



May 31, 2008

By email to HPRACSubmissions@ontario.ca

Annie Schiefer, Project Manager
Health Professions Regulatory Advisory Council
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Dear Ms. Schiefer,

On behalf of the members of the Ontario Dental Hygienists' Association (ODHA), I am pleased to provide HPRAC with our comments with respect to *Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals*.

ODHA would also like to express its appreciation for the extension of time within which submissions could be made. HPRAC has set an aggressive timetable for itself to complete its consultation and to provide advice to the Minister and ODHA recognizes that the 6 week extension for submission will have an effect on the subsequent workload of HPRAC.

Sincerely,

Margaret Carter
Executive Director

INTRODUCTION

The Ontario Dental Hygienists' Association (ODHA) appreciates the opportunity to participate in HPRAC's consultation on Interprofessional Collaboration. In its response, ODHA will address general issues as well making comments on some of the questions raised by HPRAC in its *Discussion Guide*.

GENERAL COMMENTS

In general, ODHA supports collaborative practice and the utilization of individual health care practitioners to the fullest extent of their scope of practice and competencies.

In its review of the *Discussion Guide* developed by HPRAC, ODHA is concerned that the questions appear to narrow the possibility of a full exploration of the issues related to interprofessional collaboration by directing the focus of the review. In addition, the questions appear to present a very narrow interpretation of the questions in the letter from the Minister of Health and Long Term Care.

In its review of the questions in the *Discussion Guide*, ODHA infers that HPRAC assumes that interprofessional collaboration can be mandated by regulation, standards of practice, guidelines, or policies. There appears to be no recognition or understanding of the significant role that the professional associations can play in promoting and championing interprofessional collaboration. In fact, there appears to be a lack of recognition that interprofessional collaboration is already happening at a clinical level and that it has been driven by the professions and changes in the health care settings and not by legislative changes.

The *Discussion Guide* is decidedly quiet on the possible role that the Ministry could play in promoting interprofessional collaboration. The Ministry has the capacity to educate the consumers of health care about interprofessional care. In addition, the public members appointed to College Councils could benefit from education about the role of individual professions and the skills and expertise each bring to health care. Too often, public members bring only their personal perspective to an issue or the profession's perspective because that is who "orients" them rather than being able to see a bigger picture in terms of public interest opportunities for collaboration.

Very clearly, one of the major barriers to interprofessional collaboration is an understanding of the value, expertise and skills each profession brings to health care. There is a role for both the professional associations

themselves and the Ministry in this regard. The professional associations need to help their members understand that it is in their interest to learn about the skills and expertise that other professions bring to health care and to collectively explore ways and means to capitalize on this expertise. It is fundamental to interprofessional collaboration that understanding the skills and expertise of other professions is a basic fundamental requirement of engaging in effective interprofessional care. Without such an understanding, there is a tendency to not trust or have confidence in the care provided by others. The Ministry can assist in this with incentives that encourage interprofessional collaboration.

The professional associations, not the regulatory colleges, represent the professionals. As such, the professional associations and educators have the best opportunity for changing attitudes within the profession and championing interprofessional collaboration and yet it appears that HPRAC considers the colleges to be both the regulatory body that governs the profession as well as the professionals who are members of the College. ODHA is of the opinion that this attitude presents a significant barrier to understanding the role that the professional associations play not only in interprofessional collaboration but in health care in general.

If the sole intent of this review is to identify any legislative or regulatory barriers to interprofessional collaboration at a college level then this is an admirable goal however it only addresses part of the issue and clearly does not recognize that the regulatory colleges have little or no impact at the clinical level in contrast to the profession – and therefore the professional associations.

DEFINING INTERPROFESSIONAL COLLABORATION

The contextual definition provided in the *discussion guide* for interprofessional collaboration appears to be focussed entirely on the regulatory colleges to the exclusion of the professional associations. Professional associations must be seen as a partner in any interprofessional collaboration endeavour or initiative.

The definition also suggests that competition is a bad thing and that collaboration and competition are mutually exclusive. ODHA disagrees. We believe that competition is healthy for the public in terms of choice of provider and the costs associated with care particularly in areas where the consumer is paying for care directly or through a private third party payor.

The definition also needs to recognize that a fundamental component of the RHPA was patient (or client) choice – that is that an informed client should be able to choose their provider of choice.

ELIMINATING THE BARRIERS TO COLLABORATION AMONG THE COLLEGES

Professional cultural issues have the potential to be barriers to collaboration. With “self-regulation,” the regulatory college structure by definition means that there is a preponderance of professionals on each Council and they are often firmly rooted in their own experiences and biases. As such, many decisions may arguably – on the surface – be in the public interest, but deeper down are related to turf protection and professional interest.

Some regulatory colleges have policies or regulations that are significant barriers to interprofessional collaboration. For example, some colleges prohibit delegation of authorized acts even when such a delegation would improve both efficiency and access to care and would therefore – with due consideration of safety – be in the public interest. Similarly, some colleges prohibit certain types of business associations under the guise of “conflict of interest” and the need for professional autonomy when these positions are clearly to protect turf or income generation.

LIABILITY ISSUES

ODHA has no specific evidence that liability issues are a barrier to interprofessional collaboration although they are often cited as a reason for avoiding such collaboration.

ODHA strongly believes that regulated health care practitioners should be required to hold minimum professional liability insurance coverage. This insurance should be held personally by the practitioner and not by the employer on behalf of the practitioner. The amount required should be reflective of the profession's scope of practice and risk exposure. Whether the coverage is “claims-made” or “occurrence-based” is immaterial as long as the coverage is complete and includes coverage in times of non-practice (e.g., medical or parental leave, retirement).

ODHA considers it a conflict of interest for a regulatory college to provide its members with professional liability insurance.

DEVELOPING ENABLERS FOR COLLABORATION AMONG THE COLLEGES

Changes in administrative functions of the regulatory colleges articulated in the *Health System Improvements Act* have not yet been implemented by the regulatory colleges. Many of these changes were aimed at streamlining processes and enabling more cooperation among the colleges, particularly in the area of investigations. Before we move on to propose more changes, it would be prudent to wait to see if the changes contemplated by the *Health System Improvements Act* have the desired effect.

Existing colleges cannot be expected to support new colleges as they are established. Regulatory colleges in Ontario are fully funded by the professionals working in the province and at a time when it is unclear what financial impact the mandated changes in the *Health System Improvements Act*, will have on the practitioner; it is clearly unfair and inappropriate to expect the existing professions to support those who have sought, and gained, self-regulation.

STRUCTURAL MECHANISMS

While there may be some merit to a common framework for interprofessional collaboration for complaints and investigations, however discipline activities, very clearly, must remain within the purview of the appropriate regulatory college – to do otherwise would erode the fundamental tenet of professional self-governance. Once again, the impact of the changes in *Health System Improvements Act*, have not yet been fully explored and as such changes in this area are premature.

ODHA is opposed to a “single complaints model”.

QUALITY ASSURANCE

While there may, in fact, be opportunities for collaborative quality assurance activities among the colleges, ODHA is of the opinion that these efforts cannot be mandated and that the individual colleges – and professions – are best positioned to identify when such collaboration is feasible and most likely to be supported by the relevant professions.

STANDARDS OF PRACTICE AND PROFESSIONAL PRACTICE GUIDELINES

ODHA is opposed to the creation of another “over-sight” body – no matter the purpose. It would simply become another layer of bureaucracy and the cost of such a body would likely have to be borne by the professions.

Any “facilitation” and “support” for collaboration among colleges could be undertaken by the Ministry’s Interprofessional Care Implementation Committee provided that all regulated health professions are included and the scope of the committee’s facilitation and support is very clearly defined.

ODHA believes that the Minister should reserve his powers to command the colleges to adopt specific initiatives to matters that address significant public safety issues. It would be very reasonable for the Ministry to identify areas of interest in terms of reporting on specific initiatives, but in such cases the Minister must also recognize that there may be a cost to provide such reporting and that cost must not be borne by the profession through its regulatory college.

ODHA supports the development of common guidelines on conflict of interest, advertising, record keeping, and consent.

Specific evidence-based clinical practice guidelines are very expensive to develop and very difficult to keep current as evidence can change rapidly and it may be difficult for a regulatory college to react in a timely manner. The profession should take the lead on whether clinical practice guidelines are needed and they should not be mandated by the regulatory college.

ODHA is vehemently opposed to the concept of joint colleges or collaborative Councils for professions with closely related activities. Having been regulated by another college and subsequently gaining self-regulation through the RHPA and more recently independence in practice through the *Health System Improvements Act*, such a concept – in our view – would be very regressive.

COLLEGE AUTONOMY, AUTHORITY, AND ACCOUNTABILITY

ODHA is of the opinion that standards of practice and practice guidelines are enforceable through the regulatory college’s professional misconduct regulations and expert testimony and that this is sufficient enforceability.

While there are concerns about the length of time it takes for the Ministry to exam and approve regulations, ODHA sees this process as an

important one of “sober second thought” that ensures that legislation and/or regulation is necessary, appropriate, transparent, and fair. The ODHA is opposed to the regulatory colleges having unilateral statutory rule-making authority and, as such, any rule-making authority needs Ministerial or legislative approval.

INTERPROFESSIONAL CARE AT THE CLINICAL LEVEL

It is unlikely that any degree of collaboration by the regulatory colleges will have a significant impact on interprofessional collaboration at a clinical level. Clinical level interprofessional collaboration will be driven by need, efficiencies, client choice and the willingness of practitioners and not because the government or the regulatory colleges mandate it.

IN CONCLUSION

ODHA has been actively involved in collaborative initiatives including:

- joint messaging with the dental and dental hygiene regulatory colleges and association;
- collaborative educational endeavours;
- public awareness activities;
- as well as a joint working group with the Ontario Dental Association that is specifically looking at access to oral health care in long-term care settings.

We anticipate that such collaboration will continue and expand to other professions as opportunities present themselves.

In summary, ODHA believes that interprofessional collaboration happens at a functional clinical level and that it is very unlikely that greater collaboration at the regulatory college level will have a significant impact upon interprofessional activities happening at a clinical level. For this reason, ODHA is of the opinion that efforts should focus on current practices that are effective and look to transferring that effectiveness into other clinical settings.

As the members of individual professions experience the success of interprofessional collaboration, their acceptance and support will move into an understanding and respect for the value each profession brings to health care in Ontario. This shift in values and thinking from the ground up will do more for the advancement of interprofessional collaboration than attempting to legislate such collaboration.