



COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

ORDRE DES THÉRAPEUTES RESPIRATOIRES DE L'ONTARIO

HPRAC Interprofessional Collaboration Project

Submission from the College of Respiratory Therapists of Ontario

May 28, 2008

Thank you for the opportunity to provide input on the Interprofessional Collaboration (IPC) Consultation among Health Colleges and Professionals. In addition to responding to the specific questions outlined in the consultation paper we also have a few preliminary comments.

First, in order to best respond to these questions, it would have been helpful to have a working definition of IPC that applies to all professions and some examples that are illustrative of IPC concerns at the "front line". Our concern is that not all health care professions (HCPs) actually interpret IPC in the same manner. It is our position that to truly operate in a collaborative model, all HCPs should be able to work as equals and to practice to the full extent of their respective scopes of practice. As a regulatory body for one of the smaller professions, we are now and have always been, in full support of collaborating in this manner.

Second, it is our experience that "allied" health professions are eager to practice intercollaboratively and examples of their ongoing ability to do so are numerous. However, we are of the view that there can sometimes be a failure to recognize the contributions and roles of non-physician and non-nursing professions at several levels, including government and employers. In our opinion, unless there is a paradigm shift in the culture of health care that incorporates knowledge and understanding of the scopes of practice and roles of all health care professionals, the current environment will not change. Structural and cultural change is needed in order for true interprofessional collaboration to be implemented.

Third, we believe that Colleges are working collaboratively to support their members and there are many examples of inter-College and Federation initiatives whose purpose it is to address the needs of College members in the intercollaborative care setting.

Defining Interprofessional Collaboration

We agree that defining IPC and how it relates to the regulatory framework is of the utmost importance. There is increasing evidence that IPC improves patient outcomes and so it is essential that there is shared agreement among the Colleges and health care professionals as to what constitutes interprofessional collaboration. The CRTO agrees with most of the elements included in HPRAC's definition, but would suggest that the word "competitively" in the first bullet should be removed as it sets a negative tone.

The College agrees that optimizing the skills and competencies of all HCPs is the foundation of a collaborative model that ensures a team approach wherein the most appropriate health care professional is available for the benefit of the patient/client. This includes enabling each individual regulated HCP to work to their full scope of practice and recognizing and respecting the competencies of the all of the team members. We question the need to "enhance" scopes of practice if members are practicing to their full scope. Some illustrative examples would have been useful.

Eliminating the Barriers to Collaboration among the Colleges

The CRTO is of the opinion that the current RHPA does not restrict or prevent interprofessional collaboration among the Colleges or the professions. On the contrary, we feel that the controlled acts model reduces the barriers found in previous scope of practice legislative models by allowing the HCP's scope to evolve naturally over time. In addition, scopes of practice, as defined in the profession-specific legislation are sufficiently broad to allow for expansion and overlap, while at the same time providing parameters that are intended to ensure patient protection. Also, the new College objectives that have been added as a result of the *Health System Improvements Act* (HSIA)¹ augment existing interprofessional collaboration among the health regulatory Colleges. These amendments do not come into force until June 2009 and we respectfully suggest that the Colleges be allowed the time they need to fully implement these new objects before more legislative changes are considered.

As already stated, the CRTO is of the view that it is the organizational structures and cultures that must change to promote and support interprofessional collaboration, rather than legislation. However, some legislation can act as a barrier, for example:

- The *Public Hospitals Act*. For example, the provision regarding orders for medical care. This creates some practical difficulties with respect to the performance of some controlled acts. Specifically, *The Respiratory Therapy Act* states that Respiratory Therapists (RTs) can suction a patient without an order, however, the *Public Hospital Act* requires an order for all procedures.

¹ To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders and the public;

- To promote interprofessional collaboration with other health profession colleges;and
- To develop, establish and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.

- The *Long Term Care Act* includes a prescribed list of HCPs whose professional services can be utilized in the community. The result is that only the services of this limited group of professionals can be funded through the Community Care Access Centre (CCAC) service procurement model. Because Respiratory Therapists (RTs) are not on the list, they are not consulted nor do they have an opportunity to collaborate on the care of patients/clients in the community. This is detrimental to IPC and has a significant impact on individuals in the community with artificial airways and who are receiving long-term mechanical ventilation.
- The *Mandatory Blood Testing Act* also has a narrowly defined “prescribed class” of HCPs who can request a blood test be done on a patient/ client if they were to come into contact with their bodily fluids in the course of his/ her duties. While we appreciate that this piece of legislation was intended for exposure in the community/ correctional facility setting, there are circumstances in which other health care professions would be at a similar risk of exposure and yet they are not part of this prescribed class. While this may or may not directly affect IPC, it is an example of legislation that includes some HCPs while unnecessarily excluding others. The issue of exclusivity, which may reinforce hierarchical structures, is one that has been raised during the discussion of interprofessional collaboration.

The key to any discussion of interprofessional collaboration is the shared philosophy that all stakeholders, including patients, have valuable contributions to make and must be at the table. We see a priority as being enhanced communication between government and all Colleges so that consistent messages are provided and input can be obtained from all relevant parties. For example, during the pilot phase of the Physician Assistant (PA) program, a group that has a significant impact on RT practice, there was initially very little in the way of consultation and this impacted on the CRTO's ability to assist our members in the clinical sites where PAs were already in place. We saw this as missed opportunity for consultation that could have enhanced intercollaborative practice.

Liability Issues

The CRTO does not have any evidence that the current legislative requirements for professional liability insurance create a barrier to IPC. Currently RTs are required to carry a minimum of \$2 million professional liability insurance and RTs must be acting within their respective scopes of practice as defined by their profession specific legislation, in order for their coverage to be valid. It is our opinion that all regulated health professions should be required to hold a minimum amount of professional liability insurance coverage. It would be useful to identify some of the specific issues related to professional liability and assess the risk and needs for all regulated health professions. For example, within Respiratory Therapy, issues related to interprovincial portability are often raised by our members who are required to attend patient transports out of province. A standard approach that addresses all members of the patient transport team would be useful here, and around which the Colleges may play a role. This may be an opportunity for interprofessional collaboration amongst the health regulatory Colleges.

Developing Enablers for Collaboration among the Colleges

We are of the view that interprofessional collaboration between Colleges is already taking place and is ongoing. This is illustrated formally by the many Working Groups and projects through the Federation of Health Regulatory Colleges of Ontario on topics that promote and support interprofessional care including; Joint Public Education Strategies, Joint Orientation for Discipline Committees; Authorizing Mechanisms Project; Working Groups related to conflict of interest, investigations and quality assurance and the Pandemic Influenza Working Group. The Federation has also devoted much time to the issue of interprofessional collaboration, and informally there are many examples of health regulatory Colleges working together to form a common understanding and interpretation of issues that affect multiple health professions.

The CRTO does not feel that any changes to the RHPA are required to enable collaboration among the health profession Colleges. There are however, some other legislative and regulation changes that would add clarity, enable consistency and update provisions with respect to actual clinical practice. For example, in our view *Ontario Regulation 107/96* s. 1, *Forms of Energy* should be expanded to include Automatic External Defibrillators (AEDs) as the *Chase MacEachern Act* does not currently provide protection from civil liability when AEDs are used by HCPs in a hospital setting.

Health care legislation needs to be less restrictive to enable other health care professionals to collaborate on patient care. The example we mentioned earlier regarding the *Long-Term Care Act* is a case in point of legislation that restricts patient/client access to services in the community. For example, Respiratory Therapy services for patients who are on long-term ventilation are currently not available for funding under this legislation. Yet the *Chronic Ventilation Task Force Report* produced under the Critical Care Transformation Strategy of the MOHLTC identified Respiratory Therapy services to be an important predictor of success for invasively ventilated patients. ^(MOH, 2006)

It would be helpful if the Federation of Health Regulatory Colleges of Ontario (FHRCO) were to facilitate orientation for each newly regulated health care College/ profession. Providing information on the role of each discipline in the health care system would be beneficial not only to the transitional Colleges, but to the existing Colleges as well. It is our understanding that the transitional Colleges are able to join FHRCO and this would likely be an excellent venue for such mentorship.

The issue of sharing administrative responsibilities has been discussed previously via FHRCO. The reality is that it would be difficult and impractical to coordinate office leases that expire at different times, and the issue of how administrative staff time be divided and how any shared staff would they be paid, has been the topic of ongoing discussion. It is however conceivable that some of the newer Colleges could look at this shared administrative model. Something like this needs to be established at the initial development phase.

Complaints, Investigation and Discipline

Currently a common framework does exist within the RHPA to address complaints, investigations and disciplinary matters. The CRTO thinks it would be useful however to develop common policy and processes for interprofessional investigations (perhaps through a working group of the Federation), but that this could be accomplished through the existing legislative framework.

It would also be helpful for Colleges to have the ability to address systems issues that contribute to the conduct or behavior of the member that resulted in the complaint or mandatory report. It is rare that the member's conduct alone is the cause of a complaint or report and frequently the employer has some culpability in the matter.

Quality Assurance

While the CRTO believes it is important to develop a common understanding around issues related to Quality Assurance, it does not believe that a joint quality assurance program among Colleges would benefit members or the public they serve. There is so much specificity in determining competency that we feel joint QA programs would be impractical to implement and would not be in the public's best interest. However, there are many opportunities for intercollaboration between Colleges on Quality Assurance issues. The Federation QA working group is an example of an on-going collaborative project that enables the sharing of resources and expertise, while still allowing for the significant differences in the QA needs of the various professions.

Standards of Practice and Professional Practice Guidelines

The FHRCO already provides a mechanism by which the Colleges can interact in a meaningful way and there has been discussion with this group regarding the value of the regulatory colleges collaborating on common standards for shared controlled acts and to develop a common understanding of terminology between professions. However, even in cases where the scopes of practice overlap and the controlled acts are the same, the activities performed by the respective professionals may be quite different. Any development of joint standards would have to be done in such a manner as to preserve the essence of self-regulation and in some cases Colleges would need to have a companion document that outlines their profession specific standards. Therefore, while in some instances it would be beneficial for the regulatory Colleges to collaborate on the development of shared professional practice guidelines (e.g., documentation, responsibilities under consent legislation, conflict of interest and prevention of abuse of patients/ clients), in other areas, shared standards and guidelines may be impractical because of differences in scopes of practice.

With respect to the facilitation of this process, the CRTO believes that the Federation of Health Regulatory Colleges is in an ideal position to identify and develop areas on which common standards can be developed and that there is no necessity for a new and independent oversight body at this time.

The CRTO supports the mandate of providing the general public, Colleges and professions with a better understanding of the regulatory model, the health professions and their role within the system. This has been the goal of a Federation Communications Working Group, and in particular the recent communications effort "*It's not a game*". However, there is still significant work that needs to be done to provide the public with a better understanding of all of the regulated HCP's role in the health care system. In addition, both the regulated and non-regulated health care professions would benefit greatly from a fuller understanding of each others' competencies and scopes of practice. This, in and of itself, would go a long way to breaking down the barriers to IPC. This could be an excellent initiative on which to work jointly, and on which to involve our educational programs, who are beginning to embrace the concept of interprofessional collaboration in the classroom and clinical teaching setting.

As stated above, the Federation could take a leadership role in helping diverse professions with shared scopes of practice to develop a common understanding of terminology. For example, even the terms "standards" and "guidelines" are defined differently by Colleges. Discrepancy in interpretation of terms such as "delegation" for example, can create a barrier to IPC. If the Colleges do not agree on interpretation of an authorized act it can create significant obstacles for collaboration at the bedside. An example of this would be the use of laryngeal mask airways (LMA) in a hospital setting. If one regulatory College interprets the use of LMAs to fall under a controlled act and another interprets it as falling within the public domain, then this creates conflict as to teaching and the need for delegation. A similar issue that has caused some confusion recently is the use of AEDs in a hospital setting and whether or not it requires delegation to those professions not authorized to perform defibrillation. It would be most useful for the Colleges, as much as is possible, to come to an agreement as to the interpretation of controlled acts when they have overlapping scopes of practice.

The CRTO does not believe that reporting to the Minister on their collaborative activities would be particularly useful. In addition to straining the Colleges' limited resources (especially those of smaller Colleges) it would like result in much duplication of effort of those Colleges working together. Rather, the CRTO recommends that, where reporting is requested by the Minister, the Federation present an annual report on the Colleges' IPC initiatives.

College Autonomy, Authority and Accountability

The College is of the view that the standards of practice and professional guidelines should be legally enforceable. This has been an ongoing issue in complaints and discipline proceedings. Objects of the College include the development, establishment and maintenance of standards of practice for entry into the profession, to assure the quality of the practice of the profession and to promote continuing competence. Without the ability to enforce these standards the College is not, in the view of the CRTO, meeting its legislative mandate.

The CRTO is supportive of the concept of statutory rule making powers for enforcing standards of practice and would welcome the opportunity to work with HBRAC and the Ministry on this issue.

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

As mentioned earlier, we are of the view that a common agreement regarding the interpretation of controlled acts would have a significant impact on IPC in the clinical setting.. The considerable variability of how various health profession Colleges interpret controlled acts and what procedures they encompass creates confusion and is often a barrier to IPC. For example, the CRTO interprets the application of Continuous Positive Airway Pressure (CPAP) to fall under the controlled act of “administering a substance by inhalation”, in this case the substance is either air or higher than ambient oxygen mixture under pressure. However, some Colleges consider this procedure to be in the public domain. Other Colleges interpret CPAP application as public domain if provided on room air but a controlled act if oxygen is added to the system. This results in confusion for home care companies that employ several health care disciplines as to whether delegation is necessary for the non-regulated HCPs.

A few years ago the Federation spearheaded a collaborative effort on authorizing mechanisms (including medical directives and delegation), and this was very helpful in enabling all regulated health care professionals to come to a common understanding.

In order to promote IPC at the clinical level the concepts and practical applications of interprofessional care should be introduced in the educational system at an early stage in student learning. Resources should be identified to support interprofessional care and interprofessional education of all health professions, not just physicians and nurses. Furthermore, any efforts at promoting IPC at the patient's bedside must be accompanied by a change in the culture of health care that incorporates knowledge and understanding of the scopes of practice and roles of all health care professionals.

In addition, some of the hierarchical issues that act as barriers to IPC need to be addressed at all levels. For IPC to be fully realized at the patient's bedside it must begin addressing systemic barriers that fail to recognize HCP's scopes of practice and unique contributions. Patient needs should be met by ensuring that the health care professional with the appropriate competency and skill provides the care. When considering opportunities, particularly around funding, it is essential that the system focus on the best health care professional for the job from a patient care perspective, rather than the profession with the most powerful voice.

Conclusion

The CRTO is of the view that while there are some regulatory issues that act as barriers to interprofessional collaboration, such as the defining common standards related shared controlled acts and scopes of practice, the Colleges are generally working intercollaboratively and a number of joint initiatives are illustrative of this approach. The current, and soon to be amended RHPA, does not act as a barrier to IPC, however, there

are some specific legislative changes that could enhance IPC such as changes to the *Public Hospitals Act* and specific rule making authority. What is needed for IPC to be effective is cultural and organizational change at a number of levels, incorporating knowledge and appreciation of the roles and responsibilities of all members of the health care team. Attitudes and views about interprofessional care need to change and this should begin in the educational system with the training of health care professionals.

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