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Submission to the Health Professions Regulatory Advisory Council (HPRAC)

**Interprofessional
Collaboration Among Health
Colleges and Professionals**

**Ontario Hospital Association
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ONTARIO HOSPITAL ASSOCIATION

The Ontario Hospital Association (OHA) is a voluntary organization representing approximately 158 public hospital corporations, across 225 sites, in Ontario. Among its members are all the public hospitals in Ontario as well as the province's psychiatric hospitals. Many other health-related organizations make up the OHA's approximately 200 associate and affiliate members. Founded in 1924 as an independent, non-profit organization, the association is governed by a 28-member Board of Directors comprised of hospital trustees and chief executive officers from across the province, as well as four directors-at-large.

The OHA is the voice of Ontario's hospitals. It is a leader in shaping the future of the health care system, fostering excellence, building linkages with the community and advocating for quality health care. It is a positive force for change in hospitals and across the health care system, advocating on behalf of its members. The OHA represents hospitals' needs and views to government, other organizations and the public.

The OHA is organized into five Regions, representing north, east, south-western and south-central regions, and the Greater Toronto Area. Each has its own Regional Council and elects members to the OHA Board of Directors. These Board members represent the following hospital constituencies:

- Complex Continuing Care, Mental Health and Rehabilitation;
- Community Hospitals;
- Small Hospitals; and
- Teaching and Specialty Hospitals.

There are six main divisions at OHA including the President's Office, Strategic Human Resources Management, Educational Services and Operations, Policy and Public Affairs, Human Resources and Information Technology, and Finance and Administration.

The OHA has formal links with over 30 professional and volunteer organizations in the health care field through its Allied Groups. This alliance enables OHA to collaborate with many health care professionals working in hospitals to improve Ontario's health care system. The OHA also has a formal relationship with the Hospital Auxiliaries Association of Ontario (HAAO).

The OHA is also a member of the Canadian Healthcare Association, the national federation of the provinces and territories, and the Ontario Health Providers Alliance, a group including representatives of all major health service providers in the province.

Our Mission

- To deliver high-quality products and services that assist our members and partners in providing effective, safe and efficient health care;
- To advance and influence health system policy to achieve positive change in Ontario's health care system; and
- To champion innovation and performance improvement through knowledge transfer, education and advocacy.

Introduction

The Ontario Hospital Association (OHA) welcomes the opportunity to respond on behalf of its members to the Health Professions Regulatory Advisory Committee's (HPRAC) "*Consultation Discussion Guide on Issues Related to the Ministerial Referral on the Interprofessional Collaboration among Health Colleges and Professionals*" (Discussion Guide). The OHA is committed to forming partnerships to ensure the ongoing, effective implementation of Interprofessional Care (IPC) in collaboration with all health care system stakeholders.

The OHA strongly supports the adoption of IPC in both the health care and education systems, which will lead to a more effective, integrated health care system that provides enhanced access to quality care.

Many of the principles of IPC have been incorporated within the hospital setting for a number of years. IPC is recognized as essential to addressing the challenges facing the health care system in delivering high quality, patient-centred care, enhancing provider satisfaction and improving organizational efficiency.

The incorporation of IPC requires a cultural transformation at the system, regional and local levels. The ongoing commitment and leadership of a hospital's board is essential to championing IPC through providing the education, resources and tools necessary to facilitate collaboration.

The OHA's submission to the issues identified in HPRAC's Discussion Guide reflects the views of senior administrative and health professional leaders from hospitals of varying types (academic, community, small, mental health, complex continuing care and rehabilitation) and geographic locations.

Executive Summary

The following points highlight OHA's response to the key themes identified in HPRAC's Discussion Guide.

- The current legislative and regulatory frameworks (the *Regulated Health Professions Act* (RHPA), the *Public Hospitals Act* (PHA) and additional health-related Acts), generally support the practice of IPC. Certain elements of the legislative framework, for example, the PHA requirement for treatment orders, over and above the requirements of the RHPA, may be amended to better reflect and support IPC. Legislative amendments should be undertaken only when it is the sole means of fostering broad-based determinants of quality care, including but not limited to IPC, and must be crafted to enable flexibility to respond to varying circumstances at the point of care.
- The governance structure and administration provided by the health regulatory Colleges (Colleges) and by the Federation of Health Regulatory Colleges of Ontario (FHRCO) support IPC and serve as a model for optimal IPC at the point of care. Colleges provide the necessary profession-specific perspectives, and the FHRCO facilitates consensus-based coordination of those perspectives all in the public interest.
- The significant barriers to IPC requiring the ongoing concerted efforts of all stakeholders (e.g., health professionals, employers, labour organizations, professional associations, regulators, educators, and government) include:
 - Incomplete understanding and varying interpretations of the legislative framework;
 - Sociocultural factors, including real and perceived power imbalances and hierarchies;
 - Funding models that prohibit participation in IPC; and
 - Lack of an integrated health record and means of direct communication across the continuum of care in Ontario.

The OHA is committed to partnering with regulatory and non-regulatory stakeholders to continue to advance IPC and provide quality health care.

Defining Regulatory Interprofessional Collaboration

The OHA acknowledges that while there are many definitions of IPC¹, there is, however, no overarching, general definition for IPC at the regulatory level. The OHA agrees with the statement provided in the Discussion Guide, specifically, that initiatives should be directed to finding ways to “enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability”². We suggest that when teams focus on patient needs at the point of care, scopes, by necessity, should be optimized rather than maximized with consideration given to the needs and circumstances of the situation.

The OHA endorses the ongoing work of the Colleges and the Federation to govern within the principles for collaboration at the regulatory level articulated by HPRAC³. For example, the FHRCO developed the *Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professions in Ontario* (2007), which has been instrumental in facilitating IPC at the point of care as well as advancing provincial initiatives.

Eliminating Barriers for Collaboration Among the Colleges

Overall Perspective

The existing legislative and regulatory framework supports the practice of IPC within and across the Colleges, as well as the integration of IPC at the point of care. Amendments may provide an increased opportunity to optimize IPC, but the larger barriers to collaboration include such factors as a lack of understanding and varying interpretations of the regulatory framework, sociocultural factors, funding models and the lack of an integrated means of communication across the continuum of care in Ontario. Additionally, policy and system factors and liability perceptions can act as barriers as well.

Considerations

Legislation

1. Regulated Health Professions Act (RHPA)

The RHPA, with its provisions for controlled acts, non-exclusive scopes of practice, delegation and common expectations for competence, accountability and evolution for

¹ HealthForceOntario (July 2007). *Interprofessional Care: A Blueprint for Action in Ontario*, Interprofessional Care Steering Committee, Government of Ontario, p.44

² Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professions, p.26.

³ *Ibid* at p. 26.

all regulated health professions, establishes an exemplary and widely respected framework for safe, quality care. This includes IPC that is responsive to evolving patient needs and widely varying health care environments.

Delegation of controlled acts as provided for in the RHPA is useful to support the evolution of all regulated health professions. However, delegation is not a permanent solution. Autonomous authority for competent providers is the preferred means for optimizing care. Thus, the OHA supports regular, timely reviews of the RHPA and health-related profession Acts, along with reviews initiated upon request, similar to being undertaken for the *Health System Improvements Act, 2007* (Bill 171).

2. Public Hospitals Act (PHA)

To reflect updated practices in the current health care system and potential amendments to the PHA should:

- Ensure that the authority of professions providing treatments, or ordering treatments, be consistent with authorities provided by the RHPA;
- Recognize that admission and discharge decisions are best made collaboratively by all team members; and
- Acknowledge that representatives of all professions can provide optimal leadership and clinical governance.

However, in the absence of amendments to the PHA, IPC can continue to be facilitated in the following ways:

- Current limitations (by profession) in the PHA with respect to the issuance of treatment orders and diagnostics create parameters that are critical to safe care. If amendments for broadening ordering authority are implemented, mechanisms to coordinate care amongst professions with this new order-making authority will need to be established.
- Medical directives (orders) and delegation can facilitate IPC, mandating the competencies and coordination necessary for safe practice within teams.
- Hospitals can enable teams to collaborate on admission and discharge decisions and can create inclusive governance structures encompassing multiple health professions. This could be facilitated by establishing a cross-professional body (e.g., Professional Advisory Committee/Council) that could report to the board.

3. Additional Legislation

The implications of the requested amendments to the *Healing Arts Radiation Protection Act* (HARP Act) and the *Laboratory and Specimen Collection Centre Licensing Act* (LSCCLA) are similar to those of the PHA, where expanding the list of individuals who may autonomously provide orders might facilitate IPC. However, in the absence of

amendments, medical directives continue to have the advantage of coordinating care without having to create other coordinating mechanisms.

Interprofessional pain teams encounter barriers because federal officials do not recognize medical directives as orders for the purposes of the Federal *Controlled Drug and Substances Act* (CDSA). Regulatory Colleges may benefit from provincial support to resolve the varying interpretations with federal officials.

Significant Barriers

1. Lack of understanding and varying interpretations of the legislative framework

Many issues arise not from the parameters imposed by legislation, but from inconsistent interpretations of the legislative framework. For example, varying applications of the provisions related to orders and delegation have the potential to impede IPC. A consistent approach by the Colleges in interpreting legislation is necessary for IPC advancement.

The OHA supports broad-based education regarding the legislative framework supported by government, beginning with that offered in programs of preparation. The FHRCO's Controlled Acts and Authorizing Mechanisms Project, in which the OHA participated, involved the Colleges, collaboratively creating the consensus-based *Interprofessional Guide on the Use of Orders, Directives and Delegation* (2007). This is an exemplary model for facilitating understanding and addressing variances across all professions and settings.

Other sample consensus-based guidelines and tools suggested for development by the Colleges and FHRCO include those identified in the Discussion Guide⁴ as well as those for:

- Clarifying accountability within teams;
- Addressing differences in clinical judgment;
- Negotiating privacy legislation across the continuum of care;
- Clarifying how consent is obtained and capacity is determined within teams;
- Coordinating overlapping scopes of practice;
- Integrating interprofessional documentation; and
- Understanding how to use the regulatory framework to facilitate teams at the point of care.

Addressing varying interpretations in a consensus-based manner within the existing regulatory framework has proven to be highly effective. The alternative (e.g., making significant changes to the regulatory framework, especially when Colleges and providers are effectively developing shared interpretations) risks creating new barriers and being more harmful than beneficial.

⁴ *Ibid.* at p. 33, Question 34.

2. Sociocultural factors

Sociocultural factors, including historic hierarchies and status and power differentials, either real or perceived, along with ‘turf’ issues often arising from fears of loss of livelihood, can be a significant barrier to IPC and to safe care.

Sociocultural issues can emerge as regulatory issues. For example, decisions regarding who can perform controlled acts, or who ‘gives’ and who ‘needs’ orders, can be misperceived as being based on power, control and ‘turf’ issues as opposed to being appropriately founded in scopes, competencies and patient need.

In order to address sociocultural issues, there needs to be recognition along with a concerted effort by all stakeholders (e.g., Colleges, educators, non-regulatory groups including health professional associations and provider organizations) to support collaboration and decisions based on patient need and the competencies necessary to address those needs.

Educators have a critical role in influencing attitudes and practices consistent with IPC, such as providing information (e.g., on the regulatory framework) and socialization (e.g., by participating in interprofessional programming that supports IPC). Employers such as hospitals also have a critical role in providing environments that support IPC. Use of distributed leadership and partnership models over hierarchical ones and facilitating professions in having a voice in decision-making supports IPC. Cultural transformation of this nature requires support and commitment from all professions and across all areas of the organization from front-line providers to the hospital board.

3. Funding models

Funding models should be aligned so that no team member is financially disadvantaged for participating in IPC. For example, fee-for-service providers are not currently paid for attendance at patient rounds. This is a significant disincentive to IPC, and government and key stakeholders need to address this, as appropriate funding models are crucial not only to the success of IPC but also to the provision of safe care.

4. Lack of an integrated electronic health record and means of direct communication across the continuum of care in Ontario

IPC demands that health care providers be able to quickly and accurately communicate the details of patients’ conditions and care plans. The ability to meet this requirement is severely limited in an environment of paper-based records. An integrated electronic health record is a critical tool to the provision of efficient, safe, quality care across the continuum.

In addition to an accessible electronic health record, the OHA emphasizes that a written record cannot substitute for direct communication between care providers. Providing health care professionals with a readily available means of direct communication, particularly for providers in different cities working with the same patients, is essential

(e.g., integrated e-mail systems, voice over internet protocols or toll free telephone lines).

The OHA supports concerted, coordinated efforts, particularly by government to achieve both an integrated health record across the continuum of care as well as providing a means for direct communication amongst providers in all settings across Ontario.

Policy and Systems Issues

Social Workers are regulated under the *Social Workers and Social Services Workers Act* and not the RHPA. Therefore, while they are regulated health professionals, they are not governed by the RHPA. This can result in questions regarding their standing vis-à-vis health legislation and IPC in hospitals. Social workers are integral members of health care teams, and the OHA suggests participation of the Ontario College of Social Workers and Social Services Workers in the FHRCO to help address issues and smooth the way for IPC.

There are significant issues associated with the introduction of unregulated care provider roles into the regulated health care teams with respect to maintaining public protection. Unregulated providers do not offer the same safeguards and accountabilities as regulated professionals. Careful cost/benefit and performance readiness analysis is required when contemplating such roles, particularly within hospitals. The provision of ongoing supervision, authorizing mechanisms (e.g., patient safety) and care coordination must be addressed.

Liability Considerations

Liability can be a barrier to IPC. Traditionally, regulated health professionals with ordering authority are seen to have, and are treated as having, 'ultimate accountability' and liability, and are thus compelled to override collaboration if necessary. Under the RHPA, each regulated team member is accountable for decisions and actions in accordance with the profession's scope and competencies. Therefore, all regulated health professionals, not just those with ordering authority, are liable. This is not broadly understood or acted upon, although it is becoming more accepted. Clarification through the Colleges, FHRCO, insurers and other stakeholders is strongly encouraged.

To the extent that liability insurance levels the playing field and clarifies accountability, thereby addressing barriers to IPC, ensuring that all professions have liability insurance may be useful. Prior to making a recommendation, the OHA would like to consider the implications regarding liability insurance in collaboration with hospital insurers and legal counsel.

Developing Enablers for Collaboration Among the Colleges

Overall Perspective

The OHA believes that within IPC, it is essential to maintain and hold health professionals accountable to profession-specific standards to ensure quality care that is responsive to patient needs. Similarly, it is important to ensure coordination and shared expectations across professions so that hospitals and teams within hospitals can practice together efficiently and effectively.

Some joint structures may help support both profession-specific and IPC. Common processes used by each College may be more helpful to support collaboration than common structures. Imposing collaboration among Colleges through law is counterproductive, especially in light of the fact that collaboration is already being realized through the Colleges and the FHRCO. Additionally, the *Health System Improvements Act, 2007* identifies objects for Colleges to further strengthen and guide IPC within and across Colleges. The OHA defers to the Colleges to determine the best mix of structures, processes and mechanisms to enable them as long as flexibility and efficiencies are facilitated at the point of care.

Considerations

1. Role of the Regulatory Colleges

The Colleges are best positioned to optimize a health profession's role because, by mandate, they are legislatively required to protect the public and hold members accountable to standards of practice and competence.

Newer Colleges would benefit from orientation to Ontario's regulatory framework and governance approaches shared by established Colleges. FHRCO would be instrumental in providing this.

2. Common Structures

OHA supports the use of joint processes (e.g., investigations) and information sharing across Colleges, but not joint structures when managing complaints, discipline, incapacity and quality assurance. Joint structures may not permit full support and evaluation of profession-specific practices and also risk adding an unnecessary layer of bureaucracy that may interfere with responsiveness to the public. Common or similar processes may be advantageous, such as shared quality assurance programs that can produce greater efficiencies for professionals, hospitals and Colleges, by enabling synchronization with hospital-based quality assurance and performance review processes for all team members.

3. Shared Guidelines

OHA supports the development of guidelines, templates and tools for shared procedures and common processes. The Colleges and FHRCO have already undertaken the development of such guidelines and processes, and the OHA endorses the approach they have employed, including:

- Consensus-based identification of broad principles and definitions for IPC, applicable to all involved professions; and
- Providing the opportunity for Colleges to adopt and tailor their profession-specific practices in accordance with these broad principles, maintaining overall consistency necessary to facilitate and govern team practice at the point of care.

Sample practices that would benefit the development of shared guidelines include those identified to address varying interpretations as previously mentioned.

4. College Autonomy, Authority and Accountability

The OHA strongly supports the role of the Colleges and the FHRCO in facilitating IPC. The establishment of the following new objects for the Colleges, set out in Schedule 2 of the *RHPA* (effective June, 2009), will further enhance the ability of the Colleges to foster IPC and:

- Promote and enhance relations between the College and its members, other health profession Colleges, key stakeholders and the public;
- Promote interprofessional collaboration with other health profession Colleges; and
- Develop, establish and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.⁵

The OHA does not support the establishment of an arms-length or oversight body to support collaboration amongst Colleges with respect to joint standards and guidelines. Rather, the OHA is supportive of the Colleges and FHRCO continuing use of consensus-based approaches to address areas of shared activities and advance IPC. The activities listed in Question 26 (of the Discussion Guide) have been and are possible objects for FHRCO, with the exception of having oversight over the Colleges to enforce resolution – which should fall under the Minister’s powers. The OHA defers to the Colleges and FHRCO for recommendations regarding the development of legislative or structural changes to facilitate their role in supporting and advancing IPC.

Regulation-making authority for Colleges proposed in the Discussion Guide may allow practice to be more responsive to rapidly evolving environments and emerging needs and can facilitate enforcement by Colleges. However, in a team environment, there are

⁵ The changes to Schedule 2 of the *RHPA* are as a result of amendments introduced through Bill 171, the *Health System Improvements Act, 2007*.

many stakeholders, in addition to the health profession, contemplating legislative change. A system-wide review and input from multiple stakeholders is essential to ensure the public interest and IPC is maintained, regardless of whether Colleges or government approves regulations.

Identifying criteria for fast tracking amendments to regulations by either the Colleges or government is warranted, along with providing capacity to fulfill fast-tracking processes. Criteria may include practices with:

- Pressing public interest implications;
- Assurance of competencies to address patient needs given the circumstances in which the practices are being implemented;
- Strong regulatory accountability; and/or
- Broad-based agreement across affected stakeholders.

Interprofessional Care at the Clinical Level

Overall Perspective

The OHA supports a balance of laws, regulations and guidelines that provide public protection and flexibility at the point of care. Guidelines and mechanisms developed within settings (e.g., hospital by-laws) may be a better means of supporting IPC than laws by providing the flexibility required to address situation-specific circumstances.

Considerations

Laws and regulations do not always provide the best means of governance for supporting IPC. While laws and regulations are good for absolutes, they do not provide the flexibility to address situation-specific circumstances which is required for collaboration within teams. Additionally, collaboration cannot be required; it can only be fostered because IPC relies upon competent team members who understand their own and other health professions' scopes and accountabilities, knowing when and how to coordinate to provide optimal care.

OHA's Role in Supporting Interprofessional Care

The OHA is committed to partnering with the regulatory Colleges, professional associations and health care professionals to facilitate the development, and implementation of IPC in hospitals and the health care system. The hospital environment provides an extensive range of programs and services delivered by a broad range of health care professionals. Sweeping health system benefits to patients, health care providers, and health care organizations can be achieved through the implementation of IPC in hospitals.

The OHA, in collaboration with its members, FHRCO, the Colleges, government and non-regulatory stakeholders, will explore further opportunities to support IPC, such as:

- Providing networking opportunities, educational workshops and conferences to facilitate enhancement of competencies, leadership strategies and capacity to advance IPC;
- Developing prototype models of governance for hospitals to use for advancing IPC consistent with the regulatory framework, as well as resources and tools (e.g., 'best practices' guide, etc.);
- Acting as an accessible e-repository for IPC resources;
- Supporting the development of performance management processes; and
- Monitoring regulatory issues with members, identifying them and participating in resolution with FHRCO and the Colleges.

The OHA is committed to working as part of the HealthForceOntario's Interprofessional Care Implementation Committee and with health care and educational partners to champion and lead the implementation of IPC at both system and local levels.

Conclusion

In summary, the regulatory framework and governance provided by the Colleges are not the primary barriers to IPC. The significant barriers to collaboration are the lack of understanding and varying interpretations of the legislative framework, sociocultural factors, and funding models that prohibit participation in IPC, along with the lack of an integrated electronic health record across the continuum of care in Ontario.

The OHA is committed to partnering with regulatory and non-regulatory stakeholders to continue advancing IPC and providing quality health care. The OHA welcomes the opportunity to participate in HealthForceOntario's IPC initiative and looks forward to HPRAC's attention to all the submissions supporting IPC and recommendations to the Minister of Health and Long Term Care.



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