The College of Midwives of Ontario

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

The College of Midwives of Ontario is pleased to be able to respond to HPRAC's consultation discussion guide on issues related to the Ministerial referral on interprofessional collaboration among health colleges and professions.

Before responding to the specific questions raised in the consultation document, we would like to take this opportunity to present a number of points that we feel are central to any discussion of interprofessional care (IPC) in the context of midwifery and maternity care in this province.

Midwives, who have always worked from a philosophical base that recognises and utilizes the benefits of collaboration, are well poised to be active contributors to effective interprofessional care. Midwives are required, through the College's "Indications for Mandatory Discussion, Consultations, and Transfer of Care" standard document, to engage in consultation with other health providers and plan care appropriately.

The College is committed to examining if or how regulatory barriers to IPC may exist and to working with government to remove these barriers as expediently as possible. The College's council approved a formal statement on IPC in January of this year and is engaged in a number of projects that will support our members in their participation in IPC.

There has been considerable work done in the area of IPC by maternity care providers and stakeholders. In particular, the Ontario Maternity Care Expert Panel's report "Emerging Crisis, Emerging Solutions" and the Multidisciplinary Collaborative Primary Maternity Care Project (MCP^2) report considered the value of IPC and arrived at, in the College's view, useful conclusions that included how collaboration among health professionals could improve maternity care in Ontario for both the women and families receiving care and the individuals and organisations providing it.

While there are many communities and hospitals in which IPC is not taking place, the College believes that interprofessional care is taking place in many settings; in some, it is at the level of high-functioning formalized interprofessional care teams and in others, through more informal relationships. We believe that efforts at the regulatory level are relevant and could be tremendously valuable in supporting the development or enhancement of IPC. We do not, however, believe that IPC can be regulated into existence. In fact, the College has concerns that if attempts are made to impose IPC requirements on professionals through regulation, the effect could be to impede the cooperation and teamwork we seek to nurture.

There are sizeable system barriers to interprofessional maternity care. Hospital issues represent one of the most significant barriers. These issues among other things include such things as the refusal of a number of the province's hospitals to extend privileges to midwives; the capping of the number of births midwives are permitted to attend; and the fact that midwives are not legally entitled to representation at advisory committee meetings. We realise that underpinning these problems are issues of differences in professional culture, concerns regarding remuneration, and fears of sustainability for obstetrical practices in smaller communities, but feel that hospital administrations should be held more accountable to requirements that they facilitate IPC for all professions.

Defining Interprofessional Care

We believe that the statement HPRAC proposes is quite reasonable but would advocate for the inclusion of "support best use of health care resources" be added. We believe that this is a point that is very much in the public interest since it speaks to the sustainability of both the health and the regulatory system through the best use of public and member dollars through increased satisfaction for health care professionals and therefore greater human resource stability.

The CMO has looked at a number of definitions of interprofessional collaboration at the clinical level and believes that one of the most comprehensive is the one developed by the Multidisciplinary Collaborative Primary Maternity Care Project (MCP^2):

> "Collaborative patient/client centred practice designed to promote the active participation of each discipline in providing quality care. It respects goals and values for patients/clients and their families, provides mechanisms for continuous communication among caregivers, optimizes caregiver participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all disciplines." (Based on Health Canada's definition of collaboration)

Eliminating the Barriers to Collaboration among the Colleges

In the CMO's experience barriers to collaboration among the Colleges are, minimal.

It has been suggested that the Health System Improvements Act may create barriers to collaboration on alternative dispute resolutions when two colleges are involved in a complaint. The CMO has not had experience with this but would be concerned if this option was not available when and if it was ever needed.

Though some barriers arise due to system issues, in our view, the most serious system issue that acts as a barrier to collaboration among the Colleges is the government's regulation amendment process, which restricts our ability to amend regulations in time to reflect current best practice and therefore restricts members from participating in IPC.

While the CMO's experience with the other RHPA colleges has been quite collaborative and there have been a number of specific initiatives on which we have consulted our regulatory colleagues and which have resulted in positive outcomes. However, it should be noted that colleges do not have that authority or power to affect the willingness of members to collaborate in care delivery. The CMO would like to emphasise that collaborative efforts at the level of the regulator, while valuable in and of themselves, should not be taken as a proxy for collaboration at the clinical level.

Professional cultural issues have not played a major part nor have been a noticeable barrier to collaboration at the college level in the CMO's experience. Professional culture continues to be a barrier to collaboration at the clinical level despite the best efforts of the regulators. The CMO is committed to continuing efforts in this area since we believe that leadership to eliminate the barriers created by professional culture needs to come from all levels: government, regulatory colleges, professional associations, and hospital administration.

We would like to note that in the CMO's experience, many barriers arise from the interpretation of Act(s). For example, the RHPA does not overtly address delegation as it provides no direction as to when and how it is desirable or how and who decides that it is. The result is that our members experience system barriers that originate with how the hospital administration or obstetrician group interprets the Act. Medical directives for narcotics are a relevant example of this situation; some hospitals and obstetrical groups allow them, some do not.

Liability Issues

The CMO sees evidence that liability issues are a barrier to IPC in the nature and frequency of both member and physician enquires related to this concern. We do not believe, however, that there are insurmountable or perhaps even substantial legitimate liability issues. Unfortunately, the perceived issues amount to and/or are used as a barrier to IPC. A good example of this is epidural monitoring; something that is in-scope for midwives and typically done by registered nurses not physicians, but often denied to midwives by physicians and/or hospital policies that - citing liability issues - dictate that once a physician has been consulted there must be a transfer of care.

In considering the need for minimum professional liability insurance, the CMO believes that, if the aim is to promote IPC, consideration should be given to structuring liability coverage in a way that is aligned with an IPC approach.

Developing Enablers for Collaboration among the Colleges

We do not believe that the RHPA represents a barrier to collaboration at the college level. We do believe that, in order to encourage, facilitate, and enable IPC among the colleges, the process for amending the regulations needs to be modified to allow changes to be made with enough expedience to keep pace with changes to clinical best practices.

To ensure support is available to new Colleges as they are established, we would recommend that the Ministry consider financial support for initial years. As a small college that continues to grow steadily but slowly, government support has been critical to developing capacity within the college.

Structural Mechanisms

The CMO believes that the RHPA is a common framework for all regulated health professions to address complaints, investigations, or disciplinary matters and that major legislative change is not needed. We would hesitate to recommend additions or changes to the framework are necessary to deal with matters arising out of an interprofessional care setting until real IPC is happening consistently. Otherwise, we may run the risk that colleges will be left to address breakdowns in the system (rather in the care provided by their members) through the complaints process.

There may already be, in fact, the needed flexibility within the RHPA to allow colleges to address collaboratively any matters arising out of an IPC setting. The CMO believes that colleges need an opportunity to work together under the interprofessional objects included in the Health System Improvements Act through provisions that permit joint investigations,

allow for increased sharing of information, and mandate regulatory bodies to support and promote IPC.

What may be needed is support for the shared development work to create more collaborative processes that respect the autonomy of each self-regulating profession and permit each college's committee to make decisions regarding their members. We feel strongly that shared procedures or approaches should support IPC but not create the ability for one college to influence or dictate outcome or consequence of complaints, investigations, or hearings for a member of another health college.

Quality Assurance

Quality assurance programs and measures developed with the intent of supporting and ensuring competence within an interprofessional team could be one relevant area for regulatory colleges to focus their IPC-related efforts. That is not to say, however that a joint quality assurance program is needed, rather that continued collaborative initiatives on the part of colleges and their members should be the goal. For example, emerging teams will need help enabling IPC through joint guidelines and protocols. Colleges could also play a role in supporting joint quality assurance efforts through the continuing competency certification they require of members.

Major legislative change is likely not needed to force or facilitate collaboration in the area of quality assurance. An excellent example of an existing joint quality assurance initiative is the MORE^{OB} (Managing Obstetrical Risk Efficiently) program. This program, which was developed by the Society of Obstetricians and Gynaecologists of Canada, is a comprehensive patient safety, quality improvement, and professional development program for obstetricians, family physicians, nurses, midwives and administrators in hospital obstetrical units. The principle driving this course is that "by learning and working together in their own practice environment, the healthcare team is able to use the shared knowledge, skills, attitudes and behaviors that contribute to safe, effective, patient-centered care in an efficient, collaborative, healthy practice environment."[1]

In considering which colleges should collaborate on quality assurance initiatives, other groupings (e.g., setting of care) may make more sense than controlled acts.

Standards of Practice and Professional Practice Guidelines

The CMO believes that by working together with HPRAC, the Federation colleges operating within the framework of the RHPA as amended by the Health System Improvements Act are well situated to address the need for common standards of practice and professional practice guidelines.

In any system that is established to produce collaborative standards, the CMO feels that there needs to be a mediated means of resolving conflicts or disputes between the colleges related to such issues as scope of practice.

Regular reporting requirements for collaborative efforts between the colleges would support transparency and accountability and would not be unwelcome provided that the requirement was not so onerous or frequent as to detract from the work already being done by colleges.

[1] https://www.moreob.com/en/whatWeDo/overview.html

Tools and Templates

A *Collaboration Toolkit* could be useful in facilitating and supporting collaboration among the colleges. The Federation of Regulatory Health Colleges of Ontario, with its considerable expertise and demonstrated commitment to inter-collegial initiatives, would be the most appropriate organisation to oversee such a toolkit.

The list of elements proposed in the consultation document appears to be a reasonable place to begin. The CMO would like to suggest that HPRAC might also wish to examine the potential benefits of developing, providing, and – most importantly – enforcing a similar toolkit for hospitals.

College Autonomy, Authority, and Accountability

The CMO believes that, if colleges can demonstrate that they are consistently transparent, consultative and working in the public interest, statutory rule-making powers would give self-regulation to professions in the most meaningful way (i.e., allowing those who know the most about the care to establish by-laws, standards, and guidelines that will dictate practice) and ensure that professionals were supported to work to most current and best practices.

To this end, the colleges should be able to amend, at a minimum, the regulations related to clinical practice without needing Ministerial or legislative approval.

Interprofessional Care at the Clinical Level

The practical benefits of increased collaboration between the colleges could enhance IPC at the clinical level through better coordination, easier enforceability, and increased accountability, and a common lexicon related to IPC.

Increased collaboration at the college level could also serve the purpose of modeling IPC for professionals and have the effect of improving or increasing their willingness to participate in IPC.

Concluding Comments

The CMO believes that HPRAC needs to consider *specifically* where IPC is not working and ask how regulators can influence or improve it. We believe that consideration should also be given to other significant barriers to IPC, including hospital-related issues, the Ontario health-funding model, and the role that professional associations play in supporting members to work in IPC teams and settings.

We are grateful for the opportunity to comment on the consultation document and hope that our response will be useful to HPRAC in preparing its report.