



**SUBMISSION TO THE HEALTH
PROFESSIONS REGULATORY
ADVISORY COUNCIL**

IN RESPONSE TO:

**THE CONSULTATION DISCUSSION GUIDE ON ISSUES
RELATED TO THE MINISTERIAL REFERRAL ON
INTERPROFESSIONAL COLLABORATION AMONG
COLLEGES AND PROFESSIONALS**

May 30, 2008

*Ontario Association of Optometrists
Suite 300, Plaza III
2000 Argentia Road
Mississauga, ON L5N 1V9*

Introduction:

The Ontario Association of Optometrists (OAO) is pleased to respond to the Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals.

Our response includes answers to some of the questions from the Guide as well as comments specific to the relationship between optometry and other professions.

Optometry and Interprofessional Collaboration:

As primary eye care providers, optometrists are often first to identify eye disease and the ocular manifestation of systemic disease that requires referral to other health care providers. Optometrists frequently collaborate with ophthalmologists and opticians and, to a lesser extent with a variety of other health professionals including, physicians (general and specialists), pharmacists, nurses, and psychologists. Optometrists share controlled acts with physicians and opticians.

Optometrists in other provinces practice with opticians, either employing opticians or in shared care arrangements. Presently, conflict of interest regulations in Ontario restrict the association between optometrists and opticians. Optometrists provide prescriptions for eye wear to their patients and in some cases the patient has the prescription dispensed at an optician store. Collaboration in these types of arrangements works well and the relationship benefits both practitioners and the patient. Once conflict of interest regulations are changed to permit association between optometrists and opticians, OAO anticipates a further expansion in collaborative care between the two professions.

Some ophthalmologists and optometrists practice together, particularly in refractive eye surgery centers. While this mode of group practice is becoming more common, it is presently not the norm. Many optometrists practice in health centers where other health care providers are located; however, the relationship is usually one of proximity.

Cooperation between optometrists and ophthalmologists is good and continues to improve. This results in early intervention and treatment of sight threatening eye disease leading to preservation of vision.

OAO expects that direct collaboration in the co-management of glaucoma patients will become common as the role and scope of practice for optometrists expands and the demand for glaucoma care exceeds the ability of medicine to provide timely treatment.

Our members report that cooperation between optometrists and family physicians is excellent.

Notwithstanding these successful interprofessional relationships, there continues to be some obstacles to collaboration that will be discussed further in this response.

Reply to Questions:

Question #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?*

The statement that HPRAC has proposed to define collaboration among Colleges is satisfactory. The emphasis on public interest and safe services is appropriate. While assisting members of regulated health professions to work collaboratively rather than competitively is a reasonable goal, when controlled acts are shared between professions, some competition will always exist.

Question #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?)*

RHPA:

Regulation of health care providers through the *RHPA* provides protection to the public while not restricting collaboration among Colleges or their members. Scope of practice definitions under the *RHPA* provide only a general description of the activities of a health profession and a frame of reference for controlled acts. Scopes of practice should neither prevent nor restrict collaboration among health professionals. OAO is unaware of any evidence that would conclude that existing scopes of practice interfere with inter-professional collaboration.

OAO supports the recommendation from *Interprofessional Care: A Blueprint for Action* that states: “professions should practice within their full scope of practice, consistent with safe care”. Unfortunately, when a health profession independently expands its scope of practice into unsafe care, the fundamental principles of collaboration are challenged. This action results in a loss of trust, respect and confidence in that profession to provide competent and quality health care. In fact, practice beyond the legislated scope of practice would lead to polarization between professions rather than cooperation.

Regulations:

Presently, under conflict of interest regulations optometrists are restricted from associating with other health care providers except optometrists and physicians. These regulations are an obstacle to collaborative and cooperative care. OAO understands that these regulations are subject to change soon under the new Ministry of Health and Long-Term Care (Ministry) guidelines. This change will remove obstacles to collaborative care between regulated health professionals. OAO supports the changes to the conflict of interest regulations proposed by the College of Optometrists and we are confident that the new regulations will balance public protection with freedom of association.

Questions #3 & #4: *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?*

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 Hospitals Act 1990

Only physicians, dentists, midwives and nurses extended class are identified in regulations related to this act. The exclusion of optometrists and other qualified health care providers creates an obstacle to collaborative care in a hospital environment. Amending regulations under this Act to include optometrists or any other qualified health professional would not only encourage inter professional collaboration but also enhance patient access to high quality and safe eye care services. Moreover, hospitals especially those in rural communities, should be encouraged to appoint optometrists to staff positions. Recent changes to legislation authorizing optometrists to prescribe drugs will create an expanded role for optometrist in the treatment of eye disease in a hospital environment.

Health Insurance Act 1990

Optometrists frequently refer patients to ophthalmologists for consultation and treatment. Under present Ontario Health Insurance Plan (OHIP) benefits, physicians cannot claim a consultation fee for a referral from an optometrist yet a consultation fee is paid when a patient is referred from a physician. This inequity creates a financial disincentive for an ophthalmologist to accept a referral from an optometrist. Easy access to urgent care can be critical to successful patient outcomes and in some cases the prevention of vision loss.

The elimination of this barrier to collaboration could easily be resolved with an amendment to the benefit to allow ophthalmologists to claim a consultation fee for referrals from optometrists.

Professional Training

In Canada, optometrists are trained through schools of optometry at Universities. Although there is some cross appointments, the majority of clinical training does not include interaction with other health professionals as would occur in a hospital setting. The lack of interaction between optometry interns and other health professionals especially physicians, at the training level, is an obstacle to the mutual appreciation of each other's skills and competencies. The integration of the training programs between physicians and optometrists at the clinical level would help resolve this isolation.

Question #5: *Are there professional cultural issues that act as barrier 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?*

OAO is unaware of any overt cultural issues that act as barriers to collaboration among Colleges. Some professions may continue to hold a paternalistic attitude toward newer health professions especially if those professions are not based on what is considered as valid scientific evidence. These biases are a product of personal attitude more than a product of regulation and would likely occur in any profession or service.

Questions #6, #7 and #8: *Do you have evidence from your experience that liability issues are a barrier to interprofessional care?*

Should all regulated health professionals be required to hold minimum professional liability insurance coverage?

If so, what would be the minimum expected terms and conditions for that insurance coverage?

OAO has no evidence that liability issues are a barrier to collaborative care for optometry. Since controlled acts pose a risk of harm to the public, all regulated health professionals should be required to have minimum professional liability insurance. OAO is not in a position to recommend requirements for insurance for other professions.

Questions #13 - #21: *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?*

If so, what should and should not be included in the common framework?

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?

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?

Considering reforms in other jurisdictions, what would be the merits of a single complaints model in Ontario? How should such a model be funded?

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?

Should Colleges have further authority to collaborate in the disposition of complaints and reports relating to professionals in a multidisciplinary setting or practice?

Could such authority contribute to patient safety in interprofessional care?

Is legislative change required to accomplish these goals?

Members of a particular College should conform to all requirements of registration regardless of whether or not they function in a multidisciplinary setting or individually. If the process of a complaint against a member practicing in a multidisciplinary setting, including the investigation and the complaints decision is unsatisfactory, Colleges for the other disciplines should have an opportunity to intervene. Legislative change would not

be necessary provided Colleges cooperate in good faith. An edict from the Minister would establish the boundaries for collaboration.

Questions #22 - #28: *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?*

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? Is legislative change required to accomplish these goals?

Should an independent arms'-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?

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.*

Are there any existing bodies that could take on responsibilities in this area? If so, what are they?

If not, should a new and independent oversight body be formed? If so, how should it be funded?

Either the present Federation of Health Regulatory Colleges of Ontario (Federation) or a similar organization could take on the responsibility to assist in the collaboration between Colleges on a variety of common subjects including some of those identified in question #26. Notwithstanding some common areas, individual Colleges should continue to be solely responsible for governing their members in the areas of standards of practice, guidelines to practice and quality assurance. If inter professional collaboration related to these three matters is identified as an issue by any stakeholder, the Federation could provide the necessary forum for cooperation and resolution.

OAO does not support common standards of practice and common professional practice guidelines for related professions. Common results or outcomes for either shared or

related controlled acts should be the same between professions and not necessarily the standards of practice for those acts.

If an expanded role is mandated to either the Federation or another over-sight body, additional funding should be available from the provincial government and not from either the College or the profession

Question #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?*

The Minister should use a directive when a College either does not comply with the requirements of legislation or refuses to collaborate on specific issues that involve patient safety. Colleges should be encouraged to work collaboratively rather than directed by authority. A directive should be a method of last resort.

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

Financial incentives should be provided to either the Federation or a similar organization that has been established to facilitate collaboration. If Colleges are directed to engage in collaborative initiatives, financial assistance should be available.

Question #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?*

General guidelines related to business practices, including conflict of interest, advertising and record keeping should be similar for all professions and based on common criteria.

Question #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).*

See answer to Question #22

Questions #36 & #37: *Should the standards of practice and professional practice guidelines that the Colleges adopt be legally enforceable? Why or why not? 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?*

Standards of practice and practice guidelines originate from a variety of sources including published research literature, professional education, consensus of practitioner opinion and the introduction of new technology. Colleges may publish standards and guidelines to assist practitioners with clinical practice and to advise their members on the expectations of the College. These standards and guidelines should exist as information to the members of a profession, indicating a level of care that is generally accepted by a majority of the profession. The standards will also serve as one part of the criteria used to judge the care provided by practitioners.

As the science and technology of a profession evolves, the clinical standards constantly change. Published standards and guidelines must be flexible enough to adapt to these changes. A mandatory standard would leave no opportunity for practitioner discretion and would offer little or no flexibility in the application of those standards.

Presently, practitioner accountability and to some extent quality care, is assured through professional misconduct regulations that require practitioners to maintain the standard of practice for the profession. The standard used to judge a practitioner should continue to be determined by a variety of sources including those stated earlier. A College does not require a legally enforceable standard to assure practitioner accountability. Similarly, practice guidelines by their very nature should not be mandatory.

Questions #38 & #39: *What kinds of enforceable rules should the Colleges be able to make without needing Ministerial or legislative approval? What accountability must accompany any rule-making authority?*

Under present legislation, Colleges have considerable authority over all matters of practice for a health profession. Accordingly, Colleges should not be permitted to enact either legislative or regulatory changes without the approval of the Minister. Furthermore, health profession associations should be considered as distinct stakeholders when Colleges propose enforceable rules.

Summary

In summary, OAO emphasizes the following points:

- A formal process that requires collaboration between health professions is not necessary
- Health professionals and Colleges should rely on collegiality and good will to encourage collaboration
- Standards of practice and practice guidelines should remain as guides to practice and not legally enforceable
- The Federation of Health Regulatory Colleges of Ontario could assume a leadership role in regulatory issues related to interprofessional collaboration
- The Ministry of Health and Long-Term care should address identified obstacles to interprofessional collaboration including legislative barriers and those related to professional training.