

**CONSULTATION DISCUSSION
INTERPROFESSIONAL COLLABORATION AMONG HEALTH COLLEGES AND PROFESSIONALS**

Submission Details:

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Defining Interprofessional Collaboration

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?

Please use the complete statement not often used in the literature: Learn with, from, and about each other

If respect is mentioned per se then all four interactional determinants should be listed:

- Foster desire to collaborate
- Enhance communication skills
- Develop mutual trusting relationships
- Learn to respect all team members including the patient/client/consumer and family

San Martin-Rodriguez, L., Beaulieu, M., D'Amour, M., & Ferrada-Videla, M. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care*, 19(suppl. 1), 132-147.

HPRAC should adhere to the work already accomplished by Health Canada's *Interprofessional Education for Collaborative Patient-Centered Practice IECPCP* initiative to avoid confusion over terminology.

Among the various terms available, Health Canada chose to adhere to the principles of interprofessional practice and the related concept of collaboration but elected to use the expression *collaborative patient-centered practice* (CPCP). Health Canada chose this term because it explicated the fact that the patient is part of the team and because research is starting to show that this improves the efficiency and quality of care (Howe, 2006). Recently, the term collaborative person-centered practice has surfaced (Hall, Weaver, Gravelle, & Thibault, 2007) and in time, this appellation could likely replace its predecessor. Since it is the definition of a chosen term that conveys meaning rather than its choice, it is important to note that CPCP is as a process:

...designed to promote the active participation of each discipline in patient care. It enhances patient- and family-centered goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision making within and across disciplines and fosters respect for disciplinary contributions of all professionals (Health Canada, 2004, p.2).

- Hall, P., Weaver L., Gravelle, D., & Thibault, H. (2007). Developing collaborative person-centred practice: A pilot project on a palliative care unit. *Journal of Interprofessional Care*, 21(1), 69-81.
- Health Canada (2004). *Interprofessional education for collaborative, patient-centred practice*. Discussion Paper & Research Report. Retrieved 24/05/2008, from the World Wide Web: <http://www.hc-sc.gc.ca/english/hhr/interprofessional/index.html>
- Howe, A. (2006). Can the patient be on our team? An operational approach to patient involvement in interprofessional approaches to safe care. *Journal of Interprofessional Care*, 20(5), 527-534.

Eliminating the Barriers to Collaboration among the Colleges

Questions for discussion:

1. 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?)
Some regulations limit the scope of practice of one profession to the exclusion of other professions. For example: If a client consults with a physiotherapist and a chiropractor, the patient must choose only one of the professionals if they overlap in roles, which is often the case. Regulations should rather obligate professionals to consult with each other and with the client to establish common goals for interventions and then be legislated to negotiate roles and responsibility pertaining to each specific client. This type of regulation will foster collaboration rather than current terminology incites professionals to ask clients to choose one profession over the other. This competition is not in the interest of the public.
2. 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?
The issue of who has primary responsibility for patient/client/end user in the healthcare system is ambiguous. Currently, regulations make it appear as if each profession has primary responsibility with most emphasis in the medical field. Although some provisions are made by some professional colleges for shared responsibility, this discourse does not transpire throughout the text. Shared responsibility, when mentioned, seems to be done as an afterthought. This has direct impact on how professionals perceive the importance of shared responsibility; they deal with it as an after thought, if at all.
3. 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?
Fee for service remuneration (i.e. physicians) compared to salaries (i.e. nurses) impedes the desire to collaborate as this has financial impact on the healthcare provider's income. If collaboration is perceived as reducing the number of services provided by one individual they will resist sharing roles and responsibilities.

Furthermore, collaboration competencies should be mandatory for entry-to-practice for all health service providers. Regulations should be developed to stimulate accreditation bodies and national examination associations to require and test for it. Interprofessional collaboration should be viewed as a paradigm of care. Consequently healthcare programs should be expected to integrate the principles of interprofessional collaboration in all aspects of their curriculum and practicum rather than as a self-contained topic. Regulations should thus

develop legislation that supports this expectation within the education field.

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

The regulation of certain professions and not others cultivates a culture of classes within the healthcare system. Unfortunately not all healthcare providers belong to one of the regulated healthcare professions. According to Davies (2007), regulation needs to extend to all individuals who interact with patients¹ since they should all be held accountable for the quality of care and services delivered and be subjected to external motivators to pursue continuing education.

The compartmentalized way of functioning in healthcare is supported by regulatory bodies. Each regulatory college decides how their members should practice and what their members need to learn in order to maintain competence. This has led to a continuing education market that tends to be structured in a discipline specific manner as each profession is looking out for its own interests for the sake of 'accountability'. In other other words, the current interest is for the maintenance of competencies within individual scopes of practice and don't include, as of yet, clear requirements for interprofessional competencies. For example continuing education prepared by one professional group will often not be recognised for continuing education credits by another professional group. This professional channelling by the regulatory bodies has been identified as a significant barrier to CPCP in the workplace (Hudson, 2007). Lahey and Currie (2005) have argued "...the need for a transformation in regulatory culture comparable to the change in practice culture that is needed to make interprofessional practice possible" (p.198). If we want health service providers to work together we need to educate them together through a continuing education program that is recognised and supported by all professional colleges.

- Davies, C. (2007). The promise of 21st century professionalism: Regulatory reform and integrated care. *Journal of Interprofessional Care*, 21(3), 233-239.
- Hudson, B. (2007). Pessimism and optimism in inter-professional working: The Sedgefield Integrated Team. *Journal of Interprofessional Care*, 21(1), 3-15.
- Lahey, W., & Currie, R. (2005). Regulatory and medico-legal barriers to interprofessional practice. *Journal of Interprofessional Care*, 19(Suppl. 1), 197-223.

Liability Issues

Questions for discussion:

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

Discourse against collaboration occurs between all professions where there are assistants (i.e. physician and nurse practitioner, physiotherapist and physiotherapy assistant, registered nurse and licensed practical nurse, psychologist and social worker, etc.) using liability issues as the foundational argument. Professional liability as dictated by professional colleges then becomes an excuse to explain why sharing roles and responsibilities is not feasible.

¹ There is substantial debate pertaining to the title we should attribute to individuals who receive healthcare or health services in Canada. According to the Champlain district Local Health Integration Network (LHIN), patients, clients, recipients, end-users, and consumers are the most commonly used terms (Jocelyne Contant, former Senior Director, Planning, Integration & Community Engagement, personal communication, July 25th, 2007). To be inclusive, the LHIN has adopted to use all these terms in their publications although they prefer to use 'consumer of health services'.

2. **Should all regulated health professionals be required to hold minimum professional liability insurance coverage?**
Yes, liability insurance should include shared liability provisions in addition to individual liability. In addition, it is our opinion that it should be a liability if health service providers don't collaborate enough.
3. **If so, what would be the minimum expected terms and conditions for that insurance coverage?**
\$1,000,000.00 however, what does this have to do with supporting collaboration, except if standards for liability are identical across all professional colleges. Then all profession would operate from an even playing field.

Developing Enablers for Collaboration among the Colleges

Questions for discussion:

1. **What changes to the RHPA, the health profession acts or their regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?**
Include provisions for required development of interdependent relationships with all other health providers involved in providing services to patients, clients, consumers, beneficiaries, etc.
2. **What changes to other Acts or regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?**
It must be required that health service providers communicate with each other for the provision of care. The provision of services should be negotiated collaboratively with the patient and their families.
3. **What collaborative policy or program initiatives are needed to ensure support is provided to new Colleges as they are being established?**
Regulations should require that members complete at least one continuing education endeavor per year intimately related to interprofessional collaboration. Regulations should also require interprofessional collaborative competencies as part of the entry-to-practice requirements. These recommendations should also be applied to existing colleges.
4. **Are there administrative responsibilities within Colleges that could be shared with related Colleges? What barriers exist to shared administration services?**
Requirements for maintain competency should be common to all regulatory colleges, with accreditation standards for continuing education programs standardized according to one system for all professions. Entry-to-practice collaborative competencies should be a uniform requirement for all regulated professions.

Structural Mechanisms

Complaints

Questions for discussion:

1. **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?**
Yes, for all settings. All settings should aspire to apply the principle of interprofessional collaborative practice.

2. If so, what should and should not be included in the common framework? All collaborative principles should be included, in particular the four interactional determinants of collaboration outlined in the first question.
3. 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?
All settings should be interprofessional; it is a paradigm of service provision not cases in isolation. For example a massage therapist working in a private facility treats clients who have a family physician, one or more medical specialists (i.e. psychologist, cardiologist, etc...), one or more rehabilitation specialists (i.e. physiotherapist, chiropractor). All members of this team should be regulated to develop collaborative relationships whether they operate within the same physical environment or not. Interprofessionalism transpires across the full continuum of care.
4. 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?
Yes, for all settings. All settings should aspire to apply the principle of interprofessional collaborative practice.
5. Considering reforms in other jurisdictions, what would be the merits of a single complaints model in Ontario? How should such a 'model' be funded?
There would be more opportunity to develop a uniform approach to address complaints. A common budget should be established from membership fees of all regulatory colleges with matching funds from the provincial government.

Investigation and Discipline

Questions for discussion:

1. 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?
Yes and it should be extended to all settings. Fundamentally, it is easy to require interprofessional practice for health service providers who work in a hospital setting (although not necessarily easy to apply), yet it is even more important to require interprofessional practice in the community setting (even more difficult to apply).
2. Should Colleges have further authority to collaborate in the disposition of complaints and reports relating to professionals in a multidisciplinary setting or practice?
Yes, for all settings.
3. Could such authority contribute to patient safety in interprofessional care?
Interprofessional collaboration could contribute to patient safety in all care settings.
4. Is legislative change required to accomplish these goals?
Yes, legislation needs to support, collaborative regulation, collaborative disciplinary measure, shared responsibility, Collaborative competency development (entry-to-practice & continuing education).

Quality Assurance

Questions for discussion:

1. 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?

Yes. Furthermore, interprofessional practices transcend individual controlled acts as all health services should be responsible for negotiated shared care plans.

2. Is legislative change required to accomplish these goals?

Yes.

Standards of Practice and Professional Practice Guidelines

Questions for discussion:

1. 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?

Creating an advisory council would help support the development of some regulations for interprofessional collaboration but it is a band-aid solution. There needs to be a complete restructuring of the regulatory system in order to embed and integrate the principles of interprofessional collaboration in all aspects of regulation. This is fundamental to fostering a system wide change of engrained uni-professional practice cultures.

2. 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;
It is necessary to education that it is everyone's obligation to communicate. To know each other's roles is one thing, knowing when to share them is another. More importantly, we must educate the public about their role in the team, about joint decision-making processes and raise the expectation with regard to collaborative healthcare. We must empower the community.
- 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);
Yes, that would be helpful.
- Research and develop standards of practice and professional practice guidelines, and disseminate best practices;
Especially as it relates to the four determinants of collaboration.
- Resolve disagreements among professions that share overlapping scopes of practice and the same or similar Controlled Acts;
Yes, that is the first step.
- Address issues arising from conflicting legislation, and
Yes, it will remove some of the barriers.
- Have an oversight function over regulatory bodies, as in the United Kingdom
Yes, but again this is adding another administrative structure that sits on a faulty

foundation.

3. Are there any existing bodies that could take on responsibilities in this area? If so, what are they?
Link with existing government committees in advisory capacity.
4. If not, should a new and independent oversight body be formed? If so, how should it be funded?
Yes. A common budget should be established from membership fees of all regulatory colleges with matching funds from the provincial government.
5. 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?
Yes, it will spearhead development, engage action, and anchor commitment. It will ensure that changed to regulatory structure align with the transformation of the healthcare system in Ontario.
6. If so, should the Minister provide financial or other incentives to the Colleges to undertake these activities?
Yes it should be a shared funding responsibility.
7. 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?
Yes they should report to both the minister and the public. There should be a marketing campaign to engage government, service providers, administrators, policy makers, and especially the public in the transformation of the regulatory culture.
8. 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?
Yes. A study should be conducted to find commonalities between guidelines and standards and reporting measures changed accordingly.
9. 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.)
Whatever, the decisions regarding interprofessional practice, they must be mandatory across all colleges. Whether internally or externally monitored, interprofessional collaboration must be regulated.

Tools and Templates

Questions for discussion:

1. 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?
Yes
2. If so, what should be included in a *Collaboration Toolkit* and who should be responsible for developing it?

Entry-to-practice competencies, literature resources, practical examples that cross the boundaries of multiple profession, exercises that help practitioners diagnose team dysfunction, steps that explain how to collaboratively set goals, professional portfolio that shows adherence to the principals of collaboration, explanation of problem-based learning strategies, tips on communication skills (conflict resolution), etc.

College Autonomy, Authority and Accountability

Questions for discussion:

1. **Should the standards of practice and professional practice guidelines that the Colleges adopt be legally enforceable? Why or why not?**
Yes, because it is in the interest of the public. Without legal implications, recommendations may not be applied.
2. **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?**
No. There must be governmental oversight.
3. **What kinds of enforceable rules should the Colleges be able to make without needing Ministerial or legislative approval?**
No. There must be governmental oversight.
4. **What accountability must accompany any rule-making authority?**
Results of quality assurance programs.

Interprofessional Care at the Clinical Level

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

Questions for discussion:

1. **How will greater collaboration among the Colleges serve to enhance inter- professional care at the clinical level?**
Greater collaboration between colleges will set the stage for interprofessional collaboration to take hold. The advantages are well documented see for example:
 - Freeth, D., Hammick, M., Koppel, I., Reeves, S., & Barr, H. (2002). *A critical review of evaluations of interprofessional education*. London: Interprofessional Education Joint Evaluation Team (JET).
 - Freeth, D., Hammick, M., Reeves, S., Koppel, I., Barr, H. (2005). *Effective Interprofessional Education: Development, Delivery & Evaluation*. Malden, MA: Blackwell Publishing.
 - Zwarenstein, M., Reeves, S., Barr, H., Hammick, M., Koppel, I., & Atkins, J. (2008). *Interprofessional education: Effects on professional practice and health care outcomes*. Oxford: The Cochrane Library.

Developing Regulatory Enablers for Interprofessional Care at the Clinical Level

Questions for discussion:

1. **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?**
As previously stated, regulations need to be changed toward entry-to-practice collaborative competencies, continuing education competencies, and expectations for collaborative

practice of its membership.

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

Yes, the law should go one step further and require collaboration not just cooperation as stated in the New Zealand legislation.

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

Yes, disciplinary measures need to be considered.



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