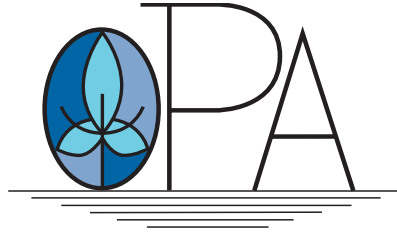


Ontario Psychological Association



May 29, 2008

OFFICERS

*Mary Broga Ph.D., C.Psych.
President*

*Jack Ferrari Ph.D., C.Psych.
President-Elect*

*Margaret Weiser Ph.D., C.Psych.
Financial Officer*

ADMINISTRATIVE STAFF

*Ruth Berman Ph.D., C.Psych.
Executive Director*

*Carla Mardonet
Administrative Officer*

*Anna DiDonato
Membership Services Coordinator*

*Jenna Barclay
Referral Service Coordinator*

Annie Schiefer, Project Manager
Health Professions Regulatory Advisory Council
55 St. Clair Ave. W., Suite 806, Box 18
Toronto, ON M4V 2Y7

Re: Consultation on Issues Relating to Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals

The Ontario Psychological Association (OPA) appreciates the opportunity extended by the Health Professions Regulatory Advisory Council (HPRAC) to comment on the “Consultation Discussion on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals. The Ontario Psychological Association is the professional organization representing practicing psychologists in this province. The Association was established in 1947 to advance psychology as an independent profession with the highest ethical standards of practice.

Since we attended the first workshop held by HPRAC on these important issues, we have been following the activities by the government and by HPRAC on interprofessional health collaboration in healthcare. We were, therefore, glad to see these questions come forth from HPRAC following the letter from the Minister of Health and Long Term Care.

As an association, we have been actively involved in a number of consultations by the Health Professions Regulatory Advisory Council over the years and fully support the activities of this council.

We welcome the opportunity to be able to comment on this important set of questions in the discussion guide. However, we have some concerns relating to underlying assumptions implicit in the questions found in the guide.

The questions suggest the role of the regulatory colleges in representing the profession. It is important to point out that the regulatory colleges’ primary role is protection of the public. The role of representation of the profession is assumed by the professional associations.

As a result, we believe that the goals related to interprofessional collaboration can best be achieved by the associations, such as the Ontario Psychological Association, because they are better situated to look at the needs of the health care professionals.

730 Yonge Street, Suite 221
Toronto, Ontario M4Y 2B7

Telephone (416) 961-5552
Fax (416) 961-5516
e-mail opa@psych.on.ca
Website www.psych.on.ca

Advancing psychology through commitment & service

Defining Interprofessional Collaboration

While many definitions exist for “interprofessional care” (i.e., interprofessional collaboration at the clinical level); none was found in the Literature Review for collaboration at the regulatory (i.e., College) level. To provide the context for this Discussion Guide and to focus its response to the Minister’s request, HPRAC proposes that any initiatives should be directed to finding ways to:

- Assist health regulatory Colleges and their members to work collaboratively, rather than competitively, and to learn from and about each other through a process of mutual respect and shared knowledge to:
- Improve patient care and facilitate better results for patients;
- Protect the public interest; and ensure the highest standards of professional conduct and patient safety;
- Regulate the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest;
- Optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services;
- Ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment, and
- Enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability.

1. Please comment on the above statement that HPRAC has used to focus this discussion and initiatives. Are there elements that should be added or removed? If so, what are they?

We support the statement relating to interprofessional collaboration in the document. However, we would like to see it expanded to ensure that it is recognized that anyone on an interprofessional health care team can be seen as the primary lead in the care of a particular patient. It should be recognized that all members of the team are equal and that the lead on the interprofessional health care team should be chosen based on the needs of a particular patient. Leadership of a clinical team should not be based on automatic assumptions of leadership due to membership in a particular profession.

Eliminating the Barriers to Collaboration among the Colleges

2. Are there barriers in the *RHPA*, the health profession acts or their regulations that restrict or prevent collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how? (For example, do existing scopes of practice restrict or prevent collaboration among health professionals?)

We do have concerns with barriers to interprofessional collaboration. We have questions, for example, about the delegation model. It should be recognized that a professional with particular skill sets to provide a service within an interprofessional health care team should be able to provide that service with independent authority without the need of a physician to delegate that authority.

We also have concerns about the lack of standardized definitions for some of the controlled acts. The lack of common definitions between colleges often results in members of interprofessional care teams working from different assumptions about their role relating to controlled acts because of differing interpretations by their colleges of these controlled acts.

There also needs to be some model for enforcement of scope of practice. In particular, we are left without effective means of enforcement of scopes of practice for individuals who are not members of

regulated health professions. The colleges often limit their role to the regulation of their members and not the regulation of non-members who may be violating the RHPA.

3. Are there barriers in other Acts or regulations that restrict or prevent collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how?

While we are not aware of barriers in other Acts or regulations that restrict or prevent collaboration among the Colleges, we are aware of other Acts that have restricted collaboration amongst the regulated members of interprofessional care teams and impede their functioning.

We have substantive concerns relating to other acts that restrict and prevent collaboration amongst the colleges and amongst individuals on interprofessional health care teams. As Health Force Ontario described in their 2007 report “*Interprofessional Care: A Blueprint for Action in Ontario*”: “Existing legislation and regulations are perceived to be barriers to health professions fully functioning to their scope of practice, thus resulting in underutilization of health human resources”.

In particular, acts such as the Public Hospitals Acts, the Mental Health Act and the Health Insurance Act, all substantively place members of interprofessional health care teams in different sets of accountabilities and responsibilities. This leads to problems of functioning within health care teams. There would need to be substantive changes in these pieces of legislation to allow for greater equity and, therefore, greater collaboration amongst members of the health care teams.

4. Are there other policy and/or systems issues that act as barriers to collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how?

While we are not aware of other policy and/or system issues that act as barriers to collaboration among the Colleges, we are aware of other issues that have restricted collaboration amongst the regulated members of interprofessional care teams and impede their functioning. For example, there are substantive differences in the sizes of many of the professional colleges that result in difficulties in their capacity to collaborate effectively with one another. The substantive disparities in human and financial resources result in some colleges having greater capacity to develop programs for their members and to devote resources to inter-college collaboration. This also often results in greater degrees of active collaboration between some colleges as well as over other colleges with the Ministry of Health and Long Term Care.

5. Are there professional cultural issues that act as barriers to collaboration among the Colleges? What steps should be taken to minimize these barriers? Who should provide the leadership to eliminate them? What role can health care associations, including associations whose members are regulated professionals, play in this process?

The main difficulty we have with the cultural issues related to our barriers to collaboration would be the strong historical sense of a hierarchy amongst the professions (which is reinforced by legislation discussed above). As well, there are few avenues for information sharing about the activities and roles of other professions amongst one another. The current training models reinforce the silo-based training of health care professionals.

We also have concerns about the perspectives in some material from the Ministry of Health and other jurisdictions that, in the past, have made reference to interprofessional collaboration but, upon

further examination, have limited these interprofessional teams to medicine and nursing alone. We believe true interprofessional teams are the result of a number of professions working together for the care of their patients.

6. Do you have evidence from your experience that liability issues are a barrier to interprofessional care?

7. Should all regulated health professionals be required to hold minimum professional liability insurance coverage?

8. If so, what would be the minimum expected terms and conditions for that insurance coverage?

We do not have evidence that the liability issues are a barrier to interprofessional care. We would concur with the recent 2007 report from the Conference Board of Canada, "*Liability Risks Interdisciplinary Care: Thinking Outside the Box*", that although interdisciplinary collaboration might entail some legal risks, there are a few liability issues that should be seen as barriers to interprofessional care. We do believe that all regulated health care professionals should be required to hold minimum professional liability insurance. However, we believe that different professions should determine for themselves what would be appropriate minimum expected terms and conditions for that insurance.

Developing Enablers for Collaboration among the Colleges

9. What changes to the RHPA, the health profession acts or their regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?

As noted above, we believe the primary change necessary within the RHPA are clearer and agreed upon definitions of controlled acts. This would include standards for competence to perform the controlled act and for continuing education to continue to perform these controlled acts. The variability between colleges often leads to confusion and negative relations between regulated professionals on health care teams.

11. What collaborative policy or program initiatives are needed to ensure support is provided to new Colleges as they are being established?

We believe one appropriate policy or program initiative for new colleges being established would be that members of related colleges be appointed to the transitional councils of these colleges as they move toward the operationalization of their mandate. This would be especially true for those new colleges that have access to controlled acts to ensure that the new colleges' operationalization of the definition of the controlled acts is consistent with that of other regulated health professions.

Structural Mechanisms

13. Should Ontario introduce a common framework, consisting of common structures and processes, for all regulated health professions to address complaints, investigations or disciplinary matters arising in an interprofessional care setting?

14. If so, what should and should not be included in the common framework?

We support the idea of collaboration amongst colleges for initial investigations for complaints that are made about the interprofessional care provided by a health care team. Collaboration during the initial investigation of a complaint would allow for a more organized approach, on behalf of the complainant, to the responses of the professions regarding an interprofessional complaint.

However, we would caution implementation beyond initial complaint investigation as each profession would have specific standards that may result in variability of responses to incidents by the regulatory bodies.

15. If not, should the *RHPA*, nonetheless, be amended to give individual Colleges greater flexibility to deal with complaints, investigations and discipline arising in an interprofessional care setting within their own already-established structures?

16. If so, what should and should not be addressed in the amendment? For example, should the *RHPA* be amended to enable Colleges to establish joint committees to deal with complaints, investigations and discipline in respect of issues arising in an interprofessional care setting?

We believe that collaboration on a complaints process needs to be determined on a case-by-case basis and should not be done by an ongoing interprofessional standing committee for complaints. We also believe it should be made easier for regulatory bodies to share information amongst one another on interprofessional complaints.

Once again, however, while we believe there may be instances where this would be appropriate for an initial investigation, we do not believe it would be appropriate for adjudication. Thus, while we agree with the basic principle, we do have concerns about how it would be operationalized.

22. Would a joint quality assurance program among relevant Colleges enable the Colleges to develop common standards of practice or professional practice guidelines where the same or similar Controlled Acts are shared?

23. Would a joint quality assurance program among Colleges whose members have similar scopes of practice, share the same or similar Controlled Acts, or provide closely related services often involving the same areas of the body, provide opportunities for enhanced continuing competence and exposure to best practices? If yes, how should program standards be jointly set and measured?

24. Is legislative change required to accomplish these goals?

We would support and work with our colleges for the development of common standards for quality assurance programs between the colleges. The substantive differences that exist currently between colleges lead to members of interprofessional care teams seeing other members as having less effective, and therefore less appropriate, ongoing quality assurance by the regulatory body.

25. Should an independent arm's-length organization facilitate and support collaboration among the Colleges, particularly with a view to the development of common standards of practice and professional practice guidelines?

26. If so, what should its specific mandate include or not include? For example:

- Educate the Colleges, professions and the public on the regulatory model, the health professions and everyone's role within the regulatory system;
- Create common resource repositories (e.g., a data warehouse to track regulatory indicators, such as the level and nature of quality assurance activities, complaints and disciplinary actions and the cost of regulation);
- Research and develop standards of practice and professional practice guidelines, and disseminate best practices;
- Resolve disagreements among professions that share overlapping scopes of practice and the same or similar Controlled Acts;
- Address issues arising from conflicting legislation, and
- Have an oversight function over regulatory bodies, as in the United Kingdom.

27. Are there any existing bodies that could take on responsibilities in this area? If so, what are they?

28. If not, should a new and independent oversight body be formed? If so, how should it be funded?

We believe that such an independent arms-length organization may be potentially useful. While we support the idea in principle, however, we are cautious about its implementation. We recognize that the Health Professions Regulatory Advisory Committee is currently fulfilling this role to some extent and it might be advantageous to enhance its role in the future to assist in these types of activities.

29. Should the Minister direct the Colleges, using his existing powers under the RHPA, to engage in specific collaborative initiatives (e.g., to develop instruments to support interprofessional care)? Why or why not?

30. If so, should the Minister provide financial or other incentives to the Colleges to undertake these activities?

31. Should the Colleges be required to report to the Minister and/or the public on their collaborative activities on a regular basis? Why or why not?

32. Should minimum guidelines, standards and policies concerning matters such as conflict of interest, advertising, record keeping and the consent process be consistent across all Colleges? If yes, what guidelines, standards and policies could effectively be applied to all regulated health professions? If not, why not?

We believe the minister should have the potential to direct colleges to engage in specific collaborative initiatives. However, we also believe that the minister would need to provide the financial support for these initiatives instead of requiring the regulated health professions to pay for these initiatives through the funding of their regulatory bodies. While there may be some areas that would be appropriate for common standards across professions (e.g., advertising), standards for record keeping, for example, should be seen as determined by specific regulatory bodies.

33. What kinds of structures and processes could facilitate collaboration among Colleges to address issues related to standards of practice and professional practice guidelines for those

professions that deal with closely related activities (e.g. dental hygiene, dental technology, dentistry and denturism; or opticianry, optometry and ophthalmology)? (For example, joint Colleges, collaborative Councils or independent bodies such as the Council for Healthcare Regulatory Excellence in the UK.)

We do have some support for the concept of facilitation of collaboration amongst colleges by greater linkages between similar professions. For example, we do not see the public benefit of the separation of the College Of Psychotherapists And Regulated Mental Health Therapists from the College of Psychologists. We believe that greater collaboration amongst these groups would be important and mechanisms to ensure that collaboration is maintained should be required. We could see the Health Professions Regulatory Advisory Committee having an important role to ensure that the colleges work together in a more collaborative manner where appropriate.

34. Would the development of a Collaboration Toolkit, containing some or all of the elements suggested above, serve to facilitate and support collaboration among the Colleges?

35. If so, what should be included in a Collaboration Toolkit and who should be responsible for developing it?

We would support the development of a “Collaboration Toolkit” and would see the responsibility for its development as being joint between the professions and the Ministry of Health and Long Term Care. Once again, the Health Professions Regulatory Advisory Committee might be able to take a leadership role in the coordination of the development of this material.

College Autonomy, Authority and Accountability

36. Should the standards of practice and professional practice guidelines that the Colleges adopt be legally enforceable? Why or why not?

37. If so, should the Colleges be given statutory rule-making powers (as in New Brunswick) allowing them to enforce the standards of practice and professional practice guidelines that they adopt? Why or why not?

38. What kinds of enforceable rules should the Colleges be able to make without needing Ministerial or legislative approval?

39. What accountability must accompany any rule-making authority?

We do not believe that professional practice guidelines should be legally enforceable. Professional standards relating to issues of professional misconduct are already strong within a regulatory body.

We are also very concerned about the linkages of guidelines for professional practice and standards. It must be remembered that guidelines are simply meant to assist professionals in guiding them in providing service and are not meant to be equivalent to standards of practice, and that standards of practice should be the area seen as having enforceable mechanisms behind it to ensure they are followed by the members of a regulated health profession.

Interprofessional Care at the Clinical Level

40. How will greater collaboration among the Colleges serve to enhance interprofessional care at the clinical level?

We believe that the development of common standards for care, particularly relating to controlled acts, will have important effects on the frontline health care professionals in their capacity to be able to work together as a team. Having a common understanding, provided by common material from the regulatory bodies, on areas of common practice would allow for greater collaboration amongst health care professionals. As well, it would allow for greater equity amongst members of health care teams and ensure that they are able to work together. In these situations, determinations of how the care teams are led should be based on the needs of the particular patient instead of the pre-supposed hierarchy of professional decision making based on regulatory body membership.

41. Are any changes to the RHPA, the health profession acts or their regulations needed to encourage, require, facilitate and enable interprofessional care at the clinical level? If so, what are they?

We believe that, if a new body is developed to enhance and ensure collaboration amongst the colleges, then this new body needs to be charged in legislation. It is important, however, to remember that the health professions often work together collaboratively now to best advance interprofessional care at the clinical level. However, the differences that exist amongst the colleges, as described above, often are seen as interfering with the collaboration amongst individuals at the clinical level of interprofessional teams.

42. Should Ontario law have a requirement similar to the one in New Zealand?

While we support the basic idea of legislation to ensure collaboration amongst health care professionals, we are unclear about how this would be implemented and enforced. We are also unclear as to the efficacy of this legislation in New Zealand. Has it changed professional practice for the betterment of patients or has it added another layer of complexity to the health care communication?

Again, we wish to thank HPRAC for allowing us the opportunity to comment on the issues related to Interprofessional Collaboration.

The Ontario Psychological Association