



COLLEGE OF OPTICIANS OF ONTARIO

SUBMISSION TO HPRAC

MINISTERIAL REFERRAL ON INTERPROFESSIONAL COLLABORATION AMONG HEALTH COLLEGES AND PROFESSIONALS

May 29, 2008

The College of Opticians of Ontario (COO) appreciates this opportunity to comment on the Health Professions Regulatory Advisory Council (HPRAC) Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals released in February 2008. The COO is keenly interested in eliminating barriers to collaboration, as we believe that the best patient-centred care is achieved through a multidisciplinary care model. It is important to point out that collaboration is, by its nature, voluntary. Regardless of any mandatory or regulated initiatives that may be put in place, interprofessional care cannot work without the support, commitment and voluntary participation of the professionals involved.

COO was actively involved in the development of FHRCO's submission to HPRAC and endorses that submission. This submission reflects the particular perspective of the COO and is designed to supplement and support the FHRCO submission.

Defining Interprofessional Collaboration

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?

The statement provides a good framework to create an environment of collaborative care within Ontario. However, one component that should be included in any plan to facilitate and encourage collaborative care is the promotion of regulated health professions and education of the public and health professionals alike. Such promotion should include detailed information as to which professions are regulated, those professions' role in the delivery of health care services to the public and how those professions can or do collaborate with one another. This additional component is in keeping with and would support the objectives of the COO that were added by *Health Systems Improvement Act, 2006 (HSIA)*.

Finally there is an unfortunate inference in the statement that could be derived from the phrase "work collaboratively, rather than competitively". The COO does not agree that competition and interprofessional collaboration are necessarily mutually exclusive. In fact, the COO has worked closely with the (federal) Bureau of Competition Policy to identify and address anticompetitive practices and procedures in the vision care sector that do not have a compelling public interest

rationale. The Competition Bureau in Canada and its peer organizations in the United States, Europe and Ireland have identified vision care as a sector where competition can enhance access and patient choice, as well as constrain prices to the public benefit.

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?)

The barriers were broadly identified during the HPRAC workshops held in 2007. The HPRAC Consultation Discussion Guide released in February 2008 summarizes those barriers accurately.

Many of these broad issues have a direct impact on the vision care sector and are discussed in greater depth later in this submission.

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?

The current restrictions contained in the Conflict of Interest Regulation of the College of Optometrists, and the proposed amendments to that regulation currently before the Ministry of Health and Long-Term Care (MOHLTC), prohibit various forms of association between optometrists and opticians and between physicians and optometrists. Since the regulation is currently being reviewed by the MOHLTC, now is the opportune time for the Ministry to encourage collaboration within the eye care sector by ensuring that amendments are made to the relevant optometry regulations to ensure facilitation of collaborative care and comply with the Ministry's own guidelines regarding conflict of interest. Another barrier to interprofessional collaboration is the current prohibition under the (Ontario) *Business Corporations Act* against members of different professions being shareholders, officers or directors of a professional corporation.

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?

In the vision care sector, the College of Optometrists' and the College of Opticians' members working together to provide the best possible patient care, offering a wide variety of services would be the model which best serves the public. The two colleges have been discussing regulatory issues such as full freedom of association and refraction for a number of years and those discussions persist to present day. The COO continues to be hopeful that compromises can be reached to support collaboration and build a new vision care system in Ontario founded on mutual professional respect, interprofessional equality, increased public access to services, patient-centred care and shortened improved wait-times.

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?

Perhaps the most prominent cultural barrier to interprofessional collaboration is the professional hierarchy that persists among the regulated health care professions. It remains an unfortunate fact of life that some healthcare professions conduct themselves as if they are, and are in fact treated as if they were, more equal than others.

Historically, health professions have not fully understood nor have had an appreciation of other regulated health professionals and their respective roles in the health care system. As health care delivery changes, so too must the system and the players. All stakeholders have a role to play in eliminating barriers to collaborative care. This includes the government, the colleges, the associations and the teaching institutions.

Liability Issues

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

This college has not experienced any barriers to interprofessional care due to liability issues.

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

All regulated health professionals should be required to hold minimum professional liability insurance coverage.

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

The minimum amount of insurance will vary due to reflect a number of factors, including, but not limited to, the nature of treatment and services provided by different regulated health professionals, the setting in which those professionals practice and their previous history of litigation and insurance claims paid. Individual regulatory colleges are well placed to determine the appropriate level of insurance that should be carried by their members. This is not a situation in which one size fits all.

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?

See above comments on the Optometry Conflict of Interest regulations outlined in question 3. The College of Opticians has not identified any required changes to the *RHPA* other than those described in Questions 15 - 19, 21 and 38.

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

HSIA did not address one of the most significant barriers to collaborative care that is present in Ontario hospitals: the *Public Hospitals Act*¹. Currently the *Hospital Management Regulation*² made pursuant to the PHA is contrary not only to the existing scopes of practice model of the RHPA, but also to collaborative care models in general, in that it contains a provision that limits health professionals in hospitals from working to their full scope of practice. Specifically, s. 24 of the regulation states:

24. (1) Every order for treatment or for a diagnostic procedure of a patient shall, except as provided in subsection (2), be in writing and shall be dated and authenticated by the physician, dentist, midwife or registered nurse in the extended class giving the order. O. Reg. 64/03, s. 10.

(2) A physician, dentist, midwife or registered nurse in the extended class may dictate an order for treatment or for a diagnostic procedure by telephone to a person designated by the administrator to take such orders. O. Reg. 64/03, s. 10.

Although medical directives or orders permit different regulated and unregulated health care providers to perform acts that are normally only within the scope of practice of another regulated health professional, the impact of this provision in the regulation is to limit the team approach to health care within Ontario hospitals and by extension adds to the perception that certain health care providers are more capable than others to direct patient care. This provision means that health care professionals other than physicians, dentists, midwives or nurses in the extended class cannot independently perform the controlled acts authorized to them under the RHPA or the activities within their legislated scope of practice. This regulation requires that one of the four listed professions provide a written order before each test or act of treatment if it is to be performed by a member of another regulated health profession. This is contrary to both the existing scopes of practice model and the future of team-based care.

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

The College of Opticians has no comment on what will be needed by the new colleges, but would be happy to respond to requests for advice and assistance, either directly or through FHRCO, from the Transition Councils or the new colleges.

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

Any of the individual colleges could enter into administrative sharing agreements with one another in an effort to take advantage of cost sharing. If the agreements were strictly for the sharing of administrative resources there would be no need for those types of agreements to be limited to only those colleges that share similar controlled acts or areas of practice. As with any agreement of this

¹ *Public Hospitals Act* R.S.O. 1990, c.P.40 [PHA]

² *Hospital Management Regulation* R.R.R. 1990, Reg. 965

type, barriers will centre on negotiating appropriate use of the shared resources. Confidentiality issues may arise when staff are shared between health care colleges. Appropriate mechanisms must, by law, be in place to ensure that information that must be kept confidential to one college is not shared with another college that is sharing staffing resources.

Structural Mechanisms

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?

A common framework that ensures complaints are handled in a consistent manner across colleges would be an improvement over the differences in the current systems in place. FHRCO could develop such a framework through its current work in assisting the colleges to implement the changes to the complaints process introduced by *HSIA*.

Nevertheless, the COO has difficulty imagining a common framework for complaints that goes beyond a common clearing house for the receipt and dissemination of complaints to the appropriate regulatory college or colleges. Given the materially different approaches to complaints and discipline, standards of practice for common procedures, regulatory philosophies and even terminology among the regulatory colleges, we do not see very much scope for the consolidation of investigations, complaints or discipline.

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

FHRCO has the expertise to determine the requirements of such a framework.

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 above framework can be established within the current *RHPA* provisions. Nevertheless, there are amendments that should be made, which are described below, that would improve the complaints process when dealing with complaints against multiple health professions.

16. If so, what should and should not be addressed in an amendment to the statute? 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?

The sharing of complaints information would improve the complaints process for all parties; namely, the complainants, the professionals and the regulatory agencies. The professionals that have been acting as a team should be treated as a team in a complaints matter. This would ensure a fair and consistent outcome and help prevent any one member of the team from receiving harsher treatment or punishment from their own regulatory body than other members of their team. Finally, the

regulatory agencies would benefit from the ability to pool their resources when processing complaints and would likely be able to make better dispositions of a complaint because they would fully understand the continuum of care the patient had received. All of which would have the salutary benefit of signaling to the health professions the importance of working together as a team when treating patients.

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?

Any merits of a single complaints system such as those in other jurisdictions that mean an agency outside of a profession-specific regulatory body is responsible for investigating and adjudicating complaints would be outweighed by the negative effect such a system would have on the principle of self-regulation. The regulatory colleges should be responsible for handling complaints against their members. Any system modeled on other jurisdictions that took that responsibility away from the professions should not be instituted in Ontario.

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

Yes. The College of Opticians supports the amendments to the *RHPA* recommended by HPRAC in the *New Directions* report:

That section 25(1) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Investigation of complaints and reports

25 (1c) Where a complaint or report concerns a service provided in a multidisciplinary environment, the investigator may conduct or participate in an investigation of the complaint or report together with one or more investigators from or appointed by other Colleges, and may share information with the other investigators for the purpose of the investigation.

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

Yes. The authority should extend beyond investigations and permit joint complaints committees where a complaint relates to care received from an interprofessional health care team.

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

Yes. Aside from the ease of reporting for the patient, it is likely the complaint would have a more satisfactory outcome if the complaint was dealt with from a multi-faceted approach that would take into account the nuances of each step of their care.

21. Is legislative change required to accomplish these goals?

Yes. *HSIA* has made significant changes to the complaints process. However, the amendments to the complaints and confidentiality provisions do not go far enough to result in true interprofessional handling of complaints. The amendments still do not permit joint investigations or the sharing of complaints information between regulatory colleges. The notion of a complaints committee comprised of more than one health profession is not contemplated at all in the 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 joint quality assurance program would theoretically enable at least some colleges to develop common standards of practice or practice guidelines when the same or similar controlled acts are shared. The COO is, however, not convinced based on its own experience that such an approach is practical and, if imposed, could actually have the effect of delaying the development or updating of standards of practice or practice guidelines.

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 joint quality assurance program as outlined in this question per se would not *necessarily* provide for the opportunities outlined. However, providing opportunities for enhanced continuing competence and exposure to best practices amongst colleges with similar or shared scopes of practice through continuing education activities would address some of the issues outlined in answer 5. A paramount barrier to collaborative care is the lack of knowledge amongst professionals as to the skill sets that other professionals possess. Encouraging joint continuing education would allow members to participate in continuing education programs that would not only increase their awareness of other professions with similar scopes of practice but allow for an environment that encourages a sharing of knowledge, skills and best practices thus enhancing collaboration in a practice setting.

24. Is legislative change required to accomplish these goals?

As noted, joint quality assurance programs through legislation would not necessarily achieve the goal of increased collaboration as each profession sets out requirements for individual quality assurance programs for its members that take into account a number of factors specific to the profession. Encouragement of shared resources through the provision of continuing education activities amongst professions with similar or shared Controlled Acts would benefit the professional's knowledge and skills, raise the "educational" bar for all participants and provide a unique opportunity and environment for sharing.

Standards of Practice and Professional Practice Guidelines

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?

This college is of the belief that such an independent arm's length organization as outlined would not be particularly beneficial..

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

Please see above.

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

FHRCO, with support (including financial) from the Ministry of Health and Long-Term Care could facilitate most of the suggested activities listed in question 26 with the exception of the oversight function. The College of Opticians believes the necessary oversight mechanisms are already in place through HPRAC (for overall evaluation and advice), HPARB (for appeals of complaints decisions), the Divisional Court (for appeals of decisions of Discipline Committees), the Ministry of Health and Long-Term Care (for regulation making oversight) and the Lieutenant Governor in Council (for the appointment of appropriate public members to college councils).

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

Please see 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?

The Minister of Health should intervene only where colleges are unable to develop collaborative initiatives of compelling importance within a reasonable time.

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

The Ministry of Health and Long-Term Care should have funding available to all colleges to assist in the development of collaborative initiatives, as is contemplated by subsection 5.-(5) of the RHPA.

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?

Not unless there is a mandate that the Ministry will act on the reports, including providing support where colleges have indicated a need. Otherwise, a reporting mechanism becomes an

exercise in the exchange of paper, using valuable resources by all parties culminating in very little benefit.

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?

Yes, there should be a commonality among the health professions. However, the guidelines should be minimalist in order to respect the differences in the circumstances and requirements of each of the professions. Any guidelines must take into account the different treatments and health services provided, as well as the large variety of practice settings in which health professionals deliver care. This is especially true for advertising regulations given that some professions such as opticians, optometrists and pharmacists operate in retail and clinical settings. All guidelines should contain sufficient flexibility to accommodate the unique environment of practitioners.

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?

Joint colleges or collaborative Councils will not foster interprofessional care, but rather are much more likely to result in the reduction of the number of independently-regulated health professions. The COO believes that this would impact negatively on the natural evolution of professions, access to health care and the public's choice among alternate health care providers. One of the hallmarks of self-regulation is the authority delegated by government to a profession to regulate itself through an independent profession-specific college. History has shown that joint colleges do not work. Combining health colleges would mark a return to the *HDA*'s system of professional monopolies and hierarchies. Originally, opticianry and optometry were regulated together by the same regulatory body. The Ontario government recognized in the 1950's that this was not an effective regulatory model for either profession and resulted in less efficient regulation. In 1961 the two professions were separated and each granted their own legislation. With the introduction of the *RHPA* a number of professions that had been previously governed by others were given the ability to self-regulate. One such profession is the dental hygienists. This profession has grown and flourished with its self-regulating status in a way that was not possible when it was regulated by dentistry. The College of Opticians is unable to support a proposal that would return to a model that has been definitively proven not to work.

Tools and Templates

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?

The College of Opticians believes a toolkit should be made available to facilitate and support collaboration among colleges.

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

The research conducted by HPRAC while preparing its report to the Minister of Health on this issue would be invaluable to an organization charged with developing a toolkit. FHRCO is well placed to develop such a tool kit, if provided with relevant information collected by HPRAC and if they are given financial support by the Ministry of Health and Long-Term Care. Included in a Collaboration Toolkit should be all of the elements suggested by HPRAC in the Discussion Guide.

College Autonomy, Authority and Accountability

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

Standards or practice and professional practice guidelines adopted by colleges should be legally enforceable. However, implementation and enforceability would be difficult. Currently, regulations are the law and are enforceable, standards of practice are not. To be enforceable they would have to be elevated to the status of regulations. It would be possible to amend professional misconduct regulations to mandate that a breach of a standard of practice is considered professional misconduct; however, it is unclear whether this would withstand a legal challenge. Generally the courts do not consider a standard of practice to be enforceable unless there is a competent and responsible body of opinion that would support the standard of practice mandated by the college.

37. 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?

Statutory rule-making powers enabling colleges to enforce standards of practice and professional practice guidelines is in keeping with the spirit of self-regulation. The Law Society of Upper Canada is already afforded this power in its regulation of lawyers and paralegals in Ontario.

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

29. The colleges should be allowed to make enforceable rules that relate to their own members, but do not impact other regulated health professions. For example, conflict of interest regulations regarding association among regulated professionals should have to be approved by the government, whereas standards of practice relating specifically to a profession should be within the purview of the colleges.

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

Adequate measures are already in place. Procedural fairness applies to any administrative decision of the college. The *RHPA* already provides oversight mechanisms. Decisions of the Complaints and Registration Committees can be appealed to HPARB and Discipline decisions can be appealed to the Divisional Court.

Interprofessional Care at a Clinical Level

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

Greater collaboration among the colleges will trickle down to the professions by enacting standards that require team work and diminish turf wars.

Developing Regulatory Enablers for Interprofessional Care at the Clinical Level

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?

The College of Opticians has not identified any required changes to the *RHPA* other than those described in questions 15 - 19, 21 and 38.

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

The College of Opticians of Ontario believes that a legal requirement for all health care providers to work and communicate effectively as noted would be a positive step.

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

Any legal requirement should encourage the facilitation of the circle of care as contemplated in *Personal Health Information Protection Act (PHIPA)*. Other recommendations in this submission if legally mandated would ensure health practitioners work collaboratively and communicate with other professions to provide the best patient care. Breaches of those requirements should be considered professional misconduct and subject to the penalties provided for in the *RHPA*.

The COO hopes our feedback has been helpful and we look forward to working with HPRAC as this project moves forward.

With kind regards,

A handwritten signature in black ink, appearing to read "MacIsaac-Power". The signature is written in a cursive, flowing style.

Caroline MacIsaac-Power, RO
Registrar