ○ Governance Policies - Deeper Dive ○ Introduction to CHO Annual Operations Cycle including planning/budgeting processes. Also covers financial management and fiduciary requirements. ○ Overview of CHO regulations ○ In-depth on CHO Bylaws ○ Chairperson training ○ Understanding professional standards, guidelines, and code of ethics ○ Complaints and discipline 101: Complaints, ICRC, fitness-to-practice, incompetency, incapacity, discipline processes and appeals Homeopathy 101: overview of how Based the outcome of the training survey the College has implemented an evolving training plan designed to meet the needs of Council members. In-person training/education will be provided at Council meetings as time allows. Additionally, Council members will be requested to participate in self-directed learning through an online portal. The College will continue to utilize outside resources where possible, cost-effective, and appropriate.	

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			Additional comments for clarification (optional): Development of the governance training library will continue. Efforts to this end will include procurement of materials developed by other colleges as well as expansion of in-house resources.	

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		iii. evolving public expectations including risk management and Diversity, Equity, and Inclusion. Further clarification: Colleges are encouraged to define public expectations based on input from the public, their members, and stakeholders. Risk management is essential to effective oversight since internal and external risks may impact the ability of Council to fulfill its mandate.	The College fulfills this requirement:	Partially
			• Please insert a link to documents outlining how evolving public expectations have informed Council and Committee training and indicate the page numbers. • Please insert a link to Council meeting materials and indicate the page number where this information is found ***OR*** • Please briefly describe how this has been done for the training provided over the last calendar year. In the Council's 2022 planning survey, the matter of Diversity, Equity and Inclusion (DEI) was ranked as very important. Our College is actively supporting the work of the Health Profession Regulators of Ontario (HPRO) as it develops supports for Colleges to advance their work in DEI within their regulatory practices. CHO is a member of the HPRO EDI Network which works to enhance sharing and consistency among Colleges and has provided valuable information for our College to use in understanding current issues and training needs related to DEI. HPRO's EDI Organizational Self-Assessment and Action Guide (including Equity Impact Assessment Tools) has and will continue to help the College better understand public expectations. Training opportunities continue to be identified, and the College will participate in HPRO training for all Colleges as part of HPRO membership. Several Council/committee members self-identify in a way that reflects the diversity of the populations we serve/the public. There is a high level of diversity of identities among Council and Committee members. Additionally, the College has become a member of the Citizen Advisory Group. It is anticipated that ongoing membership will be helpful in informing public expectations in the areas of risk management, DEI and public protection.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			Additional comments for clarification (optional): Current HPRO project activities are designed to provide a set of guiding indicators and support tools that our College will use in the next two reporting periods to engage our staff, Council and Committee members in ongoing learning related to DEI. Specifically, we anticipate using the materials to evaluate our current strengths and gaps, for action planning and implementation to close key gaps. The College will continue to follow the guidance for demonstrating commitment to EDI at the Board level, including representation, awareness, and appointments), and mitigating unconscious bias in decision making at both system and personal levels. (See page 41 of the Guide.)	

DOMAIN 1: GOVERNANCE	STANDARD 2	**Measure:** **2.1 All decisions related to a Council's strategic objectives, regulatory processes, and activities are impartial, evidence-informed, and advance the public interest.**	
		Required Evidence	**College Response**
		a. The College Council has a Code of Conduct and 'Conflict of Interest' policy that is: i. reviewed at least every three years to ensure it reflects current legislation, practices, public expectations, issues, and emerging initiatives (e.g., Diversity, Equity, and Inclusion); and <u>Further clarification:</u> Colleges are best placed to determine the public expectations, issues and emerging initiatives based on input from their members, stakeholders, and the public. While there will be similarities across Colleges such as Diversity, Equity, and Inclusion, this is also an opportunity to reflect additional issues, expectations, and emerging initiatives unique to a College or profession.	The College fulfills this requirement: **Yes** • Please provide the year when the Council Code of Conduct and 'Conflict of Interest' Policy was last evaluated/updated. • Please briefly describe any changes made to the Council Code of Conduct and 'Conflict of Interest Policy' resulting from the last review. The College's Conflict of Interest policy is found in 1. Section 16 of the Bylaws (page 20 of bylaws, 25 of pdf) and 2. Governance Policy GOV-07. These documents are included in the Council Reference Binder. The Conflict-of-Interest Bylaw was first adopted by the transitional Council of CHO in November 2009. It has not been re-evaluated since and only the cooling off bylaw has changed to lengthen the amount of time prior to when a Council member can become an employee from one year to two years. CHO Human Resources / Employee Policies Handbook (last approved by Council in June 2015) also contains a Conflict of Interest Policy (#HR - 17) which is based on CHO Bylaw 16. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* **Yes** *Additional comments for clarification (optional)* The College is in the process of setting a regular policy review schedule for all policies across the organization. In accordance with this standard the Conflict of Interest policy will be reviewed every three years. Diversity, Equity and Inclusion (DEI) will be integrated into the next iteration of the policy. As of 2024, the Code of Conduct and Conflict of Interest related bylaws and policies are under review to ensure currency and relevance. A series of revisions will add both renewed clarity and currency and are expected to work their way through Governance Panel, Executive Committee and Council before the end of 2024. The revisions will also be circulated for public consultation. The College's code of conduct and conflict of interest bylaws and policies will be reviewed using HPRO's EDI Organizational Self-Assessment and Action Guide, specifically using guidance on meaningful and safe engagement, types of feedback, applying an intersectional lens, and equity in consultations. The College will examine its organizational policies and procedures to identify opportunities for reducing barriers to equity, diversity, and inclusion leading to EDI and anti-racism being ingrained in the College's culture. (See page 57 of the Guide.)

		ii. accessible to the public.	The College fulfills this requirement:	Met in 2023, continues to meet in 2024
			• Please insert a link to the Council Code of Conduct and 'Conflict of Interest' Policy ***OR*** Council meeting materials where the policy is found and was last discussed and approved and indicate the page number. The College's Code of Conduct is Schedule 3 of the Bylaws (page 37 of the bylaws, 42 of the pdf) and the Conflict of Interest policy is found in Bylaws Section 16 (page 20 of bylaws, 25 of pdf).	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	
		b. The College enforces a minimum time before an individual can be elected to Council after holding a position that could create an actual or perceived conflict of interest with respect their Council duties (i.e., cooling off periods). Further clarification: Colleges may provide additional methods not listed here by which they meet the evidence.	The College fulfills this requirement:	Met in 2023, continues to meet in 2024
			• Cooling off period is enforced through: By-law • Please provide the year that the cooling off period policy was developed ***OR*** last evaluated/updated. • Please provide the length of the cooling off period. Two years • How does the College define the cooling off period? – Insert a link to policy / document specifying the cooling off period, including circumstances where it is enforced and indicate the page number; CHO Bylaws, Bylaw 16.10, page 22 of Bylaws (page 27 of pdf) – Insert a link to Council meeting where cooling off period has been discussed and decided upon and indicate the page number; ***OR*** – Where not publicly available, please briefly describe the cooling off policy. **Council to Staff** CHO Bylaw 16.10 - Staff (Employee) Positions A member of Council or a Committee member may not hold any other position, employment, contract or appointment with the College while serving as a member of Council or its Committees. There is a two-year waiting period before the individual may apply for a staff or consultant position with the College. This includes, but is not limited to, positions as peer assessor, investigator, inspector, examiner or other management or administrative staff. **Staff to Council or Committee Member** CHO Human Resources/Employee Policies Handbook (Last approved by Council in June 2015)	

6. Council Positions
A member of staff may not hold any position on Council, Committee, or Panel with The College. There is a two-year waiting period before the individual may apply for a Council, Committee or Panel position with The College.
Association Authority - Council
CHO Bylaw 16.03 - Conflicts Relating to Involvement with a Professional Association
A member of Council or a Committee member shall be perceived to have conflict of interest in a matter and should not serve on Council or its Committees at all if he or she holds a responsible position such as director, owner, board member or officer in or is an Employee of any Professional Association relating to homeopathy.

Other Organization Authority - Council
CHO Bylaw 16.04 - Conflicts Relating to Position in Other Organizations
A member of Council or a Committee member should refrain from participating in any discussion or voting if he or she holds a responsible position such as director, owner, board member or officer in or is an Employee of another organization where his or her duties may be seen by a reasonable person as influencing his or her judgment in the matter under consideration by the Council or its Committees. For example, an educator in a school should not participate in any decisions relating to the status of that school, its program(s) or the acceptability for registration of graduates from that school.

The CHO bylaws reflect various other cooling off periods that apply to different circumstances which may give rise to an actual or perceived conflict of interest in connection with the member's role on Council or committee. This may include recent employment with the College (within two years), maximum consecutive term of an officer of the College in one position (three (3) consecutive, full-year terms), or where an officer has been the subject of any professional misconduct, incompetence or incapacity finding in the preceding 3 years, or where the officer has had his or her certificate of registration revoked or suspended in the preceding 6 years, or for disqualification for any reason from Council or Committee (preceding 3 years), or reaching the nine year term limit for board members (3 years).

Action required but no cooling off period:
The Registrant
a) has agreed to resign and does, before taking office, any position such as director, owner, board member, officer or Employee that the Registrant holds with a Professional Association relating to homeopathy.
b) does not have a conflict of interest to serve as a Council or committee member or has agreed to remove any such conflict of interest before sitting on the committee or panel.

Other Eligibility Requirements
A Registrant is eligible for election to Council or appointment to a committee if the Registrant has been nominated in accordance with the bylaws,
- is not in default of payment of any fees to the College;
- is not the subject of any disciplinary or incapacity proceeding;
- his/her certificate of registration is not subject to a term, condition, or limitation imposed by the Discipline Committee or the Fitness to Practice Committee;
- is not in any default of returning any required form or information to the College.

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	
		c. The College has a conflict-of-interest questionnaire that all Council members must complete annually. Additionally: i. the completed questionnaires are included as an appendix to each Council meeting package; ii. questionnaires include definitions of conflict of interest; iii. questionnaires include questions based on areas of risk for conflict of interest identified by Council that are specific to the profession and/or College; and iv. at the beginning of each Council meeting, members must declare any updates to their responses and any conflict of interest specific to the meeting agenda.	The College fulfills this requirement:	Yes
			• Please provide the year when conflict of interest the questionnaire was implemented ***OR*** last evaluated/updated. 2021 • Member(s) note whether their questionnaire requires amendments at each Council meeting and whether they have any conflicts of interest based on Council agenda items: Yes • Please insert a link to the most recent Council meeting materials that includes the questionnaire and indicate the page number. The Conflict of Interest form was implemented in 2009 and last updated/evaluated in 2021. Currently, all Council members are required to sign an annual acknowledgment of their fiduciary duties and responsibilities that includes an acknowledgment and undertaking to declare any conflicts of interest. Council members are also required to complete a Declaration of Conflict of Interest form which provides members with a copy of the College's Bylaws and conflict of interest policy. The document asks the member to declare his or her current and recent affiliations with Professional Associations and other organizations. Both new and returning nominees for professional seats on Council are also required to complete a conflict of interest form. In relation to standard 2.1c. the College demonstrates the following: i. A summary of each Council member's identified affiliations is provided in the Council package. ii. The questionnaire provides a copy of the conflict of Interest policy and bylaw which defines real and perceived conflict of interest. iii. While the conflict of interest policy is Council approved, the questionnaire/form contains no specific questions based on areas of risk identified by Council that are specific to the profession and/or College. 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. Materials for the September 26, 2024 Council meeting include a summary each Council member's conflict of interest declaration (see agenda item 4, page 3).	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.

			Additional comments for clarification (optional)	
		d. Meeting materials for Council enable the public to clearly identify the public interest rationale and the evidence supporting a decision related to the College's strategic direction or regulatory processes and actions (e.g., the minutes include a link to a publicly available briefing note).	The College fulfills this requirement:	Met in 2023, continues to meet in 2024
			• Please briefly describe how the College makes public interest rationale for Council decisions accessible for the public. • Please insert a link to Council meeting materials that include an example of how the College references a public interest rationale and indicate the page number. All briefing notes include a section on public interest considerations as well as alignment with strategic and legislative direction and guiding legislation/bylaw/policy. Specifically, the section relating to protecting the public is intended to prompt a discussion on the public interest rationale and/or implications of the decision that is being made by Council. The report writer is to provide context in each one of these areas. Examples of such reports can be found in each of the Council materials packages posted here. Contents of each briefing note include: STRATEGIC DIRECTIONS: This initiative fits with the strategic direction of the College's Operating Plan, Goals and Objectives in the Key Result Area or other requirement: □ 1 Delivering on Legislative & Legal Mandate □ 2 Practicing Good Governance □ 3 Achieving Growth □ Fulfilling RHPA Objects □ Meeting a Legislative/Regulatory or Bylaw Requirement □ CPMF - College Performance Measurement Framework □ Other, specify: _____ GUIDING LEGISLATION/BYLAW/POLICY: PROTECTING THE PUBLIC: Provide a brief summary and rationale for any proposed decision and how it may impact and advance public interest and protection. I.e. How action taken or proposed demonstrates and advances public interest and protection, increases public trust and transparency, reduces risk to patients/public, and/or addresses changing public expectations. Meeting minutes do not include a link to publicly available briefing notes; however, prior Council meeting packages are available online and content reports discussed in public.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.

			Additional comments for clarification (if needed)

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		e. The College has and regularly reviews a formal approach to identify, assess, and manage internal and external risks. This approach is integrated into the College's strategic planning and operations. <u>Further clarification:</u> Formal approach refers to the documented method or which a College undertakes to identify, assess, and manage risk. This method or process should be regularly reviewed as appropriate. Risk management planning activities should be tied to strategic objectives of Council since internal and external risks may impact the ability of Council to fulfill its mandate, especially in the absence of mitigations. Internal risks are related to operations of the College and may impact its ability to meet its strategic objectives. External risks are economic, political and/or natural factors that happen outside of the organization.	The College fulfills this requirement:	Partially
			• Please provide the year that the formal approach was last reviewed. • Please insert a link to the internal and external risks identified by the College ***OR*** Council meeting materials where the risks were discussed and integrated into the College's strategic planning activities and indicate page number. The CHO has an established risk-assessment framework, primarily used to assess risks of undertaking (or not undertaking) major projects. It was developed in 2012 and last employed in 2016. An informal risk-assessment approach is used in the development of each year's strategic goals and objectives. Additionally, risk assessment measures are built into the processing and review of Inquiries, Complaints and Reports and System Partner Initiative review process (developed in 2021).	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			Additional comments for clarification (if needed) Formalization of the risk management process as it relates to complaints will be undertaken in 2025.	

DOMAIN 1: GOVERNANCE	STANDARD 3	**Measure:** **3.1 Council decisions are transparent.**		
		Required Evidence	**College Response**	
		a. Council minutes (once approved) and status updates on the implementation of Council decisions to date are accessible on the College's website, or a process for requesting materials is clearly outlined.	The College fulfills this requirement:	Met in 2023, continues to meet in 2024
			• Please insert a link to the webpage where Council minutes are posted. • Please insert a link to where the status updates on implementation of Council decisions to date are posted ***OR*** where the process for requesting these materials is posted. Council minutes are posted separately and as part of Council meeting packages here. Status updates on the implementation of Council decisions and other action items are included as part of the minutes. Status updates on ongoing items are included in each set of Council meeting materials. The College's annual operating goals and objectives (OPGO) are reported on in the OPGO status report. Action item tracking is included in every set of minutes. Additionally, a note is included on the website to instruct visitors to the site on how to request additional information.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

		b. The following information about Executive Committee meetings is clearly posted on the College's website (alternatively the College can post the approved minutes if it includes the following information). i. the meeting date; ii. the rationale for the meeting; iii. a report on discussions and decisions when Executive Committee acts as 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.	The College fulfills this requirement:	Yes
			• Please insert a link to the webpage where Executive Committee minutes/meeting information are posted. Executive Committee reports are included in the Council package for each meeting and are available on the website. Information provided includes the meeting date, rationale for the meeting, a report on discussions and decisions of Executive Committee when it acts on behalf of Council or discusses or deliberates on matters or materials that will be brought forward to Council, and finally an indication as to whether decisions will be ratified by Council.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

		Measure: **3.2 Information provided by the College is accessible and timely.**	
		Required Evidence	**College Response**
		a. With respect to Council meetings: i. Notice of Council meeting and relevant materials are posted at least one week in advance; and ii. Council meeting materials remain accessible on the College's website for a minimum of 3 years, or a process for requesting materials is clearly outlined.	The College fulfills this requirement: — Met in 2023, continues to meet in 2024 • Please insert a link to where past Council meeting materials can be accessed ***OR*** where the process for requesting these materials is clearly posted. Notice of Council meetings and materials can be found here until the date of the meeting. Following the meeting, materials are posted here *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item. *Additional comments for clarification (optional)*
		b. Notice of Discipline Hearings are posted at least one month in advance and include a link to allegations posted on the public register.	The College fulfills this requirement: — Met in 2023, continues to meet in 2024 • Please insert a link to the College's Notice of Discipline Hearings. Notice of Discipline Hearings can be found here.

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	
		Measure: **3.3 The College has a Diversity, Equity, and Inclusion (DEI) Plan.**		
		Required Evidence	**College Response**	
		a. The DEI plan is reflected in the Council's strategic planning activities and appropriately resourced within the organization to support relevant operational initiatives (e.g., DEI training for staff).	The College fulfills this requirement:	Partially
			• Please insert a link to the College's DEI plan. • Please insert a link to the Council meeting minutes where DEI was discussed as part of strategic planning and appropriate resources were approved and indicate page number. The development and implementation of a DEI plan is part of the College's Operating Plan Goals and Objectives. The College will be using HPRO's EDI Organizational Self-Assessment and Action Guide to develop an implementation plan. CHO will be ensuring that, within its capacity as a small college, proposed measures to address adverse impacts and/or the new or amended policy, program, or standards are implemented appropriately, considering feasibility, sustainability, and accountability. (See page 71 of the Guide.) The College is actively supporting the work of the Health Profession Regulators of Ontario (HPRO) as it develops supports for Colleges to advance their work in Diversity, Equity and Inclusion within the full range of their regulatory practices. CHO is a member of the HPRO DEI Network.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes

			Additional comments for clarification (optional) The College will continue to follow the lead of HPRO.

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		b. The College conducts Equity Impact Assessments to ensure that decisions are fair and that a policy, or program, or process is not discriminatory. <u>Further clarification:</u> Colleges are best placed to determine how best to report on an Evidence. There are several Equity Impact Assessments from which a College may draw upon. The ministry encourages Colleges to use the tool best suited to its situation based on the profession, stakeholders, and patients it serves.	The College fulfills this requirement:	No
			• Please insert a link to the Equity Impact Assessments conducted by the College and indicate the page number ***OR*** please briefly describe how the College conducts Equity Impact Assessments. • If the Equity Impact Assessments are not publicly accessible, please provide examples of the circumstances (e.g., applied to a policy, program, or process) in which Equity Impact Assessments were conducted. The College will be using HPRO's EDI Organizational Self-Assessment and Action Guide's Equity Impact Assessment (EIA) tool to identify and monitor equity impacts and outcomes of policies, programs, and standards on applicants to and registrants. We will be incorporating the EIA tool in our sequentially phased approach of information gathering, analyses, and engagement/consultation to assess our policies, programs, and standards. (See page 50 of the Guide.) Our preliminary assessment is that overall our College is blended in terms of our ability to conduct Equity Impact Assessments. • DEI in registration is limited to what is legally required. • DEI competence is not part of continuing development and quality assurance and is deferred to schools training new graduates. • Only mandatory areas of focus (e.g., sexual abuse and registration) are being addressed. • The complaint, investigation and tribunal processes have limited scope and/or capacity for addressing DEI issues. • Training relating to harassment or discrimination may be recommended if determined relevant as part of discipline and re-licensing. • Limited data may impact insight into potential issues (i.e., bias, differential failure/rejection rates). Patients/clients are viewed holistically, and beyond a bio-medical and individualist lens, while protecting privacy and confidentiality.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			Additional comments for clarification (optional) The HPRO Anti-Racism in Health Regulation project provides valuable information for our College to use in conducting these reviews within the context of an Equity Impact Assessment. Current HPRO project activities are designed to provide a set of guiding indicators and support tools that our College will use in the next two reporting periods to enable a customized assessment of equity impact, reflecting this College's particular needs. Specifically, based on our preliminary assessment, we will identify priority areas for a more thorough review of strengths and gaps, for action planning and implementation of actions to close the gaps.	

	Measure: **4.1 The College demonstrates responsible stewardship of its financial and human resources in achieving its statutory objectives and regulatory mandate.**	
DOMAIN 2: RESOURCES STANDARD 4	**Required Evidence**	**College Response**
	a. The College identifies activities and/or projects that support its strategic plan including how resources have been allocated. Further clarification: A College's strategic plan and budget should be designed to complement and support each other. To that end, budget allocation should depend on the activities or programs a College undertakes or identifies to achieve its goals. To do this, a College should have estimated the costs of each activity or program and the budget should be allocated accordingly.	The College fulfills this requirement: **Yes** • Please insert a link to Council meeting materials that include discussions about activities or projects to support the strategic plan ***AND*** a link to the most recent approved budget and indicate the page number. 2024-2025 Budget • Please briefly describe how resources were allocated to activities/projects in support of the strategic plan. The CHO has a small human resource complement and a limited financial budget. All responsibilities were managed by a staff of four until September 2024, when the staff complement dropped to three. Until September, one staff member was responsible for registration; one was responsible for communication and support to Council and Executive Committees and additional support as required, and two senior staff managed all other components of the College's activities and mandate and provide direction to support staff. Starting in September, duties were reallocated accordingly. Small teams of assessors have been contracted and trained to conduct substantially equivalent evaluation of applicants and academic program-based assessments. Staff support regulatory programs and Council and committee training, in addition to the tasks identified in the operating plan goals and objectives (OPGO), although in many cases there is an overlap between regulatory program needs and OPGO. The OPGO is tied to three Key Result Areas including: 1. CHO Effectively Delivers its Legislative & Legal Mandate; 2. CHO to Practice Good Governance; and 3. CHO to Achieve Growth (Growth = Profession, Supporting Institutions, CHO Membership Levels). Staff are supported by outside services in the areas of bookkeeping, legal, investigations and database management. The current CHO budget provides limited discretion for additional initiatives or expenditures. All activities undertaken must fit within the budget and existing staff complement. College work is somewhat variable due to contingencies such as complaints which may not be predictable (e.g., the number of complaints received and when they arise, discipline cases resulting in investigations and hearings, and other directives from the Ministry or other external agencies). Consequently, any attempt to predefine human resources allocation can be challenging especially with a small staff. Nevertheless, monitoring of each goal, objective, and ongoing responsibility occurs on a continuous basis and takes into account both those activities scheduled for completion and those activities identified as important but which could not be completed due to a lack of resources. The final goals and objectives were identified following an extensive review of risk, impact, requirement, priority, and consideration of available/existing human resources. Following outcome review and some modifications, the College will continue to take this approach moving forward. While the financial budget does not delineate a breakdown by area or project, the planning tools clearly demonstrate the allocation of human resources.

Choose an

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

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		b. The College: i. has a "financial reserve policy" that sets out the level of reserves the College needs to build and maintain in order to meet its legislative requirements in case there are unexpected expenses and/or a reduction in revenue and ii. possesses the level of reserve set out in its "financial reserve policy".	The College fulfills this requirement:	Partially
			• Please insert a link to the "financial reserve policy" ***OR*** Council meeting materials where financial reserve policy has been discussed and approved and indicate the page number. • Please insert the most recent date when the "financial reserve policy" has been developed ***OR*** reviewed/updated. • Has the financial reserve policy been validated by a financial auditor? No The College has conducted a review of best practices employed by other RHPA colleges and is in the process of developing a draft reserve policy for consideration by Council.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			Additional comments for clarification (if needed) While it is certainly the intent of the College to achieve the level of reserves set out in policy, the ability to do so is largely contingent on factors outside its control, namely the number of new and returning registrants and the number of complaints received, new and ongoing investigations and files referred to Discipline Committee. In 2023 and 2024, the College increased its fees at the rate of cost of living. The 2023 increase was the first in five years. Despite the recent fee increases and cost-efficiency in its operations, the College faces a fine balance in ensuring there is always adequate reserves to cover any sudden increase in complaints and investigations. Contingencies are not always predictable and can impact reserves. Prudent management of resources in 2024 resulted in replenishment of a significant portion of the reserves depleted by an unusual number of complaints in 2021 and 2022.	

		c. Council is accountable for the success and sustainability of the organization it governs. This includes: i. regularly reviewing and updating written operational policies to ensure that the organization has the staffing complement it needs to be successful now and, in the future (e.g., processes and procedures for succession planning for Senior Leadership and ensuring an organizational culture that attracts and retains key talent, through elements such as training and engagement). *Benchmarked Evidence*	The College fulfills this requirement:	Partially
			• Please insert a link to the College's written operational policies which address staffing complement to address current and future needs. • Please insert a link to Council meeting materials where the operational policy was last reviewed and indicate the page number. **Note:** Colleges are encouraged to add examples of written operational policies that they identify as enabling a sustainable human resource complement to ensure organizational success. The College addresses sustainability in its annual operational plan goals and objectives. The College has a growth plan and a goal to maintain membership at a level which is supportive of the operations of the College. Council and Executive Committee review the plan and monitor progress at each meeting. The College currently does not have operational policy which address staffing complement. A succession plan had been in development but required a change in approach due to the departure of a senior staff member. Further planning and approval will take place in 2025. Annually the Executive Committee reviews the Registrar's performance. This review is closely aligned with the specific goals and objectives approved for the review period. The Registrar is responsible for the management of the College's staff and ensuring fulfillment of the College's mandate and annual operating plan goals and objectives.	

			If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation. The College continues to discuss with other small and medium size RHPA colleges where resource-sharing and collaboration may be mutually beneficial. The College will be reviewing this area and implementing improvements over the next two reporting periods. Steps include: • Review of existing human resource capacity, staff roles and responsibilities, cross-training and opportunities for reorganization, as required. • Review of areas for resource sharing and collaboration with other RHPA colleges and like-minded organizations. • Policy development and adoption based on research of other organizations to establish clear processes and procedures for succession planning. The new plan, policies and processes will be reviewed on an annual basis.	
		ii. regularly reviewing and updating the College's data and technology plan to reflect how it adapts its use of technology to improve College processes in order to meet its mandate (e.g., digitization of processes such as registration, updated cyber security technology, searchable databases).	The College fulfills this requirement:	Yes
			• Please insert a link to the College's data and technology plan which speaks to improving College processes ***OR*** please briefly describe the plan. The majority of the College's information systems are digitally based. This applies to registration, complaints, quality assurance, and information management. Further changes are enhancements are being explored and implemented. The College operates on a Microsoft Office 365 for Business platform with enhanced capacity for administrative and committee management, as well as an electronic file storage/records management and telephone system. As part of its Operating Plan Goals and Objectives, the College has identified the implementation of mitigation efforts to enhance cybersecurity. Technology implementations are currently monitored by staff with input from an IT and database consultant. The College's database is managed by an independent third-party IT database specialist with high levels of cybersecurity. All data is backed up daily by our IT specialist partners. Significant improvements were made to the College's data management system as part of the HPDB submission made in 2024.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.

		Additional comments for clarification (optional)

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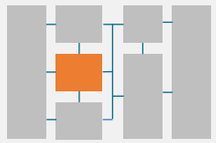
DOMAIN 3: SYSTEM PARTNER **STANDARD 5 and STANDARD 6**	
Measure / Required evidence: N/A	**College response** ***Colleges are requested to provide a narrative that highlights their organization's best practices for the following two standards. An exhaustive list of interactions with every system partner that the College engaged with is not required.*** ***Colleges may wish to provide information that includes their key activities and outcomes for each best practice discussed with the ministry, or examples of system partnership that, while not specifically discussed, a College may wish to highlight as a result of dialogue.***
The two standards under this domain are not assessed based on measures and evidence like other domains, as there is no 'best practice' regarding the execution of these two standards. Instead, Colleges will report on key activities, outcomes, and next steps that have emerged through a dialogue with the ministry. Beyond discussing what Colleges have done, the dialogue might also identify other potential areas for alignment with other Colleges and system partners. -	**Standard 5: The College actively engages with other health regulatory colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.** Recognizing that a College determines entry to practice for the profession it governs, and that it sets ongoing standards of practice for the profession it regulates and that the profession has multiple layers of oversight (e.g. by employers, different legislation, etc.), Standard 5 captures how the College works with other health regulatory colleges and other system partners to support and strengthen alignment of practice expectations, discipline processes, and quality improvement across all parts of the health system where the profession practices. In particular, a College is asked to report on: • *How it has engaged other health regulatory Colleges and other system partners to strengthen the execution of its oversight mandate and aligned practice expectations? Please provide details of initiatives undertaken, how engagement has shaped the outcome of the policy/program and identify the specific changes implemented at the College (e.g., joint standards of practice, common expectations in workplace settings, communications, policies, guidance, website, etc.).* • 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. • As an active participant in HPRO, the College has both contributed to and benefited from initiatives designed to advance DEI, modernize governance and regulatory management, understand and address regulatory changes to registration requirements, and ensure compliance with CPMF requirements. • Additionally, participation in HPRO's communications network has resulted in the implementation of a number of projects based on the successes of other colleges, with particular attention to low or no cost options. • During the reporting period, the Registrar met with representatives from other Colleges to discuss areas of common interest and ways in which to build stronger relationships.

- The Registrar continuted to engage in discussion with HPRO and other registrars individually regarding the potential benefits of interprofessional collaboration across all regulated providers within the health care system. These discussions focused on encouraging and supporting the integration and utilization alternative health care providers to improve access to care. It is hoped that this can lead to the development of interprofessional competencies and other resources as tools for engagement.
- Among the College's goals and objectives is stakeholder outreach (Regulatory College/Education/Professional Association) to support professional growth and practice excellence in homeopathy in Ontario. To this end, the CHO continued to engage in discussions with homeopathic education programs and the profession's main association to promote, among the leadership, greater awareness of the unique roles and responsibilities of each partner. This initiative, through an environment of trust, mutual respect and appropriate collaboration, was successful in bringing the partners to a common understanding and commitment to pursue growth of the profession. Further, it established a solid foundation and commitment to explore a range of possible initiatives to encourage progress, including public and profession education, and to explore ways to improve patient access to care, among other opportunities. This will be beneficial to the College in supporting continuing education/QA projects and increasing interest in College and Council membership. Arising out of this initiative was the creation of a new membership organization, the Ontario Alliance for Homeopathic Advancement, which is led by representatives of the two schools and a number of committed homeopaths. CHO will participate as far as possible within its mandate of public protection.
- Work toward meeting the requirements of the Office of the Fairness Commissioner is ongoing. Effective Spring 2024, CHO was granted a status of Low Risk and moved to an annual meeting with OFC.
- In 2023, the College became a member of the Citizen Advisory Group. Participation has been limited so far, but it is anticipated that 2025 will bring more activity in this area.

Standard 6: The College maintains cooperative and collaborative relationships and responds in a timely and effective manner to changing public/societal expectations.

The intent of Standard 6 is to demonstrate that a College has formed the necessary relationships with system partners to ensure that it receives and contributes information about relevant changes to public expectations. This could include both relationships where the College is asked to provide information by system partners, or where the College proactively seeks information in a timely manner.

- *Please provide examples of key successes and achievements from the reporting year where the College engaged with partners, including patients/public to ensure it can respond to changing public/societal expectations (e.g., COVID-19 Pandemic, mental health, labor mobility etc.). Please also describe the matters that were discussed with each of these partners and how the information that the College obtained/provided was used to ensure the College could respond to a public/societal expectation.*
- *In addition to the partners it regularly interacts with, the College is asked to include information about how it identifies relevant system partners, maintains relationships so that the College is able access relevant information from partners in a timely manner, and leverages the information obtained to respond (specific examples of when and how a College responded is requested in Standard 7).*

	• The College approved a System Partner Initiatives framework in 2022. This framework proposed two areas of activity that would fulfill CPMF requirements for system partnerships. With limited human resources capacity to move these initiatives forward during the 2023/2024 fiscal year, these projects will be considered again in 2024/2025. These projects remain a priority. • In addition, the CHO moved toward increasing its public engagement as a member of the Citizen Advisory Group. • The College has staff as members of HPRO's EDI Network and they actively participate in meetings and educational opportunities. The Network's activities include environmental scans and knowledge sharing, outreach to system partners through HPRO (e.g., Office of the Fairness Commissioner), opportunities for sharing in a safe and inclusive space, and documents and tools that the College can consider for possible implementation. (See page 47 of the Guide.) • A representative of the College attends meetings of the Infection Prevention and Control Regulatory Working Group. Information presented at these meetings is shared with registrants wherever appropriate. • The College has been actively involved with Health Canada in shaping policy related to the importation of homeopathic remedies. While consultation with Health Canada has been going on for several years, new concerns arose when a number of registrants reported that packages containing homeopathic remedies had been stopped at the border. This interaction appears to have led to a resolution of the problem. • *Rubrics*, the College's newsletter, moved to a regular monthly schedule. Starting in early 2024, the newsletter offered significant content and included short surveys on topics of regulatory interest. Responses to these surveys provided content for subsequent issues, thereby enhancing engagement and developing a two-way communications vehicle between the College and its registrants. Issues of Rubrics were added to the News and Events page of the website and are publicly available.

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		Measure: **7.1 The College demonstrates how it protects against and addresses unauthorized disclosure of information.**	
DOMAIN 4: INFORMATION MANAGEMENT	STANDARD 7	**Required Evidence**	**College Response**
		a. The College demonstrates how it: i. uses policies and processes to govern the disclosure of, and requests for information;	The College fulfills this requirement: — Yes
			• Please insert a link to policies and processes ***OR*** please briefly describe the respective policies and processes that addresses disclosure and requests for information. Policy documents pertaining to Privacy and Confidentiality Bylaws CHO By-Laws Bylaw 17 Confidentiality SCHEDULE 3 TO THE BYLAWS Code of Conduct for Council and Committee Members (page 37) **Human Resource Policies** HR - 22 Confidentiality HR - 27 Standards for Telecommuting HR - 28 Email and Internet Use **Operations and Governance Policies** OP - 01 Records Management OP - 02 Privacy Code OP - 03 Privacy Breach Reporting Process COM - 06 Privacy Code - Website **GOV -15 Confidentiality** The College has policy which defines a privacy breach, provides an overview of applicable privacy legislation, and describes how the College will address breaches. The College relies on the best practices approach of the Information and Privacy Commissioner of Ontario and Office of the Privacy Commissioner of Canada. The College has a records management policy adopted from that of the College of Physicians and Surgeons. This policy describes how the College stores information, how long information is retained and how it should be destructed. All board and committee members sign a confidentiality agreement on an annual basis.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item.

		Additional comments for clarification (optional)

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		ii. uses cybersecurity measures to protect against unauthorized disclosure of information; and iii. uses policies, practices and processes to address accidental or unauthorized disclosure of information. *Benchmarked Evidence*	The College fulfills this requirement:	Partially
			• Please insert a link to policies and processes ***OR*** please briefly describe the respective policies and processes to address cybersecurity and accidental or unauthorized disclosure of information. The College has implemented several procedural processes including: • Establishing secure online record management through *Microsoft Office 365* under the guidance of a third-party consultant. • Introducing new automated payment processes so that it will no longer be necessary to collect credit card information. • Consulting with our third-party database provider to ensure data safety.	
			If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation. Work will continue on this requirement over the next two reporting periods. Future steps include: • Developing a cyber security checklist and questionnaire for consultation with our existing data/information management partners. Identification of gaps and weaknesses, and creation of a plan to address. • Research into existing plans, policies, procedures, and processes utilized by other RHPA colleges. Requests for information sharing, modification, and adoption. • Implementation of staff education plan to improve cyber security and information privacy knowledge. • Sharing of plan and policies with Executive Committee and Council. • Review and updating of policies, practices and processes to address accidental or unauthorized disclosure of information. • Implement annual review of policy and plans.	

	Measure: **8.1 All policies, standards of practice, and practice guidelines are up to date and relevant to the current practice environment (e.g., where appropriate, reflective of changing population health needs, public/societal expectations, models of care, clinical evidence, advances in technology).**	
DOMAIN 5: REGULATORY POLICIES STANDARD 8	**Required Evidence**	**College Response**
	a. The College regularly evaluates its policies, standards of practice, and practice guidelines to determine whether they are appropriate, or require revisions, or if new direction or guidance is required based on the current practice environment. *Benchmarked Evidence*	The College fulfills this requirement: **Partially** • Please insert a link to document(s) that outline how the College evaluates its policies, standards of practice, and practice guidelines to ensure they are up to date and relevant to the current practice environment and indicate the page number(s) ***OR*** please briefly describe the College's evaluation process (e.g., what triggers an evaluation, how often are evaluations conducted, what steps are being taken, which stakeholders are being engaged in the evaluation and how are they involved). The college regularly monitors changing practice environments and technology through environmental scans and consultations with stakeholders and system partners, including but not limited to homeopathy educators and associations, Health Profession Regulators of Ontario (HPRO), Health Canada, and Ontario Regulators for Access Consortium (ORAC). Standards of Practice and Practice Guidelines were last reviewed in 2018 for currency and are revised as required. In late 2021, the Patient Relations Committee commenced on the review and revision of three professional practice standards/guidelines in addition to one practice guide. While the review and development will continue through 2025, the Committee has proposed the elimination of one practice guideline, to be replaced with three new standards. Additionally, the committee is proposing revisions to two existing standards and the introduction of one new public facing policy. *If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation.* The College is in the process of setting a regular policy review schedule for all policies across the organization which will create an expected time framework for review of policies, standards of practice and practice guidelines. Consideration is being given to engaging small groups of non-Council volunteers to review standards and guidelines for currency and relevance and make recommendations to Council accordingly. It is anticipated that the review process will be underway as of July 2025.

		b. Provide information on how the College takes into account the following components when developing or amending policies, standards and practice guidelines: i. evidence and data; ii. the risk posed to patients / the public; iii. the current practice environment; iv. alignment with other health regulatory Colleges (where appropriate, for example where practice matters overlap); v. expectations of the public; and vi. stakeholder views and feedback. *Benchmarked Evidence*	The College fulfills this requirement: • Please insert a link to document(s) that outline how the College develops or amends its policies, standards of practice, and practice guidelines to ensure they address the listed components and indicate the page number(s) ***OR*** please briefly describe the College's development and amendment process. Considerable effort during the past two reporting periods went into developing the Spousal Exception regulation and related policies. The College did not conduct any reviews or make amendments to any other policies, standards, or practice guidelines in 2024. The review of professional practice standard/guideline/policy considers the following components: i. **Evidence and Data**: What do complaints to the college tell the committee about red flag issues? What are the typical questions received from registrants and the public on these topics? Do the existing and proposed standards adhere to legislation? What changes are required? ii. **Risk to Patients/Public**: What information is needed for both the patient and the registrant to eliminate sexual abuse of a patient? What information is required to protect patients/the public from harm? What information is necessary to ensure patients have a clear understanding of what to expect from a Homeopath, and what their rights are? iii. **Current Practice Environment**: How does remote practice impact the patient and practitioner experience in relation to these documents? What has changed in the practice environment since the original documents were created in 2014 (reviewed with editorial updates in 2018)? How has remote practice impacted the patient examination process? What do patients and registrants need to know about sending pictures and data to support examination and assessment while ensuring patient privacy and confidentiality? iv. **Alignment with other Health Regulatory Colleges**: CHO conducts a thorough review of how other RHPA colleges address the same subject and adopts with permission and modification materials which are similar in approach to that of homeopathy. In some cases, the CHO may use an integrated approach to creating documents by using the best approach from several sources. v. **Expectations of the public**: the College works to meet the expectations of the public through consultation and feedback and through a common-sense approach to policy/standards/guideline updates. vi. **Stakeholder views and feedback**: Once the draft professional practice documents have been approved in principle by Council, they are circulated for public consultation for 60 days. The consultation process involves distribution by email to any interested party including all registrants and stakeholders, regular reminders to provide feedback, and posting the documentation on the College's website.	Yes
			If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation.	

		c. The College's policies, guidelines, standards and Code of Ethics should promote Diversity, Equity, and Inclusion (DEI) so that these principles and values are reflected in the care provided by the registrants of the College.	The College fulfills this requirement:	Partially
			• Please briefly describe how the College reviews its policies, guidelines, standards and Code of Ethics to ensure that they promote Diversity, Equity and Inclusion. • Please highlight some examples of policies, guidelines, standards or the Code of Ethics where Diversity, Equity and Inclusion are reflected. Assessment at end of 2024: CHO's assessment is that overall the College is blended in terms of ensuring that policies, guidelines, standards and Code of Ethics promote Diversity, Equity and Inclusion. Currently, the following is applicable: • Limited DEI consideration in most policies, current practice standards and guidelines. Elevated level incorporated into registration policies with further review planned for 2025. • The College's Code of Ethics for the profession is well grounded and effectively promotes DEI. • Review of policies, practice standards and guidelines through a DEI-lens is being planned; when documents are being created or reviewed DEI impact is considered. • DEI position statement and integration of DEI into the College's bylaws is under development for 2024. • Research into the best available evidence is incorporated as part of any policy/guidelines/standard development or review. • External DEI stakeholders initiate relations. • DEI stakeholder relations are minimal. • There is ongoing collaboration across health professions groups via the HPRO EDI Network.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			Additional comments for clarification (optional) The College will be using HPRO's EDI Organizational Self-Assessment and Action Guide to inform the review and consultation of future changes to policies, guidelines, standards, and the Code of Ethics. (See page 50 of the Guide.)	

	Measure: **9.1 Applicants meet all College requirements before they are able to practice.**	
DOMAIN 6: SUITABILITY TO PRACTICE STANDARD 9	**Required Evidence**	**College Response**
	a. Processes are in place to ensure that those who meet the registration requirements receive a certificate to practice (e.g., how it operationalizes the registration of members, including the review and validation of submitted documentation to detect fraudulent documents, confirmation of information from supervisors, etc.)[1].	The College fulfills this requirement: — Met in 2023, continues to meet in 2024 • Please insert a link that outlines the policies or processes in place to ensure the documentation provided by candidates meets registration requirements and indicate page number ***OR*** please briefly describe in a few words the processes and checks that are carried out. • Please insert a link and indicate the page number ***OR*** please briefly describe an overview of the process undertaken to review how a College operationalizes its registration processes to ensure documentation provided by candidates meets registration requirements (e.g., communication with other regulators in other jurisdictions to secure records of good conduct, confirmation of information from supervisors, educators, etc.). The following links inform much of the registration process: o Guide to Registration o Substantially Equivalent Competence Assessment (SECA) Handbook, o Substantially Equivalent Interview Preparation Guide, and o the Homeopathy Individual Assessment Application Guide In addition, two policies inform the substantial equivalence and individual assessment processes: o REG CS 08 Substantially Equivalent o REG AD 02 Individual Assessment Appeals Process and Timelines Registrants enter the College in one of two ways: as graduates of a post-secondary program in homeopathy which has been approved by Council, or through a process of demonstrating that their education and clinical training is substantially equivalent to that received by a graduate of an approved program. Ensuring that those who enter the College have an appropriate level of education and clinical training and demonstrate entry to practice knowledge, skill and judgment is a critical role for the College and an important aspect in ensuring public protection. In 2023, 43% of applicants graduated from CHO-approved post-secondary programs in homeopathy in Ontario. Some applicants to the College come with a wide and diverse range of education and clinical training, sometimes earned from outside of Ontario. The College's 2023 Fair Registration Practice Report to the Ontario Office of the Fairness Commissioner shows 56% of applicants who went on to become registrants received their initial education outside of Canada. The content of the education and clinical training received by applicants outside of Ontario varies from greatly exceeding the CHO requirements to falling below the complement of courses and skills training required to demonstrate the requirements laid out in Ontario Regulation 18/14 Registration, College policies and/or evidence that the applicant has been taught and evaluated on the competencies laid out in the Entry-to-Practice Competency Profile for Homeopaths Practicing in Ontario.

			The CHO has excellent rapport with the administrators of the CHO-approved programs. These schools provide transcripts and any additional support information required (i.e. training logs, supervisor reports, etc.) on a as needed and as requested basis. Sometimes this information is required if an applicant is re-entering the workforce and graduated prior to the program becoming approved. Most applicants who are program graduates from a post-secondary program in homeopathy within Canada, but outside of Ontario, come from one program in Quebec. The CHO also has an excellent rapport with that school. Between 2015 and 2024, the majority of applicants from outside of Canada received their education from India (57%), Pakistan (17%), the United Kingdom (9%) or the United States (7%). Typically, the homeopathy programs in India and Pakistan are medically based four-and-a-half-year degree programs followed by one year of internship. While these programs generally meet or exceed the Ontario-based program requirements, all individuals who have not graduated from an Ontario approved program must undergo a Substantially Equivalent Competency Assessment (SECA) review administered by the CHO. Additionally, the individual must provide proof of education and training along with all other registration requirements. Certification boards in India, Pakistan and Quebec oversee and validate the applicant's training and education. These certification bodies provide verification information directly to the CHO. All applications, regardless of the pathway to registration, must include verified proof of identification. Supporting information received from educators, supervisors, or regulators must be submitted directly from source. Applicants who have been or are currently registered with another regulatory body must request that a Certificate of Professional Conduct be issued to CHO. The CHO registration process also includes the following components: **Applicants without currency in the past three years**: If an applicant does not have currency, he/she may be directed to undergo a Refresher Program from a CHO approved program in Ontario. This program includes theory refreshment set to CHO entry-to-practice competency profile and clinical supervision. The program provider issues a progress report and a certificate of completion. **Substantial Equivalence Competency Assessment (SECA)**: The SECA review for individuals who have not graduated from an approved post-secondary program in homeopathy includes a thorough examination of the applicant's submission package including training and education, and a comprehensive in-person interview (conducted via video call, prior to 2020 the interview may have been in person). The interview is conducted by a trained assessor who is also a homeopath. The applicant must provide proof of identification prior to commencing with the interview. The SECA process can result in one of the following outcomes: 1. Demonstration of substantial equivalence [scored 80% or more on both the theory and clinical requirements] 2. Failure to demonstrate [scored less than 80% on either the theory or clinical requirements or both] Where gaps in the applicant's knowledge, skill and judgment exist, the applicant is notified of the results and is provided with a complete results report. The applicant may remedy the outcome by a. retaking the SECA interview to improve their demonstration or b. the file will be referred to the Registration Committee who provides specific instruction to the applicant on the additional education or clinical training, and the acceptable source, required to satisfy the registration requirements. The SECA process may be undertaken up to three times. If the individual is unable to demonstrate equivalence by the third attempt, the College requires the individual to provide proof of additional training or education prior to again attempting the SECA process. The SECA results can be appealed to the Registration Committee.

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

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	
		b. The College periodically reviews its criteria and processes for determining whether an applicant meets its registration requirements, against best practices (e.g., how a College determines language proficiency, how Colleges detect fraudulent applications or documents including applicant use of third parties, how Colleges confirm registration status in other jurisdictions or professions where relevant etc.).	The College fulfills this requirement:	Yes
			• Please insert a link that outlines the policies or processes in place for identifying best practices to assess whether an applicant meets registration requirements (e.g., how to assess English proficiency, suitability to practice etc.), a link to Council meeting materials where these have been discussed and decided upon and indicate page numbers ***OR*** please briefly describe the process and checks that are carried out. • Please provide the date when the criteria to assess registration requirements was last reviewed and updated. 2024 Also refer to the answer in 9.1a for information on the validation process to detect fraudulent applications or documents. CHO's criteria for applicants of full class is outlined in section 6 (1) of Ontario Regulation 18/14 O. Reg. 18/14: REGISTRATION (ontario.ca) **Registration requirements, Full class** 6. (1) The following are registration requirements for a Full certificate of registration: 1. The applicant must have, i. successfully completed a post-secondary program in homeopathy in Ontario that is approved by Council, or another body approved by Council for that purpose, or ii. successfully completed a program in homeopathy together with other education or training which a panel of the Registration Committee considers, when taken together, to be substantially equivalent to the requirements set out in subparagraph i. The criteria for an approved post-secondary program in homeopathy in Ontario, supported by 6.(1)1i was approved in 2015 and has remained unchanged since that time. Criteria for the determination of applicants who are deemed to have successfully completed education and clinical training considered to be substantially equivalent to that of a graduate from an approved post-secondary program in homeopathy in Ontario have undergone substantial fine-tuning since they were first introduced in 2016. In late 2018 staff undertook a review of the substantially equivalent process to make the process more transparent for the applicant while enhancing public protection. Throughout 2024, the College continued to work on strengthening its SECA (substantially equivalent competency assessment) review process to include a thorough interview process intended to provide a deeper understanding of an applicant's knowledge, education and training and to determine if gaps exist between the applicant's training and the College's requirements. This interview process, utilizing homeopaths trained as assessors, provides the College and the public with a greater level of confidence about the entry-to-practice readiness of future registrants. Where gaps are identified, the College provides the applicant with clear direction on additional education and/or training required to demonstrate eligibility to register in Full Class. Once the applicant	

			demonstrates substantial equivalence, they are still required to successfully complete all remaining registration requirements including the Individual Assessment (IA) process. This stronger assessment component was in place throughout 2024. The IA, first adopted in 2014, is administered by an independent third-party psychometric assessment company. Together the substantial equivalence review and the individual assessment requirement help to ensure registrants are knowledgeable and appropriately trained on entry to practice competencies and requirements. Discussion with the College's third-party assessor commenced in 2023 to audit and review the process and determine if any fine-tuning is required to modernize and refresh the process. This audit will take place in 2025. The substantial equivalence and the individual assessment processes has been developed in accordance with the general and specific duties outlined in the *Fair Access to Regulated Professions and Compulsory Trades Act* and supporting materials provided by the Office of the Fairness Commissioner of Ontario. The process meets both the applicant's needs for a process which is transparent, objective, impartial and fair, and the public's need for protection and confidence in their health care providers. Additional review and adjustments were considered during development of the Emergency Class which utilizes a modified version of the substantial equivalence process. All registration requirements have been reviewed against the regulatory changes mandated under O.Reg. 508/22 *Registration Requirements*. CHO made amendments to its language requirements policy. CHO was already in compliance with the majority of the new registration requirements. In 2023, CHO completed a proposal for changes to O.Reg. 18/14 Registration in preparation to add an Emergency Class in accordance with O.Reg. 508/22. The government approved the amendments effective August 31, 2024.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

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		Measure: **9.2 Registrants continuously demonstrate they are competent and practice safely and ethically.**		
		c. A risk-based approach is used to ensure that currency[2] and other competency requirements are monitored and regularly validated (e.g., procedures are in place to verify good character, continuing education, practice hours requirements etc.).	The College fulfills this requirement:	Yes
			• Please briefly describe the currency and competency requirements registrants are required to meet. • Please briefly describe how the College identified currency and competency requirements. • Please provide the date when currency and competency requirements were last reviewed and updated. • Please briefly describe how the College monitors that registrants meet currency and competency requirements (e.g., self-declaration, audits, random audit etc.) and how frequently this is done. CHO's currency requirements are outlined in section 7(1) of Ontario Regulation 18/14 O. Reg. 18/14: REGISTRATION (ontario.ca) **Terms, etc., Full class** 7. (1) Subject to subsection (2), the following are terms, conditions and limitations on every Full certificate of registration: 1. The member shall practise the profession a minimum of 750 hours during every three-year period, with the first three-year period beginning on the day that the member is issued a Full certificate of registration, and each subsequent three-year period beginning on the first anniversary of the commencement of the previous period. 2. At all times the member must be certified in health care provider CPR and standard first aid. O. Reg. 18/14, s. 7 (1). These requirements were last reviewed in 2014. Monitoring of currency requirements occurs through self-declaration once a year at renewal time. The annual reporting on actual currency hours is provides a detailed recording of the registrant's practice hours during their selected 12-month reporting period. This information is reviewed for completeness and is followed up by staff and confirmed. Additionally, staff review each registrant's practice currency over a rolling three-year period. Registrants issued a Full Class certificate of registration, who report very small or minimal practice hours are flagged for further follow-up. As the primary focus is ongoing competent and safe practice, the registrant maybe referred for peer assessment by the College's Registrar. Registrants are required annually to reaffirm matters of good character. The registrant has the option to provide additional information at the time of renewal. Any matter that is flagged by the registrant is followed up by staff. Throughout the remainder of the year registrants are required to declare matters of good character within 30-days of any reportable matters including professional misconduct with another regulatory body, conditions of bail, findings of guilt, etc. Additionally, at the time of renewal registrants are required to provide proof of renewal of their certificate in health care provider CPR and standard first aid and insurance.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.

		Additional comments for clarification (optional)

[2] 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).

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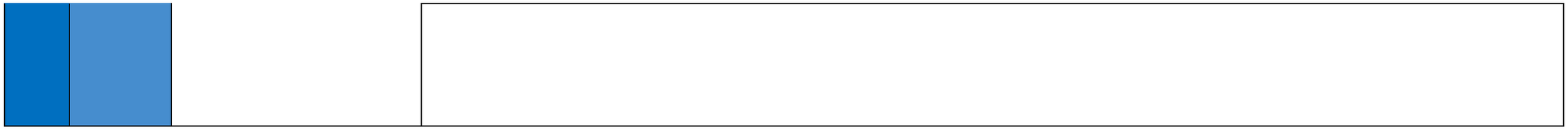
		Measure: **9.3 Registration practices are transparent, objective, impartial, and fair.**		
		a. The College addressed all recommendations, actions for improvement and next steps from its most recent Audit by the Office of the Fairness Commissioner (OFC).	The College fulfills this requirement:	Yes
			• Please insert a link to the most recent assessment report by the OFC ***OR*** please provide a summary of outcome assessment report. OFC Assessment Letter • Where an action plan was issued, is it: Completed In the OFC 2023-2024 annual report, the agency notified CHO that it falls into the low risk category for the period of April 1, 2024 to March 31, 2026. This is an improvement from the moderately low risk category for the 2022-2024 period. During the 2023 calendar year, the College met quarterly with the OFC to discuss progress. This schedule changed to an annual meeting starting April 1, 2024.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (if needed)	

DOMAIN 6: SUITABILITY TO PRACTICE

STANDARD 10

Measure:
10.1 The College supports registrants in applying the (new/revised) standards of practice and practice guidelines applicable to their practice.

Required Evidence	College Response	
a. Provide examples of how the College assists registrants in implementing required changes to standards of practice or practice guidelines (beyond communicating the existence of new standard, FAQs, or supporting documents). Further clarification: Colleges are encouraged to support registrants when implementing changes to standards of practice or guidelines. Such activities could include carrying out a follow-up survey on how registrants are adopting updated standards of practice and addressing identifiable gaps.	The College fulfills this requirement:	Partially
	• Please briefly describe a recent example of how the College has assisted its registrants in the uptake of a new or amended standard: – Name of Standard – Duration of period that support was provided – Activities undertaken to support registrants – % of registrants reached/participated by each activity – Evaluation conducted on effectiveness of support provided • Does the College always provide this level of support: No *If not, please provide a brief explanation:* The College did not revise or create/release any new standards or practice guidelines during the 2023 calendar year. Most predominantly support is provided through one-on-one practice advisory service and newsletter articles. Registrants were notified of changes related to the Spousal Exception regulation.	
	If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
	Additional comments for clarification (optional) The College is in the process of setting a regular policy review schedule for all policies across the organization which will create an expected timeline and framework for review of policies, standards of practice and practice guidelines. Consideration is being given to engaging small groups of non-Council volunteers to review standards and guidelines for currency and relevance and make recommendations to Council accordingly. Should any changes arise as a result of this review, a communications and education plan will be established to ensure support for registrants as changes are introduced. The monthly newsletter will be used to disseminate information and conduct follow-up surveys as appropriate.	



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		Measure: **10.2 The College effectively administers the assessment component(s) of its QA Program in a manner that is aligned with right touch regulation[3].**		
		a. The College has processes and policies in place outlining: i. how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice;	The College fulfills this requirement:	No
			• Please list the College's priority areas of focus for QA assessment and briefly describe how they have been identified ***OR*** please insert a link to the website where this information can be found and indicate the page number. • Is the process taken above for identifying priority areas codified in a policy: Choose an item. • *If yes, please insert link to the policy.*	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			Additional comments for clarification (optional) The implementation and expansion of the CHO's QAP moved forward in 2024, starting with educational material on what to expect and the components of the program. By the fall of 2025, all registrants will have completed one cycle of the Quality Assurance Program and the results will be in the hands of the Committee for review. The action plan will bring CHO into the required alignment of both program offerings and monitoring/registrant compliance. This will be done in conjunction with seeking mentorship assistance, as required, from some fellow RHPA colleges.	

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

		ii. details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity (and which type of multiple assessment activities); and	The College fulfills this requirement:	No
			• Please insert a link to document(s) outlining details of right touch approach and evidence used (e.g., data, literature, expert panel) to inform assessment approach and indicate page number(s). ***OR*** please briefly describe right touch approach and evidence used. • Please provide the year the right touch approach was implemented ***OR*** when it was evaluated/updated (if applicable). *If evaluated/updated, did the college engage the following stakeholders in the evaluation:* – *Public* Choose an item. – *Employers* Choose an item. – *Registrants* Choose an item. – *other stakeholders* Choose an item.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			Additional comments for clarification (optional) The implementation and expansion of the CHO's QAP moved forward in 2024, starting with educational material on what to expect and the components of the program. By the fall of 2025, all registrants will have completed one cycle of the Quality Assurance Program and the results will be in the hands of the Committee for review. The action plan will bring CHO into the required alignment of both program offerings and monitoring/registrant compliance. This will be done in conjunction with seeking mentorship assistance, as required, from some fellow RHPA colleges.	
		iii. criteria that will inform the remediation activities a registrant must undergo based on the QA assessment, where necessary.	The College fulfills this requirement:	No
			• Please insert a link to the document that outlines criteria to inform remediation activities and indicate page number ***OR*** list criteria.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes

			The implementation and expansion of the CHO's QAP moved forward in 2024, starting with educational material on what to expect and the components of the program. By the fall of 2025, all registrants will have completed one cycle of the Quality Assurance Program and the results will be in the hands of the Committee for review. The action plan will bring CHO into the required alignment of both program offerings and monitoring/registrant compliance. This will be done in conjunction with seeking mentorship assistance, as required, from some fellow RHPA colleges.	
		Measure: **10.3 The College effectively remediates and monitors registrants who demonstrate unsatisfactory knowledge, skills, and judgement.**		
		a. The College tracks the results of remediation activities a registrant is directed to undertake as part of any College committee and assesses whether the registrant subsequently demonstrates the required knowledge, skill and judgement while practicing.	The College fulfills this requirement:	Partially
			• Please insert a link to the College's process for monitoring whether registrant's complete remediation activities ***OR*** please briefly describe the process. • Please insert a link to the College's process for determining whether a registrant has demonstrated the knowledge, skills and judgement following remediation ***OR*** please briefly describe the process. The College uses a variety of spreadsheets and relational databases to monitor remediation activities. In conjunction with the data/information management tools College staff utilize template letters and emails to communicate with registrants as well as one-on-one phone contact/outreach were appropriate and required. **Complaints/Discipline** activities are monitored through a combination of the registration database which attaches monitoring to the administrative side of the registrant's profile. Additionally, the College uses a customized tracking process developed through Microsoft Lists which is interactive and alerts staff when follow-up is required, or activities are due. **Registration** activities are monitored through a combination of the registration database which attaches monitoring to the administrative side of the registrant's profile. Additionally, the College uses Excel spreadsheets to tracking other pertinent data points and follow-up notes. Registration related processes are most frequently tied to specific annual events and activities and follow-up is built into the functional task specific sequences performed by registration staff. **Quality Assurance** activities in addition to monitoring of CEPD and hour currency are monitored through a combination of the registration database which attaches monitoring to the administrative side of the registrant's profile, Excel spreadsheet and Microsoft Lists. The College uses a customized tracking process developed through Microsoft Lists which is interactive and alerts staff when follow-up is required, or activities are due for remediation.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes

			Additional comments for clarification (if needed) The implementation and expansion of the CHO's QAP moved forward in 2024, starting with educational material on what to expect and the components of the program. By the fall of 2025, all registrants will have completed one cycle of the Quality Assurance Program and the results will be in the hands of the Committee for review. The action plan will bring CHO into the required alignment of both program offerings and monitoring/registrant compliance. This will be done in conjunction with seeking mentorship assistance, as required, from some fellow RHPA colleges.

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DOMAIN 6: SUITABILITY TO PRACTICE	STANDARD 11	**Measure 11.1** **The College enables and supports anyone who raises a concern about a registrant.**		
		Required Evidence	**College Response**	
		a. The different stages of the complaints process and all relevant supports available to complainants are: i. supported by formal policies and procedures to ensure all relevant information is received during intake at each stage, including next steps for follow up; ii. clearly communicated directly to complainants who are engaged in the complaints process, including what a complainant can expect at each stage and the supports available to them (e.g., funding for sexual abuse therapy);	The College fulfills this requirement:	Yes
			• Please insert a link to the College's website that clearly describes the College's complaints process including, options to resolve a complaint, the potential outcomes associated with the respective options and supports available to the complainant. • Please insert a link to the polices/procedures for ensuring all relevant information is received during intake ***OR*** please briefly describe the policies and procedures if the documents are not publicly accessible. The College's website includes a page describing the complaints process in detail. Additionally, a number of downloadable resources are available, in addition to a Word or Adobe form fillable complaints form: Information Package on How to Make a Complaint What should you do if you suspect sexual abuse by a homeopath? I Have Been or Know of a Client Who has Been Sexually Abused by a Homeopath. What do I do? Understanding sexual abuse Information and support are provided to the complainant throughout the process both by telephone and email. The complainant is provided with documents related to the specific complaints, such as the registrant's response to the complaint and a copy of the investigations report (if this exists). At the end of the process the complainant is also provided with a copy of the decision and reasons, all of which promotes transparency. For patients who are victims of alleged sexual assault, information is provided on sexual assault telephone and community resources for immediate access to support care, and access to the application form for funding for therapy and counselling services. Fifty percent of alleged sexual assault victims have utilized the College's fund for therapy and counselling services. College staff are flexible and can speak to complainants during regular business hours or evenings. Both male and female staff are available to speak with complainants.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.

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		and;	*Additional comments for clarification (optional)*
		iii. evaluated by the College to ensure the information provided to complainants is clear and useful. *Benchmarked Evidence*	The College fulfills this requirement: **Partially** • Please provide details of how the College evaluates whether the information provided to complainants is clear and useful. The College has reviewed all the materials on its website related to the complaints process, and specifically reviewed the information intended for the public. Further it compared this information to other RHPA websites with special attention to those Colleges who have already conducted such an evaluation. Generally, the CHO information for complainants is clear and useful. However, additional resources and presentation methods have been identified as areas of improvement including the addition of video and audio material, and translation of materials into French, Hindi, Punjabi, and Bengali. These additions will be undertaken in 2025. *If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation.* Please see note in second paragraph above.

		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:	Met in 2023, continues to meet in 2024
			Please insert rate (see Companion Document: Technical Specifications for Quantitative CPMF Measures). • in 2024, 7 complaints/reports were received. 100% of these inquiries received a response within 2 days, with an average of 1 day. • in 2023, 4 complaints/reports were received. 100% of these inquiries received a response within 3 days, with an average of 1 day. • in 2022, 5 inquiries were received. 100% of these inquiries received a response within 3 days, with an average of 1 day. • in 2021, 5 inquiries were received. 80% (all but one) of these inquiries received a response within 3 days, with an average of 2 days. • In 2020, 10 inquiries were received. 90% (all but one) of these inquiries received a response within 3 days, with an average of 2 days. All 7 complaints received in 2024 were resolved by the Registrar within 4-5 business days. No complaints were referred to the ICRC in 2024.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

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		c. Demonstrate how the College supports the public during the complaints process to ensure that the process is inclusive and transparent (e.g., translation services are available, use of technology, access outside regular business hours, transparency in decision-making to make sure the public understand how the College makes decisions that affect them etc.).	The College fulfills this requirement:	Met in 2023, continues to meet in 2024
			• Please list supports available for the public during the complaints process. • Please briefly describe at what points during the complaints process that complainants are made aware of supports available. College staff provide complainants access to the following supports throughout the complaints process. Their availability is detailed on the College's website and in the available materials. • Information on the college's website with additional access to sexual abuse funding for therapy and counselling. • Providing a list of resources and hotlines for victims of abuse for immediate assistance and support. • One-on-one discussions with Registrar to use the right-touch approach, where appropriate, to address matters raised by the complainant. This is not the approach taken with matters of sexual abuse which are prioritized and referred to ICRC in a prompt and timely manner. • Responding to email and phone inquiries about the complaints process. • Helping members of the public identify a homeopath for the purpose of making a complaint. • Helping complainants to record or transcribe their complaint if they were unable to write their complaint. • Providing status updates throughout the process both by telephone and email. • In an attempt to be user-friendly, the College makes necessary adjustments to its communication style and approach to accommodate a complainant's accessibility and comprehension requirements. • Recording and resolving concerns about the complaints process. • The complainant is provided with documents related to the specific complaints, such as the registrant's response to the complaint and a copy of the investigations report (if this exists). At the end of the process the complainant is also provided with a copy of the decision on reasons. All of which promotes transparency. • College staff are flexible and can speak to complainants during regular business hours or evenings. Both male and female staff are available to speak with complainants.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

		Measure: **11.2 All parties to a complaint and discipline process are kept up to date on the progress of their case, and complainants are supported to participate effectively in the process.**		
		a. Provide details about how the College ensures that all parties are regularly updated on the progress of their complaint or discipline case, including how complainants can contact the College for information (e.g., availability and accessibility to relevant information, translation services etc.).	The College fulfills this requirement:	Yes
			• Please insert a link to document(s) outlining how complainants can contact the College during the complaints process and indicate the page number(s) ***OR*** please provide a brief description. https://collegeofhomeopaths.com/complaints.html • Please insert a link to document(s) outlining how complainants are supported to participate in the complaints process and indicate the page number(s) ***OR*** please provide a brief description. The College communicates regularly, by email and telephone, with the parties throughout the complaints process and each stage of the matter. Complainants and respondents are provided with new relevant information that is received by the college during the complaints investigation process and invited to make submissions. If the complaint is not disposed of within 150 days, the College notifies the parties that the investigation is still ongoing. If a complaint has not been disposed of within 150 days, both parties receive a letter advising of the status of the investigation and expected completion time (if known). The parties receive subsequent letters at 210 days, and then every 30 days thereafter until the matter is disposed of. Once the ICRC has met and made a decision, the College advises the parties that a decision has been made, and that the decision will be issued during a particular time frame. College staff also respond to all inquiries from parties about the status of matters. In these communications, staff describe the next steps regarding the matter. The procedure manual directs that complainants be notified by the college if allegations of professional misconduct arising out of their complaint are referred to the Discipline Committee. Complainants subsequently receive updates from the prosecutor representing the college in the discipline matter, either directly or through their legal counsel or representative. In the case of discipline matters, information about hearing dates and the specific allegations that have been referred to Discipline Committee are posted on the College's website, and the prosecuting lawyer will advise the parties of hearing dates.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.

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			Additional comments for clarification (optional)
DOMAIN 6: SUITABILITY TO PRACTICE	STANDARD 12	**Measure:** **12.1 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: **Partially** • Please insert a link to guidance document and indicate the page number ***OR*** please briefly describe the framework and how it is being applied. • Please provide the year when it was implemented ***OR*** evaluated/updated (if applicable). While the risk assessment/triage protocol for assessing complaints and reports at intake is not formally documented, every complaint and report is reviewed within two business days to assess risk, determine whether any urgent action is required (e.g., appointment of an investigator) and otherwise prioritize the matter for investigation. Legal counsel is consulted early in the process.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes
			Additional comments for clarification (optional) CHO has reviewed the approach taken by a number of other RHPA colleges, and will be formalizing a more systematic approach to complaint intake in 2025.

DOMAIN 6: SUITABILITY TO PRACTICE	STANDARD 13	**Measure:** **13.1 The College demonstrates that it shares concerns about a registrant with other relevant regulators and external system partners (e.g. law enforcement, government, etc.).**		
		a. The College's policy outlining consistent criteria for disclosure and examples of the general circumstances and type of information that has been shared between the College and other relevant system partners, within the legal framework, about concerns with individuals and any results.	The College fulfills this requirement:	Partially
			• Please insert a link to the policy and indicate page number ***OR*** please briefly describe the policy. • Please provide an overview of whom the College has shared information with over the past year and the purpose of sharing that information (i.e., general sectors of system partner, such as 'hospital', or 'long-term care home'). Information is sought and/or shared with other colleges or other relevant system partners on a case-by-case basis. Legal counsel is consulted prior to disclosing any confidential information with another college or system partner.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			Additional comments for clarification (if needed) The College is looking to the HPRO ICR working group for policy development assistance for the coming year.	

DOMAIN 7: MEASUREMENT, REPORTING & IMPROVEMENT

STANDARD 14

Measure:

14.1 Council uses Key Performance Indicators (KPIs) in tracking and reviewing the College's performance and regularly reviews internal and external risks that could impact the College's performance.

Required Evidence	College Response	
a. Outline the College's KPIs, including a clear rationale for why each is important.	The College fulfills this requirement:	Met in 2023, continues to meet in 2024
	• Please insert a link to a document that list College's KPIs with an explanation for why these KPIs have been selected (including what the results the respective KPIs tells, and how it relates to the College meeting its strategic objectives and is therefore relevant to track), a link to Council meeting materials where this information is included and indicate page number ***OR*** list KPIs and rationale for selection. **Key Result Area 1: CHO Effectively Delivers its Legislative & Legal Mandate** The College's activities are outlined in the Objects under section 3 of the Health Professions Procedural Code, embedded as Schedule 2 of the Regulated Health Professions Act. The Objects give structure to the College's role to safeguard public protection by ensuring 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. These programs come in the form of registration, quality assurance, patient relations, inquiries/complaints and reports, fitness-to-practice and disciplines. **Key Result Area 2: CHO to Practice Good Governance** It is important for the College's Council (which acts as a Board of Directors) to manage its Governance. The CHO creates efficiency in the work they do, and with current resources, they meet their statutory objects and regulatory mandate. With the oversight provided, the legal and ethical standing that they maintain, they uphold the reputation on behalf of the College. On behalf of the College, the Public and Registrants, the CHO Council practices good governance allowing it to flag potential issues and respond efficiently and appropriately. They make decisions with integrity and transparency through the setting and achieving of goals, training Council and statutory committee members, with monitoring of programs and activities under its legislative and legal mandate. The CHO imparts transparent communication about its performance and the College strives to effectively manage its activities, keep its stakeholders informed and fulfil its mandate. **Key Result Area 3: CHO to Achieve Growth (Growth = Profession, Supporting Institutions, CHO Membership Levels)** The College strives to achieve the growth of its membership along with keeping the organization and registrant base strong and viable. In addition to delivering its legislative and legal mandate, it practices good governance. The College endeavors to work with other Colleges and system partners, where appropriate, to help execute its mandate in an effective, efficient and/or coordinated manner to ensure it is responsive to changing public expectations. Embedded in these activities, is the added intent to improve patient access to quality care and advance the College's ability to protect the public.	
	If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.

			Additional comments for clarification (if needed)	
		b. The College regularly reports to Council on its performance and risk review against: i. stated strategic objectives (i.e., the objectives set out in a College's strategic plan); ii. regulatory outcomes (i.e., operational indicators/targets with reference to the goals we are expected to achieve under the RHPA); and iii. its risk management approach.	The College fulfills this requirement:	Met in 2023, continues to meet in 2024
			• Please insert a link to Council meeting materials where the College reported to Council on its progress against stated strategic objectives, regulatory outcomes and risks that may impact the College's ability to meet its objectives and the corresponding meeting minutes and indicate the page number. Council meeting materials including discussion of the College's progress against stated strategic objectives: Agenda and Meeting Materials, September 26, 2024 (consent agenda item 3.1.1) Agenda and Meeting Materials, June 19, 2024 (consent agenda item 3.1.1, page 21 of package) Agenda and Meeting Materials, February 28, 2024 (consent agenda item 3.1.2, page 48 of package) The College regularly reports to the President, Executive Committee and Council on the College's performance of the initiatives identified under each KRA in the College's strategic and operating goals and objectives. Risk and impact assessments are built into each item on the College's annual operating plan goals and objectives. This assessment ranking is reviewed annually. While the College has a risk management policy, more refinement of the reporting process is required to integrate the risk management approach and policy framework into the process.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.

		Additional comments for clarification (if needed)

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Measure: **14.2 Council directs action in response to College performance on its KPIs and risk reviews.**		
a. Council uses performance and risk review findings to identify where improvement activities are needed. *Benchmarked Evidence*	The College fulfills this requirement:	Partially
	• Please insert a link to Council meeting materials where the Council used performance and risk review findings to identify where the College needs to implement improvement activities and indicate the page number. Council meetings include discussion of the College's progress against stated strategic objectives and with improvement activities in mind. Evaluation of Council performance as well as the Registrar's annual assessment are integrated into the Council agenda each year.	
	If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation. The College is aware that several other RHPA colleges have developed this process. CHO will review the approaches taken and adopt a similar process. This will be researched, developed and integrated over the next reporting periods.	
Measure: **14.3 The College regularly reports publicly on its performance.**		
a. Performance results related to a College's strategic objectives and regulatory outcomes are made public on the College's website.	The College fulfills this requirement:	Met in 2023, continues to meet in 2024
	• Please insert a link to the College's dashboard or relevant section of the College's website. Council meeting materials, including discussion of the College's progress against stated strategic objectives, can be found here.	
	If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
	Additional comments for clarification (if needed)	

Part 2: Context Measures

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

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

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

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

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

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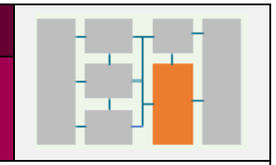
Table 1 – Context Measure 1

DOMAIN 6: SUITABILITY TO PRACTICE **STANDARD 10**	
Statistical data collected in accordance with the recommended method or the College's own method: Recommended *If a College method is used, please specify the rationale for its use:*	

Context Measure (CM)		
CM 1. Type and distribution of QA/QI activities and assessments used in CY 2024*		
Type of QA/QI activity or assessment:	#	
i. Completion of CEPD	380	*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 2024. 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 10.2(a) of Standard 10.*
ii. Currency of hours reported for 2023/2024 (period of April 1, 2023 to March 31, 2024)	380	
-		

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

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Table 2 – Context Measures 2 and 3

DOMAIN 6: SUITABILITY TO PRACTICE **STANDARD 10**			
Statistical data collected in accordance with the recommended method or the College own method: Recommended *If a College method is used, please specify the rationale for its use:*			
Context Measure (CM)			
	#	%	*What does this information tell us? If a registrant's knowledge, skills, and judgement to practice safely, effectively, and ethically have been assessed or reassessed and found to be unsatisfactory or a registrant is non-compliant with a College's QA Program, the College may refer them to the College's QA Committee.* *The information provided here shows how many registrants who underwent an activity or assessment as part of the QA program where the QA Committee deemed that their practice is unsatisfactory and as a result have been directed to participate in specified continuing education or remediation program as of the start of CY 2024, understanding that some cases may carry over.*
CM 2. Total number of registrants who participated in the QA Program CY 2024	0	0	
CM 3. Rate of registrants who were referred to the QA Committee as part of the QA Program where the QA Committee directed the registrant to undertake remediation in CY 2024.	0	0	
NR			
Additional comments for clarification (if needed) -			

Table 3 – Context Measure 4

DOMAIN 6: SUITABILITY TO PRACTICE **STANDARD 10**			
Statistical data collected in accordance with the recommended method or the College's own method: Recommended *If a College method is used, please specify the rationale for its use:*			
Context Measure (CM)			
CM 4. Outcome of remedial activities as at the end of CY 2024:**	#	%	*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 judgement following remediation*	0	0	
II. Registrants still undertaking remediation (i.e., remediation in progress)	0	0	
NR ** This number may include registrants who were directed to undertake remediation in the previous year and completed reassessment in CY 2024.* ***This measure may include any outcomes from the previous year that were carried over into CY 2024.*			
Additional comments for clarification (if needed) -			

Table 4 – Context Measure 5

DOMAIN 6: SUITABILITY TO PRACTICE	
STANDARD 12	

Statistical data is collected in accordance with the recommended method or the College's own method: Recommended
If a College method is used, please specify the rationale for its use: See below.

Context Measure (CM)					
CM 5. Distribution of formal complaints and Registrar's Investigations by theme in CY 2024	Formal Complaints received		Registrar Investigations initiated		
Themes:	#	%	#	%	
I. Advertising					
II. Billing and Fees					
III. Communication					
IV. Competence / Patient Care					
V. Intent to Mislead including Fraud					
VI. Professional Conduct & Behaviour					
VII. Record keeping					
VIII. Sexual Abuse					
IX. Harassment / Boundary Violations					
X. Unauthorized Practice					
XI. Qther <*please specify*>					
Total number of formal complaints and Registrar's Investigations**	0	**100%**		**100%**	

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

Formal Complaints *NR* Registrar's Investigation ***The requested statistical information (number and distribution by theme) recognizes that formal complaints and Registrar's Investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or Registrar's Investigations.*	
Additional comments for clarification (if needed) *No formal, written complaints were submitted in 2024; however, using a right-touch approach, the Registrar resolved 7 concerns that arose over the course of the year. In each of these cases, consultation with the complainants and registrants resulted in resolutions that did not involve the submission of a formal, written complaint and therefore did not require engagement of the ICRC. All 7 cases fit into the categories of Competence/Patient Care and Communication but are not included in this table as they were not formal complaints.*	

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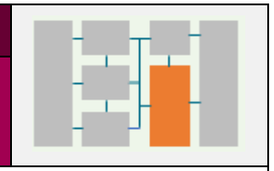
Table 5 – Context Measures 6, 7, 8 and 9

DOMAIN 6: SUITABILITY TO PRACTICE **STANDARD 12**			
Statistical data collected in accordance with the recommended method or the College's own method: College Method *If a College method is used, please specify the rationale for its use: See below.*			
Context Measure (CM)			
CM 6. Total number of formal complaints that were brought forward to the ICRC in CY 2024	3		*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 Inquiries, Complaints and Reports Committee.*
CM 7. Total number of ICRC matters brought forward as a result of a Registrar's Investigation in CY 2024	0		
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 2024	0		
CM 9. Of the formal complaints and Registrar's Investigations received in CY 2024**:	#	%	
I. Formal complaints that proceeded to Alternative Dispute Resolution (ADR)	0	0	
II. Formal complaints that were resolved through ADR	0	0	
III. Formal complaints that were disposed of by ICRC	2	67	
IV. Formal complaints that proceeded to ICRC and are still pending	0	0	
V. Formal complaints withdrawn by Registrar at the request of a complainant	0	0	
VI. Formal complaints that are disposed of by the ICRC as frivolous and vexatious	0	0	

VII. Formal complaints and Registrar's Investigations that are disposed of by the ICRC as a referral to the Discipline Committee	1	33	*(referral in late 2023 – dealt with by Discipline Committee in 2024)*

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

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

Additional comments for clarification (if needed)

The Committee disposed of three complaints in 2024, however no new complaints were referred to the ICRC in 2024. Of these, the Committee referred one long-standing case to Discipline in December of 2023, which was resolved in 2024.

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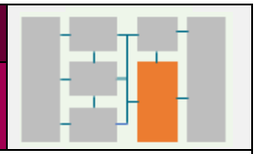
Table 6 – Context Measure 10

DOMAIN 6: SUITABILITY TO PRACTICE **STANDARD 12**	
Statistical data collected in accordance with the recommended method or the College's own method: College Method *If a College method is used, please specify the rationale for its use:* *Both cases shown here reflect complaints submitted in 2023 and disposed of by the ICRC in 2024.*	

Context Measure (CM)							
CM 10. Total number of ICRC decisions in 2024							
Distribution of ICRC decisions by theme in 2024*	# of ICRC Decisions++						
Nature of Decision	Take no action	Proves advice or recommendations	Issues a caution (oral or written) (all same case)	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							
II. Billing and Fees							
III. Communication	1		1				
IV. Competence / Patient Care			1				
V. Intent to Mislead Including Fraud							
VI. Professional Conduct & Behaviour			1				
VII. Record Keeping							
VIII. Sexual Abuse							
IX. Harassment / Boundary Violations							

X. Unauthorized Practice							
XI. Other <*please specify*>							

- *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 2024.*

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

NR

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

Additional comments for clarification (if needed)

No formal, written complaints were submitted in 2024; however, using a right-touch approach, the Registrar resolved 7 concerns that arose over the course of the year. In each of these cases, consultation with the complainants and registrants resulted in resolutions that did not involve the submission of a formal, written complaint and therefore did not require engagement of the ICRC. All 7 cases fit into the category of Competence/Patient Care but are not included in this table as they were not formal complaints.

The ICRC disposed of two complaints in 2024. One case involved taking no action and another resulted in an oral caution. Both of these cases arose from complaints made in 2023. Additionally, the Committee referred one long-standing case to Discipline in December of 2023, which was resolved in 2024. This case involved a criminal conviction for sexual abuse as well as misuse of title.

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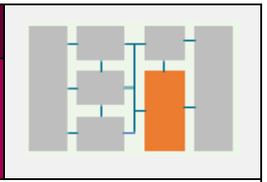
Table 7 – Context Measure 11

DOMAIN 6: SUITABILITY TO PRACTICE	
STANDARD 12	

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

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

The data collected in these documents relate to complaints that were received by the College and addressed through right-touch regulation which included registrar's dialogue with the complainant and the registrant. Using educational monitoring, the registrant was asked to rectify the issues of concern and demonstrate compliance. These steps were taken prior to determining referral to ICRC. All of the 7 cases were resolved without referral. Because they were not formal, written complaints, they have not been included here.

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 2024		
II. A Registrar's investigation in working days in CY 2024		
Disposal		

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Additional comments for clarification (if needed) *In all cases, a response was sent, and action initiated within one to two business days. All complaints were fully resolved within five business days.*

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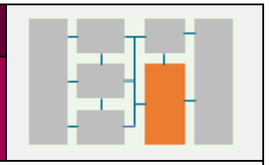
Table 8 – Context Measure 12

DOMAIN 6: SUITABILITY TO PRACTICE	
STANDARD 12	

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

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

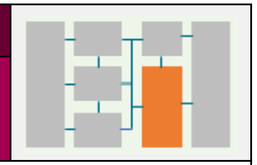
Context Measure (CM)		
CM 12. 90th Percentile disposal of:	Days	*What does this information tell us? This information illustrates the maximum length of time in which 9 out of 10 uncontested discipline hearings and 9 out of 10 contested discipline hearings are being disposed.* *The information enhances 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 2024		
II. A contested discipline hearing in working days in CY 2024		

Disposal
Uncontested Discipline Hearing
Contested Discipline Hearing

Additional comments for clarification (if needed)

One uncontested discipline hearing was completed in 2024. It was a long case involving criminal charges and a discipline process carried out by another regulatory college with which the registrant was also registered. Both the Court proceedings and the proceedings of the other college took place prior to the CHO's handling of the case. The CHO ICRC released its decision to refer to discipline in December 2023. An Agreed Statement of Facts was presented to the registrant in July 2024 but not signed until just prior to the scheduled hearing in November 2024. The hearing was held on November 5, 2024 at which time penalties were imposed.

Table 9 – Context Measure 13

DOMAIN 6: SUITABILITY TO PRACTICE	
STANDARD 12	

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

If College method is used, please specify the rationale for its use: *All of these findings relate to the same registrant.*

Context Measure (CM)			
CM 13. Distribution of Discipline finding by type*			
Type		#	
I.	Sexual abuse	1	*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.*
II.	Incompetence		
III.	Fail to maintain Standard		
IV.	Improper use of a controlled act		
V.	Conduct unbecoming	1	
VI.	Dishonourable, disgraceful, unprofessional	1	
VII.	Offence conviction	1	
VIII.	Contravene certificate restrictions		
IX.	Findings in another jurisdiction		
X.	Breach of orders and/or undertaking	1	
XI.	Falsifying records		
XII.	False or misleading document	1	
XIII.	Contravene relevant Acts	1	

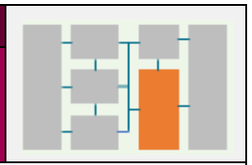
** The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the number of findings may not equal the total number of discipline cases.* *NR*
Additional comments for clarification (if needed)

-

Table 10 – Context Measure 14

DOMAIN 6: SUITABILITY TO PRACTICE

STANDARD 12



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

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

Context Measure (CM)		
CM 14. Distribution of Discipline orders by type*		
Type	#	
I. Revocation	1	*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.*
II. Suspension		
III. Terms, Conditions and Limitations on a Certificate of Registration		
IV. Reprimand		
V. Undertaking		

** 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 equal the total number of discipline cases.*

Revocation
Suspension
Terms, Conditions and Limitations
Reprimand
Undertaking
NR -

Additional comments for clarification (if needed)

Glossary

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

Return to:-Table 5

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

Return to: Table 8

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

Return to: Table 5, Table 7, Table 8

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

Return to: Table 4, Table 5

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

Return to: Table 5

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

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

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

Return to: Table 4, Table 5

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

Return to: Table 10

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

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

Return to: Table 10

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

Return to: Table 10

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

Return to: Table 10

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

Return to: Table 8

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

Return to: Table 10

College of HOMEOPATHS of Ontario

2024 Fair Registration Practices Report

Prepared for the Office of the Fairness Commissioner (OFC)

FAIRNESS COMMISSIONER
COMMISSAIRE À L'ÉQUITÉ

Content

1. Background
2. Organization information
3. Registration requirements
4. Third party assessments
5. Accomplishments, risks and mitigations
6. Changes to registration practices
7. Membership and application data

Glossary of terms

1. Background

Under section 22.7(1) of Schedule 2 of the Regulated Health Professions Act, 1991 (RHPA), which is substantially similar to section 20 of the Fair Access to Regulated Professions and Compulsory Trades Act, 2006 (FARPACTA).

> "A regulated profession shall prepare a fair registration practices report annually or at such other times as the Fairness Commissioner may specify or at such times as may be specified in the regulations".

Section 22.9 of Schedule 2 of the RHPA and Section 23 of FARPACTA then go on to indicate that the Fairness Commissioner shall specify the form in which these reports shall be prepared, along with the required filing dates. This section also stipulates that a regulator must make these reports public.

It is pursuant to these authorities that the Office of the Fairness Commissioner (OFC) has required that each regulator complete its annual Fair Registration Practices Report (FRP).

Please note that this report covers the time-period from January 1 to December 31, 2024.

The FRP:

- Collects information about the organization, applicants to the profession and current membership.
- Provides information to the public about how the organization has implemented fair registration practices during the reporting period.
- Helps the OFC to successfully undertake the education and compliance activities which include monitoring, applying a risk-informed compliance framework, assessing performance, and sharing best practices.
- Determines whether the regulator is complying with recently enacted legislative and regulatory provisions designed to reduce barriers for domestic labour mobility and internationally trained applicants.
- Identifies trends across regulated professions and regulated health colleges.

2. Organization information

Organization name	College of HOMEOPATHS of Ontario

For questions about this report, please contact:

Name	Heidi Ricks
Job Title	Registration Manager
E-mail	registration@collegeofhomeopaths.com

3. Registration requirements

Applicants to the regulated professions and compulsory trades must fulfil registration requirements to practice their profession or use a professional title. This section summarizes registration requirements for each profession or trade regulated by College of HOMEOPATHS of Ontario

Licensing requirements (brief description for each requirement listed):

Profession/ Trade Name	Homeopath
Academic requirement	The CHO Council has approved two Ontario post-secondary programs in homeopathy. Both programs received approval for their theory and clinical components: Canadian College of Homeopathic Medicine and Ontario College of Homeopathic Medicine. As part of the registration requirements, a graduate of an academic Program in Homeopathy needs to demonstrate that he/she has the knowledge, skill and judgment to safely and effectively practice homeopathy. The knowledge,

	skill and judgment required for entry to-practice into the homeopathy profession in Ontario is outlined in the Competency Profile for Entry-to-Practice Homeopaths Practising in Ontario (February, 2012) and O. Reg. 18/14 requirements for clinical practice experience. A Program in Homeopathy may be approved for the theory component, the clinical component or both. Approved programs include: • 750 hours of theoretical instruction • 225 hours of clinical experience in homeopathy consisting of a minimum of 45 weeks in length and 225 hours of direct client contact that is structured, comprehensive, supervised and evaluated, and • Demonstration that the entry-to-practice competencies have been taught and evaluated by qualified instructors and supervisors. An applicant who did not graduate from an approved program in homeopathy in Ontario shall submit documentation outlining his/her education and training for review through the Substantially Equivalent Competence Assessment (SECA) process to determine if the education and training received is substantially equivalent to that of a graduate from an approved program in homeopathy in Ontario.
Experience requirement	For eligible applicants completing a Full Class Application Form who graduated more than 12 months ago, in order to prove currency in the profession, the applicant must demonstrate 750 hours

	of homeopathy practice over a three year (36-month) period immediately before the date of the application. For recent graduates, the hour requirement maybe prorated in the first three years post-graduation. For all eligible applicants who are required to demonstrate 750 practice hours, a minimum of 500 of the 750 hours must consist of direct patient contact. Clinical experience hours are based on patient visits. For the purposes of meeting the registration requirements, each intake visit counts as two hours and each follow-up visit counts as one hour, regardless of the time the applicant actually spent in each patient visit. This is in order to ensure that all applicants are calculating hours the same way. Clinical practice hours may be paid or unpaid. All hours must be verifiable in order to be included on the application form. When demonstrating practice hours, a maximum of 250 of the 750 hours can consist of non-clinical experience. The Registration Regulation indicates specific categories of nonclinical experience that can be counted towards practice hours. They are: •Formal professional development •Academic research • Employment teaching hours • Employment related direct supervision • Employment related administration
Language requirement	In order to be registered, each applicant must declare reasonable fluency in French or English or provide proof of reasonable fluency in English

	or French achieved through a language assessment. This requirement is necessary to ensure that Registrants have the ability to communicate with their patients and other health -care professionals in Ontario. Applicants whose first language is English or French or who currently speak, read and write English or French as a primary language will be considered to have met this requirement and can declare this on their application form. Applicants who have obtained post-secondary education taught in English or French will be considered to have met this requirement and can declare this on their application form. An individual who has successfully completed a language test approved by the Government of Canada which is equivalent to a minimum level of 7 on the Canadian Language Benchmark (CLB) assessment scale and was completed within two years of making application to Canada will be considered to have met this requirement and can declare this on their application form. (For information on the equivalence scales visit Language test equivalency charts-Canada.ca) Those for whom the categories above do not apply must submit proof of reasonable fluency achieved through a language assessment that meets the Centre for Canadian Language Benchmarks test using the Occupational Language Assessment (OLA) for Homeopaths to a

	minimum level of 7 in each assessment area.
Additional information on licensing requirements (may include links to appropriate page on regulator website):	Applicants must also submit their supporting documentation package containing the following additional requirements: -Individual Assessment Congratulatory Letter from HRSG Jurisprudence Program Certificate of Completion -Criminal Background Check -CPR and Standard First Aid Certifications

4. Third party assessments

Third party organizations that assess qualifications on behalf of the regulator.

Organization name	Function
Dual Code	Jurisprudence exam
Human Resource Systems Group (HRSG)	Competency-based assessment

Fair access legislation requires regulators to take reasonable measures to ensure that any third parties undertake assessment of qualifications in a way that is transparent, objective, impartial and fair.

College of HOMEOPATHS of Ontario takes the following measure(s) to ensure fair and timely assessments:

CHO has worked with HRSG since 2013 and have been partners in developing the individual assessment (IA) process. Fair practices considerations have been built into the assessment process which was reviewed in 2014 by the OFC. -HRSG contacts CHO when each application form and payment is received and seek

approval to proceed (i.e. verifies applicant eligibility). -When HRSG completes and approves the assessment – it immediately notifies CHO. -The College and HRSG have a procedural policy outlining processes, timelines and expectations for fair and timely completion of assessment. This also applies to assessments requiring multiple reviews by assessors (i.e. confirmation of failure to demonstrate). -CHO has regular and fluid contact with the HRSG. -HRSG also has a contractual service agreement with CHO.

5. Accomplishments, risks and mitigations

Key accomplishments and risks pertaining to fair registration practices during the reporting period are summarized below.

A. Accomplishments

1	1. Fair practices utilized in review of applicants and individuals undergoing the Substantially Equivalent Competency Assessment (SECA) process. 2. Ongoing one on one workshops offered to all Applicants free of charge, for guidance on navigating the competency-driven Individual Assessment process. 3. Timely review and approval of Applications for Registration. 4. Ongoing equity and inclusion for all qualified Registrants.

B. Risks and Mitigations

Risk	Mitigation Measure
1.Small Staff Size 2. Fulfilment of all OFC requirements	1.Mitigated by efficiency of staff members, and the CHO has a relatively small and manageable number of new Applicants annually. 2. Completion is ongoing.

6. Changes to registration practices

During the January 1 to December 31, 2024 reporting period, College of HOMEOPATHS of Ontario has introduced the following changes impacting its

registration processes. Changes, anticipated impacts, and risk mitigation are summarized below.

A. Registration requirements and practices

Registration process	Changes Made (Yes / No)	Description
Registration requirements either through regulation, by-law or policy	No	
New or consolidated class of certificates or licenses	No	
Assessment of qualifications, including competency-based assessments and examinations	No	
Documentation requirements for registration	No	
Timelines for registration, decisions and/or responses	No	
Registration and/or assessment fees	No	
Changes to internal review or appeal process	No	
Access by applicants to their records	No	

Other	No	

B. Training, policy and applicant supports

Registration process	Changes Made (Yes / No)	Description
Training and resources for staff who deal with registration issues	No	
Resources or training to support applicants to move through the licensing process	No	
Anti-racism and inclusion-based policies and practices	No	

C. System partners

Registration process	Changes Made (Yes / No)	Description
Steps to increase accountability of third-party service provider(s)	No	
Accreditation of educational programs	No	
Mutual recognition agreements	No	

D. Responsiveness to changes in the regulatory environment

Registration process	Changes Made (Yes / No)	Description
Emergency registration plans	Yes	The College's Emergency class provisions (proclaimed into law on August 31, 2024) include the following non-exemptible requirements: - Allowance for the class to open i. at the request of the Minister, based on the Minister's opinion that emergency circumstances call for it; or b. if the Council has determined, after taking into account all of the relevant circumstances that impact the ability of applicants to meet the ordinary registration requirements, that there are emergency circumstances and it is in the public interest that the College issue emergency certificates of registration. (13.1(1)1) - The applicant must have satisfied the educational requirements of having completed a post-secondary program in homeopathy in Ontario or in another jurisdiction that is equivalent to such program. (13.1(1)2) Where the applicant has not successfully completed either stream or education/training within the three-year period immediately before the date on which the applicant submitted their completed application for an Emergency certificate of registration, it is an additional requirement that the applicant has (a) practised the profession for 750 hours in that three-year period or (b) successfully completed a refresher program approved by the Registration Committee. (13.1(3)) - The applicant must have successfully completed a CHO approved jurisprudence course. (13.1(1)3) - The applicant must have successfully completed a CHO approved

		jurisprudence course. (13.1(1)3) Moving from Emergency class to Full Certificate: A member who holds an Emergency certificate of registration, or a former member who held an Emergency certificate of registration within the previous six months, may be issued a Full certificate of registration despite not having completed the individual assessment requirement, if they apply for the Full certificate of registration and: (a) satisfy all other requirements for the Full certificate of registration; and (b) provide satisfactory evidence based on their practice of the profession, that they will practice competently and ethically with or without supervision. (13.2) Expiry of an Emergency certificate: Unless stated otherwise on the certificate, an Emergency certificate of registration expires on March 31 following the date it is issued unless otherwise renewed. The certificate may be repeatedly renewed until the class is closed for active registration. An Emergency certificate of registration expires six months after the date the Council or the Minister determines that emergency circumstances no longer exist even where the certificate would otherwise expire before or after that time. (13.3) Other Activities: CHO has set the fees for Emergency class application, registration and renewal. All administrative processes will be similar to Full class registration with an emphasis on expediating review and approval of applications for Emergency class.
Technological or digital improvements	No	

Steps to address labour shortages in the profession or trade	No	

7. Membership and application data

The Office of the Fairness Commissioner collects membership and application data from regulators through annual Fair Registration Practices Reports, which are also made available to the public. Information is collected for the purpose of discerning statistical changes and trends related to a regulator's membership, application volumes, licensure/certification results, and appeals year over year.

A. Race-based data collected

	Race-based data collected? **(Yes or No)**
Members	No
Applicants	No

Additional description:

B. Other identity-based or demographic data collected

	Other identity-based or demographic data collected? **(Yes or No)**
Members	No
Applicants	No

Additional description:

C. Languages of service provision

College of HOMEOPATHS of Ontario makes application materials and information available to applicants in the following languages.

Language	Yes / No
English	Yes
French	Yes
Other (please specify)	

D. Membership Profile

Profession Name	Total Number of Members
Homeopath	434

Class of License	Total Number of Members	Number of Internationally Educated Members
Full / General/ Independent Practice Inactive	403 31	159 10

Gender	Number of Members
Female Male	306 128

Jurisdiction of Initial Training	Number of Members
Ontario	251
Other provinces and territories	11
United States	7
Other International	159
Other/not collected	6

Country of Initial Training	Number of Members
India	107
Pakistan	29
United Kingdom	11
Bangladesh	2
South Africa	2
Greece	1
Australia	1
Germany	1
France	1
Iran	1
Sri Lanka	1
Romania	1
Russia	1
Canada	268

Official language of preference	Number of Members
English	434

Racial identity (optional)	Number of Members
Not collected	434

E. Data Notes

F. Applicant Profile

Profession Name	Total Number of Applicants
Homeopath	**23**

Gender	Number of Applicants
Male Female	7 16

Jurisdiction of Initial Training	Applications received in 2024	Applications with decisions pending (in progress at end of reporting year)
Ontario Other International	12 11	2 4

Country of Initial Training	Number of Applicants
Canada India Pakistan	12 10 1

Official language of preference	Number of Applicants
English	23

Racial identity (optional)	Number of Applicants
Not collected	23

G. Data Notes

H. Application Decisions

The table below summarizes the outcome of registration decisions finalized in 2024. Some applications may have been received in the previous year.

Jurisdiction of initial training	Successful	Unsuccessful	Withdrawn
Ontario	11	0	0
Other International	7	0	0

I. New Registrants

For the 2024 reporting year, the breakdown of new registrants by class of registration is provided below:

Class of registration	Total new registrants	Number of internationally educated registrants

Full / General/ Independent Practice	18	7

J. Data Notes

K. Reviews and Appeals

Applicants for registration may appeal a registration decision. An **internal review or appeal** involves formal reconsideration of a registration decision further to an application and submissions by the applicant.

Jurisdiction of initial training	Number of internal reviews and appeals processed	Number of decisions changed following internal review or appeal
Other/not collected	0	0

An **external review or appeal** involves review of a registration decision by an external appeal tribunal or court, such as the Health Professions Review and Appeal Board or Divisional Court.

Jurisdiction of initial training	Number of applicants who sought external review or appeal	Number of decisions changed following external review or appeal
Other/not collected	0	0

Issues raised in reviews and appeals can point to challenges in the registration process. The table below summarizes top issues or reasons that applicants raised during these appeal proceedings.

Issue or reason raised	Number of appeals
1. n/a	0

Internationally trained applicants face additional challenges in the registration process. The table below summarizes top reasons for not registering internationally trained individuals.

Reason for not registering	Number of internationally trained applicants

L. Data Notes

Applications which were not approved during the reporting period were not complete (had outstanding documentation or payment).

Glossary of terms

Applicant: An individual who has applied for membership in a regulated profession or compulsory trade, with the associated rights to practice their profession / trade or use a professional title.

Domestic labour mobility: Applications subject to the Canadian Free Trade Agreement, which stipulates that a certificate issued by one province or territory should be recognized by all others unless there is an exception due to public health, safety and security reasons.

Internationally educated / trained: An individual whose initial professional education was not from a Canadian educational institution, or who is applying for trade certification based on experience gained outside Canada. This category includes individuals with education / training in the US and other countries. It also includes individuals who completed their initial professional education outside Canada and later addressed gaps with courses or a bridging program based in Canada.

Jurisdiction of initial training: For professions, the jurisdiction in which an applicant obtained their initial professional education used in full or partial fulfilment of registration requirements. For trades, the jurisdiction of initial trade experience listed on a Trades Equivalency Assessment (TEA) application.

Member: An individual who has satisfied the conditions for registration in their profession / trade and has been granted the right to practice and/or the right to use a professional designation or title. Members may hold a full license to engage in independent practice, or they may hold an alternate class of registration.

Racial identity: Voluntary self-report data of racial identity as a social description. Follows categories identified in the Ontario Anti-Racism Directorate Data <https://www.ontario.ca/document/data-standards-identification-and-monitoring-systemic-racism> .

Registration requirements: the entry-to-practice requirements that that an applicant must meet to be granted full membership in a regulated profession or trade, with the associated right to practice or right to use a professional title.

- **Academic requirement**: The formal education, or equivalent, that is required for licensing or certification in a particular regulated profession or trade.
- **Experience requirement:** The experiential training or work experience that is required for licensing or certification in a particular regulated profession or trade.
- **Language requirement**: The level of language proficiency that is required for licensing or certification in a particular regulated profession or trade, and the language proficiency tests accepted in fulfillment of this requirement.

Third party service provider: An external organization that assesses applicant qualifications on behalf of the regulator.

STEINECKE MACIURA LEBLANC

GREY AREAS NEWSLETTER

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

sml-law.com/resources/grey-areas/

When Regulated Persons Are Suspected of Committing Crimes

Rebecca Durcan

March 2025 - No. 300

From a public policy perspective, there is little consensus on how regulators of professions and law enforcement agencies should coordinate their efforts when a registrant is suspected of committing a crime. Despite some media articles in the past (e.g., related to lawyers and physicians), few regulators even have a published policy on the topic. The policies that do exist tend to be brief and do not address the coordination of efforts.

The hesitancy to develop a comprehensive policy is understandable. There are several policy challenges including the following:

1. How serious should the apparent criminal conduct be before a regulator notifies law enforcement? Some conduct, while technically criminal in nature, is unlikely to result in charges.
2. How certain should the regulator be that the conduct is criminal in nature before reporting it to law enforcement? Regulators are not experts in criminal law.
3. Should a report be made by a regulator without the consent of the possible "victim" of the crime? In *To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act*, the Task Force warned against the reporting of sexual abuse cases to law enforcement without the consent of the patient who may have consciously chosen not to go to the police.
4. What are the unintended consequences of such reports? For example, will people be less willing to come forward to regulators with incompetence or misconduct concerns for fear of being conscripted into a criminal investigation?
5. When should the notification be made? Will law enforcement involvement result in reduced access to witnesses and documents for the regulator if the regulator's investigation is not substantially

completed by the time the notification is made?
6. If notification is made early, should regulators continue to investigate concerns in parallel with any law enforcement investigation or proceedings?
7. Would coordination between regulators and law enforcement create impediments to either process? For example, would any evidence gathered by regulators be rendered inadmissible in the related criminal proceedings because the safeguards contained in criminal law were not followed (e.g., relating to restrictions on using evidence obtained through an authorized regulatory search and seizure)? Or would there be any concern about an abuse of process by the regulator in any such coordination?
8. What impact does the confidentiality provisions applicable to the regulator have on its ability to disclose information to law enforcement authorities?
9. Should there be a corresponding obligation on law enforcement to report matters relating to registrants to regulators? If so, in what circumstances?

In England a comprehensive memorandum of understanding (MOU) on the topic was recently updated. The updated MOU follows the 2018 report of Professor Sir Norman Williams on *Gross negligence manslaughter in healthcare*. That report states:

> The review was set up to consider the wider patient safety impact resulting from concerns among healthcare professionals that simple errors could result in prosecution for gross negligence manslaughter, even if they occur in the context of broader organisation and system failings. In particular, there was concern that this fear had had a negative impact on healthcare professionals being open and transparent should they be involved in an untoward event, as well as on their reflective practice, both of which are vital to learning and improving patient care.

The MOU itself addresses the following topics:

Who is agreeing? The MOU is between UK's health and social care regulators, health organizations, such as the National Health Service, and law enforcement.

What triggers the duties under the MOU? The MOU applies "in the course of healthcare delivery where suspected criminal activity on the part of an individual is believed to have 'led to or significantly contributed to' the death or serious life-changing harm (whether of a physical or psychological nature) of a patient or service user." This is a lower threshold than the "reasonable grounds to believe" test. However, the "harm" requirement is intended to result in the use of the MOU only in more serious types of criminal conduct.

What is the goal of the MOU? The goal is described as aiming to:

- "facilitate efficient and effective co-ordination of appropriate approaches, patient safety learning responses and investigations, while taking steps to avoid prejudicing regulatory or criminal investigations or criminal proceedings
- ensure relevant information and 'confidential information' is quickly, lawfully and efficiently shared between the relevant signatories where necessary to progress learning responses, investigations and proceedings
- ensure evidence is quickly identified, secured and handled in accordance with best practice

- allow steps to be taken quickly to manage ongoing risk and as far as possible protect the public and service users"

What happens when the MOU is triggered? The party who believes the MOU has been triggered will convene a meeting of the parties' representatives, called the incident coordination group (ICG). Other agencies (e.g., coroner) can be invited in appropriate cases. In some circumstances it may be inappropriate for some parties to attend the meeting(s). For example, if the police are already involved in an investigation, it may not be suitable for them to share information with the group. Similarly, it may not be appropriate for the provider of the service to be involved if their own conduct is in issue.

At their meetings the ICG will canvass the following:

- sharing of information amongst the parties consistent with the applicable confidentiality provisions,
- coordinating parallel investigations and proceedings (including amongst regulators),
- ensuring that the suspected individual's rights are respected,
- securing, preserving and sharing (where appropriate) evidence,
- organizing the liaison with the patient and their family and representatives,
- harmonizing public messaging,
- facilitating future learning and patient-safety plans, and
- recording the discussions and action items.

What about the original concerns about organizational and system failings? The ICG is intended to be a vehicle for identifying and considering the contributions of the broader context to the conduct. The ICG's mandate includes facilitating and coordinating learnings that the individual parties can then develop in parallel to the criminal investigation. Also, the MOU specifies that any expert witnesses to be used in criminal proceedings act under the authority of law enforcement and are to be instructed to be impartial and neutral. Such experts are to be told to consider any systemic contributions to the conduct.

While the MOU is largely an aspirational and process-orientated document, it should facilitate a thoughtful approach to suspected criminal conduct coming to the attention of regulators.

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GREY AREAS NEWSLETTER

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

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Wrestling with Witness Weaknesses

Natasha Danson

April 2025 - No. 301

Hearing panels often make credibility assessments. Many times, the finding is based on the most reliable evidence even though no witness was "lying". Events might not have been observed closely. Memories might have faded. Motivation might have tainted the witness' recollection. However, sometimes one of the witnesses is simply not being candid.

In the English case of *Hindle v The Nursing And Midwifery Council* [2025] EWHC 373 (Admin), the Court gave guidance on managing this type of challenging credibility conundrum. Four nursing colleagues working at a boarding school jointly submitted a "collective grievance" containing a "blizzard of allegations" against their manager to both their employer and the managing nurse's regulator. The allegations included verbal and physical abuse of students, breaching confidentiality, dishonesty with management, and record keeping failures. Upon being notified of the complaint, the managing nurse took sick leave and eventually left her employment by "mutual agreement".

The regulator brought 32 allegations of misconduct against the managing nurse. Except for acknowledging some minor administrative deficiencies, the managing nurse's defence was that the complaining nurses "had created a catalogue of fabricated and exaggerated allegations against her, to rid themselves of a manager with whose decisions they disagreed and whose job they thought should have gone to one of them." Once the managing nurse was gone from the position, the complaining nurses were less eager to assist in either of the employer's or regulator's investigations or at the discipline hearing. In fact, one of them had to be summonsed to testify.

The hearing panel found that about half of the allegations were proven and that the managing nurse's fitness to practise was impaired (i.e., worthy of protective sanctions). Her registration was suspended for six months and an interim suspension pending appeal was also imposed. By the time the Court rendered its decision, the managing nurse had been suspended for 13 months.

The Court reversed the finding on the basis that the credibility findings were not justified. In particular, the Court noted the following issues with the hearing panel decision:

1. **Need for reasons.** Where, as here, the evidence is so strikingly inconsistent, it was insufficient for the hearing panel to summarize the conflicting evidence and prefer one version over the other. An explanation was required as to why one version was accepted and the other was not.

2. **Assessment of Overall Credibility.** The assessments of credibility were separated for each finding. The Court said:

   > The Panel's approach of considering each charge individually in a silo, and its failure to assess the overall credibility and reliability of each of the Complainant Nurses, led the Panel to ignore an important relevant consideration when assessing whether the burden of proof had been met in respect of each charge. The fact that those witnesses appeared to have given incorrect accounts in relation to certain of the charges that the Panel had found 'not proved' was simply ignored when the Panel was considering whether it could rely on those witnesses' evidence as satisfying the NMC's [regulator's] burden of proof in respect of other allegations. In the circumstances of this case, it was not rationally open to the Panel to simply ignore that matter by taking the rigidly siloed approach that it did.

A troubling (but far from only) example was that contemporaneous video evidence demonstrated that a specific allegation of physically mishandling a student was incorrect. While acknowledging that witnesses can be unreliable on some issues and reliable on others, the Court said:

> Yet there is nothing within the Reasons to suggest that the Panel then asked itself whether, and how, the apparent unreliability of the Complainant Nurses' version of this incident should influence the view taken of the reliability of the Key Witnesses' factual evidence generally, including in relation to the charges for which no contemporaneous objective evidence was available. In my judgment, this was a significant gap in the Panel's reasoning in relation to those charges.

While it is not obligatory in every case to analyze the overall credibility of key witnesses, in this case the Court concluded it was necessary.

3. **Collusion.** The hearing panel failed to adequately address the concern that the complaining nurses had not only made a "collective grievance", but they had also collaborated in the formulation of their specific concerns. Despite denying it, there were substantial indications that collusion had occurred. The hearing panel wrongly characterized this concern as whether there was "a conspiracy to deceive" without considering the other possible impact of the collusion on the credibility of the complaining nurses' testimony.

4. **Addressing Inconsistencies.** The hearing panel did not adequately address the inconsistencies in the complaining nurses' evidence. For example, in at least one instance, a complaining nurse stated that she was present for an incident when other compelling evidence indicated she was not. Similarly, one of the complaining nurses was inconsistent

as to whether she had burned or shredded contemporaneous notes (either of which would be disturbing). Also, a complaining nurse denied applying for the managing nurse's job after it became available, while other documented evidence indicated that she had.

5. **Evasiveness.** When cross-examined on several points, some of the complaining nurses were evasive. In fact, at least one of the complaining nurses refused to answer questions on cross-examination (and the hearing panel did not compel her to answer). In another instance, a complaining nurse indicated that the managing nurse had posted a "bullying", "aggressive" or "intimidating" note; but when confronted with the actual note which could not reasonably be characterized in that way, she continued to insist that it was.

6. **Inferences.** The Court was also concerned about some of the inferences made by the hearing panel. For example, the fact that the managing nurse was frustrated by a particular student did not corroborate a finding that she had shouted at them.

The Court accepted a characterization that the complaining nurses engaged in a "witch-hunt". The Court said: "Their collective grievance, though copied to the NMC [regulator], was not truly motivated by a concern to protect the public interest."

Some other issues addressed by the Court include the following:

a) **Proving Standards of Practice.** For borderline issues, such as how to document certain events, the regulator should have provided objective evidence of the professional expectation through a written policy or a formal opinion of an accepted standard of practice that applied.

b) **Delay and Over-Charging.** The Court was critical of the regulator proceeding with 32 allegations, not all of which were serious, for almost six years. The Court noted that the managing nurse had worked without concern for 4.5 years after the complaint was made and lost that position because the regulator's proceedings were taking so long.

c) **Interim Suspension Pending Appeal.** While the interim suspension order was not before the Court, it noted:

> Against this background, it is very difficult to understand why the Panel considered an interim suspension order to be "*necessary for the protection of the public*" and "*otherwise in the public interest*", as the relevant section of its Reasons asserted it to be. The Panel's reasoning (such as it was) evinces no consideration of the severity of the potential impact on the Appellant of an 18-month interim suspension order, its intrinsic potential to disincentivise her from appealing, or the risk of unfairness if her appeal ultimately succeeded but she had, in the meantime, been suspended from practising for a prolonged period. Those considerations ought, in my view, to be expressly thought about, and carefully weighed, by a Panel when it is considering whether to impose an interim suspension order. The Panel should also be clear as to the nature of the harm it fears could occur, absent the contemplated interim suspension order. Absent such careful weighing of the competing interests at play, it is hard

> to see how a Panel could properly decide that the imposition of an interim order was necessary and proportionate.

Panels making credibility findings, particularly where the competing version of events are so dramatically different, should consider and address the weaknesses in the witnesses' evidence.

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Book Review: "The Licensing Racket" – Part 1

Erica Richler

May 2025 - No. 302

Rebecca Haw Allensworth of Vanderbilt Law School has published a thought-provoking book on professional regulation (licensing) in the United States: *The Licensing Racket: How We Decide Who is Allowed to Work & Why it Goes Wrong* (Cambridge: Harvard University Press, 2025). While the approach in the US is different in several respects from that in Canada, there are lessons in her book for regulators in this country.

Allensworth argues that the licensing system in the US is broken and needs fixing. Relying on a systematic review of licensing bodies in the US, and illustrating her findings through real world examples, she presents two major themes in the book. First, licensing creates barriers, often unnecessary, to entering the profession and these barriers result in a monopoly. Second, licensing creates systemic challenges for regulatory boards to adequately protect the public.

Barriers to Entry

Allensworth begins by describing the broad scope of licensing in the US, estimating that about 20 percent of workers cannot practice their occupation without a licence. She also provides an analysis of the theory of professional regulation (e.g., to address information asymmetry) and its economic impact (e.g., licensing reduces the number of providers, resulting in scarcity of services, and creates a premium for the cost of services) resulting in marginalized communities having difficulty in accessing the services.

She describes licensing boards as private professional associations "dressed up in governmental clothing." The majority of board members are from the profession, often recently retired from serving in the professional association. They are funded by licensing fees which are often kept too low to properly fund their activities. Being practising members of the profession means that they generally do not have regulatory expertise (that a state bureaucrat would usually possess). Government oversight of the regulator, while possible, is often perfunctory. She observed repeated instances when board members let down their guard and viewed licensees as their "constituents" or "stakeholders."

In attending board meetings and reviewing board decisions, Allensworth observed a pattern of boards applying strict entry standards but not going nearly far enough in disciplining dangerous practitioners. “It may be hard to get into the club of the professionally licensed, but once you’re in, you’re in.”

Entry standards achieve three rewards for members of licensed occupations: reduced competition (but increased compensation); increased prestige (sometimes called credibility, legitimacy, or identity); and control and autonomy over their work. Once regulation is achieved, entry requirements (e.g., amount of education, hours of experience, and fees) only “rachet” one way, which is up.

Barriers to entry take various forms:

> One overlooked barrier raised by licensing is the bureaucratic thicket that must be traversed to get a license. An applicant has to learn all the rules and deadlines in her state, obtain official documents from testing companies, educational institutions, and sometimes courts, all in the proper notarized format and by the sometimes draconian deadlines.

Other barriers include inappropriately strict educational, language proficiency, and criminal record requirements.

These barriers have contradictory implications. They generally provide an advantage to privileged demographics (e.g., white males) but also provide an opportunity for less privileged demographics (e.g., racialized women) to achieve economic advances if they can obtain a licence.

The focus on barriers to entry (vs. protection of the public) was reinforced by statistical analysis. For the professions reviewed (health professions were excluded for this aspect of the analysis) complaints about service quality or safety were much more likely to come from the public than from other licensees. In contrast, complaints about unlicensed practice were much more likely from licensees than from the public. Also, the likelihood of enforcement action against those practising without a licence was significantly higher than that against licensees for quality or safety concerns.

The discussion regarding turf wars (“dressed up in health and safety concerns”) will ring familiar to Canadian regulators. “Unsurprisingly, most turf wars are less about safety and more about exclusivity.” Allensworth describes the tactics used by various professions to expand turf (e.g., teach it in school) or resist encroachments upon turf (e.g., enforce title protection, issue cease and desist letters). Innovation is discouraged by turf battles.

Some of Allensworth’s extended illustrations are particularly informative. For example, in a chapter about the COVID pandemic, she describes how the turf war between physicians and nurses revealed barriers that led to real world consequences. The death rate in jurisdictions that had fewer restrictions on nurses, especially nurse practitioners, was materially lower than jurisdictions with more rigid rules.

As noted, Allensworth makes the important point that boards composed largely of part-time practitioners may be familiar with the profession but often have little regulatory expertise. However, for many Canadian regulators, this gap is at least partially filled by staff and organizations of regulators. Allensworth’s observation is that US boards often address this gap by relying on professional associations (e.g., to draft standards), taskforces dominated by professional groups, adopting private industry standards of practice, using testing organizations often affiliated with advocacy organizations, and deferring to professional educational institutions that benefit from high

educational and continuing education requirements.

Our sense is that Canadian regulators need to resist the complacency she describes as existing in US licensing boards. However, there are several differences between the US context, as outlined by Allensworth, and the Canadian experience which may, at least partially, address the concerns. For example:

- Canada appears to have fewer regulated professions and occupations per jurisdiction than many US states. Most Canadian jurisdictions have fewer than 50 such regulators, rather than hundreds.
- Most Canadian jurisdictions have made a concerted effort to separate professional regulators from associations. Membership in a professional association is generally voluntary, and they usually have fewer numbers than their regulatory counterparts.
- While licensure still exists for many professions in Canada, legislatures are increasingly using other regulatory mechanisms such as title protection, or a narrower list of restricted acts, which reduces the monopolistic effect of professional regulation.
- While there are exceptions, at least some third-party providers of regulatory-related services such as examinations and registration candidate assessments, are either affiliated with the regulator or independent of professional associations and advocacy organizations.
- Many Canadian regulators are beginning to adopt some form of competency-based selection for their boards or councils, and some have higher proportions of public appointees to boards and discipline committees than those in the US as described by Allensworth.
- Many regulators have independent oversight bodies such as appeal boards and fairness commissioners. Some even have superintendents. At a minimum, there is a government department to whom they report and need approval for most major policy regulations or by-laws. In addition, there are judicial appeals and reviews available, which seem to be relied upon regularly (although the latter is likely also accessible in the US).

In part 2 of this article, we will look at the second theme of Allensworth's book, ineffective public protection. We will also review some reforms that she proposes.

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