



Interprofessional Care in Ontario: The Regulatory Role

Submission to:

Health Professions Regulatory Advisory Council

**College of Physicians & Surgeons of Ontario Submission
To the Health Professions Regulatory Advisory Council**

May 30, 2008

Introduction

The College of Physicians & Surgeons of Ontario welcomes the opportunity to offer our comments and advice in HPRAC's consultation on issues related to interprofessional collaboration among health colleges and professionals.

The health human resource pressures continue to grow, new physicians tend to work fewer hours than their predecessors and the health care requirements of our aging population are destined to increase for many years. Together, these factors make continued dependence on traditional models of health care delivery unfeasible. It is imperative that Interprofessional care takes its place, recognized as Ontario's norm. We believe that the Ontario health colleges have championed Interprofessional care. We will continue to do so, supporting the continued evolution of health care delivery.

While we are happy to consider the existing legislative and regulatory regime and its impact on the ability of health care professionals to function as effective teams, we believe that the real and fundamental barriers to true interprofessional care lay outside the ambit of this consultation. For example, we urge HPRAC to recommend that government look at remuneration models, their implications for health care spending management by LHINs and at the myriad other, funding-based, inhibitors to a restructuring of health care delivery. Examples of the impact of funding structures on team delivery are incorporated in the discussion below. We also urge HPRAC to look beyond regulation of individual health professionals and consider how best to ensure that "systems" are subject to the same regulatory rigor. This, too, will be discussed in more detail below.

Controlled Acts

The RHPA, which has governed the health professions since 1993, sets out a number of controlled acts which may only be performed by certain of the regulated health professions. Of the 13 original controlled acts, physicians are entitled to perform 12 and may, in appropriate circumstances, delegate the performance of those acts to other individuals who may or may not be members of a regulated health profession. When controlled acts are delegated in appropriate circumstances, this process makes optimal use of health-care resources and personnel. In every instance of delegation, the primary consideration must be the best interests of the patient.

The CPSO believes that the controlled acts model provides flexibility while ensuring safety and oversight. The structure of the RHPA, especially with the changes that will be introduced with implementation of the *Health Systems Improvement Act* is a fundamentally sound basis for health regulation.

With respect to this consultation, we believe that the focus that the government has taken on controlled acts as the locus of shared or overlapping scopes of practice is not the optimal way to approach Interprofessional collaboration. Some of the controlled acts (prescribing a hearing aid, for example) are relatively simple and ought to look very similar independent of where and by whom they are performed. Others of the other controlled acts, arguably the more potentially dangerous ones, will look altogether different depending on the context in which they are being delivered. Accordingly, at the risk of hyperbole, although they are realizations of the same controlled act (a procedure below the dermis), administering a flu shot and using a bone saw to open a patient's skull have little in common. Standards of practice that addressed both activities would need to be at such a high level of principle that they would add nothing to enhancement of quality care or collaboration among professionals.

The CPSO shares the government's objective to ensure that patients receive appropriate care independent of the health professional providing it. All health care professionals will be more open to an evolving distribution of tasks as long as they are certain that their patients will be well cared for. A patient's health care experience will be the result of a range of professionals performing their duties and meeting an established level of quality. The quality of the care provided must meet a common standard, but the best means to ensuring quality is a focus on the patient's journey in the particular setting: this requires a point of care, rather than a regulatory, focus. What works in terms of a team protocol for a labour and delivery conducted by a midwife in northern Ontario may be quite different than what works for an obstetrician in a large hospital in a city centre.

Barriers

The change to the RHPA's objects which creates an obligation to promote and enhance relations between the College and other health professional colleges, together with the information sharing provisions in the Act should be sufficient to ensure that the RHPA itself is not a barrier to collaboration among the Colleges.

With respect to cultural barriers to collaboration among the Colleges, the CPSO submits, with respect, that any such barriers could not be removed by legislation. These barriers may be more illusory than real. Not only does the new object in the RHPA provide context for us to renew our efforts to work together, but there is abundant evidence that we are doing so more today than ever before. We are working with our College colleagues on a number of joint initiatives at a College-by-College level as well as through the Federation of Health Regulatory Colleges of Ontario (FHRCO).

RHPA

Problems with the RHPA lie not in the regime that it creates but sometimes in its application by a range of regulators.

For example, in the past, confusion has arisen because of our independent interpretations of RHPA language. The Colleges' different interpretations of the word "delegation" would be an example. The difference in interpretations had a direct impact on the ability of regulated health professions to work together smoothly at point of care, because individuals from different disciplines were receiving different, and sometimes conflicting, advice from their Colleges. At the regulatory level, this led to cumbersome processes such as requiring Committee approval before delegation could be sanctioned. Recently, however, most of the difficulties arising from differing interpretations of the word "delegation" have been resolved through a joint project undertaken by FHRCO. The ability to reach consensus and develop an Interprofessional tool (which is being used across the province) demonstrates both that the RHPA works and that we already have the necessary foundation for interprofessional collaboration.

We believe that introducing another regulatory voice into the framework is unnecessary: as this example demonstrates, where there is a public interest demand for collaborating, the Colleges will do so.

PHA

Barriers to collaboration (at point of care, rather than between Colleges) are more concerning in other legislation. In particular, we would urge government to review the requirement in the *Public Hospitals Act* (the PHA) that physicians, dentists or midwives must provide an order for all treatments received by inpatients. This section frustrates members of all Colleges in their ability to deliver quality care and sometimes causes unnecessary conflict. It creates a practical barrier to proceeding with safe and timely delivery of care (many times professionals who wish to proceed with an activity well within their scope of practice are barred from performing it in the hospital setting because of this requirement). This section of the PHA also presents a cultural barrier by perpetuating an apparent hierarchy among the professions.

We are aware that other pieces of legislation create hurdles to teams as well. One such example is the *Healing Arts Radiation Protection Act*.

We recommend undertaking a comprehensive review of the network of related laws to determine which require revision to facilitate seamless point of care delivery.

Liability

With respect to liability issues, the CPSO, together with the OMA and the CMPA, have assured our members that liability concerns need not be a barrier to interprofessional care. Nevertheless, our members are reluctant to delegate when they lack the security of knowing that the patient will have access to appropriate compensation should another health care professional perform negligently.

Physicians, therefore, may be reluctant to delegate where they might otherwise. Those to whom they might delegate are not able to use the full range of their knowledge, skills and judgment. This situation would be alleviated if all health care professionals carried appropriate liability insurance. The fact that patients could be protected in the event of a bad outcome would likely result in a more liberal approach to delegation.

Here, though, is an example of where health funding policy is fundamentally at odds with the creation of an environment of true interprofessional care. Physicians' liability protection is provided by the CMPA and is not wholly funded by the profession. It may be advisable to consider how best to fund universal professional liability protection to enable professionals to embrace Interprofessional teams.

Funding Issues

Ontario has made some interesting and productive alternative funding arrangements – in the Academic Health Sciences Centres, and in Family Health Teams, for example. We recommend building on the strengths of and lessons learned from these experiences to explore further creative funding arrangements that might foster an interdisciplinary team-based approach to health care delivery.

Sometimes the funding structure acts as an impediment at the point of care. For example, in the long term care setting, many institutions find that they are having trouble recruiting or retaining physicians. The institutional funding is based on a traditional model of health care delivery: physicians, who are remunerated through fee for service and whose compensation does not come out of the facility's budget, are required to provide treatment. An alternative delivery scheme might see a team with a reduced physician role and more reliance on registered nurses in the extended class. This would diminish the demand for the physician's presence for routine matters and would likely tighten the time for implementation of treatment plans in some cases. However, under the traditional funding structure, the nursing home cannot afford to substitute nurse practitioner care for physician care because they count on OHIP billings to fund a significant portion of the care they provide.

At the CPSO, we have been part of the steering committee involved in the introduction of a pilot project to bring physician assistants (PAs) into the health care system. PAs may prove to be true assets to health care teams. Sustaining their use in hospital settings after the pilot project, however, will require either additional hospital funding or a creative alternative that considers bringing some funds previously streamed through OHIP billings into the LHIN domain.

A third example of a care environment where funding arrangements may have a direct impact on the ability of health care professionals to deliver the best care quickly is in the area of methadone maintenance. A Ministry task force was convened to look at access, best practices, quality assurance and funding mechanisms in this context. In March 2007, the Methadone Maintenance

Treatment Practices Task Force recommended that the Ministry of Health and Long-Term Care should phase in blended physician payment models to support methadone maintenance treatment models, that a funding model should be developed to permit pharmacists to dispense methadone maintenance treatment and that funding should be allocated to Family Health Teams, LHINs, CHCs and others for addiction, counseling and case management services. These recommendations provide another example of the links between quality of care, a team approach and funding mechanisms.

The CPSO encourages government to continue to explore efficient and effective alternative health care funding models. We believe that as payment models continue to evolve, their development and evaluation should be considered through the perspective of an Interprofessional health delivery framework.

Enablers

As discussed above, the CPSO does not believe that any changes to the RHPA are necessary to collaboration among the Colleges.

There are dozens of examples annually where, on an informal basis, Colleges with common concerns discuss the best means of addressing them. We have developed formal mechanisms to work collaboratively in some cases, working groups meet regularly to discuss common Quality Assurance, Investigations and Hearings and Communications concerns. We also work together to achieve administrative efficiencies, with Colleges sharing independent legal opinions on certain issues or with joint Discipline Committee Member training.

We offer support to our new College colleagues as they come on line through FHRCO and through individual consultations.

There may be opportunities to realize further benefits to sharing administrative activities, especially among the smaller Colleges. We think that these opportunities ought not to be related to the type of care provided by the College's members, but rather to the opportunities afforded by economies of scale. The Colleges are currently in the process of discussing the potential benefits of a common regulatory insurer, for example. When the possibility for efficiencies presents itself, we are eager to work together to achieve them.

Structural Mechanisms

The mechanisms that are in place to deal with member specific concerns do not pose a problem particular to interprofessional care. They are flawed in their rigidity. The current complaints process is resource intensive but has a minimal impact on patient safety. We would urge HPRAC to look at the opportunities for permitting more flexibility in the system to ensure the best protection of the public interest, both at the collective "public" level and for the individual with a concern.

Joint Investigations

In our view, a common framework for complaints, investigation and disciplinary matters is already codified by the RHPA. We believe that attempts to refine this to a more detailed level in the legislation would not have an impact on collaboration.

As indicated above, we believe that the amendments already made to the RHPA will permit our Colleges to share information in a way that would permit joint investigations. We see a variety of benefits to proceeding this way in some cases: there have been occasions when our Complaints Committee has identified a concern about care where the problem was not attributable to the physician but may have been connected with the care provided by another health professional. (As distinct from problems that seem to have arisen because of an administrative decision on the part of the hospital, or by a resource allocation decision made at a higher level). With respect to the situation where the problem may have been due to another health care provider, the ability to share information in the course of the investigation may help ensure that the most information possible is available to the Committee for decision-making purposes. There are economic and time-saving efficiencies in this approach. There is also the benefit of ensuring that the Committee has the best possible record upon which to base its decision. The CPSO has worked together with the CNO and the CPO in the investigative context in the past.

There are limitations on our ability to get the best outcome for patients in this scenario, however. One is the stricter alternative dispute resolution regime introduced in the revisions to the RHPA. Many individuals who are seeking to understand what happened in their own course of care or the care provided to a loved one would benefit from the ability to discuss the whole care situation with members of the involved Colleges but without the cumbersome process involved in the ADR or Complaints processes set out in the RHPA. We believe that it is entirely possible to ensure the best interests of those individuals, as well as the general patient population, without activating the formal complaints process. Our ability to achieve interdisciplinary resolutions will be particularly encumbered by the revisions to the RHPA. For further details about our position, we would direct HPRAC to review our submissions about Bill 171.

With respect to joint Complaints or Discipline Committees, the CPSO strongly recommends against this. We are strong proponents of the benefits of looking at the course of care provided through an interdisciplinary lens, however, when it comes to consideration of individual health care professionals, the analysis ought to take place through their own regulatory body. In our view, one of the central values of self-regulation lies in the regulator's ability to assemble a group of peers who can evaluate a professional against realistic standards and expectations. This enables the standards to evolve and the professional to rely on the fairness of the process. The essential expertise inherent in this system is recognized in the

circumstance of judicial review, where deference is accorded to a tribunal of experts (i.e. peers). If the specific expertise of the decision-making panel is in doubt, however, the ruling of the decision-making panel is considered, by the court, to be compromised. The introduction of other health care professionals into a decision-making body focused on a particular professional would dilute this expertise. Accordingly, while we endorse efforts to investigate jointly, to conduct quality assurance activities in partnership and to attempt to reach joint complaints resolutions (where appropriate), we believe that it would be inappropriate to create joint Complaints or Discipline Committees.

Dangerous Gaps

A gap remains even when Colleges work together to investigate a complaint or report, and even if their respective Committees fairly evaluate the circumstances.

Complainants approach the Colleges with a complex of feelings and motivations. Often they are angry. They are always seeking truth. They tell us that they want to see the cause of the problem addressed so that harm will not come to the next patient. The alarming gap in our present system is where the Committee finds a flaw in the care delivered but the flaw is not attributable to a regulated health professional. There is no body charged with receiving and acting upon this information. Thus, if the information received by the Committee indicated that the equipment in a hospital had not been properly maintained, it is questionable under the RHPA whether the Committee is entitled to share that information with the hospital.¹ In turn, when a hospital receives such information, there is no requirement that it should take any action and no broader system overview of the problem.² At a minimum, clarification of our role and responsibilities in this context would be helpful, but, as discussed below, we believe there may be benefits in considering a more structured approach.

An example, drawn from a case, demonstrates the Complaints Committee's limited power when it is in receipt of information about a systems problem. In this case, a patient with ischemic heart disease presented at a regional hospital. He required transfer to a tertiary care centre to receive the care he needed to survive. There were no beds available, however, and no hospitals were willing or able to admit him in time. Despite the very best care by all the health professionals in the hospital to which he had been taken, this patient died before definitive care could be provided. While the investigation included interaction with Criticall Ontario, they had been unable to solve the problem for this particular patient. Our Committee had no body to which to specifically convey this information, however, and no authority to do anything with it. The complainant, the patient's widow, received no satisfaction from her complaint, and, despite the Committee having obtained the information

¹ Despite a certain amount of ambiguity in the RHPA, the College considers it necessary in the public interest to notify Chiefs of Staff when findings like this are made.

² We believe that most hospitals act on such information if it reveals problems that are within the hospital's control.

which revealed where the problem lay, this information could not be effectively used to the benefit of future patients.

An example of a similar problem that has been much in the press recently is the “hand-washing crackdown”.³ Accreditation Canada has stepped in to address a gap like the one described above – while there is no federal oversight body that could mandate improvements in professionals’ hand-washing rates, Accreditation Canada will make hand-washing audits a requirement for hospital accreditation in 2009. This looks like a promising beginning to addressing a serious “systems” issue. However, the piecemeal approach (i.e. in the fact that there is no single “systems” overview) may leave too much to chance.

We are confident that we have a structure that facilitates meaningful and effective review of the care provided by individuals. Under the current regime we believe that we can build on our history of working together with other Colleges to review the care provided by interdisciplinary teams. However, we have no mechanism by which to effectively react to the problems that are not attributable to individuals. The College strongly recommends that considering such a mechanism take top priority in HPRAC’s advice to government.

On our part, we are prepared to commit to continuing to work with our sister Colleges to identify these systems problems and to the extent we are able, to share the information wherever it is in the public interest to do so.

Information Barriers

An example of the barrier to information-sharing that proceeds in the other direction is that imposed by QCIPA, which prevents hospitals from sharing information that they obtain through their quality assurance processes. One example of such a situation is within our complaints system at the time of writing. In this case, a complaint has been lodged about a physician. The hospital in which the care was provided has a video record central to the investigation. However, the matter falls under the purview of the hospital’s own quality assurance activities and they have indicated that they are unable to provide the record to the College. There are occasions when such information sharing may be essential to protect patients. The College recommends reviewing this legislation to determine whether it is possible to ensure that communication takes place where there may be an immediate risk to patient safety.

No discussion of the transmission of information would be complete without discussion of electronic records. There is no doubt that team performance is facilitated when a common electronic record is used. This College urges HPRAC to recommend that the Ministry continue to focus on this area of development as part of its Interprofessional care mandate.

³ Globe & Mail, May 20, 2008

Quality Assurance

As with complaints procedures, the RHPA already establishes common requirements for the College's quality assurance programs. The CPSO does not believe that statutory change is warranted or advisable at this time.

This College engages in joint quality assurance activities with other Colleges. We have worked with the College of Medical Radiation Technologists and the College of Pharmacists in this context. We anticipate further opportunities for joint quality assurance assessments and see no barriers in the existing legislation to proceeding in this fashion.

Apart from our own regulatory quality assurance activities, the College sees a tremendous benefit in relying on extra-regulatory point of care models to ensure that best practices and continuing education are in place. Such a non-regulatory model can be found in the voluntary self-assessment program established by the Quality in Family Practice project for Family Health Teams. This project was funded by the Ontario Ministry of Health and Long Term Care through the Primary Health Care Transition Fund. In Phase 1, the Quality Assessment Tool was developed and a group of interdisciplinary providers and consumers were trained as Quality Master Assessors. Phase 2 set up a demonstration pilot project to test the feasibility, acceptability and affordability of the program. Phase 3 is currently underway, with field testing of the voluntary assessment program in seven Family Health Teams. Other models for team quality assurance exist in the long history of hospitals undertaking multi-disciplinary reviews of care using a variety of quality assurance practices.

In the examples of QA activities set out above, quality assurance programs which look at particular points of care (including all of the professions working there) are underway in the current legislative environment. In our view this demonstrates the sound foundation already in place. We would encourage continued growth of environment-specific programs. We are committed to working together with extra regulatory quality assurance programs to ensure that the quality assurance activities achieve the appropriate environment-specific focus and that our own quality assurance activities meet needs and avoid duplication.

Standards of Practice and Professional Practice Guidelines

In many ways, it is hard to see the professionals regulated by the College of Physicians and Surgeons of Ontario as belonging to one profession. We regulate dozens of distinct disciplines: from paediatricians to pathologists, radiologists to psychotherapists. And within each discipline, each professional is likely undertaking dozens of separate activities. It is not possible to have written guidelines for every possible scenario. Standards of practice or professional practice guidelines that would address all of the activities of our members would number in the thousands or tens of thousands. Furthermore, given the research and testing that goes into developing defensible practice guidelines, each one would require hundreds of hours of development.

In order to ensure that the very best quality of care is delivered to patients, it is our firm belief that our members must be taught critical thinking and problem-solving and then be free to use their own knowledge, skills and judgment to determine the clinical practice expectations applicable under the circumstances with which they are faced.

Analysis of our peer assessment data indicates that performance is inextricably linked to the factors in the environment in which a physician works and the patients he or she sees⁴. As with complaints, we believe that the best approach to quality assurance is custom made: the right process for the circumstances. We can get there by working together with our sister Colleges where several professions are working in collaboration, by continuing our efforts to increase and improve our peer assessments and by making every effort we can to assess and change the systems problems (those outside the control of the individual practitioner) which have a deleterious impact on patient care.

With respect to matters that focus more on process than clinical practice (for example, advertising, obtaining informed consent, conflict of interest), we strongly endorse collaborative efforts and Interprofessional consistency. We are currently working with the College of Nurses and the College of Pharmacists on common dispensing guidelines. A similar collaborative example is the Pandemic Planning group established by FHRCO. These examples demonstrate that there will be circumstances in which it will benefit patients for our Colleges to work together (because our members are already doing so). And these examples demonstrate that we have the capability and motivation to do so. There are several such projects underway at any given time.

We look forward to undertaking several collaborative projects that seem particularly critical to supporting the evolution of interprofessional care. For example, teams would benefit enormously from guidance that provided a well-documented delineation of responsibilities of team members, including a protocol for establishing overall responsibility for health care decisions. While we believe that such matters are best decided at point of care (based on the individuals making up the team, the professions, the environment and the patient needs), regulators could play a role in developing common frameworks and messaging about expectations. Likewise, there are unresolved issues and differences in professional approaches to record-keeping. This is another area in which the regulators can work towards developing common guidelines. Finally, rather than approaching encouraging interprofessional collaboration through a rules-based approach, there may be much ground to be gained through joint education. Members of all the Colleges need to understand the scopes of practice of the professionals with whom they work: clear

⁴ “Physician-Patient Encounters: The Structure of Performance in Family and General Office Practice”, *Journal of Continuing Education in the Health Professions*, v. 26, n 4, p 285-293, Fall 2006

communication about this evolving area would assist with the policies and guidelines referred to above.

On another note, our conflict of interest expectations are articulated in regulation. HPRAC's question refers to guidelines, standards and policies. We aren't certain whether HPRAC was signalling a different approach or whether these were just examples. We believe that some of the examples listed properly belong in regulation and should not be reverted to policies or guidelines. In the past, such as with conflict of interest and advertising, the Colleges have worked with government to develop templates for regulation. This has benefits in consistency between the Colleges and we were pleased to be involved in the process. There is no barrier to its use today and, in fact, could be a model for working collaboratively towards other regulation. It is noteworthy, we believe, that the template work did not come to fruition because regulations that were developed based on the template were never passed. This problem, of moving regulation quickly and efficiently through the approval process, is discussed more fully below.

Tools and Templates

The CPSO does not think that a *Collaboration Toolkit* would provide much benefit. We believe that the examples provided above demonstrate the collaboration at the regulatory level is already underway. We believe that development of a toolkit would be a large undertaking that would delay the process of collaborating on content matters.

College Autonomy, Authority and Accountability

In the past, the CPSO has made submissions, and HPRAC has made recommendations with respect to regulation-making authority. Whether the issue requiring regulatory change pertains to prescribing (as has been the case for the Colleges of Nurses and Midwives), Duty to Warn (a regulation that we ultimately withdrew because of the delay) or any other matter, most of the health colleges have found their ability to respond quickly to the public interest impaired by inefficiencies in the process.

Since HPRAC's recommendations in "New Directions", we have experienced improvement in the regulation-making processes within government. We applaud government for its efforts in this regard. Nevertheless, we suggest that a more viable long term solution may lie in a model that permits regulation-making authority to reside with the Colleges themselves. For example, in Saskatchewan the Medical College has the ability to make regulation which may then be vetoed within 90 days by the Minister of Health. We believe that retaining the stakeholder consultation process currently in place would offer transparency and accountability and that the current requirement that draft regulation be presented to our Councils, circulated to our members and then returned to Council ensures that stakeholder concerns can be voiced in the appropriate public forum. With these safeguards in

place as well as a Ministerial veto power, we believe that much could be gained by bringing regulation-making power within the College's role. We recommend that consultations be undertaken to determine whether the Saskatchewan model, or some variation, would work for Ontario.

We find the question of accountability provocative. Our College, together with the other physician regulators across the country, is currently exploring the possibility of developing a self-assessment of our regulatory performance. We think that this has the potential to be an outstanding accountability tool. It may be that the Ontario health Colleges could work together to develop a common self-assessment tool and that assessment results could be provided, as part of our annual report, to the Minister.

The Role of Colleges

Ongoing collaboration among the regulators will provide consistency and clarity to our members at point of care. This will reduce conflict and misunderstanding at the clinical coalface. As clinical relationships and scopes of practice continue to evolve, the foundation of consistency and clarity will help our members to work together smoothly to provide quality care. More importantly, perhaps, our regulatory voice in support of the principles of Interprofessional care and in development of regulatory tools can promote cultural shift. We cite our Professional behaviour in the Workplace policy or perhaps a multi-College awards program for outstanding team performance as such tools to effect change.

Regulatory Enablers

As discussed above, the CPSO does not believe that significant change is required in the RHPA to encourage interprofessional care at the clinical level. We do believe, however, that the PHA provides a real barrier.

We do not believe that a law requiring collaboration would achieve the stated goal and we would be concerned that it sends an incorrect message to health care professionals and to the public that, in the absence of such legislation, collaboration is impossible.

Conclusion

When we are seeking to improve the quality of patient care and optimize access, we need to look beyond ensuring that the players are working well together. We need to step back and look at the playing field as well. The CPSO believes that the regulatory Colleges and the individuals delivering care are working, both consciously and unconsciously, towards establishing interprofessional frameworks at point of care. We see huge steps forward due, perhaps, to health human resource pressures, patient safety data and the focus that this aspect of health care

delivery has enjoyed in the last few years. We see evolving multi-disciplinary education programs and the will, at every level, to see interdisciplinary care as the best path forward for quality health care delivery. We believe that the RHPA provides the objects and the flexibility that we, as regulators, require in order to support and drive forward this evolutionary process.

In conclusion, we offer the following recommendations:

1. We recommend that the government should continue to explore creative remuneration models that foster interprofessional care delivery.
2. We recommend that consideration be given to ensuring that all health professionals have adequate liability protection and how best to fund such an arrangement.
3. We recommend undertaking a comprehensive review of the network of laws pertaining to health care settings in Ontario to determine which require revision to facilitate seamless point of care delivery.
4. We recommend that government consider a mechanism by which to provide systems oversight across the health care sector.
5. We recommend a review of privacy legislation (including QCIPA) to ensure that there are no barriers to open communication in the public interest.
6. We recommend that the Ministry continue to focus on development of electronic records as part of its interprofessional care mandate.
7. We recommend that consultations be undertaken to determine whether the Colleges could be given regulation-making authority in the public interest.