



May 29, 2008

Ms. Annie Schiefer
Project Manager
Health Professions Regulatory Advisory Council
55 St. Clair Avenue West
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Toronto, ON M4V 2Y7

Dear Ms. Schiefer

The Ontario Dental Association is pleased to be included in the consultation regarding the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals.

The ODA believes that the earlier review which resulted in substantive revisions to the *Regulated Health Professions Act* through the *Health System Improvements Act* introduced more flexibility to the existing regulatory process. However, the staged implementation of the revisions, which includes a focus on interprofessional collaboration, means that we have not had the opportunity to understand the actual impact of the changes to the RHPA. Our comments on the HPRAC Consultation Guide highlights the need to consider the revisions introduced through the *Health System Improvements Act* before making additional legislative changes.

As always, the ODA appreciates the opportunity to address the issues raised by the Health Professions Regulatory Advisory Council. Should you have any questions regarding the attached submission, please contact me at [redacted] or by e-mail at [redacted]

Sincerely

A handwritten signature in blue ink that reads "Linda Samek". The signature is fluid and cursive.

Linda Samek, CAE
Director of Professional Affairs

c: Dr. Donald K. Russell, President
Mr. Tom Magyarody, Executive Director



Ontario Dental Association

Submission

to

The Health Professions Regulatory Advisory Council

Respecting

**The Consultation Discussion Guide on Issues Related to the
Ministerial Referral on Interprofessional Collaboration among
Health Colleges and Professionals**

May 2008

Contact:

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**Ontario Dental Association
Commentary On
HPRAC Consultation Discussion Guide on
Issues Related to the Ministerial Referral on
Interprofessional Collaboration among Health Colleges and Professionals**

INTRODUCTION

The Ontario Dental Association (ODA) is a voluntary professional organization which represents the dentists of Ontario. The ODA is dedicated to the provision of exemplary oral health care, and promotes the attainment of optimal health for the people of Ontario. The ODA is pleased to have this opportunity to provide comments on the HPRAC consultation document on Interprofessional Collaboration. At the outset, the ODA notes that some of the items in the discussion document appear to have been a part of the dialogue raised by HPRAC in consultation leading to the introduction of Bill 171, *The Health Systems Improvement Act*. The ODA finds it curious that some of the ideas raised around that earlier consultation that did not become law have been raised again by HPRAC. Of particular interest and concern to the ODA are proposals that appear to diminish the concept and philosophy of self-regulation of health professions. This is especially so when many of the revisions to the Regulated Health Professions Act (RHPA) will not be implemented until 2009, and it is not clear that the current considerations for further change fully acknowledge the implications of the full range of revisions related to the passing of Bill 171.

DEFINING INTERPROFESSIONAL COLLABORATION

HPRAC Proposal: Interprofessional Collaboration

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.***

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: 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.

The HPRAC Consultation Discussion Guide notes that the “Interprofessional Care” (IPC) model defines interprofessional care at the clinical level but there is no similar definition for collaboration at the regulatory College level. Yet, the first point of the definition proposed by HPRAC refers to assisting “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”. The ODA has several comments regarding this proposal. If IPC already speaks to the interprofessional collaboration at the clinical level, this does not have to be duplicated by HPRAC or included in the RHPA. More importantly, the June 28, 2007 referral to HPRAC from the Minister of Health and Long-Term Care requested that HPRAC recommend mechanisms to facilitate and support interprofessional collaboration between health colleges (emphasis added). The ODA questions why HPRAC has extended the consultation to include IPC which is currently being addressed in several forums.

Voluntary Interprofessional Collaboration

The RHPA framework, as revised under the Health Systems Improvement Act already establishes the following objective for colleges: (1) To promote and enhance relations between the College and its members, other health profession colleges, key stakeholder, and the public. (2) To promote interprofessional collaboration with other health profession colleges. The ODA believes that there are many approaches for the Colleges to achieve these objects without specific direction and / or assistance through additional legislation.

Certainly, Ontario offers a strong example of interprofessional collaboration for the delivery of oral health care within the existing framework of the RHPA. The vast majority of dentists, dental hygienists, dental assistants, dental technologists and, in some instances, denturists, work together on a collaborative model on a daily basis. This does not reflect legislative requirements, but practical practice requirements related directly to the delivery of comprehensive, patient focused care. This collaborative approach enables patient access to a range of comprehensive oral health care services within the dental practice. This collaborative approach to the delivery of dental care continues to work even though dental hygienists have been able to practice independently since December 1993. Existing options to refer patients to dental specialists and physicians is key to ensuring the needs of the patients are served.

Many of the challenges and barriers to delivering optimal oral health care are not created by the existing RHPA legislation but by other legislative and regulatory initiatives. For instance, dentists are not able to make direct referrals to physician specialists for consultations. This limitation can delay needed medical specialty input to patient care on a timely basis. Permitting medical specialists to receive a consult fee where the patient has been referred by a dentist is one option to alleviate this barrier. Other challenges for interprofessional care exist in settings such as hospitals, where there are extensive wait times for dentists to access operating rooms and physician anaesthesiologists, and in long-term care homes, where there is no mandate to have a dentist provide care or to have an appropriate space / room for a dentist to deliver oral health services. These barriers are outside of the terms of the RHPA and therefore will not be

addressed through this HPRAC consultation. The ODA identifies these latter areas as a more significant priority for facilitating improved access to quality oral health care for patients whether that care is to be provided by a dentist or dental hygienist.

Mutual Respect

With regards to the proposal related to mutual respect, ultimately, the ODA does not believe that legislation can mandate mutual respect. Further, it is not changes to the RHPA that will foster mutual respect and shared knowledge between / among health care professions. These are matters that would be encouraged and enhanced through an education framework that relies on a multi-professional focus where appropriate.

While there is limited opportunity for overlap in the education of dentists and dental hygienists at this time, it is a model of education that the ODA has discussed with the Ministry and dental hygiene. When looking at continuing education, the ODA feels strongly about the promotion of the dental team. Accordingly, the ODA invites dental hygienists, dental assistants and dental technologists to attend the Annual Spring Meeting with dentists to take continuing education courses that will benefit the entire team and, ultimately the delivery of patient care. This three day event with 50 to 65 speakers (dentists, dental hygienists, physicians, pharmacists, microbiologists, etc.), most having an international reputation of excellence, was attended by more than 3,600 dentists and dental students, 1,700 dental hygienists and dental hygiene students and nearly 2,500 dental assistants and dental assisting students in April of 2008. This continuing trend of team attendance at continuing education programs, is a strong indicator of the collaborative approach to the delivery of care and the availability of shared education offerings in the dental community. All of this occurs in a voluntary environment where the ODA enters into a contract with the Ontario Dental Hygienists' Association, the Ontario Dental Assistants Association and the Association of Dental Technologists to pay them a flat fee for every member of their individual associations who register to attend the annual education forum, with the request that they promote the event to their members. These organizations make no financial contribution to holding this event, yet, they receive a revenue stream because the ODA and its members value the importance of educating the entire dental team.

Issue of "Competition"

The concept of "competition" between professions should not be seen as applicable to Colleges since Colleges are creatures of statute and their mandate is already governed in legislation. The RHPA itself does not explicitly nor implicitly encourage "competition" between colleges. In this province, colleges have in fact already taken initiatives to work together – particularly through the Federation of Health Regulatory Colleges of Ontario (FHRCO).

The concept of “competition” between colleges should not be confused with the reality that competing issues exist between professions. The ODA recommends any reference to competition in the proposed definition be deleted.

HPRAC: Optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services.

The ODA recommends that any reference to this should be about qualified health care professionals. By way of example, some dentists routinely work not only with dental hygienists, dental assistants and other oral health care providers, but also with nurses, respiratory therapists, physicians and some others in the delivery of certain services or procedures. It is not the promotion of diversity that should serve as the drive to form an interprofessional health care team. It is the purpose of the team and the appropriate qualifications for each member of the team that is integral to the formation of the team. The Cleft Lip and Palate Program is an excellent example of dentists working in a multi-disciplinary team of experts to provide specialized patient services. Patient focused care should be at the centre of the collaboration. With specific reference to optimizing the skills and competencies of individual professions and / or individual providers, the ODA continues to support the importance of the registration process in recognizing competencies to enter practice. Similarly, the ODA supports the need for continuous improvement for regulated health care professionals and believes that the Quality Assurance Programs can promote life-long learning relevant to professional practice as important mechanisms to enhance competencies and promote quality care.

HPRAC: Regulate the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest.

The ODA questions what “collective” resources this might reference. Individual regulated health care providers pay dues levied by their individual Colleges and volunteer their time in the interests of self-regulating the profession. Colleges should not be required to fund the operations of other professions. While regulatory colleges currently exchange information and capitalize on collective working relations, mandating the pooling of financial resources, would be seen to be a violation of the principles and concept of self-regulation. HPRAC criteria for Regulating a New Profession under the RHPA make specific reference to “membership support and willingness to be regulated and the likelihood of complying with regulations”. There is a further and explicit requirement to explain how members of the profession will be able to assume the responsibilities, including the expense, of administering their own College.

Notwithstanding this requirement, the ODA recognizes that Colleges have already formed collaborative working relationships through the Federation. This voluntary approach permits the sharing of information and even education sessions. One such example was where the Royal College of Dental Surgeons of Ontario invited each of the Colleges to attend sessions related to patient relations and quality assurance. Expert speakers on child abuse, sexual abuse and continuing education program evaluation made presentations not only for the RCDSO Council but shared this information directly with all guests, including several representatives of other health regulatory colleges.

Finally, the ODA does not support the creation of a conjoint complaint and investigation process. As noted earlier in this section, the Health System Improvements Act provides more information sharing authority to the Colleges. Until the results of the revisions to the Regulated Health Professions Act are known, it is unnecessary to consider such further structural changes. Similarly, the ODA does not support the creation of a conjoint discipline panel.

HPRAC: Ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment.

The ODA does not believe that finding mechanisms to encourage and foster interprofessional collaboration at either the College level or through IPC will ensure access and recommends that any such reference should be to facilitate access. Neither the regulatory Colleges nor the individual professional should be held accountable for access issues that relate more directly to other systemic problems. As noted previously, other legislative and regulatory initiatives related to timely access to hospital operating rooms; co-ordination and supportive delivery of care within designated health rooms in long-term care facilities; and, the option to have direct referrals to medical specialists by appropriately qualified providers, most specifically dentists, could assist to enhance access to high quality care through appropriately qualified professionals. These issues are recognized as being systemic issues outside of the RHPA. Addressing such matters will go further to facilitating access to needed health care through a range of professional services and in a variety of settings, without introducing further changes to the RHPA or setting out new objects for colleges.

HPRAC: Enhance scopes of practice to ensure that regulated health professionals work to their maximum competence and capability.

It is not clear why HPRAC has focused on the enhancements to scopes of practice. IPC requires a broad range of regulated and, in some instances, non-regulated health care providers to work in teams. When working in teams there will be varying roles carried out by individual team members. Understanding the value of each member of the team is important. It is not necessary to promote changing scopes to maximize the way that individuals can contribute to the care of

the patient. Changing scopes often reflect changing or differing education requirements for some professions or segments of the profession, such as in the case of the nurse practitioner. The ODA does not oppose changing scopes of practice that are reflective of the education and / or evolving / changing education of the provider; however, where the scope is set out in the legislation it would be inappropriate to encourage individuals to work beyond their scope of practice or to promote a change of scope where there is not a solid education foundation.

HPRAC: Eliminating the Barriers to Collaboration Among Colleges

- 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?)***
- 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?***
- 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?***

Questions 2 through 5 relate primarily to the identification of barriers that could restrict or prevent collaboration among Colleges. As noted previously there have been a number of revisions to the RHPA that will come into force in 2009. Some of those changes were intended to enhance the transfer of information between and among Colleges. The ODA is sure that the Colleges and the Minister look forward to reviewing the benefits of such changes. The ODA believes that there are currently numerous examples of collaboration at the College level and suggests the promotion of current and past success in an effort to encourage future collaborative endeavours. Where these voluntary initiatives work, it seems unnecessary to mandate specific working relationships that may not have the flexibility to evolve and be suited to the specific situation.

Colleges have the primary role of public protection in the public interest.

Colleges are required to ensure justice by implementing procedures that are fair to members who participate in the regulatory investigation, complaint and disciplinary proceedings. With specific reference to question 5, it is the view of the ODA that voluntary professional associations play a key role in advocacy for a particular profession. In carrying out this role associations often promote access to health care for the public. The advocacy role of professional associations does not interfere with the regulatory, public interest role of the Colleges and should not be viewed as a "cultural barrier" but rather as a fundamental right of members of a profession in a democratic society. Ultimately, associations often assist members to meet their professional responsibilities by developing education programs, materials and tool kits which promote excellence in the delivery of care and within the legislative and regulatory requirements of many layers of government and government agencies.

It is the view of the ODA that collaboration between professions is not achievable by force or legislation that has as its main purpose to mandate collaboration. Collaboration between two or more individual health practitioners for the purpose of patient care is a concept that is already embraced by many individual providers and professions (as discussed above from the perspective of dentistry). It is essential not to confuse or attempt to interchange the two concepts of interprofessional care and interprofessional collaboration between regulatory colleges. Notwithstanding this view, there are many positive examples of collaboration at the College level, some of which have been outlined in the earlier section of this submission.

HPRAC: Liability Issues

- 6. Do you have evidence from your experience that liability issues are a barrier to interprofessional care?***
- 7. Should all regulated health professionals be required to hold minimum professional liability insurance coverage?***
- 8. If so, what would be the minimum expected terms and conditions for that insurance coverage?***

The ODA has no evidence that liability issues are a barrier to interprofessional care. Nonetheless, there have been numerous questions raised about liability related to the delivery of interprofessional care when that care is not provided within a team environment, without a team leader and delivered at distant locations. The ODA believes that it is essential for regulated health care professionals to maintain professional liability coverage.

HPRAC: Enablers for Collaboration among the Colleges

- 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?***
- 10. What changes to other Acts or regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?***
- 11. What collaborative policy or program initiatives are needed to ensure support is provided to new Colleges as they are being established?***
- 12. Are there administrative responsibilities within Colleges that could be shared with related Colleges? What barriers exist to shared administration services?***

The ODA supports the existing flexibility that permits colleges to collaborate without setting out explicit requirements to form joint statutory committees. It is the view of the ODA that revisions outlined in the Health System Improvements Act already permits and even encourages collaboration through the sharing of information in appropriate situations.

With specific reference to ensuring support to new Colleges, the ODA again reinforces the principles of self-regulation and the criteria to be self-regulated. The Colleges have already recognized the benefits of information sharing by forming the Federation. Colleges come together in various forums to address issues of importance to regulators, meet with experts and to learn from the experiences of others. In some instances, these forums can and do serve as a

coaching and mentoring process – a process that would be open to newly regulated Colleges. There is a similar forum for associations.

There is no legislative barrier to continuing this process. It would however, be inappropriate to enable one college to download administrative responsibilities to any other College. Any College being forced to accept this support may even resent what might be considered to be interference in self-regulation. With the diversity of geographical locations, the actual numbers of professionals within a specific college and the variation in staff resources, the forced sharing of college administration would be difficult to implement. Importantly, it would be difficult to promote the resourcing of such requirements to individual regulated professionals required to provide the financial support.

HPRAC: Structural Mechanisms

- 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?**
- 14. If so, what should and should not be included in the common framework?**
- 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?**
- 16. If so, what should and should not be addressed in the amendment? 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?**

The ODA does not believe that is necessary to develop a new framework to address complaints, investigations or disciplinary matters involving regulated health professionals. Indeed, the revisions to the RHPA through Bill 171 introduced significant change, creating the Inquiries, Complaints and Reports Committee (ICR) and other changes which are yet to be implemented fully. The ODA encourages understanding the implications of these revisions prior to introducing broader revisions to the RHPA framework in these areas.

HPRAC has raised the matter of “systemic” issues that were identified during the HPRAC workshops in the fall of 2007. This may have been addressing settings such as public hospitals and long-term care homes, or other settings that are not managed by a specified regulated health care professional.

It is the ODA’s position that if there is a desire to improve or expand legislative mechanisms to address systemic issues arising in hospitals or long term care homes, any new mechanisms should not duplicate the existing disciplinary / regulatory processes under the RHPA, but rather should ensure legislative and regulatory issues that are complementary to the RHPA. With specific reference to the formation of a single complaints model in Ontario, the ODA believes that it is essential to have a process that respects the clinical practice requirements of

each individual profession. In situations where the intent is to have the parties to a complaint come to a mutual agreement on a method to address the concern, it may not be necessary to understand the intricacies of clinical practice, options and standards of practice; however, where the intent of the investigation is to consider the appropriateness of the care or the context within which the care is provided, it is essential to include individuals in that process who will be able to bring clinical knowledge to the process. In addition, the ODA continues to express concern about suggested legislative revisions which will dilute further self-regulation. In general, the ODA does not support the formation of a single complaint process; nor does it understand how fairness would be achieved with respect to funding and resourcing such a process.

- 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?***
- 19. *Should Colleges have further authority to collaborate in the disposition of complaints and reports relating to professionals in a multidisciplinary setting or practice?***
- 20. *Could such authority contribute to patient safety in interprofessional care?***
- 21. *Is legislative change required to accomplish these goals?***

There may be specific circumstances that would warrant joint investigations within a multi-disciplinary setting. The Health System Improvements Act introduced greater flexibility in sharing information between Colleges. It is the view of the ODA that no legislative change is required to accommodate such investigations should the Colleges agree on the necessity of such an approach.

HPRAC: Quality Assurance

- 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?***
- 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?***
- 24. *Is legislative change required to accomplish these goals?***

The ODA is not aware of any prohibition on opportunities for Quality Assurance Committees or other College committees / representatives to agree to discuss the development of common standards of practice. While the ODA has no objection to Colleges agreeing to explore such options, there is some concern about it being necessarily possible or realistic to expect this to result in the formation of equivalent standards of practice or professional practice guidelines, simply based on a shared controlled act. For instance, specialists have expanded education and training which may result in the specialist being held to a higher standard of care than that of the general practitioner within the same profession. It may be misleading to suggest that different professions will be held accountable to maintain a common standard of practice.

HPRAC: Standards of Practice and Professional Practice Guidelines

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?***
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;***
 - ***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);***
 - ***Research and develop standards of practice and professional practice guidelines, and disseminate best practices;***
 - ***Resolve disagreements among professions that share overlapping scopes of practice and the same or similar Controlled Acts;***
 - ***Address issues arising from conflicting legislation, and***
 - ***Have an oversight function over regulatory bodies, as in the United Kingdom.***
27. ***Are there any existing bodies that could take on responsibilities in this area? If so, what are they?***
28. ***If not, should a new and independent oversight body be formed? If so, how should it be funded?***

The ODA does not believe that there is a need to develop yet another legislated oversight body. Moving in this direction would appear to create more red tape and add to the cost of regulating health care in Ontario. The ODA would reiterate its view that issues such as educating the public on the regulatory model, the regulated health professions and everyone's role within the regulatory system is a communication strategy that would be most effective coming from the Ministry. Government created this legislative model to reduce risk and promote public protection. Accordingly, the Ministry should take some responsibility in the promotion of the benefits of this model. The Ministry is the most credible supplier of information to the public in this area. While individual practitioners and professional associations have a strong interest in promoting the role(s) of various professions, individual associations or even regulatory colleges should not be required to be the informative, credible voice on other regulated or non regulated providers.

The ODA reaffirms its view that different provider group have different educational experience, which may lead to variation in practice requirements. There are areas where it is possible not only for Colleges to come together to address best practices; but also, to have Associations contribute to this process. Indeed, the ODA worked collaboratively with colleges, associations and educators for dentists, dental hygienists and dental assistants as well as with the Ministry of the Environment in the development of Best Management Practices in Waste Management for the Dental Community. Despite this informal arrangement to meet specific needs, the formation of specific external agencies may dilute accountability and reduce the autonomy of a self-regulated profession. Given past experience and other identified concerns, the ODA does not believe that there is a need to form and fund an oversight body to address the areas identified in this section.

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

The ODA believes that interprofessional care has long been a cornerstone of the delivery of comprehensive, patient focused care in the oral health community. Mandating initiatives that address, for instance, one type of practice setting may not facilitate the evolution of creative and unique practice arrangements. Because Colleges must address many RHPA requirements, the ODA believes that it would be inappropriate for the Ministry to reinforce the importance of only one role of the Colleges.

Most colleges already have in place minimum guidelines, standards and policies concerning conflict of interest, advertising, record keeping and consent. In regards to consent, this is an area already heavily regulated under the Health Care Consent Act and Substitute Decisions Act, and more recently the Personal Health Information Protection Act. In addition, some of these areas are also governed under the Public Hospitals Act and Long-Term Care Homes Act, as applicable. Any initiatives aimed at applying changes to existing requirements across regulated professions could be complex, and at the same time unnecessary, particularly when there has been no evidence provided by HPRAC that would suggest an urgent need to address this. Furthermore, standards of practice (as defined in the Guide's Appendix) clearly contemplate that these are aimed at guiding "a profession in its delivery of health care and ensure the appropriate level of quality within a profession" (emphasis added). Clearly, this definition presumes that standards may vary from one profession to another – that is what makes professions unique and distinct from each other, and that is the essence of self-regulation.

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.)***

As noted previously, no changes to structures are required to address these issues.

HPRAC: Tools and Templates

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?***

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

As HPRAC has reported in its consultation and this discussion document, there are resources world-wide that are accessible to regulatory colleges. While it would be an interesting project to bring some of these tools together, there should be no requirement for the Colleges to develop and adopt a specific a toolkit. Whatever resources are adopted by individual, multiple or all regulatory health colleges should be at the discretion of the individual colleges. Colleges have significant and complex roles in the regulation of health professions and it is important that they not be distracted from their important regulatory functions to address issues that can be accommodated without specific direction from legislation.

HPRAC: College Autonomy, Authority and Accountability

- 36. Should the standards of practice and professional practice guidelines that the Colleges adopt be legally enforceable? Why or why not?**
- 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?**
- 38. What kinds of enforceable rules should the Colleges be able to make without needing Ministerial or legislative approval?**
- 39. What accountability must accompany any rule-making authority?**

The concept of “rolling incorporation” was addressed in an earlier HPRAC review. The ODA has general support for the concept of rolling incorporation to address the issue of enforceability. Notwithstanding this support, the ODA believes in the principle of circulation of standards and professional practice guidelines to the profession and interested stakeholders to ensure an opportunity for broad review of and public comment related to such “rules”.

HPRAC: Interprofessional Care at the Clinical Level

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

As stated at the outset, it is the ODA’s experience that there is significant evidence of interprofessional care at the clinical level. The dental community serves as a long-standing example of the collaborative working relationship. There also is evidence of collaboration among the colleges through various forums. We have noted previous specific examples of such collaboration. The Federation continues to serve as a centre for the sharing of information and collaboration at the College level. The ODA supports the collaborative approach; but, does not believe that that the legislation should mandate how collaboration should take place. Should we get the collaborative framework wrong we will lose the flexibility to address specific and changing needs on a timely basis.

HPRAC: Developing Regulatory Enablers for Interprofessional Care at the Clinical Level

- 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?***
- 42. Should Ontario law have a requirement similar to the one in New Zealand?***
- 43. If so, what should the requirement look like and should there be consequences for a failure to meet the requirement?***

The ODA continues to promote flexible options for collaboration at the practice level. There is no requirement to revise the RHPA to promote the delivery of comprehensive, multi-disciplinary, patient focused care. The dental community has a long history of working through such a model without any related legislative requirement.

SUMMARY / CONCLUDING COMMENTS

The ODA believes that there are numerous examples of the flexibility of the existing legislative framework of the RHPA which enable Colleges to collaborate. With the passage of the *Health System Improvements Act*, further collaborative options will be available to Colleges. Where there are common issues Colleges may decide that collaboration is the most appropriate approach to share information and knowledge and to co-ordinate and collaborate on options to address such matters. This can and is being done without specific direction.

There will not always be agreement on common but contentious issues. Nonetheless, Colleges and even Associations have found creative options in coming together to address even these matters. The ODA, for example, worked with the Ontario Dental Hygienists' Association and a facilitator, selected and paid for by the two organizations, in an effort to address specific matters related to "self-initiation". Ultimately, this group was broadened to include the respective Colleges in an effort to work toward a "common voice". This process was not intended to, and did not exclude the role of the Minister. Nor did it negate the importance of stakeholder review through the introduction of revised legislation to implement the principles of the agreement. The ODA does not support legislative changes that would attempt to leave HPRAC or some other oversight / third party as the final arbiter. There is no indication that even the most contentious matters cannot be addressed through the existing legislative framework and the costs of creating and maintaining an external process should not be downloaded to each regulatory College. Nor should the role of HPRAC as an advisory body be refocused to take on a decision making role that rests, and should continue to rest, primarily with the Minister of Health.