



Ontario Society of
Occupational Therapists

**Submission to the
Health Professions
Regulatory Advisory Council**

respecting

**Consultation Discussion Guide on Issues
Related to the Ministerial Referral
on
Interprofessional Collaboration among
Health Colleges and Professionals**

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55 Eglinton Ave. E., Suite 210, Toronto, Ontario M4P 1G8 ♦ www.osot.on.ca

Introduction

The Ontario Society of Occupational Therapists (OSOT) appreciates the opportunity to comment in response to the Health Professions Regulatory Advisory Committee's (HPRAC's) consultation document on Collaboration among Health Colleges and Professionals.

The Society, which represents the profession of occupational therapy and over 3000 members in the province of Ontario, concurs with the conclusions of the Ministry of Health and Long-Term Care's HealthForce Ontario Interprofessional Care Steering Committee in 2007 when it positioned that;

A collaborative, team-based approach to care can be an enabler for improving patient care and meeting the demands that the system is facing. This process, called interprofessional care, is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings. Interprofessional care can be systematically implemented to assist in health care system renewal and improved sustainability.

OSOT appreciates that HPRAC has selected this definition of interprofessional care. Interprofessional care is facilitated when interprofessional collaboration and mutual respect is present in the workplace and is philosophically supported by professions themselves as well as the systemic framework in which they work. In this regard, the notion that interprofessional collaboration is supported both philosophically and functionally by the health professions' regulatory system is important. However, interprofessional collaboration amongst health professions' regulatory colleges is only one contributor to the enablement of true interprofessional care.

OSOT would assert that a more comprehensive review of strategies to promote interprofessional care must engage the professions themselves, including the professional associations. Regulatory colleges and associations alike can lead by example through interprofessional collaborations to address health policy development, health care services delivery models, etc. Further, both associations and regulators can address barriers to interprofessional collaboration and seek solutions that minimize or remove barriers. It is our position that interprofessional collaboration and interprofessional respect is not something that can be effected through regulation in the absence of other strategies that promote collaboration from within the professions.

We note that the Minister's referral specifies attention to the development of recommendations for *mechanisms to facilitate and support collaboration among **health colleges**...beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession.*

To some extent, we would position that HPRAC has extended their consultation beyond the scope of the Minister's referral. We note that most questions request feedback on issues/points as they relate to collaboration *among the Colleges*. In many of the questions, however, it would appear that when HPRAC refers to "the Colleges" it means the professions and the practice of individual registrants of each college. We raise this point to underline the challenge of addressing the collaboration of the profession or individual registrants by addressing only the opportunities of the regulatory system's redesign – there are just too many additional factors that affect potentials to truly exercise interprofessional care.

As the Society has approached its response to the consultation questions, we have worked in support of the underlying principles that HPRAC has identified

for strengthening collaboration between and among colleges which include;

- the responsibility to meet the public's expectations for improved access to high quality, safe services and patient centred care
- Optimizing the contribution of all health care professionals
- Maintaining self regulation

We note however, that the consultation document makes consistent references to "high quality" or "highest standards of professional practice" and although as a representative of the profession of occupational therapy we would support and aspire to such high standards, we are thoughtful that the regulatory system realistically regulates to a minimum standard, ensuring public safety. This may be an important concept to highlight in the context of a consultation focused on the potential for change. It is critical that regulatory standards clearly assure patient safety but that they are not so exclusive that entry level practitioners or those working in health system environments that cannot support "highest standards" or excellence are not penalized for providing simply safe and competent care.

Question 1 – support for scope of discussion and consult focus

OSOT supports the consultation elements as articulated in the discussion guide. That said, we recognize that there are limits to the solutions/strategies that can be identified in response to a question because solutions require not only attention to the regulatory framework and strategies that are reasonable for Colleges to undertake but also to the many stakeholders that are engaged in the process of facilitating or enabling interprofessional care who are not regulators – eg. Associations, educators, policy makers, health sector employers, etc.

Question 2 – are there barriers in the RHPA, health profession acts or their regulations that prohibit collaboration among the colleges?

The *RHPA* was intended to “level the playing field” by treating all professions in the same way within the same regulatory framework. This notwithstanding, the reality is that some professions have entrenched positions of power or prestige that persist in today’s health care system, in the public’s mind and in day to day clinical practice. Although the legislation was intended to level the playing field the *RHPA* cannot be seen to be entirely successful in this regard. This disparity of both power and profile plays a role as a barrier to effective interprofessional collaboration.

Use of the title doctor is an example of an issue that in theory should have little to do with enabling interprofessional care. However, when some professions and not others are able to use the title doctor (when earned through educational preparation in their field) it tends to perpetuate notions and resentment of persisting hierarchical layers

Educational preparation, evidence, growing and evolving bodies of knowledge, changing practice environments, etc. contribute to significant evolution of all health professions. Scopes of practice within the *RHPA* have not been updated since 1991. There is likely a need for a wholistic review of scopes, delegation of controlled acts, etc.

Occupational therapists are likely amongst others that would welcome a review of scope and authorized acts. Practice system changes and magnifying demand for health services that could be provided by OTs, increasing autonomy of practice and evolution of competencies of occupational therapists are all factors that draw attention to the need to review scope of practice, access to controlled acts and potentials to extend scope in advanced practice models to enable occupational therapists to

contribute vibrantly to interprofessional care to the full extent of their scope and competency.

Question 3 - Are there barriers in other acts that restrict or prevent interprofessional collaboration among the colleges?

OSOT would highlight the following potential barriers to interprofessional collaborations

- *Public Hospitals Act* – limits those professions that have admission and discharge privileges at public hospitals and who may serve in supervisory or management positions in hospitals

- College regulations that prohibit incorporation of multi-disciplinary health care corporations

- MOHLTC funding structures – for example fee for service billing under *OHIP* may be a disincentive for physician delegation or sharing responsibility for health care services with other professions.

- To date provisions under the *LTC Homes Act* which promote interdisciplinary services do not provide requirement for funding for all services to be present within the home. Access to interdisciplinary services may be variably enabled through CCACs.

Question 4 - Are there other policy and/or system issues that act as barriers to collaboration among the Colleges?

OSOT observes a variety of health system issues that limit the potentials for full collaboration of professionals at the clinical level. These include;

- Funding issues – collaboration at the front line is only possible when professionals are funded to work in manners that support

interprofessional collaboration or care. The absence of equitable access to health professions limits the utilization of skills and competencies not shared routinely amongst professions. For example, occupational therapists have positioned that funding of limited OT services in LTC Homes could not only facilitate specialized OT service delivery to residents but also more effectively support nursing staff to effect their roles. The capacity to share roles to extend the reach of a rehab/OT skillset through other professions, etc. is minimized when no OT is available to even provide consultation in this regard. Provincial policy currently supports interdisciplinary primary health care provided through Family Health Teams, yet Ministry policy has consistently withheld funding for rehabilitation professionals on these teams. The capacity for other professionals to assist physicians to manage components of practice management, which tax their time and restrict their accessibility to other patients, (e.g. physiotherapy or occupational therapy) is a lost opportunity in this situation.

- Funding/resource support to truly support interprofessional education strategies – interprofessional collaboration is thought best to evolve from well seeded principles and values of interprofessional understanding and respect at the entry to practice level. There are costs to engage effective interprofessional education. Until educational institutions are truly vested in supporting and delivering creative options for health professions to learn together, the early nurturing of principles of interprofessional collaboration is challenging at best.
- Human resource issues create pressures and priorities that single out professions, sometimes at exclusion of others. For example, focus on nursing and medical professions in the past decade has eroded visibility of and public awareness and knowledge of the important contributions of other professions. To some extent the very public focus on these human resource shortages has underlined to the public

that these professions are critical to their health care and may contribute to the public's discomfort in some interprofessional strategies. (e.g. want to see a doctor rather than any other professional).

Lack of professional human resources in some professions can be an inhibitor to interprofessional collaboration e.g. access to therapy services in rural areas. Effective collaboration of the colleges, associations and health system would help identify whether an effective strategy to support interprofessional collaboration would be establishment of targeted HR strategies (for example, more educational seats for professions like OT).

- Systemic pressures for early discharge, limits on length of stay in a service, etc. have impacts on timing available to develop/utilize collaborative approaches.

Question Five - Are there professional cultural issues that act as barriers to collaboration among the Colleges?

OSOT identifies the following professional "culture" issues which we believe promote barriers to collaboration;

- The Society observes the persistence of historical hierarchies of professions which is a pervasive deterrent to the level playing field on which true team collaboration can be built. Even today, much of our health system is entrenched in the medical model which may be not be an underpinning principle of all professions.
- Unionized perspectives versus non-union perspectives as they may relate to the protection of jobs may limit potentials for shared roles,

collaboration, etc.

- Institutional and community based sectors have functioned in silos (both funding and practice) for years and this creates significant disincentives for collaborations across the continuum of care. OSOT applauds the expanding evolution of more effective systemic integration which is needed to enable collaboration amongst health care professionals across the continuum of care
- Specialist versus generalist mentalities affects both intra and inter professional collaboration and efficiency of system.

Question Six - Is there evidence that liability issues are a barrier to interprofessional care?

OSOT would propose that indeed liability issues persist as barriers to interprofessional collaboration at the clinical frontline. This said, however, we query whether the barriers are a result of real issues and risks related to liability or perceptions that are based on inadequate information and understanding. For example, occupational therapists have heard that physicians are uncomfortable to explore potentials to engage OTs in Family Health Teams because of the increased liability that would fall to the physician related to an OT's practice. To this end, we query whether such physicians are aware that occupational therapists carry their own professional liability insurance.

Question Seven - Should all health professionals be required to hold liability insurance – how much?

Occupational therapists are not required to carry professional liability insurance except for a *Sexual Abuse Therapy and Counselling Fund endorsement*. This notwithstanding, the reality is that no insurer will provide

this unique endorsement without attaching it to a professional liability insurance program. The result is that all registered OTs in Ontario secure PLI with a limit of \$5,000,000. liability protection. OSOT is not in a position to comment on other professions, however, in principle, it would appear that this could be an effective strategy to remove the barrier of concern that in collaborative practice approaches any one profession is more at risk than another or assumes the risk of harm that may result from another professional's practice.

Question Nine - What changes to the *RHPA*, health profession acts or their regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges.

In light of the amendments to the *RHPA* included in Bill 171, OSOT queries whether this question is premature. It would appear that the amendments provide for additional capacity for Colleges to collaborate on a variety of issues including communications, complaints processes, etc. There may be specific opportunities to review components such as;

- Modifying professional regulations and standards to reference collaboration with other health care professionals
- Consideration of need for standards for interprofessional collaboration, although OSOT would assert that the notion of regulating "collaboration" is counterintuitive to the principles of interprofessional collaboration which are based on mutual understanding and respect for the roles and contributions each profession brings to the client service experience.
- potential for specific common standards in some areas – e.g. Record keeping, consent, business management (advertising, etc.)
- review of provisions for delegation of responsibility for controlled acts to ensure that processes are sufficiently grounded in patient safety but

not so onerous to the delegating professional (e.g. physician) that it is a disincentive.

Question Twelve - Are there administrative responsibilities within Colleges that could be shared with related Colleges? What barriers exist?

OSOT would assert that there may be considerable value in exploring what can and can't be shared administratively amongst colleges, particularly smaller colleges. Economic efficiencies seem only reasonable to strive for in fairness to the professionals regulated by each college. OSOT speaks from it's own experience in this regard, having shared space and some administrative functions in a collegial manner with another health professional association. Although the cost efficiencies were the primary driver in our initial relationship, the inherent opportunities to share reasonable opportunities for collaboration are abundant and have served both associations and professions well. It should be noted that sharing of administrative responsibilities need not detract from the autonomy of each college and OSOT would argue, in fact, for the maintenance of the unique autonomy of each profession to maintain independent functions related development of regulations, standards, etc. This, we believe, is in keeping with the HPRAC's principle of maintaining a stalwart commitment to the foundations and principles of self regulation.

Question Thirteen - Should there be a common framework for all professions to address complaints?

It would seem reasonable from outside the regulatory context to see common approaches to managing complaints and investigations amongst colleges and potentially even a common structure to which complaints are addressed and then referred to the appropriate College when initial processing is complete. That said, it is our understanding that HPRAC has

previously reviewed this issue and found no evidence that this is a more effective complaints management process. Review of complaint data across professions may give clarity to the number of complaints that are made to address teams of professionals or that result from problems that are tied to the system as much or more so than professional errors or omissions. Review of data in this regard may illuminate whether there is natural justification of shared processes to facilitate the experience of the consumer as well as the efficiency of the college complaint investigation processes beyond that which is already enabled. OSOT is not comfortable to advocate for shared disciplinary processes. The Health Professions Appeal and Review Board would be a valued stakeholder in assessing the value of shared frameworks to streamline and fairly address complaints processes.

Question 23 - Would a joint quality assurance program among relevant colleges enable colleges to develop common standards of practice or professional practice guidelines where the same or similar controlled acts are shared?

OSOT queries whether the best strategies may be to promote common or similar QA processes rather than joint QA programs? We understand that there is considerable variability amongst professions in approach to QA. It could be argued that increased consistency of approach might start to diminish some of the perceived "differences" amongst professions. However, it would seem reasonable to build in components of interprofessional education in quality assurance program components. For example, the College of Occupational Therapists of Ontario might develop a PREP module that underlines collaboration that is consistent across those professions that utilize a similar approach to their QA Program.

Question 25 - Should a separate arms length organization facilitate and support collaboration among the Colleges?

OSOT questions whether a separate body to provide oversight to collaboration is necessary and proposes that dedicated project funding to support colleges to collaborate on the development of joint standards, quality assurance materials, etc. might be a more effective use of dedicated funding. In this vein one queries who pays for such an additional organization? The Society would position that this could well fit within the responsibility of the Minister of Health and Long-Term Care, particularly when interprofessional care appears to be a strategic priority of the Ministry. Could this be a function of the Health Professions Regulatory Policy Branch of the MOHLTC? This branch already has relationships with each college, understanding of core similarities and critical differences in approaches and could be an effective facilitator of interprofessional collaboration amongst colleges as well as be in a position to hold parties accountable.

Question Twenty-nine - Should the Minister direct the Colleges to engage in specific collaborative initiatives (eg. Develop instruments to support collaborative care). Should there be financial incentives to undertake such activities/

OSOT is unclear as to what exactly is meant by instruments to support collaborative care? It is perceived that this is well within the Minister's authority to direct colleges to engage in collaborative approaches or initiatives. Alternatively the Ministry could "lead" in collaboration with regulatory bodies to affect and influence care on the front lines.

Question Thirty-Two - Should minimum guidelines, standards and policies concerning matters such as conflict of interest, advertising, record keeping and consent be consistent across all Colleges? Which ones?

The Society would support the development of a fair and consistent approach to common issues such as conflict of interest, advertising, record-keeping.

We view this as an opportunity to encourage inter-professional understanding and to break down barriers in common areas. We know that in some practice environments inconsistent professional standards and expectations related to common matters, such as accessing consent, create friction and frustration amongst team members. OSOT is conservative in our assessment of the number of issues that can reasonably be addressed by common standards. Professions must be able to maintain their independent capacity to develop their own clinical practice standards, ensuring that all registrants can participate in the process of such standard development thereby living the responsibilities and opportunity of self regulation.

Question Thirty-Six - Should guidelines and standards of practice that colleges develop be legally enforceable?

OSOT questions the real need for change. Regulations are enforceable but Colleges argue the process to establish or change regulations takes too long. It would appear that the first place to start is to fix the regulation making process. Standards of practice enable the profession to set guidance for itself that can reflect more current practice and be more readily changed to adapt to changing practice.

Question Forty - How will greater collaboration among the colleges serve to enhance interprofessional care at the clinical level

The Society has already articulated a healthy cynicism that regulation cannot force collaboration. However, collaboration at the level of the regulatory colleges has the potential to lend foundational and principled guidance to all professions and professionals. Leading by example is a healthy and effective leadership style for change. Common standards of practice can promote a uniform and universally understood approach to issues that are truly of an interprofessional relevance and underline the principle that all professions are treated in the same manner under the *RHPA*. Notwithstanding that we feel

strongly about the inadequacies of trying “regulate” collaboration, we recognize and applaud initiatives that would serve to create the structures and context in which facilitation of interprofessional collaboration can truly be engaged.

Summary of General Comments

- Support initiatives that minimize barriers to interprofessional care, support and enable interprofessional care at the clinical level. View opportunity to create a regulatory framework that enables and facilitates interprofessional collaboration and care.
- Barriers to interprofessional collaboration exist outside of the regulatory framework and cannot be addressed by the Colleges alone. Attention to interprofessional collaboration with a focus on the colleges alone cannot be successful.....can't regulate collaboration.
- Need to engage colleges, professional associations, professionals and Ministry of Health and Long-Term Care in systemic reform and attitudinal reframing
- Need clarification and simplification of processes for delegation and medical directives as these are restrictive and can inhibit collaboration.
- There is an opportunity to explore potentials to enhance capacity of professions to support interprofessional practice in review of scopes of practice, delegation of controlled acts and extension of advanced practice models
- Support evolution of common approach to common practice components and development of common standards of practice for common practices but professions need to develop own standards of clinical practice.
- Shared quality assurance practices can support interprofessional collaboration at the clinical frontline.

The Ontario Society of Occupational Therapists is pleased to provide further clarity to its positions if required. Please contact Christie Brenchley, Executive Director at [REDACTED].