



May 15, 2008

Annie Schiefer, Project Manager
Health Professions Regulatory Advisory Council
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Dear Ms. Schiefer,

The College of Medical Laboratory Technologists of Ontario (CMLTO) is pleased to provide the following submission in response to the Health Professions Regulatory Advisory Council's (HPRAC's) *Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals*, February 2008 (the Discussion Guide).

Firstly, we would like to thank HPRAC for allowing us an extension of time within which to file this submission. We are cognizant of the very tight deadlines HPRAC is required to meet, but the extension did allow us to consult, however briefly, with our Council. We believe the importance of member input on the issue of interprofessional collaboration (IPC) cannot be overstated. In fact, the most consistent feedback we received was how very important this issue is for the future of our health care system. Members urge HPRAC to take a measured, grassroots approach to this issue. Today, IPC is happening throughout the province. It would be most unfortunate if a rush to change legislation or impose frameworks culminated in the unintended effect of impeding or reversing the important gains being made by innovative teams of health professionals.

Interprofessional collaboration and patient-centred care are not new concepts, however, there are many activities that could be undertaken to nurture these initiatives and highlight their benefits. The time has certainly come to identify ways to support what is currently happening and to ease the path of those who wish to practice in multi-disciplinary teams for the benefit of patients. We also need to celebrate the many IPC success stories to motivate others, and perhaps

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even provide incentives for IPC projects that can demonstrate evidence of improved patient outcomes. Interprofessional collaboration cannot be imposed from the top-down and the CMLTO believes that more innovation, not more regulation, is what is needed.

The CMLTO is the regulatory body for more than 7,700 medical laboratory technologists (MLTs) in Ontario. The CMLTO works together with the Laboratory Services Branch of the Ministry of Health and Long-Term Care and the Quality Management Program - Laboratory Services (QMP-LS) to develop and monitor best practice standards. The CMLTO exists to ensure that the public of Ontario has access to quality laboratory services and care.

MLTs play a crucial role in the health care of the public of Ontario. Not only is at least 70 percent of a person's medical file comprised of medical laboratory test results, but more than 70 percent of the medical decisions made and the treatment plans developed for patients are based on those test results. Every day MLTs collaborate with other health professionals as diagnostic consultants in areas including, but not limited to, infection control and point of care testing. MLTs have much to offer a multidisciplinary health care team.

As experts in diagnostic laboratory medicine, MLTs have a distinctive competency that needs to be used to maximum patient advantage. The CMLTO sees enormous opportunity in IPC and we are encouraged that this movement is the cornerstone of the vision for our health care system. To succeed, the CMLTO believes all health care professionals must recognize IPC represents a change in the very culture and values of our system and this change must be carefully managed and embraced by all.

Executive Summary

The CMLTO fully endorses and supports all aspects of IPC. Medical laboratory science is collaborative by its very nature. There are many professions that rely on diagnostic test results to create treatment plans and provide patient care, and MLTs are accustomed to collaborating and working in multidisciplinary teams to advance patient care.

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The CMLTO believes that IPC is occurring and steadily growing. We therefore do not believe that regulation is necessary to support advancement of IPC. Patients increasingly expect interprofessional collaboration among health providers and our members are responding to that expectation. We need to support those efforts and remove any barriers; we do not need to create more levels of regulation and bureaucracy. Ontario has the advantage of having a very flexible regulatory model, which enables IPC. By building better understanding among health professionals of each profession's strengths and competencies, we will build a stronger team that is better able to provide quality patient care.

For ease of reference, our specific submissions related to each area of the Discussion Guide are set out below.

Introduction and Background

In reviewing the steps that might be taken to encourage and support IPC in the health care system, we urge HPRAC to be mindful of the fact that the *Health Systems Improvement Act, 2006* made many significant changes to the *Regulated Health Professions Act, 1991* (RHPA), most of which have yet to even take effect. Specifically relevant to the issue of IPC is the inclusion of the following new objects for Colleges:

To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.

To promote inter-professional collaboration with other health profession colleges.

To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.

Despite the lack of any statutory authority for IPC to date, remarkable strides have already been made in this area. This would seem to indicate that there are no real statutory impediments to IPC in the current regulatory structure. On June 4, 2009,

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when these amendments take effect, IPC will be included in the objects of all health regulatory Colleges for the first time. At the same time, consumers of health care services are becoming better informed and are demanding to be involved in their care. These factors alone will increase the prevalence of IPC within the health care system without any regulatory intervention or statutory amendment. We would encourage HPRAC to recommend that time be taken to allow IPC to evolve naturally rather than through imposition. The best answers are always found by those most intimately involved with the questions. Individuals choose to become health care professionals to help patients and they continue to find innovative ways to do so in a resource challenged, rapidly changing environment. We would recommend focusing on removing barriers rather than imposing structures. To facilitate IPC, much work needs to be done to streamline and align the system from a technological and funding perspective. Funding for research and education (entry-to-practice and continuing) will have far more impact than oversight bodies and regulated conflict resolution.

In reviewing the literature and jurisdictional review, we take note that Canada is one of only three entirely publicly funded health care systems in the world and many of the exigencies of providing fully funded health care give the system certain eccentricities that do not exist in other systems. It is important to keep these realities in mind when making comparisons. We would also note that the RHPA continues to be viewed nationally and internationally as a very progressive and envied model of health regulation. The system of controlled acts, non-exclusive scopes of practice and delegation make it flexible and able to respond to changes in practice and technology. We believe that in many respects Ontario is, in fact, a leader in regulation and IPC.

Defining Interprofessional Collaboration

HPRAC has asked for comments on the statement it has used to focus the discussion and initiatives. While we agree there is much we can learn from one another in terms of our professions, distinctive competencies and special skills, we

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do not believe that Colleges or their members work competitively. However, sometimes by its very nature, the system is competitive in the way it is operated and funded. Fee for service and budgeting by workload units have institutionalized competition among professionals. Government programs that support or highlight only nurses or doctors leave other health professionals feeling undervalued and unrecognized. Despite these systemic realities, all health professionals and their regulatory Colleges continue to collaborate as they always have to improve the health outcomes for the public of Ontario.

Colleges have demonstrated a high level of collaboration through the formation of the Federation of Health Regulatory Colleges of Ontario (FHRCO), a voluntary, self-funding consortium that supports joint initiatives among Colleges including public relations, regulatory committee training, working groups and government relations. FHRCO has supported initiatives such as the delegation and authorizing mechanisms project, which is enabling IPC in health workplaces every day. We believe there is a continued role for FHRCO in the future development and growth of IPC. Whether it is through shared resources or jointly developed tools and templates, FHRCO benefits health professionals across the province, and ultimately patients, and would itself benefit from funding, recognition and support.

With regard to regulating in a manner that maximizes collective resources, we note that each College is entirely funded by member fees. College Councils take their financial stewardship role very seriously, are always seeking efficiencies, and, we believe, already operate extremely efficient organizations.

Eliminating the Barriers to Collaboration among the Colleges

We are not aware of any barriers in the RHPA, the health profession specific Acts, or the regulations that would restrict or impede IPC. The RHPA was drafted specifically to be flexible in order to respond to a changing health care environment, emerging technologies and patient population. What does slow the system is the inability to get regulations passed in a timely fashion. The lack of response from government to regulatory inconsistencies, requests for changes in

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scope of practice and requests to regulate other health care workers who are providing health care services within the laboratory environment further delays progress.

These issues discourage innovation and attempts on the part of professionals to make the highest and best use of their skills to advance patient outcomes. If the RHPA is to operate to its maximum flexibility, the remnants of the pre-existing regulatory framework need to be removed or realigned to reflect the values of the RHPA and all those who provide health care services need to be appropriately regulated.

One example of the dual regulatory structure created is Regulation 682 under the *Laboratory and Specimen Collection Centre Licensing Act*, which allows the Director of Laboratory and Specimen Collection Centre Licensing to permit someone to practice as a medical laboratory technologist in Ontario despite the fact that he or she does not belong to the CMLTO and has not met entry-to-practice requirements. In light of recent events in Newfoundland, New Brunswick and Ontario, it is crucial to remove these archaic loopholes to ensure that all laboratory practitioners in the province are appropriately regulated.

One system issue which remains a significant barrier to IPC is the lack of a comprehensive and accessible electronic health record for each patient. Enabling health professionals to access this kind of current information would benefit patients enormously and IPC would be realizable in real time. We note that the provincial privacy legislation was drafted to ensure that this access by health professionals would be permissible to facilitate patient care. Providers within a patient's 'circle of care' are permitted access to health information for the purpose of providing that care. Unfortunately, we seem no closer to a comprehensive electronic health record. This is one systemic barrier to IPC that our members frequently mention, particularly as it relates to the problem of duplicate testing.

A lack of consistent accountability across the health care system is another issue that requires attention. While health care professionals are for the most part

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regulated, their places of practice are not. Our members work in a variety of public and private employment settings, some highly regulated and others completely unregulated. There is no central place to refer issues that relate to the facilities or systems over which regulatory Colleges have no jurisdiction. With the existence of the RHPA, the public has come to expect a level of accountability for health care professionals. It is frustrating for them not to have that same level of accountability for the places of practice. There needs to be a baseline of accountability across the system for IPC to function.

Funding and reimbursement models will need to be restructured to facilitate and encourage IPC, and education and training programs will need to ensure that IPC competencies are covered in the curriculum. Current practitioners will also need to be educated on IPC, in preparation for working relationships with new graduates already familiar with the concept.

There are certainly professional cultural barriers that need to be recognized. Turf protection, professional control, mistrust and misunderstanding will need to be abandoned in favour of a shared, clearly patient-focused vision. While it is true there are currently some issues of culture that need to be addressed we believe this is only the case because IPC is still in development. As with all change however, the 'new and different' quickly becomes commonplace and acceptable. The same will be true of IPC as more IPC initiatives are funded, piloted and launched and the success stories emerge. Front line professionals are aware that IPC is the way of the future and are also keenly aware of the demographic realities that make it necessary as they live with the daily realities of staff shortages and retiring experts.

Liability Issues

Although there is no evidence to suggest that the lack of individual liability insurance is an actual barrier to IPC, our members recognize that mandatory liability insurance may level the playing field and enhance trust and accountability among the members of the health care team. Currently, individual liability is not

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mandatory for medical laboratory technologists and this is an issue for Council consideration. Whatever coverage is required of each member of the health care team should, of course, be determined by the actuarial risk of the care they are providing.

Developing Enablers for Collaboration among the Colleges

The CMLTO believes that the changes made to the RHPA by the *Health Systems Improvements Act, 2006*, which adds IPC to College objects will do much to promote and support IPC. The new College objects, however, will only come into effect in June 2009. Given that the jurisdictional review seems to indicate that Ontario is at the forefront with common process legislation (RHPA Code) for all Colleges and a model of controlled acts and non-exclusive scopes of practice, it makes sense to give Colleges time to operationalize these new objects prior to making any additional legislative amendments.

We believe that no further change to the RHPA is necessary. In addition to the new objects, there are many substantial changes to the RHPA, which will come into effect in June 2009, and we would recommend that Colleges and their members be given time to adapt to these changes before more are proposed. This is not to say that some legislative reform is not in order. As noted above, there are other pieces of health care legislation and funding processes that need to be reviewed, realigned and in some cases revoked in order to support IPC. However, the specifics are beyond the scope of this submission or the time provided to prepare it. There is much to be done outside the regulatory arena to smooth the way for IPC. We encourage HPRAC to recommend that the Minister review aspects of the overall system's preparedness for, and ability to support, IPC. Electronic health records and compensation models are two areas the Minister may wish to examine.

Structural Mechanisms

The CMLTO feels it is important to recognize that Ontario already has in the RHPA a set of common processes for complaints, discipline, quality assurance and

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patient relations by virtue of having these prescribed in the legislation. In addition when Colleges were first formed, many used regulation templates. FHRCO has working groups associated with each program area and a great deal of sharing and collaboration happens through these groups. The Colleges have shown leadership in this area and these efforts should be supported.

Colleges already conduct joint investigations into multidisciplinary complaints. Nothing more is needed in the regulatory structure to allow this to happen and we caution that more regulation may inadvertently stand in the way of the very initiatives that are responsible for advancing patient confidence in IPC today. From our perspective, we are concerned that a single intake point for all complaints would result in a bigger bureaucracy. It is questionable if the small number of complainants we receive each year would be better served by being one of several thousand complaints dealt with in a single-intake system.

There continues to be a pressing need for public education regarding regulated health professions, the role of regulatory Colleges and IPC. It was the intention of the Ministry of Health and Long-Term Care to undertake public education with the passage of the RHPA and this commitment needs to be reaffirmed.

We would encourage HPRAC to recommend that FHRCO be supported in its collaborative efforts and be the body to guide IPC at the regulatory level and decide on how conflicts and overlaps are best resolved. FHRCO is the ideal forum because the regulatory experts are at the table with public interest as their focus. We urge HPRAC and the Ministry to seek out and rely on this regulatory expertise and view FHRCO as a valued partner in public protection.

The CMLTO does not believe that IPC can be legislated and, therefore, would discourage any move in that direction. We would recommend instead that the government fund and support pilot projects and clear the barriers for these projects so that evidence-based results regarding the impact on patient care can be gathered. We need to seek out the IPC leaders within the profession and highlight their efforts and successes to demonstrate best practices to members,

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along with the many different ways they can contribute to IPC. Many of our members are already involved in IPC. MLTs are essential members of multidisciplinary teams serving as diagnostic consultants and Professional Practice Group members, dealing with infection control and point of care testing. In addition, MLTs in the northern regions of the province play key roles on multidisciplinary teams and through IPC are able to offer health care services across vast distances, sometimes under extreme conditions. Many of our members who are in collaborative practice may refer to this practice by a different name, or may not recognize it as IPC as it has become second nature to them.

In terms of tools and templates, we would encourage HPRAC to review FHRCO's delegation, medical directives and authorizing mechanisms projects as examples of what can be produced by a voluntary group of regulators working with public interest as their focus. These projects need to be supported, funded, piloted and celebrated. Tools and templates will develop with each initiative. They cannot be created in a vacuum as it is the 'grassroots', front line professionals who best know what is needed, what works well and where the tensions lie.

College Autonomy, Authority and Accountability

The CMLTO has not experienced any difficulties enforcing professional standards through our professional misconduct regulation. We would welcome the opportunity to review the concept of rule-making authority in more detail and consider its application to our processes prior to making further comment.

Interprofessional Care at the Clinical Level

Continued collaboration by Colleges through FHRCO and other partnerships will advance IPC at a clinical level by increasing common understanding, language, dialogue and solutions to the challenges faced by our members each day. The CMLTO believes that IPC will be facilitated through positive support, increased communication, mutual understanding and respect, and creative solutions. We would, therefore, strongly discourage imposing a "New Zealand-like" requirement for members to collaborate. Not only does it send a negative message that health

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professionals have to be legislated to collaborate with one another, it is also virtually unenforceable and, therefore, somewhat meaningless. Interprofessional collaboration would be better promoted through MOHLTC support of leadership skills development within the regulated health professions through curricula change and professional development programs for existing practitioners.

Conclusion

The CMLTO believes that IPC is making progress in Ontario today. We also believe that there is much that can be done to increase support for IPC in the health care system. We suggest there is a need for a system-readiness analysis to identify those areas within the health care system, such as funding and compensation models and electronic health records, where barriers to IPC do exist, and to work towards addressing these barriers in a timely fashion. We would also encourage the government to endorse and support FHRCO's collaborative efforts and work in partnership with FHRCO to ensure that the health care system can respond to the inevitable change that will accompany the growth of IPC. Further, the CMLTO would support collaboration between the MOHLTC and the Ministry of Training, Colleges and Universities in the evolution of health profession curricula that promotes and enhances IPC and professional leadership.

Thank you for the opportunity to provide our comments on the Discussion Guide and the very important issue of IPC. We look forward to working with our partners, stakeholders and government to improve Ontario's health care system. Please do not hesitate to contact either one of us directly with any questions regarding this submission or if you require additional information.

Yours sincerely,

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Pat Mercuri, MBA, MLT, ART
President

A handwritten signature in black ink, appearing to read 'Kathy Wilkie', is written over a light grey rectangular background.

Kathy Wilkie, BHA, MLT
Registrar & Executive Director