

# YOUR OPINION COUNTS...

MAKING YOUR SUBMISSION TO HPRAC:

PLEASE ATTACH THE FOLLOWING INFORMATION SHEET TO YOUR SUBMISSION TO HPRAC. YOUR SUBMISSION SHOULD BE SENT NO LATER THAN MAY 31, 2008, TO:

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We prefer submissions to be made in Microsoft Word, either on disk (by mail) or by email when possible. Electronic submissions can be made to: [HPRACSubmissions@ontario.ca](mailto:HPRACSubmissions@ontario.ca). If fax is more convenient for you, please address your comments to: HPRAC, INTERPROFESSIONAL COLLABORATION PROJECT, at 416-326-1549. Hard copy submissions should be sent to the above address.

## Submission Details:

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***Please note that complete submissions or excerpts may be referenced in HPRAC's report to the Minister of Health and Long-Term Care, and that they will be posted on HPRAC's website. All submissions and correspondence may be the subject of a request under the Freedom of Information and Protection of Privacy Act (FIPPA). If you wish any part of your response, submission or correspondence to be withheld, please indicate that and provide the reason for your request.***

This sheet can be downloaded with the full Discussion Guide (PDF format) from the HPRAC website, <http://www.hprac.org>, in the Interprofessional Collaboration section under Current Ministerial Referrals.

## **PART 5: Your Opinion Counts: How to Make your Submission to HPRAC**

### **Possible Mechanisms to Facilitate and Support Collaboration among Health Professions' Colleges**

The *Health System Improvements Act, 2007*, established a clear mandate for the Colleges to engage in greater interprofessional collaboration.

The Act provides new enablers for Colleges to interact with one another, including the additional College objects, to take effect no later than June 2009, as well as revised confidentiality provisions that clarify the Colleges' ability to share information with one another for the purposes of the *RHPA*.

To assist the Colleges in achieving the new objects, the Minister has asked HPRAC to recommend mechanisms to facilitate and support collaboration among the Colleges.

The literature and jurisdictional reviews demonstrate the important role that regulators must fulfill in supporting and enabling interprofessional care at the clinical level.

HPRAC has an opportunity to recommend options to the Minister that will provide Colleges with needed tools to improve collaboration among the Colleges and their members.

HPRAC has considered:

- The challenges Colleges have faced in their collaborative endeavours;
- The steps taken in other jurisdictions, and
- Possible mechanisms for a made-in-Ontario solution to advance collaboration among the Colleges.

## HPRAC'S QUESTIONS

To assist HPRAC in developing advice for the Minister, the Council has developed a number of questions on which your comments and insights are sought. We welcome and appreciate your participation, and hope that you will provide notes and references from your knowledge and experience, as well as other thoughts about ways in which interprofessional collaboration can and should be supported. We are asking that all responses be forwarded to HPRAC no later than April 15, 2008.

### Defining Interprofessional Collaboration

**Background:** This Discussion Guide is focused on exploring the issues, challenges and opportunities concerning the Minister's request for advice from HPRAC.

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.

### QUESTION FOR DISCUSSION:

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? **No Changes**

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## Eliminating the Barriers to Collaboration among the Colleges

**Background:** People who participated in HPRAC's workshops as well as information from the literature review confirm that many patients and clients, caregivers, health care professionals, health care providers, regulators and decision-makers are ready to embrace interprofessional care. Evolution and change within the health care system requires examination of the various legislation, regulations and policies that support the system to ensure that they are keeping pace with the changing needs of those affected.

In response to the Minister's request, HPRAC is seeking to find ways to enable the Colleges to collaborate by eliminating the barriers to collaboration and identifying new ways for the Colleges to support and enable interprofessional care by their respective members at the clinical level. In this Discussion Guide, HPRAC has identified some possible mechanisms to facilitate and support enhanced collaboration among the Colleges as a step towards the ultimate goal of enhancing the delivery of interprofessional, patient-centred care.

In its report to the Minister, HPRAC intends to address the legal, policy and systems issues that are currently acting as barriers to collaboration among the Colleges. By way of example, in *New Directions*, HPRAC reported to the Minister that the language of section 36 of the *RHPA* (the so-called "secrecy clause") acted as a barrier to the transfer of information between and among Colleges. This barrier was addressed in the *Health System Improvements Act, 2007*, by clarifying the Colleges' ability to share information with one another for the purposes of the *RHPA*.

### QUESTIONS FOR DISCUSSION:

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?)

**Details related to scope of practice that enter into legislation are a barrier to the individual health care provider group. The classic example is the RN(EC) drug and lab list. The list was entered into Regulation in 1998 rather than managed at the College level. Thus, changes to the list require an arduous and, ultimately political process that takes many years. The process has become a tool used by some agencies to forward their own agendas against NPs despite evidence contrary to their recommendations.**

**Overarching issues, such as the granting of authority for controlled acts, should be in regulation. However, the details related to how this will play out in practice should be directed at the College level.**

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?

**These two questions can be answered at the same time. The most significant legislative and regulatory barriers to interprofessional collaboration are not those**

within the RHPA, but rather are the Acts that continue to exist in other areas of government that conflict with changes in legislation at the College level. For example, RN(EC)s have a legislated scope of practice that is relevant in the community. However, due to continued restrictions in the Public Hospital Act and Long-Term Care Act, RN(EC)s are restricted from the care they are able to provide.

Another equally significant policy and system barrier to interprofessional collaboration is the remuneration of each regulated health care professional. In part this is a reflection of lack of change in old regulation in order to support the changes in regulation at the College level. An example of this is the RN(EC) referral to specialist. It has long been known that medical specialists are able to receive a referral directly from a NP, however, they are able to bill OHIP considerably less than if the referral comes from another physician. The result is that specialists require 'co-signatures' of NP and collaborative GP for referrals even if the assessment and referral were completely within the NP scope of practice and completed by her in its entirety. In other words, OHIP coding practices did not change to reflect the change in legislation for RN(EC)s.

Another example is that many regulated health care professionals are remunerated from direct patient payment, third party or insurance billing. This creates difficulty in collaboration if the patient in question is not covered for the service of the other provider. It has been my experience in practice that many people with musculoskeletal issues would benefit greatly from the assessment and treatment of a chiropractor or physiotherapist, but were unable to do so due to the cost. Unfortunately, the treatment provided in these cases is usually pain symptom control rather than treatment and potentially elimination of the underlying problem.

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?

Many cultural issues which have been barriers to interprofessional collaboration have been addressed. One of the biggest barriers to this care in the past has been the situation of physician as gate-keeper to health care. There are now many points of entry. People can see RN(EC)s for their primary health care. They can see physiotherapist, massage therapists and chiropractors without a referral from physician. Work needs to continue toward addressing inequities in the access to all health care providers. Colleges need to support work toward primary health care, acute and long-term care settings which implement truly interprofessional teams including RN(EC)s, physicians, dieticians, social workers, physiotherpists, massage therapists, chiropractors, etc.

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Liability Issues

**Background:** Some organizations have indicated that lack of a legislative requirement for professional liability insurance coverage for all regulated health professionals may be a significant impediment to collaborative team building. Others disagree.

**QUESTIONS FOR DISCUSSION:**

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

One liability issue that has been a barrier in the past for nurse practitioners is related to misinformation and confusion about physician liability when working with nurse practitioners. The Canadian Nurse Protective Society worked with the NPAO to clarify the issues of individual provider's liability issues which has eliminated the concerns of physician groups.

The CNPS formulated a joint statement with the CMPA to clarify the various terms and issues related to liability within interprofessional groups. It can be reviewed at:

[http://www.cnps.ca/joint\\_statement/joint\\_statement\\_e.html](http://www.cnps.ca/joint_statement/joint_statement_e.html)

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

The answer to this question is related to the work environment of each health care provider. If the provider is an employee of an agency, such as a community health centre, the agency is the first named in a suit. If the provider is an independent contractor, they are personally liable and need to purchase the insurance separately. Therefore, yes, each health care provider should hold a minimum liability insurance, but this could arise either from agency based liability insurance or self-purchased, depending on their work arrangement.

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

The liability insurance should be occurrence-based with a rate which is determined by the insurance industry standards. Occurrence-based is the preferred insurance as it continues to be in effect even if the provider discontinues work with the environment in question and is in effect if the provider held liability insurance coverage during the time that the incident occurred. This ensures that if a provider changes work environments, retires, changes work etc, he or she continues to be covered for previous work.

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## **Developing Enablers for Collaboration among the Colleges**

**Background:** As mentioned at the beginning of Part 5, the *Health System Improvements Act, 2007*, establishes a clear mandate for the Colleges to engage in greater collaboration with one another. The questions in this section examine some different approaches that could be used to facilitate this.

HPRAC's literature review indicates that the legislation and regulations governing Colleges should not prohibit collaboration among the Colleges nor should it be silent on the issue of collaboration. Instead, the legislation and regulations should specifically encourage, require, facilitate and enable collaboration among the Colleges.

*Legislatures and regulators have not traditionally made collaborative care one of their main objectives. Current legislation and regulation do not prohibit collaborative practice, nor do they encourage, require, facilitate or enable it. Legislation and regulations should be updated and amended to expressly support collaboration. In Canada, there is inconsistency and a lack of clarity in legislation and regulation with respect to collaboration. When these flaws exist, regulators and health care professionals err on the side of caution. Therefore, legislators and regulators must be clear and consistent in emphasizing the importance of collaboration.<sup>1</sup>*

Mechanisms should be built into the legislative framework to enable regulators of various health professions to work together to build effective interprofessional collaborative arrangements within and across the health care continuum.

#### QUESTIONS FOR DISCUSSION:

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?

**The RHPA could ensure that each profession has criteria for collaboration. This is similar to the criteria for consultation with a physician that is embedded within the Standards of Practice of the RN(EC). However, the criteria for collaboration would have to be more generalized in order to provide flexibility related to the details of collaboration.**

10. What changes to other Acts or regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?

**It is important that when a scope of practice is legislated through a professional college, that all other Acts and Regulations are changed to support it. Nurse practitioners have struggled with this issue from the outset of the enactment of our legislation. We were given the authority to complete physical exams, diagnostic tests, diagnose and prescribe treatments within a specific scope of practice. Unfortunately, this authority was not recognized in other Acts and Regulations, such as the Highway Traffic Act. The result is that NPs working in Ontario must have a physician to sign the Driver's physical assessment form that is required by many of their patients (eg. to be a bus driver). The actual assessment criteria on the form is completely within the NP scope of practice. This situation has re-occurred many times and NPs have had to fight each legislation separately. Examples include completion of the Ontario Disability Forms, completion of physical assessments required by Children's Aid Society and completion of the disability parking permit. This situation does not promote interprofessional collaboration. It creates a situation where NPs are not able to provide care for their patients that they are qualified to provide. Patients are often inconvenienced in that they have to either find a different provider to complete the**

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<sup>1</sup> Ibid.

**forms, or return to the clinic to see a provider who is able to complete the forms. It does not support interprofessional collaboration. Rather it creates barriers.**

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

**A system of Cross-Appointments between established Colleges and newly forming Colleges could provide a system of support to the newer Colleges as well as information sharing between each.**

12. Are there administrative responsibilities within Colleges that could be shared with related Colleges? What barriers exist to shared administration services?

**Barriers include lack of understanding of the scope of practice, practice settings etc related to the new College has to face. Another reality is that each College is housed in a separate physical space with its own overhead costs.**

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## **Structural Mechanisms**

**Background:** HPRAC's jurisdictional review identified some approaches to health professions' regulation that are supported by *structural mechanisms* worthy of consideration. Several jurisdictions have established common complaints, investigations or disciplinary frameworks for all or several health professions.

Some say that "*encouraging regulators to work together in areas of quality assurance, complaints and discipline would signal the importance of collaboration to health professionals*".<sup>2</sup> A common framework for such matters might lend itself to more effective and efficient management of complaints that might arise in an interprofessional care setting.

Standards of practice are developed by regulated health professions through mechanisms reflected in legislation. They are intended to guide a profession in its delivery of health care and ensure the appropriate level of quality. They may also promote continuous learning and improvement. Examples of standards of practice include record keeping, reporting of diseases and standards for the performance of one's duties.<sup>3</sup>

Professional practice guidelines are regulatory instruments that provide recommendations to members of a profession on matters such as codes of ethics, consent and advertising.<sup>4</sup>

### Complaints, Investigation and Discipline

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<sup>2</sup> Ibid.

<sup>3</sup> Ibid., p. 14 and 51.

<sup>4</sup> Ibid., p. 14 and 50.

**Background:** Victoria (Australia), New Zealand, Denmark, Nebraska, Virginia and Washington all have a common complaints, investigation or disciplinary framework for all regulated health professions.

**QUESTIONS FOR DISCUSSION:**

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?

**A common framework to address complaints etc arising in an interprofessional care setting is a good idea, however, immediately a number of concerns are raised. The government should be careful that this step is necessary and is not merely an added layer of administration. It is not clear from this discussion if the idea is to create a common framework that is utilized individually by the Colleges that represent the professions in question or if there is a separate body that utilizes the framework for investigation and decisions related to complaints of this nature. The latter makes more sense. However, if there is a separate body to conduct the investigations it will need to have final authority in this issues brought to it so that individual Colleges are not able to veto or alter the decisions. The actual utilization of the framework must be put forward in an impartial and non-political manner so that the interests of specific groups or disciplines does not take precedence over decisions related to safety of the public. Finally, the definition of an “interprofessional care setting” will need to be carefully constructed. As a nurse and nurse practitioner, I cannot name a single agency or setting where I worked in isolation of other health care professions. However, not all the professions worked in the same facility. An example is a call made to a pharmacist for advice on a prescription.**

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

**The common framework should not include authority to recommend changes to or comment on the scope of practice of the individual health professions. It should focus on specifics related to the manner in which the professions work and the complaint that has arisen from this site.**

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?

**Not sure how this could be done effectively.**

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?

Please see my comments related to this in question # 13. There are a number of possible mechanisms for funding. Since it is meant to serve Regulated Health Professions, the model could be funded by a percentage of professional dues from each of the professions. In contrast, the model could be funded exclusively by the MOHLTC.

**Background:** In its 2006 *New Directions* report to the Minister, HPRAC recommended that, when a complaint or report concerns a service provided in a multidisciplinary environment, Colleges be given explicit authority for their investigators to work with investigators from other Colleges, and to share information in the course of the investigation. Evidence from the Patient Safety movement indicates that medical errors most frequently are not the fault of one individual, but may be the result of several systemic failings.

**QUESTIONS FOR DISCUSSION:**

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?

It is also my experience that many mistakes are, in part, system or process concerns that involve many other people. Theoretically, joint investigations would be more efficient.

19. Should Colleges have further authority to collaborate in the disposition of complaints and reports relating to professionals in a multidisciplinary setting or practice?

Yes. This could be an important change in some settings. It is important that the factors in the case that relate to a specific scope of practice of a professional are taken into account. Recommendations, then, would reflect the practice of all participants.

20. Could such authority contribute to patient safety in interprofessional care?

All parties working together to complete a comprehensive portrait of an issue will more easily be able to address all the factors related to the concern and put preventative recommendations in place.

21. Is legislative change required to accomplish these goals?

Yes, it is likely best that legislation be put in place to ensure that recommendations made by these joint investigations are put into practice. Otherwise, Boards, Medical Advisory Committees etc may not be willing to address the concerns.

## Quality Assurance

**Background:** Some Ontario Colleges have informally developed joint quality assurance programs that involve more than one profession.

### QUESTIONS FOR DISCUSSION:

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?

**This program would be helpful for a number of reasons. First, it could eliminate the need for each College to work on these guidelines independently and create more efficiency in the process. Second, it may facilitate discussion about collaborative practice.**

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?

**Yes, a joint quality assurance program among Colleges could provide enhanced continuing competence and exposure to best practices if this same program encouraged certification and education programs related to the common areas of scope of practice. A good example of how this is currently working is with the Society of Obstetricians and Gynecologists. They host conferences across Canada every year which highlight new research and best practice in women's health along with some specific certifications (ALARM program). The membership of the SOGC includes OB/GYNs, physicians, nurses, nurse practitioners and midwives. Other groups of professionals with similar scope of practice could be encouraged to create associations with the goal of enhancing the work related to this common practice.**

24. Is legislative change required to accomplish these goals?

**NO. It is important that as little as possible is put into legislation. The reason for this is that the health care system is a dynamic, ever-changing entity. For a shared quality assurance program to truly work, it needs to have flexibility to respond to evolving environments. Nurse Practitioners have learned the hard way that legislation is not permanent, but is extremely difficult to change. The NP drug and lab list was put into legislation rather than**

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## Standards of Practice and Professional Practice Guidelines

**Background:** Some jurisdictions have introduced a new body (independent of government and of the regulatory bodies) to assist with interprofessional collaboration and, in some cases, with the development of standards of practice and professional practice guidelines. For example:

- Quebec has established an Interprofessional Council that acts as an advisory body to the Government and as a coordinating body for the regulatory orders (i.e., the Colleges). The Interprofessional Council creates opportunities for the exchange of ideas and information among the regulatory bodies, intervening as the collective voice on issues of common interest to them and providing information to the public.
- Virginia has established a Board of Health Professions that:
  - Evaluates the need for coordination among the health regulatory boards and their staff and reports its findings and recommendations to the Director and the boards;
  - Monitors the policies and activities of the Department, serves as a forum for resolving conflicts among the health regulatory boards and between the health regulatory boards and the Department and has access to departmental information;
  - Promotes the development of standards to evaluate the competency of the professions and occupations represented on the boards, and
  - Examines scope of practice conflicts involving regulated and unregulated professions and advises the health regulatory boards and the General Assembly of the nature and degree of such conflicts.
- The United Kingdom has established the Council for Healthcare Regulatory Excellence (CHRE), an arm's-length agency accountable to Parliament and responsible for overseeing the health regulatory bodies. Its mandate includes the promotion of best practice, cooperation and consistency in the regulation of health care professions, in the interest of patients. The Council also has the power to direct regulators to make or change its rules if it believes that such a change is necessary to protect the public (subject to the approval of both Houses of Parliament).
- Denmark has established a Secretariat for Clinical Guidelines as a unit of the National Board of Health. It supports medical societies and other health care professionals in developing clinical guidelines. The clinical guidelines are evidence-based, involving interdisciplinary work. This encompasses relevant medical specialists as well as other health care professionals and integrates organizational and health economic aspects and patients' views.

**QUESTIONS FOR DISCUSSION:**

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?

**As with the discussion about the common framework to review complaints, this is a good idea in theory, with some very big concerns about how it will play out in practice. This organization will represent not only an additional layer of bureaucracy, but also a very big expense. The MOHLTC should endeavor to ensure that there is a real need for it before moving forward with implementation.**

If there is a separate body to conduct the investigations it will need to have final authority in this issues brought to it so that individual Colleges are not able to veto or alter the decisions. The actual utilization of the framework must be put forward in an impartial and non-political manner so that the interests of specific groups or disciplines does not take precedence over decisions related to safety of the public. Members of this organization should have to demonstrate a good knowledge of the structure of RHPA and how scope of practice is determined and administered.

My concerns with this type or organization arise from experience with work on the NPAO. The College of Nurses hosts a process for review of the list of medications and diagnostic tests that should be added to the RNEC list. This is a LONG and difficult process which includes, as one part, a meeting of Stakeholders. The stakeholders included not only CNO, but representatives from the MOHLTC, and a host of other health care professional groups. I attended one of these meetings as the Practice Director of the Nurse Practitioner Association of Ontario. It was clear that many members on the panel were not well versed in the scope of practice of the RN(EC), had never worked in a collaborative relationship with a NP and were not attending to review the list in question, rather were there to encourage the restriction of the scope of practice of the RNEC. The ability for one or two members on this panel to create such havoc leads me to conclude that there are many risks with the “independent arm’s-length organization” that has been suggested.

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; Yes, this is important. Many NPs have been entrenched for years in trying to enhance legislative authority of RNECs so that, as a group we are fairly well versed in “how the system works”. However, I am not sure that the same is true for all health care professionals. It is very important to understand key elements of the regulatory model and role in order to facilitate collaborative practice.
- 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); This is also a very helpful. Rather than each College “reinventing the wheel” and implementing varying policies, a repository with evidence-based data and frameworks will save time, money and create a common language between the Colleges.
- Research and develop standards of practice and professional practice guidelines, and disseminate best practices; These three points could be part of the joint quality assurance program which is discussed in a previous question.
- Resolve disagreements among professions that share overlapping scopes of practice and the same or similar Controlled Acts; I’m not sure how this would differ from a joint quality assurance program, except that this recommendation appears to give the independent body final authority in these issues. I am not in favour of this.
- Address issues arising from conflicting legislation, and This will be very helpful. As I brought forward in other questions, NPs have struggled with legislation that conflicts and restricts our Scope of Practice (eg. Ministry of Transportation Driver’s physicals, Public Hospital Act preventing NPs from working to full

scope in hospital settings, Long-Term Care Act etc etc). I'm sure that other regulated health care professions will face the same difficulties as they gain regulation and/or work to expand their scope of practice. A central body to address these issues would be extremely helpful, especially as it would have easier access to the necessary resources and ministries.

- Have an oversight function over regulatory bodies, as in the United Kingdom.

This is possible, but I am cautious with recommending it as outlined in question #25

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

This could possibly be a division of HPRAC.

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

If it is an independent body, it could be funded through MOHLTC or through a percentage of professional dues from every regulated health care professional.

**Background:** The Minister's request states that "regulators should develop standards of practice and professional practice guidelines where regulated health professions share the same or similar Controlled Acts."

However, without a clear legislative mandate to do this, it may be difficult for the Colleges to justify spending limited time and scarce resources on something that is not legally required of them.

#### QUESTIONS FOR DISCUSSION:

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?

While this is one possible strategy, it would be more effective to address the barriers to practice that exist outside of the regulatory bodies. The most pressing of this is the method of remuneration. Collaboration between the professions is enhanced when there are no financial barriers brought on by method of payment. In other words, interprofessional collaboration would take place more readily if a variety of professions could be hired to work at the same site. A primary health care clinic with staff including nurse practitioners, physicians, social workers, dietitians, chiropractors, pharmacists etc. intrinsically work in an interprofessional manner without legislative interference.

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

No, it has been my recent experience that funding directed toward interprofessional endeavors has not met the objective. The most effective interprofessional collaborative teams I have witnessed have arisen from the

**practice level, not from the Colleges. When there is appropriate funding and a will to make it happen, interprofessional collaboration naturally evolves.**

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?

I'm not sure what value there would be in this extra reporting requirement, especially if some of the other measures are put into place (eg. independent organization, quality assurance program etc) The Colleges should ensure that interprofessional collaboration is reflected in the scope of practice of the health care professions under their jurisdiction and monitor the practitioners through such things as annual reviews.

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?

There should definitely be common standards and policies for all Colleges with respect to the matters addressed above. The inconsistency within and across professions creates difficulty for patients. For example, the process and availability in obtaining medical records for new patients from their previous family practices is as varied as the number of providers. In addition, it is next to impossible to obtain a record from a walk-in clinic. I recently moved to a new dentist after 15 years and the only record that the old office sent over was my most recent x-ray, even after I made a request and signed a consent. Another example is a system where the OMA and MOHLTC want all NP patients rostered to a physician whether or not he/she ever meets or knows the patient. This results in physician payments of primary health care bonuses for work they have not completed. It is not only a professional issue, but a taxpayer's issue. Guidelines related to conflicting policies need to be implemented so that these problems come to light more readily and are addressed.

**Background:** When closely related professions are regulated by the same College, one set of standards of practice and professional practice guidelines may govern those professions.

Ontario regulates audiology and speech-language pathology as two distinct professions within a single College. As part of its regulatory reform process, British Columbia will designate audiology, speech-language pathology and hearing instrument dispensing as three distinct professions within a single "umbrella" college. The United Kingdom regulates dentists, dental hygienists and dental therapists under one regulatory body, and dispensing opticians and optometrists under another. Nebraska has stated that closely related professions should be regulated by the same body when possible.

Some have suggested that joint structures may be a viable approach to facilitating interprofessional collaboration.

QUESTION FOR DISCUSSION:

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.)

**Joint colleges are a good approach to accommodate closely related professions. This is similar to nursing which includes RPNs, RNs and NPs. This creates more efficiency from an administrative perspective.**

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Tools and Templates

**Background:** Some of the participants who attended the October 2007 workshops suggested the development of templates or tools that regulators could use to facilitate collaboration among Colleges, including:

- Terms of reference for joint College committees established to address common standards of practice or professional practice guidelines (e.g., composition, objectives, roles and responsibilities, mechanisms for exchanging information, coordination of activities, staffing, ground rules);
- Sample Memorandum of Understanding language between Colleges on their collaborative initiatives (e.g., principles, purpose, goals, targets, measures and evaluation framework);
- Templates for regulatory and non-regulatory instruments that could be adopted or adapted by the Colleges;
- Approaches to common strategic planning, oversight, public and member engagement on specific collaborative initiatives, and
- Tools to measure collaborative initiatives and identify key success factors.

QUESTIONS FOR DISCUSSION:

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?

**The Standards of Practice of the RN(EC) include criteria for consultation with a physician. This creates a template of minimum baseline for interprofessional collaboration. In order to meet the set standards a nurse practitioner must create a collaborative relationship with a physician. In practice the collaborative relationship is much broader, reciprocal and comprehensive than the criteria for consultation imply. Given this experience, the development of a Collaborative Toolkit may facilitate all Colleges to examine how their own profession can collaborate more formally with others.**

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

**It would likely be best to have a committee that includes some health care professionals who have experience in interprofessional collaboration in their practices.**

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### **College Autonomy, Authority and Accountability**

**Background:** Some workshop participants described their concerns related to their ability to govern their members because:

- The standards of practice and professional practice guidelines adopted by Colleges are not legally enforceable;
- The Colleges do not have independent rule-making authority, and
- Government examination and approval of regulations concerning such matters can be a lengthy process.

Some jurisdictions provide greater autonomy for health professions regulators, allowing them to develop legally enforceable rules without approval from government or the Minister. For example, New Brunswick provides for autonomous self-regulation for medicine, nursing and dentistry. In other words, there is no need for these New Brunswick regulators to seek legislative action (i.e. pass a regulation) to fulfill their regulatory mandate.

Collaboration among the Colleges (particularly in respect of the development of standards of practice or professional practice guidelines concerning shared or similar Controlled Acts) might allow interprofessional care and patient-centred care to continue to evolve in Ontario; however, if the Colleges were to successfully collaborate in the development of such standards of practice or professional practice guidelines, issues concerning their enforcement by Colleges could remain.

### **QUESTIONS FOR DISCUSSION:**

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

**This will depend upon whether the government appoints an independent organization. If yes, then perhaps granting the Colleges the authority to legally enforce their practice guidelines would be in conflict with the authority of the independent organization. However, if not, then it is reasonable to grant the Colleges this authority.**

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?

**A system that takes powers out of legislation is preferred. Legislation is too slow to meet the changes in the health care system in a practical and efficient manner.**

The Colleges are more easily able to ensure first of all that the standards of practice continually meet the most up to date evidence for practice.

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

For example, in the case of NPs, the CNO should be able to ensure that an NP in practice has entered into a collaborative relationship with a physician in order to appropriately meet the criteria for consultation when the need arises.

Physicians should demonstrate that they are not profiting inappropriately for work that other disciplines are performing.

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

A system for monitoring and reporting areas of enforcement should be implemented. Each College should carry out these measures and report on a regularly basis to a central body.

\* \* \* \*

### The Role of Colleges in Promoting Interprofessional Care at the Clinical Level

**Background:** In *New Directions*, HPRAC recognized the importance of collaboration among the Colleges, and recommended that Ontario’s regulatory environment for health professions be structured to support innovative ways to deliver health care to patients – including a greater focus on interprofessional care. The *Health System Improvements Act, 2007*, amended the *RHPA* to include an instruction to Colleges (within their new objects) concerning interprofessional collaboration similar to HPRAC’s recommendation contained in *New Directions*.

#### QUESTION FOR DISCUSSION:

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

**Greater collaboration between the Colleges will increase awareness of the scope of practice and barriers to practice for each profession.**

\* \* \* \*

### Developing Regulatory Enablers for Interprofessional Care at the Clinical Level

**Background:** The literature states that the law must do more than simply “not prohibit” interprofessional care at the clinical level; it must encourage, require, facilitate or enable it.

By way of example, New Zealand has implemented a positive legal requirement for all health care providers to work and communicate effectively in or between teams to ensure quality and continuity of services.

QUESTIONS FOR DISCUSSION:

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?

The individual Colleges could review legislation and change to include specific areas that encourage interprofessional collaboration. However, I believe that the biggest hurdle to interprofessional collaboration continues to be remuneration. Legislation that provides a common funding mechanism will naturally support interprofessional teams. The Sudbury District Nurse Practitioner Clinic is one example. Currently, the NPs are paid salary. Physician collaborators are provided a small amount of funding toward their collaboration with the NPs and the remainder is fee-for-service. The physicians also provide work for which they are not compensated, but which contributes directly to the interprofessional team concept, things such as policy and Medical Directive development with the clinic team. The ability to fund the physicians by salary would enhance the team approach by providing them with remuneration for not only the patients seen and consultation, but for all the other work that is done to enhance the overall clinic function. In addition, we have always identified the need for additional members to the clinic team. A Social Worker with counseling skills will provide a much needed service to the large number of patients with mental health concerns. Also, a dietician will provide expertise in areas of diet and nutrition that will enhance the care of all patients, particularly those with chronic diseases. As of yet, the MOHLTC has not provided funding for these other providers.

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

**Not sure this is appropriate.**

43. If so, what should the requirement look like and should there be consequences for a failure to meet the requirement?

Thank you for your response to these questions.

## **PART 6: Next Steps**

Responses to this Discussion Guide, along with feedback from consultations to be held in the spring and summer of 2008, will be considered by HPRAC in preparing its advice and its Final Report to the Minister.

HPRAC welcomes all responses to this document. **The deadline for written submissions is April 15, 2008.** HPRAC encourages submissions prior to that date.

Responses should be addressed to:

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Electronic submissions can be made to: [HPRACSubmissions@ontario.ca](mailto:HPRACSubmissions@ontario.ca)

If possible, we prefer submissions to be made in Microsoft Word, either on disk (by mail) or electronically. Electronic submissions can be made to:  
[HPRACSubmissions@ontario.ca](mailto:HPRACSubmissions@ontario.ca).

If fax is more convenient for you, please address your comments to: HPRAC, INTERPROFESSIONAL COLLABORATION PROJECT, at 416-326-1549. Hard copy submissions should be sent to the above address.

Please continue to monitor HPRAC's website at <http://www.hprac.org> for information on consultations and ongoing updates.