



## **Interprofessional Collaboration amongst Health Colleges and Professionals**

**Respectfully submitted to:**

**The Health Professionals Regulatory Advisory Council**

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April 28, 2008

**Interprofessional Collaboration  
is built upon  
the bedrock of  
mutual trust and respect.**

**It can be enabled; it cannot  
be legislated.**

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## INDEX

<b>1.0</b>	<b>Introduction</b> .....	<b>3</b>
<b>2.0</b>	<b>Defining Interprofessional Collaboration</b> .....	<b>3</b>
<b>3.0</b>	<b>Eliminating the Barriers to Collaboration among the Colleges</b> .....	<b>5</b>
	<b>3.1 Funding, Policy, System and Cultural Issues</b> .....	<b>5</b>
<b>4.0</b>	<b>Developing Enablers for Collaboration amongst the Colleges</b> .....	<b>8</b>
	<b>4.1 Encouragement</b> .....	<b>9</b>
	<b>4.2 Enablers – Focus on successful elements of collaboration vs. on legislation</b> .....	<b>10</b>
	<b>4.3 Enablers – Synergy vs. Autonomy</b> .....	<b>10</b>
<b>5.0</b>	<b>Structural Mechanisms</b> .....	<b>11</b>
	<b>5.1 Complaints, Investigation and Discipline</b> .....	<b>11</b>
	<b>5.2 Shared Quality Assurance Programs</b> .....	<b>11</b>
	<b>5.3 Joint Practice Standards</b> .....	<b>11</b>
	<b>5.4 Arm’s Length Oversight Body</b> .....	<b>12</b>
	<b>5.5 Practice Guidelines</b> .....	<b>12</b>
	<b>5.6 Ministerial Powers</b> .....	<b>12</b>
	<b>5.7 Toolkits and Templates</b> .....	<b>12</b>
<b>6.0</b>	<b>College Autonomy, Authority and Accountability</b> .....	<b>13</b>
<b>7.0</b>	<b>Interprofessional Care at the Clinical Level</b> .....	<b>13</b>
<b>8.0</b>	<b>Conclusion</b> .....	<b>14</b>

## 1.0 Introduction

The Ontario College of Family Physicians (OCFP) welcomes the opportunity to participate in the Health Professions Regulatory Advisory Council's (HPRAC) "Consultation Discussion on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Regulatory Colleges and Professionals" (Feb 08). We thank HPRAC for providing the Discussion Guide and for developing a comprehensive feedback process.

In response to HPRAC's request, the OCFP reviewed the questions individually and provided a response that is based on our research and experience. Rather than addressing each question individually, these responses are grouped into general themes, as provided in the Guide.

The OCFP supports the concept and practice of interprofessional collaboration (IPC) and has led and/or been involved in extensive research on the topic. At the outset, the OCFP would like to highlight that the contribution the regulatory colleges could make to IPC would be limited due to the fact that there are many other enablers. The other enablers include compensation and funding, interprofessional education, organizational supports, patient/caregiver involvement, health human resource planning, integration of traditional providers, education of western providers and more evidence of collaborative outcomes. All of these enablers are required to move IPC forward.<sup>1</sup> Moreover, it is important to place a significant emphasis on these other powerful enablers because the essence of IPC success is so deeply rooted in developing trust and respect among colleagues in day to day practice.<sup>2</sup> Many of these enablers will create the environment for health professionals to work in close proximity, thereby developing a clearer understanding of their roles and functions which then leads to familiarity, respect and mutual trust. The long history of "silos" of professional practice that often acts as a barrier<sup>3</sup> will require a comprehensive plan such as the one outlined in the MOHLTC's *Interprofessional Care Blueprint for Action* to successfully guide IPC implementation.<sup>4</sup>

## 2.0 Defining Interprofessional Collaboration

In general, the OCFP agrees with elements of the statement describing the goals for IPC initiatives amongst the Regulatory Colleges. In the context of primary care reform, the OCFP's recommendations to government over the years emphasized the importance of IPC: OCFP recommended collaborative, interdisciplinary team supports for all comprehensive family doctors and their patients as one of the first

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<sup>1</sup> Primary Health Care Transition Fund, *Collaborative Care*, March 2007. [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf).

<sup>2</sup> The Ontario College of Family Physicians (OCFP). *Implementation Strategies: "Collaboration in Primary Care – Family doctors & Nurse Practitioners Delivering Shared Care"*, 2000.

<sup>3</sup> D'Amour, Sicotte, & Levy, in Primary Health Care Transition Fund, *Collaborative Care*, March 2007. [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)

<sup>4</sup> Interprofessional Care: A Blueprint for Action. July 2007. Submitted by the Interprofessional Care Steering Committee. [www.healthforceontario.ca/IPCProject](http://www.healthforceontario.ca/IPCProject)

steps in stabilizing family medicine in the province.<sup>5</sup> Our recommendations are anchored in our research and belief that teamwork amongst physicians, nurses and other healthcare professionals would assist in the delivery of comprehensive care for patients, contribute to quality care and reduce the burdens facing family physicians. We are concerned that the focus on scopes of practice is and will remain divisive. Supporting front-line healthcare professionals to work together in the best interest of patients should be the focus (i.e. the essence of interprofessional collaboration).

However, we offer the following guidance with respect to the statement that HPRAC is proposing:

- *There are seven essential elements for successful implementation of collaborative practice including responsibility and accountability, coordination, communication, cooperation, assertiveness, autonomy and mutual trust and respect.*<sup>6</sup> Underlying these seven essential elements is the critical task of *clear delineation of roles and functions* of the interprofessional members within teams.<sup>7</sup> As professionals develop a clearer understanding of their roles and functions, mutual respect and confidence will be cultivated. Then, in keeping with the goal of fully utilizing provider resources in the most effective and efficient manner possible, the group members would make decisions resulting in a clear understanding about who will do what.<sup>8</sup> These elements and the importance of role clarification should be reflected in the statement as areas that the Colleges should acknowledge and develop, as part of its education/continuing professional development mandate, in order to achieve the goals as outline in the statement.<sup>9</sup>
- While the OCFP supports the concepts that all regulated health professionals work to their maximum competence and capability, that they optimize their skills to ensure access to high quality care and that health professionals be regulated in a manner that maximizes collective resources, *we believe that clarification is required to ensure that these elements of HPRAC's statement does not have the creation of "physician substitution" models as an underlying theme or goal.* The focus must be on collaboration, rather than competition with, or replacement of, family physicians. While the various regulated health professionals have specialized/narrower scopes of practice, it must be acknowledged that family physicians have the broadest scope of practice, which often places them in a clinical leadership role. However, this does not imply a direct supervisory role over all of the clinical services provided by a team. The ultimate focus should be on interprofessional teams, actively working together in the joint care of the patient producing synergistic results, with team functioning that is anchored in the principles of collaboration, cooperation, open communication and mutual respect

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<sup>5</sup> The Ontario College of Family Physicians. Summary of the Proceedings of Family Medicine Forum VI . September 24, 2005.

<sup>6</sup> The Ontario College of Family Physicians (OCFP). *Implementation Strategies: "Collaboration in Primary Care – Family doctors & Nurse Practitioners Delivering Shared Care"*, 2000.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> The word 'autonomy' should not be misunderstood and requires explanation. Autonomy is addressed under the Enablers section of this submission but the main point is that the erosion of autonomy of the Colleges or professionals should not be the goal; the goal should be developing synergistic outcomes among Colleges and professionals working together to develop innovative approaches to IPC

and trust. Working in an interprofessional model of care should be the goal. Supporting various disciplines to work towards their full scope of practice or towards an increased scope of practice is a minor secondary goal. Safety and quality of patient care should always be our first consideration. That goal is best met in a model of interdependent care that builds in family practices in particular, on the knowledge and skills of the family doctor and the trusting relationship established between the doctor and his or her patients. Interdependence, rather than independence should be the guiding framework for IPC both at the level of the Colleges and practice level.

- While the regulatory bodies may have roles to play in supporting interprofessional, collaborative care, the important roles that educational organizations such as the Ontario College of Family Physicians, our universities and professional associations such as the Ontario Medical Association play in educating and representing their members needs to be recognized and they need to be included in any discussions that ensue. The efforts that are made in the educational arena and the professional associations can facilitate collaborative care or provide effective barriers. Professional associations in particular can provide important resources in terms of modifying collaborative care amongst their members. For example, the *Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative* undertook extensive consultations with professional associations' memberships. One topic area, *Increasing Support for Family Physicians in Primary Care* focused on the needs of family physicians for managing the changes brought about by PHC reform. The initiative led to the creation of a web-based Primary Care Toolkit for Family Physicians and established a Change Management Leadership Group of family physicians from across Canada. These initiatives were important in initiating and fostering change within the professional system to promote collaborative PHC.<sup>10</sup>
- The OCFP believes that many of the issues around college objectives, complaint processes, investigations and joint Quality Improvement programs have been addressed with the enactment of Bill 171 and therefore, we suggest that a legislative and regulatory framework supportive of college level collaboration is in place and that greater emphasis is now required on the other system enablers, as identified in the introductory paragraph and throughout this submission.

### **3.0 Eliminating the Barriers to Collaboration among the Colleges**

#### **3.1 Funding, Policy, System and Cultural Issues**

- 3.1.1 The Guide asks questions about the obstacles in legislation that could restrict or prevent collaboration among colleges. While the OCFP is unaware of barriers that prevents collaboration amongst the Colleges, there are barriers in legislation that interfere with collaboration. Barriers are in place that inhibit collaboration between midwives and family

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<sup>10</sup> Primary Health Care Transition Fund, *Collaborative Care*, March 2007. [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)

physicians. In addition, the Health Insurance Act (HIA) (and the fee-for-service model of payment encoded therein) is not a barrier per se; however, the current fee structure provides little incentives for physicians to collaborate with other healthcare professionals. While enhancement to the systems to support team participation and indirect services are entirely feasible, the bulk of funding in the primary care systems for interprofessional team based care has been directed towards physicians in salaries or capitation funding models. The majority of family physicians and their patients are not provided with the levels of supports seen in Family Health Teams, Family Health Organizations or Community Health Centres. Despite the fact that these physicians are struggling to provide comprehensive care, their patients do not have access to the benefits of interprofessional team-based health care. To emphasize our concerns, the OCFP has repeatedly identified the fact that the healthcare system was established on the basis of the value of “equity” (i.e. the most care for those most in need). Basing access to care on physician payment models and thereby creating inequitable access to care has been referred to as “two tiered” medicine.<sup>11</sup> The Regulatory Colleges, associations and educators have a great opportunity to advocate on behalf of access to the benefits of interprofessional care for all citizens of Ontario. If the goal is effective healthcare and IPC is a tool towards that goal, as we argue is the case, then policy and funding changes are required to reduce the inequitable access to funding support, which in the end, creates inequitable access for patients: patients are being penalized based on their physician’s choice of physician payment models, although no evidence exists showing the superiority of one funding model over another in terms of improving quality of care, achieving better patient outcomes or achieving successful IPC.<sup>12</sup> Importantly, a complicated funding/governance model is not required to support IPC; it may be as straightforward as establishing new IPC fee codes. Moreover, funding models that reflect the equality of partners is fundamental to increasing health professional’s acceptance of IPC.

3.1.2 The Guide asks about other funding, policy, system or professional cultural issues that act as barriers to collaboration among the Colleges. In response, we would like to highlight the following four areas where progress towards developing an interprofessional collaborative environment could be made:

- The research conducted by OCFP highlights that *coaching and mentoring in decision-making and conflict resolution is more important than complex governance structures, in terms developing IPC capacity among team members.*<sup>13</sup> With this in mind, our academic Colleges and universities provide a ready environment for interprofessional

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<sup>11</sup> The Ontario College of Family Physicians. Resource Allocation: Creating “Two Tiered Medicine” in Ontario. May 11, 2005.

<sup>12</sup> The Ontario College of Family Physicians. Family Physicians and Public Policy: The Light at the End of the Tunnel, October 2005

<sup>13</sup> RNAO/OCFP Supporting Interprofessional Collaboration RN/FPs Mentoring Project

education (IPE) but the lack of resources in the Academic Departments of Family Medicine results in a lost opportunity. Our Academic Departments of Family Medicine have a very small cadre of leaders capable of taking on the many challenges associated with: 1) the expansion in medical schools including more medical students, increased in the family medicine residency programs and distributive learning sites; 2) the requirements to provide teaching opportunities for nurses, nurse practitioners, social workers, dietitians and pharmacists' to develop skills in primary care; 4) training of specialist residents in shared-care; and, 5) ensuring credible outcomes.<sup>14</sup> These leaders are overworked and overextended and so the opportunities to engage in interprofessional coaching, mentoring, decision-making and conflict resolution may be lost. Indeed, the research shows that interprofessional education (IPE) and training are pivotal to fostering conditions and skills required for sustained collaboration in PHC<sup>15</sup>. Funding to support more academic leaders is required together with more curriculum planning and preceptor resources and additional practicums for all aspiring primary care professionals (doctors, nurses, nurse practitioners, pharmacists, dietitians, social workers, etc.) to develop skills in delivering primary care in a collaborative interdisciplinary team environment.<sup>16</sup> *Since entry-to-practice qualifications and continuing professional development are matters of concern to the Colleges in terms of optimizing/enhancing skills and competencies of health professionals, it's our position that IPE be a core policy/program area for collaboration among the Colleges.*

- *Additional investments in team building and skill development at the practice level are required.* Recognizing that establishing a group practice or practice network of physicians is hard work and that integrating other disciplines into the practice is even harder, investments are therefore needed to provide leadership and team building skills and this can best be accomplished through a focus on improving the quality of care delivered by the team, since this is a common goal for health professionals.<sup>17</sup> *Again, this should be a core policy/program area that the Colleges address collaboratively, given their continuing professional development mandate and concern for improved skills and competencies of members.* Established programs with evidence of success (e.g. The OCFP/McMaster's Quality in Family Medicine) should be funded on a permanent basis to meet the dual needs of need for continuous quality improvements in family practices, but is also a tool for team development. Colleges and professional associations can play a leadership role in this regard.

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<sup>14</sup> Summary of the Proceedings from Family Physician Check-Up: A Forum Examining Why the Shortage and How to Solve it.

<sup>15</sup> Vanclay, L. (1996). *Sustaining collaboration between general practitioners and social workers*. London: Centre for the Advancement of Interprofessional Education.

<sup>16</sup> RNAO/OCFP Supporting Interprofessional Collaboration RN/FPs Mentoring Project

<sup>17</sup> Family Physicians and Public Policy: the Light at the end of the Tunnel

- *When proposing to alter scope of practice, Colleges should be required to engage in consultations with other colleges of professions whose scope of practice is impacted upon by the proposed changes. We would like to highlight the College of Nurses of Ontario's recent submission to alter the scope of practice of Registered Nurses – Extended Class (RN-EC) without due consultations, and the OCFP's response to this submission, as a case in point.*<sup>18</sup>
- The Guide requests feedback on whether the lack of a legislative requirement for professional liability insurance coverage for all regulated health professionals is an impediment to collaborative team building. The OCFP's position is that *liability issues are an impediment and need to be addressed because this limits physician's interest in exploring shared care relationships and limits the potential leadership roles that other professionals can assume.* The OCFP's position supports the recommendation in the Interprofessional Care Blueprint for Action that a key concern among physicians is the issue of who would ultimately be responsible and held accountable if an adverse event were to occur as the result of interprofessional care. Physicians will not enter into situations that leave them exposed to medical-legal risk. For this reason, mandatory adequate liability insurance should be introduced for all caregivers participating in interprofessional care and needs to be addressed from the perspective of providing clarification on roles and responsibilities with respect to legal liability. While adequate insurance coverage will address some of the issues, the process for delegating authority from physicians to other healthcare professionals need to be reviewed as well. The complexity of the current system under the auspices of CPSO is a further deterrent to interprofessional care.

#### **4.0 Developing Enablers for Collaboration among the Colleges**

- While HPRAC may find a recommendation to embed collaboration in the legislative and regulatory framework for registered health care professionals which is a reasonable recommendation, the OCFP recognizes that collaboration is built on the development of trust amongst providers rather than legislation. We are moving from a situation in which providers were dependent upon one another (e.g. the physician writes orders that are carried out by others) to one of interdependence. Far too often, providers move from dependence to independence. Creating opportunities for working together is the main strategy for interdependent practices to flourish.
- While it would be admirable for established regulatory Colleges to support new Colleges, mandating such support seems counter intuitive to the spirit of co-operation and collaboration.

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<sup>18</sup> (Submission from the Ontario college of Family Physicians to the Health Professions Regulatory Advisory Council In Respect to The Scope of Practice for Registered Nurses in the Extended Class, January 2008).

- We believe that each College needs to oversee its own administrative responsibilities. The term “related” Colleges would be hard to define and seems to defeat the concept of “self-regulation”.

#### 4.1 Encouragement

HPRAC notes that the Health System Improvements Act, 2007 establishes a clear mandate for the Colleges to engage in greater collaboration with one another. The Guide speaks to some ways that Colleges are promoting interprofessional collaboration and it is the OCFP’s perspective that these be expanded upon, with a yearly reporting requirement so the Colleges demonstrate efforts in these or other areas. Encouragement can take many forms, such as in the following areas:

##### At the Practice Level:

- Identifying of collaboration as a core competency amongst its members.
- Providing supports for the implementation of interprofessional teams in clinical settings and as the basis for education of its members.
- Supporting interprofessional quality improvement programs such as the OCFP/McMaster Quality in Family Medicine program.
- Developing delegation and medical directors’ guidelines; and sharing current directives amongst practitioners.
- Advocating for simple, flexible models of interprofessional teams that reduce administrative and liability concerns such as the Shared Care Collaborative model developed as pilot amongst Family Health Groups; the Hamilton HSO model which utilizes a central agency to support the integration of social workers, mental health workers and dieticians into family practices; the Shared Care model that supports collaboration between family physicians and other specialists and, the Canadian Home Care Association’s National Home Care and Primary Health Care Partnership Initiative (2006) which is a CCAC enhanced case management model in Ontario and in Alberta.<sup>19</sup> Research shows that by emphasizing flexibility in model design and implementation, practice groups will be able to adapt the structure and function of successful collaborative practice in a manner that preserves the characteristics of the partners’ preferred practice styles and respects the needs of the patient population and any geographical variations or limitations.<sup>20</sup> Structures that are supportive of new ways of working together, provide administrative support, time and space for interaction, supportive leadership and culture, change management, information and communication technologies.<sup>21</sup>

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<sup>19</sup> The CHCA Primary Healthcare Partnership Project

<sup>20</sup> Summary of Proceedings of Family Medicine Forum V – Special Communities, Special Populations, - Addressing the Gap.

<sup>21</sup> PHCTF, Collaborative Care, March 2007.

### At the Educational Level:

- Supporting a renewed focus on interprofessional education and training at universities and colleges, including curriculum design and collaborative research on interprofessional education policy;
- Organization of interprofessional collaboration conferences and think tanks; and journal articles.

### At the College Level:

- Requiring yearly reports of demonstrations of efforts to collaborate.
- Supporting cross appointments and representatives from other Colleges on professional committees.

## 4.2 Enablers - Focus on successful elements of collaboration vs. on legislation

It was noted in the Guide that a key barrier to interprofessional collaboration is lack of a common understanding of terms such as collaborative care, together with a general lack of awareness understanding and trust among professionals and the Regulatory Colleges with respect to each other's roles, scopes of practice and competencies. These barriers are not ones that will be solved by changes to legislation or regulation; they require the seven essential elements identified earlier in this submission (responsibility and accountability, coordination, communication, cooperation, assertiveness, autonomy and mutual trust and respect), together with role clarification and delineation, all of which develop at the education, teaching and clinical practice levels, through respectful interaction.

## 4.3 Enablers - Synergy vs. Autonomy

The erosion of autonomy of each of the Colleges should not be the goal, nor should the focus be on merging the powers and procedures of the various Colleges. The goal should be developing synergistic outcomes with all Colleges working together to develop innovative approaches to IPC. The same concept applies in practice, where the goal is not erosion of the autonomy of professions but a synergistic combination of their efforts.<sup>22</sup> Our research with nurse practitioners and family physicians working together in collaborative practice provide the following definition: "Collaborative Practice is an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided."<sup>23</sup> A similar definition could apply to the College level.

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<sup>22</sup> The Ontario College of Family Physicians (OCFP). *Implementation Strategies: "Collaboration in Primary Care – Family doctors & Nurse Practitioners Delivering Shared Care"*, 2000.

<sup>23</sup> The Ontario College of Family Physicians (OCFP). *Implementation Strategies: "Collaboration in Primary Care – Family doctors & Nurse Practitioners Delivering Shared Care"*, 2000.

## 5.0 Structural Mechanisms

### 5.1 Complaints, Investigation and Discipline

The Guide notes that evidence from the Patient Safety movement indicates that when services are provided in a multidisciplinary environment, medical errors are often not the fault of one individual but the result of several systemic failings. The OCFP believes that exploring a common framework for addressing complaints and investigations related to team-based services provided by health professionals is a viable approach. However, we are not supportive of a conjoint process or body for dealing with complaints and investigations between Regulatory Colleges. A common framework would represent a good step forward towards information sharing among regulatory bodies, building familiarity about each other's professions and further building relationships, before taking any further steps in terms of new regulatory processes.

The OCFP does not believe that a conjoint process is appropriate for addressing disciplinary matters. We have concerns that multi-disciplinary hearings would not only increase interprofessional turbulence and interfere with collegial multidisciplinary care, but the focus on patient safety may be lost in a process of individual parties deflecting blame from themselves to one another.

### 5.2 Shared Quality Assurance Programs

From the Regulatory Colleges' perspective, a quality assurance program usually has two arms: one arm uses an educational approach to support practitioners to know the rules of the game and to avoid problems in the first place with the second arm identifying and addressing identified problems. The OCFP believes that joint educational opportunities should be explored to address the former; however, remedial programs need to be addressed by the individual Colleges. The adversarial nature of such processes would only serve to create divisiveness.

### 5.3 Joint Practice Standards

The College of Physicians and Surgeons has, for the most part, avoided the development of **standards for clinical practice** in recognition of the fact that practice environments differ throughout Ontario and need too frequent upgrades as research findings drive practice change. Moreover, it is the profession (i.e. the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons) that sets standards. To ensure self-regulation, our profession needs to maintain its ability to set its own clinical practice standards.

McMaster University's Department of Family Medicine and the Ontario College of Family Physicians have developed the Quality in Family Practice program. The program identifies the features one would expect to see in a high quality practice. Rather than focusing on independent practices and the scopes of practices of individual practitioners, the model builds teams by concentrating on areas for improvement and supports each professional to identify how his or her skills can

be best utilized to provide quality care. The program is not anchored in the individual scopes of practice of practitioners but rather on how team members in the practice work well together and how they collaborate with other healthcare professional throughout the community healthcare system. It is a program clearly anchored in quality improvement and learning together how to do it better.

Borrowing from the hospital sector, joint practice standards might be developed to support effective communication amongst team members or to deal with administrative issues such as the health records, conflict of interest, etc.

Hospital accreditation is another example, if done well, of non-college driven quality programs that build teams at the same time that they improve the quality of care provided jointly by teams of interprofessional practitioners. Having the Colleges support such initiatives and others such as care map development as evidence of the individual practitioner's level of competence would be seen as helpful. Demonstrations of functioning within ones own scope of practice is important to be addressed by the individual College.

#### 5.4 Arm's Length Oversight Body

The Discussion Guide proposes an independent arm's-length organization to facilitate and support collaboration, including collaboration among colleges. It is the OCFP's position that mandate and scope of the Interprofessional Care Implementation Committee (as outlined in the MOHLTC's Interprofessional Care: A Blueprint for Action) is clearly defined, this will be a sufficient start to facilitating and supporting collaboration among the Colleges.

#### 5.5 Practice Guidelines

The Guide speaks to the Denmark example where a Secretariat for Clinical Guidelines was established to support medical societies and other health care professionals in developing evidence-based clinical guidelines involving interdisciplinary work. The OCFP would like to highlight that the Ontario government in partnership with the OMA, established a body called the Guidelines Advisory Committee (GAC) in 1997, but has recently withdrawn funding for this arms-length body. It's OCFP's perspective that permanent funding be reinstated to support the GAC and to expand its mandate to include the development/review of interprofessional guidelines.

#### 5.6 Ministerial Powers

The Minister has broad discretionary powers in section 5 of RHPA; however, the OCFP contend that interprofessional collaboration is based on mutual trust and cannot be mandated – by HPRAC, by the College or by the Minister.

#### 5.7 Toolkits and Templates

The Guide asks whether tools and templates could facilitate and support collaboration. There is evidence that the development of collaborative practice at

the clinical level requires appropriate coordination and communication and therefore benefits from availability of standards, policies and interprofessional protocols, communication protocols, guidelines, education materials etc.<sup>24</sup> It is the OCFP's position that this approach may also be valuable at the college level and the range of resources suggested in the Guide may all be valuable for inclusion in a toolkit, depending upon the goals of the specific situation.

## 6.0 College Autonomy, Authority and Accountability

The CPSO and other colleagues have the autonomy, authority and accountability for identifying certain standards of practice and professional practice guidelines. In other instances, the policy directives are not deemed enforceable but used as a “touchstone” by the professionals. The system as it is currently works well. Having all of the power resting with each College is not supported. While it is important that each College is able to provide guidelines and advice to its members, the transparent process of having government (and therefore input from other Colleges) input is important in maintaining a system of “checks and balances”. The government review process of added drugs for nurse practitioners is one excellence example of errors identified prior to implementation. The Guide suggests that legally enforceable policies would be resented and we agree.

## 7.0 Interprofessional Care at the Clinical Level

The Guide queries how greater collaboration among the colleges will enhance interprofessional care at the clinical level and whether legislation should be introduced to require professions to work together. The OCFP's position on this topic is noted in the very first statement of this submission: *At the outset, the OCFP would like to highlight that the contribution of the Regulatory Colleges to enabling IPC is only one among many enablers. Enablers including compensation and funding, interprofessional education, organizational supports, patient/caregiver involvement, health human resource planning, integration of traditional providers, education of western providers and more evidence of collaborative outcomes, are all required to move IPC forward.*<sup>25</sup> *Moreover, it is important to place a significant emphasis on these other powerful enablers because the essence of IPC success is so deeply rooted in creating environments that will support and facilitate development of trust and respect among colleagues in day to day practice. Therefore a comprehensive action plan that implements recommendations as outlined in The Interprofessional Care Blueprint for Action is required to successfully guide IPC implementation and overcome a long history of “silos” of professional practice that often acts as a barrier.*<sup>26</sup> Therefore, while OCFP is supportive of the literature that says improvements in the legislative and regulatory environment are required, we believe that significant progress has been made in this environment with the Health System Improvements Act, 2007 and that development of the mechanisms outlined under the Enablers section of this submission, together with exploration of some areas for joint

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<sup>24</sup> Primary Health Care Transition Fund, *Collaborative Care*, March 2007. [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)

<sup>25</sup> *ibid*

<sup>26</sup> D'Amour, Sicotte, & Levy, 1999, in Primary Health Care Transition Fund, *Collaborative Care*, March 2007. [www.healthcanada.gc.ca/phctf](http://www.healthcanada.gc.ca/phctf)

practice standards, for collaborative quality assurance, with attention to funding, compensation and other system enablers, offer greater potential.

## 8.0 Conclusion

Overall, the OCFP supports IPC and recognizes the importance of collaboration among Health Colleges and professionals, as an enabler. In summary, the OCFP would like to emphasize the following points from this submission:

- We should not place undue emphasis on the value of legislation and regulation at the College level to achieve IPC; the greatest gains will be achieved through a comprehensive action plan that begins by addressing primary enablers such as compensation and funding, interprofessional education/teaching/ training, organizational supports and liability. These enablers will create the environment for health professionals to work in close proximity, develop a clearer understanding of their roles and functions and therefore build familiarly, respect and mutual trust among each other. There is a long and strong history of family physicians working collaboratively with health care professionals in hospital and community settings, to support the delivery of comprehensive care for patients, contribute to quality care and reduce the burdens facing family physicians. This is especially true in the primary care/family practice sector with the establishment of Family Health Teams, the Health Services Organizations that preceded them and the Share Care Collaborative model in FHGs. It's not legislation or regulation that is making this possible, but the primary enablers that are creating a supportive context.
- Health professionals working to their maximum competence and capability and in a manner that maximizes collective resources is key aspect of IPC, however the OCFP cautions that the underlying theme or goal should not become the creation of "physician substitution" models. The focus must be on collaboration rather than competition with, or replacement of, family physicians. While the various regulated health professionals have specialized/narrower scopes of practice, it must be acknowledged that family physicians have the broadest scope of practice, which often places them in a clinical leadership role, though this does not imply a direct supervisory role over all the clinical services.
- In the legislative/regulatory discussion it's important not to lose sight of the value of promoting IPC through Enablers, which can be supported by an accreditation process and/or yearly reporting requirement. The goal would be for the Colleges to demonstrate a commitment towards initiatives that have the effect of developing awareness of each other's roles, scopes of practice and competencies, thereby building an increased understanding and trust among professionals.
- To address patient safety concerns, exploring a common framework for addressing complaints and investigations related to team-based services provided by health professionals is a viable approach. Together with collaborative tool kits, common frameworks represent a good step forward towards information sharing among regulatory bodies, building familiarity about each other's professions and further

building relationships, before taking any further steps in terms of new regulatory processes.

- The erosion of autonomy of each of the Colleges should not be the goal, nor should the focus be on merging the powers and procedures of the various Colleges. The goal should be on developing synergistic outcomes with all Colleges working together to develop innovative approaches to IPC. Hence the OCFP is not supportive of initiatives such as a conjoint process for addressing disciplinary matters.
- With respect to the creation of an arm's-length organization to facilitate and support collaboration, or an oversight body to develop common guidelines, the OCFP encourages HPRAC to look at initiatives under development or in existence (e.g. Guidelines Advisory Committee; Interprofessional Care Implementation Committee), before complicating matters with new bodies and/or additional/new legislative changes.
- The McMaster/OCFP Quality in Family Practice and other models of quality improvement provide the best opportunity for the College to collaborate and support their individual and collective members to learn together how to deliver high quality care and to appreciate the value of working collaboratively. Quality assurance affords an opportunity for mutual respect and trust to develop amongst the team members. The development of respect and trust cannot be legislated.