SOUTHLAKE
REGIONAL HEALTH CENTRE

Responses to HPRAC Call for Consultation
Southlake Regional Health Centre

- Assist health regulatory colleges and their members to work collaboratively, rather than competitively, and to learn from and about each other through a process of mutual respect and shared knowledge to:
- Improve patient care and facilitate better results for patients;
- Protect the public interest; and ensure the highest standards of professional conduct and patient safety;
- Regulate the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest;
- Optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services;
- Ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment, and
- Enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability.

1. Please comment on the above statement that HPRAC has used to focus this discussion and initiatives. Are there elements that should be added or removed? If so, what are they?

Statement is adequate.

Eliminating the Barriers to Collaboration among the Colleges

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?)

Wording in the RHPA and in profession specific acts that denotes exclusivity for activities or interventions colludes in silo approaches to care. Additionally, current scope of practice statements while generally broad with overlap are in some cases sufficiently distinct as to impede collaboration between specific health professions related to certain specific activities. Duplication in provisions within the RHPA requiring each regulatory college to set up and maintain separate complaints, investigations, discipline and fitness to practice mechanisms mediates against collaborative efforts in the cases of complaints involving more than one discipline and may not entail the most judicious of funds.

3. 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?

As have been previously identified, there are specific barriers within the Public Hospitals Act with respect to the authority invested within physicians for the "ordering" of health care interventions that have created a complex set of "work around" strategies and work to impede collaborative patient care initiatives. These barriers apply to the assessment and treatment domains of patient care, impact on admission and discharge documentation and dispositions and generally prevent without suitable accommodations the discharge of duties by other health professionals when to do so would overlap with certain exclusive powers of physicians.

4. Are there other policy and/or systems issues that act as barriers to collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how?

Issues previously identified including the socialization of health care professions in silo based academic environments (not withstanding the move toward more Interprofessional curriculum in recent years) mediate against overall health system realignment in favour of collaborative patient centred systems of care. Levers to move Interprofessional collaborative practice environments forward do not rest on colleges alone, but rather are more systemic in nature. Addressing health human resource policy, funding mechanisms for post secondary health faculty education, health sector accreditation and payment/reimbursement mechanisms are significant elements of a realigned health system. The role of collective agreements, unions and professional associations in finding mechanisms and indeed the will to collaborate must be addressed.

5. Are there professional cultural issues that act as barriers to collaboration among the Colleges? What steps should be taken to minimize these barriers? Who should provide the leadership to eliminate them? What role can health care associations, including associations whose members are regulated professionals, play in this process?

There are indeed cultural issues in promoting competitive, territorial mind sets and behaviours on the part of regulators that mediate against collaborative patient centered practice. While there has been some progress in bringing regulators together through such mechanisms of the Federation of Regulatory Health Colleges, such collaboration has been aimed at practice outcomes only and has been voluntary and time consuming.

Provincial policy enabled by legislation setting the terms, scope and deliverables for regulatory collaboration within defined timeframes is an avenue for serious consideration in bringing about timely collaboration amongst territorial players in a timely and goal directed manner fitting an Ontario agenda. The creation of a Health Professions Board with overarching powers within which the various regulated colleges report may greatly facilitate a process of real system reform.

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

The patchwork of liability coverage for various health disciplines in Ontario works against high functioning collaborative delivery of health care services, particularly at the "team" level. Mandatory liability coverage for all regulated health professionals will work to decrease the reluctance of teams to deal with controversial issues and the perception that some team members are "more liable" than others for adverse outcomes. Liability coverage on the part of all regulated professionals will also serve to reinforce the individual and collective accountability for practice and its outcomes.

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

As above in question 6, all regulated professionals must be required to maintain liability insurance at all time.

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

Liability protection should be required for all students in the health professions engaged in practical learning with patients and part of a licensure system for "supervised practice" as a student. Upon graduation, proof of liability coverage must be provided at the time of application for licensure to the appropriate regulatory body and that proof must be re-submitted upon license renewal. A minimum insurance threshold must be set and held in common for all professional disciplines. Such coverage should provide for redress by the public for errors and omissions, negligence and professional misconduct.

Developing Enablers for Collaboration among the Colleges

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

As noted above in question 5, creation of a Health Professions Board to provide a collaborative frame for common activities would require both enabling legislation in its own right, along with changes to the RHPA and profession specific legislation. Such a Board would logically be charged with the development, implementation and periodic evaluation of systems and processes for

1. Entry to Practice – standard application processes and procedures
2. Complaints (with the support of the appropriate regulatory college(s))
3. Investigations of Complaints (with the support of the appropriate regulatory college(s)
4. Discipline (with the support of the appropriate regulatory college(s))

5. Alternate Dispute Resolution mechanisms (with the support of the appropriate regulatory college(s))
6. Quality Assurance processes and procedures
7. Continuing competency processes and procedures

Such a Board would also be charged with facilitating by directing the establishment of guidance documents policies, procedures for common activities found within all regulated professions, including but not limited to documentation, registration processes etc.

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

No comment

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

In the current Ontario environment each new regulatory college must develop policy, standards and practices related to registration, complaints, investigation, discipline, fitness to practice, continuing competency, quality assurance among others. Establishment of a Health Professions Board as noted above would greatly facilitate the introduction of new regulators into the spectrum by providing a framework for the core functions as noted. In the absence of a Health Professions Board, there may be some advantage to the Federation of Health Regulatory Colleges (if properly resourced and supported) in working with start up colleges in sharing already established frameworks related to the items aforementioned.

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

There are a host of activities related to administrative process that could in fact be shared amongst all of the regulated colleges. Such sharing however would be suggested to be an interim step at best on the road to the creation of a Health Professions Board which would provide the economy of scale to administer those processes held in common amongst all colleges. Administrative processes related to the following items could be shared currently and as argued be rolled in a Health Professions Board at a later date:

1. Entry to Practice – standard application processes and procedures
2. Complaints (with the support of the appropriate regulatory college(s))
3. Investigations of Complaints (with the support of the appropriate regulatory college(s)
4. Discipline (with the support of the appropriate regulatory college(s))
5. Alternate Dispute Resolution mechanisms (with the support of the appropriate regulatory college(s))
6. Quality Assurance processes and procedures

7. Continuing competency processes and procedures

13. 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?

As noted above, a common structure (Health Professions Board) should be developed as soon as possible to standardize responses to complaints, investigation and disciplinary matters along with common process for registration, proof of insurance verification, continuing competency and quality assurance. While the Board would work with individual regulators on content/profession specific issues, the Board would provide the overall centralized/standardized system and processes for all professions related to the above noted matters and use regulator expertise to address profession specific matters within the centralized process.

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

As noted previously, it is suggested that this common framework include but not necessarily be limited to:

1. Entry to Practice – standard application processes and procedures
2. Complaints (with the support of the appropriate regulatory college(s))
3. Investigations of Complaints (with the support of the appropriate regulatory college(s)
4. Discipline (with the support of the appropriate regulatory college(s))
5. Alternate Dispute Resolution mechanisms (with the support of the appropriate regulatory college(s))
6. Quality Assurance processes and procedures
7. Continuing competency processes and procedures
8. Standard core competencies that stretch across disciplines (documentation, advertising, code of conduct, privacy, confidentiality, consent etc)

15. 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?

The RHPA should be amended to allow for greater flexibility on the part of individual colleges only on an interim basis as a Health Professions Board is established.

16. 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?

As noted in question 15. Amendments to the RHPA should be made only in the service of moving toward a more comprehensive plan involving the establishment of a Health Professions Board. A patchwork, workaround remedy such as amendments to the RHPA should not be viewed as the best or permanent solution but rather only a remedy in the event of a significant time delay in establishing a Health Professions Board.

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

As noted above, a single Health Professions Board with responsibility to include standardizing the complaints process should be established. Such Board should be funded by regulated health professionals as part of a revised licence fee structure with some portion of the fee paid supporting the regulated college and some portion of the fee supporting the centralized functions of the Board.

18. 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?

A centralized (Health Professions Board) body and process to investigate complaints against health professionals especially in the case of complaints lodged within the context of interdisciplinary teams would be of considerable benefit. This benefit would be derived through the economy of scale, deployment of the appropriate investigate resources and structured collaboration between the respective colleges potentially involved in the investigation of their respective members.

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

As noted previously Colleges should be granted further authority only in the service of moving toward a more comprehensive plan involving the establishment of a Health Professions Board. A patchwork, workaround remedy such as amendments to the RHPA to facilitate such expanded abilities should not be viewed as the best or permanent solution but rather only a remedy in the event of a significant time delay in establishing a Health Professions Board.

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

The creation of a Health Professions Board would support the timely, efficient, effective and judicious use of resources in supporting complaints from the public with respect to regulated health care providers. With the anticipated rise of Interprofessional practice forums, Interprofessional/collaborative teams, one would assume the increased likelihood that complaints/reports may be more team based on multiprofessional than uniprofessional in the future. A Health Professions Board would allow for systems and

processes to address this new practice reality (Interprofessional teams) and complaints regarding its members to be handled in the most efficient manner.

21. Is legislative change required to accomplish these goals?

As previously noted, legislative change would be required to address the creation of a Health Professions Board, including changes to the RHPA, and profession specific legislation.

22. Would a joint quality assurance program among relevant Colleges enable the Colleges to develop common standards of practice or professional practice guidelines where the same or similar Controlled Acts are shared?

A master framework developed and monitored by a Health Professions Board would support quality assurance initiatives by all Colleges. While College specific requirements might well be established by individual regulators to accurately reflect the scope of practice of its members, a common set of quality assurance measures and a common system of reporting could be supported by a Board.

23. 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?

A major initiative of a Health Professions Board would in addition to the items previously noted be to develop continuing competency and best practice requirements across the spectrum of health professions. Within this context, individual regulatory colleges would likely develop profession specific requirements as appropriate, but broader competencies and the reporting frameworks could and should be centrally administered.

24. Is legislative change required to accomplish these goals?

As noted previously Colleges should be granted further authority through legislative changes only in the service of moving toward a more comprehensive plan involving the establishment of a Health Professions Board. A patchwork, workaround remedy such as amendments to the RHPA to facilitate such expanded abilities should not be viewed as the best or permanent solution but rather only a remedy in the event of a significant time delay in establishing a Health Professions Board.

25. Should an independent arm's-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?

An independent arm's-length organization would be an asset to the promotion of common standards and practices, but should not take the place of a Health Professions Board. Rather such a body should serve in an advisory capacity providing academic, practice, and research and evaluation expertise to the regulated Colleges and the Board.

Such an advisory body could and should provide empirical based advice to the Board and regulators on common practice guideline development with an eye to harmonization between all (or as many) Colleges as feasible. Such practice guideline work could include but not be limited to:

1. Consent to treatment
2. Consent to admission to care facilities
3. Consent to power of attorney for personal care
4. Privacy
5. Confidentiality
6. Disclosure of Medical Error
7. Resuscitation
8. End of Life Care
9. Telephone Advise
10. Statutory reporting

26. 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.

Such a body as described in question 26 and 25 should serve in an advisory capacity to a Health Professions Board which would maintain legislative authority to support those function as outlined in questions 9, 12 and 14. As such, the suggested advisory body would not have specific oversight functions or serve to resolve disagreements among professions, but might be mandated much as HPRAC is mandated to do in providing advice to the Health Professions Board on such matters.

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

The Federation of Regulatory Health Colleges could serve to be the springboard for an Advisory Council to support the work of regulatory colleges and a proposed Health Professions Board. A Health Professions Board would need to be created separately and is unlikely to be found in a format currently that could be migrated into such responsibilities.

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

As above

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?

As noted previously Colleges should be granted further authority through legislative changes only in the service of moving toward a more comprehensive plan involving the establishment of a Health Professions Board and potentially an Advisory Council A patchwork, workaround remedy such as amendments to the RHPA to facilitate such expanded abilities should not be viewed as the best or permanent solution but rather only a remedy in the event of a significant time delay in establishing a Health Professions Board.

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

As above

31. Should the Colleges be required to report to the Minister and/or the public on their collaborative activities on a regular basis? Why or why not?

Until such time as a Health Professions Board is in place, Colleges should be required to report to the public and to the Minister on collaborative initiatives. Once a Health Professions Board is in place, the Board and Colleges (where appropriate) would jointly be responsible for such reporting on a yearly basis. Should an Advisory Council be established, this Council may also use the annual reporting as a vehicle to establish advisory initiatives and investigative priorities for the following year.

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?

As noted previously, consistent common guidelines related to the issues in question 32 and others identified in the response to question to 25 should and can be developed and shared operationally by all regulated health professionals. There is no need for 20+ separate guidance documents on obtaining patient consent for treatment and harmonization based on best evidence and collaborative dialogue, through an Advisory Council and operationalized by a Health Professions Board is entirely reasonable.

33. What kinds of structures and processes could facilitate collaboration among Colleges to address issues related to standards of practice and professional practice guidelines for those professions that deal with closely related activities (e.g. dental hygiene, dental technology, dentistry and denturism; or opticianry, optometry and opthalmology)? (For example, joint colleges, collaborative Councils or independent bodies such as the Council for Healthcare Regulatory Excellence in the UK.)

As proposed in this response, a realigned system in Ontario would see in addition to new Interprofessional curriculum and course delivery mechanisms at post secondary institutions providing health science education, the continuation of the health regulatory colleges with the establishment of a new oversight body, the Health Professions Board (to address commonalities in regulatory requirements amongst all Colleges – complaints, investigation, discipline, registration, quality assurance etc) and establishment of an Advisory Council (to educate the Colleges, professions and public regarding regulatory issues, create repositories, develop standards and practice collaboratively etc). Over and above such recommendations, professions providing similar services such as those noted in this question should be joined to form one single College with the ability to licence professionals in the subset of service provision. A model is suggested similar to the College of Audiologist and Speech Language Pathologists of Ontario.

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?

Such a toolkit would be useful in the context of a means to move collaboration forward until structures and processes outline in this response are operational. Such a toolkit should however not take the place of structural change. A toolkit developed to accomplish the aims as noted above, should have wide applicability and be useful to health care organizations and providers to support collaborative practice initiatives at the institutional level.

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

A toolkit if developed should identify a framework for Collaborative Competencies at the clinical level, address scope of practice and regulation and suggest mechanisms for communication enhancement and teambuilding skills. Frameworks developed through initiatives of the Centre for Interprofessional Education (University of Toronto), HealthForce Ontario and Health Canada are in existence and should be consulted. Stewardship of such a project in the short term with adequate resourcing might be undertaken by the Federation of Regulatory Health Colleges.

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

Professional standards of practice should be in general legally enforceable. Through the proposed Health Professions Board who would be mandated to standardize as many standards of practice as practical, a common mechanism for reporting of deviations to standards of practice would be in place. Additional profession specific standards of practice may also be instituted where appropriate and also generally enforceable and reported through the Board as the centralized authority for complaint investigation and reporting. There may be standards which do not carry legal mandate and serve as profession specific guidance, but a move should be made to establish key practice standards (consent, confidentiality, privacy, etc) in law (as several are now under related legislation).

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

In accepting the establishment of a Health Professions Board with the mandate to administer common processes related to complaints, reports, investigations, discipline, and common standards (consent, disclosure, privacy etc) Colleges would be empowered to enact standards specific to their discipline that may not carry the gravity of need for force of law. Such standards may relate to specific continuing education competencies, expected conduct, conflict resolution, service provision in management/supervisory capacities etc.

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

A Health Professions Board and Colleges must maintain accountability for development, approval, dissemination and monitoring of standards/rules. To that end, a mechanism for public education related to practitioner requirements (vis a vis the standards, regulations) must take place and a vehicle for complaints/reporting (through the common access point of the Health Professions Board) must be established and empowered to act.

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

Collaboration at the point of patient/client service will be facilitated by a new generation of care providers trained in Interprofessional and collaborative practice educational formats, exposed at the clinical level to advanced collaborative practice teams in a system that is realigned and restructured to support Interprofessional patient centred practice. A variety of transformations are required including the post secondary health sciences setting, legislation, regulation, regulatory colleges, remuneration systems, public policy, funding, collective agreements and union/professional associations. Regulators are but one factor in such a transition. Streamlining common regulatory requirements, systems and processes, establishment of common standards are but two broad areas of regulator collaboration that is long overdue, but can only succeed in the context of system change in the health care delivery system of this province.

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?

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

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

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