



**Children's Treatment Network
OF SIMCOE YORK**

SUBMISSION RE
HPRAC INTERPROFESSIONAL
COLLABORATION PROJECT

April 2008



**Children's Treatment Network
OF SIMCOE YORK**

13175 Yonge Street
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Dear Ms. Schiefer:

Re: HPRAC Interprofessional Collaboration Project

On behalf of the Children's Treatment Network of Simcoe York ("CTN" or "Network"), I am pleased to provide the following response to HPRAC's request for submissions with respect to its Interprofessional Collaboration Project. This submission has been a collaborative effort and has been prepared by a Working Group of members of CTN many of whom are themselves "front-line" providers and reflects a wide and varied background of professional expertise and experience. The Working Group included members of the following professions: Occupational Therapy; Nursing; Physiotherapy; Speech Language Pathology; Early Intervention; Social Work; Teaching; and Health Human Resources Management.

This submission is divided into five sections: Introduction; HPRAC Questions; Other Issues; Suggested Recommendations; and Conclusions and Observations.

Brief Answer

In considering the totality of questions posed by HPRAC in its Discussion Guide on Interprofessional Collaboration, CTN is of the view that there are three key principles to understanding and arriving at the correct answers to those questions:

First, collaborative practice is much more than regulation. Indeed, the terms "collaborative practice" and "regulation" might be regarded as an oxymoron, as collaborative practice is something which cannot be required or mandated. It is a philosophical and clinical/pragmatic disposition to the provision of patient-centred care which is not the product of regulation *per se*, but rather a professional culture which values safe, effective patient-centred shared care.

Second, that regulatory collaboration in support of collaborative practice to be effective requires a paradigm shift in the culture of regulatory colleges, and professions, away from being profession-centred toward being patient/client centred; and

Third, it must be remembered that Regulation of the profession is not the same thing as the practice of the profession. Regulators should not be confused with those who actually deliver clinical care. Accordingly, collaborative practice understood in terms of being patient/client-centred focused on needs of the patient/client must be mirrored and applied in all College activities if truly supportive regulation of collaborative practice is to occur.

I. INTRODUCTION

Who We Are

The Children's Treatment Network was first formally proposed in 2002 and launched in 2006 as a new service delivery model specifically designed as a means of removing barriers for families and expanding the range of treatment and services options that are needed in Simcoe County and York Region to help children and youth with physical, developmental, and communication needs progress and participate fully in daily living, school and play.

As of February 2008, we have 43 Network Partners, including: school boards; hospitals; rehabilitation providers; social and community service organizations. In addition, we also have a number of provincial organizations, government ministries and provincial agencies as partners. , We currently support the efforts of 670 Network partner professionals through the use of CTN's online collaboration and communication centre, SharePoint. Sharepoint enables Network staff to share information, access discussion forums and engage in professional development. Most importantly CTN's integrative approach to client care is supported by the use of a shared electronic client record. To date 380 users from various professions are authorized to use the record. CTN's shared record, *singleplanofcare.com*, supports the development and monitoring of a Single Plan of Care across multiple sectors. It promotes interprofessional practice by facilitating communication, joint planning and shared care.

As CTN expands, it will serve more than 4,700 children with multiple disabilities and their families in Simcoe County and York Region. They include children with physical, developmental and communications needs who are receiving services from Network partners and require ongoing, intensive or specialized rehabilitation treatment.

Our Board of Directors reflect a multi-discipline/profession approach to the provision of health, rehabilitation, mental health and education services and includes: Doctors, academics Early Childhood Education Specialist, Physiotherapist, Social worker, Senior Managers of Hospitals and Family and Community members. In addition, CTN governance is also assisted by the Reference Group composed of senior managers and CEO's of all the Network Partners which gives CTN a truly multi-disciplinary approach to the complexities of governing a collaborative enterprise.

What We Do

The types of care and services provided through CTN and its members cover the full spectrum and involve a good number of the regulated health professions and other associated professions. The range of services includes:

- Service Navigation
- Service Co-ordination
- Occupational Therapy
- Speech and Language Therapy
- Physiotherapy
- Feeding and Swallowing
- Recreation Therapy
- Social Work
- Psychology
- Nursing
- Orthotics
- Audiology
- Seating and Mobility
- Augmentative Communication
- Medical and child development services.

CTN services are available to children and their families from birth to age 19 with a wide range of needs and multi-complex conditions and requirements, including:

- Cerebral palsy
- Muscular dystrophy
- Acquired brain injury
- Developmental issues with learning difficulties
- Spina bifida
- Autism or pervasive developmental disorder (PDD)
- Chronic and/or long-term medical conditions that require intensive therapy, specialized equipment or travel to treatment centres outside of the community
- Significant family psycho-social factors.

In providing these services, the Network uses an entirely new collaborative team approach that is first and foremost *client-centred*. The focus of our service delivery model is to create and support an integrated single plan of care for children with multiple disabilities and their families. CTN links and coordinates existing services from our Network Partners of healthcare, recreation, education, social and community organizations, so they can work together with the family to develop a long-term plan of care that adapts to each child's changing needs as they grow. In focusing on the comprehensive needs of the child and their family, the emphasis is on more than just traditional "health care". The client-centred care plan recognizes that it must be based upon a broad understanding of "health", which includes educational, recreational, and social services if the care plan is to be effective and co-ordinated and the appropriate positive client outcomes achieved.

A Brief Word on Context and Definitions

Before addressing a number of questions posed by HPRAC, we believe that it is of paramount importance to set the proper context for collaborative practice the goal of which is needs-based client/patient-centred care. This context can only be understood by first defining a number of key terms: health; client; client-centred care; and collaborative practice.

Health

What is “health”? The traditional understanding of health relating to a strict medical paradigm in which “health” is measured in terms of the absence, or cure, of disease is insufficient to clearly articulate what “health” actually means in the real world of people’s lives. CTN believes that a broader understanding of what constitutes “health” provides one important element in properly understanding the scope and possibilities associated with collaborative practice. Accordingly, when we speak of “health” in this submission - unless a contrary indication appears, we understand “health” in more holistic or “determinants of health”¹ terms in order to expand the idea of collaboration among the client’s entire health care team. It is important to realize that a restrictive definition of “health” does not support client choice and client-centred care - two important goals contained in HPRAC’s Discussion Guide.

Client

As with the term “health”, so too understanding the term “client” - a restricted and narrow definition of “client” will impact upon the nature of collaborative practice both with respect to the members of the team as well as the way in which the team operates. While we are aware that there are a number of names used to describe the user of health care services, such as patient, client, customer, consumer *etc.*, CTN believes that it is important to recognize that no matter what label is used as the identifier it is more than likely that one is dealing with more than just an individual. Thus, we at CTN prefer to adopt the

¹ The Public Health Agency of Canada has noted that:

The federal government also recognizes that spending more on health research is only part of the solution. We can also address health issues by broadening our approach to health interventions. We’ve learned a lot in the past several decades about what determines health and where we should be concentrating our efforts. Much of the research is telling us that we need to look at the big picture of health to examine factors both inside and outside the health care system that affect our health. At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour. These factors are referred to as ‘determinants of health’. They do not exist in isolation from each other. It is the combined influence of the determinants of health that determines health status. (<http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html#determinants>)

The key factors are: (1) Income and Social Status; (2) Social Support Networks; (3) Education and Literacy; (4) Employment/Working Conditions; (5) Social Environments; (6) Physical Environments; (7) Personal Health Practices and Coping Skills; (8) Healthy Child Development; (9) Biology and Genetic Endowment; (10) Health Services; (11) Gender; and (12) Culture.

This view is echoed by the World Health Organization’s own definition of health: “Health is not only the absence of infirmity and disease but also a state of physical, mental and social well-being.”

nomenclature of “family-centred” care, although throughout this Submission we will use the above noted terms interchangeably. This reflects the multi-faceted reality that in providing health care services to children from birth to age 19, one is also working with and serving their family in order to deliver effective health care to the child or youth. Thus, given the context, a broad understanding of who the “client” is allows for the creation and support of a collaborative practice team sufficient in its depth to meet the needs of the client.

Client-centred Care

Client-centred care is first and foremost about the *needs of the client*. It is *not* about the needs of different health care professionals or systemic requirements with respect to the provision of services to the client.

Client-centred care starts with reviewing/assessing the needs of the client in terms of their particular needs and concerns and then developing and providing an *integrated* single plan of care which is focused on outcomes that are relevant to the child and family. “Needs” include not only such things as clinical health status in terms of morbidity, but also educational and social aspects as well as vision and goals of the treatment/therapy/services process which impact upon the client’s overall health.

“Integration” means that instead of health care providers working in parallel silos with each other, they all look for ways in which to integrate efforts of all providers in supporting each other’s work through the provision of services to address the client’s needs and achieve the vision and goals of the care plan.

Finally, client-centred care never loses sight of the fact that the most important member of the health care team is the client them self. Nothing happens in terms of the care plan, from its initial assessment to actual treatment, without the consent of the client/patient, or those who may need to give consent on the client’s behalf. It may seem obvious that there is no proprietary interest in a client/patient, but health care providers and regulators who at times are only too happy to engage in turf wars with each other over who can do what to a client/patient would do well to remember that the only vested interest they have in the client/patient is seeing that appropriate regulatory structures are in place to ensure that safe effective care/treatment is provided by their members so that appropriate health outcomes are achieved.

Collaborative Practice

For purposes of the Minister’s Referral to HPRAC’s, this is perhaps the most important definition. It is this reality which sets the benchmark against which Colleges’ activities can be measured and judged.

Collaborative practice is much more than regulation. Indeed, the terms “collaborative practice” and “regulation” might be regarded as an oxymoron, as collaborative practice is something which cannot be required or mandated. It is a philosophical and clinical/pragmatic disposition to the provision of patient-centred care which is not the product of regulation *per se*, but rather a professional culture which values safe, effective

patient-centred shared care. **The key to understanding effective and real collaborative practice is: when you put the client's needs first, collaborative practice naturally follows.**

There are a number of alternative terms to describe “collaborative practice”, e.g., collaborative or interprofessional care, interprofessional teams, interprofessional practice, transprofessional care, etc. It is not without some sense of irony to note that without clear articulation of these terms, they can themselves act as barriers to team practice. Just as there are a number of terms, so too are there a number of definitions, as HPRAC notes in its Discussion Guide before settling on the definition provided in the HealthForceOntario Report:¹

Interprofessional care is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.

No matter what name or definition is used, it must be remembered that at the heart of what is being discussed is *shared care* and *shared responsibility* for that care. Similarly, because care is delivered in a variety of settings, some traditional such as hospitals to non-traditional settings in the community and at home by a wide variety of care givers, some regulated health care provides, others who are not, it ought to be appreciated that the exact definition and terminology chosen to articulate that definition will vary. Accordingly, what may be more important than any one definition is an understanding of collaborative practice/care which must include the following tenets:

- services provided need to be *safe* as well as *high quality* and *appropriate* - delivered by an appropriate provider (the right service by the right provider at the right time);
- participation in collaborative practice if *voluntary*;
- an appropriate broad understanding of *who the patient/client is* and that they are the key team member(s);
- an appropriate (given the clinical and social circumstances of the client) definition of “health”;
- *Shared decision making and planning* with the patient/client and family - *collaborative care is really about shared care*;
- mutual *respect* and *equality* among team members
- mutual *confidence* among team members
- *recognition* of the *knowledge* of team members and its *transfer* between team members, including the expertise of the patient/client and their family
- *Communication* with all members of the team
- *integration* of knowledge, skills in furtherance of treatment plan
- *Shared responsibility* for all stages of the services provided

¹ HealthForceOntario (July 2007). Interprofessional Care: A Blueprint for Action in Ontario, Interprofessional Care Steering Committee, Government of Ontario, p. 44 cited at *Consultation Discussion Guide on Issues Related to the Ministerial Referral in Interprofessional Collaboration among Health Colleges and Professions* (HPRAC, February 2008) at p.9.

- *Shared and integrated focus on client/patient-centred goals*

It is against this definitional/contextual background that CTN has considered the questions and issues raised by HPRAC in its Discussion Guide.

II. HPRAC QUESTIONS

This following section of CTN's Submission will address a number of questions posed by HPRAC in its Discussion Guide. We have chosen not to comment on all of HPRAC's questions due to time limitations and because many of the questions are legal and technical nature focused on regulators. Instead, our focus has been to address questions that have an impact on the provisions of client-centred care in the context of our experience with collaborative practice. The Questions CTN have chosen to comment upon reflect, we believe, the more important issues underlying collaborative practice which impact upon the Minister's Referral to HPRAC.

A. Definition of "Interprofessional Collaboration"

HPRAC has provided the following "goals" which provide a context for its Discussion Guide and a means of focusing its response to the Minister's Referral. The goals are:

1. 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:
2. Improve patient care and facilitate better results for patients;
3. Protect the public interest; and ensure the highest standards of professional conduct and patient safety;
4. Regulate the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest;
5. Optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services;
6. Ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment, and
7. Enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability.

HPRAC's Question

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?

CTN's Response

HPRAC's initial comment on this section of the Discussion Guide was to observe that it could find no definition of "interprofessional care" in the "Literature Review for collaboration at the regulatory (i.e., College) level." This is not surprising given the fact that regulatory Colleges do not offer clinical care to people. More importantly, it also underscores a basic reality which is often lost sight of, namely: regulation of the profession is *not* the same as the practice of the profession. This axiom will be discussed further below.

At this juncture, it is sufficient to note that given the lack of definition for “regulatory collaboration”, the goals HPRAC have listed appear to be an attempt to arrive at a definition of regulatory collaboration by first identifying the goals of that collaboration and then coming to a definition. Leaving aside for the moment the question of whether this is the best way to arrive at a definition of collaborative regulation in the context of collaborative care, there are a number of observations to make with respect to these goals.

First and foremost is the fact that whatever goals may be articulated, the first and most important goal is to ensure patient safety. Full stop. No other goal, whether regulatory, systemic, political or economic should be allowed to compromise patient safety. Goals 2 and 3 of HPRAC’s list should be combined to reflect this reality and placed as the first goal.

With respect to HPRAC’s first goal, CTN believes that it offers a false dichotomy by giving a choice between competition and collaboration. Indeed, we respectfully submit that competition between health care providers can be a good thing provided that such competition is aimed at striving to provide better care by improving one’s profession abilities. Thus, instead of considering the issue as competition vs. collaboration, we would submit that the real choice Colleges face is one between co-operation on the one hand, and collaboration on the other. Co-operation suggests activities between separate entities which remain siloed and apart from each other, while collaboration suggests activities which are shared between entities that while they may retain their independence, nevertheless share common values and norms - including safety standards, which make their collaboration possible.

In this regard, it is a legitimate question to ask: Why should College’s care about collaborative practice/care in the first place? The *Regulated Health Professions Act, 1991*¹ (“RHPA”) provides the answer: patient safety; quality of care; and access - three key legislative principles which underlie the RHPA. Moreover, there are other RHPA principles which support collaborative practice, namely, Equality as between health care providers, and Equity amongst health care providers. For some reason, HPRAC ignored these important RHPA principles in its discussion of “Policy Objectives” which serve to provide legal support for collaborative practice.²

Second, as College’s primary responsibility is to regulate the profession in the public interest, it may be more propitious to consider the question of regulatory collaboration as really being a question of how regulatory collaboration can support and assist those members of the profession who choose to work in collaborative practice/care settings. That question/goal

¹ S.O. 1991, c. 18, as am.

² It is one thing to talk about “Policy Objective” and another to talk about “legislative principles.” The former are found in the Health Professions Legislation Review’s *Striking a New Balance: A Blueprint for the Regulation of Ontario’s Health Professions* (Toronto: Queen’s Printer, 1989) which contains the policy objectives upon which the RHPA is based; the latter in the actual legislation, as the RHPA is a creature of the legislature with the force of law and its legislative principles are what govern its interpretation and provide for its authority.

seems to be absent from HPRAC's current list and ought to be accounted for given HPRAC's own interpretation of the Minister's Referral Question.

Missing from HPRAC's goals, and which in CTN's view ought to be included, is the recognition of other disciplines, professionals and providers - whether regulated or not, have an influence on the client's health outcomes and play an important part on a collaborative team. For example, it is significant to note that inter-professional collaboration is widely practiced (with consent) in such non-tradition environments as educational settings via In-school Team Meetings and consultation services as well as through multi-disciplinary teams. Boards of Education employ professional professionals from a number of Health and non-Health Profession regulatory bodies *e.g.* College of Teachers, College of Audiologists and Speech-Language Pathologists, College of Occupational Therapists, College of Psychologists, College of Physiotherapists. Within school settings, inter-professional collaboration is supported by practice and most often results in enhanced student achievement. It is this type of reality which HPRAC's goals should seek to support and validate.

While HPRAC's goals appear to be largely centred on systemic issues of efficiency etc, it has been CTN's experience that by putting the patient first, systemic benefits follow. In other words, experience teaches that if one puts the system first, which so much of health care reform is aimed at these days, the end results are almost always the same: poor patient care; longer wait times; fragmentation of care; lack of providers; increasing costs, *etc.* In contrast, by putting the patient/client first many of the current systemic hurdles are overcome with surprising efficiencies.

In the final analysis, CTN believes that HPRAC's discussion can only be enhanced by ensuring that the collaborative practice goals are tied to an understanding of collaborative practice/care as outlined above as tenets in our definition of "collaborative practice." At page 9 of the Discussion Guide there seemed to be an awareness of the need for such a tie in, but unfortunately, that earlier analysis was not carried forward into the Question Section. This is unfortunate, because getting the definitions/context right is essential for all the following questions. Indeed, CTN submits that it is essential to ground the goals of collaborative practice and its regulation in a broad-based understanding of health and service delivery settings, which includes more than just physical/mental health and traditional clinical models of delivery. There is a real need to facilitate definitional change and bring about a new paradigm that sees health in broad terms and collaborative practice as shared care amongst a number of individuals, some of whom may be regulated under the RHPA. That is the challenge facing regulators, to ensure that *all* those involved in collaborative practice/care are able to work to their maximum competence and capacity.

B. Eliminating Barriers

HPRAC's Questions

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?)

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?
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?
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?

CTN's Response

With respect to Question 2, CTN submits that what barriers exist largely exist not because of the legislation *per se*, but rather because of the way in which the RHPA has been interpreted. A key fact, which should not be lost sight of, is that from a legislative perspective the RHPA, with its overlapping scopes of practice and shared controlled acts regime, provides an excellent regulatory framework for collaborative practice to occur. But is it only a framework - much depends upon how that framework is utilized. In other words, the current challenges facing collaborative practice and its support may be more of a software problem and not a hardware problem if regulators are not making the most of opportunities to support collaborative practice.

Colleges working together are one of the best ways to eliminate barriers. In this regard, the Federation of Health Regulatory Colleges of Ontario ought to be commended for the work they do in providing a forum for the Colleges to address common regulatory issues and could be a useful forum to consider issues of collaborative practice.

In particular, the work the Federation has done to arrive at a consensus amongst all 21 regulatory Colleges with respect to delegation and medical directives is a splendid example of collaborative regulation.¹ The Federation framework complements the standards which each College has with respect to delegation, and is an important step, albeit only one step, in making delegation mechanisms more workable and accountable.

However, it must be noted that there still remains restrictions on delegation of controlled acts which can act as a barrier. The extent to which those restrictions negatively impact collaborative practice ought to be fully explored on HPRAC's subsequent consultations in order to arrive at an appropriate remedy which lifts unnecessary restrictions to provide for better patient care.

Recordkeeping requirements can also be a barrier to collaborative practice. For example, the College of Physiotherapists of Ontario requires that physiotherapists clearly identify their particular contributions when multidisciplinary reports are utilized, which is a barrier to collaborative report writing. The college requires that the physiotherapist must clearly identify his/herself next to his/her contributions to the report by initialling specific entries

¹ Can be accessed at: <http://mdguide.regulatedhealthprofessions.on.ca/why/default.asp>.

and/or the use of profession-specific sections with headings followed by a signature. It is not acceptable for the physiotherapist to simply sign the bottom of the record. In addition, the physiotherapist must document a summary statement on every assessment report analyzing findings and determining a clinical impression. This presents a challenge with respect to collaborative report writing.

In a similar manner, Ontario's emerging E-Health strategy will present yet another challenge to collaborative care issues from the following perspective: there will need to be language and definition differences between professions and institutions worked out as the E-Health strategy unfolds. The architecture of Electronic Health Records and Electronic Medical Records will need to be standardized for interoperability, and within that process, it will be of paramount importance to see that shared care frameworks are developed.

In asking the specific question about scopes of practice, HPRAC needs to be aware that "scope of practice" is a two-edged sword. One edge is the legislative framework of scope statement, controlled acts - where applicable, title protection and harm clause. The other edge is associated with the individual health care practitioner and their own personal scope of practice, *i.e.*, their own competency to do certain activities or specialties within their profession's Scope of Practice. This in turn raises the important question of professional competencies and continuing professional education ("CPE") to ensure that competencies are current. One way to ensure the competencies for collaborative practice are current is to require that relevant CPE courses exist for dealing with collaborative practice, including Colleges recognizing other professions accredited CPE courses where relevant to collaborative practice issues.

With respect to Question 3, it must be observed that other ancillary Acts, such as the *Public Hospitals Act*, have not kept pace with the evolving world of professional health regulation. The *Public Hospitals Act* continues to reflect the regulatory world of the old *Health Disciplines Act*. Since the RHPA's proclamation in 1992, changes to the *Public Hospitals Act* and its Regulations have been, at best, a patchwork to address specific provider issues, *e.g.*, Registered Nurses in the Extended Class (Nurse Practitioners).

Similarly, the *Health Care Consent Act* also presumes that all members of the regulatory colleges work in a health care setting rather than in a variety of settings outside of the traditional medico-centric setting.

Information sharing is one of the important keys to successful collaborative practice. Yet new legislation designed to protect privacy and personal safety has made it harder to promote safety through the timely delivery of health care. Specially, the *Personal Health Information Protection Act, 2004*¹ ("PHIPA") places barriers to the timely sharing of pertinent information in non-traditional settings amongst non-traditional health care providers.² To

¹ S.O 2004, c.3 Schedule A, as am.

² Although, it must be noted that the PHIPA express recognition of "implied consent" has helped in improving timeliness of response in health care within traditional settings amongst traditional regulated health care providers.

give but one example, in an educational setting the primary responsibility for student achievement and thus programming for the child lies with the school staff - the teacher, the educational assistant and the school administrator, as defined by the *Education Act*¹ and Regulations. Educational institutions are not defined under PHIPA as a “Health Information Custodian” and there is no “Circle of Care” in a school setting as defined by PHIPA. As a result, professional support staff employed by the school board (Physiotherapist, Occupational Therapist, Speech Language Pathologist, Psychologists) are required to individually gain parent/guardian/student consent to be included in the school team. The health privacy legislation inhibits and restricts the timely response to requests for regulated health professions to engage in the collaboration process between school staff and other professionals within the board.

The real question should be aimed at eliminating barriers posed by ancillary legislation which impacts providers in delivering, and Colleges in supporting, collaborative practice. Unless the ancillary legislation² is also changed, it will provide just one more excuse (barrier) for Colleges and professional associations to drag their feet in supporting collaborative practice, in stead of actively supporting it.

With respect to Question 4, the Ministry of Health and Long-Term Care, and the Minister thereof, play an important systemic role in the operation of the regulatory system. This is particularly true where Ministry policies impact upon health human resources or processes are required to effect regulatory change, e.g., HealthForceOntario initiative or the promulgation of regulations in s. 95 of the *Health Professions Procedural Code* (“HPPC”).³

Perhaps the most problematic system issue facing collaborative practice is the proverbial elephant in the room that nobody wants to talk about, yet which lies at the heart of many a turf battle, and that is: Funding. Funding is another form of regulation; implemented by government as opposed to the Colleges. Accordingly, how one pays for collaborative practice is just as important as how one goes about regulating it. CTN strongly recommends that HPRAC consider in depth funding issues as it moves forward with the next stage of this consultation process both in terms of funding actual collaborative practices as well as the regulatory costs associated with College efforts at supporting collaborative practice.

Policies governing collaborative practice that exist within Colleges must be flexible enough to allow for multiple applications given the compositions of collaborative practice teams and varied settings in which they work. Detailed Guidelines and actual regulations are not appropriate for collaborative practice. Instead, CTN submits that general guidelines and clear articulation of collaborative principles would ensure sufficient regulatory direction;

¹ R.S.O. 1990, c. E.2, as am.

² In this respect, CTN believes that the full range of legislation which may impact upon how a profession practices its profession must be examined, including such Acts as: *The Public Hospitals Act*, *Personal Health Information Protection Act*, *Consent to Treatment Act*, *Mental Health Act*, *Health Arts Radiation Protection Act*, *Laboratory and Specimen Collection Centre Licensing Act*, etc., etc.

³ Being Schedule 2 of the *RHPA*, as am.

remembering that these guidelines and principles must be grounded in the reality that regulation of the profession is *not* the same as the practice of the profession. Regulators have a legitimate role to play in supporting collaborative practice, but Regulators are not clinicians. In addition, as will be discussed more fully below, guidelines should be supplemented with active support through a Collaborative Practice Programme, which is part of a College's Quality Assurance regime. Throughout this process of establishing collaborative Guidelines Principles and Colleges' Collaborative Practice Programmes, there ought to be manifest absolute clarity about the new collaborative and regulatory roles which make clear how accountability is being managed and patient safety achieved through shared regulatory obligations and responsibilities to support, facilitate and sustain collaborative practice.

With respect to Question 5, this is perhaps the most important question in this section of the Discussion Guide. Professional cultures are certainly one large factor - after all, it is through a profession's cultural lens that its regulators interpret the RHPA. However, it is not just professions who have cultures. One must also look to the regulatory cultures inside each College. While these regulatory cultures are reflective of the professional culture the College is responsible to regulate, it should not be forgotten that the Colleges themselves are institutions which have a memory and culture which, in some cases, is the product of generations of regulation. Obviously, the newer Colleges may lack the depth of historical memory and culture which is evident in the older Colleges. Nevertheless, all Colleges regardless of their age possess a culture which shares many of the same traits - not all commendable. For example: a history of working independently as self-regulating bodies rather than as collaborative partners; a tendency to be reactive rather than proactive; cautious instead of innovative; bureaucratic instead of efficient; secret instead of transparent; profession-centred rather than patient/public-centred.

There are of course, exceptions to these generally shared traits as well as degrees of responsibility for sharing in them. However, by and large regulatory culture needs to fundamentally shift towards a patient-centred paradigm if real and meaningful collaboration between Colleges is to come about. Changing the culture of the regulatory Colleges is perhaps the single most important step that needs to be accomplished if collaborative regulation is going to be successful.

In Ontario, health professions remain "self-regulating" - this means that leadership should come from the profession itself, if it takes the privilege of self-regulation seriously; and clearly, there are a number of examples of Colleges and Professions who are taking the challenges and opportunities posed by collaborative practice seriously. For example, the College of Physiotherapists of Ontario has embraced a clear mandate to foster collaborative practice as is evident in their *Strategic Framework 2007-2010* which states as its first strategic objective to: "promote quality health outcomes through advancing interprofessional collaborative practice opportunities that leverage physiotherapists' competencies."

College and professions, however, are not the only ones who need to change their culture towards the client/patient-centred paradigm; so to does the Ministry of Health and Long-Term Care. How this culture change can come about will be addressed in our answer to Question 29 below.

C. Structural Mechanisms

HPRAC Questions

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?
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 an amendment to the statute? 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?
17. Considering reforms in other jurisdictions, what would be the merits of a single complaints model in Ontario? How should such a 'model' be funded?
18. Would the authority to conduct joint investigations following complaints or reports relating to professionals who work in a multidisciplinary setting or practice provide more efficient investigations of such cases?
19. Should Colleges have further authority to collaborate in the disposition of complaints and reports relating to professionals in a multidisciplinary setting or practice?
20. Could such authority contribute to patient safety in interprofessional care?
21. Is legislative change required to accomplish these goals?
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?

CTN's Response

This section of the Discussion Guide, together with its questions, provides an interesting opportunity to consider a substantially different regulatory landscape than the one presently offered by the *RHPA*. However, as interesting as this opportunity may be, in CTN's view, it is rather premature at this juncture to have such a discussion for the following reasons:

First, making such radical structural changes to the regulatory environment raises serious questions about the nature of self-regulation and to what extent the

professions are indeed truly self-regulating. While this may be a valuable discussion to have, it does rather distract from the immediate issues facing collaborative practice and its regulatory support.

Second, such a discussion misses the point by suggesting that collaborative practice and the collaborative regulation thereof can come about through changes to the legal structure. Collaborative practice is not the result of regulatory structures, but rather the creative and innovative impetus of individual health care providers seeking to provide better care to their patients.

Third, many of the questions posed raise serious questions regarding legal rights, obligations and remedies which all engender a conversation which moves the discussion away from support for collaborative practice. Instead, it might be more propitious to recognize that many of these questions would be more appropriately re-drafted and asked with a view to addressing culture and education changes that are required to support collaborative practice at both the clinical and regulatory levels.

Fourth, the introduction of yet another layer of bureaucracy is the last thing that the regulatory system needs at present. The system is complex enough. Experience shows that layers of bureaucracy tend only to protect the “system”, lessen accountability and transparency and stifle innovation and creativity - all of which is counter productive to both supporting and creating collaborative practice.

Fifth, CTN submits that instead of looking to new structures, current structures and resources should be first utilized. In doing so, one does not waste time and resources by raising controversial and contentious issues. Nevertheless, CTN is aware of the importance that legislative structures can play in supporting collaborative practice. To this end, and in order to utilize existing structure and resources, CTN is of the view that s. 80.1 of the HPPC should be amended to specially require that each College have a Collaborative Practice Programme (“CPP”) as part of its Quality Assurance Programme. Minimum specifics of the CPP should be articulated in the legislation and should include public reporting requirements. It should also be required that CPPs should be collaboratively developed as between Colleges - once again, the Federation of Health Regulatory Colleges of Ontario could provide a valuable forum in which this could take place.

Sixth, consistent with placing collaborative practice within the purview of Quality Assurance, there must be a shift in the regulatory approach to discipline away from the punishment paradigm towards a model of patient safety and professional development through remediation. In other words, appropriate accountability in the context of a collaborative practice framework will be made possible through shared responsibility which is aimed at remediation and correcting practice error, rather than looking to punish through disciplinary sanctions. This shift, and its accompanying cultural shift towards patient/client-centred regulation of health care professions should not be sidetracked by the false issues raised by the proposed structural changes outlined in HPRAC’s questions.

D. Instruments to Support Interprofessional Care

HPRAC's Questions

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?

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?

CTN's Response

With respect to Question 29, CTN believes that s. 5(1)(d) of the *RHPA* gives the Minister sufficient authority and provides the Minister with an excellent opportunity to further collaborative practice development by showing the necessary leadership and commitment to transitional systemic reform. Indeed, *leadership and the articulation of a clear vision will be the key elements and catalyst in facilitating Colleges' collaboration on a common approach, framework and guidelines*. However, such development is contingent upon the Minister requiring the Colleges to undertake the appropriate initiatives and consultation with their members in the context of changing regulatory and professional cultures. In doing so, it must be remembered that: Regulation of the profession is not the same thing as the practice of the profession. Regulators should not be confused with those who actually deliver clinical care.

Accordingly, CTN submits that the Minister should, after consultation with the Colleges, expressly direct the Colleges to jointly work towards and produce a common framework for implementing and sustaining regulatory cultural change which includes supporting collaborative practice, one component of which would involve collaborative regulation. CTN believes that such a direction from the Minister would have the following benefits:

- Provide the opportunity for real cultural change within Colleges and professions which is essential if collaborative regulation and practice is to be effective;
- Provide the Colleges with a level of accountability to move forward on an issue which may prove difficult for some professions to get behind;
- Provide the opportunity to be supportive of collaborative practice;
- Provide health care practitioners with the ability to consult with their regulator for the benefit of their clients in an open and required discussion;
- Provide for the development of principles and guidelines that could be applied in any practice setting through consistent application among the Colleges;
- Provide the opportunity to develop co-ordinated remedial best practices for dealing with complaints raised in the context of collaborative practice as a means of improving patient safety and supporting collaborative practice; and

- Provide the opportunity for leaders and champions of collaborative practice and culture change to come forward thereby allowing Colleges to work together to develop collaborative regulatory practices which maximize efficiencies in the current regulatory structure.

With respect to Question 31, collaborative practice programmes and activities should be reported annually as part of the College's current obligations under s. 6(1) the RHPA. While transparency and accountability are important, however in addition there also needs to be a broad public education initiative undertaken to explain to the public the nature and benefits of collaborative practice and the roles played by the various actors, including client/patients, health care providers, regulators and the professions' associations. Such an education initiative should co-inside with College annual reports to ensure accurate and up-to-date information.

E. Interprofessional Care at the Clinical Level

HPRAC's Questions

40. How will greater collaboration among the Colleges serve to enhance interprofessional care at the clinical level?
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?
42. Should Ontario law have a requirement similar to the one in New Zealand?
43. If so, what should the requirement look like and should there be consequences for a failure to meet the requirement?

CTN's Response

With respect to Question 40, CTN believes that greater collaboration among Colleges must start first with Colleges greater collaboration with their members around the ways and means Colleges can support the their respective members in collaborative practice.

In addition, it is important to recognize that inter-professional collaboration among colleges should also include non-health colleges, e.g. Teachers, Social Workers, in the collaboration process as their members often share common clients and work as part of a collaborative practice team. The move to recognize other non-regulated health care members of the collaborative teams ultimately reflects the fact patient care happens in a variety of settings other then hospitals or medical clinics.

In the health profession education environment, changes to permit inter-professional care between health care professionals would be advantageous in a school setting but it does not address the need for inter-professional care among non-health professionals e.g. members of the College of Teachers or College of Social Workers.

CTN submits that once the College/member collaboration has been secured, greater collaboration between regulatory Colleges will naturally follow and may provide the following benefits:

1. first and foremost, better clinical outcomes for patients which features the delivery of safer and more effective care;
2. through inter-college collaboration comes the regulatory endorsement of interprofessional teams. This is how support for such team models is *demonstrated*. This will likely lessen fears and insecurities related to the model of collaborative practice;
3. collaboration and focus of multiple colleges increases potential for research in this area and encourage innovation across a wide spectrum of clinical practice fields;
4. with the decrease in health human resources, collaborative practice appears to enhance job satisfaction, which will be reflected in nursing and other health care professional recruitment and retention. Participants are *valued* members of the team and College's demonstrating their support for collaborative practice will add confirmation that this is so;
5. collaborative work by the Colleges will result in increased respect and understanding of all disciplines;
6. with the demonstrated success of various collaborative practice models comes the ability to build on and learn from those successes in order to duplicate and/or offer innovative models of interprofessional team practice in other clinical areas;
7. collaboration may result in getting the attention of the Provincial Ministries and funders other than the Ministry of Health and Long-Term Care. This will help offset costs, as developing interprofessional teams can, while being worth while, be a time and resource consuming process; and
8. collaboration will assist in ensuring that all professions recognize the client/patient as central to the care process and that determination of successful "health" outcomes.

With respect to Question 41, CTN has previously answered this Question in relation to other Questions.

With respect to Questions 42 and 43, great care must be taken before introducing a "right" to collaborative care. By definition, "rights" are meaningless unless there are effective and efficient remedies to their violation. Moreover, equally important is the corresponding "duty" which accompanies a "right". The New Zealand model is premised upon both rights and duties. Any right to collaborative care and the corresponding duty to provide such care ought to be part of a comprehensive Patient Bill of Rights - a major and necessary reform which needs to be undertaken if the health care system, including

regulators as well as professions, is to move towards a client/patient-centred culture which is both sustainable and effective.

III. OTHER QUESTIONS/ISSUES

After having had the chance to work through HPRAC's questions and the issues which those questions engage, we have had the opportunity to identify a number of additional issues which are germane to the Minister's Referral:

1. As noted earlier, funding is a large and important issue which effects not only collaborative practice at the clinical level, but also at the regulatory level. Funding models and associated issues, such as Transitional Funding, ought to be addressed.
2. Team building amongst regulatory Colleges and how this can be effectively accomplished is another issue which would bear fruit in supporting not only collaborative practice but also cultural change.
3. The issue of "common clients" poses the challenge of how to embrace collaborative regulatory practice which involves non-health regulated professions such as the College of Teachers or the College of Social Workers? There is a real need to reach out to these other professional regulatory bodies and include them in this process.

IV. SUGGESTED RECOMMENDATIONS

We believe that, at a minimum, the following should be recommended to the Minister of Health and Long-Term Care with respect to the question posed by the Minister in his referral to HPRAC:

1. That any regulatory collaborative practice initiatives undertaken by the Colleges and Ministry of Health and Long-Term Care be based on, and tied to, a broad appreciation for what constitutes "health" which reflects an understanding of collaborative practice which is client/patient needs-centred and based upon the tenets outline above in CTN's definition of "collaborative practice."
2. That all ancillary health legislation be thoroughly reviewed, revised and amended to make it consistent with current health profession regulatory regime ensuing that barriers to collaborative practice are eliminated.
3. That s. 80.1 the HPPC be amended to specifically require that College's maintain, as part of their Quality Assurance Programme, a Collaborative Practice component. Part of this programme should include development, and recognition, of interprofessional Continuing Professional Education programmes.

4. That the College's Objects contained in s. 3 of the Health Professions Procedural Code be amended to clearly state that the College is required to support and develop collaborative practice of their members in addition to regulatory collaboration currently listed.
5. That the Minister of Health and Long Term-Care direct the Colleges to carry out consultations with their members and each other on their Collaborative Practice programmes as part of a regulatory culture paradigm shift towards client/patient-centred health care delivery. This culture shift is of paramount importance, and should include moving the regulation of health care professionals away from a disciplinary model based upon punishment to a professional development model based upon remediation principles.
6. That the Ministry of Health and Long-Term Care, together with other allied Ministries, become actively involved in promoting collaborative practice to the public in such a way that the public begin to recognize the benefits of working in, and with, a collaborative team.
7. That in collaboration with other Ministries, the Minister of Health and Long-Term Care fund pilot projects for the development of collaborative practice models and the evaluation of current models to gather information and research on other collaborative practice models.
8. That the Ministry of Health and Long-Term Care be directed to look at other initiatives currently being undertaken by the Ministry of Education's collaborative practice model for Autism as well as the Ministry of Health and Long-Term Care's Central LHIN's Doorway to Care project for assistance in developing a collaborative practice policy for the Ministry.
9. In recognizing that interprofessional care goes far beyond just regulatory health profession colleges, it is recommended that interprofessional collaboration becomes a broader government initiative across a number of Ministries and that the co-ordination of interprofessional practice across all self-regulating professions becomes a policy priority.

V. CONCLUSIONS AND OBSERVATIONS

The Children's Treatment Network would like to conclude with the following five observations:

1. Regulation is not the same as the practice of the profession. While there is a role for Regulators to play in supporting collaborative practice, regulators should not be allowed to get in the way of collaborative practice through its over-regulation or through applying sole practitioner regulation templates to team practice.
2. Suggestions of radical changes in the regulatory model to address one model of professional practice go too far to address the real needs of clients/patients and

those who provide care. It must be remembered that collaborative practice is properly grounded in client/patient needs which means that not all client/patients will need collaborative practice.

3. Collaborative regulation to be effective must start from the ground up - with those who practice collaborative care and have already integrated the profession-specific requirements into a new model of shared care that is more than just the sum of the individual professions. Both the legitimacy and effectiveness of collaborative regulation depend upon this reality being respected and utilized in developing the appropriate regulatory support which is itself dependent upon cultural change in both regulated health professions and their regulatory Colleges.

4. The education of health professionals must be recognized as being an important catalyst to collaborative practice and that the Institute of Interprofessional Education at the University of Toronto provides a model for other health profession education centres in the province.

5. We at CTN are especially aware of the positive impact that collaborative practice can have on the outcomes of children with multi-complex needs and their families. This provides a sense of optimism and a realization that collaborative practice can work so long as it is client-centred. At the same time, however, we are also deeply aware of the costs of failure to children and their families if collaborative practice does not work. The lesson is clear: we, that is all of us involved in the provision of services to others, need to make sure that we get collaborative practice, including its regulatory facilitation and support, right.

We trust that HPRAC will find these responses and comments of use as it moves forward with the Interprofessional Collaboration Project. If I and my colleagues can be of further assistance to HPRAC, please do not hesitate to contact the undersigned.

All of which is respectfully submitted.

A handwritten signature in black ink, appearing to read "Robert Morton". The signature is written in a cursive, slightly slanted style.

Robert Morton
CEO