MINISTERIAL REFERRAL ON INTERPROFESSIONAL COLLABORATION

SUBMISSION

To

HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL

From

ONTARIO CHIROPRACTIC ASSOCIATION

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EXECUTIVE SUMMARY

1. The Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals (the Referral), which provides the basis for the current consultation and this submission, is on interprofessional collaboration (IPC) among health Colleges and between their members. A major part of the referral relates to the collaborative development of "standards of practice and clinical practice guidelines where regulated health professions share the same or similar controlled acts."

   The ultimate goal of IPC relative to controlled acts and in general, as noted in the Referral and HPRAC's Consultation Discussion Guide (HPRAC Guide), is advancing safe, effective and high-quality patient care.

2. A number of initiatives for improved IPC between Colleges are suggested in the HPRAC Guide and discussed in this submission. The OCA submits:

   (a) IPC action promoted and taken at the level of Colleges and their leadership is important. Examples include:

      (i) Common structures and processes for all Colleges to address complaints, investigations and disciplinary matters, especially in interprofessional care settings [page 5 para E1].

      (ii) Joint quality assurance programs where Colleges have members with common areas of practice, exposing members to best practices and enhancing continuing competency [pgs 5-6 para E4].

      (iii) At the direction of the Minister, collaboration on development of minimum standards in areas such as conflict of interest, advertising, recordkeeping and consent to process [page 6 para E6]

   (b) Far more significant and important, however, is action taken at two other levels, namely:

      (i) By individual professionals in education, research and clinical practice, including the development of clinical practice guidelines.

      (ii) By the Ministry of Health and Long-Term Care (the Ministry) and the government in policy and funding decisions.

3. **Action by Individuals Promoting IPC**. HPRAC has asked for examples drawn from the experience of the OCA. These include:

(a) Neck Pain Task Force Report 2008[1]. This recently published report of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and its Associated Disorders:

- Is interdisciplinary, collaborative, evidence-based and international
- Is published with the participation and support of peer leaders in the professions most frequently engaged in managing patients with neck pain.
- Covers all surgical and non-surgical approaches to patient management
- Presents a new patient-centred model of neck pain and its management
- Identifies and makes recommendations with respect to generic treatment approaches, rather than recommending services of specific professions
- Deals with a highly prevalent complaint and large burden of disability in the population
- Calls for a high degree of IPC in recommending that patients should be advised of all appropriate evidence-based treatment approaches no matter which provider they choose

Effective IPC by Colleges will be secondary to primary IPC at the clinical level such as this, and should involve specific action to identify and act upon best work by individuals and groups of individuals at the clinical, educational and research levels.

(b) **Recent acute and/or chronic back pain reviews and guidelines published in North America[2] and Europe[3]**. These have similar features to the above neck pain review and report. Back pain, however, is even more prevalent and represents an even higher burden of illness and disability.

Regulated health professions in Ontario with overlapping scopes of practice and/or controlled acts for patients with neck pain and/or back pain include acupuncture, chiropractic, massage therapy, medicine, naturopathy, nursing, osteopathy, physiotherapy and traditional Chinese medicine.

Accordingly, the areas of neck and back pain represent important areas in which Colleges for these professions could commence practical and meaningful projects of IPC in quality assurance programs and in other ways.

4. **Action by Government Promoting IPC**. Experience in Ontario and other jurisdictions clearly indicates that policy and funding decisions by the government are of fundamental importance to effective development of IPC, whether by Colleges or others. Examples include:

   (a) **Primary care reform in Ontario.** When the Ministry made decisions supporting the integration of chiropractic services in pilot projects for primary care reform, this resulted in high levels of IPC, excellent patient results and effective use of health care resources in a context where this would never have happened without Ministry direction and funding.

   With continued funding these results can be duplicated, significantly addressing what HPRAC describes as "top of mind issues" for the government : wait times, safety and quality of care, and the sustainability of the health care system. (HPRAC Guide, page 14).

   (b) **Hospital-based services in Ontario**. Since 2005 chiropractic services have been integrated into the Family Health Unit at St. Michael's Hospital in Toronto, a major urban teaching hospital affiliated with the Faculty of Medicine at the University of Toronto. This was at the request of patients, with the support of the hospital and the Canadian Memorial Chiropractic College, and with interim funding from the Ministry. It has proved a significant success in terms of IPC (among physicians, doctors of chiropractic, physiotherapists and others) and improved quality of care and patient outcomes. However, the determining factor on whether this IPC project will continue, and be duplicated in other hospital settings in Ontario, is government policy and funding decisions.

   Colleges, even enjoying an improved regulatory and structural framework for IPC and motivated to act, can do little to promote continuation and enhancement of such IPC unless funding is in place.

5. **Key recommended actions by the Ministry.** The OCA submits that important and priority action steps by the Ministry to promote a culture of IPC in Ontario, in colleges and otherwise are:

(a) Developing and promoting wide public awareness of a Ministry website designed to educate the public, including health professionals, about Ontario's regulated health professions [pages 3-4 para B2(b)(ii)].

(b) Creating a Secretariat for Clinical Guidelines within the Ministry, modelled on a similar body in Denmark [page 6 para E5].

(c) Imposing a positive legal requirement of interprofessional collaboration on health care professionals, similar to that referred to in New Zealand [page 8 para G2].

6. **Roles of Colleges and professional associations.** HPRAC has received a Referral that relates to standards of practice and practice guidelines and the roles of Colleges and their members in enhancing interprofessional collaboration in these areas, with the ultimate goal of improving quality of patient care. The OCA submits that the role of professional associations is at least as important as the role of colleges. For the Ministry to achieve its goal, the Ministry and HPRAC should be consulting with and fully engaging professional associations.

Response to Questions in HPRAC's Consultation Discussion Guide

In the text of this submission HPRAC's questions are summarized. For the full questions see Appendix A.

A. DEFINING INTERPROFESSIONAL COLLABORATION.

1. **Question 1.** This asks whether elements should be added or removed to a series of background statements. The OCA recommends that the final statement, "Enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability" be amended to:

   "Enhance scopes of practice *and how scopes of practice work together* to ensure that all regulated health professionals work to their maximum competence and capability."

   Scopes of practice will always be different, are difficult to change and it is not different scopes of practice that inhibit IPC but rather how the scopes work together. Examples from chiropractic practice are that doctors of chiropractic have the right to make and communicate diagnoses of disorders and to take, order and interpret diagnostic imaging. However, when they suspect a disorder that requires medical specialist attention and/or imaging (e.g. spinal tumour or fracture) they cannot refer patients directly to the relevant medical specialists or order imaging from public hospitals. Doctors of chiropractic have these rights in other jurisdictions (e.g. Denmark, Norway, Switzerland, USA).

B. ELIMINATING THE BARRIERS TO COLLABORATION AMONG THE COLLEGES.

1. **Questions 2-4.** These relate to structural and policy barriers which may exist between Colleges, and the OCA leaves answers to these questions to the College of Chiropractors of Ontario (CCO).

2. **Question 5.** This asks about professional cultural issues that may act as barriers to IPC, what steps should be taken to minimize them, who should provide leadership, and the appropriate role of associations such as the OCA. In answer the OCA notes:

   (a) There are professional cultural barriers to collaboration by various health care professions, and these affect the members and leadership of Colleges. These barriers are often based on history, perception and lack of knowledge, as opposed to true cultural differences. The professions of chiropractic and medicine provide a good example of this. In response to HPRAC's request

for specific examples from experience the OCA refers to the matter of university affiliation for chiropractic education in Ontario.

In many countries, including Australia and the United Kingdom, which have social and political similarities to Canada, chiropractic education takes place in publicly funded universities. This is also the case in Canada, at the University of Quebec at Trois-Rivières. In Denmark chiropractic and medical students take common courses for three years and then branch out into either medical or chiropractic clinical training and qualifications. Chiropractic education in public universities, in association with other health science students, promotes mutual understanding and respect, and a strong foundation for IPC.

In Ontario, chiropractic education remains privately funded and separate from other health science students at the Canadian Memorial Chiropractic College (CMCC), in Toronto. Although the program provides high-quality education and skilled graduates, and holds formal degree granting status, other associations of health professionals and their members in Ontario have promoted the perception that chiropractic education is inadequate and based upon principles of health that are unscientific and inconsistent with mainstream health care.

In the 1990s, when CMCC sought affiliation with York University in response to an approach from the university and a vote in favour by the university Senate, the initiative was strongly opposed and ultimately defeated by a campaign organized by a small group of physician-led opponents who portrayed the chiropractic profession as unscientific and its services as unacceptably dangerous, inappropriate and taking market share away from the medical profession. Further details of this can be provided upon request. Similar campaigns have been seen in other jurisdictions, such as the State of Florida, where a proposal to commence chiropractic education at Florida State University in 2005 was defeated by medical opponents claiming that chiropractic education and practice was so suspect on scientific grounds that it was unworthy of public support.

Actual or perceived cultural differences exist as one barrier to IPC between most regulated health professions, but particularly among the medical profession and those professions currently viewed by many as complementary or alternative medicine (CAM) – including chiropractic, naturopathy and traditional Chinese medicine. Paradoxically, the medical profession is increasingly embracing and seeking to deliver CAM treatments in response to patient preferences and demand, and evolving health care systems in Ontario and internationally. As noted, the cultural barriers arise more from perceived differences than actual ones and are intertwined with

other barriers arising from lack of knowledge and turf protection – challenges correctly described by HPRAC as "competition, fear and misunderstanding among health professionals." [HPRAC Guide, pg. 15]

(b) The leadership to eliminate professional cultural barriers such as these, and associated turf competition, needs to be taken at many and all levels. The key problem to be addressed is simple lack of knowledge. Each profession has little understanding of the many others. As students and then busy clinicians, health professionals have not had the time or opportunity to learn about others. A related problem is that the public, and even most health policy experts, are confused by the evolving and multifaceted health care system. What is the difference between a chiropractor, an osteopath and a physiotherapist; between an optometrist and an ophthalmologist, between a psychologist, psychotherapist and psychiatrist, etc? HPRAC has described the situation well by positing this challenge to IPC:

"Lack of knowledge, acceptance and respect of competencies, skills and training of all health professions by patients and other health professionals." [HPRAC Guide, pg. 15]

With respect to what leadership interventions have been or should be taken, and by whom:

(i) World Health Organization. With respect to full integration of CAM professions within national health care systems and on the basis of appropriate education and regulation, WHO has taken a leadership role since the adoption of the WHO Traditional Medicine Strategy 2002-2005.[4] This has led to the development of guidelines for education and practice for major international CAM disciplines such as acupuncture,[5] chiropractic[6] and osteopathy.[7] In November 2008 WHO holds its first Congress on Traditional Medicine. This Congress, to be held in Beijing, China, the country with the most balanced integration of traditional and modern medicine, is expected to result in a new declaration by and to member governments worldwide concerning the importance of full integration of TM/CAM into national health care systems in the interests of patients and patient-centred health care.

(ii) Ontario Ministry. The OCA submits there is now demonstrated and urgent need for the Ministry to take leadership in educating regulated health professionals and the public about all regulated health professions in Ontario. No one else can lead this effort to mitigate the cultural barriers between professions as effectively as the Ministry. It has the independence, authority and resources that are needed and

that others, including Colleges, lack. The OCA recommends that as a central feature of a new public education initiative the Ministry should develop and then promote wide public awareness of a website that introduces and gives appropriate information on each regulated health profession. Aspects of this might include:

- A title such as *The Health Professions of Ontario*
- Video clip interviews with several Ontarians demonstrating confusion about the various health professions and their roles
- A standard format for information for each profession. This information should cover education, scope of practice, numbers/availability/cost, clinical practice, research and regulation.
- In this information, a requirement of comment on and examples of interprofessional collaboration (IPC) in the areas of education, practice and research.
- Initial development of content by the professional association for each profession according to a Ministry template, but subject to direction and editing of final content by the Ministry.
- With respect to clinical information, a video of agreed duration demonstrating approximately two contrasting mock patients receiving patient assessment and management in typical clinical settings in Ontario. This video footage should be produced by Ministry consultants to produce consistency of quality and format.

Such an initiative would have a very significant impact in education of the public, including health professionals, would greatly mitigate cultural and professional barriers in itself, and would encourage and enhance the effectiveness of other IPC initiatives by Colleges, professionals associations, educational institutions, individuals and others.

C. LIABILITY ISSUES

1. **Questions 6-7.** These ask whether liability issues are a barrier to IPC, and whether all regulated health professionals should be required to hold minimum professional liability insurance coverage. The OCA does have evidence that liability issues are a barrier. When Dr. Silvano Mior and his team, as a Primary Health Care Transition Fund project developed a model for collaborative care for pilot projects incorporating chiropractic services in primary care networks, a significant concern of family physicians that needed to be addressed was whether or not they would face additional legal risk and cost if they referred patients to doctors of chiropractic.

Similar concerns had to be addressed when chiropractic services were commenced at the Family Practice Unit at St. Michael's Hospital in Toronto and at the Carlington Community Health Centre in Ottawa. Summary overviews of these projects are attached as **Appendix B.** (*Texts from pgs 16-18 of the OCA 2006-2007 Annual Report).* More details can be provided upon request.

The OCA considers that all regulated health professionals should be required to hold professional liability insurance coverage as a matter of public interest.

D. DEVELOPING ENABLERS FOR COLLABORATION AMONG THE COLLEGES.

1. **Questions 9-12**. These are addressed primarily to Colleges.

E. STRUCTURAL MECHANISMS.

1. **Questions 13-17.** The OCA supports the concept of a common framework, consisting of common structures and processes, for all regulated health professions to address complaints, investigations and disciplinary matters arising in interprofessional care settings. This is consistent with the core structure and principles of the Regulated Health Professions Act.

2. **Questions 18-21.** These questions relate to collaboration between the Colleges in investigating and disposing of complaints. The OCA supports such improved collaboration.

3. **Quality assurance – Question 22**. "Would a joint quality assurance program among relevant Colleges enable the Colleges to develop common standards of practice or professional practice guidelines where the same or similar controlled acts are shared?"

   Yes with respect to professional practice guidelines, no with respect to standards of practice that relate to controlled acts. Standards of practice are prescriptive and failure to satisfy them generally amounts to professional misconduct. A joint quality assurance program aimed at common standards may seem attractive in principle, but represents a major assault upon the principle of self regulation. An additional problem exists where one profession has significantly more education and clinical practice relative to a controlled act than others authorized to use it. The more qualified profession and its College may come under pressure to lower the standard of care.

   Professional practice guidelines are not prescriptive and are recommendations only. They are based on best available evidence and acknowledge that individual cases may well fall outside the ambit of the guidelines. Joint quality assurance programs to develop common professional practice guidelines for the same or similar controlled acts are supported by the OCA.

4. **Quality assurance – Question 23.** "Would a joint quality assurance program among Colleges whose members have similar scopes of practice, share the same or similar controlled acts, or provide closely related services often involving the same areas of the body, provide opportunities for enhanced continuing competence and exposure to best practices? If yes, how should program standards be jointly set and measured?"

   Yes. Consider the example already given of the management of patients with neck pain. If there were mandatory continuing education, and the many Colleges with members who treat neck pain had a joint program that led to adoption of and familiarity with the new Neck Pain Task Force Report and its new model of care and recommendations, this would:

   - Enhance continuing competence
   - Expose all relevant professions to best practices
   - Improve the quality of patient care
   - Greatly improve IPC

5. **Standards of practice and professional practice guidelines – Questions 25-28**. These questions ask whether there should be an independent organization to support collaboration among the Colleges, particularly in the development of common standards of practice and professional practice guidelines, and if so what the mandate of the organization should be.

   (a) The OCA submits there should be an organization with the specific purpose of development of professional guidelines, a primary area for development of IPC that has direct impact on quality of care across professions. This should be modeled on the Secretariat for Clinical Guidelines, National Board of Health in Denmark. This would enhance IPC between professionals and their Colleges in a more practical, important and cost-effective way than organizations with broader mandates as described in Quebec, Virginia and the United Kingdom.

   (b) With respect to the suggested mandate to "educate Colleges, professions and the public on the regulatory model, the health professions, and everyone's role within the regulatory system", that should not be the mandate of an arm's length organization but a core responsibility of the Ministry itself in today's complex and evolving health care system. Comment on that issue, and the action step of the Ministry developing an appropriate website, has already been made [pages 3-4].

6. **Questions 29-32.** These ask whether the Minister should direct the Colleges to engage in specific IPC initiatives, provide incentives and require reports.

(a) The Minister should give such direction to the Colleges and a direction on development of minimum guidelines, standards and policies across all Colleges is appropriate in the areas mentioned in the HPRAC Guide – conflict of interest, advertising, recordkeeping and consent process.

(b) The Colleges should be required to report to the Minister and the public on their IPC activities on a regular basis but with a special focus on IPC activities that have clinical impact.

(c) Again, although such direction from the Minister and collaboration by Colleges is important, collaboration at the clinical professional level remains most important. First, this has more impact in attaining the overall goal of improved patient care. Second it is IPC at the clinical level that will promote IPC at the level of Colleges, more so than direction and oversight from the Minister, Ministry or other bodies.

7. **Tools and templates – Questions 34 and 35.** These are questions directed primarily to Colleges.

F. COLLEGE AUTONOMY, AUTHORITY AND ACCOUNTABILITY

1. **Questions 36-39.** These questions relate to whether standards of practice and practice guidelines that are developed by Colleges should be legally enforceable without the current requirement of ministerial or legislative approval.

   (a) First, the OCA makes the point once more that there is a fundamental difference between standards, which are prescriptive and should have the force of law, and guidelines, which are recommendations only, should not seek to replace clinical judgement and should not be legally enforceable by Colleges.

   (b) Next, the OCA strongly supports the continued need for ministerial or legislative approval before standards of practice or other rules developed by Colleges are legally enforceable. Reasons include:

      (i) There will be a much better climate for IPC between Colleges on the development of standards, and better prospects of success if all parties know the outcome is subject to Ministry approval.

      (ii) The Ministry should have the final say, not Colleges. This has always been seen as important and remains so – in terms of Ministry control and the opportunity for other parties, including associations with health professionals, such as the OCA, being assured of appropriate opportunities to express their points of view.

G. INTERPROFESSIONAL CARE AT THE CLINICAL LEVEL

1. **Question 40.** "How will greater collaboration among the Colleges serve to enhance interprofessional care at the clinical level?"

   (a) Such collaboration has the strong likelihood of doing this in direct and indirect ways. As to direct ways, this would be the impact of specific initiatives, such as joint standards of care in areas such as clinical records and consent process, and other initiatives taken – for example, a joint mandatory component of continuing education programs by Colleges and professionals with common areas of practice relevant to understanding, adopting and using clinical practice guidelines.

   As to indirect ways, the simple example of IPC by Colleges would encourage similar behaviour by individuals at the clinical level.

   (b) Again, although IPC by Colleges is important for reasons just given, main leadership must come from the Ministry itself and peer leaders in clinical practice. If there is not appropriate leadership, policy and funding from the Ministry, IPC at the College, association, and individual levels will have little success in enhancing interprofessional care at the clinical level.

2. **Developing regulatory enablers for IPC at the clinical level – Questions 41-43**. These questions ask whether any legislative changes are required to facilitate IPC at the clinical level, whether Ontario should impose a legal requirement of IPC on health care professionals as, for example, in New Zealand, and if so what the requirement should be and the consequences of failure to meet it.

   (a) The OCA submits that there should be a positive legal requirement for all regulated health care providers to display competence in IPC and to work and communicate effectively with other relevant professionals to ensure quality and continuity of care. Imposition of such a requirement should be one of the leadership steps now taken by the Ministry.

   (b) An appropriate knowledge of and respect for the clinical skills of other professionals who are likely to be consulted by your patients for the health concerns for which they consult you could also be regarded by Colleges as a core competency. If so then:

      (i) There could, for example, be a mandatory continuing education requirement to help maintain and enhance this core competency. Relevant Colleges could collaborate in this area.

      (ii) Health care practitioners might be open to a charge of professional misconduct before their Colleges following complaint by a patient.

(iii) A health care practitioner might be liable in negligence for a breach of a duty of care to a patient where there was a significant lack of IPC causing harm to the patient.

(c) With respect to any changes needed to current legislation to facilitate IPC at the clinical level:

(i) There may well be changes that could be made to the RHPA, the health professions acts and regulations, although the OCA has no specific concerns in that regard.

(ii) Changes to other Ontario legislation, however, would greatly facilitate interprofessional care at the clinical level for doctors of chiropractic – and these changes would have a major impact on quality of care for patients. One example is the amendment of the Public Hospitals Act to allow doctors of chiropractic to order spinal diagnostic imaging from hospital radiology departments. Chiropractors can order such imaging from independent health facilities, formerly had that right at public hospitals, and the Wells Report recommended the right be restored in the public interest. Another example is amendment of the regulations under the Health Insurance Act to allow direct referrals of patients from doctors of chiropractic to medical specialists. This would materially impact quality and cost of care.

References:

1. Haldeman S, Carroll LJ, Cassidy D et al. (2008) *A Best Evidence Synthesis on Neck Pain: Findings from the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders*, Spine 33(4S):S1-S214..

2. Haldeman S, Dagenais S, (2008) *What Have We Learned About the Evidence-Informed Management of Chronic Low-Back Pain*, The Spine Journal, 8:266-277 and associated papers. Available online without charge at www.elsevier.com.

3. Hildebrandt J, Airaksinen O et al. (2004) *European Guidelines for the Management Of Chronic Non-Specific Low Back Pain*, available at http://www.backpaineurope.org.

4. *WHO Traditional Medicine Strategy 2002-2005* (2002), World Health Organization, Geneva. WHO/EDM/TRM/2002.1

5. *WHO Guidelines on Basic Training and Safety in Acupuncture* (1999) World Health Organization, Geneva, WHO/EDM/TRM/99.1.

6. *WHO Guidelines on Basic Training and Safety in Chiropractic* (2005) World Health Organization, Geneva.

7. *WHO Guidelines on Basic Training and Safety in Osteopathy* - in print.

Appendix A

Questions to Consultation Discussion Guide

1. Please comment on the above statement that HPRAC has used to focus this discussion and initiatives. Are there elements that should be added or removed? If so, what are they?

2. Are there barriers in the *RHPA*, the health profession acts or their regulations that restrict or prevent collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how? (For example, do existing scopes of practice restrict or prevent collaboration among health professionals?)

3. Are there barriers in other Acts or regulations that restrict or prevent collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how?

4. Are there other policy and/or systems issues that act as barriers to collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how?

5. Are there professional cultural issues that act as barriers to collaboration among the Colleges? What steps should be taken to minimize these barriers? Who should provide the leadership to eliminate them? What role can health care associations, including associations whose members are regulated professionals, play in this process?

6. Do you have evidence from your experience that liability issues are a barrier to interprofessional care?

7. Should all regulated health professionals be required to hold minimum professional liability insurance coverage?

8. If so, what would be the minimum expected terms and conditions for that insurance coverage?

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

10. What changes to other Acts or regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?

11. What collaborative policy or program initiatives are needed to ensure support is provided to new Colleges as they are being established?

12. Are there administrative responsibilities within Colleges that could be shared with related Colleges? What barriers exist to shared administration services?

13. Should Ontario introduce a common framework, consisting of common structures and processes, for all regulated health professions to address complaints, investigations or disciplinary matters arising in an interprofessional care setting?

14. If so, what should and should not be included in the common framework?

15. If not, should the *RHPA*, nonetheless, be amended to give individual Colleges greater flexibility to deal with complaints, investigations and discipline arising in an interprofessional care setting within their own already-established structures?

16. If so, what should and should not be addressed in an amendment to the statute? For example, should the *RHPA* be amended to enable Colleges to establish joint committees to deal with complaints, investigations and discipline in respect of issues arising in an interprofessional care setting?

17. Considering reforms in other jurisdictions, what would be the merits of a single complaints model in Ontario? How should such a 'model' be funded?

18. Would the authority to conduct joint investigations following complaints or reports relating to professionals who work in a multidisciplinary setting or practice provide more efficient investigations of such cases?

19. Should Colleges have further authority to collaborate in the disposition of complaints and reports relating to professionals in a multidisciplinary setting or practice?

20. Could such authority contribute to patient safety in interprofessional care?

21. Is legislative change required to accomplish these goals?

22. Would a joint quality assurance program among relevant Colleges enable the Colleges to develop common standards of practice or professional practice guidelines where the same or similar Controlled Acts are shared?

23. Would a joint quality assurance program among Colleges whose members have similar scopes of practice, share the same or similar Controlled Acts, or provide closely related services often involving the same areas of the body, provide opportunities for enhanced continuing competence and exposure to best practices? If yes, how should program standards be jointly set and measured?

24. Is legislative change required to accomplish these goals?

25. Should an independent arm's-length organization facilitate and support collaboration among the Colleges, particularly with a view to the development of common standards of practice and professional practice guidelines?

26. If so, what should its specific mandate include or not include? For example:

- Educate the Colleges, professions and the public on the regulatory model, the health professions and everyone's role within the regulatory system;
- Create common resource repositories (e.g., a data warehouse to track regulatory indicators, such as the level and nature of quality assurance activities, complaints and disciplinary actions and the cost of regulation);
- Research and develop standards of practice and professional practice guidelines, and disseminate best practices;
- Resolve disagreements among professions that share overlapping scopes of practice and the same or similar Controlled Acts;
- Address issues arising from conflicting legislation, and
- Have an oversight function over regulatory bodies, as in the United Kingdom.

27. Are there any existing bodies that could take on responsibilities in this area? If so, what are they?

28. If not, should a new and independent oversight body be formed? If so, how should it be funded?

29. Should the Minister direct the Colleges, using his existing powers under the *RHPA*, to engage in specific collaborative initiatives (e.g., to develop instruments to support interprofessional care)? Why or why not?

30. If so, should the Minister provide financial or other incentives to the Colleges to undertake these activities?

31. Should the Colleges be required to report to the Minister and/or the public on their collaborative activities on a regular basis? Why or why not?

32. Should minimum guidelines, standards and policies concerning matters such as conflict of interest, advertising, record keeping and the consent process be consistent

across all Colleges? If yes, what guidelines, standards and policies could effectively be applied to all regulated health professions? If not, why not?

33. What kinds of structures and processes could facilitate collaboration among Colleges to address issues related to standards of practice and professional practice guidelines for those professions that deal with closely related activities (e.g. dental hygiene, dental technology, dentistry and denturism; or opticianry, optometry and ophthalmology)? (For example, joint colleges, collaborative Councils or independent bodies such as the Council for Healthcare Regulatory Excellence in the UK.)

34. Would the development of a *Collaboration Toolkit*, containing some or all of the elements suggested above, serve to facilitate and support collaboration among the Colleges?

35. If so, what should be included in a *Collaboration Toolkit* and who should be responsible for developing it?

36. Should the standards of practice and professional practice guidelines that the Colleges adopt be legally enforceable? Why or why not?

37. If so, should the Colleges be given statutory rule-making powers (as in New Brunswick) allowing them to enforce the standards of practice and professional practice guidelines that they adopt? Why or why not?

38. What kinds of enforceable rules should the Colleges be able to make without needing Ministerial or legislative approval?

39. What accountability must accompany any rule-making authority?

40. How will greater collaboration among the Colleges serve to enhance interprofessional care at the clinical level?

41. Are any changes to the *RHPA*, the health profession acts or their regulations needed to encourage, require, facilitate and enable interprofessional care at the clinical level? If so, what are they?

42. Should Ontario law have a requirement similar to the one in New Zealand?

43. If so, what should the requirement look like and should there be consequences for a failure to meet the requirement?

Appendix B

CASE STUDIES DEMONSTRATE THE BENFITS OF COLLABORATION

St. Michael's Hospital

Integrating Chiropractic Into a Hospital-based Primary Care Setting: Evaluation of Clinical Outcomes

Principal Investigators: OCA members Deborah Kopansky-Giles, DC (Principal Investigator); Igor Steiman, DC; Howard Vernon, DC.

With: Jim O'Neill, Inner City Health Program Director; Dr. Philip Berger, Chief, Department of Family and Community Medicine; Dr. Heather Boon, Co-Investigator, University of Toronto; Maureen Kelly, Project Manager; Anne-Marie Tynan, Research Assistant; Chad Leaver, Research Assistant. Collaborating Institutions were the Canadian Memorial Chiropractic College, St. Michael's Hospital and the University of Toronto. The OCA was also instrumental in helping to secure the MOHLTC grant.

Funded by: Ontario Ministry of Health and Long-Term Care: Primary Health Care Transition Fund.

Project overview: Chiropractic services are being delivered to an inner city population of Toronto through a partnership between the Canadian Memorial Chiropractic College and St. Michael's Hospital. Chiropractors are on staff, working in a collaborative model of care with the department's other health care providers, including physicians, physiotherapists, pharmacists, nurses, social workers and dieticians.

Goal: To introduce strategies to improve collaboration between chiropractors and physicians in the co-ordinated delivery of interdisciplinary neuromusculoskeletal care in a primary care environment; to facilitate coordination and continuity of care within a patient-centred model; and to improve access to care for patients that otherwise could not afford care.

Results: The project was completed with more than 600 patients accessing care in the chiropractic program. Patients were referred by family physicians, the employee health unit or the Positive Care Clinic (HIV/AIDS). A more than 95% endorsement of "very good" or "excellent" was achieved on the patient satisfaction questionnaires. Clinical outcomes demonstrated important differences in quality of life, including pain reduction, improvement in function and perceived well being. Physician respondents to the physician satisfaction

questionnaire unanimously supported the continuation of the program.

Conclusions: Upon completion of the project, both St. Michael's Hospital and the Canadian Memorial Chiropractic College have committed to continuing the program. Planning is underway at St. Michael's Hospital for a permanent program, embedded in the Department of Family and Community Medicine. Education initiatives have focused on interprofessional education. It is believed that the model created, not only ensures fair access to patients (this project focused on the inner-city community) and patient-centred care, but is also generalizable to other jurisdictions.

Rosedale/Mount Forest/Chatham Collaboration Study
Chiropractic Primary Care Demonstration Projects: Implementing a Model of Interdisciplinary Collaborative Practice

Principal Investigators: OCA member Silvano Mior, DC; and Jan Barnsley, PhD.

With: Heather Boon, PhD; Pierre Cote, DC, PhD; Brian Gamble, MD; Robert Haig, DC; and Project Manager Janet Hayes, RN.

Funded by: Ontario Ministry of Health and Long-Term Care: Primary Health Care Transition Fund.

Project overview: This study, which took place in Mount Forest, Chatham, and is still ongoing at the Rosedale Clinic in Hamilton, builds upon previous Ministry-funded research that proposed attributes for successful collaboration between chiropractors and physicians in the delivery of musculoskeletal care. The model suggests numerous communications strategies to facilitate co-ordination and continuity of care within a patient-centred paradigm. Interprofessional education sessions were a key element of the communications strategy.

Goal: To implement a model for collaboration between different health providers, specifically chiropractors and physicians, in the co-ordinated delivery of interdisciplinary musculoskeletal care.

Results: The study found significant changes in pain and disability outcomes. Patients reported that pain and disability not only improved but that the number of patients taking medication for their condition dropped from 48% to 37%, and medication dosage levels among patients taking medications dropped on average from 12 to 8 doses per week. Education sessions helped to demystify differences between providers, and enhanced understanding of each profession.

Co-location was seen as an important but not essential enabler for success. Patients were pleased with the perceived level of interdisciplinary communication and co-operation between physicians and chiropractors, and felt that it resulted in improved continuity of care.

Conclusions: This study forms the basis of an effective collaborative model of care. A patient-centred, evidence-based approach to including chiropractic care into primary care results in high provider and patient satisfaction. The creation of an interprofessional education program is seen as an important element of a collaborative model. Co-location supports the effectiveness of interdisciplinary collaboration. Access to health care services is enhanced when cost barriers are removed, especially for vulnerable populations.

Carlington Community & Health Services

Integrated Collaboration in Existing Community Health Centres: Adding a Chiropractor to the Team

Principal Investigators: OCA members Jeff Balon, DC, MD; Dirk Keenan, DC; Peter Aker, DC, MSc, and Michael Birmingham, PhD; Pran Manga, PhD; with MJ Garner, MSc; David Moher, PhD, and Carlington Community and Health Services

Funded by: Ontario Ministry of Health and Long-Term Care: Primary Health Care Transition Fund

Project overview: Limited access to health care resources for Canadians of low socio-economic standing contributes to acute musculoskeletal disorders developing into chronic disorders. Delisting from the Ontario health care plan made chiropractic care less accessible to people without private insurance. The effectiveness of chiropractic in a low-income urban population is unknown, because there has been limited study of the ability of chiropractors and traditional medical providers to work in a collaborative team.

Goal: To examine the impact of introducing a chiropractor into a multidisciplinary health care team, both on traditional medical providers and on patients.

Results: Twelve providers were followed for the 18 months of collaboration. The health care teams expressed increased willingness to trust the chiropractor in shared care cases. Providers shifted their views of the legitimacy of chiropractic from neutral to positive. By study’s end, they indicated that chiropractic was

safer than anti-inflammatory medication for treating low back pain.

Patients saw significant positive change in health status for both physical and mental composite score. All patients reported significant reduction in current and typical pain. Those with low back pain and neck pain reported significant reduction in disability.

Conclusions: This study has demonstrated the ability of chiropractors and traditional medical practitioners to work together in a collaborative multidisciplinary team, and to successfully treat clients of CHCs with complex chronic conditions. Primary health care benefits from the inclusion of a chiropractor in a clinic setting.