



CMRITO
Regulator of medical radiation and
imaging technologists in Ontario

College of Medical Radiation and Imaging Technologists of Ontario

Report for 2020

College Performance Measurement Framework (CPMF) Reporting Tool

March 2021

Explanatory Note regarding the name of the College of Medical Radiation and Imaging Technologists of Ontario

In December 2020, the Ministry of Health released its new College Performance Measurement Framework (CPMF), which sets out the expectations and reporting requirements for all health regulatory colleges in Ontario. The CPMF requires that the College provide evidence to support demonstration of achievement of the standards by providing evidence such as: “decisions, activities, processes or the quantifiable results that are being used to demonstrate and assess a college’s achievement of a standard”.

Under each standard, the College of Medical Radiation and Imaging Technologists (CMRITO) has provided evidence of how the standard is met. In identifying the documents, policies and processes that provide evidence that the CMRITO meets the requirements in the standards, it is noted that a number of these documents are documents from the College of Medical Radiation Technologists of Ontario (CMRTO).

The College of Medical Radiation Technologists of Ontario (CMRTO) changed its name to the College of Medical Radiation and Imaging Technologists of Ontario (CMRITO), effective January 1, 2020. The CMRTO was established under the *Medical Radiation Technology Act, 1991 (MRT Act)*. The *Medical Radiation and Imaging Technology Act, 2017 (MRIT Act)* came into force on January 1, 2020 repealing and replacing the *Medical Radiation Technology Act (MRT Act)*. The MRIT Act is available on the e-laws site and can be found here: <https://www.ontario.ca/laws/statute/17m25?search=medical+radiation>

The MRIT Act changed the name of the College and changed the name of the profession to medical radiation and imaging technology to encompass the regulation of diagnostic medical sonographers by the College, which began in 2018.

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INTRODUCTION

THE COLLEGE PERFORMANCE MEASUREMENT FRAMEWORK (CPMF)

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

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

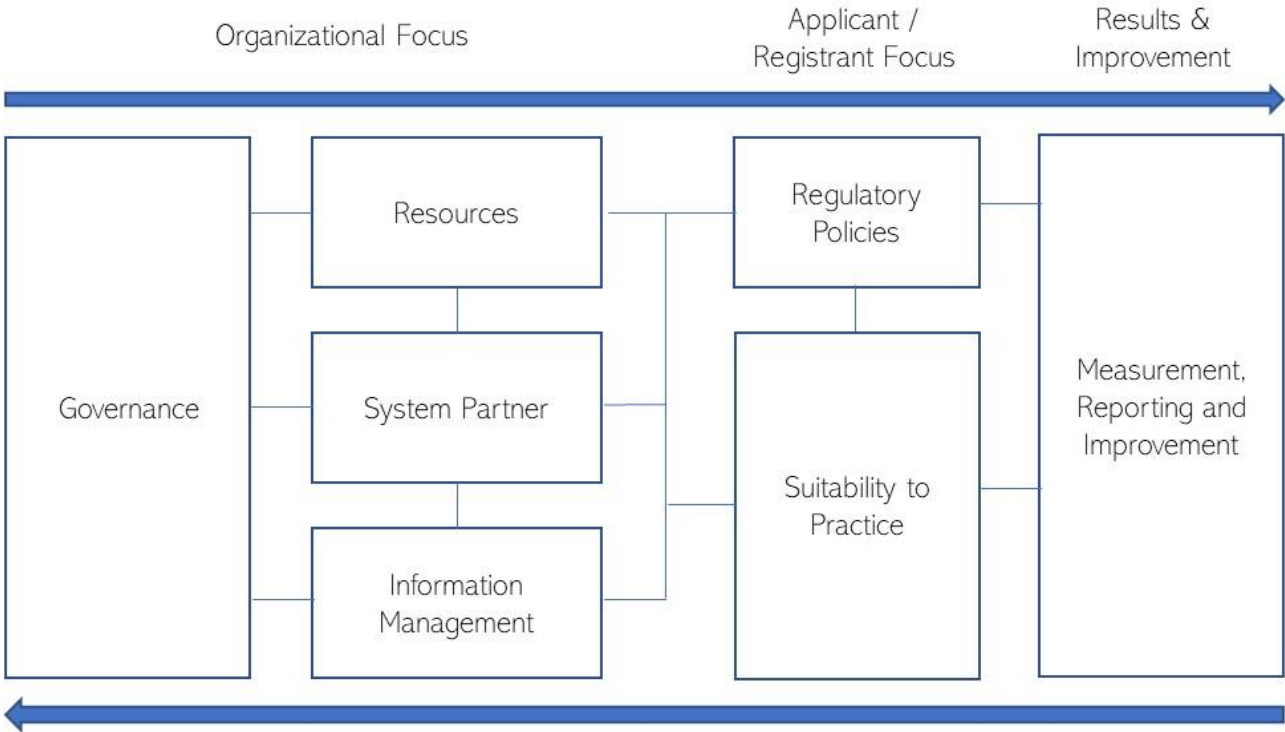
a) Components of the CPMF:

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

b) Measurement domains:

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

Figure 1: CPMF Model for measuring regulatory excellence



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

Table 1: Overview of what the Framework is measuring

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

c) Standards, Measures, Evidence, and Improvement:

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

Example:

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

THE CPMF REPORTING TOOL

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

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

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

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

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

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

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

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

Completing the CPMF Reporting Tool

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

Furthermore,

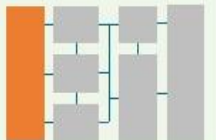
- where a College fulfills the “required evidence” it will have to:
 - provide link(s) to relevant background materials, policies and processes **OR** provide a concise overview of this information.
- where a College responds that it “partially” meets required evidence, the following information is required: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

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

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

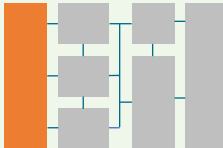
The areas outlined in red in the example below are what Colleges will be asked to complete.

Example:

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

PART 1: MEASUREMENT DOMAINS

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

DOMAIN 1: GOVERNANCE			
Standard 1			
Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.			
Measure	Required evidence	College response	
1.1 Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College’s mandate and expectations pertaining to the member’s role and responsibilities.	The College fulfills this requirement: Yes X Partially ☐ No ☐	
		The competency/suitability criteria are public: Yes X No Link where criteria can be found: CMRITO Council member competencies and expectations Orientation training: 2021 Election Information Orientation Session Agenda	
		If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes No Y Improvement opportunity There is currently no assessment component to the orientation training required to be completed as part of the nomination process by professional members who are standing for election to Council. The CMRITO sees this as a continuous improvement opportunity and will be exploring options in this regard in 2021.	

	11.a.i. a. Professional members are eligible to stand for election to Council only after meeting pre-defined competency / suitability criteria Yes, the candidates who meet the eligibility requirements to stand for election to Council have met the predefined competency and suitability criteria. • The CMRITO provides all registrants with information regarding the pre-defined competencies and expectations for professional members who are considering standing for election and serving on the CMRITO Council each year in the Fall edition of the CMRITO newsletter Insights. Clarification of the required competencies and expectations form part of the annual election process. The latest edition of Insights where this information has been provided can be found at this link. https://www.cmrito.org/pdfs/insights/insights-fall-2020.pdf . • The required competencies, as approved by Council in September 2014, that are provided to registrants as part of the notice of election, can be accessed from this link in the Fall edition of Insights. CMRITO Council member competencies and expectations • Further information for professional members who are interested in standing for election is provided on the CMRITO website at this link https://www.cmrito.org/about/council-cmritees/election-process/ . This page provides information on eligibility criteria, length of terms of office, the nomination procedures and steps in the process. The eligibility criteria for registrants to stand for election to Council are set out in section 28.5 of Bylaw 60 which is available on the CMRITO website. • In addition to the above, once a professional member has been elected to Council these competencies and expectations are provided to all Council members (professional and public members) attending Council meetings as a governance resource tool and are reviewed at each Council meeting. This serves as a reminder of the competencies and expected behaviours of all Council members including focusing on strategic intent, personal effectiveness, engaging others, ensuring stewardship, using a systematic approach to decision making, effectively communicating and having a commitment to serve the public interest. 1.1.a. ii. Professional members are eligible to stand for election to Council only after attending an orientation training about the College’s mandate and expectations pertaining to the member’s role and responsibilities. Yes, all professional members who are eligible to stand for election to Council are required to attend orientation training about the College’s mandate and expectations. • All candidates who have put their name forward for nomination for election to the CMRITO Council, and whose nominations have been seconded by two eligible voting registrants in the district for which the candidate is being nominated, are required to attend an orientation training about the College’s mandate and expectations pertaining to the member’s role and responsibilities. The orientation is provided by the College’s Legal Counsel and the Registrar & CEO, and often current Council members attend as mentors. The orientation training prior to 2021 has been a day long information session that was conducted at the offices of the CMRITO in Toronto. Attendance at the orientation session is mandatory in order for the candidate to successfully complete the nomination process overseen by the Registrar, and to be eligible to stand for election to Council
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	In 2021, The orientation session was delivered in a virtual online format as two half day sessions, due to the COVID-19 pandemic. The agenda for the latest education sessions for Council nominees can be viewed here. In addition to the content of these two sessions, which are delivered by the CMRITO legal counsel and supported by the Registrar & CEO and other members of the leadership team, nominees were required to review an agenda of a recent meeting of Council, to become familiar with the workload and complexity of the issues that Council considers at their meetings, and how to make decisions in the public interest. There is currently no formal assessment component to this training. The CMRITO sees this as a development opportunity and will be exploring options in this regard in 2021.										
	<table><tr><td>b. Statutory Committee candidates have:</td><td>The College fulfills this requirement: Yes ☒ Partially ☐ No ☐</td></tr><tr><td><table><tr><td>i. met pre-defined competency / suitability criteria, and</td><td> - The competency / suitability criteria are public: Yes ☒ No ☐ <i>If yes, please insert link to where they can be found, if not please list criteria:</i> Competencies suitability criteria to serve on CMRITO Statutory Committees Statutory Committee orientation training: Insert link to website if training topics are public OR list orientation training topics for Statutory Committee: See topics below in narrative. CMRTO Council and Committee Education Session - Presentation </td></tr><tr><td>ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member’s role and responsibilities.</td><td></td></tr></table></td><td></td></tr><tr><td colspan="2"><i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i></td></tr></table>	b. Statutory Committee candidates have:	The College fulfills this requirement: Yes ☒ Partially ☐ No ☐	<table><tr><td>i. met pre-defined competency / suitability criteria, and</td><td> - The competency / suitability criteria are public: Yes ☒ No ☐ <i>If yes, please insert link to where they can be found, if not please list criteria:</i> Competencies suitability criteria to serve on CMRITO Statutory Committees Statutory Committee orientation training: Insert link to website if training topics are public OR list orientation training topics for Statutory Committee: See topics below in narrative. CMRTO Council and Committee Education Session - Presentation </td></tr><tr><td>ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member’s role and responsibilities.</td><td></td></tr></table>	i. met pre-defined competency / suitability criteria, and	- The competency / suitability criteria are public: Yes ☒ No ☐ <i>If yes, please insert link to where they can be found, if not please list criteria:</i> Competencies suitability criteria to serve on CMRITO Statutory Committees Statutory Committee orientation training: Insert link to website if training topics are public OR list orientation training topics for Statutory Committee: See topics below in narrative. CMRTO Council and Committee Education Session - Presentation	ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member’s role and responsibilities.			<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>	
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<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>											
	1.1.b.i. Statutory Committee candidates have met pre-defined competency / suitability criteria Yes, the candidates who are appointed to the statutory and non-statutory Committees have met the predefined competency and suitability criteria. - The CMRITO provides all registrants with information regarding the pre-defined competencies and expectations for registrants who are considering applying to be appointed to one of the statutory committees. Each year all active registered registrants of the CMRITO are sent an email invitation to be appointed to CMRITO committees. A listing of all the statutory committees and a description of the mandate and areas of responsibility of each committee is provided to registrants for their information. In addition to the information about the committees, the desired competencies of members of these committees is included in the email. A copy of the email can be viewed at this link. - The predefined competencies and suitability criteria include that committee members understand that CMRITO’s mandate as a regulator is public protection, through the regulation of the profession (the role of CMRITO is not member advocacy or representation). Committee members must be committed to the protection of the public and operating within the legal framework and specific committee mandates and resources. They must also be good listeners, effective and respectful communicators and work well with others in diverse groups. Committee members must be committed to lifelong learning and open to differing perspectives and opinions.										

	- In addition to the email that is sent to registrants, the CMRITO website on the Committees information page provides information about each Committee including the mandate and members of each committee. The CMRITO Bylaw 60 in section 30 sets out the composition of the statutory committees and the eligibility criteria for appointment is included in section 35.1. The terms of reference for each statutory committee is set out in policy. These policies will be made available on the CMRITO website in 2021. A summary of the CMRITO committee descriptions can be viewed at this link - The Nominating Committee of the CMRITO reviews all applications to serve on a statutory committee to determine if applicants meet the required competencies and suitability criteria. The Nominating Committee makes recommendations for committee composition based on competency requirements to Council prior to the appointments to statutory committees at the June meeting of Council each year. 1.1.b. ii. Statutory Committee candidates have attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities. Yes, all appointees to the Statutory and non-statutory committees attend an orientation training specific to the mandate of the Committee to which they have been appointed to understand expectations related to their role and responsibilities on that Committee. - The training and orientation that is provided to registrants once they are appointed to one of the statutory or non-statutory committees is tailored to meet the specific role of each committee. The orientation and training sessions prior to 2021 have all been conducted as in person presentations with interactive question and answer opportunities to address any questions. In 2020 these orientation sessions were delivered as virtual online sessions due to the COVID-19 pandemic. - In addition to the general orientation to the CMRITO and the legislation, the appointees to each of the statutory committees also complete annual training. This has included an orientation to the legislation, applicable regulations and policies for each committee as well as additional related training in topics more specifically pertinent to the mandate of each committee. For example, decision-making committees receive training on the Ontario Human Rights Code every two to three years. - More specific training related to committee processes is provided to new appointees to prepare them for their roles and responsibilities and expectations. This training is typically between ½ day to full day in length and the format of the presentation is tailored to meet the needs of the new committee member. This one-on-one training is completed by the CMRITO staff responsible for supporting the committee and provides the new committee member with an opportunity to ask questions and clarify any questions around their roles and responsibilities. - The CMRITO engages relevant experts to complete additional training for committees such as the specific training provided by independent legal counsel to members appointed to the Discipline Committee, accountants for training in understanding financial statements for Council and the Finance and Audit Committee, and training in human rights and fair registration practices. In addition to this the CMRITO supports Council and Committees members to attend education sessions and conferences offered by organizations such as Ontario Regulators for Access Consortium (ORAC), Canadian National Association of Regulators (CNAR), Health Professions Regulators of Ontario (HPRO) and Council on Licensure Enforcement and Regulation (CLEAR). The topics covered in the general orientation for all Council and Committee members include the following topics:
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	• CMRTO’s/CMRITO’s legal and governance framework • Roles and responsibilities • Public Interest • Competencies and expectations • Code of conduct • Conflict of interest • Confidentiality	
	c. Prior to attending their first meeting, public appointments to Council undertake an orientation training course about the College’s mandate and expectations pertaining to the appointee’s role and responsibilities.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Duration of orientation training: • Format of orientation training (e.g., in-person, online, with facilitator, testing knowledge at the end): • Insert link to website if training topics are public OR list orientation training topics: The training provided for public appointments to Council is the same as the training offered to professional members on Council. See narrative below.
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>
	1.1.c. Prior to attending their first meeting, public appointments to Council undertake an orientation training course about the College’s mandate and expectations pertaining to the appointee’s role and responsibilities. Yes, all public appointments to Council are provided with an orientation training course about the mandate of the College and the expectations regarding their role and responsibilities. • The CMRITO provides all public appointments to Council with the same orientation training courses that are offered to professional members who serve on Council or committees. As public appointments can occur at any time throughout the year, the training is typically offered as one on one training session with the Registrar & CEO, CMRITO legal counsel and appropriate senior leadership staff with interactive question and answer opportunities to address any questions. In 2020 these orientation sessions have been provided as virtual online sessions due to the COVID-19 pandemic. • The content of the training is focused on promoting understanding of the College’s mandate and expectations as they relate to the appointee’s role and responsibilities. Included in the training are the following topics: • CMRTO’s legal and governance framework • Roles and responsibilities • Public Interest • Competencies and expectations	

	• Code of conduct • Conflict of interest • Confidentiality • Once a publicly appointed member has been appointed to one or more of the statutory and non-statutory committees, they too are provided with specific training related to committee processes to prepare them for their roles, responsibilities and expectations as it relates to the work of each committee. This training is typically between ½ day to full day in length and the format of the presentation is tailored to meet the needs of the new public member. This one-on-one training is completed by the CMRITO staff responsible for supporting the committee and provides the new public member with an opportunity to ask questions and clarify any questions around their roles and responsibilities. • The CMRITO will also include any public members in additional training provided to committees by relevant experts. Such training could include external training provided to registrants appointed to the Discipline Committee, engaging accountants to offer training in understanding financial statements and training in human rights and fair registration practices, depending on the needs of a particular committee. In addition to this the CMRITO supports all members of Council and committees, including all publicly appointed members to attend education sessions and conferences offered by organizations such as ORAC, HPRO, CNAR and CLEAR.	
1.2 Council regularly assesses its effectiveness and addresses identified opportunities for improvement through ongoing education.	a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; ii. Council	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Year when Framework was developed OR last updated: Framework was approved in September 2014 • Insert a link to Framework OR link to Council meeting materials where (updated) Framework is found and was approved: September-23-2014-Council-highlights • Evaluation and assessment results are discussed at public Council meeting: Yes X No ☐ • If yes, insert link to last Council meeting where the most recent evaluation results have been presented and discussed: December 3, 2020 Council Agenda
		If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
	1.2.a. Council has developed and implemented a framework to regularly evaluate the effectiveness of Council meetings and Council Yes, the CMRITO Council has developed and implemented a framework to regularly evaluate the effectiveness of Council meetings and Council. As part of a governance review project that was undertaken in 2013- 2014, Council reviewed and approved policies, bylaws and tools related to Council and Committees at their September meeting that year. Council developed a framework that included a code of conduct, defining conflict of interest, making decisions in the public interest, and a framework for meeting evaluations. Council developed a tool for assessment that is completed by all members of Council at the end	

	of each meeting. The questions included in the evaluation and assessment tool assess both the effectiveness of Council meetings and the effectiveness of Council as a whole. The evaluation focuses on assessing three components: • whether Council has received the information that is needed for decision making, including whether the information was received in advance of the meeting in a timely manner, whether the information and reports are clear and include the necessary information to make informed decisions and whether adequate opportunities was provided to discuss the issues under consideration and to ask questions. • Whether Council meetings are effective. The evaluation of this facet includes whether the issues being considered by Council are appropriate and relevant to the mandate and goals of the CMRITO and whether the goal of including the item on the agenda has been identified, specifically whether the topic has been included for information, discussion or decision. Other indicators in this section are whether meeting time has been used effectively, whether discussions were kept on topic, whether the level of conversation was at the appropriate level and did not delve into administrative or management details and whether Council members remained focused on the discussion and avoided distractions. • Whether Council members are fulfilling their duty of care and diligence and instilling a positive culture and values. In this facet of the evaluation, Council members assess whether all the Council members are prepared for the meeting and discussions, whether they participated responsibly exercising their judgement and made decisions with a public interest focus, and in accordance with their fiduciary duties. Whether the discussions took place in a positive climate of trust and candour and whether Council members have lived the values of integrity, fairness, transparency, respect and professionalism in their interactions.				
	b. The framework includes a third-party assessment of Council effectiveness at a minimum every three years.	<table border="1"> <tr> <td data-bbox="1295 782 2483 841"> The College fulfills this requirement: Yes ☐ Partially ☐ No X </td> </tr> <tr> <td data-bbox="1295 841 2483 974"> • A third party has been engaged by the College for evaluation of Council effectiveness: Yes ☒ No X If yes, how often over the last five years? <insert number> • Year of last third-party evaluation: <insert year> </td> </tr> <tr> <td data-bbox="1295 974 2483 1192"> If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes X No ☐ Improvement opportunity The CMRITO will be undertaking a governance review in 2021 and will engage governance expert to assist Council with this activity. As part of this review process, Council will consider whether to develop a third-party assessment of the effectiveness of Council. </td> </tr> </table>	The College fulfills this requirement: Yes ☐ Partially ☐ No X	• A third party has been engaged by the College for evaluation of Council effectiveness: Yes ☒ No X If yes, how often over the last five years? <insert number> • Year of last third-party evaluation: <insert year>	If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes X No ☐ Improvement opportunity The CMRITO will be undertaking a governance review in 2021 and will engage governance expert to assist Council with this activity. As part of this review process, Council will consider whether to develop a third-party assessment of the effectiveness of Council.
The College fulfills this requirement: Yes ☐ Partially ☐ No X					
• A third party has been engaged by the College for evaluation of Council effectiveness: Yes ☒ No X If yes, how often over the last five years? <insert number> • Year of last third-party evaluation: <insert year>					
If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes X No ☐ Improvement opportunity The CMRITO will be undertaking a governance review in 2021 and will engage governance expert to assist Council with this activity. As part of this review process, Council will consider whether to develop a third-party assessment of the effectiveness of Council.					

	1.2.b. The framework includes a third-party assessment of Council effectiveness at a minimum every three years No, the framework used by the CMRITO Council does not currently include a third-party assessment of Council effectiveness. While the CMRITO has not completed a third-party assessment of Council effectiveness, the CMRITO Council as part of its ongoing continuous improvement activities has been actively monitoring and evaluating CMRITO performance and effectiveness, using as a benchmark other reports that have been made publicly available. In addition to these activities the CMRITO has undergone continuous assessments of its processes as part of various Ministry initiatives and government agencies such as the Office of the Fairness Commissioner. Below are some of the assessment initiatives that have been completed. • The governance framework that was approved by Council in 2014 was established with the assistance of a governance expert who assisted the CMRTO in setting up the policies and governance tools for Council. The policies that were established at that time are reviewed every three years as part of the ongoing continuous improvement activities that Council undertakes to evaluate the effectiveness of the organization. These governance tools were established at the time that the last strategic planning process was being completed. The CMRITO will be undertaking the next strategic planning process in 2021 and will engage with an expert in strategic planning to assist Council with this activity. • There have also been a number of internal reviews that have been undertaken by CMRTO/CMRITO staff to compare the performance and effectiveness of the CMRITO to some of the landmark benchmarking reports that have been released in recent years. In November 2014, the CMRTO undertook a comprehensive review of our internal processes to respond to a request from Minister Hoskins. The request from the Minister was to provide a report on the progress the CMRTO had made on implementing transparency initiatives that confirmed the CMRTO’s commitment to making accountability and transparency the keystones of decision making and strategic direction. The response can be viewed at this link. • In March 2015, the CMRTO’s Director of Professional Conduct and Internal Legal Counsel conducted an internal review of our regulatory processes using criteria from the PriceWaterHouse Coopers (PWC) review of the College of Denturists of Ontario (CDO) and the voluntary review of the Royal College of Dental Surgeons of Ontario (RCDSO) that was completed by the independent regulatory expert, Harry Cayton and the Professional Standards Authority for Health and Social Care. The report can be viewed here. • The College completes an assessment of the registration practices annually for the Office of the Fairness Commissioner (OFC) to ensure that registration practices comply with the principles of fairness, transparency, impartiality and objectivity. The CMRTO/CMRITO has complied with all requirements for the OFC including completing a comprehensive audit of registration practices, a review of the entry to practice requirements and submission of the required yearly assessment reports. The reports submitted to the OFC can be viewed on the CMRITO website at this link. • The College has engaged in a number of self-assessments of the College’s patient relations program’s measures for preventing and dealing with the sexual abuse of patients ranging from evaluations by the Health Professions Regulatory Advisory Council (HPRAC) in 2001 and 2008 and more recently in 2014 as part of the Minister’s Task Force on the Prevention of Sexual Abuse of Patients and the <i>Regulated Health Professions Act</i>, 1991. As demonstrated above the CMRITO is an organization that is committed to excellence and engages in ongoing continuous assessment of the effectiveness of all program areas of the organization. The CMRITO will be undertaking its next governance review in 2021 and will engage a governance expert to assist Council with this activity. As part of this review process, Council will consider whether to develop and include a third-party assessment of the effectiveness of Council.
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	c. Ongoing training provided to Council has been informed by: i. the outcome of relevant evaluation(s), and/or ii. the needs identified by Council members.	The College fulfills this requirement: Yes ☒ Partially No ☐ • Insert a link to documents outlining how outcome evaluations and/or needs identified by members have informed Council training; • Insert a link to Council meeting materials where this information is found OR December 3, 2020 Council Agenda • Describe briefly how this has been done for the training provided <u>over the last year</u>. See narrative below <i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☒ No ☐</i> Although the essential and mandatory training for Council members has been completed in 2020, the CMRITO has been unable to provide additional training as identified by Council members as the four education days planned for 2020 were cancelled due to the COVID-19 pandemic. Neither have any Council members identified or requested additional training on the Council meeting evaluations in 2020. The CMRITO will be providing training by special virtual sessions in 2021, starting with reviewing financial statements on March 23, 2021.
	1.2 c. Ongoing training provided to Council has been informed by the outcome of relevant evaluation(s), and/or the needs identified by Council members. Yes, the ongoing training provided to Council has been informed by the needs identified by Council members. Education has been identified as a key strategic measure by the College Council in the Strategic Plan 2017 – 2021: Commitment to Regulatory Excellence. • As a learning organization one of the measures that Council has approved in the Operational plan, and tracks in the Balanced Scorecard, is that all Council meetings have an educational component included in the meeting. The reason that Council have implemented this measure is that they have determined that ongoing education and orientation is essential in ensuring Council’s capacity to govern in a manner that reflects regulatory excellence. Part of the evaluation assessment that each member on Council completes at the end of each meeting includes an opportunity for Council members to identify any specific education needs they may have. Based on this feedback, education and orientation sessions are provided to Council. Education to support specific information needs is also provided for Council to ensure that the Directors have the necessary background information about issues and matters under consideration to be able to make informed, evidence-based decisions. An example of this type of training is the education that is provided on a regular basis by an independent accountant, on how to read and understand audited financial statements. • Examples of the education sessions that Council has participated in recently have included: • A presentation from Thomas Custers regarding the implementation of the new CPMF framework	

	• A presentation from Erica Richler, Partner, Steinecke Maicura LeBlanc on ‘Continuing to Regulate in the Public Interest –Responding to Changing Public Expectations’ which was based on a presentation they gave at CLEAR’s International Congress on Professional and Occupational Regulation in Vancouver, BC on June 28, 2019. • A presentation from Sidsel Pederson, MRT(R) regarding 'Improving healthcare for transgender patients in diagnostic imaging departments’ • Lisa Pretty, Manager of Communications, College of Physiotherapists of Ontario, provided a presentation on the Citizen Advisory Group • A presentation by Michael Conde and Valerie Ip from eHealth Ontario, regarding the status of the electronic health record project • Debbie Tarshis from WeirFoulds LLP led Council through a review of the proposed registration regulation under the <i>Medical Radiation and Imaging Technology Act, 2017</i> • John Risk from WeirFoulds LLP provided a presentation on ‘The perils of prediction: legal issues for regulation in the age of big data’ • In addition to the education and training offered during Council meetings, CMRITO supports both professional and public members in attending education sessions on governance and other regulatory training that is offered by organizations such as HPRO, CNAR, ORAC and CLEAR. The College also holds an annual education dinner where presentations are provided by members of the profession to improve the understanding of the practice of the profession of the public members on Council. Recent topics for these education dinners have included a presentation on the use of Artificial Intelligence (AI) in diagnostic imaging and the Thunder Bay Hospital initiative for patient engagement with a specific focus on meeting the needs of the indigenous community when providing services. • In 2020 Council education sessions were placed on hold in response to the COVID-19 pandemic and the need to move to virtual office operations. At the start of the pandemic Council also reviewed the planned activities in the strategic plan for 2020 and determined to scale the plan to focus on regulatory essentials for 2020. As the pandemic continues in 2021, the CMRITO is resuming the education activities that Council has identified to be an important component of the supports that are needed for Council to be informed and to promote excellence in fulfilling their obligations and duties. These educational activities will be offered through a new virtual online format that will include a variety of delivery formats including on-line training sessions, recorded sessions, developing information packages with in-person and recorded discussion forums available to discuss these materials and developing a website-based microsite for Council and Committee members to access material. • Education for Council members in 2020 has been focused and targeted and has primarily related to enabling and equipping Council members to participate in virtual online meetings to continue to fulfill their responsibilities and duties. Tools to support Council in participating in online meetings to fulfill their obligations and the mandate of the College, have been developed and can be viewed at this link.
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Standard 2		
Council decisions are made in the public interest.		
Measure	Required evidence	College response
2.1 All decisions related to a Council's strategic objectives, regulatory processes, and activities are impartial, evidence-informed, and advance the public interest.	a. The College Council has a Code of Conduct and 'Conflict of Interest' policy that is accessible to the public.	The College fulfills this requirement: Yes ☒ Partially ☐ No ☐
		- Year when Council Code of Conduct and 'Conflict of Interest' Policy was implemented OR last evaluated/updated: The policy was implemented in 2014 and was last reviewed in September 2020 as part of the ongoing three-year cycle of review. - Insert a link to Council Code of Conduct and 'Conflict or Interest' Policy OR Council meeting materials where the policy is found and was discussed and approved: The Council materials where the policy was discussed and approved can be found here: September-23-2014-Council-highlights The Code of Conduct policy 2.12. is part of the agenda package for all Council meetings. The latest December 3, 2020 Council Agenda can be accessed at this link and includes this policy. A copy can also be viewed at this link The Conflict of Interest Policy 2.13 was last reviewed and approved at the September 2020 meeting of Council and can be found in the publicly available agenda material. A copy can also be viewed at this link
		<i>If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i> Improvement opportunity While Policies 2.12 and 2.13 are not currently posted on the CMRITO website, the CMRITO is in the process of constructing a designated section of the CMRITO website for Council policies so that they will be accessible to the public. These and other policies will be posted to the website by the end of 2021.
<i>Additional comments for clarification (optional)</i> 2.1.a. The College Council has a Code of Conduct and 'Conflict of Interest' policy that is accessible to the public. Yes, the CMRITO has a Code of Conduct and Conflict of Interest policy that is available to the public.		

	- As part of a governance review project that was undertaken in 2013- 2014, Council reviewed and approved policies, bylaws and tools related to Council and Committees at their September meeting that year. Governance tools regarding the code of conduct, conflict of interest and meeting evaluations were approved. - As part of that governance review process the College developed both a Code of Conduct and Conflict of Interest policy. Council Policy 2.12, Code of Conduct for Councillors and Non-Council Committee Members was approved by Council in 2014 (September 23, 2014). Policy 2.12 was last reviewed by Council in September 2020 as part of Council’s standardized policy review process. Policy 2.12’s next review date is September 2023, as it is on a three-year review schedule. However, Council does consider whether interim amendments are required and will do so before September 2023 if necessary. - Appended to Policy 2.12 is an “Acknowledgment and Agreement” wherein all Councillors and Non-Council Committee members are required to acknowledge that they have read and understand the Code of Conduct and agree to conduct themselves in accordance with it. Councillors and Non-Council Committee members review Policy 2.12 and sign the agreement as part of their orientation process. - Although Council Policy 2.12 is not available on the website as a single document, it is available in all Council agenda packages (which are publicly available). Policy 2.12 is reviewed by Council at each Council meeting as part of the standing agenda item “Review of Roles & Responsibilities of Council” which occurs following the approval of the agenda and before the declaration of conflicts of interest. While Policy 2.12 is not currently posted on the CMRITO website, the CMRITO is in the process of constructing a designated section of the CMRITO for Council policies so that they will be accessible to the public. This and other policies will be posted to the website by the end of 2021. - Council Policy 2.13, Conflict of Interest for Councillors and Non-Council Committee Members was approved by Council in 2014 (September 23, 2014). Policy 2.13 was last reviewed by Council in September 2020 as part of Council’s standardized policy review process. Policy 2.13’s next review date is September 2023, as it is on a three-year review schedule. However, Council does consider whether interim amendments are required and will do so before September 2023 if necessary. The purpose of Policy 2.13, together with the conflict of interest provisions set out in CMRITO By-law No. 60, is to define circumstances in which a conflict of interest may exist or appear to exist, and set out the responsibilities of Councillors and Non-Council Committee Members with respect to such conflicts. - By-law No. 60, which also speaks to conflict of interest, is available on the CMRITO website, here: https://www.cmrito.org/pdfs/by-laws/by-law-60.pdf. The conflict of interest provisions of By-law No. 60 can be found in subsection 11 (page 8). - On the cover page of all CMRITO Council and Committee meeting agendas, there is a note that asks Councillors and Non-Council Committee members to contact a designated staff person and/or the relevant Chair if, in their review of the materials, they become aware that they have a conflict of interest with any item on the agenda or if they are concerned that they may have a conflict of interest with any item on the agenda. Declarations of conflict of interest are a standing item on all Council and Committee agendas, and all Councillors and Non-Council Committee members are provided with a fulsome orientation to actual and perceived conflicts of interest and the procedure for dealing with such conflicts (which is set out in Policy 2.13 and By-law No. 60).
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	b. The College enforces cooling off periods ² .	The College fulfills this requirement: Yes X No
		- Cooling off period is enforced through: Conflict of interest policy ☐ By-law X Competency/Suitability criteria ☐ Other <i><please specify></i> - The year that the cooling off period policy was developed OR last evaluated/updated: Bylaw 60 was last updated January 1, 2019 - 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; - insert a link to Council meeting where cooling of period has been discussed and decided upon; OR - where not publicly available, please describe briefly cooling off policy:
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No X</i>
		While the CMRITO does not identify cooling off periods as set out in the definition for this standard, the CMRITO does have very clear eligibility criteria for being elected to Council and serving on any of the Committees. The CMRITO believes that the eligibility criteria as defined in the bylaws satisfies the intent of this standard and excludes any persons that could be placed in an actual or perceived conflict of interest from serving on Council or any of the Committees.
2.1.b. The College enforces cooling off periods		
No, the CMRITO does not enforce cooling off periods as defined in the CPMF. The CMRITO does however have clear eligibility criteria for members of the profession to serve on Council or any of the Committees.		
By-law No. 60 (https://www.cmrito.org/pdfs/by-laws/by-law-60.pdf) clearly sets out the eligibility criteria for members of the profession to be (a) elected to Council, (b) appointed to Council (in the case of the Academic Councillor), and (c) appointed to committees of the College.		
A member is not eligible for election or appointment if the member is:		

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

	• an officer, director or person employed by a professional association representing the profession or any of the specialties or both, • an executive officer of a bargaining unit of a union representing members of the profession or any of the specialties or both, or • an executive officer of an association of managers of members of the profession or any of the specialties or both. These criteria are set out in subsections 28.5.1.9, 29.2.1.7, and 35.1.1.7 respectively. • These same criteria are also referenced on the “Election Process” page, available under the “Council and Committees” tab. The information on this page clearly sets out when a member of the profession is not eligible for election. • Additionally, the information and forms circulated to registrants for election to Council and Appointment to Committee also include this information and require registrants to declare that they meet the eligibility criteria outlined above. • CMRITO By-law No. 60 also provides that a Councillor may not be the Registrar & CEO (see subsection 12.6).	
	c. The College has a conflict of interest questionnaire that all Council members must complete annually. <u>Additionally:</u> 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 <u>specific to the meeting agenda</u>.	The College fulfills this requirement: Yes X Partially ☐ No
		• The year when conflict of interest the questionnaire was implemented OR last evaluated/updated • Member(s) update his or her questionnaire at each Council meeting based on Council agenda items: Always ☐ Often ☐ Sometimes ☐ Never ☐ • Insert a link to most recent Council meeting materials that includes the questionnaire:
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period?</i> Yes X No ☐ Improvement opportunity The CMRITO will in 2021, as part of its governance review project, consider whether to develop and implement a conflict of interest questionnaire that can be completed annually by Council members and could be included in the Council meeting package.

	2.1.c. The College has a conflict of interest questionnaire that all Council members must complete annually. No, the CMRITO does not currently have a written conflict of interest questionnaire that all Council members must complete annually. There are however a number of other processes that form part of our standard practices that reiterate the need to declare conflicts of interest for CMRITO Council and Committee members. - On the cover page of all CMRITO Council and Committee meeting agendas, there is a note that asks Councillors and Non-Council Committee Members to contact a designated staff person and/or the relevant Chair if, in their review of the materials, they become aware that they have a conflict of interest with any item on the agenda or if they are concerned that they may have a conflict of interest with any item on the agenda. - Declarations of conflict of interest are a standing item on all Council and Committee agendas, and all Councillors and Non-Council Committee Members are provided with a fulsome orientation to actual and perceived conflicts of interest and the procedure for dealing with such conflicts (which is set out in Policy 2.13 and By-law No. 60. All CMRITO Councillors and Non-Council Committee Members are encouraged to discuss potential conflict of interest at the earliest possible opportunity and always err on the side of caution. - As outlined in our response to 2.1a above, the CMRITO has also developed policies to support the requirement for declarations of conflict of interest. Council Policy 2.13, Conflict of Interest for Councillors and Non-Council Committee members was approved by Council in 2014 (September 23, 2014). Policy 2.13 was last reviewed by Council in September 2020 as part of Council's standardized policy review process. Policy 2.13's next review date is September 2023, as it is on a three-year review schedule. However, Council would consider interim amendments if required before September 2023. While Policy 2.12 is not currently posted on the CMRITO website, the CMRITO is in the process of constructing a designated section of the CMRITO for Council policies so that they will be accessible to the public. This and other policies will be posted to the website by the end of 2021. - The purpose of Policy 2.13, together with the conflict of interest provisions set out in CMRITO By-law No. 60, is to define circumstances in which a conflict of interest may exist or appear to exist, and set out the responsibilities of Councillors and Non-Council Committee members with respect to such conflicts. By-law No. 60, also speaks to conflict of interest, and is available on the CMRITO website, here: https://www.cmrito.org/pdfs/by-laws/by-law-60.pdf. The conflict of interest provisions of By-law No. 60 can be found in subsection 11 (page 8).	
	d. Meeting materials for Council enable the public to clearly identify the public interest rationale (See Appendix A) and the evidence supporting a decision related to the College's strategic direction or regulatory processes and actions (e.g. the minutes include a link to a publicly available briefing note).	The College fulfills this requirement: Yes ☐ Partially X No ☐ - Describe how the College makes public interest rationale for Council decisions accessible for the public: See narrative below. - Insert a link to meeting materials that include an example of how the College references a public interest rationale:

		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☒ No ☐</i> Improvement opportunity The governance tool that was developed in 2014 as part of the governance review project, for evaluating if a decision is in the public interest. To date, the tool has not been included in the Council agenda package that is publicly available. CMRITO has added this governance tool to the information that is available on the website in 2021 and will now be including the tool in the Council agenda package. This governance tool can be viewed here. In addition to adding this governance tool to the website, CMRITO may consider an evaluation of current decision-making processes to more clearly identify the public interest rationale, the evidence that supports a decision and how it relates to the College’s strategic direction or regulatory processes and actions, as part of the 2021 governance review.
	2.1.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 No, the meeting materials as currently developed do not enable the public to connect the public interest rationale and the evidence supporting a decision of Council. There are however a number of tools and processes that in place to keep the public interest mandate foremost for Council. For example: - Policy 2.11 Roles and Responsibilities of the Council is included in each Council agenda package and the review of this policy is a standing item on the agenda at the start of each meeting. Policy 2.11 clearly sets out Council’s responsibility to act in the public interest and describes how this is accomplished. The duty and objects of a college as set out in RHPA are also attached to Policy 2.11. In this way, Council sets the public interest focus at the outset of each meeting. Policy 2.11 Roles and Responsibilities of the Council can be viewed here. - Briefing notes setting out the rationale and evidence for any matter that requires a Council decision are included in the publicly available agenda package. - Council has also developed a governance tool, which is made available to them at meetings, setting out considerations for evaluating if a decision is in the public interest. To date this tool has not been included in the Council agenda package that is publicly available, but the CMRITO will be adding this governance tool to the information that is available on the website in 2021. Click here to view the “Questions to ask when considering the public interest” governance tool.	

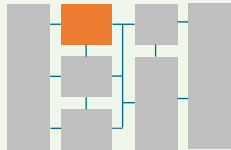
Standard 3		
The College acts to foster public trust through transparency about decisions made and actions taken.		
Measure	Required evidence	College response
3.1 Council decisions are transparent.	a. Council minutes (once approved) are clearly posted on the College’s website. Attached to the minutes is a status update on implementation of Council decisions to date (e.g. indicate whether decisions have been implemented, and if not, the status of the implementation).	The College fulfills this requirement: Yes ☐ Partially X No ☐
		Insert link to webpage where Council minutes are posted: The draft Council minutes for the previous meeting are included in the Council agenda package materials for every meeting. Agenda materials can be found at this link. https://www.cmrito.org/about/council-committees/our-council/
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period?</i> Yes X No ☐ Improvement opportunity Staff will add the minutes, following approval by Council, to the website beside the meeting to which they relate. Staff will also add a written Action Item Summary at the end of each set of minutes.
	3.1.a. Council minutes (once approved) are clearly posted on the College’s website. Attached to the minutes is a status update on implementation of Council decisions to date (e.g. indicate whether decisions have been implemented, and if not, the status of the implementation). Yes, draft Council minutes are posted on the CMRITO website as part of the Council agenda package materials for the following meeting. The agenda packages are posted at least one week prior to a Council meeting. Staff will add the minutes, following approval by Council, to the website beside the meeting to which they relate. While the minutes do not include a status update on the implementation of Council decisions to date, there are a number of methods that are used to provide an update on decisions made by Council, where Council has approved a decision that requires implementation and operationalization by College staff. These methods include: The minutes from each meeting include discrete action items where Council has given direction to staff to support decisions that were reached. As part of the review and approval of the minutes of the previous meeting, the Registrar & CEO provides a verbal update with respect to the status of all action items to Council at each meeting, which is open to the public. Council appreciates the verbal update and the opportunity to ask questions and engage in meaningful discussion on progress.	

	• Council has also approved an operational plan to identify the activities that are planned to achieve the goals of the Strategic Plan. The Registrar & CEO provides a verbal update on progress relative to the operational plan to Council at the meeting, and the documented operational plan is updated and included in the Council agenda package as a visual reference on progress that has been made in achieving the initiatives approved by Council. • The third method that Council uses to assess progress against approved activities is the Balanced Scorecard. The scorecard includes a number of measures that Council has determined are important to evaluate the effectiveness of the activities of CMRITO. Included in the Balanced Scorecard, which is included in the Council agenda package materials, is an update on the progress against the goals that have been set out in the Strategic Plan. • Staff will also add a written Action Item Summary at the end of each set of minutes.	
	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 ☐ Partially ☐ No X • Insert a link to webpage where Executive Committee minutes / meeting information are posted: <i>If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No X</i> The College Executive Committee meets regularly in between meetings of Council. The main purpose of the Executive Committee is to provide leadership to Council and facilitate the effective functioning of Council by providing input to background materials and making policy recommendations. The Executive Committee also functions as the Patient Relations Committee, Staff Relations Committee and Privacy Committee. The Executive Committee provides advice to the President on the development of Council agendas, as required. The College Council has delegated the oversight of risk identification and risk management to the Executive Committee. Section 12(1) of the Health Professions Procedural Code states "Between the meetings of the Council, the Executive Committee has all the powers of the Council with respect to any matter that, in the Committee's opinion, requires immediate attention, other than the power to make, amend or revoke a regulation or by-law." The CMRITO Executive Committee has limited the use of these powers to time sensitive issues, such as the appointment of new public members to the statutory committees in between meetings of Council. Reports from the Executive Committee on discussions and decisions when the Executive Committee discusses matters or materials that will be brought forward to Council are included as part of the agenda

		and materials for meetings of Council. In accordance with Council Policy 2.1, the Executive Committee is required to report its actions to Council on a timely basis. Council has no plans at this time to review the purpose or terms of reference for the Executive Committee. The terms of reference for the Executive Committee can be viewed here.
	3.1.b. Information about Executive Committee meetings is clearly posted on the College’s website No, the CMRITO does not separately post information about Executive Committee meeting dates and the rationale for those meetings on the website. However, reports from the Executive Committee to Council are included as part of the agenda and materials for meetings of Council and the CMRITO meeting calendar is also available as part of the Council agenda package and outlines the meeting schedule for all Council and College committees, including the Executive Committee. The Executive Committee meets on a regularly established schedule. The Executive Committee meets approximately 4 times per year, with each meeting of the Executive Committee occurring approximately one month before each regularly scheduled Council meeting. This meeting schedule facilitates the Executive Committee providing leadership to Council and facilitating the effective functioning of Council in accordance with Council Policy 2.1, Terms of Reference for the Executive Committee. Policy 2.1 can be viewed at this link. In support of Council, the Executive Committee facilitates the effective functioning of Council by providing input to background materials and making policy recommendations. While the Executive Committee has the authority to act as Council in between meetings of Council in accordance with the Health Professions Procedural Code (the Code), being Schedule 2 to the Regulated Health Professions Act, 1991, this is only done if absolutely necessary and any such decision would later be ratified by Council and would be made public in accordance with the CMRITO’s legislative obligations and commitment to transparency. An example of this would be if the term of a publicly appointed Councillor ended in between regularly scheduled meetings of Council, and that publicly appointed Councillor left a vacancy on a statutory committee that needed to be filled by another publicly appointed Councillor so that the Committee could be properly constituted, quorum requirements could be met, and the Committee could continue its essential statutory work. In accordance with the HPPC and Council Policy 2.1, the Executive Committee is required to report its actions to Council on a timely basis. Any decisions made by Executive are made in accordance with policies approved by Council, and those decisions are reported to Council by Executive at the next regularly scheduled meeting of Council. An example of this would be the approval of educational programs in accordance with Council Policy 1.8, Procedures respecting approval of accreditation of educational programs.	
	c. Colleges that have a strategic plan and/or strategic objectives post them clearly on the College’s website (where a College does not	The College fulfills this requirement: Yes X Partially ☐ No ☐ Insert a link to the College’s latest strategic plan and/or strategic objectives: https://www.cmrito.org/pdfs/publications/strategic-plan-2017-2021.pdf

	have a strategic plan, the activities or programs it plans to undertake).	<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>
3.2 Information provided by the College is accessible and timely.	a. Notice of Council meeting and relevant materials are posted at least one week in advance.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>
		Additional comments for clarification (optional) https://www.cmrito.org/about/council-committees/our-council/
	b. Notice of Discipline Hearings are posted at least one week in advance and materials are posted (e.g. allegations referred)	The College fulfills this requirement: Yes X Partially ☐ No ☐
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>
	3.2. b. Notice of Discipline Hearings are posted at least one week in advance and materials are posted Yes, Notice of Discipline Hearings and relevant materials are posted at least one week in advance. There is an entire section of the CMRITO website designated to Discipline Hearings & Findings. The relevant pages can be found under the “Public” tab, here: https://www.cmrito.org/programs/professional-conduct/hearings/ . If there are any scheduled Discipline Hearings, they are posted on the webpage with the registrant’s name, the allegations, as well as the date, time and location of the hearing. It is also confirmed on the webpage that Hearings of the Discipline Committee are open to the public. A notation regarding the referral, along with a copy of the specified allegations, are also posted on the registrant’s public register profile in accordance with the requirements of the Health Professions Procedural Code (the Code), being Schedule 2 to the <i>Regulated Health Professions Act, 1991</i> .	

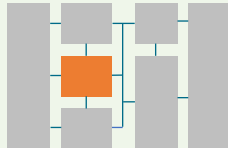
DOMAIN 2: RESOURCES		
Standard 4		
The College is a responsible steward of its (financial and human) resources.		
Measure	Required evidence	College response
4.1 The College demonstrates responsible stewardship of its financial and human resources in achieving its statutory objectives and regulatory mandate.	a. The College’s strategic plan (or, where a College does not have a strategic plan, the activities or programs it plans to undertake) has been costed and resources have been allocated accordingly. <u>Further clarification:</u> A College’s strategic plan and budget should be designed to complement and support each other. To that end, budget allocation should depend on the activities or programs a College undertakes or identifies to achieve its goals. To do this, a College should have estimated the costs of each activity or program and the budget should be allocated accordingly.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		Insert a link to Council meeting materials that include approved budget OR link to most recent approved budget: December 3, 2020 Council Agenda
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes X No ☐</i>
	4.1. a. The College’s strategic plan has been costed and resources have been allocated accordingly Yes, the College has an annual operational plan developed from the five-year strategic plan that has been costed and resources have been allocated to achieve the plan. The approved CMRTO Strategic Plan 2017 – 2021: Commitment to Regulatory Excellence is available on the CMRITO website and can be accessed at this link. https://www.cmrito.org/pdfs/publications/strategic-plan-2017-2021.pdf The annual budgeting process for the CMRITO includes:	



	• The development of an operational plan to identify activities that will be undertaken to achieve the strategic and enabling goals, as set out in the approved Strategic Plan. A budget to support the work in the operational plan, including costing out the work and identifying the necessary resources, is developed. • The draft operational plan and the proposed budgeting to support the operational plan is reviewed and scrutinized by the Finance and Audit Committee. The role of the Finance and Audit Committee of the College is to assist the Council in meeting its financial responsibilities. The Committee provides guidance to Council on financial matters as required. A number of policies have been approved by Council to define the roles and responsibilities of the Finance and Audit Committee. Policy 4.2 Financial Plan, Annual Budget and Quarterly Financial Reporting sets out the required content of the College's Financial Plan, its Annual Budget and quarterly financial reports. This Policy also sets out the process for their review by the Finance and Audit Committee and their subsequent review and approval by Council. • One of the responsibilities of the Finance and Audit Committee is to consider and make recommendations to Council on resource planning including the development of a three-year financial projection and an annual budget. • The recommendations from the Finance and Audit Committee regarding the annual budget are considered by Council at their meeting in December of each year. The link to the 2020 December Council meeting material where the recommendations for the 2021 Budget and 2021 – 2023 Financial Plan from the Finance and Audit Committee were provided to Council for their consideration, can be seen here. • The Council highlights from the December 2020 meeting where the 2021 budget was approved to support the work set out in the 2021 Operational plan, as approved by Council, can be viewed here. Policy 4.2 Financial Plan, Annual Budget and Quarterly Financial Reporting can be viewed here.	
	b. The College: i. has a “financial reserve policy” that sets out the level of reserves the College needs to build and maintain in order to meet its legislative requirements in case there are unexpected expenses and/or a reduction in revenue and furthermore, sets out the criteria for using the reserves;	The College fulfills this requirement: Yes X Partially ☐ No ☐ <u>If applicable:</u> • Insert a link to “financial reserve policy” OR Council meeting materials where financial reserve policy has been discussed and approved: • Policy 4.12 Internally Restricted Net Assets Policy can be viewed here. • Insert most recent date when “financial reserve policy” has been developed OR reviewed/updated: The current policy was approved in March 2020. The policy will next be reviewed in March 2021. • Has the financial reserve policy been validated by a financial auditor? Yes X No ☐

	ii. possesses the level of reserve set out in its “financial reserve policy”.	<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>			
	4.1.b. The College has a “financial reserve policy” that sets out the level of reserves the College needs to build and maintain in order to meet its legislative requirements in case there are unexpected expenses and/or a reduction in revenue and furthermore, sets out the criteria for using the reserves and possesses the level of reserve set out in its “financial reserve policy”. Yes, the College 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. The policy also sets out the criteria for using the reserves and responsibility for the Finance and Audit Committee to determine if the CMRITO possesses the level of reserve set out in its “financial reserve policy”. The CMRITO Council established a Finance and Audit Committee. The role of the Finance and Audit Committee of the College is to assist the Council in meeting its financial responsibilities. The Finance and Audit Committee provides guidance to Council on financial matters as required. One of the responsibilities of the Finance and Audit Committee to consider and make recommendations to the Council on major policies governing financial, budgetary and investment matters including the appropriate level of unrestricted net assets balance to be maintained at year end. A number of policies have been approved by Council to define the roles and responsibilities of the Finance and Audit Committee. Policy 4.12 Internally Restricted Net Assets Policy sets out the process and guideline relating to establishing and using unrestricted net assets of the College to fund unanticipated future needs of the College. The Finance and Audit Committee provides oversight of the methodology used in establishing and maintaining the internally restricted and unrestricted net assets of the College in accordance with the guidelines, process and criteria set out in this Policy. The Finance and Audit Committee at the end of each fiscal year recommends to Council the amount of the College’s unrestricted net assets to be designated as internally restricted net assets and the amount of the internally restricted net assets that can be used to fund the needs of the College within the guidelines. The guidelines include the criteria that the unrestricted net assets can be used for, which includes funding of unforeseen expenditures arising from the operations of the College and the funding of special projects approved by Council from time to time. Policy 4.12 can be viewed here. The terms reference for the Finance and Audit Committee can be viewed here.				
	c. Council is accountable for the success and sustainability of the organization it governs. This includes ensuring that the organization has the workforce it needs to be successful now and, in the future (e.g. processes and procedures for succession planning, as well as current staffing levels to support College operations).	<table><tr><td> The College fulfills this requirement: Yes ☒ Partially ☐ No ☐ </td></tr><tr><td> - Insert a date and link to Council meeting materials where the College's Human Resource plan, as it relates to the Operational and Financial plan, was discussed. December 3, 2020 Council Agenda for Council </td></tr><tr><td> <i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i> </td></tr></table>	The College fulfills this requirement: Yes ☒ Partially ☐ No ☐	- Insert a date and link to Council meeting materials where the College's Human Resource plan, as it relates to the Operational and Financial plan, was discussed. December 3, 2020 Council Agenda for Council	<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>
The College fulfills this requirement: Yes ☒ Partially ☐ No ☐					
- Insert a date and link to Council meeting materials where the College's Human Resource plan, as it relates to the Operational and Financial plan, was discussed. December 3, 2020 Council Agenda for Council					
<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>					

	4.1.c. Council is accountable for the success and sustainability of the organization it governs. This includes ensuring that the organization has the workforce it needs to be successful now and, in the future Yes, Council is accountable for the success and sustainability of the CMRITO. Council ensures that the CMRITO has the workforce it needs to be successful now and, in the future. Council has identified that the success of the CMRITO’s work hinges on ensuring sufficient organizational capacity to have a well-aligned and high-performing organization to meet our statutory obligations and deliver on the mission, vision and strategic plan. One of the enabling goals identified in the strategic plan is to ensure sufficient organizational capacity. Council therefore ensures that the CMRITO has the necessary financial resources, people and facilities to do the work of regulation through the budget planning and approval processes. The organizational chart is provided to Council at the December meeting as part of the planning activities for the upcoming year. Most recently this was included in the December 2020 Agenda for the Council meeting as part of Agenda item 6.b. Should an operational need arise between budgeting cycles, such as an increase in volumes for example that requires additional staffing to address the increased workload, the need would be identified, costed and a request will be prepared for Council to consider whether to approve additional resources to address the need for additional staffing to meet the strategic goals or objects of the College.
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DOMAIN 3: SYSTEM PARTNER		
Standard 5 The College actively engages with other health regulatory Colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.		
Standard 6 The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public expectations.		
Standard 7 The College responds in a timely and effective manner to changing public expectations.		
Measure / Required evidence: N/A	College response	
	<i>Colleges are requested to provide a narrative that highlights their organization’s best practices for each of the following three standards. An exhaustive list of interactions with every system partner the College engages is not required.</i> <i>Colleges may wish to provide Information that includes their key activities and outcomes for each best practice discussed with the ministry, or examples of system partnership that, while not specifically discussed, a College may wish to highlight as a result of that dialogue. For the initial reporting cycle, information may be from the recent past, the reporting period, or is related to an ongoing activity (e.g., planned outcomes).</i>	

The three standards under this domain are not assessed based on measures and evidence like other domains, as there is no ‘best practice’ regarding the execution of these three standards. Instead, <u>Colleges will report on key activities, outcomes, and next steps that have emerged through a dialogue with the Ministry of Health.</u> Beyond discussing what Colleges have done, the dialogue might also identify other potential areas for alignment with other Colleges and system partners. In preparation for their meetings with the ministry, Colleges have been asked to submit the following information: • Colleges should consider the questions pertaining to each standard and identify examples of initiatives and projects undertaken during the reporting period that demonstrate the three standards, and the dates on which these initiatives were undertaken.	Standard 5: The College actively engages with other health regulatory colleges and system partners to align oversight of the practice of the profession and support execution of its mandate. Recognizing that a College determines entry to practice for the profession it governs, and that it sets ongoing standards of practice within a health system where the profession it regulates has multiple layers of oversight (e.g. by employers, different legislation, etc.), Standard 5 captures how the College works with other health regulatory colleges and other system partners to support and strengthen alignment of practice expectations, discipline processes, and quality improvement across all parts of the health system where the profession practices. In particular, a College is asked to report on: • <i>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.).</i> Standard 6: The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public/societal expectations. The intent of standard 6 is to demonstrate that a College has formed the necessary relationships with system partners to ensure that it receives and contributes information about relevant changes to public expectations. This could include both relationships where the College is “pushed” information by system partners, or where the College proactively seeks information in a timely manner. • <i>Please provide some examples of partners the College regularly interacts with including patients/public and how the College leverages those relationships to ensure it can respond to changing public/societal expectations.</i> • <i>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).</i> Standard 7: The College responds in a timely and effective manner to changing public expectations. Standard 7 highlights successful achievements of when a College leveraged the system partner relationships outlined in Standard 6 to implement changes to College policies, programs, standards etc., demonstrating how the College responded to changing public expectations in a timely manner. • <i>How has the College responded to changing public expectations over the reporting period and how has this shaped the outcome of a College policy/program? How did the College engage the public/patients to inform changes to the relevant policy/program? (e.g. Instances where the College has taken the lead in strengthening interprofessional collaboration to improve patient experience, examples of how the College has signaled professional obligations and/or learning opportunities with respect to the treatment of opioid addictions, etc.).</i> • <i>The College is asked to provide an example(s) of key successes and achievements from the reporting year.</i>
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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.

Question: How has the College engaged other health regulatory Colleges and other system partners to strengthen the execution of its oversight mandate? Please provide details of initiatives undertaken, and how engagement has shaped the outcome of the policy/program (e.g. joint standards of practice, common expectations in workplace settings, etc.).

Yes, the CMRITO 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. The College has continued to engage with other health regulatory Colleges and system partners throughout 2020 despite the challenges that the global pandemic has presented this year. Some of these initiatives included:

- The implementation of the MRIT Act, which included a change to the name of the College effective January 1, 2020 required extensive communication with other regulatory Colleges and system partners to ensure that all understood that the 'College of Medical Radiation Technologists of Ontario', continues to meet its oversight mandate with its new name - the 'College of Medical Radiation and Imaging Technologists of Ontario'. We notified all other regulatory Colleges, other system partners, the relevant government agencies, members, professional associations and corporate service providers.
- On January 2, 2020 the College released a new website (www.cmrito.org), changed its website URL and email addresses, and released updates to several foundational documents with the new name and acronym of the College. These documents included the Standards of Practice which apply to all five specialties, the Code of Ethics, and the legislation learning package which forms part of the jurisprudence course approved by the College. The Standards of Practice and Code of Ethics were updated in January 2018 to include the addition of diagnostic medical sonography as a fifth specialty. Since January 2018 the College has held numerous webinars and in-person workshops across the province to inform members and other system partners that diagnostic medical sonographers are now regulated with the College, and to increase awareness of the Standards of Practice that apply to all five specialties of medical radiation and imaging technology. In 2020 the College planned a series of in-person professional practice workshops for members across the province. The first workshop was held on February 22, 2020, but unfortunately, the remaining workshops were indefinitely postponed as a result of the COVID-19 pandemic. The College has continued to educate members regarding their professional practice obligations through a series of webinars which are available on our website.
- The College continues to work with the government to approve the proposed registration regulation made under the MRIT Act. The government posted the proposed registration regulation on the Ontario Regulatory Registry from June 12, 2020 to July 22, 2020 for public comment. There were no comments received from the posting and the College will be submitting the proposed registration regulation under the MRIT Act in the fall of 2020.
- The College collaborated with the College of Physicians and Surgeons of Ontario (CPSO) in the latest update to the [Independent Health Facilities \(IHF\) Clinical Practice Parameters and Facility Standards for Diagnostic Imaging](#) (Revised September 2020). This document sets out common standards and practice expectations for all medical radiation and imaging technologists (MRITs), physicians and support staff who work within IHFs. With the recent regulation of diagnostic medical sonographers this was an important collaboration to ensure consistent standards for all MRITs practising in IHFs, and an understanding of the changes that the regulation of diagnostic medical sonographers brings to the inspection process.
- The College collaborated with CorHealth Ontario (<https://www.corhealthontario.ca/>) regarding the impact of the regulation of diagnostic medical sonographers (DMSs), whose area of practice is cardiac and vascular sonography, and the required changes to the system. CorHealth Ontario focuses on enhancing cardiac, stroke and vascular care in the province by providing strategic leadership to improve the quality, efficiency, accessibility and equity of cardiac, stroke and vascular services for patients across Ontario. The College continues to communicate with CorHealth through its reorganization into Health Ontario.
- The Ministry of Health has been working with many system partners throughout the pandemic. The College, as one of those system partners, has attended the daily/weekly teleconference updates regarding the COVID-19 pandemic. As the Directives and Orders from the Provincial Medical Officer of Health regarding infection control, screening procedures and personal protective equipment have been released, the College has distributed the information relevant to the clinical practice of medical radiation and imaging technologists. The College also developed a COVID-19 resource page on our website (<https://www.cmrito.org/static-resources/covid-19/>) to provide this essential information to the public and MRITs.

- The Health Workforce Regulatory Oversight Branch of the Ministry of Health held a series of meetings with the Health Profession Regulators of Ontario (HPRO) earlier in 2020 regarding an initiative to ensure sufficient numbers of healthcare practitioners to staff the hospitals during the pandemic. The College supported this initiative by reviewing the draft recruitment website and providing feedback and ensuring accurate information relating to the practice of MRITs. The College assisted in sharing communications with current and retired MRITs about this initiative. The College was also able to review the list of MRIT volunteers and provided timely pertinent registration information to the Ministry of Health.
- The College has worked closely with the national certification examination providers for students who completed their approved educational programs during the COVID-19 pandemic. The Canadian Association of Medical Radiation Technologists (CAMRT) (<https://www.camrt.ca/>) sets and administers the national certification examination for medical radiation technologists in the specialties of radiography, nuclear medicine, radiation therapy and magnetic resonance, and Sonography Canada sets and administers the national certification examination for diagnostic medical sonographers. The College has approved these examinations as its approved examination for registration with CMRITO. Agreements are in place with both organizations for access to the national certification examinations. The College has met with both providers to ensure access to certification examination for graduates of approved educational programs during COVID-19 and has provided support and guidance to the organizations.

Both organizations have ensured that students were able to write their examinations by working with Yardstick Assessment Strategies to enable candidates to write their examinations using remote proctoring. Both organizations have ensured that access to the certification examinations has been maintained, and the CAMRT also ran an additional sitting in July to accommodate those students delayed in completing the approved educational program.

We are pleased that the educational institutions delivering the approved educational programs and the national certification organizations have ensured that new graduates have been able to meet the requirements for successful completion of the approved educational programs and access to the examination during the COVID-19 pandemic, to ensure that there is no decrease in new graduates entering the workforce during the pandemic.

- The College has collaborated with the Ministry regarding the development of the CPMF. The Registrar & CEO has been a member of the Registrars' working group and the Deputy Registrar has been a member of the Standards Working Group (SWG) to provide feedback on specific metrics and the ability for Colleges to provide the information requested. The Finance and HR Manager has also provided feedback on some of the financial metrics.
- The College has collaborated with the other health regulatory colleges in HPRO in the HPRO CPMF Network regarding the completion of the CPMF report to identify opportunities for improvement and to support and strengthen alignment of processes, and quality improvement initiatives.
- The College participates in the Infection Prevention and Control (IPAC) (<https://ipac-canada.org/>) Knowledge, Translation and Exchange Working Group. This MOH and Public Health Ontario group discusses and updates relevant IPAC initiatives, issues, concerns and opportunities for alignment/overlap related to infection control issues in the clinical setting, in conjunction with college partners.
- The College is a founding member of the Alliance of Medical Radiation and Imaging Technologists Regulators of Canada (AMRITRC) (<http://www.amritrc.ca/>). This group of regulators are responsible, in each of their respective jurisdictions, for ensuring safe, quality, professional, competent diagnostic imaging and radiation therapy services. This is achieved through the regulation and licensing of MRITs which helps ensure that MRITs practice in accordance with defined practice, competence, conduct, ethical and professional standards. MRIT regulators also endorse professional development, encourage and promote excellence in patient care. The College works with other members of the Alliance regarding the automatic recognition of MRITs and provides support and advice to newly regulated jurisdictions.

The College provides leadership to this national group of regulators by providing administrative support and resources as required. The College Registrar & CEO has been the Chair of this national alliance for the past three years. The College provided further leadership in 2019 when the alliance changed its name from 'Alliance of Medical Radiation Technologists Regulators of Canada' to 'Alliance of Medical Radiation and Imaging Technologists Regulators of Canada' in anticipation of the coming into force of Ontario's MRIT Act, and the regulation of diagnostic medical sonographers with medical radiation technologists across Canada.

- The College continues to support and provide leadership to Accreditation Canada (<https://accreditation.ca/>) in the accreditation of medical radiation and imaging technology educational programs through the EQual Canada Program. Accreditation of the educational programs is an important part of the College in meeting its public protection mandate as it is the mechanism by which the College approves the educational programs for entry to practice in the profession.

The CMRITO Registrar & CEO is the Chair of the Program Council and the Deputy Registrar is a member of the Allied Health Technical Standards Committee. The accreditation of educational programs is an important quality process that supports health education programs preparing graduates to deliver safe and effective care at entry to practice. The educational programs provide education and training for students to support achievement of the competencies identified in the national competency profile and provincial standards for the profession.

- The College is an active collaborator with the other health regulatory colleges in Ontario through HPRO (<https://www.regulatedhealthprofessions.on.ca/>) and continues to provide leadership to this important group. The College's Registrar & CEO is a past President of HPRO's predecessor and is appointed to HPRO's Management (Executive) Committee. The College's Director of Professional Conduct and Internal Legal Counsel Chairs HPRO's Discipline Orientation Committee which has led the development and delivery of the training on How to Conduct Hearings for Discipline and Fitness to Practise Committee members. Other College Directors and Managers participate in other HPRO other regulatory groups such as the deputy registrars, corporate services, professional practice advisors, communications, quality assurance and registration groups. These groups collaborate to develop common principles, guidelines, and tools to support Colleges in meeting their mandate and to advance the regulation of health professionals in the public interest.
- The College is an active member of Ontario Regulators for Access Consortium (<https://regulatorsforaccess.ca/>). The Consortium exists to engage profession-based regulators/organizations in the development and implementation of proactive/collaborative approaches that facilitate the integration of qualified professionals, both internationally and domestically educated, into self-regulated professions in Ontario while recognizing individual legislative mandates.
- The College is a member of the Advisory Group for Regulatory Excellence (AGRE). This year the CMRITO Registrar & CEO was elected as Chair for a one-year term. The goal of the AGRE group is to identify opportunities and make policy recommendations that will strengthen public confidence in self-regulation. This is done through research, debate and policy development. The audiences are the public, government and other regulators who share an interest in regulation in the public interest.

Standard 6: The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public expectations.

Question: Please provide some examples of partners the College regularly interacts with including patients/public and how the College leverages those relationships to ensure it can respond to changing public expectations.

Yes, the CMRITO maintains cooperative and collaborative relationships to ensure it is responsive to changing public expectations. The College regularly interacts with a range of stakeholders and organizations to monitor, influence and respond to changes in the system, including monitoring to identify changing public expectations. Maintaining cooperative and collaborative relationships to ensure responsiveness to changing public expectations is one of our strategic directions and approved by Council.

Since January 2018 and continuing well into 2020, the College has focused its efforts in responding to changing public expectations through the regulation of diagnostic medical sonographers (DMSs). The College is now receiving and responding to complaints from the public and patients regarding their experience with diagnostic medical sonographers. The College has maintained and built on collaborative relationships with a number of important organizations and services to ensure it is able to respond to individual complainants and more general public expectations.

The organizations specific to the changing expectations through the regulation of DMSs with whom we maintain collaborative and cooperative relationships include CPSO, CPSO's IHF Group, College of Midwives of Ontario, and the College of Nurses of Ontario (CNO). Another Ministry division that has provided us with valuable information relating to changing patient expectations specific to complaints is the Independent Health Facilities Program.

The College is one of the founding partners of the Citizens Advisory group. This group helps to elevate the patient voice and perspective in healthcare regulation in Ontario. The group is composed of patients and caregivers who provide essential feedback on topics such as professional rules, standards of practice, policies, strategic priorities and communications directed at the public. Their voice helps to shape health regulators' work in protecting the public interest. The College reviews the research and reviews conducted by the Citizens Advisory Group on a regular basis and incorporates learning into its patient communications and website.

The maintenance of collaborative relationships with the national and provincial associations (CAMRT, Ontario Association of Medical Radiation Sciences (OAMRS) and Sonography Canada) is important to identify any changes in practice environments and patient care initiatives. These organizations also develop the national competency profiles for the profession, which forms the basis of the national certification examinations and the accreditation of approved programs in medical radiation and imaging technology. The CMRITO is an important stakeholder in the review of these competency profiles to ensure congruence with the Standards of Practice of the College and approves the national competency profiles as the basis for accreditation and the certification examinations. The College also provides feedback on best practice guidelines and other initiatives from the professional associations.

Other collaborative relationships the College leverages to ensure it is responding to changing public expectations include:

- HPRO: public communication website and outreach such as the Zoomer conference, Discipline orientation including holding discipline hearings virtually, Anti-Black Racism Awareness and Prevention Working Group, Consent and Capacity working group, CPMF Network working group
- AGRE – governance initiatives including the CNO Vision 2020
- Educational programs - The College provides regular presentations to students in approved educational programs on the standards of practice, the role of the College and public protection, and communicating with patients.

The College also has a number of outreach initiatives, including conducting the Registrar's in person workshops, and hosting a booth at national and local conferences and meetings of medical radiation and imaging technologists (MRITs) and managers of MRITs, that encourages MRITs to provide feedback to the College on changing public expectations that affect the practice of MRITs, to ensure that our standards of practice and practice guidelines are current for the safe practice of the profession and changing public expectations.

Standard 7: The College responds in a timely and effective manner to changing public expectations.

Question: How has the College responded to changing public expectations over the reporting period and how has this shaped the outcome of a College policy/program? How did the College engage the public/patients to inform changes to the relevant policy/program? (e.g. Instances where the College has taken the lead in strengthening interprofessional collaboration to improve patient experience, examples of how the College has signaled professional obligations and/or learning opportunities with respect to the treatment of opioid addictions, etc.)

Yes the CMRITO responds in a timely and effective manner to changing public expectations. Over 2020, the College has responded to changing public expectations and the practice of MRITs in Ontario in a number of ways.

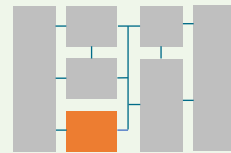
- On March 17, 2020 the Ontario government declared a state of emergency under the *Emergency Management and Civil Protection Act* due to COVID-19. At the Quality Assurance (QA) meeting of March 25, 2020 the QA Committee considered the effects of the COVID-19 pandemic and the changing public expectations related to receiving medical radiation and imaging technology services during the pandemic. The Committee considered the College's peer and practice assessment component of the QA Program which includes the use of a multi-source feedback (MSF) assessment. The MSF assessment includes a self, peer and patient assessment of a member's practice, based on the standards of practice, using a paper-based survey tool.

In particular, the QA Committee considered the challenges of maintaining effective infection control and complying with Ministry guidelines in relation to the process of gathering data from patients through the completion and mailing of those paper surveys. The Committee also considered the impact that restrictions in facilities, reduced patient appointments and the closure of facilities that were

not providing essential services would have on the MSF program. The QA Committee put forth a recommendation to Council that the MSF assessment be delayed or cancelled for 2020. On March 27, 2020, after consideration of all of these factors, the CMRITO Council decided to cancel the MSF assessment for 2020.

The College also continues to monitor changing public expectations and assesses how these expectations may shape College policies or programs. In this regard the College has:

- Collaborated with CPSO, Born Ontario (<https://www.bornontario.ca/en/index.aspx>), and the Ontario Association of Radiology Managers (OARM) (<https://oarm.org/>) regarding policies and care standards for sonography examinations of pregnancies
- Reviewed organizational capacity and has expanded the CMRITO staff by two additional persons to address the increase in complaints from patients and the public related to the regulation of DMS
- Developed and released practice guidelines related to communicating with patients and performing procedures explaining the legislative and regulatory framework related to performing medical radiation and imaging technology procedures
- Released a new website on January 1, 2020 with the new name of the College, a new URL, and a section specifically for the public, which was developed based on feedback from a survey of members of the public
- Added a COVID-19 section of the website with information specific to the practice settings of MRITs
- Updated the College’s by-laws in 2018 to add diagnostic medical sonography, reduced the number of professional members, and changed one elected Council position to a competency based selection process
- Since April 2020, CMRITO has provided live streaming of virtual Council meetings to the public, in addition to live social media posts on LinkedIn, Facebook and Twitter.

Domain 4: Information Management			
Standard 8			
Information collected by the College is protected from unauthorized disclosure.			
Measure	Required evidence	College response	
8.1 The College demonstrates how it protects against unauthorized disclosure of information.	a. The College has and uses policies and processes to govern the collection, use, disclosure, and protection of information that is of a personal (both health and non-health) or sensitive nature that it holds	The College fulfills this requirement: Yes ☒ Partially ☐ No ☐	
		• Insert a link to policies and processes OR provide brief description of the respective policies and processes https://www.cmrito.org/privacy-code/	
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period?</i> Yes ☐ No ☐	

	8.1.a. The College has and uses policies and processes to govern the collection, use, disclosure, and protection of information that is of a personal (both health and non-health) or sensitive nature that it holds. Yes, the CMRITO has policies and processes to govern the collection, use, disclosure, and protection of personal and sensitive information. Privacy Code A copy of the CMRITO’s Privacy Code is available on the CMRITO website, here. The CMRITO Privacy Code is approved by Council and is reviewed regularly as part of the Council’s standardized policy review process. Confidentiality Agreements All Councillors and Non-Council Committee members are provided with a fulsome orientation to the confidentiality provisions set out in section 36 of the Regulated Health Professions Act, 1991. All Councillors and Non-Council Committee members are required to sign a confidentiality agreement as part of their role. All CMRITO staff are provided with a fulsome orientation to the confidentiality provisions set out in section 36 of the Regulated Health Professions Act, 1991 and acknowledge that they are bound by section 36 as part of their employment agreement. Contracts with Vendors & Consultants As part of the contracts the CMRITO enters into with vendors and consultants, the CMRITO requires that they acknowledge that they are bound by the confidentiality provisions set out in section 36 of the Regulated Health Professions Act, 1991, as well as the CMRITO Privacy Code. Disclosure of Personal Health Information by Complainants As part of the CMRITO’s complaints process, the Inquiries, Complaints and Reports (ICR) Committee may require the disclosure of a complainant’s personal health information in order to investigate their complaint. To facilitate this, the complainant (patient) is provided with a form to sign in order to authorize the disclosure of their personal health information to CMRITO to assist with the investigation of their complaint. The CMRITO Consent to Disclosure Form can be viewed at this link. For example, in order to determine whether a registrant followed facility protocol in the performance of an examination, a panel of the ICR Committee may need to review the patient’s requisition, the diagnostic images captured by the CMRITO as part of the performance of the procedure, and the radiologist’s report. This information would only be requested (and later reviewed) by a panel of the ICR Committee with the patient’s consent. Information and Records Management The CMRITO has developed a comprehensive Records and Information Policy and program. The Records and Information Management Procedures Manual establishes clear organizational standards for the management of records and information from creation to disposal or permanent retention. The Records and Information Policy promotes the efficient creation, use, maintenance, retention and disposal of records and information and ensures that records and information is retained or disposed of according to legal and statutory requirements. The information security program of the College is a comprehensive program that integrates policies for information security with procedures to maintain the integrity and availability of records and information and information processing facilities. This program also includes information technology specific procedures
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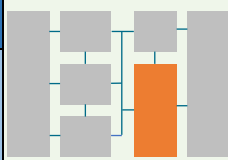
	to support the above policy requirements and an online operational manual that establishes standards and guidelines for College staff related to operationalizing some of the policy requirements. In addition to these policies and programs the CMRITO has integrated industry best practices for the security of the IT systems used by the College. These systems are monitored for intrusion and CMRITO follows best practice for system access and has implemented a number of controls including appropriate authentication for access.
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DOMAIN 5: REGULATORY POLICIES			
Standard 9			
Policies, standards of practice, and practice guidelines are based in the best available evidence, reflect current best practices, are aligned with changing public expectations, and where appropriate aligned with other Colleges.			
Measure	Required evidence	College response	
9.1 All policies, standards of practice, and practice guidelines are up to date and relevant to the current practice environment (e.g. where appropriate, reflective of changing population health needs, public/societal expectations, models of care,	a. The College has processes in place for evaluating its policies, standards of practice, and practice guidelines to determine whether they are appropriate, or require revisions, or if new direction or guidance is required based on the current practice environment.	The College fulfills this requirement: Yes X Partially ☐ No ☐	
		Insert a link to document(s) that outline how the College evaluates its policies, standards of practice, and practice guidelines to ensure they are up to date and relevant to the current practice environment OR describe in a few words the College’s evaluation process (e.g. what triggers an evaluation, what steps are being taken, which stakeholders are being engaged in the evaluation and how). See narrative below.	
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period?</i> Yes ☐ No ☐	

clinical evidence, advances in technology).	9.1. a. The College has processes in place for evaluating its policies, standards of practice, and practice guidelines to determine whether they are appropriate, or require revisions, or if new direction or guidance is required based on the current practice environment. Yes, the CMRITO has a process in place for evaluating its policies, standards of practice, and practice guidelines to determine whether they are appropriate, or require revisions, or if new direction or guidance is required based on the current practice environment. The CMRITO’s Standards of Practice, which are approved by Council. apply equally to all five specialties: radiography, radiation therapy, nuclear medicine, magnetic resonance, and diagnostic medical sonography. When the College commenced regulating magnetic resonance as a fourth specialty in 2004 and diagnostic medical sonography as a fifth specialty in 2020, the Standards of Practice were updated to include these specialties. The Standards of Practice were also reviewed and revised when the scope of practice statement and controlled acts authorized to the profession were amended in 2018. CMRITO registrants practice in complex, highly regulated practice environments such as hospitals and independent health facilities (IHF) subject to their own legislative requirements. As such, the CMRITO Standards of Practice are intended to be generic, acknowledging that the method for implementing a certain task may be determined by facility and/or departmental policies and procedures. In this way, the CMRITO Standards of Practice remain current despite changes in practice environments. The CMRITO has developed a series of publications called “What you must know about ...” or “WYMKA.” These publications, which are available on the CMRITO website, here explain the legal requirements regarding the practice of medical radiation and imaging technology in plain language, and also provide detailed practice guidelines to assist registrants in providing safe, effective and ethical care to their patients. WYMKAs are updated as required, and new WYMKAs are developed as needed to ensure they remain current and relevant to the practice of the profession. The need for new WYMKA documents is identified by the College’s various program areas through the ongoing monitoring of data to identify trends in Professional Conduct or quality assurance, as well as the CMRITO’s Practice Advisors who monitor current practice to identify emerging issues. While WYMKAs are prepared by College staff, members of the committees of the College and Council members also provide their input and expertise in the development process. Depending on the topic of the WYMKA, other stakeholders such as patients, are also consulted in the process of developing the guideline. For example, the WYMKA ... communicating with patients was developed in consultation with a patient and their family who had lived experience of receiving diagnostic services. The patient engagement in this initiative provided a unique perspective on the patient experience and the family’s input significantly improved the final guideline. In addition to WYMKAs, the CMRITO produces webinars and videos that can be viewed at this link. These webinars have been developed as an alternate learning medium to provide context and engage with registrants in a more interactive manner to clarify practice expectations and requirements. Recently, the CMRITO implemented a new section in its quarterly newsletter publication “Insights” titled “That’s a good question” where emerging issues are discussed and explained for registrants.
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	b. Provide information on when policies, standards, and practice guidelines have been newly developed or updated, and demonstrate how the College took into account the following components: i. evidence and data, ii. the risk posed to patients / the public, iii. the current practice environment, iv. alignment with other health regulatory Colleges (where appropriate, for example where practice matters overlap) v. expectations of the public, and vi. stakeholder views and feedback.	The College fulfills this requirement: Yes ☒ Partially ☐ No ☐ For two recent new policies or amendments, either insert a link to document(s) that demonstrate how those components were taken into account in developing or amending the respective policy, standard or practice guideline (including with whom it engaged and how) OR describe it in a few words. Link to the consultation page for the CMRITO https://www.cmrito.org/programs/consultations/ Link to Bylaw 60 https://www.cmrito.org/pdfs/by-laws/by-law-60.pdf <i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>
	9.1.b. Provide information on when policies, standards, and practice guidelines have been newly developed or updated When changes or revisions to substantive standards, bylaws or practice guidelines are required, the College engages in research to ensure that the latest evidence, data and pertinent changes in the current practice environment are considered. In addition to considering these variables, stakeholder engagement using a variety of engagement strategies is also undertaken. The College has developed a dedicated consultation page on our website to facilitate gathering input and feedback from registrants, other regulatory colleges and the public. Two examples of recent changes to the standards of practice and Bylaws were: 1. Revisions to the CMRTO Standards of Practice and Code of Ethics In November 2017 the CMRTO posted a consultation on the website proposing revisions to the CMRTO Standards of Practice and Code of Ethics in preparation for the regulation of diagnostic medical sonographers with CMRTO. One of the key objects of the College is to develop, establish and maintain standards of practice to assure the quality of the practice of the profession. The Standards of Practice set out the minimum requirements for professional practice and conduct for registrants of CMRITO and apply at all times and in all practice settings. The College circulated a survey to all medical radiation technologists, diagnostic medical sonographers, other health professionals and members of the public to get feedback regarding the revisions that were proposed and to identify any significant changes in practice. This consultation provided Council with information regarding changes in the practice environment, provided opportunity for other health regulatory Colleges to provide input, to ensure alignment with other College’s practice matters, and provided a mechanism to include other stakeholder views and feedback. 2. Bylaw update In September 2018, the Council of the CMRTO committed to review and update the by-laws to improve plain language and format. Updating the by-laws was also part of the CMRTO’s Transparency Implementation Plan. The goal was to take the current eight by-laws and combine them into one by-law that is more accessible and easier to understand to improve transparency. Transparency has been a priority for the College for quite some time. In 2014, the Ministry of Health and Long-Term Care directed all	

	health regulatory colleges in Ontario to make transparency a priority and make tangible strides to continually increase transparency in College processes and decision-making. Another key purpose of updating the Bylaw was the preparation for the change of the CMRTO to the CMRITO, and the regulatory and governance changes associated with regulating the specialty of diagnostic medical sonographers. Commencing on January 1, 2018 the CMRTO began registering diagnostic medical sonographers. The by-laws were also amended to integrate this new specialty into the College. As part of the research and activities to ensure that Council was familiar with the latest governance best practices and legal requirements, Council conducted a workshop before identifying the new Council composition. The changes that were made to Bylaw 60 are: • providing for six electoral districts: one district for each of the five specialties of medical radiation and imaging technology, and one member-at-large elected from the entire membership. • Changing the previous elected faculty Council position to a competency-based appointment of an academic councillor. • Reducing the total number of professional members on Council by one with an aim to have equal numbers of public and professional Councillors. This reflects the governance best practice to move to a smaller Council size with a more balanced professional/public ratio. This change resulted in Council being composed of equal numbers of professional and public members for a period of time until the number of public members was reduced. • Expanding the criteria for ineligibility for election or appointment to Council and/or Committees of the CMRITO. Individuals who are employed by a professional association representing the profession are not eligible for election.
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DOMAIN 6: SUITABILITY TO PRACTICE			
Standard 10			
The College has processes and procedures in place to assess the competency, safety, and ethics of the people it registers.			
Measure	Required evidence	College response	
10.1Applicants meet all College requirements before they are able to practice.	a. Processes are in place to ensure that only those who meet the registration requirements receive a certificate to practice (e.g., how it operationalizes the registration of members, including the review and validation of submitted documentation to detect fraudulent documents, confirmation of information from supervisors, etc.) ³ .	The College fulfills this requirement: Yes X Partially ☐ No ☐	
		- Insert a link that outlines the policies or processes in place to ensure the documentation provided by candidates meets registration requirements OR describe in a few words the processes and checks that are carried out: See narrative below. - Insert a link OR provide an overview of the process undertaken to review how a college operationalizes its registration processes to ensure documentation provided by candidates meets registration requirements (e.g., communication with other regulators in other jurisdictions to secure records of good conduct, confirmation of information from supervisors, educators, etc.): See narrative below.	
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>	

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

	10.1.a. Processes and checks are in place to ensure that only those who meet the registration requirements receive a certificate to practice (e.g., how it operationalizes the registration of members, including the review and validation of submitted documentation to detect fraudulent documents, confirmation of information from supervisors, etc.) Yes, processes and checks are in place to ensure that only those applicants who meet the registration requirements receive a certificate of registration. Applicants must successfully complete a medical radiation and imaging technology program in the specialty which meets one of the following criteria: • offered in Ontario and listed in the registration regulation or offered in Ontario and approved by the College Council as equivalent to a listed Ontario program (approved programs in Ontario) • offered outside Ontario and approved by the College Council as equivalent to a listed Ontario program (approved programs in Canada but outside Ontario) • offered outside Ontario and considered by the Registration Committee to be substantially similar, but not equivalent, to an approved Ontario program (programs offered outside Canada) Acceptable proof of program completion includes a copy of an original degree, diploma or certificate (if available), and a copy of transcript of marks, or direct confirmation from the program director in the College’s acceptable format. Prior to 2020 all international applicants were required to submit original or notarized copies of their documents for validation and authentication. Any documents which are not in English or French must be accompanied by an official translation into English. The translation must be an official translation and a notarized copy of the original document was required to be attached. In 2019, the College expanded the use of credential evaluation reports that applicants had already completed through credentialing agencies such as WES, ICAS or the Medical Council of Canada for the authentication and validation of documents from programs where applicants had completed their education. In 2020, as a result of the worldwide pandemic, the CMRITO needed to amend this practice as original or notarized copies were not being accepted due to infection control concerns. As the secure document management website is able to accept files in a variety of formats, applicants were requested to scan the original documents or those that were notarised and upload them. Applicants are also able to take images of their original documents and upload them to the secure site. Registration staff then validate the documents. Should any concerns be identified with documents, the applicants are requested to provide credential evaluation reports in addition to providing the scanned documents or images of the originals. Where applicants had not already completed credential evaluation reports, they were still provided with options such as providing notarized copies of their documents or meeting with CMRITO staff to view original documentation. Applicants also used several alternatives where the usual or official documentation was not available including providing personal declarations, sworn statements and references from former colleagues or supervisors. In addition to this, applicants submitting an application must sign a number of declarations and authorize the CMRITO to contact any authority, institution, association, body or person in any jurisdiction to verify the statements in their application and the related documents. The approved educational programs in Canada undergo an accreditation process through the Health Standards Organization (HSO) Equal Program through Accreditation Canada to achieve accreditation of their program. Graduates of accredited programs in Ontario, which are approved by the CMRITO Council as
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	programs for the purposes of registration in Ontario, are eligible for registration once they demonstrate that they have successfully completed one of the approved programs and one of the approved competency-based certification examinations. Through the accreditation process the CMRITO ensures that students from the approved programs have received the necessary education and training to provide safe and ethical services to patients in Ontario. Applicants must also successfully complete either the examination set by the Canadian Association of Medical Radiation Technologists (CAMRT) for the specialties of radiography, nuclear medicine, magnetic resonance or radiation therapy, or the examination(s) set by Sonography Canada for the specialty of diagnostic medical sonography. These are the examinations approved by the CMRITO Council. These competency -based examinations test that candidates have acquired the necessary competencies as defined the national competency profiles to provide safe care to patients. These competency-based examinations are based on a national competency profile. The national competency profiles are developed by the certification bodies and reflect the required competencies for practice in Canada. The competency profiles are reviewed and approved by the CMRITO Council as the basis of the accreditation process and the national certification examinations. The CMRITO has developed a series of application guides to provide applicants with guidance on how to navigate the online application process and to provide direction on the requirements for registration and the required documentation that must be provided by applicants. The CMRITO website has a series of pages that are set up to provide applicants with information on the registration requirements and the documentation that is required for applicants to demonstrate that they meet the requirements for registration. For international applicants the College has developed a career map that provides step-by-step instructions on the application process, the evaluation process, the registration requirements, and sets out what documentation is required to support an application for registration. The Career Map for Internationally Educated Medical Radiation Technologists can be found here. The CMRITO has developed application guides for each of the categories of applicants that can apply for a certificate of registration which includes information on each of the registration requirements and what information or documentation applicants must provide to demonstrate they meet the requirements: • graduates of approved Ontario educational programs in medical radiation and imaging technology https://www.cmrito.org/pdfs/application-guides/ontario-application-guide.pdf • graduates of accredited educational programs in medical radiation and imaging technology in one of the other provinces in Canada and who have not become registered in a jurisdiction or applicants who have been engaged in the practice of the profession in an unregulated jurisdiction (non-labour mobility) https://www.cmrito.org/pdfs/application-guides/non-labour-mobility-application-guide.pdf • applicants who are currently registered in another regulated jurisdiction in Canada (labour mobility) https://www.cmrito.org/pdfs/application-guides/labour-mobility-application-guide.pdf • applicants who have completed a program in medical radiation and imaging technology outside of Canada. https://www.cmrito.org/pdfs/application-guides/international-application-guide.pdf As the application process is now an online application process, applicants are required to upload copies of their documents to a secure document management system. The CMRITO registration staff review all documentation that has been provided by applicants for completeness and authenticity. These staff members are provided with orientation and training in processing applications and reviewing the documentation that is provided for authenticity. The College has developed specific standardized business processes for reviewing different types of applications. When an application is received, the registration team follows the relevant process to ensure that validated the documentation that has been provided and demonstrates that the registration requirements have been met.
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	The members of the Registration Committee have also received training from WES on how to detect fraudulent documents, and any documents that raise concerns will be sent to a credentialling agency such as WES or ICAS for validation of the program and confirmation of the graduation of the applicant from that program. 10.1.a. continued - Provide an overview of the process undertaken to review how a college operationalizes its registration processes to ensure documentation provided by candidates meets registration requirements (eg. communication with other regulators in other jurisdictions to secure records of good conduct, confirmation of information from supervisors, educators, etc.): In addition to the above there are a number of other operational processes that are used to ensure documentation provided by applicants meets the registration requirements. CMRITO obtains confirmation directly from Program Directors for Ontario graduates of approved programs who apply for a certificate of registration. The Program Director confirms that a student has successfully completed their program in medical radiation and imaging technology and attests that their validation is evidence of each applicant’s successful completion of one of the approved programs in medical radiation and imaging technology. Where an applicant has provided information relating to their recent practice, if there are any concerns or questions, the CMRITO will contact the supervisor who has completed the certificate of competence to validate the information that has been provided. As described above all applicants for registration with the CMRITO are required to complete one of the approved examinations in the specialty for which they are applying. The CMRITO has an agreement with the certification examination providers and the results from each examination sitting are sent directly to the CMRITO. In this way the College is able to validate the examination results that are provided by the applicant to support their application for registration. Medical radiation and imaging technologists who are currently registered by a regulatory authority in a province other than Ontario and to whom Canadian labour mobility provisions may be applicable do not need to provide proof of program completion or proof of passing the approved examinations. They are however required to provide a certificate from the out-of-province regulatory authority of every jurisdiction where they currently hold an out-of-province certificate of registration. This certificate must establish, to the satisfaction of the CMRITO, that they are in good standing in that jurisdiction. When an application is received from an applicant who is currently registered in another regulated jurisdiction, the CMRITO receives an out of province certificate directly from the other provincial regulator. The CMRITO is a member of the Alliance of Medical Radiation and Imaging Technologists of Canada (AMRITRC). The AMRITRC is a group of provincial regulators, who collaborate regarding the regulation of medical radiation and imaging technologist to enhance safe, competent, and ethical care for Canadians. The six MRIT regulatory authorities in the AMRITRC have agreed to use a standard out of province certificate for MRITs who hold a current registration in another regulated jurisdiction. The certificate includes information on: • Name of worker • Registration status • Type of certificate of registration including the specialty(ies) in which they are registered • Any protected title the worker is entitled to use • Any terms, conditions or limitations on the certificate of registration
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	• Good character information such as ○ current referrals to the Discipline Process/Committee ○ past findings of professional misconduct ○ any other information relating to the worker’s competency, conduct or character	
	b. The College periodically reviews its criteria and processes for determining whether an applicant meets its registration requirements, against best practices (e.g. how a College determines language proficiency).	The College fulfills this requirement: Yes ☒ Partially ☐ No ☐
		• Insert a link that outlines the policies or processes in place for identifying best practices to assess whether an applicant meets registration requirements (e.g. how to assess English proficiency, suitability to practice etc.), link to Council meeting materials where these have been discussed and decided upon OR describe in a few words the process and checks that are carried out. See narrative below • Provide the date when the criteria to assess registration requirements was last reviewed and updated.
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☒ No ☐</i>

	10.1.b. The College periodically reviews its criteria and processes for determining whether an applicant meets its registration requirements, against best practices Yes, the College periodically reviews its criteria and processes for determining whether an applicant meets its registration requirements, against best practices. The review of registration criteria is an ongoing process. As part of the annual reporting to the Office of the Fairness Commissioner of Ontario (OFC) the entire registration process is reviewed annually to evaluate if the registration processes and practices are fair, impartial, transparent and objective. A link to the last review completed for the OFC can be found here. The College has completed a number of directed evaluations of specific registration criteria in the past including: • Conducting an independent analysis of the necessity and relevance of the requirements for practical training and/or work experience, including any practicum, mentorship, internship or residency requirements • Completing a comprehensive research project to determine the required cut scores on a number of language fluency tests to determine the occupational communicative competencies required for safe practice in medical radiation and imaging technology and to determine the minimum required scores for applicants on selected language fluency tests. The project resulted in additional language fluency tests being approved for use by applicants and through active collaboration with other regulators of medical radiation technologists in Canada and the national association for medical radiation technologists (CAMRT), standardization was achieved across Canada on the tests and scores that are approved for assessment of language fluency. • Participating in a project with the national association of medical radiation technologists (CAMRT) and other regulators of medical radiation technologists to standardize the process for evaluation of the competence of applicants who apply for registration in jurisdictions across Canada. The CMRITO is a member of the Alliance of Medical Radiation and Imaging Technologists of Canada (AMRITRC). The AMRITRC is a group of provincial regulators, who collaborate regarding the regulation of medical radiation and imaging technologist to enhance safe, competent, and ethical care for Canadians. The six MRIT regulatory authorities in the AMRITRC have aligned registration processes to reflect best practices across Canada, in order to facilitate the free movement of medical radiation and imaging technologists under the labor mobility provisions of the Canadian Free Trade Agreement (CFTA). This group continually collaborates to ensure that criteria and processes that are used for registration reflect best practices. The CMRITO, as part of our ongoing continuous quality improvement activities, monitors changes in practices and processes within the larger regulatory industry. The CMRITO supports College staff and Council and committee members to attend conferences and seminars, related to the regulation of health professionals, to keep abreast of changes. to network and to collaborate to identify best practices. The CMRITO monitors and reviews the Exemplary Practices Database Office of the Fairness Commissioner (OFC)to identify commendable registration practices that are listed in the database. The College maintains membership with a number of organizations to garner knowledge about changes in best registration practices. This includes membership in organizations such as: • Ontario Regulators for Access to Care (ORAC) registration working group • Council on Licensure, Enforcement and Regulation (CLEAR) • The Canadian Network of Agencies of Regulation (CNAR)
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	Health Professions Regulators of Ontario (HPRO) On January 1, 2020 the Medical Radiation and Imaging Technology Act, 2017 (the MRITA) came into force. The MRITA changed the name of the CMRTO to the College of Medical Radiation and Imaging Technologists of Ontario (CMRITO) and changed the name of the profession to the profession of medical radiation and imaging technology. The CMRITO Council conducted an extensive review of the existing registration regulation with respect to best practices in regulation and circulated proposed changes to the regulation to members and stakeholders for comment. Following a review of the comments, Council in 2020 approved the new Registration Regulation to be made under the MRITA. The proposed Registration Regulation refers to the new name of the profession and streamlines the regulation so that it reflects the consistency of the registration requirements for all five specialties that are regulated by the CMRITO – radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography. It expands the information applicants and members must provide regarding their past and present conduct, consistent with amendments made to the Health Professions Procedural Code. The proposed regulation is consistent with the government’s policy of transparency and requires applicants and members to provide information regarding conduct matters, if any, related to their practice of a non-health profession, both in Ontario and in other jurisdictions. The new Registration Regulation is waiting for final approval by government to come into force.	
10.2Registrants continuously demonstrate they are competent and practice safely and ethically.		The College fulfills this requirement: Yes ☒ Partially ☐ No ☐
		- Insert a link to the regulation and/or internal policy document outlining how checks are carried out and what the currency and other requirements include, link to Council meeting materials where documents are found and have been discussed and decided upon OR provide a brief overview: https://www.cmrito.org/programs/consultations/ See narrative below - List the experts / stakeholders who were consulted on currency: Council, Registration Committee, AMRITRC, professional associations, public consultation - Identify the date when currency requirements were last reviewed and updated: - Describe how the College monitors that registrants meet currency requirements (e.g. self-declaration, audits, random audit etc.) and how frequently this is done. The CMRITO monitors that registrants meet currency requirements annually through self declaration with individual follow up as necessary. Please see narrative below for more information.

	a. Checks are carried out to ensure that currency ⁴ and other ongoing requirements are continually met (e.g., good character, etc.).	<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes Y No Y</i>
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⁴ A ‘currency requirement’ is a requirement for recent experience that demonstrates that a member’s skills or related work experience is up-to-date. In the context of this measure, only those currency requirements assessed as part of registration processes are included (e.g. during renewal of a certificate of registration, or at any other time).

	10.2.a. Checks are carried out to ensure that currency and other ongoing requirements are continually met Yes, the CMRITO carries out checks to ensure that registrants continuously demonstrate they are competent to practice safely and ethically. Under the <i>Regulated Health Professions Act</i>, all CMRITO registrants are required to renew their registration each year in order to be legally authorized to practise the profession of medical radiation and imaging technology in Ontario. It is a condition on every registrant’s certificate of registration that they must be educated and experienced in every area in which they practice. CMRITO registrants are authorized to practise in more than one specialty provided they have satisfied the registration requirements for each specialty and are registered in each specialty. It is a condition of a specialty certificate of registration that, within every five year period after issuance of the certificate a registrant must engage in competent practice as a medical radiation and imaging technologist in at least one of the specialties in which they hold a certificate of registration. There are a number of additional conditions of registration that a registrant attests to at the time of annual renew their certificate of registration. Registrants attest that they meet the following conditions during the renewal process. The conditions of registration include: • Registrants must provide the College with details of any of the following that relates to them ○ A finding of guilt for any offence, including any criminal offence and any offence related to the regulation of the practice of the profession. Offences relate to findings of guilt made by a court that are typically punishable by a fine or jail term. ○ A finding of professional misconduct, incompetency or incapacity, in Ontario in relation to another health profession or in another jurisdiction in relation to the profession or another health profession ○ If they are the subject of an investigation or a proceeding involving an allegation of professional misconduct, incompetency or incapacity, in Ontario in relation to another profession or in another jurisdiction in relation to the profession or another health profession • registrants must maintain professional liability insurance or protection against professional liability in accordance with the requirements set out in the by-laws of the College if they are engaging in the practice of medical radiation and imaging technology. Registrants also attest to a number of declarations at renewal to confirm compliance with ongoing requirements such as: • Participation in the College's Quality Assurance Program each year and an attestation that they understand the requirements of the Quality Assurance Program and are in compliance, • Acknowledge agreement to comply with all requirements under the legislation and the Standards of Practice • Acknowledgement to only use the appropriate protected titles in their practice • Agreement to pay the annual renewal fees and update personal information as required by the bylaws • Acknowledgement of an understanding that information that is designated as public information in the bylaws will be posted on the public register of members • Acknowledgement that the CMRITO uses personal information provided by a member for regulatory purposes and as described in the CMRITO Privacy Code
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10.3Registration 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 ☒ Partially ☐ No ☐
		- Insert a link to the most recent assessment report by the OFC OR provide summary of outcome assessment report: https://www.cmrito.org/pdfs/reports/Revised-Assessment-Report-CMRTTO.pdf See narrative below - Where an action plan was issued, is it: Completed ☐ In Progress ☐ Not Started ☐ No Action Plan was Issued ☒
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☒</i>

	10.3.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 CMRTO had no recommendations or actions for improvement from its most recent Audit by the Office of the Fairness Commissioner (OFC). The CMRTO filed a Fair Registration Practices Report with the Office of the Fairness Commissioner (OFC) on March 1, 2020 regarding registration practices for 2019. The CMRTO also filed a Registration Practices Assessment Report on August 30, 2018 with the OFC. In the Registration Practices Assessment Report filed on August 30, 2018, the OFC conducted a full assessment of the registration practices of CMRTO using a three-year assessment cycle for 2016-2018. The OFC assessed and determined that CMRTO demonstrated all of the practices in the following specific-duty areas: • Information for applicants • Timely decisions, responses and reasons • Internal review or appeal processes • Information to applicants on appeal rights • Documentation of qualifications • Internal training for College's staff • Access to applicants records The OFC assessed and determined that CMRTO has also demonstrated that it fulfills all of the general duty principles: transparency, objectivity, impartiality and fairness. The assessment report made no recommendations for improvement and noted a number of commendable practices in connection with the general duty of fairness. The report can be viewed at this link https://www.cmrito.org/pdfs/reports/Revised-Assessment-Report-CMRTO.pdf The OFC previously noted one of CMRTO’s commendable practices for other regulators who want to analyze the rationale for their registration requirements. The example deals with language benchmarks. The CMRTO completed a research project to analyze its language requirements. Its English Language Proficiency Standards project evaluated the College's language requirements for internationally educated medical radiation technologists.
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Standard 11		
The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.		
Measure	Required evidence	College response
11.1The College supports registrants in applying the (new/revised) standards of practice and practice guidelines applicable to their practice.	a. Provide examples of how the College assists registrants in implementing required changes to standards of practice or practice guidelines (beyond communicating the existence of new standard, FAQs, or supporting documents).	The College fulfills this requirement: Yes X Partially ☐ No ☐
		- Provide a brief description of a recent example of how the College has assisted its registrants in the uptake of a new or amended standard: See the description below of the resources that are used to assist registrants in applying the standards of practice or practice guidelines to their practice - Name of Standard – Regulation of almost 4,000 new registrants – Diagnostic Medical Sonographers - Duration of period that support was provided – Started in 2019 and is ongoing - Activities undertaken to support registrants – See description below % of registrants reached/participated by each activity – Numbers of registrants reached is tracked in the balanced scorecard which is available as part of the Council materials and is reported on quarterly - Evaluation conducted on effectiveness of support provided – The CMRITO Council monitors the uptake and use of resources that are developed and used by members in the balanced scorecard which is available as part of the Council materials and is reported on quarterly. The QA Committee monitors compliance with the QA program requirements for self-assessment based on the CMRITO’s standards of practice - Does the College always provide this level of support: Yes X No ☐ <i>If not, please provide a brief explanation:</i>
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>

	11.1. a. Provide examples of how the College assists registrants in implementing required changes to standards of practice or practice guidelines Commencing on January 1, 2018 the College began registering members in a fifth specialty, diagnostic medical sonography, and on January 1, 2020 registration with the CMRITO was mandatory for all diagnostic medical sonographers practising in Ontario. Almost 4,000 new registrants were registered in this specialty by January 2020. These new registrants are new to regulation and the obligations and accountabilities of self-regulated professionals in Ontario. For these new registrants, a variety of tools were employed to disseminate the information necessary to support successful implementation of the updated standards of practice and practice guidelines to ensure safe, competent care by registrants. In addition to supporting the education of this cohort of new registrants, existing registrants in the other four specialties still require information to support expectations for practice. The resources available to assist registrants in applying the standards of practice or practice guidelines to their practice include: • Practice advisory service: The CMRITO provides one on one consultation services for registrants who have questions or require assistance with practice related matters. Registrants are able to call and connect with a practice advisor, send an email to the dedicated practiceadvice@cmrito.org mailbox or use the contact us feature on the website to submit questions and requests for advice around the legislated requirements and standards of practice for MRITs. • Website and Social Media: The CMRITO website also has a dedicated page for professional practice that includes links to important practice documents and other resources. https://www.cmrito.org/programs/professional-practice/. In addition to the professional practice page, in response to changes in the practice environment due to the pandemic, in 2020 to provide practice supports for registrants, the CMRITO developed a dedicated webpage with links to COVID resources https://www.cmrito.org/static-resources/covid-19/. To alert registrants to changes on the website and to advise them about important information, CMRITO has made extensive use of social media platforms including Facebook, LinkedIn and Twitter. • Newsletter: The CMRITO has a digital newsletter, “Insights” that is produced at least three times per year to update registrants about the activities of the College, provide important updates on changes and provide other pertinent information. A new feature in the newsletter “That’s a good question” addresses specific topics that have been identified as topics that require further clarification for registrants. The latest and past copies of Insights can be found here. • What You Must Know About.... (WYMKA): The CMRITO publications ‘What you must know about ...’, or ‘WYMKA’ explain legal requirements regarding the practice of medical radiation and imaging technology in plain language, and also provides detailed practice guidelines to assist members in providing excellent care to their patients, such as those found in ‘What you must know about ... communicating with patients’. The CMRITO has developed a series of WYMKA’s for a number of topics which can be found here. • Webinars: The CMRITO recognizes that everyone learns in different ways and that having resources in media, other than written documents is important to address these different learning needs. To that end the CMRITO has developed a number of webinars and videos to provide registrants with an alternative method of support and to promote understanding of requirements and guidelines. The CMRITO website has a page where this material is available to registrants which can be accessed here. • Annual Quality Assurance Program: Each year, a registrant is required to complete a self-assessment based on the CMRITO’s standards of practice, including the Practice Standards and the Indicators related to each Practice Standard. Registrants are required to assess their individual practice
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	against a minimum of two of the eight Practice Standards and the Indicators related to that Practice Standard applicable to the registrant's specialty, using an online self-assessment tool. A registrant may identify opportunities to enhance their knowledge of particular Practice Standards and Indicators through this annual self assessment and reflection process. • Jurisprudence Course: All applicants, and registrants who are reinstating their membership, are required to complete an online jurisprudence course and quiz that is available on the CMRITO website here. Registrants have access to the jurisprudence course and quiz through their online QA portfolio and completion of the eight learning modules can be used by registrants as part of their continuing education. The eight learning modules are designed as an overview of relevant regulations and laws. • In person workshops and townhalls: The CMRITO has always valued face to face interactions with registrants to update them on important changes. The Registrar & CEO has conducted a number of in-person province wide workshops and presentations for registrants over the past 10 years. These presentations have provided a vehicle to interact with registrants and provide a forum for addressing questions about important upcoming changes. The regulation of diagnostic medical sonographers and the changes to the scope of practice statement and controlled acts would be examples of the focus of the latest presentations. In 2020, the Deputy Registrar had planned a series of day long interactive workshops based on the standards of practice. One workshop was conducted in Toronto before the pandemic began. These workshops will be developed using online options in 2021. • Conference Booth: The CMRITO has over the last 5 years attended conferences related to the profession and has set up a booth that is staffed by the professional staff and Council members. The booth provides a mechanism to interact with registrants attending the conference to address questions and provide registrant support. Attendance at the conference also enable professional staff to remain current regarding practice and industry changes.		
11.2The College effectively administers the assessment component(s) of its QA	<table border="1"> <tr> <td data-bbox="739 938 1284 1380"> a. The College has processes and policies in place outlining: i. how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice; ii. details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity (and </td><td data-bbox="1284 938 2486 1380"> The College fulfills this requirement: Yes ☒ Y Partially ☐ No ☐ • List the College's priority areas of focus for QA assessment and briefly describe how they have been identified OR link to website where this information can be found: Information on the QA program and the assessment methods can be found on the website at https://www.cmrito.org/programs/quality-assurance-program/ The resources available to registrants can be viewed by clicking on these links https://www.cmrito.org/programs/quality-assurance-program/qa-resources/ Quality Assurance Program Handbook Quality Assurance Peer and Practice Assessment Handbook </td></tr> </table>	a. The College has processes and policies in place outlining: i. how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice; ii. details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity (and	The College fulfills this requirement: Yes ☒ Y Partially ☐ No ☐ • List the College's priority areas of focus for QA assessment and briefly describe how they have been identified OR link to website where this information can be found: Information on the QA program and the assessment methods can be found on the website at https://www.cmrito.org/programs/quality-assurance-program/ The resources available to registrants can be viewed by clicking on these links https://www.cmrito.org/programs/quality-assurance-program/qa-resources/ Quality Assurance Program Handbook Quality Assurance Peer and Practice Assessment Handbook
a. The College has processes and policies in place outlining: i. how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice; ii. details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity (and	The College fulfills this requirement: Yes ☒ Y Partially ☐ No ☐ • List the College's priority areas of focus for QA assessment and briefly describe how they have been identified OR link to website where this information can be found: Information on the QA program and the assessment methods can be found on the website at https://www.cmrito.org/programs/quality-assurance-program/ The resources available to registrants can be viewed by clicking on these links https://www.cmrito.org/programs/quality-assurance-program/qa-resources/ Quality Assurance Program Handbook Quality Assurance Peer and Practice Assessment Handbook		

Program in a manner that is aligned with right touch regulation ⁵ .	which type if multiple assessment activities); and iii. criteria that will inform the remediation activities a registrant must undergo based on the QA assessment, where necessary.	Quality Assurance Individual Practice Assessment Framework and Guidelines, 2021 The College randomly selects a percentage of registrants in each of the five specialties to undergo a QA assessment each year. These assessments for random selection include an assessment of the registrant’s QA Portfolio, or an Independent Practice Assessment using a Multi-Source Feedback System that includes a self, peer and co-worker, and patient assessment. The Council approves the percentage of members that are assessed each year, based on the recommendations of the QAC, which may include a targeted assessment or prioritization of areas of focus. As Council has approved that 20% of the registrants are required to undergo a QA assessment each year for the past few years, effectively each registrant is required to undergo an assessment at least once every five years. Registrants are also required to complete a number of declarations regarding their participation in the QA program each year at the time of their annual renewal of registration. Where registrants have attested that they have not complied with the requirements of the QA program, further follow-up and assessment is triggered through this process. Is the process taken above for identifying priority areas codified in a policy: Yes X No ☐ <i>If yes, please insert link to policy</i> The requirements for the QA program are set out in the Quality Assurance Regulation (<i>Ontario Regulation 375/12</i>) made under the <i>Medical Radiation and Imaging Technology Act, 2017</i> https://www.ontario.ca/laws/regulation/120375 In accordance with the requirements of the QA Regulation, Council has developed the following policies respecting the selection of members for participation in the QA program annually. Policy 7.1 Quality Assurance Portfolio Percentage of Members Policy 7.2 Peer and Practice Assessment by MSF or by an Assessor Percentage of Members Policy 7.3 Random selection without replacement Policy 9.2 Members who resign or reinstate during a QA assessment cycle
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⁵ “Right touch” regulation is an approach to regulatory oversight that applies the minimal amount of regulatory force required to achieve a desired outcome. (Professional Standards Authority. Right Touch Regulation. <https://www.professionalstandards.org.uk/publications/right-touch-regulation>).

		- Insert a link to document(s) outlining details of right touch approach and evidence used (e.g. data, literature, expert panel) to inform assessment approach OR describe right touch approach and evidence used: Right Touch Regulation 2019 – Presentation to the Quality Assurance Committee Provide the year the right touch approach was implemented OR when it was evaluated/updated (if applicable): The right touch approach was implemented in 2015. The QAC also annually assesses the flowcharts, guidelines and tools that have been developed to assist the QAC in applying the principles of right touch regulation when administering the QA program. As part of their ongoing continuous quality improvement activities the QAC regularly evaluates their policies and procedures to determine whether they are appropriate, require revisions, or if new direction or changes are required. CQI changes to the policies and guidelines would be made based on new evidence and data, changes in the practice environment, for alignment with best practices regarding the right touch approach. <i>If evaluated/updated, did the college engage the following stakeholders in the evaluation:</i><table><tr><td>– Public</td><td>Yes</td><td>Y</td><td>No</td><td>Y</td></tr><tr><td>– Employers</td><td>Yes</td><td>Y</td><td>No</td><td>Y</td></tr><tr><td>– Registrants</td><td>Yes</td><td>Y</td><td>No</td><td>Y</td></tr><tr><td>– other stakeholders</td><td>Yes</td><td>Y</td><td>No</td><td>Y</td></tr></table> - Insert link to document that outlines criteria to inform remediation activities OR list criteria: See narrative below for more detail. The policies listed below outline the criteria that are considered to inform remediation activities: Policy 9.4 - Quality Assurance (QA) Portfolio Assessment Policy 9.5 - Quality Assurance (QA) Portfolio Assessments – Fail to submit Policy 9.6 - Quality Assurance (QA) Portfolio Assessment – Fail to meet criteria Policy 9.7 - Peer and Practice Assessment - Multi-Source Feedback (MSF) Assessment: Criteria for members to participate Policy 9.8 - Peer and Practice Assessment - Multi-Source Feedback (MSF) Assessment: Criteria for successful completion Policy 9.9 – Peer and Practice Assessment – Multi-Source Feedback (MSF) Assessment: Fail to Submit	– Public	Yes	Y	No	Y	– Employers	Yes	Y	No	Y	– Registrants	Yes	Y	No	Y	– other stakeholders	Yes	Y	No	Y
– Public	Yes	Y	No	Y																		
– Employers	Yes	Y	No	Y																		
– Registrants	Yes	Y	No	Y																		
– other stakeholders	Yes	Y	No	Y																		

		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes Y No Y</i>
	11.2. The College effectively administers the assessment component(s) of its QA Program in a manner that is aligned with right touch regulation a. The College has processes and policies in place: Yes, the College has processes and policies in place to administer the assessment component(s) of the QA Program in a manner that is aligned with right touch regulation. The Quality Assurance Committee (QAC) has adopted the principles of right touch regulation in the administration of the QA program for the CMRITO. The QAC has completed training on right touch regulation. A link to the presentation can be found here. The right touch methodology that the QAC employs when evaluating QA assessments completed by registrants, includes a thorough assessment of any identified issue before solutions are developed. The QAC is committed to being agile in proposing solutions, after considering the level of risk to the public and ensuring the response is proportional to the issue. • The College has processes and policies in place outlining 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; A right touch regulatory approach is used in multiple levels of the program administration and forms the basis of the principles the QAC uses to complete assessments of the QA activities undertaken by registrants. The QA program has been developed to include escalating levels of assessment to provide targeted and agile options to the QAC as they fulfill their responsibility to administer the program. All registrants of CMRITO are required to complete a QA portfolio each year that includes a self assessment based on the standards of practice of the College, complete a QA profile to describe the registrant’s practice and maintain a record of the continuing education and professional development activities they have completed in that year. The record of the activities includes a reflection component where registrants must identify how the activity contributed to their learning and how that learning improved the quality of their practice. A percentage of registrants are randomly selected each year, or are individually selected by the QAC, to have their QA records (QA Portfolio) assessed. QA assessors appointed by the QAC review the portfolios to ensure they are in compliance with the requirements of the program and will identify any areas of concern. A second element of the QA program where a registrant’s area of practice is assessed is through a peer and practice assessment by means of a multi-source feedback (MSF) assessment. Registrants are randomly selected for assessment or are individually selected by the QAC. The assessment is based on the Standards of Practice and includes a self, peer and patient assessment of a registrant’s practice. QA assessors appointed by the QAC review the results of the MSF assessment to identify any areas of concern with a registrant’s practice. The MSF assessment provides a registrant and the QAC with feedback as a formative or developmental evaluation regarding the registrant’s performance in the practice setting; as a diagnostic tool to evaluate competence to improve the quality of a registrant’s practice; and lastly as a screening tool to identify areas of practice that require reflection, further assessment, continuing education or remediation. Any areas of concern that are identified through the assessment of the QA portfolios and MSF assessments are brought to the QAC for evaluation and determination of next steps. The escalation processes that the QAC could employ are documented in flowcharts that enable the QAC to employ a structured, consistent, proportionate approach to reach a decision and supports accountability for their decisions. Where the QAC has concerns with a registrant’s practice a further individual practice assessment (IPA) by means of an assessor can be implemented. The IPA is a diagnostic tool that is implemented when the screening tools identify areas where further assessment is required in relation to a registrant’s practice.	

	The policies outlining 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 are listed below and can be viewed by clicking on the links: Policies • Policy 9.4 - Quality Assurance (QA) Portfolio Assessment • Policy 9.5 - Quality Assurance (QA) Portfolio Assessments – Fail to submit • Policy 9.6 - Quality Assurance (QA) Portfolio Assessment – Fail to meet criteria • Policy 9.7 - Peer and Practice Assessment - Multi-Source Feedback (MSF) Assessment: Criteria for members to participate • Policy 9.8 - Peer and Practice Assessment - Multi-Source Feedback (MSF) Assessment: Criteria for successful completion • Policy 9.9 – Peer and Practice Assessment – Multi-Source Feedback (MSF) Assessment: Fail to Submit In addition to these policies the QA Committee has developed the following processes to support the above policies. Processes • Flowchart and Guidelines: QAP – require the member to complete a QA Portfolio • Flowchart and Guidelines: QAP – member failed to submit • Flowchart and Guidelines: QAP – member failed to meet criteria • Flowcharts and Guidelines MSF assessment • Flowchart and Guidelines: MSF Assessment – assessment criteria • Flowchart and Guidelines: MSF Assessment – failed to submit • Flowchart and Guidelines: QAP –require member to complete a SCERP • The College has processes and policies in place outlining details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity (and which type if multiple assessment activities); and The College’s process to determine which registrants will undergo an assessment activity begins with a random selection of registrants who are selected for assessment of their participation in the program each year. Registrants are selected to undergo an assessment of either their QA portfolios or an assessment of their practice, based on the standards of practice, by an MSF assessment. The CMRITO Council at the December 2019 meeting approved the random selection of 20% of the registrants for assessment in 2020 and in December 2020 approved 20% of the registrants for assessment in 2021. At these levels of monitoring, it is anticipated that the entire registrant pool will be selected for assessment at least once in a five-year period. The QAC and Council monitors the practice environment and uses evidence to inform decisions around which assessment activities registrants will undergo. As an example, in 2020 the Ontario government declared a provincial state of emergency due to the COVID-19 pandemic. In March 2020, the QA Committee met and reviewed the challenges members were facing with increased infection prevention protocols, increased work in some areas, reduced patient appointments and service closures in others. The QAC reviewed the issues that members would face participating in an MSF assessment under these conditions. Since the MSF patient surveys are paper-based, members would be facing added challenges in distributing and gathering paper information from patients while maintaining the required COVID-19 protocols. The QA Committee therefore put forth a recommendation to Council to delay or cancel the MSF assessments for the year 2020, and to delay running the April 2020 QA Portfolio random selection until later in the year.
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	The QAC has developed criteria for the assessment of the QA portfolios and participation in the MSF program which uses an evidence informed approach to determine which registrants will undergo an assessment activity. Based on the evidence provided by registrants regarding their practice, adjustments can be made for those who don't meet the criteria to still undergo assessment. For example, where a registrant is not engaged in frontline patient care, if they are selected for participation in the MSF assessment, which includes self, peer and patient assessments, the QAC may determine to rely upon the self and peer assessments or may require the registrant to undergo a portfolio assessment in lieu of completing the MSF assessment. This demonstrates an evidence informed approach to determine which registrants undergo what kind of assessment based on their practice in the profession. Another example of where the QAC has exercised the principles of right touch regulation in assisting registrants to comply with the requirements of the program is appointing a mentor to meet with selected registrants who have been identified through the screening assessment processes. The purpose of appointing a mentor is to coach and support registrants to understand their obligations and accountabilities as self regulated professionals in Ontario, rather than directly referring the registrant to the ICRC. The resulting compliance of these registrants with the QA Program requirements is evidence of the success of this approach. The policies outlining details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity are listed below and can be viewed by clicking on the links: Policies • Policy 9.6 - Quality Assurance (QA) Portfolio Assessment – Fail to meet criteria • Policy 9.8 - Peer and Practice Assessment - Multi-Source Feedback (MSF) Assessment: Criteria for successful completion In addition to these policies the QA Committee has developed the following processes to support the above policies. Processes • Flowchart and Guidelines: MSF Assessment – assessment criteria • Flowchart and Guidelines: QAP –require member to complete a SCERP • Flowchart and Guidelines: QAP – member failed to meet criteria • The College has processes and policies in place outlining the criteria that will inform the remediation activities a registrant must undergo based on the QA assessment, where necessary. Criteria have been developed that inform what remediation activities may be required based on the outcomes of a QA assessment. The CMRITO has not developed a specific policy outlining the types of remediation activities, as these activities vary and are dependant on the type of QA assessment that has been completed and the circumstances of each situation. The policies listed below identify where in the process of administering each of the different QA assessment methods, remediation activities are considered and would take place. The QAC has developed flowcharts for possible pathways to identify the required remediation activities where registrants don't meet the criteria for compliance with the program requirements through the assessment they have completed or where they have not complied with the requirements of the program. These flow charts support the QAC policies, which are based on the requirements in the QA regulation. An example of a process that identifies registrants who may not meet the criteria for compliance with the QA program is one that touches each registrant each year at the time of their annual renewal of registration. Each registrant is required to complete a number of declarations each year as part of this process. This component of the QA program assesses whether members understand their obligations with respect to participation in the QA program and whether they have
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	complied with the requirements. Where registrants have attested that they have not complied with the requirements of the QA program, further follow-up and assistance by assessors, appointed by the QAC, is initiated. Through this process, registrants who require further evaluation and assistance are identified. Depending on the specific circumstances of the registrant, they may be referred to the QAC committee for evaluation, and to determine whether remediation activities are appropriate in the circumstances. Examples of the criteria that will inform remediation activities for an individual practice assessment are listed in the IPA Handbook, which can be viewed here. A copy of the handbook is provided to any registrants who are required to undergo an IPA to ensure transparency on the process for registrants. Where the QAC has determined that a screening assessment, such as the QA portfolio or MSF, has identified concerns about a registrant’s practice, the QAC determines if they have sufficient information to determine an Outcome Action Plan (OAP) or whether further information is needed. The additional information is gained through completing an IPA. If the concerns about the registrant’s practice are confirmed, the level of risk is then determined using a risk management framework. The level of risk assigned to the concern determines the most appropriate OAP. The policies outlining the criteria that will inform the remediation activities a registrant must undergo, based on each type of QA assessment, are listed below and can be viewed by clicking on the links: Policies • Policy 9.5 - Quality Assurance (QA) Portfolio Assessments – Fail to submit • Policy 9.6 - Quality Assurance (QA) Portfolio Assessment – Fail to meet criteria • Policy 9.8 - Peer and Practice Assessment - Multi-Source Feedback (MSF) Assessment: Criteria for successful completion • Policy 9.9 – Peer and Practice Assessment – Multi-Source Feedback (MSF) Assessment: Fail to Submit In addition to the above policies the QA Committee has developed the following processes to support the above policies. Processes • Flowchart and Guidelines: QAP – member failed to submit • Flowchart and Guidelines: QAP – member failed to meet criteria • Flowchart and Guidelines: MSF Assessment – assessment criteria • Flowchart and Guidelines: MSF Assessment – failed to submit • Flowchart and Guidelines: QAP –require member to complete a SCERP • QA IPA Framework and Guidelines, 2021
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11.3 The College effectively remediates and monitors registrants who demonstrate unsatisfactory knowledge, skills, and judgment.	a. The College tracks the results of remediation activities a registrant is directed to undertake as part of its QA Program and assesses whether the registrant subsequently demonstrates the required knowledge, skill and judgement while practising.	The College fulfills this requirement: Yes ☒ Partially ☐ No ☐ • Insert a link to the College's process for monitoring whether registrant's complete remediation activities OR describe the process: • Insert a link to the College's process for determining whether a registrant has demonstrated the knowledge, skills and judgement following remediation OR describe the process: See narrative below. <i>If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>
	11.3.a The College tracks the results of remediation activities a registrant is directed to undertake as part of its QA Program and assesses whether the registrant subsequently demonstrates the required knowledge, skill and judgement while practising. Yes, the College tracks the results of remediation activities a registrant has undertaken as part of the QA program and assesses whether the registrant subsequently demonstrates the required knowledge, skill and judgement while practising. The College has developed an application for managing the QA program in the College register database. The application has been customized by the QA staff and enables tracking of registrants engaged in the various processes of the QA program, including tracking the progress of remediation activities a registrant is directed to undertake. Registrants are directed to complete remediation activities by the QAC as a result of one of the QA assessment methods. One of the remediation activities a registrant could be directed to undertake includes an independent practice assessment. The QAC have identified a number of assessment methods that the QAC can use to complete an independent practice assessment. Further information on this can be found at this link. Through this process the QAC will identify an outcome action plan (OAP), if appropriate, and direct a registrant to complete the plan. The OAP could include such remedial activities as completing a specific continuing education remedial plan (SCERP), imposing terms, conditions and limitations on a registrant's certificate of registration, or appointing a mentor to support the member in improving the identified area of concern in the member's practice. An example of remediation activities where the results of an assessment are tracked to determine if a registrant who was directed to undertake a remediation activity subsequently demonstrates the required knowledge, skill and judgement while practising, is where a registrant is directed by the QAC to complete a SCERP. The College has developed a jurisprudence course that is available to members in their online QA portfolio. The jurisprudence course includes eight learning modules which are designed as an overview of relevant regulations and laws. On completion of the course, to successfully complete the assessment quiz, a registrant must answer all of the questions correctly. The registrant must repeat the quiz until they achieve 100%. In this way the registrant must have sufficient knowledge of the content to be able to complete the course. If a registrant is directed to complete this course, the result is tracked and will be provided to the QAC as part of their ongoing assessment of compliance with the requirements of the remediation. A second example of a remediation activity where the result of an assessment is assessed and tracked once the remediation activity is completed, is when a mentor is appointed by the QAC to meet with a registrant. Mentors have been appointed from time to time by the QAC when a registrant has submitted a QA portfolio that does not comply with the requirements of the program. The mentor meets with the registrant to provide direction, support and assistance to the registrant in understanding their accountability as a self regulated professional to comply with the QA program requirements. Once the registrant has made	

	submissions to the QAC, the QA portfolio is reassessed to determine if the member is now in compliance and has therefore demonstrated the required knowledge, skill and judgement.	
Standard 12 The complaints process is accessible and supportive.		
Measure	Required evidence	College response
12.1The College enables and supports anyone who raises a concern about a registrant.	a. The different stages of the complaints process and all relevant supports available to complainants are clearly communicated and set out on the College’s website and are communicated directly to complainants who are engaged in the complaints process, including what a complainant can expect at each stage and the supports available to them (e.g. funding for sexual abuse therapy).	The College fulfills this requirement: Yes X Partially No ☐ - Insert a link to the College’s website that describes in an accessible manner for the public the College’s complaints process including, options to resolve a complaint and the potential outcomes associated with the respective options and supports available to the complainant: https://www.cmrito.org/public/complaint-process/. - Does the College have policies and procedures in place to ensure that all relevant information is received during intake and at each stage of the complaints process: Yes Y No The CMRITO has processes, procedures and an electronic checklist to ensure that all relevant information is received during intake and at each stage of the complaints process. One of the values of the College is empathetic intake, and the staff are trained on how to obtain the relevant information from the complainant in a respectful and empathetic manner. The information that is initially required on intake is limited and clearly articulated on the website. This is because complainants to the CMRITO often do not have the name of the registrant they are complaining about. The complainant will have the date, time and location of the procedure the registrant performed on them, and using this information, College staff work with the management of the facility in order to identify the registrant. Once the registrant is identified, College staff send the complaint to the registrant requesting their response in accordance with the processes set out in the RHPA. The CMRITO process also includes sharing the registrant's response with the complainant with a request for their comments. This step has been included for many years since the Health Professions Appeal & Review Board (HPARB) recommended that Colleges include this step in their process. From that point forward the investigation is directed by the ICRC in accordance with the RHPA.

		The CMRITO has developed a Professional Conduct (PC) application in the College Register database. This application has been customised to meet the needs of the PC team for information gathering and case management. At each stage of the process relevant information is recorded and progress on the management of the case is tracked. Does the College evaluate whether the information provided is clear and useful: Yes X No ☐ The CMRITO continually assesses the information that is provided on the website to evaluate whether the information is clear and useful. The CMRITO launched a refreshed website in 2019 as part of the rebranding activities associated with the change in name of the College. As part of the launch of the new website all the content on the website underwent a thorough review for pertinence, clarity and ease of navigation with the site being reorganized to address the needs of the different audiences that access the site. If any feedback is received that identifies an opportunity to improve the clarity of the information on the website, appropriate changes are made. As the website is managed in-house by the communications team, changes that are required can be made expeditiously.
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i> Improvement opportunity While all relevant supports available to complainants are 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, this review identified that the information about the availability of funding for sexual abuse therapy is not on the CMRITO website. Staff will add this information to the website.
		12.1.a. The different stages of the complaints process and all relevant supports available to complainants are clearly communicated and set out on the College’s website and are communicated directly to complainants who are engaged in the complaints process, including what a complainant can expect at each stage and the supports available to them (e.g. funding for sexual abuse therapy). Yes, the different stages of the complaints process are clearly communicated and set out on the College’s website and are communicated directly to complainants who are engaged in the complaints process, including what a complainant can expect at each stage. Information on the College’s complaints process is available on our website under the “Public” tab, here: https://www.cmrito.org/public/complaint-process/. Additional information is also available under the “Programs” tab, here: https://www.cmrito.org/programs/professional-conduct/.

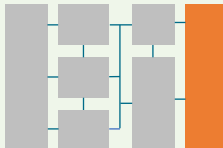
	The same information is communicated directly to individuals who inquire about the CMRITO’s complaints process, and those individuals who choose to proceed in filing a complaint. Process information is provided in the manner requested by members of the public (verbally over the phone, in writing via email, or in writing via hard copy letter). The information that is provided to a complainant can be seen here. If members of the public have questions about the information set out on the CMRITO website or provided to them directly, those questions are answered.	
b. The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary.	The College fulfills this requirement: Yes X Partially ☐ No ☐	
	Insert rate (see Companion Document: Technical Specifications for Quantitative CPMF Measures) 100%	
	<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>	
12.1.b. The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary. Yes, the CMRITO responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary. The CMRITO’s standard response time for inquiries is 2 business days. This includes inquiries made via telephone, email, letter, and social media. It would be highly unusual for a member of the public to wait 5 business days before hearing from a member of the Professional Conduct Team. The same is true even if CMRITO does not have the jurisdiction to investigate the public’s concern. The CMRITO frequently receives inquiries that are under the jurisdiction of the College of Physicians and Surgeons of Ontario (CPSO), the Ministry of Health’s Independent Health Facilities Program (IHFP), and/or the Patient Ombudsman. In addition to confirming that the CMRITO does not have jurisdiction to investigate the concern, CMRITO staff provide members of the public with meaningful referrals within 2 business days.		
c. Examples of the activities the College has undertaken in supporting the public during the complaints process.	- List all the support available for public during complaints process: The CMRITO provides one on one support for complainants - Most frequently provided supports in CY 2020: All inquiries from the public are responded to within 5 business days The College provides meaningful referrals to members of the public who contact us with concerns beyond our jurisdiction (i.e., IHF, Patient Ombudsman, CPSO, etc.) The College provide status updates to complainants as required Staff will provide assistance in taking complaint statements if required The College ensures that intake staff are available to answer phone calls, and communicate with complainants/members of the public in the way that best suits them, etc.	

		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>
	12.1.c. Examples of the activities the College has undertaken in supporting the public during the complaints process CMRITO staff provide support to members of the public at every stage of a complaint including identifying the date of an examination, identifying the member involved so a complaint can be filed. Staff is also available by phone or email to answer questions about the process and provide the support a complainant may require. Staff are also trained in empathetic intake to support complainants through the process. Recent examples include taking a statement and reviewing correspondence over the phone for a complainant who is visually impaired. Staff also spend a significant amount of time on the phone with members of the public answering questions about the process, the standards of practice of the profession and providing meaningful referrals when the public’s concern is not within the CMRITO’s jurisdiction. For example, as CMRITO registrants work within a team of healthcare providers, complaints from the public may relate to roles of other members of that team, that are outside of the practice of members of the profession. When such a concern is raised the member of the public is referred to the most appropriate regulatory college with appropriate contact information when it is known.	
12.2 All parties to a complaint and discipline process are kept up to date on the progress of their case, and complainants are supported to participate effectively in the process.	a. Provide details about how the College ensures that all parties are regularly updated on the progress of their complaint or discipline case and are supported to participate in the process.	The College fulfills this requirement: Yes ☒ Partially ☐ No ☐
		Insert a link to document(s) outlining how all parties will be kept up to date and support available at the various stages of the process OR provide a brief description: See narrative below.
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>
	12.2.a. Provide details about how the College ensures that all parties are regularly updated on the progress of their complaint or discipline case and are supported to participate in the process. Yes, the CMRITO ensures that all parties are regularly updated on the progress of their complaint or discipline case and are supported to participate in the process. In accordance with subsection 28 of the Health Professions Procedural Code (the Code), being Schedule 2 to the Regulated Health Professions Act, 1991, the CMRITO provides statutory notices at certain points during the complaints process. If a complaint is not disposed of within 150 days, both the complainant and the member receive a notice letter advising them of the expected date of disposition. Another notice is sent to both the complainant and the member (and the	

	Health Professions Appeal and Review Board) if a complaint is not disposed of within 210 days. This notice letter includes an expected date of disposition, along with a reason for the delay.	
	In addition to these statutory notices, the CMRITO provides status updates on request. Status updates are provided in the form requested by the party (i.e., verbally by phone or in writing via email and/or hard copy letter).	
	The CMRITO also provides support for any complainant who participates in a hearing as a witness. This includes travel and accommodation expense support as well as support from prosecution counsel in understanding and navigating the hearing process.	
Standard 13		
All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.		
Measure	Required evidence	College response
13.1The College addresses complaints in a right touch manner.	a. The College has accessible, up-to-date, documented guidance setting out the framework for assessing risk and acting on complaints, including the prioritization of investigations, complaints, and reports (e.g. risk matrix, decision matrix/tree, triage protocol).	The College fulfills this requirement: Yes ☒ Partially ☐ No ☐
		- Insert a link to guidance document OR describe briefly the framework and how it is being applied: CMRITO risk assessment framework Interim Order Assessment ICRC Triage Form - Provide the year when it was implemented OR evaluated/updated (if applicable): 2014
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☒ No ☐</i>
	13.1.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.	
	Yes, the CMRITO 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.	
	The CMRITO has developed a framework for assessing risk and acting on complaints which includes prioritizing high-risk matters. This framework includes a risk-based decision-making tool used by the Inquiries, Complaints & Reports Committee as well as a risk based interim order assessment process.	

	The framework can be viewed here . The framework assesses the level of risk of harm on a scale from no risk to high risk with definitions for each level of risk and appropriate outcomes for each level. The assessment framework also allows the ICRC to assess the aggravating and mitigating factors in each case and determine whether those factors impact the risk rating. The outcomes range from no action for no risk complaints, to referrals to Discipline for complaints that have been assessed by the Inquiries, Complaints & Reports Committee to present a high risk of harm to patients.	
Standard 14		
The College complaints process is coordinated and integrated.		
Measure	Required evidence	College response
14.1The College demonstrates that it shares concerns about a registrant with other relevant regulators and external system partners (e.g. law enforcement, government, etc.).	a. The College’s policy outlining consistent criteria for disclosure and examples of the general circumstances and type of information that has been shared between the College and other relevant system partners, within the legal framework, about concerns with individuals and any results.	The College fulfills this requirement: Yes ☒ Partially ☐ No ☐
		- Insert a link to policy OR describe briefly the policy: Disclosure of information related to registrants is shared in accordance with Section 36 of the RHPA - Provide an overview of whom the College has shared information over the past year and purpose of sharing that information (i.e. general sectors of system partner, such as ‘hospital’, or ‘long-term care home’). See narrative below
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period?</i> Yes ☐ No ☐
	14.1.a. The College demonstrates that it shares concerns about a registrant with other relevant regulators and external system partners. Yes, the CMRITO shares concerns regarding registrants with other regulators and external system partners where appropriate and always in accordance with Section 36 of the RHPA. As an example, the CMRITO shares information regarding registrants with other provincial regulators of the profession including otherwise confidential information about complaints received and compliance with the quality assurance program. The CMRITO is a member of the Alliance of Medical Radiation and Imaging Technologists of Canada (AMRITRC). The AMRITRC is a group of provincial regulators, who collaborate regarding the regulation of medical radiation and imaging technologists to enhance safe, competent, and ethical care for Canadians. The six MRIT regulatory authorities in the AMRITRC have agreed to use a standard out of province certificate for MRITs who hold a current registration in another regulated jurisdiction. The certificate includes information on: - any terms, conditions or limitations on the certificate of registration - good character including:	

	• current referrals to the Discipline Process/Committee • past findings of professional misconduct • any other information relating to the MRIT’s competency, conduct or character that would be pertinent to the registration of an MRIT in another jurisdiction. The CMRITO has also shared information about registrants with law enforcement to aid with investigations and with the Independent Health Facilities and Xray Inspection branches of the Ministry of Health. In a reciprocal manner CMRITO receives information about registrants from the Independent Health Facilities Inspection Branch where inspections have identified possible concerns with the practice of registrants. It is the Registrar that determines when information will be shared and pursuant to which discretionary exemption under section 36 of the RHPA.
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DOMAIN 7: MEASUREMENT, REPORTING, AND IMPROVEMENT			
Standard 15			
The College monitors, reports on, and improves its performance.			
Measure	Required evidence	College response	
15.1 Council uses Key Performance Indicators (KPIs) in tracking and reviewing the College’s performance and regularly reviews internal and external risks that could impact the College’s performance.	a. Outline the College’s KPI’s, including a clear rationale for why each is important.	The College fulfills this requirement: Yes X Partially ☐ No ☐	
		• Insert a link to document that list College’s KPIs with an explanation for why these KPIs have been selected (including what the results the respective KPIs tells, and how it relates to the College meeting its strategic objectives and is therefore relevant to track), link to Council meeting materials where this information is included OR list KPIs and rationale for selection: December 3, 2020 Council Agenda	
		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>	
	15.1.a. Outline the College’s KPI’s, including a clear rationale for why each is important.		
	The College Council in 2014, as part of governance review project developed a number of KPI’s that Council determined were important indicators to track to monitor and review the College’s performance. Council at that time developed scorecard measure profiles for each of the indicators in the Balanced Scorecard.		

	These indicators are evaluated periodically and were last reviewed in January 2017. The scorecard measure profiles can be viewed at this link. Each indicator in the profile identifies: • A definition of the indicator • Rationale for inclusion of the indicator in the balanced scorecard • The frequency of the updates • The formula or method to be used for calculations, in the case of statistical data • The data elements, parameters and sources of the data in the CMRITO systems • Targets for the indicator where appropriate • Owners responsible for maintaining and tracking the indicator The indicators that were developed by Council were established to measure: • Statistical data for the key mandated functional program areas of registration, quality assurance, and professional conduct • Compliance with mandated College obligations such as annual reporting • Compliance with established governance policies • Effectiveness of Council and statutory committees • Financial performance of the organization • Compliance with financial deductions and remittances • Progress against strategic goals as determined by Council in the Strategic Plan • Progress against enabling goals as determined by Council in the Strategic Plan • Effectiveness of communication strategies • Level of engagement with stakeholders and other strategic alliances The Balanced Scorecard is included in each agenda for Council as part of the meeting materials. The Balanced Scorecard for 2020 can be found in the agenda materials at this link. In addition to the Balanced Scorecard that includes all the indicators approved by Council, a Dashboard is also posted on the College website to provide a visual of key indicators respecting registration, quality assurance, professional conduct and communications from the scorecard. The dashboards from 2015 to 2020 can be viewed at this link. The year end dashboards are also published in the College’s annual reports.	
	b. Council uses performance and risk information to regularly assess the College’s progress against stated strategic objectives and regulatory outcomes.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Insert a link to last year’s Council meetings materials where Council discussed the College’s progress against stated strategic objectives, regulatory outcomes and risks that may impact the College’s ability to meet its objectives and the corresponding meeting minutes: December 3, 2020 Council Agenda

		<i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes Y No Y</i>
	15.1.b. Council uses performance and risk information to regularly assess the College’s progress against stated strategic objectives and regulatory outcomes. Yes, Council uses performance and risk information to regularly assess the College’s progress against stated strategic objectives and regulatory outcomes. Council monitors performance and progress against the strategic objectives that are defined in the Strategic Plan at each meeting and assesses whether the College is achieving the anticipated regulatory outcomes. Council also approved the College’s Risk Management Framework in September 2016 and the Executive Committee, by policy, is responsible for oversight of risk management. Executive reports to Council any significant change in the risk level or risk mitigation strategies at each meeting of Council. Council receives information and a verbal report at each meeting from the Registrar & CEO respecting progress against the operational plan and any risks identified by the Executive Committee. To provide Council with the relevant information to assess the College’s progress, the agenda for each meeting of Council includes a standing agenda item under Operations, Reports and Plans that provides Council with: • the approved Strategic Plan, • the operational plan for the current year • the Balanced Scorecard report and Dashboard • the risk register and a briefing note respecting any risks where a significant change in the risk level or risk mitigation strategies have been identified by the Executive Committee. The Risk Management Framework which was approved by Council in September 2016 has four key elements: 1. Foundational element: The CMRITO Council Policy 2.14 – Risk Management which identifies Council’s commitment and expectations, and sets out the roles and responsibilities of the Council, the Executive Committee and Management relating to risk management 2. Organizational management element: Identifies the risk management context, systems, procedures and processes that are included in the Risk Register which is included in the Council agenda and can be viewed at this link • identifies adverse events or circumstances relevant to CMRITO objectives • assesses the likelihood and magnitude of the impact of any adverse events • identifies mitigation strategies 3. Culture and capacity element: Sets out approaches that enable CMRITO to develop and embed a risk management culture in the organization through defining the values, beliefs, knowledge, attitudes and understanding about risk, and tasking staff with the role of being the ‘eyes and ears’ of Council in identifying, assessing and responding to risks 4. Governance Oversight: Defines the Risk Register as the reporting mechanism to provide a snapshot of significant risks and the related risk management responses, to promote risk management accountability and to assist Council to discharge its oversight responsibility.	

15.2 Council directs action in response to College performance on its KPIs and risk reviews.	a. Where relevant, demonstrate how performance and risk review findings have translated into improvement activities.	The College fulfills this requirement: Yes X Partially ☐ No ☐ Insert a link to Council meeting materials where relevant changes were discussed and decided upon: March 27, 2020 Council agenda package September 26, 2017 Council Agenda <i>If the response is “partially” or “no”, is the College planning to improve its performance over the next reporting period? Yes Y No Y</i>
	15.2.a. Where relevant, demonstrate how performance and risk review findings have translated into improvement activities. The College Council monitors the College performance, the practice environment of registrants and results of the risk review findings to identify required changes to processes and activities that are planned or to identify new initiatives that should be undertaken to protect the public interest and fulfil the mandate of the College. An example of where Council used evidence around performance and risk to inform changes to planned activities in 2020, relates to the decision around the quality assurance assessment activities registrants would be required to undergo in 2020. In March 2020, the Ontario government declared a provincial state of emergency due to the COVID-19 pandemic. In March 2020, the QA Committee met and reviewed the challenges members were facing with increased infection prevention protocols, increased work in some areas, and reduced patient appointments and service closures in others. The QAC reviewed the issues that registrants would face participating in an MSF assessment under these conditions and considered the risk associated with requiring registrants to participate in a practice assessment using a multisource feedback survey (MSF). Since the MSF patient surveys are paper-based, registrants would be facing added challenges in distributing and gathering paper information from patients while maintaining the required COVID-19 protocols. The QA Committee therefore put forth a recommendation to Council to delay or cancel the MSF assessments for the year 2020, and to delay running the April 2020 QA Portfolio random selection until later in the year. Council considered this information and the associated risks at its meeting in April 2020 and determined to cancel the MSF assessments for 2020. Council also considered the impact that the pandemic would have on the planned activities in the approved 2020 Operational Plan - Commitment to Regulatory Excellence, which was approved by Council in December 2019. On March 27, 2020, Council approved Policy 12.1 COVID-19 Pandemic which was designed to: - ensure that CMRITO’s regulatory processes do not put an undue burden on its members or patients, - work collaboratively with the Ministry to ensure an adequate supply of MRITs during the state of emergency - continue to ensure the protection of the public through the regulation of the profession. On April 3, 2020 Council approved amendments to the 2020 Operational Plan to focus CMRITO’s efforts on the key regulatory essentials in 2020. Another example of a significant improvement activity where Council considered the practice environment of registrants, the role and mandate of the College and the risk of harm to the public in determining strategic direction for the CMRTO, is the regulation of diagnostic medical sonographers with CMRITO. The CMRITO worked for many years to assist the Ontario Ministry of Health and Long-Term Care in completing the public protection framework for medical radiation and imaging technology by regulating diagnostic medical sonographers (DMSs) with MRITs. This improvement protects the public interest because it establishes standards of qualification for entry to practice the specialty of diagnostic medical sonography and requires diagnostic medical sonographers to practice in accordance with the standards of practice. In August 2017, the Minister of Health directed the CMRTO to begin the registration of diagnostic medical	

	sonographers in 2018. By January 1, 2020, the CMRITO had registered almost 4,000 registrants in the specialty of diagnostic medical sonography and the Government had implemented a comprehensive and integrated framework to ensure the protection of the public of Ontario.	
15.3The College regularly reports publicly on its performance.	a. Performance results related to a College's strategic objectives and regulatory activities are made public on the College's website.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		Insert a link to College's dashboard or relevant section of the College's website: https://www.cmrito.org/about/council-committees/our-council/dashboard/
		<i>If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐</i>
	15.3.a. Performance results related to a College's strategic objectives and regulatory activities are made public on the College's website. The CMRITO publishes performance results related to the College's strategic objectives on the CMRITO website at www.cmrito.org . There are a number of communication tools that are used to make performance results public. These include: The Balanced scorecard which is included in each Council agenda. The most recent scorecard can be viewed here . - The CMRITO Dashboard, copies of which are available on the website from 2015 -2020, are published in the annual report, and can be accessed at this link. https://www.cmrito.org/about/council-committees/our-council/dashboard/ - The CMRITO publishes a newsletter "Insights" for registrants that includes information on strategic objectives and regulatory activities. Copies of the newsletter can be accessed here. - CMRITO also maintains a Facebook (https://www.facebook.com/CMRITO/) and Twitter account (https://twitter.com/TheCMRITO) where information on regulatory activities and strategic initiatives is made available, including 'live' coverage of Council meetings.	

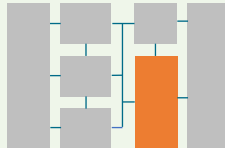
PART 2: CONTEXT MEASURES

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

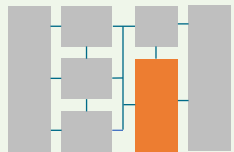
In order to facilitate consistency in reporting, a recommended methodology to calculate the information is provided in the companion document “Technical Specifications for Quantitative College Performance Measurement Framework Measures.” However, recognizing that at this point in time, the data may not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

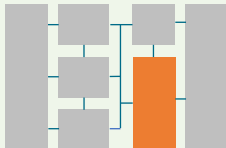
In those instances where a College does not have the data or the ability to calculate the context measure at this point in time it should state: ‘Nil’ and indicate any plans to collect the data in the future.

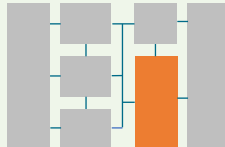
Where deemed appropriate, Colleges are encouraged to provide additional information to ensure the context measure is properly contextualized to its unique situation. Finally, where a College chooses to report a context measure using methodology other than outlined in the following Technical Document,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

DOMAIN 6: SUITABILITY TO PRACTICE			
Standard 11			
The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.			
Statistical data collected in accordance with recommended methodology or College own methodology: Y Recommended College methodology			
If College methodology, please specify rationale for reporting according to College methodology:			
Context Measure (CM)			

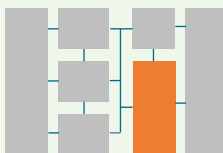
CM 1. Type and distribution of QA/QI activities and assessments used in CY 2020*		What does this information tell us? Quality assurance (QA) and Quality Improvement (QI) are critical components in ensuring that professionals provide care that is safe, effective, patient centred and ethical. In addition, health care professionals face a number of ongoing changes that might impact how they practice (e.g. changing roles and responsibilities, changing public expectations, legislative changes). The information provided here illustrates the diversity of QA activities the College undertook in assessing the competency of its registrants and the QA and QI activities its registrants undertook to maintain competency in CY 2020. The diversity of QA/QI activities and assessments is reflective of a College’s risk-based approach in executing its QA program, whereby the frequency of assessment and activities to maintain competency are informed by the risk of a registrant not acting competently. Details of how the College determined the appropriateness of its assessment component of its QA program are described or referenced by the College in Measure 13(a) of Standard 11.
Type of QA/QI activity or assessment	#	
a. QA Annual Declaration of Compliance with the QA Program which includes: • QA Profile • QA Self-Assessment against the Standards of Practice of the Profession • Documentation of 25 hours of Continuing Education and Professional Development Activities	11,084	
b. QA Portfolio Assessment	1,431	
c. Multi-Source Feedback (MSF) Assessment	0	
d. Independent Practice Assessment	0	
e. <Insert QA activity or assessment>QA		
f. <Insert QA activity or assessment>		
g. <Insert QA activity or assessment>		
h. <Insert QA activity or assessment>		
i. <Insert QA activity or assessment>		
j. <Insert QA activity or assessment>		
* Registrants may be undergoing multiple QA activities over the course of the reporting period. While future iterations of the CPMF may evolve to capture the different permutations of pathways registrants may undergo as part of a College’s QA Program, the requested statistical information recognizes the current limitations in data availability today and is therefore limited to type and distribution of QA/QI activities or assessments used in the reporting period. NR = Non-reportable: results are not shown due to < 5 cases		
Additional comments for clarification (if needed) 5% of members were to be randomly selected in 2020 to undergo a multi-source feedback assessment but Council determined not to run the assessment program due to the COVID-19 pandemic		

DOMAIN 6: SUITABILITY TO PRACTICE			
Standard 11			
The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care			
Statistical data collected in accordance with recommended methodology or College own methodology: ☐ Recommended ☐ College methodology			
If College methodology, please specify rationale for reporting according to College methodology:			
Context Measure (CM)			
	#	%	What does this information tell us? If a registrant’s knowledge, skills and judgement to practice safely, effectively and ethically have been assessed or reassessed and found to be unsatisfactory or a registrant is non-compliant with a College’s QA Program, the College may refer him or her to the College’s QA Committee.
CM 2. Total number of registrants who participated in the QA Program CY 2020	11,084		
CM 3. Rate of registrants who were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undertake remediation. *	NR	NR	
The information provided here shows how many registrants who underwent an activity or assessment in CY 2020 as part of the QA program where the QA Committee deemed that their practice is unsatisfactory and as a result have been directed to participate in specified continuing education or remediation program.			
Additional comments for clarification (optional)			
* NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)			

DOMAIN 6: SUITABILITY TO PRACTICE			
Standard 11 The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.			
Statistical data collected in accordance with recommended methodology or College own methodology: ☐ Recommended ☐ College methodology <i>If College methodology, please specify rationale for reporting according to College methodology:</i>			
Context Measure (CM)			
CM 4. Outcome of remedial activities in CY 2020*:	#	%	<i>What does this information tell us?</i> This information provides insight into the outcome of the College’s remedial activities directed by the QA Committee and may help a College evaluate the effectiveness of its “QA remediation activities”. Without additional context no conclusions can be drawn on how successful the QA remediation activities are, as many factors may influence the practice and behaviour registrants (continue to) display.
I. Registrants who demonstrated required knowledge, skills, and judgment following remediation**	NR	NR	
II. Registrants still undertaking remediation (i.e. remediation in progress)	0	0	
<i>Additional comments for clarification (if needed)</i>			
<i>* NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)</i> <i>** This measure may include registrants who were directed to undertake remediation in the previous year and completed reassessment in CY2020.</i>			

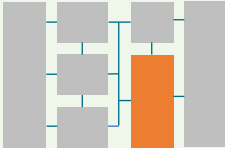
DOMAIN 6: SUITABILITY TO PRACTICE					
Standard 13					
All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.					
Statistical data collected in accordance with recommended methodology or College own methodology:			Recommended		☒ College methodology
If College methodology, please specify rationale for reporting according to College methodology:					
The CMRITO Inquiries, Complaints and Reports (ICR) Committee directs the investigation of all complaints. The “theme” for complaints and Registrar’s Investigations is assigned by a Panel of the ICR Committee as part of their investigation. The Standards of Practice engaged by the allegations in a complaint or report are assigned by the panel and noted in the decision and reasons. Because the CMRITO has no ADR process and all complaints are investigated by the ICR Committee, staff do not engage in any sort of internal triaging process, except for triaging complaints or Registrar’s Investigation that may be a candidate for an interim order. For this reason, there are no themes assigned to complaints until the decision is rendered from the ICR Committee. The triaging and interim order assessment forms that are used in this process have been made available as part of the CPMF report. Pease note that the numbers for CM5, CM6, CM7 and CM10 will not align as not all of these matters have been decided (i.e. assigned a theme) and the values in CM10 includes carry over from the previous year.					
Context Measure (CM)					
CM 5. Distribution of formal complaints* and Registrar’s Investigations by theme in CY 2020	Formal Complaints received†		Registrar Investigations initiated‡		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.
Themes:	#	%	#	%	
I. Advertising					
II. Billing and Fees					
III. Communication	5	56%			
IV. Competence / Patient Care	NR	NR			
V. Fraud					
VI. Professional Conduct & Behaviour			NR	NR	
VII. Record keeping					
VIII. Sexual Abuse / Harassment / Boundary Violations					
IX. Unauthorized Practice					
X. Other <please specify>	NR	NR	NR	NR	
Total number of formal complaints and Registrar’s Investigations**	9	100%	NR	100%	

* Formal Complaint: A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquires and other interactions with the College that do not result in a formally submitted complaint. Registrar’s Investigation: Where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days. ‡ NR = Non-reportable: results are not shown due to < 5 cases (for both # and %) ** The requested statistical information (number and distribution by theme) recognizes that formal complaints and registrar’s investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar’s investigations.	
Additional comments for clarification (if needed)	

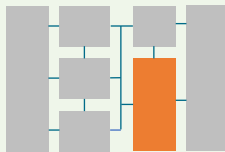
DOMAIN 6: SUITABILITY TO PRACTICE			
Standard 13			
All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.			
Statistical data collected in accordance with recommended methodology or College own methodology:		Y Recommended	Y College methodology
If College methodology, please specify rationale for reporting according to College methodology:			
Context Measure (CM)			
CM 6. Total number of formal complaints that were brought forward to the ICRC in CY 2020	29		
CM 7. Total number of ICRC matters brought forward as a result of a Registrars Investigation in CY 2020	11		
CM 8. Total number of requests or notifications for appointment of an investigator through a Registrar’s Investigation brought forward to the ICRC that were approved in CY 2020	11		
CM 9. Of the formal complaints* received in CY 2020**:	#	%	What does this information tell us? The information helps the public better understand how formal complaints filed with the College and Registrar’s Investigations are disposed of or resolved. Furthermore, it provides transparency on key sources
I. Formal complaints that proceeded to Alternative Dispute Resolution (ADR)†			
II. Formal complaints that were resolved through ADR			

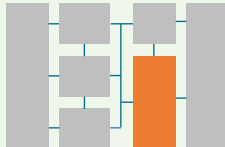
III. Formal complaints that were disposed** of by ICRC	10	34.5	of concern that are being brought forward to the College's committee that investigates concerns about its registrants.
IV. Formal complaints that proceeded to ICRC and are still pending	18	62.1	
V. Formal complaints withdrawn by Registrar at the request of a complainant Δ	NR	NR	
VI. Formal complaints that are disposed of by the ICRC as frivolous and vexatious			
VII. Formal complaints and Registrars Investigations that are disposed of by the ICRC as a referral to the Discipline Committee			
** Disposal: The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant). * Formal Complaints: A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquires and other interactions with the College that do not result in a formally submitted complaint. ‡ ADR: Means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute. Δ The Registrar may withdraw a formal complaint prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. # May relate to Registrars Investigations that were brought to ICRC in the previous year. ** The total number of formal complaints received may not equal the numbers from 9(i) to (vi) as complaints that proceed to ADR and are not resolved will be reviewed at ICRC, and complaints that the ICRC disposes of as frivolous and vexatious and a referral to the Discipline Committee will also be counted in total number of complaints disposed of by ICRC. φ Registrar's Investigation: Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days. NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)			
Additional comments for clarification (if needed)			

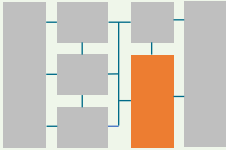
DOMAIN 6: SUITABILITY TO PRACTICE							
Standard 13 All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.							
Statistical data collected in accordance with recommended methodology or College own methodology: Y Recommended Y College methodology If College methodology, please specify rationale for reporting according to College methodology:							
Context Measure (CM)							
CM 10. Total number of ICRC decisions in 2020							
Distribution of ICRC decisions by theme in 2020*	# of ICRC Decision†						
Nature of issue	Take no action	Provides advice or recommendations	Issues an oral caution	Orders a specified continuing education or remediation program	Agrees to undertaking	Refers specified allegations to the Discipline Committee	Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations or by-laws.
I. Advertising							
II. Billing and Fees							
III. Communication	NR	11					
IV. Competence / Patient Care	8	5					
V. Fraud					NR		
VI. Professional Conduct & Behaviour		NR		NR		NR	
VII. Record keeping							
VIII. Sexual Abuse / Harassment / Boundary Violations							
IX. Unauthorized Practice							
X. Other <please specify>	NR			NR	NR		
* Number of decisions are corrected for formal complaints ICRC deemed frivolous and vexatious AND decisions can be regarding formal complaints and registrar’s investigations brought forward prior to 2020.							
† NR = Non-reportable: results are not shown due to < 5 cases.							

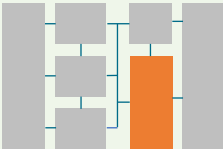


<i>++ The requested statistical information (number and distribution by theme) recognizes that formal complaints and Registrar’s Investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar’s investigations, or findings.</i>
What does this information tell us? <i>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.</i>
<i>Additional comments for clarification (if needed)</i>

Domain 6: Suitability to Practice			
Standard 13			
All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.			
Statistical data collected in accordance with recommended methodology or College own methodology:		☐ Recommended	☐ College methodology
If College methodology, please specify rationale for reporting according to College methodology:			
Context Measure (CM)			
CM 11. 90 th 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.	
I. A formal complaint in working days in CY 2020	174	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.	
II. A Registrar’s investigation in working days in CY 2020	341		
* Disposal Complaint: The day where a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).			
* Disposal Registrar’s Investigation: The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).			
Additional comments for clarification (if needed)			

DOMAIN 6: SUITABILITY TO PRACTICE			
Standard 13			
All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.			
Statistical data collected in accordance with recommended methodology or College own methodology:		Y Recommended	Y College methodology
If College methodology, please specify rationale for reporting according to College methodology:			
Context Measure (CM)			
CM 12. 90th Percentile disposal* of:	Days	What does this information tell us? This information illustrates the maximum length of time in which 9 out of 10 uncontested discipline hearings and 9 out of 10 contested discipline hearings are being disposed. * The information enhances transparency about the timeliness with which a discipline hearing undertaken by a College is concluded. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the resolution of a discipline proceeding undertaken by the College.	
I. An uncontested^ discipline hearing in working days in CY 2020	107		
II. A contested# discipline hearing in working days in CY 2020	0		
* Disposal: Day where all relevant decisions were provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant, including both liability and penalty decisions, where relevant).			
^ Uncontested Discipline Hearing: In an uncontested hearing, the College reads a statement of facts into the record which is either agreed to or uncontested by the Respondent. Subsequently, the College and the respondent may make a joint submission on penalty and costs or the College may make submissions which are uncontested by the Respondent.			
# Contested Discipline Hearing: In a contested hearing, the College and registrant disagree on some or all of the allegations, penalty and/or costs.			
Additional comments for clarification (if needed)			

DOMAIN 6: SUITABILITY TO PRACTICE		
Standard 13		
All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.		
Statistical data collected in accordance with recommended methodology or College own methodology:		Y Recommended Y College methodology
If College methodology, please specify rationale for reporting according to College methodology:		
Context Measure (CM)		
CM 13. Distribution of Discipline finding by type*		<i>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.</i>
Type	#	
I. Sexual abuse		
II. Incompetence		
III. Fail to maintain Standard		
IV. Improper use of a controlled act		
V. Conduct unbecoming		
VI. Dishonourable, disgraceful, unprofessional	NR	
VII. Offence conviction	NR	
VIII. Contravene certificate restrictions		
IX. Findings in another jurisdiction		
X. Breach of orders and/or undertaking		
XI. Falsifying records		
XII. False or misleading document		
XIII. Contravene relevant Acts		
* The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the number of findings may not equal the total number of discipline cases. NR = Non-reportable: results are not shown due to < 5 cases. Additional comments for clarification (if needed)		

DOMAIN 6: SUITABILITY TO PRACTICE		
Standard 13		
All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.		
Statistical data collected in accordance with recommended methodology or College own methodology:		Y Recommended Y College methodology
If College methodology, please specify rationale for reporting according to College methodology:		
Context Measure (CM)		
CM 14. Distribution of Discipline orders by type*		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.
Type	#	
I. Revocation ⁺		
II. Suspension ^{\$}	NR	
III. Terms, Conditions and Limitations on a Certificate of Registration ^{**}		
IV. Reprimand [^] and an Undertaking [#]		
V. Reprimand [^]	NR	
* The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the numbers set out for findings and orders may not be equal and may not equal the total number of discipline cases. + Revocation of a registrant’s certificate of registration occurs where the discipline or fitness to practice committee of a health regulatory college makes an order to “revoke” the certificate which terminates the registrant’s registration with the college and therefore his/her ability to practice the profession. \$ A suspension of a registrant’s certificate of registration occurs for a set period of time during which the registrant is not permitted to: • Hold himself/herself out as a person qualified to practice the profession in Ontario, including using restricted titles (e.g. doctor, nurse), • Practice the profession in Ontario, or • Perform controlled acts restricted to the profession under the Regulated Health Professions Act, 1991. ** Terms, Conditions and Limitations on a Certificate of Registration are restrictions placed on a registrant’s practice and are part of the Public Register posted on a health regulatory college’s website. ^ A reprimand is where a registrant is required to attend publicly before a discipline panel of the College to hear the concerns that the panel has with his or her practice # An undertaking is a written promise from a registrant that he/she will carry out certain activities or meet specified conditions requested by the College committee. NR = Non-reportable: results are not shown due to < 5 cases		
Additional comments for clarification (if needed)		

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

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Appendix A: Public Interest

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

PUBLIC INTEREST

in the context of the College Performance Measurement Framework

