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COLLEGE OF AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS OF ONTARIO

ORDRE DES AUDIOLOGISTES ET DES ORTHOPHONISTES DE L'ONTARIO

May 30 2008

Annie Schiefer
Project Manager
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Dear Ms. Schiefer

The College of Audiologists and Speech-Language Pathologists (CASLPO) is pleased to make this submission to assist the Health Professions Regulatory Advisory Council (HPRAC) to provide advice to the Minister of Health and Long Term Care on various issues related to Interprofessional Collaboration.

We share the belief that the health professions should be regulated in a manner that maximizes collective resources and optimizes the skills and competencies of diverse health professionals. All regulated health professionals should work to their maximum competence and capability.

Both audiologists and speech-language pathologists can do more within the health care system and provide even more efficient and effective services. We believe there are many opportunities to facilitate interprofessional collaboration and interprofessional care including enhancing the scopes of practice of our members.

We look forward to working with HPRAC, the Ministry and our health professional colleagues to enhance the services we provide to the public.

Regards,

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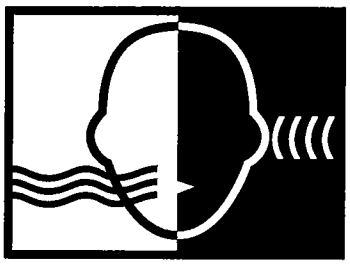

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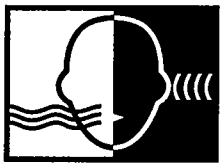
SUBMISSION TO HPRAC

ON

INTERPROFESSIONAL COLLABORATION

MAY 2008

CASLPO



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CASLPO SUBMISSION TO HPRAC ON INTERPROFESSIONAL COLLABORATION

MAY 2008

The College of Audiologists and Speech-Language Pathologists (CASLPO) is pleased to make this submission to assist the Health Professions Regulatory Advisory Council (HPRAC) to provide advice to the Minister of Health and Long Term Care on various issues related to Interprofessional Collaboration.

The Minister has asked HPRAC to "recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession".

The Minister has also asked that HPRAC "take into account, when controlled acts are shared, of public expectations for high quality services no matter which health profession is responsible for delivering care or treatment".

In addition to the Minister's question, HPRAC has raised a number of matters for discussion in its February 2008 Consultation Discussion Guide Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals.

CASLPO will respond to both the Minister's question and to some of the questions in the Discussion Guide.

1. Response to the Minister's question:

Although audiologists and physicians are both authorized to prescribe hearing aids, they do so according to very different standards. CASLPO has produced two Practice Standards and Guidelines documents setting detailed standards for prescribing hearing aids for children and adults. Audiologists must write a very detailed prescription after completing a full audiological assessment. They use their cognitive skills, training and judgment to determine the cause and extent of the hearing loss and then prescribe a hearing aid that will provide the maximum benefit for the patient.

On the other hand, many physicians issue what are called generic prescriptions, which are often just a signature on an Assistive Devices Program form that says "Mrs. Jones has hearing loss sufficient to warrant the use of a hearing aid". The patient then takes this generic prescription, with no details about the hearing aid to be dispensed, to an unregulated hearing aid dispenser who will do a hearing test and select the hearing aid, determine the settings to meet the patient's hearing loss and dispense it. In essence, the unregulated person "prescribes" the hearing aid to meet the patient's assessed hearing loss and then dispenses it.

If this concept were applied to drugs or eyeglasses, a physician could issue a generic prescription that says a person needs a cancer drug and let the pharmacist choose the

medication, dosage and frequency. Similarly, a physician could issue a prescription that says a person needs eyeglasses and then let an optician evaluate the patient and decide all the parameters of the eyeglasses. But neither of these situations is permitted by the *RHPA*.

The principle of "generic prescriptions" is at odds with HPRAC's statement that "prescribing involves determining what needs to be prescribed, whether it is a particular medication or strength of eyeglasses, and ordering it." There is no justification for a generic process for hearing health care and a specific process for eye health care, and vice versa.

Hearing aids are very complex devices that have a vast array of types, configurations, features and electroacoustical operating parameters to address an equally broad range of client needs. For a high-quality, effective rehabilitation process, the prescription must specify all relevant operating characteristics of the hearing aid, including the precise electroacoustic performance targets, in order to meet individual needs. If a physician issues a generic prescription without a full hearing assessment and refers the patient/client to an unregulated provider for the selection and dispensing of a hearing aid, the device may be inappropriate and cause serious physical and other types of harm.

CASLPO has made numerous submissions to HPRAC and various Ministers of Health and Long Term Care stating our belief that physicians and audiologists should perform the controlled act of prescribing a hearing aid to similar if not identical standards.

In answer to the Minister's question, CASLPO believes that when controlled acts are shared, the public should expect and receive high quality services no matter which health profession is responsible for delivering care or treatment. CASLPO and the College of Physicians and Surgeons should develop appropriate standards for prescribing hearing aids for regulation of both professions within a one year time period.

2. Response to Questions raised in HPRAC's Discussion Guide:

Defining Interprofessional Collaboration:

HPRAC has developed the following statement to convey its interpretation of what the Minister's question portends. Our view is that any initiative should be directed to finding ways to:

> 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?**

   CASLPO agrees that interprofessional collaboration initiatives should be directed to finding ways to:

   - " Assist health regulatory colleges and their members to work collaboratively rather than competitively".

   In the hearing health care field, ways must be found to minimize the competition between audiologists and physicians. Both professions, in some ways, are competing for clients who ultimately purchase hearing aids. Both professions should be regulated in a manner that sets a fair and level playing field so that patient/clients may go to the professional of their choice, and obtain the highest level of service from either.

   - "Regulate the health professions in a manner that maximizes collective resources" "Optimize the skills and competencies of diverse health professionals." "Enhance scopes of practice to ensure all regulated health professionals work to their maximum competence and capability."

   Both audiologists and speech-language pathologists could do more within the health care system and produce more efficient and effective services if time was devoted to the clarification and enhancement of scopes of practice in those situations where overlap exists.

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?)**

   One of the most confusing and problematic aspects of the RHPA for the public and for audiologists and speech-language pathologists is access to and interpretation of the controlled act of communicating a diagnosis.

   Members of the public look to CASLPO members for diagnostic information about their communication disorders but the RHPA prevents audiologists and speech-language pathologists from communicating the diagnoses that they legitimately make. Other provinces that regulate audiologists and speech-language pathologists have authorized them to make a profession-specific diagnosis and there is no restriction on communicating such a diagnosis.

   The prohibition against audiologists and speech-language pathologists communicating a diagnosis is problematic. The current model has created a situation whereby audiologists and speech-language pathologists can "diagnose" a communication disorder but cannot communicate this to their patient/client. However, a psychologist or physician who may not have the same knowledge, skills and expertise in communication disorders as one of our members can do so. This frequently causes conflict, especially when a psychologist or

physician "diagnoses" a communication disorder and recommends a "treatment plan" that may be erroneous and/or in conflict with the assessment and recommendations of the speech-language pathologist who evaluates the patient/client. This also creates a potential risk of harm when the diagnosis and treatment plan are not correct.

The fact that audiologists and speech-language pathologists can make diagnoses of the communication disorders but not communicate them has lead to situations where many CASLPO members are reluctant to use any diagnostic terms when they communicate the results of their assessments. They fear violating the RHPA and do not want to be seen as communicating a diagnosis. This may limit the patient/client's understanding of their disorder. It may also have a significant impact on other matters, such as timely access to services or funding where a diagnosis is required to complete the funding application.

Not allowing audiologists and speech-language pathologists to communicate a communication disorder diagnosis is in opposition to the Government's HealthForce Strategy to enable health professionals to practice to the utmost of their ability. Audiologists and speech-language pathologists should be encouraged to make better use of their knowledge and skills. Legislation should empower them to communicate a diagnosis and not prohibit them from providing a service they are qualified to perform.

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?

Public funding programs (OHIP, ADP) play an important role in the delivery of high quality health care, and should be designed and managed in a manner that enables and supports the goals and principles listed in HPRAC's definition of interprofessional collaboration.

While funding issues are not within the scope of the current HPRAC review, the ability of some regulated professionals to practice independently, the ability for the public to access the professional of their choice, and competition amongst professionals are directly impacted by government funding programs. For example, audiologists are required to be employed and supervised by ENTs in order for the public to obtain publicly funded advanced diagnostic services. The Ministry has acknowledged there are no medical or safety reasons for these restrictions. These measures are meant to control expenditures by placing physicians in a gatekeeper role. However, audiologists possess the academic knowledge, clinical expertise and training to perform these evaluations, and therefore do not require physician supervision.

The current system requires the patient to go to their family physician for a consultation, and perhaps a basic hearing test. The family physician then refers the patient to an ENT who offers a consultation, and then has basic and advanced hearing tests conducted by their "employed" audiologist. Subsequently, the audiologist sends the results back to the ENT, who then sends them back to the family physician for another consultation with the patient. The patient then goes to an audiologist for a hearing aid.

There are approximately 200 ENTs in Ontario. Establishing ENTs as 'gate keeper' for treatment of hearing problems, slows down the effectiveness of caring for the hearing impaired. Furthermore, the task of supervising audiologists diverts specialists from their medical and surgical practices, thus creating waiting lists and the need to train new physicians to compensate for shortages. With over 400 members in Ontario having broader

geographical distribution than ENTs, audiologists are able to provide service in a timelier manner.

Integrating audiologists into the primary health care delivery system will alleviate some of the critical issues concerning physician shortages. This would include reducing ENT caseload and thus allow ENTs to focus on patients with medically necessary health care.

In the event that an audiologist determines that referral of a patient to an ENT is required, they must first refer to their GP. This causes significant delay to obtaining treatment, is problematic for patients and costly for the health care system. It is especially problematic in areas poorly serviced by family physicians.

This requirement is unnecessary, as audiologists have the professional knowledge to refer appropriately to ENT, which is the rationale for allowing only physicians to refer to specialists for consultations. Allowing direct referral to ENTs by audiologists is certainly in the patient's best interests and facilitates effective collaboration between ENTs and audiologists.

On another front, the Tri-Ministry Agreement, Memo 81, acts as a barrier to collaboration especially as it relates to speech-language services. This agreement is very outdated and requires a review with revisions that reflect current practices and the population of students to whom it is directed. The aspect addressing speech services was flawed from the outset as it recommended an "artificial" split of speech and language. In addition, it suggests that students with motor speech disorders should be the responsibility of the Ministry of Health. This is not feasible when the intervention needs to be an integral component of the students overall program, as is the case with many students with developmental delay and/or autism. This lack of clarity has resulted in litigation and complaints to the Ontario Human Rights Commission.

In addition, the administration of the CCAC's has caused significant difficulty historically and continues to do so. The result of the competitive bidding for contracts (RFP) as introduced when the previous Home Care/CCAC divested, meant many Children's Treatment Centres were no longer awarded contracts to provide service to those most vulnerable students. The impact of that "loss of expertise" is still being felt in therapists' refusal to collaborate in the transition between pre-school and school services. Additionally, the mandate of locally designed service is now being replaced by the new philosophy of the LIHNS demanding consistency across regions. This is a complete "change of direction" resulting in considerable confusion, disagreement and reduced service to students. It is particularly disruptive in the speech area.

The current structure does not adequately address the area of dysphagia services for both adults and children. This represents a tremendous challenge requiring the *ultimate* in collaborative efforts between ministries and professionals (Speech-Language Pathologists, Occupational Therapists, and Dietitians).

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?**

The health care system is physician driven and the public generally seems to be of the opinion that they must see a physician before they see or have access to other regulated health professionals such as audiologists and speech-language pathologists.

There are some simple solutions that would recognize the skills and expertise of regulated professionals. For example, the public should be encouraged to go directly to regulated health professionals other than physicians. The public should be encouraged to trust the expertise of a wide range of primary health care providers. In a related move, where appropriate, regulated health professionals should be able to refer to physician specialists. For example, only 10% of hearing loss requires treatment by a physician. The public should be encouraged to go first to an audiologist and the audiologist should be able to refer to an ENT specialist when necessary.

Similarly, the public should be encouraged/enabled to go directly to speech-language pathologists who could assess a patient's speech, language and communication disorders and determine if a medical problem was present. If a medical problem did present the SLP should be able to refer to a physician or specialist within specific protocols.

Another professional cultural issue is the restriction on the use of the title "doctor". This does the public a disservice by not recognizing the education and skills of regulated professionals who have earned a doctoral degree. Presumably, this provision was included in the RHPA to help members of the public avoid the confusion of assuming that a professional with the title "doctor" is invariably a medical doctor. However, four of the five professions that are allowed to use the title are not medical doctors. The public may, in fact, be quite aware that not all "doctors" are M.D.s. If so, this would suggest that very few people would be confused if, for example, an audiologist with a Doctor of Audiology (Au.D.) degree or a speech-language pathologist with a Ph.D. were to refer to himself or herself as "doctor". On the other hand, all health practitioners should be required to identify themselves clearly and accurately to their clients. If health practitioners were required to do so, we believe the resulting public awareness would render the present restrictions on the use of the title "doctor" unnecessary.

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?**

Some trigger mechanism is necessary to ensure that colleges be directed to collaborate in the case where one college wishes to collaborate with another and the other college does not.

In addition, some form of mandatory dispute resolution mechanism is required to resolve issues where two colleges share scopes of practice or controlled acts and cannot agree on common or similar standards of practice.

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?**

A joint quality assurance program for colleges of different sizes may be difficult to administer and coordinate. The major principle is to ensure that professions who share controlled acts have the same standards and enforce them. How they do it could be left to the individual colleges.

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?**

    The Minister should direct colleges to develop common standards where professions share controlled acts or similar scopes of practice.

    The Minister should not need to provide financial incentives; however, there must be some form of incentive or penalty to ensure that colleges do collaborate where it is necessary as indicated above.

    The Minister may wish to provide incentives to Colleges to undertake interprofessional collaborative (pilot) projects at the clinical level.

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?**

    For some standards such as consent and record keeping, consistent standards should be in place. Many of our members have cited problems in sharing records as a barrier to interprofessional care.

    In other situations where professions share controlled acts or scopes of practice consistent standards and application of the standards may be advisable. However, it must also be recognized that some professions operate in the "retail" health sector and are in direct competition with unregulated providers of identical products and services. The regulations affecting the regulated health professionals must not be so stringent so as to put them in a competitive disadvantage as compared to the unregulated persons. A competitive disadvantage could actually harm the public by encouraging them to go to an unregulated person because their prices are lower, as they do not have to perform to the same standards as regulated professionals.

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 opthalmology)? (For example, joint colleges, collaborative Councils or independent bodies such as the Council for Healthcare Regulatory Excellence in the UK.)**

Joint colleges might be feasible for professions that deal with closely related activities. Of equal importance is to ensure that unregulated providers of identical services are regulated. For example, all persons who dispense hearing aids should be regulated, not just audiologists. Given that similar services are being offered by two different groups of service providers with very different levels of education, one of which (audiologists) is regulated and the other (hearing instrument practitioners) not, it is definitely in the public interest that they both be regulated so that they can share minimum standards, guidelines and policies around shared scopes of practice.

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?**

Colleges should have the power to make and enforce professional practice standards dealing with clinical matters as well as business practice standards dealing with advertising, and conflict of interest.

An appeal mechanism should be put in place so that members or the public who disagree with the standard may be heard and a decision made by the Minister or possibly HPARB.

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

The examples given earlier in this submission speak to ways to enhance interprofessional care at the clinical level. But colleges can only do so much. Interprofessional collaboration and care must be addressed when professionals are being educated. Health professionals need to understand the competencies and potential of all their regulated colleagues and be instilled with an attitude that says we are all here to make the most of each other's talents in the public interest.

Both the University of Toronto and the University of Ottawa have programs that encourage interprofessional collaboration through initiatives such as interprofessional clinical practicums in the rehabilitation sciences. The University of Toronto has an Office of Interprofessional Education and Ottawa has an Interprofessional Rehabilitation University Clinic.

CASLPO surveyed our members about opportunities to enhance interprofessional care at the clinical level. Many suggestions have been put forward that will involve discussions with a number of other regulated health professions. It is our intention to pursue these in the coming months and years.

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?

As this college continues to examine ways to improve interprofessional care we plan to submit specific proposals to the Minister and HPRAC.

We note that the Minister has asked HPRAC "to examine the authority given to non-physician health professions to prescribe and/or use drugs in the course of their practice under the *Regulated Health Professions Act, 1991 (RHPA)* and the health profession acts. I ask that the Council provide advice specific to each of these professions respecting whether lists, categories or classes of drugs should be prescribed by regulation for the profession, or whether restrictions on prescribing of drugs should be placed in regulation under the respective health profession Act".

Audiologists hold considerable diagnostic and clinical competencies in determining whether fluid, with or without infection, is present in the middle ear space. It stands to reason that audiologists may have or could attain competency in prescribing therapeutic pharmaceutical agents for these conditions. If it were decided that pursuing the right to prescribe antibiotics was too great an advance for now, audiologists could be given the right to prescribe steroidal medications for the treatment of contact dermatitis, which is a condition that can arise directly from the use of hearing aids. It seems straightforward that a patient who develops this condition in the course of undergoing audiologic treatment would benefit by having it managed by his or her audiologist. The risks for adverse reactions/complications are next to nil.

This is one example where expanding the scope of practice of audiologists and speech-language pathologists will enable them to maximize their participation in a truly interprofessional health care system in Ontario.