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COMMENTS AND FEEDBACK



INTERPROFESSIONAL CARE

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APPRECIATION

The Ontario Association of Medical Radiation Technologists (OAMRT) appreciates the opportunity to continue to provide input to Health Force Ontario regarding the ***“Interprofessional Care: A Blueprint for Action in Ontario”***.

For the Association, this is an extension of the opportunity we had regarding the original consultations of which we participated in, and of which we also were grateful to be a part of. This is an important Initiative with potential long-term impacts for the Province as a whole, patients and Diagnostic Imaging and Radiation Therapy, which are key and strategic services in the health-care system.

Craig Willson, M.R.T. (R.), RTR
Chair of the Board and President

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THE ASSOCIATION

THE ONTARIO ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS (OAMRT)

The OAMRT is a voluntary Association representing approximately 4,500 Members.

The OAMRT is the official voice for the Profession of Medical Radiation Technology in the Province of Ontario. As such, the Association is the advocate for Medical Radiation Technologists (MRTs) representing their needs and their views to the government and other stakeholders.

The OAMRT was founded in 1935 as an independent, non-profit organization. During this time, it has been responsible for a number of Initiatives that have shaped and helped to shape health care in Ontario. The Association has been a driving force concerning the evolution of Medical Radiation Technology and Radiation Therapy in Canada and will continue to be as a key partner and stakeholder in the Ontario health-care system.

The OAMRT believes in the principles of collaboration and partnership to ensure an effective, efficient and safe health-care environment.

The OAMRT is governed by a nine-Member Board of Directors, including a representative from the National Association sitting on the Board. It has representation from all areas of the province through its regional or "Section" system. In this way, communications flow from the grass roots up and from the decision-makers down, and laterally to the various volunteers and leaders of the Association.

The OAMRT is committed to building and maintaining an effective and sustainable health-care system in partnership with the government and other bodies and organizations.

Although the Association's mandate is to provide leadership, advocacy, and education on behalf of its Members and to represent their needs, the safety and interests of the public is of primary concern to the Association in meeting its Core Values, Vision, Beliefs and Goals.

MISSION STATEMENT

"The OAMRT is the collective and influential voice of the Profession of Medical Radiation Technology dedicated to the support and promotion of the interests and needs of its Members."

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CORE VALUES

- **Accountability** - we believe in being accountable to our Membership, our Profession and the public we serve.
- **Transparency** - we are committed to providing all our stakeholders, a window into the Association in order for them to see that we operate in an ethical and professional manner.
- **Integrity** - we are committed to inclusive, respectful and ethical business practices.
- **Trust** - we believe that trust comes with transparency and integrity and that this is essential for the Association's future.
- **Sensitivity to Members' Views** - we are committed to seeking out and evaluating Members' views, to move the Association forward, and providing them a community they can trust.
- **Collaboration** - we believe that the best results are achieved through collaboration and team work.
- **Wisdom through knowledge** - we are committed to seeking knowledge, in order to make sound decisions, keeping the Association nimble and build trust to create respect among Members, partners and Staff.
- **Evidence based** - we are committed to using the best available evidence and experience in making decisions.

BELIEFS

- That the welfare and dignity of the patient are paramount in the delivery of health care
- That we should strive to create and sustain an organizational environment that inspires trust, integrity, collaboration, a sense of community, personal responsibility, and well-being
- That a climate of life-long learning will ensure the growth of our Members and the Association
- That participating decision-making and consultation are essential in order to achieve an effective Association
- That a diversity of perspectives leads to a deeper understanding of issues and enriched knowledge for decision making
- That the empowerment of our Members and our Employees results in our success
- That supporting calculated risk-taking and innovation is a means to achieve organizational improvement.

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EXECUTIVE SUMMARY

The OAMRT supports the IPC concept and is a champion of the Initiative.

The OAMRT believes that the Medical Radiation Technology Profession, as a core and essential service, has not been addressed in a manner that the collaborative doctrine states, with the respect that the practice of Medical Radiation Technology deserves. If the health-care system is to be improved and become more cost effective but efficient, while providing safe and quality patient care, Medical Radiation Technology needs to be more prominent in the implementation process. There is no evidence in the Blueprint that it will be.

IPC will only work if the systemic macro issues are dealt with successfully. These include government policy changes, shaping social and cultural values, dealing with the professional and educational systems.

Funding will be a major factor in the success of this venture. No less importance will be having a realistic and timely implementation plan.

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INTRODUCTION

The Ontario Association of Medical Radiation Technologists (OAMRT) was involved in the consultations that led to the document *“Interprofessional Care: A Blueprint for Action in Ontario”* and were grateful for that experience.

This response relates to that experience, the “Blueprint” and our own experiences, which hopefully will be of use to the Implementation Committee, Health Force Ontario and the Ministers of both the Ministry of Health and Long-Term Care (MoHLTC) and the Ministry of Colleges and Universities.

COLLABORATIVE LEARNING

“Collaborative learning is often a special event and not an established instructional routine. The key to collaborative learning is the requirement for independent products from this group collaboration. This approach differs from many group learning situations in which one product is produced. In those situations, teachers are often concerned that one Student did all the work, while the others talked. When collaborative learning is done right, our experience suggests that it is during this phase that students consolidate their thinking and understanding.

Negotiating with peers, discussing ideas and information, or engaging in inquiry with others causes students to use what they learned during focussed lessons and guided instruction. Importantly, collaborative learning is not the time for students to introduce new information to students. Rather, collaborative learning should be a time for students to apply information in novel situations or to engage in a special review of previous knowledge.”

Douglas Fisher, Nancy Frey “Better Learning Through Structured Teaching”, 2008.

The IPC Blueprint is ambitious and challenging for everyone in the health-care system and implementation will need to be creative, practical, cost effective and efficient in meeting the goals of high quality health care.

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DISCUSSION

SHORTCOMINGS

In our view, a major shortcoming is that a key component of the health system, Diagnostic Imaging and Radiation Therapy Services appear to be virtually ignored. Diagnostic Imaging and Radiation Therapy are key and major services in the health-care system and the Medical Radiation Technology Profession, as a core and essential service, has not been addressed in a collaborative manner that the Profession deserves. Almost every patient has a Diagnostic Imaging (DI) examination, and many of those end up with Radiation Therapy-related treatments. Looking at the document, Diagnostic Services and Radiation Therapy form no part of interprofessional care (IPC), which we are sure will not be the case in reality, being the cost and necessity they are in the health-care system.

It was disappointing that the document appears to us to be focussing on physicians, nurses and educators. As an example, other than what was mentioned in terms of physicians, nurses and educators, there was no representation from the diagnostic-care sector on the Education Working Group.

We do not see evidence that Radiation Sciences educators or experts in the Radiation Sciences were involved in the deliberations, yet currently in the health-care system there are many examples of inappropriate DI examinations being ordered by individuals who have had little or no training and education to do so. This is a safety, quality and systemic issue and an issue related to reducing wait times.

The document focusses on undergraduate education. However, the main challenge will come from existing practitioners. There is little in the Blueprint on educating present practitioners and changing work practices and attitudes. If, in fact, the majority of the focus is on the undergraduate - it has little chance of success.

It appears from the Blueprint that educators will be defining the core competencies. Many are far removed from the “real world” and some educators being hired in our area have less than five (5) years clinical hands-on patient experience. The Implementation Committee needs to involve professional practice leaders, and others doing the day-to-day work to assist in designing the competencies. Perhaps we aren’t clear on what is intended by the term in this case. If so, please clarify this for us.

There appears to be no definitive time lines except that the Implementation Committee has a three (3) year term (starting and ending when?). There needs to be a “Plan” to implement and we do not see that in terms of setting out and managing this project. What other groups will be formed? What statistics will be collected; by whom; how will they be analysed; who will be responsible for what, when, etc?

Funding is an issue not addressed well, and it will be essential to the success of this project. There are issues related to those that are on fee-for-service and if this project impacts negatively on those

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individuals' earnings, the Initiative will fail. Funding is an issue for associations and regulatory bodies if IPC is to be seen through and successful. In the case of associations in particular, there are no funds to address IPC seriously and with purpose. Both associations and regulatory bodies will be key players to meet the IPC dream and brings IPC to fruition.

BLUEPRINT OBSERVATIONS - THE CONTEXT

The document has a great deal of good motherhood statements and “shoulds”. We realize that it is a Blueprint, but by using softer terms and vagueness, it could hamper what the IPC Implementation Committee needs to do. We view it more as laying out concepts than a detailed document, which a Blueprint usually is.

We agree that health-care organizations are working with finite human and financial resources. For Medical Radiation Technology, the attrition issue and retirement predictions are the same as for the nursing Profession. What is needed is not only “collaboration” in terms of health-care providers collaborating with each other, but also Ministry branches and bureaucratic cells of the government working together with associations, employers, regulatory and other bodies to eliminate the “piecemeal” approach to solving the issues in the health-care system.

In Medical Radiation Technology, we have a collaboration issue internally, which may have to be solved first, or while the IPC Initiative is occurring. We have four (4) Professions within the umbrella Profession of Medical Radiation Technology. Our technologies and practices are merging, which is a major challenge for us. We are needing to form internal teams of MRTs. We have been collaborating in a variety of ways for decades with other caregivers.

One of Medical Radiation Technology's major barriers to collaborative care is the nursing Profession itself. Although the doctrine of IPC may be articulated, it is not practised when it comes to our sector. MRTs experience a high degree of disregard, or perhaps ignorance or misconception, of the competencies MRTs possess. MRTs suffer from a lack of mutual respect, support, and arrogance related to what they do and are capable of doing.

The document discusses the separation of caregivers. As noted above, this is an issue for Medical Radiation Technology. We are aware that the Federation of Health Regulatory Colleges of Ontario is addressing issues related to the RHPA, and these are complicated by the legislation and its regulations, as well as the practice of each professional caregiver group. Associations need to know what the specific issues are, so that we can assist in the continuing education of our Members. This information, at the time of crafting this document, is not known, nor is any boundaries, parameters, etc., on which we can become more involved with the Initiative.

The dream of breaking down the “silos” will never happen. It needs to be recognized that there will always be “silos” because of the expertise required to deliver high quality and safe patient care. What will be important to determine and acknowledge is what functions need to remain and what should be siloed.

We agree that interprofessional care and education need to be advanced simultaneously. That will have to be a core function of designing the “Plan”, as we see it. We will be very interested in the

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timetable, cost and collaborations needed to do that, especially as Medical Radiation Technology is a major thread in the health-care system's fabric.

We agree that changes will need to occur. We are open to that and have offered solutions to government. A major barrier for MRTs, as we noted, has been the nursing Profession, who seem bent on taking the road of wanting to practice in other Professions' practice domains, but refusing those other Professions to take on practices in their domain.

We see undergraduate Programs, associations and regulatory bodies working together to address IPC educational needs. It has to be a "big picture" effort. If it is left to the undergraduate Programs alone, the new graduate will soon be reeducated because of the realities of practice.

We advocate that all health-care providers carry personal professional liability insurance. Our experience is that Independent Health Facilities do not provide it. Hospitals do to some degree or another, or when the person appears to be in trouble, terminates them. We further suggest that the professional associations are the best avenue to provide it rather than a regulatory body, where it is seen as a conflict of interest.

BLUEPRINT OBSERVATIONS - DEVELOPMENT PROCESS

As we noted in the "shortcomings" section, the absence of Diagnostic Services and Radiation Therapy is an issue for us. Physicians, nurses and educators were over represented in our view.

At the consultations, we were represented on two (2) discussion groups and not all of them. We restate our argument that diagnostic services, and in our case, Diagnostic Imaging, is an essential expensive and core service, but is absent in its input compared to the groups mentioned.

BLUEPRINT OBSERVATIONS - BLUEPRINT FOR ACTION

In "building the foundation" there was a comment about local interprofessional health sciences students' association. From what we can determine, MRT students are not aware, in many cases, of such an organization at their college or university. We have concerns that the Profession has no official representation on most of the Radiation Sciences advisory boards. There may be MRTs involved, but they are not speaking for the Profession, nor do they know the issues. Our attempts to sign all MRT Students for free Student Membership, so we can network them together, has met with mediocre support from undergraduate Programs (better with some; little from others). We could use this advisory board structure to further promote IPC, along with linking Radiation Sciences Students to us.

We agree that Standards of Practice, where the practice overlaps, should be "standardized". It would help if undergraduate Programs were redesigned so that core and common topics were taken together, or perhaps everyone in health sciences does a common year.

We noted our position on liability insurance previously in this document. To restate it; we believe that every health-care provider should have personal professional liability insurance provided by associations that cover their practice domain.

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We would be excited to be IPC champions and leaders, but we have no funding to do it as an association. Placing this on the backs of our Members will result in a loss of Membership in our volunteer body, and as a result, will make the IPC movement less effective.

We are not sure what e-health strategies the Blueprint had in mind. We have not seen any of these strategies, and as a result, cannot determine where teleradiology, as an example, may fit in.

We agree with providing incentives vs. punishment for noncompliance. Incentives for us would be to move on with Advance practice Initiatives within the DI sector by supporting and funding us. Another incentive would be to feature successes on the Ministry and relative association web sites. A consideration could be to recognize successes as credits at any university providing health-care educators' higher learning Programs (MBA, etc.). Another idea is to have an IPC symposium on how to address IPC paid for by government.

We would suggest that for the nationally Certified MRT, that in order to meet the Interprofessional Competencies required under IPC, all MRTs need to graduate with an undergraduate degree. The competencies we have seen stated include:

- Communication (sharing information, listening, consulting, validating, reflecting)
- Teamwork
- Leadership (shared, assume when needed, accept responsibility)
- Knowledge of one's own Profession
- Knowledge of the other's Professions
- Negotiation
- Conflict resolution
- Creative and critical thinking.

It would be helpful to us to have confirmation on what the expected competencies are.

GENERAL COMMENTS

The issue of IPC is very complex. There are systemic factors involved, including the education system, the professional system, government policies at all levels and social and cultural values. Right now we see these as independent, rather than interdependent, and the Implementation Committee will have to address this as they move to create a culture of Interprofessional Collaborative Learning and Practice.

The Romanow Report in 2002 stated that "education should be changed to focus more on integrated team-based approaches to meeting health-care needs and service delivery". There is no disagreement with that on our end, but it will bear no fruit if, at the same time existing practitioners are also not educated on IPC, which would need to include the changing of attitudes. The Implementation Plan needs to be a coordination tool to achieve IPC synergy. You can increase all the teams you want (Health Council of Canada), but if the barriers are still up, any teams formed will be dysfunctional teams regardless of everyone's best interests.

Professions like Medical Radiation Technology, and particularly its Radiological Technology

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(Radiography, as our regulatory legislation labels it), will require moving to a Degree as entry to practice. This will impact policy makers and government bureaucrats. Radiological Technologists and other health-care providers will need Degree credentials if they are to be technically competent, adept at solving problems, capable of functioning as part of a multi-disciplinary team committed to life-long learning, understanding and exhibiting ethical behaviour and compassion when providing patient care, effective and efficient use of health resources, and an inquiring attitude towards health care and the health-care system.

The patient/client is an important and the key factor in IPC, since IPC is all about better health outcomes. The patient/client needs to be part of any education of Students or practising Professionals, which will require shared learning opportunities for them and with them, as they learn the various roles of health providers and the provider learns from them.

Partnership between the clinical and educational environments is very important. The clinical environment needs the resources to teach effectively, and that includes financial, from the educational facility that the clinical site is partnered with and/or government. If the partnership is stressed, then IPC initiatives will suffer. If the partnership is not forged well, there will be minimum contact between Educators and Practitioners within and across the Disciplines. In this situation, IPC will be negatively impacted.

Accreditation of undergraduate Programs, hospitals and the quality assurance Programs of Independent Health Facilities all need to be targeted in terms of requiring criteria that fosters and insists upon IPC as a core competency in terms of identified collaboration per Discipline/provider group.

The government should work with groups such as the Coalition of Regulated Health Professions' Association (CORHPA) in terms of funding educational sessions on "Training of IPC Champions", which can be directed at the clinical educators and other clinical Practitioners to assist the IPC movement in the clinical environment. It is those who are presently practising that may need the IPC behavioural changes the most. Perhaps every teaching institution should submit for approval and coordination, a Project Plan on how they will implement IPC at the undergraduate and postgraduate levels.

We would hope that a work plan would be produced and shared with stakeholders regarding advancing IPC and IPE together as stated on page 15 of the document, or at least a mind map illustrating how this will be done.

We see the IPC Initiatives as a piece of the overall sustainability of the health-care pie, and this needs to be kept in mind in terms of resource allocation. In that regard, we see the Initiative dovetailing into the Canada Health Infoway Project, and we are interested on how the implementation plan will accommodate that Project and other activities in terms of coordinating everything.

We would hope that the Implementation Team ensures that for every decision being made as to recommendations, the ethical and moral aspects are described, and those important and critical decision-making factors are compared with existing legislation and regulations in order to identify

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gaps that need addressing. As an example, if the ethics of patient care facilities causes moral distress, or working conditions cause moral distress, then IPC and IPE efforts will fail. This is a trust and respect issue between employee and employer. It is a governance issue for the employers, as is the need for employers to provide the right infrastructure, human resources and to support continuing professional development of their Staff and Staff's activity in the "Profession".

CONCLUSION

The OAMRT supports the IPC Initiative and would like to be a champion. We lack direction, the tools and the funds to be a strong advocate. We have concerns that the Initiative does not take into account our Profession, which is the hub of health care (all patients come to DI and / or Radiation Therapy at some point), and this is perceived as a shortcoming in terms of the Blueprint.

The Blueprint appears to be of a vision document rather than a detailed Blueprint, so we look forward to the next steps of the Implementation Committee, especially if it gives MRTs the benefits the Initiative is to provide, such as greater job satisfaction, less stress and burnout, and the opportunity to work within the full scope our Profession potentially offers us.