

ONTARIO KINESIOLOGY ASSOCIATION

Submission to:

Health Professions Regulatory Advisory Council

Respecting

The Consultation Guide on Issues Related to the
ministerial Referral on Interprofessional Collaboration
Among Health Colleges and Professionals

May 30, 2008

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 Ontario Kinesiology Association (OKA) feels that the statement outlines collaboration within the colleges but the following points should be added:

- Increase transparency amongst the colleges
- Decrease the competitiveness and proprietary nature amongst the colleges. This will lead to better services for the client, more thorough investigations, sharing of information, elimination of duplication of services and more access to additional services for clients.
- Improve understanding amongst the colleges of the services and scopes of each college to allow for more complete collaboration.

1. 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?)

The OKA feels that there are some barriers with the RHPA acts and regulations. There are overlapping scopes and skill sets amongst some of the colleges. This leads to a lack of information sharing and respect between colleges.

Suggestions to decrease the barriers would be to:

- increase understanding of the health professionals on the skills of the other colleges
- support a collaboration between colleges with overlapping scopes of practice
- professions have a scope of service within their scope of practice to allow specialization and less competition

Ultimately funding will be a significant issue. College members may be hesitant to refer business to another health profession if their income is compromised.

2. 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?

The OKA believes that there are several pieces of legislation that are restrictive if a new model were to be developed. Any legislation that includes regulated health care providers within the language may require modification. For example the Automobile Insurance Act restricts collaboration as it does not recognize all health care practitioners equally within the pay schedule. In addition, the WSIB regulations currently exclude or restrict the services of Kinesiologists.

3. 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?

There are other barriers with respect to extended health care insurance carriers and their policies. Many colleges are not included which creates a barrier for collaboration since clients are unable to access services. Examples would include the Statutory Accident Benefits provincially or the Veterans Affairs nationally.

- 4. 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?**

There are professional cultural issues that act as barriers and these are doctor centred care. The doctor should remain an important component of the client's care, but many conditions and issues are well managed by other health care providers and if required the client could be referred to the physician. The client should have more power in the choice of their care. Some of these changes have been made with the integration of family health teams, LHINs, etc.

- 5. Do you have evidence from your experience that liability issues are a barrier to interprofessional care?**

Yes, liability issues can cause barriers with interprofessional care and collaboration. Certain health care professionals may be hesitant to refer to other professionals if they do not understand the scope of the health care providers' services or limits of their liability. For example a physician may not refer a client to a Kinesiologist for exercise programming related to obesity due to concerns of quality or safety of the Kinesiologist. They may also restrict the referral to the Kinesiologist out of fear of liability. For example if the client were to have a heart attack during the exercise program, would their referral be subject to collegial discipline?

- 6. Should all regulated health professionals be required to hold minimum professional liability insurance coverage?**

Professional liability insurance is necessary for both the client and the health care professional's protection but it is also necessary as a means of closing the gap that is created by aforementioned fears.

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

This would depend on the practice. The OKA offers a 2 million dollar policy. There should be discussion with the insurance carriers to develop a model to cover all colleges. This would eliminate any gaps between the colleges and allow for more collaboration. A suggestion would be a pooled access system of coverage that would blend the funds in the case of a complaint against a multidisciplinary group or due to a referral issue.

- 8. What changes to the RHPA, the health profession acts or their regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?**

The language of collaboration needs to be included and declared. Re-focus the nature of collective college structure from “title” focused activities to “mission” focused activities.

9. What changes to other Acts or regulations are needed to encourage, require, facilitate and enable collaboration among the colleges?

Each regulatory act should be changed to de-emphasize the title and emphasize the scope. This would allow people to work together towards a common goal for the betterment of the client, rather than feel limited by the title of their profession.

10. What collaborative policy or program initiatives are needed to ensure support is provided to new Colleges as they are being established?

A statement announcing the new colleges and their scope would help other colleges recognize them. Documentation outlining what they do backed up by scientific evidence would be helpful.

11. Are there administrative responsibilities within Colleges that could be shared with related Colleges? What barriers exist to shared administration services?

Administrative responsibilities that could be shared by the colleges would be a central office for processing memberships, receiving complaints, dealing with training and CESP issues, marketing, etc.

12. 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?

Yes

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

A centralized area for questions and complaints would help the public in knowing where to go. This would help with complaints that cross between colleges.

14. 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?

N/A

15. 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?

Yes, they could also deal with membership and ongoing professionalism issues.

16. 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 merits of a single complaints model are as follows:

- Reduces the duplication amongst the current colleges by reducing the number of people required in an amalgamated model, reduces related overhead, and reduces related time demands thereby reducing wait times.
- Central complaints point for the public which allows for easier access for concerned citizens, less confusion related to the function for the public with one system rather than more than 15 (who do they call, when, etc), allows better marketing or public relations on the part of the joint colleges to advise the public of their rights, and makes the rights of the client the same across all of the distinct professions.
- Could reduce a professional bias or polarity with a multidisciplinary committee which would reduce the impression that the system is targeting a profession or a discipline within the system
- Allows the more established members access to newer methods or 'out of the box' thinking with the newly added groups
- Introduces the new regulated health professions to the experience of established members
- Provides a greater depth of precedence of research into the decision making process by visiting the decisions of allied professionals

This model should be funded initially by the Ministry of Health and Long-Term Care through savings garnered by the reduction of duplicate systems that are currently observed within each college.

A portion of the college dues could be re-allocated to the merged system. The formula could be indexed based on each college's membership, the rate of access per member by that college and an index of the costs associated with access historically.

This formula should be reviewed on a fixed renewable term.

IP Complaints Commission funding model concept:

$$IPCC = C_1(M_1 * R_1 * P_1) + C_2(M_2 * R_2 * P_2) + C_3(M_3 * R_3 * P_3) \dots C_n(M_n * R_n * P_n)$$

Where

C = College member

M = Membership number

R = Rate of access (Access/M*10,000)

P = Cost per access – (Cost of annual access/R)

N = Number of colleges in the proposed system

This model would address the size of the different member groups, their risk and their frequency of access.

17. Would the authority to conduct joint venture investigations following complaints or reports related to professionals who work in a multidisciplinary setting or practice provide more efficient investigations of such cases?

A centralized committee would complete the investigation. They could be charged with setting up an investigative team with multidisciplinary membership but headed up by a non-RHP investigative professional. This would address many of the redundancies mentioned above.

18. Should colleges have further authority to collaborate in the disposition of complaint and reports relating to professionals in a multidisciplinary setting or practice?

Yes, the amalgamated committee should increase their boundaries to support the individual members after the primary task of disposition is complete. Secondary duties should include access to precedent cases for decision on corrective action or member support. There should be increased support in research and professional and administrative matters.

19. Could such authority contribute to patient safety in interprofessional care?

A tertiary activity of this group must be a centralization of certain policies that would be client centred or universal to the population accessing care. Such policies should include:

- Administration of files
- Billing
- Marketing
- Ethics
- Technology advances in health care
- Confidentiality
- IP communication
- IP referral methods

They should oversee research into new emerging health care models and initiatives. They should also commit to System Reviews of known peer reviewed research to support the access to credible, relevant research for practitioners.

20. Is the legislation change required to accomplish these goals?

Yes, the Amalgamated Committee should be given the regulatory power necessary to exercise their mandate. This would come with limits. For example, the composition of the committee must be declared, unbiased and have public representation. The regulations should define the scope of the term and the limits thereof.

Consideration should be given to non-medical models such as judicial models for inquest or law. The judge (of whatever specialization) is presented to by specialists and they collaborate/debate a final position and outcomes. In this case, the judge would be an IP and public committee.

21. 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?

Yes, there must be a centralized body that houses and manages peer reviewed and grey literature research for access by practitioners. Subcommittees could be set up through this group to focus on specific targets or practice standards such as calibration of equipment or hygiene and housekeeping of facilities.

This would require a funding model similar to #17 but in doing so would reduce the total funds expended on each individual college in investing (costs, manpower and time) in this process.

It would be just as relevant where colleges have scope of practice similarities without Controlled Acts. This would cause the colleges to work together collaboratively to create the program, and to ensure that it runs successfully. As an example, in hospitals, multi-disciplinary health care teams have been working together for years when looking at care and treatments programs, discharge planning, etc. The first role of quality assurance is to protect the public interest through excellent health care provision.

22. 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?

Yes, we can learn from each other. To set standards, discover what the other Colleges are already doing (on their own), and build a new program using the best components of the existing College programs, it would be just as relevant where Colleges have scope of practice similarities without Controlled Acts. The first role of quality assurance is to protect the public interest through excellent health care. Program standards should be jointly measured by a panel with mixed or collaborative membership. This standards panel may have subcommittees that would specialize from time to time but as a whole would be capable of dealing with issues such as billing and ethics.

23. Is legislative change required to accomplish these goals?

Not necessarily, depending on what already exists, it may only require a request from the government (Ministry of Health and Long-Term Care) to develop and accomplish these goals.

24. 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?

The Ontario Kinesiology Association could support this recommendation. It would not be (or be seen to be) particularly biased or controlled by either the Colleges or

the government. A modification of the current “Council or regulatory professions colleges” may be the most efficient method.

25. If so, what should its specific mandate include or not include?

We should learn from the experiences of other countries and take the best decisions and findings from them. They should be incorporated into an Ontario-specific organization. All of the components that are listed should be included. These functions would be best not to be controlled directly by the government, to be seen to be most fair to all parties.

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

Consider the following:

- Council of Colleges
- Professional business management company
- A new structure

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

It should be demographically designed to include members from each of the colleges, members of the public and other selected specialists. Partial funds may be reallocated from the partial merging of similar colleges in the current structure.

28. Should the Minister direct the Colleges, using his existing powers under the RHPA, to engage in specific collaborative initiatives? Why or why not?

Yes, this will ensure that consistency is present throughout the colleges and potentially take away some of the uneasiness that colleges may feel from similar scopes.

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

Initial funding should come from the Ministry of Health and Long-Term Care with the College fees contributing to the process.

30. 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?

Yes, this will ensure that the colleges are accountable for their activities. It will ensure that the colleges are working together for the same common goal. It will provide better communication to the public on what is going on in health care – patient central care. A schedule for the colleges to report their activities should be established.

31. 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?

Yes, the following guidelines, standards and policies should be established:

- Conflict of interest, including treating family members
- Advertising – to ensure that the message is the same at all levels to the public
- Consent process
- Professional development – to ensure consistency with all health care providers
- Standards of practice
- Ethics
- Business Methods (billing, etc)

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?

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?

This would allow existing colleges to have some direction in developing roles and knowing what is expected of them. It would eliminate miscommunication or misunderstanding regarding the responsibilities of the colleges with respect to collaboration.

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

Included in the toolkit should be:

- Scope of practice for all colleges
- Typical jobs or areas that members of colleges work
- Examples of how the members of colleges can work together

A representative from each college should be involved in the development of this toolkit.

36. Should the standards of practice and professional practice guidelines that the Colleges adopt be legally enforceable? Why or why not?

Yes it allows for accountability from the professional and greater protection for the public.

37. If so, should the Colleges be given statutory rule-making powers allowing them to enforce standards of practice and professional practice guidelines they adopt? Why or why not?

Rule making powers should be given to a committee that overlooks the colleges. This committee should have interprofessional collaboration and an authority/discipline board.

38. What kinds of enforceable rules should the Colleges be able to make without needing Ministerial or legislative approval?

This would be dependent upon the scope and powers that would be given to the new centralized structure. If there was a centralized 'college' that controls common functions, there may be a need for legislated power and control under a central authority such as the Ministry of Health and Long-Term Care.

39. What accountability must accompany any rule-making authority?

If a legislated group were developed, there must be some limits of power defined in the legislation. There should also be an independent review panel or ombudsman prepared as an arm's length review ability.

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

It will allow clinics to have a greater variety of professionals working together to better serve the clients. It will allow more in depth treatment and investigation, which leads to better quality service for the clients.

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?

Yes, it needs to be written out in the regulations to ensure that it occurs across all colleges.

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

The model observed in New Zealand is a unique one with many benefits. The concerns that would require further research such as the difference in demographics, geography, cost structures, legislated structures and how those could negatively affect a New Zealand structure as it applies in Ontario's current system. In short – more research into the application of the New Zealand structure would be prudent.

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