



College of
Medical Radiation
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Ordre des
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CMRTO Response to the HPRAC Consultation Discussion Guide on Interprofessional Collaboration

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To: Health Professions Regulatory Advisory Council

By: College of Medical Radiation Technologists of Ontario

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Introduction

The College of Medical Radiation Technologists of Ontario (the CMRTO) is pleased to provide this 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). The CMRTO is the regulatory body for over 6,200 medical radiation technologists (MRTs) who provide vital diagnostic and therapeutic care to patients across Ontario. MRTs work in diverse settings and across four distinct specialties with state of the art technology. Interprofessional collaboration (IPC) and patient-centred care are not new concepts to MRTs who are accustomed to working in multidisciplinary teams and are active participants in IPC. Medical radiation technology is by its very nature a collaborative practice as its use and application involves several health professions and the diagnostic and therapeutic services provided by MRTs are crucial to patient treatment and health.

The CMRTO supports IPC across the continuum of patient care. MRTs are already finding innovative ways to contribute more to the goal of improving patient outcomes today and will continue to support IPC and patient-centred care in the future. We are encouraged that the Minister of Health and Long-Term Care has identified IPC as an important part of the future success of the healthcare system as we believe there is much that can be done to facilitate, support and encourage IPC.

Although the timelines for providing this response were very short, the extension of time granted by HPRAC did allow a small working group, which included MRTs from all four specialties as well as public members of Council, to provide input into the submission and allowed the Council of the CMRTO an opportunity to review it prior to it being submitted. We appreciate that HPRAC is operating under its own strict deadlines and therefore wish to acknowledge that the extension did allow for some consultation, however brief, to take place with members and practice leaders.

Executive Summary

The CMRTO does not believe that changes to the *Regulated Health Professions Act* (RHPA) are needed to promote IPC but changes to the health care system definitely are. The CMRTO believes that IPC is alive and well in Ontario today. There are many examples of innovative IPC projects improving patient care across our system. We do not believe that IPC needs to be legislated or that any changes are required to the current health regulatory structure contained in the RHPA beyond those which were recently made by the *Health System Improvements Act* (HSIA). The RHPA was specifically written to allow for flexibility in scopes of practice across the professions and it continues to be seen as a progressive and enviable regulatory structure. Colleges should be given the opportunity to work with the new IPC objects and continue their collaborative efforts through the Federation of Health Regulatory Colleges of Ontario (FHRCO). In addition, we support the need to review scopes of practice and consider legislative amendments to the *Medical Radiation Technology Act* (MRTA) to address possible barriers to full utilization of MRTs as part of the health care team.

While we do not believe that changes to the RHPA are required, there are systemic issues that need to be addressed to facilitate and promote IPC. Most notably, the current hospital funding and physician compensation models and the lack of an accessible comprehensive health record for every patient in Ontario. These barriers stand in the way of innovation and breakthroughs in patient care and need to be removed or revised to allow IPC to flourish. IPC has evolved site by site based on identified needs and the CMRTO believes that it should be nurtured rather than imposed or legislated so this evolution can continue.

We have set out our specific responses to the questions in the Discussion Guide below by subject area for ease of reference.

Response to Discussion Guide

Defining Interprofessional Collaboration

HPRAC has asked for input regarding the statement it has used to focus the discussion. The CMRTO agrees that there needs to be mutual respect and understanding amongst health professionals for IPC to work to the patient's advantage. Professionals must understand and recognize one another's' distinct competence and accept the range of activities each is able to perform to ensure we are making the highest and best use of each professional's unique skills and abilities. There is a need for health professions to build on the concepts of patient-centred care and rely on the unique expertise of each member of the health care team. Where competition between professions does exist, we believe it is due in large part to factors imposed by the system such as competition for billings, staffing and budget allocations.

Colleges, we would argue, have demonstrated a high level of regulatory collaboration by forming and supporting the Federation of Health Regulatory Colleges of Ontario (FHRCO), a voluntary organization that promotes collaboration amongst health colleges on such diverse matters as committee training and orientation, public education and most recently the guide to medical directives and delegation project which is instrumental in promoting IPC in practice settings across the province every day. We would encourage HPRAC to recommend that the Minister recognize FHRCO for its unique regulatory expertise and public protection focus and work in partnership with FHRCO on matters related to IPC.

It is unclear what HPRAC is referring to when it speaks of 'collective resources' as each regulatory college is entirely funded by its own members. As the regulatory framework is self-funded, it should be left to find its own efficiencies as it has already done through the formation of FHRCO and by sharing information, resources and expertise.

IPC is not new to MRTs. There are examples across the province of MRTs working together with physicians, nurses, respiratory therapists, psychologists, social workers, occupational therapists, dieticians and physiotherapists to provide diagnostic and therapeutic care to patients. Whether it is by increasing access to vital diagnostic tests through advanced practice models or working together with physicians and nurses to provide patient-centred cancer care, MRTs have shown they are willing and able participants in IPC.

For example, in radiation therapy, MRTs collaborate with radiation oncologists and nurses to provide cancer care. In the early years, nurses were not always aware of what MRTs could do. So the team members worked together to delineate each profession's distinctive competencies and identify those competencies that were shared. It then became accepted practice that shared competencies would be performed by either profession with ongoing communication among team members to ensure the patient had optimal care.

Another example of the benefits of IPC is the great work being done by MRTs in the area of gastro-intestinal studies. The work being done by MRTs in this area, once the sole domain of radiologists, ensures that patients have access to vital diagnostic services that, due to the current shortage of radiologists, may not otherwise be available.

Some other examples include the Hospital for Sick Children's Image Guided Therapy Centre, where MRTs work together with radiologists and nurses to provide minimally invasive procedures using imaging guidance. In the north, MRTs and nurses collaborate to provide mobile breast screening to women in remote First Nations communities, offering ready access to crucial cancer screening. MRTs in nuclear medicine work with cardiologists and respiratory therapists in centres across the province to perform cardiac stress testing. Hospital trauma teams rely heavily on the skills of MRTs working within emergency departments and operating rooms to provide the images that are necessary to provide potentially life-saving medical treatment. These are just a few of the many examples of IPC initiatives MRTs are already involved in and supporting.

The CMRTO believes that Ontario has the ideal regulatory framework to support IPC. The RHPA with its controlled acts that may be delegated and non-exclusive scopes of practice provides the flexibility necessary to allow health professionals to safely practice to the full extent of their scope. A common regulatory framework, programs and processes ensure a consistency of regulation and accountability across the health professions.

Not that there is not significant work to be done to promote IPC. Scopes of practice have become outdated and no longer reflect the realities of current practice let alone the possibilities of future practice. We are encouraged that HPRAC will undertake a review of the scope of practice of MRTs along with a few other select professions as the second phase of this project. We would recommend that the Minister engage in a regular scope review process and ensure that necessary changes are facilitated in a timely fashion. If the system is to respond to change, the government must also respond and engage in the regulatory reform necessary to enable IPC.

Eliminating the Barriers to Collaboration among the Colleges

The CMRTO does not believe that there are barriers to IPC in the RHPA. However, scopes of practice have become outdated and need to be reviewed and revised. Government needs to acknowledge the rapid pace of change and the impact of technology on practice and engage regulatory bodies in partnerships to effectively revise scopes of practice to reflect the realities of daily practice as well as to encourage and support IPC. The CMRTO welcomes the opportunity to review the scope of practice of MRTs under the MRTA. The interrelationship between the scope of practice statement, authorized acts and harm clause means that a scope of practice that does not reflect the current competencies of MRTs may be a barrier to full utilization of MRTs as part of the health care team. Unless the government collaborates with regulators it will be impossible to effect the changes necessary for IPC to thrive. The RHPA was drafted to be

flexible and responsive to change but for this to be a reality, government needs to embrace that change and be engaged with regulatory bodies to enable that change.

The current structure of the health care system and some of its fundamental components, like the funding and compensation models and patient records, create barriers to IPC. While professionals are regulated, the regulatory framework in place for facilities or places of practice is less accessible to patients. This not only frustrates patients who have come to expect a level of accountability that the system does not provide but also regulatory colleges who have no place to which to refer facility related issues because these issues are beyond their jurisdiction. This is further compounded by the lack of integration of services across the system and the continuum of patient care. Increasingly, patients do not have primary care physicians which can complicate their transition from hospital to home. This patchwork does not lend itself easily to the kind of patient-centred care we are striving to achieve. Much can and should be done to align the system and rationalize services and care around patient need and access.

One ongoing systemic barrier to IPC is the lack of an accessible comprehensive electronic patient record. If health professionals had access to this kind of record, they could provide each patient with more informed and appropriate care, having access to a full picture of previous treatment and all available diagnostic information. Currently, a lack of a common accessible patient record and incompatibility of systems across facilities pose significant barriers to IPC, especially multi-site IPC. We would encourage HPRAC to recommend that this necessary foundation of patient-centred care be immediately put in place.

It is interesting to note that while privacy legislation in Ontario was specifically written to ensure that all health professionals within a patient's circle of care had access to that patient's personal health information, some current interpretations have in fact restricted the meaning given to a patient's 'circle of care'. As a result, MRTs sometime do not have access to vital patient information required to safely perform diagnostic and therapeutic procedures. It is important that privacy legislation not be too narrowly interpreted as to become a barrier to IPC. A patient's circle of care should include the entire continuum of patient care both within facilities and institutions and in the community.

Another systemic reality which can be a barrier to IPC is resource shortages. Shortages of people, money, time and technology plague our health care system. Patients are living longer and presenting with more serious complex diseases and this patient volume can no longer be addressed solely through greater efficiencies. Pressure to reduce 'table time' (the amount of time a patient spends on the CT, MRI or radiation therapy table for a procedure or treatment) and increase 'patient throughput' through wait time strategies have taken the focus away from the patient. The current OHIP Schedule of Benefits and physician compensation system drive inefficiencies into the system, do not recognize some procedures or therapies that are commonly offered to patients and fail to recognize the increasing complexity of those procedures. Billing codes and compensation models are in need of review to reflect current practice realities and remove any barriers to IPC. Our system and the professionals who work

within it are under a significant amount of stress as we struggle to do more with less. Health professionals need to be protected to ensure that they can continue to practise safely.

From time to time, programs and initiatives aimed at addressing one issue in the system have an unintended negative impact on other areas. For example, wait time strategies can result in resources being diverted from other areas. Such time-limited strategies require time and money for set-up and training and drain resources from other vital program areas. It is important that programs be rationalized so that we do not find ourselves solving one problem only to create another. This is also true in the area of new technologies. It is important to recognize that new technology requires time for training and optimization and may not always improve efficiencies.

While there are some professional cultural barriers to IPC in the traditional physician controlled model, there are also strong models of patient-centred care in some practice settings that have been successful in overcoming these barriers. Key to these breakthroughs is mutual respect, understanding and communication. Health professionals need to understand the regulatory framework they practise in and the extent and limits of each professional's scope of practice and where overlap exists. Professions need to develop care models that are inclusive of other professions and do not limit the potential for IPC. The unique competencies of each profession should be valued along with their contributions to overall patient care. As IPC grows and evolves and the benefits of this model of practice are highlighted, the culture will also evolve and change. MRTs are aware of the important role IPC plays in the future of healthcare and are also keenly aware of the demographic realities that make it necessary.

Liability Issues

The CMRTO is not aware of any evidence that suggests that liability issues are a barrier to IPC but there is a sense that individual liability insurance might enhance trust and credibility. This is in part because liability has become somewhat confused with accountability. At present, physicians often feel they bear all the liability which may contribute to the reluctance on the part of some physicians to delegate some aspects of patient care to other professions. MRTs who are members of multidisciplinary teams are unclear as to how responsibility and liability would be assessed if something were to go wrong. Clarity regarding issues of liability, coverage and accountability would help facilitate and support IPC. As professions expand their role in patient care, increased responsibility and liability inevitably follow as does the need for appropriate insurance coverage to address the risks of practice.

Developing Enablers for Collaboration among the Colleges

Subject to the changes that may be needed in respect of scopes of practice, the CMRTO does not believe that there is any change needed in the health regulatory statutory structure to enable IPC. The RHPA with its system of controlled acts and non-exclusive scopes of practice was created specifically to be flexible enough to respond to changing health care needs. The HSIA

added three new objects to the mandate of health colleges which specifically address IPC. These changes take effect on June 4, 2009 and colleges need to be given an opportunity to operationalize these objects before any further statutory revisions are contemplated. IPC cannot be legislated or imposed but should be permitted to emerge from the grass roots one practice setting at a time. The focus should be on removing existing systemic barriers to IPC rather than imposing additional regulatory frameworks or structures.

Public education regarding regulated health professionals, the existence and role of colleges and the emergence and importance of IPC is desperately needed. In addition to public education, IPC must be included in the curriculum for all health professionals in training as well as for existing members for whom IPC may be new. Members will need to have access to training to develop and enhance the competencies necessary to participate in and support IPC. IPC is another example of the need for life-long learning among health professionals. Health care is a rapidly changing environment and initial training will not necessarily match the expectations of practice over time. We would recommend that MOHLTC work with educational institutions under its jurisdiction and the Ministry of Training, Colleges and Universities to ensure the curriculum teaches and supports IPC.

Role clarity is a great enabler of IPC. If each member of the health care team is aware of each other's skills, training and ability, there is a greater opportunity to maximize the flexibility contemplated by the RHPA, to advance IPC and improve patient outcomes. Communication is also a crucial enabler for IPC because for professionals to collaborate they need to be able to communicate effectively. Perhaps the biggest enabler of IPC is patient-centred care which encourages all health professionals to seek ways to maximize their contribution to improve patient outcomes.

Structural Mechanisms

Complaints, Investigation and Discipline

The CMRTO feels it is important to recognize that the RHPA already has common committee structures, programs and processes for all health colleges. Further, the RHPA will undergo substantial revisions on June 4, 2009 as a result of the HSIA. Considering these are the first major revisions to the RHPA since proclamation, it makes sense to allow colleges time to implement these changes and work with them, particularly as they relate directly to IPC.

With regards to the suggestion of a single-intake complaint system for all health professionals, we do not understand how the few complainants the CMRTO deals with annually would be better served as one of thousands of complainants within a single-intake system. It is also not clear how such a system would be funded. The CMRTO also believes that the involvement of MRTs and their professional expertise in the investigation and handling of complaints is fundamental to the appropriate disposition of complaints. There is definitely a need for an improved information and referral system within the MOHLTC to direct members of the public to the appropriate college. It is frustrating for a member of the public to be referred to the

incorrect college by Ministry staff and a concern that the Ministry is not more familiar with the regulatory framework and where the public can get assistance.

Quality Assurance

As IPC initiatives emerge by practice setting and may take different forms, it is unlikely that IPC requires or would be promoted through joint quality assurance programs. Certainly quality assurance initiatives like that undertaken by the Independent Health Facilities program are multidisciplinary in nature and scope and have been operating effectively for some time. In fact the multi-source feedback system of the CMRTO's quality assurance program incorporates IPC by seeking the input of MRT peers and co-workers as part of the practice review. Clearly, where it is appropriate, joint quality assurance initiatives have emerged and there is no need for regulatory change to allow this to happen.

Standards of Practice and Professional Practice Guidelines

Although we believe there is merit in exploring common language and expectations particularly where there are overlapping scopes of practice, we do not feel this is best accomplished through another oversight body. The colleges have voluntarily formed FHRCO as a place to share best practices and advance common goals such as the guide to medical directives and delegation project. We would recommend that the Minister recognize FHRCO as a partner in public protection and work with FHRCO to address issues of common concern and interest. Similarly, the resolution of conflicts should be left to the colleges involved with the support of FHRCO as conflicts are generally best resolved by those directly involved and affected.

We do not feel that IPC would be promoted through the development of common standards. IPC emerges on a site by site basis in response to specific needs and individual circumstances. It is our experience that where professions within a practice setting have overlapping scopes of practice, policies are developed to articulate the common expectations of practice within that setting. These policies are then able to evolve in response to changes in practice and advances in technology. IPC will not look the same at each site nor will it necessarily involve the same professions or authorizing mechanisms. A profession's clinical application of the controlled acts that are authorized to it is distinct to its particular scope of practice. Therefore, imposing common standards might in fact be a barrier to the kind of site specific IPC initiatives that have developed to date.

The CMRTO does not believe that IPC can be mandated or legislated and would discourage this approach. We feel more would be accomplished through the funding and promotion of IPC pilots and initiatives that can provide the evidenced-based research to illustrate the benefits of IPC. Similarly we do not believe that additional reporting requirements will promote IPC. Colleges already report to the Minister annually on all programs and initiatives and reporting on the new IPC specific college objects can easily be incorporated into existing reports.

Tools and templates

Tools and templates are valuable resources and FHRCO has illustrated this by developing tools and templates as part of the guide to medical directives and delegations project that facilitate IPC every day. Other tools will emerge with each IPC project and FHRCO should continue to play a role in identifying best practices and sharing information. FHRCO has demonstrated a willingness and provides a forum where public protection is the focus and regulatory excellence the goal and it should be recognized and consulted as a regulatory leader and partner in public protection.

College Autonomy, Authority and Accountability

The CMRTO has not encountered any difficulty in enforcing standards through our professional misconduct regulation and therefore would need to examine the need for rule-making authority in greater detail prior to making further comment. There is definitely a need to make the regulatory system more responsive to change and this has not been possible through the regulation amendment process currently in place.

IPC at a Clinical Level

Including IPC objects in the mandate of all health colleges is an important step in recognizing the importance IPC will play in the future of health care. This will establish a culture of collaboration and allow colleges to model IPC behaviours for members. In addition it will allow colleges to engage members about their broader contributions to the healthcare system and explore the patient benefits of expanded roles.

Developing Regulatory Enablers for IPC at the Clinical Level

IPC does not require regulatory enablers because it is not a creature of statute but rather one born of cooperation, mutual respect and common goals. Legislating collaboration seems like an oxymoron and sends the false message that health professionals are not willing to work together. IPC is alive and well and needs to be nurtured rather than regulated or imposed. Additional regulation can sometimes have the unintended effect of restricting or impeding progress that is already being made. IPC is evolving logically at the point of care and efforts to artificially mandate or regulate it may stifle that growth.

Summary & Conclusion

IPC is currently an integral component of health care delivery in Ontario as patients demand it and resources require it. Imposing additional regulatory structure to this practice is not necessary, nor do we feel it is advisable. IPC needs to be nurtured and supported not regulated and monitored. The RHPA has already put in place a comprehensive and flexible model of health care regulation that ensures patient safety. There is nothing in that framework that presents a barrier to IPC but there are elements of the health care system that do. Work needs to be done to ensure our system supports IPC for the public and health professionals in Ontario.

Thank you for the opportunity to comment on the Discussion Guide. We are happy to provide additional information or respond to any questions that may assist HPRAC in this important work.