

May 29, 2008

Annie Schiefer, Project Manager
Health Professionals Regulatory Advisory Committee
55 St. Clair Ave. West, Suite 806, Box 18
Toronto, ON M4V 2 Y7

Re: Brant Community Healthcare System response to the HPRAC
Consultation Discussion Guide.

Dear Ms. Schiefer,

The Brant Community Health Care Systems (BCHS) welcomes the MOHLTC initiative to examine the structures, process and benefits to be realized from a more interprofessional approach, especially in those situations where controlled acts are shared by more than one discipline.

To ensure the broadest consultation, given the time frame, we pulled together a small task force with invited representatives from the various health disciplines practicing at BCHS. Most notably, the task force contained our Chief of Staff, a Hospitalist, and our Professional Practice Leader. The task force determined that a targeted and focused response was the best approach. Consequently, the attached submission addresses the following questions from the Consultation Discussion Guide: 2, 9 13, 14, 16, 22,23,29, 32, 40. Overall, the response to each question represents a consensus of opinion with the exception of the physicians. Our physicians indicate that they do not see any compelling evidence to substantiate a change from the status quo.

In the event there is a need for further clarification to any part of our submission or there is a desire to explore an idea or thought to a deeper level of understanding; please contact me directly.

Sincerely,

Mary. K. Stewart
VP Patient Services & CNO

C: Richard Woodcock, CEO
Dr. Richard Johnson, Chief of Staff
Eric Doucette, Professional Practice Leader
Shelia Menezes, Interim Chair, Interprofessional Practice Council



DRAFT # 2

Regulated Health Professions Advisory Council
Consultation Discussion Guide Submission

The Brant Community Healthcare System
200 Terrance Hill St.
Brantford, ON N3R 1G9

May 30/2008



Introduction

In 1999, as part of the ongoing efforts in healthcare restructuring, The Willett Hospital in Paris and the Brantford General Hospital became partners in The Brant Community Healthcare System (BCHS), a community wide system that supports the improvement of programs and services provided through two principal sites. The BCHS is a vital member of the Hamilton, Niagara, Haldimand Brant Local Health Integration Network.

The Brantford General Hospital site, a 300+ bed, acute care facility, is located in the City of Brantford and boasts stable, state-of-the-art programs within a team environment that ensures high level patient-focused care. The Brantford General is this area's acute care facility, providing all of Brantford and Brant County's specialty programs and services for our 120,000+ residents. We are the regional centre for [Paediatrics](#), [Mental Health](#), [Obstetrics](#), [Gynaecology](#), [CT Scanning](#), [Critical Care](#), [Surgical Services](#), [Ambulatory Care](#) and [Emergency Medicine](#). We are also the site of the [Brant Community Cancer Clinic](#) and the [S.C. Johnson Dialysis Clinic](#) for patients throughout Brant County and Haldimand-Norfolk.

The BGH site has more than 175 physicians and 26 members of the Department of Dentistry using the facilities. In addition, 1,282 highly trained employees work at the Brantford General site.

The Willett site, has been meeting the health care needs of the residents of Paris, Ontario and surrounding rural areas [since 1922](#). Due to the rationalizing of medical services throughout the area, the Willett is expanding its programs to become a multi-service health care centre. There is a daily [Urgent Care Department](#) as well as a state-of-the-art [Diagnostic Imaging Service](#). The hospital also provides a full range of recreation, occupational and physiotherapy services on an outpatient basis.

Submission Responses

The response to each question represents a consensus of opinion of the interprofessional members of our task force. Out of respect for our Physician members, it is important to note that they do not see any compelling evidence to substantiate a change from the status quo. We do agree that compelling or "burning platform" evidence was not well described in the Consultation Guide. Despite this observation, other discipline representatives viewed the consultation as an opportunity. It availed an internal opportunity for further discussion, create additional insights and put forth creative ideas.

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 RHPA, is an example of effective umbrella legislation. It represents the first and true piece of legislation addressing interprofessional practice in the protection of the public.

It provides the necessary facilities and processes that permit overlapping scopes of practice. It is our understanding that nothing in the RHPA or its procedural code prevents or serves as a legislative barrier to more effective interprofessional collaboration. Despite this observation, the procedural code is written in such a fashion as to reinforce that each Regulatory Healthcare College must execute its fiduciary responsibilities in administering its own specific Act (e.g., Nursing Act 1991, Medicine Act, 1991, Medical Radiation Technology Act, 1991, etc.). The RHPA and its procedural Code are silent on the potential that independent Regulatory Colleges might or have the legislative authority to undertake interprofessional initiatives (e.g. establishing joint standards, guidelines, fact sheets, policy statements, etc) or initiate joint processes (egg. complaints, investigation, quality assurance, etc.).

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

Reflecting on this question, the BCHS considered the benefits and disadvantages of legislating interprofessional collaboration. The RHPA has been in existence for about 15 years and while interprofessional collaboration has moved forward at a clinical level, there is less visible activity at the Regulatory College level. Given the political, environmental, social and technological drivers impacting the health care system today, the need for clients to receive timely intervention and shrinking human health resources, it might be reasonable to expect that each Regulatory College define core competencies and minimal standards for interprofessional practice.

While the Federation of Regulatory Health Colleges has recently produced a consensus guideline entitled *An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario*, there have been no other examples of similar guidelines or standards produced. BCHS recognizes that this does not mean that interprofessional collaboration is not happening at the Federation level. We understand that the Federation is used extensively by Regulatory Colleges in consulting on discipline specific changes (e.g. prescriptive authorities for nurses in extended class, launching of expanded role in physiotherapy, etc.). Perhaps one of the most important pieces of work the Federation may wish to undertake is the creation of a harmonized standard on Interprofessional Practice in Ontario that includes a set of core competencies. Such a document would help to inform the emerging Interprofessional Education Programs at the undergraduate level.

In review of the RHPA, the Minister may wish to examine the benefits of making amendments to sections 7.1 and 11.0 of the RHPA. BCHS sees an advantage to defining the role of HPRAC as an overarching body committed to advising on the necessary structures and process required to facilitate interprofessional practice. Reading through the RHPA illustrates that the words “interprofessional practice” are glaringly absent. Given its’ vantage point, the constituent membership, and HPRAC’s commitment to protect the public, the Council may well be in “non-biased” position to advise the Minister on the interprofessional agenda in the best interest of public protection.

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?

BCHS views this question as interesting given that the procedural code sets out the core requirements by which each regulatory College will administer its' registration, complaints, discipline and quality assurance processes. Through a linking statement in the "definitions section" of each discipline Act, the RHPA Procedural code is deemed to be part of that discipline's Act. As a result, it is perceived that a common framework currently exists. However, what appears to be missing in the current framework is the notion that complaints and/or discipline might be managed in a more interprofessional nature in the event that a complaint names several regulated health care professionals in the same interprofessional care setting.

BCHS believes that a common framework would promote a more efficient regulatory system and make it easier for a member of the public to file a complaint. Creating a single point of access for members of the public to initiate the complaints process is more transparent and eases the navigation of the various regulatory college complaint processes. Under the existing system, a member of the public would need to file a letter of complaint with each regulatory college. This in itself could be a deterrent to members of the public filing complaints and this is not in the best interest of self-regulation or public protection.

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

BCHS believes that a common framework would be helpful and may be applicable to many situations. Components of a joint complaints, investigations, or disciplinary framework would include, but not limited to:

- Joint statements of principles underpinning safe and ethical practice
- Common Standards against which practitioners are judged (Therapeutic Relationship, Ethics, Patient Safety, Documentation, etc)
- Common "interprofessional" investigations process and core investigative personnel who are mandated to bring enhanced consistency, integrity and depth to the investigations process
- Common Patient Relations program
 - Provides easy access to information and informs
 - Creates purposeful "awareness engagement" of the public
- Defined Structures to support centralized complaints processing including
 - Central intake processes
 - Regulatory College Referral Mechanism
 - Fast Track complaints investigation stream
- Common service delivery standards including the metric of complaint to adjudication time.

- Feedback loop such that information about complaints is used for broader purposes, such as improving training for health professionals by further defining core competencies for intra and interprofessional practice.
- Common dispositions for complaints and disciplinary processes to ensure fairness and equity across practitioners.

BCHS recognizes that all regulated healthcare professions may not agree with this joint complaints/discipline management concept. To increase acceptability of a joint process to the various Colleges the integrity of self-regulation will need to be maintained. BCBS believes that a joint investigation process would result in the development of a completed investigation case file, which is referred to the appropriate regulatory body. The regulatory body would review and validate the investigative findings, and then hold hearing, as necessary, to adjudicate the case and determine dispositions within the predefined joint complaints/discipline disposition options.

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?

BCBS sees merit in amending the RHPA and procedural code to facilitate joint committees for complaints. BCBS suggests that legislative amendments would be required to establish the Joint Complaints/Discipline Committee that could possibly operate as an extension of HPRAC's mandate. Alternatively, it could also be operationalized under a reconfigured Federation of Regulatory Health Care Colleges mandate.

BCBS envisions that the complaints and discipline process could be established as a two-step process such that the investigations process is expedited and investigators time is used efficiently. The outcome of the joint investigation process would be a case file that is then referred to the appropriate regulatory college for adjudication and, where appropriate, assignment of a penalty.

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?

In reflecting on this question one asks, does the quality assurance program give rise to the development of common standards or does the development of common interprofessional standards give rise to the content and components of an interprofessional quality assurance program? BCBS believes that common interprofessional standards give rise to the need for a common Quality Assurance Program. A common framework for quality assurance programs would encourage similar member expectations among various colleges.

This certainly positions employers to be more supportive of the QA process which impacts all regulated health care practitioners. At present, employers try to support a wide variety of QA programs and expectations. We suggest that a common framework would make it easier to develop common standards of practice for practitioners who share the same and or similar controlled acts.

The RHPA Procedural Code holds each regulatory college accountable to have a QA program that 1) promotes the ongoing competence of its members and 2) raises the bar on the quality of practice of the profession as a whole. Recent examination of the various College QA programs demonstrates a large degree of variability in the nature and rigor of the QA program components. Programs are influence by their receptivity and rationale to their members, the size of membership and the administrative ease associated with specific program approaches. To the public this might appear as varying levels of compliance to HPRAC's requirements and varying levels of rigor and commitment in maintaining quality assurance (e.g. some college use randomized sampling and others are able to support peer review processes). The most significant advantage to having a joint QA program, built on common interprofessional standards, is found in the significant enrichment of the standards derived from using a broader based of interprofessional research evidence. Currently, college specific standards are largely based on literature reviews from within the discipline's body of knowledge.

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?

In short, the answer is yes to joint quality assurance programs among Colleges. In fact, on review of the assignment of Controlled acts clusters begin to surface, which may help to inform the creation of Joint Programs. The following clusters were identified based on similar scopes of practice:

Cluster 1	Chiroprody, Podiatry,
Cluster 2	Occupational and Physiotherapy including Speech Language Pathology
Cluster 3	Dental Technology, Dentistry, Denturism
Cluster 4	Medical Lab Technologists, Medical Radiological Technologists
Cluster 5	Nursing, Midwifery, Respiratory Therapy

Based on our review of the 13 controlled acts it would appear that acts # 2, 5, 6, and 8 cross a number of regulated health care professionals as either authorized acts or modified authorized acts.

We believe the creation of a joint approach offers the potential for standards to be interprofessional in nature and be founded on a broader body of evidence. Collaboratively developed Interprofessional standards become the footings of a well-defined quality assurance program. In considering this possibility, HPRAC may wish to consider if the focus of quality activity should be solely aimed at assuring quality, which is about measuring achievement of quality controls. Perhaps, HPRAC may also want to think about the benefits of regulatory colleges engaging in and reporting on continuous quality improvement. Requiring all regulatory colleges to define quality controls in the form of practice in standards, monitoring if those quality controls are being achieved and building in a continuous quality improvement component begins to create more of a total quality management approach.

To operationalize such an approach BCHS suggests that HPRAC may need to go back to the drawing board and strengthen the requirements for continuing competence and promoting the overall quality of practice of the profession. The articulation of program specific guiding principles may also be helpful to bring more standardized approaches to quality assurance across the various colleges. This also creates the opportunity for joint determination of core competencies specific to those interprofessionally developed standards.

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?**

Central to the concept of interprofessional collaboration is the need to view this initiative in the large frame. Clearly, undergraduate programs are recognizing the need for and are embracing Interprofessional Education. Students graduating from these new programs will need to be integrated into existing regulatory and work environments which value and support interprofessional practice.

Interprofessional practice is a vision, a value and represents a significant cultural shift in healthcare. This is not a shift that can be mandated. We believe that the Minister using his powers under the RHPA is in direct conflict with the whole notion of self-regulation. Yet, the interprofessional agenda needs to be set and if past experience is the best predictor of the future then the lack of visible evidence of interprofessional collaboration at the regulatory college level will continue. In setting a vision and a strategy to achieve and sustain the vision, the Minister may wish to consider enhancing the overall mandate of HPRAC to have a more interactive coordinating role in setting and holding regulatory colleges accountable to deliverables associated with the interprofessional practice agenda.

Before interprofessional collaboration can be realized in Ontario, it is the opinion of the BCHS that significant legislative barriers needs to be removed.

The Public Hospitals Act remains a dated piece of legislation that gets tweaked from time to time by adding amendments. However, as a structural support it may be more helpful for the Public Hospitals Act to be opened with a view to embedding Interprofessional collaboration. This would result in the removal of the requirement that a hierarchy must exist among practitioners.

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 professionals? If not, why not?

The complexities within the healthcare system and the volume of information requiring management, compel the need for standardization of standards, guidelines, and policies. The complexity associated with understanding various employer requirements associated with each regulatory college would be simplified and likely result in an improved compliance rate. Also, considering the migration of staff within the healthcare system more standardization would be helpful to minimize the orientation and learning curve associated with new hires. It would seem these areas are common to all regulatory colleges and perhaps represent the best starting place for development of interprofessional standards.

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

BCHS understands that greater collaboration among the Colleges will serve to enhance interprofessional care at the clinical level in the following manner:

- It sets the direction and expectations for interprofessional practice in the province of Ontario through effective articulation of standards, guidelines, and policies. A potentially revamped quality function, to a more total quality management approach, will ensure that those standards, guidelines and policies ensure public safety.
- The creation of common standards, underpinned with common competencies, will be of great support to academic facilities as they undertake to shape the minds of new practitioners in valuing interprofessional practice through comprehensive, insightful and engaging program curricula.
- Increased visible collaboration at the college level producing positive outcomes for practitioners and clients underscores a fundamental principle in transformative leadership. That principle, is to lead by example and model the change you would like to see in others.
- We think there is an impact on the knowing-doing gap. That is, if we know the value and the outcomes associated with collaborative practice and practitioners believe in the relevance of interprofessional collaboration then why does it not happen at all levels of practice.

- Clearly, there are structural barriers (e.g. siloed execution of regulatory functions which at times takes the form of turf wars, antiquated legislation such as the Public Hospitals Act, etc) that need to be removed.

The regulation and legislation parameters need to change to set in motion a facilitating structure that results in the creation, sustainability and enhancement of interprofessional collaboration in the long term.

Summary:

BCHS wishes to take this opportunity to thank the MOHLTC and HPRAC for the creation of the Consultation Guide and inviting submissions. Interprofessional collaboration must be second nature to our way of being with each other in the delivery of health service to Ontarians. Interprofessional collaboration will not happen by chance. Strategy is required to make this preferred future a reality at all levels of the industry. Strategy must be fuelled by political will and action to create the necessary infrastructure to create, maintain and continually enhance interprofessional collaboration. Interprofessional collaboration can be achieved in a regulatory and legislative framework without sacrificing self-regulation.