

**May 29, 2008**

**Ms. Annie Schiefer, Project Manager  
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**Dear Ms. Schiefer and Health Professions Regulatory Advisory Council**

We commend HPRAC for undertaking the interprofessional consultation. Our Professional Advisory Council at Trillium Health Centre has reviewed the HPRAC Interprofessional consultation discussion guide and proposed questions. We have provided some thoughts for your consideration in response to some of the questions as you compile opinions from a variety of groups. Our Professional Advisory Council has representatives from a variety of professional groups as well as our ethicist. Professional groups on our PAC who participated in this submission include: nursing, physiotherapy, occupational therapy, speech language pathology, psychology, respiratory therapy, pharmacy, and dieticians.

### **Defining Interprofessional Collaboration**

Interprofessional collaboration is defined well.

Suggest add to statement: **Assist regulatory colleges and their members to identify overlapping scopes of practice and to develop consistent quality through commonly and collaboratively defined standards of practice for overlapping areas.**

### **Developing Enablers among the Colleges**

**Should an independent arm's length organization facilitate and support collaboration among the Colleges, particularly with the view to development of common standards of practice and professional practice guidelines?**

There are likely numerous practice standards and practice guidelines that could be standardized across colleges such as documentation, education requirements, consent, code of ethics, disciplinary processes. Uniformity in standards would create understanding of other professions and foster trust among professions. With this, there would be increased confidence of another profession's practice and documented information to reduce redundancy of work (assessment, documentation). The standardization of practice will ultimately cascade to benefit the public.

Standards of practice and practice guidelines should continue to be developed by the colleges. Best practice, on the other hand, is the implementation of these standards and

guidelines for various patient populations within a variety of diagnostic groups from an integrated interprofessional perspective. Currently there is no mechanism for assisting with the integration of practice standards and guidelines across disciplines to ensure common understanding and transforming discipline specific guidelines into interprofessional practice guidelines. Having an interprofessional body responsible for such an undertaking would be very beneficial for the education of professionals and ultimately improving quality of care for patients.

The minister could consider directing the colleges to establish a process for coordination and collaboration related to development of practice standards to ensure consistency between colleges as well as strategy for integration across professions. Perhaps the Federation of Colleges could take on an integrating role. Additional funding should not be required if membership is comprised of college staff. It could be an expectation of each college to participate in this collaborative work to ensure standards and guidelines are created a view for how the standards would be integrated with other professional groups.

Financial incentives often result in prioritization of and increased commitment to the work. It also stresses the importance and value of interprofessional collaboration the ministry places on creating a responsive healthcare environment. Ultimately however, whether financial incentives are offered or not, it is prudent for the colleges to unite in this regard for not only for future cost savings, but for standardization among professions, improvement in services to and expectations by the public. This will also set the stage for ongoing movement toward interprofessional education and practice.

**31) Should the colleges be required to report to the minister and/or public on their collaborative activities on a regular basis? Why or why not?**

Colleges have been put in place by the ministry for the public and therefore HPRAC could consider recommending reporting to the ministry and the public. It would be most succinct to have this new interprofessional collaborative body report to ministry and public as well. Currently there is no body responsible for reporting on interprofessional or collaborative activities. In the health care environment there is already some degree of collaborative practice thus the implementation of practice changes at a college level inevitably would require clinicians to communicate and negotiate process changes. It would be very beneficial for the public to become informed of practice changes as they affects them in a manner that is coordinated and reflective of the experiential changes from a consumer's perspective. Most healthcare consumers appreciate changes as they affect them as service recipients for a specific problem and not service recipients of a specific healthcare provider.

**32) Should minimum guidelines, standards and policies concerning matters such as conflict of interest, advertising, record keeping and the consent process be consistent across the colleges? If yes, what guidelines, standards and policies could effectively be applied to all regulated health professions? If not, why not?**

Yes, where possible. However there must be recognition of the unique requirements of some professions. To this end, there must be due diligence to ensure standardization does not conflict with professional requirements that might negatively impact patient safety and care. A thorough review of existing practice standards could be conducted to review possibilities. Some possibilities may include documentation, infection prevention and control standards, standards for disagreeing with the interprofessional plan of care, consent, code of ethics, complaints and possibly disciplinary processes.

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

As with the professions of speech-language pathology and audiology having combined to form one college, there may be other similar opportunities for efficiency, improved collaboration and definition of roles as in with related professions. Having a single governing college may assist in the collaborative development of scopes of practice and communication to educate the public on the distinction between the various professional roles.

### **Eliminating Barriers to Collaboration**

RHPA does not provide direction to professional groups who share a similar scope of practice related to how to work within an overlapping scope of practice framework. This guidance would assist with collaboration concerning these elements of care.

The Public Hospitals Act often necessitates labour intense workarounds to achieve effective collaboration as all treatment needs to be ordered by a physician, dentist or midwife. This creates inefficiencies in the system and can interfere with achieving timely access to care and collaboration among health care professionals. These inefficiencies also interfere with timely discharge when discharge issues are non physician related. Nurse Practitioners (RNECs) should be able to discharge patients for whom he/she has developed, implemented and evaluated an interprofessional plan of care when the patient is assessed to be discharge ready for home or another level of care facility.

Professional cultural issues: Each professional group seems to function as a silo with attention to how the specific professional group will provide access to high quality care through specific professional group regulation and standards without attention for how this might be accomplished in collaboration with other professional groups. Lots of common standards developed in isolation of each other without attention for how these will be implemented in the work setting with other professional groups. Funding mechanisms and union policies do not always support interprofessional approaches to care. For example, if a referral is made to a physician specialist by anyone other than a physician, there is no requirement for the physician to communicate back to the referring

professional, additionally there is a financial penalty for the physician accepting the referral when not referred directly by a physician. This prevents timely follow-up and unnecessarily interrupts physicians for physician referrals.

## **Interprofessional Care at the Clinical Level**

### **40) How will greater collaboration among the colleges serve to enhance interprofessional care at the clinical level?**

Greater collaboration among colleges will enhance greater collaboration among professions and its members which in turn will improve patient care and satisfaction and reduction in repetition, redundancy and referral.

Having an interprofessional body, with a mandate to facilitate and support collaboration among the Colleges would certainly enable interprofessional understanding and appreciation. Collaboration among colleges within this interprofessional body would provide an opportunity for more collaborative work with professional associations and academic centres to ensure that regulatory changes are in line with education and training, clinical practice and work environments.

The potential for the Federation of Health Regulatory Colleges of Ontario to transform into a body with the mandate of integrating individual regulatory college work to achieve the mandate described under #26 could be considered. This would increase transparency and integration of work. Some College specific processes could be transformed using existing college resources to become interprofessional. Some upfront resources to initiate may be required if considering an external facilitator/leader with view to evolve to a self sustaining shared governance model. This group could possibly fulfill the mandate of integrating work among the regulatory colleges in Ontario and monitoring interprofessional indicators (to be defined). In essence they could be part of a stewardship model where all professional groups are part of an interprofessional leadership model monitoring consistency of same/similar standards, integration of similar standards and interprofesional approaches.

This body could also have responsibility for developing the tools needed to support the evolution of interprofessional care. This body could report to the public and the minister annually on collaborative activities. This may help the transformation from siloed health care practices to integrated professional practices and assist the public understand the progress of interprofessional care and practice patterns in Ontario.

One example of lack of college collaboration was CASLPO's institution of the practice guideline requiring all speech-language pathologists and audiologists to obtain consent for screening and assessment. This practice guideline was not congruent with other profession's consent guidelines and in the acute care setting this has caused confusion for interprofessional teams as well as patients and substitute decision makers. When all professions are not uniform in their consent dialogue, the public's understanding of their role as patients and/or substitute decisions makers is not clear. Judicious scrutiny of the

impact to the practice of the interprofessional team failed to be considered when such a guideline was approved by CASLPO. There was certainly an opportunity for the colleges to have discussed the possibility of developing a consent guideline that could be applied across professions.

Greater collaboration among colleges will also help with education of the professional roles to the public. There is considerable variability in knowledge, skill and judgment within and between professional groups. Within professional groups highly specialized areas of work create different roles. Colleges could work to educate across professions about these differences as well as having an active role in educating the public.

**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?**

There is an opportunity to modernize various legislations to enable interprofessional care, access to services, increase professional opportunities for clinicians, and quality of care. Currently controlled acts are limited to select regulated health professions. Why could they not be delegated to any regulated health profession who has demonstrated adequate knowledge, skill and judgment in carrying out such controlled acts? Currently numerous acts are being delegated to various professions through medical directives or other internal quality practices because of the breadth and depth of knowledge and skill demonstrated by non-physician clinicians. Such practices have improved availability of and access to care for patients.

Professions requiring regular delegation of specific controlled acts should have access to these controlled acts within their regulated scope of practice. Standards of practice for procedures that fall within controlled acts should be consistent across professions.

Currently the public hospitals act does not allow non-physician clinicians to provide treatment without a physician's order. With the growth of the number health care professions and expertise, it is no longer reasonable to expect a physician to be solely responsible for determining need for treatment. This requirement continues to delay access to care providers in the hospital environment. Accountability for treatment decisions should lie with the most knowledgeable service provider and not necessarily the physician.

With respect assessment and treatment of oropharyngeal dysphagia, there is an opportunity to expand SLP's scope of practice to include the provision of assessment and treatment of oropharyngeal swallowing disorders. The academic world is now including this as part of the education and training with requirement in practical hours within this field prior to graduation. No other profession has the same level of training in this regard. There are potentially serious complications with unqualified assessment and treatment thus it is prudent to contain such a practice within a discipline's scope.

## **Liability Issues**

Our experience suggests that there are many misconceptions about liability and a perception that with interprofessional team approaches to care, individual liability is less clear. Clarification of liability misconceptions across health care settings and contexts should be undertaken.

Minimum liability insurance coverage should be discussed for a variety of practice settings and practice contexts.

## **Developing Enablers for Collaboration among the Colleges**

Attention to encouraging, requiring, facilitating and enabling collaboration among the colleges is critical for the work of the college to without exception have collaborative practice embedded in its approaches and standards to guide professional groups both individually and in their team based practice environments as applicable.

Consider RHPA and discipline specific acts to be reviewed in detail by an interprofessional team to identify legislative and regulatory barriers for interprofessional practice. Ensure that amendments are added to specifically address the need for interprofessional collaboration when feasible for practice, complaints investigation and discipline.

Shared administrative services should be considered for processes that are duplicated among the colleges. For example shared administrative services should be considered with respect to making processes consistent across colleges for duplicated processes such as annual renewal of college registration. Shared human health resources data bases in Ontario would help with a more integrated understanding of our regulated professionals.

Additional potential for shared administrative services should be identified by the colleges.

## **Structural Mechanisms**

The RHPA could be amended to enable Colleges to establish joint committees to deal with complaints, investigations and discipline in respect to issues arising in an interprofessional care setting when appropriate. “Appropriate” would have to be defined. Such a process may enable greater professional understanding of the interrelated and system impacts that might not be consistently apparent in a siloed approach.

## **Quality Assurance**

Joint quality assurance programs would ensure standardization of common standards of practice and professional practice guidelines where the same or similar controlled acts are shared. Work effort to create, review and revise would be reduced and the quality of the standard enhanced through sharing of current practices while interprofessional colleges can define best practices and build mechanisms for improvement. Consistency among professions is needed. As well consistency in interpretation would be enhanced. Much of the current variability in interpretation could be reduced.

## **College Autonomy, Authority and Accountability**

Enabling patient centred interprofessional care to evolve in Ontario will be critical aspect of achieving a sustainable health care system. Being responsive to ongoing health care needs at a rate that keeps pace with the profession specific and interprofessional practice requirements will necessitate nimble system that can accommodate rapid change while continuing to protect the public as a high standard of care is delivered. Enabling rule making at the College level and in the context of interprofessional practice patterns rather than at the legislative level will be important to accommodate the rate at which change will be required to meet population health needs. Regulatory Colleges will need to be able to set and enforce practice standards if we are to be able to meet the changing health care needs of Ontarians in a timely way that enables professional groups to practice to their changing scope of practice in the future. Authority and types of statutory rule-making powers should be discussed with attention to how these would be enforced and how members of the professional colleges would be educated about application of various standards. Support for professionals to apply various standards is not well defined within or across all professions.

## **Interprofessional Care at the Clinical Level**

Greater collaboration among the regulatory colleges will serve to create consistency related to application of standards across professional groups. Greater clarity of roles associated with controlled acts and standards will enhance profession specific and interprofessional understanding of expectations associated with controlled acts and standards of practice. Consistency of practice standards for shared aspects of practice will lead to consistent practice patterns and perhaps consistently improved patient outcomes.

Regulatory enablers for interprofessional care at the clinical level is an interesting concept. If there was a legal requirement for encouraging, requiring, facilitating and enabling quality patient care through interprofessional practice patterns at the clinical level, tracking and monitoring systems would have to be developed to monitor specific indicators of interprofessional practice patterns with regular reporting mechanisms and expectations. This change in practice pattern would have to be well defined and hard wired into the health care system across the continuum of care. The need for interprofessional practice patterns would have to be identified and learned in all

universities and colleges preparing professional groups for practice. The goal for interprofessional practice would be integrated competencies of team members to deliver high quality, effective and efficient health care.

**42) Should Ontario law have a requirement similar to the one in New Zealand?**

We suggest consideration of an overarching practice standard for all regulated health professions whereby an expectation for collaboration in care in the best interest of the patient is mandatory. With uniformity in practice standards as suggested above, there may be improved and mutual understanding of scopes of practice and expectations in processes or care to allow for better clinical collaboration.

As we strive to move toward an integrated electronic health record, such an overarching practice standard requiring collaboration might expedite greater uniformity across professions for documentation standards and practices, which will create an environment more conducive to uniform electronic documentation formats across professions. Standards or event legislation imposing collaboration might result in software providers being required to provide interoperability solutions. With greater access to information with an integrated EHR, there will be increased communication across providers and increased continuity of care.

**43) If so what should the requirement look like and should there be consequences for a failure to meet the requirement?**

There should be clear definition as to what constitutes collaborative practice and how it typically would look in a variety of practice settings with attention to specific practice settings and across the full continuum of care. As with any occurrence of non-compliance, there should be corresponding consequences and a process for managing such.

Respectfully submitted

Trillium Health Centre  
Professional Advisory Council