

## **PART 5: Your Opinion Counts: How to Make your Submission to HPRAC**

### **Possible Mechanisms to Facilitate and Support Collaboration among Health Professions' Colleges**

The *Health System Improvements Act, 2007*, established a clear mandate for the Colleges to engage in greater interprofessional collaboration.

The Act provides new enablers for Colleges to interact with one another, including the additional College objects, to take effect no later than June 2009, as well as revised confidentiality provisions that clarify the Colleges' ability to share information with one another for the purposes of the *RHPA*.

To assist the Colleges in achieving the new objects, the Minister has asked HPRAC to recommend mechanisms to facilitate and support collaboration among the Colleges.

The literature and jurisdictional reviews demonstrate the important role that regulators must fulfill in supporting and enabling interprofessional care at the clinical level.

HPRAC has an opportunity to recommend options to the Minister that will provide Colleges with needed tools to improve collaboration among the Colleges and their members.

HPRAC has considered:

- The challenges Colleges have faced in their collaborative endeavors;
- The steps taken in other jurisdictions, and
- Possible mechanisms for a made-in-Ontario solution to advance collaboration among the Colleges.

## HPRAC'S QUESTIONS

To assist HPRAC in developing advice for the Minister, the Council has developed a number of questions on which your comments and insights are sought. We welcome and appreciate your participation, and hope that you will provide notes and references from your knowledge and experience, as well as other thoughts about ways in which interprofessional collaboration can and should be supported. We are asking that all responses be forwarded to HPRAC no later than April 15, 2008.

### Defining Interprofessional Collaboration

**Background:** This Discussion Guide is focused on exploring the issues, challenges and opportunities concerning the Minister's request for advice from HPRAC.

While many definitions exist for "interprofessional care" (i.e., interprofessional collaboration at the clinical level); none was found in the Literature Review for collaboration at the regulatory (i.e., College) level. To provide the context for this Discussion Guide and to focus its response to the Minister's request, HPRAC proposes that any initiatives should be directed to finding ways to:

- 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 professional's work to their maximum competence and capability.

### QUESTION FOR DISCUSSION:

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? **No Changes**

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## Eliminating the Barriers to Collaboration among the Colleges

**Background:** People who participated in HPRAC's workshops as well as information from the literature review confirm that many patients and clients, caregivers, health care professionals, health care providers, regulators and decision-makers are ready to embrace interprofessional care. Evolution and change within the health care system requires examination of the various legislation, regulations and policies that support the system to ensure that they are keeping pace with the changing needs of those affected.

In response to the Minister's request, HPRAC is seeking to find ways to enable the Colleges to collaborate by eliminating the barriers to collaboration and identifying new ways for the Colleges to support and enable interprofessional care by their respective members at the clinical level. In this Discussion Guide, HPRAC has identified some possible mechanisms to facilitate and support enhanced collaboration among the Colleges as a step towards the ultimate goal of enhancing the delivery of interprofessional, patient-centered care.

In its report to the Minister, HPRAC intends to address the legal, policy and systems issues that are currently acting as barriers to collaboration among the Colleges. By way of example, in *New Directions*, HPRAC reported to the Minister that the language of section 36 of the *RHPA* (the so-called "secrecy clause") acted as a barrier to the transfer of information between and among Colleges. This barrier was addressed in the *Health System Improvements Act, 2007*, by clarifying the Colleges' ability to share information with one another for the purposes of the *RHPA*.

### QUESTIONS FOR DISCUSSION:

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 minute details of a profession's scope of practice should not be written into legislation. This has created an enormous unnecessary barrier to health care for patients seeking care from NP. The classic example is RN (EC drug and lab list. Legislation should read that the NP can order & prescribe & dispense but the details were included Regulation in 1998. The details of the controlled act should be in the individual Colleges standards of practice document. This change will allow for greater flexibility and expedience in meeting the needs of the evolving health care system (College of Nurses of Ontario, 2006). And once and for all abolish the arduous & extremely political, lengthy process that is needed to modify one colleges scope of practice.**

**The present process has become a tool for some agencies to forward his or her own agenda against the NPs despite the evidence that says we are safe prescribers (Carryer et al., 2007). In summary the *RHPA* should state who could perform the controlled but the individual college should have the authority to how it will be done in practice.**

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?
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?

The RHPA continues to be a barrier to collaboration for the reasons above. It makes no sense that if a NP is qualified to prescribe and order tests, that the skill be limited to a list of drugs or labs. It is not the list that keeps the public safe it is the individual practitioners critical thinking and assessment of the situation, which does.

Although NP legislation has been in place for 10 years allowing the NP to practice autonomously the Public Hospital Act and Long-Term Care Act, Ministry of Transportation have not been modified to allow the NP to practice autonomously to their full scope of practice in these settings. NPs are trained to perform annual physicals but the MTO has said the NP cannot sign the driver's physical. Not changing legislation to support the RHPA continues to create barriers and under mind the credibility of NP unnecessarily.

Having worked in both the hospital and long term care setting I was never able to deliver the care I was capable of delivering because the acts would not let me practice autonomously in these settings defeating the purpose of me being there which was to increase patients access to care.

Remuneration policies are barriers to interprofessional collaboration.

1. RN (EC) can directly refer to a specialist, but the OHIP model of remunerations compensates the specialist far less than if a physician makes the same referral. The result is that specialists require 'co-signatures' of NP and collaborative GP for a referral. This extra step creates an unnecessary barrier even when the assessment and referral are completed and totally within the NP's scope of practice In other words, OHIP coding practices did not change to reflect the change in legislation for RN (EC) s.

2. Remunerated from direct patient payment, third party or insurance billing. These methods of payment create barriers collaboration with other health care professional such as chiropractors, dentists, and physiotherapists. Many of my patients would benefit from physiotherapist services to keep them mobile and active but have no means to pay for these services.

3. Rostering patients & incentive bonuses, which directly benefits only one professional group (MD) creates extreme animosity between professions as one profession is financially benefiting from the work of another profession (NP). If the NP for example does a pap, stool for occult blood the MD receives the incentive bonus for these services delivered by the NP. This structure does not encourage collaboration but creates animosity between professionals.

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?

1. The professional Cultural issue that creates barrier to collaboration is “ the physician as gate-keeper to health care” There are now many points of entry. . Patients should be able to enter into the health care system through any regulated health care provider (RD, social worker, PT, OT, MD, NP, RN etc). This would avoid unnecessary costly visits to other health care providers..
2. No one profession should have the power to police another profession directly or indirectly or propagate negative media about another health professional. For example the OMA letter re NP clinics

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### Liability Issues

**Background:** Some organizations have indicated that lack of a legislative requirement for professional liability insurance coverage for all regulated health professionals may be a significant impediment to collaborative team building. Others disagree.

#### QUESTIONS FOR DISCUSSION:

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

The only barrier I know related to liability is the misinformation and confusions Physicians’ have about when they are working with nurse practitioners. The Canadian Nurse Protective Society and the NPAO to clarified the issues of individual provider’s liability issues, which have eliminated the concerns of physician groups.

The CNPS formulated a joint statement with the CMPA to clarify the various terms and issues related to liability within interprofessional groups. It can be reviewed at:

[http://www.cnps.ca/joint\\_statement/joint\\_statement\\_e.html](http://www.cnps.ca/joint_statement/joint_statement_e.html)

Each health care provider is responsible for the care they deliver. Not the care that someone else delivers!

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

This depends on the HP work environment. If they are employed by an agency the agency has to have liability insurance for their employee and is the first to be named in a lawsuit.

2. If the HP is an independent contractor they must purchase their own liability insurance

Therefore, every HP should have minimum liability insurance, through the employer or as independent contract personal liability insurance.

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

The liability insurance should be occurrence-based. Occurrence-based is necessary as it continues provide coverage for the provider even if the provider discontinues work with the environment in question and is in effect if the provider held liability insurance coverage during the time that the incident occurred. This ensures that if a provider changes work environments, retires, changes work etc, he or she continues to be covered for previous work.

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### Developing Enablers for Collaboration among the Colleges

**Background:** As mentioned at the beginning of Part 5, the *Health System Improvements Act, 2007*, establishes a clear mandate for the Colleges to engage in greater collaboration with one another. The questions in this section examine some different approaches that could be used to facilitate this.

HPRAC's literature review indicates that the legislation and regulations governing Colleges should not prohibit collaboration among the Colleges nor should it be silent on the issue of collaboration. Instead, the legislation and regulations should specifically encourage, require, facilitate and enable collaboration among the Colleges.

*Legislatures and regulators have not traditionally made collaborative care one of their main objectives. Current legislation and regulation do not prohibit collaborative practice, nor do they encourage, require, facilitate or enable it. Legislation and regulations should be updated and amended to expressly support collaboration. In Canada, there is inconsistency and a lack of clarity in legislation and regulation with respect to collaboration. When these flaws exist, regulators and health care professionals err on the side of caution. Therefore, legislators and regulators must be clear and consistent in emphasizing the importance of collaboration.<sup>1</sup>*

Mechanisms should be built into the legislative framework to enable regulators of various health professions to work together to build effective interprofessional collaborative arrangements within and across the health care continuum.

#### QUESTIONS FOR DISCUSSION:

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?

**The RHPA could ensure that each profession has criteria for collaboration**

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

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<sup>1</sup> Ibid.

It is imperative when a scope of practice is legislated through a professional college, that all subsequent supporting Acts and Regulations also be changed to support it.

For example: 1. NP although legislation supports NP performing annual physicals (physical examination, diagnostic tests, diagnose, prescribe treatment within our scope of practice the MTO who controls the Highway Traffic Act does recognize The signature of a NP on an Ontario Drivers physical form even when it is the Np who performed the assessment and completed the form the MTO wants a MD signature. Creating a duplication of services.

1. Because other supporting Acts have where not changed when the RHPA was modified NPs continue to fight each piece of legislation separately:  
Ontario Disability Forms
2. Completing Physical exams for Children's Aid Society
3. Disability Parking Forms

Creating more barriers and discouraging interprofessional collaboration it creates a situation where NPs are not able to provide care for their patients that they are qualified to provide. It incontinences the patients as they often have to either find a different provider to complete the forms, or return to the clinic to see a provider who is able to complete the forms.

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

A system of Cross-Appointments between established Colleges and newly forming Colleges could provide a system of support to the newer Colleges as well as information sharing between each.

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

Sharing administrative responsibilities is concerning to me as this has the potential to create a large ineffective structure that does not facilitate self-regulation of each college. There is the potential for a loss of autonomy of each college, which is not acceptable to any group.

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## Structural Mechanisms

**Background:** HPRAC's jurisdictional review identified some approaches to health professions' regulation that are supported by *structural mechanisms* worthy of consideration. Several jurisdictions have established common complaints, investigations or disciplinary frameworks for all or several health professions.

Some say that "*encouraging regulators to work together in areas of quality assurance, complaints and discipline would signal the importance of collaboration to health*

professionals".<sup>2</sup> A common framework for such matters might lend itself to more effective and efficient management of complaints that might arise in an interprofessional care setting.

Standards of practice are developed by regulated health professions through mechanisms reflected in legislation. They are intended to guide a profession in its delivery of health care and ensure the appropriate level of quality. They may also promote continuous learning and improvement. Examples of standards of practice include record keeping, reporting of diseases and standards for the performance of one's duties.<sup>3</sup>

Professional practice guidelines are regulatory instruments that provide recommendations to members of a profession on matters such as codes of ethics, consent and advertising.<sup>4</sup>

### Complaints, Investigation and Discipline

**Background:** Victoria (Australia), New Zealand, Denmark, Nebraska, Virginia and Washington all have a common complaints, investigation or disciplinary framework for all regulated health professions.

#### QUESTIONS FOR DISCUSSION:

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?

**The idea of a common framework utilized to address complaints, etc sounds like a good idea. But I am concerned this would just be another layer of unnecessary legislation/administration and that not all colleges would submit to such a structure. For such a structure to function with any authority it would have to be an independent interdisciplinary body, which investigates complaints, disciplinary action, etc which arise out of an interdisciplinary setting of care delivery.**

**This body would need to be the final authority and non-political so the specific interests of specific disciplines do not receive special favors or consideration.**

**Lastly a concise definition of "interprofessional care setting" needs to be developed. As RN and NP I have always delivered care in an interprofessional team, but many other health care professionals still function in silos.**

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

**The framework would have no authority to recommend or modify changes to a to a health cares scope of practice. It's only objective should focus the complaint and the circumstances surrounding the complaint.**

<sup>2</sup> Ibid.

<sup>3</sup> Ibid., p. 14 and 51.

<sup>4</sup> Ibid., p. 14 and 50.

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?

**I am not sure what stops colleges from investigating complaints now that happen interprofessional care?**

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?

Not sure

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?

**Fund it through the MOHLTC, dues are already too high.  
See #13**

**Background:** In its 2006 *New Directions* report to the Minister, HPRAC recommended that, when a complaint or report concerns a service provided in a multidisciplinary environment, Colleges be given explicit authority for their investigators to work with investigators from other Colleges, and to share information in the course of the investigation. Evidence from the Patient Safety movement indicates that medical errors most frequently are not the fault of one individual, but may be the result of several systemic failings.

QUESTIONS FOR DISCUSSION:

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?

**I think joint investigation would bring a broader more balance prospective to the investigation. Hopefully the team would look ant the system and process failures that lead to the complaint as well.**

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

**If the objective is to improve patient safety then this could be beneficial method to do so as each college could contribute their expertise according to their discipline.**

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

I would hope that improving patient safety would be the main objective of the colleges' investigation and not a punitive investigation.

21. Is legislative change required to accomplish these goals?

Yes, a legislation change is required to reach the above because there is nothing obliging colleges to participate.

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### Quality Assurance

**Background:** Some Ontario Colleges have informally developed joint quality assurance programs that involve more than one profession.

### QUESTIONS FOR DISCUSSION:

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?

I think a joint quality assurance will encourage collaboration between colleges and generate discussion on collaboration and better understanding each other's professions. But I am concerned there is the potential that one college could dominate this process.

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?

I would hope that one of the goals of the joint quality assurance program would provide opportunities for professionals to cross train with other health professional to enhance and broaden their competence and expose them to best practice of other health care professionals and integrate them into their practices. The Society of Obstetricians and Gynecologists already does this as they provided new research to their SOGC, which consist of OB/GYNs, physicians, NP, and nurses on an annual bases.

There is no reason why other professionals who share common scopes of practice could not form groups to enhance a high quality of care of all professionals delivering similar services.

24. Is legislative change required to accomplish these goals?

**No legislation does not be changed to accomplish the above goal. If any legislation is changed it should be minimal. The rationale for this statement is the health care system is constantly changing and legislation cannot keep up with the rapid changes of health care. Nurse Practitioners have experienced this first hand. For example the drug and lab list is in legislation and has become a barrier to patients receiving health care from their NP. For a shared quality assurance program to function and have the flexibility to respond to an ever-evolving health care environments every small detail should not be placed in legislation.**

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### Standards of Practice and Professional Practice Guidelines

**Background:** Some jurisdictions have introduced a new body (independent of government and of the regulatory bodies) to assist with interprofessional collaboration and, in some cases, with the development of standards of practice and professional practice guidelines. For example:

- Quebec has established an Interprofessional Council that acts as an advisory body to the Government and as a coordinating body for the regulatory orders (i.e., the Colleges). The Interprofessional Council creates opportunities for the exchange of ideas and information among the regulatory bodies, intervening as the collective voice on issues of common interest to them and providing information to the public.
- Virginia has established a Board of Health Professions that:
  - Evaluates the need for coordination among the health regulatory boards and their staff and reports its findings and recommendations to the Director and the boards;
  - Monitors the policies and activities of the Department, serves as a forum for resolving conflicts among the health regulatory boards and between the health regulatory boards and the Department and has access to departmental information;
  - Promotes the development of standards to evaluate the competency of the professions and occupations represented on the boards, and
  - Examines scope of practice conflicts involving regulated and unregulated professions and advises the health regulatory boards and the General Assembly of the nature and degree of such conflicts.
- The United Kingdom has established the Council for Healthcare Regulatory Excellence (CHRE), an arm's-length agency accountable to Parliament and responsible for overseeing the health regulatory bodies. Its mandate includes the promotion of best practice, cooperation and consistency in the regulation of health care professions, in the interest of patients. The Council also has the power to direct regulators to make or change its rules if it believes that such a change is necessary to protect the public (subject to the approval of both Houses of Parliament).
- Denmark has established a Secretariat for Clinical Guidelines as a unit of the National Board of Health. It supports medical societies and other health care professionals in developing clinical guidelines. The clinical guidelines are evidence-

based, involving interdisciplinary work. This encompasses relevant medical specialists as well as other health care professionals and integrates organizational and health economic aspects and patients' views.

**QUESTIONS FOR DISCUSSION:**

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?

1. **Firstly, I think this organization maybe quite costly to the taxpayer and not increase patient safety or access to care.**
2. **If it is determined that such an organization is necessary than it must give recommendations that are evidenced based. It has been my experience when trying to change legislation that the recommendations are not evidence based but dominated by the stack holders who have the most power, money and their professional agenda, which was not patient, centered.**
3. **This organization would have to be apolitical. So no one member or college could high jack the process and block the increased scope of practice of other health professionals. Unfortunately I have experience this as a NP. I have watched as members of another profession (who's information is not based on evidence) have publicly fought against NPs having an increased scope of practice. Members would also have to have a comprehensive understanding of RHPA and individual professions scope of practice**
4. **My greatest fear with this organization is the process will be high –jacked by more powerful organizations whose goal is to protect their own professional turf.**

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; Yes, this is important. Many NPs have been entrenched for years in trying to enhance legislative authority of RNECs so that, as a group we are fairly well versed in "how the system works". However, I am not sure that the same is true for all health care professionals. It is very important to understand key elements of the regulatory model and role in order to facilitate collaborative practice.**
- **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); This is also a very helpful. Rather than each College "reinventing the wheel" and implementing varying policies, a repository with evidence-based data and frameworks will save time, money and create a common language between the Colleges.**
- **Research and develop standards of practice and professional practice guidelines, and disseminate best practices; These three points could be part of the joint quality assurance program which is discussed in a previous question.**

- Resolve disagreements among professions that share overlapping scopes of practice and the same or similar Controlled Acts; I'm not sure how this would differ from a joint quality assurance program, except that this recommendation appears to give the independent body final authority in these issues. I am not in favor of this.
- Address issues arising from conflicting legislation, and
- This would be a welcome relief as mentioned above NPs battle daily with the legislative barriers which unnecessarily prevent us from delivering patient care that is within our scope of practice because no one has the political will to change the legislations for example the Public Hospital Act which prevents the NP from working to their full scope of practice in the Hospital or long term care setting.
- Other regulated health care professions will encounter similar difficulties as legislation is changed to increase their scope of practice.
- A Central body that uses the evidence to address the arising conflicting legislation would hopefully expedite the removal of the legislative barriers that prevent any regulated health profession from functioning to their full scope of practice.
- Have an oversight function over regulatory bodies, as in the United Kingdom.

**NO.** I think it gives one body the potential to mandate recommendations that may not be compatible to the mandate/vision of an individual college.

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

**This could possibly be a division of HPRAC. If this new structure is formed it must be interdisciplinary with no one discipline mandating or highjacking the process.**

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

**Government funded, professional dues are already too high as Nurse Practitioners are not sufficiently remunerated as it is.**

**Background:** The Minister's request states that "regulators should develop standards of practice and professional practice guidelines where regulated health professions share the same or similar Controlled Acts."

However, without a clear legislative mandate to do this, it may be difficult for the Colleges to justify spending limited time and scarce resources on something that is not legally required of them.

#### QUESTIONS FOR DISCUSSION:

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?

**NO.**

**It isn't legislation that inhibits health professionals from collaborating. It is the remuneration models that do this. When I worked in a community health access**

center everyone was salaried even the MD. We never had an issue with collaboration as health professionals intuitively seek out other professionals to give their patients optimal care.

The Family Health Team rostering system creates a barrier to collaboration between the MD and NP and the other health professionals. The MD receives monies for service that the NP delivers autonomously to the patient. This builds resentment between the MD and the NP, which doesn't foster a collaborative spirit. Also the MD is not directly compensated for collaborating with other health professionals or participating in team meetings, program development and helping with the formulation of medical directives.

Collaboration between professions will be better facilitated when all health professionals are compensated fairly for their services. Also that another profession does not benefit financially from service provided by other health care professionals like in the case of the NP.

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

No, The most effective interprofessional collaborative teams have arisen from the practice level. I organized, delivered diabetes care on an interdisciplinary team with great success. Part of our success was we were all salaried so remuneration was not a barrier to collaboration. When there is appropriate funding (not necessarily salary model) and a will to make it happen, interprofessional collaboration happens.

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?

I don't see this as the role of the Minister to police collaborative activities of the colleges.

The Colleges should ensure that interprofessional collaboration is present the standards of practice and monitor their own practitioners (this is how the College of Nurses functions now).

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. Standardized shared guidelines, standards and policies concerning matter such as conflict of interest, advertising, record keeping and the consent process should be consistent across all the colleges. The present inconsistencies create difficulties for the patient in several manners i.e. retreating their past medical records as all offices have different policies and fees. Getting information from walk in clinics is very difficult. Hopefully with information management systems in place some of this issue will disappear.

Standardized Guidelines/policies to resolve conflict between the colleges, which inhibit collaboration, must be include. The most pressing example that is

hindering collaboration between NP and the MD is the OMA and MOHLTC agreement that has all patients rostered to the MD whether the MD ever participates in the direct care of that patient this includes the primary health care incentives for Pap, stool for occult blood etc care which is being done independently by the NP and the MD who did not do the care is being financially compensated for and the tax payer is paying twice for. Hopefully guidelines related to conflict resolution would resolve this issue in a more timely satisfactory manner.

**Background:** When closely related professions are regulated by the same College, one set of standards of practice and professional practice guidelines may govern those professions.

Ontario regulates audiology and speech-language pathology as two distinct professions within a single College. As part of its regulatory reform process, British Columbia will designate audiology, speech-language pathology and hearing instrument dispensing as three distinct professions within a single “umbrella” college. The United Kingdom regulates dentists, dental hygienists and dental therapists under one regulatory body, and dispensing opticians and optometrists under another. Nebraska has stated that closely related professions should be regulated by the same body when possible.

Some have suggested that joint structures may be a viable approach to facilitating interprofessional collaboration.

#### QUESTION FOR DISCUSSION:

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

The College of Nurses already uses the approach of regulating similar professions RPN, RNs, NPs. Joint colleges are a good approach to accommodate closely related professions but should not be used to create unnecessary barriers to the growth and development of a particular profession. As we all know health professionals are continuous life long learners and health care is forever changing, so joint Colleges should function the public but not limit the growth of the individual professions.

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#### Tools and Templates

**Background:** Some of the participants who attended the October 2007 workshops suggested the development of templates or tools that regulators could use to facilitate collaboration among Colleges, including:

- Terms of reference for joint College committees established to address common standards of practice or professional practice guidelines (e.g., composition,

- objectives, roles and responsibilities, mechanisms for exchanging information, coordination of activities, staffing, ground rules);
- Sample Memorandum of Understanding language between Colleges on their collaborative initiatives (e.g., principles, purpose, goals, targets, measures and evaluation framework);
  - Templates for regulatory and non-regulatory instruments that could be adopted or adapted by the Colleges;
  - Approaches to common strategic planning, oversight, public and member engagement on specific collaborative initiatives, and
  - Tools to measure collaborative initiatives and identify key success factors.

**QUESTIONS FOR DISCUSSION:**

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?

**Much work is being done or has been done on Collaborative process and supporting “toolkits” for example the Family Health Team Quality Management Committee (which is funded by MOHLTC)**

**Is rolling out their collaborative training for the FHTs this spring so why not tap into this work, which is already being done.**

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

**A interprofessional committee with a strong understanding and experience of collaborative practice.**

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### **College Autonomy, Authority and Accountability**

**Background:** Some workshop participants described their concerns related to their ability to govern their members because:

- The standards of practice and professional practice guidelines adopted by Colleges are not legally enforceable;
- The Colleges do not have independent rule-making authority, and
- Government examination and approval of regulations concerning such matters can be a lengthy process.

Some jurisdictions provide greater autonomy for health professions regulators, allowing them to develop legally enforceable rules without approval from government or the Minister. For example, New Brunswick provides for autonomous self-regulation for medicine, nursing and dentistry. In other words, there is no need for these New Brunswick regulators to seek legislative action (i.e. pass a regulation) to fulfill their regulatory mandate.

Collaboration among the Colleges (particularly in respect of the development of standards of practice or professional practice guidelines concerning shared or similar Controlled Acts) might allow interprofessional care and patient-centered care to continue to evolve in Ontario; however, if the Colleges were to successfully collaborate in the development of such standards of practice or professional practice guidelines, issues concerning their enforcement by Colleges could remain.

**QUESTIONS FOR DISCUSSION:**

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

**If the government adopts the model of an independent organization to govern/over see colleges the colleges legally enforcing the standards of practice the colleges maybe in conflict with the role of the independent organization.**

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?

**I am pro a system that removes what should be in the colleges' standards of practice out of legislation. What I mean by this is the RHPA should state who can before the controlled act and the parameters of how the professional will perform the controlled at be in the colleges' standards of practice not legislation. Legislation is too slow to meet the changes in the health care system in a practical and efficient manner. The Colleges are more capable of ensuring that all that the standards of practice continually meet the most up to date evidence based practice.**

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

**Presently NPs at their 1800 hr review must demonstrate to CNO that they meet the collaborative relationship with a physician according to the standard of practice (that is if there is a MD to collaborate with)**

**All health care professionals including physicians should demonstrate that they are not profiting inappropriately for work that other disciplines are performing.**

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

**A system for monitoring and reporting areas of enforcement should be implemented. Each College should carry out these measures and report on a regularly basis to a central body.**

\* \* \* \*

[The Role of Colleges in Promoting Interprofessional Care at the Clinical Level](#)

**Background:** In *New Directions*, HPRAC recognized the importance of collaboration among the Colleges, and recommended that Ontario's regulatory environment for health professions be structured to support innovative ways to deliver health care to patients – including a greater focus on interprofessional care. The *Health System Improvements Act, 2007*, amended the *RHPA* to include an instruction to Colleges (within their new objects) concerning interprofessional collaboration similar to HPRAC's recommendation contained in *New Directions*.

**QUESTION FOR DISCUSSION:**

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

**Greater collaboration between the Colleges will :** 1. Educate each profession about the others scope of practice. 2. Make every stakeholder aware of the unnecessary barriers to practice and maybe work together to remove the barriers. 3. Continue to demonstrate to other Colleges that NP are an evidenced based/safe profession and we all should be working together to remove barriers in all health professionals' way, which prevent them from working to their full potential. We need to remember that if health professionals cannot collaborate effectively because of remuneration issues, turf protection it is the patient that suffers.

\* \* \* \*

**Developing Regulatory Enablers for Interprofessional Care at the Clinical Level**

**Background:** The literature states that the law must do more than simply “not prohibit” interprofessional care at the clinical level; it must encourage, require, facilitate or enable it.

By way of example, New Zealand has implemented a positive legal requirement for all health care providers to work and communicate effectively in or between teams to ensure quality and continuity of services.

**QUESTIONS FOR DISCUSSION:**

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 RHPA is not the true barrier to interprofessional collaboration accept in the sense that all the act should state is who can perform the controlled act and the intimate details of the controlled act be spelled out in the individual colleges' standards of practice. Give the NP the legislative power to openly, prescribe, dispense and order laboratory and diagnostic imaging.**

**The true barrier to interprofessional collaboration is the professional turf protection and remuneration models which compensate one profession for the work of another profession (rostering model), or do not compensate the**

professional for their collaboration services, attending meetings, and development of programs including medical directives (rostering and fee for service model). The rostering model and fee for service model create barriers to collaboration between interprofessionals.

As I stated above I have worked in an interdisciplinary team where every member was salaried and we all collaborated with each other for the good of the patient. Collaboration was not an expectation it was the norm.

I have also worked in a clinic where the MDs were fee for service and received a minimal payment for collaborating with me but I also had to make deals such as for the MD I will do all your female patient paps and diabetes education if you will collaborate with me on my patients. This ADHOC lets make a deal to gain collaborative services is unnecessary if the government would just pay the MD for their collaborative services.

Another example of remuneration being a barrier to MD participating in collaborative practice is the Sudbury District Nurse Practitioner clinics where the MD is provided a small amount of compensation toward their collaboration with the NPs and are compensated the remainder through fee for service. The MDs also provide other services such as policy development, medical directives and attend team meetings for which they are not directly compensated. This is not ok and is not supportive of a collaborative approach if one team member is not appropriately funded for all the services they are providing for the collaborative.

A solution to the remuneration barrier is to give salary dollars to the SDNPC so the MD can be appropriately compensated for all the service they provided.

Lastly health professionals cannot collaborate with other health professionals they do not have access to. The SDNPC have requested a Social Worker and Registered Dietitian to provide much need services to our under serviced community but as of yet have not received funding for these positions.

Presently, a family health team employs me and the present model of remuneration does not facilitate collaboration between the NP and the MD. The reason for this is the MD is benefiting financially from service provided by the NP for the patients who is fully within the NP scope of practice. Which the NP needs no MD consultation for. Secondly, the MD is not compensated directly for participating in team meetings, collaborating etc.

Lastly, I have worked in interdisciplinary teams my entire nursing career (15 years, 5 as RN and 6 as NP) with several models of MD remuneration (fee for service, rostering, salary). Collaboration happens when all members of the team are adequately compensated for their contribution to patient care and no one is benefiting financially from services provided by another health profession.

42. Should Ontario law have a requirement similar to the one in New Zealand?  
Not sure this is appropriate.

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

Thank you for your response to these questions.

## **PART 6: Next Steps**

Responses to this Discussion Guide, along with feedback from consultations to be held in the spring and summer of 2008, will be considered by HPRAC in preparing its advice and its Final Report to the Minister.

HPRAC welcomes all responses to this document. **The deadline for written submissions is April 15, 2008.** HPRAC encourages submissions prior to that date.

Responses should be addressed to:

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Electronic submissions can be made to: [HPRACSubmissions@ontario.ca](mailto:HPRACSubmissions@ontario.ca)

If possible, we prefer submissions to be made in Microsoft Word, either on disk (by mail) or electronically. Electronic submissions can be made to:  
[HPRACSubmissions@ontario.ca](mailto:HPRACSubmissions@ontario.ca).

If fax is more convenient for you, please address your comments to: HPRAC, INTERPROFESSIONAL COLLABORATION PROJECT, at 416-326-1549. Hard copy submissions should be sent to the above address.

Please continue to monitor HPRAC's website at <http://www.hprac.org> for information on consultations and ongoing updates.