

Dietitians of Canada (Ontario)

Response to

The Health Professions Regulatory Advisory Council

Interprofessional Collaboration Discussion Guide

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Submitted by:
Linda Dietrich, M.Ed., RD
Regional Executive Director
Dietitians of Canada

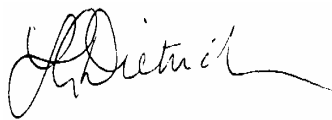
Dietitians of Canada (DC) welcomes the opportunity to provide input to HPRAC's consultation on Interprofessional Collaboration. As participants in the October 2007 consultation, we are pleased to see the ideas generated at that forum included in the discussion guide. DC strongly supports collaborative, interprofessional, patient-centred care across the healthcare system. The education and training of dietitians emphasizes the multidisciplinary approach and the unique expertise each profession can contribute to optimize patient care. It is important to ensure that efforts to support and promote IPC across the province be integrated to ensure efficient use of resources and unintended duplication of efforts.

The advancement of interprofessional collaboration involves removing some regulatory barriers, which are noted in this submission and further detailed in the scope of practice review submission to HPRAC by DC and the College of Dietitians of Ontario, to be finalized in June 2008.

Our response does not include each question in the discussion guide, but specific questions are referenced.

We would be happy to provide further information or clarify any points made in this submission.

Sincerely



Linda Dietrich, M.Ed., RD
Regional Executive Director
Dietitians of Canada

[Redacted]

Tel: [Redacted]
Fax: [Redacted]
E-mail: [Redacted]



Leslie Whittington-Carter, RD
Ontario Government Relations Coordinator
Dietitians of Canada

[Redacted]

Tel. [Redacted]
Fax: [Redacted]
E-mail : [Redacted]

Defining Interprofessional Collaboration

DC supports the working definition included in the discussion guide, with the recommended addition of learning *with*, from, and about each other. This change would align with the broadly-used definition of interprofessional education, and positions IPC as an integral part of the training of all health professionals. It also positions the development of IPC as a process of development that all professions should undertake.

Eliminating the Barriers to Collaboration among the Colleges (question #2,3,4,5)

The current system of controlled acts prevents many professionals from working to their full scope of practice and prevents the patient from benefiting from each professional working to their full capacity.

The system also creates inequalities among the healthcare team (those that have access to controlled acts vs. those that do not) and can become the basis for cultural identity and implied hierarchy among professions. This may inhibit interprofessional care.

Registered Dietitians are trained to work collaboratively, yet autonomously, and the inability to practice to their full capacity is constrained by the current legislative requirements.

Specific legislative/regulatory barriers to IPC that affect dietitians are primarily found in The Public Hospitals Act. Approximately 50% of DC members work in hospital settings, making this a major impediment for our profession. Specifically, the Act requires a physician's order for all treatments, including therapeutic diet orders and orders for enteral/parenteral nutrition. Many hospitals currently deal with this restriction by

- a) physician orders "diet as per RD" or "RD to assess" or similar wording.
- b) creating medical directives or delegations to enable RDs to write orders as per hospital policy.

These interim solutions to the regulatory requirements are *not* an efficient use of healthcare professionals' limited time, and do not serve the best interests of the patients. Dietitians have cited examples of surgeons being paged in the operating room to approve a diet change that the RD has made, and further examples of time spent by dietitians, nurses, and other staff "tracking down" a physician to approve order changes or lab work needed for the RD's assessment, which is time that would be much better spent on direct patient care. Physicians routinely defer to the dietitian's expertise in nutrition care, however since it remains officially the physician's responsibility, there are those who choose not to implement the dietitian's recommendations, resulting in inconsistent patient care.

Wage differentials and inconsistent health human resources are also barriers to IPC in some settings. For example, inequity in the remuneration among allied health professions in the Community Health Centres in Ontario has been implicated as a barrier to IPC by devaluing some members of the healthcare team. Funding models currently in place in several healthcare settings are not conducive to collaborative care. Although HPRAC has stated that funding models are not within the scope of this review, it is essential that an analysis of funding models be undertaken by the Ministry of Health and Long Term Care to assess the effect on interprofessional care.

Recruitment and retention issues for RDs in various settings, linked to the overall shortage of RDs in Ontario, can impede appropriate patient care in all settings. IPC will be inhibited when professional turnover is high, since it will be more difficult to develop the professional respect and trust needed to ensure efficient collaborative teams.

Liability Issues (questions 6,7,8)

Liability concerns have been identified as a barrier to interprofessional collaboration. DC recommends that all healthcare professionals be required to practice with liability insurance. While practitioners in some organizations will have coverage through the institutional policy, a personal liability policy would protect the practitioner, and may facilitate collaborative care by reducing concern among other members of the healthcare team.

Developing Enablers for Collaboration among the Colleges (questions 9 and 11)

Some type of oversight mechanism is recommended to actively support collaboration and to resolve conflicts as they emerge. Specific programs to facilitate learning about IPC and its value in patient care may assist in developing a shared vision of IPC and a collaborative approach to care. As new Colleges are established, the Federation of Health Regulatory Colleges of Ontario could provide support to ensure IPC development.

Administrative Responsibilities (question 12)

Sharing of administrative responsibilities appears to be a reasonable and efficient use of resources. Detailed consultation, planning, and training would be needed to ensure smooth functioning. Communicating explicit expectations of each party would help to manage potential conflicts.

Common Framework and Complaints Processes (questions 13 – 20)

DC supports the concept of a common framework for complaints processes and joint investigations by Colleges. This would seem to be an efficient use of resources and consistent with public expectations of safety. Again, detailed consultation, planning, and training is needed to ensure expectations are clearly and consistently communicated to all regulators and professionals.

Quality Assurance Programs and Standards of Practice (questions 22-28)

DC strongly asserts that professional associations must be included in the setting of standards of practice. Continuing education and professional development can be seen as shared responsibilities of employers, the associations and regulatory bodies. While the regulatory bodies must provide education related to College processes and jurisprudence, the professional associations provide members with crucial education related to emerging evidence and new directions in specific areas of practice in each profession. The Colleges' role in protecting the public requires establishing the *minimum* requirements of the practicing professional; the Associations' role in advancing each profession emphasizes raising the standards and promoting best practices within professions. Beyond this, additional development by employers and others is underway to promote IPC. The collaboratives initiative of the Quality Improvement and Innovation Partnership for Family Health Teams adds to other programs. Public safety is best accomplished when interprofessional teams learn with and from each other, and engage in on-going collaborative reflection.

We commend the College of Dietitians of Ontario for being part of the consultative model used in the development of our national Professional Standards document, and in adopting the national Code of Ethics as the basis for developing a Code of Ethics Interpretive Guide. The Quality Assurance program was also developed using this model, with review and input sought from both CDO and DC members. Collaboration at this intra-professional level provides a strong base to support emerging inter-professional collaboration.

A joint quality assurance program, developed with input from the Colleges and Associations, would help to establish standards of practice for interprofessional care and the performance of professionals with closely related scopes of practice. This appears to be a more efficient use of resources and would provide the professionals and the public with consistent expectations. Development of an independent body to oversee these processes would require further investigation of models in other jurisdictions to determine feasibility for the Ontario context. Professional associations have expertise in development of standards of practice and professional practice guidelines, and have the ability to disseminate best practices. The Coalition of Regulated Health Professionals Associations (CORPHA) is well positioned to assist in development and dissemination of joint standards of practice. Dedicated funding to support this process would need to be provided.

Minister's Involvement (questions 29 – 31)

The Minister's support and encouragement of interprofessional care initiatives is key to enabling collaboration, shared responsibility, cooperation, communication, and accountability. It is imperative that additional responsibilities for collaborative initiatives among the Colleges NOT result in increased member fees. Therefore, if the Colleges cannot undertake these activities within existing budgets, additional dedicated funding should be provided.

Transparency and accountability are integral to the public's trust in the healthcare system. Reports to the Minister, members, and the public on initiatives supporting IPC should be required.

Consistent Guidelines, Standards, and Policies (question 32)

Each professional in an interdisciplinary team requires all pertinent information about the patient/client in order to provide the best possible care. Consistent guidelines and standards governing documentation of care, and access to results of diagnostic tests and response to treatments, are needed for effective functioning of an interdisciplinary team.

Collaboration Toolkit (questions 34 and 35)

A toolkit may be helpful in setting common expectations and developing a shared vision of collaborative care among the various professions. However, a toolkit will not be able to overcome all of the barriers to IPC that we have identified. As such, the amount of resources dedicated to such a project should be carefully considered. Regulatory bodies, associations, and HPRAC should be equally involved in development of a toolkit, if this option is chosen.

Standards of Practice Legally Enforceable (question 36)

The Professional Misconduct regulation (Ontario Regulation 680/93) under the Dietetics Act, 1991, states that "failing to maintain a standard of practice of the profession" constitutes professional misconduct. In addition, the Standards of Practice for Dietitians in Canada, developed jointly by DC and CDO (1997) communicates that one use of standards is to "act as a legal reference for reasonable and prudent practice in employment situations, inquests, negligence cases, and complaints to the professional body." Legal enforceability of standards of practice should be thoroughly investigated and clear expectations communicated to all regulatory bodies and professional associations. Any changes should be subject to a transparent process where member and public input is encouraged.

It is becoming increasingly clear that an integrated well functioning health care system cannot occur without coordination in best practices and standards of practice ACROSS disciplines. Recent work to define and develop models for interdisciplinary practice in primary health care has revealed problems with the current silos for standards of practice and best practices in the professions. Formal processes need to be put in place requiring collaboration across professions in developing interdisciplinary models. DC has been involved in several projects funded by the Primary Health Care Transition Fund and others to develop interdisciplinary models and is committed to this ongoing work.

DC has a wide member base comprised of experts in many fields of dietetics and includes top researchers whose work establishes new practices to foster excellence in dietetic practice. The Canadian Foundation for Dietetic Research funds, catalogues, and disseminates a large body of research that is highly valued by registered dietitians. DC's involvement in CFDR ensures that cutting-edge research is available to the practicing professional dietitian.

DC members have recently developed Practice-based Evidence in Nutrition (PEN), which allows dietitians to incorporate the latest research-based evidence into their practice. PEN reviews and synthesizes pertinent information by leading experts in the field, allowing practitioners to serve and protect their clients by using the most up-to-date recommendations.

DC is affiliated with universities and dietetic internship programs across the country and can bring valuable experiences from other provinces. Involvement of educational and training institutions is vital in the development of Standards of Practice, to ensure new professionals have solid background knowledge and skills.

It is important to note that the College of Dietitians of Ontario (CDO) and DC have collaborated on many important projects, including development of:

- ❑ the Code of Ethics interpretive guide (based on DC's national Code of Ethics)
- ❑ Standards of Practice
- ❑ CDO's Quality Assurance program.

Formalizing this type of collaboration would ensure that the two bodies continue to work together for the best interest of the public and the profession.

Interprofessional Care at the Clinical Level (questions 40 – 43)

Collaboration at the College level will assist practitioners by assisting in the cultural and attitudinal shift toward IPC. Healthcare professionals will understand that collaborative interdisciplinary practice is expected, and this may help reduce anxiety regarding liability concerns and/or concerns regarding their own regulators' expectations. As the regulatory bodies model collaborative and cooperative practice, processes within healthcare and educational institutions can be changed to align with them.

As stated under Barriers to Collaboration, changes to the RHPA including the controlled acts, are needed to support and encourage IPC at a clinical level. Public safety is maintained and improved through competent healthcare practitioners working at their full scope of practice, with clear accountability for performance. Although mechanisms exist for delegation of controlled acts, the process in some cases is an inefficient use of healthcare professionals' time, and does not recognize the competencies of some clinicians.

A legal requirement for the promotion of interprofessional care seems to already have been put in place by the Health Systems Improvement Act, with the addition of the objects of the College "to promote interprofessional collaboration with other health Colleges". DC supports the concept of encouraging healthcare professionals to work and communicate effectively to ensure quality and continuity of service. The implications of a legal requirement such as the one in place in New Zealand would need to be thoroughly investigated for its impact on healthcare teams in Ontario.

In summary, DC is supportive of interprofessional care, and believes HPRAC 's direction in this project will help identify barriers under the current system that may be rectified to create a collaborative, patient-centred team.