

## Feedback on HPRAC

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### Preamble

'Allied health' professionals have been left out of this document as it refers to only regulated professionals. Allied Health professionals in public health include a diverse range of staff including university (undergraduate and graduate) level trained individuals such as epidemiologists, health promotion consultants, evaluation specialists, research consultants, community health officers, sexual health counsellors, family home visitors and others. There is more than 200 Allied health Professionals at Toronto Public Health division representing over 20 diverse job titles, education and disciplines.

In the HPRAC discussion paper on interprofessional collaboration, allied health professionals have been left out in all discussion related to interprofessional/ multi-disciplinary collaboration. Their contributions are valuable and key to the work of public health as evidenced by recent provincial and federal strategic developments on renewal of public health services. For example, a majority of the new public health core competencies developed by the new federal Public Health Agency of Canada closely match the skills sets that allied health professionals bring to public health.

Several universities in Ontario graduate hundreds of undergraduate (Bachelor of Health Sciences) and graduate (Masters in Health Sciences) students each year. Also, hundreds of students receive undergraduate and graduate degrees each year in the Environmental Health Sciences. These programs equip professionals with skills that are highly relevant to public health; yet there is no mention anywhere in the HPRAC discussion paper about potential for collaboration with these staff and their integration into the system of public health care professionals.

Inclusion of allied health staff in the discussion on inter professional collaboration will ultimately enhance the standards of public health practice and maximize the quality of health outcomes for consumers of public health programs.

1. Please comment on the above statement that HPRAC has used to define collaboration among the Colleges. Are there elements that should be added or removed? If so, what are they?

HPRAC needs to define clinical so that it includes the community. Suggest changing the word 'patient' to "client, individual, families and population" to increase the scope to individuals, families, groups, communities and populations.

It is not just professional conduct and safe care ('service'?), but care that is appropriate, ethical, evidence-informed etc. should be added here. No mention of non regulated health professionals who are part of our Interprofessional teams.

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?)

Barriers may be lack of understanding of different disciplines practice. Unwillingness to enter into a collaborative venture for fear of losing status. In looking forward if there are some efficiencies to be made the colleges may feel they would lose resources. Some regulatory colleges are better resourced due to the size of their membership.

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?

Unionized environments, HPPA and funding mechanisms may all be barriers to collaboration. Little Interprofessional education and continuing education available. Maintenance of competence differs significantly for different disciplines.

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?

There is a culture of Medicine taking the lead when sometimes the lead is better elsewhere.

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

Evidence that some colleges do not understand public health practice well.

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

Having all staff have liability insurance may be prohibitive for some disciplines. Some workplaces like TPH already pay for this (AMOHs, Dentists). If the workplace does not provide it (or professional is in independent practice) it should be mandatory and minimum amounts for liability should be established.

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?

Suggest cross-college representation (e.g., member of CNO on CPSO).

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

Mentoring programs and contact liaison person from each college to provide communication and support.

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

Registration of professionals, updates to legislation that affects all disciplines, standardization of practices around quality assurance, records, consent etc.

Barriers may be the current database systems of each College.

Need standardization of definitions (e.g., incompetence).

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?

Yes, to minimize confusion for the public.

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

There should be standard process for filing a complaint, for reporting, for alerting the public, for evaluating the complaint and subsequent resolution

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?

Less confusion for the public. It would streamline the process especially were several disciplines are involved. Would also reduce barriers (e.g., some colleges require written complaint and some verbal). Lastly this would allow a systems view of errors and complaints. Take some funding from each of the associated colleges.

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?

Emerging evidence on systemic approaches to improving safety address root causes of adverse events and investigating systems issues that contribute to safety. While sending complaints to the regulatory body of a regulated profession may sometimes be warranted, a core concept in the literature is a movement away from defining the problem as "bad people" to a "system that needs to be made safer" (IOM 2000). Joint investigations would allow more investigation on a systems level.

Institute of Medicine (2000). To Err is Human: Building a Safer Health System. Washington: National Academies of Science Accessed May 5, 2008 from <http://www.iom.edu/CMS/8089/5575.aspx>

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

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

Yes

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?

Yes, we support a joint QA program.

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?

Membership from all colleges to set standards with all colleges having equal vote.

24. Is legislative change required to accomplish these goals?

Yes

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?

We support an arms length agency to facilitate this collaboration so no one College can usurp the power and control. The minister should not be able to exert too much control.

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?

Yes, we do think the ministry should set some priorities and start with small projects if this collaboration is to work.

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

Further resources should be provided for this collaboration.

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?

Yes, there definitely should be reporting on the work that was completed and recommendations for moving forward.

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?

Having minimum standards is a reasonable and appropriate approach to take.

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.)

Perhaps a joint committee with reps. from each discipline and the public

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?

We are concerned if a tool kit would work. This would mean the colleges could use if they feel it was needed. The best way to get all involved is to have it legislated as a requirement.

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

Better quality, More efficient, Seamless system, Better response to the public, Hopefully better client/population outcomes